

Tuesday, 26 November 2024

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2 (10.00 am)  
3 **MS NIELD:** My Lady, are you able to see and hear the hearing  
4 room?  
5 **LADY HALLETT:** I can, thank you, Ms Nield.  
6 **MS NIELD:** My Lady, I'd like to call, please,  
7 Anna-Louise Marsh-Reese.  
8 **MS ANNA-LOUISE MARSH-REESE (affirmed)**  
9 **Questions from COUNSEL TO THE INQUIRY**  
10 **LADY HALLETT:** Ms Marsh-Reese, can I just say how sorry I am  
11 that I can't be there today. I think you know me well  
12 enough by now that I would have been there if I could.  
13 But I'm obviously very appreciative of you and your  
14 fellow bereaved coming along to give evidence again.  
15 **THE WITNESS:** Thank you, and I hope your Honour mends  
16 quickly.  
17 **MS NIELD:** Can you give your full name, please.  
18 **A.** It's Anna-Louise Marsh-Reese.  
19 **Q.** Ms Marsh-Reese, you've provided a witness statement for  
20 this module of the Inquiry, dated 10 November 2024.  
21 That's INQ000343992. Can I check that you have a copy  
22 of that witness statement in front of you?  
23 **A.** I do.  
24 **Q.** I think you're familiar with that witness statement?  
25 **A.** I am.

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1 they can contact the group directly or go via our legal  
2 team.  
3 **Q.** And could you please explain the purpose and the primary  
4 aims of your group.  
5 **A.** As I said, initially we wanted answers. We just --  
6 which we couldn't get via the formal complaints process.  
7 So our initial objective was to call for  
8 a Wales-specific inquiry. We felt that would be the  
9 right way to scrutinise the very specific problems in  
10 Wales. And that's not to say we didn't want to be in  
11 the UK inquiry too, we just felt that that would be able  
12 to cover the breadth and depth of the very specific  
13 issues in Wales.  
14 **Q.** Thank you.  
15 You've helpfully set out in your witness statement  
16 at paragraph 56 the extent of the Covid Bereaved  
17 Families for Justice Cymru's engagement with a number of  
18 organisations, the Welsh Government primarily but also,  
19 to some extent, the UK Government, the Welsh NHS bodies  
20 and other interest groups and independent bodies in  
21 Wales. But I think it's right to say that the group had  
22 a number of meetings with the Welsh Government during  
23 the relevant period and subsequently, and those were  
24 meetings with the First Minister, the Minister for  
25 Health and Social Services, and the Deputy Chief Medical

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1 **Q.** Thank you. You're a founding member and co-leader of  
2 the Covid Bereaved Families for Justice Cymru; is that  
3 right?  
4 **A.** That's correct.  
5 **Q.** And I think that organisation is the non-political not  
6 for profit organisation; is that correct?  
7 **A.** That's correct.  
8 **Q.** Could you tell us, please, how the group came to be  
9 established.  
10 **A.** It came to be established -- my father died of  
11 hospital-acquired Covid in October 2020, and  
12 I immediately tried to get some answers as to how that  
13 had happened. I then found other people in the same  
14 hospital and the same health board that had experienced  
15 similar. And then that grew and found, sort of, many  
16 people across Wales that had experienced the same,  
17 and -- we were part of a UK group, UK-wide group, but  
18 we, you know, quickly realised that because healthcare  
19 and social care are devolved to Wales that we needed to  
20 focus on the Welsh issue specifically.  
21 **Q.** And can you tell me how many members the group has  
22 currently?  
23 **A.** We have about 400 members.  
24 **Q.** And how do members join the group?  
25 **A.** They can join via Facebook, they can join via Twitter,

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1 Officer, Dr Chris Jones; is that correct?  
2 **A.** That's correct, yes.  
3 **Q.** For the remainder of your evidence I'd like, if I may,  
4 to look at the key areas of concern to your group that  
5 fall within the scope of Module 3. So, first of all,  
6 primary care and access to primary care in particular  
7 I think was a concern for a number of your members, and  
8 I think you set this out at paragraphs 16 to 17 of your  
9 witness statement. But is it right to say that there  
10 was certainly at least a perception for many of your  
11 members that general practice was closed or certainly  
12 closed for inpatient -- in-person visits; is that  
13 correct?  
14 **A.** Absolutely, yes. More than the perception, many of our  
15 members, including my family, could not access their GP.  
16 There was never any question that there would be  
17 a face-to-face consultation. Video consultations never  
18 mentioned.  
19 **Q.** I think you explain in your witness statement that when  
20 your father was discharged from hospital, he'd been  
21 admitted to hospital for a non-Covid complaint, I think  
22 that's right, but he'd been exposed to Covid-19 when he  
23 was on the hospital ward, and after he was discharged  
24 and was unwell, your contact was with the out-of-hours  
25 GP; is that right?

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1 A. Initially it was with his personal GP, so there was  
2 a number of calls with him, and then as his condition  
3 deteriorated, we had visits from four out-of-hours  
4 doctors, not one of whom suggested Covid even though it  
5 was written on his discharge summary that he had been  
6 exposed to Covid on his ward.

7 Q. Did the out-of-hours doctors appear to have access to  
8 those discharge notes?

9 A. We have checked. They did.

10 Q. And now if we could move on, please, to issues that had  
11 been raised by your members in relation to 999,  
12 emergency ambulances, and the 111 telephone triage  
13 service. I think it's right to say that 111, in fact,  
14 wasn't available across all of Wales during the relevant  
15 period; is that right?

16 A. Sadly not. Three of the health boards did not have  
17 a 111 service, so this is where the divergence between  
18 England and Wales starts. Yeah, I mean -- and it was  
19 also chargeable in those three health boards. It  
20 wasn't free.

21 Q. So the health boards that offered 111, it was  
22 a chargeable phone number?

23 A. Yes, it's all very complicated and it's unique to Wales,  
24 of course, that the 111 service is run by the Welsh  
25 Ambulance Service, but then the triage and sort of

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1 hospital or needed a test with everything, but the lack  
2 of acknowledgement that those were Covid symptoms and,  
3 you know -- and it was definitely acknowledged they were  
4 by October 2020. It was a real miss.

5 Q. I think one of your members had had one of those  
6 experiences where they were calling the 111 service  
7 repeatedly and being told that their loved one was fine,  
8 there was no need to go to hospital, it wasn't going to  
9 be Covid, and eventually, I think that patient was  
10 admitted to hospital, did have Covid and, sadly, died  
11 from Covid; is that right?

12 A. That's correct, yes.

13 Q. I think there are also some issues that you've raised  
14 from your members with emergency ambulances and calling  
15 the 999 number and the excessive waiting times in Wales.  
16 What steps did your members have to take when they were  
17 told they were going to have to wait for hours for  
18 an emergency ambulance?

19 A. I mean, most of us were told, "Don't bother ringing 999,  
20 take them yourselves." My sister had to literally bump  
21 my dad down the stairs and take him in the car. I mean,  
22 the poor man could barely walk.

23 Q. And was your sister living with your father at that time  
24 so she came from another household in order to travel --

25 A. I mean, we had no choice at that point. He was so

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1 callbacks are done by the respective health boards.

2 Q. I think one of your members had an experience of trying  
3 to call 111 and not being able to get through, but there  
4 wasn't actually a recorded message at that time  
5 explaining that the 111 service wasn't operating in that  
6 area; is that correct?

7 A. That's correct, yes, and I think one of the main  
8 concerns is the confusing, conflicting information that  
9 we did get when we called, and part of the problem was  
10 that Covid was only deemed -- there was only three  
11 symptoms that were attributed to Covid. So if you had  
12 any of those other symptoms you were just told it's  
13 fine, just, you know, don't worry, when in fact they  
14 were clearly Covid symptoms.

15 Q. So I think the initial three symptoms that were  
16 identified on the 111 service were fever or chills,  
17 a persistent cough, and shortness of breath. So it's  
18 anything out of those three symptoms that wasn't  
19 recognised as a potential symptom of Covid; is that  
20 correct?

21 A. That's correct, and I think many older people don't  
22 display those three cardinal symptoms and they,  
23 you know, it is extreme fatigue, it's headaches, it's  
24 nausea, it's diarrhoea, and some others. We're not  
25 suggesting that everybody should have, you know, gone to

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1 unwell that she had to do that to help him.

2 Q. You also raise issues in your witness statement in  
3 relation to the guidance that was being put out for  
4 members of the public, the guidance around the symptoms  
5 of Covid and the fact that many of your members found it  
6 confusing and unclear; is that right?

7 A. Yes. I mean, it was unclear for many reasons, you know,  
8 we have the whole England/Wales differences. But,  
9 you know, we have a Chief Medical Officer in Wales who  
10 said there's no need to wear face coverings, you know,  
11 we got conflicting and confusing communications about  
12 shielding. Pretty much across the board different ways  
13 of saying things and, again, the symptoms was a key part  
14 of that. The whole, sort of, Protect the NHS, my family  
15 would -- my dad was absolutely not going to go to  
16 hospital unless he absolutely needed to. It wasn't the  
17 right thing to do. Sadly he did have to go and,  
18 of course, that was where he got Covid so ...

19 Q. I think you give the example of your father receiving  
20 a shielding letter -- or at least a shielding letter  
21 being sent to your father in fact after he had died,  
22 in October of 2020, and some of the advice given in that  
23 letter including that Covid tests would only work if the  
24 patient was symptomatic; is that correct?

25 A. Yes, and not only -- so it actually says in this

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1 shielding letter that was -- that arrived the day after  
 2 my father died that was (a) telling him he didn't need  
 3 to shield, which seemed completely baffling because  
 4 obviously he was 85 with comorbidities, but not only  
 5 that you should only take a PCR test if you had  
 6 symptoms, but only with these three symptoms, and that  
 7 it was pointless to do one if you didn't have symptoms,  
 8 which I -- we know in October 2020 that everyone knew  
 9 that, you know, you could test positive and be  
 10 asymptomatic.

11 **Q.** I think you've also identified that there was an issue  
 12 with accessibility of the guidance and advice that was  
 13 being produced by the Welsh Government in that it wasn't  
 14 easily accessible for people who were deaf or visually  
 15 impaired or indeed had learning disabilities, and it was  
 16 the case, was it, that not all Welsh Government  
 17 broadcasts included a BSL interpreter?

18 **A.** Yeah, absolutely.

19 **Q.** What about information about local outbreaks? Was there  
 20 any information put out by hospitals about whether they  
 21 had an outbreak of Covid at their hospital and whether  
 22 to stay away? Was that information easily accessible?

23 **A.** No, and in fact it was well hidden. It was proactively  
 24 not broadcast, you know, and I think that's one of  
 25 the -- obviously the main -- one of our main concerns is

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1 that were in place. I think you give the example of  
 2 a patient who had moved hospitals within a single health  
 3 board in Wales; is that right?

4 **A.** That's correct.

5 **Q.** Experienced quite different care in those two different  
 6 hospitals?

7 **A.** And I know the Chair is looking at systemic issues, but  
 8 there are systemic issues that are pertinent just for  
 9 Wales, but there is also a lack of systemic issues  
 10 because each health board does things so differently.  
 11 And that's -- you know, that's -- it just seems crazy  
 12 that there is not at least a commonality, you know,  
 13 about processes and policies.

14 You know, we understand there needs to be some  
 15 flex for the local, but there should at least be some  
 16 consistency. And this wasn't just across health boards,  
 17 this was, you know, across hospitals within health  
 18 boards and also at ward level: different rules,  
 19 different policies, different interpretation of those  
 20 policies.

21 **Q.** And so you've given the example of a family of a patient  
 22 who wasn't allowed to visit their loved one when they  
 23 were dying but also there wasn't any process or means by  
 24 which they were offered a video call; is that correct?

25 **A.** I don't think anyone was. There was zero patient

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1 that clusters and outbreaks were not communicated.

2 You know, I literally had to take screenshots of  
 3 each health board's Covid pages, and I did them,  
 4 you know, two years ago, and there was just practically  
 5 nothing about Covid on there, even how to protect what  
 6 you do, you know, and it seemed such a simple way of  
 7 communicating to people, you know, via a website, you  
 8 know, what you should do and how you should do it. You  
 9 know, what visiting hours were, what protections were in  
 10 place at the time. Just absolutely nothing. It was  
 11 almost like the pages had been forgotten.

12 Also no letters sent about things. I mean, my  
 13 father's GP and the out-of-hours doctors didn't seem to  
 14 be aware that there'd been a cluster outbreak in my  
 15 father's hospital, which was 21 patients, 13 staff, and  
 16 yet the ward had been closed for four days after. So it  
 17 just seemed, in a small place, that that wasn't  
 18 well-known or communicated -- or at least communicated  
 19 to local GPs.

20 **Q.** If we could look at some of the examples that your  
 21 members have given about their concerns about the  
 22 quality of care that was being provided in hospitals in  
 23 Wales, I think you refer to a "postcode lottery" in  
 24 terms of inconsistency between different hospitals in  
 25 terms of the sort of care and the kind of procedures

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1 liaison. I think that's one of the biggest things as  
 2 well, for a recommendation, is the lack of a patient  
 3 voice for the patient themselves and the liaison with  
 4 the families. That should -- you know, if you can't see  
 5 your loved one when they're dying, which we do believe  
 6 you should anyway, but if you can't there has to be --  
 7 you know, with all the technology we've got nowadays  
 8 it's not beyond the wit of man to have an iPad to be  
 9 able to communicate with them.

10 But then of course we come back to the lack of  
 11 digitisation: in many hospitals and wards there was no  
 12 Wi-Fi. So many, many issues across that communication  
 13 piece.

14 **Q.** I think some of your members had to say goodbye to their  
 15 loved ones by text message; is that correct?

16 **A.** That's right, and they just had to hope that somebody  
 17 gave them that text message. You know, we have many  
 18 examples of when their loved one's items are returned  
 19 there's a mobile phone with, you know, hundreds of  
 20 missed calls. You know -- and it's not just that kind  
 21 of communication, it's also the communication with the  
 22 patient. Many patients were not, sort of, you know,  
 23 technically disabled, but age is, of course,  
 24 a disability in itself, but, you know, people weren't  
 25 given hearing aids or glasses. You know, their world

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1 was already quite small and silent, and yet that only  
2 added to it. And I think, you know, we really have to  
3 think about, you know, that.

4 And one of the things I did want to say, that,  
5 you know, was -- you know, we've heard a lot about --  
6 and absolutely rightly -- about emergency medicine and,  
7 you know, what happened in ICUs, all vital to  
8 understand, but most of our loved ones, you know, in our  
9 group, were older. They led very silent, quiet deaths.  
10 And as Julia Jones from John's Campaign said, it's  
11 almost death by indifference. You know, nobody  
12 communicated to them, nobody told them what was  
13 happening, they didn't have communication with their  
14 loved ones. And I really do think we need to ponder on,  
15 you know, that element of it. It's those quiet silent  
16 deaths that are the real tragedy, I would say.

17 **Q.** And you have set out, I think this is at paragraphs 37  
18 and onwards in your witness statement, your members  
19 certainly have felt that at times there appeared to be  
20 some discriminatory practices within hospitals in terms  
21 of access to treatment or escalation of treatment for  
22 their loved ones when their loved ones were elderly, and  
23 you give the example of having to wait 12 hours before  
24 the administering of medication, having to wait for CPAP  
25 devices, having to wait for high-flow nasal oxygen.

13

1 member; is that right?

2 **A.** That's correct, yes, and she was also power of attorney  
3 as well.

4 **Q.** She had power of attorney?

5 **A.** Yes, and that wasn't -- that seemed to be ignored.

6 **Q.** So she wasn't consulted?

7 **A.** Not at all. I don't think any of us were explained what  
8 treatment -- you know, once Covid was diagnosed we  
9 weren't explained what treatments were being undertaken.

10 It was more a question of we were told what we weren't  
11 getting so, "Your loved one will not be ventilated". We  
12 would recommend that it's so important to explain the  
13 good things that are being done. You know, steroids,  
14 you know, dexamethasone, very effective, you know, if  
15 I had known my dad was being given that I would have  
16 felt, you know, more confident that he was being treated  
17 with the right steroid or the right -- yeah, it's just  
18 those -- it's not a little thing, obviously, but they're  
19 relatively easy things to solve and, you know, one of  
20 the things I did canvas my group last night and said,  
21 "What is the one thing you want me to say tomorrow", and  
22 they said communication is absolutely vital. Clear,  
23 honest communication.

24 **Q.** And I think there were a number of examples when there  
25 wasn't any communication from the hospitals, calls went

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1 I think your father had to wait some time after his  
2 oxygen levels had dropped before he was offered oxygen;  
3 is that correct?

4 **A.** Yes, his oxygen levels dropped dramatically and, you  
5 know, they knew they weren't going to ventilate him and  
6 we understood that but he was -- they couldn't find the  
7 high-flow oxygen machine for 40 minutes, and then they  
8 told us he was dying. We didn't find out about that  
9 until two years after. That was not explained to us at  
10 the time. When I asked -- when I did arrive --  
11 fortunately we were allowed to be with him when he  
12 died -- I was told -- he became agitated. Well, now we  
13 know he was probably agitated because he hadn't had  
14 oxygen for 40 minutes but I, you know, as you do, and  
15 I was in a panic and very distressed I said, "Please,  
16 please can you try again", and the doctor said, "That  
17 ship has sailed", and I think this is also something  
18 we're really keen, you know, to change, is that words  
19 matter, the way the words are written, the way that  
20 words are said. Things like that are just, you know, it  
21 haunts my sister and I. That -- it's just so casual  
22 and -- well, you know.

23 **Q.** I think you also give the example of a patient who was  
24 refused antibiotics on the basis of their clinical  
25 frailty score, that was relayed to you by another

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1 unanswered, and loved ones and families were not being  
2 given updates either about the progress of their family  
3 member, or indeed what kind of treatment they were  
4 receiving.

5 **A.** Exactly. We understand people are busy. But, you know,  
6 when my father was dying of Covid, it wasn't  
7 a particularly busy time but, you know, this is where  
8 you have to look at other -- this is where the patient  
9 voice groups and the patient liaison teams come in, all  
10 of which seemed to be -- were not -- were definitely not  
11 around when -- you know, during the first and second  
12 waves in Wales.

13 **Q.** And perhaps also related to that communication issue,  
14 you set out a number of your members' concerns around  
15 DNACPR notices during the pandemic, and in particular  
16 a lack of communication around those decisions. And  
17 I think you give the example of one patient who lacked  
18 capacity and had, in fact, a lasting power of attorney  
19 for one of their family members but they weren't  
20 involved in any consultation around the making of  
21 a DNACPR notice; is that correct?

22 **A.** That's correct. Most of us were not consulted. And  
23 most of us didn't find out there even was one placed  
24 until we got hold of the hospital notes and that could  
25 be some months, even years, later. And then also the

16

1 confusion with the DNACPR and the treatment escalation  
2 plan. My dad's are contradictory to each other, the  
3 treatment escalation plan says he is eligible for CPR;  
4 his DNACPR says he's not. Neither of them are filled in  
5 completely, and, you know, we were told by the health  
6 board that they had tried to contact us, but that we  
7 were having our dinner. How they knew this, we've no  
8 idea, but they have subsequently apologised that they  
9 did not attempt to consult us on that.

10 But apparently my dad was fine with it. And,  
11 again, words matter. It says on my dad's CPR, "We  
12 explained to the patient that CPR would be futile".  
13 I pray that they did not use the word "futile" to my dad  
14 because, I mean, you just wouldn't, would you?

15 **Q.** Also perhaps on this subject of communication and  
16 insensitive communication, I think it's right that  
17 a number of your members voiced concerns about the  
18 communication they had from hospitals after their loved  
19 ones had died, and returning their loved one's  
20 belongings to them. I think you give the example of one  
21 family being told to burn their loved one's belongings;  
22 is that right?

23 **A.** Yes, or they got someone else's. You know, really --  
24 soiled, undergarments, urine-soaked slippers. One lady  
25 got her stuff back about -- her husband's stuff back

17

1 DNACPR. We've had to do that all of our own volition  
2 and lobbied very hard to get those changes.

3 **Q.** Can we move on, please, to look at some of the issues  
4 that you've raised and your members have raised in  
5 relation to concerns around infection prevention and  
6 control measures in Welsh hospitals. I think there are  
7 a number of concerns that have been raised by your  
8 members -- and this is paragraphs 40 to 50 in your  
9 witness statement, Mrs Marsh-Reese -- particularly  
10 around failures to segregate patients according to their  
11 Covid status. I think that was experienced by a number  
12 of yours members; is that correct?

13 **A.** Yes, there was seemingly a categorisation system of  
14 amber, green and red wards, but, you know, we all  
15 witnessed non-Covid patients being put on Covid wards,  
16 conversely, you know, one of our members had both her  
17 mother and father with Covid put on a non-Covid ward,  
18 people on corridors. You know, an inconsistent  
19 utilisation of those categories. I mean, any of us that  
20 were there, you know, experienced it firsthand in both  
21 waves 1 -- and seemingly particularly in wave 2, there  
22 just seemed no rhyme nor reason to what people were  
23 doing. You know, we hear repeatedly "I was following  
24 the IPC guidelines". We'd just have to say, well, did  
25 someone not -- you know, it's a sign of insanity, isn't

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1 about a year later with two half-opened packets of  
2 biscuits in them. You'd have thought that there would  
3 just be some kind of process to check what was being  
4 handed over, usually in a bin liner or a plastic bag,  
5 and, you know, it's back to that dignity in death.  
6 These are people's lives and I think that was largely  
7 forgotten. I think the individual was forgotten, you  
8 know, in amongst all of the confusion and chaos.

9 **Q.** I think you set out in your witness statement that four  
10 of your members, at least four of your members,  
11 experienced the hospital morgue having lost the bodies  
12 of their loved ones temporarily and not being able to  
13 locate those bodies.

14 **A.** Absolutely, and not even a real apology. It was just  
15 like, "Oh, well, they've been moved to hospital X". One  
16 of our members had to actually stop her father's body  
17 being transported to a supermorgue many, many miles  
18 away. Yeah, it's all about communication. It's all  
19 about respect. And it's about listening. And I think,  
20 you know, we know there's been a number of reviews and  
21 investigations, albeit a patchwork, cobbled-together  
22 list, but never once have any of the health boards or  
23 the Welsh Government consulted those who were actually  
24 there and asked us how we think things could be made  
25 better, be it communication or infection control or

18

1 it, to keep doing the same thing and expect different  
2 results, but cluster outbreak after cluster outbreak was  
3 happening in Wales and yet nobody seemed to go, "Hang on  
4 a minute, are those IPC guidelines working then because  
5 we -- you know, with the same -- how is it still  
6 happening? How are we still having so many infections  
7 and deaths?"

8 **Q.** I think there were occasions when your members had  
9 intervened to try to ask for their loved ones not to be  
10 placed on a Covid ward. I think you give the example of  
11 a patient who was immunosuppressed and asked for them  
12 not to go on the main ward but they were placed on that  
13 ward and contracted Covid in those circumstances; is  
14 that right?

15 **A.** Absolutely. And, you know, even when somebody was with  
16 suspected Covid, they kept them on the ward until they  
17 tested positive. So that was a scenario in my dad's  
18 non-Covid ward was that, you know, patient zero got it,  
19 and then everyone else got it, but they weren't testing  
20 regularly, they -- you know, they weren't -- there was  
21 just no system or structure to, you know -- and, you  
22 know, we'd say IPC, the prevention, the P word, you  
23 know, you need to prevent it first of all. And that  
24 comes back to, you know, building hospitals or starting  
25 to build hospitals with the right ventilation.

20

1 I mean, Florence Nightingale was saying this  
2 160 years ago. I mean, it's no surprise. We have  
3 reports from 2001 from Welsh Government saying,  
4 you know, that -- I think one in ten Welsh hospitals  
5 were built before 1900. It's not unknown that this  
6 stuff needs to happen. So prevention is absolutely key.

7 We know that ventilation can't be implemented  
8 overnight but there could have been HEPA filters put in.  
9 They had been -- their efficacy had been tested,  
10 you know, I think at the -- Addenbrooke's, Cambridge,  
11 in, I'm going to say, July 2020. You know, it's not the  
12 only solution but it's -- it cleans the air. You know?

13 And it's every human -- it's a human right to have  
14 fresh, uncontaminated air, isn't it? You know, you  
15 wouldn't build a public building without fire  
16 prevention, you wouldn't make people eat contaminated  
17 food, and yet this concept of having clean, fresh,  
18 uncontaminated air just seems to have bypassed  
19 everybody. And I'll be honest, it still has.

20 **Q.** I think there are also concerns around the way that PPE  
21 was being used or worn in Welsh hospitals. I think  
22 a number of your members saw healthcare workers with  
23 inadequate PPE or sometimes wearing it incorrectly,  
24 masks being worn --

25 **A.** Chin wearers, yes. That's a thing, yes.

21

1 local health boards, particularly in relation to  
2 visiting around end of life. And what were the views of  
3 your members in relation to those visiting restrictions  
4 when it appeared that other IPC measures were  
5 implemented in quite a lax manner?

6 **A.** Well, that's exactly it, isn't it? I mean, if -- there  
7 would be no reason for you not to visit your loved one  
8 if you had been given an FFP3 mask. There would be no  
9 reason. You would not be -- there would be no risk of  
10 you passing it to anyone else on your way to visit them.  
11 Clearly they'd already got Covid. You would also be  
12 protected from them giving you Covid.

13 Everybody must have someone with them when they  
14 die. They just must. And it would have been, again,  
15 a simple solution to have enabled that.

16 **Q.** Another aspect of IPC, testing, which you've touched on  
17 briefly.

18 I think your group have a number of concerns,  
19 particularly around testing of asymptomatic healthcare  
20 workers and the delay in bringing in that policy in  
21 Wales and then implementing that policy across all of  
22 the health boards.

23 I think it's right that some health boards had not  
24 implemented that policy until March of 2021; is that  
25 right?

23

1 **Q.** And also I think there were some concerns from your  
2 members about the use of agency staff who may have moved  
3 between several different hospitals and the potential to  
4 spread nosocomial infection in that way; is that right?

5 **A.** Yes, and there's a number of things there. Obviously,  
6 you know, we know -- I mean, I didn't know at the time,  
7 but, you know, the right masks weren't being worn anyway  
8 but even surgical masks weren't always being worn or  
9 being worn incorrectly. You know, the whole apron  
10 thing, we have no idea what -- how an apron was going to  
11 protect you from Covid but that seemed to be a thing.  
12 And absolutely this is, again, where consistency is  
13 required. If you have agency staff maybe working across  
14 a number of hospitals, if they don't -- if there's  
15 different rules and policies in different hospitals and  
16 health boards, it's opening up the risk of human error.  
17 I mean, it's not even -- it's not a risk, it's likely to  
18 happen, isn't it? Because they just don't know. Oh, in  
19 this hospital we do it this way and in another hospital  
20 we do it that way. I mean, it's just so simple, isn't  
21 it, to have a set of consistent policies that everybody  
22 follows?

23 **Q.** And you identify, particularly in relation to IPC  
24 measures, inconsistencies in the visiting restrictions  
25 that applied in different hospitals or across different

22

1 **A.** Yes, and Professor Kloer, who gave evidence a couple  
2 of weeks ago, said in his health board it was  
3 actually July. In England that was brought in  
4 in November 2020, as soon as, basically, lateral flow  
5 tests were made available, so this enabled healthcare  
6 workers to test twice weekly and, clearly, not work if  
7 you -- even if you were asymptomatic.

8 Now, what the reason for that is, we've heard many  
9 and varied reasons, from distribution to UK Government  
10 comms, didn't quite get that one. But when we met with  
11 the then health minister, Eluned Morgan, she told us  
12 they needed a strategy, that was why it was delayed:  
13 they needed a strategy and it wasn't an easy thing to do  
14 to get those tests out. I mean, how it took over  
15 six months to get lateral flow tests when hospitals  
16 already have an established distribution network is  
17 beyond our understanding. We can only imagine -- maybe  
18 that was -- it was done on purpose, we don't know.

19 But just to touch on it, it's not just the  
20 healthcare worker testing. Once they realised that they  
21 shouldn't be discharging -- not realised, it was  
22 absolutely tragic that they were discharging those from  
23 hospitals to care homes without testing. But  
24 discharging to community hospitals and discharging to  
25 people's homes -- you know, when I asked why my dad

24

1 wasn't tested before he was discharged, they said that's  
2 because it wasn't their policy. I'm like: but he was  
3 an old man -- where is the risk assessment? He was 85,  
4 immunocompromised. You told him you were sending him  
5 home because it was the safest place for him to be --  
6 which is great in the fact they're acknowledging that  
7 hospitals aren't safe, so at least that's one win for  
8 us.

9 But, you know, they can't -- you can't just --  
10 you've got to have -- and one of the things -- and  
11 I've written down on one of my many postcards in front  
12 of me was, this lack of common sense and personal  
13 accountability. Whatever the rules were or the IPC  
14 guidelines were, or your particular hospital, national  
15 or local, if you've got someone that's been, you know,  
16 exposed to 20 other patients on a ward, whether it's  
17 your policy or not, you should, just because that's what  
18 you do, you know, you have to test someone. And,  
19 of course, by not testing him that meant he's never been  
20 actually categorised as having hospital-acquired Covid  
21 because of -- so, you know, there's many, many questions  
22 to be asked about that.

23 **Q.** I think in addition to concerns about not testing  
24 patients before discharge, some of your members also had  
25 concerns that their loved ones were not tested on

25

1 **Q.** I think you've also identified concerns from your  
2 members about issues with the use of technology in the  
3 healthcare system in Wales, and particular problems with  
4 the IT infrastructure, a lack of integration which  
5 the Inquiry has heard about between primary and  
6 secondary care, and also incompatible IT systems being  
7 used by different boards and different GP surgeries, and  
8 you identify some of those problems that are  
9 particularly clear in relation to DNACPR notices.

10 Is it your understanding that DNACPR notices in  
11 Wales are generally paper copies rather than digital  
12 records?

13 **A.** They are all paper and one of the things we really want  
14 is the digitisation of DNACPR forms.

15 Apparently they're on a pad and you rip one off  
16 when you want to use it. It's not numbered so it can't  
17 be traceable, it's not auditable, and that is then just  
18 manually attached to a patient's physical folder. So  
19 when we asked how many DNACPRs had been, you know, had  
20 been placed during the, sort of, key points of the  
21 pandemic, we were told, "Not possible to tell you  
22 because it would take too long to -- it would be a, sort  
23 of, manual paper exercise". I mean, it's astonishing.

24 Also, you know, there's good digitisation -- you  
25 know, there's a stark difference in what NHS England do

27

1 admission to hospital or not tested until several days  
2 had passed; is that right?

3 **A.** Yes, there's many, many stories. Not on admittance,  
4 not -- eventually. But the other thing that Wales was  
5 very late on was the repeat testing of patients, which  
6 is absolutely vital because obviously when you do a test  
7 that's a kind of -- that's a point in time when you're  
8 testing. We know that, you know, the viral load is  
9 different at different points. So I think England  
10 started to do re-tests of patients, I think  
11 from September, and that was every three days. Wales  
12 did not do that, and it was every five days, and I'm  
13 pretty sure it wasn't until January 2021.

14 Again, this is why Wales had so many nosocomial  
15 infections and deaths because all of those very  
16 straightforward things that you could have done to  
17 identify someone with Covid weren't done and then,  
18 of course, that escalated, and it's just a shame that  
19 the -- that there's been -- there's been a sort of  
20 investigation into deaths, nosocomial deaths by the  
21 Welsh Government but, interestingly, nothing on the  
22 cluster outbreaks, which is of course the whole point.  
23 It shouldn't be about individual investigations.  
24 Lessons learnt has to be on how nosocomial infections  
25 start and how they can be prevented and controlled.

26

1 and what NHS Wales do. There is that interoperability  
2 between primary and secondary healthcare in Wales.

3 There's also, you know -- and my sister said to  
4 please tell you this: every time my dad moved bed within  
5 the same hospital she had to tell them the same things  
6 about his condition because they didn't know. There was  
7 no electronic way -- it wasn't that they picked an iPad  
8 up and can see -- you know, it's the same thing with the  
9 out-of-hours doctors. It's just this pattern.

10 And I'd say -- I know Andrew Goodall said that the  
11 Welsh Government hit their targets on digital inclusion.  
12 Well, I'd say that's because Wales has very little  
13 digitisation so it's a very easy target to hit. It's  
14 very difficult to exclude people when there isn't any --  
15 isn't much of it.

16 **Q.** Finally, you've identified in your witness statement  
17 a number of areas that your group have identified as  
18 lessons learned and potential recommendations for this  
19 Inquiry. I'd like to take you to three particular  
20 areas, if I may.

21 First of all, you've identified the issues that  
22 arose because of the state of the Welsh NHS estate, and  
23 the challenges that that has created, in particular for  
24 the implementation of IPC measures, and you referred  
25 earlier to a number of pre-pandemic reports and reviews

28

1 that were carried out in relation to that.

2 So, is that one of the key points of learning that  
3 your members would like the Inquiry to consider?  
4 **A.** Absolutely. And interestingly, Vaughan Gething said to  
5 stop tinkering around with hospitals but to build the  
6 right ones. So it's great to know that the Welsh  
7 Government are listening. But absolutely, we've got  
8 a very old NHS estate in Wales. If you don't do  
9 something now you're just building up that backlog year  
10 after year after year.

11 If a Covid pandemic hasn't shone a light on what  
12 need to be changed, I don't know what will, and I know  
13 it will cost money but that has to be cost effective in  
14 the long run and, again, if it saves lives, that has to  
15 be the right thing.

16 And it's also not just about patients, it's about  
17 those that work there as well, so absolutely.

18 **Q.** As well as the physical infrastructure of NHS Wales,  
19 you've also identified problems which I think we've  
20 already looked at in relation to the IT infrastructure  
21 and the way that that can help with the pandemic  
22 response in future.

23 You've also identified issues around palliative  
24 care and pandemic palliative care, and the need to build  
25 into pandemic plans provision for the rapid training and  
29

1 there was so little compassion and, you know, we were  
2 there, we weren't demanding, we weren't rude, but it  
3 just looked like they couldn't wait to get rid of us and  
4 it's just so important to do that.

5 And I cannot see -- you know, we're not for one  
6 minute suggesting we take frontline nurses off two weeks  
7 to do a course. We've suggested modular online courses  
8 that, you know, they can do updates on regularly.

9 And I'm probably being a big cheeky here but one  
10 of the things we did just want to mention as a group was  
11 a lack of data in Wales. Well, maybe not the lack of  
12 data but -- there's a lot of data but maybe it's not  
13 interoperable and it's not the right data. But, for us,  
14 data itself has no value. It's what you do with the  
15 data and the questions you ask of the data. And the  
16 data, in our view, is required to tell the truth and if  
17 it doesn't tell the truth it's useless, isn't it? And  
18 you don't want it to be manipulated for the wrong  
19 reasons. So we really want there to be -- I don't know  
20 whether the Welsh Government need a chief data officer  
21 or health boards lead to, you know, liaise more. But  
22 there has to be the right use of data and I feel like  
23 I hear about it a lot, "We need good data". That's  
24 fairly meaningless. I think what we're trying to say is  
25 we need the right data in the right format and for it to  
31

1 upskilling of clinical staff around palliative care and  
2 particularly compassionate communication with families  
3 and loved ones at the end of life and when patients have  
4 died.

5 Why is it so important to your members that  
6 the Inquiry considers the role of palliative and  
7 end-of-life care?

8 **A.** Because, again, it's someone's life. It's their last --  
9 we have to treat everyone as an individual and our group  
10 have lobbied very successfully to get bereavement leads  
11 in each of the health boards and we've now got permanent  
12 funding, but what we haven't been successful in doing  
13 yet is lobbying for mandatory compassionate training for  
14 all NHS staff. And this doesn't necessarily have to be  
15 just the frontline clinicians but people that deal with  
16 complaints or deal with calls.

17 As I said before, words really matter, and it also  
18 helps those that are, you know, delivering the  
19 palliative care as well. It is so important to  
20 understand how a patient needs to be spoken to, how the  
21 loved ones need to be spoken to, how things need to be  
22 explained. Again, I say this, it's a human right. It  
23 is a human right to have the right treatment when you  
24 die. When I think, you know, my dad's death, it haunts  
25 us, my mum, my sister and I, it just haunts us because  
30

1 answer the right questions and then to be actionable,  
2 and that's the key thing here.

3 **MS NIELD:** Thank you very much, Mrs Marsh-Reese, I have no  
4 more questions for you.

5 **A.** Could I just say one thing? I just wanted to say we've  
6 seen a lot of people in the Inquiry that, you know, a,  
7 sort of, a lack of accountability and contrition. But  
8 what we wanted to say was a massive thank you to groups  
9 like CATA, John's Campaign, Clinically Vulnerable  
10 Families, the Long Covid groups, who have, outside of  
11 their day job, passionately, tenaciously, fought to get  
12 the right -- to expose the truth that Covid is airborne  
13 and many other things. And I think we need to have to  
14 call on our leaders, government and healthcare leaders  
15 to stop the gaslighting, stop the scapegoating, own it,  
16 take action and stop this happening again.

17 Thank you very much.

18 **MS NIELD:** Thank you, Mrs Marsh-Reese.

19 **LADY HALLETT:** Thank you very much indeed, Mrs Marsh-Reese.  
20 As ever, extremely helpful and constructive, and I'm  
21 really grateful to you.

22 You talked earlier how the individuals we've lost  
23 will be forgotten. Well, as long as there are as people  
24 articulate as you are, advocating on their behalf,  
25 they'll never be forgotten. So thank you very much  
32



1 indeed for all your help.

2 **THE WITNESS:** And thank you from my mum and sister and my

3 dad, too.

4 **LADY HALLETT:** Thank you.

5 Is it best that we take a break now, Ms Nield, is

6 that right, so that Ms Marsh-Reese can speak to those

7 who represent her and others, and I shall return at

8 11 o'clock.

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

10 **(The witness withdrew)**

11 **(10.49 am)**

12 **(A short break)**

13 **(11.00 am)**

14 **MR SCOTT:** Good morning, my Lady. May we please call

15 Margaret Waterton.

16 **LADY HALLETT:** Thank you, Mr Scott.

17 **MS MARGARET WATERTON (affirmed)**

18 **Questions from COUNSEL TO THE INQUIRY**

19 **LADY HALLETT:** I hope you heard what I said earlier. I'm so

20 sorry I can't be with you in person but I shall be

21 paying very close attention obviously to everything you

22 say and I'm really grateful to you for coming along.

23 **A.** Thank you, my Lady, totally understand, and we hope that

24 you're fully recovered soon.

25 **MR SCOTT:** Good morning, Mrs Waterton.

33

1 But -- and we are tortured by it every day. I'm

2 haunted by it every day.

3 **Q.** Does it feel different being bereaved due to Covid

4 compared to in non-pandemic times then?

5 **A.** I've been reflecting long and weary on that. My father

6 died in 1999 and I wasn't there with my father when he

7 died, my mum was. And the inability to be with the

8 people that we love the most while they were taking

9 their final breaths in this life, to offer them comfort,

10 to tell them how much we love them, that was taken away

11 from us. And I feel entirely different about my

12 father's death and the circumstances surrounding that.

13 I have come to terms with all of that. But the

14 circumstances that we were in, being excluded, being

15 kept away -- we have members who were told that they

16 could be with their loved ones when they died but if

17 they did that they wouldn't be able to attend the

18 funeral. So that was a Hobson's choice, that was no

19 choice at all, because those two things were vitally

20 important to us. There were restrictions around the

21 funerals, in terms of numbers, everything was forbidden,

22 and it was all related to: it's all because of Covid.

23 So those things we haven't been able to do, we haven't

24 been able to put people to rest properly, is how we

25 feel. And that's the difference between being bereaved

35

1 **A.** Good morning.

2 **Q.** You're a member of Scottish Covid Bereaved?

3 **A.** That's correct.

4 **Q.** And I think you're particularly keen to give evidence on

5 behalf all of the members of Scottish Covid Bereaved and

6 give the Inquiry a sense of how the majority of the

7 members feel and how they're impacted by the pandemic;

8 is that right?

9 **A.** Yes, that's correct.

10 **Q.** Just dealing with your own personal experience of Covid

11 bereavement, and it's right that your mother died on

12 18 June 2020 as a result of a nosocomial infection, and

13 your husband died on 2 January 2021, less than two weeks

14 after his 71st birthday?

15 **A.** That's correct.

16 **Q.** Would you please describe how it feels to have lost

17 someone to Covid-19 during the pandemic.

18 **A.** It's devastating. Any bereavement is devastating in its

19 own right, but the complexities, the restrictions, the

20 situation that we had to experience and endure and our

21 loved ones had to experience and endure make that so

22 much worse. And we -- I -- we all feel the trauma, we

23 feel self-blame, we feel guilt that we could have done

24 more to protect and shield and save their lives, and

25 that we should have done more to do that.

34

1 by Covid and before.

2 And yesterday I went to the National Covid

3 Memorial Wall and I found the hearts for both my mum and

4 my husband and I put my hands onto those hearts, and

5 feet -- two feet away from me were dozens of tourists

6 taking selfies in the background of the Houses of

7 Parliament, while I'm weeping. And that's the

8 difference, because we understand what it is to have

9 been bereaved by Covid, but for the majority of the

10 world, the rest of the world, Covid is forgotten.

11 **Q.** I think the three main areas that Scottish Covid

12 Bereaved wanted to talk about are DNACPRs, nosocomial

13 infection and then visiting restrictions; is that right?

14 **A.** That's correct, yeah.

15 **Q.** I'll deal with nosocomial infections first. How big

16 an issue was nosocomial infection in Scotland during the

17 pandemic?

18 **A.** Well, for our members in Scottish Covid Bereaved it's

19 one of the main issues that we are facing. 1 in 4 of

20 our members lost loved ones to nosocomial infection, so

21 it's a significant area, and we are particularly glad

22 that this module is looking at nosocomial infection,

23 infection prevention and control, in depth.

24 Nosocomial infection was an issue in Scottish

25 hospitals right across Scotland pre-pandemic, and we

36

1 heard evidence from our previous Cabinet Secretary for  
 2 Health and Social Care, Mr Yousaf, who said in his  
 3 written evidence that hospitals were safe and sterile  
 4 environments. Well, during the pandemic they were never  
 5 safe. They were places of high risk because of the risk  
 6 of hospital-acquired infection, nosocomial infection.  
 7 Hospitals have never been sterile environments in their  
 8 entirety. Yes, of course you can have sterile theatre,  
 9 for example, but they're not sterile environments, and  
 10 the pressures of the Scottish hospitals, the  
 11 contributory factors of nosocomial infection, include  
 12 the capacity at which the hospital is working.

13 So Scottish hospitals were working well over 90%  
 14 pre-pandemic and then exacerbated in the pandemic.  
 15 Patient movement from ward to ward, commonly known as  
 16 "boarding", was also a major issue and well established  
 17 in research as a contributory factor to nosocomial  
 18 infection.

19 Asymptomatic transmission was not recognised  
 20 quickly enough, so patients were in non-Covid wards but  
 21 were asymptomatic. Testing was insufficient in terms of  
 22 capacity. The timing of getting the test results back.  
 23 Some of our hospitals in the highlands of Scotland had  
 24 to wait a week to get a Covid test result back for  
 25 a patient by which time of course the infection has

37

1 application of IPC practice. And I think that did  
 2 a huge disservice to our healthcare workers who gave  
 3 their all during the pandemic, some gave their lives to  
 4 the pandemic, and it completely ignored the other  
 5 contributory factors that I've already mentioned and,  
 6 of course, staff movement, as we've heard from my  
 7 colleague previously, bank and agency staff, and so on,  
 8 also moving from place to place, IPC guidance being --  
 9 changed frequently such that staff had no real chance to  
 10 keep up with it and, as I say, the situation that's been  
 11 well explored in this module around the availability and  
 12 the appropriateness of PPE.

13 **Q.** I want to look now at DNACPRs then. Your statement sets  
 14 out that there's a significant concern about  
 15 communication about DNACPRs in Scotland. What is  
 16 Scottish Covid Bereaved's number one concern about how  
 17 DNACPRs operated during the pandemic?

18 **A.** That there were times and situations, and our members  
 19 can attest to that from their lived experience, that not  
 20 only was the discussion around DNACPR not had with  
 21 family members, the next of kin, people with power of  
 22 attorney, and so on, but that DNACPR consent was gained  
 23 inappropriately.

24 And if I may use my own mum's situation. When my  
 25 mum went into hospital for the very first time with

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1 spread.

2 Availability of PPE, and the nature of that, and  
 3 we've heard lots of evidence in this particular module  
 4 about the reluctance of Scottish Government to accept  
 5 that Covid was transmitted via the airborne route, and  
 6 focused entirely on droplet. So the provision of PPE  
 7 was inadequate for all of our healthcare staff who gave  
 8 their all during the pandemic.

9 **Q.** Let me just bring you back to what you were talking  
 10 about with the Scottish estate. So, those features that  
 11 you have just been describing that made up the reason  
 12 why there was nosocomial infection to the level it was  
 13 in Scotland, how many of those features do you think  
 14 were unique to Scotland and how many of them were across  
 15 the United Kingdom?

16 **A.** None were unique to Scotland. All were across the  
 17 United Kingdom. None were unique.

18 **Q.** And you mentioned the evidence earlier on of Mr Yousaf.  
 19 I think you also had some observations about the  
 20 evidence of Ms Freeman in relation to nosocomial  
 21 infections.

22 **A.** I did. I heard, or we heard in her evidence that she  
 23 was asked a question by counsel around what she  
 24 understood the main cause of nosocomial infection was,  
 25 and her response to that was that it was poor

38

1 a chest infection she was in hospital for four nights,  
 2 three days, came home. And in her bundle of belongings  
 3 I found a DNACPR consent form. And when I asked my mum  
 4 what that was and did she understand what it was, she at  
 5 first of all couldn't remember. When I explained to her  
 6 what it was, she was absolutely horrified at its  
 7 meaning. And once she'd had time to gather herself she  
 8 was able to recall -- now, my mother was admitted in  
 9 a state of delirium, with a very high temperature and  
 10 therefore, in my view, she did not have capacity to  
 11 consent to DNACPR. She had signed the form and she  
 12 remembered doing that but what she said to me was,  
 13 "I didn't understand what the doctor was telling me, and  
 14 I felt that she was putting words in my mouth."

15 Now, I complained to the health board about that  
 16 and the response indicated that it was a junior doctor  
 17 who had acted inappropriately and that would be dealt  
 18 with locally by the medical director.

19 **Q.** But just in terms of general communication, as  
 20 experienced across the whole of Scottish Covid Bereaved,  
 21 was it a concern about discussions not being had with  
 22 families, or was it discussions with patients?

23 **A.** Both. Some of our members were completely unaware that  
 24 DNACPR consent had been arrived at until some  
 25 considerable time after their loved ones had died, and

40

1 that might have been by looking through -- you know,  
2 finding their medical notes, looking through the notes,  
3 or some other means. And without -- almost without  
4 exception DNACPR communication was poor.

5 Again, I had two different experiences of that  
6 where it was handled very, very well, compassionate,  
7 clear communication, very clear what the rationale was,  
8 and in another situation with my husband, I was being  
9 asked to determine how far he could walk.

10 So we're not clear about how these decisions were  
11 being arrived at, and there's concern that they were  
12 being intertwined with treatment escalation plans and  
13 used as a proxy for no escalation of care.

14 **Q.** Because your statement sets out there were guidelines in  
15 place in Scotland, I think well-established guidelines,  
16 is how they're described, about how the process should  
17 operate?

18 **A.** Yes.

19 **Q.** Do you think that during the pandemic there was a lack  
20 of clarity in what the guidelines said should happen, in  
21 terms of communication about DNACPRs, or that the  
22 guidelines were clear but they weren't always being  
23 followed?

24 **A.** I think there was a plethora of guidance for clinicians  
25 around DNACPR treatment escalation and I can only

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1 evidence in this module around the ReSPECT form, for  
2 example, and that was used in variation across NHS  
3 Scotland, it wasn't used consistently. So I think  
4 there's something around a recommendation, if I may make  
5 so bold, for the -- for my Lady and the Inquiry around,  
6 whether it's ReSPECT, or whatever it is, but across the  
7 nation that can be used consistently with clear guidance  
8 underpinning it that is based around care, compassion  
9 and person-centred approach.

10 **Q.** I want to move now to visiting restrictions, please.

11 Do you think that hospital visiting restrictions  
12 in Scotland struck the right balance during the pandemic  
13 between maintaining infection prevention and control  
14 measures and allowing families to visit their loved ones  
15 in hospital?

16 **A.** I think we understood and we understand the nature of  
17 the pandemic and the virus at the outset wasn't entirely  
18 known, and of course footfall needed to be reduced. We  
19 understand that. But we have heard consistently through  
20 the module, particularly from the chief nursing officers  
21 of the four nations about visiting restrictions and the  
22 guidance around that and that individuals at end of life  
23 were to be enabled to have their loved ones with them in  
24 their last moments. And that was not consistently  
25 applied across a ward, across hospitals, across health

43

1 imagine what it was like in terms of pressure for  
2 clinicians during the first and the second waves and the  
3 amount of decision-making that they were having to do.

4 **Q.** Just to pause you there. You had been a nurse yourself  
5 for a number of years; is that right?

6 **A.** I had been. I was a registrar with the NMC for  
7 39 years.

8 **Q.** So you have an understanding --

9 **A.** So ...

10 **Q.** And there are other Scottish Covid Bereaved members who  
11 are healthcare workers?

12 **A.** Yes, we have several healthcare workers so -- as our  
13 members. I understand, or we understand, you know, we  
14 can imagine the pressures but the number of our members  
15 who were not communicated with about the decisions that  
16 were having to be made about their loved one's care,  
17 ongoing treatment and escalation of care, and DNACPR are  
18 the majority.

19 So there are huge concerns that it's not just  
20 about poor communication, but how that guidance was  
21 being applied in the moment.

22 **Q.** In the event of a future pandemic, what do you think  
23 should happen in terms of communication about DNACPR  
24 decisions?

25 **A.** I think, if I might take a step back, and we've heard

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1 boards. And we were denied the opportunity and so were  
2 our loved ones denied that opportunity for us to be with  
3 them, to offer them comfort.

4 And I have been described as lucky because I was  
5 with both my mum -- I was able to be with both my mum  
6 and my husband when they died. I don't consider myself  
7 lucky, I consider that that was my right to be with my  
8 mum and my husband when they were dying, to offer them  
9 as much comfort and love and reassurance as I could in  
10 their final moments, and it was equally their right to  
11 have me there and extrapolate that across all of  
12 Scottish Covid Bereaved. We all had the right to be  
13 there. We all had that right. And it was denied us  
14 because the guidance was not consistently applied.

15 And if we link that in our heads, because that's  
16 where we've got to wonder, to DNACPR discussion,  
17 escalation of care, we weren't there. We were trying to  
18 determine what was happening to our loved ones remotely.  
19 We couldn't see them. We couldn't touch them. The  
20 deterioration was not obvious to us. And that would  
21 have enabled many of us to have understood what was  
22 happening to them in a much kinder way.

23 And we've heard about moral distress, moral injury  
24 from BMA and RCN in particular during their evidence,  
25 and we understand that, but I understand how much of

44

1 that we could have helped reduce, minimise, avoid, if we  
2 had been there with those that we loved the most when  
3 they were dying.

4 **Q.** Do you think there was enough care and compassion being  
5 built into how the visiting restrictions were being  
6 drafted?

7 **A.** Not consistently. I think -- we think -- that it was  
8 all about the mechanics of it. And we understand about  
9 reducing footfall and we understand the difficulties of  
10 members of the public, you know, ranging through  
11 hospitals and so on and not adhering to IPC guidance.  
12 And many of our members saw that. I witnessed breaches  
13 of infection prevention and control practice in staff.  
14 Many of us witnessed that, in all aspects.

15 We understand that. But all of those chief  
16 nursing officers said that the guidance was to be  
17 applied in an individual way and compassionately, and  
18 that's not been our experience of that.

19 People, members, whose loved ones were on life  
20 support and the life support being switched off while  
21 they were on the phone, why couldn't they have been  
22 there? Why couldn't they have been there?

23 That looks back into the "You can be in for  
24 15 minutes but then you can't go to a funeral". And  
25 that's a Hobson's choice for anyone to have to make.

45

1 able to be clear and be sure that when our loved ones  
2 were dying we would be allowed to be with them. 100%.

3 **Q.** Just leaving aside the end of life for a minute, just  
4 generally in terms of visiting in hospitals, do you  
5 think there would have been a benefit to the Scottish  
6 Covid Bereaved members if there had been explanations  
7 about why, in certain circumstances, the restrictions  
8 needed to be tighter or in certain places they needed to  
9 be tighter than in others?

10 **A.** Communication is key, and clear communication would have  
11 been hugely beneficial. So if, for example, there had  
12 been a cluster of Covid cases in a particular ward,  
13 an outbreak in a particular ward, then that's  
14 explanation enough, about: we need to manage this in  
15 a different way and we need to -- it happens. If  
16 a ward, for example, or a hospital, has an outbreak of  
17 norovirus, that happens. So why couldn't it have  
18 happened with Covid, so that we were much clearer about  
19 the necessity for the level of restriction that was put  
20 in place?

21 **Q.** I want to talk now about use of technology as  
22 a substitute for visiting. You describe in your  
23 statement how technology such as tablets and mobile  
24 phones were often used to allow contact when visiting  
25 was not permitted. How well did that function in

47

1 But particularly when we're watching the media, online,  
2 scenes from Italy -- you know, were there enough  
3 ventilators? Was there enough piped oxygen? Was there  
4 enough staff and PPE? All those things where -- we were  
5 wondering about and how that impacted on visiting,  
6 whether we could actually wear PPE to visit, whether  
7 there was enough to supply to that to us as visitors,  
8 and how was that decision-making happening, what was  
9 impacting on the decision-making.

10 So it wasn't consistently applied.

11 And I have to say to you that as a nurse for all  
12 those years, whilst I admire everyone in healthcare who  
13 was working and giving their all, we lost care and  
14 compassion, and we must work hard to get that back.

15 **Q.** Were the reasons why there was a different application  
16 of visiting restrictions within individual hospital  
17 wards across Scotland, were there ever any explanations  
18 given as to why they were being applied differently?

19 **A.** No. That was very much down to the local discretion of  
20 a ward or an ICU or, you know, that clinical area, and  
21 so it was up to the individual who would be in charge of  
22 the ward at that time, for example. So there was no  
23 consistency around it at all.

24 And that then leads to the fact that we all had  
25 a different experience of it, and we should have been

46

1 Scotland?

2 **A.** I think, again, that was variable. There was huge  
3 reliance on individuals having access to mobile phones,  
4 tablets, whatever, and that they would be able to use  
5 them. But the Wi-Fi connection in many of Scotland's  
6 hospitals is entirely variable and not every ward has  
7 good connection, not every room in every ward has good  
8 connection. So there was that whole sense of digital  
9 exclusion.

10 And people going into hospital with Covid were  
11 very seriously unwell. They would be receiving oxygen  
12 through full face masks. So if you wear glasses and  
13 you're then forced to wear a full face mask to have  
14 high-flow oxygen, you can't see. So you can't see to  
15 use a mobile phone, you can't see to use a tablet.

16 If you're having to be placed in the prone  
17 position for periods of time during the day to try to  
18 help your oxygen saturations, using technology is not  
19 possible for you. And there was just a huge reliance on  
20 the individual.

21 At the same time, we were watching the media  
22 telling us that tablets were available everywhere, in  
23 wards, in ICUs and staff would use them. When my mother  
24 went back into hospital with Covid, a nurse used her own  
25 mobile phone to help me have a WhatsApp call with my

48

1 mum, and that was the one and only time in a week that  
 2 I was able to see and speak directly to my mum.  
 3 **Q.** You just used the word "see" there. When technology was  
 4 being used, how important was it to be able to see the  
 5 person rather than just being able to talk to them via  
 6 a phone call?  
 7 **A.** It's vital, because we're reading -- you read all sorts,  
 8 you see all sorts from each other, and looking at  
 9 a well-kent, well-loved face was hugely comforting and  
 10 reassuring, and when I looked at my mum on that call  
 11 I was reassured because I thought, "Oh, she doesn't look  
 12 as sick as I thought she might". So there was a level  
 13 of reassurance and comfort from both sides. And my mum  
 14 was glad to see and hear me.  
 15 I had to speak with my husband over the phone and  
 16 try to reassure him. He was terrified. People were  
 17 terrified of what was happening them to in hospital. My  
 18 mum said, "If I get that Covid, I'll be a goner", and  
 19 she was right. She knew with her respiratory conditions  
 20 she would not find very much chance of surviving. And  
 21 my husband was terrified because I think he knew what  
 22 was potentially lying in front of him. And when we had  
 23 both been -- had Covid and been unwell, we were both  
 24 worried that each was going to die. The outcomes were  
 25 unknown.

49

1 **Q.** I'm just going to move away now from visiting  
 2 restrictions. Is there anything else you wish to say in  
 3 relation to visiting restrictions, how they were  
 4 applied, consistency, use of technology, that you  
 5 haven't already covered?  
 6 **A.** No, I think we've covered all of it.  
 7 **Q.** I'm just going to ask, then, about Covid hubs,  
 8 assessment centres, access to GPs. I think Covid hubs  
 9 and assessment centres were used in Scotland and your  
 10 statement sets out how they functioned, what they did,  
 11 and what they were meant to achieve.  
 12 Did the Scottish Covid Bereaved find them useful  
 13 in principle to have these Scottish Covid hubs?  
 14 **A.** I think in principle it was a really good way of  
 15 enhancing primary care and triaging individuals who  
 16 either had tested positive for Covid or had Covid  
 17 symptoms. I think in principle they were -- it was  
 18 a really good step, and it was there to support -- in  
 19 Scotland NHS 24 runs the 111 service and it was a really  
 20 good positive move to enhance that primary contact with  
 21 healthcare because across the nation, everybody was  
 22 being told to Stay at Home, Protect the NHS, Save Lives,  
 23 and there was a -- in our membership there was a real  
 24 struggle trying to get hold of GPs, particularly to see  
 25 them face to face, have them do a home visit was almost

51

1 So that seeing individuals is so vitally  
 2 important, because we can see a smile, we can see  
 3 a reassuring look, and we're comforted by that.  
 4 **Q.** Can you think of any way that it would be possible for  
 5 more video calls to have been used during the pandemic  
 6 or was it simply a reflection of the capacity of  
 7 healthcare workers to be able to facilitate that?  
 8 **A.** I think it was a reflection of their capacity, the  
 9 digital ability in the hospitals and that whole sense of  
 10 digital exclusion.  
 11 **Q.** Did the health boards, whether across a region or for  
 12 individual hospitals, for example, provide any  
 13 information about the best way to use technology as  
 14 a replacement for visiting?  
 15 **A.** No. Not across our membership. Not in any real sense.  
 16 **Q.** Do you think that would have been beneficial?  
 17 **A.** I think there was an -- I think it would have been  
 18 beneficial, but I think there was an expectation in this  
 19 day and age that everybody has a mobile phone, can  
 20 adequately use it, that everybody has access to  
 21 a tablet, or whatever device of that nature, and is able  
 22 to use it. And I think there was an assumption that  
 23 that would all work when in fact, when people are sick  
 24 those are the last things they're going to be able  
 25 to use.

50

1 impossible, and calling 111 was a very variable and  
 2 mixed experience for our members, some of whom, because  
 3 they didn't have the three main symptoms and had other  
 4 symptoms, were being told that "You don't have Covid and  
 5 don't be -- come back to us if anything worsens".  
 6 I think the issue going forward, if we were to  
 7 have things around Covid assessment centres and hubs  
 8 again, is the means by which you access them, by which  
 9 you're transported there, because in Scotland that  
 10 was -- it was taxis that were used in the main to  
 11 transport people from home to the assessment centre and  
 12 then back again.  
 13 It was taxi drivers who were doing that, and they  
 14 were really brave and courageous, but they weren't  
 15 allowed to offer any assistance whatsoever, and if you  
 16 are needing to go to a Covid hub you're pretty unwell.  
 17 So there needs to be thought given about that transport.  
 18 And in fact one of our members, her brother was to go to  
 19 a Covid hub and was so unwell he couldn't manage down --  
 20 fully down the length of the garden path and was hanging  
 21 over the garden fence, when at the same time, the Covid  
 22 transport, hub transport arrived, and an ambulance,  
 23 because his condition had deteriorated and his  
 24 familiarly had called the ambulance and the ambulance  
 25 crew wouldn't take him and stayed in their vehicle and

52

1 he was transported to the Covid hub in the taxi and then  
 2 ultimately taken to hospital.

3 **Q.** So would it be fair to sum it up that in principle these  
 4 Covid hubs and assessment centres were a good idea and  
 5 functioned well, but how they actually functioned in  
 6 practice is a different matter?

7 **A.** I think so. I think they are -- they were a good asset  
 8 but just needed further work and refinement as to how  
 9 they actually were operationalised.

10 **Q.** And you mentioned earlier on about GPs as well. How  
 11 accessible did Scottish Covid Bereaved members generally  
 12 find their GP surgeries were?

13 **A.** I think, overall, the view, initially certainly, was  
 14 that GP surgeries, health centres were closed and it  
 15 was -- then it became very difficult to access a GP face  
 16 to face. Some of the Near Me stuff in NHS Scotland  
 17 didn't -- wasn't functioning in every health board.  
 18 Home visits from a GP. So, again, if I just --  
 19 you know, one of -- my mother's first comment, actually,  
 20 to me was, if I need the doctor, how will I do that?  
 21 Because she believed from the messaging that she  
 22 couldn't access a GP at all.

23 So there's a mixed experience again.

24 But home visits, very difficult to secure, and  
 25 seeing a GP face to face, so telephone consult, video

53

1 after their family members?

2 **A.** Again, a mixed experience but individuals -- we've heard  
 3 already about individuals being -- who were unclear  
 4 whether their family members had been tested, whether  
 5 they were Covid-positive or not, and indeed we have one  
 6 member who his wife was discharged after two days with  
 7 Covid, and she was seriously unwell, and subsequently  
 8 she died. So, again, that mixed experience of not being  
 9 clear what the status of somebody was when they were  
 10 being discharged, not sure whether they had been tested  
 11 on discharge, to protect family members.

12 And remember that some of our members were  
 13 shielding, some of our members were -- you know, had --  
 14 were immunocompromised, unwell, frail. And to be -- so  
 15 there was a situation where you just weren't sure what  
 16 was going on, and then the impact of that on the wider  
 17 family, Covid, and the situation I've just articulated.

