

Monday, 30 September 2024

(10.30 am)

(Proceedings delayed)

(10.34 am)

MS NIELD: Good morning, my Lady. May I please call Professor Sir Frank Atherton, who can be sworn.

PROFESSOR SIR FRANK ATHERTON (sworn)

Questions from COUNSEL TO THE INQUIRY for MODULE 3

LADY HALLETT: Welcome back, Sir Frank.

A. Thank you, my Lady.

MS NIELD: Can you give your full name, please.

A. Yes, I'm Dr Frank Atherton. Francis officially, but Frank, everybody knows me as Frank.

Q. Now, I think despite the fact being formally Professor Sir Frank Atherton, you've indicated that you would prefer to be called Dr Atherton; is that right?

A. That's how the people of Wales would know me so I prefer that, thank you.

Q. Thank you.

You have provided two witness statements to this module of the Inquiry. That's INQ000416178 dated 21 February 2024 and INQ000474224 dated 1 May 2024. You are familiar with those statements and I think you have a copy of each of those in front of you; is that right?

A. I am and I do. Thank you.

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November of 2021 he was succeeded in that role by Judith Paget; is that right?

A. That's correct, yes.

Q. You have explained in your witness statement that while the Chief Medical Officer role is a member of staff of the Welsh Government, your role requires you to retain a high degree of independence and separation from the concerns of government, and you are providing your advice without regard to government policy or direction; is that correct?

A. That is correct, yes. I have a degree of independence so I can bring issues that the attention of ministers if I feel it's appropriate to do so, yes.

Q. I think your advisory role to the Welsh Government during the pandemic was twofold. Firstly, you attended cabinet and advised the First Minister and cabinet in relation to lockdown measures and other interventions aimed at controlling the pandemic for the population of Wales generally; is that right?

A. Mm-hm.

Q. And secondly, in relation to matters within the scope of this module, you provided advice to the Minister for Health and Social Services; is that correct?

A. That is correct, yes.

Q. And I think you've clarified that decisions on the

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Q. If we could deal, first of all, with your professional background and your career, please, Dr Atherton, you studied medicine at Leeds University going on to work in a broad range of medical areas before you completed your training in general practice, and later going on to undertake specialist training and then to practise in public health, I think initially overseas and then in the UK; is that right?

A. That's correct, yes.

Q. And I think you were the Deputy Chief Medical Officer for Nova Scotia in Canada before taking up your current role as the Chief Medical Officer of Wales in August 2016; is that correct?

A. That's true.

Q. I think there has in fact been a Chief Medical Officer for Wales since 1969; so predating devolution; is that correct?

A. As far as I understand, yes.

Q. And the Chief Medical Officer is a director-level post within the Welsh Government, and you report to the Director General of the Health and Social Services Group; is that correct?

A. I do, yes.

Q. I think at the start of the pandemic, the Director General was Sir Andrew Goodall and then later in

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healthcare system response to Covid-19 were not taken at cabinet; they were a matter for the minister; is that correct?

A. They would largely be led by the Minister for Health and Social Service, or social care, through Andrew Goodall as the chief executive of the NHS, yes.

LADY HALLETT: Could you keep your voice up.

A. I will try, my Lady.

LADY HALLETT: Thank you.

MS NIELD: Can we look, please, at paragraph 79. That's page 27 of your first witness statement.

Thank you.

You explain there that there was a weekly -- from mid-April to October 2020, a weekly check-in meeting with the First Minister and the Minister for Health and Social Services, attended by key officials as well as yourself and Dr Robert Orford. I think Dr Robert Orford was the Chief Scientific Adviser for Health for Wales; is that right?

A. That's correct, yes, he was.

Q. "This was a 'sitrep' style meeting and the updates from myself and Dr ... Orford would inform the First Minister and enable him, along with the Minister for Health and Social Services to set the tone for the priority areas for officials that week ... This would include

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1 discussion on the wider healthcare response, but at
2 a high level (as oppose[d] to operational detail) with
3 a focus on the assessment [of] NHS capacity."

4 Two questions arising from that, please,
5 Dr Atherton: who provided the information on NHS
6 capacity to the minister?

7 **A.** So I think by this stage the planning and response cell
8 had already been created within the health and social
9 care group, and they were monitoring what was happening
10 in the NHS, reporting that through to Andrew Goodall and
11 myself, and there would have been -- there was updates
12 to the minister and the First Minister on those aspects
13 as well as on the public health aspects of the pandemic.

14 One thing I should add, and I can't remember
15 whether it was in every occasion but Andrew Goodall, as
16 the chief executive of the NHS, would often have been at
17 those meetings as well.

18 **Q.** Thank you.

19 In terms of the operational detail about what was
20 happening in the healthcare system in Wales, if that was
21 not provided during these weekly check-in meetings how
22 was the minister kept informed about operational issues
23 in the NHS in Wales during the pandemic?

24 **A.** As I say, on occasions certainly Andrew would have been
25 at those meetings, and I'm sure the minister and the

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1 medical director, and to liaise with the medical
2 directors in health boards, who were responsible, of
3 course, for the operational delivery of health services
4 within each of their own individual health boards.

5 **Q.** We will see in due course some documents that are badged
6 "NHS Wales". I think it's right that there isn't
7 a single entity called "NHS Wales" but there are
8 a number of NHS bodies that make up the NHS in Wales,
9 and that includes seven local health boards who are
10 responsible for providing primary and secondary care
11 within their geographical area; is that correct?

12 **A.** Yes. You describe the architecture very well. Seven
13 local health boards, a number of health trusts, no such
14 thing, as you rightly say, as NHS Wales, although in
15 more recent times an NHS Executive has been created. So
16 perhaps there is a move post-pandemic towards a more
17 recognisable NHS Wales. But that at the time was the
18 correct position.

19 **Q.** And I think each of those local health boards in Wales
20 has its own medical director. In your role as medical
21 director of NHS Wales, did you have any power or
22 authority to direct the medical directors of the local
23 health boards?

24 **A.** No.

25 **Q.** And how would you characterise then the relationship

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1 First Minister were having separate briefings from
2 Andrew and other policy leads leading on the planning
3 and response work. So this wasn't the only occasion
4 that a minister and First Minister would have had
5 opportunity to talk to policy officials, such as myself,
6 but there were a range of opportunities for them to
7 fully appraise themselves of what was going on.

8 **Q.** And were you providing any detail about operational
9 issues that were arising in the NHS to the Minister for
10 Health and Social Services?

11 **A.** I would have been having broad overview of where the
12 system was, whether we were running towards capacity,
13 problems. I wouldn't have had the operational detail,
14 as you describe it.

15 **Q.** Thank you.

16 I understand that as the Chief Medical Officer for
17 Wales that is a dual role: you're also medical director
18 of NHS Wales; is that correct?

19 **A.** That is correct, yes.

20 **Q.** Is that an advisory role or a decision-making role?

21 **A.** It's an oversight role. It's to provide leadership
22 across the health profession, particularly the medical
23 profession of course, within Wales, to act as the senior
24 responsible officer. So all doctors have to follow
25 re-validation procedures and that escalates up to the

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1 between the medical director of NHS Wales and your role
2 in that capacity and the medical directors of each of
3 the local health boards?

4 **A.** So I was a member of the medical directors' group,
5 I used to chair the medical director meetings which
6 would happen once every month and we'd use those
7 meetings to discuss matters of policy, which were
8 emanating from Welsh Government, so that medical
9 directors in local health boards were kept aware of them
10 and they would use the opportunity to discuss issues
11 around Health Service delivery with me. But it wasn't
12 a power relationship in the way you describe it. It was
13 more of a first among equals, let's say.

14 **Q.** Did those monthly meetings continue throughout the
15 pandemic?

16 **A.** They did.

17 **Q.** And when you were meeting with the medical directors of
18 the local health boards during the pandemic, was that
19 a two-way flow of information? Were the medical
20 directors communicating to you the issues that they were
21 encountering within their hospitals or within primary
22 care in their areas?

23 **A.** Yes, of course we moved, as everything did, towards
24 virtual meetings as opposed to physical in-person
25 meetings. The meetings continued and there would have

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1 been a two-way flow of information exactly as you
 2 described. Thank you.

3 **Q.** And in terms of any issues or particular concerns that
 4 were brought to your attention during those meetings
 5 with the medical directors of the local health boards,
 6 was there any mechanism by which you could share that
 7 information with relevant Welsh Government officials
 8 and, indeed, the Minister for Health and Social
 9 Services?

10 **A.** So I would attend those meetings along with Chris Jones,
 11 my deputy, Deputy CMO. Chris and I would feed -- any
 12 issues which were escalated to us we'd feed in two
 13 different directions. If there's anything that required
 14 the attention of ministers or the First Minister, then
 15 I would obviously bring them up to speed with issues.
 16 But the main route to solve problems would have been
 17 more through into the planning and response group which
 18 was leading the policy work around how the NHS and
 19 social care system responded.

20 **Q.** You've mentioned your deputy -- I think that was
 21 Dr Chris Jones --

22 **A.** Yes.

23 **Q.** -- during the pandemic also attended those meetings.
 24 I think in his witness statement -- I don't think we
 25 need to get it up -- he's also described himself as

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1 background, as you described earlier, and so it was
 2 natural for me to lead on more of the public health
 3 issues.

4 **Q.** I think you were also -- as well as Chief Medical
 5 Officer, medical director of NHS Wales, you were also
 6 the director of the public health directorate at least
 7 for the first two years I think of the pandemic. Is
 8 that right?

9 **A.** There was a directorate which was within Welsh
 10 Government when -- and I was the director of that
 11 directorate, excuse me. It had various names over time
 12 and I think by the time the pandemic arrived it was the
 13 population health directorate.

14 **Q.** So that was in relation to your public health
 15 responsibilities?

16 **A.** It encompassed the public health work but also some of
 17 the medical director roles which Chris, as you rightly
 18 say, as deputy, was leading on. So, for example, there
 19 were a number of major health conditions which the
 20 directorate was responsible for as well.

21 **Q.** Thank you.

22 In terms of the Chief Medical Officer's Covid-19
 23 response team, can we look, please, at an organogram of
 24 that system -- thank you.

25 This is INQ000066199, and can we have a look

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1 a medical director of NHS Wales.

2 Was that -- were you both medical directors
 3 effectively on an equal footing or was he your deputy
 4 medical director?

5 **A.** I think what Chris is referring to, and if we read it we
 6 could bring it up, but he was at one point -- before
 7 I arrived in Wales, he was formerly the medical
 8 director. I think when my predecessor, Dr Ruth Hussey,
 9 arrived I think she became the medical director and
 10 Chris became the Deputy Chief Medical Officer and that
 11 was the arrangement I inherited when I arrived in 2016.

12 **Q.** I think Dr Jones explained that prior to the pandemic
 13 you fulfilled the main leadership role as Chief Medical
 14 Officer for public health and he provided support mainly
 15 for the role of medical director. Did that division of
 16 roles between you remain the case or did that change
 17 during the pandemic?

18 **A.** I think it was broadly -- it broadly remained the same.
 19 Chris Jones is of a highly skilled cardiology background
 20 and had a deep understanding -- had worked in Wales for
 21 many, many years, a deep understanding of the healthcare
 22 system, and so there was a natural division of
 23 responsibilities that he led on a lot of the healthcare
 24 work, not exclusively, there was always overlap, but
 25 I come from a public health profession, public health

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1 please at page 3. Thank you.

2 You are named there, Dr Atherton, as having
 3 responsibility for governance and resources and also
 4 oversight.

5 And if we can go over to the next page, page 4
 6 please.

7 This is the structure and functions of the Chief
 8 Medical Officer's Covid-19 response team, and in blue
 9 along the top line we can see the principal bodies with
 10 whom I think the Office of the Chief Medical Officer
 11 liaised and then the different subgroups or cells that
 12 make up the response team are in pink boxes around the
 13 centre.

14 I make it 21 cells in that team. Would it be
 15 right to say that there was a lot of work being done by
 16 the Office of the Chief Medical Officer on many
 17 different areas?

18 **A.** It would.

19 **Q.** And I think up until April 2021 when Dr Gillian
 20 Richardson was appointed as an additional Deputy Chief
 21 Medical Officer to lead on vaccination issues, you were
 22 assisted by just one deputy. That was Dr Chris Jones;
 23 is that right?

24 **A.** That's correct, yes.

25 **Q.** What's the situation now? Are you assisted by two

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1 deputies currently or just one?

2 **A.** Relatively recently we appointed a second Deputy Chief
3 Medical Officer, DCMO, and so there's a division of
4 labour again, with -- Chris Jones, you understand, has
5 retired from Welsh Government now and so there's
6 a direct replacement for him but we also have an
7 additional Deputy Chief Medical Officer working on the
8 public health side, a former public health director who
9 understands the public health architecture and system.

10 **Q.** Dr Atherton, you explained in the Module 2B hearings
11 that there was a lack of administrative support within
12 the Office of the Chief Medical Officer prior to
13 May 2020 which meant that you had no minutes taken of
14 your meetings prior to that date with the UK Chief
15 Medical Officers or your meetings with Public Health
16 Wales.

17 Do you consider that in the event of a pandemic
18 there needs to be more than one Deputy Chief Medical
19 Officer to support the Chief Medical Officer and
20 additional administrative support?

21 **A.** Well, in terms of the number of deputies that's a moot
22 point I think. I do think we were under-resourced,
23 certainly compared with other UK nations, in terms of
24 senior leadership, and that certainly was an issue. We
25 tried to address that by bringing in health

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1 Government reallocation of responsibilities, and I think
2 I covered that in Module 2B, as you say.

3 **Q.** Can we turn, please, to the Welsh Government oversight
4 of the NHS in Wales during the pandemic period.

5 I think it's right, as you have said, that there's
6 no single organisation which is the NHS, NHS Wales.
7 I don't think there was a single organisation that could
8 take national command and control of the NHS in Wales
9 during the pandemic; is that right?

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

11 **Q.** In February of 2020, the Health and Social Services
12 Group Covid-19 Planning and Response Group was
13 established within the Welsh Government Health and
14 Social Services Group; I think that's right?

15 **A.** Can you give me the date again?

16 **Q.** February of 2020.

17 **A.** That sounds about right, yes.

18 **Q.** And can we get up, please, page 2 of this document which
19 is on screen.

20 And that sets out, I think, the structure of the
21 Covid-19 Planning and Response Group. That's situated
22 in the middle of that diagram, and it reports to a group
23 of five people, including yourself as Chief Medical
24 Officer. Albert Heaney I think was the Deputy Director
25 General responsible for Social Services; is that

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1 professionals. Gill Richardson you have mentioned,
2 there were a number of other retired health
3 professionals that we brought in.

4 The administrative issue was extremely difficult
5 because, as perhaps the diagram demonstrates, there was
6 a huge amount going on at the time. There was a river
7 of information which was flowing extremely fast. It was
8 very difficult to maintain an understanding of that and,
9 at the same time, keep the administration of the office
10 in place.

11 I remember having quite early in the pandemic
12 quite a lengthy discussion with my counterpart in
13 Scotland, Dr Catherine Calderwood, about the way that my
14 office was structured and she was horrified, I would
15 say, that we had the resource that we had to be able to
16 deal with the issues we were facing.

17 So, yes, we did feel under-resourced. It was
18 difficult and it was an extremely busy time. The
19 individuals, some of whose names appear there and many
20 of whom are redacted, did a fantastic job. We pulled
21 people from all across the public health directorate --
22 the population health directorate to take on new
23 functions and they did that willingly and with great
24 aplomb.

25 In my mind there should have been a broader Welsh

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1 correct?

2 **A.** He was the director of social care and also acted, yes,
3 as Deputy Director General, correct, yes.

4 **Q.** Jean White, the Chief Nursing Officer, and
5 Samia Saeed-Edmonds of the Covid-19 Planning and
6 Response Group. And there are a large number of cells
7 and subgroups we can see below the planning and response
8 group in the middle there that feed into the Health and
9 Social Services planning and response group.

10 Did you chair or have membership of any of those
11 cells that we see along the bottom? I think your deputy
12 was a co-chair of the Acute [and] Secondary Care Cell.

13 **A.** No, I did not.

14 **Q.** In his role as co-chair of the Acute [and] Secondary
15 Care Cell, did Chris Jones report to you or keep you
16 updated? Were you sighted on his work?

17 **A.** Yes, absolutely.

18 **Q.** If we can look at some of those subgroups that feed into
19 the planning and response group, there's the Technical
20 Advisory Cell on the right of this document, which
21 I think we'll come to in due course, and that was
22 co-chaired by the Chief Scientific Adviser for Health?

23 **A.** Yes.

24 **Q.** There's the PPE Supply Cell that feeds into the Planning
25 and Response Group. There's the Essential Services

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1 Cell. Was that group concerned with essential health
 2 services, effectively priority non-Covid healthcare?
 3 **A.** That's my recollection, yes. The essential services
 4 which was important to maintain and to keep running
 5 throughout the pandemic, yes.
 6 **Q.** And then in terms of the Acute Secondary Care Cell,
 7 I think you have explained in your witness statement
 8 that that subgroup was in charge of discussing and
 9 planning the hospital response to the pandemic and that
 10 included areas such as critical care, ventilators, the
 11 Covid treatment pathway, maintenance of non-Covid care,
 12 field hospitals, end-of-life care; is that right?
 13 **A.** Yes, that's my recollection, yes.
 14 **Q.** And I think Dr Jones sets out in his witness statement
 15 that in addition to his role on this Acute Secondary
 16 Care Subgroup, he regularly attended meetings with
 17 Andrew Goodall and the chief executives of the NHS
 18 organisations in Wales. Were you present during those
 19 meetings or did he report those back to you?
 20 **A.** Very often we would both be present. I would give an
 21 update to chief executives of the epidemiology where we
 22 were up to. Chris would talk about the NHS response and
 23 where perhaps there were issues that chief executives
 24 needed to be aware of, yes.
 25 **Q.** I think Dr Jones also had some early involvement in

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1 correct? Do you recall that?
 2 **A.** I don't remember but it wouldn't surprise me.
 3 **Q.** I think he's named in the draft terms of reference for
 4 that group. Would that accord with your --
 5 **A.** It would have been appropriate, yes. I don't think he
 6 chaired that group, though, but he may well have been
 7 a member, yes.
 8 **Q.** Did he report back to you as he was your deputy
 9 regarding the work he undertook as a member of that
 10 group?
 11 **A.** I don't recall any specific briefings on that but -- no,
 12 I don't recall any.
 13 **Q.** All right, thank you.
 14 Reflecting then on the response of the Welsh
 15 Government's Covid-19 planning and response structure
 16 and looking at that organogram, do you think that that
 17 was an effective structure for dealing with the many
 18 issues that arose in the healthcare system during the
 19 pandemic? Do you think it would have been better to
 20 have a separate national overarching body to co-ordinate
 21 and lead the NHS?
 22 **A.** Well, I mean, the organogram that we see there is a
 23 point in time. I suppose it evolved over time as well.
 24 I'm not quite sure the date that this refers to but I do
 25 recognise it. Did it work well? Well, it certainly

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1 issues around PPE supplies for the healthcare sector; is
 2 that correct?
 3 **A.** He did. Chris stepped into that role very early on when
 4 there was an anxiety about the levels of PPE stocks that
 5 we were holding. Subsequently, the supply cell, chaired
 6 there by Alan Brace, who was the director of finance
 7 actually for NHS -- for the Health and Social Care Group
 8 took over the leadership of that role.
 9 **Q.** And I think Dr Chris Jones -- I think you and the Chief
 10 Nursing Officer established the Nosocomial Transmission
 11 Group in April or May of 2020 which was co-chaired by
 12 your deputy with the Chief Nursing Officer; is that
 13 correct?
 14 **A.** Exactly.
 15 **Q.** We'll come on to the work of the Nosocomial Transmission
 16 Group a little later.
 17 I think in your witness statement you have said
 18 that neither you nor the Office of the Chief Medical
 19 Officer for Wales were involved in advice on the
 20 identification or characterisation of the post-Covid
 21 conditions such as Long Covid, and you weren't involved
 22 in formulating protocols or guidance around that
 23 condition. I think it's right that your deputy,
 24 Dr Chris Jones, was a member of the Welsh Long Covid
 25 subgroup that was established in November 2020; is that

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1 worked. The flow of information seemed to work and it's
 2 notable, isn't it, that, you know, it follows up towards
 3 the Minister for Health and Social Services so that he
 4 was kept informed as to what was going on.
 5 I think the issue you touch on is an important
 6 one. It's about the command and control of the NHS, is
 7 it not? Is that what you're asking about?
 8 **Q.** Yes, that's essentially the question.
 9 **A.** There is a history to this. When I arrived in 2016 in
 10 Wales, there had been a report by the OECD, the
 11 Organisation for Economic Co-operation and Development,
 12 which had looked at -- actually, there had been a report
 13 on each of the four nations and it looked at the
 14 strengths of the Welsh health system, small in size,
 15 seven local health boards, reasonable size, but it did
 16 make the comment that there was insufficient ability to
 17 have a command and control arrangement within Wales.
 18 That's something which has bubbled around, I would
 19 say, ever since I've been there and it certainly was a
 20 feature when Covid hit us. Subsequently, as I say,
 21 there has been the creation of a national NHS Executive
 22 which is designed, was designed, to have that stronger
 23 guiding hand, let's say. I think that was the term used
 24 in the OECD report.
 25 So in Wales things are done by collaboration and

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1 when you have a pandemic like this, there is a need to
 2 move to a more directive approach, I believe. I think
 3 to some degree that did happen. Andrew Goodall as the
 4 Chief Executive of the NHS, alongside being the Director
 5 General for the health and social care group -- he has
 6 two roles in that regard -- I think did a good job in
 7 terms of corralling the local health boards, making sure
 8 that they knew what was expected of them. But it was
 9 done on the basis of collaboration rather than
 10 direction, I think, and I think that is a weakness, has
 11 been a weakness, in the health system which
 12 the NHS Executive system is designed to try to put
 13 right.

14 **Q.** This NHS Executive, does it have any statutory basis?

15 **A.** I can't tell you the -- it is -- I'm sorry, I don't know
 16 the legal entity of it.

17 **Q.** But what I'm getting at, Dr Atherton, is, does it have
 18 the legal power or authority to be able to lead NHS
 19 Wales? Does it have authority to take national command
 20 and control or would that remain with the local health
 21 boards?

22 **A.** I think it's a work in progress. It is a fact in Wales
 23 that the local health boards are sovereign organisations
 24 that have to manage their own system within their own
 25 budgets. I don't think -- I could be wrong but I don't

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1 already developed a relationship. He had spent a lot of
 2 time in building the relationship and the trust between
 3 the four of us. We settled into a pattern of meeting
 4 regularly on a quarterly basis in person and regularly
 5 as needed and so the relationship was excellent.

6 I think actually having that pre-existing
 7 relationship before the pandemic struck really helped us
 8 to remain as a coherent group that worked very closely
 9 together.

10 **Q.** In addition to the regular Chief Medical Officer
 11 meetings between the four UK Chief Medical Officers,
 12 I think you also all met weekly at a Senior Clinicians
 13 Group, which included a wider membership. What were the
 14 issues discussed at those senior clinicians groups and
 15 how did you feed back relevant information for the Welsh
 16 healthcare system from those meetings?

17 **A.** So the Senior Clinicians Group originally was set up as
 18 an England-only body but Chris, Sir Chris Whitty,
 19 rapidly realised that there was a benefit in extending
 20 that to the other devolved nations and so myself and
 21 colleagues were invited. Our Chief Nursing Officer
 22 colleagues also joined the group.

23 **Q.** What issues were discussed there?

24 **A.** So it would be matters relating to any clinical issues
 25 which were of relevance, some of the research and

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1 think the NHS Executive currently has the ability to
 2 direct in the way perhaps which is envisaged when the
 3 OECD report was produced in 2015.

4 **Q.** I think it's right, isn't it, that the local health
 5 boards, the seven local health boards are each
 6 designated as category 1 responders under the Civil
 7 Contingencies Act?

8 **A.** Correct.

9 **Q.** If we can move on, please, to look at co-operation
 10 between your office and the other UK nations, you've
 11 explained that as the Chief Medical Officer you played a
 12 key role in sharing information and practice between
 13 Wales, the healthcare system in Wales, and that of the
 14 other nations and feeding back to the Welsh Government,
 15 and that took place predominantly through the meetings
 16 with the four UK Chief Medical Officers; is that
 17 correct?

18 **A.** That's correct, yes.

19 **Q.** How would you describe your working relationships with
 20 your counterparts in the other nations?

21 **A.** They were excellent. I don't think we could have asked
 22 for closer collaboration really. Professor Whitty,
 23 Sir Chris, had taken up the post of Chief Medical
 24 Officer for England and the UK aspects of the role not
 25 long before the pandemic struck, of course, but we'd

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1 development findings, in early days in the findings,
 2 would be brought to that group, issues around testing
 3 strategies would be discussed, the IPC cell would have
 4 brought issues to the group for notification so that we
 5 knew what was going on in the cell there. It was also
 6 a forum for sharing information, as the Chief Medical
 7 Officer meetings were as well. It was a slightly wider
 8 group.

9 So a very broad range of clinical issues, really,
 10 I would say, yes.

11 **Q.** How did you feed back to the officials and the minister
 12 in the Welsh Government?

13 **A.** So my habit in these meetings was to try to keep my own
 14 notes. We talked about the lack of administrative
 15 assistance. So I tried to keep my own notes of really
 16 quite complex issues which were being discussed and
 17 complex papers which were being presented. So I would
 18 maintain my own notes and where there was something that
 19 was directly relevant either to the ministers or to
 20 other people in Welsh Government, or the policy leads,
 21 I would try after the meeting to drop an email or to
 22 include that in my briefings to the minister and the
 23 First Minister.

24 **Q.** As you had this dual role which we've spoken about, the
 25 medical director of NHS Wales, did you or indeed your

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1 deputy ever meet with the National Medical Director of
 2 NHS England or medical directors of the other devolved
 3 administrations as part of the Senior Clinicians Group
 4 or through any other means?

5 **A.** Well, the medical director of England was a member of
 6 the clinical group we just described so we met with him
 7 regularly. There were issues occasionally, not
 8 frequently, where we had specific problems in Wales
 9 where I needed to contact the national -- the UK medical
 10 director, Sir Stephen Powis, but that would have been
 11 quite infrequent really, if we needed, for example,
 12 mutual aid on specific issues across the board and
 13 between England and Wales.

14 **Q.** And arising from these Senior Clinicians Group meetings
 15 and in relation to the oversight of healthcare services
 16 and the healthcare sector's pandemic response, were you
 17 aware of the Welsh Government response ever diverging in
 18 a significant fashion from the approach in England?

19 **A.** On healthcare responses?

20 **Q.** Yes, in terms of the way that the pandemic response of
 21 the healthcare systems. Were you ever aware of
 22 a divergent approach from what you were hearing from
 23 your counterparts in the devolved administrations?

24 **A.** I can't recall any specific instances. I mean, there
 25 may well have been later in the pandemic, I'm sure we're
 25

1 remember to link up as closely as they might with policy
 2 leads in the other devolved nations. It's something we
 3 need to continually work at as civil servants, I think,
 4 as the Civil Service generally.

5 **Q.** Thank you.

6 Can we move on, please, to look at sources of
 7 scientific knowledge that was made available to you as
 8 Chief Medical Officer and the developing understanding
 9 of Covid-19.

10 Your second witness statement to this module sets
 11 out those matters and you explain that in making that
 12 statement you had access to contemporaneous
 13 documentation to assist you to recall your state of
 14 knowledge at the beginning of the pandemic in
 15 March 2020, and that documentation includes updates that
 16 you received from the Technical Advisory Cell, the SAGE
 17 briefing papers, and emails from Dr Orford in which he
 18 summarised what was discussed at SAGE meetings. Is that
 19 right? That was the documentation that you had access
 20 to?

21 **A.** Yes, that was broadly the flow of information, yes.

22 **Q.** Did you keep any notes or records yourself of the
 23 information that you were receiving about Covid-19 and
 24 any significant developments in the scientific
 25 understanding of the virus?
 27

1 going to go and talk about oximeters, we had a different
 2 use to the approach of use of oximeters.

3 Testing was a bit of an issue, the testing
 4 strategies generally, I mean. Although information on
 5 the public health basis flowed very smoothly, I think,
 6 between the Chief Medical Officers, sometimes -- because
 7 the work -- understandably, because the work was being
 8 undertaken so rapidly, sometimes policy leads at UK
 9 level, in England, let's say, didn't communicate as
 10 rapidly as I would have liked with colleagues who were
 11 working on similar issues in Wales and that did lead,
 12 I think, to some divergence and some difficulties in
 13 keeping up with everybody was doing.

14 **Q.** What do you think would be a solution to that
 15 communication issue, if I can put it in that way?

16 **A.** I think in the same way that Chief Medical Officers met
 17 and continued to meet regularly, there needs to be more
 18 communication between policy officials, policy leads,
 19 between the four nations. I think to some degree that
 20 is already happening but that to me would make far more
 21 sense.

22 It's very difficult in the heat of a pandemic, of
 23 course, because work was being often directed by, say,
 24 the Secretary of State at UK level and it was very
 25 difficult, I think, for policy officials there to always
 26

1 **A.** I didn't keep any formal notes as such. I think as the
 2 Inquiry knows, I keep a day book where I scribble
 3 outcomes of meetings I have and just as aide-memoires to
 4 myself, so there may be issues in there. Those have
 5 been disclosed, of course, to the Inquiry but no formal
 6 notes of that information, no.

7 **Q.** Can we look, please, at page 2, paragraph 4 of that
 8 witness statement. You say that you have now had the
 9 chance to consider these contemporaneous documents we
 10 have just referred to:

11 "... with the benefit of time, during the pandemic
 12 I was often being sent considerable amounts of
 13 information to consider and assimilate daily.
 14 Therefore, the summary information rather than the
 15 detailed information contained in papers was often my
 16 primary source of information."

17 Is that right?

18 **A.** That's absolutely right, yes.

19 **Q.** So is it the case that where you have referred back to
 20 SAGE papers or Technical Advisory Cell briefings to
 21 identify what you understood about Covid in the early
 22 part of the pandemic, it may be that you hadn't in fact
 23 read those detailed papers at the time; you were relying
 24 on a summary?

25 **A.** That would be correct. I mean, at the time, just to
 28

1 expand on that slightly, you rightly mention -- so a TAC
 2 summary, a Technical Advisory Cell summary, would come
 3 to me and that would be a very lengthy summary,
 4 sometimes 30/40 pages, and embedded in that would be all
 5 of the SAGE papers, for example. So it would have been
 6 impossible -- this is what I referred to as the river of
 7 information flowing very fast, it was in spates, and it
 8 would have been impossible for me to understand the
 9 detail of each of the individual papers, and in a way
 10 that's why we set up the system where Rob Orford, as the
 11 chief science officer for health was attending SAGE,
 12 collecting that information, bringing it back, working
 13 with the TAC, the Technical Advisory Cell, to summarise
 14 it, and bring that to me in a way that I could then
 15 absorb and summarise for the health minister and the
 16 First Minister, yes.

17 **Q.** So if we can take that in stages in a chronological
 18 order, please, I think it's right that prior to
 19 11 February, when Dr Orford first attended SAGE,
 20 information from SAGE and indeed from NERVTAG was
 21 conveyed to you through your meetings with the four
 22 nations' Chief Medical Officers; is that correct?

23 **A.** That's correct. I think that's correct, yes.

24 **Q.** And the Welsh Government I think wasn't invited to SAGE
 25 until that date in February, 11 February; is that

29

1 correct?

2 **A.** I believe so --

3 **Q.** That's from your witness statement.

4 Prior to setting up the Technical Advisory Cell,
 5 if Dr Orford was giving you these updates verbally, were
 6 you recording those in any way, these verbal updates?

7 **A.** Only in the way that I previously described as to
 8 meetings and discussions I had. I would make notes in
 9 my day book. There may be records there but no formal
 10 note of meetings. These were not minuted meetings, you
 11 understand. Things were moving extraordinarily fast.

12 **Q.** In terms of the witness statement that you provided to
 13 us, you haven't listed there as your contemporaneous
 14 documentation to which you've referred any of your day
 15 books or notes. Did you go back and look at your
 16 day book or your notes of the time to see what your
 17 state of understanding was in March of 2020?

18 **A.** Can you ask that again in a slightly -- way that I can
 19 understand the question.

20 **Q.** You've explained -- perhaps we can have a look at
 21 paragraph 4 of your second witness statement -- forgive
 22 me, paragraph 5 of your second witness statement.
 23 That's INQ000474224.
 24 You explained earlier that you referred to
 25 contemporaneous documentation including updates from the

31

1 correct?

2 **A.** I think there had been a couple of meetings, preliminary
 3 meetings, of SAGE which the devolved nations were not
 4 invited to, and that then -- that invitation I think
 5 initially as observers and then subsequently as full
 6 members then became the norm. I can't tell you exactly
 7 when but at that point we identified Rob Orford as the
 8 right person for Wales, to be representing us.

9 **Q.** I think you were technically a member of SAGE; is that
 10 correct?

11 **A.** I was, correct, yes.

12 **Q.** Did you ever attend any meetings?

13 **A.** I didn't. No, I delegated at a very early stage.
 14 I recognised that I wouldn't be able to absorb all the
 15 information and do everything else that I was doing, so
 16 we very early on identified Rob Orford as the right
 17 person to represent Welsh Government.

18 **Q.** How did Dr Orford then keep you updated on the evolving
 19 information?

20 **A.** Exactly as I say. Well, he would talk to me, of course,
 21 so if there was any matters of the pressing issue, you
 22 know, he'd often verbally communicate to me. But then,
 23 as TAC became established, he would provide those
 24 written summaries through the TAC briefings.

25 **Q.** I think TAC was established on 27 February 2020; is that

30

1 Technical Advisory Cell, SAGE briefing papers and emails
 2 from Dr Orford.

3 **A.** Yes.

4 **Q.** I'm asking whether the notes that you've told us that
 5 you kept on an informal basis in your day books, whether
 6 you referred to those notes in finding --

7 **A.** I understand the question now, thank you.

8 **Q.** -- in producing this witness statement?

9 **A.** Thank you for clarifying.

10 Your question is did I -- have I systematically
 11 gone back through those notebooks. I have not. Those
 12 notebooks, as I'm sure you'll be aware if you've seen
 13 any of them, are scribbles. I can read some of them;
 14 I can't read all of them. I don't think it would be
 15 terribly helpful for me to go back to them. My main
 16 source of information would have been the TAC summaries
 17 and information contained in those.

18 **Q.** Thank you. We can move on.
 19 We can take that down now thank you.
 20 The Technical Advisory Cell, what was the
 21 membership of that? Was that a rolling membership?
 22 Were people invited to come to the advisory cell or was
 23 there a fixed membership of experts?

24 **A.** There were two constructs: there was a Technical
 25 Advisory Cell and a Technical Advisory Group. The cell

32

1 was a relatively small number of people in Welsh
2 Government. I can't tell you just now exactly who were
3 members but Rob Orford was the chair, Fliss Bennee --
4 Fliss, his deputy, was co-chair, and there would have
5 been a group of civil servants within the cell who were
6 compiling the information and summarising it.

7 There was a broader Technical Advisory Group which
8 was much wider, drawn much more widely, which included
9 people from a number of organisations, including
10 academia and external organisations but also other
11 departments within Welsh Government. So the cell and
12 the group were related but slightly different
13 constructs.

14 **Q.** So the cell was providing advice to assist you and to
15 assist the Welsh Government?

16 **A.** The ministers, yes.

17 **Q.** What was the purpose of the Technical Advisory Group?

18 **A.** To get a broader perspective. And specifically it had
19 a role in modelling. As the modelling which was being
20 undertaken -- modelling of the pandemic, the
21 epidemiological monitoring of the pandemic was being
22 undertaken at UK level, we recognised that there wasn't
23 enough detail perhaps about the Welsh context and we
24 wanted specific modelling of the virus and the
25 epidemiology within Wales.

33

1 Could you explain what your understanding was at
2 that time of what was meant by "droplet", "aerosol" and
3 "airborne" in that context.

4 **A.** So my understanding of the transmission early in the
5 pandemic was that we rapidly realised that it was
6 primarily a respiratory infection.

7 **Q.** If I can stop you there, please.

8 Dr Atherton, I'm asking what you understood by
9 those three terms: "droplet", "aerosol" and "airborne".
10 What was your understanding of what those three terms
11 meant?

12 **A.** I was about to try to help you understand that --

13 I mean, a respiratory infection is by its nature
14 transmissible through airborne transmission. So I see
15 droplets and aerosols as a form of airborne
16 transmission.

17 **Q.** So you saw droplet and aerosols both as being indicative
18 of airborne transmission, is that --

19 **A.** I believe, yes.

20 **Q.** You've also set out that by 5 June a Technical Advisory
21 Cell summary provided to you set out key conclusions of
22 a SAGE report including that there was weak evidence
23 that aerosol transmission may play a role in poorly
24 ventilated environments.

25 Where you were provided with scientific evidence

35

1 So it took on -- the group took on specific
2 functions like that. It was also a broader group for
3 considering issues related to science generally.

4 **Q.** Was there clarity between the role and the output of the
5 Technical Advisory Cell and the role and output of the
6 Technical Advisory Group?

7 **A.** I believe so. They did have different functions. The
8 cell was entirely within the Welsh Government and the
9 group was much broader. But there are terms of
10 reference for both those groups.

11 **Q.** And did both of those groups provide advice that you
12 relied upon?

13 **A.** I think they would have been summarised in the TAC --
14 the Technical Advisory Cell briefings.

15 **Q.** Moving to look at the advice and information about
16 Covid-19 that you received from the Technical Advisory
17 Cell and other sources in the early stages of the
18 pandemic, you've explained in that second witness
19 statement that you have provided that having seen a SAGE
20 paper from 14 February 2020 you conclude that your
21 understanding in early March as to how the virus was
22 transmitted would have been that the two main modes of
23 transmission were touch, fomites and droplet but
24 airborne transmission was a possibility, particularly
25 following aerosol-generating procedures.

34

1 that was unclear or uncertain or assessed or described
2 as "weak", what was your approach to providing advice
3 based on that evidence?

4 **A.** My advice would always be to acknowledge the strength --
5 you are talking about my advice to ministers, for
6 example?

7 **Q.** Yes.

8 **A.** It would always be to let ministers know what was known
9 but also the strength of the evidence with which we knew
10 it and the uncertainties which would be around that.
11 That would be my normal policy, my normal way of
12 working.

13 **Q.** Were you aware of what's been described as the
14 precautionary principle at that early stage in the
15 pandemic?

16 **A.** Throughout my career I've worked on the basis of
17 precautionary principle. People have mentioned it and
18 used it. It's a term which I find slightly confusing
19 sometimes in that, as I understand it, there are
20 different formulations of the precautionary principle.
21 But it's one way that we're helped to think about things
22 but it's not the only way that we think about things in
23 public health terms. But of course I'm aware of the
24 precautionary principle if that's what you are asking.

25 **Q.** Did that inform your advice or the way that you

36

1 formulated advice during the pandemic?
 2 **A.** It would be one of the ways in which my advice was
 3 formulated. It would be one of the considerations
 4 I would give to evidence as it became available.
 5 **LADY HALLETT:** Dr Atherton, as -- you're obviously right,
 6 I have heard different definitions of the precautionary
 7 principle. Do you have the same understanding as
 8 Professor Sir Chris Whitty, which is the precautionary
 9 principle applies where there are no downsides to taking
 10 a particular course of action? Is that how you
 11 interpret the precautionary principle -- or significant
 12 downsides?
 13 **A.** Well, I do, my Lady, and that's one of the difficulties
 14 with the precautionary principle. I could give you an
 15 example from way beyond Covid but it might take too long
 16 but I will if it would help.
 17 **LADY HALLETT:** Depends on how long.
 18 **A.** I will do it very quickly.
 19 When I was working in Nova Scotia I was a member
 20 of a panel looking at the issue of fracking and the
 21 question was whether Nova Scotia should frack, should
 22 allow, you know -- the policy environment should allow
 23 fracking. And the argument is always made: well, on the
 24 precautionary principle, there are downsides to
 25 fracking, because you might get earth tremors, you might

37

1 adhere to the UK IPC guidance ... issued jointly by
 2 [Department of Health and Social Care], Public Health
 3 Wales, the Public Health Agency (Northern Ireland),
 4 Public Health Scotland, UK Health Security Agency ...
 5 and NHS England -- also referred to as the 'UK IPC
 6 Cell'.
 7 Is that correct, there was no deviation from the
 8 UK IPC cell guidance in healthcare settings in Wales?
 9 **A.** I don't believe we ever deviated from it, and I think
 10 that was quite important, to get consistency across the
 11 four nations.
 12 **Q.** And I think Wales' involvement in the UK IPC cell was
 13 through Dr Eleri Davies at Public Health Wales; is that
 14 correct?
 15 **A.** Dr Davies was a member of Public Health Wales, still
 16 is -- actually, I think she may have retired, forgive
 17 me. But she was, and she subsequently took on the chair
 18 of that cell as well.
 19 **Q.** In your role as Chief Medical Officer, did you consider
 20 that it was any part of your role to undertake a review
 21 or analysis of whether the IPC guidance and
 22 recommendations for PPE measures were suitable or
 23 appropriate for healthcare settings in Wales?
 24 **A.** It's our job to receive the IPC guidelines, to
 25 understand them, to disseminate them. It wasn't our

39

1 get an increase in global warming. But of course the
 2 opposite applies in as much as if you don't frack then
 3 you end up importing fuel and hydrocarbons from
 4 somewhere else at a greater cost. So actually you can
 5 use the precautionary principle in both directions. So
 6 it doesn't really help you to come to a final decision.

7 It's useful in your thinking and it was useful in
 8 the thinking around Covid but it's not the only
 9 principle that you should use.

10 I agree with Sir Chris I think when he summarised
 11 it perhaps as saying that we need to look at evidence
 12 about the benefits and the harms and the evidence that
 13 sits around those. I find it better -- more helpful to
 14 work in that way than purely to think about the
 15 precautionary principle. But I think it's always at the
 16 back of my mind, yes.

17 **MS NIELD:** Thank you, my Lady.

18 Can we move on now to look at infection prevention
 19 and control guidance in Welsh healthcare settings during
 20 the pandemic.

21 Can we go, please, to page 53, paragraph 149 of
 22 your first witness statement, please.

23 You've said that:

24 "During all phases of the Covid-19 pandemic,
 25 health and social care providers in Wales were asked to

38

1 role to second-guess them. And this comes to the
 2 question of where we establish expert groups with far
 3 more experience than I would have, for example, or any
 4 of my -- a member of team would have had, that we would
 5 usually follow that advice rather than second-guessing
 6 it.

7 Obviously, if there were controversial areas, as
 8 subsequently arose, then we would discuss those with the
 9 IPC cell or we would discuss them at the Senior
 10 Clinicians Group, but, yes, that's how we worked with
 11 the IPC cell. Broadly we accepted their recommendations
 12 on the basis that there were experts in there, national
 13 and international experts, who were assembling the
 14 evidence base as well as they could.

15 **Q.** I'm going to move on and ask you about two occasions
 16 when there were issues that were raised about the
 17 suitability of PPE, particularly that was stipulated in
 18 those -- in that IPC guidance.

19 Were there any occasions where you had concerns
 20 about the effectiveness of the IPC guidance in
 21 healthcare settings in Wales or the level of PPE that
 22 was being specified for healthcare workers?

23 **A.** I don't think there were occasions where I had specific
 24 concerns but clearly there were concerns being raised
 25 elsewhere, which I was not unaware of, I was acutely

40

1 aware of in fact, and so managing that interface between
 2 the IPC cell and the rest of the system was quite
 3 a challenge, I would say.

4 **Q.** Perhaps we can come on and look at the first of those
 5 incidents to which I think you're probably referring.
 6 There was, I think in April of 2020, an occasion when
 7 you and the Chief Nursing Officer sent out a joint
 8 letter to hospitals in relation to the PPE for
 9 cardiopulmonary resuscitation. Do you recall that?

10 **A.** I do, yes.

11 **Q.** I think at that time there was a divergence between the
 12 UK IPC guidance, which indicated that cardiopulmonary
 13 resuscitation was not considered to be -- or chest
 14 compressions during cardiopulmonary resuscitation was
 15 not considered to be an aerosol-generating procedure and
 16 therefore full PPE and respiratory protective equipment
 17 was not required. And the Resuscitation Council UK were
 18 recommending that full PPE with RP should be worn in the
 19 absence of clear evidence that CPR was not an
 20 aerosol-generating procedure. Do you recall that that
 21 was the divergence?

22 **A.** You describe the divergence very well.

23 **Q.** Can we look, please, at the email chain that you have
 24 provided to us around this.
 25 It's INQ000384586.

41

1 the level of distrust now apparent with the PHE PPE
 2 guidance."

3 And she says she would "welcome a professional
 4 conversation about this".

5 So that was the issue that was being proposed by
 6 the Chief Nursing Officer, that it would be possible to
 7 simply accept the Resuscitation Council's advice on
 8 this.

9 And if we can go to page 1, please, first of all
 10 your deputy, Dr Chris Jones, assess that:

11 "... we cannot control or mediate this standoff
 12 between the [Resuscitation Council] and [Public Health
 13 England].
 14 "...
 15 "I remain clear our position has to be that we
 16 support the PHE guidance informed by NERVTAG advice.
 17 "It is for organisations to consider what advice
 18 they wish to adopt."
 19 Then if we can go to the very top of that page,
 20 please, Jean says that she has spoken to you, and:
 21 "... we both agree with your advice on this [this
 22 is to Chris Jones] and will take no further action."
 23 I'd like to ask why you agreed with your deputy
 24 that it was for organisations, that is health boards, to
 25 decide what kind of PPE should be used rather than

43

1 It's behind tab 51 in your bundle, if that
 2 assists.

3 **A.** Forgive me. It may take me a little time to get there.

4 **Q.** I think we probably don't need to look at the RCUK
 5 statement on page 4 because we've summarised that.

6 **A.** Can you give me the tab again, please.

7 **Q.** It's tab 51.

8 **A.** Got it, okay, thank you.

9 **Q.** I hope.

10 **A.** Yes.

11 **Q.** If you could go to page 2, please, of that.

12 This is an email from Jean White, the Chief Nursing
 13 Officer, to yourself to your deputy, to Gill Richardson,
 14 and copying in Andrew Goodall. She is requesting that
 15 you discuss the latest statement which has been produced
 16 below from the Resuscitation Council.

17 She says that she has:
 18 "... been told that many of the Health Boards are
 19 now rejecting the [Public Health England] [that's the
 20 UK] PPE guidance and our suggested compromise of
 21 covering the mouth and insisting the boards accept the
 22 Resus Council position. I think [Cardiff and Vale] is
 23 the latest in a line to go down this route ... I wonder
 24 if we should have made a decision to just accept the
 25 Resus Council position as best practice for Wales given

42

1 adopting that proposal of the Chief Nursing Officer to
 2 accept the Resuscitation Council's position?

3 **A.** Well, I think as the email chain shows, there was
 4 a clear divergence of opinion between the Resuscitation
 5 Council UK, NERVTAG and the IPC cell. So there was
 6 something of an impasse there, both claiming to be based
 7 on the best evidence.

8 Our inclination, of course, as I think we've just
 9 been discussing, was to follow the advice of the
 10 IPC cell, based on international best practice and the
 11 experts they had available.

12 The compromise that Jean had suggested, I think of
 13 covering the mouth, seemed a sensible one, because how
 14 can an aerosol escape from a person's mouth if you cover
 15 the mouth with cloth? It seems unlikely that aerosols
 16 would be able to escape, just on first principles,
 17 really.

18 That clearly didn't satisfy everybody's need and
 19 so there was an impasse. There was a very difficult
 20 impasse to manage.

21 The way I think it was managed eventually was to
 22 say to health boards: well, if higher grade PPE is
 23 available then staff should be allowed, empowered, you
 24 know, enabled to use it. But it wasn't a directive that
 25 they should use it. As Chris Jones rightly points

44

1 out -- well, there are two problems that arise from this
2 discussion. One is that any delay, of course, in CPR
3 when a patient has suffered a cardiac arrest is
4 disastrous, can lead to death and/or -- death or brain
5 damage of course. So any delay was to be avoided. And
6 this really didn't address the issue of what happens
7 when somebody has a cardiac arrest in the community and
8 the issue of people, bystanders, who might be providing
9 CPR who would have access to no PPE essentially.

10 So that's why it was left to the health boards to
11 decide. It was permissive rather than directive, let's
12 say.

13 **Q.** But doesn't that lead to a situation where there's still
14 going to be inconsistency potentially between different
15 local health boards and already a degree of mistrust
16 about the guidance that's being provided? Did you not
17 consider that it was your role, in terms of your
18 professional leadership role, to bring a consistent
19 voice?

20 **A.** Well, we did bring a consistent voice: Jean and
21 I consistently said we should follow the PPE -- the IPC
22 guidance based on the NERVTAG advice. So we did provide
23 that consistency. But if that doesn't meet everybody's
24 needs and, as we've just been discussing, health boards
25 or autonomous bodies, then providing the reassurance to

45

1 precautionary principle in all of that.

2 The other problem would be, if you took a purely
3 precautionary principle where would it lead you? Would
4 it lead you to people wearing powered respiratory hoods?
5 You know. So we have to be careful about the
6 precautionary principle again because becoming too
7 precautionary stops the thing you want to happen.

8 If you say you cannot provide CPR unless you have
9 a certain level of kit, whether that's an FFP3 mask or
10 a powered hood or a HAZMAT suit, you're putting the
11 lives of individuals at risk. And so, on
12 a precautionary basis, if you support what the patient
13 needs, you would say -- you would come to the exact
14 opposite of what you just described.

15 **Q.** I think later in the pandemic, in November of 2021, you
16 were involved with another issue that was raised in
17 relation to the PPE specified in the IPC guidance, and
18 this was around the emergence of the more transmissible
19 Omicron variant. Can we look, please, at page 55 of
20 your first witness statement. This is paragraph 158.

21 You've noted that:

22 "In November 2021 the UK [Chief Medical Officers]
23 and nursing officers asked the UK IPC cell, then chaired
24 by Dr Eleri Davies to review evidence around the route
25 of transmission."

47

1 staff that they could use additional measures if they
2 risk-assessed the situation and felt it was most
3 appropriate and it was available, then that's fine.

4 I think what happened as a consequence was that --
5 I mean, I don't know the details but I think what
6 happened was that health boards did have more
7 PPE equipment on the resuscitation trolleys. And these
8 are, let's not forget, relatively rare events. So the
9 whole issue was quite difficult to manage, the interface
10 was difficult to manage, but it settled down.

11 **Q.** What was your view on the position of the Resuscitation
12 Council UK that the absence of high-quality evidence as
13 to whether chest compressions generated aerosols should
14 not be interpreted as an absence of risk, applying the
15 precautionary principle that you enunciated earlier?

16 **A.** Can you ask that again, please. Sorry.

17 **Q.** So the position of the Resuscitation Council UK that
18 absence of high-quality evidence that chest compressions
19 generated aerosols should not be interpreted as absence
20 of risk, were they not taking a precautionary approach?
21 And what was your views on that?

22 **A.** Well, I didn't have a particular view. I recognised
23 that the expert opinion on the opposite side through the
24 NERVTAG and IPC was a balanced view. I didn't see that
25 the application of -- I don't think I considered the

46

1 Dr Eleri Davies provided you with informal updates
2 around the work of the IPC cell.

3 "This email [that you've included] confirmed that
4 the Cell had discussed the implications of the Omicron
5 variant for the [UK] IPC guidance, and that all member
6 organisations/countries of the cell were represented and
7 a wide-ranging discussion was had. The consensus view
8 of the Cell was that the IPC Guidance as it stood was
9 currently fit for purpose."

10 And:

11 "... the Cell considered that current PPE
12 recommendations remained appropriate."

13 We can take that down, thank you.

14 What were the concerns of the four Chief Medical
15 Officers at that point? Why is it that you had asked
16 for the PPE aspect of the IPC guidance to be reviewed?

17 **A.** I don't remember exactly, but I think it was to do with
18 the fact that there was increasing evidence that Omicron
19 variant was more transmissible. In fact, if we look
20 back, every variant which arose had a little bit more
21 transmissibility and that's how they became the dominant
22 variant.

23 So it was to do with the transmissibility from
24 person to person. And I think the thinking, the
25 questioning, was whether this represented different

48

1 modes of transmission and whether the IPC guidelines
 2 were still robust, and that's exactly what we asked the
 3 cell to look at. I think the CNOs, the Chief Nursing
 4 Officers, were also asking the cell to do the same
 5 thing.

6 **Q.** I think the focus of the request was whether
 7 fluid-resistant surgical masks were still appropriate or
 8 whether there should be a move to specifying RPE
 9 (respiratory protective equipment). Is that what you
 10 recall?

11 **A.** That may well -- yes, that may well have been part of
 12 the questioning, yes.

13 **Q.** Can we get up, please, the email that you have referred
 14 to there.

15 That's INQ000252535.

16 This was the email sent from Dr Eleri Davies to
 17 you on 6 December, and I think, having informed you that
 18 the IPC cell had met and discussed this, Dr Davies
 19 advises you there that.

20 "[They] will [be discussing it again] at [the] IPC
 21 cell on Wednesday and happy to feed back to Thursday's
 22 Senior Leaders group.

23 "Happy also to meet with you tomorrow as Sue
 24 [Hopkins] suggested to discuss further if that helps."

25 I think the list of key meetings that you've

49

1 **MS NIELD:** Dr Atherton, nosocomial transmission of Covid-19
 2 in Wales, can we go, please, to page 56, paragraph 159
 3 of your first witness statement. You say that:

4 "Another source of guidance and oversight of IPC
 5 measures was via the Nosocomial Transmission Group ..."

6 That was established by yourself and the Chief
 7 Nursing Officer for Wales in May 2020 with your deputy,
 8 Professor Chris Jones, as chair, and the membership of
 9 that group was drawn from Welsh Government, Public
 10 Health Wales and colleagues from health, social care and
 11 professional organisations.

12 As you considered the Nosocomial Transmission
 13 Group to be a source of guidance and oversight of IPC
 14 measures, does that mean that you considered that
 15 nosocomial infections were an indication of how
 16 effective or not IPC measures were in hospitals?

17 **A.** Well, of course, we were hugely conscious throughout the
 18 pandemic, even from quite early days, that closed
 19 settings, including hospitals, were sources where,
 20 places where outbreaks could happen.

21 Your question is did the fact that outbreaks were
 22 happening, did that affect our decisions, our views of
 23 the IPC? Is that kind of roughly what you're asking?

24 **Q.** Yes, perhaps to put it another way: if there were issues
 25 with frequent or repeated hospital outbreaks, would that

51

1 helpfully provided to the Inquiry indicated that an
 2 informal meeting took place between yourself and Public
 3 Health Wales on 8 December 2021. The subject was
 4 "Omicron variant and IPC guidance". Would that meeting
 5 have been with Dr Eleri Davies?

6 **A.** I really can't recall but I'm sure it would have been,
 7 given the nature of the email. Is there a tab number
 8 for that, can I ask?

9 **Q.** There is but I wasn't going to suggest that we
 10 necessarily get that up.

11 **A.** Okay.

12 **Q.** That's literally all the information that you have, is
 13 the title of the meeting.

14 But do you have any recollection of Dr Eleri
 15 Davies explaining to you the reason for their
 16 confirmation that the PPE guidance would remain the
 17 same?

18 **A.** No, I'm sorry, I can't remember that.

19 **LADY HALLETT:** Are you moving to a different topic?

20 **MS NIELD:** I am.

21 **LADY HALLETT:** As you may remember, Dr Atherton, we break
 22 regularly. I shall return at midday.

23 **(11.45 am)**

24 **(A short break)**

25 **(11.59 am)**

50

1 indicate that either the IPC measures stipulated in the
 2 guidance were not being implemented or the measures
 3 stipulated were not effective?

4 **A.** I don't think it would mean either of those things,
 5 really. In hospital settings it's impossible to
 6 completely eradicate nosocomial transmission. That was
 7 true before the pandemic, it was certainly true, of
 8 course, during the pandemic. No matter how good your
 9 IPC is, the only way to stop nosocomial transmission in
 10 hospitals would be to close the hospital.

11 So the issue for me was rigorous application of
 12 evidence-based policy and the evidence-based policy
 13 clearly was coming from the IPC cell and we were working
 14 with the health boards to make sure that it was
 15 rigorously applied. That, to me, is the way that you
 16 should deal with nosocomial transmission. You will
 17 never eradicate it but you should reduce it as much as
 18 you possibly can.

19 **Q.** Wouldn't the way to reduce it be to have effective
 20 infection prevention and control measures that were
 21 rigorously implemented?

22 **A.** That's what I just said.

23 **Q.** So does it follow from that then that if there are
 24 regular and repeated outbreaks, something has gone wrong
 25 with the IPC measures?

52

1 A. No, it doesn't.
2 Q. It may be that it's not possible to eradicate entirely
3 but wouldn't one expect to be able to reduce nosocomial
4 infections?

5 A. It's the whole purpose of IPC.

6 Q. Thank you.

7 The Nosocomial Transmission Group, I think
8 reported to the Minister for Health and Social Services;
9 is that correct?

10 A. Whether it reported directly, I mean, you'd have to look
11 back at the terms of reference, I am sure you have them
12 I thought it reported through the group that
13 Andrew Goodall chaired, indirectly perhaps, but
14 ultimately, yes to the minister.

15 Q. It provided ministerial briefings.

16 And can we look at, please, INQ000396261.

17 This is behind tab 13 in your bundle if you would
18 like to go to the paper copy, Dr Atherton. This
19 a ministerial briefing dated 15 November 2020, and this
20 paper set out that nosocomial infections had risen
21 across Wales in the previous few weeks in every health
22 board area.

23 If we could look at the second paragraph, please,
24 it explains that in the week ending 8 November 2020,
25 there were 210 cases of probable or definite

53

1 of that was at play, absolutely.

2 Q. And then we can see in the following paragraph that one
3 health board had recently found that although staff
4 should be testing positive at a similar rate to their
5 local community, one health board recently found 24% of
6 staff were positive despite only a 1% community
7 prevalence in that area.

8 I think if we can go to page 6 of the report,
9 please, it's proposed there that asymptomatic NHS staff
10 testing should commence, all patient-facing staff being
11 tested twice weekly. I think that proposal was
12 implemented beginning in hospitals on 14 December 2020,
13 and I think you have noted that the wider roll-out,
14 including in general practice, began on 11 January 2021.

15 We can take that down, thank you.

16 Was that programme then that was announced and
17 begun in December of 2020 the first time that there was
18 a national policy of asymptomatic testing of healthcare
19 workers in Wales?

20 A. I think it was. There had been a pilot of testing in
21 Merthyr Tydfil and I can't remember whether that was
22 only in the community or also included the hospital. So
23 there may have been some piloting really. But at this
24 stage of the pandemic we finally had access to the
25 lateral flow tests which were available in bulk in large

55

1 hospital-acquired Covid-19 infections. These
2 represented 3% of all cases diagnosed in that week but
3 50% of all cases diagnosed in hospitals.

4 So, in other words, 50% of those Covid infections
5 in hospital were people who had come into hospital for
6 treatment for another condition or health problem and
7 contracted Covid-19 during their stay.

8 If we can look at the bottom half of that, the
9 lower half of that page, we can see that it states there
10 in the penultimate paragraph:

11 "The evidence suggests that properly used [I think
12 that should be PPE] limits transmission between staff
13 and patients but that transmission is occurring between
14 patients and between staff."

15 Was that your understanding of one of the major
16 issues with nosocomial transmission at that point?

17 A. I think at that point in time it was certainly
18 recognised that there was infection between -- from
19 patient to patient, from staff to staff, and from
20 patients to staff. So Public Health Wales was trying to
21 kind of work out where the balance of those
22 transmissions were. I don't think we ever got fully to
23 the bottom of it. But of course there was also the
24 issue of, you know, people coming in from outside and
25 transmission from the community into hospitals. So all

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1 numbers and so testing, asymptomatic testing of large
2 numbers of people, including healthcare workers, became
3 a possibility, yes.

4 Q. So had the limiting factor in rolling out routine
5 asymptomatic testing been the testing capacity for PCR
6 tests in Wales prior to that point?

7 A. That was certainly an issue, absolutely, yes.

8 Q. Can we go, please, to a further update from the
9 Nosocomial Transmission Group.

10 This is INQ000227307.

11 It is behind tab 12 in your bundle, Dr Atherton.

12 A. Tab 12?

13 Q. Tab 12, please. It's headed "Update on COVID-19
14 Nosocomial Transmission, the [Welsh Government]
15 Nosocomial Transmission Group and current priorities".

16 I think there isn't a date, actually, on that
17 report but you have indicated in your witness statement
18 where this is exhibited, that the report was issued on
19 18 February 2021. So three months after the briefing
20 paper that we just looked at.

21 We can see on that document on page 1 under the
22 heading "Hospital onset cases" the last two sentences of
23 that paragraph that:

24 "... in the week ending [14 February 2021],
25 a Wales total of 211 hospital onset cases ... were

56

1 reported [representing] 8% of all confirmed COVID-19
2 cases and 53% of total COVID cases within Welsh
3 hospitals."

