

Wednesday, 9 October 2024

1
2 (10.00 am)
3 **LADY HALLETT:** Yes, Mr Mills.
4 **MR MILLS:** My Lady, may I please call the witness M3/WI who
5 will affirm.
6 **MS NORA OHRENSTEIN (Interpreter) (affirmed)**
7 **M3/WI (affirmed)**
8 **Questions from COUNSEL TO THE INQUIRY**
9 *(Interpreted, unless otherwise indicated)*
10 **MR MILLS:** You are providing evidence to the Inquiry this
11 morning under the cypher M3/WI; is that right?
12 **A.** (In English) Yes.
13 **Q.** During the pandemic, you worked as a cleaner in
14 a hospital?
15 **A.** (In English) Yes.
16 **Q.** It is right, isn't it, that you were not directly
17 employed by the hospital but you worked for
18 an outsourced company?
19 **A.** Yes.
20 **Q.** Can you begin by describing to us your normal working
21 day before the pandemic?
22 **A.** My usual day before the pandemic was working in the
23 cardiology floor, three hours a day.
24 **Q.** When the pandemic began, did your working hours
25 increase?

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1 family, it was something to be considered.
2 **Q.** I would like to explore that a little bit.
3 **A.** (In English) Okay, no problem.
4 **Q.** What did you fear would happen if you had said no to
5 working longer hours?
6 **A.** I feared losing my job, everything was closing down at
7 the time.
8 **Q.** Were you told which wards in the hospital were being
9 used for treating patients with Covid-19?
10 **A.** We had no information whatsoever.
11 **Q.** Did that make you feel anxious?
12 **A.** Yes, I was very anxious. I didn't even take a lift
13 because I had fear.
14 **Q.** Did you ask your supervisor or anyone within the
15 management of the hospital to tell you which wards were
16 being used for treating patients with Covid-19?
17 **A.** They didn't provide information but I heard rumours,
18 just rumours that perhaps they were all on the fourth
19 floor.
20 **Q.** As well as cleaning wards, I think it is right that you
21 also cleaned individual rooms?
22 **A.** Yes.
23 **Q.** Was the patient ever in the room when you were cleaning
24 the individual rooms?
25 **A.** No, the patient was no longer there.

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1 **A.** Yes, due to the situation we were going through.
2 **Q.** How many hours did you have to start working?
3 **A.** I would start work 6, 7 o'clock in the evening and go
4 until 4, 5 am in the morning, depending.
5 **Q.** And that was how many days a week?
6 **A.** Usually for five days a week, but sometimes even
7 weekends.
8 **Q.** You said, before the pandemic, you were cleaning one
9 department in the hospital. Were you asked, when the
10 pandemic struck, to clean more areas of the hospital?
11 **A.** Due to the situation, I was obliged to work for more
12 hours during the crisis we were going through.
13 **Q.** You refer to the "situation". I think it is right,
14 isn't it, that the hospital was short-staffed at this
15 time?
16 **A.** Yes, short-staffed due to the illness we were suffering.
17 **Q.** Is it right that many cleaners also were feeling too
18 scared to go to work?
19 **A.** Yes, we were short of staff all due to the pandemic.
20 **Q.** In your statement you say this:
21 "I also didn't really want to work additional
22 hours but I felt pressured by the circumstances and
23 didn't feel able to say no."
24 **A.** Yes, because of the general circumstances, but also due
25 to my own circumstances, having to pay rent, help my

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1 **Q.** And again, were you told whether the patient whose room
2 you were cleaning had Covid-19?
3 **A.** No, we didn't receive any information at all.
4 **Q.** Did you receive any training about how to clean
5 differently in accordance with Covid-19 guidelines?
6 **A.** No, we didn't have any information and we just went on
7 cleaning the way we were cleaning before doing things to
8 the best of our ability.
9 **Q.** So you weren't, for example, given any new cleaning
10 products?
11 **A.** We started using a product called Bihe(?), and that's
12 the one we used for everything.
13 **Q.** Did you receive any guidance about Infection, Prevention
14 and Control?
15 **A.** No. No guidance, no information.
16 **Q.** In the absence of guidance about infection prevention
17 and control and about how to clean in a Covid-19
18 compliant way, did you have concerns?
19 **A.** I was very worried, I was -- I had fear of being ill
20 myself, contagious.
21 **Q.** Did you raise the concerns you had with anyone at the
22 hospital?
23 **A.** We had nobody to speak to. All we had to do was work
24 and work.
25 **Q.** What about with anyone at the outsourced company?

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- 1 A. No, nothing with them.
- 2 Q. In your statement you say this:
- 3 "Despite my concerns, I didn't raise a complaint
- 4 with my employers or with hospital management because
- 5 I was scared there would be negative consequences ..."
- 6 A. Yes, at that time I couldn't be without a job. We
- 7 needed to support ourselves.
- 8 Q. Do I take it that the negative consequence was that you
- 9 feared you would lose your job?
- 10 A. Yes.
- 11 Q. If you had fallen ill with Covid-19, would you have been
- 12 able to survive on the sick pay you were entitled to?
- 13 A. No. We had a very small pay, we didn't have the salary
- 14 we actually deserved.
- 15 Q. Did you in fact manage to avoid catching Covid-19 during
- 16 the pandemic?
- 17 A. Yes. Thank goodness that was the case. I looked after
- 18 myself, and together with my colleague, my partner.
- 19 Q. We will come on to some of the ways that you looked
- 20 after yourself. Can I first ask you this, if you had
- 21 fallen ill with Covid-19, would you have felt that you
- 22 had to carry on working because if you don't work you
- 23 wouldn't be paid your wage?
- 24 A. I would have done so, because I had to survive.
- 25 Q. I will come now to the personal protective equipment you

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- 1 myself that would be picking stuff up for myself and my
- 2 partner, my colleague.
- 3 Q. Did you receive any training about how to wear PPE and
- 4 how to safely dispose of it?
- 5 A. No, we didn't receive any training, but we knew
- 6 ourselves to use some orange bags that are for
- 7 contaminated articles, and we would use those to dispose
- 8 of ours.
- 9 Q. Taking all of this together can I ask you this, did you
- 10 feel safe performing your job?
- 11 A. No, I didn't have any feeling of safety but I had to go
- 12 ahead and do things.
- 13 Q. Did you receive a testing kit at any point during the
- 14 pandemic?
- 15 A. Much later, not actually during the pandemic, the
- 16 pandemic itself, but much later we received some and we
- 17 had to check and report if we were found contaminated.
- 18 Q. How many boxes of testing kits did you personally
- 19 receive?
- 20 A. I believe three perhaps four, not many.
- 21 Q. Can I move finally to ask you about your physical and
- 22 mental well-being during this time.
- 23 Can you describe to us the impact that working
- 24 during the pandemic had on your mental health?
- 25 A. I suffer a great impact from all this situation, this

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- 1 were provided with. Was there a difference in the PPE
- 2 that outsourced workers like you received, compared to
- 3 what the employed clinical staff at the hospital were
- 4 given?
- 5 A. Yes. We only received a mask, a blue mask, and we had
- 6 to find, by ourselves, a way to protect ourselves.
- 7 And we were not actually given this mask, we had
- 8 to pick them up ourselves, find them ourselves.
- 9 Q. Find them outside of the hospital?
- 10 A. They were not given to us, we had to pick them sometimes
- 11 from reception, sometimes from some consulting room
- 12 where there were some spares.
- 13 Q. In addition to the mask, did you acquire any other PPE
- 14 to give yourself greater protection?
- 15 A. No, they didn't give us anything but myself, together
- 16 with my partner, will pick up things from places where
- 17 they would be available.
- 18 Q. What kind of --
- 19 A. By hiding ourselves we will pick them up.
- 20 Q. What kind of things? What kind of things?
- 21 A. Hats, aprons, stronger masks.
- 22 Q. You say "they" wouldn't give us; were you and your
- 23 colleagues asking for more PPE?
- 24 A. No, we had nobody to ask. We only had a supervisor who
- 25 would say always, "Later on, later on", so it was mainly

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- 1 fear of becoming ill, I had an obligation towards my
- 2 family, the whole thing caused a lot of stress.
- 3 Eventually I lost a lot of weight too due to this
- 4 stress.
- 5 Q. Were you ever asked about your well-being by either the
- 6 hospital management or the outsourced company you worked
- 7 for?
- 8 A. At no time we had any questions from them or any
- 9 inquiries from them.
- 10 Q. Can I ask how that made you feel?
- 11 A. I had just the support of my sister, she works in
- 12 Colombia as a nurse and she was the one that supported
- 13 me.
- 14 Q. Do you think that you and your colleagues have received
- 15 the recognition you deserve for the work you performed
- 16 during the pandemic?
- 17 A. Not at all. Not at all.
- 18 Q. Finally this, I think it is right, isn't it, that you
- 19 and your colleagues are now employed directly by the
- 20 hospital?
- 21 A. At this present time yes.
- 22 Q. Can you tell us how, if at all, that has improved your
- 23 working conditions?
- 24 A. There has been some improvement in the payment, not as
- 25 much as should be but yes, better than before.

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1 **MR MILLS:** Thank you.

2 **LADY HALLETT:** Can I just ask, was it a private hospital or
3 an NHS hospital? Please don't name the hospital but was
4 it private or NHS?

5 **A.** As far as I know it is a private hospital.

6 **LADY HALLETT:** Thank you.
7 Those are all the questions we have. Thank you
8 very much for your courage in coming forward to help us.
9 It is absolutely essential that we hear from a wide
10 range of people who were working throughout the pandemic
11 in hospitals. So we are very grateful.

12 **A.** Thank you and it has been very hard.

13 **LADY HALLETT:** I can imagine. Thank you. I have been asked
14 to rise while we break for the next witnesses. I shall
15 return as soon as we are ready.

16 (The witness withdrew)

17 (10.25 am)

18 (A short break)

19 (10.31 am)

20 **PROFESSOR CHARLOTTE SUMMERS (continued)**
21 **DR GANESH SUNTHARALINGAM (continued)**
22 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**
23 **(continued)**

24 **LADY HALLETT:** Ms Carey.
25 I am sorry about last week.

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1 inevitably time-critical decisions. By the nature of
2 these conditions, they can happen quickly, some
3 unexpectedly, and wherever possible the patient's wishes
4 and values, their own thoughts about what will happen to
5 them and what outcomes they would like should be known
6 where possible.

7 **MS CAREY:** So outside of the pandemic one might, for
8 example, embark on an advance care plan if they know
9 they have cancer and unfortunately that it is now at
10 a terminal stage?

11 **DR SUNTHARALINGAM:** Yes, I think anyone who, for whatever
12 reason, is nearing the end of their life, to their
13 knowledge, or is at risk of death for whatever reason.

14 **MS CAREY:** Now, there are various iterations of forms but
15 there's one I would like to ask you about, acknowledging
16 as I do that it is not the only form out there. But can
17 we have a look, please, at the ReSPECT form. Can you
18 just help us please, what is this intended for?

19 **DR SUNTHARALINGAM:** So this is a model which, and to make
20 this point, it really encapsulates what is already good
21 practice, so it is not new policy. What it brings is a
22 way of systematically looking at things which are
23 already known to be important, and that includes
24 establishing a shared understanding of the patient's
25 condition, what outcomes they value and fear

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1 **MS CAREY:** My Lady, the next witness was in fact due to be
2 Mrs Lesley Moore but due, unfortunately, to a family
3 emergency she is unable to attend today and the Inquiry
4 will update both you and the core participants in due
5 course once we are able to do so.

6 Can we return then please to Professor Summers and
7 Dr Suntharalingam. You are still under your oaths or
8 affirmations that you made last week.

9 And I would like to start with you, Doctor,
10 please, on the topic of advance care planning and do not
11 attempt cardiopulmonary resuscitation. All right?

12 And if it helps you, Doctor, we are starting at
13 paragraph 37 at your report.

14 **DR SUNTHARALINGAM:** Okay.

15 **MS CAREY:** Some people may find discussing this quite
16 distressing, so can we take our time and set out the
17 principles, the legalities and the realities at a steady
18 and slow pace if we may.

19 I would like to ask you please about why advance
20 care planning is important generally and then why it was
21 particularly important by the time we came to the
22 pandemic. So could we start there.

23 **DR SUNTHARALINGAM:** I think the broadest way to look at it
24 is that it is a way of ensuring the patient's informed
25 wishes are taken into account when making what are

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1 importantly, and what medical treatments would benefit
2 them and it is a structured way of looking at that in a
3 way that leads to being able to write down the
4 information for reference when it becomes relevant.

5 **MS CAREY:** It has been, I think you say, implemented in
6 parts of England and Scotland since 2016 and I think it
7 is currently being implemented across Northern Ireland.
8 I will deal with Wales separately, but let's just look
9 at the form itself.

10 Obviously it has got the patient's details in
11 there, the diagnosis or relevant information,
12 communication aids, whether they need an interpreter.
13 Would this also be used, for example, if someone had
14 perhaps a support worker or needed someone to help
15 communicate perhaps if they were learning disabled.
16 Would that information all be included in there?

17 **DR SUNTHARALINGAM:** Yes, I think anyone close to the patient
18 and able to represent -- firstly help them with the
19 decision-making and also able to represent them.

20 **MS CAREY:** Then there is a box of:
21 "Details of other relevant planning documents and
22 where to find them."
23 And "Advance Decision to Refuse Treatment" is
24 different, isn't it, as I understand it?

25 **DR SUNTHARALINGAM:** Yes. So that's a legal instrument. Not

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1 so in Scotland but it would still be taken into account,
2 so the sort of legal framework may differ but they,
3 unlike these other documents which broadly can be
4 considered called treatment escalation plans, the
5 advance decision to refuse treatment is legally
6 binding -- for the condition it applies for, it is
7 important to say. So it may be for particular
8 circumstances only.

9 **MS CAREY:** Right, so someone could say, for example, I don't
10 want to have chemotherapy, let's take it outside of
11 a pandemic context. They could make an advance decision
12 to refuse treatment and that would be binding and
13 therefore they would not have chemotherapy; is that
14 correct?

15 **DR SUNTHARALINGAM:** Yes. So they have legally declared they
16 are not consenting which is different to a statement of
17 values and preferences.

18 **MS CAREY:** Organ donation may also be discussed. And then
19 there is a section dealing with personal preferences
20 where people explain what is important to them, the
21 quality of life, that they might want to be able to do
22 this but not that. Can you give us some examples of
23 what might be included in that box there?

24 **DR SUNTHARALINGAM:** So if a discussion, for example, was
25 around instituting mechanical ventilation, something

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1 form, is it?

2 **DR SUNTHARALINGAM:** Yes. It includes the same information
3 and in a way it is wider and one of the benefits of this
4 sort of document is it avoids a DNACPR document in
5 isolation becoming sort of accidentally seen as a proxy
6 for wider treatment decisions. So by expressly
7 including all of those and then including the CPR part
8 as one end of the treatment process it puts it all into
9 context.

10 **MS CAREY:** As we go on to page 2, we can see there that is
11 reference to the capacity of the person at the time the
12 ReSPECT form is being filled in, and then various
13 options depending on who is involved in it, and the
14 capacity of the person. ReSPECT forms and those like
15 this, who are they ordinarily filled in by?

16 **DR SUNTHARALINGAM:** So by clinicians, but in terms of which
17 clinicians, really those in the best position to do it
18 at the time.

19 **MS CAREY:** Right.

20 **DR SUNTHARALINGAM:** Which, due to the nature of critical
21 illness -- and it may obviously involve treatment other
22 than critical care -- really, as early as possible, when
23 it becomes relevant. So it may be somebody with
24 a stable condition that they want to have taken into
25 account, it may be somebody who has come into hospital

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1 that might lead them to be weaker than they are already,
2 then they might say, actually, if the risk is -- there
3 is no certain outcomes -- but if there is a substantial
4 risk that I'm going to be worse off than I am now, even
5 if I survive the intensive care process, as an example,
6 or -- and I wouldn't wish to be living under those
7 conditions, I would only want aggressive treatment if it
8 left me fully able to do certain activities, then that
9 is to be taken into consideration. It is not
10 an absolute bar but it provides their input into the
11 decision.

12 **MS CAREY:** Right, and then it goes onto the clinical
13 recommendations, and who fills in that part of the form?

14 **DR SUNTHARALINGAM:** So really this is about -- although it
15 is signed by a clinician, the purpose of all these
16 documents is to establish a shared understanding and
17 an expression of values and preferences, so it would be
18 done with the patient, or those close to them, or both,
19 but it is filled in and signed by the clinician.

20 **MS CAREY:** Then we can see the boxes for signature, and if
21 we look to the -- just pause there, please, just come
22 down slightly, I just want to look at the box that's
23 ringed in red where CPR attempts are not recommended.
24 So this form can be used for someone to indicate whether
25 they would want CPR but it is not a do not attempt CPR

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1 with an acute condition, which case really as close to
2 the front door as possible if they're able to take --

3 **MS CAREY:** So a GP could fill this in with a patient --

4 **DR SUNTHARALINGAM:** Yes.

5 **LADY HALLETT:** -- or if you were going through cancer
6 treatment, you might fill it in with someone who is
7 providing that treatment for you?

8 **DR SUNTHARALINGAM:** Yes.

9 **MS CAREY:** Clearly slightly different considerations by the
10 time we get to critical care, potentially.

11 **DR SUNTHARALINGAM:** Yes.

12 **MS CAREY:** All right. And this form, where does it stay?
13 On whose records?

14 **DR SUNTHARALINGAM:** I think that is an important point about
15 this. The intention of the ReSPECT form, although
16 similar, is that it is transportable, it stays with the
17 patient. They themselves would have a copy. Where
18 there are electronic systems across regions, it would be
19 part of that, such as an electronic care plan.

20 And that contrasts with -- so it is an advantage
21 over something like a DNACPR form which is very specific
22 to an institution, so you may need different ones for
23 the ambulance service than ones for the hospital.

24 **MS CAREY:** We are going to look at a DNACPR form in
25 a moment. But do I understand it correctly that if

16

1 I went into hospital and I had a ReSPECT form if they
2 called up my records they should find the ReSPECT form
3 within them?

4 **DR SUNTHARALINGAM:** It does depend on the information
5 systems, but also -- you know, in an ideal world you
6 would have a copy with you, and you would be in
7 a position to highlight it and say, look, here is my
8 understanding of things at the moment.

9 **MS CAREY:** All right. Okay. This is a form in England,
10 Scotland and being rolled out in Northern Ireland. Can
11 we just consider the position in Wales. There is an All
12 Wales DNACPR policy which is different and I will come
13 back to that, but is there any equivalent of ReSPECT or
14 a form like it operating in Wales?

15 **DR SUNTHARALINGAM:** So the overarching -- this is
16 Resuscitation Council UK who I know you have as
17 a witness subsequently, they have adopted this as their
18 recommendation for all four nations. I think in terms
19 of the implementation, it is my understanding is that
20 the All Wales DNACPR form is under review as of
21 June 2024.

22 **LADY HALLETT:** Right.

23 **DR SUNTHARALINGAM:** And certainly the expert recommendation
24 from the Resuscitation Council is that it should be
25 considered across all the nations.

17

1 please, about DNACPRs. And some basics, please, if
2 I may, Doctor.

3 Is this the position, though, that in fact if you
4 have a cardiac arrest outside of hospital the survival
5 rate is relatively low, somewhere around 8%.

6 **DR SUNTHARALINGAM:** Yes.

7 **MS CAREY:** And if you indeed have a cardiac arrest and your
8 heart stops in hospital, survival rate is higher but it
9 is still only 23%?

10 **DR SUNTHARALINGAM:** Yes.

11 **MS CAREY:** Now, the DNACPR -- is this right -- means that
12 cardiopulmonary resuscitation should not be started for
13 that particular patient, or continued? Can you help me
14 why there might be circumstances where someone has
15 a DNACPR but nonetheless CPR has started and therefore
16 needs to be stopped?

17 **DR SUNTHARALINGAM:** CPR itself is clearly time-critical,
18 life-saving in those situations where it does work, but
19 only when it is started promptly. So where there is any
20 doubt, the presumption is always to start. Which is why
21 paper DNACPR forms often have red borders, they can be
22 easily identified, in electronic systems they are
23 flagged prominently so that you know in advance -- or
24 it's easy to spot, but if there's any --

25 **MS CAREY:** Pause there. We will pull one up on the screen

19

1 **MS CAREY:** Why would it help to have a form like ReSPECT
2 working across all four nations?

3 **DR SUNTHARALINGAM:** In a practical sense, people obviously
4 may travel across borders, and I think it is also about
5 just establishing shared best practice, so even if you
6 were to leave home, so to speak, if it works in one
7 place, it should -- the principle should apply
8 elsewhere.

9 It is probably worth emphasising this is, as we
10 said, one form among many, and it is a way of capturing
11 what are already existing principles. So it is about
12 best practice rather than new policy.

13 **MS CAREY:** Whatever the actual format of the form, are they
14 all asking similar questions and have similar
15 considerations set out in them?

16 **DR SUNTHARALINGAM:** Yes.

17 **MS CAREY:** Understood. I think, and you say in your
18 statement, you say there is a treatment escalation plan
19 document created by one of the health boards that was
20 adapted after Covid-19 and now carries the All Wales NHS
21 logo, and that applies in hospitals in Wales. Is that
22 correct?

23 **DR SUNTHARALINGAM:** That's my understanding.

24 **MS CAREY:** Clearly we have seen, on that ReSPECT form,
25 reference to DNACPRs, and I would like to ask you,

18

1 so that everyone can follow what you are talking about.
2 Could we have INQ000227411, please.

3 I won't go through the detail but we can just look
4 at one so we can see. 227411. Page 23, sorry, it's my
5 fault.

6 There we are. All right. This is an example of a
7 DNACPR form, and we can see there clearly the red
8 border. And where does that go on the patient's notes?

9 **DR SUNTHARALINGAM:** It can be in any particular place, but
10 it should be easily identifiable. And to return to your
11 previous question, the scenario where CPR may be stopped
12 is where it has been started because a patient is
13 observed to collapse. Appropriately, people may start
14 if they weren't aware of the existence of this form, but
15 once it is found, then it would be an indication to
16 stop, so that's a scenario where that might arise.

17 **MS CAREY:** So the patient would be treated, but if someone
18 had to go and locate the notes, for whatever reason, and
19 then realise there was a DNACPR, that would be
20 a circumstance in which you would stop, you wouldn't
21 just leave the patient without any treatment --

22 **DR SUNTHARALINGAM:** Yes.

23 **MS CAREY:** -- pending location of the form?

24 **DR SUNTHARALINGAM:** Yes.

25 **MS CAREY:** I understood. And in fact this form says on it,
20

1 it must be filled in at the front of the patient's
 2 healthcare record --
 3 **DR SUNTHARALINGAM:** Yes.
 4 **MS CAREY:** -- and we'd hope it would be somewhere visible.
 5 All right?
 6 **DR SUNTHARALINGAM:** It is worth saying that the verbal
 7 information about this, although it should be backed up
 8 obviously by the document as well, form part of
 9 handovers and ward safety briefings and so on so the
 10 information is passed on from shift to shift, as it
 11 were, or at handover.
 12 **MS CAREY:** Okay. Now, I think there are different
 13 circumstances in which a DNACPR notice may be made.
 14 Is this right, firstly, they can be made in
 15 advance where the person has the capacity to say,
 16 "I don't want CPR"?
 17 **DR SUNTHARALINGAM:** Yes.
 18 **MS CAREY:** All right, and we have looked at an example of
 19 that on the ReSPECT form, someone may come to that
 20 decision of their own volition?
 21 **DR SUNTHARALINGAM:** Yes.
 22 **MS CAREY:** If someone comes to that decision, is that
 23 decision respected? It is?
 24 **DR SUNTHARALINGAM:** Yes.
 25 For them to come to that position, they should
 21

1 **DR SUNTHARALINGAM:** Yes.
 2 **MS CAREY:** -- where a clinician has decided that there
 3 should be a DNACPR notice?
 4 **DR SUNTHARALINGAM:** Yes.
 5 **MS CAREY:** Right. And is this the position, a patient or
 6 loved one cannot demand CPR if it would be clinically
 7 inappropriate?
 8 **DR SUNTHARALINGAM:** That is right. It is a treatment
 9 decision and the treatment itself, it is not a switch
 10 where you simply decide to save someone's life, it is
 11 a treatment process often quite intrusive, and it is
 12 like any other treatment: you do it because you think it
 13 will work.
 14 **LADY HALLETT:** Sorry to interrupt. You say it is a legal
 15 requirement that a patient should be consulted before
 16 the decision is taken. Just looking at the form,
 17 I appreciate that there are several boxes which include
 18 having discussions with those close to the patient at
 19 box 4, for example. But I'm just a bit concerned; box 1
 20 or question 1:
 21 "Has the patient appointed a health or welfare
 22 attorney to make decisions on their behalf? If yes,
 23 they must be consulted."
 24 Surely that is not highlighting the fact that
 25 there is a legal requirement that loved ones of the
 23

1 obviously be able to have all the information about
 2 their condition, which they have themselves, but to have
 3 clinical scenarios explained to them or might be
 4 relevant to this if they are acutely ill or things are
 5 deteriorating, and despite access to support as well,
 6 having written information where feasible. So, again,
 7 it all comes to the benefits of having that discussion
 8 early.
 9 **MS CAREY:** Early. All right. Understood. There may also
 10 be circumstances, though, where it is a medical
 11 treatment decision, made by clinicians such as
 12 yourselves, that CPR should not be offered because it is
 13 not clinically appropriate, and I want to be clear about
 14 that. In the circumstances where a clinician says, "We
 15 shouldn't do CPR because it won't work", does the
 16 patient or their loved one have to consent to that
 17 clinical treatment decision?
 18 **DR SUNTHARALINGAM:** No, they should be aware of it, and
 19 should be able to be involved in it and, if necessary,
 20 question it, but they don't specifically consent to it.
 21 It is about what treatment may be clinically appropriate
 22 and is on offer, so to speak.
 23 **MS CAREY:** Am I right, though, that the law does require the
 24 patient, if they have capacity, or their carers/loved
 25 ones, to be consulted --
 22

1 patient to be consulted by just taking the health and
 2 welfare attorney example. Do you see what I mean?
 3 **DR SUNTHARALINGAM:** Yes, yes, my Lady.
 4 I think the way -- I think the issue of a
 5 chronology is -- my understanding of this is that this
 6 shouldn't come as a surprise, if you like to the patient
 7 or those close to them after the event, it is not
 8 necessarily the same as saying they must be consulted
 9 first, so they should be made aware of it, and I agree
 10 it should be anyone that is in a position to be
 11 a representative of the patient if they themselves can't
 12 take part in that discussion.
 13 **LADY HALLETT:** I just wonder if that form should be clearer?
 14 **PROFESSOR SUMMERS:** I think the other important thing is
 15 this is just one DNACPR form of one particular
 16 organisation, I do not think there is one unified --
 17 **LADY HALLETT:** They won't necessarily be the same.
 18 **PROFESSOR SUMMERS:** It won't necessarily be the same in
 19 every single institution. This is just one example of
 20 such a form.
 21 **LADY HALLETT:** No. I'm just --
 22 **MS CAREY:** So this one, for example, does not refer to loved
 23 ones, families, carers and the like, and people with
 24 a power of attorney are in a potentially slightly
 25 different category, it doesn't even mention that. But
 24

1 I don't want anyone to be confused between who has to be
2 consulted.

3 I was going to look at the form, if I may,
4 my Lady, and just go through some of the boxes.

5 But, does the patient have capacity to make and
6 communicate decisions? If they do then they should be
7 consulted. Is that the position?

8 **DR SUNTHARALINGAM:** Yes.

9 **MS CAREY:** Right. If they don't, you have to see whether
10 there is an advanced decision to refuse treatment, in
11 which case that would be legally binding, as
12 I understand it. Do they have a health and welfare
13 attorney, potentially called different things across the
14 four nations?

15 **DR SUNTHARALINGAM:** Yes, this is the Welsh document --

16 **MS CAREY:** All right. This is the Welsh document, yes, to
17 make decisions on behalf. But if they do have the
18 health and welfare power of attorney in Wales or power
19 of attorney in some other countries, then they must be
20 consulted; is that correct?

21 **DR SUNTHARALINGAM:** It's correct, and it is worth making the
22 point at this stage, which is relevant to other
23 discussion as well, that a patient's capacity can be a
24 stable fixed condition or it can change. So if somebody
25 is confused and delirious on one day, they may not be

25

1 attorney, or a IMCA?

2 I'm afraid I'm not familiar with "IMCA". Can you
3 help with that?

4 **DR SUNTHARALINGAM:** That is an independent advocate for --
5 *(Unclear: simultaneous speakers)*

6 **MS CAREY:** Thank you. And then it is filled in, as we can
7 see, by the healthcare professional, and they have to
8 give various of their details.

9 Cancellation of decision, can I ask you about
10 that. In what circumstances would a DNACPR be
11 cancelled?

12 **DR SUNTHARALINGAM:** So the factors leading into that
13 discussion are partly around the underlying condition of
14 the patient, but also about their acute condition. And
15 it may be their severity at that stage is such that it
16 is felt that they wouldn't benefit further from CPR if,
17 for example, they are already receiving maximum life
18 support on intensive care. If their heart stops at the
19 end of that, it may be felt that that's not going to
20 benefit.

21 However, if they then, under the existing
22 treatments, get better, then it may be -- and if that
23 acute condition was part of the reason for the DNACPR,
24 then that may need to be reversed. So it is very much
25 a live document that is always under review.

27

1 the next, and even with the attorney involved, if the
2 patient has capacity on the day, then that takes
3 precedence.

4 **MS CAREY:** But to follow up to her Ladyship's question, in
5 fact nothing on here about "Has the patient's family,
6 loved one, carer been consulted?", and that ought to
7 happen legally, as I understand it?

8 **DR SUNTHARALINGAM:** I think so. It is touched on in
9 question 4 in terms of asking the question, but it says
10 those close to the patient rather than specifying who
11 that should be, so.

12 **MS CAREY:** Family, loved one, carer, it could be any one of
13 the aforementioned, all right.

14 Then, the clinician has to fill in why CPR would
15 be inappropriate, unsuccessful or not in the patient's
16 best interests.

17 Has the discussion taken place with the patient,
18 "yes" or "no"? If it has not been discussed that ought
19 to be recorded in the form. And presumably would say
20 patient is ventilated, patient is unconscious --

21 **DR SUNTHARALINGAM:** Yes.

22 **MS CAREY:** -- something along those lines.

23 **DR SUNTHARALINGAM:** Yes.

24 **MS CAREY:** Has an appropriate discussion taken place with
25 those close to the patient, the health and welfare

26

1 **MS CAREY:** Who makes the decision to cancel the DNACPR?

2 **DR SUNTHARALINGAM:** Really the same set of clinicians who
3 institute it -- potentially. So it may have been
4 a DNACPR that was set up on a ward, they come to
5 intensive care, things change. So, really the clinician
6 looking after the patient at that time.

7 **LADY HALLETT:** Right. And then box 8:

8 "Copies of the DNACPR decision have been sent to:
9 [The] patient/carers

10 GP

11 Nursing or Care Home."

12 In a hospital setting, is there someone

13 responsible for sending the DNACPR to the patient or
14 their carer and the GP?

15 **DR SUNTHARALINGAM:** I think --

16 **LADY HALLETT:** Or is that either/or?

17 **DR SUNTHARALINGAM:** Yes, it's either/or, and I think it
18 comes under sort of discharge management and sharing
19 information when the patient leaves the -- leaves the
20 institution.

21 **LADY HALLETT:** And then if we just keep scrolling down
22 slightly:

23 "All boxes must be completed.

24 In the event of cardiac or respiratory arrest, no
25 ... (CPR) will be made. All other ... treatment and

28

1 care will be provided."

2 Clearly, I think you have made the point a number
3 of times already in your report that a decision to not
4 perform CPR is not the same as not treating someone in
5 all other respects.

6 **DR SUNTHARALINGAM:** Yes.

7 **LADY HALLETT:** All right. And then there is various other
8 parts of the form that I don't need to trouble you with.

9 Now, we have looked at this in a rather sterile
10 and non-pandemic situation. But can I ask you please
11 about how one fills in this form in critical care
12 settings and perhaps, Professor, if I can come to you:
13 if someone is brought into critical care and is not
14 getting better, pre-pandemic, can you give us an example
15 of how you would discuss DNACPRs with the patient's
16 family?

17 **PROFESSOR SUMMERS:** As you rightly point out, it is often in
18 the critical care setting with the patient's loved ones
19 rather than with the patient themselves because at that
20 point they have been so compromised that they are unable
21 to participate in the discussions because they don't
22 have capacity.

23 I suppose talking you through the nuts and bolts
24 of how one does that, you usually would be meeting face
25 to face wherever possible with those family and loved

29

1 family to make a decision, that the burden of that
2 decision is made about what's clinically appropriate by
3 the doctors, and explain very clearly that that's my
4 responsibility, I'm not asking them to carry that burden
5 and nor should anyone because you are asking them to
6 make a decision about someone whom they love and care
7 for very much at a time of great distress.

8 But it is important that they have the opportunity
9 to input into that decision and then explain, having
10 heard what they have said and reflected on what they
11 have said about what they think the patient would think
12 or any discussion that has ever happened, I explain my
13 viewpoint on the situation as a clinician, that
14 actually, taking everything into consideration, I do or
15 do not feel that resuscitation is appropriate in this
16 particular scenario.

17 **MS CAREY:** Pausing there. If a clinical decision is made by
18 someone like you that there should be a DNACPR, and the
19 patient's loved ones disagree, can they ask for a second
20 opinion?

21 **PROFESSOR SUMMERS:** Absolutely yes.

22 **MS CAREY:** And if a second clinician comes along and says,
23 "No, I think it is clinically inappropriate", at that
24 point is the DNACPR notice made?

25 **PROFESSOR SUMMERS:** Yes, but I would say that we would make

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1 ones and the place in which I would normally start those
2 conversations is to ask the loved ones what's their
3 understanding about the clinical situation in which we
4 are, so that we can all start from the same place.

5 Sometimes they have just attended the intensive
6 care unit in an emergency, they aren't fully up to speed
7 with how their loved one ended up here and so it is
8 important for everyone to clarify their understanding
9 about the circumstances that have brought us to the
10 point we need to have this conversation.

11 And once we have clarified that and it is --
12 I feel that everybody understands what has happened and
13 why we are all in the room having this conversation,
14 I then ask, have the patient or their loved ones ever
15 discussed what they would want at the end of their life?
16 You know, what are their values? What are the things
17 that they would say if they were not here, or if they
18 were here and they are not able to contribute? And very
19 often people haven't ever discussed this as a family and
20 so we are asking the loved ones, as the people who know
21 the patient best, given that we have rarely met them
22 when they are well in a critical care setting, what do
23 you think they would say if they were able to contribute
24 to this conversation?

25 I'm usually very clear that I'm not asking the

30

1 tremendous effort to try and reach an agreed
2 understanding of the situation. I don't think it is in
3 anybody's interests for there to be wild disagreement.
4 Because this is the family's loved ones, trying to
5 explain why we are where we are is important.

6 **MS CAREY:** Now, in pandemic times I suspect there was not
7 the time -- there wasn't the bedside conversation or in
8 a side room. How did you practically go about having
9 DNACPR discussions with loved ones perhaps over Zoom or
10 some other kind of remote meeting? Can you tell us how
11 you went about it and how you found it?

12 **PROFESSOR SUMMERS:** This was one of the most extraordinarily
13 difficult parts of ICU care in the pandemic. Very often
14 the loved ones of our patients had last seen them when
15 they were leaving home to come into hospital and at that
16 point often they were conscious, they were talking, and
17 they were in a very different state to they are at the
18 point that we are contacting them to have this
19 conversation.

20 That differs enormously from the usual clinical
21 practice when the patient's loved ones would often have
22 been at the bed side and seen that deterioration over
23 days and I remember very often people who came into
24 intensive care for Covid had been in hospital for a few
25 days beforehand, so they had deteriorated over some days

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1 and then come to us because of the course of the
2 clinical illness and they would not have seen any of
3 that.

4 **MS CAREY:** So it may have come as a real shock --

5 **PROFESSOR SUMMERS:** Yes.

6 **MS CAREY:** -- when you have to make the call or speak to
7 them on the Zoom, that you haven't even had the
8 conversation, never mind the actual detail of the
9 conversation, and how did those conversations go when
10 you had to speak to the loved ones?

11 **PROFESSOR SUMMERS:** They were hard because you have never
12 been in the same room as that individual. They have
13 someone who therefore they have not met talking to them
14 about a situation that they have not been able to
15 witness over a period of days, in a very remote and
16 disconnected way, either via telephone or via Zoom and
17 we were having to have these conversations in greater
18 number than you would ordinarily because the number of
19 patients in critical care was greater and the level of
20 severity of the illness and the outcomes were, overall,
21 worse than they would be for the usual ICU population.
22 So you would have done several ward rounds and then
23 maybe making several of these calls in the course of
24 a day to explain to a family the situation their loved
25 one was in. It was not easy for the families or for the

33

1 out that there is a DNACPR on their record. What is the
2 circumstances -- what is the process then if someone
3 says, "Well, there is one on my record and I'm awake now
4 and I'm alert and I'm better", how does one go about
5 having a DNACPR notice reviewed?

6 I don't know if, Professor, or Doctor, whichever
7 of you feels best able to speak to this.

8 **DR SUNTHARALINGAM:** I think it means going through the
9 institution where it was generated so likely in an acute
10 hospital and through the services of that hospital. So
11 there are outpatient liaison services or an email to the
12 chief executive, whatever is required to get in touch
13 with the hospital through existing routes, and they can
14 then take it from there.

15 **MS CAREY:** Right, so if it was made in a hospital, they
16 ought to contact the hospital; if it was made by a GP,
17 go back to the GP and any other settings and every other
18 setting in between.

19 Can I ask you about the CQC findings.

20 **LADY HALLETT:** Just before you do that, I have also heard
21 from a large number of bereaved families that not only
22 did they find out about the DNACPR notice on their loved
23 one's records but that they weren't consulted or no
24 discussion took place with them and they knew their
25 loved one was not in a position to have had

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1 healthcare staff.

2 **MS CAREY:** No, well, I was going to ask you, who was
3 actually -- obviously you may have made some calls
4 yourself, but was there a set person who had to made the
5 call, was it always the clinician, was there other
6 people supporting in this role during the pandemic, do
7 you know?

8 **PROFESSOR SUMMERS:** Different hospitals and institutions
9 organised how they did this differently. Some hospitals
10 set up family liaison teams where they had non-critical
11 care positions having conversations with families about
12 that. We chose not to do that in the hospital in which
13 I work and as the critical care consultant and medical
14 team we made those phone calls.

15 **MS CAREY:** Can I ask you, Professor, since you are speaking,
16 do you personally have any experience or are aware of
17 blanket use of DNACPRs in your hospital?

18 **PROFESSOR SUMMERS:** I do not.

19 **MS CAREY:** And Dr Suntharalingam, do you have any personal
20 experience?

21 **DR SUNTHARALINGAM:** No.

22 **MS CAREY:** We have heard of them, clearly, in a number of
23 respects. Can I ask you this, the Inquiry has also
24 heard there were some examples of families whose
25 patients had been discharged and have subsequently found

34

1 a discussion. Are you aware of situations where notices
2 were put on without any discussion with the patient
3 because the patient didn't have capacity and without any
4 discussion with the family member?

5 **DR SUNTHARALINGAM:** I think it depends on the context. I
6 think in our clinical setting of critical care, because
7 we are very hands on with the patients and the situation
8 is changing every day, the sort of discussions the
9 professor describes would have been had. There may have
10 been some slipped through the net but it wouldn't be the
11 normal case. I think some of the examples you have had
12 may have been from other settings where there may be
13 fewer people looking after larger number of patients.
14 So I can't really comment on that but I would think in
15 our setting it would be very unusual.

16 **LADY HALLETT:** Is your setting a large teaching hospital?

17 **DR SUNTHARALINGAM:** A clinical setting regardless of site,
18 actually, so any intensive care unit --

19 **LADY HALLETT:** Oh, I see.

20 **DR SUNTHARALINGAM:** -- (overspeaking) -- these sort of
21 discussions are really part and parcel and it is not to
22 say they wouldn't be for other people but it may have
23 been a DNACPR decision that was in records from much
24 earlier, may have been made in a very different setting.
25 It is difficult to comment without knowing --

36

1 **LADY HALLETT:** It could have been made in a setting -- in a
2 ward where maybe the staff weren't not used to -- as you
3 are, obviously, sadly, too used to this kind of
4 discussion or process -- but they could have been made
5 in situations where the staff weren't as familiar with
6 the process that needs to be gone through.

7 **DR SUNTHARALINGAM:** Potentially, and I think some of the
8 potential benefits of widespread treatment escalation
9 planning such as a ReSPECT form, part of that includes
10 normalising discussions, not only for the public and the
11 patients themselves but also for all staff in all areas,
12 so it becomes part of the process of healthcare for
13 those patients where it is appropriate. So they are at
14 risk of dying.

15 **LADY HALLETT:** Sorry to interrupt.

16 **MS CAREY:** No, not at all because actually it alights on
17 exactly what I was going to ask about with the CQC
18 findings.

19 Could we call on screen INQ00474255_27.

20 My Lady will recall there was an interim report
21 and then a final report done by the CQC and it really
22 just picks up on the questions your Ladyship was posing.
23 The CQC found that the healthcare professionals they
24 spoke to:

25 "... recognised the importance of ensuring the

37

1 did improve after, so it partly reflects the sort of
2 multitude of policies and changes early on. But I think
3 your wider point, I absolutely agree.

4 And it is worth saying, this is a positive
5 discussion, as well. It is about how people want their
6 last days of life to be and whether CPR is something
7 they want as the means of their death, which
8 unfortunately is often the case, or whether they would
9 rather die at home without intervention. So obviously
10 those answers will vary a lot depending on the patient's
11 medical condition itself, their values and wishes, so it
12 is really a positive discussion around -- and it is
13 a society-wide discussion around death really.

14 I agree the more open and prevalent that is and
15 people not feeling embarrassed to talk about it with
16 their family members, the more likely it will be that
17 these sorts of situations don't arise in a crisis.

18 **MS CAREY:** The CQC report goes on to refer to a lack of
19 training and support for staff and how confident they
20 were in holding these conversations has impacted on the
21 quality of people's experience.

22 Now, you two, I'm afraid, have to deal with this
23 more often than a number of other staff. Can I ask you,
24 who practically do you think should be responsible for
25 training those who are not working in critical care or

39

1 conversations around advance care planning ... But how
2 well people were involved in conversations about their
3 care and whether or not they wanted to receive [CPR]
4 varied. Some people experienced compassionate,
5 person-centred care where they were fully involved ..."

6 And then there were others where it did not happen
7 and they found it hugely distressing. In these cases,
8 they say:

9 "Conversations took place at short notice and
10 people did not fully understand what was happening or
11 what a DNACPR was. Having the time and information to
12 talk about what care and support people want and need to
13 have a dignified and peaceful death is essential."

14 Can I ask you both this, do you agree with the
15 CQC's conclusion there about trying to talk about this
16 when we are not in a pandemic situation with stretched
17 ratios, where people have seen someone leave in
18 an ambulance and then see them potentially on
19 a ventilator, is this really all about talking about
20 death and how we would like to die in advance of the
21 urgent critical situation we ended up in the pandemic?

22 **DR SUNTHARALINGAM:** Absolutely yes. I think it is worth
23 just starting with the point that I believe this is the
24 CQC report about what was happening in nursing and care
25 homes and at an earlier stage of the pandemic and things

38

1 end of life treatment? Who would be responsible for
2 providing that kind of training? The Trust, the
3 hospital, NHSE, the regulators?

4 **PROFESSOR SUMMERS:** So communication training and having
5 conversations such as this actually is a core part of
6 the medical training curriculum for medical students as
7 set out by, I think, the General Medical Council. So
8 actually it is a training thread that should go through,
9 certainly for doctors, and I would argue other
10 healthcare professionals too, throughout their training.
11 We are required in the nature of our work to have all
12 kinds of difficult conversations with people around
13 death and other personal issues and I don't think saying
14 it was just the responsibility of Trusts is broad
15 enough. I think that actually it should be embedded as
16 a core part of professional education.

17 **MS CAREY:** I was going to say, do you have to do continuing
18 professional education?

19 **PROFESSOR SUMMERS:** Yes.

20 **MS CAREY:** Is it part currently of any continuing
21 professional education programme that you are aware of?

22 **PROFESSOR SUMMERS:** Certainly the matrix for intensive care
23 positions and members of the Royal College of Physicians
24 includes having the skills on keeping up to date with
25 both the legal and the professional best practice.

40

1 **DR SUNTHARALINGAM:** It is worth adding the point that
 2 I think those who generated the ReSPECT form would say
 3 that as part of the implementation of that, so we are
 4 talking about four nations' implementation that funded
 5 training by institutions, organisations supporting the
 6 Trusts and Health Boards and employers is a key part of
 7 it as well, and there is a wider point behind that,
 8 which is whether it is about DNACPR, or around treatment
 9 escalation planning, having clinician time to actually
 10 have these conversations, clearly in a pandemic certain
 11 things apply but in normal life it's making sure the
 12 time is there to have those conversations as well as the
 13 training.

14 **MS CAREY:** Thank you. Can I move to a different topic with
 15 you, Doctor, and it is the work that you undertook in
 16 March 2020 in relation to a clinical prioritisation tool
 17 that you were asked to consider working on some
 18 guidelines for by I think the Chief Medical Officer. We
 19 heard from Professor Whitty two weeks ago now and I said
 20 then we were hearing from the person involved or one of
 21 the three involved.

22 Can I just start like this: I think it is obvious
 23 from what you have said that clinicians make decisions
 24 about who should be admitted to care on a daily basis.
 25 I think you told us last time that you would have

41

1 saturated, by which I mean there was no bed available.

2 **DR SUNTHARALINGAM:** Yes.

3 **MS CAREY:** And we have heard about the NHS being in CRITCON
 4 4. Is it this that the tool was designed to address?

5 **DR SUNTHARALINGAM:** Yes. In fact the wider framework that
 6 was very much part of this work, so bearing in mind this
 7 was very early on in the pandemic, and at that point
 8 numbers were rising, and in fact the framework very
 9 explicitly tied CRITCON and mutual aid to the potential
 10 trigger for a tool. So it wasn't the tool in isolation,
 11 it was pairing those two things so there was
 12 an operational context to what might then be needed.

13 **MS CAREY:** I just wanted -- can I perhaps put it more
 14 simply. Was this designed in the event that there was
 15 no bed anywhere and you had two people vying for one
 16 bed?

17 **DR SUNTHARALINGAM:** Essentially, yes.

18 **MS CAREY:** Now, that is a very heartless way, I appreciate,
 19 of describing it but that's what we are talking about
 20 here and no other bed in a neighbouring hospital?

21 **DR SUNTHARALINGAM:** No.

22 **MS CAREY:** Or, indeed, a neighbouring region that could be
 23 sensibly someone transferred to?

24 **DR SUNTHARALINGAM:** That is right, and in the context that
 25 mutual aid and decompression would already have happened

43

1 a discussion with the ward if the ward thought the
 2 patient was deteriorating and you would be involved then
 3 in deciding whether it was appropriate for the person to
 4 be admitted to ICU.

5 Yesterday I think you are aware we heard about
 6 a NICE guideline to assess patients when they are
 7 admitted to hospital to consider whether they might need
 8 critical care. Is that correct?

9 **DR SUNTHARALINGAM:** I believe so, yes.

10 **MS CAREY:** That's not the same thing that the tool that you
 11 were working on that Professor Whitty --

12 **DR SUNTHARALINGAM:** No.

13 **MS CAREY:** And as I understand it you were asked to draw up
 14 guidance in the event that critical care was saturated?

15 **DR SUNTHARALINGAM:** That is right. In fact the lead for it
 16 was Professor Whitty and he was kind enough to comment
 17 on it two weeks ago, as you say, saying that it was
 18 difficult but he felt the outcome at the time was useful
 19 and sensible. It was for the four nations, so it was
 20 the quintet of four CMOs and the National Medical
 21 Director.

22 **MS CAREY:** And if I understand it, I think on 21 March you
 23 and two other colleagues were asked to form a group to
 24 consider the clinical prioritisation model to be used in
 25 the event that the NHS critical care resources were

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1 so essentially talking about -- (overspeaking) -- which
 2 would be a very extreme scenario.

3 **MS CAREY:** We looked at all the transfers and the rising
 4 numbers and indeed we looked at the circular diagram of
 5 the example of Northwick Park and the number of other
 6 hospitals that they transferred patients to. But
 7 assuming in that example that there was no other bed
 8 available and CRITCON 4 had been declared, this was when
 9 the tool was envisaged to operate; is that correct?

10 **DR SUNTHARALINGAM:** That is correct. And two things to
 11 emphasise. Firstly, CRITCON 4 is a national situation
 12 not just in that hospital. We have talked about
 13 scenarios where CRITCON might be triggered as
 14 an alerting tool but where CRITCON 4 is agreed by those
 15 in authority to be a national state, and then the other
 16 point to make is this is all time sensitive. It is
 17 really about queuing for the next available bed and that
 18 might change when a bed comes up. So it is not about
 19 barring people from being admitted, it is saying who we
 20 would admit into the beds available right now.

21 **MS CAREY:** Perhaps if we look at how the tool was envisaged
 22 to work by reference to your paragraph 110, Doctor.

23 Could we call up on screen -- thank you very
 24 much -- a summary of how the framework was proposed.
 25 I won't necessarily go through all of these but we can

44

1 see there it was designed to effectively only operate
 2 once CRITCON 4 was declared in one or more regions and
 3 where CRITCON 4 is declared, NHS England, in this case,
 4 have to be notified so they know the position and all
 5 other possible sources of mutual aid between hospitals
 6 have been exhausted.

7 **DR SUNTHARALINGAM:** That is right.

8 **MS CAREY:** So it really is in extremis?

9 **DR SUNTHARALINGAM:** That is right. And although CRITCON was
 10 sort of convenient vocabulary for this, obviously for
 11 the other three nations it is around that same
 12 information being escalated in other ways about capacity
 13 and saturation.

14 **MS CAREY:** It makes the point there at 110.2 that there
 15 should be no triage until every accessible ICU is full.

16 **DR SUNTHARALINGAM:** Absolutely.

17 **MS CAREY:** "This assessment should be based on accurate
 18 collection and communication of realistic frontline ICU
 19 conditions using CRITCON or equivalent ... rather than
 20 abstract bed counts against a theoretical bed base."
 21 What were you getting at there, if I may ask?

22 **DR SUNTHARALINGAM:** It was the discussion we had earlier
 23 really about having -- although it's useful to think in
 24 terms of notional surge capacity, those are, sort of,
 25 fairly abstract numbers and if units are becoming

45

1 and both are eligible and it is appropriate to escalate
 2 them to ICU, you would use the tool to say that person
 3 should be number 1 to get that bed and then if one
 4 becomes available, the next person gets it. Is that how
 5 it was meant to work?

6 **DR SUNTHARALINGAM:** Yes. The tool in its final form was
 7 about "expected to survive" or "likely to survive"
 8 versus "may" or "may not survive", versus "unlikely" or
 9 "not expected to survive". So it was really just
 10 a verbal description rather than a numerical score and
 11 using that you would use it as a ranking system in the
 12 scenario that you found yourself.

13 **MS CAREY:** Was it ever envisaged the tool would say that
 14 someone should be taken out of ICU? Was that part of
 15 the framework you were considering?

16 **DR SUNTHARALINGAM:** No. Under the label of reverse triage,
 17 it is a concept and people did raise whether we should
 18 but in the context of this, no, it wasn't. I think, in
 19 this case, it was too difficult to put into a structured
 20 form that would make sense to people at the time.

21 **MS CAREY:** So you were not asked, nor did you in fact,
 22 I think, consider the possibility of having to take
 23 someone off a ventilator, for example, to make room for
 24 others; that is not what the tool was designed for?

25 **DR SUNTHARALINGAM:** No.

47

1 realistically saturated under the conditions at the
 2 time, that's what's going to start influencing clinical
 3 decision-making, albeit subconsciously, and in practical
 4 terms through simple lack of available beds. So that is
 5 the realistic frontline conditions in the view of those
 6 working there that needs to feed into this level of
 7 realistic decision-making. And percentages of notional
 8 total surge capacity may not help with that.

9 **MS CAREY:** Then 110.4:
 10 "If critical care resources become exhausted
 11 nationally, any declared clinical prioritisation would
 12 operate on a ranking basis in the event of needing to
 13 prioritise one patient over another when competing for
 14 the same resource (in effect, 'the last ICU bed')."
 15 What was that trying to convey?

16 **DR SUNTHARALINGAM:** It was really the point we made earlier
 17 that this is reflecting -- this is not about triaging
 18 people in the sense of saying they will never get
 19 an intensive care bed unless that is the clinically
 20 appropriate scenario in any case, but under pandemic
 21 conditions it is not about ruling people in or out, it
 22 is saying for the next available bed who should take
 23 precedence over somebody else on the grounds of
 24 survivability using these principles.

