

Friday, 6 December 2024

(9.59 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: My Lady, may I call Mr Rheinberg.

LADY JUSTICE THIRLWALL: Mr Rheinberg, do come forward.

MR NICHOLAS RHEINBERG (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS LANGDALE: Mr Rheinberg, you prepared a statement for the Inquiry dated 11 April 2024.

Can you confirm that the contents are true and accurate as far as you are concerned?

A. Yes, I confirm that.

Q. You tell us you qualified as a solicitor in 1974 working as a partner in a local solicitors' practice. You, in February 1992, were appointed Coroner for East Somerset as a part-time post.

In July 1999, appointed to the full time post of Coroner for Cheshire acquiring the title Senior Coroner when the law changed in July 2013 with the coming into force of the Coroners and Justice Act 2009.

Can you tell us, Mr Rheinberg, and you expand it from paragraph 5 onwards, the Coroner's relationship

1

deaths where there was a suspicion of criminality in relation to the deaths."

You continue further down:

"... indeed, in an obviously suspicious case it would often be the police who contacted me asking me to order a forensic postmortem examination."

A. Yes. Coroners take a more active part than perhaps is generally known in relation to suspicious deaths.

So although we see on television the police ordering a pathologist and running the show, as it were, in fact the permission has to come from the Coroner because the Coroner has custody of -- of the deceased's body and it's only by the Coroner's authority that a postmortem examination can take place.

When there are suspicious circumstances, it would not be appropriate for a general pathologist to carry out a postmortem examination, instead appropriate to employ one of the fully trained forensic pathologists, I think there are about 35 currently in the country.

Q. So where there is suspicious circumstances, or you are made aware of them, where children are concerned, what's the difference between a postmortem examination where there's no suspicion and the one that you would order if there was suspicion? What do you

3

with the police?

A. Yes. Complicated relationships within the Coroner's office. So we are funded by the local authority and in Cheshire certainly part funded by the police in that the police in Cheshire provided me with my Coroner's officers.

So my Coroner's officers had I suppose potentially a dual loyalty; they obviously were loyal to the police, who employed them, but also loyal to me as leader of the Coroners Service.

The advantage in having police employees, although they were no longer serving officers, was that they had access to the police computer and so could keep abreast of information that was available to police officers and I suppose the most important part of that was what's sometimes called the STORM log where all incidents could be picked up on.

So typically my officers would come into the office really quite early and have reference to the STORM log and they could pick out perhaps matters that might be coming my way, as it were, at the earliest possible opportunity.

Q. You say at paragraph 10:

"My most frequent contact with senior police officers would be in relation to organ donation and

2

expect to happen where there is suspicion in a forensic postmortem situation?

A. Moving away from the death of a child, the normal routine in respect of an individual requiring a postmortem would be for a general pathologist to carry out that responsibility and it would be quite a swift process in -- in many cases. The pathologist would scan any medical information that was available, look at the circumstances as described to the pathologist, rely on the anatomical assistant to eviscerate and then would examine first externally and then the organs each in turn, produce a postmortem report.

When it comes --

Q. Would you expect engagement between the pathologist and the clinicians who had seen the deceased around the time of death or before death in a forensic analysis?

A. It --

LADY JUSTICE THIRLWALL: I wonder if we just might be at cross-purposes or it may be that I've got at cross-purposes. I think the question was about forensic pathology --

A. Yes, I was sort of -- my Lady --

LADY JUSTICE THIRLWALL: You then answered about general pathology.

4

1 A. Yes.

2 **LADY JUSTICE THIRLWALL:** But I think the question
3 then was in relation to forensic, so can we just be
4 clear --

5 A. My Lady --

6 **LADY JUSTICE THIRLWALL:** -- about which we are
7 talking about?

8 A. Yes.

9 **LADY JUSTICE THIRLWALL:** So you have given
10 a general background in relation to forensic pathology
11 but perhaps it might help if we move on to forensic.

12 A. Yes, absolutely.

13 I was trying to sort of build the -- the picture by
14 way of contrast.

15 So if a forensic pathologist is employed, the
16 scrutiny and care is very much greater. The forensic
17 pathologist will demand a very full background briefing
18 by the police, the police will be present during the
19 entire process.

20 There will be a meticulous external examination of
21 the body looking and documenting every single injury,
22 blemish, anything that is found, whether it is
23 ultimately going to be relevant in relation to the cause
24 of death.

25 The internal examination takes place with similar

5

1 a very full briefing is needed in written form from the
2 clinician or clinicians.

3 So, for instance, you will have the case of an
4 individual who is brought into hospital near death, who
5 is given treatment, but sadly does not survive. There
6 are suspicions surrounding the death so a forensic
7 pathologist has been engaged and then the pathologist
8 will need to be briefed on every set of circumstances
9 relating to the hospital stay: what tests have been
10 carried out, what results there have been -- what
11 diagnoses have been offered by the treating doctors.

12 **Q.** You say at paragraph 24 of your statement, if
13 you have a look in the first sentence:

14 "Unfortunately, it is very often the case with
15 infant pathology that a cause of death cannot be found."

16 Are you referring there to babies who die at home
17 usually in their sleep by SIDS? You mention SIDS, or
18 what are you referring to?

19 **A.** Right. Yes, you are right, that would present
20 the greatest difficulty but even with hospital tests the
21 pathology may be extremely difficult to find or to
22 interpret to the extent of offering an opinion as to the
23 cause of death. But you are right, the problem would be
24 very much greater in all likelihood if the death has
25 occurred in the community.

7

1 care. There will be a Scenes Of Crime Officer in
2 attendance taking photographs of anything relevant as
3 directed by the pathologist, who will tend to carry out
4 a commentary as he or she is going on so that everybody
5 understands what is happening and to be sure that the
6 appropriate photographs for instance are taken.

7 Everything that is going to be withheld for further
8 examination, for instance small pieces of tissue, are
9 given exhibit numbers and so the process continues until
10 the examination has been completed to the pathologist's
11 satisfaction.

12 A process that will take a number of hours, whereas
13 in the case of a general postmortem perhaps 30 minutes
14 or so may be devoted to the process. With the forensic
15 postmortem it's meticulous in every degree, carried out
16 by a pathologist who has been trained to look for and
17 interpret forensically all relevant details.

18 **Q.** Should it be meticulous in terms of the
19 information the pathologist gets from the clinicians
20 about?

21 **A.** Yes, it's absolutely vital that the forensic
22 pathologist is fully briefed, both from the police who
23 will provide as accurate information as possible with
24 regard to the circumstances surrounding the death. If
25 there is relevant medical information to be had, then

6

1 **Q.** Paragraph 27, you tell us:

2 "From my earliest years as a Coroner, I was
3 conscious of the fact that there were many deaths that
4 should have been the subject of an Inquest but were
5 never reported to the Coroner."

6 You in fact issued guidance, if we can go to
7 INQ0017840, page 1. Putting on the screen,
8 Mr Rheinberg, your September 2024 version of the
9 guidance --

10 **A.** Yes.

11 **Q.** -- I know there was subsequent that you have
12 alerted us to.

13 But you set out there:

14 "Reporting deaths to the Coroner, contact details."

15 You say you gave a mobile number as well for those
16 purposes. If we go to page 2.

17 "Setting out circumstances of reporting."

18 Page 3, we see (xxi):

19 "Deaths involving children under the age of 18 from
20 whatever cause must be reported."

21 Over the page, page 4.

22 "Common misconceptions and difficulties."

23 And you set out four bullet points up from the
24 bottom:

25 "Do not guess. You have a duty to report on the

8

1 cause of death to the best of your knowledge,
2 information and belief."

3 We see at page 5 that is signed off by you. Did
4 you endeavour to promulgate that guidance as best you
5 could?

6 **A.** Yes. I made sure that every single doctor
7 within -- within Cheshire had a copy.

8 **Q.** How do you say you did that?

9 **A.** There was the -- I think if I remember
10 correctly there were two bodies in Cheshire, Cheshire
11 being divided in half. They -- all GPs were members, as
12 it were, and so by informing that particular or those
13 particular bodies, sending a copy of the direction and
14 requiring it to be sent to every single GP and receiving
15 confirmation that that had been done.

16 And similarly, in, in hospitals, I made sure that
17 every new intake of doctors as part of their induction
18 pack was given a copy of my directions.

19 **Q.** We see -- if that can come off the screen,
20 please, and have instead INQ0008638, page 1 --
21 a document emanating from the Countess of Chester's
22 internal guidance, "Guidance on Writing Statements".

23 I don't know if you have seen this before,
24 Mr Rheinberg.

25 **A.** No, I don't remember this.

9

1 and hopefully so that lessons can be learnt and similar
2 tragedies can be avoided for the future.

3 **Q.** Four bullet points down:

4 "You are not being called as an expert. Don't give
5 opinions, leave that to senior Consultants. Just stick
6 to facts."

7 The Inquiry has heard evidence from a junior doctor
8 at that their understanding was they just stuck to the
9 facts and wrote the period of time they were caring for
10 an infant in isolation, just sticking to the facts of
11 their involvement at any period of time in the care of
12 a baby.

13 Just stick to facts, what would you say about that?

14 Does that need elaboration or not?

15 **A.** Right, okay, well, doctors, unless
16 specifically called as expert witnesses, are witnesses
17 of fact, witnesses of fact are not permitted to give
18 opinions.

19 However, within the Coroner's Office in Cheshire,
20 when -- when I was there we were holding an enormous
21 number of Inquests and it wasn't appropriate to instruct
22 an expert in every case. We would never have got
23 through a huge list of cases if that was -- if that was
24 done and also the cost would have been very great.

25 In those circumstances, where someone perhaps of

11

1 **Q.** It's not your document so there's no reason
2 why you should have done?

3 **A.** No.

4 **Q.** Take your time to read page 1, I just want to
5 ask your comments about hints and tips over the next
6 page but read the whole document.

7 (Pause).

8 **A.** Yes, thank you.

9 **Q.** And the next page.

10 **A.** Yes.

11 **Q.** Then the next page under "Hints and Tips"?

12 **A.** Yes.

13 **Q.** Do you see the third bullet point:
14 "Avoid criticism of colleagues/other departments."

15 **A.** Yes.

16 **Q.** What do you think of that as a hint or a tip?

17 **A.** It not very helpful.

18 It's -- I suppose it's in the context of Inquests
19 are not there to apportion blame, but if there have been
20 medical mistakes --

21 **Q.** Yes.

22 **A.** -- it's very, very important that these come
23 to light. Not so as -- not as a matter of retribution
24 or punishment but to first of all to identify what has
25 happened, what has caused or contributed to the death

10

1 Consultant grade was giving evidence, it was my practice
2 to accept expert evidence in -- from them if
3 appropriate.

4 **Q.** To be fair to the Countess of Chester
5 document, if you go over to the next page, finally, it
6 states:

7 "Do not repeat what is already in the notes.

8 Expand and clarify if appropriate and do not leave out
9 significant information"?

10 **A.** Sorry, I am not hearing you.

11 **Q.** The top two bullet points?

12 **LADY JUSTICE THIRLWALL:** She is just reading the
13 top line.

14 **MS LANGDALE:** Just read it, thank you.

15 **A.** Okay, got it, yes.

16 **Q.** That can come down and now can we have on the
17 screen INQ0008941, page 24, please.

18 This, Mr Rheinberg, is a guidance document,
19 I think, prepared by you and records show it was sent to
20 Mrs Sarah Harper-Lea on 1 July 2016 attached to request
21 for statement. So this is guidance I think that you
22 have drafted. Do you recognise that as your guidance or
23 guidance from the Coroner's Office, perhaps it's not
24 yours.

25 **LADY JUSTICE THIRLWALL:** I think your name is at

12

1 the bottom.

2 **A.** Yes, yes. Thank you. Yes, I don't remember
3 issuing this but clearly it is advice that I have given.

4 **Q.** You set out at 5 and 6 more broadly, don't
5 you:

6 "From details extracted from the notes, set out
7 relevant medical information relating to the cause or
8 circumstances of the death following the chronology
9 order."

10 At 6 you say:

11 "Hearsay evidence is acceptable provided you are
12 confident of the accuracy of the information you are
13 giving."

14 Can you just expand on what you meant by that,
15 "hearsay evidence is acceptable", which is perhaps
16 different from sticking to the facts of your own
17 knowledge in a moment in time, isn't it?

18 **A.** Yes. The rules of evidence in the
19 Coroners Court are not the same as in the civil and
20 criminal courts and we are permitted to accept hearsay
21 evidence.

22 The good practice would demand that as much as
23 possible one would rely on hard evidence, adhering to
24 the usual rules of evidence, but we could spread our net
25 wider and still -- and not be in contravention of any of

13

1 solicitor writing:

2 "Frustrated over the duration of the investigations
3 as the death happened a year ago."

4 If we go, take your time to read that and we will
5 put another document up then.

6 If we can have INQ0002042, page 173.

7 What do you say in response?

8 **A.** What do I say, sorry?

9 **Q.** Yes, what do you say in response, if you don't
10 mind reading out your email so we have it on the record?

11 **A.** Right. I was expecting a full report from the
12 hospital. Bearing in mind the circumstances surrounding
13 the death of Baby A, there had been medical errors that
14 could potentially have been implicated in the death.
15 I think I remember correctly it was in relation to the
16 insertion of lines.

17 **Q.** A long line, yes.

18 **A.** And of potential relevance the fact that the
19 misplacement of one of the lines coincided with an
20 arrest quite shortly afterwards.

21 So my anticipation was that there would be -- would
22 have been a very full investigation, either internally
23 or through an independent person called in by the Trust
24 and clearly that report would be very important in
25 relation to the Inquest.

15

1 the rules.

2 **Q.** Thank you, that can go down.

3 I am going to move now, Mr Rheinberg, to Baby A and
4 the death of Child A. I make it clear at the outset
5 I am not asking you any questions about your
6 decision-making and the Inquest itself. We are
7 interested in exploring the information provided to you?

8 **A.** Okay.

9 **Q.** And the adequacy of that, so I am going take
10 you to various documents on the screen and where it's
11 helpful for you, refer you to a paragraph in your
12 statement where you have set out postmortem results that
13 might make it easier for you to set those out for us?

14 **A.** Okay.

15 **Q.** So Child A, we know Child A's death was
16 reported to the Coroner on 8 June 2015 and in an
17 investigation opened, a postmortem gave cause of death
18 unascertained and there was an Inquest held on
19 10 October and a narrative verdict given.

20 If we can start, please, with INQ0002042, page 174,
21 so we know the death has been reported to you in
22 June 2015 and you have here when it comes on the
23 screen --

24 **A.** Right.

25 **Q.** -- we see at the bottom 2016, the parents'

14

1 **Q.** So you respond and then suggest dates to avoid
2 from their perspective --

3 **A.** Yes.

4 **Q.** -- moving it forward. Thank you.

5 If we can then have INQ0002042, page 186. This
6 email is an email from Mr Cross to you?

7 **A.** Oh right, yes.

8 **Q.** Suggesting an obstetric secondary review will
9 be sent to you?

10 **A.** Yes.

11 **Q.** You then, if we go to page 169 -- it's the
12 same INQ number, Mrs Killingback, it's just a different
13 page, 169 -- what do you say there to the mother's
14 solicitor or parents' solicitor?

15 **A.** Sorry, what?

16 **Q.** What do you say there in this email?

17 **A.** It was a letter.

18 **Q.** Yes, a letter. What are you setting out?

19 **A.** It -- it's my preliminary decision as to the
20 relevant witnesses to the Inquest, bearing in mind the
21 fact that Baby A's Family were legally represented,
22 I wanted to run this past the solicitors in case they
23 had any suggestions about further witnesses that they
24 might regard as relevant, so that I could consider any
25 representations in that regard.

16

1 Q. You say subject to anything unexpected within
2 the SUI. So again explain what you are expecting from
3 an SUI?

4 A. A detailed review of -- of what had happened.

5 Typically, these reports would come through with
6 all participants anonymised through a series of letters
7 and so if unasked the Trust sent me through a list of
8 the witnesses to match up to the letters, I would always
9 demand the -- a means of identifying which witnesses are
10 being referred to and so after a detailed report I could
11 check that I hadn't missed out any witnesses from my
12 preliminary list.

13 Q. Can we next have, please, INQ0050707, page 1.
14 It's not an email that you saw?

15 A. No.

16 Q. But it's been sent to your office from
17 Joshua Swash --

18 A. Right.

19 Q. -- A paralegal at the Countess of Chester and
20 it says:

21 "Please could you bring this to the attention of
22 Mr Rheinberg.

23 "As stated in Stephen Cross's email of Friday,
24 12 August please find attached the OSR report for this
25 case and action plan documents. Please note the NNU

17

1 practice and record-keeping ..."

2 Et cetera and it relates to Child A only?

3 A. Yes.

4 Q. So you are sent that.

5 We then see in September, if we can have
6 INQ0002042, page 155, a letter from the solicitors for
7 the parents --

8 A. Yes.

9 Q. -- of Baby A. Take your time to read that.

10 A. Yes.

11 (Pause)

12 Thank you, yes, I am familiar with that letter.

13 Q. Yes. They say:

14 "We were of the understanding that a full
15 investigation was taking place."

16 They are unhappy, aren't they --

17 A. Yes.

18 Q. -- with what they have received. A short
19 document that bears the date 1 July 2015. Do you think
20 that was the page that Dr Brearey -- the one before --

21 A. Yes.

22 Q. -- that they were sent?

23 It doesn't look from that letter as though they
24 were sent the Thematic Review document but they were
25 sent Dr Brearey's letter; do you think that's right?

19

1 Mortality Thematic Review has been redacted due to the
2 other patients' confidentiality."

3 If we can see what that looks like, please, it's

4 INQ0008841 page 1.

5 So this appears, Mr Rheinberg, to have been sent on
6 19 August --

7 A. Right.

8 Q. -- 2016.

9 The Inquiry has seen different versions of this but
10 this copy for you is -- appears as follows for the
11 Coroner's Office, see page 1 there. If we can go over
12 the page to page 2, page 3, page 4, 5, 6 and then the
13 last page, page?

14 A. Yes.

15 Q. Page 7 and page 8, please. So this appears to
16 only have Child A but as the document refers to, there
17 are other babies in a version of that, but you have been
18 sent the one related or the office has been sent the one
19 in relation to Baby A ^.

20 You also tell us at paragraph 43 of your statement,
21 if we can have on the screen INQ0002042, page 777, you
22 are sent that.

23 A. Yes.

24 Q. We see:

25 "Learning from these cases notable excellence in

18

1 A. Yes.

2 Q. If we go to INQ0002042, page 154, your letter
3 to them?

4 A. Yes.

5 Q. "... [you] too was disappointed with the
6 brevity of the report which I received. However, I have
7 no power to order a hospital to conduct an
8 investigation, still less give directions as to the
9 nature and extent of any investigation that's
10 undertaken."

11 And that you won't be adjourning the Inquest next
12 week.

13 "It would be inappropriate to do so."

14 If we go next to 0167, so the same INQ number
15 ending 2042 and then 0167, your office, when it comes
16 up, chasing statements.

17 If we go to page, the next page of that, 168 first,
18 we know Dr Saladi's statement is in fact dated
19 16 August 2015, Theresa McCormack's April 2016,
20 Ravi Jayaram's July 2015 and February 2016 and I think
21 the ones on the first page too between February,
22 April 2016 I think only Dr Harkness' was later in
23 September.

24 In terms of that time lapse in receiving
25 statements, was that not unusual or was that ...

20

1 A. No, it -- it -- it wasn't unusual to have to
2 chase for statements. I had developed a protocol with
3 all the hospitals giving deadlines with regard to
4 production of statements, et cetera. On occasions,
5 those deadlines were breached, they were -- they were
6 followed up and the usual result would be an apology and
7 the statement to hand.

8 This was unusual. It -- there were to me at any
9 rate unacceptable delays.

10 Q. We know you are moving forwards to the Inquest
11 on 10 October. On 6 October you get this email,
12 INQ0053069, page 1.

13 We see from the bottom from Mr Cross:

14 "Dear Mr Rheinberg, you will recall that in your
15 absence I advised your deputy that the Countess was
16 undertaking a review of neonatal deaths by the Royal
17 College of Paediatrics and Child Health which was
18 undertaken at the beginning of September and the Trust
19 is awaiting their report. The Review Team have
20 indicated that they were entirely satisfied with the
21 care within the neonatal unit and raised no concerns.
22 However, they recommended that a detailed forensic
23 Casenote Review of each of the deaths from July 2015
24 should be undertaken, so consequently this is still work
25 in progress."

21

1 as I was not in -- available to take the call. That,
2 that -- I picked that up from the documents sent to me.

3 Q. Indeed, Mr Moore said yesterday so you are
4 aware that he was -- he did take a call --

5 A. Yes.

6 Q. -- that was meant for you where he was told
7 about the RCPCH review and that a review was being
8 undertaken?

9 A. Yes.

10 Q. And that he told you about the call and said
11 that there was a review being undertaken?

12 A. Yes. I am absolutely positive he -- he will
13 have done so. He was meticulous in that regard. It's
14 my failing memory, I'm afraid, I -- I can't remember.
15 But I did know that there was -- was to be a review. It
16 may have been that conversation that had been passed on
17 by Mr Moore, but I -- I can't now remember.

18 Q. To be clear, Mr Moore's evidence was that when
19 he said that to you, you were aware of a review into
20 neonatal deaths but his evidence is he wasn't aware that
21 there was a suspicion about a nurse or a member of
22 staff --

23 A. No.

24 Q. -- being involved in deaths but you were -- he
25 was aware of neonatal deaths and a review?

23

1 Over the page, if we can:

2 "I have instructed Louis Browne of counsel in this
3 matter and he is fully aware of the review and
4 Dr Jayaram as the lead Consultant is also fully aware of
5 this matter. He is called to give evidence at this
6 Inquest and will be able to answer any questions
7 regarding the review."

8 For completeness, if we go back to the previous
9 page and look at the email at the top. Thank you,
10 that's been enlarged, we see for our purposes that
11 Mr Cross makes it clear that he hasn't sent a copy to
12 the Coroner?

13 A. Yes.

14 Q. But explained it in the email below.

15 In terms of the email below, it's clear you weren't
16 sent a copy at that stage. Were you aware that Mr Moore
17 had had a conversation with Mr Cross previously about
18 the fact that a review was being undertaken?

19 A. No. I think if I remember correctly from the
20 documents provided to me that it was alleged or stated
21 that a telephone conversation had taken place between
22 Mr Cross and Mr Moore, was it 13 July?

23 Q. It was in July.

24 A. Yes. And that this conversation imparted
25 information to Mr Moore which was to be passed on to me

22

1 A. Oh absolutely. I mean, it was a concern that
2 there had been a number of deaths at the Countess of
3 Chester and good to know that the matter was being
4 looked into independently. But certainly so far as
5 I was concerned there was not a whisper of any
6 suspicion.

7 Q. And indeed when you hear the Inquest for
8 10 October 2016, as we know when we go through the
9 sequence, by then you have had the deaths of A,C,D,E,I,
10 O and P --

11 A. Yes.

12 Q. -- notified to you. So you were aware of
13 a series of neonatal deaths?

14 A. Yes.

15 Q. We have got a note of the Inquest hearing, we
16 have got a number of notes and there seems to be
17 a particularly full one from the Family's solicitors.
18 If we can look, please, at INQ0107909, page 8. If we
19 can just have the last paragraph on the screen. Perhaps
20 enlarge that. Dr Jayaram's evidence.

21 Mr Rheinberg, we see you asked Dr Jayaram whether
22 or not he has seen anything similar. Can you read that
23 again now --

24 A. Yes, I will, yes.

25 Q. -- and tell us what you understood from that

24

1 evidence?

2 **A.** Okay.

3 (Pause)

4 So I don't remember this. So my understanding will
5 be relating to the reading of this now.

6 **Q.** Yes, understood.

7 (Pause)

8 **A.** Yes, I have read that.

9 **Q.** What did you make of that at the time? What
10 did you understand from that?

11 **A.** Well, he was giving details or referring to
12 previous cases and where the cause could not be found
13 and that whilst there was nothing specific in relation
14 to the department, it was being downgraded as a general
15 safeguard presumably pending a -- the result of a review
16 just in case there was something amiss within the
17 department from a clinical excellence point of view.

18 **Q.** Thank you. That can go down. If we go to
19 your statement, please, at paragraph 45, you set out
20 there your conclusions and you say at the end of
21 paragraph 45 you had stated:

22 "It cannot be determined what caused Child A's
23 collapse and subsequent death and further it cannot be
24 determined whether this was due to a natural or
25 unnatural event."

25

1 so I could theoretically have just put "open verdict" --

2 **Q.** Don't worry, we are not worried about your
3 decision -- not worried about that?

4 **A.** It didn't strike me that that was appropriate.

5 **Q.** Child C, moving to Child C. We know Child C's
6 death was reported to the Coroner on 15 June 2015 and an
7 investigation was opened. If you go to paragraph 53 of
8 your statement, we see you ordered a postmortem
9 examination to be performed.

10 Can you tell us what the conclusion of that was and
11 therefore how the investigation discontinued?

12 **A.** Right. I can't remember offhand the specifics
13 of the report, I think it was Dr Kokai.

14 **Q.** Don't worry, you summarise it at paragraph 53
15 of your statement?

16 **A.** Sorry, I will look it up.

17 **Q.** It may be easier -- I would look it up rather
18 than ...

19 **A.** Which paragraph?

20 **Q.** 53. You say:

21 "At an early stage the pathologist indicated his
22 opinion that Child C had died from natural causes but
23 was unable to provide a cause of death without carrying
24 out further tests."

25 **A.** Yes.

27

1 Can you just clarify for us, which you do later in
2 your statement, what you were referring to there when
3 you said "or a natural event"?

4 **A.** Okay, there were two possible factors that
5 could have been relevant to the cause of death. The one
6 iatrogenic, the other natural. So I have already
7 mentioned the misplaced line, misplaced on two occasions
8 and I think it was after the second line insertion,
9 misinsertion, very shortly afterwards that there was
10 a collapse.

11 The other pathological finding was a crossing over
12 of the pulmonary artery and that was described by the
13 pathologist as "extraordinarily rare", I think it was
14 something like 27 cases only known, but unlikely to
15 explain the death, although the pathologist set out
16 a theoretical basis upon which death could have ensued,
17 but then rather dismissed it.

18 I was struck by the coincidence of the error and
19 the death, although I had to take on board the
20 pathologist's opinion that this probably was not
21 relevant so far as the cause of death was concerned.

22 So this was one of those very unfortunate cases
23 where despite all the investigations that had been
24 undertaken, and in particular despite a paediatric
25 postmortem, the -- the cause of death was not apparent

26

1 **Q.** "[You] opened an investigation. Dr Kokai had
2 already expressed an opinion that the cause of death was
3 natural. Nevertheless ..."

4 **A.** Yes.

5 **Q.** "... at that stage the cause of death was
6 unknown."

7 **A.** Yes.

8 **Q.** "After an investigation had been formally
9 opened Dr Kokai gave his opinion as to the cause of
10 death. The cause given was naturally occurring."

11 Therefore you discontinued the investigation?

12 **A.** Yes, and this would follow a very usual line
13 with a paediatric postmortem. There would be
14 an immediate response from the -- or a speedy response
15 from the pathologist, to give a steer as to where things
16 might be going. But the opinion as to the cause of
17 death being withheld until all investigations, both
18 microscopic and biological, had been undertaken.

19 **Q.** Child D's death was reported on 22 June 2015.
20 If we go to INQ0002045, page 8, we see Dr Newby
21 reporting that death, referred to it being the third
22 death in 12 days for neonatal?

23 **A.** Yes.

24 **Q.** Also a further episode of apnoeic event and
25 CPR for previous twin death. Surviving Twin had

28

1 successful ... ^
 2 Postmortem was conducted and we know that the
 3 conclusion of that was pneumonia with acute lung injury
 4 and you had provisionally decided to discontinue the
 5 investigation but received a letter, didn't you, from
 6 the parents requesting further investigation?
 7 **A.** Yes.
 8 **Q.** So your letter in response, INQ0002045,
 9 page 962.
 10 **A.** Yes.
 11 **Q.** Tell us what you are saying there or stating
 12 there.
 13 **A.** Messrs Gamlins had been appointed to act for
 14 the Family. I think I had received a letter from
 15 Baby D's parents direct, giving a number of details
 16 relating to what they saw as mismanagement in relation
 17 to the death and I decided that this did need further
 18 investigation, and although a natural cause of death had
 19 been given, and so in normal circumstances
 20 a discontinuance would be the only course of action
 21 appropriate, in these particular circumstances I decided
 22 to accede to the request made by Messrs Gamlins.
 23 **Q.** If we can have the next page up, the same
 24 INQ number page 974.
 25 While it comes up, Mr Rheinberg --
 29

1 **Q.** And you set out at paragraph 66:
 2 "It appears from the paperwork that she [that is
 3 the doctor] was satisfied that the reporting doctor had
 4 correctly identified the cause of death which could be
 5 registered without a postmortem examination or further
 6 investigation by the Coroner's Office."
 7 Sorry, I should make clear it was somebody at the
 8 Coroner's Office working as a senior partner in a GP
 9 practice, forensically trained, et cetera, she was
 10 satisfied that the reporting doctor had correctly
 11 identified the cause of death and so it was there was no
 12 postmortem and no Inquest; is that right?
 13 **A.** Yes. Correct.
 14 **Q.** So where there was no request for an Inquest
 15 the Coroner's Office also had to ratify or see that
 16 and --
 17 **A.** Sorry?
 18 **Q.** The Coroner's Office needed to look at that
 19 for themselves and ratify what the doctor had said?
 20 **A.** Absolutely, yes. From a legal point of view,
 21 the death, strictly speaking, didn't have to be reported
 22 because the cause of death was known or purportedly
 23 known and purportedly the cause of death was -- was
 24 natural.
 25 But this was in adherence to my Practice Direction
 31

1 **A.** Yes.
 2 **Q.** -- you retired in March, didn't you?
 3 **A.** Yes.
 4 **Q.** March 2017?
 5 **A.** Yes.
 6 **Q.** We see a letter that your successor Mr Moore
 7 sends on 3 May 2017:
 8 "Dear Mr Cross,
 9 "I write further to Mr Rheinberg's letter to you
 10 dated 13 February in which he indicated he was looking
 11 forward to receiving from you copies of the in-depth
 12 reviews carried out in respect of Twins and Child D and
 13 Child A."
 14 **A.** Yes.
 15 **Q.** That is sent 3 May. And I think that's the
 16 day after the Countess of Chester have written to the
 17 police. But at this point, Mr Moore is asking for those
 18 reviews?
 19 **A.** Yes, yes.
 20 **Q.** That can come down. Child E. If you can go
 21 to paragraph 65 of your statement, please?
 22 **A.** Right, thank you.
 23 **Q.** Child E's death was reported on 4 August 2015.
 24 There was no postmortem and no Inquest opened?
 25 **A.** No.

30

1 that all deaths of children under the age of 18 should
 2 be reported. So quite proper that the death was
 3 reported.
 4 **Q.** Child I's death was reported on
 5 23 October 2015. You tell us at paragraph 67 of your
 6 statement that the investigation was discontinued
 7 following receipt of a postmortem on 6 February 2016.
 8 **A.** Yes.
 9 **Q.** You set out at paragraph 69 that:
 10 "Dr Kokai produced a full postmortem report dated
 11 10 February [and] gave his opinion as to the cause of
 12 death as hypoxic ischaemic damage of brain and chronic
 13 lung disease of prematurity due to extreme prematurity."
 14 The concluding remarks, he wrote:
 15 "'I find it justifiable to conclude that Child I's
 16 death was a result of natural causes and a result of a
 17 combination of several underlying pathological processes
 18 as a consequence of prematurity ...'"
 19 And so it was that investigation was discontinued.
 20 **A.** Correct. Yes.
 21 **Q.** We then come to two babies from three Triplets
 22 and deaths are notified to you as well and if we go to
 23 INQ0002046 0083, we see this is an email, isn't it, to
 24 you from your office, Christine Hurst?
 25 **LADY JUSTICE THIRLWALL:** It's just coming up now.