4 So a slight increase on the previous position.

5 Then if we could go to page 2, please, there's
6 there a graph. This is setting out across Wales the
7 weekly counts of probable and definite nosocomial
8 Covid-19 in Wales, and we can see that the nosocomial
9 infection rates were actually higher in wave 2 towards
10 the end of 2020 than they were in wave 1 in around March
11 and April of 2020.

12 Looking at that graph, those figures nationally
13 peaked in the week ending 13 December 2020 at 360 cases
14 and they dropped before rising again to around 300 for
15 the week ending 17 January.

16 If we can go to the graph below, please, this
17 shows nosocomial infection rates by health board and on
18 that document we can see that each health board has been
19 given a different colour line on that graph. We can see
20 that there is considerable variation between the local
21 health boards in terms of both the timing and the size
22 of their hospital outbreaks.

23 I think the lowest line on that graph is the
24 yellow graph for Powys. I think it's right that there
25 are no general and acute hospitals in the Powys health

57

1 Q. February 2021.

2 A. So by this time some hospitals were employing red and
3 green zones and trying to manage the risks in that way,
4 keeping patients who were Covid positive together. That
5 wasn't -- that was a local response, let me say, rather
6 than any kind of national response. It was about
7 hospitals working out their estate and the way that they
8 could segregate patients. Yes.

9 Q. So if we can look at specifically Velindre cancer
10 specialist hospital, was the process there not that all
11 patients were tested for Covid before they were admitted
12 to the hospital?

13 A. I think by that time that was happening.

14 Q. So does that tend to indicate -- or was the Nosocomial
15 Transmission Group able to identify whether those
16 hospital-acquired cases, albeit they're in low numbers,
17 the hospital-acquired cases at Velindre hospital came
18 from patient-to-patient transmission or from staff
19 infecting patients?

20 A. I don't think the paper elucidates that issue, correct
21 me if I'm wrong, if somewhere further in it, it does.

22 Q. We can also see in the middle of that graph a very
23 noticeable spike for Betsi Cadwaladr local health board
24 in around the summer of 2020 when cases are low in the
25 other health boards. Were the Nosocomial Transmission

59

1 board area; is that correct?

2 A. That's correct, yes.

3 Q. There are just community hospitals, I think.

4 A. Correct.

5 Q. Does that go some way to explaining the lower rates
6 there?

7 A. I think it explains it entirely.

8 Q. We can see also at -- very low on the graph, a pink line
9 which occasionally does rise above zero. That is the
10 Velindre trust, and I think Velindre trust does not run
11 any general hospitals but there is a specialist cancer
12 facility within the Velindre trust; is that correct?

13 A. It's a cancer service, yes.

14 Q. So that area was supposed to be a Covid-free green zone,
15 was it not?

16 A. Well, everywhere -- all the hospitals we tried to make
17 as Covid-light as possible. It wasn't possible to make
18 anywhere entirely Covid-free because Covid was
19 circulating in the community at this time -- at these
20 times, I should say, first and second waves of course.

21 Q. In the general acute hospitals in the other boards there
22 would be red and green zones, is that right, patients
23 would be cohorted according to their Covid status?

24 A. Not initially. Towards the latter part and -- sorry,
25 what's the date of this, can you remind me?

58

1 Group able to establish the reason for that isolated
2 spike when hospital outbreaks in the rest of the Wales
3 were very low?

4 A. Again, I don't know whether that's covered later in this
5 paper or not. I wasn't a member of the group, so
6 I don't know.

7 Q. If we can go to page 4 of this document, please, I think
8 a number of priorities are indicated there, the first
9 amongst which is "Develop[ing] a patient testing
10 framework". By this time, in February 2021, was there
11 no such patient testing framework in place for the
12 hospitals in Wales?

13 A. Well, we did bring in a patient testing framework. The
14 testing programme was run through a thing called TTP,
15 Test, Trace, Protect. So there was a group working
16 within Welsh Government which was working on the policy
17 for testing and that would be for testing patients, for
18 testing members of the community, for testing healthcare
19 workers. So there was a group developing the framework
20 but I couldn't tell you from memory exactly where that
21 was in -- did you say January 2020?

22 Q. This is February 2021.

23 A. February 2021?

24 Q. Aside from the work of Test, Trace, Protect --

25 A. Yes.

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1 Q. -- was there not a framework for patient testing as part
2 of the infection prevention and control measures in
3 place for healthcare workers?

4 A. I believe there was. I believe there was a policy of
5 testing patients prior to admission, and I think
6 retesting ten days after admission, and that was a way
7 in which, from the previous graphs, you could try to
8 distinguish, not wholly, but try to distinguish between
9 patients who had become infected in the community and
10 then came into hospitals, from patients who were
11 contracting infection within the hospital.

12 So the short answer is I believe there was.

13 Q. So if there was already a testing framework in place,
14 why was that being proposed in February of 2021 in this
15 document, if it was already in existence?

16 A. Well, I can't tell you other than to read the sentence
17 which says that there's a revised testing strategy and
18 maybe it was about updating the patient testing
19 framework, but that's all I can surmise from what I see
20 in front of me.

21 Q. Thank you.

22 Could we go to page 7 of that document, please.
23 The top point there:

24 "Continue to provide robust advice on ... (PPE) in
25 the context of new variants ...

61

1 that specified in the UK guidance?

2 A. I don't believe so.

3 Q. We can take that down now, thank you, Lawrence.

4 There was an internal audit service report on the
5 NTG dated 1 September 2021 which you have provided to
6 the Inquiry.

7 Can we look, please, at INQ000022598, page 3,
8 please.

9 This is at tab 39 of your bundle if you would like
10 to go to the hard copy, Dr Atherton.

11 This service report noted that the Welsh
12 Government had issued guidance throughout the pandemic
13 to all trusts and boards and at paragraph 3.6 we can
14 see:

15 "We considered what further actions the [Welsh
16 Government] might take to ensure the guidance issued is
17 having the desired effect."

18 The final sentence says:

19 "The NTG ... routinely monitors rates of
20 transmission, as discussed below, but not with the
21 expectation there is a direct correlation between the
22 guidance issued and lower infection rates."

23 Could you explain that last sentence, please.

24 A. I could try. I mean, I think it reflects what I was
25 just describing to you, really, which is that it's the

63

1 "[Healthcare workers] have expressed concern about
2 the adequacy of PPE following the discovery of the new
3 more transmissible variants of COVID-19.

4 "The NTG will continue to address concerns raised
5 by [healthcare workers] and engage with colleagues from
6 the UK IP&C COVID-19 Guidance Cell to ensure the
7 provision of robust, evidence-based advice."

8 Is this a reference to the occasion that we
9 considered prior to the break, is this why the four
10 Chief Medical Officers had asked the UK IPC cell to
11 review the PPE specified in the IPC guidance, the PPE
12 specified?

13 A. The two may be related but whether they were directly
14 related or one was a consequence of the other I couldn't
15 say. I think, yes, there were still rumblings about PPE
16 and professional bodies were raising questions, quite
17 reasonably, and so I think the approach of the
18 Nosocomial Transmission Group quite rightly was to try
19 to engage with the system to try to understand and allay
20 some of those fears but also to work with the IPC cell
21 to make sure things were up to date.

22 Q. So far as you are aware, did the Nosocomial Transmission
23 Group ever advise that the PPE specified in the UK IPC
24 guidance should change or that healthcare workers in
25 Wales should have access to a higher level of PPE than

62

1 job of IPC to reduce transmission rates as much as
2 possible but you can't direct -- you can't eliminate the
3 issue. So I think it's really just a reiteration of
4 what we just discussed, to me, just reading it there.

5 Q. So the Welsh Government NTG were responding to issues of
6 nosocomial infection rates in Wales by issuing further
7 guidance about the importance of IPC measures but did
8 not expect there to be any correlation between that
9 guidance and lower rates of infection? This isn't
10 talking about eliminating nosocomial infection but
11 reducing it. So what was the purpose of issuing further
12 guidance if there was no expectation that that was going
13 to make any difference?

14 A. Well, it's an unusual line, I agree. You know, it's in
15 the internal audit report. You'd have to ask the
16 internal audit people exactly what they meant by it.

17 But certainly the task of the NTG -- sorry, the
18 role of IPC absolutely is to reduce infection rates, to
19 reduce nosocomial infection. So to that degree I would
20 disagree with the internal auditors in that comment.
21 But I don't know what they had in mind when they wrote
22 it.

23 Q. I think this is the internal auditors saying what the
24 expectation is of the Nosocomial Transmission Group
25 rather than their own expectation.

64

1 **A.** Yes, it is, yes. It's their interpretation of what they
2 think the NTG believes.

3 **Q.** Thank you.

4 The Nosocomial Transmission Group was stood down,
5 you say in your statement, on 28 March 2022. In the
6 time that it was active from May 2020 to that date, did
7 the Nosocomial Transmission Group identify what was the
8 primary cause or causes of these recurrent hospital
9 outbreaks in Wales?

10 **A.** It was the transmission of virus, as we discussed,
11 between patients, between members of staff, from
12 patients to members of staff and possibly to some degree
13 vice versa. I don't think that the NTG was able to
14 disentangle that. I think that there has been work at
15 UK level to try to understand that better but I don't
16 think we fully understand it. But the prime purpose of
17 the NTG was to reduce -- to monitor and reduce the level
18 of nosocomial transmission.

19 **Q.** The internal audit report that we saw was dated
20 1 September 2021. By the time that the Nosocomial
21 Transmission Group was stood down at the end of
22 March 2022, did it appear that it had been successful in
23 reducing the number or severity of hospital outbreaks of
24 Covid in Wales?

25 **A.** You will never know without applying the counterfactual
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1 for preventing transmission to patients were: firstly,
2 testing patients on admission; secondly, increasing
3 space between beds; and thirdly, decreasing hospital
4 occupancy.

5 Did you agree first of all with those conclusions
6 that were in the report?

7 **A.** Yes. The report is jointly issued by the CMOs so I'm
8 sure it's correct.

9 **Q.** To your knowledge, in Wales were there practical
10 difficulties in reconfiguring rooms and decreasing
11 occupancy which proved a barrier to implementing those
12 steps in Wales?

13 **A.** Yes. It's widely understood in Wales that the estate is
14 not as modern or as adaptable as it needs to be. A lot
15 of our hospitals are very old. They're from the 60s and
16 70s. Achieving good levels of patient care and
17 particularly IPC infection -- following IPC guidance is
18 a real challenge for many of our hospitals. So
19 absolutely, yes.

20 **Q.** On reflection, and perhaps with the benefit of the
21 hindsight, do you consider that sufficient steps were
22 taken to try to implement those aspects of IPC guidance
23 and to address nosocomial spread between patients in
24 Wales?

25 **A.** So my main route of knowledge of that, to answer your
67

1 what would have happened if the Nosocomial Transmission
2 Group had not been active. I would suggest things would
3 have been much worse. There would have been much less
4 advice and support to the health boards, who -- let's
5 remember, the health boards were responsible for
6 managing the risk around nosocomial transmission, not
7 the Welsh Government. The Nosocomial Transmission Group
8 did support them in all of that work. If it hadn't been
9 there, would things have been worse? I suspect it
10 would.

11 **Q.** Do you know if any final report was issued by the
12 Nosocomial Transmission Group at the point it was stood
13 down?

14 I can say that one doesn't appear in your witness
15 statement.

16 **A.** I don't recall one.

17 **Q.** Thank you.

18 In relation to effective IPC measures, I would
19 like to ask you about an observation in the Chief
20 Medical Officer's technical report. That's the
21 technical report of the four Chief Medical Officers to
22 which I think you contributed, Dr Atherton. I don't
23 think we need to get this up but it's at page 363 of
24 that report.

25 It indicated that the most effective IPC measures
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1 question, would be through medical directors who were
2 bending over backwards to try to manage, reconfigure the
3 space, meet the demands of patients coming in through
4 successive waves -- a very challenging time for them.
5 But they were all working with their estate colleagues
6 to try very hard to achieve those aims. The estate
7 worked against us in terms of its age and the
8 infrastructure that we had available.

9 **Q.** In terms of the estate, were you aware of any planning
10 or discussion around the possibility of other
11 interventions such as the use of air filtration or
12 improving ventilation systems?

13 **A.** I think all hospitals were looking at how they could
14 provide better ventilation. I wasn't working directly
15 with them or involved in discussions with the hospital
16 engineers, but there was -- by the middle of 2020 there
17 was a widespread recognition that because this was an
18 airborne transmission through respiratory --
19 a respiratory infection that better ventilation was
20 a part of the IPC, and in fact it features quite
21 significantly in the IPC guidelines.

22 So there were efforts to try to improve, but,
23 again, the estate didn't always make that easy.

24 **Q.** Were you aware of any steps that were taken or measures
25 that were proposed specifically in relation to patients
68

1 who had been identified as clinically extremely
 2 vulnerable, for example, prioritising those patients for
 3 single occupancy rooms?
 4 **A.** I don't know whether that happened in health boards.
 5 I do know that there was very close consideration of
 6 providing surgical masks to those patients when they
 7 were coming into hospital to support them.
 8 **Q.** Can we move on, please, to the shielding programme in
 9 Wales, having touched very briefly on the clinically
 10 extremely vulnerable.
 11 I think it's right that the shielding plans for
 12 the UK were developed by the four-nation Chief Medical
 13 Officers working together on that plan or that
 14 programme; is that right?
 15 **A.** There was a kind of clinical -- sorry, there's
 16 a clinical group who worked up the processes around that
 17 but the four Chief Medical Officers asked for that work
 18 and signed it off, I think, yes.
 19 **Q.** I think it's right that through that process, two lists
 20 of conditions, health conditions were formulated. One
 21 was those conditions giving rise to what was considered
 22 to be clinical vulnerability and those were: anyone over
 23 the age of 70 and then those under the age of 70 with
 24 certain specified health conditions such as diabetes,
 25 mild to moderate asthma and other respiratory diseases

69

1 Having issued that guidance for the clinically
 2 vulnerable, I don't think the Welsh Government issued
 3 any further guidance to that group of patients; is that
 4 right?
 5 **A.** You could well be right.
 6 **Q.** And then subsequently, I think on 18 March, the list of
 7 conditions identifying the clinically extremely
 8 vulnerable was cleared by the four Chief Medical
 9 Officers, and that included solid organ transplant
 10 recipients, people with specific cancers, severe
 11 respiratory conditions, rare diseases and inborn errors
 12 of metabolism that significantly increased the risk of
 13 infection, people on immunosuppressant therapies, and
 14 pregnant women with significant congenital heart
 15 disease.

16 I think it may follow from your previous answer,
 17 but did you have input directly in formulating the list
 18 of health conditions for the clinically vulnerable and
 19 clinically extremely vulnerable?
 20 **A.** No, I didn't.
 21 **Q.** During the process of discussing who should be on that
 22 clinically extremely vulnerable list, do you know
 23 whether any disabilities were considered as a criterion
 24 that should qualify for clinically extremely vulnerable?
 25 **A.** Well, "disability" is a very broad term.

71

1 and chronic diseases of the heart, liver, kidneys, some
 2 neurological conditions, those who were seriously
 3 overweight and pregnant women. That was the list of
 4 conditions giving rise to clinical vulnerability;
 5 I think that's right, isn't it?
 6 **A.** I think that was the starting point when the shielding
 7 programme was first envisaged.
 8 **Q.** I don't think these were people who were advised to
 9 shield but those who had been advised simply to follow
 10 stringently the social distancing advice that was given
 11 to the general population?
 12 **A.** You're right, there were broadly three groups: the
 13 general population; the more vulnerable people, broadly
 14 people who received the flu jab, that was as derived
 15 from first principles, really, thinking that they would
 16 be at increased risk; and then the clinically extremely
 17 vulnerable, CEV, clinically extremely vulnerable, who
 18 had specific conditions which would render them
 19 particularly likely to suffer serious harm or death if
 20 they became infected.
 21 **Q.** I think you set out in your witness statement that on
 22 17 March the Welsh Government issued guidance on social
 23 distancing and advised the clinically vulnerable group
 24 to be very stringent in following those social
 25 distancing measures.

70

1 **Q.** Were there any specific disabilities that were
 2 considered?
 3 **A.** Not initially perhaps but in later phases people with
 4 Down's syndrome were given specific consideration.
 5 **Q.** I think that was on 30 September 2020 as a result of the
 6 work that had been done on QCovid. I think that was
 7 Sir Chris Whitty's work on QCovid. It was agreed
 8 between the four UK Chief Medical Officers that patients
 9 over 18 with Down's syndrome and, indeed, chronic kidney
 10 disease should be added to the shielded patient list?
 11 **A.** If I may, it was slightly more complicated than that.
 12 People with Down's syndrome, adults with Down's syndrome
 13 were not initially on the list because there wasn't an
 14 understanding that they were at particular risk. And
 15 the issue came back twice actually to the clinical panel
 16 which was led by Dame Jenny Harries, and I can't
 17 remember why it came back the first time, I think in
 18 June or July it came back, and they looked at it -- it
 19 probably came about because we were being asked by
 20 patient representative groups to look at it, and in June
 21 there was no particular evidence that people in those or
 22 people with Down's syndrome had a higher level of
 23 mortality. So at that point the decision was not to
 24 include them.

25 Then it came back a second time because there was

72

1 further published evidence in one of the journals that
 2 there was actually an increased risk of harm and death
 3 in people with Down's syndrome. So probably by August
 4 or September it came back the second time through the
 5 clinical panel which made a recommendation to the CMOs
 6 that people with Down's syndrome should be included on
 7 the shielding list and at that point they were.

8 **Q.** Can I ask you this: once that decision had been made on
 9 30 September 2020, were adults with Down's syndrome in
 10 Wales contacted about the decision to include them on
 11 the shielded patient list?

12 **A.** They were.

13 **Q.** Thank you.

14 Do you know when that happened?

15 **A.** I don't off the top of my head, no.

16 **Q.** Thank you.

17 So if we can go back, please, to that initial
 18 stage in March of 2020 when there was some delineation
 19 of the different health conditions that would be
 20 considered to give rise to clinical extreme
 21 vulnerability, were you involved in the decision-making
 22 to delineate between those two groups and to advise the
 23 extremely vulnerable to shield but not the clinically
 24 vulnerable?

25 **A.** In the decision, yes. The broad proposals had been

73

1 otherwise we wouldn't have written to them. But the
 2 numbers would have been so enormous that you couldn't
 3 possibly -- well, it would be like asking -- you might
 4 as well ask the whole population to shield which is
 5 essentially what we did when we moved into lockdown.

6 **Q.** Were economic considerations part of that decision that
 7 it would not be workable to ask?

8 **A.** I don't remember them being discussed at CMOs group at
 9 all, no.

10 **Q.** Once the list of conditions of the clinically extremely
 11 vulnerable had been finalised on 18 March, then the
 12 patients in Wales with those conditions had to be
 13 identified and contacted with the shielding advice and
 14 I think you co-ordinated that operation as Chief Medical
 15 Officer; is that right?

16 **A.** Well, I didn't co-ordinate it personally, you will
 17 understand, but a group that worked within my
 18 directorate was set up to do the really quite difficult
 19 technical job of identifying those patients and then
 20 writing to them and keeping in contact with them.

21 **Q.** I think that process of identifying the patients was
 22 a two-phase process; is that right?

23 **A.** Well, it was two-phase in as much as initially the
 24 patient groups were -- yes, were defined, and then there
 25 was a second phase when the QCovid that you described,

75

1 drawn up, as I say, from first principles. Sir Chris
 2 Whitty I think had done a think piece on it. We were
 3 all concerned about specific groups in the population.
 4 Remember, we didn't know an awful lot about Covid or the
 5 impact it was going to have at that time but we had seen
 6 with pandemic flu, for example, that specific groups
 7 were more vulnerable and so there was thinking about --
 8 and recognising that the population had no immunity, we
 9 were thinking about, well, what could we do? The
 10 original term was "cocooning", the idea was to cocoon
 11 people, and that then morphed into the terminology of
 12 shielding.

13 So yes, I think these came to the four CMOs, we
 14 agreed it was a good idea, and a clinical panel then
 15 worked up the details.

16 **Q.** Can I ask you about this distinction between the
 17 clinically extremely vulnerable who were advised to
 18 shield and the clinically vulnerable who had been
 19 identified and told by letter that they were at
 20 additional risk of developing severe complications from
 21 Covid-19 but they were not advised to shield. Did you
 22 have any concerns that that group were at additional
 23 risk but were not given the protection, as it were, of
 24 the shielding programme?

25 **A.** Well, there were some additional risks, quite clearly,

74

1 the QCovid -- came to fruition, yes.

2 **Q.** So was QCovid used in Wales then to identify patients on
 3 the shielded patient list?

4 **A.** Indirectly. The same criteria were applied in Wales but
 5 what we didn't have in Wales was an IT system which
 6 could very rapidly identify those people. So there was
 7 a huge amount of work that had to be done by digital
 8 healthcare Wales to try to marry up the IT
 9 infrastructure, the databases, the different databases
 10 to identify those patients.

11 So in a very -- it was a technical process which
 12 was very elaborate and way beyond my understanding but
 13 they did manage to do that.

14 Now, having said that, there was always
 15 a recognition that there would be some patients who were
 16 missed, some patients who were included but shouldn't
 17 have been included. So it was a bit like any screening
 18 programme that people were -- there were false positives
 19 and false negatives, but they did the best they could,
 20 I think, to interrogate the databases and make them work
 21 together.

22 **Q.** I think you have identified in your witness statement
 23 something in the region of 12 different databases that
 24 had to be interrogated --

25 **A.** Yes.

76

1 Q. -- in order to identify those patients --
 2 A. Yes.
 3 Q. -- with those conditions.
 4 If there was, in a future pandemic, again
 5 a decision to undertake a shielding programme and to
 6 identify a particular cohort of patients, do you
 7 consider that the data systems are now in place in Wales
 8 to enable that to be done more quickly than in 2020?
 9 A. No, I don't, if I'm honest. I don't. I think there's
 10 a huge job in terms of improving the digital
 11 connectedness of the various databases that we hold. We
 12 are behind the curve in Wales on digital records.
 13 There's a huge effort to try to improve that but we are
 14 behind. So I think it's absolutely the case that we
 15 need to strengthen those systems.
 16 Q. And are any steps being taken in that regard?
 17 A. There is a Chief Digital Officer within Welsh
 18 Government. There is a counterpart in the NHS Executive
 19 that we've just described. We do have -- we've
 20 relatively recently, by which I mean a couple of years
 21 ago, reorganised our digital support at Welsh Government
 22 level through digital healthcare Wales. So there's
 23 a huge amount going on and work with the health boards
 24 but --
 25 Q. Is anything specific happening to try to align those

77

1 the letter sent to the clinically extremely vulnerable
 2 advising them not to leave their house for at least
 3 12 weeks -- we know, I think, that that 12-week period
 4 was extended until August ultimately -- to strictly
 5 avoid contact with anyone with Covid-19 symptoms.
 6 Did you have any concerns about the potential
 7 effects of this on the clinically extremely vulnerable
 8 in terms of the potential for social isolation?
 9 A. I think it was very high in our minds that this was not
 10 an easy thing to ask anybody to do, to remain isolated
 11 from society as much as possible, absolutely.
 12 Q. Did you take any steps to address that risk?
 13 A. The main steps I took personally were to make sure that
 14 we continued to correspond, to contact with these
 15 people. Obviously there was support that was put in
 16 around the clinically extremely vulnerable in terms of
 17 access to services, access to primary care, access to
 18 food deliveries, to pharmaceutical supplies, et cetera.
 19 So there was some things in that space, yes.
 20 Q. Thank you.
 21 Can we look at page 2 of that letter, please.
 22 This explains at number 1, the bottom of that
 23 page, that visits from carers or healthcare workers
 24 would continue as normal. Clearly people who had been
 25 identified as clinically extremely vulnerable were going

79

1 different --
 2 A. No, that's a great question. I mean, the -- I think for
 3 a future pandemic we need to have a much simpler way of
 4 identifying who are the vulnerable. Of course, in
 5 a future pandemic the vulnerabilities may be different.
 6 It may be a different group.
 7 But we need better marrying up of the digital
 8 infrastructure to allow that to happen, but something
 9 specific to future pandemics would, I think, be very
 10 useful.
 11 Q. Is there also an issue about primary care systems not
 12 talking to one another and also not being compatible
 13 with secondary care database systems?
 14 A. There is. Compatibility across primary and community
 15 care is a problem. There's also very significant issues
 16 around personal data and the use of personalised data
 17 within the NHS, which we continue to grapple with.
 18 I mean, patients have to give licence, they have to give
 19 agreement that their data can be used in a certain way.
 20 So all of that absolutely needs to be worked out.
 21 I don't think that's specific to Wales, I think
 22 that's an issue across the piece, to be honest.
 23 Q. Thank you.
 24 Can we look please briefly that shielding letter
 25 that was sent in your name on 24 March 2020. This was

78

1 to have greater healthcare needs than the rest of the
 2 population. And it explained there, in the second line:
 3 "All carers or support workers must wash their
 4 hands with soap and warm water for 20 seconds when they
 5 enter your home and often while they are in your home."
 6 There was certainly nothing in that letter about
 7 PPE or other IPC measures that could protect shielding
 8 patients from the risk of infection by healthcare
 9 workers or carers coming to visit them in their home.
 10 Did that omission, in your view, expose the clinically
 11 extremely vulnerable to a foreseeable and avoidable
 12 risk?
 13 A. Have you got the tab number for it, please?
 14 Q. It's tab 44 --
 15 A. Thank you.
 16 Q. -- in your bundle, and it's the second page of the
 17 letter.
 18 A. So, yes, looking back, would it have been good to
 19 include something like that? Certainly supplies of PPE
 20 were being provided through councils to help -- to
 21 social care workers at that time. With hindsight it
 22 would have been a good idea to include it.
 23 Q. So do you think that the effectiveness of the shielding
 24 programme would have been improved by explicitly
 25 addressing the risk of infection from healthcare workers

80

1 and including some measures to mitigate that risk?
 2 **A.** It may well have done, and whether they were included in
 3 subsequent advice I don't know. This, of course, was by
 4 24 March, which was really quite -- still quite early
 5 on. But, yes, I would agree with your point.

6 **Q.** Thank you.

7 I think we can take that down now, thank you,
 8 Lawrence.

9 The shielding programme in Wales I think diverged
 10 from the other nations of the UK in the summer of 2020
 11 when the clinically extremely vulnerable in Wales were
 12 advised to shield until 16 August, as originally
 13 notified, and the programme in the other nations of UK
 14 was paused from 31 July.

15 You've explained that your advice to the minister
 16 to align with the other nations was rejected by the
 17 Welsh health minister, partially because of concerns
 18 about disability rights groups and other advocates for
 19 the shielding and also the minister's understanding that
 20 some people had felt abandoned and not liberated by
 21 being taken out of shielding.

22 I would like to ask whether the minister's -- what
 23 your view was of the minister's decision in July of 2020
 24 to continue to advise them to shield.

25 **A.** Well, I was entirely comfortable with the decisions that

81

1 on the shielded patient list to take extra care during
 2 periods of high community infection rates. Was the
 3 shielding programme restarted again at any point during
 4 the pandemic after 16 August 2020?

5 **A.** No, I don't think it was. I think when we got into
 6 possibly the Omicron wave, we contacted people to advise
 7 them not to fully shield but that it wouldn't have been
 8 sensible to go to -- no, I'm wrong. It wasn't the
 9 Omicron, it was -- it was Christmas. It was the
 10 Christmas of 2020 wave, the second wave, that we advised
 11 people not to go to work or to school but to remain at
 12 home. So it wasn't full shielding.

13 **Q.** There wasn't a formal restarting of the shielding
 14 programme?

15 **A.** No. No, indeed not.

16 **Q.** Thank you. I think it's right that the Welsh Government
 17 itself did not undertake any assessment of the
 18 effectiveness of the shielding programme in Wales or the
 19 impact of shielding on the clinically extremely
 20 vulnerable, although it did facilitate some research
 21 into that led by Professor Helen Snooks at
 22 Cardiff University, and I would like to ask you about
 23 the report that Professor Snooks has provided to this
 24 Inquiry, which has been provided, I think, to you.

25 I'd like to ask you about your views of

83

1 ministers make. Of course I was. The background to
 2 that, though, was that originally my advice to pause the
 3 shielding at exactly the same time as the other nations
 4 was to avoid that divergence, which we know causes
 5 confusion and alarm. So that was the basis of my
 6 advice.

7 But in the short-term before that I think, I'd
 8 been to a meeting of the -- which a different minister,
 9 minister for social policy, I can't remember which
 10 minister, a different minister, not a health minister,
 11 was chairing -- of the disability equality group, and
 12 we'd heard very loud and clear from disabled
 13 representatives -- sorry, not representatives of
 14 disabled but representatives of disabled groups in that
 15 forum that that commitment had been given to extend the
 16 screening to -- by an additional two weeks. And so
 17 there was a very clear steer through that forum.

18 I think that is what probably influenced the First
 19 Minister in his decision-making. But your question, you
 20 know, was -- your question was what did I think about
 21 the decision. Are you asking was I angry because there
 22 was a variance? No, of course not. I understood it
 23 absolutely.

24 **Q.** I think after shielding was paused in Wales from
 25 16 August 2020, you also wrote out again to advise those

82

1 Professor Snooks' conclusions at paragraph 146 and 148
 2 of that report as to the effectiveness of the shielding
 3 programme. These are the conclusions of --

4 **A.** Tab number, if I may? Oh, you are not putting it up.
 5 That's okay. I can listen.

6 **Q.** "There is no evidence" -- this is Professor Snooks'
 7 conclusion:

8 "There is no evidence of overall reductions in
 9 Covid-19 infection associated with shielding ... There
 10 is evidence that hospital acquired infection was higher
 11 in the shielded group. As the mechanism for protecting
 12 [clinically extremely vulnerable] people from serious
 13 harm of death during the pandemic is to avoid infection,
 14 these results cast doubt on the effectiveness of the
 15 shielding policy."

16 At paragraph 148:

17 "There is little high-quality evidence on the
 18 impact of shielding on mortality but those researchers
 19 that have investigated this have not found consistent or
 20 sustained effects ... Although some uncertainty remains,
 21 with findings from several studies -- using different
 22 approaches -- showing increased infections, mortality
 23 and Covid-19-related mortality associated with
 24 shielding, we conclude that shielding did not have the
 25 protective effect that was hoped for."

84

1 I'd like to ask for your views on those
2 conclusions as the Chief Medical Officer who had
3 responsibility for some of the oversight of the
4 shielding programme in Wales.

5 **A.** Yes, thank you. I mean, it's an interesting finding.
6 Obviously it's something that we need to give careful
7 consideration to in terms of in any -- the question as
8 to whether in any future pandemic shielding would be an
9 appropriate tool to use.

10 It is a rather definitive statement, you know,
11 that Professor Snooks is making. I suspect that there's
12 more evaluation, more evidence, that needs to come to
13 bear and that needs to be consolidated in a body of
14 evidence to inform future planning.

15 What I can say is, you know, the individuals --
16 some individuals who I've spoken to who were shielding
17 did feel supported and they valued that. So maybe
18 there's a question of mortality which absolutely needs
19 to be worked through, but there's a question also about
20 how we support the most vulnerable people in our
21 communities and if there are other ways that the Inquiry
22 can identify to support those people through very
23 difficult times, then that would be a splendid thing to
24 have as a recommendation. But I can't off the top of my
25 head think what they are.

85

1 say I became aware that there was an issue with
2 Long Covid, but relatively early on there had been
3 a recognition that viruses can lead to -- the viruses
4 such as coronavirus can lead to post-viral syndromes,
5 and I think a group was set up in Welsh Government to
6 start to consider that. I wasn't directly involved with
7 that.

8 **Q.** Can I ask you this then, Dr Atherton: once you were
9 aware of at least the potential for long-term
10 consequences, how did you factor that potential harm in
11 to your advice to the minister?

12 **A.** I think it's fair to say that in the very early days of
13 the pandemic it wasn't top of the mind. It wouldn't
14 have been, and I don't think it should have been,
15 because we were trying to work out how to reduce
16 infections to a level which would keep people alive,
17 stop people dying, and stop the hospitals becoming
18 overloaded. That was absolutely the priority in the
19 early days.

20 In later times, say, from -- I don't know --
21 roughly, say, September/October onwards perhaps, when we
22 got into the pause between the first and the second
23 wave, and at that time we were starting to get stories
24 of people who were having long-term sequelae of the
25 infection. We didn't know an awful lot about Long Covid

87

1 So I accept the report but it's only one report.
2 It's not -- I don't think it should be as definitively
3 stated as it is that it had no impact in terms of
4 mortality, and it probably had other impacts in terms of
5 people feeling supported and enabled.

6 **Q.** Thank you.

7 Can we move on now, please, to a different topic:
8 the impact of Covid-19 and inequalities and the
9 exacerbation of inequalities during the pandemic.

10 You've set out in your witness statement the four
11 harms of the pandemic which had been articulated,
12 I think, by Sir Chris Whitty, and these were taken into
13 account, you say, when advising the Welsh Government.

14 Those harms included: direct harm from Covid-19;
15 indirect harms if services became overwhelmed; harms
16 from non-Covid illness if medical services were not
17 accessed; and socio-economic harms from the imposition
18 of pandemic restrictions.

19 Did direct harm from Covid include at any point
20 the impact of Long Covid?

21 **A.** Yes.

22 **Q.** And at what point did you become aware of the impact of
23 Long Covid in terms of providing your advice to the
24 minister?

25 **A.** Oh, I don't think there's any particular point I could

86

1 at that point. Of course, we don't know an awful lot
2 about it now; there's still a lot more we need to learn.

3 So from that point, the consequences would have
4 been factored in certainly through the TAC advice that
5 was coming through.

6 **Q.** Thank you.

7 **A.** I do remember them reflecting on that but, as the
8 pandemic unfolded, increasingly that became a concern.

9 **Q.** Thank you.

10 I think a fifth harm of Covid or the pandemic was
11 added by the tactical advice group in July of 2021, and
12 this was focused on harm due to Covid creating or
13 exacerbating inequalities in society.

14 Can I ask you this: prior to July 2021, had
15 a consideration of health inequalities and their
16 potential exacerbation informed the advice that you
17 provided to the Welsh Government or to the healthcare
18 system in Wales?

19 **A.** Yes, it absolutely had. The adding -- the addition of
20 the fifth harm, it was recommended through TAC --
21 obviously, the ministers signed up to that. Ministers
22 in Wales are very focused on tackling inequalities and
23 reducing inequalities.

24 So two things I should say. One is, really from
25 early days in the pandemic, we had an economic and

88

1 social subgroup of the Technical Advisory Cell --
 2 I think it was, yes, a subgroup of the cell and that was
 3 focused very much on economic harms to people and very
 4 much also on the inequalities and the impacts on
 5 particularly more marginalised people in Wales.

6 Then the other thing I would add is that
 7 throughout all the advice I gave to ministers, I was
 8 conscious that the impact of the pandemic was not
 9 falling equally on the whole of society.

10 It was -- there were different groups, of course.
 11 We can talk about black, Asian, minority ethnic groups
 12 bearing a heavier burden. I was very concerned about
 13 socio-economic groups who were really facing the brunt
 14 of this. I was really worried at one point, at several
 15 points within the pandemic, about migrant workers and
 16 people living in really quite difficult, straitened
 17 circumstances. There were individual groups -- such as
 18 taxi drivers -- again, low socio-economic status
 19 relatively, who had specific needs.

20 So we tried to include the information we were
 21 getting on all of these groups into the advice we were
 22 giving through to ministers and we tried to find ways of
 23 ameliorating that harm, so that the poorest, the people
 24 being most disadvantaged by Covid were given the
 25 additional support that they needed.

89

1 be taken either by the Welsh Government or NHS bodies to
 2 try to mitigate those risks and avoid the exacerbation
 3 of inequalities?

4 **A.** Well, I think, yes, following on from my previous answer
 5 really. You know, when we became aware of specific
 6 issues affecting specific groups, we tried to find ways
 7 to solve it.

8 **Q.** Can you give us some examples?

9 **A.** Yes, of course I can.

10 We had issues when vaccines became available. We
 11 had issues with low uptake in some communities, some of
 12 our Asian communities in particular, and so the First
 13 Minister asked -- we worked very closely with our
 14 colleagues in BAPIO (that's the British Association of
 15 Physicians of Indian Origin), a very, very supportive
 16 group in Wales, and we set up specific centres in places
 17 where their communities could easily access information
 18 and get the vaccines.

19 I talked about taxi drivers. I met with the taxi
 20 driver associations and had a long conversation with
 21 them about how they could protect themselves, you know,
 22 given that they're driving around in a vehicle with
 23 people who might potentially have Covid, and that led to
 24 Welsh Government putting in screens in the taxi cabs, as
 25 an example. So there are micro-examples like that.

91

1 **Q.** I think you presented a paper to the Executive Director
 2 Team in June of 2020 called "Covid-19 and Health
 3 Inequalities". I don't think we need to get it up. It
 4 is behind tab 20 in your bundle.

5 But I think that that paper identified the sort of
 6 inequalities that you have set out now, both by
 7 socio-economic position and in terms of a greater impact
 8 on black and minority ethnic communities. And I think
 9 there was also a report on the impact of Covid on black
 10 and minority ethnic communities produced by the First
 11 Minister's advisory group. I don't think your office
 12 had direct input into that report; is that right?

13 **A.** Well, one of my team who was a member of that panel that
 14 looked at that, Heather Payne, a very talented
 15 paediatrician who worked with us -- also led the MEAG
 16 work, the ethical work -- and she was closely involved
 17 in Judge Ray Singh's panel and also in the subgroup that
 18 worked on developing a risk assessment tool for health
 19 workers.

20 So we had some involvement but I wasn't personally
 21 directly involved, you are correct.

22 **Q.** Can I ask you this: various reports presented the data
 23 on the unequal impact of Covid-19 and identified some of
 24 those issues in relation to inequalities for various
 25 groups in Wales. Did you identify any specific steps to

90

1 **Q.** But if I could focus on the healthcare system
 2 specifically rather than wider steps, one of the
 3 recommendations in the First Minister's Advisory Group
 4 report was to take immediate action on the quality of
 5 recording ethnicity data in health and social care
 6 services.

7 Do you know if that was done; whether there had
 8 been any steps to improve data collection?

9 **A.** Yes, I think it was done. I think there is -- there was
 10 an extension, I think, of mortality data collection to
 11 address that issue. I think we talked with ONS (the
 12 Office for National Statistics) about that and I think
 13 that did become available through the ONS.

14 **Q.** I'm not asking about the broader data that's collected
 15 by the Office for National Statistics but in terms of
 16 the data, the ethnicity coding in hospitals, in primary
 17 care, so within the NHS in Wales, were any steps taken
 18 to improve collection of ethnicity data?

19 **A.** I'm sorry, I can't remember. I can't help you on that.

20 **Q.** Thank you.

21 You mentioned the risk assessment tool that was
 22 developed and that, I think, particularly had regard to
 23 black and minority ethnic healthcare workers having
 24 increased risks.

25 Do you know whether it was mandatory for the NHS

92

1 bodies in Wales to ensure that all healthcare workers
 2 were risk assessed using that tool?
 3 **A.** I don't recall it being mandatory, but certainly the
 4 tool was made available and widely used by health boards
 5 and welcomed by them. But I don't remember it being --
 6 **Q.** Was that use monitored by the Welsh Government? Did the
 7 Welsh Government collect any information from the health
 8 boards?
 9 **A.** I don't believe so.
 10 **MS NIELD:** Thank you.

11 My Lady, I wonder if that's a good point.

12 **LADY HALLETT:** Certainly. 2.00, please.

13 (1.03 pm)

14 (Luncheon Adjournment)

15 (2.00 pm)

16 **MS NIELD:** Just two more topics, if we may, both of which
 17 relate to ethical issues in clinical decision-making
 18 during the pandemic, and the first of those concerns
 19 a clinical prioritisation tool.

20 Did you consider that if at some point in the
 21 pandemic demand exceeded critical care capacity that
 22 clinicians would need a national decision-making tool
 23 with clear criteria to apply to ensure that those
 24 decisions were based on an agreed approach and
 25 consistent across Wales?

93

1 **Q.** I think that as was in March 2020, does that --
 2 **A.** Quite likely, quite likely.
 3 **Q.** Was that taken forward?
 4 **A.** In Wales I think what happened was that the Welsh
 5 clinicians were engaged with that work and they
 6 obviously knew that that work was going on and so the
 7 Welsh Intensive Care Society actually produced
 8 a document which it circulated to the system which
 9 provided advice should we get into that position. It
 10 was trying to prepare the system for if we reached that
 11 unfortunate position where we couldn't meet the needs of
 12 the population.

13 **Q.** I think that was the decision-making tool that was also
 14 produced with the Wales Critical Care and Trauma
 15 Network.

16 **A.** Exactly. Yes, it was.

17 **Q.** Perhaps we can have a look at that document, please.
 18 It's INQ000338460.

19 It's behind tab 46, I hope, in your bundle,
 20 Dr Atherton, if we need to look at it.

21 The "Wales Critical Care and Trauma Network", is
 22 that an NHS Wales body? What's the status of that
 23 organisation?

24 **A.** Sorry, the Welsh --

25 **Q.** The Welsh -- we can see that its badged here, NHS,

95

1 **A.** Yes, that was a material consideration for us. You will
 2 remember back in the days, late February early March, we
 3 were looking at what was that happening in Italy and
 4 watching the difficulties that hospitals systems were
 5 experiencing there and there was a real visceral fear
 6 that we would get into that same position in the UK and
 7 in Wales. So there was some thinking about what would
 8 we do if we reached that point and how would we make
 9 sure that people had access to services, how would we
 10 prioritise care for people if we reached that point
 11 where the system could no longer cope with the demands
 12 that were placed on it.

13 **Q.** And did the Welsh Government in fact produce
 14 a decision-making tool to assist clinicians in the event
 15 that they needed to make those kind of prioritisation
 16 decisions?

17 **A.** No, it didn't, but the Welsh Intensive Care Society
 18 produced one.

19 Just to go back a bit, there were discussions at
 20 the four nations I think through the Senior Clinicians
 21 Group about what we would do and there was some work
 22 which was initiated by intensive care leads at UK level
 23 to develop a decision-making tool to help with that
 24 issue should it arise. So there was some work that
 25 happened at UK level --

94

1 "Wales Critical Care and Trauma Network". Is that part
 2 of the NHS bodies?

3 **A.** It's not a body, a formal body in its own right, but
 4 it's a pulling together of critical care leads from
 5 across the different health boards to provide
 6 leadership. We have a number of networks in Wales.
 7 This would be one of them, yes.

8 **Q.** Thank you.

9 We can see that that's dated 13 April 2020.

10 If we can go to page 5 of that document, please,
 11 this is the tool itself and we see that there are four
 12 numbered factors to take into account "Assessment of
 13 critical care benefit and risk". Number 1 is age, with
 14 an arrow pointing from age below 50 to above 80; and
 15 then number 2, a clinical frailty scale going from very
 16 fit to terminally ill; and then number 3, a comorbidity
 17 box that lists a number of conditions with empty boxes
 18 next to them, tick boxes; and number 4, female and male
 19 with the arrow pointing towards "male".

20 Below that, "critical care escalation":

21 "Unless patient with capacity declines for full
 22 escalation where necessary."

23 Then:

24 "May benefit from critical care admission --
 25 consider discussion."

96

1 And then:
2 "Less likely to benefit from critical care
3 admission."
4 So we can see that the clinical frailty scale is
5 included there but not with a numerical scoring system;
6 is that right?

7 **A.** Correct, yes.

8 **Q.** I think by email of 10 April 2020 this tool was
9 circulated to you and at that time I think it did
10 include a numerical scoring system. Do you recall that?

11 **A.** I do recall it very well, and can I clarify as well.
12 You know I referred to the work that was done at UK
13 level which did come back to the Senior Clinicians Group
14 and that did have a scoring system on it and when it
15 came back we recognised that it was not appropriate and
16 so it was never agreed at a UK level. I think the same
17 discussion partly played out in Wales.

18 I think you're right that there was a version
19 which had a scoring system and it was felt that that was
20 an inappropriate thing to have on a document of this
21 nature.

22 **Q.** What was the problem with having -- or perhaps I can put
23 it another way. Why was it appropriate to have this
24 clinical frailty scale set out but without the numbers?
25 How did removing the numbers from this render it

97

1 used in isolation and must be read in conjunction with
2 the narrative". And the narrative explains that
3 individualised decision-making is absolutely what we
4 need to achieve.

5 So as a tool to assist in that process I think
6 this was a very useful thing but on its own, certainly
7 with a scoring system, a numerical scoring system, it
8 was seen as not appropriate.

9 **Q.** There's still an arrow going from the bottom of the
10 clinical frailty scale to the top of the clinical
11 frailty scale. So were clinicians not taking into
12 account exactly the same factors, just without
13 a numerical scoring system?

14 **A.** These are all things to think about. So the arrow also
15 applies to the less than 50 to the over 50. All it's
16 saying is that the risk of intensive care increases as
17 you go up that -- up the arrows and the benefits
18 decrease. That's all it's saying.

19 So it's helping -- it's intended to help
20 clinicians decide who can best benefit from intensive
21 care facilities. Something that they have to decide on
22 a daily basis within or without the Covid issue.

23 **Q.** Were you made aware during the pandemic of any incidence
24 of individuals being denied escalation in their care
25 simply due to their age -- in Wales?

99

1 appropriate?

2 **A.** Well, the problem with the scoring system was it was
3 viewed as being too medicalised. There were concerns
4 which were expressed -- because there was quite a wide
5 consultation at UK level on the document but quite late
6 on there were concerns expressed, particularly by
7 charities and bodies representing disabled people, that
8 the CFS, the clinical frailty score, by itself was --
9 could lead to -- you can't be too objective with it,
10 it should be regarded as a subjective thing, and that
11 the way that a treating clinician views a person's
12 health and the value that that person places on their
13 health isn't necessarily the same value that a person
14 would place on their health.

15 So it became highly problematic and on that basis
16 we never approved at the four nations level the use of
17 a scoring system.

18 **Q.** If we can come back to this document --

19 **A.** I'm about to. So what this document I think very
20 sensibly does, and you need to read it of course in its
21 entirety because I felt that this was an excellent
22 communication from the lead clinicians here into the
23 system, but they made it extremely clear that both the
24 tool here, the appendix 1, the tool -- there it is in
25 black and white at the top: "this tool should not be

98

1 **A.** Denied ...

2 **Q.** Escalation of care --

3 **A.** No.

4 **Q.** -- due to their age?

5 **A.** No, I wasn't, no.

6 **Q.** Was this tool in this final form without the numerical
7 scoring system, was this approved by the Welsh
8 Government?

9 **A.** No.

10 **Q.** Can we have a look at your email about this.
11 INQ000484821. It's behind tab 37 in your bundle,
12 please. Can we go, I think, to the -- down to the next
13 page.

14 This is where you say: the approach is fine, it's
15 the scoring system which is causing the anxiety at the
16 moment.

17 Then if we can go up to the first page, please,
18 and this is your deputy Chris Jones saying:

19 "Yes agreed, very helpful suggestion."

20 So this tool had been circulated to you, or to the
21 Office of the Chief Medical Officer, and you've been
22 asked for your input on this and you have given your
23 input and they have accorded with your suggestion of
24 removing the numbers.

25 **A.** Yes.

100

1 **Q.** So what did the Welsh Government do in relation to this
 2 tool? Was it circulated amongst -- what --
 3 **A.** Yes, it was circulated by the Welsh -- excuse me, by the
 4 Welsh Intensive Care Society and the trauma network. So
 5 it was circulated to all the relevant clinicians.
 6 **Q.** Do you know whether that tool was used within local
 7 health boards to make decisions about prioritising
 8 patients for critical care?
 9 **A.** I suspect it was helpful to clinicians but I don't know
 10 that for sure. You'd have to ask them.
 11 **Q.** Can we come on, please, to the topic of do not attempt
 12 cardiopulmonary resuscitation (DNACPR) notices.
 13 I think there was, throughout and prior to the
 14 pandemic, an All-Wales DNACPR policy for medical
 15 professionals --
 16 **A.** Yes.
 17 **Q.** -- calling Sharing and Involving. I think the version
 18 in circulation at the beginning of the pandemic was
 19 version 3, published in 2017, and that was updated
 20 in 2020.
 21 Did the Office of the Chief Medical Officer have
 22 any involvement in formulating that DNACPR policy for
 23 Wales?
 24 **A.** Well, I didn't have any personal involvement. Now,
 25 Chris Jones may well have been involved and discussed it

101

1 **A.** I'd have to read through the policy to see whether it's
 2 mentioned in there but I think it would be appropriate
 3 for it to be one of the considerations which clinicians
 4 would use to determine about whether an attempt at
 5 cardiopulmonary resuscitation should be made.
 6 **Q.** Thank you.
 7 If we can look at page 2 you identify that:
 8 "There have also been concerns raised by the Older
 9 People's Commissioner ... about the care and treatment
 10 options that will be available to older ... people, some
 11 of who have felt pressurised into signing DNACPR forms."
 12 You have gone on to say that you were not aware of
 13 any CPR decisions being made purely on the basis of an
 14 individual's age, disability, autism, mental illness or
 15 other condition but nevertheless you felt it important
 16 to write out to the system to provide some measure of
 17 reassurance; is that correct?
 18 **A.** That is correct, yes.
 19 **Q.** You go on to say age, disability or long-term condition
 20 alone should never be a sole reason for issuing a DNACPR
 21 order against an individual's wishes.
 22 Was that your understanding at the time that it
 23 was necessary to have patient consent to a DNACPR order?
 24 **A.** Yes.
 25 **Q.** Thank you.

103

1 with the clinicians who led on it, because it was
 2 a clinically-led document, and in as much as it became
 3 a Welsh policy, it would have been approved, you know,
 4 by -- ultimately by the minister I guess.
 5 **Q.** Thank you.
 6 Now, in relation to issues around DNACPR notices
 7 during the pandemic, on 17 April you, together with the
 8 Chief Nursing Officer of Wales, issued a joint letter to
 9 all the local health boards.
 10 Can we get that up, please. It's INQ000300106.
 11 This is behind tab 41 in your bundle if you want
 12 to look at the paper copy, Dr Atherton.
 13 **A.** Thank you. Yes.
 14 **Q.** If we can move down that page, please, on page 1.
 15 You've indicated that you'd been made aware:
 16 "Recently, we have been made aware of concerns
 17 from the groups advocating for disabled and learning
 18 disability communities in Wales about how the Clinical
 19 Frailty Scale ... could be used inappropriately in
 20 making decisions on escalation of care and 'do not
 21 attempt cardiopulmonary resuscitation' ... for
 22 individuals being treated for Covid-19."
 23 Just pausing there, under the All-Wales DNACPR
 24 policy, would it be appropriate to take the clinical
 25 frailty scale into account when imposing a DNACPR?

102

1 **A.** I need to clarify that. So if a patient has mental
 2 capacity, then it's clearly a duty on doctors to have
 3 that discussion with a patient before they make that
 4 decision. It becomes problematic where people don't
 5 have mental capacity, in which case the discretion would
 6 normally be had with the relatives or ...
 7 **Q.** If I can take you back, not to have a discussion but to
 8 have consent.
 9 **A.** Yes.
 10 **Q.** Did you consider it was necessary to obtain a patient's
 11 consent to a DNACPR order or did you think that that was
 12 a clinical decision for a doctor that should be
 13 discussed but wasn't determined by --
 14 **A.** I think there can be -- it would be very unusual to have
 15 a DNACPR order without the patient's consent but the
 16 patient can't always give consent, of course.
 17 **Q.** Thank you.
 18 You go on to say:
 19 "It remains essential that decisions are made on
 20 an individual and consultative basis with people. It is
 21 unacceptable for advance care plans, with or without a
 22 DNACPR form completion to be applied to groups of people
 23 of any description. These decisions must continue to be
 24 made of an individual basis according to need and
 25 individual wishes."

104

1 What was it about advance care plans that was
2 objectionable in your view?

3 **A.** It wasn't advance care plans which were objectionable.
4 I think advance care plans are excellent if used
5 appropriately and we have a whole process in Wales of
6 developing advance care plans.

7 **Q.** Can I take you to the wording, please, of the letter
8 that you sent out:

9 "It is unacceptable for advance care plans, with
10 or without DNACPR form completion to be applied to
11 groups of people of any description."

12 Do you think that the message there was
13 potentially a little confusing, that there was something
14 unacceptable about advance care planning?

15 **A.** No, I don't agree with that at all. I think it's
16 clearly saying that advance care planning cannot be
17 applied to groups of people; they should be applied to
18 an individual not to a group of people. I think that's
19 absolutely clear in the text.

20 **Q.** What did you understand by advance care planning?

21 **A.** Advanced care planning is the discussion that you have
22 with an individual or, on occasions, with the relatives
23 of an individual, or sometimes with both, about what
24 their future wishes will be. So it may include
25 discussion around DNACPR; it doesn't have to include

105

1 directors of nursing, and directors of therapies and
2 healthcare scientists. So this was going out to the
3 local health boards. Do you think it would have been
4 helpful for those recipients of the letter to have been
5 signposted to the existing detailed DNACPR policy?

6 **A.** It may have been, it may have helped, yes.

7 **Q.** Thank you.

8 You wrote again to the system with the Chief
9 Nursing Officer on 10 March 2021. This time you were
10 writing following media reports, I think, of
11 inappropriate DNACPR notices in England in relation to
12 people with disabilities or learning disabilities
13 specifically.

14 Were you aware at that point of any similar issues
15 in Wales?

16 **A.** There had been a couple of instances where it had been
17 brought to our attention that there may be problems with
18 that issue. I think one was out in west Wales and there
19 was a practice somewhere, I think in one of our health
20 board areas, where it was reported that there had been
21 inappropriate -- either group or issuing of DNACPR
22 without proper consideration or discussion with the
23 patients as we were just discussing.

24 So that's what triggered the second letter, as
25 I recall. It was a reminder.

107

1 a discussion around that at all. It may include
2 a discussion about their advance wishes, you know, if
3 they become ill or if their condition was to
4 deteriorate. So it covers a whole range of things. And
5 there's a comprehensive suite of documents which is
6 produced by -- we have in Wales an advance planning
7 strategic group, again led by clinicians, that develop
8 and update all of these documents and tools.

9 **Q.** Thank you.

10 In this letter that you've sent on 17 April,
11 I think there's a link, I think further down the
12 letter -- forgive me, it's on page 1, I think -- to the
13 statement of the Covid-19 moral and ethical guidance in
14 Wales, and you don't appear to have signposted in that
15 letter to the existing All-Wales DNACPR policy. Do you
16 consider that that was an oversight?

17 **A.** Well, I think that that would have been quite widely
18 circulated not by Welsh Government as we just discussed
19 but by the clinical network, and I think it was more
20 targeted towards the leaders of the intensive care
21 systems really. I'm sure medical -- excuse me, medical
22 directors would have seen it.

23 **Q.** If we can scroll up, please, we can see who that letter
24 was actually addressed to. And it was addressed to the
25 Health Board chief executives, the medical directors,

106

1 Now, none of those experiences, as far as I could
2 see, were ever clinically -- I mean, obviously it was
3 a very difficult time and people were anxious about
4 decisions being made about themselves, about their loved
5 ones, but I don't -- what we made very clear to the
6 system -- again through medical directors, we discussed
7 this at medical directors' meetings -- was that when
8 a DNACPR process was felt not to have been followed, if
9 a patient or a relative complaint about that, that it
10 should be properly investigated by the health board, and
11 as far as I'm aware that did happen.

12 **Q.** I think in fact you wrote out to the system for a third
13 time in April 2022 and on that occasion there was
14 reference made to a specific incident that had taken
15 place in relation to a patient with a learning
16 disability who had had a DNACPR notice issued solely on
17 the basis of that learning disability.

18 I think, again, in the letters of March 2021 and
19 April 2022 there was no link or reference to the
20 All-Wales DNACPR policy for clinicians. Do you know why
21 that wasn't linked in those letters or referred to in
22 those letters?

23 **A.** No, I don't know. I do not know why that was.

24 **Q.** Having been made aware then of both media reports and
25 some specific incidents in Wales in relation to

108

1 inappropriate DNACPR notices, did your office or any
2 other Welsh Government body, to your knowledge, either
3 investigate or commission an investigation into whether
4 there had been a widespread issue with inappropriate
5 DNACPRs in Wales?

6 **A.** I don't recall commissioning anything or Welsh
7 Government commissioning anything but the implication
8 that these were widespread was not something that
9 certainly I felt or Jean White or Sue Tranka
10 subsequently felt was an issue.

11 These were rare events which needed to be
12 investigated by the health boards and our view was that
13 even one event was wrong and it should be absolutely not
14 the practice and that's why we consistently wrote out to
15 the system.

16 **Q.** Can you tell us how you came to the conclusion that
17 these were not indicative of a widespread practice in
18 the absence of any review or investigation?

19 **A.** Well, it's really not the Welsh Government's
20 responsibility or ability to monitor the number of
21 DNACPRs or whether they're appropriate or not. That's
22 really a job for the health boards. So when all this
23 was coming up repeatedly we had discussions with medical
24 directors who were responsible for overseeing within
25 their health boards how the DNACPR policies were being

109

1 So I am reassured that the system does have that
2 training, that -- and the monitoring function through
3 the health boards, yes.

4 **Q.** Are you aware of the -- turning to advance care planning
5 specifically rather than DNACPR notices, are you aware
6 of the ReSPECT forms that are used in many regions of
7 England and, indeed, in Scotland to record patient
8 wishes and views in terms of advance care planning and
9 are there any reasons why the ReSPECT form could not be
10 adopted in Wales?

11 **A.** Can I just backtrack slightly just to correct something
12 which I previously said. I think Healthcare
13 Inspectorate Wales undertook an audit of DNACPR policies
14 in Wales in 2024.

15 **Q.** In 2024?

16 **A.** I think it's very important we, kind of, look at that
17 because HIW is the body which sits, if you like, above
18 the health boards and monitors their compliance with
19 some of the policies that came out. So there is a --
20 there is a piece of work around that.

21 **Q.** So as far as you are aware, there is an audit of
22 policies but not an audit or review of individual
23 DNACPR --

24 **A.** No, that would be done by their health boards. The
25 audit of the policy and how it was being adhered to by

111

1 implemented.

2 **Q.** Did you ask the local health boards to undertake that
3 sort of review?

4 **A.** I didn't, no, no.

5 **Q.** Did you ascertain whether the local health boards had
6 policies that were in accordance with the all-Wales
7 DNACPR policy?

8 **A.** Well, there was an expectation that they would have
9 that. I mean, that was clear in the DNACPR policy that
10 individual health boards should be having their own
11 policies and monitoring their policies. It's the health
12 boards to monitor the policies and implementation, not
13 the Welsh Government.

14 **Q.** So those three letters to the system did not refer to
15 the all-Wales DNACPR policy. Were any steps taken
16 during or after the pandemic to ensure that clinicians
17 in Wales were familiar with and fully understood the
18 all-Wales DNACPR policy Sharing and Involving?

19 **A.** Well, the policy is updated every two years. I think it
20 was updated again in 2022. Whenever it's updated it
21 goes to medical directors. I've talked already about
22 the advanced care planning policy and processes and the
23 tools that are contained within there. So tools are
24 widely available to staff and health boards include them
25 in their staff training.

110

1 the health boards would be done by HIW, yes.

2 **Q.** But you're not aware whether the health boards did
3 undertake any such review?

4 **A.** Well, I wouldn't know that but the HIW report may well
5 refer to that because it should look at that.

6 **Q.** Thank you.

7 **A.** I'm sorry to go. Back to your question maybe.

8 **LADY HALLETT:** The question was: is there any reason why the
9 policy of ReSPECT used in parts of England should be
10 used in Wales as well?

11 **A.** As I say, we do have an advance care policy and we --
12 that's updated regularly. It's not owned by the Welsh
13 Government, it's a network issue again. As I understand
14 it, the clinical leads of that do look, whenever the
15 policy is updated, at the ReSPECT process.

16 There are some concerns in Wales from some groups
17 that it's perhaps not the -- it doesn't meet all of the
18 needs in Wales. I think the principles of the ReSPECT
19 process are incorporated within our advance care
20 planning but the tool itself, elements are taken from it
21 but I don't think there's a desire to -- wholesale just
22 to adopt that policy. We have our own policies in Wales
23 which we believe are robust, and actually, in some ways,
24 more comprehensive, because it's not just a policy, it's
25 a suite of tools which people can use.

112

1 **LADY HALLETT:** Thank you.

2 **MS NIELD:** Moving on now to your views of the lessons
3 learned from the healthcare system response to the Covid
4 pandemic, what do you consider to be the most important
5 lesson that can be learned from the response of the
6 clinical healthcare system in Wales? And do you have
7 any recommendations building on that for future
8 pandemics?

9 **A.** So I mean, I don't want to just reiterate some things
10 I've already said, I'm sure you've heard this before.

