1 Monday, 2 December 2024
2 **(10.00 am)**
3 **(Proceedings delayed)**
4 **(10.04 am)**
5 **LADY JUSTICE THIRLWALL:** Good morning. I'm sorry
6 to have kept you all waiting. Ms Langdale.
7 **MS LANGDALE:** May I call Sir Duncan Nichol, please.
8 **LADY JUSTICE THIRLWALL:** Sir Duncan, please come
9 forward.
10 SIR DUNCAN NICHOL (sworn)
11 Questions by MS LANGDALE
12 **LADY JUSTICE THIRLWALL:** Do sit down.
13 **MS LANGDALE:** Sir Duncan, you have provided
14 a statement to the Inquiry dated 20 June 2024.
15 Do you have a copy of it in front of you?
16 **A.** I do.
17 **Q.** Can you confirm that the contents are true and
18 accurate as far as you are concerned?
19 **A.** I can.
20 **Q.** You tell us that you have held several senior
21 leadership positions across hospitals at all levels
22 within the National Health Service between 1968 and
23 1994. These included Non-Executive Director in 1989 for
24 the NHS Management Board, Chief Executive of the NHS
25 Management Executive from 1989 to 1994 and chair of the

1 board of the Countess of Chester Hospital NHS Foundation
2 Trust from 2012 to 2020.
3 You have been appointed to other roles if you would
4 like to tell us what those are?
5 **A.** Yes, I was appointed as chairman of the Parole
6 Board for England and Wales and I was appointed as
7 chairman of Her Majesty's Court Service.
8 **Q.** And also deputy chair at the Christie Hospital
9 between 2008 and 2012 and a professional Fellow at the
10 University of Manchester between 1994 and 2004?
11 **A.** Yes.
12 **LADY JUSTICE THIRLWALL:** Professorial Fellow,
13 I think.
14 **MS LANGDALE:** Professorial Fellow, yes.
15 You were, when you were NHS Chief Executive,
16 involved at a time when Beverley Allitt was convicted of
17 four murders, weren't you?
18 **A.** Yes, I was.
19 **Q.** We see from the then Secretary of State, The
20 Right Honourable Virginia Bottomley's addressed
21 information to the Commons, that you were tasked with
22 circulating the conclusions of the Inquiry, so the
23 Clothier Inquiry.
24 You had written to people throughout the health
25 service to be certain that management, nurses, doctors

1 and all concerned study and observe the lessons of the
2 Inquiry.
3 Do you remember doing that in that role?
4 **A.** The -- the latter part of your question?
5 **Q.** Yes.
6 **A.** No, so for one reason and that was that I had
7 left -- left my post within a month or two of sending
8 out the letter that Mrs Bottomley asked me to send to
9 the service and there was no possibility of follow-up
10 action in that time period.
11 **Q.** If we can go, please, to INQ0017497, page 135.
12 It will come on the screen, Sir Duncan.
13 **A.** Thank you.
14 **Q.** We can see the recommendation at 13:
15 "The main lesson from our Inquiry and our principal
16 recommendation is that the Grantham disaster should
17 serve to heighten awareness in all those caring for
18 children of the possibility of malevolent intervention
19 as a cause of unexplained clinical events."
20 The report wasn't published, was it, the Clothier
21 Inquiry report? It wasn't a Public Inquiry with
22 a published report at the time, was it?
23 **A.** I can't recall. It wasn't a Public Inquiry
24 but I can't recall whether it was published.
25 **Q.** But it was circulated to people and you tell

1 us that you yourself read it --
2 **A.** Yes.
3 **Q.** -- at the time?
4 **A.** Yes.
5 **Q.** Do you know who was responsible for
6 implementing this particular recommendation, ie making
7 sure that there was a heightened awareness from the
8 events at Grantham within hospitals?
9 **A.** Yes. This -- this was principally I think
10 directed at clinicians and managers in hospitals. But
11 there were those who -- who supervised the hospitals at
12 the district level and regional level who would have
13 responsibility, I think, for looking to see whether they
14 were doing that.
15 **Q.** During your time as chair of the board, were
16 you aware of any training or discussions around this
17 issue taking place within the hospital?
18 **A.** At the Countess of Chester?
19 **Q.** Mm-hm.
20 **A.** Forgive me if I am -- if I'm not picking
21 everything up straight away. I was aware of the
22 safeguarding training for children and indeed took part
23 in it.
24 **Q.** Did governors take part in that as well?
25 **A.** Governors?

1 **Q.** Safeguarding training?
2 **A.** Yes, yes.
3 **Q.** Did you have that as well?
4 **A.** I did.
5 **Q.** Can you remember if in that training what to
6 do where suspicions about a member of staff arose was
7 discussed or was it training about safeguarding,
8 protecting children from actions of family members?
9 **A.** I -- I remember it predominantly being about
10 protecting children from -- vulnerable children in
11 particular from risks in the community and -- and risks
12 that they might encounter.
13 I don't -- I don't recall the detail of the
14 training to any great extent, I'm afraid.
15 **Q.** That can come down, thank you.
16 Well, you tell us in your statement at
17 paragraph 14:
18 "My understanding of when suspicions or concerns
19 about a member of staff's conduct towards a child should
20 be reported to the police was that the police should
21 investigate when no final assurance had been received
22 from any internal or external review."
23 By all means have a look at paragraph 14 as well as
24 I ask my questions, Sir Duncan. You have set it out
25 there for us.

1 How did you arrive at that understanding?
2 **A.** This was based on my understanding of Speak
3 Out Safely policies and indeed safeguarding policies.
4 I was aware of the responsibilities in general terms of
5 clinical staff at ward level needing to report Serious
6 Incidents. My -- my belief was that they would be then
7 fully investigated and as necessary logged into the
8 system for further enquiry and, if necessary, external
9 enquiry, and if there was still no explanations as to
10 cause of death, then I believe that was timely at that
11 point in time for the police to be -- to be called.
12 I think the board should be party to that decision.
13 **Q.** What was your understanding about where
14 a hospital should report Sudden and Unexpected Deaths of
15 babies, neonates, who should they report those kinds of
16 deaths to?
17 **A.** Yes, my -- my understanding was that that
18 should be reported to the Coroner.
19 **Q.** Any other external bodies?
20 **A.** At the time, I had not -- at the time, I was
21 not thinking of CDOP. Since that time, I am now aware
22 of CDOP.
23 **Q.** What about the local authority safeguarding
24 board or --
25 **A.** I wasn't aware of that at the time.

1 **Q.** So whatever training you had had around
2 safeguarding or child protection, you weren't at the
3 time conscious of working together with the local
4 authority and sharing concerns about children, where you
5 thought they might be being harmed?
6 **A.** Yes, I was generally aware of that but not of
7 the particular named person.
8 **Q.** You mention policies, can we just go to
9 a couple surrounding governance and safeguarding so we
10 have them in our mind. The first is the Code of
11 Conduct, code of accountability in the NHS, INQ0108477,
12 beginning at page 1. I think you highlighted these
13 documents for us, Sir Duncan, or at least some of them.
14 Thank you. If we go to page 5 and we can highlight
15 the role of the chair:
16 "The overall role of the chair is one of enabling
17 and leading so that the attributes and specific roles of
18 the Executive Team and the Non-Executives are brought
19 together in a constructive partnership to take forward
20 the business of the organisation."
21 At the end of that paragraph:
22 "A complementary relationship between the chair and
23 Chief Executive is important. The Chief Executive is
24 accountable to the chair and Non-Executive Directors of
25 the board for ensuring that the board is empowered to

1 govern the organisation and that the objectives, if set,
2 are accomplished through effective and properly
3 controlled Executive action. The Chief Executive should
4 be allowed full scope within clearly defined delegated
5 powers for action in fulfilling the decisions of the
6 board."
7 Obviously an important role for you as chair of the
8 board at the Countess with Mr Chambers as the Chief
9 Executive and you describe in your statement that that
10 relationship was a professional and warm relationship?
11 **A.** I did.
12 **Q.** Would you like to expand upon that?
13 **A.** We met very frequently. I was in the hospital
14 two or three times a week and I would meet Mr Chambers
15 on some, if not most of -- of those days and we had
16 informal discussions. We would -- we would do
17 walkabouts together in-- in the hospital. We would
18 discuss issues of the day and we did so professionally
19 and openly and in a cordial way.
20 **Q.** Did you ever do a walkabout with him in the
21 neonatal unit --
22 **A.** Yes.
23 **Q.** -- during the events with --
24 **A.** Sorry, yes, I did.
25 **Q.** Yes. When, how often and when do you

1 remember?
2 **A.** In the neonatal unit, I -- from memory I would
3 have visited two or three times.
4 **Q.** In a year period or --
5 **A.** No, in a -- no, in two or three -- over a two
6 or three-year period.
7 **Q.** Did anything particularly take you to visit
8 there one day or was it just part of your generic
9 walkabout?
10 **A.** No, it was, it was part of -- Women's and
11 Children's was a separate block, it was part of going
12 part into that part of the -- of the site and looking at
13 different departments at different times in that -- in
14 that particular building.
15 **Q.** When you went into the neonatal unit who did
16 you speak with and what was it like?
17 **A.** I -- I would speak with whoever the -- the
18 nurse in charge on duty at that -- at that particular
19 shift was. If the ward manager was around I would
20 talk -- talk to her and if there was a junior doctor,
21 I would -- I would -- we would talk to the people as
22 I would on any ward visit to any part of the hospital.
23 **Q.** So is there anything eventful or not that you
24 remember from one of those walk rounds the neonatal
25 unit?

9

1 **A.** I remember -- I remember a very busy -- a very
2 crowded unit and I think a sense that oh, we are looking
3 forward to the new unit that we were seeking to fund.
4 **Q.** With more space, the new unit with more space?
5 **A.** Absolutely, with more space.
6 **Q.** Can we have on screen now -- and that one can
7 go down, please -- INQ0009246, page 1. This is the NHS
8 Foundation Trust code of governance that was updated in
9 July 2014. If we go to page 12, it's the next page,
10 thank you, if we see four paragraphs down:
11 "The chairperson is responsible for leadership of
12 the Board of Directors and the Council of Governors
13 ensuring their effectiveness on all aspects of their
14 role and leading on setting the agenda for meetings."
15 The Council of Governors, can you tell us something
16 about how they or that worked?
17 **A.** Yes, they are a group that are representative
18 of the bodies in -- in the local community, from the
19 local authority and from inside the hospital, the
20 hospital had three -- three staff members on -- on the
21 Council.
22 The Council is responsible for appointing the Chair
23 and the Non-Executive Directors. I chaired their
24 meetings and ...
25 **Q.** The Council of Governors, where there were

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1 suspicions or concerns about a nurse, that's not where
2 that would have been discussed; is that right?
3 **A.** No, it isn't.
4 **Q.** Why is that?
5 **A.** That -- that was -- where a named -- a named
6 person is in question, for the same reason that the
7 board didn't discuss that in -- in public meetings, this
8 was confidential to a member of -- a member of our staff
9 and was not discussed outside those -- those
10 confidential surroundings of an extraordinary board
11 meeting.
12 **Q.** What was the reason for the confidentiality?
13 If you were, for example, going to say a nurse and not
14 name the nurse, would that still have been a problem to
15 discuss it in those forums, do you think?
16 **A.** I -- I think, I think it would have been
17 a problem. We took the decision to -- we -- we took
18 very few matters into private session and the only time
19 we had an extraordinary board meeting was in relation to
20 a neonatal death. We felt it was -- we felt it was
21 important to talk about that privately at that time.
22 **Q.** Did that limit, when you look back, the number
23 or pairs of eyes on the problem and the risk that may
24 have been posed, the fact that you kept it confidential
25 to the Executives and extraordinary board meetings only

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1 for the Non-Executive Directors?
2 **A.** No, this -- this is a matter that had, had
3 been raised to board level and on the first occasion,
4 our first extraordinary board meeting, we -- we did
5 invite paediatricians to that meeting.
6 **Q.** We will go to that. Thank you.
7 If we look back at this in front of us, the next
8 paragraph:
9 "As part of their role as members of a unitary
10 board, Non-Executive Directors should constructively
11 challenge and help develop proposals on strategy."
12 If we go to page 17 you can see at A.1.G:
13 "The Board of Directors as a whole is responsible
14 for ensuring the quality and safety of healthcare
15 services."
16 Over the page, page 18:
17 "All members of the Board of Directors have joint
18 responsibility for every decision of the board
19 regardless of their individual skills or status."
20 That is at A.1.K.
21 Just below that:
22 "All Directors, Executive and Non-Executive, have
23 a responsibility to constructively challenge during
24 board discussions and help develop proposals on
25 priorities, risk mitigation, values, standards and

12

1 strategy. As part of their role as members of a unitary
2 board, all Directors have a duty to ensure appropriate
3 challenge is made. They should satisfy themselves as to
4 the integrity of financial, clinical and other
5 information and make sure that financial and clinical
6 quality controls and systems of risk management and
7 governance are robust and implemented."
8 If we go to page 19 at A.3.D:
9 "The chairperson is also responsible for ensuring
10 that Directors and Governors receive accurate, timely
11 and clear information which enables them to perform
12 their duties effectively. The chairperson person should
13 take steps to ensure that Governors have the skills and
14 knowledge they require to undertake their role."
15 We see on page 20:
16 "The chairperson should also promote a culture of
17 openness and debate by facilitating the effective
18 contribution of Non-Executive Directors."
19 Dealing with that point, do you think the
20 Non-Executive Directors had adequate information? You
21 have described how you were meeting with Mr Chambers and
22 others yourself. But did the Non-Executive Directors
23 get as full as information as they might have needed
24 when you look back to make some of the decisions that
25 they were being asked to make?

1 **A.** In general?
2 **Q.** Yes, and particularly we are going to move to
3 the specifics but we are focusing on the issue of the
4 neonatal unit and what the NEDs knew when we come to
5 those board meetings?
6 **A.** In general terms I believe the board -- the
7 board was -- was well informed through the reports we --
8 we always received from the board assurance framework,
9 from specific reports, from financial reports.
10 So I think we -- we covered -- we covered the
11 ground, the reports were there. The reports because
12 they were voluminous, were red flagged to assist all of
13 us to make sure we focused on the things we should be
14 focusing on.
15 I -- I think the board worked well in that respect
16 in general.
17 **Q.** If we go to page 31. 0031, not the internal
18 page number, the INQ number, we see B.5.C:
19 "The responsibilities of the chairperson include
20 ensuring good information flows across the board, the
21 Council of Governors and their committees, between
22 Directors and Governors and between senior management
23 and Non-Executive Directors."
24 What was your understanding of the information that
25 the Non-Executive Directors got from the senior

1 management, assuming they weren't at the meetings that
2 you were at with the senior management?
3 **A.** The -- the Non-Executive Directors were at
4 a number of meetings, not least the sub committees of
5 the board which they individually chaired with the
6 associated Executive Directors that were linked to those
7 meetings.
8 So there was frequent conversation in areas of
9 their -- of their special interest -- as -- as it were
10 through those mechanisms.
11 The -- the Non-Executive Directors were also of the
12 habit of knocking on the door of -- of Executive
13 Directors either for a particular reason or generally
14 just to -- just to call in.
15 **Q.** So you encouraged that that they would call in
16 and speak for themselves, if they wanted to, with --
17 **A.** Yes.
18 **Q.** -- any Exec?
19 **A.** Yes, I was happy they did as much of that as
20 possible. And of course the Non-Executive Directors
21 were also in and about -- in and about the hospital
22 talking to a range of people on -- on the visits that
23 they themselves made.
24 **Q.** That can come down and if we can have instead,
25 please, the risk management strategy and operational

1 policy at the Countess of Chester, INQ0014962, page 1.
2 If we can go to page 3 of this policy. We see at
3 the bottom:
4 "The Board of Directors is responsible for
5 reviewing the effectiveness of risk management
6 throughout the Trust."
7 Over the page, page 4:
8 "... discharges its responsibility via the Quality,
9 Safety and Patient Experience Committee to oversee the
10 ongoing development, implementation and monitoring of
11 all matters relating to quality, safety and patient
12 experience within the Trust."
13 I think you invited people to chair the committees,
14 didn't you --
15 **A.** I did.
16 **Q.** -- from the governors.
17 We know Mr Higgins has suggested -- said in his
18 statement he refers to doing a double take on being
19 asked to chair QSPEC, his lack of medical NHS background
20 was clear and he discussed that with you. Can you
21 remember him saying that?
22 **A.** I -- I don't remember the actual conversation
23 but I understand the point that's being made.
24 **Q.** It sounds sensible, doesn't it, if you have
25 not got that background you might be surprised that you

1 are chairing that one that's --
2 A. No, I don't -- I don't actually -- I don't
3 actually agree with that.
4 Q. So what did you think was the role of the
5 chair in terms of their own understanding of medical
6 matters to chair QSPEC?
7 A. I think -- I think they -- they had the
8 ability to -- to listen, to dissect, to understand the
9 clinical advice that they were receiving from the
10 Medical Director, the Nursing Directors, the Divisional
11 Directors and other department heads that came, had --
12 they had the ability to assimilate, understand the
13 information, and to stand back from it and make -- make
14 sure that issues were taken properly on board by the
15 committee.
16 Q. If we go to page 12 of this document, we see
17 the high-level risk committee's reporting arrangements
18 to the board. We can see there that the Quality Safety
19 and Patient Experience Committee feeds into the Board of
20 Directors?
21 A. Yes.
22 Q. We see The Council of Governors placed above
23 that. The Council of Governors, if it wasn't a safety
24 concern about a member of staff or a risk about a member
25 of staff, would you share other safety concerns with the

1 Council of Governors or not?
2 A. Yes, we -- we would. If, I mean, for example
3 the gross overcrowding of the Accident and Emergency
4 Department posed risk for the -- for the safety of
5 patients. The fact that patients were not flowing
6 through the hospital. The fact that patients couldn't
7 be discharged adequately, these were all issues which
8 connected to the well-being, if not to the direct
9 safety, but to the well-being of patients and their
10 experience in the hospital and we would discuss that
11 with the Council of Governors.
12 Q. Were those minutes public, publicly available?
13 A. Yes.
14 Q. And you tell us the only issue that you had
15 extraordinary board meetings was about the issue this
16 Inquiry is examining, the --
17 A. The extraordinary board meetings, yes. We
18 had -- we had a private meeting about a commercial,
19 a commercial transaction which we felt needed to remain
20 confidential.
21 Q. So you -- you would take a decision if you
22 thought it needed to remain confidential but that was
23 sparingly used; was that a fair summary?
24 A. It was sparingly used, I would be advised and
25 I usually concurred because it was sparingly used.

1 Q. And who advised you about that?
2 A. The Director of Corporate Affairs, Mr Cross.
3 Q. Mr Cross and what was your relationship with
4 him like?
5 A. As -- as with other Executive Directors. As
6 with the Chief Executive. We were a cohesive group that
7 shared -- worked on the principle that there should be
8 no surprises between us.
9 Q. You make the point in your statement that the
10 concerns about the neonatal unit weren't managed through
11 this risk management system particularly. Is that what
12 you understood; that it wasn't referred through the risk
13 management system?
14 A. Yes, the risk management system works, on risk
15 issues being logged at ward level and -- and escalated
16 as appropriate through the divisional structures to the
17 Quality and Safety Committee. That -- that did not
18 happen.
19 Q. But where from February 2016 with the Thematic
20 Review Dr Brearey had raised issues directly with
21 Ms Kelly and I think Mr Harvey had that from about March
22 time, did it matter, really? They were with the people
23 they needed to be with, weren't they, the concerns, and
24 then they could be entered by those people into Risk
25 Registers or in conjunction with Ms Millward if they

1 wanted to, couldn't they?
2 A. They could have done. They perhaps could have
3 done both things, the other being themselves to take
4 those matters straight to the Quality and Safety
5 Committee.
6 Q. In terms of -- let me take you to the
7 documents where we do see them logged as risks or see
8 this issue broadly logged as a risk. If we can go,
9 please, now -- that document can go down, it is
10 a different one -- INQ0004657, page 1.
11 We see there, at the top:
12 "Potential damage to reputation of neonatal service
13 and wider trust due to apparent increased mortality
14 within the neonatal unit."
15 That was entered on 11 July 2016.
16 Did you ever see it entered on the Risk Register
17 like that, Sir Duncan?
18 A. No, I -- I didn't view the Divisional Risk
19 Registers and I did not see that reference.
20 Q. What do you think about the risk that you were
21 discussing by July 2016 being described in that way?
22 A. I think it's inappropriate.
23 Q. Why?
24 A. I don't think a matter of safety, patient
25 safety and the explanation of that should present any

1 reputational risk to the hospital. I think it raises
2 important questions of how we communicate with the
3 community, in the case of neonates, with the parents.
4 But I don't think it's a reputational risk at all.
5 **Q.** It's also described as an apparent increase,
6 when it was known by then that there was an increase,
7 wasn't there, this is a small number and it's a small
8 number of unexpected deaths that was greater than the
9 number the year before and the year before that. That
10 was known?
11 **A.** I don't think there was any doubt about --
12 about the fact that there was an increased mortality.
13 **Q.** Do you think whoever scripted this --
14 Ms Townsend tells us she didn't but whoever scripted it,
15 that did not transparently state what the issue was or
16 what the risk was?
17 **A.** I don't think that does. It -- it doesn't
18 refer to the spike in deaths and the number of deaths at
19 that point in time.
20 **Q.** Also that there was a risk to babies that was
21 being assessed in terms of a nurse who was suspected of
22 causing harm and where she was in the hospital at that
23 time. I know at this point she wasn't back on the ward
24 but that was the risk, wasn't it, a risk of --
25 **A.** I am not -- I'm not sure of the timings of --

1 of the association at that point with -- with this
2 entry.
3 **Q.** If it was the case, that she had been moved
4 from night to day shifts and then moved to a Risk Team,
5 so there were movements within the hospital of a nurse
6 because of a suspicion, that's the risk, isn't it,
7 that's being managed, the risk of the nurse to baby
8 safety?
9 **A.** Being redeployed?
10 **Q.** Yes.
11 **A.** That is the management of the risk.
12 **Q.** That can come down, please, and if we can have
13 INQ0014818, page 157. What this is, Sir Duncan, is the
14 board's assurance framework presented to the
15 Board of Directors on 6 September 2016.
16 So this is how you, coming through the board
17 assurance way, see the risk of the neonates.
18 So if we look at the box on the side, on the
19 right-hand side at the bottom, G2, NNU Risks?
20 **A.** Just scroll.
21 **Q.** It will be highlighted for you, it's very
22 difficult to see.
23 **A.** Yes, no.
24 **Q.** But that's where it appears.
25 **A.** Yes, I have.

1 **LADY JUSTICE THIRLWALL:** Are you able to see that?
2 **A.** Yes.
3 **LADY JUSTICE THIRLWALL:** That's better now.
4 **MS LANGDALE:** And we see there:
5 "Action plan in place.
6 "Weekly Exec monitoring re operational activity and
7 risks. External review to commence 1 September 2016."
8 If we go up further up in the table, the zoomed in
9 one can come down, and if we look at the table at the
10 top, "Potential consequences of the risk", please can we
11 enlarge that box.
12 Sorry, it's not that one, it is the one with the
13 four -- PC1, PC2, PC3 and PC4.
14 They are the four consequences. That is how they
15 are listed, the consequences:
16 "Non compliance with regulatory and conditional
17 contracts, risk to registrations and licence, poor
18 patient experience, impact on Trust's reputation, breach
19 of monitors' terms of authorisation."
20 Again we see "Poor patient experience, impact on
21 Trust's reputation"?
22 **A.** Yes.
23 **Q.** Do you know as a category why those two are
24 linked in that way?
25 **A.** No. I mean, it's not -- it's not a frame --

1 a frame of reference to me that brings those two items
2 together.
3 **Q.** No. Actually the poor patient experience
4 might understate that in the context of a hospital,
5 there's a risk of serious injury and death, isn't there,
6 in -- there is a risk of serious injury and death if
7 mistakes occur and certainly if there is deliberate
8 harm, that is the risk you are talking about, risk of
9 injury and death?
10 **A.** Yes, those risks exist.
11 **Q.** That can come down, thank you, and we will
12 move, if we may, to the safeguarding policy and that's
13 INQ0009485, page 1. We see at page 3, an Executive
14 introduction to the policy, prepared by Alison Kelly the
15 Director of Nursing, Quality and Environment and the
16 Executive Lead for Safeguarding Children in 2015.
17 Pausing there, did you ever have a conversation
18 with Ms Kelly about safeguarding in relation to the
19 neonates?
20 **A.** No, I didn't.
21 **Q.** Never raised by her?
22 **A.** Not a conversation about safeguarding.
23 **Q.** We see in paragraph 1:
24 "Every adult has a responsibility to protect
25 children and as employees of the Trust we are duty bound

1 always to act in the best interests of a child about
2 whom we may have concerns."
3 Page 30 of this policy, INQ0009485, page 30, we see
4 there under "Speak out Safely: Raising Concerns" it's
5 made clear:
6 "It is the responsibility of all members of staff,
7 medical, clinical or non-clinical, to ensure that high
8 standards of care, treatment and services are
9 prioritised at all times for patients and that they are
10 safely in our care."
11 It continues further down:
12 "Managers have a particular responsibility to
13 protect patients and to handle concerns about their care
14 in a way that will encourage the voicing of genuine
15 misgivings, while at the same time protecting staff
16 against unfounded allegations."
17 So within the safeguarding policy recognised that
18 you need people to speak out with any misgivings about
19 patient safety?
20 **A.** Absolutely.
21 **Q.** Did you at any time think that the fact that
22 the neonates were tiny babies should have afforded them
23 an even greater protection than vulnerable adult
24 patients in the hospital. All patients who are
25 vulnerable need protection, but children have particular

1 protections afforded to them under safeguarding?
2 **A.** That is my instinct, they can't speak for
3 themselves --
4 **Q.** No.
5 **A.** -- and they would need someone to speak for
6 them so they are in a more disadvantaged position from
7 that point of view.
8 **Q.** And at the beginning of life, with all the
9 hope and expectations that brings for families?
10 **A.** Yes, I agree with you.
11 **Q.** Did you doubt at any time that Doctors
12 Brearey, Jayaram and the other Consultants had genuine
13 misgivings and worries about the nurse?
14 **A.** About?
15 **Q.** Did you doubt at any time that they had
16 genuine misgivings, the doctors, about the nurse?
17 **A.** No, I didn't doubt that.
18 **Q.** Right. You say that with clarity. Was that
19 your understanding, that they --
20 **A.** Yes, I genuinely felt that, that they had
21 those -- those misgivings.
22 **Q.** That can come down. Can I have, please, on
23 the screen INQ0101079, page 60. The Inquiry instructed
24 Sir Robert Francis, King's Counsel, to provide an expert
25 report, Sir Duncan, and this is a helpful summary

1 provided by him from the NHS England issues guidance on
2 Safeguarding.
3 This was a framework assurance framework in place
4 in March 2013 and updated in August 2019 and we see at
5 F:
6 "Information must be shared to protect children and
7 to prevent or detect crime."
8 If we look at the next one at G:
9 "Where it is considered a member of staff poses
10 a risk to children or might have committed a criminal
11 offence against one or more children information must be
12 shared with the local authority designated officer."
13 So the safeguarding test was very clear there, that
14 it wasn't a question of having to investigate when there
15 was no final assurance from any internal or external
16 review, but information should be -- must be -- must be
17 shared to protect children to prevent or detect crime
18 and particularly where it's considered a member of staff
19 poses a risk or might have committed a criminal offence.
20 You didn't need strict proof or certainty or
21 excluding all other possibilities before going to the
22 police.
23 Is that something that anybody told you at the
24 time? This was in place since 2014 but did anyone make
25 that clear to you? This was 2019 but Sir Robert said

1 I have no reason to --
2 **LADY JUSTICE THIRLWALL:** You may have answered, did
3 you say no?
4 **A.** I didn't, I didn't, I didn't hear that I was
5 invited, I was wondering whether I had been.
6 **LADY JUSTICE THIRLWALL:** Yes. No, no, you had
7 been. We will just take that again.
8 **A.** Thank you, my Lady.
9 **LADY JUSTICE THIRLWALL:** We hope we have got the
10 microphones suitably adjusted but we do understand
11 difficulty, so if there is a problem, please just say.
12 **A.** Thank you.
13 **MS LANGDALE:** Sir Duncan, highlighted on the screen
14 in front of you, F and G.
15 **A.** Yes.
16 **Q.** This is what 2019 guidance says and,
17 Sir Robert tells us "I have no reason to believe the
18 2013 edition didn't contain similar requirements".
19 Did anyone discuss this kind of test or when it was
20 appropriate to report the concerns the Consultants had
21 about Letby to the local authority or even the police?
22 **A.** No one discussed the gist of F and G with me.
23 **Q.** That can come down now, thank you. So we can
24 be confident, as you told us, your understanding at
25 paragraph 14 in your statement was what you thought was

1 the case?
2 **A.** That -- that was my -- that was my
3 understanding.
4 **Q.** You say at paragraph 26 of your statement, if
5 you go to that, Sir Duncan:
6 "As chair of the board I would have been expected
7 to be informed if major concerns were shared with any
8 external organisation."
9 You tell us you were aware that Stephen Cross
10 approached the Coroner about the deaths.
11 **A.** Yes.
12 **Q.** I think you told us earlier, but can you
13 clarify, were you ever asked about whether they should
14 be telling the specialist Commissioners or NHS England
15 or any other external body about the deaths?
16 **A.** There were no references to me for -- with
17 regard to those bodies.
18 **Q.** You comment at paragraph 35 what your
19 expectations were of various board members. Can you
20 tell us what your expectation was of Mr Harvey as the
21 Medical Director between July 2012 and August 2018?
22 **A.** That the Medical Director, Mr Harvey, would
23 be -- would be leading on -- on the development of -- of
24 clinical policies in the hospital. He would be advising
25 and in a leadership position with regard to clinical

1 governance in -- in the hospital which embraced issues
2 of -- of safety of patients in the hospital.
3 He had many other responsibilities in relation to
4 staffing the hospital, not least at Consultant and
5 junior medical levels. But I would draw those out.
6 **Q.** You say here:
7 "... also to maintain excellent professional
8 relationships with the doctors at the Trust."
9 **A.** Absolutely.
10 **Q.** How did he do that generally?
11 **A.** I don't know how he did it but he -- you can't
12 do it without -- without close contact, without
13 communication, without being in the presence of doctors
14 and in their workplaces.
15 **Q.** You refer to likewise for Alison Kelly with
16 the nursing teams. What did you expect from
17 Alison Kelly in relation to the nursing teams?
18 **A.** Again, a Director of Nursing is -- is
19 responsible for -- for the nursing service. That is the
20 effectiveness, the quality, the appropriate staffing of
21 the nursing service, for the development of nurses, for
22 the training of nurses and in the role that she had as
23 Director of Nursing for the safeguarding of patients in
24 the hospital.
25 **Q.** What did you think the relationships were like

1 when you were chair of the board between the doctors and
2 nurses generally at the hospital?
3 **A.** Generally, I -- I thought, thought we had
4 a happy team that, that worked together. You will
5 always find a hot spot or two somewhere. But in
6 general, I thought we had a cohesive team that was
7 working as a team across professions and with clinical
8 and diagnostic departments and generally.
9 **Q.** You say here at paragraph 36 what you saw
10 Mr Chambers's role was as CEO. Can you just expand on
11 that for us, please?
12 **A.** Mr Chambers in the end was -- was the
13 accountable officer for the operations of, of the
14 hospital. So anything in the hospital would be a matter
15 of oversight and management on the part of the Chief
16 Executive, Tony Chambers, in this case.
17 **Q.** You comment about Mr Cross, Stephen Cross, at
18 paragraph 38. What did you think in your Facere Melius
19 interview, that is the interview you and others did --
20 **A.** Yes.
21 **Q.** -- with the organisation you instructed to
22 look at governance and generally events at the Countess
23 of Chester. What did you think about the quality of
24 note-taking in respect of these neonatal reviews and
25 meetings that you had all been having?

1 **A.** I didn't see the contemporary notes at the
2 time but I observed when I had that documentation
3 available to me through the Inquiry, I -- I thought that
4 wasn't good enough.
5 **Q.** And Mr Cross's notes, because they were, what,
6 short and not complete?
7 **A.** Well, they were difficult to understand, not
8 all of them made it easy to connect the point to -- to
9 who was taking action. There were -- they were short
10 but I found -- I found them difficult to -- to follow.
11 **Q.** You say at paragraph 9:
12 "In general, the records of meetings were well
13 documented. Looking back at the handwritten notes
14 relating to the neonatal deaths, my view now is that
15 they should have been typed up with a clear chronology
16 and an action plan with clear individual
17 responsibility."
18 You felt that that didn't happen; that they weren't
19 the action plans followed up with accountability for who
20 was doing what, is that what you think?
21 **A.** From the -- from the written notes it wasn't
22 entirely clear to me who was following up and I had no
23 sense of whether that was happening or not at the time.
24 **Q.** At paragraph 42, you say:
25 "In my view, it was primarily the people and not

1 the structure or processes in place at the Trust, which
2 were the overriding factor in this tragedy."
3 **A.** Yes.
4 **Q.** Would you like to expand on that?
5 **A.** Yes. I mean, we had -- we had the systems, we
6 had a multitude of systems around governance, around
7 risk management, around safeguarding and -- and
8 I thought they were sound and robust documents and
9 policies and systems.
10 My -- my point was that if people are not observing
11 them or following them, in -- in the way that they
12 should or -- then -- then they are not, they are not
13 I nearly said worth the paper they are printed on, I am
14 trying to find a better expression.
15 But the important thing was it matters that people
16 respond appropriately to the policies. The example of
17 course is of not logging and of not escalating. The
18 policies were designed for that. If the people weren't
19 operating the policies, then the policies were not
20 helpful to the organisation and in this instance,
21 I thought there were failures in following the policies
22 by people.
23 **Q.** Did anyone, for example, tell you whether the
24 Speak Out Safely policy had been followed in this case
25 when the doctors had raised concerns? Did you know

1 whether that policy had been followed in practice?
2 **A.** I didn't know that.
3 **Q.** Did you know that policy sufficiently well to
4 ask them if they were following that, to ask the
5 Executives: are you following that policy?
6 **A.** Yes, I knew -- I knew that the policy -- to
7 the extent that it was an obligation, a duty, without --
8 without fear to report concerns as individuals might
9 have seen them or suspected them in the conduct of
10 colleagues.
11 I know -- I knew that was the purpose of the
12 policy.
13 We were aware at board level of reports of how the
14 policy was developing and I -- I felt that it was being
15 followed in general.
16 **Q.** You say in your statement that at paragraph 49
17 you would have expected the neonatal deaths to be
18 discussed at the Quality Safety and Patient Experience
19 Committee and I am going to take you, if I may,
20 Sir Duncan, to the three references where we find these
21 issues raised in that forum.
22 I'm not sure if you are there for all of the
23 meetings where they are raised, we'll see. But we'll
24 see how they are raised. So the first one is
25 INQ0003204, page 1.

1 So this is a meeting held on 14 December 2015. And
2 we know of course now the deaths of A, C, D, E and I
3 have occurred by then. We have at page 5 of this
4 a report from Julie Fogarty about a review of neonatal
5 deaths and stillbirths, but both Ms Fogarty and
6 Mr McCormack have been clear with the Inquiry that this
7 was largely an obstetric review?
8 **A.** It was.
9 **Q.** Yes. So tell me what your understanding was
10 about that review, the Fogarty or Brigham Review,
11 whatever you choose to call it?
12 **A.** Exactly that, that the concentration of that
13 review was on the obstetric service and did not raise
14 concerns. The Director of Nursing is reported as saying
15 that she was -- she was comfortable with that report.
16 But I -- I personally didn't see references in that
17 report to -- as I recall it to -- to the neonatal
18 deaths. It was an obstetric report.
19 **Q.** You tell us in your statement at paragraph 54
20 an external reviewer as far as you were aware had
21 commended the Trust's reviews process.
22 Did you get reassurance from that?
23 **A.** I would have done.
24 **Q.** That can come down, please, and can we have
25 INQ0003178, page 1. This is a QSPEC meeting on

1 19 September. We see on page 2, so we are in 2016 now.
2 **A.** Yes.
3 **Q.** We see here this is Mr Harvey talking about
4 the RCPCH having given a verbal update on the recently
5 completed review:
6 "The external Review Team had not raised any
7 immediate concerns and the Trust was awaiting the final
8 report."
9 We know of course Mr Harvey -- that in fact the
10 Trust -- the RCPCH rather had recommended an immediate
11 HR process to investigate the allegation made against
12 a nurse.
13 Did you know that at the time of that update being
14 given?
15 **A.** That was not made known to me at any time.
16 **Q.** So do you regard "the external Review Team had
17 not raised any immediate concerns" as accurate when in
18 fact they had recommended an immediate HR process to
19 investigate the allegation --
20 **A.** No.
21 **Q.** -- made?
22 That can go down, please. The last meeting that's
23 mentioned at QSPEC, Monday, 20 February 2017,
24 INQ0002653, page 1. If we can go to page 4, I think you
25 are at this meeting, Sir Duncan, as well.

1 I will give people time, including you, Sir Duncan,
2 to read that summary of the review.
3 **A.** Yes. (Pause)
4 Thank you.
5 **Q.** So at this time, you are being told the Trust
6 had been invited to a meeting with specialist
7 commissioning to discuss the review and documentation
8 had been shared with the Coroner and Deputy Coroner, as
9 you told us earlier in your statement.
10 What did you understand was going to be done where
11 it says:
12 "A meeting has been arranged to review all the case
13 reviews with the paediatricians and the network and
14 following this, meetings with the parents concerned will
15 be set up to discuss the individual cases."
16 In terms of "parents concerned", what did you
17 understand that referred to?
18 **A.** My understanding was that the parents would be
19 brought up to speed with what -- what information -- the
20 information we had received as a result of the -- of the
21 RCPCH Review in relation to in the context of that --
22 their own baby.
23 **Q.** In terms of the entries that we have just gone
24 to, do you think in fact the Quality and Patient Safety
25 Committee had very much or adequate information

1 surrounding what was happening on the neonatal unit and
2 the issues that were being discussed?
3 **A.** The -- the matter hadn't -- hadn't been
4 escalated to the -- to the Quality and Safety Committee
5 in -- in advance of the board meeting in July 16 at
6 which point the board took over.
7 **Q.** Yes. So what we see is effectively they
8 weren't discussing the issues that we are going to come
9 to when we come to the board minutes.
10 **A.** They hadn't --
11 **Q.** That was you and the board finally and not
12 through this committee.
13 Looking back, do you think more should have been
14 discussed at this committee or not?
15 **A.** Yes, the committee should have been -- should
16 have been alerted from early stages about the -- the
17 increase in, in mortality in -- in -- in my view.
18 **Q.** Do you think each unexpected baby death should
19 have been referred to that committee for discussion or
20 not?
21 **A.** I'm not sure.
22 **Q.** But a cluster of deaths by the time of --
23 **A.** Yes.
24 **Q.** -- those three deaths in three weeks, what we
25 see of course is the stillbirth in neonatals combined in

1 that first reference. But the neonatal deaths in
2 a different unit and in rapid succession would you have
3 expected those to have been discussed --
4 **A.** Yes, cluster, yes.
5 **Q.** -- more thoroughly.
6 Was in your experience QSPEC better at giving
7 actions and follow-ups and making sure that happened?
8 Was QSPEC as a committee effective in stating actions
9 and making sure the actions were followed up or not?
10 **A.** I'm really sorry. I don't know quite sure
11 what's happening, but I missed the early part of that.
12 **LADY JUSTICE THIRLWALL:** Let's try it again.
13 **A.** Thank you.
14 **MS LANGDALE:** This committee.
15 **A.** Yes.
16 **Q.** In your experience of it generally?
17 **A.** Yes.
18 **Q.** Was it effective in following up action plans?
19 **A.** In general that was my experience of it.
20 I was clearly not closely connected to the actions of
21 the Nursing Director and the Medical Director and indeed
22 the chair outside of the meetings. But my sense was
23 that matters were followed up as per the action plan.
24 **Q.** So if those early clusters of deaths had been
25 reported to that committee, do you think the action

1 plans and who was responsible for what might have been
2 followed up more effectively?
3 **A.** Yes.
4 **Q.** Can you explain why these deaths weren't
5 discussed at this meeting, who set the agenda for these
6 meetings?
7 **A.** The agenda was set by -- jointly really by the
8 Director of Nursing and the Medical Director with the
9 chair, I can't -- I can't explain.
10 **Q.** That can come down then and let's go to the
11 30 June meetings that you mentioned and the first
12 meeting you have, we can have it on screen, you may not
13 need to go to it but it's INQ0003361, page 1.
14 We know, Sir Duncan, on 30 June you have a meeting
15 with the Execs and then you have a meeting on the same
16 day with the paediatricians and some of the Execs?
17 **A.** Yes.
18 **Q.** Two meetings on one day. This is the first
19 meeting. You can have these notes to assist you if they
20 do and there is another page of them. You also refer to
21 it from page 58 onwards in your statement.
22 Can you tell us about this meeting with the Execs?
23 **A.** Yes. In my understanding my recall of this
24 meeting was that it was in anticipation that there would
25 be the extraordinary board meeting to follow in a couple

1 of weeks --
2 **Q.** Mmm mm.
3 **A.** -- in preparation and in anticipation.
4 **Q.** Who -- tell us what was discussed in this
5 meeting and tell us when you first became aware of this
6 downgrade to a Level 1 and what it meant. Was there any
7 discussion before this meeting, how did this come to
8 your attention?
9 **A.** No, for me that was the first time that I had
10 heard about the unit being downgraded to Level 1.
11 **Q.** So who called this meeting?
12 **A.** I don't know who called it. I didn't.
13 I wasn't -- I didn't chair it. Mr Cross and Mr Chambers
14 I think, I think would have been responsible.
15 But the answer is I don't know. I don't know who
16 called the meeting.
17 **Q.** But we see at the beginning:
18 "Mr Harvey: we cannot accept that the unit is safe
19 despite there ..."
20 Then the notes finish
21 And you say:
22 "Did they say they would go to Level 1? Is that
23 just Special Care Baby Unit?"
24 So what did you think when Mr Harvey said "we can't
25 accept that the unit is safe", what did you think he was

1 saying about the unit?
2 **A.** I think he was saying that we had commissioned
3 an external review to seek to understand and to find
4 answers to the questions that we hadn't got answers
5 about; namely the unexplained and unexpected deaths.
6 And until that review reported, we couldn't be sure.
7 **Q.** When did they first tell you about the
8 unexplained and unexpected deaths?
9 **A.** This was -- trying to separate what I knew
10 then from what I know now, my first knowledge of the
11 unexplained deaths was at the -- at the board meeting
12 itself in July 16 and through -- via these preparatory
13 meetings.
14 **Q.** So at this point, you have been told that the
15 review supports going down to Level 1, is that your
16 understanding?
17 **A.** Yes.
18 **Q.** Then we see Alison Kelly say:
19 "How do we manage the nurse and unit?"
20 Looks like:
21 "Could nurse go to police/NMC?"
22 What was said then?
23 **A.** I don't recall that conversation.
24 **Q.** If we go over the page of the notes. There's
25 reference to Child A's baby death and an Inquest, obtain

1 referral for death. Did you remember that baby being
2 discussed or not?
3 **A.** I'm afraid I don't.
4 **Q.** Mr Chambers says:
5 "Can we decide what we are doing? Review
6 two weeks. Staff member ..."
7 And it's referred to:
8 "Clear articulation of Consultants' concerns."
9 That action appears to be Sue Hodkinson.
10 Do you remember what you were being told at this
11 meeting about the Consultants' concerns about a staff
12 member or not?
13 **A.** No, the first clear recollection I have of
14 that is when the Consultants themselves talked to the
15 board at the extraordinary meeting.
16 **Q.** If we go further down you say:
17 "Commission in-depth review. It will take as long
18 as it takes. Unit will not be operating the same as it
19 is now. During period nurses will have to be redeployed
20 or visibility ..."
21 It's difficult to see what's said there, can you
22 remember?
23 **A.** I haven't got this at all in front of me.
24 **LADY JUSTICE THIRLWALL:** You haven't got it in
25 front of you?

1 **A.** No.
2 **LADY JUSTICE THIRLWALL:** I'm sorry.
3 **A.** I have got one page.
4 **MS LANGDALE:** Yes. If you look where it says "DN"
5 three quarters of the way down, can you see it
6 highlighted in green?
7 **A.** Yes.
8 **Q.** That is you, that is your contribution there.
9 **LADY JUSTICE THIRLWALL:** If you just want to take
10 a minute to read through it.
11 **A.** Got it.
12 (Pause)
13 Yes, got that.
14 **MS LANGDALE:** Does that remind you what you may
15 have been saying there?
16 **A.** I -- just -- just what it says in the, in the
17 sense that we needed to take some actions which would
18 involve the redeployment of -- of the nurse, the
19 downgrading of -- of the unit which I think was
20 happening and -- and a need to find out what was going
21 on through external -- external help.
22 **Q.** Rather than one nurse, does it look like you
23 are saying during the period nurses will have to be
24 redeployed -- that you are more worried about all of the
25 nurses in the unit or not; you can't remember?

1 **A.** No, I don't remember talking about nurses or
2 a nurse.
3 **Q.** All right. So at the very end:
4 "World going forward. Bristol review report."
5 If we can just highlight the contribution at the
6 end. Can you shed any light on that or not?
7 **A.** I think my reference would have been I think
8 then to the complexity and challenge of -- of
9 communications in relation to matters such as this.
10 **Q.** What sort of challenge in communications?
11 **A.** Just that we needed to be extremely well
12 prepared, what -- what did we need to communicate? And
13 how could we be clear about the messages that went out
14 to -- to the public, to mothers; we had to get that
15 right.
16 **Q.** That can come down, please, and if we can have
17 instead INQ0006023, page 1. These are notes of the next
18 meeting, later in the day.
19 **A.** Yes.
20 **Q.** When you do meet with some of the
21 paediatricians and Mr McCormack.
22 **A.** Yes.
23 **Q.** If we go to page 4, Dr Ravi Jayaram's
24 concerns, we can highlight there and Jim McCormack at
25 the bottom as well.

1 What's being discussed, if I can help you,
2 Sir Duncan, is whether the Royal College should be doing
3 a review or not and it looks like Dr Jayaram is raising
4 concerns about a particular member of staff and
5 Mr McCormack's saying: I don't think it's fair to ask
6 the College to do the forensic review, it's not what the
7 College does.
8 Can you remember that now?
9 **A.** Only -- only as reminded by the note.
10 **Q.** Right. So we should take it from the notes.
11 You don't remember that that was the issue being
12 discussed?
13 **A.** No.
14 **Q.** Can you remember the impact of anything the
15 paediatricians said about the concern of a nurse now?
16 Do you remember that or not?
17 **A.** I -- I don't, I don't have a clear recall of
18 this, of this meeting at all.
19 **Q.** We do know from Ms Hodkinson's note which was
20 a fuller note that Mr McCormack said: this is
21 a Beverley Allitt/Shipman situation being raised or
22 something like that. He mentions Beverley Allitt case
23 and the Shipman case.
24 Did that make you sit up when you heard that?
25 **A.** I didn't -- I don't recall Dr McCormack saying

1 that.
2 **Q.** If we go to page 6, finally. If you look
3 there, the reference to "sweet spot" and you appear to
4 be saying:
5 "The review has to take its course, say two months.
6 May get some glimpses ..."
7 Or something. Then it says:
8 "May be inconclusive, may say unthinkable."
9 So it looks as though you are saying the review
10 could take two months and it may say the unthinkable.
11 And there's reference we know, the doctors talk about
12 thinking the unthinkable, that someone might be killing
13 or harming babies.
14 Can you remember that, "may say the unthinkable"?
15 You thought that that review might do that?
16 **A.** I remember -- I remember thinking will this
17 review give us the answers we need? I -- I don't
18 remember, I don't remember anything else from that
19 meeting.
20 **Q.** It looks as though you have landed on, say,
21 two months; you know, it might take two months?
22 **A.** Yes.
23 **Q.** We know, and I am not going to take you to it,
24 Sir Duncan, there is another meeting of QSPEC on Monday,
25 15 August. For everybody's reference it is INQ0003176,

1 page 6 but we don't need to go to it, where Mrs Rees
2 advises it could take up to six months for the report to
3 come from the RCPCH. So it did take longer, didn't it,
4 than this meeting anticipated when you said two months?
5 **A.** It did.
6 **Q.** If that note can come down, please --
7 **LADY JUSTICE THIRLWALL:** I'm sorry, Ms Langdale,
8 just before we leave that note. If you would just look
9 at the same page and then three lines down from "may be
10 inconclusive".
11 I just want to ask you if you can remember what you
12 meant here. It looks like:
13 "Difficult between two weeks (nurse) and review
14 (six weeks)."
15 I think earlier in the notes of the meeting there's
16 a note about the fact that she's on two weeks' annual
17 leave.
18 **A.** My Lady, I can't -- I can't -- I can't
19 remember -- I can't remember this. If it had been more
20 expansive it might have refreshed my memory today.
21 **LADY JUSTICE THIRLWALL:** It doesn't now.
22 **A.** I'm sorry.
23 **LADY JUSTICE THIRLWALL:** I mean, we're just really
24 trying to understand what you -- what this is trying to
25 record.

1 **A.** Yes.
2 **LADY JUSTICE THIRLWALL:** I suppose it's simply
3 there's two weeks when she's on leave and the review is
4 going to take six?
5 **A.** I -- I -- I don't know what the two weeks is
6 referring to.
7 **LADY JUSTICE THIRLWALL:** The fact that she was on
8 annual leave.
9 **A.** Okay.
10 **LADY JUSTICE THIRLWALL:** We see that earlier in the
11 meeting.
12 **A.** I don't remember this, I don't remember.
13 **LADY JUSTICE THIRLWALL:** You don't remember it at
14 all. All right.
15 **A.** This part of the meeting.
16 **LADY JUSTICE THIRLWALL:** We will make of it what we
17 will. Thank you.
18 **MS LANGDALE:** That can come down, please.
19 If we can have INQ0003174, page 1. This is just
20 a list of names, Sir Duncan, and the same overleaf.
21 This was the Silver Command that was set up
22 in July, so this is 8 July.
23 **A.** (Nods)
24 **Q.** Can you tell us anything now from memory what
25 the Silver Command was looking at? You are listed as

1 being there --
2 **A.** Yes.
3 **Q.** -- in that boardroom with about 36 people in
4 there or being given jobs. Can you remember what that
5 was all about?
6 **A.** I -- I think it was in anticipation of the --
7 the actions that would be taken in July and August. A
8 -- a great many of them would have great effect on the
9 hospital, on the community, on the mothers and we just
10 needed to -- to prepare for what would be a very
11 demanding communications exercise, an exercise in making
12 sure that what followed from the decisions that were
13 taken in July were -- were carefully thought through.
14 **Q.** What were the key messages that needed
15 communicating at that time?
16 **A.** At -- the messages that I think needed, needed
17 to be communicated were: the closure, the closure of
18 the -- the downgrading, the downgrading of the unit to
19 a Level 1. I thought it was also important for people
20 to understand that we were looking at seeking external
21 help so that we could understand events in the neonatal
22 unit.
23 That was as far as I think the communications
24 should extend.
25 **Q.** Did they show you anything that was going to

1 be published in the press about communications, did you
2 get to see that in advance?
3 **A.** I don't remember seeing that in advance.
4 **Q.** Who would sign off communications or press
5 releases on such an important topic?
6 **A.** I would -- I would expect the Chief Executive
7 to sign off.
8 **Q.** But you met him quite frequently. Would he
9 share a draft with you or a final draft with the press
10 or not?
11 **A.** He didn't share that with me.
12 **Q.** Did you understand at this time two TPN bags
13 relating to the deaths of two babies, O and P, were
14 stored in the hospital in case they needed to be
15 forensically examined later? Did you understand at this
16 time that those bags had been retained in case they were
17 needed by the police later on?
18 **A.** No, I didn't.
19 **Q.** If someone said to you "we are keeping these
20 bags in case", what would you have thought?
21 **A.** I -- I would have asked the question but
22 I would have said well, you know, "Why? Can you
23 explain?"
24 **Q.** And if someone said: well we are just waiting
25 for final assurance as to whether there's a natural

1 cause of death here, or something similar, would you
2 have accepted that and said just wait until you have got
3 that final assurance before you go to the police?
4 **A.** I can't be sure, but I think I likely would
5 have accepted that.
6 **MS LANGDALE:** Thank you. I think that's probably
7 a good moment to break before we go to the
8 Board of Directors meetings.
9 **LADY JUSTICE THIRLWALL:** Thank you. So we will
10 take a break now for 15 minutes.
11 **A.** Thank you.
12 **LADY JUSTICE THIRLWALL:** We will start at 25 to 12.
13 **(11.19 am)**
14 **(A short break)**
15 **(11.35 am)**
16 **MS LANGDALE:** Can we have on the screen, please,
17 INQ0103147. Sir Duncan, just picking up what you were
18 saying earlier about communications being important,
19 this is the communication that followed the downgrade.
20 Can you just have a look for us, please.
21 **A.** Yes.
22 **Q.** That communication didn't make reference, did
23 it, to Sudden and Unexpected Deaths or that the doctors
24 or paediatricians were concerned and suspicious about
25 the actions of a nurse?

1 **A.** No.
2 **Q.** But rather it says: some of our most poorly
3 babies with high dependency needs in some way may have
4 increased the neonatal mortality rates.
5 Do you think that was a transparent communication
6 or accurate?
7 **A.** I think at the point we were, it -- it -- it
8 was the right communication and it was transparent.
9 If I could add. The -- the enquiries were, were
10 going to find answers, the indications that the board
11 had had from Executives was that the causes could be
12 multifactorial. At the first board meeting we heard
13 about a suspicion but the causes could be multi-factoral
14 from acuity to heightened activity.
15 So we had -- we had no -- no basis for I think
16 going further than that.
17 So I -- I don't remember seeing that at the time
18 but as I read it now I am, I am content, content that
19 that was a fair press release at that time.
20 **Q.** Thank you, that can go down.
21 We know you had a meeting on 14 July, a board
22 meeting, and we know you had had conversation with the
23 Executives before that meeting. So you knew what the
24 issue was by 14 July?
25 **A.** Yes.

1 **Q.** The question is: what did your colleagues on
2 the board know? We have got a note from one of the
3 Non-Executive Directors, Ms Fallon, at INQ0102040,
4 page 2, if that can go on the screen.
5 This was on 5 July. You said you didn't discuss
6 neonatal deaths at the public board meeting and you
7 wanted to keep that to an extraordinary board meeting
8 and it looks as though there was a private Non-Executive
9 Director meeting on 5 July.
10 Do you recollect that now, that having chosen not
11 to put it in the public meeting, you spoke with your
12 fellow Non-Executive Directors to tell them what was
13 going on?
14 **A.** Yes, I would have -- would have expected to
15 give advance notice of why we were meeting on the -- as
16 an extraordinary board and I think that was the purpose
17 of that --
18 **Q.** Yes?
19 **A.** -- information.
20 **Q.** It says there:
21 "External review, unexplained unexpected. Reducing
22 the unit to Level 1. Closing intensive care cots.
23 Won't be delivering babies below 32 weeks. Difficult
24 message."
25 I can't read the writing to be able to tell us with

1 that and then a reference to an internal review.
2 So what was your communication with the
3 Non-Executive Directors about? Can you remember now
4 meeting with them?
5 **A.** I can't, I can't remember that meeting. I --
6 I -- the timing of the meeting suggests that I would
7 have wanted to give them some forewarning of the
8 extraordinary board meeting.
9 **Q.** So if we take that down, please, and then have
10 INQ0003238, page 1. This is the extraordinary board
11 meeting on 14 July. If we go to page 4. We know
12 doctors Brearey and Jayaram are at the meeting.
13 It records four paragraphs down:
14 "Dr Jayaram stated that what he was to say next was
15 confidential and not to be minuted."
16 Were you content to agree the request that it
17 should not be minuted?
18 **A.** Yes, I agreed to that.
19 **Q.** In retrospect, you have said it would have
20 been helpful to have fuller minutes, do you think it
21 would have been helpful to have that minuted and why
22 shouldn't it be?
23 **A.** Well. it's a balance, but I think in this case
24 it is more helpful to hear what people want to say and
25 that -- and that they are prepared to say it in

1 confidence --
2 **Q.** Sorry.
3 **A.** Sorry.
4 **Q.** Better to say it in confidence, you said?
5 **A.** Yes.
6 **Q.** So what do you remember now Dr Jayaram saying
7 at that time?
8 **A.** I recall that he was expanding on the fact
9 that not just that the babies were -- who had died were
10 not expected to die but that I recall also that he
11 mentioned they were failing to respond to resuscitation
12 in a way that he would have expected.
13 I can't remember whether he then reiterated the
14 concerns around the association of Letby with the rotas
15 and the timings of -- of the deaths. Dr Brearey was the
16 main spokesman for the paediatricians on that issue.
17 I can't remember whether Dr Jayaram mentioned that
18 as well. I think he probably did but I can't -- I can't
19 remember.
20 **Q.** Did he use the expression "the elephant in the
21 room"?
22 **A.** Yes. Yes, he did.
23 **Q.** What does that mean or what did you take him
24 to mean by "the elephant"?
25 **A.** I think -- I think by that he meant the

1 suspicions about Nurse Letby's association with the
2 timing of the deaths.
3 **Q.** One of the meetings' discussion points was
4 whether she should be supervised, wasn't it, with
5 whether they should be supervised working on the clinic
6 because the review was going to take longer should she
7 still be able to work there while she was supervised?
8 **A.** Yes.
9 **Q.** The elephant in the room was him saying;
10 I don't think that's safe and we shouldn't have that?
11 **A.** I -- I'm not sure, I remember the discussion
12 around being supervised. I think there were issues as
13 to whether that would be enough. There were issues
14 about whether that was a practical thing to do in terms
15 of the scarce resources on the unit, for example.
16 I -- so there were questions raised about is
17 this -- is this -- is this enough? Is this appropriate?
18 **Q.** Then at page 5, we see what Mr Wilkie says in
19 the last but one paragraph, if you could -- we can
20 highlight that and have a read of that.
21 (Pause)
22 "Mr Wilkie stated he accepted that no evidence to
23 say is due to an individual but there is no evidence to
24 say the contrary ... He understands the stakes here and
25 in previous discussions there was considerable disquiet

1 about an individual."
2 And Dr Brearey expresses anxiety.
3 "People do have anxiety and there's definitely
4 discomfort."
5 If we go over the page, to page 6 in the third
6 paragraph. Mrs Hopwood asked how practical it was for
7 the staff member to work under supervision.
8 If we go to page 7.
9 "Mr Wilkie said as a layperson he did not know how
10 effective the measures will be and asked how confident
11 the Trust were that we were removing all risk."
12 Did you think, Sir Duncan, it was necessary to
13 remove all risk at that time, some risk or how did you
14 view what you were doing, the exercise that you were all
15 undertaking?
16 **A.** I thought the measures we were taking should
17 be the measures that were sufficient to safe -- to
18 safeguard the unit, to ensure the safety of babies on
19 the unit.
20 **Q.** If you go to the bottom of that page:
21 "Sir Duncan stated that there is a major future
22 exercise to look at everything and noticed that the
23 Trust is committed to do this.
24 "In the meantime the previously expressed concerns
25 about the individual, actions are being taken and it is

1 agreed that these are reasonable as we cannot see
2 a single hypothesis".
3 What did you mean by a single hypothesis?
4 **A.** I think, okay, that our attention had been
5 drawn in the earlier part of the meeting to the
6 possibility that there were multiple factors that could
7 be bearing on why the children had died, including the
8 suspicion, but multiple factors.
9 **Q.** Who did you understand that from, that there
10 was multiple factors?
11 **A.** From the introduction to the meeting by
12 Mr Harvey and principally Mr Harvey.
13 **Q.** At the end:
14 "Dr Jayaram replied the only alternative is to go
15 straight to the police and that they would want hard
16 evidence.
17 "Mr Cross outlined his understanding of what action
18 the police would take if they were called in to
19 investigate this matter."
20 What do you remember now Mr Cross saying about what
21 action the police would take if they came in, do you
22 remember?
23 **A.** No, I don't remember what he actually said in
24 amplification of that -- of that paragraph.
25 **Q.** Some witnesses have commented on reference to

1 blue tape and how the --
2 **A.** Yes, I saw that later elsewhere but at the
3 time I didn't -- I don't recall that.
4 **Q.** When Dr Jayaram said that they would want hard
5 evidence did you agree with that or did you think about
6 that at the time or not?
7 **A.** I -- I thought it would be in everybody's
8 interests and we would be in a much stronger position of
9 course to call the police in if we had hard evidence.
10 There -- there would have been no debate. If we had
11 hard evidence, we would have called the police.
12 **Q.** When you heard the doctors say that they were
13 suspicious --
14 **A.** Yes.
15 **Q.** -- that this nurse had caused the sudden and
16 unexpected deaths, they had no natural explanation for
17 the deaths?
18 **A.** No.
19 **Q.** Experienced doctors?
20 Did you -- did you not consider that as evidence,
21 that was your evidence; these baby deaths were not
22 medically explained and they were suspicious about her,
23 that was the evidence, the deaths not being understood?
24 **A.** Not sufficient at the time, and forgive me if
25 I interject something slightly inappropriate here.