25 **MS CAREY:** Right. In a scenario where you have two patients

46

1 **MS CAREY:** Understood, all right.
 2 So, effectively, it was a ranking system for who
 3 should get the next bed available whilst there were
 4 these extreme conditions?

5 **DR SUNTHARALINGAM:** That is right. I think in terms --
 6 although it is quite appropriate to talk about beds it
 7 is really about starting a treatment process in
 8 a limited setting in CRITCON 4 and in extremis.

9 **MS CAREY:** Can I ask you, why is it important to have a tool
 10 at all?

11 **DR SUNTHARALINGAM:** I think the benefits are, firstly,
 12 transparency. Both within the profession and also to
 13 the public and particularly those who might be
 14 disadvantaged in general. So even if people may not
 15 agree with it or like it, the fact that they can see it
 16 I think is important and that replaces any risk of
 17 subconscious bias or unseen decision-making. So,
 18 firstly, there is one of transparency.

19 Secondly, there is one of efficacy, which is that
 20 by publishing something and having a plan it may be
 21 adapted and modified and improved and disputed if
 22 necessary, but you have to work with what is available
 23 and it means that what we do have is the best we could
 24 manage at the time.

25 **MS CAREY:** Can I pause you there. Do I take it from that

48

1 that prior to the pandemic there was no in extremis
 2 saturation tool available?
 3 **DR SUNTHARALINGAM:** No.
 4 Thirdly, I would say there is reassurance in two
 5 forms, one is for clinicians to know that even if you
 6 are saying this is usual conditions, we are not
 7 saturated yet, for clinicians to know that there is some
 8 sort of plan for what happens next means, firstly -- it
 9 means that they don't feel that sense of moral doubt and
 10 injury, potentially worrying they will find themselves
 11 in that situation on their own in the middle of the
 12 night at their site. They know there is a plan.
 13 Secondly, for the public and for patients it gives
 14 them the safety that people aren't going to find
 15 themselves in a position of being triaged
 16 inappropriately. If there is a national plan and people
 17 know when it's switched on and when it's switched off,
 18 that only the CMOs can activate it, it protects the
 19 public by avoiding -- the risk that we're not talking
 20 about something, it sort of happens unseen.
 21 **MS CAREY:** Is there any, do you know, will or desire among
 22 the medical profession to have a tool such as this in
 23 case we find ourselves again in a situation where we are
 24 overflowing in ICU beds?
 25 **DR SUNTHARALINGAM:** I would say yes. Obviously, having been
 49

1 and the tool wouldn't be needed, there was a discussion
 2 around publishing it so it could be developed openly and
 3 with as much professional and public input as possible
 4 by a professional society.
 5 The Intensive Care Society took that on, in
 6 consultation with as many other groups as possible.
 7 What was originally published, firstly as a guideline
 8 from the Intensive Care Society, endorsed by the Royal
 9 College of Physicians and --
 10 **MS CAREY:** Pause there, because we'll have a look at it.
 11 **DR SUNTHARALINGAM:** Sure.
 12 **MS CAREY:** Can I have on screen, please, INQ000395282. Just
 13 before, you were about to tell us who it was endorsed
 14 by, this was obviously not the framework that you worked
 15 on in that week in March 2020, but it is effectively
 16 using your work, this guidance was then developed based
 17 on it; is that correct?
 18 **DR SUNTHARALINGAM:** That is correct, and in the context of
 19 if a national guidance at NHS level were to be required,
 20 then this provides a starting point to pick up and start
 21 from this rather than from a blank page. So it would be
 22 sort of relevant and looping back again if necessary, so
 23 to speak.
 24 **MS CAREY:** I think this guidance came out on 28th May 2020;
 25 is that correct?
 51

1 involved in that particular point of view, but I think
 2 genuinely looking at wider discussions there was a need
 3 for it and, to be clear, it is not about a tool that you
 4 pick up and start using on your own, it is knowing that
 5 there is something -- there is a plan in the background
 6 that may be activated and I think that in itself
 7 provides reassurance for people.
 8 **MS CAREY:** I think just to finish this topic, albeit only
 9 the -- only seven days when the framework was being
 10 considered by your group, I think you say that the group
 11 consulted with the critical care professional community,
 12 age and disability groups, and with the Department of
 13 Health and Social Care's moral and ethical advisory
 14 group, and there were various changes made to the
 15 putative framework during that period as a result of
 16 those meetings.
 17 Just finally on this topic then, did your work as
 18 part of that group effectively form a starting point for
 19 a document that is now in existence, which is the
 20 clinical guidance published by the Intensive Care
 21 Society.
 22 **DR SUNTHARALINGAM:** That is correct. On 28 March when the
 23 work for the quintet of CMOs and National Medical
 24 Director was stood down on the grounds that, at that
 25 stage, it looked as if the first wave was as seceding
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1 **DR SUNTHARALINGAM:** That is correct.
 2 **MS CAREY:** We can see there that it is endorsed by Royal
 3 College of Physicians, the Scottish Intensive Care
 4 Society, the Welsh Intensive Care Society, All Wales
 5 Trauma Critical network, the national Critical Care
 6 Networks of England and Northern Ireland.
 7 So a UK-wide document. It is entitled "Assessing
 8 whether Covid-19 patients will benefit from critical
 9 care ... an objective approach ..."
 10 But is it solely for use during a respiratory
 11 pandemic that involves Covid-19?
 12 **DR SUNTHARALINGAM:** No, I would say, and then there are
 13 three elements to this, and I think also to reassure
 14 anyone listening, the guidance has the same elements as
 15 the original framework, which is including the shared
 16 escalation, the mutual aid, the fact that any decision
 17 tool would apply in CRITCON 4, so if somebody has to
 18 pick those up and use this today, they would say, well,
 19 we're in CRITCON 2 or 3, therefore the usual
 20 decision-making applies, nobody is going -- should be
 21 going to the back page and using the tool on its own.
 22 But in that context, in terms of applicability,
 23 the document has statements of moral and ethical
 24 principles which are applicable to any crisis, and
 25 potentially outside a crisis. It has a statement about
 52

1 shared escalation, mutual aid, the CRITCON framework,
2 which are also -- should apply to any crisis.

3 And then the tool at the end is specific to Covid,
4 and would need to be re-assessed, re-designed as indeed
5 it would have done during the pandemic itself if it were
6 in use, because it was based on available data at
7 28 March, or would in any case have been adapted.

8 For a different disease there would be different
9 criteria, different things to look at.

10 **MS CAREY:** So barring the, I think it is appendix 2, if we
11 just look at it at page 12 of the document, there is the
12 decision to support aid in relation to Covid. But
13 essentially, if one looked at pages 1 to 11, they would
14 be applicable whatever the virus, whatever the disease,
15 whatever the extremis circumstances underpinning it.

16 **DR SUNTHARALINGAM:** Yes.

17 **MS CAREY:** You could basically use pages 1 to 11, and add on
18 an appendix, to be specific, to whatever circumstance
19 that was appropriate?

20 **DR SUNTHARALINGAM:** I think so, I don't know, would it be
21 useful to look at page 11 briefly?

22 **MS CAREY:** Yes, let's go back to that then, because that is
23 a more general application.

24 **DR SUNTHARALINGAM:** Yes. To some extent this is a further
25 version of the discussion about CRITCON that we had

53

1 **MS CAREY:** -- and you said it could be done with publicly
2 accountable oversight. Who did you envisage might
3 provide that oversight?

4 **DR SUNTHARALINGAM:** So, in a sense I'm very open to sort of
5 expert opinion as to how this could be implemented, but
6 some form of public commission or stakeholder meeting,
7 with a very wide buy-in from interested members of the
8 public, particularly those representing disability and
9 other disadvantaged -- potentially disadvantaged groups,
10 and to make sure that all sections of society are
11 involved.

12 There is some academic work which suggests that
13 actually the public may be sort of ahead of the
14 profession in things that they might want to have
15 considered. This is purely from a research paper in
16 Oxford, but they found ideas coming up were around
17 prioritising people with young children, or even
18 healthcare workers, and they wanted to talk about things
19 like taking people off ventilators. I'm not advocating
20 for that, but it is interesting that the discussion
21 beyond the profession can be wider than the discussion
22 that we ourselves have.

23 **MS CAREY:** I wonder if we could leave that topic there.

24 My Lady, I'm moving to a new topic. It is
25 a little early, but I can start the new topic or we

55

1 previously. But I think the bits to highlight here are
2 that usual decision-making applies when we are at
3 CRITCON 0 to 3, with the sort of blue arrows saying
4 that.

5 **MS CAREY:** Yes.

6 **DR SUNTHARALINGAM:** And then CRITCON 4, and in fact that
7 table we just looked at at the back, the decision aid,
8 only applies at a stage of sort of universal CRITCON 4
9 as declared by -- at, sort of, government level.

10 **MS CAREY:** If I follow you correctly, Doctor, if we go down
11 to the 4 triage risk, all in red there, we are at
12 CRITCON 4, it is only then that you would turn over to
13 appendix 2 and follow the tool for whatever disease or
14 virus or situation was necessary?

15 **DR SUNTHARALINGAM:** Absolutely. And the logic of having it
16 there is so they can talk about it openly. It really is
17 in order to avoid having to use it, so everyone is at
18 least aware of what we would be facing if we got to that
19 position.

20 **MS CAREY:** Right. Can I just then finish on this topic.

21 There is this prototype that could be adapted in the
22 event of future need. I think you make the point in
23 your statement that there is a potential benefit to
24 discussing this in non-pandemic times --

25 **DR SUNTHARALINGAM:** Yes.

54

1 might perhaps take our mid-morning break?

2 **LADY HALLETT:** No, that's absolutely fine.

3 I shall return at 11.45 am.

4 **MS CAREY:** Thank you, my Lady.

5 (11.25 am)

(A short break)

7 (11.46 am)

8 **LADY HALLETT:** Thank you.

9 **MS CAREY:** Thank you, my Lady.

10 Professor Summers, can I turn to you, please, and
11 just look briefly at ICU capacity in 2021. Because we
12 concentrated a lot on the early stages of the pandemic,
13 and I think you make the point in your report that, in
14 fact, by early 2021 there was a far larger surge in
15 critically ill patients than there had been earlier on
16 in the pandemic. If it helps you, I'm at page 60 in
17 your report.

18 I wonder if we could call up on screen figure 11
19 at INQ000474255_0060.

20 With your help, Professor, I would like you just
21 to explain -- we are not going through all the regions
22 but all four nations are represented on this figure,
23 which is the regional increases in occupied ICU beds
24 above baseline, provided by The Intensive Care Society,
25 and it is really to get a sense of how different it was

56

1 in 2021 than how it was in 2020, or, in some cases, it
2 is the data from 2019.
3 Perhaps if we take Scotland as the first example,
4 can you speak to this? And is this showing us that in
5 2019 in Scotland they had 203 occupied beds in ICU? And
6 by 2021 that jumped considerably to 303?

7 **PROFESSOR SUMMERS:** Exactly. So this is an attempt to
8 quantify the degree of the surge in ICU capacity that
9 was required in January 2021 by using exact data at this
10 time from NHS England and estimates that they could
11 acquire, I think, from Scotland and Northern Ireland.
12 Subsequently, actually, it looks like their best
13 estimates for Scotland were almost exactly correct when
14 the real data had become available from SICSAG.

15 I think the important message from the entire UK
16 picture is that the equivalent of about 141 extra
17 intensive care units were required in January 2021 above
18 the capacity that was available in January 2020, and
19 that's assuming an average size of 15 or 16 beds in
20 intensive care.

21 **MS CAREY:** I think at the bottom of the screen it says it
22 was based on one ICU being a 16-bed unit --

23 **PROFESSOR SUMMERS:** Yes.

24 **MS CAREY:** -- and so by 2021 we needed 141 extra ICUs across
25 the UK.

57

1 And you can see some of these ratios are absolutely
2 extraordinary.

3 **MS CAREY:** And ordinarily, would these be all the people
4 that would be around the bedside of the patient in ICU?

5 **PROFESSOR SUMMERS:** So they are all part of the intensive
6 care multidisciplinary team.

7 **MS CAREY:** Would they therefore be wearing a higher level of
8 PPE because they were in an intensive care setting?

9 **PROFESSOR SUMMERS:** In most cases, yes.

10 **MS CAREY:** Now, we have looked at increases in intensive
11 care, and I think when you gave evidence last week, we
12 had already made the point that the data was not
13 necessarily entirely representative because there was
14 a lot of people receiving critical care outside of
15 an ICU and therefore weren't captured by the data, but
16 can I ask you about any alterations to the kinds of
17 people that came into ICU. I'm at your paragraph 158.

18 You make the point there that the data doesn't
19 tell us entirely accurately the people that were
20 receiving critical care outside of ICU. I think you say
21 in your report there was also a fall in admissions, for
22 example, those people that had suffered a heart attack
23 and stroke. There was a significant drop in the number
24 of those people attending ICU.

25 Could we have on the screen, please, figure 12a,

59

1 **PROFESSOR SUMMERS:** Yes. And we did not create that
2 physical capacity of 141 extra ICUs with any more staff,
3 to reiterate that point again; we did it with exactly
4 the same number of staff as we had in January 2020 in
5 terms of specialist critical care staff. We stretched
6 what we had to make that extra capacity.

7 **MS CAREY:** Understood. I think in fact there is
8 an accompanying document on page 61 which exemplifies
9 this, and can we have the table at the top there, that,
10 ordinarily in -- well, not ordinarily in January 2020,
11 so just pre-pandemic, one member of staff cares for --
12 it was a consultant, they can care for 12 patients, and
13 you can see the jump there from -- into 2021, they were
14 caring for 16 or as many as 33 patients. We're familiar
15 with the changes to the nursing ratios, but when you
16 look at some of the other people involved in providing
17 care, pharmacists, there is a jump again.
18 Physiotherapists. Speech and language. Members of
19 staff, occupational therapists. Huge increases in the
20 number of patients they had to care for in January 2021.

21 **PROFESSOR SUMMERS:** Intensive care is a multidisciplinary
22 package of care for patients. All of these people and
23 others besides, like the ICNARC data clerks that we
24 heard about from Professor Rowan when she was speaking,
25 administrative staff, support staff, are all required.

58

1 which is a very neat depiction -- there we are -- of the
2 fall in the number of admissions to intensive care.

3 This is data that comes from ICNARC, my Lady.

4 One can see that ordinarily, fluctuations just
5 above or below 300 people on average coming into
6 intensive care with a heart attack per month.

7 And then when we look at the yellow line which
8 indicates the pandemic, if one looks just after January
9 2020, a huge drop in the number of people being
10 admitted, so what is that, under 150 or thereabouts, and
11 it slowly rises but still doesn't reach the same rough
12 grey area that had been the case in the three years from
13 2016 to 2019.

14 So people weren't presenting to ICU in the way
15 that they had. Can you help me with this, I think you
16 make the point in your report that there were fewer
17 older people being admitted to ICU during the pandemic,
18 and can you help with why that was?

19 **PROFESSOR SUMMERS:** So, I guess, to allude to the myocardial
20 infarction graph that we were shown, I think there is
21 data that very eloquently speak to the fact that not
22 only were they not appearing in intensive care units
23 with myocardial infarction, people were not appearing in
24 hospital. And that actually, as a result of changes in
25 behaviour, and in people's trying to, I guess, do the

60

1 best that they could, and people were probably dying at
2 home rather than being admitted to hospital and having
3 the care from hospital and, as a consequence of that,
4 intensive care units that they might have done otherwise
5 for their myocardial infarctions, and you can see that
6 the decrease in admissions to ICU happened both in the
7 peak of spring 2020 but also again in
8 January/February 2021. So both of those coincide.

9 **MS CAREY:** Whilst you are dealing with this, and perhaps
10 looking at older people, of course, my Lady has the
11 report from Professor Gale, dealing with not only falls
12 in ICU admissions but falls generally into the
13 healthcare system in relation to people with ischaemic
14 heart disease. So it is really tallying a number of
15 different ways of showing that people weren't coming
16 into the healthcare system for heart attacks and the
17 like.

18 All right, now on to older people --

19 **PROFESSOR SUMMERS:** Yes.

20 **MS CAREY:** -- admissions to ICU. What did you set out in
21 your report, please, Professor?

22 **PROFESSOR SUMMERS:** There are several lines of evidence that
23 suggest that at peaks of the ICU strain, that people who
24 were admitted to intensive care, despite there being no
25 national change in policy, may actually not have been

61

1 December 2020, so again covering the sort of wave one
2 period rather than wave two.

3 **MS CAREY:** Yes.

4 **PROFESSOR SUMMERS:** And they found that the likelihood of
5 a patient being in ICU, three or seven days after
6 admission, varied by month and such that actually you
7 were more likely in periods between surges to get
8 admitted to intensive care than you were at periods of
9 surge. So, actually, the people who were getting
10 admitted were more likely to be younger during the
11 peaks, which accords with the ICNARC suggestion from
12 their looking at the peak of 2020.

13 **MS CAREY:** Can I see if I can summarise this accurately and
14 correct me if I have got it wrong: older people less
15 likely to go into ICU during pre and post-peak
16 periods --and people more generally to get into ICU
17 between the surges?

18 **PROFESSOR SUMMERS:** So, older people less likely to be
19 admitted and people with higher degrees of dependency
20 were less likely to be admitted during the surges.

21 **MS CAREY:** Understood. Now why that might be may be
22 difficult to ascertain, but can I ask you this: was
23 there any policy or diktat that said: don't admit older
24 people or anything of that nature?

25 **PROFESSOR SUMMERS:** I'm aware of absolutely no circumstances

63

1 the same as those at times of less strain. And I think
2 that Professor Rowan spoke to some of this, but to
3 reiterate, one example of the data supporting that
4 proposal comes from ICNARC that looked at admissions to
5 ICU during the first wave, and they found that people
6 who were admitted during that wave were younger and less
7 severely ill when compared to those who admitted pre and
8 post-period. So that was my paragraph 161.

9 Their paper suggests that the proportion of
10 patients aged greater than 75 years, or had any prior
11 dependency, was lower during the peak period in 2020.

12 **MS CAREY:** That's not what one would have expected
13 ordinarily?

14 **PROFESSOR SUMMERS:** I wouldn't have expected to see any
15 change.

16 **MS CAREY:** Yes, and you say the older and sicker patients
17 would not have disappeared during that time, but fewer
18 will have been admitted to ICU?

19 **PROFESSOR SUMMERS:** There is a second line of evidence that
20 comes from a different organisation that suggests that
21 this may have been the case. So ISARIC, by their
22 clinical characterisation group, tracked the clinical
23 longitudinal paths of just over 142,000 people who were
24 admitted from across the four nations of the United
25 Kingdom with Covid to hospital between March and

62

1 in which a policy was issued about age as a cut-off in
2 the United Kingdom.

3 I should also point out that also, the type of
4 care of critically ill people that was happening, and
5 where that was happening, as you point out, not all
6 critically ill people were in intensive care units, and
7 the strain on the intensive care units will have
8 affected -- at some times you may have had your CPAP in
9 an intensive care unit, at times of great strain where
10 everybody in intensive care was receiving invasive
11 mechanical ventilation, you may have had that on a ward.

12 So, being inside the walls of an intensive care
13 unit doesn't necessarily mean you did or did not receive
14 critical care.

15 **MS CAREY:** Understood. I think, though, Professor, you are
16 aware of the research that was conducted by the Inquiry
17 and have seen the findings of the survey. Can we have
18 up on screen INQ000499523_0017.

19 This is a slide depicting what happened during the
20 first wave and people contributing to the survey, and
21 there were nearly 1700 healthcare professionals who were
22 spoken to UK-wide. If one looks at the critical care
23 nurse and the critical care doctor, they were asked
24 during the first wave how they were able to escalate by
25 role the frequency of their inappropriate to escalate,

64

1 and the critical care nurses said that there was 20% of
2 them that had to make a decision about that on a daily
3 basis, 19% for critical care doctors, and we can see the
4 varying statistics there.

5 But when one looks at the last two columns, "At
6 least weekly", 34% of those critical care nurses had
7 an inability to escalate and, indeed, critical care
8 doctors, 35% at least weekly. And then if we look at
9 the "Ever" -- again, 49% of critical care nurses had
10 an inability to escalate, and critical care doctors 48%.

11 So fairly grim statistics, if I may put it like
12 that, as to the people that contributed to this survey,
13 suggesting that there was various reasons why the nurses
14 and the doctors felt there was an inability to
15 escalate -- and some of those reasons, I think, were
16 given. If one looks at page 19.

17 The survey asked about the reasons for difficulty
18 escalating, and if we could highlight the two columns
19 that deal with "Critical care nurse" and "Critical care
20 doctor", one can see that "Lack of available beds for
21 high dependency care such as high flow oxygen or CPAP",
22 look at the figures there for critical care nurses and
23 critical care doctors, that clearly was a reason they
24 felt unable to escalate.

25 Lack of care or staff, 62 and 61% respectively.
65

1 see what kind of people died of this disease despite
2 escalated care. So we decided not to admit to critical
3 care whereas had they had a different illness, they
4 probably would have been more likely to benefit so we
5 would have escalated. We didn't have enough space to
6 'give people a go' who had a very remote chance of
7 getting better. If we had had more capacity, we might
8 have been in a position to try."

9 I suspect not an easy thing for that doctor to
10 have said, but can I ask you, please, about page 33 of
11 the survey. This is entitled "Acting in conflict with
12 values by role". But critical care nurses were
13 particularly likely to have to act in a way which
14 conflicted with their values when at work during the
15 pandemic, likely linked to the higher proportion feeling
16 that there were insufficient staff. And if we look
17 there, daily, critical care nurses were reporting that
18 they were acting in conflict with values by role.

19 And indeed the critical care doctors, if one looks
20 down the page slightly, 26% of those were saying they
21 had that on a daily basis.

22 Can you help with how acting in conflict with your
23 roles and your values affected the staff on the ground,
24 Professor?

25 **PROFESSOR SUMMERS:** I can. I think we heard very powerfully
67

1 Lack of available beds for invasive mechanical
2 ventilation, 85 and 80%.

3 Lack of available beds for acute wards. Lack of
4 equipment. And I don't need to ask you about the lack
5 of access to ambulance. But clearly indicative -- I put
6 it no higher than that -- of difficult decisions having
7 to be made, and a number of varying resource reasons why
8 people may not have been escalated.

9 Does that not necessarily accord entirely with
10 your experience, but does it come as a surprise to you
11 that there are quite significant numbers of critical
12 care nurses and doctors answering this survey saying
13 they could not escalate for the reasons that are set out
14 on page 19?

15 **PROFESSOR SUMMERS:** No, I think like Professor Whitty, who I
16 think was shown similar evidence when he testified the
17 other day, this accords with the totality of the
18 evidence that's available. It is a snapshot done this
19 year, I understand, of how people felt their experiences
20 were in 2020, and I'm not in any way surprised.

21 **MS CAREY:** No. If one just looks, please, at page 22,
22 Professor, there is a quotation given there from
23 a critical care doctor in Wales. And they were giving
24 their experience of escalating care, they said:

25 "We knew it wouldn't help because we had come to
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1 the other day from Professor Fong, he organised and led
2 the peer support programme of visits. I should declare
3 that I also participated in leading and attending some
4 of those visits, and some of the evidence that he shared
5 is evidence that I was privileged but also unfortunate
6 to have to hear from staff members, from various regions
7 of the United Kingdom. I am only too painfully aware of
8 the conflict and the moral injury that occurred to,
9 particularly, critical care nurses, but healthcare staff
10 of all kinds during the pandemic.

11 It was and continues to be an ongoing issue for
12 many of us.

13 **MS CAREY:** I think in your report you set out some studies
14 that were done into staff well-being and indeed whether
15 the stresses they were under in fact impaired their
16 ability to do their job, and I would like to ask you
17 about that please.

18 **PROFESSOR SUMMERS:** Yes.

19 **MS CAREY:** I think there was, if it helps you, 135 onwards
20 in your report --

21 **PROFESSOR SUMMERS:** So there was work undertaken, again
22 actually led by Professor Fong in an academic capacity
23 to undertake a series of surveys at different points,
24 looking at how staff were doing in terms of their
25 well-being and actually 56 hospitals in England
68

1 participated with round about 6,000 respondents across
2 the time points. And it happened before the winter
3 2020/21 peak and during and after the winter 2020/21
4 peak.

5 **MS CAREY:** So just pausing there. I think, as a result of
6 at least one part of the surveys over different periods
7 of time, in November to December 2020, more than 50% of
8 staff met or exceeded the threshold criteria for at
9 least one of the surveyed mental health disorders.

10 And what were those disorders, please?

11 **PROFESSOR SUMMERS:** So post-traumatic distress symptoms and
12 functional impairment predominantly, but also there were
13 questions around problematic alcohol misuse and other
14 markers of mental health and functional impairment.

15 **MS CAREY:** That's in the run up to the pressures we have
16 seen in January 2021. I think the survey went on to
17 look at January to February 2021. Can you help, what
18 did the survey find in relation to that particularly
19 stressful period in ICU?

20 **PROFESSOR SUMMERS:** So I think it found that later on, at
21 peak, those symptoms were increased in prevalence, as
22 you would expect. I mean, no one can be surprised by
23 this. You have a healthcare system and healthcare staff
24 that were under tremendous stress in wave 1 or in spring
25 2020. The pressure never fully came off during the

69

1 that we would all hope, that we have to remember the
2 impact on staff is still having an effect.

3 **PROFESSOR SUMMERS:** I think I would say that I don't know
4 a healthcare worker and certainly not an intensive care
5 clinician who does not carry the scars of the last five
6 years, and you may have to forgive me a moment. All of
7 us have carried it forwards. You cannot see what we
8 have seen, hear what we have heard, and do what we have
9 had to do and be untouched by it. You cannot and be
10 human and we are very much human.

11 **LADY HALLETT:** Doctor, you are nodding.

12 **DR SUNTHARALINGAM:** Yes, I absolutely agree with all of
13 that.

14 **MS CAREY:** Professor, that brings me onto something I wanted
15 to ask you about which was a phrase in your report which
16 is as follows:

17 "We coped but only just."

18 **PROFESSOR SUMMERS:** Yes.

19 **MS CAREY:** Can you just try, please, to help her Ladyship
20 and us understand why it is your phrase it in that way?

21 **PROFESSOR SUMMERS:** I think what is often forgotten is that
22 the catastrophic failure of the healthcare system would
23 not be a switch that was just thrown in an instant where
24 we went from everything being okay to everything not
25 being okay the next second. It is in the dilution of

71

1 whole of 2020 and then going into 2021's peak, there was
2 both the demands of a greater number of critically ill
3 patients, alongside the demands of trying to resume
4 elective surgical care and many of the people who were
5 trying to support the ICU surge are the same people who
6 are required to undertake the delivery of elective
7 surgical care.

8 Anaesthetists often unusually are in operating
9 theatres. In 2021, we were using their operating
10 theatres for ad hoc intensive care units and they
11 weren't doing their day job. Of course they were
12 distressed. As were nurses, healthcare support workers,
13 administrators, and not just in intensive care, I think
14 that's the other point to make here. Whilst this data
15 is around intensive care, there are data about
16 healthcare workers in hospitals all of whom have similar
17 patterns of impairment.

18 **LADY HALLETT:** I don't know if you heard Professor Fong on
19 the radio this morning.

20 **PROFESSOR SUMMERS:** I did not.

21 **LADY HALLETT:** He was talking about something else initially
22 but he was asked about giving evidence here and one of
23 the things he said was that the kind of impact that you
24 have just described on staff is continuing today and so
25 if anybody is trying to make sure the NHS works in a way

70

1 a million and one tiny little things, particularly in
2 intensive care. We are a speciality of attention to
3 detail. Every single tiny little bit of attention to
4 detail is what makes the difference and cumulatively
5 provide better outcomes for patients. When we stretch
6 those and we are unable to pay the attention to all of
7 those details in the way that we would want to and that
8 we know we are capable of, we are failing our patients
9 really, or at least that is how it feels to us. We are
10 not providing the care that we would want to if -- and
11 that we would want for our own families.

12 And whether you describe that as coping or not, is
13 a very moot point. Coped as in the outcomes were as
14 good as we could make it and we didn't get to the point
15 where we had to say that there was national triage, but
16 we would never want to be where we were. Large numbers
17 of intensive care units declared CRITCON 3. That wasn't
18 okay.

19 **MS CAREY:** Final couple of discreet topics if I may.

20 If I may turn to you, Doctor. I would like your
21 help, please, about PPE in intensive care units. And we
22 are familiar with the problems with lack of PPE that
23 suits a diverse range of faces, size, ethnicities and
24 the like. I would like to ask you please about your
25 paragraph 199 where you say:

72

1 "In general, there were adequate numerical
2 quantities of PPE in ICUs as these were often
3 prioritised over other parts of the health and social
4 care system."
5 But I want to understand, were there any shortages
6 of PPE within individual ICUs that you are aware of?
7 **DR SUNTHARALINGAM:** So I use the word "numerically" there
8 because there certainly were factors that were very --
9 the opposite of reassuring. So different models
10 arriving every day. Although hospitals carried out fit
11 testing the supplies changed. I'm not aware of specific
12 shortages as a systematic factor. And the comment about
13 ICUs compared to others is partly based on some research
14 work that others have done of surveying people. So
15 there was some advantage. However, it certainly felt at
16 any given moment that things might be short, that things
17 were changing all the time, particularly early in the
18 pandemic, and obviously people had anxieties about their
19 own health and about taking disease home to families.
20 So it felt under pressure. It felt dangerous. It
21 felt like shortages. Numerically, intensive care was
22 arguably better than some other areas. Also due to
23 decisions that FFP3 was used universally and that wasn't
24 the case elsewhere in the hospital. And arguably should
25 be.

73

1 **DR SUNTHARALINGAM:** Yes. For example, recommendations
2 about -- and to be fair to the organisation in the UK,
3 obviously it was also affected by perceptions from
4 elsewhere. So if you are seeing healthcare workers in
5 other countries wearing full body Hazmat suits then it
6 raised questions about what should be the right course
7 of action here.
8 **MS CAREY:** Understood. I would like to ask you about
9 aerosol-generating procedures. We have heard quite
10 a bit of evidence about that already including that some
11 of them may not in fact generate as many aerosols as
12 hitherto believed and also evidence that AGPs aside,
13 talking, coughing, singing, shouting, inevitably
14 generates aerosols.
15 I just would like your views, please, on the AGP
16 list. I think you have set them out in your
17 paragraph 210. Help us with that, please.
18 **DR SUNTHARALINGAM:** So this was something where there was,
19 again, debate about, including in elements such as
20 resuscitation, which you may hear about from another
21 witness. Also some professions and specialities, as we
22 have heard from Professor Summers, it is a very
23 multidisciplinary profession and particularly speech and
24 language therapists felt that some of the interventions
25 they do weren't adequately recognised.

75

1 **MS CAREY:** I won't take up that thread with you, if I may,
2 Doctor, but can I ask you about this. You say in your
3 report that there was -- clearly, obviously, the
4 physical and emotional challenges of working with the
5 significant, more quantities of PPE being worn. You
6 make reference to uncertainty and changing guidelines,
7 anxiety over supplies and fit testing generally
8 contributing to the psychological impact of the
9 pandemic.

10 Can I just ask you, which guidelines were you
11 referring to in that part of your report?

12 **DR SUNTHARALINGAM:** There was initially guidance coming from
13 the various bodies at the time which did actually change
14 identity during the pandemic. So I think Public Health
15 England moving into the other organisations. So there
16 was reorganisation going on as well. And it was really
17 around the best way of coping and diminishing risk early
18 on.

19 So, appropriately, things were kept under review
20 and disseminated as they changed but at the frontline
21 I think it felt difficult to keep abreast of all of it
22 and on the background of people's concerns that they
23 were getting what they needed.

24 **MS CAREY:** Even within the ICU setting where, as you say,
25 you had FFP3?

74

1 However, I think there is a wider issue which is
2 the "P" in AGP. I'm not really qualified to talk about
3 the aerosol and droplet side of it, but I think the
4 focus on procedures, rather than risk, is a problem
5 because it means when there is no procedure going on,
6 but you are in front of the infected patient, that risk
7 is sort of diminished in the guidance whereas actually
8 taking the risk into account rather than what particular
9 procedure they are having at the time is a better way of
10 doing it, and particularly in an intensive care setting
11 where there is a procedure going on all the time
12 somewhere and the patients are all together, again, a
13 focus on procedure is not necessarily the right thing.
14 So guidance based on environment and risk profile
15 would make more intuitive sense and be easier to handle.
16 And as you say, there are many things that are not
17 interventions that put you at risk if a patient coughs,
18 for example.

19 **MS CAREY:** Finally, please, this. I would like to ask in a
20 minute about recommendations but can I just draw
21 together some of the things that you have been telling
22 us during the course of your evidence.

23 There was clearly a significant impact on those
24 working in ICU. Was any support in place to help the
25 critical care nurse, those that were redeployed? Was

76

1 there any support in place during any of the waves of
2 the pandemic.

3 Perhaps, Professor, if I turn to you first?

4 **PROFESSOR SUMMERS:** Definitely healthcare system providers
5 in a variety of ways attempted to provide support by
6 making sure that counselling or other mental health
7 services were made available.

8 I think what's also important to remember is that
9 providing support is fine. However, you are not also
10 able to remove the source of the ongoing injury if you
11 have another wave coming and more patients coming in and
12 you are trying to restore elective surgical services
13 because there are a backlog of people who are also
14 experiencing harm from not having their surgery. People
15 cannot and do not want to stop working and continuing
16 being exposed to the ongoing moral injury of not being
17 able to provide care as they would want to.

18 So it is a complex situation and just providing
19 a mental health service doesn't necessarily remove the
20 strain.

21 **Q.** Shutting the door after the horse has bolted may be
22 a very inelegant way of putting it. But you have to
23 tackle the underlying problem. That's what I really
24 wanted to ask you about.

25 You have set out in your report a number of
77

1 earlier decompression of the hot sites rather than
2 letting them get to 1:6 and then seeing what happened
3 next I think was a crucial step. So whatever the number
4 is, it's more likely to be 4 than 6, in a surge pattern.

5 **PROFESSOR SUMMERS:** There is a reason we have 1:1 nursing of
6 intensive care outside of pandemics.

7 **DR SUNTHARALINGAM:** Absolutely, yes.

8 **MS CAREY:** I won't ask you about all of the other
9 recommendations you set out save for one of them,
10 Doctor. I think you wanted to speak to the
11 recommendation where you say to address the issue of
12 future public health emergency, you recommend
13 a citizen's assembly or other formal government
14 consultation with an appropriate range of stakeholders.

15 Why do you advocate for a citizen's assembly, and
16 what is it you envisage they might do and assist with?

17 **DR SUNTHARALINGAM:** Thank you. It was largely just because
18 I was a bit vague to answer your question before. So in
19 terms of a practical aspect of how this could be, sort
20 of, addressed. But, really, the wider topic is of
21 making sure that everyone who has an interest is
22 involved. We can work on developing moral and ethical
23 principles for an agreed, fair and just framework for
24 allocating healthcare if demand exceeds supply, so in
25 a crisis.

79

1 lessons learned and recommendations and I wanted to ask,
2 we have heard a lot about the stretching of ratios
3 within the critical care setting. Do you know if there
4 is any research ongoing to understand the minimum safe
5 staffing requirements that we could stretch to if we
6 needed to in the event of a future pandemic?

7 **PROFESSOR SUMMERS:** Actually, since before the pandemic
8 there has been a piece of research going on called
9 SEISMIC, that has been looking to generate an evidence
10 base around staffing ratios, particularly nurse staffing
11 ratios in intensive care units. I don't think at the
12 time the work was conceived it was thought about in
13 terms of pandemic and stretch but I understand that the
14 authors and the people who are working on that are also
15 including that strain in their work but the results of
16 that work are not yet available, but it is important
17 work that I think will provide an evidence for how we
18 provide care and ratios.

19 **DR SUNTHARALINGAM:** I think just less academically but from
20 practical experience, I think something learnt during
21 the pandemic was, just to put a figure on it, very
22 unscientifically, but the 1:6 ratios originally proposed
23 caused excessive strain even in this context.

24 So moving to a 1:4 during the course of the
25 pandemic before wave 2, which in a practical sense meant
78

1 But also it's an opportunity to have an honest
2 conversation about the role of, if you like, extreme
3 healthcare, aggressive healthcare, towards the end of
4 someone's life, both on a societal basis about how we
5 might do things differently during a crisis and when
6 things are overwhelmed but also for people to have
7 discussions with their families about what they
8 themselves would want under normal conditions but also
9 in a future crisis and to take that time while we are
10 able to have those conversations in an open way and
11 doing it in a structured format through a citizen's
12 assembly.

13 Thank you for that.

14 Is it okay if we can pick out two of the others?

15 **MS CAREY:** I was going to ask you each actually for a -- it
16 is not about single recommendations but if there were
17 one you wanted to impress upon her Ladyship, what would
18 it be?

19 Perhaps you, Professor, first -- or I don't mind
20 who goes first.

21 **PROFESSOR SUMMERS:** I'm happy to go first. I think the
22 thing that I would like to emphasise is that intensive
23 care is, as we have entitled the report, the last line
24 of defence. We are required when everything else has
25 failed, when prevention hasn't worked, when improving

80

1 and tackling health inequalities, all of those other
2 things, have not prevented disaster arriving at our door
3 and intensive care is a supportive care package. It did
4 not change the trajectory of the pandemic. What changed
5 the trajectory of the pandemic is therapies and vaccines
6 and our research being embedded into the care system.
7 If we do not ensure that that is a continued line of
8 defence, it doesn't matter how much resource we put into
9 healthcare systems, in the absence of being able to
10 change the trajectory of any kind of emergency we will
11 potentially exhaust all capacity.

12 So we have to embed into our response to
13 emergencies, pandemic and otherwise, means to change the
14 trajectory of them and that means having robust supply
15 lines, having the ability to understand novel emerging
16 threats, to develop vaccinations and treatments, and to
17 do that rapidly and at scale.

18 **MS CAREY:** Ideally we wouldn't need you.

19 **PROFESSOR SUMMERS:** Exactly.

20 **DR SUNTHARALINGAM:** Exactly.

21 **MS CAREY:** And Doctor?

22 **DR SUNTHARALINGAM:** Thank you.

23 Firstly, I would very much agree with that, that
24 intensive care is to provide life support while the
25 disease gets better, so we need to address that, I

81

1 what can be afforded and provided becomes a separate
2 discussion and I think this is a piece of work that
3 hasn't been done but the pandemic should be a trigger
4 for doing it.

5 **MS CAREY:** Thank you very much.

6 My Lady, they are all the questions that I had.

7 **LADY HALLETT:** It may be you can't answer, this

8 Professor/Doctor, I have been asked to ask you about the
9 making of DNACPRs in a wider hospital setting. Is that
10 a question for you or perhaps for later experts?

11 **PROFESSOR SUMMERS:** I do not clinically practise outside of
12 the intensive care unit.

13 **LADY HALLETT:** Doctor?

14 **DR SUNTHARALINGAM:** Sorry, the question was about a wider --

15 **LADY HALLETT:** Yes, it is about people who are clinically
16 vulnerable receiving calls at home about having notices
17 put on their records.

18 **DR SUNTHARALINGAM:** Again, I think that's outside our remit.

19 **LADY HALLETT:** Thank you.

20 The next person to ask questions is Mr Jacobs.

21 Please don't worry about turning your back to me as long
22 as your reply goes into the microphone, thank you.

23 **Questions from MR JACOBS**

24 **MR JACOBS:** Yes. Thank you.

25 Just one question, actually, on behalf of the

83

1 completely agree with my colleague.

2 The point I would like to raise, though, is about
3 the capacity side of it, we have talked about it many
4 times, but we would propose as an objective measure, in
5 the next two years, a systematic UK-wide review of
6 baseline ICU capacity. And the justification for that
7 in this pandemic discussion is if we start lower then we
8 have to stretch more and that does more damage. So it
9 is about getting it right, not only in absolute quantum
10 but also where it is, matching it to local populations,
11 healthcare needs, planning ahead for changing patterns
12 and disease and other processes, and we propose that be
13 done by an independent body and not by, for example,
14 NHS England or the other NHS bodies, not because they
15 can't be trusted but because it puts them in a difficult
16 position, they are the providers, and have to look at
17 the funding. This is about identifying the need in
18 an independent way.

19 So a body such as The Nuffield Foundation or The
20 King's Fund or a university, to look at it independently
21 with expert input from the critical care bodies but also
22 all of those involved in acute care as well as
23 epidemiology experts.

24 So really a baseline look from the ground up at
25 what critical care in the UK should look like, and then

82

1 Trades Union Congress, and it takes up, Doctor, what you
2 were describing a moment ago in terms of the
3 recommendation for a UK-wide review of baseline capacity
4 and an objective assessment of whether it is adequate
5 and matched to local health needs.

6 The need for a review is noted, but do you both
7 have a view as to what baseline capacity should
8 reasonably be, so as to have a reasonable level of
9 resilience in a pandemic?

10 **PROFESSOR SUMMERS:** I guess I might to pick that up,
11 reminding everybody that there are OECD figures for the
12 number of intensive care beds per 100,000 population is
13 one way of looking at the problem, but that doesn't take
14 into account individual health inequalities and health
15 need and burden of particular areas of geography. So
16 the situation in how healthcare systems are delivered in
17 one country compared to another, and the health
18 inequalities in those, don't make that a straightforward
19 calculation, so I would hesitate to give a precise
20 number. It is more than we have because I do not
21 think -- I think we have demonstrated we do not have the
22 capacity that we should do for routine care, let alone
23 in pandemics, but I think it needs to be properly
24 conducted piece of work, and no one has done it.

25 **DR SUNTHARALINGAM:** And I think just to add to the previous

84

1 point about where it is as much as how much it is. As
 2 somebody who works in London, I might be arguing against
 3 myself, but it is -- is everything in the right places
 4 and properly distributed around the regions and nations?
 5 **Q.** Are you able to give us a sense of how much the dial
 6 needs to shift, in broad terms?
 7 **DR SUNTHARALINGAM:** I think to compare just among the OECD
 8 figures, so I think we entered into the pandemic with
 9 about half the number of the median figure, so we were
 10 clearly way behind, and the level of stretch seemed to
 11 be a lot higher than us.
 12 **PROFESSOR SUMMERS:** To give some context to that, the OECD
 13 average in 2021 was 16.9 per 100,000 population, and we
 14 went in, in the UK, considerably lower than that. Italy
 15 has 11.6 at that point, Sweden had 4.9, and Germany had
 16 29.3. So there is wide variation which I think feeds
 17 into how healthcare systems are delivered and individual
 18 nations, but we were definitely substantially below the
 19 average of the OECD nations.
 20 **MR JACOBS:** Thank you very much.
 21 **LADY HALLETT:** Thank you, Mr Jacobs.
 22 Who is next?
 23 Mr Odogwu.
 24 **Questions from MR ODOGWU**
 25 **MR ODOGWU:** My Lady.

85

1 it doesn't exist. What it means is there was no
 2 publicly available data that I could find. I'm not
 3 denying that that was the case, just that I could not
 4 find a data source to be able to reference.
 5 **Q.** The data gap. Okay.
 6 Well, given that, well-documented, higher rates of
 7 infection and mortality among ethnic minority healthcare
 8 workers, were you able to assess whether there were any
 9 adequate risk assessments or safeguards or policies that
 10 were put in place in ICU for ethnic minority healthcare
 11 workers?
 12 **PROFESSOR SUMMERS:** So the occupational risk assessments
 13 that were done within the NHS were the same for critical
 14 care staff as they were for all other NHS staff. So
 15 there wasn't a separate critical care risk assessment
 16 undertaken.
 17 **Q.** So there was nothing tailored specifically to ethnic
 18 minority healthcare workers?
 19 **PROFESSOR SUMMERS:** Or to intensive care workers is what I'm
 20 saying. It was the standard NHS occupational risk
 21 assessment, rather than it being tailored to one
 22 particular group.
 23 **Q.** Given the vulnerabilities of ethnic minority healthcare
 24 workers in particular, do you consider that there were
 25 adequate measures within the ICU setting for those

87

1 Good afternoon. I represent the Federation of
 2 Ethnic Minority Healthcare Organisations which advocates
 3 for healthcare workers from ethnic minority backgrounds
 4 who were disproportionately impacted by the pandemic.
 5 My question is probably best addressed to
 6 Professor Summers, but I'm happy for Dr Suntharalingam
 7 to answer if better placed.
 8 The report acknowledges at paragraph 32 that staff
 9 ratios were diluted, and that non-critical care staff
 10 were redeployed to assist ICU during the pandemic which
 11 came at significant costs to both staff and patients.
 12 My question relates to potential racial
 13 disparities in the redeployment of healthcare workers
 14 during the pandemic. There has been some evidence in
 15 this Inquiry of ethnic minority workers reporting that
 16 they were given higher risk tasks and being redeployed
 17 to Covid wards more often than their white colleagues.
 18 Did you, as part of your assessment and report, assess
 19 whether ethnic minority healthcare workers were over
 20 represented and more likely to be placed within ICU or
 21 critical care settings?
 22 **PROFESSOR SUMMERS:** So I recognise very much the evidence
 23 that you reference has been heard by the Inquiry.
 24 I could not find systemic data that outlined that
 25 problem for any of the nations. That doesn't mean that

86

1 workers?
 2 **PROFESSOR SUMMERS:** I think when -- as Dr Suntharalingam has
 3 emphasised, the availability of PPE and protective
 4 measures in intensive care settings was arguably better
 5 available than in other parts of the hospital, so
 6 I think that that is a complex question.
 7 **MR ODOGWU:** Thank you very much, my Lady.
 8 **LADY HALLETT:** Thank you very much.
 9 Next, I think it is Ms Mitchell who is directly
 10 ahead of you.
 11 **Questions from MS MITCHELL KC**
 12 **MS MITCHELL:** (inaudible).
 13 **PROFESSOR SUMMERS:** I'm terribly sorry, I can't hear you --
 14 **MS MITCHELL:** The microphone appears on.
 15 **LADY HALLETT:** Yes, you're on now.
 16 **MS MITCHELL:** I'm on now, thank you.
 17 I appear as instructed by Amer Anwar & Co
 18 on behalf of the Scottish Covid Bereaved, and I have got
 19 some questions to ask you about DNACPR.
 20 Firstly, it is in relation to the confusion
 21 surrounding some of these notices. I don't need to take
 22 you to it, but at paragraph 40 of your report you state
 23 that:
 24 "A DNACPR notice is not meant as a proxy for
 25 broader treatment decisions. However, in the absence of

88

1 [a] clearly documented discussion and decisions about
2 other forms of treatment, there is a potential for
3 inappropriate over-interpretation of DNACPR[s] as
4 a generalised treatment limitation option."

5 Now, I presume that that potential for
6 over-interpretation is in respect of medical
7 professionals, not of families and patients? Is that
8 correct?

9 **DR SUNTHARALINGAM:** Potentially, although arguably it could
10 be both; if that's the only discussion around treatment
11 limitation that happens, then people may go away
12 thinking that's been the wider discussion, and -- I say
13 it can also lead to misinterpretation in the healthcare
14 community. So going back to treatment escalation
15 planning such as the ReSPECT form which is being
16 implemented in parts of Scotland, part of the argument
17 before having that broader discussion is to be very
18 clear about which is the CPR decision and which is
19 around other treatments, and having the opportunity for
20 people to say, "I would like for myself or for my loved
21 one active treatment, but I hear that CPR might not be
22 the right thing for them. We can draw a line there, but
23 other treatments should be actively pursued", which is
24 actually a very standard set of circumstances, and it
25 avoids the risk of the DNACPR itself being

89

1 obviously on occasion from being with their loved ones
2 when they were in hospital. Was the exclusion of loved
3 ones from visiting a possible way that inadvertently
4 DNACPR discussions were lost for families at that time?

5 **DR SUNTHARALINGAM:** I think in a -- so to start a bit with
6 the part of the hospital where I'm most familiar with
7 and am really qualified to comment on, which is in
8 intensive care, the sort of processes that
9 Professor Summers described would have been how it was
10 done. If the families weren't there, which was clearly
11 the case most of the time, they would have had the
12 discussion or the explanation by telephone. Elsewhere
13 in the hospital we can't sort of necessarily comment,
14 but if your question is, does the necessary visiting
15 restriction raise a risk of things happening without
16 those phone calls being made, then again theoretically
17 I would say that it would be a risk.

18 **Q.** Can I ask you then briefly about the issue of reviewing
19 of DNACPRs. Is the situation, as you understand it, in
20 respect of the review of making a DNACPR, different in
21 Scotland?

22 **DR SUNTHARALINGAM:** I don't -- as far as I'm aware, no. In
23 that the principles are the same. The legal position,
24 I think, is roughly similar in that although the legal
25 position of advanced decisions to refuse treatment and

91

1 over-interpreted to cover other aspects of healthcare.

2 **Q.** And indeed, one might make sense of that in terms of the
3 recommendations that you have made in that regard.

4 What I would like to ask on behalf of the Scottish
5 Covid Bereaved about those potential
6 over-interpretations or, as you describe later,
7 potential misrepresentation, is: what were the possible
8 implications for patients of those things that you
9 describe?

10 **DR SUNTHARALINGAM:** This is theoretical, but if it led to
11 somebody thinking that somebody has a DNACPR order and
12 is therefore not for active treatment of any sort, that
13 would be incorrect.

14 And, to take sort of a fictional example, if it
15 resulted in them not getting antibiotics for sepsis
16 because they are somehow felt to be not for further
17 active treatment of any sort, that would obviously be
18 quite a serious misunderstanding of what the DNACPR
19 meant. But this is a fictional example.

20 **Q.** Can I ask you, moving on from that, you spoke about the
21 questions, in fact my Lady posed a question to you about
22 how the bereaved found out that there were DNACPRs
23 sometimes from their loved ones who were still with us
24 or sometimes sadly no longer with us.

25 Families were excluded for very good reason

90

1 so on is different, the DNACPR is an advisory notice,
2 and the principles that it should be discussed with
3 a patient where possible, that people should be
4 informed, that it guides treatment options, I think, are
5 the same across the nations.

6 **Q.** And particularly in respect of the issue of review of
7 DNACPRs, is there a difference in Scotland as you
8 understand it?

9 **DR SUNTHARALINGAM:** Not as I understand it. And as far as
10 I know, no nation has a sort of scheduled review process
11 or anything formalised, but the principles are the same
12 which is that, if there are elements of the patient's
13 condition that are acute, and those may change, and
14 therefore if the patient's condition changes, for
15 example they improve, then any DNACPR that's in place
16 partly for that reason, due to severity, should be
17 reviewed on clinical grounds rather than on any
18 particular calendar or timescale.

19 If the DNACPR reflects fixed factors, such as
20 their stable condition or where they are in their life
21 in terms of getting towards the end of their life, in
22 terms of a natural death, then that may not be necessary
23 for review on any particular timetable.

24 If there is any sort of formal system for that,
25 that's different between the countries I'm not aware of

92

1 it, I'm afraid.

2 **Q.** I wonder if there is or there may be such a review. It
3 doesn't seem entirely clear, I would have to say, but
4 there is certainly a suggestion in the guidelines in
5 Scotland that there may be an opportunity for timed
6 reviews. If this is something that the Chair may be
7 interested in, might you be able to look into that and
8 give us your expert response on that?

9 **PROFESSOR SUMMERS:** I guess I would put it, as
10 Dr Suntharalingam has just said, there are circumstances
11 in which a timed review would be appropriate if the
12 status was likely to change, but I can think of other
13 circumstances in which a patient would have had
14 an informed discussion with their healthcare team, for
15 example, in the setting of widely disseminating
16 malignancy, and they were towards the end of their life,
17 that it may not be appropriate to have a recurrent
18 discussion with that patient because that status is
19 unlikely to change.

20 So I think it should be reviewed where clinically
21 appropriate, and where patients feel that they wish it
22 to be reviewed too. Setting a hard and fast time point
23 of reviewing it every so many days might not necessarily
24 facilitate the kind of patient discussions that we would
25 all hope for.

93

1 And that meant that those who might usually be
2 admitted to ICU were not.

3 And we have also discussed in your evidence today
4 that critical care was often being delivered outside of
5 the ICU setting, and that that means, as you also set
6 out in your report, that the data likely underestimates
7 the overall number of critically ill patients.

8 My question arising from that is, is it likely
9 that the informal variations in ICU admissions, combined
10 with the data underestimating the overall number of
11 critically-ill patients, created an incorrect perception
12 that critical care was not saturated?

13 **PROFESSOR SUMMERS:** I think that is one interpretation of
14 the situation. I guess what I would like to be able to
15 give you a definitive answer is absolute concrete data
16 to say that that was the case. I have, in writing this
17 particular section and it was me who drafted this
18 particular section, set out the data that I could find
19 to support that there may have been a change in the
20 people who were admitted to intensive care units whilst
21 acknowledging, as you rightly highlight, that not
22 everybody who was critically ill was admitted to
23 a intensive care unit, and often critically ill
24 treatment was carried out in places that would not
25 normally do so.