18 **Q.** And then finally in terms of shielding, you just  
 19 mentioned some of your members had been shielding. What  
 20 were the experience of Scottish Covid Bereaved in terms  
 21 of either themselves or their family members of  
 22 shielding?

23 **A.** Shielding was a hugely isolating experience for those of  
 24 us who were shielding in our group and those of us who  
 25 had family members that were shielding, and it had

55

1 consult. But there are many things a GP and doctor has  
 2 to lay hands on and can't do over the phone.

3 **Q.** But broadly, did remote GP appointments work across  
 4 Scotland or were there difficulties with how they were  
 5 set up, how people were able to access them? How did  
 6 Scottish Covid Bereaved members find them?

7 **A.** Again, a mixed experience. One of our members, for  
 8 example, their family member had several repeat  
 9 telephone consultations, with repeat medication  
 10 happening, and when eventually that individual did  
 11 manage to have a GP appointment and then required to be  
 12 referred to hospital, and they had an underlying cancer,  
 13 that hadn't been picked up for some months. So a mixed  
 14 experience.

15 Again, I would say that -- again, if I might just  
 16 use my mum as an example, when she had developed Covid,  
 17 one of the things we were asked to do was to get her own  
 18 GP to come and visit her, and it was her family GP who  
 19 came to see her, and the reassurance that that provided  
 20 for my mum was significant.

21 **Q.** I want to ask you about the experience of Scottish Covid  
 22 Bereaved where family members were discharged from  
 23 hospital, not to care homes, but they were discharged  
 24 home, about how Scottish Covid Bereaved found the  
 25 experience of discharge and what it was like looking

54

1 a huge significant impact on emotional well-being as  
 2 well as physical well-being. But that group were --  
 3 probably make up quite a component of our number who  
 4 developed nosocomial infection, and that group of  
 5 individuals were hugely protected at home, but they were  
 6 the most likely to have to seek hospital care and to be  
 7 hospitalised. And at that point then they're plunged  
 8 into the hospital environment where there is no testing,  
 9 huge patient movement, clusters of Covid, outbreaks of  
 10 Covid, patients with Covid in non-Covid wards, and they  
 11 become hugely vulnerable to it. And that's actually  
 12 what happened to my own mum. She was admitted to  
 13 hospital and there were four patients in what  
 14 I understood to be a non-Covid ward, a care of  
 15 frail/elderly ward, and that's where my mother  
 16 contracted Covid.

17 **Q.** You've set out in your statement some lessons learned as  
 18 the Scottish Covid Bereaved hopes her Ladyship takes on  
 19 board when considering the evidence. Is there anything  
 20 on behalf of Scottish Covid Bereaved that you hope  
 21 her Ladyship bears in mind while she's considering both  
 22 the oral evidence and the written evidence that she's  
 23 heard in Module 3?

24 **A.** My Lady, we are so grateful to you for your work and we  
 25 look forward to further robust, clear recommendations,

56

1 with clear accountability. And for us that's one of the  
2 things that we seek to achieve, is truth, justice and  
3 accountability. And accountability isn't about blame,  
4 accountability is accepting responsibility for what's  
5 yours to own.

6 And we have heard previously and --  
7 recommendations around hospital estate, ventilation.  
8 We've said in our statement around the workforce plan in  
9 NHS Scotland, to make sure that is robust, that staff  
10 are prepared/enabled to function in a pandemic, and that  
11 care and compassion come back and person-centred care  
12 come back into that workforce.

13 Communication.

14 We've again heard about ventilation, HEPA  
15 filtration.

16 We've got a very old estate. We're not alone but  
17 we've got a very old hospital estate in Scotland, and  
18 whilst we don't expect that you're going to be able to  
19 instruct that new hospitals are built immediately, there  
20 has to be something that's done to take away the  
21 Nightingale wards that still exist in our hospital  
22 estate in Scotland.

23 Care and compassion.

24 DNACPR and how that is managed, handled,  
25 communicated.

57

1 (A short break)

2 (11.50 am)

3 **MS CAREY:** My Lady, good morning. I'm taking the next  
4 witness, who is Dr Saleyha Ahsan.

5 **LADY HALLETT:** Thank you, Ms Carey.

6 **DR SALEYHA AHSAN (affirmed)**

7 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**

8 **LADY HALLETT:** Dr Ahsan, I'm truly sorry I can't be with you  
9 in person but I promise you it doesn't mean I'm not  
10 going to pay huge attention to all the help that I know  
11 you're going to give, so thank you very much.

12 **THE WITNESS:** Thank you.

13 **MS CAREY:** Dr Ahsan, your full name, please.

14 **A.** It's Dr Saleyha Ahsan.

15 **Q.** Dr Ahsan, I'm going to ask you about two witness  
16 statements, one that you've prepared for the Inquiry and  
17 also one that you're going to speak to from Matt Fowler,  
18 who was a co-founder of Covid-19 Bereaved Families for  
19 Justice UK. Can I just ask about you firstly.

20 You lead the healthcare worker group within  
21 Covid-19 Bereaved Families for Justice UK and I think  
22 you are a doctor by background, in emergency medicine.  
23 You have a PhD -- you are a PhD candidate at the  
24 University of Cambridge on the subject of delivery of  
25 healthcare. You're part of the Royal College of

59

1 And those for us I think are the main issues.

2 **MR SCOTT:** Thank you.

3 My Lady, I have no further questions.

4 **LADY HALLETT:** Thank you very much indeed, Mrs Waterton.

5 You got through a huge amount extremely efficiently and  
6 I'm really grateful to you and I promise, as I'm sure  
7 you accept, that I'll do my very best to bear all the  
8 matters you raise in mind and, if I can, come up with  
9 some recommendations. Of course it will then be for  
10 others to implement them. So it won't just be  
11 a question of what recommendations I can make, it'll be  
12 in getting the support of people to get them  
13 implemented. That's where things sometimes fall down.

14 But I promise to do my very best and thank you so  
15 much for all that you've -- all the help that you've  
16 given to the Inquiry and the support that you've given  
17 to us.

18 **THE WITNESS:** Thank you, my Lady, and we wish you a speedy  
19 recovery and we stand ready to assist you and the  
20 Inquiry going forward.

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

22 We'll take a -- I shall come back at 11.50, so you  
23 can talk to your representatives.

(The witness withdrew)

24 (11.38 am)

25

58

1 Emergency Medicine, in their EPRR committee, and you are  
2 a former British Army officer commissioned into the  
3 Royal Army Medical Corps, and you are going to help us  
4 I think in respect of a number of matters that touch on  
5 you speaking on behalf of the group, you speaking on  
6 behalf of your experience as a doctor, and also, sadly,  
7 your experiences of the death of your father and the  
8 impact that's had on you and the family.

9 So, take it nice and slow, please, Dr Ahsan, and  
10 can we start, please, with some of the wider  
11 observations from Covid Bereaved Families for  
12 Justice UK, and I think you say in the statement that  
13 there are around 7,000 members, all of whom have lost  
14 a loved one to Covid-19, and that the campaign was  
15 founded in March 2020 with the purpose of learning  
16 lessons throughout the pandemic in order to save lives.

17 And is this right, that Covid Bereaved Families  
18 for Justice UK has campaigned for improved accessibility  
19 to bereavement support, policy reviews to prevent  
20 avoidable mistakes, and continues to empower its members  
21 to hold the government and public bodies to account.  
22 And I think was it your group that helped create the  
23 National Covid Memorial Wall? Indeed, we just heard the  
24 last witness speak about that.

25 **A.** That's correct.

60

1 **Q.** Can I start, please, with some of the concerns of the  
2 group in relation to NHS 111 and the 999 service,  
3 please. And I think you say that a number of the  
4 members are critical of the way that 111, firstly,  
5 functioned. What were the concerns of Covid Bereaved  
6 Families for Justice members?

7 **A.** So whilst speaking about this, again, it's not from my  
8 perspective as a clinician but representing the group,  
9 and also just to say that this is -- unfortunately,  
10 we've all been brought together by this unifying factor  
11 of having lost a loved one, so we didn't know each other  
12 before, we've sadly become a member of this group that  
13 no one wanted to be part of.

14 But through being part of the group, we've got to  
15 hear about everyone's stories and experiences and --  
16 gaining an insight into everyone's journey through this  
17 horrendous time, and one of the aspects was the  
18 encounters with 111 and 999, calling for help from home.  
19 And it was quite clear from the accounts of people  
20 within the group that access to these services was at  
21 times really, really challenged. Not everyone could  
22 actually get through on 111, that there were delays,  
23 that sometimes the advice wasn't clear, and that trying  
24 to get access to urgent care at home sometimes didn't  
25 happen. And the order of events of how to get

61

1 Was there any concerns raised amongst the members  
2 about accessibility for those who were perhaps not so  
3 proficient at either ringing 111 or providing care at  
4 home, perhaps for those who are either disabled or whose  
5 English was not the first language?

6 **A.** I think those challenges existed from pre-Covid, to be  
7 honest. 111 had reported in the media over the years  
8 different sorts of challenges. But we had -- I think  
9 generally within the healthcare system we knew it was  
10 challenged in different parts of a very complex system,  
11 different branches in different systems within  
12 an overall complex system were challenged and when we  
13 hit Covid, those challenges didn't go away, they were  
14 actually increased.

15 So you had 111 that during busy peak periods,  
16 every winter for example, every time there was  
17 Christmas, New Year, et cetera, those peak times of  
18 other infectious diseases that were rife within the  
19 community, we had, and I speak drawing on my background  
20 within emergency medicine, these were not new challenges  
21 but they were heightened and more severe within Covid.  
22 So it was as if there was -- you know, we were already  
23 running on nearly empty, that there was nothing left in  
24 the tank by the time Covid came. So these kinds of  
25 experiences unfortunately happened and I'm not surprised

63

1 a clinician to come home, whether it was calling 111  
2 first and then a GP coming or -- which order it came in  
3 was sometimes confusing.

4 **Q.** I see. So if I understand you correctly, was there  
5 a tendency sometimes to ring 111 to try to get a GP but  
6 sometimes a GP would say, "I'm not coming out until  
7 you've rung 111", a sort of -- stuck between a gatepost  
8 and the gate; is that really what you're trying to tell  
9 us?

10 **A.** I think that's what some of the accounts from some of  
11 the members have been. And bearing in mind that this is  
12 a UK-wide group so different experiences, it appears, in  
13 different areas.

14 **Q.** I think --

15 **A.** And, again, with the difference between rural and urban,  
16 where access to services can be challenged by distance,  
17 whether it's a very rural location versus an urban one  
18 where things might be more accessible.

19 **Q.** I think you say in the statement that some of the  
20 members certainly consider that those who died of  
21 Covid-19 could and should have had access to treatment  
22 earlier but the advice of NHS 111 was to Stay at Home,  
23 and that will resonate with her Ladyship because we've  
24 heard about a HSIB report into 111 and some of the  
25 concerns there.

62

1 that they happened and I just feel so -- and having  
2 been, you know, just because I'm a healthcare worker  
3 didn't mean that I haven't had to use, or for my family,  
4 draw on the emergency services for our own care. So  
5 when you have the knowledge of what's needed and you  
6 can't get that help through the door, it's really  
7 distressing. And so my heart really goes out to people  
8 who had loved ones in desperate need of someone with  
9 medical knowledge arriving to give help and they  
10 couldn't access that. The minutes would have dragged  
11 like hours and the hours would have dragged like days as  
12 they waited for someone to come and there was no one  
13 to come.

14 **Q.** I think, in short, the concerns about NHS 111, and  
15 indeed 999, was: could I get through in the first place,  
16 how long did I have to wait if I was going to be  
17 answered, and then what was the kind of quality of the  
18 advice I was given once I managed to get through.

19 Does that, sort of, fairly encapsulate the  
20 concerns of Covid Bereaved Families' members?

21 **A.** I think that has been the overall theme of the concern,  
22 yes.

23 **Q.** You say in the statement that the picture with regard to  
24 access to GPs was mixed. Some GPs would conduct a home  
25 visit but some patients asked for a home visit, is this

64



1 right, but in fact the GP would not go to see them? So,  
 2 again, perhaps a slightly inconsistent picture across  
 3 the UK and across your membership; is that fair?  
 4 **A.** Yeah, I think that is fair. And again, as I said  
 5 before, different regions in different areas, different  
 6 stresses and strains. We have, if I may, her name is in  
 7 the statement, Helen Brewer, who talks about her mother  
 8 in North Wales, in Deganwy. I was actually a clinical  
 9 in North Wales, so I can speak with some knowledge of  
 10 what it was like to deliver primary healthcare in areas  
 11 that are more rural. It can be challenging.  
 12 **Q.** Tell us about that, then, since you mention -- can  
 13 I just say whilst we're on that, we are very grateful to  
 14 Covid Bereaved Families for Justice because the  
 15 statement is peppered with real examples from your  
 16 members. I wasn't going to go through them all,  
 17 Dr Ahsan, but you mentioned Helen Brewer there. But  
 18 from your perspective what was it like trying to, in  
 19 Covid times, deliver primary healthcare in a rural  
 20 setting?  
 21 **A.** So I see this from the perspective of not being a GP but  
 22 being an emergency medicine doctor, but knowing many  
 23 GPs, in fact I have two siblings who are GPs, but they  
 24 work in urban settings, trying to -- I think GPs were  
 25 stretched. They -- like many other sections of the

65

1 immediately sent --  
 2 **Q.** Yes.  
 3 **A.** -- to Glan Clwyd Hospital -- to the nearest hospital,  
 4 and was found to have Covid.  
 5 But it's that -- it's the agony of the wait that  
 6 will be, you know, really horrendous.  
 7 That's an account of one of the members and that's  
 8 what I want to relay, because that's their experience  
 9 and their story and that's what they went through. The  
 10 unpicking of why and what is another matter, but that's  
 11 what they went through.  
 12 **Q.** Well, I think you say, or Mr Fowler does in his  
 13 statement certainly, that a number of the members of  
 14 your group provide accounts of people dying at home as  
 15 a result of deciding not to seek medical assistance and  
 16 increased deaths, obviously, through things like delays  
 17 to cancer treatment, and the like. And her Ladyship has  
 18 heard a number of pieces of evidence that echo that  
 19 experience of your members.  
 20 Can I ask about those that then got into hospital,  
 21 and I think particularly there is a concern amongst  
 22 Covid Bereaved members about hospital-acquired  
 23 infection.  
 24 If it helps you, Dr Ahsan, I think it's at your  
 25 paragraph 36 in your statement, and there's a number of

67

1 health service. And they were looking after vast  
 2 numbers of people. People were -- again, this is not  
 3 taking away at all from what Helen Brewer experienced  
 4 with her poor mother but, from my understanding of it  
 5 and from what we were witnessing, there was a strain on  
 6 the services that -- again, no one is going to find  
 7 that, like, news, that GPs were under pressure, but  
 8 during that time we had a lot of people within the  
 9 community that would need some sort of input, didn't  
 10 really want to come into the hospital in the way that  
 11 they normally would have done, come into A&E, because  
 12 they were afraid of what was, you know, lurking behind  
 13 the front doors in terms of Covid. I had patients who  
 14 clearly were unwell and should have come in but thought  
 15 that their condition would get worse if they came to  
 16 hospital.  
 17 In the case of Helen Brewer, her mother became  
 18 unwell, it turned out to be Covid. They did try to get  
 19 access to the GP, they called 111 many times and without  
 20 success. It took a while. You know, the dates -- when  
 21 you look at the dates, between 16 March and 23 March,  
 22 that's just a horrendously long time to be so  
 23 desperately worried and deteriorating and alone  
 24 actually. And then she says that the GP did finally  
 25 visit and then she was immediately -- the mother was

66

1 accounts set out there about concerns about it. But  
 2 just help us, are you able to, sort of, give us  
 3 an overview of the Covid Bereaved's concerns about  
 4 hospital-acquired infection and what could be done to  
 5 try and reduce it if it's not possible to minimise it  
 6 entirely?  
 7 **A.** I think again, and I speak as not an infection control  
 8 expert. It wasn't my role. But each healthcare  
 9 provider did, and we do, operate within our sort of  
 10 realm of infection control, but again, infection control  
 11 of the whole hospital had designated roles. But --  
 12 personnel that were put in charge of doing that.  
 13 Yeah, absolutely, hospital-acquired infection from  
 14 the perspective of the bereaved group members, harrowing  
 15 stories, accounts of people coming in with one  
 16 condition, really in need of hospital care because other  
 17 things didn't stop during Covid, other conditions, other  
 18 needs for hospital didn't stop.  
 19 So people, for example in the case of  
 20 Andrew Ireland and his wife Susannah who needed -- she  
 21 needed to come in because of acute pancreatitis and  
 22 becoming quite unwell, needed to come in, and, you know,  
 23 that is a condition that can make people very, very  
 24 sick, can -- they can need intensive care for this care.  
 25 She had that treatment but unfortunately acquired

68

1 Covid-19 during that time, which, again, just  
2 horrendous. And from a perspective of what it was like  
3 working in hospitals where -- I mean, that was  
4 a constant worry. I mean, that wasn't something that  
5 was taken lightly. That was a constant, constant worry,  
6 of patients acquiring infection when they'd come for  
7 a different reason.

8 And often, you know, at that time really only the  
9 very sickest were coming in, or who needed to be in  
10 hospital, and then to actually -- you know, they were  
11 already on a back foot with their health anyway, and  
12 then to have the risk of Covid.

13 **Q.** Can I just pick up on something you just said there,  
14 because obviously PPE is one of the ways that we can  
15 prevent infection. And I think it was June 2020 that  
16 face masks were made mandatory for staff and face  
17 coverings were made mandatory for patients and visitors,  
18 providing the patient could tolerate it. Do your  
19 members have any views about whether that was brought in  
20 too soon, too late, struck the right balance? Can you  
21 help with that, Doctor?

22 **A.** I think generally within the group I think the overall  
23 consensus was that many of the steps were too late. Too  
24 late, too slow, lots of confused messaging coming  
25 centrally. I refer to some of the comments, press

69

1 within a -- the other perspective would be from someone  
2 who had no real health background but just was a --  
3 you know, a broadcaster who had spent a lot of time on  
4 Google reading evidence incorrectly.

5 So I feel by June it was too late. I feel as  
6 a group we also have that consensus.

7 **Q.** Right. And I think there was also concerns raised by  
8 a number of the members of the group about the lack of  
9 consistency in the way that some NHS staff use their  
10 PPE, not across the board, clearly, and we might look at  
11 some examples of that from your own experience in  
12 a moment.

13 Can I just ask you about shielding, because  
14 I think a number of the members of the CBFFJ UK group  
15 were shielders. And certainly they were concerned about  
16 information that was provided to them, the quality of  
17 it, and indeed that they may themselves have to go into  
18 hospital and therefore run higher risks of catching  
19 Covid.

20 Is there any consensus among the group about how  
21 best to relay information to those who are shielding or  
22 any practical things that you've been asked to relay to  
23 us about how it could be improved?

24 **A.** Improved in terms of how to shield?

25 **Q.** In terms of the communication that was given to

71

1 conferences, for example, interviews that were done by  
2 the Prime Minister at the time with the Deputy Chief  
3 Medical Officer, Jenny Harries, having a whole  
4 discussion about whether we should be wearing face masks  
5 or not. Which, as a healthcare provider, and amongst  
6 other healthcare providers, we felt that was really  
7 confusing the message of what people should be doing and  
8 shouldn't be doing when really, if we looked at other  
9 countries who had brought -- who had a tradition of  
10 face mask wearing, for example, or where steps were  
11 taken earlier with less confusion and less dithering, if  
12 I may say, that their outcomes were better.

13 So I think come -- by the time June had happened,  
14 the horse had already bolted. And not only had it  
15 bolted because of infection spread but also the mindset  
16 of people. So rather than it becoming something that  
17 people thought was the right thing to do, protective of  
18 themselves and others, there was an onslaught of debate  
19 and discussion that carried on long after it was made  
20 mandatory. You still had people who were reluctant to  
21 put on face masks and we had -- and I know this from the  
22 fact that I work in television as well and I was asked  
23 quite frequently to come on and have debates about  
24 whether it was -- whether we should be wearing masks or  
25 not, whether we should be having lockdowns, often

70

1 shielders.

2 **A.** I think, again from the perspective of my own father,  
3 I remember him and one of my siblings, who also had to  
4 shield, for health reasons, that a text message came  
5 through to say -- but it was -- and again, I'm trying to  
6 remember the dates and the timings but I just remember  
7 it feeling quite late and definitely for the second  
8 wave, I -- in the second wave I had decided -- I was  
9 working in intensive care in North Wales but I -- and  
10 I was also making documentary for Channel 4 about Covid  
11 and what was coming, the second wave, and we knew that  
12 it was going to be bad, hence I managed to get  
13 a commission to make the film. I didn't need a crystal  
14 ball to say -- know how bad it was going to be, but  
15 I had made the decision around about, sort of, towards  
16 the end of November, December time to go home and impose  
17 a lockdown on my father even before national guidance  
18 because I could see the direction of travel of this.

19 Unfortunately, I was a week too late and he caught  
20 Covid, and it was during the Partygate season. So  
21 I think the messaging on shielding came too late for  
22 many, especially during the second wave and I think  
23 that's unforgivable. We had been through the first  
24 wave. If we were going to be generous at all we could  
25 say, okay, this was the first time. But the second wave

72

1 is the disaster and had some of the worst figures out of  
2 both, I think, periods, both waves.

3 But I think, again -- text messaging, that's  
4 an effective way but -- and I think now people would  
5 know what that means but in the beginning it was  
6 challenging.

7 But also I think it also caused anxiety, a lot of  
8 anxiety about shielding which I think has, and this is  
9 also part of what the Bereaved Families group are  
10 calling for, better support for mental health and  
11 well-being after the event, because I think there's  
12 a lot of anxiety of what people can and cannot do now  
13 even, when they can go out, when they can't go out, who  
14 they can be with. Again -- but that side of it has now  
15 suddenly all gone away as if it doesn't exist, but it  
16 very much still does exist and we're still getting quite  
17 sick people coming to emergency departments with Covid  
18 or other respiratory, sort of, viral illnesses. So the  
19 whole area of shielding, I think -- as a group, we think  
20 could have been done better and I think it's suddenly  
21 now all gone away without any further advice.

22 **Q.** Much of what you said there will -- echoes what we heard  
23 from the Clinically Vulnerable Families witnesses and  
24 their evidence they gave us.

25 Can I turn to your father because he picks up on  
73

1 somehow and have this, you know, briefing of, you know,  
2 this is what we're facing, this is what we're going to  
3 do. That never really came. And, again, not to put any  
4 blame whatsoever on my clinical leaders, I've now  
5 subsequently learnt that they were also waiting for that  
6 big moment, that big central briefing: okay, this is it,  
7 guys, this is what we're going to be doing. That didn't  
8 come for them.

9 And what I've learnt subsequently, as well, and  
10 I have permission to say this from meetings I have been  
11 having with other people in relation to future response  
12 and resilience, is that leaders, clinical leaders were  
13 phoning other colleagues in other hospitals to say: we  
14 know this is coming, we're watching the news, we're  
15 seeing what's happening in China, we can see it coming  
16 across Europe, what are you doing to get ready?

17 So that was the environment that we were operating  
18 in.

19 **Q.** So slightly informal, if you like, when actually what  
20 you really wanted was some direction from leadership; is  
21 that really where --

22 **A.** Absolutely, and I was drawing on my own background in  
23 the military. I mean, that's -- whenever we were  
24 deployed anywhere there was a big, you know, a big  
25 movement of preparation and deployment and preparedness

75

1 a number of issues that I'd like to ask you about. Just  
2 before we go, is this right, at the beginning of the  
3 pandemic you were working in North Wales, is that right,  
4 and during the first wave you worked for Public Health  
5 England doing shifts at Heathrow, certainly monitoring  
6 those that were coming into the UK at the time when we  
7 still could travel?

8 And then certainly you say in your statement that  
9 in February 2020 you were on a shift in North Wales and  
10 asked to respond to a call from passengers on a train  
11 coming to North Wales from Scotland and the passengers  
12 had been around someone with confirmed Covid. At that  
13 point in time, there were no recorded Covid infections  
14 in the North Wales area and you wanted to seek some  
15 guidance on what to advise the passengers and where they  
16 should go and what they should do. And what happened  
17 when you tried to find out what you should advise the  
18 passengers?

19 **A.** Yeah, in those early days I think, just to give some  
20 context, there was a lot of confusion, if I can say,  
21 about what we should be doing as a profession in terms  
22 of guidance, strategies, et cetera. Things hadn't  
23 filtered through centrally. We were waiting,  
24 I remember, and colleagues just waiting for that moment  
25 where we were all going to be called to some big meeting

74

1 but we didn't have any of that in this situation. And  
2 I think that was a bit of a shock for many of us.

3 We had healthcare workers not even sure if they  
4 should take their leave, you know, things like that,  
5 in February time, or travel abroad on holiday, should we  
6 go, should we not, don't know what to do, no one is  
7 telling us what to do. So that was the level of  
8 confusion that was going on at the time, sort of  
9 January, February time.

10 And then, again, I do want to talk a little bit  
11 about Heathrow. I was really shocked, if I may --

12 **Q.** I do, but I'd like to try and just stick within the  
13 confines of the healthcare system --

14 **A.** Fine, fine.

15 **Q.** -- but, of course, clearly some of those people went  
16 into quarantine, and the like.

17 **A.** Absolutely, absolutely. So within -- so we saw it from  
18 the perspective -- what happened at Heathrow and what  
19 happened on that day when I got that phone call kind of  
20 made me realise that actually the entire system is not  
21 ready.

22 **Q.** Right.

23 **A.** So whether it's within my hospital in a small trust in  
24 North Wales, or working within a wider healthcare system  
25 in London in one of the busiest airports in the UK, but

76

1 for a big entity like Public Health England, you know,  
 2 which was, you know, designed to keep people safe. So  
 3 in terms of the, very briefly, the Heathrow airport  
 4 scenario, I was really shocked how the week before  
 5 I'd been there and the response was as I would expect it  
 6 to be. If the crew from the aircraft calls to say,  
 7 "We've got someone, these are the symptoms, okay, what  
 8 do we do?", the action would be: keep the person on the  
 9 plane, we will meet you at the plane, come up the steps  
 10 in our PPE and we'll take a history, take a name, decide  
 11 on what the next action is but hold the person there,  
 12 we'll take their details, we'll log and track and trace,  
 13 if you like, tracking of that.

14 The following week I went in, nothing had changed.  
 15 The number -- in terms of the wider situation, the  
 16 numbers were still going up within the country, the  
 17 stats of people getting sick every day, we were hearing  
 18 that it was getting higher. When I came in to the shift  
 19 that week with higher numbers, the advice was: we're not  
 20 going out to meet any more planes, we're not even taking  
 21 their names, this is all you have to do, you've just got  
 22 to take the phone call from the flight and then you've  
 23 just got to tell the person to get home. And my  
 24 question was, well, do we need to know where they live?  
 25 Do we need to know who they are? No, we don't need to

77

1 account, please. When you sought advice as to what to  
 2 tell them and where they should go, what advice were you  
 3 given?

4 **A.** Okay, so when I phoned up -- I remember getting the  
 5 call. We were in doctors' and nurses' sort of room  
 6 where we make all decisions and have the board with all  
 7 the patients, et cetera, and I remember speaking to my  
 8 colleague saying, okay, what do we do about this, and  
 9 I was -- the consultants had gone home for the evening  
 10 and I was the in-charge registrar in the evening and  
 11 I spoke to the nurse in charge and we pulled out  
 12 a folder, the folder said: call this number. I called  
 13 that number and I think what we had were a few pages at  
 14 that point of what to do "if".

15 And I found that there was -- I can't remember if  
 16 there was actually someone to call.

17 **Q.** Let me help you. Let me say, you tried to call  
 18 Public Health Wales, it was a Friday, late at night, and  
 19 in fact they'd gone home. You left a message and you  
 20 were told you would get a call back the following week.  
 21 Of course, the point being that the passengers by that  
 22 time were already in Wales --

23 **A.** Exactly.

24 **Q.** -- and absent the advice they were looking for.

25 **A.** So what I can't remember is if it was an automated phone

79

1 know what their names are, we don't need to know where  
 2 they live, we don't even need to get them home. Just  
 3 you tell them to get home by whatever means. And  
 4 I asked, "Do you mean even by public transport, on a bus  
 5 or on the tube?" "Yeah, that's fine, just tell them to  
 6 get home."

7 And that was February. So -- and then at the same  
 8 time in North Wales when I was on shift --

9 **Q.** Can I just stop you there, Dr Ahsan, and just pause for  
 10 a moment and it may be my fault for not making you slow  
 11 down just so we can keep up.

12 **A.** Sorry.

13 **Q.** It's all right. But really, essentially, what you are  
 14 saying to us there is there was a shift within the week  
 15 in your experience at Heathrow, which really goes back  
 16 to preparedness, which is something that her Ladyship  
 17 has already heard about and obviously looked at in depth  
 18 in Module 1. And so I just would want to, sort of,  
 19 actually bring us back to what was going on, perhaps not  
 20 at Heathrow but in that smaller setting that you were  
 21 coming on to telling us about --

22 **A.** Sure.

23 **Q.** -- and certainly then coming on to deal with your  
 24 experiences when your father went in to hospital.

25 Can I just finish the passengers on the train

78

1 call or whether there was a human being on that Friday  
 2 night, and I think it was an automated message. But  
 3 I just remember that I was able to relay that I needed  
 4 to pass on a message that someone is coming from --  
 5 I think it might have been an out-of-hours individual  
 6 person who basically relayed that "You need to call back  
 7 next week".

8 **Q.** So another example there of preparedness or the lack  
 9 thereof potentially. All right.

10 Can I jump forward in time to December 2020. And  
 11 I think it's the case that on 17 December your dad, who  
 12 I think was 81, a retired teacher, had asthma and  
 13 a number of other symptoms but was generally well, had  
 14 to go into A&E, and -- on 17 December, it's suspected  
 15 that he caught Covid-19 in the hospital. And he was  
 16 discharged I think -- is that right?

17 **A.** He went in for just a standard --

18 **Q.** Procedure?

19 **A.** Yeah, something that I had done with him many times  
 20 before. It was just about a catheter that was blocked.  
 21 Quite routine. And we believe -- and this was during  
 22 that period of time where I had wanted to get home to  
 23 lock down but I was on shift and I was working, but it  
 24 was during that period -- we feel that he caught Covid  
 25 during that period of time.

80

- 1 **Q.** I think you said he tested -- he was tested upon arrival  
 2 but the result was lost and when they re-tested him  
 3 a couple of days later he received a positive test  
 4 result and then was placed, nonetheless, on a normal  
 5 ward initially. Was that whilst the lost test result --  
 6 **A.** Yeah.  
 7 **Q.** Right. Understood.  
 8 **A.** So yeah, during that period of time he'd gone in for  
 9 a normal, rather routine thing, catheter change. He  
 10 wasn't -- he didn't normally have a catheter, something  
 11 had happened during that period of time that he needed  
 12 it, and he went in very, very quickly with one of my  
 13 siblings, came back home. But a few days later started  
 14 to have signs and symptoms that made us worried and he  
 15 -- we were -- again, we knew there would be waits,  
 16 et cetera, for him to be seen. Again, this was all  
 17 second-hand relayed to me, because I was on shift in  
 18 North Wales, and it was a case of two of my siblings,  
 19 both of them medical, just making the decision to take  
 20 him into A&E and it was a frightening journey because he  
 21 was having difficulty in breathing. And they got him to  
 22 A&E, a swab was taken at that point but lost. A chest  
 23 x-ray was done. It was quite typical of the Covid  
 24 picture.  
 25 **Q.** Right.

81

- 1 **A.** Yes.  
 2 **Q.** And can you help at all with --  
 3 **A.** I can't recall if it was an FFP3 or a surgical --  
 4 I think it was a surgical mask. FFP3s, I think were for  
 5 when there was nebulised -- aerosol-generating  
 6 procedures.  
 7 **Q.** We've heard about those, all right.  
 8 And I think you say, though, that whilst your dad  
 9 was in the Covid-19 ward he was not taken to a high  
 10 dependency unit although you were told that would have  
 11 been the right place for him. Were you told why it  
 12 wasn't possible to admit your dad an HDU?  
 13 **A.** So -- and this was happening -- again, it was really  
 14 challenging because I just really -- during that time  
 15 I really sort of wished I didn't know the details, that  
 16 I didn't know what was happening. I just really, like,  
 17 wished for ignorance because I knew that I was -- I knew  
 18 what we were doing in our hospital where pressures -- we  
 19 were busy and actually everything coincided at the same  
 20 time. I got compassionate leave to come home for my  
 21 father whilst things were getting busy in my own  
 22 hospital. So it was -- it wasn't just an increase in  
 23 cases in London, it was also simultaneously increasing  
 24 in North Wales, as well, and I felt, bizarrely, you  
 25 know, my normal reaction was feeling guilty leaving my

83

- 1 **A.** And my siblings were there, yeah.  
 2 **Q.** And I think, did -- were you able, then, in due course  
 3 to take some compassionate leave from your job and come  
 4 down to join him in the hospital?  
 5 **A.** I think -- yeah.  
 6 **Q.** I just want to ask you about that because you say he was  
 7 moved to a Covid-19 ward. He needed one-to-one care  
 8 which you provided and you stayed in his room for  
 9 24 hours a day for six days in full PPE. So clearly  
 10 visiting was allowed. Can you tell us, what PPE were  
 11 you wearing whilst you were with your father at his  
 12 bedside?  
 13 **A.** So it was almost the same PPE as I'd been wearing in ITU  
 14 in my hospital bar the big -- excuse me, I've forgotten  
 15 the name of the big respirator that we wear, but I wore  
 16 in the hospital with my father in the room, it was  
 17 a full gown, gloves, a fluid-resistant mask, not  
 18 an FFP --  
 19 **Q.** One of the blue ones?  
 20 **A.** Yeah, but fluid-resistant, so three-ply, and a visor.  
 21 **Q.** And was that PPE that was provided to you?  
 22 **A.** Yes.  
 23 **Q.** So you wore that throughout the time at your dad's. Did  
 24 you observe what the nurses and doctors were wearing?  
 25 Were they wearing similar levels of PPE?

82

- 1 colleagues, but my colleagues were incredible and gave  
 2 me that time to be with my father. And so I went --  
 3 I was with him and I knew that just even the week  
 4 before, or even the weeks after when I went back to  
 5 work, that there were patients who were similar to my  
 6 father, if we had capacity, you know, even at that age  
 7 and other comorbidities they would be -- they would  
 8 get -- if it was deemed correct for their care, for  
 9 their care package, and in the patient's best interest,  
 10 then, and there was capacity, then that's where they  
 11 would be going which is how we would normally function,  
 12 where you have those important conversations with family  
 13 members and the patient about ceilings of care.  
 14 What we had on this occasion, and what  
 15 I experienced with my father during that time in this  
 16 particular hospital, which was under enormous pressure,  
 17 and this is a hospital that I have worked in in the past  
 18 within the emergency department.  
 19 **Q.** Just tell us, what did the consultant tell you about why  
 20 your dad could or couldn't go into HDU?  
 21 **A.** So we waited all day. I remember it being a really,  
 22 again, that's why I feel so much family members on the  
 23 issue of time where, you know, time takes on a different  
 24 meaning when you're just terrified for your loved one,  
 25 and there's -- things are not moving in the way that

84

1 they should be. And within healthcare time is really  
 2 critical, as we all know, I don't need to tell people  
 3 that. But I remember those couple of days where  
 4 everyone was just exhausted and working without breaks.  
 5 Working without -- I couldn't recognise this hospital  
 6 that I had known and worked in for years before.  
 7 Bearing in mind my sister was also a GP in that hospital  
 8 running urgent care downstairs. None of us could  
 9 recognise this place that we'd all grown up in  
 10 clinically as doctors and worked in. It had just  
 11 transformed and the consultant that day, eventually she  
 12 came to see me, she looked exhausted, really exhausted,  
 13 and her registrar had come earlier in the day and  
 14 I could see the list of things that they had to do. It  
 15 was huge. It went on for pages and pages and they  
 16 hadn't -- the registrar had definitely not had a break.  
 17 I could tell. This was about 5 or 6 in the evening.

18 Essentially, we just had a really sort of frank  
 19 discussion with the consultant and she said, "Look,  
 20 you know and I know that this isn't how it would  
 21 normally be. I have got 40-year-old male patients that  
 22 I am trying to desperately find an ITU bed for across  
 23 the region, you know, that's what I'm dealing with."  
 24 And at that point I knew that this is it for my dad.

25 **Q.** Was she basically saying to you that in normal times he

85

1 patients in this normal ward had respiratory symptoms as  
 2 well. And we had to sort of advocate for him to go  
 3 to -- you know, for them to repeat the test and to prove  
 4 that he had Covid. But also look at the patient  
 5 symptomatically: it looks like Covid, it must be Covid.  
 6 And to move him onto the Covid ward. Because then that  
 7 kind of opened up another passage of care, including  
 8 CPAP and -- which is the big mask that I think everyone  
 9 is aware of, and the medications.

10 And I think -- I'm so sorry, could you just repeat  
 11 that question.

12 **Q.** Not at all. You described it as being truly frightening  
 13 to have contemplated what care your father would have  
 14 got had you not been there. Is really what you are  
 15 saying to us is because they're so overrun had you not  
 16 been there his care would have inevitably been less?

17 **A.** I think it would have been -- again, I think this is one  
 18 of -- we're now going into one of the areas where I have  
 19 had a huge number of flashbacks, because I remember --

20 **Q.** Take your time.

21 **A.** All right. And it's one of the things -- one of the  
 22 contributing factors as to why I haven't yet gone back  
 23 to work. But I just remember feeling so completely  
 24 helpless. And, you know, from the perspective of  
 25 someone the week before looking after other people's

87

1 might have been a candidate for HDU but because of the  
 2 pressures they were under region-wide, he was not going  
 3 to be admitted into high dependency?

4 **A.** Yeah, he was not going to get that level -- escalation  
 5 of care. He'd reached the ceiling of ward-based care.  
 6 The next step would have been one-to-one care. Yeah.

7 **Q.** Can I ask you about care, because clearly you were at  
 8 his bedside for a number of days and the hospital had  
 9 a policy that if the patient had had a carer at home,  
 10 they would allow the carer to remain in hospital, and  
 11 I think your dad had had some care at home.

12 Are you able to tell us, Dr Ahsan, what you think  
 13 his care would have been like or how it would have been  
 14 impacted if you had not been present?

15 **A.** Yeah, that's frightening. It's really frightening.

16 **Q.** Why do you describe it in that way?

17 **A.** There were so many -- he was in a side room. And we had  
 18 to advocate hard for him to get into the Covid ward.  
 19 I remember those few days of just frantic phone calls.  
 20 Again, you just got the sense of the system being so  
 21 overwhelmed. People were exhausted, running on empty,  
 22 just overwhelmed by the numbers.

23 And he -- my father, before he went into the Covid  
 24 ward, had been in a normal ward. Yeah, he was in  
 25 a normal ward but I think, to be honest, many other

86

1 parents and -- fathers and mothers, and now really  
 2 relying on others to look after mine, and just being  
 3 super frightened, I just remember feeling like my legs  
 4 were going to give way at some point and feeling so  
 5 scared I felt sick. But like seeing that my dad would  
 6 sometimes slide down the bed and the moment -- Covid is  
 7 so positional and the minute a patient moved, anything  
 8 could just set them off and they'd be fighting for  
 9 breath, like fighting for breath in a way that you see  
 10 horrendous, you know, on television people suffocating  
 11 for other reasons, you know, dramatised, you know, in  
 12 films. Well, this was suddenly very real. And seeing  
 13 a grown man thrashing on the bed to breathe was really  
 14 harrowing.

15 And bearing in mind that I'd actually been in ITU  
 16 and so we had intubated patients that were calm, you  
 17 know, that weren't in that -- they might have been like  
 18 that for a short while before we took over and relieved  
 19 those kind of symptoms, but with my father, because  
 20 there was a ceiling of care made that he wasn't going to  
 21 be for intubation -- and we'd had those discussions and  
 22 I think I agreed with those discussions, we'd had those  
 23 discussions earlier --

24 **Q.** I'm going to ask you about that if I may.

25 **A.** Yeah. So for him the ceiling of care was CPAP and

88

1 ongoing treatment, but during that period of time he  
2 would slide down the bed, sometimes he would thrash, he  
3 would be really, really frightened and he'd cry out. It  
4 was -- I've -- you know, I've never seen my father like  
5 that. And sometimes the piping from the CPAP would get  
6 dislodged and, you know, again, that was his source of  
7 oxygen. But if I hadn't been in the room, I don't know  
8 how the overworked nurses in that space would have been  
9 able to keep an eye on every single side room.

10 **Q.** Yes.

11 **A.** So I just kept thinking, "Thank God I'm here, what about  
12 the others?" And I hope that by being there it took  
13 some of the pressure off the nurses for the other  
14 patients, but again I remember being in that side room  
15 and seeing the porters taking yet another trolley of  
16 another person out just across -- you know, behind us.

17 Obviously the nurses -- we have a routine normally  
18 that when a patient dies the curtains are drawn. Every  
19 effort is made so that other patients don't see this.  
20 But there were too many.

21 **Q.** Can I perhaps bring you to the end of your father's  
22 life, and you just touched on it there were some  
23 discussions had. Was any DNACPR discussion had with you  
24 or your siblings in relation to your dad? What was the  
25 communication like when those discussions were being had

89

1 Families' perspective, it's the communication around the  
2 DNACPRs that is the real concern. The way you  
3 communicate with a patient, the way you communicate with  
4 the family, how it's recorded. We've heard a lot of  
5 evidence about potential failings in that regard, areas  
6 of good practice in that regard. So I won't need to  
7 trouble you with that, all right.

8 **A.** But I have to say that I think we were fortunate. We  
9 were fortunate that we did have those conversations.  
10 Again, with DNACPR -- and I really feel for the  
11 families, because the end of a life happens once, and it  
12 has to be done properly. Because the impact of when  
13 it's not done properly can last a lifetime for others.  
14 It's so important.

15 And again very, very quickly I know the impact of  
16 it going wrong, because it happened to my mother in  
17 2019, horrendous death without adequate -- and this was  
18 pre-Covid, without anyone really being sympathetic or  
19 giving us the time for end of life. And at that point  
20 we were really desperate for her to have proper  
21 end-of-life care and it didn't happen and we were really  
22 terrified, and my father was terrified -- well, he had  
23 witnessed it and we were terrified of him going through  
24 that same route.

25 But on this occasion we were very fortunate that

91

1 with you and your family?

2 **A.** I think we were, again, minded that that was the -- that  
3 was an important area for us and for my father. He at  
4 some point got so bad that he just said, "I want to  
5 die", and to hear that -- and he just said, "I want to  
6 die". And at this point his mouth was full of blood  
7 from -- I don't know whether it was the pressure of  
8 the CPAP -- he'd been on CPAP for a good few days and he  
9 had not eaten and he had lost a lot of weight, his  
10 stomach was rumbling from hunger but he was too scared  
11 to take the mask off because every time we took the mask  
12 off to try to feed him he would desaturate, become  
13 really frightened. I remember taking -- I took him  
14 a favourite drink of his -- I took a -- it's a drink,  
15 a yoghurt drink, and I thought he might like that, and  
16 I can remember his face lighting up when he saw that  
17 drink and then when I went "Shall I pour it?" and then  
18 he thought and he said no, because he didn't want to  
19 take his mask off.

20 **Q.** All right. Just pause there for a moment, all right,  
21 Doctor.

22 Obviously you had to have painful discussions with  
23 doctors and indeed your family about what may happen to  
24 him. And do I take it from everything that Matt Fowler  
25 has said in his statement that from the Covid Bereaved

90

1 the conversations were had and they were had in  
2 a supportive way. And when he said -- when my father  
3 had said, "I want to die", we were able to then move  
4 forward with the appropriate medication to help him to  
5 be more comfortable and to stop having those horrendous  
6 symptoms.

7 **Q.** Two very contrasting experiences there.

8 **A.** Mm. And what I -- really, really am sad and upset for  
9 the other members of the group, that they didn't have  
10 that opportunity, and I fully feel their pain because we  
11 experienced what they experienced with our mother.

12 **Q.** And your dad sadly passed away on 28 December, is that  
13 right, of 2020, so just before the New Year?

14 **A.** Yes.

15 **Q.** Can I ask a bit about your experience.

16 You've told us about the PPE that you wore as  
17 a visitor when you were caring for your dad. What about  
18 when you were actually working in Wales, what PPE were  
19 you provided with then?

20 **A.** So when I was working in the emergency department it  
21 was -- I remember it varied. It changed. I remember  
22 right at the beginning of the first wave there was  
23 a period of time where -- when guidance was coming out  
24 of how we need to respond. Eventually guidance was  
25 coming, centrally. When I say "centrally", I suppose

92

1 what -- I'm thinking about, you know, the Department of  
2 Health, NHS England, et cetera. Eventually it would  
3 arrive to us all the way in North Wales and then we  
4 would be given guidance on what we had to wear. And it  
5 started -- I remember one particular week it was -- full  
6 PPE was the guidance if we come into contact with  
7 suspected Covid, and we were fit tested for this, which  
8 is, you know, tested with the FFP3. And so we started  
9 the week thinking that that's what we're going to be  
10 wearing. During that same week, I believe it was  
11 about March time, it was downgraded almost on a daily  
12 basis, three or four times that same week, to  
13 eventually, at the end of the week, it was literally  
14 just a normal surgical mask and then an apron and  
15 gloves.

16 And when we -- you know, you've got an informed,  
17 scientifically-minded workforce that are asking: why?  
18 Is there new evidence? Has something emerged?

19 And we would be pointed back to the guidelines,  
20 and they would say: well, the guidelines say ... And  
21 then when you referred to the guidelines -- and I was  
22 making another -- dispatches at the time, so we were  
23 looking at this evidence. There was no new evidence.  
24 They were still relying on the same scientific evidence  
25 but just the guidelines had changed.

93

1 Is that a reference to FFP3 -- it is, I can see  
2 you nodding.

3 **A.** Yeah. I have photographs of them -- they're all on this  
4 phone -- where you can see -- which I'm more than happy  
5 to provide you, because I took photographs of them and  
6 I filmed them because I was, as I mentioned, also  
7 filming at the time. But you could quite clearly see  
8 stickers that said a date in the future and then when  
9 you looked underneath that sticker there was another  
10 sticker that was an out-of-date sticker, by at least two  
11 or three layers of different dates.

12 **Q.** Were you ever told what tests had been conducted on the  
13 masks to make sure that they were safe?

14 **A.** No.

15 **Q.** And I think you said it was the elastic breaking?

16 **A.** Yeah.

17 **Q.** And indeed you experienced that yourself?

18 **A.** Yes, I experienced that. I remember speaking to another  
19 nurse who that had happened to as well within the  
20 decontamination space. And when you're in that space,  
21 it's -- there's a process to get in and out. It's not  
22 a normal room. There's an inner door and there's the  
23 donning and doffing space, and then the outside bit. So  
24 when it -- and you would be in that room because there  
25 would be, you know, a patient was either going to be

95

1 And then --

2 **Q.** I just want to clarify. When you were talking about the  
3 same week in March time, I assume we're talking about  
4 March 2020?

5 **A.** Yes, March 2020, to the point -- and I remember it so  
6 well. I remember that period. And I've now  
7 subsequently learned that that wasn't just unique to us  
8 in our hospital, that was happening everywhere. And  
9 I remember it and, if I may, I remember colleagues being  
10 really alarmed that -- one person even posted on  
11 a Facebook group that we'll be in flip flops and speedos  
12 by the end of the week. You know, that's how bad it  
13 was. And people being generally concerned. But then  
14 with no real explanation.

15 But then, in different -- again, it was where you  
16 were in a different section of the hospital. So if you  
17 were within the decontamination space of ED, which is  
18 where the really sick Covid patients who would need  
19 aerosol procedures or intubation would go, we would then  
20 wear full PPE. So it was FFP3 masks, visors, gowns,  
21 et cetera.

22 **Q.** In your statement you made reference to, whilst working,  
23 you saw and wore out-of-date PPE, including masks,  
24 during the second wave. And you say this:

25 "[The] face masks broke whilst wearing them."

94

1 intubated or -- there'd be lots of viral load in that  
2 room. And when, you know, the masks -- the straps --  
3 I don't know if people have worn the FFP3 masks, they're  
4 quite thin, but, you know, these ones were, sort of, out  
5 of date by at least ten years, and they did snap. And  
6 it snapped on my face during a procedure. I just  
7 remember going, sort of, like this, trying to, you  
8 know --

9 **Q.** Put your head on your shoulder to try to hold the mask  
10 on?

11 **A.** Yes.

12 **Q.** I follow you.

13 **A.** And I don't know what the nurse did, how she managed,  
14 I think she -- because it happened to her on a separate  
15 occasion, but I just -- and again, I didn't want to  
16 alarm anyone, we just -- you just kind of extract  
17 yourself as quietly and quickly as possible and sort  
18 yourself out.

19 **Q.** Can I ask you about some experiences that you had with  
20 Covid. I think you contracted Covid yourself. And you  
21 said you've subsequently developed symptoms that are  
22 being examined for Long Covid. Have you actually had  
23 a diagnosis now of Long Covid or --

24 **A.** So I have a diagnosis of lupus. I began to feel unwell  
25 in -- so I just thought it was burnout. I thought it

96



1 was bereavement grief, I thought it was all of that.  
 2 But I went to the GP and, you know, I thought it must be  
 3 the time of life and she said, no, let's just do some  
 4 bloods and the blood test came back as abnormal, that  
 5 had been normal in earlier years, and then that just  
 6 unlocked the door to other tests and it turned out that  
 7 I had developed lupus. And I've seen a few professors  
 8 and, you know, I'm looked after quite well. There is --  
 9 I've been told a number of times it's quite unusual for  
 10 someone your age to suddenly just develop lupus.  
 11 **Q.** Had you had the lupus symptoms before you had had Covid?  
 12 **A.** No. So there's obviously a trigger. The way that it  
 13 was, you know, described was that somehow the lupus has  
 14 been unlocked. You might have had a dormant, sort of,  
 15 tendency to have it but something has come and  
 16 unlocked -- what has happened? Well, I've had Covid.  
 17 And evidence within literature does suggest that there  
 18 have been cases of lupus being developed as  
 19 a consequence of Covid. But unfortunately I'm not sure  
 20 if it's come up already but, you know, in terms of  
 21 Long Covid and research into this area, there's not much  
 22 funding and funding is being shut down and also funding  
 23 for the care of people with things like this in this  
 24 spectrum of area, is being quietly ended. So, for  
 25 example, in North East London Foundation Trust they did  
 97

1 who had fractured her hip, that's something that we  
 2 normally would see almost immediately as soon as  
 3 a patient is scooped off the floor and brought in. This  
 4 lady had stayed at home for four weeks with a broken  
 5 neck of femur, you know, neck of femur fracture.  
 6 I've never heard of anything like that before.  
 7 We had patients who were terrified of coming in.  
 8 My brother, for example, an immunocompromised patient,  
 9 but himself a doctor had caught Covid whilst working.  
 10 And if I may quickly say, he was working within the  
 11 first wave. Again, horrendously poor PPE, and he was  
 12 actually working in the same hospital where my father  
 13 had died later that year. He didn't have PPE. He was  
 14 being sent to work in cubicles with patients with, as he  
 15 described it: there's some really strange patients  
 16 coming in right now with weird respiratory symptoms, and  
 17 this was the wave 1, and he caught it. I was able to  
 18 look after him during the first wave because I myself  
 19 was terrified of him going in.  
 20 **Q.** Dr Ahsan, can I ask you, your brother's concerns about  
 21 PPE, was that things you were hearing from the staff  
 22 that you were working with on the documentaries and TV  
 23 programmes?  
 24 **A.** Yeah, I think there was a real -- there was fear about  
 25 PPE, about the lack of PPE, about not being told the  
 99

1 have four Covid clinics. I think they've shut three  
 2 down and there's only one.  
 3 **Q.** Can I ask you something, if you can, about a number of  
 4 things that you've alluded to. In your statement you've  
 5 set out that the number of TV and radio documentaries  
 6 that you have been involved in, in relation to Covid,  
 7 and I'd just like, sort of, an overview of what talking  
 8 to other patients and staff has given you, as if your  
 9 own personal experiences weren't enough.  
 10 Can I just ask you this, Dr Ahsan. In making the  
 11 documentaries and the programmes, how many clinicians  
 12 and patients have you spoken to, roughly?  
 13 **A.** I think in excess of 50 along a course of a year's worth  
 14 of filmmaking, writing, print and radio documentaries.  
 15 Really, a large number of people.  
 16 **Q.** Can I ask you about the patients, firstly.  
 17 **A.** Yes.  
 18 **Q.** What were their main concerns or things they were  
 19 raising with you about the impact that Covid had had on  
 20 them and their experience of the healthcare system?  
 21 **A.** You had people who -- again, I just remember quite  
 22 clearly people who had other conditions who needed  
 23 high-level care, critical care, but with other  
 24 conditions and the fear that they had of catching Covid,  
 25 of delays of coming in. I remember speaking to one lady  
 98

1 truth about why we're not having -- you know,  
 2 insufficient levels of PPE. And why, again,  
 3 a scientifically-minded informed population are being  
 4 told things that just don't add up. And now we know the  
 5 reasons: that there wasn't enough; it wasn't the fact  
 6 that it was safe.  
 7 And I think -- again, with healthcare workers and  
 8 what they were telling me, there was -- I think it  
 9 was -- a lot of them -- well, let's talk about the  
 10 patients -- concern about coming into hospitals, concern  
 11 about what impact this was having on existing  
 12 conditions. I interviewed a woman with cancer, in the  
 13 early stages of cancer diagnosis, and the absolute  
 14 terror and fear that her and her family were going  
 15 through on how they were going to navigate this  
 16 during -- she got her diagnosis around about the first  
 17 wave, so that was quite an impactful interview. And  
 18 just alerted, you know, reminders of the fact that  
 19 there's a whole -- you know, the rest of healthcare is  
 20 not going to stop because of this.  
 21 **Q.** If I can bring you back to the staff. I think you say  
 22 in your statement you have four months of footage that  
 23 details concerns, poor supplies, out-of-date PPE which  
 24 you yourself have experienced, and staff stress, which  
 25 again you've very ably, if I may say, brought to life  
 100

1 today having, watched what happened with your dad.  
 2 Can I just finally ask you this, please, Doctor.  
 3 I think you say that as a result of everything that  
 4 you've been through, you've suffered depression, anxiety  
 5 and burnout from about March 2021?

6 **A.** Hmm.

7 **Q.** And you had to take, I think, a break from your PhD and  
 8 it's impacted your ability to return to clinical  
 9 practice. Have you been able to resume clinical  
 10 practice? What's the update there?

11 **A.** I haven't yet but I must. And it's about -- it's about  
 12 being able to go back into an environment where there  
 13 will be patients who are short of breath and being able  
 14 to deal with that. I know that this has had a really  
 15 detrimental impact on my career progression and my  
 16 ambitions of what I want to achieve within emergency  
 17 medicine, but I'm very fortunate that I have really  
 18 generous and empathetic colleagues who have -- but  
 19 I think it's because we all know what we've each been  
 20 through.

21 I just want to sort of -- and again, during that  
 22 time I was filming I cannot not mention the healthcare  
 23 workers that didn't make it. Our colleagues. You know,  
 24 that's -- up to 52, that's a doctor a year that didn't  
 25 make it, that died from Covid. And there were

101

1 well, you know, and trying their best to the end, and  
 2 sort of dying in the line of service.

3 And we had people from all ages. You know,  
 4 I think the youngest was, that I've read about is  
 5 a 44-year-old, Dr Sedghi, Abdorreza Sedghi, who was a GP  
 6 trainee, we had surgeons, we had anaesthetists, we had  
 7 so many healthcare workers and, you know, frontline  
 8 staff succumbing to their illnesses, and I spoke to, in  
 9 the course of my work, trying to tell their stories,  
 10 I spoke to many of these people and I think the data was  
 11 one thing, but the real-life stories and the accounts of  
 12 what people experienced and saw and witnessed is really  
 13 crucial. It's so, so crucial.

14 And that's one of the reasons why I tried to make,  
 15 you know, content, tried to do two jobs at the same time  
 16 because something didn't feel right. That we were being  
 17 told these numbers that were going the wrong way on  
 18 an almost daily basis, wrong way, ie going up, but we  
 19 were still having alternative narratives coming out,  
 20 right from, you know, the Prime Minister himself, from  
 21 the Secretary of State for Health at that time, from  
 22 other people associated with that department, that were  
 23 downplaying or giving alternative narratives to what we  
 24 were actually physically witnessing.

25 And if I may talk about just one very quick

103

1 a significant number of healthcare workers who were from  
 2 the black and Asian minority community, extra  
 3 vulnerable. What might be helpful to know early on --  
 4 well, not that early on, but I think it was around about  
 5 June/July time, that we were all being screened. We got  
 6 phone calls from our hospital if we were from a black  
 7 and Asian minority community, identified that we would  
 8 be at higher risk and we had a telephone call for  
 9 screening. So that, at that point, meant that someone  
 10 somewhere has recognised that we are extra vulnerable.

11 But during the course of the media work that I was  
 12 doing, I spoke to a surgeon -- the family of a surgeon,  
 13 Mr Abdul Mabud Chowdhury, who was a surgeon, a urology  
 14 surgeon, in the Homerton, I mean, we're talking about  
 15 urology, we're talking about surgery, so just confining  
 16 high-level PPE to certain professions wasn't correct.  
 17 He had posted on Facebook an open letter to the  
 18 Prime Minister asking for adequate PPE. He, sadly,  
 19 caught Covid and died and his -- I had the privilege of  
 20 speaking to his son and arranging for him to tell his  
 21 story on Channel 4 News. Really painful.

22 We have the story of Dr Yusuf Patel who was an  
 23 East End GP, much loved by his community. Again, we  
 24 talked about GPs earlier, but again, healthcare workers  
 25 were -- he was in his early 60s -- very vulnerable, as

102

1 example. Like, as I say, things didn't make sense with  
 2 what we were seeing on the ground, with what our  
 3 patients were telling us and what they were witnessing  
 4 and experiencing.

5 I tried to understand how there could be such  
 6 a disconnect. Okay for the first wave, but definitely  
 7 for the second wave, what was going on? And I -- and  
 8 this was a year later, I had an opportunity to speak to  
 9 a civil servant. It was at a social gathering so  
 10 I wasn't prepared. I didn't realise that she would be  
 11 there. It was a social gathering. And obviously the  
 12 subject of Covid came up, as it often does, and people  
 13 wanted to ask about what I'd done during it, and I told  
 14 them it, and it turns out that this individual was  
 15 a former adviser to Matt Hancock. And she, at that  
 16 point, stated that everyone was on -- well, she was on  
 17 the front line, her front line was just as hard, and so  
 18 it was very combative and defensive and that her  
 19 experience was just as challenging and as hard as  
 20 a frontline healthcare worker dealing with patients who  
 21 couldn't breath and were thrashing on the bed. And that  
 22 gave me an insight into the absolute disconnect  
 23 between -- the people that were actually making the  
 24 decisions were not connected with the people that were  
 25 actually delivering the care. And there was a massive

104

1 gulf.  
 2 I would still like to have --  
 3 **Q.** Can I pause you there, because as you were giving that  
 4 answer, her Ladyship was nodding when you said the data  
 5 is one thing but it's not everything, and we've heard  
 6 a number of pieces of evidence to that effect. And so  
 7 can I just ask you this finally, please. I suspect the  
 8 lesson learned is to try to bridge that gap between what  
 9 was going on on the front line and what the  
 10 decision-makers were being told or the data was telling  
 11 them. Is there any way, Dr Ahsan, that you think that  
 12 that gap could be bridged and that practically we could  
 13 do different in the event of a future pandemic?  
 14 **A.** I think there are a couple of things. I think  
 15 understanding that data are not -- each -- each specific  
 16 number is a human life, and a human life that has gone  
 17 on a journey, and when you're thinking about the data  
 18 that relates to Covid, that's a death that has not been  
 19 an easy death. The illness is not an easy death illness  
 20 and, at that point in time, where the system was under  
 21 so much pressure, that it would not have been an easy  
 22 journey, it would have been a frightening journey for  
 23 all involved.  
 24 I think resources and -- I have to bring it back  
 25 to funding.

105

1 thank you very much.  
 2 My Lady, is there anything that you would wish to  
 3 ask Dr Ahsan?  
 4 **LADY HALLETT:** No, thank you very much indeed, Dr Ahsan.  
 5 I'm extremely grateful to you, obviously for the work  
 6 you did on the front line, the work you've done trying  
 7 to bring to the attention of the public -- it shouldn't  
 8 really need it but I'm afraid people are beginning to  
 9 forget the -- all that you're trying to do to bring  
 10 matters of concern to the public attention.  
 11 And I do hope that you haven't suffered too much  
 12 distress from helping us today. I appreciate that some  
 13 of the things you have been talking about may have been  
 14 triggering. I know you're a doctor but don't forget to  
 15 look after yourself and get support if you need it. And  
 16 I'm really grateful to you for the help you have given  
 17 us.  
 18 **THE WITNESS:** Thank you.  
 19 **MS CAREY:** Thank you, my Lady.  
 20 **LADY HALLETT:** Thank you.  
 21 **(The witness withdrew)**  
 22 **LADY HALLETT:** Very well, I shall return at 2.05.  
 23 **(1.06 pm)**  
 24 **(The short adjournment)**  
 25 **(2.05 pm)**

107

1 **Q.** Yes.  
 2 **A.** But, you know, the Health Foundation states, you know,  
 3 even with an extra 38 billion per year, by the end of  
 4 next Parliament -- so that's 38 billion a year -- will  
 5 allow the NHS in England to meet growing demands. And  
 6 where we are, you will know the graphs better than me  
 7 and you'll have pored over them, but right now, in terms  
 8 of the EU14, we are so low down on that scale. We are  
 9 No. 10 out of the 14. And there is no -- when you talk  
 10 about the pressures that we face, and I know that there  
 11 was extra funding ploughed into the NHS during Covid,  
 12 but then you're asking for ready-made things to be able  
 13 to be bought off the shelf. Well, you can't just buy  
 14 a ready-made highly experienced consultant or a nurse to  
 15 suddenly buy them off-the-shelf. These are not sort of  
 16 pre-packed things that you can just suddenly build  
 17 overnight. This takes money, time and investment, and  
 18 resources as well, that take many years to build up.  
 19 Training, for example, takes years to build up.  
 20 So it does boil down -- without any shadow of  
 21 a doubt, and through the NHS that I started in and to  
 22 the NHS that began to emerge from 2010 onwards, it was  
 23 very different.  
 24 **MS CAREY:** And I'm going to stop you there if I may,  
 25 Dr Ahsan. That's all the questions I have for you,

106

1 **MS CAREY:** My Lady, good afternoon. The final witness is  
 2 Mrs Martina Ferguson.  
 3 **LADY HALLETT:** Thank you, Ms Carey.  
 4 **MS MARTINA FERGUSON (sworn)**  
 5 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**  
 6 **LADY HALLETT:** Ms Ferguson, as you probably heard, I can't  
 7 be with you today in person and I'm genuinely sorry, as  
 8 I said to your predecessor bereaved witnesses. I can't  
 9 be with you in person but I promise you that doesn't  
 10 mean that your evidence isn't extremely important to me  
 11 and to the Inquiry. And if I'm not with you in person,  
 12 I'm with you in spirit.  
 13 **THE WITNESS:** Thank you, my Lady, and I hope you are feeling  
 14 much better soon.  
 15 **LADY HALLETT:** Thank you.  
 16 **MS CAREY:** Mrs Ferguson, you are one of the group leads of  
 17 the Northern Ireland Covid Bereaved Families for  
 18 Justice, NICBFFJ, if I might just call you the Northern  
 19 Irish Bereaved, if I may. And the Northern Irish  
 20 Bereaved group is a branch of the UK-wide Covid Bereaved  
 21 Families for Justice group; is that correct?  
 22 **A.** That is correct, Ms Carey.  
 23 **Q.** And I think you started in around December 2021,  
 24 although prior to that, a number of the group's members  
 25 were involved in trying to discuss matters with people

108

1 in the state, public representatives, and were involved  
2 in other support and, indeed, memorial groups. So no  
3 one should think it just emerged until the end of 2021,  
4 there'd been work going on for some time before that; is  
5 that correct?