1 Had Dr Jayaram not indicated to us his view that
2 the police would need hard evidence, I was influenced by
3 that at the time. The police will need hard evidence.
4 **Q.** You say at page 9:
5 "Sir Duncan said that in light of the data if we
6 take the basis that it was proportionate to call the
7 police, we would."
8 What did you mean by "proportionate to call the
9 police"?
10 **A.** If we had enough -- if we had enough grounds
11 for calling the police in the context of our discussions
12 with the paediatricians at that meeting.
13 **Q.** You say "we recommend to the board". When you
14 say "we", who would "we" have been?
15 **A.** That would have been me. I would have been
16 summing up the recommendation, I think.
17 **Q.** Is it you and the Execs "we recommend", or --
18 it is unusual, isn't it, it is not "I recommend as
19 chair", it is "we recommend"?
20 **A.** Yes -- no -- are we comfortable? Is this
21 where the board is after hearing what we have heard?
22 **Q.** At the end, Mrs Hopwood stated she felt this
23 was fine. Another board meeting should be held post
24 review.
25 That can come down. We know that following that

1 meeting, Mr Wilkie went to speak with Alison Kelly
2 because he was concerned about Letby being on the unit
3 under supervision and whether that was adequate or not.
4 So you were saying earlier you thought the
5 Non-Executive Directors could go to the Executives, that
6 appears to be what he did and he remembers now pushing
7 back on that point. Do you remember having a further
8 conversation with Mr Wilkie about that or not? You
9 don't know if you did?
10 **A.** Not at the time, I don't think I was around
11 when he sought Ms Kelly out and I -- I didn't know he
12 had made that approach at that time.
13 **Q.** But we know he tells us that Ms Kelly said she
14 would put his views to the Chief Executive and received
15 an email the following week advising that Ms Letby would
16 be moved from the NNU when she returned to work and that
17 indeed happened, she was redeployed to risk, wasn't she,
18 the Risk Team?
19 **A.** Yes, I think a number of pressures were
20 occurring at that time, Mr Wilkie's own intervention and
21 the paediatricians who were maintaining that this
22 wouldn't work.
23 **Q.** Do you remember having a discussion with the
24 Executives about redacted versions of the RCPCH and
25 whether they should be sent and who should get redacted

1 versions when the reports came in?
2 **A.** No, I -- I remember being informed that the
3 redacted version was because of the confidential
4 reference to Lucy Letby and -- and that's all I recall
5 about that. But I think, yes, let me stop there.
6 **Q.** Did you see the confidential version yourself?
7 **A.** Yes, I did.
8 **Q.** All of it, so you saw the green text about the
9 nurse?
10 **A.** I -- I recall asking for -- for the full
11 version.
12 **Q.** Do you remember it saying something about the
13 nurse and the HR process that needs --
14 **A.** No, I don't, no, I don't. Not from the full
15 version. I -- I remember discovering that from the
16 covering letter that I saw -- that I have seen.
17 **Q.** But you didn't spot any gaps in the version
18 that you saw?
19 **A.** I didn't, no.
20 **Q.** You didn't see --
21 **A.** No.
22 **Q.** -- an appendix not there that had been
23 referred to or anything like that? Because sometimes
24 you can tell if you have got a version that's got less
25 in it, can't you, because things are missing out when

1 you read it?
2 **A.** Yes, I didn't see anything like --
3 **Q.** You didn't see anything like that?
4 **A.** No.
5 **Q.** So you think you got the full version there is
6 a note INQ00042999, page 1, and it looks like it's
7 a meeting with you and the Execs, Mr Cross, Mr Harvey,
8 Mr Chambers.
9 You see at the bottom:
10 "Distribution? Parents, Coroner, in-house paeds
11 team, network."
12 What did you think the position was for the
13 paediatricians in terms of seeing that report?
14 **A.** I would have thought -- I thought it was
15 essential that they should see it.
16 **Q.** The full report?
17 **A.** Yes.
18 **Q.** Did you ask or check whether they had?
19 **A.** No.
20 **Q.** Do you think you might have done that, looking
21 back now?
22 **A.** I might have done, indeed.
23 **Q.** Was there a reason you didn't check with that
24 point at the time?
25 **A.** No. It was not normal practice to check on

1 the actions of -- of the -- of the Executives. They did
2 their job.
3 **Q.** And it does say "?", doesn't it?
4 **A.** It does.
5 **Q.** "Distribution?" Like: who are we thinking of?
6 When you look at that list now, have you any memory --
7 and don't guess if you don't -- where you were
8 suggesting or agreeing that the report should be sent
9 to?
10 **A.** I have no memory.
11 **Q.** But you knew there were two versions, if you
12 like?
13 **A.** I did.
14 **Q.** Redacted and unredacted and what was the
15 principle about the redacted one?
16 **A.** What was the?
17 **Q.** What was the principle behind it, what was the
18 reason?
19 **A.** Well, I believe it was to omit the
20 confidential information about a member of staff.
21 **Q.** So it was protecting a member of staff --
22 **A.** Yes.
23 **Q.** -- and not circulating information about her?
24 **A.** Yes.
25 **Q.** And with that principle in mind, how far would

1 you have extended that, who is entitled or who would you
2 have thought was entitled to know about that member of
3 staff?
4 **A.** Yes, I was -- I would have certainly have
5 expected the full board to be -- to know about that.
6 **Q.** Did the full board ever receive the full
7 report?
8 **A.** I don't know.
9 **Q.** We are going to hear from the Non-Executive
10 Directors so they will be able to tell us that.
11 **A.** Right.
12 **Q.** Do you remember suggesting if they didn't,
13 that they should see the full report?
14 **A.** I believe they should see the -- certain that
15 they should see the full report.
16 **Q.** But I suppose you would be at the meetings and
17 if they didn't see the full report, you would have known
18 that?
19 **A.** I wouldn't necessarily be at the meetings.
20 I -- I think the report was briefly shown at the meeting
21 but I would have expected more -- more time to digest
22 the report outside the meeting. I had that opportunity.
23 **Q.** Over the page at this meeting with you and the
24 Execs in December, in the middle of the page, there's
25 a reference to the grievance of Lucy.

1 "Apology requested from paediatricians. [Question]
2 what is the apology for."
3 This is in December. When did you first know about
4 the grievance?
5 **A.** I can't remember when I knew about the
6 grievance. I think -- I think it would have been more
7 or less as soon as it was raised. What I do remember is
8 that the -- the chairman of the Staff-Side sought me out
9 for a personal conversation and said -- to ask me if
10 I had heard about Lucy -- Lucy Letby and the grievance.
11 So it would have been early on, prior to it
12 actually starting.
13 **Q.** I think you are right, you were actually
14 sent -- if we go to INQ0002748, page 1, you were copied
15 into the grievance itself.
16 **A.** I don't recall that. But fine.
17 **Q.** Ms Cooper says:
18 "Please find attached a copy of a grievance ..."
19 **A.** Okay.
20 **Q.** "... we have submitted on behalf of our
21 member. I appreciate you will feel you cannot get
22 involved but I believe you should know how a member of
23 staff is feeling within the Trust. As this has now
24 dragged on for several weeks, my member has been left
25 with no other alternative."

1 So this is 8 September. You of course have had
2 that meeting in July, so presumably you know which
3 member of staff or what's this about?
4 **A.** Yes.
5 **Q.** Were you normally copied into grievance
6 procedures or --
7 **A.** No.
8 **Q.** -- processes?
9 **A.** Never. This was Hayley Cooper who I had an
10 open-door policy with thought she would knock on my door
11 and show me.
12 **Q.** What did you think when you got that, when you
13 knew -- made the connection between the nurse and who it
14 was?
15 **A.** I -- I thought it would proceed, this is
16 an entitlement, a grievance had been lodged and it would
17 proceed. But I would play no part in that.
18 **Q.** Did you read it? It looks like it was
19 attached to the grievance itself.
20 **A.** I can't remember.
21 **Q.** No. If we go back to the meeting we were on
22 before INQ0004299, page 2, we see that:
23 "Grievance of Lucy. Apology requested from
24 paediatricians ... what's apology for. Victimisation."
25 What did you make of the fact that an apology was

1 requested and we see here, Mr Harvey:
2 "Apology for behaviour, language used by paediatric
3 Consultants."
4 Did you ask anything about that apology and why it
5 was having to be made and what Mr Harvey was referring
6 to when he said "apology for behaviour, language used"?
7 **A.** Yes, I was aware of the -- the background to
8 the concerns about remarks that had been -- had been
9 made about -- about Lucy, "angel of death" type
10 references and so forth.
11 **Q.** What did you make of all of that?
12 **A.** I thought that was inappropriate.
13 **Q.** Did you accept that it had -- well, what did
14 you think had happened? Did you think the Consultants
15 had said anything like that?
16 **A.** I didn't know whether they had or not. This
17 was the inference, though.
18 **Q.** Did you say at the time: do we know if that's
19 right, or not?
20 **A.** No.
21 **Q.** You just accepted they had done that?
22 **A.** No, the inference was that they had said that
23 and I -- I -- I didn't make further enquiries.
24 **Q.** Do you think you might have done, given that
25 you knew they had raised genuine concerns you told us

1 earlier about this nurse, would you have liked to know
2 more before what that was being suggested they had done?
3 **A.** Not whilst matters -- you know, matters were
4 still, as it were, progressing to try and get to the
5 bottom of everything.
6 **Q.** If we go to page 3, halfway down, Mr Chambers
7 following up -- to follow up with paediatric
8 Consultants.
9 "Duncan Nichol to represent NEDs and relevant
10 Execs. Meeting to include behaviours and outcome from
11 meeting with Lucy."
12 So were you being asked to do anything in terms of
13 representing the Non-Executive Directors and the
14 relevant Execs on this issue about the Consultants'
15 behaviour or what, what do we take from that?
16 **A.** I -- I don't think -- I don't recall being --
17 I am trying to determine what the timescales are, are
18 here.
19 I don't recall being asked to do anything. I would
20 have been invited to the meeting later in January with
21 the Consultants, I think it was the 24th, which Rachel
22 Hopwood attended on my behalf, I -- I wasn't able to go
23 but I don't recall being asked to become involved in --
24 in any other matter in any capacity.
25 **Q.** Did you communicate your view that you did

1 think it was inappropriate "angel of death"-like
2 comments?
3 **A.** No, perhaps conversationally, I wouldn't have
4 expected that. But not -- not formally in any way.
5 **Q.** But there was no challenge when that was put
6 to you to say: hang on a minute, what's your evidence
7 for that? They've raised genuine concerns, you need to
8 think about that. You didn't say anything like that
9 to --
10 **A.** No, it was -- it was coming from senior people
11 who were relaying that they had heard this and I took --
12 I took that in good faith at that time.
13 **Q.** Well, we have seen it. Mr Harvey tells you,
14 so you took that to be right?
15 **A.** Took that?
16 **Q.** You took that to be right?
17 **A.** I did take that to be right.
18 **Q.** If we go, please, to INQ0003518, page 1 and
19 over to page 2. This is documents in preparation for
20 the board meeting on Tuesday, 10 January. If we go to
21 page 2, we can see the recommendations from Mr Harvey --
22 **A.** Yes.
23 **Q.** -- to:
24 "Accept the report of the Invited Review which is
25 attached.

1 "Support the Executive in implementing the review
2 recommendations and issues.
3 "Support the Executive in assisting the staff
4 member's return to work on the neonatal unit."
5 So that's what the board is invited to consider?
6 **A.** Yes.
7 **Q.** Because the RCPCH Review has come back. If we
8 go to page 4., we see Mr Chambers setting out -- sorry,
9 INQ0003237, page 4. So these are now the minutes -- the
10 meeting minutes themselves as opposed to the
11 recommendations.
12 We see there at paragraph 5:
13 "Mr Chambers stated there is an important set of
14 consequences for people and for one individual. There's
15 an unsubstantiated claim that the issue is down to one
16 individual's actions and behaviours. We did explore
17 supervised practice for the individual but this was not
18 supported by clinical colleagues."
19 So to be clear in the meeting Mr Chambers is saying
20 an unsubstantiated claim that the issue was down to the
21 nurse; yes?
22 **A.** Yes.
23 **Q.** He also says in the first part of that
24 paragraph:
25 "... there is an important set of consequences for

1 people and for one individual."
2 So how did you hear that? "Consequences for people
3 and for one individual"; what did you think that meant?
4 **A.** I'm not sure now what that, what that -- that
5 meant. Let me just read it again, if I may.
6 **Q.** Of course.
7 **A.** No, I -- I don't, I -- I can't, I can't
8 interpret that now.
9 **Q.** Let's have a look at the second paragraph on
10 page 5, if that helps.
11 "Mr Chambers has said to the individual and their
12 family that we will manage as best we can a safe
13 transition back to the unit. But you see from her
14 statement this may be tricky, it may not be possible in
15 the end but we will do everything we can. The
16 recommendations from the grievance and some of the
17 unprofessional behaviour from the Consultants will mean
18 that we are seeking an apology from the Consultants for
19 their behaviour and verbal statements which border on
20 victimisation. This is deeply uncomfortable."
21 So it looks there, doesn't it, as though
22 Mr Chambers has already spoken to Letby and her family
23 about managing the safe transition back to the ward.
24 Then it refers to the fact that they are seeking an
25 apology from the Consultants. Did you see this at the

1 time as a big u-turn or not from the supervised practice
2 there was then a redeployment and then suddenly it is
3 after this grievance she's coming back on the unit. Did
4 that make sense to you at the time?
5 **A.** Not, not a massive change. If -- if the level
6 of supervision was adequate ultimately to ensure the
7 safety of the unit, then redeployment did that without
8 any uncertainty.
9 **Q.** We see further down:
10 "Mrs Fallon referred to members of staff hearing
11 comments that from the board's perspective this is
12 unacceptable behaviour and Mr Wilkie felt the decision
13 was right but the behaviours were not."
14 So expression of the behaviours of the doctors, as
15 far as the board was concerned, from your colleagues as
16 well as yourself saying earlier you thought it was
17 inappropriate if that's what had happened?
18 **A.** On this -- on the basis that these behaviours
19 had taken place, colleagues felt that wasn't
20 appropriate.
21 **Q.** If we go to page 6., paragraph 5:
22 "Mr Harvey stated that the draft report had been
23 shared in a controlled way with Dr Brearey and
24 Dr Jayaram for comments."
25 What did you understand "a controlled way" to mean

1 if you heard that at the time?
2 **A.** That there hadn't yet been the opportunity for
3 the Consultants to fully -- to fully digest merely, as
4 it were, a glimpse of the overall advice.
5 **Q.** Do you think as a board it might have been
6 helpful for you to have the Consultants' views of the
7 adequacy of the report and the supposed multi-factorial
8 reasons that were ascribed to it for causation of any of
9 the deaths?
10 **A.** Yes, I do. Absolutely.
11 **Q.** And --
12 **A.** If I could add that I regard as personally
13 a big -- big failure on my part that the Consultants
14 were present at the first extraordinary board meeting
15 and they were not present at this one and they should
16 have been.
17 **Q.** Who gets to decide whether the Consultants can
18 be there or not?
19 **A.** Well, ultimately it's my decision.
20 **Q.** Mm-hm.
21 **A.** Usually it would be suggested and I would say
22 absolutely, yes, let's please invite them.
23 **Q.** Because the tone of this meeting is very
24 different from the last, isn't it, in terms of
25 discussing the risks to babies or patients?

1 **A.** Yes, yes.
2 **Q.** We then have Mrs Hopwood asking:
3 "Are there assurances that the report will not be
4 leaked to the press by the Consultants? Mr Chambers
5 replied this would form part of the conversation where
6 we would be very clear about the expectations."
7 Had the Consultants leaking things to the press
8 been suggested before in any other context?
9 **A.** I can't recall any such thing.
10 **Q.** Was there any discussion at this meeting about
11 what the parents would be told about the report insofar
12 as it impacted on any of their children?
13 **A.** I can't recall the detail of that.
14 **Q.** At the bottom of page 6:
15 "Sir Duncan stated that the board accepted the
16 report and support the implementations subject to the
17 strategic review supported the individual going back on
18 the unit and the admission criteria should not be
19 changed."
20 Did you appreciate in anything that was said at
21 that meeting that the RCPCH Report did not exclude Letby
22 as a possibility for the cause of harm and death to
23 babies? Did not exclude her as a possibility?
24 **A.** Yes, that didn't -- didn't come across to me
25 at that meeting.

1 **Q.** But you had read the report?
2 **A.** I had.
3 **Q.** Did it not come across in the report or did
4 you not analyse the report in that way?
5 **A.** I didn't -- I didn't pick it up from the
6 report that I read.
7 **Q.** Mr MacCormack had said the RCPCH were the
8 wrong people to do the review because they weren't going
9 to do a forensic analysis and look where there's
10 suspicion to see if a crime has been caused. That is
11 not what they would do.
12 Did you appreciate that at all at the time, that
13 this report didn't really deal with the issue the board
14 was grappling with?
15 **A.** No, no, I noted Dr McCormack's comment. My
16 understanding was that the Terms of Reference were being
17 drafted but a reference, a reference to the suspicions
18 the paediatricians had about Letby would -- would also
19 be intimated to the College.
20 I --
21 **Q.** In your statement, Sir Duncan, you say at
22 paragraph 158:
23 "In August 2016, BBC News reported that I provided
24 the following statement to them."
25 And the statement was this:

1 "I believe that the board was misled in
2 December 2016 when it received a report on the outcome
3 of the external, independent case reviews. We were told
4 explicitly that there was no criminal activity pointing
5 to any one individual, when in truth the investigating
6 neonatologist had stated that she had not had the time
7 to complete the necessary in-depth case reviews."
8 Then you tell us at paragraph 159:
9 "I did not have the date to hand when talking to
10 the BBC. The report I referred to the board receiving
11 was Ian Harvey's report to the extraordinary meeting on
12 10 January."
13 The report at INQ000239 references:
14 "Inconclusive results from internal reviews."
15 Is that what you say, Sir Duncan; that you were
16 misled at that meeting?
17 **A.** I was misled. I didn't say what I was misled
18 about. I don't -- not to the press.
19 **Q.** Yes, okay. So my first comment then: is that
20 what you said and what do you think?
21 **A.** What I think, may I start with?
22 **Q.** Of course.
23 **A.** What I thought at the time was that I was
24 misled because I was not informed that Dr Hawdon had not
25 had the capacity to do the job that she had been asked

1 to do in the depth that was required. I thought that
2 was essential information that was not made available to
3 either myself or the board and that was the only
4 reference that I -- I intended to make to being misled.
5 **Q.** Because you didn't know that she couldn't take
6 on what the RCPCH had suggested?
7 **A.** She couldn't take on what I think Mr Harvey
8 had asked her to do.
9 **Q.** Right. But you saw, did you, anything that
10 Dr Hawdon had written. Did you see for yourself?
11 **A.** I saw -- I saw the some summaries of, of
12 cases. But I -- I didn't -- I didn't see anything else.
13 **Q.** So do you think you were misled or not? When
14 we look at the 10 January meeting particularly, I am not
15 talking about the details of the review, were you or do
16 you think you got their views, Mr Harvey and
17 Mr Chambers' views?
18 **A.** I think a critical piece of information of the
19 kind that I have just mentioned, namely that the
20 reviewer, Dr Hawdon, didn't have the capacity to do the
21 review in the required depth, for us not to be -- for me
22 not to be told about that was misleading.
23 **Q.** You could have asked for the full report to
24 see that and read that for yourself, couldn't you?
25 **A.** I could have asked for the full report. What

1 I am referring to, I think, is the covering letter from
2 Dr Hawdon which -- which tells Mr Harvey that she
3 couldn't do the job he had asked.
4 **Q.** What would your response be to that? If you
5 couldn't do the job he asked what would you think should
6 be done next or --
7 **A.** Well, I think there would have been a board
8 discussion that would have been based on: well, we
9 haven't got what we asked for. What should happen next?
10 It's -- it's impossible to say what the outcome of
11 that collective board discussion would have been. It
12 could have been to say: no, no, no let's go to the
13 police or let's -- let's follow up on the forensic
14 pathology reviews that she did recommend and see where
15 they take us. There were a number of possibilities that
16 could have emerged had we had the chance to debate them.
17 **Q.** 13 April 2017, the next boardroom meeting,
18 INQ0003236, page 1. This is one where Mr Medland QC, as
19 he then was, attends.
20 **A.** Yes.
21 **Q.** Can you remember much about this meeting?
22 **A.** Yes, I can remember -- remember quite a bit
23 about that meeting.
24 **Q.** Do you want to tell us about that then?
25 **A.** Yes. I think we -- we had sought Mr Medland's

1 independent view at a meeting with the paediatricians,
2 which he held, as to whether there was sufficient
3 evidence of criminality.
4 This is something suggested to me by Mr Cross and
5 I thought it was a good idea to put that point and to
6 explore the strength of the argument, the evidence that
7 might be put -- put to the press.
8 Mr Medland reported back to us as I recall that he
9 didn't find any evidence of -- of criminality. But he
10 used an expression that stayed in my memory arguably
11 since then, along the lines that: if events are still
12 unexplained and if well-minded people still have
13 concerns, then the police should be called and I wish we
14 had had that advice in July 16.
15 **Q.** And indeed at that time, in June/July 2016 we
16 have seen at least one email from Mr Harvey thinking
17 about going to the police then?
18 **A.** (Nods)
19 **Q.** It appears I think Ms Kelly raises that.
20 There's an understanding at that point that that's
21 a real moment, isn't it, when the police could have been
22 contacted?
23 **A.** There were a number of references not --
24 including members, from members of the Non-Executive
25 Directors who were saying should we? Is it time? When?

1 And we were in the position of waiting for an extra
2 piece of information, one -- one piece would have been
3 the deep dive forensic reviews from Alder Hey Hospital,
4 which came quite late in the day.
5 **Q.** So instead the decision then was the RCPCH
6 review, Dr Hawdon review, then following up with
7 Dr McPartland, the Silver Command investigations. It
8 continued, didn't it, a series of internal and some
9 external investigations for considerable time?
10 **A.** Yes.
11 **Q.** We see at this meeting at page 2, paragraph 3,
12 that's where Mr Medland emphasises no evidence of
13 a crime but the Consultant view is to go to the police
14 and he suggests going via the police member of CDOP as
15 well which we know eventually is what occurred.
16 On the last page, page 6:
17 "Sir Duncan added that that the biggest risk is
18 losing control of the situation and again noted the need
19 to communicate with the parents."
20 The communication with the parents, how focused on
21 that were you? Did you ever see any of the draft
22 letters from Mr Harvey to parents or ask to see which
23 parents had been contacted or any of that kind of detail
24 or not?
25 **A.** No, I didn't see the letters or the -- which

1 parents were approached.
2 **Q.** Who did you think was in charge of that?
3 **A.** I think Mr Harvey himself.
4 **Q.** Did you get any feedback on that process from
5 him or not?
6 **A.** No, I didn't.
7 **Q.** That can come down from the screen now.
8 If we can go, please, to INQ0107734, page 2. You
9 were cc'd into an email with this message that Letby had
10 sent to her colleagues. You see the 31 January, we see
11 what it says there:
12 "I was redeployed from the unit in July 2016
13 following serious and distressing allegations. From
14 then until now I have been unable to visit or contact
15 the unit whilst these matters were investigated. After
16 a thorough investigation it was established that all the
17 allegations are unfounded and untrue and I have
18 therefore been fully exonerated."
19 So it continues.
20 When you saw that, and if it helps refresh your
21 memory, if we go to the page before we will see it is
22 Ms Hodkinson that has forwarded it to you, or sent it to
23 you, when you read that, her referring to being fully
24 exonerated, what did you make of that when you read?
25 **A.** Well, what I thought she would have referred

1 to was the vindication of the grievance panel, of her
2 grievance.
3 **Q.** But what did you think her grievance was
4 about?
5 **A.** I -- I -- I thought from -- I am trying to
6 recall this -- I thought her grievance related to -- to
7 the way that she had been dealt with, handled, maligned
8 if you like by -- by the Consultants.
9 **Q.** But that necessarily wouldn't fully exonerate
10 her, would it?
11 **A.** No.
12 **Q.** Exonerated sounds different, doesn't it? If
13 we go back to the page before she's speaking about in
14 the first paragraph:
15 "Following serious and distressing allegations of
16 a personal and professional nature made by some members
17 of the medical team, I have been fully exonerated."
18 In other words, their allegations were not
19 justified; that is what that suggests, doesn't it, even
20 without knowing the allegations?
21 **A.** I think these were -- these were the
22 allegations that were -- were circulating round, round
23 the hospital; that were common knowledge in the hospital
24 at that time, at which she -- she argues that what they
25 were, what -- the import of them was not true and she

1 was exonerated.
2 **Q.** So when you say what allegations were going
3 round the hospital at that time --
4 **A.** The allegations were of the "angel of death",
5 the allegations -- is allegations the right word? The
6 Coroner conversations, messages, words onwards were
7 about somebody may be harming our babies.
8 **Q.** So it was pretty widely known within the
9 hospital, as you would expect at this point really, that
10 someone harming babies was under consideration or that
11 had been alleged?
12 **A.** Had been alleged.
13 **Q.** How clear are you that it was widely known
14 across the hospital; in other words not just within
15 a unit here or there?
16 **A.** I am not clear how wide -- wide that was in
17 circulation on the grapevine.
18 **Q.** You were walking around, it wouldn't be
19 surprising at this point --
20 **A.** Yes, no -- nobody mentioned it to me --
21 **Q.** Pardon?
22 **A.** -- as I walked. I'm so sorry --
23 **Q.** No, go on.
24 **A.** Nobody mentioned it to me on my -- on my
25 walkabouts.

1 **Q.** Certainly emails are going to groups of staff,
2 aren't they? A number of staff on a ward will have
3 friends presumably in the hospital. So that was known
4 that there were concerns someone was harming a baby or
5 harming babies?
6 But what about the allegations that there was
7 name-calling or behaviour of Consultants; was that
8 talked about as well or known about?
9 **A.** Probably in a more -- in a more restricted
10 circle and, but, brought to the attention of senior
11 Executives, Divisional Nursing Director, Karen Rees and
12 others were party to that information.
13 **Q.** You receive -- if we can go, please, to
14 INQ0099388, page 2, 0099388, page 2. Mr Chambers and
15 yourself receive this letter from the parents of
16 Ms Letby saying:
17 "It's now one year since our nightmare began.
18 There is a saying 'innocent until proven guilty' but it
19 does not seem to apply to Lucy. She is still the only
20 one of all the staff on the neonatal unit to be singled
21 out for punishment.
22 "Whilst we are appreciate things cannot be
23 finalised until the police investigation has ended we
24 have to have a way of moving forward in terms of her
25 career for however long the investigation takes.

1 "We therefore wish to request an urgent meeting
2 with you both to discuss what restrictions are on Lucy
3 and what expectations she can have regarding work
4 training for the time until the police investigation has
5 been completed.
6 "... would appreciate the meeting to be as soon as
7 possible as the anguish the situation is causing has
8 become intolerable."
9 You didn't meet with the parents, did you?
10 **A.** No, no.
11 **Q.** Did you respond in any way to that?
12 **A.** No. I talked to Mr Chambers and agreed that
13 he would meet the parents.
14 **Q.** Were you asked on any other occasion to meet
15 the parents?
16 **A.** No.
17 **Q.** Were you aware how many of your senior staff
18 were meeting the parents?
19 **A.** My understanding that it was quite limited.
20 Certainly Mr Harvey, Mr Chambers. I can't be clear
21 about the Director of Nursing.
22 **Q.** What level of support did you think was being
23 provided to Letby herself from either Occupational
24 Health or other nurses? What did you think she was
25 getting in terms of support during this?

1 **A.** I had no insight into that.
2 **Q.** You, along with others, received from
3 Ms Cooper INQ0057492, page 1. Ms Cooper is sending you
4 a statement that Letby wished to be read out to the
5 Consultants when the Trust board meets with them and
6 also a statement from her parents was attached as well
7 which they felt should be communicated.
8 Did you read that statement at the time?
9 **A.** I heard it read -- read out. But I can't
10 remember the actual occasion when it was read out.
11 **Q.** So if we go to -- just so people can see it
12 INQ0057493, page 1.
13 **A.** Oh, yes.
14 **Q.** So if we look at it there. That was the
15 statement and I think that was read out at the board
16 meeting at 10 January, was it?
17 **A.** I don't -- I don't recall it being read out at
18 10 January. It might be my memory.
19 **Q.** Where do you think --
20 **A.** Well, again I have at the back of my mind that
21 it -- it might have been read out at the meeting
22 I couldn't attend which Rachel Hopwood attended in late
23 January with the paediatricians. The paediatricians
24 weren't at the January board meeting.
25 **Q.** Yes, so it may have been 26 January?

1 **A.** 26 January.
2 **Q.** Is that the one you weren't at? So you didn't
3 sit through that being read but did you know that that
4 was going to be read to the board?
5 **A.** No, I don't, read to the board? No,
6 I didn't -- I didn't think there was going to be
7 an opportunity when the paediatricians and the board
8 were -- would be there to hear it.
9 **Q.** Yes. We will have to see whether it is the
10 10th or the 26th but either way you know it was read and
11 you can't -- there may be some dispute about when it was
12 read but you know it was read and you can't remember
13 hearing it now?
14 **A.** I wasn't there when it was read.
15 **Q.** Right. Do you think reading that out in that
16 kind of meeting with the paediatricians there would have
17 been an appropriate thing to do?
18 **A.** No.
19 **Q.** Why not?
20 **A.** I just don't, I just think you -- you have to
21 look to, as it were, not aggravate matters and I thought
22 it was -- I thought it was provocative --
23 **Q.** Who was the person driving that then, that it
24 should be read, do you remember?
25 **A.** No. I remember who read it but I don't

1 remember who drove it.
2 **Q.** Who, who --
3 **A.** I thought Karen Rees read it.
4 **Q.** That can go down then, please. Were you aware
5 whether there had been pressure put on the Consultants
6 Dr Brearey and Dr Jayaram to attend mediation?
7 **A.** I'm not sure whether "pressure" is the word.
8 But certainly a suggestion, an invitation to join in
9 mediation had been -- had been made to them.
10 **Q.** By 29 March 2018 you received this letter from
11 the Consultants, didn't you, INQ0088531, page 1. It's
12 an email first from Ravi Jayaram highlighting concerns
13 about the relationship with the Executive Board. Whose
14 writing -- is that your writing?
15 **A.** Yes, it is.
16 **Q.** Excellent. Can you tell us what it says then,
17 please?
18 **A.** No -- yes, I am sure I can.
19 "Acknowledge serious breakdown in working relations
20 with the Exec board. Shared your concern about the
21 potential damaging impact on patient care clinical
22 practice and the development of services for children.
23 Commit to try to resolve the problem and restore
24 a professional working relationship."
25 **Q.** If we go over the page, it is the same

1 INQ number, you have obviously met with Dr Jayaram and:
2 "... the Consultants say they remain extremely
3 concerned. Our relationship with the Executive Board
4 has deteriorated and ... no meaningful efforts are being
5 made to repair it."
6 You, if we go to INQ0102361, page 76:
7 "Thank you for the letter from you and your
8 colleagues which I received today. As I said when we
9 met on 26 February high on my agenda was concern about
10 the damaging breakdown in relationships between
11 Consultant paediatricians and the Executive Team and my
12 desire to broker a positive way forward. So the board
13 understands that a problem exists and will press for it
14 to be resolved in the interests of patients and the
15 future development of our services to children."
16 How did you think you were going to be able to
17 resolve that? What was your thinking?
18 **A.** It's -- it's trying to bring the parties
19 together. There's no -- there's no magic bullet or
20 quick fix but the relationships were fractured.
21 I wanted, of course, to hear the basis of the
22 Consultants' concerns and, and why it had got to this,
23 to this point and they expressed that very clearly to
24 me. I communicated that with, with Mr Chambers and
25 urged a meeting, meeting of -- in the same room, please,

1 let's see what, see what you can do to repair
2 relationships. This is where they're coming from. What
3 do you think?
4 That kind of conversation.
5 **Q.** We see, if we go to INQ0006682, page 1, this
6 is a letter Dr Gibbs sends, or an email, to his fellow
7 Consultants. I'm sure you have seen this, Sir Duncan,
8 but take your time and read through that now.
9 **A.** Yes.
10 (Pause).
11 Yes, thank you.
12 **Q.** We see in paragraph 3 that you say to the
13 Consultants that you understood what we were saying, but
14 it was not his role to take sides.
15 **A.** Yes.
16 **Q.** Was that an option in terms of not at least
17 forming a view on the merits of what both sides were
18 saying at this point?
19 **A.** I mean, arguably I was, I was trying to
20 position myself in a mediation/arbitration type of role.
21 I did need to know why it had got to this stage from the
22 perspective of each of the parties. But that was, that
23 was my -- that was why I was referring to not taking
24 a position in favour of one or the other whilst that was
25 going on.

1 **Q.** Well, it had got to the position, hadn't it,
2 where they had raised concerns and suspicions about
3 a nurse who was being investigated by the police and, at
4 the same time, there had been a grievance process where
5 they had been criticised for poor behaviour. And that
6 must have felt very unjustified, mustn't it, at this
7 time; did you get a sense of that --
8 **A.** That was --
9 **Q.** -- a sense of --
10 **A.** Certainly I was, you know, aware of the -- of
11 that as background to the build up which crystallised in
12 meetings with them in terms of, "we don't feel listened
13 to, we feel victimised, we feel intimidated, we feel
14 bullied."
15 **Q.** You then, if we go to INQ0003092, page 1,
16 write to the Execs.
17 **A.** Yes.
18 **Q.** And you say:
19 "The overall concern was their perceived
20 breakdown... "
21 Do you think "perceived" was the right word there?
22 **A.** No. No, it was a real breakdown. This was in
23 mutual trust and respect.
24 **Q.** "They cited examples of late and partial
25 communication and views attributed to them which they

1 did not hold. In general for them there was lack of
2 transparency and a feeling of exclusion. They felt
3 intimidated, victimised and under pressure to toe the
4 line and that their concerns had been sidelined. They
5 had no clarity about what had been said to parents.
6 They felt their concerns around risk management had not
7 been addressed satisfactorily."
8 That was a two-hour meeting, so it doesn't look
9 like they held back; you knew what they were saying?
10 **A.** Yes.
11 **Q.** You also send INQ0004474, page 1, a further
12 email. You say:
13 "I have reported back fully, albeit succinctly, on
14 Monday's meeting and expanded verbally to you, Tony and
15 to Stephen."
16 When you expanded verbally, presumably you gave
17 some of your views in that context. Can you remember
18 what else you said?
19 **A.** No, I can't.
20 **Q.** We then see, please, INQ0102361, page 78.
21 The paediatricians had asked 26 questions, hadn't
22 they, they wanted 26 questions answering?
23 **A.** Yes.
24 **Q.** We see here a draft from Mr Chambers,
25 30 April, his first draft reply to the questions.

1 Sorry, this one is the paediatricians' questions.
2 Yes, these were their questions. These were sent.
3 If we can scroll through them so people can read them.
4 And then we see -- well, we'll give a moment to see
5 that.
6 (Pause)
7 And then you send us, there's a draft response from
8 Mr Chambers, isn't it, INQ0102361, page 87. So that's
9 Mr Chambers' response.
10 **A.** Yes.
11 **Q.** If we see an email you send at INQ0102361,
12 page 83.
13 **A.** Yes.
14 **Q.** Take your time to read that.
15 **A.** No, I know that one, thank you.
16 **Q.** You had seen a draft, had you, before he sent
17 the response?
18 **A.** Yes, I would have seen a draft.
19 **Q.** And provided these comments before the final
20 one was sent --
21 **A.** Yes.
22 **Q.** -- or not?
23 Did you have a conversation with Mr Chambers as
24 well about this?
25 **A.** Oh, yes. Yes. This was my advice to him and

1 I gave it to him in person as well.
2 **Q.** And tell us what you said in person.
3 **A.** He, he was -- I think he took the advice.
4 Certainly was going to reflect on it. And I think in
5 large measure, when he responded, he had taken, taken
6 the points I was making.
7 **Q.** Did you see the one that he sent back, the one
8 we put on screen a moment ago?
9 **A.** I don't, sorry. I don't recall seeing that,
10 no.
11 **Q.** Did he send you the draft first for comment or
12 what? How was it you were commenting on the draft
13 response in the first place? Who had asked to see it?
14 **A.** I can't remember. He shared it with me, but
15 I -- I can't remember how that came about.
16 **Q.** On the same date as this, you popped your head
17 around the door in your corridor to speak to
18 Dr Ravi Jayaram, I think, because we have an email where
19 you say:
20 "Dear Ravi, we shared an emotional conversation and
21 that's okay."
22 Can you remember having an emotional conversation
23 with Dr Jayaram on the 25th?
24 **A.** Oh, yes. Yes. I remember putting our arms
25 round each other.

1 **Q.** Sorry?
2 **A.** I remember us putting our arms round each
3 other.
4 **Q.** And you said in this email:
5 "I want you and Consultant colleagues to know how
6 deeply sorry I am for the personal distress that you
7 have and are all suffering and for my part in not
8 intervening sooner."
9 Can you remember saying that in an email?
10 **A.** Yes. Yes.
11 **Q.** Tell us about that; the 25th May, what he said
12 you said and ...
13 **A.** I think this was the occasion when he was
14 giving me the examples of how they had been, in his
15 words, "treated" during the grievance process, my words
16 "as if they were in the dark."
17 **Q.** When you said in the email:
18 "... for my part in not intervening sooner."
19 What did you mean by that?
20 **A.** I don't know. I can't remember that now. No.
21 **Q.** Do you think at the time when they were in the
22 meetings, Dr Jayaram and Dr Brearey, you did take their
23 concerns seriously enough? You were hearing what the
24 Executives said and particularly Mr Harvey about the
25 multi-factoral issues. But the concerns they were

1 raising, do you think you took those seriously enough?
2 **A.** Yes, I -- I -- I believe I did.
3 These are serious concerns expressed genuinely and
4 they, they fed into -- fed into the process that
5 followed. I took them seriously.
6 **Q.** You also sent an email at INQ0107964,
7 page 0213. It's going to come on the screen, don't
8 worry.
9 So this is 8 Feb 2017 at the time of the
10 publication of the RCPCH Review:
11 "Dear Ravi,
12 "However events unfold following today's release,
13 I will be standing with you. I do understand how very
14 difficult this is for you and your colleagues and I want
15 you to know that I am personally here for you as I will
16 be for any member of the neonatal unit."
17 Do you remember sending that?
18 **A.** Sorry? Is there a question?
19 **LADY JUSTICE THIRLWALL:** Do you remember sending
20 that?
21 **A.** No. No, I don't.
22 **MS LANGDALE:** But it's clear your style was to be
23 supportive where you could be?
24 **A.** Yes.
25 **Q.** At least expressing that support in that way?

1 **A.** This was -- I don't need to say this, but
2 there's enormous stress and pressure in the, in the
3 hospital around these events and, I mean, I wanted to
4 let people know that they weren't, they weren't on their
5 own.
6 **Q.** It came to it, didn't it, that there was an
7 extraordinary Medical Staff Committee meeting on
8 19 September, where all of the staff were discussing
9 Mr Chambers, INQ0098147, page 1, and you were present as
10 well?
11 **A.** Yes.
12 **Q.** By then -- and I should say I don't need to
13 put them on the screen -- Mr Chambers, 30 May 2018, had
14 sent his response to the questions raised by the
15 consultant paediatricians on 30 April. So that's
16 INQ0102361, page 87 onwards.
17 So he has responded to that and the paediatricians
18 have responded with answers to some of his answers,
19 haven't they? The document was doing some toing and
20 froing, can you remember that; that the 26 questions he
21 answered and the Consultants had responses --
22 **A.** Yes.
23 **Q.** -- to those answers?
24 **A.** And ...
25 **Q.** And then we arrive at the meeting.

1 **A.** Yes.
2 **LADY JUSTICE THIRLWALL:** Sorry. Did you want to
3 say something else?
4 **A.** How connected the questions and answers were
5 to the meeting, I'm -- I'm not sure.
6 The paediatricians had reached a point of no, no
7 possibility of reconciliation and wanted to take their,
8 their points to the Medical Staff Committee meeting and
9 I attended, yes.
10 **MS LANGDALE:** That's what we see here at page 1 and
11 page 2. Dr Jameson introduces the meeting and the
12 purpose of the meeting:
13 "... emphasised sensitivity and confidentiality and
14 that bereaved parents were at the heart of the matter."
15 Page 3. A list of concerns.
16 Dr Saladi sets out his concerns at the bottom of
17 the page and going over to page 4.
18 Dr ZA sets out her concerns.
19 If we move over to the next page, Dr Jayaram.
20 Dr Brearey next page.
21 Dr Holt, her views.
22 It's a discussion from the floor that begins and
23 goes over on to page 8 and we see Dr Tighe in the
24 discussion:
25 "... speculated that motives for board decisions

1 might include concern about the hospital's reputation
2 and for the other employee's rights. He said that there
3 were two issues; patient safety and the possible delay
4 in taking measures and the way that the paediatricians
5 had been victimised and bullied."
6 Pausing there, Sir Duncan:
7 " ... speculated that motives for board decisions
8 might include concern about the hospital's reputation."
9 You were concerned that communication was affected.
10 What about reputation, the standing of the
11 hospital, was that a factor?
12 **A.** I don't believe it was a factor.
13 **Q.** What about for the other employee's rights,
14 the nurse's rights. You have said you had extraordinary
15 board meetings and because of an employee's position,
16 you didn't expect it to be discussed in some places.
17 Do you think the employee's rights influenced your
18 manner of the discussions or decision-making as a board?
19 **A.** I'm not clear what Dr Tighe had in mind there.
20 The grievance process was an entitlement. I --
21 I had no part to play in that.
22 So I -- I -- I can't, I can't explain that point.
23 **Q.** Did you have much experience of grievances
24 being raised in the Trust?
25 **A.** Over, over years --

1 **Q.** Yes.
2 **A.** -- yes.
3 **Q.** Were they ever raised in response to concerns
4 being raised about an individual, was that a common
5 thing or not?
6 **A.** I'm not sure whether it was a common thing.
7 But people, people would raise concerns about how they
8 would -- were they were being managed, treated,
9 mistreated, bullied.
10 So those were -- those were grounds for, for some
11 of the grievance hearings that I was involved in in
12 earlier years.
13 **Q.** Was it sometimes a response when a person
14 criticised their behaviour though, do you see? I fully
15 understand grievance procedures, people can raise them.
16 But if I criticise someone's behaviour and then
17 they raise a grievance, did you get that situation?
18 **A.** Yes. I mean, lots of situations where there
19 were two points of view.
20 Yes, yes, I was. From the manager, let's say,
21 "Yes, I was unhappy with your performance and we've got
22 to do something about this, so ..."
23 And then on the other side, "I didn't like the way
24 that you spoke to me. I felt I was being bullied."
25 So that, that -- sorry, I keep thinking I'm

1 knocking the glass over, my Lady.
2 **LADY JUSTICE THIRLWALL:** That's all right. You're
3 just touching the microphone.
4 **A.** So that's the two sides to the grievances
5 involving people's views on being managed or bullied.
6 **MS LANGDALE:** At the end of the meeting, we see the
7 conclusion:
8 "Dr Jameson said that the main aim of the meeting
9 was to facilitate the paediatricians' expression of
10 their experiences and that he would call another
11 extraordinary meeting soon to form definitive
12 conclusions and actions."
13 So at 20 September, they hadn't formed conclusions
14 about what next but everybody had aired their views in
15 that meeting?
16 **A.** Yes, certainly the -- the meeting was, was --
17 was for them to tell their story, to hear views and
18 I was informed at the time also to ask whether other
19 Consultants had similar experiences.
20 **MS LANGDALE:** Thank you. I have a very few
21 questions left, Sir Duncan, but perhaps we should take
22 the lunch break and I'll ask them afterwards.
23 **LADY JUSTICE THIRLWALL:** Very well. So we will
24 break now and we'll start again at ten to 2.
25 **MS LANGDALE:** Is that a problem, Sir Duncan?

1 **A.** No. Look, I defer.
2 My daughter, my daughter is coming to mop my brow
3 and she's coming all the way from Yorkshire and we're
4 having lunch, and I can come any time.
5 I can come back at any time, but I can come back at
6 ten to 2 as well.
7 **MS LANGDALE:** We would still comfortably finish if
8 we started at 2.15.
9 **LADY JUSTICE THIRLWALL:** Very well. Will 2.15 be
10 better for you?
11 **A.** Yes.
12 **LADY JUSTICE THIRLWALL:** Yes.
13 **A.** Thank you, my Lady.
14 **LADY JUSTICE THIRLWALL:** Very well. We will say
15 2.15. No, no, don't worry. That will suit everybody
16 else as well. We have had some very short lunch breaks
17 these last couple of weeks. 2.15 pm.
18 **(12.57 pm)**
19 **(The luncheon adjournment)**
20 **(2.14 pm)**
21 **MS LANGDALE:** Sir Duncan, we had just looked at the
22 meeting that the staff committee held surrounding
23 Mr Chambers and the Inquiry has heard evidence from Lyn
24 Simpson, who told us that she took a call from you to
25 discuss Mr Chambers's position.

1 So can you help us. When -- first of all can you
2 remember speaking with Lyn Simpson? I think you spoke
3 with Mr Dalton first and then you spoke with
4 Lyn Simpson?
5 **A.** Yes, I remember both conversations.
6 **Q.** Tell us about the one first of all with
7 Ian Dalton then?
8 **A.** I think that we had reached the point where
9 Mr Chambers was looking for a placement outside the
10 Countess of Chester, and Mr Chambers had talked to
11 Ian Dalton, Ian Dalton was open to helping him and he
12 delegated that responsibility to Lyn Simpson to put
13 the -- put things in motion.
14 **Q.** So who did you speak to, did you speak to
15 Mr Dalton or just Ms Simpson?
16 **A.** I can't remember a conversation with
17 Ian Dalton but certainly I had conversations with Lyn
18 Simpson.
19 **Q.** Lyn Simpson told us that her understanding was
20 the main issue was a breakdown in relationship of the
21 board; that that was the issue?
22 **A.** I -- I don't --
23 **Q.** Remember?
24 **A.** I don't accept that. The -- the issue was the
25 breakdown of relationships between Mr Chambers and the

1 paediatricians. That was a relationship which was
2 impaired to such an extent that the board needed to deal
3 with it but it wasn't an issue in the board.
4 **Q.** What did you tell her about the issue, if
5 anything, about the breakdown of relationship with the
6 paediatricians?
7 **A.** I can't remember exactly what I told her. She
8 was aware that that was the reason why we were looking
9 for, for placements. What was not unknown in either
10 NHSI North or NHSE North was that what had provoked the
11 breakdown in relationships was total loss of mutual
12 trust, respect and personal animosity.
13 Now, I did not go into a great detail of detail,
14 I am sure, about each of those ingredients, components
15 of the breakdown in relationships but it was not
16 something I was withholding from anyone.
17 **Q.** So you didn't give her the detail of why those
18 relationships had broken down but you said they had
19 broken down, there was a breakdown of relationships and
20 trust?
21 **A.** Yes, I can't remember whether I would have
22 elaborated or not.
23 **Q.** But you didn't send her, for example, the 26
24 questions or the paediatricians' emails?
25 **A.** No.

1 **Q.** Nothing like that?
2 **A.** No.
3 **Q.** She didn't get the detail we have seen
4 today --
5 **A.** No.
6 **Q.** -- that we have?
7 If we go to INQ0101357, page 1, this is
8 a conversation on 19 September and we see:
9 "LS and DN agreed the suggested way forward was;
10 "a. to prevent the vote of no confidence and ON to
11 take this forward.
12 "b. to ensure TC does not go back on site and
13 perhaps works from home for the next week, whilst LS
14 considers alternative options
15 "c. to agree that if an alternative option for
16 6~months could be found that TC would not go back to
17 Countess of Chester."
18 So reference there to preventing the vote of no
19 confidence. Why did you agree to prevent that or what
20 do you understand --
21 **A.** I didn't, I did not agree to prevent a vote of
22 no confidence, I didn't intervene at any -- at any point
23 in in that matter. There was only one intervention and
24 that was from Dr Gilby at Mr Chambers' request which
25 only succeeded when the MSC knew he had resigned.

1 **Q.** But there is reference there that he shouldn't
2 go back on site, so he doesn't go back on site, so the
3 vote of no confidence didn't happen but you say you
4 didn't actively prevent the staff committee re-meeting
5 or anything?
6 **A.** I spoke to -- I spoke to no one to influence
7 the vote of no confidence, which I thought was going to
8 take place.
9 **Q.** The agreement that Ms Simpson brokered was for
10 Mr Chambers to work for six months for a different
11 organisation funded by the Countess; is that right? Can
12 you remember what the agreement was that was discussed
13 between you and Ms Simpson?
14 **A.** The agreement that was discussed was that
15 Mr Chambers would be, would be allowed as it were
16 three months to find the placement. The placement would
17 then be covered financially by the Countess of Chester
18 which equated to his notice period.
19 That was approved by the RemCo of the Countess and
20 also by the national body, which has to approve
21 exceptional provider remuneration.
22 **Q.** So is the notice period normally six months?
23 **A.** Yes.
24 **Q.** So with the three months to find a placement
25 is in fact slightly longer then, it is nine months

1 funded by the Countess?
2 **A.** Yes, that is why it had to be approved at
3 a higher level.
4 **Q.** Does that mean at one point there would be an
5 overlap where you are paying for two Chief Execs if you
6 had another one?
7 **A.** If we had another, that is correct, we would
8 have been -- Mr Chambers was being paid for his notice
9 period but not serving it -- with, with the extra
10 three months while he sought the placement.
11 **Q.** Ms Simpson we know described Mr Chambers going
12 to work elsewhere as a rehabilitation period, I think
13 that is at page 24, reference to that, in the same
14 document.
15 **A.** Yes, not a word I recognise or would have used
16 myself.
17 **Q.** Okay. So that's not something that you
18 recognise. It's at the top there:
19 "Terms of his settlement sit with you and your
20 Remuneration Committee, I would advise that
21 rehabilitation periods linked to similar settlements in
22 the NHS seldom last more than one year."
23 So you wouldn't recognise the term but were you
24 familiar with what was happening in effect which was him
25 moving on in these circumstances to another role?

1 **A.** I recognise that technically our lawyer's
2 advice, this had to be a secondment which terminated
3 in -- in June of '19 and that at that point the Trust
4 had no further financial obligation towards Mr Chambers.
5 He certainly wouldn't be returning to the Trust.
6 **Q.** You said in your own statement to us at
7 paragraph 139:
8 "The performance of Tony Chambers at annual review
9 2013/2014 to 2016/2017 had exceeded expectations but had
10 dipped in 2017/2018."
11 In terms of how those appraisals were done are
12 those the 360-degree appraisals where it's what do you
13 think of yourself, what do others around you think of
14 you colleagues and the like?
15 **A.** The appraisals -- annual appraisals are
16 between in this case myself and the Chief Executive.
17 They, they address preestablished objectives under four
18 of five headings and they are assessed by the Chair in
19 this case as either exceeding expectations or partially
20 or not meeting expectations. Tony Chambers had five
21 years at the Trust where he exceeded expectations.
22 In 17/18, it was judged by me that he had not met
23 expectations. That I communicated to the Non-Executive
24 Directors. It was also agreed at that meeting that
25 I had, which was a one-on-one performance review, that

1 -- that he would -- he would be looking for a new --
2 a new job, the best years possibly behind him at that
3 time.
4 **Q.** We can no doubt find those appraisals or the
5 documentation. But were you involved directly in his
6 appraisals or not?
7 **A.** In the appraisal?
8 **Q.** In the appraisals?
9 **A.** Yes, it was my just the two of us.
10 **Q.** Just the two?
11 **A.** It was my appraisal of Mr Chambers.
12 **Q.** Thank you. So we can find those, I'm sure.
13 **A.** I shared that with the Non-Execs but it was my
14 appraisal.
15 **Q.** Right. There was a narrative announcement, if
16 we go to INQ0015683, page 31. Was that something agreed
17 between you and Mr Chambers --
18 **A.** Yes.
19 **Q.** -- in terms of his moving forwards?
20 That penultimate paragraph:
21 "These investigations into neonatal deaths at the
22 Trust have escalated over the past two years and
23 inevitably put relations between senior management and
24 paediatricians under exceptional strain."
25 What does that communicate, if anything, about

1 Mr Chambers' role or part in that?
2 **A.** That doesn't communicate anything about either
3 party's part in -- in the breakdown of relationships.
4 **Q.** Was that the purpose of this not to
5 communicate what had happened how or why but simply to
6 say there is a breakdown in relationships?
7 **A.** It is not the purpose to withhold that but in
8 the light of the announcement it was felt to be the --
9 the right -- the right way to express the situation
10 which we had arrived at.
11 **Q.** And if we go, please, to INQ0102361, 0101, we
12 see on the front page:
13 "Please confirm Tony's reason for leaving, if
14 known, secondment and resignation."
15 **A.** Yes.
16 **Q.** Is -- was this a secondment?
17 **A.** A secondment was the -- the -- the legal way
18 in which I was advised the placement had to take place
19 after Mr Chambers' resignation.
20 **Q.** The next page, please, overleaf. You sign
21 that off. There is no other reference -- in fact, we
22 should go to the page before, page, there was no
23 warnings, could have been imposed, not under
24 investigation for any matter?
25 **A.** No.

1 **Q.** Nothing.
2 **A.** There were -- there were telephone calls
3 between points along the way, with prospective chairs of
4 Trusts that might be appointing Mr Chambers. But
5 nothing in this particular reference.
6 **Q.** So would you have expected a prospective chair
7 appointing him to speak to you or is that not how the
8 system worked --
9 **A.** Some did. I didn't, but if I had been
10 appointing someone as a chair, I would have spoken to
11 the predecessor chair, yes.
12 **Q.** And if someone spoke with you and had asked
13 more information about it, would you give that
14 information?
15 **A.** Yes.
16 **Q.** Did anyone ask you for more information?
17 **A.** Yes. Yes, there was a chair who -- who asked
18 me whether there was anything that she should know and
19 I -- I responded to that by saying that Mr Chambers had
20 been facing a vote of no confidence.
21 **Q.** So you wouldn't withhold that if someone asked
22 that?
23 **A.** Sorry?
24 **Q.** You wouldn't withhold that; if someone asked
25 about that, you did tell them?

1 **A.** I did and I also told Mr Chambers that that's
2 what I had done.
3 **Q.** Were you -- following the Kark review of a Fit
4 and Proper Person Test, do you have a view about that,
5 somebody in Mr Chambers's position being able to move on
6 at this point or not?
7 **A.** We didn't review Kark in the board or in the
8 Trust, no.
9 **MS LANGDALE:** Those are my questions, thank you,
10 Sir Duncan.
11 **LADY JUSTICE THIRLWALL:** Ms Sutherland.
12 Questions by MS SUTHERLAND
13 **MS SUTHERLAND:** Thank you, my Lady.
14 Sir Duncan, can you hear me?
15 **A.** I can.
16 **Q.** Thank you. My name is Sarah Sutherland,
17 I represent some of the Families. Please let me know if
18 my voice dips and you can't hear me?
19 **A.** Thank you.
20 **Q.** I am going to cover a couple of topics my
21 learned friend has touched upon. The first one is in
22 relation to the Clothier Inquiry?
23 **A.** The?
24 **Q.** Clothier Inquiry?
25 **A.** Yes, yes.

1 **Q.** You had it, you read it --
2 **A.** Yes.
3 **Q.** -- and you disseminated it in the 90s?
4 **A.** Yes.
5 **Q.** My learned friend Ms Langdale KC took you to
6 the most important conclusion and that was to serve to
7 heighten awareness in all those caring for children --
8 **A.** Yes.
9 **Q.** -- of the possibility of malevolent
10 intervention as the cause of unexplained events; do you
11 recall that?
12 **A.** I do.
13 **Q.** Your experience over the years, you would have
14 been aware of Shipman?
15 **A.** Yes.
16 **Q.** And from those cases of healthcare homicide,
17 your experience would teach you that often the signs of
18 malevolent influence are subtle, would you agree with
19 that?
20 **A.** Yes.
21 **Q.** They would require prompt, urgent
22 intervention?
23 **A.** Yes.
24 **Q.** You have told us today that children would
25 require they need somebody to speak for them; is that

1 right?
2 **A.** Yes.
3 **Q.** So we know that on 30 June 2016, you began two
4 week meetings, preparatory meetings, leading up to the
5 extraordinary board meeting?
6 **A.** Yes.
7 **Q.** You discussed the increased neonatal deaths;
8 that's right, isn't it?
9 **A.** To discuss?
10 **Q.** You discussed the increase in neonatal deaths?
11 **A.** Yes.
12 **Q.** Now, this process, this two-week process, was
13 a highly unusual process; would you agree with that?
14 **A.** No, I think it was a matter of preparing for
15 the extraordinary board meeting and bore heavily on the
16 availability of people to -- to join those meetings, not
17 least the paediatricians for the second one.
18 **Q.** Okay, well, we'll have another look at
19 a couple of the documents, if we may, the first is
20 INQ0003361. I am going to ask you to look at page 2,
21 please.
22 Now, we can see just over halfway down that page
23 the initials "DN"?
24 **A.** Yes.
25 **Q.** Do you see that?

1 **A.** Yes.
2 **Q.** It's got a loop around it. This says:
3 "Commission in-depth review. It will take as long
4 as it takes."
5 Further on down there it says:
6 "Why haven't we closed the unit?"
7 And just slightly before that:
8 "If so much concern, why haven't we closed the
9 unit?"
10 **A.** Yes.
11 **Q.** Do you see that?
12 **A.** I can.
13 **Q.** Then we can see a couple of lines down:
14 "Next meeting 1 pm today."
15 And that appears to read:
16 "Nurses and HR."
17 Do you see that?
18 **A.** No, can I just --
19 **Q.** There we go. Thank you. Then just below
20 that: next meeting with the Consultants at 3.00 pm
21 today?
22 **A.** Yes.
23 **Q.** So this document arises from the first
24 meeting, it would seem, of that day, which is with
25 Alison Kelly, Ian Harvey, Tony Chambers, Stephen Cross,

1 Sue Hodkinson and yourself?
2 **A.** Yes.
3 **Q.** Do you recall that meeting?
4 **A.** I -- I recall the meeting. I don't recall the
5 detail of discussions at the meeting. This note
6 refreshes my -- my memory to some extent.
7 **Q.** What I am interested in is why was that the
8 order of meetings? So the first meeting is with you and
9 the Executive Team, the second meeting seems to be with
10 the nursing team and the HR team?
11 **LADY JUSTICE THIRLWALL:** Sorry, Ms Sutherland, is
12 that "comms" in front of that?
13 **MS SUTHERLAND:** Yes, forgive me, my Lady:
14 "Comms, nurses and HR."
15 **A.** Yes.
16 **Q.** Yes, at 1 pm. Then finally, the meeting with
17 the Consultants.
18 Why was the order of the meetings?
19 **A.** We were preparing for a very important meeting
20 which was the extraordinary meeting in -- later --
21 later, two weeks later and it was important to have
22 these briefings, these preparation for that meeting and
23 we took it in two parts on this occasion so that we
24 heard from the paediatricians and others at a separate
25 meeting. That seems to me a reasonable thing to do.