11 The big lesson to me was that the system didn't
12 have enough capacity to be able to respond in the way
13 that we needed it to and in a way that's because --
14 we've tried to make our NHS, and it's true in Wales as
15 in the rest of the UK, as efficient as possible, and in
16 some ways efficiency is the enemy of preparedness,
17 because we don't have the sufficient expanse in
18 capacity.

19 So the biggest lesson for me is thinking about how
20 we can expand capacity in intensive care, as we have
21 been discussing. We did expand intensive care capacity,
22 from 152 beds to more than 300, we more that doubled,
23 but there weren't the staff trained to be able to move
24 into those positions.

25 So thinking about how much spare capacity for all
113

1 of, main things which come to my mind.

2 **MS NIELD:** Thank you very much, Dr Atherton. I have no more
3 questions for you.

4 **LADY HALLETT:** Thank you, Ms Nield.

5 Mrs Weeraratne.

6 She's that way.

7 **A.** I see her thank you.

8 **Questions from MS WEERERATNE KC**

9 **MS WEERERATNE:** Good afternoon, Dr Atherton.

10 I ask questions on behalf of the Welsh Covid
11 Bereaved Families for Justice group, many of whose
12 members lost loved ones through nosocomial infection,
13 and I have a number of questions for you on their behalf
14 today.

15 The first is this: today you were asked about the
16 EMG report of 4 June 2020 which said that there was weak
17 evidence of transmission, and you were asked about the
18 application of the precautionary principle.

19 In fact, the EMG report states that: the evidence
20 of aerosol is weak but there is significant uncertainty
21 around the relative contribution of all transmission
22 routes; the approach to risk should be based on the well
23 established hierarchy controls.

24 So the Welsh bereaved are concerned that when
25 asked about the precautionary principle, witnesses tend

115

1 sorts of things, we talk about intensive care, but for
2 all sorts of things is really important going forwards.

3 The second thing is the flexibility of the
4 workforce, the ability to move the workforce, who did
5 a fantastic job, but to move them and to make sure they
6 have multi-professional skills that can move between
7 roles when needed. I mean, that's my first
8 recommendation.

9 The second one really is more about the basic
10 health of people in Wales. This is a big ask but the
11 health of people in Wales is not as good as it needs to
12 be. We didn't start from the right place and so when we
13 talked about those inequalities, we talked about the
14 differential impact on people, but if those inequalities
15 were smaller, if the basic health of the population was
16 better, we would have fared better than we subsequently
17 did.

18 Yes, those I think are the main areas that
19 I think -- I am sure our communications, you know, could
20 have been better but that's an internal matter and we
21 can think about that. Some of the connections, do you
22 remember we talked about the connection on policy level
23 between Welsh Government and -- the devolved nations,
24 let's say, and the UK Government. Strengthening those
25 would be really important as well. Those are the, kind

114

1 to revert to masks and suggest that application of the
2 principle would, as you suggested today, result in
3 everyone wearing respiratory hoods. Do you think that
4 when considering the precautionary principle the focus
5 is in fact too much on such outcomes like masks than on
6 the risks arising from the science?

7 **A.** Forgive me, it's a rather theoretical question. I'll
8 try to answer it.

9 I do think at the stage we were at in the
10 pandemic, even in June 2020, the risks, the modes of
11 transmission were all becoming clearer. They weren't
12 entirely clear. I think I've already mentioned the
13 precautionary principle. I don't just apply it to
14 masks, I don't think. I do apply it to the whole
15 process of healthcare but it's only one tool in the box.
16 It's not the only or the one that supersedes all others.
17 I do think we have to balance evidence very carefully
18 and that's why we created the scientific architecture,
19 including the EMG that you mention, feeding into
20 NERVTAG, feeding through into the IPC cell.

21 I do think that the precautionary principle can
22 mislead us sometimes because it can be argued both ways.
23 It can be argued as a reason to do things and as
24 a reason not to do things.

25 **Q.** I think that reflects your earlier answer but may I ask

116

1 just this: what was the downside in your estimation of
2 assuming that long-range aerosol transmission was taking
3 place when the evidence for it was weak?

4 **A.** I don't think we did assume that it wasn't taking place.

5 As I say, there's a continuum of droplets to small
6 particles to tiny particles. I think that was
7 understood really from quite early on. So I don't
8 really think that that -- sorry, ask your question again
9 please, can you?

10 **Q.** What was the downside -- you talked about the downsides
11 of assuming that long-range transmission was taking
12 place when the evidence was weak.

13 **A.** So there was an acceptance that particles of all
14 sizes -- the empirical evidence was the closer you were
15 to somebody, to somebody who was infected, the greater
16 the risk. That came about very early and didn't really
17 change. So there was a good reason to take the action
18 that we -- that the IPC cell did take.

19 **Q.** Thank you.

20 I am going to ask you my next question. We also
21 heard your evidence this morning that there was an
22 anxiety around the levels of PPE stock that you were
23 holding. At paragraph 174 of your witness statement you
24 say that you do not recall any specific concerns on
25 shortages of PPE or poorly fitting PPE that was notified

117

1 "do not recall any specific concerns on shortages", not
2 running out, but I'm going to move on to my next
3 question, which is on supply again.

4 Concerns are raised in an email trail -- I'm going
5 to ask, please, if we could have INQ000383997, page 1,
6 up on the screen, if I may.

7 It's an email trail dated 27 March, and it's the
8 first page to the bottom of the first page that I want
9 to ask you about, Dr Atherton.

10 It's between -- it's sent by clinicians from
11 health boards in Wales and ultimately brought to your
12 attention at the top of the page where it says:

13 "Hi Frank ..."

14 Do you see that?

15 **A.** Yes, I do. Do you have a tab number, please? I find it
16 difficult to read these --

17 **Q.** It should be 57, I apologise.

18 **A.** Tab?

19 **Q.** 57.

20 **A.** Thank you.

21 **Q.** I'm looking at the screen because there are some
22 redactions on the version there which were not in the
23 version that I downloaded last week, but I see your name
24 is there. So perhaps you can look at that copy.

25 So you were sent an email saying that there is

119

1 to you directly.

2 Now, on 4 June, Vaughan Gething told the Senedd
3 Health, Social Care and Sport Committee that Wales came
4 within days of supplies of some items rather than weeks.

5 So in the light of all of that, do you agree that there
6 were issues with the supply of PPE at the early stages
7 of the pandemic in Wales?

8 **A.** So thank you. Very early in the pandemic there were
9 real concerns, visceral concerns that we were going to
10 run out of PPE. The stocks were running down very, very
11 quickly. I think what I say in my statement is that,
12 you know, I was never informed that we actually ran out
13 of stocks. I believe that to be true. We never in
14 Wales ran out of stocks. I think we came very close but
15 we continued to keep the pipeline of stocks moving into
16 health and into social care to keep those pipelines
17 moving.

18 Now, what I can't say is that there weren't local
19 distribution issues because obviously the local health
20 boards had to receive stock and distribute them within
21 their -- both the healthcare facilities, primary care
22 and subsequently into social care as well, so there may
23 well have been local distribution -- but we never ran
24 out of PPE, yes.

25 **Q.** Thank you. I'm just going to remind you that it says

118

1 a situation in Swansea, contrary to a discussion about
2 unified PPE approaches across Wales following Public
3 Health England advice.

4 That's the top email. You see that.

5 It forwards to you the email below from
6 Esther Youd, and that says she entirely agrees with the
7 comments regarding the need to unify Royal College
8 guidance with PHE guidance on infection control.

9 Do you see that? It's the second paragraph there,
10 or the third paragraph that I'm interested in, where it
11 says:

12 "[Frank] ..."

13 And that's correct, it says "Frank", doesn't it?

14 "... made it clear that it is important that we
15 all follow the PHE guidance so that high levels of PPE
16 are not used unnecessarily, risking the supply chain at
17 a later date."

18 So my question is this: do you agree that
19 decisions were being made as to what level of PPE should
20 be used by healthcare workers to avoid running out of
21 supplies rather than due to the risk presented to
22 healthcare workers?

23 **A.** No, I don't agree with that.

24 So this email chain, you know, was sent to me
25 actually by David Tuthill, who's a paediatrician working

120

1 in Wales, a very, very gifted paediatrician, and he was
2 raising the issue of whether babies should be regarded
3 as Covid --

4 **Q.** Sorry, Doctor Atherton, I am really going to stop
5 because I have limited time, but I just wanted to focus
6 you on to the comment that was made by you that you were
7 concerned that it was necessary to follow guidance so
8 that high levels of PPE are not used. The context is
9 not necessarily necessary at this point.

10 **A.** Understood. Thank you for that. Yes, thank you.

11 So that's the reported account of my discussion
12 that I had with the Academy of Medical Royal Colleges
13 Wales. I met with the academy on a regular basis
14 throughout the pandemic and all of the clinical leads,
15 the college leads, would have been present at that
16 meeting. So this is a reporting of what I'd said at
17 that. And basically what I was saying at that meeting,
18 from my recollection and from what I'm seeing in front
19 of me, was that it was important that we follow the IPC
20 guidelines.

21 I'm not saying that the primary reason is because
22 of a stock level. I don't believe that I felt that at
23 all. I mean, it may well have been something --
24 a concern, a subsidiary concern, but the main reason for
25 following IPC guidance was because that was based on the

121

1 time but in early March, when we were still learning
2 about the virus, that statement would have been true.

3 **Q.** Oh, thank you.

4 The next point then is that testing of
5 asymptomatic healthcare workers in England started from
6 30 April 2020, and you further said to the BBC then that
7 the Welsh Government was "still trying to reach
8 a cross" --

9 **MS NIELD:** I do apologise for interrupting. I think it has
10 been necessary to stop the live feed.

11 *(Pause)*

12 I think we can resume shortly.

13 *(Pause)*

14 **LADY HALLETT:** No, I'm not going to stop it. Somebody can
15 alter that later if it has been mentioned in error. We
16 can go back over it and amend it. We're short of time
17 this afternoon, so no.

18 Please carry on.

19 **MS WEERERATNE:** All right. I am going to repeat that
20 question. I'm sure that would help you, Dr Atherton.

21 My question was around testing of asymptomatic
22 healthcare workers from 30 April 2020 and that you said
23 to the BBC that the Welsh Government was:

24 "... still trying to reach across to England to
25 understand the exact rationale for the changes that

123

1 best evidence that we in Wales and we in the UK had
2 through NERVTAG and the IPC cell.

3 So it wasn't a question of supply.

4 **Q.** But you accept that that is accurate in terms --

5 **A.** Well, I accept that's what he said, I accept that's his
6 interpretation of what I said, but I would have had
7 a 40-minute discussion with the academy and he may have
8 taken one line from that.

9 **Q.** Thank you.

10 My next question is on asymptomatic testing. At
11 the Senedd's Health, Social Care and Sport Committee on
12 18 March you said -- and that's 2020:

13 "I just need to stress that there's very little
14 point in testing anybody who is not symptomatic. The
15 test will only be positive if someone actually has
16 symptoms."

17 So at this date it's correct to say, isn't it,
18 that you did not believe there was any point in testing
19 asymptomatic healthcare workers?

20 **A.** Date of that again, please?

21 **Q.** 18 March 2020.

22 **A.** So at that point in the pandemic, asymptomatic infection
23 was starting to be recognised. Asymptomatic
24 transmission was not regarded as a very significant mode
25 of transmission. Now, that became -- that changed over

122

1 they've made in various categories."

2 So the question is: why did you not recognise the
3 value in asymptomatic testing at that time and at that
4 date, 30 April 2020?

5 **A.** Thank you. Look, I have to confess I'm a little puzzled
6 by the question because in March 2020 there was very
7 little testing capacity available. So it certainly
8 wasn't the case that England or anywhere was testing all
9 healthcare workers who were asymptomatic. Asymptomatic
10 testing came in much, much later, round about
11 September/October/November 2020.

12 **Q.** Well, I can reliably inform you that on 30 April England
13 started asymptomatic testing of healthcare workers?

14 **A.** Not of all healthcare workers.

15 **Q.** Well, that is my question to you.

16 **A.** They couldn't have, because there just wasn't enough
17 capacity.

18 **Q.** So my question is focused on the value of asymptomatic
19 testing at that time. Do you accept that or not?

20 **A.** Well, at that time, in April 2020, as in March, there
21 wasn't an understanding that asymptomatic transmission
22 was a main -- a significant feature of the pattern of
23 transmission of the disease.

24 **Q.** Okay, thank you.

25 So I will move on to the next question, which is

124

1 that at a Senior Clinicians Group on 4 May it's minuted
2 that approximately 5% of staff are asymptomatic
3 carriers, with up to 9% in one hospital, CF 0.64% in the
4 community from an ONS study. Then it records:

5 "Need to be really clear why we will not test all
6 HCWs."

7 So again the question is, do you agree that by
8 4 May 2020 it was untenable to maintain a stance that
9 there was no value in regularly testing healthcare
10 workers regardless of symptoms?

11 **A.** I think by the time we reached May it was becoming
12 increasingly clear. And this was -- as I recall, this
13 was quite a complex paper which Aidan Fowler, the Deputy
14 Chief Medical Officer in England, one of the DCMOs in
15 England, brought to the Senior Clinicians Group. It was
16 a very preliminary finding from the Vivaldi Study.

17 And it did concern me. I think it concerned all
18 of us that that there was a relatively high prevalence
19 of asymptomatic infection -- not asymptomatic
20 transmission, you know, but asymptomatic infection --
21 among healthcare workers.

22 The comments I think that I made at that time was:
23 well, if that's the case then we will need to move
24 towards testing asymptomatic healthcare workers at some
25 point.

125

1 **Q.** Yes, so the policy was in December 2020, and I'm asking
2 you: do you know and do you accept that it wasn't
3 actually rolled out until mid-March and July 2021? Just
4 answer that if --

5 **A.** If you let me finish my answer, I know that the supplies
6 of the lateral flow devices that came into Wales were
7 distributed in December, fairly quickly after the policy
8 was agreed through our TTP programme. They went out to
9 all the health boards. I think there was a variance in
10 the speed with which the health boards were able to
11 implement the testing. So in terms of full roll-out,
12 I suspect you're right, that some health boards didn't
13 quite get there as quickly as we would have expected.

14 I think there are two other things you need to
15 think about when you look at that. One is what else
16 health boards were doing. And if you remember, this was
17 exactly the time, my Lady, that vaccines were being
18 brought in, and so there was a huge impetus on getting
19 vaccines into people.

20 And the other thing I would also flag is that
21 although there was a delay -- I think health boards
22 could have been quicker, I will accept that -- I don't
23 think the situation was much different in England, which
24 is obviously a much bigger system anyway.

25 So I think those comparisons are perhaps not

127

1 At that time, on 4 May, again, there was not
2 sufficient capacity of PCR testing --

3 **Q.** Thank you --

4 **A.** -- within the system to be able to undertake that.

5 **Q.** I think you've answered my question --

6 **A.** Subsequently, it's when lateral flow devices became
7 available, widely available, that that become a feasible
8 option. But it just shows -- I think that line just
9 shows that we were thinking in those terms about how we
10 could bring in testing for asymptomatic healthcare
11 workers.

12 **Q.** Thank you.

13 I want to move to another topic, which is about
14 introduction of routine testing.

15 Now, you have already been asked about the delays
16 by the Welsh Government in announcing routine testing of
17 healthcare workers in December 2020. I want to ask you
18 about the incremental testing of healthcare workers
19 which was due to be rolled out after that time, with
20 full roll-out due to be January 2021.

21 Do you agree that the regime was not in fact
22 rolled out until mid-March 2021, and often as late as
23 July 2021 in some cases?

24 **A.** I think it was rolled out earlier than that as
25 a national policy. Again, my colleagues --

126

1 entirely ...

2 **Q.** I am grateful. I'm moving on to another question.

3 In the expert report by Dr Shin, Professor Gould
4 and Dr Warne, they say that hospital-onset cases during
5 the first wave represented 5.3% of all
6 laboratory-confirmed Covid-19 cases in England, 6.4% of
7 cases in Scotland, and 10.5% of all laboratory-confirmed
8 cases in Wales.

9 The question is why were the rates of
10 hospital-acquired Covid-19 as a percentage of all cases
11 so much higher in Wales?

12 **A.** If you read down that report you'll see that the
13 professors also point out that not too much should be
14 read into that because of the differences in counting,
15 the differences in testing, the differences in hospital
16 admissions. So they put enormous caveats around that
17 data. So it's not data that I recognise.

18 The reality is that there were high rates, there
19 were high rates in all the countries. I don't accept
20 the -- just on the face of it, the differences in the
21 statistics.

22 **Q.** Thank you.

23 I just wanted to ask you about the Covid pathway.
24 There's a letter that we have, dated 9 April 2020, to
25 all CEOs, the chief operating officer, and medical

128

1 directors of Welsh Health Boards and trusts in which you
 2 discuss the all-Wales hospital Covid-19 pathway, but it
 3 appears that a copy of this document no longer exists.
 4 So the question is, can you assist the Inquiry with why
 5 that is and why there's no copy retained in order to
 6 ensure accountability and compliance with that pathway?

7 **A.** Yes, I can. So the pathway was a very innovative piece
 8 of work done by one of our esteemed respiratory
 9 consultants, who I won't name, who was a consultant in
 10 west Wales, and he led the Respiratory Health
 11 Implementation Group, and was very effective, I think,
 12 early in the pandemic in assembling the evidence on what
 13 works and putting that into a toolkit which was
 14 available, including the pathway that you rightly
 15 describe.

16 That pathway was then distributed through
 17 a private company and the reason it's not available now
 18 I think is because it was in the domain of the private
 19 company rather than owned by Welsh Government.

20 **LADY HALLETT:** I think we're going to have to leave it
 21 there.

22 **MS WEERERATNE:** And that was my final question.

23 **LADY HALLETT:** Okay, thank you very much. Very grateful.
 24 Sorry about the interruption.
 25 Right, Ms Hannett.

129

1 characterisation of Long Covid?

2 **A.** I don't believe I did. I'm not an expert in that field.

3 **Q.** You describe your role as medical director of the NHS at
 4 paragraph 32 of your statement as a co-ordination role,
 5 through the sharing of common issues and best practice
 6 amongst medical directors.

7 You say at paragraph 92 that your office would
 8 meet with NHS Wales medical directors, directors of
 9 public health, to ensure learning and consistency across
 10 the health and social care sector.

11 Did you ever use those meetings to discuss Long
 12 Covid?

13 **A.** I honestly don't know. We'd have to trawl back through
 14 the minutes of those meetings. I would be surprised if
 15 we hadn't or if it hadn't come up in some form, whether
 16 as a specific item or any other business or as something
 17 which was raised by members. I think it would have been
 18 discussed but I can't tell you whether it was.

19 **Q.** Does that mean you can't recall, yourself personally,
 20 providing advice on Long Covid to that meeting?

21 **A.** Yes.

22 **Q.** Similarly, many Long Covid patients reported that they
 23 weren't believed when they sought care and support from
 24 clinicians or that clinicians didn't know how to support
 25 them. Did you take any specific steps in your role as

131

Questions from MS HANNETT KC

1 **MS HANNETT:** Dr Atherton, I appear on behalf of the Long
 2 Covid groups.
 3
 4 My Lady, in light of the evidence that was given
 5 this mornings we do not need to ask all the questions
 6 that we have been given permission for, so I anticipate
 7 I'll be a little less than the time that has been
 8 allocated.

9 Dr Atherton, I have questions first about your
 10 role in advising on the Long Covid. You gave evidence
 11 this morning that you were not involved in advice on the
 12 identification or characterisation of Long Covid, and
 13 you agreed that Dr Chris Jones was a member of the Welsh
 14 Long Covid subgroup. You stated that you couldn't
 15 recall being provided with a briefing by Dr Jones on the
 16 matters discussed at that subgroup.

17 Did, you ever ask Dr Jones to provide you with the
 18 briefing?

19 **A.** I don't remember asking him. As I think I said earlier,
 20 I think most of my information flowed through probably
 21 from Chris or from that group rather than Chris, through
 22 into the Technical Advisory Cell, and to me in that
 23 direction.

24 **Q.** And did you personally ever provide any advice to the
 25 Welsh Government on the identification or

130

1 medical director to ensure there was awareness of
 2 diagnosis and care for Long Covid sufferers?

3 **A.** Me personally, no, but I think that the communication --
 4 it was understandable in the early days of the pandemic
 5 that primary care particularly, but doctors generally,
 6 wouldn't have known really how to handle these kinds of
 7 questions. I think as the evidence became assembled
 8 that there was more communication I believe from the
 9 group, but not from me personally, no.

10 **Q.** Not from you.

11 Can I just now ask you about Long Covid services.
 12 NICE guidance published in December 2020 recommended
 13 specific Long Covid clinics. Similarly, the Welsh
 14 Technical Advisory Group, on Long Covid, at
 15 February 2021 recommended integrated multidisciplinary
 16 care pathways for Long Covid.

17 Wales has not developed specific Long Covid
 18 clinics. Did you provide any advice to the Welsh
 19 Government or to the health boards, after either the
 20 NICE guidance guidelines or the Welsh Technical Advisory
 21 Group on what services should be provided for Long Covid
 22 in Wales?

23 **A.** Me personally, no, but I am aware, of course, that the
 24 group we just discussed has been providing that advice
 25 and that systems have been set up to support people with

132

1 Long Covid in Wales.
2 We've taken a different approach, it is true. We
3 have a much more community-based approach. One of the
4 main reasons for that is that we are trying to shift
5 many of our services into the community.

6 There are specialists who are active in the field
7 of Long Covid. I think we're still learning a huge
8 amount about Long Covid. The vast majority of the
9 people -- of people with Long Covid I think should be
10 treated and treatable within the community. Those few
11 who cannot should have access to specialist care. We
12 need to make sure that happens in Wales. It does happen
13 to a degree, probably need to expand it more. But
14 that's the approach we've taken in Wales.

15 **Q.** Thank you, Dr Atherton.

16 Have you personally taken any steps at all in
17 relation to Long Covid? You personally?

18 **A.** No.

19 **Q.** Can I ask if that's because Long Covid wasn't a priority
20 for the Office of the Chief Medical Officer?

21 **A.** Well, I it wasn't early on. And latterly that function
22 has been discharged through my deputy, who has much more
23 of an interest and much more of an expertise in that
24 area.

25 **Q.** Can I just ask you about that, because your evidence
133

1 I think that's been at the forefront of thinking as
2 we've developed the Adferiad service in Wales.
3 **Q.** Can I just ask you this, Dr Atherton, finally. Given
4 that the Welsh Government has estimated there are some
5 96,000 people with Long Covid, and given that that can
6 be a condition which is both long-term and disabling, do
7 you agree that that should be a public health priority
8 in Wales?

9 **A.** I think it should be a priority and has to be looked at
10 in terms of all the other difficult issues which health
11 boards are responsible for. At the end of the day it's
12 the responsibility of health boards to develop those
13 services, to understand the needs of their population,
14 and to make sure that the services they provide meet
15 those needs.

16 **MS HANNETT:** Thank you.

17 Thank you, my Lady.

18 **LADY HALLETT:** Thank you, Ms Hannett.

19 Ms Waddoup. Over there.

20 **Questions from MS WADDOUP**

21 **LADY HALLETT:** I don't think you are switched on.

22 **MS WADDOUP:** Dr Atherton, I ask questions on behalf of
23 Clinically Vulnerable Families, and I would like to ask
24 you first, please, about communication.

25 The CMO's technical report acknowledges the
135

1 doesn't set out any steps taken by Dr Jones, and
2 Dr Jones' own witness statement doesn't give any account
3 what steps he has taken in respect of Long Covid. So
4 the Inquiry isn't actually in a position to understand
5 what steps the Office of the Chief Medical Officer has
6 taken in respect of Long Covid in Wales.

7 **A.** So the group that's looking at that, I think we
8 established that Chris is probably a member, I don't
9 think we established that he certainly is but I think we
10 established he's probably a member of it, but there's
11 a whole group working on that important issue. And they
12 will -- they have produced recommendations, they've led
13 to the development of services, the Adferiad service in
14 Wales, which is our community-based multidisciplinary
15 service.

16 So service development is going on. Whether it
17 needs the Chief Medical Officer involved in that, when
18 I'm not a specialist in that area, is a moot point. But
19 there are clinicians closely involved in it with strong
20 interest and strong professional background.

21 I think it's also important to flag that we need
22 to support people with Long Covid, absolutely we do, but
23 there are a range of other people who, you know, suffer
24 from various post-viral syndromes and we need to make
25 sure that we don't forget about those as well. And
134

1 importance of communication in relation to clinical
2 vulnerability and, in particular, the need for
3 communications to be clear about who was vulnerable,
4 what was being asked of them in the guidance and why, as
5 well as the reasons for changes in that guidance.

6 Do you think that communications in Wales to the
7 clinically vulnerable and clinically extremely
8 vulnerable in relation to those issues were sufficiently
9 clear, prompt and regular?

10 **A.** I certainly hope they were. We tried very hard to
11 make -- to fill all those criteria that you just rightly
12 described, because communication with this group was
13 really important. As we discussed earlier, we were
14 asking them to do something really very, very difficult.

15 In Wales we had a team working on this. We didn't
16 just produce formulaic letters, or we tried not to. We
17 tried to personalise it. We tried to make Easy Read
18 versions available wherever possible. So, for example,
19 for the -- we talked about people with Down's syndrome.
20 We produced an Easy Read, which I think was a really
21 good model of good communication. And of course we
22 tried very hard to do everything -- we did everything in
23 Welsh as well as English, so we had that additional
24 thing that we absolutely needed to do.

25 Could we have done better? Of course. You know,
136

1 we could do better. We always need to learn how to do
2 better. Our communication needs to be better. It was
3 not easy.

4 As I think I've said, I've spoken to some people
5 in that group, I'm sure you've spoken to many more, who
6 were kind of grateful for the way we communicated. I'm
7 sure there are plenty who felt that communication let
8 them down and should have been better, and we need to
9 learn from that.

10 **Q.** Thank you. That actually leads me to my next question,
11 which is about understanding the impact of the shielding
12 programme.

13 We know that in Northern Ireland a survey of those
14 shielding was carried out which identified, amongst
15 other things, a number of adverse social and
16 psychological impacts associated with shielding, and
17 we've heard in evidence from your colleague,
18 Professor McBride, that the results of that survey,
19 published in July 2020, were used to inform his advice
20 after that, for example in relation to the pausing of
21 shielding, formulation of communications, et cetera.

22 We understand that in Wales there weren't any
23 specific surveys of those shielding about the impacts on
24 them whilst the programme was in place, and my question
25 is: should there have been?

137

1 largely non-clinical spaces or the clinical spaces that
2 those clinically extremely vulnerable or clinically
3 vulnerable people would have been moving into. That was
4 the basic provision, of course, for healthcare workers
5 as well at the time.

6 I think that had we suggested -- had there been
7 a suggestion -- I don't remember anybody ever suggesting
8 FFP3 masks. I think that would have been
9 extraordinarily difficult given the issues around
10 fitting and fit testing et cetera. FFP2 masks were not
11 widely used in Wales or in the UK generally,
12 interestingly, which is a complete contradistinction
13 from the rest of the Europe, but they weren't a factor
14 in thinking.

15 So it was felt that the best protection for those
16 groups was through the provision of surgical face masks.

17 **MS WADDOUP:** Thank you, Dr Atherton.

18 My Lady, those are all my questions.

19 **LADY HALLETT:** Thank you very much indeed.

20 Mr Thomas.

21 Mr Thomas is sitting behind you, so please could
22 you make sure that when you answer his questions you
23 turn back, but by all means look at Mr Thomas whilst he
24 is asking the question.

25

139

1 **A.** Well, I didn't know actually about the Northern Ireland
2 approach until I heard it, as you did, from Professor
3 Sir Michael McBride, and I think it was an excellent
4 piece of work that they did there.

5 I don't remember it being discussed at the time.
6 I think -- I agree with you it would have been useful
7 had we had the time and the resource to be able to do
8 that. We would have learnt much more. So the answer to
9 your question is yes.

10 **Q.** Thank you. Then, finally, I have a question relating to
11 measures taken to protect clinically extremely
12 vulnerable and clinically vulnerable patients while they
13 were accessing healthcare.

14 In your evidence this morning you described the
15 very close consideration being given to providing
16 surgical masks to clinically extremely vulnerable
17 patients when they were coming to hospital in order to
18 support them.

19 Was consideration given to providing clinically
20 extremely vulnerable and clinically vulnerable patients
21 with higher-grade, better-fitting masks like FFP2 or
22 FFP3 masks, and if not, why not?

23 **A.** No. Well, I'm not saying it wasn't considered, I'm
24 saying it wasn't a policy. I think that the view is and
25 was that surgical masks provided good protection in

138

Questions from PROFESSOR THOMAS KC

2 **PROFESSOR THOMAS:** Thank you, my Lady.

3 My Lady, just so you don't become confused, I'm
4 taking my questions 3 and 4 out of order. I'm doing
5 them first.

6 **LADY HALLETT:** Thank you.

7 **PROFESSOR THOMAS:** Dr Atherton, I'm representing the
8 Federation of Ethnic Minority Healthcare Organisations
9 (FEMHO), who advocate on behalf of healthcare workers
10 from the black, Asian and minority ethnic communities
11 who were disproportionately affected by the pandemic,
12 okay.

13 When did you first become aware that there was an
14 issue of disproportionate infection and death rates
15 amongst black, Asian and minority ethnic healthcare
16 workers and patients?

17 **A.** Thank you, Mr Thomas. I can't pin a date on that but
18 I think, you know, the early data coming out of the
19 first few hundred studies which were commissioned in
20 the UK, that's looking at the demographics and the
21 outcomes and the treatments provided to the first
22 hundreds of patients that come through the system with
23 Covid, I think that started quite early on to shine
24 a light on the fact that there was a disparity, which
25 you describe, in terms of, first of all, infection and,

140

1 subsequently, the mortality issue.

2 So if you were to ask me -- if you tried to pin me
3 down on dates, I would say April into May probably, but
4 that's when we were starting to see significant numbers
5 of patients.

6 **Q.** Let me just ask you just a very quick follow-up on that.
7 So when you became aware April into May, what immediate
8 steps were taken to mitigate this risk?

9 **A.** So at that point it was still about gathering
10 information. It wasn't entirely clear what was
11 happening. The process in Wales was to make sure that
12 we tried to understand it better. It was really about
13 understanding.

14 And really quite on -- early on, of course, our
15 First Minister and the minister for health took a very
16 strong and active interest in this and established the
17 council of Inquiry which Judge Ray Singh chaired. So
18 there was a specific group set up to look at the broad
19 issue of how people from the communities you describe
20 were faring and then a specific subgroup which was to
21 look at the risks that healthcare workers specifically
22 were facing and to come up with recommendations about
23 how they could be better protected.

24 **Q.** Right, so the answer to my question, if I've just
25 followed your answer, apart from looking at the data,
141

1 assessment tool for healthcare workers, I think
2 I mentioned the migrant workers particularly from
3 Eastern European countries who were working in quite
4 difficult circumstances in some of our food processing
5 plants. So there was some very specific things during
6 Covid.

7 If you want to ask about how we're addressing
8 inequalities more widely in Wales, this predates the
9 pandemic but it's ongoing work. There's quite a lot
10 that we're trying to do. We recognise that focusing on
11 the early years and getting the early years right is
12 really important. We've had a process of looking at
13 adverse child events in Wales which has led to a better
14 understanding of how we can support children and young
15 people: support for free school meals, support for
16 people coming out of the care system, because they often
17 get left behind and when they emerge from the care
18 system really struggle and so additional financial
19 support for them. There are a number of things like
20 that.

21 And then in broad terms -- and I realise this is
22 kind of broad policy -- we work very closely with the
23 World Health Organization to try to better understand
24 our inequalities. We have a process called the WHESRI,
25 it's a horrible acronym, it's about looking at equity,
143

1 there were no immediate steps taken?

2 **A.** There were two steps taken: the ones I just described,
3 which was to set up a group to look at the issue broadly
4 in terms of the impact of Covid, and specifically around
5 healthcare and the impact on healthcare workers.

6 So I think those are fairly specific.

7 **PROFESSOR THOMAS:** My Lady, question 4 has just been
8 answered so I'm going to come back to questions 1 and 2.

9 **LADY HALLETT:** Thank you.

10 **PROFESSOR THOMAS:** In your statement at paragraph 267 you
11 mention that Covid-19 exacerbated existing inequalities,
12 and in paragraph 273 you discuss how reducing these
13 inequalities became a central ambition to shift towards
14 prevention.

15 My question: could you please identify what, if
16 anything, has been done to reduce these inequalities as
17 you suggested.

18 **A.** Do you mean during the pandemic or subsequently?

19 **Q.** Well, let's start with the pandemic and then let's turn
20 to subsequently.

21 **A.** During the pandemic I think I've highlighted a few
22 actually, earlier in my statement. I can go over them
23 again if you like. But it was specific to different
24 groups who were being disproportionately affected.
25 I mentioned taxi drivers, I mentioned the risk
142

1 it's a tool that we have developed jointly with the
2 World Health Organization to try to understand our
3 situation much better.

4 **Q.** Thank you.

5 Second question. In the report titled
6 "[Coronavirus] and [the] Health Inequalities", at
7 paragraphs 4 and 19 structural inequalities and
8 additional effects of racism are identified as
9 additional contributors to worsen Covid-19 outcomes.
10 Question: was anything done to address these findings
11 and was there any monitoring that was carried out?

12 **A.** So this was a real eye-opener, I think for all of us,
13 and it came out of Judge Ray Singh's work, as
14 I described, the kind of broader context of Covid rather
15 than the specificity around the healthcare workers.

16 Yes, I mean I think that has fed into our whole
17 process of thinking about race and race equity in Wales.
18 We have a very elaborate race equity scheme. It's never
19 perfect. We need to do further work on that. All of
20 our departments in Welsh Government and across the NHS
21 are focused on race equity issues. There's far, far
22 more than we need to do, but in process terms, that's
23 where we are, I think, yes.

24 **Q.** Were policies or actions implemented to address the
25 disparities identified and to minimise preventable harm?
144

1 And if so, in your view, were these actions timely and
2 effective?

3 **A.** In terms of the policy and practices, I think the thing
4 that I'm most impressed by was the work that our
5 colleagues in BAPIO, who I mentioned earlier, did
6 undertake as part of that broader race equity work.
7 They looked very carefully at the risks the healthcare
8 workers were facing and they developed a risk
9 measurement tool which was disseminated across the
10 health boards, was used very widely in the health
11 boards, and actually was then picked up across the other
12 four nations of the UK. So it's the one thing I would,
13 kind of, point to. I'm sure there are others. But
14 there were practical implications which were coming out
15 of those --

16 **Q.** I've got one more question, but just a cheeky little
17 follow-up to the answer you have just given. You say
18 that's one thing that you feel has been successful. How
19 was the success measured?

20 **A.** By its uptake across the healthcare system in Wales and
21 beyond.

22 **Q.** Okay.

23 Final question: with the benefit of your
24 first-hand experience and engagement with healthcare
25 workers, what do you think can and ought to be done to

145

1 their socio-economic status and their race, their
2 origins, and I think more consideration needs to be
3 given to how we support people in those groups to do
4 things like self-isolating, which was much more
5 difficult for people in those groups.

6 **PROFESSOR THOMAS:** Thank you, Dr Atherton.
7 Thank you, my Lady.

8 **LADY HALLETT:** Thank you, Mr Thomas.
9 Mr Simblet.
10 Again, behind you to your right, Dr Atherton.

11 **Questions from MR SIMBLET KC**

12 **MR SIMBLET:** Good afternoon, Dr Atherton. I'm asking
13 questions on behalf of the Covid-19 Airborne
14 Transmission Alliance (CATA). You have supplied two
15 detailed statements and given evidence in the course of
16 the day. What's not in those statements is what you
17 thought about the classification and declassification of
18 Covid-19 as an airborne, high consequence infectious
19 disease, and I want to ask you about that, please.

20 In January 2020 Covid-19 had been designated an
21 airborne HCID, and you understood the rationale for
22 that, did you?

23 **A.** Yes, I did.

24 **Q.** And what I want to move to is, that designation having
25 been made, did you support actively the declassification

147

1 reduce inequalities for ethnic minority healthcare
2 workers to ensure that they don't suffer such disparate
3 impact in the event of a future pandemic?

4 **A.** Well, I would probably broaden that beyond healthcare
5 workers, but certainly within healthcare workers there
6 are questions about parity of esteem, about promotion,
7 about access to training, to learning opportunities.
8 All of these are things which we're determined to get
9 better in Wales at both monitoring and influencing.

10 **Q.** Would you also agree allowing them to have a seat at the
11 table where decision are being made?

12 **A.** I think that's what I mean when I talk about promotion
13 and, you know, getting more people into senior
14 positions. Many of our -- if I think about the medical
15 profession, many of our doctors in Wales, Mr Thomas,
16 many of them are working in SAS positions -- that's
17 subconsultant posts, my Lady -- and so their terms and
18 conditions are not as good as consultants, and I think
19 there's more that we can do, and we are doing actually,
20 to try to ease the pathway for them into consultant
21 posts. That's, kind of, one example.

22 The other bit of your question, broader, is more
23 societal, is we do need to look at access to resources
24 when we have something like a pandemic. People's access
25 to statutory sick pay was limited sometimes according to

146

1 decision in March 2020?

2 **A.** Yes. I'll expand.

3 **Q.** Please do.

4 **A.** So it was inevitable that with a new disease like
5 Covid-19, not knowing anything or very much at all --
6 yes, nothing, about the pandemic in January 2020, when
7 it first became likely that we would start to see it in
8 the UK, any new disease like that would be treated as an
9 HCID, a high consequence infectious disease, and the
10 reason for that, of course, is that we don't know enough
11 about it, we don't know how infectious it is, we don't
12 know how it would affect healthcare workers. We had had
13 experience with MERS-CoV, not in the UK but in other
14 parts of the world, where healthcare workers had been
15 very severely and adversely affected.

16 So it was right to treat it as an HCID in the
17 first instance. Once we started to see cases in the UK,
18 that, first of all, no longer became tenable and,
19 secondly, no longer became desirable.

20 It wasn't tenable because the HCID units only have
21 a certain amount of capacity, and it wasn't necessary
22 because we were learning more about how we could treat
23 that, and it could be treated as a routine infection --
24 I shouldn't say "routine" but as a normal, perhaps,
25 infectious disease as we would treat any other

148

1 respiratory disease.

2 **Q.** Thank you. Of course it was also an airborne HCID, and
3 that moves me to my next question. Were there any
4 discussions about the declassification decision being
5 connected to problems with the supply or, as you said
6 earlier, distribution or suitability of PPE or RPE?

7 **A.** No. The decision to move from being an HCID to not
8 being an HCID any more had nothing to do with the
9 availability of any particular form of PPE, no.

10 **MR SIMBLET:** Thank you very much for your answers.
11 Thank you.

12 **LADY HALLETT:** Thank you, Mr Simblet.
13 Ms Jones, Jessica Jones, get the right one.

Questions from MS JONES

14 **MS JONES:** Thank you, my Lady.
15 Dr Atherton, I ask questions on behalf of
16 Care Rights UK, John's Campaign and The Patients
17 Association, all of whom represent people drawing on
18 health and social care and their loved ones.
19 In terms of what was known and when, your evidence
20 in your witness statements is that from the earlier
21 stage of the pandemic it was known that age was
22 a significant risk factor for severe illness and
23 fatality from Covid-19, and that this was known from at
24 least the beginning of March 2020. Is that correct?
25

149

1 with the connection: where you know that there is
2 a vulnerable group, namely older people, and where you
3 cannot rule out that there is asymptomatic and
4 pre-symptomatic transmission, do you agree that
5 a precautionary approach should have been taken in light
6 of that evidence so that, using the terminology that you
7 used earlier, in the balance of benefits and harms, the
8 risk of harm caused by the decision to discharge without
9 testing outweighed any benefit?

10 **A.** Well, leaving aside the supply issue and the fact that
11 it wouldn't have been feasible -- I mean, there was a
12 lot of thinking going on really in the early days of the
13 pandemic. It was apparent that people in care homes
14 were suffering, we started to see outbreaks, of course,
15 in care homes, and the systems were put in place to try
16 to limit that: the PPE was provided to care staff,
17 discussions about spacing, about isolating people when
18 they came back from hospitals. But it was much later
19 that testing capacity became available and it became an
20 option to start to test people being discharged from
21 hospital.
22 So the precautionary principle really wasn't an
23 issue there. The precautionary principle doesn't help
24 you in terms of applying the whole suite of IPC
25 arrangements which, if I'm honest -- you know, we talk

151

1 **A.** Yes, I would agree with that, yes.

2 **Q.** And at the same time, also in February and March 2020,
3 the understanding in respect of routes of transmission
4 was that the extent of asymptomatic and pre-symptomatic
5 transmission was not yet known but that they could not
6 be ruled out, correct?

7 **A.** Yes.

8 **Q.** In this context, do you agree that the decision then to
9 discharge patients from hospital without testing them
10 increased transmission and mortality from Covid-19?

11 **A.** I fail to see the connection between the two previous
12 statements, but to your question about whether in
13 March/April discharge policies should have included
14 testing on discharge, no, there was no testing, there
15 was very, very little testing. It would have been
16 practically impossible to achieve that.
17 So, yes -- I mean, at that point in the pandemic,
18 you know, we were just starting to learn about the
19 virus. We were starting to develop testing. The result
20 is the PCR testing, which then came onstream first of
21 all in the UK, and then we did develop testing
22 relatively quickly in Wales, but getting to the volume
23 that would have been required would have -- that was
24 much, much later.

25 **Q.** Dr Atherton, perhaps I can ask this which might help
150

1 about care homes, I know there's going to be a future
2 module looking at care homes -- we do need to be better
3 at IPC arrangements and training and provision within
4 care homes. That's where our focus should be. And
5 testing is probably one small part of that.

6 **MS JONES:** Thank you.

7 **LADY HALLETT:** Thank you very much.
8 Mr Pezzani. You are over there.

Questions from MR PEZZANI

10 **LADY HALLETT:** I'm not sure we're getting you.

11 **MR PEZZANI:** Dr Atherton, I ask questions on behalf of Mind,
12 the mental health charity. The first question is this:
13 at paragraph 269 of your first witness statement you
14 explain how in July 2020 you advised the First Minister
15 that you remained concerned that the restrictions which
16 were in place were leading to significant negative
17 impacts on mental health and well-being, which were
18 particularly acute for the young.
19 My first question is whether you can help with
20 identifying the information upon which you based that
21 assessment and which gave rise to your concerns?

22 **A.** No, I can't really point to any specific document or
23 technical report or anything. It was really just
24 recognising the difficulties that everybody in society,
25 I suppose there was newspaper reports, all sorts of
152

1 things.

2 So we were hearing from the public in the same way
3 as everybody was. These were not easy times for
4 anybody. But there's no specific source of information
5 I can point to.

6 **Q.** No. Can I seek to assist you by perhaps reminding you
7 of a Mind Cymru report from the month before that,
8 June 2020. It was a survey that found that over a third
9 of young people in Wales had been unable to access the
10 support that they sought during lockdown and over half
11 of them said that that difficulty in getting mental
12 health support had made their mental health worse.

13 Would that -- was that something that maybe had
14 figured into your assessment of the state of children
15 and young people's mental health?

16 **A.** I don't remember seeing the report. Of course, as
17 I described earlier, you know, May/June, the river of
18 information was flowing and it may be something that
19 wasn't brought to my attention or I missed. But what
20 I would say is I absolutely recognise the issue that
21 you're describing because by that time, of course, we
22 had suspended all non-essential, let's say,
23 non-essential services within the health boards and
24 mental health suffered -- mental health services
25 suffered that same setback as people were redeployed to

153

1 I absolutely recognise that.

2 **Q.** Thank you, Dr Atherton.

3 Just one more short topic which has already been
4 addressed somewhat by Mr Thomas and that is
5 inequalities.

6 My specific question to you is on the potential
7 for compound inequalities. We've already seen your
8 concerns about the impact of lockdown on young people in
9 Wales in relation to their mental health. My question
10 is whether children and young people's vulnerabilities
11 to the harms from lockdown, which is a phrase used in
12 a paper you presented in June 2020 for the Executive
13 Director Team, whether that vulnerability to harms from
14 lockdown was compounded by extant inequalities. So, for
15 example, the risk to mental health may have been
16 particularly acute for a child from a racialised
17 community who is living in poverty.

18 **A.** I absolutely agree with everything you're saying, that
19 there is almost a ladder of inequalities, different
20 steps. So if you're from a black -- minority -- or
21 a minority ethnic -- ethnic minority group and you are
22 poor and you're coming from a socio-economic
23 deprivation, in a poorer part of Wales, then your risk
24 of both physical and mental well-being being damaged is
25 much, much greater.

155

1 the front line to try to keep people alive.

2 So absolutely there was a downside and
3 a consequence to all of that, and it wasn't just young
4 people but young people, as I think I said in the
5 report -- so I'm grateful to you for bringing it to my
6 attention because it does, as you rightly say, help me
7 to understand the impact and we were aware of it but
8 I don't remember the specific report.

9 **Q.** Thank you, Dr Atherton.

10 My second question is this. Are you able to
11 assist on what immediate steps were taken to address
12 this particularly acute negative impact on the mental
13 health of the young in Wales?

14 **A.** I can't. I can't tell you the specific steps during the
15 pandemic. As we started to emerge from the pandemic we
16 gradually restarted all of our services and -- including
17 mental health services and it was important that we did
18 that. Of course, for all the services, physical,
19 mental, there is a backlog of care which we need to deal
20 with, and I am grateful to Mind not just for the tools
21 that you -- that the organisation you represent has been
22 putting into the public domain to try to help to deal
23 with some of that through self-care, through community
24 care, but there's so much more we need to do. So
25 there's a backlog as we come out of the pandemic,

154

1 This is why we try, as I have tried to describe,
2 to address this through our approaches to inequalities,
3 but there's no doubt that you're right. There are
4 layers of deprivation -- sorry, layers of inequality
5 which affect people's mental health. I recognise that
6 absolutely.

7 **Q.** I am grateful.

8 Just one last question. In relation to that, were
9 there any immediate steps that were taken or in
10 hindsight were possible to take to mitigate that
11 inequality? For example, in relation to the issue of
12 digital exclusion just at the time that many mental
13 health services for children and young people were
14 moving to remote delivery?

15 **A.** I think if we look at what happen through the education
16 system there was a recognition that as education moved
17 to online learning that people would be excluded.
18 I can't remember the details but I think there was more
19 provision of information technology support to people
20 who didn't have access to it. It was acutely in our
21 minds, really.

22 And even the -- the support I was, you know,
23 applauding your organisation, the organisation you
24 represent, for providing CBT and online support for
25 mental health, I recognise that that's not equitably

156

1 provided if people are digitally excluded. It's
2 absolutely something we need to consider as we try to
3 improve our approaches to equity.

4 Thank you.

5 **LADY HALLETT:** Thank you very much.

6 Right, Dr Atherton, I think that completes the
7 questions we have for you. I hope it hasn't been too
8 long a day for you.

9 **A.** Thank you, my Lady.

10 **LADY HALLETT:** I am going to say the same as I have said to
11 your colleagues. I appreciate the burden we place upon
12 you and your office when the Inquiry asks you to
13 contribute to the Inquiry by providing written material
14 or by giving evidence. I will tell the teams to please
15 not impose upon you again unless we absolutely have to.
16 So if you do get more requests, then I am afraid it will
17 be because they consider it inevitable. So thank you
18 very much for your help to date.

19 **A.** Thank you, my Lady.

20 **LADY HALLETT:** I shall return at 3.40.

21 (3.28 pm)

22 (A short break)

23 (3.41 pm)

24 **LADY HALLETT:** Mr Mills.

25 **MR MILLS:** My Lady, the next piece of evidence comes from
157

1 Northern Ireland and abuts the border with the Republic
2 of Ireland. The hospital serves a population of about
3 180,000 which is a mixed rural and urban population.

4 The demographics, it's got a very small ethnic
5 minority community of about 2% but it has high levels of
6 social deprivation with recent statistics telling us
7 that a male in the area will live six years less than
8 the average in Northern Ireland, that 22% of people live
9 in poverty, as compared to 16% across Northern Ireland,
10 and that it's got the highest level of non-elective
11 inpatient admissions which is in keeping with what you
12 would expect in terms of high levels of demand on health
13 and social care services.

14 **Q.** Did the hospital's position close to the border present
15 unique challenges during the pandemic?

16 **A.** I do believe it did. I suppose I should have mentioned
17 that we do provide some cross-border services, in
18 particular cancer services and emergency cardiac
19 services, such as PCI, percutaneous, and interventions.

20 So -- and a large number of our staff live across
21 the border so we have a footfall that crosses daily and
22 at times during the pandemic that border was closed.

23 So the trust was required to provide paperwork to
24 staff to identify themselves as essential travellers and
25 some of our patients who were coming across the border

159

1 our first spotlight hospital. For availability reasons
2 we move from day of Welsh evidence to Northern Ireland.
3 With that, may I please call, via the video link,
4 Dr Catherine McDonnell, who will affirm.

5 **DR CATHERINE McDONNELL (affirmed)**

6 **LADY HALLETT:** Dr McDonnell, I'm sorry if we've kept you
7 waiting. I am afraid we overran a bit this afternoon.
8 Thank you.

9 **Questions from COUNSEL TO THE INQUIRY for MODULE 3**

10 **MR MILLS:** Your full name, please.

11 **A.** Dr Catherine McDonnell, former medical director of the
12 Western Health and Social Care Trust of which
13 Altnagelvin Hospital is a part.

14 **Q.** Just to give the date of your tenure, Dr McDonnell, that
15 was between 1 March 2020, I think, and 23 June 2022; is
16 that right?

17 **A.** It was indeed.

18 **Q.** Your witness statement, for the transcript, is reference
19 INQ000477593.

20 Let us begin, please, with the background to
21 Altnagelvin Hospital. Can you tell us, please, where
22 the hospital is located and describe the demographics of
23 the population it serves?

24 **A.** Altnagelvin Area Hospital is located in
25 Derry/Londonderry, which is in the northwest corner of
158

1 to look for services.

2 I suppose I'd also say because we are two
3 different jurisdictions the guidance on restrictions
4 often varied, and that in particular in the first surge,
5 was extremely confusing for staff because there was so
6 much rapid change and they were hearing some conflicting
7 messages.

8 I also believe that we were particularly at some
9 times not quite in step with the rest of the region in
10 terms of our surges and our spikes and that might have
11 been to do with some of the differences in terms of
12 lockdowns. So if we unlocked early we got a footfall of
13 residents from across the border to enjoy our
14 restaurants and pubs and I think that might have
15 contributed to some of our particular peaks.

16 **Q.** Can we move please now to staffing capacity. At
17 paragraph 10 of your statement you say this:

18 "Altnagelvin had staffing shortfalls prior to the
19 pandemic, particularly nurses and doctors, creating a
20 high dependency on agency and locum staff."

21 Again, just thinking please about the location,
22 did that have an impact on the hospital's ability to
23 fill those shortfalls?

24 **A.** Absolutely. I understand that the Inquiry has already
25 heard about the challenges in terms of the region and
160

1 workforce difficulties and as is quite common place that
 2 when there are shortfalls in a region it's most
 3 extremely felt in the peripheries. So we would have
 4 been a peripheral hospital to start with and that meant
 5 that we had had a long-standing strategy around trying
 6 to recruit and particularly with an international work
 7 stream and that had to slow up through the pandemic
 8 because of all the different -- the difficulties with
 9 travel restrictions with PLAB exams, et cetera, and that
 10 was for both medicine -- for doctors and for nurses.

11 It also means that when there are temporary
 12 funding for positions you are very rarely going to get
 13 people moving to a peripheral area, moving to
 14 a temporary post. So some of the Covid funding was
 15 temporary and it was very hard for us, for example, to
 16 really -- to bring additional staff into our
 17 infection prevention control team, into our outpatient
 18 health team, all sorts of challenges such as that. And
 19 I should add that in the Republic of Ireland, the terms
 20 and conditions for doctors are much, much better than
 21 they are within the region so that's also
 22 a long-standing and chronic difficulty.

23 **Q.** With all of that in mind, were you able to effectively
 24 recruit at all during the pandemic?

25 **A.** We used the regional workforce appeal and through that
 161

1 help us with how this was achieved?

2 **A.** We were highly ambitious and we had not truly worked out
 3 that the actual bed constraint was not going to be the
 4 number of beds, it was going to be the number of staff
 5 that could staff a bed. So I don't think we actually
 6 moved beyond 14 to 16.

7 But we did have some innovative ways of trying to
 8 take pressure off our ICU in terms of developing high
 9 dependency beds within our respiratory units. We
 10 expanded the ICU to some extent by expanding and
 11 elevating what could be achieved in a respiratory ward
 12 by anaesthetists working into that respiratory ward, and
 13 the ICU itself was expanded by moving into recovery
 14 areas, theatre recovery areas, and additional spaces
 15 being set up by bringing theatre staff and training them
 16 up as ICU nurses, and additional anaesthetists joining
 17 the ICU team by the -- to technicians securing
 18 additional ventilators and all the additional equipment
 19 that was required to provide patient care within those
 20 beds.

21 So we gathered all of what is needed, not just
 22 beds, in terms of really providing that additional ICU
 23 service and had it well supported in terms of a very
 24 collaborative piece of work carried between respiratory
 25 consultants and anaesthetists.

163

1 appeal we got about 500 additional staff. Those staff
 2 were less likely to be on the acute front line but they
 3 certainly were very helpful in supporting us in
 4 delivering additional services that Covid required that
 5 we set up, such as vaccination clinics such as testing
 6 centres. So we definitely got some benefits from the
 7 regional workforce appeal but it was much more difficult
 8 to get highly skilled and professional staff such as
 9 nurses and doctors.

10 **Q.** Next, please, bed capacity. At the start of 2020 can
 11 you help us, please, with the ICU bed capacity at the
 12 hospital.

13 **A.** The ICU bed capacity was ten, ten beds in total which
 14 was -- and curiously, 7.5 level 3, and three level 2.
 15 As all organisations, we had surge planning in terms of
 16 determining how we were going to increase that capacity
 17 and the expectation of a high level of demand that
 18 required us looking at the footprint, looking at getting
 19 additional equipment, looking at getting additional
 20 staff and really setting up systems to look at how best
 21 to use that capacity should we be under excess demand.
 22 I can give some more detail, if you would like, as to
 23 what we did.

24 **Q.** Yes, please. I think it's right, is it not, that the
 25 plan was to increase this figure to 24 beds. Can you
 162

1 **Q.** Dr McDonnell, that's very clear, thank you. Can I ask
 2 you try, if possible, to slow down your answers. We
 3 have a stenographer trying to keep up.

4 Can you help us with this, please. How did the
 5 length of ICU stays during the pandemic compare to
 6 pre-pandemic non-Covid admissions?

7 **A.** The figures which I am told anecdotally would be that
 8 a normal ICU stay would have been about two to three
 9 weeks but in Covid times this could have extended for,
 10 you know, 130 days ... at ten weeks, so that the
 11 whole -- and the patients that were in the ICU were
 12 extremely unwell. So there was none of what might have
 13 been described as slightly easier ICU work. It was
 14 highly intensive and patients were there a long time
 15 with the additionality of families not being able to
 16 visit in the same way and the demands on this team to be
 17 providing that component of care that families would and
 18 the building of relationships because of that absence.

19 It was also more challenging because all of the
 20 communication with families was being done by phone or
 21 by video links. So the psychological and traumatic
 22 impact on staff was definitely highly significant.

23 **Q.** Can you tell us a little bit about the atmosphere in the
 24 ICU at this time, the collective feeling amongst the
 25 staff about the standard of care that they felt as if
 164

1 they were able to provide?

2 **A.** The atmosphere changed with surges. In the first surge
3 there was real challenge because this was a completely
4 new experience for the staff in terms of how they had to
5 work in full PPE in terms of trying to manage to have
6 those communications and relationships with patients
7 with significant mask-wearing and changing how they did
8 things. And there was absolute fear. I mean, when you
9 think about the society in general, it was anxious about
10 Covid and we were asking staff to walk into situations
11 where they were actually exposing themselves to it.
12 There was an unfamiliarity with actually wearing PPE.
13 So there was -- it was a real fear of the unknown
14 and a real unfamiliarity that made that first surge just
15 very difficult in terms of the day-to-day work. But
16 things -- as things changed and that bit eased, that
17 stress eased, then it became more difficult because of
18 the chronicity because of the repeated surges, because
19 of the level of illness, because of the increased
20 frequency of death in ICUs, these patients were very ill
21 so the number of deaths was much higher. The management
22 of end of life care was much more difficult.
23 So it was extremely -- and some of these staff
24 weren't ICU staff. They were theatre staff who had been
25 brought into an area again that they were unfamiliar

165

1 were so poorly staffed in terms of nurses and doctors as
2 compared to usual, because Omicron, which was highly
3 infective, it spread like wildfire. If you look at some
4 of the reporting at that time the numbers of patients,
5 people affected across Northern Ireland was described as
6 extraordinary, up to 1 in 10. 1 in 10 people in some
7 areas and that would have been our locality.
8 So we had significant losses of staff and I think
9 some of that was even more difficult because at the time
10 society was getting on with life as normal and yet
11 within the hospital we were desperately trying to keep
12 that still Covid-free because we still knew we had
13 really vulnerable patients, we were still trying to keep
14 staff levels at a level to deliver the best patient care
15 that we could, staff were getting Covid. It was the
16 most chaotic moment, I would say, in terms of our
17 particular part of the country.
18 **Q.** What problems arose from the dissonance between what
19 people were allowed to do outside and what both patients
20 and staff had to follow in the hospital?
21 **A.** We were still in full Covid alert in terms of how --
22 what we expected of staff. So, for example, within the
23 workplace staff would not be able to sit in the tea room
24 together. There was still social distancing. There was
25 still limited numbers particularly in the tea room and

167

1 with. So the whole experience was just high intensity
2 demand on a very chronic basis over a period of
3 two years.
4 **Q.** At your paragraph 100 you say this:
5 "Altnagelvin Hospital faced particular challenges
6 in the fifth surge which took place over December 2021 -
7 February 2022. It was the second Christmas where the
8 hospital was overwhelmed with admissions of patients
9 with Covid."
10 We often hear that word "overwhelmed". When you
11 use it in that context can you describe to us what that
12 meant for staff and patients on the ground in the
13 hospital at that time?
14 **A.** When I look back over the two years I think that was the
15 lowest point for the staff group in Altnagelvin
16 Hospital. I suppose we understood that level of concern
17 that a staff felt when both nurses and doctors were
18 coming to us as their directors and asking us about
19 where they stood individually, professionally because of
20 the fact that they felt they were not able to deliver
21 care in the way that they usually would. And I,
22 for example, discussed that with the General Medical
23 Council, my nursing colleague would have discussed that
24 with NMC because -- and that was to do with staff
25 absence. That was to do with the fact that the wards

166

1 yet the same staff, if they were following what was
2 happening outside, could all have gone on a Christmas
3 night out. They could all have gone out to a restaurant
4 or to a movie together. So we were asking different
5 things of them. Different things were expected of them
6 in the hospital as compared to what was happening
7 outside.
8 And it was really confusing for visitors who
9 were -- mask wearing had stopped but as soon as they're
10 into the hospital, there's hand sanitisation, there's
11 mask wearing, there was potentially restrictions to some
12 extent in terms of how many visitors might come. So
13 they found it really confusing as well and it felt that
14 they were two parallel universes going on at that point
15 in time. There was Covid world, which was work, and
16 then there was non-Covid world, which was outside.
17 So I think that tension was extremely difficult.
18 And then Omicron just was so infective that it
19 went like wildfire through people groups and through
20 staffing groups. So it meant that we were trying to
21 balance and when staff got Covid or they were in contact
22 with Covid, balancing the risk of bringing them back and
23 then bringing Covid into the hospital or not bringing
24 them back and having a really fragile workforce that
25 might not be able to deliver the care that we wished.

168

1 So we were making very difficult risk assessment
2 decisions every day.

3 **Q.** Next, please, infection prevention and control. Did the
4 hospital always follow national guidance in respect of
5 IPC measures or did it at times deviate?

6 **A.** Generally, we followed guidance but occasionally we
7 applied what I would describe as a little bit of common
8 sense. For example, guidance came through to downgrade
9 some of our PPE just before Omicron struck and that
10 wasn't to be predicted. So we delayed implementation of
11 the new guidance until our community transmission rates
12 dropped and we were content that there was -- that the
13 rate of potential of transmission within the hospital
14 had eased.

15 **Q.** At paragraph 41 of your statement you say this:
16 "The biggest challenge to implementing IPC
17 guidance was concern in the early stages of the pandemic
18 that guidance was developed around supply issues rather
19 than safety and that safety measures being advised were
20 inadequate."
21 Are you able to provide us with an example to
22 illustrate this point?

23 **A.** I think that when we look back, the IPC protection or
24 PPE protection was particularly for people who were in
25 Covid areas but it wasn't really being prescribed for

169

1 the start in terms of who needed PPE and who didn't.
2 But, gratefully, we were seeing the new guidance coming
3 that allowed us to provide protection for all our staff.