6 **A.** That is correct, yeah.

7 **Q.** You say in your statement, which we will publish, and is  
8 INQ000360941, that the Northern Irish Bereaved group was  
9 formed as both a support group and an action group.  
10 Could you give us an example of the kind of support the  
11 group has provided?

12 **A.** Yeah. So I suppose I should say during the pandemic,  
13 probably not at the beginning of the pandemic, it would  
14 have been after my mum's first period of  
15 hospitalisation, I had felt very strongly that we needed  
16 a public inquiry into what was happening, so I had  
17 connections with other groups, and it would have been  
18 summer/autumn 2021, we had joined the UK Covid Bereaved  
19 Families for Justice group that Jo and Matt had set up.  
20 So Brenda, my co-lead and I, had connected. We had  
21 discussed setting up a Northern Ireland branch, and  
22 thankfully we've had the privilege of working with very  
23 highly experienced legal teams and campaigning with  
24 like-minded bereaved families.

25 The aims of the group, when we set up the Northern  
109

1 of bodies and their different remits.

2 And was that engagement letters, demonstrations:  
3 Just give us an insight into what was done.

4 **A.** Yeah, the engagement with state entities, whilst that  
5 has continued, when we got together, you know, as  
6 a group -- can I just put that into perspective? During  
7 the first week of the pandemic, between 23 March and  
8 31 March, I was completely at my wits' end, you know,  
9 when I wasn't allowed into my mummy's care home. And  
10 that first week I had contacted, you know, the  
11 Department of Health, the private office of the former  
12 health minister, Robin Swann, the social -- the Southern  
13 Trust directors and assistant directors for older people  
14 in primary care. I actually got speaking directly to  
15 the Human Rights Commissioner at the time, Les Allamby.  
16 We had a discussion around, you know, human rights and  
17 how the state could interfere, you know, in -- when  
18 there's a public health crisis.

19 I had contacted RQIA, four of the MLA officers,  
20 the DUP, the SDLP and Sinn Fein.

21 I also had contacted the UUP, but that wasn't  
22 within the first week of the pandemic.

23 **Q.** Can I ask you this. About what topic or topics were you  
24 contacting all these different types of people and  
25 organisations?

111

1 Ireland branch, was really to have, like, a supportive  
2 place for, you know, bereaved families to kind of  
3 connect for those that wanted to connect. It was  
4 to place a focus on devolved matters, and also,  
5 you know, to support one another as a bereaved person.

6 There's lots of questions bereaved families had  
7 around, you know, finances because maybe the bread  
8 winner in their family had, you know, passed away. They  
9 had maybe legal questions. And just general questions  
10 around, you know, grief and support, so we were able to,  
11 you know, signpost those families.

12 **Q.** Now, you say in the statement you're also not just on  
13 the support side of things but an action group, and  
14 I think that included that engagement from the start of  
15 the pandemic -- so back into March 2020, engagement with  
16 senior officials from the Department of Health, its  
17 arm's length bodies, Public Health Agency, the  
18 Regulation and Quality Improvement Agency, the RQIA, the  
19 Patient and Client Council, senior management  
20 representatives the health and social care trusts in  
21 Northern Ireland, Commissioner for Older People, Human  
22 Rights Commissioner and, indeed, the former UK  
23 Prime Minister, Boris Johnson.

24 So a great deal of work being done by the members  
25 of the group to engage with all of those different types  
110

1 **A.** So my email, for example to Boris Johnson, what made me  
2 think he was going to respond, I don't know, but I was a  
3 really desperate daughter.

4 **Q.** Was this about getting in to see your mum in the care  
5 home?

6 **A.** It was actually asking -- I was very conscious -- you  
7 know, my mummy had dementia, she couldn't speak for  
8 herself, and I wanted to know, you know, could there be  
9 exceptional circumstances for those that, you know, had  
10 dementia or Alzheimer's. I was also asking about  
11 testing. And in normal circumstances when there is  
12 an outbreak of vomiting and diarrhoea, admissions would  
13 normally be stopped in a care home. So I was asking for  
14 admissions to be stopped, you know, to help stop the  
15 spread, you know, of the virus.

16 So there was a number of issues but they were the  
17 main issues that I'd highlighted all of these state  
18 entities within the first week of the pandemic. And  
19 then as our group grew we continued to engage with state  
20 entities, with public health as well, and the First  
21 Minister and deputy First Minister and all of the  
22 political leaders.

23 **Q.** Now, I think you know, Mrs Ferguson, that the focus of  
24 this module is on the healthcare systems, and your mum  
25 went into hospital and we're going to turn to that. But

112

1 clearly her Ladyship has got another module dealing with  
2 the impact on the care homes, so can we focus perhaps on  
3 what happened to your mum, who went into hospital,  
4 I think, firstly, from her nursing home, in  
5 July of 2020, and I think during that month, is it right  
6 that your mum had two admissions? She went in firstly  
7 on 5 July until 8 July, so a 3-day spell, and then she  
8 went in later again that month?

9 **A.** Yeah.

10 **Q.** Can I just ask you about the month generally. Were you  
11 able to visit your mum in the hospital in July 2020?

12 **A.** Yes, so in -- it was Sunday, 5 July. If I remember, it  
13 was the day before -- so this is 2020 -- it was the day  
14 before the rest of the restrictions -- they were kind of  
15 relaxed, I think, that Monday, 6 July. So my mummy went  
16 in that Sunday, the 5th, and she went in with seizure  
17 activity, and was normal because that had happened the  
18 year before and I think the year before that as well.

19 But can I -- I know we have a separate module and  
20 it's -- care homes will be dealt with later, but can  
21 I just explain and put a little bit of context around  
22 how vulnerable my mummy was and all of the bereaved  
23 families who have lost, you know, a loved one.

24 In my mummy's situation, I just want you to think  
25 for a moment. Let's imagine that your arms were in

113

1 back to the care home."

2 **Q.** And they discharged her, in your view, at least a day  
3 early?

4 **A.** Yeah, it was too early. I knew that and -- you know, we  
5 often talk about specialists and experts amongst doctors  
6 and clinicians, you know, and healthcare professionals  
7 are the specialist. I think, you know, it's families  
8 that are really the expert because they know their loved  
9 one well.

10 So I knew she was being discharged soon, but  
11 anyhow we went with the flow, my mummy went back into  
12 the care home, and then I got a phone call the next day,  
13 you know, on, I think it was, Thursday, 9 July, to say  
14 that my mummy had mild tremoring again and seizure  
15 activity, so she had to go back in. So we had to go  
16 through the whole process around, you know, A&E and  
17 being triaged again, and then they decided to keep my  
18 mum in and she was in for approximately -- you know,  
19 from 5 July really, apart from that 24-hour discharge,  
20 to 22 July.

21 **Q.** Pause there, Mrs Ferguson, because you obviously went  
22 with her the first time and again the second time. When  
23 you were visiting her, were you required to wear any  
24 PPE?

25 **A.** Yes.

115

1 a fixed flexion. You know, you've got dementia, so --  
2 advanced dementia. You can't speak. If you sneezed and  
3 your nose was dripping, with your arms in a fixed  
4 flexion you wouldn't be able to clean your nose. If  
5 your head was itchy, you wouldn't be able to scratch  
6 your head. And that was my mummy.

7 **Q.** So when she went into the hospital, were people, the  
8 nurses, the healthcare professionals, were they able to  
9 provide that most basic care, the wiping of her nose,  
10 the scratching of an itch? Tell us what it was like at,  
11 sort of, that level for you and your mum.

12 **A.** Yeah, when she went in she was triaged, you know, at  
13 A&E. She didn't look very well that day. And,  
14 you know, the doctors checked her. They were going to  
15 discharge her, you know, a couple of days later, which  
16 was the Wednesday, 8 July.

17 I remember having a conversation with the doctor  
18 and I said, "Look, you know, my mummy's had this seizure  
19 activity before, it happened last year if you want to  
20 check her notes, and she was discharged back into the  
21 care home too soon, you know, and I'd really appreciate  
22 if you could keep her under observation just for another  
23 24 hours."

24 And the doctor's response was, you know, "Your  
25 mummy's medically fit to be discharged. She's going

114

1 **Q.** And what did you wear?

2 **A.** My mum was up on one of the normal wards and I was  
3 wearing -- I remember because I was involved heavily in  
4 her -- you know, help, assisting with feeding.  
5 You know, there didn't -- I remember I was allowed to  
6 come into the hospital for about three four times during  
7 the day, and I know that that has been a major issue for  
8 some of the bereaved families in our group. You know,  
9 there's been a lot of inconsistency, you know, where  
10 they've been told in one trust that you are only allowed  
11 in for an hour a day and another trust they get in  
12 a couple of times during the day. But my mummy was  
13 in -- I was assisting with her feeding. She was on  
14 a particular diet.

15 **Q.** Yes.

16 **A.** You know, level 4, I think it was, on her diet, and  
17 a level 3 on her fluids. So I was wearing a paper apron  
18 and gloves. I was doubling up on the gloves but then  
19 I was told I didn't need to wear the gloves in  
20 July 2020. And I was wearing a paper face mask.

21 So back then, you know, that July, I knew that we  
22 could manage with Covid. I know not everybody wants to  
23 hear that but we had some of the critical tools then,  
24 you know, the PPE. My mummy went in. She had seizure  
25 activity, she was discharged. She was tested twice

116

1 before she was discharged back into the care home after  
 2 those two weeks and she was negative.  
 3 **Q.** Can I ask you this. Given your mum's dementia, how was  
 4 it communicating with her if you were wearing the mask?  
 5 And indeed, how were the staff able to communicate with  
 6 her through masks?  
 7 **A.** So my mummy would have recognised my voice, you know,  
 8 and just things that we would have said to each other --  
 9 sorry, she wouldn't have responded apart from, like,  
 10 maybe a "yes" or a "no" but wouldn't have understood the  
 11 instruction, but just laughing with her she would have  
 12 recognised me, she would have recognised my voice, and  
 13 I knew that straight away.  
 14 **Q.** Were there any difficulties with the staff communicating  
 15 with her or were you really the one looking after her,  
 16 helping her to feed, drink --  
 17 **A.** I felt like I was looking after her, yeah, because I had  
 18 asked the staff at the time, you know, could we get some  
 19 food charts displayed, because I wanted to take a note  
 20 of what my mum was eating, because I had went into the  
 21 hospital one day and asked, you know, what did my mum  
 22 have for lunch -- this was one of the days that I wasn't  
 23 there at lunch time -- and a member of staff wasn't sure  
 24 what she had, so I had asked for food charts to be  
 25 implemented straight away so we knew, you know, what

117

1 that year, who advised that your mum had to go to  
 2 hospital due to a high heart rate and they were going to  
 3 phone for an ambulance for your mum.  
 4 **A.** Yes.  
 5 **Q.** And is it right then that you went to A&E and that's  
 6 where you met up with your mother at the hospital?  
 7 **A.** Yes. If you're going to fast forward to December 2020  
 8 or January 2021, you know I lost the two most important  
 9 women --  
 10 **Q.** Well, I was just going to say --  
 11 **A.** -- in my life.  
 12 **Q.** You say in your statement the news that your mum was  
 13 going into hospital in fact came the day after you  
 14 buried your mother-in-law?  
 15 **A.** Yeah.  
 16 **Q.** So just clearly a lot going on in your life in the  
 17 run-up to Christmas that year.  
 18 **A.** So, in -- it was Saturday 19 December we lost my  
 19 mother-in-law.  
 20 **Q.** And then four days later you get the call to say your  
 21 mum is now going into hospital. All right.  
 22 **A.** So my mother-in-law was diagnosed during the pandemic  
 23 with a brain tumour and lung cancer. We had buried her  
 24 on 22 December. And then the next day I received that  
 25 phone call from the care home to say that my mummy had

119

1 fluids and what my mum was eating as well.  
 2 **Q.** And is it right that your mum had to take her medication  
 3 in liquid form not in tablet form?  
 4 **A.** So a couple of years prior to the pandemic my mummy,  
 5 just because of the dementia and the advanced dementia,  
 6 she wasn't able to chew, you know, like, a tablet, so  
 7 she was on liquid medication, probably about 3, 4 years  
 8 prior to the pandemic. Yeah, I mean --  
 9 **Q.** All right --  
 10 **A.** -- during that ...  
 11 **Q.** No, no, don't let me interrupt. Say what you want to  
 12 say about July because I want to come on to December  
 13 then, and that's really why I asked you about the level  
 14 of care you were providing for your mum.  
 15 If you hadn't been there in July, do you think  
 16 there was sufficient staff in and around the hospital to  
 17 provide the most basic care for your mother?  
 18 **A.** Yeah, I mean, I didn't -- never really experienced  
 19 a shortage of staff. I found the staffing levels,  
 20 you know, in July 2020 and in December 2020 similar to  
 21 prior to the pandemic. So I didn't really notice, you  
 22 know, a decline in staffing levels.  
 23 **Q.** Can I come on to December 2020, because I think you  
 24 received a phone call from one of the nurses at your  
 25 mum's care home on 23 December, so just before Christmas

118

1 high heart rate, she needed to go to hospital.  
 2 You know, there was a couple of different conversations  
 3 going on that morning because the GP was contacted as  
 4 well. I contacted the GP. And I asked -- I was just  
 5 concerned about my mummy going back into hospital.  
 6 **Q.** What were you concerned -- what was it that particularly  
 7 concerned you about her going back in?  
 8 **A.** I think it was the September 2020 -- yeah, it was after  
 9 the first period of hospitalisation -- and this is in  
 10 the public domain as well, but there was a number of  
 11 patients in the haematology ward in Craigavon Area  
 12 Hospital and the former health minister Robin Swann had  
 13 called a serious adverse incident. So these were  
 14 patients that had went into hospital, it was  
 15 non-Covid-related, there was very poor infection  
 16 prevention and control measures in place, and that is  
 17 now -- you know, came out of this Inquiry around  
 18 Craigavon Area Hospital, and I was just really worried  
 19 that my mummy was going into hospital and it wasn't --  
 20 you know, we think that hospitals are a safe place to be  
 21 in, that you're going to be -- you know, get well, and  
 22 I didn't feel that.  
 23 So I can't remember if the GP rang me that morning  
 24 or I rang the GP and I said, "Look, is there any  
 25 chance -- you know, because my mummy's got high heart

120

1 rate, is there any chance -- and again she had that  
2 prior to the pandemic -- would -- could the acute care  
3 team come to the care home and deal with my mummy?"

4 And to be fair, the GP that morning, you know, she  
5 phoned me back very quickly and said, "Martina, there is  
6 no capacity, you know, with the acute care team", and  
7 I said, "Right, okay, so my mum is going to hospital."

8 **Q.** But your primary concern for her not going was because  
9 you didn't want her to catch Covid at the hospital; is  
10 that right?

11 **A.** Yes, and I was just afraid for her.

12 So my mummy went to -- the ambulance was rang that  
13 morning and my mummy -- I think it came quite quickly.  
14 And again I'm just thinking of other families, you know,  
15 in our group who rang for ambulances and they didn't  
16 come. And my heart goes out to them.

17 **Q.** Pause there for a moment.

18 You met your mum at A&E and I think after she was  
19 triaged she had a Covid test and the doctor came to tell  
20 you, is this right, that your mum had actually tested  
21 positive for Covid. Had anyone told you prior to the  
22 doctor confirming the positive test that your mum was  
23 suspected of having Covid? They wanted to do some  
24 investigations to see if she had Covid? Had anything  
25 been mentioned even about her possibly having Covid?

121

1 going with suspected Covid. That is only something that  
2 I realised a couple of months after my mummy passed away  
3 whenever I requested my mother's hospital records and  
4 I contacted, through an MLA, the Northern Ireland  
5 Ambulance Service, I requested my mummy's 999 patient  
6 call record and some of it was redacted but it clearly  
7 stated on that 999 call that my mummy was going in with  
8 suspected Covid.

9 **Q.** But no one had told you that?

10 **A.** No one had told me that.

11 **Q.** Now, once your mum had tested positive, I think she was  
12 transferred to the Covid ward on Christmas Eve, but can  
13 I ask you about a conversation that a doctor had with  
14 you about a DNACPR or a DNR, call it whichever is easier  
15 for you, Mrs Ferguson, what did the doctors say to you  
16 when they spoke to you about a possible DNR for your  
17 mother?

18 **A.** So that actually happened that evening in A&E, so when  
19 I was in A&E when the doctor came over and explained  
20 that my mummy was positive for Covid. He started to  
21 discuss with me a DNR and whilst I understand that  
22 clinicians, you know, it's their decision, and they can  
23 also decide not to perform CPR, me being me, I said,  
24 "Look, Doctor, I need to speak with the rest of my  
25 family." And I just got the distinct impression that,

123

1 **A.** No, the nurse on the phone from the care home had rang  
2 to say it was high heart rate. Nobody mentioned Covid.  
3 When my mummy -- I met my mummy in A&E. She'd been  
4 triaged quite quickly as well. She had also been tested  
5 and her swab, you know, went to the lab quite quickly.  
6 It was only later that night -- so my mummy was becoming  
7 unwell, you know, she had a high temperature, and later  
8 on that night the doctor approached me and said,  
9 you know, your mummy has tested positive. And I was  
10 really shocked, you know. And I know that maybe -- it  
11 was the second wave and I should have expected something  
12 like that, but when you're told that your mummy's going  
13 in with high heart rate and Covid wasn't mentioned,  
14 I didn't really think about it too much.

15 **Q.** Let me ask you this. Before you knew she was Covid  
16 positive, were you wearing any masks or PPE before you  
17 knew that she was -- she had Covid?

18 **A.** Yes, when I met my mummy in A&E she was wearing a paper  
19 mask and I was wearing a paper mask but, I mean, you  
20 know, we took them off, I gave her a kiss and a hug  
21 because I hadn't, you know, been in her company,  
22 you know, to touch her, you know, to provide that kind  
23 of tactile and sensory therapy that dementia residents  
24 need when they are non-verbal. So I probably wouldn't  
25 have done that if I had of been told that my mummy was

122

1 you know, a DNR was being placed on my mummy.

2 At the time I thought, well, I need to give  
3 consent to this and I wasn't sure of the entire process.

4 **Q.** Right.

5 **A.** But when the doctor walked away and I sat and I thought  
6 about it, I went back over to the doctor, there was  
7 probably about 5 to 10 doctors in A&E, and there was  
8 a lot of staff about, again very similar levels prior to  
9 the pandemic. But I went back over to the doctor and  
10 I said, "Look, just because you are placing -- or if  
11 you're going to place a DNR on my mummy, that doesn't  
12 mean to me, and it shouldn't mean that my mummy will not  
13 be receiving treatment and I want to make sure that my  
14 mummy receives the same treatment that somebody else  
15 would get despite her age."

16 **Q.** I think --

17 **A.** I -- whenever I was -- I had lived in the States with  
18 two doctors, one was a heart surgeon and one was  
19 a doctor, I had phoned them that evening and I said,  
20 "Look, I need some medical advice. If you have got  
21 Covid, how is this being treated in the States? What  
22 kind of treatment should my mummy be receiving,  
23 you know, setting her age aside?" And their response  
24 was, "Look, in the States they're using steroids and,  
25 you know, oxygen if that's required," so I kind of knew

124

1 in A&E, right, this is the treatment that my mummy  
2 should be getting.

3 So when I left for maybe five, ten, fifteen  
4 minutes I came back in and my mummy was really  
5 distressed, so she was -- so they were giving my mummy  
6 oxygen and I think initially she had, like, 10 litres of  
7 oxygen and she just deteriorated, you know, really  
8 quickly in that space of time. But the oxygen obviously  
9 was helping her. And I went back over to the doctor and  
10 I said, "Look, my mummy needs to be on steroids. I know  
11 you're the specialist but, you know, remember what  
12 I said earlier, I want my mummy treated."

13 So they were putting my mummy on steroids and then  
14 the following morning they had explained to me that  
15 night, "Look, your mum has to go to the Covid ward", and  
16 I said, "Okay". So I went home just for a couple of  
17 hours to get some sleep.

18 **Q.** Let me pause you there because I want to come on to what  
19 happened to your mum on the Covid ward. But I think,  
20 although you had the discussion with the doctor about  
21 the DNR, no doubt discussed it amongst your siblings, in  
22 your statement you say that there are a number of  
23 concerns of members of the Northern Irish Covid Bereaved  
24 group about what you call institutional pessimism,  
25 resignation, indeed fatalism, on the part of care

125

1 can't be with that person, you know, it's really, really  
2 important that communication is, you know -- that it  
3 flows. One particular lady who had lost her husband,  
4 and her husband was in Craigavon Area Hospital, the same  
5 hospital that my mummy was in, you know, she had  
6 overheard staff saying, you know, that we're far too  
7 busy, you know, to update your family.

8 Her husband had heard the nurse in charge say  
9 that, you know, "You've been fond of the drink during  
10 your time", and I mean, to hear something like that,  
11 notwithstanding the fact that that patient had been  
12 a lifelong pioneer, so he had never drank. So it was  
13 that -- it was the tone. It was the tenor, you know.  
14 It was really, really upsetting for families to hear  
15 things like that. And to be also hearing "We don't have  
16 time to update families".

17 **Q.** I interposed that because it just seemed to fit in with  
18 some of the things that the Northern Irish Covid  
19 Bereaved members are concerned about and, clearly,  
20 communication not just in respect of DNACPRs, but all of  
21 these areas is important.

22 Can I come back to your mother on the Covid ward  
23 between, I think it was Christmas Eve and her death on  
24 4 January, and I think in your statement, Mrs Ferguson,  
25 you wanted to cover some of the treatment that she

127

1 professionals and often families being unaware that  
2 DNACPR decisions had been made, who had made them, or  
3 why they had been made. Are you able to give us,  
4 Mrs Ferguson, a sort of sense of the scale of the  
5 concern amongst the Covid Bereaved members of all these  
6 problems with DNACPR notices?

7 **A.** I know this has been highlighted so many time but, yeah,  
8 this has been a major issue for, you know, Bereaved  
9 Families in our Northern Ireland group. One lady in our  
10 group had lost her husband, there was no discussion  
11 at all with that family. Another young woman, who is  
12 here today, and her mother, they lost their brother,  
13 uncle. He had Down's syndrome. And, you know, one  
14 minute they were told that, you know, he was fine, he  
15 was recovering well, you know, and then the next  
16 five minutes they got a phone call to say, "You need to  
17 be at the hospital here" and unfortunately they weren't  
18 at the hospital to be with their loved one.

19 **Q.** One of our witnesses this morning said, I think, to  
20 quote "communication is key". And do I take it that you  
21 would wholeheartedly agree with that?

22 **A.** You know, absolutely. This was a horrendous time for  
23 families during the pandemic, and grief is bad enough,  
24 you know, during normal times but, you know, when you  
25 are locked out of the hospital or a care setting and you

126

1 received or didn't receive as the case may be. Can  
2 I just ask you this. This time round now, in December  
3 into January, you told us that you were wearing a mask  
4 in A&E. Once she moved to the Covid ward were you  
5 wearing any PPE when you were visiting her on the Covid  
6 ward?

7 **A.** So when my mummy left A&E and she was transferred up to  
8 the Covid ward, you know, I grabbed her bag and I  
9 assumed that I was going with her. I was met with the  
10 nurse in charge on the ward, and I hope no other  
11 families feel distressed about this because I know that  
12 not a lot of families get into the Covid ward. So the  
13 nurse said to me, her response to me was, "Where do you  
14 think you're going?" And I said, "I am accompanying my  
15 mummy." And she said, "No, you're not, there are no  
16 families allowed into this ward." And I said, "Says  
17 who?" And I know that probably didn't sound right but  
18 you've got to bear in mind that I had been locked out of  
19 my mummy's care home for nine months.

20 So she explained to me, "We have a policy" and  
21 I said, "Well, I read your policy and I read that last  
22 night and it is three months out of date". And it was  
23 a policy that was on their website, and only because  
24 I had engaged with the Department of Health I knew that  
25 they should be receiving communication from the

128



1 Department of Health and that should filter down to all  
2 of the trusts in Northern Ireland.

3 And I said, "Look, I am my mummy's care partner,  
4 I'm not sure if you're familiar with the guidance but  
5 you should be, and at that time" -- I mean, we can talk  
6 about the care partner guidance another day, but at that  
7 time that was endorsed, you know, and it was released by  
8 the Department of Health and the Executive and that was  
9 September 2020, and that is something that I had been  
10 instrumental on in terms of campaigning for. And  
11 I assumed that that care partner stayed with that  
12 person. So it wouldn't have mattered whether they were  
13 in a care home or they went into hospital.

14 So when I was saying to the nurse that day, "Look,  
15 I'm my mummy's care partner, you should be familiar with  
16 that guidance", she said she wasn't. And I said, "Look,  
17 I want to come in here to help and my mummy needs me.  
18 None of the staff know my mummy, they don't know her  
19 likes and her dislikes." And she took a note, actually,  
20 on the corridor of my mummy's likes and dislikes, and  
21 I said, "Look, we need to compromise, I need to be with  
22 my mum", and she said, "Right" -- I wasn't getting  
23 anywhere with her and I don't like to name drop but  
24 I did say to her, "I have contacted the  
25 chief executive", and at the time it was Shane Devlin,

129

1 choking; soiled clothes not being changed regularly;  
2 they left tablets at your mum's bedside even though, as  
3 you told us, she required liquid medication; and you say  
4 the staff lacked training and understanding of dementia  
5 patients, despite that trust and other trusts across  
6 Northern Ireland having implemented, prior to Covid, the  
7 Butterfly Scheme for dementia patients.

8 Can I just ask you about that. Are you able just  
9 to summarise, what was the Butterfly Scheme aimed to  
10 ensure?

11 **A.** It was really for highlighting whether a patient had  
12 dementia or not. So that scheme was rolled out in the  
13 Southern Health and Social Care Trust. I think it was  
14 a couple of years prior to the pandemic because  
15 I remember when my mummy was hospitalised prior to the  
16 pandemic she was on a ward that had -- it was a massive  
17 wall display of the dementia-friendly scheme, and  
18 instead of, you know, writing up on your hospital  
19 bedside that this person has got dementia, then  
20 a butterfly would have been drawn and that should have  
21 explained to staff, you know, that this particular  
22 person or patient has dementia.

23 **Q.** So when you were looking after your mum over that  
24 December into January, was there a butterfly up on the  
25 wall or did anyone even seem to acknowledge or be aware

131

1 and that was early December, and I said, "Look, can  
2 I suggest that you get him on the phone or you get him  
3 to this ward now, because I'm not going home unless  
4 I know that I am getting into this ward to be with my  
5 mum."

6 She literally walked around the corner and she  
7 came back two minutes later and said, "Right, one hour."

8 And I said to her, "Well, What's that for?" And she  
9 said, "To feed your mummy", and I said, "Well, my mummy  
10 feeds seven times a day", but at that stage, Ms Carey, I  
11 thought I'm not going to push this because I want in  
12 there.

13 **Q.** Yes, you wanted -- I understand.

14 **A.** So the Covid ward, it was full PPE.

15 **Q.** Mask, gloves, apron?

16 **A.** It was like hazmat, kind of, outfit, yeah. And I said  
17 to her, "Look, I am a quick learner, I'm willing to  
18 learn how to don and duff", I kind of knew how to do  
19 that and she explained to me, so I did get in to the  
20 Covid ward.

21 **Q.** Now, in your statement you set out that during your  
22 mum's time on the Covid ward you had a number of  
23 concerns about some of the care that she was receiving.  
24 It included the wrong levels of food and consistency to  
25 enable your mum to be able to take the food without

130

1 of the existence of the Butterfly Scheme?

2 **A.** No, I mean, prior to the pandemic when my mummy was in  
3 hospital, you know, when my husband and I went to visit  
4 her we would have drew the butterfly ourselves.

5 I remember one time that I had wrote "my mother is  
6 a dementia patient" and when I came back in to visit her  
7 it was removed. But nobody replaced it with the actual  
8 picture of a butterfly.

9 So it just didn't seem to filter down to the staff  
10 even though they were promoting. They had it in place  
11 prior to the pandemic. And it seemed a really excellent  
12 scheme if it had have been used properly.

13 **Q.** You've told us about the PPE you were wearing. What  
14 were the staff wearing over that period of time that  
15 your mum was in hospital? Were they in full PPE as  
16 well?

17 **A.** Full hazmat suits, yes, on the Covid ward.

18 **Q.** Now, I think you say notwithstanding that that there are  
19 examples amongst the members of Northern Irish Covid  
20 Bereaved about PPE that wasn't always being worn  
21 appropriately. I think one of the members gives  
22 an account of masks being worn under the chin and the  
23 like. Did you get any sense of how much compliance or  
24 how little compliance there was with PPE being worn by  
25 staff, from either your experience or the experience of

132

1 the members?  
 2 **A.** Yeah, I mean, again, this has come from a lot of the  
 3 families, you know, in our group where, you know, yeah,  
 4 masks, were worn, you know, beneath chins, beneath  
 5 noses, they maybe weren't wearing PPE at all. You know,  
 6 I certainly experienced that looking through a window  
 7 for nine months in my mummy's care home.

8 In the hospital I probably didn't notice it as  
 9 much, you know, on the Covid ward, the staff, you know,  
 10 they were in their hazmat suit, they continued. They  
 11 were quite strict in that there was no food or drink  
 12 allowed on the Covid ward for staff. So I didn't  
 13 witness anything, you know, when I was there.

14 **Q.** I think your mum was on the ward for about two weeks and  
 15 passed away in January, on 4th January 2021. Were you  
 16 allowed or any of your siblings allowed to be with her  
 17 at the end of her life?

18 **A.** Yeah, I mean, I had been on the Covid ward for, you  
 19 know, approximately two weeks. I remember the staff had  
 20 come in, you know, to check on my mum, the early hours  
 21 of the morning of 4 January 2021. And they left and  
 22 then my mummy had been moved a couple of times on the  
 23 Covid ward. I think it was about three times. And she  
 24 was in a room, you know, a side room. It was just her  
 25 and I. I had used the toilet, I came back out, and

133

1 story where a -- daughters had their mother and father  
 2 in the same hospital and, you know, why they were not  
 3 allowed to come together, you know, and they died, like,  
 4 days apart from one another, it just made no sense.

5 But that morning, you know, when my mummy passed  
 6 away, I remember I just knew, you know, it was the end.  
 7 I had phoned the funeral parlour because all sorts of  
 8 questions, you know, were going through your head,  
 9 you know: who is going to wash my mummy? Who is going  
 10 to embalm her body? You know, and staff were explaining  
 11 that, you know, your mummy will be wrapped in a --  
 12 I think they said shroud and I said, "You mean a bed  
 13 sheet and put into a body bag?"

14 **Q.** Mm.

15 **A.** And I thought, "This can't be happening."

16 So the funeral home, you know, they were very  
 17 professional. You know, they explained, "Martina, we're  
 18 following the guidelines. We can't do anything like  
 19 that."

20 And, you know, I remember one of the nurses on the  
 21 Covid ward, she was absolutely brilliant, you know.  
 22 She -- she said to me, "Martina, calm down, this isn't  
 23 the time to think about things like this. We will do  
 24 whatever you want."

25 Do you know? Whereas had another member of staff

135

1 I remember washing my hands and I looked over at her and  
 2 I thought, I'm not so sure if there's any signs of, you  
 3 know, life. So ...

4 **Q.** Take a moment. Take a moment.

5 **A.** So ...

6 **Q.** You were with your mum then?

7 **A.** I went over, just said some things to her.

8 **Q.** All right. Can I ask you this. Clearly you were with  
 9 your mum in her last moments with us. What about other  
 10 members of the Covid Bereaved? Were they able to be  
 11 with their loved ones or was there a very mixed picture  
 12 across the --

13 **A.** There was a very -- yeah, a very mixed picture amongst  
 14 the group. Some people, you know, got to be with their  
 15 loved one, some people didn't.

16 **Q.** And --

17 **A.** Um --

18 **Q.** I'm so sorry, I didn't mean to interrupt you, but I just  
 19 was wondering, were they allowed in, sort of, perhaps in  
 20 wave 2 and not in -- is there a sort of a sense of --

21 **A.** It was just a mixture in both.

22 **Q.** Okay.

23 **A.** You know, a lot of the families had to say goodbye  
 24 through an iPad or a telephone. You know, it -- some of  
 25 it just didn't make sense. I remember, you know, one

134

1 who -- would have come along and said, "No, that will  
 2 not be happening."

3 So you had a real inconsistency. And this has  
 4 been a big problem, you know, for our group, and we have  
 5 found across all the hospitals in Northern Ireland where  
 6 you have a nurse in charge of a ward. And whilst I get  
 7 that and that is required, but the discretion is left to  
 8 them. And you see when discretion is left to people,  
 9 that can just create chaos. Because I've seen that in  
 10 the care homes when discretion was left to care home  
 11 managers. You got so much inconsistency across the  
 12 board, it was unbelievable.

13 So that morning when my mummy passed away, I said  
 14 to the nurse, you know, "What's happening now?"

15 And she explained the porter will be coming up,  
 16 they'll be putting my mummy in a bed -- you know, in  
 17 body bag, and I said, "Look, if nobody is going to help  
 18 me, I am washing my mummy's body, my mummy is not  
 19 leaving here in a sheet, my mummy is going in her suit."

20 So I had brought the clothes with me. And a nurse  
 21 very kindly came in and she helped me, you know, wash my  
 22 mummy's body. And we dressed my mummy. And whilst  
 23 I feel very privileged to have done something like that  
 24 and feel really lucky and I know families didn't get  
 25 a chance, but I was one of six children, so ...

136

1 Q. All right.

2 A. The rest of our family had to say goodbye through  
3 FaceTime, you know, and it was horrendous.

4 Q. Ms Ferguson, that is no doubt why you urge her Ladyship  
5 at the end of your statement to say visiting must be  
6 enabled as a default position. And I don't need to ask  
7 you anything about that. It speaks for itself.

8 A. The funeral, you know, it was very heavily restricted.  
9 There was -- we contacted the church chapel, whatever  
10 you want to call it. We were told that, you know, there  
11 would be no service for my mummy. That wasn't allowed.  
12 We were allowed only, I think it was, 15, and the  
13 cemetery gates would be locked, nobody else was allowed  
14 in. But whenever -- it was a very short service by the  
15 graveside, you know, it was a couple of prayers, and  
16 then the gates would be allowed to be open, you know,  
17 and they would have allowed social distancing.

18 None of it made sense. You know, we were outside.  
19 You know, we had learned a little bit more about the  
20 virus at that time.

21 Q. Can I just, I suppose, ask you this finally. You've  
22 actually covered, through the prism of what happened  
23 with you and your mum, a number of the concerns of the  
24 bereaved members of the Northern Irish Covid Bereaved  
25 group. Is there anything else, Mrs Ferguson, you would

137

1 MS CAREY: Mrs Ferguson, you are our final witness for  
2 Module 3. Can I thank you.

3 And can I turn to her Ladyship to see if there's  
4 any questions you'd like to ask Mrs Ferguson?

5 LADY HALLETT: No, I have no questions, Mrs Ferguson. Thank  
6 you so much for all the help, because it's not just  
7 today but you obviously helped the Inquiry before and  
8 I'm really grateful to you.

9 And you mentioned just now about the first report  
10 and the recommendations. The only way, as I said,  
11 I think to Mrs Waterton this morning, that my  
12 recommendations will get implemented is if groups like  
13 yours keep the pressure up. So thank you for all you're  
14 trying to do to get any recommendations implemented and  
15 change implemented because that's why we're here doing  
16 this Inquiry, we're trying to make some change for the  
17 good so that people don't have to suffer as you did.

18 And I hope that by helping the Inquiry we're not  
19 increasing your suffering because obviously your grief  
20 is still very raw and I understand that. One of the  
21 very first things I learned when I went around the UK  
22 was just how bereavement during the pandemic is very  
23 different from other bereavement and that's why it seems  
24 to last so long and seems to be so traumatic. So I do  
25 hope we haven't played any part in making it worse but

139

1 like to say to her Ladyship or any other recommendation  
2 that you'd like to urge the Inquiry to consider?

3 A. Yeah, I mean, what we're looking -- is we want  
4 a legislative change. I know it's come out from  
5 Module 1. You know, I'm grateful that, my Lady, you put  
6 a report together, and we have contacted the First  
7 Minister and deputy First Minister. We've contacted  
8 them a couple of times. You know, I would hope that,  
9 you know, our group will be allowed to meet with them  
10 and that they will make change happen. But I was  
11 campaigning, you know, before my mummy died, after my  
12 mummy died, for the care partner guidance. You will  
13 have heard during this Inquiry that that was ruled out  
14 in care homes in September 2020. It was extended in  
15 hospitals in February 2022. I want that on  
16 a legislative footing. You know, it has to be.

17 You know, because when you have a member of the  
18 Department of Health in an email says -- that says to  
19 me, you know, "Guidance is guidance", that's not good  
20 enough. That is not good enough. We need to see  
21 a legislative change, we need to make sure that nobody  
22 dies alone ever again, because it's so important that  
23 their family is with them. Because at the end of the  
24 day family is the most important people to those in  
25 their dying hours and days.

138

1 we are extremely helpful for all the help you have  
2 given.

3 THE WITNESS: Thank you, my Lady. And I am really, you  
4 know, privileged to be here today. Whilst it was very  
5 nerve racking, you know, but I think that everyone needs  
6 to reflect on what has happened, specifically the  
7 Department of Health, because I don't think that they  
8 have reflected and I think that that has come to light,  
9 you know, when we heard the evidence from the former  
10 health minister, who I did meet in person early in the  
11 pandemic in May 2020 and in May 2021. I don't think  
12 a lot of change has happened since then. You know, we  
13 want to work closer with the Inquiry team. We want  
14 better outcomes for everybody, d'you know?

15 And sometimes people ask me, you know: why do you  
16 bother? Why do you do this? Because I have realised  
17 over the last couple of years that, you know, democracy  
18 is everybody's responsibility.

19 LADY HALLETT: It is, Mrs Ferguson, spot on. We all have  
20 a duty and public service is part of that duty, so thank  
21 you very much indeed.

22 A. Thank you, my Lady.

23 (The witness withdrew)

24 MS CAREY: My Lady, may I invite a short break this  
25 afternoon before we turn to the next phase of the

140

1 Inquiry's hearing.  
 2 **LADY HALLETT:** Certainly. Shall I break for ten minutes to  
 3 allow Mrs Ferguson to speak to those who are  
 4 representing her.  
 5 There won't be any more breaks today, and I shall  
 6 obviously begin closing submissions.  
 7 I'm really grateful to everybody that has led us  
 8 to the stage where we have completed the evidence this  
 9 afternoon, as we'd planned to do. So, thank you all  
 10 very much indeed.

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

12 **LADY HALLETT:** See everybody at, shall I say, 3.05.

13 (2.53 pm)

(A short break)

15 (3.05 pm)

**CLOSING SUBMISSIONS**

17 **MS CAREY:** Before we turn to closing submissions, can I just  
 18 deal with one matter. Can I invite you, please, to  
 19 publish 69 statements.

20 I'm going to show on screen, rather than read out  
 21 descriptions and INQs of all 69, but we would invite  
 22 you, please, to publish these statements which include  
 23 statements from the royal colleges, a number of  
 24 government departments, the spotlight hospitals,  
 25 a number of charities, including those involved with the

141

1 I hadn't thought about it before but it must be a bit  
 2 strange.

3 **MS CAREY:** I don't know if people sit down whether the  
 4 camera will pick them up, but I suspect the advocates  
 5 will feel comfortable standing, it being our natural  
 6 habitat.

7 **LADY HALLETT:** Well, I leave it to anybody's preference.

8 **MS CAREY:** Thank you very much, my Lady.

9 **LADY HALLETT:** Mr Rawat, please.

10 **Closing statement on behalf of UK Health and Security Agency**

**by MR RAWAT**

12 **MR RAWAT:** Good afternoon, my Lady. As you can see,  
 13 I've opted to stand.

14 I appear today on behalf of the United Kingdom  
 15 Health and Security Agency, or UKHSA, as it has been  
 16 called during this module.

17 UKHSA is an executive agency of the Department for  
 18 Health and Social Care and today I appear with  
 19 Ms Verrall-Withers.

20 I'll say a little something about UKHSA's role.

21 That role is to protect the public from infectious  
 22 diseases, as well as external hazards, including  
 23 biological, nuclear, and environmental threats.

24 UKHSA brings together expertise from several  
 25 predecessor organisations, including Public Health

143

1 modules non-Covid conditions, the regulators, and some  
 2 other NHS bodies.

3 As ever, the fact that other statements obtained  
 4 by Module 3 are not being published at this stage, does  
 5 not diminish their importance. Of course, all the  
 6 evidence obtained by the module will be taken into  
 7 account by you and, indeed, the Inquiry may publish  
 8 further statements in due course.

9 And in a moment the document handler will have  
 10 scrolled through all 69 of the statements that we invite  
 11 you to publish this afternoon.

12 Once that's done can I invite, please, Mr Rawat  
 13 King's Counsel to address you on behalf of the UK Health  
 14 and Security Agency.

15 **LADY HALLETT:** Certainly. And I, too, wish to emphasise  
 16 that obviously people pay attention to the oral hearings  
 17 but there's a great deal of very important material in  
 18 the written evidence and I shall take it all into  
 19 account.

20 Something that should have occurred to me before  
 21 and you're doing it now, Ms Carey, you're on your feet  
 22 addressing what I assume is an empty chair.

23 **MS CAREY:** Yes.

24 **LADY HALLETT:** I just wondered whether people would rather  
 25 make their closing submissions sitting down. I'm sorry

142

1 England or PHE.

2 UKHSA's capabilities lie in, for example, health  
 3 protection science and data analytics and surveillance  
 4 and it responds to future health security hazards by  
 5 collaborating with the NHS, among others.

6 My Lady, with an eye to the future I want today to  
 7 touch on three issues which have been explored during  
 8 the Module 3 hearings, the first being infection  
 9 prevention and control guidance. Or, as we've all  
 10 called it, IPC guidance.

11 One issue that may arise in relation to IPC  
 12 guidance is how it evolved over the course of the  
 13 pandemic and it's useful to make some observations about  
 14 the developing understanding of the virus. First, as  
 15 with any other novel virus, PHE's initial understanding  
 16 had to be based on available research on other  
 17 genetically similar viruses. That showed that such  
 18 viruses were transmitted via touch, contact with  
 19 contaminated surfaces or materials, and respiratory.  
 20 This evidence base, in turn, informed consideration of  
 21 likely routes of transmission.

22 Second, defining particle sizes in relation to the  
 23 transmission of Covid-19 is not a helpful metric as the  
 24 transmission of infectious airborne particles depends on  
 25 many environmental factors. Recognising that, better

144

1 informs the choice of the most effective measures of  
2 mitigation for all respiratory infections and those  
3 measures include ventilation and the physical separation  
4 of patients.

5 Third, many infections are transmitted through the  
6 respiratory route where airborne components may play  
7 a role. However, emerging evidence is critical to  
8 determining the public health response.

9 Fourth, while over the course of the pandemic the  
10 national and international understanding of the  
11 contribution of airborne transmission evolved, the  
12 precise delineation of particle sizes and the extent to  
13 which evidence supported the dominant transmission route  
14 through the different phases of the pandemic remains  
15 unclear.

16 And finally, PHE recognised the possibility of  
17 asymptomatic transmission as early as 28 January 2020.  
18 However, at that time, while the clinical evidence did  
19 not rule out the existence of asymptomatic transmission,  
20 expert opinion and scientific consensus concluded that  
21 it was less likely to be the major driver of  
22 transmission and there remained insufficient data to  
23 assess the scale of it until April 2020.

24 Turning now to the IPC cell. PHE, and  
25 subsequently UKHSA, were not responsible specifically

145

1 And third, that local implementation can draw on  
2 the IPC expertise that exists within the NHS.

3 It's pertinent also to mention the position of PPE  
4 in IPC guidance. Your Ladyship has heard about the  
5 hierarchy of controls and, while these form a packet of  
6 measures, PPE is the last measure to be considered.  
7 It's still important, of course, to have evidence as to  
8 the effectiveness of a particular form of PPE, and we  
9 can use FFP3 masks as an example. As the Inquiry's own  
10 expert Dr Ben Warne explained, there is a lack of  
11 high-quality evidence as to the efficacy of such masks,  
12 as compared to fluid-resistant surgical masks, and the  
13 question of when FFP3 masks should be used therefore  
14 demonstrates two factors of wider relevance to the  
15 development of guidance.

16 The first is the need to balance benefits against  
17 harms.

18 Using an FFP3 mask can make communication with  
19 patients more difficult. Prolonged use of such a mask  
20 can lead to pressure sores and the risk of infection.

21 The second factor is that there may be  
22 a difference between a person's perception as to the  
23 effectiveness of a piece of equipment and the evidence  
24 of that effectiveness. You'll remember, my Lady, the  
25 evidence of Professor Dinah Gould, who spoke of

147

1 for IPC in healthcare settings. PHE's role within the  
2 IPC cell was to provide technical advice and to support  
3 others in their operational delivery of guidance  
4 produced by the IPC cell. That guidance was published.  
5 It was directed to all four nations and it reflected  
6 a consensus view.

7 The IPC cell demonstrates the importance of having  
8 mechanisms for working collaboratively and ways of  
9 working evolved during the pandemic and there is now  
10 a written agreement between UKHSA, NHS England, and DHSC  
11 setting out their roles and responsibilities in relation  
12 to IPC guidance in England.

13 There is an important distinction, however,  
14 between UKHSA's role in providing technical advice and  
15 contributing to what is national guidance and the work  
16 of those responsible for implementing such guidance.  
17 That responsibility would fall to healthcare providers  
18 in the four nations, and we say that there are good  
19 reasons for this.

20 First, the NHS is the employer of many of those to  
21 whom the guidance was directed.

22 Second, the NHS estate is varied. So what risk  
23 assessments are undertaken and how national guidance  
24 is to be implemented is a matter best determined at  
25 the local level.

146

1 hand washing being seen as more effective than the use  
2 of an alcohol rub even though the latter was recommended  
3 in IPC guidance.

4 There is, therefore, a need for more research in  
5 the field of IPC. Now -- including clinical trials to  
6 strengthen the evidence base for specific interventions.

7 My Lady, can I move on to a second matter, which  
8 is the shielding programme.

9 This was a protective programme recommended by  
10 SAGE which aimed to reduce mortality in, and offer  
11 practical support to, those individuals who were  
12 predictably most at risk from Covid-19. It was a novel  
13 programme, only made possible by the structure of the  
14 National Health Service in the United Kingdom. The  
15 programme was always voluntary and this was made clear  
16 in guidance and in public health messaging.

17 You'll be familiar with the terms "clinically  
18 vulnerable" and "clinically extremely vulnerable". The  
19 clinical basis for the CV and CEV lists was  
20 a condition-led process which was reviewed throughout  
21 the pandemic, with additional groups being added as it  
22 progressed.

23 The development of QCovid, a risk prediction tool,  
24 allowed for the adding of patients using a data-driven  
25 approach.

148

1 The shielding programme itself was an exercise in  
2 balancing benefit and risk. It was recognised at the  
3 time that while shielding conceptually was likely to  
4 reduce the risk of severe disease in the most  
5 vulnerable, it brought with it risks, such as an impact  
6 on mental health.

7 You have heard evidence about the operation of the  
8 programme, about its effect on individuals, and from  
9 Professor Snooks about its effectiveness.

10 A fundamental problem with trying to evaluate the  
11 shielding programme, however, was the lack of a control  
12 group and the studies cited by Professor Snooks reflect  
13 that crucial difficulty. They also reflect the  
14 inability to disentangle the impact of shielding from  
15 that of wider non-pharmaceutical interventions.

16 Given the lack of a robust evidence base to show  
17 that shielding did not work, our submission is that  
18 Professor Snooks' central conclusion in relation to the  
19 future use of this strategy is one that lacks the  
20 necessary rigour.

21 The better question is whether if in a future  
22 pandemic there is a policy decision to adopt shielding,  
23 then how could such a programme be delivered in a better  
24 way to reduce the risks that come with it. And there is  
25 a wider lesson, we say, to be learned from the shielding

149

1 data sharing could be improved, particularly by more  
2 clearly defining roles and responsibilities and  
3 accountability to underpin a culture of data sharing and  
4 to establish the platforms that are needed to make  
5 improvements in the future.

6 UKHSA has a published data strategy and as a body  
7 with a surveillance role, it wants the best data.  
8 However, the agency relies on other organisations across  
9 the healthcare sector for the provision of timely and  
10 robust data. Improving how the system collects and uses  
11 data is not for UKHSA alone. The agency is, however,  
12 committed to working with the relevant bodies to improve  
13 and implement data utilisation within healthcare.

14 My Lady, can I finally draw these threads together  
15 by setting out some headline points which are, we hope,  
16 focused on the future and which we will develop in our  
17 written closing submission.

18 The first is, and this is as your Ladyship will be  
19 aware, that the IPC cell operated on a multidisciplinary  
20 basis. And looking forward that approach is one that  
21 could be broadened to ensure that the production of  
22 guidance is informed by as wide a range of views as  
23 possible. And those views come, for example, from  
24 hospital engineers or even from those who have to  
25 operationalise and use national guidance at a local

151

1 programme, because it highlighted the importance of  
2 data.

3 Identifying individuals as clinical extremely  
4 vulnerable was a difficult task about because it  
5 required drawing in data from multiple sources and such  
6 an exercise can cause delay.

7 That allows me to move on to the third point that  
8 I wished to make submissions on today, and that is the  
9 future use of data.

10 Data preparedness is vital in responding to future  
11 health threats, including pandemics. As  
12 Professor Harris observed, much of UKHSA's work involves  
13 interpreting data. And to give an example relevant to  
14 this module, while UKHSA cannot and does not advise  
15 NHS England on operational matters, its analysis of data  
16 allows it to give advice and contribute to actions taken  
17 to improving health responses both for patients and for  
18 healthcare workers. And reference has been made during  
19 the course of these hearings, for example, to PHE's  
20 analysis of disparities in the risks and outcomes of  
21 Covid-19 and to the impact of the virus on BAME groups.  
22 Your Ladyship is also aware of the ongoing SIREN studies  
23 which are examining the impact of Covid-19 on a cohort  
24 of healthcare workers.

25 A key lesson from the pandemic, therefore, is that  
150

1 level.

2 Second, we should not ignore the importance of  
3 ventilation as an IPC measure. Improving ventilation in  
4 the NHS estate, whether temporary or permanent, would  
5 bring benefits.

6 Third, and returning to the need for more research  
7 in IPC, the effectiveness of FFP3 masks does need to be  
8 investigated. And if as a result, their use were to be  
9 more -- were to be recommended on a more routine or  
10 a wider basis, then there would be a need for  
11 a permanent cadre of staff trained to fit such masks.

12 Fourth, and you'll be aware, my Lady, that during  
13 the pandemic when the shielding programme was up and  
14 running, the clinical aspects of it were overseen by  
15 Professor Harries, when she was the Deputy Chief Medical  
16 Officer, and then she returned to that co-ordinating  
17 role when she subsequently became chief executive of  
18 UKHSA. But, again, looking forward, we say that the  
19 clinical aspect of any future shielding programme should  
20 be led by a senior responsible officer operating at  
21 departmental level. That is not a role for UKHSA, given  
22 its remit, but ideally it does -- it would be a role for  
23 DHSC given its position within the healthcare system.  
24 And that co-ordinating role could then take forward the  
25 bringing together of key clinicians, including from

152

1 UKHSA, NHS England, and the devolved administrations, to  
2 create a group that would then have links to relevant  
3 policy teams across government and be supported by  
4 a dedicated digital team to better be able to identify  
5 clinically vulnerable individuals.

6 My Lady, the final point we make is, again,  
7 returning to the question of data.

8 Being able to obtain data from multiple sources  
9 quickly means that you can more accurately assess  
10 individual risk rather than putting people into very  
11 broad categories. It therefore makes for more focused  
12 interventions.

13 Advances in technology means that tools which are  
14 even more sophisticated than QCovid was can be developed  
15 for future pandemics. However, before we can use  
16 technology to get a head start on the next pandemic,  
17 there is a need for a conversation on how to improve  
18 data sharing, and what regulatory frameworks are  
19 necessary. Given the legal and ethical issues that  
20 arise, and that there are competing interests, this will  
21 not be an easy conversation, but it is one that needs to  
22 begin now.

23 My Lady, those are the submissions on behalf of  
24 UKHSA.

25 **LADY HALLETT:** Thank you very much indeed, Mr Rawat, I'm  
153

1 used, and in particular the communication in respect of  
2 same. Nevertheless, it is hoped that it should be clear  
3 that in Northern Ireland blanket decisions or policies  
4 based solely on age, disability or a clinician's view of  
5 quality of life did not occur. Not only was there never  
6 a policy for the blanket use of DNACPR notices in  
7 Northern Ireland, but there was also no increase in the  
8 use of such notices during the pandemic.

9 Indeed in 2022, our former health minister,  
10 Mr Swann, launched a policy which provides a framework  
11 for advanced care planning for adults in  
12 Northern Ireland. The advanced care planning policy  
13 aims to support people in having greater choice and  
14 control over decisions about their future.

15 Central to this is ensuring that individuals have  
16 regular opportunities to express their feelings, wishes,  
17 beliefs, and values, in relation to advanced care  
18 planning. Those aspirations will then be reflected in  
19 the care, support, and/or treatment that they will  
20 receive. This policy will mean that difficult decisions  
21 around DNACPRs will be avoided in future.

22 The department considers that individuals should  
23 be encouraged and indeed empowered to have conversations  
24 about what matters to them as they approach the end of  
25 life.

155

1 very grateful.

2 Ms Murnaghan. I thought I saw you behind Mr  
3 Rawat.

4 **MS MURNAGHAN:** Yes, my Lady.

5 **Closing statement on behalf of Department of Health  
6 Northern Ireland by MS MURNAGHAN KC**

7 **MS MURNAGHAN:** Thank you very much. This is a closing  
8 statement which I wish to make on behalf of the  
9 Department of Health of Northern Ireland, which  
10 I'll refer to as "the department".

11 The department wishes to emphasise that it has  
12 carefully listened to and reflected on all of the  
13 evidence adduced and the issues that have emerged over  
14 the course of these hearing sessions. In these  
15 submissions, the department would like to expand on and  
16 address some issues which pertain to its work.

17 And the first thing, my Lady, that I'd like to  
18 touch on is the issue of the DNACPR and, as recently as  
19 this afternoon, of course, my Lady, many witnesses,  
20 including those from Northern Ireland have been asked  
21 about the use of DNACPR or do not attempt  
22 cardiopulmonary resuscitation notices.

23 The department, my Lady, is very conscious of  
24 individual bereaved families' concerns around the  
25 particular circumstances in which such notices were  
154

1 Now, my Lady, another issue that we'd like to  
2 mention is the potential confusion arising out of some  
3 of the PHE evidence, and the department is concerned  
4 that there is the potential for some confusion following  
5 evidence that was given by Mr Aidan Dawson, given that  
6 he only took up his role as the CEO of the  
7 Northern Ireland PHA from 1 January 2021. This  
8 confusion may have arisen from evidence in relation to  
9 professional and technical matters which may, in the  
10 department's view, be outwith Mr Dawson's personal and  
11 professional experience and knowledge, given the  
12 relevant time frame within which they took place.

13 The first such issue was the reference that  
14 Mr Dawson made to the difficulties of accessing primary  
15 care tracking data in respect of the number of Covid-19  
16 cases. The department considers that Mr Dawson's  
17 evidence on this matter does not fully explain the  
18 situation.

19 Following the establishment of Covid-19 centres in  
20 March and April 2020, which had been developed in  
21 partnership with GPs and the five HSC trusts, GPs  
22 submitted data to newly developed data collection  
23 processes which were created and managed by the then  
24 HSCB directors of Integrated Care. While the process  
25 was manual and labour intensive, GPs did participate in  
156

1 the process willingly and proactively, both in the  
2 establishment of the Covid-19 centres and in the  
3 provision of the data required.

4 Reports that were based on the data collected were  
5 presented by the then director of Integrated Care at the  
6 HSC silver meetings.

7 The second issue, my Lady, is in relation to the  
8 agreement that Mr Dawson had with Counsel to the  
9 Inquiry's suggestion that the PHA in Northern Ireland  
10 had failed to identify the importance of widespread  
11 testing of healthcare workers and patients in various  
12 settings. While Mr Dawson may legitimately consider  
13 that the PHA failed to recognise the importance of  
14 testing, this does not accord with the opinion or  
15 experience of the department with respect to the  
16 operational implementation of testing by the PHA.

17 Neither was this the experience of the expert  
18 advice provided to the department by the Expert Advisory  
19 Group on Testing, which was chaired by the PHA.

20 The department did not fail to recognise the  
21 importance of widespread testing. This, of course,  
22 should not be conflated with the fact that, in the early  
23 stages of the pandemic, there was a lack of testing  
24 capacity, which was accompanied with the need to  
25 prioritise the limited number of tests available.

157

1 Since 2015 the department has been planning the  
2 introduction of an electronic record system that  
3 digitises health and social care records known as  
4 encompass. A phased rollout of encompass began in  
5 November 2023 and at present it is in place in three out  
6 of five of the health trusts. The two remaining trusts  
7 are scheduled to implement encompass in 2025.

8 We acknowledge that encompass is not a panacea but  
9 it does address deficiencies in information gathering in  
10 respect of ethnic minorities in Northern Ireland. The  
11 changes that encompass implements will address the  
12 department's inability in 2020 to consider ethnicity in  
13 its Coronavirus health inequalities reports, when  
14 information on ethnicity was not uniformly collated  
15 across the system.

16 My Lady, I'd like to say something now about  
17 health inequalities, and tackling health inequalities is  
18 a priority of the Minister of Health, Minister Nesbitt,  
19 and he has announced an initiative called Live Better.  
20 Live Better is designed to bring targeted health support  
21 to communities which need it most. This initiative will  
22 focus initially on health and social care services, and  
23 will look at better alignment of and access to existing  
24 resources and services.

25 Live Better is focused on the outcomes, summarised

159

1 The department considers that this is an important  
2 distinction to draw.

3 My Lady, I'd also like to make some comments  
4 around data collection in Northern Ireland, and much has  
5 been said about the quality of data collection in  
6 Northern Ireland in relation to disabilities, ethnic  
7 minorities, those suffering with Long Covid, and other  
8 vulnerable groups.

9 Criticisms have also been made about data  
10 collection in respect of healthcare workers and Covid.

11 While the ethnic composition of the population of  
12 Northern Ireland is materially different to the rest of  
13 the UK, it is accepted that Northern Ireland's  
14 performance in this area was lacking during the  
15 pandemic. However, the department wishes to dispel the  
16 impression that just because such data was not  
17 adequately monitored does not mean that the impact on  
18 those groups did not matter.

19 The department would highlight the significant  
20 practical and operational steps that it took, as well as  
21 steps taken by the PHA, across the totality of the  
22 pandemic response with respect to ethnic minorities.  
23 These steps included communication and engagement with  
24 the ethnic minority groups in relation to testing,  
25 isolation and vaccination.

158

1 as Starting Well, Living Well and Ageing Well. For  
2 example, my Lady, Starting Well will focus on improving  
3 issues such as regional areas of low immunisation  
4 take-up amongst children. Living Well will tackle  
5 health inequalities such as preventing disparity in  
6 diabetes in lower socioeconomic groups. The Ageing Well  
7 component will focus on the benefits and importance of  
8 physical activity to help the community live longer and  
9 stronger.

10 Recognising that health inequalities is an issue  
11 which requires action across all parts of government,  
12 Live Better has been referenced in the draft programme  
13 for government, published by the Executive Office  
14 in September 2024.

15 There is also a new framework for planning health  
16 and social care services in Northern Ireland: the  
17 Integrated Care System. This system is focused on  
18 collaboration, outcomes, and person-centred care. It  
19 will place greater focus on prevention, early  
20 intervention, and community health and well-being whilst  
21 ensuring that resources available are maximised.

22 My Lady, I'd also like to say something now about  
23 the military assessment team and its recommendations.  
24 In his oral evidence, Mr Swann was asked about the  
25 military assessment team's recommendations in respect of

160



1 the central control. The department refutes suggestions  
2 that there was no central control prior to the military  
3 assessment recommendation.

4 Fundamental to the nature and function of health  
5 and social care in Northern Ireland is the application  
6 of the principle of subsidiarity. In other words,  
7 matters will be dealt with at the most appropriate local  
8 level possible, given that those local levels will have  
9 the most operational knowledge and the highest level of  
10 expertise.

11 In the case of the central control of the  
12 management of critical care, this meant that the  
13 Critical Care Network for Northern Ireland was best  
14 placed to fulfil this role, and did so expertly during  
15 the first surge. However, as the military assessment  
16 team identified, the role required greater co-ordination  
17 given the scale of the pandemic in anticipation of  
18 future waves.