1 **Q.** So it wasn't the case that the Executives are
2 dictating the narrative in this first meeting?
3 **A.** No, no.
4 **Q.** Thereafter meeting with the nurses and then
5 finally the Consultants who were the people raising the
6 concern.
7 **A.** No, there was not -- there was not a conscious
8 division here. There were -- there were two sessions
9 I think in the same -- the same afternoon.
10 **Q.** Nothing about the Families --
11 **A.** No.
12 **Q.** -- at all?
13 **A.** No.
14 **Q.** They should have been included in this,
15 shouldn't they?
16 **A.** I am -- I'm not sure at this stage whether the
17 Families should have been included in these meetings.
18 This was the first time that I had heard anything about
19 a spike in deaths. We were looking to the principal
20 concern which was the safety of babies on the unit and
21 we had actions that we needed -- needed to take.
22 We hadn't got confirmation of those actions apart
23 from the downgrading of the unit to special care unit
24 and it wasn't until the board approved later actions
25 that we -- we had decided where we were, where we were

1 going forward to.
2 **Q.** Okay. Well, let's have a look at the meeting
3 with the paediatricians, please, that is INQ0006023. So
4 you can see there at the top it reads: "Thursday
5 30 June"?
6 **A.** Yes.
7 **Q.** You can see the attendees there, DN, so that
8 would appear to be your initials?
9 **A.** Yes.
10 **Q.** We can see that there are a number of
11 Consultants who attend including Steve B, Ravi --
12 **A.** Jayaram.
13 **Q.** -- and Jim is referred to as well; yes?
14 Now, you see at the top:
15 "outline from TC: unexplained increase in deaths"?
16 Then if we go on to page 2 -- forgive me, before
17 you do, just bear with me. At the bottom of that,
18 "Steve B", so that appears to be Stephen Brearey:
19 "... went back a step" or "won't back a step. Does
20 not matter what level with concerns about a member of
21 staff.
22 "We can reduce the cots HDU gestation but still not
23 safe because of staffing."
24 Do you see that?
25 **A.** I do, yes.

1 **Q.** If we go over the page. It says:
2 "Ravi: starting point. What is safe? Reduce
3 service but staff member not addressed. Discussed going
4 to police and the impact of an investigation."
5 Then we go on further on down the page. Further
6 discussions between the Consultants, on to page 3,
7 please. Towards the bottom we can see again:
8 "Steve B: care is not perfect. Common theme of
9 this nurse. Doesn't take away concern re this
10 individual. Not [and underlined] change my opinion.
11 Spoken in May to AK and IH re concerns."
12 Do you recall this conversation?
13 **A.** Sorry, do I?
14 **Q.** Do you recall this conversation?
15 **A.** As -- as reminded by the note that we have
16 just looked at.
17 **Q.** So we can see that Steve Brearey is quite
18 clearly saying: whatever changes are put in place, it's
19 not going to change his mind. The common theme is that
20 individual. Do you see that?
21 So if we go back to the conclusion, the main
22 conclusion of the Clothier Inquiry, which we have
23 already talked through to serve to heighten awareness in
24 all those caring for children of the possibility of
25 malevolent intervention as the cause of unexplained

1 events, so Steve Brearey, paediatrician, head of the
2 neonatal unit saying there: it will not change his
3 opinion.
4 That's the date you should have called the police.
5 **A.** The --
6 **Q.** You should have called the police, that is the
7 date.
8 **A.** These were views being expressed by
9 individuals in anticipation of the -- the meeting that
10 took place. Those were not -- not the views that were
11 expressed at the meeting that was going to make the
12 decisions about -- about the future of the unit and
13 indeed about the issue of the police and I would --
14 I would say again that the consensus in that meeting was
15 that the majority -- this was from the paediatricians,
16 the majority of paediatricians agreed that the next
17 steps were to undertake the external enquiries not --
18 not to call the police.
19 So these -- these are thoughts in advance of that
20 meeting which was taking the decision about police or
21 not, external enquiries or not, supervision or not.
22 **Q.** Okay. Well, let's just carry on in this note.
23 The next page, please, page 4. About halfway down, Ravi
24 again -- sorry, just above halfway:
25 "Ravi: concern potentially member of staff causing

1 harm, recurring theme."
2 Then Sarah:
3 "These babies should never have died."
4 **A.** Yes.
5 **Q.** You see that. Now --
6 **A.** This -- this is -- these were the views being
7 expressed. This is why we invited the paediatricians to
8 come to the board directly to express their -- their
9 concerns and not to be party to the decisions, they
10 weren't board members, but -- but to express their
11 opinions about what the next steps should be.
12 **Q.** These were Consultant paediatricians, who were
13 clearly identifying unexpected, unexplained deaths of
14 babies on 30 June 2016. There was nothing stopping
15 anybody calling the police, was there?
16 **A.** There was nothing stopping anybody calling the
17 police.
18 **Q.** Can I just ask you about a slightly separate
19 topic, just for a moment, moving away from that document
20 which can come down, thank you.
21 The Health and Social Care Act 2008 (Regulated
22 Activities) 2014; that is a piece of legislation that
23 you would be familiar with; is that right?
24 **A.** Not without referencing it to -- to see what
25 the content was.

1 **Q.** Do you know what a notifiable incident is,
2 a notifiable incident?
3 **A.** A notifiable incident would I think be
4 an unexplained death, it would certainly include
5 an unexplained death.
6 **Q.** The Health and Social Care Act 2008 "Regulated
7 Activities" 2014 sets out the duty of candour at
8 section 20.
9 **A.** Yes.
10 **Q.** That requires a health service body to act in
11 an open and transparent way with relevant persons in
12 relation to care and treatment and it mandates a series
13 of steps. While I appreciate you may not recall the
14 intricacies of it today, is it a piece of legislation
15 you were familiar with --
16 **A.** Yes, it was.
17 **Q.** -- in 2015 and 2016?
18 **A.** Yes.
19 **Q.** So these were notifiable incidents and they
20 should have been reported within the terms of that
21 legislation, would you agree with that?
22 **A.** They should.
23 **Q.** Have you seen any evidence that that is what
24 took place?
25 **A.** No, I haven't.

1 **Q.** I just wanted to ask you a little bit about
2 systems as well. This is something that you talk about
3 in your witness statement. Paragraph 42, you said it
4 was primarily the people and not the systems that were
5 the overriding factor.
6 But you need to know that systems exist for them to
7 work; would you agree with that?
8 **A.** Absolutely.
9 **Q.** You need to be trained into how to operate
10 those systems for them to work; would you agree with
11 that?
12 **A.** Yes.
13 **Q.** So I am just going to pray on your expertise
14 for a moment. But Datix reports, do you know what Datix
15 reports are?
16 **A.** Yes.
17 **Q.** And you will appreciate that incidents should
18 be reported through Datix systems?
19 **A.** Yes.
20 **Q.** That's on the ground reporting of incidents,
21 incidents, accidents and near misses; is that right?
22 **A.** Yes.
23 **Q.** We have heard over the course of the evidence
24 these descriptions of Datix at the Countess of Chester.
25 Dr Brearey described the grading as variable, the

1 grading of risk as variable.
2 Dr Jayaram said there was no standardisation of
3 which -- which incident would be Datixed. Ms Townsend
4 said Datix weren't always completed and if they were,
5 the quality was variable.
6 Mr Semple, who took over from Ms Townsend, said
7 there was no feedback on Datix reports and no feedback
8 on incidents.
9 Yvonne Farmer, who was a nurse of 15 years on the
10 neonatal unit, confirmed she hadn't had any training in
11 respect of Datix.
12 So at a ground level, the Datix system having heard
13 that evidence, appears not to have been working; would
14 you agree with that?
15 **A.** Hearing that evidence there were deficiencies.
16 **Q.** For your risk management to work, you need
17 your ground level reporting to work, don't you?
18 **A.** Yes, you do.
19 **Q.** So if your ground level reporting is not
20 working, your risk management and your risk strategy
21 cannot work; would you agree with that?
22 **A.** That's correct.
23 **Q.** Tony Chambers. You have told us a little bit
24 about Tony Chambers. You appointed him in 2013 and we
25 know that you describe him as a colleague, you had

1 a warm working relationship. Was he a friend?
2 **A.** Not a friend, no.
3 **Q.** But he was accountable to you --
4 **A.** He was.
5 **Q.** -- would you agree with that?
6 We know from your witness statement, paragraph 109,
7 you recalled the conversation with Dr Jayaram that we
8 have heard today where you put your arms around each
9 other, we've looked at the letter that the Consultants
10 wrote and just perhaps we could have a quick look at
11 that again.
12 INQ0102361. It's page 78, please. You saw this
13 letter on or around April 2018, April/May?
14 **A.** Yes, I did, yes.
15 **Q.** Sections of that relate very clearly to Tony
16 Chambers. If we go over the page, if we may, and you
17 will see there a box:
18 "The Chief Executive's tone was aggressive and
19 threatening."
20 Above that:
21 "The Chief Executive indicated we must agree to the
22 decisions of the board and that a line had been drawn
23 under this affair. We were to apologise to the nurse in
24 question."
25 Below the bold bullet points we have got in the

1 middle of the page:
2 "Following the meeting, the paediatricians wrote
3 3 letters to the Chief Executive, signed by all, for
4 fear that any one paediatrician might be singled out and
5 victimised."
6 Reading that description, would you agree
7 Tony Chambers was not a fit and proper person?
8 **A.** No.
9 **Q.** You wouldn't agree?
10 **A.** I don't agree with that.
11 **Q.** You don't agree. You don't agree that?
12 **A.** I agree -- I agree these matters were raised
13 directly with me by the paediatricians. I was not at
14 that meeting. This is the 26th which Rachel Hopwood
15 attended for me; I was not at that meeting. And -- and
16 I discussed the matter afterwards with them in relation
17 to very strong feelings they had about being bullied and
18 victimised and -- and threatened which is reflected in
19 this -- in this particular question.
20 **Q.** Okay.
21 Well, if we may go to the next page, please. Just
22 over -- sorry, just under halfway down that page:
23 "Some paediatricians were coerced to enter
24 mediation with the nurse in question with a threat of
25 GMC referral if they refused.

1 "In March 2017, the Chief Executive met with two
2 paediatricians. The paediatricians explained 'we felt
3 the deaths had not been adequately investigated and were
4 concerned that parents had been misled. We asked the
5 Chief Executive to refer the Trust for a police
6 investigation'."
7 Reading that description, if that was right,
8 Tony Chambers was not a fit and proper person, was he?
9 **A.** No, I don't agree. I think he was in the
10 middle -- in the middle of a process, I don't -- I don't
11 believe the paediatricians were coerced into mediation
12 and these, these were the views of the paediatricians
13 but I -- I don't fully subscribe to -- to all those
14 points to the level of saying Tony Chambers wasn't a fit
15 and proper person.
16 **Q.** We know from the evidence of Lyn Simpson that
17 she has recorded the way forward was to prevent a vote
18 of no confidence so that Tony Chambers could obtain
19 a new role, effectively.
20 Now, I am not going to ask you to look at her
21 chronology again. But I am going to go back to the
22 Health and Social Care Act 2008 (Regulated Activities)
23 Regulations 2014 and you will recall Regulation 19
24 places a duty on NHS providers not to appoint a person
25 or allow a person to continue to be an Executive

1 Director or equivalent or a Non-Executive Director under
2 given circumstances.
3 To meet that requirement, there has to be
4 assessment and review of individuals, doesn't there?
5 **A.** Yes.
6 **Q.** There have to be regular checks, don't there?
7 **A.** There has to be -- there have to be checks,
8 yes, absolutely.
9 **Q.** NHS providers must have appropriate
10 arrangements in place to deal with staff who are no
11 longer fit to carry out the duties required of them?
12 **A.** Yes.
13 **Q.** You didn't investigate what these clinicians
14 were saying in that letter, did you?
15 **A.** No, it was for Mr Chambers to -- to respond to
16 the letter addressed to him.
17 **Q.** But he's accountable to you?
18 **A.** He is accountable to me and we needed to
19 I think understand how that conversation was going to be
20 played out -- this -- these were challenges in the form
21 of questions. Mr Chambers responded. In the meantime,
22 I was hoping that it would be possible to -- to mediate
23 a bringing together of the clinicians and management
24 which had fractured.
25 So we were -- we were in the middle of a process of

1 reconciliation that had no quick fix.
2 **Q.** In your witness statement, you refer to the
3 Kark review and I know you have referred to it today and
4 you will be aware that that relates to a fit and proper
5 person setting out seven recommendations and it says
6 this at paragraph 5:
7 "One of the identified problems relating to
8 management in relation to those two organisational
9 failures in that review was the ability of poorly
10 performing managers and directors to move from Trust to
11 Trust, often following a settlement agreement and
12 a pay-off."
13 Now, Mr Chambers finished his role with the
14 Countess of Chester and he moved elsewhere, to
15 Northern Alliance, didn't he?
16 **A.** Yes.
17 **MS SUTHERLAND:** My Lady, I have no further
18 questions, thank you.
19 **LADY JUSTICE THIRLWALL:** Thank you very much
20 indeed, Ms Sutherland.
21 Ms Woods.
22 Questions by MS WOODS
23 **MS WOODS:** Sir Duncan, my name is Leanne Woods and
24 I ask questions on behalf of the other Family group.
25 Again, if my voice drops, please let me know, okay?

1 Can I go back to Beverley Allitt, please --
2 **A.** Yes.
3 **Q.** -- and the Clothier Inquiry.
4 So Beverley Allitt's offences were committed on
5 babies during the time you were heading the NHS; that's
6 right, isn't it?
7 **A.** Yes, it is.
8 **Q.** She was convicted of murders and attempted
9 murders during the time you were heading the NHS;
10 correct?
11 **A.** Yes.
12 **Q.** The Clothier Inquiry was set up and indeed
13 reported during the time you were heading the NHS; is
14 that right?
15 **A.** Yes.
16 **Q.** Presumably it was a significant event both for
17 the NHS and by extension for you?
18 **A.** Very much so.
19 **Q.** You have been taken to Recommendation 13 of
20 the Clothier Inquiry but can I just ask about your
21 witness statement. At the very start of your 30-page
22 witness statement there's a short section on
23 Beverley Allitt and the Clothier Inquiry.
24 Then to my eyes, both Allitt and the Clothier
25 Inquiry disappear entirely from your witness statement

1 when you are talking about these events at the Countess
2 of Chester Hospital.
3 The next brief reference comes -- it's
4 paragraph 99, but in the chronology where it comes is an
5 extraordinary board meeting on 13 April 2017 and there
6 it seems that you asked a question which built in
7 a comparison with Beverley Allitt.
8 May I ask you this: from that, should the Inquiry
9 or indeed the Families take it that so far as you can
10 recall, that -- so the 13 April 2017 was the first time
11 that you articulated a comparison with Beverley Allitt?
12 **A.** That's correct.
13 **Q.** Mr Harvey said in his oral evidence last week
14 that he wasn't aware of your knowledge of and experience
15 with the Beverley Allitt case and he never discussed
16 Beverley Allitt with you. Does that fit with your
17 recollection?
18 **A.** I missed with whom?
19 **Q.** Mr Harvey?
20 **A.** No, he didn't -- we didn't discuss that.
21 **Q.** You did not discuss that?
22 **A.** No.
23 **Q.** Okay. At paragraph 152 of your witness
24 statement, you refer to the principal recommendation of
25 the Clothier Inquiry and you say this:

1 "In practice, this important aspiration [so of
2 keeping the possibility of malevolent intention in mind]
3 runs up against the short term collective memory of the
4 NHS and that of individuals working within the NHS."
5 What I take from that is that you are saying
6 memories fade, time passes, personnel change. So just
7 to take an example, you might have a junior doctor
8 coming in who probably was at school at the time of the
9 Beverley Allitt events?
10 **A.** Yes, correct.
11 **Q.** Is that what you mean?
12 **A.** I do.
13 **Q.** But of course you didn't fall into that
14 category, Sir Duncan, you were there at the time of
15 Beverley Allitt and of course you were there in the
16 Countess of Chester. So can you explain to the Families
17 where Allitt and the possibility or indeed the actuality
18 of nurses causing deliberate harm sat in your thinking
19 and indeed the board's thinking between the end of
20 June 2016 and April 2017?
21 **A.** I think the Allitt Inquiry and the
22 recommendations it made were not in the forefront of my
23 memory and it would not appear from the conversations
24 that didn't take place which reference Allitt that they
25 were in the minds or the front of the minds of -- of

1 anyone. And I tried to explain that this is absolutely
2 fundamental aspiration. But you cannot rely on -- on
3 collective memory, individual memory. And I --
4 I suggested -- when I was invited to recommend,
5 I suggested that we had to embed this way of thinking
6 into the system, almost by way of a checklist, a tick
7 box, if there is an unexplained death, please tell us
8 that you have considered the possibility of malevolent
9 action.
10 **Q.** Well, I wanted to ask you about that because
11 you obviously have a vast amount of experience both
12 within the NHS and in public service generally. So one
13 can see a checklist or some kind of document like that
14 perhaps working on the ground with the clinicians right
15 we have got an unexplained death, this is one of the
16 many things that we need to think about.
17 But how does that apply to the board and board
18 members? How does it -- how should the memory of this
19 kind of event be brought to the forefront of the minds
20 of board members or indeed chairs of boards?
21 **A.** It certainly should through -- through the
22 obvious mechanism perhaps of the safeguarding training
23 for those members.
24 **Q.** Can I move to a different topic, please, which
25 is the approach to communicating with Families.

1 Wrapped up in Letby's grievance against the
2 hospital was a complaint about the hospital's lack of
3 transparency on why she had been moved away from the
4 neonatal unit and the Inquiry has heard evidence that
5 the Trust took numerous steps to try to manage that and
6 really then put it right for Letby, so there was
7 a grievance procedure which proceeded, there were
8 discussions at the extraordinary meeting on
9 10 January 2017 about not being as honest with her as
10 the Trust could have been.
11 She got an apology from Mr Harvey. Mr Chambers was
12 telling her "Lucy, we have got your back". She was
13 given very high levels of support from various Trust
14 staff and we know, I think, that she saw the
15 Royal College report before some of the Consultants and
16 certainly before the Families saw that report.
17 Did you -- did the board collectively -- ever
18 consider that there was an imbalance, a somewhat
19 perverse imbalance between the Trust's consideration of
20 trying to remedy the lack of transparency with Letby on
21 one hand and the ongoing lack of transparency with the
22 Families?
23 **A.** I don't believe the Trust board did consider
24 that.
25 **Q.** Do you know why?

1 **A.** I don't know why.
2 **Q.** Can you try just to take a moment and think
3 about that, because it is clearly important to the
4 Families?
5 **A.** I can -- I can try. I think we had -- we had
6 the -- we had the grievance. You know, I have commented
7 in my evidence about the grievance. I think it was
8 basically misconceived as something that was happening
9 at the time of -- of all that -- all else that was
10 happening but it was -- it was an entitlement of
11 Lucy Letby to -- it took place and that -- that was kind
12 of running -- running in parallel to -- to other
13 matters.
14 It's clear from what I know now from the evidence
15 that I have read that a huge amount of sympathetic
16 support was being given by senior managers to Lucy Letby
17 during the course of those events. The board I don't
18 think was sufficiently sighted or sighted on -- on those
19 matters.
20 **Q.** But of course one of the roles of the board is
21 to provide -- I think some of the documents talk about
22 robust challenge or constructive challenge, and to
23 remind people who -- like the Executives who are there
24 in the day-to-day, in the thick of it, to try to step
25 back and try to see the bigger picture, would you agree

1 with that?
2 **A.** We -- we try to do that, I do agree with that.
3 **Q.** So where in the bigger picture were the
4 Families?
5 **A.** The Families were not in the big picture. We
6 didn't exercise appropriate duty of candour towards the
7 Families and that, that was -- that was a failure.
8 A serious failure.
9 **Q.** Sir Duncan, can I then ask you the same
10 question, again going back to someone with your long
11 experience of the NHS and public life and someone who's
12 presumably given this a lot of thought.
13 What more can be done at board Executive level to
14 ensure that families are not kept in the dark and that
15 are -- are not -- kept outside when things go wrong?
16 **A.** We just -- we have to reinforce the key
17 messages of good governance and good board practice. We
18 have to do this in training events, we have to do this
19 almost, as it were, by way of on the job learning. We
20 don't always succeed in doing that as well as we should.
21 But we should redouble our efforts to -- to make
22 sure that that happens in the future and in the present.
23 **Q.** With respect, Sir Duncan, that sounds like
24 more of the same?
25 **A.** No --

1 **Q.** Have you thought of anything different or more
2 radical than that?
3 **A.** I think I said earlier, we, we have
4 a multitude of, of systems, board assurance, of risk
5 assessment, of safeguarding, of Speak Out Safely. They
6 all exist. There is training for those -- those
7 systems.
8 But at the end of the day we need I think to pay
9 more attention to whether they are being observed in
10 practice. So -- so that's -- for example, there should
11 be audit of whether the -- the Risk Registers generated
12 at ward level are being so generated through Datix and
13 escalated appropriately.
14 We need -- we need audit, we need external checks
15 to tell us whether we -- what we have in place by way of
16 a system of policy or a process is actually happening on
17 the ground in practice and through the behaviours of
18 people and you need to go out and find out through,
19 through audit and other measures.
20 **Q.** Can I just bring you back to the Families?
21 **A.** Yes.
22 **Q.** So audit somewhat different from communicating
23 with families?
24 **A.** Absolutely.
25 **Q.** Okay. So I think you have accepted that there

1 should have been, families should have been at the
2 centre of the thinking on this in terms of how to
3 communicate with them and can I ask, what went wrong for
4 you, why were they not at the centre of your thoughts?
5 **A.** I am not -- I am not entirely sure.
6 I think -- I mean, we failed and I don't want to --
7 we were in the middle of a hugely complex process that
8 we hadn't finished, but that shouldn't have -- shouldn't
9 have meant we couldn't have kept people informed along
10 the way and we did not do that appropriately.
11 **Q.** Linked with that, please, the Royal College
12 report, as you know, there were certainly at least two
13 versions, the confidential version and the version that
14 had the information about Lucy Letby in it.
15 The version that was published and was eventually
16 sent to the Families was the edited or redacted version.
17 Doing that was not being open with the Families, was it?
18 **A.** No, but it -- arguably it was not being open
19 with a number of other people who didn't receive the
20 redacted report for the reasons that I've explained
21 before, so the nature of the confidentiality of the
22 individual involved.
23 **Q.** Can you see an argument that there should
24 never be different versions of reports such as this
25 where the report arises directly out of incidents

1 involving patients and concerns of patient safety?
2 **A.** I think it -- I think having the two reports
3 which the College were comfortable with I think was
4 right in these circumstances and there could be similar
5 circumstances in the future in relation to individual
6 confidentiality.
7 **Q.** So let me just follow that through. Does it
8 follow then that you are saying in this instance it was
9 the right thing to do to send the redacted version to
10 the Families --
11 **A.** Yes, I believe it was.
12 **Q.** -- and therefore keep them in the dark?
13 **A.** Not, not disclosing that information to them.
14 **Q.** Therefore keeping them in the dark?
15 **A.** I wouldn't put it that way.
16 **Q.** Final issue, please, Sir Duncan. At
17 paragraph 26 of your witness statement, you say:
18 "I was aware that Mr Cross had approached the
19 Coroner about the deaths in the neonatal unit and he
20 kept me updated."
21 Did Mr Cross tell you directly that he had
22 approached the Coroner?
23 **A.** He did.
24 **Q.** Okay, so that information came from Mr Cross?
25 **A.** Yes.

1 **Q.** Okay. Your statement says and that he had
2 approached the Coroner about the deaths in the neonatal
3 unit. Now, that phrasing could cover a wide variety of
4 things. What did Mr Cross tell you that he had reported
5 to the Coroner?
6 **A.** I can't remember the detail of what he told
7 me. I knew he had approached the Coroner but I don't
8 recall the detail now.
9 **Q.** Do you recall, because this is important and
10 would have been important at the time, if he told you he
11 had informed the Coroner about the paediatricians'
12 suspicions that Letby was harming babies?
13 **A.** I don't recall him telling me that.
14 **Q.** Do you recall either you or the board asking
15 either Mr Cross or the Executives directly: "Look, what
16 has the Coroner been told about all of this?"
17 **A.** No, I don't remember that, I don't remember
18 that question being asked.
19 **Q.** Okay. It's a question that should have been
20 asked, isn't it?
21 **A.** Yes.
22 **MS WOODS:** Thank you, my Lady, thank you,
23 Sir Duncan.
24 **LADY JUSTICE THIRLWALL:** Thank you, Ms Wood,
25 Mr Kennedy, I am sorry, are you --

1 **MR KENNEDY:** Just one moment.
2 **LADY JUSTICE THIRLWALL:** Yes, of course.
3 Questions by MR KENNEDY
4 **MR KENNEDY:** Sir Duncan, can I just go back to the
5 questions Ms Woods asked you about duty of candour and
6 you told my Lady that there was a failure to communicate
7 with the Families.
8 You also then said to her that you felt it was
9 reasonable for only the redacted RCPCH Report to be
10 provided to the Families and I just wonder whether
11 there's a consistency or inconsistency in those two
12 propositions that you would like to explore a little
13 further?
14 **A.** I don't believe there is an inconsistency.
15 What I think the Families would have wanted to be
16 informed about given there was information that could
17 have been given to them was about -- about the enquiries
18 that were happening, about the progress that was being
19 made in the whole process of trying to ascertain answers
20 to the fundamental question of why these deaths had --
21 had occurred.
22 But I don't think that involves making available
23 every piece of information. One in particular which had
24 been classified as -- as confidential to an individual.
25 **Q.** So the principle is that the Families need to

1 be kept in the picture?
2 **A.** Yes.
3 **Q.** The question then becomes: to what extent
4 whether they need to be given --
5 **A.** It does.
6 **Q.** -- all information, perhaps mislabel it,
7 whether there is some information which is treated as
8 confidential?
9 **A.** Yes. As much information as possible, but if
10 there is confidential information, that should not be
11 shared, let's say, in my view, or other views, then that
12 should not be shared.
13 **MR KENNEDY:** Very well, my Lady, thank you.
14 **LADY JUSTICE THIRLWALL:** Thank you very much,
15 Mr Kennedy.
16 **MS LANGDALE:** No more questions from the Bar. I do
17 understand that, Sir Duncan, you wanted to have
18 an opportunity to say something at some point, I don't
19 know whether that is still the case?
20 **A.** Thank you Ms Langdale. I do -- I do want to
21 say I had a long career in the health service. I have
22 never encountered a situation which generates as much --
23 as much angst, stress as this one and I wanted to say
24 that the Countess of Chester failed to keep babies safe
25 in their care and something that I -- I have found very,

1 very stressful over time.
2 More importantly, that -- that caused unimaginable
3 grief for the Families involved with the babies who
4 died, whose parents of the babies that died were, and
5 I'm so sorry, I am so sorry that that happened in the
6 way it did.
7 Thank you.
8 **LADY JUSTICE THIRLWALL:** If you would just like to
9 take a moment --
10 **A.** Thank you.
11 **LADY JUSTICE THIRLWALL:** -- while I just check
12 through my notes, Sir Duncan, in case I have got
13 anything else that I need to ask you about, I won't be
14 very long.
15 Questions by LADY JUSTICE THIRLWALL
16 **LADY JUSTICE THIRLWALL:** One very short and I think
17 very easy question.
18 You mentioned that you conducted the appraisal for
19 the Chief Executives, so you conducted it for
20 Tony Chambers. Would those appraisals have been
21 recorded somewhere?
22 **A.** They are, they would -- they would -- there is
23 a yes there is a written account of the appraisal.
24 **LADY JUSTICE THIRLWALL:** Thank you, just something
25 I need to have a look for.

1 You mentioned that for several years he was
2 exceeding expectations and then the year came when he
3 was not meeting expectations?
4 **A.** Yes.
5 **LADY JUSTICE THIRLWALL:** Are you able now to say in
6 summary what the issue was there?
7 **A.** I probably need to look at the -- the
8 performance appraisal but there were a number of things
9 which were not being delivered to the level that we
10 wanted involving, for example, the Accident and
11 Emergency Department performance, a raft of operational
12 issues, maybe two or three or four operational issues
13 where we felt that the progress -- I felt that the
14 progress hadn't been sufficiently made to the point
15 where the appraisal was recorded as not meeting
16 expectations.
17 **LADY JUSTICE THIRLWALL:** And was there anything in
18 respect of the matter that I am inquiring into, did that
19 form any part --
20 **A.** It did not.
21 **LADY JUSTICE THIRLWALL:** -- of it? So
22 relationships with the Consultants, that wasn't a part
23 of your --
24 **A.** It is not part of that appraisal. The
25 appraisal was looking at objectives that had been set

1 12 months ago.
2 **LADY JUSTICE THIRLWALL:** Yes.
3 **A.** The issue of relationships with the
4 paediatricians which -- and the fractured relationships
5 that were so detrimental to the hospital were -- were
6 discussed elsewhere, not through the appraisal system,
7 leading to the conclusion that we arrived at.
8 **LADY JUSTICE THIRLWALL:** You mentioned that Tony
9 Chambers was looking for a new --
10 **A.** I did.
11 **LADY JUSTICE THIRLWALL:** -- position so he had
12 obviously taken a decision to do that?
13 **A.** Yes.
14 **LADY JUSTICE THIRLWALL:** Do you know why he
15 decided?
16 **A.** I think he had been in the post for nearly six
17 years.
18 **LADY JUSTICE THIRLWALL:** Yes.
19 **A.** I think he felt that he had another job in
20 him. He noted that in my appraisal with him in the year
21 in question that I thought that his -- if I could use
22 this terminology, I thought his best years perhaps were
23 behind him.
24 **LADY JUSTICE THIRLWALL:** Yes, you mentioned that
25 earlier.

1 **A.** I did -- he had -- he had been with us for
2 five years and he wanted to move on; he thought he could
3 aspire to another post in the NHS.
4 **LADY JUSTICE THIRLWALL:** Yes. Was there anything
5 in what he was reflecting on which was to do with that
6 which we are dealing with in this Inquiry?
7 **A.** No, I don't believe it was.
8 **LADY JUSTICE THIRLWALL:** That wasn't part of it.
9 Thank you.
10 We looked briefly at INQ -- and I'm afraid I have
11 got a partial reference -- 56830031 which I think is the
12 letter from the Consultants to you, but it may not be.
13 I'm sorry. It will be 0005683.
14 It could be, yes, thank you. Let's have a look,
15 I'm sorry, I have underlined a section I want to ask you
16 about but I'm afraid I didn't actually do it on the
17 document itself, we won't take a long time. If we can't
18 find it, we will move on.
19 Can we look at page 31. I don't think this is the
20 right document. It is the right document, thank you
21 very, much Mrs Killingback.
22 So if we go -- we have looked at this already,
23 Sir Duncan and we won't take a long time over it, but if
24 you go to the second last paragraph, it's the
25 announcement about why Tony Chambers is stepping down

1 then:
2 "These investigations into neonatal deaths at the
3 Trust have escalated over the past two years and
4 inevitably put relations between senior management and
5 paediatricians under exceptional strain."
6 Can I just ask you about the use of the word
7 "inevitably": was it inevitable that relationships would
8 be under exceptional strain or was it result of the way
9 it was managed?
10 **A.** It wasn't inevitable. I mean, it was a very
11 stressful situation.
12 **LADY JUSTICE THIRLWALL:** Yes, indeed.
13 **A.** But it wasn't inevitable that people should
14 have fallen out to the extent they did around that --
15 around that matter.
16 **LADY JUSTICE THIRLWALL:** Thank you. And then one
17 short point. You were asked about whether or not the
18 Consultants were coerced into mediation or something --
19 **A.** Yes.
20 **LADY JUSTICE THIRLWALL:** -- like that and you said
21 you didn't accept that.
22 Did you know that Mr Harvey, for example, didn't
23 know that mediation was something that was voluntary?
24 **A.** I knew it was voluntary. I didn't know
25 whether Mr Harvey knew it was voluntary.

1 **LADY JUSTICE THIRLWALL:** No, he didn't.
2 **A.** He didn't?
3 **LADY JUSTICE THIRLWALL:** Yes, so he approached it
4 in a particular way.
5 **A.** Ah.
6 **LADY JUSTICE THIRLWALL:** Thank you.
7 Then I suppose the last question is a more general
8 one. You have made the point that there were lots of
9 processes and lots of systems in place.
10 **A.** Yes.
11 **LADY JUSTICE THIRLWALL:** Some of them -- well, the
12 whole -- well, we know what happened as a result of the
13 use or non-use of systems and you say it's to do with
14 what individuals, to do with systems.
15 But I wondered, is the way of testing whether
16 a system is effective by working out whether or not
17 people find it easy to use?
18 **A.** I think we -- I think we have, we have to work
19 -- work to that end. I think the systems are robust,
20 I think there's variable practice around compliance with
21 the -- with the systems.
22 But unless we know where the compliance failures
23 are, through questions, through examinations, through
24 audit, then, then we are in the dark as to whether the
25 systems are serving it.

1 **LADY JUSTICE THIRLWALL:** And I suppose there may be
2 a point to think about, well, if you have so many
3 systems and processes, perhaps that of itself is
4 inimical to people using the process.
5 **A.** I -- I completely, I completely agree, and
6 forgive me if this comes over in the wrong way, but I --
7 my analogy, I am sure an imperfect one, is I have
8 a 300-page car manual. But what I really need to know
9 is that there is anti-freeze, that the tyres are at the
10 correct pressure and that it is safe to drive down the
11 road. I do not want 300 pages of manual; I am not even
12 sure who the manual is for.
13 **LADY JUSTICE THIRLWALL:** No, thank you. Those are
14 all my questions. Anybody else want to just anything
15 arising out of that? No, thank you very much indeed,
16 Sir Duncan, you are free to go.
17 **A.** Thank you.
18 **MS LANGDALE:** My Lady the next witness is Mr Wilkie
19 who I think is ready to take the stand.
20 **LADY JUSTICE THIRLWALL:** Very good. Do come
21 forward, Mr Wilkie.
22 MR JAMES WILKIE (sworn)
23 Questions by MS BROWN
24 **LADY JUSTICE THIRLWALL:** Do sit down. Ms Brown.
25 **MS BROWN:** Mr Wilkie, could you just give your full

1 name, please.
2 **A.** James Douglas Wilkie.
3 **Q.** Mr Wilkie, you have provided a witness
4 statement to the Inquiry dated 28 May 2004(sic), is that
5 true to the best of your knowledge and belief?
6 **A.** Yes.
7 **Q.** In terms of your background, you were in local
8 government and had a position of Director and
9 subsequently as Chief Executive of the Council and were
10 appointed to the Non-Executive Director of the Countess
11 of Chester in April 2013; is that correct?
12 **A.** That's correct.
13 **Q.** You remained in position as a Non-Executive
14 Director until autumn of 2017?
15 **A.** Also correct.
16 **Q.** Was this your first role as a NED?
17 **A.** It was.
18 **Q.** Is it correct that the time commitment at that
19 stage was three days a month?
20 **A.** That was probably what was in the application
21 form. I found in practice it was probably a little bit
22 more than that, maybe 4, 4 and a half days, a month,
23 that averaged out.
24 **Q.** Is it correct in addition to sitting on the
25 board you also sat on the Finance and Integrated

1 Governance Committee, the Audit Committee and you shared
2 the partnership forum which liaised between management
3 and trade unions?
4 **A.** Yes.
5 **Q.** Just in relation to your answer about the
6 three days, whilst three days you think was on the
7 application form, is your evidence that three days was
8 not quite sufficient for the task indicated?
9 **A.** No, that is not what I meant and if that was
10 the impression I gave, I apologise.
11 **LADY JUSTICE THIRLWALL:** No, no, it is just an open
12 question.
13 **A.** I thought I was being asked how much did
14 I actually spend on it and it would have been at least
15 three days a month, but I think, looking back on it, it
16 was probably four, I think it probably averaged out
17 about one day a week.
18 **Q.** Why did you stand down as a NED of the
19 Countess of Chester in autumn 2017?
20 **A.** Because I was moving house and I was moving
21 outside the constituency area and would no longer be
22 eligible to serve as a Non-Executive on the board.
23 **Q.** Do you currently have any position on any NHS
24 Trust board?
25 **A.** Yes.

1 **Q.** What's that?
2 **A.** The chair of Blackpool Teaching Hospitals
3 Trust.
4 **Q.** If we could turn up INQ0009246. Mr Wilkie,
5 this -- and page 21 of that, please -- is an extract
6 from the NHS Foundation Trust Code of Governance?
7 **A.** Yes.
8 **Q.** From the version of 2014?
9 **A.** Yes.
10 **Q.** It says there under "Main Principles":
11 "The board is collectively responsible for the
12 performance of the NHS Foundation Trust."
13 Then going down to point G:
14 "The Board of Directors as a whole is responsible
15 for ensuring the quality and safety of healthcare
16 services."
17 If we then just turn to page 21 of that document.
18 We will see then when it comes up, page 21 -- 21 of the
19 INQ number, sorry, that deals with Non-Executive
20 Directors?
21 **A.** Yes.
22 **Q.** Are we on 21, yes?
23 **LADY JUSTICE THIRLWALL:** Yes.
24 **MS BROWN:** That says:
25 "Non-Executive Directors should constructively

1 challenge and help proposals on strategy."
2 Then below that:
3 "Non-Executive Directors should scrutinise the
4 performance of management in meeting agreed goals and
5 objectives and monitor the reporting of performance."
6 Did you understand during your time -- that can
7 come down, thank you -- at the Countess of Chester that
8 you had collective responsibility for quality and safety
9 of the hospital?
10 **A.** Yes, my -- my understanding was that I had
11 both collective responsibility and individual
12 responsibility as a member of the board. It was -- you
13 asked me earlier, was it the first time I had been
14 a Non-Executive Director? And the answer to that is
15 yes. I have to say that when I started as
16 a Non-Executive initially I found the transition quite
17 challenging because I had been used, as an Executive, to
18 have been able to get a lot more detail about the issues
19 I was looking at. In simple terms, being able to look
20 under the hood. It is not as simple to do that as
21 a Non-Executive, but I was very clear and remain clear
22 about the roles and responsibilities I had as
23 a Non-Executive Director.
24 **Q.** Did you understand that your role was to
25 constructively challenge and to scrutinise the

1 performance of the Executive?
2 **A.** I did and I believe I did so.
3 **Q.** Did you get that understanding from being
4 familiar with the code of governance or was that from
5 your past experience?
6 **A.** It was -- it was both. I mean, when I applied
7 for the job at the Countess obviously I did my research
8 and wanted to know exactly what was involved in it but
9 I was under no illusions about the seriousness and the
10 responsibilities attached to the position.
11 **Q.** Just dealing very briefly with training you
12 say in your statement that you don't recall any
13 significant training and that you got no recollection of
14 safeguarding training and no recollection of guidance on
15 whistleblowing or Freedom to Speak Up but that you
16 accept on reflection training would have been helpful?
17 **A.** I --
18 **Q.** What training would have been helpful?
19 **A.** Right. What I am very clear about is I can't
20 recall what training I may have done. Okay.
21 I am not saying I didn't do that training but
22 I just cannot recall it right. In terms of the -- the
23 training that would have been helpful would have been
24 provided or not was some of the subject matter that's
25 been dealt with by some of the earlier witnesses today

1 about asking questions, about roles and
2 responsibilities, about safeguarding, about
3 whistleblowing and so on.
4 **Q.** So your evidence is --
5 **A.** To be clear, I am not saying I didn't get that
6 training. It's just that I can't recall participating
7 in that training.
8 **Q.** Just dealing with written policies. In terms
9 of the policies that this Inquiry are concerned with
10 relating to safeguarding, risk management and to
11 Speak Out Safely, when these events occurred, did you
12 consider the Consultants were speaking out, was that
13 what you understood them to be doing?
14 **A.** I cannot now recall whether I framed it in
15 those terms. What I absolutely remember is thinking
16 that this was an opportunity for the Consultants to talk
17 directly to the board and to articulate their concerns
18 to the board.
19 **Q.** If we could just turn to INQ0003014. So,
20 Mr Wilkie, this is -- at page 2 of that, 30140002 -- the
21 Speak Out Safely policy and we'll see there, I am just
22 going to take to you a very short section in the bottom
23 third of the page:
24 "All concerns raised by staff about patient care
25 will be dealt with seriously, promptly and be subject to

1 thorough and impartial investigation."
2 It goes on a little bit further:
3 "No recriminations will follow reports which are
4 made in good faith about low standards of care."
5 If we could then look at page 9 of the same
6 document. This is looking about if a concern is raised
7 in the middle of the page if a concern is raised or
8 an allegation made about a person who works with
9 children including a staff member who may have harmed
10 a child, possibly committed a criminal offence, and then
11 it outlines the policy which in essence is to refer it
12 to a manager who will then liaise with the LADO.
13 Now, we know in this case that none of those things
14 happened. There wasn't a prompt investigation into the
15 concerns about Letby, recriminations did follow against
16 the paediatricians who were made to apologise by letter
17 and there was no referral to the LADO until 2018.
18 The document can come down, thank you.
19 Looking back now, do you think that familiarity
20 with those policies and in particular with the Speak Out
21 Safely policy that we have just looked at, do you think
22 that would have assisted you being able to
23 constructively challenge the Executives and scrutinise
24 their performance?
25 **A.** I do, but more than that, I also believe that

1 was it have the responsibility of the Executives who
2 should have had a detailed working knowledge of those
3 factors to bring that to the attention of the board.
4 **Q.** Do you think you ever consulted the speaking
5 out policy?
6 **A.** Sorry, when you say "consulted"?
7 **Q.** Looked at. Did you go to see what the
8 policy -- whether -- one, whether there was a possibly;
9 two, if there was one, what it said?
10 **A.** I can't recall, I cannot recall doing that.
11 **Q.** In terms of Risk Registers, the Inquiry has
12 seen a number of Risk Registers. These are the charts
13 obviously with the green and the red. You were faced on
14 the board with the situation where a number of
15 individuals were worried about the risk that a member of
16 staff, Letby, posed to vulnerable babies.
17 That risk, the risk of a member of staff, wasn't
18 ever put on a Risk Register. We know, and we will come
19 to it, that you did recognise that risk and you went to
20 see Alison Kelly specifically about it?
21 **A.** (Nods)
22 **Q.** How useful as a NED did you find the Risk
23 Registers in assisting you as to what the real concerns
24 were?
25 **A.** They were useful to an extent. I think what

1 the board was dealing with in this particular case was
2 an extraordinary set of circumstances. Reading the Risk
3 Register, you could probably find things in there that
4 could have applied to that. But my feeling at the time
5 and my recollection is that the board had to respond to
6 the events as they were, as was reported to them at that
7 time.
8 **Q.** Just turning to some meetings now, please,
9 Mr Wilkie. On 5 July we know there was a public board
10 meeting but prior to that, one of the other NEDs,
11 Mrs Fallon, recalls that there was a private meeting of
12 NEDs before that meeting and from her brief handwritten
13 note it appears what was discussed was the neonatal
14 unit, the fact there had been unexplained and unexpected
15 deaths, that there was -- had been an internal review
16 and was to be an external review and that the level, the
17 unit level was going to be reduced down to a Level 1.
18 Do you recall that meeting?
19 **A.** I don't. I see from the note that it said
20 I was at that meeting and I have got no reason to
21 disagree with that. Nor do I have any reason to argue
22 that the matters relating to the increase in deaths was
23 actually discussed at that meeting.
24 However, what I am very clear about was that at
25 that meeting, there was no mention of a suspicion that

1 the paediatric Consultants had about this being
2 a potential link to an individual.
3 **Q.** So is it your evidence that you don't recall
4 the meeting?
5 **A.** I don't recall the meeting.
6 **Q.** But you are clear that you, prior to the board
7 meeting on 5 July, certainly weren't informed about or
8 concerned about --
9 **A.** No, had I -- had I been told about the
10 paediatricians' concerns at that meeting, I would have
11 remembered.
12 **Q.** Just turning to the public board meeting that
13 was held. It appears that neither the increase in
14 mortality on the NNU or the downgrading that was to be
15 announced a few days later was discussed at that
16 meeting. Why do you think that was?
17 **A.** I -- I don't know. This -- which date?
18 **Q.** This was the 5 July.
19 **A.** 5 July.
20 **Q.** It was a public board meeting.
21 **A.** I don't know, is the honest answer.
22 **Q.** When we say "public board meeting" that is
23 public in that members of the public could in principle
24 turn up?
25 **A.** Yes, yes, yes.

1 **Q.** Do you think the fact that it was a public
2 board meeting in fact inhibited discussion of those
3 issues and in fact inhibited the effectiveness of those
4 meetings?
5 **A.** Possibly. Probably, actually, if I am
6 being ... yes.
7 **Q.** Now, if we could turn to 14 July meeting and
8 if we could call up INQ0003238, this was an
9 extraordinary board meeting that was held. Can you
10 recall what you were informed about the reason for this
11 meeting, were you aware when you turned up what you were
12 going to be discussing?
13 **A.** I can't recall. I suspect we might have been
14 told it was about the increase in deaths. I have got no
15 recollection that we were told in advance about the
16 paediatric Consultants' concerns.
17 **Q.** Just to set the scene: of the Non-Executive
18 Directors it was you Ros Fallon and Rachel Hopwood who
19 were there. Mr Oliver and Mr Higgins were absent and
20 this is the meeting that was attended by Dr Jayaram and
21 Dr Brearey.
22 You say in your statement that this was the first
23 occasion that you became aware of the concerns --
24 **A.** Yes.
25 **Q.** -- about Letby; is that a clear recollection?

1 **A.** Yes, that is my belief that was the first
2 time -- that is my recollection and my belief that was
3 the first time I became aware of the paediatric
4 Consultants' concerns.
5 **Q.** Because it appears that some of the NEDs may
6 have been aware of this before, but you are clear that
7 you weren't amongst that group.
8 **A.** Yes. I have seen from evidence bundles that
9 have been provided to me that following the meeting
10 referred to earlier, the NEDs meeting on 5 July, that
11 a couple of NEDs went to see Sir Duncan and Sir Duncan
12 shared the concerns but I was unaware --
13 **Q.** If you just stick to what you can recall --
14 **A.** Okay no, I don't recall.
15 **Q.** It's clear from those minutes -- we will go
16 very briefly to them shortly, but it is clear from the
17 minutes of that meeting that the decision had already
18 been taken to downgrade the unit?
19 **A.** Yes.
20 **Q.** Obviously a significant step and the decision
21 had been made to go to the RCPCH for a review?
22 **A.** (Nods)
23 **Q.** Was there any concern from you or from your
24 fellow NEDs that these decisions had been made without
25 reference to the full board?

1 **A.** No. And I can try and explain that. I mean,
2 you asked me about the meeting. Thinking back, we
3 walked into the meeting and were faced with a situation
4 where we are told that paediatric Consultants have
5 suspicions that an individual is deliberately harming
6 babies on the unit. That then became the focus of my
7 attention and whilst I can't speak for the other NEDs or
8 the members of the board, I suspect that was the same
9 for them.
10 **Q.** So nobody was raising why has this decision
11 been made to downgrade --
12 **A.** No, no, no.
13 **Q.** -- and so on. Just in terms of your
14 impression of the meeting, Mr Wilkie, you address this
15 in your statement and you say and this is paragraph 44
16 of your statement, you say:
17 "After almost eight years I do not have total
18 recall of everything said at this meeting. However,
19 I do clearly recall that Dr Brearey and Dr Jayaram
20 seemed convinced that the baby deaths were connected
21 with one individual Lucy Letby whilst the Executives
22 took the position that there was no evidence to support
23 this."
24 You say later in your statement, and this is
25 paragraph 92, that at this meeting when you first

1 noticed the tension between the Consultants and the
2 members of the Executive Team.
3 Just bearing those impressions that you recall now,
4 if we could go to page 4 of this meeting, we will see
5 there just before halfway down Dr Jayaram stated -- and
6 the meeting prior to this had been discussing the
7 mortality increasing and the fact that the babies were
8 not expected to die and the downgrade of the unit, and
9 then at this point there came a moment when Dr Jayaram
10 stated what he was to say next was confidential and not
11 to be minuted.
12 I am not going to turn you to it, but there are
13 handwritten notes --
14 **A.** Yes.
15 **Q.** -- that say -- I think you have seen reference
16 to "elephant in the room" and the clinical body being
17 uncomfortable with Lucy Letby.
18 Your recollection that I have just read out saying
19 that you recall Dr Brearey and Dr Jayaram being
20 convinced the baby deaths were connected to Letby sounds
21 stronger than "uncomfortable".
22 I just wondered if you could give us a feel of that
23 meeting and what you understood --
24 **A.** Okay.
25 **Q.** -- about what Dr Jayaram was saying.

1 **A.** At that meeting, and after the meeting, I felt
2 convinced that the paediatric Consultants absolutely and
3 truly believed that an individual was responsible for
4 harm to the babies.
5 The view of the Executives was there was no
6 evidence to support that and that's -- that's documented
7 in the -- in the minute.
8 **Q.** Yes, and if we could go then, please --
9 because I think as you say this is rather reflected in
10 some of your interventions, if we could go to page 5.
11 We will see there Mr Wilkie, three quarters of the way
12 down the page:
13 "Mr Wilkie stated that he accepted that no evidence
14 to say is due to an individual but there is no evidence
15 to say the contrary.
16 "His question is what has been changed since the
17 last conversations. He understands the stakes here and
18 in previous discussion there was considerable disquiet
19 about an individual."
20 The first question, Mr Wilkie there is: that refers
21 to the last conversations and previous discussions. Can
22 you recall now what that was referring to?
23 **A.** No, I was, I was puzzled when because the one
24 of the questions I was asked by the Inquiry for the
25 witness statement was what were the previous

1 discussions.
2 And either I was minuted inaccurately or what I was
3 doing was referring to what Dr Jayaram and others may
4 have said at an earlier stage in the meeting because
5 I am very clear that I did not know about the doctors'
6 concerns until I got into that meeting.
7 **Q.** But you were expressing there that you were
8 aware there was considerable disquiet about an
9 individual?
10 **A.** Yes and it was -- it was very clear, they
11 were -- they were very concerned about it.
12 **Q.** You go on, or the note goes on:
13 "We are saying there is something wrong here as we
14 are now supervising that person and Mr Wilkie stated
15 that he wanted to better understand what are the
16 critical issues that mean it is not appropriate to
17 engage the police as he could see disquiet."
18 What was your view when you came into this meeting,
19 and as I understand it you were reacting at the time
20 because you didn't know this was going to be raised in
21 the meeting?
22 **A.** Yes.
23 **Q.** What was your reaction on the moment of
24 contacting the police?
25 **A.** Okay, I have to say that in the meeting, at

1 that point, my primary concern was the safety of babies.
2 Okay?
3 I was -- I am going to use the word surprised that
4 the Executives were recommending that the individual, we
5 didn't know the name at that stage, I didn't know the
6 name until much later but that the individual should be
7 should remain on the unit on supervised practice. As
8 you can see in the minutes, I asked a number of
9 questions about the effect of this -- of that response
10 and how safe the babies would be, okay?
11 **Q.** If you just pause there, so we can look --
12 have those minutes in front of us --
13 **A.** Sorry.
14 **Q.** -- as you are speaking, Mr Wilkie, if we could
15 turn to first of all page 6.
16 **A.** Yes.
17 **Q.** We see there first of all it's your colleague
18 Mrs Hopwood who picks up this issue and it says there
19 the third paragraph down:
20 "Mrs Hopwood asked how practical it was for the
21 staff member to work under supervision."
22 **A.** Yes, yes.
23 **Q.** Then if we go to page 7, this is where you
24 intervene, Mr Wilkie, and you say at the top:
25 "Mr Wilkie said that as a layperson he did not know

1 how effective the measures will be and asked how
2 confident the Trust were they were removing all risk."
3 It seems that Mr Chambers answered -- seems to
4 answer slightly at a tangent, it says:
5 "Mr Chambers replied there will be weekly
6 monitoring on the neonatal services at the Executive
7 Directors Group."
8 You said:
9 "Mr Wilkie said this was about the member of
10 staff."
11 We see at the bottom of that paragraph Mrs Kelly
12 replying.
13 "There was the option given that the staff members
14 may feel too stressful, then they would be moved to
15 a non-clinical area. However, the individual did not
16 want to do so and wants to go to a clinical area" --
17 **A.** I'm sorry, where is that reference to
18 Mrs Kelly? I am just trying to find it.
19 **Q.** Sorry, it's at the bottom of the paragraph
20 that's been highlighted for you?
21 **A.** Right.
22 **Q.** "However", if you look at the last sentence of
23 that --
24 **A.** Yes, I see it.
25 **Q.** "However, the individual did not want to do so

1 and wants to go back to the clinical area where the
2 individual's clinical skills" --
3 **A.** Thank you.
4 **Q.** Then below that again:
5 "Mr Wilkie asked if that would abate any
6 possibility of further issues. Dr Brearey replied 'not
7 completely'."
8 So this is where you said your focus was the
9 concern about the nurse?
10 **A.** Yes, yes, I mean, the reason I jumped ahead
11 was because you asked me a question about the police
12 involvement and what I wanted to just explain was that
13 at that point in time sitting in that meeting I believed
14 my primary responsibility individually collectively, was
15 to do what I needed to do to ensure the future safety of
16 that unit and the babies on it, right.
17 I don't want to dismiss or reduce the significance
18 of the police involvement. But at that meeting, that
19 was -- that was the predominant concern that I had and
20 that's why I asked the questions that I had, as you can
21 see from subsequent events I was not satisfied with the
22 responses I was given.
23 **Q.** We will come to those.
24 **A.** Yes.
25 **Q.** I just want to go to a few other matters that

1 were discussed at this meeting?
2 **A.** Yes.
3 **Q.** So if we could go to page 8. First of all,
4 just at the top just to return briefly to the police, it
5 says there:
6 "Mr Cross outlined his understanding of what action
7 the police would take if they were called to investigate
8 the matter".
9 Can you -- I appreciate it wasn't your focus but
10 can you recall what Mr Cross was saying about what would
11 happen if the police were called in?
12 **A.** I can't -- I have seen -- I have seen
13 references but I cannot recall what he said at that
14 meeting.
15 **Q.** No, we are interested in your recollection.
16 **A.** Yes.
17 **Q.** Then the discussion moves on to the RCPCH
18 Review --
19 **A.** Yes.
20 **Q.** -- and in summary, it seems to be there are
21 two issues that are arising that are dealt with by you
22 and Mrs Fallon concerned with what would be the Terms of
23 Reference and what would be the focus of that review and
24 also you bring up timing.
25 **A.** Yes.

1 **Q.** Dealing first with the focus of the review, we
2 see halfway down Mrs Fallon asked if the external review
3 would look at staffing. Then the paragraph down again,
4 Mrs Fallon asked if there was a direct correlation,
5 would they uncover this, referring to the RCPCH:
6 "Mr Harvey replied that as part of the process any
7 issues will be outed and we will advise them of the
8 supervision of staff as it will be part of the measures
9 we have undertaken."
10 Then there is a reference to Mr Harvey giving
11 details of the draft Terms of Reference.
12 Do you recall yourself looking in detail at the
13 draft or at all at the draft Terms of Reference to
14 understand exactly what the focus of that review was
15 going to be?
16 **A.** I -- I don't recall looking at it at that
17 point, I have looked at it subsequently. I can give you
18 a view if you are interested in what I probably thought
19 at the time. But basically the -- the impression that
20 the board was being given was there's something
21 happening here, there's no evidence to support the
22 paediatric Consultants' concerns. What we want to do is
23 a detailed piece of work to inform the board's position
24 on this. That was my broad understanding of what the
25 exercises were about.

1 **Q.** I think you helpfully have set out in your
2 statement what you understood or what you believed you
3 understood at the time and you say:
4 "I understood the purpose of the review was to
5 identify any possible cause of the baby deaths other
6 than the actions of an individual."
7 **A.** Yes. Sorry, what paragraph is that?
8 **Q.** It is paragraph 51.
9 **A.** 81, sorry.
10 **Q.** 51, sorry?
11 **A.** 51, sorry.
12 **Q.** So it's the second the last sentence of
13 that -- sorry, the penultimate sentence:
14 "I understood the purpose of the review was to
15 identify any possible cause of the baby deaths other
16 than the actions of an individual."
17 **A.** Yes, yes, yes.
18 **Q.** So you understood that the RCPCH would be
19 looking at it directly in a sense to see if there was
20 some other cause?
21 **A.** That -- that is the way -- that is the way
22 it's phrased, okay. That is what I said in the
23 statement at the time because I thought initially -- and
24 might come on to this on the board of 10 January, but
25 I thought initially that if -- if the -- if the -- the

1 Royal College came back and said this probably happened
2 because of X Y and Z, then that would inform the board's
3 views about the accuracy of the paediatric Consultants'
4 concerns.
5 **Q.** We see on that page as well in the middle of
6 the page that you are also concerned about timing?
7 **A.** Yes.
8 **Q.** Because you are asking whether it would be
9 available in mid-September?
10 **A.** Yes.
11 **Q.** Then if we could go on to page 9 we see that
12 Mrs Hopwood at the very bottom page picks up this theme
13 and says another board meeting should be held post
14 review as a minimum?
15 **A.** Yes.
16 **Q.** Unless there is a need to get together sooner.
17 So at that point the board seems to be concerned to
18 follow up what's going to happen. In fact, we know that
19 another board meeting to discuss this issue wasn't held
20 until January. Looking back, do you feel you should
21 have been requesting an update sooner?
22 **A.** In retrospect, yes, but equally what I can't
23 recall is whether we any information from the Executives
24 why they hadn't reported back. I just cannot recall
25 that.

1 **Q.** If we can go then to page-paragraph 52 of your
2 statement?
3 **A.** Yes.
4 **Q.** Because you deal with what happened then. So
5 the conclusion of that meeting was that the point was
6 that Letby was going to return under supervision to the
7 unit?
8 **A.** Correct.
9 **Q.** And that the RCPCH Review was going to go on.
10 **A.** Yes.
11 **Q.** You say in paragraph 52, the second part of
12 that:
13 "I was deeply concerned over whether the view of
14 the Executives that Letby should remain on the unit but
15 be placed under supervision was an adequate and
16 effective response to prevent any further harm to babies
17 occurring. At the meeting on 14 June I reluctantly went
18 along with the view of the Executives. However, after
19 the meeting I immediately regretted not dissenting to
20 the view of the Executives and not insisting that Letby
21 ... removed from the unit".
22 Did you feel at the meeting that you were not being
23 listened to or is it that you didn't express your views
24 forcefully enough?
25 **A.** I think I expressed my views pretty forcibly.

1 I think I was very clear in what my views were. I'm not
2 sure who else round the table agreed with me, some of
3 the other Non-Executives did ask questions.
4 But my recollection is I was asking more questions
5 and more direct questions about how sensible this was,
6 that is not the words I used at the time but that was --
7 that was my intent.
8 I think also I know also that the chair, because
9 it's minuted, indicated that if a majority decide this
10 is what we should do, then that's what we should do. So
11 from the sense I got was he picked up disquiet on my
12 part but felt it needed to go with a consensus majority
13 and I can understand why -- why he said that at the
14 time. But I left the meeting and, as I say, I was
15 immediately -- I immediately regretted it.
16 **Q.** You set this out in your statement and you
17 sort of evocatively say you had a sleepless night and
18 decided --
19 **A.** Yes.
20 **Q.** -- you wanted to go and see the
21 Chief Executive, I think. He wasn't available and you
22 in fact saw Alison Kelly?
23 **A.** Yes.
24 **Q.** Can you just very briefly describe that, that
25 meeting with Alison Kelly?