32

1 **MS LANGDALE:** It's actually page 83, please. 2046,
2 page 83, not that page.

3 **LADY JUSTICE THIRLWALL:** Can we take that off,
4 please?

5 **MS LANGDALE:** Yes. 0083.

6 **A.** Right.

7 **Q.** We see there attached postmortem reports for
8 Babies O and P.

9 **A.** Yes.

10 **Q.** You tell us as indeed Christine Hurst
11 mentioned in her statement to the Inquiry that soon
12 after the deaths had been reported, you had
13 a conversation and she came over to your office to
14 discuss the deaths.

15 By all means refresh your memory from paragraph 74
16 of your statement, if you would like to do so.

17 **A.** Yes.

18 **Q.** So what do you remember now about any
19 conversation between you both?

20 **A.** Christine and I had frequent conversations on
21 all manner of things relating to the jurisdiction. But
22 I do remember her coming over and us having a discussion
23 about our concerns about the -- this being yet another
24 unexpected death of an infant or infants at the Countess
25 of Chester Hospital.

33

1 they might have statistically expected, what information
2 were you relying on for that? Can you remember now or
3 would you rather we went through --

4 **A.** Well, I know generally it was an investigation
5 into the operation of the unit to identify any
6 shortcomings or any issues that could explain some or
7 all of the deaths or might have been a factor rather
8 than explaining the causes of death.

9 **Q.** If we can go to INQ0058202, page 3, these are
10 follow-up emails on reports for Babies O and P but also
11 refer to the review, so let's look at these emails in
12 sequence.

13 So you see at the bottom from Claire Raggett at the
14 hospital to Christine Hurst, your office, 31 October?

15 **A.** Yes.

16 **Q.** "Good afternoon Christine,

17 "I write further to our telephone conversation and
18 I have just spoken to Stephen who has asked Josh to send
19 the two reports over to you this afternoon. The Reports
20 are unsigned as [Dr V] is on leave until Friday when she
21 will be in a position to sign them."

22 So these are reports relating to O and P:

23 "But to avoid any delay for the Coroner to have
24 sight of the report Stephen asked for the unsigned
25 reports to be sent over to you. In respect of the

35

1 **Q.** If we can go to page 82, the page before.

2 Your response at the top, 17 October:

3 "The postmortem reports" --

4 **A.** Yes.

5 **Q.** "... disclose a naturally occurring death and
6 I am discontinuing the investigations. There is nothing
7 in the reports to indicate any clinical mismanagement in
8 relation to these deaths which were both sudden and
9 unexpected. It can be seen Dr Kokai ascribes the death
10 to prematurity, albeit the processes which occurred in
11 each case were different.

12 "I am aware of the investigation that you refer to.
13 The hospital itself called for an investigation by dint
14 of the fact that they had experienced a number of
15 perinatal deaths in excess of what they might have
16 statistically expected. The investigation was not
17 instituted because of specific concerns about the deaths
18 in this instance and as noted above, I know of no
19 clinical mismanagement."

20 So you were aware of the review at that time?

21 **A.** Yes.

22 **Q.** The RCPCH review?

23 **A.** Yes.

24 **Q.** In terms of referring to what it was looking
25 into, a number of perinatal deaths in excess of what

34

1 review, the Trust has now received a draft report which
2 it is considering factual accuracy and this will be done
3 by the end of this week.

4 "It is anticipated that the final report will be
5 received within 14 days from the review as receipt of
6 the Trust comments which will then be in a position to
7 share with the Coroner.

8 "I have also raised your earlier email with Stephen
9 which, as you suggested, raises a number of issues
10 particularly around the strict legal position regarding
11 the time of death and we will be interested to hear your
12 view in due course."

13 Then we see above that, so that is the email that
14 is come to your office 31 October, 7 December:

15 "Hi Claire, any news on the review done by the
16 College yet?"

17 **A.** Yes, yes.

18 **Q.** So -- and if we go, please, to page 87, it's
19 a different INQ number actually, INQ0002046: page 86
20 actually is the first page of it.

21 Can we have page 88, please and the email at the
22 bottom of page 88.

23 **A.** Right.

24 **Q.** "Good morning Christine."

25 From Claire Raggett:

36

1 "I write further to my email yesterday [this is
2 9 December]. Stephen has met with Ian Harvey earlier
3 this morning and as mentioned, the neonatal service
4 review has been received in the Trust. The review does
5 advise that the Countess undertake some internal review
6 which will involve a secondary review of some of the
7 cases.

8 "The Trust would like permission from the Coroner
9 to approach the appropriate pathologist where they have
10 been involved with a particular death. This will enable
11 us to be in a position to present a comprehensive review
12 to the Coroner which we would anticipate to be completed
13 earlier in the New Year.

14 "It would be helpful for Ian and Stephen to meet
15 with the Coroner to discuss the findings of the reviews.
16 Perhaps you could suggest some dates for the Coroner for
17 a meeting, say third week of January 2017."

18 Then above, from Christine Hurst to you.

19 **A.** Yes.

20 **Q.** "Please see regarding the Royal College Review
21 at the Countess of Chester, the Children O and P cases
22 were, as I was told, part of the review."

23 If we go back to page 86, your response to
24 Christine:

25 "This does seem to be going over backwards.

37

1 "I write further to your email below. Stephen has
2 asked that I forward a copy of the review for the
3 attention of the Coroner. Please note this is still
4 confidential to the Trust board and will be shared with
5 our relevant clinicians at a meeting to be held on
6 Thursday, 26 January.

7 "Stephen has therefore asked you to advise the
8 Coroner accordingly and once it has been shared with our
9 clinicians the Trust has a communication plan for
10 a wider dissemination of the report."

11 Do you see that?

12 **A.** Yes, I do, yes.

13 **Q.** So we know a report is sent to you. We need
14 to go to a document from within the Countess of Chester
15 to see what was sent to you, specifically and if we can
16 have please on the screen, INQ0058202, page 1. This is
17 early stages for the Trust with this report.

18 So they say we see from the email from Mr Cross:

19 "Please see email below which confirms I have sent
20 the redacted version of the review to the Coroner as
21 agreed."

22 So with his colleagues stating he sends the
23 redacted version?

24 **A.** Yes.

25 **Q.** I am going to put on the screen the bits that

39

1 However, I have no objection to the Trust consulting
2 pathologist. At this stage I would like a copy of the
3 document which has been produced. I also need to know
4 which cases the Trust decide to review. Finally,
5 I would like a date for the final comprehensive review.
6 Early in the New Year is too vague and in any event
7 I would want to have an opportunity to see the review
8 and consider its implications prior to my retirement."

9 **LADY JUSTICE THIRLWALL:** Were you able to see that,
10 we had a bit of movement of the document?

11 **A.** Sorry?

12 **LADY JUSTICE THIRLWALL:** Are we all content we have
13 now had a chance to look at it?

14 **MS LANGDALE:** Can you see it?

15 **A.** I can, yes.

16 **Q.** And you can confirm that is what you sent
17 between yourselves at that time?

18 **A.** Absolutely, yes.

19 **Q.** If we go now to page 91, same INQ number, 91.

20 At the bottom of the page:

21 "Hi Claire, [17 January] Mr Rheinberg has asked
22 that he is sent without further delay a copy of the
23 neonatal service review."

24 20 January:

25 "Good morning Chris

38

1 were therefore redacted, Mr Rheinberg --

2 **A.** Okay.

3 **Q.** -- at that time. INQ0009618, page 8,
4 paragraph 3.12. If we can just highlight that. That
5 paragraph.

6 **A.** Right. Oh, thank you.

7 **Q.** So mention a nurse had been rostered on shift
8 for all the deaths although the nurse had not always
9 been assigned to care for that specific infant?

10 **A.** Yes.

11 **Q.** Sorry. Can we go back to it. 3.12:

12 "Subsequently paediatric lead and all the
13 Consultant paediatricians had become convinced by the
14 link although this was a subjective view with no other
15 evidence or reports of clinical concerns about the nurse
16 beyond this simple correlation an allegation made to the
17 Medical Director and Director of Nursing."

18 Then if we go to page 9 of the same INQ number and
19 those three paragraphs as well, if you can read those.

20 (Pause)

21 **A.** Thank you.

22 **Q.** Then the next page, where the blue starts
23 "recommendations", you see that? That's on the redacted
24 version but the top two paragraphs.

25 **A.** Okay.

40

1 (Pause)

2 Thank you.

3 **Q.** Can we then have an email, please, that can
4 come down, INQ0002046, page 95. This is an email from
5 you to Christine Hurst and cc'ing Mr Moore. You say
6 here:

7 "Having reviewed the files again in relation to the
8 tragic deaths of the two Twins there is nothing to
9 indicate that the deaths were anything other than due to
10 natural causes. I was going to discontinue the
11 investigations but the parents asked me to wait until
12 the result of the Royal College's investigations into
13 neonates at Countess of Chester had been concluded.

14 "This report has now been received and its findings
15 do not add any information pertinent to the deaths in
16 question. The Countess of Chester called the
17 Royal College in because statistically there had been
18 a rise in infant mortality which could not easily be
19 explained. The report reveals a level of understaffing
20 for a unit of its size, possible delays in referrals to
21 tertiary care and other matters which no doubt will be
22 addressed. However, nothing in the report throws any
23 light on the deaths in question and these being natural
24 deaths with nothing to indicate gross human failure,
25 I have no jurisdiction to hold Inquests.

41

1 **Q.** If we can go, please, to INQ0002046, page 77,
2 internal emails between yourself and your office,
3 Christine Hurst on 1 February.

4 Ms Hurst tells you:

5 "In the email I forwarded to you from
6 Claire Raggett from the Countess of Chester she
7 confirmed that an independent review is to be done of
8 each unexpected death and that a full independent review
9 of Children O and P and Child A cases currently been
10 undertaken.

11 "In light of this do you wish to discontinue the
12 investigation or wait until these reviews are complete?"

13 And you say:

14 "We will await the outcome of the review."

15 **A.** Yes.

16 **Q.** On 8 February --

17 **A.** Sorry to interrupt. Is this in relation to --
18 yes, it is. If I remember correctly the parents had, of
19 the two babies had made a request that the Inquests or
20 the investigations shouldn't be discontinued despite the
21 fact that Dr Kokai had found the deaths due to natural
22 causes and it seemed a perfectly reasonable request in
23 view of the fact that there were further investigations
24 to be undertaken.

25 So I countermanded my original instruction that the

43

1 "Let the parents absorb the report and please

2 communicate my thoughts to them."

3 You hadn't seen the full report at that time. Do
4 you think you would have liked to have done or would it
5 have made no difference to see --

6 **A.** Well, clearly I had not received the full
7 report. My attitude would be somewhat different or
8 would have been somewhat different if I had seen those
9 passages which appear to have been redacted.

10 **Q.** Why would it have been any different?

11 **A.** Well -- it, it opened up a whole new line of
12 enquiry. We, we have a mystery: why are there more
13 deaths than would be expected? A review which
14 apparently or appears to throw no light on the matter,
15 but in particular doesn't show any systemic failure
16 which could explain the deaths other than staffing level
17 issues.

18 The paragraphs that were redacted clearly raise
19 a matter that needs investigation, and the response to
20 that would be reporting the matter to the police,
21 whether or not I would have out of courtesy told the
22 Countess of Chester my intention to give them
23 an opportunity to make representations, I don't know.

24 But clearly this was a matter that needed further
25 independent investigation.

42

1 investigation should be discontinued.

2 **Q.** It's apparent from your communications that
3 you do communicate with parents when you are minded to
4 discontinue in case they have anything to add or say.

5 We see that in the case of Baby D --

6 **A.** Yes.

7 **Q.** -- and here. So --

8 **A.** It would most normally be not me direct but my
9 officers on my behalf. When solicitors were involved,
10 then normally I would engage in correspondence direct.

11 **Q.** If we can go please to INQ0005815, page 1.

12 That's a letter to Mr Cross from Christine Hurst.

13 **A.** Yes.

14 **Q.** She says:

15 "I was assured last week by your department that
16 all Family members would be contacted and informed about
17 the Royal College of Paediatrics report prior to it
18 being made public. In light of this assurance I
19 therefore did not get in touch with Father O,P&R to
20 inform him that this document was now complete and that
21 it would be going public this week. I have just
22 received a telephone call from Father O,P&R who was
23 extremely distraught and very angry he has not been made
24 aware of the publication and he and his Family have only
25 now found out about this via the babies' grandparents

44

1 who saw it on the news.
 2 "It was a very difficult and distressing phone
 3 call?"
 4 **A.** Yes.
 5 **Q.** What was your understanding if you had
 6 a report like that, would you think that that should be
 7 shared with the Families or express a view about that?
 8 **A.** Absolutely. Absolutely.
 9 **Q.** If we can go to paragraph 95 of your
 10 statement. You tell us that you are satisfied you did
 11 have a meeting at the hospital with Mr Cross and
 12 Mr Harvey because in subsequent correspondence they
 13 refer to a meeting at the Countess on 8 February. So
 14 you don't recollect a meeting now but you think that's
 15 probably right, you did have one with them at the
 16 hospital?
 17 **A.** Yes, I am sure the meeting took place. I -- I
 18 just have no recollection. Having been taken through
 19 all the documents just now, I imagine that the meeting
 20 was to discuss the report but --
 21 **Q.** The RCPCH report?
 22 **A.** Yes.
 23 **Q.** If we go to INQ0106817, page 34, this is
 24 Mr Cross's note of a meeting. We can enlarge it and see
 25 if it helps you or not?

45

1
 2 "NR: [presumably you] anything come out of in-depth
 3 investigations?
 4 "IH: no theme has emerged."
 5 And then you appear to say, if this is right:
 6 "Wouldn't want to get in the way of talking to the
 7 Families."
 8 Would that be the sort of thing you talked about?
 9 **A.** Right. Yes, I am prepared to accept that, as
 10 I say I have no recollection.
 11 **Q.** "Needs in-depth investigation. Coroner should
 12 share any further info with Families."
 13 Then it looks like it says:
 14 "Trust done right thing."
 15 We don't have Mr Cross to tell us what that
 16 represents or whether there's -- what's alongside that?
 17 **A.** I can't, I'm afraid --
 18 **Q.** Can you remember any discussion about right
 19 thing, or doing the right thing or wrong thing, anything
 20 like that?
 21 **A.** As I say, I really can't remember anything
 22 about this meeting, so I'm at the mercy of the note, as
 23 it were.
 24 **Q.** Fair enough.
 25 It then says:

47

1 **A.** Right. Oh, gosh.
 2 **Q.** It is not easy, is it?
 3 **A.** Can you translate?
 4 **Q.** Yes. Top 8 February. It is that top
 5 right-hand box?
 6 **A.** Yes.
 7 **Q.** You can enlarge it, I think. It's better in
 8 hard copy.
 9 **A.** Right.
 10 **Q.** Mr Harvey outlining ...
 11 Would you rather see a hard copy? This is a good
 12 time for a break anyway.
 13 **LADY JUSTICE THIRLWALL:** We could take the break
 14 and get you a hard copy, is that convenient?
 15 **MS LANGDALE:** Yes.
 16 **LADY JUSTICE THIRLWALL:** So we will take a break
 17 now. We will come back at 20 to 12.
 18 **A.** Thank you.
 19 **(11.20 am)**
 20 **(A short break)**
 21 **(11.40 am)**
 22 **MS LANGDALE:** Mr Rheinberg, you and I both have
 23 a hard copy.
 24 **A.** Yes, that is helpful, thank you.
 25 **Q.** We see that Mr Harvey outlines the meeting.

46

1 "Coroner will advise his staff no comment. Never
 2 associated paediatric deaths with the Countess."
 3 But you have got no recollection of what that's
 4 about?
 5 **A.** Yes.
 6 **Q.** If we can have instead on the screen, please,
 7 INQ0002048, page 33,.
 8 A letter from you to Mr Cross, further to the
 9 meeting of 8 February.
 10 **A.** Right.
 11 **Q.** It will come on screen in a moment.
 12 **A.** Right.
 13 **Q.** "I look forward to receiving copies of the
 14 in-depth reviews carried out in respect of the children.
 15 So far I have received no press enquiries following
 16 publication of the report."
 17 We then know you have a meeting on 15 February?
 18 **A.** Yes.
 19 **Q.** If we can look, please, at INQ0002048,
 20 page 34. We know you say and also Mr Harvey says that
 21 a bundle of documents were given to you at this meeting.
 22 Can we just look at what those documents were,
 23 please.
 24 **A.** Okay.
 25 **Q.** In-depth review into baby deaths. Advisory

48

1 medical report from Dr Hawdon dated October 2016.
 2 I won't put the whole report on the screen,
 3 Mr Rheinberg, but if I can ask, please, for INQ0002048,
 4 page 89 and page 90.
 5 We see recommendations at page 90, if we go back to
 6 page 89 we see a list:
 7 "Child D change following PM review."
 8 So moving it in the document making it clear that
 9 is a change following a PM review?
 10 **A.** Right.
 11 **Q.** We see a list of other infants there.
 12 So the Dr Hawdon report is in this bundle. Then if
 13 we go, please, to INQ0002048, page 91. We see a letter
 14 from the paediatricians to Mr Chambers and we see at
 15 paragraph 2 respectfully requesting you to urgently ask
 16 the Coroner to undertake a full investigation of all the
 17 deaths and unexpected collapses.
 18 It sets out the Royal College Review. It sets out
 19 comments on Dr Hawdon's Casenote Reviews. And we see at
 20 paragraph 5 overleaf:
 21 "No deaths or unexpected collapses since July 2016,
 22 unwell babies have been cared for, received intensive
 23 care and in some cases transferred to the hospitals but
 24 their clinical courses have been far more predictable
 25 and responsive to treatment than previous cases. This
 49

1 think the version that we looked at with Mr Rheinberg
 2 had green text, it was just the original.
 3 **MS LANGDALE:** That is -- my apologies,
 4 Mr Rheinberg. So the findings in relation to a nurse
 5 that you looked at earlier, remember that document?
 6 **A.** Yes.
 7 **Q.** This document has the same information in
 8 it --
 9 **A.** Right.
 10 **Q.** -- except for the last paragraph --
 11 **A.** Okay.
 12 **Q.** -- for our purposes.
 13 **A.** Right.
 14 **Q.** But it has information about the nurse in it.
 15 This document doesn't include the reference to advising
 16 the Trust to follow corporate processes but it sets out
 17 that sheet of paragraphs?
 18 **A.** Yes.
 19 **Q.** That sheet that had the paragraphs?
 20 **A.** Okay.
 21 **Q.** So it appears those are three items that you
 22 are given: the Dr Hawdon report, the Consultants' letter
 23 and the observations described as observations, that
 24 section from the RCPCH review --
 25 **A.** Right.
 51

1 change cannot solely be attributed to the redesignation
 2 of the neonatal unit or any other changes in practice.
 3 "Some of the babies who collapsed in 2015 and 2016
 4 were born at greater than 32 weeks' gestation and many
 5 were not receiving intensive care at the time of their
 6 collapses."
 7 At the end, saying:
 8 "We are making this request because patient safety
 9 is our absolute priority."
 10 Then we see at page 93, a document entitled there
 11 we are, observations additional to the RCPCH review.
 12 This document, I can tell you, Mr Rheinberg,
 13 includes the green text of the report, remember we
 14 looked at the green text?
 15 **A.** Yes.
 16 **Q.** That wasn't there, all but one paragraph. It
 17 doesn't include the last paragraph about:
 18 "In the light of information shared with the Review
 19 Team the RCPCH advise the Trust to follow corporate
 20 processes in responding to allegations of misconduct by
 21 opening investigation."
 22 But it does contain the other paragraphs in that
 23 green text?
 24 **LADY JUSTICE THIRLWALL:** Ms Langdale, I know that
 25 you know and we know about green text. But I don't
 50

1 **Q.** -- that you hadn't seen before?
 2 **A.** Right.
 3 **Q.** Tell us when you had the meeting at what stage
 4 were you given those documents?
 5 **A.** I can't remember. It may have been at the
 6 outset. I -- I can't remember. In fact, I'm glad that
 7 I took a note of the meeting because that served to
 8 remind me of the meeting. Before I read my attendance
 9 note the recollection of the meeting was somewhat --
 10 somewhat vague.
 11 **Q.** Shall we go to your meeting note then and see
 12 what you can tell us about the meeting itself.
 13 INQ0002048, page 102.
 14 **A.** While we are just getting that on the screen
 15 would it be unusual to have the Medical Director
 16 Mr Harvey and Mr Cross coming to see you like this?
 17 **A.** Yes. Very unusual. Not unusual for me to
 18 meet representatives from the hospital. I -- if I had
 19 any issues, I would often arrange for an appointment to
 20 see the Chief Executive or the Medical Director,
 21 probably more the Medical Director than the Chief
 22 Executive. But unusual to get a delegation, as it were.
 23 **Q.** So why did you think at the time they wanted
 24 to come and see you, what did they want to share or
 25 discuss with you, as far as you were concerned?
 52

1 **A.** My understanding was that they wanted me to
2 conduct some sort of overall review, a sort of
3 independent inquiry into all the deaths, not something
4 that I would have any power or authority to do. But
5 that, that was my general understanding, that they
6 wanted me to make some sort of further investigation.
7 But it was just -- I don't think I was given any
8 specific reason prior to the meeting. But that is
9 a little bit of conjecture because I cannot quite
10 remember the circumstances in which the meeting was
11 arranged.

12 **Q.** So they were concerned about the deaths or
13 wanted a review, or you can't remember now?

14 **A.** Yes. I think the fact that I asked for
15 Alan Moore to be or suggested that he should be present
16 was clearly going to be relevant for ongoing themes and
17 with my retirement imminent, it was important that he
18 shouldn't be left out of any, any discussion.

19 **Q.** If we look at paragraph 2:

20 "The first item of the enclosures is a bundle of
21 in-depth reviews into the baby deaths in question and
22 towards the end of the bundle is a sheet indicating
23 which review relates to which baby. In the case of each
24 review, a document will be expanded and written in an
25 easily comprehensible form to be delivered to the

53

1 "NLR observed that Inquests can only be held when
2 there is a jurisdiction to do so and explained that the
3 Coroner must have a body within his jurisdiction and
4 have reasonable cause to suspect that the death was
5 unnatural, came with a particular further category or
6 where the cause of death was unknown. It seems to NLR
7 that in relation to the list of deaths in question they
8 may into one of a number of categories as follows."

9 Before we go to that, do you think you read that
10 letter, you are referring to the letter, the copy of the
11 letter is enclosed, did you read it?

12 **A.** I -- I imagine I had -- either I had or I had
13 received a summary of it, I -- I can't say which.

14 **Q.** So those two documents, the Hawdon document
15 you had looked at, report, likely the letter or had it
16 summarised. What about the third one, the observations
17 document I have just taken you to from the RCPCH review?
18 Did you look at that? If it helps in your statement you
19 say "I don't recollect looking at that document"?

20 **A.** No. I have to say I would really only be
21 guessing. I -- I can't, I have no actual collection.

22 **Q.** You say:

23 "If it had been the subject of any discussion,
24 I would have made reference to this in my note."

25 **A.** Yes.

55

1 parents. We will be given a copy."

2 So might you have gone into the notes or
3 Dr Hawdon's report in the meeting?

4 **A.** Yes.

5 **Q.** You look uncertain there but it makes sense
6 from the notes, doesn't it?

7 **A.** Yes, it does, yes, yes.

8 **Q.** You are talking about the report and looking
9 at it so you think -- how long was this meeting,
10 roughly, do you know now?

11 **A.** I don't remember it being very long, possibly
12 because I wasn't delivering what they hoped I would
13 deliver.

14 I -- at a guess I would say about 30 minutes. But
15 that -- that is only a bit of a guess.

16 **Q.** So it looks as though you have got -- you were
17 sighted on the Hawdon Review or at least the babies --

18 **A.** Yes.

19 **Q.** -- that they were looking at.

20 Then we have got the clinicians from the neonatal
21 unit have written to the Chief Executive and a copy of
22 that letter is also enclosed?

23 **A.** Yes.

24 **Q.** They are asking for the Coroner to hold an
25 Inquest in each case.

54

1 **Q.** But you can't remember now one way or another?

2 **A.** I can't remember. When I do take a note of
3 a meeting or a conversation, I do try to make it
4 comprehensive and I would hope that relevant matters
5 that were raised or whatever would appear in -- in my
6 note. No point in making a note if it isn't
7 comprehensive.

8 **Q.** But --

9 **A.** But since I have no recollection, I can't --
10 can't say one way or the other.

11 **Q.** If we look at the six points you make, then,
12 can you just summarise for us now what you say?

13 **A.** Well, I am explaining that in those cases
14 where I have already had held an Inquest, I can't go
15 back over it because I have no legal authority to do so.

16 I have explained that where I have, or my one of my
17 deputies has signed a part A, a form 100A, indicating
18 that the Coroner does not intend to exercise any
19 jurisdiction, there are problems in holding an Inquest
20 subsequently, the principal one of which being that you
21 don't have a body lying within your jurisdiction, so you
22 would need to get permission from the Chief Coroner
23 under section 2 of the Act.

24 I'm explaining in clause 3 that I am not *functus*
25 *officio*, as it were, I am not without jurisdiction if

56

1 I have discontinued an investigation and further
2 information has -- has come to light.
3 Then I refer to deaths already listed for Inquest,
4 obviously those can be heard, and then deaths where
5 investigations are ongoing.

6 Then I say, I'm not sure that it is very elegant:
7 "NLR made it clear that the Coroner's office does
8 not operate as a system of governance."

9 I got really got the idea that what the Consultants
10 wanted was me to have an overall review of all the cases
11 to see if there were any, any mistakes or any common
12 themes or whatever. And I was explaining that that --
13 I don't have jurisdiction to do -- to do that, no
14 authority to carry out a general review, as it were,
15 only to hold an Inquest into a specific death.

16 **Q.** Thank you.
17 Just finally from me, in terms of the bundle, can
18 you remember now having it with you and being able to
19 flick through that?

20 **A.** I don't, no, I'm afraid.

21 **Q.** But it's reasonable looking at that as though
22 you would have had it and at least been cross-referring
23 to it?

24 **A.** It may well be the case. It's all a matter of
25 interpretation from my note. I haven't got any actual

57

1 **A.** No.
2 **Q.** I am not going to put the note of the meetings
3 to you.

4 **A.** Right.

5 **Q.** But it is fair to say at this meeting and at
6 other meetings at this time there was discussion about
7 the Consultants' concerns about Lucy Letby?

8 **A.** Concerns about?

9 **Q.** Lucy Letby.

10 **A.** Oh, yes, okay.

11 **Q.** In particular, at the meeting in question on
12 the 29th, Dr Brearey mentioned her being a common theme
13 between the deaths as early as July 2015, after which,
14 as you know, three children had died --

15 **A.** Yes --

16 **Q.** -- including Child A. They described the
17 types of deterioration that the babies suffered which
18 were sudden and unexpected, the fact that they didn't
19 respond to resuscitation measures as would be expected
20 and Dr Jayaram speculated that there may be some issue
21 with injection of air and air embolism via a cannula.

22 But of course that discussion didn't evolve into
23 any particular investigation as you know.

24 They in particular discussed the Twins on a number
25 of occasions, including mentioning that only one of the

59

1 recollection.

2 **Q.** But from those present at the meeting with
3 you, Mr Harvey and Mr Cross, it's a fair assumption for
4 them to make that you have got that information --

5 **A.** Yes.

6 **Q.** -- or you can see that information?

7 **A.** I -- I can't challenge that.

8 **MS LANGDALE:** Thank you, those are my questions.

9 **A.** Thank you.

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

11 Questions by MR SKELTON

12 **MR SKELTON:** Mr Rheinberg, I ask questions on
13 behalf of one of the Family groups --

14 **A.** Yes, thank you.

15 **Q.** -- including the Family of Child A, whose
16 Inquest was conducted in 2016. After the death of the
17 two Triplets O&P in June 2016, there were a series of
18 internal meetings at the hospital attended by the
19 Consultants and the Executives.

20 One such meeting took place on 29 June and was
21 attended by Dr Brearey, Dr Saladi, Dr Jayaram, Mr Cross,
22 and Mr Harvey.

23 **A.** Okay.

24 **Q.** You won't have been aware of these internal
25 meetings?

58

1 Twins survived but they had both collapsed, as you know?

2 **A.** Yes.

3 **Q.** Child A had a Twin who also collapsed but
4 fortunately survived, Child B.

5 All of this I think you were entirely unaware of --

6 **A.** Completely.

7 **Q.** -- throughout 2015 and 2016?

8 **A.** Yes, and it's horribly disappointing.

9 **Q.** That is exactly what I was going to ask you
10 about, Mr Rheinberg.

11 **A.** Yes.

12 **Q.** Would you have expected Mr Cross or someone
13 else prior to Child A's Inquest to have raised those
14 types of concerns with you as the Coroner?

15 **A.** Absolutely. It was all within the -- the
16 ethos of the SUDI Sudden Unexpected Infant Death
17 protocol, that we should approach all these tragedies
18 not just in our own ivory towers; that we should share
19 all information because we might individually have
20 pieces of the picture to put together.

21 So police, hospital, everybody that has anything to
22 add should add to the discussion, as I say, to complete
23 a full picture what have has happened. And within
24 Cheshire, the protocol went out under my badge, as it
25 were, so I was the -- I was to be the co-ordinator of

60

1 action, if action was required.

2 So the protocol went out initially in my -- by this
3 time it had been superseded by further iterations of the
4 document but the initial intention was that the
5 Coroner's office should be the focus for the inquiries
6 partly because of course the Coroner's office had powers
7 that the others didn't have.

8 So yes, I'm sorry, I have rambled on a bit but
9 very, very disappointing that relevant information is
10 not shared.

11 **Q.** Just on the SUDIc protocol, is that a local
12 protocol that you would have assisted in drafting?

13 **A.** Yes. I think the first protocol was produced
14 in 2001, it -- there was a general -- up until that time
15 there had been a general feeling across the country that
16 there should be better co-ordination in relation to
17 infant deaths and I forget which area had produced the
18 first protocol; it may have been Sussex, it may have
19 been Suffolk, I can't remember, but a very excellent
20 document.

21 And I think I'm right in saying that the
22 triumvirate, me, Dr Nisar Mir and Dr Ruth Spedding, who
23 put together the initial protocol, leant very heavily on
24 that, that precedent, as it were, because it was a very
25 good document.

61

1 But any individual that had that information should
2 could and should have passed it on, whether by informal
3 chat with me or through one of my officers.

4 **Q.** Your evidence I think in writing and today was
5 a suspicion of that type immediately warrants contact
6 with the police, formally or informally?

7 **A.** Absolutely. And I -- I think I explained the
8 mechanism in my statement.

9 **Q.** Yes.

10 **A.** One of the participants or one of the SUDI
11 team, as it were, was Inspector Mark Tasker and I think
12 probably on getting information such as that, I might
13 have gone straight to Inspector Tasker because he -- he
14 would have all relevant knowledge about procedures
15 within the police force for investigating deaths such as
16 this.

17 **Q.** Do you take that view, that that contact with
18 the police is required, notwithstanding that at that
19 stage all you have is the opinion of the Consultant or
20 body of Consultants?