19 Accordingly, a critical care hub was created in  
20 early January 2021 to strategically manage critical care  
21 admissions and transfers on a regional basis.

22 My Lady, I'd also like to remark on the question  
23 of surge planning, which was addressed in evidence, and  
24 the apparent lack of a specific critical care surge plan  
25 until 16 April 2020. The department wishes to emphasise

161

1 a preferred site, this was before a full viability  
2 assessment had been carried out. The department remains  
3 of the view that a Nightingale hospital would never have  
4 been appropriate as a detached standalone facility in  
5 a location such as that of the Eikon centre. Having  
6 a Nightingale hospital in such a detached location would  
7 have had a significant adverse impact on every other  
8 hospital caring for critically-ill patients and  
9 providing emergency surgical services. This is because  
10 staff from those other hospitals would have had to have  
11 been redeployed to that detached location.

12 As the region had, and indeed continues to have,  
13 a finite number of experienced staff to provide critical  
14 care support, the approach taken in locating the  
15 hospital in Belfast City Hospital was assessed as being  
16 more efficient, and lower risk than removing staff from  
17 individual trusts to staff a detached Nightingale  
18 hospital.

19 Such an approach, also allowed for continued  
20 critical care at hospitals around the region for those  
21 patients who were non-Covid.

22 Finally, my Lady in conclusion, I'd like to remark  
23 that this module has been focused on healthcare systems  
24 and it should be emphasised that no healthcare system  
25 can even exist without its staff.

163

1 that it is important to note that Northern Ireland has  
2 had a critical care escalation plan in place since 2011.  
3 This was modelled on a response to pandemic influenza.  
4 At the direction of the department in early February  
5 and March 2020, significant work was undertaken by the  
6 HSCB, the PHA, and the trusts, to adapt the existing  
7 escalation plan to the known risks and likely impact of  
8 Covid-19, and this plan was published on 19 March 2020.

9 A summary plan was underpinned by detailed  
10 operational plans in each individual trust, and was  
11 further revised and updated on 1 April 2020, based on  
12 revised Covid-19 modelling and was in place in the low  
13 surge period of the first wave.

14 The basis of these plans was for an escalation of  
15 trust, that is to say local hospital level, prior to  
16 regional escalation. Even at the highest level of the  
17 pandemic such local escalation was not completely  
18 exhausted.

19 Finally, my Lady, I'd like to make some remarks  
20 about the Nightingale hospital. The department would  
21 like to refute any perception that planning for  
22 a Nightingale hospital in Northern Ireland was too slow.  
23 The department rejects the suggestion that the Belfast  
24 City Hospital was the incorrect location. Whilst at one  
25 stage it is correct that the Eikon centre had emerged as

162

1 Over the course of this hearing, many tributes  
2 have been paid to health and social care workers for  
3 their contribution and commitment during the pandemic.  
4 These tributes bare repeating and the department  
5 believes that this is an appropriate point at which to,  
6 again, express its sincere thanks to those staff for  
7 their unerring and unselfish commitment.

8 Thank you very much, my Lady.

9 **LADY HALLETT:** Thank you very much indeed, Ms Murnaghan, I'm  
10 very grateful.

11 Ms McNeill on behalf of the Welsh Government.

12 **Closing statement on behalf of Welsh Government by**  
13 **MS McNEILL**

14 **MS McNEILL:** Thank you, my Lady.

15 In opening, the Welsh Government acknowledged that  
16 the evidence of the bereaved of frontline NHS workers  
17 and the Inquiry's experts would cast an unflinching and  
18 critical light on decisions taken in Wales and,  
19 crucially, identify those that did not work.

20 Our written closing statement will address the  
21 significant issues which have emerged or crystallised  
22 during these hearings, including NHS capacity and  
23 critical care capacity in particular, the availability  
24 and distribution of PPE, field hospitals, nosocomial  
25 transmissions, and the services available to treat

164

1 Long Covid.  
2 Today, my Lady, I will concentrate on the  
3 important and complex question of recommendations.

4 In considering potential recommendations, the  
5 Welsh Government's views have been formed by two  
6 principal factors.

7 First, any recommendation should clearly and  
8 effectively address a clear deficiency or problem  
9 arising from the evidence.

10 Secondly, although there is no ideal number and  
11 the Inquiry will make such recommendations as are  
12 considered necessary to cure any significant deficiency,  
13 this may be a situation where the Inquiry is better  
14 assisted by an approach of less is more.

15 To that end the Welsh Government would put three  
16 potential recommendations before the Inquiry for its  
17 consideration.

18 First, establishing a reserve NHS workforce list  
19 that could be swiftly deployed in a public health  
20 emergency.

21 Second, establishing arrangements to be overseen  
22 by the NHS Executive in Wales for collating, reviewing  
23 and implementing NHS healthcare-related  
24 recommendations in order to ensure effective and  
25 consistent implementation.

165

1 Wales by ensuring that the Welsh NHS Executive collects  
2 and considers all relevant recommendations to make sure  
3 that they are effectively implemented. The substance of  
4 the arrangements for doing so will be informed by this  
5 Inquiry's findings about the effectiveness of  
6 implementation.

7 The aim of the Welsh Government's third  
8 recommendation is to address unnecessary inconsistency  
9 between relevant health organisations in their  
10 application of Welsh Government policies, with a view to  
11 achieving more effective and efficient application.

12 One point that has emerged from the evidence is  
13 the incidence of avoidable inconsistencies in local  
14 health boards' applications of Welsh Government policies  
15 on, for example, visiting restrictions, where those  
16 inconsistencies are not explained or justified by local  
17 requirements.

18 This proposal is aimed at ensuring greater  
19 consistency while not interfering with or limiting the  
20 local health boards' discretion to tailor clinical  
21 provision to local needs.

22 My Lady, I should finish this closing statement  
23 with the assurance that the Welsh Government has  
24 carefully and humbly listened to the evidence that has  
25 been adduced over the past three months. That was

167

1 Thirdly, establishing arrangements to ensure  
2 greater consistency in the implementation of Welsh  
3 Government policy by NHS bodies in Wales.

4 Returning to the first, my Lady. An NHS reserve  
5 workforce would consist of recently retired NHS  
6 employees and possibly former military medical personnel  
7 who could be called upon, if required, for a fixed term  
8 following their retirement. Although the detail of pay,  
9 conditions of service, and professional obligations  
10 pre-eminently continuing professional development would  
11 need to be carefully considered, in principle there is  
12 much to commend a mechanism which allows the NHS to  
13 increase its personnel swiftly, significantly and at  
14 short notice.

15 As to the second recommendation, there is  
16 a systemic and chronic issue about how best to ensure  
17 that recommendations and learning from public and other  
18 inquiries are effectively implemented so that the  
19 identified problem is cured. That concern has been  
20 recently echoed by statements in the Thirlwall Inquiry  
21 that the many recommendations made by various healthcare  
22 investigations over the past decade have not been  
23 implemented effectively or at all.

24 This Welsh Government's second proposed  
25 recommendation is designed to address that problem in

166

1 reflected in the evidence of ministers and of senior  
2 officials.

3 The Welsh Government's written closing statement  
4 will deal with the one stance of Module 3 evidence but,  
5 as it is recognised in opening, the Welsh Government  
6 accepts that not every measure was as effective as was  
7 hoped and there will be criticism of some decisions and  
8 policies.

9 In that light, the Welsh Government will continue  
10 to give every assistance to the Inquiry as it continues  
11 its necessary and valuable work.

12 Thank you, my Lady.

13 **LADY HALLETT:** Thank you very much, Ms McNeill, very  
14 grateful.

15 Mr Mitchell for the Scottish Government.

16 **Closing statement on behalf of the Scottish Government by**  
17 **GEOFFREY MITCHELL KC**

18 **MR MITCHELL:** Good afternoon, my Lady.

19 This is the oral closing statement on behalf of  
20 the Scottish Government. I appear today along with  
21 junior counsel, Ms Julie McKinlay. I am instructed by  
22 Caroline Beattie and John McPhail for the Scottish  
23 Government Legal Directorate.

24 Across the United Kingdom the human cost of the  
25 pandemic was enormous. Everyone paid a price. The

168

1 impact on people, families, communities and the  
2 workforce was devastating. Across Scotland, in hospital  
3 settings alone, 9,573 people, workers included, lost  
4 their lives.

5 Frankly, we cannot be reminded enough about such  
6 statistics. They cannot be forgotten. The Scottish  
7 Government expresses its sincere condolences to those  
8 who have lost loved ones and those who have suffered and  
9 who continue to suffer. We've heard some emotive and  
10 upsetting evidence today in that regard.

11 It also expresses its sincere gratitude for the  
12 many sacrifices that people made, often for the benefit  
13 of others, and the Herculean efforts of the health and  
14 social care workforce, particularly when looking after  
15 our most vulnerable.

16 The Scottish Government has made such statements  
17 before and it will continue to make them because in  
18 truth there is no limit to the number of times that they  
19 can and should be made.

20 The Scottish Government talks a lot about the core  
21 values that underpin the health and social care system  
22 in Scotland. Those values, such as care, compassion  
23 dignity and respect, are evident in those who perform  
24 the day-to-day job of keeping the system going. The  
25 pandemic response was a prime example of those core

169

1 Several important decisions were made which, taken  
2 together, resulted in an increase in capacity in  
3 expectation of the reasonable worst-case scenario. And  
4 at in time was the provision of healthcare in Scotland  
5 rationed.

6 It is worth reminding listeners of the guiding  
7 light that steered decision-makers through the pandemic  
8 in Scotland, namely the four harms approach. This  
9 allowed for reasonable and proportionate decision-making  
10 in the context where no option was risk free. It  
11 allowed for a nuanced approach which recognised risk  
12 across the board, and sought to mitigate those risks  
13 with a range of measures. It also allowed for  
14 an approach that evolved over time in response to  
15 specific developments and advancements in our knowledge  
16 of the behaviour of the virus.

17 In our opening statement we highlighted the  
18 absence of an NHS trust structure in Scotland. As we  
19 believe my Lady recognises, while a local approach have  
20 the effect of regional variation, in a country of the  
21 size of Scotland it can lead to more effective delivery  
22 of the services that matter most in a particular area.

23 The evidence showed that there was and is a strong  
24 collaborative working relationship between the Scottish  
25 Government and the health boards. As Caroline Lamb

171

1 values in action.

2 The quality of care provided, the myriad of ways  
3 in which people took on new roles and worked across  
4 boundaries, and the distress felt by many at what they  
5 witnessed in our hospitals and care homes are all  
6 testament to those values.

7 Importantly, the values are on display across the  
8 whole of the health and social care system because the  
9 response to the pandemic was a whole-system response.

10 There was collaboration across the whole system  
11 for the benefit of people and their families, and  
12 Scottish Government worked to ensure that the workforce  
13 was supported. Thus, terms and conditions were adapted,  
14 a bonus was paid and a life assurance scheme was  
15 created.

16 We submit that the evidence has clearly shown that  
17 during the pandemic in Scotland there was public health  
18 capability. That is, there was a strategy, there were  
19 plans and there was guidance.

20 We submit that the evidence shows that the  
21 response was comprehensive and effective. Certainly at  
22 times the system was severely tested and stretched but,  
23 as Ms Freeman said, it was not overwhelmed,  
24 acknowledging, of course, that others may define that  
25 term differently.

170

1 explained in evidence, it produces a shared  
2 understanding of the priority of ministers and  
3 consequent alignment of policy, planning and delivery.  
4 And, as Ms Freeman noted in evidence, it is important  
5 that the highest spending public service and the largest  
6 employer is directly accountable to the Cabinet  
7 Secretary for Health.

8 Turning now to specific aspects of the response in  
9 Scotland, and looking firstly at capacity issues.

10 A number of key decisions were taken that  
11 increased capacity, allowed staff to be redeployed, and  
12 prevented the NHS from being overwhelmed.

13 Crucially, on 17 March of 2020, Ms Freeman put the  
14 NHS in Scotland on an emergency footing. Strategic and  
15 operational leadership was required in order to  
16 determine which areas should be focused on. Elective  
17 and non-urgent healthcare was cancelled. Cancer  
18 screening programmes were paused. Covid-19 community  
19 pathways for primary care were introduced. Retired  
20 health staff, final year medical students and nursing  
21 students were brought into the workforce.

22 The NHS Louisa Jordan, commissioned on  
23 30 March 2020 and officially opened a month later, on  
24 30 April 2020, provided backup to the permanent acute  
25 estate if needed.

172

1 Sir Gregor Smith and Ms Freeman told the Inquiry  
2 that at no stage was the further expansion of capacity,  
3 that is the quadrupling of the baseline, exceeded. The  
4 CMO was unaware of any resource-based escalation of care  
5 decisions being taken. Miss Freeman said there were no  
6 discussions at all about the rationing of healthcare.  
7 She was concerned that increase in capacity would have  
8 consequences for the quality of care. Yet, as she said,  
9 everyone worked to make it as good as it can be.

10 The evidence of Ms Freeman and Ms Lamb showed the  
11 Scottish Government closely monitored bed and staff  
12 capacity, not simply by means of spreadsheets, but  
13 through multiple telephone conversations and meetings  
14 throughout the course of a day, with everyone from  
15 health board CEOs to the Chief Nursing Officer.

16 In summary, we submit that the evidence showed  
17 a government that had a good grasp of the figures, knew  
18 when problems arose and strove to prevent the NHS from  
19 being overwhelmed.

20 Turning now to health and healthcare inequalities.  
21 Tackling health inequalities has long been a key mission  
22 for successive governments in Scotland. Measures to  
23 create immediate capacity in March 2020 were taken, with  
24 the protection of the vulnerable in mind. So, for  
25 example, the decision to pause non-urgent elective care

173

1 in the future, Scotland has better access to the data  
2 concerning ethnic minorities.

3 Turning to shielding. The Inquiry has heard  
4 contrasting evidence about the shielding programme, the  
5 Scottish Government is under no illusions about how  
6 difficult shielding was for many people. It  
7 acknowledges the indirect harms, particularly in terms  
8 of isolation, loneliness and mental health. No witness  
9 unequivocally suggested that with the benefit of  
10 hindsight they would re-run the shielding programme  
11 exactly as it had been. The Scottish Government  
12 recognised this early in the pandemic and commissioned  
13 rapid evaluation of the programme. There are,  
14 inevitably, costs and benefits that would have to be  
15 weighed in the event of a future pandemic.

16 The Scottish Government agrees with  
17 Sir Chris Whitty that some form of government-backed  
18 support framework would be required.

19 Certainly, the principle of supporting the  
20 vulnerable to help keep them safe is one that the  
21 Scottish Government does endorse and would endorse in  
22 a future pandemic. It may involve a variation on  
23 a model whereby people are provided with information and  
24 tools to allow them to make personalised, informed  
25 decisions, as spoken to in evidence by Sir Gregor Smith.

175

1 was one with which, even in hindsight, all the expert  
2 evidence has agreed.

3 But it had obvious negative effects. The decision  
4 balanced different risks and considerations to arrive at  
5 a proportionate outcome, albeit one which did not  
6 eliminate all of those risks.

7 Acknowledging the point made by Ms Freeman that it  
8 is not only through formal equality impact assessments  
9 that a government minister comes to understand  
10 equalities, formal assessments did become a regular part  
11 of Scottish Government decision-making.

12 However, as Mr Yousaf candidly recognised, had  
13 Cabinet heard directly from disabled people's  
14 organisations, it may have helped to inform  
15 decision-making, particularly in removing NPIs.

16 Ministers did engage with ethnic minority  
17 stakeholder groups such as BEMIS and, as  
18 Professor Bamrah said, with FEMHO. However, as  
19 Mr Yousaf acknowledged, the data available on the  
20 experience and impact of the pandemic on ethnic minority  
21 groups was, in his words, sub-optimal.

22 To that end, the Inquiry has heard evidence on the  
23 steps taken to improve data collection in this regard,  
24 including the establishment of anti -- of the  
25 anti-racism observatory. This will help to ensure that,

174

1 This would be similar, in fact, to the one that the  
2 Scottish Government moved to in May of 2020.

3 Looking now at infection prevention and control.  
4 The Inquiry has heard that by the end of September 2020  
5 there was sufficient evidence to suggest strongly that  
6 Covid-19 could be transmitted via the airborne route.  
7 The Scottish Government did not close its eyes to the  
8 possibility of airborne transmission. From the  
9 beginning of the pandemic, the CMO for Scotland kept  
10 an open mind and was alive to the prospect.

11 It was clear, even at that early stage, that  
12 aerosol transmission contributed to the spread, albeit  
13 thought to be less significant than other routes. The  
14 unequivocal statement from the WHO on 28 March that  
15 Covid-19 was not airborne was considered by Sir Gregor  
16 Smith to be unhelpful.

17 As the evidence and the understanding of the virus  
18 developed, so too did the advice of the CMO and the  
19 guidance from the Scottish Government. The issue was  
20 discussed at a Cabinet meeting on 8 July 2020, with it  
21 being noted that airborne transmission would alter the  
22 measures required to protect against infection.

23 On 4 August 2020, a ministerial submission  
24 specifically acknowledged aerosol as a possible route of  
25 transmission. It is therefore simply not the case, as

176

1 has been suggested, that the Scottish Government has not  
2 acknowledged this possibility. In light of the emerging  
3 evidence, there was greater emphasis on good ventilation  
4 and meeting outdoors to reduce the risk.

5 All that said, there continues to be scientific  
6 disagreement on the contribution made by aerosol spread.  
7 WHO's current position is that maintaining a strict  
8 dichotomy between droplet and aerosol transmission with  
9 reference to particle size is unhelpful, rather that the  
10 descriptor "through the air" should be used in a general  
11 way to characterise an infectious disease where the main  
12 mode of transmission involves the pathogen travelling or  
13 being suspended in the air.

14 Ms Laura Imrie told the Inquiry that following a  
15 systematic literature review, ARHAI support this  
16 position.

17 Looking now to PPE. The Scottish Government  
18 recognises that the droplet against aerosol debate was  
19 not academic or inconsequential. It led to widespread  
20 anxiety amongst healthcare workers who felt they were  
21 not being provided with appropriate PPE. Many advocated  
22 for more extensive use of FFP3 masks. The Inquiry heard  
23 from Dr Ben Warne that although such masks would have  
24 provided greater protection, the extent to which their  
25 widespread use by healthcare workers would have reduced

177

1 issues to be raised, heard and quickly acted upon.

2 The Scottish Government also recognised the  
3 difficulties with face fit testing, particularly for  
4 women and ethnic minorities. Concerns were listened to,  
5 taken seriously, and concerted efforts were made to  
6 improve the PPE provided. Where available, adjustable  
7 products were bought to reduce the risk of fit test  
8 failures. In June of 2020 the Scottish Government  
9 established an expert reference group on Covid-19 and  
10 ethnicity to understand better the challenges faced.

11 As Ms Lamb told the Inquiry, in May and July of  
12 2020 guidance was produced that required health boards  
13 as employers to ensure that risk assessments were  
14 performed for individual health workers who may be  
15 particularly vulnerable, including black, Asian and  
16 ethnic minority staff.

17 In October 2020, the Scottish Government published  
18 a PPE action plan which recognised the challenges faced  
19 by such individuals and detailed the ongoing work to  
20 resolve this issue.

21 By March of 2021, NHS National Services Scotland  
22 were providing at least eight different models of FFP3  
23 masks to ensure that the majority of healthcare workers  
24 could be provided with a mask that fitted.

25 My Lady, turning finally to Long Covid.

179

1 nosocomial infections amongst that group is unclear.

2 However, the Scottish Government saw the real  
3 difficulties this issue was causing for some healthcare  
4 workers who felt that they were not being provided with  
5 sufficient protection.

6 As spoken to in evidence by Ms Lamb, there were  
7 several occasions, the first as early as May of 2020,  
8 when the Scottish Government recognised the personal  
9 preference of healthcare workers to wear an FFP3 mask  
10 and issued guidance accordingly.

11 The Scottish Government recognises that  
12 notwithstanding every effort made by NSS Scotland to  
13 procure sufficient PPE, parts of the healthcare system  
14 had, as Ms Freeman put it, concerns about getting their  
15 hands on PPE that she knew we had. At the beginning of  
16 the pandemic there were clearly issues for workers on  
17 the ground, as highlighted the BMA and spoken to in  
18 evidence by Rozanne Foyer of the STUC, and  
19 Professor Colin MacKay from Greater Glasgow Health  
20 Board. There were particularly acute difficulties for  
21 the Scottish Ambulance Service. The Scottish Government  
22 reacted quickly to these issues.

23 Ministers met with union representatives and  
24 subsequently set up a helpline so that healthcare  
25 workers could report problems directly. This enabled

178

1 Of course, every pandemic is different and different  
2 viruses produce different long-term sequelae, but as Sir  
3 Gregor Smith frankly acknowledged, Scotland was not  
4 prepared to deal with either the volume or type of  
5 long-term sequelae that Covid-19 produced. Recognising  
6 that Long Covid comprises a number of different  
7 syndromes and that it is consequently not  
8 straightforward either to diagnose or to treat, fairly  
9 significant steps have been taken in Scotland to redress  
10 the balance. A Long Covid Support fund of £10 million  
11 was established, from which resource has been allocated  
12 to health boards to use as they deem appropriate for  
13 their populations to deliver the best models of care.  
14 All 14 territorial health boards in Scotland now have  
15 rehabilitation and clinical pathways for Long Covid  
16 patient referrals.

17 My Lady, in conclusion, a key learning point from  
18 this and from other modules is that too rigid a plan for  
19 future pandemics is of limited value. All pandemics are  
20 different. By contrast investment in Scotland's health  
21 and social care system is of value, as too is strength  
22 and depth of relationship, trust that permits honest  
23 conversations, and decision-making that is unrestricted  
24 by organisational boundaries.

25 Counterintuitively, the pandemic had some positive

180

1 effects on the health and social care system in  
 2 Scotland. It has placed us in a stronger position to  
 3 respond in the future. For example, the detailed  
 4 planning that went into the rollout of the vaccine  
 5 programme, Test and Protect, and the National Treatment  
 6 Centres has helped to change forever the nature of  
 7 public sector service planning and design in Scotland.  
 8 Again, the reality of responding to a global  
 9 pandemic at pace, with implications for every aspect of  
 10 society, has led to improvements in how people are  
 11 redeployed at speed and how capacity can be supplemented  
 12 in creative ways.  
 13 Further, there is the success of the NHS 24  
 14 programme. It has led to a 10% reduction in people  
 15 presenting at Accident & Emergency. Also the Integrated  
 16 Clinical Hub, now used by the Scottish Ambulance  
 17 Service, provides enhanced remote triage to patients who  
 18 present with urgent care needs, and ambulance crews with  
 19 access to clinical advice and support whilst on scene.  
 20 The effect has been to reduce by 50% the number of  
 21 ambulance call-outs that result in conveyance to A&E.  
 22 But, my Lady, we end where we began, with the  
 23 human cost of the pandemic.  
 24 The Scottish Government once again passes its  
 25 sincere condolences and sympathies to those who have

1 lost loved ones and to those who have suffered and  
 2 continue to suffer. And it once again acknowledges the  
 3 efforts and sacrifices of our health and social care  
 4 workforce during the pandemic.  
 5 My Lady, those are our oral submissions.  
 6 Thank you.  
 7 **LADY HALLETT:** Thank you very much indeed, Mr Mitchell, I'm  
 8 very grateful.  
 9 It's been a long day emotionally if not time wise,  
 10 so I think we'll close there, and I understand the next  
 11 speaker isn't here today anyway.  
 12 So I will resume at 10 o'clock tomorrow morning.  
 13 **MS CAREY:** Thank you, my Lady.  
 14 **LADY HALLETT:** Thank you, Ms Carey.  
 15 **(4.00 pm)**  
 16 **(The hearing adjourned until 10.00 am**  
 17 **on Wednesday, 27 November 2024)**  
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 20  
 21  
 22  
 23  
 24  
 25

1	INDEX	
2		PAGE
3	MS ANNA-LOUISE MARSH-REESE .....	1
4	(affirmed)	
5	Questions from COUNSEL TO THE INQUIRY .....	1
6	MS MARGARET WATERTON (affirmed) .....	33
7	Questions from COUNSEL TO THE INQUIRY .....	33
8	DR SALEYHA AHSAN (affirmed) .....	59
9	Questions from LEAD COUNSEL TO THE .....	59
10	INQUIRY for MODULE 3	
11	MS MARTINA FERGUSON (sworn) .....	108
12	Questions from LEAD COUNSEL TO THE .....	108
13	INQUIRY for MODULE 3	
14	CLOSING SUBMISSIONS .....	141
15	Closing statement on behalf of UK .....	143
16	Health and Security Agency by MR RAWAT	
17	Closing statement on behalf of .....	154
18	Department of Health Northern Ireland by	
19	MS MURNAGHAN KC	
20	Closing statement on behalf of Welsh .....	164
21	Government by MS McNEILL	
22	Closing statement on behalf of the .....	168
23	Scottish Government by GEOFFREY MITCHELL KC	
24		
25		

<b>LADY HALLETT:</b> <b>[29]</b> 1/5 1/10 32/19 33/4 33/16 33/19 58/4 58/21 59/5 59/8 107/4 107/20 107/22 108/3 108/6 108/15 139/5 140/19 141/2 141/12 142/15 142/24 143/7 143/9 153/25 164/9 168/13 182/7 182/14 <b>MR MITCHELL: [1]</b> 168/18 <b>MR RAWAT: [1]</b> 143/12 <b>MR SCOTT: [3]</b> 33/14 33/25 58/2 <b>MS CAREY: [14]</b> 59/3 59/13 106/24 107/19 108/1 108/16 139/1 140/24 141/11 141/17 142/23 143/3 143/8 182/13 <b>MS McNEILL: [1]</b> 164/14 <b>MS MURNAGHAN:</b> <b>[2]</b> 154/4 154/7 <b>MS NIELD: [6]</b> 1/3 1/6 1/17 32/3 32/18 33/9 <b>THE WITNESS: [7]</b> 1/15 33/2 58/18 59/12 107/18 108/13 140/3	<b>13 staff [1]</b> 10/15 <b>14 [2]</b> 106/9 180/14 <b>15 [1]</b> 137/12 <b>15 minutes [1]</b> 45/24 <b>16 [1]</b> 4/8 <b>16 April 2020 [1]</b> 161/25 <b>16 March [1]</b> 66/21 <b>160 years [1]</b> 21/2 <b>17 [1]</b> 4/8 <b>17 December [2]</b> 80/11 80/14 <b>17 March [1]</b> 172/13 <b>18 June 2020 [1]</b> 34/12 <b>19 [24]</b> 4/22 34/17 59/18 59/21 60/14 62/21 69/1 80/15 82/7 83/9 144/23 148/12 150/21 150/23 156/15 156/19 157/2 162/8 162/12 172/18 176/6 176/15 179/9 180/5 <b>19 December [1]</b> 119/18 <b>19 March 2020 [1]</b> 162/8 <b>1900 [1]</b> 21/5 <b>1999 [1]</b> 35/6	<b>2022 [2]</b> 138/15 155/9 <b>2023 [1]</b> 159/5 <b>2024 [4]</b> 1/1 1/20 160/14 182/17 <b>2025 [1]</b> 159/7 <b>21 [1]</b> 10/15 <b>22 December [1]</b> 119/24 <b>22 July [1]</b> 115/20 <b>23 December [1]</b> 118/25 <b>23 March [2]</b> 66/21 111/7 <b>24 [2]</b> 51/19 181/13 <b>24 hours [2]</b> 82/9 114/23 <b>24-hour [1]</b> 115/19 <b>26 November 2024</b> <b>[1]</b> 1/1 <b>27 November 2024</b> <b>[1]</b> 182/17 <b>28 [1]</b> 176/14 <b>28 December [1]</b> 92/12 <b>28 January 2020 [1]</b> 145/17	<b>56 [1]</b> 3/16 <b>5th [1]</b> 113/16 <b>6</b> <b>6 July [1]</b> 113/15 <b>60s [1]</b> 102/25 <b>69 [3]</b> 141/19 141/21 142/10 <b>7</b> <b>7,000 members [1]</b> 60/13 <b>71st [1]</b> 34/14 <b>8</b> <b>8 July [2]</b> 113/7 114/16 <b>8 July 2020 [1]</b> 176/20 <b>81 [1]</b> 80/12 <b>85 [2]</b> 9/4 25/3 <b>9</b> <b>9 July [1]</b> 115/13 <b>9,573 [1]</b> 169/3 <b>90 [1]</b> 37/13 <b>999 [7]</b> 5/11 7/15 7/19 61/18 64/15 123/5 123/7 <b>999 service [1]</b> 61/2	8/15 8/16 9/18 10/10 13/6 15/22 18/14 20/15 21/6 22/12 24/22 26/6 29/4 29/7 29/17 40/6 68/13 75/22 76/17 76/17 126/22 135/21 <b>academic [1]</b> 177/19 <b>accept [2]</b> 38/4 58/7 <b>accepted [1]</b> 158/13 <b>accepting [1]</b> 57/4 <b>accepts [1]</b> 168/6 <b>access [21]</b> 4/6 4/15 5/7 13/21 48/3 50/20 51/8 52/8 53/15 53/22 54/5 61/20 61/24 62/16 62/21 64/10 64/24 66/19 159/23 175/1 181/19 <b>accessibility [3]</b> 9/12 60/18 63/2 <b>accessible [4]</b> 9/14 9/22 53/11 62/18 <b>accessing [1]</b> 156/14 <b>Accident [1]</b> 181/15 <b>accompanied [1]</b> 157/24 <b>accompanying [1]</b> 128/14 <b>accord [1]</b> 157/14 <b>according [1]</b> 19/10 <b>accordingly [2]</b> 161/19 178/10 <b>account [6]</b> 60/21 67/7 79/1 132/22 142/7 142/19 <b>accountability [7]</b> 25/13 32/7 57/1 57/3 57/3 57/4 151/3 <b>accountable [1]</b> 172/6 <b>accounts [6]</b> 61/19 62/10 67/14 68/1 68/15 103/11 <b>accurately [1]</b> 153/9 <b>achieve [3]</b> 51/11 57/2 101/16 <b>achieving [1]</b> 167/11 <b>acknowledge [2]</b> 131/25 159/8 <b>acknowledged [6]</b> 7/3 164/15 174/19 176/24 177/2 180/3 <b>acknowledgement</b> <b>[1]</b> 7/2 <b>acknowledges [2]</b> 175/7 182/2 <b>acknowledging [3]</b> 25/6 170/24 174/7 <b>acquired [7]</b> 2/11 25/20 37/6 67/22 68/4 68/13 68/25 <b>acquiring [1]</b> 69/6 <b>across [45]</b> 2/16 5/14
<b>1</b> <b>1 April 2020 [1]</b> 162/11 <b>1 January 2021 [1]</b> 156/7 <b>1.06 pm [1]</b> 107/23 <b>10 [3]</b> 106/9 124/7 181/14 <b>10 litres [1]</b> 125/6 <b>10 million [1]</b> 180/10 <b>10 November 2024</b> <b>[1]</b> 1/20 <b>10 o'clock [1]</b> 182/12 <b>10.00 [2]</b> 1/2 182/16 <b>10.49 [1]</b> 33/11 <b>100 [1]</b> 47/2 <b>11 o'clock [1]</b> 33/8 <b>11.00 [1]</b> 33/13 <b>11.38 [1]</b> 58/25 <b>11.50 [2]</b> 58/22 59/2 <b>111 [24]</b> 5/12 5/13 5/17 5/21 5/24 6/3 6/5 6/16 7/6 51/19 52/1 61/2 61/18 61/22 62/1 62/5 62/7 62/22 62/24 63/3 63/7 63/15 64/14 66/19 <b>111, firstly [1]</b> 61/4 <b>12 hours [1]</b> 13/23	<b>2</b> <b>2 January 2021 [1]</b> 34/13 <b>2.05 [1]</b> 107/22 <b>2.05 pm [1]</b> 107/25 <b>2.53 pm [1]</b> 141/13 <b>20 [1]</b> 25/16 <b>2001 [1]</b> 21/3 <b>2010 [1]</b> 106/22 <b>2011 [1]</b> 162/2 <b>2015 [1]</b> 159/1 <b>2019 [1]</b> 91/17 <b>2020 [47]</b> 2/11 7/4 8/22 9/8 21/11 24/4 34/12 60/15 69/15 74/9 80/10 92/13 94/4 94/5 110/15 113/5 113/11 113/13 116/20 118/20 118/20 118/23 119/7 120/8 129/9 138/14 140/11 145/17 145/23 156/20 159/12 161/25 162/5 162/8 162/11 172/13 172/23 172/24 173/23 176/2 176/4 176/20 176/23 178/7 179/8 179/12 179/17 <b>2021 [14]</b> 23/24 26/13 34/13 101/5 108/23 109/3 109/18 119/8 133/15 133/21 140/11 156/7 161/20 179/21	<b>3</b> <b>3.05 [1]</b> 141/12 <b>3.05 pm [1]</b> 141/15 <b>30 April 2020 [1]</b> 172/24 <b>30 March 2020 [1]</b> 172/23 <b>31 March [1]</b> 111/8 <b>36 [1]</b> 67/25 <b>37 [1]</b> 13/17 <b>38 billion [2]</b> 106/3 106/4 <b>39 years [1]</b> 42/7 <b>4</b> <b>4 August 2020 [1]</b> 176/23 <b>4 January [1]</b> 127/24 <b>4 January 2021 [1]</b> 133/21 <b>4 years [1]</b> 118/7 <b>4.00 pm [1]</b> 182/15 <b>40 [1]</b> 19/8 <b>40 minutes [2]</b> 14/7 14/14 <b>40-year-old [1]</b> 85/21 <b>400 [1]</b> 2/23 <b>4th January 2021 [1]</b> 133/15 <b>5</b> <b>5 July [3]</b> 113/7 113/12 115/19 <b>50 [3]</b> 19/8 98/13 181/20 <b>52 [1]</b> 101/24	<b>6</b> <b>6 July [1]</b> 113/15 <b>60s [1]</b> 102/25 <b>69 [3]</b> 141/19 141/21 142/10 <b>7</b> <b>7,000 members [1]</b> 60/13 <b>71st [1]</b> 34/14 <b>8</b> <b>8 July [2]</b> 113/7 114/16 <b>8 July 2020 [1]</b> 176/20 <b>81 [1]</b> 80/12 <b>85 [2]</b> 9/4 25/3 <b>9</b> <b>9 July [1]</b> 115/13 <b>9,573 [1]</b> 169/3 <b>90 [1]</b> 37/13 <b>999 [7]</b> 5/11 7/15 7/19 61/18 64/15 123/5 123/7 <b>999 service [1]</b> 61/2 <b>A</b> <b>Abdorrezza [1]</b> 103/5 <b>Abdul [1]</b> 102/13 <b>ability [2]</b> 50/9 101/8 <b>able [44]</b> 1/3 3/11 6/3 12/9 18/12 35/17 35/23 35/24 40/8 44/5 47/1 48/4 49/2 49/4 49/5 50/7 50/21 50/24 54/5 57/18 68/2 80/3 82/2 86/12 89/9 92/3 99/17 101/9 101/12 101/13 106/12 110/10 113/11 114/4 114/5 114/8 117/5 118/6 126/3 130/25 131/8 134/10 153/4 153/8 <b>ably [1]</b> 100/25 <b>abnormal [1]</b> 97/4 <b>about [202]</b> <b>about because [1]</b> 150/4 <b>about July [1]</b> 118/12 <b>about March [1]</b> 93/11 <b>about March 2021 [1]</b> 101/5 <b>abroad [1]</b> 76/5 <b>absence [1]</b> 171/18 <b>absent [1]</b> 79/24 <b>absolute [2]</b> 100/13 104/22 <b>absolutely [23]</b> 4/14	

<b>A</b>	<b>adequately [2]</b> 50/20 158/17	117/17 119/13 120/8 121/18 123/2 131/23 138/11 169/14	148/10 167/18	<b>allowed [26]</b> 11/22 14/11 47/2 52/15 82/10 111/9 116/5 116/10 128/16 133/12 133/16 133/16 134/19 135/3 137/11 137/12 137/13 137/16 137/17 138/9 148/24 163/19 171/9 171/11 171/13 172/11
<b>across... [43]</b> 8/12 11/16 11/17 12/12 22/13 22/25 23/21 36/25 38/14 38/16 40/20 43/2 43/6 43/25 43/25 43/25 44/11 46/17 50/11 50/15 51/21 54/3 65/2 65/3 71/10 75/16 85/22 89/16 131/5 134/12 136/5 136/11 151/8 153/3 158/21 159/15 160/11 168/24 169/2 170/3 170/7 170/10 171/12	<b>adhering [1]</b> 45/11	<b>afternoon [7]</b> 108/1 140/25 141/9 142/11 143/12 154/19 168/18	<b>air [5]</b> 21/12 21/14 21/18 177/10 177/13 <b>airborne [9]</b> 32/12 38/5 144/24 145/6 145/11 176/6 176/8 176/15 176/21	<b>allowing [1]</b> 43/14
<b>acted [2]</b> 40/17 179/1	<b>admission [1]</b> 26/1	<b>again [74]</b> 1/14 8/13 14/16 17/11 22/12 23/14 26/14 29/14 30/8 30/22 32/16 41/5 48/2 52/8 52/12 53/18 53/23 54/7 54/15 54/15 55/2 55/8 57/14 61/7 62/15 65/2 65/4 66/2 66/6 68/7 68/10 69/1 72/2 72/5 73/3 73/14 75/3 76/10 81/15 81/16 83/13 84/22 86/20 87/17 89/6 89/14 90/2 91/10 91/15 94/15 96/15 98/21 99/11 100/2 100/7 100/25 101/21 102/23 102/24 113/8 115/14 115/17 115/22 121/1 121/14 124/8 133/2 138/22 152/18 153/6 164/6 181/8 181/24 182/2	<b>aircraft [1]</b> 77/6	<b>allows [3]</b> 150/7 150/16 166/12
<b>action [8]</b> 32/16 77/8 77/11 109/9 110/13 160/11 170/1 179/18	<b>admittance [1]</b> 26/3	<b>against [3]</b> 147/16 176/22 177/18	<b>alarm [1]</b> 96/16	<b>alluded [1]</b> 98/4
<b>actionable [1]</b> 32/1	<b>admitted [5]</b> 4/21 7/10 40/8 56/12 86/3	<b>age [7]</b> 12/23 50/19 84/6 97/10 124/15 124/23 155/4	<b>alarmed [1]</b> 94/10	<b>almost [8]</b> 10/11 13/11 41/3 51/25 82/13 93/11 99/2 103/18
<b>actions [1]</b> 150/16	<b>adopt [1]</b> 149/22	<b>Ageing [2]</b> 160/1 160/6	<b>albeit [3]</b> 18/21 174/5 176/12	<b>alone [5]</b> 57/16 66/23 138/22 151/11 169/3
<b>activity [5]</b> 113/17 114/19 115/15 116/25 160/8	<b>adults [1]</b> 155/11	<b>agency [12]</b> 22/2 22/13 39/7 110/17 110/18 142/14 143/10 143/15 143/17 151/8 151/11 183/16	<b>alignment [2]</b> 159/23 172/3	<b>along [5]</b> 1/14 33/22 98/13 136/1 168/20
<b>actual [1]</b> 132/7	<b>advanced [5]</b> 114/2 118/5 155/11 155/12 155/17	<b>ages [1]</b> 103/3	<b>alive [1]</b> 176/10	<b>already [13]</b> 13/1 23/11 24/16 29/20 39/5 51/5 55/3 63/22 69/11 70/14 78/17 79/22 97/20
<b>actually [34]</b> 6/4 8/25 18/16 18/23 24/3 25/20 46/6 53/5 53/9 53/19 56/11 61/22 63/14 65/8 66/24 69/10 75/19 76/20 78/19 79/16 83/19 88/15 92/18 96/22 99/12 103/24 104/23 104/25 111/14 112/6 121/20 123/18 129/19 137/22	<b>advancements [1]</b> 171/15	<b>agitated [2]</b> 14/12 14/13	<b>all [123]</b> 4/5 5/14 5/23 9/16 12/7 13/7 15/7 16/9 18/8 18/18 18/18 19/1 19/14 20/23 23/21 26/15 27/13 28/21 30/14 33/1 34/5 34/22 35/13 35/19 35/22 35/22 38/7 38/8 38/16 39/3 40/5 44/11 44/12 44/13 45/8 45/14 45/15 46/4 46/11 46/13 46/23 46/24 49/7 49/8 50/23 51/6 53/22 58/7 58/15 58/15 59/10 60/13 61/10 65/16 66/3 72/24 73/15 73/21 74/25 77/21 78/13 79/6 79/6 80/9 81/16 83/2 83/7 84/21 85/2 85/9 87/12 87/21 90/20 90/20 91/7 93/3 95/3 97/1 101/19 102/5 103/3 105/23 106/25 107/9 110/25 111/24 112/17 112/21 113/22 118/9 119/21 126/5 126/11 127/20 129/1 133/5 134/8 135/7 136/5 137/1 139/6 139/13 140/1 140/19 141/9 141/21 142/5 142/10 142/18 144/9 145/2 146/5 154/12 160/11 166/23 167/2 170/5 173/6 174/1 174/6 177/5 180/14 180/19	<b>also [69]</b> 3/18 5/19 7/13 8/2 9/11 10/12 11/9 11/18 11/23 12/21 14/17 14/23 15/2 16/13 16/25 17/15 21/20 22/1 23/11 25/24 27/1 27/6 27/24 28/3 29/16 29/19 29/23 30/17 37/16 38/19 39/8 59/17 60/6 61/9 70/15 71/6 71/7 72/3 72/10 73/7 73/7 73/9 75/5 83/23 85/7 87/4 95/6 97/22 110/4 110/12 111/21 112/10 122/4 123/23 127/15 147/3 149/13 150/22 155/7 158/3 158/9 160/15 160/22 161/22 163/19 169/11 171/13 179/2 181/15
<b>actually July [1]</b> 24/3	<b>Advances [1]</b> 153/13	<b>ago [3]</b> 10/4 21/2 24/2	<b>aligned [1]</b> 100/18	<b>alter [1]</b> 176/21
<b>acute [5]</b> 68/21 121/2 121/6 172/24 178/20	<b>adverse [2]</b> 120/13 163/7	<b>agony [1]</b> 67/5	<b>align [2]</b> 159/23 172/3	<b>alternative [2]</b> 103/19 103/23
<b>adapt [1]</b> 162/6	<b>advice [17]</b> 8/22 9/12 61/23 62/22 64/18 73/21 77/19 79/1 79/2 79/24 124/20 146/2 146/14 150/16 157/18 176/18 181/19	<b>agrees [1]</b> 175/16	<b>alignment [2]</b> 159/23 172/3	<b>although [6]</b> 83/10 108/24 125/20 165/10 166/8 177/23
<b>adapted [1]</b> 170/13	<b>advise [3]</b> 74/15 74/17 150/14	<b>Ahsan [18]</b> 59/4 59/6 59/8 59/13 59/14 59/15 60/9 65/17 67/24 78/9 86/12 98/10 99/20 105/11 106/25 107/3 107/4 183/8	<b>alignment [2]</b> 159/23 172/3	<b>always [4]</b> 22/8 41/22 132/20 148/15
<b>add [1]</b> 100/4	<b>advised [1]</b> 119/1	<b>aid [1]</b> 12/25	<b>alignment [2]</b> 159/23 172/3	<b>Alzheimer's [1]</b> 112/10
<b>added [2]</b> 13/2 148/21	<b>adviser [1]</b> 104/15	<b>aided [3]</b> 131/9	<b>alignment [2]</b> 159/23 172/3	<b>am [17]</b> 1/2 1/10 1/25 33/11 33/13 58/25 59/2 85/22 92/8 128/14 129/3 130/4 130/17 136/18 140/3
<b>Addenbrooke's [1]</b> 21/10	<b>Advisory [1]</b> 157/18		<b>alignment [2]</b> 159/23 172/3	
<b>adding [1]</b> 148/24	<b>advocate [2]</b> 86/18 87/2		<b>alignment [2]</b> 159/23 172/3	
<b>addition [1]</b> 25/23	<b>advocated [1]</b> 177/21		<b>alignment [2]</b> 159/23 172/3	
<b>additional [1]</b> 148/21	<b>advocates [1]</b> 143/4		<b>alignment [2]</b> 159/23 172/3	
<b>address [8]</b> 142/13 154/16 159/9 159/11 164/20 165/8 166/25 167/8	<b>advocating [1]</b> 32/24		<b>alignment [2]</b> 159/23 172/3	
<b>addressed [1]</b> 161/23	<b>aerosol [7]</b> 83/5 94/19 176/12 176/24 177/6 177/8 177/18		<b>alignment [2]</b> 159/23 172/3	
<b>addressing [1]</b> 142/22	<b>aerosol-generating [1]</b> 83/5		<b>alignment [2]</b> 159/23 172/3	
<b>adduced [2]</b> 154/13 167/25	<b>affirmed [6]</b> 1/8 33/17 59/6 183/4 183/6 183/8		<b>alignment [2]</b> 159/23 172/3	
<b>adequate [2]</b> 91/17 102/18	<b>afraid [3]</b> 66/12 107/8 121/11		<b>alignment [2]</b> 159/23 172/3	



<b>A</b>	28/14 34/18 46/17 50/4 50/12 50/15 52/15 63/1 69/19 71/20 71/22 73/21 75/3 76/1 77/20 89/23 105/11 106/20 115/23 117/14 120/24 121/1 122/16 128/5 132/23 133/16 134/2 138/1 139/4 139/14 139/25 141/5 144/15 152/19 162/21 165/7 165/12 173/4	177/21 180/12 <b>appropriately</b> [1] 132/21 <b>appropriateness</b> [1] 39/12 <b>approximately</b> [2] 115/18 133/19 <b>April</b> [5] 145/23 156/20 161/25 162/11 172/24 <b>April 2020</b> [1] 156/20 <b>apron</b> [5] 22/9 22/10 93/14 116/17 130/15 <b>are</b> [121] 1/3 2/19 6/1 7/13 11/8 11/8 12/18 13/16 14/19 14/20 14/20 15/13 16/5 17/2 17/4 18/6 19/6 20/4 20/6 21/20 27/8 27/11 27/13 29/7 30/18 32/23 32/24 35/1 36/12 36/19 36/21 42/10 42/11 42/17 42/19 50/23 50/24 52/16 53/7 54/1 56/24 57/10 57/19 58/1 59/22 59/23 60/1 60/3 60/13 61/4 63/4 65/11 65/13 65/23 68/2 71/21 73/9 75/16 77/7 77/25 78/1 78/13 84/25 86/12 87/14 89/18 93/17 96/21 100/3 101/13 102/10 105/14 105/15 106/6 106/8 106/8 106/15 107/8 108/13 108/16 115/7 115/8 116/10 120/20 122/24 124/10 125/22 126/3 126/25 127/19 128/15 131/8 132/18 139/1 140/1 141/3 142/4 145/5 146/18 146/23 150/23 151/4 151/15 153/13 153/18 153/20 153/23 159/7 160/21 165/11 166/18 167/3 167/16 169/23 170/5 170/7 175/13 175/23 180/19 181/10 182/5 <b>area</b> [13] 6/6 36/21 46/20 73/19 74/14 90/3 97/21 97/24 120/11 120/18 127/4 158/14 171/22 <b>areas</b> [12] 4/4 28/17 28/20 36/11 62/13 65/5 65/10 87/18 91/5 127/21 160/3 172/16 <b>aren't</b> [1] 25/7 <b>ARHAI</b> [1] 177/15 <b>arise</b> [2] 144/11 153/20	<b>arisen</b> [1] 156/8 <b>arising</b> [2] 156/2 165/9 <b>arm's</b> [1] 110/17 <b>arm's length</b> [1] 110/17 <b>arms</b> [2] 113/25 114/3 <b>Army</b> [2] 60/2 60/3 <b>arose</b> [2] 28/22 173/18 <b>around</b> [47] 8/4 16/11 16/14 16/16 16/20 19/5 19/10 21/20 23/2 23/19 29/5 29/23 30/1 35/20 38/23 39/11 39/20 41/25 43/1 43/4 43/5 43/8 43/22 46/23 52/7 57/7 57/8 60/13 72/15 74/12 91/1 100/16 102/4 108/23 110/7 110/10 111/16 113/21 115/16 118/16 120/17 130/6 139/21 154/24 155/21 158/4 163/20 <b>arrangements</b> [3] 165/21 166/1 167/4 <b>arranging</b> [1] 102/20 <b>arrival</b> [1] 81/1 <b>arrive</b> [3] 14/10 93/3 174/4 <b>arrived</b> [4] 9/1 40/24 41/11 52/22 <b>arriving</b> [1] 64/9 <b>articulate</b> [1] 32/24 <b>articulated</b> [1] 55/17 <b>as</b> [191] <b>as May</b> [1] 178/7 <b>Asian</b> [3] 102/2 102/7 179/15 <b>aside</b> [2] 47/3 124/23 <b>ask</b> [34] 20/9 31/15 51/7 54/21 59/15 59/19 67/20 71/13 74/1 82/6 86/7 88/24 92/15 96/19 98/3 98/10 98/16 99/20 101/2 104/13 105/7 107/3 111/23 113/10 117/3 122/15 123/13 128/2 131/8 134/8 137/6 137/21 139/4 140/15 <b>asked</b> [22] 14/10 18/24 20/11 24/25 25/22 27/19 38/23 40/3 41/9 54/17 64/25 70/22 71/22 74/10 78/4 117/18 117/21 117/24 118/13 120/4 154/20 160/24 <b>asking</b> [5] 102/18 106/12 112/6 112/10	112/13 <b>asking:</b> [1] 93/17 <b>asking: why</b> [1] 93/17 <b>aspect</b> [3] 23/16 152/19 181/9 <b>aspects</b> [4] 45/14 61/17 152/14 172/8 <b>aspirations</b> [1] 155/18 <b>assess</b> [2] 145/23 153/9 <b>assessed</b> [1] 163/15 <b>assessment</b> [11] 25/3 51/8 51/9 52/7 52/11 53/4 160/23 160/25 161/3 161/15 163/2 <b>assessments</b> [4] 146/23 174/8 174/10 179/13 <b>asset</b> [1] 53/7 <b>assist</b> [1] 58/19 <b>assistance</b> [3] 52/15 67/15 168/10 <b>assistant</b> [1] 111/13 <b>assisted</b> [1] 165/14 <b>assisting</b> [2] 116/4 116/13 <b>associated</b> [1] 103/22 <b>assume</b> [2] 94/3 142/22 <b>assumed</b> [2] 128/9 129/11 <b>assumption</b> [1] 50/22 <b>assurance</b> [2] 167/23 170/14 <b>asthma</b> [1] 80/12 <b>astomishing</b> [1] 27/23 <b>asymptomatic</b> [7] 9/10 23/19 24/7 37/19 37/21 145/17 145/19 <b>at</b> [174] 3/16 4/4 4/8 4/10 6/4 7/23 7/25 8/20 9/21 10/10 10/18 10/20 11/7 11/12 11/15 11/18 13/17 13/19 14/9 15/7 16/8 18/10 19/3 21/10 22/6 25/7 26/9 29/20 30/3 33/7 35/19 36/22 37/12 39/13 40/4 40/6 40/24 41/11 43/17 43/22 46/22 46/23 48/21 49/8 49/10 51/22 52/21 53/22 56/5 56/7 58/22 59/23 61/20 61/24 62/22 63/3 63/3 66/3 66/21 67/14 67/24 69/8 70/2 70/8 71/10 72/24 74/2
----------	---	--	---	--

<b>A</b>	<b>avoid [1]</b> 45/1	80/6 85/25	25/19 26/19 26/19	153/23 154/5 154/8
<b>at... [107]</b> 74/5 74/6	<b>avoidable [2]</b> 60/20	<b>basis [8]</b> 14/24 93/12	27/19 27/20 30/12	164/11 164/12 168/16
74/12 76/8 76/18 77/9	167/13	103/18 148/19 151/20	32/25 35/5 35/23	168/19 183/15 183/17
78/7 78/15 78/17	<b>avoided [1]</b> 155/21	152/10 161/21 162/14	35/24 36/9 37/7 38/11	183/20 183/22
78/20 79/13 79/18	<b>aware [6]</b> 10/14 87/9	<b>be [262]</b>	39/10 40/24 41/1 42/4	<b>behaviour [1]</b> 171/16
81/22 82/11 82/23	131/25 150/22 151/19	<b>bear [2]</b> 58/7 128/18	42/6 44/4 45/2 45/18	<b>behind [3]</b> 66/12
83/2 83/19 84/6 85/24	152/12	<b>bearing [3]</b> 62/11	45/21 45/22 46/25	89/16 154/2
86/7 86/9 86/11 87/4	<b>away [20]</b> 9/22 18/18	85/7 88/15	47/5 47/6 47/11 47/12	<b>being [101]</b> 6/3 7/7
87/12 88/4 90/3 90/6	35/10 35/15 36/5 51/1	<b>bears [1]</b> 56/21	49/23 49/23 50/5	8/3 8/21 9/13 10/22
91/19 92/22 93/13	57/20 63/13 66/3	<b>Beattie [1]</b> 168/22	50/16 50/17 54/13	15/9 15/13 15/15
93/22 93/23 95/7	73/15 73/21 92/12	<b>became [4]</b> 14/12	55/4 55/10 55/19	15/16 16/1 17/21 18/3
95/10 96/5 99/4 102/8	110/8 117/13 117/25	53/15 66/17 152/17	61/10 62/11 64/2	18/12 18/17 19/15
102/9 103/15 103/21	123/2 124/5 133/15	<b>because [114]</b> 2/18	64/21 71/22 72/23	21/21 21/24 22/7 22/8
104/9 104/15 105/20	135/6 136/13	9/3 11/10 14/13 17/14	73/20 74/12 75/10	22/9 27/6 31/9 35/3
107/22 109/13 111/8	<b>B</b>	20/4 22/18 25/2 25/5	77/5 80/5 82/13 83/11	35/14 35/14 35/25
111/15 114/10 114/12	<b>back [48]</b> 12/10	25/17 25/21 26/6	86/1 86/6 86/13 86/13	39/8 40/21 41/8 41/11
115/2 117/18 117/23	17/25 17/25 18/5	26/15 27/22 28/6	86/14 86/24 87/14	41/12 41/22 42/21
118/24 119/6 121/9	20/24 37/22 37/24	28/12 28/22 30/8	87/16 87/16 87/17	45/4 45/5 45/20 46/18
121/18 124/2 126/11	38/9 42/25 45/23	30/25 35/19 35/22	88/15 88/17 89/7 89/8	49/4 49/5 51/22 52/4
126/17 126/18 129/5	46/14 48/24 52/5	36/8 37/5 41/14 44/4	90/8 95/12 97/5 97/9	55/3 55/8 55/10 56/1
129/6 129/25 130/10	52/12 57/11 57/12	44/14 44/15 49/7	97/14 97/18 98/6	56/2 61/14 65/21
131/2 133/5 133/17	58/22 69/11 78/15	49/11 49/21 50/2	101/4 101/9 101/19	65/22 73/11 79/21
134/1 137/5 137/20	78/19 79/20 80/6	51/21 52/2 52/9 52/23	105/18 105/21 105/22	80/1 84/21 86/20
138/23 141/12 142/4	81/13 84/4 87/22	53/21 62/23 64/2	107/13 107/13 109/4	87/12 88/2 89/12
145/18 146/24 148/12	93/19 97/4 100/21	65/14 66/11 67/8	109/14 109/17 116/7	89/14 89/25 91/18
149/2 151/25 152/20	101/12 105/24 110/15	68/16 68/21 69/14	116/9 116/10 118/15	94/9 94/13 96/22
157/5 159/5 159/23	114/20 115/1 115/11	70/15 71/13 72/18	121/25 122/3 122/4	97/18 97/22 97/24
161/7 162/4 162/16	115/15 116/21 117/1	73/11 73/25 81/17	122/21 122/25 126/2	99/14 99/25 100/3
162/24 163/20 164/5	120/5 120/7 121/5	81/20 82/6 83/14	126/3 126/7 126/8	101/12 101/13 102/5
166/13 166/23 167/18	124/6 124/9 125/4	83/17 86/1 86/7 87/6	127/9 127/11 128/18	103/16 105/10 110/24
170/4 170/21 171/4	125/9 127/22 130/7	87/15 87/19 88/19	129/9 131/20 132/12	115/10 115/17 123/23
172/9 173/2 173/6	132/6 133/25	90/11 90/18 91/11	133/18 133/22 136/4	124/1 124/21 126/1
174/4 176/3 176/11	<b>backed [1]</b> 175/17	91/12 91/16 92/10	143/15 144/7 150/18	131/1 132/20 132/22
176/20 178/15 179/22	<b>background [5]</b> 36/6	95/5 95/6 95/24 96/14	154/20 156/20 158/5	132/24 142/4 143/5
181/9 181/11 181/15	59/22 63/19 71/2	99/18 100/20 101/19	158/9 159/1 160/12	144/8 148/1 148/21
182/12	75/22	103/16 105/3 110/7	163/2 163/4 163/11	153/8 160/20 163/15
<b>at all [12]</b> 15/7 35/19	<b>backlog [1]</b> 29/9	113/17 115/8 115/21	163/23 164/2 165/5	172/12 173/5 173/19
46/23 53/22 66/3	<b>backup [1]</b> 172/24	116/3 117/17 117/19	166/19 166/22 167/25	176/21 177/13 177/21
72/24 83/2 87/12	<b>bad [5]</b> 72/12 72/14	117/20 118/5 118/12	173/21 175/11 177/1	178/4
126/11 133/5 166/23	90/4 94/12 126/23	118/23 120/3 120/25	180/9 180/11 181/20	<b>Belfast [2]</b> 162/23
173/6	<b>baffling [1]</b> 9/3	121/8 122/21 124/10	182/9	163/15
<b>attached [1]</b> 27/18	<b>bag [4]</b> 18/4 128/8	125/18 127/17 128/11	<b>before [41]</b> 13/23	<b>beliefs [1]</b> 155/17
<b>attempt [2]</b> 17/9	135/13 136/17	128/23 130/3 130/11	14/2 21/5 25/1 25/24	<b>believe [4]</b> 12/5
154/21	<b>balance [4]</b> 43/12	131/14 135/7 136/9	30/17 36/1 61/12 65/5	80/21 93/10 171/19
<b>attend [1]</b> 35/17	69/20 147/16 180/10	138/17 138/22 138/23	72/17 74/2 77/4 80/20	<b>believed [1]</b> 53/21
<b>attention [5]</b> 33/21	<b>balanced [1]</b> 174/4	139/6 139/15 139/19	84/4 85/6 86/23 87/25	<b>believes [1]</b> 164/5
59/10 107/7 107/10	<b>balancing [1]</b> 149/2	140/7 140/16 150/1	88/18 92/13 97/11	<b>belongings [3]</b> 17/20
142/16	<b>ball [1]</b> 72/14	150/4 158/16 163/9	99/6 109/4 113/13	17/21 40/2
<b>attest [1]</b> 39/19	<b>BAME [1]</b> 150/21	169/17 170/8	113/14 113/18 113/18	<b>BEMIS [1]</b> 174/17
<b>attorney [4]</b> 15/2	<b>Bamrah [1]</b> 174/18	<b>become [4]</b> 56/11	114/19 117/1 118/25	<b>Ben [2]</b> 147/10
15/4 16/18 39/22	<b>bank [1]</b> 39/7	61/12 90/12 174/10	122/15 122/16 138/11	177/23
<b>attributed [1]</b> 6/11	<b>bar [1]</b> 82/14	<b>becoming [3]</b> 68/22	139/7 140/25 141/17	<b>beneath [2]</b> 133/4
<b>auditable [1]</b> 27/17	<b>bare [1]</b> 164/4	70/16 122/6	142/20 143/1 153/15	133/4
<b>August [1]</b> 176/23	<b>barely [1]</b> 7/22	<b>bed [9]</b> 28/4 85/22	163/1 165/16 169/17	<b>beneficial [3]</b> 47/11
<b>automated [2]</b> 79/25	<b>base [3]</b> 144/20	88/6 88/13 89/2	<b>began [4]</b> 96/24	50/16 50/18
80/2	148/6 149/16	104/21 135/12 136/16	106/22 159/4 181/22	<b>benefit [5]</b> 47/5 149/2
<b>autumn [1]</b> 109/18	<b>based [7]</b> 43/8 86/5	173/11	<b>begin [2]</b> 141/6	169/12 170/11 175/9
<b>availability [3]</b> 38/2	144/16 155/4 157/4	<b>bedside [4]</b> 82/12	153/22	<b>benefits [4]</b> 147/16
39/11 164/23	162/11 173/4	86/8 131/2 131/19	<b>beginning [7]</b> 73/5	152/5 160/7 175/14
<b>available [9]</b> 5/14	<b>baseline [1]</b> 173/3	<b>been [146]</b> 1/12 4/20	74/2 92/22 107/8	<b>bereaved [56]</b> 1/14
24/5 48/22 144/16	<b>basic [2]</b> 114/9	4/22 5/5 5/11 10/11	109/13 176/9 178/15	2/2 3/16 34/2 34/5
157/25 160/21 164/25	118/17	10/14 10/16 18/15	<b>behalf [19]</b> 32/24	35/3 35/25 36/9 36/12
174/19 179/6	<b>basically [3]</b> 24/4	18/20 19/7 21/8 21/9	34/5 56/20 60/5 60/6	36/18 40/20 42/10
		21/9 23/8 23/14 25/15	142/13 143/10 143/14	44/12 47/6 51/12

**B**  
**bereaved... [41]**  
53/11 54/6 54/22  
54/24 55/20 56/18  
56/20 59/18 59/21  
60/11 60/17 61/5  
64/20 65/14 67/22  
68/14 73/9 90/25  
108/8 108/17 108/19  
108/20 108/20 109/8  
109/18 109/24 110/2  
110/5 110/6 113/22  
116/8 125/23 126/5  
126/8 127/19 132/20  
134/10 137/24 137/24  
154/24 164/16  
**Bereaved's [2]** 39/16  
68/3  
**bereavement [7]**  
30/10 34/11 34/18  
60/19 97/1 139/22  
139/23  
**best [12]** 33/5 50/13  
58/7 58/14 71/21 84/9  
103/1 146/24 151/7  
161/13 166/16 180/13  
**better [19]** 18/25  
70/12 73/10 73/20  
106/6 108/14 140/14  
144/25 149/21 149/23  
153/4 159/19 159/20  
159/23 159/25 160/12  
165/13 175/1 179/10  
**between [20]** 5/17  
10/24 22/3 27/5 28/2  
35/25 43/13 62/7  
62/15 66/21 104/23  
105/8 111/7 127/23  
146/10 146/14 147/22  
167/9 171/24 177/8  
**beyond [2]** 12/8  
24/17  
**big [12]** 31/9 36/15  
74/25 75/6 75/6 75/24  
75/24 77/1 82/14  
82/15 87/8 136/4  
**biggest [1]** 12/1  
**billion [2]** 106/3  
106/4  
**bin [1]** 18/4  
**biological [1]** 143/23  
**birthday [1]** 34/14  
**biscuits [1]** 18/2  
**bit [7]** 76/2 76/10  
92/15 95/23 113/21  
137/19 143/1  
**bizarrely [1]** 83/24  
**black [3]** 102/2 102/6  
179/15  
**blame [3]** 34/23 57/3  
75/4  
**blanket [2]** 155/3  
155/6