1 **A.** Right. I can't remember word for word but my
2 overall impression some time after was: it was
3 a perfectly cordial civilised meeting. Alison's
4 overriding concern seemed to be the impact that removal
5 from the unit would have on the individual. I took the
6 view that patient safety trumped any concern of an
7 individual member of staff's feelings, yes?
8 She then said that she would speak to Tony Chambers
9 about my concerns because, as you have said, he wasn't
10 on site that day.
11 **Q.** You say in your statement you asked her to put
12 your views to the Chief Executive and I think you then
13 called Sir Duncan Nichol?
14 **A.** I did. I phoned Duncan that afternoon just to
15 tell him what happened because I didn't want him
16 blindsided or surprised by what I had done.
17 **Q.** What was his response to you?
18 **A.** I can't remember the exact words. It was --
19 I think it was along the lines of: well, that's fine.
20 If that's what you feel that you need to do, then that's
21 fine by me.
22 **Q.** If we could turn now to another document, this
23 is INQ0003120.
24 Mr Wilkie, this is a letter that you didn't see at
25 the time but I think have subsequently been shown. And

1 this was a letter that was sent to Mr Harvey on
2 5 September, it was Monday 5 September?
3 **A.** Yes.
4 **Q.** It's the letter from the RCPCH about the
5 review they have done:
6 "Thank you for inviting the RCPCH to review your
7 neonatal services last week. I explained that we would
8 write to confirm the short-term advice which the team
9 shared with you, Alison [that is Alison Kelly] and
10 Tony Chambers on Friday."
11 Then they go on:
12 "The Review Team was not aware until we met you
13 [that is until they met Ian Harvey] on 1 September that
14 action had also been taken in early July to move one of
15 your nurses from the unit to other duties with
16 a requirement she does not contact colleagues from the
17 neonatal unit."
18 Would that have concerned you, that it seems that
19 the RCPCH weren't fully aware until they met on
20 1 September?
21 **A.** Yes.
22 **Q.** If we could go over to the next page, we look
23 at what action they were recommending. They are saying:
24 "Our understanding is that an allegation has been
25 made and therefore a process of investigation needs to

1 be put in place which sets out the nature of the
2 allegation and the process you will follow to
3 investigate it."
4 That's investigate the allegations in relation to
5 the nurse.
6 Then below that:
7 "The Review Team agrees from the information
8 received that the pattern of recent deaths and the mode
9 of deterioration prior to death in some of them appears
10 unusual and needs further enquiry to try to explain the
11 cluster of deaths. This was not possible within the
12 terms of reference for the reviews or from the
13 information received. To this end, we recommend that
14 a detailed forensic Casenote Review of each of the
15 deaths since July 2015 should be undertaken, ideally
16 using at least two senior doctors with expertise in
17 neonatology/pathology in order to determine all the
18 factors around the deaths."
19 Do you think, as I say, just in terms of timing
20 this was received in the following day, there was in
21 fact a board meeting, a public board meeting, do you
22 think you should as the board, as a Non-Executive
23 Director of the board, should have been informed of the
24 contents of this letter, either at the public board
25 meeting or as a pre-meeting on 6 September?

1 **A.** Yes, and other things we should have been
2 informed about also. But yes, we should have been.
3 **Q.** If you had been, do you think this would have
4 prompted you to reconsider whether the police was
5 something that needed to be considered?
6 **A.** Absolutely, as soon as I saw that and some of
7 the other documentation that was available to the
8 Executives, I mean, bluntly had at the time of that
9 board meeting on 10 January that I been aware that the
10 confidential version of the report had actually
11 highlighted an immediate action, to investigate the
12 allegations, had I been aware that Dr Hawdon had
13 identified there were four unexpected and unexplained
14 deaths, I think I would have taken a very different via.
15 Now, we were never given as a board the
16 confidential report nor -- nor the letter that's sitting
17 in front of me just now. We were given the redacted
18 version of the report and the Executives did say that we
19 had been given a redacted version because -- I can't
20 remember the phrase, but there was sensitive, personal
21 information in it --
22 **Q.** We are going to look at the meeting of
23 10 January but just in terms of that report --
24 **A.** Yes.
25 **Q.** -- when, just to tie that down, do you think

1 you were given the redacted report? Was that prior to
2 the meeting?
3 **A.** I cannot -- I cannot remember but I've since
4 been told that the report was handed out at the meeting
5 on 10 January, right.
6 **Q.** But you can't -- you are not clear on that
7 recollection?
8 **A.** I cannot recall that, right.
9 **Q.** If we could go then to the minutes of the
10 10 January, so this is INQ0003237.
11 **A.** Yes.
12 **Q.** We will look in a minute, a paper was given by
13 Mr Harvey, we will go to that in a moment. But this,
14 Mr Higgins wasn't at this meeting but the rest of the
15 Non-Executive Directors including yourself were present.
16 It's clear that Mr Harvey there, we see on the first
17 page, is talking about the detailed review of the RCPCH?
18 **A.** Yes.
19 **Q.** I think the evidence you have just given is
20 that you -- you can't recall whether you are given it,
21 but you are clear you never saw the full version; is
22 that right?
23 **A.** The confidential version that refers to the
24 investigation into the individual I never saw, neither
25 letter nor report.

1 **Q.** If we can go over the page, at the top there
2 it mentions that one of the recommendations -- so one of
3 the recommendations of the RCPCH -- was for an in-depth
4 review to be commissioned, this in-depth review not yet
5 circulated. It says that postmortem results --
6 **A.** Yes.
7 **Q.** Given the role you had to scrutinise and hold
8 to account, do you think you should have requested in
9 firm terms that you needed to see that report in order
10 to make any reasoned decisions on something that was so
11 important?
12 **A.** Right. In retrospect yes, having read
13 everything that I read. But on that date at that board
14 meeting, the whole outcome of the Royal College report
15 was framed in a way that the inference that I drew was
16 that basically Letby had been exonerated, right.
17 I did not know at that point that they had not
18 looked at those issues and I didn't know a number of
19 other things which we may come on to.
20 **Q.** I think if we can see at the bottom of that
21 paragraph the one that's already been highlighted for
22 you on the screen, but the bottom sentence of that
23 paragraph says:
24 "The case reviews [this is Mr Harvey speaking] very
25 much reinforce what is in the review."

1 So that is Hawdon's report reinforces what's in the
2 RCPCH review.
3 "It comes down to issues of leadership, escalation,
4 timely intervention and does not highlight any single
5 individual."
6 **A.** (Nods)
7 **Q.** That was the message that you understood from
8 the Executives, was it?
9 **A.** Correct and that's -- that same message is
10 replicated in the recommendation I recall from -- from
11 that meeting.
12 **Q.** We see then going on that Mr Chambers explains
13 that they could draw a line under this part of the
14 review once they have the full four reviews from
15 Alder Hey. So it was clear that there was something
16 that was incomplete there. In fairness, I should read
17 the bottom of that paragraph. Mr Chambers goes on to
18 say:
19 "There was an unsubstantiated explanation that
20 there was a causal link to the individual. This is not
21 the case and the issues were around leadership and the
22 timely clinical intervention."
23 So he is repeating in effect what Mr Harvey has
24 been said.
25 But given the fact that you had heard from the

1 Consultants on 14 July and the strength of the message
2 they were giving you that you, as you say, recall eight
3 years later and given that you were being told there
4 that the review was incomplete, they were still waiting
5 for four, do you think that you should have challenged
6 and not accepted -- we will come on to what the
7 Executive decided, but do you think you should have been
8 more challenging at that point?
9 **A.** Okay, later in that same meeting, I can
10 recall -- and it's probably in the minute somewhere --
11 asking whether the Consultants accepted the
12 recommendations of the report. And I think from memory,
13 I was told something along the lines of the report had
14 been shared in a controlled fashion -- I am not looking
15 at the paragraph.
16 **Q.** Yes, should we turn to that --
17 **A.** Please.
18 **Q.** -- so that we are speaking with results?
19 **A.** Yes.
20 **Q.** -- in front of us. If we can go then to
21 page 6, in the middle of the page:
22 "Mr Wilkie asked if the Consultants accept the
23 recommendations from the report and Mr Harvey then
24 explains that the draft report had been shared in
25 a controlled way with Dr Brearey and Dr Jayaram for

1 comments."
2 Were you concerned at that point that they hadn't
3 -- it appears from that that not all the Consultants had
4 seen the report?
5 **A.** I've -- I have agonised that point because
6 when I've read that over, I can't -- I can't really
7 reconcile in my own head why I didn't come back on that
8 because he hadn't actually answered the question.
9 Now, I have to be very careful here I am not saying
10 that this is an incorrect record of the meeting. All
11 I'm saying is that I don't understand why I didn't come
12 back on that particular point.
13 The -- the other point I would make is that the --
14 one of the reports -- and Dr Hawdon's report actually
15 identified four unexpected and unexplained deaths. In
16 Ian Harvey's introduction he actually said there was one
17 unexplained death and that that was not unusual, or
18 words to that effect. Now, the simple fact is I had no
19 basis to disbelieve what I was being told by the
20 Executives at that stage.
21 Now, I don't know whether Ian Harvey had just
22 forgotten or just hadn't, you know, triangulated the two
23 bits of information. But when I saw the Royal College
24 report, particularly the confidential one and I also saw
25 Dr Hawdon's letter which refers to the unexpected and

1 unexplained deaths, had I seen those bits of information
2 on 10 January, been made aware of those, my view would
3 have been: why are we not calling the police?
4 **Q.** Just turning to the situation with the return
5 of Letby to the ward --
6 **A.** Yes.
7 **Q.** -- at this stage.
8 We needn't go back to it, I will just read what it
9 says to you in the notes:
10 "Mr Chambers has said to the individual and their
11 family that we will manage as best we can a safe
12 transition back to the unit but you will see from her
13 statement this may be tricky."
14 And that reference to the statement is the
15 statement that was read out to you at the meeting?
16 **A.** Yes.
17 **Q.** The statement from Letby that was read out to
18 you at the meeting.
19 Then on the page that we have already got up, we
20 see about a third of the way down:
21 "Mr Chambers replied the individual's family want
22 assurance that the bad behaviour by the Consultants will
23 be dealt with."
24 And then goes on:
25 "We have given that commitment and will support the

1 individual back to the unit."
2 Now, did you understand that the decision of the
3 meeting was that Letby was going to return?
4 **A.** That's certainly what the minute says. I have
5 to say that at that meeting and subsequently that was
6 not the impression I got.
7 Now, I cannot now say why I didn't believe Letby
8 would be returning to the unit any time soon and look,
9 there's two things at play here. One, I have already
10 indicated that the board was basically told that all the
11 problems are the result of these other factors, right.
12 And the clear inference I drew from that was that Letby
13 was no longer a possibility, okay.
14 So on the one hand I might have been much more
15 relaxed about Letby coming back, but I have to say
16 I still didn't at that meeting have recollection
17 I thought she was coming back. I don't quite know why.
18 **Q.** If we could just go to another document, so
19 this is now the document that Mr Harvey -- the report
20 that Mr Harvey produced at that meeting and you
21 considered. That is 0003518.
22 So this is the report, a brief report that was
23 produced to the board. Do you recall seeing this?
24 **A.** I can't remember.
25 **Q.** What that says, it refers the first section to

1 the Royal College of Child Health and Paediatrics. It
2 doesn't say that they were unable to find a reason for
3 the unexplained cluster of deaths but it does go there
4 was -- refer to the secondary case review, that is the
5 review by Dr Hawdon that you hadn't seen and that the
6 other review, further review by Dr McPartland, was
7 incomplete in the process of completion.
8 Then with that short summary, if you go on to
9 page 2, we see the board being asked to, and if we look
10 specifically at C:
11 "... to support the Executive in assisting a staff
12 member's return to work on the neonatal unit."
13 Looking back over the overview of this report and
14 that meeting, do you think that you were being given the
15 full picture?
16 **A.** No. I have already said there were -- first
17 of all those issues framing of how it was described by
18 the Executives in the meeting. Secondly, there was the
19 question of the Royal College's recommendation and
20 investigation into Letby should take place. Thirdly,
21 there was the juxtaposition of Dr Hawdon's view, there
22 were four unexpected, unexplained deaths and Ian Harvey
23 saying there was one, but I didn't.
24 And in that recommendation, it's really clear that
25 the reviews having found no evidence of a single

1 person's culpability. So the inference I drew from that
2 was that that had been discounted. Now, clearly that
3 was wrong and I now know.
4 **Q.** Given that you had had the experience of --
5 the sleepless night experience --
6 **A.** Yes.
7 **Q.** -- earlier and given that you fully understood
8 the import of this, that whilst you have said that you
9 don't consider you were given the full picture, you were
10 aware that the review was not complete?
11 **A.** Yes.
12 **Q.** Do you feel that the very safety mechanism
13 that is the NED to question and interrogate and
14 scrutinise was not working here effectively?
15 **A.** That's a big question because as a NED, as
16 already said in my introductory comments you are in
17 a very different position from an Executive. You don't
18 have all the access to information, I used the phrase
19 "look under the bonnet". When I was an Executive and I
20 was writing reports -- were going in my name, I would go
21 and interrogate people, I want to make absolutely
22 certain that everything that was in the report was
23 absolutely as it was stated. It's much more difficult
24 to do that as a NED.
25 And also we were being given assurances or we

1 were -- I will rephrase that, we were allowed to draw an
2 inference, right, from what the -- from what the
3 Executives were saying in the way they phrased it,
4 right, that basically, there was no -- it wasn't down to
5 a single person, single person's culpability. Nobody
6 said: but they haven't looked at that; nobody said: but
7 they asked us to do another piece of work, any of the
8 rest of it.
9 So in retrospect, the answer to your question is
10 yes, at the time. I think as a NED it's not
11 unreasonable that you take credible views that are given
12 to you by the Executives if you do not have any other
13 information sources available to contradict those.
14 **LADY JUSTICE THIRLWALL:** Thank you, I have just
15 realised we have been going without a break, I am very
16 sorry that we have done that, it's nearly two hours
17 since the shorthand writer started, which is far too
18 long.
19 How much longer is there, Ms Brown?
20 **MS BROWN:** Five, ten minutes, I would say, if that.
21 **A.** I am happy to carry on, my Lady.
22 **LADY JUSTICE THIRLWALL:** Yes, thank you, but we
23 have got a single shorthand writer who needs to take --
24 **A.** Sorry.
25 **LADY JUSTICE THIRLWALL:** That is all right. So we

1 will just take 10 minutes so she can stretch her fingers
2 and we will start again at 20 past.
3 **(4.08 pm)**
4 **(A short break)**
5 **(4.20 pm)**
6 **MS BROWN:** Mr Wilkie, we had just been looking at
7 the 10 January. If we move on a month now to 7 February
8 when there was a public board meeting. The reference is
9 INQ0014821 and 0009, page 9 of that document.
10 So this is the CEO update at the public board
11 meeting on 7 February and you will see down there under
12 the block that's been redacted, it says:
13 "Mr Chambers stated the board would be aware ...
14 July 2016 the clinicians raised concerns regarding
15 an increase of deaths on the neonatal unit. The unit
16 changed the admission criteria and the Trust invited the
17 RCPCH to undertake a review."
18 Then:
19 "The RCPCH suggested a more in-depth independent
20 review be undertaken which had been completed."
21 And then says:
22 "The independent case review highlighted some areas
23 for improvement but did not identify a single causal
24 factor or raise concerns regarding unnatural causes."
25 At the time, can you recall thinking about whether

1 that was an accurate summary?
2 **A.** Okay, if I make one comment about my previous
3 testimony --
4 **Q.** Yes, of course.
5 **A.** -- about the meeting on the 10th.
6 Reflecting on it over the break, I think what
7 I said was I had never seen various documents. That is
8 my belief, right, I don't recall.
9 But with the amount of emails and stuff I was sent,
10 it's -- it's possible. I don't think so but it's
11 possible. So just for accuracy, you know, I have no
12 recollection, certainly I was unaware, just to be clear.
13 So the question on this was: do I think that that
14 was an accurate reflection of the situation at the time?
15 **Q.** Yes. At the time, did you feel that was
16 accurate because what it doesn't say of course is that
17 there are still outstanding matters going on and
18 I wondered if that was anything that you picked up at
19 the time?
20 **A.** Right. So that is certainly consistent with
21 the narrative that the board represented on 10 January,
22 but I now know that that isn't accurate.
23 **Q.** If we can go on then, thank you, to jump
24 forward again to 13 April.
25 So in the intervening time, is it correct,

1 Mr Wilkie, that the concerns you'd had before regarding
2 the nurse that had led you to go to speak to Mrs Kelly,
3 to an extent those, you didn't have those concerns
4 after January?
5 **A.** Okay. At that point in time, okay, the board
6 had been told by the Chief Executive that there was no
7 single causal effect identified.
8 What they didn't tell us was they didn't look for
9 it or they weren't able to do that piece of work. We
10 could only go on the basis of what was there.
11 So it is the case that at that stage my frame of
12 mind was probably less anxious than it had been because
13 of the statements that had been made to the board.
14 **Q.** Then we come to 13 April and this is the board
15 meeting that Mr Medland --
16 **A.** Yes.
17 **Q.** -- the barrister attends.
18 We see that, INQ0003236, and if we go over the page
19 to page 2 of that, and in the middle of the page:
20 "Mr Medland [so this is the barrister] stated that
21 in his view there is no evidence of a crime but the
22 Consultant view is to go to the police. He suggested
23 that an alternative approach would be to approach the
24 police member of the Child Death Overview Panel,
25 although it is possible he may say he is unable to help

1 due to his position. He also suggested the Coroner
2 Mr Rheinberg, but there would be a conflict of
3 interest."
4 Presumably it was something of a surprise at this
5 point that having thought that the matter was not of
6 concern we are back here, not quite a year on, thinking
7 about the police again?
8 **A.** Yes, and I mean it's difficult to reconstruct
9 events in your head after the passage of eight years,
10 okay, but certainly I had come through a -- I had come
11 through a process where I was very concerned because she
12 was going to be left on the unit. I was then reassured
13 when she was removed from the unit. I was reassured
14 when I got the report on 10 January to say there was no
15 single causal factor et cetera, et cetera.
16 I suppose the conclusion I came to at that point
17 was that because the paediatric Consultants were still
18 articulating their concern about this, then that is why
19 there was still a debate about going to the police.
20 **Q.** Did you, at any point, either the 10 January
21 where we see you were asking the questions, we went to
22 your comments about --
23 **A.** Yes.
24 **Q.** -- do the Consultants accept this and so on.
25 Did it over occur to you or was it ever a point of

1 discussion with your fellow NEDs to ask the Consultants
2 to attend again as they had in that first meeting, a
3 need to see them separately from the Executives?
4 **A.** It, it -- it didn't. I mean I was, I was very
5 clear in my own mind that the Consultants were convinced
6 that an individual had deliberately harmed babies.
7 In retrospect, should we have done that? Knowing
8 all that I know now, then the answer is yes.
9 **Q.** So at this meeting, there's reference to the
10 Child Death Overview Panel. What did you understand
11 this, the next step that had been reached now?
12 **A.** I think the conclusion I came to at that
13 meeting was that we were getting closer to a point of
14 closure on this.
15 But as, as referenced later in that report, in that
16 minute, there was reference to the forensic work that
17 needed to be done and I can remember, and it's minuted,
18 expressing some concern about the length of time it had
19 taken us to do that work and I think -- it will be in
20 there somewhere -- I think I said, you know, "Can we
21 truly argue that we acted expeditiously when, you know,
22 we got these reports in January. Well, you got -- they
23 got the reports in September/October, didn't they, but
24 they went to the board in January and it's only now that
25 we're actually talking about doing these pieces of work.

1 **Q.** I think if we go, just so we can see that to
2 page 3, the next page. We will see that that's I think
3 the point you are referring to the paragraph down?
4 **A.** Yes.
5 **Q.** Concern about the delay and that's the delay,
6 is it, from July 2016 until the present, until the date
7 then in April?
8 **A.** I think, I think what I was more referring to
9 was not necessarily -- not necessarily the delay
10 from January 16 as reflected on this, but I think it was
11 about the delay between the report, we'd been told of
12 the Royal College's work in January, and a suggestion
13 that some further work had to be carried out and then
14 here we are in April and the work still hasn't been
15 carried out.
16 **Q.** If we just maybe go on to the end of that
17 meeting. So page 5. We will see then Mrs Hopwood asks:
18 "What if the Consultants after the forensic review
19 still want to go to the police?" Mr Chambers replied
20 that, "We would have a discussion with the Consultants."
21 So was it your understanding that even at this
22 point, in April, it was still being suggested that it
23 was CDOP, the Child Death Overview Panel, was the route
24 and that you weren't quite at the stage of going to the
25 police?

1 **A.** But I think had we gone to CDOP at that point,
2 it would inevitably have led to us going to the police.
3 **Q.** And I think that's -- Mr Wenham came across
4 the case and that's in fact what happened?
5 **A.** Yes.
6 **Q.** But did you think to raise at that point,
7 "This is enough. We have simply got to go directly to
8 the police now" or were you reassured at that point that
9 that's where the route was leading you?
10 **A.** Knowing what I know now, okay, we should have
11 gone to the police on Day 1. We should have gone to the
12 Local Authority Designated Officer within the 24 hours
13 or what the statutory period is.
14 We didn't do that. Now, I didn't know that at the
15 time, but there were people on the board that should
16 have known that.
17 **Q.** And if we can just finish the picture.
18 **A.** Yes.
19 **Q.** This is the last document I will take you to,
20 Mr Wilkie. INQ0003517 and this is the meeting of 2 May.
21 If we go to page 2 of that, we will see that, on page 2
22 we will see part way down that first paragraph:
23 "The feeling was that we had done everything and
24 that the next step was to consider a police
25 investigation."

1 **A.** Yes.
2 **Q.** There's a question that you then raise
3 a little further down in response to a question from
4 Mr Wilkie about informing parents and staff.
5 **A.** Yes.
6 **Q.** What did you understand or had you given
7 thought to what parents had been told up to this point?
8 **A.** Okay, I --I'm not sure if I was clear at the
9 time what parents had been told.
10 I certainly -- and I was asked this question by the
11 Inquiry when I was producing my evidence -- would've
12 thought we should have told the parents much earlier in
13 the process.
14 And I found it difficult to answer that question
15 because originally we had a contended point with
16 paediatric Consultants saying that they had suspicions
17 and with Executives saying there was no grounds and
18 there was clearly a genuine concern about giving the
19 parents even more heartache by telling them that.
20 However, by the time we get to this meeting we are
21 now, we are now saying, "Right, we are going to go to
22 the police" and my question was intended to actually try
23 and inform -- well, are we going to tell the perhaps
24 that we're going to the police? And as you see the
25 answer I got was that the police would prefer the police

1 and the Trust to manage this and I didn't gainsay this
2 because I didn't want to be doing anything that in any
3 way prejudiced a police inquiry.
4 **Q.** Thank you very much, Mr Wilkie.
5 If I can just take you back just finally to some
6 reflections you make in your statement and if you could
7 just maybe look at paragraph 97.
8 **A.** Yes.
9 **Q.** And also then read through paragraph 101.
10 **A.** Sorry, paragraph 97?
11 **Q.** 97.
12 **A.** Yes.
13 **Q.** Because you're reflecting on this --
14 **A.** Yes.
15 **Q.** -- the Consultants' position and the
16 Executives' position.
17 **A.** Yes.
18 **Q.** Then if you could just now, in your own words
19 to the Inquiry, explain what you felt about why this
20 situation had occurred, why the debate had gone on so
21 long and why the delay that you were raising at the end
22 had occurred?
23 **A.** Okay. I thought at the time, and I still
24 think, that the Executive Directors could not bring
25 themselves to believe that a nurse had actually done

1 this, that it was such an egregious act, right, they
2 just could not accept it.
3 And I think -- and I don't know, this is my
4 thoughts, right -- I think that that framed their
5 actions moving forward.
6 **Q.** You say at paragraph 101 that you thought that
7 at the time.
8 **A.** Yes.
9 **Q.** Do you have any reflections now on how as
10 a NED that system could have been more effective at
11 challenging that perception that you say you were
12 conscious of at the time?
13 **A.** Yes, on -- had I had my time over again,
14 right, and if I knew everything that I knew now on the
15 14th of -- I'm trying to remember which month it
16 was now -- July 16, as well as insisting that they moved
17 Letby off the unit, I would have also insisted it went
18 to the police.
19 **Q.** Just on the point of how the NEDs could more
20 effectively challenge that. How -- or do you have any
21 reflections on given those rather polarised positions
22 that you observed?
23 **A.** Yes, I think I certainly effectively
24 challenged on the first point about Letby's presence on
25 the unit, right. I think that could we -- could the

1 NEDs have more effectively challenged? Yes, in
2 retrospect, the answer has got to be yes, okay.
3 I think at the time, right, if you look in detail
4 at what the NEDs were being told and the way it was
5 being framed, I think you might understand why they
6 didn't more effectively challenge.
7 **Q.** You use the phrase in paragraph 97, you say,
8 not in relation as you have said to removing Letby from
9 the ward, we have heard what -- you did go and see
10 Mrs Kelly about that. But in relation to the attitude
11 of the Executives that you deferred to their judgment --
12 **A.** Yes.
13 **Q.** -- that there was no evidence to support the
14 views of the Consultants?
15 **A.** Yes.
16 **Q.** Do you think you had the right level of
17 expertise to challenge them because you have used the
18 word "deferred" there?
19 **A.** And I am not -- I'm not dodging the issue.
20 But you could ask a NED that question about virtually
21 any matter that comes in front of the board. As a NED,
22 as you know, your role is to constructively challenge.
23 It's trying to be independent, it's to try to bring an
24 external perspective to it.
25 I deferred to their views because it was the Chief

1 Executive and it was the Medical Director, right, and
2 I took the view that had this been me in a previous life
3 and I had been presented with this and with the
4 situation that we had, then I certainly would not have
5 accepted the individual staying on the unit because it
6 was an unnecessary risk in my view.
7 You know, on the police coming in, at that time
8 I took the view that we had experts. I know there's --
9 I know there's a debate about the paediatric Consultants
10 and their degree of expertise as opposed to Medical
11 Director, et cetera, but the Medical Director is still
12 a very influential figure, right.
13 In retrospect, should we have pushed back more?
14 Should we have challenged more? I think the answer is
15 probably yes. But I have to look at this in terms of
16 what was done at the time, what was being said at the
17 time, what we were being told at the time and what we
18 all understood the situation to be at the time.
19 **MS BROWN:** Thank you very much, Mr Wilkie. I don't
20 have any further questions. I don't believe --
21 **LADY JUSTICE THIRLWALL:** Ms Sutherland looks as
22 though she wants to ask a question.
23 Questions by MS SUTHERLAND
24 **MS SUTHERLAND:** My Lady, thank you.
25 Mr Wilkie, my name is Sara Sutherland, I represent

1 a number of the Families.
2 **A.** Yes.
3 **Q.** You will be pleased to hear I just have a few
4 questions if I may.
5 **A.** Yes.
6 **Q.** July 2016, you are recorded as being deeply
7 concerned and your evidence has been that you should
8 have gone to the police then?
9 **A.** In retrospect, yes, yes.
10 **Q.** In retrospect. But you said people in that
11 room should have known to go to the police then.
12 What did you mean by that?
13 **A.** Right. If, if I look -- what I meant quite
14 simply was the Executives, right, the people that were
15 dealing with safeguarding issues on a day-to-day basis,
16 right.
17 **Q.** You said the Medical Director was very
18 influential.
19 **A.** Yes.
20 **Q.** And --
21 **A.** And not just that. But all medical directors
22 are influential people.
23 **Q.** Of course. Clinicians --
24 **A.** Yes.
25 **Q.** -- with medical experience?

1 **A.** Yes.
2 **Q.** -- medical training. You are a NED who has
3 a vast amount of experience, none of it medical?
4 **A.** Yes.
5 **Q.** You are on a board with other NEDs?
6 **A.** Yes.
7 **Q.** One I think that had some nursing training in
8 the background?
9 **A.** Yes.
10 **Q.** But none of the others?
11 **A.** Yes.
12 **Q.** On reflection, would it have made it easier
13 for you to challenge with a NED who was medically
14 qualified?
15 **A.** On reflection, yes, assuming that that NED
16 would have accepted the position that I was taking on
17 the issue.
18 **Q.** Having heard the information that you heard?
19 **A.** Yes.
20 **Q.** But being medically qualified, having medical
21 training as a NED would give an advantage. You would be
22 able to push back, you would understand the terminology,
23 the framework and it would make it easier to push back
24 and challenge?
25 **A.** Broadly, yes.

1 **Q.** Were you told where Letby was being moved to?
2 **A.** Sorry, say again?
3 **Q.** Were you told where Letby was being moved to?
4 **A.** I -- my recollection was I was told she would
5 be moved on to clerical duties. I know she was now
6 moved to the risk unit. I honestly cannot remember if
7 I was told it was the risk unit. In my head, she was
8 going to clerical duties off the -- off the unit.
9 **Q.** So would you have been concerned to hear that
10 she was going to the patient safety unit, the risk unit?
11 **A.** I honestly don't know. My primary concern was
12 I thought it was an unnecessary risk and an avoidable
13 risk to have her continue to be on the unit.
14 **Q.** January 2017, we have been to the notes. If
15 you want to see if again we can pull it up but we have
16 just heard you asked if the Consultants accept the
17 recommendations from the report and Mr Harvey stated the
18 draft report had been shared in a controlled way.
19 **A.** Yes.
20 **Q.** You questioned what that meant?
21 **A.** I -- if I look at the minute, right, I asked
22 a question, right, "Are the paediatric Consultants happy
23 with the recommendations of the report?" I'm told that
24 the report's been shared with them.
25 Now, as I said earlier, right, I don't know why

1 I didn't push back on that at that point in time because
2 that wasn't a clear answer to the question that I asked.
3 Now, it may, it might have been that I had drawn an
4 inference that because I wasn't told they were unhappy
5 that I assumed they were happy, right.
6 But my primary point is I'm surprised I let that
7 lie. And I don't know why I let it lie at that point.
8 **Q.** Well, you described it earlier as the
9 narrative the board was creating?
10 **A.** Yes.
11 **Q.** At the time, did you feel that there was
12 a narrative being created, that the clinicians were
13 causing trouble?
14 **A.** Initially, no, right. When I -- when I used
15 the word, the words "how it was framed" in my earlier
16 testimony that was with the benefit of seeing all the
17 documentation that I don't recall seeing at the time.
18 So I was able to triangulate what was in that other
19 documentation with what was said by key players at the
20 board and that's why I said it was being framed.
21 Later on in the process, when we get into the
22 questions about grievances, right, and somewhere in the
23 minutes -- and there's lots of pages but somewhere in
24 those minutes I can remember asking about the nature of
25 the, the comments that the Consultants were accused of

1 making and I was given the clear impression they were,
2 they were unacceptable.
3 So at that point nobody ever used the word
4 "troublemaker", right. But in response to your
5 question, at that point, I probably did come to that
6 conclusion.
7 Nobody used that language, by the way, it's just
8 the conclusion I --
9 **Q.** The impression that was created?
10 **A.** Yes.
11 **Q.** Just going back a step to 10 January. It's
12 also recorded in the notes:
13 "We need to be clear on the message from the board
14 and also the consequences for stepping over the line."
15 Do you recall that being said?
16 **A.** It's in the minutes but I don't know what the
17 intention of that statement was.
18 **Q.** You are recorded as having a discussion with
19 Mrs Kelly?
20 **A.** Yes.
21 **Q.** You asked if the issues around the behaviours
22 were accurate and Mrs Kelly replied that it was
23 accurate, Mrs Kelly being the same person you had gone
24 to in July --
25 **A.** Yes, yes.

1 **Q.** -- the previous year to raise your concerns --
2 **A.** Yes.
3 **Q.** -- and your complaints?
4 So looking back, thinking about the documentation,
5 you should have had available to you --
6 **A.** Yes.
7 **Q.** -- that should have been brought to your
8 attention, do you feel that you were misled?
9 **A.** I feel I was misled at the board meeting on
10 10 January, yes.
11 **MS SUTHERLAND:** My Lady, I have no further
12 questions, thank you.
13 **LADY JUSTICE THIRLWALL:** Thank you very much,
14 Ms Sutherland. I think those are all the questions.
15 **MS BROWN:** Yes, those are and, my Lady, the next
16 witness is now going to be coming tomorrow morning, so
17 that concludes the evidence for today.
18 **LADY JUSTICE THIRLWALL:** Thank you very much.
19 Mr Wilkie, thank you very much indeed for coming
20 and giving your evidence.
21 **A.** Thank you.
22 **LADY JUSTICE THIRLWALL:** You are free to go and we
23 will start again tomorrow morning at 10 o'clock, it's
24 obviously inconvenient for Mr Holden, but he is coming
25 tomorrow, for which we are very grateful. We can't sit

1 late this evening and I would like to avoid sitting late
2 for all the obvious reasons this week.
3 So we will rise now. 10 o'clock tomorrow morning.
4 **(4.45 pm)**
5 (The Inquiry adjourned until 10.00 am
6 on Tuesday, 3 December 2024)
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 INDEX
2
3 SIR DUNCAN NICHOL (sworn) 1
4 Questions by MS LANGDALE 1
5 Questions by MS SUTHERLAND 114
6 Questions by MS WOODS 131
7 Questions by MR KENNEDY 143
8 Questions by LADY JUSTICE THIRLWALL 145
9 MR JAMES WILKIE (sworn) 151
10 Questions by MS BROWN 151
11 Questions by MS SUTHERLAND 202
12
13
14
15
16
17
18
19
20
21
22
23
24
25

LADY JUSTICE THIRLWALL: [71] 1/5 1/8 1/12 2/12 23/1 23/3 28/2 28/6 28/9 39/12 43/24 44/2 44/9 48/7 48/21 48/23 49/2 49/7 49/10 49/13 49/16 52/9 52/12 98/19 100/2 103/2 103/23 104/9 104/12 104/14 114/11 118/11 131/19 142/24 143/2 144/14 145/8 145/11 145/16 145/24 146/5 146/17 146/21 147/2 147/8 147/11 147/14 147/18 147/24 148/4 148/8 149/12 149/16 149/20 150/1 150/3 150/6 150/11 151/1 151/13 151/20 151/24 153/11 154/23 190/14 190/22 190/25 202/21 208/13 208/18 208/22
MR KENNEDY: [3] 143/1 143/4 144/13
MS BROWN: [6] 151/25 154/24 190/20 191/6 202/19 208/15
MS LANGDALE: [21] 1/7 1/13 2/14 23/4 28/13 39/14 44/4 44/14 49/18 52/6 52/16 98/22 100/10 103/6 103/20 103/25 104/7 104/21 114/9 144/16 151/18
MS SUTHERLAND: [5] 114/13 118/13 131/17 202/24 208/11
MS WOODS: [2] 131/23 142/22

'

'19 [1] 110/3
'innocent [1] 86/18
'not [1] 170/6
'we [1] 129/2

-

-like [1] 71/1

0

0003518 [1] 187/21
0005683 [1] 148/13
0009 [1] 191/9
0031 [1] 14/17
0099388 [1] 86/14
0101 [1] 112/11
0213 [1] 98/7

1

1 pm [2] 117/14 118/16
1 September [2] 178/13 178/20
1 September 2016 [1] 23/7
10 January [17] 71/20 78/12 79/14 88/16 88/18 173/24 180/9 180/23 181/5 181/10 186/2 191/7 192/21 194/14 194/20 207/11 208/10
10 January 2017 [1] 136/9
10 minutes [1] 191/1
10 o'clock [2] 208/23 209/3
10.00 [2] 1/2 209/5
10.04 [1] 1/4
101 [2] 199/9 200/6
109 [1] 127/6
10th [2] 89/10 192/5
11 July 2016 [1] 20/15
11.19 [1] 52/13
11.35 [1] 52/15
12 [3] 10/9 17/16 52/12
12 months [1] 147/1
12.57 pm [1] 104/18
13 [2] 3/14 132/19
13 April [2] 192/24 193/14
13 April 2017 [3] 80/17 133/5 133/10
135 [1] 3/11
139 [1] 110/7
14 [3] 5/17 5/23 28/25
14 December 2015 [1] 35/1
14 July [5] 53/21 53/24 55/11 162/7 184/1
14 June [1] 175/17
14th [1] 200/15
15 August [1] 47/25
15 minutes [1] 52/10
15 years [1] 126/9
152 [1] 133/23
157 [1] 22/13
158 [1] 77/22
159 [1] 78/8
16 [5] 38/5 42/12 81/14 196/10 200/16
17 [1] 12/12
17/18 [1] 110/22
18 [2] 12/16 110/22
19 [2] 13/8 129/23
19 September [3] 36/1 99/8 107/8
1968 [1] 1/22
1989 [2] 1/23 1/25
1994 [3] 1/23 1/25 2/10

2

2 December 2024 [1] 1/1
2 May [1] 197/20
2.14 pm [1] 104/20
2.15 [3] 104/8 104/9 104/15
2.15 pm [1] 104/17
20 [3] 13/15 124/8 191/2
20 February 2017 [1] 36/23
20 June 2024 [1] 1/14
20 September [1] 103/13
2004 [2] 2/10 152/4
2008 [4] 2/9 123/21 124/6 129/22
2012 [3] 2/2 2/9 29/21
2013 [4] 27/4 28/18 126/24 152/11
2013/2014 [1] 110/9
2014 [7] 10/9 27/24 110/9 123/22 124/7 129/23 154/8
2015 [4] 24/16 35/1 124/17 179/15
2016 [17] 19/19 20/15 20/21 22/15 23/7 36/1 77/23 78/2 81/15 83/12 116/3 123/14 124/17 134/20 191/14 196/6 203/6
2016/2017 [1] 110/9
2017 [12] 36/23 80/17 98/9 110/9 129/1 133/5 133/10 134/20 136/9 152/14 153/19 205/14
2017/2018 [1] 110/10
2018 [6] 29/21 90/10 99/13 110/10 127/13 158/17
2019 [3] 27/4 27/25 28/16
2020 [1] 2/2
2024 [3] 1/1 1/14 209/6
21 [5] 154/5 154/17 154/18 154/18 154/22
24 [1] 109/13
24 hours [1] 197/12
24th [1] 70/21
25 [1] 52/12
25th [1] 96/23
25th May [1] 97/11
26 [6] 29/4 94/21 94/22 99/20 106/23 141/17
26 February [1] 91/9
26 January [2] 88/25 89/1
26th [2] 89/10 128/14
28 May 2004 [1] 152/4
29 March 2018 [1] 90/10

3

3 December 2024 [1] 209/6
3 letters [1] 128/3
3.00 pm [1] 117/20
30 [2] 25/3 25/3
30 April [2] 94/25 99/15
30 June [3] 40/11 40/14 120/5
30 June 2016 [2] 116/3 123/14
30 May 2018 [1] 99/13
30-page [1] 132/21
300 pages [1] 151/11
30140002 [1] 157/20
31 [3] 14/17 111/16 148/19
31 January [1] 83/10
32 [1] 54/23
35 [1] 29/18
36 [2] 31/9 50/3
360-degree [1] 110/12
38 [1] 31/18

4

4.08 pm [1] 191/3
4.20 pm [1] 191/5
4.45 pm [1] 209/4
42 [2] 32/24 125/3
44 [1] 164/15
49 [1] 34/16

5

5 July [7] 54/5 54/9 160/9 161/7 161/18 161/19 163/10
5 September [2] 178/2 178/2
51 [3] 173/8 173/10 173/11
52 [2] 175/1 175/11
54 [1] 35/19
56830031 [1] 148/11
58 [1] 40/21

6

6 September [1] 179/25
6 September 2016 [1] 22/15
60 [1] 26/23

7

7 February [2] 191/7 191/11
76 [1] 91/6
78 [2] 94/20 127/12

8

8 July [1] 49/22
8 September [1] 68/1
81 [1] 173/9
83 [1] 95/12
87 [2] 95/8 99/16

9

90s [1] 115/3
92 [1] 164/25
97 [4] 199/7 199/10 199/11 201/7
99 [1] 133/4

A

A's [1] 42/25
A.1.G [1] 12/12
A.1.K [1] 12/20
A.3.D [1] 13/8
abate [1] 170/5
ability [3] 17/8 17/12 131/9
able [14] 23/1 54/25 57/7 66/10 70/22 91/16 114/5 146/5 155/18 155/19 158/22 193/9 204/22 206/18
about [245]
above [3] 17/22 122/24 127/20
absent [1] 162/19
absolutely [14] 10/5 25/20 30/9 75/10 75/22 125/8 130/8 135/1 139/24 157/15 166/2 180/6 189/21 189/23
accept [11] 41/18 41/25 69/13 71/24 105/24 149/21 156/16 184/22 194/24 200/2 205/16
accepted [11] 52/2 52/5 57/22 69/21 76/15 139/25 166/13 184/6 184/11 202/5 204/16
access [1] 189/18
Accident [2] 18/3 146/10
accidents [1] 125/21
accomplished [1] 8/2
account [2] 145/23 182/8
accountability [2] 7/11 32/19
accountable [5] 7/24

A

accountable... [4] 31/13 127/3 130/17 130/18
accuracy [2] 174/3 192/11
accurate [10] 1/18 13/10 36/17 53/6 192/1 192/14 192/16 192/22 207/22 207/23
accused [1] 206/25
Acknowledge [1] 90/19
across [7] 1/21 14/20 31/7 76/24 77/3 85/14 197/3
act [6] 25/1 123/21 124/6 124/10 129/22 200/1
acted [1] 195/21
action [18] 3/10 8/3 8/5 23/5 32/9 32/16 32/19 39/18 39/23 39/25 43/9 59/17 59/21 135/9 171/6 178/14 178/23 180/11
actions [18] 5/8 39/7 39/8 39/9 39/20 44/17 50/7 52/25 58/25 65/1 72/16 103/12 119/21 119/22 119/24 173/6 173/16 200/5
actively [1] 108/4
Activities [3] 123/22 124/7 129/22
activity [3] 23/6 53/14 78/4
actual [2] 16/22 88/10
actuality [1] 134/17
actually [18] 17/2 17/3 24/3 59/23 67/12 67/13 139/16 148/16 153/14 160/23 162/5 180/10 185/8 185/14 185/16 195/25 198/22 199/25
acuity [1] 53/14
add [2] 53/9 75/12
added [1] 82/17
addition [1] 152/24
address [2] 110/17 164/14
addressed [4] 2/20 94/7 121/3 130/16
adequacy [1] 75/7
adequate [5] 13/20 37/25 62/3 74/6 175/15
adequately [2] 18/7 129/3
adjourned [1] 209/5
adjournment [1] 104/19
adjusted [1] 28/10
admission [2] 76/18 191/16
adult [2] 24/24 25/23
advance [6] 38/5 51/2 51/3 54/15 122/19 162/15
advantage [1] 204/21
advice [7] 17/9 75/4 81/14 95/25 96/3 110/2 178/8
advise [2] 109/20 172/7
advised [3] 18/24 19/1 112/18
advises [1] 48/2
advising [2] 29/24 62/15
affair [1] 127/23
Affairs [1] 19/2
affected [1] 101/9
afforded [2] 25/22 26/1
afraid [4] 5/14 43/3 148/10 148/16
after [11] 61/21 74/3 83/15 112/19 164/17 166/1 175/18 177/2 193/4 194/9 196/18
after January [1] 193/4
afternoon [2] 119/9 177/14
afterwards [2] 103/22 128/16
again [25] 23/20 28/7 30/18 39/12 73/5 82/18 88/20 103/24 121/7 122/14 122/24 127/11 129/21 131/25 138/10 170/4 172/3 191/2 192/24 194/7 195/2 200/13 205/2 205/15 208/23
against [6] 25/16 27/11 36/11 134/3 136/1 158/15
agenda [4] 10/14 40/5 40/7 91/9
aggravate [1] 89/21
aggressive [1] 127/18
ago [2] 96/8 147/1
agonised [1] 185/5
agree [27] 17/3 26/10 55/16 60/5 107/15 107/19 107/21 115/18 116/13 124/21 125/7 125/10 126/14 126/21 127/5 127/21 128/6 128/9 128/10 128/11 128/11 128/12 128/12 129/9 137/25 138/2 151/5
agreed [9] 55/18 59/1 87/12 107/9 110/24 111/16 122/16 155/4 176/2
agreeing [1] 65/8
agreement [4] 108/9 108/12 108/14 131/11
agrees [1] 179/7
Ah [1] 150/5
ahead [1] 170/10
aim [1] 103/8
aired [1] 103/14
AK [1] 121/11
albeit [1] 94/13
Alder [2] 82/3 183/15
Alder Hey [2] 82/3 183/15
alerted [1] 38/16
Alison [11] 24/14 30/15 30/17 42/18 62/1 117/25 159/20 176/22 176/25 178/9 178/9
Alison Kelly [10] 24/14 30/15 30/17 42/18 62/1 117/25 159/20 176/22 176/25 178/9
Alison's [1] 177/3
all [74] 1/6 1/21 3/1 3/17 5/23 10/13 12/17 12/22 13/2 14/12 16/11 18/7 21/4 25/6 25/9 25/24 26/8 27/21 31/25 32/8 34/22 37/12 43/23 44/24 45/3 46/18 49/14 49/14 50/5 58/11 58/13 58/14 63/4 63/8 69/11 77/12 83/16 86/20 97/7 99/8 103/2 104/3 105/1 105/6 115/7 119/12 121/24 128/3 129/13 137/9 137/9 139/6 142/16 144/6 151/14 157/24 168/15 168/17 169/2 171/3 172/13 179/17 185/3 185/10 187/10 188/17 189/18 190/25 195/8 202/18 203/21 206/16 208/14 209/2
allegation [5] 36/11 36/19 158/8 178/24 179/2
allegations [14] 25/16 83/13 83/17 84/15 84/18 84/20 84/22 85/2 85/4 85/5 85/5 86/6 179/4 180/12
alleged [2] 85/11 85/12
Alliance [1] 131/15
Allitt [15] 2/16 46/21 46/22 132/1 132/23 132/24 133/7 133/11 133/15 133/16 134/9 134/15 134/17 134/21 134/24
Allitt's [1] 132/4
allow [1] 129/25
allowed [3] 8/4 108/15 190/1
almost [3] 135/6 138/19 164/17
along [7] 81/11 88/2 113/3 140/9 175/18 177/19 184/13
already [9] 73/22 121/23 148/22 163/17 182/21 186/19 187/9 188/16 189/16
also [37] 2/8 13/9 13/16 15/11 15/21 21/5 21/20 30/7 40/20 50/19 56/10 72/23 77/18 88/6 94/11 98/6 103/18 108/20 110/24 114/1 143/8 152/15 152/25 158/25 171/24 174/6 176/8 176/8 178/14 180/2 185/24 189/25 194/1 199/9 200/17 207/12 207/14
alternative [5] 59/14 67/25 107/14 107/15 193/23
although [1] 193/25
always [5] 14/8 25/1 31/5 126/4 138/20
am [51] 1/2 1/4 4/20 6/21 21/25 33/13 34/19 47/23 52/13 52/15 53/18 53/18 70/17 79/14 80/1 84/5 85/16 90/18 97/6 98/15 106/14 114/20 116/20 118/7 119/16 125/13 129/20 129/21 140/5 140/5 142/25 145/5 146/18 151/7 151/11 156/19 156/21 157/5 157/21 160/24 162/5 165/12 167/5 168/3 169/18 184/14 185/9 190/15 190/21 201/19 209/5
amongst [1] 163/7
amount [4] 135/11 137/15 192/9 204/3
amplification [1] 59/24
analogy [1] 151/7
analyse [1] 77/4
analysis [1] 77/9
angel [3] 69/9 71/1 85/4
angst [1] 144/23
anguish [1] 87/7
animosity [1] 106/12
announced [1] 161/15
announcement [3] 111/15 112/8 148/25
annual [4] 48/16 49/8 110/8 110/15
another [15] 40/20 47/24 61/23 103/10 109/6 109/7 109/25 116/18 147/19 148/3 174/13 174/19 177/22 187/18 190/7
answer [12] 41/15 153/5 155/14 161/21 169/4 190/9 195/8 198/14 198/25 201/2 202/14 206/2
answered [4] 28/2 99/21 169/3 185/8
answering [1] 94/22
answers [9] 42/4 42/4 47/17 53/10 99/18 99/18 99/23 100/4 143/19
anti [1] 151/9
anti-freeze [1] 151/9
anticipated [1] 48/4
anticipation [4] 40/24 41/3 50/6 122/9
anxiety [2] 58/2 58/3
anxious [1] 193/12
any [72] 4/16 5/14 5/22 6/19 9/22 9/22 15/18 20/25 21/11 25/18 25/21 26/11 26/15 27/15 29/7 29/15 36/6 36/15 36/17 41/6 45/6 63/17 65/6 70/24 70/24 71/4 74/8 75/8 76/8 76/9 76/10 76/12 78/5 81/9 82/21 82/23 83/4 87/11 87/14 98/16 104/4 104/5 107/22 107/22 112/24 124/23 126/10 128/4 146/19 153/23 153/23 156/12 160/21 163/23 170/5 172/6 173/5 173/15 174/23 175/16 177/6 182/10 183/4 187/8 190/7 190/12 194/20 199/2 200/9 200/20 201/21 202/20
anybody [4] 27/23 123/15 123/16 151/14
anyone [6] 27/24 28/19 33/23 106/16 113/16 135/1
anything [31] 9/7

A

anything... [30] 9/23 31/14 46/14 47/18 49/24 50/25 63/23 64/2 64/3 69/4 69/15 70/12 70/19 71/8 76/20 79/9 79/12 106/5 108/5 111/25 112/2 113/18 119/18 139/1 145/13 146/17 148/4 151/14 192/18 199/2
apart [1] 119/22
apologise [3] 127/23 153/10 158/16
apology [11] 67/1 67/2 68/23 68/24 68/25 69/2 69/4 69/6 73/18 73/25 136/11
apparent [2] 20/13 21/5
appear [3] 47/3 120/8 134/23
appears [12] 22/24 43/9 62/6 81/19 117/15 120/18 126/13 160/13 161/13 163/5 179/9 185/3
appendix [1] 63/22
application [2] 152/20 153/7
applied [2] 156/6 160/4
apply [2] 86/19 135/17
appoint [1] 129/24
appointed [5] 2/3 2/5 2/6 126/24 152/10
appointing [4] 10/22 113/4 113/7 113/10
appraisal [11] 111/7 111/11 111/14 145/18 145/23 146/8 146/15 146/24 146/25 147/6 147/20
appraisals [8] 110/11 110/12 110/15 110/15 111/4 111/6 111/8 145/20
appreciate [8] 67/21 76/20 77/12 86/22 87/6 124/13 125/17 171/9
approach [4] 62/12 135/25 193/23 193/23
approached [7] 29/10 83/1 141/18 141/22 142/2 142/7 150/3
appropriate [10] 13/2 19/16 28/20 30/20 57/17 74/20 89/17 130/9 138/6 167/16
appropriately [3] 33/16 139/13 140/10
approve [1] 108/20
approved [3] 108/19 109/2 119/24
April [14] 80/17 94/25 99/15 127/13 127/13 133/5 133/10 134/20 152/11 192/24 193/14 196/7 196/14 196/22
April/May [1] 127/13
arbitration [1] 92/20
are [145] 1/17 1/18 2/4 7/18 8/2 10/2 10/17 10/17 13/7 14/2 14/3 17/1 23/1 23/14 23/15 23/23 24/8 24/25 25/8 25/9 25/24 26/6 33/10 33/12 33/12 33/13 34/5 34/22 34/23 34/24 36/1 36/25 37/5 38/8 43/5 44/23 44/24 45/17 47/9 49/25 51/19 51/24 55/12 55/25 58/25 59/1 61/20 63/25 65/5 66/9 67/13 70/17 70/17 72/9 73/18 73/24 76/3 81/11 83/17 85/13 86/1 86/22 87/2 91/4 97/7 98/3 109/5 110/11 110/15 110/18 114/9 115/18 119/1 120/10 121/18 122/19 125/15 130/10 133/1 134/5 137/23 138/14 138/15 138/15 139/9 139/12 141/8 142/25 145/22 146/5 148/6 150/19 150/23 150/24 150/25 151/9 151/13 151/16 154/22 157/9 158/3 159/12 161/6 163/6 164/4 165/12 167/13 167/14 167/15 168/14 171/15 171/20 171/21 171/21 172/18 174/6 174/8 178/23 180/22 181/6 181/20 181/21 184/18 186/3 187/11 189/16 190/11 192/17 194/6 196/3 196/14 198/20 198/21 198/21 198/23 203/6 203/22 204/2 204/5 205/22 207/18 208/14 208/15 208/22 208/25
are representative [1] 10/17
area [4] 153/21 169/15 169/16 170/1
areas [2] 15/8 191/22
aren't [1] 86/2
arguably [3] 81/10 92/19 140/18
argue [2] 160/21 195/21
argues [1] 84/24
argument [2] 81/6 140/23
arises [2] 117/23 140/25
arising [2] 151/15 171/21
arms [3] 96/24 97/2 127/8
arose [1] 5/6
around [23] 4/16 7/1 9/19 33/6 33/6 33/7 56/14 57/12 62/10 85/18 94/6 96/17 99/3 110/13 117/2 127/8 127/13 149/14 149/15 150/20 179/18 183/21 207/21
around April 2018 [1] 127/13
arranged [1] 37/12
arrangements [2] 17/17 130/10
arrive [2] 6/1 99/25
arrived [2] 112/10 147/7
articulate [1] 157/17
articulated [1] 133/11
articulating [1] 194/18
articulation [1] 43/8
as [213]
ascertain [1] 143/19
ascribed [1] 75/8
ask [29] 5/24 34/4 34/4 46/5 48/11 64/18 67/9 69/4 82/22 103/18 103/22 113/16 116/20 123/18 125/1 129/20 131/24 132/20 133/8 135/10 138/9 140/3 145/13 148/15 149/6 176/3 195/1 201/20 202/22
asked [51] 3/8 13/25 16/19 29/13 51/21 58/6 58/10 70/12 70/19 70/23 78/25 79/8 79/23 79/25 80/3 80/5 80/9 87/14 94/21 96/13 113/12 113/17 113/21 113/24 129/4 133/6 142/18 142/20 143/5 149/17 153/13 155/13 164/2 166/24 168/8 168/20 169/1 170/5 170/11 170/20 172/2 172/4 177/11 184/22 188/9 190/7 198/10 205/16 205/21 206/2 207/21
asked if [1] 184/22
asking [9] 63/10 76/2 142/14 157/1 174/8 176/4 184/11 194/21 206/24
asks [1] 196/17
aspects [1] 10/13
aspiration [2] 134/1 135/2
aspire [1] 148/3
assessed [2] 21/21 110/18
assessment [2] 130/4 139/5
assimilate [1] 17/12
assist [2] 14/12 40/19
assisted [1] 158/22
assisting [3] 72/3 159/23 188/11
associated [1] 15/6
association [3] 22/1 56/14 57/1
assumed [1] 206/5
assuming [2] 15/1 204/15
assurance [10] 5/21 14/8 22/14 22/17 27/3 27/15 51/25 52/3 139/4 186/22
assurances [2] 76/3 189/25
at [390]
attached [5] 67/18 68/19 71/25 88/6 156/10
attempted [1] 132/8
attend [4] 88/22 90/6 120/11 195/2
attended [5] 70/22 88/22 100/9 128/15 162/20
attendees [1] 120/7
attends [2] 80/19 193/17
attention [7] 41/8 59/4 86/10 139/9 159/3 164/7 208/8
attitude [1] 201/10
attributed [1] 93/25
attributes [1] 7/17
audit [6] 139/11 139/14 139/19 139/22 150/24 153/1
Audit Committee [1] 153/1
August [5] 27/4 29/21 47/25 50/7 77/23
authorisation [1] 23/19
authority [6] 6/23 7/4 10/19 27/12 28/21 197/12
autumn [2] 152/14 153/19
availability [1] 116/16
available [9] 18/12 32/3 79/2 143/22 174/9 176/21 180/7 190/13 208/5
averaged [2] 152/23 153/16
avoid [1] 209/1
avoidable [1] 205/12
awaiting [1] 36/7
aware [31] 4/16 4/21 6/4 6/21 6/25 7/6 29/9 34/13 35/20 41/5 69/7 87/17 90/4 93/10 106/8 115/14 131/4 133/14 141/18 162/11 162/23 163/3 163/6 167/8 178/12 178/19 180/9 180/12 186/2 189/10 191/13
awareness [4] 3/17 4/7 115/7 121/23
away [4] 4/21 121/9 123/19 136/3

B

B.5.C [1] 14/18
babies [31] 6/15 21/20 25/22 47/13 51/13 53/3 54/23 56/9 58/18 75/25 76/23 85/7 85/10 86/5 119/20 123/3 123/14 132/5 142/12 144/24 145/3 145/4 159/16 164/6 165/7 166/4 168/1 168/10 170/16 175/16 195/6
baby [12] 22/7 37/22 38/18 41/23 42/25 43/1 60/21 86/4 164/20 165/20 173/5 173/15
back [60] 11/22 12/7 13/24 17/13 21/23 32/13 38/13 62/7 64/21 68/21 72/7 73/13 73/23 74/3 76/17 81/8 84/13 88/20 94/9 94/13 96/7 104/5 104/5 107/12 107/16 108/2 108/2 120/19 120/19 121/21 129/21 132/1 136/12 137/25 138/10 139/20 143/4 153/15 158/19 164/2 170/1 174/1 174/20 174/24 185/7