95

1 **DR SUNTHARALINGAM:** I agree. It may also have unpredictable
2 effect. If there is a timed review every week, for the
3 sake of argument, and the patient improves within two
4 days, it may actually delay a discussion that might
5 otherwise happen. I mean, it shouldn't do, but there
6 are ups and downs, all these things, in healthcare.

7 **MS MITCHELL:** I'm obliged my, Lady.

8 **LADY HALLETT:** Thank you Ms Mitchell, very grateful.
9 Ms Woodward.

10 Questions from MS WOODWARD

11 **MS WOODWARD:** I ask questions on behalf of Covid-19 Bereaved
12 Families for Justice Cymru, and we have heard evidence
13 today about the drafting of a national prioritisation
14 framework, and notwithstanding the fact that this was
15 never formally implemented, at paragraph 156 of your
16 report you state that:

17 "Unfortunately, it is likely that in practice, ICU
18 capacity was overwhelmed in some individual locations at
19 certain times and that the criteria for ICU admission
20 changed via local informal processes when capacity was
21 stretched ..."

22 And you set out that this was:

23 "... (conscious or unconscious alterations in
24 decision-making by individual clinicians rather than due
25 to policies or guidelines being issued) ..."

94

1 So I think we have an incomplete picture but
2 I certainly cannot tell you that it was not saturated,
3 and I guess the other thing that I would highlight is
4 that -- and I have quoted it I think, Helen MacNamara,
5 the Deputy Cabinet Secretary, suggests that she had a
6 conversation, was present for a conversation, where it
7 was suggested that ventilator capacity may have been
8 exceeded in January 2021, that was not something I was
9 aware of until reading her evidence to Module 2, and it
10 is concerning.

11 **DR SUNTHARALINGAM:** Just on the -- leaving aside data, but
12 sort of anecdotally, as it were, I noted that the IFF
13 survey, it was actually a doctor from Wales, as it
14 happened, who stated that they were perhaps not
15 admitting people at lower threshold as they might have
16 done because it was perceived that the disease process
17 for Covid was different, and that is really an example
18 of where there is an arguable need for guidance, so that
19 individual clinicians are not put in that position, and
20 either they know to wait until there is a stage of
21 triage, or they have some guidance, whether
22 professionally or nationally, to encourage that
23 decision-making.

24 So I would make the wider point that it is the
25 role of national bodies to step into that breach and

96

1 support not only their members but the wider patients
2 and public in order to provide variation and provide
3 consistency among the four nations, but also to make
4 sure the staff don't have that moral injury of feeling
5 themselves in that position without external support of
6 people that are meant to be representing and protecting
7 them.

8 **Q.** Do you think that perhaps that incorrect perception may
9 have led those in charge to believe that a formal
10 prioritisation framework was not needed when, in fact,
11 perhaps, either a framework or more formal guidance was
12 in fact needed from those in charge?

13 **PROFESSOR SUMMERS:** So I do not think -- and we looked at
14 the data when we were here a week ago -- the proportion
15 of critical care units that declared CRITCON 4 and
16 I think NHS England have shared their data on that, was
17 incredibly small. So I think actually the units, when
18 asked to assess their strain, almost all, and whilst
19 under huge strain, did not declare that they had reached
20 the point where they thought that that was
21 an appropriate thing and that we needed to proceed to
22 national triage.

23 **DR SUNTHARALINGAM:** I would echo that among the three
24 nations including Wales, because although they weren't
25 specifically using CRITCON as a tool due to different

97

1 guidance to perhaps bridge that gap where critical care
2 was reaching saturation but we weren't quite at CRITCON
3 4 or the equivalent for the devolved nations?

4 **PROFESSOR SUMMERS:** I think there was very clear guidance
5 that usual decision-making should proceed and that
6 decisions should be made in the best interest of
7 individual patients, absolutely, until the point it was
8 declared people were at CRITCON 4 and there was national
9 guidance for anything to change. I think that was
10 repeatedly and appropriately shared by all nations at
11 multiple time points during the pandemic.

12 **DR SUNTHARALINGAM:** I think there was a greater awareness of
13 the guidance that did exist and there was something in
14 the background that could be activated and engagement by
15 all the relevant parties, which in this case was
16 endorsed by the Welsh Intensive Care Society and
17 Critical Care Network Wales. But, I think, broader
18 awareness of that is probably the answer to your
19 question that there is a plan and it could be brought
20 out, but in the meantime usual decision-making applies,
21 as Professor Summer has said.

22 **Q.** Thank you.

23 Given the evidence that we heard earlier from you,
24 Professor Summers, about older people being less likely
25 to be admitted into ICU during the surges despite no

99

1 sizes and layers and the complexity, but I think that
2 information about local strain was being passed up and
3 down the chain in a similar way, so I think had that --
4 hospitals reached that state, it would have been
5 transmitted in a way that then triggered the activation
6 of further measures, and that wasn't the case.

7 **Q.** But given what you said in your report about local
8 informal processes likely changing, is it likely that
9 prioritisation decisions were made, and were in fact
10 incurring but just in the absence of formal guidance as
11 to how those decisions should be approached?

12 **PROFESSOR SUMMERS:** So, to be really clear, there is a very
13 big difference between prioritising whether critical
14 care is appropriate for an individual patient, and we
15 know from data before the pandemic that people
16 sometimes, when their intensive care restrained vary in
17 a soft or ill-defined way, the way in which they make
18 those decisions -- I think the data from Wales, the
19 doctor said in the survey about patients who they think
20 might not make -- have benefit from critical care, but
21 there is a small chance they might on some days would
22 get admitted, but at times of strain would not, that is
23 a very different thing from triage by absence of
24 resource.

25 **Q.** Do you think that there was any scope for further

98

1 policy that you were aware of regarding this, is it
2 likely that the elderly were disproportionately
3 disadvantaged by unconscious or conscious alterations in
4 decision making made on an informal basis?

5 **PROFESSOR SUMMERS:** So I think to clarify exactly what
6 I said both verbally and in the report, I said elderly
7 people and those with greater burdens of comorbidities,
8 so it was not just purely an age phenomenon, excluding
9 anybody from anything on a purely age basis -- I'm
10 surrounded by lawyers so I'm aware of this -- is legally
11 dubious is I think where I will go. But actually, it is
12 ethically inappropriate too. What matters is the
13 individual patient and their circumstance and their
14 comorbidities and their health status and their values
15 and wishes. So I'm not aware of anywhere where there
16 was an expressed policy, formal or informal where age
17 was used as a cut-off.

18 **Q.** My next question is about continuous positive airway
19 pressure, or CPAP, as it is more commonly referred to.

20 If we could bring up INQ000480136.

21 This is a witness statement prepared on behalf of
22 the Cardiff and Vale University Health Board and if we
23 could look at the bullet point right at the bottom of
24 the page. This is setting out the various steps that
25 were taken at the local level by the Health Board to

100

1 increase ICU capacity. And it says:
 2 "Patients who, under normal circumstances, would
 3 have gone to critical care for CPAP, [non-invasive
 4 ventilation] or High Flow Nasal Oxygen were admitted to
 5 the escalated Respiratory Support Unit on the
 6 respiratory ward instead."

7 At the top of the next page, on the third line
 8 down, it says:

9 "It was agreed that should a patient not improve
 10 after 3 days on ward level with CPAP/high level nasal
 11 oxygen then we would refer for possible transfer to
 12 ICU."

13 At the very bottom of that paragraph it states
 14 that:

15 "The published data (from across all of Wales)
 16 showed that there was no significant difference in
 17 mortality for patients receiving CPAP managed on the
 18 respiratory wards and/or on ICU when corrected for age
 19 and comorbidity."

20 But:

21 "There was a notable difference between Wales and
 22 England in this regard as many more patients in England
 23 had CPAP on ICU."

24 I wanted to ask you on the basis of this, what the
 25 drawbacks and risks are to patient safety of not

101

1 your evidence.

2 My Lady, I will try and rationalise and summarise
 3 my questions accordingly.

4 The first one is in relation to escalation to ICU.
 5 Dr Suntharalingam, I look towards you but, of course,
 6 Professor Summers feel free to jump in and vice versa.

7 In the same paragraph you have just been referred
 8 to actually, paragraph 156 at your page 61, but
 9 a different question arising.

10 That is the paragraph where you note that in
 11 practice ICU capacity was overwhelmed in some locations
 12 at certain times, which chimes in with the evidence from
 13 Professor Fong of last week. You go on to say:

14 "The criteria for ICU admissions changed via local
 15 informal processes (conscious or unconscious)
 16 alterations in decision-making by individual clinicians
 17 rather than due to policy or guidelines being issued."

18 Then you add:

19 "This is a contentious topic for which robust data
 20 is challenging to assemble."

21 Doctor, in terms of what we can glean or what we
 22 can take from those observations, does that mean that
 23 although national guidance and policies had not
 24 officially changed or altered there were instances of
 25 some local hospitals and ICUs operating a system of

103

1 receiving CPAP on the ICU and instead receiving it on
 2 a ward.

3 **PROFESSOR SUMMERS:** So ordinarily acutely unwell and
 4 hypoxemic, so lacking in oxygen, patients would receive
 5 CPAP inside a critical care setting. We do that because
 6 it provides an increased level of ability to monitor the
 7 patient, both their oxygen levels, experienced care
 8 providers and also a higher nursing ratio and
 9 physiotherapy ratio than you might perhaps have on
 10 a regular ward.

11 So that would be our default gold standard way of
 12 delivering care. Unfortunately that was not possible
 13 during the pandemic at scale and not just in Wales,
 14 there is data suggesting that in many hospitals up to
 15 50% of people received their CPAP outside an intensive
 16 care unit.

17 It is the critically ill people who are not inside
 18 critical care units who I have repeatedly referred to.

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

20 Ms Munroe.

21 Questions from MS MUNROE KC

22 **MS MUNROE:** Good afternoon. My name is Allison Munroe,
 23 I represent Covid-19 Bereaved Families for Justice UK.
 24 I have a few questions. Some of them have been touched
 25 upon to a lesser or larger extent during the course of

102

1 perhaps what -- if I can call it resource-led clinical
 2 prioritisation? I don't know if this chimes in this
 3 triage in the absence of a resource.

4 **DR SUNTHARALINGAM:** I will defer to Professor Summers, in a
 5 sense that was sort of a bridging paragraph looking at
 6 what the guidelines and the policy was and then leading
 7 into what might be more data led, so I will pass on to
 8 my colleague.

9 **PROFESSOR SUMMERS:** Thank you.

10 So in drafting this paragraph what I was trying
 11 perhaps ineloquently to communicate is that, whilst no
 12 policy was -- and guidance that decision-making should
 13 change was ever issued, I wasn't certain that that
 14 hadn't happened. Hence my use of "conscious" and
 15 "unconscious" because I cannot speculate about the
 16 individual decision-making that happened in every case
 17 by every clinician across all four nations of the
 18 country. And I was trying to communicate uncertainty as
 19 opposed to me having evidence that particular things
 20 happened.

21 **Q.** And so on that specific point of resource-led clinical
 22 prioritisation, do we simply not have the data, robust
 23 data to come to any conclusions?

24 **PROFESSOR SUMMERS:** Other than the data that I presented
 25 about the changes during the peak of the demographic

104

1 characteristics of the people who were admitted,
 2 I couldn't find any data and I did look quite hard, but
 3 that doesn't mean that it didn't happen, and it doesn't
 4 mean it did happen, it just means I could not find data.
 5 **Q.** Thank you. Staying on the issue of data, ICNARC data,
 6 you again touched upon this in your evidence just after
 7 the break, and I want to highlight two parts of your
 8 report, and I think again you mentioned paragraph 161 on
 9 page 64. But the next paragraph, at 162, you note that
 10 the ICNARC publication data raised the possibility --
 11 and you put it no higher than a possibility -- that:

12 "... efforts were directed at saving patients with
 13 the greatest chance of survival (those who were younger
 14 and previously fitter but with the most severe illness)
 15 during the peak of the first wave."

16 Then you talk about, again, same page,
 17 paragraph 164, this group, the 142,000 longitudinal
 18 clinical path, where they found:

19 "... ward mortality was highest when older
 20 patients were least likely to be admitted into ICU,
 21 suggesting these patients may potentially have benefited
 22 from ICU admission."

23 Just a couple of questions arising from that
 24 please. Firstly, is it fair to conclude then that the
 25 corollary of that data, and those observations, was that

105

1 My question is this, Professor: do you accept or
 2 believe that the informal "rationing of care", due to
 3 a lack of ICU capacity, likely caused or contributed to
 4 deaths during this period?

5 **PROFESSOR SUMMERS:** I think what I would say is that I have
 6 uncertainty. I do not think I can tell you either way.
 7 I don't have anything to support it. I cannot rule it
 8 out and I cannot rule it in.

9 **Q.** All right.

10 **PROFESSOR SUMMERS:** If you ask me for an overall impression,
 11 I think it would be a very unwise person who tells you
 12 that in every circumstance in every hospital across the
 13 country, that something happened as it was supposed to
 14 happen.

15 **Q.** Thank you very much. Then, thirdly, on this related
 16 topic and this may be a question for you, Doctor, you
 17 spoke earlier about transparency and the need for
 18 transparency when you were discussing the clinical tool
 19 for the four nations to consider clinical prioritisation
 20 levels.

21 Now, this question is maybe a difficult one
 22 because it sort of traverses perhaps moral, ethical and
 23 perhaps even political considerations, but do you
 24 consider that patients and their families could or
 25 should have been told that there were instances -- if

107

1 patients who became very ill with Covid-19 in this
 2 period, who required intensive care but were not
 3 admitted to ICU, for example, due to old age or
 4 pre-existing health conditions and disabilities,
 5 effectively had their chances of survival reduced?

6 **PROFESSOR SUMMERS:** I think what I was trying to say was
 7 that at times of strain, the data and the authors of
 8 both these separate publications said that in people who
 9 were thought to be less likely to survive, so people who
 10 were older and had a greater burden of healthcare,
 11 co-morbidity, they were less likely to be admitted into
 12 an intensive care unit, and that their mortality was
 13 thereby increased.

14 Now, whether that mortality is increased as
 15 a function of the fact that they were thought initially
 16 to not be as likely to survive as a younger, less
 17 comorbid person, I'm unable to tell. I can tell you
 18 that their mortality was increased, and that they were
 19 less likely to come to an intensive care unit. Whether
 20 those two things are causally related, I can't tell from
 21 you the available data.

22 **Q.** All right. Secondly, at paragraph 163, you further
 23 consider the analysis of the data. And you use
 24 a phrase -- it is by the authors of the report, not
 25 yours -- rationing of care.

106

1 there were instances -- where decisions not to admit
 2 them to ICU were based on resources rather than whether
 3 or not admission was clinically indicated? Is that
 4 something they should have been told or indeed could
 5 have been told?

6 **DR SUNTHARALINGAM:** I think the question takes the premise
 7 that it happened, which we don't know --

8 **Q.** Yes.

9 **DR SUNTHARALINGAM:** -- and in fact, just to reference your
 10 last question, I noticed the quote that you gave came
 11 from London, and actually there was a lot of transfer
 12 activity and hospital that became overwhelmed would be
 13 transferring out. In London, the hospitals are closer
 14 -- I happened to work there, the hospitals are fairly
 15 close together, the transfer systems were there prior to
 16 Covid, to a large extent, so I think it is less likely,
 17 if anything, that somebody would simply turn someone
 18 away for lack of beds when there is another hospital not
 19 far away. But that's just a comment on that particular
 20 paragraph, as it were.

21 I think, to answer your -- the present question,
 22 as a matter of principle, I would say yes, they should
 23 be told. It is difficult to answer whether they were
 24 told because I'm not aware of those particular scenarios
 25 happening.

108

1 I think, if there were some future crisis, whether
2 it is disease or anything else, some major incident,
3 and decisions were made on that basis using whatever
4 framework or tool was in use at the time, then, as
5 a matter of principle, yes, people should be told that
6 "This is the reason. We would admit you to ICU
7 normally, we are unable to now for these and these
8 factors, this is how we made the decision", and there
9 should be transparency.

10 As I say, I can't comment on whether that's
11 happened this time. We don't believe it did. And so
12 that's as far as I can answer that I think.

13 **Q.** Thank you. Frailty scoring and DNACPR. We have dealt
14 quite a lot with DNACPR, so perhaps looking more at the
15 frailty scoring aspect here.

16 You refer to the NICE in your report at pages 45
17 and 46, paragraph 108 -- the NICE algorithm of
18 22 March 2020, which was part of a broader written
19 agreement that emphasised the limitations of using
20 Clinical Frailty Scale.

21 Do you believe that as a result of the NICE
22 algorithm and guidance, there was a risk that clinicians
23 would perhaps over estimate clinical frailty scores
24 associated to factors such as age, pre-existing health
25 conditions when considering whether patients were

109

1 speak, in their bodily tissues, may become labelled with
2 that. So a clarification was made by the authors of the
3 NICE guidance which was not ours, that firstly this
4 shouldn't be used under 65 where it is not validated.
5 The tool is validated in those older, and that care
6 should be taken to consider other factors.

7 Now, in the terms of the guidance and your
8 question, the later work that was done very clearly
9 paired those discussions with capacity and escalation,
10 mutual age, and CRITCON or other measures of units being
11 overwhelmed, so in any formal sense, people should not
12 be using the tool because they had not been authorised
13 to do so because the nation was not in a state of
14 CRITCON 4.

15 And part of the argument for making it public and
16 open and transparent is that people are aware that's the
17 framework and the sort of guard rails to stop it being
18 used prematurely.

19 So I think I would answer the question that way,
20 which is that the discussion around frailty is complex.
21 Including it in a decision-making tool, in a situation
22 of the healthcare system being overwhelmed is a topic
23 for discussion, and the more discussion and development
24 we have of it, the better. But there wasn't a situation
25 where it would have been used in its current form as we

111

1 eligible for ICU admission, ventilation, and other
2 hospital care at a time when there was a severe
3 constraints on resources and capacity?

4 **DR SUNTHARALINGAM:** So that guidance was separate to our
5 piece of work. I think my understanding is that it was
6 brought out in a form which talked about the frailty
7 score without qualification, and was then rapidly
8 withdrawn and replaced with a version that made some
9 points about not misinterpreting frailty in the context
10 of stable disability.

11 And just to sort of gloss that a little bit, the
12 frailty score, which is a clinically validated tool used
13 in the care of the elderly community as a marker of
14 biological frailty, in other words, people's bodily
15 tissues slowly deteriorate to the point where their
16 ability recover from illness is impaired, and there are
17 proxy measures for that, which include their state of
18 mobility and general health.

19 Inevitably, in putting things into that sort of
20 framework, things get simplified, and for example, the
21 need for being bed-bound or need for carers and so on
22 becomes part of the assessment. And one of the dangers
23 of it is that somebody who, for example, might need
24 carers for another reason such as learning disability,
25 but that doesn't reflect biological weakness, so to

110

1 didn't reach that operational trigger.

2 The NICE guidance, I can't really comment on, but
3 I do note a version was withdrawn and replaced with one
4 which made some explanatory notes to clarify the use of
5 frailty scoring.

6 The document which we then later worked on was
7 a separate one which went into a little bit more detail,
8 and that's something as well -- I can leave it there.

9 In consultation with -- as part of that piece of
10 work, discussion with, I believe, Age UK and other
11 bodies, they commented on the fact that graphics were
12 what they felt to be simplifying and potentially
13 demeaning, so the graphical element of the frailty score
14 was taken out in the version that we then used. But
15 there's obviously a lot more to it than just that.

16 **Q.** Thank you. My final question has for the most part been
17 answered, but if I can just ask you, perhaps,
18 Professor Summers, a point of clarification more than
19 anything else.

20 In your paragraph 55 of the report you talk about,
21 obviously, the poor mental health of ICU staff and the
22 phenomenon of presenteeism, working while sick, where
23 staff continue to work even though their functioning is
24 impaired.

25 I think, from your answers both to my Lady and to

112

1 Ms Carey KC, that you would agree that the poor mental
2 health of healthcare workers during the pandemic is
3 likely or could have been likely to negatively impact
4 upon the quality of care and safety of patients?

5 **PROFESSOR SUMMERS:** Unquestionably.

6 **Q.** You said in answers right at the end of your examination
7 by Ms Carey KC that "No one can be surprised by this,
8 the pressure never came off in 2020, and then going into
9 2021 peaks, there were greater demands as well as trying
10 to resume elective surgery care. We all carry the scars
11 of the last five years."

12 My question is simply this on behalf of those
13 I represent: has enough, do you think, been done to help
14 healthcare workers heal from those scars, and prevent
15 the moral distress leading to moral injury that
16 Dr Suntharalingam described last week, and the poor
17 mental health impacting negatively upon patients?

18 **PROFESSOR SUMMERS:** I think that is a really difficult and
19 complicated question that's not easy to answer. How
20 much would be enough to offset what everybody has been
21 through? I'm not sure that for people whose loved ones
22 who were in hospital, for those of us that were in
23 hospital or in primary care settings or in social care
24 settings, there would ever be enough support to make
25 what we all went through better.

113

1 either the same people or different teams look after the
2 staff or patients. This is part of standard critical
3 care in other countries such as France, and I think this
4 has been an important positive development.

5 I wouldn't want, in any way, to say that is enough
6 for a part of it, but it is a group of staff, just to
7 mention, really, the work they do, and the importance of
8 having them resourced and funded. But that's only one
9 small part and I completely agree with Professor
10 Summers's wider message.

11 **PROFESSOR SUMMERS:** And it is not just intensive care staff
12 that carry these scars.

13 **MS MUNROE:** Thank you both very much.

14 We've gone over into lunch, I do apologise.

15 **LADY HALLETT:** Don't worry, not your fault. That completes
16 all the questions we have for you, thank you both for
17 all your clinical work, obviously, and I can only
18 imagine the scars you talked about.

19 Thank you for your help in preparing the written
20 report, and, of course, the help you have given in the
21 course of your evidence. It has been extremely helpful.
22 And thank you for your patience, having had your
23 evidence disrupted last week. So thank you again.

24 2.10 pm.

25 **(The witnesses withdrew)**

115

1 Is there enough support to enable people to
2 continue to do their roles in a way that makes the
3 healthcare safe? I think the commitment and the amazing
4 efforts by healthcare workers, and social care
5 workers -- I think that should be recognised too -- to
6 continue to deliver care for those that need it, has
7 been extraordinary. Many of them are continuing to do
8 so, carrying the scars that I talked about. They won't
9 ever be the same. There is no going back to how we were
10 before; that is not possible, we can't unsee things, but
11 there is a huge, huge burden of care that is still
12 needed. There are enormous elective waiting lists and
13 care lists that need to be addressed because they were
14 delayed during the pandemic, and we went into the
15 pandemic with some fairly sizeable waiting lists too.

16 So, there is no chance to pause and reflect and
17 stop and repair; people are doing the very best they
18 can.

19 **DR SUNTHARALINGAM:** I would completely agree with that, and
20 I would like to raise anyway -- without taking away
21 anything from that -- so one positive learning, I think,
22 an improvement has been there is greater emphasis now
23 across the healthcare sector about well-being, but also
24 in concrete terms more ICUs now have clinical
25 psychologists, funded and deployed, and they look after

114

1 **(1.06 pm)**

2 **(Luncheon adjournment)**

3 **(2.10 pm)**

4 **LADY HALLETT:** Mr Fireman.

5 **MR FIREMAN:** May I please call Dr Mathieu.

6 **DR STEPHEN MATHIEU (affirmed)**

7 **Questions from COUNSEL TO THE INQUIRY**

8 **LADY HALLETT:** I hope you haven't been waiting for too long.

9 **A.** No, not at all. Thank you.

10 **MR FIREMAN:** Could you please give your full name.

11 **A.** Stephen Mathieu.

12 **Q.** Dr Mathieu, you have given two witness statements to the
13 Inquiry. They are dated 26th March 2024 and
14 20 August 2024 and for the record they are INQ000472300
15 and INQ000474302.

16 Dr Mathieu, you are the president of The Intensive
17 Care Society; is that correct?

18 **A.** That is correct.

19 **Q.** And you have been in that position since December 2022?

20 **A.** That is correct.

21 **Q.** You are also a consultant in critical care at Portsmouth
22 Hospital University Trust; is that right?

23 **A.** Correct.

24 **Q.** What is the role of The Intensive Care Society?

25 **A.** Thank you.

116

1 So The Intensive Care Society is a charity. It
 2 was founded in 1970. It is the largest
 3 multi-professional intensive care society, certainly in
 4 the UK and across Europe, and its main purpose is
 5 effectively to be the voice and support for patients,
 6 relatives and do that through our team. So our
 7 multi-professional staff.

8 So we do that through education, policy standards,
 9 guidelines, encouraging research, education.

10 The Society itself has 23 council members and it
 11 has 10 professional advisory groups which means that
 12 amongst the team we have probably got to near 100 people
 13 that are active clinicians, multi-professionals, that
 14 work throughout our country.

15 **Q.** You say across the UK, is the society UK-wide or it is
 16 England-specific?

17 **A.** It is UK-wide. And thank you, that was the purpose of
 18 the supplementary appendix. We do our very best to
 19 support and to provide a voice for all nations but
 20 clearly we do that in very close collaboration with
 21 other partner organisations, including the Welsh
 22 Intensive Care Society, Northern Ireland and Scottish
 23 Intensive Care Society.

24 **Q.** Just for clarity, what is the role of those individual
 25 societies given that The Intensive Care Society has

117

1 Just for clarity, you confirmed earlier your
 2 professional role as well as your role as president of
 3 the Society. Were you also working in intensive care
 4 during the relevant period?

5 **A.** I was. So I have a clinical and a management role in my
 6 organisation throughout the pandemic period. I would
 7 have effectively worked full-time on critical care.

8 **Q.** Were you also heavily involved with the Society although
 9 you weren't president, were you heavily involved with
 10 many of the ongoing activities of the Society during the
 11 pandemic and during the relevant period of the pandemic?

12 **A.** Sorry to interrupt. Yes, I have been a member of the
 13 Society for eight years now.

14 **Q.** You describe in your witness statement some of the
 15 activities of the Society during the relevant period
 16 which included the establishment of the National
 17 Emergency Critical Care Committee. Can you explain --
 18 I think you use the acronym the NECCC -- can you explain
 19 the work that was done by that committee?

20 **A.** Yes. So the NECCC, the National Emergency Critical Care
 21 Committee, was set up at pace and set up specifically
 22 for us to understand and support our plans, our
 23 understanding, our engagement, our interactions with all
 24 the other professional teams, the other disciplines.

25 So it was set up by Professor Hugh Montgomery and

119

1 a UK-wide reach?

2 **A.** I think they have a very important role but -- and, as
 3 I say, we do collaborate with them. The intent is very
 4 much for us to do that together, but I think it is
 5 important that we reflect that we are not only trying to
 6 do what we need to do for patients, relatives and our
 7 teams just in England alone but as you allude to there
 8 are other organisations that are important and we work
 9 closely with them.

10 **Q.** Dr Mathieu, we have heard earlier this morning from
 11 Professor Summers and Dr Suntharalingam who are
 12 obviously in the intensive care sphere. There may well
 13 be some of the issues that we will talk about today that
 14 they have covered but so that you are aware, we will
 15 cover some of those topics perhaps a little bit more
 16 briefly. But those are the topics that I was going to
 17 ask you about and so just to give you a heads up that in
 18 terms of those topics they include capacity, to some
 19 degree, ICU capacity, ethical issues, the mental health
 20 and wellbeing of staff working in intensive care, and
 21 I will ask you a little bit more specifically about some
 22 of the work that The Intensive Care Society did during
 23 the pandemic.

24 If I could start with the last of those given
 25 that's your specific role.

118

1 Dr Ganesh Suntharalingam, who is one of the expert
 2 witnesses, and it was done very quickly and it was,
 3 I suppose, unique in the sense that it was done
 4 intentionally to try and -- for us to understand as much
 5 as we could quickly about the SARS-2 virus Covid-19, but
 6 also to understand learning from other organisations and
 7 other countries, particularly Italy, at that point in
 8 time that had just had quite a significant impact from
 9 Covid.

10 It was a very different type of committee in that
 11 it was very much bottom up. It was nonhierarchical, it
 12 was very much an open invite to those that were able who
 13 felt they could offer some support/guidance. So we
 14 opened it up to all of our council members and the
 15 Operational Delivery Networks leads throughout the
 16 country. We opened it up to other societies, so
 17 actually, what we also did, which I think was the
 18 benefit and the power of it, was opening it up to
 19 emergency medicine, acute medicine, British Thoracic
 20 Society, the Renal Association. So suddenly we had
 21 a lot more granular detail about what their experiences
 22 were and how we could support each other.

23 **Q.** Just for clarity, was this a series of virtual meetings
 24 that were taking place?

25 **A.** Yes. So it was set up, as I say, at pace with -- in the

120

1 end there were about 30 virtual meetings, there were no
2 face-to-face meetings, they were all done virtually, and
3 there were also knowledge-sharing webinars. So
4 actually, by doing that, we were able to extend our
5 reach to around 100 organisations.

6 **Q.** Did those organisations include government agencies or
7 government departments?

8 **A.** So they included the presidents of the societies of
9 Wales, Northern Ireland and Scotland critical care and
10 they included some of the medical directors of NHSE.
11 But they also included lots of other important people
12 through military, we had all sorts of invites that
13 actually were helpful to get their understanding, the
14 likes of Google, Microsoft, lots of different ideas to
15 try and generate as much information as we could about
16 data, how we could share it, how we could use it, really
17 as a bit of a hive of understanding and knowledge
18 dissemination.

19 **Q.** Just for the Inquiry's understanding, was the Committee
20 more concentrated on information sharing and supporting
21 members or was it involved actually in shaping any
22 policy in relation to intensive care?

23 **A.** I think the intent was to do both and, if I may, I will
24 perhaps give some examples. So the context to some of
25 this in terms of feeding information through was that

121

1 you are giving examples of where there were discussions
2 that ultimately then led to the production of relevant
3 guidance albeit not necessarily direct cause and effect;
4 is that correct?

5 **A.** Yes.

6 **Q.** There were discussions about the relevant issues with
7 professionals within the sphere and some of these points
8 were then taken on and produced in a more formal way; is
9 that right?

10 **A.** Yes. I think the intent was always for somebody with
11 the expert knowledge and access to the right people
12 would be the person who would take responsibility for
13 those actions and research is obviously a big part of
14 that, as well as trying to make sure we were asking the
15 right questions and using our directors of research
16 through The Intensive Care Society to help us with that.

17 **Q.** Within your witness statement you have set out a number
18 of recommendations for her Ladyship to consider in the
19 context of recommendations around intensive care. One
20 of them is about the Society having a voice -- this is,
21 for your reference, recommendation Q at the second-last
22 paragraph of your witness statement, and you refer to
23 the Society having a voice at the relevant fora
24 informing national policy and decision-making for acute
25 and intensive care, both in peace time and during

123

1 The Intensive Care Society set up a national leads
2 WhatsApp group very quickly. That was the sort of
3 trying to get an understanding of what people were
4 feeling at a unit-by-unit level, bringing those
5 experiences and information into NECCC to see whether
6 there was -- that sort of information was something that
7 others were experiencing and then trying to address what
8 the problem was and help with some solutions.

9 So in terms of the guidance, the statements, the
10 policy side of things, one example is we knew that, for
11 instance, that there was a risk around if there would be
12 enough dialysis machines. I think in the end we were
13 able to provide enough options for renal replacement
14 therapy but at the time we weren't sure, so what we were
15 able to do is work very quickly and agilely with other
16 organisations -- I think probably removing some of the
17 bureaucracy that can be associated with committees and
18 associations and how you want to navigate some of this
19 guidance documents by getting straight to the experts
20 and getting the guidance out very quickly.

21 I guess that was one example.

22 The treatment decision support guidance framework
23 that has been discussed, that was also discussed at
24 NECCC meetings.

25 **Q.** If I could just pause you there for a second. I suppose

122

1 national emergencies.

2 Do I take it from that that you didn't feel that
3 the Society did have the voice that it should have had
4 during the relevant period?

5 **A.** We are a charity, we are not a Royal College or
6 obviously part of the Academy of Royal Colleges so
7 therefore I suppose our accessibility directly to higher
8 level, sort of, ministers, is different to the
9 experiences that those organisations will have.

10 I think we have an important place in those
11 discussions and we do have those discussions but they
12 are often a little bit more difficult to navigate and
13 I think the strength of our place and I think it was
14 demonstrated through NECCC, was that we are genuinely
15 a very multi-professional organisation. We are not
16 doctors, we are not nurses, we are not physiotherapists,
17 we are not pharmacists, we are not the other HPs that
18 are important, the psychologists we talked about. We
19 represent all of them, and that's where I think we have
20 the benefit of being able to provide that different way
21 of thinking and therefore our ability, I think, to
22 extend into those professions and to get their views is
23 an important one.

24 **Q.** Do you think there's anything in the fact that you are
25 a charity rather than perhaps a body that might

124

1 otherwise be seen to be more part of, to use
 2 a colloquial term, the establishment or something to
 3 that effect, the fact that you have charitable status
 4 and you are not embedded within the institutions, does
 5 that have any relevance here?
 6 **A.** I don't necessarily think so and I would want to point
 7 out I think the other organisations have an important
 8 role to play and we are strategic partners with many of
 9 those organisations. I guess the ask, which is the
 10 recommendation, is that it would be helpful and I think
 11 we would genuinely be able to provide a positive and
 12 supportive influence particularly around learning and
 13 genuine multi-professional representation; we would have
 14 a helpful place.
 15 **Q.** Can I turn to another topic which is something which we
 16 did cover to a great degree earlier on this morning,
 17 which is that of intensive care capacity. If I can just
 18 ask you a few questions about this area. One of these
 19 is in relation to the way in which you measure intensive
 20 care capacity, and we heard about the fact that it can
 21 be measured and was indeed measured in different ways.
 22 You say in your witness statement that on
 23 3rd January 2021 -- this is at paragraph 129 -- that the
 24 Society issued a document advising all hospitals to use
 25 the percentage change from baseline as a reporting

125

1 So if I use that same example, if we create
 2 another 20 beds in another part of the hospital and
 3 perhaps use a theatre recovery as the example, if ten of
 4 those beds are full, you don't then have 75% occupancy,
 5 you have got 100 plus 50 or 150%, however you want to
 6 describe it, but it just meant that what it looked like
 7 was that there were many empty beds available across the
 8 UK, which there absolutely were not.
 9 So it's about descriptions, it is about
 10 definitions, it wasn't in any way, I don't think
 11 intended to cause confusion, but that was the result of
 12 it, and it is recorded differently I think in Scotland,
 13 Wales and Northern Ireland as opposed to how it was very
 14 early on in the pandemic in England.
 15 **Q.** Why is it so important on a practical level to
 16 understand the real terms capacity across ICUs, across
 17 the country?
 18 **A.** So I think why it is important is that we know that when
 19 we are at or near capacity, and certainly if we are over
 20 capacity, that will have an impact, the impact being the
 21 ability to admit patients in a more timely fashion. The
 22 ability for staff to stretch to meet those demands
 23 because they are already stretched. It also has
 24 an impact on decision-making around mutual aid
 25 transfers, for an example.

127

1 figure. Do you recall why it was the Society felt it
 2 was necessary to issue that statement?
 3 **A.** I do, thank you. So, there was a variation in the way
 4 that data was being recorded, and that was leading to
 5 confusion, not intended, but it was leading to
 6 confusion, and the data that was therefore being
 7 declared and discussed at a sort of media level, public
 8 level was sometimes inaccurate. Not intentionally, but
 9 that was the result of it. So if I could give
 10 an example, if we had a 20-bedded intensive care unit,
 11 we have a physical capacity of 20 beds. If all of those
 12 beds are filled with unwell patients, we have
 13 an occupancy versus our baseline capacity of
 14 100 per cent.

15 The problem happened is that everyone at the early
 16 phase of the pandemic was asked to see where there were
 17 opportunities to expand their intensive care bed spaces,
 18 and we did that, and I think we did that very well. But
 19 what then -- the risk that then happened is that those
 20 beds that were not intensive care beds, they were pop-up
 21 ICUs with different staffing ratios, with access that
 22 was different to some of the equipment that we have
 23 discussed already, meant that as a result of that, it
 24 looked like there was more available ICU bed capacity
 25 than there was.

126

1 So that is one element of a wider group of tools
 2 I guess we use to describe pressure on intensive care
 3 unit occupancy capacity. CRITCON, which we have talked
 4 about already -- and then if I may, the other bit that
 5 none of this describes is all of the activity that was
 6 happening outside of what would be an expanded intensive
 7 care or critical care footprint. So none of this data
 8 captured all of the work that was being done and all the
 9 patients that were only cared for on respiratory high
 10 care support units in acute medical wards.

11 And that's why I think the definitions are so key
 12 here, that we really do capture the amount of work and
 13 effort, the amount of people -- because there is a risk
 14 we are talking about beds and capacity -- people that we
 15 are desperately trying to do our best for.

16 **Q.** Can I take it from what you have said, then, that you
 17 would support there being a nationally agreed definition
 18 of capacity to be used both in non-pandemic and in
 19 pandemic times?

20 **A.** Yes, and that was very much the reason that we issued
 21 our statement and made it public in the hope that that
 22 would be captured, and it did. I think it did influence
 23 change. We saw some of the data being better accorded.
 24 I have seen, first-hand, within my own region, the way
 25 we capture data now is much more advanced and accurate

128

1 compared to where it used to be.
 2 **Q.** One of the measures that was used to try to increase
 3 capacity was the introduction of Nightingale hospitals.
 4 You touch on that very briefly within your statement but
 5 I want to just ask you do you consider that the role of
 6 Nightingale hospitals and the use of them was
 7 an appropriate way to try to increase intensive care
 8 capacity?

9 **A.** I think the intent was right in that the data very early
 10 on in the pandemic, as we were looking at various
 11 scenarios, which obviously at that point we didn't have
 12 the vaccine, we were still trying to understand
 13 a multi-system pathogen that affects all organs, we were
 14 trying to better understand what our therapeutic options
 15 were.

16 All of the scenarios were showing that we just
 17 would not have enough physical capacity, never mind
 18 about staffing or equipment.

19 So I can understand the rationale for looking at
 20 it and exploring it. I think the reality as we all then
 21 understood is that intensive care is so reliant on
 22 a team, a multi-professional team, that need to be in
 23 the same place; we need the access to the diagnostics,
 24 the other important specialists provide us with their
 25 input, and I think with all the best intent, the

129

1 terms of stretching the staffing models are all reliant
 2 on the existing staff working more, harder, more shifts,
 3 all of those things, with the impact that created. So
 4 moving them to another hospital not only meant it was
 5 the same staff doing that, but actually made you less
 6 resilient within your own organisations.

7 **MR FIREMAN:** I don't know whether you are able to answer
 8 this, but do you think that maybe there is a role for
 9 a temporary hospital in circumstances where you need to
 10 increase capacity, but that's not necessarily in the
 11 context of intensive care?

12 **A.** Yes. I think that's probably -- well, I think the first
 13 thing is that now, in the situation we are in at the
 14 moment, it is something we have to explore, which is
 15 what would we do and what would we use it for if we were
 16 to ask that same question again, and I think the answer
 17 is right, that it wouldn't be used for intensive care.
 18 The question is, could it be used for other lower acuity
 19 level care, provided it has the right staff mix there
 20 available to look after those patients, or as a form of
 21 rehabilitation, post-acute illness?

22 But I think we do need to understand whether --
 23 what the benefits would be in the future, and the impact
 24 particularly around the staffing models.

25 **Q.** The Society produced a report in January 2021 called

131

1 Nightingale hospitals were not going to be able to do
 2 that reliably for intensive care. It might work in some
 3 places, for instance, in London, in terms of
 4 decompressing, but the reality is I don't think it will
 5 have worked in the way that it was intended to, and in
 6 some ways probably was an unintended distraction in
 7 terms of us trying to consolidate and manage the
 8 workforce that we had within our own hospitals.

9 **LADY HALLETT:** Taking up that point, Doctor, given that the
 10 staff you had was stretched beyond capacity --

11 **A.** Yes.

12 **LADY HALLETT:** -- some might argue, and you could only open
 13 a Nightingale hospital if you had the staff, the intent
 14 may have been good, but the intent was physical beds.
 15 How was anybody ever going to staff a Nightingale
 16 hospital, given the pressures on all of you working
 17 already, full stretch?

18 **A.** Yes, I think you have probably eloquently described it
 19 in a better way than I have. I think it is exactly
 20 that, which is that -- space is one thing, equipment is
 21 one thing, but the staff is fixed, and intensive care
 22 staff, many of the other speciality staffs, they can't
 23 -- we can't just generate them quickly. They take years
 24 and years of training, and those staff were not
 25 available. So all of these things that we talk about in

130

1 "Recovery and restitution of critical care". I want to
 2 have a look at a passage that was in that report. It is
 3 INQ000395297, and it is the third page. If we could
 4 just look at this text here that has been enlarged. If
 5 we look about four sentences down, there is a sentence
 6 that starts:

7 "Bed occupancy was thus greater: on
 8 24th January 2021, 5446 English ICU beds were occupied,
 9 compared to 3423 in January 2020."

10 Then it describes the difference there and it goes
 11 on at the bottom the final sentence which says that:

12 "UK-wide in January 2021, 2,251 intensive care
 13 beds were occupied above baseline capacity, equivalent
 14 to 141 new 16-bedded ICUs."

15 We looked briefly at this earlier today, but if we
 16 just come away from this text and look at the box below,
 17 you have then mapped these onto the recommended
 18 guidelines for the provision of intensive care services.
 19 These guidelines, just to be clear, we have heard a lot
 20 about staffing ratios, nurses, trained ICU nurses, 1:1
 21 being the ideal ratio, and is it 1:8 for consultants or
 22 1:12?

23 **A.** I think it is 1:8 to 12.

24 **Q.** 1:8 to 12. Okay, that's helpful. You have set out here
 25 all of the additional staff that would be needed to

132

1 ensure that ratios weren't stretched at the point that
2 we were in, in January 2021. Have I understood that
3 correctly?

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

5 **Q.** We can see there is a huge amount of additional staff
6 that would be needed, including up to almost
7 2-and-a-half thousand critical care nurses in order to
8 maintain ratios. You would accept, would you not, that
9 in January 2021, which is -- we have seen data to
10 suggest that was the peak of the pandemic, and the
11 highest point in terms of occupancy of ICU -- can I just
12 clarify, you aren't suggesting that all of these
13 additional staff need to be recruited to account for
14 that scenario, are you?

15 **A.** So, in order for us to be able to deliver the pandemic
16 level of care in terms of the GPIC standards of -- the
17 ratios that we recommend, those additional staff would
18 be required, and it is worth just pointing out that
19 that's for every 12 hour shift. It is double those
20 numbers for a 24 hour period.

21 Just to give a sense of what that is. For one
22 critical care nurse -- for us to have one critical care
23 nurse looking after a level 3 patient on intensive care,
24 24 hours a day, 7 days a week, you would need about five
25 to six whole-time equivalent critical care nurses to

133

1 decisions being that will impact on the services that
2 they would usually provide for, and we have seen that
3 through the delays in planned surgery, and that truly is
4 one of the collateral damages of the Covid pandemic.

5 **Q.** Can I ask you about that, following up on what you said
6 about the need to redeploy staff from other areas. From
7 the intensive care perspective, professionals working
8 routinely in intensive care, what was the impact of
9 having to work with staff that weren't ordinarily
10 trained in intensive care?

11 **A.** So my experience of it was that everyone wanted to do
12 the absolute best they could do. That feeling was just
13 palpable throughout my organisation and all of the other
14 units that I have sort of discussed with through
15 colleagues, and everyone wanted to help, so that was the
16 first thing to say, is whilst some colleagues were not
17 necessarily wanting to or felt comfortable within their
18 skill mixes to support intensive care, they absolutely
19 stepped up and did more than we could possibly ever ask
20 of them, and we will be very grateful forever for that.

21 In terms of what it meant, it meant that the
22 existing critical care staff took on a very supervisory
23 role, as well as supporting direct patient care, which
24 creates its own pressures and it creates its own
25 psychological impact on them, as well as obviously those

135

1 cover that.

2 **Q.** Given that this is the amount of staff that would be
3 needed at a peak of the pandemic, do you accept that
4 during peaks of pandemics, if we had a pandemic that
5 stretched ICU capacity to the same degree or in fact
6 greater than was the case in January 2021, do you accept
7 that it is necessary to allow staffing ratios to be
8 stretched in that scenario?

9 **A.** I think we have to accept that that's the best that we
10 could provide in terms of stretching the staffing ratios
11 because the staff that are needed, were needed, are
12 simply not there. So one of the lessons around that is
13 how we can be better prepared for the future. The
14 corollary of that is that we do stretch the staffing
15 ratios. We know that that's not the recommendations.
16 The recommendations are based on what is the right
17 staffing ratios to keep patients safe. So we know there
18 is an impact from us doing that, both in terms of the
19 patient quality care that we can deliver, but also the
20 impact on the staff themselves.

21 There are other repercussions of stretching the
22 work of the staffing ratios, which is the only way that
23 we can try and improve the number of practitioners,
24 improve the quality of care, is to redeploy staff from
25 other areas, with the collateral damage of those

134

1 that have come into a new environment, with lots of
2 skills, but different skills to do their very best as
3 well.

4 **Q.** Looking forward, were we to need to redeploy staff to
5 intensive care in another scenario, would you support
6 a programme, perhaps, of staff who routinely don't work
7 in intensive care, receiving training on intensive care
8 skills or in fact perhaps working a shift in intensive
9 care every so often? That may not be practical, but do
10 any or -- either of those two options offer suitable
11 ways of improving the workforce should we need to rely
12 on redeployment?

13 **A.** I think so, and I think it is an important
14 recommendation because the reality is that we can't plan
15 to staff intensive care for a pandemic every single day,
16 but what we can do is we can make incremental steps that
17 get us closer to what we need to, when that happens
18 again, and anything we can do to reduce that gap, in
19 terms of numbers and knowledge base, are key. So, you
20 will have heard yesterday about enhanced care beds,
21 level 1 beds, which are effectively somewhere between
22 a ward base level of care and a level 2 care bed, and
23 critical care, and I think that probably gives us some
24 opportunities to do some rotational programmes that
25 enable people to get exposure to critical care.

136

1 I would say I don't think that in itself is
 2 enough, there is still a gap to be bridged in terms of
 3 intensive care capacity.

4 **Q.** Does it follow that based on the difficulties for staff
 5 who don't ordinarily work in intensive care in perhaps
 6 it perhaps being a little bit traumatic for them in
 7 terms of not being used to seeing very, very severely
 8 ill patients and often patients dying, does it follow
 9 that any training should include support around the
 10 impact of seeing those patients?

11 **A.** Yes. Thank you. So it does and I think one of the
 12 benefits we saw from Kevin Fong's testimony was around
 13 peer review support and I think that was a very powerful
 14 way of understanding what was happening at
 15 a unit-by-unit level and hearing what the staff were
 16 saying and what the relatives were saying.

17 I think as part of that there has to be
 18 psychological support as well. It is something I can
 19 expand on if helpful but there has been work that The
 20 Intensive Care Society has done to I think probably
 21 dovetail quite well with what Professor Fong discussed
 22 in terms of psychological support.

23 **Q.** Dr Suntharalingam was talking earlier this morning about
 24 the prioritisation guidance that he was working on and
 25 he explained that The Intensive Care Society ultimately

137

1 emergency phase of the pandemic?

2 **A.** I would, yes. We made a decision that whilst that
 3 decision support framework was not needed, that actually
 4 it was a really important guideline that needed to be in
 5 the public domain which is why we have published in our
 6 journal, which is peer reviewed, an academic journal,
 7 because actually one of the lessons we have to learn
 8 from this is that the discussions we need to have around
 9 being genuinely overwhelmed where we have got national
 10 decompensation and inadequate resources, that we have
 11 all of the right tools, all of the right discussions, we
 12 have engaged with all of the right people, and that is
 13 society, around what is the right thing to do in those
 14 situations and hope that we never will need them but
 15 that's not a reason not to have the discussion.

16 **Q.** Can I ask you about a different topic that you have
 17 discussed in your witness statement and that is oxygen.

18 You describe particular challenges that were
 19 caused by oxygen supply during the pandemic and you
 20 describe particularly the impact of supply pipes having
 21 automatic cut offs.

22 Are you able to give us a sense of how widespread
 23 this issue was?

24 **A.** So I think what we have always thought is that oxygen
 25 would be an endless supply in a hospital, that there

139

1 published and updated a version of the draft that he had
 2 worked on initially. I don't need to take you to the
 3 guidance but one of the comments he made was about the
 4 reassurance that guidance such as this, albeit hopefully
 5 never used, may provide for staff. Is that a view that
 6 you and the Society would endorse?

7 **A.** Yes, we do. I think the decision support framework and
 8 ensuring that it was very much related dependent on
 9 CRITCON status and the use of mutual aid transfers is
 10 really important and it is important for a platform for
 11 us to have more society discussion around these things
 12 but it is also really important for the staff to know
 13 that what they are doing is the best that they can
 14 provide and that they know that if they are under
 15 immense pressure there is a mechanism to enable them to
 16 be supported and that's through CRITCON status, decision
 17 support frameworks, and also the sort of trigger peer
 18 support visits that we have discussed.

19 **Q.** I understand that the document that was published by The
 20 Intensive Care Society which we looked at briefly
 21 earlier was obviously developed and issued in the
 22 context of the Covid-19 emergency. Would you support
 23 the development of a tool that could be adapted to
 24 different emergencies produced perhaps not in the midst
 25 of an emergency but now or -- now we are not in the

138

1 would be no limitation of oxygen supply and I think
 2 there was a really important lesson in this pandemic,
 3 which I don't think we necessarily realised or learnt
 4 back in 2009 with the H1N1 pandemic, which is the way
 5 a hospital is designed means that there is -- can be
 6 a plentiful supply of oxygen but it is deliberately
 7 designed in a way that it is used for the purpose that
 8 it is intended to be used for. So if you have
 9 a critical care unit, the diameters of those pipes, the
 10 flow, the pressure of those pipes is manufactured
 11 differently to other areas of the hospitals where you
 12 might not need as high volume of oxygen, which is why
 13 the theatre recovery areas and the theatre environments
 14 were the ones that were generally used much more
 15 frequently than other areas for surge capacity in
 16 intensive care because they are also designed to have
 17 an oxygen-rich provision.

18 What we have learned from that is that I think we
 19 spent a lot of time trying to understand the schematics
 20 of a hospital, the flow, the pressure differences, which
 21 actually, if we understood them correctly beforehand
 22 would have enabled us to have really decided very
 23 quickly early on which were the best places to look
 24 after patients.

25 So it wasn't necessarily a case of we couldn't

140

1 provide the oxygen in the hospital, it was trying to
 2 find the right location to look after patients that were
 3 needing different levels of oxygen.

4 **Q.** Is it an issue with the nature of the hospital estate
 5 rather than the supply?

6 **A.** Yes, so I think initially there was a concern that we
 7 would not have enough oxygen supply delivered through
 8 BOC. That wasn't an issue. There was enough oxygen.
 9 It was purely the estates and some of the hospitals, the
 10 designs clearly are very, very old which means that they
 11 were designed for different purposes or different
 12 reasons at those time points.

13 So it was about identifying where the right places
 14 were to look after the patients, being really cognisant
 15 of the fact that where we wanted to look after the
 16 patients might not necessarily be the best location in
 17 terms of oxygen provision and we would have to adapt
 18 that and also for cohorting patients and working out
 19 what the right balance was in terms of the cohorting of
 20 patients, the proximity to an intensive care environment
 21 and what would be the best care of course for the
 22 patient.

23 **Q.** Beyond building new hospitals, what are the best ways to
 24 ensure that these issues don't arise again?

25 **A.** So, I think there are some really quite simple measures
 141

1 which allows us then to titrate oxygen accordingly.

2 **Q.** On 22 June 2021, the Society issued a statement entitled
 3 "Pulse Oximetry and Ethnicity -- the time to act is
 4 now".

5 We can have a look at it. It is INQ000395299.
 6 If we have a look at the problem, it says here:
 7 "Thirty years ago, it was recognised that SpO2
 8 measurements were less accurate when pulse oximeters
 9 were used in patients with darker skin pigmentation ...
 10 and research in the 2000s confirmed this."

11 If this is right why did the Society need to issue
 12 a statement in 2021 to this effect?

13 **A.** I think, as you say, this has been known for quite some
 14 years and there are still ongoing studies looking at
 15 exactly this problem. I think we felt it was important
 16 because of our reliance on pulse oximetry that we were
 17 really cascading it for awareness. But also -- well,
 18 I was going to say indirectly but actually I mean
 19 directly, to actually put some pressure on industry to
 20 actually make equipment that is useful and is calibrated
 21 for all of our populations and I know some of the
 22 manufacturers are doing a lot of work in this area but
 23 this is a really important basic-level piece of
 24 equipment that we use all of the time and therefore it
 25 is absolutely essential that it can be used for all of
 143

1 in here which is to understand and to ensure that every
 2 hospital understands the schematics of their
 3 environment, and that's something that can be done, to
 4 work alongside our colleagues in clinical engineering,
 5 to work alongside our oxygen committee, which is often
 6 led by a clinical pharmacist, and to basically do
 7 a review of all of those things in a hospital. To
 8 understand what the schematics are, first and foremost,
 9 and then design what you might do differently, if at
 10 all. It might be that we made all the correct decisions
 11 but actually what we would do differently faced with
 12 another pandemic that required patients to need more
 13 oxygen than they would during our baseline level of
 14 acuity.