**blocked [1]** 80/20  
**blood [2]** 90/6 97/4  
**bloods [1]** 97/4  
**blue [1]** 82/19  
**BMA [2]** 44/24  
178/17  
**board [15]** 2/14 8/12  
11/3 11/10 17/6 24/2  
40/15 53/17 56/19  
71/10 79/6 136/12  
171/12 173/15 178/20  
**board's [1]** 10/3  
**boarding [1]** 37/16  
**boards [20]** 5/16  
5/19 5/21 6/1 11/16  
11/18 18/22 22/16  
23/1 23/22 23/23 27/7  
30/11 31/21 44/1  
50/11 171/25 179/12  
180/12 180/14  
**boards' [2]** 167/14  
167/20  
**bodies [10]** 3/19 3/20  
18/11 18/13 60/21  
110/17 111/1 142/2  
151/12 166/3  
**body [7]** 18/16  
135/10 135/13 136/17  
136/18 136/22 151/6  
**boil [1]** 106/20  
**bold [1]** 43/5  
**bolted [2]** 70/14  
70/15  
**bonus [1]** 170/14  
**Boris [2]** 110/23  
112/1  
**Boris Johnson [2]**  
110/23 112/1  
**both [17]** 19/16 19/20  
36/3 40/23 44/5 44/5  
49/13 49/23 49/23  
56/21 73/2 73/2 81/19  
109/9 134/21 150/17  
157/1  
**bother [2]** 7/19  
140/16  
**bought [2]** 106/13  
179/7  
**boundaries [2]** 170/4  
180/24  
**brain [1]** 119/23  
**branch [3]** 108/20  
109/21 110/1  
**branches [1]** 63/11  
**brave [1]** 52/14  
**breaches [1]** 45/12  
**bread [1]** 110/7  
**breadth [1]** 3/12  
**break [8]** 33/5 33/12  
59/1 85/16 101/7  
140/24 141/2 141/14  
**breaking [1]** 95/15  
**breaks [2]** 85/4 141/5  
**breath [5]** 6/17 88/9

88/9 101/13 104/21  
**breathe [1]** 88/13  
**breathing [1]** 81/21  
**breaths [1]** 35/9  
**Brenda [1]** 109/20  
**Brewer [4]** 65/7  
65/17 66/3 66/17  
**bridge [1]** 105/8  
**bridged [1]** 105/12  
**briefing [2]** 75/1 75/6  
**briefly [2]** 23/17 77/3  
**brilliant [1]** 135/21  
**bring [9]** 38/9 78/19  
89/21 100/21 105/24  
107/7 107/9 152/5  
159/20  
**bringing [2]** 23/20  
152/25  
**brings [1]** 143/24  
**British [1]** 60/2  
**broad [1]** 153/11  
**broadcast [1]** 9/24  
**broadcaster [1]** 71/3  
**broadcasts [1]** 9/17  
**broadened [1]**  
151/21  
**broadly [1]** 54/3  
**broke [1]** 94/25  
**broken [1]** 99/4  
**brother [3]** 52/18  
99/8 126/12  
**brother's [1]** 99/20  
**brought [9]** 24/3  
61/10 69/19 70/9 99/3  
100/25 136/20 149/5  
172/21  
**BSL [1]** 9/17  
**build [7]** 20/25 21/15  
29/5 29/24 106/16  
106/18 106/19  
**building [3]** 20/24  
21/15 29/9  
**built [3]** 21/5 45/5  
57/19  
**bump [1]** 7/20  
**bundle [1]** 40/2  
**bundle of [1]** 40/2  
**buried [2]** 119/14  
119/23  
**burn [1]** 17/21  
**burnout [2]** 96/25  
101/5  
**bus [1]** 78/4  
**busiest [1]** 76/25  
**busy [6]** 16/5 16/7  
63/15 83/19 83/21  
127/7  
**but [247]**  
**butterfly [7]** 131/7  
131/9 131/20 131/24  
132/1 132/4 132/8  
**buy [2]** 106/13  
106/15  
**bypassed [1]** 21/18

**C**  
**Cabinet [4]** 37/1  
172/6 174/13 176/20  
**cadre [1]** 152/11  
**call [32]** 1/6 3/7 6/3  
11/24 32/14 33/14  
48/25 49/6 49/10  
74/10 76/19 77/22  
79/5 79/12 79/16  
79/17 79/20 80/1 80/6  
102/8 108/18 115/12  
118/24 119/20 119/25  
123/6 123/7 123/14  
125/24 126/16 137/10  
181/21  
**call-outs [1]** 181/21  
**callbacks [1]** 6/1  
**called [10]** 6/9 52/24  
66/19 74/25 79/12  
120/13 143/16 144/10  
159/19 166/7  
**calling [6]** 7/6 7/14  
52/1 61/18 62/1 73/10  
**calls [8]** 5/2 12/20  
15/25 30/16 50/5 77/6  
86/19 102/6  
**calm [2]** 88/16  
135/22  
**Cambridge [2]** 21/10  
59/24  
**came [29]** 2/8 2/10  
7/24 40/2 54/19 62/2  
63/24 66/15 72/4  
72/21 75/3 77/18  
81/13 85/12 97/4  
104/12 119/13 120/17  
121/13 121/19 123/19  
125/4 130/7 132/6  
133/25 136/1 136/21  
138/4 140/8  
**camera [1]** 143/4  
**campaign [3]** 13/10  
32/9 60/14  
**campaigned [1]**  
60/18  
**campaigning [3]**  
109/23 129/10 138/11  
**can [113]** 1/5 1/10  
1/17 1/21 2/21 2/25  
2/25 3/1 14/16 19/3  
24/17 26/25 28/8  
29/21 31/8 33/6 37/8  
39/19 41/25 42/14  
43/7 45/23 50/2 50/2  
50/4 50/19 58/8 58/11  
58/23 59/19 60/10  
61/1 62/16 65/9 65/11  
65/12 67/20 68/23  
68/24 68/24 69/13  
69/14 69/20 71/13  
73/12 73/13 73/14  
73/25 74/20 75/15  
78/9 78/11 78/25

80/10 82/10 83/2 86/7  
89/21 90/16 91/13  
92/15 95/1 95/4 96/19  
98/3 98/3 98/10 98/16  
99/20 100/21 101/2  
105/3 105/7 106/16  
111/6 111/23 113/2  
113/10 113/19 113/20  
117/3 118/23 123/12  
123/22 127/22 128/1  
129/5 130/1 131/8  
134/8 136/9 137/21  
139/2 139/3 141/17  
141/18 142/12 143/12  
147/1 147/9 147/18  
147/20 148/7 150/6  
151/14 153/9 153/14  
153/15 163/25 169/19  
171/21 173/9 181/11  
**can't [27]** 1/11 12/4  
12/6 21/7 25/9 25/9  
27/16 33/20 45/24  
48/14 48/14 48/15  
54/2 59/8 64/6 73/13  
79/15 79/25 83/3  
106/13 108/6 108/8  
114/2 120/23 127/1  
135/15 135/18  
**cancelled [1]** 172/17  
**cancer [6]** 54/12  
67/17 100/12 100/13  
119/23 172/17  
**candidate [2]** 59/23  
86/1  
**candidly [1]** 174/12  
**cannot [6]** 31/5 73/12  
101/22 150/14 169/5  
169/6  
**canvas [1]** 15/20  
**capabilities [1]** 144/2  
**capability [1]** 170/18  
**capacity [20]** 16/18  
37/12 37/22 40/10  
50/6 50/8 84/6 84/10  
121/6 157/24 164/22  
164/23 171/2 172/9  
172/11 173/2 173/7  
173/12 173/23 181/11  
**car [1]** 7/21  
**cardinal [1]** 6/22  
**cardiopulmonary [1]**  
154/22  
**care [130]** 2/19 4/6  
4/6 10/22 10/25 11/5  
24/23 27/6 29/24  
29/24 30/1 30/7 30/19  
37/2 41/13 42/16  
42/17 43/8 44/17 45/4  
46/13 51/15 54/23  
56/6 56/14 57/11  
57/11 57/23 61/24  
63/3 64/4 68/16 68/24  
68/24 72/9 82/7 84/8  
84/9 84/13 85/8 86/5

<b>C</b>	25/20	<b>Channel [2]</b> 72/10 102/21	165/8 176/11	144/5
<b>care...</b> [89] 86/5 86/6 86/7 86/11 86/13 87/7 87/13 87/16 88/20 88/25 91/21 97/23 98/23 98/23 104/25 110/20 111/9 111/14 112/4 112/13 113/2 113/20 114/9 114/21 115/1 115/12 117/1 118/14 118/17 118/25 119/25 121/2 121/3 121/6 122/1 125/25 126/25 128/19 129/3 129/6 129/11 129/13 129/15 130/23 131/13 133/7 136/10 136/10 138/12 138/14 143/18 155/11 155/12 155/17 155/19 156/15 156/24 157/5 159/3 159/22 160/16 160/17 160/18 161/5 161/12 161/13 161/19 161/20 161/24 162/2 163/14 163/20 164/2 164/23 169/14 169/21 169/22 170/2 170/5 170/8 172/19 173/4 173/8 173/25 180/13 180/21 181/1 181/18 182/3	<b>catheter [3]</b> 80/20 81/9 81/10 <b>caught [6]</b> 72/19 80/15 80/24 99/9 99/17 102/19 <b>cause [2]</b> 38/24 150/6 <b>caused [1]</b> 73/7 <b>causing [1]</b> 178/3 <b>CBFFJ [1]</b> 71/14 <b>ceiling [3]</b> 86/5 88/20 88/25 <b>ceilings [1]</b> 84/13 <b>cell [5]</b> 145/24 146/2 146/4 146/7 151/19 <b>cemetery [1]</b> 137/13 <b>central [6]</b> 75/6 149/18 155/15 161/1 161/2 161/11 <b>centrally [4]</b> 69/25 74/23 92/25 92/25 <b>centre [3]</b> 52/11 162/25 163/5 <b>centred [3]</b> 43/9 57/11 160/18 <b>centres [8]</b> 51/8 51/9 52/7 53/4 53/14 156/19 157/2 181/6 <b>CEO [1]</b> 156/6 <b>CEOs [1]</b> 173/15 <b>certain [3]</b> 47/7 47/8 102/16 <b>certainly [15]</b> 4/10 4/11 13/19 53/13 62/20 67/13 71/15 74/5 74/8 78/23 133/6 141/2 142/15 170/21 175/19 <b>cetera [6]</b> 63/17 74/22 79/7 81/16 93/2 94/21 <b>CEV [1]</b> 148/19 <b>chair [2]</b> 11/7 142/22 <b>chaired [1]</b> 157/19 <b>challenged [4]</b> 61/21 62/16 63/10 63/12 <b>challenges [7]</b> 28/23 63/6 63/8 63/13 63/20 179/10 179/18 <b>challenging [4]</b> 65/11 73/6 83/14 104/19 <b>chance [5]</b> 39/9 49/20 120/25 121/1 136/25 <b>change [9]</b> 14/18 81/9 138/4 138/10 138/21 139/15 139/16 140/12 181/6 <b>changed [6]</b> 29/12 39/9 77/14 92/21 93/25 131/1 <b>changes [2]</b> 19/2 159/11	<b>Channel 4 [2]</b> 72/10 102/21 <b>chaos [2]</b> 18/8 136/9 <b>chapel [1]</b> 137/9 <b>characterise [1]</b> 177/11 <b>charge [7]</b> 46/21 68/12 79/10 79/11 127/8 128/10 136/6 <b>chargeable [2]</b> 5/19 5/22 <b>charities [1]</b> 141/25 <b>charts [2]</b> 117/19 117/24 <b>check [4]</b> 1/21 18/3 114/20 133/20 <b>checked [2]</b> 5/9 114/14 <b>cheeky [1]</b> 31/9 <b>chest [2]</b> 40/1 81/22 <b>chew [1]</b> 118/6 <b>chief [10]</b> 3/25 8/9 31/20 43/20 45/15 70/2 129/25 152/15 152/17 173/15 <b>chief executive [2]</b> 129/25 152/17 <b>children [2]</b> 136/25 160/4 <b>chills [1]</b> 6/16 <b>chin [2]</b> 21/25 132/22 <b>China [1]</b> 75/15 <b>chins [1]</b> 133/4 <b>choice [6]</b> 7/25 35/18 35/19 45/25 145/1 155/13 <b>choking [1]</b> 131/1 <b>Chowdhury [1]</b> 102/13 <b>Chris [2]</b> 4/1 175/17 <b>Christmas [5]</b> 63/17 118/25 119/17 123/12 127/23 <b>chronic [1]</b> 166/16 <b>church [1]</b> 137/9 <b>circumstances [7]</b> 20/13 35/12 35/14 47/7 112/9 112/11 154/25 <b>cited [1]</b> 149/12 <b>City [2]</b> 162/24 163/15 <b>civil [1]</b> 104/9 <b>clarify [1]</b> 94/2 <b>clarity [1]</b> 41/20 <b>clean [2]</b> 21/17 114/4 <b>cleans [1]</b> 21/12 <b>clear [18]</b> 15/22 27/9 41/7 41/7 41/10 41/22 43/7 47/1 47/10 55/9 56/25 57/1 61/19 61/23 148/15 155/2	<b>clearer [1]</b> 47/18 <b>clearly [19]</b> 6/14 23/11 24/6 66/14 71/10 76/15 82/9 86/7 95/7 98/22 113/1 119/16 123/6 127/19 134/8 151/2 165/7 170/16 178/16 <b>Client [1]</b> 110/19 <b>clinical [18]</b> 14/24 30/1 46/20 65/8 75/4 75/12 101/8 101/9 145/18 148/5 148/19 150/3 152/14 152/19 167/20 180/15 181/16 181/19 <b>clinically [6]</b> 32/9 73/23 85/10 148/17 148/18 153/5 <b>clinician [2]</b> 61/8 62/1 <b>clinician's [1]</b> 155/4 <b>clinicians [7]</b> 30/15 41/24 42/2 98/11 115/6 123/22 152/25 <b>clinics [1]</b> 98/1 <b>close [3]</b> 33/21 176/7 182/10 <b>closed [4]</b> 4/11 4/12 10/16 53/14 <b>closely [1]</b> 173/11 <b>closer [1]</b> 140/13 <b>closing [19]</b> 141/6 141/16 141/17 142/25 143/10 151/17 154/5 154/7 164/12 164/20 167/22 168/3 168/16 168/19 183/14 183/15 183/17 183/20 183/22 <b>clothes [2]</b> 131/1 136/20 <b>cluster [5]</b> 10/14 20/2 20/2 26/22 47/12 <b>clusters [2]</b> 10/1 56/9 <b>Clwyd [1]</b> 67/3 <b>CMO [3]</b> 173/4 176/9 176/18 <b>co [6]</b> 2/1 59/18 109/20 152/16 152/24 161/16 <b>co-lead [1]</b> 109/20 <b>co-leader [1]</b> 2/1 <b>co-ordinating [2]</b> 152/16 152/24 <b>co-ordination [1]</b> 161/16 <b>cobbled [1]</b> 18/21 <b>cobbled-together [1]</b> 18/21 <b>cohort [1]</b> 150/23 <b>coincided [1]</b> 83/19 <b>Colin [1]</b> 178/19 <b>collaborating [1]</b>	<b>collaboration [2]</b> 160/18 170/10 <b>collaborative [1]</b> 171/24 <b>collaboratively [1]</b> 146/8 <b>collated [1]</b> 159/14 <b>collating [1]</b> 165/22 <b>colleague [2]</b> 39/7 79/8 <b>colleagues [7]</b> 74/24 75/13 84/1 84/1 94/9 101/18 101/23 <b>collected [1]</b> 157/4 <b>collection [5]</b> 156/22 158/4 158/5 158/10 174/23 <b>collects [2]</b> 151/10 167/1 <b>College [1]</b> 59/25 <b>colleges [1]</b> 141/23 <b>combative [1]</b> 104/18 <b>come [41]</b> 12/10 16/9 35/13 52/5 54/18 57/11 57/12 58/8 58/22 62/1 64/12 64/13 66/10 66/11 66/14 68/21 68/22 69/6 70/13 70/23 75/8 77/9 82/3 83/20 85/13 93/6 97/15 97/20 116/6 118/12 118/23 121/3 121/16 125/18 127/22 129/17 133/2 133/20 135/3 149/24 151/23 <b>comes [2]</b> 20/24 174/9 <b>comfort [4]</b> 35/9 44/3 44/9 49/13 <b>comfortable [2]</b> 92/5 143/5 <b>comforted [1]</b> 50/3 <b>comforting [1]</b> 49/9 <b>coming [24]</b> 1/14 33/22 62/2 62/6 68/15 69/9 69/24 72/11 73/17 74/6 74/11 75/14 75/15 78/21 78/23 80/4 92/23 92/25 98/25 99/7 99/16 100/10 103/19 136/15 <b>commend [1]</b> 166/12 <b>comment [1]</b> 53/19 <b>comments [2]</b> 69/25 158/3 <b>commission [1]</b> 72/13 <b>commissioned [3]</b> 60/2 172/22 175/12 <b>Commissioner [3]</b> 110/21 110/22 111/15

<p><b>C</b></p> <p><b>Commissioner for [1]</b> 110/21</p> <p><b>commitment [2]</b> 164/3 164/7</p> <p><b>committed [1]</b> 151/12</p> <p><b>committee [1]</b> 60/1</p> <p><b>common [1]</b> 25/12</p> <p><b>commonality [1]</b> 11/12</p> <p><b>commonly [1]</b> 37/15</p> <p><b>comms [1]</b> 24/10</p> <p><b>communicate [4]</b> 12/9 91/3 91/3 117/5</p> <p><b>communicated [6]</b> 10/1 10/18 10/18 13/12 42/15 57/25</p> <p><b>communicating [3]</b> 10/7 117/4 117/14</p> <p><b>communication [35]</b> 12/12 12/21 12/21 13/13 15/22 15/23 15/25 16/13 16/16 17/15 17/16 17/18 18/18 18/25 30/2 39/15 40/19 41/4 41/7 41/21 42/20 42/23 47/10 47/10 57/13 71/25 89/25 91/1 126/20 127/2 127/20 128/25 147/18 155/1 158/23</p> <p><b>communications [1]</b> 8/11</p> <p><b>communities [2]</b> 159/21 169/1</p> <p><b>community [9]</b> 24/24 63/19 66/9 102/2 102/7 102/23 160/8 160/20 172/18</p> <p><b>comorbidities [2]</b> 9/4 84/7</p> <p><b>company [1]</b> 122/21</p> <p><b>compared [2]</b> 35/4 147/12</p> <p><b>compassion [7]</b> 31/1 43/8 45/4 46/14 57/11 57/23 169/22</p> <p><b>compassionate [5]</b> 30/2 30/13 41/6 82/3 83/20</p> <p><b>compassionately [1]</b> 45/17</p> <p><b>competing [1]</b> 153/20</p> <p><b>complained [1]</b> 40/15</p> <p><b>complaint [1]</b> 4/21</p> <p><b>complaints [2]</b> 3/6 30/16</p> <p><b>completed [1]</b> 141/8</p> <p><b>completely [7]</b> 9/3 17/5 39/4 40/23 87/23</p>	<p>111/8 162/17</p> <p><b>complex [3]</b> 63/10 63/12 165/3</p> <p><b>complexities [1]</b> 34/19</p> <p><b>compliance [2]</b> 132/23 132/24</p> <p><b>complicated [1]</b> 5/23</p> <p><b>component [2]</b> 56/3 160/7</p> <p><b>components [1]</b> 145/6</p> <p><b>composition [1]</b> 158/11</p> <p><b>comprehensive [1]</b> 170/21</p> <p><b>comprises [1]</b> 180/6</p> <p><b>compromise [1]</b> 129/21</p> <p><b>concentrate [1]</b> 165/2</p> <p><b>concept [1]</b> 21/17</p> <p><b>conceptually [1]</b> 149/3</p> <p><b>concern [15]</b> 4/4 4/7 39/14 39/16 40/21 41/11 64/21 67/21 91/2 100/10 100/10 107/10 121/8 126/5 166/19</p> <p><b>concerned [8]</b> 71/15 94/13 120/5 120/6 120/7 127/19 156/3 173/7</p> <p><b>concerning [1]</b> 175/2</p> <p><b>concerns [32]</b> 6/8 9/25 10/21 16/14 17/17 19/5 19/7 21/20 22/1 23/18 25/23 25/25 27/1 42/19 61/1 61/5 62/25 63/1 64/14 64/20 68/1 68/3 71/7 98/18 99/20 100/23 125/23 130/23 137/23 154/24 178/14 179/4</p> <p><b>concerted [1]</b> 179/5</p> <p><b>concluded [1]</b> 145/20</p> <p><b>conclusion [3]</b> 149/18 163/22 180/17</p> <p><b>condition [7]</b> 5/2 28/6 52/23 66/15 68/16 68/23 148/20</p> <p><b>conditions [8]</b> 49/19 68/17 98/22 98/24 100/12 142/1 166/9 170/13</p> <p><b>condolences [2]</b> 169/7 181/25</p> <p><b>conduct [1]</b> 64/24</p> <p><b>conducted [1]</b> 95/12</p> <p><b>conferences [1]</b> 70/1</p> <p><b>confident [1]</b> 15/16</p> <p><b>confines [1]</b> 76/13</p> <p><b>confining [1]</b> 102/15</p>	<p><b>confirmed [1]</b> 74/12</p> <p><b>confirming [1]</b> 121/22</p> <p><b>conflated [1]</b> 157/22</p> <p><b>conflicting [2]</b> 6/8 8/11</p> <p><b>confused [1]</b> 69/24</p> <p><b>confusing [5]</b> 6/8 8/6 8/11 62/3 70/7</p> <p><b>confusion [8]</b> 17/1 18/8 70/11 74/20 76/8 156/2 156/4 156/8</p> <p><b>connect [2]</b> 110/3 110/3</p> <p><b>connected [2]</b> 104/24 109/20</p> <p><b>connection [3]</b> 48/5 48/7 48/8</p> <p><b>connections [1]</b> 109/17</p> <p><b>conscious [2]</b> 112/6 154/23</p> <p><b>consensus [5]</b> 69/23 71/6 71/20 145/20 146/6</p> <p><b>consent [5]</b> 39/22 40/3 40/11 40/24 124/3</p> <p><b>consequence [1]</b> 97/19</p> <p><b>consequences [1]</b> 173/8</p> <p><b>consequent [1]</b> 172/3</p> <p><b>consequently [1]</b> 180/7</p> <p><b>consider [7]</b> 29/3 44/6 44/7 62/20 138/2 157/12 159/12</p> <p><b>considerable [1]</b> 40/25</p> <p><b>consideration [2]</b> 144/20 165/17</p> <p><b>considerations [1]</b> 174/4</p> <p><b>considered [4]</b> 147/6 165/12 166/11 176/15</p> <p><b>considering [3]</b> 56/19 56/21 165/4</p> <p><b>considers [5]</b> 30/6 155/22 156/16 158/1 167/2</p> <p><b>consist [1]</b> 166/5</p> <p><b>consistency [8]</b> 11/16 22/12 46/23 51/4 71/9 130/24 166/2 167/19</p> <p><b>consistent [2]</b> 22/21 165/25</p> <p><b>consistently [7]</b> 43/3 43/7 43/19 43/24 44/14 45/7 46/10</p> <p><b>constant [3]</b> 69/4 69/5 69/5</p>	<p><b>constructive [1]</b> 32/20</p> <p><b>consult [3]</b> 17/9 53/25 54/1</p> <p><b>consultant [4]</b> 84/19 85/11 85/19 106/14</p> <p><b>consultants [1]</b> 79/9</p> <p><b>consultation [2]</b> 4/17 16/20</p> <p><b>consultations [2]</b> 4/17 54/9</p> <p><b>consulted [3]</b> 15/6 16/22 18/23</p> <p><b>contact [7]</b> 3/1 4/24 17/6 47/24 51/20 93/6 144/18</p> <p><b>contacted [10]</b> 111/10 111/19 111/21 120/3 120/4 123/4 129/24 137/9 138/6 138/7</p> <p><b>contacting [1]</b> 111/24</p> <p><b>contaminated [2]</b> 21/16 144/19</p> <p><b>contemplated [1]</b> 87/13</p> <p><b>content [1]</b> 103/15</p> <p><b>context [3]</b> 74/20 113/21 171/10</p> <p><b>continue [4]</b> 168/9 169/9 169/17 182/2</p> <p><b>continued [4]</b> 111/5 112/19 133/10 163/19</p> <p><b>continues [4]</b> 60/20 163/12 168/10 177/5</p> <p><b>continuing [1]</b> 166/10</p> <p><b>contracted [3]</b> 20/13 56/16 96/20</p> <p><b>contradictory [1]</b> 17/2</p> <p><b>contrast [1]</b> 180/20</p> <p><b>contrasting [2]</b> 92/7 175/4</p> <p><b>contribute [1]</b> 150/16</p> <p><b>contributed [1]</b> 176/12</p> <p><b>contributing [2]</b> 87/22 146/15</p> <p><b>contribution [3]</b> 145/11 164/3 177/6</p> <p><b>contributory [3]</b> 37/11 37/17 39/5</p> <p><b>contrition [1]</b> 32/7</p> <p><b>control [16]</b> 18/25 19/6 36/23 43/13 45/13 68/7 68/10 68/10 120/16 144/9 149/11 155/14 161/1 161/2 161/11 176/3</p> <p><b>controlled [1]</b> 26/25</p> <p><b>controls [1]</b> 147/5</p> <p><b>conversation [4]</b></p>	<p>114/17 123/13 153/17 153/21</p> <p><b>conversations [7]</b> 84/12 91/9 92/1 120/2 155/23 173/13 180/23</p> <p><b>conversely [1]</b> 19/16</p> <p><b>conveyance [1]</b> 181/21</p> <p><b>copies [1]</b> 27/11</p> <p><b>copy [1]</b> 1/21</p> <p><b>core [2]</b> 169/20 169/25</p> <p><b>corner [1]</b> 130/6</p> <p><b>Coronavirus [1]</b> 159/13</p> <p><b>Corps [1]</b> 60/3</p> <p><b>correct [32]</b> 2/4 2/6 2/7 4/1 4/2 4/13 6/6 6/7 6/20 6/21 7/12 8/24 11/4 11/24 12/15 14/3 15/2 16/21 16/22 19/12 34/3 34/9 34/15 36/14 60/25 84/8 102/16 108/21 108/22 109/5 109/6 162/25</p> <p><b>correctly [1]</b> 62/4</p> <p><b>corridor [1]</b> 129/20</p> <p><b>corridors [1]</b> 19/18</p> <p><b>cost [4]</b> 29/13 29/13 168/24 181/23</p> <p><b>costs [1]</b> 175/14</p> <p><b>cough [1]</b> 6/17</p> <p><b>could [55]</b> 1/12 2/8 3/3 4/15 5/10 7/22 9/9 10/20 16/24 18/24 21/8 26/16 32/5 34/23 35/16 41/9 44/9 45/1 46/6 61/21 62/21 64/15 68/4 69/18 71/23 72/18 72/24 73/20 74/7 84/20 85/8 85/14 85/17 87/10 88/8 95/7 104/5 105/12 105/12 109/10 111/17 112/8 114/22 116/22 117/18 121/2 149/23 151/1 151/21 152/24 165/19 166/7 176/6 178/25 179/24</p> <p><b>couldn't [16]</b> 3/6 14/6 31/3 40/5 44/19 44/19 45/21 45/22 47/17 52/19 53/22 64/10 84/20 85/5 104/21 112/7</p> <p><b>Council [1]</b> 110/19</p> <p><b>counsel [12]</b> 1/9 33/18 38/23 59/7 108/5 142/13 157/8 168/21 183/5 183/7 183/9 183/12</p> <p><b>Counterintuitively [1]</b> 180/25</p> <p><b>countries [1]</b> 70/9</p>
--	--	---	--	--

<b>C</b>	<b>criticism [1]</b> 168/7 <b>Criticisms [1]</b> 158/9 <b>crucial [3]</b> 103/13 103/13 149/13 <b>crucially [2]</b> 164/19 172/13 <b>cry [1]</b> 89/3 <b>crystal [1]</b> 72/13 <b>crystallised [1]</b> 164/21 <b>cubicles [1]</b> 99/14 <b>culture [1]</b> 151/3 <b>cure [1]</b> 165/12 <b>cured [1]</b> 166/19 <b>current [1]</b> 177/7 <b>currently [1]</b> 2/22 <b>curtains [1]</b> 89/18 <b>CV [1]</b> 148/19 <b>Cymru [1]</b> 2/2 <b>Cymru's [1]</b> 3/17	35/1 35/2 48/17 50/19 76/19 77/17 82/9 84/21 85/11 85/13 113/7 113/13 113/13 114/13 115/2 115/12 116/7 116/11 116/12 117/21 119/13 119/24 129/6 129/14 130/10 138/24 169/24 169/24 173/14 182/9 <b>days [20]</b> 10/16 26/1 26/11 26/12 40/2 55/6 64/11 74/19 81/3 81/13 82/9 85/3 86/8 86/19 90/8 114/15 117/22 119/20 135/4 138/25 <b>deaf [1]</b> 9/14 <b>deal [11]</b> 30/15 30/16 36/15 78/23 101/14 110/24 121/3 141/18 142/17 168/4 180/4 <b>dealing [4]</b> 34/10 85/23 104/20 113/1 <b>dealt [3]</b> 40/17 113/20 161/7 <b>death [10]</b> 13/11 18/5 30/24 35/12 60/7 91/17 105/18 105/19 105/19 127/23 <b>deaths [7]</b> 13/9 13/16 20/7 26/15 26/20 26/20 67/16 <b>debate [2]</b> 70/18 177/18 <b>debates [1]</b> 70/23 <b>decade [1]</b> 166/22 <b>December [16]</b> 72/16 80/10 80/11 80/14 92/12 108/23 118/12 118/20 118/23 118/25 119/7 119/18 119/24 128/2 130/1 131/24 <b>December 2020 [1]</b> 118/20 <b>December 2021 [1]</b> 108/23 <b>decide [2]</b> 77/10 123/23 <b>decided [2]</b> 72/8 115/17 <b>deciding [1]</b> 67/15 <b>decision [15]</b> 42/3 46/8 46/9 72/15 81/19 105/10 123/22 149/22 171/7 171/9 173/25 174/3 174/11 174/15 180/23 <b>decision-makers [2]</b> 105/10 171/7 <b>decision-making [7]</b> 42/3 46/8 46/9 171/9 174/11 174/15 180/23 <b>decisions [16]</b> 16/16	41/10 42/15 42/24 79/6 104/24 126/2 155/3 155/14 155/20 164/18 168/7 171/1 172/10 173/5 175/25 <b>decline [1]</b> 118/22 <b>decontamination [2]</b> 94/17 95/20 <b>dedicated [1]</b> 153/4 <b>deem [1]</b> 180/12 <b>deemed [2]</b> 6/10 84/8 <b>default [1]</b> 137/6 <b>defensive [1]</b> 104/18 <b>deficiencies [1]</b> 159/9 <b>deficiency [2]</b> 165/8 165/12 <b>define [1]</b> 170/24 <b>defining [2]</b> 144/22 151/2 <b>definitely [5]</b> 7/3 16/10 72/7 85/16 104/6 <b>Deganwy [1]</b> 65/8 <b>delay [2]</b> 23/20 150/6 <b>delayed [1]</b> 24/12 <b>delays [3]</b> 61/22 67/16 98/25 <b>delineation [1]</b> 145/12 <b>delirium [1]</b> 40/9 <b>deliver [3]</b> 65/10 65/19 180/13 <b>delivered [1]</b> 149/23 <b>delivering [2]</b> 30/18 104/25 <b>delivery [4]</b> 59/24 146/3 171/21 172/3 <b>demanding [1]</b> 31/2 <b>demands [1]</b> 106/5 <b>dementia [15]</b> 112/7 112/10 114/1 114/2 117/3 118/5 118/5 122/23 131/4 131/7 131/12 131/17 131/19 131/22 132/6 <b>dementia-friendly [1]</b> 131/17 <b>democracy [1]</b> 140/17 <b>demonstrates [2]</b> 146/7 147/14 <b>demonstrations [1]</b> 111/2 <b>denied [3]</b> 44/1 44/2 44/13 <b>department [36]</b> 84/18 92/20 93/1 103/22 110/16 111/11 128/24 129/1 129/8 138/18 140/7 143/17 154/5 154/9 154/10 154/11 154/15 154/23 155/22 156/3 156/16	157/15 157/18 157/20 158/1 158/15 158/19 159/1 161/1 161/25 162/4 162/20 162/23 163/2 164/4 183/18 <b>department's [2]</b> 156/10 159/12 <b>departmental [1]</b> 152/21 <b>departments [2]</b> 73/17 141/24 <b>dependency [2]</b> 83/10 86/3 <b>depends [1]</b> 144/24 <b>deployed [2]</b> 75/24 165/19 <b>deployment [1]</b> 75/25 <b>depression [1]</b> 101/4 <b>depth [4]</b> 3/12 36/23 78/17 180/22 <b>deputy [5]</b> 3/25 70/2 112/21 138/7 152/15 <b>desaturate [1]</b> 90/12 <b>describe [3]</b> 34/16 47/22 86/16 <b>described [5]</b> 41/16 44/4 87/12 97/13 99/15 <b>describing [1]</b> 38/11 <b>descriptions [1]</b> 141/21 <b>descriptor [1]</b> 177/10 <b>design [1]</b> 181/7 <b>designated [1]</b> 68/11 <b>designed [3]</b> 77/2 159/20 166/25 <b>desperate [3]</b> 64/8 91/20 112/3 <b>desperately [2]</b> 66/23 85/22 <b>despite [2]</b> 124/15 131/5 <b>detached [4]</b> 163/4 163/6 163/11 163/17 <b>detail [1]</b> 166/8 <b>detailed [3]</b> 162/9 179/19 181/3 <b>details [3]</b> 77/12 83/15 100/23 <b>deteriorated [3]</b> 5/3 52/23 125/7 <b>deteriorating [1]</b> 66/23 <b>deterioration [1]</b> 44/20 <b>determine [3]</b> 41/9 44/18 172/16 <b>determined [1]</b> 146/24 <b>determining [1]</b> 145/8 <b>detrimental [1]</b> 101/15
----------	---	---	---	---

<b>D</b>	114/13 116/5 116/19 118/18 118/21 120/22 121/9 121/15 122/14 128/1 128/17 132/9 133/8 133/12 134/15 134/18 134/25 136/24	<b>directly</b> [6] 3/1 49/2 111/14 172/6 174/13 178/25 <b>director</b> [2] 40/18 157/5 <b>Directorate</b> [1] 168/23 <b>directors</b> [3] 111/13 111/13 156/24 <b>disabilities</b> [2] 9/15 158/6 <b>disability</b> [2] 12/24 155/4 <b>disabled</b> [3] 12/23 63/4 174/13 <b>disagreement</b> [1] 177/6 <b>disaster</b> [1] 73/1 <b>discharge</b> [7] 5/5 5/8 25/24 54/25 55/11 114/15 115/19 <b>discharged</b> [14] 4/20 4/23 25/1 54/22 54/23 55/6 55/10 80/16 114/20 114/25 115/2 115/10 116/25 117/1 <b>discharging</b> [4] 24/21 24/22 24/24 24/24 <b>disconnect</b> [2] 104/6 104/22 <b>discretion</b> [5] 46/19 136/7 136/8 136/10 167/20 <b>discriminatory</b> [1] 13/20 <b>discuss</b> [2] 108/25 123/21 <b>discussed</b> [3] 109/21 125/21 176/20 <b>discussion</b> [9] 39/20 44/16 70/4 70/19 85/19 89/23 111/16 125/20 126/10 <b>discussions</b> [9] 40/21 40/22 88/21 88/22 88/23 89/23 89/25 90/22 173/6 <b>disease</b> [2] 149/4 177/11 <b>diseases</b> [2] 63/18 143/22 <b>disentangle</b> [1] 149/14 <b>dislikes</b> [2] 129/19 129/20 <b>dislodged</b> [1] 89/6 <b>disparities</b> [1] 150/20 <b>disparity</b> [1] 160/5 <b>dispatches</b> [1] 93/22 <b>dispel</b> [1] 158/15 <b>display</b> [3] 6/22 131/17 170/7	<b>displayed</b> [1] 117/19 <b>disservice</b> [1] 39/2 <b>distance</b> [1] 62/16 <b>distancing</b> [1] 137/17 <b>distinct</b> [1] 123/25 <b>distinction</b> [2] 146/13 158/2 <b>distress</b> [3] 44/23 107/12 170/4 <b>distressed</b> [3] 14/15 125/5 128/11 <b>distressing</b> [1] 64/7 <b>distribution</b> [3] 24/9 24/16 164/24 <b>dithering</b> [1] 70/11 <b>divergence</b> [1] 5/17 <b>DNACPR</b> [27] 16/15 16/21 17/1 17/4 19/1 27/9 27/10 27/14 39/20 39/22 40/3 40/11 40/24 41/4 41/25 42/17 42/23 44/16 57/24 89/23 91/10 123/14 126/2 126/6 154/18 154/21 155/6 <b>DNACPRs</b> [9] 27/19 36/12 39/13 39/15 39/17 41/21 91/2 127/20 155/21 <b>DNR</b> [6] 123/14 123/16 123/21 124/1 124/11 125/21 <b>do</b> [84] 1/23 2/24 8/1 8/17 9/7 10/6 10/8 10/8 12/5 13/14 14/14 19/1 22/19 22/20 24/13 25/18 26/6 26/10 26/12 27/25 28/1 29/8 31/4 31/7 31/8 31/14 34/25 35/23 38/13 41/19 42/3 42/22 43/11 45/4 47/4 50/16 51/25 53/20 54/2 54/17 58/7 58/14 68/9 69/18 70/17 73/12 74/16 75/3 76/6 76/7 76/10 76/12 77/8 77/8 77/21 77/24 77/25 78/4 79/8 79/8 79/14 85/14 86/16 90/24 97/3 103/15 105/13 107/9 107/11 118/15 121/23 126/20 128/13 130/18 135/18 135/23 135/25 139/14 139/24 140/15 140/16 140/16 141/9 154/21 <b>doctor</b> [27] 14/16 40/13 40/16 53/20 54/1 59/22 60/6 65/22 69/21 90/21 99/9 101/2 101/24 107/14	114/17 121/19 121/22 122/8 123/13 123/19 123/24 124/5 124/6 124/9 124/19 125/9 125/20 <b>doctor's</b> [1] 114/24 <b>doctors</b> [12] 5/4 5/7 10/13 28/9 82/24 85/10 90/23 114/14 115/5 123/15 124/7 124/18 <b>doctors'</b> [1] 79/5 <b>document</b> [1] 142/9 <b>documentaries</b> [4] 98/5 98/11 98/14 99/22 <b>documentary</b> [1] 72/10 <b>does</b> [17] 11/10 35/3 64/19 67/12 73/16 97/17 104/12 106/20 142/4 150/14 152/7 152/22 156/17 157/14 158/17 159/9 175/21 <b>doesn't</b> [7] 30/14 31/17 49/11 59/9 73/15 108/9 124/11 <b>doffing</b> [1] 95/23 <b>doing</b> [17] 19/23 20/1 30/12 40/12 52/13 68/12 70/7 70/8 74/5 74/21 75/7 75/16 83/18 102/12 139/15 142/21 167/4 <b>domain</b> [1] 120/10 <b>dominant</b> [1] 145/13 <b>don</b> [1] 130/18 <b>don't</b> [38] 6/13 6/21 7/19 11/25 15/7 22/14 22/18 24/18 29/8 29/12 31/18 31/19 44/6 52/4 52/5 57/18 76/6 77/25 78/1 78/2 85/2 89/7 89/19 90/7 96/3 96/13 100/4 107/14 112/2 118/11 127/15 129/18 129/23 137/6 139/17 140/7 140/11 143/3 <b>done</b> [23] 6/1 15/13 24/18 26/16 26/17 34/23 34/25 57/20 66/11 68/4 70/1 73/20 80/19 81/23 91/12 91/13 104/13 107/6 110/24 111/3 122/25 136/23 142/12 <b>donning</b> [1] 95/23 <b>door</b> [3] 64/6 95/22 97/6 <b>doors</b> [1] 66/13 <b>dormant</b> [1] 97/14 <b>doubling</b> [1] 116/18 <b>doubt</b> [3] 106/21
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<b>D</b>	<b>droplet [3]</b> 38/6 177/8 177/18 <b>dropped [2]</b> 14/2 14/4 <b>due [4]</b> 35/3 82/2 119/2 142/8 <b>duff [1]</b> 130/18 <b>DUP [1]</b> 111/20 <b>during [66]</b> 3/22 5/14 16/11 16/15 27/20 34/17 36/16 37/4 38/8 39/3 39/17 41/19 42/2 43/12 44/24 48/17 50/5 63/15 66/8 68/17 69/1 72/20 72/22 74/4 80/21 80/24 80/25 81/8 81/11 83/14 84/15 89/1 93/10 94/24 96/6 99/18 100/16 101/21 102/11 104/13 106/11 109/12 111/6 113/5 116/6 116/12 118/10 119/22 126/23 126/24 127/9 130/21 138/13 139/22 143/16 144/7 146/9 150/18 152/12 155/8 158/14 161/14 164/3 164/22 170/17 182/4 <b>duty [2]</b> 140/20 140/20 <b>dying [10]</b> 11/23 12/5 14/8 16/6 44/8 45/3 47/2 67/14 103/2 138/25 <b>dying hours [1]</b> 138/25	<b>easier [1]</b> 123/14 <b>easily [2]</b> 9/14 9/22 <b>East [2]</b> 97/25 102/23 <b>easy [7]</b> 15/19 24/13 28/13 105/19 105/19 105/21 153/21 <b>eat [1]</b> 21/16 <b>eaten [1]</b> 90/9 <b>eating [2]</b> 117/20 118/1 <b>echo [1]</b> 67/18 <b>echoed [1]</b> 166/20 <b>echoes [1]</b> 73/22 <b>ED [1]</b> 94/17 <b>effect [4]</b> 105/6 149/8 171/20 181/20 <b>effective [10]</b> 15/14 29/13 73/4 145/1 148/1 165/24 167/11 168/6 170/21 171/21 <b>effectively [4]</b> 165/8 166/18 166/23 167/3 <b>effectiveness [6]</b> 147/8 147/23 147/24 149/9 152/7 167/5 <b>effects [2]</b> 174/3 181/1 <b>efficacy [2]</b> 21/9 147/11 <b>efficient [2]</b> 163/16 167/11 <b>efficiently [1]</b> 58/5 <b>effort [2]</b> 89/19 178/12 <b>efforts [3]</b> 169/13 179/5 182/3 <b>eight [1]</b> 179/22 <b>Eikon [2]</b> 162/25 163/5 <b>either [9]</b> 16/2 51/16 55/21 63/3 63/4 95/25 132/25 180/4 180/8 <b>elastic [1]</b> 95/15 <b>elderly [2]</b> 13/22 56/15 <b>elective [2]</b> 172/16 173/25 <b>electronic [2]</b> 28/7 159/2 <b>element [1]</b> 13/15 <b>eligible [1]</b> 17/3 <b>eliminate [1]</b> 174/6 <b>else [6]</b> 20/19 23/10 51/2 124/14 137/13 137/25 <b>else's [1]</b> 17/23 <b>Eluned [1]</b> 24/11 <b>email [2]</b> 112/1 138/18 <b>embalm [1]</b> 135/10 <b>emerge [1]</b> 106/22 <b>emerged [6]</b> 93/18 109/3 154/13 162/25 164/21 167/12	<b>emergency [17]</b> 5/12 7/14 7/18 13/6 59/22 60/1 63/20 64/4 65/22 73/17 84/18 92/20 101/16 163/9 165/20 172/14 181/15 <b>emerging [2]</b> 145/7 177/2 <b>eminently [1]</b> 166/10 <b>emotional [1]</b> 56/1 <b>emotionally [1]</b> 182/9 <b>emotive [1]</b> 169/9 <b>empathetic [1]</b> 101/18 <b>emphasis [1]</b> 177/3 <b>emphasise [3]</b> 142/15 154/11 161/25 <b>emphasised [1]</b> 163/24 <b>employees [1]</b> 166/6 <b>employer [2]</b> 146/20 172/6 <b>employers [1]</b> 179/13 <b>empower [1]</b> 60/20 <b>empowered [1]</b> 155/23 <b>empty [3]</b> 63/23 86/21 142/22 <b>enable [1]</b> 130/25 <b>enabled [7]</b> 23/15 24/5 43/23 44/21 57/10 137/6 178/25 <b>encapsulate [1]</b> 64/19 <b>encompass [5]</b> 159/4 159/4 159/7 159/8 159/11 <b>encounters [1]</b> 61/18 <b>encouraged [1]</b> 155/23 <b>end [26]</b> 23/2 30/3 30/7 43/22 47/3 72/16 89/21 91/11 91/19 91/21 93/13 94/12 102/23 103/1 106/3 109/3 111/8 133/17 135/6 137/5 138/23 155/24 165/15 174/22 176/4 181/22 <b>ended [1]</b> 97/24 <b>endorse [2]</b> 175/21 175/21 <b>endorsed [1]</b> 129/7 <b>endure [2]</b> 34/20 34/21 <b>engage [3]</b> 110/25 112/19 174/16 <b>engaged [1]</b> 128/24 <b>engagement [6]</b> 3/17 110/14 110/15 111/2 111/4 158/23 <b>engineers [1]</b> 151/24 <b>England [14]</b> 5/18 8/8 24/3 26/9 27/25	74/5 77/1 93/2 106/5 144/1 146/10 146/12 150/15 153/1 <b>England/Wales [1]</b> 8/8 <b>English [1]</b> 63/5 <b>enhance [1]</b> 51/20 <b>enhanced [1]</b> 181/17 <b>enhancing [1]</b> 51/15 <b>enormous [2]</b> 84/16 168/25 <b>enough [14]</b> 1/12 37/20 45/4 46/2 46/3 46/4 46/7 47/14 98/9 100/5 126/23 138/20 138/20 169/5 <b>ensure [9]</b> 131/10 151/21 165/24 166/1 166/16 170/12 174/25 179/13 179/23 <b>ensuring [4]</b> 155/15 160/21 167/1 167/18 <b>entire [2]</b> 76/20 124/3 <b>entirely [5]</b> 35/11 38/6 43/17 48/6 68/6 <b>entirety [1]</b> 37/8 <b>entities [3]</b> 111/4 112/18 112/20 <b>entity [1]</b> 77/1 <b>environment [3]</b> 56/8 75/17 101/12 <b>environmental [2]</b> 143/23 144/25 <b>environments [3]</b> 37/4 37/7 37/9 <b>EPRR [1]</b> 60/1 <b>equalities [1]</b> 174/10 <b>equality [1]</b> 174/8 <b>equally [1]</b> 44/10 <b>equipment [1]</b> 147/23 <b>error [1]</b> 22/16 <b>escalated [1]</b> 26/18 <b>escalation [15]</b> 13/21 17/1 17/3 41/12 41/13 41/25 42/17 44/17 86/4 162/2 162/7 162/14 162/16 162/17 173/4 <b>especially [1]</b> 72/22 <b>essentially [2]</b> 78/13 85/18 <b>establish [1]</b> 151/4 <b>established [7]</b> 2/9 2/10 24/16 37/16 41/15 179/9 180/11 <b>establishing [3]</b> 165/18 165/21 166/1 <b>establishment [3]</b> 156/19 157/2 174/24 <b>estate [10]</b> 28/22 29/8 38/10 57/7 57/16 57/17 57/22 146/22 152/4 172/25
	<b>E</b>			
<b>each [13]</b> 10/3 11/10 17/2 30/11 49/8 49/24 61/11 68/8 101/19 105/15 105/15 117/8 162/10 <b>earlier [12]</b> 28/25 32/22 33/19 38/18 53/10 62/22 70/11 85/13 88/23 97/5 102/24 125/12 <b>earlier years [1]</b> 97/5 <b>early [18]</b> 74/19 100/13 102/3 102/4 102/25 115/3 115/4 130/1 133/20 140/10 145/17 157/22 160/19 161/20 162/4 175/12 176/11 178/7 <b>early days [1]</b> 74/19 <b>early December [1]</b> 130/1 <b>early February [1]</b> 162/4 <b>early hours [1]</b> 133/20				



<b>E</b>	<b>everything [7]</b> 7/1 33/21 35/21 83/19 90/24 101/3 105/5	<b>excuse [1]</b> 82/14	<b>explaining [2]</b> 6/5 135/10	<b>failings [1]</b> 91/5
<b>et [6]</b> 63/17 74/22 79/7 81/16 93/2 94/21	<b>everywhere [2]</b> 48/22 94/8	<b>executive [7]</b> 129/8 129/25 143/17 152/17 160/13 165/22 167/1	<b>explanation [2]</b> 47/14 94/14	<b>failures [2]</b> 19/10 179/8
<b>et cetera [6]</b> 63/17 74/22 79/7 81/16 93/2 94/21	<b>evidence [71]</b> 1/14 4/3 24/1 34/4 37/1 37/3 38/3 38/18 38/20 38/22 43/1 44/24 56/19 56/22 56/22 67/18 71/4 73/24 91/5 93/18 93/23 93/23 93/24 97/17 105/6 108/10 140/9 141/8 142/6 142/18 144/20 145/7 145/13 145/18 147/7 147/11 147/23 147/25 148/6 149/7 149/16 154/13 156/3 156/5 156/8 156/17 160/24 161/23 164/16 165/9 167/12 167/24 168/1 168/4 169/10 170/16 170/20 171/23 172/1 172/4 173/10 173/16 174/2 174/22 175/4 175/25 176/5 176/17 177/3 178/6 178/18	<b>exercise [3]</b> 27/23 149/1 150/6	<b>explanations [2]</b> 46/17 47/6	<b>fair [4]</b> 53/3 65/3 65/4 121/4
<b>ethical [1]</b> 153/19	<b>evicted [1]</b> 169/23	<b>exhausted [5]</b> 85/4 85/12 85/12 86/21 162/18	<b>explored [2]</b> 39/11 144/7	<b>fairly [3]</b> 31/24 64/19 180/8
<b>ethnic [10]</b> 158/6 158/11 158/22 158/24 159/10 174/16 174/20 175/2 179/4 179/16	<b>evident [4]</b> 144/12 145/11 146/9 171/14	<b>exist [4]</b> 57/21 73/15 73/16 163/25	<b>expose [1]</b> 32/12	<b>fall [3]</b> 4/5 58/13 146/17
<b>ethnicity [3]</b> 159/12 159/14 179/10	<b>evolved [4]</b> 144/12 145/11 146/9 171/14	<b>existed [1]</b> 63/6	<b>exposed [3]</b> 4/22 5/6 25/16	<b>familiar [4]</b> 1/24 129/4 129/15 148/17
<b>EU14 [1]</b> 106/8	<b>exacerbated [1]</b> 37/14	<b>existence [2]</b> 132/1 145/19	<b>express [2]</b> 155/16 164/6	<b>familiarly [1]</b> 52/24
<b>Europe [1]</b> 75/16	<b>exactly [4]</b> 16/5 23/6 79/23 175/11	<b>existing [3]</b> 100/11 159/23 162/6	<b>expresses [2]</b> 169/7 169/11	<b>families [41]</b> 2/2 3/17 12/4 16/1 30/2 32/10 40/22 43/14 59/18 59/21 60/11 60/17 61/6 65/14 73/9 73/23 91/11 108/17 108/21 109/19 109/24 110/2 110/6 110/11 113/23 115/7 116/8 121/14 126/1 126/9 126/23 127/14 127/16 128/11 128/12 128/16 133/3 134/23 136/24 169/1 170/11
<b>evaluate [1]</b> 149/10	<b>examined [1]</b> 96/22	<b>exists [1]</b> 147/2	<b>extract [1]</b> 96/16	<b>families' [3]</b> 64/20 91/1 154/24
<b>evaluation [1]</b> 175/13	<b>examining [1]</b> 150/23	<b>expand [1]</b> 154/15	<b>extract [1]</b> 96/16	<b>family [32]</b> 4/15 8/14 11/21 16/2 16/19 17/21 39/21 54/8 54/18 54/22 55/1 55/4 55/11 55/17 55/21 55/25 60/8 64/3 84/12 84/22 90/1 90/23 91/4 100/14 102/12 110/8 123/25 126/11 127/7 137/2 138/23 138/24
<b>Eve [2]</b> 123/12 127/23	<b>example [37]</b> 8/19 11/1 11/21 13/23 14/23 16/17 17/20 20/10 37/9 43/2 46/22 47/11 47/16 50/12 54/8 54/16 63/16 68/19 70/1 70/10 80/8 97/25 99/8 104/1 106/19 109/10 112/1 144/2 147/9 150/13 150/19 151/23 160/2 167/15 169/25 173/25 181/3	<b>expect [3]</b> 20/1 57/18 77/5	<b>extra [4]</b> 102/2 102/10 106/3 106/11	<b>far [2]</b> 41/9 127/6
<b>even [31]</b> 5/4 10/5 16/23 16/25 18/14 20/15 22/8 22/17 24/7 72/17 73/13 76/3 77/20 78/2 78/4 84/3 84/4 84/6 94/10 106/3 121/25 131/2 131/25 132/10 148/2 151/24 153/14 162/16 163/25 174/1 176/11	<b>exceeded [1]</b> 173/3	<b>expectation [2]</b> 50/18 171/3	<b>eye [2]</b> 89/9 144/6	<b>fast [1]</b> 119/7
<b>even years [1]</b> 16/25	<b>examples [6]</b> 10/20 12/18 15/24 65/15 71/11 132/19	<b>expected [1]</b> 122/11	<b>eyes [1]</b> 176/7	<b>fatalism [1]</b> 125/25
<b>evening [5]</b> 79/9 79/10 85/17 123/18 124/19	<b>excellent [1]</b> 132/11	<b>experienced [20]</b> 2/14 2/16 11/5 18/11 19/11 19/20 40/20 66/3 84/15 92/11 92/11 95/17 95/18 100/24 103/12 106/14 109/23 118/18 133/6 163/13	<b>face [23]</b> 4/17 4/17 8/10 48/12 48/13 49/9 51/25 51/25 53/15 53/16 53/25 53/25 69/16 69/16 70/4 70/10 70/21 90/16 94/25 96/6 106/10 116/20 179/3	<b>father [31]</b> 2/10 4/20 7/23 8/19 8/21 9/2 14/1 16/6 19/17 35/5 35/6 60/7 72/2 72/17 73/25 78/24 82/11 82/16 83/21 84/2 84/6 84/15 86/23 87/13 88/19 89/4 90/3 91/22 92/2 99/12 135/1
<b>event [4]</b> 42/22 73/11 105/13 175/15	<b>exception [1]</b> 41/4	<b>experience [31]</b> 6/2 34/10 34/20 34/21 39/19 45/18 46/25 52/2 53/23 54/7 54/14 54/21 54/25 55/2 55/8 55/20 55/23 60/6 67/8 67/19 71/11 78/15 92/15 98/20 104/19 132/25 132/25 156/11 157/15 157/17 174/20	<b>face mask [1]</b> 70/10	<b>father's [5]</b> 10/13 10/15 18/16 35/12 89/21
<b>events [1]</b> 61/25	<b>exceptional [1]</b> 112/9	<b>experiences [10]</b> 7/6 41/5 60/7 61/15 62/12 63/25 78/24 92/7 96/19 98/9	<b>Facebook [3]</b> 2/25 94/11 102/17	<b>fathers [1]</b> 88/1
<b>eventually [7]</b> 7/9 26/4 54/10 85/11 92/24 93/2 93/13	<b>excess [1]</b> 98/13	<b>experiencing [1]</b> 104/4	<b>faced [2]</b> 179/10 179/18	<b>fatigue [1]</b> 6/23
<b>ever [5]</b> 32/20 46/17 95/12 138/22 142/3	<b>excessive [1]</b> 7/15	<b>expert [8]</b> 68/8 115/8 145/20 147/10 157/17 157/18 174/1 179/9	<b>FaceTime [1]</b> 137/3	<b>fault [1]</b> 78/10
<b>every [22]</b> 21/13 26/11 26/12 28/4 35/1 35/2 48/6 48/7 48/7 53/17 63/16 63/16 77/17 89/9 89/18 90/11 163/7 168/6 168/10 178/12 180/1 181/9	<b>excluded [1]</b> 35/14	<b>expertise [3]</b> 143/24 147/2 161/10	<b>facilitate [1]</b> 50/7	<b>favourite [1]</b> 90/14
<b>everybody [11]</b> 6/25 21/19 22/21 23/13 50/19 50/20 51/21 116/22 140/14 141/7 141/12	<b>exclusion [2]</b> 48/9 50/10	<b>expertly [1]</b> 161/14	<b>facility [1]</b> 163/4	<b>February [6]</b> 74/9 76/5 76/9 78/7 138/15 162/4
<b>everybody's [1]</b> 140/18		<b>experts [2]</b> 115/5 164/17	<b>fact [21]</b> 5/13 6/13 8/5 8/21 9/23 16/18 25/6 46/24 50/23 52/18 65/1 65/23 70/22 79/19 100/5 100/18 119/13 127/11 142/3 157/22 176/1	<b>features [2]</b> 38/10 38/13
<b>everyone [12]</b> 9/8 20/19 30/9 46/12 61/21 85/4 87/8 104/16 140/5 168/25 173/9 173/14		<b>explain [5]</b> 3/3 4/19 15/12 113/21 156/17	<b>factored [3]</b> 37/17 61/10 147/21	
<b>everyone's [2]</b> 61/15 61/16		<b>explained [16]</b> 14/9 15/7 15/9 17/12 30/22 40/5 123/19 125/14 128/20 130/19 131/21 135/17 136/15 147/10 167/16 172/1	<b>factors [6]</b> 37/11 39/5 87/22 144/25 147/14 165/6	