B

back... [15] 185/12 186/8 186/12 187/1 187/15 187/17 188/13 194/6 199/5 202/13 204/22 204/23 206/1 207/11 208/4
background [6] 16/19 16/25 69/7 93/11 152/7 204/8
bad [1] 186/22
bags [3] 51/12 51/16 51/20
balance [1] 55/23
Bar [1] 144/16
barrister [2] 193/17 193/20
based [2] 6/2 80/8
basically [5] 137/8 172/19 182/16 187/10 190/4
basis [7] 53/15 61/6 74/18 91/21 185/19 193/10 203/15
BBC [2] 77/23 78/10
BBC News [1] 77/23
be [221]
bear [1] 120/17
bearing [2] 59/7 165/3
became [4] 41/5 162/23 163/3 164/6
because [51] 14/11 18/25 22/6 32/5 57/6 62/2 63/3 63/23 63/25 72/7 75/23 77/8 78/24 79/5 96/18 101/15 120/23 135/10 137/3 142/9 153/20 155/17 163/5 166/9 166/23 167/4 167/20 170/11 173/23 174/2 174/8 175/4 176/8 177/9 177/15 180/19 185/5 185/8 189/15 192/16 193/12 194/11 194/17 198/15 199/2 199/13 201/17 201/25 202/5 206/1 206/4
become [2] 70/23 87/8
becomes [1] 144/3
been [175] 2/3 5/21 11/2 11/14 11/16 11/24 12/3 22/3 28/5 28/7 29/6 31/25 32/15 33/24 34/1 35/6 37/6 37/8 37/12 38/3 38/13 38/15 38/16 38/19 39/3 39/24 40/1 41/14 42/14 44/15 45/7 48/19 51/16 55/20 55/21 59/4 60/10 61/14 61/15 61/15 63/22 67/6 67/11 67/24 68/16 69/8 69/8 70/20 74/22 75/2 75/5 75/16 76/8 77/10 78/25 80/7 80/8 80/11 80/12 81/21 82/2 82/23 83/14 83/18 84/7 84/17 85/11 85/12 87/5 88/21 88/25 89/17 90/5 90/9 90/9 93/4 93/5 94/4 94/5 94/7 97/14 101/5 109/8 112/23 113/9 113/20 115/14 119/14 119/17 124/20 126/13 127/22 129/3 129/4 132/19 136/3 136/10 140/1 140/1 142/10 142/16 142/19 143/17 143/24 145/20 146/14 146/25 147/16 148/1 153/14 155/13 155/17 155/18 156/16 156/18 156/23 156/23 156/25 160/14 160/15 161/9 162/13 163/6 163/9 163/18 163/21 163/24 164/11 165/6 166/16 169/20 174/21 177/25 178/14 178/24 179/23 180/1 180/2 180/3 180/9 180/12 180/19 181/4 182/16 182/21 183/24 184/7 184/14 184/24 186/2 186/3 187/14 189/2 190/15 191/6 191/12 191/20 193/6 193/12 193/13 195/11 196/11 196/14 198/7 198/9 200/10 202/2 202/3 203/7 205/9 205/14 205/18 205/24 206/3 208/7
before [25] 21/9 21/9 27/21 41/7 48/8 52/3 52/7 53/23 68/22 70/2 76/8 83/21 84/13 95/16 95/19 112/22 117/7 120/16 136/15 136/16 140/21 160/12 163/6 165/5 193/1
began [2] 86/17 116/3
beginning [3] 7/12 26/8 41/17
begins [1] 100/22
behalf [3] 67/20 70/22 131/24
behaviour [11] 69/2 69/6 70/15 73/17 73/19 74/12 86/7 93/5 102/14 102/16 186/22
behaviours [7] 70/10 72/16 74/13 74/14 74/18 139/17 207/21
behind [3] 65/17 111/2 147/23
being [92] 5/9 7/5 13/25 16/18 16/23 18/8 18/9 19/15 20/3 20/21 21/21 22/7 22/9 30/13 34/14 36/13 37/5 38/2 41/10 43/1 43/10 46/1 46/11 46/21 50/1 50/4 52/18 57/12 58/25 60/23 62/2 63/2 70/2 70/12 70/16 70/19 70/23 77/16 79/4 83/23 87/22 88/17 89/3 91/4 93/3 101/24 102/4 102/8 102/24 103/5 109/8 114/5 122/8 123/6 128/17 136/9 137/16 139/9 139/12 140/17 140/18 142/18 143/18 146/9 153/13 155/19 156/3 158/22 161/1 162/6 165/16 165/19 172/20 175/22 184/3 185/19 188/9 188/14 189/25 196/22 201/4 201/5 202/16 202/17 203/6 204/20 205/1 205/3 206/12 206/20 207/15 207/23
belief [5] 6/6 152/5 163/1 163/2 192/8
believe [19] 6/10 14/6 28/17 65/19 66/14 67/22 78/1 98/2 101/12 129/11 136/23 141/11 143/14 148/7 156/2 158/25 187/7 199/25 202/20
believed [3] 166/3 170/13 173/2
below [7] 12/21 54/23 117/19 127/25 155/2 170/4 179/6
benefit [1] 206/16
bereaved [1] 100/14
best [6] 25/1 73/12 111/2 147/22 152/5 186/11
better [6] 23/3 33/14 39/6 56/4 104/10 167/15
between [25] 1/22 2/9 2/10 7/22 14/21 14/22 19/8 29/21 31/1 48/13 68/13 91/10 105/25 108/13 110/16 111/17 111/23 113/3 121/6 134/19 136/19 149/4 153/2 165/1 196/11
between July 2012 [1] 29/21
Beverley [12] 2/16 46/21 46/22 132/1 132/4 132/23 133/7 133/11 133/15 133/16 134/9 134/15
Beverley Allitt [10] 2/16 46/22 132/1 132/23 133/7 133/11 133/15 133/16 134/9 134/15
Beverley Allitt's [1] 132/4
big [5] 74/1 75/13 75/13 138/5 189/15
bigger [2] 137/25 138/3
biggest [1] 82/17
bit [5] 80/22 125/1 126/23 152/21 158/2
bits [2] 185/23 186/1
Blackpool [1] 154/2
blindsided [1] 177/16
block [2] 9/11 191/12
blue [1] 60/1
bluntly [1] 180/8
board [164] 1/24 2/1 2/6 4/15 6/12 6/24 7/25 7/25 8/6 8/8 10/12 11/7 11/10 11/19 11/25 12/3 12/4 12/10 12/13 12/17 12/18 12/24 13/2 14/5 14/6 14/7 14/8 14/15 14/20 15/5 16/4 17/14 17/18 17/19 18/15 18/17 22/15 22/16 29/6 29/19 31/1 34/13 38/5 38/6 38/9 38/11 40/25 42/11 43/15 52/8 53/10 53/12 53/21 54/2 54/6 54/7 54/16 55/8 55/10 61/13 61/21 61/23 66/5 66/6 71/20 72/5 74/15 75/5 75/14 76/15 77/13 78/1 78/10 79/3 80/7 80/11 88/5 88/15 88/24 89/4 89/5 89/7 90/13 90/20 91/3 91/12 100/25 101/7 101/15 101/18 105/21 106/2 106/3 114/7 116/5 116/15 119/24 123/8 123/10 127/22 133/5 135/17 135/17 135/20 136/17 136/23 137/17 137/20 138/13 138/17 139/4 142/14 152/25 153/22 153/24 154/11 154/14 155/12 157/17 157/18 159/3 159/14 160/1 160/5 160/9 161/6 161/12 161/20 161/22 162/2 162/9 163/25 164/8 172/20 173/24 174/13 174/17 174/19 179/21 179/21 179/22 179/23 179/24 180/9 180/15 182/13 187/10 187/23 188/9 191/8 191/10 191/13 192/21 193/5 193/13 193/14 195/24 197/15 201/21 204/5 206/9 206/20 207/13 208/9
board's [5] 22/14 74/11 134/19 172/23 174/2
boardroom [2] 50/3 80/17
boards [1] 135/20
bodies [3] 6/19 10/18 29/17
body [4] 29/15 108/20 124/10 165/16
bold [1] 127/25
bonnet [1] 189/19
border [1] 73/19
bore [1] 116/15
both [10] 20/3 35/5 87/2 92/17 105/5 132/16 132/24 135/11 155/11 156/6
bottom [17] 16/3 22/19 45/25 58/20 64/9 70/5 76/14 100/16 120/17 121/7 157/22 169/11 169/19 174/12 182/20 182/22 183/17
Bottomley [1] 3/8
Bottomley's [1] 2/20
bound [1] 24/25
box [4] 22/18 23/11 127/17 135/7
breach [1] 23/18
break [8] 52/7 52/10 52/14 103/22 103/24 190/15 191/4 192/6
breakdown [12] 90/19 91/10 93/20 93/22 105/20 105/25 106/5 106/11 106/15 106/19 112/3 112/6
breaks [1] 104/16
Brearey [18] 19/20 26/12 55/12 56/15 58/2 74/23 90/6 97/22 100/20 120/18 121/17 122/1 125/25 162/21 164/19 165/19 170/6 184/25
brief [3] 133/3 160/12 187/22
briefings [1] 118/22

B

briefly [6] 66/20 148/10 156/11 163/16 171/4 176/24
Brigham [1] 35/10
bring [6] 91/18 139/20 159/3 171/24 199/24 201/23
bringing [1] 130/23
brings [2] 24/1 26/9
Bristol [1] 45/4
broad [1] 172/24
broadly [2] 20/8 204/25
broken [2] 106/18 106/19
broker [1] 91/12
brokered [1] 108/9
brought [5] 7/18 37/19 86/10 135/19 208/7
brow [1] 104/2
BROWN [4] 151/23 151/24 190/19 210/10
build [1] 93/11
building [1] 9/14
built [1] 133/6
bullet [2] 91/19 127/25
bullied [6] 93/14 101/5 102/9 102/24 103/5 128/17
bundles [1] 163/8
business [1] 7/20
busy [1] 10/1
but [221] 29/12 29/19 31/10 35/24 35/24 36/22 36/24 40/4 40/10 40/12 40/19 40/22 43/5 43/21 44/5 45/5 45/6 45/16 45/16 45/24 46/1 46/8 46/14 47/14 48/6 48/11 49/18 49/19 49/24 50/4 51/22 52/16 52/20 53/20 54/4 55/3 57/19 61/25 63/24 71/21 73/12 73/15 75/17 80/21 80/22 83/7 83/8 86/13 87/3 88/11 90/4 90/16 90/18 92/1 94/17 95/3 95/3 96/22 97/9 99/20 102/15 104/4 104/5 104/5 105/1 105/1 108/11 111/4 111/12 114/14 114/15 116/22 117/12 117/13 117/18 120/4 120/7 120/10 120/22 121/7 121/17 123/18 123/20 132/1 132/20 133/9 134/16 135/13 135/24 137/2 137/5 137/5 138/9 138/13 139/20 140/3 140/23 143/4 148/19 149/6 155/6 158/18 162/9 163/13 164/1 166/21 168/8 168/11 170/20 171/9 171/10 172/17 175/1 176/13 176/24 182/1 182/20 184/9 184/20 186/11 191/1 191/25 192/23 195/17 195/20 196/1 197/17 199/5 205/15 206/24

C

call [11] 1/7 15/14 15/15 35/11 60/9 61/6 61/8 103/10 104/24 122/18 162/8
called [12] 6/11 41/11 41/12 41/16 59/18 60/11 81/13 122/4 122/6 171/7 171/11 177/13
calling [5] 61/11 86/7 123/15 123/16 186/3
calls [1] 113/2
came [14] 17/11 59/21 63/1 82/4 96/15 99/6 141/24 146/2 165/9 167/18 174/1 194/16 195/12 197/3
can [158] 1/17 1/19 3/11 3/14 5/5 5/15 7/8 7/14 10/6 10/6 10/15 12/12 15/24 15/24 16/2 16/20 17/18 20/8 20/9 22/12 22/12 23/9 23/10 24/11 26/22 26/22 28/23 28/23 59/1 67/21 86/22 126/21 135/2 156/22 157/14 159/10 171/13 174/24 181/3 181/3 181/8 187/7 205/6
can't [59] 3/23 3/24 26/2 30/11 40/9 40/9 41/24 44/25 48/18 48/18 48/18 48/19 52/4 54/25 55/5 55/5 56/13 56/17 56/18 56/18 63/25 67/5 68/20 73/7 73/7 76/9 76/13 87/20 88/9 89/11 89/12 94/19 96/14 96/15 97/20 101/22 101/22 105/16 106/7 106/21 114/18 142/6 148/17 156/19 157/6 159/10 162/13 164/7 171/12 174/22 177/1 177/18 180/19 181/6 181/20 185/6 185/6 187/24 208/25
candour [3] 124/7 138/6 143/5
cannot [16] 41/18 105/17 110/5 124/4 135/21 136/16 140/12 161/7 187/4 192/12 192/20 194/10 198/10 200/23 202/4
capacity [3] 70/24 78/25 79/20
car [1] 151/8
care [15] 25/8 25/10 25/13 41/23 54/22 90/21 119/23 121/8 123/21 124/6 124/12 129/22 144/25 157/24 158/4
career [2] 86/25 144/21
careful [1] 185/9
carefully [1] 50/13
caring [3] 3/17 115/7 121/24
carried [2] 196/13 196/15
carry [3] 122/22 130/11 190/21
case [28] 21/3 22/3 29/1 31/16 33/24 37/12 46/22 46/23 51/14 51/16 51/20 55/23 78/3 78/7 110/16 110/19 119/1 133/15 144/19 145/12 158/13 160/1 182/24 183/21 188/4 191/22 193/11 197/4
Casenote [1] 179/14
cases [3] 37/15 79/12 115/16
category [2] 23/23 134/14
causal [4] 183/20 191/23 193/7 194/15
causation [1] 75/8
cause [9] 3/19 6/10 52/1 76/22 115/10 121/25 173/5 173/15 173/20
caused [3] 60/15 77/10 145/2
causes [3] 53/11 53/13 191/24
causing [5] 21/22 87/7 122/25 134/18 206/13
cc'd [1] 83/9
CDOP [5] 6/21 6/22 82/14 196/23 197/1
centre [2] 140/2 140/4
CEO [2] 31/10 191/10
certain [3] 2/25 66/14 189/22
certainly [22] 24/7 66/4 86/1 87/20 90/8 93/10 96/4 103/16 31/10 104/25 114/5
certainty [1] 27/20
cetera [3] 194/15 194/15 202/11
chair [26] 1/25 2/8 4/15 7/15 7/16 7/22 7/24 8/7 10/22 16/13 16/19 17/5 17/6 29/6 31/1 39/22 40/9 41/13 61/19 110/18 113/6 113/10 113/11 113/17 154/2 176/8
chaired [2] 10/23 15/5
chairing [1] 17/1
chairman [3] 2/5 2/7 67/8
chairperson [5] 10/11 13/9 13/12 13/16 14/19
chairs [2] 113/3 135/20
challenge [17] 12/11 12/23 13/3 45/8 45/10 71/5 137/22 137/22 155/1 155/25 158/23 200/20 201/6 201/17 201/22 204/13 204/24
challenged [4] 184/5 200/24 201/1 202/14
challenges [1] 130/20
challenging [3] 155/17 184/8 200/11
Chambers [65] 8/8 8/14 13/21 31/12 31/16 41/13 43/4 64/8 70/6 72/8 72/13 72/19 73/11 73/22 76/4 86/14 87/12 87/20 91/24 94/24 95/8 95/23 99/9 99/13 104/23 105/9 105/10 105/25 108/10 108/15 109/8 109/11 110/4 110/8 110/20 111/11 111/17 113/4 113/19 114/1 117/25 126/23 126/24 127/16 128/7 129/8 129/14 129/18 130/15 130/21 131/13 136/11 145/20 147/9 148/25 169/3 169/5 177/8 178/10 183/12 183/17 186/10 186/21 191/13 196/19
Chambers' [5] 79/17 95/9 107/24 112/1 112/19
Chambers's [3]
chance [1] 80/16
change [5] 74/5 121/10 121/19 122/2 134/6
changed [3] 76/19 166/16 191/16
changes [1] 121/18
charge [2] 9/18 83/2
charts [1] 159/12
check [4] 64/18 64/23 64/25 145/11
checklist [2] 135/6 135/13
checks [3] 130/6 130/7 139/14
Chester [15] 2/1 4/18 16/1 31/23 105/10 107/17 108/17 125/24 131/14 133/2 134/16 144/24 152/11 153/19 155/7
Chief [23] 1/24 2/15 7/23 7/23 8/3 8/8 19/6 31/15 51/6 62/14 109/5 110/16 127/18 127/21 128/3 129/1 129/5 145/19 152/9 176/21 177/12 193/6 201/25
Chief Executive [1] 176/21
child [9] 5/19 7/2 25/1 42/25 158/10 188/1 193/24 195/10 196/23
Child A's [1] 42/25
children [21] 3/18 4/22 5/8 5/10 5/10 7/4 24/16 24/25 25/25 27/6 27/10 27/11 27/17 59/7 76/12 90/22 91/15 115/7 115/24 121/24 158/9
Children's [1] 9/11
choose [1] 35/11
chosen [1] 54/10
Christie [1] 2/8
chronology [3] 32/15 129/21 133/4
circle [1] 86/10
circulated [2] 3/25 182/5
circulating [3] 2/22 65/23 84/22
circulation [1] 85/17
circumstances [5] 109/25 130/2 141/4 141/5 160/2
cited [1] 93/24
civilised [1] 177/3
claim [2] 72/15 72/20
claim that [1] 72/15
clarify [1] 29/13

C

clarity [2] 26/18 94/5
classified [1] 143/24
clear [46] 13/11 16/20 25/5 27/13 27/25 32/15 32/16 32/22 35/6 43/8 43/13 45/13 46/17 72/19 76/6 85/13 85/16 87/20 98/22 101/19 137/14 155/21 155/21 156/19 157/5 160/24 161/6 162/25 163/6 163/15 163/16 167/5 167/10 176/1 181/6 181/16 181/21 183/15 187/12 188/24 192/12 195/5 198/8 206/2 207/1 207/13
clearly [10] 8/4 39/20 91/23 121/18 123/13 127/15 137/3 164/19 189/2 198/18
clerical [2] 205/5 205/8
clinic [1] 57/5
clinical [18] 3/19 6/5 13/4 13/5 17/9 25/7 25/7 29/24 29/25 31/7 72/18 90/21 165/16 169/15 169/16 170/1 170/2 183/22
clinicians [7] 4/10 130/13 130/23 135/14 191/14 203/23 206/12
close [1] 30/12
closed [2] 117/6 117/8
closely [1] 39/20
closer [1] 195/13
Closing [1] 54/22
closure [3] 50/17 50/17 195/14
Clothier [11] 2/23 3/20 114/22 114/24 121/22 132/3 132/12 132/20 132/23 132/24 133/25
cluster [4] 38/22 39/4 179/11 188/3
clusters [1] 39/24
code [5] 7/10 7/11 10/8 154/6 156/4
coerced [3] 128/23 129/11 149/18
cohesive [2] 19/6 31/6
colleague [2] 126/25 168/17
colleagues [11] 34/10 54/1 72/18 74/15 74/19 83/10 91/8 97/5 98/14 110/14 178/16
collective [5] 80/11 134/3 135/3 155/8 155/11
collectively [3] 136/17 154/11 170/14
College [11] 46/2 46/6 46/7 77/19 136/15 140/11 141/3 174/1 182/14 185/23 188/1
College's [2] 188/19 196/12
combined [1] 38/25
come [44] 1/8 3/12 5/15 14/4 15/24 22/12 23/9 24/11 26/22 28/23 35/24 38/8 38/9 40/10 41/7 45/16 48/3 48/6 49/18 61/25 72/7 76/24 77/3 83/7 98/7 104/4 104/5 104/5 123/8 123/20 151/20 155/7 158/18 159/18 170/23 173/24 182/19 184/6 185/7 185/11 193/14 194/10 194/10 207/5
comes [6] 133/3 133/4 151/6 154/18 183/3 201/21
comfortable [3] 35/15 61/20 141/3
comfortably [1] 104/7
coming [13] 22/16 71/10 74/3 92/2 104/2 104/3 134/8 187/15 187/17 202/7 208/16 208/19 208/24
Command [3] 49/21 49/25 82/7
commence [1] 23/7
commended [1] 35/21
comment [6] 29/18 31/17 77/15 78/19 96/11 192/2
commented [2] 59/25 137/6
commenting [1] 96/12
comments [8] 71/2 74/11 74/24 95/19 185/1 189/16 194/22 206/25
commercial [2] 18/18 18/19
Commission [2] 43/17 117/3
commissioned [2] 42/2 182/4
Commissioners [1] 29/14
commissioning [1] 37/7
Commit [1] 90/23
commitment [2] 152/18 186/25
committed [5] 27/10 27/19 58/23 132/4 158/10
committee [22] 16/9 17/15 17/19 19/17 20/5 34/19 37/25 38/4 38/12 38/14 38/15 38/19 39/8 39/14 39/25 99/7 100/8 104/22 108/4 109/20 153/1 153/1
committee's [1] 17/17
committees [3] 14/21 15/4 16/13
common [5] 84/23 102/4 102/6 121/8 121/19
Commons [1] 2/21
comms [2] 118/12 118/14
communicate [9] 21/2 45/12 70/25 82/19 111/25 112/2 112/5 140/3 143/6
communicated [4] 50/17 88/7 91/24 110/23
communicating [3] 50/15 135/25 139/22
communication [9] 30/13 52/19 52/22 53/5 53/8 55/2 82/20 93/25 101/9
communications [7] 45/9 45/10 50/11 50/23 51/1 51/4 52/18
community [4] 5/11 10/18 21/3 50/9
comparison [2] 133/7 133/11
complaint [1] 136/2
complaints [1] 208/3
complementary [1] 7/22
complete [3] 32/6 78/7 189/10
completed [4] 36/5 87/5 126/4 191/20
completely [2] 151/5 151/5
completely' [1] 170/7
completion [1] 188/7
complex [1] 140/7
complexity [1] 45/8
compliance [3] 23/16 150/20 150/22
components [1] 106/14
concentration [1] 35/12
concern [26] 17/24 46/15 90/20 91/9 93/19 101/1 101/8 117/8 119/6 119/20 121/9 122/25 158/6 158/7 163/23 168/1 170/9 170/19 177/4 177/6 194/6 194/18 195/18 196/5 198/18 205/11
concerned [22] 1/18 3/1 37/14 37/16 52/24 62/2 74/15 91/3 101/9 129/4 157/9 161/8 167/11 171/22 174/6 174/17 175/13 178/18 185/2 194/11 203/7 205/9
concerns [62] 5/18 7/4 11/1 17/25 19/10 19/23 25/2 25/4 25/13 28/20 29/7 33/25 34/8 35/14 36/7 36/17 43/8 43/11 45/24 46/4 56/14 58/24 69/8 69/25 71/7 81/13 86/4 90/12 91/22 93/2 94/4 94/6 97/23 97/25 98/3 100/15 100/16 100/18 102/3 102/7 120/20 121/11 123/9 141/1 157/17 157/24 158/15 159/23 161/10 162/16 162/23 163/4 163/12 167/6 172/22 174/4 177/9 191/14 191/24 193/1 193/3 208/1
concludes [1] 208/17
conclusion [10] 103/7 115/6 121/21 121/22 147/7 175/5 194/16 195/12 207/6 207/8
conclusions [3] 2/22 103/12 103/13
concurred [1] 18/25
conditional [1] 23/16
conduct [3] 5/19 7/11 34/9
conducted [2] 145/18 145/19
confidence [9] 56/1 56/4 107/10 107/19 107/22 108/3 108/7 113/20 129/18
confident [3] 28/24 58/10 169/2
confidential [18] 11/8 11/10 11/24 18/20 18/22 55/15 63/3 63/6 65/20 140/13 143/24 144/8 144/10 165/10 180/10 180/16 181/23 185/24
confidentiality [4] 11/12 100/13 140/21 141/6
confirm [3] 1/17 112/13 178/8
confirmation [1] 119/22
confirmed [1] 126/10
conflict [1] 194/2
conjunction [1] 19/25
connect [1] 32/8
connected [5] 18/8 39/20 100/4 164/20 165/20
connection [1] 68/13
conscious [3] 7/3 119/7 200/12
consensus [2] 122/14 176/12
consequences [7] 23/10 23/14 23/15 72/14 72/25 73/2 207/14
consider [7] 60/20 72/5 136/18 136/23 157/12 189/9 197/24
considerable [4] 57/25 82/9 166/18 167/8
consideration [2] 85/10 136/19
considered [5] 27/9 27/18 135/8 180/5 187/21
considers [1] 107/14
consistency [1] 143/11
consistent [1] 192/20
constituency [1] 153/21
constructive [2] 7/19 137/22
constructively [6] 12/10 12/23 154/25 155/25 158/23 201/22
consultant [7] 30/4 82/13 91/11 97/5 99/15 123/12 193/22
Consultants [58] 26/12 28/20 43/14 69/3 69/14 70/8 70/21 73/17 73/18 73/25 75/3 75/13 75/17 76/4 76/7 84/8 86/7 88/5 90/5 90/11 91/2 92/7 92/13 99/21 103/19 117/20 118/17 119/5 120/11 121/6 127/9 136/15 146/22 148/12 149/18 157/12 157/16

C

Consultants... [21] 161/1 164/4 165/1 166/2 184/1 184/11 184/22 185/3 186/22 194/17 194/24 195/1 195/5 196/18 196/20 198/16 201/14 202/9 205/16 205/22 206/25
Consultants' [10] 43/8 43/11 70/14 75/6 91/22 162/16 163/4 172/22 174/3 199/15
consulted [2] 159/4 159/6
contact [3] 30/12 83/14 178/16
contacted [2] 81/22 82/23
contacting [1] 167/24
contain [1] 28/18
contemporary [1] 32/1
contended [1] 198/15
content [4] 53/18 53/18 55/16 123/25
contents [2] 1/17 179/24
context [5] 24/4 37/21 61/11 76/8 94/17
continue [2] 129/25 205/13
continued [1] 82/8
continues [2] 25/11 83/19
contracts [1] 23/17
contradict [1] 190/13
contrary [2] 57/24 166/15
contribution [3] 13/18 44/8 45/5
control [1] 82/18
controlled [6] 8/3 74/23 74/25 184/14 184/25 205/18
controls [1] 13/6
conversation [19] 15/8 16/22 24/17 24/22 42/23 53/22 62/8 67/9 76/5 92/4 95/23 96/20 96/22 105/16 107/8 121/12 121/14 127/7 130/19
conversationally [1] 71/3
conversations [6] 85/6 105/5 105/17 134/23 166/17 166/21
convicted [2] 2/16 132/8
convinced [4] 164/20 165/20 166/2 195/5
Cooper [4] 67/17 68/9 88/3 88/3
copied [2] 67/14 68/5
copy [2] 1/15 67/18
cordial [2] 8/19 177/3
Coroner [14] 6/18 29/10 37/8 37/8 64/10 85/6 141/19 141/22 142/2 142/5 142/7 142/11 142/16 194/1
Corporate [1] 19/2
correct [14] 109/7 126/22 132/10 133/12 134/10 151/10 152/11 152/12 152/15 152/18 152/24 175/8 183/9 192/25
correlation [1] 172/4
corridor [1] 96/17
cots [2] 54/22 120/22
could [64] 19/24 20/2 20/2 42/21 45/13 47/10 48/2 50/21 53/9 53/11 53/13 57/19 59/6 62/5 75/12 79/23 79/25 80/12 80/16 81/21 98/23 107/16 112/23 127/10 129/18 136/10 141/4 142/3 143/16 147/21 148/2 148/14 151/25 154/4 157/19 158/5 160/3 160/4 161/23 162/7 162/8 165/4 165/22 166/8 166/10 167/17 168/14 171/3 174/11 177/22 178/22 181/9 183/13 187/18 193/10 199/6 199/18 199/24 200/2 200/10 200/19 200/25 200/25 201/20
couldn't [10] 18/6 20/1 42/6 79/5 79/7 79/24 80/3 80/5 88/22 140/9
Council [11] 10/12 10/15 10/21 10/22 10/25 14/21 17/22 17/23 18/1 18/11 152/9
Counsel [1] 26/24
Countess [20] 2/1 4/18 8/8 16/1 31/22 105/10 107/17 108/11 108/17 108/19 109/1 125/24 131/14 133/1 134/16 144/24 152/10 153/19 155/7 156/7
couple [7] 7/9 40/25 104/17 114/20 116/19 117/13 163/11
course [20] 15/20 33/17 35/2 36/9 38/25 47/5 60/9 68/1 73/6 78/22 91/21 125/23 134/13 134/15 137/17 137/20 143/2 192/4 192/16 203/23
Court [1] 2/7
cover [2] 114/20 142/3
covered [3] 14/10 14/10 108/17
covering [2] 63/16 80/1
created [2] 206/12 207/9
creating [1] 206/9
credible [1] 190/11
crime [5] 27/7 27/17 77/10 82/13 193/21
criminal [4] 27/10 27/19 78/4 158/10
criminality [2] 81/3 81/9
criteria [2] 76/18 191/16
critical [2] 79/18 167/16
criticise [1] 102/16
criticised [2] 93/5 102/14
Cross [18] 19/2 19/3 29/9 31/17 31/17 41/13 59/17 59/20 64/7 81/4 117/25 141/18 141/21 141/24 142/4 142/15 171/6 171/10
Cross's [1] 32/5
crowded [1] 10/2
crystallised [1] 93/11
culpability [2] 189/1 190/5
culture [1] 13/16
currently [1] 153/23

D

Dalton [6] 105/3 105/7 105/11 105/11 105/15 105/17
damage [1] 20/12
damaging [2] 90/21 91/10
dark [5] 97/16 138/14 141/12 141/14 150/24
data [1] 61/5
date [7] 78/9 96/16 122/4 122/7 161/17 182/13 196/6
dated [2] 1/14 152/4
Datix [9] 125/14 125/14 125/18 125/24 126/4 126/7 126/11 126/12 139/12
Datixed [1] 126/3
daughter [2] 104/2 104/2
day [17] 8/18 9/8 22/4 40/16 40/18 45/18 82/4 117/24 137/24 137/24 139/8 153/17 177/10 179/20 197/11 203/15 203/15
Day 1 [1] 197/11
days [8] 8/15 152/19 152/22 153/6 153/6 153/7 153/15 161/15
deal [4] 77/13 106/2 130/10 175/4
dealing [7] 13/19 148/6 156/11 157/8 160/1 172/1 203/15
deals [1] 154/19
dealt [5] 84/7 156/25 157/25 171/21 186/23
Dear [2] 96/20 98/11
death [22] 6/10 11/20 24/5 24/6 24/9 38/18 42/25 43/1 52/1 69/9 71/1 76/22 85/4 124/4 124/5 135/7 135/15 179/9 185/17 193/24 195/10 196/23
deaths [58] 6/14 6/16 21/8 21/18 21/18 29/10 29/15 32/14 34/17 35/2 35/5 35/18 38/22 38/24 39/1 39/24 40/4 42/5 42/8 42/11 51/13 52/23 54/6 56/15 57/2 60/16 60/17 60/21 60/23 75/9 111/21 116/7 116/10 119/19 120/15 123/13 129/3 141/19 142/2 143/20 149/2 160/15 160/22 162/14 164/20 165/20 173/5 173/15 179/8 179/11 179/15 179/18 180/14 185/15 186/1 188/3 188/22 191/15
debate [6] 13/17 60/10 80/16 194/19 199/20 202/9
December [6] 1/1 35/1 66/24 67/3 78/2 209/6
December 2016 [1] 78/2
decide [3] 43/5 75/17 176/9
decided [4] 119/25 147/15 176/18 184/7
decision [14] 6/12 11/17 12/18 18/21 74/12 75/19 82/5 101/18 122/20 147/12 163/17 163/20 164/10 187/2
decision-making [1] 101/18
decisions [10] 8/5 13/24 50/12 100/25 101/7 122/12 123/9 127/22 163/24 182/10
deep [1] 82/3
deeply [4] 73/20 97/6 175/13 203/6
defer [1] 104/1
deferred [3] 201/11 201/18 201/25
deficiencies [1] 126/15
defined [1] 8/4
definitely [1] 58/3
definitive [1] 103/11
degree [2] 110/12 202/10
delay [6] 101/3 196/5 196/5 196/9 196/11 199/21
delayed [1] 1/3
delegated [2] 8/4 105/12
deliberate [2] 24/7 134/18
deliberately [2] 164/5 195/6
delivered [1] 146/9
delivering [1] 54/23
demanding [1] 50/11
department [3] 17/11 18/4 146/11
departments [2] 9/13 31/8
dependency [1] 53/3
depth [8] 43/17 78/7 79/1 79/21 117/3 182/3 182/4 191/19
deputy [2] 2/8 37/8
describe [3] 8/9 126/25 176/24
described [7] 13/21 20/21 21/5 109/11 125/25 188/17 206/8
description [2] 128/6 129/7
descriptions [1] 125/24
designated [2] 27/12 197/12
designed [1] 33/18
desire [1] 91/12
despite [1] 41/19
detail [13] 5/13 76/13 82/23 106/13 106/13 106/17 107/3 118/5 142/6 142/8 155/18 172/12 201/3
detailed [4] 159/2 172/23 179/14 181/17
details [2] 79/15

D

details... [1] 172/11
detect [2] 27/7 27/17
deteriorated [1] 91/4
deterioration [1] 179/9
determine [2] 70/17 179/17
detrimental [1] 147/5
develop [2] 12/11 12/24
developing [1] 34/14
development [5] 16/10 29/23 30/21 90/22 91/15
diagnostic [1] 31/8
dictating [1] 119/2
did [197] 4/24 5/3 5/4 6/1 8/11 8/18 8/20 8/24 9/7 9/15 11/22 12/4 13/22 15/19 16/15 17/4 19/17 19/22 20/16 20/19 21/15 24/17 25/21 26/11 26/15 27/24 28/2 28/19 30/10 30/11 30/16 30/25 31/18 31/19 31/23 33/23 33/25 34/3 35/13 35/22 36/13 37/10 37/16 41/7 41/22 41/24 41/25 42/7 43/1 45/12 46/24 48/3 48/5 50/25 51/1 51/12 51/15 52/22 54/1 56/18 56/20 56/22 56/23 58/9 58/12 58/13 59/3 59/9 60/5 60/5 60/20 60/20 61/8 62/6 62/9 63/6 63/7 64/12 64/18 65/1 65/13 66/6 67/3 68/12 68/18 68/25 69/4 69/11 69/13 69/13 69/14 69/18 70/25 70/25 71/17 72/16 73/2 73/3 73/25 74/3 74/7 74/25 76/20 76/21 76/23 77/3 77/3 77/12 78/9 79/9 79/10 80/14 82/21 83/2 83/4 83/24 84/3 87/9 87/11 87/22 87/24 88/8 89/3 91/16 92/21 93/7 94/1 95/23 96/7 96/11 97/19 97/22 98/2 100/2 101/23 102/17 105/14 105/14 106/4 106/13 107/19 107/21 113/9 113/16 113/25 114/1 127/14 130/14 133/21 136/17 136/17 136/23 140/10 141/21 141/23 142/4 145/6 146/18 146/20 147/10 148/1 149/14 149/22 153/13 153/18 155/6 155/24 156/2 156/2 156/3 156/7 157/11 158/15 159/7 159/19 159/22 167/5 168/25 169/15 169/25 175/22 176/3 177/14 180/18 182/17 187/2 191/23 192/15 194/20 194/25 195/10 197/6 198/6 201/9 203/12 206/11 207/5
didn't [106] 11/7 16/14 20/18 21/14 24/20 26/17 27/20 28/4 28/4 28/4 28/18 32/1 32/18 34/2 35/16 41/12 41/13 46/25 48/3 51/11 51/18 52/22 54/5 60/3 62/11 63/17 63/19 63/20 64/2 64/3 64/23 66/12 66/17 69/16 69/23 71/8 76/24 76/24 77/5 77/5 77/13 78/17 79/5 79/12 79/12 79/20 81/9 82/8 82/25 83/6 87/9 89/2 89/6 89/6 90/11 99/6 101/16 102/23 106/17 106/23 107/3 107/21 107/22 108/3 108/4 113/9 114/7 130/13 131/15 133/20 133/20 134/13 134/24 138/6 140/19 148/16 149/21 149/22 149/24 150/1 150/2 156/21 157/5 167/20 168/5 168/5 175/23 177/15 177/24 182/18 185/7 185/11 187/7 187/16 188/23 193/3 193/8 193/8 195/4 195/23 197/14 197/14 199/1 199/2 201/6 206/1
die [2] 56/10 165/8
died [5] 56/9 59/7 123/3 145/4 145/4
different [13] 9/13 9/13 20/10 39/2 75/24 84/12 108/10 135/24 139/1 139/22 140/24 180/14 189/17
difficult [10] 22/22 32/7 32/10 43/21 48/13 54/23 98/14 189/23 194/8 198/14
difficulty [1] 28/11
digest [2] 66/21 75/3
dipped [1] 110/10
dips [1] 114/18
direct [3] 18/8 172/4 176/5
directed [1] 4/10
directly [10] 19/20 111/5 123/8 128/13 140/25 141/21 142/15 157/17 173/19 197/7
Director [28] 1/23 17/10 19/2 24/15 29/21 29/22 30/18 30/23 35/14 39/21 39/21 40/8 40/8 54/9 86/11 87/21 130/1 130/1 152/8 152/10 152/14 155/14 155/23 179/23 202/1 202/11 202/11 203/17
directors [46] 7/24 10/12 10/23 12/1 12/10 12/13 12/17 12/22 13/2 13/10 13/18 13/20 13/22 14/22 14/23 14/25 15/3 15/6 15/11 15/13 15/20 16/4 17/10 17/11 17/20 19/5 22/15 52/8 54/3 54/12 55/3 62/5 66/10 70/13 81/25 110/24 131/10 154/14 154/20 154/25 155/3 162/18 169/7 181/15 199/24 203/21
disadvantaged [1] 26/6
disagree [1] 160/21
disappear [1] 132/25
disaster [1] 3/16
disbelieve [1] 185/19
discharged [1] 18/7
discharges [1] 16/8
disclosing [1] 141/13
discomfort [1] 58/4
discounted [1] 189/2
discovering [1] 63/15
discuss [14] 8/18 11/7 11/15 18/10 28/19 37/7 37/15 54/5 87/2 104/25 116/9 133/20 133/21 174/19
discussed [27] 5/7 11/2 11/9 16/20 28/22 34/18 38/2 38/14 39/3 40/5 41/4 43/2 46/1 46/12 101/16 108/12 108/14 116/7 116/10 121/3 128/16 133/15 147/6 160/13 160/23 161/15 171/1
discussing [6] 20/21 38/8 75/25 99/8 162/12 165/6
discussion [16] 38/19 41/7 57/3 57/11 62/23 76/10 80/8 80/11 100/22 100/24 162/2 166/18 171/17 195/1 196/20 207/18
discussions [11] 4/16 8/16 12/24 57/25 61/11 101/18 118/5 121/6 136/8 166/21 167/1
dismiss [1] 170/17
dispute [1] 89/11
disquiet [5] 57/25 166/18 167/8 167/17 176/11
dissect [1] 17/8
disseminated [1] 115/3
dissenting [1] 175/19
distress [1] 97/6
distressing [2] 83/13 84/15
Distribution [2] 64/10 65/5
district [1] 4/12
dive [1] 82/3
division [1] 119/8
divisional [4] 17/10 19/16 20/18 86/11
DN [4] 44/4 107/9 116/23 120/7
do [171] 1/12 1/15 1/16 3/3 4/5 5/6 8/16 8/20 8/25 11/15 13/19 20/7 20/20 21/13 23/23 28/10 30/10 30/12 36/16 37/24 38/13 38/18 39/25 40/20 42/19 43/10 45/20 46/6 46/16 46/19 47/15 53/5 54/10 55/20 56/6 57/14 58/3 58/23 59/20 59/21 62/7 62/23 63/12 64/20 66/12 67/7 69/18 69/24 70/12 70/15 70/19 73/15 75/5 75/10 77/8 77/9 77/11 78/20 78/25 79/1 79/8 79/13 79/15 79/20 80/3 80/5 80/24 88/19 89/15 89/17 89/24 92/1 92/3 93/21 97/21 98/1 98/13 98/17 98/19 101/17 102/14 102/22 107/20 110/12 110/13 114/4 115/10 115/12 116/25 117/11 117/17 118/3 118/25 120/17 120/24 120/25 121/12 121/13 121/14 121/20 124/1 125/14 126/18 134/12 136/25 138/2 138/2 138/18 138/18 140/10 141/9 142/9 142/14 144/16 144/20 144/20 147/12 147/14 148/5 148/16 150/13 150/14 151/11 151/20 151/24 153/23 155/20 156/21 158/19 158/21 158/25 159/4 160/18 160/21 161/16 162/1 164/17 164/19 169/16 169/25 170/15 170/15 172/12 172/22 174/20 176/10 176/10 177/20 179/19 179/21 180/3 180/25 182/8 184/5 184/7 187/23 188/14 189/12 189/24 190/7 190/12 192/13 193/9 194/24 195/19 197/14 200/9 200/20 201/16 207/15 208/8
doctor [2] 9/20 134/7
doctors [14] 2/25 26/11 26/16 30/8 30/13 31/1 33/25 47/11 52/23 55/12 60/12 60/19 74/14 179/16
doctors' [1] 167/5
document [18] 17/16 20/9 99/19 109/14 117/23 123/19 135/13 148/17 148/20 148/20 154/17 158/6 158/18 177/22 187/18 187/19 191/9 197/19
documentation [7] 32/2 37/7 111/5 180/7 206/17 206/19 208/4
documented [2] 32/13 166/6
documents [7] 7/13 20/7 33/8 71/19 116/19 137/21 192/7
dodging [1] 201/19
does [20] 21/17 44/14 44/22 46/7 56/23 65/3 65/4 86/19 107/12 109/4 111/25 120/19 133/16 135/17 135/18 141/7 144/5 178/16 183/4 188/3
doesn't [14] 16/24 21/17 48/21 65/3 73/21 84/12 84/19 94/8 108/2 112/2 121/9 130/4 188/2 192/16
doing [15] 3/3 4/14 16/18 32/20 43/5 46/2 58/14 99/19 138/20 140/17 157/13 159/10 167/3 195/25 199/2

D

don't [114] 5/13 5/13 16/22 17/2 17/2 17/2 20/24 21/4 21/11 21/17 30/11 39/10 41/12 41/15 41/15 42/23 43/3 45/1 46/5 46/11 46/17 46/17 46/25 47/17 47/18 48/1 49/5 49/12 49/12 49/13 51/3 53/17 57/10 59/23 60/3 62/9 62/10 63/14 63/14 65/7 65/7 66/8 67/16 70/16 70/16 70/19 70/23 73/7 78/18 88/17 88/17 89/5 89/20 89/25 93/12 96/9 96/9 97/20 98/7 98/21 99/1 99/12 101/12 104/15 105/22 105/24 118/4 126/17 128/10 128/11 128/11 129/9 129/10 129/10 129/13 130/6 136/23 137/1 137/17 138/20 140/6 142/7 142/13 142/17 142/17 143/14 143/22 144/18 148/7 148/19 156/12 160/19 161/3 161/5 161/17 161/21 163/14 170/17 172/16 185/11 185/21 187/17 189/9 189/17 192/8 192/10 200/3 202/19 202/20 205/11 205/25 206/7 206/17 207/16
done [22] 20/2 20/3 35/23 37/10 64/20 64/22 69/21 69/24 70/2 80/6 110/11 114/2 138/13 156/20 177/16 178/5 190/16 195/7 195/17 197/23 199/25 202/16
door [4] 15/12 68/10 68/10 96/17
double [1] 16/18
doubt [5] 21/11 26/11 26/15 26/17 111/4
Douglas [1] 152/2
down [62] 1/12 5/15 10/7 10/10 15/24 20/9 22/12 23/9 24/11 25/11 26/22 28/23 35/24 36/22 40/10 42/15 43/16 44/5 45/16 48/6 48/9 49/18 53/20 55/9 55/13 61/25 70/6 72/15 72/20 74/9 83/7 90/4 106/18 106/19 116/22 117/5 117/13 121/5 122/23 123/20 128/22 148/25 151/10 151/24 153/18 154/13 155/7 158/18 160/17 165/5 166/12 168/19 172/2 172/3 180/25 183/3 186/20 190/4 191/11 196/3 197/22 198/3
downgrade [5] 41/6 52/19 163/18 164/11 165/8
downgraded [1] 41/10
downgrading [5] 44/19 50/18 50/18 119/23 161/14
Dr [61] 19/20 45/23 46/3 46/25 55/14 56/6 56/15 56/17 58/2 59/14 60/4 61/1 74/23 74/24 77/15 78/24 79/10 79/20 80/2 82/6 82/7 90/6 90/6 91/1 92/6 96/18 96/23 97/22 97/22 100/11 100/16 100/18 100/19 100/20 100/21 100/23 101/19 103/8 107/24 125/25 126/2 127/7 162/20 162/21 164/19 164/19 165/5 165/9 165/19 165/19 165/25 167/3 170/6 180/12 184/25 184/25 185/14 185/25 188/5 188/6 188/21
Dr Brearey [13] 19/20 56/15 58/2 74/23 90/6 97/22 100/20 125/25 162/21 164/19 165/19 170/6 184/25
Dr Gibbs [1] 92/6
Dr Gilby [1] 107/24
Dr Hawdon [7] 78/24 79/10 79/20 80/2 82/6 180/12 188/5
Dr Hawdon's [3] 185/14 185/25 188/21
Dr Holt [1] 100/21
Dr Jameson [2] 100/11 103/8
Dr Jayaram [22] 46/3 56/6 56/17 59/14 60/4 61/1 74/24 90/6 91/1 96/23 97/22 100/19 126/2 127/7 162/20 164/19 165/5 165/9 165/19 165/25 167/3 184/25
Dr McCormack [1] 46/25
Dr McCormack's [1] 77/15
Dr McPartland [2] 82/7 188/6
Dr Ravi Jayaram [1] 96/18
Dr Ravi Jayaram's [1] 45/23
Dr Saladi [1] 100/16
Dr Tighe [2] 100/23 101/19
Dr ZA [1] 100/18
draft [16] 51/9 51/9 74/22 82/21 94/24 94/25 95/7 95/16 95/18 96/11 96/12 172/11 172/13 172/13 184/24 205/18
drafted [1] 77/17
dragged [1] 67/24
draw [3] 30/5 183/13 190/1
drawn [3] 59/5 127/22 206/3
drew [3] 182/15 187/12 189/1
drive [1] 151/10
driving [1] 89/23
drops [1] 131/25
drove [1] 90/1
due [4] 20/13 57/23 166/14 194/1
Duncan [51] 1/7 1/8 1/10 1/13 3/12 5/24 7/13 20/17 22/13 26/25 28/13 29/5 34/20 36/25 37/1 40/14 46/2 47/24 49/20 52/17 58/12 58/21 61/5 70/9 76/15 77/21 78/15 82/17 92/7 101/6 103/21 103/25 104/21 114/10 114/14 131/23 134/14 138/9 138/23 141/16 142/23 143/4 144/17 145/12 148/23 151/16 163/11 163/11 177/13 177/14 210/3
during [12] 4/15 8/23 12/23 43/19 44/23 87/25 97/15 132/5 132/9 132/13 137/17 155/6
duties [5] 13/12 130/11 178/15 205/5 205/8
duty [8] 9/18 13/2 24/25 34/7 124/7 129/24 138/6 143/5

E

each [7] 38/18 92/22 96/25 97/2 106/14 127/8 179/14
earlier [21] 29/12 37/9 48/15 49/10 52/18 59/5 62/4 70/1 74/16 102/12 139/3 147/25 155/13 156/25 163/10 167/4 189/7 198/12 205/25 206/8 206/15
early [5] 38/16 39/11 39/24 67/11 178/14
early July [1] 178/14
easier [2] 204/12 204/23
easy [3] 32/8 145/17 150/17
edited [1] 140/16
edition [1] 28/18
effect [6] 50/8 109/24 168/9 183/23 185/18 193/7
effective [9] 8/2 13/17 39/8 39/18 58/10 150/16 169/1 175/16 200/10
effectively [9] 13/12 38/7 40/2 129/19 189/14 200/20 200/23 201/1 201/6
effectiveness [4] 10/13 16/5 30/20 162/3
efforts [2] 91/4 138/21
egregious [1] 200/1
eight [3] 164/17 184/2 194/9
either [12] 15/13 79/3 87/23 89/10 106/9 110/19 112/2 142/14 142/15 167/2 179/24 194/20
elaborated [1] 106/22
elephant [4] 56/20 56/24 57/9 165/16
eligible [1] 153/22
else [9] 47/18 79/12 94/18 100/3 104/16 137/9 145/13 151/14 176/2
elsewhere [4] 60/2 109/12 131/14 147/6
email [12] 62/15 81/16 83/9 90/12 92/6 94/12 95/11 96/18 97/4 97/9 97/17 98/6
emails [3] 86/1 106/24 192/9
embed [1] 135/5
embraced [1] 30/1
emerged [1] 80/16
Emergency [2] 18/3 146/11
emotional [2] 96/20 96/22
emphasised [1] 100/13
emphasises [1] 82/12
employee's [4] 101/2 101/13 101/15 101/17
employees [1] 24/25
empowered [1] 7/25
enables [1] 13/11
enabling [1] 7/16
encounter [1] 5/12
encountered [1] 144/22
encourage [1] 25/14
encouraged [1] 15/15
end [14] 7/21 31/12 45/3 45/6 59/13 61/22 73/15 103/6 134/19 139/8 150/19 179/13 196/16 199/21
ended [1] 86/23
engage [1] 167/17
England [3] 2/6 27/1 29/14
enlarge [1] 23/11
enormous [1] 99/2
enough [9] 32/4 57/13 57/17 61/10 61/10 97/23 98/1 175/24 197/7
enquiries [5] 53/9 69/23 122/17 122/21 143/17
enquiry [3] 6/8 6/9 179/10
ensure [8] 13/2 13/13 25/7 58/18 74/6 107/12 138/14 170/15
ensuring [6] 7/25 10/13 12/14 13/9 14/20 154/15
enter [1] 128/23
entered [3] 19/24 20/15 20/16
entirely [3] 32/22 132/25 140/5
entitled [2] 66/1 66/2
entitlement [3] 68/16 101/20 137/10
entries [1] 37/23
entry [1] 22/2
Environment [1] 24/15
equally [1] 174/22
equated [1] 108/18
equivalent [1] 130/1
escalated [5] 19/15 38/4 111/22 139/13 149/3
escalating [1] 33/17
escalation [1] 183/3
essence [1] 158/11

E

essential [2] 64/15 79/2
established [1] 83/16
et [3] 194/15 194/15 202/11
et cetera [3] 194/15 194/15 202/11
even [6] 25/23 28/21 84/19 151/11 196/21 198/19
evening [1] 209/1
event [2] 132/16 135/19
eventful [1] 9/23
events [18] 3/19 4/8 8/23 31/22 50/21 81/11 98/12 99/3 115/10 122/1 133/1 134/9 137/17 138/18 157/11 160/6 170/21 194/9
eventually [2] 82/15 140/15
ever [12] 8/20 20/16 24/17 29/13 66/6 82/21 102/3 136/17 159/4 159/18 194/25 207/3
every [3] 12/18 24/24 143/23
everybody [2] 103/14 104/15
everybody's [2] 47/25 60/7
everything [9] 4/21 58/22 70/5 73/15 164/18 182/13 189/22 197/23 200/14
evidence [43] 57/22 57/23 59/16 60/5 60/9 60/11 60/20 60/21 60/23 61/2 61/3 71/6 81/3 81/6 81/9 82/12 104/23 124/23 125/23 126/13 126/15 129/16 133/13 136/4 137/7 137/14 153/7 157/4 161/3 163/8 164/22 166/6 166/13 166/14 172/21 181/19 188/25 193/21 198/11 201/13 203/7 208/17 208/20
evocatively [1] 176/17
exact [1] 177/18
exactly [4] 35/12 106/7 156/8 172/14
examinations [1] 150/23
examined [1] 51/15
examining [1] 18/16
example [10] 11/13 18/2 33/16 33/23 57/15 106/23 134/7 139/10 146/10 149/22
examples [2] 93/24 97/14
exceeded [2] 110/9 110/21
exceeding [2] 110/19 146/2
excellent [2] 30/7 90/16
exceptional [4] 108/21 111/24 149/5 149/8
exclude [2] 76/21 76/23
excluding [1] 27/21
exclusion [1] 94/2
Exec [3] 15/18 23/6 90/20
Execs [11] 40/15 40/16 40/22 61/17 64/7 66/24 70/10 70/14 93/16 109/5 111/13
Executive [83] 1/23 1/24 1/25 2/15 7/18 7/23 7/23 7/24 8/3 8/3 8/9 10/23 12/1 12/10 12/22 12/22 13/18 13/20 13/22 14/23 14/25 15/3 15/6 15/11 15/12 15/20 19/5 19/6 24/13 24/16 31/16 51/6 54/3 54/8 54/12 55/3 62/5 62/14 66/9 70/13 72/1 72/3 81/24 90/13 91/3 91/11 110/16 110/23 118/9 127/21 128/3 129/1 129/5 129/25 130/1 138/13 152/9 152/10 152/13 153/22 154/19 154/25 155/3 155/14 155/16 155/17 155/21 155/23 156/1 162/17 165/2 169/6 176/21 177/12 179/22 181/15 184/7 188/11 189/17 189/19 193/6 199/24 202/1
Executive Board [2] 90/13 91/3
Executive's [1] 127/18
Executives [35] 7/18 11/25 34/5 53/11 53/23 62/5 62/24 65/1 86/11 97/24 119/1 137/23 142/15 145/19 158/23 159/1 164/21 166/5 168/4 174/23 175/14 175/18 175/20 176/3 180/8 180/18 183/8 185/20 188/18 190/3 190/12 195/3 198/17 201/11 203/14
Executives' [1] 199/16
exercise [5] 50/11 50/11 58/14 58/22 138/6
exercises [1] 172/25
exist [3] 24/10 125/6 139/6
exists [1] 91/13
exonerate [1] 84/9
exonerated [6] 83/18 83/24 84/12 84/17 85/1 182/16
expand [3] 8/12 31/10 33/4
expanded [2] 94/14 94/16
expanding [1] 56/8
expansive [1] 48/20
expect [4] 30/16 51/6 85/9 101/16
expectation [1] 29/20
expectations [12] 26/9 29/19 76/6 87/3 110/9 110/19 110/20 110/21 110/23 146/2 146/3 146/16
expected [11] 29/6 34/17 39/3 54/14 56/10 56/12 66/5 66/21 71/4 113/6 165/8
expeditiously [1] 195/21
experience [22] 16/9 16/12 17/19 18/10 23/18 23/20 24/3 34/18 39/6 39/16 39/19 101/23 115/13 115/17 133/14 135/11 138/11 156/5 189/4 189/5 203/25 204/3
Experienced [1] 60/19
experiences [2] 103/10 103/19
expert [1] 26/24
expertise [4] 125/13 179/16 201/17 202/10
experts [1] 202/8
explain [10] 40/4 40/9 51/23 101/22 134/16 135/1 164/1 170/12 179/10 199/19
explained [4] 60/22 129/2 140/20 178/7
explains [2] 183/12 184/24
explanation [3] 20/25 60/16 183/19
explanations [1] 6/9
explicitly [1] 78/4
explore [3] 72/16 81/6 143/12
express [4] 112/9 123/8 123/10 175/23
expressed [7] 58/24 91/23 98/3 122/8 122/11 123/7 175/25
expresses [1] 58/2
expressing [3] 98/25 167/7 195/18
expression [5] 33/14 56/20 74/14 81/10 103/9
extend [1] 50/24
extended [1] 66/1
extension [1] 132/17
extent [8] 5/14 34/7 106/2 118/6 144/3 149/14 159/25 193/3
external [23] 5/22 6/8 6/19 23/7 27/15 29/8 29/15 35/20 36/6 36/16 42/3 44/21 44/21 50/20 54/21 78/3 82/9 122/17 122/21 139/14 160/16 172/2 201/24
extra [2] 82/1 109/9
extract [1] 154/5
extraordinary [24] 11/10 11/19 11/25 12/4 18/15 18/17 40/25 43/15 54/7 54/16 55/8 55/10 75/14 78/11 99/7 101/14 103/11 116/5 116/15 118/20 133/5 136/8 160/2 162/9
extremely [2] 45/11 91/2
eyes [2] 11/23 132/24

F

faced [2] 159/13 164/3
Facere [1] 31/18
Facere Melius [1] 31/18
facilitate [1] 103/9
facilitating [1] 13/17
facing [1] 113/20
fact [26] 11/24 18/5 18/6 21/12 25/21 36/9 36/18 37/24 48/16 49/7 56/8 68/25 73/24 108/25 112/21 160/14 162/1 162/2 162/3 165/7 174/18 176/22 179/21 183/25 185/18 197/4
factor [6] 33/2 101/11 101/12 125/5 191/24 194/15
factoral [2] 53/13 97/25
factorial [1] 75/7
factors [6] 59/6 59/8 59/10 159/3 179/18 187/11
fade [1] 134/6
failed [2] 140/6 144/24
failing [1] 56/11
failure [4] 75/13 138/7 138/8 143/6
failures [3] 33/21 131/9 150/22
fair [3] 18/23 46/5 53/19
fairness [1] 183/16
faith [2] 71/12 158/4
fall [1] 134/13
fallen [1] 149/14
Fallon [7] 54/3 74/10 160/11 162/18 171/22 172/2 172/4
familiar [4] 109/24 123/23 124/15 156/4
familiarity [1] 158/19
families [26] 26/9 114/17 119/10 119/17 133/9 134/16 135/25 136/16 136/22 137/4 138/4 138/5 138/7 138/14 139/20 139/23 140/1 140/16 140/17 141/10 143/7 143/10 143/15 143/25 145/3 203/1
family [6] 5/8 73/12 73/22 131/24 186/11 186/21
far [7] 1/18 35/20 50/23 65/25 74/15 133/9 190/17
Farmer [1] 126/9
fashion [1] 184/14
favour [1] 92/24
fear [2] 34/8 128/4
Feb [1] 98/9
February [5] 19/19 36/23 91/9 191/7 191/11
fed [2] 98/4 98/4
feedback [3] 83/4 126/7 126/7
feeds [1] 17/19
feel [15] 67/21 93/12 93/13 93/13 93/13 165/22 169/14 174/20 175/22 177/20 189/12 192/15 206/11 208/8 208/9
feeling [4] 67/23 94/2 160/4 197/23

F

feelings [2] 128/17 177/7
fellow [7] 2/9 2/12 2/14 54/12 92/6 163/24 195/1
felt [23] 11/20 11/20 18/19 26/20 32/18 34/14 61/22 74/12 74/19 88/7 93/6 94/2 94/6 102/24 112/8 129/2 143/8 146/13 146/13 147/19 166/1 176/12 199/19
few [5] 11/18 103/20 161/15 170/25 203/3
figure [1] 202/12
final [8] 5/21 27/15 36/7 51/9 51/25 52/3 95/19 141/16
finalised [1] 86/23
finally [5] 38/11 47/2 118/16 119/5 199/5
Finance [1] 152/25
financial [4] 13/4 13/5 14/9 110/4
financially [1] 108/17
find [19] 31/5 33/14 34/20 42/3 44/20 53/10 67/18 81/9 108/16 108/24 111/4 111/12 139/18 148/18 150/17 159/22 160/3 169/18 188/2
fine [4] 61/23 67/16 177/19 177/21
fingers [1] 191/1
finish [3] 41/20 104/7 197/17
finished [2] 131/13 140/8
firm [1] 182/9
first [49] 7/10 12/3 12/4 34/24 39/1 40/11 40/18 41/5 41/9 42/7 42/10 43/13 53/12 67/3 72/23 75/14 78/19 84/14 90/12 94/25 96/11 96/13 105/1 105/3 105/6 114/21 116/19 117/23 118/8 119/2 119/18 133/10 152/16 155/13 162/22 163/1 163/3 164/25 166/20 168/15 168/17 171/3 172/1 181/16 187/25 188/16 195/2 197/22 200/24
fit [7] 114/3 128/7 129/8 129/14 130/11 131/4 133/16
five [4] 110/18 110/20 148/2 190/20
fix [2] 91/20 131/1
flagged [1] 14/12
floor [1] 100/22
flowing [1] 18/5
flows [1] 14/20
focus [6] 164/6 170/8 171/9 171/23 172/1 172/14
focused [2] 14/13 82/20
focusing [2] 14/3 14/14
Fogarty [3] 35/4 35/5 35/10
follow [12] 3/9 32/10 39/7 40/25 70/7 80/13 141/7 141/8 158/3 158/15 174/18 179/2
follow-up [1] 3/9
follow-ups [1] 39/7
followed [10] 32/19 33/24 34/1 34/15 39/9 39/23 40/2 50/12 52/19 98/5
following [20] 32/22 33/11 33/21 34/4 34/5 37/14 39/18 61/25 62/15 70/7 77/24 82/6 83/13 84/15 98/12 114/3 128/2 131/11 163/9 179/20
forcefully [1] 175/24
forcibly [1] 175/25
forefront [2] 134/22 135/19
forensic [7] 46/6 77/9 80/13 82/3 179/14 195/16 196/18
forensically [1] 51/15
forewarning [1] 55/7
forgive [5] 4/20 60/24 118/13 120/16 151/6
forgotten [1] 185/22
form [6] 76/5 103/11 130/20 146/19 152/21 153/7
formally [1] 71/4
formed [1] 103/13
forming [1] 92/17
forth [1] 69/10
forum [2] 34/21 153/2
forums [1] 11/15
forward [13] 1/9 7/19 10/3 45/4 86/24 91/12 107/9 107/11 120/1 129/17 151/21 192/24 200/5
forwarded [1] 83/22
forwards [1] 111/19
found [8] 32/10 32/10 107/16 144/25 152/21 155/16 188/25 198/14
Foundation [4] 2/1 10/8 154/6 154/12
four [13] 2/17 10/10 23/13 23/14 55/13 110/17 146/12 153/16 180/13 183/14 184/5 185/15 188/22
fractured [3] 91/20 130/24 147/4
frame [3] 23/25 24/1 193/11
framed [6] 157/14 182/15 200/4 201/5 206/15 206/20
framework [5] 14/8 22/14 27/3 27/3 204/23
framing [1] 188/17
Francis [1] 26/24
free [2] 151/16 208/22
Freedom [1] 156/15
freeze [1] 151/9
frequent [1] 15/8
frequently [2] 8/13 51/8
Friday [1] 178/10
friend [4] 114/21 115/5 127/1 127/2
friends [1] 86/3
froing [1] 99/20
front [12] 1/15 12/7 28/14 43/23 43/25 112/12 118/12 134/25 168/12 180/17 184/20 201/21
fulfilling [1] 8/5
full [20] 8/4 13/23 63/10 63/14 64/5 64/16 66/5 66/6 66/6 66/13 66/15 66/17 79/23 79/25 151/25 163/25 181/21 183/14 188/15 189/9
fuller [2] 46/20 55/20
fully [12] 6/7 75/3 75/3 83/18 83/23 84/9 84/17 94/13 102/14 129/13 178/19 189/7
fund [1] 10/3
fundamental [2] 135/2 143/20
funded [2] 108/11 109/1
further [24] 6/8 23/8 25/11 43/16 53/16 62/7 69/23 74/9 94/11 110/4 117/5 121/5 121/5 131/17 143/13 158/2 170/6 175/16 179/10 188/6 196/13 198/3 202/20 208/11
future [6] 58/21 91/15 122/12 138/22 141/5 170/15