4 **Q.** Did that tension lead to a loss of trust and confidence
5 in national directives on the part of your staff?

6 **A.** I think so.

7 **Q.** What, if anything, were you able to do to restore that?

8 **A.** What we tried to do was to continue to have
9 conversations and to be as open and transparent as
10 possible. I met -- on a weekly basis I had an open
11 meeting for all doctors, senior doctors, and there were
12 opportunities to just have conversations to support
13 people in understanding what was possible and what was
14 not possible at points in time.

15 **Q.** Next, please, visiting restrictions. It's right, isn't
16 it, that the hospital developed a risk assessment tool
17 to make decisions about whether to allow visits. Can
18 you explain to us how that tool worked in practice?

19 **A.** I suppose I'd start by referring to the first visit.
20 Visiting was very challenging and there was -- we
21 weren't able to offer visiting but as we started to open
22 up to visiting, the first visit was of a young woman to
23 her husband, the father of her children, in the first
24 surge and we were worried he was close to end of life.
25 There was a lot of -- there was a lot to learn about how

171

1 people who sat outside those Covid areas. So the
2 concern for a lot of nurses and doctors were that with
3 the limited knowledge that there was of how Covid
4 presented that they too should have had that protection
5 and, thankfully, fairly quickly that did happen. But
6 there was a sense that normally when you suspect that
7 there might be a risk that you would use personal
8 protective equipment and that wasn't possible at the
9 start because of lack of availability.

10 And I would also point out that this wasn't just
11 within health settings. Society at large was concerned
12 for the safety of staff working within health. We got
13 multiple donations, very generously, from people to
14 provide us with PPE. So there was a collective
15 understanding not just in health facilities that perhaps
16 there wasn't enough PPE available to protect the staff
17 in their day-to-day work.

18 **Q.** Did you ever perceive any difference between national
19 guidance and that issued by the Royal Colleges?

20 **A.** Just the difference that I've described, that again that
21 the Royal Colleges would at times have suggested that in
22 the absence of knowing a patient was Covid positive or
23 negative that some protection should be in place but at
24 the same time they would have encouraged us to follow
25 national guidance. So there was just that tension at

170

1 to do visiting safely if we think about that as a
2 scenario it was really important that this young woman
3 was safe, that she did not contract Covid during the
4 visit.

5 So you know it took -- we set up a system whereby
6 a nurse, for example, met her at the door so that she
7 could walk her through the hospital, through the
8 Covid-safe pathways to support her in terms of putting
9 on her PPE and bringing her into a very difficult
10 environment which ICU always is but was even more
11 difficult when all the staff were wearing PPE and to
12 provide her with not just a support around Covid but
13 just the emotional challenge of that visit to take her
14 out of that ICU to make sure she took off her PPE
15 safely, because one of the most critical moments when
16 you are wearing PPE is to make sure you take it off
17 properly because you are most likely to get infected at
18 that point in time, and to take her safely off the
19 hospital premises.

20 So there was a lot of learning for us in that
21 about what needed to happen to keep the visitors safe
22 and what sorts of levels of staffing we needed to
23 support someone on a visit. That's what we gathered.
24 It was through the ethics committee that we sat and we
25 did a template to try and make sure that we could offer

172

1 visiting equitably within the facility because some days
2 it would be easier to do because there would be staff
3 availability, there would be less ill patients, and
4 other times it would be more difficult. So that's what
5 we did.

6 **Q.** In your view, did the tool allow the hospital to find
7 the right balance between maintaining a Covid-safe
8 environment and the emotional cost that visiting
9 restrictions could cause?

10 **A.** Yes, absolutely. Absolutely. It was a tremendously
11 supportive tool to staff and it also was helpful,
12 I think, in terms of conversations with families because
13 they understood the rationale, they were beginning to
14 understand the risks that had to be managed to allow for
15 safe visiting.

16 **Q.** Was the risk -- was the tool used to approach the
17 question of visiting in a maternity setting or did the
18 hospital approach that question slightly differently?

19 **A.** I'm back to memory now. I can't remember. Apologies.
20 I can't remember.

21 **Q.** Do you recall whether in the early stages of the
22 pandemic there was an absence of national guidance on
23 visiting in a maternity setting?

24 **A.** I remember our guidance. I remember the local
25 guidance -- I remember the regional guidance in visiting

173

1 as best we could, recognising the particular
2 vulnerability in pregnant women and for their babies.

3 **Q.** You mentioned the ethics committee. I think it's right
4 that that was established on 27 March 2020 with you as
5 its chair?

6 **A.** Yes.

7 **Q.** In broad terms, can you help us with what the purpose of
8 that committee was?

9 **A.** If we think back to 27 March 2020 and we had a look
10 towards experiences in Europe as to what we might expect
11 in terms of demand and the pandemic, there was
12 a crushing concern that we would be in a position of
13 needing to ration care and how that might happen and
14 some very difficult clinical decisions might have to be
15 made.

16 So we decided to start having those discussions as
17 early as possible so we opened up our ethics committee.
18 The ethics committee was extremely important in terms of
19 bringing a wide range of people to the table in terms of
20 having discussions. So we had our chaplains, we had lay
21 people, we had academics, we a non-executive director,
22 and we had obviously some trust staff. And it really
23 was with the purpose of ensuring that we did the right
24 thing and ensuring that we were supporting clinicians on
25 the ground whose anxiety levels were extremely high

175

1 our maternity unit. I can remember that and it really
2 was that they were only allowed to visit a partner
3 available -- sitting with them through labour.

4 I remember there was significant restrictions and I had
5 some discussions with the team in preparation for the
6 Inquiry as to how they managed that.

7 **Q.** Can you tell us anything about the impact of visiting
8 restrictions in that particular context on patients?

9 **A.** Maternity was particularly difficult because pregnant
10 women were all highly vulnerable. So we were -- again,
11 we were challenged to balance our duty of care to every
12 woman who came into the hospital to ensure that they
13 were safe and within the trust we lost one mother and
14 that felt like one mother too many. So it was
15 absolutely critically important that we kept them safe
16 but then we were really mindful of the emotional journey
17 of anyone in terms of a baby and the importance of their
18 partner within that.

19 So I know that what happened within the scans were
20 partners did not routinely attend that there was an
21 arrangement that they would be outside and if there were
22 any difficulties that the partner would be invited in to
23 support the mother if there was bad news to be broken
24 and I understand that partners were allowed to be with
25 the mothers through labour and that was our compromise

174

1 about this aspect of potential decision-making in the
2 future.

3 It was to -- it was a place to bring dilemmas, it
4 was a place for anyone to bring questions and it was for
5 us to be on the front foot in terms of developing some
6 tools that might be helpful to them in the moments of
7 crisis.

8 **Q.** Some might think that clinicians have to make all sorts
9 of difficult decisions all the time. Can you help us
10 understand how a national decision-making tool about the
11 rationing of care might have helped those working in the
12 hospital?

13 **A.** Clinicians do -- a lot of what we think in terms of or
14 talk about in terms of difficult decision-making in
15 Covid, as you rightly say, is what happens daily but
16 Covid intensified all that and asked us to really look
17 at it and added layers of complexity. So it was really
18 important that we dealt with that.

19 I think it felt like an extremely heavy burden for
20 a clinician to carry on their own and that's why it was
21 really important for us as an organisation to ensure
22 that those clinicians were supported and we did that by
23 developing some tools and developing an emergency
24 decision support group should they have been in that
25 particular acute position of trying to determine who

176

1 should receive care. I think it's an area that needs --
 2 in peace times, we talk about peace times, non-Covid,
 3 non-pandemic times. It's an area that we really should
 4 be doing work on now rather than waiting until we get
 5 into the eye of the storm and I think that we can never
 6 have too much guidance, whether it's regional or
 7 national, in terms of helping us to explore these
 8 difficult topics and help us and direct us and guide us
 9 to do the right thing by each individual patient.

10 **Q.** I think it's right that, as it transpires, the services
 11 of the emergency decision-making support group were
 12 never in fact needed.

13 **A.** They weren't needed but some of the documentation that
 14 we developed around it was just really helpful for
 15 clinicians when they were working their way through some
 16 clinical decision-making. But thankfully it was
 17 actually not needed.

18 **Q.** Having gone through the process of developing
 19 documentation in this area, are there any specific
 20 references that you would like this Inquiry to consider?

21 **A.** I don't quite understand the question.

22 **Q.** In the context of creating a decision-making tool in
 23 respect of the rationing of care, having created that at
 24 the hospital within the trust, do you have any insight
 25 into --

177

1 clinicians. It was -- all these refs -- the decisions
 2 that came out of it are always referenced using the
 3 clinicians.

4 So there was a lot of very good stuff in that and
 5 there was a real support to junior doctors to make sure
 6 they were doing best decision-making in conjunction with
 7 patients and their families in a very complex time, and
 8 I think I would definitely recommend that that would be
 9 available to support all doctors in all hospitals at
 10 times like this.

11 **Q.** Considering the picture more widely about the support
 12 the trust introduced for staff, can you tell us a little
 13 about the measures that were introduced to support their
 14 psychological needs?

15 **A.** I suppose my background is psychiatry so I thought it
 16 was extremely important, as did many in the
 17 organisation, that we look after not just protect our
 18 staff in terms of infection, prevention, control but
 19 also be very mindful of the level of stress and anxiety,
 20 trauma that they were going to experience in a pandemic.
 21 So the first that's happened, which was critical, was we
 22 had two senior psychologists who took a lead role in
 23 helping develop a raft of interventions, some of which
 24 were linked to the regional initiative of having
 25 a psychological helpline, others that were related to

179

1 **A.** Sorry, you just froze.

2 **Q.** Having created the decision-making tool about the
 3 rationing of care, do you have any insight, any
 4 recommendations you would like the Inquiry to consider
 5 about what worked well?

6 **A.** About what worked well? I think the security of knowing
 7 that there was an emergency decision-making support team
 8 being there was critical to free the minds of our
 9 clinicians up to look after patients without having that
 10 additional worry. We also developed what was called
 11 a hospital treatment escalation plan which was
 12 a document which is in keeping with best practice around
 13 anticipatory care planning which had not developed fully
 14 in Northern Ireland.

15 There's been more development since Covid. It was
 16 developed with reference to best practice and based on a
 17 template that had been used in the any big trust and
 18 I think that it was a really important tool as a support
 19 to doctors to do the right thing. We want documentation
 20 that prompts people to do the right thing and I think
 21 that's what it did. It was a document that we were very
 22 concerned as the ethics committee to make sure that it
 23 was for a single episode of NLS(?). It wasn't our carte
 24 blanche, this is what's going to happen, to have every
 25 admission have its single. It was tested out by senior

178

1 team debriefs, crisis interventions, all of which were
 2 delivered by the psychologists plus a wider team pulling
 3 on skills from our mental health services.

4 There were already well-being programmes within
 5 the trust and they were expanded upon. There's a work
 6 stream within -- called TWIST West, which was all about
 7 really trying to help people just do well in the middle
 8 of the crisis.

9 So there was a lot of work in terms of trying to
 10 support staff in IC work in circumstances that were
 11 completely unexpected, and that's extremely critical in
 12 terms of delivering good patient care. If your staff
 13 are well they will do a good job. If your staff are
 14 stressed and anxious they will not be able to be there
 15 for patients as they would normally like to be. So it
 16 was part of the whole approach to patient safety and
 17 quality of care.

18 **Q.** Finally then, Dr McDonnell, are there any lessons and/or
 19 recommendations that you would like to share with the
 20 Inquiry based on your experience at Altnagelvin during
 21 the pandemic?

22 **A.** I think I'm going to be repetitive and say things that
 23 have already been said but I think the most important
 24 one is the workforce and the baseline from which we
 25 launch ourselves into a pandemic. I think that that's

180

1 absolutely critical. And I think the second one is, and
2 it's been talked about, pandemic preparedness. We need
3 the PPE. We need things like the visiting guide. We
4 need some of that -- those ethical performers that we
5 were speaking about. We need those things in place
6 before another pandemic hits.

7 I think the evidence thrown(?) up but I think it's
8 really important to understand the impact of the
9 pandemic on elective services in a crisis, and the
10 resources are eaten up by the crisis, and the non --
11 patients not in absolute peril get left behind. So
12 I think there's something about how we think about --
13 how we manage elective services.

14 And I think the fourth one, I would obviously be
15 passionate about is that we really need to think about
16 our staff, how we look after staff and, you know, if we
17 look back on those two years, in the midst of all of
18 that, there was no opportunity for staff to rest. Staff
19 did not get an opportunity to rest. We launched from
20 surge to surge and then we launched into reset and
21 rebuild and we need to think seriously about how we
22 recruit staff and then how we retain them, how we keep
23 them well.

24 **MR MILLS:** Dr McDonnell, thank you.
25 My Lady, that's all I ask.

181

- 1 **A.** Sorry, 2.8. Yes, appreciate that. I've got it now.
2 Yes.
3 **Q.** This is an extract from a 2021 report that you will be
4 familiar with?
5 **A.** I'm familiar with the report.
6 **Q.** We can see, can't we, that the hospital was lucky enough
7 to have a 72 ward block opened right at the start of the
8 pandemic. I'm not sure whether it's April or June 2020
9 but it says June in that document. That's correct,
10 isn't it?
11 **A.** That's correct. Actually, it was in April. You're
12 correct.
13 **Q.** What I wanted to ask you was whether you agreed with the
14 conclusions in that paragraph that that undoubtedly
15 contributed to the hospital experiencing what the
16 subgroup described as, in a different part of the
17 report, lower, less frequent, less complex and less
18 sustained rates of nosocomial transmission up until the
19 report was written in May 2021.

20 Do you agree with that proposition?

- 21 **A.** I do agree that it absolutely contributed. We were
22 fortunate to have a new build that opened up which had
23 single rooms, better ventilation than the older parts of
24 the hospital, and that certainly contributed to the
25 lower level of nosocomial infections.

183

1 **LADY HALLETT:** Thank you very much.

2 Mr Wilcock.

3 **Questions from MR WILCOCK KC**

4 **MR WILCOCK:** Dr McDonnell, I represent Northern Ireland
5 Covid Bereaved Families for Justice campaign and
6 I should say, in the spirit of full disclosure, that
7 Altnagelvin was the hospital I was born at and the only
8 hospital I'm lucky enough ever to have been an inpatient
9 in.

10 I have been granted permission to ask you
11 questions on two subjects. The first is the hospital's
12 relative success in combating nosocomial infection
13 during the pandemic and the second is the approach
14 within the Western Trust's ward DNACPR orders. Can
15 I deal with the first first.

16 Can we please have on the screen -- and you have
17 it in your tab 7 at page 4, doctor -- INQ333416864,
18 page 4 as paragraph 2.8. I don't know, doctor, does
19 this come up on a screen in front of you?

- 20 **A.** It does but it's in small writing, so I can't actually
21 read it.
22 **Q.** That's not helpful. As I said, if you have your papers,
23 it's in your tab 7 at page 4.
24 **A.** That's better. 2.6.
25 **Q.** 2.8 is what I'm going to look at.

182

1 But I also think -- and we and a little bit of
2 a look at this because we certainly were a bit of an
3 outlier in terms of having less nosocomial infections
4 and less death for those who suffered nosocomial
5 infections. I do think that there were contributing
6 factors, such as the manner in which we worked through
7 IPC around infection prevention control strategy which
8 was really about making infection prevention control
9 everybody's business. It wasn't just for a small team;
10 it was how we networked and how we got everyone on board
11 in realising it was our business. And the good news
12 might be -- for you might be -- that there's a continued
13 decrease. It still continues to be an outlier for other
14 non-Covid hospital-acquired infections. The west
15 continues to be an outlier in terms of performing
16 better, which I think is a combination of estate, many
17 other things and also how we think about our IPC
18 practice.

19 **Q.** Thank you for that.

20 Can I come on to the IPC practice during the
21 pandemic because, in your statement, you identify two
22 areas on top of the common sense deviations you've told
23 us about where staff at Altnagelvin appear to have taken
24 measures to counter nosocomial infection which had not
25 been fully reflected in the IPC guidance.

184

1 The first one I'm referring to is at paragraph 47
 2 of your statement. You state that staff recognised risk
 3 linked to ventilation "... in the very early stages" and
 4 that this, and again I quote from your statement:
 5 "... was highlighted for them as they re-purposed
 6 theatre spaces as part of the first ICU surge plan in
 7 March 2020."

8 Then the second example where it may be thought
 9 that you are identifying areas where staff appear to
 10 have gone beyond IPC guidance is at paragraph 50 where
 11 you seem to identify that for testing your trust adopted
 12 a practice wider than guidance and, as a result,
 13 identified Covid positives among staff who would have
 14 fallen outside the regional definition for testing.

15 So I suppose, assuming that I'm right, and that
 16 they were beyond the guidance at the time, is it a
 17 matter of concern to you that, in order to take the
 18 effective steps you've described to reduce nosocomial
 19 infection, your trust felt it necessary to take what you
 20 thought were commonsense steps and steps which could be
 21 felt to amount to departures from the IPC guidance?

22 **A.** I think there's always a tension in terms of a pandemic
 23 where there's a mixture of approaches in terms of a
 24 guide, a command and control approach to guidance or
 25 a guidance that is given with a permission to have some
 185

1 working through the pandemic and what you have described
 2 as a pervasive climate of fear of scarcity. We're going
 3 to hear expert evidence on this topic on Wednesday but
 4 do you think that, notwithstanding the guidance that you
 5 developed, that pervasive climate of fear and of
 6 scarcity resulted in subconscious applications of the
 7 clinical thresholds the guidance expected clinicians to
 8 apply to DNACPR decisions?

9 **A.** I can't talk in generalities but I can talk about what
 10 happened within Altnagelvin Hospital. And what I've
 11 talked about in terms of our ethics committee, of me
 12 meeting regularly with doctors, was to really try and
 13 alleviate anxiety so that people would continue to make
 14 good clinical decisions and not move into that space
 15 that you're describing where they get so anxious about
 16 the future.

17 But I would really want to reassure people about
 18 Altnagelvin Area Hospital that there was a really tight
 19 senior consultant decision-making group that met every
 20 day across every aspect of patients who had Covid,
 21 whether they be in older people's service, whether they
 22 were in ICU, whether in a respiratory ward or in general
 23 medical wards, and they reviewed all those patients as
 24 a collective in terms of determining were they placed in
 25 the right pathway of care, whether they were improving,
 187

1 level of nuance depending on local intelligence
 2 experience and concerns.

3 So I suppose sometimes we take the liberty of
 4 expecting that people would forgive us if we made some
 5 decisions around how -- what we needed to do all in the
 6 spirit of keeping patients and staff as safe as
 7 possible. And I suppose that piece that you refer to,
 8 in terms of having test a small cluster of staff in the
 9 early days before testing, tracking and trace was all in
 10 place, was just overarching concern that the narrow
 11 definition of Covid in the first instance couldn't truly
 12 reflect a virus because no virus would behave in such
 13 a -- would behave so perfectly as to only have three
 14 potentially presenting symptoms. And it helped to
 15 inform us and keep us far from complacent when we were
 16 looking at staff and understanding that they could carry
 17 Covid and be asymptomatic.

18 **Q.** Thank you for that answer, doctor.

19 Can I turn to my second topic, which is DNACPR
 20 because many members of the group I represent have made
 21 clear that in their experience their relatives were
 22 "given up on" and simply abandoned to their fate.

23 In paragraph 96 of your statement, you describe
 24 the development of a trust decision-making tool to
 25 provide additional support to decision-makers who were
 186

1 whether they were deteriorating, exactly.

2 So it was very nuanced. Within Altnagelvin
 3 Hospital, it was very nuanced in terms of making sure
 4 that all patients were getting the best care in the
 5 right place at the right time. I'm recognising that was
 6 dynamic but sometimes patients got better, sometimes
 7 patients got worse, and that you reframed your
 8 expectation in terms of the patient pathway in terms of
 9 the patient's own clinical progress.

10 So I can't speak for other hospitals but I can
 11 speak with confidence around how that decision-making
 12 happened in Altnagelvin because of the strong clinical
 13 leadership in terms of the consultants who led those
 14 services and whom I met on a regular basis, and who got
 15 all those concerns to our ethics group which met on
 16 a weekly basis or twice-weekly at the acute stage of the
 17 pandemic when I required.

18 **Q.** Dr McDonnell, we understand your answer. It's very
 19 clear. But, following on from that, can I just ask you
 20 my last question which is that at paragraph 97 of your
 21 report you point out, in keeping with what you've just
 22 said, that DNACPR was a topic regularly discussed at the
 23 trust's ethics group and that, to your knowledge, you
 24 say there were no issues raised through incident
 25 reporting, complaints and raising concerns in relation
 188

1 to changes to practice in applying DNACPR.
 2 I just want to ask you this: is it possible that
 3 the reason you weren't aware, in spite of the efforts
 4 you made to find out, of any issues in relation to the
 5 application of DNACPR within the trust is because the
 6 system for complaining about or challenging individual's
 7 DNACPR issues was not accessible to patients or
 8 effective in practice?

9 **A.** You know, I appreciate that things could be missed but
 10 I suppose that all complaints -- I sat on -- I chaired
 11 a group every week that reviewed every single complaint
 12 that came through to the hospital, constantly looking
 13 for trends that related to -- relate to anything but --
 14 and, in particular, we had a group looking specifically
 15 at anything relating to Covid.

16 The group is not just myself. I chair a group
 17 with senior professional leads and directors every week
 18 looking at every complaint and looking at every incident
 19 that comes through and it's for that purpose, looking to
 20 see is anything going on that we need to know about.

21 But I'm not saying that perhaps people didn't
 22 understand just to use the complaints system to help us
 23 know what was going on on the ground. I would wish to
 24 assure people that we were constantly looking to get
 25 feedback to make sure that we were doing the right

1 thing. It was part of our strategy as to how to manage
 2 a pandemic.

3 **MR WILCOCK:** Dr McDonnell, thank you very much for your
 4 answers.

5 My Lady, that's all I ask and I think it's 4.30
 6 exactly.

7 **LADY HALLETT:** Perfect timing, Mr Wilcock. Thank you very
 8 much indeed. I think that completes the questioning for
 9 the doctor.

10 Dr McDonnell, thank you so much for your help, I'm
 11 really grateful, and obviously for all the work that you
 12 and your colleagues did during the worst parts of the
 13 pandemic. Thank you.

14 10 o'clock tomorrow, please.

15 **(4.30 pm)**

**(The hearing adjourned until 10.00 am
 on Tuesday, 18 September 2024)**

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I N D E X

1 PROFESSOR SIR FRANK ATHERTON (sworn) 1
 2 Questions from COUNSEL TO THE INQUIRY for 1
 3 MODULE 3
 4 Questions from MS WEERERATNE KC 115
 5 Questions from MS HANNETT KC 130
 6 Questions from MS WADDOUP 135
 7 Questions from PROFESSOR THOMAS KC 140
 8 Questions from MR SIMBLET KC 147
 9 Questions from MS JONES 149
 10 Questions from MR PEZZANI 152
 11 DR CATHERINE McDONNELL (affirmed) 158
 12 Questions from COUNSEL TO THE INQUIRY for ... 158
 13 MODULE 3
 14 Questions from MR WILCOCK KC 182

15
16
17
18
19
20
21
22
23
24
25

	107/9	90/23 102/22 106/13	24 March [1] 81/4	6
LADY HALLETT:	10.00 [1] 190/16	128/6 128/10 129/2	24 March 2020 [1]	6 December [1]
[30] 1/9 4/7 4/9 37/5	10.30 [1] 1/2	142/11 144/7 144/9	78/25	49/17
37/17 50/19 50/21	10.34 [1] 1/4	147/13 147/18 147/20	267 [1] 142/10	6.4 [1] 128/6
93/12 112/8 113/1	10.5 [1] 128/7	148/5 149/24 150/10	269 [1] 152/13	60s [1] 67/15
115/4 123/14 129/20	100 [1] 166/4	1969 [1] 2/16	27 [1] 4/11	
129/23 135/18 135/21	11 February [2]		27 February 2020 [1]	7
139/19 140/6 142/9	29/19 29/25		30/25	7.5 [1] 162/14
147/8 149/12 152/7	11 January 2021 [1]	2.00 [2] 93/12 93/15	27 March [1] 119/7	70 [2] 69/23 69/23
152/10 157/5 157/10	55/14	2.6 [1] 182/24	27 March 2020 [2]	70s [1] 67/16
157/20 157/24 158/6	11.45 [1] 50/23	2.8 [3] 182/18 182/25	175/4 175/9	72 [1] 183/7
182/1 190/7	11.59 [1] 50/25	183/1	273 [1] 142/12	79 [1] 4/10
MR MILLS: [3]	12 [4] 56/11 56/12	20 [2] 80/4 90/4	28 March 2022 [1]	
157/25 158/10 181/24	56/13 76/23	2015 [1] 22/3	65/5	8
MR PEZZANI: [1]	12 weeks [1] 79/3	2016 [3] 2/13 10/11	2B [2] 13/10 15/2	8 December 2021 [1]
152/11	12-week [1] 79/3	20/9		50/3
MR SIMBLET: [2]	13 [1] 53/17	2017 [1] 101/19	3	8 November 2020 [1]
147/12 149/10	13 April 2020 [1]	2020 [68] 4/14 13/13	3.28 pm [1] 157/21	53/24
MR WILCOCK: [2]	96/9	15/11 15/16 18/11	3.40 [1] 157/20	80 [1] 96/14
182/4 190/3	13 December 2020	18/25 27/15 30/25	3.41 [1] 157/23	
MS HANNETT: [2]	[1] 57/13	31/17 34/20 41/6 51/7	3.6 [1] 63/13	9
130/2 135/16	130 [1] 164/10	53/19 53/24 55/12	30 April [1] 124/12	9 April 2020 [1]
MS JONES: [2]	14 [1] 163/6	55/17 57/10 57/11	30 April 2020 [3]	128/24
149/15 152/6	14 December 2020	57/13 59/24 60/21	123/6 123/22 124/4	92 [1] 131/7
MS NIELD: [11] 1/5	[1] 55/12	65/6 68/16 72/5 73/9	30 September 2020	96 [1] 186/23
1/11 4/10 38/17 50/20	14 February 2020 [1]	73/18 77/8 78/25	[2] 72/5 73/9	96,000 [1] 135/5
51/1 93/10 93/16	34/20	81/10 81/23 82/25	30 September 2024	97 [1] 188/20
113/2 115/2 123/9	14 February 2021 [1]	83/4 83/10 90/2 95/1	[1] 1/1	
MS WADDOP: [2]	56/24	96/9 97/8 101/20	30/40 pages [1] 29/4	A
135/22 139/17	146 [1] 84/1	115/16 116/10 122/12	300 [2] 57/14 113/22	abandoned [2] 81/20
MS WEERERATNE:	148 [2] 84/1 84/16	122/21 123/6 123/22	31 July [1] 81/14	186/22
[3] 115/9 123/19	149 [1] 38/21	124/4 124/6 124/11	32 [1] 131/4	ability [5] 20/16 22/1
129/22	15 November 2020	124/20 125/8 126/17	360 [1] 57/13	109/20 114/4 160/22
PROFESSOR	[1] 53/19	127/1 128/24 132/12	363 [1] 66/23	able [24] 14/15 21/18
THOMAS: [5] 140/2	152 [1] 113/22	137/19 147/20 148/1	37 [1] 100/11	30/14 44/16 53/3
140/7 142/7 142/10	158 [1] 47/20	148/6 149/25 150/2	39 [1] 63/9	59/15 60/1 65/13
147/6	159 [1] 51/2	152/14 153/8 155/12		113/12 113/23 126/4
	16 [2] 159/9 163/6	158/15 162/10 175/4		127/10 138/7 154/10
	16 August [2] 81/12	175/9 183/8 185/7	4	161/23 164/15 165/1
	82/25	2021 [27] 3/1 12/19	4 June [1] 118/2	166/20 167/23 168/25
	16 August 2020 [1]	47/15 47/22 50/3	4 June 2020 [1]	169/21 171/7 171/21
	83/4	55/14 56/19 56/24	115/16	180/14
	17 [1] 106/10	59/1 60/10 60/22	4 May [2] 125/1	about [177] 5/19 5/22
	17 April [1] 102/7	60/23 61/14 63/5	126/1	6/8 14/13 15/17 17/22
	17 January [1] 57/15	65/20 88/11 88/14	4 May 2020 [1] 125/8	18/4 20/6 20/7 24/14
	17 March [1] 70/22	107/9 108/18 126/20	4.30 [2] 190/5 190/15	24/24 26/1 27/23
	174 [1] 117/23	126/22 126/23 127/3	41 [2] 102/11 169/15	28/21 33/23 34/15
	18 [1] 72/9	132/15 166/6 183/3	44 [1] 80/14	35/12 36/5 36/21
	18 February 2021 [1]	183/19	46 [1] 95/19	36/22 38/12 38/14
	56/19	2022 [7] 65/5 65/22	47 [1] 185/1	40/15 40/16 40/20
	18 March [3] 71/6	108/13 108/19 110/20		43/4 45/16 47/5 59/6
	75/11 122/12	158/15 166/7	5	61/18 62/1 62/15 64/7
	18 March 2020 [1]	2024 [6] 1/1 1/22	5 June [1] 35/20	64/10 66/19 72/19
	122/21	1/22 111/14 111/15	5.3 [1] 128/5	73/10 74/3 74/4 74/7
	18 September 2024	190/17	50 [6] 54/3 54/4	74/9 74/16 78/11 79/6
	[1] 190/17	21 [1] 12/14	96/14 99/15 99/15	80/6 81/18 82/20
	180,000 [1] 159/3	21 February 2024 [1]	185/10	83/22 83/25 85/19
	19 [40] 4/1 11/22	1/22	500 [1] 162/1	87/25 88/2 89/11
	12/8 15/12 15/21 16/5	210 cases [1] 53/25	51 [2] 42/1 42/7	89/12 89/15 91/19
	19/15 27/9 27/23	211 [1] 56/25	53 [2] 38/21 57/2	91/21 92/12 92/14
	34/16 38/24 51/1 54/1	22 [1] 159/8	55 [1] 47/19	94/7 94/21 98/19
	54/7 56/13 57/1 57/8	23 June 2022 [1]	56 [1] 51/2	99/14 100/10 101/7
	62/3 62/6 74/21 79/5	158/15	57 [2] 119/17 119/19	102/18 103/4 103/9
	84/9 86/8 86/14 90/2	24 [2] 55/5 162/25		
'do [1] 102/20				
'sitrep' [1] 4/21				
'UK [1] 39/5				
'UK IPC [1] 39/5				
... [5] 39/1 56/25				
63/19 102/19 103/10				
0				
0.64 [1] 125/3				
1				
1 March 2020 [1]				
158/15				
1 May 2024 [1] 1/22				
1 September 2021 [2]				
63/5 65/20				
1.03 pm [1] 93/13				
10 [4] 160/17 167/6				
167/6 190/14				
10 April 2020 [1]				
97/8				
10 March 2021 [1]				

A	academy [3] 121/12 121/13 122/7	20/12 23/6 38/4 39/16 56/16 57/9 72/15 73/2 95/7 106/24 112/23 118/12 120/25 122/15 127/3 134/4 137/10 138/1 142/22 145/11 146/19 163/5 165/11 165/12 177/17 182/20 183/11	admitted [1] 59/11 adopt [2] 43/18 112/22 adopted [2] 111/10 185/11 adopting [1] 44/1 adults [2] 72/12 73/9 advance [15] 104/21 105/1 105/3 105/4 105/6 105/9 105/14 105/16 105/20 106/2 106/6 111/4 111/8 112/11 112/19 advanced [2] 105/21 110/22 adverse [2] 137/15 143/13 adversely [1] 148/15 advice [43] 3/9 3/22 18/19 33/14 34/11 34/15 36/2 36/4 36/5 36/25 37/1 37/2 40/5 43/7 43/16 43/17 43/21 44/9 45/22 61/24 62/7 66/4 70/10 75/13 81/3 81/15 82/2 82/6 86/23 87/11 88/4 88/11 88/16 89/7 89/21 95/9 120/3 130/11 130/24 131/20 132/18 132/24 137/19 advise [5] 62/23 73/22 81/24 82/25 83/6 advised [10] 3/16 70/8 70/9 70/23 74/17 74/21 81/12 83/10 152/14 169/19 Adviser [2] 4/18 16/22 advises [1] 49/19 advising [3] 79/2 86/13 130/10 advisory [26] 3/14 6/20 16/20 27/16 28/20 29/2 29/13 31/4 32/1 32/20 32/22 32/25 32/25 33/7 33/17 34/5 34/6 34/14 34/16 35/20 89/1 90/11 92/3 130/22 132/14 132/20 advocate [1] 140/9 advocates [1] 81/18 advocating [1] 102/17 aerosol [9] 34/25 35/2 35/9 35/23 41/15 41/20 44/14 115/20 117/2 aerosol-generating [3] 34/25 41/15 41/20 aerosols [5] 35/15	35/17 44/15 46/13 46/19 affect [3] 51/22 148/12 156/5 affected [4] 140/11 142/24 148/15 167/5 affecting [1] 91/6 affirm [1] 158/4 affirmed [2] 158/5 191/11 afraid [2] 157/16 158/7 after [13] 24/21 56/19 61/6 82/24 83/4 110/16 126/19 127/7 132/19 137/20 178/9 179/17 181/16 afternoon [4] 115/9 123/17 147/12 158/7 again [34] 13/4 15/15 31/18 42/6 46/16 47/6 49/20 57/14 60/4 68/23 77/4 82/25 83/3 89/18 106/7 107/8 108/6 108/18 110/20 112/13 117/8 119/3 122/20 125/7 126/1 126/25 142/23 147/10 157/15 160/21 165/25 170/20 174/10 185/4 against [2] 68/7 103/21 age [10] 68/7 69/23 69/23 96/13 96/14 99/25 100/4 103/14 103/19 149/22 agency [3] 39/3 39/4 160/20 ago [1] 77/21 agree [20] 38/10 43/21 64/14 67/5 81/5 105/15 118/5 120/18 120/23 125/7 126/21 135/7 138/6 146/10 150/1 150/8 151/4 155/18 183/20 183/21 agreed [9] 43/23 72/7 74/14 93/24 97/16 100/19 127/8 130/13 183/13 agreement [1] 78/19 agrees [1] 120/6 aid [1] 25/12 Aidan [1] 125/13 Aidan Fowler [1] 125/13 aide [1] 28/3 aide-memoires [1] 28/3 aimed [1] 3/18 aims [1] 68/6 air [1] 68/11 airborne [11] 34/24 35/3 35/9 35/14 35/15
about... [109] 105/1 105/14 105/23 106/2 108/3 108/4 108/4 108/9 110/21 113/19 113/25 114/1 114/9 114/13 114/13 114/21 114/22 115/15 115/17 115/25 117/10 117/16 119/9 120/1 123/2 124/10 126/9 126/13 126/15 126/18 127/15 128/23 129/24 130/9 132/11 133/8 133/25 134/25 135/24 136/3 136/19 137/11 137/23 138/1 141/9 141/12 141/22 143/7 143/25 144/17 146/6 146/6 146/7 146/12 146/14 147/17 147/19 148/6 148/11 148/22 149/4 150/12 150/18 151/17 151/17 152/1 155/8 159/2 159/5 160/21 160/25 162/1 164/8 164/23 164/25 165/9 165/9 166/18 171/17 171/25 172/1 172/21 174/7 176/1 176/10 176/14 177/2 178/2 178/5 178/6 179/11 179/13 180/6 181/2 181/5 181/12 181/12 181/15 181/15 181/21 184/8 184/17 184/23 187/9 187/11 187/15 187/17 189/6 189/20 above [3] 58/9 96/14 111/17 absence [10] 41/19 46/12 46/14 46/18 46/19 109/18 164/18 166/25 170/22 173/22 absolute [2] 165/8 181/11 absolutely [31] 16/17 28/18 55/1 56/7 64/18 67/19 77/14 78/20 79/11 82/23 85/18 87/18 88/19 99/3 105/19 109/13 134/22 136/24 153/20 154/2 155/1 155/18 156/6 157/2 157/15 160/24 173/10 173/10 174/15 181/1 183/21 absorb [2] 29/15 30/14 abuts [1] 159/1 academia [1] 33/10 academics [1] 175/21	academy [3] 121/12 121/13 122/7 accept [12] 42/21 42/24 43/7 44/2 86/1 122/4 122/5 122/5 124/19 127/2 127/22 128/19 acceptance [1] 117/13 accepted [1] 40/11 access [16] 27/12 27/19 45/9 55/24 62/25 79/17 79/17 79/17 91/17 94/9 133/11 146/7 146/23 146/24 153/9 156/20 accessed [1] 86/17 accessible [1] 189/7 accessing [1] 138/13 accord [1] 19/4 accordance [1] 110/6 accorded [1] 100/23 according [3] 58/23 104/24 146/25 account [6] 86/13 96/12 99/12 102/25 121/11 134/2 accountability [1] 129/6 accurate [1] 122/4 achieve [3] 68/6 99/4 150/16 achieved [2] 163/1 163/11 Achieving [1] 67/16 acknowledge [1] 36/4 acknowledges [1] 135/25 acquired [6] 54/1 59/16 59/17 84/10 128/10 184/14 acronym [1] 143/25 across [23] 6/22 14/21 25/12 39/10 53/21 57/6 78/14 78/22 93/25 96/5 120/2 123/24 131/9 144/20 145/9 145/11 145/20 159/9 159/20 159/25 160/13 167/5 187/20 act [2] 6/23 22/7 acted [1] 16/2 action [4] 37/10 43/22 92/4 117/17 actions [3] 63/15 144/24 145/1 active [4] 65/6 66/2 133/6 141/16 actively [1] 147/25 actual [1] 163/3 actually [28] 18/7			

A	78/8 171/17 173/6 173/14	amongst [6] 60/9 101/2 131/6 137/14 140/15 164/24	119/1 122/18 130/24 131/16 131/25 132/18 133/16 134/1 134/2 137/22 144/11 148/8 148/25 149/3 149/8 149/9 151/9 152/22 156/9 170/18 174/22 177/19 177/24 178/3 178/3 178/17 180/18 189/4	180/16 182/13 185/24
airborne... [6] 35/18 68/18 147/13 147/18 147/21 149/2	allowed [5] 44/23 167/19 171/3 174/2 174/24	amount [6] 14/6 76/7 77/23 133/8 148/21 185/21	anybody [4] 79/10 122/14 139/7 153/4	approaches [5] 84/22 120/2 156/2 157/3 185/23
Alan [1] 18/6	allowing [1] 146/10	amounts [1] 28/12	anything [13] 9/13 77/25 109/6 109/7 142/16 144/10 148/5 152/23 171/7 174/7 189/13 189/15 189/20	appropriate [14] 3/13 19/5 39/23 46/3 48/12 49/7 85/9 97/15 97/23 98/1 99/8 102/24 103/2 109/21
Alan Brace [1] 18/6	almost [1] 155/19	anaesthetists [3] 163/12 163/16 163/25	anyway [1] 127/24	appropriately [1] 105/5
alarm [1] 82/5	alone [1] 103/20	analysis [1] 39/21	anywhere [2] 58/18 124/8	approved [3] 98/16 100/7 102/3
albeit [1] 59/16	along [4] 4/23 9/10 12/9 16/11	Andrew [10] 2/25 4/5 5/10 5/15 5/24 6/2 17/17 21/3 42/14 53/13	apart [1] 141/25	approximately [1] 125/2
Albert [1] 15/24	alongside [1] 21/4	Andrew Goodall [7] 4/5 5/10 5/15 17/17 21/3 42/14 53/13	aplomb [1] 14/24	April [22] 4/14 12/19 18/11 41/6 57/11 96/9 97/8 102/7 106/10 108/13 108/19 123/6 123/22 124/4 124/12 124/20 128/24 141/3 141/7 150/13 183/8 183/11
Albert Heaney [1] 15/24	already [15] 5/8 23/1 26/20 45/15 61/13 61/15 110/21 113/10 116/12 126/15 155/3 155/7 160/24 180/4 180/23	announced [1] 55/16	apologies [1] 173/19	April 2020 [1] 124/20
alert [1] 167/21	also [56] 6/17 9/23 9/25 11/4 11/5 11/16 12/3 13/6 16/2 17/25 23/12 23/22 24/5 33/10 34/2 35/20 36/9 39/5 49/4 49/23 54/23 55/22 58/8 59/22 62/20 78/11 78/12 78/15 81/19 82/25 85/19 89/4 90/9 90/15 90/17 95/13 99/14 103/8 117/20 127/20 128/13 134/21 146/10 149/2 150/2 160/2 160/8 161/11 161/21 164/19 170/10 173/11 178/10 179/19 184/1 184/17	announcing [1] 126/16	apologise [2] 119/17 123/9	April 2021 [1] 12/19
align [2] 77/25 81/16	alter [1] 123/15	another [9] 47/16 51/4 51/24 54/6 78/12 97/23 126/13 128/2 181/6	apparent [2] 43/1 151/13	April 2022 [2] 108/13 108/19
alive [2] 87/16 154/1	although [6] 7/14 26/4 55/3 83/20 84/20 127/21	answered [2] 126/5 142/8	appeal [3] 161/25 162/1 162/7	architecture [3] 7/12 13/9 116/18
all [123] 2/1 6/24 14/21 19/13 23/12 29/4 30/14 32/14 38/24 43/9 47/1 48/5 50/12 54/2 54/3 54/25 55/10 57/1 58/16 59/10 61/19 63/13 66/8 67/5 68/5 68/13 74/3 75/9 78/20 80/3 89/7 89/21 93/1 99/14 99/15 99/18 101/5 101/14 102/9 102/23 105/15 106/1 106/8 106/15 108/20 109/22 110/6 110/15 110/18 112/17 113/25 114/2 115/21 116/11 116/16 117/13 118/5 120/15 121/14 121/23 123/19 124/8 124/14 125/5 125/17 127/9 128/5 128/7 128/10 128/19 128/25 129/2 130/5 133/16 135/10 136/11 139/18 139/23 140/25 144/12 144/19 146/8 148/5 148/18 149/18 150/21 152/25 153/22 154/3 154/16 154/18 161/8 161/18 161/23 161/24 162/15 163/18 163/21 164/19 168/2 168/3 171/3 171/11 172/11 174/10 176/8 176/9 176/16 179/1 179/9 179/9 180/1 180/6 181/17 181/25 186/5 186/9 187/23 188/4 188/15 189/10 190/5 190/11	am [21] 1/2 1/4 1/25 50/20 50/23 50/25 53/11 111/1 114/19 117/20 121/4 123/19 128/2 132/23 154/20 156/7 157/10 157/16 158/7 164/7 190/16	answers [3] 149/10 164/2 190/4	appear [7] 14/19 65/22 66/14 106/14 130/2 184/23 185/9	are [113] 1/23 3/8 7/5 7/7 7/9 12/2 12/12 12/25 14/20 16/6 20/25 21/23 22/5 32/13 34/9 36/5 36/19 36/24 37/9 37/24 42/18 45/1 46/8 50/19 52/23 57/25 58/3 59/24 60/8 62/22 67/15 77/7 77/12 77/13 77/16 78/4 80/5 82/21 84/3 84/4 85/21 85/25 88/22 90/21 91/25 96/11 99/14 104/19 105/4 110/23 110/23 111/4 111/5 111/6 111/9 111/21 112/16 112/19 112/20 112/23 114/18 114/25 115/24 119/4 119/21 120/16 121/8 125/2 127/14 127/25 133/4 133/6 133/6 134/19 134/23 135/4 135/11 135/21 137/7 139/18 142/6 143/19 144/8 144/21 144/23 145/13 146/6 146/8 146/11 146/16 146/18 146/19 152/8 154/10 155/21 156/3 157/1 160/2 161/2 161/11 161/12 161/20 161/21 169/21 172/16 172/17 177/19 179/2 180/13 180/13
all-Wales [8] 101/14 102/23 106/15 108/20 110/6 110/15 110/18 129/2	ambition [1] 142/13	anticipated [1] 130/6	appears [1] 129/3	architectural [1] 108/13
allay [1] 62/19	ambitious [1] 163/2	anxiety [6] 18/4 100/15 117/22 175/25 179/19 187/13	appendix [1] 98/24	architectural [1] 108/13
alleviate [1] 187/13	ameliorating [1] 89/23	anxious [4] 108/3 165/9 180/14 187/15	appendix 1 [1] 98/24	architecture [1] 108/13
Alliance [1] 147/14	amend [1] 123/16	any [94] 6/8 7/21 9/3 9/6 9/11 16/10 19/11 19/12 21/14 23/24 25/4 25/24 27/22 27/24 28/1 30/12 30/21 31/6 31/14 32/13 39/20 40/3 40/19 45/2 45/5 50/14 58/11 59/6 64/8 64/13 66/11 68/9 68/24 71/3 71/23 72/1 74/22 76/17 77/16 79/6 79/12 83/3 83/17 85/7 85/8 86/19 86/25 90/25 92/8 92/17 93/7 99/23 101/22 101/24 103/13 104/23 105/11 107/14 109/1 109/18 110/15 111/9 112/3 112/8 113/7 117/24	applauding [1] 156/23	architectural [1] 108/13
allocated [1] 130/8	among [3] 8/13 125/21 185/13	answered [2] 126/5 142/8	application [5] 46/25 52/11 115/18 116/1 189/5	architectural [1] 108/13
allow [6] 37/22 37/22		answers [3] 149/10 164/2 190/4	applications [1] 187/6	architectural [1] 108/13

A	130/17 132/11 133/19 133/25 135/3 135/22 135/23 141/2 141/6 143/7 147/19 149/16 150/25 152/11 164/1 181/25 182/10 183/13 188/19 189/2 190/5 asked [16] 22/21 38/25 47/23 48/15 49/2 62/10 69/17 72/19 91/13 100/22 115/15 115/17 115/25 126/15 136/4 176/16 asking [17] 20/7 32/4 35/8 36/24 49/4 51/23 75/3 82/21 92/14 127/1 130/19 136/14 139/24 147/12 165/10 166/18 168/4 asks [1] 157/12 aspect [3] 48/16 176/1 187/20 aspects [4] 5/12 5/13 22/24 67/22 assembled [1] 132/7 assembling [2] 40/13 129/12 assess [1] 43/10 assessed [3] 36/1 46/2 93/2 assessment [10] 5/3 83/17 90/18 92/21 96/12 143/1 152/21 153/14 169/1 171/16 assimilate [1] 28/13 assist [8] 27/13 33/14 33/15 94/14 99/5 129/4 153/6 154/11 assistance [1] 24/15 assisted [2] 12/22 12/25 assists [1] 42/2 associated [3] 84/9 84/23 137/16 Association [2] 91/14 149/18 associations [1] 91/20 assume [1] 117/4 assuming [3] 117/2 117/11 185/15 assure [1] 189/24 asthma [1] 69/25 asymptomatic [25] 55/9 55/18 56/1 56/5 122/10 122/19 122/22 122/23 123/5 123/21 124/3 124/9 124/9 124/13 124/18 124/21 125/2 125/19 125/19 125/20 125/24 126/10 150/4 151/3 186/17 at [251]	Atherton [43] 1/6 1/7 1/12 1/15 1/16 2/2 5/5 12/2 13/10 21/17 35/8 37/5 50/21 51/1 53/18 56/11 63/10 66/22 87/8 95/20 102/12 115/2 115/9 119/9 121/4 123/20 130/2 130/9 133/15 135/3 135/22 139/17 140/7 147/6 147/10 147/12 149/16 150/25 152/11 154/9 155/2 157/6 191/2 atmosphere [2] 164/23 165/2 attempt [3] 101/11 102/21 103/4 attend [3] 9/10 30/12 174/20 attended [5] 3/15 4/16 9/23 17/16 29/19 attending [1] 29/11 attention [7] 3/12 9/4 9/14 107/17 119/12 153/19 154/6 audit [8] 63/4 64/15 64/16 65/19 111/13 111/21 111/22 111/25 auditors [2] 64/20 64/23 August [6] 2/13 73/3 79/4 81/12 82/25 83/4 August 2016 [1] 2/13 authority [3] 7/22 21/18 21/19 autism [1] 103/14 autonomous [1] 45/25 availability [4] 149/9 158/1 170/9 173/3 available [22] 27/7 37/4 44/11 44/23 46/3 55/25 68/8 91/10 92/13 93/4 103/10 110/24 124/7 126/7 126/7 129/14 129/17 136/18 151/19 170/16 174/3 179/9 average [1] 159/8 avoid [5] 79/5 82/4 84/13 91/2 120/20 avoidable [1] 80/11 avoided [1] 45/5 aware [31] 8/9 17/24 25/17 25/21 32/12 36/13 36/23 41/1 62/22 68/9 68/24 86/22 87/1 87/9 91/5 99/23 102/15 102/16 103/12 107/14 108/11 108/24 111/4 111/5 111/21 112/2 132/23 140/13 141/7 154/7	189/3 awareness [1] 132/1 awful [3] 74/4 87/25 88/1 B babies [2] 121/2 175/2 baby [1] 174/17 back [41] 1/9 17/19 19/8 22/14 23/15 24/11 28/19 29/12 31/15 32/11 32/15 38/16 48/20 49/21 53/11 72/15 72/17 72/18 72/25 73/4 73/17 80/18 94/2 94/19 97/13 97/15 98/18 104/7 112/7 123/16 131/13 139/23 142/8 151/18 166/14 168/22 168/24 169/23 173/19 175/9 181/17 background [7] 2/2 10/19 11/1 82/1 134/20 158/20 179/15 backlog [2] 154/19 154/25 backtrack [1] 111/11 backwards [1] 68/2 bad [1] 174/23 badged [2] 7/5 95/25 balance [6] 54/21 116/17 151/7 168/21 173/7 174/11 balanced [1] 46/24 balancing [1] 168/22 BAPIO [2] 91/14 145/5 barrier [1] 67/11 base [1] 40/14 based [15] 36/3 44/6 44/10 45/22 52/12 52/12 62/7 93/24 115/22 121/25 133/3 134/14 152/20 178/16 180/20 baseline [1] 180/24 basic [3] 114/9 114/15 139/4 basically [1] 121/17 basis [20] 21/9 21/14 23/4 26/5 32/5 36/16 40/12 47/12 82/5 98/15 99/22 103/13 104/20 104/24 108/17 121/13 166/2 171/10 188/14 188/16 BBC [2] 123/6 123/23 be [210] bear [1] 85/13 bearing [1] 89/12 became [26] 10/9 10/10 30/6 30/23 37/4	48/21 56/2 70/20 86/15 87/1 88/8 91/5 91/10 98/15 102/2 122/25 126/6 132/7 141/7 142/13 148/7 148/18 148/19 151/19 151/19 165/17 because [71] 14/5 26/6 26/7 26/23 37/25 42/5 44/13 47/6 58/18 68/17 72/13 72/19 72/25 81/17 82/21 87/15 98/4 98/21 102/1 111/17 112/5 112/24 113/13 113/17 116/22 118/19 119/21 121/5 121/21 121/25 124/6 124/16 128/14 129/18 133/19 133/25 136/12 143/16 148/20 148/22 153/21 154/6 157/17 160/2 160/5 161/8 164/18 164/19 165/3 165/17 165/18 165/18 165/19 166/19 166/24 167/2 167/9 167/12 170/9 172/15 172/17 173/1 173/2 173/12 174/9 184/2 184/21 186/12 186/20 188/12 189/5 become [7] 61/9 86/22 92/13 106/3 126/7 140/3 140/13 becomes [1] 104/4 becoming [4] 47/6 87/17 116/11 125/11 bed [5] 162/10 162/11 162/13 163/3 163/5 beds [8] 67/3 113/22 162/13 162/25 163/4 163/9 163/20 163/22 been [139] 2/15 5/8 5/11 5/16 5/24 6/11 7/15 9/1 9/16 14/25 19/5 19/6 19/19 20/10 20/12 20/19 20/21 21/11 25/10 25/25 28/5 29/5 29/8 30/2 32/16 33/5 34/13 34/22 36/13 42/15 42/18 44/9 45/24 49/11 50/5 50/6 55/20 55/23 56/5 57/18 65/14 65/22 66/2 66/3 66/3 66/8 66/9 69/1 70/9 72/6 73/8 73/25 74/18 75/2 75/11 76/17 79/24 80/18 80/22 80/24 82/8 82/15 83/7 83/24 86/11 87/2 87/14 87/14 88/4 92/8
----------	--	---	---	--

B	164/15 164/20 169/19 169/25 178/8 180/4 believe [18] 21/2 31/2 34/7 35/19 39/9 61/4 61/4 61/12 63/2 93/9 112/23 118/13 121/22 122/18 131/2 132/8 159/16 160/8 believed [1] 131/23 believes [1] 65/2 below [7] 16/7 42/16 57/16 63/20 96/14 96/20 120/5 bending [1] 68/2 benefit [9] 23/19 28/11 67/20 96/13 96/24 97/2 99/20 145/23 151/9 benefits [4] 38/12 99/17 151/7 162/6 Bennee [1] 33/3 bereaved [3] 115/11 115/24 182/5 best [15] 42/25 44/7 44/10 76/19 99/20 122/1 131/5 139/15 162/20 167/14 175/1 178/12 178/16 179/6 188/4 Betsi [1] 59/23 Betsi Cadwaladr [1] 59/23 better [27] 19/19 38/13 65/15 68/14 68/19 78/7 114/16 114/16 114/20 136/25 137/1 137/2 137/2 137/8 138/21 141/12 141/23 143/13 143/23 144/3 146/9 152/2 161/20 182/24 183/23 184/16 188/6 better-fitting [1] 138/21 between [42] 8/1 10/16 22/10 22/12 23/2 23/11 25/13 26/6 26/18 26/19 34/4 41/1 41/11 43/12 44/4 45/14 50/2 54/12 54/13 54/14 54/18 57/20 61/8 63/21 64/8 65/11 65/11 67/3 67/23 72/8 73/22 74/16 87/22 114/6 114/23 119/10 150/11 158/15 163/24 167/18 170/18 173/7 beyond [7] 37/15 76/12 145/21 146/4 163/6 185/10 185/16 big [3] 113/11 114/10 178/17 bigger [1] 127/24	biggest [2] 113/19 169/16 bit [11] 26/3 48/20 76/17 94/19 146/22 158/7 164/23 165/16 169/7 184/1 184/2 black [8] 89/11 90/8 90/9 92/23 98/25 140/10 140/15 155/20 blanche [1] 178/24 block [1] 183/7 blue [1] 12/8 board [12] 25/12 53/22 55/3 55/5 57/17 57/18 58/1 59/23 106/25 107/20 108/10 184/10 boards [65] 7/2 7/4 7/9 7/13 7/19 7/23 8/3 8/9 8/18 9/5 20/15 21/7 21/21 21/23 22/5 22/5 42/18 42/21 43/24 45/10 45/15 45/24 46/6 52/14 57/21 58/21 59/25 63/13 66/4 66/5 69/4 77/23 93/4 93/8 96/5 101/7 102/9 107/3 109/12 109/22 109/25 110/2 110/5 110/10 110/12 110/24 111/3 111/18 111/24 112/1 112/2 118/20 119/11 127/9 127/10 127/12 127/16 127/21 129/1 132/19 135/11 135/12 145/10 145/11 153/23 boards: [1] 44/22 boards: well [1] 44/22 bodies [8] 7/8 12/9 45/25 62/16 91/1 93/1 96/2 98/7 body [8] 19/20 23/18 85/13 95/22 96/3 96/3 109/2 111/17 book [3] 28/2 31/9 31/16 books [2] 31/15 32/5 border [7] 159/1 159/14 159/17 159/21 159/22 159/25 160/13 born [1] 182/7 both [22] 10/2 17/20 34/10 34/11 35/17 38/5 43/21 44/6 57/21 90/6 93/16 98/23 105/23 108/24 116/22 118/21 135/6 146/9 155/24 161/10 166/17 167/19 bottom [6] 16/11 54/8 54/23 79/22 99/9 119/8	box [2] 96/17 116/15 14/13 boxes [3] 12/12 96/17 96/18 Brace [1] 18/6 brain [1] 45/4 break [4] 50/21 50/24 62/9 157/22 briefing [6] 27/17 32/1 53/19 56/19 130/15 130/18 briefings [7] 6/1 19/11 24/22 28/20 30/24 34/14 53/15 briefly [2] 69/9 78/24 bring [11] 3/12 9/15 10/6 29/14 45/18 45/20 60/13 126/10 161/16 176/3 176/4 bringing [9] 13/25 29/12 154/5 163/15 168/22 168/23 168/23 172/9 175/19 British [1] 91/14 broad [9] 2/4 6/11 24/9 71/25 73/25 141/18 143/21 143/22 175/7 broaden [1] 146/4 broader [9] 14/25 33/7 33/18 34/2 34/9 92/14 144/14 145/6 146/22 broadly [7] 10/18 10/18 27/21 40/11 70/12 70/13 142/3 broken [1] 174/23 brought [10] 9/4 14/3 24/2 24/4 107/17 119/11 125/15 127/18 153/19 165/25 brunt [1] 89/13 bubbled [1] 20/18 budgets [1] 21/25 build [1] 183/22 building [3] 23/2 113/7 164/18 bulk [1] 55/25 bundle [9] 42/1 53/17 56/11 63/9 80/16 90/4 95/19 100/11 102/11 burden [3] 89/12 157/11 176/19 business [3] 131/16 184/9 184/11 busy [1] 14/18 but [225] bystanders [1] 45/8	call [2] 1/5 158/3 called [7] 1/16 7/7 60/14 90/2 143/24 178/10 180/6 calling [1] 101/17 came [25] 59/17 61/10 72/15 72/17 72/18 72/19 72/25 73/4 74/13 76/1 97/15 109/16 111/19 117/16 118/3 118/14 124/10 127/6 144/13 150/20 151/18 169/8 174/12 179/2 189/12 campaign [2] 149/17 182/5 can [160] 1/6 1/11 3/12 4/10 11/23 11/25 12/5 12/9 15/3 15/15 15/18 16/7 16/18 22/9 26/15 27/6 28/7 29/17 31/18 31/18 31/20 32/13 32/18 32/19 35/7 38/4 38/18 38/21 41/4 41/23 42/6 43/9 43/19 44/14 45/4 46/16 47/19 48/13 49/13 50/8 51/2 52/18 53/16 54/8 54/9 55/2 55/8 55/15 56/8 56/21 57/8 57/16 57/18 57/19 58/8 58/25 59/9 59/22 60/7 61/19 63/3 63/7 63/13 66/14 69/8 73/8 73/17 74/16 78/19 78/24 79/21 81/7 84/5 85/15 85/22 86/7 87/3 87/4 87/8 88/14 89/11 90/22 91/8 91/9 95/17 95/25 96/9 96/10 97/4 97/11 97/22 98/18 99/20 100/10 100/12 100/17 101/11 102/10 102/14 103/7 104/7 104/14 105/7 106/23 106/23 109/16 111/11 112/25 113/5 113/20 114/6 114/21 116/21 116/22 116/23 117/9 119/24 123/12 123/14 123/16 124/12 129/4 129/7 132/11 133/19 133/25 135/3 135/5 142/22 143/14 145/25 146/19 150/25 152/19 153/5 153/6 158/21 160/16 162/10 162/22 162/25 164/1 164/4 164/23 166/11 171/17 174/1 174/7 175/7 176/9 177/5 179/12 182/14 182/16 183/6 184/20
----------	---	---	---	--