<b>F</b>	<b>filtered [1]</b> 74/23 <b>filters [1]</b> 21/8 <b>filtration [1]</b> 57/15 <b>final [6]</b> 35/9 44/10 108/1 139/1 153/6 172/20 <b>finally [11]</b> 28/16 55/18 66/24 101/2 105/7 137/21 145/16 151/14 162/19 163/22 179/25 <b>finances [1]</b> 110/7 <b>find [10]</b> 14/6 14/8 16/23 49/20 51/12 53/12 54/6 66/6 74/17 85/22 <b>finding [1]</b> 41/2 <b>findings [1]</b> 167/5 <b>fine [7]</b> 6/13 7/7 17/10 76/14 76/14 78/5 126/14 <b>finish [2]</b> 78/25 167/22 <b>finite [1]</b> 163/13 <b>fire [1]</b> 21/15 <b>first [47]</b> 3/24 4/5 16/11 20/23 28/21 36/15 39/25 40/5 42/2 53/19 62/2 63/5 64/15 72/23 72/25 74/4 92/22 99/11 99/18 100/16 104/6 109/14 111/7 111/10 111/22 112/18 112/20 112/21 115/22 120/9 138/6 138/7 139/9 139/21 144/8 144/14 146/20 147/16 151/18 154/17 156/13 161/15 162/13 165/7 165/18 166/4 178/7 <b>firsthand [1]</b> 19/20 <b>firstly [6]</b> 59/19 61/4 98/16 113/4 113/6 172/9 <b>fit [6]</b> 93/7 114/25 127/17 152/11 179/3 179/7 <b>fitted [1]</b> 179/24 <b>five [5]</b> 26/12 125/3 126/16 156/21 159/6 <b>five days [1]</b> 26/12 <b>five minutes [1]</b> 126/16 <b>fixed [3]</b> 114/1 114/3 166/7 <b>flashbacks [1]</b> 87/19 <b>flex [1]</b> 11/15 <b>flexion [2]</b> 114/1 114/4 <b>flight [1]</b> 77/22 <b>flip [1]</b> 94/11 <b>floor [1]</b> 99/3 <b>flops [1]</b> 94/11	<b>Florence [1]</b> 21/1 <b>flow [6]</b> 13/25 14/7 24/4 24/15 48/14 115/11 <b>flows [1]</b> 127/3 <b>fluid [3]</b> 82/17 82/20 147/12 <b>fluid-resistant [2]</b> 82/20 147/12 <b>fluids [2]</b> 116/17 118/1 <b>focus [8]</b> 2/20 110/4 112/23 113/2 159/22 160/2 160/7 160/19 <b>focused [7]</b> 38/6 151/16 153/11 159/25 160/17 163/23 172/16 <b>folder [3]</b> 27/18 79/12 79/12 <b>follow [1]</b> 96/12 <b>followed [1]</b> 41/23 <b>following [9]</b> 19/23 77/14 79/20 125/14 135/18 156/4 156/19 166/8 177/14 <b>follows [1]</b> 22/22 <b>fond [1]</b> 127/9 <b>food [6]</b> 21/17 117/19 117/24 130/24 130/25 133/11 <b>foot [1]</b> 69/11 <b>footage [1]</b> 100/22 <b>footfall [2]</b> 43/18 45/9 <b>footing [2]</b> 138/16 172/14 <b>forbidden [1]</b> 35/21 <b>forced [1]</b> 48/13 <b>forever [1]</b> 181/6 <b>forget [2]</b> 107/9 107/14 <b>forgotten [8]</b> 10/11 18/7 18/7 32/23 32/25 36/10 82/14 169/6 <b>form [8]</b> 40/3 40/11 43/1 118/3 118/3 147/5 147/8 175/17 <b>formal [3]</b> 3/6 174/8 174/10 <b>format [1]</b> 31/25 <b>formed [2]</b> 109/9 165/5 <b>former [8]</b> 60/2 104/15 110/22 111/11 120/12 140/9 155/9 166/6 <b>forms [1]</b> 27/14 <b>fortunate [4]</b> 91/8 91/9 91/25 101/17 <b>fortunately [1]</b> 14/11 <b>forward [9]</b> 52/6 56/25 58/20 80/10 92/4 119/7 151/20 152/18 152/24 <b>fought [1]</b> 32/11	<b>found [10]</b> 2/13 2/15 8/5 36/3 40/3 54/24 67/4 79/15 118/19 136/5 <b>Foundation [2]</b> 97/25 106/2 <b>founded [1]</b> 60/15 <b>founder [1]</b> 59/18 <b>founding [1]</b> 2/1 <b>four [17]</b> 5/3 10/16 18/9 18/10 40/1 43/21 56/13 93/12 98/1 99/4 100/22 111/19 116/6 119/20 146/5 146/18 171/8 <b>four days [2]</b> 10/16 119/20 <b>four months [1]</b> 100/22 <b>four weeks [1]</b> 99/4 <b>Fourth [2]</b> 145/9 152/12 <b>Fowler [3]</b> 59/17 67/12 90/24 <b>Foyer [1]</b> 178/18 <b>fracture [1]</b> 99/5 <b>fractured [1]</b> 99/1 <b>frail [2]</b> 55/14 56/15 <b>frail/elderly [1]</b> 56/15 <b>frailty [1]</b> 14/25 <b>frame [1]</b> 156/12 <b>framework [3]</b> 155/10 160/15 175/18 <b>frameworks [1]</b> 153/18 <b>frank [1]</b> 85/18 <b>frankly [2]</b> 169/5 180/3 <b>frantic [1]</b> 86/19 <b>free [2]</b> 5/20 171/10 <b>Freeman [9]</b> 38/20 170/23 172/4 172/13 173/1 173/5 173/10 174/7 178/14 <b>frequently [2]</b> 39/9 70/23 <b>fresh [2]</b> 21/14 21/17 <b>Friday [2]</b> 79/18 80/1 <b>friendly [1]</b> 131/17 <b>frightened [3]</b> 88/3 89/3 90/13 <b>frightening [5]</b> 81/20 86/15 86/15 87/12 105/22 <b>front [8]</b> 1/22 25/11 49/22 66/13 104/17 104/17 105/9 107/6 <b>frontline [5]</b> 30/15 31/6 103/7 104/20 164/16 <b>fulfil [1]</b> 161/14 <b>full [13]</b> 1/17 48/12 48/13 59/13 82/9 82/17 90/6 93/5 94/20	130/14 132/15 132/17 163/1 <b>fully [4]</b> 33/24 52/20 92/10 156/17 <b>function [4]</b> 47/25 57/10 84/11 161/4 <b>functioned [4]</b> 51/10 53/5 53/5 61/5 <b>functioning [1]</b> 53/17 <b>fund [1]</b> 180/10 <b>fundamental [2]</b> 149/10 161/4 <b>funding [6]</b> 30/12 97/22 97/22 97/22 105/25 106/11 <b>funeral [5]</b> 35/18 45/24 135/7 135/16 137/8 <b>funerals [1]</b> 35/21 <b>further [8]</b> 53/8 56/25 58/3 73/21 142/8 162/11 173/2 181/13 <b>futile [2]</b> 17/12 17/13 <b>future [23]</b> 29/22 42/22 75/11 95/8 105/13 144/4 144/6 149/19 149/21 150/9 150/10 151/5 151/16 152/19 153/15 155/14 155/21 161/18 175/1 175/15 175/22 180/19 181/3
			<b>G</b>	
			<b>gained [1]</b> 39/22 <b>gaining [1]</b> 61/16 <b>gap [2]</b> 105/8 105/12 <b>garden [2]</b> 52/20 52/21 <b>gaslighting [1]</b> 32/15 <b>gate [1]</b> 62/8 <b>gatepost [1]</b> 62/7 <b>gates [2]</b> 137/13 137/16 <b>gather [1]</b> 40/7 <b>gathering [3]</b> 104/9 104/11 159/9 <b>gave [9]</b> 12/17 24/1 38/7 39/2 39/3 73/24 84/1 104/22 122/20 <b>general [4]</b> 4/11 40/19 110/9 177/10 <b>generally [8]</b> 27/11 47/4 53/11 63/9 69/22 80/13 94/13 113/10 <b>generating [1]</b> 83/5 <b>generous [2]</b> 72/24 101/18 <b>genetically [1]</b> 144/17 <b>genuinely [1]</b> 108/7 <b>GEOFFREY [2]</b> 168/17 183/23 <b>GEOFFREY MITCHELL KC [2]</b>	

<b>G</b>	72/16 73/13 73/13 74/2 74/16 76/6 79/2 80/14 84/20 87/2 94/19 101/12 115/15 115/15 119/1 120/1 125/15 <b>God [1]</b> 89/11 <b>goes [3]</b> 64/7 78/15 121/16 <b>going [87]</b> 7/8 7/17 8/15 14/5 21/11 22/10 48/10 49/24 50/24 51/1 51/7 52/6 55/16 57/18 58/20 59/10 59/11 59/15 59/17 60/3 64/16 65/16 66/6 72/12 72/14 72/24 74/25 75/2 75/7 76/8 77/16 77/20 78/19 84/11 86/2 86/4 87/18 88/4 88/20 88/24 91/16 91/23 93/9 95/25 96/7 99/19 100/14 100/15 100/20 103/17 103/18 104/7 105/9 106/24 109/4 112/2 112/25 114/14 114/25 119/2 119/7 119/10 119/13 119/16 119/21 120/3 120/5 120/7 120/19 120/21 121/7 121/8 122/12 123/1 123/7 124/11 128/9 128/14 130/3 130/11 135/8 135/9 135/9 136/17 136/19 141/20 169/24 <b>gone [8]</b> 6/25 73/15 73/21 79/9 79/19 81/8 87/22 105/16 <b>goner [1]</b> 49/18 <b>good [26]</b> 15/13 27/24 31/23 33/14 33/25 34/1 48/7 48/7 51/14 51/18 51/20 53/4 53/7 59/3 90/8 91/6 108/1 138/19 138/20 139/17 143/12 146/18 168/18 173/9 173/17 177/3 <b>Goodall [1]</b> 28/10 <b>goodbye [3]</b> 12/14 134/23 137/2 <b>Google [1]</b> 71/4 <b>got [45]</b> 8/11 8/18 12/7 16/24 17/23 17/25 20/18 20/19 23/11 25/10 25/15 29/7 30/11 44/16 57/16 57/17 58/5 61/14 67/20 76/19 77/7 77/21 77/23 81/21 83/20 85/21 86/20 87/14 90/4	93/16 100/16 102/5 111/5 111/14 113/1 114/1 115/12 120/25 123/25 124/20 126/16 128/18 131/19 134/14 136/11 <b>Gould [1]</b> 147/25 <b>government [62]</b> 3/18 3/19 3/22 9/13 9/16 18/23 21/3 24/9 26/21 28/11 29/7 31/20 32/14 38/4 60/21 141/24 153/3 160/11 160/13 164/11 164/12 164/15 165/15 166/3 167/10 167/14 167/23 168/5 168/9 168/15 168/16 168/20 168/23 169/7 169/16 169/20 170/12 171/25 173/11 173/17 174/9 174/11 175/5 175/11 175/16 175/17 175/21 176/2 176/7 176/19 177/1 177/17 178/2 178/8 178/11 178/21 179/2 179/8 179/17 181/24 183/21 183/23 <b>Government's [4]</b> 165/5 166/24 167/7 168/3 <b>government-backed [1]</b> 175/17 <b>governments [1]</b> 173/22 <b>gown [1]</b> 82/17 <b>gowns [1]</b> 94/20 <b>GP [32]</b> 4/15 4/25 5/1 10/13 27/7 53/12 53/14 53/15 53/18 53/22 53/25 54/1 54/3 54/11 54/18 54/18 62/2 62/5 62/6 65/1 65/21 66/19 66/24 85/7 97/2 102/23 103/5 120/3 120/4 120/23 120/24 121/4 <b>GPs [14]</b> 10/19 51/8 51/24 53/10 64/24 64/24 65/23 65/23 65/24 66/7 102/24 156/21 156/21 156/25 <b>grabbed [1]</b> 128/8 <b>graphs [1]</b> 106/6 <b>grasp [1]</b> 173/17 <b>grateful [14]</b> 32/21 33/22 56/24 58/6 65/13 107/5 107/16 138/5 139/8 141/7 154/1 164/10 168/14 182/8 <b>gratitude [1]</b> 169/11 <b>graveside [1]</b> 137/15 <b>great [4]</b> 25/6 29/6	110/24 142/17 <b>greater [8]</b> 155/13 160/19 161/16 166/2 167/18 177/3 177/24 178/19 <b>greater protection [1]</b> 177/24 <b>green [1]</b> 19/14 <b>Gregor [4]</b> 173/1 175/25 176/15 180/3 <b>Gregor Smith [1]</b> 173/1 <b>grew [2]</b> 2/15 112/19 <b>grief [4]</b> 97/1 110/10 126/23 139/19 <b>ground [2]</b> 104/2 178/17 <b>group [66]</b> 2/8 2/17 2/17 2/21 2/24 3/1 3/4 3/21 4/4 13/9 15/20 23/18 28/17 30/9 31/10 55/24 56/2 56/4 59/20 60/5 60/22 61/2 61/8 61/12 61/14 61/20 62/12 67/14 68/14 69/22 71/6 71/8 71/14 71/20 73/9 73/19 92/9 94/11 108/16 108/20 108/21 109/8 109/9 109/9 109/11 109/19 109/25 110/13 110/25 111/6 112/19 116/8 121/15 125/24 126/9 126/10 133/3 134/14 136/4 137/25 138/9 149/12 153/2 157/19 178/1 179/9 <b>group's [1]</b> 108/24 <b>groups [15]</b> 3/20 16/9 32/8 32/10 109/2 109/17 139/12 148/21 150/21 158/8 158/18 158/24 160/6 174/17 174/21 <b>growing [1]</b> 106/5 <b>grown [2]</b> 85/9 88/13 <b>guidance [44]</b> 8/3 8/4 9/12 39/8 41/24 42/20 43/7 43/22 44/14 45/11 45/16 72/17 74/15 74/22 92/23 92/24 93/4 93/6 129/4 129/6 129/16 138/12 138/19 138/19 144/9 144/10 144/12 146/3 146/4 146/12 146/15 146/16 146/21 146/23 147/4 147/15 148/3 148/16 151/22 151/25 170/19 176/19 178/10 179/12 <b>guidelines [12]</b> 19/24 20/4 25/14 41/14	41/15 41/20 41/22 93/19 93/20 93/21 93/25 135/18 <b>guiding [1]</b> 171/6 <b>guilt [1]</b> 34/23 <b>guilty [1]</b> 83/25 <b>gulf [1]</b> 105/1 <b>guys [1]</b> 75/7
			<b>H</b>	
			<b>habitat [1]</b> 143/6 <b>had [293]</b> <b>hadn't [8]</b> 14/13 54/13 74/22 85/16 89/7 118/15 122/21 143/1 <b>haematology [1]</b> 120/11 <b>half [1]</b> 18/1 <b>half-opened [1]</b> 18/1 <b>Hancock [1]</b> 104/15 <b>hand [2]</b> 81/17 148/1 <b>hand washing [1]</b> 148/1 <b>handed [1]</b> 18/4 <b>handled [2]</b> 41/6 57/24 <b>handler [1]</b> 142/9 <b>hands [4]</b> 36/4 54/2 134/1 178/15 <b>Hang [1]</b> 20/3 <b>hanging [1]</b> 52/20 <b>happen [8]</b> 21/6 22/18 41/20 42/23 61/25 90/23 91/21 138/10 <b>happened [24]</b> 2/13 13/7 47/18 56/12 63/25 64/1 70/13 74/16 76/18 76/19 81/11 91/16 95/19 96/14 97/16 101/1 113/3 113/17 114/19 123/18 125/19 137/22 140/6 140/12 <b>happening [17]</b> 13/13 20/3 20/6 32/16 44/18 44/22 46/8 49/17 54/10 75/15 83/13 83/16 94/8 109/16 135/15 136/2 136/14 <b>happens [3]</b> 47/15 47/17 91/11 <b>happy [1]</b> 95/4 <b>hard [5]</b> 19/2 46/14 86/18 104/17 104/19 <b>harms [3]</b> 147/17 171/8 175/7 <b>Harries [2]</b> 70/3 152/15 <b>Harris [1]</b> 150/12 <b>harrowing [2]</b> 68/14 88/14	

<b>H</b>	73/25 80/15 80/15 80/17 80/24 81/1 81/1 81/3 81/9 81/10 81/11 81/12 81/14 81/20 82/6 82/7 83/9 85/25 86/2 86/4 86/17 86/23 86/23 86/24 87/4 88/20 89/1 89/2 89/2 90/3 90/4 90/5 90/8 90/9 90/10 90/12 90/15 90/16 90/18 90/18 90/18 91/22 92/2 99/10 99/11 99/13 99/13 99/14 99/17 102/17 102/18 102/25 112/2 123/20 126/13 126/14 126/14 127/12 156/6 159/19	24/20 27/3 28/2 32/14 38/7 39/2 42/11 42/12 46/12 50/7 51/21 59/20 59/25 63/9 64/2 65/10 65/19 68/8 70/5 70/6 76/3 76/13 76/24 85/1 98/20 100/7 100/19 101/22 102/1 102/24 103/7 104/20 112/24 114/8 115/6 146/1 146/17 150/18 150/24 151/9 151/13 152/23 157/11 158/10 163/23 163/24 165/23 166/21 171/4 172/17 173/6 173/20 177/20 177/25 178/3 178/9 178/13 178/24 179/23	136/21 139/7 174/14 181/6 <b>helpful [4]</b> 32/20 102/3 140/1 144/23 <b>helpfully [1]</b> 3/15 <b>helping [4]</b> 107/12 117/16 125/9 139/18 <b>helpless [1]</b> 87/24 <b>helpline [1]</b> 178/24 <b>helps [2]</b> 30/18 67/24 <b>hence [1]</b> 72/12 <b>HEPA [2]</b> 21/8 57/14 <b>her [100]</b> 17/25 17/25 18/16 19/16 33/7 38/22 38/25 40/2 40/5 48/24 49/19 52/18 54/17 54/18 54/18 54/19 56/18 56/21 62/23 65/6 65/7 66/4 66/17 67/17 78/16 85/13 91/20 96/14 99/1 100/14 100/14 100/16 104/17 104/18 105/4 113/1 113/4 114/9 114/14 114/15 114/20 114/22 115/2 115/22 115/23 116/4 116/13 116/16 116/17 117/4 117/6 117/11 117/15 117/15 117/16 117/17 118/2 119/23 120/7 121/8 121/9 121/11 121/25 122/5 122/20 122/21 122/22 124/15 124/23 125/9 126/10 126/12 127/3 127/4 127/8 127/23 128/5 128/8 128/9 128/13 129/18 129/19 129/23 129/24 130/8 130/17 132/4 132/6 133/16 133/17 133/24 134/1 134/7 134/9 135/10 136/19 137/4 138/1 139/3 141/4 <b>her Ladyship [10]</b> 56/18 56/21 62/23 67/17 78/16 105/4 113/1 137/4 138/1 139/3 <b>Herculean [1]</b> 169/13 <b>here [10]</b> 31/9 32/2 89/11 126/12 126/17 129/17 136/19 139/15 140/4 182/11 <b>herself [2]</b> 40/7 112/8 <b>hidden [1]</b> 9/23 <b>hierarchy [1]</b> 147/5 <b>high [16]</b> 13/25 14/7 37/5 40/9 48/14 83/9 86/3 98/23 102/16 119/2 120/1 120/25 122/2 122/7 122/13 147/11	<b>high-flow [3]</b> 13/25 14/7 48/14 <b>high-level [2]</b> 98/23 102/16 <b>high-quality [1]</b> 147/11 <b>higher [4]</b> 71/18 77/18 77/19 102/8 <b>highest [3]</b> 161/9 162/16 172/5 <b>highlands [1]</b> 37/23 <b>highlight [1]</b> 158/19 <b>highlighted [5]</b> 112/17 126/7 150/1 171/17 178/17 <b>highlighting [1]</b> 131/11 <b>highly [2]</b> 106/14 109/23 <b>him [36]</b> 5/2 7/21 8/1 9/2 14/5 14/11 25/4 25/4 25/5 25/19 49/16 49/22 52/25 72/3 80/19 81/2 81/16 81/20 81/21 82/4 83/11 84/3 86/18 87/2 87/6 88/25 90/12 90/13 90/24 91/23 92/4 99/18 99/19 102/20 130/2 130/2 <b>himself [2]</b> 99/9 103/20 <b>hindsight [2]</b> 174/1 175/10 <b>hip [1]</b> 99/1 <b>his [36]</b> 5/1 5/2 5/5 5/6 14/1 14/4 17/4 24/2 28/6 34/14 37/2 52/23 52/23 55/6 67/12 68/20 82/8 82/11 86/8 86/13 87/16 89/6 90/6 90/9 90/14 90/16 90/19 90/25 102/19 102/20 102/20 102/23 102/25 156/6 160/24 174/21 <b>history [1]</b> 77/10 <b>hit [3]</b> 28/11 28/13 63/13 <b>Hmm [1]</b> 101/6 <b>Hobson's [2]</b> 35/18 45/25 <b>hold [5]</b> 16/24 51/24 60/21 77/11 96/9 <b>holiday [1]</b> 76/5 <b>home [49]</b> 25/5 40/2 51/22 51/25 52/11 53/18 53/24 54/24 56/5 61/18 61/24 62/1 62/22 63/4 64/24 64/25 67/14 72/16 77/23 78/2 78/3 78/6 79/9 79/19 80/22 81/13 83/20 86/9
<b>has [85]</b> 2/21 12/6 14/17 21/19 26/24 27/5 28/12 28/23 29/13 29/14 31/14 31/22 37/25 47/16 48/6 48/7 50/19 50/20 54/1 57/20 60/18 64/21 67/17 73/8 73/14 78/17 90/25 91/12 93/18 97/13 97/15 97/16 98/8 101/14 102/10 105/16 105/18 109/11 111/5 113/1 116/7 122/9 125/15 126/7 126/8 131/19 131/22 133/2 136/3 138/16 140/6 140/8 140/12 141/7 143/15 147/4 150/18 151/6 154/11 158/4 159/1 159/19 160/12 162/1 163/23 166/19 167/12 167/23 167/24 169/16 170/16 173/21 174/2 174/22 175/1 175/3 176/4 177/1 177/1 180/11 181/2 181/6 181/10 181/14 181/20 <b>hasn't [1]</b> 29/11 <b>haunted [1]</b> 35/2 <b>haunts [3]</b> 14/21 30/24 30/25 <b>have [245]</b> <b>haven't [9]</b> 30/12 35/23 35/23 51/5 64/3 87/22 101/11 107/11 139/25 <b>having [30]</b> 13/23 13/24 13/25 17/7 18/11 20/6 21/17 25/20 42/3 42/16 48/3 48/16 61/11 64/1 70/3 70/25 75/11 81/21 92/5 100/1 100/11 101/1 103/19 114/17 121/23 121/25 131/6 146/7 155/13 163/5 <b>hazards [2]</b> 143/22 144/4 <b>hazmat [3]</b> 130/16 132/17 133/10 <b>HDU [3]</b> 83/12 84/20 86/1 <b>he [89]</b> 4/22 4/23 5/5 7/25 8/16 8/17 8/18 8/21 9/2 9/4 14/2 14/6 14/8 14/11 14/12 14/13 14/13 15/16 17/3 25/1 25/2 25/3 35/6 41/9 49/16 49/21 52/19 53/1 72/19	<b>he'd [6]</b> 4/20 4/22 81/8 86/5 89/3 90/8 <b>he's [2]</b> 17/4 25/19 <b>head [5]</b> 96/9 114/5 114/6 135/8 153/16 <b>headaches [1]</b> 6/23 <b>headline [1]</b> 151/15 <b>heads [1]</b> 44/15 <b>health [108]</b> 2/14 3/25 5/16 5/19 5/21 6/1 10/3 11/2 11/10 11/16 11/17 17/5 18/22 22/16 23/1 23/22 23/23 24/2 24/11 30/11 31/21 37/2 40/15 43/25 50/11 53/14 53/17 66/1 69/11 71/2 72/4 73/10 74/4 77/1 79/18 93/2 103/21 106/2 110/16 110/17 110/20 111/11 111/12 111/18 112/20 120/12 128/24 129/1 129/8 131/13 138/18 140/7 140/10 142/13 143/10 143/15 143/18 143/25 144/2 144/4 145/8 148/14 148/16 149/6 150/11 150/17 154/5 154/9 155/9 159/3 159/6 159/13 159/17 159/17 159/18 159/20 159/22 160/5 160/10 160/15 160/20 161/4 164/2 165/19 167/9 167/14 167/20 169/13 169/21 170/8 170/17 171/25 172/7 172/20 173/15 173/20 173/21 175/8 178/19 179/12 179/14 180/12 180/14 180/20 181/1 182/3 183/16 183/18 <b>healthcare [63]</b> 2/18 21/22 23/19 24/5	<b>healthcare-related [1]</b> 165/23 <b>hear [9]</b> 1/3 19/23 31/23 49/14 61/15 90/5 116/23 127/10 127/14 <b>heard [38]</b> 13/5 24/8 27/5 33/19 37/1 38/3 38/22 38/22 39/6 42/25 43/19 44/23 55/2 56/23 57/6 57/14 60/23 62/24 67/18 73/22 78/17 83/7 91/4 99/6 105/5 108/6 127/8 138/13 140/9 147/4 149/7 169/9 174/13 174/22 175/3 176/4 177/22 179/1 <b>hearing [9]</b> 1/3 12/25 77/17 99/21 127/15 141/1 154/14 164/1 182/16 <b>hearts [4]</b> 142/16 144/8 150/19 164/22 <b>heart [8]</b> 64/7 119/2 120/1 120/25 121/16 122/2 122/13 124/18 <b>hearts [2]</b> 36/3 36/4 <b>Heathrow [6]</b> 74/5 76/11 76/18 77/3 78/15 78/20 <b>heavily [2]</b> 116/3 137/8 <b>heightened [1]</b> 63/21 <b>Helen [4]</b> 65/7 65/17 66/3 66/17 <b>help [26]</b> 8/1 29/21 33/1 48/18 48/25 58/15 59/10 60/3 61/18 64/6 64/9 68/2 69/21 79/17 83/2 92/4 107/16 112/14 116/4 129/17 136/17 139/6 140/1 160/8 174/25 175/20 <b>helped [6]</b> 45/1 60/22		

<b>H</b>	129/13 131/18 132/3 132/15 133/8 135/2 151/24 162/15 162/20 162/22 162/24 163/3 163/6 163/8 163/15 163/15 163/18 169/2 <b>hospital-acquired [6]</b> 2/11 25/20 37/6 67/22 68/4 68/13 <b>hospitalisation [2]</b> 109/15 120/9 <b>hospitalised [2]</b> 56/7 131/15 <b>hospitals [48]</b> 9/20 10/22 10/24 11/2 11/6 11/17 12/11 13/20 15/25 17/18 19/6 20/24 20/25 21/4 21/21 22/3 22/14 22/15 22/25 24/15 24/23 24/24 25/7 29/5 36/25 37/3 37/7 37/10 37/13 37/23 43/25 45/11 47/4 48/6 50/9 50/12 57/19 69/3 75/13 100/10 120/20 136/5 138/15 141/24 163/10 163/20 164/24 170/5 <b>hour [3]</b> 115/19 116/11 130/7 <b>hours [16]</b> 4/24 5/3 5/7 7/17 10/9 10/13 13/23 28/9 64/11 64/11 80/5 82/9 114/23 125/17 133/20 138/25 <b>household [1]</b> 7/24 <b>Houses [1]</b> 36/6 <b>how [89]</b> 1/10 2/8 2/12 2/21 2/24 10/5 10/8 17/7 18/24 20/5 20/6 22/10 24/14 26/24 26/25 27/19 30/20 30/20 30/21 32/22 34/6 34/7 34/16 35/10 35/24 36/15 38/13 38/14 39/16 41/9 41/10 41/16 41/16 42/20 44/25 45/5 46/5 46/8 47/23 47/25 49/4 51/3 51/10 53/5 53/8 53/10 53/20 54/4 54/5 54/5 54/24 57/24 61/25 64/16 71/20 71/23 71/24 72/14 77/4 84/11 85/20 86/13 89/8 91/4 92/24 94/12 96/13 98/11 100/15 104/5 111/17 113/22 117/3 117/5 124/21 130/18 130/18 132/23 132/24 139/22 144/12 146/23	149/23 151/10 153/17 166/16 175/5 181/10 181/11 <b>however [12]</b> 145/7 145/18 146/13 149/11 151/8 151/11 153/15 158/15 161/15 174/12 174/18 178/2 <b>HSC [2]</b> 156/21 157/6 <b>HSCB [2]</b> 156/24 162/6 <b>HSIB [1]</b> 62/24 <b>hub [6]</b> 52/16 52/19 52/22 53/1 161/19 181/16 <b>hubs [5]</b> 51/7 51/8 51/13 52/7 53/4 <b>hug [1]</b> 122/20 <b>huge [10]</b> 39/2 42/19 48/2 48/19 56/1 56/9 58/5 59/10 85/15 87/19 <b>hugely [5]</b> 47/11 49/9 55/23 56/5 56/11 <b>human [13]</b> 21/13 21/13 22/16 30/22 30/23 80/1 105/16 105/16 110/21 111/15 111/16 168/24 181/23 <b>humbly [1]</b> 167/24 <b>hundreds [1]</b> 12/19 <b>hunger [1]</b> 90/10 <b>husband [12]</b> 34/13 36/4 41/8 44/6 44/8 49/15 49/21 126/10 127/3 127/4 127/8 132/3 <b>husband's [1]</b> 17/25	<b>I break [1]</b> 141/2 <b>I called [1]</b> 79/12 <b>I came [4]</b> 77/18 125/4 132/6 133/25 <b>I can [9]</b> 1/5 41/25 58/8 58/11 65/9 74/20 90/16 95/1 100/21 <b>I can't [9]</b> 1/11 33/20 59/8 79/15 79/25 83/3 108/6 108/8 120/23 <b>I cannot [2]</b> 31/5 101/22 <b>I certainly [1]</b> 133/6 <b>I check [1]</b> 1/21 <b>I come [2]</b> 118/23 127/22 <b>I complained [1]</b> 40/15 <b>I consider [1]</b> 44/7 <b>I contacted [2]</b> 120/4 123/4 <b>I could [4]</b> 1/12 72/18 85/14 85/17 <b>I couldn't [1]</b> 85/5 <b>I did [8]</b> 10/3 13/4 14/10 15/20 38/22 129/24 130/19 140/10 <b>I didn't [14]</b> 22/6 40/13 72/13 83/15 83/16 96/15 104/10 116/19 118/18 118/21 120/22 122/14 133/12 134/18 <b>I do [6]</b> 1/23 53/20 76/10 76/12 107/11 139/24 <b>I don't [16]</b> 11/25 15/7 29/12 31/19 44/6 85/2 89/7 90/7 96/3 96/13 112/2 129/23 137/6 140/7 140/11 143/3 <b>I experienced [2]</b> 84/15 95/18 <b>I explained [1]</b> 40/5 <b>I feel [6]</b> 31/22 35/11 71/5 71/5 84/22 136/23 <b>I felt [4]</b> 40/14 83/24 88/5 117/17 <b>I filmed [1]</b> 95/6 <b>I finally [1]</b> 151/14 <b>I follow [1]</b> 96/12 <b>I found [4]</b> 36/3 40/3 79/15 118/19 <b>I fully [1]</b> 92/10 <b>I gave [1]</b> 122/20 <b>I get [3]</b> 49/18 64/15 136/6 <b>I got [3]</b> 76/19 83/20 115/12 <b>I grabbed [1]</b> 128/8 <b>I had [31]</b> 15/15 41/5 42/6 49/15 66/13 72/8	72/15 80/19 80/22 85/6 97/7 102/19 104/8 109/15 109/16 111/10 111/19 117/17 117/20 117/24 122/25 124/17 124/19 128/18 128/24 129/9 132/5 133/18 133/25 135/7 136/20 <b>I hadn't [3]</b> 89/7 122/21 143/1 <b>I have [21]</b> 32/3 35/13 44/4 46/11 58/3 64/16 65/23 75/10 75/10 84/17 85/21 87/18 91/8 95/3 96/24 101/17 105/24 106/25 129/24 139/5 140/16 <b>I haven't [3]</b> 64/3 87/22 101/11 <b>I hear [1]</b> 31/23 <b>I heard [1]</b> 38/22 <b>I hope [6]</b> 1/15 33/19 89/12 108/13 128/10 139/18 <b>I immediately [1]</b> 2/12 <b>I interposed [1]</b> 127/17 <b>I interviewed [1]</b> 100/12 <b>I invite [3]</b> 140/24 141/18 142/12 <b>I jump [1]</b> 80/10 <b>I just [40]</b> 1/10 32/5 32/5 53/18 59/19 64/1 65/13 69/13 71/13 72/6 78/9 78/18 78/25 80/3 82/6 83/14 83/16 87/23 88/3 89/11 94/2 96/6 96/15 96/25 98/10 98/21 101/2 101/21 105/7 111/6 113/10 113/21 113/24 123/25 128/2 131/8 134/18 135/6 137/21 141/17 <b>I kind [2]</b> 124/25 130/18 <b>I knew [9]</b> 83/17 83/17 84/3 85/24 115/4 115/10 116/21 117/13 128/24 <b>I know [20]</b> 11/7 28/10 29/12 70/21 85/20 91/15 101/14 106/10 107/14 113/19 116/7 116/22 122/10 125/10 126/7 128/11 128/17 130/4 136/24 138/4 <b>I learned [1]</b> 139/21 <b>I leave [1]</b> 143/7 <b>I left [1]</b> 125/3
----------	---	---	---	---

<b>I</b>	124/19 125/10 125/12 125/16 128/14 128/16 128/21 129/3 129/16 129/21 130/1 130/8 130/9 130/16 135/12 136/13 136/17 139/10	80/16 81/1 82/2 82/5 83/4 83/4 83/8 86/11 86/25 87/17 88/22 90/2 91/8 95/15 96/14 96/20 98/1 99/24 100/7 100/8 100/21 101/3 101/7 101/19 102/4 103/4 103/10 105/14 105/14 105/24 110/14 112/23 113/4 113/5 113/15 113/18 115/7 115/13 116/16 118/23 120/8 121/13 121/18 123/11 125/6 125/19 126/19 127/24 131/13 132/18 132/21 133/14 133/23 135/12 137/12 139/11 140/5 182/10	<b>I went [13]</b> 36/2 77/14 84/2 84/4 90/17 97/2 124/6 124/9 125/9 125/16 132/3 134/7 139/21 <b>I will [2]</b> 165/2 182/12 <b>I wish [1]</b> 154/8 <b>I wished [1]</b> 150/8 <b>I witnessed [1]</b> 45/12 <b>I won't [1]</b> 91/6 <b>I wore [1]</b> 82/15 <b>I work [1]</b> 70/22 <b>I would [6]</b> 1/12 13/16 15/15 54/15 77/5 138/8 <b>I'd [21]</b> 1/6 4/3 28/10 28/12 28/19 74/1 76/12 77/5 82/13 88/15 98/7 104/13 112/17 114/21 154/17 158/3 159/16 160/22 161/22 162/19 163/22 <b>I'd also [3]</b> 158/3 160/22 161/22 <b>I'd been [2]</b> 77/5 82/13 <b>I'd done [1]</b> 104/13 <b>I'd highlighted [1]</b> 112/17 <b>I'd just [1]</b> 98/7 <b>I'd like [9]</b> 1/6 4/3 28/19 74/1 76/12 154/17 159/16 162/19 163/22 <b>I'd really [1]</b> 114/21 <b>I'd say [2]</b> 28/10 28/12 <b>I'll [6]</b> 21/19 36/15 49/18 58/7 143/20 154/10 <b>I'll be [2]</b> 21/19 49/18 <b>I'll do [1]</b> 58/7 <b>I'll refer [1]</b> 154/10 <b>I'm [54]</b> 1/13 21/11 25/2 26/12 31/9 32/20 33/19 33/22 35/1 36/7 51/1 51/7 58/6 58/6 59/3 59/8 59/9 59/15 62/6 63/25 64/2 72/5 85/23 87/10 88/24 89/11 93/1 95/4 97/8 97/19 101/17 106/24 107/5 107/8 107/16 108/7 108/11 108/12 121/14 129/4 129/15 130/3 130/11 130/17 134/2 134/18 138/5 139/8 141/7 141/20 142/25 153/25 164/9 182/7 <b>I've [17]</b> 25/11 35/5 39/5 55/17 75/4 75/9 82/14 89/4 89/4 94/6 97/7 97/9 97/16 99/6	103/4 136/9 143/13 <b>I've already [1]</b> 39/5 <b>I've been [2]</b> 35/5 97/9 <b>I've forgotten [1]</b> 82/14 <b>I've had [1]</b> 97/16 <b>I've just [1]</b> 55/17 <b>I've learnt [1]</b> 75/9 <b>I've never [2]</b> 89/4 99/6 <b>I've now [2]</b> 75/4 94/6 <b>I've opted [1]</b> 143/13 <b>I've read [1]</b> 103/4 <b>I've seen [2]</b> 97/7 136/9 <b>I've written [1]</b> 25/11 <b>ICU [1]</b> 46/20 <b>ICUs [2]</b> 13/7 48/23 <b>idea [3]</b> 17/8 22/10 53/4 <b>ideal [1]</b> 165/10 <b>ideally [1]</b> 152/22 <b>identified [11]</b> 6/16 9/11 27/1 28/16 28/17 28/21 29/19 29/23 102/7 161/16 166/19 <b>identify [6]</b> 22/23 26/17 27/8 153/4 157/10 164/19 <b>Identifying [1]</b> 150/3 <b>ie [1]</b> 103/18 <b>if [113]</b> 1/12 4/3 5/10 6/11 8/23 9/5 9/7 10/20 12/4 12/6 15/14 22/13 22/14 22/14 23/6 23/8 24/6 24/7 25/15 28/20 29/8 29/11 29/14 31/16 35/16 39/24 42/25 43/4 44/15 45/1 47/6 47/11 47/15 48/12 48/16 49/18 52/5 52/6 52/15 53/18 53/20 54/15 58/8 62/4 63/22 64/16 65/6 66/15 67/24 68/5 70/8 70/11 72/24 73/15 74/20 75/19 76/3 76/11 77/6 77/13 79/14 79/15 79/25 83/3 84/6 84/8 86/9 86/14 88/24 89/7 93/6 94/9 94/16 96/3 97/20 98/3 98/8 99/10 100/21 100/25 102/6 103/25 106/24 107/15 108/11 108/18 108/19 113/12 114/2 114/4 114/19 114/22 117/4 118/15 119/7 120/23 121/24 122/25 124/10 124/20 124/25 129/4 132/12 134/2 136/17
<b>I literally [1]</b> 10/2 <b>I looked [2]</b> 49/10 134/1 <b>I lost [1]</b> 119/8 <b>I managed [2]</b> 64/18 72/12 <b>I may [14]</b> 4/3 28/20 39/24 43/4 65/6 70/12 76/11 88/24 94/9 99/10 100/25 103/25 106/24 108/19 <b>I mean [14]</b> 7/19 8/7 10/12 17/14 19/19 23/6 27/23 75/23 118/18 127/10 132/2 133/2 133/18 138/3 <b>I mentioned [1]</b> 95/6 <b>I met [2]</b> 122/3 122/18 <b>I might [3]</b> 42/25 54/15 108/18 <b>I move [1]</b> 148/7 <b>I must [1]</b> 101/11 <b>I myself [1]</b> 99/18 <b>I need [5]</b> 53/20 123/24 124/2 124/20 129/21 <b>I needed [1]</b> 80/3 <b>I pause [1]</b> 105/3 <b>I perhaps [1]</b> 89/21 <b>I phoned [1]</b> 79/4 <b>I pour [1]</b> 90/17 <b>I pray [1]</b> 17/13 <b>I probably [2]</b> 122/24 133/8 <b>I promise [4]</b> 58/6 58/14 59/9 108/9 <b>I put [1]</b> 36/4 <b>I rang [1]</b> 120/24 <b>I read [2]</b> 128/21 128/21 <b>I realised [1]</b> 123/2 <b>I really [3]</b> 13/14 83/15 91/10 <b>I received [1]</b> 119/24 <b>I refer [1]</b> 69/25 <b>I remember [29]</b> 72/3 74/24 79/4 79/7 84/21 85/3 86/19 89/14 90/13 92/21 92/21 93/5 94/5 94/6 94/9 94/9 95/18 98/25 113/12 114/17 116/3 116/5 131/15 132/5 133/19 134/1 134/25 135/6 135/20 <b>I requested [2]</b> 123/3 123/5 <b>I said [29]</b> 3/5 14/15 30/17 33/19 65/4 108/8 114/18 120/24 121/7 123/23 124/10	<b>I sat [1]</b> 124/5 <b>I say [4]</b> 30/22 39/10 92/25 104/1 <b>I see [2]</b> 62/4 65/21 <b>I shall [6]</b> 33/7 33/20 58/22 107/22 141/5 142/18 <b>I should [2]</b> 122/11 167/22 <b>I speak [2]</b> 63/19 68/7 <b>I spoke [4]</b> 79/11 102/12 103/8 103/10 <b>I start [1]</b> 61/1 <b>I started [1]</b> 106/21 <b>I suggest [1]</b> 130/2 <b>I suppose [3]</b> 92/25 109/12 137/21 <b>I suspect [2]</b> 105/7 143/4 <b>I take [2]</b> 90/24 126/20 <b>I thank [1]</b> 139/2 <b>I then [1]</b> 2/13 <b>I think [178]</b> 1/11 1/24 2/5 3/21 4/7 4/8 4/19 4/21 5/13 6/2 6/7 6/15 6/21 7/5 7/9 7/13 8/19 9/11 9/24 10/23 11/1 12/1 12/14 13/2 13/17 14/1 14/17 14/23 15/24 16/17 17/16 17/20 18/6 18/7 18/9 18/19 19/6 19/11 20/8 20/10 21/4 21/10 21/20 21/21 22/1 23/18 23/23 25/23 26/9 26/10 27/1 29/19 30/24 31/24 32/13 36/11 38/19 39/1 41/15 41/24 42/25 43/3 43/16 45/7 48/2 49/21 50/8 50/17 50/17 50/18 50/22 51/6 51/8 51/14 51/17 52/6 53/7 53/7 53/13 58/1 59/21 60/4 60/12 60/22 61/3 62/10 62/14 62/19 63/6 63/8 64/14 64/21 65/4 65/24 67/21 67/24 68/7 69/15 69/22 69/22 70/13 71/7 71/14 72/2 72/21 72/22 73/2 73/3 73/4 73/7 73/8 73/11 73/20 74/19 76/2 79/13 80/2 80/5 80/11 80/12	<b>I thought [9]</b> 49/11 49/12 90/15 96/25 97/1 97/2 124/2 134/2 135/15 <b>I told [1]</b> 104/13 <b>I took [2]</b> 90/13 95/5 <b>I tried [2]</b> 103/14 104/5 <b>I turn [2]</b> 73/25 139/3 <b>I understand [6]</b> 42/13 44/25 62/4 123/21 139/20 182/10 <b>I understood [1]</b> 56/14 <b>I want [17]</b> 39/13 43/10 47/21 54/21 67/8 90/4 90/5 92/3 101/16 118/12 124/13 125/12 125/18 129/17 130/11 138/15 144/6 <b>I wanted [2]</b> 112/8 117/19 <b>I was [61]</b> 14/12 14/15 19/23 41/8 44/4 44/5 49/2 49/11 64/16 64/18 65/8 70/22 72/8 72/10 72/19 75/22 76/11 77/4 78/8 79/9 79/10 80/3 80/23 80/23 81/17 83/17 84/3 92/20 93/21 95/6 99/17 101/22 102/11 111/8 112/2 112/6 112/10 112/13 116/2 116/3 116/5 116/13 116/17 116/18 116/19 116/20 117/17 119/10 120/4 120/18 121/11 122/9 122/19 123/19 124/17 128/9 128/9 129/14 133/13 136/25 138/10 <b>I wasn't [7]</b> 35/6 65/16 104/10 111/9 117/22 124/3 129/22		

<b>I</b>	165/3 171/1 172/4	125/25 140/21 141/10	<b>initiative [2]</b> 159/19	11/19
<b>if... [8]</b> 139/3 139/12	<b>Importantly [1]</b> 170/7	142/7 153/25 155/9	159/21	<b>interpreter [1]</b> 9/17
143/3 149/21 152/8	<b>impose [1]</b> 72/16	155/23 163/12 164/9	<b>injury [1]</b> 44/23	<b>interpreting [1]</b>
166/7 172/25 182/9	<b>impossible [1]</b> 52/1	182/7	<b>inner [1]</b> 95/22	150/13
<b>ignorance [1]</b> 83/17	<b>impression [2]</b>	<b>independent [1]</b> 3/20	<b>inpatient [1]</b> 4/12	<b>interrupt [2]</b> 118/11
<b>ignore [1]</b> 152/2	123/25 158/16	<b>INDEX [1]</b> 182/18	<b>input [1]</b> 66/9	134/18
<b>ignored [2]</b> 15/5 39/4	<b>improve [4]</b> 151/12	<b>indicated [1]</b> 40/16	<b>INQ000343992 [1]</b>	<b>intertwined [1]</b> 41/12
<b>ill [1]</b> 163/8	153/17 174/23 179/6	<b>indifference [1]</b>	1/21	<b>intervened [1]</b> 20/9
<b>illness [2]</b> 105/19	<b>improved [4]</b> 60/18	13/11	<b>INQ000360941 [1]</b>	<b>intervention [1]</b>
105/19	71/23 71/24 151/1	<b>indirect [1]</b> 175/7	109/8	160/20
<b>illnesses [2]</b> 73/18	<b>Improvement [1]</b>	<b>individual [16]</b> 18/7	<b>INQs [1]</b> 141/21	<b>interventions [3]</b>
103/8	110/18	26/23 30/9 45/17	<b>inquires [1]</b> 166/18	148/6 149/15 153/12
<b>illusions [1]</b> 175/5	<b>improvements [2]</b>	46/16 46/21 48/20	<b>inquiry [43]</b> 1/9 1/20	<b>interview [1]</b> 100/17
<b>imagine [4]</b> 24/17	151/5 181/10	50/12 54/10 80/5	3/8 3/11 27/5 28/19	<b>interviewed [1]</b>
42/1 42/14 113/25	<b>improving [4]</b> 150/17	104/14 153/10 154/24	29/3 30/6 32/6 33/18	100/12
<b>immediate [1]</b> 173/23	151/10 152/3 160/2	162/10 163/17 179/14	34/6 43/5 58/16 58/20	<b>interviews [1]</b> 70/1
<b>immediately [5]</b> 2/12	<b>Imrie [1]</b> 177/14	<b>individuals [15]</b>	59/7 59/16 108/5	<b>into [61]</b> 26/20 29/25
57/19 66/25 67/1 99/2	<b>inability [3]</b> 35/7	32/22 43/22 48/3 50/1	108/11 109/16 120/17	39/25 45/5 45/23
<b>immunisation [1]</b>	149/14 159/12	51/15 55/2 55/3 56/5	138/2 138/13 139/7	48/10 48/24 56/8
160/3	<b>inadequate [2]</b> 21/23	148/11 149/8 150/3	139/16 139/18 140/13	57/12 60/2 61/16
<b>immunocompromise</b>	38/7	153/5 155/15 155/22	142/7 165/11 165/13	62/24 66/10 66/11
<b>d [3]</b> 25/4 55/14 99/8	<b>inappropriately [2]</b>	179/19	165/16 166/20 168/10	67/20 71/17 74/6
<b>immunosuppressed</b>	39/23 40/17	<b>inequalities [7]</b>	173/1 174/22 175/3	76/16 80/14 81/20
<b>[1]</b> 20/11	<b>incidence [1]</b> 167/13	159/13 159/17 159/17	176/4 177/14 177/22	84/20 86/3 86/18
<b>impact [19]</b> 55/16	<b>incident [1]</b> 120/13	160/5 160/10 173/20	179/11 183/5 183/7	86/23 87/18 93/6
56/1 60/8 91/12 91/15	<b>include [3]</b> 37/11	173/21	183/10 183/13	97/21 100/10 101/12
98/19 100/11 101/15	141/22 145/3	<b>inevitably [2]</b> 87/16	<b>Inquiry's [5]</b> 141/1	104/22 106/11 109/16
113/2 149/5 149/14	<b>included [5]</b> 9/17	175/14	147/9 157/9 164/17	110/15 111/3 111/6
150/21 150/23 158/17	110/14 130/24 158/23	<b>infection [35]</b> 18/25	167/5	111/9 112/25 113/3
162/7 163/7 169/1	169/3	19/5 22/4 34/12 36/13	<b>insanity [1]</b> 19/25	114/7 114/20 115/11
174/8 174/20	<b>including [14]</b> 4/15	36/16 36/20 36/22	<b>insensitive [1]</b> 17/16	116/6 117/1 117/20
<b>impacted [4]</b> 34/7	8/23 87/7 94/23	36/23 36/24 37/6 37/6	<b>insight [3]</b> 61/16	119/13 119/21 120/5
46/5 86/14 101/8	141/25 143/22 143/25	37/11 37/18 37/25	104/22 111/3	120/14 120/19 128/3
<b>impactful [1]</b> 100/17	148/5 150/11 152/25	38/12 38/24 40/1	<b>instead [1]</b> 131/18	128/12 128/16 129/13
<b>impacting [1]</b> 46/9	154/20 164/22 174/24	43/13 45/13 56/4	<b>institutional [1]</b>	130/4 131/24 135/13
<b>impaired [1]</b> 9/15	179/15	67/23 68/4 68/7 68/10	125/24	142/6 142/18 153/10
<b>implement [3]</b> 58/10	<b>inclusion [1]</b> 28/11	68/10 68/13 69/6	<b>instruct [1]</b> 57/19	172/21 181/4
151/13 159/7	<b>incompatible [1]</b>	69/15 70/15 120/15	<b>instructed [1]</b> 168/21	<b>into January [2]</b>
<b>implementation [6]</b>	27/6	144/8 147/20 176/3	<b>instruction [1]</b>	128/3 131/24
28/24 147/1 157/16	<b>inconsequential [1]</b>	176/22	117/11	<b>into March 2020 [1]</b>
165/25 166/2 167/6	177/19	<b>infections [9]</b> 20/6	<b>instrumental [1]</b>	110/15
<b>implemented [13]</b>	<b>inconsistencies [3]</b>	26/15 26/24 36/15	129/10	<b>introduced [1]</b>
21/7 23/5 23/24 58/13	22/24 167/13 167/16	38/21 74/13 145/2	<b>insufficient [3]</b> 37/21	172/19
117/25 131/6 139/12	<b>inconsistency [5]</b>	145/5 178/1	100/2 145/22	<b>introduction [1]</b>
139/14 139/15 146/24	10/24 116/9 136/3	<b>infectious [4]</b> 63/18	<b>Integrated [4]</b> 156/24	159/2
166/18 166/23 167/3	136/11 167/8	143/21 144/24 177/11	157/5 160/17 181/15	<b>intubated [2]</b> 88/16
<b>implementing [3]</b>	<b>inconsistent [2]</b>	<b>influenza [1]</b> 162/3	<b>integration [1]</b> 27/4	96/1
23/21 146/16 165/23	19/18 65/2	<b>inform [1]</b> 174/14	<b>intensive [3]</b> 68/24	<b>intubation [2]</b> 88/21
<b>implements [1]</b>	<b>incorrect [1]</b> 162/24	<b>informal [1]</b> 75/19	72/9 156/25	94/19
159/11	<b>incorrectly [3]</b> 21/23	<b>information [10]</b> 6/8	<b>interest [2]</b> 3/20 84/9	<b>investigated [1]</b>
<b>implications [1]</b>	22/9 71/4	9/19 9/20 9/22 50/13	<b>interestingly [2]</b>	152/8
181/9	<b>increase [5]</b> 83/22	71/16 71/21 159/9	26/21 29/4	<b>investigation [1]</b>
<b>importance [8]</b> 142/5	155/7 166/13 171/2	159/14 175/23	<b>interests [1]</b> 153/20	26/20
146/7 150/1 152/2	173/7	<b>informed [6]</b> 93/16	<b>interfere [1]</b> 111/17	<b>investigations [4]</b>
157/10 157/13 157/21	<b>increased [3]</b> 63/14	100/3 144/20 151/22	<b>interfering [1]</b> 167/19	18/21 26/23 121/24
160/7	67/16 172/11	167/4 175/24	<b>international [1]</b>	166/22
<b>important [24]</b> 15/12	<b>increasing [2]</b> 83/23	<b>informs [1]</b> 145/1	145/10	<b>investment [2]</b>
30/5 30/19 31/4 35/20	139/19	<b>infrastructure [3]</b>	<b>interoperability [1]</b>	106/17 180/20
49/4 50/2 84/12 90/3	<b>incredible [1]</b> 84/1	27/4 29/18 29/20	28/1	<b>invite [5]</b> 140/24
91/14 108/10 119/8	<b>indeed [25]</b> 9/15 16/3	<b>initial [3]</b> 3/7 6/15	<b>interoperable [1]</b>	141/18 141/21 142/10
127/2 127/21 138/22	32/19 33/1 55/5 58/4	144/15	31/13	142/12
138/24 142/17 146/13	60/23 64/15 71/17	<b>initially [6]</b> 3/5 5/1	<b>interposed [1]</b>	<b>involve [1]</b> 175/22
147/7 158/1 162/1	90/23 95/17 107/4	53/13 81/5 125/6	127/17	<b>involved [7]</b> 16/20
	109/2 110/22 117/5	159/22	<b>interpretation [1]</b>	98/6 105/23 108/25

<b>I</b>	7/13 8/2 11/7 11/8 11/9 12/12 19/3 27/2 28/21 29/23 36/19 58/1 74/1 112/16 112/17 144/7 153/19 154/13 154/16 160/3 164/21 172/9 178/16 178/22 179/1	128/3 131/24 133/15 133/15 133/21 145/17 156/7 161/20 <b>January 2021 [1]</b> 161/20 <b>January, [1]</b> 76/9 <b>January, February</b> <b>[1]</b> 76/9 <b>Jenny [1]</b> 70/3 <b>Jenny Harries [1]</b> 70/3 <b>Jo [1]</b> 109/19 <b>job [3]</b> 32/11 82/3 169/24 <b>jobs [1]</b> 103/15 <b>John [1]</b> 168/22 <b>John's [2]</b> 13/10 32/9 <b>Johnson [2]</b> 110/23 112/1 <b>join [4]</b> 2/24 2/25 2/25 82/4 <b>joined [1]</b> 109/18 <b>Jones [2]</b> 4/1 13/10 <b>Jordan [1]</b> 172/22 <b>journey [5]</b> 61/16 81/20 105/17 105/22 105/22 <b>Julia [1]</b> 13/10 <b>Julia Jones [1]</b> 13/10 <b>Julie [1]</b> 168/21 <b>July [20]</b> 21/11 24/3 102/5 113/5 113/7 113/7 113/11 113/12 113/15 114/16 115/13 115/19 115/20 116/20 116/21 118/12 118/15 118/20 176/20 179/11 <b>July 2020 [2]</b> 21/11 116/20 <b>jump [1]</b> 80/10 <b>June [6]</b> 34/12 69/15 70/13 71/5 102/5 179/8 <b>June 2020 [1]</b> 69/15 <b>June/July [1]</b> 102/5 <b>junior [2]</b> 40/16 168/21 <b>just [189]</b> <b>justice [12]</b> 2/2 3/17 57/2 59/19 59/21 60/12 60/18 61/6 65/14 108/18 108/21 109/19 <b>Justice UK [1]</b> 60/12 <b>justified [1]</b> 167/16	<b>keeping [1]</b> 169/24 <b>kent [1]</b> 49/9 <b>kept [4]</b> 20/16 35/15 89/11 176/9 <b>key [13]</b> 4/4 8/13 21/6 27/20 29/2 32/2 47/10 126/20 150/25 152/25 172/10 173/21 180/17 <b>kin [1]</b> 39/21 <b>kind [18]</b> 10/25 12/20 16/3 18/3 26/7 64/17 76/19 87/7 88/19 96/16 109/10 110/2 113/14 122/22 124/22 124/25 130/16 130/18 <b>kinder [1]</b> 44/22 <b>kindly [1]</b> 136/21 <b>kinds [1]</b> 63/24 <b>King's [1]</b> 142/13 <b>King's Counsel [1]</b> 142/13 <b>Kingdom [5]</b> 38/15 38/17 143/14 148/14 168/24 <b>kiss [1]</b> 122/20 <b>Kloer [1]</b> 24/1 <b>knew [25]</b> 9/8 14/5 17/7 49/19 49/21 63/9 72/11 81/15 83/17 83/17 84/3 85/24 115/4 115/10 116/21 117/13 117/25 122/15 122/17 124/25 128/24 130/18 135/6 173/17 178/15 <b>know [356]</b> <b>knowing [1]</b> 65/22 <b>knowledge [6]</b> 64/5 64/9 65/9 156/11 161/9 171/15 <b>known [7]</b> 10/18 15/15 37/15 43/18 85/6 159/3 162/7	138/5 140/3 140/22 140/24 141/11 143/8 143/12 144/6 147/24 148/7 151/14 152/12 153/6 153/23 154/4 154/17 154/19 154/23 156/1 157/7 158/3 159/16 160/2 160/22 161/22 162/19 163/22 164/8 164/14 165/2 166/4 167/22 168/12 168/18 171/19 179/25 180/17 181/22 182/5 182/13 <b>Ladyship [13]</b> 56/18 56/21 62/23 67/17 78/16 105/4 113/1 137/4 138/1 139/3 147/4 150/22 151/18 <b>Lamb [4]</b> 171/25 173/10 178/6 179/11 <b>language [1]</b> 63/5 <b>large [1]</b> 98/15 <b>largely [1]</b> 18/6 <b>largest [1]</b> 172/5 <b>last [12]</b> 15/20 30/8 43/24 50/24 60/24 91/13 114/19 128/21 134/9 139/24 140/17 147/6 <b>lasting [1]</b> 16/18 <b>late [9]</b> 26/5 69/20 69/23 69/24 71/5 72/7 72/19 72/21 79/18 <b>later [14]</b> 16/25 18/1 81/3 81/13 99/13 104/8 113/8 113/20 114/15 119/20 122/6 122/7 130/7 172/23 <b>lateral [2]</b> 24/4 24/15 <b>latter [1]</b> 148/2 <b>laughing [1]</b> 117/11 <b>launched [1]</b> 155/10 <b>Laura [1]</b> 177/14 <b>law [3]</b> 119/14 119/19 119/22 <b>lax [1]</b> 23/5 <b>lay [1]</b> 54/2 <b>layers [1]</b> 95/11 <b>lead [9]</b> 31/21 59/7 59/20 108/5 109/20 147/20 171/21 183/9 183/12 <b>leader [1]</b> 2/1 <b>leaders [6]</b> 32/14 32/14 75/4 75/12 75/12 112/22 <b>leadership [2]</b> 75/20 172/15 <b>leads [3]</b> 30/10 46/24 108/16 <b>learn [1]</b> 130/18 <b>learned [7]</b> 28/18 56/17 94/7 105/8
<b>involved... [3]</b> 109/1 116/3 141/25 <b>involves [2]</b> 150/12 177/12 <b>iPad [3]</b> 12/8 28/7 134/24 <b>IPC [26]</b> 19/24 20/4 20/22 22/23 23/4 23/16 25/13 28/24 39/1 39/8 45/11 144/10 144/11 145/24 146/1 146/2 146/4 146/7 146/12 147/2 147/4 148/3 148/5 151/19 152/3 152/7 <b>Ireland [28]</b> 68/20 108/17 109/21 110/1 110/21 123/4 126/9 129/2 131/6 136/5 154/6 154/9 154/20 155/3 155/7 155/12 156/7 157/9 158/4 158/6 158/12 159/10 160/16 161/5 161/13 162/1 162/22 183/18 <b>Ireland's [1]</b> 158/13 <b>Irish [7]</b> 108/19 108/19 109/8 125/23 127/18 132/19 137/24 <b>is [320]</b> <b>is directly [1]</b> 172/6 <b>isn't [13]</b> 19/25 21/14 22/18 22/20 23/6 28/14 28/15 31/17 57/3 85/20 108/10 135/22 182/11 <b>isolating [1]</b> 55/23 <b>isolation [2]</b> 158/25 175/8 <b>issue [20]</b> 2/20 9/11 16/13 36/16 36/24 37/16 52/6 84/23 116/7 126/8 144/11 154/18 156/1 156/13 157/7 160/10 166/16 176/19 178/3 179/20 <b>issue about [1]</b> 166/16 <b>issue and [1]</b> 37/16 <b>issue for [2]</b> 116/7 126/8 <b>issue going [1]</b> 52/6 <b>issue of [2]</b> 84/23 154/18 <b>issue specifically [1]</b> 2/20 <b>issue that [2]</b> 144/11 156/1 <b>issue was [2]</b> 176/19 178/3 <b>issued [1]</b> 178/10 <b>issues [27]</b> 3/13 5/10	<b>it [435]</b> <b>it'll [1]</b> 58/11 <b>it's [107]</b> 1/18 3/21 5/13 5/23 5/23 6/12 6/17 6/23 6/23 6/24 12/8 12/20 12/21 13/10 13/15 14/21 15/12 15/17 15/18 17/16 18/5 18/18 18/18 18/19 19/25 21/2 21/5 21/11 21/12 21/13 21/13 22/16 22/17 22/17 22/17 22/20 23/23 24/19 25/16 26/18 27/16 27/17 27/23 28/8 28/9 28/13 28/13 29/6 29/16 29/16 30/8 30/8 30/22 31/4 31/12 31/13 31/14 31/17 34/11 34/18 35/22 36/18 36/21 42/19 43/6 49/7 59/14 61/7 62/17 64/6 67/5 67/5 67/24 68/5 73/20 76/23 78/13 80/11 80/14 86/15 87/21 90/14 91/1 91/4 91/13 91/14 95/21 95/21 97/9 97/20 101/8 101/11 101/11 101/19 103/13 105/5 113/20 115/7 123/22 127/1 138/4 138/22 139/6 144/13 147/3 147/7 182/9 <b>Italy [1]</b> 46/2 <b>itch [1]</b> 114/10 <b>itchy [1]</b> 114/5 <b>items [1]</b> 12/18 <b>its [21]</b> 34/18 40/6 60/20 110/16 149/8 149/9 150/15 152/22 152/23 154/16 159/13 160/23 163/25 164/6 165/16 166/13 168/11 169/7 169/11 176/7 181/24 <b>itself [4]</b> 12/24 31/14 137/7 149/1 <b>ITU [3]</b> 82/13 85/22 88/15	<b>January [12]</b> 26/13 34/13 119/8 127/24	<b>J</b>	
	<b>J</b>	<b>K</b>		
		<b>KC [4]</b> 154/6 168/17 183/19 183/23 <b>keen [2]</b> 14/18 34/4 <b>keep [10]</b> 20/1 39/10 77/2 77/8 78/11 89/9 114/22 115/17 139/13 175/20	<b>lab [1]</b> 122/5 <b>labour [1]</b> 156/25 <b>lack [19]</b> 7/1 11/9 12/2 12/10 16/16 25/12 27/4 31/11 31/11 32/7 41/19 71/8 80/8 99/25 147/10 149/11 149/16 157/23 161/24 <b>lacked [2]</b> 16/17 131/4 <b>lacking [1]</b> 158/14 <b>lacks [1]</b> 149/19 <b>lady [59]</b> 1/3 1/6 17/24 33/9 33/14 33/23 43/5 56/24 58/3 58/18 59/3 98/25 99/4 107/2 107/19 108/1 108/13 126/9 127/3	
		<b>L</b>		