G

G2 [1] 22/19
gainsay [1] 199/1
gaps [1] 63/17
gave [3] 94/16 96/1 153/10
general [10] 6/4 14/1 14/6 14/16 31/6 32/12 34/15 39/19 94/1 150/7
generally [9] 7/6 15/13 30/10 31/2 31/3 31/8 31/22 39/16 135/12
generated [2] 139/11 139/12
generates [1] 144/22
generic [1] 9/8
genuine [6] 25/14 26/12 26/16 69/25 71/7 198/18
genuinely [2] 26/20 98/3
gestation [1] 120/22
get [18] 13/23 35/22 45/14 47/6 51/2 62/25 67/21 70/4 83/4 93/7 102/17 107/3 155/18 156/3 157/5 174/16 198/20 206/21
gets [1] 75/17
getting [2] 87/25 195/13
Gibbs [1] 92/6
Gilby [1] 107/24
gist [1] 28/22
give [11] 37/1 47/17 54/15 55/7 95/4 106/17 113/13 151/25 165/22 172/17 204/21
given [34] 36/4 36/14 50/4 69/24 130/2 136/13 137/16 138/12 143/16 143/17 144/4 169/13 170/22 172/20 180/15 180/17 180/19 181/1 181/12 181/19 181/20 182/7 183/25 184/3 186/25 188/14 189/4 189/7 189/9 189/25 190/11 198/6 200/21 207/1
giving [6] 39/6 97/14 172/10 184/2 198/18 208/20
glass [1] 103/1
glimpse [1] 75/4
glimpses [1] 47/6
GMC [1] 128/25
go [123] 3/11 7/8 7/14 10/7 10/9 12/6 12/12 13/8 14/17 16/2 17/16 20/8 20/9 23/8 29/5 36/22 36/24 40/10 40/13 41/22 42/21 42/24 43/16 45/23 47/2 48/1 52/3 52/7 53/20 54/4 55/11 58/5 58/8 58/20 59/14 62/5 67/14 68/21 70/6 70/22 71/18 71/20 72/8 74/21 80/12 82/13 83/8 83/21 84/13 85/23 86/13 88/11 90/4 90/25 91/6 92/5 93/15 106/13 107/7 107/12 107/16 108/2 108/2 111/16 112/11 112/22 117/19 120/16 121/1 121/5 121/21 127/16 128/21 129/21 132/1 138/15 139/18 143/4 148/22 148/24 151/16 159/7 163/15 163/21 165/4 166/8 166/10 167/12 168/23 169/16 170/1 170/25 171/3 174/11 175/1 175/9 176/12 176/20 178/11 178/22 181/9 181/13 182/1 184/20 186/8 187/18 188/3 188/8 189/20 192/23 193/2 193/10 193/18 193/22 196/1 196/16 196/19 197/7 197/21 198/21 201/9 203/11 208/22
goals [1] 155/4
goes [5] 100/23 158/2 167/12 183/17 186/24
going [72] 9/11 11/13 14/2 27/21 34/19 37/10 38/8 42/15 44/20 45/4 47/23 49/4 50/25 53/10 53/16 54/13 57/6 66/9 76/17 77/8 81/17 82/14 85/2 86/1 89/4 89/6 91/16 92/25 96/4 98/7 100/17 108/7 109/11 114/20 116/20 120/1 121/3 121/19 122/11 125/13 129/20 129/21 130/19 138/10 154/13 157/22 160/17 162/12 165/12 167/20 168/3 172/15 174/18 175/6 175/9 180/22 183/12 187/3 189/20 190/15 192/17 194/12 194/19 196/24 197/2 198/21 198/23 198/24 205/8 205/10 207/11 208/16
gone [7] 37/23 197/1 197/11 197/11 199/20

G

gone... [2] 203/8 207/23
good [10] 1/5 14/20 32/4 52/7 71/12 81/5 138/17 138/17 151/20 158/4
got [44] 14/25 16/25 28/9 42/4 43/23 43/24 44/3 44/11 44/13 52/2 54/2 63/24 63/24 64/5 68/12 79/16 80/9 91/22 92/21 93/1 102/21 117/2 119/22 127/25 135/15 136/11 136/12 145/12 148/11 156/13 160/20 162/14 167/6 176/11 186/19 187/6 190/23 194/14 195/22 195/22 195/23 197/7 198/25 201/2
govern [1] 8/1
governance [10] 7/9 10/8 13/7 30/1 31/22 33/6 138/17 153/1 154/6 156/4
government [1] 152/8
governors [14] 4/24 4/25 10/12 10/15 10/25 13/10 13/13 14/21 14/22 16/16 17/22 17/23 18/1 18/11
grading [2] 125/25 126/1
Grantham [2] 3/16 4/8
grapevine [1] 85/17
grappling [1] 77/14
grateful [1] 208/25
great [4] 5/14 50/8 50/8 106/13
greater [2] 21/8 25/23
green [3] 44/6 63/8 159/13
grief [1] 145/3
grievance [26] 66/25 67/4 67/6 67/10 67/15 67/18 68/5 68/16 68/19 68/23 73/16 74/3 84/1 84/2 84/3 84/6 93/4 97/15 101/20 102/11 102/15 102/17 136/1 136/7 137/6 137/7
grievances [3] 101/23 103/4 206/22
gross [1] 18/3
ground [7] 14/11 125/20 126/12 126/17 126/19 135/14 139/17
grounds [3] 61/10 102/10 198/17
group [5] 10/17 19/6 131/24 163/7 169/7
groups [1] 86/1
guess [1] 65/7
guidance [3] 27/1 28/16 156/14
guilty' [1] 86/18

H

habit [1] 15/12
had [287]
hadn't [17] 38/3 38/3 38/10 42/4 75/2 93/1 94/21 103/13 119/22 126/10 140/8 146/14 174/24 185/2 185/8 185/22 188/5
half [1] 152/22
halfway [7] 70/6 116/22 122/23 122/24 128/22 165/5 172/2
hand [4] 22/19 78/9 136/21 187/14
handed [1] 181/4
handle [1] 25/13
handled [1] 84/7
handwritten [3] 32/13 160/12 165/13
hang [1] 71/6
happen [6] 19/18 32/18 80/9 108/3 171/11 174/18
happened [12] 39/7 62/17 69/14 74/17 112/5 145/5 150/12 158/14 174/1 175/4 177/15 197/4
happening [10] 32/23 38/1 39/11 44/20 109/24 137/8 137/10 139/16 143/18 172/21
happens [1] 138/22
happy [5] 15/19 31/4 190/21 205/22 206/5
hard [6] 59/15 60/4 60/9 60/11 61/2 61/3
harm [7] 21/22 24/8 76/22 123/1 134/18 166/4 175/16
harmed [3] 7/5 158/9 195/6
harming [7] 47/13 85/7 85/10 86/4 86/5 142/12 164/5
Harvey [43] 19/21 29/20 29/22 36/3 36/9 41/18 41/24 59/12 59/12 64/7 69/1 69/5 71/13 71/21 74/22 79/7 79/16 80/2 81/16 82/22 83/3 87/20 97/24 117/25 133/13 133/19 136/11 149/22 149/25 172/6 172/10 178/1 178/13 181/13 181/16 182/24 183/23 184/23 185/21 187/19 187/20 188/22 205/17
Harvey's [2] 78/11 185/16
has [33] 16/17 24/24 37/12 47/5 67/23 67/24 72/7 73/11 73/22 77/10 83/22 86/23 87/4 87/7 91/4 99/17 104/23 108/20 114/21 129/17 130/3 130/7 136/4 142/16 159/11 164/10 166/16 178/24 183/23 186/10 201/2 203/7 204/2
hasn't [1] 196/14
have [357]
haven't [8] 43/23 43/24 80/9 99/19 117/6 117/8 124/25 190/6
having [17] 27/14 31/25 36/4 54/10 62/7 62/23 69/5 96/22 104/4 126/12 141/2 182/12 188/25 194/5 204/18 204/20 207/18
Hawdon [7] 78/24 79/10 79/20 80/2 82/6 180/12 188/5
Hawdon's [4] 183/1 185/14 185/25 188/21
Hayley [1] 68/9
Hayley Cooper [1] 68/9
HDU [1] 120/22
he [122] 16/18 16/20 29/24 30/3 30/10 30/11 30/11 41/25 42/2 46/22 51/8 51/11 55/14 56/8 56/10 56/12 56/13 56/18 56/20 56/22 56/25 57/22 57/24 58/9 59/23 62/2 62/6 62/6 62/11 62/11 62/13 69/6 72/23 80/3 80/5 80/19 81/2 81/8 81/9 82/14 87/13 95/16 96/3 96/3 96/3 96/5 96/5 96/7 96/11 96/14 97/11 97/13 99/17 99/20 101/2 103/10 105/11 107/25 108/1 108/2 109/10 110/5 110/21 110/22 111/1 111/1 127/1 127/3 127/4 129/8 129/9 130/18 131/14 131/15 133/14 133/15 133/20 141/19 141/21 141/23 142/1 142/4 142/6 142/7 142/10 142/10 146/1 146/2 147/11 147/14 147/16 147/19 147/19 147/20 148/1 148/1 148/2 148/2 148/2 148/5 150/1 150/2 150/3 165/10 166/13 166/17 167/15 167/17 168/25 171/13 176/11 176/13 176/21 177/9 183/23 185/8 185/16 193/22 193/25 193/25 194/1 208/24
he's [1] 130/17
head [5] 96/16 122/1 185/7 194/9 205/7
heading [3] 132/5 132/9 132/13
headings [1] 110/18
heads [1] 17/11
health [9] 1/22 2/24 87/24 123/21 124/6 124/10 129/22 144/21 188/1
healthcare [3] 12/14 115/16 154/15
hear [11] 28/4 55/24 66/9 73/2 89/8 91/21 103/17 114/14 114/18 203/3 205/9
heard [21] 41/10 46/24 53/12 60/12 61/21 67/10 71/11 75/1 88/9 104/23 118/24 119/18 125/23 126/12 127/8 136/4 183/25 201/9 204/18 204/18 205/16
hearing [5] 61/21 74/10 89/13 97/23 126/15
hearings [1] 102/11
heart [1] 100/14
heartache [1] 198/19
heavily [1] 116/15
heighten [3] 3/17 115/7 121/23
heightened [2] 4/7 53/14
held [10] 1/20 35/1 61/23 81/2 94/9 104/22 161/13 162/9 174/13 174/19
help [8] 12/11 12/24 44/21 46/1 50/21 105/1 155/1 193/25
helpful [9] 26/25 33/20 55/20 55/21 55/24 75/6 156/16 156/18 156/23
helpfully [1] 173/1
helping [1] 105/11
helps [2] 73/10 83/20
her [33] 2/7 9/20 24/21 60/22 65/23 73/13 73/22 76/23 79/8 83/10 83/23 84/1 84/3 84/6 84/10 86/24 88/6 100/18 100/21 105/19 106/4 106/7 106/17 106/23 129/20 136/9 136/12 143/8 160/12 177/11 186/12 191/1 205/13
Her Majesty's [1] 2/7
here [22] 30/6 31/9 36/3 48/12 52/1 57/24 60/25 69/1 70/18 85/15 94/24 98/15 100/10 119/8 166/17 167/13 172/21 185/9 187/9 189/14 194/6 196/14
herself [1] 87/23
Hey [2] 82/3 183/15
Higgins [3] 16/17 162/19 181/14
high [5] 17/17 25/7 53/3 91/9 136/13
high-level [1] 17/17
higher [1] 109/3
highlight [5] 7/14 45/5 45/24 57/20 183/4
highlighted [8] 7/12 22/21 28/13 44/6 169/20 180/11 182/21 191/22
highlighting [1] 90/12
highly [1] 116/13
him [23] 8/20 16/21 19/4 27/1 51/8 56/23 57/9 83/5 95/25 96/1 105/11 109/24 111/2 113/7 126/24 126/25 130/16 142/13 147/20 147/20 147/23 177/15 177/15
himself [1] 83/3
his [28] 16/17 16/19 59/17 61/1 62/14 92/6 92/14 94/25 97/14 99/14 99/18 100/16 108/18 109/8 109/19 111/5 111/19 121/19 122/2 131/13 133/13 147/21 147/22 166/16 171/6 177/17 193/21 194/1
hm [2] 4/19 75/20
Hodkinson [3] 43/9 83/22 118/1
Hodkinson's [1] 46/19

H

hold [2] 94/1 182/7
Holden [1] 208/24
Holt [1] 100/21
home [1] 107/13
homicide [1] 115/16
honest [2] 136/9 161/21
honestly [2] 205/6 205/11
Honourable [1] 2/20
hood [1] 155/20
hope [2] 26/9 28/9
hoping [1] 130/22
Hopwood [11] 58/6 61/22 70/22 76/2 88/22 128/14 162/18 168/18 168/20 174/12 196/17
hospital [40] 2/1 2/8 4/17 6/14 8/13 8/17 9/22 10/19 10/20 15/21 18/6 18/10 21/1 21/22 22/5 24/4 25/24 29/24 30/1 30/2 30/4 30/24 31/2 31/14 31/14 50/9 51/14 82/3 84/23 84/23 85/3 85/9 85/14 86/3 99/3 101/11 133/2 136/2 147/5 155/9
hospital's [3] 101/1 101/8 136/2
hospitals [5] 1/21 4/8 4/10 4/11 154/2
hot [1] 31/5
hour [1] 94/8
hours [2] 190/16 197/12
house [2] 64/10 153/20
how [56] 6/1 8/25 10/16 13/21 21/2 22/16 23/14 30/10 30/11 34/13 34/24 41/7 42/19 45/13 58/6 58/9 58/10 58/13 60/1 65/25 67/22 73/2 82/20 85/13 85/16 87/17 91/16 96/12 96/15 97/5 97/14 98/13 100/4 102/7 110/11 112/5 113/7 125/9 130/19 135/17 135/18 135/18 140/2 153/13 159/22 168/10 168/20 169/1 169/1 176/5 188/17 190/19 200/9 200/19 200/20 206/15
however [9] 86/25 98/12 160/24 164/18 169/15 169/22 169/25 175/18 198/20
HR [6] 36/11 36/18 63/13 117/16 118/10 118/14
huge [1] 137/15
hugely [1] 140/7
hypothesis [2] 59/2 59/3

I

I --I'm [1] 198/8
I absolutely [1] 157/15
I actually [1] 153/14
I agree [3] 26/10 128/12 128/12
I also [3] 114/1 158/25 185/24
I am [44] 4/20 6/21 21/25 33/13 34/19 47/23 53/18 53/18 70/17 80/1 84/5 85/16 90/18 97/6 106/14 114/20 116/20 118/7 119/16 125/13 129/20 129/21 140/5 140/5 142/25 145/5 146/18 151/7 151/11 156/19 156/21 157/5 157/21 160/24 162/5 165/12 167/5 168/3 169/18 184/14 185/9 190/15 190/21 201/19
I apologise [1] 153/10
I applied [1] 156/6
I appreciate [3] 67/21 124/13 171/9
I ask [4] 5/24 131/24 133/8 140/3
I asked [4] 168/8 170/20 205/21 206/2
I assumed [1] 206/5
I attended [1] 100/9
I became [1] 163/3
I been [3] 161/9 180/9 180/12
I believe [7] 6/10 14/6 66/14 67/22 78/1 98/2 156/2
I believed [1] 170/13
I call [1] 1/7
I came [2] 194/16 195/12
I can [18] 1/19 46/1 80/22 90/18 104/4 104/5 104/5 114/15 117/12 137/5 137/5 164/1 172/17 176/13 184/9 195/17 199/5 206/24
I can't [46] 3/23 3/24 40/9 40/9 48/18 48/18 48/18 48/19 52/4 54/25 55/5 55/5 56/13 56/17 56/18 67/5 68/20 73/7 73/7 76/9 76/13 87/20 88/9 94/19 96/14 96/15 97/20 101/22 101/22 105/16 106/7 106/21 142/6 156/19 157/6 159/10 162/13 164/7 171/12 174/22 177/1 177/18 180/19 185/6 185/6 187/24
I cannot [7] 157/14 159/10 171/13 181/3 181/3 181/8 187/7
I certainly [3] 198/10 200/23 202/4
I chaired [1] 10/23
I communicated [2] 91/24 110/23
I completely [2] 151/5 151/5
I could [4] 53/9 75/12 79/25 147/21
I couldn't [1] 88/22
I criticise [1] 102/16
I defer [1] 104/1
I deferred [1] 201/25
I did [23] 5/4 8/11 8/24 16/15 20/19 63/7 65/13 71/17 78/9 92/21 98/2 106/13 107/21 114/1 127/14 147/10 148/1 156/2 156/2 156/7 167/5 177/14 182/17
I didn't [41] 20/18 28/4 28/4 28/4 32/1 34/2 41/12 41/13 46/25 60/3 62/11 63/19 69/16 69/23 77/5 77/5 78/17 79/12 79/12 82/25 83/6 89/6 89/6 102/23 107/21 107/22 113/9 148/16 149/24 156/21 157/5 168/5 177/15 182/18 185/11 187/7 188/23 197/14 199/1 199/2 206/1
I discussed [1] 128/16
I do [15] 1/16 67/7 75/10 98/13 115/12 120/25 134/12 138/2 144/16 144/20 144/20 151/11 158/25 164/17 164/19
I don't [89] 5/13 5/13 16/22 17/2 17/2 17/2 20/24 21/4 21/11 21/17 30/11 39/10 41/12 41/15 41/15 42/23 43/3 45/1 46/5 46/17 46/17 46/25 47/17 47/18 49/5 49/12 49/12 51/3 53/17 57/10 59/23 60/3 62/10 66/8 67/16 70/16 70/16 70/19 70/23 73/7 78/18 88/17 88/17 89/25 96/9 96/9 97/20 98/21 99/1 99/12 101/12 105/22 105/24 118/4 128/10 129/10 129/10 129/13 136/23 137/1 137/17 140/6 142/7 142/13 142/17 143/14 143/22 144/18 148/7 148/19 160/19 161/5 161/17 161/21 163/14 170/17 172/16 185/11 185/21 187/17 192/8 192/10 200/3 202/19 202/20 205/25 206/7 206/17 207/16
I drew [3] 182/15 187/12 189/1
I explained [1] 178/7
I expressed [1] 175/25
I feel [1] 208/9
I felt [4] 34/14 102/24 146/13 166/1
I found [5] 32/10 32/10 152/21 155/16 198/14
I framed [1] 157/14
I fully [1] 102/14
I gave [2] 96/1 153/10
I go [1] 132/1
I got [5] 167/6 176/11 187/6 194/14 198/25
I had [29] 3/6 6/20 28/5 32/2 32/22 41/9 66/22 67/10 77/2 88/1 101/21 105/17 110/25 113/9 114/2 119/18 144/21 155/10 155/13 155/17 155/22 170/19 177/16 185/18 192/7 194/10 194/10 202/3 206/3
I have [44] 22/25 26/22 28/1 28/17 43/13 44/3 63/16 65/10 79/19 83/14 83/17 84/17 88/20 94/13 103/20 131/17 137/6 137/15 144/21 144/25 145/12 148/10 148/15 151/7 155/15 160/20 160/21 162/14 163/8 165/18 167/25 171/12 171/12 172/17 185/5 185/9 187/4 187/9 187/15 188/16 190/14 192/11 202/15 208/11
I haven't [2] 43/23 124/25
I heard [1] 88/9
I honestly [2] 205/6 205/11
I immediately [2] 175/19 176/15
I intended [1] 79/4
I interject [1] 60/25
I jumped [1] 170/10
I just [17] 48/11 89/20 89/20 117/18 123/18 125/1 132/20 139/20 143/4 143/10 145/11 149/6 156/22 165/22 170/25 174/24 203/3
I keep [1] 102/25
I knew [8] 34/6 34/11 42/9 67/5 142/7 149/24 200/14 200/14
I know [11] 21/23 34/11 42/10 95/15 131/3 137/14 176/8 195/8 197/10 202/8 205/5
I left [1] 176/14
I let [2] 206/6 206/7
I likely [1] 52/4
I look [2] 203/13 205/21
I make [1] 192/2
I may [4] 34/19 73/5 156/20 203/4
I mean [14] 18/2 23/25 33/5 48/23 92/19 99/3 102/18 140/6 149/10 156/6 164/1 180/8 194/8 195/4
I meant [2] 153/9 203/13
I might [2] 64/22 187/14
I missed [2] 39/11 133/18
I move [1] 135/24
I nearly [1] 33/13
I need [2] 145/13 145/25
I needed [1] 170/15
I never [1] 181/24
I noted [1] 77/15
I now [2] 189/3 192/22
I observed [1] 32/2
I personally [1] 35/16
I phoned [1] 177/14
I probably [3] 146/7 172/18 207/5
I provided [1] 77/23

I

I read [3] 53/18 77/6 182/13
I really [1] 151/8
I recall [8] 35/17 56/8 56/10 63/4 63/10 81/8 118/4 183/10
I received [1] 91/8
I recognise [2] 109/15 110/1
I recommend [1] 61/18
I referred [1] 78/10
I regard [1] 75/12
I reluctantly [1] 175/17
I remember [10] 5/9 10/1 10/1 47/16 47/16 57/11 63/2 63/15 89/25 97/2
I represent [2] 114/17 202/25
I responded [1] 113/19
I said [7] 91/8 139/3 173/22 192/7 195/20 205/25 206/20
I saw [5] 63/16 79/11 79/11 180/6 185/23
I say [2] 176/14 179/19
I see [2] 160/19 169/24
I seen [1] 186/1
I shared [1] 111/13
I should [2] 99/12 183/16
I spoke [2] 108/6 108/6
I start [1] 78/21
I started [1] 155/15
I still [2] 187/16 199/23
I suggested [2] 135/4 135/5
I suppose [5] 49/2 66/16 150/7 151/1 194/16
I suspect [2] 162/13 164/8
I take [1] 134/5
I talked [1] 87/12
I then [1] 138/9
I think [129] 2/13 4/9 4/13 6/12 7/12 10/2 11/16 11/16 14/10 14/15 16/13 17/7 17/7 19/21 20/22 21/1 29/12 36/24 41/14 41/14 42/2 44/19 45/7 45/7 48/15 50/6 50/16 50/23 52/4 52/6 53/7 53/15 54/16 55/23 56/18 56/25 56/25 57/12 59/4 61/16 62/19 63/5 66/20 67/6 67/6 67/13 70/21 78/21 79/7 79/18 80/1 80/25 81/19 83/3 84/21 88/15 96/3 96/4 96/18 97/13 105/2 105/8 109/12 116/14 119/9 124/3 129/9 130/19 134/21 136/14 137/5 137/7 137/21 139/3 139/8 139/25 140/6 141/2 141/2 141/3 143/15 145/16 147/16 147/19 148/11 150/18 150/18 150/19 150/20 151/19 153/15 153/16 159/25 165/15 166/9 173/1 175/25 176/1 176/8 176/21 177/12 177/19 177/25 180/14 181/19 182/20 184/12 190/10 192/6 192/13 195/12 195/19 195/20 196/1 196/2 196/8 196/8 196/10 197/1 197/3 200/3 200/4 200/23 200/25 201/3 201/5 202/14 204/7 208/14
I thought [28] 31/3 31/6 32/3 33/8 33/21 50/19 58/16 60/7 64/14 68/15 69/12 78/23 79/1 81/5 84/5 84/6 89/21 89/22 90/3 108/7 147/21 147/22 153/13 173/23 173/25 187/17 199/23 205/12
I told [1] 106/7
I took [6] 71/11 71/12 98/5 177/5 202/2 202/8
I tried [1] 135/1
I understand [2] 16/23 167/19
I understood [2] 173/4 173/14
I used [3] 176/6 189/18 206/14
I usually [1] 18/25
I walked [1] 85/22
I want [3] 97/5 148/15 189/21
I wanted [4] 91/21 99/3 144/23 170/12
I was [77] 2/5 2/6 2/18 4/21 6/4 6/20 7/6 8/13 15/19 28/4 28/5 39/20 61/2 62/10 66/4 69/7 78/17 78/17 78/23 78/24 83/12 92/19 92/19 92/23 93/10 96/6 102/11 102/20 102/21 102/24 103/18 106/16 112/18 128/13 128/15 130/22 135/4 141/18 153/13 153/20 153/20 155/19 155/21 156/9 160/20 166/23 166/23 166/24 167/2 167/2 168/3 170/21 170/22 175/13 176/1 176/4 176/14 184/13 185/19 189/19 192/9 192/12 194/11 194/12 194/13 195/4 195/4 196/8 198/8 198/10 198/11 204/16 205/4 205/7 206/18 207/1 208/9
I wasn't [5] 6/25 41/13 70/22 89/14 206/4
I will [6] 37/1 98/13 98/15 186/8 190/1 197/19
I wish [1] 81/13
I won't [1] 145/13
I wondered [2] 150/15 192/18
I would [34] 8/14 9/2 9/17 9/19 9/21 9/21 9/22 18/24 29/6 30/5 35/23 51/6 51/6 51/21 51/22 55/6 61/15 64/14 66/4 66/21 68/17 70/19 75/21 106/21 113/10 122/13 122/14 161/10 180/14 185/13 189/20 190/20 200/17 209/1
I wouldn't [3] 66/19 71/3 141/15
I'll [1] 103/22
I'm [36] 1/5 4/20 5/14 21/25 34/22 38/21 39/10 43/3 44/2 48/7 48/22 57/11 73/4 85/22 90/7 92/7 100/5 100/5 101/19 102/6 102/25 111/12 119/16 145/5 148/10 148/13 148/15 148/16 169/17 176/1 185/11 198/8 200/15 201/19 205/23 206/6
I'm afraid [3] 5/14 148/10 148/16
I've [4] 140/20 181/3 185/5 185/6
Ian [10] 78/11 105/7 105/11 105/11 105/17 117/25 178/13 185/16 185/21 188/22
Ian Dalton [4] 105/7 105/11 105/11 105/17
Ian Harvey [3] 117/25 178/13 185/21
Ian Harvey's [2] 78/11 185/16
idea [1] 81/5
ideally [1] 179/15
identified [4] 131/7 180/13 185/15 193/7
identify [3] 173/5 173/15 191/23
identifying [1] 123/13
ie [1] 4/6
if [237]
IH [1] 121/11
illusions [1] 156/9
imbalance [2] 136/18 136/19
immediate [5] 36/7 36/10 36/17 36/18 180/11
immediately [3] 175/19 176/15 176/15
impact [6] 23/18 23/20 46/14 90/21 121/4 177/4
impacted [1] 76/12
impaired [1] 106/2
impartial [1] 158/1
imperfect [1] 151/7
implementation [1] 16/10
implementations [1] 76/16
implemented [1] 13/7
implementing [2] 4/6 72/1
import [2] 84/25 189/8
important [18] 7/23 8/7 11/21 21/2 33/15 50/19 51/5 52/18 72/13 72/25 115/6 118/19 118/21 134/1 137/3 142/9 142/10 182/11
importantly [1] 145/2
imposed [1] 112/23
impossible [1] 80/10
impression [7] 153/10 164/14 172/19 177/2 187/6 207/1 207/9
impressions [1] 165/3
improvement [1] 191/23
inaccurately [1] 167/2
inappropriate [5] 20/22 60/25 69/12 71/1 74/17
incident [4] 124/1 124/2 124/3 126/3
incidents [7] 6/6 124/19 125/17 125/20 125/21 126/8 140/25
include [5] 14/19 70/10 101/1 101/8 124/4
included [3] 1/23 119/14 119/17
including [6] 37/1 59/7 81/24 120/11 158/9 181/15
incomplete [3] 183/16 184/4 188/7
inconclusive [3] 47/8 48/10 78/14
inconsistency [2] 143/11 143/14
inconvenient [1] 208/24
incorrect [1] 185/10
increase [9] 21/5 21/6 38/17 116/10 120/15 160/22 161/13 162/14 191/15
increased [4] 20/13 21/12 53/4 116/7
increasing [1] 165/7
indeed [16] 4/22 6/3 39/21 62/17 64/22 81/15 122/13 131/20 132/12 133/9 134/17 134/19 135/20 149/12 151/15 208/19
independent [5] 78/3 81/1 191/19 191/22 201/23
INDEX [1] 209/8
indicated [5] 61/1 127/21 153/8 176/9 187/10
indications [1] 53/10
individual [43] 12/19 32/16 37/15 57/23 58/1 58/25 72/14 72/17 73/1 73/3 73/11 76/17 78/5 102/4 121/10 121/20 135/3 140/22 141/5 143/24 155/11 161/2 164/5 164/21 166/3 166/14 166/19 167/9 168/4 168/6 169/15 169/25 173/6 173/16 177/5 177/7 181/24 183/5 183/20 186/10 187/1 195/6 202/5
individual's [3] 72/16 170/2 186/21
individually [2] 15/5 170/14
individuals [6] 34/8 122/9 130/4 134/4 150/14 159/15

I

inevitable [3] 149/7 149/10 149/13
inevitably [4] 111/23 149/4 149/7 197/2
inference [7] 69/17 69/22 182/15 187/12 189/1 190/2 206/4
influence [2] 108/6 115/18
influenced [2] 61/2 101/17
influential [3] 202/12 203/18 203/22
inform [3] 172/23 174/2 198/23
informal [1] 8/16
information [42] 2/21 13/5 13/11 13/20 13/23 14/20 14/24 17/13 27/6 27/11 27/16 37/19 37/20 37/25 54/19 65/20 65/23 79/2 79/18 82/2 86/12 113/13 113/14 113/16 140/14 141/13 141/24 143/16 143/23 144/6 144/7 144/9 144/10 174/23 179/7 179/13 180/21 185/23 186/1 189/18 190/13 204/18
informed [12] 14/7 29/7 63/2 78/24 103/18 140/9 142/11 143/16 161/7 162/10 179/23 180/2
informing [1] 198/4
ingredients [1] 106/14
inhibited [2] 162/2 162/3
inimical [1] 151/4
initially [4] 155/16 173/23 173/25 206/14
initials [2] 116/23 120/8
injury [3] 24/5 24/6 24/9
INQ [4] 14/18 91/1 148/10 154/19
INQ number [1] 91/1
INQ000239 [1] 78/13
INQ0002653 [1] 36/24
INQ0002748 [1] 67/14
INQ0003014 [1] 157/19
INQ0003092 [1] 93/15
INQ0003120 [1] 177/23
INQ0003174 [1] 49/19
INQ0003176 [1] 47/25
INQ0003178 [1] 35/25
INQ0003204 [1] 34/25
INQ0003236 [2] 80/18 193/18
INQ0003237 [2] 72/9 181/10
INQ0003238 [2] 55/10 162/8
INQ0003361 [2] 40/13 116/20
INQ0003517 [1] 197/20
INQ0003518 [1] 71/18
INQ0004299 [1] 68/22
INQ00042999 [1] 64/6
INQ0004474 [1] 94/11
INQ0004657 [1] 20/10
INQ0006023 [2] 45/17 120/3
INQ0006682 [1] 92/5
INQ0009246 [2] 10/7 154/4
INQ0009485 [2] 24/13 25/3
INQ0014818 [1] 22/13
INQ0014821 [1] 191/9
INQ0014962 [1] 16/1
INQ0015683 [1] 111/16
INQ0017497 [1] 3/11
INQ0057492 [1] 88/3
INQ0057493 [1] 88/12
INQ0088531 [1] 90/11
INQ0098147 [1] 99/9
INQ0099388 [1] 86/14
INQ0101079 [1] 26/23
INQ0101357 [1] 107/7
INQ0102040 [1] 54/3
INQ0102361 [7] 91/6 94/20 95/8 95/11 99/16 112/11 127/12
INQ0103147 [1] 52/17
INQ0107734 [1] 83/8
INQ0107964 [1] 98/6
INQ0108477 [1] 7/11
Inquest [1] 42/25
inquiring [1] 146/18
inquiry [34] 1/14 2/22 2/23 3/2 3/15 3/21 3/21 3/23 18/16 26/23 32/3 35/6 104/23 114/22 114/24 121/22 132/3 132/12 132/20 132/23 132/25 133/8 133/25 134/21 136/4 148/6 152/4 157/9 159/11 166/24 198/11 199/3 199/19 209/5
inside [1] 10/19
insight [1] 88/1
insisted [1] 200/17
insisting [2] 175/20 200/16
insofar [1] 76/11
instance [2] 33/20 141/8
instead [3] 15/24 45/17 82/5
instinct [1] 26/2
instructed [2] 26/23 31/21
Integrated [1] 152/25
integrity [1] 13/4
intended [2] 79/4 198/22
intensive [1] 54/22
intent [1] 176/7
intention [2] 134/2 207/17
interest [2] 15/9 194/3
interested [3] 118/7 171/15 172/18
interests [3] 25/1 60/8 91/14
interject [1] 60/25
internal [7] 5/22 14/17 27/15 55/1 78/14 82/8 160/15
interpret [1] 73/8
interrogate [2] 189/13 189/21
intervene [2] 107/22 168/24
intervening [3] 97/8 97/18 192/25
intervention [8] 3/18 62/20 107/23 115/10 115/22 121/25 183/4 183/22
interventions [1] 166/10
interview [2] 31/19 31/19
intimated [1] 77/19
intimidated [2] 93/13 94/3
into [28] 6/7 9/12 9/15 11/18 17/19 19/24 67/15 68/5 83/9 88/1 98/4 98/4 106/13 111/21 125/9 129/11 134/13 135/6 146/18 149/2 149/18 158/14 164/3 167/6 167/18 181/24 188/20 206/21
intolerable [1] 87/8
intricacies [1] 124/14
introduces [1] 100/11
introduction [3] 24/14 59/11 185/16
introductory [1] 189/16
investigate [10] 5/21 27/14 36/11 36/19 59/19 130/13 171/7 179/3 179/4 180/11
investigated [4] 6/7 83/15 93/3 129/3
investigating [1] 78/5
investigation [12] 83/16 86/23 86/25 87/4 112/24 121/4 158/1 158/14 178/25 181/24 188/20 197/25
investigation' [1] 129/6
investigations [4] 82/7 82/9 111/21 149/2
invitation [1] 90/8
invite [2] 12/5 75/22
invited [9] 16/13 28/5 37/6 70/20 71/24 72/5 123/7 135/4 191/16
inviting [1] 178/6
involve [1] 44/18
involved [8] 2/16 67/22 70/23 102/11 111/5 140/22 145/3 156/8
involvement [2] 170/12 170/18
involves [1] 143/22
involving [3] 103/5 141/1 146/10
is [337]
isn't [11] 11/3 22/6 24/5 61/18 75/24 81/21 95/8 116/8 132/6 142/20 192/22
issue [26] 4/17 14/3 18/14 18/15 20/8 21/15 46/11 53/24 56/16 70/14 72/15 72/20 77/13 105/20 105/21 105/24 106/3 106/4 122/13 141/16 146/6 147/3 168/18 174/19 201/19 204/17
issues [29] 8/18 17/14 18/7 19/15 19/20 27/1 30/1 34/21 38/2 38/8 57/12 57/13 72/2 97/25 101/3 146/12 146/12 155/18 162/3 167/16 170/6 171/21 172/7 182/18 183/3 183/21 188/17 203/15 207/21
it [492]
it's [65] 10/9 20/22 21/4 21/5 21/7 22/21 23/12 23/25 23/25 25/4 27/18 40/13 43/7 43/21 46/5 46/6 49/2 55/23 64/6 75/19 80/10 80/10 86/17 90/11 91/18 91/18 98/7 98/22 100/22 109/18 110/12 117/2 121/18 127/12 133/3 137/14 142/19 148/24 150/13 157/6 163/15 168/17 169/19 173/12 173/22 176/9 178/4 181/16 184/10 188/24 189/23 190/10 190/16 192/10 192/10 192/10 194/8 195/17 195/24 201/23 201/23 207/7 207/11 207/16 208/23
it's trying [1] 91/18
items [1] 24/1
its [2] 16/8 47/5
itself [5] 42/12 67/15 68/19 148/17 151/3

J

JAMES [3] 151/22 152/2 210/9
Jameson [2] 100/11 103/8
January [31] 70/20 71/20 78/12 79/14 83/10 88/16 88/18 88/23 88/24 88/25 89/1 136/9 173/24 174/20 180/9 180/23 181/5 181/10 186/2 191/7 192/21 193/4 194/14 194/20 195/22 195/24 196/10 196/12 205/14 207/11 208/10
January 2017 [1] 205/14
Jayaram [28] 26/12 46/3 55/12 55/14 56/6 56/17 59/14 60/4 61/1 74/24 90/6 90/12 91/1 96/18 96/23 97/22 100/19 120/12 126/2 127/7 162/20 164/19 165/5 165/9 165/19 165/25 167/3 184/25

J

Jayaram's [1] 45/23
Jim [2] 45/24 120/13
Jim McCormack [1] 45/24
job [8] 65/2 78/25 80/3 80/5 111/2 138/19 147/19 156/7
jobs [1] 50/4
join [2] 90/8 116/16
joint [1] 12/17
jointly [1] 40/7
judged [1] 110/22
judgment [1] 201/11
Julie [1] 35/4
Julie Fogarty [1] 35/4
July [33] 10/9 20/15 20/21 29/21 38/5 42/12 49/22 49/22 50/7 50/13 53/21 53/24 54/5 54/9 55/11 68/2 81/14 81/15 83/12 160/9 161/7 161/18 161/19 162/7 163/10 178/14 179/15 184/1 191/14 196/6 200/16 203/6 207/24
July 16 [1] 200/16
July 2014 [1] 10/9
July 2016 [2] 191/14 203/6
jump [1] 192/23
jumped [1] 170/10
June [10] 1/14 40/11 40/14 81/15 110/3 116/3 120/5 123/14 134/20 175/17
June 2016 [1] 134/20
June/July [1] 81/15
junior [3] 9/20 30/5 134/7
just [126] 7/8 9/8 12/21 15/14 15/14 22/20 28/7 28/11 31/10 37/23 41/23 44/9 44/16 44/16 45/5 45/11 48/8 48/8 48/11 48/23 49/19 50/9 51/24 52/2 52/17 52/20 56/9 69/21 73/5 79/19 85/14 88/11 89/20 89/20 103/3 104/21 105/15 111/9 111/10 116/22 117/7 117/18 117/19 120/17 121/16 122/22 122/24 123/18 123/19 125/1 125/13 127/10 128/21 128/22 132/20 134/6 137/2 138/16 139/20 141/7 143/1 143/4 143/10 145/8 145/11 145/24 149/6 151/14 151/25 153/5 153/11 154/17 156/11 156/22 157/6 157/8 157/19 157/21 158/21 160/8 161/12 162/17 163/13 164/13 165/3 165/5 165/18 165/22 168/11 169/18 170/12 170/25 171/4 171/4 174/24 176/24 177/14 179/19 180/17 180/23 180/25 181/19 185/21 185/22 186/4 186/8 187/18 190/14 191/1 191/6 192/11 192/12 196/1 196/16 197/17 199/5 199/5 199/7 199/18 200/2 200/19 203/3 203/21 205/16 207/7 207/11
JUSTICE [2] 145/15 210/8
justified [1] 84/19
juxtaposition [1] 188/21

K

Karen [2] 86/11 90/3
Karen Rees [2] 86/11 90/3
Kark [3] 114/3 114/7 131/3
KC [1] 115/5
keep [4] 54/7 102/25 141/12 144/24
keeping [3] 51/19 134/2 141/14
Kelly [22] 19/21 24/14 24/18 30/15 30/17 42/18 62/1 62/11 62/13 81/19 117/25 159/20 169/11 169/18 176/22 176/25 178/9 193/2 201/10 207/19 207/22 207/23
Kennedy [4] 142/25 143/3 144/15 210/7
kept [7] 1/6 11/24 138/14 138/15 140/9 141/20 144/1
key [3] 50/14 138/16 206/19
killing [1] 47/12
Killingback [1] 148/21
kind [8] 28/19 79/19 82/23 89/16 92/4 135/13 135/19 137/11
kinds [1] 6/15
King's [1] 26/24
King's Counsel [1] 26/24
knew [17] 14/4 34/6 34/6 34/11 42/9 53/23 65/11 67/5 68/13 69/25 94/9 107/25 142/7 149/24 149/25 200/14 200/14
knock [1] 68/10
knocking [2] 15/12 103/1
know [117] 4/5 16/17 21/23 23/23 30/11 33/25 34/2 34/3 34/11 35/2 36/9 36/13 39/10 40/14 41/12 41/15 41/15 42/10 46/19 47/11 47/21 47/23 49/5 51/22 53/21 53/22 54/2 55/11 58/9 61/25 62/9 62/11 62/13 66/2 66/5 66/8 67/3 67/22 68/2 69/16 69/18 70/1 70/3 79/5 82/15 89/3 89/10 89/12 92/21 93/10 95/15 97/5 97/20 98/15 99/4 109/11 113/18 114/17 116/3 124/1 125/6 125/14 126/25 127/6 129/16 131/3 131/25 136/14 136/25 137/1 137/6 137/14 140/12 144/19 147/14 149/22 149/23 149/24 150/12 150/22 151/8 156/8 158/13 159/18 160/9 161/17 161/21 167/5 167/20 168/5 168/5 168/25 174/18 176/8 182/17 182/18 185/21 185/22 187/17 189/3 192/11 192/22 195/8 195/20 195/21 197/10 197/14 200/3 201/22 202/7 202/8 202/9 205/5 205/11 205/25 206/7 207/16
knowing [3] 84/20 195/7 197/10
knowledge [6] 13/14 42/10 84/23 133/14 152/5 159/2
known [11] 21/6 21/10 36/15 66/17 85/8 85/13 86/3 86/8 112/14 197/16 203/11

L

lack [5] 16/19 94/1 136/2 136/20 136/21
LADO [2] 158/12 158/17
Lady [17] 28/8 48/18 103/1 104/13 114/13 118/13 131/17 142/22 143/6 144/13 145/15 151/18 190/21 202/24 208/11 208/15 210/8
landed [1] 47/20
Langdale [6] 1/6 1/11 48/7 115/5 144/20 210/4
language [3] 69/2 69/6 207/7
large [1] 96/5
largely [1] 35/7
last [15] 36/22 57/19 75/24 82/16 104/17 109/22 133/13 148/24 150/7 166/17 166/21 169/22 173/12 178/7 197/19
late [5] 82/4 88/22 93/24 209/1 209/1
later [16] 45/18 51/15 51/17 60/2 70/20 118/20 118/21 118/21 119/24 161/15 164/24 168/6 184/3 184/9 195/15 206/21
latter [1] 3/4
lawyer's [1] 110/1
layperson [2] 58/9 168/25
Lead [1] 24/16
leadership [5] 1/21 10/11 29/25 183/3 183/21
leading [6] 7/17 10/14 29/23 116/4 147/7 197/9
leaked [1] 76/4
leaking [1] 76/7
Leanne [1] 131/23
Leanne Woods [1] 131/23
learned [2] 114/21 115/5
learning [1] 138/19
least [10] 7/13 15/4 30/4 81/16 92/16 98/25 116/17 140/12 153/14 179/16
leave [4] 48/8 48/17 49/3 49/8
leaving [1] 112/13
led [2] 193/2 197/2
left [6] 3/7 3/7 67/24 103/21 176/14 194/12
legal [1] 112/17
legislation [3] 123/22 124/14 124/21
length [1] 195/18
less [3] 63/24 67/7 193/12
lesson [1] 3/15
lessons [1] 3/1
let [9] 20/6 63/5 73/5 99/4 114/17 131/25 141/7 206/6 206/7
let's [13] 39/12 40/10 73/9 75/22 80/12 80/13 80/13 92/1 102/20 120/2 122/22 144/11 148/14
Letby [40] 28/21 56/14 62/2 62/15 63/4 67/10 73/22 76/21 77/18 83/9 86/16 87/23 88/4 136/6 136/20 137/11 137/16 140/14 142/12 158/15 159/16 162/25 164/21 165/17 165/20 175/6 175/14 175/20 182/16 186/5 186/17 187/3 187/7 187/12 187/15 188/20 200/17 201/8 205/1 205/3
Letby's [3] 57/1 136/1 200/24
letter [20] 3/8 63/16 80/1 86/15 90/10 91/7 92/6 127/9 127/13 130/14 130/16 148/12 158/16 177/24 178/1 178/4 179/24 180/16 181/25 185/25
letters [3] 82/22 82/25 128/3
level [28] 4/12 4/12 6/5 12/3 17/17 19/15 34/13 41/6 41/10 41/22 42/15 50/19 54/22 74/5 87/22 109/3 120/20 126/12 126/17 126/19 129/14 138/13 139/12 146/9 160/16 160/17 160/17 201/16
levels [3] 1/21 30/5 136/13
liaise [1] 158/12
liaised [1] 153/2
licence [1] 23/17
lie [2] 206/7 206/7
life [3] 26/8 138/11 202/2
light [3] 45/6 61/5 112/8
like [34] 2/4 8/12 9/16 19/4 20/17 30/25 33/4 42/20 44/22 46/3 46/22 48/12 63/23 64/2 64/3 64/6 65/5 65/12 68/18 69/15 71/1 71/8 84/8 94/9 102/23 107/1 110/14 135/13 137/23 138/23 143/12 145/8 149/20 209/1
liked [1] 70/1
likely [1] 52/4

L

likewise [1] 30/15
limit [1] 11/22
limited [1] 87/19
line [4] 94/4 127/22 183/13 207/14
lines [5] 48/9 81/11 117/13 177/19 184/13
link [2] 161/2 183/20
linked [4] 15/6 23/24 109/21 140/11
list [3] 49/20 65/6 100/15
listed [2] 23/15 49/25
listen [1] 17/8
listened [2] 93/12 175/23
little [6] 125/1 126/23 143/12 152/21 158/2 198/3
local [8] 6/23 7/3 10/18 10/19 27/12 28/21 152/7 197/12
lodged [1] 68/16
logged [4] 6/7 19/15 20/7 20/8
logging [1] 33/17
long [10] 43/17 86/25 117/3 138/10 144/21 145/14 148/17 148/23 190/18 199/21
longer [7] 48/3 57/6 108/25 130/11 153/21 187/13 190/19
look [49] 5/23 11/22 12/7 13/24 22/18 23/9 27/8 31/22 44/4 44/22 47/2 48/8 52/20 58/22 65/6 73/9 77/9 79/14 88/14 89/21 94/8 104/1 116/18 116/20 120/2 127/10 129/20 142/15 145/25 146/7 148/14 148/19 155/19 158/5 168/11 169/22 172/3 178/22 180/22 181/12 187/8 188/9 189/19 193/8 199/7 201/3 202/15 203/13 205/21
looked [10] 104/21 121/16 127/9 148/10 148/22 158/21 159/7 172/17 182/18 190/6
looking [26] 4/13 9/12 10/2 32/13 38/13 49/25 50/20 64/20 105/9 106/8 111/1 119/19 146/25 147/9 153/15 155/19 158/6 158/19 172/12 172/16 173/19 174/20 184/14 188/13 191/6 208/4
looks [10] 42/20 46/3 47/9 47/20 48/12 54/8 64/6 68/18 73/21 202/21
loop [1] 117/2
losing [1] 82/18
loss [1] 106/11
lot [2] 138/12 155/18
lots [4] 102/18 150/8 150/9 206/23
low [1] 158/4
LS [2] 107/9 107/13
Lucy [15] 63/4 66/25 67/10 67/10 68/23 69/9 70/11 86/19 87/2 136/12 137/11 137/16 140/14 164/21 165/17
Lucy Letby [7] 63/4 67/10 137/11 137/16 140/14 164/21 165/17
lunch [3] 103/22 104/4 104/16
luncheon [1] 104/19
Lyn [7] 104/23 105/2 105/4 105/12 105/17 105/19 129/16
Lyn Simpson [1] 105/4

M

MacCormack [1] 77/7
made [30] 13/3 15/23 16/23 25/5 32/8 36/11 36/15 36/21 62/12 68/13 69/5 69/9 79/2 84/16 90/9 91/5 134/22 143/19 146/14 150/8 158/4 158/8 158/16 163/21 163/24 164/11 178/25 186/2 193/13 204/12
magic [1] 91/19
main [6] 3/15 56/16 103/8 105/20 121/21 154/10
maintain [1] 30/7
maintaining [1] 62/21
Majesty's [1] 2/7
major [2] 29/7 58/21
majority [4] 122/15 122/16 176/9 176/12
make [25] 13/5 13/24 13/25 14/13 17/13 17/13 19/9 27/24 46/24 49/16 52/22 68/25 69/11 69/23 74/4 79/4 83/24 122/11 138/21 182/10 185/13 189/21 192/2 199/6 204/23
making [8] 4/6 39/7 39/9 50/11 96/6 101/18 143/22 207/1
malevolent [6] 3/18 115/9 115/18 121/25 134/2 135/8
maligned [1] 84/7
manage [5] 42/19 73/12 136/5 186/11 199/1
managed [5] 19/10 22/7 102/8 103/5 149/9
management [25] 1/24 1/25 2/25 13/6 14/22 15/1 15/2 15/25 16/5 19/11 19/13 19/14 22/11 31/15 33/7 94/6 111/23 126/16 126/20 130/23 131/8 149/4 153/2 155/4 157/10
manager [3] 9/19 102/20 158/12
managers [4] 4/10 25/12 131/10 137/16
managing [1] 73/23
Manchester [1] 2/10
mandates [1] 124/12
manner [1] 101/18
manual [3] 151/8 151/11 151/12
many [5] 30/3 50/8 87/17 135/16 151/2
March [4] 19/21 27/4 90/10 129/1
March 2013 [1] 27/4
massive [1] 74/5
matter [19] 12/2 19/22 20/24 31/14 38/3 59/19 70/24 100/14 107/23 112/24 116/14 120/20 128/16 146/18 149/15 156/24 171/8 194/5 201/21
matters [17] 11/18 16/11 17/6 20/4 33/15 39/23 45/9 70/3 70/3 83/15 89/21 128/12 137/13 137/19 160/22 170/25 192/17
may [45] 1/7 11/23 24/12 25/2 28/2 34/19 40/12 44/14 47/6 47/8 47/8 47/10 47/14 48/9 53/3 73/5 73/14 73/14 78/21 85/7 88/25 89/11 97/11 99/13 116/19 121/11 124/13 127/13 127/16 128/21 133/8 148/12 151/1 152/4 156/20 158/9 163/5 167/3 169/14 182/19 186/13 193/25 197/20 203/4 206/3
maybe [4] 146/12 152/22 196/16 199/7
McCormack [5] 35/6 45/21 45/24 46/20 46/25
McCormack's [2] 46/5 77/15
McPartland [2] 82/7 188/6
me [55] 3/8 4/20 20/6 24/1 28/22 29/16 32/3 32/22 35/9 36/15 41/9 43/23 51/11 60/24 61/15 63/5 67/8 67/9 68/11 73/5 76/24 79/21 81/4 85/20 85/24 91/24 96/14 97/14 102/24 110/22 113/18 114/14 114/17 114/18 118/13 118/25 120/16 120/17 128/13 128/15 130/18 131/25 141/7 141/20 142/7 142/13 151/6 155/13 163/9 164/2 170/11 176/2 177/21 180/17 202/2
mean [26] 18/2 23/25 33/5 48/23 56/23 56/24 59/3 61/8 73/17 74/25 92/19 97/19 99/3 102/18 109/4 134/11 140/6 149/10 156/6 164/1 167/16 170/10 180/8 194/8 195/4 203/12
meaningful [1] 91/4
means [1] 5/23
meant [9] 41/6 48/12 56/25 73/3 73/5 140/9 153/9 203/13 205/20
meantime [2] 58/24 130/21
measure [1] 96/5
measures [7] 58/10 58/16 58/17 101/4 139/19 169/1 172/8
mechanism [2] 135/22 189/12
mechanisms [1] 15/10
mediate [1] 130/22
mediation [7] 90/6 90/9 92/20 128/24 129/11 149/18 149/23
medical [21] 16/19 17/5 17/10 25/7 29/21 29/22 30/5 39/21 40/8 84/17 99/7 100/8 202/1 202/10 202/11 203/17 203/21 203/25 204/2 204/3 204/20
medically [3] 60/22 204/13 204/20
Medland [5] 80/18 81/8 82/12 193/15 193/20
Medland's [1] 80/25
meet [6] 8/14 45/20 87/9 87/13 87/14 130/3
meeting [220]
meetings [33] 10/14 10/24 11/7 11/25 14/5 15/1 15/4 15/7 18/15 18/17 31/25 32/12 34/23 37/14 39/22 40/6 40/11 40/18 42/13 52/8 66/16 66/19 93/12 97/22 101/15 116/4 116/4 116/16 118/8 118/18 119/17 160/8 162/4
meetings' [1] 57/3
meets [1] 88/5
Melius [1] 31/18
member [32] 5/6 5/19 11/8 11/8 17/24 17/24 27/9 27/18 43/6 43/12 46/4 58/7 65/20 65/21 66/2 67/21 67/22 67/24 68/3 82/14 98/16 120/20 121/3 122/25 155/12 158/9 159/15 159/17 168/21 169/9 177/7 193/24
member's [2] 72/4 188/12
members [19] 5/8 10/20 12/9 12/17 13/1 25/6 29/19 74/10 81/24 81/24 84/16 123/10 135/18 135/20 135/23 161/23 164/8 165/2 169/13
memories [1] 134/6
memory [15] 9/2 48/20 49/24 65/6 65/10 81/10 83/21 88/18 118/6 134/3 134/23 135/3 135/3 135/18 184/12
mention [2] 7/8 160/25
mentioned [11] 36/23 40/11 56/11 56/17 79/19 85/20 85/24 145/18 146/1 147/8 147/24
mentions [2] 46/22 182/2
merely [1] 75/3
merits [1] 92/17
message [6] 54/24 83/9 183/7 183/9 184/1 207/13
messages [5] 45/13 50/14 50/16 85/6

M

messages... [1] 138/17
met [9] 8/13 51/8 91/1 91/9 110/22 129/1 178/12 178/13 178/19
microphone [1] 103/3
microphones [1] 28/10
mid [1] 174/9
mid-September [1] 174/9
middle [10] 66/24 128/1 129/10 129/10 130/25 140/7 158/7 174/5 184/21 193/19
might [30] 5/12 7/5 13/23 16/25 24/4 27/10 27/19 34/8 40/1 47/12 47/15 47/21 48/20 64/20 64/22 69/24 75/5 81/7 88/18 88/21 101/1 101/8 113/4 128/4 134/7 162/13 173/24 187/14 201/5 206/3
Millward [1] 19/25
mind [8] 7/10 65/25 88/20 101/19 121/19 134/2 193/12 195/5
minded [1] 81/12
minds [3] 134/25 134/25 135/19
minimum [1] 174/14
minute [8] 44/10 71/6 166/7 181/12 184/10 187/4 195/16 205/21
minuted [7] 55/15 55/17 55/21 165/11 167/2 176/9 195/17
minutes [16] 18/12 38/9 52/10 55/20 72/9 72/10 163/15 163/17 168/8 168/12 181/9 190/20 191/1 206/23 206/24 207/16
misconceived [1] 137/8
misgivings [5] 25/15 25/18 26/13 26/16 26/21
mislabel [1] 144/6
misleading [1] 79/22
misled [10] 78/1 78/16 78/17 78/17 78/24 79/4 79/13 129/4 208/8 208/9
missed [2] 39/11 133/18
misses [1] 125/21
missing [1] 63/25
mistakes [1] 24/7
mistreated [1] 102/9
mitigation [1] 12/25
mm [3] 4/19 41/2 75/20
Mm-hm [2] 4/19 75/20
Mmm [1] 41/2
Mmm mm [1] 41/2
mode [1] 179/8
moment [12] 52/7 81/21 95/4 96/8 123/19 125/14 137/2 143/1 145/9 165/9 167/23 181/13
Monday [4] 1/1 36/23 47/24 178/2
Monday's [1] 94/14
monitor [1] 155/5
monitoring [3] 16/10 23/6 169/6
monitors' [1] 23/19
month [6] 3/7 152/19 152/22 153/15 191/7 200/15
months [14] 47/5 47/10 47/21 47/21 48/2 48/4 107/16 108/10 108/16 108/22 108/24 108/25 109/10 147/1
mop [1] 104/2
more [44] 10/4 10/4 10/5 26/6 27/11 38/13 39/5 40/2 44/24 48/19 55/24 66/21 66/21 67/6 70/2 86/9 86/9 109/22 113/13 113/16 138/13 138/24 139/1 139/9 144/16 145/2 150/7 152/22 155/18 158/25 176/4 176/5 184/8 187/14 189/23 191/19 196/8 198/19 200/10 200/19 201/1 201/6 202/13 202/14
morning [4] 1/5 208/16 208/23 209/3
mortality [6] 20/13 21/12 38/17 53/4 161/14 165/7
most [3] 8/15 53/2 115/6
mothers [2] 45/14 50/9
motion [1] 105/13
motives [2] 100/25 101/7
move [10] 14/2 24/12 100/19 114/5 131/10 135/24 148/2 148/18 178/14 191/7
moved [11] 22/3 22/4 62/16 131/14 136/3 169/14 200/16 205/1 205/3 205/5 205/6
movements [1] 22/5
moves [1] 171/17
moving [7] 86/24 109/25 111/19 123/19 153/20 153/20 200/5
Mr [173] 8/8 8/14 13/21 16/17 19/2 19/3 19/21 29/20 29/22 31/10 31/12 31/17 32/5 35/6 36/3 36/9 41/13 41/13 41/18 41/24 43/4 45/21 46/5 46/20 57/18 57/22 58/9 59/12 59/12 59/17 59/20 62/1 62/8 62/20 64/7 64/7 64/8 69/1 69/5 70/6 71/13 71/21 72/8 72/13 72/19 73/11 73/22 74/12 74/22 76/4 77/7 79/7 79/16 79/17 80/2 80/18 80/25 81/4 81/8 81/16 82/12 82/22 83/3 86/14 87/12 87/20 87/20 91/24 94/24 95/8 95/9 95/23 97/24 99/9 99/13 104/23 104/25 105/3 105/9 105/10 105/15 105/25 107/24 108/10 108/15 109/8 109/11 110/4 111/11 111/17 112/1 112/19 113/4 113/19 114/1 114/5 126/6 130/15 130/21 131/13 133/13 133/19 136/11 136/11 141/18 141/21 141/24 142/4 142/15 142/25 143/3 144/15 149/22 149/25 151/18 151/21 151/22 151/25 152/3 154/4 157/20 160/9 162/19 162/19 164/14 166/11 166/13 166/20 167/14 168/14 168/24 168/25 169/3 169/5 169/9 170/5 171/6 171/10 172/6 172/10 177/24 178/1 181/13 181/14 181/16 182/24 183/12 183/17 183/23 184/22 184/23 186/10 186/21 187/19 187/20 191/6 191/13 193/1 193/15 193/20 194/2 196/19 197/3 197/20 198/4 199/4 202/19 202/25 205/17 208/19 208/24 210/7 210/9
Mr Chambers [49] 8/8 8/14 13/21 31/12 41/13 43/4 64/8 70/6 72/8 72/13 72/19 73/11 73/22 76/4 86/14 87/12 87/20 91/24 94/24 95/8 95/23 99/9 99/13 104/23 105/9 105/10 105/25 108/10 108/15 109/8 109/11 110/4 111/11 111/17 113/4 113/19 114/1 130/15 130/21 131/13 136/11 169/3 169/5 183/12 183/17 186/10 186/21 191/13 196/19
Mr Chambers' [5] 79/17 95/9 107/24 112/1 112/19
Mr Chambers's [3] 31/10 104/25 114/5
Mr Cross [15] 19/2 19/3 31/17 41/13 59/17 59/20 64/7 81/4 141/18 141/21 141/24 142/4 142/15 171/6 171/10
Mr Cross's [1] 32/5
Mr Dalton [2] 105/3 105/15
Mr Harvey [39] 19/21 29/20 29/22 36/3 36/9 41/18 41/24 59/12 59/12 64/7 69/1 69/5 71/13 71/21 74/22 79/7 79/16 80/2 81/16 82/22 83/3 87/20 97/24 133/13 133/19 136/11 149/22 149/25 172/6 172/10 178/1 181/13 181/16 182/24 183/23 184/23 187/19 187/20 205/17
Mr Higgins [2] 16/17 181/14
Mr Holden [1] 208/24
Mr Kennedy [4] 142/25 143/3 144/15 210/7
Mr MacCormack [1] 77/7
Mr McCormack [3] 35/6 45/21 46/20
Mr McCormack's [1] 46/5
Mr Medland [5] 80/18 81/8 82/12 193/15 193/20
Mr Medland's [1] 80/25
Mr Oliver [1] 162/19
Mr Rheinberg [1] 194/2
Mr Semple [1] 126/6
Mr Wenham [1] 197/3
Mr Wilkie [32] 57/18 57/22 58/9 62/1 62/8 74/12 151/18 151/21 151/25 152/3 154/4 157/20 160/9 164/14 166/11 166/13 166/20 167/14 168/14 168/24 168/25 169/9 170/5 177/24 184/22 191/6 193/1 197/20 198/4 202/19 202/25 208/19
Mr Wilkie's [1] 62/20
Mrs [22] 3/8 48/1 58/6 61/22 74/10 76/2 148/21 160/11 168/18 168/20 169/11 169/18 171/22 172/2 172/4 174/12 193/2 196/17 201/10 207/19 207/22 207/23
Mrs Bottomley [1] 3/8
Mrs Fallon [5] 74/10 160/11 171/22 172/2 172/4
Mrs Hopwood [7] 58/6 61/22 76/2 168/18 168/20 174/12 196/17
Mrs Kelly [7] 169/11 169/18 193/2 201/10 207/19 207/22 207/23
Mrs Killingback [1] 148/21
Mrs Rees [1] 48/1
Ms [46] 1/6 1/11 19/21 19/25 21/14 24/18 35/5 46/19 48/7 54/3 62/11 62/13 62/15 67/17 81/19 83/22 86/16 88/3 88/3 105/15 108/9 108/13 109/11 114/11 114/12 115/5 118/11 126/3 126/6 131/20 131/21 131/22 142/24 143/5 144/20 151/23 151/24 190/19 202/21 202/23 208/14 210/4 210/5 210/6 210/10 210/11
MS BROWN [4] 151/23 151/24 190/19 210/10
Ms Cooper [3] 67/17 88/3 88/3
Ms Fallon [1] 54/3
Ms Fogarty [1] 35/5
Ms Hodkinson [1] 83/22
Ms Hodkinson's [1] 46/19
Ms Kelly [5] 19/21 24/18 62/11 62/13