C				
<p>can... [4] 186/19 187/9 188/10 188/19</p> <p>can't [33] 5/14 21/15 25/24 30/6 32/14 33/2 50/6 50/18 55/21 61/16 64/2 64/2 72/16 82/9 85/24 92/19 92/19 98/9 104/16 118/18 131/18 131/19 140/17 152/22 154/14 154/14 156/18 173/19 173/20 182/20 183/6 187/9 188/10</p> <p>Canada [1] 2/11</p> <p>cancer [4] 58/11 58/13 59/9 159/18</p> <p>cancers [1] 71/10</p> <p>cannot [5] 43/11 47/8 105/16 133/11 151/3</p> <p>capacity [25] 5/3 5/6 6/12 8/2 56/5 93/21 96/21 104/2 104/5 113/12 113/18 113/20 113/21 113/25 124/7 124/17 126/2 148/21 151/19 160/16 162/10 162/11 162/13 162/16 162/21</p> <p>cardiac [3] 45/3 45/7 159/18</p> <p>Cardiff [2] 42/22 83/22</p> <p>Cardiff University [1] 83/22</p> <p>cardiology [1] 10/19</p> <p>cardiopulmonary [6] 41/9 41/12 41/14 101/12 102/21 103/5</p> <p>care [111] 4/5 5/9 7/10 8/22 9/19 16/2 16/12 16/15 17/6 17/10 17/11 17/12 17/16 18/7 21/5 38/25 39/2 51/10 67/16 78/11 78/13 78/15 79/17 80/21 83/1 92/5 92/17 93/21 94/10 94/17 94/22 95/7 95/14 95/21 96/1 96/4 96/13 96/20 96/24 97/2 99/16 99/21 99/24 100/2 101/4 101/8 102/20 103/9 104/21 105/1 105/3 105/4 105/6 105/9 105/14 105/16 105/20 105/21 106/20 110/22 111/4 111/8 112/11 112/19 113/20 113/21 114/1 118/3 118/16 118/21 118/22 122/11 131/10 131/23 132/2</p>	<p>132/5 132/16 133/11 143/16 143/17 149/17 149/19 151/13 151/15 151/16 152/1 152/2 152/4 154/19 154/23 154/24 158/12 159/13 163/19 164/17 164/25 165/22 166/21 167/14 168/25 174/11 175/13 176/11 177/1 177/23 178/3 178/13 180/12 180/17 187/25 188/4</p> <p>Care Rights UK [1] 149/17</p> <p>career [2] 2/2 36/16</p> <p>careful [2] 47/5 85/6</p> <p>carefully [2] 116/17 145/7</p> <p>carers [3] 79/23 80/3 80/9</p> <p>carried [3] 137/14 144/11 163/24</p> <p>carriers [1] 125/3</p> <p>carry [3] 123/18 176/20 186/16</p> <p>carte [1] 178/23</p> <p>case [6] 10/16 28/19 77/14 104/5 124/8 125/23</p> <p>cases [18] 53/25 54/2 54/3 56/22 56/25 57/2 57/2 57/13 59/16 59/17 59/24 126/23 128/4 128/6 128/7 128/8 128/10 148/17</p> <p>cases ... were [1] 56/25</p> <p>cast [1] 84/14</p> <p>CATA [1] 147/14</p> <p>categories [1] 124/1</p> <p>category [1] 22/6</p> <p>Catherine [5] 14/13 158/4 158/5 158/11 191/11</p> <p>cause [2] 65/8 173/9</p> <p>caused [1] 151/8</p> <p>causes [2] 65/8 82/4</p> <p>causing [1] 100/15</p> <p>caveats [1] 128/16</p> <p>CBT [1] 156/24</p> <p>cell [56] 5/7 16/12 16/15 16/20 16/24 17/1 17/6 18/5 24/3 24/5 27/16 28/20 29/2 29/13 31/4 32/1 32/20 32/22 32/25 32/25 33/5 33/11 33/14 34/5 34/8 34/14 34/17 35/21 39/8 39/12 39/18 40/9 40/11 41/2 44/5 44/10 47/23 48/2 48/4 48/6 48/8 48/11 49/3 49/4 49/18 49/21 52/13 62/6 62/10</p>	<p>62/20 89/1 89/2 116/20 117/18 122/2 130/22</p> <p>Cell' [1] 39/6</p> <p>cells [4] 12/11 12/14 16/6 16/11</p> <p>central [1] 142/13</p> <p>centre [1] 12/13</p> <p>centres [2] 91/16 162/6</p> <p>CEOs [1] 128/25</p> <p>certain [4] 47/9 69/24 78/19 148/21</p> <p>certainly [23] 5/24 13/23 13/24 19/25 20/19 52/7 54/17 56/7 64/17 80/6 80/19 88/4 93/3 93/12 99/6 109/9 124/7 134/9 136/10 146/5 162/3 183/24 184/2</p> <p>cetera [4] 79/18 137/21 139/10 161/9</p> <p>CEV [1] 70/17</p> <p>CF [1] 125/3</p> <p>CFS [1] 98/8</p> <p>chain [4] 41/23 44/3 120/16 120/24</p> <p>chair [10] 8/5 16/10 16/12 16/14 33/3 33/4 39/17 51/8 175/5 189/16</p> <p>chaired [8] 16/22 18/5 18/11 19/6 47/23 53/13 141/17 189/10</p> <p>chairing [1] 82/11</p> <p>challenge [5] 41/3 67/18 165/3 169/16 172/13</p> <p>challenged [1] 174/11</p> <p>challenges [4] 159/15 160/25 161/18 166/5</p> <p>challenging [4] 68/4 164/19 171/20 189/6</p> <p>chance [1] 28/9</p> <p>change [4] 10/16 62/24 117/17 160/6</p> <p>changed [3] 122/25 165/2 165/16</p> <p>changes [3] 123/25 136/5 189/1</p> <p>changing [1] 165/7</p> <p>chaotic [1] 167/16</p> <p>chaplains [1] 175/20</p> <p>characterisation [3] 18/20 130/12 131/1</p> <p>characterise [1] 7/25</p> <p>charge [1] 17/8</p> <p>charities [1] 98/7</p> <p>charity [1] 152/12</p> <p>check [2] 4/14 5/21</p> <p>check-in [2] 4/14</p>	<p>5/21</p> <p>cheeky [1] 145/16</p> <p>chest [3] 41/13 46/13 46/18</p> <p>chief [74] 2/10 2/12 2/15 2/19 3/5 4/6 4/18 5/16 6/16 10/10 10/13 11/4 11/22 12/7 12/10 12/16 12/20 13/2 13/7 13/12 13/14 13/18 13/19 15/23 16/4 16/22 17/17 17/21 17/23 18/9 18/12 18/18 21/4 22/11 22/16 22/23 23/10 23/11 23/21 24/6 26/6 26/16 27/8 29/11 29/22 39/19 41/7 42/12 43/6 44/1 47/22 48/14 49/3 51/6 62/10 66/19 66/21 69/12 69/17 71/8 72/8 75/14 77/17 85/2 100/21 101/21 102/8 106/25 107/8 125/14 128/25 133/20 134/5 134/17</p> <p>child [2] 143/13 155/16</p> <p>children [5] 143/14 153/14 155/10 156/13 171/23</p> <p>Chris [32] 9/10 9/11 9/21 10/5 10/10 10/19 11/17 12/22 13/4 16/15 17/22 18/3 18/9 18/24 22/23 23/18 23/18 37/8 38/10 43/10 43/22 44/25 51/8 72/7 74/1 86/12 100/18 101/25 130/13 130/21 130/21 134/8</p> <p>Chris Jones [8] 9/10 10/19 13/4 16/15 44/25 51/8 100/18 101/25</p> <p>Christmas [4] 83/9 83/10 166/7 168/2</p> <p>chronic [4] 70/1 72/9 161/22 166/2</p> <p>chronicity [1] 165/18</p> <p>chronological [1] 29/17</p> <p>circulated [7] 95/8 97/9 100/20 101/2 101/3 101/5 106/18</p> <p>circulating [1] 58/19</p> <p>circulation [1] 101/18</p> <p>circumstances [3] 89/17 143/4 180/10</p> <p>civil [4] 22/6 27/3 27/4 33/5</p> <p>claiming [1] 44/6</p> <p>clarified [1] 3/25</p>	<p>clarify [2] 97/11 104/1</p> <p>clarifying [1] 32/9</p> <p>clarity [1] 34/4</p> <p>classification [1] 147/17</p> <p>clear [20] 41/19 43/15 44/4 82/12 82/17 93/23 98/23 105/19 108/5 110/9 116/12 120/14 125/5 125/12 136/3 136/9 141/10 164/1 186/21 188/19</p> <p>cleared [1] 71/8</p> <p>clearer [1] 116/11</p> <p>clearly [7] 40/24 44/18 52/13 74/25 79/24 104/2 105/16</p> <p>climate [2] 187/2 187/5</p> <p>clinical [35] 23/24 24/9 25/6 69/15 69/16 69/22 70/4 72/15 73/5 73/20 74/14 93/17 93/19 96/15 97/4 97/24 98/8 99/10 99/10 102/18 102/24 104/12 106/19 112/14 113/6 121/14 136/1 139/1 139/1 175/14 177/16 187/7 187/14 188/9 188/12</p> <p>clinically [35] 69/1 69/9 70/16 70/17 70/23 71/1 71/7 71/18 71/19 71/22 71/24 73/23 74/17 74/18 75/10 79/1 79/7 79/16 79/25 80/10 81/11 83/19 84/12 102/2 108/2 135/23 136/7 136/7 138/11 138/12 138/16 138/19 138/20 139/2 139/2</p> <p>clinician [2] 98/11 176/20</p> <p>clinicians [36] 23/12 23/14 23/17 25/3 25/14 40/10 93/22 94/14 94/20 95/5 97/13 98/22 99/11 99/20 101/5 101/9 102/1 103/3 106/7 108/20 110/16 119/10 125/1 125/15 131/24 131/24 134/19 175/24 176/8 176/13 176/22 177/15 178/9 179/1 179/3 187/7</p> <p>clinics [3] 132/13 132/18 162/5</p> <p>close [6] 52/10 69/5 118/14 138/15 159/14</p>

C	combination [1] 184/16	community [20] 45/7 54/25 55/5 55/6 55/22 58/3 58/19 60/18 61/9 78/14 83/2 125/4 133/3 133/5 133/10 134/14 154/23 155/17 159/5 169/11	186/10	87/10 88/3
close... [1] 171/24	come [22] 10/25 16/21 18/15 29/2 32/22 38/6 41/4 47/13 54/5 85/12 97/13 98/18 101/11 115/1 131/15 140/22 141/22 142/8 154/25 168/12 182/19 184/20	community-based [2] 133/3 134/14	concerned [9] 17/1 74/3 89/12 115/24 121/7 125/17 152/15 170/11 178/22	consider [18] 13/17 28/9 28/13 39/19 43/17 45/17 67/21 77/7 87/6 93/20 96/25 104/10 106/16 113/4 157/2 157/17 177/20 178/4
closed [2] 51/18 159/22	comes [3] 40/1 157/25 189/19	comorbidity [1] 96/16	concerns [26] 3/8 9/3 40/19 40/24 40/24 48/14 62/4 74/22 79/6 81/17 93/18 98/3 98/6 102/16 103/8 112/16 117/24 118/9 118/9 119/1 119/4 152/21 155/8 186/2 188/15 188/25	considerable [2] 28/12 57/20
closely [6] 23/8 27/1 90/16 91/13 134/19 143/22	comfortable [1] 81/25	company [2] 129/17 129/19	conclude [2] 34/20 84/24	consideration [9] 69/5 72/4 85/7 88/15 94/1 107/22 138/15 138/19 147/2
closer [2] 22/22 117/14	coming [15] 52/13 54/24 68/3 69/7 80/9 88/5 109/23 138/17 140/18 143/16 145/14 155/22 159/25 166/18 171/2	compare [1] 164/5	conclusion [2] 84/7 109/16	considerations [3] 37/3 75/6 103/3
cloth [1] 44/15	command [5] 15/8 20/6 20/17 21/19 185/24	compared [4] 13/23 159/9 167/2 168/6	conclusions [6] 35/21 67/5 84/1 84/3 85/2 183/14	considered [13] 41/13 41/15 46/25 48/11 51/12 51/14 62/9 63/15 69/21 71/23 72/2 73/20 138/23
cluster [1] 186/8	commence [1] 55/10	comparisons [1] 127/25	condition [6] 18/23 54/6 103/15 103/19 106/3 135/6	considering [3] 34/3 116/4 179/11
CMO [1] 9/11	comment [3] 20/16 64/20 121/6	Compatibility [1] 78/14	conditions [19] 11/19 18/21 69/20 69/20 69/21 69/24 70/2 70/4 70/18 71/7 71/11 71/18 73/19 75/10 75/12 77/3 96/17 146/18 161/20	consistency [3] 39/10 45/23 131/9
CMO's [1] 135/25	comments [2] 120/7 125/22	complaining [1] 189/6	confess [1] 124/5	consistent [4] 45/18 45/20 84/19 93/25
CMOs [4] 67/7 73/5 74/13 75/8	commission [1] 109/3	complaint [3] 108/9 189/11 189/18	confidence [2] 171/4 188/11	consistently [2] 45/21 109/14
CNOs [1] 49/3	commissioned [1] 140/19	complaints [3] 188/25 189/10 189/22	confirmation [1] 50/16	consolidated [1] 85/13
co [11] 16/12 16/14 16/22 18/11 19/20 20/11 22/9 33/4 75/14 75/16 131/4	Commissioner [1] 103/9	complete [1] 139/12	confirmed [4] 48/3 57/1 128/6 128/7	constantly [2] 189/12 189/24
co-chair [3] 16/12 16/14 33/4	commissioning [2] 109/6 109/7	completed [1] 2/4	conflicting [1] 160/6 140/3	constraint [1] 163/3
co-chaired [2] 16/22 18/11	commitment [1] 82/15	completely [3] 52/6 165/3 180/11	confusing [5] 36/18 105/13 160/5 168/8 168/13	constructs [2] 32/24 33/13
co-operation [2] 20/11 22/9	committee [9] 118/3 122/11 172/24 175/3 175/8 175/17 175/18 178/22 187/11	completes [2] 157/6 190/8	confusion [1] 82/5	consultant [3] 129/9 146/20 187/19
co-ordinate [2] 19/20 75/16	common [4] 131/5 161/1 169/7 184/22	completion [2] 104/22 105/10	congenital [1] 71/14	consultants [4] 129/9 146/18 163/25 188/13
co-ordinated [1] 75/14	commonsense [1] 185/20	complex [5] 24/16 24/17 125/13 179/7 183/17	conjunction [2] 99/1 179/6	consultation [1] 98/5
co-ordination [1] 131/4	communicate [2] 26/9 30/22	complexity [1] 176/17	connected [1] 149/5	consultative [1] 104/20
cocoon [1] 74/10	communicated [1] 137/6	compliance [2] 111/18 129/6	connectedness [1] 77/11	contact [5] 25/9 75/20 79/5 79/14 168/21
cocooning [1] 74/10	communicating [1] 8/20	complicated [1] 72/11	connection [3] 114/22 150/11 151/1	contacted [3] 73/10 75/13 83/6
coding [1] 92/16	communication [12] 26/15 26/18 98/22 132/3 132/8 135/24 136/1 136/12 136/21 137/2 137/7 164/20	complications [1] 74/20	connections [1] 114/21	contained [3] 28/15 32/17 110/23
coherent [1] 23/8	communications [5] 114/19 136/3 136/6 137/21 165/6	completes [2] 157/6 190/8	conscious [2] 51/17 89/8	contemporaneous [4] 27/12 28/9 31/13 31/25
cohort [1] 77/6	communities [9] 85/21 90/8 90/10 91/11 91/12 91/17 102/18 140/10 141/19	completion [2] 104/22 105/10	consensus [1] 48/7	content [1] 169/12
cohorted [1] 58/23		complex [5] 24/16 24/17 125/13 179/7 183/17	consent [5] 103/23 104/8 104/11 104/15 104/16	context [9] 33/23 35/3 61/25 121/8 144/14 150/8 166/11 174/8 177/22
collaboration [3] 20/25 21/9 22/22		comprehensiveness [2] 106/5 112/24	consequence [5] 46/4 62/14 147/18 148/9 154/3	context is [1] 121/8
collaborative [1] 163/24		compressions [3] 41/14 46/13 46/18	consequences [2]	Contingencies [1] 22/7
colleague [2] 137/17 166/23		compromise [3] 42/20 44/12 174/25		continually [1] 27/3
colleagues [11] 23/21 23/22 26/10 51/10 62/5 68/5 91/14 126/25 145/5 157/11 190/12		concern [11] 62/1 88/8 121/24 121/24 125/17 166/16 169/17 170/2 175/12 185/17		
collect [1] 93/7				
collected [1] 92/14				
collecting [1] 29/12				
collection [3] 92/8 92/10 92/18				
collective [3] 164/24 170/14 187/24				
college [2] 120/7 121/15				
Colleges [3] 121/12 170/19 170/21				
colour [1] 57/19				
combating [1] 182/12				

C	90/21 97/7 103/17 103/18 111/11 120/13 122/17 149/25 150/6 183/9 183/11 183/12 correlation [2] 63/21 64/8 correspond [1] 79/14 cost [2] 38/4 173/8 could [61] 2/1 4/7 9/6 10/6 15/7 21/25 22/21 29/14 35/1 37/14 40/14 42/11 46/1 51/20 53/23 57/5 59/8 61/7 61/22 63/23 63/24 68/13 71/5 74/9 76/6 76/19 80/7 86/25 91/17 91/21 92/1 94/11 98/9 102/19 108/1 111/9 114/19 119/5 126/10 127/22 136/25 137/1 139/21 141/23 142/15 148/22 148/23 150/5 163/5 163/11 164/9 167/15 168/2 168/3 172/7 172/25 173/9 175/1 185/20 186/16 189/9 couldn't [7] 60/20 62/14 75/2 95/11 124/16 130/14 186/11 council [10] 41/17 42/16 42/22 42/25 43/12 44/5 46/12 46/17 141/17 166/23 Council's [2] 43/7 44/2 councils [1] 80/20 COUNSEL [4] 1/8 158/9 191/3 191/12 counter [1] 184/24 counterfactual [1] 65/25 counterpart [2] 14/12 77/18 counterparts [2] 22/20 25/23 counting [1] 128/14 countries [3] 48/6 128/19 143/3 country [1] 167/17 counts [1] 57/7 couple [3] 30/2 77/20 107/16 course [40] 6/23 7/3 7/5 8/23 16/21 22/25 26/23 28/5 30/20 36/23 37/10 38/1 44/8 45/2 45/5 51/17 52/8 54/23 58/20 78/4 81/3 82/1 82/22 88/1 89/10 91/9 98/20 104/16 132/23 136/21 136/25 139/4 141/14 147/15 148/10 149/2 151/14	153/16 153/21 154/18 CoV [1] 148/13 cover [1] 44/14 covered [2] 15/2 60/4 covering [2] 42/21 44/13 covers [1] 106/4 Covid [139] 4/1 11/22 12/8 15/12 15/21 16/5 17/2 17/11 17/11 18/20 18/21 18/24 19/15 20/20 27/9 27/23 28/21 34/16 37/15 38/8 38/24 51/1 54/1 54/4 54/7 56/13 57/1 57/2 57/8 58/14 58/17 58/18 58/18 58/23 59/4 59/11 62/3 62/6 65/24 74/4 74/21 79/5 84/9 84/23 86/8 86/14 86/16 86/19 86/20 86/23 87/2 87/25 88/10 88/12 89/24 90/2 90/9 90/23 91/23 99/22 102/22 106/13 113/3 115/10 121/3 128/6 128/10 128/23 129/2 130/3 130/10 130/12 130/14 131/1 131/12 131/20 131/22 132/2 132/11 132/13 132/14 132/16 132/17 132/21 133/1 133/7 133/8 133/9 133/17 133/19 134/3 134/6 134/22 135/5 140/23 142/4 142/11 143/6 144/9 144/14 147/13 147/18 147/20 148/5 149/24 150/10 161/14 162/4 164/6 164/9 165/10 166/9 167/12 167/15 167/21 168/15 168/16 168/21 168/22 168/23 169/25 170/1 170/3 170/22 172/3 172/8 172/12 173/7 176/15 176/16 177/2 178/15 182/5 184/14 185/13 186/11 186/17 187/20 189/15 Covid-19 [39] 4/1 11/22 12/8 15/12 15/21 16/5 19/15 27/9 27/23 34/16 38/24 51/1 54/1 54/7 56/13 57/1 57/8 62/3 62/6 74/21 79/5 84/9 86/8 86/14 90/2 90/23 102/22 106/13 128/6 128/10 129/2 142/11 144/9 147/13 147/18 147/20 148/5 149/24 150/10	Covid-19-related [1] 84/23 Covid-free [3] 58/14 58/18 167/12 Covid-light [1] 58/17 Covid-safe [2] 172/8 173/7 CPR [5] 41/19 45/2 45/9 47/8 103/13 created [5] 5/8 7/15 116/18 177/23 178/2 creating [3] 88/12 160/19 177/22 creation [1] 20/21 crisis [5] 176/7 180/1 180/8 181/9 181/10 criteria [3] 76/4 93/23 136/11 criterion [1] 71/23 critical [16] 17/10 93/21 95/14 95/21 96/1 96/4 96/13 96/20 96/24 97/2 101/8 172/15 178/8 179/21 180/11 181/1 critically [1] 174/15 cross [2] 123/8 159/17 cross-border [1] 159/17 crosses [1] 159/21 crushing [1] 175/12 curiously [1] 162/14 current [3] 2/11 48/11 56/15 currently [3] 13/1 22/1 48/9 curve [1] 77/12 Cymru [1] 153/7	dates [1] 141/3 David [1] 120/25 David Tuthill [1] 120/25 Davies [8] 39/13 39/15 47/24 48/1 49/16 49/18 50/5 50/15 day [15] 28/2 31/9 31/14 31/16 32/5 135/11 147/16 157/8 158/2 165/15 165/15 169/2 170/17 170/17 187/20 day book [1] 31/16 days [13] 24/1 51/18 61/6 87/12 87/19 88/25 94/2 118/4 132/4 151/12 164/10 173/1 186/9 DCMO [1] 13/3 DCMOs [1] 125/14 deal [6] 2/1 14/16 52/16 154/19 154/22 182/15 dealing [1] 19/17 dealt [1] 176/18 death [8] 45/4 45/4 70/19 73/2 84/13 140/14 165/20 184/4 deaths [1] 165/21 debriefs [1] 180/1 December [10] 49/17 50/3 55/12 55/17 57/13 126/17 127/1 127/7 132/12 166/6 December 2020 [3] 126/17 127/1 132/12 December 2021 [1] 166/6 decide [4] 43/25 45/11 99/20 99/21 decided [1] 175/16 decision [41] 6/20 38/6 42/24 72/23 73/8 73/10 73/21 73/25 75/6 77/5 81/23 82/19 82/21 93/17 93/22 94/14 94/23 95/13 99/3 104/4 104/12 146/11 148/1 149/4 149/7 150/8 151/8 176/1 176/10 176/14 176/24 177/11 177/16 177/22 178/2 178/7 179/6 186/24 186/25 187/19 188/11 decision-makers [1] 186/25 decision-making [20] 6/20 73/21 82/19 93/17 93/22 94/23 95/13 99/3 176/1 176/10 176/14 177/11
		D		
		daily [4] 28/13 99/22 159/21 176/15 damage [1] 45/5 damaged [1] 155/24 Dame [1] 72/16 data [15] 77/7 78/16 78/16 78/19 90/22 92/5 92/8 92/10 92/14 92/16 92/18 128/17 128/17 140/18 141/25 database [1] 78/13 databases [5] 76/9 76/9 76/20 76/23 77/11 date [15] 13/14 15/15 19/24 29/25 56/16 58/25 62/21 65/6 120/17 122/17 122/20 124/4 140/17 157/18 158/14 dated [8] 1/21 1/22 53/19 63/5 65/19 96/9 119/7 128/24		

D	33/11 144/20	determine [2] 103/4 176/25	109/1 110/2 110/5 110/14 112/2 113/21 114/4 114/17 117/4 117/18 122/18 124/2 125/17 130/17 130/24 131/2 131/11 131/25 132/18 136/22 138/2 138/4 140/13 145/5 147/22 147/23 147/25 150/21 154/17 159/14 159/16 160/22 162/23 163/7 164/4 165/7 169/3 169/5 170/5 170/18 171/4 172/3 172/25 173/5 173/6 173/17 174/20 175/23 176/22 178/21 179/16 181/19 190/12	digital [8] 76/7 77/10 77/12 77/17 77/21 77/22 78/7 156/12 digitally [1] 157/1 dilemmas [1] 176/3 direct [9] 7/22 13/6 22/2 63/21 64/2 86/14 86/19 90/12 177/8 directed [1] 26/23 direction [3] 3/9 21/10 130/23 directions [2] 9/13 38/5 directive [3] 21/2 44/24 45/11 directives [1] 171/5 directly [8] 24/19 53/10 62/13 68/14 71/17 87/6 90/21 118/1 director [34] 2/19 2/21 2/24 6/17 7/1 7/20 7/21 8/1 8/5 10/1 10/4 10/8 10/9 10/15 11/5 11/6 11/10 11/17 13/8 15/24 16/2 16/3 18/6 21/4 24/25 25/1 25/5 25/10 90/1 131/3 132/1 155/13 158/11 175/21 director-level [1] 2/19 directorate [8] 11/6 11/9 11/11 11/13 11/20 14/21 14/22 75/18 directors [23] 7/2 7/22 8/2 8/9 8/17 8/20 9/5 10/2 25/2 68/1 106/22 106/25 107/1 107/1 108/6 109/24 110/21 129/1 131/6 131/8 131/8 166/18 189/17 directors' [2] 8/4 108/7 disabilities [4] 71/23 72/1 107/12 107/12 disability [8] 71/25 81/18 82/11 102/18 103/14 103/19 108/16 108/17 disabled [5] 82/12 82/14 82/14 98/7 102/17 disabling [1] 135/6 disadvantaged [1] 89/24 disagree [1] 64/20 disastrous [1] 45/4 discharge [4] 150/9 150/13 150/14 151/8 discharged [2] 133/22 151/20
decision-making... [8] 177/16 177/22 178/2 178/7 179/6 186/24 187/19 188/11	departures [1] 185/21 dependency [2] 160/20 163/9 depending [1] 186/1 Depends [1] 37/17 deprivation [3] 155/23 156/4 159/6 deputies [2] 13/1 13/21 deputy [27] 2/10 9/11 9/11 9/20 10/3 10/10 11/18 12/20 12/22 13/2 13/7 13/18 15/24 16/3 16/11 18/12 18/23 19/8 25/1 33/4 42/13 43/10 43/23 51/7 100/18 125/13 133/22 Deputy CMO [1] 9/11 derived [1] 70/14 Derry [1] 158/25 Derry/Londonderry [1] 158/25 describe [14] 6/14 7/12 8/12 22/19 41/22 129/15 131/3 140/25 141/19 156/1 158/22 166/11 169/7 186/23 described [21] 9/2 9/25 11/1 25/6 31/7 36/1 36/13 47/14 75/25 77/19 136/12 138/14 142/2 144/14 153/17 164/13 167/5 170/20 183/16 185/18 187/1 describing [3] 63/25 153/21 187/15 description [2] 104/23 105/11 designated [2] 22/6 147/20 designation [1] 147/24 designed [3] 20/22 20/22 21/12 desirable [1] 148/19 desire [1] 112/21 desired [1] 63/17 desperately [1] 167/11 despite [2] 1/14 55/6 detail [7] 5/2 5/19 6/8 6/13 29/9 33/23 162/22 detailed [4] 28/15 28/23 107/5 147/15 details [3] 46/5 74/15 156/18 deteriorate [1] 106/4 deteriorating [1] 188/1	develop [7] 60/9 94/23 106/7 135/12 150/19 150/21 179/23 developed [14] 23/1 69/12 92/22 132/17 135/2 144/1 145/8 169/18 171/16 177/14 178/10 178/13 178/16 187/5 developing [10] 27/8 60/19 74/20 90/18 105/6 163/8 176/5 176/23 176/23 177/18 development [6] 20/11 24/1 134/13 134/16 178/15 186/24 developments [1] 27/24 deviate [1] 169/5 deviated [1] 39/9 deviation [1] 39/7 deviations [1] 184/22 devices [2] 126/6 127/6 devolution [1] 2/16 devolved [6] 23/20 25/2 25/23 27/2 30/3 114/23 diabetes [1] 69/24 diagnosed [2] 54/2 54/3 diagnosis [1] 132/2 diagram [2] 14/5 15/22 did [130] 7/21 8/14 8/16 8/23 10/15 10/16 14/17 14/20 14/23 16/10 16/13 16/15 17/19 18/3 19/8 19/25 20/15 21/3 21/6 23/15 24/11 24/25 26/11 27/22 30/12 30/18 31/15 32/10 34/7 34/11 36/25 39/19 45/16 45/20 45/22 46/6 51/21 51/22 60/13 60/21 62/22 64/7 65/6 65/22 66/8 67/5 71/17 74/21 75/5 76/13 76/19 79/6 79/12 80/10 82/20 83/17 83/20 84/24 85/17 86/19 86/22 87/10 90/25 92/13 93/6 93/20 94/13 97/9 97/13 97/14 97/25 101/1 101/21 104/10 104/11 105/20 108/11	110/1 110/2 110/5 110/14 112/2 113/21 114/4 114/17 117/4 117/18 122/18 124/2 125/17 130/17 130/24 131/2 131/11 131/25 132/18 136/22 138/2 138/4 140/13 145/5 147/22 147/23 147/25 150/21 154/17 159/14 159/16 160/22 162/23 163/7 164/4 165/7 169/3 169/5 170/5 170/18 171/4 172/3 172/25 173/5 173/6 173/17 174/20 175/23 176/22 178/21 179/16 181/19 190/12 didn't [26] 26/9 28/1 30/13 44/18 45/6 46/22 46/24 68/23 71/20 74/4 75/16 76/5 87/25 94/17 101/24 110/4 113/11 114/12 117/16 127/12 131/24 136/15 138/1 156/20 171/1 189/21 difference [3] 64/13 170/18 170/20 differences [5] 128/14 128/15 128/15 128/20 160/11 different [33] 9/13 12/11 12/17 26/1 33/12 34/7 36/20 37/6 45/14 48/25 50/19 57/19 73/19 76/9 76/23 78/1 78/5 78/6 82/8 82/10 84/21 86/7 89/10 96/5 127/23 133/2 142/23 155/19 160/3 161/8 168/4 168/5 183/16 differential [1] 114/14 differently [1] 173/18 difficult [33] 14/4 14/8 14/18 26/22 26/25 44/19 46/9 46/10 75/18 85/23 89/16 108/3 119/16 135/10 136/14 139/9 143/4 147/5 162/7 165/15 165/17 165/22 167/9 168/17 169/1 172/9 172/11 173/4 174/9 175/14 176/9 176/14 177/8 difficulties [8] 26/12 37/13 67/10 94/4 152/24 161/1 161/8 174/22 difficulty [2] 153/11 161/22	

D	41/11 41/21 41/22 44/4 82/4 divergent [1] 25/22 diverging [1] 25/17 division [3] 10/15 10/22 13/3 DNACPR [37] 101/12 101/14 101/22 102/6 102/23 102/25 103/11 103/20 103/23 104/11 104/15 104/22 105/10 105/25 106/15 107/5 107/11 107/21 108/8 108/16 108/20 109/1 109/25 110/7 110/9 110/15 110/18 111/5 111/13 111/23 182/14 186/19 187/8 188/22 189/1 189/5 189/7 DNACPRs [2] 109/5 109/21 do [123] 1/25 2/23 3/13 13/17 13/22 19/1 19/16 19/19 19/24 26/14 30/15 37/7 37/13 37/18 41/9 41/10 41/20 48/17 48/23 49/4 50/14 66/11 67/21 69/5 71/22 73/14 74/9 75/18 76/13 77/6 77/19 79/10 80/23 88/7 92/7 92/25 94/8 94/21 97/10 97/11 101/1 101/6 101/11 105/12 106/15 107/3 108/20 108/23 112/11 112/14 113/4 113/6 114/21 116/3 116/9 116/14 116/17 116/21 116/23 116/24 117/24 118/5 119/1 119/14 119/15 119/15 120/9 120/18 123/9 124/19 125/7 126/21 127/2 127/2 130/5 134/22 135/6 136/6 136/14 136/22 136/24 137/1 137/1 138/7 142/18 143/10 144/19 144/22 145/25 146/19 146/23 147/3 148/3 149/8 150/8 151/4 152/2 154/24 157/16 159/16 159/17 160/11 166/24 166/25 167/19 171/7 171/8 172/1 173/2 173/21 176/13 177/9 177/24 178/3 178/19 178/20 180/7 180/13 183/20 183/21 184/5 186/5 187/4 doctor [6] 104/12 121/4 182/17 182/18	186/18 190/9 Doctor Atherton [1] 121/4 doctors [17] 6/24 104/2 132/5 146/15 160/19 161/10 161/20 162/9 166/17 167/1 170/2 171/11 171/11 178/19 179/5 179/9 187/12 document [20] 15/18 16/20 56/21 57/18 60/7 61/15 61/22 95/8 95/17 96/10 97/20 98/5 98/18 98/19 102/2 129/3 152/22 178/12 178/21 183/9 documentation [8] 27/13 27/15 27/19 31/14 31/25 177/13 177/19 178/19 documents [4] 7/5 28/9 106/5 106/8 does [18] 21/14 21/17 21/19 51/14 52/23 58/5 58/9 58/10 59/14 59/21 95/1 98/20 111/1 131/19 133/12 154/6 182/18 182/20 doesn't [11] 38/6 45/13 45/23 53/1 66/14 105/25 112/17 120/13 134/1 134/2 151/23 doing [8] 26/13 30/15 127/16 140/4 146/19 177/4 179/6 189/25 domain [2] 129/18 154/22 dominant [1] 48/21 don't [85] 9/24 15/7 19/2 19/5 19/11 19/12 21/15 21/25 21/25 22/21 32/14 38/2 39/9 40/23 42/4 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 88/1 90/3 90/11 93/3 93/5 93/9 101/9 104/4 105/15 106/14 108/5 108/23 109/6 112/21 113/9 113/17 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 131/13 134/8 134/25 135/21 138/5 139/7 140/3 146/2	148/10 148/11 148/11 153/16 154/8 163/5 177/21 182/18 donations [1] 170/13 done [19] 12/15 20/25 21/9 72/6 74/2 76/7 77/8 81/2 92/7 92/9 97/12 111/24 112/1 129/8 136/25 142/16 144/10 145/25 164/20 door [1] 172/6 doubled [1] 113/22 doubt [2] 84/14 156/3 down [18] 32/19 42/23 46/10 48/13 55/15 63/3 65/4 65/21 66/13 81/7 100/12 102/14 106/11 118/10 128/12 137/8 141/3 164/2 Down's [9] 72/4 72/9 72/12 72/12 72/22 73/3 73/6 73/9 136/19 downgrade [1] 169/8 downloaded [1] 119/23 downside [3] 117/1 117/10 154/2 downsides [4] 37/9 37/12 37/24 117/10 Dr [85] 1/12 1/16 2/2 4/17 4/17 4/22 5/5 9/21 10/8 10/12 12/2 12/19 12/22 13/10 14/13 17/14 17/25 18/9 18/24 21/17 27/17 29/19 30/18 31/5 32/2 35/8 37/5 39/13 39/15 43/10 47/24 48/1 49/16 49/18 50/5 50/14 50/21 51/1 53/18 56/11 63/10 66/22 87/8 95/20 102/12 115/2 115/9 119/9 123/20 128/3 128/4 130/2 130/9 130/13 130/15 130/17 133/15 134/1 134/2 135/3 135/22 139/17 140/7 147/6 147/10 147/12 149/16 150/25 152/11 154/9 155/2 157/6 158/4 158/5 158/6 158/11 158/14 164/1 180/18 181/24 182/4 188/18 190/3 190/10 191/11 Dr Atherton [34] 1/16 2/2 5/5 12/2 13/10 21/17 35/8 37/5 50/21 51/1 53/18 56/11 63/10 66/22 87/8	95/20 102/12 115/2 119/9 123/20 130/2 130/9 133/15 135/3 135/22 139/17 147/10 147/12 149/16 150/25 152/11 154/9 155/2 157/6 Dr Catherine [3] 14/13 158/4 158/11 Dr Chris Jones [6] 9/21 12/22 18/9 18/24 43/10 130/13 Dr Davies [2] 39/15 49/18 Dr Eleri [6] 39/13 47/24 48/1 49/16 50/5 50/14 Dr Frank [1] 1/12 Dr Gillian [1] 12/19 Dr Jones [6] 10/12 17/14 17/25 130/15 130/17 134/1 Dr Jones' [1] 134/2 Dr McDonnell [4] 158/14 180/18 181/24 190/3 Dr Orford [5] 27/17 29/19 30/18 31/5 32/2 Dr Robert Orford [2] 4/17 4/17 Dr Ruth Hussey [1] 10/8 Dr Warne [1] 128/4 draft [1] 19/3 drawing [1] 149/18 drawn [3] 33/8 51/9 74/1 driver [1] 91/20 drivers [3] 89/18 91/19 142/25 driving [1] 91/22 drop [1] 24/21 droplet [4] 34/23 35/2 35/9 35/17 droplets [2] 35/15 117/5 dropped [2] 57/14 169/12 dual [2] 6/17 24/24 due [8] 7/5 16/21 88/12 99/25 100/4 120/21 126/19 126/20 during [42] 3/15 5/21 5/23 8/18 9/4 9/23 10/17 15/4 15/9 17/18 19/18 28/11 37/1 38/19 38/24 41/14 52/8 54/7 71/21 83/1 83/3 84/13 86/9 93/18 99/23 102/7 110/16 128/4 142/18 142/21 143/5 153/10 154/14 159/15 159/22 161/24 164/5 172/3 180/20
----------	---	--	---	--

D	efforts [2] 68/22 189/3	England [22] 22/24 23/18 25/2 25/5 25/13 25/18 26/9 39/5 42/19 43/13 107/11 111/7 112/9 120/3 123/5 123/24 124/8 124/12 125/14 125/15 127/23 128/6	escape [2] 44/14 44/16	189/18
during... [3] 182/13 184/20 190/12	either [7] 24/19 52/1 52/4 91/1 107/21 109/2 132/19	English [1] 136/23	essential [7] 16/25 17/1 17/3 104/19 153/22 153/23 159/24	everybody [4] 1/13 26/13 152/24 153/3
duty [2] 104/2 174/11	elaborate [2] 76/12 144/18	enjoy [1] 160/13	essentially [3] 20/8 45/9 75/5	everybody's [3] 44/18 45/23 184/9
dying [1] 87/17	elective [3] 159/10 181/9 181/13	England-only [1] 23/18	establish [2] 40/2 60/1	everyone [2] 116/3 184/10
dynamic [1] 188/6	elements [1] 112/20	enormous [2] 75/2 128/16	established [12] 15/13 18/10 18/25 30/23 30/25 51/6 115/23 134/8 134/9 134/10 141/16 175/4	everything [5] 8/23 30/15 136/22 136/22 155/18
E	Eleri [6] 39/13 47/24 48/1 49/16 50/5 50/14	enough [7] 33/23 113/12 124/16 148/10 170/16 182/8 183/6	estate [7] 59/7 67/13 68/5 68/6 68/9 68/23 184/16	everywhere [1] 58/16
each [9] 1/24 7/4 7/19 8/2 20/13 22/5 29/9 57/18 177/9	elevating [1] 163/11	ensure [11] 62/6 63/16 93/1 93/23 110/16 129/6 131/9 132/1 146/2 174/12 176/21	esteem [1] 146/6	evidence [49] 35/22 35/25 36/3 36/9 37/4 38/11 38/12 40/14 41/19 44/7 46/12 46/18 47/24 48/18 52/12 52/12 54/11 62/7 72/21 73/1 84/6 84/8 84/10 84/17 85/12 85/14 115/17 115/19 116/17 117/3 117/12 117/14 117/21 122/1 129/12 130/4 130/10 132/7 133/25 137/17 138/14 147/15 149/20 151/6 157/14 157/25 158/2 181/7 187/3
earlier [13] 11/1 31/24 46/15 116/25 126/24 130/19 136/13 142/22 145/5 149/6 149/21 151/7 153/17	eliminate [1] 64/2	entirely [9] 34/8 53/2 58/7 58/18 81/25 116/12 120/6 128/1 141/10	Esther [1] 120/6	evidence-based [3] 52/12 52/12 62/7
early [38] 14/11 17/25 18/3 24/1 28/21 30/13 30/16 34/17 34/21 35/4 36/14 51/18 81/4 87/2 87/12 87/19 88/25 94/2 117/7 117/16 118/6 118/8 123/1 129/12 132/4 133/21 140/18 140/23 141/14 143/11 143/11 151/12 160/12 169/17 173/21 175/17 185/3 186/9	eliminating [1] 64/10	enter [1] 80/5	Esther Youd [1] 120/6	evolved [1] 19/23
earth [1] 37/25	else [3] 30/15 38/4 127/15	ensuring [2] 175/23 175/24	et [4] 79/18 137/21 139/10 161/9	evolving [1] 30/18
ease [1] 146/20	elsewhere [1] 40/25	entirety [1] 98/21	et cetera [4] 79/18 137/21 139/10 161/9	exacerbated [1] 142/11
eased [3] 165/16 165/17 169/14	elucidates [1] 59/20	entity [2] 7/7 21/16	ethical [4] 90/16 93/17 106/13 181/4	exacerbating [1] 88/13
easier [2] 164/13 173/2	email [15] 24/21 41/23 44/3 48/3 49/13 49/16 50/7 97/8 100/10 119/4 119/7 119/25 120/4 120/5 120/24	enunciated [1] 46/15	ethics [8] 172/24 175/3 175/17 175/18 178/22 187/11 188/15 188/23	exacerbation [3] 86/9 88/16 91/2
earthly [1] 91/17	emerge [2] 143/17 154/15	environment [3] 37/22 172/10 173/8	ethnic [11] 89/11 90/8 90/10 92/23 140/8 140/10 140/15 146/1 155/21 155/21 159/4	exact [2] 47/13 123/25
Eastern [1] 143/3	emergence [1] 47/18	environnements [1] 35/24	ethnicity [3] 92/5 92/16 92/18	exactly [15] 9/1 18/14 30/6 30/20 33/2 48/17 49/2 60/20 64/16 82/3 95/16 99/12 127/17 188/1 190/6
easy [6] 68/23 79/10 136/17 136/20 137/3 153/3	emergency [4] 159/18 176/23 177/11 178/7	envisaged [2] 22/2 70/7	Europe [2] 139/13 175/10	example [21] 11/18 25/11 29/5 36/6 37/15 40/3 69/2 74/6 91/25 136/18 137/20 146/21 155/15 156/11 161/15 166/22 167/22 169/8 169/21 172/6 185/8
eaten [1] 181/10	EMG [3] 115/16 115/19 116/19	epidemiological [1] 33/21	European [1] 143/3	examples [2] 91/8 91/25
economic [10] 20/11 75/6 86/17 88/25 89/3 89/13 89/18 90/7 147/1 155/22	empirical [1] 117/14	epidemiology [2] 17/21 33/25	evaluation [1] 85/12	exams [1] 161/9
Edmonds [1] 16/5	employing [1] 59/2	episode [1] 178/23	even [6] 51/18 109/13 116/10 156/22 167/9 172/10	exceeded [1] 93/21
education [2] 156/15 156/16	empowered [1] 44/23	equal [1] 10/3	event [4] 13/17 94/14 109/13 146/3	excellent [5] 22/21 23/5 98/21 105/4 138/3
effect [2] 63/17 84/25	empty [1] 96/17	equality [1] 82/11	events [3] 46/8 109/11 143/13	excess [1] 162/21
effective [10] 19/17 51/16 52/3 52/19 66/18 66/25 129/11 145/2 185/18 189/8	enable [2] 4/23 77/8	equally [1] 89/9	eventually [1] 44/21	excluded [2] 156/17 157/1
effectively [3] 10/3 17/2 161/23	enabled [2] 44/24 86/5	equals [1] 8/13	ever [15] 20/19 25/1 25/17 25/21 30/12 39/9 54/22 62/23 108/2 130/17 130/24 131/11 139/7 170/18 182/8	exclusion [1] 156/12
effectiveness [5] 40/20 80/23 83/18 84/2 84/14	encompassed [1] 11/16	equipment [6] 41/16 46/7 49/9 162/19 163/18 170/8	eventually [1] 44/21	
effects [3] 79/7 84/20 144/8	encountering [1] 8/21	equitably [2] 156/25 173/1	eventually [1] 44/21	
efficiency [1] 113/16	encouraged [1] 170/24	equity [6] 143/25 144/17 144/18 144/21 145/6 157/3	eventually [1] 44/21	
efficient [1] 113/15	ending [4] 53/24 56/24 57/13 57/15	eradicate [3] 52/6 52/17 53/2	eventually [1] 44/21	
effort [1] 77/13	enemy [1] 113/16	error [1] 123/15	eventually [1] 44/21	
	engage [2] 62/5 62/19	errors [1] 71/11	eventually [1] 44/21	
	engaged [1] 95/5	escalated [1] 9/12	eventually [1] 44/21	
	engagement [1] 145/24	escalates [1] 6/25	eventually [1] 44/21	
	engineers [1] 68/16	escalation [6] 96/20 96/22 99/24 100/2 102/20 178/11	eventually [1] 44/21	

E	extant [1] 155/14 extend [1] 82/15 extended [2] 79/4 164/9 extending [1] 23/19 extension [1] 92/10 extent [3] 150/4 163/10 168/12 external [1] 33/10 extra [1] 83/1 extract [1] 183/3 extraordinarily [2] 31/11 139/9 extraordinary [1] 167/6 extreme [1] 73/20 extremely [38] 14/4 14/7 14/18 69/1 69/10 70/16 70/17 71/7 71/19 71/22 71/24 73/23 74/17 75/10 79/1 79/7 79/16 79/25 80/11 81/11 83/19 84/12 98/23 136/7 138/11 138/16 138/20 139/2 160/5 161/3 164/12 165/23 168/17 175/18 175/25 176/19 179/16 180/11 eye [2] 144/12 177/5 eye-opener [1] 144/12	familiar [4] 1/23 110/17 183/4 183/5 families [8] 115/11 135/23 164/15 164/17 164/20 173/12 179/7 182/5 fantastic [2] 14/20 114/5 far [10] 2/18 26/20 40/2 62/22 108/1 108/11 111/21 144/21 144/21 186/15 fared [1] 114/16 faring [1] 141/20 fashion [1] 25/18 fast [3] 14/7 29/7 31/11 fatality [1] 149/24 fate [1] 186/22 father [1] 171/23 fear [5] 94/5 165/8 165/13 187/2 187/5 fears [1] 62/20 feasible [2] 126/7 151/11 feature [2] 20/20 124/22 features [1] 68/20 February [19] 1/22 15/11 15/16 29/19 29/25 29/25 30/25 34/20 56/19 56/24 59/1 60/10 60/22 60/23 61/14 94/2 132/15 150/2 166/7 February 2021 [5] 59/1 60/10 60/22 60/23 132/15 February 2022 [1] 166/7 fed [1] 144/16 Federation [1] 140/8 feed [8] 9/11 9/12 16/8 16/18 23/15 24/11 49/21 123/10 feedback [1] 189/25 feeding [3] 22/14 116/19 116/20 feeds [1] 16/24 feel [4] 3/13 14/17 85/17 145/18 feel under-resourced [1] 14/17 feeling [2] 86/5 164/24 felt [21] 46/2 81/20 97/19 98/21 103/11 103/15 108/8 109/9 109/10 121/22 137/7 139/15 161/3 164/25 166/17 166/20 168/13 174/14 176/19 185/19 185/21 female [1] 96/18	FEMHO [1] 140/9 few [4] 53/21 133/10 140/19 142/21 FFP2 [2] 138/21 139/10 FFP3 [3] 47/9 138/22 139/8 field [3] 17/12 131/2 133/6 fifth [3] 88/10 88/20 166/6 figure [1] 162/25 figured [1] 153/14 figures [2] 57/12 164/7 fill [2] 136/11 160/23 filtration [1] 68/11 final [6] 38/6 63/18 66/11 100/6 129/22 145/23 finalised [1] 75/11 finally [4] 55/24 135/3 138/10 180/18 finance [1] 18/6 financial [1] 143/18 find [7] 36/18 38/13 89/22 91/6 119/15 173/6 189/4 finding [3] 32/6 85/5 125/16 findings [4] 24/1 24/1 84/21 144/10 fine [2] 46/3 100/14 finish [1] 127/5 first [71] 2/1 3/16 4/11 4/15 4/22 5/12 6/1 6/4 8/13 9/14 11/7 24/23 29/16 29/19 38/22 41/4 43/9 44/16 47/20 51/3 55/17 58/20 60/8 67/5 70/7 70/15 72/17 74/1 82/18 87/22 90/10 91/12 92/3 93/18 100/17 114/7 115/15 119/8 119/8 128/5 130/9 135/24 140/5 140/13 140/19 140/21 140/25 141/15 145/24 148/7 148/17 148/18 150/20 152/12 152/13 152/14 152/19 158/1 160/4 165/2 165/14 171/19 171/22 171/23 179/21 182/11 182/15 182/15 185/1 185/6 186/11 first-hand [1] 145/24 firstly [2] 3/15 67/1 fit [3] 48/9 96/16 139/10 fitting [3] 117/25 138/21 139/10 five [1] 15/23	fixed [1] 32/23 flag [2] 127/20 134/21 flexibility [1] 114/3 Fliss [2] 33/3 33/4 Fliss Bennee [1] 33/3 flow [7] 8/19 9/1 20/1 27/21 55/25 126/6 127/6 flowed [2] 26/5 130/20 flowing [3] 14/7 29/7 153/18 flu [2] 70/14 74/6 fluid [1] 49/7 fluid-resistant [1] 49/7 focus [6] 5/3 49/6 92/1 116/4 121/5 152/4 focused [5] 88/12 88/22 89/3 124/18 144/21 focusing [1] 143/10 follow [15] 6/24 40/5 44/9 45/21 52/23 70/9 71/16 120/15 121/7 121/19 141/6 145/17 167/20 169/4 170/24 follow-up [2] 141/6 145/17 followed [3] 108/8 141/25 169/6 following [11] 34/25 55/2 62/2 67/17 70/24 91/4 107/10 120/2 121/25 168/1 188/19 follows [1] 20/2 fomites [1] 34/23 food [2] 79/18 143/4 foot [1] 176/5 footfall [2] 159/21 160/12 footing [1] 10/3 footprint [1] 162/18 forefront [1] 135/1 foreseeable [1] 80/11 forget [2] 46/8 134/25 forgive [6] 31/21 39/16 42/3 106/12 116/7 186/4 form [7] 35/15 100/6 104/22 105/10 111/9 131/15 149/9 formal [5] 28/1 28/5 31/9 83/13 96/3 formally [1] 1/14 former [2] 13/8 158/11 formerly [1] 10/7 forms [2] 103/11
----------	---	---	---	---

F	65/16 83/7 110/17 178/13 184/25	17/20 37/4 37/14 42/6 73/20 78/18 78/18 85/6 91/8 104/16 134/2 158/14 162/22	governance [1] 12/3 government [59] 2/20 3/6 3/8 3/9 3/14 8/8 9/7 11/10 13/5 15/1 15/3 15/13 22/14 24/12 24/20 25/17 29/24 30/17 33/2 33/11 33/15 34/8 51/9 56/14 60/16 63/12 63/16 64/5 66/7 70/22 71/2 77/18 77/21 83/16 86/13 87/5 88/17 91/1 91/24 93/6 93/7 94/13 100/8 101/1 106/18 109/2 109/7 110/13 112/13 114/23 114/24 123/7 123/23 126/16 129/19 130/25 132/19 135/4 144/20	105/18 106/7 107/21 115/11 125/1 125/15 129/11 130/21 132/9 132/14 132/21 132/24 134/7 134/11 136/12 137/5 141/18 142/3 151/2 155/21 166/15 176/24 177/11 186/20 187/19 188/15 188/23 189/11 189/14 189/16 189/16
forms... [1] 111/6 formulaic [1] 136/16 formulated [3] 37/1 37/3 69/20 formulating [3] 18/22 71/17 101/22 formulation [1] 137/21 formulations [1] 36/20 fortunate [1] 183/22 forum [3] 24/6 82/15 82/17 forward [1] 95/3 forwards [2] 114/2 120/5 found [5] 55/3 55/5 84/19 153/8 168/13 four [20] 20/13 22/16 23/3 23/11 26/19 29/21 39/11 48/14 62/9 66/21 69/12 69/17 71/8 72/8 74/13 86/10 94/20 96/11 98/16 145/12 four-nation [1] 69/12 fourth [1] 181/14 Fowler [1] 125/13 frack [2] 37/21 38/2 fracking [3] 37/20 37/23 37/25 fragile [1] 168/24 frailty [8] 96/15 97/4 97/24 98/8 99/10 99/11 102/19 102/25 framework [7] 60/10 60/11 60/13 60/19 61/1 61/13 61/19 Francis [1] 1/12 Frank [11] 1/6 1/7 1/9 1/12 1/13 1/13 1/15 119/13 120/12 120/13 191/2 free [5] 58/14 58/18 143/15 167/12 178/8 frequency [1] 165/20 frequent [2] 51/25 183/17 frequently [1] 25/8 front [7] 1/24 61/20 121/18 154/1 162/2 176/5 182/19 froze [1] 178/1 fruition [1] 76/1 fuel [1] 38/3 fulfilled [1] 10/13 full [12] 1/11 30/5 41/16 41/18 83/12 96/21 126/20 127/11 158/10 165/5 167/21 182/6 fully [7] 6/7 54/22	function [2] 111/2 133/21 functions [4] 12/7 14/23 34/2 34/7 funding [2] 161/12 161/14 further [12] 43/22 49/24 56/8 59/21 63/15 64/6 64/11 71/3 73/1 106/11 123/6 144/19 future [12] 77/4 78/3 78/5 78/9 85/8 85/14 105/24 113/7 146/3 152/1 176/2 187/16	given [22] 42/25 50/7 57/19 70/10 72/4 74/23 82/15 89/24 91/22 100/22 130/4 130/6 135/3 135/5 138/15 138/19 139/9 145/17 147/3 147/15 185/25 186/22 giving [5] 31/5 69/21 70/4 89/22 157/14 global [1] 38/1 go [32] 12/5 26/1 31/15 32/15 38/21 42/11 42/23 43/9 43/19 51/2 53/18 55/8 56/8 57/5 57/16 58/5 60/7 61/22 63/10 73/17 83/8 83/11 94/19 96/10 99/17 100/12 100/17 103/19 104/18 112/7 123/16 142/22 goes [1] 110/21 going [45] 2/3 2/5 6/7 14/6 20/4 24/5 26/1 40/15 45/14 50/9 64/12 74/5 77/23 79/25 95/6 96/15 99/9 107/2 114/2 117/20 118/9 118/25 119/2 119/4 121/4 123/14 123/19 129/20 134/16 142/8 151/12 152/1 157/10 161/12 162/16 163/3 163/4 168/14 178/24 179/20 180/22 182/25 187/2 189/20 189/23 gone [7] 32/11 52/24 103/12 168/2 168/3 177/18 185/10 good [21] 1/5 21/6 52/8 67/16 74/14 80/18 80/22 93/11 114/11 115/9 117/17 136/21 136/21 138/25 146/18 147/12 179/4 180/12 180/13 184/11 187/14 Goodall [8] 2/25 4/5 5/10 5/15 17/17 21/3 42/14 53/13 got [18] 42/8 54/22 80/13 83/5 87/22 145/16 159/4 159/10 160/12 162/1 162/6 168/21 170/12 183/1 184/10 188/6 188/7 188/14 Gould [1] 128/3	groups [31] 23/14 34/10 34/11 40/2 70/12 72/20 73/22 74/3 74/6 75/24 81/18 82/14 89/10 89/11 89/13 89/17 89/21 90/25 91/6 102/17 104/22 105/11 105/17 112/16 130/3 139/16 142/24 147/3 147/5 168/19 168/20 guess [2] 40/1 102/4 guessing [1] 40/5 guidance [71] 18/22 38/19 39/1 39/8 39/21 40/18 40/20 41/12 42/20 43/2 43/16 45/16 45/22 47/17 48/5 48/8 48/16 50/4 50/16 51/4 51/13 52/2 62/6 62/11 62/24 63/1 63/12 63/16 63/22 64/7 64/9 64/12 67/17 67/22 70/22 71/1 71/3 106/13 120/8 120/8 120/15 121/7 121/25 132/12 132/20 136/4 136/5 160/3 169/4 169/6 169/8 169/11 169/17 169/18 170/19 170/25 171/2 173/22 173/24 173/25 173/25 177/6 184/25 185/10 185/12 185/16 185/21 185/24 185/25 187/4 187/7 guidance ... issued [1] 39/1 guide [3] 177/8 181/3 185/24 guidelines [5] 39/24 49/1 68/21 121/20 132/20 guiding [1] 20/23	
G	gathered [2] 163/21 172/23 gathering [1] 141/9 gave [3] 89/7 130/10 152/21 general [15] 2/5 2/21 2/25 15/25 16/3 21/5 55/14 57/25 58/11 58/21 70/11 70/13 165/9 166/22 187/22 generalities [1] 187/9 generally [7] 3/19 26/4 27/4 34/3 132/5 139/11 169/6 generated [2] 46/13 46/19 generating [3] 34/25 41/15 41/20 generously [1] 170/13 geographical [1] 7/11 get [29] 9/25 15/18 33/18 37/25 38/1 39/10 42/3 49/13 50/10 66/23 87/23 90/3 91/18 94/6 95/9 102/10 127/13 143/17 146/8 149/13 157/16 161/12 162/8 172/17 177/4 181/11 181/19 187/15 189/24 Gething [1] 118/2 getting [13] 21/17 89/21 127/18 143/11 146/13 150/22 152/10 153/11 162/18 162/19 167/10 167/15 188/4 gifted [1] 121/1 Gill [2] 14/1 42/13 Gill Richardson [2] 14/1 42/13 Gillian [1] 12/19 give [15] 1/11 15/15	Government's [2] 19/15 109/19 grade [2] 44/22 138/21 gradually [1] 154/16 granted [1] 182/10 graph [8] 57/6 57/12 57/16 57/19 57/23 57/24 58/8 59/22 graphs [1] 61/7 grapple [1] 78/17 grateful [7] 128/2 129/23 137/6 154/5 154/20 156/7 190/11 gratefully [1] 171/2 great [2] 14/23 78/2 greater [5] 38/4 80/1 90/7 117/15 155/25 green [3] 58/14 58/22 59/3 ground [3] 166/12 175/25 189/23 group [111] 2/22 5/9 8/4 9/17 15/12 15/12 15/14 15/21 15/22 16/6 16/8 16/9 16/19 16/25 17/1 18/7 18/11 18/16 19/4 19/6 19/10 21/5 23/8 23/13 23/17 23/22 24/2 24/4 24/8 25/3 25/6 25/14 32/25 33/5 33/7 33/12 33/17 34/1 34/2 34/6 34/9 40/10 49/22 51/5 51/9 51/13 53/7 53/12 56/9 56/15 59/15 60/1 60/5 60/15 60/19 62/18 62/23 64/24 65/4 65/7 65/21 66/2 66/7 66/12 69/16 70/23 71/3 74/22 75/8 75/17 78/6 82/11 84/11 87/5 88/11 90/11 91/16 92/3 94/21 97/13	habit [1] 24/13 had [144] 5/8 6/4 6/13 10/20 10/20 11/11 13/13 14/15 14/15 17/25 20/10 20/12 20/12 22/23 23/1 24/24 25/8 26/1	