15 **Q.** On a related note is it right that one of the ways in
 16 which patient oxygen concerns are managed is --
 17 including within intensive care, is with the use of
 18 pulse oximeters?

19 **A.** So a pulse oximeter is a very readily available piece of
 20 equipment, effectively a peg that usually goes on the
 21 finger or an ear and patients will also use them at home
 22 to monitor their oxygens for certain chronic conditions.
 23 So it is readily available and we use it as
 24 a marker to understand what the oxygen levels might be
 25 in the bloodstream but doing it in a noninvasive way
 142

1 the patients that we look after.

2 **Q.** So is it about manufacturing and testing products prior
 3 to them coming into force that don't risk inaccurately
 4 assessing a person's oxygen saturation levels?

5 **A.** I think so. I think it is part of the review process
 6 before any product is licensed that every opportunity
 7 has been taken to ensure that it is calibrated and
 8 validated in a way that is meaningful to the patients
 9 that we are caring for.

10 **Q.** Dr Mathieu, you have been very helpful and you have
 11 explained a number of points within the questions that
 12 I have asked you, so those are the questions that I have
 13 to ask you. I'm going to just ask you now whether you
 14 have any particular recommendations that you would like
 15 to point out at this stage that we haven't already
 16 spoken about?

17 **A.** Thank you. So, I think probably the key recommendation
 18 or the key recommendations, if I may, are around
 19 workforce. I think there is two elements of that. One
 20 is around looking at opportunities to bridge the gaps in
 21 our existing workforce. We know that we came into the
 22 pandemic with not enough staff to look after the sickest
 23 patients that we care for in hospital. So there's that
 24 element to it.
 25 I think the bit that is probably the more urgent
 144

1 and pressing matter is retention of staff. The pandemic
2 has really harmed people. We talked about well-being
3 and psychological support and moral distress. The
4 number of staff that have left because of what is
5 basically embedded scars because of the pandemic, trying
6 to do their very best, is something that we have to
7 learn from and we have to support them, and whatever
8 psychological support we can provide and learning
9 opportunities is key.

10 I think the oxygen schematics one we have talked
11 about is what I have described is a relatively quick
12 win, in that we can plan better for the future with no
13 additional resource by doing that.

14 **MR FIREMAN:** Thank you very much.

15 Those are my questions.

16 **Questions from THE CHAIR**

17 **LADY HALLETT:** Can I go back to the pulse oximeters,
18 Dr Mathieu, please. It seems extraordinary that over
19 30 years ago, people could have recognised that those
20 who had a darker coloured skin might have their lives
21 put at risk because these pieces of equipment weren't
22 measuring the oxygen in their blood. Whose fault is it
23 that nothing has happened? Is it the manufacturers? Is
24 it regulations? Is it those who buy the manufacturer's
25 products? Where is it going wrong because it is

145

1 avoid doing them because whilst they will give us more
2 reliable data, actually we don't want to do unnecessary
3 blood tests on people, if we can avoid it.

4 **LADY HALLETT:** Presumably intensive care specialists would
5 be trained and know of the problems with pulse oximeters
6 if you have darker, or black or brown skin?

7 **A.** Yes. It is well understood, but part of the reason we
8 wanted to put that statement out was just as another
9 reminder, really.

10 **LADY HALLETT:** The NHS must have huge buying power. You
11 might have thought -- anyway. You are not
12 a manufacturer so maybe I need to pursue it with someone
13 else, but I do find it extraordinary we haven't solved
14 that problem.

15 Right. Mr Jacobs.

16 **MR JACOBS:** My Lady, in fact the question I was going to ask
17 has been amply covered, so I shan't cover the same
18 ground.

19 Thank you very much.

20 **LADY HALLETT:** Thank you very much.

21 Mr Weatherby.

22 **Questions from MR WEATHERBY**

23 **MR WEATHERBY:** I'm going to ask you a few questions, Doctor,
24 on behalf of the Covid Bereaved Families for Justice UK.

25 I want to pick up just a couple of points on staffing

147

1 seriously wrong, isn't it?

2 **A.** I think I'm making an assumption that this is
3 resolvable. I find it frustrating that we have
4 a product that is so important that isn't -- doesn't
5 provide the same reliability of data of evidence that we
6 need for all of our population. I think the question of
7 the manufacturers and those that validate those pieces
8 of equipment and allow them to go onto the public market
9 is really, is this the very best we can do? And if the
10 answer is no, then we should not be validating it and
11 allowing it to be used, and pushing industry to find
12 solutions.

13 What I would say is that a lot of the --
14 I understand the manufacturers looked at different
15 algorithms to try and resolve it to some success, but
16 not complete success, so what I would say if I may, just
17 for assurance for patients who we would be caring for in
18 a hospital environment, is that is one element of
19 physiology that we look at. There are many others which
20 would tell us -- give us some idea of whether the oxygen
21 levels were lower than were being seen or recorded,
22 including wakefulness, cognition, other elements of
23 organ or body dysfunction.

24 We also have access to doing more invasive blood
25 tests, but of course we don't want to do those if we can

146

1 and capacity which I know you have been asked a lot
2 about, we have heard a lot of evidence about. I want to
3 preface them by making clear that I'm not criticising
4 the massive efforts that were made by yourself and staff
5 in intensive care units to fill the gaps. Not least
6 because some of the families that I represent are the
7 families of healthcare workers that actually died.

8 But the starting point, as I think you said only
9 a moment ago, is that you have started the pandemic, you
10 came into it, we -- came into the pandemic where,
11 already, business as usual, ICU staffing was under
12 strain, it was understaffed, yes?

13 **A.** Yes.

14 **Q.** And at paragraph 128 of your statement you say that:
15 "... ICUs were very quickly at or over capacity
16 ..."

17 So those are the two sort of starting points, if
18 you like.

19 It is right, isn't it, that during the course of
20 the pandemic in March 2021, the Society produced
21 a consensus statement entitled "Levels of adult critical
22 care", which was a consensus statement because it was
23 agreed by a number of other groups including the faculty
24 the RCM, the British Association of Critical Care Nurses
25 and et cetera. One of the things that the consensus

148

1 said made clear was that probably the biggest
2 contributing factor to the delivery of care in intensive
3 care is staffing.

4 Now, that might seem a very obvious statement to
5 make, but you felt the necessity of reinforcing that.
6 Am I right that the Society reinforced that point
7 because it is the quality of staffing or the level of
8 training of staffing, rather than quality, that is a key
9 part of the staffing issues?

10 **A.** You are absolutely correct.

11 **Q.** Yes.

12 **A.** So there is the staffing in terms of the numbers of
13 trained staff --

14 **Q.** Yes.

15 **A.** -- there is also the experience of those trained staff.
16 It takes many years to train as a specialist in critical
17 care. It takes even more years for them to become those
18 really, really experienced, high-level performing staff
19 that we are all accustomed to working with. That is
20 the risk of recruitment problems at this stage.

21 **Q.** Yes. So in March 2021, here you are, reinforcing the
22 point that although you have managed to draft in many
23 other staff who did their absolute level best, a key
24 problem was that even where you had the numbers, they
25 weren't the sufficiently trained staff. So there's only

149

1 faculty and yourselves put out, just for the record
2 INQ000361989 -- so during the pandemic, although you had
3 to have this work-round as best as you possibly could,
4 you were underlining that that shouldn't become the new
5 norm, and that the recommendations that had been made
6 before the pandemic should remain in place. That is
7 right, isn't it?

8 **A.** That's absolutely correct. The point being that those
9 standards are the best evidence that we have for our
10 safe staffing model at present, and we have to or had to
11 stretch that staffing ratio to enable us to care for the
12 number of patients that we needed to look after. What
13 we couldn't do and shouldn't do is reset those standards
14 as business as usual.

15 **Q.** Yes, and the worry was that if those standards slipped
16 without evidence to the contrary, but unless they were
17 kept, then the problem was that they would be a negative
18 impact on patient outcomes. That is right, isn't it?

19 **A.** Yes, I think that's absolutely right. The staffing
20 levels, the staffing ratios are embedded within the
21 Guidelines to the Provision of Intensive Care Services
22 for that exact reasons, which is safe staffing models.

23 **Q.** We don't need to go to the GPICS guidance from 2019 but
24 I do just want to read out one sentence from it if I can
25 find it, which is at page 32 of it. It is this:

151

1 so much they could add.

2 **A.** That's correct. The way that many intensive care units
3 would have done their very best to manage that would
4 have been to bring those staff that were I suppose most
5 familiar with intensive care, whether they had had
6 previous background in intensive care training and had
7 gone off to do other specialist work including community
8 nursing as well, research -- obviously, the impact of
9 that is that meant some of the research work that needed
10 to be done might get delayed. So, obviously, we would
11 try and redeploy the staff that were most capable and
12 able and willing to --

13 **Q.** You would be as smart as possible in the way that you
14 redeployed?

15 **A.** Correct.

16 **Q.** The consensus statement went on and expressly stated
17 that although things had to be done that way, the
18 staffing ratios that had been recommended in peacetime
19 should remain as they are until or unless there was
20 further evidence about them. That is right, isn't it?
21 So --

22 **A.** Yeah.

23 **Q.** -- what the consensus statement said was that GPICS
24 addition to recommendations -- now that's the Guidelines
25 to the Provision of Intensive Care Services that the

150

1 "It is widely acknowledged that the intensive care
2 workforce is costly. However, previous attempts to
3 re-configure this workforce in order to reduce staffing
4 budgets have resulted in negative patient outcomes."

5 That's pre-pandemic. So, during the pandemic, the
6 Society puts out this consensus statement indicating
7 that so far as is possible we have to keep to the
8 recommended levels, otherwise patient outcomes will be
9 negatively impacted. That is right?

10 **A.** So that's correct --

11 **Q.** Yes.

12 **A.** -- and the only way of managing to keep to those
13 staffing levels was for the existing staff to do more,
14 and that's exactly what they did do.

15 **Q.** Because you simply didn't have the sufficiency of staff,
16 then that would inevitably have led to a negative
17 impact?

18 **A.** Correct. I'm in agreement, the staffing levels are
19 there for a purpose, which is that we know that those
20 are the safest staffing levels that we require to look
21 after acutely unwell patients -- (overspeaking) --

22 **Q.** Yes, and in fact there is ICNARC data showing there were
23 higher acute hospital mortality rates where there was
24 a higher capacity strain on ICUs?

25 **A.** That is correct.

152

1 **Q.** Quickly moving on, changing the subject to older people.
 2 The Society's clinical guidance about critical care and
 3 Covid -- again I will give the reference, we don't need
 4 to put it up -- INQ000395282 and it is at page 5 -- that
 5 clinical guidance that the ICS put out makes clear, and
 6 I quote:

7 "Each patient will continue to be considered as
 8 an individual ... comprehensive individualised
 9 assessments will be used and that short of reaching
 10 a CRITCON 4 ..."

11 We discussed earlier today that had other
 12 approaches should not be used for individualised
 13 decision-making. Is that a fair summary of the guidance
 14 that was put out?

15 **A.** It is, yes. I mean, it is absolutely clear, as you say,
 16 that the guidance is only to be used in the context of
 17 national de-compensation at CRITCON level 4, with some
 18 decision support frameworks and ethical guidance that
 19 surrounds that, yes.

20 **Q.** I think you have seen the research that was done for the
 21 Inquiry, the IFF research on escalation of care. I do
 22 want to show you this bit. We looked at it briefly with
 23 the experts this morning, but there is one more page
 24 I just want to put to you for your comment. I think it
 25 is available. It is INQ000499523, and it is page 24.

153

1 a clinical decision.

2 **Q.** All right. I shan't ask you anything more about that
 3 data then, but obviously it is there.

4 Just one more point on this. We heard earlier
 5 today of research which shows that admissions to ICUs in
 6 March and early April of 2020, the average age of
 7 admissions went down and again there is a lack of
 8 evidence as to why that was as I understood the evidence
 9 earlier. Are you able to comment on that?

10 **A.** So I listened to Professor Rowan's response to that and
 11 I think I would probably come to the same conclusion
 12 which is I don't know why the data is different.

13 I think there are probably a number of reasons which
 14 include vaccination, therapeutic strategies available
 15 being different during the second wave. There was --

16 **Q.** Can I just stop you there, just on that point, sorry to
 17 interrupt you, but we are here talking about data from
 18 late March, early April 2020.

19 **A.** Oh, apologies.

20 I'm afraid I can't give you an answer to that
 21 question.

22 **Q.** I shan't pursue that further. But it is disturbing,
 23 isn't it, that there are these reports and there is this
 24 data which does paint a picture of the admissions not
 25 being in accordance with the clinical guidance,

155

1 On the left-hand side we have "Instructions from
 2 employers". This is the survey of healthcare
 3 professionals:

4 "During each wave of the pandemic, 1 in 3 HCPs
 5 said they received instructions from their employer on
 6 which groups should not be he is circulated to the next
 7 level of care."

8 That is a huge proportion, yes? Then, on the
 9 right-hand side, just the bits that you will be most
 10 concerned about, is that within that figure, 28% of
 11 critical care nurses and 17% of critical care doctors --

12 **LADY HALLETT:** Microphone, Mr Weatherby, because you are
 13 leaning down.

14 **MR WEATHERBY:** I'm so sorry.

15 It's 28% of critical care nurses and 17% of
 16 critical care doctors were included in those figures.
 17 Would you agree that doesn't really fit with the
 18 guidance in terms of individualised assessments? It
 19 rather indicates that there were instructions on blanket
 20 criteria?

21 **A.** So that's exactly what this data suggests, and I have
 22 reviewed the survey. I genuinely cannot understand
 23 those responses because I am not aware of any employer
 24 within an intensive care environment being given
 25 instructions on who should be escalated. That is

154

1 individualised clinical guidance?

2 **A.** I'm not -- I'm sorry, I can't comment on that.

3 **Q.** Fair enough.

4 **A.** I do not think the guideline or the guidance is
 5 different to what is current practice for intensive
 6 care, which is very much around those staffing ratio,
 7 they should be protected unless we are in a position
 8 where we have local pressure to regional to national
 9 pressure or with the option to try and decompress
 10 through to using our workforce differently, internally,
 11 I don't mean redeploying staff but moving people away
 12 from other important ICU roles to ensure that we protect
 13 the clinical, direct clinical care but also with that
 14 mutual aid transfer option.

15 **MR WEATHERBY:** I shan't pursue it any further, thank you
 16 very much.

17 **LADY HALLETT:** Thank you Mr Weatherby.

18 Ms Woodward.

19 Questions from MS WOODWARD

20 **MS WOODWARD:** Thank you, Doctor. I ask questions on behalf
 21 of Covid-19 Bereaved Families for Justice Cymru and my
 22 first question is about the draft guidance published
 23 from the Intensive Care Society for use as a decision
 24 support tool, which we have heard quite a lot about now,
 25 and you said during your evidence earlier today that

156

1 that guidance was very related to CRITCON status.
 2 My question is given that CRITCON was not formally
 3 adopted in Wales how was it intended that the guidance
 4 would be used in Wales?

5 **A.** So I think -- thank you. I think CRITCON is, as you
 6 rightly point out, is not universally used in Wales or
 7 indeed Scotland and Northern Ireland. It very much is
 8 used within England. I think the size, the
 9 organisational structures of Scotland, Wales and
 10 Northern Ireland are different and different in a way
 11 that the connectivity to higher levels of
 12 decision-making at sort of CMO level is probably more
 13 direct than it is in England, and that's not meant to
 14 be -- that is a comment rather than a point of view.
 15 They are just different types of structures. So what
 16 I do know is that there are -- the way that pressure is
 17 discussed and concerns raised will still be to the
 18 Parliamentarians, the main decision makers, but not
 19 necessarily using CRITCON as that way of describing it.

20 I think CRITCON would be a really helpful tool to
 21 be used across all devolved nations because actually
 22 what it would do is give us just one simple language
 23 that we could then use to enable us when we are at
 24 a point of national -- if we were at a point of national
 25 decompensation to use that scoring -- that description

157

1 difficulties in talking about capacity because of the
 2 way the data was collected. Were there any other
 3 barriers or deficiencies in respect of effective data
 4 collection, analysis or sharing between the four nations
 5 that you were aware of outside of the capacity issue?

6 **A.** Not that I'm aware of. I think probably, if I may, just
 7 to try and describe a positive around data capture is
 8 obviously we -- the data needs to be anonymised and that
 9 is obviously important and whatever we do around data
 10 collection we need to be clear that we are not -- that
 11 we are sticking to the standards that we would expect of
 12 that data capture.

13 But the reality of it is that what we did and
 14 I think did really well across all nations was knowledge
 15 share, understand, use data, work out what it was
 16 telling us, direct the research activity that we needed
 17 to be directed towards and try to use that common
 18 language as best we could to describe the best treatment
 19 strategies that we could.

20 So I think the data is there and the data is
 21 enriched by having as many nations involved in sharing
 22 that information. I guess what would be helpful for the
 23 future is to be able to access it through a single
 24 portal.

25 **Q.** Thank you, Doctor.

159

1 of pressure and the action associated which may include
 2 transfers outside of regional boundaries to be used.

3 **Q.** Thank you. My next question is about data collection
 4 and access and you address this at paragraph 75 of your
 5 witness statement.

6 You state that the absence of centrally held data
 7 for Covid-19 patients made it difficult to obtain,
 8 compare and analyse data being recorded and you
 9 highlight in that paragraph the differences between
 10 England and Scotland in the way they hold data.

11 What was the position regarding data collection in
 12 Wales, to your knowledge?

13 **A.** So, I'm afraid I don't have a detailed answer to that
 14 but what I can say is that the way -- so Wales will
 15 capture data in a similar way to the other nations.
 16 I think where we are perhaps different across nations
 17 and including within regions in England is the
 18 descriptions, the definitions that we use and that's the
 19 point very much I was making around occupancy and
 20 capacity and surge capacity and we do need to try and
 21 come up with a common terminology that means that
 22 actually when we do review the data, to try and get much
 23 more of a UK understanding of where we are, that
 24 actually we are using the same descriptions.

25 **Q.** As you said, Doctor, there you spoke earlier about the

158

1 My next question is about staff wellbeing which
 2 you have addressed at paragraph 94 of your witness
 3 statement where you look at the impact of the pandemic
 4 on the society's members, patients and their families.
 5 In there you identify the many challenges faced by staff
 6 including lack of beds, lack of experience and trained
 7 intensive care staff, a lack of PPE and concerns about
 8 staffing protecting themselves and their own families at
 9 home.

10 My question is whether staff, from your knowledge,
 11 were also concerned about the absence of routine patient
 12 and staff testing?

13 **A.** I think like everyone the view was very much that we
 14 needed to just try and conform to whatever the guideline
 15 would tell us to do but I think equally I think there
 16 were concerns expressed about staff testing, when it
 17 should be done. I think one of the problems we had
 18 certainly at points of the pandemic was the fact that
 19 lateral flow tests for example would remain positive for
 20 a very long period of time even though we knew that from
 21 a viremic point of view in terms of risk, it probably
 22 was much shorter than that and the challenge then became
 23 what do you do with that information when you have got
 24 staff that are incredibly stretched and staff that want
 25 to work, are available to work but might have a positive

160

1 test.

2 I think that's probably a different way to

3 describe your point, and I'm sorry for doing it that

4 way, but I guess like everyone we were looking at the

5 guidelines and being consistent with how we approached

6 it.

7 **Q.** And were there any concerns specifically raised about

8 absence of routine testing for patients, which is

9 perhaps a slightly different issue to what you have just

10 said about staff?

11 **A.** Yes, but probably modified by the use of PPE for

12 aerosol-generating procedures.

13 **MS WOODWARD:** Thank you very much. Those are my questions.

14 Thank you.

15 **LADY HALLETT:** Thank you Ms Woodward, very grateful.

16 That completes the questioning for you,

17 Dr Mathieu. Thank you very much for all your work you

18 do on the frontline, and obviously for your work in

19 preparing your written statement, which I will consider

20 as well as your oral evidence, so don't worry if you

21 haven't covered something. Thank you very much for

22 coming today.

23 **A.** Thank you.

24 **(The witness withdrew)**

25 **LADY HALLETT:** I think that completes the evidence we can

161

1 Critical Care Network and so speaks to the impact from

2 his perspective in Wales.

3 Sarah Jones, who is a member of the 13 PBPOs,

4 suffered an ectopic pregnancy during the pandemic, and

5 she speaks powerfully of the impact of that on her.

6 There is the statement from M3/W2, who was a nurse

7 originally from the Philippines, who worked in the NHS,

8 who gave a statement on behalf of FMHWG.

9 There is a statement from Sanjeev Panesar, who is

10 a pharmacist based in Birmingham and a member of the

11 National Pharmacy Association that we would like you to

12 publish.

13 There is a statement from M3/W3, who is an ethnic

14 minority healthcare worker who assessed patients with

15 suspected mental health difficulties that presented

16 themselves at A&E that we would ask you to publish.

17 Two statements from witnesses from Qatar, Gillian

18 Higgins and Nathalie McDermott who speak to IPC

19 measures, but in addition, Ms Higgins was redeployed to

20 A&E during January 2021, and she attests to that.

21 Indeed Nathalie McDermott, along with the other

22 matters that she set out, worked on a Covid ward during

23 the pandemic. She speaks to that.

24 Clare Cole from the John's Campaign speaks about

25 the circumstances of her father's death.

163

1 hear today. I do hope that the witness' emergency

2 resolves itself successfully.

3 **MS CAREY:** So do we, and we will update your Ladyship as

4 soon as we are able.

5 My Lady, all being well, we have a very busy

6 timetable for tomorrow. So there is one matter I would

7 like to, with your permission, deal with today, and it

8 is the statements of some additional impact evidence

9 that we would like to invite your Ladyship to publish.

10 There are 13 statements in all at this stage to be

11 published, and may I just indicate, without giving the

12 INQs, just the witnesses' names and the brief outline of

13 the topics they cover.

14 There is a statement from Mrs Carla Jones-Charles,

15 who is a member of Trades Union Congress. She is

16 a director of midwifery at the Walsall Healthcare NHS

17 Trust and speaks to the impact on midwives, picking up

18 on some of the evidence you heard this week.

19 The statement of Dr David Bailey, who is a member

20 of the BMA. He is a GP in Wales and so attests to the

21 impact of the pandemic from his perspective.

22 Dr Jack Parry-Jones, who is a member of the Royal

23 College of Anaesthetists, the Faculty of Intensive

24 Medicine and the Association of Anaesthetists. He is in

25 fact the lead clinician for the South East Wales

162

1 And Rachel Ashton, also from the John's Campaign,

2 was a nurse working during the pandemic, but she sadly

3 cared for her brother who had mental health difficulties

4 and during the pandemic died by suicide in

5 February 2021.

6 And there are two statements from Josh Miller and

7 Priyanka Patel, both of whom are members of the Royal

8 Pharmaceutical Society. Mr Miller was based in Scotland

9 and gives evidence from his perspective there. Ms Patel

10 was a student at the start of the pandemic, and so

11 brings to bear some slightly different evidence about

12 how the pandemic affected her, her studies and her

13 training thereafter. May --

14 **LADY HALLETT:** Thank you. Not only may they be published

15 but I wish to emphasise, yet again, that I will ensure

16 that they are all read extremely carefully and the

17 contents considered. The oral part of these hearings is

18 just one part. The written material is as important and

19 I am just sorry that we haven't got the time to call

20 everybody to give oral evidence. We just don't. Thank

21 you very much. Very well, 10 o'clock tomorrow please.

22 **(3.26 pm)**

23 **(The hearing adjourned until 10.00 am**

24 **on Thursday, 10 October 2024)**

25

164

1	INDEX	
2	MS NORA OHRENSTEIN (Interpreter)	1
3	(affirmed)	
4	M3/WI (affirmed)	1
5	Questions from COUNSEL TO THE INQUIRY	1
6	PROFESSOR CHARLOTTE SUMMERS	9
7	(continued)	
8	DR GANESH SUNTHARALINGAM (continued)	9
9	Questions from LEAD COUNSEL TO THE INQUIRY ...	9
10	for MODULE 3 (continued)	
11	Questions from MR JACOBS	84
12	Questions from MR ODOGWU	86
13	Questions from MS MITCHELL KC	88
14	Questions from MS WOODWARD	94
15	Questions from MS MUNROE KC	102
16	DR STEPHEN MATHIEU (affirmed)	116
17	Questions from COUNSEL TO THE INQUIRY	116
18	Questions from THE CHAIR	145
19	Questions from MR WEATHERBY	148
20	Questions from MS WOODWARD	156
21		
22		
23		
24		
25		

**DR
SUNTHARALINGAM**

: [119] 10/14 10/23
11/11 11/19 12/17
12/25 13/15 13/24
14/14 15/2 15/16
15/20 16/4 16/8 16/11
16/14 17/4 17/15
17/23 18/3 18/16
18/23 19/6 19/10
19/17 20/9 20/22
20/24 21/3 21/6 21/17
21/21 21/24 22/18
23/1 23/4 23/8 24/3
25/8 25/15 25/21 26/8
26/21 26/23 27/4
27/12 28/2 28/15
28/17 29/6 34/21 35/8
36/5 36/17 36/20 37/7
38/22 41/1 42/9 42/12
42/15 43/2 43/5 43/17
43/21 43/24 44/10
45/7 45/9 45/16 45/22
46/16 47/6 47/16
47/25 48/5 48/11 49/3
49/25 50/22 51/11
51/18 52/1 52/12
53/16 53/20 53/24
54/6 54/15 54/25 55/4
71/12 73/7 74/12 75/1
75/18 78/19 79/7
79/17 81/20 81/22
83/14 83/18 84/25
85/7 89/9 90/10 91/5
91/22 92/9 94/1 96/11
97/23 99/12 104/4
108/6 108/9 110/4
114/19

LADY HALLETT:

[48] 1/3 9/2 9/6 9/13
9/24 16/5 17/22 23/14
24/13 24/17 24/21
28/7 28/16 28/21 29/7
35/20 36/16 36/19
37/1 37/15 56/2 56/8
70/18 70/21 71/11
83/7 83/13 83/15
83/19 85/21 88/8
88/15 94/8 102/19
115/15 116/4 116/8
130/9 130/12 145/17
147/4 147/10 147/20
154/12 156/17 161/15
161/25 164/14

MR FIREMAN: [4]
116/5 116/10 131/7
145/14

MR JACOBS: [3]
83/24 85/20 147/16

MR MILLS: [3] 1/4
1/10 9/1

MR ODOGWU: [2]

85/25 88/7

MR WEATHERBY:
[3] 147/23 154/14
156/15

MS CAREY: [126]
10/1 10/15 11/7 11/14
12/5 12/20 13/9 13/18
14/12 14/20 15/10
15/19 16/3 16/9 16/12
16/24 17/9 18/1 18/13
18/17 18/24 19/7
19/11 19/25 20/17
20/23 20/25 21/4
21/12 21/18 21/22
22/9 22/23 23/2 23/5
24/22 25/9 25/16 26/4
26/12 26/22 26/24
27/6 28/1 31/17 31/22
32/6 33/4 33/6 34/2
34/15 34/19 34/22
35/15 37/16 39/18
40/17 40/20 41/14
42/10 42/13 42/22
43/3 43/13 43/18
43/22 44/3 44/21 45/8
45/14 45/17 46/9
46/25 47/13 47/21
48/1 48/9 48/25 49/21
50/8 51/10 51/12
51/24 52/2 53/10
53/17 53/22 54/5
54/10 54/20 55/1
55/23 56/4 56/9 57/21
57/24 58/7 59/3 59/7
59/10 61/9 61/20
62/12 62/16 63/3
63/13 63/21 64/15
66/21 68/13 68/19
69/5 69/15 71/14
71/19 72/19 74/1
74/24 75/8 76/19 79/8
80/15 81/18 81/21
83/5 162/3

MS MITCHELL: [4]
88/12 88/14 88/16
94/7
MS MUNROE: [2]
102/22 115/13
MS WOODWARD:
[3] 94/11 156/20
161/13
**PROFESSOR
SUMMERS: [65]**
24/14 24/18 29/17
31/21 31/25 32/12
33/5 33/11 34/8 34/18
40/4 40/19 40/22 57/7
57/23 58/1 58/21 59/5
59/9 60/19 61/19
61/22 62/14 62/19
63/4 63/18 63/25
66/15 67/25 68/18
68/21 69/11 69/20
70/20 71/3 71/18

71/21 77/4 78/7 79/5
80/21 81/19 83/11
84/10 85/12 86/22
87/12 87/19 88/2
88/13 93/9 95/13
97/13 98/12 99/4
100/5 102/3 104/9
104/24 106/6 107/5
107/10 113/5 113/18
115/11

'give [1] 67/6
'the [1] 46/14

0
0017 [1] 64/18
0060 [1] 56/19

1
1.06 pm [1] 116/1
10 [1] 117/11
10 o'clock [1] 164/21
10 October 2024 [1]
164/24
10.00 [2] 1/2 164/23
10.25 [1] 9/17
10.31 [1] 9/19
100 [3] 117/12 121/5
127/5

100 per cent [1]
126/14
100,000 [2] 84/12
85/13
108 [1] 109/17
11 [4] 53/13 53/17
53/21 56/18
11.25 [1] 56/5
11.45 [1] 56/3
11.46 [1] 56/7
11.6 [1] 85/15
110 [1] 44/22
110.2 [1] 45/14
110.4 [1] 46/9
12 [4] 53/11 58/12
132/23 132/24
12 hour [1] 133/19
128 [1] 148/14
129 [1] 125/23
12a [1] 59/25
13 [1] 162/10
13 PBPOs [1] 163/3
135 [1] 68/19
141 [4] 57/16 57/24
58/2 132/14
142,000 [2] 62/23
105/17
15 [1] 57/19
150 [2] 60/10 127/5
156 [2] 94/15 103/8
158 [1] 59/17
16 [2] 57/19 58/14
16-bedded [1]
132/14

16.9 [1] 85/13
161 [2] 62/8 105/8
162 [1] 105/9
163 [1] 106/22
164 [1] 105/17
17 [2] 154/11 154/15
1700 [1] 64/21
19 [21] 3/9 3/16 4/2
4/5 4/17 5/11 5/15
5/21 18/20 52/8 52/11
65/3 65/16 66/14
94/11 102/23 106/1
120/5 138/22 156/21
158/7
1970 [1] 117/2
199 [1] 72/25
1:1 [2] 79/5 132/20
1:12 [1] 132/22
1:4 [1] 78/24
1:6 [2] 78/22 79/2
1:8 [3] 132/21 132/23
132/24

2
2,251 [1] 132/12
2.10 pm [2] 115/24
116/3
20 [3] 65/1 126/11
127/2
20 August 2024 [1]
116/14
2000s [1] 143/10
2009 [1] 140/4
2016 [2] 12/6 60/13
2019 [4] 57/2 57/5
60/13 151/23
2020 [21] 41/16
51/15 51/24 57/1
57/18 58/4 58/10 60/9
61/7 62/11 63/1 63/12
66/20 69/7 69/25 70/1
109/18 113/8 132/9
155/6 155/18
2020/21 [2] 69/3 69/3
2021 [29] 56/11
56/14 57/1 57/6 57/9
57/17 57/24 58/13
58/20 61/8 69/16
69/17 70/9 85/13 96/8
113/9 125/23 131/25
132/8 132/12 133/2
133/9 134/6 143/2
143/12 148/20 149/21
163/20 164/5
2021's [1] 70/1
2022 [1] 116/19
2024 [5] 1/1 17/21
116/13 116/14 164/24
203 [1] 57/5
21 [3] 42/22 69/3
69/3
210 [1] 75/17
22 [1] 66/21
22 June 2021 [1]

143/2
22 March 2020 [1]
109/18
227411 [1] 20/4
23 [3] 19/9 20/4
117/10
24 [2] 133/24 153/25
24th January 2021
[1] 132/8
26 [1] 67/20
26th March 2024 [1]
116/13
27 [1] 37/19
28 [2] 154/10 154/15
28 March [2] 50/22
53/7
28th May 2020 [1]
51/24
29.3 [1] 85/16

3
3.26 pm [1] 164/22
30 [1] 121/1
30 years [1] 145/19
300 [1] 60/5
303 [1] 57/6
32 [2] 86/8 151/25
33 [2] 58/14 67/10
34 [1] 65/6
3423 [1] 132/9
35 [1] 65/8
37 [1] 10/13
3rd January 2021 [1]
125/23

4
4.9 [1] 85/15
40 [1] 88/22
45 [1] 109/16
46 [1] 109/17
48 [1] 65/10
49 [1] 65/9

5
50 [3] 69/7 102/15
127/5
5446 [1] 132/8
55 [1] 112/20
56 [1] 68/25

6
6,000 [1] 69/1
60 [1] 56/16
61 [3] 58/8 65/25
103/8
62 [1] 65/25
64 [1] 105/9
65 [1] 111/4

7
7 o'clock [1] 2/3
75 [2] 127/4 158/4
75 years [1] 62/10

8	accord [1] 66/9	140/21 142/11 143/18	advance [10] 10/10	84/2 97/14 143/7
85 [1] 66/2	accordance [2] 4/5 155/25	143/19 143/20 147/2 148/7 157/21 158/22 158/24	10/19 11/8 12/23 13/5 13/11 19/23 21/15 38/1 38/20	145/19 148/9
9	accorded [1] 128/23	acuity [2] 131/18 142/14	advanced [3] 25/10 91/25 128/25	AGP [2] 75/15 76/2
9 October 2024 [1] 1/1	accordingly [2] 103/3 143/1	acute [12] 16/1 27/14 27/23 35/9 66/3 82/22 92/13 120/19 123/24 128/10 131/21 152/23	advantage [2] 16/20 73/15	AGPs [1] 75/12
94 [1] 160/2	accords [2] 63/11 66/17	acutely [3] 22/4 102/3 152/21	advising [1] 125/24	agree [13] 24/9 38/14 39/3 39/14 48/15 71/12 81/23 82/1 94/1 113/1 114/19 115/9 154/17
A	account [6] 10/25 13/1 15/25 76/8 84/14 133/13	ad [1] 70/10	advisory [3] 50/13 92/1 117/11	agreed [6] 32/1 44/14 79/23 101/9 128/17 148/23
Aamer [1] 88/17	accountable [1] 55/2	adapt [1] 141/17	advocate [2] 27/4 79/15	agreement [2] 109/19 152/18
ability [8] 4/8 68/16 81/15 102/6 110/16 124/21 127/21 127/22	accurate [3] 45/17 128/25 143/8	adapted [5] 18/20 48/21 53/7 54/21 138/23	advocates [1] 86/2	ahead [4] 7/12 55/13 82/11 88/10
able [39] 2/23 5/12 10/5 12/3 12/18 12/19 13/21 14/8 16/2 22/1 22/19 30/18 30/23 33/14 35/7 64/24 77/10 77/17 80/10 81/9 85/5 87/4 87/8 93/7 95/14 120/12 121/4 122/13 122/15 124/20 125/11 130/1 131/7 133/15 139/22 150/12 155/9 159/23 162/4	accurately [2] 59/19 63/13	adding [1] 41/1	advocating [1] 55/19	aid [10] 43/9 43/25 45/5 52/16 53/1 53/12 54/7 127/24 138/9 156/14
about [194]	accustomed [1] 149/19	add [4] 53/17 84/25 103/18 150/1	aerosol [3] 75/9 76/3 161/12	aerosol-generating [2] 75/9 161/12
above [4] 56/24 57/17 60/5 132/13	acknowledged [1] 152/1	address [5] 43/4 79/11 81/25 122/7 158/4	aerosols [2] 75/11 75/14	aerols [2] 75/11 75/14
abreast [1] 74/21	acknowledges [1] 86/8	adding [1] 41/1	affected [4] 64/8 67/23 75/3 164/12	affects [1] 129/13
absence [9] 4/16 81/9 88/25 98/10 98/23 104/3 158/6 160/11 161/8	acknowledging [2] 11/15 95/21	addition [3] 6/13 150/24 163/19	affirm [1] 1/5	affirmations [1] 10/8
absolute [5] 14/10 82/9 95/15 135/12 149/23	acquire [2] 6/13 57/11	additional [7] 2/21 132/25 133/5 133/13 133/17 145/13 162/8	affirmed [6] 1/6 1/7 116/6 165/3 165/4 165/16	affirmed [6] 1/6 1/7 116/6 165/3 165/4 165/16
absolutely [19] 9/9 31/21 38/22 39/3 45/16 54/15 56/2 59/1 63/25 71/12 79/7 99/7 127/8 135/18 143/25 149/10 151/8 151/19 153/15	acronym [1] 119/18	addressed [4] 79/20 86/5 114/13 160/2	afforded [1] 83/1	afforded [1] 83/1
abstract [2] 45/20 45/25	across [22] 12/7 16/18 17/25 18/2 18/4 25/13 57/24 62/24 69/1 92/5 101/15 104/17 107/12 114/23 117/4 117/15 127/7 127/16 127/16 157/21 158/16 159/14	adequate [4] 73/1 84/4 87/9 87/25	afforementioned [1] 26/13	afforementioned [1] 26/13
academic [3] 55/12 68/22 139/6	act [2] 67/13 143/3	adequately [1] 75/25	after [25] 5/17 5/20 18/20 24/7 28/6 36/13 39/1 60/8 63/5 69/3 77/21 101/10 105/6 114/25 115/1 131/20 133/23 140/24 141/2 141/14 141/15 144/1 144/22 151/12 152/21	afternoon [2] 86/1 102/22
academically [1] 78/19	acting [3] 67/11 67/18 67/22	adjoined [1] 164/23 116/2	after [25] 5/17 5/20 18/20 24/7 28/6 36/13 39/1 60/8 63/5 69/3 77/21 101/10 105/6 114/25 115/1 131/20 133/23 140/24 141/2 141/14 141/15 144/1 144/22 151/12 152/21	afternoon [2] 86/1 102/22
Academy [1] 124/6	action [2] 75/7 158/1	admission [5] 63/6 94/19 105/22 108/3 110/1	afternoon [2] 86/1 102/22	afternoon [2] 86/1 102/22
accept [5] 107/1 133/8 134/3 134/6 134/9	actions [1] 123/13	administrative [1] 58/25	against [2] 45/20 85/2	against [2] 45/20 85/2
access [8] 22/5 66/5 123/11 126/21 129/23 146/24 158/4 159/23	activate [1] 49/18	administrators [1] 70/13	age [11] 50/12 64/1 100/8 100/9 100/16 101/18 106/3 109/24 111/10 112/10 155/6	age [11] 50/12 64/1 100/8 100/9 100/16 101/18 106/3 109/24 111/10 112/10 155/6
accessibility [1] 124/7	activated [2] 50/6 99/14	admission [5] 63/6 94/19 105/22 108/3 110/1	aged [1] 62/10	aged [1] 62/10
accessible [1] 45/15	activation [1] 98/5	admissions [11] 59/21 60/2 61/6 61/12 61/20 62/4 95/9 103/14 155/5 155/7 155/24	agencies [1] 121/6	agencies [1] 121/6
accidentally [1] 15/5	active [4] 89/21 90/12 90/17 117/13	admitted [26] 41/24 42/4 42/7 44/19 60/10 60/17 61/2 61/24 62/6 62/7 62/18 62/24 63/8 63/10 63/19 63/20 95/2 95/20 95/22 98/22 99/25 101/4 105/1 105/20 106/3 106/11	aggressive [2] 14/7 80/3	aggressive [2] 14/7 80/3
accompanying [1] 58/8	activities [3] 14/8 119/10 119/15	admitted [26] 41/24 42/4 42/7 44/19 60/10 60/17 61/2 61/24 62/6 62/7 62/18 62/24 63/8 63/10 63/19 63/20 95/2 95/20 95/22 98/22 99/25 101/4 105/1 105/20 106/3 106/11	agilely [1] 122/15	agilely [1] 122/15

A	91/7 149/6 154/23 164/19 164/23 amazing [1] 114/3 ambulance [3] 16/23 38/18 66/5 among [6] 18/10 49/21 85/7 87/7 97/3 97/23 amongst [1] 117/12 amount [4] 128/12 128/13 133/5 134/2 amply [1] 147/17 Anaesthetists [3] 70/8 162/23 162/24 analyse [1] 158/8 analysis [2] 106/23 159/4 anecdotally [1] 96/12 anonymised [1] 159/8 another [13] 46/13 75/20 77/11 84/17 108/18 110/24 125/15 127/2 127/2 131/4 136/5 142/12 147/8 answer [15] 79/18 83/7 86/7 95/15 99/18 108/21 108/23 109/12 111/19 113/19 131/7 131/16 146/10 155/20 158/13 answered [1] 112/17 answering [1] 66/12 answers [3] 39/10 112/25 113/6 antibiotics [1] 90/15 Anwar [1] 88/17 anxieties [1] 73/18 anxiety [1] 74/7 anxious [2] 3/11 3/12 any [73] 4/3 4/4 4/6 4/9 4/13 6/13 7/3 7/5 7/11 7/13 8/8 8/8 17/13 19/19 19/24 20/9 20/21 23/12 26/12 31/12 33/2 34/16 34/19 35/17 36/2 36/3 36/18 40/20 46/11 46/20 48/16 49/21 52/16 52/24 53/2 53/7 58/2 59/16 62/10 62/14 63/23 66/20 73/5 73/16 76/24 77/1 77/1 78/4 81/10 86/25 87/8 90/12 90/17 92/15 92/17 92/23 92/24 98/25 104/23 105/2 111/11 115/5 121/21 125/5 127/10 136/10 137/9 144/6 144/14 154/23 156/15 159/2 161/7 any relevance [1]	125/5 anybody [3] 70/25 100/9 130/15 anybody's [1] 32/3 anyone [9] 3/14 4/21 4/25 11/11 12/17 24/10 25/1 31/5 52/14 anything [13] 6/15 63/24 92/11 99/9 100/9 107/7 108/17 109/2 112/19 114/21 124/24 136/18 155/2 anyway [2] 114/20 147/11 anywhere [2] 43/15 100/15 apologies [1] 155/19 apologise [1] 115/14 appear [1] 88/17 appearing [2] 60/22 60/23 appears [1] 88/14 appendix [4] 53/10 53/18 54/13 117/18 appendix 2 [2] 53/10 54/13 applicability [1] 52/22 applicable [2] 52/24 53/14 application [1] 53/23 applies [6] 13/6 18/21 52/20 54/2 54/8 99/20 apply [4] 18/7 41/11 52/17 53/2 appointed [1] 23/21 appreciate [2] 23/17 43/18 approach [1] 52/9 approached [2] 98/11 161/5 approaches [1] 153/12 appropriate [18] 22/13 22/21 26/24 31/2 31/15 37/13 42/3 46/20 47/1 48/6 53/19 79/14 93/11 93/17 93/21 97/21 98/14 129/7 appropriately [3] 20/13 74/19 99/10 April [2] 155/6 155/18 April 2020 [1] 155/18 aprons [1] 6/21 are [237] area [3] 60/12 125/18 143/22 areas [9] 2/10 37/11 73/22 84/15 134/25 135/6 140/11 140/13 140/15	aren't [3] 30/6 49/14 133/12 arguable [1] 96/18 arguably [4] 73/22 73/24 88/4 89/9 argue [2] 40/9 130/12 arguing [1] 85/2 argument [3] 89/16 94/3 111/15 arise [3] 20/16 39/17 141/24 arising [3] 95/8 103/9 105/23 around [38] 13/25 19/5 27/13 38/1 39/12 39/13 40/12 41/8 45/11 51/2 55/16 59/4 69/13 70/15 74/17 78/10 85/4 89/10 89/19 111/20 121/5 122/11 123/19 125/12 127/24 131/24 134/12 137/9 137/12 138/11 139/8 139/13 144/18 144/20 156/6 158/19 159/7 159/9 arrest [3] 19/4 19/7 28/24 arriving [2] 73/10 81/2 arrows [1] 54/3 articles [1] 7/7 as [224] ascertain [1] 63/22 Ashton [1] 164/1 aside [2] 75/12 96/11 ask [65] 3/14 5/20 6/24 7/9 7/21 8/10 9/2 10/19 11/15 18/25 27/9 29/10 30/2 30/14 31/19 34/2 34/15 34/23 35/19 37/17 38/14 39/23 45/21 48/9 59/16 63/22 66/4 67/10 68/16 71/15 72/24 74/2 74/10 75/8 76/19 77/24 78/1 79/8 80/15 83/8 83/20 88/19 90/4 90/20 91/18 94/11 101/24 107/10 112/17 118/17 118/21 125/9 125/18 129/5 131/16 135/5 135/19 139/16 144/13 144/13 147/16 147/23 155/2 156/20 163/16 asked [15] 2/9 8/5 9/13 41/17 42/13 42/23 47/21 64/23 65/17 70/22 83/8 97/18 126/16 144/12 148/1 asking [8] 6/23 18/14 26/9 30/20 30/25 31/4	31/5 123/14 aspect [2] 79/19 109/15 aspects [1] 90/1 assembly [1] 103/20 assembly [3] 79/13 79/15 80/12 assess [4] 42/6 86/18 87/8 97/18 assessed [2] 53/4 163/14 assessing [2] 52/7 144/4 assessment [6] 45/17 84/4 86/18 87/15 87/21 110/22 assessments [4] 87/9 87/12 153/9 154/18 assist [2] 79/16 86/10 associated [3] 109/24 122/17 158/1 Association [4] 120/20 148/24 162/24 163/11 associations [1] 122/18 assuming [2] 44/7 57/19 assumption [1] 146/2 assurance [1] 146/17 at [221] attack [2] 59/22 60/6 attacks [1] 61/16 attempt [3] 10/11 14/25 57/7 attempted [1] 77/5 attempts [2] 14/23 152/2 attend [1] 10/3 attended [1] 30/5 attending [2] 59/24 68/3 attention [3] 72/2 72/3 72/6 attests [2] 162/20 163/20 attorney [8] 23/22 24/2 24/24 25/13 25/18 25/19 26/1 27/1 August [1] 116/14 authorised [1] 111/12 authority [1] 44/15 authors [4] 78/14 106/7 106/24 111/2 automatic [1] 139/21 availability [1] 88/3 available [32] 6/17 43/1 44/8 44/17 44/20 46/4 46/22 47/4 48/3 48/22 49/2 53/6 57/14
----------	---	---	--	--

A	143/23 basically [3] 53/17 142/6 145/5 basics [1] 19/1 basis [9] 41/24 46/12 65/3 67/21 80/4 100/4 100/9 101/24 109/3 be [296] bear [1] 164/11 bearing [1] 43/6 became [3] 106/1 108/12 160/22 because [64] 2/24 3/13 5/4 5/22 5/24 20/12 22/12 22/15 23/12 29/19 29/21 31/5 32/4 33/1 33/11 33/18 36/3 36/6 37/16 51/10 53/6 53/22 56/11 59/8 59/13 66/25 73/8 76/5 77/13 79/17 82/14 82/15 84/20 90/16 93/18 96/16 97/24 102/5 104/15 107/22 108/24 111/12 111/13 114/13 127/23 128/13 134/11 136/14 139/7 140/16 143/16 145/4 145/5 145/21 145/25 147/1 148/6 148/22 149/7 152/15 154/12 154/23 157/21 159/1 become [5] 46/10 57/14 111/1 149/17 151/4 becomes [6] 12/4 15/23 37/12 47/4 83/1 110/22 becoming [3] 8/1 15/5 45/25 bed [20] 32/22 43/1 43/15 43/16 43/20 44/7 44/17 44/18 45/20 45/20 46/19 46/22 47/3 48/3 57/22 110/21 126/17 126/24 132/7 136/22 bed' [1] 46/14 bed-bound [1] 110/21 bedded [2] 126/10 132/14 beds [26] 44/20 46/4 48/6 49/24 56/23 57/5 57/19 65/20 66/1 66/3 84/12 108/18 126/11 126/12 126/20 126/20 127/2 127/4 127/7 128/14 130/14 132/8 132/13 136/20 136/21 160/6 bedside [2] 32/7 59/4 been [77] 5/11 8/24	9/12 9/13 12/5 20/12 26/6 26/18 28/3 28/8 29/20 32/22 32/24 33/12 33/14 34/25 36/9 36/10 36/12 36/23 36/24 37/1 37/4 44/8 45/6 49/25 53/7 56/15 60/12 61/25 62/18 62/21 66/8 67/4 67/8 76/21 78/8 78/9 83/3 83/8 86/14 86/23 89/12 91/9 95/19 96/7 98/4 102/24 103/7 107/25 108/4 108/5 111/12 111/25 112/16 113/3 113/13 113/20 114/7 114/22 115/4 115/21 116/8 116/19 119/12 122/23 130/14 132/4 137/19 143/13 144/7 144/10 147/17 148/1 150/4 150/18 151/5 before [17] 1/21 1/22 2/8 4/7 8/25 23/15 35/20 51/13 69/2 78/7 78/25 79/18 89/17 98/15 114/10 144/6 151/6 beforehand [2] 32/25 140/21 began [1] 1/24 begin [1] 1/20 behalf [11] 23/22 25/17 83/25 88/18 90/4 94/11 100/21 113/12 147/24 156/20 163/8 behaviour [1] 60/25 behind [2] 41/7 85/10 being [68] 3/8 3/16 4/19 7/22 8/5 12/3 12/7 15/12 17/10 43/3 44/19 45/12 49/15 50/9 57/22 60/9 60/17 61/2 61/24 63/5 64/12 68/14 68/25 71/24 71/25 74/5 77/16 77/16 81/6 81/9 86/16 87/21 89/15 89/25 91/1 91/16 94/25 95/4 98/2 99/24 103/17 110/21 111/10 111/17 111/22 114/23 124/20 126/4 126/6 127/20 128/8 128/17 128/23 132/21 135/1 137/6 137/7 139/9 141/14 145/2 146/21 151/8 154/24 155/15 155/25 158/8 161/5 162/5 believe [8] 7/20 38/23 42/9 97/9 107/2 109/11 109/21 112/10	believed [1] 75/12 below [3] 60/5 85/18 132/16 benefit [9] 12/1 27/16 27/20 52/8 54/23 67/4 98/20 120/18 124/20 benefited [1] 105/21 benefits [6] 15/3 22/7 37/8 48/11 131/23 137/12 bereaved [8] 35/21 88/18 90/5 90/22 94/11 102/23 147/24 156/21 besides [1] 58/23 best [34] 4/8 15/17 18/5 18/12 26/16 30/21 35/7 40/25 48/23 57/12 61/1 74/17 86/5 99/6 114/17 117/18 128/15 129/25 134/9 135/12 136/2 138/13 140/23 141/16 141/21 141/23 145/6 146/9 149/23 150/3 151/3 151/9 159/18 159/18 better [18] 8/25 27/22 29/14 35/4 67/7 72/5 73/22 76/9 81/25 86/7 88/4 111/24 113/25 128/23 129/14 130/19 134/13 145/12 between [12] 25/1 35/18 45/5 62/25 63/7 63/17 92/25 98/13 101/21 136/21 158/9 159/4 beyond [3] 55/21 130/10 141/23 bias [1] 48/17 big [2] 98/13 123/13 biggest [1] 149/1 Bihes [1] 4/11 binding [3] 13/6 13/12 25/11 biological [2] 110/14 110/25 Birmingham [1] 163/10 bit [16] 3/2 23/19 72/3 75/10 79/18 91/5 110/11 112/7 118/15 118/21 121/17 124/12 128/4 137/6 144/25 153/22 bits [2] 54/1 154/9 black [1] 147/6 blank [1] 51/21 blanket [2] 34/17 154/19 blood [3] 145/22 146/24 147/3 bloodstream [1]	142/25 blue [2] 6/5 54/3 BMA [1] 162/20 Board [2] 100/22 100/25 boards [2] 18/19 41/6 BOC [1] 141/8 bodies [5] 74/13 82/14 82/21 96/25 112/11 bodily [2] 110/14 111/1 body [5] 75/5 82/13 82/19 124/25 146/23 bolted [1] 77/21 bolts [1] 29/23 border [1] 20/8 borders [2] 18/4 19/21 both [24] 10/4 14/18 38/14 40/25 47/1 48/12 61/6 61/8 70/2 80/4 84/6 86/11 89/10 100/6 102/7 106/8 112/25 115/13 115/16 121/23 123/25 128/18 134/18 164/7 bottom [5] 57/21 100/23 101/13 120/11 132/11 bound [1] 110/21 boundaries [1] 158/2 box [7] 12/20 13/23 14/22 23/19 23/19 28/7 132/16 box 1 [1] 23/19 boxes [5] 7/18 14/20 23/17 25/4 28/23 breach [1] 96/25 break [5] 9/14 9/18 56/1 56/6 105/7 bridge [2] 99/1 144/20 bridged [1] 137/2 bridging [1] 104/5 brief [1] 162/12 briefings [1] 21/9 briefly [8] 53/21 56/11 91/18 118/16 129/4 132/15 138/20 153/22 bring [2] 100/20 150/4 bringing [1] 122/4 brings [3] 11/21 71/14 164/11 British [2] 120/19 148/24 broad [2] 40/14 85/6 broader [4] 88/25 89/17 99/17 109/18 broadest [1] 10/23 broadly [1] 13/3
----------	---	---	--	---