M

Ms Kelly... [1] 81/19
Ms Langdale [6] 1/6 1/11 48/7 115/5 144/20 210/4
Ms Letby [2] 62/15 86/16
Ms Millward [1] 19/25
Ms Simpson [4] 105/15 108/9 108/13 109/11
Ms Sutherland [7] 114/11 114/12 118/11 131/20 202/21 208/14 210/5
Ms Townsend [3] 21/14 126/3 126/6
Ms Wood [1] 142/24
Ms Woods [4] 131/21 131/22 143/5 210/6
MSC [1] 107/25
much [26] 15/19 37/25 60/8 80/21 101/23 117/8 131/19 132/18 144/9 144/14 144/22 144/23 148/21 151/15 153/13 168/6 182/25 187/14 189/23 190/19 198/12 199/4 202/19 208/13 208/18 208/19
multi [3] 53/13 75/7 97/25
multi-factoral [2] 53/13 97/25
multi-factorial [1] 75/7
multifactorial [1] 53/12
multiple [3] 59/6 59/8 59/10
multitude [2] 33/6 139/4
murders [3] 2/17 132/8 132/9
must [7] 27/6 27/11 27/16 27/16 93/6 127/21 130/9
mustn't [1] 93/6
mutual [2] 93/23 106/11
my [121] 3/7 5/18 5/24 6/2 6/6 6/6 6/17 6/17 26/2 28/8 29/2 29/2 32/14 32/25 33/10 33/10 37/18 38/17 39/19 39/22 40/23 40/23 42/10 45/7 48/18 48/20 67/24 68/10 70/22 75/13 75/19 77/15 78/19 81/10 85/24 85/24 87/19 88/18 88/20 91/9 91/11 92/23 95/25 97/7 97/15 97/18 103/1 104/2 104/2 104/2 104/13 111/9 111/11 111/13 114/9 114/13 114/16 114/18 114/20 115/5 118/6 118/6 118/13 121/10 131/17 131/23 131/25 132/24 134/22 137/7 142/22 143/6 144/11 144/13 145/12 147/20 151/7 151/14 151/18 155/10 155/10 156/7 160/4 160/5 163/1 163/2 163/2 164/6 168/1 170/14 172/24 175/25 176/1 176/4 176/7 176/11 177/1 177/9 185/7 186/2 189/16 189/20 190/21 192/2 192/8 193/11 195/5 198/11 198/22 200/3 200/13 202/6 202/24 202/25 205/4 205/7 205/11 206/6 206/15 208/11 208/15
my Lady [15] 28/8 48/18 103/1 104/13 114/13 118/13 131/17 142/22 143/6 144/13 151/18 190/21 202/24 208/11 208/15
myself [4] 79/3 92/20 109/16 110/16

N

name [9] 11/14 86/7 114/16 131/23 152/1 168/5 168/6 189/20 202/25
name-calling [1] 86/7
named [3] 7/7 11/5 11/5
namely [2] 42/5 79/19
names [1] 49/20
narrative [5] 111/15 119/2 192/21 206/9 206/12
national [2] 1/22 108/20
natural [2] 51/25 60/16
nature [4] 84/16 140/21 179/1 206/24
near [1] 125/21
nearly [3] 33/13 147/16 190/16
necessarily [4] 66/19 84/9 196/9 196/9
necessary [4] 6/7 6/8 58/12 78/7
NED [14] 152/16 153/18 159/22 189/13 189/15 189/24 190/10 200/10 201/20 201/21 204/2 204/13 204/15 204/21
NEDs [14] 14/4 70/9 160/10 160/12 163/5 163/10 163/11 163/24 164/7 195/1 200/19 201/1 201/4 204/5
need [36] 25/18 25/25 26/5 27/20 40/13 44/20 45/12 47/17 48/1 61/2 61/3 71/7 82/18 92/21 99/1 99/12 115/25 125/6 125/9 126/16 135/16 139/8 139/14 139/14 139/14 139/18 143/25 144/4 145/13 145/25 146/7 151/8 174/16 177/20 195/3 207/13
needed [21] 13/23 18/19 18/22 19/23 44/17 45/11 50/10 50/14 50/16 50/16 51/14 51/17 106/2 119/21 119/21 130/18 170/15 176/12 180/5 182/9 195/17
needing [1] 6/5
needn't [1] 186/8
needs [5] 53/3 63/13 178/25 179/10 190/23
neither [2] 161/13 181/24
neonatal [37] 8/21 9/2 9/15 9/24 11/20 14/4 19/10 20/12 20/14 31/24 32/14 34/17 35/4 35/17 38/1 39/1 50/21 53/4 54/6 72/4 86/20 98/16 111/21 116/7 116/10 122/2 126/10 136/4 141/19 142/2 149/2 160/13 169/6 178/7 178/17 188/12 191/15
neonatals [1] 38/25
neonates [5] 6/15 21/3 22/17 24/19 25/22
neonatologist [1] 78/6
neonatology [1] 179/17
neonatology/pathology [1] 179/17
network [2] 37/13 64/11
never [10] 24/21 68/9 123/3 133/15 140/24 144/22 180/15 181/21 181/24 192/7
new [6] 10/3 10/4 111/1 111/2 129/19 147/9
News [1] 77/23
next [27] 10/9 12/7 27/8 45/17 55/14 80/6 80/9 80/17 100/19 100/20 103/14 107/13 112/20 117/14 117/20 122/16 122/23 123/11 128/21 133/3 151/18 165/10 178/22 195/11 196/2 197/24 208/15
NHS [24] 1/24 1/24 2/1 2/15 7/11 10/7 16/19 27/1 29/14 109/22 129/24 130/9 132/5 132/9 132/13 132/17 134/4 134/4 135/12 138/11 148/3 153/23 154/6 154/12
NHS England [2] 27/1 29/14
NHSE [1] 106/10
NHSI [1] 106/10
Nichol [5] 1/7 1/10 70/9 177/13 210/3
night [3] 22/4 176/17 189/5
nightmare [1] 86/17
nine [1] 108/25
NMC [1] 42/21
NNU [3] 22/19 62/16 161/14
no [186] 3/6 3/9 5/21 6/9 9/5 9/5 9/10 11/3 12/2 17/2 19/8 20/18 22/23 23/25 24/3 24/20 26/4 26/17 27/15 28/1 28/3 28/6 28/6 28/17 28/22 29/16 32/22 36/20 41/9 43/13 44/1 45/1 46/13 51/18 53/1 53/15 53/15 57/22 57/23 59/23 60/10 60/16 60/18 61/20 63/2 63/14 63/14 63/19 63/21 64/4 64/19 64/25 65/10 67/25 68/7 68/17 68/21 69/20 69/22 71/3 71/5 71/10 73/7 77/15 77/15 78/4 80/12 80/12 80/12 82/12 82/25 83/6 84/11 85/20 85/23 87/10 87/10 87/12 87/16 88/1 89/5 89/5 89/18 89/25 90/18 91/4 91/19 91/19 93/22 93/22 94/5 94/19 95/15 96/10 97/20 98/21 98/21 100/6 100/6 101/21 104/1 104/15 104/15 106/25 107/2 107/5 107/10 107/18 107/22 108/3 108/6 108/7 110/4 111/4 112/21 112/22 112/25 113/20 114/8 116/14 117/18 119/3 119/3 119/7 119/11 119/13 124/25 126/2 126/7 126/7 127/2 128/8 129/9 129/18 130/10 130/15 131/1 131/17 133/20 133/22 138/25 140/18 142/17 144/16 148/7 150/1 151/13 151/15 153/9 153/11 153/11 153/21 156/9 156/13 156/14 158/3 158/17 160/20 160/25 161/9 162/14 163/14 164/1 164/12 164/12 164/12 164/22 166/5 166/13 166/14 166/23 171/15 172/21 185/18 187/13 188/16 188/25 190/4 192/11 193/6 193/21 194/14 198/17 201/13 206/14 208/11
no one [2] 28/22 108/6
nobody [7] 85/20 85/24 164/10 190/5 190/6 207/3 207/7
Nods [5] 49/23 81/18 159/21 163/22 183/6
non [44] 1/23 7/18 7/24 10/23 12/1 12/10 12/22 13/18 13/20 13/22 14/23 14/25 15/3 15/11 15/20 23/16 25/7 54/3 54/8 54/12 55/3 62/5 66/9 70/13 81/24 110/23 111/13 130/1 150/13 152/10 152/13 153/22 154/19 154/25 155/3 155/14 155/16 155/21 155/23 162/17 169/15 176/3 179/22 181/15
non-clinical [1] 25/7
Non-Execs [1] 111/13
Non-Executive [30] 1/23 7/24 10/23 12/1 12/10 12/22 13/18 13/20 13/22 14/23 14/25 15/3 15/11 15/20 54/3 54/8 54/12 55/3 62/5 66/9 70/13

N

Non-Executive... [9] 81/24 110/23 152/10 154/19 154/25 155/3 162/17 179/22 181/15
Non-Executives [2] 7/18 176/3
non-use [1] 150/13
none [3] 158/13 204/3 204/10
nor [4] 160/21 180/16 180/16 181/25
normal [1] 64/25
normally [2] 68/5 108/22
North [2] 106/10 106/10
Northern [1] 131/15
Northern Alliance [1] 131/15
not [264]
note [15] 31/24 46/9 46/19 46/20 48/6 48/8 48/16 54/2 64/6 118/5 121/15 122/22 160/13 160/19 167/12
note-taking [1] 31/24
noted [3] 77/15 82/18 147/20
notes [15] 32/1 32/5 32/13 32/21 40/19 41/20 42/24 45/17 46/10 48/15 145/12 165/13 186/9 205/14 207/12
nothing [6] 107/1 113/1 113/5 119/10 123/14 123/16
notice [4] 54/15 108/18 108/22 109/8
noticed [2] 58/22 165/1
notifiable [4] 124/1 124/2 124/3 124/19
now [84] 6/21 10/6 20/9 23/3 28/23 32/14 35/2 36/1 42/10 43/19 46/8 46/15 48/21 49/24 52/10 53/18 54/10 55/3 56/6 59/20 62/6 64/21 65/6 67/23 72/9 73/4 73/8 83/7 83/14 86/17 89/13 92/8 97/20 103/24 106/13 116/12 116/22 120/14 123/5 129/20 131/13 137/14 142/3 142/8 146/5 157/14 158/13 158/19 160/8 162/7 165/3 166/22 167/14 177/22 180/15 180/17 185/9 185/18 185/21 187/2 187/7 187/19 189/2 189/3 191/7 192/22 195/8 195/11 195/24 197/8 197/10 197/14 198/21 198/21 199/18 200/9 200/14 200/16 205/5 205/25 206/3 208/16 209/3
number [22] 11/22 14/18 14/18 15/4 21/7 21/8 21/9 21/18 62/19 80/15 81/23 86/2 91/1 120/10 140/19 146/8 154/19 159/12 159/14 168/8 182/18 203/1
numerous [1] 136/5
nurse [34] 9/18 11/1 11/13 11/14 21/21 22/5 22/7 26/13 26/16 36/12 42/19 42/21 44/18 44/22 45/2 46/15 48/13 52/25 57/1 60/15 63/9 63/13 68/13 70/1 72/21 93/3 121/9 126/9 127/23 128/24 170/9 179/5 193/2 199/25
Nurse Letby's [1] 57/1
nurse's [1] 101/14
nurses [14] 2/25 30/21 30/22 31/2 43/19 44/23 44/25 45/1 87/24 117/16 118/14 119/4 134/18 178/15
nursing [15] 17/10 24/15 30/16 30/17 30/18 30/19 30/21 30/23 35/14 39/21 40/8 86/11 87/21 118/10 204/7

O

o'clock [2] 208/23 209/3
objectives [4] 8/1 110/17 146/25 155/5
obligation [2] 34/7 110/4
observe [1] 3/1
observed [3] 32/2 139/9 200/22
observing [1] 33/10
obstetric [3] 35/7 35/13 35/18
obstetric review [1] 35/7
obtain [2] 42/25 129/18
obvious [2] 135/22 209/2
obviously [8] 8/7 91/1 135/11 147/12 156/7 159/13 163/20 208/24
occasion [6] 12/3 87/14 88/10 97/13 118/23 162/23
Occupational [1] 87/23
occur [2] 24/7 194/25
occurred [6] 35/3 82/15 143/21 157/11 199/20 199/22
occurring [2] 62/20 175/17
October [1] 195/23
off [7] 51/4 51/7 112/21 131/12 200/17 205/8 205/8
offence [3] 27/11 27/19 158/10
offences [1] 132/4
officer [3] 27/12 31/13 197/12
often [3] 8/25 115/17 131/11
oh [4] 10/2 88/13 95/25 96/24
okay [33] 49/9 59/4 67/19 78/19 96/21 109/17 116/18 120/2 122/22 128/20 131/25 133/23 139/25 141/24 142/1 142/19 156/20 163/14 165/24 167/25 168/2 168/10 173/22 184/9 187/13 192/2 193/5 193/5 194/10 197/10 198/8 199/23 201/2
Oliver [1] 162/19
omit [1] 65/19
on [294]
on -- had [1] 200/13
once [1] 183/14
one [81] 3/6 7/16 9/8 9/24 10/6 17/1 20/10 23/9 23/12 23/12 27/8 27/11 28/22 34/24 40/18 44/3 44/22 54/2 57/3 57/19 65/15 72/14 72/15 73/1 73/3 75/15 78/5 80/18 81/16 82/2 82/2 86/17 86/20 89/2 92/24 95/1 95/15 95/20 96/7 96/7 105/6 107/23 108/6 109/4 109/6 109/22 110/25 110/25 114/21 116/17 128/4 131/7 135/12 135/15 136/21 137/20 143/1 143/23 144/23 145/16 149/16 150/8 151/7 153/17 159/8 159/9 160/10 164/21 166/23 178/14 182/2 182/2 182/21 185/14 185/16 185/24 187/9 187/14 188/23 192/2 204/7
one-on-one [1] 110/25
ongoing [2] 16/10 136/21
only [13] 11/18 11/25 18/14 46/9 46/9 59/14 79/3 86/19 107/23 107/25 143/9 193/10 195/24
onwards [3] 40/21 85/6 99/16
open [6] 68/10 105/11 124/11 140/17 140/18 153/11
open-door [1] 68/10
openly [1] 8/19
openness [1] 13/17
operate [1] 125/9
operating [2] 33/19 43/18
operational [4] 15/25 23/6 146/11 146/12
operations [1] 31/13
opinion [2] 121/10 122/3
opinions [1] 123/11
opportunity [5] 66/22 75/2 89/7 144/18 157/16
opposed [2] 72/10 202/10
option [3] 92/16 107/15 169/13
options [1] 107/14
or [188] 3/7 4/16 5/7 5/18 5/22 6/24 7/2 7/13 8/14 9/3 9/4 9/5 9/6 9/8 9/23 10/16 11/1 11/23 12/19 15/13 17/24 18/1 19/25 20/7 21/15 25/7 27/7 27/10 27/11 27/15 27/17 27/19 27/20 27/20 28/19 28/21 29/14 29/15 31/5 32/23 33/1 33/11 33/12 34/9 35/10 37/25 38/14 38/19 39/9 43/2 43/12 43/20 44/25 45/1 45/6 46/3 46/16 46/21 47/7 47/13 50/4 51/4 51/9 51/10 52/1 52/23 52/24 53/6 56/23 58/13 60/5 60/6 61/17 62/3 62/8 63/23 64/18 65/8 66/1 67/7 68/3 68/6 69/16 69/19 70/15 74/1 75/18 75/25 77/3 79/3 79/13 79/15 80/6 80/13 82/22 82/23 82/24 82/25 83/5 83/14 83/22 85/10 85/15 86/4 86/7 86/8 87/24 89/10 91/19 92/6 92/24 95/22 96/11 101/18 102/5 103/5 105/15 106/10 106/22 106/24 107/19 108/5 109/15 110/19 110/20 111/4 111/6 112/1 112/5 113/7 114/6 114/7 120/19 122/20 122/21 122/21 127/13 129/25 130/1 130/1 133/9 134/17 134/25 135/13 135/20 137/18 137/22 139/1 139/16 140/16 142/14 142/15 143/11 144/11 146/12 146/12 149/8 149/17 149/18 150/13 150/16 156/4 156/15 156/24 158/7 161/7 161/14 163/23 164/7 167/2 167/12 170/17 172/13 173/2 175/23 177/16 179/12 179/25 185/17 185/22 189/25 191/24 193/9 194/25 197/8 197/13 198/6 200/20
oral [1] 133/13
order [4] 118/8 118/18 179/17 182/9
organisation [6] 7/20 8/1 29/8 31/21 33/20 108/11
organisational [1] 131/8
originally [1] 198/15
other [49] 2/3 6/19 13/4 17/11 17/25 19/5 20/3 26/12 27/21 29/15 30/3 67/25 70/24 76/8 84/18 85/14 87/14 87/24 92/24 96/25 97/3 101/2 101/13 102/23 103/18 112/21 127/9 131/24 137/12 139/19 140/19 144/11 160/10 164/7 170/25 173/5 173/15 173/20 176/3 178/15 180/1 180/7 182/19 185/13 187/11 188/6 190/12 204/5 206/18
others [8] 13/22 31/19 86/12 88/2 110/13 118/24 167/3 204/10
our [19] 3/15 3/15 7/10 11/8 12/4 25/10

O

our... [13] 53/2 59/4 61/11 67/20 85/7 86/17 91/3 91/15 96/24 97/2 110/1 138/21 178/24
out [51] 3/8 5/24 6/3 25/4 25/18 30/5 33/24 44/20 45/13 62/11 63/25 67/8 72/8 86/21 88/4 88/9 88/10 88/15 88/17 88/21 89/15 100/16 100/18 124/7 128/4 130/11 130/20 131/5 139/5 139/18 139/18 140/25 149/14 150/16 151/15 152/23 153/16 157/11 157/12 157/21 158/20 159/5 165/18 173/1 176/16 179/1 181/4 186/15 186/17 196/13 196/15
outcome [4] 70/10 78/2 80/10 182/14
outed [1] 172/7
outline [1] 120/15
outlined [2] 59/17 171/6
outlines [1] 158/11
outside [6] 11/9 39/22 66/22 105/9 138/15 153/21
outstanding [1] 192/17
over [37] 9/5 12/16 16/7 38/6 42/24 58/5 66/23 71/19 90/25 100/17 100/19 100/23 101/25 101/25 103/1 111/22 115/13 116/22 121/1 125/23 126/6 127/16 128/22 145/1 148/23 149/3 151/6 175/13 178/22 182/1 185/6 188/13 192/6 193/18 194/25 200/13 207/14
overall [4] 7/16 75/4 93/19 177/2
overcrowding [1] 18/3
overlap [1] 109/5
overleaf [2] 49/20 112/20
overriding [3] 33/2 125/5 177/4
oversee [1] 16/9
oversight [1] 31/15
overview [4] 188/13 193/24 195/10 196/23
own [8] 17/5 37/22 62/20 99/5 110/6 185/7 195/5 199/18

P

paediatric [13] 69/2 70/7 161/1 162/16 163/3 164/4 166/2 172/22 174/3 194/17 198/16 202/9 205/22
paediatrician [2] 122/1 128/4
paediatricians [44] 12/5 37/13 40/16 45/21 46/15 52/24 56/16 61/12 62/21 64/13 67/1 68/24 77/18 81/1 88/23 88/23 89/7 89/16 91/11 94/21 99/15 99/17 100/6 101/4 106/1 106/6 111/24 116/17 118/24 120/3 122/15 122/16 123/7 123/12 128/2 128/13 128/23 129/2 129/2 129/11 129/12 147/4 149/5 158/16
paediatricians' [5] 95/1 103/9 106/24 142/11 161/10
Paediatrics [1] 188/1
paeds [1] 64/10
page [153] 3/11 7/12 7/14 10/7 10/9 10/9 12/12 12/16 12/16 13/8 13/15 14/17 14/18 16/1 16/2 16/7 16/7 17/16 20/10 22/13 24/13 24/13 25/3 25/3 26/23 34/25 35/3 35/25 36/1 36/24 36/24 40/13 40/20 40/21 42/24 44/3 45/17 45/23 47/2 48/1 48/9 49/19 54/4 55/10 55/11 57/18 58/5 58/5 58/8 58/20 61/4 64/6 66/23 66/24 67/14 68/22 70/6 71/18 71/19 71/21 72/8 72/9 73/10 74/21 76/14 80/18 82/11 82/16 82/16 83/8 83/21 84/13 86/14 86/14 88/3 88/12 90/11 90/25 91/6 92/5 93/15 94/11 94/20 95/8 95/12 98/7 99/9 99/16 100/10 100/11 100/15 100/17 100/17 100/19 100/20 100/23 107/7 109/13 111/16 112/12 112/20 112/22 112/22 116/20 116/22 120/16 121/1 121/5 121/6 122/23 122/23 127/12 127/16 128/1 128/21 128/22 132/21 148/19 151/8 154/5 154/17 154/18 157/20 157/23 158/5 158/7 165/4 166/10 166/12 168/15 168/23 171/3 174/5 174/6 174/11 174/12 175/1 178/22 181/17 182/1 184/21 184/21 186/19 188/9 191/9 193/18 193/19 193/19 196/2 196/2 196/17 197/21 197/21
page 0213 [1] 98/7
page 1 [25] 7/12 10/7 16/1 20/10 24/13 34/25 35/25 36/24 40/13 45/17 49/19 55/10 64/6 67/14 71/18 80/18 88/3 88/12 90/11 92/5 93/15 94/11 99/9 100/10 107/7
page 12 [2] 10/9 17/16
page 135 [1] 3/11
page 157 [1] 22/13
page 17 [1] 12/12
page 18 [1] 12/16
page 19 [1] 13/8
page 2 [17] 36/1 54/4 68/22 71/19 71/21 82/11 83/8 86/14 86/14 100/11 116/20 120/16 157/20 188/9 193/19 197/21 197/21
page 20 [1] 13/15
page 21 [3] 154/5 154/17 154/18
page 24 [1] 109/13
page 3 [6] 16/2 24/13 70/6 100/15 121/6 196/2
page 30 [2] 25/3 25/3
page 31 [3] 14/17 111/16 148/19
page 4 [9] 16/7 36/24 45/23 55/11 72/8 72/9 100/17 122/23 165/4
page 5 [6] 7/14 35/3 57/18 73/10 166/10 196/17
page 58 [1] 40/21
page 6 [8] 47/2 48/1 58/5 74/21 76/14 82/16 168/15 184/21
page 60 [1] 26/23
page 7 [2] 58/8 168/23
page 76 [1] 91/6
page 78 [2] 94/20 127/12
page 8 [2] 100/23 171/3
page 83 [1] 95/12
page 87 [2] 95/8 99/16
page 9 [4] 61/4 158/5 174/11 191/9
page-paragraph 52 [1] 175/1
pages [2] 151/11 206/23
paid [1] 109/8
pairs [1] 11/23
panel [4] 84/1 193/24 195/10 196/23
paper [2] 33/13 181/12
paragraph [56] 5/17 5/23 7/21 12/8 24/23 28/25 29/4 29/18 31/9 31/18 32/11 32/24 34/16 35/19 57/19 58/6 59/24 72/12 72/24 73/9 74/21 77/22 78/8 82/11 84/14 92/12 110/7 111/20 125/3 127/6 131/6 133/4 133/23 141/17 148/24 164/15 164/25 168/19 169/11 169/19 172/3 173/7 173/8 175/1 175/11 182/21 182/23 183/17 184/15 196/3 197/22 199/7 199/9 199/10 200/6 201/7
paragraph 1 [1] 24/23
paragraph 101 [2] 199/9 200/6
paragraph 109 [1] 127/6
paragraph 139 [1] 110/7
paragraph 14 [3] 5/17 5/23 28/25
paragraph 152 [1] 133/23
paragraph 158 [1] 77/22
paragraph 159 [1] 78/8
paragraph 26 [2] 29/4 141/17
paragraph 3 [2] 82/11 92/12
paragraph 35 [1] 29/18
paragraph 36 [1] 31/9
paragraph 38 [1] 31/18
paragraph 42 [2] 32/24 125/3
paragraph 44 [1] 164/15
paragraph 49 [1] 34/16
paragraph 5 [3] 72/12 74/21 131/6
paragraph 51 [1] 173/8
paragraph 52 [1] 175/11
paragraph 54 [1] 35/19
paragraph 9 [1] 32/11
paragraph 92 [1] 164/25
paragraph 97 [3] 199/7 199/10 201/7
paragraph 99 [1] 133/4
paragraphs [2] 10/10 55/13
parallel [1] 137/12
Pardon [1] 85/21
parents [26] 21/3 37/14 37/16 37/18 64/10 76/11 82/19 82/20 82/22 82/23 83/1 86/15 87/9 87/13 87/15 87/18 88/6 94/5 100/14 129/4 145/4 198/4 198/7 198/9 198/12 198/19
Parole [1] 2/5
part [34] 3/4 4/22 4/24 9/8 9/10 9/11 9/12 9/12 9/22 12/9 13/1 31/15 39/11 49/15 59/5 68/17 72/23 75/13 76/5 97/7 97/18 101/21 112/1 112/3 146/19 146/22 146/24 148/8 172/6 172/8 175/11 176/12 183/13 197/22
partial [2] 93/24 148/11
partially [1] 110/19
participating [1] 157/6
particular [16] 4/6 5/11 7/7 9/14 9/18 15/13 25/12 25/25 46/4 113/5 128/19 143/23 150/4 158/20 160/1 185/12
particularly [7] 9/7 14/2 19/11 27/18 79/14 97/24 185/24
parties [2] 91/18 92/22
partnership [2] 7/19 153/2
parts [1] 118/23
party [3] 6/12 86/12

P

party... [1] 123/9
party's [1] 112/3
passage [1] 194/9
passes [1] 134/6
past [4] 111/22 149/3 156/5 191/2
pathology [2] 80/14 179/17
patient [16] 16/9 16/11 17/19 20/24 23/18 23/20 24/3 25/19 34/18 37/24 90/21 101/3 141/1 157/24 177/6 205/10
patients [13] 18/5 18/5 18/6 18/9 25/9 25/13 25/24 25/24 30/2 30/23 75/25 91/14 141/1
pattern [1] 179/8
pause [6] 37/3 44/12 57/21 92/10 95/6 168/11
Pausing [2] 24/17 101/6
pay [2] 131/12 139/8
paying [1] 109/5
PC1 [1] 23/13
PC2 [1] 23/13
PC3 [1] 23/13
PC4 [1] 23/13
penultimate [2] 111/20 173/13
people [45] 2/24 3/25 9/21 15/22 16/13 19/22 19/24 25/18 32/25 33/10 33/15 33/18 33/22 37/1 50/3 50/19 55/24 58/3 71/10 72/14 73/1 73/2 77/8 81/12 88/11 95/3 99/4 102/7 102/7 102/15 116/16 119/5 125/4 137/23 139/18 140/9 140/19 149/13 150/17 151/4 189/21 197/15 203/10 203/14 203/22
people's [1] 103/5
per [1] 39/23
perceived [2] 93/19 93/21
perception [1] 200/11
perfect [1] 121/8
perfectly [1] 177/3
perform [1] 13/11
performance [10] 102/21 110/8 110/25 146/8 146/11 154/12 155/4 155/5 156/1 158/24
performing [1] 131/10
perhaps [11] 20/2 71/3 103/21 107/13 127/10 135/14 135/22 144/6 147/22 151/3 198/23
period [10] 3/10 9/4 9/6 43/19 44/23 108/18 108/22 109/9 109/12 197/13
periods [1] 109/21
person [18] 7/7 11/6 13/12 89/23 96/1 96/2 102/13 114/4 128/7 129/8 129/15 129/24 129/25 131/5 158/8 167/14 190/5 207/23
person's [2] 189/1 190/5
personal [5] 67/9 84/16 97/6 106/12 180/20
personally [3] 35/16 75/12 98/15
personnel [1] 134/6
persons [1] 124/11
perspective [3] 74/11 92/22 201/24
perverse [1] 136/19
phoned [1] 177/14
phrase [3] 180/20 189/18 201/7
phrased [2] 173/22 190/3
phrasing [1] 142/3
pick [1] 77/5
picked [2] 176/11 192/18
picking [2] 4/20 52/17
picks [2] 168/18 174/12
picture [7] 137/25 138/3 138/5 144/1 188/15 189/9 197/17
piece [9] 79/18 82/2 82/2 123/22 124/14 143/23 172/23 190/7 193/9
pieces [1] 195/25
place [19] 4/17 23/5 27/3 27/24 33/1 74/19 96/13 108/8 112/18 121/18 122/10 124/24 130/10 134/24 137/11 139/15 150/9 179/1 188/20
placed [2] 17/22 175/15
placement [6] 105/9 108/16 108/16 108/24 109/10 112/18
placements [1] 106/9
places [2] 101/16 129/24
plan [3] 23/5 32/16 39/23
plans [3] 32/19 39/18 40/1
play [3] 68/17 101/21 187/9
played [1] 130/20
players [1] 206/19
please [49] 1/7 1/8 3/11 10/7 15/25 20/9 22/12 23/10 26/22 28/11 31/11 35/24 36/22 45/16 48/6 49/18 52/16 52/20 55/9 67/18 71/18 75/22 83/8 86/13 90/4 90/17 91/25 94/20 112/11 112/13 112/20 114/17 116/21 120/3 121/7 122/23 127/12 128/21 131/25 132/1 135/7 135/24 140/11 141/16 152/1 154/5 160/8 166/8 184/17
pleased [1] 203/3
pm [9] 104/17 104/18 104/20 117/14 117/20 118/16 191/3 191/5 209/4
point [67] 6/11 13/19 16/23 19/9 21/19 21/23 22/1 26/7 32/8 33/10 38/6 42/14 53/7 62/7 64/24 81/5 81/20 85/9 85/19 91/23 92/18 100/6 101/22 105/8 107/22 109/4 110/3 114/6 121/2 144/18 146/14 149/17 150/8 151/2 154/13 165/9 168/1 170/13 172/17 174/17 175/5 182/17 184/8 185/2 185/5 185/12 185/13 193/5 194/5 194/16 194/20 194/25 195/13 196/3 196/22 197/1 197/6 197/8 198/7 198/15 200/19 200/24 206/1 206/6 206/7 207/3 207/5
pointing [1] 78/4
points [7] 57/3 96/6 100/8 102/19 113/3 127/25 129/14
polarised [1] 200/21
police [64] 5/20 5/20 6/11 27/22 28/21 42/21 51/17 52/3 59/15 59/18 59/21 60/9 60/11 61/2 61/3 61/7 61/9 61/11 80/13 81/13 81/17 81/21 82/13 82/14 86/23 87/4 93/3 121/4 122/4 122/6 122/13 122/18 122/20 123/15 123/17 129/5 167/17 167/24 170/11 170/18 171/4 171/7 171/11 180/4 186/3 193/22 193/24 194/7 194/19 196/19 196/25 197/2 197/8 197/11 197/24 198/22 198/24 198/25 198/25 199/3 200/18 202/7 203/8 203/11
police/NMC [1] 42/21
policies [13] 6/3 6/3 7/8 29/24 33/9 33/16 33/18 33/19 33/19 33/21 157/8 157/9 158/20
policy [20] 16/1 16/2 24/12 24/14 25/3 25/17 33/24 34/1 34/3 34/5 34/6 34/12 34/14 68/10 139/16 157/21 158/11 158/21 159/5 159/8
poor [4] 23/17 23/20 24/3 93/5
poorly [2] 53/2 131/9
popped [1] 96/16
posed [3] 11/24 18/4 159/16
poses [2] 27/9 27/19
position [23] 26/6 29/25 60/8 64/12 82/1 92/20 92/24 93/1 101/15 104/25 114/5 147/11 152/8 152/13 153/23 156/10 164/22 172/23 189/17 194/1 199/15 199/16 204/16
positions [2] 1/21 200/21
positive [1] 91/12
possibilities [2] 27/21 80/15
possibility [13] 3/9 3/18 59/6 76/22 76/23 100/7 115/9 121/24 134/2 134/17 135/8 170/6 187/13
possible [12] 15/20 73/14 87/7 101/3 130/22 144/9 173/5 173/15 179/11 192/10 192/11 193/25
possibly [4] 111/2 158/10 159/8 162/5
post [5] 3/7 61/23 147/16 148/3 174/13
postmortem [1] 182/5
potential [4] 20/12 23/10 90/21 161/2
potentially [1] 122/25
powers [1] 8/5
practical [3] 57/14 58/6 168/20
practice [12] 34/1 64/25 72/17 74/1 90/22 134/1 138/17 139/10 139/17 150/20 152/21 168/7
pray [1] 125/13
pre [1] 179/25
predecessor [1] 113/11
predominant [1] 170/19
predominantly [1] 5/9
preestablished [1] 110/17
prefer [1] 198/25
prejudiced [1] 199/3
preparation [3] 41/3 71/19 118/22
preparatory [2] 42/12 116/4
prepare [1] 50/10
prepared [3] 24/14 45/12 55/25
preparing [2] 116/14 118/19
presence [2] 30/13 200/24
present [7] 20/25 75/14 75/15 99/9 138/22 181/15 196/6
presented [2] 22/14 202/3
press [9] 51/1 51/4 51/9 53/19 76/4 76/7 78/18 81/7 91/13
pressure [5] 90/5 90/7 94/3 99/2 151/10
pressures [1] 62/19
presumably [6] 68/2 86/3 94/16 132/16 138/12 194/4
pretty [2] 85/8 175/25
prevent [8] 27/7 27/17 107/10 107/19 107/21 108/4 129/17 175/16
preventing [1] 107/18
previous [7] 57/25 166/18 166/21 166/25 192/2 202/2 208/1
previously [1] 58/24
primarily [2] 32/25 125/4
primary [4] 168/1 170/14 205/11 206/6
principal [3] 3/15

P

principal... [2] 119/19 133/24
principally [2] 4/9 59/12
principle [6] 19/7 65/15 65/17 65/25 143/25 161/23
Principles [1] 154/10
printed [1] 33/13
prior [6] 67/11 160/10 161/6 165/6 179/9 181/1
priorities [1] 12/25
prioritised [1] 25/9
private [4] 11/18 18/18 54/8 160/11
privately [1] 11/21
probably [17] 52/6 56/18 86/9 134/8 146/7 152/20 152/21 153/16 153/16 160/3 162/5 172/18 174/1 184/10 193/12 202/15 207/5
problem [7] 11/14 11/17 11/23 28/11 90/23 91/13 103/25
problems [2] 131/7 187/11
procedure [1] 136/7
procedures [2] 68/6 102/15
proceed [2] 68/15 68/17
proceeded [1] 136/7
Proceedings [1] 1/3
process [25] 35/21 36/11 36/18 63/13 83/4 93/4 97/15 98/4 101/20 116/12 116/12 116/13 129/10 130/25 139/16 140/7 143/19 151/4 172/6 178/25 179/2 188/7 194/11 198/13 206/21
processes [4] 33/1 68/8 150/9 151/3
produced [2] 187/20 187/23
producing [1] 198/11
professional [5] 2/9 8/10 30/7 84/16 90/24
professionally [1] 8/18
professions [1] 31/7
Professorial [2] 2/12 2/14
progress [3] 143/18 146/13 146/14
progressing [1] 70/4
promote [1] 13/16
prompt [2] 115/21 158/14
prompted [1] 180/4
promptly [1] 157/25
proof [1] 27/20
proper [5] 114/4 128/7 129/8 129/15 131/4
properly [2] 8/2 17/14
proportionate [2] 61/6 61/8
proposals [3] 12/11 12/24 155/1
propositions [1] 143/12
prospective [2] 113/3 113/6
protect [4] 24/24 25/13 27/6 27/17
protecting [4] 5/8 5/10 25/15 65/21
protection [3] 7/2 25/23 25/25
protections [1] 26/1
proven [1] 86/18
provide [2] 26/24 137/21
provided [9] 1/13 27/1 77/23 87/23 95/19 143/10 152/3 156/24 163/9
provider [1] 108/21
providers [2] 129/24 130/9
provocative [1] 89/22
provoked [1] 106/10
public [20] 3/21 3/23 11/7 18/12 45/14 54/6 54/11 135/12 138/11 160/9 161/12 161/20 161/22 161/23 161/23 162/1 179/21 179/24 191/8 191/10
publication [1] 98/10
publicly [1] 18/12
published [5] 3/20 3/22 3/24 51/1 140/15
pull [1] 205/15
punishment [1] 86/21
purpose [7] 34/11 54/16 100/12 112/4 112/7 173/4 173/14
push [3] 204/22 204/23 206/1
pushed [1] 202/13
pushing [1] 62/6
put [20] 54/11 62/14 71/5 81/5 81/7 81/7 90/5 96/8 99/13 105/12 105/13 111/23 121/18 127/8 136/6 141/15 149/4 159/18 177/11 179/1
putting [2] 96/24 97/2
puzzled [1] 166/23

Q

QC [1] 80/18
QSPEC [7] 16/19 17/6 35/25 36/23 39/6 39/8 47/24
qualified [2] 204/14 204/20
quality [16] 12/14 13/6 16/8 16/11 17/18 19/17 20/4 24/15 30/20 31/23 34/18 37/24 38/4 126/5 154/15 155/8
quarters [2] 44/5 166/11
question [39] 3/4 11/6 27/14 51/21 54/1 67/1 98/18 127/24 128/19 128/24 133/6 138/10 142/18 142/19 143/20 144/3 145/17 147/21 150/7 153/12 166/16 166/20 170/11 185/8 188/19 189/13 189/15 190/9 192/13 198/2 198/3 198/10 198/14 198/22 201/20 202/22 205/22 206/2 207/5
questioned [1] 205/20
questions [49] 1/11 5/24 21/2 42/4 57/16 94/21 94/22 94/25 95/1 95/2 99/14 99/20 100/4 103/21 106/24 114/9 114/12 130/21 131/18 131/22 131/24 143/3 143/5 144/16 145/15 150/23 151/14 151/23 157/1 166/24 168/9 170/20 176/3 176/4 176/5 194/21 202/20 202/23 203/4 206/22 208/12 208/14 210/4 210/5 210/6 210/7 210/8 210/10 210/11
quick [3] 91/20 127/10 131/1
quite [12] 39/10 51/8 80/22 82/4 87/19 121/17 153/8 155/16 187/17 194/6 196/24 203/13

R

Rachel [4] 70/21 88/22 128/14 162/18
radical [1] 139/2
raft [1] 146/11
raise [8] 35/13 102/7 102/15 102/17 191/24 197/6 198/2 208/1
raised [25] 12/3 19/20 24/21 33/25 34/21 34/23 34/24 36/6 36/17 46/21 57/16 67/7 69/25 71/7 93/2 99/14 101/24 102/3 102/4 128/12 157/24 158/6 158/7 167/20 191/14
raises [2] 21/1 81/19
raising [6] 25/4 46/3 98/1 119/5 164/10 199/21
range [1] 15/22
rapid [1] 39/2
rates [1] 53/4
rather [5] 36/10 44/22 53/2 166/9 200/21
Ravi [9] 45/23 90/12 96/18 96/20 98/11 120/11 121/2 122/23 122/25
Ravi Jayaram [1] 90/12
RCPCH [25] 36/4 36/10 37/21 48/3 62/24 72/7 76/21 77/7 79/6 82/5 98/10 143/9 163/21 171/17 172/5 173/18 175/9 178/4 178/6 178/19 181/17 182/3 183/2 191/17 191/19
re [4] 23/6 108/4 121/9 121/11
re-meeting [1] 108/4
reached [3] 100/6 105/8 195/11
reacting [1] 167/19
reaction [1] 167/23
read [47] 4/1 37/2 44/10 53/18 54/25 57/20 64/1 68/18 73/5 77/1 77/6 79/24 83/23 83/24 88/4 88/8 88/9 88/9 88/10 88/15 88/17 88/21 89/3 89/4 89/5 89/10 89/12 89/12 89/14 89/24 89/25 90/3 92/8 95/3 95/14 115/1 117/15 137/15 165/18 182/12 182/13 183/16 185/6 186/8 186/15 186/17 199/9
reading [4] 89/15 128/6 129/7 160/2
reads [1] 120/4
ready [1] 151/19
real [3] 81/21 93/22 159/23
realised [1] 190/15
really [10] 19/22 39/10 40/7 48/23 77/13 85/9 136/6 151/8 185/6 188/24
reason [15] 3/6 11/6 11/12 15/13 28/1 28/17 64/23 65/18 106/8 112/13 160/20 160/21 162/10 170/10 188/2
reasonable [3] 59/1 118/25 143/9
reasoned [1] 182/10
reasons [3] 75/8 140/20 209/2
reassurance [1] 35/22
reassured [3] 194/12 194/13 197/8
recall [71] 3/23 3/24 5/13 35/17 40/23 42/23 46/17 46/25 56/8 56/10 60/3 63/4 63/10 67/16 70/16 70/19 70/23 76/9 76/13 81/8 84/6 88/17 96/9 115/11 118/3 118/4 118/4 121/12 121/14 124/13 129/23 133/10 142/8 142/9 142/13 142/14 156/12 156/20 156/22 157/6 157/14 159/10 159/10 160/18 161/3 161/5 162/10 162/13 163/13 163/14 164/18 164/19 165/3 165/19 166/22 171/10 171/13 172/12 172/16 174/23 174/24 181/8 181/20 183/10 184/2 184/10 187/23 191/25 192/8 206/17 207/15
recalled [1] 127/7
recalls [1] 160/11
receive [5] 13/10 66/6 86/13 86/15 140/19
received [11] 5/21 14/8 37/20 62/14 78/2 88/2 90/10 91/8 179/8 179/13 179/20
receiving [2] 17/9 78/10
recent [1] 179/8
recently [1] 36/4
recognise [5] 109/15 109/18 109/23 110/1 159/19
recognised [1] 25/17

R

recollect [1] 54/10
recollection [15] 43/13 133/17 156/13 156/14 160/5 162/15 162/25 163/2 165/18 171/15 176/4 181/7 187/16 192/12 205/4
recommend [7] 61/13 61/17 61/18 61/19 80/14 135/4 179/13
recommendation [9] 3/14 3/16 4/6 61/16 132/19 133/24 183/10 188/19 188/24
recommendations [12] 71/21 72/2 72/11 73/16 131/5 134/22 182/2 182/3 184/12 184/23 205/17 205/23
recommended [2] 36/10 36/18
recommending [2] 168/4 178/23
reconcile [1] 185/7
reconciliation [2] 100/7 131/1
reconsider [1] 180/4
reconstruct [1] 194/8
record [2] 48/25 185/10
recorded [6] 129/17 145/21 146/15 203/6 207/12 207/18
records [2] 32/12 55/13
recriminations [2] 158/3 158/15
recurring [1] 123/1
red [2] 14/12 159/13
redacted [13] 62/24 62/25 63/3 65/14 65/15 140/16 140/20 141/9 143/9 180/17 180/19 181/1 191/12
redeployed [5] 22/9 43/19 44/24 62/17 83/12
redeployment [3] 44/18 74/2 74/7
redouble [1] 138/21
reduce [3] 120/22 121/2 170/17
reduced [1] 160/17
Reducing [1] 54/21
Rees [3] 48/1 86/11 90/3
refer [8] 21/18 30/15 40/20 129/5 131/2 133/24 158/11 188/4
reference [37] 20/19 24/1 39/1 42/25 45/7 47/3 47/11 47/25 52/22 55/1 59/25 63/4 66/25 77/16 77/17 77/17 79/4 107/18 108/1 109/13 112/21 113/5 133/3 134/24 148/11 163/25 165/15 169/17 171/23 172/10 172/11 172/13 179/12 186/14 191/8 195/9 195/16
referenced [1] 195/15
references [7] 29/16 34/20 35/16 69/10 78/13 81/23 171/13
referencing [1] 123/24
referral [3] 43/1 128/25 158/17
referred [11] 19/12 37/17 38/19 43/7 63/23 74/10 78/10 83/25 120/13 131/3 163/10
referring [10] 49/6 69/5 80/1 83/23 92/23 166/22 167/3 172/5 196/3 196/8
refers [6] 16/18 73/24 166/20 181/23 185/25 187/25
reflect [1] 96/4
reflected [3] 128/18 166/9 196/10
reflecting [3] 148/5 192/6 199/13
reflection [4] 156/16 192/14 204/12 204/15
reflections [3] 199/6 200/9 200/21
refresh [1] 83/20
refreshed [1] 48/20
refreshes [1] 118/6
refused [1] 128/25
regard [4] 29/17 29/25 36/16 75/12
regarding [4] 87/3 191/14 191/24 193/1
regardless [1] 12/19
regional [1] 4/12
Register [3] 20/16 159/18 160/3
Registers [6] 19/25 20/19 139/11 159/11 159/12 159/23
registrations [1] 23/17
regretted [2] 175/19 176/15
regular [1] 130/6
Regulated [3] 123/21 124/6 129/22
Regulation [1] 129/23
Regulations [1] 129/23
regulatory [1] 23/16
rehabilitation [2] 109/12 109/21
reinforce [2] 138/16 182/25
reinforces [1] 183/1
reiterated [1] 56/13
relate [1] 127/15
related [1] 84/6
relates [1] 131/4
relating [6] 16/11 32/14 51/13 131/7 157/10 160/22
relation [15] 11/19 24/18 30/3 30/17 37/21 45/9 114/22 124/12 128/16 131/8 141/5 153/5 179/4 201/8 201/10
relations [3] 90/19 111/23 149/4
relationship [11] 7/22 8/10 8/10 19/3 90/13 90/24 91/3 105/20 106/1 106/5 127/1
relationships [16] 30/8 30/25 91/10 91/20 92/2 105/25 106/11 106/15 106/18 106/19 112/3 112/6 146/22 147/3 147/4 149/7
relaxed [1] 187/15
relaying [1] 71/11
release [2] 53/19 98/12
releases [1] 51/5
relevant [3] 70/9 70/14 124/11
reluctantly [1] 175/17
rely [1] 135/2
remain [6] 18/19 18/22 91/2 155/21 168/7 175/14
remained [1] 152/13
remarks [1] 69/8
RemCo [1] 108/19
remedy [1] 136/20
remember [90] 3/3 5/5 5/9 9/1 9/24 10/1 10/1 16/21 16/22 43/1 43/10 43/22 44/25 45/1 46/8 46/11 46/14 46/16 47/14 47/16 47/16 47/18 47/18 48/11 48/19 48/19 49/12 49/12 49/13 50/4 51/3 53/17 55/3 55/5 56/6 56/13 56/17 56/19 57/11 59/20 59/22 59/23 62/7 62/23 63/2 63/12 63/15 66/12 67/5 67/7 68/20 80/21 80/22 80/22 88/10 89/12 89/24 89/25 90/1 94/17 96/14 96/15 96/22 96/24 97/2 97/9 97/20 98/17 98/19 99/20 105/2 105/5 105/16 105/23 106/7 106/21 108/12 142/6 142/17 142/17 157/15 177/1 177/18 180/20 181/3 187/24 195/17 200/15 205/6 206/24
remembered [1] 161/11
remembers [1] 62/6
remind [2] 44/14 137/23
reminded [2] 46/9 121/15
removal [1] 177/4
remove [1] 58/13
removed [2] 175/21 194/13
removing [3] 58/11 169/2 201/8
remuneration [2] 108/21 109/20
repair [2] 91/5 92/1
repeating [1] 183/23
rephrase [1] 190/1
replicated [1] 183/10
replied [8] 59/14 76/5 169/5 170/6 172/6 186/21 196/19 207/22
reply [1] 94/25
replying [1] 169/12
report [77] 3/20 3/21 3/22 6/5 6/14 6/15 26/25 28/20 34/8 35/4 35/15 35/17 35/18 36/8 45/4 48/2 64/13 64/16 65/8 66/7 66/13 66/15 66/17 66/20 66/22 71/24 74/22 75/7 76/3 76/11 76/16 76/21 77/1 77/3 77/4 77/6 77/13 78/2 78/10 78/11 78/13 79/23 79/25 136/15 136/16 140/12 140/20 140/25 143/9 180/10 180/16 180/18 180/23 181/1 181/4 181/25 182/9 182/14 183/1 184/12 184/13 184/23 184/24 185/4 185/14 185/24 187/19 187/22 187/22 188/13 189/22 194/14 195/15 196/11 205/17 205/18 205/23
report's [1] 205/24
reported [14] 5/20 6/18 35/14 39/25 42/6 77/23 81/8 94/13 124/20 125/18 132/13 142/4 160/6 174/24
reporting [5] 17/17 125/20 126/17 126/19 155/5
reports [17] 14/7 14/9 14/9 14/11 14/11 34/13 63/1 125/14 125/15 126/7 140/24 141/2 158/3 185/14 189/20 195/22 195/23
represent [3] 70/9 114/17 202/25
representative [1] 10/17
represented [1] 192/21
representing [1] 70/13
reputation [6] 20/12 23/18 23/21 101/1 101/8 101/10
reputational [2] 21/1 21/4
request [3] 55/16 87/1 107/24
requested [4] 67/1 68/23 69/1 182/8
requesting [1] 174/21
require [3] 13/14 115/21 115/25
required [3] 79/1 79/21 130/11
requirement [2] 130/3 178/16
requirements [1] 28/18
requires [1] 124/10
research [1] 156/7
resignation [2] 112/14 112/19
resigned [1] 107/25
resolve [2] 90/23 91/17
resolved [1] 91/14
resources [1] 57/15
respect [7] 14/15 31/24 93/23 106/12 126/11 138/23 146/18
respond [5] 33/16 56/11 87/11 130/15 160/5
responded [5] 96/5 99/17 99/18 113/19 130/21
response [13] 80/4 95/7 95/9 95/17 96/13

R

response... [8] 99/14 102/3 102/13 168/9 175/16 177/17 198/3 207/4
responses [2] 99/21 170/22
responsibilities [6] 6/4 14/19 30/3 155/22 156/10 157/2
responsibility [14] 4/13 12/18 12/23 16/8 24/24 25/6 25/12 32/17 105/12 155/8 155/11 155/12 159/1 170/14
responsible [12] 4/5 10/11 10/22 12/13 13/9 16/4 30/19 40/1 41/14 154/11 154/14 166/3
rest [2] 181/14 190/8
restore [1] 90/23
restricted [1] 86/9
restrictions [1] 87/2
result [4] 37/20 149/8 150/12 187/11
results [3] 78/14 182/5 184/18
resuscitation [1] 56/11
retained [1] 51/16
retrospect [9] 55/19 174/22 182/12 190/9 195/7 201/2 202/13 203/9 203/10
return [6] 72/4 171/4 175/6 186/4 187/3 188/12
returned [1] 62/16
returning [2] 110/5 187/8
review [85] 5/22 19/20 23/7 27/16 35/4 35/7 35/10 35/10 35/13 36/5 36/6 36/16 37/2 37/7 37/12 37/21 42/3 42/6 42/15 43/5 43/17 45/4 46/3 46/6 47/5 47/9 47/15 47/17 48/13 49/3 54/21 55/1 57/6 61/24 71/24 72/1 72/7 76/17 77/8 79/15 79/21 82/6 82/6 98/10 110/8 110/25 114/3 114/7 117/3 130/4 131/3 131/9 160/15 160/16 163/21 171/18 171/23 172/1 172/2 172/14 173/4 173/14 174/14 175/9 178/5 178/6 178/12 179/7 179/14 181/17 182/4 182/4 182/25 183/2 183/14 184/4 188/4 188/5 188/6 188/6 189/10 191/17 191/20 191/22 196/18
reviewer [2] 35/20 79/20
reviewing [1] 16/5
reviews [12] 31/24 35/21 37/13 78/3 78/7 78/14 80/14 82/3 179/12 182/24 183/14 188/25
Rheinberg [1] 194/2
right [73] 2/20 11/2 22/19 26/18 45/3 45/15 46/10 49/14 53/8 66/11 67/13 69/19 71/14 71/16 71/17 74/13 79/9 85/5 89/15 93/21 103/2 108/11 111/15 112/9 112/9 116/1 116/8 123/23 125/21 129/7 132/6 132/14 135/14 136/6 141/4 141/9 148/20 148/20 156/19 156/22 169/21 170/16 177/1 181/5 181/8 181/22 182/12 182/16 187/11 190/2 190/4 190/25 192/8 192/20 198/21 200/1 200/4 200/14 200/25 201/3 201/16 202/1 202/12 203/13 203/14 203/16 205/21 205/22 205/25 206/5 206/14 206/22 207/4
right-hand [1] 22/19
rights [4] 101/2 101/13 101/14 101/17
rise [1] 209/3
risk [67] 11/23 12/25 13/6 15/25 16/5 17/17 17/24 18/4 19/11 19/12 19/14 19/14 19/24 20/8 20/16 20/18 20/20 21/1 21/4 21/16 21/20 21/24 21/24 22/4 22/6 22/7 22/11 22/17 23/10 23/17 24/5 24/6 24/8 24/8 27/10 27/19 33/7 58/11 58/13 58/13 62/17 62/18 82/17 94/6 126/1 126/16 126/20 126/20 139/4 139/11 157/10 159/11 159/12 159/15 159/17 159/17 159/18 159/19 159/22 160/2 169/2 202/6 205/6 205/7 205/10 205/12 205/13
risks [7] 5/11 5/11 20/7 22/19 23/7 24/10 75/25
road [1] 151/11
Robert [3] 26/24 27/25 28/17
robust [4] 13/7 33/8 137/22 150/19
role [21] 3/3 7/15 7/16 8/7 10/14 12/9 13/1 13/14 17/4 30/22 31/10 92/14 92/20 109/25 112/1 129/19 131/13 152/16 155/24 182/7 201/22
roles [5] 2/3 7/17 137/20 155/22 157/1
room [5] 56/21 57/9 91/25 165/16 203/11
Ros [1] 162/18
Ros Fallon [1] 162/18
rotas [1] 56/14
round [6] 84/22 84/22 85/3 96/25 97/2 176/2
rounds [1] 9/24
route [2] 196/23 197/9
Royal [9] 46/2 136/15 140/11 174/1 182/14 185/23 188/1 188/19 196/12
Royal College [7] 46/2 136/15 140/11 174/1 182/14 185/23 188/1
Royal College's [2] 188/19 196/12
running [2] 137/12 137/12
runs [1] 134/3

S

safe [12] 41/18 41/25 57/10 58/17 73/12 73/23 120/23 121/2 144/24 151/10 168/10 186/11
safeguard [1] 58/18
safeguarding [23] 4/22 5/1 5/7 6/3 6/23 7/2 7/9 24/12 24/16 24/18 24/22 25/17 26/1 27/2 27/13 30/23 33/7 135/22 139/5 156/14 157/2 157/10 203/15
safely [8] 6/3 25/4 25/10 33/24 139/5 157/11 157/21 158/21
safety [30] 12/14 16/9 16/11 17/18 17/23 17/25 18/4 18/9 19/17 20/4 20/24 20/25 22/8 25/19 30/2 34/18 37/24 38/4 58/18 74/7 101/3 119/20 141/1 154/15 155/8 168/1 170/15 177/6 189/12 205/10
said [83] 16/17 27/25 33/13 41/24 42/22 43/21 46/15 46/20 48/4 51/19 51/22 51/24 52/2 54/5 55/19 56/4 58/9 59/23 60/4 61/5 62/13 67/9 69/6 69/15 69/22 73/11 76/20 77/7 78/20 91/8 94/5 94/18 96/2 97/4 97/11 97/12 97/17 97/24 101/2 101/14 103/8 106/18 110/6 125/3 126/2 126/4 126/6 133/13 139/3 143/8 149/20 159/9 160/19 164/18 167/4 168/25 169/8 169/9 170/8 171/13 173/22 174/1 176/13 177/8 177/9 183/24 185/16 186/10 188/16 189/8 189/16 190/6 190/6 192/7 195/20 201/8 202/16 203/10 203/17 205/25 206/19 206/20 207/15
Saladi [1] 100/16
same [20] 11/6 25/15 40/15 43/18 48/9 49/20 90/25 91/25 93/4 96/16 109/13 119/9 119/9 138/9 138/24 158/5 164/8 183/9 184/9 207/23
Sara [1] 202/25
Sara Sutherland [1] 202/25
Sarah [2] 114/16 123/2
sat [2] 134/18 152/25
satisfactorily [1] 94/7
satisfied [1] 170/21
satisfy [1] 13/3
saw [18] 31/9 60/2 63/8 63/16 63/18 79/9 79/11 79/11 83/20 127/12 136/14 136/16 176/22 180/6 181/21 181/24 185/23 185/24
say [97] 11/13 26/18 28/3 28/11 29/4 30/6 31/9 32/11 32/24 34/16 41/21 41/22 42/18 43/16 47/5 47/8 47/10 47/14 47/20 55/14 55/24 55/25 56/4 57/23 57/24 60/12 61/4 61/13 61/14 65/3 69/18 71/6 71/8 75/21 77/21 78/15 78/17 80/10 80/12 85/2 91/2 92/12 93/18 94/12 96/19 99/1 99/12 100/3 102/20 104/14 108/3 112/6 122/14 133/25 141/17 144/11 144/18 144/21 144/23 146/5 150/13 155/15 156/12 159/6 161/22 162/22 164/15 164/16 164/24 165/10 165/15 166/9 166/14 166/15 167/25 168/24 173/3 175/11 176/14 176/17 177/11 179/19 180/18 183/18 184/2 187/5 187/7 187/15 188/2 190/20 192/16 193/25 194/14 200/6 200/11 201/7 205/2
saying [46] 16/21 35/14 42/1 42/2 44/15 44/23 46/5 46/25 47/4 47/9 52/18 56/6 57/9 59/20 62/4 63/12 72/19 74/16 81/25 86/16 86/18 92/13 92/18 94/9 97/9 113/19 121/18 122/2 129/14 130/14 134/5 141/8 156/21 157/5 165/18 165/25 167/13 171/10 178/23 185/9 185/11 188/23 190/3 198/16 198/17 198/21
says [31] 28/16 37/11 43/4 44/4 44/16 47/7 53/2 54/20 57/18 67/17 72/23 83/11 90/16 117/2 117/5 121/1 131/5 142/1 154/10 154/24 168/18 169/4 171/5 174/13 182/5 182/23 186/9 187/4 187/25 191/12 191/21
scarce [1] 57/15
scene [1] 162/17
school [1] 134/8
scope [1] 8/4
screen [12] 3/12 10/6 26/23 28/13 40/12 52/16 54/4 83/7 96/8 98/7 99/13 182/22
scripted [2] 21/13 21/14
scroll [2] 22/20 95/3
scrutinise [5] 155/3