<p>H</p> <p>had... [126] 27/12 27/19 28/8 30/2 31/8 33/18 40/4 40/19 40/23 44/11 44/12 48/4 48/7 48/15 48/20 49/18 53/20 54/5 55/3 55/20 55/24 56/4 61/9 62/10 63/12 64/21 65/22 66/2 68/8 69/1 70/9 70/18 72/6 72/22 73/8 73/25 74/2 74/5 74/8 74/18 75/11 75/12 76/7 76/24 79/24 81/20 82/15 85/2 86/3 86/4 86/11 87/2 88/14 88/19 88/25 89/19 90/12 90/20 91/10 91/11 91/20 92/7 92/22 94/9 97/19 100/20 104/6 107/16 107/16 107/20 108/14 108/16 108/16 109/4 109/23 110/5 118/20 121/12 122/1 122/6 136/15 136/23 138/7 138/7 139/6 139/6 143/12 147/20 148/12 148/12 148/14 149/8 153/9 153/12 153/13 153/22 160/18 161/5 161/5 161/7 162/15 163/2 163/23 165/4 165/24 167/8 167/12 167/20 168/9 169/14 170/4 171/10 173/14 174/4 175/9 175/20 175/20 175/21 175/22 178/13 178/17 179/22 183/22 184/24 187/20 189/14</p> <p>hadn't [4] 28/22 66/8 131/15 131/15</p> <p>half [3] 54/8 54/9 153/10</p> <p>hams [1] 86/14</p> <p>hand [3] 20/23 145/24 168/10</p> <p>handle [1] 132/6</p> <p>hands [1] 80/4</p> <p>Hannett [4] 129/25 130/1 135/18 191/5</p> <p>happen [12] 8/6 21/3 47/7 51/20 78/8 108/11 133/12 156/15 170/5 172/21 175/13 178/24</p> <p>happened [11] 46/4 46/6 66/1 69/4 73/14 94/25 95/4 174/19 179/21 187/10 188/12</p> <p>happening [10] 5/9 5/20 26/20 51/22</p>	<p>59/13 77/25 94/3 141/11 168/2 168/6</p> <p>happens [3] 45/6 133/12 176/15</p> <p>happy [2] 49/21 49/23</p> <p>hard [5] 63/10 68/6 136/10 136/22 161/15</p> <p>harm [12] 70/19 73/2 84/13 86/14 86/19 87/10 88/10 88/12 88/20 89/23 144/25 151/8</p> <p>harms [9] 38/12 86/11 86/15 86/15 86/17 89/3 151/7 155/11 155/13</p> <p>Harries [1] 72/16</p> <p>has [42] 2/15 7/15 7/20 13/4 20/18 20/21 21/5 21/10 22/1 42/15 42/17 43/15 43/20 45/3 45/7 52/24 57/18 65/14 83/23 83/24 104/1 122/15 123/9 123/15 130/7 132/17 132/24 133/22 133/22 134/3 134/5 135/4 135/9 142/7 142/16 143/13 144/16 145/18 154/21 155/3 159/5 160/24</p> <p>hasn't [1] 157/7</p> <p>have [266]</p> <p>haven't [1] 31/13</p> <p>having [27] 6/1 6/11 12/2 14/11 23/6 34/19 49/17 63/17 69/9 71/1 76/14 87/24 92/23 97/22 108/24 110/10 147/24 168/24 175/16 175/20 177/18 177/23 178/2 178/9 179/24 184/3 186/8</p> <p>HAZMAT [1] 47/10</p> <p>HCID [7] 147/21 148/9 148/16 148/20 149/2 149/7 149/8</p> <p>HCWs [1] 125/6</p> <p>he [31] 3/1 4/20 10/3 10/6 10/7 10/14 10/23 16/2 17/16 17/19 18/3 19/5 19/6 19/8 19/8 19/9 20/3 21/5 23/1 27/17 30/20 30/23 38/10 121/1 122/5 122/7 129/10 134/3 134/9 139/23 171/24</p> <p>he'd [1] 30/22</p> <p>he's [3] 9/25 19/3 134/10</p> <p>head [2] 73/15 85/25</p> <p>headed [1] 56/13</p> <p>heading [1] 56/22</p>	<p>health [185] 2/7 2/21 3/23 4/4 4/15 4/18 4/23 5/8 5/13 6/10 6/22 7/2 7/3 7/4 7/9 7/13 7/13 7/19 7/23 8/3 8/9 8/11 8/18 9/5 9/8 10/14 10/25 10/25 11/2 11/6 11/13 11/14 11/16 11/19 13/8 13/8 13/9 13/15 13/25 14/2 14/21 14/22 15/11 15/13 16/8 16/22 17/1 18/7 20/3 20/14 20/15 21/5 21/7 21/11 21/20 21/23 22/4 22/5 26/5 29/11 29/15 36/23 38/25 39/2 39/2 39/3 39/4 39/4 39/13 39/15 42/18 42/19 43/12 43/24 44/22 45/10 45/15 45/24 46/6 50/3 51/10 51/10 52/14 53/8 53/21 54/6 54/20 55/3 55/5 57/17 57/18 57/21 57/25 59/23 59/25 66/4 66/5 69/4 69/20 69/24 71/18 73/19 77/23 81/17 82/10 88/15 90/2 90/18 92/5 93/4 93/7 96/5 98/12 98/13 98/14 101/7 102/9 106/25 107/3 107/19 108/10 109/12 109/22 109/25 110/2 110/5 110/10 110/11 110/24 111/3 111/18 111/24 112/1 112/2 114/10 114/11 114/15 118/3 118/16 118/19 119/11 120/3 122/11 127/9 127/10 127/12 127/16 127/21 129/1 129/10 131/9 131/10 132/19 135/7 135/10 135/12 141/15 143/23 144/2 144/6 145/10 145/10 149/19 152/12 152/17 153/12 153/12 153/15 153/23 153/24 153/24 154/13 154/17 155/9 155/15 156/5 156/13 156/25 158/12 159/12 161/18 170/11 170/12 170/15 180/3</p> <p>healthcare [74] 4/1 5/1 5/20 10/21 10/23 17/2 18/1 19/18 22/13 23/16 25/15 25/16 25/19 25/21 38/19 39/8 39/23 40/21 40/22 55/18 56/2 60/18 61/3 62/1 62/5 62/24 76/8 77/22</p>	<p>79/23 80/1 80/8 80/25 88/17 92/1 92/23 93/1 107/2 111/12 113/3 113/6 116/15 118/21 120/20 120/22 122/19 123/5 123/22 124/9 124/13 124/14 125/9 125/21 125/24 126/10 126/17 126/18 138/13 139/4 140/8 140/9 140/15 141/21 142/5 142/5 143/1 144/15 145/7 145/20 145/24 146/1 146/4 146/5 148/12 148/14</p> <p>Heaney [1] 15/24</p> <p>hear [2] 166/10 187/3</p> <p>heard [7] 37/6 82/12 113/10 117/21 137/17 138/2 160/25</p> <p>hearing [4] 25/22 153/2 160/6 190/16</p> <p>hearings [1] 13/10</p> <p>heart [2] 70/1 71/14</p> <p>heat [1] 26/22</p> <p>Heather [1] 90/14</p> <p>heavier [1] 89/12</p> <p>heavy [1] 176/19</p> <p>Helen [1] 83/21</p> <p>help [23] 35/12 37/16 38/6 80/20 92/19 94/23 99/19 123/20 150/25 151/23 152/19 154/6 154/22 157/18 162/11 163/1 164/4 175/7 176/9 177/8 180/7 189/22 190/10</p> <p>helped [5] 23/7 36/21 107/6 176/11 186/14</p> <p>helpful [10] 32/15 38/13 100/19 101/9 107/4 162/3 173/11 176/6 177/14 182/22</p> <p>helpfully [1] 50/1</p> <p>helping [3] 99/19 177/7 179/23</p> <p>helpline [1] 179/25</p> <p>helps [1] 49/24</p> <p>her [12] 115/7 171/23 171/23 172/6 172/7 172/8 172/9 172/9 172/12 172/13 172/14 172/18</p> <p>here [3] 95/25 98/22 98/24</p> <p>Hi [1] 119/13</p> <p>hierarchy [1] 115/23</p> <p>high [21] 3/7 5/2 46/12 46/18 79/9 83/2 84/17 120/15 121/8 125/18 128/18 128/19 147/18 148/9 159/5 159/12 160/20 162/17 163/8 166/1 175/25</p>	<p>high-quality [3] 46/12 46/18 84/17</p> <p>higher [8] 44/22 57/9 62/25 72/22 84/10 128/11 138/21 165/21</p> <p>higher-grade [1] 138/21</p> <p>highest [1] 159/10</p> <p>highlighted [2] 142/21 185/5</p> <p>highly [8] 10/19 98/15 162/8 163/2 164/14 164/22 167/2 174/10</p> <p>him [4] 4/23 13/6 25/6 130/19</p> <p>himself [1] 9/25</p> <p>hindsight [3] 67/21 80/21 156/10</p> <p>his [10] 9/24 16/14 16/16 17/14 17/15 33/4 82/19 122/5 137/19 139/22</p> <p>history [1] 20/9</p> <p>hit [1] 20/20</p> <p>hits [1] 181/6</p> <p>HIW [3] 111/17 112/1 112/4</p> <p>hm [1] 3/20</p> <p>hold [1] 77/11</p> <p>holding [2] 18/5 117/23</p> <p>home [4] 80/5 80/5 80/9 83/12</p> <p>homes [5] 151/13 151/15 152/1 152/2 152/4</p> <p>honest [3] 77/9 78/22 151/25</p> <p>honestly [1] 131/13</p> <p>hood [1] 47/10</p> <p>hoods [2] 47/4 116/3</p> <p>hope [4] 42/9 95/19 136/10 157/7</p> <p>hoped [1] 84/25</p> <p>Hopkins [1] 49/24</p> <p>horrible [1] 143/25</p> <p>horrified [1] 14/14</p> <p>hospital [70] 17/9 51/25 52/5 52/10 54/1 54/5 54/5 55/22 56/22 56/25 57/22 59/10 59/12 59/16 59/17 59/17 60/2 61/11 65/8 65/23 67/3 68/15 69/7 84/10 125/3 128/4 128/10 128/15 129/2 138/17 150/9 151/21 158/1 158/13 158/21 158/22 158/24 159/2 161/4 162/12 166/5 166/8 166/13 166/16 167/11 167/20 168/6 168/10 168/23 169/4</p>
--	--	--	--	--

H	I	I do [16] 1/25 13/22 19/24 37/13 41/10 69/5 88/7 97/11 116/9 116/14 116/17 116/21 123/9 159/16 183/21 184/5	78/2 78/18 85/5 108/2 110/9 113/9 114/7 121/23 146/12 150/17 151/11 165/8	82/22
hospital... [20] 169/13 171/16 172/7 172/19 173/6 173/18 174/12 176/12 177/24 178/11 182/7 182/8 183/6 183/15 183/24 184/14 187/10 187/18 188/3 189/12	I absolutely [3] 153/20 155/1 155/18	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I mentioned [4] 142/25 142/25 143/2 145/5	I used [1] 8/5
hospital's [3] 159/14 160/22 182/11	I accept [3] 86/1 122/5 122/5	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I met [4] 91/19 121/13 171/10 188/14	I want [5] 119/8 126/13 126/17 147/19 147/24
hospital-acquired [5] 54/1 59/16 59/17 128/10 184/14	I agree [3] 38/10 64/14 138/6	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I missed [1] 153/19	I wanted [1] 183/13
hospital-onset [1] 128/4	I also [2] 160/8 184/1	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I need [1] 104/1	I was [19] 8/4 11/10 30/11 30/15 35/12 37/19 37/19 40/25 40/25 63/24 81/25 82/1 89/7 89/12 89/14 118/12 121/17 156/22 182/7
hospitals [28] 8/21 17/12 41/8 51/16 51/19 52/10 54/3 54/25 55/12 57/3 57/25 58/3 58/11 58/16 58/21 59/2 59/7 60/12 61/10 67/15 67/18 68/13 87/17 92/16 94/4 151/18 179/9 188/10	I am [15] 1/25 50/20 111/1 114/19 117/20 121/4 123/19 128/2 132/23 154/20 156/7 157/10 157/16 158/7 164/7	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I previously [2] 31/7 111/12	I wasn't [5] 50/9 60/5 68/14 87/6 90/20
house [1] 79/2	I anticipate [1] 130/6	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I quote [1] 185/4	I will [2] 37/16 127/22
how [71] 1/17 5/21 7/25 9/18 22/19 23/15 24/11 30/18 34/21 37/10 37/17 40/10 44/13 48/21 51/15 52/8 68/13 85/20 87/10 87/15 91/21 94/8 94/9 97/25 102/18 109/16 109/25 111/25 113/19 113/25 126/9 131/24 132/6 137/1 141/19 141/23 142/12 143/7 143/14 145/18 147/3 148/11 148/12 148/22 152/14 162/16 162/20 163/1 164/4 165/4 165/7 167/21 168/12 170/3 171/18 171/25 174/6 175/13 176/10 181/12 181/13 181/16 181/21 181/22 181/22 184/10 184/10 184/17 186/5 188/11 190/1	I appear [1] 130/2	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I realise [1] 143/21	I won't [1] 129/9
huge [7] 14/6 76/7 77/10 77/13 77/23 127/18 133/7	I appreciate [2] 157/11 189/9	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I recall [1] 107/25	I wonder [2] 42/23 93/11
hugely [1] 51/17	I arrived [3] 10/7 10/11 20/9	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I recognise [3] 128/17 156/5 156/25	I would [38] 6/11 9/10 9/11 9/15 14/14 17/20 20/18 24/10 24/17 24/21 26/10 31/8 37/4 40/3 41/3 64/19 66/2 66/18 81/5 81/22 83/22 89/6 122/6 127/20 131/14 135/23 141/3 145/12 146/4 150/1 153/20 167/16 169/7 170/10 179/8 181/14 187/17 189/23
hundred [1] 140/19	I ask [7] 115/10 116/25 135/22 149/16 152/11 181/25 190/5	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I recognised [2] 30/14 46/22	I wouldn't [2] 6/13 30/14
hundreds [1] 140/22	I became [1] 87/1	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I remain [1] 43/15	I'd [8] 43/23 82/7 83/25 85/1 103/1 121/16 160/2 171/19
husband [1] 171/23	I believe [4] 21/2 61/12 118/13 132/8	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I remember [5] 14/11 173/24 173/24 173/25 174/4	I'll [3] 116/7 130/7 148/2
Hussey [1] 10/8	I can [21] 3/12 26/15 31/18 32/13 35/7 61/19 66/14 84/5 85/15 91/9 97/22 104/7 124/12 129/7 142/22 150/25 153/5 162/22 174/1 187/9 188/10	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I say [3] 20/20 117/5 118/11	I'm [64] 1/12 5/25 19/24 21/15 21/17 25/25 32/4 32/12 35/8 36/23 40/15 50/6 50/18 59/21 67/7 77/9 83/8 92/14 92/19 98/19 106/21 108/11 112/7 113/10 118/25 119/2 119/4 119/21 120/10 121/18 121/21 123/14 123/20 124/5 127/1 128/2 131/2 134/18 137/5 137/6 138/23 138/23 140/3 140/4 140/7 142/8 145/4 145/13 147/12 151/25 152/10 154/5 158/6 173/19 180/22 182/8 182/25 183/5 183/8 185/1 185/15 188/5 189/21 190/10
hydrocarbons [1] 38/3	I can't [26] 5/14 21/15 25/24 30/6 32/14 33/2 50/18 55/21 61/16 72/16 82/9 85/24 92/19 92/19 118/18 131/18 140/17 152/22 154/14 154/14 156/18 173/19 173/20 182/20 187/9 188/10	I don't [71] 9/24 15/7 19/2 19/5 19/11 21/15 21/25 21/25 22/21 32/14 39/9 40/23 46/5 46/25 48/17 52/4 54/22 59/20 60/4 60/6 63/2 64/21 65/13 65/15 66/16 66/22 69/4 70/8 71/2 73/15 75/8 77/9 77/9 78/21 81/3 83/5 86/2 86/25 87/14 87/20 90/3 90/11 93/3 93/5 93/9 101/9 105/15 108/5 108/23 109/6 112/21 113/9 116/13 116/14 117/4 117/7 120/23 121/22 127/22 128/19 130/19 131/2 134/8 135/21 138/5 139/7 153/16 154/8 163/5 177/21 182/18	I scribble [1] 28/2	I've [14] 20/19 36/16 85/16 110/21 113/10 116/12 137/4 137/4 141/24 142/21 145/16

I	146/14 151/25 155/20 156/15 157/1 157/16 158/6 160/12 162/22 164/2 164/25 167/3 168/1 171/7 172/1 174/21 174/23 175/9 180/12 180/13 181/16 182/22 186/4 ill [4] 96/16 106/3 165/20 173/3 illness [4] 86/16 103/14 149/23 165/19 illustrate [1] 169/22 immediate [5] 92/4 141/7 142/1 154/11 156/9 immunity [1] 74/8 immunosuppressant [1] 71/13 impact [23] 74/5 83/19 84/18 86/3 86/8 86/20 86/22 89/8 90/7 90/9 90/23 114/14 137/11 142/4 142/5 146/3 154/7 154/12 155/8 160/22 164/22 174/7 181/8 impacts [5] 86/4 89/4 137/16 137/23 152/17 impasse [3] 44/6 44/19 44/20 impetus [1] 127/18 implement [2] 67/22 127/11 implementation [3] 110/12 129/11 169/10 implemented [5] 52/2 52/21 55/12 110/1 144/24 implementing [2] 67/11 169/16 implication [1] 109/7 implications [2] 48/4 145/14 importance [3] 64/7 136/1 174/17 important [24] 17/4 20/5 39/10 103/15 111/16 113/4 114/2 114/25 120/14 121/19 134/11 134/21 136/13 143/12 154/17 172/2 174/15 175/18 176/18 176/21 178/18 179/16 180/23 181/8 importing [1] 38/3 impose [1] 157/15 imposing [1] 102/25 imposition [1] 86/17 impossible [4] 29/6 29/8 52/5 150/16 impressed [1] 145/4 improve [5] 68/22 77/13 92/8 92/18	157/3 improved [1] 80/24 improving [3] 68/12 77/10 187/25 inadequate [1] 169/20 inappropriate [5] 97/20 107/11 107/21 109/1 109/4 inappropriately [1] 102/19 inborn [1] 71/11 incidence [1] 99/23 incident [3] 108/14 188/24 189/18 incidents [2] 41/5 108/25 inclination [1] 44/8 include [13] 4/25 24/22 72/24 73/10 80/19 80/22 86/19 89/20 97/10 105/24 105/25 106/1 110/24 included [13] 17/10 23/13 33/8 48/3 55/22 71/9 73/6 76/16 76/17 81/2 86/14 97/5 150/13 includes [2] 7/9 27/15 including [11] 15/23 31/25 33/9 35/22 51/19 55/14 56/2 81/1 116/19 129/14 154/16 inconsistency [1] 45/14 incorporated [1] 112/19 increase [4] 38/1 57/4 162/16 162/25 increased [7] 70/16 71/12 73/2 84/22 92/24 150/10 165/19 increases [1] 99/16 increasing [2] 48/18 67/2 increasingly [2] 88/8 125/12 incremental [1] 126/18 indeed [9] 9/8 24/25 29/20 72/9 83/15 111/7 139/19 158/17 190/8 independence [2] 3/7 3/11 Indian [1] 91/15 indicate [2] 52/1 59/14 indicated [7] 1/15 41/12 50/1 56/17 60/8 66/25 102/15 indication [1] 51/15 indicative [2] 35/17	109/17 indirect [1] 86/15 indirectly [2] 53/13 76/4 individual [12] 7/4 29/9 89/17 104/20 104/24 104/25 105/18 105/22 105/23 110/10 111/22 177/9 individual's [3] 103/14 103/21 189/6 individualised [1] 99/3 individually [1] 166/19 individuals [6] 14/19 47/11 85/15 85/16 99/24 102/22 inequalities [26] 86/8 86/9 88/13 88/15 88/22 88/23 89/4 90/3 90/6 90/24 91/3 114/13 114/14 142/11 142/13 142/16 143/8 143/24 144/6 144/7 146/1 155/5 155/7 155/14 155/19 156/2 inequality [2] 156/4 156/11 inevitable [2] 148/4 157/17 infected [4] 61/9 70/20 117/15 172/17 infecting [1] 59/19 infection [41] 35/6 35/13 38/18 52/20 54/18 57/9 57/17 61/2 61/11 63/22 64/6 64/9 64/10 64/18 64/19 67/17 68/19 71/13 80/8 80/25 83/2 84/9 84/10 84/13 87/25 115/12 120/8 122/22 125/19 125/20 140/14 140/25 148/23 161/17 169/3 179/18 182/12 184/7 184/8 184/24 185/19 infection prevention [1] 161/17 infections [11] 51/15 53/4 53/20 54/1 54/4 84/22 87/16 183/25 184/3 184/5 184/14 infectious [4] 147/18 148/9 148/11 148/25 infective [2] 167/3 168/18 influenced [1] 82/18 influencing [1] 146/9 inform [6] 4/22 36/25 85/14 124/12 137/19 186/15 informal [3] 32/5	48/1 50/2 information [36] 5/5 8/19 9/1 9/7 14/7 20/1 22/12 23/15 24/6 26/4 27/21 27/23 28/6 28/13 28/14 28/15 28/16 29/7 29/12 29/20 30/15 30/19 32/16 32/17 33/6 34/15 50/12 89/20 91/17 93/7 130/20 141/10 152/20 153/4 153/18 156/19 informed [6] 5/22 20/4 43/16 49/17 88/16 118/12 infrastructure [3] 68/8 76/9 78/8 infrequent [1] 25/11 ing [1] 60/9 inherited [1] 10/11 initial [1] 73/17 initially [6] 2/7 30/5 58/24 72/3 72/13 75/23 initiated [1] 94/22 initiative [1] 179/24 innovative [2] 129/7 163/7 inpatient [2] 159/11 182/8 input [4] 71/17 90/12 100/22 100/23 INQ000022598 [1] 63/7 INQ000066199 [1] 11/25 INQ000227307 [1] 56/10 INQ000252535 [1] 49/15 INQ000300106 [1] 102/10 INQ000338460 [1] 95/18 INQ000383997 [1] 119/5 INQ000384586 [1] 41/25 INQ000396261 [1] 53/16 INQ000416178 [1] 1/21 INQ000474224 [2] 1/22 31/23 INQ000477593 [1] 158/19 INQ000484821 [1] 100/11 INQ333416864 [1] 182/17 INQUIRY [21] 1/8 1/21 28/2 28/5 50/1 63/6 83/24 85/21
----------	--	---	---	--

I	118/16 118/22 127/6 127/19 128/14 129/13 130/22 133/5 139/3 141/3 141/7 144/16 146/13 146/20 153/14 154/22 161/16 161/17 163/12 163/13 165/10 165/25 168/10 168/23 172/9 174/12 177/5 177/25 180/25 181/20 187/14	is [288] isn't [11] 7/6 20/2 22/4 56/16 64/9 70/5 98/13 122/17 134/4 171/15 183/10 isolated [2] 60/1 79/10 isolating [2] 147/4 151/17 isolation [2] 79/8 99/1 issue [38] 13/24 14/4 20/5 26/3 26/15 30/21 37/20 43/5 45/6 45/8 46/9 47/16 52/11 54/24 56/7 59/20 64/3 72/15 78/11 78/22 87/1 92/11 94/24 99/22 107/18 109/4 109/10 112/13 121/2 134/11 140/14 141/1 141/19 142/3 151/10 151/23 153/20 156/11 issued [13] 39/1 56/18 63/12 63/16 63/22 66/11 67/7 70/22 71/1 71/2 102/8 108/16 170/19 issues [49] 3/12 5/22 6/9 8/10 8/20 9/3 9/12 9/15 11/3 12/21 14/16 17/23 18/1 19/18 23/14 23/23 23/24 24/2 24/4 24/9 24/16 25/7 25/12 26/11 28/4 34/3 40/16 51/24 54/16 64/5 78/15 90/24 91/6 91/10 91/11 93/17 102/6 107/14 118/6 118/19 131/5 135/10 136/8 139/9 144/21 169/18 188/24 189/4 189/7 issuing [4] 64/6 64/11 103/20 107/21	87/12 95/18 95/19 96/3 96/4 99/15 99/18 99/19 99/19 100/11 100/14 102/10 103/1 104/2 105/15 106/12 109/19 110/11 110/20 111/16 112/12 112/13 112/17 112/24 112/24 113/14 116/7 116/15 116/16 119/7 119/7 119/10 119/10 120/9 122/17 125/1 126/6 128/17 129/17 134/21 135/11 143/9 143/25 143/25 144/1 144/18 145/12 157/1 159/4 159/10 161/2 162/24 171/15 175/3 177/1 177/3 177/6 177/10 181/2 181/7 182/20 182/23 183/8 188/18 189/19 190/5 Italy [1] 94/3 item [1] 131/16 items [1] 118/4 its [10] 7/20 35/13 68/7 95/25 96/3 98/20 99/6 145/20 175/5 178/25 itself [5] 83/17 96/11 98/8 112/20 163/13	43/10 43/22 44/25 51/8 100/18 101/25 130/13 130/15 130/17 134/1 149/13 149/13 149/14 191/9 Jones' [1] 134/2 journals [1] 73/1 journal [1] 174/16 Judge [3] 90/17 141/17 144/13 Judith [1] 3/2 Judith Paget [1] 3/2 July [9] 72/18 81/14 81/23 88/11 88/14 126/23 127/3 137/19 152/14 July 2020 [2] 137/19 152/14 July 2021 [3] 88/14 126/23 127/3 June [13] 35/20 72/18 72/20 90/2 115/16 116/10 118/2 153/8 153/17 155/12 158/15 183/8 183/9 June 2020 [3] 116/10 153/8 155/12 junior [1] 179/5 jurisdictions [1] 160/3 just [88] 12/22 13/1 25/6 28/3 28/10 28/25 33/2 42/24 44/8 44/16 45/24 47/14 52/22 56/20 58/3 63/25 64/3 64/4 64/4 77/19 93/16 94/19 99/12 102/23 106/18 107/23 111/11 111/11 112/21 112/24 113/9 116/13 117/1 118/25 121/5 122/13 124/16 126/8 126/8 127/3 128/20 128/23 132/11 132/24 133/25 135/3 136/11 136/16 140/3 141/6 141/6 141/24 142/2 142/7 145/16 145/17 150/18 152/23 154/3 154/20 155/3 156/8 156/12 158/14 160/21 163/21 165/14 166/1 168/18 169/9 170/10 170/15 170/20 170/25 171/12 172/12 172/13 177/14 178/1 179/17 180/7 184/9 186/10 188/19 188/21 189/2 189/16 189/22 Justice [2] 115/11 182/5		
INQUIRY... [13] 129/4 134/4 141/17 157/12 157/13 158/9 160/24 174/6 177/20 178/4 180/20 191/3 191/12 insight [2] 177/24 178/3 insisting [1] 42/21 Inspectorate [1] 111/13 instance [2] 148/17 186/11 instances [2] 25/24 107/16 insufficient [1] 20/16 integrated [1] 132/15 intelligence [1] 186/1 intended [1] 99/19 intensified [1] 176/16 intensity [1] 166/1 intensive [11] 94/17 94/22 95/7 99/16 99/20 101/4 106/20 113/20 113/21 114/1 164/14 interest [3] 133/23 134/20 141/16 interested [1] 120/10 interesting [1] 85/5 interestingly [1] 139/12 interface [2] 41/1 46/9 internal [7] 63/4 64/15 64/16 64/20 64/23 65/19 114/20 international [3] 40/13 44/10 161/6 interpret [1] 37/11 interpretation [2] 65/1 122/6 interpreted [2] 46/14 46/19 interrogate [1] 76/20 interrogated [1] 76/24 interrupting [1] 123/9 interruption [1] 129/24 interventions [5] 3/17 68/11 159/19 179/23 180/1 into [61] 9/17 16/8 16/18 16/24 18/3 23/3 54/5 54/25 61/10 69/7 74/11 75/5 83/5 83/21 86/12 87/22 89/21 90/12 94/6 95/9 96/12 98/22 99/11 102/25 103/11 109/3 113/24 116/19 116/20 118/15	introduced [2] 179/12 179/13 introduction [1] 126/14 investigate [1] 109/3 investigated [3] 84/19 108/10 109/12 investigation [2] 109/3 109/18 invitation [1] 30/4 invited [5] 23/21 29/24 30/4 32/22 174/22 involved [12] 18/19 18/21 47/16 68/15 73/21 87/6 90/16 90/21 101/25 130/11 134/17 134/19 involvement [5] 17/25 39/12 90/20 101/22 101/24 involvement in [1] 39/12 Involving [2] 101/17 110/18 IP [1] 62/6 IPC [67] 24/3 39/1 39/5 39/8 39/12 39/21 39/24 40/9 40/11 40/18 40/20 41/2 41/12 44/5 44/10 45/21 46/24 47/17 47/23 48/2 48/5 48/8 48/16 49/1 49/18 49/20 50/4 51/4 51/13 51/16 51/23 52/1 52/9 52/13 52/25 53/5 62/10 62/11 62/20 62/23 64/1 64/7 64/18 66/18 66/25 67/17 67/17 67/22 68/20 68/21 80/7 116/20 117/18 121/19 121/25 122/2 151/24 152/3 169/5 169/16 169/23 184/7 184/17 184/20 184/25 185/10 185/21 IPC cell [1] 44/10 Ireland [12] 39/3 137/13 138/1 158/2 159/1 159/2 159/8 159/9 161/19 167/5 178/14 182/4	is [288] isn't [11] 7/6 20/2 22/4 56/16 64/9 70/5 98/13 122/17 134/4 171/15 183/10 isolated [2] 60/1 79/10 isolating [2] 147/4 151/17 isolation [2] 79/8 99/1 issue [38] 13/24 14/4 20/5 26/3 26/15 30/21 37/20 43/5 45/6 45/8 46/9 47/16 52/11 54/24 56/7 59/20 64/3 72/15 78/11 78/22 87/1 92/11 94/24 99/22 107/18 109/4 109/10 112/13 121/2 134/11 140/14 141/1 141/19 142/3 151/10 151/23 153/20 156/11 issued [13] 39/1 56/18 63/12 63/16 63/22 66/11 67/7 70/22 71/1 71/2 102/8 108/16 170/19 issues [49] 3/12 5/22 6/9 8/10 8/20 9/3 9/12 9/15 11/3 12/21 14/16 17/23 18/1 19/18 23/14 23/23 23/24 24/2 24/4 24/9 24/16 25/7 25/12 26/11 28/4 34/3 40/16 51/24 54/16 64/5 78/15 90/24 91/6 91/10 91/11 93/17 102/6 107/14 118/6 118/19 131/5 135/10 136/8 139/9 144/21 169/18 188/24 189/4 189/7 issuing [4] 64/6 64/11 103/20 107/21	it [463] it felt [1] 168/13 it important [1] 103/15 it should [1] 98/10 it's [114] 3/13 6/21 6/21 7/6 15/5 18/23 20/1 20/6 21/22 22/4 26/22 27/2 29/18 36/18 36/21 36/22 38/7 38/8 38/15 39/24 41/25 42/1 42/7 52/5 53/2 53/5 55/9 56/13 57/24 58/13 63/25 64/3 64/14 64/14 65/1 66/23 67/8 67/13 69/11 69/19 77/14 80/14 80/16 83/16 85/5 85/6 86/1 86/2	87/12 95/18 95/19 96/3 96/4 99/15 99/18 99/19 99/19 100/11 100/14 102/10 103/1 104/2 105/15 106/12 109/19 110/11 110/20 111/16 112/12 112/13 112/17 112/24 112/24 113/14 116/7 116/15 116/16 119/7 119/7 119/10 119/10 120/9 122/17 125/1 126/6 128/17 129/17 134/21 135/11 143/9 143/25 143/25 144/1 144/18 145/12 157/1 159/4 159/10 161/2 162/24 171/15 175/3 177/1 177/3 177/6 177/10 181/2 181/7 182/20 182/23 183/8 188/18 189/19 190/5 Italy [1] 94/3 item [1] 131/16 items [1] 118/4 its [10] 7/20 35/13 68/7 95/25 96/3 98/20 99/6 145/20 175/5 178/25 itself [5] 83/17 96/11 98/8 112/20 163/13	J jab [1] 70/14 January [6] 55/14 57/15 60/21 126/20 147/20 148/6 January 2020 [3] 60/21 147/20 148/6 January 2021 [1] 126/20 jean [6] 16/4 42/12 43/20 44/12 45/20 109/9 Jean White [2] 42/12 109/9 Jenny [1] 72/16 Jessica [1] 149/13 Jessica Jones [1] 149/13 job [9] 14/20 21/6 39/24 64/1 75/19 77/10 109/22 114/5 180/13 John's [1] 149/17 joined [1] 23/22 joining [1] 163/16 joint [2] 41/7 102/8 jointly [3] 39/1 67/7 144/1 Jones [25] 9/10 9/21 10/12 10/19 12/22 13/4 16/15 17/14 17/25 18/9 18/24	43/10 43/22 44/25 51/8 100/18 101/25 130/13 130/15 130/17 134/1 149/13 149/13 149/14 191/9 Jones' [1] 134/2 journals [1] 73/1 journal [1] 174/16 Judge [3] 90/17 141/17 144/13 Judith [1] 3/2 Judith Paget [1] 3/2 July [9] 72/18 81/14 81/23 88/11 88/14 126/23 127/3 137/19 152/14 July 2020 [2] 137/19 152/14 July 2021 [3] 88/14 126/23 127/3 June [13] 35/20 72/18 72/20 90/2 115/16 116/10 118/2 153/8 153/17 155/12 158/15 183/8 183/9 June 2020 [3] 116/10 153/8 155/12 junior [1] 179/5 jurisdictions [1] 160/3 just [88] 12/22 13/1 25/6 28/3 28/10 28/25 33/2 42/24 44/8 44/16 45/24 47/14 52/22 56/20 58/3 63/25 64/3 64/4 64/4 77/19 93/16 94/19 99/12 102/23 106/18 107/23 111/11 111/11 112/21 112/24 113/9 116/13 117/1 118/25 121/5 122/13 124/16 126/8 126/8 127/3 128/20 128/23 132/11 132/24 133/25 135/3 136/11 136/16 140/3 141/6 141/6 141/24 142/2 142/7 145/16 145/17 150/18 152/23 154/3 154/20 155/3 156/8 156/12 158/14 160/21 163/21 165/14 166/1 168/18 169/9 170/10 170/15 170/20 170/25 171/12 172/12 172/13 177/14 178/1 179/17 180/7 184/9 186/10 188/19 188/21 189/2 189/16 189/22 Justice [2] 115/11 182/5
				K KC [10] 115/8 130/1		

K	L		
KC... [8] 140/1 147/11 182/3 191/4 191/5 191/7 191/8 191/14	laboratory [2] 128/6 128/7	107/12 108/15 108/17 123/1 131/9 133/7 146/7 148/22 156/17 172/20	liberty [1] 186/3 licence [1] 78/18 life [4] 17/12 165/22 167/10 171/24
keep [20] 4/7 14/9 16/15 17/4 24/13 24/15 27/22 28/1 28/2 30/18 87/16 118/15 118/16 154/1 164/3 167/11 167/13 172/21 181/22 186/15	laboratory-confirmed [2] 128/6 128/7	learnt [1] 138/8 least [4] 11/6 79/2 87/9 149/25	light [5] 58/17 118/5 130/4 140/24 151/5 like [35] 21/1 34/2 43/23 53/18 63/9 66/19 75/3 76/17 80/19 81/22 83/22 83/25 85/1 91/25 111/17 116/5 135/23 138/21 142/23 143/19 146/24 147/4 148/4 148/8 162/22 167/3 168/19 174/14 176/19 177/20 178/4 179/10 180/15 180/19 181/3
keeping [7] 26/13 59/4 75/20 159/11 178/12 186/6 188/21	labour [3] 13/4 174/3 174/25	leave [2] 79/2 129/20 leaving [1] 151/10 led [13] 4/4 10/23 72/16 83/21 90/15 91/23 102/1 102/2 106/7 129/10 134/12 143/13 188/13	liked [1] 26/10 likely [7] 70/19 95/2 95/2 97/2 148/7 162/2 172/17
kept [6] 5/22 8/9 20/4 32/5 158/6 174/15	lack [3] 13/11 24/14 170/9	Leeds [1] 2/3 left [3] 45/10 143/17 181/11	limit [1] 151/16 limited [4] 121/5 146/25 167/25 170/3
key [4] 4/16 22/12 35/21 49/25	ladder [1] 155/19	legal [2] 21/16 21/18 length [1] 164/5 lengthy [2] 14/12 29/3	limiting [1] 56/4 limits [1] 54/12 line [11] 12/9 42/23 57/19 57/23 58/8 64/14 80/2 122/8 126/8 154/1 162/2
kidney [1] 72/9	Lady [21] 1/5 1/10 4/8 37/13 38/17 93/11 127/17 130/4 135/17 139/18 140/2 140/3 142/7 146/17 147/7 149/15 157/9 157/19 157/25 181/25 190/5	less [12] 66/3 97/2 99/15 130/7 159/7 162/2 173/3 183/17 183/17 183/17 184/3 184/4	link [4] 27/1 106/11 108/19 158/3
kidneys [1] 70/1	large [5] 16/6 55/25 56/1 159/20 170/11	lesson [3] 113/5 113/11 113/19	linked [3] 108/21 179/24 185/3
kind [13] 43/25 51/23 54/21 59/6 69/15 94/15 111/16 114/25 137/6 143/22 144/14 145/13 146/21	largely [2] 4/4 139/1	lessons [2] 113/2 180/18	links [1] 164/21
kinds [1] 132/6	last [5] 56/22 63/23 119/23 156/8 188/20	let [6] 36/8 59/5 127/5 137/7 141/6 158/20	list [12] 49/25 70/3 71/6 71/17 71/22 72/10 72/13 73/7 73/11 75/10 76/3 83/1
kit [1] 47/9	late [3] 94/2 98/5 126/22	let's [10] 8/13 20/23 26/9 45/11 46/8 66/4 114/24 142/19 142/19 153/22	listed [1] 31/13
knew [5] 21/8 24/5 36/9 95/6 167/12	later [13] 2/5 2/25 18/16 25/25 47/15 60/4 72/3 87/20 120/17 123/15 124/10 150/24 151/18	letter [16] 41/8 74/19 78/24 79/1 79/21 80/6 80/17 102/8 105/7 106/10 106/12 106/15 106/23 107/4 107/24 128/24	listen [1] 84/5
know [74] 1/17 20/2 21/15 30/22 36/8 37/22 44/24 46/5 47/5 54/24 60/4 60/6 64/14 64/21 65/25 66/11 69/4 69/5 71/22 73/14 74/4 79/3 81/3 82/4 82/20 85/10 85/15 87/20 87/25 88/1 91/5 91/21 92/7 92/25 97/12 101/6 101/9 102/3 106/2 108/20 108/23 108/23 112/4 114/19 118/12 120/24 125/20 127/2 127/5 131/13 131/24 134/23 136/25 137/13 138/1 140/18 146/13 148/10 148/11 148/12 150/18 151/1 151/25 152/1 153/17 156/22 164/10 172/5 174/19 181/16 182/18 189/9 189/20 189/23	latest [2] 42/15 42/23	letters [5] 108/18 108/21 108/22 110/14 136/16	lists [2] 69/19 96/17
knowing [3] 148/5 170/22 178/6	latter [1] 58/24	level [33] 2/19 5/2 26/9 26/24 33/22 40/21 43/1 47/9 62/25 65/15 65/17 72/22 77/22 87/16 94/22 94/25 97/13 97/16 98/5 98/16 114/22 120/19 121/22 159/10 162/14 162/14 162/17 165/19 166/16 167/14 179/19 183/25 186/1	literally [1] 50/12
knowledge [7] 27/7 27/14 67/9 67/25 109/2 170/3 188/23	latterly [1] 133/21	levels [10] 18/4 67/16 117/22 120/15 121/8 159/5 159/12 167/14 172/22 175/25	little [15] 18/16 42/3 48/20 84/17 105/13 122/13 124/5 124/7 130/7 145/16 150/15 164/23 169/7 179/12 184/1
known [6] 36/8 132/6 149/20 149/22 149/24 150/5	launch [1] 180/25	live [4] 123/10 159/7 159/8 159/20	liver [1] 70/1
knows [2] 1/13 28/2	launched [2] 181/19 181/20	lives [1] 47/11	living [2] 89/16 155/17
	Lawrence [2] 63/3 81/8	liase [1] 7/1	local [29] 7/9 7/13 7/19 7/22 8/3 8/9 8/18 9/5 20/15 21/7 21/20 21/23 22/4 22/5 45/15 55/5 57/20 59/5 59/23 101/6 102/9 107/3 110/2 110/5 118/18 118/19 118/23 173/24
	lay [1] 175/20	liased [1] 12/11	186/1
	layers [3] 156/4 156/4 176/17	liberated [1] 81/20	locality [1] 167/7
	lead [15] 11/2 12/21 19/21 21/18 26/11 45/4 45/13 47/3 47/4 87/3 87/4 98/9 98/22 171/4 179/22		located [2] 158/22 158/24
	leaders [2] 49/22 106/20		location [1] 160/21
	leadership [7] 6/21 10/13 13/24 18/8 45/18 96/6 188/13		lockdown [6] 3/17 75/5 153/10 155/8 155/11 155/14
	leading [4] 6/2 9/18 11/18 152/16		lockdowns [1] 160/12
	leads [12] 6/2 24/20 26/8 26/18 27/2 94/22 96/4 112/14 121/14 121/15 137/10 189/17		locum [1] 160/20
	learn [5] 88/2 137/1 137/9 150/18 171/25		Londonderry [1] 158/25
	learned [2] 113/3 113/5		long [45] 18/21 18/24 22/25 37/15 37/17 86/20 86/23 87/2 87/9 87/24 87/25 91/20 103/19 117/2 117/11 130/2 130/10 130/12 130/14 131/1 131/11 131/20 131/22 132/2 132/11 132/13 132/14 132/16 132/17 132/21 133/1 133/7 133/8 133/9 133/17 133/19 134/3 134/6 134/22 135/5 135/6 157/8 161/5 161/22 164/14
	learning [11] 102/17		Long Covid [1] 87/2
			long-range [2] 117/2 117/11
			long-standing [1] 161/5
			long-term [4] 87/9 87/24 103/19 135/6
			longer [4] 94/11 129/3 148/18 148/19
			look [57] 4/10 11/23 11/25 16/18 22/9 27/6 28/7 31/15 31/20 34/15 38/11 38/18 41/4 41/23 42/4 47/19 48/19 49/3 53/10 53/16 53/23 54/8 59/9 63/7 72/20 78/24 79/21 95/17 95/20 100/10 102/12 103/7 111/16 112/5 112/14 119/24 124/5 127/15 139/23 141/18 141/21 142/3 146/23 156/15 160/1 162/20 166/14 167/3 169/23 175/9 176/16 178/9 179/17 181/16 181/17 182/25 184/2
			looking [23] 19/16 37/20 57/12 68/13 80/18 94/3 119/21 134/7 140/20 141/25 143/12 143/25 152/2

L	136/11 136/17 139/22 141/11 171/17 172/14 172/16 172/25 176/8 178/22 179/5 187/13 189/25	mask-wearing [1] 165/7	25/24 26/4 28/25 35/13 46/5 51/14 52/4 53/10 63/24 77/20 78/2 78/18 85/5 108/2 110/9 113/9 114/7 121/23 131/19 142/18 144/16 146/12 150/17 151/11 165/8	95/11 112/17 131/8 135/14
looking... [10] 162/18 162/18 162/19 186/16 189/12 189/14 189/18 189/18 189/19 189/24	makers [1] 186/25 making [28] 6/20 21/7 27/11 73/21 82/19 85/11 93/17 93/22 94/14 94/23 95/13 99/3 102/20 169/1 176/1 176/10 176/14 177/11 177/16 177/22 178/2 178/7 179/6 184/8 186/24 187/19 188/3 188/11	masks [12] 49/7 69/6 116/1 116/5 116/14 138/16 138/21 138/22 138/25 139/8 139/10 139/16	110/9 113/9 114/7 121/23 131/19 142/18 144/16 146/12 150/17 151/11 165/8	meeting [14] 4/14 4/21 8/17 23/3 24/21 50/2 50/4 50/13 82/8 121/16 121/17 131/20 171/11 187/12
loss [1] 171/4 losses [1] 167/8 lost [2] 115/12 174/13	male [3] 96/18 96/19 159/7	material [2] 94/1 157/13	means [3] 25/4 139/23 161/11	meetings [35] 5/17 5/21 5/25 8/5 8/7 8/14 8/24 8/25 8/25 9/4 9/10 9/23 13/14 13/15 17/16 17/19 22/15 23/11 23/16 24/7 24/13 25/14 27/18 28/3 29/21 30/2 30/3 30/12 31/8 31/10 31/10 49/25 108/7 131/11 131/14
lot [17] 10/23 12/15 23/1 67/14 74/4 87/25 88/1 88/2 143/9 151/12 170/2 171/25 171/25 172/20 176/13 179/4 180/9	managed [3] 44/21 173/14 174/6	maternity [4] 173/17 173/23 174/1 174/9	meant [7] 13/13 35/2 35/11 64/16 161/4 166/12 168/20	17/16 17/19 22/15 23/11 23/16 24/7 24/13 25/14 27/18 28/3 29/21 30/2 30/3 30/12 31/8 31/10 31/10 49/25 108/7 131/11 131/14
loud [1] 82/12 loved [3] 108/4 115/12 149/19	manage [10] 21/24 44/20 46/9 46/10 59/3 68/2 76/13 165/5 181/13 190/1	may [52] 1/5 1/22 13/13 18/11 19/6 25/25 28/4 28/22 31/9 35/23 39/16 42/3 49/11 49/11 50/21 51/7 53/2 55/23 62/13 65/6 71/16 72/11 78/5 78/6 81/2 84/4 93/16 96/24 101/25 105/24 106/1 107/6 107/6 107/17 112/4 116/25 118/22 119/6 121/23 122/7 125/1 125/8 125/11 126/1 141/3 141/7 153/17 153/18 155/15 158/3 183/19 185/8	measure [1] 103/16 measured [1] 145/19 measurement [1] 145/9	171/16 17/19 22/15 23/11 23/16 24/7 24/13 25/14 27/18 28/3 29/21 30/2 30/3 30/12 31/8 31/10 31/10 49/25 108/7 131/11 131/14
low [6] 58/8 59/16 59/24 60/3 89/18 91/11	mandatory [2] 92/25 93/3	matter [4] 4/2 52/8 114/20 185/17	measures [23] 3/17 39/22 46/1 51/5 51/14 51/16 52/1 52/2 52/20 52/25 61/2 64/7 66/18 66/25 68/24 70/25 80/7 81/1 138/11 169/5 169/19 179/13 184/24	member [16] 3/5 8/4 18/24 19/7 19/9 25/5 30/9 37/19 39/15 40/4 48/5 60/5 90/13 130/13 134/8 134/10
lower [6] 54/9 58/5 63/22 64/9 183/17 183/25	management [1] 165/21	matters [6] 3/21 8/7 23/24 27/11 30/21 130/16	mechanism [2] 9/6 84/11	members [8] 30/6 33/3 60/18 65/11 65/12 115/12 131/17 186/20
lowest [2] 57/23 166/15	managing [2] 41/1 66/6	may [52] 1/5 1/22 13/13 18/11 19/6 25/25 28/4 28/22 31/9 35/23 39/16 42/3 49/11 49/11 50/21 51/7 53/2 55/23 62/13 65/6 71/16 72/11 78/5 78/6 81/2 84/4 93/16 96/24 101/25 105/24 106/1 107/6 107/6 107/17 112/4 116/25 118/22 119/6 121/23 122/7 125/1 125/8 125/11 126/1 141/3 141/7 153/17 153/18 155/15 158/3 183/19 185/8	media [2] 107/10 108/24	memberships [6] 16/10 23/13 32/21 32/21 32/23 51/8
lucky [2] 182/8 183/6 Luncheon [1] 93/14	mandatory [2] 92/25 93/3	May [52] 1/5 1/22 13/13 18/11 19/6 25/25 28/4 28/22 31/9 35/23 39/16 42/3 49/11 49/11 50/21 51/7 53/2 55/23 62/13 65/6 71/16 72/11 78/5 78/6 81/2 84/4 93/16 96/24 101/25 105/24 106/1 107/6 107/6 107/17 112/4 116/25 118/22 119/6 121/23 122/7 125/1 125/8 125/11 126/1 141/3 141/7 153/17 153/18 155/15 158/3 183/19 185/8	mediate [1] 43/11 medical [99] 2/4 2/10 2/12 2/15 2/19 3/5 6/16 6/17 6/22 7/1 7/1 7/20 7/20 7/22 8/1 8/2 8/4 8/5 8/8 8/17 8/19 9/5 10/1 10/2 10/4 10/7 10/9 10/10 10/13 10/15 11/4 11/5 11/17 11/22 12/8 12/10 12/16 12/21 13/3 13/7 13/12 13/15 13/18 13/19 15/23 18/18 22/11 22/16 22/23 23/10 23/11 24/6 24/25 25/1 25/2 25/5 25/9 26/6 26/16 27/8 29/22 39/19 47/22 48/14 62/10 66/20 66/21 68/1 69/12 69/17 71/8 72/8 75/14 85/2 86/16 100/21 101/14 101/21 106/21 106/21 106/25 108/6 108/7 109/23 110/21 121/12 125/14 128/25 131/3 131/6 131/8 132/1 133/20 134/5 134/17 146/14 158/11 166/22 187/23	memoires [1] 28/3 memory [2] 60/20 173/19
M	manner [1] 184/6 many [21] 10/21 10/21 12/16 14/19 19/17 42/18 67/18 111/6 115/11 131/22 133/5 137/5 146/14 146/15 146/16 156/12 168/12 174/14 179/16 184/16 186/20	May 2020 [3] 13/13 51/7 65/6 May/June [1] 153/17 maybe [4] 61/18 85/17 112/7 153/13 McBride [2] 137/18 138/3 McDonnell [13] 158/4 158/5 158/6 158/11 158/14 164/1 180/18 181/24 182/4 188/18 190/3 190/10 191/11	mechanism [2] 9/6 84/11	mentals [1] 28/3 memory [2] 60/20 173/19
made [31] 27/7 37/23 42/24 73/5 73/8 93/4 98/23 99/23 102/15 102/16 103/5 103/13 104/19 104/24 108/4 108/5 108/14 108/24 120/14 120/19 121/6 124/1 125/22 146/11 147/25 153/12 165/14 175/15 186/4 186/20 189/4	March [32] 27/15 31/17 34/21 57/10 65/5 65/22 70/22 71/6 73/18 75/11 78/25 81/4 94/2 95/1 107/9 108/18 119/7 122/12 122/21 123/1 124/6 124/20 126/22 127/3 148/1 149/25 150/2 150/13 158/15 175/4 175/9 185/7	me [47] 1/13 1/17 8/11 11/2 11/11 15/15 19/2 26/20 29/3 29/8 29/14 30/20 30/22 31/22 32/15 39/17 42/3 42/3 42/6 52/11 52/15 58/25 59/5 59/21 61/20 64/4 101/3 106/12 106/21 113/11 113/19 116/7 120/24 121/19 125/17 127/5 130/22 132/3 132/9 132/23 137/10 141/2 141/2 141/6 149/3 154/6 187/11	media [2] 107/10 108/24	mental [20] 103/14 104/1 104/5 152/12 152/17 153/11 153/12 153/15 153/24 153/24 154/12 154/17 154/19 155/9 155/15 155/24 156/5 156/12 156/25 180/3
mail [1] 42/12 main [11] 9/16 10/13 32/15 34/22 67/25 79/13 114/18 115/1 121/24 124/22 133/4	March 2020 [6] 27/15 124/6 148/1 149/25 150/2 185/7	me [47] 1/13 1/17 8/11 11/2 11/11 15/15 19/2 26/20 29/3 29/8 29/14 30/20 30/22 31/22 32/15 39/17 42/3 42/3 42/6 52/11 52/15 58/25 59/5 59/21 61/20 64/4 101/3 106/12 106/21 113/11 113/19 116/7 120/24 121/19 125/17 127/5 130/22 132/3 132/9 132/23 137/10 141/2 141/2 141/6 149/3 154/6 187/11	mentals [1] 28/3 memory [2] 60/20 173/19	mention [3] 29/1 116/19 142/11
mainly [1] 10/14 maintain [4] 14/8 17/4 24/18 125/8	March 2021 [1] 108/18	MEAG [1] 90/15 meals [1] 143/15 mean [26] 19/22	mentioned [13] 9/20 14/1 36/17 92/21 103/2 116/12 123/15 142/25 142/25 143/2 145/5 159/16 175/3	mentioned [13] 9/20 14/1 36/17 92/21 103/2 116/12 123/15 142/25 142/25 143/2 145/5 159/16 175/3
maintaining [1] 173/7	March 2022 [1] 65/22 March/April [1] 150/13	MEAG [1] 90/15 meals [1] 143/15 mean [26] 19/22	MERS [1] 148/13 MERS-CoV [1] 148/13	MERS [1] 148/13 MERS-CoV [1] 148/13
maintenance [1] 17/11	marginalised [1] 89/5	MEAG [1] 90/15 meals [1] 143/15 mean [26] 19/22	Merthyr [1] 55/21 message [1] 105/12 messages [1] 160/7 met [11] 23/12 25/6 26/16 49/18 91/19 121/13 171/10 172/6 187/19 188/14 188/15	Merthyr [1] 55/21 message [1] 105/12 messages [1] 160/7 met [11] 23/12 25/6 26/16 49/18 91/19 121/13 171/10 172/6 187/19 188/14 188/15
major [2] 11/19 54/15 majority [1] 133/8 make [37] 7/8 12/12 12/14 20/16 26/20 31/8 52/14 58/16 58/17 62/21 64/13 68/23 76/20 79/13 82/1 94/8 94/15 101/7 104/3 113/14 114/5 133/12 134/24 135/14	marry [1] 76/8 marrying [1] 78/7 mask [4] 47/9 165/7 168/9 168/11	MEAG [1] 90/15 meals [1] 143/15 mean [26] 19/22	met [11] 23/12 25/6 26/16 49/18 91/19 121/13 171/10 172/6 187/19 188/14 188/15	metabolism [1] 71/12 Michael [1] 138/3 micro [1] 91/25 micro-examples [1] 91/25

M	131/14	morning [4] 1/5 117/21 130/11 138/14	66/3 66/3 75/23 78/3 79/11 89/3 89/4 102/2 113/25 115/2 116/5 124/10 124/10 127/23 127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	99/2
mid [3] 4/14 126/22 127/3	mislead [1] 116/22	mornings [1] 130/5	113/25 115/2 116/5 124/10 124/10 127/23 127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	narrow [1] 186/10
mid-April [1] 4/14	missed [3] 76/16 153/19 189/9	morphed [1] 74/11	113/25 115/2 116/5 124/10 124/10 127/23 127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	nation [1] 69/12
mid-March [1] 127/3	mistrust [1] 45/15	mortality [9] 72/23 84/18 84/22 84/23 85/18 86/4 92/10 141/1 150/10	124/10 124/10 127/23 127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	national [20] 15/8 19/20 20/21 21/19 25/1 25/9 40/12 55/18 59/6 92/12 92/15 93/22 126/25 169/4 170/18 170/25 171/5 173/22 176/10 177/7
mid-March 2021 [1] 126/22	mitigate [4] 81/1 91/2 141/8 156/10	mother [3] 174/13 174/14 174/23	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	nationally [1] 57/12
midday [1] 50/22	mixed [1] 159/3	mothers [1] 174/25	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	nations [18] 13/23 20/13 22/10 22/14 22/20 23/20 26/19 27/2 30/3 39/11 81/10 81/13 81/16 82/3 94/20 98/16 114/23 145/12
middle [5] 15/22 16/8 59/22 68/16 180/7	mixture [1] 185/23	mouth [4] 42/21 44/13 44/14 44/15	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	nations' [1] 29/22
midst [1] 181/17	Mm [1] 3/20	move [24] 7/16 21/2 22/9 27/6 32/18 38/18 40/15 49/8 69/8 86/7 102/14 113/23 114/4 114/5 114/6 119/2 124/25 125/23 126/13 147/24 149/7 158/2 160/16 187/14	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	natural [2] 10/22 11/2
might [23] 27/1 37/15 37/25 37/25 45/8 63/16 75/3 91/23 150/25 160/10 160/14 164/12 168/12 168/25 170/7 175/10 175/13 175/14 176/6 176/8 176/11 184/12 184/12	Mm-hm [1] 3/20	Mr [19] 139/20 139/21 139/23 140/17 146/15 147/8 147/9 147/11 149/12 152/8 152/9 155/4 157/24 182/2 182/3 190/7 191/8 191/10 191/14	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	nature [3] 35/13 50/7 97/21
migrant [2] 89/15 143/2	mode [1] 122/24	Mr Mills [1] 157/24	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	necessarily [3] 50/10 98/13 121/9
mild [1] 69/25	model [1] 136/21	Mr Pezzani [1] 152/8	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	necessary [8] 96/22 103/23 104/10 121/7 121/9 123/10 148/21 185/19
Mills [1] 157/24	modelling [4] 33/19 33/19 33/20 33/24	Mr Simblet [2] 147/9 149/12	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	need [46] 9/25 21/1 27/3 38/11 42/4 44/18 66/23 77/15 78/3 78/7 85/6 88/2 90/3 93/22 95/20 98/20 99/4 104/1 104/24 120/7 122/13 125/5 125/23 127/14 130/5 133/12 133/13 134/21 134/24 136/2 137/1 137/8 144/19 144/22 146/23 152/2 154/19 154/24 157/2 181/2 181/3 181/4 181/5 181/15 181/21 189/20
mind [9] 14/25 38/16 64/21 87/13 115/1 152/11 153/7 154/20 161/23	modern [1] 67/14	Mr Thomas [6] 139/20 139/21 139/23 140/17 146/15 155/4	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	needed [18] 17/24 23/5 25/9 25/11 89/25 94/15 109/11 113/13 114/7 136/24 163/21 171/1 172/21 172/22 177/12 177/13 177/17 186/5
mindful [2] 174/16 179/19	modes [3] 34/22 49/1 116/10	Mr Wilcock [2] 182/2 190/7	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	needing [1] 175/13
minds [3] 79/9 156/21 178/8	module [10] 1/8 1/21 3/22 13/10 15/2 27/10 152/2 158/9 191/3 191/13	Mrs [1] 115/5	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	needs [21] 13/18 26/17 45/24 47/13 67/14 78/20 80/1 85/12 85/13 85/18 89/19 95/11 112/18 114/11 134/17 135/13 135/15 137/2 147/2 177/1 179/14
minimise [1] 144/25	Module 2B [2] 13/10 15/2	Mrs Weeraratne [1] 115/5	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	negative [3] 152/16 154/12 170/23
minister [41] 3/16 3/22 4/2 4/4 4/15 4/15 4/22 5/6 5/12 5/12 5/22 5/25 6/1 6/4 6/4 6/9 9/8 9/14 20/3 24/11 24/22 24/23 29/15 29/16 53/8 53/14 81/15 81/17 82/8 82/9 82/10 82/10 82/10 82/19 86/24 87/11 91/13 102/4 141/15 141/15 152/14	moment [2] 100/16 167/16	Ms [13] 115/4 115/8 129/25 130/1 135/18 135/19 135/20 149/13 149/14 191/4 191/5 191/6 191/9	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	negatives [1] 76/19
minister's [5] 81/19 81/22 81/23 90/11 92/3	moments [2] 172/15 176/6	Much [53] 33/8 33/8 34/9 38/2 52/17 64/1	127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	neither [1] 18/18
ministerial [2] 53/15 53/19	Monday [1] 1/1		127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	
ministers [11] 3/12 9/14 24/19 33/16 36/5 36/8 82/1 88/21 88/21 89/7 89/22	monitor [3] 65/17 109/20 110/12		127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	
ministry [12] 89/11 90/8 90/10 92/23 140/8 140/10 140/15 146/1 155/20 155/21 155/21 159/5	monitored [1] 93/6		127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	
Minster [1] 4/23	monitoring [6] 5/9 33/21 110/11 111/2 144/11 146/9		127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	
minute [1] 122/7	monitors [2] 63/19 111/18		127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	
minuted [2] 31/10 125/1	month [2] 8/6 153/7		127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	
minutes [2] 13/13	monthly [1] 8/14		127/24 128/11 128/13 129/23 133/3 133/22 133/23 138/8 139/19 144/3 147/4 148/5 149/10 150/24 150/24 151/18 152/7 154/24 155/25 155/25 157/5 157/18 160/6 161/20 161/20 162/7 165/21 165/22 177/6 182/1 190/3 190/8 190/10	