21 **A.** Yes. The relationship with the police was
22 a close one. I have already explained about my officers
23 being employed by the -- by the -- the police and on
24 many occasions because I only had a limited amount of
25 officers, it was the police that were investigating on

63

1 **Q.** Just in terms of specifics. How would that --
2 those concerns have been or how should they have been
3 communicated to you, by whom and by what means?

4 **A.** I suppose that we are talking about
5 a discussion after -- some time after the events, as it
6 were. In the initial stages under the protocol, there
7 would be a first meeting within 72 hours, when
8 representatives from hospital, police, paediatricians,
9 et cetera, would decide on a strategy for further
10 investigation.

11 Now, that tended to occur almost exclusively for
12 deaths in the -- in the community rather than in
13 hospital, although the mechanism was there to be
14 employed for the -- in the hospital as well.

15 But under the spirit of the -- the protocol which
16 the hospital had or the hospitals in Cheshire had
17 contributed to the discussions, any information that was
18 relevant should be passed on to the Coroner. But quite
19 outside the protocol, that -- that should be the case in
20 any event. I am holding Inquests, I need information.
21 I am holding investigations. I need people to be
22 forthcoming with information.

23 **Q.** Would you have expected Mr Cross to have
24 contacted you with that type of information?

25 **A.** As apparent spokesman, yes.

62

1 my behalf. And in cases where the -- there was any
2 suspicion of a gross failure within a hospital, the
3 first thing that I would do would be contact the police
4 to seize medical records, not that I distrusted the
5 medics, as it were, but I didn't want any possibility of
6 notes being interfered with or written up subsequently.

7 So yes, I -- I would contact the police in the
8 event of a suspicion.

9 **Q.** Ms Langdale asked you about the Serious
10 Untoward Incident or Serious Incident Investigation?

11 **A.** Yes.

12 **Q.** There is a series of correspondence by email
13 and by letter which you express a great deal of
14 frustration about the non-production of that?

15 **A.** Yes, yes.

16 **Q.** How common was it for the hospital or other
17 hospitals in your jurisdiction not to produce a report
18 that you requested like that?

19 **A.** If it -- there was often a delay not -- not so
20 much in the production of the report but in the
21 disclosure of the report but in the actual preparation
22 of the report. But invariably when a report was
23 available and I had requested a copy, it -- the hospital
24 would provide it.

25 **Q.** Your answer may be understood as if one is

64

1 already there --
 2 **A.** Yes.
 3 **Q.** -- you would expect to get it, but if they
 4 haven't already done an investigation but you are saying
 5 "one is needed and I need to see a report" would that --
 6 **A.** Okay, clearly my understanding was that this
 7 -- there was an ongoing specific investigation. So my
 8 expectation would be immediately any report was produced
 9 that I had requested, it -- a copy you would be provided
 10 to me.
 11 **Q.** But not that they would do one to your
 12 direction?
 13 **A.** No. No, I didn't have any power to do this.
 14 I -- I might make strong suggestions that this would,
 15 was an appropriate course for them to take, but not
 16 something that I could demand.
 17 **Q.** You were provided a copy I think of the
 18 Thematic Review that had been conducted at the end of
 19 2015 --
 20 **A.** Yes.
 21 **Q.** -- into 2016. Do you recall whether or not
 22 that version of the report that you saw identified that
 23 the babies had suddenly deteriorated and that was
 24 a common factor across the mortality?
 25 **A.** I can't -- I can't recall. I can't recall
 65

1 **A.** Yes.
 2 **Q.** And that you can see he is saying they have
 3 indicated they are entirely satisfied with the care
 4 within the neonatal unit and raise no concerns, however
 5 they recommended the detailed forensic Casenote Review
 6 of each of the deaths. And you were aware of that from
 7 this email?
 8 **A.** Yes, yes.
 9 **Q.** You weren't, I think, provided with
 10 Dr Hawdon's instructions specifically?
 11 **A.** No.
 12 **Q.** Can I just ask you to look at those on the
 13 screen as well, please, that is INQ0012066. And the
 14 reason I ask you to look at this, Mr Rheinberg, if you
 15 could just have at that first substantive paragraph 2?
 16 **A.** Paragraph?
 17 **Q.** Paragraph 2 made a bit bigger because it is
 18 quite hard to read on the screen?
 19 **A.** Okay, yes. Thank you.
 20 **Q.** That's it, if you just take a moment to read
 21 that, Mr Rheinberg, please?
 22 **A.** Yes.
 23 (Pause)
 24 Yes, thank you.
 25 **Q.** So the information in that paragraph is not
 67

1 now.
 2 **Q.** Dr Hawdon's review, Mr Cross emailed you and
 3 I think may we have the email on the screen just to sort
 4 of anchor the period of time on 6 October, INQ0053069.
 5 You will see the email there to you from Mr Cross at the
 6 bottom.
 7 Mr Rheinberg, just by way of summary as you
 8 probably have picked up there was a lot going on after
 9 June and that included the instruction of the
 10 Royal College to do a review?
 11 **A.** Yes.
 12 **Q.** And their recommendation that a forensic
 13 Casenote Review --
 14 **A.** Yes.
 15 **Q.** -- or detailed forensic Casenote Review be
 16 done and Dr Hawdon was instructed as a result of that --
 17 **A.** Yes.
 18 **Q.** -- before in fact the College had formally
 19 reported?
 20 **A.** Right.
 21 **Q.** They advised in writing that that was needed?
 22 **A.** Yes.
 23 **Q.** I think what is happening here is Mr Cross is
 24 contacting you before the formal report but with the
 25 recommendation that a Casenote Review be conducted?
 66

1 provided to you by Mr Cross, but this is the
 2 justification that the Royal College give and you will
 3 see that it raises a few issues and in particular the
 4 pattern of deaths?
 5 **A.** Yes.
 6 **Q.** The mode of deterioration in some of them
 7 which is unusual --
 8 **A.** Yes.
 9 **Q.** -- and requires further inquiry.
 10 Is that the type of information that you needed to
 11 know when you were approaching Child A's Inquest?
 12 **A.** It -- it would be extremely helpful. I think
 13 one of the things that wasn't undertaken in relation to
 14 Child A's Inquest was an independent examination of
 15 evidence by an expert instructed by me.
 16 The more information that I had raising questions,
 17 might well have prompted me to get independent expert
 18 advice.
 19 **Q.** Is the fact that the mode of deterioration is
 20 unusual and there is a cluster of children itself
 21 something that you as Coroner would be concerned by?
 22 **A.** Certainly it would be a factor, yes.
 23 **Q.** Something to --
 24 **A.** Of concern, yes.
 25 **Q.** Something to investigate?
 68

1 A. Yes.
 2 Q. I won't ask you to read the whole document but
 3 it does mention you will see in paragraph --
 4 A. Sorry, can I just -- sorry, just to give --
 5 put that in context with a case that I was dealing with
 6 at that time with a cluster of deaths at an old people's
 7 home that appeared to relate to the fact that they had
 8 been lock, stock and barrel moved from another home and
 9 then had died within a period of time.
 10 That was an investigation that I had an expert
 11 undertake because of the fact of a -- an apparent common
 12 theme.
 13 Q. Would you have considered the other baby
 14 mortalities that occurred in the neonatal unit and
 15 thought: well do I need to start looking at these
 16 together rather than independently?
 17 A. I -- yes, if there was any common theme
 18 identified then, yes, that, that was certainly something
 19 to take into consideration.
 20 I have it in mind, however, on the other hand the
 21 fact that I knew that there was an independent
 22 investigation being undertaken by the Royal College, so
 23 that is something also I would take into -- into
 24 account. I'm not sure if I had been given that
 25 knowledge how the balance would, would have tipped;

69

1 straws to find an answer.
 2 So if there was any suggestion provided that there
 3 might have been another mechanism, that is something
 4 I definitely would have wanted to explore.
 5 Q. At the Inquest, Dr Jayaram gave evidence --
 6 A. Yes.
 7 Q. -- twice.
 8 He first gave evidence about his own involvement
 9 with the child?
 10 A. Yes.
 11 Q. And then I think you brought him back after
 12 speaking to the pathologist to explain his opinion?
 13 A. Yes.
 14 Q. So was he in that sort of quasi expert role
 15 that you previously described?
 16 A. Yes, absolutely.
 17 Q. So you are looking to him to assist you on --
 18 A. Yes.
 19 Q. -- possibilities at that point?
 20 A. Yes.
 21 Q. Rather than the facts of what he did or didn't
 22 do?
 23 A. Well, I suppose he's -- I'm expecting him to
 24 give evidence on a mixed basis; the bases being his own
 25 actual knowledge and as a witness of fact but with his

71

1 whether I had thought, well, it's been looked into, or
 2 whether I would have thought: I -- I better take this up
 3 independently.
 4 I -- I can't -- I can't say which way I -- I would
 5 have gone.
 6 Q. What appears to occur at the Inquest into
 7 Child A, which I will come on to in a minute, if I may?
 8 A. Yes.
 9 Q. Is that you are looking to try and test what
 10 might have happened to this child to cause death?
 11 A. Yes.
 12 Q. Because on the face of it the doctors and
 13 pathologist aren't able to provide a --
 14 A. No.
 15 Q. An explanation that satisfies you.
 16 If you had known that this investigation was going
 17 on independently, and also if you see from
 18 sub-paragraph (c) that it was going to be looking at
 19 rare conditions, such as air embolism and metabolic
 20 derangement, how would you have responded to that fact?
 21 A. Yes. It would be a line that I would want to
 22 have been looked into. All that I have at, before the
 23 Inquest is a question mark: these could have been causes
 24 of death, the error with the line, the crossed pulmonary
 25 artery, but not, not a -- it was rather grabbing at

70

1 expertise to explain as well.
 2 Q. As I set out earlier in my preface to the
 3 questions, Dr Jayaram was in fact suspicious of
 4 Lucy Letby at that time and also suspected that she may
 5 have injected air into one or more children and was
 6 suspicious about Child A's death in particular. He has
 7 accepted he should have mentioned that suspicion to you.
 8 Can I ask for your reaction to that?
 9 A. Yes. Absolute horror. Why, why not? Why
 10 wouldn't you? I -- I think in those, if that had come
 11 out at the Inquest, I would have adjourned, I wouldn't
 12 have gone on any further, and probably sought police
 13 involvement.
 14 Q. Likewise in respect presumably of Dr Saladi
 15 although his role at the Inquest was much more minor but
 16 he was aware of the suspicions and indeed shared them as
 17 well?
 18 A. Yes. It -- it does seem extraordinary.
 19 Q. Can I ask you --
 20 A. Can I ask, did either of these individuals
 21 explain why they hadn't brought that information out?
 22 Q. It's --
 23 **LADY JUSTICE THIRLWALL:** I think that is probably
 24 a matter for me to determine. You can certainly read
 25 the transcripts if you want.

72

1 A. It's inappropriate, I beg your pardon.
 2 **LADY JUSTICE THIRLWALL:** No, it's all right.
 3 **MR SKELTON:** The hospital were represented at the
 4 Inquest and there is a question about what their
 5 counsel, who is a senior barrister at that point,
 6 Mr Browne, knew.
 7 But it is clear and he has accepted that he was
 8 told prior to the Inquest that there was some connection
 9 between a specific nurse and Child A which the hospital
 10 had been considering?
 11 A. Right.
 12 Q. He was also aware of Dr Hawdon's instructions
 13 and which is still on screen in front of you which
 14 I have taken you through?
 15 A. Yes.
 16 Q. I can't put it any higher than that because
 17 Mr Browne, to be fair to him, has not got a clear
 18 recollection?
 19 A. Yes.
 20 Q. And note isn't precise about exactly what he
 21 was told?
 22 A. Okay.
 23 Q. He was aware of a connection between a nurse
 24 and indeed had asked that some research be done to see
 25 if the nurse was involved with Child A's care?

73

1 this is relevant, you must either disclose this
 2 yourselves, if you will not do so I am bound by my own
 3 professional conduct and must withdraw from this
 4 particular set of instructions.
 5 But one way or another I would expect a legal
 6 representative to seek to have that information brought
 7 to the attention of the Inquest.
 8 Q. Just finally on Child A's Inquest can I just
 9 ask for your overall observations on the Inquest and in
 10 particular the position of the Family. I think as you
 11 are aware, because you were in contact with them, the
 12 Family were represented and they were extremely anxious
 13 to find out why Child A had died?
 14 A. Absolutely yes.
 15 Q. Many, many months had passed since his death
 16 and they still didn't have any answers?
 17 A. No.
 18 Q. Can I ask just for your observations on the
 19 sort of dissonance between what the hospital knew and
 20 were investigating and the way the Inquest ended up not
 21 answering any questions?
 22 A. Right. Of course I didn't know that there
 23 were questions that --
 24 Q. No.
 25 A. -- were unanswered.

75

1 A. Okay.
 2 Q. Had advised that that fact be disclosed to the
 3 Family?
 4 A. Yes.
 5 Q. As far as you were concerned, the Coroner at
 6 the Inquest, would you expect counsel to raise that
 7 issue with you the fact that the hospital were
 8 considering a nurse and her connection to the Child A's
 9 death?
 10 A. Okay. Answering more generally, first of all.
 11 It's been my happy experience that the more senior
 12 the counsel attending an Inquest the more they embrace
 13 the philosophy, if you like, that an Inquest -- that
 14 they are here to assist the inquiry.
 15 So it's been my experience that in asking questions
 16 of their witness, if there is relevant information, even
 17 if it might detract from their own client's position,
 18 that that question will be asked. So going back to the
 19 specific. If counsel knew of serious concerns, then,
 20 I would expect at the very least for those concerns to
 21 be put as questions to their witness so that the matter
 22 came out in the open.
 23 I'm not sure what the legal position would be so
 24 far as the barrister actually informing the Coroner.
 25 I -- I suppose the correct course of action would be:

74

1 From my own point of view, I was not happy with the
 2 Inquest. It didn't really achieve very much. It
 3 brought the legal process to an end, but without any --
 4 without any solid answers and sadly that is, that --
 5 that can be the case; that the evidence just isn't
 6 there. It can't be, can't be found.
 7 But it was a disappointment that nothing really
 8 very solid emerged from that Inquest.
 9 Q. In this case I was asking you specifically
 10 about the fact that the hospital were aware of things
 11 that related to Child A's death but that was never
 12 brought to the family's attention via the Inquest
 13 process?
 14 A. Right. No, to put it mildly, that is
 15 extraordinarily disappointing.
 16 Q. After the Inquest you had contact with --
 17 continuing contact with the hospital. Ms Langdale has
 18 asked you about the various meetings --
 19 A. Yes.
 20 Q. -- and the correspondence that you had.
 21 Can I be clear that at no time did Mr Harvey or
 22 Mr Cross or anyone else bring the -- raise the concerns
 23 directly in terms with you and discuss them with you?
 24 A. No.
 25 Q. Your answer to what you would have done is

76

1 exactly the same in terms of contacting the police --

2 **A.** Yes.

3 **Q.** -- and setting in train a series of
4 investigations through that means?

5 **A.** Yes. I used -- probably it was regarded as
6 a bit of a pain but I would go to the police with any
7 suggestion of criminality. As I am sure you can
8 imagine, an Coroners office in an area as large as
9 Cheshire gets a fair number of crank email --
10 correspondence. The block capitals, underlined, green
11 ink sort of style.

12 Some of these will relate to totally irrelevant
13 matters, some will allege criminality no matter how
14 extraordinary or however unlikely, or however it may be
15 almost crystal clear that the person in question is
16 mentally ill. All such communication was sent to the
17 police for investigation with the instruction that I was
18 to be informed as to the -- as to the result of that
19 investigation.

20 So there would be no case of me withholding
21 information such as that from the police. It didn't
22 mean that it had my endorsement, it didn't mean that
23 I was saying somebody was guilty of a crime. It was --
24 I was just asking in each case: please investigate.

25 **Q.** Even after Child A's Inquest had concluded,

77

1 Child A and other children. But focusing on Child A --

2 **A.** Yes.

3 **Q.** -- the reasons for that, of course, are the
4 focus of this Inquiry, at least one of its focuses.

5 But can you think of any reform or recommendations
6 that could be made to stop that from happening again?

7 **A.** Well, it -- it's so much a matter of
8 professional conduct and particularly in this era of
9 full disclosure, et cetera, it -- it's difficult to see
10 how existing professional standards don't cover it
11 already. But I can't think of anything over and above
12 what is in existence already that could be brought
13 into -- into play.

14 **Q.** Could it be for example that it should be made
15 clear in policy and guidance that if a member of staff
16 is suspicious that a child may have died from deliberate
17 harm, no higher than that, that you at least must be
18 informed?

19 **A.** Yes. And of course there is a duty which
20 I think is reproduced as a medical standard that the
21 Coroner must be informed. Back to the Middle Ages, it's
22 always been the case that there is a duty to inform the
23 Coroner. It's nothing new.

24 **MR SKELTON:** Thank you, Mr Rheinberg. Thank you,
25 my Lady.

79

1 and as you said you were functus officio by that

2 stage --

3 **A.** Yes, yes.

4 **Q.** -- if evidence or information comes to your
5 attention which may mean that the result of the Inquest
6 is wrong --

7 **A.** Yes.

8 **Q.** That is something that you can raise as being
9 a possible?

10 **A.** Absolutely and I have judicially reviewed
11 myself. One case in particular where really very
12 pertinent information came out due to an advance in
13 medical understanding which showed that what had been
14 delivered as an open verdict in fact had a -- a very
15 specific cause and because it -- it was so important
16 even though the appropriate conclusion would be natural
17 causes as opposed to open, the matter in my view was so
18 important that I -- I sought to set aside the original
19 Inquest and start again, as it were.

20 So being functus officio doesn't -- well, A,
21 obviously stop me passing on information to the police;
22 but also it doesn't stop me going to the High Court to
23 get my Inquest set aside.

24 **Q.** In this case, again stepping back, you were
25 not provided with relevant information in respect of

78

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

2 Questions by MR BAKER

3 **MR BAKER:** Good afternoon, Mr Rheinberg, I ask
4 questions on behalf of the other two Family groups.

5 **A.** Yes, thank you.

6 **Q.** I want to begin by asking about sharing
7 learning between different Coroner areas.

8 **A.** Okay.

9 **Q.** So there are a number of different Coroner
10 areas across North West --

11 **A.** Yes.

12 **Q.** -- of England?

13 **A.** Yes.

14 **Q.** Many of them adjacent to each other?

15 **A.** Yes.

16 **Q.** Do the Coroners -- Senior Coroners meet up and
17 exchange information, learning or experience at all?

18 **A.** Yes. I was -- because my jurisdiction was
19 contiguous to them, I was brought into the -- I was
20 going to say "club", it sounds entirely wrong, but the
21 Manchester Coroners held regular meetings and I was
22 invited to join that group, as it were, so that we
23 should strive to be consistent, nothing worse than
24 having the Coroner in Cheshire acting completely outside
25 the -- the practice of the Manchester Coroners.

80

1 Wider than that, we have the North West Coroners
2 Society meeting regularly, having education sessions and
3 to a certain extent acting as a discussion point.

4 Not so much though, perhaps, but what has been
5 a unifying factor since before 2013 has been the
6 appointment of the Chief Coroner --

7 **Q.** Yes.

8 **A.** -- and that has been enormously helpful. For
9 the first time it sounds extraordinary to say this but
10 for the first time ever education is compulsory and not
11 something that you -- you go to if you happen to have
12 the time to spare and we -- we have all the Practice
13 Directions, legal sheets et cetera, very, very helpful
14 in trying to get unity of practice.

15 **Q.** Yes. Now --

16 **A.** It doesn't answer your question because of
17 course you are asking about sharing information.

18 **Q.** It goes to the next question, in fact?

19 **A.** Yes.

20 **Q.** Because of course the crimes of Harold Shipman
21 were committed not in your jurisdiction but immediately
22 adjacent to your jurisdiction?

23 **A.** Yes, yes.

24 **Q.** Did the Shipman crimes and subsequent Inquiry
25 trigger any discussion or training provided to Coroners

81

1 about a single nurse being present for all of those
2 deaths, or at crucial points during them, is it fair for
3 the Chair to infer that if that had been drawn to your
4 attention, it would have immediately triggered an alarm
5 bell for you?

6 **A.** Yes, it would certainly trigger an alarm bell
7 I'm not sure that I would discuss it with -- with
8 colleagues on the basis that --

9 **Q.** No, no?

10 **A.** -- at that stage it would be tittle-tattle.

11 **Q.** Yes.

12 **A.** As opposed to something to be taken into
13 account.

14 **Q.** I suppose the point I am making is that by the
15 time we get to 2016/2017 --

16 **A.** Yes.

17 **Q.** -- there has been so much discussion arising
18 out of Shipman, you have had incidents at Stepping Hill
19 Hospital, you have had your own experience of a spike of
20 deaths in a care home which you described --

21 **A.** Yes.

22 **Q.** -- all of that learning and information would
23 have put you on heightened alert, wouldn't it, to
24 information surrounding suspicions about a nurse being
25 involved in deaths in a hospital?

83

1 including yourself in the North West?

2 **A.** Yes, a huge amount. It, it -- we all looked
3 at our practices and it had a huge impact also on
4 doctors, particularly lead general practitioners who
5 started reporting absolutely everything and the -- it
6 was what we described as "the Shipman effect". So it --
7 it didn't actually paralyze the service but it did lead
8 to a whole lot of inappropriate referrals.

9 **Q.** Yes, but a greater awareness?

10 **A.** It created a huge awareness and, I mean, it
11 sent a horrible shudder throughout -- well, through all
12 the Coroners: could this occur in my jurisdiction?

13 **Q.** And in 2015, Victorino Chua was convicted of
14 committing murders at Stepping Hill hospital?

15 **A.** Yes.

16 **Q.** Of course that would have fallen within
17 Manchester South's jurisdiction. But again, do you
18 recall any discussions in 2015 as part of the Manchester
19 group relating to the crimes of Stepping Hill hospital
20 at?

21 **A.** I am sure there will have been -- I cannot
22 bring them to mind now.

23 **Q.** All this brings us to this: if your attention
24 had been drawn to a cluster of unusual, unexpected,
25 sudden, unexplained deaths with comments or concerns

82

1 **A.** Yes. Absolutely. Perhaps relevant to mention
2 a murderous nurse in one of my hospitals, Leighton
3 Hospital.

4 **Q.** Yes.

5 **A.** There are certain parallels in that case
6 parallels, this nurse was -- it's not an appropriate
7 word but euthanasing individuals in a way that was
8 absolutely undetectable. She was choosing victims at
9 the end of their life typically suffering from
10 congestive cardiac failure which leads to a build-up of
11 fluid on the lungs and the simple expedient that she was
12 using was removing a pillow so that in effect the victim
13 was dying almost drowning on their own fluid.

14 Absolutely no sign at postmortem. But a very
15 terrible state of circumstances.

16 **Q.** How did that come to your attention?

17 **A.** I can't now remember. It was very early on --

18 **Q.** Yes.

19 **A.** -- fortunately and the nurse in question was
20 arrested. It wasn't this sort of timescale.

21 **Q.** No, but given all of that experience --

22 **A.** Yes.

23 **Q.** -- one of the issues the Chair may have to
24 determine is what information was provided to you about
25 suspicions regard Lucy Letby?

84

1 A. Yes, yes.
 2 Q. Would it not be fair to say that given your
 3 experience, given the general level of sensitivity
 4 towards crimes in hospital or Coroner sensitivity
 5 towards the possibility of crimes that if it was raised
 6 with you in any sort of explicit way, that you would
 7 have acted immediately upon it?
 8 A. Yes, of course.
 9 Q. Yes. Moving on to a slightly different topic.
 10 You were asked a question by Ms Langdale about
 11 challenges sometimes in finding the cause of death in
 12 a neonate and it is correct the Inquiry has heard
 13 evidence from Dr McPartland that it can sometimes be
 14 challenging to identify a cause of death at postmortem?
 15 A. Yes.
 16 Q. That's because for a number of diseases that
 17 don't or processes that don't leave obvious marks on, to
 18 be visible at postmortem so --
 19 A. I fear that that to some extent underlines the
 20 deficiencies in pathology.
 21 Q. Yes.
 22 A. You have a postmortem examination into -- with
 23 an elderly patient, you can find so much pathology you
 24 could write three or four death certificates.
 25 Q. Yes.

85

1 by the opinions of others.
 2 That was absolutely crazy.
 3 Q. Yes.
 4 A. The pathologist cannot see an errant
 5 electrical activity within the heart that was -- that
 6 was observed in the hospital.
 7 Q. Yes.
 8 A. You -- you have to have as much information as
 9 possible. 99% of it may be irrelevant but the
 10 pathologist has to be engaged fully with all available
 11 evidence.
 12 Q. If I come on to Child C whose Family
 13 I represent. Again, to be very clear, I am not asking
 14 you to comment on any judicial decision-making. I just
 15 want to understand what information was provided to
 16 you --
 17 A. Yes.
 18 Q. -- and in what format. You discuss the
 19 conclusions you reached with regard to cause of death at
 20 paragraph 52 of your witness statement. Effectively
 21 what you say is that it was communicated to you by
 22 Dr Kokai that there was a natural cause of death, ie
 23 hypoxic ischaemic to the heart caused by respiratory
 24 failure?
 25 A. Yes.

87

1 A. The actual cause that's identified is the
 2 leader in the pack. But whether it actually is the
 3 cause of death is another question. With an infant,
 4 there's often so little to see that it, it is
 5 extraordinarily difficult to find a cause of death.
 6 Q. But of course, if you have evidence from
 7 clinicians or accounts from clinicians, it is usually
 8 the clinical history that tells you what the cause of
 9 death was in those cases?
 10 A. Yes, yes.
 11 Q. So in other words, sepsis, which may not leave
 12 many marks --
 13 A. Yes.
 14 Q. -- on the body of a baby, there will be
 15 a history of sepsis --
 16 A. Yes.
 17 Q. -- and progression of that disease and
 18 likewise, you know, cardiac disorders, again bring about
 19 obvious symptoms in life in many cases that can be
 20 described by doctors in evidence?
 21 A. When I first became a Coroner, it was the
 22 practice of some Coroners to give instructions that the
 23 pathologist was to be given no information whatsoever on
 24 the basis that the pathologist was to act as a totally
 25 independent expert and not in any way to be influenced

86

1 Q. Lung dysfunction?
 2 A. Yes.
 3 Q. So the Inquiry has heard evidence to suggest
 4 that Dr Gibbs, who was the treating paediatrician for
 5 Child A, was concerned that the damage to Child C's
 6 heart occurred following his collapse; so in other
 7 words, he had a collapse and then lived for a period --
 8 A. Right okay.
 9 Q. -- on the edge of life --
 10 A. Yes.
 11 Q. Before passing away and that the damage to his
 12 heart was caused during that period?
 13 A. Right okay.
 14 Q. But wasn't the cause of his collapse?
 15 A. Right.
 16 Q. His evidence was that actually with regard to
 17 his respiratory function and heart function leading up
 18 to the collapse, that all seemed to be normal to him?
 19 A. Okay.
 20 Q. So he was -- he had discussions with Dr Kokai
 21 about Dr Kokai's finding and may or may not have
 22 expressed concerns to Dr Kokai, it would certainly be
 23 evidence of Mother C that she understood there to be
 24 concerns by Dr Gibbs regarding the cause of death?
 25 A. Right.

88

1 Q. Was any of that debate communicated to you?

2 A. No. I can't remember having any discussion
3 with Dr Kokai or anyone else at Alder Hey. It was
4 a very comprehensive postmortem report that seemed to
5 produce a very clear line of causation.

6 Q. Yes.

7 A. The appearance was of a completely natural
8 cause of death.

9 Q. Yes, and of course any Coroner is reliant upon
10 the medical expertise of the pathologist in providing
11 their description of what the cause of death is based
12 upon the postmortem findings, but it is ultimately the
13 role of the Coroner is it not to determine the cause of
14 death?

15 A. Absolutely, yes.

16 Q. In some cases a Coroner may disregard what
17 a pathologist says because there is other evidence in
18 conflict --

19 A. Absolutely. Every postmortem report is looked
20 at extremely carefully, particularly with a paediatric
21 postmortem, and yes, if there are any queries or any
22 apparent anomalies, these are taken up and personally
23 I always found Dr Kokai extremely approachable --

24 Q. Yes.

25 A. -- and more than happy to discuss matters and
89

1 A. Yes.

2 Q. But it would go, in Child C's case, to be
3 important for an Inquest because it isn't a disagreement
4 between two potential natural causes, it is
5 a disagreement between a given natural cause or death
6 being unascertained as a cause of death?

7 A. Yes, yes.

8 Q. That would be the reason to have an Inquest.
9 So that would have been relevant and important
10 information to provide to the Coroner?

11 A. Yes.

12 Q. Yes. In relation to Child E, again you have
13 been asked some questions, I hope not to repeat them but
14 advice was given to the parents of Child E not to have
15 a postmortem, or in other words that a postmortem
16 wouldn't give any more information?

17 A. Right.

18 Q. Because the doctor concluded that the cause of
19 death was Necrotising Enterocolitis?

20 A. Yes.

21 Q. Again, the evidence for that condition was
22 somewhat fragile, it might be said?

23 A. Okay.

24 Q. The doctor who gave that advice has since said
25 that actually I shouldn't have given that advice, there
91

1 explain findings.

2 Q. I want to be clear I am not impugning
3 Dr Kokai's competence, but there is sometimes
4 a difference in opinion between clinicians and
5 pathologist as to cause of death?

6 A. Yes, yes, I would hope normally though that
7 that would be made clear in a report.

8 Q. Yes. Indeed. And the usual way to determine
9 that dispute, if it can be categorised as a dispute, is
10 to have an Inquest and to hear evidence, isn't it?

11 A. Yes.

12 Q. So if there is a disagreement as to the cause
13 of death?

14 A. Yes, if it -- if it is that stark.

15 Q. Yes.

16 A. And I would anticipate or expect you will have
17 seen in the postmortem reports it's invariable the
18 correlation between the antemortem details and the
19 postmortem details, just to tie the two up and I would
20 have expected something there.

21 Q. Indeed recognising as we you said before that
22 the postmortem findings are contingent upon in many
23 cases what happened in life --

24 A. Yes.

25 Q. -- when you come to that point?
90

1 wasn't enough evidence for Necrotising Enterocolitis?

2 A. Right, that is disturbing.

3 Q. Yes. Speaking as a Coroner, would you expect
4 a clinician giving advice to parents about a postmortem
5 to say a postmortem is going to be difficult and
6 traumatic and it will be upsetting for you to have
7 a postmortem, so even if there is a reason for it, we
8 shouldn't have it?

9 A. What I -- well, that may or may not be the
10 case. What I would expect was that the doctor reporting
11 the death to make it clear that there were considerable
12 doubts as to whether this was the correct --

13 Q. Yes?

14 A. -- diagnosis. In which case I would order
15 a postmortem and obviously one tries to take into
16 account the views of a family and before any postmortem
17 the family will be consulted. Ultimately, it's for the
18 Coroner to make the decision so it's not a question of
19 this isn't a set of circumstances where one is
20 contemplating in an absolutely stock natural cause
21 death, discussing the possibility of a hospital
22 postmortem.

23 This is the Coroner's case and it is the Coroner
24 that will make the decision.

25 Q. So going to two key points. One is that the
92

1 Coroner is a person ultimately who make a decision about
2 a postmortem?

3 **A.** Yes.

4 **Q.** Not the doctor or the parents. But secondly,
5 Coroners shouldn't be misled by --

6 **A.** Oh, absolutely not. I mean, again the duty of
7 candour, it's --

8 **Q.** Yes.

9 **A.** Am I right in recalling that it was Dr Napier
10 that was the Assistant Coroner that dealt with -- I have
11 got a feeling it was.

12 **Q.** It was the sitting Coroner.

13 **A.** On that particular day.