<b>L</b>	<b>liaise [1]</b> 31/21	<b>list [3]</b> 18/22 85/14 165/18	<b>long-term [2]</b> 180/2 180/5	<b>lower [2]</b> 160/6 163/16
<b>learned... [3]</b> 137/19 139/21 149/25	<b>liaison [3]</b> 12/1 12/3 16/9	<b>listened [3]</b> 154/12 167/24 179/4	<b>longer [1]</b> 160/8	<b>lucky [3]</b> 44/4 44/7 136/24
<b>learner [1]</b> 130/17	<b>lie [1]</b> 144/2	<b>listeners [1]</b> 171/6	<b>look [32]</b> 4/4 10/20 16/8 19/3 39/13 49/11 50/3 56/25 66/21 71/10 85/19 87/4 88/2 99/18 107/15 114/13 114/18 120/24 123/24 124/10 124/20 124/24 125/10 125/15 129/3 129/14 129/16 129/21 130/1 130/17 136/17 159/23	<b>lunch [2]</b> 117/22 117/23
<b>learning [5]</b> 9/15 29/2 60/15 166/17 180/17	<b>life [25]</b> 23/2 30/3 30/7 30/8 35/9 43/22 45/19 45/20 47/3 89/22 91/11 91/19 91/21 97/3 100/25 103/11 105/16 105/16 119/11 119/16 133/17 134/3 155/5 155/25 170/14	<b>listening [2]</b> 18/19 29/7	<b>looking [21]</b> 11/7 36/22 41/1 41/2 49/8 54/25 66/1 79/24 87/25 93/23 117/15 117/17 131/23 133/6 138/3 151/20 152/18 169/14 172/9 176/3 177/17	<b>lung [1]</b> 119/23
<b>learnt [3]</b> 26/24 75/5 75/9	<b>lifelong [1]</b> 127/12	<b>lists [1]</b> 148/19	<b>looks [2]</b> 45/23 87/5	<b>lupus [6]</b> 96/24 97/7 97/10 97/11 97/13 97/18
<b>least [11]</b> 4/10 8/20 10/18 11/12 11/15 18/10 25/7 95/10 96/5 115/2 179/22	<b>lifetime [1]</b> 91/13	<b>literally [4]</b> 7/20 10/2 93/13 130/6	<b>lost [20]</b> 18/11 32/22 34/16 36/20 46/13 60/13 61/11 81/2 81/5 81/22 90/9 113/23 119/8 119/18 126/10 126/12 127/3 169/3 169/8 182/1	<b>lying [1]</b> 66/12 <b>lying [1]</b> 49/22
<b>leave [4]</b> 76/4 82/3 83/20 143/7	<b>light [6]</b> 29/11 140/8 164/18 168/9 171/7 177/2	<b>literature [2]</b> 97/17 177/15	<b>lot [20]</b> 13/5 31/12 31/23 32/6 66/8 71/3 73/7 73/12 74/20 90/9 91/4 100/9 116/9 119/16 124/8 128/12 133/2 134/23 140/12 169/20	<b>M</b>
<b>leaving [3]</b> 47/3 83/25 136/19	<b>lighting [1]</b> 90/16	<b>litres [1]</b> 125/6	<b>lots [4]</b> 38/3 69/24 96/1 110/6	<b>Mabud [1]</b> 102/13
<b>led [7]</b> 13/9 141/7 148/20 152/20 177/19 181/10 181/14	<b>lightly [1]</b> 69/5	<b>little [8]</b> 15/18 28/12 31/1 76/10 113/21 132/24 137/19 143/20	<b>lottery [1]</b> 10/23	<b>machine [1]</b> 14/7
<b>left [9]</b> 63/23 79/19 125/3 128/7 131/2 133/21 136/7 136/8 136/10	<b>like [76]</b> 1/6 4/3 10/11 14/20 18/15 25/2 28/19 29/3 31/3 31/22 32/9 42/1 54/25 64/11 64/11 65/10 65/18 65/25 66/7 67/16 67/17 69/2 74/1 75/19 76/4 76/12 76/16 77/1 77/13 83/16 86/13 87/5 88/3 88/5 88/9 88/17 89/4 89/25 90/15 96/7 97/23 98/7 99/6 104/1 105/2 109/24 110/1 114/10 117/9 117/17 118/6 122/12 125/6 127/10 127/15 129/23 130/16 132/23 135/3 135/18 135/23 136/23 138/1 138/2 139/4 139/12 154/15 154/17 156/1 158/3 159/16 160/22 161/22 162/19 162/21 163/22	<b>live [7]</b> 77/24 78/2 159/19 159/20 159/25 160/8 160/12	<b>Louisa [1]</b> 172/22	<b>Mackay [1]</b> 178/19
<b>legal [5]</b> 3/1 109/23 110/9 153/19 168/23	<b>like days [1]</b> 64/11	<b>lives [7]</b> 18/6 29/14 34/24 39/3 51/22 60/16 169/4	<b>Louise [4]</b> 1/7 1/8 1/18 183/3	<b>made [35]</b> 18/24 24/5 38/11 42/16 69/16 69/17 70/19 72/15 76/20 81/14 88/20 89/19 94/22 106/12 106/14 112/1 126/2 126/2 126/3 135/4 137/18 148/13 148/15 150/18 156/14 158/9 166/21 169/12 169/16 169/19 171/1 174/7 177/6 178/12 179/5
<b>legislative [3]</b> 138/4 138/16 138/21	<b>like hours [1]</b> 64/11	<b>living [3]</b> 7/23 160/1 160/4	<b>love [3]</b> 35/8 35/10 44/9	<b>main [13]</b> 6/7 9/25 9/25 20/12 36/11 36/19 38/24 52/3 52/10 58/1 98/18 112/17 177/11
<b>legitimately [1]</b> 157/12	<b>like-minded [1]</b> 109/24	<b>load [2]</b> 26/8 96/1	<b>loved [45]</b> 7/7 11/22 12/5 12/15 12/18 13/8 13/14 13/22 13/22 15/11 16/1 17/18 17/19 17/21 18/12 20/9 23/7 25/25 30/3 30/21 34/21 35/16 36/20 40/25 42/16 43/14 43/23 44/2 44/18 45/2 45/19 47/1 49/9 60/14 61/11 64/8 84/24 102/23 113/23 115/8 126/18 134/11 134/15 169/8 182/1	<b>maintaining [2]</b> 43/13 177/7
<b>legs [1]</b> 88/3	<b>likes [2]</b> 129/19 129/20	<b>lobbied [2]</b> 19/2 30/10	<b>low [3]</b> 106/8 160/3 162/12	<b>major [4]</b> 37/16 116/7 126/8 145/21
<b>length [2]</b> 52/20 110/17	<b>likely [6]</b> 22/17 56/6 144/21 145/21 149/3 162/7	<b>lobbying [1]</b> 30/13	<b>lots [4]</b> 38/3 69/24 96/1 110/6	<b>majority [4]</b> 34/6 36/9 42/18 179/23
<b>Les [1]</b> 111/15	<b>limit [1]</b> 169/18	<b>local [18]</b> 9/19 10/19 11/15 23/1 25/15 46/19 146/25 147/1 151/25 161/7 161/8 162/15 162/17 167/13 167/16 167/20 167/21 171/19	<b>lottery [1]</b> 10/23	<b>make [34]</b> 21/16 34/21 43/4 45/25 56/3 57/9 58/11 68/23 72/13 79/6 95/13 101/23 101/25 103/14 104/1 124/13 134/25 138/10 138/21 139/16 142/25 144/13 147/18 150/8 151/4 153/6 154/8 158/3 162/19 165/11 167/2 169/17 173/9 175/24
<b>Les Allamby [1]</b> 111/15	<b>limited [2]</b> 157/25 180/19	<b>local [18]</b> 9/19 10/19 11/15 23/1 25/15 46/19 146/25 147/1 151/25 161/7 161/8 162/15 162/17 167/13 167/16 167/20 167/21 171/19	<b>lottery [1]</b> 10/23	<b>makers [2]</b> 105/10 171/7
<b>less [7]</b> 34/13 70/11 70/11 87/16 145/21 165/14 176/13	<b>limiting [1]</b> 167/19	<b>locate [1]</b> 18/13	<b>lots [4]</b> 38/3 69/24 96/1 110/6	<b>makes [1]</b> 153/11
<b>lesson [3]</b> 105/8 149/25 150/25	<b>line [5]</b> 103/2 104/17 104/17 105/9 107/6	<b>locating [1]</b> 163/14	<b>lottery [1]</b> 10/23	<b>making [15]</b> 16/20 42/3 46/8 46/9 72/10 78/10 81/19 93/22 98/10 104/23 139/25 171/9 174/11 174/15 180/23
<b>lessons [4]</b> 26/24 28/18 56/17 60/16	<b>liner [1]</b> 18/4	<b>location [5]</b> 62/17 162/24 163/5 163/6 163/11	<b>lots [4]</b> 38/3 69/24 96/1 110/6	<b>making another [1]</b> 93/22
<b>let [6]</b> 38/9 79/17 79/17 118/11 122/15 125/18	<b>link [1]</b> 44/15	<b>lock [1]</b> 80/23	<b>lots [4]</b> 38/3 69/24 96/1 110/6	<b>male [1]</b> 85/21
<b>let's [3]</b> 97/3 100/9 113/25	<b>links [1]</b> 153/2	<b>lockdown [1]</b> 72/17	<b>lots [4]</b> 38/3 69/24 96/1 110/6	
<b>letter [5]</b> 8/20 8/20 8/23 9/1 102/17	<b>liquid [3]</b> 118/3 118/7 131/3	<b>lockdowns [1]</b> 70/25	<b>lots [4]</b> 38/3 69/24 96/1 110/6	
<b>letters [2]</b> 10/12 111/2		<b>locked [3]</b> 126/25 128/18 137/13	<b>lots [4]</b> 38/3 69/24 96/1 110/6	
<b>level [19]</b> 11/18 38/12 47/19 49/12 76/7 86/4 98/23 102/16 114/11 116/16 116/17 118/13 146/25 152/1 152/21 161/8 161/9 162/15 162/16		<b>log [1]</b> 77/12	<b>lots [4]</b> 38/3 69/24 96/1 110/6	
<b>level 4 [1]</b> 116/16		<b>London [3]</b> 76/25 83/23 97/25	<b>lots [4]</b> 38/3 69/24 96/1 110/6	
<b>levels [9]</b> 14/2 14/4 82/25 100/2 118/19 118/22 124/8 130/24 161/8		<b>loneliness [1]</b> 175/8	<b>lots [4]</b> 38/3 69/24 96/1 110/6	

<b>M</b>	93/14 96/9 116/20 117/4 122/19 122/19 128/3 130/15 147/18 147/19 178/9 179/24 <b>masks [27]</b> 21/24 22/7 22/8 48/12 69/16 70/4 70/21 70/24 94/20 94/23 94/25 95/13 96/2 96/3 117/6 122/16 132/22 133/4 147/9 147/11 147/12 147/13 152/7 152/11 177/22 177/23 179/23 <b>massive [3]</b> 32/8 104/25 131/16 <b>material [1]</b> 142/17 <b>materially [1]</b> 158/12 <b>materials [1]</b> 144/19 <b>Matt [4]</b> 59/17 90/24 104/15 109/19 <b>Matt Hancock [1]</b> 104/15 <b>matter [11]</b> 14/19 17/11 30/17 53/6 67/10 141/18 146/24 148/7 156/17 158/18 171/22 <b>mattered [1]</b> 129/12 <b>matters [9]</b> 58/8 60/4 107/10 108/25 110/4 150/15 155/24 156/9 161/7 <b>maximised [1]</b> 160/21 <b>may [39]</b> 4/3 22/2 28/20 33/14 39/24 43/4 65/6 70/12 71/17 76/11 78/10 88/24 90/23 94/9 99/10 100/25 103/25 106/24 107/13 108/19 128/1 140/11 140/11 140/24 142/7 144/11 145/6 147/21 156/8 156/9 157/12 165/13 170/24 174/14 175/22 176/2 178/7 179/11 179/14 <b>maybe [10]</b> 22/13 24/17 31/11 31/12 110/7 110/9 117/10 122/10 125/3 133/5 <b>McKinlay [1]</b> 168/21 <b>McNeill [4]</b> 164/11 164/13 168/13 183/21 <b>McPhail [1]</b> 168/22 <b>me [51]</b> 1/11 2/21 15/21 25/12 36/5 38/9 40/12 40/13 44/11 48/25 49/14 53/16 53/20 76/20 79/17 79/17 81/17 82/14 84/2 85/12 100/8 104/22 106/6 108/10 112/1 117/12 118/11	120/23 121/5 122/8 122/15 123/10 123/21 123/23 123/23 124/12 125/14 125/18 128/13 128/13 128/20 129/17 130/19 135/22 136/18 136/20 136/21 138/19 140/15 142/20 150/7 <b>mean [39]</b> 5/18 7/19 7/21 7/25 8/7 10/12 17/14 19/19 21/1 21/2 22/6 22/17 22/20 23/6 24/14 27/23 59/9 64/3 69/3 69/4 75/23 78/4 102/14 108/10 118/8 118/18 122/19 124/12 124/12 127/10 129/5 132/2 133/2 133/18 134/18 135/12 138/3 155/20 158/17 <b>meaning [2]</b> 40/7 84/24 <b>meaningless [1]</b> 31/24 <b>means [8]</b> 11/23 41/3 52/8 73/5 78/3 153/9 153/13 173/12 <b>meant [4]</b> 25/19 51/11 102/9 161/12 <b>measure [3]</b> 147/6 152/3 168/6 <b>measures [12]</b> 19/6 22/24 23/4 28/24 43/14 120/16 145/1 145/3 147/6 171/13 173/22 176/22 <b>mechanics [1]</b> 45/8 <b>mechanism [1]</b> 166/12 <b>mechanisms [1]</b> 146/8 <b>media [4]</b> 46/1 48/21 63/7 102/11 <b>medical [13]</b> 3/25 8/9 40/18 41/2 60/3 64/9 67/15 70/3 81/19 124/20 152/15 166/6 172/20 <b>medically [1]</b> 114/25 <b>medication [6]</b> 13/24 54/9 92/4 118/2 118/7 131/3 <b>medications [1]</b> 87/9 <b>medicine [6]</b> 13/6 59/22 60/1 63/20 65/22 101/17 <b>meet [5]</b> 77/9 77/20 106/5 138/9 140/10 <b>meeting [3]</b> 74/25 176/20 177/4 <b>meetings [5]</b> 3/22 3/24 75/10 157/6 173/13 <b>member [10]</b> 2/1	15/1 16/3 34/2 54/8 55/6 61/12 117/23 135/25 138/17 <b>members [92]</b> 2/21 2/23 2/24 4/7 4/11 4/15 5/11 6/2 7/5 7/14 7/16 8/4 8/5 10/21 12/14 13/18 16/19 17/17 18/10 18/10 18/16 19/4 19/8 19/12 19/16 20/8 21/22 22/2 23/3 25/24 27/2 29/3 30/5 34/5 34/7 35/15 36/18 36/20 39/18 39/21 40/23 42/10 42/13 42/14 45/10 45/12 45/19 47/6 52/2 52/18 53/11 54/6 54/7 54/22 55/1 55/4 55/11 55/12 55/13 55/19 55/21 55/25 60/13 60/20 61/4 61/6 62/11 62/20 63/1 64/20 65/16 67/7 67/13 67/19 67/22 68/14 69/19 71/8 71/14 84/13 84/22 92/9 108/24 110/24 125/23 126/5 127/19 132/19 132/21 133/1 134/10 137/24 <b>members' [1]</b> 16/14 <b>membership [3]</b> 50/15 51/23 65/3 <b>memorial [3]</b> 36/3 60/23 109/2 <b>mends [1]</b> 1/15 <b>mental [3]</b> 73/10 149/6 175/8 <b>mention [5]</b> 31/10 65/12 101/22 147/3 156/2 <b>mentioned [11]</b> 4/18 38/18 39/5 53/10 55/19 65/17 95/6 121/25 122/2 122/13 139/9 <b>message [8]</b> 6/4 12/15 12/17 70/7 72/4 79/19 80/2 80/4 <b>messaging [5]</b> 53/21 69/24 72/21 73/3 148/16 <b>met [7]</b> 24/10 119/6 121/18 122/3 122/18 128/9 178/23 <b>metric [1]</b> 144/23 <b>might [13]</b> 41/1 42/25 49/12 54/15 62/18 71/10 80/5 86/1 88/17 90/15 97/14 102/3 108/18 <b>mild [1]</b> 115/14 <b>miles [1]</b> 18/17	<b>military [5]</b> 75/23 160/23 160/25 161/2 166/6 <b>milliary [1]</b> 161/15 <b>million [1]</b> 180/10 <b>mind [8]</b> 56/21 58/8 62/11 85/7 88/15 128/18 173/24 176/10 <b>minded [4]</b> 90/2 93/17 100/3 109/24 <b>mindset [1]</b> 70/15 <b>mine [1]</b> 88/2 <b>minimise [2]</b> 45/1 68/5 <b>minister [18]</b> 3/24 3/24 24/11 70/2 102/18 103/20 110/23 111/12 112/21 112/21 120/12 138/7 138/7 140/10 155/9 159/18 159/18 174/9 <b>Minister Nesbitt [1]</b> 159/18 <b>ministerial [1]</b> 176/23 <b>ministers [4]</b> 168/1 172/2 174/16 178/23 <b>minorities [5]</b> 158/7 158/22 159/10 175/2 179/4 <b>minority [6]</b> 102/2 102/7 158/24 174/16 174/20 179/16 <b>minute [5]</b> 20/4 31/6 47/3 88/7 126/14 <b>minutes [8]</b> 14/7 14/14 45/24 64/10 125/4 126/16 130/7 141/2 <b>miss [2]</b> 7/4 173/5 <b>Miss Freeman [1]</b> 173/5 <b>missed [1]</b> 12/20 <b>mission [1]</b> 173/21 <b>mistakes [1]</b> 60/20 <b>Mitchell [4]</b> 168/15 168/17 182/7 183/23 <b>mitigate [1]</b> 171/12 <b>mitigation [1]</b> 145/2 <b>mixed [9]</b> 52/2 53/23 54/7 54/13 55/2 55/8 64/24 134/11 134/13 <b>mixture [1]</b> 134/21 <b>MLA [2]</b> 111/19 123/4 <b>Mm [2]</b> 92/8 135/14 <b>mobile [6]</b> 12/19 47/23 48/3 48/15 48/25 50/19 <b>mode [1]</b> 177/12 <b>model [1]</b> 175/23 <b>modelled [1]</b> 162/3 <b>modelling [1]</b> 162/12 <b>models [2]</b> 179/22 180/13
----------	---	--	--	---

<b>M</b>	161/7 161/9 169/15 171/22	<b>Mrs Waterton [3]</b> 33/25 58/4 139/11	<b>mum [51]</b> 30/25 33/2 35/7 36/3 39/25 40/3 44/5 44/5 44/8 49/1 49/2 49/10 49/13 49/18 54/16 54/20 56/12 112/4 112/24 113/3 113/6 113/11 114/11 115/18 116/2 117/20 117/21 118/1 118/2 118/14 119/1 119/3 119/12 119/21 121/7 121/18 121/20 121/22 123/11 125/15 125/19 129/22 130/5 130/25 131/23 132/15 133/14 133/20 134/6 134/9 137/23	164/14 165/2 166/4 167/22 168/12 171/19 179/25 180/17 181/22 182/5 182/13
<b>modular [1]</b> 31/7	<b>mother [21]</b> 19/17 34/11 40/8 48/23 56/15 65/7 66/4 66/17 66/25 91/16 92/11 118/17 119/6 119/14 119/19 119/22 123/17 126/12 127/22 132/5 135/1	<b>Ms [41]</b> 1/5 1/8 1/10 1/19 33/5 33/6 33/17 38/20 59/5 108/3 108/4 108/6 108/22 130/10 137/4 142/21 143/19 154/2 154/6 164/9 164/11 164/13 168/13 168/21 170/23 172/4 172/13 173/1 173/10 173/10 174/7 177/14 178/6 178/14 179/11 182/14 183/3 183/6 183/11 183/19 183/21	182/5 182/13	<b>myriad [1]</b> 170/2
<b>module [25]</b> 1/20 4/5 36/22 38/3 39/11 43/1 43/20 56/23 59/7 78/18 108/5 112/24 113/1 113/19 138/5 139/2 142/4 142/6 143/16 144/8 150/14 163/23 168/4 183/10 183/13	<b>mother's [2]</b> 53/19 123/3	<b>Ms Carey [5]</b> 59/5 108/3 108/22 142/21 182/14	182/5 182/13	<b>myself [2]</b> 44/6 99/18
<b>Module 1 [2]</b> 78/18 138/5	<b>mothers [1]</b> 88/1	<b>Ms Ferguson [2]</b> 108/6 137/4		<b>N</b>
<b>Module 3 [6]</b> 4/5 56/23 139/2 142/4 144/8 168/4	<b>mouth [2]</b> 40/14 90/6	<b>Ms Freeman [8]</b> 38/20 170/23 172/4 172/13 173/1 173/10 174/7 178/14		<b>name [6]</b> 1/17 59/13 65/6 77/10 82/15 129/23
<b>modules [2]</b> 142/1 180/18	<b>move [9]</b> 5/10 19/3 43/10 51/1 51/20 87/6 92/3 148/7 150/7	<b>Ms Lamb [3]</b> 173/10 178/6 179/11		<b>namely [1]</b> 171/8
<b>moment [12]</b> 42/21 71/12 74/24 75/6 78/10 88/6 90/20 113/25 121/17 134/4 134/4 142/9	<b>moved [9]</b> 11/2 18/15 22/2 28/4 82/7 88/7 128/4 133/22 176/2	<b>Ms Laura Imrie [1]</b> 177/14		<b>names [2]</b> 77/21 78/1 103/23
<b>moments [3]</b> 43/24 44/10 134/9	<b>movement [4]</b> 37/15 39/6 56/9 75/25	<b>MS MARGARET [2]</b> 33/17 183/6		<b>narratives [2]</b> 103/19 103/23
<b>Monday [1]</b> 113/15	<b>moving [2]</b> 39/8 84/25	<b>Ms Marsh-Reese [3]</b> 1/10 1/19 33/6		<b>nasal [1]</b> 13/25
<b>money [2]</b> 29/13 106/17	<b>Mr [23]</b> 33/16 37/2 38/18 67/12 102/13 142/12 143/9 143/11 153/25 154/2 155/10 156/5 156/10 156/14 156/16 157/8 157/12 160/24 168/15 174/12 174/19 182/7 183/16	<b>MS MARTINA FERGUSON [2]</b> 108/4 183/11		<b>nation [2]</b> 43/7 51/21
<b>monitored [2]</b> 158/17 173/11	<b>Mr Abdul [1]</b> 102/13	<b>Ms McNeill [4]</b> 164/11 164/13 168/13 183/21		<b>national [11]</b> 25/14 36/2 60/23 72/17 145/10 146/15 146/23 148/14 151/25 179/21 181/5
<b>monitoring [1]</b> 74/5	<b>Mr Aidan Dawson [1]</b> 156/5	<b>Ms Murnaghan [3]</b> 154/2 164/9 183/19		<b>nations [3]</b> 43/21 146/5 146/18
<b>month [4]</b> 113/5 113/8 113/10 172/23	<b>Mr Dawson [3]</b> 156/14 157/8 157/12	<b>Ms Nield [2]</b> 1/5 33/5		<b>natural [1]</b> 143/5
<b>months [9]</b> 16/25 24/15 54/13 100/22 123/2 128/19 128/22 133/7 167/25	<b>Mr Dawson's [2]</b> 156/10 156/16	<b>Ms Verrall-Withers [1]</b> 143/19		<b>nature [5]</b> 38/2 43/16 50/21 161/4 181/6
<b>moral [2]</b> 44/23 44/23	<b>Mr Fowler [1]</b> 67/12	<b>much [45]</b> 8/12 28/15 32/3 32/17 32/19 32/25 34/22 35/10 44/9 44/22 44/25 46/19 47/18 49/20 58/4 58/15 58/21 59/11 73/16 73/22 84/22 97/21 102/23 105/21 107/1 107/4 107/11 108/14 122/14 132/23 133/9 136/11 139/6 140/21 141/10 143/8 150/12 153/25 154/7 158/4 164/8 164/9 166/12 168/13 182/7		<b>nausea [1]</b> 6/24
<b>more [31]</b> 4/14 15/10 15/16 31/21 32/4 34/24 34/25 50/5 62/18 63/21 65/11 77/20 92/5 95/4 137/19 141/5 147/19 148/1 148/4 151/1 152/6 152/9 152/9 153/9 153/11 153/14 163/16 165/14 167/11 171/21 177/22	<b>Mr Mitchell [2]</b> 168/15 182/7	<b>multiple [3]</b> 150/5 153/8 173/13		<b>navigate [1]</b> 100/15
<b>Morgan [1]</b> 24/11	<b>Mr Rawat [4]</b> 142/12 143/11 153/25 183/16			<b>Near [1]</b> 53/16
<b>morgue [1]</b> 18/11	<b>Mr Scott [1]</b> 33/16			<b>nearest [1]</b> 67/3
<b>morning [15]</b> 33/14 33/25 34/1 59/3 120/3 120/23 121/4 121/13 125/14 126/19 133/21 135/5 136/13 139/11 182/12	<b>Mr Swann [2]</b> 155/10 160/24			<b>nearly [1]</b> 63/23
<b>mortality [1]</b> 148/10	<b>Mr Yousaf [4]</b> 37/2 38/18 174/12 174/19			<b>nebulised [1]</b> 83/5
<b>most [19]</b> 7/19 13/8 16/22 16/23 35/8 45/2 56/6 114/9 118/17 119/8 138/24 145/1 148/12 149/4 159/21	<b>Mrs [20]</b> 19/9 32/3 32/18 32/19 33/25 58/4 108/2 108/16 112/23 115/21 123/15 126/4 127/24 137/25 139/1 139/4 139/5 139/11 140/19 141/3			<b>necessarily [1]</b> 30/14
	<b>Mrs Ferguson [11]</b> 112/23 115/21 123/15 126/4 127/24 137/25 139/1 139/4 139/5 140/19 141/3			<b>necessary [4]</b> 149/20 153/19 165/12 168/11
	<b>Mrs Marsh-Reese [4]</b> 19/9 32/3 32/18 32/19			<b>need [53]</b> 7/8 8/10 9/2 13/14 20/23 29/12 29/24 30/21 30/21 31/20 31/23 31/25 32/13 47/14 47/15 53/20 64/8 66/9 68/16 68/24 72/13 77/24 77/25 77/25 78/1 78/2 80/6 85/2 91/6 92/24 94/18 107/8 107/15 116/19 122/24 123/24 124/2 124/20 126/16 129/21 129/21 137/6 138/20 138/21 147/16 148/4 152/6 152/7 152/10 153/17 157/24 159/21 166/11
	<b>Mrs Martina Ferguson [1]</b> 108/2			<b>needed [22]</b> 2/19 7/1 8/16 24/12 24/13 43/18 47/8 47/8 53/8 64/5 68/20 68/21 68/22 69/9 80/3 81/11 82/7 98/22 109/15 120/1 151/4 172/25

<b>N</b>	<b>Nightingale [7]</b> 21/1 57/21 162/20 162/22 163/3 163/6 163/17 <b>nights [1]</b> 40/1 <b>nine [2]</b> 128/19 133/7 <b>nine months [1]</b> 128/19 <b>NMC [1]</b> 42/6 <b>no [72]</b> 7/8 7/25 8/10 9/23 10/12 12/11 17/7 19/22 20/21 21/2 22/10 23/7 23/8 23/9 28/7 31/14 32/3 35/18 39/9 41/13 46/19 46/22 50/15 51/6 56/8 58/3 61/13 64/12 66/6 71/2 74/13 76/6 77/25 90/18 93/23 94/14 95/14 97/3 97/12 106/9 107/4 109/2 117/10 118/11 118/11 121/6 122/1 123/9 123/10 125/21 126/10 128/10 128/15 128/15 132/2 133/11 135/4 136/1 137/4 137/11 139/5 139/5 155/7 161/2 163/24 165/10 169/18 171/10 173/2 173/5 175/5 175/8 <b>No. [1]</b> 106/9 <b>No. 10 [1]</b> 106/9 <b>nobody [8]</b> 13/11 13/12 20/3 122/2 132/7 136/17 137/13 138/21 <b>nodding [2]</b> 95/2 105/4 <b>non [16]</b> 2/5 4/21 19/15 19/17 20/18 35/4 37/20 56/10 56/14 120/15 122/24 142/1 149/15 163/21 172/17 173/25 <b>non-Covid [6]</b> 19/15 20/18 37/20 56/10 142/1 163/21 <b>non-Covid-related [1]</b> 120/15 <b>non-pandemic [1]</b> 35/4 <b>non-pharmaceutical [1]</b> 149/15 <b>non-political [1]</b> 2/5 <b>non-urgent [2]</b> 172/17 173/25 <b>non-verbal [1]</b> 122/24 <b>None [5]</b> 38/16 38/17 85/8 129/18 137/18 <b>nonetheless [1]</b> 81/4 <b>nor [1]</b> 19/22 <b>normal [14]</b> 81/4 81/9 83/25 85/25	86/24 86/25 87/1 93/14 95/22 97/5 112/11 113/17 116/2 126/24 <b>normally [7]</b> 66/11 81/10 84/11 85/21 89/17 99/2 112/13 <b>norovirus [1]</b> 47/17 <b>North [13]</b> 65/8 65/9 72/9 74/3 74/9 74/11 74/14 76/24 78/8 81/18 83/24 93/3 97/25 <b>Northern [35]</b> 108/17 108/18 108/19 109/8 109/21 109/25 110/21 123/4 125/23 126/9 127/18 129/2 131/6 132/19 136/5 137/24 154/6 154/9 154/20 155/3 155/7 155/12 156/7 157/9 158/4 158/6 158/12 158/13 159/10 160/16 161/5 161/13 162/1 162/22 183/18 <b>Northern Ireland [23]</b> 110/21 126/9 129/2 131/6 136/5 154/6 154/9 154/20 155/3 155/7 155/12 156/7 157/9 158/4 158/6 158/12 159/10 160/16 161/5 161/13 162/1 162/22 183/18 <b>Northern Ireland's [1]</b> 158/13 <b>nose [3]</b> 114/3 114/4 114/9 <b>noses [1]</b> 133/5 <b>nosocomial [20]</b> 22/4 26/14 26/20 26/24 34/12 36/12 36/15 36/16 36/20 36/22 36/24 37/6 37/11 37/17 38/12 38/20 38/24 56/4 164/24 178/1 <b>not [208]</b> <b>note [3]</b> 117/19 129/19 162/1 <b>noted [2]</b> 172/4 176/21 <b>notes [5]</b> 5/8 16/24 41/2 41/2 114/20 <b>nothing [5]</b> 10/5 10/10 26/21 63/23 77/14 <b>notice [4]</b> 16/21 118/21 133/8 166/14 <b>notices [8]</b> 16/15 27/9 27/10 126/6 154/22 154/25 155/6 155/8	<b>notwithstanding [3]</b> 127/11 132/18 178/12 <b>novel [2]</b> 144/15 148/12 <b>November [5]</b> 1/1 1/20 24/4 159/5 182/17 <b>November 2023 [1]</b> 159/5 <b>November, [1]</b> 72/16 <b>now [50]</b> 1/12 5/10 14/12 24/8 29/9 30/11 33/5 39/13 40/8 40/15 43/10 47/21 51/1 73/4 73/12 73/14 73/21 75/4 87/18 88/1 94/6 96/23 99/16 100/4 106/7 110/12 112/23 119/21 120/17 123/11 128/2 130/3 130/21 132/18 136/14 139/9 142/21 145/24 146/9 148/5 153/22 156/1 159/16 160/22 172/8 173/20 176/3 177/17 180/14 181/16 <b>nowadays [1]</b> 12/7 <b>NPIs [1]</b> 174/15 <b>NSS [1]</b> 178/12 <b>nuanced [1]</b> 171/11 <b>nuclear [1]</b> 143/23 <b>number [59]</b> 3/17 3/22 4/7 5/2 5/22 7/15 15/24 16/14 17/17 18/20 19/7 19/11 21/22 22/5 22/14 23/18 28/17 28/25 39/16 42/5 42/14 56/3 60/4 61/3 67/13 67/18 67/25 71/8 71/14 74/1 77/15 79/12 79/13 80/13 86/8 87/19 97/9 98/3 98/5 98/15 102/1 105/6 105/16 108/24 112/16 120/10 125/22 130/22 137/23 141/23 141/25 156/15 157/25 163/13 165/10 169/18 172/10 180/6 181/20 <b>numbered [1]</b> 27/16 <b>numbers [6]</b> 35/21 66/2 77/16 77/19 86/22 103/17 <b>nurse [15]</b> 42/4 46/11 48/24 79/11 95/19 96/13 106/14 122/1 127/8 128/10 128/13 129/14 136/6 136/14 136/20 <b>nurses [8]</b> 31/6 82/24 89/8 89/13 89/17 114/8 118/24 135/20 <b>nurses' [1]</b> 79/5 <b>nursing [5]</b> 43/20	45/16 113/4 172/20 173/15
		<b>O</b>		
		<b>o'clock [2]</b> 33/8 182/12 <b>objective [1]</b> 3/7 <b>obligations [1]</b> 166/9 <b>observation [1]</b> 114/22 <b>observations [3]</b> 38/19 60/11 144/13 <b>observatory [1]</b> 174/25 <b>observe [1]</b> 82/24 <b>observed [1]</b> 150/12 <b>obtain [1]</b> 153/8 <b>obtained [2]</b> 142/3 142/6 <b>obvious [2]</b> 44/20 174/3 <b>obviously [21]</b> 1/13 9/4 9/25 15/18 22/5 26/6 33/21 67/16 69/14 78/17 89/17 90/22 97/12 104/11 107/5 115/21 125/8 139/7 139/19 141/6 142/16 <b>occasion [3]</b> 84/14 91/25 96/15 <b>occasions [2]</b> 20/8 178/7 <b>occur [1]</b> 155/5 <b>occurred [1]</b> 142/20 <b>October [5]</b> 2/11 7/4 8/22 9/8 179/17 <b>off [12]</b> 27/15 31/6 45/20 88/8 89/13 90/11 90/12 90/19 99/3 106/13 106/15 122/20 <b>offer [6]</b> 35/9 44/3 44/8 52/15 148/10 167/25 <b>offered [3]</b> 5/21 11/24 14/2 <b>office [2]</b> 111/11 160/13 <b>officer [8]</b> 4/1 8/9 31/20 60/2 70/3 152/16 152/20 173/15 <b>officers [3]</b> 43/20 45/16 111/19 <b>officially [1]</b> 172/23 <b>officials [2]</b> 110/16 168/2 <b>often [7]</b> 47/24 69/8 70/25 104/12 115/5 126/1 169/12 <b>Oh [3]</b> 18/15 22/18 49/11 <b>okay [9]</b> 72/25 75/6 77/7 79/4 79/8 104/6		

<b>O</b>	<p><b>online [2]</b> 31/7 46/1</p> <p><b>only [26]</b> 6/10 6/10 8/23 8/25 9/4 9/5 9/6 13/1 21/12 24/17 39/20 41/25 49/1 69/8 70/14 98/2 116/10 122/6 123/1 128/23 137/12 139/10 148/13 155/5 156/6 174/8</p> <p><b>onslaught [1]</b> 70/18</p> <p><b>onto [2]</b> 36/4 87/6</p> <p><b>onwards [2]</b> 13/18 106/22</p> <p><b>open [3]</b> 102/17 137/16 176/10</p> <p><b>opened [3]</b> 18/1 87/7 172/23</p> <p><b>opening [4]</b> 22/16 164/15 168/5 171/17</p> <p><b>operate [2]</b> 41/17 68/9</p> <p><b>operated [2]</b> 39/17 151/19</p> <p><b>operating [3]</b> 6/5 75/17 152/20</p> <p><b>operation [1]</b> 149/7</p> <p><b>operational [7]</b> 146/3 150/15 157/16 158/20 161/9 162/10 172/15</p> <p><b>operationalise [1]</b> 151/25</p> <p><b>operationalised [1]</b> 53/9</p> <p><b>opinion [2]</b> 145/20 157/14</p> <p><b>opportunities [1]</b> 155/16</p> <p><b>opportunity [4]</b> 44/1 44/2 92/10 104/8</p> <p><b>opted [1]</b> 143/13</p> <p><b>optimal [1]</b> 174/21</p> <p><b>option [1]</b> 171/10</p> <p><b>or [127]</b> 3/1 4/11 6/16 7/1 8/20 9/14 9/15 10/18 10/18 11/23 12/25 13/21 15/17 16/3 17/23 18/4 18/22 18/25 18/25 20/21 20/24 21/21 21/23 22/8 22/25 25/13 25/14 25/15 25/17 26/1 30/16 31/21 38/22 40/22 41/3 41/21 42/13 43/6 46/20 46/20 47/8 47/16 50/6 50/11 50/21 51/16 54/4 55/5 55/21 62/2 63/3 63/4 64/3 67/12 69/9 70/5 70/10 70/24 71/21 73/18 76/5 76/24 78/5 80/1 80/8 83/3 84/4 84/20 85/17 86/13 89/24 91/18 93/12</p>	<p>94/19 95/11 96/1 96/23 98/18 103/23 105/10 106/14 111/23 112/10 117/10 117/15 119/8 120/24 122/16 123/14 124/10 126/2 126/25 128/1 129/13 130/2 131/12 131/22 131/25 131/25 132/23 132/25 133/11 133/16 134/11 134/24 138/1 143/15 144/1 144/9 144/19 151/24 152/4 152/9 154/21 155/3 155/4 155/19 157/14 164/21 165/8 166/23 167/16 167/19 177/12 177/19 180/4 180/8</p> <p><b>or January 2021 [1]</b> 119/8</p> <p><b>oral [5]</b> 56/22 142/16 160/24 168/19 182/5</p> <p><b>order [6]</b> 7/24 60/16 61/25 62/2 165/24 172/15</p> <p><b>ordinating [2]</b> 152/16 152/24</p> <p><b>ordination [1]</b> 161/16</p> <p><b>organisation [2]</b> 2/5 2/6</p> <p><b>organisational [1]</b> 180/24</p> <p><b>organisations [6]</b> 3/18 111/25 143/25 151/8 167/9 174/14</p> <p><b>other [61]</b> 2/13 3/20 6/12 16/8 17/2 23/4 25/16 26/4 32/13 39/4 41/3 42/10 49/8 52/3 61/11 63/18 65/25 68/16 68/17 68/17 70/6 70/8 71/1 73/18 75/11 75/13 75/13 80/13 84/7 86/25 87/25 88/11 89/13 89/19 92/9 97/6 98/8 98/22 98/23 103/22 109/2 109/17 117/8 121/14 128/10 131/5 134/9 138/1 139/23 142/2 142/3 144/15 144/16 151/8 158/7 161/6 163/7 163/10 166/17 176/13 180/18</p> <p><b>others [12]</b> 6/24 33/7 47/9 58/10 70/18 88/2 89/12 91/13 144/5 146/3 169/13 170/24</p> <p><b>our [73]</b> 3/1 3/7 4/14 9/25 13/8 13/8 17/7 18/16 19/1 19/16 24/17 30/9 31/16 32/14 34/20 36/18 36/20 37/1 37/23 38/7</p>	<p>39/2 39/18 40/23 42/12 42/14 44/2 44/15 44/18 45/12 45/18 47/1 50/15 51/23 52/2 52/18 54/7 55/12 55/13 55/24 56/3 57/8 57/21 64/4 68/9 77/10 83/18 92/11 94/8 101/23 102/6 104/2 112/19 116/8 121/15 126/9 126/9 126/19 133/3 136/4 137/2 138/9 139/1 143/5 149/17 151/16 155/9 164/20 169/15 170/5 171/15 171/17 182/3 182/5</p> <p><b>ourselves [1]</b> 132/4</p> <p><b>out [63]</b> 3/15 4/8 4/24 5/3 5/7 6/18 8/3 9/20 10/13 13/17 14/8 16/14 16/23 18/9 24/14 28/9 29/1 39/14 41/14 51/10 56/17 62/6 64/7 66/18 68/1 73/1 73/13 73/13 74/17 77/20 79/11 80/5 89/3 89/16 92/23 94/23 95/10 95/21 96/4 96/18 97/6 98/5 100/23 103/19 104/14 106/9 120/17 121/16 126/25 128/18 128/22 130/21 131/12 133/25 138/4 138/13 141/20 145/19 146/11 151/15 156/2 159/5 163/2</p> <p><b>outbreak [7]</b> 9/21 10/14 20/2 20/2 47/13 47/16 112/12</p> <p><b>outbreaks [4]</b> 9/19 10/1 26/22 56/9</p> <p><b>outcome [1]</b> 174/5</p> <p><b>outcomes [6]</b> 49/24 70/12 140/14 150/20 159/25 160/18</p> <p><b>outdoors [1]</b> 177/4</p> <p><b>outfit [1]</b> 130/16</p> <p><b>outs [1]</b> 181/21</p> <p><b>outset [1]</b> 43/17</p> <p><b>outside [3]</b> 32/10 95/23 137/18</p> <p><b>outwith [1]</b> 156/10</p> <p><b>over [25]</b> 18/4 24/14 37/13 49/15 52/21 54/2 63/7 88/18 106/7 123/19 124/6 124/9 125/9 131/23 132/14 134/1 134/7 140/17 144/12 145/9 154/13 155/14 164/1 166/22 171/14</p> <p><b>overall [4]</b> 53/13 63/12 64/21 69/22</p>	<p><b>overheard [1]</b> 127/6</p> <p><b>overnight [2]</b> 21/8 106/17</p> <p><b>overrun [1]</b> 87/15</p> <p><b>overseen [2]</b> 152/14 165/21</p> <p><b>overview [2]</b> 68/3 98/7</p> <p><b>overwhelmed [5]</b> 86/21 86/22 170/23 172/12 173/19</p> <p><b>overworked [1]</b> 89/8</p> <p><b>own [16]</b> 19/1 32/15 34/10 34/19 39/24 48/24 54/17 56/12 57/5 64/4 71/11 72/2 75/22 83/21 98/9 147/9</p> <p><b>oxygen [15]</b> 13/25 14/2 14/2 14/4 14/7 14/14 46/3 48/11 48/14 48/18 89/7 124/25 125/6 125/7 125/8</p>
			<b>P</b>	
			<p><b>pace [1]</b> 181/9</p> <p><b>package [1]</b> 84/9</p> <p><b>packed [1]</b> 106/16</p> <p><b>packet [1]</b> 147/5</p> <p><b>packets [1]</b> 18/1</p> <p><b>pad [1]</b> 27/15</p> <p><b>PAGE [1]</b> 183/2</p> <p><b>pages [5]</b> 10/3 10/11 79/13 85/15 85/15</p> <p><b>paid [3]</b> 164/2 168/25 170/14</p> <p><b>pain [1]</b> 92/10</p> <p><b>painful [2]</b> 90/22 102/21</p> <p><b>palliative [5]</b> 29/23 29/24 30/1 30/6 30/19</p> <p><b>panacea [1]</b> 159/8</p> <p><b>pancreatitis [1]</b> 68/21</p> <p><b>pandemic [80]</b> 16/15 27/21 28/25 29/11 29/21 29/24 29/25 34/7 34/17 35/4 36/17 36/25 37/4 37/14 37/14 38/8 39/3 39/4 39/17 41/19 42/22 43/12 43/17 50/5 57/10 60/16 74/3 105/13 109/12 109/13 110/15 111/7 111/22 112/18 118/4 118/8 118/21 119/22 121/2 124/9 126/23 131/14 131/16 132/2 132/11 139/22 140/11 144/13 145/9 145/14 146/9 148/21 149/22 150/25 152/13 153/16 155/8</p>	

<b>P</b>	<b>partnership [1]</b> 156/21	<b>people [86]</b> 2/13 2/16 6/21 9/14 10/7 12/24 16/5 19/18 19/22 21/16 28/14 30/15 32/6 32/23 35/8 35/24 39/21 45/19 48/10 49/16 50/23 52/11 54/5 58/12 61/19 64/7 66/2 66/2 66/8 67/14 68/15 68/19 68/23 70/7 70/16 70/17 70/20 73/4 73/12 73/17 75/11 76/15 77/2 77/17 85/2 86/21 88/10 94/13 96/3 97/23 98/15 98/21 98/22 103/3 103/10 103/12 103/22 104/12 104/23 104/24 107/8 108/25 110/21 111/13 111/24 114/7 134/14 134/15 136/8 138/24 139/17 140/15 142/16 142/24 143/3 153/10 155/13 169/1 169/3 169/12 170/3 170/11 175/6 175/23 181/10 181/14	<b>person's [1]</b> 147/22	<b>piped [1]</b> 46/3
<b>pandemic... [23]</b> 157/23 158/15 158/22 161/17 162/3 162/17 164/3 168/25 169/25 170/9 170/17 171/7 174/20 175/12 175/15 175/22 176/9 178/16 180/1 180/25 181/9 181/23 182/4	<b>parts [3]</b> 63/10 160/11 178/13	<b>peppered [1]</b> 65/15	<b>person-centred [3]</b> 43/9 57/11 160/18	<b>piping [1]</b> 89/5
<b>pandemics [4]</b> 150/11 153/15 180/19 180/19	<b>Partygate [1]</b> 72/20	<b>per [1]</b> 106/3	<b>personal [6]</b> 5/1 25/12 34/10 98/9 156/10 178/8	<b>place [22]</b> 10/10 10/17 11/1 25/5 39/8 39/8 41/15 47/20 64/15 83/11 85/9 110/2 110/4 120/16 120/20 124/11 132/10 156/12 159/5 160/19 162/2 162/12
<b>panic [1]</b> 14/15	<b>pass [1]</b> 80/4	<b>perception [4]</b> 4/10 4/14 147/22 162/21	<b>personalised [1]</b> 175/24	<b>places [2]</b> 37/5 47/8
<b>paper [7]</b> 27/11 27/13 27/23 116/17 116/20 122/18 122/19	<b>passage [1]</b> 87/7	<b>perform [2]</b> 123/23 169/23	<b>personnel [3]</b> 68/12 166/6 166/13	<b>placing [1]</b> 124/10
<b>paragraph [2]</b> 3/16 67/25	<b>passed [7]</b> 26/2 92/12 110/8 123/2 133/15 135/5 136/13	<b>performance [1]</b> 158/14	<b>perspective [11]</b> 61/8 65/18 65/21 68/14 69/2 71/1 72/2 76/18 87/24 91/1 111/6	<b>plan [10]</b> 17/2 17/3 57/8 161/24 162/2 162/7 162/8 162/9 179/18 180/18
<b>paragraph 36 [1]</b> 67/25	<b>passenger [6]</b> 74/10 74/11 74/15 74/18 78/25 79/21	<b>performed [1]</b> 179/14	<b>pertain [1]</b> 154/16	<b>planes [1]</b> 77/20
<b>paragraph 56 [1]</b> 3/16	<b>passes [1]</b> 181/24	<b>perhaps [9]</b> 16/13 17/15 63/2 63/4 65/2 78/19 89/21 113/2 134/19	<b>pertinent [2]</b> 11/8 147/3	<b>planned [1]</b> 141/9
<b>paragraphs [3]</b> 4/8 13/17 19/8	<b>patchwork [1]</b> 18/21	<b>period [14]</b> 3/23 5/15 80/22 80/24 80/25 81/8 81/11 89/1 92/23 94/6 109/14 120/9 132/14 162/13	<b>pest [1]</b> 154/16	<b>planning [10]</b> 155/11 155/12 155/18 159/1 160/15 161/23 162/21 172/3 181/4 181/7
<b>paragraphs 16 [1]</b> 4/8	<b>Patel [1]</b> 102/22	<b>permanent [4]</b> 30/11 152/4 152/11 172/24	<b>PHA [7]</b> 156/7 157/9 157/13 157/16 157/19 158/21 162/6	<b>plastic [1]</b> 18/4
<b>paragraphs 37 [1]</b> 13/17	<b>path [1]</b> 52/20	<b>permission [1]</b> 75/10	<b>pharmaceutical [1]</b> 149/15	<b>platforms [1]</b> 151/4
<b>paragraphs 40 [1]</b> 19/8	<b>pathogen [1]</b> 177/12	<b>permits [1]</b> 180/22	<b>phase [1]</b> 140/25	<b>play [1]</b> 145/6
<b>parents [1]</b> 88/1	<b>pathways [2]</b> 172/19 180/15	<b>permitted [1]</b> 47/25	<b>phased [1]</b> 159/4	<b>played [1]</b> 139/25
<b>Parliament [2]</b> 36/7 106/4	<b>patient [36]</b> 7/9 8/24 11/2 11/21 11/25 12/2 12/3 12/22 14/23 16/8 16/9 16/17 17/12 20/11 20/18 30/20 37/15 37/25 56/9 69/18 84/13 86/9 87/4 88/7 89/18 91/3 95/25 99/3 99/8 110/19 123/5 127/11 131/11 131/22 132/6 180/16	<b>persist [1]</b> 6/17	<b>phases [1]</b> 145/14	<b>please [24]</b> 1/6 1/17 2/8 3/3 5/10 14/15 14/16 19/3 28/4 33/14 34/16 43/10 59/13 60/9 60/10 61/1 61/3 79/1 101/2 105/7 141/18 141/22 142/12 143/9
<b>parlour [1]</b> 135/7	<b>patient's [2]</b> 27/18 84/9	<b>person [22]</b> 4/12 33/20 43/9 49/5 57/11 59/9 77/8 77/11 77/23 80/6 89/16 94/10 108/7 108/9 108/11 110/5 127/1 129/12 131/19 131/22 140/10 160/18	<b>PhD [3]</b> 59/23 59/23 101/7	<b>plans [5]</b> 29/25 41/12 162/10 162/14 170/19
<b>part [11]</b> 2/17 6/9 8/13 59/25 61/13 61/14 73/9 125/25 139/25 140/20 174/10	<b>patients [48]</b> 10/15 12/22 19/10 19/15 25/16 25/24 26/5 26/10 29/16 30/3 37/20 40/22 56/10 56/13 64/25 66/13 69/6 69/17 79/7 84/5 85/21 87/1 88/16 89/14 89/19 94/18 98/8 98/12 98/16 99/7 99/14 99/15 100/10 101/13 104/3 104/20 120/11 120/14 131/5 131/7 145/4 147/19 148/24 150/17 157/11 163/8 163/21 181/17	<b>periods [3]</b> 48/17 63/15 73/2	<b>phed [4]</b> 79/4 121/5 124/19 135/7	<b>platforms [1]</b> 151/4
<b>participate [1]</b> 156/25	<b>pattern [1]</b> 28/9	<b>permissible [1]</b> 47/25	<b>phone [22]</b> 5/22 12/19 45/21 48/15 48/25 49/6 49/15 50/19 54/2 76/19 77/22 79/25 86/19 95/4 102/6 115/12 118/24 119/3 119/25 122/1 126/16 130/2	<b>played [1]</b> 139/25
<b>particle [3]</b> 144/22 145/12 177/9	<b>pause [8]</b> 42/4 78/9 90/20 105/3 115/21 121/17 125/18 173/25	<b>person [22]</b> 4/12 33/20 43/9 49/5 57/11 59/9 77/8 77/11 77/23 80/6 89/16 94/10 108/7 108/9 108/11 110/5 127/1 129/12 131/19 131/22 140/10 160/18	<b>phoned [4]</b> 79/4 121/5 124/19 135/7	<b>please [24]</b> 1/6 1/17 2/8 3/3 5/10 14/15 14/16 19/3 28/4 33/14 34/16 43/10 59/13 60/9 60/10 61/1 61/3 79/1 101/2 105/7 141/18 141/22 142/12 143/9
<b>particles [1]</b> 144/24	<b>pay [3]</b> 59/10 142/16 166/8	<b>permissible [1]</b> 47/25	<b>phones [2]</b> 47/24 48/3	<b>please [24]</b> 1/6 1/17 2/8 3/3 5/10 14/15 14/16 19/3 28/4 33/14 34/16 43/10 59/13 60/9 60/10 61/1 61/3 79/1 101/2 105/7 141/18 141/22 142/12 143/9
<b>particular [20]</b> 4/6 16/15 25/14 27/3 28/19 28/23 38/3 44/24 47/12 47/13 84/16 93/5 116/14 127/3 131/21 147/8 154/25 155/1 164/23 171/22	<b>paying [1]</b> 33/21	<b>permissible [1]</b> 47/25	<b>phoning [1]</b> 75/13	<b>please [24]</b> 1/6 1/17 2/8 3/3 5/10 14/15 14/16 19/3 28/4 33/14 34/16 43/10 59/13 60/9 60/10 61/1 61/3 79/1 101/2 105/7 141/18 141/22 142/12 143/9
<b>particularly [22]</b> 16/7 19/9 19/21 22/23 23/1 23/19 27/9 30/2 34/4 36/21 43/20 46/1 51/24 67/21 120/6 151/1 169/14 174/15 175/7 178/20 179/3 179/15	<b>PCR [1]</b> 9/5	<b>permissible [1]</b> 47/25	<b>photographs [2]</b> 95/3 95/5	<b>please [24]</b> 1/6 1/17 2/8 3/3 5/10 14/15 14/16 19/3 28/4 33/14 34/16 43/10 59/13 60/9 60/10 61/1 61/3 79/1 101/2 105/7 141/18 141/22 142/12 143/9
<b>partner [5]</b> 129/3 129/6 129/11 129/15 138/12	<b>peak [2]</b> 63/15 63/17	<b>permissible [1]</b> 47/25	<b>physical [5]</b> 27/18 29/18 56/2 145/3 160/8	<b>please [24]</b> 1/6 1/17 2/8 3/3 5/10 14/15 14/16 19/3 28/4 33/14 34/16 43/10 59/13 60/9 60/10 61/1 61/3 79/1 101/2 105/7 141/18 141/22 142/12 143/9

<b>P</b>	147/3 147/6 147/8 164/24 177/17 177/21 178/13 178/15 179/6 179/18 <b>practical [3]</b> 71/22 148/11 158/20 <b>practically [2]</b> 10/4 105/12 <b>practice [7]</b> 4/11 39/1 45/13 53/6 91/6 101/9 101/10 <b>practices [1]</b> 13/20 <b>pray [1]</b> 17/13 <b>prayers [1]</b> 137/15 <b>pre [7]</b> 28/25 36/25 37/14 63/6 91/18 106/16 166/10 <b>pre-Covid [2]</b> 63/6 91/18 <b>pre-eminently [1]</b> 166/10 <b>pre-packed [1]</b> 106/16 <b>pre-pandemic [3]</b> 28/25 36/25 37/14 <b>precise [1]</b> 145/12 <b>predecessor [2]</b> 108/8 143/25 <b>predictably [1]</b> 148/12 <b>prediction [1]</b> 148/23 <b>preference [2]</b> 143/7 178/9 <b>preferred [1]</b> 163/1 <b>preparation [1]</b> 75/25 <b>prepared [4]</b> 57/10 59/16 104/10 180/4 <b>prepared/enabled [1]</b> 57/10 <b>preparedness [4]</b> 75/25 78/16 80/8 150/10 <b>present [3]</b> 86/14 159/5 181/18 <b>presented [1]</b> 157/5 <b>presenting [1]</b> 181/15 <b>press [1]</b> 69/25 <b>pressure [8]</b> 42/1 66/7 84/16 89/13 90/7 105/21 139/13 147/20 <b>pressures [5]</b> 37/10 42/14 83/18 86/2 106/10 <b>pretty [3]</b> 8/12 26/13 52/16 <b>prevent [4]</b> 20/23 60/19 69/15 173/18 <b>prevented [2]</b> 26/25 172/12 <b>preventing [1]</b> 160/5 <b>prevention [11]</b> 19/5 20/22 21/6 21/16 36/23 43/13 45/13	120/16 144/9 160/19 176/3 <b>previous [1]</b> 37/1 <b>previously [2]</b> 39/7 57/6 <b>price [1]</b> 168/25 <b>primarily [1]</b> 3/18 <b>primary [13]</b> 3/3 4/6 4/6 27/5 28/2 51/15 51/20 65/10 65/19 111/14 121/8 156/14 172/19 <b>prime [5]</b> 70/2 102/18 103/20 110/23 169/25 <b>Prime Minister [4]</b> 70/2 102/18 103/20 110/23 <b>principal [1]</b> 165/6 <b>principle [7]</b> 51/13 51/14 51/17 53/3 161/6 166/11 175/19 <b>print [1]</b> 98/14 <b>prior [14]</b> 108/24 118/4 118/8 118/21 121/2 121/21 124/8 131/6 131/14 131/15 132/2 132/11 161/2 162/15 <b>prioritise [1]</b> 157/25 <b>priority [2]</b> 159/18 172/2 <b>prism [1]</b> 137/22 <b>private [1]</b> 111/11 <b>privilege [2]</b> 102/19 109/22 <b>privileged [2]</b> 136/23 140/4 <b>proactively [2]</b> 9/23 157/1 <b>probably [10]</b> 14/13 31/9 56/3 108/6 109/13 118/7 122/24 124/7 128/17 133/8 <b>problem [6]</b> 6/9 136/4 149/10 165/8 166/19 166/25 <b>problems [7]</b> 3/9 27/3 27/8 29/19 126/6 173/18 178/25 <b>procedure [2]</b> 80/18 96/6 <b>procedures [3]</b> 10/25 83/6 94/19 <b>process [10]</b> 3/6 11/23 18/3 41/16 95/21 115/16 124/3 148/20 156/24 157/1 <b>processes [2]</b> 11/13 156/23 <b>procure [1]</b> 178/13 <b>produce [1]</b> 180/2 <b>produced [4]</b> 9/13 146/4 179/12 180/5 <b>produces [1]</b> 172/1	<b>production [1]</b> 151/21 <b>products [1]</b> 179/7 <b>profession [1]</b> 74/21 <b>professional [5]</b> 135/17 156/9 156/11 166/9 166/10 <b>professionals [3]</b> 114/8 115/6 126/1 <b>professions [1]</b> 102/16 <b>Professor [9]</b> 24/1 147/25 149/9 149/12 149/18 150/12 152/15 174/18 178/19 <b>Professor Bamrah [1]</b> 174/18 <b>Professor Colin [1]</b> 178/19 <b>Professor Dinah Gould [1]</b> 147/25 <b>Professor Harries [1]</b> 152/15 <b>Professor Harris [1]</b> 150/12 <b>Professor Kloer [1]</b> 24/1 <b>Professor Snooks [2]</b> 149/9 149/12 <b>Professor Snooks' [1]</b> 149/18 <b>professors [1]</b> 97/7 <b>proficient [1]</b> 63/3 <b>profit [1]</b> 2/6 <b>programme [17]</b> 148/8 148/9 148/13 148/15 149/1 149/8 149/11 149/23 150/1 152/13 152/19 160/12 175/4 175/10 175/13 181/5 181/14 <b>programmes [3]</b> 98/11 99/23 172/18 <b>progress [1]</b> 16/2 <b>progressed [1]</b> 148/22 <b>progression [1]</b> 101/15 <b>Prolonged [1]</b> 147/19 <b>promise [4]</b> 58/6 58/14 59/9 108/9 <b>promoting [1]</b> 132/10 <b>prone [1]</b> 48/16 <b>proper [1]</b> 91/20 <b>properly [4]</b> 35/24 91/12 91/13 132/12 <b>proportionate [2]</b> 171/9 174/5 <b>proposal [1]</b> 167/18 <b>proposed [1]</b> 166/24 <b>prospect [1]</b> 176/10 <b>protect [9]</b> 8/14 10/5 22/11 34/24 51/22 55/11 143/21 176/22	181/5 <b>protected [2]</b> 23/12 56/5 <b>protection [4]</b> 144/3 173/24 177/24 178/5 <b>protections [1]</b> 10/9 <b>protective [2]</b> 70/17 148/9 <b>prove [1]</b> 87/3 <b>provide [8]</b> 50/12 67/14 95/5 114/9 118/17 122/22 146/2 163/13 <b>provided [17]</b> 1/19 10/22 54/19 71/16 82/8 82/21 92/19 109/11 157/18 170/2 172/24 175/23 177/21 177/24 178/4 179/6 179/24 <b>provider [2]</b> 68/9 70/5 <b>providers [2]</b> 70/6 146/17 <b>provides [2]</b> 155/10 181/17 <b>providing [6]</b> 63/3 69/18 118/14 146/14 163/9 179/22 <b>provision [6]</b> 29/25 38/6 151/9 157/3 167/21 171/4 <b>proxy [1]</b> 41/13 <b>public [26]</b> 8/4 21/15 45/10 60/21 74/4 77/1 78/4 79/18 107/7 107/10 109/1 109/16 110/17 111/18 112/20 120/10 140/20 143/21 143/25 145/8 148/16 165/19 166/17 170/17 172/5 181/7 <b>Public Health Wales [1]</b> 79/18 <b>publish [5]</b> 109/7 141/19 141/22 142/7 142/11 <b>published [6]</b> 142/4 146/4 151/6 160/13 162/8 179/17 <b>pulled [1]</b> 79/11 <b>purpose [3]</b> 3/3 24/18 60/15 <b>push [1]</b> 130/11 <b>put [19]</b> 8/3 9/20 19/15 19/17 21/8 35/24 36/4 47/19 68/12 70/21 75/3 96/9 111/6 113/21 135/13 138/5 165/15 172/13 178/14 <b>putting [4]</b> 40/14 125/13 136/16 153/10
----------	---	---	---	--