<p>B</p> <p>brother [1] 164/3 brought [4] 29/13 30/9 99/19 110/6 brown [1] 147/6 budgets [1] 152/4 building [1] 141/23 bullet [1] 100/23 burden [5] 31/1 31/4 84/15 106/10 114/11 burdens [1] 100/7 bureaucracy [1] 122/17 business [2] 148/11 151/14 busy [1] 162/5 but [226] buy [2] 55/7 145/24 buy-in [1] 55/7 buying [1] 147/10</p>	<p>60/18 61/5 63/13 63/13 63/22 64/17 65/3 65/20 67/10 67/22 67/25 69/17 69/22 71/19 74/2 74/10 76/20 79/22 80/14 83/1 89/13 89/22 90/20 91/18 93/12 103/21 103/22 104/1 106/17 107/6 109/12 112/8 112/17 113/7 114/18 115/17 119/17 119/18 122/17 125/15 125/17 125/20 128/16 129/19 133/5 133/11 134/13 134/19 134/23 135/5 136/16 136/16 136/18 137/18 138/13 139/16 140/5 142/3 143/5 143/25 145/8 145/12 145/17 146/9 146/25 147/3 151/24 155/16 158/14 161/25</p>	<p>128/8 128/22 capturing [1] 18/10 cardiac [3] 19/4 19/7 28/24 Cardiff [1] 100/22 cardiology [1] 1/23 cardiopulmonary [2] 10/11 19/12 care [270] Care's [1] 50/13 cared [2] 128/9 164/3 carefully [1] 164/16 carer [4] 26/6 26/12 28/9 28/14 carers [4] 22/24 24/23 110/21 110/24 carers/loved [1] 22/24 cares [1] 58/11 Carey [3] 9/24 113/1 113/7 caring [3] 58/14 144/9 146/17 Carla [1] 162/14 carried [3] 71/7 73/10 95/24 carries [1] 18/20 carry [5] 5/22 31/4 71/5 113/10 115/12 carrying [1] 114/8 cascading [1] 143/17 case [21] 5/17 16/1 25/11 36/11 39/8 45/3 46/20 47/19 49/23 53/7 60/12 62/21 73/24 87/3 91/11 95/16 98/6 99/15 104/16 134/6 140/25 cases [3] 38/7 57/1 59/9 catastrophic [1] 71/22 catching [1] 5/15 category [1] 24/25 causally [1] 106/20 cause [2] 123/3 127/11 caused [4] 8/2 78/23 107/3 139/19 cent [1] 126/14 centrally [1] 158/6 centred [1] 38/5 certain [7] 14/3 14/8 41/10 94/19 103/12 104/13 142/22 certainly [11] 17/23 40/9 40/22 71/4 73/8 73/15 93/4 96/2 117/3 127/19 160/18 cetera [1] 148/25 chain [1] 98/3 Chair [3] 93/6 145/16 165/18 challenge [1] 160/22</p>	<p>challenges [3] 74/4 139/18 160/5 challenging [1] 103/20 chance [4] 67/6 98/21 105/13 114/16 chances [1] 106/5 change [17] 25/24 28/5 44/18 61/25 62/15 74/13 81/4 81/10 81/13 92/13 93/12 93/19 95/19 99/9 104/13 125/25 128/23 changed [6] 73/11 74/20 81/4 94/20 103/14 103/24 changes [6] 39/2 50/14 58/15 60/24 92/14 104/25 changing [6] 36/8 73/17 74/6 82/11 98/8 153/1 characterisation [1] 62/22 characteristics [1] 105/1 charge [2] 97/9 97/12 charitable [1] 125/3 charity [3] 117/1 124/5 124/25 Charles [1] 162/14 CHARLOTTE [2] 9/20 165/6 check [1] 7/17 chemotherapy [2] 13/10 13/13 chief [2] 35/12 41/18 children [1] 55/17 chimes [2] 103/12 104/2 chose [1] 34/12 chronic [1] 142/22 chronology [1] 24/5 circular [1] 44/4 circulated [1] 154/6 circumstance [4] 20/20 53/18 100/13 107/12 circumstances [19] 2/22 2/24 2/25 13/8 19/14 21/13 22/10 22/14 27/10 30/9 35/2 53/15 63/25 89/24 93/10 93/13 101/2 131/9 163/25 citizen's [3] 79/13 79/15 80/11 Clare [1] 163/24 clarification [2] 111/2 112/18 clarified [1] 30/11 clarify [4] 30/8 100/5 112/4 133/12</p>	<p>clarity [3] 117/24 119/1 120/23 clean [3] 2/10 4/4 4/17 cleaned [1] 3/21 cleaner [1] 1/13 cleaners [1] 2/17 cleaning [7] 2/8 3/20 3/23 4/2 4/7 4/7 4/9 clear [13] 22/13 30/25 50/3 89/18 93/3 98/12 99/4 132/19 148/3 149/1 153/5 153/15 159/10 clearer [1] 24/13 clearly [18] 16/9 18/24 19/17 20/7 29/2 31/3 34/22 41/10 65/23 66/5 74/3 76/23 85/10 89/1 91/10 111/8 117/20 141/10 clerks [1] 58/23 clinical [37] 6/3 14/12 22/3 22/17 30/3 31/17 32/20 33/2 36/6 36/17 41/16 42/24 46/2 46/11 50/20 62/22 62/22 92/17 104/1 104/21 105/18 107/18 107/19 109/20 109/23 114/24 115/17 119/5 142/4 142/6 153/2 153/5 155/1 155/25 156/1 156/13 156/13 clinically [11] 22/13 22/21 23/6 31/2 31/23 46/19 83/11 83/15 93/20 108/3 110/12 clinician [13] 14/15 14/19 22/14 23/2 26/14 28/5 31/13 31/22 34/5 41/9 71/5 104/17 162/25 clinicians [12] 15/16 15/17 22/11 28/2 41/23 49/5 49/7 94/24 96/19 103/16 109/22 117/13 close [9] 12/17 14/18 16/1 23/18 24/7 26/10 26/25 108/15 117/20 closely [1] 118/9 closer [2] 108/13 136/17 closing [1] 3/6 CMO [1] 157/12 CMOs [3] 42/20 49/18 50/23 co [2] 88/17 106/11 co-morbidity [1] 106/11 cognisant [1] 141/14 cognition [1] 146/22</p>
C				
<p>Cabinet [1] 96/5 calculation [1] 84/19 calendar [1] 92/18 calibrated [2] 143/20 144/7 call [9] 1/4 33/6 34/5 37/19 44/23 56/18 104/1 116/5 164/19 called [6] 4/11 13/4 17/2 25/13 78/8 131/25 calls [5] 33/23 34/3 34/14 83/16 91/16 came [11] 10/21 32/23 51/24 59/17 69/25 86/11 108/10 113/8 144/21 148/10 148/10 Campaign [2] 163/24 164/1 can [138] 1/20 5/20 7/9 7/21 7/23 8/10 8/22 9/2 9/13 10/6 10/16 11/2 11/16 11/17 13/3 13/22 14/20 14/24 15/10 17/10 19/13 19/21 20/1 20/3 20/4 20/7 20/9 21/14 25/23 25/24 27/2 27/6 27/9 29/10 29/12 29/14 30/4 31/19 32/10 34/15 34/23 35/13 35/19 38/14 39/23 41/14 41/22 43/13 44/25 48/9 48/15 48/25 49/18 51/12 52/2 54/16 54/20 55/21 55/25 56/10 57/4 58/9 58/12 58/13 59/1 59/16 60/4 60/15</p>	<p>24/11 36/14 82/15 83/7 88/13 91/13 106/20 109/10 112/2 114/10 130/22 130/23 136/14 155/20 156/2 cancel [1] 28/1 Cancellation [1] 27/9 cancelled [1] 27/11 cancer [2] 11/9 16/5 cannot [9] 23/6 71/7 71/9 77/15 96/2 104/15 107/7 107/8 154/22 capable [2] 72/8 150/11 capacity [62] 15/11 15/14 21/15 22/24 25/5 25/23 26/2 29/22 36/3 45/12 45/24 46/8 56/11 57/8 57/18 58/2 58/6 67/7 68/22 81/11 82/3 82/6 84/3 84/7 84/22 94/18 94/20 96/7 101/1 103/11 107/3 110/3 111/9 118/18 118/19 125/17 125/20 126/11 126/13 126/24 127/16 127/19 127/20 128/3 128/14 128/18 129/3 129/8 129/17 130/10 131/10 132/13 134/5 137/3 140/15 148/1 148/15 152/24 158/20 158/20 159/1 159/5 capture [5] 128/12 128/25 158/15 159/7 159/12 captured [3] 59/15</p>	<p>Carla [1] 162/14 carried [3] 71/7 73/10 95/24 carries [1] 18/20 carry [5] 5/22 31/4 71/5 113/10 115/12 carrying [1] 114/8 cascading [1] 143/17 case [21] 5/17 16/1 25/11 36/11 39/8 45/3 46/20 47/19 49/23 53/7 60/12 62/21 73/24 87/3 91/11 95/16 98/6 99/15 104/16 134/6 140/25 cases [3] 38/7 57/1 59/9 catastrophic [1] 71/22 catching [1] 5/15 category [1] 24/25 causally [1] 106/20 cause [2] 123/3 127/11 caused [4] 8/2 78/23 107/3 139/19 cent [1] 126/14 centrally [1] 158/6 centred [1] 38/5 certain [7] 14/3 14/8 41/10 94/19 103/12 104/13 142/22 certainly [11] 17/23 40/9 40/22 71/4 73/8 73/15 93/4 96/2 117/3 127/19 160/18 cetera [1] 148/25 chain [1] 98/3 Chair [3] 93/6 145/16 165/18 challenge [1] 160/22</p>	<p>challenges [3] 74/4 139/18 160/5 challenging [1] 103/20 chance [4] 67/6 98/21 105/13 114/16 chances [1] 106/5 change [17] 25/24 28/5 44/18 61/25 62/15 74/13 81/4 81/10 81/13 92/13 93/12 93/19 95/19 99/9 104/13 125/25 128/23 changed [6] 73/11 74/20 81/4 94/20 103/14 103/24 changes [6] 39/2 50/14 58/15 60/24 92/14 104/25 changing [6] 36/8 73/17 74/6 82/11 98/8 153/1 characterisation [1] 62/22 characteristics [1] 105/1 charge [2] 97/9 97/12 charitable [1] 125/3 charity [3] 117/1 124/5 124/25 Charles [1] 162/14 CHARLOTTE [2] 9/20 165/6 check [1] 7/17 chemotherapy [2] 13/10 13/13 chief [2] 35/12 41/18 children [1] 55/17 chimes [2] 103/12 104/2 chose [1] 34/12 chronic [1] 142/22 chronology [1] 24/5 circular [1] 44/4 circulated [1] 154/6 circumstance [4] 20/20 53/18 100/13 107/12 circumstances [19] 2/22 2/24 2/25 13/8 19/14 21/13 22/10 22/14 27/10 30/9 35/2 53/15 63/25 89/24 93/10 93/13 101/2 131/9 163/25 citizen's [3] 79/13 79/15 80/11 Clare [1] 163/24 clarification [2] 111/2 112/18 clarified [1] 30/11 clarify [4] 30/8 100/5 112/4 133/12</p>	<p>clarity [3] 117/24 119/1 120/23 clean [3] 2/10 4/4 4/17 cleaned [1] 3/21 cleaner [1] 1/13 cleaners [1] 2/17 cleaning [7] 2/8 3/20 3/23 4/2 4/7 4/7 4/9 clear [13] 22/13 30/25 50/3 89/18 93/3 98/12 99/4 132/19 148/3 149/1 153/5 153/15 159/10 clearer [1] 24/13 clearly [18] 16/9 18/24 19/17 20/7 29/2 31/3 34/22 41/10 65/23 66/5 74/3 76/23 85/10 89/1 91/10 111/8 117/20 141/10 clerks [1] 58/23 clinical [37] 6/3 14/12 22/3 22/17 30/3 31/17 32/20 33/2 36/6 36/17 41/16 42/24 46/2 46/11 50/20 62/22 62/22 92/17 104/1 104/21 105/18 107/18 107/19 109/20 109/23 114/24 115/17 119/5 142/4 142/6 153/2 153/5 155/1 155/25 156/1 156/13 156/13 clinically [11] 22/13 22/21 23/6 31/2 31/23 46/19 83/11 83/15 93/20 108/3 110/12 clinician [13] 14/15 14/19 22/14 23/2 26/14 28/5 31/13 31/22 34/5 41/9 71/5 104/17 162/25 clinicians [12] 15/16 15/17 22/11 28/2 41/23 49/5 49/7 94/24 96/19 103/16 109/22 117/13 close [9] 12/17 14/18 16/1 23/18 24/7 26/10 26/25 108/15 117/20 closely [1] 118/9 closer [2] 108/13 136/17 closing [1] 3/6 CMO [1] 157/12 CMOs [3] 42/20 49/18 50/23 co [2] 88/17 106/11 co-morbidity [1] 106/11 cognisant [1] 141/14 cognition [1] 146/22</p>

C				
cohorting [2] 141/18 141/19	159/17 commonly [1] 100/19	25/24 27/13 27/14 27/23 39/11 92/13 92/14 92/20	79/14 112/9 consulted [11] 22/25 23/15 23/23 24/1 24/8	51/17 51/18 51/25 52/1 57/13 63/14 89/8 116/17 116/18 116/20
coincide [1] 61/8 Cole [1] 163/24	12/15 25/6 104/11 104/18	conditions [13] 8/23 11/2 14/7 45/19 46/1 46/5 46/21 48/4 49/6 80/8 106/4 109/25 142/22	25/2 25/7 25/20 26/6 35/23 50/11	116/23 123/4 133/4 142/10 149/10 150/2 150/15 151/8 152/10 152/18 152/25
collaborate [1] 118/3 collaboration [1] 117/20	communication [3] 12/12 40/4 45/18	conducted [2] 64/16 84/24	consulting [1] 6/11 contact [1] 35/16	corrected [1] 101/18 correctly [4] 16/25 54/10 133/3 140/21
collapse [1] 20/13 collateral [2] 134/25 135/4	community [4] 50/11 89/14 110/13 150/7	confident [1] 39/19 configure [1] 152/3 confirmed [2] 119/1 143/10	contagious [1] 4/20 contaminated [2] 7/7 7/17	costly [1] 152/2 costs [1] 86/11 coughing [1] 75/13 coughs [1] 76/17
colleague [4] 5/18 7/2 82/1 104/8	comorbidity [1] 101/19	conflict [4] 67/11 67/18 67/22 68/8	contentious [1] 103/19	could [63] 10/22 13/9 13/11 16/3 20/2 26/12 37/1 37/4 37/19 43/22 44/23 48/23 51/2 53/17 54/21 55/1 55/5 55/23 56/18 57/10 59/25 61/1 65/18 66/13 72/14 78/5 79/19 86/24 87/2 87/3 89/9 95/18 99/14 99/19 100/20 100/23 105/4 107/24 108/4 113/3 116/10 118/24 120/5 120/13 120/22 121/15 121/16 121/16 122/25 126/9 130/12 131/18 132/3 134/10 135/12 135/19 138/23 145/19 150/1 151/3 157/23 159/18 159/19 couldn't [4] 5/6 105/2 140/25 151/13 council [5] 17/16 17/24 40/7 117/10 120/14
colleagues [8] 6/23 8/14 8/19 42/23 86/17 135/15 135/16 142/4	company [3] 1/18 4/25 8/6	conflicted [1] 67/14 conform [1] 160/14 confused [2] 25/1 25/25	contents [1] 164/17 context [16] 13/11 15/9 36/5 43/12 43/24 47/18 51/18 52/22 78/23 85/12 110/9 121/24 123/19 131/11 138/22 153/16	continue [4] 112/23 114/2 114/6 153/7 continued [8] 9/20 9/21 9/23 19/13 81/7 165/7 165/8 165/10 continues [1] 68/11 continuing [5] 40/17 40/20 70/24 77/15 114/7
collected [1] 159/2 collection [5] 45/18 158/3 158/11 159/4 159/10	compare [2] 85/7 158/8	confusion [4] 88/20 126/5 126/6 127/11	contribute [2] 30/18 30/23	congress [2] 84/1 162/15 connectivity [1] 157/11
College [5] 40/23 51/9 52/3 124/5 162/23	compared [6] 6/2 62/7 73/13 84/17 129/1 132/9	Congress [2] 84/1 162/15	contrary [1] 151/16 contrasts [1] 16/20 contribute [2] 30/18 30/23	contributed [2] 65/12 107/3 contributing [3] 64/20 74/8 149/2
Colleges [1] 124/6 colloquial [1] 125/2 Colombia [1] 8/12 coloured [1] 145/20 columns [2] 65/5 65/18	compassionate [1] 38/4	consensus [6] 148/21 148/22 148/25 150/16 150/23 152/6	consequence [2] 5/8 61/3	consequences [1] 5/5
combined [1] 95/9 come [21] 5/19 5/25 14/21 15/25 17/12 21/19 21/25 24/6 28/4 29/12 32/15 33/1 33/4 66/10 66/25 104/23 106/19 132/16 136/1 155/11 158/21	compensation [1] 153/17	consider [13] 17/11 41/17 42/7 42/24 47/22 87/24 106/23 107/19 107/24 111/6 123/18 129/5 161/19	consequence [2] 5/8 61/3	control [2] 4/14 4/17 convenient [1] 45/10 conversation [10] 30/10 30/13 30/24 32/7 32/19 33/8 33/9 80/2 96/6 96/6
Collegiate [5] 40/23 51/9 52/3 124/5 162/23	complex [3] 77/18 88/6 111/20	considerably [2] 57/6 85/14	conversations [13] 30/2 33/9 33/17 34/11 38/1 38/2 38/9 39/20 40/5 40/12 41/10 41/12 80/10	consoles [1] 151/16 contrasts [1] 16/20 contribute [2] 30/18 30/23
Colleges [1] 124/6 colloquial [1] 125/2 Colombia [1] 8/12 coloured [1] 145/20 columns [2] 65/5 65/18	complexity [1] 98/1 compliant [1] 4/18 complicated [1] 113/19	considered [7] 3/1 13/4 17/25 50/10 55/15 153/7 164/17	convey [1] 46/15 coped [2] 71/17 72/13	contribute [2] 30/18 30/23
combined [1] 95/9 come [21] 5/19 5/25 14/21 15/25 17/12 21/19 21/25 24/6 28/4 29/12 32/15 33/1 33/4 66/10 66/25 104/23 106/19 132/16 136/1 155/11 158/21	comprehensive [1] 153/8	considering [2] 47/15 109/25	copies [1] 28/8 coping [2] 72/12 74/17	contribute [2] 30/18 30/23
comes [8] 21/22 22/7 28/18 31/22 44/18 60/3 62/4 62/20	compromised [1] 29/20	consistency [1] 97/3 consistent [1] 161/5 consolidate [1] 130/7 constraints [1] 110/3 consultant [3] 34/13 58/12 116/21	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23
comfortable [1] 135/17	conclude [1] 105/24 conclusion [2] 38/15 155/11	consultants [1] 132/21	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23
coming [9] 9/8 55/16 60/5 61/15 74/12 77/11 77/11 144/3 161/22	conceived [1] 78/12 concentrated [2] 56/12 121/20	consultation [3] 51/6	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23
comment [13] 36/14 36/25 42/16 73/12 91/7 91/13 108/19 109/10 112/2 153/24 155/9 156/2 157/14	concept [1] 47/17 concern [1] 141/6 concerned [3] 23/19 154/10 160/11	conclude [1] 105/24 conclusion [2] 38/15 155/11	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23
commented [1] 112/11	concerning [1] 96/10 concerns [9] 4/18 4/21 5/3 74/22 142/16 157/17 160/7 160/16 161/7	conclude [1] 105/24 conclusion [2] 38/15 155/11	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23
comments [1] 138/3 commission [1] 55/6 commitment [1] 114/3	conclude [1] 105/24 conclusion [2] 38/15 155/11	conclude [1] 105/24 conclusion [2] 38/15 155/11	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23
committee [6] 119/17 119/19 119/21 120/10 121/19 142/5	conclude [1] 105/24 conclusion [2] 38/15 155/11	conclude [1] 105/24 conclusion [2] 38/15 155/11	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23
committees [1] 122/17	conclude [1] 105/24 conclusion [2] 38/15 155/11	conclude [1] 105/24 conclusion [2] 38/15 155/11	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23
common [2] 158/21	conclude [1] 105/24 conclusion [2] 38/15 155/11	conclude [1] 105/24 conclusion [2] 38/15 155/11	consequence [2] 5/8 61/3	contribute [2] 30/18 30/23

<p>C</p> <p>covering [1] 63/1</p> <p>Covid [32] 3/9 3/16 4/2 4/5 4/17 5/11 5/15 5/21 18/20 32/24 52/8 52/11 53/3 53/12 62/25 86/17 88/18 90/5 94/11 96/17 102/23 106/1 108/16 120/5 120/9 135/4 138/22 147/24 153/3 156/21 158/7 163/22</p> <p>Covid-19 [17] 3/9 3/16 4/2 4/5 5/11 5/15 5/21 18/20 52/8 52/11 94/11 102/23 106/1 120/5 138/22 156/21 158/7</p> <p>CPAP [10] 64/8 65/21 100/19 101/3 101/10 101/17 101/23 102/1 102/5 102/15</p> <p>CPAP/high [1] 101/10</p> <p>CPR [19] 14/23 14/25 14/25 15/7 19/15 19/17 20/11 21/16 22/12 22/15 23/6 26/14 27/16 28/25 29/4 38/3 39/6 89/18 89/21</p> <p>CQC [6] 35/19 37/17 37/21 37/23 38/24 39/18</p> <p>CQC's [1] 38/15</p> <p>create [2] 58/1 127/1</p> <p>created [3] 18/19 95/11 131/3</p> <p>creates [2] 135/24 135/24</p> <p>crisis [9] 2/12 39/17 52/24 52/25 53/2 79/25 80/5 80/9 109/1</p> <p>CRITCON [36] 43/3 43/9 44/8 44/11 44/13 44/14 45/2 45/3 45/9 45/19 48/8 52/17 52/19 53/1 53/25 54/3 54/6 54/8 54/12 72/17 97/15 97/25 99/2 99/8 111/10 111/14 128/3 138/9 138/16 153/10 153/17 157/1 157/2 157/5 157/19 157/20</p> <p>CRITCON 4 [3] 44/14 45/3 111/14</p> <p>criteria [5] 53/9 69/8 94/19 103/14 154/20</p> <p>critical [89] 11/1 15/20 15/22 16/10 19/17 29/11 29/13 29/18 30/22 33/19 34/10 34/13 36/6</p>	<p>38/21 39/25 42/8 42/14 42/25 46/10 50/11 52/5 52/5 52/8 58/5 59/14 59/20 64/14 64/22 64/23 65/1 65/3 65/6 65/7 65/9 65/10 65/19 65/19 65/22 65/23 66/11 66/23 67/2 67/12 67/17 67/19 68/9 76/25 78/3 82/21 82/25 86/9 86/21 87/13 87/15 95/4 95/12 97/15 98/13 98/20 99/1 99/17 101/3 102/5 102/18 115/2 116/21 119/7 119/17 119/20 121/9 128/7 132/1 133/7 133/22 133/22 133/25 135/22 136/23 136/25 140/9 148/21 148/24 149/16 153/2 154/11 154/11 154/15 154/16 163/1</p> <p>critically [9] 56/15 64/4 64/6 70/2 95/7 95/11 95/22 95/23 102/17</p> <p>critically-ill [1] 95/11</p> <p>criticising [1] 148/3</p> <p>crucial [1] 79/3</p> <p>cumulatively [1] 72/4</p> <p>current [2] 111/25 156/5</p> <p>currently [2] 12/7 40/20</p> <p>curriculum [1] 40/6</p> <p>cut [3] 64/1 100/17 139/21</p> <p>Cymru [2] 94/12 156/21</p> <p>cypher [1] 1/11</p>	<p>104/24 105/2 105/4 105/5 105/5 105/10 105/25 106/7 106/21 106/23 121/16 126/4 126/6 128/7 128/23 128/25 129/9 133/9 146/5 147/2 152/22 154/21 155/3 155/12 155/17 155/24 158/3 158/6 158/8 158/10 158/11 158/15 158/22 159/2 159/3 159/7 159/8 159/9 159/12 159/15 159/20 159/20</p> <p>date [1] 40/24</p> <p>dated [1] 116/13</p> <p>David [1] 162/19</p> <p>day [13] 1/21 1/22 1/23 25/25 26/2 33/24 36/8 66/17 68/1 70/11 73/10 133/24 136/15</p> <p>days [14] 2/5 2/6 32/23 32/25 32/25 33/15 39/6 50/9 63/5 93/23 94/4 98/21 101/10 133/24</p> <p>de [1] 153/17</p> <p>de-compensation [1] 153/17</p> <p>deal [4] 12/8 39/22 65/19 162/7</p> <p>dealing [3] 13/19 61/9 61/11</p> <p>dealt [1] 109/13</p> <p>death [8] 11/13 38/13 38/20 39/7 39/13 40/13 92/22 163/25</p> <p>deaths [1] 107/4</p> <p>debate [1] 75/19</p> <p>December [3] 63/1 69/7 116/19</p> <p>December 2020 [2] 63/1 69/7</p> <p>December 2022 [1] 116/19</p> <p>decide [1] 23/10</p> <p>decided [3] 23/2 67/2 140/22</p> <p>deciding [1] 42/3</p> <p>decision [56] 12/19 12/23 13/5 13/11 14/11 21/20 21/22 21/23 22/11 22/17 23/9 23/16 25/10 27/9 28/1 28/8 29/3 31/1 31/2 31/6 31/9 31/17 36/23 46/3 46/7 48/17 52/16 52/20 53/12 54/2 54/7 65/2 89/18 94/24 96/23 99/5 99/20 100/4 103/16 104/12 104/16 109/8 111/21 122/22 123/24 127/24 138/7 138/16</p>	<p>139/2 139/3 153/13 153/18 155/1 156/23 157/12 157/18</p> <p>decision-making [18] 12/19 46/3 46/7 48/17 52/20 54/2 94/24 96/23 99/5 99/20 103/16 104/12 104/16 111/21 123/24 127/24 153/13 157/12</p> <p>decisions [19] 11/1 15/6 23/22 25/6 25/17 41/23 66/6 73/23 88/25 89/1 91/25 98/9 98/11 98/18 99/6 108/1 109/3 135/1 142/10</p> <p>declare [2] 68/2 97/19</p> <p>declared [10] 13/15 44/8 45/2 45/3 46/11 54/9 72/17 97/15 99/8 126/7</p> <p>decompensation [2] 139/10 157/25</p> <p>decompress [1] 156/9</p> <p>decompressing [1] 130/4</p> <p>decompression [2] 43/25 79/1</p> <p>decrease [1] 61/6</p> <p>default [1] 102/11</p> <p>defence [2] 80/24 81/8</p> <p>defer [1] 104/4</p> <p>deficiencies [1] 159/3</p> <p>defined [1] 98/17</p> <p>definitely [2] 77/4 85/18</p> <p>definition [1] 128/17</p> <p>definitions [3] 127/10 128/11 158/18</p> <p>definitive [1] 95/15</p> <p>degree [4] 57/8 118/19 125/16 134/5</p> <p>degrees [1] 63/19</p> <p>delay [1] 94/4</p> <p>delayed [2] 114/14 150/10</p> <p>delays [1] 135/3</p> <p>deliberately [1] 140/6</p> <p>delirious [1] 25/25</p> <p>deliver [3] 114/6 133/15 134/19</p> <p>delivered [4] 84/16 85/17 95/4 141/7</p> <p>delivering [1] 102/12</p> <p>delivery [3] 70/6 120/15 149/2</p> <p>demand [2] 23/6 79/24</p> <p>demands [4] 70/2</p>	<p>70/3 113/9 127/22</p> <p>demeaning [1] 112/13</p> <p>demographic [1] 104/25</p> <p>demonstrated [2] 84/21 124/14</p> <p>denying [1] 87/3</p> <p>department [2] 2/9 50/12</p> <p>departments [1] 121/7</p> <p>depend [1] 17/4</p> <p>dependency [3] 62/11 63/19 65/21</p> <p>dependent [1] 138/8</p> <p>depending [3] 2/4 15/13 39/10</p> <p>depends [1] 36/5</p> <p>depicting [1] 64/19</p> <p>depiction [1] 60/1</p> <p>deployed [1] 114/25</p> <p>Deputy [1] 96/5</p> <p>describe [12] 7/23 72/12 90/6 90/9 119/14 127/6 128/2 139/18 139/20 159/7 159/18 161/3</p> <p>described [5] 70/24 91/9 113/16 130/18 145/11</p> <p>describes [3] 36/9 128/5 132/10</p> <p>describing [4] 1/20 43/19 84/2 157/19</p> <p>description [2] 47/10 157/25</p> <p>descriptions [3] 127/9 158/18 158/24</p> <p>deserve [1] 8/15</p> <p>deserved [1] 5/14</p> <p>design [1] 142/9</p> <p>designed [9] 43/4 43/14 45/1 47/24 53/4 140/5 140/7 140/16 141/11</p> <p>designs [1] 141/10</p> <p>desire [1] 49/21</p> <p>desperately [1] 128/15</p> <p>despite [5] 5/3 22/5 61/24 67/1 99/25</p> <p>detail [6] 20/3 33/8 72/3 72/4 112/7 120/21</p> <p>detailed [1] 158/13</p> <p>details [4] 12/10 12/21 27/8 72/7</p> <p>deteriorate [1] 110/15</p> <p>deteriorated [1] 32/25</p> <p>deteriorating [2] 22/5 42/2</p>
(49) covering - deteriorating				

D	141/3 141/11 141/11 146/14 155/12 155/15 156/5 157/10 157/10 157/15 158/16 161/2 161/9 164/11	54/24 107/18	7/12 8/14 10/5 10/10 11/16 13/21 14/8 14/25 15/17 16/25 22/15 23/12 24/2 24/16 25/6 25/12 25/17 30/22 31/14 31/15 34/6 34/12 34/16 34/18 34/19 35/20 38/14 39/24 40/17 40/17 48/23 48/25 49/21 60/25 68/16 71/8 71/9 75/25 77/15 78/3 79/15 79/16 80/5 81/7 81/17 83/11 84/6 84/20 84/21 84/22 87/24 94/5 95/25 97/8 97/13 98/25 102/5 104/22 107/1 107/6 107/23 109/21 111/13 112/3 113/13 114/2 114/7 115/7 115/14 117/6 117/8 117/18 117/20 118/3 118/4 118/6 118/6 121/23 122/15 124/2 124/11 124/24 126/1 126/3 128/12 128/15 129/5 130/1 131/8 131/15 131/22 134/3 134/6 134/14 135/11 135/12 136/2 136/9 136/16 136/18 136/24 138/7 139/13 142/6 142/9 142/11 145/6 146/9 146/25 147/2 147/13 150/7 151/13 151/13 151/24 152/13 152/14 153/21 156/4 157/16 157/22 158/20 158/22 159/9 160/15 160/23 160/23 161/18 162/1 162/3	documents [4] 12/21 13/3 14/16 122/19 does [21] 16/12 17/4 19/18 20/8 22/15 22/23 24/22 25/5 29/24 35/4 66/9 66/10 71/5 82/8 91/14 103/22 125/4 137/4 137/8 137/11 155/24 doesn't [15] 24/25 59/18 60/11 64/13 77/19 81/8 84/13 86/25 87/1 93/3 105/3 105/3 110/25 146/4 154/17 doing [17] 4/7 68/24 70/11 76/10 80/11 83/4 114/17 121/4 131/5 134/18 138/13 142/25 143/22 145/13 146/24 147/1 161/3 domain [1] 139/5 don't [52] 5/22 9/3 13/9 21/16 22/20 25/1 25/9 29/8 29/21 32/2 35/6 39/17 40/13 49/9 53/20 63/23 66/4 70/18 71/3 78/11 80/19 83/21 84/18 88/21 91/22 97/4 104/2 107/7 108/7 109/11 115/15 125/6 127/4 127/10 130/4 131/7 136/6 137/1 137/5 138/2 140/3 141/24 144/3 146/25 147/2 151/23 153/3 155/12 156/11 158/13 161/20 164/20 donation [1] 13/18 done [30] 5/24 14/18 33/22 37/21 53/5 55/1 61/4 66/18 68/14 73/14 82/13 83/3 84/24 87/13 91/10 96/16 111/8 113/13 119/19 120/2 120/3 121/2 128/8 137/20 142/3 150/3 150/10 150/17 153/20 160/17 door [3] 16/2 77/21 81/2 double [1] 133/19 doubt [2] 19/20 49/9 dovetail [1] 137/21 down [12] 3/6 12/3 14/22 28/21 50/24 54/10 67/20 98/3 101/8 132/5 154/13 155/7 downs [1] 94/6 DR [23] 9/21 10/7 34/19 86/6 88/2 93/10 103/5 113/16 116/5
deterioration [1] 32/22	141/3 141/11 141/11 146/14 155/12 155/15 156/5 157/10 157/10 157/15 158/16 161/2 161/9 164/11	discussion [38] 13/24 22/7 24/12 25/23 26/17 26/24 27/13 31/12 35/24 36/1 36/2 36/4 37/4 39/5 39/12 39/13 42/1 45/22 51/1 53/25 55/20 55/21 82/7 83/2 89/1 89/10 89/12 89/17 91/12 93/14 93/18 94/4 111/20 111/23 111/23 112/10 138/11 139/15	doctor [28] 10/9 10/12 19/2 35/6 41/15 44/22 54/10 64/23 65/20 66/23 67/9 71/11 72/20 74/2 79/10 81/21 83/8 83/13 84/1 96/13 98/19 103/21 107/16 130/9 147/23 156/20 158/25 159/25	
develop [1] 81/16	differently [8] 4/5 34/9 80/5 127/12 140/11 142/9 142/11 156/10	discussions [17] 23/18 29/21 32/9 36/8 36/21 37/10 50/2 80/7 91/4 93/24 111/9 123/1 123/6 124/11 124/11 139/8 139/11	doctors [12] 31/3 40/9 65/3 65/8 65/10 65/14 65/23 66/12 67/19 124/16 154/11 154/16	
developed [3] 51/2 51/16 138/21	differs [1] 32/20	disease [10] 53/8 53/14 54/13 61/14 67/1 73/19 81/25 82/12 96/16 109/2	document [15] 15/4 15/4 18/19 21/8 25/15 25/16 27/25 50/19 52/7 52/23 53/11 58/8 112/6 125/24 138/19	
developing [1] 79/22	difficult [14] 32/13 36/25 40/12 42/18 47/19 63/22 66/6 74/21 82/15 107/21 108/23 113/18 124/12 158/7	disorders [2] 69/9 69/10	documented [2] 87/6 89/1	
development [3] 111/23 115/4 138/23	difficulties [4] 137/4 159/1 163/15 164/3	disparities [1] 86/13		
devolved [2] 99/3 157/21	difficulty [1] 65/17	disparate [1] 7/4 7/7		
diagnosis [1] 12/11	dignified [1] 38/13	disproportionately [2] 86/4 100/2		
diagnostics [1] 129/23	diktat [1] 63/23	disputed [1] 48/21		
diagram [1] 44/4	diluted [1] 86/9	disrupted [1] 115/23		
dial [1] 85/5	dilution [1] 71/25	disseminated [1] 74/20		
dialysis [1] 122/12	diminished [1] 76/7	disseminating [1] 93/15		
diameters [1] 140/9	diminishing [1] 74/17	dissemination [1] 121/18		
did [56] 1/24 2/2 3/4 3/11 3/14 4/4 4/13 4/18 4/21 5/15 6/13 7/3 7/9 7/13 7/18 32/8 33/9 34/9 35/22 38/6 38/10 39/1 47/17 47/21 50/17 55/2 58/1 58/3 61/20 64/13 64/13 69/18 70/20 74/13 81/3 86/18 97/19 99/13 105/2 105/4 109/11 118/22 120/17 121/6 124/3 125/16 126/18 126/18 128/22 128/22 135/19 143/11 149/23 152/14 159/13 159/14	direct [5] 123/3 135/23 156/13 157/13 159/16	distraction [1] 130/6		
didn't [19] 2/21 2/23 3/12 3/17 4/3 4/6 5/3 5/13 6/15 7/5 7/11 36/3 67/5 72/14 105/3 112/1 124/2 129/11 152/15	directed [2] 105/12 159/17	distress [4] 31/7 69/11 113/15 145/3		
die [2] 38/20 39/9	directly [5] 1/16 8/19 88/9 124/7 143/19	distressed [1] 70/12		
died [3] 67/1 148/7 164/4	director [3] 42/21 50/24 162/16	distressing [2] 10/16 38/7		
differ [1] 13/2	directors [2] 121/10 123/15	distributed [1] 85/4		
difference [7] 6/1 72/4 92/7 98/13 101/16 101/21 132/10	disabilities [1] 106/4	disturbing [1] 155/22		
differences [2] 140/20 158/9	disability [4] 50/12 55/8 110/10 110/24	diverse [1] 72/23		
different [54] 12/24 13/16 16/9 16/22 17/12 21/12 24/25 25/13 32/17 34/8 36/24 41/14 53/8 53/8 53/9 56/25 61/15 62/20 67/3 68/23 69/6 73/9 91/20 92/1 92/25 96/17 97/25 98/23 103/9 115/1 120/10 121/14 124/8 124/20 125/21 126/21 126/22 136/2 138/24 139/16	disabled [1] 12/15	DNACPR [41] 15/4 16/21 16/24 17/12 17/20 19/11 19/15 19/21 20/7 20/19 21/13 23/3 24/15 27/10 27/23 28/1 28/4 28/8 28/13 31/18 31/24 32/9 35/1 35/5 35/22 36/23 38/11 41/8 88/19 88/24 89/3 89/25 90/11 90/18 91/4 91/20 92/1 92/15 92/19 109/13 109/14		
	disadvantaged [4] 48/14 55/9 55/9 100/3	DNACPRs [8] 18/25 19/1 29/15 34/17 83/9 90/22 91/19 92/7		
	disagree [1] 31/19	do [132] 4/23 5/8		
	disagreement [1] 32/3			
	disappeared [1] 62/17			
	disaster [1] 81/2			
	discharge [1] 28/18			
	discharged [1] 34/25			
	disciplines [1] 119/24			
	disconnected [1] 33/16			
	discreet [1] 72/19			
	discuss [1] 29/15			
	discussed [16] 13/18 26/18 30/15 30/19 92/2 95/3 122/23 122/23 126/7 126/23 135/14 137/21 138/18 139/17 153/11 157/17			

D	E			establishing [2] 11/24 18/5
DR... [14] 116/6	each [4] 80/15	147/13	117/16	establishment [2] 119/16 125/2
116/12 116/16 118/10	120/22 153/7 154/4	elsewhere [4] 18/8	English [4] 1/12 1/15	estate [1] 141/4
118/11 120/1 137/23	ear [1] 142/21	73/24 75/4 91/12	3/3 132/8	estates [1] 141/9
144/10 145/18 161/17	earlier [19] 36/24	email [1] 35/11	enhanced [1] 136/20	estimate [1] 109/23
162/19 162/22 165/8	38/25 45/22 46/16	embark [1] 11/8	enlarged [1] 132/4	estimates [2] 57/10
165/16	56/15 79/1 99/23	embarrassed [1] 39/15	enormous [1] 114/12	57/13
Dr David [1] 162/19	107/17 118/10 119/1	embed [1] 81/12	enormously [1] 32/20	et [1] 148/25
DR GANESH [3] 9/21	125/16 132/15 137/23	embedded [5] 40/15	enough [16] 40/15	ethical [6] 50/13
120/1 165/8	138/21 153/11 155/4	81/6 125/4 145/5	42/16 67/5 113/13	52/23 79/22 107/22
Dr Jack [1] 162/22	155/9 156/25 158/25	151/20	113/20 113/24 114/1	118/19 153/18
Dr Mathieu [7] 116/5	early [16] 15/22 22/8	emergencies [3] 81/13 124/1 138/24	115/5 122/12 122/13	ethically [1] 100/12
116/12 116/16 118/10	22/9 39/2 43/7 55/25	emergency [11] 10/3	129/17 137/2 141/7	ethnic [9] 86/2 86/3
144/10 145/18 161/17	56/12 56/14 73/17	30/6 79/12 81/10	141/8 144/22 156/3	86/15 86/19 87/7
DR STEPHEN [2]	74/17 126/15 127/14	119/17 119/20 120/19	enriched [1] 159/21	87/10 87/17 87/23
116/6 165/16	129/9 140/23 155/6	138/22 138/25 139/1	ensure [7] 81/7 133/1	163/13
Dr Suntharalingam	155/18	162/1	141/24 142/1 144/7	ethnicities [1] 72/23
[9] 10/7 34/19 86/6	easier [1] 76/15	emerging [1] 81/15	156/12 164/15	Ethnicity [1] 143/3
88/2 93/10 103/5	easily [2] 19/22 20/10	emotional [1] 74/4	ensuring [3] 10/24	Europe [1] 117/4
113/16 118/11 137/23	East [1] 162/25	emphasis [1] 114/22	37/25 138/8	even [17] 2/6 3/12
draft [3] 138/1	easy [4] 19/24 33/25	emphasise [3] 44/11	entered [1] 85/8	14/4 18/5 24/25 26/1
149/22 156/22	67/9 113/19	80/22 164/15	entire [1] 57/15	33/7 48/14 49/5 55/17
drafted [1] 95/17	echo [1] 97/23	emphasised [2] 88/3	entirely [4] 59/13	74/24 78/23 107/23
drafting [2] 94/13	ectopic [1] 163/4	109/19	59/19 66/9 93/3	112/23 149/17 149/24
104/10	education [5] 40/16	emphasising [1] 18/9	entitled [6] 5/12 52/7	160/20
draw [3] 42/13 76/20	40/18 40/21 117/8	employed [3] 1/17	67/11 80/23 143/2	evening [1] 2/3
89/22	117/9	6/3 8/19	148/21	event [8] 24/7 28/24
drawbacks [1]	effect [6] 46/14 71/2	employer [2] 154/5	environment [6]	42/14 42/25 43/14
101/25	94/2 123/3 125/3	154/23	76/14 136/1 141/20	46/12 54/22 78/6
drop [2] 59/23 60/9	143/12	employers [3] 5/4	142/3 146/18 154/24	Eventually [1] 8/3
droplet [1] 76/3	effective [1] 159/3	41/6 154/2	environments [1]	ever [12] 3/23 8/5
dubious [1] 100/11	effectively [9] 45/1	empty [1] 127/7	140/13	30/14 30/19 31/12
due [17] 2/1 2/11	48/2 50/18 51/15	enable [5] 114/1	envisage [2] 55/2	47/13 65/9 104/13
2/16 2/19 2/24 8/3	106/5 117/5 119/7	136/25 138/15 151/11	79/16	113/24 114/9 130/15
10/1 10/2 10/4 15/20	136/21 142/20	157/23	envisaged [3] 44/9	135/19
73/22 92/16 94/24	efficacy [1] 48/19	enabled [1] 140/22	44/21 47/13	every [17] 24/19
97/25 103/17 106/3	effort [2] 32/1 128/13	encapsulates [1]	epidemiology [1]	35/17 36/8 45/15 72/3
107/2	efforts [3] 105/12	11/20	82/23	73/10 93/23 94/2
during [64] 1/13 2/12	114/4 148/4	encourage [1] 96/22	equally [1] 160/15	104/16 104/17 107/12
5/15 7/13 7/15 7/22	eight [1] 119/13	encouraging [1]	equipment [10] 5/25	107/12 133/19 136/9
7/24 8/16 34/6 50/15	either [9] 8/5 28/16	117/9	66/4 126/22 129/18	136/15 142/1 144/6
52/10 53/5 60/17 62/5	28/17 33/16 96/20	end [12] 11/12 15/8	130/20 142/20 143/20	everybody [6] 30/12
62/6 62/11 62/17	97/11 107/6 115/1	27/19 30/15 40/1 53/3	143/24 145/21 146/8	64/10 84/11 95/22
63/10 63/15 63/20	136/10	80/3 92/21 93/16	equivalent [6] 17/13	113/20 164/20
64/19 64/24 67/14	either/or [2] 28/16	113/6 121/1 122/12	45/19 57/16 99/3	everyone [9] 20/1
68/10 69/3 69/25	28/17	ended [2] 30/7 38/21	132/13 133/25	30/8 54/17 79/21
74/14 76/22 77/1	elderly [3] 100/2	endless [1] 139/25	escalate [8] 47/1	126/15 135/11 135/15
78/20 78/24 80/5	100/6 110/13	endorse [1] 138/6	64/24 64/25 65/7	160/13 161/4
86/10 86/14 99/11	elective [5] 70/4 70/6	endorsed [4] 51/8	65/10 65/15 65/24	everything [7] 3/6
99/25 102/13 102/25	77/12 113/10 114/12	51/13 52/2 99/16	66/13	4/12 31/14 71/24
104/25 105/15 107/4	electronic [3] 16/18	engaged [1] 139/12	escalated [6] 45/12	71/24 80/24 85/3
113/2 114/14 118/22	16/19 19/22	engagement [2]	66/8 67/2 67/5 101/5	evidence [41] 1/10
119/4 119/10 119/11	element [4] 112/13	99/14 119/23	154/25	59/11 61/22 62/19
119/15 123/25 124/4	128/1 144/24 146/18	engineering [1]	escalating [2] 65/18	66/16 66/18 68/4 68/5
134/4 139/19 142/13	elements [6] 52/13	142/4	66/24	70/22 75/10 75/12
148/19 151/2 152/5	52/14 75/19 92/12	England [18] 12/6	escalation [10] 13/4	76/22 78/9 78/17
154/4 155/15 156/25	144/19 146/22	17/9 45/3 52/6 57/10	18/18 37/8 41/9 52/16	86/14 86/22 94/12
163/4 163/20 163/22	eligible [2] 47/1	68/25 74/15 82/14	53/1 89/14 103/4	95/3 96/9 99/23 103/1
164/2 164/4	110/1	97/16 101/22 101/22	111/9 153/21	103/12 104/19 105/6
dying [3] 37/14 61/1	eloquently [2] 60/21	117/16 118/7 127/14	essential [3] 9/9	115/21 115/23 146/5
137/8	130/18	157/8 157/13 158/10	38/13 143/25	148/2 150/20 151/9
dysfunction [1]	else [6] 46/23 70/21	158/17	essentially [3] 43/17	151/16 155/8 155/8
146/23	80/24 109/2 112/19	England-specific [1]	establish [1] 14/16	

E	77/14 122/7	160/18 162/25	27/16 27/19 42/18	fluctuations [1] 60/4
evidence... [8]	expert [6] 17/23 55/5	factor [2] 73/12	65/14 65/24 66/19	FMHWG [1] 163/8
156/25 161/20 161/25	82/21 93/8 120/1	149/2	73/15 73/20 73/20	focus [2] 76/4 76/13
162/8 162/18 164/9	123/11	factors [6] 27/12	73/21 74/21 75/24	follow [6] 20/1 26/4
164/11 164/20	experts [4] 82/23	73/8 92/19 109/8	90/16 112/12 120/13	54/10 54/13 137/4
exact [2] 57/9 151/22	83/10 122/19 153/23	109/24 111/6	126/1 135/17 143/15	137/8
exactly [11] 37/17	explain [9] 13/20	faculty [3] 148/23	149/5	following [1] 135/5
57/7 57/13 58/3 81/19	31/3 31/9 31/12 32/5	151/1 162/23	few [4] 32/24 102/24	follows [1] 71/16
81/20 100/5 130/19	33/24 56/21 119/17	failed [1] 80/25	125/18 147/23	Fong [5] 68/1 68/22
143/15 152/14 154/21	119/18	failure [1] 71/22	fewer [3] 36/13 60/16	70/18 103/13 137/21
examination [1]	explained [3] 22/3	fair [5] 75/2 79/23	62/17	Fong's [1] 137/12
113/6	137/25 144/11	105/24 153/13 156/3	FFP3 [2] 73/23 74/25	footprint [1] 128/7
example [38] 4/9	explanation [1] 91/12	fairly [4] 45/25 65/11	fictional [2] 90/14	fora [1] 123/23
11/8 12/13 13/9 13/24	explanatory [1]	108/14 114/15	90/19	force [1] 144/3
14/5 20/6 21/18 23/19	112/4	fall [2] 59/21 60/2	figure [7] 56/18	foremost [1] 142/8
24/2 24/19 24/22	explicitly [1] 43/9	fallen [2] 5/11 5/21	56/22 59/25 78/21	forever [1] 135/20
27/17 29/14 44/5 44/7	explore [2] 3/2	falls [2] 61/11 61/12	85/9 126/1 154/10	forgive [1] 71/6
47/23 57/3 59/22 62/3	131/14	familiar [6] 27/2 37/5	figures [4] 65/22	forgotten [1] 71/21
75/1 76/18 82/13	exploring [1] 129/20	58/14 72/22 91/6	84/11 85/8 154/16	form [45] 11/16
90/14 90/19 92/15	exposed [1] 77/16	150/5	fill [4] 16/3 16/6	11/17 12/9 14/13
93/15 96/17 106/3	exposure [1] 136/25	families [21] 24/23	26/14 148/5	14/24 15/1 15/12
110/20 110/23 122/10	expressed [2] 100/16	33/25 34/11 34/24	filled [6] 14/19 15/12	16/12 16/15 16/21
122/21 126/10 127/1	160/16	35/21 72/11 73/19	15/15 21/1 27/6	16/24 17/1 17/2 17/9
127/3 127/25 160/19	expression [1] 14/17	80/7 89/7 90/25 91/4	126/12	17/14 17/20 18/1
examples [5] 13/22	expressly [2] 15/6	91/10 94/12 102/23	fills [2] 14/13 29/11	18/10 18/13 18/24
34/24 36/11 121/24	150/16	107/24 147/24 148/6	final [5] 37/21 47/6	20/7 20/14 20/23
123/1	extend [2] 121/4	148/7 156/21 160/4	72/19 112/16 132/11	20/25 21/8 21/19
exceeded [2] 69/8	124/22	160/8	finally [4] 7/21 8/18	23/16 24/13 24/15
96/8	extent [3] 53/24	family [13] 3/1 8/2	50/17 76/19	24/20 25/3 26/19 29/8
exceeds [1] 79/24	102/25 108/16	10/2 26/5 26/12 29/16	find [22] 6/6 6/8 6/9	29/11 37/9 41/2 42/23
excessive [1] 78/23	external [1] 97/5	29/25 30/19 31/1	10/15 12/22 17/2	47/6 47/20 50/18 55/6
excluded [1] 90/25	extra [4] 57/16 57/24	33/24 34/10 36/4	35/22 49/10 49/14	89/15 110/6 111/25
excluding [1] 100/8	58/2 58/6	39/16	49/23 69/18 86/24	131/20
exclusion [1] 91/2	extraordinarily [1]	family's [1] 32/4	87/2 87/4 95/18 105/2	formal [8] 79/13
executive [1] 35/12	32/12	far [7] 9/5 56/14	105/4 141/2 146/3	92/24 97/9 97/11
exemplifies [1] 58/8	extraordinary [4]	91/22 92/9 108/19	146/11 147/13 151/25	98/10 100/16 111/11
exhaust [1] 81/11	59/2 114/7 145/18	109/12 152/7	findings [3] 35/19	123/8
exhausted [2] 45/6	147/13	fashion [1] 127/21	37/18 64/17	formalised [1] 92/11
46/10	extreme [3] 44/2 48/4	fast [1] 93/22	fine [2] 56/2 77/9	formally [2] 94/15
exist [2] 87/1 99/13	80/2	father's [1] 163/25	finger [1] 142/21	157/2
existence [2] 20/14	extremely [2] 115/21	fault [3] 20/5 115/15	finish [2] 50/8 54/20	format [2] 18/13
50/19	164/16	145/22	Fireman [1] 116/4	80/11
existing [9] 18/11	extremis [4] 45/8	fear [5] 3/4 3/13 4/19	first [18] 5/20 24/9	forms [5] 11/14
27/21 35/13 106/4	48/8 49/1 53/15	8/1 11/25	50/25 57/3 62/5 64/20	15/14 19/21 49/5 89/2
109/24 131/2 135/22	F	feared [2] 3/6 5/9	64/24 77/3 80/19	forward [2] 9/8 136/4
144/21 152/13	face [4] 29/24 29/25	feasible [1] 22/6	80/20 80/21 103/4	forwards [1] 71/7
expand [2] 126/17	121/2 121/2	February [3] 61/8	105/15 128/24 131/12	found [13] 7/17 20/15
137/19	faced [2] 142/11	69/17 164/5	135/16 142/8 156/22	32/11 34/25 37/23
expanded [1] 128/6	160/5	February 2021 [2]	first-hand [1] 128/24	38/7 47/12 55/16 62/5
expect [2] 69/22	faces [1] 72/23	69/17 164/5	firstly [11] 12/18	63/4 69/20 90/22
159/11	facilitate [1] 93/24	Federation [1] 86/1	21/14 44/11 48/11	105/18
expected [4] 47/7	facing [1] 54/18	feed [1] 46/6	48/18 49/8 51/7 81/23	Foundation [1] 82/19
47/9 62/12 62/14	fact [36] 5/15 10/1	feeding [1] 121/25	88/20 105/24 111/3	founded [1] 117/2
experience [9] 34/16	19/3 20/25 23/24 26/5	feeds [1] 85/16	fit [3] 73/10 74/7	four [14] 7/20 17/18
34/20 39/21 66/10	42/15 43/5 43/8 47/21	feel [10] 2/23 3/11	154/17	18/2 25/14 41/4 42/19
66/24 78/20 135/11	48/15 52/16 54/6	7/10 8/10 30/12 31/15	fitter [1] 105/14	42/20 56/22 62/24
149/15 160/6	56/14 58/7 60/21	49/9 93/21 103/6	five [4] 2/6 71/5	97/3 104/17 107/19
experienced [3] 38/4	68/15 75/11 90/21	124/2	113/11 133/24	132/5 159/4
102/7 149/18	94/14 97/10 97/12	feeling [7] 2/17 7/11	fixed [3] 25/24 92/19	fourth [1] 3/18
experiences [4]	98/9 106/15 108/9	39/15 67/15 97/4	130/21	frailty [11] 109/13
66/19 120/21 122/5	112/11 124/24 125/3	122/4 135/12	flagged [1] 19/23	109/15 109/20 109/23
124/9	125/20 134/5 136/8	feels [2] 35/7 72/9	floor [2] 1/23 3/19	110/6 110/9 110/12
experiencing [2]	141/15 147/16 152/22	felt [21] 2/22 5/21	flow [5] 65/21 101/4	110/14 111/20 112/5
			140/10 140/20 160/19	112/13