14 **Q.** I don't --

15 **A.** Right. I am almost certain it was.

16 **Q.** Yes.

17 **A.** And the advantage there would be that whereas
18 most of my team were not medically qualified, Dr Napier
19 is and was and -- a doctor second to none. And would
20 have understood the nuances if full details were -- were
21 given.

22 **Q.** But in Coroner's practice if you receive
23 a telephone call from a treating clinician who says:
24 I think it's Necrotising Enterocolitis, it would be
25 a bold decision, wouldn't it, to disagree with that --

93

1 today.

2 **A.** Okay.

3 **Q.** In terms of the meeting of 8 February 2017 --

4 **A.** Yes.

5 **Q.** -- you have told the Inquiry that you have no
6 independent recollection of that meeting but you accept
7 from the notes that were made that the meeting took
8 place and that you were there?

9 **A.** Yes.

10 **Q.** Yes. And my note of one issue that was
11 discussed during the course of that meeting, the note
12 made by Stephen Cross --

13 **A.** Yes.

14 **Q.** Is that you are recorded as having said the
15 Trust has done the right thing?

16 **A.** Yes.

17 **Q.** Now, in his meeting note of 15 February
18 meeting, so the following week, there is another note
19 made by him that echoes that note?

20 **A.** Okay.

21 **Q.** It says "absolutely right action by the Trust"
22 Those comments made by you about the Trust
23 commissioning the RCPCH report and then later
24 Dr Hawdon's report?

25 **A.** They may, may well have been.

95

1 **A.** Oh absolutely, yes.

2 **Q.** -- conversation?

3 **A.** Oh, absolutely, yes, and I have to say that
4 I think without exception in the case of the babies
5 here, it was always a Consultant that made the report.

6 **Q.** Yes.

7 **A.** Which -- which is good practice. In the
8 Coroners office we often are beset with difficulty
9 because the -- it's the poor junior doctor that doesn't
10 know a left leg from a right leg who's asked to report
11 a death and trying to get something comprehensive before
12 one gives up and says: I must speak to the Registrar ...

13 So to have a Consultant report a death, unusual,
14 but one would expect a very much higher standard.

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

17 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
18 Ms Blackwell.

19 Questions by MS BLACKWELL

20 **MS BLACKWELL:** Mr Rheinberg, my name is Kate
21 Blackwell and I ask questions on behalf of the former
22 Executives of the Trust.

23 **A.** Yes, thank you.

24 **Q.** I don't have very many questions and they are
25 based around the evidence that you have already given

94

1 **Q.** Thank you. During the course of that meeting,
2 the second meeting on 15 February --

3 **A.** Yes.

4 **Q.** -- we know that you were provided with three
5 documents?

6 **A.** Yes.

7 **Q.** The letter from the Consultants.

8 **A.** Yes.

9 **Q.** Dr Hawdon's report.

10 **A.** Yes.

11 **Q.** And the third document, which is headed
12 "Observations Additional to the RCPCH Review" --

13 **A.** Yes.

14 **Q.** "... of Neonatal Services."

15 That includes the text that we have referred to --

16 **A.** Yes.

17 **Q.** -- as the green text?

18 **A.** Yes.

19 **Q.** You have said this morning, Mr Rheinberg, that
20 you can't remember if that third document was discussed
21 during the course of the meeting.

22 **A.** Yes. I think if it was, it would have been in
23 my note.

24 **Q.** Well, we have looked at your notes --

25 **A.** Yes.

96

1 Q. -- and they are typed notes, aren't they?
 2 A. Yes.
 3 Q. Do we take it from that that they weren't
 4 being made contemporaneously during the course of the
 5 meeting but written up afterwards or typed up
 6 afterwards?
 7 A. No. My writing is absolutely appalling.
 8 I take a contemporaneous note and then immediately
 9 afterwards, I type it up.
 10 So, no. I do -- they are as near as can be
 11 properly described as a contemporaneous note.
 12 Q. If you didn't look through that third document
 13 during the course of that meeting, would you have looked
 14 at it afterwards, perhaps in the course of typing up
 15 your notes?
 16 A. I can't remember having done so.
 17 Q. All right. Would it be unusual for you not to
 18 have read the full bundle of documents which you had
 19 been provided with?
 20 A. I would hope so, but this particular time was
 21 horrendously hectic. I was seeking to hold as many
 22 Inquests as I could that on outstanding cases, handing
 23 over everything, preparing for retirement, going and
 24 doing the rounds of farewells, et cetera. So it, it was
 25 a busy time. I can't say one way or another.

97

1 Q. You also went on in the latest session to tell
 2 the Inquiry that you were regarded as a bit of a pain
 3 because you would go to the police with any suggestion
 4 of criminality?
 5 A. Yes.
 6 Q. But you didn't go to the police when you were
 7 provided with that information during the course of the
 8 meeting on 15 February, did you?
 9 A. Which suggests that I -- I hadn't seen it.
 10 Q. You hadn't read it?
 11 A. I hadn't read it.
 12 Q. All right. In fact, you could have gone to
 13 the police without informing the Countess of Chester
 14 Hospital, couldn't you?
 15 A. Of course, yes.
 16 Q. Yes, because it's only a matter of courtesy,
 17 as you told the Inquiry --
 18 A. Yes.
 19 Q. -- that you would inform them if you had gone
 20 to the police.
 21 You also told the Inquiry this morning that you had
 22 a conversation with your colleague Christine Hurst --
 23 A. Yes.
 24 Q. -- a Senior Coroner's officer, about the
 25 unexpected deaths at the hospital when you had had

99

1 Q. Should you have looked at it?
 2 A. Yes, obviously.
 3 Q. You have told the Inquiry this morning that
 4 the police, the hospital, clinicians, everybody, bear
 5 a responsibility for bringing any relevant information
 6 to your attention?
 7 A. Yes.
 8 Q. And only then does the system become fully
 9 effective?
 10 A. Yes.
 11 Q. We know that you were not provided with the
 12 full RCPCH report in January of 2017 and you were asked
 13 by Ms Langdale this morning what difference, if any, it
 14 would have made if you had been provided with the full
 15 report?
 16 A. Yes.
 17 Q. Including the green text?
 18 A. Yes.
 19 Q. Your answer to that was that: the redacted
 20 paragraphs clearly raised a matter that needed
 21 investigating.
 22 A. Yes.
 23 Q. Your response would have been to report the
 24 matter to the police?
 25 A. Yes.

98

1 reported to you the deaths of Child O and Child P. You
 2 told us that this morning?
 3 A. Yes.
 4 Q. Was that the first such conversation that you
 5 had with Ms Hurst or any of your Coroner's officers?
 6 A. No, no, it -- having three deaths quite close
 7 together in --
 8 Q. In June of 2015.
 9 A. -- 2015 we will, we will have discussed that
 10 as a team.
 11 Q. What was the state of your professional
 12 curiosity back in June of 2015?
 13 A. What was state of ...?
 14 Q. What was the state of your professional
 15 curiosity in June of 2015? How professionally curious
 16 were you about the cluster of deaths then and what was
 17 being discussed?
 18 A. Well, it, it was worrying. But -- well, there
 19 we are. It was worrying.
 20 But as, as the results came, came out they all
 21 seemed to be explicable.
 22 Q. There were no forensic postmortems in any of
 23 the neonatal deaths that were referred to you, were
 24 there?
 25 A. Correct.

100

1 Q. As you have explained to the Inquiry, scrutiny
2 and care is much greater with a forensic pathologist
3 than with -- and during a forensic postmortem?

4 A. Right, okay. I may -- that's why I introduced
5 the -- my mention of general postmortems.

6 Q. Yes.

7 A. A paediatric postmortem is absolutely
8 meticulous; not in any way deficient or unsatisfactory
9 when placed against a forensic postmortem. It's just
10 a different focus.

11 So the paediatric pathologist will look with
12 expertise with regard to paediatric mortality. The
13 forensic pathologist will look for any evidence, signs
14 of criminality and will involve the police to a vastly
15 greater extent.

16 The postmortem typically will still be carried out
17 by the paediatric pathologist with the forensic
18 pathologist looking on. Typically it will be the
19 paediatric pathologist who takes the lead in
20 histopathological areas --

21 Q. Yes.

22 A. -- and in relation to all the other tests.

23 But, as I said, the focus of the forensic
24 pathologist will be on the possibility of criminality.
25 And what that adds to the investigation is partly the

101

1 to you by the clinicians?

2 A. Yes.

3 Q. Yes, and one of the additional benefits of
4 a forensic postmortem might be that samples would be
5 retained. There might be a toxicological examination
6 ordered and those additional aspects that wouldn't
7 necessarily --

8 A. No, those are always standard with, with
9 any --

10 Q. With any postmortem?

11 A. Within Alder Hey.

12 Q. Right.

13 A. I can't say for the rest of the country.

14 MS BLACKWELL: Yes. Thank you very much. That is
15 all I ask, my Lady.

16 LADY JUSTICE THIRLWALL: Thank you very much,
17 Ms Blackwell.

18 Mr Rheinberg, we are going to take a short break
19 but I hope if we just take 15 minutes, then we can
20 conclude. I have one or two questions for you but
21 I want the shorthand writer to have a break and I want
22 to check some references, so we will come back again at
23 quarter past 1.

24 (1.01 pm)

25 (A short break)

103

1 forensic knowledge and what to look for --

2 Q. Yes.

3 A. -- but, secondly, the close communication with
4 the police and the extra information obtained.

5 Q. So what you are describing in a forensic
6 postmortem of a neonate or a child --

7 A. Yes.

8 Q. -- would be the presence of the neonatal
9 pathologist?

10 A. Yes.

11 Q. The forensic pathologist and the police?

12 A. Yes, exactly. It's a collaborative process.

13 Q. Yes. Thank you. In terms of the deaths that
14 were reported to you during the period relevant for this
15 customer, there was only one. I am so sorry -- yes,
16 there was only one Inquest held and that was in relation
17 to Child A because there were three awaiting --

18 A. Yes.

19 Q. Child D, Child O and Child P?

20 A. Yes.

21 Q. But in fact those were adjourned once the
22 police investigation was launched?

23 A. Yes, so I understand, yes.

24 Q. Yes. As a Coroner, the decision for you to
25 order a postmortem is driven by the information provided

102

1 (1.15 pm)

2 Questions by LADY JUSTICE THIRLWALL

3 LADY JUSTICE THIRLWALL: Now, Mr Rheinberg,
4 I wanted just to ask you one or two questions about one
5 or two of the documents.

6 A. Certainly.

7 LADY JUSTICE THIRLWALL: You will recall earlier in
8 your evidence you were asked about the Inquest of
9 Baby A.

10 A. Yes.

11 LADY JUSTICE THIRLWALL: And that in the early
12 days, when you were first involved, this is well before
13 the Inquest took place, documents were sent to you and
14 then on -- and some of them on to the parents of Baby A.
15 The first was the short report with Dr Brearey's
16 signature --

17 A. Yes.

18 LADY JUSTICE THIRLWALL: -- on the bottom, do you
19 remember.

20 A. Yes.

21 LADY JUSTICE THIRLWALL: The other document that
22 you received, but it isn't clear to me that that was
23 sent on was the Thematic Review. We have seen --

24 A. Right.

25 LADY JUSTICE THIRLWALL: -- various versions of the

104

1 Thematic Review but we know that you had one and we have
2 looked at it earlier. Would you like to have a look at
3 it just to --

4 **A.** No, I can remember. I cannot recall whether
5 or not that was sent to the Family.

6 **LADY JUSTICE THIRLWALL:** Certainly the document
7 that we have looked at sending the other letter --

8 **A.** Yes.

9 **LADY JUSTICE THIRLWALL:** -- doesn't include that
10 report. Can you think of any reason why that report
11 wasn't sent?

12 **A.** No. I -- I cannot recall the fact that it --
13 that anything was sent out. But so I am relying
14 entirely on the -- the documentation that's been
15 produced to me.

16 **LADY JUSTICE THIRLWALL:** Would there be a reason
17 not to send it out --

18 **A.** Absolutely not.

19 **LADY JUSTICE THIRLWALL:** -- now that you have had
20 a chance to see it?

21 **A.** No. We had a rule that everything would be
22 sent out to a family if it was very sensitive
23 information, such as a postmortem report, that might
24 well be distressing, the instruction was that the report
25 should be placed in a separate sealed envelope, clearly

105

1 **A.** It is a possibility. But it's absolute
2 speculation.

3 **LADY JUSTICE THIRLWALL:** But would you expect to
4 have known what had been sent to the parents at the
5 time, would that be on the file?

6 **A.** Yes, yes, I suppose so. The instruction would
7 come from me and so I would give an instruction as to
8 what was -- what was included. I had very good staff.
9 They didn't often make mistakes.

10 **LADY JUSTICE THIRLWALL:** No and we have got the
11 letter that was sent.

12 **A.** Yes, yes.

13 **LADY JUSTICE THIRLWALL:** Anyway. You presumably
14 then thought nothing more about it --

15 **A.** No.

16 **LADY JUSTICE THIRLWALL:** -- at the Inquest.
17 Does it follow from that that the Thematic Review
18 wasn't in front of you at the Inquest?

19 **A.** Almost certainly it wasn't. But again I can,
20 I can recall in fairly shady terms the Inquest but as to
21 what was before me, I -- I really can't say.

22 **LADY JUSTICE THIRLWALL:** And we have got the --
23 that you have been taken through.

24 **A.** I think the Inquest took place in
25 a Magistrates Court in Chester, again --

107

1 marked with what it was, with the explanation given to
2 the family that if they would prefer not to look at the
3 document themselves, then they could send it or take it
4 to their doctor or someone else to look at it on their
5 behalf.

6 So there would never be a reason for withholding
7 information but if it was sensitive it would be dealt
8 with in that sort of way.

9 **LADY JUSTICE THIRLWALL:** But there would be a paper
10 trail for that, wouldn't there, if it was dealt with
11 like that.

12 **A.** Yes, I would hope so.

13 **LADY JUSTICE THIRLWALL:** Yes, we would expect that
14 to have happened.

15 **A.** What was a little bit peculiar in the office
16 at that time was that we were operating on two different
17 computer systems, neither of which talked to the other
18 in typical bureaucratic way.

19 So my office was working on one computer system,
20 the officers were working on another.

21 **LADY JUSTICE THIRLWALL:** So does it follow from
22 that that things got lost from time to time?

23 **A.** It was a possibility, yes.

24 **LADY JUSTICE THIRLWALL:** Do you think that might be
25 a possibility here?

106

1 **LADY JUSTICE THIRLWALL:** I don't think we need --
2 I don't think anything turns on where --

3 **A.** I am just trying to reassure myself --

4 **LADY JUSTICE THIRLWALL:** -- it took place.

5 **A.** -- I am recollecting everything correctly.

6 **LADY JUSTICE THIRLWALL:** Thinking of the right one.
7 Yes.

8 Thank you.

9 You were asked some questions just now about the
10 meeting of 8 February, where I think you have --

11 **A.** Yes.

12 **LADY JUSTICE THIRLWALL:** -- got at least a legible
13 or nearly legible copy of what was said?

14 **A.** Yes, yes.

15 **LADY JUSTICE THIRLWALL:** It was put to you and you
16 agreed that Mr Cross records you as saying that the
17 Trust had done the right thing.

18 Can you remember anything about that?

19 **A.** Right, I -- sadly, I cannot remember the
20 meeting at all. I certainly saw the note, the writing
21 is very much better than my own. I had no reason to
22 believe that Mr Cross wasn't accurately recording what
23 was said.

24 **LADY JUSTICE THIRLWALL:** Recording.

25 **A.** It is just that I can't remember.

108

1 **LADY JUSTICE THIRLWALL:** No, all right. So I won't
 2 ask you what you meant by that. Then a few days after
 3 that, you had the meeting --
 4 **A.** Yes.
 5 **LADY JUSTICE THIRLWALL:** -- on 15 February. Now we
 6 are into 2017 by this stage.
 7 **A.** Yes, yes.
 8 **LADY JUSTICE THIRLWALL:** At that point, you have
 9 got a very detailed note.
 10 **A.** Yes.
 11 **LADY JUSTICE THIRLWALL:** You have explained how you
 12 kept your notes. I just wanted to refresh my memory
 13 because this is something that I may need to resolve in
 14 due course and this is the evidence from Mr Harvey --
 15 **A.** Yes.
 16 **LADY JUSTICE THIRLWALL:** -- who was being asked
 17 about the --
 18 **A.** Yes.
 19 **LADY JUSTICE THIRLWALL:** About the meeting itself.
 20 He was told that, it was put to him that:
 21 "There's nothing that said that puts centre front,
 22 does it, that there are concerns and concerns of a nurse
 23 deliberately harming a baby?"
 24 I should say that question was put on the basis of
 25 what your note said?

109

1 meeting was on the request that there should be
 2 a general inquiry/investigation carried out by the
 3 Coroners service.
 4 That seemed to be the -- the theme throughout the
 5 meeting with me explaining that I couldn't, couldn't
 6 meet their requirements. So yes, I knew that the, at
 7 that stage, that the Consultants had concerns.
 8 **LADY JUSTICE THIRLWALL:** What was the nature of
 9 their concerns?
 10 **A.** I think just in general that some -- something
 11 wasn't going right or that they just wanted more
 12 information. I think -- I saw Alan Moore's statement,
 13 where he had said he wondered whether he had asked
 14 rather pointedly: why do you want this investigation?
 15 Is it a matter of reputational concern or whatever? By
 16 that I suppose he meant: was it a question of trying to
 17 deflect blame and find some other factor that could
 18 exonerate --
 19 **LADY JUSTICE THIRLWALL:** Well, yes, he gave us his
 20 evidence and explained that wasn't what he meant but
 21 anyway --
 22 **A.** But I can't remember that being said but it
 23 does rather fit in with my recollection, that just about
 24 everything that was discussed at that meeting related to
 25 the request that the Coroner's office should carry out

111

1 **A.** Right, yes.
 2 **LADY JUSTICE THIRLWALL:** The response was:
 3 "I recall that either Mr Cross or I in passing the
 4 paediatricians' letter across to Mr Rheinberg explained
 5 the background to that letter and the paediatricians'
 6 concerns."
 7 He went on to say:
 8 "I am also aware that there is documentation within
 9 the Inquiry that confirms that part of the bundle that
 10 Mr Rheinberg received was actually the full RCPCH report
 11 which included reference to the paediatricians'
 12 concerns."
 13 So let's just unpick that a little bit. The last
 14 bit I think what's in the bundle in fact are those
 15 passages of the bundle of the RCPCH report that had been
 16 taken out and then reformatted and put into the bundle
 17 that you have; the redacted parts as we have been
 18 referring to them?
 19 **A.** Yes.
 20 **LADY JUSTICE THIRLWALL:** So we know that that
 21 document is in the bundle. What's your view about
 22 what's said there, that they explained the background to
 23 the letter and the paediatricians' concerns? Did they
 24 explain the paediatricians' concerns?
 25 **A.** My recollection is that the focus of the

110

1 some form of investigation.
 2 **LADY JUSTICE THIRLWALL:** Should I infer from that
 3 that there was no reference to the document that's
 4 headed additional observations?
 5 **A.** No, no, I don't remember any actual reference
 6 to the documents. I -- I think I was handed a bundle,
 7 I seem to remember quite a thick bundle, but the -- the
 8 meeting then followed on to discuss that particular
 9 theme.
 10 **LADY JUSTICE THIRLWALL:** Yes, thank you.
 11 Those are all my questions, anybody want to ask
 12 anything else? No. Thank you very much indeed,
 13 Mr Rheinberg, you are free to go.
 14 **A.** Yes, thank you, my Lady.
 15 **LADY JUSTICE THIRLWALL:** You are free to go. Yes,
 16 absolutely, you are free to go?
 17 **A.** Okay, thank you very much.
 18 **LADY JUSTICE THIRLWALL:** So we will adjourn now and
 19 start again on.
 20 **MS LANGDALE:** Tuesday at 10 am.
 21 **LADY JUSTICE THIRLWALL:** -- Tuesday 10 o'clock.
 22 Thank you all very much.
 23 **(1.28 pm)**
 24 (The Inquiry adjourned until 10.00 am
 25 on Tuesday, 10 December 2024)

112

1 INDEX

2

3 MR NICHOLAS RHEINBERG (sworn) 1

4 Questions by MS LANGDALE 1

5 Questions by MR SKELTON 58

6 Questions by MR BAKER 80

7 Questions by MS BLACKWELL 94

8 Questions by LADY JUSTICE THIRLWALL 104

9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

LADY JUSTICE THIRLWALL: [63] 1/3 1/5 1/9 4/19 4/24 5/2 5/6 5/9 12/12 12/25 32/25 33/3 38/9 38/12 46/13 46/16 50/24 58/10 72/23 73/2 80/1 94/17 103/16 104/3 104/7 104/11 104/18 104/21 104/25 105/6 105/9 105/16 105/19 106/9 106/13 106/21 106/24 107/3 107/10 107/13 107/16 107/22 108/1 108/4 108/6 108/12 108/15 108/24 109/1 109/5 109/8 109/11 109/16 109/19 110/2 110/20 111/8 111/19 112/2 112/10 112/15 112/18 112/21	20 October 2016 [1] 24/8 10.00 [1] 112/24 100A [1] 56/17 102 [1] 52/13 11 April 2024 [1] 1/12 11.20 [1] 46/19 11.40 [1] 46/21 12 [2] 28/22 46/17 12 August [1] 17/24 13 February [1] 30/10 13 July [1] 22/22 14 days [1] 36/5 15 February [5] 48/17 95/17 96/2 99/8 109/5 15 June 2015 [1] 27/6 15 minutes [1] 103/19 154 [1] 20/2 155 [1] 19/6 16 August 2015 [1] 20/19 168 [1] 20/17 169 [2] 16/11 16/13 17 January [1] 38/21 17 October [1] 34/2 173 [1] 15/6 174 [1] 14/20 18 [2] 8/19 32/1 186 [1] 16/5 19 August [1] 18/6 1974 [1] 1/17 1992 [1] 1/18 1999 [1] 1/20	2046 [1] 33/1 22 June 2015 [1] 28/19 23 October 2015 [1] 32/5 24 [2] 7/12 12/17 26 January [1] 39/6 27 [2] 8/1 26/14 29 June [1] 58/20 29th [1] 59/12	89 [2] 49/4 49/6 9 9 December [1] 37/2 9.59 [1] 1/2 90 [2] 49/4 49/5 91 [3] 38/19 38/19 49/13 93 [1] 50/10 95 [2] 41/4 45/9 962 [1] 29/9 974 [1] 29/24 99 [1] 87/9	13/15 accepted [2] 72/7 73/7 access [1] 2/13 accordingly [1] 39/8 account [3] 69/24 83/13 92/16 accounts [1] 86/7 accuracy [2] 13/12 36/2 accurate [2] 1/14 6/23 accurately [1] 108/22 achieve [1] 76/2 acquiring [1] 1/21 across [4] 61/15 65/24 80/10 110/4 act [4] 1/23 29/13 56/23 86/24 acted [1] 85/7 acting [2] 80/24 81/3 action [6] 17/25 29/20 61/1 61/1 74/25 95/21 active [1] 3/7 activity [1] 87/5 actual [6] 55/21 57/25 64/21 71/25 86/1 112/5 actually [9] 33/1 36/19 36/20 74/24 82/7 86/2 88/16 91/25 110/10 acute [1] 29/3 add [4] 41/15 44/4 60/22 60/22 additional [5] 50/11 96/12 103/3 103/6 112/4 addressed [1] 41/22 adds [1] 101/25 adequacy [1] 14/9 adherence [1] 31/25 adhering [1] 13/23 adjacent [2] 80/14 81/22 adjourn [1] 112/18 adjourned [3] 72/11 102/21 112/24 adjourning [1] 20/11 advance [1] 78/12 advantage [2] 2/11 93/17 advice [6] 13/3 68/18 91/14 91/24 91/25 92/4 advise [4] 37/5 39/7 48/1 50/19 advised [3] 21/15 66/21 74/2 advising [1] 51/15 Advisory [1] 48/25 afraid [3] 23/14 47/17 57/20
MR BAKER: [2] 80/3 94/15 MR SKELTON: [3] 58/12 73/3 79/24 MS BLACKWELL: [2] 94/20 103/14 MS LANGDALE: [11] 1/4 1/11 12/14 33/1 33/5 38/14 46/15 46/22 51/3 58/8 112/20	2 20 [1] 46/17 20 January [1] 38/24 2001 [1] 61/14 2009 [1] 1/23 2013 [2] 1/22 81/5 2015 [20] 14/16 14/22 19/19 20/19 20/20 21/23 27/6 28/19 30/23 32/5 50/3 59/13 60/7 65/19 82/13 82/18 100/8 100/9 100/12 100/15 2016 [15] 12/20 14/25 18/8 20/19 20/20 20/22 24/8 32/7 49/1 49/21 50/3 58/16 58/17 60/7 65/21 2016/2017 [1] 83/15 2017 [7] 30/4 30/7 37/17 83/15 95/3 98/12 109/6 2024 [4] 1/1 1/12 8/8 112/25 2042 [1] 20/15	3 3 May [1] 30/15 3 May 2017 [1] 30/7 3.12 [2] 40/4 40/11 30 minutes [2] 6/13 54/14 31 October [2] 35/14 36/14 32 [1] 50/4 33 [1] 48/7 34 [2] 45/23 48/20 35 [1] 3/20	A A's [12] 14/15 16/21 25/22 60/13 68/11 68/14 72/6 73/25 74/8 75/8 76/11 77/25 A,C,D,E,I [1] 24/9 able [4] 22/6 38/9 57/18 70/13 about [73] 3/20 4/21 4/24 5/6 5/7 6/20 10/5 11/13 14/5 16/23 22/17 23/7 23/10 23/21 27/2 27/3 33/18 33/23 33/23 34/17 40/15 44/16 44/25 45/7 47/8 47/18 47/22 48/4 50/17 50/25 51/14 52/12 53/12 54/8 54/14 55/16 59/6 59/7 59/8 60/10 62/4 63/14 63/22 64/9 64/14 71/8 72/6 73/4 73/20 76/10 76/18 80/6 81/17 83/1 83/24 84/24 85/10 86/18 88/21 92/4 93/1 95/22 99/24 100/16 104/4 104/8 107/14 108/9 108/18 109/17 109/19 110/21 111/23 above [4] 34/18 36/13 37/18 79/11 abreast [1] 2/13 absence [1] 21/15 absolute [3] 50/9 72/9 107/1 absolutely [29] 5/12 6/21 23/12 24/1 31/20 38/18 45/8 45/8 60/15 63/7 71/16 75/14 78/10 82/5 84/1 84/8 84/14 87/2 89/15 89/19 92/20 93/6 94/1 94/3 95/21 97/7 101/7 105/18 112/16 absorb [1] 42/1 accede [1] 29/22 accept [4] 12/2 13/20 47/9 95/6 acceptable [2] 13/11	3 3 May [1] 30/15 3 May 2017 [1] 30/7 3.12 [2] 40/4 40/11 30 minutes [2] 6/13 54/14 31 October [2] 35/14 36/14 32 [1] 50/4 33 [1] 48/7 34 [2] 45/23 48/20 35 [1] 3/20
MR BAKER: [2] 80/3 94/15 MR SKELTON: [3] 58/12 73/3 79/24 MS BLACKWELL: [2] 94/20 103/14 MS LANGDALE: [11] 1/4 1/11 12/14 33/1 33/5 38/14 46/15 46/22 51/3 58/8 112/20	4 43 [1] 18/20 45 [2] 25/19 25/21	4 43 [1] 18/20 45 [2] 25/19 25/21	5 52 [1] 87/20 53 [3] 27/7 27/14 27/20	5 52 [1] 87/20 53 [3] 27/7 27/14 27/20
MR BAKER: [2] 80/3 94/15 MR SKELTON: [3] 58/12 73/3 79/24 MS BLACKWELL: [2] 94/20 103/14 MS LANGDALE: [11] 1/4 1/11 12/14 33/1 33/5 38/14 46/15 46/22 51/3 58/8 112/20	6 6 December 2024 [1] 1/1 6 February 2016 [1] 32/7 6 October [2] 21/11 66/4 65 [1] 30/21 66 [1] 31/1 67 [1] 32/5 69 [1] 32/9	6 6 December 2024 [1] 1/1 6 February 2016 [1] 32/7 6 October [2] 21/11 66/4 65 [1] 30/21 66 [1] 31/1 67 [1] 32/5 69 [1] 32/9	7 7 December [1] 36/14 72 hours [1] 62/7 74 [1] 33/15 77 [1] 43/1 777 [1] 18/21	7 7 December [1] 36/14 72 hours [1] 62/7 74 [1] 33/15 77 [1] 43/1 777 [1] 18/21
MR BAKER: [2] 80/3 94/15 MR SKELTON: [3] 58/12 73/3 79/24 MS BLACKWELL: [2] 94/20 103/14 MS LANGDALE: [11] 1/4 1/11 12/14 33/1 33/5 38/14 46/15 46/22 51/3 58/8 112/20	8 8 February [6] 43/16 45/13 46/4 48/9 95/3 108/10 8 June 2015 [1] 14/16 82 [1] 34/1 83 [2] 33/1 33/2 86 [2] 36/19 37/23 87 [1] 36/18 88 [2] 36/21 36/22	8 8 February [6] 43/16 45/13 46/4 48/9 95/3 108/10 8 June 2015 [1] 14/16 82 [1] 34/1 83 [2] 33/1 33/2 86 [2] 36/19 37/23 87 [1] 36/18 88 [2] 36/21 36/22	8 8 February [6] 43/16 45/13 46/4 48/9 95/3 108/10 8 June 2015 [1] 14/16 82 [1] 34/1 83 [2] 33/1 33/2 86 [2] 36/19 37/23 87 [1] 36/18 88 [2] 36/21 36/22	8 8 February [6] 43/16 45/13 46/4 48/9 95/3 108/10 8 June 2015 [1] 14/16 82 [1] 34/1 83 [2] 33/1 33/2 86 [2] 36/19 37/23 87 [1] 36/18 88 [2] 36/21 36/22
MR BAKER: [2] 80/3 94/15 MR SKELTON: [3] 58/12 73/3 79/24 MS BLACKWELL: [2] 94/20 103/14 MS LANGDALE: [11] 1/4 1/11 12/14 33/1 33/5 38/14 46/15 46/22 51/3 58/8 112/20	9 9 December [1] 37/2 9.59 [1] 1/2 90 [2] 49/4 49/5 91 [3] 38/19 38/19 49/13 93 [1] 50/10 95 [2] 41/4 45/9 962 [1] 29/9 974 [1] 29/24 99 [1] 87/9	9 9 December [1] 37/2 9.59 [1] 1/2 90 [2] 49/4 49/5 91 [3] 38/19 38/19 49/13 93 [1] 50/10 95 [2] 41/4 45/9 962 [1] 29/9 974 [1] 29/24 99 [1] 87/9	9 9 December [1] 37/2 9.59 [1] 1/2 90 [2] 49/4 49/5 91 [3] 38/19 38/19 49/13 93 [1] 50/10 95 [2] 41/4 45/9 962 [1] 29/9 974 [1] 29/24 99 [1] 87/9	9 9 December [1] 37/2 9.59 [1] 1/2 90 [2] 49/4 49/5 91 [3] 38/19 38/19 49/13 93 [1] 50/10 95 [2] 41/4 45/9 962 [1] 29/9 974 [1] 29/24 99 [1] 87/9
MR BAKER: [2] 80/3 94/15 MR SKELTON: [3] 58/12 73/3 79/24 MS BLACKWELL: [2] 94/20 103/14 MS LANGDALE: [11] 1/4 1/11 12/14 33/1 33/5 38/14 46/15 46/22 51/3 58/8 112/20	10 10083 [2] 32/23 33/5 10167 [2] 20/14 20/15	10 10083 [2] 32/23 33/5 10167 [2] 20/14 20/15	10 10083 [2] 32/23 33/5 10167 [2] 20/14 20/15	10 10083 [2] 32/23 33/5 10167 [2] 20/14 20/15
MR BAKER: [2] 80/3 94/15 MR SKELTON: [3] 58/12 73/3 79/24 MS BLACKWELL: [2] 94/20 103/14 MS LANGDALE: [11] 1/4 1/11 12/14 33/1 33/5 38/14 46/15 46/22 51/3 58/8 112/20	1 1 February [1] 43/3 1 July 2015 [1] 19/19 1 July 2016 [1] 12/20 1.01 pm [1] 103/24 1.15 pm [1] 104/1 1.28 pm [1] 112/23 10 [1] 2/23 10 am [1] 112/20 10 December 2024 [1] 112/25 10 February [1] 32/11 10 o'clock [1] 112/21 10 October [2] 14/19 21/11	1 1 February [1] 43/3 1 July 2015 [1] 19/19 1 July 2016 [1] 12/20 1.01 pm [1] 103/24 1.15 pm [1] 104/1 1.28 pm [1] 112/23 10 [1] 2/23 10 am [1] 112/20 10 December 2024 [1] 112/25 10 February [1] 32/11 10 o'clock [1] 112/21 10 October [2] 14/19 21/11	1 1 February [1] 43/3 1 July 2015 [1] 19/19 1 July 2016 [1] 12/20 1.01 pm [1] 103/24 1.15 pm [1] 104/1 1.28 pm [1] 112/23 10 [1] 2/23 10 am [1] 112/20 10 December 2024 [1] 112/25 10 February [1] 32/11 10 o'clock [1] 112/21 10 October [2] 14/19 21/11	1 1 February [1] 43/3 1 July 2015 [1] 19/19 1 July 2016 [1] 12/20 1.01 pm [1] 103/24 1.15 pm [1] 104/1 1.28 pm [1] 112/23 10 [1] 2/23 10 am [1] 112/20 10 December 2024 [1] 112/25 10 February [1] 32/11 10 o'clock [1] 112/21 10 October [2] 14/19 21/11