<p>N</p> <p>NERVTAG [7] 29/20 43/16 44/5 45/22 46/24 116/20 122/2</p> <p>network [6] 95/15 95/21 96/1 101/4 106/19 112/13</p> <p>networked [1] 184/10</p> <p>networks [1] 96/6</p> <p>neurological [1] 70/2</p> <p>never [11] 52/17 65/25 97/16 98/16 103/20 118/12 118/13 118/23 144/18 177/5 177/12</p> <p>nevertheless [1] 103/15</p> <p>new [9] 14/22 61/25 62/2 148/4 148/8 165/4 169/11 171/2 183/22</p> <p>news [2] 174/23 184/11</p> <p>newspaper [1] 152/25</p> <p>next [14] 12/5 96/18 100/12 117/20 119/2 122/10 123/4 124/25 137/10 149/3 157/25 162/10 169/3 171/15</p> <p>NHS [51] 4/6 5/3 5/5 5/10 5/16 5/23 6/9 6/18 7/6 7/7 7/8 7/8 7/14 7/15 7/17 7/21 8/1 9/18 10/1 11/5 15/4 15/6 15/6 15/8 17/17 17/22 18/7 19/21 20/6 20/21 21/4 21/12 21/14 21/18 22/1 24/25 25/2 39/5 55/9 77/18 78/17 91/1 92/17 92/25 95/22 95/25 96/2 113/14 131/3 131/8 144/20</p> <p>NHS England [1] 25/2</p> <p>NHS Executive [1] 77/18</p> <p>NICE [2] 132/12 132/20</p> <p>Nield [1] 115/4</p> <p>night [1] 168/3</p> <p>NLS [1] 178/23</p> <p>NMC [1] 166/24</p> <p>no [73] 7/13 7/24 13/13 15/6 16/13 19/11 28/5 28/6 30/13 31/9 37/9 39/7 43/22 45/9 50/18 52/8 53/1 57/25 60/11 64/12 71/20 72/21 73/15 74/8 75/9 77/9 78/2</p>	<p>82/22 83/5 83/8 83/15 83/15 84/6 84/8 86/3 94/11 94/17 100/3 100/5 100/5 100/9 105/15 108/19 108/23 110/4 110/4 111/24 115/2 120/23 123/14 123/17 125/9 129/3 129/5 132/3 132/9 132/23 133/18 138/23 142/1 148/18 148/19 149/7 149/9 150/14 150/14 152/22 153/4 153/6 156/3 181/18 186/12 188/24</p> <p>non [14] 17/2 17/11 86/16 139/1 153/22 153/23 159/10 164/6 168/16 175/21 177/2 177/3 181/10 184/14</p> <p>non-clinical [1] 139/1</p> <p>non-Covid [7] 17/2 17/11 86/16 164/6 168/16 177/2 184/14</p> <p>non-elective [1] 159/10</p> <p>non-essential [2] 153/22 153/23</p> <p>non-executive [1] 175/21</p> <p>non-pandemic [1] 177/3</p> <p>none [2] 108/1 164/12</p> <p>nor [1] 18/18</p> <p>norm [1] 30/6</p> <p>normal [6] 36/11 36/11 79/24 148/24 164/8 167/10</p> <p>normally [3] 104/6 170/6 180/15</p> <p>Northern [10] 39/3 137/13 138/1 158/2 159/1 159/8 159/9 167/5 178/14 182/4</p> <p>northwest [1] 158/25</p> <p>nosocomial [44] 18/10 18/15 51/1 51/5 51/12 51/15 52/6 52/9 52/16 53/3 53/7 53/20 54/16 56/9 56/14 56/15 57/7 57/8 57/17 59/14 59/25 62/18 62/22 64/6 64/10 64/19 64/24 65/4 65/7 65/18 65/20 66/1 66/6 66/7 66/12 67/23 115/12 182/12 183/18 183/25 184/3 184/4 184/24 185/18</p> <p>not [171] 4/1 5/21 10/24 16/13 19/24 20/7 22/24 25/7 30/3 31/10 32/11 36/22</p>	<p>38/8 40/25 41/13 41/15 41/17 41/19 45/16 46/8 46/14 46/19 46/20 51/16 52/2 52/3 53/2 58/10 58/15 58/24 59/10 60/5 61/1 61/8 63/20 64/8 66/2 66/6 67/14 72/3 72/13 72/23 73/23 74/21 74/23 75/7 78/11 78/12 79/2 79/9 81/20 82/10 82/13 82/22 83/7 83/11 83/15 83/17 84/4 84/19 84/24 86/2 86/16 89/8 92/14 96/3 97/5 97/15 98/25 99/8 99/11 101/11 102/20 103/12 104/7 105/18 106/18 108/8 108/23 109/8 109/13 109/17 109/19 109/21 110/12 110/14 111/9 111/22 112/2 112/12 112/17 112/24 114/11 116/16 116/24 117/24 119/1 119/1 119/22 120/16 121/8 121/9 121/21 122/14 122/18 122/24 123/14 124/2 124/14 124/19 125/5 125/19 126/1 126/21 127/25 128/13 128/17 129/17 130/5 130/11 131/2 132/9 132/10 132/17 134/18 136/16 137/3 138/22 138/22 138/23 139/10 146/18 147/16 148/5 148/13 149/7 150/5 150/5 152/10 153/3 154/20 156/25 157/15 160/9 162/24 163/2 163/3 163/21 164/15 166/20 167/23 168/23 168/25 170/15 171/14 172/3 172/12 174/20 177/17 178/13 179/17 180/14 181/11 181/19 182/22 183/8 184/24 187/14 189/7 189/16 189/21</p> <p>notable [1] 20/2</p> <p>note [1] 31/10</p> <p>notebooks [2] 32/11 32/12</p> <p>noted [3] 47/21 55/13 63/11</p> <p>notes [11] 24/14 24/15 24/18 27/22 28/1 28/6 31/8 31/15 31/16 32/4 32/6</p> <p>nothing [3] 80/6 148/6 149/8</p> <p>notice [1] 108/16</p>	<p>noticeable [1] 59/23</p> <p>notices [5] 101/12 102/6 107/11 109/1 111/5</p> <p>notification [1] 24/4</p> <p>notified [2] 81/13 117/25</p> <p>notwithstanding [1] 187/4</p> <p>Nova [3] 2/11 37/19 37/21</p> <p>November [7] 3/1 18/25 47/15 47/22 53/19 53/24 124/11</p> <p>November 2020 [1] 18/25</p> <p>November 2021 [1] 47/22</p> <p>now [31] 1/14 12/25 13/5 28/8 32/7 32/19 33/2 38/18 42/19 43/1 63/3 76/14 77/7 81/7 86/7 88/2 90/6 101/24 102/6 108/1 113/2 118/2 118/18 122/25 126/15 129/17 132/11 160/16 173/19 177/4 183/1</p> <p>NTG [8] 62/4 63/5 63/19 64/5 64/17 65/2 65/13 65/17</p> <p>NTG ... routinely [1] 63/19</p> <p>nuance [1] 186/1</p> <p>nuanced [2] 188/2 188/3</p> <p>number [29] 7/8 7/13 11/19 13/21 14/2 16/6 33/1 33/9 50/7 60/8 65/23 79/22 80/13 84/4 96/6 96/13 96/15 96/16 96/17 96/18 109/20 115/13 119/15 137/15 143/19 159/20 163/4 163/4 165/21</p> <p>numbered [1] 96/12</p> <p>numbers [10] 56/1 56/2 59/16 75/2 97/24 97/25 100/24 141/4 167/4 167/25</p> <p>numerical [5] 97/5 97/10 99/7 99/13 100/6</p> <p>nurse [1] 172/6</p> <p>nurses [7] 160/19 161/10 162/9 163/16 166/17 167/1 170/2</p> <p>nursing [15] 16/4 18/10 18/12 23/21 41/7 42/12 43/6 44/1 47/23 49/3 51/7 102/8 107/1 107/9 166/23</p>	<p>O</p> <p>o'clock [1] 190/14</p> <p>objectionable [2] 105/2 105/3</p> <p>objective [1] 98/9</p> <p>observation [1] 66/19</p> <p>observers [1] 30/5</p> <p>obtain [1] 104/10</p> <p>obviously [13] 9/15 37/5 40/7 79/15 85/6 88/21 95/6 108/2 118/19 127/24 175/22 181/14 190/11</p> <p>occasion [5] 5/15 6/3 41/6 62/8 108/13</p> <p>occasionally [3] 25/7 58/9 169/6</p> <p>occasions [5] 5/24 40/15 40/19 40/23 105/22</p> <p>occupancy [3] 67/4 67/11 69/3</p> <p>occurring [1] 54/13</p> <p>October [3] 4/14 87/21 124/11</p> <p>October 2020 [1] 4/14</p> <p>OECD [3] 20/10 20/24 22/3</p> <p>off [7] 69/18 73/15 85/24 163/8 172/14 172/16 172/18</p> <p>offer [2] 171/21 172/25</p> <p>office [17] 12/10 12/16 13/12 14/9 14/14 18/18 22/10 90/11 92/12 92/15 100/21 101/21 109/1 131/7 133/20 134/5 157/12</p> <p>officer [48] 2/10 2/12 2/15 2/19 3/5 6/16 6/24 10/10 10/14 11/5 12/10 12/16 12/21 13/3 13/7 13/12 13/19 13/19 15/24 16/4 18/10 18/12 18/19 22/11 22/24 23/10 23/21 24/7 27/8 29/11 39/19 41/7 42/13 43/6 44/1 51/7 75/15 77/17 85/2 100/21 101/21 102/8 107/9 125/14 128/25 133/20 134/5 134/17</p> <p>Officer's [3] 11/22 12/8 66/20</p> <p>officers [16] 13/15 22/16 23/11 26/6 26/16 29/22 47/22 47/23 48/15 49/4</p>
--	--	--	--	--

O	128/4 onstream [1] 150/20 onwards [1] 87/21 open [3] 171/9 171/10 171/21 opened [3] 175/17 183/7 183/22 opener [1] 144/12 operating [1] 128/25 operation [3] 20/11 22/9 75/14 operational [6] 5/2 5/19 5/22 6/8 6/13 7/3 opinion [2] 44/4 46/23 opportunities [3] 6/6 146/7 171/12 opportunity [4] 6/5 8/10 181/18 181/19 oppose [1] 5/2 opposed [1] 8/24 opposite [3] 38/2 46/23 47/14 option [2] 126/8 151/20 options [1] 103/10 or [161] 3/9 4/5 6/20 7/21 8/21 9/3 9/14 10/3 10/16 12/11 13/1 13/15 16/10 16/15 17/19 18/11 18/20 18/22 21/18 21/20 24/19 24/20 24/21 24/25 25/2 25/4 27/22 28/20 31/15 31/16 32/22 36/1 36/1 36/1 36/25 37/11 39/21 39/22 40/3 40/9 40/21 41/13 43/11 45/4 45/4 45/25 47/9 47/10 49/7 51/16 51/25 52/2 53/25 54/6 55/22 59/14 59/18 60/5 62/14 62/24 65/8 65/23 67/14 68/10 68/11 68/15 68/24 69/13 70/19 72/18 72/21 73/4 74/4 79/23 80/3 80/7 80/9 83/11 83/18 84/19 88/10 88/12 88/17 91/1 97/22 99/22 100/20 103/14 103/19 104/6 104/11 104/21 105/10 105/22 105/23 106/3 107/12 107/21 107/22 108/9 108/19 108/21 109/1 109/3 109/6 109/9 109/9 109/18 109/20 109/21 109/21 110/16 111/22 116/16 117/25 120/10 124/8 124/19 130/12 130/21 130/25 131/15 131/16	131/16 131/24 132/19 132/20 136/16 138/21 139/1 139/2 139/11 142/18 144/24 148/5 149/5 149/6 149/6 152/22 152/23 153/19 155/20 156/9 157/14 164/20 168/4 168/21 168/23 169/5 169/23 170/22 173/17 176/13 177/6 180/18 183/8 185/24 187/22 188/16 189/6 189/7 order [10] 29/18 77/1 103/21 103/23 104/11 104/15 129/5 138/17 140/4 185/17 orders [1] 182/14 ordinate [2] 19/20 75/16 ordinated [1] 75/14 ordination [1] 131/4 Orford [12] 4/17 4/17 4/22 27/17 29/10 29/19 30/7 30/16 30/18 31/5 32/2 33/3 organ [1] 71/9 organisation [9] 15/6 15/7 20/11 95/23 154/21 156/23 156/23 176/21 179/17 organisations [10] 17/18 21/23 33/9 33/10 43/17 43/24 48/6 51/11 140/8 162/15 organisations/countr ies [1] 48/6 Organization [2] 143/23 144/2 organogram [3] 11/23 19/16 19/22 Origin [1] 91/15 original [1] 74/10 originally [3] 23/17 81/12 82/2 origins [1] 147/2 other [47] 3/17 6/2 13/23 14/2 22/10 22/14 22/20 23/20 24/20 25/2 25/4 27/2 33/10 34/17 47/2 54/4 58/21 59/25 61/16 62/14 68/10 69/25 80/7 81/10 81/13 81/16 81/18 82/3 85/21 86/4 89/6 103/15 109/2 127/14 127/20 131/16 134/23 135/10 137/15 145/11 146/22 148/13 148/25 173/4 184/13 184/17 188/10 others [3] 116/16	145/13 179/25 otherwise [1] 75/1 ought [1] 145/25 our [73] 23/21 39/24 39/25 42/20 43/15 44/8 51/22 51/22 67/15 67/18 77/21 79/9 85/20 91/12 91/13 107/17 107/19 109/12 112/19 112/22 113/14 114/19 127/8 129/8 133/5 134/14 137/2 141/14 143/4 143/24 144/2 144/16 144/20 145/4 146/14 146/15 152/4 154/16 156/2 156/20 157/3 158/1 159/20 159/25 160/10 160/10 160/13 160/15 161/16 161/17 163/8 163/9 167/7 167/16 169/9 169/11 171/3 173/24 174/1 174/11 174/25 175/17 175/20 178/8 178/23 179/17 180/3 181/16 184/11 184/17 187/11 188/15 190/1 ourselves [1] 180/25 out [63] 15/20 17/14 27/11 35/20 35/21 41/7 45/1 53/20 54/21 55/13 56/4 57/6 59/7 70/21 78/20 81/21 82/25 86/10 87/15 90/6 97/17 97/24 103/16 105/8 107/2 107/18 108/12 109/14 111/19 118/10 118/12 118/14 118/24 119/2 120/20 126/19 126/20 126/22 126/24 127/3 127/8 127/11 128/13 134/1 137/14 140/4 140/18 143/16 144/11 144/13 145/14 150/6 151/3 154/25 163/2 168/3 168/3 170/10 172/14 178/25 179/2 188/21 189/4 outbreaks [9] 51/20 51/21 51/25 52/24 57/22 60/2 65/9 65/23 151/14 outcomes [4] 28/3 116/5 140/21 144/9 outlier [3] 184/3 184/13 184/15 outpatient [1] 161/17 output [2] 34/4 34/5 outside [8] 54/24 167/19 168/2 168/7 168/16 170/1 174/21 185/14	outweighed [1] 151/9 over [18] 11/11 12/5 18/8 19/23 68/2 69/22 72/9 99/15 122/25 123/16 135/19 142/22 152/8 153/8 153/10 166/2 166/6 166/14 overall [1] 84/8 overarching [2] 19/20 186/10 overlap [1] 10/24 overloaded [1] 87/18 overran [1] 158/7 overseas [1] 2/7 overseeing [1] 109/24 oversight [8] 6/21 12/4 15/3 25/15 51/4 51/13 85/3 106/16 overview [1] 6/11 overweight [1] 70/3 overwhelmed [3] 86/15 166/8 166/10 own [15] 7/4 7/20 21/24 21/24 24/13 24/15 24/18 64/25 96/3 99/6 110/10 112/22 134/2 176/20 188/9 owned [2] 112/12 129/19 oximeters [2] 26/1 26/2
			P	
			paediatrician [3] 90/15 120/25 121/1 page [38] 4/11 12/1 12/5 12/5 15/18 28/7 38/21 42/5 42/11 43/9 43/19 47/19 51/2 54/9 55/8 56/21 57/5 60/7 61/22 63/7 66/23 79/21 79/23 80/16 96/10 100/13 100/17 102/14 102/14 103/7 106/12 119/5 119/8 119/8 119/12 182/17 182/18 182/23 page 1 [5] 43/9 56/21 102/14 106/12 119/5 page 2 [6] 15/18 28/7 42/11 57/5 79/21 103/7 page 27 [1] 4/11 page 3 [2] 12/1 63/7 page 363 [1] 66/23 page 4 [6] 12/5 42/5 60/7 182/17 182/18 182/23 page 5 [1] 96/10 page 53 [1] 38/21 page 55 [1] 47/19	

P	120/10 131/4 131/7 142/10 142/12 152/13 160/17 166/4 169/15 182/18 183/14 185/1 185/10 186/23 188/20	particular [19] 9/3 37/10 46/22 72/14 72/21 77/6 86/25 91/12 136/2 149/9 159/18 160/4 160/15 166/5 167/17 174/8 175/1 176/25 189/14	186/6 187/20 187/23 188/4 188/6 188/7 189/7	percutaneous [1] 159/19
page 56 [1] 51/2	paragraph 10 [1] 160/17	particularly [19] 6/22 34/24 40/17 67/17 70/19 89/5 92/22 98/6 132/5 143/2 152/18 154/12 155/16 160/8 160/19 161/6 167/25 169/24 174/9	pattern [2] 23/3 124/22	perfect [2] 144/19 190/7
page 6 [1] 55/8	paragraph 100 [1] 166/4	partly [1] 97/17	pause [4] 82/2 87/22 123/11 123/13	perfectly [1] 186/13
page 7 [1] 61/22	paragraph 146 [1] 84/1	partner [3] 174/2 174/18 174/22	paused [2] 81/14 82/24	performers [1] 181/4
pages [1] 29/4	paragraph 148 [1] 84/16	partners [2] 174/20 174/24	pausing [2] 102/23 137/20	performing [1] 184/15
Paget [1] 3/2	paragraph 149 [1] 38/21	parts [4] 112/9 148/14 183/23 190/12	pay [1] 146/25	perhaps [23] 7/16 14/5 17/23 22/2 31/20 33/23 38/11 41/4 51/24 53/13 67/20 72/3 87/21 95/17 97/22 112/17 119/24 127/25 148/24 150/25 153/6 170/15 189/21
pandemic [114] 2/24 3/15 3/18 5/13 5/23 7/16 8/15 8/18 9/23 10/12 10/17 11/7 11/12 13/17 14/11 15/4 15/9 17/5 17/9 19/19 21/1 22/25 23/7 25/16 25/20 25/25 26/22 27/14 28/11 28/22 33/20 33/21 34/18 35/5 36/15 37/1 38/20 38/24 47/15 51/18 52/7 52/8 55/24 63/12 74/6 77/4 78/3 78/5 83/4 84/13 85/8 86/9 86/11 86/18 87/13 88/8 88/10 88/25 89/8 89/15 93/18 93/21 99/23 101/14 101/18 102/7 110/16 113/4 116/10 118/7 118/8 121/14 122/22 129/12 132/4 140/11 142/18 142/19 142/21 143/9 146/3 146/24 148/6 149/22 150/17 151/13 154/15 154/15 154/25 159/15 159/22 160/19 161/7 161/24 164/5 164/6 169/17 173/22 175/11 177/3 179/20 180/21 180/25 181/2 181/6 181/9 182/13 183/8 184/21 185/22 187/1 188/17 190/2 190/13	paragraph 158 [1] 47/20	passionate [1] 181/15	PCI [1] 159/19	peril [1] 181/11
pandemics [2] 78/9 113/8	paragraph 159 [1] 51/2	pathway [10] 17/11 128/23 129/2 129/6 129/7 129/14 129/16 146/20 187/25 188/8	PCR [3] 56/5 126/2 150/20	period [3] 15/4 79/3 166/2
panel [6] 37/20 72/15 73/5 74/14 90/13 90/17	paragraph 174 [1] 117/23	pathways [2] 132/16 172/8	peace [2] 177/2 177/2	periods [1] 83/2
paper [11] 34/20 53/18 53/20 56/20 59/20 60/5 90/1 90/5 102/12 125/13 155/12	paragraph 2.8 [1] 182/18	patient [34] 45/3 47/12 54/19 54/19 55/10 59/18 59/18 60/9 60/11 60/13 61/1 61/18 67/16 72/10 72/20 73/11 75/24 76/3 83/1 96/21 103/23 104/1 104/3 104/16 108/9 108/15 111/7 163/19 167/14 170/22 177/9 180/12 180/16 188/8	people [111] 1/17 14/21 15/23 24/20 32/22 33/1 33/9 36/17 45/8 47/4 54/5 54/24 56/2 64/16 70/8 70/13 70/14 71/10 71/13 72/3 72/12 72/21 72/22 73/3 73/6 74/11 76/6 76/18 79/15 79/24 81/20 83/6 83/11 84/12 85/20 85/22 86/5 87/16 87/17 87/24 89/3 89/5 89/16 89/23 91/23 94/9 94/10 98/7 103/10 104/4 104/20 104/22 105/11 105/17 105/18 107/12 108/3 112/25 114/10 114/11 114/14 127/19 132/25 133/9 133/9 134/22 134/23 135/5 136/19 137/4 139/3 141/19 143/15 143/16 146/13 147/3 147/5 149/18 151/2 151/13 151/17 151/20 153/9 153/25 154/1 154/4 154/4 155/8 156/13 156/17 156/19 157/1 159/8 161/13 167/5 167/6 167/19 168/19 169/24 170/1 170/13 171/13 175/19 175/21 178/20 180/7 186/4 187/13 187/17 189/21 189/24	peripheral [2] 161/4 161/13
papers [9] 24/17 27/17 28/15 28/20 28/23 29/5 29/9 32/1 182/22	paragraph 4 [2] 28/7 31/21	patient's [3] 104/10 104/15 188/9	peaked [1] 57/13	peripherals [1] 161/3
paperwork [1] 159/23	paragraph 41 [1] 169/15	patient-facing [1] 55/10	peaks [1] 160/15	permission [3] 130/6 182/10 185/25
paragraph [31] 4/10 28/7 31/21 31/22 38/21 47/20 51/2 53/23 54/10 55/2 56/23 63/13 84/1 84/16 117/23 120/9	paragraph 47 [1] 185/1	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalise [1] 136/17	person [8] 8/24 23/4 30/8 30/17 48/24 48/24 98/12 98/13
	paragraph 50 [1] 185/10	patient-facing [1] 55/10	personalised [1] 78/16	person's [2] 44/14 98/11
	paragraph 79 [1] 4/10	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personally [10] 75/16 79/13 90/20 130/24 131/19 132/3 132/9 132/23 133/16 133/17	perspective [1] 33/18
	paragraph 92 [1] 131/7	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	pervasive [2] 187/2 187/5
	paragraph 96 [1] 186/23	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personally [10] 75/16 79/13 90/20 130/24 131/19 132/3 132/9 132/23 133/16 133/17	Pezzani [3] 152/8 152/9 191/10
	paragraph 97 [1] 188/20	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalise [1] 136/17	pharmaceutical [1] 79/18
	paragraphs [1] 144/7	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	phases [2] 38/24 72/3
	parallel [1] 168/14	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personally [10] 75/16 79/13 90/20 130/24 131/19 132/3 132/9 132/23 133/16 133/17	PHE [4] 43/1 43/16 120/8 120/15
	parity [1] 146/6	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	phone [1] 164/20
	part [19] 25/3 28/22 39/20 49/11 58/24 61/1 68/20 75/6 96/1 145/6 152/5 155/23 158/13 167/17 171/5 180/16 183/16 185/6 190/1	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	phrase [1] 155/11
	partially [1] 81/17	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	physical [3] 8/24 154/18 155/24
	particles [3] 117/6 117/6 117/13	patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	Physicians [1] 91/15
		patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	picked [1] 145/11
		patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	picture [1] 179/11
		patients [68] 54/13 54/14 54/20 58/22 59/4 59/8 59/11 59/19 60/17 61/5 61/9 61/10 65/11 65/12 67/1 67/2 67/23 68/3 68/25 69/2 69/6 71/3 72/8 75/12 75/19 75/21 76/2 76/10 76/15 76/16 77/1 77/6 78/18 80/8 101/8 107/23 131/22 138/12 138/17 138/20 140/16 140/22 141/5 149/17 150/9 159/25 164/11 164/14 165/6 165/20 166/8 166/12 167/4 167/13 167/19 173/3 174/8 178/9 179/7 180/15 181/11	personalised [1] 78/16	piece [8] 74/2 78/22 111/20 129/7 138/4

<p>P</p> <p>piece... [3] 157/25 163/24 186/7</p> <p>pilot [1] 55/20</p> <p>piloting [1] 55/23</p> <p>pin [2] 140/17 141/2</p> <p>pink [2] 12/12 58/8</p> <p>pipeline [1] 118/15</p> <p>pipelines [1] 118/16</p> <p>PLAB [1] 161/9</p> <p>place [25] 14/10 22/15 50/2 60/11 61/3 61/13 77/7 98/14 108/15 114/12 117/3 117/4 117/12 137/24 151/15 152/16 157/11 161/1 166/6 170/23 176/3 176/4 181/5 186/10 188/5</p> <p>placed [2] 94/12 187/24</p> <p>places [3] 51/20 91/16 98/12</p> <p>plan [4] 69/13 162/25 178/11 185/6</p> <p>planning [25] 5/7 6/2 9/17 15/12 15/21 16/5 16/7 16/9 16/19 16/24 17/9 19/15 68/9 85/14 105/14 105/16 105/20 105/21 106/6 110/22 111/4 111/8 112/20 162/15 178/13</p> <p>plans [7] 69/11 104/21 105/1 105/3 105/4 105/6 105/9</p> <p>plants [1] 143/5</p> <p>play [2] 35/23 55/1</p> <p>played [2] 22/11 97/17</p> <p>please [79] 1/5 1/11 2/2 4/10 5/4 11/23 12/1 12/6 15/3 15/18 22/9 27/6 28/7 29/18 35/7 38/21 38/22 41/23 42/6 42/11 43/9 43/20 46/16 47/19 49/13 51/2 53/16 53/23 55/9 56/8 56/13 57/5 57/16 60/7 61/22 63/7 63/8 63/23 69/8 73/17 78/24 79/21 80/13 86/7 93/12 95/17 96/10 100/12 100/17 101/11 102/10 102/14 105/7 106/23 117/9 119/5 119/15 122/20 123/18 135/24 139/21 142/15 147/19 148/3 157/14 158/3 158/10 158/20 158/21 160/16 160/21 162/10 162/11 162/24 164/4</p>	<p>169/3 171/15 182/16 190/14</p> <p>plenty [1] 137/7</p> <p>plus [1] 180/2</p> <p>pm [5] 93/13 93/15 157/21 157/23 190/15</p> <p>point [45] 10/6 13/22 19/23 30/7 48/15 54/16 54/17 56/6 61/23 66/12 70/6 72/23 73/7 81/5 83/3 86/19 86/22 86/25 88/1 88/3 89/14 93/11 93/20 94/8 94/10 107/14 121/9 122/14 122/18 122/22 123/4 125/25 128/13 134/18 141/9 145/13 150/17 152/22 153/5 166/15 168/14 169/22 170/10 172/18 188/21</p> <p>pointing [2] 96/14 96/19</p> <p>points [3] 44/25 89/15 171/14</p> <p>policies [11] 109/25 110/6 110/11 110/11 110/12 111/13 111/19 111/22 112/22 144/24 150/13</p> <p>policy [47] 3/9 6/2 6/5 8/7 9/18 24/20 26/8 26/18 26/18 26/25 27/1 36/11 37/22 52/12 52/12 55/18 60/16 61/4 82/9 84/15 101/14 101/22 102/3 102/24 103/1 106/15 107/5 108/20 110/7 110/9 110/15 110/18 110/19 110/22 111/25 112/9 112/11 112/15 112/22 112/24 114/22 126/25 127/1 127/7 138/24 143/22 145/3</p> <p>poor [1] 155/22</p> <p>poorer [1] 155/23</p> <p>poorest [1] 89/23</p> <p>poorly [3] 35/23 117/25 167/1</p> <p>population [15] 3/18 11/13 14/22 70/11 70/13 74/3 74/8 75/4 80/2 95/12 114/15 135/13 158/23 159/2 159/3</p> <p>position [16] 7/18 42/22 42/25 43/15 44/2 46/11 46/17 57/4 90/7 94/6 95/9 95/11 134/4 159/14 175/12 176/25</p> <p>positions [4] 113/24</p>	<p>146/14 146/16 161/12</p> <p>positive [5] 55/4 55/6 59/4 122/15 170/22</p> <p>positives [2] 76/18 185/13</p> <p>possibility [3] 34/24 56/3 68/10</p> <p>possible [17] 43/6 53/2 58/17 58/17 64/2 79/11 113/15 136/18 156/10 164/2 170/8 171/10 171/13 171/14 175/17 186/7 189/2</p> <p>possibly [4] 52/18 65/12 75/3 83/6</p> <p>post [7] 2/19 7/16 18/20 22/23 87/4 134/24 161/14</p> <p>post-Covid [1] 18/20</p> <p>post-pandemic [1] 7/16</p> <p>post-viral [2] 87/4 134/24</p> <p>posts [2] 146/17 146/21</p> <p>potential [8] 79/6 79/8 87/9 87/10 88/16 155/6 169/13 176/1</p> <p>potentially [5] 45/14 91/23 105/13 168/11 186/14</p> <p>poverty [2] 155/17 159/9</p> <p>power [3] 7/21 8/12 21/18</p> <p>powered [2] 47/4 47/10</p> <p>Powis [1] 25/10</p> <p>Powys [2] 57/24 57/25</p> <p>PPE [55] 16/24 18/1 18/4 39/22 40/17 40/21 41/8 41/16 41/18 42/20 43/1 43/25 44/22 45/9 45/21 46/7 47/17 48/11 48/16 50/16 54/12 61/24 62/2 62/11 62/11 62/15 62/23 62/25 80/7 80/19 117/22 117/25 117/25 118/6 118/10 118/24 120/2 120/15 120/19 121/8 149/6 149/9 151/16 165/5 165/12 169/9 169/24 170/14 170/16 171/1 172/9 172/11 172/14 172/16 181/3</p> <p>PPE equipment [1] 46/7</p> <p>practical [2] 67/9 145/14</p> <p>practically [1] 150/16</p>	<p>practice [17] 2/5 22/12 42/25 44/10 55/14 107/19 109/14 109/17 131/5 171/18 178/12 178/16 184/18 184/20 185/12 189/1 189/8</p> <p>practices [1] 145/3</p> <p>practise [1] 2/6</p> <p>pre [4] 23/6 150/4 151/4 164/6</p> <p>pre-existing [1] 23/6</p> <p>pre-pandemic [1] 164/6</p> <p>pre-symptomatic [2] 150/4 151/4</p> <p>precautionary [26] 36/14 36/17 36/20 36/24 37/6 37/8 37/11 37/14 37/24 38/5 38/15 46/15 46/20 47/1 47/3 47/6 47/7 47/12 115/18 115/25 116/4 116/13 116/21 151/5 151/22 151/23</p> <p>predates [1] 143/8</p> <p>predating [1] 2/16</p> <p>predecessor [1] 10/8</p> <p>predicted [1] 169/10</p> <p>predominantly [1] 22/15</p> <p>prefer [2] 1/16 1/17</p> <p>pregnant [4] 70/3 71/14 174/9 175/2</p> <p>preliminary [2] 30/2 125/16</p> <p>premises [1] 172/19</p> <p>preparation [1] 174/5</p> <p>prepare [1] 95/10</p> <p>preparedness [2] 113/16 181/2</p> <p>prescribed [1] 169/25</p> <p>present [4] 17/18 17/20 121/15 159/14</p> <p>presented [6] 24/17 90/1 90/22 120/21 155/12 170/4</p> <p>presenting [1] 186/14</p> <p>pressing [1] 30/21</p> <p>pressure [1] 163/8</p> <p>pressurised [1] 103/11</p> <p>prevalence [2] 55/7 125/18</p> <p>preventible [1] 144/25</p> <p>preventing [1] 67/1</p> <p>prevention [9] 38/18 52/20 61/2 142/14 161/17 169/3 179/18 184/7 184/8</p> <p>previous [6] 53/21</p>	<p>57/4 61/7 71/16 91/4 150/11</p> <p>previously [2] 31/7 111/12</p> <p>primarily [1] 35/6</p> <p>primary [11] 7/10 8/21 28/16 65/8 78/11 78/14 79/17 92/16 118/21 121/21 132/5</p> <p>prime [1] 65/16</p> <p>principal [1] 12/9</p> <p>principle [24] 36/14 36/17 36/20 36/24 37/7 37/9 37/11 37/14 37/24 38/5 38/9 38/15 46/15 47/1 47/3 47/6 115/18 115/25 116/2 116/4 116/13 116/21 151/22 151/23</p> <p>principles [4] 44/16 70/15 74/1 112/18</p> <p>prior [11] 10/12 13/12 13/14 29/18 31/4 56/6 61/5 62/9 88/14 101/13 160/18</p> <p>priorities [2] 56/15 60/8</p> <p>prioritisation [2] 93/19 94/15</p> <p>prioritise [1] 94/10</p> <p>prioritising [2] 69/2 101/7</p> <p>priority [6] 4/24 17/2 87/18 133/19 135/7 135/9</p> <p>private [2] 129/17 129/18</p> <p>probable [2] 53/25 57/7</p> <p>probably [13] 41/5 42/4 72/19 73/3 82/18 86/4 130/20 133/13 134/8 134/10 141/3 146/4 152/5</p> <p>problem [5] 47/2 54/6 78/15 97/22 98/2</p> <p>problematic [2] 98/15 104/4</p> <p>problems [7] 6/13 9/16 25/8 45/1 107/17 149/5 167/18</p> <p>procedure [2] 41/15 41/20</p> <p>procedures [2] 6/25 34/25</p> <p>Proceedings [1] 1/3</p> <p>process [18] 59/10 69/19 71/21 75/21 75/22 76/11 99/5 105/5 108/8 112/15 112/19 116/15 141/11 143/12 143/24 144/17 144/22 177/18</p> <p>processes [2] 69/16</p>
--	--	--	--	---

P	183/20	48/9 53/5 64/11 65/16 175/7 175/23 189/19	51/18 62/16 62/18 68/20 74/25 75/18 81/4 81/4 89/16 95/2 95/2 98/4 98/5 106/17 117/7 125/13 127/13 140/23 141/14 143/3 143/9 160/9 161/1 177/21	read [14] 10/5 28/23 32/13 32/14 61/16 98/20 99/1 103/1 119/16 128/12 128/14 136/17 136/20 182/21 reading [1] 64/4 real [8] 67/18 94/5 118/9 144/12 165/3 165/13 165/14 179/5
processes... [1] 110/22	protect [7] 60/15 60/24 80/7 91/21 138/11 170/16 179/17	purposed [1] 185/5 put [7] 21/12 26/15 51/24 79/15 97/22 128/16 151/15	quote [1] 185/4	realise [1] 143/21 realised [2] 23/19 35/5
processing [1] 143/4	protected [1] 141/23	putting [6] 47/10 84/4 91/24 129/13 154/22 172/8	R	realising [1] 184/11
produce [2] 94/13 136/16	protecting [1] 84/11	puzzled [1] 124/5	race [6] 144/17 144/17 144/18 144/21 145/6 147/1	reality [1] 128/18
produced [9] 22/3 42/15 90/10 94/18 95/7 95/14 106/6 134/12 136/20	protection [8] 74/23 138/25 139/15 169/23 169/24 170/4 170/23 171/3		racialised [1] 155/16	reallocation [1] 15/1
producing [1] 32/8	protective [4] 41/16 49/9 84/25 170/8		racism [1] 144/8	really [71] 22/22 23/7 24/9 24/15 25/11 38/6 44/17 45/6 50/6 52/5 55/23 63/25 64/3 70/15 75/18 81/4 88/24 89/13 89/14 89/16 91/5 106/21 109/19 109/22 114/2 114/9 114/25 117/7 117/8 117/16 121/4 125/5 132/6 136/13 136/14 136/20 141/12 141/14 143/12 143/18 151/12 151/22 152/22 152/23 156/21 161/16 162/20 163/22 167/13 168/8 168/13 168/24 169/25 172/2 174/1 174/16 175/22 176/16 176/17 176/21 177/3 177/14 178/18 180/7 181/8 181/15 184/8 187/12 187/17 187/18 190/11
profession [4] 6/22 6/23 10/25 146/15	protocols [1] 18/22	Q	raising [3] 62/16 121/2 188/25	reason [12] 50/15 60/1 103/20 112/8 116/23 116/24 117/17 121/21 121/24 129/17 148/10 189/3
professional [9] 2/1 43/3 45/18 51/11 62/16 114/6 134/20 162/8 189/17	proved [1] 67/11	QCovid [5] 72/6 72/7 75/25 76/1 76/2	ran [3] 118/12 118/14 118/23	reasonable [1] 20/15
professionally [1] 166/19	provide [22] 6/21 30/23 34/11 45/22 47/8 61/24 68/14 96/5 103/16 130/17 130/24 132/18 135/14 159/17 159/23 163/19 165/1 169/21 170/14 171/3 172/12 186/25	qualify [1] 71/24	range [8] 2/4 6/6 24/9 106/4 117/2 117/11 134/23 175/19	reasonably [1] 62/17
professionals [3] 14/1 14/3 101/15	provided [26] 1/20 3/22 5/5 5/21 10/14 31/12 34/19 35/21 35/25 41/24 45/16 48/1 50/1 53/15 63/5 80/20 83/23 83/24 88/17 95/9 130/15 132/21 138/25 140/21 151/16 157/1	quality [5] 46/12 46/18 84/17 92/4 180/17	ranging [1] 48/7	reasons [4] 111/9 133/4 136/5 158/1
Professor [17] 1/6 1/7 1/14 22/22 37/8 51/8 83/21 83/23 84/1 84/6 85/11 128/3 137/18 138/2 140/1 191/2 191/7	providers [1] 38/25	quarterly [1] 23/4	rapid [1] 160/6	reassurance [2] 45/25 103/17
Professor Helen [1] 83/21	providing [17] 3/8 6/8 7/10 33/14 36/2 45/8 45/25 69/6 86/23 131/20 132/24 138/15 138/19 156/24 157/13 163/22 164/17	question [61] 20/8 31/19 32/7 32/10 37/21 40/2 51/21 68/1 78/2 82/19 82/20 85/7 85/18 85/19 112/7 112/8 116/7 117/8 117/20 119/3 120/18 122/3 122/10 123/20 123/21 124/2 124/6 124/15 124/18 124/25 125/7 126/5 128/2 128/9 129/4 129/22 137/10 137/24 138/9 138/10 139/24 141/24 142/7 142/15 144/5 144/10 145/16 145/23 146/22 149/3 150/12 152/12 152/19 154/10 155/6 155/9 156/8 173/17 173/18 177/21 188/20	raising [3] 62/16 121/2 188/25	reassure [1] 187/17
Professor McBride [1] 137/18	provision [5] 62/7 139/4 139/16 152/3 156/19	questioning [3] 48/25 49/12 190/8	rapidly [5] 23/19 26/8 26/10 35/5 76/6	reassured [1] 111/1
Professor Snooks [2] 83/23 85/11	psychiatry [1] 179/15	questions [40] 1/8 5/4 62/16 115/3 115/8 115/10 115/13 130/1 130/5 130/9 132/7 135/20 135/22 139/18 139/22 139/25 140/4 142/8 146/6 147/11 147/13 149/14 149/16 152/9 152/11 157/7 158/9 176/4 182/3 182/11 191/3 191/4 191/5 191/6 191/7 191/8 191/9 191/10 191/12 191/14	rare [3] 46/8 71/11 109/11	rebuild [1] 181/21
Professor Snooks' [1] 84/1	psychological [4] 137/16 164/21 179/14 179/25	quick [1] 141/6	rather [18] 21/9 28/14 40/5 43/25 45/11 59/5 64/25 85/10 92/2 111/5 116/7 118/4 120/21 129/19 130/21 144/14 169/18 177/4	recall [21] 19/1 19/11 19/12 25/24 27/13 41/9 41/20 49/10 50/6 66/16 93/3 97/10 97/11 107/25 109/6 117/24 119/1 125/12 130/15 131/19 173/21
Professor Whitty [1] 22/22	psychologists [2] 179/22 180/2	quicker [1] 127/22	rate [2] 55/4 169/13	received [3] 27/16 34/16 70/14
professors [1] 128/13	public [31] 2/7 5/13 10/14 10/25 10/25 11/2 11/6 11/14 11/16 13/8 13/8 13/9 13/15 14/21 26/5 36/23 39/2 39/3 39/4 39/13 39/15 42/19 43/12 50/2 51/9 54/20 120/2 131/9 135/7 153/2 154/22	quickly [7] 37/18 77/8 118/11 127/7 127/13 150/22 170/5	rates [16] 57/9 57/17 58/5 63/19 63/22 64/1 64/6 64/9 64/18 83/2 128/9 128/18 128/19 140/14 169/11 183/18	
programme [19] 55/16 60/14 69/8 69/14 70/7 74/24 76/18 77/5 80/24 81/9 81/13 83/3 83/14 83/18 84/3 85/4 127/8 137/12 137/24	published [4] 73/1 101/19 132/12 137/19	quite [32] 14/11 14/12 19/24 24/16 25/11 39/10 41/2 46/9	Ray [3] 90/17 141/17 144/13	
programmes [1] 180/4	pubs [1] 160/14		re [2] 6/25 185/5	
progress [2] 21/22 188/9	pulled [1] 14/20		re-purposed [1] 185/5	
promotion [2] 146/6 146/12	pulling [2] 96/4 180/2		re-validation [1] 6/25	
prompt [1] 136/9	purely [3] 38/14 47/2 103/13		reach [2] 123/7 123/24	
prompts [1] 178/20	purpose [8] 33/17		reached [4] 94/8 94/10 95/10 125/11	
proper [1] 107/22				
properly [3] 54/11 108/10 172/17				
proposal [2] 44/1 55/11				
proposals [1] 73/25				
proposed [4] 43/5 55/9 61/14 68/25				
proposition [1]				

R	112/5 186/7	137/20 155/9 156/8	92/4 112/4 115/16	5/1 5/7 6/3 9/17 11/23
receiving [1] 27/23	reference [8] 19/3	156/11 188/25 189/4	115/19 128/3 128/12	12/8 12/12 15/12
recent [2] 7/15 159/6	34/10 53/11 62/8	relationship [6] 7/25	135/25 144/5 152/23	15/21 16/6 16/7 16/9
recently [5] 13/2 55/3	108/14 108/19 158/18	8/12 23/1 23/2 23/5	153/7 153/16 154/5	16/19 16/25 17/9
55/5 77/20 102/16	178/16	23/7	154/8 183/3 183/5	17/22 19/14 19/15
recipients [2] 71/10	referenced [1] 179/2	relationships [3]	183/17 183/19 188/21	25/16 25/17 25/20
107/4	references [1]	22/19 164/18 165/6	reported [7] 53/8	59/5 59/6 113/3 113/5
recognisable [1]	177/20	relative [3] 108/9	53/10 53/12 57/1	responses [1] 25/19
7/17	referred [10] 28/10	115/21 182/12	107/20 121/11 131/22	responsibilities [3]
recognise [8] 19/25	28/19 29/6 31/14	relatively [8] 13/2	reporting [4] 5/10	10/23 11/15 15/1
124/2 128/17 143/10	31/24 32/6 39/5 49/13	33/1 46/8 77/20 87/2	121/16 167/4 188/25	responsibility [4]
153/20 155/1 156/5	97/12 108/21	89/19 125/18 150/22	reports [5] 15/22	12/3 85/3 109/20
156/25	referring [4] 10/5	relatives [3] 104/6	90/22 107/10 108/24	135/12
recognised [7] 30/14	41/5 171/19 185/1	105/22 186/21	152/25	responsible [8] 6/24
33/22 46/22 54/18	refers [1] 19/24	relevance [1] 23/25	represent [6] 30/17	7/2 7/10 11/20 15/25
97/15 122/23 185/2	reflect [1] 186/12	relevant [4] 9/7 23/15	149/18 154/21 156/24	66/5 109/24 135/11
recognising [4] 74/8	reflected [1] 184/25	24/19 101/5	182/4 186/20	rest [8] 41/2 60/2
152/24 175/1 188/5	reflecting [2] 19/14	reliably [1] 124/12	representative [1]	80/1 113/15 139/13
recognition [4] 68/17	88/7	relied [1] 34/12	72/20	160/9 181/18 181/19
76/15 87/3 156/16	reflection [1] 67/20	relying [1] 28/23	representatives [3]	restarted [2] 83/3
recollection [4] 17/3	reflects [2] 63/24	remain [7] 10/16	82/13 82/13 82/14	154/16
17/13 50/14 121/18	116/25	21/20 23/8 43/15	represented [4] 48/6	restarting [1] 83/13
recommend [1]	reframed [1] 188/7	50/16 79/10 83/11	48/25 54/2 128/5	restaurant [1] 168/3
179/8	refs [1] 179/1	remained [3] 10/18	representing [4] 30/8	restaurants [1]
recommendation [3]	regard [4] 3/9 21/6	48/12 152/15	57/1 98/7 140/7	160/14
73/5 85/24 114/8	regarded [3] 98/10	remains [2] 84/20	Republic [2] 159/1	restore [1] 171/7
recommendations	121/2 122/24	104/19	161/19	restrictions [9] 86/18
[9] 39/22 40/11	regarding [2] 19/9	remember [32] 5/14	request [1] 49/6	152/15 160/3 161/9
48/12 92/3 113/7	120/7	14/11 19/2 27/1 48/17	requesting [1] 42/14	168/11 171/15 173/9
134/12 141/22 178/4	regardless [1]	50/18 50/21 55/21	requests [1] 157/16	174/4 174/8
180/19	125/10	66/5 72/17 74/4 75/8	required [8] 9/13	result [4] 72/5 116/2
recommended [3]	regime [1] 126/21	82/9 88/7 92/19 93/5	41/17 150/23 159/23	150/19 185/12
88/20 132/12 132/15	region [5] 76/23	94/2 114/22 127/16	162/4 162/18 163/19	resulted [1] 187/6
recommending [1]	160/9 160/25 161/2	130/19 138/5 139/7	188/17	results [2] 84/14
41/18	161/21	153/16 154/8 156/18	requires [1] 3/6	137/18
reconfigure [1] 68/2	regional [6] 161/25	173/19 173/20 173/24	research [2] 23/25	resume [1] 123/12
reconfiguring [1]	162/7 173/25 177/6	173/24 173/25 174/1	83/20	Resus [2] 42/22
67/10	179/24 185/14	174/4	researchers [1]	42/25
record [1] 111/7	regions [1] 111/6	remind [2] 58/25	84/18	resuscitation [14]
recording [2] 31/6	regular [5] 23/10	118/25	reset [1] 181/20	41/9 41/13 41/14
92/5	52/24 121/13 136/9	reminder [1] 107/25	residents [1] 160/13	41/17 42/16 43/7
records [4] 27/22	188/14	reminding [1] 153/6	resistant [1] 49/7	43/12 44/2 44/4 46/7
31/9 77/12 125/4	regularly [10] 17/16	remote [1] 156/14	resource [2] 14/15	46/11 46/17 101/12
recovery [2] 163/13	23/4 23/4 25/7 26/17	removing [2] 97/25	138/7	103/5
163/14	50/22 112/12 125/9	100/24	resourced [2] 13/22	resuscitation' [1]
recruit [3] 161/6	187/12 188/22	render [2] 70/18	14/17	102/21
161/24 181/22	reiterate [1] 113/9	97/25	resources [3] 12/3	retain [2] 3/6 181/22
recurrent [1] 65/8	reiteration [1] 64/3	reorganised [1]	146/23 181/10	retained [1] 129/5
red [2] 58/22 59/2	rejected [1] 81/16	77/21	respect [10] 111/6	retesting [1] 61/6
redacted [1] 14/20	rejecting [1] 42/19	repeat [1] 123/19	111/9 112/9 112/15	retired [3] 13/5 14/2
redactions [1]	relate [2] 93/17	repeated [3] 51/25	112/18 134/3 134/6	39/16
119/22	189/13	52/24 165/18	150/3 169/4 177/23	return [2] 50/22
redeployed [1]	related [7] 33/12 34/3	repeatedly [1] 109/23	respiratory [18] 35/6	157/20
153/25	62/13 62/14 84/23	repetitive [1] 180/22	35/13 41/16 47/4 49/9	revert [1] 116/1
reduce [12] 52/17	179/25 189/13	replacement [1] 13/6	68/18 68/19 69/25	review [7] 39/20
52/19 53/3 64/1 64/18	relating [3] 23/24	report [46] 2/20	71/11 116/3 129/8	47/24 62/11 109/18
64/19 65/17 65/17	138/10 189/15	16/15 17/19 19/8	129/10 149/1 163/9	110/3 111/22 112/3
87/15 142/16 146/1	relation [23] 3/17	20/10 20/12 20/24	163/11 163/12 163/24	reviewed [3] 48/16
185/18	3/21 11/14 25/15 41/8	22/3 35/22 55/8 56/17	187/22	187/23 189/11
reducing [4] 64/11	47/17 66/18 68/25	56/18 63/4 63/11	respond [1] 113/12	revised [1] 61/17
65/23 88/23 142/12	90/24 101/1 102/6	64/15 65/19 66/11	responded [1] 9/19	Richardson [3] 12/20
reductions [1] 84/8	107/11 108/15 108/25	66/20 66/21 66/24	responders [1] 22/6	14/1 42/13
refer [3] 110/14	133/17 136/1 136/8	67/6 67/7 83/23 84/2	responding [1] 64/5	right [70] 1/16 1/24
		86/1 86/1 90/9 90/12	response [26] 4/1	2/8 3/2 3/19 4/19 7/6

R	62/7 112/23	34/19 35/22	187/6	95/25 96/9 96/11 97/4
right... [63] 11/8	role [35] 2/12 3/1 3/5	said [24] 15/5 18/17	scenario [1] 172/2	103/1 106/23 108/2
12/15 12/23 15/5 15/9	3/6 3/14 6/17 6/20	38/23 45/21 52/22	scheme [1] 144/18	115/7 119/14 119/23
15/14 15/17 16/20	6/20 6/21 7/20 8/1	76/14 111/12 113/10	school [2] 83/11	120/4 120/9 128/12
17/12 18/23 19/13	10/13 10/15 16/14	115/16 121/16 122/5	143/15	141/4 148/7 148/17
21/13 22/4 27/19	17/15 18/3 18/8 22/12	122/6 122/12 123/6	science [3] 29/11	150/11 151/14 183/6
28/17 28/18 29/18	22/24 24/24 33/19	123/22 130/19 137/4	34/3 116/6	189/20
30/8 30/16 37/5 57/24	34/4 34/5 35/23 39/19	149/5 153/11 154/4	scientific [6] 4/18	see in [1] 55/2
58/22 69/11 69/14	39/20 40/1 45/17	157/10 180/23 182/22	16/22 27/7 27/24	seeing [3] 121/18
69/19 70/5 70/12 71/4	45/18 64/18 130/10	188/22	35/25 116/18	153/16 171/2
71/5 75/15 75/22	131/3 131/4 131/25	same [19] 10/18 14/9	scientists [1] 107/2	seek [1] 153/6
83/16 90/12 96/3 97/6	179/22	26/16 37/7 49/4 50/17	scope [1] 3/21	seem [1] 185/11
97/18 114/12 123/19	roles [4] 10/16 11/17	76/4 82/3 94/6 97/16	score [1] 98/8	seemed [2] 20/1
127/12 129/25 141/24	21/6 114/7	98/13 99/12 150/2	scoring [11] 97/5	44/13
143/11 147/10 148/16	roll [3] 55/13 126/20	153/2 153/25 157/10	97/10 97/14 97/19	seems [1] 44/15
149/13 156/3 157/6	127/11	164/16 168/1 170/24	98/2 98/17 99/7 99/7	seen [6] 32/12 34/19
158/16 162/24 171/15	roll-out [3] 55/13	Samia [1] 16/5	99/13 100/7 100/15	74/5 99/8 106/22
173/7 175/3 175/23	126/20 127/11	Samia	Scotia [3] 2/11 37/19	155/7
177/9 177/10 178/19	rolled [4] 126/19	Saeed-Edmonds [1]	37/21	segregate [1] 59/8
178/20 183/7 185/15	126/22 126/24 127/3	16/5	Scotland [4] 14/13	self [2] 147/4 154/23
187/25 188/5 188/5	rolling [2] 32/21 56/4	sanitisation [1]	39/4 111/7 128/7	self-care [1] 154/23
189/25	room [2] 167/23	168/10	screen [5] 15/19	self-isolating [1]
rightly [9] 7/14 11/17	167/25	SAS [1] 146/16	119/6 119/21 182/16	147/4
29/1 44/25 62/18	rooms [3] 67/10 69/3	sat [3] 170/1 172/24	182/19	Senedd [1] 118/2
129/14 136/11 154/6	183/23	189/10	screening [2] 76/17	Senedd's [1] 122/11
176/15	roughly [2] 51/23	satisfy [1] 44/18	82/16	senior [19] 6/23
rights [2] 81/18	87/21	saw [2] 35/17 65/19	screens [1] 91/24	13/24 23/12 23/14
149/17	round [1] 124/10	say [64] 5/24 7/14	scribble [1] 28/2	23/17 25/3 25/14 40/9
rigorous [1] 52/11	route [4] 9/16 42/23	8/13 11/18 12/15	scribbles [1] 32/13	49/22 94/20 97/13
rigorously [2] 52/15	47/24 67/25	14/15 15/2 20/19	scroll [1] 106/23	125/1 125/15 146/13
52/21	routes [2] 115/22	20/20 20/23 24/10	seat [1] 146/10	171/11 178/25 179/22
rise [5] 58/9 69/21	150/3	26/9 26/23 28/8 30/20	second [27] 13/2	187/19 189/17
70/4 73/20 152/21	routine [5] 56/4	41/3 44/22 45/12 47/8	27/10 31/21 31/22	sense [4] 26/21
risen [1] 53/20	126/14 126/16 148/23	47/13 51/3 58/20 59/5	34/18 40/1 40/5 53/23	169/8 170/6 184/22
rising [1] 57/14	148/24	60/21 62/15 65/5	58/20 72/25 73/4	sensible [2] 44/13
risk [37] 46/2 46/14	routinely [2] 63/19	66/14 74/1 85/15	75/25 80/2 80/16	83/8
46/20 47/11 66/6	174/20	86/13 87/1 87/12	83/10 87/22 107/24	sensibly [1] 98/20
70/16 71/12 72/14	Royal [4] 120/7	87/20 87/21 88/24	114/3 114/9 120/9	sent [10] 28/12 41/7
73/2 74/20 74/23	121/12 170/19 170/21	100/14 103/12 103/19	144/5 154/10 166/7	49/16 78/25 79/1
79/12 80/8 80/12	RP [1] 41/18	104/18 112/11 114/24	181/1 182/13 185/8	105/8 106/10 119/10
80/25 81/1 90/18	RPE [2] 49/8 149/6	117/5 117/24 118/11	186/19	119/25 120/24
92/21 93/2 96/13	rule [1] 151/3	118/18 122/17 128/4	second-guess [1]	sentence [3] 61/16
99/16 115/22 117/16	ruled [1] 150/6	131/7 141/3 145/17	40/1	63/18 63/23
120/21 141/8 142/25	rumbings [1] 62/15	148/24 153/20 153/22	second-guessing [1]	sentences [1] 56/22
145/8 149/23 151/8	run [3] 58/10 60/14	154/6 157/10 160/2	40/5	separate [2] 6/1
155/15 155/23 168/22	118/10	160/17 166/4 167/16	secondary [6] 7/10	19/20
169/1 170/7 171/16	running [5] 6/12 17/4	169/15 176/15 180/22	16/12 16/14 17/6	separation [1] 3/7
173/16 185/2	118/10 119/2 120/20	182/6 188/24	17/15 78/13	September [9] 1/1
risk-assessed [1]	rural [1] 159/3	saying [13] 38/11	secondly [3] 3/21	63/5 65/20 72/5 73/4
46/2	Ruth [1] 10/8	64/23 99/16 99/18	67/2 148/19	73/9 87/21 124/11
risking [1] 120/16	S	100/18 105/16 119/25	seconds [1] 80/4	190/17
risks [9] 59/3 74/25	Saeed [1] 16/5	121/17 121/21 138/23	Secretary [1] 26/24	September/October
91/2 92/24 116/6	safe [8] 172/3 172/8	138/24 155/18 189/21	sector [2] 18/1	[1] 87/21
116/10 141/21 145/7	172/21 173/7 173/15	says [11] 42/17 43/3	131/10	September/October/
173/14	174/13 174/15 186/6	43/20 61/17 63/18	sector's [1] 25/16	November 2020 [1]
river [3] 14/6 29/6	safely [3] 172/1	118/25 119/12 120/6	securing [1] 163/17	124/11
153/17	172/15 172/18	120/11 120/13 183/9	security [2] 39/4	sequelae [1] 87/24
Rob [4] 29/10 30/7	safety [4] 169/19	scale [7] 96/15 97/4	178/6	serious [2] 70/19
30/16 33/3	169/19 170/12 180/16	97/24 99/10 99/11	see [38] 7/5 12/9	84/12
Rob Orford [4] 29/10	SAGE [13] 27/16	102/19 102/25	16/7 16/11 19/22	seriously [2] 70/2
30/7 30/16 33/3	27/18 28/20 29/5	Scale ... could [1]	31/16 35/14 46/24	181/21
Robert [2] 4/17 4/17	29/11 29/19 29/20	102/19	54/9 55/2 56/21 57/8	servants [2] 27/3
robust [4] 49/2 61/24	29/24 30/3 30/9 32/1	scans [1] 174/19	57/18 57/19 58/8	33/5
		scarcity [2] 187/2	59/22 61/19 63/14	serves [2] 158/23

S	shielding [35] 69/8 69/11 70/6 73/7 74/12 74/24 75/13 77/5 78/24 80/7 80/23 81/9 81/19 81/21 82/3 82/24 83/3 83/12 83/13 83/18 83/19 84/2 84/9 84/15 84/18 84/24 84/24 85/4 85/8 85/16 137/11 137/14 137/16 137/21 137/23	signing [1] 103/11 signposted [2] 106/14 107/5 Simblet [4] 147/9 147/11 149/12 191/8 similar [3] 26/11 55/4 107/14 Similarly [2] 131/22 132/13 simpler [1] 78/3 simply [4] 43/7 70/9 99/25 186/22 since [3] 2/16 20/19 178/15 Singh [1] 141/17 Singh's [2] 90/17 144/13 single [8] 7/7 15/6 15/7 69/3 178/23 178/25 183/23 189/11 Sir [15] 1/6 1/7 1/9 1/15 2/25 22/23 23/18 25/10 37/8 38/10 72/7 74/1 86/12 138/3 191/2 Sir Chris [7] 22/23 23/18 37/8 38/10 72/7 74/1 86/12 Sir Frank [5] 1/6 1/7 1/9 1/15 191/2 Sir Michael [1] 138/3 sit [1] 167/23 sits [2] 38/13 111/17 sitting [2] 139/21 174/3 situated [1] 15/21 situation [6] 12/25 45/13 46/2 120/1 127/23 144/3 situations [1] 165/10 six [1] 159/7 size [3] 20/14 20/15 57/21 sizes [1] 117/14 skilled [2] 10/19 162/8 skills [2] 114/6 180/3 slight [1] 57/4 slightly [9] 24/7 29/1 31/18 33/12 36/18 72/11 111/11 164/13 173/18 slow [2] 161/7 164/2 small [8] 20/14 33/1 117/5 152/5 159/4 182/20 184/9 186/8 smaller [1] 114/15 smoothly [1] 26/5 Snooks [3] 83/21 83/23 85/11 Snooks' [2] 84/1 84/6 so [277] So this [1] 120/24 soap [1] 80/4	social [41] 2/21 3/23 4/5 4/5 4/16 4/24 5/8 6/10 9/8 9/19 15/11 15/14 15/25 16/2 16/9 18/7 20/3 21/5 38/25 39/2 51/10 53/8 70/10 70/22 70/24 79/8 80/21 82/9 89/1 92/5 118/3 118/16 118/22 122/11 131/10 137/15 149/19 158/12 159/6 159/13 167/24 societal [1] 146/23 society [10] 79/11 88/13 89/9 94/17 95/7 101/4 152/24 165/9 167/10 170/11 socio [6] 86/17 89/13 89/18 90/7 147/1 155/22 socio-economic [6] 86/17 89/13 89/18 90/7 147/1 155/22 sole [1] 103/20 solely [1] 108/16 solid [1] 71/9 solution [1] 26/14 solve [2] 9/16 91/7 some [89] 7/5 11/16 14/19 16/18 17/25 21/3 23/25 26/12 26/12 26/19 32/13 55/23 58/5 59/2 62/20 65/12 70/1 73/18 74/25 76/15 76/16 79/19 81/1 81/20 83/20 84/20 85/3 85/16 90/20 90/23 91/8 91/11 91/11 93/20 94/7 94/21 94/24 103/10 103/16 108/25 111/19 112/16 112/16 112/23 113/9 113/16 114/21 118/4 119/21 125/24 126/23 127/12 131/15 135/4 137/4 143/4 143/5 154/23 159/17 159/25 160/6 160/8 160/11 160/15 161/14 162/6 162/22 163/7 163/10 165/23 167/3 167/6 167/9 168/11 169/9 170/23 173/1 174/5 175/14 175/22 176/5 176/8 176/23 177/13 177/15 179/23 181/4 185/25 186/4 somebody [4] 45/7 117/15 117/15 123/14 someone [2] 122/15 172/23 something [21] 20/18 24/18 27/2 44/6	52/24 76/23 78/8 80/19 85/6 99/21 105/13 109/8 111/11 121/23 131/16 136/14 146/24 153/13 153/18 157/2 181/12 sometimes [10] 26/6 26/8 29/4 36/19 105/23 116/22 146/25 186/3 188/6 188/6 somewhat [1] 155/4 somewhere [3] 38/4 59/21 107/19 soon [1] 168/9 sorry [17] 21/15 46/16 50/18 58/24 64/17 69/15 82/13 92/19 95/24 112/7 117/8 121/4 129/24 156/4 158/6 178/1 183/1 sort [2] 90/5 110/3 sorts [6] 114/1 114/2 152/25 161/18 172/22 176/8 sought [2] 131/23 153/10 sounds [1] 15/17 source [5] 28/16 32/16 51/4 51/13 153/4 sources [3] 27/6 34/17 51/19 sovereign [1] 21/23 space [4] 67/3 68/3 79/19 187/14 spaces [4] 139/1 139/1 163/14 185/6 spacing [1] 151/17 spare [1] 113/25 spates [1] 29/7 speak [2] 188/10 188/11 speaking [1] 181/5 specialist [5] 2/6 58/11 59/10 133/11 134/18 specialists [1] 133/6 specific [41] 19/11 25/8 25/12 25/24 33/24 34/1 40/23 70/18 71/10 72/1 72/4 74/3 74/6 77/25 78/9 78/21 89/19 90/25 91/5 91/6 91/16 108/14 108/25 117/24 119/1 131/16 131/25 132/13 132/17 137/23 141/18 141/20 142/6 142/23 143/5 152/22 153/4 154/8 154/14 155/6 177/19 specifically [9] 33/18 59/9 68/25 92/2
----------	--	--	---	--