F
framework [20] 13/2
 43/5 43/8 44/24 47/15
 50/9 50/15 51/14
 52/15 53/1 79/23
 94/14 97/10 97/11
 109/4 110/20 111/17
 122/22 138/7 139/3
frameworks [2]
 138/17 153/18
France [1] 115/3
free [1] 103/6
frequency [1] 64/25
frequently [1] 140/15
front [3] 16/2 21/1
 76/6
frontline [4] 45/18
 46/5 74/20 161/18
frustrating [1] 146/3
full [6] 45/15 75/5
 116/10 119/7 127/4
 130/17
full-time [1] 119/7
fully [5] 14/8 30/6
 38/5 38/10 69/25
function [1] 106/15
functional [2] 69/12
 69/14
functioning [1]
 112/23
Fund [1] 82/20
funded [3] 41/4
 114/25 115/8
funding [1] 82/17
further [9] 27/16
 53/24 90/16 98/6
 98/25 106/22 150/20
 155/22 156/15
future [9] 54/22 78/6
 79/12 80/9 109/1
 131/23 134/13 145/12
 159/23

G
Gale [1] 61/11
GANESH [3] 9/21
 120/1 165/8
gap [4] 87/5 99/1
 136/18 137/2
gaps [2] 144/20
 148/5
gave [3] 59/11
 108/10 163/8
general [6] 2/24 40/7
 48/14 53/23 73/1
 110/18
generalised [1] 89/4
generally [5] 10/20
 61/12 63/16 74/7
 140/14
generate [4] 75/11
 78/9 121/15 130/23
generated [2] 35/9

41/2
generates [1] 75/14
generating [2] 75/9
 161/12
genuine [1] 125/13
genuinely [5] 50/2
 124/14 125/11 139/9
 154/22
geography [1] 84/15
Germany [1] 85/15
get [20] 16/10 27/22
 35/12 46/18 47/3 48/3
 56/25 63/7 63/16
 72/14 79/2 98/22
 110/20 121/13 122/3
 124/22 136/17 136/25
 150/10 158/22
gets [2] 47/4 81/25
getting [10] 29/14
 45/21 63/9 67/7 74/23
 82/9 90/15 92/21
 122/19 122/20
Gillian [1] 163/17
give [23] 6/14 6/15
 6/22 13/22 27/8 29/14
 84/19 85/5 85/12 93/8
 95/15 116/10 118/17
 121/24 126/9 133/21
 139/22 146/20 147/1
 153/3 155/20 157/22
 164/20
given [22] 4/9 6/4 6/7
 6/10 30/21 65/16
 66/22 73/16 86/16
 87/6 87/23 98/7 99/23
 115/20 116/12 117/25
 118/24 130/9 130/16
 134/2 154/24 157/2
gives [3] 49/13
 136/23 164/9
giving [4] 66/23
 70/22 123/1 162/11
glean [1] 103/21
gloss [1] 110/11
go [24] 2/3 2/18 7/11
 15/10 20/3 20/8 20/18
 25/4 32/8 33/9 35/4
 35/17 40/8 44/25
 53/22 54/10 63/15
 80/21 89/11 100/11
 103/13 145/17 146/8
 151/23
go' [1] 67/6
goes [6] 14/12 39/18
 80/20 83/22 132/10
 142/20
going [33] 2/1 2/12
 14/4 16/5 16/24 25/3
 27/19 34/2 35/8 37/17
 40/17 46/2 49/14
 52/20 52/21 56/21
 70/1 74/16 76/5 76/11
 78/8 80/15 89/14
 113/8 114/9 118/16

130/1 130/15 143/18
 144/13 145/25 147/16
 147/23
gold [1] 102/11
gone [4] 37/6 101/3
 115/14 150/7
good [6] 11/20 72/14
 86/1 90/25 102/22
 130/14
goodness [1] 5/17
Google [1] 121/14
got [9] 12/10 54/18
 63/14 88/18 117/12
 127/5 139/9 160/23
 164/19
government [4] 54/9
 79/13 121/6 121/7
GP [6] 16/3 28/10
 28/14 35/16 35/17
 162/20
GPIC [1] 133/16
GPICS [2] 150/23
 151/23
granular [1] 120/21
graph [1] 60/20
graphical [1] 112/13
graphics [1] 112/11
grateful [4] 9/11 94/8
 135/20 161/15
great [4] 7/25 31/7
 64/9 125/16
greater [12] 6/14
 33/17 33/19 62/10
 70/2 99/12 100/7
 106/10 113/9 114/22
 132/7 134/6
greatest [1] 105/13
grey [1] 60/12
grim [1] 65/11
ground [3] 67/23
 82/24 147/18
grounds [3] 46/23
 50/24 92/17
group [11] 42/23
 50/10 50/10 50/14
 50/18 62/22 87/22
 105/17 115/6 122/2
 128/1
groups [6] 50/12
 51/6 55/9 117/11
 148/23 154/6
guard [1] 111/17
guess [11] 60/19
 60/25 84/10 93/9
 95/14 96/3 122/21
 125/9 128/2 159/22
 161/4
guidance [49] 4/13
 4/15 4/16 42/14 50/20
 51/16 51/19 51/24
 52/14 74/12 76/7
 76/14 96/18 96/21
 97/11 98/10 99/1 99/4
 99/9 99/13 103/23

104/12 109/22 110/4
 111/3 111/7 112/2
 120/13 122/9 122/19
 122/20 122/22 123/3
 137/24 138/3 138/4
 151/23 153/2 153/5
 153/13 153/16 153/18
 154/18 155/25 156/1
 156/4 156/22 157/1
 157/3
guideline [5] 42/6
 51/7 139/4 156/4
 160/14
guidelines [14] 4/5
 41/18 74/6 74/10 93/4
 94/25 103/17 104/6
 117/9 132/18 132/19
 150/24 151/21 161/5
guides [1] 92/4

H
H1N1 [1] 140/4
had [107] 3/4 3/10
 3/13 4/2 4/19 4/21
 4/23 4/23 5/11 5/13
 5/20 5/22 5/24 6/5 6/7
 6/10 6/24 6/24 7/11
 7/17 7/24 8/1 8/8 8/11
 12/13 17/1 20/18
 32/14 32/24 32/25
 33/7 33/10 34/4 34/10
 34/25 35/25 36/9
 36/11 43/15 44/8
 45/22 53/25 56/15
 57/5 57/14 58/4 58/6
 58/20 59/12 59/22
 60/12 60/15 62/10
 64/8 64/11 65/2 65/6
 65/9 66/25 67/3 67/3
 67/6 67/7 67/7 67/21
 71/9 72/15 73/18
 74/25 83/6 85/15
 85/15 91/11 93/13
 96/5 97/19 98/3
 101/23 103/23 106/5
 106/10 111/12 115/22
 120/8 120/8 120/20
 121/12 124/3 126/10
 130/8 130/10 130/13
 134/4 138/1 145/20
 149/24 150/5 150/5
 150/6 150/17 150/18
 151/2 151/5 151/10
 153/11 160/17 164/3
hadn't [1] 104/14
half [2] 85/9 133/7
hand [3] 128/24
 154/1 154/9
handle [1] 76/15
handover [1] 21/11
handovers [1] 21/9
hands [1] 36/7
happen [9] 3/4 11/2
 11/4 26/7 38/6 94/5

105/3 105/4 107/14
happened [18] 30/12
 31/12 43/25 61/6
 64/19 69/2 79/2 96/14
 104/14 104/16 104/20
 107/13 108/7 108/14
 109/11 126/15 126/19
 145/23
happening [8] 38/10
 38/24 64/4 64/5 91/15
 108/25 128/6 137/14
happens [4] 49/8
 49/20 89/11 136/17
happy [2] 80/21 86/6
hard [4] 9/12 33/11
 93/22 105/2
harder [1] 131/2
harm [1] 77/14
harmed [1] 145/2
has [64] 8/22 8/24
 9/12 12/5 12/10 15/25
 19/14 19/15 20/12
 21/15 23/2 23/21 25/1
 26/2 26/5 26/14 26/17
 26/18 26/24 30/12
 31/12 34/23 39/20
 52/14 52/17 52/23
 52/25 61/10 77/21
 78/8 78/9 79/21 80/24
 84/24 85/15 86/14
 86/23 88/2 90/11
 92/10 93/10 99/21
 112/16 113/13 113/20
 114/6 114/22 115/4
 115/21 117/10 117/11
 117/25 122/23 127/23
 131/19 132/4 137/17
 137/19 137/20 143/13
 144/7 145/2 145/23
 147/17
hasn't [2] 80/25 83/3
Hats [1] 6/21
have [316]
haven't [7] 30/19
 33/7 116/8 144/15
 147/13 161/21 164/19
having [38] 2/25 22/6
 22/7 23/18 30/13 31/9
 32/8 33/17 34/11 35/5
 38/11 40/4 40/24 41/9
 45/23 47/22 48/20
 49/25 54/15 54/17
 61/2 66/6 71/2 76/9
 77/14 81/14 81/15
 83/16 89/17 89/19
 104/19 115/8 115/22
 123/20 123/23 135/9
 139/20 159/21
Hazmat [1] 75/5
HCPs [1] 154/4
he [15] 42/16 42/18
 66/16 68/1 68/4 70/21
 70/22 70/23 137/24
 137/25 138/1 138/3

H	76/24 113/13 115/19 115/20 122/8 123/16 135/15	32/24 34/12 34/17 35/10 35/10 35/13 35/15 35/16 36/16 40/3 42/7 43/20 44/12 60/24 61/2 61/3 62/25 73/24 83/9 88/5 91/2 91/6 91/13 107/12 108/12 108/18 110/2 113/22 113/23 116/22 127/2 130/13 130/16 131/4 131/9 139/25 140/5 140/20 141/1 141/4 142/2 142/7 144/23 146/18 152/23	I am [4] 14/4 68/7 154/23 164/19 I appear [1] 88/17 I appreciate [2] 23/17 43/18 I ask [20] 7/9 8/10 27/9 29/10 34/15 34/23 35/19 38/14 39/23 48/9 59/16 63/22 67/10 74/2 90/20 91/18 94/11 135/5 139/16 156/20 I believe [3] 7/20 42/9 112/10 I can [17] 9/13 29/12 55/25 63/13 67/25 93/12 104/1 106/17 107/6 109/12 112/17 115/17 125/17 129/19 137/18 151/24 158/14 I can't [6] 36/14 106/20 109/10 112/2 155/20 156/2 I cannot [3] 104/15 107/7 107/8 I certainly [1] 96/2 I could [8] 86/24 87/2 87/3 95/18 105/4 118/24 122/25 126/9 I couldn't [2] 5/6 105/2 I did [2] 70/20 105/2 I didn't [3] 3/12 5/3 7/11 I do [15] 11/16 24/16 31/14 34/18 83/11 84/20 107/6 112/3 126/3 147/13 151/24 153/21 156/4 157/16 162/1 I don't [25] 13/9 21/16 25/1 29/8 32/2 35/6 40/13 66/4 70/18 71/3 78/11 80/19 88/21 104/2 107/7 125/6 127/10 130/4 131/7 137/1 138/2 140/3 155/12 156/11 158/13 I explain [1] 31/12 I feared [1] 3/6 I feel [1] 30/12 I felt [1] 2/22 I find [1] 146/3 I first [1] 5/20 I follow [1] 54/10 I genuinely [1] 154/22 I go [1] 145/17 I guess [10] 60/25 84/10 93/9 95/14 96/3 122/21 125/9 128/2 159/22 161/4 I had [8] 3/13 4/19	5/24 7/11 8/1 8/11 17/1 83/6 I happened [1] 108/14 I have [20] 9/13 35/20 51/12 63/14 83/8 88/18 95/16 96/4 102/18 102/24 107/5 119/5 119/12 128/24 130/19 135/14 144/12 144/12 145/11 154/21 I hear [1] 89/21 I heard [1] 3/17 I hope [1] 116/8 I just [11] 9/2 24/13 41/22 43/13 54/20 74/10 75/15 133/11 153/24 155/16 162/11 I know [5] 9/5 17/16 92/10 143/21 148/1 I listened [1] 155/10 I look [1] 103/5 I looked [1] 5/17 I lost [1] 8/3 I may [12] 19/2 25/3 45/21 65/11 72/19 72/20 74/1 121/23 128/4 144/18 146/16 159/6 I mean [4] 24/2 43/1 69/22 143/18 I move [2] 7/21 41/14 I need [1] 147/12 I noted [1] 96/12 I noticed [1] 108/10 I perhaps [1] 43/13 I please [2] 1/4 116/5 I presented [1] 104/24 I presume [1] 89/5 I put [1] 66/5 I really [1] 77/23 I recognise [1] 86/22 I remember [1] 32/23 I represent [4] 86/1 102/23 113/13 148/6 I right [2] 22/23 149/6 I said [3] 41/19 100/6 100/6 I say [2] 118/3 120/25 I see [2] 36/19 63/13 I shall [2] 9/14 56/3 I shan't [4] 147/17 155/2 155/22 156/15 I should [2] 64/3 68/2 I suffer [1] 7/25 I suppose [4] 29/23 120/3 122/25 150/4 I survive [1] 14/5 I suspect [2] 32/6 67/9 I take [4] 5/8 48/25 124/2 128/16 I talked [1] 114/8
he... [3] 154/6 162/20 162/24 heads [1] 118/17 heal [1] 113/14 health [34] 7/24 18/19 23/21 24/1 25/12 25/18 26/25 41/6 50/13 69/9 69/14 73/3 73/19 74/14 77/6 77/19 79/12 81/1 84/5 84/14 84/14 84/17 100/14 100/22 100/25 106/4 109/24 110/18 112/21 113/2 113/17 118/19 163/15 164/3 healthcare [49] 2/12 27/7 34/1 37/12 37/23 40/10 55/18 61/13 61/16 64/21 68/9 69/23 69/23 70/12 70/16 71/4 71/22 75/4 77/4 79/24 80/3 80/3 81/9 82/11 84/16 85/17 86/2 86/3 86/13 86/19 87/7 87/10 87/18 87/23 89/13 90/1 93/14 94/6 106/10 111/22 113/2 113/14 114/3 114/4 114/23 148/7 154/2 162/16 163/14 hear [7] 9/9 68/6 71/8 75/20 88/13 89/21 162/1 heard [26] 3/17 31/10 34/22 34/24 35/20 41/19 42/5 43/3 58/24 67/25 70/18 71/8 75/9 75/22 78/2 86/23 94/12 99/23 118/10 125/20 132/19 136/20 148/2 155/4 156/24 162/18 hearing [3] 41/20 137/15 164/23 hearings [1] 164/17 heart [6] 19/8 27/18 59/22 60/6 61/14 61/16 heartless [1] 43/18 heavily [2] 119/8 119/9 held [1] 158/6 Helen [1] 96/4 Helen MacNamara [1] 96/4 help [25] 2/25 9/8 11/18 12/14 12/18 18/1 19/13 27/3 46/8 56/20 60/15 60/18 66/25 67/22 69/17 71/19 72/21 75/17	helpful [9] 115/21 121/13 125/10 125/14 132/24 137/19 144/10 157/20 159/22 helps [3] 10/12 56/16 68/19 Hence [1] 104/14 her [11] 26/4 71/19 80/17 96/9 123/18 163/5 163/25 164/3 164/12 164/12 164/12 here [20] 17/7 26/5 30/7 30/17 30/18 43/20 54/1 70/14 70/22 75/7 97/14 109/15 125/5 128/12 132/4 132/24 142/1 143/6 149/21 155/17 hesitate [1] 84/19 hiding [1] 6/19 Higgins [2] 163/18 163/19 high [7] 65/21 65/21 101/4 101/10 128/9 140/12 149/18 high-level [1] 149/18 higher [14] 19/8 59/7 63/19 66/6 67/15 85/11 86/16 87/6 102/8 105/11 124/7 152/23 152/24 157/11 highest [2] 105/19 133/11 highlight [7] 17/7 54/1 65/18 95/21 96/3 105/7 158/9 highlighting [1] 23/24 his [3] 162/21 163/2 164/9 hitherto [1] 75/12 hive [1] 121/17 hoc [1] 70/10 hold [1] 158/10 holding [1] 39/20 home [9] 18/6 28/11 32/15 39/9 61/2 73/19 83/16 142/21 160/9 homes [1] 38/25 honest [1] 80/1 hope [7] 21/4 71/1 93/25 116/8 128/21 139/14 162/1 hopefully [1] 138/4 horse [1] 77/21 hospital [69] 1/14 1/17 2/9 2/10 2/14 3/8 3/15 4/22 5/4 6/3 6/9 8/6 8/20 9/2 9/3 9/3 9/5 15/25 16/23 17/1 19/4 19/8 28/12 32/15	hospitals [22] 9/11 18/21 34/8 34/9 44/6 45/5 68/25 70/16 73/10 98/4 102/14 103/25 108/13 108/14 125/24 129/3 129/6 130/1 130/8 140/11 141/9 141/23 hot [1] 79/1 hour [2] 133/19 133/20 hours [7] 1/23 1/24 2/2 2/12 2/22 3/5 133/24 how [59] 2/2 2/5 4/4 4/17 7/3 7/4 7/18 8/10 8/22 29/11 29/15 29/24 30/7 32/8 32/10 32/11 33/9 34/9 35/4 38/1 38/20 39/5 39/19 44/21 44/24 47/4 55/5 56/25 57/1 64/24 66/19 67/22 68/24 72/9 78/17 79/19 80/4 81/8 84/16 85/1 85/5 85/17 90/22 91/9 98/11 109/8 113/19 114/9 120/22 121/16 121/16 122/18 127/13 130/15 134/13 139/22 157/3 161/5 164/12 however [7] 27/21 73/15 76/1 77/9 88/25 127/5 152/2 HPs [1] 124/17 huge [8] 58/19 60/9 97/19 114/11 114/11 133/5 147/10 154/8 hugely [1] 38/7 Hugh [1] 119/25 human [2] 71/10 71/10 hypoxemic [1] 102/4		
I	I absolutely [2] 39/3 71/12 I agree [3] 24/9 39/14 94/1 I also [2] 2/21 68/3	I am [4] 14/4 68/7 154/23 164/19 I appear [1] 88/17 I appreciate [2] 23/17 43/18 I ask [20] 7/9 8/10 27/9 29/10 34/15 34/23 35/19 38/14 39/23 48/9 59/16 63/22 67/10 74/2 90/20 91/18 94/11 135/5 139/16 156/20 I believe [3] 7/20 42/9 112/10 I can [17] 9/13 29/12 55/25 63/13 67/25 93/12 104/1 106/17 107/6 109/12 112/17 115/17 125/17 129/19 137/18 151/24 158/14 I can't [6] 36/14 106/20 109/10 112/2 155/20 156/2 I cannot [3] 104/15 107/7 107/8 I certainly [1] 96/2 I could [8] 86/24 87/2 87/3 95/18 105/4 118/24 122/25 126/9 I couldn't [2] 5/6 105/2 I did [2] 70/20 105/2 I didn't [3] 3/12 5/3 7/11 I do [15] 11/16 24/16 31/14 34/18 83/11 84/20 107/6 112/3 126/3 147/13 151/24 153/21 156/4 157/16 162/1 I don't [25] 13/9 21/16 25/1 29/8 32/2 35/6 40/13 66/4 70/18 71/3 78/11 80/19 88/21 104/2 107/7 125/6 127/10 130/4 131/7 137/1 138/2 140/3 155/12 156/11 158/13 I explain [1] 31/12 I feared [1] 3/6 I feel [1] 30/12 I felt [1] 2/22 I find [1] 146/3 I first [1] 5/20 I follow [1] 54/10 I genuinely [1] 154/22 I go [1] 145/17 I guess [10] 60/25 84/10 93/9 95/14 96/3 122/21 125/9 128/2 159/22 161/4 I had [8] 3/13 4/19	5/24 7/11 8/1 8/11 17/1 83/6 I happened [1] 108/14 I have [20] 9/13 35/20 51/12 63/14 83/8 88/18 95/16 96/4 102/18 102/24 107/5 119/5 119/12 128/24 130/19 135/14 144/12 144/12 145/11 154/21 I hear [1] 89/21 I heard [1] 3/17 I hope [1] 116/8 I just [11] 9/2 24/13 41/22 43/13 54/20 74/10 75/15 133/11 153/24 155/16 162/11 I know [5] 9/5 17/16 92/10 143/21 148/1 I listened [1] 155/10 I look [1] 103/5 I looked [1] 5/17 I lost [1] 8/3 I may [12] 19/2 25/3 45/21 65/11 72/19 72/20 74/1 121/23 128/4 144/18 146/16 159/6 I mean [4] 24/2 43/1 69/22 143/18 I move [2] 7/21 41/14 I need [1] 147/12 I noted [1] 96/12 I noticed [1] 108/10 I perhaps [1] 43/13 I please [2] 1/4 116/5 I presented [1] 104/24 I presume [1] 89/5 I put [1] 66/5 I really [1] 77/23 I recognise [1] 86/22 I remember [1] 32/23 I represent [4] 86/1 102/23 113/13 148/6 I right [2] 22/23 149/6 I said [3] 41/19 100/6 100/6 I say [2] 118/3 120/25 I see [2] 36/19 63/13 I shall [2] 9/14 56/3 I shan't [4] 147/17 155/2 155/22 156/15 I should [2] 64/3 68/2 I suffer [1] 7/25 I suppose [4] 29/23 120/3 122/25 150/4 I survive [1] 14/5 I suspect [2] 32/6 67/9 I take [4] 5/8 48/25 124/2 128/16 I talked [1] 114/8	

I	94/7 100/9 100/10 100/15 106/17 108/24 113/21 144/13 146/2 147/23 148/3 152/18 154/14 155/20 156/2 156/2 158/13 159/6 161/3 ICNARC [7] 58/23 60/3 62/4 63/11 105/5 105/10 152/22 ICS [1] 153/5 ICU [69] 32/13 33/21 42/4 45/15 45/18 46/14 47/2 47/14 49/24 56/11 56/23 57/5 57/8 57/22 59/4 59/15 59/17 59/20 59/24 60/14 60/17 61/6 61/12 61/20 61/23 62/5 62/18 63/5 63/15 63/16 69/19 70/5 74/24 76/24 82/6 86/10 86/20 87/10 87/25 94/17 94/19 95/2 95/5 95/9 99/25 101/1 101/12 101/18 101/23 102/1 103/4 103/11 103/14 105/20 105/22 106/3 107/3 108/2 109/6 110/1 112/21 118/19 126/24 132/8 132/20 133/11 134/5 148/11 156/12 ICUs [13] 57/24 58/2 73/2 73/6 73/13 103/25 114/24 126/21 127/16 132/14 148/15 152/24 155/5 idea [1] 146/20 ideal [2] 17/5 132/21 Ideally [1] 81/18 ideas [2] 55/16 121/14 identifiable [1] 20/10 identified [1] 19/22 identify [1] 160/5 identifying [2] 82/17 141/13 identity [1] 74/14 if [178] IFF [2] 96/12 153/21 ill [18] 4/19 5/11 5/21 8/1 22/4 56/15 62/7 64/4 64/6 70/2 95/7 95/11 95/22 95/23 98/17 102/17 106/1 137/8 ill-defined [1] 98/17 illness [8] 2/16 15/21 33/2 33/20 67/3 105/14 110/16 131/21 imagine [2] 9/13 115/18 IMCA [2] 27/1 27/2	immense [1] 138/15 impact [29] 7/23 7/25 70/23 71/2 74/8 76/23 113/3 120/8 127/20 127/20 127/24 131/3 131/23 134/18 134/20 135/1 135/8 135/25 137/10 139/20 150/8 151/18 152/17 160/3 162/8 162/17 162/21 163/1 163/5 impacted [3] 39/20 86/4 152/9 impacting [1] 113/17 impaired [3] 68/15 110/16 112/24 impairment [3] 69/12 69/14 70/17 implementation [3] 17/19 41/3 41/4 implemented [5] 12/5 12/7 55/5 89/16 94/15 implications [1] 90/8 importance [2] 37/25 115/7 important [39] 10/20 10/21 11/23 13/7 13/20 16/14 24/14 30/8 31/8 32/5 48/9 48/16 57/15 77/8 78/16 115/4 118/2 118/5 118/8 121/11 124/10 124/18 124/23 125/7 127/15 127/18 129/24 136/13 138/10 138/10 138/12 139/4 140/2 143/15 143/23 146/4 156/12 159/9 164/18 importantly [1] 12/1 impress [1] 80/17 impression [1] 107/10 improve [5] 39/1 92/15 101/9 134/23 134/24 improved [2] 8/22 48/21 improvement [2] 8/24 114/22 improves [1] 94/3 improving [2] 80/25 136/11 inability [3] 65/7 65/10 65/14 inaccurate [1] 126/8 inaccurately [1] 144/3 inadequate [1] 139/10 inadvertently [1] 91/3 inappropriate [6]	23/7 26/15 31/23 64/25 89/3 100/12 inappropriately [1] 49/16 inaudible [1] 88/12 incident [1] 109/2 include [7] 23/17 110/17 118/18 121/6 137/9 155/14 158/1 included [7] 12/16 13/23 119/16 121/8 121/10 121/11 154/16 includes [4] 11/23 15/2 37/9 40/24 including [16] 15/7 15/7 52/15 75/10 75/19 78/15 97/24 111/21 117/21 133/6 142/17 146/22 148/23 150/7 158/17 160/6 incomplete [1] 96/1 incorrect [3] 90/13 95/11 97/8 increase [5] 1/25 101/1 129/2 129/7 131/10 increased [5] 69/21 102/6 106/13 106/14 106/18 increases [3] 56/23 58/19 59/10 incredibly [2] 97/17 160/24 incremental [1] 136/16 incurring [1] 98/10 indeed [12] 19/7 43/22 44/4 53/4 65/7 67/19 68/14 90/2 108/4 125/21 157/7 163/21 independent [3] 27/4 82/13 82/18 independently [1] 82/20 INDEX [1] 165/1 indicate [2] 14/24 162/11 indicated [2] 1/9 108/3 indicates [2] 60/8 154/19 indicating [1] 152/6 indication [1] 20/15 indicative [1] 66/5 indirectly [1] 143/18 individual [16] 3/21 3/24 33/12 73/6 84/14 85/17 94/18 94/24 96/19 98/14 99/7 100/13 103/16 104/16 117/24 153/8 individualised [4] 153/8 153/12 154/18	156/1 industry [2] 143/19 146/11 inelegant [1] 77/22 ineloquently [1] 104/11 inequalities [3] 81/1 84/14 84/18 inevitably [4] 11/1 75/13 110/19 152/16 infarction [2] 60/20 60/23 infarctions [1] 61/5 infected [1] 76/6 infection [3] 4/13 4/16 87/7 influence [2] 125/12 128/22 influencing [1] 46/2 informal [7] 94/20 95/9 98/8 100/4 100/16 103/15 107/2 information [25] 3/10 3/17 4/3 4/6 4/15 12/4 12/11 12/16 15/2 17/4 21/7 21/10 22/1 22/6 28/19 38/11 45/12 98/2 121/15 121/20 121/25 122/5 122/6 159/22 160/23 informed [3] 10/24 92/4 93/14 informing [1] 123/24 initially [5] 70/21 74/12 106/15 138/2 141/6 injury [6] 49/10 68/8 77/10 77/16 97/4 113/15 input [5] 14/10 31/9 51/3 82/21 129/25 INQ000227411 [1] 20/2 INQ000361989 [1] 151/2 INQ000395282 [2] 51/12 153/4 INQ000395297 [1] 132/3 INQ000395299 [1] 143/5 INQ000472300 [1] 116/14 INQ000474255 [1] 56/19 INQ000474302 [1] 116/15 INQ000480136 [1] 100/20 INQ000499523 [2] 64/18 153/25 INQ00474255 [1] 37/19 INQs [1] 162/12
----------	---	--	---	--

I	137/3 137/5 137/20 137/25 138/20 140/16 141/20 142/17 147/4 148/5 149/2 150/2 150/5 150/6 150/25 151/21 152/1 154/24 156/5 156/23 160/7 162/23 intent [7] 118/3 121/23 123/10 129/9 129/25 130/13 130/14 intention [1] 16/15 intentionally [2] 120/4 126/8 interactions [1] 119/23 interest [2] 79/21 99/6 interested [2] 55/7 93/7 interesting [1] 55/20 interests [2] 26/16 32/3 interim [1] 37/20 internally [1] 156/10 interpretation [3] 89/3 89/6 95/13 interpretations [1] 90/6 interpreted [2] 1/9 90/1 interpreter [3] 1/6 12/12 165/2 interrupt [4] 23/14 37/15 119/12 155/17 intervention [1] 39/9 interventions [2] 75/24 76/17 into [53] 10/25 13/1 14/9 14/10 15/8 15/24 15/25 17/1 27/12 29/13 31/9 31/14 32/15 32/23 44/20 46/6 47/19 58/13 59/17 60/5 61/12 61/16 63/15 63/16 68/14 70/1 74/15 76/8 81/6 81/8 81/12 83/22 84/14 85/8 85/17 93/7 96/25 99/25 104/7 105/20 106/11 110/19 112/7 113/8 114/14 115/14 122/5 124/22 136/1 144/3 144/21 148/10 148/10 introduction [1] 129/3 intrusive [1] 23/11 intuitive [1] 76/15 invasive [4] 64/10 66/1 101/3 146/24 invite [2] 120/12 162/9 invites [1] 121/12	involve [1] 15/21 involved [17] 15/13 22/19 26/1 38/2 38/5 41/20 41/21 42/2 50/1 55/11 58/16 79/22 82/22 119/8 119/9 121/21 159/21 involves [1] 52/11 IPC [1] 163/18 Ireland [9] 12/7 17/10 52/6 57/11 117/22 121/9 127/13 157/7 157/10 is [680] ISARIC [1] 62/21 ischaemic [1] 61/13 isn't [11] 1/16 2/14 8/18 12/24 146/1 146/4 148/19 150/20 151/7 151/18 155/23 isolation [2] 15/5 43/10 issue [14] 24/4 68/11 76/1 79/11 91/18 92/6 105/5 126/2 139/23 141/4 141/8 143/11 159/5 161/9 issued [8] 64/1 94/25 103/17 104/13 125/24 128/20 138/21 143/2 issues [6] 40/13 118/13 118/19 123/6 141/24 149/9 it [588] it's [12] 19/24 20/4 25/21 28/17 41/11 45/23 49/17 49/17 79/4 80/1 127/9 154/15 Italy [2] 85/14 120/7 iterations [1] 11/14 its [6] 47/6 52/21 111/25 117/4 135/24 135/24 itself [11] 7/16 12/9 19/17 23/9 39/11 50/6 53/5 89/25 117/10 137/1 162/2	January 2021 [10] 57/9 57/17 58/20 69/16 131/25 132/12 133/2 133/9 134/6 163/20 January/February 2021 [1] 61/8 job [6] 3/6 5/6 5/9 7/10 68/16 70/11 John's [2] 163/24 164/1 Jones [3] 162/14 162/22 163/3 Jones-Charles [1] 162/14 Josh [1] 164/6 journal [2] 139/6 139/6 jump [3] 58/13 58/17 103/6 jumped [1] 57/6 June [2] 17/21 143/2 June 2024 [1] 17/21 just [119] 3/18 4/6 8/11 9/2 11/18 12/8 14/21 14/21 14/22 17/11 18/5 20/3 20/21 23/16 23/19 24/1 24/13 24/15 24/19 24/21 25/4 28/21 30/5 35/20 37/22 38/23 40/14 41/22 43/13 44/12 47/9 50/8 50/17 51/12 53/11 54/7 54/20 56/11 56/20 58/11 60/4 60/8 62/23 66/21 69/5 70/13 70/24 71/17 71/19 71/23 74/10 75/15 76/20 77/18 78/19 78/21 79/17 79/23 83/25 84/25 85/7 87/3 93/10 96/11 98/10 100/8 102/13 103/7 105/4 105/6 105/23 108/9 108/19 110/11 112/15 112/17 115/6 115/11 117/24 118/7 118/17 119/1 120/8 120/23 121/19 122/25 125/17 127/6 129/5 129/16 130/23 132/4 132/16 132/19 133/11 133/18 133/21 135/12 144/13 146/16 147/8 147/25 151/1 151/24 153/24 154/9 155/4 155/16 155/16 157/15 157/22 159/6 160/14 161/9 162/11 162/12 164/18 164/19 164/20 Justice [4] 94/12 102/23 147/24 156/21 Justice Cymru [2]	94/12 156/21 Justice UK [2] 102/23 147/24 justification [1] 82/6
			K	
			KC [6] 88/11 102/21 113/1 113/7 165/13 165/15 keep [5] 28/21 74/21 134/17 152/7 152/12 keeping [1] 40/24 kept [2] 74/19 151/17 Kevin [1] 137/12 key [8] 41/6 128/11 136/19 144/17 144/18 145/9 149/8 149/23 kind [11] 6/18 6/20 6/20 32/10 37/3 40/2 42/16 67/1 70/23 81/10 93/24 kinds [3] 40/12 59/16 68/10 King's [1] 82/20 Kingdom [3] 62/25 64/2 68/7 kit [1] 7/13 kits [1] 7/18 knew [5] 7/5 35/24 66/25 122/10 160/20 know [38] 9/5 11/8 17/5 17/16 19/23 30/16 30/20 34/7 35/6 45/4 49/5 49/7 49/12 49/17 49/21 53/20 70/18 71/3 72/8 78/3 92/10 96/20 98/15 104/2 108/7 127/18 131/7 134/15 134/17 138/12 138/14 143/21 144/21 147/5 148/1 152/19 155/12 157/16 knowing [2] 36/25 50/4 knowledge [8] 11/13 121/3 121/17 123/11 136/19 158/12 159/14 160/10 knowledge-sharing [1] 121/3 known [3] 11/5 11/23 143/13	
			L	
			label [1] 47/16 labelled [1] 111/1 lack [15] 39/18 46/4 65/20 65/25 66/1 66/3 66/3 66/4 72/22 107/3 108/18 155/7 160/6 160/6 160/7 lacking [1] 102/4 Lady [19] 1/4 10/1 24/3 25/4 37/20 55/24	

L	legal [7] 12/25 13/2 23/14 23/25 40/25 91/23 91/24 legalities [1] 10/17 legally [5] 13/5 13/15 25/11 26/7 100/10 Lesley [1] 10/2 less [14] 62/1 62/6 63/14 63/18 63/20 78/19 99/24 106/9 106/11 106/16 106/19 108/16 131/5 143/8 lesser [1] 102/25 lesson [1] 140/2 lessons [3] 78/1 134/12 139/7 let [1] 84/22 let's [3] 12/8 13/10 53/22 letting [1] 79/2 level [31] 33/19 46/6 51/19 54/9 59/7 84/8 85/10 100/25 101/10 101/10 102/6 122/4 124/8 126/7 126/8 127/15 131/19 133/16 133/23 136/21 136/22 136/22 137/15 142/13 143/23 149/7 149/18 149/23 153/17 154/7 157/12 level 1 [1] 136/21 levels [13] 102/7 107/20 141/3 142/24 144/4 146/21 148/21 151/20 152/8 152/13 152/18 152/20 157/11 liaison [2] 34/10 35/11 licensed [1] 144/6 life [14] 11/12 13/21 19/18 23/10 27/17 30/15 39/6 40/1 41/11 80/4 81/24 92/20 92/21 93/16 life-saving [1] 19/18 lift [1] 3/12 like [50] 3/2 6/2 10/9 10/19 11/5 11/15 15/14 16/21 17/14 18/1 18/25 23/12 24/6 24/23 31/18 38/20 41/22 48/15 55/19 56/20 57/12 58/23 61/17 65/11 66/15 68/16 72/20 72/24 72/24 73/21 75/8 75/15 76/19 80/2 80/22 82/2 82/25 89/20 90/4 95/14 114/20 126/24 127/6 144/14 148/18 160/13 161/4 162/7 162/9 163/11	likelihood [1] 63/4 likely [30] 35/9 39/16 47/7 63/7 63/10 63/15 63/18 63/20 67/4 67/13 67/15 79/4 86/20 93/12 94/17 95/6 95/8 98/8 98/8 99/24 100/2 105/20 106/9 106/11 106/16 106/19 107/3 108/16 113/3 113/3 likes [1] 121/14 limitation [3] 89/4 89/11 140/1 limitations [1] 109/19 limited [1] 48/8 line [6] 60/7 62/19 80/23 81/7 89/22 101/7 lines [3] 26/22 61/22 81/15 linked [1] 67/15 list [1] 75/16 listened [1] 155/10 listening [1] 52/14 lists [3] 114/12 114/13 114/15 little [10] 3/2 55/25 72/1 72/3 110/11 112/7 118/15 118/21 124/12 137/6 live [1] 27/25 lives [1] 145/20 living [1] 14/6 local [9] 82/10 84/5 94/20 98/2 98/7 100/25 103/14 103/25 156/8 locate [1] 20/18 location [3] 20/23 141/2 141/16 locations [2] 94/18 103/11 logic [1] 54/15 logo [1] 18/21 London [4] 85/2 108/11 108/13 130/3 long [3] 83/21 116/8 160/20 longer [3] 3/5 3/25 90/24 longitudinal [2] 62/23 105/17 look [48] 10/23 11/17 12/8 14/21 14/22 16/24 17/7 20/3 25/3 44/21 51/10 53/9 53/11 53/21 56/11 58/16 60/7 65/8 65/22 67/16 69/17 82/16 82/20 82/24 82/25 93/7 100/23 103/5 105/2 114/25 115/1 131/20 132/2 132/4	132/5 132/16 140/23 141/2 141/14 141/15 143/5 143/6 144/1 144/22 146/19 151/12 152/20 160/3 looked [18] 5/17 5/19 21/18 29/9 44/3 44/4 50/25 53/13 54/7 59/10 62/4 97/13 126/24 127/6 132/15 138/20 146/14 153/22 looking [20] 11/22 12/2 23/16 28/6 36/13 50/2 61/10 63/12 68/24 78/9 84/13 104/5 109/14 129/10 129/19 133/23 136/4 143/14 144/20 161/4 looks [7] 57/12 60/8 64/22 65/5 65/16 66/21 67/19 looping [1] 51/22 lose [1] 5/9 losing [1] 3/6 lost [2] 8/3 91/4 lot [18] 8/2 8/3 39/10 56/12 59/14 78/2 85/11 108/11 109/14 112/15 120/21 132/19 140/19 143/22 146/13 148/1 148/2 156/24 lots [3] 121/11 121/14 136/1 love [1] 31/6 loved [27] 22/16 22/24 23/6 23/25 24/22 26/6 26/12 29/18 29/25 30/2 30/7 30/14 30/20 31/19 32/4 32/9 32/14 32/21 33/10 33/24 35/22 35/25 89/20 90/23 91/1 91/2 113/21 low [1] 19/5 lower [6] 62/11 82/7 85/14 96/15 131/18 146/21 lunch [1] 115/14 Luncheon [1] 116/2	36/24 37/1 37/4 46/16 50/14 59/12 66/7 77/7 90/3 91/16 98/9 99/6 100/4 109/3 109/8 110/8 111/2 112/4 128/21 131/5 138/3 139/2 142/10 148/4 149/1 151/5 158/7 main [2] 117/4 157/18 mainly [1] 6/25 maintain [1] 133/8 major [1] 109/2 make [37] 3/11 11/19 13/11 23/22 25/5 25/17 31/1 31/6 31/25 33/6 41/23 44/16 47/20 47/23 54/22 55/10 56/13 58/6 59/18 60/16 65/2 70/14 70/25 72/14 74/6 76/15 84/18 90/2 96/24 97/3 98/17 98/20 113/24 123/14 136/16 143/20 149/5 makers [1] 157/18 makes [5] 28/1 45/14 72/4 114/2 153/5 making [31] 10/25 12/19 25/21 33/23 41/11 46/3 46/7 48/17 52/20 54/2 77/6 79/21 83/9 91/20 94/24 96/23 99/5 99/20 100/4 103/16 104/12 104/16 111/15 111/21 123/24 127/24 146/2 148/3 153/13 157/12 158/19 malignancy [1] 93/16 manage [4] 5/15 48/24 130/7 150/3 managed [3] 101/17 142/16 149/22 management [5] 3/15 5/4 8/6 28/18 119/5 managing [1] 152/12 manufactured [1] 140/10 manufacturer [1] 147/12 manufacturer's [1] 145/24 manufacturers [4] 143/22 145/23 146/7 146/14 manufacturing [1] 144/2 many [27] 2/2 2/5 2/17 7/18 7/20 18/10 51/6 58/14 68/12 70/4 75/11 76/16 82/3 93/23 101/22 102/14
			M	
			M3 [6] 1/4 1/7 1/11 163/6 163/13 165/4 M3/W2 [1] 163/6 M3/W3 [1] 163/13 M3/WI [4] 1/4 1/7 1/11 165/4 machines [1] 122/12 MacNamara [1] 96/4 made [43] 8/10 10/8 21/13 21/14 22/11 24/9 28/25 29/2 31/2 31/17 31/24 34/3 34/4 34/14 35/15 35/16	

M	162/11 164/13 164/14	97/1 117/10 120/14	model [3] 11/19	Mr Fireman [1] 116/4
many... [11] 114/7	maybe [5] 33/23 37/2	121/21 160/4 164/7	42/24 151/10	Mr Jacobs [3] 83/20
119/10 125/8 127/7	107/21 131/8 147/12	mental [12] 7/22 7/24	models [4] 73/9	85/21 147/15
130/22 146/19 149/16	McDermott [2]	69/9 69/14 77/6 77/19	131/1 131/24 151/22	Mr Miller [1] 164/8
149/22 150/2 159/21	163/18 163/21	112/21 113/1 113/17	modified [2] 48/21	Mr Mills [1] 1/3
160/5	me [11] 8/13 14/8	118/19 163/15 164/3	161/11	Mr Odogwu [1] 85/23
mapped [1] 132/17	19/13 60/15 63/14	mention [2] 24/25	MODULE [3] 9/22	Mr Weatherby [3]
March [12] 41/16	71/6 71/14 83/21	115/7	96/9 165/10	147/21 154/12 156/17
42/22 50/22 51/15	95/17 104/19 107/10	mentioned [1] 105/8	Module 2 [1] 96/9	Mrs [2] 10/2 162/14
53/7 62/25 109/18	mean [12] 24/2 43/1	message [2] 57/15	moment [7] 16/25	Mrs Carla [1] 162/14
116/13 148/20 149/21	64/13 69/22 86/25	115/10	17/8 71/6 73/16 84/2	Mrs Lesley [1] 10/2
155/6 155/18	94/5 103/22 105/3	met [3] 30/21 33/13	131/14 148/9	MS [21] 1/6 9/24 88/9
March 2020 [2] 41/16	105/4 143/18 153/15	69/8	monitor [2] 102/6	88/11 94/8 94/9 94/10
51/15	156/11	microphone [3]	142/22	102/20 102/21 113/1
March 2021 [2]	meaningful [1] 144/8	83/22 88/14 154/12	Montgomery [1]	113/7 156/18 156/19
148/20 149/21	means [16] 19/11	Microsoft [1] 121/14	119/25	161/15 163/19 164/9
marker [2] 110/13	35/8 39/7 48/23 49/8	mid [1] 56/1	month [2] 60/6 63/6	165/2 165/13 165/14
142/24	49/9 76/5 81/13 81/14	mid-morning [1] 56/1	Moore [1] 10/2	165/15 165/20
markers [1] 69/14	87/1 95/5 105/4	middle [1] 49/11	moot [1] 72/13	Ms Carey [3] 9/24
market [1] 146/8	117/11 140/5 141/10	midst [1] 138/24	moral [11] 49/9 50/13	113/1 113/7
mask [4] 6/5 6/5 6/7	158/21	midwifery [1] 162/16	52/23 68/8 77/16	Ms Higgins [1]
6/13	meant [13] 47/5	midwives [1] 162/17	79/22 97/4 107/22	163/19
masks [1] 6/21	78/25 88/24 90/19	might [50] 11/7 13/21	113/15 113/15 145/3	Ms Mitchell [2] 88/9
massive [1] 148/4	95/1 97/6 126/23	13/23 14/1 14/2 16/6	morbidity [1] 106/11	94/8
matched [1] 84/5	127/6 131/4 135/21	19/14 20/16 22/3 42/7	more [61] 2/10 2/11	Ms Munroe [1]
matching [1] 82/10	135/21 150/9 157/13	43/12 44/13 44/18	6/23 39/14 39/16	102/20
material [1] 164/18	meantime [1] 99/20	48/13 55/2 55/14 56/1	39/23 43/13 45/2	Ms Patel [1] 164/9
Mathieu [10] 116/5	measure [2] 82/4	61/4 63/21 67/7 73/16	53/23 58/2 63/7 63/10	Ms Woodward [2]
116/6 116/11 116/12	125/19	79/16 80/5 84/10 85/2	63/16 67/4 67/7 69/7	156/18 161/15
116/16 118/10 144/10	measured [2] 125/21	89/21 90/2 93/7 93/23	74/5 76/15 77/11 79/4	much [49] 7/15 7/16
145/18 161/17 165/16	125/21	94/4 95/1 96/15 98/20	82/8 82/8 84/20 86/17	8/25 9/8 27/24 31/7
matrix [1] 40/22	measurements [1]	98/21 102/9 104/7	86/20 97/11 100/19	36/23 43/6 44/24 51/3
matter [5] 81/8	143/8	110/23 124/25 130/2	101/22 104/7 109/14	71/10 81/8 81/23 83/5
108/22 109/5 145/1	measures [8] 87/25	130/12 140/12 141/16	111/23 112/7 112/15	85/1 85/1 85/5 85/20
162/6	88/4 98/6 110/17	142/9 142/10 142/24	112/18 114/24 118/15	86/22 88/7 88/8
matters [2] 100/12	111/10 129/2 141/25	145/20 147/11 149/4	118/21 120/21 121/20	102/19 107/15 113/20
163/22	163/19	150/10 160/25	123/8 124/12 125/1	115/13 118/4 120/4
maximum [1] 27/17	measuring [1]	military [1] 121/12	126/24 127/21 128/25	120/11 120/12 121/15
may [85] 1/4 10/15	145/22	Miller [2] 164/6 164/8	131/2 131/2 135/19	128/20 128/25 138/8
10/18 13/2 13/7 13/18	mechanical [3] 13/25	million [1] 72/1	138/11 140/14 142/12	140/14 145/14 147/19
15/21 15/23 15/25	64/11 66/1	Mills [1] 1/3	144/25 146/24 147/1	147/20 150/1 156/6
16/22 18/4 19/2 20/11	mechanism [1]	mind [4] 33/8 43/6	149/17 152/13 153/23	156/16 157/7 158/19
20/13 21/13 21/19	138/15	80/19 129/17	155/2 155/4 157/12	158/22 160/13 160/22
22/9 22/21 25/3 25/25	media [1] 126/7	minimum [1] 78/4	158/23	161/13 161/17 161/21
27/15 27/19 27/22	median [1] 85/9	ministers [1] 124/8	morning [8] 1/11 2/4	164/21
27/24 28/3 33/4 34/3	medical [14] 12/1	minority [9] 86/2	56/1 70/19 118/10	multi [7] 117/3 117/7
36/9 36/12 36/12	22/10 34/13 39/11	86/3 86/15 86/19 87/7	125/16 137/23 153/23	117/13 124/15 125/13
36/22 36/24 45/21	40/6 40/6 40/7 41/18	87/10 87/18 87/23	mortality [7] 87/7	129/13 129/22
46/8 47/8 47/8 48/14	42/20 49/22 50/23	163/14	101/17 105/19 106/12	multi-professional
48/20 50/6 51/24	89/6 121/10 128/10	minute [1] 76/20	106/14 106/18 152/23	[4] 117/3 117/7
55/13 61/25 62/21	medicine [3] 120/19	misinterpretation [1]	most [9] 32/12 59/9	124/15 125/13
63/21 64/8 64/11	120/19 162/24	89/13	91/6 91/11 105/14	multi-professionals
65/11 66/8 71/6 72/19	meet [1] 127/22	misinterpreting [1]	112/16 150/4 150/11	[1] 117/13
72/20 74/1 75/11	meeting [3] 29/24	110/9	154/9	multidisciplinary [3]
75/20 77/21 83/7	32/10 55/6	misrepresentation	move [2] 7/21 41/14	58/21 59/6 75/23
89/11 92/13 92/22	meetings [5] 50/16	[1] 90/7	moving [7] 55/24	multiple [1] 99/11
93/2 93/5 93/6 93/17	120/23 121/1 121/2	misunderstanding	74/15 78/24 90/20	multitude [1] 39/2
94/1 94/4 95/19 96/7	122/24	[1] 90/18	131/4 153/1 156/11	Munroe [4] 102/20
97/8 105/21 107/16	member [8] 36/4	misuse [1] 69/13	Mr [16] 1/3 83/20	102/21 102/22 165/15
111/1 116/5 118/12	58/11 119/12 162/15	Mitchell [4] 88/9	83/23 85/21 85/23	must [6] 21/1 23/23
121/23 128/4 130/14	162/19 162/22 163/3	88/11 94/8 165/13	85/24 116/4 147/15	24/8 25/19 28/23
136/9 138/5 144/18	163/10	mix [1] 131/19	147/21 147/22 154/12	147/10
146/16 158/1 159/6	members [11] 39/16	mixes [1] 135/18	156/17 164/8 165/11	mutual [9] 43/9 43/25
	40/23 55/7 58/18 68/6	mobility [1] 110/18	165/12 165/19	45/5 52/16 53/1