<p>A</p> <p>after [14] 17/10 26/8 28/8 30/16 33/12 58/16 59/13 62/5 62/5 66/8 71/11 76/16 77/25 109/2</p> <p>afternoon [3] 35/16 35/19 80/3</p> <p>afterwards [6] 15/20 26/9 97/5 97/6 97/9 97/14</p> <p>again [16] 17/2 24/23 41/7 78/19 78/24 79/6 82/17 86/18 87/13 91/12 91/21 93/6 103/22 107/19 107/25 112/19</p> <p>against [1] 101/9</p> <p>age [2] 8/19 32/1</p> <p>Ages [1] 79/21</p> <p>ago [1] 15/3</p> <p>agreed [2] 39/21 108/16</p> <p>air [4] 59/21 59/21 70/19 72/5</p> <p>Alan [2] 53/15 111/12</p> <p>Alan Moore [1] 53/15</p> <p>alarm [2] 83/4 83/6</p> <p>albeit [1] 34/10</p> <p>Alder [2] 89/3 103/11</p> <p>Alder Hey [2] 89/3 103/11</p> <p>alert [1] 83/23</p> <p>alerted [1] 8/12</p> <p>all [52] 2/16 6/17 7/24 9/11 10/24 17/6 21/3 26/23 28/17 32/1 33/15 33/21 35/7 38/12 40/8 40/12 44/16 45/19 49/16 50/16 53/3 57/10 57/24 60/5 60/15 60/17 60/19 63/14 63/19 70/22 73/2 74/10 77/16 80/17 81/12 82/2 82/11 82/23 83/1 83/22 84/21 87/10 88/18 97/17 99/12 100/20 101/22 103/15 108/20 109/1 112/11 112/22</p> <p>allegation [1] 40/16</p> <p>allegations [1] 50/20</p> <p>allege [1] 77/13</p> <p>alleged [1] 22/20</p> <p>almost [5] 62/11 77/15 84/13 93/15 107/19</p> <p>alongside [1] 47/16</p> <p>already [11] 12/7 26/6 28/2 56/14 57/3 63/22 65/1 65/4 79/11 79/12 94/25</p>	<p>also [21] 2/9 11/24 18/20 22/4 28/24 31/15 35/10 36/8 38/3 48/20 54/22 60/3 69/23 70/17 72/4 73/12 78/22 82/3 99/1 99/21 110/8</p> <p>although [9] 2/11 3/10 26/15 26/19 29/18 40/8 40/14 62/13 72/15</p> <p>always [6] 17/8 40/8 79/22 89/23 94/5 103/8</p> <p>am [35] 1/2 12/10 14/3 14/5 14/9 19/12 23/12 34/6 34/12 39/25 45/17 46/19 46/21 47/9 56/13 56/24 56/25 59/2 62/20 62/21 75/2 77/7 82/21 83/14 87/13 90/2 93/9 93/15 102/15 105/13 108/3 108/5 110/8 112/20 112/24</p> <p>amiss [1] 25/16</p> <p>amount [2] 63/24 82/2</p> <p>analysis [1] 4/17</p> <p>anatomical [1] 4/10</p> <p>anchor [1] 66/4</p> <p>angry [1] 44/23</p> <p>anomalies [1] 89/22</p> <p>anonymised [1] 17/6</p> <p>another [10] 15/5 33/23 56/1 69/8 71/3 75/5 86/3 95/18 97/25 106/20</p> <p>answer [6] 22/6 64/25 71/1 76/25 81/16 98/19</p> <p>answered [1] 4/24</p> <p>answering [2] 74/10 75/21</p> <p>answers [2] 75/16 76/4</p> <p>antemortem [1] 90/18</p> <p>anticipate [2] 37/12 90/16</p> <p>anticipated [1] 36/4</p> <p>anticipation [1] 15/21</p> <p>anxious [1] 75/12</p> <p>any [77] 4/8 11/11 13/25 14/5 16/23 16/24 17/11 20/9 21/8 22/6 24/5 33/18 34/7 35/5 35/6 35/23 36/15 38/6 41/15 41/22 42/10 42/15 47/12 47/18 50/2 52/19 53/4 53/7 53/18 53/18</p>	<p>55/23 56/18 57/11 57/11 57/11 57/25 59/23 62/17 62/20 63/1 64/1 64/5 65/8 65/13 69/17 71/2 72/12 73/16 75/16 75/21 76/3 76/4 77/6 79/5 81/25 82/18 85/6 86/25 87/14 89/1 89/2 89/9 89/21 89/21 91/16 92/16 98/5 98/13 99/3 100/5 100/22 101/8 101/13 103/9 103/10 105/10 112/5</p> <p>anybody [1] 112/11</p> <p>anyone [2] 76/22 89/3</p> <p>anything [15] 5/22 6/2 17/1 24/22 41/9 44/4 47/2 47/19 47/21 60/21 79/11 105/13 108/2 108/18 112/12</p> <p>anyway [3] 46/12 107/13 111/21</p> <p>apnoeic [1] 28/24</p> <p>apologies [1] 51/3</p> <p>apology [1] 21/6</p> <p>appalling [1] 97/7</p> <p>apparent [5] 26/25 44/2 62/25 69/11 89/22</p> <p>apparently [1] 42/14</p> <p>appear [3] 42/9 47/5 56/5</p> <p>appearance [1] 89/7</p> <p>appeared [1] 69/7</p> <p>appears [7] 18/5 18/10 18/15 31/2 42/14 51/21 70/6</p> <p>appointed [3] 1/18 1/20 29/13</p> <p>appointment [2] 52/19 81/6</p> <p>apportion [1] 10/19</p> <p>approach [2] 37/9 60/17</p> <p>approachable [1] 89/23</p> <p>approaching [1] 68/11</p> <p>appropriate [12] 3/17 3/18 6/6 11/21 12/3 12/8 27/4 29/21 37/9 65/15 78/16 84/6</p> <p>April [3] 1/12 20/19 20/22</p> <p>April 2016 [2] 20/19 20/22</p> <p>are [85] 1/13 1/14 2/3 3/16 3/20 3/22 3/22 5/6 6/6 6/8 7/6 7/16 7/18 7/19 7/23 10/19 11/4 11/16 11/17</p>	<p>13/11 13/12 13/19 13/20 14/6 16/18 17/2 17/9 18/17 18/22 19/4 19/16 21/10 23/3 27/2 29/11 32/22 35/9 35/20 35/22 38/12 42/12 43/12 44/3 45/10 50/8 50/11 51/21 51/22 52/14 54/8 54/24 55/10 56/19 57/5 58/8 62/4 65/4 67/3 70/9 71/17 74/14 75/11 79/3 80/9 81/17 84/5 89/21 89/22 90/22 94/8 94/24 95/14 97/1 97/10 100/19 102/5 103/8 103/18 109/6 109/22 110/14 112/11 112/13 112/15 112/16</p> <p>area [2] 61/17 77/8</p> <p>areas [3] 80/7 80/10 101/20</p> <p>aren't [3] 19/16 70/13 97/1</p> <p>arising [1] 83/17</p> <p>around [3] 4/16 36/10 94/25</p> <p>arrange [1] 52/19</p> <p>arranged [1] 53/11</p> <p>arrest [1] 15/20</p> <p>arrested [1] 84/20</p> <p>artery [2] 26/12 70/25</p> <p>as [154]</p> <p>as July 2015 [1] 59/13</p> <p>ascribes [1] 34/9</p> <p>aside [2] 78/18 78/23</p> <p>ask [19] 10/5 49/3 49/15 58/12 60/9 67/12 67/14 69/2 72/8 72/19 72/20 75/9 75/18 80/3 94/21 103/15 104/4 109/2 112/11</p> <p>asked [20] 24/21 35/18 35/24 38/21 39/2 39/7 41/11 53/14 64/9 73/24 74/18 76/18 85/10 91/13 94/10 98/12 104/8 108/9 109/16 111/13</p> <p>asking [10] 3/5 14/5 30/17 54/24 74/15 76/9 77/24 80/6 81/17 87/13</p> <p>aspects [1] 103/6</p> <p>assigned [1] 40/9</p> <p>assist [2] 71/17 74/14</p> <p>assistant [2] 4/10 93/10</p> <p>assisted [1] 61/12</p>	<p>associated [1] 48/2</p> <p>assumption [1] 58/3</p> <p>assurance [1] 44/18</p> <p>assured [1] 44/15</p> <p>at [150]</p> <p>At 6 [1] 13/10</p> <p>attached [3] 12/20 17/24 33/7</p> <p>attendance [2] 6/2 52/8</p> <p>attended [2] 58/18 58/21</p> <p>attending [1] 74/12</p> <p>attention [9] 17/21 39/3 75/7 76/12 78/5 82/23 83/4 84/16 98/6</p> <p>attitude [1] 42/7</p> <p>attributed [1] 50/1</p> <p>August [4] 17/24 18/6 20/19 30/23</p> <p>authority [5] 2/4 3/14 53/4 56/15 57/14</p> <p>available [5] 2/14 4/8 23/1 64/23 87/10</p> <p>avoid [3] 10/14 16/1 35/23</p> <p>avoided [1] 11/2</p> <p>await [1] 43/14</p> <p>awaiting [2] 21/19 102/17</p> <p>aware [20] 3/22 22/3 22/4 22/16 23/4 23/19 23/20 23/25 24/12 34/12 34/20 44/24 58/24 67/6 72/16 73/12 73/23 75/11 76/10 110/8</p> <p>awareness [2] 82/9 82/10</p> <p>away [2] 4/3 88/11</p> <hr/> <p>B</p> <p>babies [12] 7/16 18/17 32/21 33/8 35/10 43/19 49/22 50/3 54/17 59/17 65/23 94/4</p> <p>babies' [1] 44/25</p> <p>baby [16] 11/12 14/3 15/13 16/21 18/19 19/9 29/15 44/5 48/25 53/21 53/23 69/13 86/14 104/9 104/14 109/23</p> <p>Baby A [6] 14/3 15/13 18/19 19/9 104/9 104/14</p> <p>Baby A's [1] 16/21</p> <p>Baby D [1] 44/5</p> <p>Baby D's [1] 29/15</p> <p>back [12] 22/8 37/23 40/11 46/17 49/5 56/15 71/11 74/18 78/24 79/21 100/12</p>
--	---	--	---	---

B	before [17] 4/16 9/23 19/20 34/1 52/1 52/8 55/9 66/18 66/24 70/22 81/5 88/11 90/21 92/16 94/11 104/12 107/21	14/25 21/13 35/13 36/22 38/20 66/6 104/18	44/11 45/9 45/24 46/3 46/7 47/18 48/6 48/19 48/22 49/3 50/12 52/12 55/1 56/12 57/4 57/17 58/6 67/2 67/12 69/4 72/8 72/19 72/20 72/24 75/8 75/18 76/5 76/21 77/7 78/8 79/5 85/13 85/23 86/19 90/9 97/10 103/19 105/4 105/10 107/19 107/20 108/18	categories [1] 55/8 categorised [1] 90/9 category [1] 55/5 causation [1] 89/5 cause [46] 5/23 7/15 7/23 8/20 9/1 13/7 14/17 25/12 26/5 26/21 26/25 27/23 28/2 28/5 28/9 28/10 28/16 29/18 31/4 31/11 31/22 31/23 32/11 55/4 55/6 70/10 78/15 85/11 85/14 86/1 86/3 86/5 86/8 87/19 87/22 88/14 88/24 89/8 89/11 89/13 90/5 90/12 91/5 91/6 91/18 92/20 caused [4] 10/25 25/22 87/23 88/12 causes [8] 27/22 32/16 35/8 41/10 43/22 70/23 78/17 91/4 cc'ing [1] 41/5 centre [1] 109/21 certain [3] 81/3 84/5 93/15 certainly [11] 2/4 24/4 68/22 69/18 72/24 83/6 88/22 104/6 105/6 107/19 108/20 certificates [1] 85/24 cetera [7] 19/2 21/4 31/9 62/9 79/9 81/13 97/24 Chair [2] 83/3 84/23 challenge [1] 58/7 challenges [1] 85/11 challenging [1] 85/14 Chambers [1] 49/14 chance [2] 38/13 105/20 change [3] 49/7 49/9 50/1 changed [1] 1/22 changes [1] 50/2 chase [1] 21/2 chasing [1] 20/16 chat [1] 63/3 check [2] 17/11 103/22 Cheshire [11] 1/21 2/4 2/5 9/7 9/10 9/10 11/19 60/24 62/16 77/9 80/24 Chester [13] 12/4 17/19 24/3 30/16 33/25 37/21 39/14 41/13 41/16 42/22 43/6 99/13 107/25 Chester's [1] 9/21 Chief [5] 52/20 52/21
back... [1] 103/22 background [4] 5/10 5/17 110/5 110/22 backwards [1] 37/25 badge [1] 60/24 Baker [4] 80/1 80/2 94/17 113/6 balance [1] 69/25 barrel [1] 69/8 barrister [2] 73/5 74/24 based [2] 89/11 94/25 bases [1] 71/24 basis [5] 26/16 71/24 83/8 86/24 109/24 be [185] bear [1] 98/4 bearing [2] 15/12 16/20 bears [1] 19/19 became [1] 86/21 because [33] 3/13 31/22 34/17 41/17 45/12 50/8 52/7 53/9 54/12 56/15 60/19 61/6 61/24 63/13 63/24 67/17 69/11 70/12 73/16 75/11 78/15 80/18 81/16 81/20 85/16 89/17 91/3 91/18 94/9 99/3 99/16 102/17 109/13 become [2] 40/13 98/8 been [89] 6/10 6/16 7/7 7/9 7/10 7/11 8/4 9/15 10/19 11/24 14/21 15/13 15/14 15/22 17/16 18/1 18/5 18/17 18/18 22/10 23/16 23/16 24/2 26/5 26/23 28/8 28/18 29/13 29/19 33/12 35/7 37/4 37/10 38/3 39/8 40/7 40/9 41/13 41/14 41/17 42/8 42/9 42/10 43/9 44/23 45/18 49/22 49/24 52/5 55/23 57/22 58/24 61/3 61/15 61/18 61/19 62/2 62/2 65/18 69/8 69/24 70/1 70/22 70/23 71/3 73/10 74/11 74/15 78/13 79/22 81/4 81/5 81/8 82/21 82/24 83/3 83/17 91/9 91/13 95/25 96/22 97/19 98/14 98/23 105/14 107/4 107/23 110/15 110/17	begin [1] 73/1 beginning [1] 80/6 beginning [1] 21/18 behalf [6] 44/9 58/13 64/1 80/4 94/21 106/5 being [31] 9/11 11/4 17/10 22/18 23/7 23/11 23/24 24/3 25/14 28/17 28/21 33/23 41/23 44/18 54/11 56/20 57/18 59/12 63/23 64/6 69/22 71/24 78/8 78/20 83/1 83/24 91/6 97/4 100/17 109/16 111/22 belief [1] 9/2 believe [1] 108/22 bell [2] 83/5 83/6 below [4] 22/14 22/15 39/1 39/19 benefits [1] 103/3 beset [1] 94/8 best [2] 9/1 9/4 better [4] 46/7 61/16 70/2 108/21 between [16] 3/23 4/14 20/21 22/21 33/19 38/17 43/2 59/13 73/9 73/23 75/19 80/7 90/4 90/18 91/4 91/5 beyond [1] 40/16 bigger [1] 67/17 biological [1] 28/18 bit [10] 38/10 53/9 54/15 61/8 67/17 77/6 99/2 106/15 110/13 110/14 bits [1] 39/25 Blackwell [5] 94/18 94/19 94/21 103/17 113/7 blame [2] 10/19 111/17 blemish [1] 5/22 block [1] 77/10 blue [1] 40/22 board [2] 26/19 39/4 bodies [2] 9/10 9/13 body [6] 3/14 5/21 55/3 56/21 63/20 86/14 bold [1] 93/25 born [1] 50/4 both [6] 6/22 28/17 33/19 34/8 46/22 60/1 bottom [9] 8/24 13/1	bound [1] 75/2 box [1] 46/5 brain [1] 32/12 breached [1] 21/5 break [7] 46/12 46/13 46/16 46/20 103/18 103/21 103/25 Brearey [3] 19/20 58/21 59/12 Brearey's [2] 19/25 104/15 brevity [1] 20/6 briefed [2] 6/22 7/8 briefing [2] 5/17 7/1 bring [4] 17/21 76/22 82/22 86/18 bringing [1] 98/5 brings [1] 82/23 broadly [1] 13/4 brought [8] 7/4 71/11 72/21 75/6 76/3 76/12 79/12 80/19 Browne [3] 22/2 73/6 73/17 build [2] 5/13 84/10 bullet [4] 8/23 10/13 11/3 12/11 bundle [13] 48/21 49/12 53/20 53/22 57/17 97/18 110/9 110/14 110/15 110/16 110/21 112/6 112/7 bureaucratic [1] 106/18 busy [1] 97/25 but [139]	can't [35] 23/14 23/17 27/12 47/17 47/21 52/5 52/6 53/13 55/13 55/21 56/1 56/2 56/9 56/10 56/14 58/7 61/19 65/25 65/25 65/25 70/4 70/4 73/16 76/6 76/6 79/11 84/17 89/2 96/20 97/16 97/25 103/13 107/21 108/25 111/22 candour [1] 93/7 cannot [10] 7/15 25/22 25/23 50/1 53/9 82/21 87/4 105/4 105/12 108/19 cannula [1] 59/21 capitals [1] 77/10 cardiac [2] 84/10 86/18 care [12] 5/16 6/1 11/11 21/21 40/9 41/21 49/23 50/5 67/3 73/25 83/20 101/2 cared [1] 49/22 carefully [1] 89/20 caring [1] 11/9 carried [6] 6/15 7/10 30/12 48/14 101/16 111/2 carry [5] 3/17 4/5 6/3 57/14 111/25 carrying [1] 27/23 case [29] 3/4 6/13 7/3 7/14 11/22 16/22 17/25 25/16 34/11 44/4 44/5 53/23 54/25 57/24 62/19 69/5 76/5 76/9 77/20 77/24 78/11 78/24 79/22 84/5 91/2 92/10 92/14 92/23 94/4 Casenote [6] 21/23 49/19 66/13 66/15 66/25 67/5 cases [20] 4/7 11/23 18/25 25/12 26/14 26/22 37/7 37/21 38/4 43/9 49/23 49/25 56/13 57/10 64/1 86/9 86/19 89/16 90/23 97/22	
C	C's [3] 27/5 88/5 91/2 call [7] 1/4 23/1 23/4 23/10 44/22 45/3 93/23 called [7] 2/16 11/4 11/16 15/23 22/5 34/13 41/16 came [6] 33/13 55/5 74/22 78/12 100/20 100/20 can [88] 1/13 1/24 3/15 5/3 8/6 9/19 11/1 11/2 12/16 12/16 13/14 14/2 14/20 15/6 16/5 17/13 18/3 18/11 18/21 19/5 22/1 24/18 24/19 24/22 25/18 26/1 27/10 29/23 30/20 30/20 33/3 34/1 34/9 35/2 35/9 36/21 38/14 38/15 38/16 39/15 40/4 40/11 40/19 41/3 41/3 43/1	categories [1] 55/8 categorised [1] 90/9 category [1] 55/5 causation [1] 89/5 cause [46] 5/23 7/15 7/23 8/20 9/1 13/7 14/17 25/12 26/5 26/21 26/25 27/23 28/2 28/5 28/9 28/10 28/16 29/18 31/4 31/11 31/22 31/23 32/11 55/4 55/6 70/10 78/15 85/11 85/14 86/1 86/3 86/5 86/8 87/19 87/22 88/14 88/24 89/8 89/11 89/13 90/5 90/12 91/5 91/6 91/18 92/20 caused [4] 10/25 25/22 87/23 88/12 causes [8] 27/22 32/16 35/8 41/10 43/22 70/23 78/17 91/4 cc'ing [1] 41/5 centre [1] 109/21 certain [3] 81/3 84/5 93/15 certainly [11] 2/4 24/4 68/22 69/18 72/24 83/6 88/22 104/6 105/6 107/19 108/20 certificates [1] 85/24 cetera [7] 19/2 21/4 31/9 62/9 79/9 81/13 97/24 Chair [2] 83/3 84/23 challenge [1] 58/7 challenges [1] 85/11 challenging [1] 85/14 Chambers [1] 49/14 chance [2] 38/13 105/20 change [3] 49/7 49/9 50/1 changed [1] 1/22 changes [1] 50/2 chase [1] 21/2 chasing [1] 20/16 chat [1] 63/3 check [2] 17/11 103/22 Cheshire [11] 1/21 2/4 2/5 9/7 9/10 9/10 11/19 60/24 62/16 77/9 80/24 Chester [13] 12/4 17/19 24/3 30/16 33/25 37/21 39/14 41/13 41/16 42/22 43/6 99/13 107/25 Chester's [1] 9/21 Chief [5] 52/20 52/21		

<p>C</p> <p>Coroner's... [10] 31/15 31/18 57/7 61/5 61/6 92/23 93/22 99/24 100/5 111/25</p> <p>Coroner's Office [7] 11/19 12/23 18/11 31/6 31/8 31/15 31/18</p> <p>Coroners [16] 1/23 2/10 3/7 13/19 77/8 80/16 80/16 80/21 80/25 81/1 81/25 82/12 86/22 93/5 94/8 111/3</p> <p>Coroners Court [1] 13/19</p> <p>corporate [2] 50/19 51/16</p> <p>correct [6] 31/13 32/20 74/25 85/12 92/12 100/25</p> <p>correctly [7] 9/10 15/15 22/19 31/4 31/10 43/18 108/5</p> <p>correlation [2] 40/16 90/18</p> <p>correspondence [5] 44/10 45/12 64/12 76/20 77/10</p> <p>cost [1] 11/24</p> <p>could [32] 2/13 2/16 2/20 9/5 13/24 15/14 16/24 17/10 17/21 25/12 26/5 26/16 27/1 31/4 35/6 37/16 41/18 42/16 46/13 63/2 65/16 67/15 70/23 79/6 79/12 79/14 82/12 85/24 97/22 99/12 106/3 111/17</p> <p>couldn't [3] 99/14 111/5 111/5</p> <p>counsel [5] 22/2 73/5 74/6 74/12 74/19</p> <p>countermanded [1] 43/25</p> <p>Countess [17] 9/21 12/4 17/19 21/15 24/2 30/16 33/24 37/5 37/21 39/14 41/13 41/16 42/22 43/6 45/13 48/2 99/13</p> <p>country [3] 3/20 61/15 103/13</p> <p>course [24] 29/20 36/12 59/22 61/6 65/15 74/25 75/22 79/3 79/19 81/17 81/20 82/16 85/8 86/6 89/9 95/11 96/1 96/21 97/4 97/13 97/14 99/7 99/15 109/14</p> <p>courses [1] 49/24</p>	<p>Court [3] 13/19 78/22 107/25</p> <p>courtesy [2] 42/21 99/16</p> <p>courts [1] 13/20</p> <p>cover [1] 79/10</p> <p>CPR [1] 28/25</p> <p>crank [1] 77/9</p> <p>crazy [1] 87/2</p> <p>created [1] 82/10</p> <p>crime [2] 6/1 77/23</p> <p>crimes [5] 81/20 81/24 82/19 85/4 85/5</p> <p>criminal [1] 13/20</p> <p>criminality [6] 3/1 77/7 77/13 99/4 101/14 101/24</p> <p>criticism [1] 10/14</p> <p>cross [28] 4/20 4/21 16/6 21/13 22/11 22/17 22/22 30/8 39/18 44/12 45/11 47/15 48/8 52/16 57/22 58/3 58/21 60/12 62/23 66/2 66/5 66/23 68/1 76/22 95/12 108/16 108/22 110/3</p> <p>Cross's [2] 17/23 45/24</p> <p>cross-purposes [2] 4/20 4/21</p> <p>cross-referring [1] 57/22</p> <p>crossed [1] 70/24</p> <p>crossing [1] 26/11</p> <p>crucial [1] 83/2</p> <p>crystal [1] 77/15</p> <p>curiosity [2] 100/12 100/15</p> <p>curious [1] 100/15</p> <p>currently [2] 3/20 43/9</p> <p>custody [1] 3/13</p> <p>customer [1] 102/15</p>	<p>death [88] 4/3 4/16 4/16 5/24 6/24 7/4 7/6 7/15 7/23 7/24 9/1 10/25 13/8 14/4 14/15 14/17 14/21 15/3 15/13 15/14 25/23 26/5 26/15 26/16 26/19 26/21 26/25 27/6 27/23 28/2 28/5 28/10 28/17 28/19 28/21 28/22 28/25 29/17 29/18 30/23 31/4 31/11 31/21 31/22 31/23 32/2 32/4 32/12 32/16 33/24 34/5 34/9 35/8 36/11 37/10 43/8 55/4 55/6 57/15 58/16 60/16 70/10 70/24 72/6 74/9 75/15 76/11 85/11 85/14 85/24 86/3 86/5 86/9 87/19 87/22 88/24 89/8 89/11 89/14 90/5 90/13 91/5 91/6 91/19 92/11 92/21 94/11 94/13</p> <p>deaths [59] 3/1 3/2 3/9 8/3 8/14 8/19 21/16 21/23 23/20 23/24 23/25 24/2 24/9 24/13 32/1 32/22 33/12 33/14 34/8 34/15 34/17 34/25 35/7 40/8 41/8 41/9 41/15 41/23 41/24 42/13 42/16 43/21 48/2 48/25 49/17 49/21 53/3 53/12 53/21 55/7 57/3 57/4 59/13 61/17 62/12 63/15 67/6 68/4 69/6 82/25 83/2 83/20 83/25 99/25 100/1 100/6 100/16 100/23 102/13</p> <p>debate [1] 89/1</p> <p>deceased [1] 4/15</p> <p>deceased's [1] 3/13</p> <p>December [4] 1/1 36/14 37/2 112/25</p> <p>decide [2] 38/4 62/9</p> <p>decided [3] 29/4 29/17 29/21</p> <p>decision [9] 14/6 16/19 27/3 87/14 92/18 92/24 93/1 93/25 102/24</p> <p>decision-making [2] 14/6 87/14</p> <p>deficiencies [1] 85/20</p> <p>deficient [1] 101/8</p> <p>definitely [1] 71/4</p> <p>deflect [1] 111/17</p>	<p>degree [1] 6/15</p> <p>delay [3] 35/23 38/22 64/19</p> <p>delays [2] 21/9 41/20</p> <p>delegation [1] 52/22</p> <p>deliberate [1] 79/16</p> <p>deliberately [1] 109/23</p> <p>deliver [1] 54/13</p> <p>delivered [2] 53/25 78/14</p> <p>delivering [1] 54/12</p> <p>demand [4] 5/17 13/22 17/9 65/16</p> <p>department [3] 25/14 25/17 44/15</p> <p>departments [1] 10/14</p> <p>depth [6] 30/11 47/2 47/11 48/14 48/25 53/21</p> <p>deputies [1] 56/17</p> <p>deputy [1] 21/15</p> <p>derangement [1] 70/20</p> <p>described [9] 4/9 26/12 51/23 59/16 71/15 82/6 83/20 86/20 97/11</p> <p>describing [1] 102/5</p> <p>description [1] 89/11</p> <p>despite [3] 26/23 26/24 43/20</p> <p>detailed [6] 17/4 17/10 21/22 66/15 67/5 109/9</p> <p>details [8] 6/17 8/14 13/6 25/11 29/15 90/18 90/19 93/20</p> <p>deteriorated [1] 65/23</p> <p>deterioration [3] 59/17 68/6 68/19</p> <p>determine [4] 72/24 84/24 89/13 90/8</p> <p>determined [2] 25/22 25/24</p> <p>detract [1] 74/17</p> <p>developed [1] 21/2</p> <p>devoted [1] 6/14</p> <p>diagnoses [1] 7/11</p> <p>diagnosis [1] 92/14</p> <p>did [22] 9/3 9/8 23/4 23/15 25/9 25/10 29/17 44/19 45/10 45/15 52/23 52/24 55/11 55/18 71/21 72/20 76/21 81/24 82/7 84/16 99/8 110/23</p> <p>didn't [19] 27/4 29/5 30/2 31/21 59/18 59/22 61/7 64/5 65/13 71/21 75/16 75/22</p>	<p>76/2 77/21 77/22 82/7 97/12 99/6 107/9</p> <p>die [1] 7/16</p> <p>died [5] 27/22 59/14 69/9 75/13 79/16</p> <p>difference [4] 3/23 42/5 90/4 98/13</p> <p>different [13] 13/16 16/12 18/9 34/11 36/19 42/7 42/8 42/10 80/7 80/9 85/9 101/10 106/16</p> <p>difficult [5] 7/21 45/2 79/9 86/5 92/5</p> <p>difficulties [1] 8/22</p> <p>difficulty [2] 7/20 94/8</p> <p>dint [1] 34/13</p> <p>direct [3] 29/15 44/8 44/10</p> <p>directed [1] 6/3</p> <p>direction [3] 9/13 31/25 65/12</p> <p>directions [3] 9/18 20/8 81/13</p> <p>directly [1] 76/23</p> <p>Director [5] 40/17 40/17 52/15 52/20 52/21</p> <p>disagree [1] 93/25</p> <p>disagreement [3] 90/12 91/3 91/5</p> <p>disappointed [1] 20/5</p> <p>disappointing [3] 60/8 61/9 76/15</p> <p>disappointment [1] 76/7</p> <p>disclose [2] 34/5 75/1</p> <p>disclosed [1] 74/2</p> <p>disclosure [2] 64/21 79/9</p> <p>discontinuance [1] 29/20</p> <p>discontinue [4] 29/4 41/10 43/11 44/4</p> <p>discontinued [7] 27/11 28/11 32/6 32/19 43/20 44/1 57/1</p> <p>discontinuing [1] 34/6</p> <p>discuss [9] 33/14 37/15 45/20 52/25 76/23 83/7 87/18 89/25 112/8</p> <p>discussed [6] 59/24 95/11 96/20 100/9 100/17 111/24</p> <p>discussing [1] 92/21</p> <p>discussion [12] 33/22 47/18 53/18 55/23 59/6 59/22 60/22 62/5 81/3 81/25</p>
--	---	---	---	--