S	161/22	88/2 99/9 123/1 123/7 123/24 133/7 141/9 167/12 167/12 167/13 167/21 167/24 167/25 184/13	90/17 130/14 130/16 141/20 183/16 subgroups [3] 12/11 16/7 16/18 subject [1] 50/3 subjective [1] 98/10 subjects [1] 182/11 subsequent [1] 81/3 subsequently [13] 18/5 20/20 30/5 39/17 40/8 71/6 109/10 114/16 118/22 126/6 141/1 142/18 142/20	35/21 summer [2] 59/24 81/10 supersedes [1] 116/16 supplied [1] 147/14 supplies [6] 18/1 79/18 80/19 118/4 120/21 127/5 supply [9] 16/24 18/5 118/6 119/3 120/16 122/3 149/5 151/10 169/18 support [46] 10/14 13/11 13/19 13/20 43/16 47/12 66/4 66/8 69/7 77/21 79/15 80/3 85/20 85/22 89/25 131/23 131/24 132/25 134/22 138/18 143/14 143/15 143/15 143/19 147/3 147/25 153/10 153/12 156/19 156/22 156/24 171/12 172/8 172/12 172/23 174/23 176/24 177/11 178/7 178/18 179/5 179/9 179/11 179/13 180/10 186/25 supported [4] 85/17 86/5 163/23 176/22 supporting [2] 162/3 175/24 supportive [2] 91/15 173/11 suppose [11] 19/23 152/25 159/16 160/2 166/16 171/19 179/15 185/15 186/3 186/7 189/10 supposed [1] 58/14 sure [35] 5/25 19/24 21/7 25/25 32/12 50/6 52/14 53/11 62/21 67/8 79/13 94/9 101/10 106/21 113/10 114/5 114/19 123/20 133/12 134/25 135/14 137/5 137/7 139/22 141/11 145/13 152/10 172/14 172/16 172/25 178/22 179/5 183/8 188/3 189/25 surge [9] 160/4 162/15 165/2 165/14 166/6 171/24 181/20 181/20 185/6 surges [3] 160/10 165/2 165/18 surgical [5] 49/7 69/6 138/16 138/25 139/16 surmise [1] 61/19 surprise [1] 19/2 surprised [1] 131/14
specifically... [5] 107/13 111/5 141/21 142/4 189/14 specificity [1] 144/15 specified [7] 40/22 47/17 62/11 62/12 62/23 63/1 69/24 specifying [1] 49/8 speed [2] 9/15 127/10 spent [1] 23/1 spike [2] 59/23 60/2 spikes [1] 160/10 spirit [2] 182/6 186/6 spite [1] 189/3 splendid [1] 85/23 spoken [5] 24/24 43/20 85/16 137/4 137/5 Sport [2] 118/3 122/11 spotlight [1] 158/1 spread [2] 67/23 167/3 staff [76] 3/5 44/23 46/1 54/12 54/14 54/19 54/19 54/20 55/3 55/6 55/9 55/10 59/18 65/11 65/12 110/24 110/25 113/23 125/2 151/16 159/20 159/24 160/5 160/20 161/16 162/1 162/1 162/8 162/20 163/4 163/5 163/15 164/22 164/25 165/4 165/10 165/23 165/24 165/24 166/12 166/15 166/17 166/24 167/8 167/14 167/15 167/20 167/22 167/23 168/1 168/21 170/12 170/16 171/3 171/5 172/11 173/2 173/11 175/22 179/12 179/18 180/10 180/12 180/13 181/16 181/16 181/18 181/18 181/22 184/23 185/2 185/9 185/13 186/6 186/8 186/16 staffed [1] 167/1 staffing [4] 160/16 160/18 168/20 172/22 stage [8] 5/7 30/13 36/14 55/24 73/18 116/9 149/22 188/16 stages [6] 29/17 34/17 118/6 169/17 173/21 185/3 stance [1] 125/8 standard [1] 164/25 standing [2] 161/5	standoff [1] 43/11 start [13] 2/24 87/6 114/12 142/19 148/7 151/20 161/4 162/10 170/9 171/1 171/19 175/16 183/7 started [7] 123/5 124/13 140/23 148/17 151/14 154/15 171/21 starting [6] 70/6 87/23 122/23 141/4 150/18 150/19 state [5] 26/24 27/13 31/17 153/14 185/2 stated [2] 86/3 130/14 statement [43] 3/4 4/11 9/24 17/7 17/14 18/17 27/10 27/12 28/8 31/3 31/12 31/21 31/22 32/8 34/19 38/22 42/5 42/15 47/20 51/3 56/17 65/5 66/15 70/21 76/22 85/10 86/10 106/13 117/23 118/11 123/2 131/4 134/2 142/10 142/22 152/13 158/18 160/17 169/15 184/21 185/2 185/4 186/23 statements [6] 1/20 1/23 147/15 147/16 149/21 150/12 states [2] 54/9 115/19 statistics [4] 92/12 92/15 128/21 159/6 status [4] 58/23 89/18 95/22 147/1 statutory [2] 21/14 146/25 stay [2] 54/7 164/8 stays [1] 164/5 steer [1] 82/17 stenographer [1] 164/3 step [1] 160/9 Stephen [1] 25/10 Stephen Powis [1] 25/10 stepped [1] 18/3 steps [26] 67/12 67/21 68/24 77/16 79/12 79/13 90/25 92/2 92/8 92/17 110/15 131/25 133/16 134/1 134/3 134/5 141/8 142/1 142/2 154/11 154/14 155/20 156/9 185/18 185/20 185/20 still [20] 39/15 45/13 49/2 49/7 62/15 81/4	stipulated [3] 40/17 52/1 52/3 stock [3] 117/22 118/20 121/22 stocks [5] 18/4 118/10 118/13 118/14 118/15 stood [5] 48/8 65/4 65/21 66/12 166/19 stop [7] 35/7 52/9 87/17 87/17 121/4 123/10 123/14 stopped [1] 168/9 stops [1] 47/7 stories [1] 87/23 storm [1] 177/5 straitened [1] 89/16 strategic [1] 106/7 strategies [2] 24/3 26/4 strategy [4] 61/17 161/5 184/7 190/1 stream [2] 161/7 180/6 strength [2] 36/4 36/9 strengthen [1] 77/15 Strengthening [1] 114/24 strengths [1] 20/14 stress [3] 122/13 165/17 179/19 stressed [1] 180/14 strictly [1] 79/4 stringent [1] 70/24 stringently [1] 70/10 strong [4] 134/19 134/20 141/16 188/12 stronger [1] 20/22 struck [3] 22/25 23/7 169/9 structural [1] 144/7 structure [4] 12/7 15/20 19/15 19/17 structured [1] 14/14 struggle [1] 143/18 studied [1] 2/3 studies [2] 84/21 140/19 study [2] 125/4 125/16 stuff [1] 179/4 style [1] 4/21 subconscious [1] 187/6 subconsultant [1] 146/17 subgroup [10] 17/8 17/16 18/25 89/1 89/2	Sue [2] 49/23 109/9 Sue Tranka [1] 109/9 suffer [3] 70/19 134/23 146/2 suffered [4] 45/3 153/24 153/25 184/4 sufferers [1] 132/2 suffering [1] 151/14 sufficient [3] 67/21 113/17 126/2 sufficiently [1] 136/8 suggest [3] 50/9 66/2 116/1 suggested [7] 42/20 44/12 49/24 116/2 139/6 142/17 170/21 suggesting [1] 139/7 suggestion [3] 100/19 100/23 139/7 suggests [1] 54/11 suit [1] 47/10 suitability [2] 40/17 149/6 suitable [1] 39/22 suite [3] 106/5 112/25 151/24 summaries [2] 30/24 32/16 summarise [2] 29/13 29/15 summarised [4] 27/18 34/13 38/10 42/5 summarising [1] 33/6 summary [6] 28/14 28/24 29/2 29/2 29/3	

S	tab 37 [1] 100/11 tab 41 [1] 102/11 tab 44 [1] 80/14 tab 46 [1] 95/19 tab 51 [2] 42/1 42/7 tab 7 [2] 182/17 182/23 table [2] 146/11 175/19 TAC [9] 29/1 29/13 30/23 30/24 30/25 32/16 34/13 88/4 88/20 tackling [1] 88/22 tactical [1] 88/11 take [31] 14/22 15/8 21/19 29/17 32/19 37/15 42/3 43/22 48/13 55/15 63/3 63/16 79/12 81/7 83/1 92/4 96/12 102/24 104/7 105/7 117/17 117/18 131/25 156/10 163/8 172/13 172/16 172/18 185/17 185/19 186/3 taken [29] 4/1 13/13 22/23 67/22 68/24 77/16 81/21 86/12 91/1 92/17 95/3 108/14 110/15 112/20 122/8 133/2 133/14 133/16 134/1 134/3 134/6 138/11 141/8 142/1 142/2 151/5 154/11 156/9 184/23 taking [8] 2/11 37/9 46/20 99/11 117/2 117/4 117/11 140/4 talented [1] 90/14 talk [12] 6/5 17/22 26/1 30/20 89/11 114/1 146/12 151/25 176/14 177/2 187/9 187/9 talked [11] 24/14 91/19 92/11 110/21 114/13 114/13 114/22 117/10 136/19 181/2 187/11 talking [3] 36/5 64/10 78/12 targeted [1] 106/20 task [1] 64/17 taxi [5] 89/18 91/19 91/19 91/24 142/25 tea [2] 167/23 167/25 team [18] 11/23 12/8 12/12 12/14 40/4 90/2 90/13 136/15 155/13 161/17 161/18 163/17 164/16 174/5 178/7 180/1 180/2 184/9 teams [1] 157/14	technical [27] 16/19 27/16 28/20 29/2 29/13 31/4 32/1 32/20 32/24 32/25 33/7 33/17 34/5 34/6 34/14 34/16 35/20 66/20 66/21 75/19 76/11 89/1 130/22 132/14 132/20 135/25 152/23 technically [1] 30/9 technicians [1] 163/17 technology [1] 156/19 tell [13] 21/15 30/6 33/2 60/20 61/16 109/16 131/18 154/14 157/14 158/21 164/23 174/7 179/12 telling [1] 159/6 template [2] 172/25 178/17 temporary [3] 161/11 161/14 161/15 ten [4] 61/6 162/13 162/13 164/10 tenable [2] 148/18 148/20 tend [2] 59/14 115/25 tension [4] 168/17 170/25 171/4 185/22 tenure [1] 158/14 term [9] 20/23 36/18 71/25 74/10 82/7 87/9 87/24 103/19 135/6 terminally [1] 96/16 terminology [2] 74/11 151/6 terms [83] 5/19 9/3 11/22 13/21 13/23 17/6 19/3 21/7 25/20 31/12 34/9 35/9 35/10 36/23 45/17 53/11 57/21 68/7 68/9 77/10 79/8 79/16 85/7 86/3 86/4 86/23 90/7 92/15 111/8 122/4 126/9 127/11 135/10 140/25 142/4 143/21 144/22 145/3 146/17 149/20 151/24 159/12 160/10 160/11 160/25 161/19 162/15 163/8 163/22 163/23 165/4 165/5 165/15 167/1 167/16 167/21 168/12 171/1 172/8 173/12 174/17 175/7 175/11 175/18 175/19 176/5 176/13 176/14 177/7 179/18 180/9 180/12 184/3 184/15 185/22 185/23 186/8 187/11 187/24 188/3 188/8 188/8	188/13 terribly [1] 32/15 test [6] 60/15 60/24 122/15 125/5 151/20 186/8 tested [3] 55/11 59/11 178/25 testing [60] 24/2 26/3 26/3 55/4 55/10 55/18 55/20 56/1 56/1 56/5 56/5 60/9 60/11 60/13 60/14 60/17 60/17 60/18 60/18 61/1 61/5 61/13 61/17 61/18 67/2 122/10 122/14 122/18 123/4 123/21 124/3 124/7 124/8 124/10 124/13 124/19 125/9 125/24 126/2 126/10 126/14 126/16 126/18 127/11 128/15 139/10 150/9 150/14 150/14 150/15 150/19 150/20 150/21 151/9 151/19 152/5 162/5 185/11 185/14 186/9 tests [2] 55/25 56/6 text [1] 105/19 than [36] 13/18 21/9 28/14 38/14 40/3 40/5 43/25 45/11 57/10 59/6 61/16 62/25 64/25 72/11 77/8 80/1 92/2 99/15 111/5 113/22 114/16 116/5 118/4 120/21 126/24 129/19 130/7 130/21 144/15 144/22 159/7 161/20 169/19 177/4 183/23 185/12 thank [108] 1/10 1/18 1/19 1/25 4/9 4/12 5/18 6/15 9/2 11/21 11/24 12/1 19/13 27/5 32/7 32/9 32/18 32/19 38/17 42/8 48/13 53/6 55/15 61/21 63/3 65/3 66/17 73/13 73/16 78/23 79/20 80/15 81/6 81/7 83/16 85/5 86/6 88/6 88/9 92/20 93/10 96/8 102/5 102/13 103/6 103/25 104/17 106/9 107/7 112/6 113/1 115/2 115/4 115/7 117/19 118/8 118/25 119/20 121/10 121/10 122/9 123/3 124/5 124/24 126/3 126/12 128/22 129/23 133/15 135/16 135/17 135/18 137/10 138/10 139/17 139/19 140/2 140/6 140/17	142/9 144/4 147/6 147/7 147/8 149/2 149/10 149/11 149/12 149/15 152/6 152/7 154/9 155/2 157/4 157/5 157/9 157/17 157/19 158/8 164/1 181/24 182/1 184/19 186/18 190/3 190/7 190/10 190/13 thankfully [2] 170/5 177/16 that [1275] that's [94] 1/17 1/21 2/9 2/14 3/3 4/10 4/20 12/24 13/21 15/10 15/14 15/21 17/3 17/13 20/8 20/18 22/18 28/18 29/10 29/23 29/23 31/3 31/23 36/24 37/13 40/10 42/19 45/10 45/16 46/3 47/9 48/21 49/2 49/15 50/12 52/22 58/2 60/4 61/19 66/20 70/5 78/2 78/21 78/22 84/5 91/14 92/14 93/11 96/9 99/18 105/18 107/24 109/14 109/21 112/12 113/13 114/7 114/20 116/18 120/4 120/13 121/11 122/5 122/5 122/12 125/23 133/14 133/19 134/7 135/1 140/20 141/4 144/22 145/18 146/12 146/16 146/21 152/4 156/25 161/21 164/1 172/23 173/4 176/20 178/21 179/21 180/11 180/25 181/25 182/22 182/24 183/9 183/11 190/5 theatre [4] 163/14 163/15 165/24 185/6 their [57] 7/4 7/11 8/21 8/22 21/24 21/24 40/11 50/15 54/7 55/4 57/22 58/23 59/7 64/25 65/1 68/5 78/19 79/2 80/3 80/9 88/15 91/17 98/12 98/14 99/24 99/25 100/4 105/24 106/2 106/3 108/4 109/25 110/10 110/11 110/25 111/18 115/13 118/21 135/13 146/17 147/1 147/1 147/1 149/19 153/12 155/9 166/18 170/17 174/17 175/2 176/20 177/15 179/7 179/13 186/21 186/21 186/22 them [63] 6/6 8/9
T	tab [20] 42/1 42/6 42/7 50/7 53/17 56/11 56/12 56/13 63/9 80/13 80/14 84/4 90/4 95/19 100/11 102/11 119/15 119/18 182/17 182/23 tab 12 [3] 56/11 56/12 56/13 tab 13 [1] 53/17 tab 20 [1] 90/4			

T	185/22 185/23	47/7 49/5 60/14 79/10	125/12 125/12 127/16	56/19 70/12 110/14
them... [61] 9/15 21/8	therefore [2] 28/14	85/23 89/6 97/20	129/3 130/5 130/11	162/14 164/8 186/13
32/13 32/13 32/14	41/16	98/10 99/6 114/3	135/3 136/12 136/15	thresholds [1] 187/7
32/15 39/25 39/25	these [36] 5/21 24/13	127/20 136/24 145/3	138/14 141/8 141/16	through [65] 4/5 5/10
40/1 40/9 53/11 66/8	25/14 28/9 31/5 31/6	145/12 145/18 175/24	143/8 143/21 144/12	9/17 22/15 25/4 29/21
68/4 68/15 69/7 70/18	31/10 46/7 54/1 58/19	177/9 178/19 178/20	149/24 150/8 150/25	30/24 32/11 35/14
72/24 73/10 75/1 75/8	65/8 70/8 74/13 79/14	190/1	152/12 154/10 154/12	39/13 46/23 53/12
75/20 75/20 76/20	84/3 84/14 86/12	things [35] 20/25	156/1 156/2 158/7	60/14 68/1 68/3 68/18
79/2 80/9 81/24 83/7	89/21 99/14 104/23	31/11 36/21 36/22	160/17 162/25 163/1	69/19 73/4 77/22
88/7 91/21 93/5 96/7	106/8 109/8 109/11	52/4 62/21 66/2 66/9	164/4 164/9 164/16	80/20 82/17 85/19
96/18 101/10 110/24	109/17 119/16 132/6	79/19 88/24 99/14	164/24 165/3 166/4	85/22 88/4 88/5 88/20
114/5 118/20 131/25	142/12 142/16 144/10	106/4 113/9 114/1	169/15 169/22 170/10	89/22 92/13 94/20
136/4 136/14 137/8	145/1 146/8 153/3	114/2 115/1 116/23	172/2 176/1 177/19	103/1 108/6 111/2
137/24 138/18 140/5	165/20 165/23 177/7	116/24 127/14 137/15	177/20 178/24 179/10	115/12 116/20 122/2
142/22 143/19 146/10	179/1	143/5 143/19 146/8	182/19 183/3 184/2	127/8 129/16 130/20
146/16 146/20 150/9	they [133] 4/2 4/4 5/9	147/4 153/1 165/8	185/4 187/3 189/2	130/21 131/5 131/13
153/11 163/15 168/5	8/10 8/16 8/20 14/23	165/16 165/16 168/5	this approved [1]	133/22 139/16 140/22
168/5 168/22 168/24	21/8 22/21 27/1 34/7	168/5 180/22 181/3	100/7	154/23 154/23 156/2
174/3 174/15 176/6	34/13 40/14 43/18	181/5 184/17 189/9	Thomas [9] 139/20	156/15 161/7 161/25
181/22 181/23 185/5	44/11 44/25 46/1 46/1	think [347]	139/21 139/23 140/1	168/19 168/19 169/8
themselves [5] 6/7	46/20 48/21 49/20	think -- I [1] 21/25	140/17 146/15 147/8	172/7 172/7 172/24
91/21 108/4 159/24	57/10 57/14 59/7	thinking [15] 38/7	155/4 191/7	174/3 174/25 177/15
165/11	59/11 62/13 64/16	38/8 48/24 70/15 74/7	those [119] 1/23 1/24	177/18 184/6 187/1
then [70] 2/6 2/7 2/25	64/21 64/21 65/1 68/5	74/9 94/7 113/19	5/12 5/17 5/25 7/19	188/24 189/12 189/19
7/25 9/14 12/11 17/6	68/13 69/6 70/15	113/25 126/9 135/1	8/6 8/14 9/4 9/10 9/23	throughout [8] 8/14
19/14 29/14 30/4 30/5	70/20 72/14 72/18	139/14 144/17 151/12	16/10 16/18 17/18	17/5 36/16 51/17
30/6 30/18 30/22 38/2	73/7 73/12 74/19	160/21	17/19 23/14 23/16	63/12 89/7 101/13
40/8 43/19 44/23	74/21 76/13 76/19	third [3] 108/12	27/11 28/4 28/23	121/14
45/25 46/3 47/23	76/19 78/18 80/4 80/5	120/10 153/8	30/23 31/6 32/6 32/11	thrown [1] 181/7
52/23 55/2 55/16 57/5	81/2 85/17 85/25	thirdly [1] 67/3	32/11 32/17 34/10	Thursday's [1] 49/21
61/10 69/23 70/16	89/25 91/21 94/15	this [160] 1/20 3/22	34/11 35/9 35/10	tick [1] 96/18
71/6 72/25 74/11	95/5 98/23 99/21	4/21 4/25 5/7 6/3	38/13 40/8 40/18 41/4	tight [1] 187/18
74/14 75/11 75/19	100/23 104/3 105/17	11/25 12/7 15/18	52/4 54/4 54/21 57/12	time [68] 7/17 11/11
75/24 76/2 85/23 87/8	106/3 110/8 114/5	16/20 17/15 19/24	59/15 62/20 67/5	11/12 14/6 14/9 14/18
89/6 96/15 96/16	116/11 124/16 127/8	20/9 21/1 21/14 24/24	67/11 67/22 68/6 69/2	19/23 19/23 23/2
96/23 97/1 100/17	128/4 128/16 131/22	27/10 29/6 32/8 40/1	69/6 69/21 69/22	28/11 28/23 28/25
104/2 108/24 123/4	131/23 134/11 134/12	41/24 42/12 42/23	69/23 70/2 70/9 70/24	31/16 35/2 41/11 42/3
123/6 125/4 125/23	135/14 136/10 138/4	43/4 43/8 43/11 43/21	72/21 73/22 75/12	54/17 55/17 58/19
129/16 138/10 141/20	138/12 138/17 139/13	43/21 45/1 45/6 47/18	75/19 76/6 76/10 77/1	59/2 59/13 60/10 65/6
142/19 143/21 145/11	141/23 143/16 143/17	47/20 48/3 48/25	77/3 77/15 77/25	65/20 68/4 72/17
150/8 150/20 150/21	145/7 145/8 146/2	49/16 49/18 53/17	82/25 84/18 85/1	72/25 73/4 74/5 80/21
155/23 157/16 165/17	150/5 151/18 153/10	53/18 53/19 55/23	85/22 86/14 90/24	82/3 87/23 97/9
168/16 168/18 168/23	157/17 160/6 161/21	56/10 56/18 57/6	91/2 93/18 93/23	103/22 107/9 108/3
174/16 180/18 181/20	162/2 164/25 165/1	57/16 58/19 58/25	94/15 107/4 108/1	108/13 121/5 123/1
181/22 185/8	165/4 165/7 165/11	59/2 60/4 60/7 60/10	108/21 108/22 110/14	123/16 124/3 124/19
theoretical [1] 116/7	165/24 165/25 166/19	60/22 61/14 62/8 62/9	113/24 114/13 114/14	124/20 125/11 125/22
therapies [2] 71/13	166/20 166/20 166/21	63/9 63/11 64/9 64/23	114/18 114/24 114/25	126/1 126/19 127/17
107/1	168/1 168/3 168/13	66/23 68/17 73/8	118/16 126/9 127/25	130/7 138/5 138/7
there [325]	168/14 168/21 170/4	74/16 78/25 79/7 79/9	131/11 131/14 133/10	139/5 150/2 153/21
there's [45] 9/13 13/3	170/24 173/13 173/13	79/22 81/3 83/23 84/6	134/25 135/12 135/15	156/12 164/14 164/24
13/5 15/5 16/19 16/24	174/2 174/6 174/12	84/19 87/8 88/12	136/8 136/11 137/13	166/13 167/4 167/9
16/25 45/13 57/5	174/21 176/24 177/13	88/14 89/14 90/22	137/23 139/2 139/15	168/15 170/24 171/14
61/17 69/15 77/9	177/15 179/6 179/20	96/7 96/11 97/8 97/20	139/18 142/6 145/15	172/18 176/9 179/7
77/13 77/22 78/15	180/5 180/13 180/14	97/23 97/25 98/18	147/3 147/5 147/16	185/16 188/5
85/11 85/18 85/19	180/15 185/5 185/16	98/19 98/21 98/25	160/23 162/1 163/19	timely [1] 145/1
86/25 88/2 99/9 106/5	186/16 187/15 187/21	99/6 100/6 100/6	165/6 170/1 175/16	times [15] 7/15 58/20
106/11 112/21 117/5	187/21 187/23 187/24	100/7 100/10 100/14	176/11 176/22 181/4	85/23 87/20 153/3
122/13 128/24 129/5	187/25 188/1	100/18 100/20 100/22	181/5 181/17 184/4	159/22 160/9 164/9
134/10 143/9 144/21	they're [5] 59/16	101/1 102/11 106/10	187/23 188/13 188/15	169/5 170/21 173/4
146/19 152/1 153/4	67/15 91/22 109/21	107/2 107/9 108/7	though [2] 19/6 82/2	177/2 177/2 177/3
154/24 154/25 156/3	168/9	109/22 113/10 114/10	thought [5] 53/12	179/10
168/10 168/10 178/15	they've [2] 124/1	115/15 117/1 117/21	147/17 179/15 185/8	timing [2] 57/21
180/5 181/12 184/12	134/12	120/18 120/24 121/9	185/20	190/7
	thing [22] 5/14 7/14	121/16 122/17 123/17	three [8] 35/9 35/10	tiny [1] 117/6

T	152/3 163/15	52/7 113/14 118/13	26/24 33/22 39/1 39/4	173/13
title [1] 50/13	Tranka [1] 109/9	123/2 133/2	39/8 39/12 41/12	undertake [8] 2/6
titled [1] 144/5	transcript [1] 158/18	truly [2] 163/2 186/11	41/17 42/20 44/5	39/20 77/5 83/17
today [3] 115/14	transmissibility [2]	trust [17] 23/2 58/10	46/12 46/17 47/22	110/2 112/3 126/4
115/15 116/2	48/21 48/23	58/10 58/12 158/12	47/23 48/5 62/6 62/10	145/6
together [8] 23/9	transmissible [4]	159/23 171/4 174/13	62/23 63/1 65/15	undertaken [3] 26/8
59/4 69/13 76/21 96/4	35/14 47/18 48/19	175/22 177/24 178/17	69/12 72/8 81/10	33/20 33/22
102/7 167/24 168/4	62/3	179/12 180/5 185/11	81/13 94/6 94/22	undertook [2] 19/9
told [6] 32/4 42/18	transmission [62]	185/19 186/24 189/5	94/25 97/12 97/16	111/13
74/19 118/2 164/7	18/10 18/15 34/23	trust's [2] 182/14	98/5 113/15 114/24	undoubtedly [1]
184/22	34/24 35/4 35/14	188/23	122/1 139/11 140/20	183/14
tomorrow [2] 49/23	35/16 35/18 35/23	trusts [3] 7/13 63/13	145/12 148/8 148/13	unequal [1] 90/23
190/14	47/25 49/1 51/1 51/5	129/1	148/17 149/17 150/21	unexpected [1]
tone [1] 4/24	51/12 52/6 52/9 52/16	try [31] 4/8 21/12	UK Government [1]	180/11
too [10] 37/15 47/6	53/7 54/12 54/13	24/13 24/21 35/12	114/24	unfamiliar [1] 165/25
98/3 98/9 116/5	54/16 54/25 56/9	61/7 61/8 62/18 62/19	UK IPC [1] 41/12	unfamiliarity [2]
128/13 157/7 170/4	56/14 56/15 59/15	63/24 65/15 67/22	UK IPC cell [4] 39/8	165/12 165/14
174/14 177/6	59/18 59/25 62/18	68/2 68/6 68/22 76/8	39/12 47/23 62/10	unfolded [1] 88/8
took [13] 18/8 22/15	62/22 63/20 64/1	77/13 77/25 91/2	ultimately [4] 53/14	unfortunate [1] 95/11
34/1 34/1 39/17 47/2	64/24 65/4 65/7 65/10	116/8 143/23 144/2	79/4 102/4 119/11	unified [1] 120/2
50/2 79/13 141/15	65/18 65/21 66/1 66/6	146/20 151/15 154/1	unable [1] 153/9	unify [1] 120/7
166/6 172/5 172/14	66/7 66/12 67/1 68/18	154/22 156/1 157/2	unacceptable [3]	unique [1] 159/15
179/22	115/17 115/21 116/11	164/2 172/25 187/12	104/21 105/9 105/14	unit [1] 174/1
tool [35] 85/9 90/18	117/2 117/11 122/24	trying [18] 54/20 59/3	unaware [1] 40/25	units [2] 148/20
92/21 93/2 93/4 93/19	122/25 124/21 124/23	87/15 95/10 123/7	uncertain [1] 36/1	163/9
93/22 94/14 94/23	125/20 147/14 150/3	123/24 133/4 143/10	uncertainties [1]	universes [1] 168/14
95/13 96/11 97/8	150/5 150/10 151/4	161/5 163/7 164/3	36/10	University [2] 2/3
98/24 98/24 98/25	169/11 169/13 183/18	165/5 167/11 167/13	uncertainty [2] 84/20	83/22
99/5 100/6 100/20	transmissions [1]	168/20 176/25 180/7	115/20	unknown [1] 165/13
101/2 101/6 112/20	54/22	180/9	unclear [1] 36/1	unless [3] 47/8 96/21
116/15 143/1 144/1	transmitted [1] 34/22	TTP [2] 60/14 127/8	under [7] 13/22	157/15
145/9 171/16 171/18	transparent [1] 171/9	Tuesday [1] 190/17	14/17 22/6 56/21	unlikely [1] 44/15
173/6 173/11 173/16	transpires [1] 177/10	turn [4] 15/3 139/23	69/23 102/23 162/21	unlocked [1] 160/12
176/10 177/22 178/2	transplant [1] 71/9	142/19 186/19	under-resourced [1]	unnecessarily [1]
178/18 186/24	trauma [5] 95/14	turning [1] 111/4	13/22	120/16
toolkit [1] 129/13	95/21 96/1 101/4	Tuthill [1] 120/25	understand [32] 2/18	untenable [1] 125/8
tools [7] 106/8	179/20	twice [3] 55/11 72/15	6/16 13/4 29/8 31/11	until [11] 12/19 29/25
110/23 110/23 112/25	traumatic [1] 164/21	188/16	31/19 32/7 35/12	79/4 81/12 126/22
154/20 176/6 176/23	travel [1] 161/9	twice-weekly [1]	36/19 39/25 62/19	127/3 138/2 169/11
top [11] 12/9 43/19	travellers [1] 159/24	188/16	65/15 65/16 75/17	177/4 183/18 190/16
61/23 73/15 85/24	trawl [1] 131/13	TWIST [1] 180/6	105/20 112/13 123/25	unusual [2] 64/14
87/13 98/25 99/10	treat [3] 148/16	two [35] 1/20 5/4	134/4 135/13 137/22	unwell [1] 164/12
119/12 120/4 184/22	148/22 148/25	8/19 9/1 9/12 11/7	141/12 143/23 144/2	up [67] 2/11 4/7 6/25
topic [8] 50/19 86/7	treatable [1] 133/10	12/25 21/6 32/24	154/7 160/24 173/14	7/8 9/15 9/25 10/6
101/11 126/13 155/3	treated [4] 102/22	34/22 40/15 45/1	174/24 176/10 177/21	12/12 12/19 15/18
186/19 187/3 188/22	133/10 148/8 148/23	56/22 62/13 69/19	181/8 188/18 189/22	17/22 20/2 22/23
topics [2] 93/16	treating [1] 98/11	73/22 75/22 75/23	understandable [1]	23/17 26/13 27/1
177/8	treatment [4] 17/11	82/16 88/24 93/16	132/4	29/10 31/4 38/3 49/13
total [3] 56/25 57/2	54/6 103/9 178/11	110/19 127/14 142/2	understandably [1]	50/10 62/21 66/23
162/13	treatments [1]	147/14 150/11 160/2	26/7	69/16 74/1 74/15
touch [2] 20/5 34/23	140/21	164/8 166/3 166/14	understanding [24]	75/18 76/8 78/7 84/4
touched [1] 69/9	tremendously [1]	168/14 179/22 181/17	10/20 10/21 14/8 27/8	87/5 88/21 90/3 91/16
towards [11] 6/12	173/10	182/11 184/21	27/25 31/17 34/21	99/17 99/17 100/17
7/16 8/23 20/2 57/9	tremors [1] 37/25	two years [3] 166/3	35/1 35/4 35/10 37/7	102/10 106/23 109/23
58/24 96/19 106/20	trends [1] 189/13	166/14 181/17	54/15 72/14 76/12	119/6 125/3 131/15
125/24 142/13 175/10	tried [16] 13/25 24/15	two-phase [1] 75/23	81/19 103/22 124/21	132/25 141/6 141/18
trace [3] 60/15 60/24	58/16 89/20 89/22	two-way [1] 9/1	137/11 141/13 143/14	141/22 142/3 145/11
186/9	91/6 113/14 136/10	twofold [1] 3/15	150/3 170/15 171/13	145/17 161/7 162/5
tracking [1] 186/9	136/16 136/17 136/17	Tydfil [1] 55/21	186/16	162/20 163/15 163/16
trail [2] 119/4 119/7	136/22 141/2 141/12	U	understands [1] 13/9	164/3 167/6 171/22
trained [1] 113/23	156/1 171/8	UK [50] 2/8 13/14	understood [10]	172/5 175/17 178/9
training [7] 2/5 2/6	triggered [1] 107/24	13/23 22/10 22/16	28/21 35/8 67/13	181/7 181/10 182/19
110/25 111/2 146/7	trolleys [1] 46/7	22/24 23/11 25/9 26/8	82/22 110/17 117/7	183/18 183/22 186/22
	true [7] 2/14 52/7		121/10 147/21 166/16	

<p>U</p> <p>update [4] 17/21 56/8 56/13 106/8</p> <p>updated [8] 16/16 30/18 101/19 110/19 110/20 110/20 112/12 112/15</p> <p>updates [7] 4/21 5/11 27/15 31/5 31/6 31/25 48/1</p> <p>updating [1] 61/18</p> <p>upon [5] 34/12 152/20 157/11 157/15 180/5</p> <p>uptake [2] 91/11 145/20</p> <p>urban [1] 159/3</p> <p>us [51] 9/12 20/20 23/3 23/7 30/8 31/13 32/4 41/24 68/7 90/15 91/8 94/1 109/16 116/22 125/18 144/12 158/20 158/21 159/6 161/15 162/3 162/11 162/18 163/1 164/4 164/23 166/11 166/18 166/18 169/21 170/14 170/24 171/3 171/18 172/20 174/7 175/7 176/5 176/9 176/16 176/21 177/7 177/8 177/8 177/8 179/12 184/23 186/4 186/15 186/15 189/22</p> <p>use [21] 8/6 8/10 26/2 26/2 38/5 38/9 44/24 44/25 46/1 68/11 78/16 85/9 93/6 98/16 103/4 112/25 131/11 162/21 166/11 170/7 189/22</p> <p>used [26] 8/5 20/23 36/18 43/25 54/11 76/2 78/19 93/4 99/1 101/6 102/19 105/4 111/6 112/9 112/10 120/16 120/20 121/8 137/19 139/11 145/10 151/7 155/11 161/25 173/16 178/17</p> <p>useful [5] 38/7 38/7 78/10 99/6 138/6</p> <p>using [4] 84/21 93/2 151/6 179/2</p> <p>usual [1] 167/2</p> <p>usually [2] 40/5 166/21</p>	<p>Vale [1] 42/22</p> <p>validation [1] 6/25</p> <p>value [5] 98/12 98/13 124/3 124/18 125/9</p> <p>valued [1] 85/17</p> <p>variance [2] 82/22 127/9</p> <p>variant [6] 47/19 48/5 48/19 48/20 48/22 50/4</p> <p>variants [2] 61/25 62/3</p> <p>variation [1] 57/20</p> <p>varied [1] 160/4</p> <p>various [6] 11/11 77/11 90/22 90/24 124/1 134/24</p> <p>vast [1] 133/8</p> <p>Vaughan [1] 118/2</p> <p>vehicle [1] 91/22</p> <p>Velindre [5] 58/10 58/10 58/12 59/9 59/17</p> <p>ventilated [1] 35/24</p> <p>ventilation [5] 68/12 68/14 68/19 183/23 185/3</p> <p>ventilators [2] 17/10 163/18</p> <p>verbal [1] 31/6</p> <p>verbally [2] 30/22 31/5</p> <p>versa [1] 65/13</p> <p>version [5] 97/18 101/17 101/19 119/22 119/23</p> <p>versions [1] 136/18</p> <p>very [117] 7/12 14/8 17/20 18/3 23/8 24/9 26/5 26/22 26/24 29/3 29/7 30/13 30/16 37/18 41/22 43/19 44/19 58/8 59/22 60/3 67/15 68/4 68/6 69/5 69/9 70/24 71/25 76/6 76/11 76/12 78/9 78/15 79/9 82/12 82/17 85/22 87/12 88/22 89/3 89/3 89/12 90/14 91/13 91/15 91/15 96/15 97/11 98/19 99/6 100/19 104/14 108/3 108/5 111/16 115/2 116/17 117/16 118/8 118/10 118/10 118/14 121/1 121/1 122/13 122/24 124/6 125/16 129/7 129/11 129/23 129/23 136/10 136/14 136/14 136/22 138/15 139/19 141/6 141/15 143/5 143/22 144/18 145/7 145/10 148/5 148/15</p>	<p>149/10 150/15 150/15 152/7 157/5 157/18 159/4 161/12 161/15 162/3 163/23 164/1 165/15 165/20 166/2 169/1 170/13 171/20 172/9 175/14 178/21 179/4 179/7 179/19 182/1 185/3 188/2 188/3 188/18 190/3 190/7</p> <p>via [2] 51/5 158/3</p> <p>vice [1] 65/13</p> <p>video [2] 158/3 164/21</p> <p>view [11] 46/11 46/22 46/24 48/7 80/10 81/23 105/2 109/12 138/24 145/1 173/6</p> <p>viewed [1] 98/3</p> <p>views [7] 46/21 51/22 83/25 85/1 98/11 111/8 113/2</p> <p>viral [2] 87/4 134/24</p> <p>virtual [1] 8/24</p> <p>virus [8] 27/25 33/24 34/21 65/10 123/2 150/19 186/12 186/12</p> <p>viruses [2] 87/3 87/3</p> <p>visceral [2] 94/5 118/9</p> <p>visit [8] 80/9 164/16 171/19 171/22 172/4 172/13 172/23 174/2</p> <p>visiting [13] 171/15 171/20 171/21 171/22 172/1 173/1 173/8 173/15 173/17 173/23 173/25 174/7 181/3</p> <p>visitors [3] 168/8 168/12 172/21</p> <p>visits [2] 79/23 171/17</p> <p>Vivaldi [1] 125/16</p> <p>voice [3] 4/7 45/19 45/20</p> <p>volume [1] 150/22</p> <p>vulnerabilities [2] 78/5 155/10</p> <p>vulnerability [6] 69/22 70/4 73/21 136/2 155/13 175/2</p> <p>vulnerable [42] 69/2 69/10 70/13 70/17 70/17 70/23 71/2 71/8 71/18 71/19 71/22 71/24 73/23 73/24 74/7 74/17 74/18 75/11 78/4 79/1 79/7 79/16 79/25 80/11 81/11 83/20 84/12 85/20 135/23 136/3 136/7 136/8 138/12 138/12 138/16 138/20</p>	<p>138/20 139/2 139/3 151/2 167/13 174/10</p> <p>W</p> <p>Waddoup [3] 135/19 135/20 191/6</p> <p>waiting [2] 158/7 177/4</p> <p>Wales [171] 1/17 2/12 2/16 3/19 4/18 5/20 5/23 6/17 6/18 6/23 7/6 7/7 7/8 7/14 7/17 7/19 7/21 8/1 10/1 10/7 10/20 11/5 13/16 15/4 15/6 15/8 17/18 18/19 20/10 20/17 20/25 21/19 21/22 22/13 22/13 24/25 25/8 25/13 26/11 30/8 33/25 38/25 39/3 39/8 39/13 39/15 39/23 40/21 42/25 50/3 51/2 51/7 51/10 53/21 54/20 55/19 56/6 56/25 57/6 57/8 60/2 60/12 62/25 64/6 65/9 65/24 67/9 67/12 67/13 67/24 69/9 73/10 75/12 76/2 76/4 76/5 76/8 77/7 77/12 77/22 78/21 81/9 81/11 82/24 83/18 85/4 88/18 88/22 89/5 90/25 91/16 92/17 93/1 93/25 94/7 95/4 95/14 95/21 95/22 96/1 96/6 97/17 99/25 101/14 101/23 102/8 102/18 102/23 105/5 106/6 106/14 106/15 107/15 107/18 108/20 108/25 109/5 110/6 110/15 110/17 110/18 111/10 111/13 111/14 112/10 112/16 112/18 112/22 113/6 113/14 114/10 114/11 118/3 118/7 118/14 119/11 120/2 121/1 121/13 122/1 127/6 128/8 128/11 129/2 129/10 131/8 132/17 132/22 133/1 133/12 133/14 134/6 134/14 135/2 135/8 136/6 136/15 137/22 139/11 141/11 143/8 143/13 144/17 145/20 146/9 146/15 150/22 153/9 154/13 155/9 155/23</p> <p>Wales or [1] 83/18</p> <p>Wales' [1] 39/12</p> <p>walk [2] 165/10 172/7</p>	<p>want [12] 47/7 102/11 113/9 119/8 126/13 126/17 143/7 147/19 147/24 178/19 187/17 189/2</p> <p>wanted [4] 33/24 121/5 128/23 183/13</p> <p>ward [5] 163/11 163/12 182/14 183/7 187/22</p> <p>wards [2] 166/25 187/23</p> <p>warm [1] 80/4</p> <p>warming [1] 38/1</p> <p>Warne [1] 128/4</p> <p>was [709]</p> <p>wash [1] 80/3</p> <p>wasn't [45] 6/3 8/11 29/24 33/22 39/25 44/24 50/9 58/17 59/5 60/5 68/14 72/13 83/8 83/12 83/13 87/6 87/13 90/20 100/5 104/13 105/3 108/21 117/4 122/3 124/8 124/16 124/21 127/2 133/19 133/21 138/23 138/24 141/10 148/20 148/21 151/22 153/19 154/3 169/10 169/25 170/8 170/10 170/16 178/23 184/9</p> <p>watching [1] 94/4</p> <p>water [1] 80/4</p> <p>wave [7] 57/9 57/10 83/6 83/10 83/10 87/23 128/5</p> <p>waves [2] 58/20 68/4</p> <p>way [41] 8/12 8/19 9/1 14/13 22/2 25/20 26/15 26/16 29/9 29/14 31/6 31/7 31/18 36/11 36/21 36/22 36/25 37/15 38/14 44/21 51/24 52/9 52/15 52/19 58/5 59/3 59/7 61/6 76/12 78/3 78/19 97/23 98/11 113/12 113/13 115/6 137/6 153/2 164/16 166/21 177/15</p> <p>ways [8] 37/2 85/21 89/22 91/6 112/23 113/16 116/22 163/7</p> <p>we [481]</p> <p>we'd [5] 8/6 9/12 22/25 82/12 131/13</p> <p>we'll [2] 16/21 18/15</p> <p>we're [10] 25/25 36/21 123/16 129/20 133/7 143/7 143/10 146/8 152/10 187/2</p> <p>we've [14] 24/24 42/5 44/8 45/24 77/19</p>
<p>V</p> <p>vaccination [2] 12/21 162/5</p> <p>vaccines [4] 91/10 91/18 127/17 127/19</p>				

W	18/24 19/14 20/14 22/14 23/15 24/12 24/20 25/17 29/24 30/17 33/1 33/11 33/15 33/23 34/8 38/19 51/9 56/14 57/2 60/16 63/11 63/15 64/5 66/7 70/22 71/2 77/17 77/21 81/17 83/16 86/13 87/5 88/17 91/1 91/24 93/6 93/7 94/13 94/17 95/4 95/7 95/24 95/25 100/7 101/1 101/3 101/4 102/3 106/18 109/2 109/6 109/19 110/13 112/12 114/23 115/10 115/24 123/7 123/23 126/16 129/1 129/19 130/13 130/25 132/13 132/18 132/20 135/4 136/23 144/20 158/2	129/12 132/21 134/3 134/5 136/4 141/7 141/10 142/15 145/25 146/12 147/16 147/24 149/20 153/19 154/11 156/15 159/11 162/23 163/11 163/21 164/12 166/11 167/18 167/18 167/19 167/22 168/1 168/6 169/7 171/7 171/8 171/13 171/13 172/21 172/22 172/23 173/4 174/19 175/7 175/10 176/13 176/15 178/5 178/6 178/10 178/21 182/25 183/13 183/15 185/19 186/5 187/1 187/9 187/10 188/21 189/23	wherever [1] 136/18 WHESRi [1] 143/24 whether [49] 5/15 6/12 32/4 32/5 37/21 39/21 46/13 47/9 48/25 49/1 49/6 49/8 53/10 55/21 59/15 60/4 62/13 69/4 71/23 81/2 81/22 85/8 92/7 92/25 101/6 103/1 103/4 109/3 109/21 110/5 112/2 121/2 131/15 131/18 134/16 150/12 152/19 155/10 155/13 171/17 173/21 177/6 183/8 183/13 187/21 187/21 187/22 187/25 188/1 which [153] 8/5 8/7 9/6 9/12 9/17 11/9 11/17 11/19 13/13 14/7 15/6 15/18 16/20 17/4 18/11 20/12 20/18 20/22 21/11 22/2 23/13 23/25 24/16 24/17 24/24 27/17 30/3 31/14 33/7 33/8 33/19 36/9 36/10 36/18 37/2 37/8 40/25 41/5 41/12 42/15 48/20 55/25 58/9 60/9 60/16 61/7 61/17 63/5 63/25 66/22 67/11 70/18 72/16 73/5 75/4 76/5 76/11 77/20 78/17 81/4 82/4 82/8 82/9 83/24 85/18 86/11 87/16 93/16 94/22 95/8 95/8 97/13 97/19 98/4 100/15 103/3 104/5 105/3 106/5 109/11 111/12 111/17 112/23 112/25 115/1 115/16 119/3 119/22 124/25 125/13 126/13 126/19 127/10 127/23 129/1 129/13 131/17 134/14 135/6 135/10 136/20 137/11 137/14 139/12 140/19 140/24 141/17 141/20 142/3 143/13 145/9 145/14 146/8 147/4 150/20 150/25 151/25 152/15 152/17 152/20 152/21 154/19 155/3 155/11 156/5 158/12 158/25 159/3 159/11 162/13 164/7 166/6 167/2 168/15 168/16 172/10 178/11 178/12 178/13 179/21 179/23 180/1 180/6 180/24 183/22 184/6 184/7	184/16 184/24 185/20 186/19 188/15 188/20 while [3] 3/4 80/5 138/12 whilst [2] 137/24 139/23 white [4] 16/4 42/12 98/25 109/9 Whitty [5] 22/22 23/18 37/8 74/2 86/12 Whitty's [1] 72/7 who [84] 1/6 5/5 7/2 7/9 13/8 18/6 26/10 33/2 33/5 40/13 45/8 45/9 54/5 59/4 61/9 61/10 66/4 68/1 69/1 69/16 70/2 70/8 70/9 70/14 70/17 71/21 74/17 74/18 76/15 76/16 78/4 79/24 85/2 85/16 85/16 87/24 89/13 89/19 90/13 90/15 91/23 99/20 102/1 103/11 106/23 108/16 109/24 114/4 117/15 122/14 124/9 129/9 129/9 133/6 133/11 133/22 134/23 136/3 137/5 137/7 140/9 140/11 142/24 143/3 145/5 155/17 156/20 158/4 159/25 165/24 168/8 169/24 170/1 171/1 171/1 174/12 176/25 179/22 184/4 185/13 186/25 187/20 188/13 188/14 who's [1] 120/25 whole [13] 46/9 53/5 75/4 89/9 105/5 106/4 116/14 134/11 144/16 151/24 164/11 166/1 180/16 wholesale [1] 112/21 wholly [1] 61/8 whom [4] 12/10 14/20 149/18 188/14 whose [3] 14/19 115/11 175/25 why [23] 29/10 43/23 45/10 48/15 61/14 62/9 72/17 97/23 108/20 108/23 109/14 111/9 112/8 116/18 124/2 125/5 128/9 129/4 129/5 136/4 138/22 156/1 176/20 wide [3] 48/7 98/4 175/19 widely [10] 33/8 67/13 93/4 106/17 110/24 126/7 139/11 143/8 145/10 179/11
we've... [9] 77/19 113/14 133/2 133/14 135/2 137/17 143/12 155/7 158/6 weak [6] 35/22 36/2 115/16 115/20 117/3 117/12 weakness [2] 21/10 21/11 wearing [8] 47/4 116/3 165/7 165/12 168/9 168/11 172/11 172/16 Wednesday [2] 49/21 187/3 week [10] 4/25 53/24 54/2 56/24 57/13 57/15 79/3 119/23 189/11 189/17 weekly [9] 4/13 4/14 5/21 23/12 55/11 57/7 171/10 188/16 188/16 weeks [6] 53/21 79/3 82/16 118/4 164/9 164/10 Weereratne [3] 115/5 115/8 191/4 welcome [2] 1/9 43/3 welcomed [1] 93/5 well [87] 4/16 5/13 5/17 7/12 11/4 11/20 13/21 19/6 19/22 19/23 19/25 19/25 24/7 25/5 25/25 30/20 37/13 37/23 39/18 40/14 41/22 44/3 44/22 45/1 45/20 46/22 49/11 49/11 51/17 58/16 60/13 61/16 64/14 71/5 71/25 74/9 74/25 75/3 75/4 75/16 75/23 81/2 81/25 90/13 91/4 97/11 97/11 98/2 101/24 101/25 106/17 109/19 110/8 110/19 112/4 112/4 112/10 114/25 115/22 118/22 118/23 121/23 122/5 124/12 124/15 124/20 125/23 133/21 134/25 136/5 136/23 138/1 138/23 139/5 142/19 146/4 151/10 152/17 155/24 163/23 168/13 178/5 178/6 180/4 180/7 180/13 181/23 well-being [3] 152/17 155/24 180/4 Welsh [81] 2/20 3/6 3/14 8/8 9/7 11/9 13/5 14/25 15/3 15/13	18/24 19/14 20/14 22/14 23/15 24/12 24/20 25/17 29/24 30/17 33/1 33/11 33/15 33/23 34/8 38/19 51/9 56/14 57/2 60/16 63/11 63/15 64/5 66/7 70/22 71/2 77/17 77/21 81/17 83/16 86/13 87/5 88/17 91/1 91/24 93/6 93/7 94/13 94/17 95/4 95/7 95/24 95/25 100/7 101/1 101/3 101/4 102/3 106/18 109/2 109/6 109/19 110/13 112/12 114/23 115/10 115/24 123/7 123/23 126/16 129/1 129/19 130/13 130/25 132/13 132/18 132/20 135/4 136/23 144/20 158/2 went [2] 127/8 168/19 were [354] were: [1] 67/1 were: firstly [1] 67/1 weren't [11] 18/21 113/23 116/11 118/18 131/23 137/22 139/13 165/24 171/21 177/13 189/3 west [4] 107/18 129/10 180/6 184/14 Western [2] 158/12 182/14 what [144] 5/9 5/19 6/7 10/5 20/4 20/7 21/8 21/17 23/13 23/23 24/5 25/22 26/14 27/18 28/21 29/6 31/16 32/20 33/17 35/1 35/2 35/8 35/10 35/10 36/2 36/8 36/24 43/17 43/25 45/6 46/4 46/5 46/11 46/21 47/12 47/14 48/14 49/2 49/9 51/23 52/22 61/19 63/15 63/24 64/4 64/11 64/16 64/21 64/23 65/1 65/7 66/1 69/21 74/9 75/5 76/5 81/22 82/18 82/20 85/15 85/25 86/22 94/3 94/7 94/21 95/4 97/22 98/19 99/3 101/1 101/2 105/1 105/20 105/23 107/24 108/5 113/4 117/1 117/10 118/11 118/18 120/19 121/16 121/17 121/18 122/5 122/6 127/15	129/12 132/21 134/3 134/5 136/4 141/7 141/10 142/15 145/25 146/12 147/16 147/24 149/20 153/19 154/11 156/15 159/11 162/23 163/11 163/21 164/12 166/11 167/18 167/18 167/19 167/22 168/1 168/6 169/7 171/7 171/8 171/13 171/13 172/21 172/22 172/23 173/4 174/19 175/7 175/10 176/13 176/15 178/5 178/6 178/10 178/21 182/25 183/13 183/15 185/19 186/5 187/1 187/9 187/10 188/21 189/23 what's [6] 12/25 36/13 58/25 95/22 147/16 178/24 when [75] 8/17 10/8 10/11 11/10 12/19 18/3 20/9 20/20 21/1 22/2 29/19 30/7 37/19 38/10 40/16 41/6 45/3 45/7 59/24 60/2 64/21 69/6 70/6 73/14 73/18 75/5 75/25 80/4 81/11 83/5 86/13 87/21 91/5 91/10 97/14 102/25 108/7 109/22 114/7 114/12 115/24 116/4 117/3 117/12 123/1 126/6 127/15 131/23 134/17 138/17 139/22 140/13 141/4 141/7 143/17 146/12 146/24 148/6 149/20 151/17 157/12 161/2 161/11 165/8 166/10 166/14 166/17 168/21 169/23 170/6 172/11 172/15 177/15 186/15 188/17 whenever [2] 110/20 112/14 where [47] 6/11 17/21 17/23 24/18 25/8 25/9 28/2 28/19 29/10 35/25 37/9 40/2 40/19 40/23 45/13 47/3 51/19 51/20 54/21 56/18 60/20 91/17 94/11 95/11 96/22 100/14 104/4 107/16 107/20 119/12 120/10 144/23 146/11 148/14 151/1 151/2 152/4 158/21 165/11 166/7 166/19 184/23 185/8 185/9 185/10 185/23 187/15 whereby [1] 172/5		

W	won't [1] 129/9	World Health [1] 144/2	148/6 150/1 150/1	105/2 109/1 109/2
wider [8] 5/1 23/13	wonder [2] 42/23	144/2	150/7 150/17 162/24	112/7 113/2 116/25
24/7 33/8 55/13 92/2	93/11	worn [1] 41/18	173/10 175/6 183/1	117/1 117/8 117/21
180/2 185/12	word [1] 166/10	worried [2] 89/14	183/2	117/23 119/11 119/23
widespread [4] 68/17	wording [1] 105/7	171/24	yet [3] 150/5 167/10	130/9 131/3 131/4
109/4 109/8 109/17	words [1] 54/4	worry [1] 178/10	168/1	131/7 131/25 133/25
Wilcock [4] 182/2	work [59] 2/3 6/3	worse [4] 66/3 66/9	you [652]	137/17 138/9 138/14
182/3 190/7 191/14	9/18 10/24 11/16	153/12 188/7	you'd [4] 53/10 64/15	141/25 142/10 145/1
wildfire [2] 167/3	12/15 16/16 18/15	worsen [1] 144/9	101/10 102/15	145/23 146/22 147/10
168/19	19/9 19/25 20/1 21/22	worst [1] 190/12	you'll [2] 32/12	149/10 149/20 149/21
will [26] 4/8 7/5 37/16	26/7 26/7 26/23 27/3	would [207]	128/12	150/12 152/13 152/21
37/18 43/22 49/20	38/14 48/2 54/21	wouldn't [11] 6/13	you're [17] 6/17 20/7	153/14 155/7 155/23
52/16 62/4 65/25	60/24 62/20 65/14	19/2 30/14 52/19 53/3	37/5 41/5 47/10 51/23	156/23 157/11 157/12
75/16 94/1 103/10	66/8 69/17 72/6 72/7	75/1 83/7 87/13 112/4	70/12 97/18 112/2	157/18 158/10 158/14
105/24 122/15 124/25	76/7 76/20 77/23	132/6 151/11	127/12 153/21 155/18	158/18 160/17 164/2
125/5 125/23 127/22	83/11 87/15 90/16	write [1] 103/16	155/20 155/22 156/3	166/4 169/15 171/5
134/12 157/14 157/16	90/16 94/21 94/24	writing [3] 75/20	183/11 187/15	173/6 180/12 180/13
158/4 159/7 180/13	95/5 95/6 97/12	107/10 182/20	you've [25] 1/15 3/25	180/20 182/17 182/22
180/14 183/3	111/20 129/8 138/4	written [4] 30/24 75/1	9/20 22/10 31/14	182/23 184/21 185/2
willingly [1] 14/23	143/9 143/22 144/13	157/13 183/19	31/20 32/4 32/12	185/4 185/11 185/19
wish [2] 43/18	144/19 145/4 145/6	wrong [5] 21/25	34/18 35/20 38/23	186/23 188/7 188/18
189/23	161/6 163/24 164/13	52/24 59/21 83/8	47/21 48/3 49/25	188/20 188/23 190/3
wished [1] 168/25	165/5 165/15 168/15	109/13	81/15 86/10 100/21	190/10 190/12
wishes [5] 103/21	170/17 177/4 180/5	wrote [5] 64/21 82/25	102/15 106/10 113/10	yourself [7] 4/17
104/25 105/24 106/2	180/9 180/10 190/11	107/8 108/12 109/14	126/5 137/5 184/22	15/23 27/22 42/13
111/8	workable [1] 75/7	Y	185/18 188/21	50/2 51/6 131/19
within [57] 2/20 3/21	worked [19] 10/20	years [10] 10/21 11/7	Youd [1] 120/6	Z
5/8 6/23 7/4 7/11 8/21	20/1 23/8 36/16 40/10	77/20 110/19 143/11	young [12] 143/14	zero [1] 58/9
8/21 11/9 13/11 15/13	68/7 69/16 74/15	143/11 159/7 166/3	152/18 153/9 153/15	zone [1] 58/14
20/17 21/24 33/5	75/17 78/20 85/19	166/14 181/17	154/3 154/4 154/13	zones [2] 58/22 59/3
33/11 33/25 34/8 57/2	90/15 90/18 91/13	yellow [1] 57/24	155/8 155/10 156/13	
58/12 60/16 61/11	163/2 171/18 178/5	yes [117] 1/12 2/9	171/22 172/2	
75/17 77/17 78/17	178/6 184/6	2/18 2/23 3/3 3/11	your [173] 1/11 2/1	
89/15 92/17 99/22	workers [46] 40/22	3/13 3/24 4/6 4/20	2/2 2/4 2/11 3/4 3/6	
101/6 109/24 110/23	55/19 56/2 60/19 61/3	6/19 7/12 8/23 9/22	3/8 3/14 4/7 4/11 7/20	
112/19 118/4 118/20	62/1 62/5 62/24 79/23	12/24 14/17 15/10	8/1 9/4 9/20 10/3	
126/4 133/10 146/5	80/3 80/9 80/21 80/25	15/17 16/2 16/3 16/17	11/14 13/14 13/15	
152/3 153/23 161/21	89/15 90/19 92/23	16/23 17/3 17/5 17/13	16/11 17/7 18/12	
163/9 163/19 167/11	93/1 120/20 120/22	17/13 17/24 19/5 19/7	18/17 18/23 19/4 19/8	
167/22 169/13 170/11	122/19 123/5 123/22	20/8 22/18 24/10	22/10 22/19 22/20	
170/12 173/1 174/13	124/9 124/13 124/14	25/20 27/21 27/21	24/25 25/23 27/10	
174/18 174/19 177/24	125/10 125/21 125/24	28/18 29/16 29/23	27/13 29/21 31/3	
180/4 180/6 182/14	126/11 126/17 126/18	30/11 32/3 33/16	31/13 31/14 31/15	
187/10 188/2 189/5	139/4 140/9 140/16	35/19 36/7 38/16	31/16 31/16 31/21	
without [13] 3/9	141/21 142/5 143/1	40/10 41/10 42/10	31/22 32/5 32/10	
65/25 97/24 99/12	143/2 144/15 145/8	49/11 49/12 51/24	34/20 35/1 35/10 36/2	
99/22 100/6 104/15	145/25 146/2 146/5	53/14 56/3 56/7 58/2	36/25 38/7 38/22	
104/21 105/10 107/22	146/5 148/12 148/14	58/13 59/8 60/25	39/19 39/20 42/1	
150/9 151/8 178/9	workforce [7] 114/4	62/15 65/1 65/1 67/7	42/13 43/10 43/21	
witness [28] 1/20 3/4	114/4 161/1 161/25	67/13 67/19 69/18	43/23 45/17 45/17	
4/11 9/24 17/7 17/14	162/7 168/24 180/24	73/25 74/13 75/24	46/11 46/21 47/20	
18/17 27/10 28/8 31/3	working [23] 13/7	76/1 76/25 77/2 79/19	51/3 51/7 51/21 52/8	
31/12 31/21 31/22	22/19 26/11 29/12	80/18 81/5 85/5 86/21	53/17 54/15 56/11	
32/8 34/18 38/22	36/12 37/19 52/13	88/19 89/2 91/4 91/9	56/17 63/9 65/5 66/14	
47/20 51/3 56/17	59/7 60/15 60/16 68/5	92/9 94/1 95/16 96/7	67/9 67/25 70/21	
66/14 70/21 76/22	68/14 69/13 120/25	97/7 100/19 100/25	71/16 76/22 78/25	
86/10 117/23 134/2	134/11 136/15 143/3	101/3 101/16 102/13	80/5 80/5 80/10 80/16	
149/21 152/13 158/18	146/16 163/12 170/12	103/18 103/24 104/9	81/5 81/15 81/23	
witnesses [1] 115/25	176/11 177/15 187/1	107/6 111/3 112/1	82/19 82/20 83/25	
woman [3] 171/22	workplace [1] 167/23	114/18 118/24 119/15	85/1 86/10 86/23	
172/2 174/12	works [1] 129/13	121/10 127/1 129/7	87/11 90/4 90/11	
women [4] 70/3	world [5] 143/23	131/21 138/9 144/16	95/19 100/10 100/11	
71/14 174/10 175/2	144/2 148/14 168/15	144/23 147/23 148/2	100/18 100/22 100/22	
	168/16		100/23 102/11 103/22	