M	157/21 158/15 158/16 159/4 159/14 159/21 nations' [1] 41/4 natural [1] 92/22 nature [5] 11/1 15/20 40/11 63/24 141/4 navigate [2] 122/18 124/12 near [2] 117/12 127/19 nearing [1] 11/12 nearly [1] 64/21 neat [1] 60/1 NECCC [5] 119/18 119/20 122/5 122/24 124/14 necessarily [19] 24/8 24/17 24/18 44/25 59/13 64/13 66/9 76/13 77/19 91/13 93/23 123/3 125/6 131/10 135/17 140/3 140/25 141/16 157/19 necessary [8] 22/19 48/22 51/22 54/14 91/14 92/22 126/2 134/7 necessity [1] 149/5 need [47] 12/12 16/22 27/24 29/8 30/10 38/12 42/7 50/2 53/4 54/22 66/4 81/18 81/25 82/17 84/6 84/15 88/21 96/18 107/17 110/21 110/21 110/23 114/6 114/13 118/6 129/22 129/23 131/9 131/22 133/13 133/24 135/6 136/4 136/11 136/17 138/2 139/8 139/14 140/12 142/12 143/11 146/6 147/12 151/23 153/3 158/20 159/10 needed [22] 5/7 12/14 43/12 51/1 57/24 74/23 78/6 97/10 97/12 97/21 114/12 132/25 133/6 134/3 134/11 134/11 139/3 139/4 150/9 151/12 159/16 160/14 needing [2] 46/12 141/3 needs [8] 19/16 37/6 46/6 82/11 84/5 84/23 85/6 159/8 negative [5] 5/5 5/8 151/17 152/4 152/16 negatively [3] 113/3 113/17 152/9 neighbouring [2] 43/20 43/22 net [1] 36/10	network [3] 52/5 99/17 163/1 Networks [2] 52/6 120/15 never [10] 33/8 33/11 46/18 69/25 72/16 94/15 113/8 129/17 138/5 139/14 new [9] 4/9 11/21 18/12 55/24 55/25 132/14 136/1 141/23 151/4 next [20] 9/14 10/1 26/1 44/17 46/22 47/4 48/3 49/8 71/25 79/3 82/5 83/20 85/22 88/9 100/18 101/7 105/9 154/6 158/3 160/1 NHS [18] 9/3 9/4 18/20 42/25 43/3 45/3 51/19 57/10 70/25 82/14 82/14 87/13 87/14 87/20 97/16 147/10 162/16 163/7 NHS England [4] 45/3 57/10 82/14 97/16 NHSE [2] 40/3 121/10 NICE [6] 42/6 109/16 109/17 109/21 111/3 112/2 night [1] 49/12 Nightingale [5] 129/3 129/6 130/1 130/13 130/15 no [66] 2/23 3/3 3/4 3/10 3/25 3/25 4/3 4/6 4/15 4/15 4/15 5/1 5/13 6/15 6/24 7/5 7/11 8/8 14/3 22/18 24/21 26/18 28/24 31/23 34/2 34/21 35/23 37/16 42/12 43/1 43/15 43/20 43/21 44/7 45/15 47/16 47/18 47/25 49/1 49/3 52/12 56/2 61/24 63/25 66/6 66/15 66/21 69/22 76/5 84/24 87/1 90/24 91/22 92/10 99/25 101/16 104/11 105/11 113/7 114/9 114/16 116/9 121/1 140/1 145/12 146/10 nobody [3] 4/23 6/24 52/20 nodding [1] 71/11 non [6] 29/10 34/10 54/24 86/9 101/3 128/18 non-critical [2] 34/10 86/9	non-invasive [1] 101/3 non-pandemic [3] 29/10 54/24 128/18 none [2] 128/5 128/7 19/15 nonhierarchical [1] 120/11 noninvasive [1] 142/25 nor [2] 31/5 47/21 NORA [2] 1/6 165/2 norm [1] 151/5 normal [5] 1/20 36/11 41/11 80/8 101/2 normalising [1] 37/10 normally [3] 30/1 95/25 109/7 Northern [9] 12/7 17/10 52/6 57/11 117/22 121/9 127/13 157/7 157/10 Northwick [1] 44/5 not [232] notable [1] 101/21 note [4] 103/10 105/9 112/3 142/15 noted [2] 84/6 96/12 notes [3] 20/8 20/18 112/4 nothing [4] 5/1 26/5 87/17 145/23 notice [8] 21/13 23/3 31/24 35/5 35/22 38/9 88/24 92/1 noticed [1] 108/10 notices [3] 36/1 83/16 88/21 notified [1] 45/4 notional [2] 45/24 46/7 notwithstanding [1] 94/14 novel [1] 81/15 November [1] 69/7 now [38] 5/25 8/19 11/9 11/14 14/4 18/20 19/11 21/12 29/9 32/6 35/3 39/22 41/19 43/18 44/20 50/19 59/10 61/18 63/21 88/15 88/16 89/5 106/14 107/21 109/7 111/7 114/22 114/24 119/13 128/25 131/13 138/25 138/25 143/4 144/13 149/4 150/24 156/24 Nuffield [1] 82/19 number [31] 29/2 33/18 33/18 34/22	35/21 36/13 39/23 44/5 47/3 58/4 58/20 59/23 60/2 60/9 61/14 66/7 70/2 77/25 79/3 84/12 84/20 85/9 95/7 95/10 123/17 134/23 144/11 145/4 148/23 151/12 155/13 numbers [9] 43/8 44/4 45/25 66/11 72/16 133/20 136/19 149/12 149/24 numerical [2] 47/10 73/1 numerically [2] 73/7 73/21 nurse [9] 8/12 64/23 65/19 76/25 78/10 133/22 133/23 163/6 164/2 nurses [18] 65/1 65/6 65/9 65/13 65/22 66/12 67/12 67/17 68/9 70/12 124/16 132/20 132/20 133/7 133/25 148/24 154/11 154/15 nursing [6] 28/11 38/24 58/15 79/5 102/8 150/8 nuts [1] 29/23
N	name [3] 9/3 102/22 116/10 names [1] 162/12 nasal [2] 101/4 101/10 Nathalie [2] 163/18 163/21 Nathalie McDermott [1] 163/21 nation [2] 92/10 111/13 national [25] 42/20 44/11 44/15 49/16 50/23 51/19 52/5 61/25 72/15 94/13 96/25 97/22 99/8 103/23 119/16 119/20 122/1 123/24 124/1 139/9 153/17 156/8 157/24 157/24 163/11 nationally [3] 46/11 96/22 128/17 nations [26] 17/18 17/25 18/2 25/14 42/19 45/11 56/22 62/24 85/4 85/18 85/19 86/25 92/5 97/3 97/24 99/3 99/10 104/17 107/19 117/19			O
				o'clock [2] 2/3 164/21 oaths [1] 10/7 objective [3] 52/9 82/4 84/4 obligation [1] 8/1 obliged [2] 2/11 94/7 observations [2] 103/22 105/25 observed [1] 20/13 obtain [1] 158/7 obvious [2] 41/22 149/4 obviously [31] 12/10 15/21 18/3 21/8 22/1 34/3 37/3 39/9 45/10 49/25 51/14 73/18 74/3 75/3 90/17 91/1 112/15 112/21 115/17 118/12 123/13 124/6 129/11 135/25 138/21 150/8 150/10 155/3 159/8 159/9 161/18 occasion [1] 91/1 occupancy [6] 126/13 127/4 128/3 132/7 133/11 158/19 occupational [3] 58/19 87/12 87/20 occupied [4] 56/23 57/5 132/8 132/13

<p>O</p> <p>occurred [1] 68/8</p> <p>October [2] 1/1 164/24</p> <p>Odogwu [3] 85/23 85/24 165/12</p> <p>OECD [4] 84/11 85/7 85/12 85/19</p> <p>off [9] 14/4 47/23 49/17 55/19 64/1 69/25 100/17 113/8 150/7</p> <p>offer [3] 22/22 120/13 136/10</p> <p>offered [1] 22/12</p> <p>Officer [1] 41/18</p> <p>officially [1] 103/24</p> <p>offs [1] 139/21</p> <p>offset [1] 113/20</p> <p>often [20] 19/21 23/11 29/17 30/19 32/13 32/16 32/21 32/23 39/8 39/23 70/8 71/21 73/2 86/17 95/4 95/23 124/12 136/9 137/8 142/5</p> <p>Oh [2] 36/19 155/19</p> <p>OHRENSTEIN [2] 1/6 165/2</p> <p>okay [10] 3/3 10/14 17/9 21/12 71/24 71/25 72/18 80/14 87/5 132/24</p> <p>old [2] 106/3 141/10</p> <p>older [12] 60/17 61/10 61/18 62/16 63/14 63/18 63/23 99/24 105/19 106/10 111/5 153/1</p> <p>on [222]</p> <p>on behalf [1] 88/18</p> <p>once [4] 10/5 20/15 30/11 45/2</p> <p>one [105] 2/8 4/12 8/12 11/7 11/15 15/3 15/8 18/6 18/10 18/19 19/25 20/4 22/16 23/6 24/15 24/15 24/16 24/19 24/22 25/25 26/6 26/12 26/12 29/11 29/24 30/7 32/12 33/25 35/3 35/4 35/25 41/20 43/15 45/2 46/13 47/3 48/18 48/19 49/5 53/13 57/22 58/11 60/4 60/8 62/3 62/12 63/1 64/22 65/5 65/16 65/20 66/21 67/19 69/6 69/9 69/22 70/22 72/1 79/9 80/17 83/25 84/13 84/17 84/24 87/21 89/21 90/2 95/13</p>	<p>103/4 107/21 110/22 112/3 112/7 113/7 114/21 115/8 120/1 122/10 122/21 123/19 124/23 125/18 128/1 129/2 130/20 130/21 133/21 133/22 134/12 135/4 137/11 138/3 139/7 142/15 144/19 145/10 146/18 148/25 151/24 153/23 155/4 157/22 160/17 162/6 164/18</p> <p>one's [1] 35/23</p> <p>ones [21] 16/22 16/23 22/25 23/25 24/23 29/18 30/1 30/2 30/14 30/20 31/19 32/4 32/9 32/14 32/21 33/10 90/23 91/1 91/3 113/21 140/14</p> <p>ongoing [6] 68/11 77/10 77/16 78/4 119/10 143/14</p> <p>only [34] 6/5 6/24 11/16 13/8 14/7 19/9 19/19 35/21 37/10 45/1 49/18 50/8 50/9 54/8 54/12 60/22 61/11 68/7 71/17 82/9 89/10 97/1 115/8 115/17 118/5 128/9 130/12 131/4 134/22 148/8 149/25 152/12 153/16 164/14</p> <p>onto [4] 14/12 71/14 132/17 146/8</p> <p>onwards [1] 68/19</p> <p>open [6] 39/14 55/4 80/10 111/16 120/12 130/12</p> <p>opened [2] 120/14 120/16</p> <p>opening [1] 120/18</p> <p>openly [2] 51/2 54/16</p> <p>operate [3] 44/9 45/1 46/12</p> <p>operating [4] 17/14 70/8 70/9 103/25</p> <p>operational [3] 43/12 112/1 120/15</p> <p>opinion [2] 31/20 55/5</p> <p>opportunities [4] 126/17 136/24 144/20 145/9</p> <p>opportunity [5] 31/8 80/1 89/19 93/5 144/6</p> <p>opposed [2] 104/19 127/13</p> <p>opposite [1] 73/9</p> <p>option [3] 89/4 156/9 156/14</p> <p>options [5] 15/13</p>	<p>92/4 122/13 129/14 136/10</p> <p>or [174]</p> <p>oral [3] 161/20 164/17 164/20</p> <p>orange [1] 7/6</p> <p>order [6] 54/17 90/11 97/2 133/7 133/15 152/3</p> <p>ordinarily [10] 15/15 33/18 58/10 58/10 59/3 60/4 62/13 102/3 135/9 137/5</p> <p>organ [2] 13/18 146/23</p> <p>organisation [6] 24/16 62/20 75/2 119/6 124/15 135/13</p> <p>organisational [1] 157/9</p> <p>organisations [13] 41/5 74/15 86/2 117/21 118/8 120/6 121/5 121/6 122/16 124/9 125/7 125/9 131/6</p> <p>organised [2] 34/9 68/1</p> <p>organs [1] 129/13</p> <p>original [1] 52/15</p> <p>originally [3] 51/7 78/22 163/7</p> <p>other [91] 6/13 12/21 13/3 15/21 23/12 24/14 25/19 25/22 28/25 29/5 29/7 32/10 34/5 35/17 35/17 36/12 36/22 39/23 40/9 40/13 42/23 43/20 44/5 44/7 44/15 45/5 45/11 45/12 51/6 55/9 58/16 66/17 68/1 69/13 70/14 73/3 73/22 74/15 75/5 77/6 79/8 79/13 81/1 82/12 82/14 87/14 88/5 89/2 89/19 89/23 90/1 93/12 96/3 104/24 110/1 110/14 111/6 111/10 112/10 115/3 117/21 118/8 119/24 119/24 120/6 120/7 120/16 120/22 121/11 122/15 124/17 125/7 128/4 129/24 130/22 131/18 134/21 134/25 135/6 135/13 140/11 140/15 146/22 148/23 149/23 150/7 153/11 156/12 158/15 159/2 163/21</p> <p>others [8] 38/6 47/24 58/23 73/13 73/14 80/14 122/7 146/19</p>	<p>otherwise [6] 1/9 61/4 81/13 94/5 125/1 152/8</p> <p>ought [3] 26/6 26/18 35/16</p> <p>our [45] 4/8 10/16 32/14 36/6 36/15 40/11 56/1 72/8 72/11 81/2 81/6 81/12 83/18 102/11 110/4 117/6 117/6 117/14 117/18 118/6 119/22 119/22 119/23 119/23 120/14 121/4 123/15 124/7 124/13 124/21 126/13 128/15 128/21 129/14 130/8 139/5 142/4 142/5 142/13 143/16 143/21 144/21 146/6 151/9 156/10</p> <p>ours [2] 7/8 111/3</p> <p>ourselves [9] 5/7 6/6 6/6 6/8 6/8 6/19 7/6 49/23 55/22</p> <p>out [48] 10/16 11/16 17/10 18/15 29/17 35/1 35/22 40/7 46/21 47/14 51/24 61/20 64/3 64/5 66/13 68/13 73/10 75/16 77/25 79/9 80/14 90/22 94/22 95/6 95/18 95/24 99/20 100/24 107/8 108/13 110/6 112/14 122/20 123/17 125/7 132/24 133/18 141/18 144/15 147/8 151/1 151/24 152/6 153/5 153/14 157/6 159/15 163/22</p> <p>outcome [1] 42/18</p> <p>outcomes [9] 11/5 11/25 14/3 33/20 72/5 72/13 151/18 152/4 152/8</p> <p>outline [1] 162/12</p> <p>outlined [1] 86/24</p> <p>outpatient [1] 35/11</p> <p>outside [15] 6/9 11/7 13/10 19/4 52/25 59/14 59/20 79/6 83/11 83/18 95/4 102/15 128/6 158/2 159/5</p> <p>outsourced [4] 1/18 4/25 6/2 8/6</p> <p>over [22] 16/21 32/9 32/22 32/25 33/15 46/13 46/23 54/12 62/23 69/6 73/3 74/7 86/19 89/3 89/6 90/1 90/6 109/23 115/14 127/19 145/18 148/15</p> <p>over-interpretation [2] 89/3 89/6</p>	<p>over-interpretations [1] 90/6</p> <p>over-interpreted [1] 90/1</p> <p>overall [4] 33/20 95/7 95/10 107/10</p> <p>overarching [1] 17/15</p> <p>overflowing [1] 49/24</p> <p>oversight [2] 55/2 55/3</p> <p>overspeaking [3] 36/20 44/1 152/21</p> <p>overwhelmed [7] 80/6 94/18 103/11 108/12 111/11 111/22 139/9</p> <p>own [14] 2/25 11/4 21/20 49/11 50/4 52/21 72/11 73/19 128/24 130/8 131/6 135/24 135/24 160/8</p> <p>Oxford [1] 55/16</p> <p>oximeter [1] 142/19</p> <p>oximeters [4] 142/18 143/8 145/17 147/5</p> <p>oximetry [2] 143/3 143/16</p> <p>oxygen [26] 65/21 101/4 101/11 102/4 102/7 139/17 139/19 139/24 140/1 140/6 140/12 140/17 141/1 141/3 141/7 141/8 141/17 142/5 142/13 142/16 142/24 143/1 144/4 145/10 145/22 146/20</p> <p>oxygens [1] 142/22</p> <hr/> <p>P</p> <p>pace [3] 10/18 119/21 120/25</p> <p>package [2] 58/22 81/3</p> <p>page [23] 15/10 20/4 51/21 52/21 53/11 53/21 56/16 58/8 65/16 66/14 66/21 67/10 67/20 100/24 101/7 103/8 105/9 105/16 132/3 151/25 153/4 153/23 153/25</p> <p>page 11 [1] 53/21</p> <p>page 12 [1] 53/11</p> <p>page 19 [2] 65/16 66/14</p> <p>page 2 [1] 15/10</p> <p>page 22 [1] 66/21</p> <p>page 24 [1] 153/25</p> <p>page 32 [1] 151/25</p> <p>page 33 [1] 67/10</p> <p>page 5 [1] 153/4</p>
--	--	--	--	--

<p>P</p> <p>page 60 [1] 56/16</p> <p>page 61 [2] 58/8 103/8</p> <p>page 64 [1] 105/9</p> <p>pages [3] 53/13 53/17 109/16</p> <p>pages 1 [2] 53/13 53/17</p> <p>pages 45 [1] 109/16</p> <p>paid [1] 5/23</p> <p>painfully [1] 68/7</p> <p>paint [1] 155/24</p> <p>paired [1] 111/9</p> <p>pairing [1] 43/11</p> <p>palpable [1] 135/13</p> <p>pandemic [104] 1/13 1/21 1/22 1/24 2/8 2/10 2/19 5/16 7/14 7/15 7/16 7/24 8/16 9/10 10/22 11/7 13/11 29/10 29/14 32/6 32/13 34/6 38/16 38/21 38/25 41/10 43/7 46/20 49/1 52/11 53/5 54/24 56/12 56/16 58/11 60/8 60/17 67/15 68/10 73/18 74/9 74/14 77/2 78/6 78/7 78/13 78/21 78/25 81/4 81/5 81/13 82/7 83/3 84/9 85/8 86/4 86/10 86/14 98/15 99/11 102/13 113/2 114/14 114/15 118/23 119/6 119/11 119/11 126/16 127/14 128/18 128/19 129/10 133/10 133/15 134/3 134/4 135/4 136/15 139/1 139/19 140/2 140/4 142/12 144/22 145/1 145/5 148/9 148/10 148/20 151/2 151/6 152/5 152/5 154/4 160/3 160/18 162/21 163/4 163/23 164/2 164/4 164/10 164/12</p> <p>pandemics [3] 79/6 84/23 134/4</p> <p>Panesar [1] 163/9</p> <p>paper [3] 19/21 55/15 62/9</p> <p>paragraph [28] 10/13 44/22 59/17 62/8 72/25 75/17 86/8 88/22 94/15 101/13 103/7 103/8 103/10 104/5 104/10 105/8 105/9 105/17 106/22 108/20 109/17 112/20 123/22 125/23 148/14</p>	<p>158/4 158/9 160/2</p> <p>paragraph 108 [1] 109/17</p> <p>paragraph 110 [1] 44/22</p> <p>paragraph 128 [1] 148/14</p> <p>paragraph 129 [1] 125/23</p> <p>paragraph 156 [2] 94/15 103/8</p> <p>paragraph 158 [1] 59/17</p> <p>paragraph 161 [2] 62/8 105/8</p> <p>paragraph 163 [1] 106/22</p> <p>paragraph 164 [1] 105/17</p> <p>paragraph 199 [1] 72/25</p> <p>paragraph 210 [1] 75/17</p> <p>paragraph 32 [1] 86/8</p> <p>paragraph 55 [1] 112/20</p> <p>paragraph 75 [1] 158/4</p> <p>paragraph 94 [1] 160/2</p> <p>parcel [1] 36/21</p> <p>Park [1] 44/5</p> <p>Parliamentarians [1] 157/18</p> <p>Parry [1] 162/22</p> <p>Parry-Jones [1] 162/22</p> <p>part [41] 14/13 15/7 16/19 21/8 24/12 27/23 36/21 37/9 37/12 40/5 40/16 40/20 41/3 41/6 43/6 47/14 50/18 59/5 69/6 74/11 86/18 89/16 91/6 109/18 110/22 111/15 112/9 112/16 115/2 115/6 115/9 123/13 124/6 125/1 127/2 137/17 144/5 147/7 149/9 164/17 164/18</p> <p>participants [1] 10/4</p> <p>participate [1] 29/21</p> <p>participated [2] 68/3 69/1</p> <p>particular [19] 13/7 19/13 20/9 24/15 31/16 50/1 76/8 84/15 87/22 87/24 92/18 92/23 95/17 95/18 104/19 108/19 108/24 139/18 144/14</p> <p>particularly [16]</p>	<p>10/21 48/13 55/8 67/13 68/9 69/18 72/1 73/17 75/23 76/10 78/10 92/6 120/7 125/12 131/24 139/20</p> <p>parties [1] 99/15</p> <p>partly [4] 27/13 39/1 73/13 92/16</p> <p>partner [4] 5/18 6/16 7/2 117/21</p> <p>partners [1] 125/8</p> <p>parts [7] 12/6 29/8 32/13 73/3 88/5 89/16 105/7</p> <p>pass [1] 104/7</p> <p>passage [1] 132/2</p> <p>passed [2] 21/10 98/2</p> <p>Patel [2] 164/7 164/9</p> <p>path [1] 105/18</p> <p>pathogen [1] 129/13</p> <p>paths [1] 62/23</p> <p>patience [1] 115/22</p> <p>patient [64] 3/23 3/25 4/1 12/17 14/18 16/3 16/17 19/13 20/12 20/17 20/21 22/16 22/24 23/5 23/15 23/18 23/21 24/1 24/6 24/11 25/5 26/2 26/10 26/17 26/20 26/20 26/25 27/14 28/6 28/9 28/13 28/19 29/19 30/14 30/21 31/11 36/2 36/3 42/2 46/13 59/4 63/5 76/6 76/17 92/3 93/13 93/18 93/24 94/3 98/14 100/13 101/9 101/25 102/7 133/23 134/19 135/23 141/22 142/16 151/18 152/4 152/8 153/7 160/11</p> <p>patient's [16] 10/24 11/3 11/24 12/10 20/8 21/1 25/23 26/5 26/15 29/15 29/18 31/19 32/21 39/10 92/12 92/14</p> <p>patient/carer [1] 28/9</p> <p>patients [77] 3/9 3/16 32/14 33/19 34/25 36/7 36/13 37/11 37/13 42/6 44/6 46/25 49/13 52/8 56/15 58/12 58/14 58/20 58/22 62/10 62/16 70/3 72/5 72/8 76/12 77/11 86/11 89/7 90/8 93/21 95/7 95/11 97/1 98/19 99/7 101/2 101/17 101/22 102/4 105/12 105/20 105/21 106/1 107/24 109/25</p>	<p>113/4 113/17 115/2 117/5 118/6 126/12 127/21 128/9 131/20 134/17 137/8 137/8 137/10 140/24 141/2 141/14 141/16 141/18 141/20 142/12 142/21 143/9 144/1 144/8 144/23 146/17 151/12 152/21 158/7 160/4 161/8 163/14</p> <p>pattern [1] 79/4</p> <p>patterns [2] 70/17 82/11</p> <p>pause [6] 14/21 19/25 48/25 51/10 114/16 122/25</p> <p>pausing [2] 31/17 69/5</p> <p>pay [4] 2/25 5/12 5/13 72/6</p> <p>payment [1] 8/24</p> <p>PBPOs [1] 163/3</p> <p>peace [1] 123/25</p> <p>peaceful [1] 38/13</p> <p>peacetime [1] 150/18</p> <p>peak [12] 61/7 62/11 63/12 63/15 69/3 69/4 69/21 70/1 104/25 105/15 133/10 134/3</p> <p>peaks [4] 61/23 63/11 113/9 134/4</p> <p>peer [4] 68/2 137/13 138/17 139/6</p> <p>peg [1] 142/20</p> <p>pending [1] 20/23</p> <p>people [111] 9/10 10/15 13/20 18/3 20/13 24/23 30/19 30/20 32/23 34/6 36/13 36/22 38/2 38/4 38/10 38/12 38/17 39/5 39/15 40/12 43/15 44/19 46/18 46/21 47/17 47/20 48/14 49/14 49/16 50/7 55/17 55/19 58/16 58/22 59/3 59/14 59/17 59/19 59/22 59/24 60/5 60/9 60/14 60/17 60/23 61/1 61/10 61/13 61/15 61/18 61/23 62/5 62/23 63/9 63/14 63/16 63/18 63/19 63/24 64/4 64/6 64/20 65/12 66/8 66/19 67/1 67/6 70/4 70/5 73/14 73/18 77/13 77/14 78/14 80/6 83/15 89/11 89/20 92/3 95/20 96/15 97/6 98/15 99/8 99/24 100/7 102/15 102/17</p>	<p>105/1 106/8 106/9 109/5 111/11 111/16 113/21 114/1 114/17 115/1 117/12 121/11 122/3 123/11 128/13 128/14 136/25 139/12 145/2 145/19 147/3 153/1 156/11</p> <p>people's [4] 39/21 60/25 74/22 110/14</p> <p>per [4] 60/6 84/12 85/13 126/14</p> <p>perceived [1] 96/16</p> <p>percentage [1] 125/25</p> <p>percentages [1] 46/7</p> <p>perception [2] 95/11 97/8</p> <p>perceptions [1] 75/3</p> <p>perform [1] 29/4</p> <p>performed [1] 8/15</p> <p>performing [2] 7/10 149/18</p> <p>perhaps [37] 3/18 7/20 12/14 12/15 29/12 32/9 43/13 44/21 56/1 57/3 61/9 77/3 80/19 83/10 96/14 97/8 97/11 99/1 102/9 104/1 104/11 107/22 107/23 109/14 109/23 112/17 118/15 121/24 124/25 127/3 136/6 136/8 137/5 137/6 138/24 158/16 161/9</p> <p>period [15] 33/15 50/15 62/8 62/11 63/2 69/19 106/2 107/4 119/4 119/6 119/11 119/15 124/4 133/20 160/20</p> <p>periods [4] 63/7 63/8 63/16 69/6</p> <p>periods --and [1] 63/16</p> <p>permission [1] 162/7</p> <p>person [13] 15/11 15/14 21/15 34/4 38/5 41/20 42/3 47/2 47/4 83/20 106/17 107/11 123/12</p> <p>person's [1] 144/4</p> <p>person-centred [1] 38/5</p> <p>personal [4] 5/25 13/19 34/19 40/13</p> <p>personally [2] 7/18 34/16</p> <p>perspective [4] 135/7 162/21 163/2 164/9</p> <p>Pharmaceutical [1] 164/8</p>
--	---	--	--	--

P	platform [1] 138/10	posing [1] 37/22	109/24 152/5	prioritisation [10] 41/16 42/24 46/11
pharmacist [2] 142/6	play [1] 125/8	position [21] 15/17	pre-existing [2] 106/4 109/24	94/13 97/10 98/9
163/10	please [32] 1/4 9/3	17/7 17/11 19/3 21/25	pre-pandemic [3] 29/14 58/11 152/5	104/2 104/22 107/19
pharmacists [2]	10/6 10/10 10/19	23/5 24/10 25/7 35/25	precedence [2] 26/3	137/24
58/17 124/17	11/17 11/18 14/21	45/4 49/15 54/19 67/8	46/23	prioritise [1] 46/13
Pharmacy [1] 163/11	19/1 19/1 20/2 29/10	82/16 91/23 91/25	precise [1] 84/19	prioritised [1] 73/3
phase [2] 126/16	51/12 56/10 59/25	96/19 97/5 116/19	predominantly [1] 69/12	prioritising [2] 55/17
139/1	61/21 66/21 67/10	156/7 158/11	40/23	98/13
phenomenon [2]	68/17 69/10 71/19	positions [2] 34/11	positive [9] 39/4	private [3] 9/2 9/4 9/5
100/8 112/22	72/21 72/24 75/15	40/23	39/12 100/18 114/21	privileged [1] 68/5
Philippines [1] 163/7	75/17 76/19 83/21	possibly [2] 135/19	115/4 125/11 159/7	Priyanka [1] 164/7
phone [2] 34/14	105/24 116/5 116/10	151/3	160/19 160/25	probably [22] 18/9
91/16	145/18 164/21	post [4] 62/8 63/15	possibility [3] 47/22	61/1 67/4 86/5 99/18
phrase [3] 71/15	plentiful [1] 140/6	69/11 131/21	105/10 105/11	117/12 122/16 130/6
71/20 106/24	plus [1] 127/5	post-acute [1] 131/21	possible [16] 11/3	130/18 131/12 136/23
physical [6] 7/21	pm [4] 115/24 116/1	post-peak [1] 63/15	11/6 15/22 16/2 29/25	137/20 144/17 144/25
58/2 74/4 126/11	116/3 164/22	post-period [1] 62/8	45/5 51/3 51/6 90/7	149/1 155/11 155/13
129/17 130/14	point [64] 7/13 11/20	post-traumatic [1] 69/11	91/3 92/3 101/11	157/12 159/6 160/21
Physicians [3] 40/23	16/14 25/22 29/2	152/7	102/12 114/10 150/13	161/2 161/11
51/9 52/3	29/17 29/20 30/10	post [4] 62/8 63/15	152/7	problem [12] 3/3
physiology [1]	31/24 32/16 32/18	69/11 131/21	possibly [2] 135/19	76/4 77/23 84/13
146/19	38/23 39/3 41/1 41/7	post-acute [1] 131/21	151/3	86/25 122/8 126/15
physiotherapists [2]	43/7 44/16 45/14	post-peak [1] 63/15	post [4] 62/8 63/15	143/6 143/15 147/14
58/18 124/16	46/16 50/1 50/18	post-period [1] 62/8	69/11 131/21	149/24 151/17
physiotherapy [1]	51/20 54/22 56/13	post-traumatic [1] 69/11	present [4] 8/21 96/6	problematic [1] 69/13
102/9	58/3 59/12 59/18	potential [8] 37/8	108/21 151/10	problems [4] 72/22
pick [10] 6/8 6/10	60/16 64/3 64/5 70/14	43/9 54/23 86/12 89/2	presented [2] 104/24	147/5 149/20 160/17
6/16 6/19 50/4 51/20	72/13 72/14 82/2 85/1	89/5 90/5 90/7	163/15	procedure [4] 76/5
52/18 80/14 84/10	85/15 93/22 96/24	potentially [13] 16/10	presenteeism [1] 112/22	76/9 76/11 76/13
147/25	97/20 99/7 100/23	24/24 25/13 28/3 37/7	presenting [1] 60/14	procedures [3] 75/9
picking [2] 7/1	104/21 110/15 112/18	38/18 49/10 52/25	president [3] 116/16	76/4 161/12
162/17	120/7 125/6 129/11	55/9 81/11 89/9	119/2 119/9	proceed [2] 97/21
picks [1] 37/22	130/9 133/1 133/11	105/21 112/12	presidents [1] 121/8	99/5
picture [3] 57/16	144/15 148/8 149/6	power [5] 24/24	pressing [1] 145/1	process [11] 14/5
96/1 155/24	149/22 151/8 155/4	25/18 25/18 120/18	pressure [13] 69/25	15/8 23/11 35/2 37/4
piece [7] 78/8 83/2	155/16 157/6 157/14	147/10	73/20 100/19 113/8	37/6 37/12 48/7 92/10
84/24 110/5 112/9	157/24 157/24 158/19	powerful [1] 137/13	128/2 138/15 140/10	96/16 144/5
142/19 143/23	160/21 161/3	powerfully [2] 67/25	140/20 143/19 156/8	processes [5] 82/12
pieces [2] 145/21	pointing [1] 133/18	163/5	156/9 157/16 158/1	91/8 94/20 98/8
146/7	points [10] 68/23	PPE [13] 6/1 6/13	pressured [1] 2/22	103/15
pigmentation [1]	69/2 99/11 110/9	6/23 7/3 59/8 72/21	pressures [3] 69/15	produced [4] 123/8
143/9	123/7 141/12 144/11	72/22 73/2 73/6 74/5	130/16 135/24	131/25 138/24 148/20
pipes [3] 139/20	147/25 148/17 160/18	88/3 160/7 161/11	presumably [2] 26/19 147/4	product [3] 4/11
140/9 140/10	policies [4] 39/2 87/9	practical [7] 18/3	presume [1] 89/5	144/6 146/4
place [18] 18/7 20/9	94/25 103/23	46/3 78/20 78/25	presumption [1] 19/20	production [1] 123/2
26/17 26/24 30/1 30/4	policy [15] 11/21	79/19 127/15 136/9	prevalence [1] 69/21	products [3] 4/10
35/24 38/9 76/24 77/1	17/12 18/12 61/25	practically [2] 32/8	prevalent [1] 39/14	144/2 145/25
87/10 92/15 120/24	63/23 64/1 100/1	39/24	prevent [1] 113/14	profession [5] 48/12
124/10 124/13 125/14	100/16 103/17 104/6	practice [8] 11/21	prevented [1] 81/2	49/22 55/14 55/21
129/23 151/6	104/12 117/8 121/22	18/5 18/12 32/21	prevention [3] 4/13	75/23
placed [2] 86/7 86/20	122/10 123/24	40/25 94/17 103/11	4/16 80/25	professionally [1] 96/22
places [6] 6/16 85/3	political [1] 107/23	156/5	previous [4] 20/11	professionals [8] 37/23 40/10 64/21
95/24 130/3 140/23	poor [3] 112/21	practise [1] 83/11	84/25 150/6 152/2	89/7 117/13 123/7
141/13	113/1 113/16	practitioners [1] 134/23	previously [2] 54/1	135/7 154/3
plan [11] 11/8 16/19	pop [1] 126/20	pre [7] 29/14 58/11	105/14	
18/18 48/20 49/8	pop-up [1] 126/20	62/7 63/15 106/4	primary [1] 113/23	
49/12 49/16 50/5	population [4] 33/21		principle [3] 18/7	
99/19 136/14 145/12	84/12 85/13 146/6		108/22 109/5	
planned [1] 135/3	populations [2]		principles [8] 10/17	
planning [8] 10/10	82/10 143/21		18/11 46/24 52/24	
10/20 12/21 37/9 38/1	portal [1] 159/24		79/23 91/23 92/2	
41/9 82/11 89/15	Portsmouth [1]		92/11	
plans [2] 13/4 119/22	116/21		prior [4] 49/1 62/10	
	posed [1] 90/21		108/15 144/2	

<p>P</p> <p>professions [2] 75/21 124/22</p> <p>professor [42] 9/20 10/6 29/12 34/15 35/6 36/9 41/19 42/11 42/16 56/10 56/20 58/24 61/11 61/21 62/2 64/15 66/15 66/22 67/24 68/1 68/22 70/18 71/14 75/22 77/3 80/19 83/8 86/6 91/9 99/21 99/24 103/6 103/13 104/4 107/1 112/18 115/9 118/11 119/25 137/21 155/10 165/6</p> <p>PROFESSOR CHARLOTTE [2] 9/20 165/6</p> <p>professor describes [1] 36/9</p> <p>Professor Fong [5] 68/1 68/22 70/18 103/13 137/21</p> <p>Professor Gale [1] 61/11</p> <p>Professor Hugh [1] 119/25</p> <p>Professor Rowan [1] 58/24</p> <p>Professor Rowan's [1] 155/10</p> <p>Professor Summers [8] 10/6 56/10 75/22 86/6 91/9 103/6 112/18 118/11</p> <p>Professor Whitty [3] 41/19 42/16 66/15</p> <p>Professor/Doctor [1] 83/8</p> <p>profile [1] 76/14</p> <p>programme [3] 40/21 68/2 136/6</p> <p>programmes [1] 136/24</p> <p>prominently [1] 19/23</p> <p>promptly [1] 19/19</p> <p>properly [2] 84/23 85/4</p> <p>proportion [4] 62/9 67/15 97/14 154/8</p> <p>proposal [1] 62/4</p> <p>propose [2] 82/4 82/12</p> <p>proposed [2] 44/24 78/22</p> <p>protect [2] 6/6 156/12</p> <p>protected [1] 156/7</p> <p>protecting [2] 97/6 160/8</p> <p>protection [1] 6/14</p> <p>protective [2] 5/25 88/3</p> <p>protects [1] 49/18</p> <p>prototype [1] 54/21</p> <p>provide [22] 3/17 55/3 72/5 77/5 77/17 78/17 78/18 81/24 97/2 97/2 117/19 122/13 124/20 125/11 129/24 134/10 135/2 138/5 138/14 141/1 145/8 146/5</p> <p>provided [5] 6/1 29/1 56/24 83/1 131/19</p> <p>providers [3] 77/4 82/16 102/8</p> <p>provides [4] 14/10 50/7 51/20 102/6</p> <p>providing [7] 1/10 16/7 40/2 58/16 72/10 77/9 77/18</p> <p>provision [5] 132/18 140/17 141/17 150/25 151/21</p> <p>proximity [1] 141/20</p> <p>proxy [3] 15/5 88/24 110/17</p> <p>psychological [6] 74/8 135/25 137/18 137/22 145/3 145/8</p> <p>psychologists [2] 114/25 124/18</p> <p>public [16] 37/10 48/13 49/13 49/19 51/3 55/6 55/8 55/13 74/14 79/12 97/2 111/15 126/7 128/21 139/5 146/8</p> <p>publication [1] 105/10</p> <p>publications [1] 106/8</p> <p>publicly [2] 55/1 87/2</p> <p>publish [3] 162/9 163/12 163/16</p> <p>published [9] 50/20 51/7 101/15 138/1 138/19 139/5 156/22 162/11 164/14</p> <p>publishing [2] 48/20 51/2</p> <p>pull [1] 19/25</p> <p>pulse [7] 142/18 142/19 143/3 143/8 143/16 145/17 147/5</p> <p>purely [4] 55/15 100/8 100/9 141/9</p> <p>purpose [5] 14/15 117/4 117/17 140/7 152/19</p> <p>purposes [1] 141/11</p> <p>pursue [3] 147/12 155/22 156/15</p>	<p>pursued [1] 89/23</p> <p>pushing [1] 146/11</p> <p>put [21] 36/2 43/13 47/19 65/11 66/5 76/17 78/21 81/8 83/17 87/10 93/9 96/19 105/11 143/19 145/21 147/8 151/1 153/4 153/5 153/14 153/24</p> <p>putative [1] 50/15</p> <p>puts [3] 15/8 82/15 152/6</p> <p>putting [2] 77/22 110/19</p> <hr/> <p>Q</p> <p>Qatar [1] 163/17</p> <p>qualification [1] 110/7</p> <p>qualified [2] 76/2 91/7</p> <p>quality [7] 13/21 39/21 113/4 134/19 134/24 149/7 149/8</p> <p>quantify [1] 57/8</p> <p>quantities [2] 73/2 74/5</p> <p>quantum [1] 82/9</p> <p>question [40] 20/11 22/20 23/20 26/4 26/9 26/9 79/18 83/10 83/14 83/25 86/5 86/12 88/6 90/21 91/14 95/8 99/19 100/18 103/9 107/1 107/16 107/21 108/6 108/10 108/21 111/8 111/19 112/16 113/12 113/19 131/16 131/18 146/6 147/16 155/21 156/22 157/2 158/3 160/1 160/10</p> <p>questioning [1] 161/16</p> <p>questions [45] 1/8 8/8 9/7 9/22 18/14 37/22 69/13 75/6 83/6 83/20 83/23 85/24 88/11 88/19 90/21 94/10 94/11 102/21 102/24 103/3 105/23 115/16 116/7 123/15 125/18 144/11 144/12 145/15 145/16 147/22 147/23 156/19 156/20 161/13 165/5 165/9 165/11 165/12 165/13 165/14 165/15 165/17 165/18 165/19 165/20</p> <p>queuing [1] 44/17</p> <p>quick [1] 145/11</p> <p>quickly [10] 11/2 120/2 120/5 122/2</p>	<p>122/15 122/20 130/23 140/23 148/15 153/1</p> <p>quintet [2] 42/20 50/23</p> <p>quite [14] 10/15 23/11 48/6 66/11 75/9 90/18 99/2 105/2 109/14 120/8 137/21 141/25 143/13 156/24</p> <p>quite significant [1] 66/11</p> <p>quotation [1] 66/22</p> <p>quote [2] 108/10 153/6</p> <p>quoted [1] 96/4</p> <hr/> <p>R</p> <p>Rachel [1] 164/1</p> <p>racial [1] 86/12</p> <p>radio [1] 70/19</p> <p>rails [1] 111/17</p> <p>raise [6] 4/21 5/3 47/17 82/2 91/15 114/20</p> <p>raised [4] 75/6 105/10 157/17 161/7</p> <p>range [3] 9/10 72/23 79/14</p> <p>ranking [3] 46/12 47/11 48/2</p> <p>rapidly [2] 81/17 110/7</p> <p>rarely [1] 30/21</p> <p>rate [2] 19/5 19/8</p> <p>rates [2] 87/6 152/23</p> <p>rather [23] 18/12 26/10 29/9 29/19 39/9 45/19 47/10 51/21 61/2 63/2 76/4 76/8 79/1 87/21 92/17 94/24 103/17 108/2 124/25 141/5 149/8 154/19 157/14</p> <p>ratio [5] 102/8 102/9 132/21 151/11 156/6</p> <p>rationale [1] 129/19</p> <p>rationalise [1] 103/2</p> <p>rationing [2] 106/25 107/2</p> <p>ratios [21] 38/17 58/15 59/1 78/2 78/10 78/11 78/18 78/22 86/9 126/21 132/20 133/1 133/8 133/17 134/7 134/10 134/15 134/17 134/22 150/18 151/20</p> <p>RCM [1] 148/24</p> <p>re [3] 53/4 53/4 152/3</p> <p>re-assessed [1] 53/4</p> <p>re-configure [1] 152/3</p> <p>re-designed [1] 53/4</p> <p>reach [5] 32/1 60/11</p>	<p>112/1 118/1 121/5 reached [2] 97/19 98/4</p> <p>reaching [2] 99/2 153/9</p> <p>read [2] 151/24 164/16</p> <p>readily [2] 142/19 142/23</p> <p>reading [1] 96/9</p> <p>ready [1] 9/15</p> <p>real [3] 33/4 57/14 127/16</p> <p>realise [1] 20/19</p> <p>realised [1] 140/3</p> <p>realistic [3] 45/18 46/5 46/7</p> <p>realistically [1] 46/1</p> <p>realities [1] 10/17</p> <p>reality [4] 129/20 130/4 136/14 159/13</p> <p>really [54] 2/21 11/20 14/14 15/17 15/22 16/1 28/2 28/5 36/14 36/21 37/21 38/19 39/12 39/13 44/17 45/8 45/23 46/16 47/9 48/7 54/16 56/25 61/14 72/9 74/16 76/2 77/23 79/20 82/24 91/7 96/17 98/12 112/2 113/18 115/7 121/16 128/12 138/10 138/12 139/4 140/2 140/22 141/14 141/25 143/17 143/23 145/2 146/9 147/9 149/18 149/18 154/17 157/20 159/14</p> <p>reason [13] 11/12 11/13 20/18 27/23 65/23 79/5 90/25 92/16 109/6 110/24 128/20 139/15 147/7</p> <p>reasonable [1] 84/8</p> <p>reasonably [1] 84/8</p> <p>reasons [8] 65/13 65/15 65/17 66/7 66/13 141/12 151/22 155/13</p> <p>reassurance [3] 49/4 50/7 138/4</p> <p>reassure [1] 52/13</p> <p>reassuring [1] 73/9</p> <p>recall [2] 37/20 126/1</p> <p>receive [10] 4/3 4/4 4/13 7/3 7/5 7/13 7/19 38/3 64/13 102/4</p> <p>received [6] 6/2 6/5 7/16 8/14 102/15 154/5</p> <p>receiving [9] 27/17 59/14 59/20 64/10 83/16 101/17 102/1</p>
--	--	--	--

R	reflect [3] 110/25 114/16 118/5 reflected [1] 31/10 reflecting [1] 46/17 reflects [2] 39/1 92/19 refuse [5] 12/23 13/5 13/12 25/10 91/25 regard [2] 90/3 101/22 regarding [2] 100/1 158/11 regardless [1] 36/17 region [2] 43/22 128/24 regional [3] 56/23 156/8 158/2 regions [6] 16/18 45/2 56/21 68/6 85/4 158/17 regular [1] 102/10 regulations [1] 145/24 regulators [1] 40/3 rehabilitation [1] 131/21 reinforced [1] 149/6 reinforcing [2] 149/5 149/21 reiterate [2] 58/3 62/3 related [5] 106/20 107/15 138/8 142/15 157/1 relates [1] 86/12 relation [8] 41/16 53/12 61/13 69/18 88/20 103/4 121/22 125/19 relatively [2] 19/5 145/11 relatives [3] 117/6 118/6 137/16 relevance [1] 125/5 relevant [15] 12/4 12/11 12/21 15/23 22/4 25/22 51/22 99/15 119/4 119/11 119/15 123/2 123/6 123/23 124/4 reliability [1] 146/5 reliable [1] 147/2 reliably [1] 130/2 reliance [1] 143/16 reliant [2] 129/21 131/1 rely [1] 136/11 remain [3] 150/19 151/6 160/19 remember [3] 32/23 71/1 77/8 reminder [1] 147/9 reminding [1] 84/11 remit [1] 83/18	remote [3] 32/10 33/15 67/6 remove [2] 77/10 77/19 removing [1] 122/16 renal [2] 120/20 122/13 rent [1] 2/25 reorganisation [1] 74/16 repair [1] 114/17 repeatedly [2] 99/10 102/18 repercussions [1] 134/21 replaced [2] 110/8 112/3 replacement [1] 122/13 replaces [1] 48/16 reply [1] 83/22 report [34] 7/17 10/13 29/3 37/20 37/21 38/24 39/18 56/13 56/17 59/21 60/16 61/11 61/21 68/13 68/20 71/15 74/3 74/11 77/25 80/23 86/8 86/18 88/22 94/16 95/6 98/7 100/6 105/8 106/24 109/16 112/20 115/20 131/25 132/2 reporting [3] 67/17 86/15 125/25 reports [1] 155/23 represent [7] 12/18 12/19 86/1 102/23 113/13 124/19 148/6 representation [1] 125/13 representative [2] 24/11 59/13 represented [2] 56/22 86/20 representing [2] 55/8 97/6 require [2] 22/23 152/20 required [11] 35/12 40/11 51/19 57/9 57/17 58/25 70/6 80/24 106/2 133/18 142/12 requirement [2] 23/15 23/25 requirements [1] 78/5 research [16] 55/15 64/16 73/13 78/4 78/8 81/6 117/9 123/13 123/15 143/10 150/8 150/9 153/20 153/21 155/5 159/16	reset [1] 151/13 resilience [1] 84/9 resilient [1] 131/6 resolvable [1] 146/3 resolve [1] 146/15 resolves [1] 162/2 resource [8] 46/14 66/7 81/8 98/24 104/1 104/3 104/21 145/13 resource-led [2] 104/1 104/21 resourced [1] 115/8 resources [5] 42/25 46/10 108/2 110/3 139/10 respect [17] 11/17 15/12 15/14 16/15 17/1 17/2 17/13 18/1 18/24 21/19 37/9 41/2 89/6 89/15 91/20 92/6 159/3 respected [1] 21/23 respectively [1] 65/25 respects [2] 29/5 34/23 respiratory [6] 28/24 52/10 101/5 101/6 101/18 128/9 respondents [1] 69/1 response [3] 81/12 93/8 155/10 responses [1] 154/23 responsibility [3] 31/4 40/14 123/12 responsible [3] 28/13 39/24 40/1 restitution [1] 132/1 restore [1] 77/12 restrained [1] 98/16 restriction [1] 91/15 result [7] 50/15 60/24 69/5 109/21 126/9 126/23 127/11 resulted [2] 90/15 152/4 results [1] 78/15 resume [2] 70/3 113/10 resuscitation [6] 10/11 17/16 17/24 19/12 31/15 75/20 retention [1] 145/1 return [4] 9/15 10/6 20/10 56/3 reverse [1] 47/16 reversed [1] 27/24 review [17] 17/20 27/25 74/19 82/5 84/3 84/6 91/20 92/6 92/10 92/23 93/2 93/11 94/2 137/13 142/7 144/5 158/22	reviewed [6] 35/5 92/17 93/20 93/22 139/6 154/22 reviewing [2] 91/18 93/23 reviews [1] 93/6 rich [1] 140/17 right [74] 1/11 1/16 2/13 2/17 3/20 8/18 10/11 13/9 14/12 15/19 16/12 17/9 17/22 19/11 20/6 21/5 21/14 21/18 22/9 22/23 23/5 23/8 25/9 25/16 26/13 28/7 29/7 35/15 42/15 43/24 44/20 45/7 45/9 46/25 48/1 48/5 54/20 61/18 75/6 76/13 82/9 85/3 89/22 100/23 106/22 107/9 113/6 116/22 123/9 123/11 123/15 129/9 131/17 131/19 134/16 139/11 139/11 139/12 139/13 141/2 141/13 141/19 142/15 143/11 147/15 148/19 149/6 150/20 151/7 151/18 151/19 152/9 154/9 155/2 right-hand [1] 154/9 rightly [3] 29/17 95/21 157/6 ringed [1] 14/23 rise [1] 9/14 rises [1] 60/11 rising [2] 43/8 44/3 risk [29] 11/13 14/2 14/4 37/14 48/16 49/19 54/11 74/17 76/4 76/6 76/8 76/14 76/17 86/16 87/9 87/12 87/15 87/20 89/25 91/15 91/17 109/22 122/11 126/19 128/13 144/3 145/21 149/20 160/21 risks [1] 101/25 robust [3] 81/14 103/19 104/22 role [17] 34/6 64/25 67/12 67/18 80/2 96/25 116/24 117/24 118/2 118/25 119/2 119/2 119/5 125/8 129/5 131/8 135/23 roles [3] 67/23 114/2 156/12 rolled [1] 17/10 room [7] 3/23 4/1 6/11 30/13 32/8 33/12 47/23 room for [1] 47/23 rooms [2] 3/21 3/24
----------	--	---	--	--