S

scrutinise... [4] 155/25 158/23 182/7 189/14
second [6] 73/9 116/17 118/9 148/24 173/12 175/11
secondary [1] 188/4
Secondly [1] 188/18
secondment [4] 110/2 112/14 112/16 112/17
Secretary [1] 2/19
section [5] 124/8 132/22 148/15 157/22 187/25
section 20 [1] 124/8
Sections [1] 127/15
see [148] 2/19 3/14 4/13 10/10 12/12 13/15 14/18 16/2 17/16 17/18 17/22 20/7 20/7 20/11 20/16 20/19 22/17 22/22 23/1 23/4 23/20 24/13 24/23 25/3 27/4 32/1 34/23 34/24 35/16 36/1 36/3 38/7 38/25 41/17 42/18 43/21 44/5 49/10 51/2 57/18 59/1 63/6 63/20 64/2 64/3 64/9 64/15 66/13 66/14 66/15 66/17 68/22 69/1 71/21 72/8 72/12 73/13 73/25 74/9 77/10 79/10 79/12 79/24 80/14 82/11 82/21 82/22 82/25 83/10 83/10 83/21 88/11 89/9 92/1 92/1 92/5 92/12 94/20 94/24 95/4 95/4 95/11 96/7 96/13 100/10 100/23 102/14 103/6 107/8 112/12 116/22 116/25 117/11 117/13 117/17 120/4 120/7 120/10 120/14 120/24 121/7 121/17 121/20 123/5 123/24 127/17 135/13 137/25 140/23 154/18 157/21 159/7 159/20 160/19 163/11 165/4 166/11 167/17 168/8 168/17 169/11 169/24 170/21 172/2 173/19 174/5 174/11 176/20 177/24 181/16 182/9 182/20 183/12 186/12 186/20 188/9 191/11 193/18 194/21 195/3 196/1 196/2 196/17 197/21 197/22 198/24 201/9 205/15
seeing [7] 51/3 53/17 64/13 96/9 187/23 206/16 206/17
seek [1] 42/3
seeking [4] 10/3 50/20 73/18 73/24
seem [2] 86/19 117/24
seemed [2] 164/20 177/4
seems [8] 118/9 118/25 133/6 169/3 169/3 171/20 174/17 178/18
seen [18] 34/9 63/16 71/13 81/16 92/7 95/16 95/18 107/3 124/23 159/12 163/8 165/15 171/12 171/12 185/4 186/1 188/5 192/7
seldom [1] 109/22
Semple [1] 126/6
send [7] 3/8 94/11 95/7 95/11 96/11 106/23 141/9
sending [4] 3/7 88/3 98/17 98/19
sends [1] 92/6
senior [11] 1/20 14/22 14/25 15/2 71/10 86/10 87/17 111/23 137/16 149/4 179/16
sense [9] 10/2 32/23 39/22 44/17 74/4 93/7 93/9 173/19 176/11
sensible [2] 16/24 176/5
sensitive [1] 180/20
sensitivity [1] 100/13
sent [14] 62/25 65/8 67/14 83/10 83/22 95/2 95/16 95/20 96/7 98/6 99/14 140/16 178/1 192/9
sentence [4] 169/22 173/12 173/13 182/22
separate [4] 9/11 42/9 118/24 123/18
separately [1] 195/3
September [14] 22/15 23/7 36/1 68/1 99/8 103/13 107/8 174/9 178/2 178/2 178/13 178/20 179/25 195/23
series [2] 82/8 124/12
serious [8] 6/5 24/5 24/6 83/13 84/15 90/19 98/3 138/8
seriously [4] 97/23 98/1 98/5 157/25
seriousness [1] 156/9
serve [4] 3/17 115/6 121/23 153/22
service [12] 1/22 2/7 2/25 3/9 20/12 30/19 30/21 35/13 121/3 124/10 135/12 144/21
services [7] 12/15 25/8 90/22 91/15 154/16 169/6 178/7
serving [2] 109/9 150/25
session [1] 11/18
sessions [1] 119/8
set [14] 5/24 8/1 37/15 40/5 40/7 49/21 72/13 72/25 132/12 146/25 160/2 162/17 173/1 176/16
sets [4] 100/16 100/18 124/7 179/1
setting [3] 10/14 72/8 131/5
settlement [2] 109/19 131/11
settlements [1] 109/21
seven [1] 131/5
several [3] 1/20 67/24 146/1
share [3] 17/25 51/9 51/11
shared [20] 19/7 27/6 27/12 27/17 29/7 37/8 74/23 90/20 96/14 96/20 111/13 144/11 144/12 153/1 163/12 178/9 184/14 184/24 205/18 205/24
sharing [1] 7/4
she [54] 21/14 21/22 21/23 22/3 30/22 35/15 35/15 49/7 57/4 57/6 57/7 61/22 62/13 62/16 62/17 62/17 68/10 78/6 78/25 79/5 79/7 80/2 80/14 83/25 84/7 84/24 84/24 84/25 86/19 87/3 87/24 104/24 106/7 107/3 113/18 126/10 129/17 132/8 136/3 136/11 136/12 136/14 177/8 177/8 178/16 187/17 191/1 194/11 194/13 202/22 205/4 205/5 205/7 205/10
she's [5] 48/16 49/3 74/3 84/13 104/3
shed [1] 45/6
shift [1] 9/19
shifts [1] 22/4
Shipman [3] 46/21 46/23 115/14
short [12] 32/6 32/9 52/14 104/16 132/22 134/3 145/16 149/17 157/22 178/8 188/8 191/4
short-term [1] 178/8
shorthand [2] 190/17 190/23
shortly [1] 163/16
should [107] 3/16 5/19 5/20 6/12 6/14 6/15 6/18 8/3 12/10 13/3 13/12 13/16 14/13 19/7 20/25 25/22 27/16 29/13 32/15 33/12 38/13 38/15 38/15 38/18 46/2 46/10 50/24 55/17 57/4 57/5 57/6 58/16 61/23 62/25 62/25 64/15 65/8 66/13 66/14 66/15 67/22 75/15 76/18 80/5 80/9 81/13 81/25 88/7 89/24 99/12 103/21 112/22 113/18 119/14 119/17 122/4 122/6 123/3 123/11 124/20 124/22 125/17 133/8 135/18 135/21 138/20 138/21 139/10 140/1 140/1 140/23 142/19 144/10 144/12 149/13 154/25 155/3 159/2 168/6 168/7 174/13 174/20 175/14 176/10 176/10 179/15 179/22 179/23 180/1 180/2 182/8 183/16 184/5 184/7 184/16 188/20 195/7 197/10 197/11 197/15 198/12 202/13 202/14 203/7 203/11 208/5 208/7
shouldn't [6] 55/22 57/10 108/1 119/15 140/8 140/8
show [2] 50/25 68/11
shown [2] 66/20 177/25
sic [1] 152/4
side [4] 22/18 22/19 67/8 102/23
sidelined [1] 94/4
sides [3] 92/14 92/17 103/4
sighted [2] 137/18 137/18
sign [3] 51/4 51/7 112/20
signed [1] 128/3
significance [1] 170/17
significant [3] 132/16 156/13 163/20
signs [1] 115/17
Silver [3] 49/21 49/25 82/7
similar [5] 28/18 52/1 103/19 109/21 141/4
simple [3] 155/19 155/20 185/18
simply [4] 49/2 112/5 197/7 203/14
Simpson [11] 104/24 105/2 105/4 105/12 105/15 105/18 105/19 108/9 108/13 109/11 129/16
since [8] 6/21 27/24 81/11 86/17 166/16 179/15 181/3 190/17
since July 2015 [1] 179/15
single [10] 59/2 59/3 183/4 188/25 190/5 190/5 190/23 191/23 193/7 194/15
singled [2] 86/20 128/4
Sir [52] 1/7 1/8 1/10 1/13 3/12 5/24 7/13 20/17 22/13 26/24 26/25 27/25 28/13 28/17 29/5 34/20 36/25 37/1 40/14 46/2 47/24 49/20 52/17 58/12 58/21 61/5 76/15 77/21 78/15 82/17 92/7 101/6 103/21 103/25 104/21 114/10 114/14 131/23 134/14 138/9 138/23 141/16 142/23 143/4 144/17 145/12 148/23 151/16 163/11 163/11 177/13 210/3
Sir Duncan [44] 1/8 1/13 3/12 5/24 7/13 20/17 22/13 26/25 28/13 29/5 34/20 36/25 37/1 40/14 46/2 47/24 49/20 52/17 58/12 58/21 61/5 76/15 77/21 78/15 92/7 101/6 103/21 104/21 114/10 114/14 131/23 134/14 138/9 138/23 141/16 142/23 143/4 144/17 145/12 148/23 151/16 163/11 163/11 177/13
Sir Duncan Nichol [3] 1/7 1/10 210/3
Sir Robert [3] 26/24 27/25 28/17

S

sit [6] 1/12 46/24 89/3 109/19 151/24 208/25
site [5] 9/12 107/12 108/2 108/2 177/10
sitting [4] 152/24 170/13 180/16 209/1
situation [14] 46/21 82/18 87/7 102/17 112/9 144/22 149/11 159/14 164/3 186/4 192/14 199/20 202/4 202/18
situations [1] 102/18
six [6] 48/2 48/14 49/4 108/10 108/22 147/16
six months [2] 108/10 108/22
skills [3] 12/19 13/13 170/2
sleepless [2] 176/17 189/5
slightly [5] 60/25 108/25 117/7 123/18 169/4
small [2] 21/7 21/7
so [201] 2/22 3/6 7/1 7/9 7/17 8/18 9/23 14/10 15/8 15/15 17/4 18/21 22/5 22/16 22/18 25/17 26/6 27/13 28/11 28/23 31/14 34/24 35/1 35/9 36/1 36/16 37/5 38/7 39/24 41/11 41/24 42/14 45/3 46/10 47/9 48/3 49/22 50/21 52/9 53/15 53/17 53/23 55/2 55/9 56/6 57/16 62/4 63/8 64/5 65/21 66/10 67/11 68/1 68/2 69/10 70/12 71/14 72/5 72/9 72/19 73/2 73/21 74/14 78/19 79/13 82/5 83/19 85/2 85/8 85/22 86/3 88/11 88/11 88/14 88/25 89/2 91/12 94/8 95/3 95/8 98/9 99/15 99/17 101/22 102/10 102/22 102/25 103/4 103/13 103/23 105/1 105/14 106/17 107/18 108/2 108/2 108/22 108/24 109/17 109/23 111/12 113/6 113/21 116/3 117/8 117/23 118/8 118/23 119/1 120/3 120/7 120/18 121/17 121/21 122/1 122/19 124/19 125/13 126/12 126/19 129/18 130/25 132/4 132/18 133/9 133/10 134/1 134/6 134/16 135/12 136/6 138/3 139/10 139/10 139/12 139/22 139/25 140/21 141/7 141/24 143/25 145/5 145/5 145/19 146/21 147/5 147/11 148/22 150/3 151/2 156/2 157/3 157/4 157/19 161/3 164/10 164/13 168/11 169/16 169/25 170/8 171/3 173/12 173/18 174/17 175/4 176/10 181/10 182/2 182/10 183/1 183/15 183/23 184/18 187/14 187/18 187/22 189/1 190/9 190/25 191/1 191/10 192/10 192/11 192/13 192/20 192/25 193/11 193/20 194/24 195/9 196/1 196/17 196/21 199/20 205/9 206/18 207/3 208/4 208/16 209/3
Social [3] 123/21 124/6 129/22
some [48] 7/13 8/15 13/24 40/16 44/17 45/20 47/6 53/2 53/3 55/7 58/13 59/25 73/16 79/11 82/8 84/16 89/11 94/17 99/18 99/19 101/16 102/10 104/16 113/9 114/17 118/6 128/23 135/13 136/15 137/21 144/7 144/18 150/11 156/24 156/25 160/8 163/5 166/10 173/20 176/2 177/2 179/9 180/6 191/22 195/18 196/13 199/5 204/7
somebody [3] 85/7 114/5 115/25
someone [12] 26/5 47/12 51/19 51/24 85/10 86/4 113/10 113/12 113/21 113/24 138/10 138/11
someone's [1] 102/16
something [27] 10/15 27/23 46/22 47/7 52/1 60/25 63/12 81/4 100/3 102/22 106/16 109/17 111/16 125/2 137/8 144/18 144/25 145/24 149/18 149/23 167/13 172/20 180/5 182/10 183/15 184/13 194/4
sometimes [2] 63/23 102/13
somewhat [2] 136/18 139/22
somewhere [6] 31/5 145/21 184/10 195/20 206/22 206/23
soon [5] 67/7 87/6 103/11 180/6 187/8
sooner [4] 97/8 97/18 174/16 174/21
sorry [42] 1/5 8/24 23/12 39/10 44/2 48/7 48/22 56/2 56/3 72/8 85/22 95/1 96/9 97/1 97/6 98/18 100/2 102/25 113/23 118/11 121/13 122/24 128/22 142/25 145/5 145/5 148/13 148/15 154/19 159/6 168/13 169/17 169/19 173/7 173/9 173/10 173/11 173/13 190/16 190/24 199/10 205/2
sort [2] 45/10 176/17
sought [4] 62/11 67/8 80/25 109/10
sound [1] 33/8
sounds [4] 16/24 84/12 138/23 165/20
sources [1] 190/13
space [3] 10/4 10/4 10/5
sparingly [3] 18/23 18/24 18/25
speak [23] 6/2 9/16 9/17 15/16 25/4 25/18 26/2 26/5 33/24 62/1 96/17 105/14 105/14 113/7 115/25 139/5 156/15 157/11 157/21 158/20 164/7 177/8 193/2
Speak out [6] 25/4 33/24 139/5 157/11 157/21 158/20
speaking [7] 84/13 105/2 157/12 159/4 168/14 182/24 184/18
special [3] 15/9 41/23 119/23
specialist [2] 29/14 37/6
specific [2] 7/17 14/9
specifically [2] 159/20 188/10
specifics [1] 14/3
speculated [2] 100/25 101/7
speed [1] 37/19
spend [1] 153/14
spike [2] 21/18 119/19
spoke [7] 54/11 102/24 105/2 105/3 108/6 108/6 113/12
spoken [3] 73/22 113/10 121/11
spokesman [1] 56/16
spot [3] 31/5 47/3 63/17
staff [46] 5/6 6/5 10/20 11/8 17/24 17/25 25/6 25/15 27/9 27/18 43/6 43/11 46/4 58/7 65/20 65/21 66/3 67/8 67/23 68/3 72/3 74/10 86/1 86/2 86/20 87/17 99/7 99/8 100/8 104/22 108/4 120/21 121/3 122/25 130/10 136/14 157/24 158/9 159/16 159/17 168/21 169/10 169/13 172/8 188/11 198/4
staff's [2] 5/19 177/7
Staff-Side [1] 67/8
staffing [4] 30/4 30/20 120/23 172/3
stage [9] 92/21 119/16 152/19 167/4 168/5 185/20 186/7 193/11 196/24
stages [1] 38/16
stakes [2] 57/24 166/17
stand [3] 17/13 151/19 153/18
standardisation [1] 126/2
standards [3] 12/25 25/8 158/4
standing [2] 98/13 101/10
start [6] 52/12 78/21 103/24 132/21 191/2 208/23
started [3] 104/8 155/15 190/17
starting [2] 67/12 121/2
state [2] 2/19 21/15
stated [16] 55/14 57/22 58/21 61/22 72/13 74/22 76/15 78/6 165/5 165/10 166/13 167/14 189/23 191/13 193/20 205/17
statement [47] 1/14 5/16 8/9 16/18 19/9 28/25 29/4 34/16 35/19 37/9 40/21 73/14 77/21 77/24 77/25 88/4 88/6 88/8 88/15 110/6 125/3 127/6 131/2 132/21 132/22 132/25 133/24 141/17 142/1 152/4 156/12 162/22 164/15 164/16 164/24 166/25 173/2 173/23 175/2 176/16 177/11 186/13 186/14 186/15 186/17 199/6 207/17
statements [2] 73/19 193/13
stating [1] 39/8
status [1] 12/19
statutory [1] 197/13
stayed [1] 81/10
staying [1] 202/5
step [7] 120/19 120/19 137/24 163/20 195/11 197/24 207/11
Stephen [5] 29/9 31/17 94/15 117/25 120/18
Stephen Brearey [1] 120/18
Stephen Cross [3] 29/9 31/17 117/25
stepping [2] 148/25 207/14
steps [5] 13/13 122/17 123/11 124/13 136/5
Steve [5] 120/11 120/18 121/8 121/17 122/1
Steve B [1] 120/18
Steve Brearey [2] 121/17 122/1
stick [1] 163/13
still [20] 6/9 11/14 57/7 70/4 81/11 81/12 86/19 104/7 120/22 144/19 184/4 187/16 192/17 194/17 194/19 196/14 196/19 196/22 199/23 202/11
stillbirth [1] 38/25
stillbirths [1] 35/5
stop [1] 63/5
stopping [2] 123/14 123/16
stored [1] 51/14
story [1] 103/17
straight [3] 4/21 20/4 59/15
strain [3] 111/24 149/5 149/8
strategic [1] 76/17
strategy [5] 12/11 13/1 15/25 126/20 155/1
strength [2] 81/6 184/1
stress [2] 99/2 144/23
stressful [3] 145/1

S

stressful... [2] 149/11 169/14
stretch [1] 191/1
strict [1] 27/20
strong [1] 128/17
stronger [2] 60/8 165/21
structure [1] 33/1
structures [1] 19/16
study [1] 3/1
stuff [1] 192/9
style [1] 98/22
sub [1] 15/4
sub committees [1] 15/4
subject [3] 76/16 156/24 157/25
submitted [1] 67/20
subscribe [1] 129/13
subsequent [1] 170/21
subsequently [4] 152/9 172/17 177/25 187/5
subtle [1] 115/18
succeed [1] 138/20
succeeded [1] 107/25
succession [1] 39/2
succinctly [1] 94/13
such [6] 45/9 51/5 76/9 106/2 140/24 200/1
sudden [3] 6/14 52/23 60/15
suddenly [1] 74/2
Sue [2] 43/9 118/1
Sue Hodkinson [2] 43/9 118/1
suffering [1] 97/7
sufficient [4] 58/17 60/24 81/2 153/8
sufficiently [3] 34/3 137/18 146/14
suggested [13] 16/17 70/2 75/21 76/8 79/6 81/4 107/9 135/4 135/5 191/19 193/22 194/1 196/22
suggesting [2] 65/8 66/12
suggestion [2] 90/8 196/12
suggests [3] 55/6 82/14 84/19
suit [1] 104/15
suitably [1] 28/10
summaries [1] 79/11
summary [7] 18/23 26/25 37/2 146/6 171/20 188/8 192/1
summing [1] 61/16
supervised [8] 4/11 57/4 57/5 57/7 57/12 72/17 74/1 168/7
supervising [1] 167/14
supervision [8] 58/7 62/3 74/6 122/21 168/21 172/8 175/6 175/15
support [14] 72/1 72/3 76/16 87/22 87/25 98/25 136/13 137/16 164/22 166/6 172/21 186/25 188/11 201/13
supported [2] 72/18 76/17
supportive [1] 98/23
supports [1] 42/15
suppose [5] 49/2 66/16 150/7 151/1 194/16
supposed [1] 75/7
sure [29] 4/7 13/5 14/13 17/14 21/25 34/22 38/21 39/7 39/9 39/10 42/6 50/12 52/4 57/11 73/4 90/7 90/18 92/7 100/5 102/6 106/14 111/12 119/16 138/22 140/5 151/7 151/12 176/2 198/8
surprise [1] 194/4
surprised [4] 16/25 168/3 177/16 206/6
surprises [1] 19/8
surprising [1] 85/19
surrounding [3] 7/9 38/1 104/22
surroundings [1] 11/10
suspect [2] 162/13 164/8
suspected [2] 21/21 34/9
suspicion [5] 22/6 53/13 59/8 77/10 160/25
suspicions [9] 5/6 5/18 11/1 57/1 77/17 93/2 142/12 164/5 198/16
suspicious [3] 52/24 60/13 60/22
Sutherland [11] 114/11 114/12 114/16 118/11 131/20 202/21 202/23 202/25 208/14 210/5 210/11
sweet [1] 47/3
sworn [4] 1/10 151/22 210/3 210/9
sympathetic [1] 137/15
system [11] 6/8 19/11 19/13 19/14 113/8 126/12 135/6 139/16 147/6 150/16 200/10
systems [18] 13/6 33/5 33/6 33/9 125/2 125/4 125/6 125/10 125/18 139/4 139/7 150/9 150/13 150/14 150/19 150/21 150/25 151/3

T

table [3] 23/8 23/9 176/2
take [62] 4/24 7/19 9/7 13/13 16/18 18/21 20/3 20/6 28/7 34/19 43/17 44/9 44/17 46/10 47/5 47/10 47/21 47/23 48/2 48/3 49/4 52/10 55/9 56/23 57/6 59/18 59/21 61/6 70/15 71/17 79/5 79/7 80/15 92/8 92/14 95/14 97/22 100/7 103/21 107/11 108/8 112/18 117/3 119/21 121/9 133/9 134/5 134/7 134/24 137/2 145/9 148/17 148/23 151/19 157/22 171/7 188/20 190/11 190/23 191/1 197/19 199/5
taken [13] 17/14 50/7 50/13 58/25 74/19 96/5 96/5 132/19 147/12 163/18 178/14 180/14 195/19
takes [3] 43/18 86/25 117/4
taking [8] 4/17 31/24 32/9 58/16 92/23 101/4 122/20 204/16
talk [8] 9/20 9/20 9/21 11/21 47/11 125/2 137/21 157/16
talked [5] 43/14 86/8 87/12 105/10 121/23
talking [9] 15/22 24/8 36/3 45/1 78/9 79/15 133/1 181/17 195/25
tangent [1] 169/4
tape [1] 60/1
task [1] 153/8
tasked [1] 2/21
TC [3] 107/12 107/16 120/15
teach [1] 115/17
Teaching [1] 154/2
team [18] 7/18 22/4 31/4 31/6 31/7 36/6 36/16 62/18 64/11 84/17 91/11 118/9 118/10 118/10 165/2 178/8 178/12 179/7
teams [2] 30/16 30/17
technically [1] 110/1
telephone [1] 113/2
tell [36] 1/20 2/4 3/25 5/16 10/15 18/14 29/9 29/20 33/23 35/9 35/19 40/22 41/4 41/5 42/7 49/24 54/12 54/25 63/24 66/10 78/8 80/24 90/16 96/2 97/11 103/17 105/6 106/4 113/25 135/7 139/15 141/21 142/4 177/15 193/8 198/23
telling [4] 29/14 136/12 142/13 198/19
tells [5] 21/14 28/17 62/13 71/13 80/2
ten [3] 103/24 104/6 190/20
ten minutes [1] 190/20
tension [1] 165/1
term [3] 109/23 134/3 178/8
terminated [1] 110/2
terminology [2] 147/22 204/22
terms [37] 6/4 14/6 17/5 20/6 21/21 23/19 37/16 37/23 57/14 64/13 70/12 75/24 77/16 86/24 87/25 92/16 93/12 109/19 110/11 111/19 124/20 140/2 152/7 155/19 156/22 157/8 157/15 159/11 164/13 171/22 172/11 172/13 179/12 179/19 180/23 182/9 202/15
test [3] 27/13 28/19 114/4
testimony [2] 192/3 206/16
testing [1] 150/15
text [1] 63/8
than [13] 21/8 25/23 44/22 48/4 53/16 109/22 139/2 152/22 158/25 165/21 173/6 173/16 193/12
thank [62] 3/13 5/15 7/14 10/10 12/6 24/11 28/8 28/12 28/23 37/4 39/13 49/17 52/6 52/9 52/11 53/20 91/7 92/11 95/15 103/20 104/13 111/12 114/9 114/13 114/16 114/19 117/19 123/20 131/18 131/19 142/22 142/22 142/24 144/13 144/14 144/20 145/7 145/10 145/24 148/9 148/14 148/20 149/16 150/6 151/13 151/15 151/17 155/7 158/18 170/3 178/6 190/14 190/22 192/23 199/4 202/19 202/24 208/12 208/13 208/18 208/19 208/21
that [1410]
that's [56] 11/1 16/23 17/1 22/6 22/7 22/24 23/3 24/12 36/22 52/6 57/10 63/4 63/24 69/18 72/5 74/17 81/20 82/12 95/8 96/21 99/15 100/10 103/2 103/4 109/17 114/1 116/8 122/4 125/20 126/22 132/5 133/12 139/10 152/12 156/24 166/6 166/6 169/20 170/20 176/10 177/19 177/20 177/20 179/4 180/16 182/21 183/9 187/4 189/15 191/12 196/2 196/5 197/3 197/4 197/9 206/20
their [46] 10/13 10/13 10/23 12/9 12/19 13/1 13/12 13/14 14/21 15/9 15/9 17/5 18/9 25/13 30/14 37/22 65/2 73/11 73/19 76/12 79/16 84/18 93/19 94/4 94/6 95/2 97/22 99/4 100/7 100/8 102/14 103/10 103/14 103/17 123/8 123/8 123/10 144/25 157/17 158/24 186/10 194/18 200/4 201/11 201/25 202/10
them [57] 7/10 7/13 13/11 20/7 25/22 26/1 26/6 32/8 32/10 33/11 33/11 34/4 34/9 34/9 40/20 50/8 54/12 55/4 55/7 75/22 77/24 80/16 84/25 88/5 90/9 93/12 93/25 94/1 95/3 95/3 98/5 99/13 102/15 103/17 103/22 113/25 115/25 125/6 125/10 128/16 130/11 140/3 141/12 141/13 141/14 143/17 150/11 157/13 160/6 163/16 164/9 172/7 179/9 195/3 198/19 201/17

T

them... [1] 205/24
Thematic [1] 19/19
theme [4] 121/8 121/19 123/1 174/12
themselves [8] 13/3 15/16 15/23 20/3 26/3 43/14 72/10 199/25
then [122] 2/19 6/6 6/10 19/24 21/6 22/4 33/12 33/12 33/19 35/3 40/10 40/15 41/20 42/10 42/18 42/22 45/8 47/7 48/9 55/1 55/9 56/13 57/18 73/24 74/2 74/2 74/7 76/2 78/8 78/19 80/19 80/24 81/11 81/13 81/17 82/5 82/6 83/14 89/23 90/4 90/16 93/15 94/20 95/4 95/7 99/12 99/25 102/16 102/23 105/3 105/7 108/17 108/25 117/13 117/19 118/16 119/4 120/16 121/5 123/2 132/24 136/6 138/9 141/8 143/8 144/3 144/11 146/2 149/1 149/16 150/7 150/24 150/24 154/13 154/17 154/18 155/2 158/5 158/10 158/12 164/6 165/9 166/8 168/23 169/14 170/4 171/17 172/3 172/10 174/2 174/11 175/1 175/4 176/10 177/8 177/12 177/20 178/11 179/6 181/9 183/12 184/20 184/23 186/19 186/24 188/8 191/18 191/21 192/23 193/14 194/12 194/18 195/8 196/7 196/13 196/17 198/2 199/9 199/18 202/4 203/8 203/11
there [238]
there's [26] 24/5 42/24 47/11 48/15 49/3 51/25 58/3 66/24 72/14 77/9 81/20 91/19 91/19 95/7 99/2 132/22 143/11 150/20 172/20 172/21 187/9 195/9 198/2 202/8 202/9 206/23
Thereafter [1] 119/4
therefore [5] 83/18 87/1 141/12 141/14 178/25
these [52] 1/23 7/12 18/7 31/24 34/20 40/4 40/5 40/19 42/12 45/17 51/19 59/1 60/21 72/9 74/18 83/15 84/21 84/21 95/2 95/2 95/19 98/3 99/3 104/17 109/25 111/21 118/22 118/22 119/17 122/8 122/19 122/19 123/3 123/6 123/12 124/19 125/24 128/12 129/12 129/12 130/13 130/20 133/1 141/4 143/20 149/2 157/11 159/12 163/24 187/11 195/22 195/25
they [188] 4/13 5/12 6/6 6/15 7/5 10/16 10/17 13/3 13/14 13/23 13/25 14/12 15/1 15/5 15/15 15/16 15/19 15/23 17/7 17/7 17/9 17/12 19/22 19/23 19/23 19/24 19/25 20/1 20/2 20/2 23/14 23/14 25/9 26/2 26/5 26/6 26/15 26/19 26/20 29/13 32/5 32/7 32/9 32/15 32/18 33/8 33/11 33/12 33/12 33/13 34/4 34/23 34/24 36/18 38/7 38/10 40/19 41/22 41/22 42/7 50/25 51/14 51/16 55/25 56/11 57/5 59/15 59/18 59/21 60/4 60/12 60/16 60/22 62/25 64/15 64/18 65/1 66/10 66/12 66/13 66/14 66/15 66/17 69/16 69/21 69/22 69/25 70/2 71/11 73/24 75/15 75/15 77/8 77/11 80/15 84/24 86/2 88/7 91/2 91/23 93/2 93/5 93/24 93/25 94/2 94/4 94/6 94/9 94/9 94/22 94/22 97/14 97/16 97/21 97/25 98/4 98/4 99/4 99/4 99/19 102/3 102/7 102/8 102/17 103/13 106/18 110/17 110/17 110/18 115/21 115/25 119/14 119/15 123/9 124/19 124/22 126/4 128/17 128/25 134/24 139/5 139/9 140/4 144/4 145/22 145/22 145/22 149/14 159/25 160/6 167/10 167/11 169/2 169/14 171/7 172/5 174/24 178/5 178/11 178/13 178/19 178/23 178/23 182/17 183/13 183/14 184/2 184/4 185/2 188/2 190/3 190/6 190/7 193/8 193/8 193/9 195/2 195/22 195/23 195/24 198/16 200/1 200/16 201/5 206/4 206/5 207/1 207/2
they're [1] 92/2
They've [1] 71/7
thick [1] 137/24
thing [8] 33/15 57/14 76/9 89/17 102/5 102/6 118/25 141/9
things [15] 14/13 20/3 63/25 76/7 86/22 105/13 135/16 138/15 142/4 146/8 158/13 160/3 180/1 182/19 187/9
think [213]
thinking [16] 6/21 47/12 47/16 65/5 81/16 91/17 102/25 134/18 134/19 135/5 140/2 157/15 164/2 191/25 194/6 208/4
third [4] 58/5 157/23 168/19 186/20
Thirdly [1] 188/20
THIRLWALL [2] 145/15 210/8
this [294]
thorough [2] 83/16 158/1
thoroughly [1] 39/5
those [75] 2/4 3/17 4/11 6/15 8/15 9/24 11/9 11/9 11/15 14/5 15/6 15/10 18/12 19/24 20/4 23/23 24/1 24/10 26/21 26/21 29/17 30/5 38/24 39/3 39/24 51/16 98/1 99/23 102/10 102/10 106/14 106/17 110/11 110/12 111/4 111/12 114/9 115/7 115/16 116/16 119/22 121/24 122/10 125/10 129/13 131/8 135/23 137/17 137/18 139/6 139/6 143/11 145/20 151/13 157/15 158/13 158/20 159/2 162/2 162/3 163/15 165/3 168/12 170/23 182/18 186/1 186/2 188/17 190/13 193/3 193/3 200/21 206/24 208/14 208/15
though [7] 47/9 47/20 54/8 69/17 73/21 102/14 202/22
thought [49] 7/5 18/22 28/25 31/3 31/3 31/6 32/3 33/8 33/21 47/15 50/13 50/19 51/20 58/16 60/7 62/4 64/14 64/14 66/2 68/10 68/15 69/12 74/16 78/23 79/1 81/5 83/25 84/5 84/6 89/21 89/22 90/3 108/7 138/12 139/1 147/21 147/22 148/2 153/13 172/18 173/23 173/25 187/17 194/5 198/7 198/12 199/23 200/6 205/12
thoughts [3] 122/19 140/4 200/4
threat [1] 128/24
threatened [1] 128/18
threatening [1] 127/19
three [21] 8/14 9/3 9/5 9/6 10/20 10/20 34/20 38/24 38/24 44/5 48/9 108/16 108/24 109/10 146/12 152/19 153/6 153/6 153/7 153/15 166/11
three days [1] 153/7
three months [3] 108/16 108/24 109/10
three quarters [2] 44/5 166/11
three weeks [1] 38/24
three-year [1] 9/6
through [34] 8/2 14/7 15/10 18/6 19/10 19/12 19/16 22/16 32/3 38/12 42/12 44/10 44/21 50/13 89/3 92/8 95/3 121/23 125/18 135/21 135/21 139/12 139/17 139/18 139/19 141/7 145/12 147/6 150/23 150/23 150/23 194/10 194/11 199/9
throughout [2] 2/24 16/6
Thursday [1] 120/4
tick [1] 135/6
tie [1] 180/25
Tighe [2] 100/23 101/19
time [125] 2/16 3/10 3/22 4/3 4/15 6/11 6/20 6/20 6/21 6/25 7/3 11/18 11/21 19/22 21/19 21/23 25/15 25/21 26/11 26/15 27/24 32/2 32/23 36/13 36/15 37/1 37/5 38/22 41/9 50/15 51/12 51/16 53/17 53/19 56/7 58/13 60/3 60/6 60/24 61/3 62/10 62/12 62/20 64/24 66/21 69/18 71/12 74/1 74/4 75/1 77/12 78/6 78/23 81/15 81/25 82/9 84/24 85/3 87/4 88/8 92/8 93/4 93/7 95/14 97/21 98/9 103/18 104/4 104/5 111/3 119/18 132/5 132/9 132/13 133/10 134/6 134/8 134/14 137/9 142/10 145/1 148/17 148/23 152/18 155/6 155/13 160/4 160/7 163/2 163/3 167/19 170/13 172/19 173/3 173/23 176/6 176/14 177/2 177/25 180/8 187/8 190/10 191/25 192/14 192/15 192/19 192/25 193/5 195/18 197/15 198/9 198/20 199/23 200/7 200/12 200/13 201/3 202/7 202/16 202/17 202/17 202/18 206/1 206/11 206/17
timely [4] 6/10 13/10 183/4 183/22
times [4] 8/14 9/3 9/13 25/9
timescales [1] 70/17
timing [5] 55/6 57/2 171/24 174/6 179/19
timings [2] 21/25 56/15
tiny [1] 25/22
today [11] 48/20 91/8 107/4 115/24 117/14 117/21 124/14 127/8 131/3 156/25 208/17
today's [1] 98/12
toe [1] 94/3
together [8] 7/3 7/19 8/17 24/2 31/4 91/19 130/23 174/16
toing [1] 99/19
told [43] 27/23 28/24 29/12 37/5 37/9 42/14 43/10 69/25 76/11 78/3 79/22 104/24 105/19 106/7 114/1 115/24 126/23 142/6 142/10 142/16 143/6 161/9 162/14 162/15 164/4 181/4 184/3 184/13 185/19 187/10 193/6 196/11 198/7

T

told... [10] 198/9 198/12 201/4 202/17 205/1 205/3 205/4 205/7 205/23 206/4
tomorrow [4] 208/16 208/23 208/25 209/3
tone [2] 75/23 127/18
Tony [17] 31/16 94/14 110/8 110/20 117/25 126/23 126/24 127/15 128/7 129/8 129/14 129/18 145/20 147/8 148/25 177/8 178/10
Tony Chambers [7] 31/16 128/7 129/8 129/14 129/18 145/20 178/10
Tony's [1] 112/13
too [2] 169/14 190/17
took [24] 4/22 11/17 11/17 38/6 71/11 71/12 71/14 71/15 71/16 96/3 98/1 98/5 104/24 115/5 118/23 122/10 124/24 126/6 136/5 137/11 164/22 177/5 202/2 202/8
top [8] 20/11 23/10 109/18 120/4 120/14 168/24 171/4 182/1
topic [3] 51/5 123/19 135/24
topics [1] 114/20
total [2] 106/11 164/17
touched [1] 114/21
touching [1] 103/3
towards [4] 5/19 110/4 121/7 138/6
Townsend [3] 21/14 126/3 126/6
TPN [1] 51/12
trade [1] 153/3
tragedy [1] 33/2
trained [1] 125/9
training [26] 4/16 4/22 5/1 5/5 5/7 5/14 7/1 30/22 87/4 126/10 135/22 138/18 139/6 156/11 156/13 156/14 156/16 156/18 156/20 156/21 156/23 157/6 157/7 204/2 204/7 204/21
transaction [1] 18/19
transition [4] 73/13 73/23 155/16 186/12
transparency [4] 94/2 136/3 136/20 136/21
transparent [3] 53/5 53/8 124/11
transparently [1] 21/15
treated [3] 97/15 102/8 144/7
treatment [2] 25/8 124/12
triangulate [1] 206/18
triangulated [1] 185/22
tricky [2] 73/14 186/13
tried [1] 135/1
trouble [1] 206/13
troublemaker [1] 207/4
true [3] 1/17 84/25 152/5
truly [2] 166/3 195/21
trumped [1] 177/6
trust [39] 2/2 10/8 16/6 16/12 20/13 24/25 30/8 33/1 36/7 36/10 37/5 58/11 58/23 67/23 88/5 93/23 101/24 106/12 106/20 110/3 110/5 110/21 111/22 114/8 129/5 131/10 131/11 136/5 136/10 136/13 136/23 149/3 153/24 154/3 154/6 154/12 169/2 191/16 199/1
Trust's [4] 23/18 23/21 35/21 136/19
Trusts [1] 113/4
truth [1] 78/5
try [13] 39/12 70/4 90/23 136/5 137/2 137/5 137/24 137/25 138/2 164/1 179/10 198/22 201/23
trying [13] 33/14 42/9 48/24 48/24 70/17 84/5 91/18 92/19 136/20 143/19 169/18 200/15 201/23
Tuesday [2] 71/20 209/6
turn [10] 74/1 154/4 154/17 157/19 161/24 162/7 165/12 168/15 177/22 184/16
turned [1] 162/11
turning [3] 160/8 161/12 186/4
two [48] 3/7 8/14 9/3 9/5 9/5 23/23 24/1 31/5 40/18 43/6 47/5 47/10 47/21 47/21 48/4 48/13 48/16 49/3 49/5 51/12 51/13 65/11 94/8 101/3 102/19 103/4 109/5 111/9 111/10 111/22 116/3 116/12 118/21 118/23 119/8 129/1 131/8 140/12 141/2 143/11 146/12 149/3 159/9 171/21 179/16 185/22 187/9 190/16
two hours [1] 190/16
two months [5] 47/5 47/10 47/21 47/21 48/4
two reports [1] 141/2
two weeks [5] 43/6 48/13 49/3 49/5 118/21
two weeks' [1] 48/16
two years [2] 111/22 149/3
two-week [1] 116/12
type [2] 69/9 92/20
typed [1] 32/15
tyres [1] 151/9

U

u-turn [1] 74/1
ultimately [2] 74/6 75/19
unable [3] 83/14 188/2 193/25
unacceptable [2] 74/12 207/2
unaware [2] 163/12 192/12
uncertainty [1] 74/8
uncomfortable [3] 73/20 165/17 165/21
uncover [1] 172/5
under [23] 25/4 26/1 58/7 62/3 85/10 94/3 110/17 111/24 112/23 127/23 128/22 130/1 149/5 149/8 154/10 155/20 156/9 168/21 175/6 175/15 183/13 189/19 191/11
underlined [2] 121/10 148/15
understand [32] 16/23 17/8 17/12 28/10 32/7 37/10 37/17 42/3 48/24 50/20 50/21 51/12 51/15 59/9 74/25 98/13 102/15 107/20 130/19 144/17 155/6 155/24 167/15 167/19 172/14 176/13 185/11 187/2 195/10 198/6 201/5 204/22
understanding [25] 5/18 6/1 6/2 6/13 6/17 14/24 17/5 26/19 28/24 29/3 35/9 37/18 40/23 42/16 59/17 77/16 81/20 87/19 105/19 155/10 156/3 171/6 172/24 178/24 196/21
understands [3] 57/24 91/13 166/17
understate [1] 24/4
understood [13] 19/12 60/23 92/13 157/13 165/23 173/2 173/3 173/4 173/14 173/18 183/7 189/7 202/18
undertake [3] 13/14 122/17 191/17
undertaken [3] 172/9 179/15 191/20
undertaking [1] 58/15
unexpected [14] 6/14 21/8 38/18 42/5 42/8 52/23 54/21 60/16 123/13 160/14 180/13 185/15 185/25 188/22
unexplained [21] 3/19 42/5 42/8 42/11 54/21 81/12 115/10 120/15 121/25 123/13 124/4 124/5 135/7 135/15 160/14 180/13 185/15 185/17 186/1 188/3 188/22
unfold [1] 98/12
unfounded [2] 25/16 83/17
unhappy [2] 102/21 206/4
unimaginable [1] 145/2
unions [1] 153/3
unit [79] 8/21 9/2 9/15 9/25 10/2 10/3 10/4 14/4 19/10 20/14 38/1 39/2 41/10 41/18 41/23 41/25 42/1 42/19 43/18 44/19 44/25 50/18 50/22 54/22 57/15 58/18 58/19 62/2 72/4 73/13 74/3 74/7 76/18 83/12 83/15 85/15 86/20 98/16 117/6 117/9 119/20 119/23 119/23 122/2 122/12 126/10 136/4 141/19 142/3 160/14 160/17 163/18 164/6 165/8 168/7 170/16 175/7 175/14 175/21 177/5 178/15 178/17 186/12 187/1 187/8 188/12 191/15 191/15 194/12 194/13 200/17 200/25 202/5 205/6 205/7 205/8 205/10 205/10 205/13
unitary [2] 12/9 13/1
University [1] 2/10
unjustified [1] 93/6
unknown [1] 106/9
unless [2] 150/22 174/16
unnatural [1] 191/24
unnecessary [2] 202/6 205/12
unprofessional [1] 73/17
unreasonable [1] 190/11
unredacted [1] 65/14
unsubstantiated [3] 72/15 72/20 183/19
unthinkable [4] 47/8 47/10 47/12 47/14
until [18] 42/6 52/2 83/14 86/18 86/23 87/4 119/24 152/14 158/17 167/6 168/6 174/20 178/12 178/13 178/19 196/6 196/6 209/5
untrue [1] 83/17
unusual [4] 61/18 116/13 179/10 185/17
up [43] 3/9 4/21 23/8 23/8 32/15 32/19 32/22 37/15 37/19 39/9 39/18 39/23 40/2 46/24 48/2 49/21 52/17 61/16 70/7 70/7 77/5 80/13 82/6 93/11 116/4 132/12 134/3 136/1 154/4 154/18 156/15 161/24 162/8 162/11 168/18 171/24 174/12 174/18 176/11 186/19 192/18 198/7 205/15
update [4] 36/4 36/13 174/21 191/10
updated [3] 10/8 27/4 141/20
upon [2] 8/12 114/21
ups [1] 39/7
urged [1] 91/25
urgent [2] 87/1 115/21
us [59] 1/20 2/4 4/1 5/16 5/25 7/13 10/15 12/7 14/13 18/14 19/8 21/14 28/17 28/24 29/9 29/12 29/20 31/11 35/19 37/9 40/22 41/4 41/5 47/17 49/24 52/20 54/25 61/1 62/13 66/10 69/25 78/8 79/21

U

us... [26] 80/15 80/24 81/8 90/16 95/7 96/2 97/2 97/11 104/24 105/1 105/6 105/19 110/6 111/9 115/24 126/23 135/7 139/15 148/1 165/22 168/12 184/20 190/7 193/8 195/19 197/2
use [8] 56/20 147/21 149/6 150/13 150/13 150/17 168/3 201/7
used [14] 18/23 18/24 18/25 69/2 69/6 81/10 109/15 155/17 176/6 189/18 201/17 206/14 207/3 207/7
useful [2] 159/22 159/25
using [2] 151/4 179/16
usually [2] 18/25 75/21

V

values [1] 12/25
variable [4] 125/25 126/1 126/5 150/20
variety [1] 142/3
various [3] 29/19 136/13 192/7
vast [2] 135/11 204/3
verbal [2] 36/4 73/19
verbally [2] 94/14 94/16
version [18] 63/3 63/6 63/11 63/15 63/17 63/24 64/5 140/13 140/13 140/15 140/16 141/9 154/8 180/10 180/18 180/19 181/21 181/23
versions [5] 62/24 63/1 65/11 140/13 140/24
very [65] 8/13 10/1 10/1 11/18 22/21 27/13 37/25 45/3 50/10 75/23 76/6 91/23 93/6 98/13 103/20 103/23 104/9 104/14 104/16 118/19 127/15 128/17 131/19 132/18 132/21 136/13 144/13 144/14 144/25 145/1 145/14 145/16 145/17 148/21 149/10 151/15 151/20 155/21 156/11 156/19 157/22 160/24 163/16 167/5 167/10 167/11 174/12 176/1 176/24 180/14 182/24 185/9 189/12 189/17 190/15 194/11 195/4 199/4 202/12 202/19 203/17 208/13 208/18 208/19 208/25
via [4] 16/8 42/12 82/14 180/14
victimisation [2] 68/24 73/20
victimised [5] 93/13 94/3 101/5 128/5 128/18
view [28] 20/18 26/7 32/14 32/25 38/17 58/14 61/1 70/25 81/1 82/13 92/17 102/19 114/4 144/11 166/5 167/18 172/18 175/13 175/18 175/20 177/6 186/2 188/21 193/21 193/22 202/2 202/6 202/8
views [23] 62/14 75/6 79/16 79/17 93/25 94/17 100/21 103/5 103/14 103/17 122/8 122/10 123/6 129/12 144/11 174/3 175/23 175/25 176/1 177/12 190/11 201/14 201/25
vindication [1] 84/1
Virginia [1] 2/20
virtually [1] 201/20
visibility [1] 43/20
visit [3] 9/7 9/22 83/14
visited [1] 9/3
visits [1] 15/22
voice [2] 114/18 131/25
voicing [1] 25/14
voluminous [1] 14/12
voluntary [3] 149/23 149/24 149/25
vote [7] 107/10 107/18 107/21 108/3 108/7 113/20 129/17
vulnerable [4] 5/10 25/23 25/25 159/16

W

wait [1] 52/2
waiting [4] 1/6 51/24 82/1 184/4
Wales [1] 2/6
walk [1] 9/24
walkabout [2] 8/20 9/9
walkabouts [2] 8/17 85/25
walked [2] 85/22 164/3
walking [1] 85/18
want [25] 44/9 48/11 55/24 59/15 60/4 80/24 97/5 98/14 100/2 140/6 144/20 148/15 151/11 151/14 169/16 169/25 170/17 170/25 172/22 177/15 186/21 189/21 196/19 199/2 205/15
wanted [19] 15/16 20/1 54/7 55/7 91/21 94/22 99/3 100/7 125/1 135/10 143/15 144/17 144/23 146/10 148/2 156/8 167/15 170/12 176/20
wants [3] 169/16 170/1 202/22
ward [10] 6/5 9/19 9/22 19/15 21/23 73/23 86/2 139/12 186/5 201/9
warm [2] 8/10 127/1
warnings [1] 112/23
was [725]
was now [1] 200/16
wasn't [37] 3/20 3/21 3/23 6/25 17/23 19/12 21/7 21/23 21/24 27/14 32/4 32/21 41/13 57/4 62/17 70/22 74/19 89/14 106/3 119/1 119/24 129/14 133/14 146/22 148/8 149/10 149/13 158/14 159/17 171/9 174/19 176/21 177/9 181/14 190/4 206/2 206/4
way [51] 8/19 20/21 22/17 23/24 25/14 33/11 44/5 53/3 56/12 71/4 74/23 74/25 77/4 84/7 86/24 87/11 89/10 91/12 98/25 101/4 102/23 104/3 107/9 112/9 112/17 113/3 124/11 129/17 135/5 135/6 138/19 139/15 140/10 141/15 145/6 149/8 150/4 150/15 151/6 166/11 173/21 173/21 182/15 184/25 186/20 190/3 197/22 199/3 201/4 205/18 207/7
we [527]
we'd [1] 196/11
we'll [6] 34/23 34/23 95/4 103/24 116/18 157/21
we're [4] 48/23 104/3 195/25 198/24
we've [2] 102/21 127/9
week [9] 8/14 62/15 107/13 116/4 116/12 133/13 153/17 178/7 209/2
weekly [2] 23/6 169/5
weeks [11] 38/24 41/1 43/6 48/13 48/14 49/3 49/5 54/23 67/24 104/17 118/21
weeks' [1] 48/16
well [59] 4/24 5/3 5/16 5/23 14/7 14/15 18/8 18/9 32/7 32/12 34/3 36/25 45/11 45/25 51/22 51/24 55/23 56/18 65/19 69/13 71/13 74/16 75/19 80/7 80/8 81/12 82/15 83/25 86/8 88/6 88/20 93/1 95/4 95/24 96/1 99/10 103/23 104/6 104/9 104/14 104/16 116/18 120/2 120/13 122/22 125/2 128/21 135/10 138/20 144/13 150/11 150/12 151/2 174/5 177/19 195/22 198/23 200/16 206/8
well-being [2] 18/8 18/9
well-minded [1] 81/12
Wenham [1] 197/3
went [11] 9/15 45/13 62/1 120/19 140/3 159/19 163/11 175/17 194/21 195/24 200/17
were [302]
weren't [21] 2/17 7/2 15/1 19/10 19/23 32/18 33/18 38/8 40/4 77/8 88/24 89/2 99/4 99/4 123/10 126/4 161/7 163/7 178/19 193/9 196/24
what [281]
what's [9] 39/11 43/21 46/1 68/3 68/24 71/6 154/1 174/18 183/1
whatever [3] 7/1 35/11 121/18
when [91] 2/15 2/16 5/18 5/21 8/25 8/25 9/15 11/22 13/24 14/4 21/6 27/14 28/19 31/1 32/2 33/25 36/17 38/9 41/5 41/24 42/7 43/14 45/20 46/24 48/4 49/3 60/4 60/12 61/13 62/11 62/16 63/1 63/25 65/6 67/3 67/5 68/12 68/12 69/6 71/5 78/2 78/5 78/9 79/13 81/21 81/25 83/20 83/23 83/24 85/2 88/5 88/10 89/7 89/11 89/14 91/8 94/16 96/5 97/13 97/17 97/21 102/13 105/1 107/25 133/1 135/4 138/15 146/2 154/18 155/15 156/6 157/11 159/6 161/22 162/11 164/25 165/9 166/23 167/18 180/25 185/6 185/23 189/19 191/8 194/13 194/14 195/21 198/11 206/14 206/14 206/21
where [57] 5/6 6/13 7/4 10/25 11/1 11/5 19/19 20/7 21/22 22/24 27/9 27/18 34/20 34/23 37/10 44/4 48/1 61/21 65/7 76/5 77/9 80/14 80/18 82/12 88/19 92/2 93/2 93/4 96/18 98/23 99/8 102/18 105/8 109/5 110/12 110/21 119/25 119/25 127/8 133/4 134/17 138/3 140/25 146/13 146/15 150/22 159/14 164/4 168/23 169/17 170/1 170/8 194/11 194/21 197/9 205/1 205/3
whether [52] 3/24 4/13 28/5 29/13 32/23 33/23 34/1 46/2 51/25 56/13 56/17 57/4 57/5 57/13 57/14 62/3 62/25 64/18 69/16 75/17 81/2 89/9 90/5 90/7 102/6 103/18 106/21 113/18 119/16 139/9 139/11 139/15 143/10 144/4 144/7 144/19 149/17 149/25 150/15 150/16 150/24 157/14 159/8 159/8 174/8 174/23 175/13 180/4 181/20 184/11 185/21 191/25
which [73] 13/11 15/5 18/7 18/19 30/1 33/1 38/6 44/17 44/19 46/19 68/2 70/21 71/24 73/19 80/2 80/2 81/2 82/4 82/15 82/22 82/25 84/24 88/7 88/22 91/8 93/11 93/25 106/1 107/24 108/7 108/18 108/20 109/24 110/2 110/25 112/10 112/18 117/24

W

which... [35] 118/20 119/20 121/22 122/20 123/20 126/3 126/3 128/14 128/18 130/24 133/6 134/24 135/24 136/7 141/3 143/23 144/7 144/22 146/9 147/4 148/5 148/6 148/11 153/2 158/3 158/11 161/17 178/8 179/1 182/19 185/25 190/17 191/20 200/15 208/25
while [5] 25/15 57/7 109/10 124/13 145/11
whilst [9] 70/3 83/15 86/22 92/24 107/13 153/6 164/7 164/21 189/8
whistleblowing [2] 156/15 157/3
who [68] 4/5 4/11 4/11 4/12 6/15 9/15 19/1 21/21 25/24 32/9 32/19 32/22 40/1 40/5 41/4 41/11 41/12 41/15 51/4 56/9 59/9 61/14 62/21 62/25 65/5 66/1 66/1 68/9 68/13 71/11 75/17 81/25 83/2 89/23 89/25 90/1 90/2 90/2 93/3 96/13 104/24 105/14 113/17 113/17 119/5 120/11 123/12 126/6 126/9 130/10 134/8 137/23 137/23 140/19 145/3 151/12 151/19 158/8 158/9 158/12 158/16 159/1 162/18 168/18 176/2 190/23 204/2 204/13
who's [1] 138/11
whoever [3] 9/17 21/13 21/14
whole [5] 12/13 143/19 150/12 154/14 182/14
whom [2] 25/2 133/18
whose [2] 90/13 145/4
why [50] 11/4 20/23 23/23 40/4 51/22 54/15 55/21 59/7 69/4 89/19 91/22 92/21 92/23 106/8 106/17 107/19 109/2 112/5 117/6 117/8 118/7 118/18 123/7 136/3 136/25 137/1 140/4 143/20 147/14 148/25 153/18 161/16 164/10 170/20 174/24 176/13 176/13 185/7 185/11 186/3 187/7 187/17 194/18 199/19 199/20 199/21 201/5 205/25 206/7 206/20
wide [3] 85/16 85/16 142/3
widely [2] 85/8 85/13
wider [1] 20/13
Wilkie [36] 57/18 57/22 58/9 62/1 62/8 74/12 151/18 151/21 151/22 151/25 152/2 152/3 154/4 157/20 160/9 164/14 166/11 166/13 166/20 167/14 168/14 168/24 168/25 169/9 170/5 177/24 184/22 191/6 193/1 197/20 198/4 199/4 202/19 202/25 208/19 210/9
Wilkie's [1] 62/20
will [80] 3/12 12/6 22/21 24/11 25/14 28/7 31/4 37/1 37/14 43/17 43/18 43/19 44/23 47/16 49/16 49/17 52/9 52/12 58/10 61/3 66/10 67/21 73/12 73/15 73/17 76/3 83/21 86/2 89/9 91/13 98/13 98/15 103/23 104/9 104/14 104/15 117/3 122/2 125/17 127/17 129/23 131/4 148/13 148/18 154/18 157/25 158/3 158/12 159/18 163/15 165/4 166/11 169/1 169/5 170/23 172/7 172/7 172/8 179/2 181/12 181/13 184/6 186/8 186/11 186/12 186/22 186/25 190/1 191/1 191/2 191/11 195/19 196/2 196/17 197/19 197/21 197/22 203/3 208/23 209/3
wish [2] 81/13 87/1
wished [1] 88/4
withhold [3] 112/7 113/21 113/24
withholding [1] 106/16
within [17] 1/22 3/7 4/8 4/17 8/4 16/12 20/14 22/5 25/17 67/23 85/8 85/14 124/20 134/4 135/12 179/11 197/12
without [11] 30/12 30/12 30/12 30/13 34/7 34/8 74/7 84/20 123/24 163/24 190/15
witness [12] 125/3 127/6 131/2 132/21 132/22 132/25 133/23 141/17 151/18 152/3 166/25 208/16
witnesses [2] 59/25 156/25
Women's [1] 9/10
won't [5] 54/23 120/19 145/13 148/17 148/23
wonder [1] 143/10
wondered [3] 150/15 165/22 192/18
wondering [1] 28/5
Wood [1] 142/24
Woods [5] 131/21 131/22 131/23 143/5 210/6
word [11] 85/5 90/7 93/21 109/15 149/6 168/3 177/1 177/1 201/18 206/15 207/3
words [10] 84/18 85/6 85/14 97/15 97/15 176/6 177/18 185/18 199/18 206/15
work [26] 57/7 58/7 62/16 62/22 72/4 87/3 108/10 109/12 125/7 125/10 126/16 126/17 126/21 150/18 150/19 168/21 172/23 188/12 190/7 193/9 195/16 195/19 195/25 196/12 196/13 196/14
worked [5] 10/16 14/15 19/7 31/4 113/8
working [13] 7/3 31/7 57/5 90/19 90/24 126/13 126/20 127/1 134/4 135/14 150/16 159/2 189/14
workplaces [1] 30/14
works [3] 19/14 107/13 158/8
World [1] 45/4
worried [2] 44/24 159/15
worries [1] 26/13
worry [2] 98/8 104/15
worth [1] 33/13
would [211]
would've [1] 198/11
wouldn't [11] 62/22 66/19 71/3 84/9 85/18 109/23 110/5 113/21 113/24 128/9 141/15
Wrapped [1] 136/1
write [2] 93/16 178/8
writer [2] 190/17 190/23
writing [4] 54/25 90/14 90/14 189/20
written [5] 2/24 32/21 79/10 145/23 157/8
wrong [6] 77/8 138/15 140/3 151/6 167/13 189/3
wrote [2] 127/10 128/2

Y

year [10] 9/4 9/6 21/9 21/9 86/17 109/22 146/2 147/20 194/6 208/1
years [15] 101/25 102/12 110/21 111/2 111/22 115/13 126/9 146/1 147/17 147/22 148/2 149/3 164/17 184/3 194/9
yes [319]
yet [2] 75/2 182/4
Yorkshire [1] 104/3
you [995]
you'd [1] 193/1
you're [2] 103/2 199/13
your [126] 3/4 4/15 5/16 6/13 8/9 9/8 14/24 19/3 19/9 26/19 28/24 28/25 29/4 29/18 29/20 31/18 34/16 35/9 35/19 37/9 39/6 39/16 40/21 41/8 42/15 44/8 54/1 54/11 55/2 60/21 70/25 71/6 74/15 77/21 80/4 83/20 87/17 90/14 90/20 91/7 91/17 92/8 94/17 95/14 96/16 96/17 98/14 98/22 101/17 102/21 109/19 110/6 115/13 115/17 120/8 125/3 125/13 126/16 126/17 126/19 126/20 126/20 127/6 127/8 131/2 132/20 132/21 132/25 133/14 133/16 133/23 134/18 136/12 138/10 140/4 141/17 142/1 146/23 151/25 152/5 152/7 152/16 153/5 153/7 155/6 155/24 156/5 156/12 157/4 161/3 162/22 163/23 164/13 164/15 164/16 164/24 165/18 166/10 167/18 167/23 168/17 170/8 171/9 171/15 173/1 175/1 175/23 176/16 177/11 177/12 178/6 178/15 190/9 194/9 194/22 195/1 196/21 199/6 199/18 201/22 203/7 207/4 208/1 208/3 208/7 208/20
yourself [11] 4/1 13/22 63/6 74/16 79/10 79/24 86/15 110/13 118/1 172/12 181/15
Yvonne [1] 126/9

Z

ZA [1] 100/18
zoomed [1] 23/8