D	14/10 17/25 22/20 23/2 45/19 48/21 48/22 52/4 55/14 96/5 97/18 104/5 104/13 112/6 does [15] 7/5 11/14 37/4 37/25 50/22 54/7 56/18 57/7 69/3 72/18 98/8 106/21 107/17 109/22 111/23 doesn't [10] 19/23 42/15 50/17 51/15 54/6 78/20 78/22 81/16 94/9 105/9 doing [2] 47/19 97/24 don't [27] 9/23 9/25 11/4 13/2 13/4 15/9 25/4 27/2 27/14 42/23 45/14 47/15 50/25 53/7 54/11 55/19 56/21 57/13 57/20 79/10 85/17 85/17 93/14 94/24 108/1 108/2 112/5 donation [1] 2/25 done [16] 9/15 10/2 11/24 23/13 36/2 36/15 42/4 43/7 47/14 65/4 66/16 73/24 76/25 95/15 97/16 108/17 doubt [1] 41/21 doubts [1] 92/12 down [8] 1/9 3/3 11/3 12/16 14/2 25/18 30/20 41/4 downgraded [1] 25/14 Dr [49] 19/20 19/25 20/18 20/22 22/4 24/20 24/21 27/13 28/1 28/9 28/20 32/10 34/9 35/20 43/21 49/1 49/12 49/19 51/22 54/3 58/21 58/21 58/21 59/12 59/20 61/22 61/22 66/2 66/16 67/10 71/5 72/3 72/14 73/12 85/13 87/22 88/4 88/20 88/21 88/22 88/24 89/3 89/23 90/3 93/9 93/18 95/24 96/9 104/15 Dr Brearey [3] 19/20 58/21 59/12 Dr Brearey's [2] 19/25 104/15 Dr Gibbs [2] 88/4 88/24 Dr Hawdon [4] 49/1 49/12 51/22 66/16 Dr Hawdon's [7] 49/19 54/3 66/2 67/10	73/12 95/24 96/9 Dr Jayaram [6] 22/4 24/21 58/21 59/20 71/5 72/3 Dr Jayaram's [1] 24/20 Dr Kokai [11] 27/13 28/1 28/9 32/10 34/9 43/21 87/22 88/20 88/22 89/3 89/23 Dr Kokai's [2] 88/21 90/3 Dr McPartland [1] 85/13 Dr Napier [2] 93/9 93/18 Dr Newby [1] 28/20 Dr Nisar Mir [1] 61/22 Dr Ruth Spedding [1] 61/22 Dr Saladi [2] 58/21 72/14 Dr Saladi's [1] 20/18 draft [1] 36/1 drafted [1] 12/22 drafting [1] 61/12 drawn [2] 82/24 83/3 driven [1] 102/25 drowning [1] 84/13 dual [1] 2/8 due [8] 18/1 25/24 32/13 36/12 41/9 43/21 78/12 109/14 duration [1] 15/2 during [11] 5/18 83/2 88/12 95/11 96/1 96/21 97/4 97/13 99/7 101/3 102/14 duty [4] 8/25 79/19 79/22 93/6 dying [1] 84/13 dysfunction [1] 88/1	education [2] 81/2 81/10 effect [2] 82/6 84/12 effective [1] 98/9 Effectively [1] 87/20 either [5] 15/22 55/12 72/20 75/1 110/3 elaboration [1] 11/14 elderly [1] 85/23 electrical [1] 87/5 elegant [1] 57/6 else [5] 60/13 76/22 89/3 106/4 112/12 email [26] 15/10 16/6 16/6 16/16 17/14 17/23 21/11 22/9 22/14 22/15 32/23 36/8 36/13 36/21 37/1 39/1 39/18 39/19 41/3 41/4 43/5 64/12 66/3 66/5 67/7 77/9 emailed [1] 66/2 emails [3] 35/10 35/11 43/2 emanating [1] 9/21 embolism [2] 59/21 70/19 embrace [1] 74/12 emerged [2] 47/4 76/8 employ [1] 3/19 employed [4] 2/9 5/15 62/14 63/23 employees [1] 2/11 enable [1] 37/10 enclosed [2] 54/22 55/11 enclosures [1] 53/20 end [7] 25/20 36/3 50/7 53/22 65/18 76/3 84/9 endeavour [1] 9/4 ended [1] 75/20 ending [1] 20/15 endorsement [1] 77/22 engage [1] 44/10 engaged [2] 7/7 87/10 engagement [1] 4/14 England [1] 80/12 enlarge [3] 24/20 45/24 46/7 enlarged [1] 22/10 enormous [1] 11/20 enormously [1] 81/8 enough [2] 47/24 92/1 enquiries [1] 48/15 enquiry [1] 42/12 ensued [1] 26/16 Enterocolitis [3] 91/19 92/1 93/24 entire [1] 5/19	entirely [5] 21/20 60/5 67/3 80/20 105/14 entitled [1] 50/10 envelope [1] 105/25 episode [1] 28/24 era [1] 79/8 errant [1] 87/4 error [2] 26/18 70/24 errors [1] 15/13 et [7] 19/2 21/4 31/9 62/9 79/9 81/13 97/24 et cetera [7] 19/2 21/4 31/9 62/9 79/9 81/13 97/24 ethos [1] 60/16 euthanasia [1] 84/7 even [5] 7/20 74/16 77/25 78/16 92/7 event [5] 26/3 28/24 38/6 62/20 64/8 event' [1] 25/25 events [1] 62/5 ever [1] 81/10 every [8] 5/21 6/15 7/8 9/6 9/14 9/17 11/22 89/19 everybody [3] 6/4 60/21 98/4 everything [6] 6/7 82/5 97/23 105/21 108/5 111/24 evidence [38] 11/7 12/1 12/2 13/11 13/15 13/18 13/21 13/23 13/24 22/5 23/18 23/20 24/20 25/1 40/15 63/4 68/15 71/5 71/8 71/24 76/5 78/4 85/13 86/6 86/20 87/11 88/3 88/16 88/23 89/17 90/10 91/21 92/1 94/25 101/13 104/8 109/14 111/20 eviscerate [1] 4/10 evolve [1] 59/22 exactly [4] 60/9 73/20 77/1 102/12 examination [13] 3/6 3/15 3/18 3/24 5/20 5/25 6/8 6/10 27/9 31/5 68/14 85/22 103/5 examine [1] 4/11 example [1] 79/14 excellence [2] 18/25 25/17 excellent [1] 61/19 except [1] 51/10 exception [1] 94/4 excess [2] 34/15 34/25 exchange [1] 80/17
----------	--	---	--	---

I	53/4 54/12 54/14 55/20 55/24 56/4 64/3 64/7 69/23 70/2 70/4 70/21 72/11 74/20 75/5 77/6 83/7 90/16 90/19 92/10 92/14 97/20 107/7	24/7 33/10 72/16 73/24 90/8 90/21 112/12 independent [10] 15/23 42/25 43/7 43/8 53/3 68/14 68/17 69/21 86/25 95/6 independently [4] 24/4 69/16 70/3 70/17 indicate [3] 34/7 41/9 41/24 indicated [4] 21/20 27/21 30/10 67/3 indicating [2] 53/22 56/17 individual [3] 4/4 7/4 63/1 individually [1] 60/19 individuals [2] 72/20 84/7 induction [1] 9/17 infant [8] 7/15 11/10 33/24 40/9 41/18 60/16 61/17 86/3 infants [2] 33/24 49/11 infer [2] 83/3 112/2 influenced [1] 86/25 info [1] 47/12 inform [3] 44/20 79/22 99/19 informal [1] 63/2 informally [1] 63/6 information [55] 2/14 4/8 6/19 6/23 6/25 9/2 12/9 13/7 13/12 14/7 22/25 35/1 41/15 50/18 51/7 51/14 57/2 58/4 58/6 60/19 61/9 62/17 62/20 62/22 62/24 63/1 63/12 67/25 68/10 68/16 72/21 74/16 75/6 77/21 78/4 78/12 78/21 78/25 80/17 81/17 83/22 83/24 84/24 86/23 87/8 87/15 91/10 91/16 98/5 99/7 102/4 102/25 105/23 106/7 111/12 informed [4] 44/16 77/18 79/18 79/21 informing [3] 9/12 74/24 99/13 initial [3] 61/4 61/23 62/6 initially [1] 61/2 injected [1] 72/5 injection [1] 59/21 injury [2] 5/21 29/3 ink [1] 77/11 INQ [6] 16/12 20/14 29/24 36/19 38/19	40/18 INQ number [6] 16/12 20/14 29/24 36/19 38/19 40/18 INQ0002042 [6] 14/20 15/6 16/5 18/21 19/6 20/2 INQ0002045 [2] 28/20 29/8 INQ0002046 [4] 32/23 36/19 41/4 43/1 INQ0002046 0083 [1] 32/23 INQ0002048 [5] 48/7 48/19 49/3 49/13 52/13 INQ0005815 [1] 44/11 INQ0008638 [1] 9/20 INQ0008841 [1] 18/4 INQ0008941 [1] 12/17 INQ0009618 [1] 40/3 INQ0012066 [1] 67/13 INQ0017840 [1] 8/7 INQ0050707 [1] 17/13 INQ0053069 [2] 21/12 66/4 INQ0058202 [2] 35/9 39/16 INQ0106817 [1] 45/23 INQ0107909 [1] 24/18 Inquest [54] 8/4 14/6 14/18 15/25 16/20 20/11 21/10 22/6 24/7 24/15 30/24 31/12 31/14 54/25 56/14 56/19 57/3 57/15 58/16 60/13 68/11 68/14 70/6 70/23 71/5 72/11 72/15 73/4 73/8 74/6 74/12 74/13 75/7 75/8 75/9 75/20 76/2 76/8 76/12 76/16 77/25 78/5 78/19 78/23 90/10 91/3 91/8 102/16 104/8 104/13 107/16 107/18 107/20 107/24 Inquests [7] 10/18 11/21 41/25 43/19 55/1 62/20 97/22 inquiries [1] 61/5 inquiry [20] 1/12 11/7 18/9 33/11 53/3 68/9 74/14 79/4 81/24 85/12 88/3 95/5 98/3 99/2 99/17 99/21 101/1 110/9 111/2 112/24	inquiry/investigation [1] 111/2 insertion [2] 15/16 26/8 Inspector [2] 63/11 63/13 instance [4] 6/6 6/8 7/3 34/18 instead [3] 3/18 9/20 48/6 instituted [1] 34/17 instruct [1] 11/21 instructed [3] 22/2 66/16 68/15 instruction [6] 43/25 66/9 77/17 105/24 107/6 107/7 instructions [4] 67/10 73/12 75/4 86/22 intake [1] 9/17 intend [1] 56/18 intensive [2] 49/22 50/5 intention [2] 42/22 61/4 interested [2] 14/7 36/11 interfered [1] 64/6 internal [6] 5/25 9/22 37/5 43/2 58/18 58/24 internally [1] 15/22 interpret [2] 6/17 7/22 interpretation [1] 57/25 interrupt [1] 43/17 into [31] 1/22 2/18 7/4 23/19 24/4 34/25 35/5 41/12 48/25 53/3 53/21 54/2 55/8 57/15 59/22 65/21 69/19 69/23 69/23 70/1 70/6 70/22 72/5 79/13 79/13 80/19 83/12 85/22 92/15 109/6 110/16 introduced [1] 101/4 invariable [1] 90/17 invariably [1] 64/22 investigate [2] 68/25 77/24 investigating [4] 63/15 63/25 75/20 98/21 investigation [44] 14/17 15/22 19/15 20/8 20/9 27/7 27/11 28/1 28/8 28/11 29/5 29/6 29/18 31/6 32/6 32/19 34/12 34/13 34/16 35/4 42/19 42/25 43/12 44/1 47/11 49/16 50/21
----------	--	--	--	--

I	38/21 38/24 39/6 98/12 Jayaram [6] 22/4 24/21 58/21 59/20 71/5 72/3 Jayaram's [2] 20/20 24/20 join [1] 80/22 Josh [1] 35/18 Joshua [1] 17/17 Joshua Swash [1] 17/17 judicial [1] 87/14 judicially [1] 78/10 July [10] 1/20 1/22 12/20 19/19 20/20 21/23 22/22 22/23 49/21 59/13 July 2015 [1] 20/20 June [10] 14/16 14/22 27/6 28/19 58/17 58/20 66/9 100/8 100/12 100/15 June 2015 [1] 14/22 junior [2] 11/7 94/9 jurisdiction [14] 33/21 41/25 55/2 55/3 56/19 56/21 56/25 57/13 64/17 80/18 81/21 81/22 82/12 82/17 just [57] 4/19 5/3 10/4 11/5 11/8 11/10 11/13 12/12 12/14 13/14 16/12 24/19 25/16 26/1 27/1 32/25 35/18 40/4 44/21 45/18 45/19 48/22 51/2 52/14 53/7 55/17 56/12 57/17 60/18 61/11 62/1 66/3 66/7 67/12 67/15 67/20 69/4 69/4 75/8 75/8 75/18 76/5 77/24 87/14 90/19 101/9 103/19 104/4 105/3 108/3 108/9 108/25 109/12 110/13 111/10 111/11 111/23 Justice [3] 1/23 104/2 113/8 justifiable [1] 32/15 justification [1] 68/2	14/15 14/21 20/18 21/10 23/15 24/3 24/8 27/5 29/2 34/18 35/4 38/3 39/13 42/23 48/17 48/20 50/24 50/25 50/25 54/10 59/14 59/23 60/1 68/11 75/22 86/18 94/10 96/4 98/11 105/1 110/20 knowledge [6] 9/1 13/17 63/14 69/25 71/25 102/1 known [6] 3/8 26/14 31/22 31/23 70/16 107/4 Kokai [11] 27/13 28/1 28/9 32/10 34/9 43/21 87/22 88/20 88/22 89/3 89/23 Kokai's [2] 88/21 90/3	less [1] 20/8 lessons [1] 11/1 Let [1] 42/1 let's [2] 35/11 110/13 Letby [4] 59/7 59/9 72/4 84/25 letter [28] 16/17 16/18 19/6 19/12 19/23 19/25 20/2 29/5 29/8 29/14 30/6 30/9 44/12 48/8 49/13 51/22 54/22 55/10 55/10 55/11 55/15 64/13 96/7 105/7 107/11 110/4 110/5 110/23 letters [2] 17/6 17/8 level [3] 41/19 42/16 85/3 life [4] 84/9 86/19 88/9 90/23 light [7] 10/23 41/23 42/14 43/11 44/18 50/18 57/2 like [14] 18/3 26/14 33/16 37/8 38/2 38/5 45/6 47/13 47/20 52/16 64/18 74/13 105/2 106/11 liked [1] 42/4 likelihood [1] 7/24 likely [1] 55/15 likewise [2] 72/14 86/18 limited [1] 63/24 line [9] 12/13 15/17 26/7 26/8 28/12 42/11 70/21 70/24 89/5 lines [2] 15/16 15/19 link [1] 40/14 list [6] 11/23 17/7 17/12 49/6 49/11 55/7 listed [1] 57/3 little [4] 53/9 86/4 106/15 110/13 lived [1] 88/7 local [3] 1/17 2/3 61/11 lock [1] 69/8 log [2] 2/16 2/19 long [3] 15/17 54/9 54/11 longer [1] 2/12 look [27] 4/8 6/16 7/13 19/23 22/9 24/18 27/16 27/17 31/18 35/11 38/13 48/13 48/19 48/22 53/19 54/5 55/18 56/11 67/12 67/14 97/12 101/11 101/13 102/1 105/2 106/2 106/4 looked [14] 24/4 50/14 51/1 51/5 55/15	70/1 70/22 82/2 89/19 96/24 97/13 98/1 105/2 105/7 looking [12] 5/21 30/10 34/24 54/8 54/19 55/19 57/21 69/15 70/9 70/18 71/17 101/18 looks [3] 18/3 47/13 54/16 lost [1] 106/22 lot [2] 66/8 82/8 Louis [1] 22/2 loyal [2] 2/8 2/9 loyalty [1] 2/8 Lucy [4] 59/7 59/9 72/4 84/25 Lucy Letby [4] 59/7 59/9 72/4 84/25 lung [3] 29/3 32/13 88/1 lungs [1] 84/11 lying [1] 56/21
J	January [5] 37/17	L	M	
		Lady [9] 1/4 4/23 5/5 79/25 94/15 103/15 104/2 112/14 113/8 Langdale [8] 1/3 1/8 50/24 64/9 76/17 85/10 98/13 113/4 lapse [1] 20/24 large [1] 77/8 last [6] 18/13 24/19 44/15 50/17 51/10 110/13 later [3] 20/22 26/1 95/23 latest [1] 99/1 launched [1] 102/22 law [1] 1/22 Lea [1] 12/20 lead [5] 22/4 40/12 82/4 82/7 101/19 leader [2] 2/9 86/2 leading [1] 88/17 leads [1] 84/10 leant [1] 61/23 learning [4] 18/25 80/7 80/17 83/22 learnt [1] 11/1 least [6] 54/17 57/22 74/20 79/4 79/17 108/12 leave [5] 11/5 12/8 35/20 85/17 86/11 left [2] 53/18 94/10 leg [2] 94/10 94/10 legal [7] 31/20 36/10 56/15 74/23 75/5 76/3 81/13 legally [1] 16/21 legible [2] 108/12 108/13 Leighton [1] 84/2	made [22] 3/22 9/6 9/16 29/22 40/16 42/5 43/19 44/18 44/23 55/24 57/7 67/17 79/6 79/14 90/7 94/5 95/7 95/12 95/19 95/22 97/4 98/14 Magistrates [1] 107/25 make [15] 14/4 14/13 25/9 31/7 42/23 53/6 56/3 56/11 58/4 65/14 92/11 92/18 92/24 93/1 107/9 makes [2] 22/11 54/5 making [6] 14/6 49/8 50/8 56/6 83/14 87/14 Manchester [4] 80/21 80/25 82/17 82/18 manner [1] 33/21 many [12] 4/7 8/3 50/4 63/24 75/15 75/15 80/14 86/12 86/19 90/22 94/24 97/21 March [2] 30/2 30/4 March 2017 [1] 30/4 mark [2] 63/11 70/23 marked [1] 106/1 marks [2] 85/17 86/12 match [1] 17/8 matter [18] 10/23 22/3 22/5 24/3 42/14 42/19 42/20 42/24 57/24 72/24 74/21 77/13 78/17 79/7 98/20 98/24 99/16	

M	80/21	22/22 22/25 23/3	48/8 52/16 58/3 58/21	23/14 25/4 31/25 37/1
matter... [1] 111/15	member [2] 23/21	23/17 30/6 30/17 41/5	60/12 62/23 66/2 66/5	38/8 42/2 42/7 42/22
matters [5] 2/20	79/15	53/15	66/23 68/1 76/22	43/25 44/8 44/9 51/3
41/21 56/4 77/13	members [2] 9/11	Moore's [2] 23/18	108/16 108/22 110/3	52/8 53/1 53/5 53/17
89/25	44/16	111/12	Mr Cross's [1] 45/24	55/24 56/5 56/16
may [33] 1/4 4/20	memory [3] 23/14	more [16] 3/7 13/4	Mr Harvey [9] 45/12	56/16 57/25 58/8
6/14 7/21 23/16 27/17	33/15 109/12	42/12 49/24 52/21	46/10 46/25 48/20	60/24 61/2 63/3 63/8
30/7 30/15 52/5 55/8	mentally [1] 77/16	68/16 72/5 72/15	52/16 58/3 58/22	63/22 64/1 65/6 65/7
57/24 59/20 61/18	mention [5] 7/17 40/7	74/10 74/11 74/12	76/21 109/14	72/2 74/11 74/15 75/2
61/18 64/25 66/3 70/7	69/3 84/1 101/5	89/25 91/16 94/15	Mr Moore [8] 22/16	76/1 77/22 78/17
72/4 77/14 78/5 79/16	mentioned [5] 26/7	107/14 111/11	22/22 22/25 23/3	78/23 79/25 80/18
84/23 86/11 87/9	33/11 37/3 59/12 72/7	morning [8] 36/24	23/17 30/6 30/17 41/5	82/12 84/2 93/18
88/21 88/21 89/16	mentioning [1] 59/25	37/3 38/25 96/19 98/3	Mr Moore's [1] 23/18	94/15 94/20 95/10
92/9 92/9 95/25 95/25	mercy [1] 47/22	98/13 99/21 100/2	MR NICHOLAS	96/23 97/7 101/5
101/4 109/13	Messrs [2] 29/13	29/22	RHEINBERG [2] 1/7	103/15 106/19 108/21
McCormack's [1]	29/22	mortalities [1] 69/14	113/3	109/12 110/25 111/23
20/19	Messrs Gamlins [1]	mortality [4] 18/1	Mr Rheinberg [34]	112/11 112/14
McPartland [1] 85/13	29/22	41/18 65/24 101/12	1/4 1/5 1/11 1/24 8/8	my Lady [6] 1/4 5/5
me [32] 2/5 2/9 3/5	met [1] 37/2	most [4] 2/15 2/24	9/24 12/18 14/3 17/22	79/25 94/15 103/15
3/5 17/7 21/8 22/20	metabolic [1] 70/19	44/8 93/18	18/5 21/14 24/21	112/14
22/25 23/2 27/4 41/11	meticulous [5] 5/20	Mother [1] 88/23	29/25 38/21 40/1	myself [2] 78/11
44/8 52/8 52/17 53/1	6/15 6/18 23/13 101/8	Mother C [1] 88/23	46/22 49/3 50/12 51/1	108/3
53/6 57/10 57/17	microscopic [1]	mother's [1] 16/13	51/4 58/12 60/10 66/7	mystery [1] 42/12
61/22 63/3 65/10	28/18	move [2] 5/11 14/3	67/14 67/21 79/24	
68/15 68/17 72/24	Middle [1] 79/21	moved [1] 69/8	80/3 94/20 96/19	N
77/20 78/21 78/22	might [22] 2/20 4/19	movement [1] 38/10	103/18 104/3 110/4	name [2] 12/25 94/20
104/22 105/15 107/7	5/11 14/13 16/24	moving [6] 4/3 16/4	110/10 112/13	Napier [2] 93/9 93/18
107/21 111/5	28/16 34/15 35/1 35/7	21/10 27/5 49/8 85/9	Mr Rheinberg's [1]	narrative [1] 14/19
mean [6] 24/1 77/22	54/2 60/19 63/12	Mr [90] 1/4 1/5 1/7	30/9	natural [17] 25/24
77/22 78/5 82/10 93/6	65/14 68/17 70/10	1/11 1/24 8/8 9/24	Mr Skelton [3] 58/10	26/3 26/6 27/22 28/3
means [4] 17/9 33/15	71/3 74/17 91/22	12/18 14/3 16/6 17/22	58/11 113/5	29/18 31/24 32/16
62/3 77/4	103/4 103/5 105/23	18/5 21/13 21/14	Mrs [2] 12/20 16/12	41/10 41/23 43/21
meant [5] 13/14 23/6	106/24	22/11 22/16 22/17	Mrs Killingback [1]	78/16 87/22 89/7 91/4
109/2 111/16 111/20	mildly [1] 76/14	22/22 22/22 22/25	16/12	91/5 92/20
measures [1] 59/19	mind [5] 15/10 15/12	23/3 23/17 23/18	Mrs Sarah [1] 12/20	naturally [2] 28/10
mechanism [3] 62/13	16/20 69/20 82/22	24/21 29/25 30/6 30/8	Ms [14] 1/3 1/8 43/4	34/5
63/8 71/3	minded [1] 44/3	30/9 30/17 38/21	50/24 64/9 76/17	nature [2] 20/9 111/8
medical [14] 4/8 6/25	minor [1] 72/15	39/18 40/1 41/5 44/12	85/10 94/18 94/19	near [2] 7/4 97/10
10/20 13/7 15/13	minute [1] 70/7	45/11 45/12 45/24	98/13 100/5 103/17	nearly [1] 108/13
40/17 49/1 52/15	minutes [3] 6/13	46/10 46/22 46/25	113/4 113/7	necessarily [1] 103/7
52/20 52/21 64/4	54/14 103/19	47/15 48/8 48/20 49/3	Ms Blackwell [4]	Necrotising [3] 91/19
78/13 79/20 89/10	Mir [1] 61/22	49/14 50/12 51/1 51/4	94/18 94/19 103/17	92/1 93/24
medically [1] 93/18	misconceptions [1]	52/16 52/16 58/3 58/3	113/7	need [12] 7/8 11/14
medics [1] 64/5	8/22	58/10 58/11 58/12	Ms Hurst [2] 43/4	29/17 38/3 39/13
meet [4] 37/14 52/18	misconduct [1]	58/21 58/22 60/10	100/5	56/22 62/20 62/21
80/16 111/6	50/20	60/12 62/23 66/2 66/5	Ms Langdale [8] 1/3	65/5 69/15 108/1
meeting [50] 37/17	misinsertion [1] 26/9	66/7 66/23 67/14	1/8 50/24 64/9 76/17	109/13
39/5 45/11 45/13	misled [1] 93/5	67/21 68/1 73/6 73/17	85/10 98/13 113/4	needed [7] 7/1 31/18
45/14 45/17 45/19	mismanagement [3]	76/21 76/22 79/24	13/22 64/20 72/15	42/24 65/5 66/21
45/24 46/25 47/22	29/16 34/7 34/19	80/1 80/2 80/3 94/17	76/2 79/7 81/4 83/17	68/10 98/20
48/9 48/17 48/21 52/3	misplaced [2] 26/7	94/20 96/19 103/18	85/23 87/8 94/14	needs [2] 42/19
52/7 52/8 52/9 52/11	26/7	104/3 108/16 108/22	101/2 103/14 103/16	47/11
52/12 53/8 53/10 54/3	misplacement [1]	109/14 110/3 110/4	108/21 112/12 112/17	neither [1] 106/17
54/9 56/3 58/2 58/20	15/19	110/10 112/13 113/3	112/22	neonatal [15] 21/16
59/5 59/11 62/7 81/2	missed [1] 17/11	113/5 113/6	murderous [1] 84/2	21/21 23/20 23/25
95/3 95/6 95/7 95/11	mistakes [3] 10/20	Mr Baker [4] 80/1	murders [1] 82/14	24/13 28/22 37/3
95/17 95/18 96/1 96/2	57/11 107/9	80/2 94/17 113/6	must [7] 8/20 55/3	38/23 50/2 54/20 67/4
96/21 97/5 97/13 99/8	mixed [1] 71/24	Mr Browne [2] 73/6	75/1 75/3 79/17 79/21	69/14 96/14 100/23
108/10 108/20 109/3	mobile [1] 8/15	73/17	94/12	102/8
109/19 111/1 111/5	mode [2] 68/6 68/19	Mr Chambers [1]	my [71] 1/4 2/6 2/7	neonate [2] 85/12
111/24 112/8	moment [3] 13/17	49/14	2/18 2/21 2/24 4/23	102/6
meetings [6] 58/18	48/11 67/20	Mr Cross [24] 16/6	5/5 8/2 9/18 12/1	neonates [1] 41/13
58/25 59/2 59/6 76/18	months [1] 75/15	22/22 30/8 39/18	15/21 16/19 17/11	net [1] 13/24
	Moore [9] 22/16	44/12 45/11 47/15		never [5] 8/5 11/22