R	96/2	127/12 157/7 157/9 158/10 164/8	service [2] 16/23 77/19	19/12 20/10 21/7 21/25 22/12 22/18
rotational [1] 136/24	saturation [4] 45/13 49/2 99/2 144/4	Scottish [4] 52/3 88/18 90/4 117/22	services [8] 35/10 35/11 77/7 77/12	22/19 23/3 23/15 24/9
rough [1] 60/11	save [2] 23/10 79/9	screen [8] 19/25 37/19 44/23 51/12	132/18 135/1 150/25 151/21	24/10 24/13 25/6
roughly [1] 91/24	saving [2] 19/18 105/12	56/18 57/21 59/25 64/18	set [25] 10/16 18/15 28/2 28/4 34/4 34/10	26/11 31/5 31/18 39/24 40/8 40/15
round [2] 69/1 151/3	saw [2] 128/23 137/12	scrolling [1] 28/21	40/7 61/20 66/13 68/13 75/16 77/25	41/24 45/15 45/17 46/22 47/3 47/14
rounds [1] 33/22	say [63] 2/20 2/23 5/2 6/22 6/25 12/5 13/7	seceding [1] 50/25	79/9 89/24 94/22 95/5 95/18 119/21 119/21	47/17 48/3 52/20 53/2
routes [1] 35/13	13/9 14/2 17/7 18/17 18/18 21/15 23/14	second [7] 31/19 31/22 62/19 71/25	122/25 123/21 155/15	64/3 68/2 73/24 75/6
routine [3] 84/22 160/11 161/8	26/19 30/17 30/23 31/25 36/22 38/8	second-last [1] 123/21	setting [22] 28/12 29/18 30/22 35/18	82/25 83/3 84/7 84/22
routinely [2] 135/8 136/6	40/17 41/2 42/17 47/2 47/13 49/4 49/25	Secondly [3] 48/19 49/13 106/22	36/6 36/15 36/16 36/17 36/24 37/1 48/8	89/23 92/2 92/3 92/16
Rowan [2] 58/24 62/2	50/10 52/12 52/18 59/20 62/16 71/3	Secretary [1] 96/5	59/8 74/24 76/10 78/3 83/9 87/25 93/15	93/20 98/11 99/5 99/6
Rowan's [1] 155/10	72/15 72/25 74/2 74/24 76/16 79/11	section [3] 13/19 95/17 95/18	93/22 95/5 100/24 102/5	101/9 104/12 107/25
Royal [7] 40/23 51/8 52/2 124/5 124/6	89/12 89/20 91/17 93/3 95/16 103/13	sections [1] 55/10	settings [7] 29/12 35/17 36/12 86/21	108/4 108/22 109/5
162/22 164/7	106/6 107/5 108/22 109/10 115/5 117/15	sector [1] 114/23	88/4 113/23 113/24	109/9 111/6 111/11
rule [2] 107/7 107/8	118/3 120/25 125/22 135/16 137/1 143/13	see [25] 14/20 15/10 20/4 20/7 24/2 25/9	seven [2] 50/9 63/5	114/5 124/3 136/11
ruling [1] 46/21	143/18 146/13 146/16 148/14 153/15 158/14	27/7 36/19 38/18 45/1 48/15 52/2 58/13 59/1	several [4] 23/17 33/22 33/23 61/22	137/9 146/10 150/19
rumours [2] 3/17 3/18	saying [15] 21/6 24/8 39/4 40/13 42/17	60/4 61/5 62/14 63/13 65/3 65/20 67/1 71/7	severe [2] 105/14 110/2	151/6 153/12 154/6
run [1] 69/15	44/19 46/18 46/22 49/6 54/3 66/12 67/20	122/5 126/16 133/5	severely [2] 62/7 137/7	154/25 156/7 160/17
S	87/20 137/16 137/16	seeing [4] 75/4 79/2 137/7 137/10	severity [3] 27/15 33/20 92/16	shouldn't [6] 22/15 24/6 94/5 111/4 151/4
sadly [3] 37/3 90/24 164/2	says [10] 20/25 22/14 26/9 31/22 35/3	seem [2] 93/3 149/4	shall [2] 9/14 56/3	151/13
safe [6] 7/10 78/4 114/3 134/17 151/10	57/21 101/1 101/8 132/11 143/6	seemed [1] 85/10	shan't [4] 147/17 155/2 155/22 156/15	shouting [1] 75/13
safeguards [1] 87/9	scale [3] 81/17 102/13 109/20	seems [1] 145/18	shaping [1] 121/21	show [1] 153/22
safely [1] 7/4	scared [2] 2/18 5/5	seen [15] 15/5 18/24 32/14 32/22 33/2	share [2] 121/16 159/15	showed [1] 101/16
safest [1] 152/20	scars [7] 71/5 113/10 113/14 114/8 115/12	38/17 64/17 69/16 71/8 125/1 128/24	shared [8] 11/24 14/16 18/5 52/15 53/1	showing [4] 57/4 61/15 129/16 152/22
safety [5] 7/11 21/9 49/14 101/25 113/4	115/18 145/5	133/9 135/2 146/21 153/20	68/4 97/16 99/10	shown [2] 60/20 66/16
said [30] 2/8 3/4 18/10 31/10 31/11	scenario [10] 20/11 20/16 31/16 44/2	SEISMIC [1] 78/9	sharing [5] 28/18 121/3 121/20 159/4	66/16
41/19 41/23 55/1	46/20 46/25 47/12 133/14 134/8 136/5	sending [1] 28/13	159/21	shows [1] 155/5
63/23 65/1 66/24	scenarios [5] 22/3 44/13 108/24 129/11	sense [15] 18/3 46/18 47/20 49/9 55/4	she [11] 8/11 8/12 10/3 58/24 96/5	Shutting [1] 77/21
67/10 70/23 93/10	129/16	56/25 76/15 78/25 85/5 90/2 104/5	162/15 163/5 163/20 163/22 163/23 164/2	sick [2] 5/12 112/22
98/7 98/19 99/21	scheduled [1] 92/10	111/11 120/3 133/21 139/22	shift [5] 21/10 21/10 85/6 133/19 136/8	sicker [1] 62/16
100/6 100/6 106/8	schematics [4] 140/19 142/2 142/8	sensible [1] 42/19	shifts [1] 131/2	sickest [1] 144/22
113/6 128/16 135/5	145/10	sensibly [1] 43/23	shock [1] 33/4	SICSAG [1] 57/14
148/8 149/1 150/23	scope [1] 98/25	sensitive [1] 44/16	short [8] 2/14 2/16 2/19 9/18 38/9 56/6	side [7] 32/8 32/22 76/3 82/3 122/10
154/5 156/25 158/25 161/10	score [4] 47/10 110/7 110/12 112/13	sent [1] 28/8	73/16 153/9	154/1 154/9
sake [1] 94/3	scores [1] 109/23	sentence [3] 132/5 132/11 151/24	short-staffed [2] 2/14 2/16	signature [1] 14/20
salary [1] 5/13	scoring [4] 109/13 109/15 112/5 157/25	sentences [1] 132/5	shortages [3] 73/5 73/12 73/21	signed [2] 14/15 14/19
same [33] 15/2 24/8 24/17 24/18 28/2 29/4	13/1 17/10 57/3 57/5 57/11 57/13 89/16	separate [5] 83/1 87/15 106/8 110/4 112/7	shorter [1] 160/22	significant [7] 59/23 66/11 74/5 76/23
30/4 33/12 42/10	Scotland [17] 12/6	sepsis [1] 90/15	162/15 163/5 163/20 163/22 163/23 164/2	86/11 101/16 120/8
45/11 46/14 52/14	13/1 17/10 57/3 57/5 57/11 57/13 89/16	series [2] 68/23 120/23	should [72] 8/25 11/5 17/2 17/24 18/7 18/7	similar [8] 16/16 18/14 18/14 66/16
58/4 60/11 62/1 70/5	91/21 92/7 93/5 121/9	serious [1] 90/18		70/16 91/24 98/3
87/13 91/23 92/5		seriously [1] 146/1		158/15
92/11 103/7 105/16				simple [3] 46/4 141/25 157/22
114/9 115/1 127/1				simplified [1] 110/20
129/23 131/5 131/16				simplifying [1] 112/12
134/5 146/5 147/17				simply [7] 23/10 43/14 104/22 108/17
155/11 158/24				113/12 134/12 152/15
Sanjeev [1] 163/9				simultaneous [1] 27/5
Sarah [1] 163/3				since [4] 12/6 34/15 78/7 116/19
SARS [1] 120/5				singing [1] 75/13
SARS-2 [1] 120/5				single [5] 24/19 72/3 80/16 136/15 159/23
saturated [6] 42/14 43/1 46/1 49/7 95/12				

S	solely [1] 52/10	sorry [12] 9/25 20/4 23/14 37/15 83/14 88/13 119/12 154/14 155/16 156/2 161/3 164/19	spring [2] 61/7 69/24	started [6] 4/11 19/12 19/15 19/19 20/12 148/9
sister [1] 8/11	solutions [2] 122/8 146/12	sort [41] 13/2 15/4 15/5 28/18 36/8 36/20 39/1 45/10 45/24 49/8 49/20 51/22 54/3 54/8 54/9 55/4 55/13 63/1 76/7 79/19 90/12 90/14 90/17 91/8 91/13 92/10 92/24 96/12 104/5 107/22 110/11 110/19 111/17 122/2 122/6 124/8 126/7 135/14 138/17 148/17 157/12	staff [90] 2/19 6/3 34/1 37/2 37/5 37/11 39/19 39/23 58/2 58/4 58/5 58/11 58/19 58/25 58/25 65/25 67/16 67/23 68/6 68/9 68/14 68/24 69/8 69/23 70/24 71/2 86/8 86/9 86/11 87/14 87/14 97/4 112/21 112/23 115/2 115/6 115/11 117/7 118/20 127/22 130/10 130/13 130/15 130/21 130/22 130/24 131/2 131/5 131/19 132/25 133/5 133/13 133/17 134/2 134/11 134/20 134/24 135/6 135/9 135/22 136/4 136/6 136/15 137/4 137/15 138/5 138/12 144/22 145/1 145/4 148/4 149/13 149/15 149/18 149/23 149/25 150/4 150/11 152/13 152/15 156/11 160/1 160/5 160/7 160/10 160/12 160/16 160/24 160/24 161/10	starting [7] 10/12 38/23 48/7 50/18 51/20 148/8 148/17
site [2] 36/17 49/12	some [91] 5/19 6/11 6/12 7/6 7/16 8/24 10/15 11/2 13/22 19/1 25/4 25/19 32/10 32/25 34/3 34/9 34/24 36/10 36/11 37/7 38/4 41/17 49/7 53/24 55/6 55/12 57/1 58/16 59/1 62/2 64/8 65/15 68/3 68/4 68/13 73/13 73/15 73/22 75/10 75/21 75/24 76/21 85/12 86/14 88/19 88/21 94/18 96/21 98/21 102/24 103/11 103/25 109/1 109/2 110/8 112/4 114/15 118/13 118/15 118/18 118/21 119/14 120/13 121/10 121/24 121/24 122/8 122/16 122/18 123/7 126/22 128/23 130/2 130/6 130/12 135/16 136/23 136/24 141/9 141/25 143/13 143/19 143/21 146/15 146/20 148/6 150/9 153/17 162/8 162/18 164/11	sorts [2] 39/17 121/12	staffed [2] 2/14 2/16	starts [1] 132/6
sites [1] 79/1	somebody [11] 15/23 15/25 25/24 46/23 52/17 85/2 90/11 90/11 108/17 110/23 123/10	sources [1] 45/5	staffing [32] 78/5 78/10 78/10 126/21 129/18 131/1 131/24 132/20 134/7 134/10 134/14 134/17 134/22 147/25 148/11 149/3 149/7 149/8 149/9 149/12 150/18 151/10 151/11 151/19 151/20 151/22 152/3 152/13 152/18 152/20 156/6 160/8	state [8] 32/17 44/15 88/22 94/16 98/4 110/17 111/13 158/6
situation [24] 2/1 2/11 2/13 7/25 29/10 30/3 31/13 32/2 33/14 33/24 36/7 38/16 38/21 44/11 49/11 49/23 54/14 77/18 84/16 91/19 95/14 111/21 111/24 131/13	someone [22] 12/13 12/14 13/9 14/24 16/6 19/14 20/17 21/19 21/22 28/12 29/4 29/13 31/6 31/18 33/13 35/2 38/17 43/23 47/14 47/23 108/17 147/12	South [1] 162/25	stated [2] 96/14 150/16	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
situations [5] 19/18 36/1 37/5 39/17 139/14	somehow [1] 90/16	space [2] 67/5 130/20	states [1] 101/13	statistics [2] 65/4 65/11
six [1] 133/25	someone's [2] 23/10 80/4	spaces [1] 126/17	status [7] 93/12 93/18 100/14 125/3 138/9 138/16 157/1	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
size [3] 57/19 72/23 157/8	something [26] 3/1 13/25 16/21 26/22 39/6 48/20 49/20 50/5 70/21 71/14 75/18 78/20 93/6 96/8 99/13 107/13 108/4 112/8 122/6 125/2 125/15 131/14 137/18 142/3 145/6 161/21	spares [1] 6/12	stays [1] 16/16	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
sizeable [1] 114/15	sometimes [8] 2/6 6/10 6/11 30/5 90/23 90/24 98/16 126/8	speak [12] 4/23 18/6 22/22 33/6 33/10 35/7 51/23 57/4 60/21 79/10 111/1 163/18	staying [1] 105/5	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
sizes [1] 98/1	somewhere [4] 19/5 21/4 76/12 136/21	speakers [1] 27/5	steady [1] 10/17	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
skill [1] 135/18	soon [2] 9/15 162/4	speaking [2] 34/15 58/24	step [2] 79/3 96/25	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
skills [4] 40/24 136/2 136/2 136/8		speaks [5] 162/17 163/1 163/5 163/23 163/24	STEPHEN [3] 116/6 116/11 165/16	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
skin [3] 143/9 145/20 147/6		specialist [3] 58/5 149/16 150/7	stepped [1] 135/19	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
slide [1] 64/19		specialists [2] 129/24 147/4	steps [2] 100/24 136/16	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
slightly [7] 14/22 16/9 24/24 28/22 67/20 161/9 164/11		specialities [1] 75/21	sterile [1] 29/9	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
slipped [2] 36/10 151/15		speciality [2] 72/2 130/22	sticking [1] 159/11	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
slow [1] 10/18		specific [7] 16/21 53/3 53/18 73/11 104/21 117/16 118/25	still [11] 10/7 13/1 19/9 60/11 71/2 90/23 114/11 129/12 137/2 143/14 157/17	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
slowly [2] 60/11 110/15		specifically [6] 22/20 87/17 97/25 118/21 119/21 161/7	stood [1] 50/24	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
small [4] 5/13 97/17 98/21 115/9		specifying [1] 26/10	stop [6] 20/16 20/20 77/15 111/17 114/17 155/16	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
smart [1] 150/13		speculate [1] 104/15	stopped [2] 19/16 20/11	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
snapshot [1] 66/18		speech [2] 58/18 75/23	stops [2] 19/8 27/18	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
so [270]		speed [1] 30/6	straight [1] 122/19	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
social [4] 50/13 73/3 113/23 114/4		spent [1] 140/19	straightforward [1] 84/18	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
societal [1] 80/4		sphere [2] 118/12 123/7	strain [14] 61/23 62/1 64/7 64/9 77/20 78/15 78/23 97/18 97/19 98/2 98/22 106/7 148/12 152/24	statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
societies [3] 117/25 120/16 121/8		SpO2 [1] 143/7		statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
society [47] 39/13 50/21 51/4 51/5 51/8 52/4 52/4 55/10 56/24 99/16 116/17 116/24 117/1 117/3 117/10 117/15 117/22 117/23 117/25 118/22 119/3 119/8 119/10 119/13 119/15 120/20 122/1 123/16 123/20 123/23 124/3 125/24 126/1 131/25 137/20 137/25 138/6 138/11 138/20 139/13 143/2 143/11 148/20 149/6 152/6 156/23 164/8		spoke [5] 37/24 62/2 90/20 107/17 158/25		statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
society's [2] 153/2 160/4		spoken [2] 64/22 144/16		statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6
soft [1] 98/17		spot [1] 19/24		statements [7] 52/23 116/12 122/9 162/8 162/10 163/17 164/6

S	suggested [1] 96/7	125/12	85/17 108/15	158/21
strategic [1] 125/8	suggesting [4] 65/13	suppose [5] 29/23	T	terms [40] 15/16
strategies [2] 155/14	102/14 105/21 133/12	120/3 122/25 124/7	table [2] 54/7 58/9	17/18 26/9 45/24 46/4
159/19	suggestion [2] 63/11	150/4	tackle [1] 77/23	48/5 52/22 58/5 68/24
strength [1] 124/13	93/4	supposed [1] 107/13	tackling [1] 81/1	78/13 79/19 84/2 85/6
stress [3] 8/2 8/4	suggests [5] 55/12	sure [10] 41/11 51/11	tailored [2] 87/17	90/2 92/21 92/22
69/24	62/9 62/20 96/5	55/10 70/25 77/6	87/21	103/21 111/7 114/24
stresses [1] 68/15	154/21	79/21 97/4 113/21	take [23] 3/12 5/8	118/18 121/25 122/9
stressful [1] 69/19	suicide [1] 164/4	122/14 123/14	10/16 13/10 16/2	127/16 130/3 130/7
stretch [9] 72/5 78/5	suitable [1] 136/10	Surely [1] 23/24	24/12 35/14 46/22	131/1 133/11 133/16
78/13 82/8 85/10	suits [2] 72/23 75/5	surge [9] 45/24 46/8	47/22 48/25 56/1 57/3	134/10 134/18 135/21
127/22 130/17 134/14	summarise [2] 63/13	56/14 57/8 63/9 70/5	74/1 80/9 84/13 88/21	136/19 137/2 137/7
151/11	103/2	79/4 140/15 158/20	90/14 103/22 123/12	137/22 141/17 141/19
stretched [9] 38/16	summary [2] 44/24	surgery [3] 77/14	124/2 128/16 130/23	149/12 154/18 160/21
58/5 94/21 127/23	153/13	113/10 135/3	138/2	terribly [1] 88/13
130/10 133/1 134/5	Summer [1] 99/21	surges [4] 63/7 63/17	taken [13] 10/25 13/1	test [1] 161/1
134/8 160/24	SUMMERS [12] 9/20	63/20 99/25	14/9 15/24 23/16	testified [1] 66/16
stretching [4] 78/2	10/6 56/10 75/22 86/6	surgical [3] 70/4 70/7	26/17 26/24 47/14	testimony [1] 137/12
131/1 134/10 134/21	91/9 99/24 103/6	77/12	100/25 111/6 112/14	testing [8] 7/13 7/18
stroke [1] 59/23	104/4 112/18 118/11	surprise [2] 24/6	123/8 144/7	73/11 74/7 144/2
stronger [1] 6/21	165/6	66/10	takes [5] 26/2 84/1	160/12 160/16 161/8
struck [1] 2/10	Summers's [1]	surprised [3] 66/20	108/6 149/16 149/17	tests [3] 146/25
structured [3] 12/2	115/10	69/22 113/7	taking [9] 7/9 24/1	147/3 160/19
47/19 80/11	SUNTARALINGAM	surrounded [1]	31/14 55/19 73/19	text [2] 132/4 132/16
structures [2] 157/9	[12] 9/21 10/7 34/19	100/10	76/8 114/20 120/24	than [56] 8/25 14/1
157/15	86/6 88/2 93/10 103/5	surrounding [1]	130/9	14/4 15/22 16/23
student [1] 164/10	113/16 118/11 120/1	88/21	talk [11] 38/12 38/15	18/12 26/10 29/19
students [1] 40/6	137/23 165/8	surrounds [1] 153/19	39/15 48/6 54/16	33/18 33/21 39/23
studies [3] 68/13	supervisor [2] 3/14	survey [12] 64/17	55/18 76/2 105/16	45/19 47/10 51/21
143/14 164/12	6/24	64/20 65/12 65/17	112/20 118/13 130/25	55/21 56/15 57/1 61/2
stuff [1] 7/1	supervisory [1]	66/12 67/11 69/16	talked [9] 44/12 82/3	62/10 63/2 63/8 66/6
subconscious [1]	135/22	69/18 96/13 98/19	110/6 114/8 115/18	69/7 73/22 76/4 76/8
48/17	supplementary [1]	154/2 154/22	124/18 128/3 145/2	79/1 79/4 84/20 85/11
subconsciously [1]	117/18	surveyed [1] 69/9	145/10	85/14 86/17 87/21
46/3	supplies [2] 73/11	surveying [1] 73/14	talking [15] 20/1	88/5 92/17 94/24
subject [1] 153/1	74/7	surveys [2] 68/23	29/23 32/16 33/13	102/9 103/17 104/24
subsequently [3]	supply [9] 79/24	69/6	38/19 41/4 43/19 44/1	105/11 108/2 112/15
17/17 34/25 57/12	81/14 139/19 139/20	survivability [1]	49/19 70/21 75/13	112/18 124/25 126/25
substantial [1] 14/3	139/25 140/1 140/6	46/24	128/14 137/23 155/17	130/19 134/6 135/19
substantially [1]	141/5 141/7	survival [4] 19/4 19/8	159/1	140/15 141/5 142/13
85/18	support [48] 5/7 8/11	105/13 106/5	tallying [1] 61/14	146/21 149/8 157/13
success [2] 146/15	12/14 22/5 27/18	survive [9] 5/12 5/24	tasks [1] 86/16	157/14 160/22
146/16	38/12 39/19 53/12	14/5 47/7 47/7 47/8	teaching [1] 36/16	thank [60] 5/17 9/1
successfully [1]	58/25 68/2 70/5 70/12	47/9 106/9 106/16	team [7] 34/14 59/6	9/6 9/7 9/12 9/13 27/6
162/2	76/24 77/1 77/5 77/9	suspect [2] 32/6 67/9	93/14 117/6 117/12	41/14 44/23 56/4 56/8
such [18] 16/19	81/24 95/19 97/1 97/5	suspected [1] 163/15	129/22 129/22	56/9 79/17 80/13
22/11 24/20 27/15	101/5 107/7 113/24	Sweden [1] 85/15	teams [4] 34/10	81/22 83/5 83/19
37/9 40/5 49/22 63/6	114/1 117/5 117/19	switch [2] 23/9 71/23	115/1 118/7 119/24	83/22 83/24 85/20
65/21 75/19 82/19	119/22 120/13 120/22	49/17	telephone [2] 33/16	85/21 88/7 88/8 88/16
89/15 92/19 93/2	122/22 128/10 128/17	symptoms [2] 69/11	91/12	94/8 99/22 102/19
109/24 110/24 115/3	135/18 136/5 137/9	69/21	tell [12] 3/15 8/22	104/9 105/5 107/15
138/4	137/13 137/18 137/22	system [13] 47/11	32/10 51/13 59/19	109/13 112/16 115/13
suddenly [1] 120/20	138/7 138/17 138/18	48/2 61/13 61/16	96/2 106/17 106/17	115/16 115/19 115/22
suffer [1] 7/25	138/22 139/3 145/3	69/23 71/22 73/4 77/4	106/20 107/6 146/20	115/23 116/9 116/25
suffered [2] 59/22	145/7 145/8 153/18	81/6 92/24 103/25	160/15	117/17 126/3 137/11
163/4	156/24	111/22 129/13	telling [2] 76/21	144/17 145/14 147/19
suffering [1] 2/16	support/guidance [1]	systematic [2] 73/12	159/16	147/20 156/15 156/17
sufficiency [1]	120/13	82/5	tells [1] 107/11	156/20 157/5 158/3
152/15	supported [2] 8/12	systematically [1]	temporary [1] 131/9	159/25 161/13 161/14
sufficiently [1]	138/16	11/22	ten [1] 127/3	161/15 161/17 161/21
149/25	supporting [5] 34/6	systemic [1] 86/24	term [1] 125/2	161/23 164/14 164/20
suggest [2] 61/23	41/5 62/3 121/20	systems [7] 16/18	terminal [1] 11/10	that [1055]
133/10	135/23	17/5 19/22 81/9 84/16	terminology [1]	that's [52] 4/11 12/25
	supportive [2] 81/3			14/22 18/23 20/16

T	75/16 79/2 79/9 81/14 82/15 89/22 90/15 97/7 102/24 108/2 114/7 115/8 118/3 118/9 123/20 124/19 129/6 130/23 131/4 135/25 137/6 138/15 139/14 140/21 142/21 144/3 145/7 146/8 147/1 148/3 149/17 150/20	59/7 59/15 90/12 92/14 124/7 124/21 126/6 143/24 these [35] 11/2 13/3 14/15 33/17 33/23 36/20 38/7 39/17 39/20 41/10 44/25 46/24 48/4 58/22 59/1 59/3 73/2 88/21 94/6 105/21 106/8 109/7 109/7 115/12 123/7 125/18 130/25 132/17 132/19 133/12 138/11 141/24 145/21 155/23 164/17	103/22 105/13 105/25 106/20 108/24 111/5 111/9 113/12 113/14 113/22 114/6 117/24 118/15 118/16 118/18 118/24 120/12 121/6 122/4 123/13 124/9 124/10 124/11 124/22 125/9 126/11 126/19 127/4 127/22 130/24 131/3 131/20 133/17 133/19 134/25 135/25 136/10 137/10 139/13 140/9 140/10 141/12 142/7 144/12 145/15 145/19 145/24 146/7 146/7 146/25 148/17 149/15 149/17 150/4 151/8 151/13 151/15 152/12 152/19 154/16 154/23 156/6 161/13	93/22 99/11 109/4 109/11 110/2 119/7 120/8 122/14 123/25 133/25 140/19 141/12 143/3 143/24 160/20 164/19 time-critical [2] 11/1 19/17 timed [3] 93/5 93/11 94/2 timely [1] 127/21 times [12] 29/3 32/6 54/24 62/1 64/8 64/9 82/4 94/19 98/22 103/12 106/7 128/19 timescale [1] 92/18 timetable [2] 92/23 162/6 tiny [2] 72/1 72/3 tissues [2] 110/15 111/1 titrate [1] 143/1 today [13] 10/3 52/18 70/24 94/13 95/3 118/13 132/15 153/11 155/5 156/25 161/22 162/1 162/7 together [7] 5/18 6/15 7/9 76/12 76/21 108/15 118/4 told [9] 3/8 4/1 41/25 107/25 108/4 108/5 108/23 108/24 109/5 tomorrow [2] 162/6 164/21 too [11] 2/17 8/3 37/3 40/10 47/19 68/7 93/22 100/12 114/5 114/15 116/8 took [4] 35/24 38/9 51/5 135/22 tool [31] 41/16 42/10 43/4 43/10 43/10 44/9 44/14 44/21 47/2 47/6 47/13 47/24 48/9 49/2 49/22 50/3 51/1 52/17 52/21 53/3 54/13 97/25 107/18 109/4 110/12 111/5 111/12 111/21 138/23 156/24 157/20 tools [2] 128/1 139/11 top [2] 58/9 101/7 topic [14] 10/10 41/14 50/8 50/17 54/20 55/23 55/24 55/25 79/20 103/19 107/16 111/22 125/15 139/16 topics [5] 72/19 118/15 118/16 118/18 162/13 total [1] 46/8
that's... [47] 27/19 31/3 42/10 43/19 46/2 56/2 57/19 62/12 66/18 69/15 70/14 77/23 83/18 89/10 89/12 92/15 92/25 108/19 109/10 109/12 111/16 112/8 113/19 115/8 118/25 124/19 128/11 131/10 131/12 132/24 133/19 134/9 134/15 138/16 139/15 142/3 150/2 150/24 151/8 151/19 152/5 152/10 152/14 154/21 157/13 158/18 161/2	themselves [12] 16/17 22/2 24/11 29/19 37/11 49/10 49/15 80/8 97/5 134/20 160/8 163/16 then [92] 10/6 10/20 12/20 13/18 14/2 14/8 14/12 14/20 15/7 15/12 20/15 20/19 25/6 25/19 26/2 26/14 27/6 27/21 27/22 27/24 28/7 28/21 29/7 30/14 31/9 33/1 33/22 35/2 35/14 37/21 38/6 38/18 41/20 42/2 43/12 44/15 46/9 47/3 50/17 51/16 51/20 52/12 53/3 53/22 54/6 54/12 54/20 60/7 65/8 70/1 75/5 79/2 82/7 82/25 89/11 91/16 91/18 92/15 92/22 98/5 101/11 103/18 104/6 105/16 105/24 107/15 109/4 110/7 112/6 112/14 113/8 122/7 123/2 123/8 126/19 126/19 127/4 128/4 128/16 129/20 132/10 132/17 135/20 142/9 143/1 146/10 151/17 152/16 154/8 155/3 157/23 160/22	they [232] they're [1] 16/2 thing [15] 8/2 24/14 42/10 67/9 76/13 80/22 89/22 96/3 97/21 98/23 130/20 130/21 131/13 135/16 139/13 things [43] 4/7 6/16 6/20 6/20 7/12 11/22 17/8 22/4 25/13 28/5 30/16 38/25 41/11 43/11 44/10 53/9 55/14 55/18 70/23 72/1 73/16 73/16 74/19 76/16 76/21 80/5 80/6 81/2 90/8 91/15 94/6 104/19 106/20 110/19 110/20 114/10 122/10 130/25 131/3 138/11 142/7 148/25 150/17	though [7] 19/3 22/10 22/23 64/15 82/2 112/23 160/20 thought [7] 42/1 78/12 97/20 106/9 106/15 139/24 147/11 thoughts [1] 11/4 thousand [1] 133/7 thread [2] 40/8 74/1 threats [1] 81/16 three [8] 1/23 7/20 41/21 45/11 52/13 60/12 63/5 97/23 threshold [2] 69/8 96/15 through [30] 2/1 2/12 16/5 20/3 25/4 29/23 35/8 35/10 35/13 36/10 37/6 40/8 44/25 46/4 56/21 80/11 113/21 113/25 117/6 117/8 121/12 121/25 123/16 124/14 135/3 135/14 138/16 141/7 156/10 159/23 throughout [6] 9/10 40/10 117/14 119/6 120/15 135/13 thrown [1] 71/23 Thursday [1] 164/24 thus [1] 132/7 tied [1] 43/9 time [53] 2/15 3/7 5/6 7/22 8/8 8/21 10/16 10/21 11/1 15/11 15/18 16/10 19/17 28/6 31/7 32/7 38/11 41/9 41/12 41/25 42/18 44/16 46/2 47/20 48/24 57/10 62/17 69/2 69/7 73/17 74/13 76/9 76/11 78/12 80/9 91/4 91/11	
theatre [3] 127/3 140/13 140/13 theatres [2] 70/9 70/10 their [96] 11/4 11/12 11/12 14/10 17/17 21/20 22/2 22/16 22/24 23/22 27/8 27/14 27/15 27/18 28/14 30/2 30/7 30/8 30/14 30/15 30/16 33/24 35/1 35/22 35/24 38/2 39/5 39/7 39/11 39/16 40/10 49/11 49/12 57/12 61/5 62/9 62/21 63/12 64/25 66/19 66/24 67/14 68/15 68/16 68/24 70/9 70/11 73/18 77/14 78/15 80/7 83/17 86/17 90/23 91/1 92/20 92/20 92/21 93/14 93/16 97/1 97/16 97/18 98/16 100/13 100/13 100/14 100/14 102/7 102/15 106/5 106/12 106/18 107/24 110/15 110/17 111/1 112/23 114/2 120/21 121/13 124/22 126/17 129/24 135/17 136/2 142/2 142/22 145/6 145/20 145/22 149/23 150/3 154/5 160/4 160/8 them [67] 5/1 6/8 6/8 6/9 6/10 6/19 8/8 8/9 11/5 12/2 12/18 12/19 12/22 13/20 14/1 14/18 17/3 18/15 21/25 22/3 24/7 30/21 31/4 31/5 32/14 32/18 33/7 33/13 34/22 35/24 38/18 47/2 49/14 65/2 75/11	therapeutic [2] 129/14 155/14 therapies [1] 81/5 therapists [2] 58/19 75/24 therapy [1] 122/14 there [275] there's [6] 11/15 19/24 112/15 124/24 144/23 149/25 thereabouts [1] 60/10 thereafter [1] 164/13 thereby [1] 106/13 therefore [12] 13/13 19/15 33/13 52/19	think [234] thinking [3] 89/12 90/11 124/21 third [2] 101/7 132/3 thirdly [2] 49/4 107/15 Thirty [1] 143/7 this [213] Thoracic [1] 120/19 those [123] 7/7 9/7 14/6 14/18 15/7 15/14 15/17 19/18 23/18 24/7 26/10 26/22 26/25 29/25 30/1 33/9 34/14 37/13 39/10 39/25 41/2 41/12 43/11 44/14 45/24 46/5 48/13 50/16 52/18 55/8 59/22 59/24 61/8 62/1 62/7 65/6 65/15 67/20 68/4 69/10 69/21 72/6 72/7 76/23 76/25 80/10 81/1 82/22 84/18 87/25 90/5 90/8 91/16 92/13 95/1 97/9 97/12 98/11 98/18 100/7	total [1] 46/8	

T	69/24	unconscious [5] 26/20 94/23 100/3 103/15 104/15	unit [18] 30/6 36/18 57/22 64/9 64/13 83/12 95/23 101/5 102/16 106/12 106/19 122/4 122/4 126/10 128/3 137/15 137/15 140/9	135/5 135/19 147/25 153/4 158/21 162/17
totality [1] 66/17	triage [8] 45/15 47/16 54/11 72/15 96/21 97/22 98/23 104/3	under [21] 1/11 10/7 14/6 17/20 27/21 27/25 28/18 46/1 46/20 47/16 60/10 68/15 69/24 73/20 74/19 80/8 97/19 101/2 111/4 138/14 148/11	United [3] 62/24 64/2 68/7	update [2] 10/4 162/3
touch [2] 35/12 129/4	triaged [1] 49/15	underestimates [1] 95/6	United Kingdom [1] 64/2	updated [1] 138/1
touched [3] 26/8 102/24 105/6	triaging [1] 46/17	underestimating [1] 95/10	units [19] 45/25 57/17 60/22 61/4 64/6 64/7 70/10 72/17 72/21 78/11 95/20 97/15 97/17 102/18 111/10 128/10 135/14 148/5 150/2	upon [5] 80/17 102/25 105/6 113/4 113/17
towards [6] 8/1 80/3 92/21 93/16 103/5 159/17	trigger [4] 43/10 83/3 112/1 138/17	underlining [1] 151/4	universal [1] 54/8	urgents [2] 38/21 144/25
tracked [1] 62/22	triggered [2] 44/13 98/5	underlying [2] 27/13 77/23	universally [2] 73/23 157/6	us [52] 1/20 6/10 6/15 6/22 7/23 8/22 9/8 11/18 13/22 29/14 30/9 32/10 33/1 41/25 51/13 57/4 59/19 68/12 71/7 71/20 72/9 75/17 76/22 85/5 85/11 90/23 90/24 93/8 113/22 118/4 119/22 120/4 123/16 129/24 130/7 133/15 133/22 134/18 136/17 136/23 138/11 139/22 140/22 143/1 146/20 146/20 147/1 151/11 157/22 157/23 159/16 160/15
Trades [2] 84/1 162/15	trouble [1] 29/8	underpinning [1] 53/15	university [3] 82/20 100/22 116/22	use [36] 7/6 7/7 34/17 47/2 47/11 52/10 52/18 53/6 53/17 54/17 73/7 104/14 106/23 109/4 112/4 119/18 121/16 125/1 125/24 127/1 127/3 128/2 129/6 131/15 138/9 142/17 142/21 142/23 143/24 156/23 157/23 157/25 158/18 159/15 159/17 161/11
train [1] 149/16	truly [1] 135/3	understaffed [1] 148/12	unlike [1] 13/3	unseen [2] 48/17 49/20
trained [7] 132/20 135/10 147/5 149/13 149/15 149/25 160/6	Trust [3] 40/2 116/22 162/17	understand [32] 12/24 16/25 25/12 26/7 38/10 42/13 42/22 66/19 71/20 73/5 78/4 78/13 81/15 91/19 92/8 92/9 119/22 120/4 120/6 127/16 129/12 129/14 129/19 131/22 138/19 140/19 142/1 142/8 142/24 146/14 154/22 159/15	unlikely [2] 47/8 93/19	unsuccessful [1] 26/15
training [18] 4/4 7/3 7/5 39/19 39/25 40/2 40/4 40/6 40/8 40/10 41/5 41/13 130/24 136/7 137/9 149/8 150/6 164/13	trusted [1] 82/15	understanding [17] 11/24 14/16 17/8 17/19 18/23 24/5 30/3 30/8 32/2 110/5 119/23 121/13 121/17 121/19 122/3 137/14 158/23	unnecessary [1] 147/2	unseen [2] 48/17 49/20
trainee [1] 149/16	Trusts [2] 40/14 41/6	understands [2] 30/12 142/2	unpredictable [1] 94/1	untouched [1] 71/9
trainee [1] 149/16	try [17] 32/1 67/8 71/19 103/2 120/4 121/15 129/2 129/7 134/23 146/15 150/11 156/9 158/20 158/22 159/7 159/17 160/14	understood [13] 18/17 20/25 22/9 48/1 58/7 63/21 64/15 75/8 129/21 133/2 140/21 147/7 155/8	unquestionably [1] 113/5	unusual [1] 36/15
trainee [1] 149/16	trying [23] 32/4 38/15 46/15 60/25 70/3 70/5 70/25 77/12 104/10 104/18 106/6 113/9 118/5 122/3 122/7 123/14 128/15 129/12 129/14 130/7 140/19 141/1 145/5	undertake [2] 68/23 70/6	unquestionably [1] 113/5	unusually [1] 70/8
trainee [1] 149/16	turn [6] 54/12 56/10 72/20 77/3 108/17 125/15	undertaken [2] 68/21 87/16	unlike [1] 13/3	unwell [3] 102/3 126/12 152/21
trainee [1] 149/16	turning [1] 83/21	undertook [1] 41/15	unlike [1] 13/3	unwise [1] 107/11
trainee [1] 149/16	two [23] 39/22 41/19 42/17 42/23 43/11 43/15 44/10 46/25 49/4 63/2 65/5 65/18 80/14 82/5 94/3 105/7 106/20 116/12 136/10 144/19 148/17 163/17 164/6	unexpectedly [1] 11/3	unlike [1] 13/3	up [51] 6/8 6/16 6/19 7/1 17/2 19/25 21/7 26/4 28/4 30/6 30/7 34/10 37/22 38/21 40/24 42/13 44/18 44/23 50/4 51/20 52/18 55/16 56/18 64/18 69/15 74/1 82/24 84/1 84/10 98/2 100/20 102/14 118/17 119/21 119/21 119/25 120/11 120/14 120/16 120/18 120/25 122/1 126/20 130/9 133/6
trainee [1] 149/16	UK [21] 17/16 52/7 57/15 57/25 64/22 75/2 82/5 82/25 84/3 85/14 102/23 112/10 117/4 117/15 117/15 117/17 118/1 127/8 132/12 147/24 158/23	unfortunate [1] 68/5	unlike [1] 13/3	urgent [2] 38/21 144/25
trainee [1] 149/16	UK-wide [5] 64/22 82/5 117/15 117/17 132/12	unfortunately [5] 10/2 11/9 39/8 94/17 102/12	unlike [1] 13/3	urgents [2] 38/21 144/25
trainee [1] 149/16	ultimately [2] 123/2 137/25	unified [1] 24/16	unlike [1] 13/3	urgents [2] 38/21 144/25
trainee [1] 149/16	unable [6] 10/3 29/20 65/24 72/6 106/17 109/7	unintended [1] 130/6	unlike [1] 13/3	urgents [2] 38/21 144/25
trainee [1] 149/16	uncertainty [3] 74/6 104/18 107/6	Union [2] 84/1 162/15	unlike [1] 13/3	urgents [2] 38/21 144/25
trainee [1] 149/16	Unclear [1] 27/5	unique [1] 120/3	unlike [1] 13/3	urgents [2] 38/21 144/25

U	98/12 98/23 99/4 101/13 102/19 106/1 107/11 107/15 111/8 114/17 115/13 117/18 117/20 118/2 118/3 120/2 120/10 120/11 120/12 122/2 122/15 122/20 124/15 126/18 127/13 128/20 129/4 129/9 135/20 135/22 136/2 137/7 137/7 137/13 138/8 140/22 141/10 141/10 142/19 144/10 145/6 145/14 146/9 147/19 147/20 148/15 149/4 150/3 156/6 156/16 157/1 157/7 158/19 160/13 160/20 161/13 161/15 161/17 161/21 162/5 164/21 164/21	25/18 52/4 66/23 96/13 97/24 98/18 99/17 101/15 101/21 102/13 121/9 127/13 157/3 157/4 157/6 157/9 158/12 158/14 162/20 162/25 163/2	144/8 150/2 150/13 150/17 152/12 157/10 157/16 157/19 158/10 158/14 158/15 159/2 161/2 161/4 ways [9] 5/19 45/12 61/15 77/5 125/21 130/6 136/11 141/23 142/15	114/14 150/16 155/7 were [250] weren't [19] 4/9 20/14 35/23 37/2 37/5 59/15 60/14 61/15 70/11 75/25 91/10 97/24 99/2 119/9 122/14 133/1 135/9 145/21 149/25 what [150] 3/4 4/25 6/3 6/18 6/20 6/20 10/25 11/4 11/5 11/18 11/20 11/21 11/25 12/1 13/20 13/23 18/11 20/1 22/21 24/2 27/10 30/12 30/15 30/16 30/16 30/22 31/10 31/10 31/11 35/1 35/2 37/17 38/10 38/11 38/12 38/24 41/23 43/12 43/19 45/21 46/15 47/24 48/22 48/23 49/8 51/7 54/18 58/6 60/10 61/20 62/12 64/19 67/1 69/10 69/17 71/7 71/8 71/8 71/21 72/4 74/23 75/6 76/8 77/23 79/2 79/16 80/7 80/17 81/4 82/25 83/1 84/1 84/7 87/1 87/19 90/4 90/7 90/18 95/14 98/7 100/5 100/12 101/24 103/21 103/21 104/1 104/6 104/7 104/10 106/6 107/5 112/12 113/20 113/25 116/24 117/24 118/6 120/17 120/21 122/3 122/7 122/14 126/19 127/6 128/6 128/16 129/14 131/15 131/15 131/23 133/21 134/16 135/5 135/8 135/21 136/16 136/17 137/14 137/15 137/16 137/21 138/13 139/13 139/24 140/18 141/19 141/21 141/23 142/8 142/9 142/11 142/24 145/4 145/11 146/13 146/16 150/23 151/12 152/14 154/21 156/5 157/15 157/22 158/11 158/14 159/13 159/15 159/22 160/23 161/9 what's [4] 30/2 31/2 46/2 77/8 whatever [15] 11/11 11/13 18/13 20/18 35/12 53/14 53/14 53/15 53/18 54/13 79/3 109/3 145/7 159/9 160/14
V	via [4] 33/16 33/16 94/20 103/14	walls [1] 64/12 Walsall [1] 162/16 want [38] 2/21 13/10 13/21 14/7 14/22 14/25 15/24 21/16 22/13 25/1 30/15 38/12 39/5 39/7 55/14 72/7 72/10 72/11 72/16 73/5 77/15 77/17 80/8 105/7 115/5 122/18 125/6 127/5 129/5 132/1 146/25 147/2 147/25 148/2 151/24 153/22 153/24 160/24	we [463] we'd [1] 21/4 we'd hope [1] 21/4 we'll [1] 51/10 we're [3] 49/19 52/19 58/14 We've [1] 115/14 weaker [1] 14/1 weakness [1] 110/25 wear [1] 7/3 wearing [2] 59/7 75/5 Weatherby [5] 147/21 147/22 154/12 156/17 165/19 webinars [1] 121/3 Wednesday [1] 1/1 week [13] 2/5 2/6 9/25 10/8 51/15 59/11 94/2 97/14 103/13 113/16 115/23 133/24 162/18 weekends [1] 2/7 weekly [2] 65/6 65/8 weeks [2] 41/19 42/17 weight [1] 8/3 welfare [5] 23/21 24/2 25/12 25/18 26/25 well [42] 3/20 7/22 8/5 21/8 22/5 25/23 30/22 34/2 35/3 38/2 39/5 41/7 41/12 52/18 58/10 68/14 68/25 74/16 82/22 87/6 87/6 112/8 113/9 114/23 118/12 119/2 123/14 126/18 131/12 135/23 135/25 136/3 137/18 137/21 143/17 145/2 147/7 150/8 159/14 161/20 162/5 164/21 well-being [6] 7/22 8/5 68/14 68/25 114/23 145/2 well-documented [1] 87/6 wellbeing [2] 118/20 160/1 Welsh [5] 25/15 25/16 52/4 99/16 117/21 went [11] 4/6 17/1 32/11 69/16 71/24 85/14 112/7 113/25	view [7] 46/5 50/1 84/7 138/5 157/14 160/13 160/21 viewpoint [1] 31/13 views [2] 75/15 124/22 viremic [1] 160/21 virtual [2] 120/23 121/1 virtually [1] 121/2 virus [3] 53/14 54/14 120/5 visible [1] 21/4 visiting [2] 91/3 91/14 visits [3] 68/2 68/4 138/18 vocabulary [1] 45/10 voice [5] 117/5 117/19 123/20 123/23 124/3 volition [1] 21/20 volume [1] 140/12 vulnerabilities [1] 87/23 vulnerable [1] 83/16 vying [1] 43/15
	W			
	W2 [1] 163/6 W3 [1] 163/13 wage [1] 5/23 wait [1] 96/20 waiting [3] 114/12 114/15 116/8 wakefulness [1] 146/22 Wales [28] 12/8 17/11 17/12 17/14 17/20 18/20 18/21	wanted [13] 38/3 43/13 55/18 71/14 77/24 78/1 79/10 80/17 101/24 135/11 135/15 141/15 147/8 wanting [1] 135/17 ward [14] 21/9 28/4 33/22 37/2 42/1 42/1 64/11 101/6 101/10 102/2 102/10 105/19 136/22 163/22 wards [7] 3/8 3/15 3/20 66/3 86/17 101/18 128/10 was [364] wasn't [12] 32/7 43/10 47/18 72/17 73/23 87/15 98/6 104/13 111/24 127/10 140/25 141/8 wave [13] 50/25 62/5 62/6 63/1 63/2 64/20 64/24 69/24 77/11 78/25 105/15 154/4 155/15 waves [1] 77/1 way [64] 4/7 4/18 6/6 10/23 10/24 11/22 12/2 12/3 15/3 18/10 24/4 33/16 43/18 60/14 66/20 67/13 70/25 71/20 72/7 74/17 76/9 77/22 80/10 82/18 84/13 85/10 91/3 98/3 98/5 98/17 98/17 102/11 107/6 111/19 114/2 115/5 123/8 124/20 125/19 126/3 127/10 128/24 129/7 130/5 130/19 134/22 137/14 140/4 140/7 142/25	W2 [1] 163/6 W3 [1] 163/13 wage [1] 5/23 wait [1] 96/20 waiting [3] 114/12 114/15 116/8 wakefulness [1] 146/22 Wales [28] 12/8 17/11 17/12 17/14 17/20 18/20 18/21	

W	which [119] 3/8 3/15 11/19 11/22 13/3 13/16 15/16 15/20 16/1 16/21 17/12 19/20 20/20 21/13 22/2 23/17 25/11 25/22 30/1 30/3 34/12 39/7 41/8 43/1 44/1 48/19 50/19 52/15 52/24 53/2 55/12 56/23 58/8 60/1 60/7 63/11 64/1 67/13 71/15 71/15 74/10 74/13 75/20 76/1 78/25 85/16 86/2 86/10 89/15 89/18 89/18 89/23 91/7 91/10 92/12 93/11 93/13 98/17 99/15 103/12 103/19 108/7 109/18 110/6 110/12 110/17 111/3 111/20 112/4 112/6 112/7 117/11 119/16 120/17 125/9 125/15 125/15 125/17 125/19 127/8 128/3 129/11 130/20 131/14 132/11 133/9 134/22 135/23 136/21 138/20 139/5 139/6 140/3 140/4 140/12 140/20 140/23 141/10 142/1 142/5 142/16 143/1 146/19 148/1 148/22 151/22 151/25 152/19 154/6 155/5 155/12 155/13 155/24 156/6 156/24 158/1 160/1 161/8 161/19 whichever [1] 35/6 while [4] 9/14 80/9 81/24 112/22 whilst [9] 48/3 61/9 70/14 95/20 97/18 104/11 135/16 139/2 147/1 white [1] 86/17 Whitty [4] 41/19 42/11 42/16 66/15 who [92] 1/4 6/24 9/10 11/11 14/13 15/13 15/15 15/25 16/6 17/16 25/1 26/10 28/1 28/2 30/20 32/23 33/13 34/2 34/4 39/24 39/25 40/1 41/2 41/24 44/19 46/22 48/2 48/13 51/13 55/2 61/23 62/6 62/7 62/23 63/9 64/21 66/15 67/6 70/4 70/5 71/5 77/13 78/14 79/21 80/20 83/15 85/2 85/22 86/4 88/9 90/23 95/1 95/17	95/20 95/22 96/14 98/19 101/2 102/17 102/18 105/1 105/13 106/1 106/2 106/8 106/9 107/11 110/23 113/22 118/11 120/1 120/12 123/12 136/6 137/5 145/20 145/24 146/17 149/23 154/25 162/15 162/19 162/22 163/3 163/6 163/7 163/8 163/9 163/13 163/14 163/18 164/3 whole [3] 8/2 70/1 133/25 whole-time [1] 133/25 whom [3] 31/6 70/16 164/7 whose [5] 4/1 16/13 34/24 113/21 145/22 why [24] 10/19 10/20 18/1 19/14 19/20 26/14 30/13 32/5 48/9 60/18 63/21 65/13 66/7 71/20 79/15 126/1 127/15 127/18 128/11 139/5 140/12 143/11 155/8 155/12 WI [4] 1/4 1/7 1/11 165/4 wide [12] 9/9 39/13 52/7 55/7 64/22 82/5 84/3 85/16 117/15 117/17 118/1 132/12 widely [2] 93/15 152/1 wider [16] 15/3 15/6 39/3 41/7 43/5 50/2 55/21 76/1 79/20 83/9 83/14 89/12 96/24 97/1 115/10 128/1 widespread [2] 37/8 139/22 wild [1] 32/3 will [51] 1/5 5/19 5/25 6/16 6/19 10/4 11/4 12/8 17/12 19/25 23/13 28/25 29/1 37/20 39/10 39/16 46/18 49/10 49/21 52/8 62/18 64/7 78/17 81/10 100/11 103/2 104/4 104/7 118/13 118/14 118/21 121/23 124/9 127/20 130/4 135/1 135/20 136/20 139/14 142/21 147/1 152/8 153/3 153/7 153/9 154/9 157/17 158/14 161/19 162/3 164/15 willing [1] 150/12 win [1] 145/12	winter [2] 69/2 69/3 wish [3] 14/6 93/21 164/15 wishes [4] 10/25 11/3 39/11 100/15 withdrawn [2] 110/8 112/3 withdrew [3] 9/16 115/25 161/24 within [25] 3/14 17/3 48/12 73/6 74/24 78/3 86/20 87/13 87/25 94/3 123/7 123/17 125/4 128/24 129/4 130/8 131/6 135/17 142/17 144/11 151/20 154/10 154/24 157/8 158/17 without [12] 5/6 20/21 36/2 36/3 36/25 39/9 91/15 97/5 110/7 114/20 151/16 162/11 witness [16] 1/4 9/16 10/1 17/17 33/15 75/21 100/21 116/12 119/14 123/17 123/22 125/22 139/17 158/5 160/2 161/24 witness' [1] 162/1 witnesses [4] 9/14 115/25 120/2 163/17 witnesses' [1] 162/12 won't [8] 20/3 22/15 24/17 24/18 44/25 74/1 79/8 114/8 wonder [4] 24/13 55/23 56/18 93/2 Woodward [7] 94/9 94/10 156/18 156/19 161/15 165/14 165/20 word [1] 73/7 words [1] 110/14 work [63] 2/3 2/11 2/18 2/21 4/23 4/24 5/22 8/15 19/18 22/15 23/13 34/13 40/11 41/15 43/6 44/22 47/5 48/22 50/17 50/23 51/16 55/12 67/14 68/21 73/14 78/12 78/15 78/16 78/17 79/22 83/2 84/24 108/14 110/5 111/8 112/10 112/23 115/7 115/17 117/14 118/8 118/22 119/19 122/15 128/8 128/12 130/2 134/22 135/9 136/6 137/5 137/19 142/4 142/5 143/22 150/7 150/9 151/3 159/15 160/25 160/25 161/17 161/18	work-round [1] 151/3 worked [11] 1/13 1/17 8/6 51/14 80/25 112/6 119/7 130/5 138/2 163/7 163/22 worker [3] 12/14 71/4 163/14 workers [20] 6/2 55/18 70/12 70/16 75/4 86/3 86/13 86/15 86/19 87/8 87/11 87/18 87/19 87/24 88/1 113/2 113/14 114/4 114/5 148/7 workforce [7] 130/8 136/11 144/19 144/21 152/2 152/3 156/10 working [29] 1/20 1/22 1/24 2/2 3/5 5/22 7/23 8/23 9/10 18/2 39/25 41/17 42/11 46/6 74/4 76/24 77/15 78/14 112/22 118/20 119/3 130/16 131/2 135/7 136/8 137/24 141/18 149/19 164/2 works [4] 8/11 18/6 70/25 85/2 world [1] 17/5 worn [1] 74/5 worried [1] 4/19 worry [4] 83/21 115/15 151/15 161/20 worrying [1] 49/10 worse [2] 14/4 33/21 worth [7] 18/9 21/6 25/21 38/22 39/4 41/1 133/18 would [218] wouldn't [13] 5/23 6/22 14/6 20/20 27/16 36/10 36/22 51/1 62/14 66/25 81/18 115/5 131/17 write [1] 12/3 writing [1] 95/16 written [5] 22/6 109/18 115/19 161/19 164/18 wrong [3] 63/14 145/25 146/1
			Y	
			Yeah [1] 150/22 year [1] 66/19 years [13] 60/12 62/10 71/6 82/5 113/11 119/13 130/23 130/24 143/7 143/14 145/19 149/16 149/17 yellow [1] 60/7 yes [107] 1/3 1/12 1/15 1/19 2/1 2/16 2/19 2/24 3/12 3/22	

Y
yes... [97] 5/6 5/10
5/17 6/5 8/21 8/25
11/11 12/17 12/25
13/15 15/2 16/4 16/8
16/11 18/16 19/6
19/10 20/22 20/24
21/3 21/17 21/21
21/24 23/1 23/4 23/22
24/3 24/3 25/8 25/15
25/16 26/18 26/21
26/23 28/17 29/6
31/21 31/25 33/5
38/22 40/19 42/9 43/2
43/5 43/17 47/6 49/25
53/16 53/22 53/24
54/5 54/25 57/23 58/1
59/9 61/19 62/16 63/3
68/18 71/12 71/18
75/1 79/7 83/15 83/24
88/15 108/8 108/22
109/5 119/12 119/20
120/25 123/5 123/10
128/20 130/11 130/18
131/12 133/4 137/11
138/7 139/2 141/6
147/7 148/12 148/13
149/11 149/14 149/21
151/15 151/19 152/11
152/22 153/15 153/19
154/8 161/11
yesterday [2] 42/5
136/20
yet [3] 49/7 78/16
164/15
you [536]
you're [1] 88/15
young [1] 55/17
younger [4] 62/6
63/10 105/13 106/16
your [110] 1/20 1/24
2/20 3/14 5/2 5/9 5/23
6/22 7/10 7/21 7/24
8/5 8/14 8/19 8/22 9/8
10/7 10/13 18/17 19/7
20/10 29/3 34/17
36/16 37/22 39/3
44/22 50/4 50/10
50/17 51/16 54/23
56/13 56/17 56/20
59/17 59/21 60/16
61/21 64/8 66/10
67/22 67/23 68/13
68/20 71/15 72/20
72/24 74/2 74/11
75/15 75/16 76/22
77/25 79/18 83/21
83/22 86/18 88/22
91/14 93/8 94/15 95/3
95/6 98/7 99/18 103/1
103/8 105/6 105/7
108/9 108/21 109/16
111/7 112/20 112/25

113/6 115/15 115/17
115/19 115/21 115/22
115/22 116/10 118/25
119/1 119/2 119/14
123/17 123/21 123/22
125/22 129/4 131/6
139/17 148/14 153/24
156/25 158/4 158/12
160/2 160/10 161/3
161/17 161/18 161/19
161/20 162/3 162/7
162/9
your Ladyship [3]
37/22 162/3 162/9
yours [1] 106/25
yourself [5] 5/20 6/14
34/4 47/12 148/4
yourselves [2] 22/12
151/1

Z
Zoom [3] 32/9 33/7
33/16