<p>N</p> <p>never... [3] 48/1 76/11 106/6</p> <p>Nevertheless [1] 28/3</p> <p>new [5] 9/17 37/13 38/6 42/11 79/23</p> <p>New Year [2] 37/13 38/6</p> <p>Newby [1] 28/20</p> <p>news [2] 36/15 45/1</p> <p>next [11] 10/5 10/9 10/11 12/5 17/13 20/11 20/14 20/17 29/23 40/22 81/18</p> <p>NICHOLAS [2] 1/7 113/3</p> <p>Nisar [1] 61/22</p> <p>NLR [3] 55/1 55/6 57/7</p> <p>NUU [1] 17/25</p> <p>no [78] 2/12 3/24 9/25 10/1 10/3 17/15 20/7 21/1 21/21 22/19 23/23 30/24 30/24 30/25 31/11 31/12 31/14 34/18 38/1 40/14 41/21 41/25 42/5 42/14 45/18 47/4 47/10 48/1 48/3 48/15 49/21 55/20 55/21 56/6 56/9 56/15 57/13 57/20 59/1 65/13 65/13 67/4 67/11 70/14 73/2 75/17 75/24 76/14 76/21 76/24 77/13 77/20 79/17 83/9 83/9 84/14 84/21 86/23 89/2 94/15 95/5 97/7 97/10 100/6 100/6 100/22 103/8 105/4 105/12 105/21 107/10 107/15 108/21 109/1 112/3 112/5 112/5 112/12</p> <p>non [1] 64/14</p> <p>non-production [1] 64/14</p> <p>none [1] 93/19</p> <p>normal [3] 4/4 29/19 88/18</p> <p>normally [3] 44/8 44/10 90/6</p> <p>North [3] 80/10 81/1 82/1</p> <p>North West [3] 80/10 81/1 82/1</p> <p>not [95] 3/17 7/5 8/25 10/1 10/17 10/19 10/23 10/23 11/4 11/14 11/17 12/7 12/8 12/10 12/23 13/19 13/25 14/5 17/14</p>	<p>20/25 23/1 24/5 24/22 25/12 26/20 26/25 27/2 27/3 33/2 34/16 40/8 41/15 41/18 42/6 42/21 44/8 44/19 44/23 45/25 46/2 50/5 52/17 53/3 56/18 56/24 56/25 57/6 57/8 59/2 60/18 61/10 64/4 64/17 64/19 64/19 65/11 65/15 65/21 67/25 69/24 70/25 70/25 72/9 73/17 74/23 75/2 75/20 76/1 78/25 81/4 81/10 81/21 83/7 84/6 85/2 86/11 86/25 87/13 88/21 89/13 90/2 91/13 91/14 92/9 92/18 93/4 93/6 93/18 97/17 98/11 101/8 105/5 105/17 105/18 106/2</p> <p>notable [1] 18/25</p> <p>note [26] 17/25 24/15 39/3 45/24 47/22 52/7 52/9 52/11 55/24 56/2 56/6 56/6 57/25 59/2 73/20 95/10 95/11 95/17 95/18 95/19 96/23 97/8 97/11 108/20 109/9 109/25</p> <p>noted [1] 34/18</p> <p>notes [11] 12/7 13/6 24/16 54/2 54/6 64/6 95/7 96/24 97/1 97/15 109/12</p> <p>nothing [10] 25/13 34/6 41/8 41/22 41/24 76/7 79/23 80/23 107/14 109/21</p> <p>notified [2] 24/12 32/22</p> <p>notwithstanding [1] 63/18</p> <p>now [33] 12/16 14/3 23/17 24/23 25/5 32/25 33/18 35/2 36/1 38/13 38/19 41/14 44/20 44/25 45/14 45/19 46/17 53/13 54/10 56/1 56/12 57/18 62/11 66/1 81/15 82/22 84/17 95/17 104/3 105/19 108/9 109/5 112/18</p> <p>NR [1] 47/2</p> <p>nuances [1] 93/20</p> <p>number [20] 6/12 8/15 11/21 16/12 20/14 24/2 24/16 29/15 29/24 34/14 34/25 36/9 36/19 38/19 40/18 55/8</p>	<p>59/24 77/9 80/9 85/16</p> <p>numbers [1] 6/9</p> <p>nurse [16] 23/21 40/7 40/8 40/15 51/4 51/14 73/9 73/23 73/25 74/8 83/1 83/24 84/2 84/6 84/19 109/22</p> <p>Nursing [1] 40/17</p> <p>O</p> <p>o'clock [1] 112/21</p> <p>O,P [2] 44/19 44/22</p> <p>objection [1] 38/1</p> <p>observations [8] 50/11 51/23 51/23 55/16 75/9 75/18 96/12 112/4</p> <p>observed [2] 55/1 87/6</p> <p>obstetric [1] 16/8</p> <p>obtained [1] 102/4</p> <p>obvious [2] 85/17 86/19</p> <p>obviously [6] 2/8 3/4 57/4 78/21 92/15 98/2</p> <p>occasions [4] 2/14 26/7 59/25 63/24</p> <p>occur [3] 62/11 70/6 82/12</p> <p>occurred [4] 7/25 34/10 69/14 88/6</p> <p>occurring [2] 28/10 34/5</p> <p>October [10] 14/19 21/11 21/11 24/8 32/5 34/2 35/14 36/14 49/1 66/4</p> <p>October 2016 [1] 49/1</p> <p>off [3] 9/3 9/19 33/3</p> <p>offered [1] 7/11</p> <p>offering [1] 7/22</p> <p>offhand [1] 27/12</p> <p>office [25] 2/3 2/18 11/19 12/23 17/16 18/11 18/18 20/15 31/6 31/8 31/15 31/18 32/24 33/13 35/14 36/14 43/2 57/7 61/5 61/6 77/8 94/8 106/15 106/19 111/25</p> <p>officer [2] 6/1 99/24</p> <p>officers [12] 2/6 2/7 2/12 2/14 2/18 2/25 44/9 63/3 63/22 63/25 100/5 106/20</p> <p>officio [3] 56/25 78/1 78/20</p> <p>often [7] 3/5 7/14 52/19 64/19 86/4 94/8 107/9</p> <p>Oh [8] 16/7 24/1 40/6 46/1 59/10 93/6 94/1 94/3</p>	<p>okay [27] 11/15 12/15 14/8 14/14 25/2 26/4 40/2 40/25 48/24 51/11 51/20 58/23 59/10 65/6 67/19 73/22 74/1 74/10 80/8 88/8 88/13 88/19 91/23 95/2 95/20 101/4 112/17</p> <p>old [1] 69/6</p> <p>on [130]</p> <p>once [2] 39/8 102/21</p> <p>one [51] 3/19 3/24 13/23 15/19 18/18 18/18 19/20 24/17 26/5 26/22 45/15 50/16 55/8 55/16 56/1 56/10 56/16 56/20 58/13 58/20 59/25 63/3 63/10 63/10 63/22 64/25 65/5 65/11 68/13 72/5 75/5 78/11 79/4 84/2 84/23 92/15 92/19 92/25 94/12 94/14 95/10 97/25 102/15 102/16 103/3 103/20 104/4 104/4 105/1 106/19 108/6</p> <p>ones [1] 20/21</p> <p>ongoing [3] 53/16 57/5 65/7</p> <p>only [17] 3/14 18/16 19/2 20/22 26/14 29/20 44/24 54/15 55/1 55/20 57/15 59/25 63/24 98/8 99/16 102/15 102/16</p> <p>onwards [1] 1/25</p> <p>open [4] 27/1 74/22 78/14 78/17</p> <p>opened [6] 14/17 27/7 28/1 28/9 30/24 42/11</p> <p>opening [1] 50/21</p> <p>operate [1] 57/8</p> <p>operating [1] 106/16</p> <p>operation [1] 35/5</p> <p>opinion [10] 7/22 26/20 27/22 28/2 28/9 28/16 32/11 63/19 71/12 90/4</p> <p>opinions [3] 11/5 11/18 87/1</p> <p>opportunity [3] 2/22 38/7 42/23</p> <p>opposed [2] 78/17 83/12</p> <p>or [122]</p> <p>order [6] 3/6 3/25 13/9 20/7 92/14 102/25</p> <p>ordered [2] 27/8 103/6</p>	<p>ordering [1] 3/11</p> <p>ordination [1] 61/16</p> <p>ordinator [1] 60/25</p> <p>organ [1] 2/25</p> <p>organs [1] 4/11</p> <p>original [3] 43/25 51/2 78/18</p> <p>OSR [1] 17/24</p> <p>other [29] 10/14 18/2 18/17 26/6 26/11 40/14 41/9 41/21 42/16 49/11 50/2 50/22 56/10 59/6 64/16 69/13 69/20 79/1 80/4 80/14 86/11 88/6 89/17 91/15 101/22 104/21 105/7 106/17 111/17</p> <p>others [2] 61/7 87/1</p> <p>our [10] 13/24 22/10 33/23 35/17 39/5 39/8 50/9 51/12 60/18 82/3</p> <p>out [49] 2/20 3/18 4/6 6/3 6/15 7/10 8/13 8/17 8/23 12/8 13/4 13/6 14/12 14/13 15/10 16/18 17/11 25/19 26/15 27/24 30/12 31/1 32/9 42/21 44/25 47/2 48/14 49/18 49/18 51/16 53/18 57/14 60/24 61/2 72/2 72/11 72/21 74/22 75/13 78/12 83/18 100/20 101/16 105/13 105/17 105/22 110/16 111/2 111/25</p> <p>outcome [1] 43/14</p> <p>outlines [1] 46/25</p> <p>outlining [1] 46/10</p> <p>outset [2] 14/4 52/6</p> <p>outside [2] 62/19 80/24</p> <p>outstanding [1] 97/22</p> <p>over [15] 8/21 10/5 12/5 15/2 18/11 22/1 26/11 33/13 33/22 35/19 35/25 37/25 56/15 79/11 97/23</p> <p>overall [3] 53/2 57/10 75/9</p> <p>overleaf [1] 49/20</p> <p>own [10] 13/16 60/18 71/8 71/24 74/17 75/2 76/1 83/19 84/13 108/21</p> <p>P</p> <p>pack [2] 9/18 86/2</p> <p>paediatric [10] 26/24 28/13 40/12 48/2 89/20 101/7 101/11 101/12 101/17 101/19</p>
--	--	--	---	--

P	36/22	43/18 44/3 54/1 91/14	12/23 13/15 24/19	63/18 63/21 63/23
paediatrician [1] 88/4	page 89 [2] 49/4 49/6	92/4 93/4 104/14	37/16 81/4 84/1 97/14	63/25 64/3 64/7 72/12
paediatricians [3] 40/13 49/14 62/8	page 9 [1] 40/18	107/4	perinatal [2] 34/15	77/1 77/6 77/17 77/21
paediatricians' [5] 110/4 110/5 110/11	page 90 [2] 49/4 49/5	parents' [2] 14/25	34/25	78/21 98/4 98/24 99/3
110/23 110/24	page 91 [2] 38/19	16/14	period [7] 11/9 11/11	99/6 99/13 99/20
Paediatrics [2] 21/17	49/13	part [9] 1/19 2/4 2/15	66/4 69/9 88/7 88/12	101/14 102/4 102/11
44/17	page 93 [1] 50/10	3/7 9/17 37/22 56/17	102/14	102/22
page [75] 8/7 8/16	page 95 [1] 41/4	82/18 110/9	permission [3] 3/12	policy [1] 79/15
8/18 8/21 8/21 9/3	page 962 [1] 29/9	participants [2] 17/6	37/8 56/22	poor [1] 94/9
9/20 10/4 10/6 10/9	page 974 [1] 29/24	63/10	permitted [2] 11/17	position [7] 35/21
10/11 12/5 12/17	pain [2] 77/6 99/2	particular [18] 9/12	13/20	36/6 36/10 37/11
14/20 15/6 16/5 16/11	paper [1] 106/9	9/13 26/24 29/21	person [3] 15/23	74/17 74/23 75/10
16/13 17/13 18/4	paperwork [1] 31/2	37/10 42/15 55/5	77/15 93/1	positive [1] 23/12
18/11 18/12 18/12	paragraph [33] 1/25	59/11 59/23 59/24	personally [1] 89/22	possibilities [1]
18/12 18/12 18/13	2/23 7/12 8/1 14/11	68/3 72/6 75/4 75/10	perspective [1] 16/2	71/19
18/13 18/15 18/15	18/20 24/19 25/19	78/11 93/13 97/20	pertinent [2] 41/15	possibility [7] 64/5
18/21 19/6 19/20 20/2	25/21 27/7 27/14	112/8	78/12	85/5 92/21 101/24
20/17 20/17 20/21	27/19 30/21 31/1 32/5	particularly [5] 24/17	philosophy [1] 74/13	106/23 106/25 107/1
21/12 22/1 22/9 24/18	32/9 33/15 40/4 40/5	36/10 79/8 82/4 89/20	phone [1] 45/2	possible [7] 2/21
28/20 29/9 29/23	45/9 49/15 49/20	partly [2] 61/6 101/25	photographs [2] 6/2	6/23 13/23 26/4 41/20
29/24 33/1 33/2 33/2	50/16 50/17 51/10	partner [2] 1/17 31/8	6/6	78/9 87/9
34/1 34/1 35/9 36/18	53/19 67/15 67/16	parts [1] 110/17	pick [1] 2/20	possibly [1] 54/11
36/19 36/20 36/21	67/17 67/25 69/3	passages [2] 42/9	picked [3] 2/17 23/2	post [2] 1/19 1/20
36/22 37/23 38/19	70/18 87/20	110/15	66/8	postmortem [51] 3/6
38/20 39/16 40/3	paragraph 2 [4]	passed [5] 22/25	picture [3] 5/13	3/15 3/18 3/23 4/2 4/5
40/18 40/22 41/4 43/1	49/15 53/19 67/15	23/16 62/18 63/2	60/20 60/23	4/12 6/13 6/15 14/12
44/11 45/23 48/7	67/17	75/15	pieces [2] 6/8 60/20	14/17 26/25 27/8
48/20 49/4 49/4 49/5	paragraph 24 [1]	passing [3] 78/21	pillow [1] 84/12	28/13 29/2 30/24 31/5
49/6 49/13 50/10	7/12	88/11 110/3	place [10] 3/15 5/25	31/12 32/7 32/10 33/7
52/13	Paragraph 27 [1] 8/1	past [2] 16/22 103/23	19/15 22/21 45/17	34/3 84/14 85/14
page 1 [9] 8/7 9/20	paragraph 3.12 [1]	pathological [2]	58/20 95/8 104/13	85/18 85/22 89/4
10/4 17/13 18/4 18/11	40/4	26/11 32/17	107/24 108/4	89/12 89/19 89/21
21/12 39/16 44/11	paragraph 43 [1]	pathologist [38] 3/11	placed [2] 101/9	90/17 90/19 90/22
page 102 [1] 52/13	18/20	3/17 4/5 4/7 4/9 4/15	105/25	91/15 91/15 92/4 92/5
page 154 [1] 20/2	paragraph 45 [2]	5/15 5/17 6/3 6/16	plan [2] 17/25 39/9	92/7 92/15 92/16
page 155 [1] 19/6	25/19 25/21	6/19 6/22 7/7 7/7	play [1] 79/13	92/22 93/2 101/3
page 169 [1] 16/11	paragraph 5 [2] 1/25	26/13 26/15 27/21	please [32] 9/20	101/7 101/9 101/16
page 173 [1] 15/6	49/20	28/15 37/9 38/2 70/13	12/17 14/20 17/13	102/6 102/25 103/4
page 174 [1] 14/20	paragraph 52 [1]	71/12 86/23 86/24	17/21 17/24 17/25	103/10 105/23
page 186 [1] 16/5	87/20	87/4 87/10 89/10	18/3 18/15 24/18	postmortems [2]
page 2 [2] 8/16 18/12	paragraph 53 [2]	89/17 90/5 101/2	25/19 30/21 33/1 33/4	100/22 101/5
page 24 [1] 12/17	27/7 27/14	101/11 101/13 101/17	36/18 36/21 37/20	potential [2] 15/18
page 3 [3] 8/18 18/12	paragraph 65 [1]	101/18 101/19 101/24	39/3 39/16 39/19 41/3	91/4
35/9	30/21	102/9 102/11	42/1 43/1 44/11 48/6	potentially [2] 2/7
page 33 [1] 48/7	paragraph 66 [1]	pathologist's [2]	48/19 48/23 49/3	15/14
page 34 [2] 45/23	31/1	6/10 26/20	49/13 67/13 67/21	power [3] 20/7 53/4
48/20	paragraph 67 [1]	pathologists [1] 3/19	77/24	65/13
page 4 [2] 8/21 18/12	32/5	pathology [7] 4/22	pm [5] 49/7 49/9	powers [1] 61/6
page 5 [1] 9/3	paragraph 69 [1]	4/25 5/10 7/15 7/21	103/24 104/1 112/23	practice [13] 1/18
Page 7 [1] 18/15	32/9	85/20 85/23	pneumonia [1] 29/3	12/1 13/22 19/1 31/9
page 77 [1] 43/1	paragraph 74 [1]	patient [2] 50/8 85/23	point [12] 10/13	31/25 50/2 80/25
page 777 [1] 18/21	33/15	patients' [1] 18/2	25/17 30/17 31/20	81/12 81/14 86/22
page 8 [4] 18/15	paragraph 95 [1]	pattern [1] 68/4	56/6 71/19 73/5 76/1	93/22 94/7
24/18 28/20 40/3	45/9	Pause [7] 10/7 19/11	81/3 83/14 90/25	practices [1] 82/3
page 82 [1] 34/1	paragraphs [7] 40/19	25/3 25/7 40/20 41/1	109/8	practitioners [1] 82/4
page 83 [2] 33/1 33/2	40/24 42/18 50/22	67/23	pointedly [1] 111/14	precedent [1] 61/24
page 86 [2] 36/19	51/17 51/19 98/20	peculiar [1] 106/15	points [6] 8/23 11/3	precise [1] 73/20
37/23	paralegal [1] 17/19	pending [1] 25/15	12/11 56/11 83/2	predictable [1] 49/24
page 87 [1] 36/18	84/6	people [1] 62/21	92/25	preface [1] 72/2
page 88 [2] 36/21	paralyze [1] 82/7	people's [1] 69/6	police [41] 2/1 2/5	prefer [1] 106/2
	pardon [1] 73/1	perfectly [1] 43/22	2/5 2/8 2/11 2/13 2/14	preliminary [2] 16/19
	parents [13] 19/7	performed [1] 27/9	2/24 3/5 3/10 5/18	17/12
	29/6 29/15 41/11 42/1	perhaps [12] 2/20	5/18 6/22 30/17 42/20	prematurity [4] 32/13
		3/8 5/11 6/13 11/25	60/21 62/8 63/6 63/15	32/13 32/18 34/10

P	87/15 96/4 97/19 98/11 98/14 99/7 102/25 providing [1] 89/10 provisionally [1] 29/4 public [2] 44/18 44/21 publication [2] 44/24 48/16 pulmonary [2] 26/12 70/24 punishment [1] 10/24 purportedly [2] 31/22 31/23 purposes [5] 4/20 4/21 8/16 22/10 51/12 put [16] 15/5 27/1 39/25 49/2 59/2 60/20 61/23 69/5 73/16 74/21 76/14 83/23 108/15 109/20 109/24 110/16 puts [1] 109/21 Putting [1] 8/7	rare [2] 26/13 70/19 rate [1] 21/9 rather [11] 26/17 27/17 35/3 35/7 46/11 62/12 69/16 70/25 71/21 111/14 111/23 ratiify [2] 31/15 31/19 Ravi [1] 20/20 Ravi Jayaram's [1] 20/20 RCPCH [12] 23/7 34/22 45/21 50/11 50/19 51/24 55/17 95/23 96/12 98/12 110/10 110/15 reached [1] 87/19 reaction [1] 72/8 read [18] 10/4 10/6 12/14 15/4 19/9 24/22 25/8 40/19 52/8 55/9 55/11 67/18 67/20 69/2 72/24 97/18 99/10 99/11 reading [3] 12/12 15/10 25/5 really [8] 2/19 47/21 55/20 57/9 76/2 76/7 78/11 107/21 reason [9] 10/1 53/8 67/14 91/8 92/7 105/10 105/16 106/6 108/21 reasonable [3] 43/22 55/4 57/21 reasons [1] 79/3 reassure [1] 108/3 recall [10] 21/14 65/21 65/25 65/25 82/18 104/7 105/4 105/12 107/20 110/3 recalling [1] 93/9 receipt [2] 32/7 36/5 receive [1] 93/22 received [15] 19/18 20/6 29/5 29/14 36/1 36/5 37/4 41/14 42/6 44/22 48/15 49/22 55/13 104/22 110/10 receiving [5] 9/14 20/24 30/11 48/13 50/5 recognise [1] 12/22 recognising [1] 90/21 recollect [2] 45/14 55/19 recollecting [1] 108/5 recollection [10] 45/18 47/10 48/3 52/9 56/9 58/1 73/18 95/6 110/25 111/23 recommendation [2] 66/12 66/25	recommendations [3] 40/23 49/5 79/5 recommended [2] 21/22 67/5 record [2] 15/10 19/1 record-keeping [1] 19/1 recorded [1] 95/14 recording [2] 108/22 108/24 records [3] 12/19 64/4 108/16 redacted [9] 18/1 39/20 39/23 40/1 40/23 42/9 42/18 98/19 110/17 redesignation [1] 50/1 refer [5] 14/11 34/12 35/11 45/13 57/3 reference [6] 2/19 51/15 55/24 110/11 112/3 112/5 references [1] 103/22 referrals [2] 41/20 82/8 referred [4] 17/10 28/21 96/15 100/23 referring [8] 7/16 7/18 25/11 26/2 34/24 55/10 57/22 110/18 refers [1] 18/16 reform [1] 79/5 reformatted [1] 110/16 refresh [2] 33/15 109/12 regard [9] 6/24 16/24 16/25 21/3 23/13 84/25 87/19 88/16 101/12 regarded [2] 77/5 99/2 regarding [4] 22/7 36/10 37/20 88/24 registered [1] 31/5 Registrar [1] 94/12 regular [1] 80/21 regularly [1] 81/2 relate [2] 69/7 77/12 related [3] 18/18 76/11 111/24 relates [2] 19/2 53/23 relating [7] 7/9 13/7 25/5 29/16 33/21 35/22 82/19 relation [21] 2/25 3/2 3/8 5/3 5/10 5/23 15/15 15/25 18/19 25/13 29/16 34/8 41/7 43/17 51/4 55/7 61/16 68/13 91/12 101/22 102/16	relationship [2] 1/25 63/21 relationships [1] 2/2 relevance [1] 15/18 relevant [22] 5/23 6/2 6/17 6/25 13/7 16/20 16/24 26/5 26/21 39/5 53/16 56/4 61/9 62/18 63/14 74/16 75/1 78/25 84/1 91/9 98/5 102/14 reliant [1] 89/9 rely [2] 4/9 13/23 relying [2] 35/2 105/13 remarks [1] 32/14 remember [38] 9/9 9/25 13/2 15/15 22/19 23/14 23/17 25/4 27/12 33/18 33/22 35/2 43/18 47/18 47/21 50/13 51/5 52/5 52/6 53/10 53/13 54/11 56/1 56/2 57/18 61/19 84/17 89/2 96/20 97/16 104/19 105/4 108/18 108/19 108/25 111/22 112/5 112/7 remind [1] 52/8 removing [1] 84/12 repeat [2] 12/7 91/13 report [63] 4/12 8/25 15/11 15/24 17/10 17/24 20/6 21/19 27/13 32/10 35/24 36/1 36/4 39/10 39/13 39/17 41/14 41/19 41/22 42/1 42/3 42/7 44/17 45/6 45/20 45/21 48/16 49/1 49/2 49/12 50/13 51/22 54/3 54/8 55/15 64/17 64/20 64/21 64/22 64/22 65/5 65/8 65/22 66/24 89/4 89/19 90/7 94/5 94/10 94/13 95/23 95/24 96/9 98/12 98/15 98/23 104/15 105/10 105/10 105/23 105/24 110/10 110/15 reported [15] 8/5 8/20 14/16 14/21 27/6 28/19 30/23 31/21 32/2 32/3 32/4 33/12 66/19 100/1 102/14 reporting [8] 8/14 8/17 28/21 31/3 31/10 42/20 82/5 92/10 reports [11] 17/5 33/7 34/3 34/7 35/10 35/19 35/19 35/22 35/25 40/15 90/17
preparation [1] 64/21 prepared [3] 1/11 12/19 47/9 preparing [1] 97/23 presence [1] 102/8 present [6] 5/18 7/19 37/11 53/15 58/2 83/1 press [1] 48/15 presumably [4] 25/15 47/2 72/14 107/13 previous [4] 22/8 25/12 28/25 49/25 previously [2] 22/17 71/15 principal [1] 56/20 prior [5] 38/8 44/17 53/8 60/13 73/8 priority [1] 50/9 probably [8] 26/20 45/15 52/21 63/12 66/8 72/12 72/23 77/5 problem [1] 7/23 problems [1] 56/19 procedures [1] 63/14 process [8] 4/7 5/19 6/9 6/12 6/14 76/3 76/13 102/12 processes [5] 32/17 34/10 50/20 51/16 85/17 produce [3] 4/12 64/17 89/5 produced [6] 32/10 38/3 61/13 61/17 65/8 105/15 production [3] 21/4 64/14 64/20 professional [5] 75/3 79/8 79/10 100/11 100/14 professionally [1] 100/15 progress [1] 21/25 progression [1] 86/17 prompted [1] 68/17 promulgate [1] 9/4 proper [1] 32/2 properly [1] 97/11 protocol [12] 21/2 60/17 60/24 61/2 61/11 61/12 61/13 61/18 61/23 62/6 62/15 62/19 provide [5] 6/23 27/23 64/24 70/13 91/10 provided [19] 2/5 13/11 14/7 22/20 65/9 65/17 67/9 68/1 71/2 78/25 81/25 84/24	qualified [2] 1/16 93/18 quarter [1] 103/23 quasi [1] 71/14 queries [1] 89/21 question [19] 4/21 5/2 41/16 41/23 53/21 55/7 59/11 70/23 73/4 74/18 77/15 81/16 81/18 84/19 85/10 86/3 92/18 109/24 111/16 questions [29] 1/8 14/5 22/6 58/8 58/11 58/12 68/16 72/3 74/15 74/21 75/21 75/23 80/2 80/4 91/13 94/16 94/19 94/21 94/24 103/20 104/2 104/4 108/9 112/11 113/4 113/5 113/6 113/7 113/8 quite [9] 2/19 4/6 15/20 32/2 53/9 62/18 67/18 100/6 112/7	Q	R	
Raggett [3] 35/13 36/25 43/6 raise [5] 42/18 67/4 74/6 76/22 78/8 raised [6] 21/21 36/8 56/5 60/13 85/5 98/20 raises [2] 36/9 68/3 raising [1] 68/16 rambled [1] 61/8	recognition [10] 45/18 47/10 48/3 52/9 56/9 58/1 73/18 95/6 110/25 111/23 recommendation [2] 66/12 66/25	relation [21] 2/25 3/2 3/8 5/3 5/10 5/23 15/15 15/25 18/19 25/13 29/16 34/8 41/7 43/17 51/4 55/7 61/16 68/13 91/12 101/22 102/16	relationship [2] 1/25 63/21 relationships [1] 2/2 relevance [1] 15/18 relevant [22] 5/23 6/2 6/17 6/25 13/7 16/20 16/24 26/5 26/21 39/5 53/16 56/4 61/9 62/18 63/14 74/16 75/1 78/25 84/1 91/9 98/5 102/14 reliant [1] 89/9 rely [2] 4/9 13/23 relying [2] 35/2 105/13 remarks [1] 32/14 remember [38] 9/9 9/25 13/2 15/15 22/19 23/14 23/17 25/4 27/12 33/18 33/22 35/2 43/18 47/18 47/21 50/13 51/5 52/5 52/6 53/10 53/13 54/11 56/1 56/2 57/18 61/19 84/17 89/2 96/20 97/16 104/19 105/4 108/18 108/19 108/25 111/22 112/5 112/7 remind [1] 52/8 removing [1] 84/12 repeat [2] 12/7 91/13 report [63] 4/12 8/25 15/11 15/24 17/10 17/24 20/6 21/19 27/13 32/10 35/24 36/1 36/4 39/10 39/13 39/17 41/14 41/19 41/22 42/1 42/3 42/7 44/17 45/6 45/20 45/21 48/16 49/1 49/2 49/12 50/13 51/22 54/3 54/8 55/15 64/17 64/20 64/21 64/22 64/22 65/5 65/8 65/22 66/24 89/4 89/19 90/7 94/5 94/10 94/13 95/23 95/24 96/9 98/12 98/15 98/23 104/15 105/10 105/10 105/23 105/24 110/10 110/15 reported [15] 8/5 8/20 14/16 14/21 27/6 28/19 30/23 31/21 32/2 32/3 32/4 33/12 66/19 100/1 102/14 reporting [8] 8/14 8/17 28/21 31/3 31/10 42/20 82/5 92/10 reports [11] 17/5 33/7 34/3 34/7 35/10 35/19 35/19 35/22 35/25 40/15 90/17	

R	18/1 19/24 21/16 21/19 21/23 22/3 22/7 22/18 23/7 23/7 23/11 23/15 23/19 23/25 25/15 34/20 34/22 35/11 36/1 36/5 36/15 37/4 37/4 37/5 37/6 37/11 37/20 37/22 38/4 38/5 38/7 38/23 39/2 39/20 42/13 43/7 43/8 43/14 48/25 49/7 49/9 49/18 50/11 50/18 51/24 53/2 53/13 53/23 53/24 54/17 55/17 57/10 57/14 65/18 66/2 66/10 66/13 66/15 66/25 67/5 96/12 104/23 105/1 107/17	41/12 41/17 44/17 49/18 66/10 68/2 69/22 Royal College [6] 37/20 41/17 49/18 66/10 68/2 69/22 Royal College's [1] 41/12 rule [1] 105/21 rules [3] 13/18 13/24 14/1 run [1] 16/22 running [1] 3/11 Ruth [1] 61/22	Scenes [1] 6/1 screen [17] 8/7 9/19 12/17 14/10 14/23 18/21 24/19 39/16 39/25 48/6 48/11 49/2 52/14 66/3 67/13 67/18 73/13 scrutiny [2] 5/16 101/1 sealed [1] 105/25 second [3] 26/8 93/19 96/2 secondary [2] 16/8 37/6 secondly [2] 93/4 102/3 section [2] 51/24 56/23 section 2 [1] 56/23 see [59] 3/10 8/18 9/3 9/19 10/13 14/25 18/3 18/11 18/24 19/5 21/13 22/10 24/21 27/8 28/20 30/6 31/15 32/23 33/7 35/13 36/13 37/20 38/7 38/9 38/14 39/11 39/15 39/18 39/19 40/23 42/5 44/5 45/24 46/11 46/25 49/5 49/6 49/11 49/13 49/14 49/19 50/10 52/11 52/16 52/20 52/24 57/11 58/6 65/5 66/5 67/2 68/3 69/3 70/17 73/24 79/9 86/4 87/4 105/20	18/18 18/18 18/22 19/4 19/22 19/24 19/25 22/11 22/16 23/2 30/15 35/25 38/16 38/22 39/13 39/15 39/19 77/16 82/11 104/13 104/23 105/5 105/11 105/13 105/22 107/4 107/11 sentence [1] 7/13 separate [1] 105/25 sepsis [2] 86/11 86/15 September [4] 8/8 19/5 20/23 21/18 September 2024 [1] 8/8 sequence [2] 24/9 35/12 series [5] 17/6 24/13 58/17 64/12 77/3 serious [3] 64/9 64/10 74/19 served [1] 52/7 service [5] 2/10 37/3 38/23 82/7 111/3 Services [1] 96/14 serving [1] 2/12 session [1] 99/1 sessions [1] 81/2 set [16] 7/8 8/13 8/23 13/4 13/6 14/12 14/13 25/19 26/15 31/1 32/9 72/2 75/4 78/18 78/23 92/19 sets [3] 49/18 49/18 51/16 setting [3] 8/17 16/18 77/3 several [1] 32/17 shady [1] 107/20 Shall [1] 52/11 share [4] 36/7 47/12 52/24 60/18 shared [6] 39/4 39/8 45/7 50/18 61/10 72/16 sharing [2] 80/6 81/17 she [12] 6/4 12/12 31/2 31/9 33/13 35/20 43/6 44/14 72/4 84/8 84/11 88/23 sheet [3] 51/17 51/19 53/22 sheets [1] 81/13 shift [1] 40/7 Shipman [4] 81/20 81/24 82/6 83/18 short [5] 19/18 46/20 103/18 103/25 104/15 shortcomings [1] 35/6 shorthand [1] 103/21
represent [1] 87/13 representations [2] 16/25 42/23 representative [1] 75/6 representatives [2] 52/18 62/8 represented [3] 16/21 73/3 75/12 represents [1] 47/16 reproduced [1] 79/20 reputational [1] 111/15 request [8] 12/20 29/22 31/14 43/19 43/22 50/8 111/1 111/25 requested [3] 64/18 64/23 65/9 requesting [2] 29/6 49/15 required [2] 61/1 63/18 requirements [1] 111/6 requires [1] 68/9 requiring [2] 4/4 9/14 research [1] 73/24 resolve [1] 109/13 respect [6] 4/4 30/12 35/25 48/14 72/14 78/25 respectfully [1] 49/15 respiratory [2] 87/23 88/17 respond [2] 16/1 59/19 responded [1] 70/20 responding [1] 50/20 response [10] 15/7 15/9 28/14 28/14 29/8 34/2 37/23 42/19 98/23 110/2 responsibility [2] 4/6 98/5 responsive [1] 49/25 rest [1] 103/13 result [8] 21/6 25/15 32/16 32/16 41/12 66/16 77/18 78/5 results [3] 7/10 14/12 100/20 resuscitation [1] 59/19 retained [1] 103/5 retired [1] 30/2 retirement [3] 38/8 53/17 97/23 retribution [1] 10/23 reveals [1] 41/19 review [66] 16/8 17/4	Rheinberg [36] 1/4 1/5 1/7 1/11 1/24 8/8 9/24 12/18 14/3 17/22 18/5 21/14 24/21 29/25 38/21 40/1 46/22 49/3 50/12 51/1 51/4 58/12 60/10 66/7 67/14 67/21 79/24 80/3 94/20 96/19 103/18 104/3 110/4 110/10 112/13 113/3 Rheinberg's [1] 30/9 right [61] 7/19 7/19 7/23 11/15 14/24 15/11 16/7 17/18 18/7 19/25 27/12 30/22 31/12 33/6 36/23 40/6 45/15 46/1 46/5 46/9 47/5 47/9 47/14 47/18 47/19 48/10 48/12 49/10 51/9 51/13 51/25 52/2 59/4 61/21 66/20 73/2 73/11 75/22 76/14 88/8 88/13 88/15 88/25 91/17 92/2 93/9 93/15 94/10 95/15 95/21 97/17 99/12 101/4 103/12 104/24 108/6 108/17 108/19 109/1 110/1 111/11 right-hand [1] 46/5 rise [1] 41/18 role [3] 71/14 72/15 89/13 rostered [1] 40/7 roughly [1] 54/10 rounds [1] 97/24 routine [1] 4/4 Royal [9] 21/16 37/20	sadly [3] 7/5 76/4 108/19 safeguard [1] 25/15 safety [1] 50/8 said [19] 23/3 23/10 23/19 26/3 31/19 78/1 90/21 91/22 91/24 95/14 96/19 101/23 108/13 108/23 109/21 109/25 110/22 111/13 111/22 Saladi [2] 58/21 72/14 Saladi's [1] 20/18 same [8] 13/19 16/12 20/14 29/23 38/19 40/18 51/7 77/1 samples [1] 103/4 Sarah [1] 12/20 satisfaction [1] 6/11 satisfied [5] 21/20 31/3 31/10 45/10 67/3 satisfies [1] 70/15 saw [6] 17/14 29/16 45/1 65/22 108/20 111/12 say [46] 2/23 7/12 8/15 9/8 11/13 13/10 15/7 15/8 15/9 16/13 16/16 17/1 19/13 25/20 27/20 37/17 39/18 41/5 43/13 44/4 47/5 47/10 47/21 48/20 54/14 55/13 55/19 55/20 55/22 56/10 56/12 57/6 59/5 60/22 70/4 80/20 81/9 85/2 87/21 92/5 94/3 97/25 103/13 107/21 109/24 110/7 saying [7] 29/11 50/7 61/21 65/4 67/2 77/23 108/16 says [9] 17/20 44/14 47/13 47/25 48/20 89/17 93/23 94/12 95/21 scan [1] 4/7	seek [1] 75/6 seeking [1] 97/21 seem [3] 37/25 72/18 112/7 seemed [5] 43/22 88/18 89/4 100/21 111/4 seems [2] 24/16 55/6 seen [11] 4/15 9/23 18/9 24/22 34/9 42/3 42/8 52/1 90/17 99/9 104/23 seize [1] 64/4 send [3] 35/18 105/17 106/3 sending [2] 9/13 105/7 sends [2] 30/7 39/22 senior [8] 1/21 2/24 11/5 31/8 73/5 74/11 80/16 99/24 sense [1] 54/5 sensitive [2] 105/22 106/7 sensitivity [2] 85/3 85/4 sent [33] 9/14 12/19 16/9 17/7 17/16 18/5	

S	somebody [2] 31/7 77/23	start [4] 14/20 69/15 78/19 112/19	subsequently [3] 40/12 56/20 64/6	106/19
shortly [2] 15/20 26/9	someone [3] 11/25 60/12 106/4	started [1] 82/5	substantive [1] 67/15	systemic [1] 42/15
should [29] 6/18 8/4 10/2 21/24 31/7 32/1 44/1 45/6 47/11 53/15 60/17 60/18 60/22 61/5 61/16 62/2 62/18 62/19 63/1 63/2 72/7 79/14 80/23 98/1 105/25 109/24 111/1 111/25 112/2	Somerset [1] 1/19	starts [1] 40/22	successful [1] 29/1	systems [1] 106/17
shouldn't [5] 43/20 53/18 91/25 92/8 93/5	something [17] 25/16 26/14 53/3 65/16 68/21 68/23 68/25 69/18 69/23 71/3 78/8 81/11 83/12 90/20 94/11 109/13 111/10	state [4] 84/15 100/11 100/13 100/14	successor [1] 30/6	T
show [3] 3/11 12/19 42/15	sometimes [4] 2/16 85/11 85/13 90/3	stated [3] 17/23 22/20 25/21	such [8] 58/20 63/12 63/15 70/19 77/16 77/21 100/4 105/23	take [26] 3/7 3/15 6/12 10/4 14/9 15/4 19/9 23/1 23/4 26/19 33/3 46/13 46/16 56/2 63/17 65/15 67/20 69/19 69/23 70/2 92/15 97/3 97/8 103/18 103/19 106/3
showed [1] 78/13	somewhat [5] 42/7 42/8 52/9 52/10 91/22	statement [20] 1/12 7/12 12/21 14/12 18/20 20/18 21/7 25/19 26/2 27/8 27/15 30/21 32/6 33/11 33/16 45/10 55/18 63/8 87/20 111/12	sudden [4] 34/8 59/18 60/16 82/25	taken [9] 6/6 22/21 45/18 55/17 73/14 83/12 89/22 107/23 110/16
shudder [1] 82/11	soon [1] 33/11	statements [5] 9/22 20/16 20/25 21/2 21/4	suddenly [1] 65/23	takes [2] 5/25 101/19
SIDS [2] 7/17 7/17	sorry [13] 12/10 15/8 16/15 27/16 31/7 31/17 38/11 40/11 43/17 61/8 69/4 69/4 102/15	states [1] 12/6	SUDI [2] 60/16 63/10	taking [2] 6/2 19/15
sight [1] 35/24	sort [13] 4/23 5/13 47/8 53/2 53/2 53/6 66/3 71/14 75/19 77/11 84/20 85/6 106/8	stating [2] 29/11 39/22	SUDiC [1] 61/11	talked [2] 47/8 106/17
sighted [1] 54/17	sought [2] 72/12 78/18	statistically [3] 34/16 35/1 41/17	suffered [1] 59/17	talking [4] 5/7 47/6 54/8 62/4
sign [2] 35/21 84/14	sounds [2] 80/20 81/9	stay [1] 7/9	suffering [1] 84/9	Tasker [2] 63/11 63/13
signature [1] 104/16	South's [1] 82/17	steer [1] 28/15	Suffolk [1] 61/19	tattle [1] 83/10
signed [2] 9/3 56/17	spare [1] 81/12	Stephen [9] 17/23 35/18 35/24 36/8 37/2 37/14 39/1 39/7 95/12	suggest [3] 16/1 37/16 88/3	team [5] 21/19 50/19 63/11 93/18 100/10
significant [1] 12/9	speak [1] 94/12	Stephen Cross [1] 95/12	suggested [2] 36/9 53/15	telephone [4] 22/21 35/17 44/22 93/23
signs [1] 101/13	speaking [3] 31/21 71/12 92/3	Stephen Cross's [1] 17/23	Suggesting [1] 16/8	television [1] 3/10
similar [3] 5/25 11/1 24/22	specific [9] 25/13 34/17 40/9 53/8 57/15 65/7 73/9 74/19 78/15	stepping [4] 78/24 82/14 82/19 83/18	suggestion [3] 71/2 77/7 99/3	tell [15] 1/16 1/24 8/1 18/20 24/25 27/10 29/11 32/5 33/10 45/10 47/15 50/12 52/3 52/12 99/1
similarly [1] 9/16	specifically [4] 11/16 39/15 67/10 76/9	step [1] 11/5 11/13	suggestions [2] 16/23 65/14	tells [2] 43/4 86/8
simple [2] 40/16 84/11	specifics [2] 27/12 62/1	sticking [2] 11/10 13/16	suggests [1] 99/9	tend [1] 6/3
since [5] 49/21 56/9 75/15 81/5 91/24	speculated [1] 59/20	still [7] 13/25 20/8 21/24 39/3 73/13 75/16 101/16	SUI [2] 17/2 17/3	tended [1] 62/11
since July 2016 [1] 49/21	speculation [1] 107/2	stock [2] 69/8 92/20	summarise [2] 27/14 56/12	terms [11] 6/18 20/24 22/15 34/24 57/17 62/1 76/23 77/1 95/3 102/13 107/20
single [4] 5/21 9/6 9/14 83/1	Spedding [1] 61/22	stop [3] 78/21 78/22 79/6	summarised [1] 55/16	terrible [1] 84/15
sit [1] 1/9	speedy [1] 28/14	STORM [2] 2/16 2/19	summary [2] 55/13 66/7	tertiary [1] 41/21
sitting [1] 93/12	spike [1] 83/19	straight [1] 63/13	superseded [1] 61/3	test [1] 70/9
situation [1] 4/2	spirit [1] 62/15	strategy [1] 62/9	suppose [9] 2/7 2/15 10/18 62/4 71/23 74/25 83/14 107/6 111/16	tests [4] 7/9 7/20 27/24 101/22
six [1] 56/11	spoken [1] 35/18	straws [1] 71/1	surrounding [4] 6/24 7/6 15/12 83/24	text [8] 50/13 50/14 50/23 50/25 51/2 96/15 96/17 98/17
size [1] 41/20	spokesman [1] 62/25	strict [1] 36/10	survive [1] 7/5	than [19] 3/7 27/18 35/8 41/9 42/13 42/16 49/25 50/4 52/21 62/12 69/16 71/21 73/16 79/17 80/23 81/1 89/25 101/3 108/21
Skelton [3] 58/10 58/11 113/5	spread [1] 13/24	strictly [1] 31/21	survived [2] 60/1 60/4	thank [37] 1/10 10/8 12/14 13/2 14/2 16/4 19/12 22/9 25/18 30/22 40/6 40/21 41/2 46/18 46/24 57/16 58/8 58/9 58/14 67/19
sleep [1] 7/17	staff [4] 23/22 48/1 79/15 107/8	strike [1] 27/4	Sussex [1] 61/18	
slightly [1] 85/9	staffing [1] 42/16	strive [1] 80/23	Swash [1] 17/17	
small [1] 6/8	stage [10] 22/16 27/21 28/5 38/2 52/3 63/19 78/2 83/10 109/6 111/7	strong [1] 65/14	swift [1] 4/6	
so [145]	standard [3] 79/20 94/14 103/8	struck [1] 26/18	sworn [2] 1/7 113/3	
Society [1] 81/2	standards [1] 79/10	stuck [1] 11/8	symptoms [1] 86/19	
solely [1] 50/1	stark [1] 90/14	style [1] 77/11	system [3] 57/8 98/8	
solicitor [4] 1/16 15/1 16/14 16/14		sub [1] 70/18		
solicitors [4] 16/22 19/6 24/17 44/9		sub-paragraph [1] 70/18		
solicitors' [1] 1/17		subject [3] 8/4 17/1 55/23		
solid [2] 76/4 76/8		subjective [1] 40/14		
some [25] 35/6 37/5 37/6 37/16 49/23 50/3 53/2 53/6 59/20 62/5 68/6 73/8 73/24 77/12 77/13 85/19 86/22 89/16 91/13 103/22 104/14 108/9 111/10 111/17 112/1		subsequent [4] 8/11 25/23 45/12 81/24		

T	these [17] 10/22 17/5 18/25 29/21 34/8 35/9 35/11 35/22 41/23 43/12 58/24 60/17 69/15 70/23 72/20 77/12 89/22	22/24 25/4 25/5 25/24 26/20 26/22 28/12 29/17 30/17 31/25 32/23 33/23 34/18 35/19 36/2 36/3 37/1 37/3 37/10 37/25 38/2 39/3 39/16 39/17 40/14 40/16 41/4 41/14 42/24 43/11 43/17 44/18 44/20 44/21 44/25 45/23 46/11 47/5 47/22 48/21 49/12 49/25 50/8 50/12 51/7 51/15 52/16 54/9 55/24 59/5 59/6 60/5 61/2 63/16 65/6 65/13 65/14 67/7 67/14 68/1 70/2 70/10 70/16 75/1 75/1 75/3 76/9 78/24 79/4 79/8 81/9 82/12 82/23 82/23 84/6 84/20 92/12 92/19 92/23 96/19 97/20 98/3 98/13 99/21 100/2 102/14 104/12 109/6 109/13 109/14 111/14	69/9 72/4 76/21 81/9 81/10 81/12 83/15 97/20 97/25 106/16 106/22 106/22 107/5 timescale [1] 84/20 tip [1] 10/16 tipped [1] 69/25 tips [2] 10/5 10/11 tissue [1] 6/8 title [1] 1/21 tittle [1] 83/10 tittle-tattle [1] 83/10 today [2] 63/4 95/1 together [4] 60/20 61/23 69/16 100/7 told [12] 23/6 23/10 37/22 42/21 73/8 73/21 95/5 98/3 99/17 99/21 100/2 109/20 too [3] 20/5 20/21 38/6 took [7] 45/17 52/7 58/20 95/7 104/13 107/24 108/4 top [7] 12/11 12/13 22/9 34/2 40/24 46/4 46/4 topic [1] 85/9 totally [2] 77/12 86/24 touch [1] 44/19 towards [3] 53/22 85/4 85/5 towers [1] 60/18 toxicological [1] 103/5 tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	95/15 95/21 95/22 108/17 try [2] 56/3 70/9 trying [5] 5/13 81/14 94/11 108/3 111/16 Tuesday [3] 112/20 112/21 112/25 turn [1] 4/12 turns [1] 108/2 twice [1] 71/7 twin [3] 28/25 28/25 60/3 Twins [4] 30/12 41/8 59/24 60/1 two [19] 9/10 12/11 26/4 26/7 32/21 35/19 40/24 41/8 43/19 55/14 58/17 80/4 90/19 91/4 92/25 103/20 104/4 104/5 106/16 type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
thank... [17] 67/24 79/24 79/24 80/5 94/15 94/17 94/23 96/1 102/13 103/14 103/16 108/8 112/10 112/12 112/14 112/17 112/22	they [67] 2/8 2/12 2/12 2/20 9/11 11/8 11/9 16/22 16/23 19/13 19/16 19/16 19/18 19/22 19/23 19/24 21/5 21/5 21/20 21/22 29/16 34/14 34/15 35/1 37/9 39/18 44/4 45/12 52/23 52/24 53/1 53/5 53/12 54/12 54/19 54/24 55/7 59/16 59/18 59/24 60/1 62/2 65/3 65/11 66/21 67/2 67/3 67/5 69/7 72/21 74/12 74/14 75/12 75/16 94/24 95/25 97/1 97/1 97/3 97/10 100/20 106/2 106/3 107/9 110/22 110/23 111/11	11/25 14/13 21/5 26/22 30/17 40/19 40/19 42/8 48/22 51/21 52/4 55/14 56/13 57/4 58/2 58/8 60/13 62/2 67/12 72/10 74/20 83/1 86/9 95/22 102/21 103/6 103/8 110/14 112/11	81/9 82/12 82/23 82/23 84/6 84/20 92/12 92/19 92/23 96/19 97/20 98/3 98/13 99/21 100/2 102/14 104/12 109/6 109/13 109/14 111/14	ultimately [4] 5/23 89/12 92/17 93/1 unable [1] 27/23 unacceptable [1] 21/9 unanswered [1] 75/25 unascertained [2] 14/18 91/6 unasked [1] 17/7 unaware [1] 60/5 uncertain [1] 54/5 under [7] 8/19 10/11 32/1 56/23 60/24 62/6 62/15 underlined [1] 77/10 underlines [1] 85/19 underlying [1] 32/17 understaffing [1] 41/19 understand [3] 25/10 87/15 102/23 understanding [8] 11/8 19/14 25/4 45/5 53/1 53/5 65/6 78/13 understands [1] 6/5 understood [5] 24/25 25/6 64/25 88/23 93/20 undertake [3] 37/5 49/16 69/11 undertaken [12]
that [619]	that's [14] 19/25 20/9 22/10 30/15 40/23 44/12 45/14 48/3 67/20 85/16 86/1 101/4 105/14 112/3	those [31] 8/15 9/12 11/25 14/13 21/5 26/22 30/17 40/19 40/19 42/8 48/22 51/21 52/4 55/14 56/13 57/4 58/2 58/8 60/13 62/2 67/12 72/10 74/20 83/1 86/9 95/22 102/21 103/6 103/8 110/14 112/11	topic [1] 85/9 totally [2] 77/12 86/24 touch [1] 44/19 towards [3] 53/22 85/4 85/5 towers [1] 60/18 toxicological [1] 103/5 tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	Twins [4] 30/12 41/8 59/24 60/1 two [19] 9/10 12/11 26/4 26/7 32/21 35/19 40/24 41/8 43/19 55/14 58/17 80/4 90/19 91/4 92/25 103/20 104/4 104/5 106/16 type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
their [20] 7/17 9/17 11/8 11/11 16/2 21/19 49/24 50/5 66/12 73/4 74/16 74/17 74/21 84/9 84/13 89/11 106/4 106/4 111/6 111/9	thick [1] 112/7	thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
them [22] 2/9 3/22 12/2 20/3 35/21 42/2 42/22 45/15 58/4 65/15 68/6 72/16 75/11 76/23 80/14 80/19 82/22 83/2 91/13 99/19 104/14 110/18	thing [8] 47/8 47/14 47/19 47/19 47/19 64/3 95/15 108/17	thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
Thematic [6] 18/1 19/24 65/18 104/23 105/1 107/17	things [5] 28/15 33/21 68/13 76/10 106/22	thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
theme [6] 47/4 59/12 69/12 69/17 111/4 112/9	think [60] 3/20 4/21 5/2 9/9 10/16 12/19 12/21 12/25 15/15 19/19 19/25 20/20 20/22 22/19 26/8 26/13 27/13 29/14 30/15 42/4 45/6 45/14 46/7 51/1 52/23 53/7 53/14 54/9 55/9 60/5 61/13 61/21 63/4 63/7 63/11 65/17 66/3 66/23 67/9 68/12 71/11 72/10 72/23 75/10 79/5 79/11 79/20 93/24 94/4 96/22 105/10 106/24 107/24 108/1 108/2 108/10 110/14 111/10 111/12 112/6	thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
themes [2] 53/16 57/12	Thinking [1] 108/6	thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
themselves [2] 31/19 106/3	third [7] 10/13 28/21 37/17 55/16 96/11 96/20 97/12	thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
then [52] 4/10 4/11 4/24 5/3 6/25 7/7 10/11 15/5 16/1 16/5 16/11 18/12 19/5 20/15 24/9 26/17 32/21 36/6 36/13 37/18 40/18 40/22 41/3 44/10 47/5 47/13 47/25 48/17 49/12 50/10 52/11 54/20 56/11 57/3 57/4 57/6 69/9 69/18 71/11 74/19 88/7 95/23 97/8 98/8 100/16 103/19 104/14 106/3 107/14 109/2 110/16 112/8	THIRLWALL [2] 104/2 113/8	thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
theoretical [1] 26/16	this [111] 9/23 9/25 12/18 12/21 13/3 16/5 16/16 16/22 17/21 17/24 18/5 18/9 18/10 18/15 21/8 21/11 21/24 22/2 22/5 22/5	thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
theoretically [1] 27/1		thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
there [121]		thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1] 46/3 traumatic [1] 92/6 treating [3] 7/11 88/4 93/23 treatment [2] 7/5 49/25 tries [1] 92/15 trigger [2] 81/25 83/6 triggered [1] 83/4 Triplets [2] 32/21 58/17 triumvirate [1] 61/22 true [1] 1/13 Trust [20] 15/23 17/7 21/18 36/1 36/6 37/4 37/8 38/1 38/4 39/4 39/9 39/17 47/14 50/19 51/16 94/22	type [4] 62/24 63/5 68/10 97/9 typed [2] 97/1 97/5 types [2] 59/17 60/14 typical [1] 106/18 typically [5] 2/18 17/5 84/9 101/16 101/18 typing [1] 97/14
there's [5] 3/24 10/1 47/16 86/4 109/21		thought [4] 69/15 70/1 70/2 107/14	tragedies [2] 11/2 60/17 tragic [1] 41/8 trail [1] 106/10 train [1] 77/3 trained [3] 3/19 6/16 31/9 training [1] 81/25 transcripts [1] 72/25 transferred [1] 49/23 translate [1	

<p>U</p> <p>undertaken... [12] 20/10 21/18 21/24 22/18 23/8 23/11 26/24 28/18 43/10 43/24 68/13 69/22</p> <p>undertaking [1] 21/16</p> <p>undetectable [1] 84/8</p> <p>unexpected [10] 17/1 33/24 34/9 43/8 49/17 49/21 59/18 60/16 82/24 99/25</p> <p>unexplained [1] 82/25</p> <p>unfortunate [1] 26/22</p> <p>Unfortunately [1] 7/14</p> <p>unhappy [1] 19/16</p> <p>unifying [1] 81/5</p> <p>unit [7] 21/21 35/5 41/20 50/2 54/21 67/4 69/14</p> <p>unity [1] 81/14</p> <p>unknown [2] 28/6 55/6</p> <p>unless [1] 11/15</p> <p>unlikely [2] 26/14 77/14</p> <p>unnatural [2] 25/25 55/5</p> <p>unpick [1] 110/13</p> <p>unsatisfactory [1] 101/8</p> <p>unsigned [2] 35/20 35/24</p> <p>until [7] 6/9 28/17 35/20 41/11 43/12 61/14 112/24</p> <p>Untoward [1] 64/10</p> <p>unusual [12] 20/25 21/1 21/8 52/15 52/17 52/17 52/22 68/7 68/20 82/24 94/13 97/17</p> <p>unwell [1] 49/22</p> <p>up [29] 2/17 8/23 15/5 17/8 20/16 21/6 23/2 27/16 27/17 29/23 29/25 32/25 35/10 42/11 61/14 64/6 66/8 70/2 75/20 80/16 84/10 88/17 89/22 90/19 94/12 97/5 97/5 97/9 97/14</p> <p>upon [5] 26/16 85/7 89/9 89/12 90/22</p> <p>upsetting [1] 92/6</p> <p>urgently [1] 49/15</p> <p>us [22] 1/16 1/24 8/1 8/12 14/13 18/20 24/25 26/1 27/10</p>	<p>29/11 32/5 33/10 33/22 37/11 45/10 47/15 52/3 52/12 56/12 82/23 100/2 111/19</p> <p>used [1] 77/5</p> <p>using [1] 84/12</p> <p>usual [4] 13/24 21/6 28/12 90/8</p> <p>usually [2] 7/17 86/7</p> <hr/> <p>V</p> <p>vague [2] 38/6 52/10</p> <p>various [3] 14/10 76/18 104/25</p> <p>vastly [1] 101/14</p> <p>verdict [3] 14/19 27/1 78/14</p> <p>version [7] 8/8 18/17 39/20 39/23 40/24 51/1 65/22</p> <p>versions [2] 18/9 104/25</p> <p>very [47] 5/16 5/17 7/1 7/14 7/24 10/17 10/22 10/22 11/24 15/22 15/24 26/9 26/22 28/12 44/23 45/2 52/17 54/11 57/6 61/9 61/9 61/19 61/23 61/24 74/20 76/2 76/8 78/11 78/14 81/13 81/13 84/14 84/17 87/13 89/4 89/5 94/14 94/24 103/14 103/16 105/22 107/8 108/21 109/9 112/12 112/17 112/22</p> <p>via [3] 44/25 59/21 76/12</p> <p>victim [1] 84/12</p> <p>victims [1] 84/8</p> <p>Victorino [1] 82/13</p> <p>Victorino Chua [1] 82/13</p> <p>view [10] 25/17 31/20 36/12 40/14 43/23 45/7 63/17 76/1 78/17 110/21</p> <p>views [1] 92/16</p> <p>visible [1] 85/18</p> <p>vital [1] 6/21</p> <hr/> <p>W</p> <p>wait [2] 41/11 43/12</p> <p>want [14] 10/4 38/7 47/6 52/24 64/5 70/21 72/25 80/6 87/15 90/2 103/21 103/21 111/14 112/11</p> <p>wanted [10] 16/22 52/23 53/1 53/6 53/13 57/10 71/4 104/4 109/12 111/11</p>	<p>warrants [1] 63/5</p> <p>was [293]</p> <p>wasn't [15] 11/21 21/1 23/20 50/16 54/12 68/13 84/20 88/14 92/1 105/11 107/18 107/19 108/22 111/11 111/20</p> <p>way [17] 2/21 5/14 47/6 56/1 56/10 66/7 70/4 75/5 75/20 84/7 85/6 86/25 90/8 97/25 101/8 106/8 106/18</p> <p>we [167]</p> <p>week [6] 20/12 36/3 37/17 44/15 44/21 95/18</p> <p>weeks' [1] 50/4</p> <p>well [29] 8/15 11/15 25/11 32/22 35/4 40/19 42/6 42/11 56/13 57/24 62/14 67/13 68/17 69/15 70/1 71/23 72/1 72/17 78/20 79/7 82/11 92/9 95/25 96/24 100/18 100/18 104/12 105/24 111/19</p> <p>went [5] 35/3 60/24 61/2 99/1 110/7</p> <p>were [106] 1/18 2/8 2/12 2/21 3/11 8/3 8/4 9/10 9/11 9/12 11/9 11/20 16/21 19/14 19/22 19/24 19/24 21/5 21/5 21/5 21/8 21/20 22/16 23/19 23/24 24/12 26/2 26/4 34/8 34/11 34/20 35/2 37/22 38/9 40/1 41/9 42/18 43/23 44/9 47/23 48/21 48/22 50/4 50/5 52/4 52/22 52/25 53/12 54/16 54/19 56/5 56/25 57/11 57/14 58/17 59/18 60/5 60/25 61/24 62/6 63/11 63/25 64/5 65/17 67/6 68/11 73/3 74/5 74/7 75/11 75/12 75/12 75/20 75/23 75/25 76/10 78/1 78/19 78/24 80/22 81/21 85/10 92/11 93/18 93/20 93/20 95/7 95/8 96/4 98/11 98/12 99/2 99/6 100/16 100/22 100/23 100/23 102/14 102/17 102/21 104/8 104/12 104/13 106/16 106/20 108/9</p> <p>weren't [3] 22/15 67/9 97/3</p>	<p>West [3] 80/10 81/1 82/1</p> <p>what [96] 3/25 6/5 7/9 7/10 7/10 7/18 10/16 10/24 10/25 11/13 12/7 13/14 15/7 15/8 15/9 16/13 16/15 16/16 16/18 17/2 17/4 18/3 19/18 24/25 25/9 25/9 25/22 26/2 27/10 29/11 29/16 31/19 33/18 34/15 34/24 34/25 35/1 38/16 39/15 45/5 47/15 48/3 48/22 52/3 52/12 52/24 54/12 55/16 56/12 57/9 60/9 60/23 62/3 66/23 70/6 70/9 71/21 73/4 73/20 74/23 75/19 76/25 78/13 79/12 81/4 82/6 84/24 86/8 87/15 87/18 87/21 89/11 89/16 90/23 92/9 92/10 98/13 100/11 100/13 100/14 100/16 101/25 102/1 102/5 106/1 106/15 107/4 107/8 107/8 107/21 108/13 108/22 109/2 109/25 111/8 111/20</p> <p>what's [6] 2/15 3/23 47/16 110/14 110/21 110/22</p> <p>whatever [4] 8/20 56/5 57/12 111/15</p> <p>whatsoever [1] 86/23</p> <p>when [26] 1/22 3/16 4/13 11/20 11/20 14/22 20/15 23/18 24/7 24/8 26/2 35/20 44/3 44/9 52/3 55/1 56/2 62/7 64/22 68/11 86/21 90/25 99/6 99/25 101/9 104/12</p> <p>where [26] 2/16 3/1 3/21 3/22 3/24 4/1 11/25 14/10 14/12 23/6 25/12 26/23 28/15 31/14 37/9 40/22 55/6 56/14 56/16 57/4 64/1 78/11 92/19 108/2 108/10 111/13</p> <p>whereas [2] 6/12 93/17</p> <p>whether [13] 5/22 24/21 25/24 42/21 47/16 63/2 65/21 70/1 70/2 86/2 92/12 105/4 111/13</p> <p>which [56] 5/6 13/15 17/9 20/6 21/17 22/25 26/1 26/16 27/19</p>	<p>30/10 31/4 34/8 34/10 36/1 36/6 36/9 37/6 37/12 38/3 38/4 39/19 41/18 41/21 42/9 42/13 42/16 53/10 53/23 53/23 55/13 56/20 59/13 59/17 61/17 62/15 64/13 68/7 70/4 70/7 73/9 73/13 73/13 78/5 78/13 79/19 83/20 84/10 86/11 92/14 94/7 94/7 96/11 97/18 99/9 106/17 110/11</p> <p>While [2] 29/25 52/14</p> <p>whilst [1] 25/13</p> <p>whisper [1] 24/5</p> <p>who [23] 2/9 3/5 4/15 6/3 6/16 6/22 7/4 7/4 7/16 35/18 44/22 45/1 50/3 60/3 61/22 73/5 82/4 88/4 91/24 93/1 93/23 101/19 109/16</p> <p>who's [1] 94/10</p> <p>whole [5] 10/6 42/11 49/2 69/2 82/8</p> <p>whom [1] 62/3</p> <p>whose [2] 58/15 87/12</p> <p>why [12] 10/2 42/10 42/12 52/23 72/9 72/9 72/9 72/21 75/13 101/4 105/10 111/14</p> <p>wider [3] 13/25 39/10 81/1</p> <p>will [58] 5/17 5/18 5/20 6/1 6/3 6/12 6/23 7/3 7/8 15/4 16/8 21/14 22/6 23/12 24/24 25/4 27/16 35/21 36/2 36/4 36/6 36/11 37/6 37/10 39/4 41/21 43/14 46/16 46/17 48/1 48/11 53/24 54/1 66/5 68/2 69/3 70/7 74/18 75/2 77/12 77/13 82/21 86/14 90/16 92/6 92/17 92/24 100/9 100/9 101/11 101/13 101/14 101/16 101/18 101/24 103/22 104/7 112/18</p> <p>wish [1] 43/11</p> <p>withdraw [1] 75/3</p> <p>withheld [2] 6/7 28/17</p> <p>withholding [2] 77/20 106/6</p> <p>within [22] 2/2 9/7 9/7 11/19 17/1 21/21 25/16 36/5 39/14 55/3 56/21 60/15 60/23 62/7 63/15 64/2 67/4</p>
--	---	---	--	---

W
within... [5] 69/9
 82/16 87/5 103/11
 110/8
without [8] 27/23
 31/5 38/22 56/25 76/3
 76/4 94/4 99/13
witness [4] 71/25
 74/16 74/21 87/20
witnesses [8] 11/16
 11/16 11/17 16/20
 16/23 17/8 17/9 17/11
won't [5] 20/11 49/2
 58/24 69/2 109/1
wonder [1] 4/19
wondered [1] 111/13
word [1] 84/7
words [3] 86/11 88/7
 91/15
work [1] 21/24
working [4] 1/17 31/8
 106/19 106/20
worried [2] 27/2 27/3
worry [2] 27/2 27/14
worrying [2] 100/18
 100/19
worse [1] 80/23
would [149]
wouldn't [8] 47/6
 72/10 72/11 83/23
 91/16 93/25 103/6
 106/10
write [5] 30/9 35/17
 37/1 39/1 85/24
writer [1] 103/21
writing [6] 9/22 15/1
 63/4 66/21 97/7
 108/20
written [6] 7/1 30/16
 53/24 54/21 64/6 97/5
wrong [3] 47/19 78/6
 80/20
wrote [2] 11/9 32/14

X
xxi [1] 8/18

Y
year [3] 15/3 37/13
 38/6
years [1] 8/2
yes [304]
yesterday [2] 23/3
 37/1
yet [2] 33/23 36/16
you [470]
your [81] 7/12 8/8 9/1
 10/1 10/4 10/5 12/22
 12/25 13/16 14/5
 14/11 15/4 15/10
 17/16 18/20 19/9 20/2
 20/15 21/14 21/15
 25/19 25/20 26/2 27/2

27/8 27/15 29/8 30/6
 30/21 32/5 32/24
 33/13 33/15 33/16
 34/2 35/14 36/8 36/11
 36/14 37/23 39/1 43/2
 44/2 44/15 45/5 45/9
 52/11 55/18 56/21
 63/4 64/17 64/25
 65/11 72/8 73/1 75/9
 75/18 76/25 78/4
 81/16 81/21 81/22
 82/23 83/3 83/19
 84/16 85/2 87/20
 96/24 97/15 98/6
 98/19 98/23 99/22
 100/5 100/11 100/14
 104/8 109/12 109/25
 110/21
yours [1] 12/24
yourself [2] 43/2 82/1
yourselves [2] 38/17
 75/2