<b>Q</b>			
<b>quadrupling [1]</b> 173/3	<b>rationed [1]</b> 171/5	<b>realm [1]</b> 68/10	<b>red [1]</b> 19/14
<b>quality [9]</b> 10/22 64/17 71/16 110/18 147/11 155/5 158/5 170/2 173/8	<b>rationing [1]</b> 173/6	<b>reason [6]</b> 19/22 23/7 23/9 24/8 38/11 69/7	<b>redacted [1]</b> 123/6
<b>quarantine [1]</b> 76/16	<b>raw [1]</b> 139/20	<b>reasonable [2]</b> 171/3 171/9	<b>redeployed [3]</b> 163/11 172/11 181/11
<b>question [11]</b> 4/16 15/10 38/23 58/11 77/24 87/11 147/13 149/21 153/7 161/22 165/3	<b>Rawat [6]</b> 142/12 143/9 143/11 153/25 154/3 183/16	<b>reasons [9]</b> 8/7 24/9 31/19 46/15 72/4 88/11 100/5 103/14 146/19	<b>redress [1]</b> 180/9
<b>questions [20]</b> 1/9 25/21 31/15 32/1 32/4 33/18 58/3 59/7 106/25 108/5 110/6 110/9 110/9 135/8 139/4 139/5 183/5 183/7 183/9 183/12	<b>ray [1]</b> 81/23	<b>reassurance [3]</b> 44/9 49/13 54/19	<b>reduce [8]</b> 45/1 68/5 148/10 149/4 149/24 177/4 179/7 181/20
<b>quick [2]</b> 103/25 130/17	<b>RCN [1]</b> 44/24	<b>reassured [1]</b> 49/11	<b>reduced [2]</b> 43/18 177/25
<b>quickly [15]</b> 1/16 2/18 37/20 81/12 91/15 96/17 99/10 121/5 121/13 122/4 122/5 125/8 153/9 178/22 179/1	<b>re [3]</b> 26/10 81/2 175/10	<b>reassuring [2]</b> 49/10 50/3	<b>reference [6]</b> 94/22 95/1 150/18 156/13 177/9 179/9
<b>quiet [2]</b> 13/9 13/15	<b>re-run [1]</b> 175/10	<b>recall [2]</b> 40/8 83/3	<b>refer [3]</b> 10/23 69/25 154/10
<b>quietly [2]</b> 96/17 97/24	<b>re-tested [1]</b> 81/2	<b>receive [2]</b> 128/1 155/20	<b>reference [6]</b> 94/22 95/1 150/18 156/13 177/9 179/9
<b>quite [22]</b> 11/5 13/1 23/5 24/10 56/3 61/19 68/22 70/23 72/7 73/16 80/21 81/23 95/7 96/4 97/8 97/9 98/21 100/17 121/13 122/4 122/5 133/11	<b>re-tests [1]</b> 26/10	<b>received [4]</b> 81/3 118/24 119/24 128/1	<b>referenced [1]</b> 160/12
<b>quote [1]</b> 126/20	<b>reached [1]</b> 86/5	<b>receives [1]</b> 124/14	<b>referrals [1]</b> 180/16
	<b>reacted [1]</b> 178/22	<b>receiving [7]</b> 8/19 16/4 48/11 124/13 124/22 128/25 130/23	<b>referred [3]</b> 28/24 54/12 93/21
	<b>reaction [1]</b> 83/25	<b>recognise [4]</b> 85/5 85/9 157/13 157/20	<b>refinement [1]</b> 53/8
	<b>read [5]</b> 49/7 103/4 128/21 128/21 141/20	<b>recognised [15]</b> 6/19 37/19 102/10 117/7 117/12 117/12 145/16 149/2 168/5 171/11 174/12 175/12 178/8 179/2 179/18	<b>reflect [3]</b> 140/6 149/12 149/13
	<b>reading [2]</b> 49/7 71/4	<b>Recognising [3]</b> 144/25 160/10 180/5	<b>reflected [5]</b> 140/8 146/5 154/12 155/18 168/1
	<b>ready [5]</b> 58/19 75/16 76/21 106/12 106/14	<b>recognises [3]</b> 171/19 177/18 178/11	<b>reflecting [1]</b> 35/5
	<b>ready-made [1]</b> 106/12	<b>recommend [1]</b> 15/12	<b>reflection [2]</b> 50/6 50/8
	<b>real [15]</b> 7/4 13/16 18/14 39/9 50/15 51/23 65/15 71/2 88/12 91/2 94/14 99/24 103/11 136/3 178/2	<b>recommendation [8]</b> 12/2 43/4 138/1 161/3 165/7 166/15 166/25 167/8	<b>refused [1]</b> 14/24
	<b>real-life [1]</b> 103/11	<b>Recommendations [18]</b> 28/18 56/25 57/7 58/9 58/11 139/10 139/12 139/14 160/23 160/25 165/3 165/4 165/11 165/16 165/24 166/17 166/21 167/2	<b>refute [1]</b> 162/21
	<b>realise [2]</b> 76/20 104/10	<b>recommended [3]</b> 148/2 148/9 152/9	<b>refutes [1]</b> 161/1
	<b>realised [5]</b> 2/18 24/20 24/21 123/2 140/16	<b>record [2]</b> 123/6 159/2	<b>regard [5]</b> 64/23 91/5 91/6 169/10 174/23
	<b>reality [1]</b> 181/8	<b>recorded [3]</b> 6/4 74/13 91/4	<b>region [5]</b> 50/11 85/23 86/2 163/12 163/20
	<b>really [87]</b> 13/2 13/14 14/18 17/23 27/13 30/17 31/19 32/21 33/22 51/14 51/18 51/19 52/14 58/6 61/21 61/21 62/8 64/6 64/7 66/10 67/6 68/16 69/8 70/6 70/8 75/3 75/20 75/21 76/11 77/4 78/13 78/15 83/13 83/14 83/15 83/16 84/21 85/1 85/12 85/18 86/15 87/14 88/1 88/13 89/3 89/3 90/13 91/10 91/18 91/20 91/21 92/8 92/8 94/10 94/18 98/15 99/15 101/14 101/17 102/21 103/12 107/8 107/16 110/1 112/3 114/21 115/8 115/19 117/15 118/13 118/18 118/21 120/18 122/10 122/14 125/4 125/7 127/1 127/1 127/14 127/14 131/11 132/11 136/24 139/8 140/3 141/7	<b>records [3]</b> 27/12 123/3 159/3	<b>region-wide [1]</b> 86/2
		<b>recovered [1]</b> 33/24	<b>regional [4]</b> 160/3 161/21 162/16 171/20
		<b>recovering [1]</b> 126/15	<b>regions [1]</b> 65/5
		<b>recovery [1]</b> 58/19	<b>registrar [4]</b> 42/6 79/10 85/13 85/16
			<b>regular [2]</b> 155/16 174/10
			<b>regularly [3]</b> 20/20 31/8 131/1
			<b>Regulation [1]</b> 110/18
			<b>regulators [1]</b> 142/1
			<b>regulatory [1]</b> 153/18
			<b>rehabilitation [1]</b> 180/15
			<b>rejects [1]</b> 162/23
			<b>related [4]</b> 16/13 35/22 120/15 165/23
			<b>relates [1]</b> 105/18
			<b>relation [24]</b> 5/11 8/3 19/5 22/23 23/1 23/3 27/9 29/1 29/20 38/20 51/3 61/2 75/11 89/24 98/6 144/11 144/22 146/11 149/18 155/17 156/8 157/7 158/6 158/24
			<b>relationship [2]</b> 171/24 180/22
			<b>relatively [1]</b> 15/19
			<b>relaxed [1]</b> 113/15
			<b>relay [4]</b> 67/8 71/21 71/22 80/3
			<b>relayed [3]</b> 14/25 80/6 81/17
			<b>released [1]</b> 129/7
			<b>relevance [1]</b> 147/14
			<b>relevant [8]</b> 3/23 5/14 150/13 151/12 153/2 156/12 167/2 167/9
			<b>reliance [2]</b> 48/3 48/19
			<b>relies [1]</b> 151/8
			<b>relieved [1]</b> 88/18
			<b>reluctance [1]</b> 38/4
			<b>reluctant [1]</b> 70/20
			<b>relying [2]</b> 88/2 93/24
			<b>remain [1]</b> 86/10
			<b>remainder [1]</b> 4/3
			<b>remained [1]</b> 145/22
			<b>remaining [1]</b> 159/6
			<b>remains [2]</b> 145/14 163/2
			<b>remark [2]</b> 161/22 163/22
			<b>remarks [1]</b> 162/19
			<b>remember [45]</b> 40/5 55/12 72/3 72/6 72/6 74/24 79/4 79/7 79/15 79/25 80/3 84/21 85/3 86/19 87/19 87/23 88/3 89/14 90/13 90/16 92/21 92/21 93/5 94/5 94/6 94/9 94/9 95/18 96/7 98/21 98/25 113/12 114/17 116/3 116/5 120/23 125/11 131/15 132/5 133/19 134/1 134/25 135/6 135/20 147/24
			<b>remembered [1]</b> 40/12
			<b>reminded [1]</b> 169/5
			<b>reminders [1]</b> 100/18
			<b>reminding [1]</b> 171/6
			<b>remit [1]</b> 152/22
			<b>remits [1]</b> 111/1
			<b>remote [2]</b> 54/3 181/17
			<b>remotely [1]</b> 44/18
			<b>removed [1]</b> 132/7
			<b>removing [2]</b> 163/16 174/15
			<b>repeat [5]</b> 26/5 54/8



<b>R</b>	<b>responding [2]</b> 150/10 181/8	26/2 29/6 29/15 30/22 30/23 30/23 31/13 31/22 31/25 31/25 32/1 32/12 33/6 34/8 34/11 34/19 36/13 36/25 42/5 43/12 44/7 44/10 44/12 44/13 49/19 60/17 65/1 69/20 70/17 71/7 74/2 74/3 76/22 78/13 80/9 80/16 81/7 81/25 83/7 83/11 87/21 90/20 90/20 91/7 92/13 92/22 99/16 103/16 103/20 106/7 113/5 118/2 118/9 119/5 119/21 121/7 121/10 121/20 124/4 125/1 128/17 129/22 130/7 134/8 137/1	176/24 <b>routes [2]</b> 144/21 176/13 <b>routine [4]</b> 80/21 81/9 89/17 152/9 <b>royal [3]</b> 59/25 60/3 141/23 <b>Rozanne [1]</b> 178/18 <b>RQIA [2]</b> 110/18 111/19 <b>rub [1]</b> 148/2 <b>rude [1]</b> 31/2 <b>rule [1]</b> 145/19 <b>ruled [1]</b> 138/13 <b>rules [3]</b> 11/18 22/15 25/13 <b>rumbling [1]</b> 90/10 <b>run [5]</b> 5/24 29/14 71/18 119/17 175/10 <b>run-up [1]</b> 119/17 <b>rung [1]</b> 62/7 <b>running [4]</b> 63/23 85/8 86/21 152/14 <b>runs [1]</b> 51/19 <b>rural [4]</b> 62/15 62/17 65/11 65/19	173/8 174/18 177/5 <b>sailed [1]</b> 14/17 <b>Saleyha [4]</b> 59/4 59/6 59/14 183/8 <b>same [24]</b> 2/13 2/14 2/16 20/1 20/5 28/5 28/5 28/8 48/21 52/21 78/7 82/13 83/19 91/24 93/10 93/12 93/24 94/3 99/12 103/15 124/14 127/4 135/2 155/2 <b>sat [1]</b> 124/5 <b>saturation [1]</b> 48/18 <b>Saturday [1]</b> 119/18 <b>save [3]</b> 34/24 51/22 60/16 <b>saves [1]</b> 29/14 <b>saw [8]</b> 21/22 45/12 76/17 90/16 94/23 103/12 154/2 178/2 <b>say [83]</b> 1/10 3/10 3/21 4/9 5/13 12/14 13/4 13/16 15/21 19/24 20/22 21/11 28/10 28/12 30/22 31/24 32/5 32/5 32/8 33/22 39/10 46/11 51/2 54/15 60/12 61/3 61/9 62/6 62/19 64/23 65/13 67/12 70/12 72/5 72/14 72/25 74/8 74/20 75/10 75/13 77/6 79/17 82/6 83/8 91/8 92/25 93/20 94/24 99/10 100/21 100/25 101/3 104/1 109/7 109/12 110/12 115/13 118/11 118/12 119/10 119/12 119/20 119/25 122/2 123/15 125/22 126/16 127/8 129/24 131/3 132/18 134/23 137/2 137/5 138/1 141/12 143/20 146/18 149/25 152/18 159/16 160/22 162/15 <b>say: [1]</b> 93/20 <b>say: well [1]</b> 93/20 <b>saying [9]</b> 8/13 21/1 21/3 78/14 79/8 85/25 87/15 127/6 129/14 <b>says [8]</b> 8/25 17/3 17/4 17/11 66/24 128/16 138/18 138/18 <b>scale [4]</b> 106/8 126/4 145/23 161/17 <b>scapegoating [1]</b> 32/15 <b>scared [2]</b> 88/5 90/10 <b>scenario [3]</b> 20/17 77/4 171/3 <b>scene [1]</b> 181/19 <b>scenes [1]</b> 46/2
<b>repeat... [3]</b> 54/9 87/3 87/10 <b>repeatedly [2]</b> 7/7 19/23 <b>repeating [1]</b> 164/4 <b>replaced [1]</b> 132/7 <b>replacement [1]</b> 50/14 <b>report [4]</b> 62/24 138/6 139/9 178/25 <b>reported [1]</b> 63/7 <b>reports [4]</b> 21/3 28/25 157/4 159/13 <b>represent [1]</b> 33/7 <b>representatives [4]</b> 58/23 109/1 110/20 178/23 <b>representing [2]</b> 61/8 141/4 <b>requested [2]</b> 123/3 123/5 <b>required [15]</b> 22/13 31/16 54/11 115/23 124/25 131/3 136/7 150/5 157/3 161/16 166/7 172/15 175/18 176/22 179/12 <b>requirements [1]</b> 167/17 <b>requires [1]</b> 160/11 <b>research [5]</b> 37/17 97/21 144/16 148/4 152/6 <b>reserve [2]</b> 165/18 166/4 <b>residents [1]</b> 122/23 <b>resignation [1]</b> 125/25 <b>resilience [1]</b> 75/12 <b>resistant [3]</b> 82/17 82/20 147/12 <b>resolve [1]</b> 179/20 <b>resonate [1]</b> 62/23 <b>resource [2]</b> 173/4 180/11 <b>resource-based [1]</b> 173/4 <b>resources [4]</b> 105/24 106/18 159/24 160/21 <b>respect [13]</b> 18/19 43/1 43/6 60/4 127/20 155/1 156/15 157/15 158/10 158/22 159/10 160/25 169/23 <b>respective [1]</b> 6/1 <b>respirator [1]</b> 82/15 <b>respiratory [7]</b> 49/19 73/18 87/1 99/16 144/19 145/2 145/6 <b>respond [4]</b> 74/10 92/24 112/2 181/3 <b>responded [1]</b> 117/9	<b>responds [1]</b> 144/4 <b>response [17]</b> 29/22 38/25 40/16 75/11 77/5 114/24 124/23 128/13 145/8 158/22 162/3 169/25 170/9 170/9 170/21 171/14 172/8 <b>responses [1]</b> 150/17 <b>responsibilities [2]</b> 146/11 151/2 <b>responsibility [3]</b> 57/4 140/18 146/17 <b>responsible [3]</b> 145/25 146/16 152/20 <b>rest [7]</b> 35/24 36/10 100/19 113/14 123/24 137/2 158/12 <b>restricted [1]</b> 137/8 <b>restriction [1]</b> 47/19 <b>restrictions [15]</b> 22/24 23/3 34/19 35/20 36/13 43/10 43/11 43/21 45/5 46/16 47/7 51/2 51/3 113/14 167/15 <b>result [9]</b> 34/12 37/24 67/15 81/2 81/4 81/5 101/3 152/8 181/21 <b>resulted [1]</b> 171/2 <b>results [2]</b> 20/2 37/22 <b>resume [2]</b> 101/9 182/12 <b>resuscitation [1]</b> 154/22 <b>retired [3]</b> 80/12 166/5 172/19 <b>retirement [1]</b> 166/8 <b>return [3]</b> 33/7 101/8 107/22 <b>returned [2]</b> 12/18 152/16 <b>returning [4]</b> 17/19 152/6 153/7 166/4 <b>review [1]</b> 177/15 <b>reviewed [1]</b> 148/20 <b>reviewing [1]</b> 165/22 <b>reviews [3]</b> 18/20 28/25 60/19 <b>revised [2]</b> 162/11 162/12 <b>rhyme [1]</b> 19/22 <b>rid [1]</b> 31/3 <b>rife [1]</b> 63/18 <b>right [90]</b> 2/3 3/9 3/21 4/9 4/22 4/25 5/13 5/15 7/11 8/6 8/17 11/3 12/16 15/1 15/17 15/17 17/16 17/22 20/14 20/25 21/13 22/4 22/7 23/23 23/25	111/15 111/16 <b>rigid [1]</b> 180/18 <b>rigour [1]</b> 149/20 <b>ring [1]</b> 62/5 <b>ringing [2]</b> 7/19 63/3 <b>rip [1]</b> 27/15 <b>risk [21]</b> 22/16 22/17 23/9 25/3 37/5 37/5 69/12 102/8 146/22 147/20 148/12 148/23 149/2 149/4 153/10 163/16 171/10 171/11 177/4 179/7 179/13 <b>risks [8]</b> 71/18 149/5 149/24 150/20 162/7 171/12 174/4 174/6 <b>Robin [2]</b> 111/12 120/12 <b>Robin Swann [2]</b> 111/12 120/12 <b>robust [4]</b> 56/25 57/9 149/16 151/10 <b>role [15]</b> 30/6 68/8 143/20 143/21 145/7 146/1 146/14 151/7 152/17 152/21 152/22 152/24 156/6 161/14 161/16 <b>roles [4]</b> 68/11 146/11 151/2 170/3 <b>rolled [1]</b> 131/12 <b>rollout [2]</b> 159/4 181/4 <b>room [14]</b> 1/4 48/7 79/5 82/8 82/16 86/17 89/7 89/9 89/14 95/22 95/24 96/2 133/24 133/24 <b>roughly [1]</b> 98/12 <b>round [1]</b> 128/2 <b>route [6]</b> 38/5 91/24 145/6 145/13 176/6	<b>S</b> <b>sacrifices [2]</b> 169/12 182/3 <b>sad [1]</b> 92/8 <b>sadly [7]</b> 5/16 7/10 8/17 60/6 61/12 92/12 102/18 <b>safe [8]</b> 25/7 37/3 37/5 77/2 95/13 100/6 120/20 175/20 <b>safest [1]</b> 25/5 <b>SAGE [1]</b> 148/10 <b>said [82]</b> 3/5 8/10 13/10 14/15 14/16 14/20 15/20 15/22 24/2 25/1 28/3 28/10 29/4 30/17 33/19 37/2 40/12 41/20 45/16 49/18 57/8 65/4 69/13 73/22 79/12 81/1 85/19 90/4 90/5 90/18 90/25 92/2 92/3 95/8 95/15 96/21 97/3 105/4 108/8 114/18 117/8 120/24 121/5 121/7 122/8 123/23 124/10 124/19 125/10 125/12 125/16 126/19 128/13 128/14 128/15 128/16 128/21 129/3 129/16 129/16 129/21 129/22 130/1 130/7 130/8 130/9 130/9 130/16 134/7 135/12 135/12 135/22 136/1 136/13 136/17 139/10 158/5 170/23 173/5	

<b>S</b>	<b>SDLP [1]</b> 111/20 <b>season [1]</b> 72/20 <b>second [21]</b> 16/11 42/2 72/7 72/8 72/11 72/22 72/25 81/17 94/24 104/7 115/22 122/11 144/22 146/22 147/21 148/7 152/2 157/7 165/21 166/15 166/24 <b>second-hand [1]</b> 81/17 <b>secondary [2]</b> 27/6 28/2 <b>Secondly [1]</b> 165/10 <b>Secretary [3]</b> 37/1 103/21 172/7 <b>section [1]</b> 94/16 <b>sections [1]</b> 65/25 <b>sector [2]</b> 151/9 181/7 <b>secure [1]</b> 53/24 <b>security [5]</b> 142/14 143/10 143/15 144/4 183/16 <b>Sedghi [2]</b> 103/5 103/5 <b>see [37]</b> 1/3 12/4 28/8 31/5 44/19 48/14 48/14 48/15 49/2 49/3 49/4 49/8 49/14 50/2 50/2 51/24 54/19 62/4 65/1 65/21 72/18 75/15 85/12 85/14 88/9 89/19 95/1 95/4 95/7 99/2 112/4 121/24 136/8 138/20 139/3 141/12 143/12 <b>seeing [7]</b> 50/1 53/25 75/15 88/5 88/12 89/15 104/2 <b>seek [4]</b> 56/6 57/2 67/15 74/14 <b>seem [3]</b> 10/13 131/25 132/9 <b>seemed [10]</b> 9/3 10/6 10/17 15/5 16/10 19/22 20/3 22/11 127/17 132/11 <b>seemingly [2]</b> 19/13 19/21 <b>seems [4]</b> 11/11 21/18 139/23 139/24 <b>seen [6]</b> 32/6 81/16 89/4 97/7 136/9 148/1 <b>segregate [1]</b> 19/10 <b>seizure [4]</b> 113/16 114/18 115/14 116/24 <b>self [1]</b> 34/23 <b>self-blame [1]</b> 34/23 <b>selfies [1]</b> 36/6 <b>sending [1]</b> 25/4 <b>senior [4]</b> 110/16 110/19 152/20 168/1	<b>sense [13]</b> 25/12 34/6 48/8 50/9 50/15 86/20 104/1 126/4 132/23 134/20 134/25 135/4 137/18 <b>sensory [1]</b> 122/23 <b>sent [4]</b> 8/21 10/12 67/1 99/14 <b>separate [2]</b> 96/14 113/19 <b>separation [1]</b> 145/3 <b>September [6]</b> 26/11 120/8 129/9 138/14 160/14 176/4 <b>September 2020 [1]</b> 129/9 <b>sequelae [2]</b> 180/2 180/5 <b>serious [1]</b> 120/13 <b>seriously [3]</b> 48/11 55/7 179/5 <b>servant [1]</b> 104/9 <b>service [21]</b> 5/13 5/17 5/24 5/25 6/5 6/16 7/6 51/19 61/2 66/1 103/2 123/5 137/11 137/14 140/20 148/14 166/9 172/5 178/21 181/7 181/17 <b>services [12]</b> 3/25 61/20 62/16 64/4 66/6 159/22 159/24 160/16 163/9 164/25 171/22 179/21 <b>sessions [1]</b> 154/14 <b>set [15]</b> 3/15 4/8 13/17 16/14 18/9 22/21 54/5 56/17 68/1 88/8 98/5 109/19 109/25 130/21 178/24 <b>sets [3]</b> 39/13 41/14 51/10 <b>setting [7]</b> 65/20 78/20 109/21 124/23 126/25 146/11 151/15 <b>settings [4]</b> 65/24 146/1 157/12 169/3 <b>seven [1]</b> 130/10 <b>several [7]</b> 22/3 26/1 42/12 54/8 143/24 171/1 178/7 <b>several days [1]</b> 26/1 <b>severe [2]</b> 63/21 149/4 <b>severely [1]</b> 170/22 <b>shadow [1]</b> 106/20 <b>shall [9]</b> 33/7 33/20 58/22 90/17 107/22 141/2 141/5 141/12 142/18 <b>shame [1]</b> 26/18 <b>Shane [1]</b> 129/25 <b>Shane Devlin [1]</b> 129/25	<b>shared [1]</b> 172/1 <b>sharing [3]</b> 151/1 151/3 153/18 <b>she [114]</b> 7/24 8/1 15/2 15/4 15/6 24/11 28/5 38/22 38/23 40/1 40/4 40/4 40/6 40/7 40/10 40/11 40/11 40/12 40/14 49/11 49/12 49/19 49/19 49/20 53/21 53/21 54/16 55/7 55/8 56/12 66/24 66/25 68/20 68/25 85/11 85/12 85/19 85/25 96/13 96/14 97/3 100/16 104/10 104/15 104/16 112/7 113/6 113/7 113/16 114/7 114/12 114/12 114/13 114/20 115/10 115/15 115/18 116/13 116/24 116/25 116/25 117/1 117/2 117/9 117/11 117/12 117/24 118/6 118/7 120/1 121/1 121/4 121/18 121/19 121/24 122/4 122/7 122/15 122/17 122/17 122/18 123/11 125/5 125/6 125/7 127/5 127/25 128/4 128/7 128/15 128/20 129/16 129/16 129/19 129/22 130/6 130/6 130/8 130/19 130/23 131/3 131/16 133/23 135/21 135/22 135/22 136/15 136/21 152/15 152/16 152/17 173/7 173/8 178/15 <b>she'd [2]</b> 40/7 122/3 <b>she's [3]</b> 56/21 56/22 114/25 <b>sheet [2]</b> 135/13 136/19 <b>shelf [2]</b> 106/13 106/15 <b>shield [4]</b> 9/3 34/24 71/24 72/4 <b>shielders [2]</b> 71/15 72/1 <b>shielding [30]</b> 8/12 8/20 8/20 9/1 55/13 55/18 55/19 55/22 55/23 55/24 55/25 71/13 71/21 72/21 73/8 73/19 148/8 149/1 149/3 149/11 149/14 149/17 149/22 149/25 152/13 152/19 175/3 175/4 175/6 175/10 <b>shift [6]</b> 74/9 77/18 78/8 78/14 80/23	81/17 <b>shifts [1]</b> 74/5 <b>ship [1]</b> 14/17 <b>shock [1]</b> 76/2 <b>shocked [3]</b> 76/11 77/4 122/10 <b>shone [1]</b> 29/11 <b>short [10]</b> 33/12 59/1 64/14 88/18 101/13 107/24 137/14 140/24 141/14 166/14 <b>shortage [1]</b> 118/19 <b>shortness [1]</b> 6/17 <b>should [51]</b> 6/25 9/5 10/8 10/8 11/15 12/4 12/6 25/17 34/25 41/16 41/20 42/23 46/25 62/21 66/14 70/4 70/7 70/24 70/25 74/16 74/16 74/17 74/21 76/4 76/5 76/6 79/2 85/1 109/3 109/12 122/11 124/22 125/2 128/25 129/1 129/5 129/15 131/20 142/20 147/13 152/2 152/19 155/2 155/22 157/22 163/24 165/7 167/22 169/19 172/16 177/10 <b>shoulder [1]</b> 96/9 <b>shouldn't [5]</b> 24/21 26/23 70/8 107/7 124/12 <b>show [2]</b> 141/20 149/16 <b>showed [4]</b> 144/17 171/23 173/10 173/16 <b>shown [1]</b> 170/16 <b>shows [1]</b> 170/20 <b>shroud [1]</b> 135/12 <b>shut [2]</b> 97/22 98/1 <b>siblings [8]</b> 65/23 72/3 81/13 81/18 82/1 89/24 125/21 133/16 <b>sick [7]</b> 49/12 50/23 68/24 73/17 77/17 88/5 94/18 <b>sickest [1]</b> 69/9 <b>side [6]</b> 73/14 86/17 89/9 89/14 110/13 133/24 <b>sides [1]</b> 49/13 <b>sign [1]</b> 19/25 <b>signed [1]</b> 40/11 <b>significant [12]</b> 36/21 39/14 54/20 56/1 102/1 158/19 162/5 163/7 164/21 165/12 176/13 180/9 <b>significantly [1]</b> 166/13 <b>signpost [1]</b> 110/11 <b>signs [2]</b> 81/14 134/2
----------	---	--	---	--

<p><b>S</b></p> <p><b>silent [3]</b> 13/1 13/9 13/15</p> <p><b>silver [1]</b> 157/6</p> <p><b>similar [7]</b> 2/15 82/25 84/5 118/20 124/8 144/17 176/1</p> <p><b>simple [3]</b> 10/6 22/20 23/15</p> <p><b>simply [3]</b> 50/6 173/12 176/25</p> <p><b>simultaneously [1]</b> 83/23</p> <p><b>since [4]</b> 65/12 140/12 159/1 162/2</p> <p><b>sincere [4]</b> 164/6 169/7 169/11 181/25</p> <p><b>single [2]</b> 11/2 89/9</p> <p><b>Sinn [1]</b> 111/20</p> <p><b>Sinn Fein [1]</b> 111/20</p> <p><b>Sir [5]</b> 173/1 175/17 175/25 176/15 180/2</p> <p><b>Sir Chris Whitty [1]</b> 175/17</p> <p><b>SIREN [1]</b> 150/22</p> <p><b>sister [7]</b> 7/20 7/23 14/21 28/3 30/25 33/2 85/7</p> <p><b>sit [1]</b> 143/3</p> <p><b>site [1]</b> 163/1</p> <p><b>sitting [1]</b> 142/25</p> <p><b>situation [11]</b> 34/20 39/10 39/24 41/8 55/15 55/17 76/1 77/15 113/24 156/18 165/13</p> <p><b>situations [1]</b> 39/18</p> <p><b>six [3]</b> 24/15 82/9 136/25</p> <p><b>six days [1]</b> 82/9</p> <p><b>six months [1]</b> 24/15</p> <p><b>size [2]</b> 171/21 177/9</p> <p><b>sizes [2]</b> 144/22 145/12</p> <p><b>sleep [1]</b> 125/17</p> <p><b>slide [2]</b> 88/6 89/2</p> <p><b>slightly [2]</b> 65/2 75/19</p> <p><b>slippers [1]</b> 17/24</p> <p><b>slow [4]</b> 60/9 69/24 78/10 162/22</p> <p><b>small [3]</b> 10/17 13/1 76/23</p> <p><b>smaller [1]</b> 78/20</p> <p><b>smile [1]</b> 50/2</p> <p><b>Smith [4]</b> 173/1 175/25 176/16 180/3</p> <p><b>snap [1]</b> 96/5</p> <p><b>snapped [1]</b> 96/6</p> <p><b>sneezed [1]</b> 114/2</p> <p><b>Snooks [2]</b> 149/9 149/12</p> <p><b>Snooks' [1]</b> 149/18</p>	<p><b>so [261]</b></p> <p><b>soaked [1]</b> 17/24</p> <p><b>social [21]</b> 2/19 3/25 37/2 104/9 104/11 110/20 111/12 131/13 137/17 143/18 159/3 159/22 160/16 161/5 164/2 169/14 169/21 170/8 180/21 181/1 182/3</p> <p><b>society [1]</b> 181/10</p> <p><b>socioeconomic [1]</b> 160/6</p> <p><b>soiled [2]</b> 17/24 131/1</p> <p><b>solely [1]</b> 155/4</p> <p><b>solution [2]</b> 21/12 23/15</p> <p><b>solve [1]</b> 15/19</p> <p><b>some [90]</b> 2/12 3/19 6/24 7/13 8/22 10/20 11/14 11/15 12/14 13/20 14/1 16/25 18/3 19/3 22/1 23/23 25/24 27/8 37/23 38/19 39/3 40/23 40/24 41/3 52/2 53/16 54/13 55/12 55/13 55/19 56/17 58/9 60/10 61/1 62/10 62/10 62/19 62/24 64/24 64/25 65/9 66/9 69/25 71/9 71/11 73/1 74/14 74/19 74/25 75/20 76/15 82/3 86/11 88/4 89/13 89/22 90/4 96/19 97/3 99/15 107/12 109/4 116/8 116/23 117/18 121/23 123/6 124/20 125/17 127/18 127/25 130/23 134/7 134/14 134/15 134/24 139/16 142/1 144/13 151/15 154/16 156/2 156/4 158/3 162/19 168/7 169/9 175/17 178/3 180/25</p> <p><b>some months [2]</b> 16/25 54/13</p> <p><b>somebody [4]</b> 12/16 20/15 55/9 124/14</p> <p><b>somehow [2]</b> 75/1 97/13</p> <p><b>someone [17]</b> 17/23 19/25 23/13 25/15 25/18 26/17 34/17 64/8 64/12 71/1 74/12 77/7 79/16 80/4 87/25 97/10 102/9</p> <p><b>someone's [1]</b> 30/8</p> <p><b>something [24]</b> 14/17 29/9 43/4 57/20 69/4 69/13 70/16 78/16 80/19 81/10</p>	<p>93/18 97/15 98/3 99/1 103/16 122/11 123/1 127/10 129/9 136/23 142/20 143/20 159/16 160/22</p> <p><b>sometimes [11]</b> 21/23 58/13 61/23 61/24 62/3 62/5 62/6 88/6 89/2 89/5 140/15</p> <p><b>somewhere [1]</b> 102/10</p> <p><b>son [1]</b> 102/20</p> <p><b>soon [7]</b> 24/4 33/24 69/20 99/2 108/14 114/21 115/10</p> <p><b>sophisticated [1]</b> 153/14</p> <p><b>sores [1]</b> 147/20</p> <p><b>sorry [9]</b> 1/10 33/20 59/8 78/12 87/10 108/7 117/9 134/18 142/25</p> <p><b>sort [34]</b> 2/15 5/25 8/14 10/25 12/22 26/19 27/20 27/22 32/7 62/7 64/19 66/9 68/2 68/9 72/15 73/18 76/8 78/18 79/5 83/15 85/18 87/2 96/4 96/7 96/17 97/14 98/7 101/21 103/2 106/15 114/11 126/4 134/19 134/20</p> <p><b>sorts [4]</b> 49/7 49/8 63/8 135/7</p> <p><b>sought [2]</b> 79/1 171/12</p> <p><b>sound [1]</b> 128/17</p> <p><b>source [1]</b> 89/6</p> <p><b>sources [2]</b> 150/5 153/8</p> <p><b>Southern [2]</b> 111/12 131/13</p> <p><b>space [6]</b> 89/8 94/17 95/20 95/20 95/23 125/8</p> <p><b>speak [13]</b> 33/6 49/2 49/15 59/17 60/24 63/19 65/9 68/7 104/8 112/7 114/2 123/24 141/3</p> <p><b>speaker [1]</b> 182/11</p> <p><b>speaking [8]</b> 60/5 60/5 61/7 79/7 95/18 98/25 102/20 111/14</p> <p><b>speaks [1]</b> 137/7</p> <p><b>specialist [2]</b> 115/7 125/11</p> <p><b>specialists [1]</b> 115/5</p> <p><b>specific [8]</b> 3/8 3/9 3/12 105/15 148/6 161/24 171/15 172/8</p> <p><b>specifically [4]</b> 2/20 140/6 145/25 176/24</p>	<p><b>spectrum [1]</b> 97/24</p> <p><b>speed [1]</b> 181/11</p> <p><b>speedos [1]</b> 94/11</p> <p><b>speedy [1]</b> 58/18</p> <p><b>spell [1]</b> 113/7</p> <p><b>spending [1]</b> 172/5</p> <p><b>spent [1]</b> 71/3</p> <p><b>spirit [1]</b> 108/12</p> <p><b>spoke [6]</b> 79/11 102/12 103/8 103/10 123/16 147/25</p> <p><b>spoken [6]</b> 30/20 30/21 98/12 175/25 178/6 178/17</p> <p><b>spot [1]</b> 140/19</p> <p><b>spotlight [1]</b> 141/24</p> <p><b>spread [6]</b> 22/4 38/1 70/15 112/15 176/12 177/6</p> <p><b>spreadsheets [1]</b> 173/12</p> <p><b>staff [50]</b> 10/15 22/2 22/13 30/1 30/14 38/7 39/6 39/7 39/9 45/13 46/4 48/23 57/9 69/16 71/9 98/8 99/21 100/21 100/24 103/8 117/5 117/14 117/18 117/23 118/16 118/19 124/8 127/6 129/18 131/4 131/21 132/9 132/14 132/25 133/9 133/12 133/19 135/10 135/25 152/11 163/10 163/13 163/16 163/17 163/25 164/6 172/11 172/20 173/11 179/16</p> <p><b>staffing [2]</b> 118/19 118/22</p> <p><b>stage [6]</b> 130/10 141/8 142/4 162/25 173/2 176/11</p> <p><b>stages [2]</b> 100/13 157/23</p> <p><b>stairs [1]</b> 7/21</p> <p><b>stakeholder [1]</b> 174/17</p> <p><b>stance [1]</b> 168/4</p> <p><b>stand [2]</b> 58/19 143/13</p> <p><b>standalone [1]</b> 163/4</p> <p><b>standard [1]</b> 80/17</p> <p><b>standing [1]</b> 143/5</p> <p><b>stark [1]</b> 27/25</p> <p><b>start [5]</b> 26/25 60/10 61/1 110/14 153/16</p> <p><b>started [7]</b> 26/10 81/13 93/5 93/8 106/21 108/23 123/20</p> <p><b>starting [3]</b> 20/24 160/1 160/2</p> <p><b>starts [1]</b> 5/18</p> <p><b>state [8]</b> 28/22 40/9 103/21 109/1 111/4</p>	<p>111/17 112/17 112/19</p> <p><b>stated [2]</b> 104/16 123/7</p> <p><b>statement [51]</b> 1/19 1/22 1/24 3/15 4/9 4/19 8/2 13/18 18/9 19/9 28/16 39/13 41/14 47/23 51/10 56/17 57/8 60/12 62/19 64/23 65/7 65/15 67/13 67/25 74/8 90/25 94/22 98/4 100/22 109/7 110/12 119/12 125/22 127/24 130/21 137/5 143/10 154/5 154/8 164/12 164/20 167/22 168/3 168/16 168/19 171/17 176/14 183/15 183/17 183/20 183/22</p> <p><b>statements [9]</b> 59/16 141/19 141/22 141/23 142/3 142/8 142/10 166/20 169/16</p> <p><b>states [4]</b> 106/2 124/17 124/21 124/24</p> <p><b>statistics [1]</b> 169/6</p> <p><b>stats [1]</b> 77/17</p> <p><b>status [2]</b> 19/11 55/9</p> <p><b>stay [3]</b> 9/22 51/22 62/22</p> <p><b>stayed [4]</b> 52/25 82/8 99/4 129/11</p> <p><b>steered [1]</b> 171/7</p> <p><b>step [3]</b> 42/25 51/18 86/6</p> <p><b>steps [9]</b> 7/16 69/23 70/10 77/9 158/20 158/21 158/23 174/23 180/9</p> <p><b>sterile [4]</b> 37/3 37/7 37/8 37/9</p> <p><b>steroid [1]</b> 15/17</p> <p><b>steroids [4]</b> 15/13 124/24 125/10 125/13</p> <p><b>stick [1]</b> 76/12</p> <p><b>sticker [3]</b> 95/9 95/10 95/10</p> <p><b>stickers [1]</b> 95/8</p> <p><b>still [14]</b> 20/5 20/6 21/19 57/21 70/20 73/16 73/16 74/7 77/16 93/24 103/19 105/2 139/20 147/7</p> <p><b>stomach [1]</b> 90/10</p> <p><b>stop [12]</b> 18/16 29/5 32/15 32/15 32/16 68/17 68/18 78/9 92/5 100/20 106/24 112/14</p> <p><b>stopped [2]</b> 112/13 112/14</p> <p><b>stories [5]</b> 26/3 61/15 68/15 103/9 103/11</p> <p><b>story [4]</b> 67/9 102/21</p>
--	---	--	---	--

<b>S</b>	145/25 152/17 178/24	181/11	<b>sympathies [1]</b> 181/25	<b>takes [4]</b> 56/18 84/23 106/17 106/19
<b>story... [2]</b> 102/22 135/1	<b>subsidiarity [1]</b> 161/6	<b>supplies [1]</b> 100/23	<b>symptom [1]</b> 6/19	<b>takes years [1]</b> 106/19
<b>straight [2]</b> 117/13 117/25	<b>substance [1]</b> 167/3	<b>supply [1]</b> 46/7	<b>symptomatic [1]</b> 8/24	<b>taking [7]</b> 35/8 36/6 59/3 66/3 77/20 89/15 90/13
<b>straightforward [2]</b> 26/16 180/8	<b>substitute [1]</b> 47/22	<b>support [24]</b> 45/20 45/20 51/18 58/12 58/16 60/19 73/10 107/15 109/2 109/9 109/10 110/5 110/10 110/13 146/2 148/11 155/13 155/19 159/20 163/14 175/18 177/15 180/10 181/19	<b>symptomatically [1]</b> 87/5	<b>talk [10]</b> 36/12 47/21 49/5 58/23 76/10 100/9 103/25 106/9 115/5 129/5
<b>strain [1]</b> 66/5	<b>success [2]</b> 66/20 181/13	<b>supported [3]</b> 145/13 153/3 170/13	<b>symptoms [24]</b> 6/11 6/12 6/14 6/15 6/18 6/22 7/2 8/4 8/13 9/6 9/6 9/7 51/17 52/3 52/4 77/7 80/13 81/14 87/1 88/19 92/6 96/21 97/11 99/16	<b>talked [2]</b> 32/22 102/24
<b>strains [1]</b> 65/6	<b>successful [1]</b> 30/12	<b>supporting [1]</b> 175/19	<b>syndrome [1]</b> 126/13	<b>talking [7]</b> 38/9 94/2 94/3 98/7 102/14 102/15 107/13
<b>strange [2]</b> 99/15 143/2	<b>successfully [1]</b> 30/10	<b>supportive [2]</b> 92/2 110/1	<b>syndromes [1]</b> 180/7	<b>talks [2]</b> 65/7 169/20
<b>straps [1]</b> 96/2	<b>successive [1]</b> 173/22	<b>suppose [3]</b> 92/25 109/12 137/21	<b>system [28]</b> 19/13 20/21 27/3 63/9 63/10 63/12 76/13 76/20 76/24 86/20 98/20 105/20 151/10 152/23 159/2 159/15 160/17 160/17 163/24 169/21 169/24 170/8 170/9 170/10 170/22 178/13 180/21 181/1	<b>target [1]</b> 28/13
<b>Strategic [1]</b> 172/14	<b>succumbing [1]</b> 103/8	<b>sure [17]</b> 26/13 47/1 55/10 55/15 57/9 58/6 76/3 78/22 95/13 97/19 117/23 124/3 124/13 129/4 134/2 138/21 167/2	<b>systematic [1]</b> 177/15	<b>targeted [1]</b> 159/20
<b>strategically [1]</b> 161/20	<b>such [29]</b> 10/6 39/9 47/23 104/5 144/17 146/16 147/11 147/19 149/5 149/23 150/5 152/11 154/25 155/8 156/13 158/16 160/3 160/5 162/17 163/5 163/6 163/19 165/11 169/5 169/16 169/22 174/17 177/23 179/19	<b>surfaces [1]</b> 144/19	<b>systemic [4]</b> 11/7 11/8 11/9 166/16	<b>targets [1]</b> 28/11
<b>strategies [1]</b> 74/22	<b>suddenly [6]</b> 73/15 73/20 88/12 97/10 106/15 106/16	<b>surge [4]</b> 161/15 161/23 161/24 162/13	<b>systems [4]</b> 27/6 63/11 112/24 163/23	<b>task [1]</b> 150/4
<b>strategy [5]</b> 24/12 24/13 149/19 151/6 170/18	<b>suffer [3]</b> 139/17 169/9 182/2	<b>surgeon [5]</b> 102/12 102/12 102/13 102/14 124/18	<b>T</b>	<b>taxi [2]</b> 52/13 53/1
<b>strength [1]</b> 180/21	<b>suffered [4]</b> 101/4 107/11 169/8 182/1	<b>surgeries [1]</b> 103/6	<b>tablet [4]</b> 48/15 50/21 118/3 118/6	<b>taxis [1]</b> 52/10
<b>strengthen [1]</b> 148/6	<b>suffering [2]</b> 139/19 158/7	<b>surgery [1]</b> 102/15	<b>tablets [4]</b> 47/23 48/4 48/22 131/2	<b>teacher [1]</b> 80/12
<b>stress [1]</b> 100/24	<b>sufficient [4]</b> 118/16 176/5 178/5 178/13	<b>surgical [6]</b> 22/8 83/3 83/4 93/14 147/12 163/9	<b>tackle [1]</b> 160/4	<b>team [7]</b> 3/2 121/3 121/6 140/13 153/4 160/23 161/16
<b>stresses [1]</b> 65/6	<b>succocating [1]</b> 88/10	<b>surprise [1]</b> 21/2	<b>tackling [2]</b> 159/17 173/21	<b>team's [1]</b> 160/25
<b>stretched [2]</b> 65/25 170/22	<b>suggest [3]</b> 97/17 130/2 176/5	<b>surprised [1]</b> 63/25	<b>tactile [1]</b> 122/23	<b>teams [3]</b> 16/9 109/23 153/3
<b>strict [2]</b> 133/11 177/7	<b>suggested [4]</b> 5/4 31/7 175/9 177/1	<b>surrounding [1]</b> 35/12	<b>tailor [1]</b> 167/20	<b>technical [3]</b> 146/2 146/14 156/9
<b>strong [1]</b> 171/23	<b>suggesting [2]</b> 6/25 31/6	<b>surveillance [2]</b> 144/3 151/7	<b>tailor clinical [1]</b> 167/20	<b>technically [1]</b> 12/23
<b>stronger [2]</b> 160/9 181/2	<b>suggestion [2]</b> 157/9 162/23	<b>surviving [1]</b> 49/20	<b>take [37]</b> 7/16 7/20 7/21 9/5 10/2 27/22 28/19 31/6 32/16 33/5 42/25 52/25 57/20 58/22 60/9 76/4 77/10 77/10 77/12 77/22 81/19 82/3 87/20 90/11 90/19 90/24 101/7 106/18 117/19 118/2 126/20 130/25 134/4 134/4 142/18 152/24 160/4	<b>technology [10]</b> 12/7 27/2 47/21 47/23 48/18 49/3 50/13 51/4 153/13 153/16
<b>strongly [2]</b> 109/15 176/5	<b>suggestions [1]</b> 161/1	<b>Susannah [1]</b> 68/20	<b>take-up [1]</b> 160/4	<b>telephone [6]</b> 5/12 53/25 54/9 102/8 134/24 173/13
<b>strove [1]</b> 173/18	<b>suit [2]</b> 133/10 136/19	<b>suspect [2]</b> 105/7 143/4	<b>taken [18]</b> 35/10 53/2 69/5 70/11 81/22 83/9 142/6 150/16 158/21 163/14 164/18 171/1 172/10 173/5 173/23 174/23 179/5 180/9	<b>television [2]</b> 70/22 88/10
<b>struck [2]</b> 43/12 69/20	<b>suits [1]</b> 132/17	<b>suspected [6]</b> 20/16 80/14 93/7 121/23 123/1 123/8	<b>tailor [1]</b> 167/20	<b>tell [24]</b> 2/8 2/21 27/21 28/4 28/5 31/16 31/17 35/10 62/8 65/12 77/23 78/3 78/5 79/2 82/10 84/19 84/19 85/2 85/17 86/12 102/20 103/9 114/10 121/19
<b>structure [3]</b> 20/21 148/13 171/18	<b>sum [1]</b> 53/3	<b>suspended [1]</b> 177/13	<b>take [37]</b> 7/16 7/20 7/21 9/5 10/2 27/22 28/19 31/6 32/16 33/5 42/25 52/25 57/20 58/22 60/9 76/4 77/10 77/10 77/12 77/22 81/19 82/3 87/20 90/11 90/19 90/24 101/7 106/18 117/19 118/2 126/20 130/25 134/4 134/4 142/18 152/24 160/4	<b>telling [8]</b> 9/2 40/13 48/22 76/7 78/21 100/8 104/3 105/10
<b>struggle [1]</b> 51/24	<b>summarise [1]</b> 131/9	<b>swab [2]</b> 81/22 122/5	<b>take-up [1]</b> 160/4	<b>temperature [2]</b> 40/9 122/7
<b>STUC [1]</b> 178/18	<b>summarised [1]</b> 159/25	<b>Swann [4]</b> 111/12 120/12 155/10 160/24	<b>taken [18]</b> 35/10 53/2 69/5 70/11 81/22 83/9 142/6 150/16 158/21 163/14 164/18 171/1 172/10 173/5 173/23 174/23 179/5 180/9	<b>temporarily [1]</b> 18/12
<b>stuck [1]</b> 62/7	<b>summary [3]</b> 5/5 162/9 173/16	<b>swiftly [2]</b> 165/19 166/13	<b>switched [1]</b> 45/20	<b>temporary [1]</b> 152/4
<b>students [2]</b> 172/20 172/21	<b>summer [1]</b> 109/18	<b>sworn [2]</b> 108/4 183/11	<b>sympathetic [1]</b> 91/18	<b>ten [4]</b> 21/4 96/5 125/3 141/2
<b>studies [2]</b> 149/12 150/22	<b>summer/autumn [1]</b> 109/18			<b>ten minutes [1]</b> 141/2
<b>stuff [4]</b> 17/25 17/25 21/6 53/16	<b>Sunday [2]</b> 113/12 113/16			<b>ten years [1]</b> 96/5
<b>sub [1]</b> 174/21	<b>super [1]</b> 88/3			<b>tenaciously [1]</b> 32/11
<b>sub-optimal [1]</b> 174/21	<b>supermorgue [1]</b> 18/17			
<b>subject [3]</b> 17/15 59/24 104/12	<b>supplemented [1]</b>			
<b>submission [3]</b> 149/17 151/17 176/23				
<b>submissions [9]</b> 141/6 141/16 141/17 142/25 150/8 153/23 154/15 182/5 183/14				
<b>submit [3]</b> 170/16 170/20 173/16				
<b>submitted [1]</b> 156/22				
<b>subsequently [10]</b> 3/23 17/8 55/7 75/5 75/9 94/7 96/21				

<b>T</b>	140/3 140/20 140/22 141/9 141/11 143/8 153/25 154/7 164/8 164/9 164/14 168/12 168/13 182/6 182/7 182/13 182/14	155/16 164/3 164/7 166/8 167/9 169/4 170/11 177/24 178/14 180/13	26/19 26/19 27/24 27/25 28/3 31/12 39/14 41/11 43/4 53/23 67/25 73/11 84/25 95/21 95/22 95/22 97/12 97/21 98/2 99/15 100/19 110/6 111/18 116/9 134/2 139/3 142/17 71/18 147/13 148/4 150/25 153/11 176/25	<b>third [5]</b> 145/5 147/1 150/7 152/6 167/7 <b>Thirdly [1]</b> 166/1 <b>Thirlwall [1]</b> 166/20 <b>this [190]</b> <b>those [98]</b> 3/23 5/8 5/19 6/12 6/18 6/22 7/2 7/5 11/5 11/19 13/15 15/18 16/16 18/13 18/23 19/2 19/19 20/4 20/13 23/3 24/14 24/22 26/15 27/8 29/17 30/18 33/6 35/19 35/23 36/4 38/10 38/13 45/2 45/15 46/4 46/12 50/24 55/23 55/24 58/1 62/20 63/2 63/4 63/6 63/13 63/17 67/20 71/21 74/6 74/19 76/15 83/7 84/12 85/3 86/19 88/19 88/21 88/22 88/22 89/25 91/9 92/5 110/3 110/11 110/25 112/9 117/2 138/24 141/3 141/25 145/2 146/16 146/20 148/11 151/23 151/24 153/23 154/20 155/18 158/7 158/18 161/8 163/10 163/20 164/6 164/19 167/15 169/7 169/8 169/22 169/23 169/25 170/6 171/12 174/6 181/25 182/1 182/5 <b>though [5]</b> 5/4 83/8 131/2 132/10 148/2 <b>thought [20]</b> 18/2 49/11 49/12 52/17 66/14 70/17 90/15 90/18 96/25 96/25 97/1 97/2 124/2 124/5 130/11 134/2 135/15 143/1 154/2 176/13 <b>thrash [1]</b> 89/2 <b>thrashing [2]</b> 88/13 104/21 <b>threads [1]</b> 151/14 <b>threats [2]</b> 143/23 150/11 <b>three [23]</b> 5/16 5/19 6/10 6/15 6/18 6/22 9/6 26/11 28/19 36/11 40/2 52/3 82/20 93/12 95/11 98/1 116/6 128/22 133/23 144/7 159/5 165/15 167/25 <b>three days [2]</b> 26/11 40/2 <b>three months [2]</b> 128/22 167/25 <b>three-ply [1]</b> 82/20 <b>through [40]</b> 6/3 41/1
<b>tendency [2]</b> 62/5 97/15 <b>tenor [1]</b> 127/13 <b>term [4]</b> 166/7 170/25 180/2 180/5 <b>terms [25]</b> 10/24 10/25 13/20 35/13 35/21 37/21 40/19 41/21 42/1 42/23 47/4 55/18 55/20 66/13 71/24 71/25 74/21 77/3 77/15 97/20 106/7 129/10 148/17 170/13 175/7 <b>terrified [9]</b> 49/16 49/17 49/21 84/24 91/22 91/22 91/23 99/7 99/19 <b>terrified -- well [1]</b> 91/22 <b>territorial [1]</b> 180/14 <b>terror [1]</b> 100/14 <b>test [16]</b> 7/1 9/5 9/9 24/6 25/18 26/6 37/22 37/24 81/3 81/5 87/3 97/4 121/19 121/22 179/7 181/5 <b>testament [1]</b> 170/6 <b>tested [19]</b> 20/17 21/9 25/1 25/25 26/1 51/16 55/4 55/10 81/1 81/1 81/2 93/7 93/8 116/25 121/20 122/4 122/9 123/11 170/22 <b>testing [20]</b> 20/19 23/16 23/19 24/20 24/23 25/19 25/23 26/5 26/8 37/21 56/8 112/11 157/11 157/14 157/16 157/19 157/21 157/23 158/24 179/3 <b>tests [8]</b> 8/23 24/5 24/14 24/15 26/10 95/12 97/6 157/25 <b>text [4]</b> 12/15 12/17 72/4 73/3 <b>than [14]</b> 4/14 27/11 34/13 47/9 49/5 70/16 95/4 106/6 141/20 148/1 153/10 153/14 163/16 176/13 <b>thank [52]</b> 1/5 1/15 2/1 3/14 32/3 32/8 32/17 32/18 32/19 32/25 33/2 33/4 33/9 33/16 33/23 58/2 58/4 58/14 58/18 58/21 59/5 59/11 59/12 89/11 107/1 107/4 107/18 107/19 107/20 108/3 108/13 108/15 139/2 139/5 139/13	<b>Thank you [1]</b> 182/6 <b>thankfully [1]</b> 109/22 <b>thanks [1]</b> 164/6 <b>that [1046]</b> <b>that July [1]</b> 116/21 <b>that's [77]</b> 1/21 2/4 2/7 3/10 4/2 4/22 6/7 6/21 7/12 9/24 11/4 11/11 11/11 12/1 12/16 15/2 16/22 21/25 23/6 25/1 25/7 25/15 25/17 26/7 26/7 28/12 31/23 32/2 34/3 34/9 34/15 35/25 36/7 36/14 39/10 44/15 45/18 45/25 47/13 56/11 56/15 57/1 57/20 58/13 60/8 60/25 62/10 66/22 67/7 67/7 67/8 67/9 67/10 72/23 73/3 75/23 78/5 84/10 84/22 85/23 86/15 93/9 94/12 99/1 101/24 101/24 103/14 105/18 106/4 106/25 118/13 119/5 124/25 138/19 139/15 139/23 142/12 <b>theatre [1]</b> 37/8 <b>their [102]</b> 4/15 7/7 9/21 10/21 11/22 12/14 12/18 12/25 13/13 13/22 13/22 14/24 16/2 16/19 17/18 17/19 17/21 18/12 19/10 20/9 21/9 25/2 25/25 28/11 30/8 32/11 32/24 34/24 35/9 35/16 37/7 38/8 39/3 39/3 39/19 40/25 41/2 42/16 43/14 43/23 43/24 44/10 44/10 44/24 46/13 50/8 52/25 53/12 54/8 55/1 55/4 55/21 60/1 66/15 67/8 67/9 69/11 70/12 71/9 73/24 76/4 77/12 77/21 78/1 84/8 84/9 92/10 98/18 98/20 103/1 103/8 103/9 110/8 111/1 115/8 123/22 124/23 126/12 126/18 128/23 133/10 134/11 134/14 135/1 138/23 138/25 142/5 142/25 146/3 146/11 152/8 155/14	<b>them [73]</b> 7/20 10/3 12/9 12/17 13/12 13/12 17/4 17/20 18/2 20/11 20/16 23/10 23/12 23/13 28/5 35/9 35/10 35/10 38/14 43/23 44/3 44/3 44/8 44/19 44/19 44/22 47/2 48/5 48/23 49/5 49/17 51/12 51/25 51/25 52/8 54/5 54/6 58/10 58/12 65/1 65/16 71/16 75/8 78/2 78/3 78/5 79/2 81/19 87/3 88/8 94/25 95/3 95/5 95/6 98/20 100/9 104/14 105/11 106/7 106/15 121/16 122/20 124/19 126/2 136/8 138/8 138/9 138/23 143/4 155/24 169/17 175/20 175/24 <b>theme [1]</b> 64/21 <b>themselves [4]</b> 12/3 55/21 70/18 71/17 <b>then [90]</b> 2/13 2/15 5/2 5/25 12/10 14/7 16/25 20/4 20/19 23/21 24/11 26/17 27/17 32/1 35/4 36/13 37/14 39/13 45/24 46/24 47/13 48/13 51/7 52/12 53/1 53/15 54/11 55/16 55/18 56/7 58/9 62/2 64/17 65/12 66/24 66/25 67/20 69/10 69/12 74/8 76/10 77/22 78/7 78/23 81/4 82/2 84/10 84/10 87/6 90/17 90/17 92/3 92/19 93/3 93/14 93/21 94/1 94/13 94/15 94/19 95/8 95/23 97/5 106/12 112/19 113/7 115/12 115/17 116/18 116/21 116/23 118/13 119/5 119/20 119/24 125/13 126/15 131/19 133/22 134/6 137/16 140/12 149/23 152/10 152/16 152/24 153/2 155/18 156/23 157/5 <b>therapy [1]</b> 122/23 <b>there [241]</b> <b>there'd [3]</b> 10/14 96/1 109/4 <b>there's [34]</b> 8/10 12/19 18/20 22/5 22/14 25/21 26/3	<b>thereof [1]</b> 80/9 <b>these [29]</b> 9/6 18/6 41/10 51/13 53/3 61/20 63/20 63/24 77/7 96/4 103/10 103/17 106/15 111/24 112/17 120/13 126/5 127/21 141/22 147/5 150/19 151/14 154/14 154/14 158/23 162/14 164/4 164/22 178/22 <b>they [209]</b> <b>they'd [4]</b> 23/11 69/6 79/19 88/8 <b>they'll [2]</b> 32/25 136/16 <b>they're [13]</b> 12/5 15/18 25/6 27/15 34/7 37/9 41/16 50/24 56/7 87/15 95/3 96/3 124/24 <b>they've [3]</b> 18/15 98/1 116/10 <b>thin [1]</b> 96/4 <b>thing [18]</b> 8/17 15/18 15/21 20/1 21/25 22/10 22/11 24/13 26/4 28/8 29/15 32/2 32/5 70/17 81/9 103/11 105/5 154/17 <b>things [54]</b> 8/13 10/12 11/10 12/1 13/4 14/20 15/13 15/19 15/20 18/24 22/5 25/10 26/16 27/13 28/5 30/21 31/10 32/13 35/19 35/23 46/4 50/24 52/7 54/1 54/17 57/2 58/13 62/18 67/16 68/17 71/22 74/22 76/4 83/21 84/25 85/14 87/21 97/23 98/4 98/18 99/21 100/4 104/1 105/14 106/12 106/16 107/13 110/13 117/8 127/15 127/18 134/7 135/23 139/21 <b>think [216]</b> <b>thinking [5]</b> 89/11 93/1 93/9 105/17 121/14	

<p><b>T</b></p> <p><b>through...</b> [38] 41/2 43/19 45/10 48/12 58/5 61/14 61/16 61/22 64/6 64/15 64/18 65/16 67/9 67/11 67/16 72/5 72/23 74/23 91/23 100/15 101/4 101/20 106/21 115/16 117/6 123/4 133/6 134/24 135/8 137/2 137/22 142/10 145/5 145/14 171/7 173/13 174/8 177/10</p> <p><b>throughout</b> [4] 60/16 82/23 148/20 173/14</p> <p><b>Thursday</b> [1] 115/13</p> <p><b>Thus</b> [1] 170/13</p> <p><b>tighter</b> [2] 47/8 47/9</p> <p><b>time</b> [93] 6/4 7/23 10/10 14/1 14/10 16/7 22/6 26/7 28/4 37/25 39/25 40/7 40/25 46/22 48/17 48/21 49/1 52/21 61/17 63/16 63/24 66/8 66/22 69/1 69/8 70/2 70/13 71/3 72/16 72/25 74/6 74/13 76/5 76/8 76/9 78/8 79/22 80/10 80/22 80/25 81/8 81/11 82/23 83/14 83/20 84/2 84/15 84/23 84/23 85/1 87/20 89/1 90/11 91/19 92/23 93/11 93/22 94/3 95/7 97/3 101/22 102/5 103/15 103/21 105/20 106/17 109/4 111/15 115/22 115/22 117/18 117/23 124/2 125/8 126/7 126/22 127/10 127/16 128/2 129/5 129/7 129/25 130/22 132/5 132/14 135/23 137/20 145/18 149/3 156/12 171/4 171/14 182/9</p> <p><b>time frame</b> [1] 156/12</p> <p><b>time June</b> [1] 70/13</p> <p><b>timely</b> [1] 151/9</p> <p><b>times</b> [21] 7/15 13/19 35/4 39/18 61/21 63/17 65/19 66/19 80/19 85/25 93/12 97/9 116/6 116/12 126/24 130/10 133/22 133/23 138/8 169/18 170/22</p> <p><b>timing</b> [1] 37/22</p> <p><b>timings</b> [1] 72/6</p>	<p><b>tinkering</b> [1] 29/5</p> <p><b>today</b> [16] 1/11 101/1 107/12 108/7 126/12 139/7 140/4 141/5 143/14 143/18 144/6 150/8 165/2 168/20 169/10 182/11</p> <p><b>together</b> [9] 18/21 61/10 111/5 135/3 138/6 143/24 151/14 152/25 171/2</p> <p><b>toilet</b> [1] 133/25</p> <p><b>told</b> [42] 6/12 7/7 7/17 7/19 13/12 14/8 14/12 15/10 17/5 17/21 24/11 25/4 27/21 35/15 51/22 52/4 79/20 83/10 83/11 92/16 95/12 97/9 99/25 100/4 103/17 104/13 105/10 116/10 116/19 121/21 122/12 122/25 123/9 123/10 126/14 128/3 131/3 132/13 137/10 173/1 177/14 179/11</p> <p><b>tolerate</b> [1] 69/18</p> <p><b>tomorrow</b> [2] 15/21 182/12</p> <p><b>tone</b> [1] 127/13</p> <p><b>too</b> [23] 3/11 27/22 33/3 69/20 69/20 69/23 69/23 69/24 71/5 72/19 72/21 89/20 90/10 107/11 114/21 115/4 122/14 127/6 142/15 162/22 176/18 180/18 180/21</p> <p><b>took</b> [14] 24/14 66/20 88/18 89/12 90/11 90/13 90/14 95/5 122/20 129/19 156/6 156/12 158/20 170/3</p> <p><b>tool</b> [1] 148/23</p> <p><b>tools</b> [3] 116/23 153/13 175/24</p> <p><b>topic</b> [1] 111/23</p> <p><b>topics</b> [1] 111/23</p> <p><b>tortured</b> [1] 35/1</p> <p><b>totality</b> [1] 158/21</p> <p><b>totally</b> [1] 33/23</p> <p><b>touch</b> [7] 24/19 44/19 60/4 122/22 144/7 144/18 154/18</p> <p><b>touched</b> [2] 23/16 89/22</p> <p><b>tourists</b> [1] 36/5</p> <p><b>towards</b> [1] 72/15</p> <p><b>trace</b> [1] 77/12</p> <p><b>traceable</b> [1] 27/17</p> <p><b>track</b> [1] 77/12</p> <p><b>tracking</b> [2] 77/13 156/15</p> <p><b>tradition</b> [1] 70/9</p>	<p><b>tragedy</b> [1] 13/16</p> <p><b>tragic</b> [1] 24/22</p> <p><b>train</b> [2] 74/10 78/25</p> <p><b>trained</b> [1] 152/11</p> <p><b>trainee</b> [1] 103/6</p> <p><b>training</b> [4] 29/25 30/13 106/19 131/4</p> <p><b>transferred</b> [2] 123/12 128/7</p> <p><b>transfers</b> [1] 161/21</p> <p><b>transformed</b> [1] 85/11</p> <p><b>transmission</b> [15] 37/19 144/21 144/23 144/24 145/11 145/13 145/17 145/19 145/22 176/8 176/12 176/21 176/25 177/8 177/12</p> <p><b>transmissions</b> [1] 164/25</p> <p><b>transmitted</b> [4] 38/5 144/18 145/5 176/6</p> <p><b>transport</b> [5] 52/11 52/17 52/22 52/22 78/4</p> <p><b>transported</b> [3] 18/17 52/9 53/1</p> <p><b>trauma</b> [1] 34/22</p> <p><b>traumatic</b> [1] 139/24</p> <p><b>travel</b> [4] 7/24 72/18 74/7 76/5</p> <p><b>travelling</b> [1] 177/12</p> <p><b>treat</b> [3] 30/9 164/25 180/8</p> <p><b>treated</b> [3] 15/16 124/21 125/12</p> <p><b>treatment</b> [21] 13/21 13/21 15/8 16/3 17/1 17/3 30/23 41/12 41/25 42/17 62/21 67/17 68/25 89/1 124/13 124/14 124/22 125/1 127/25 155/19 181/5</p> <p><b>treatments</b> [1] 15/9</p> <p><b>tremoring</b> [1] 115/14</p> <p><b>triage</b> [3] 5/12 5/25 181/17</p> <p><b>triaged</b> [4] 114/12 115/17 121/19 122/4</p> <p><b>triaging</b> [1] 51/15</p> <p><b>trials</b> [1] 148/5</p> <p><b>tributes</b> [2] 164/1 164/4</p> <p><b>tried</b> [7] 2/12 17/6 74/17 79/17 103/14 103/15 104/5</p> <p><b>trigger</b> [1] 97/12</p> <p><b>triggering</b> [1] 107/14</p> <p><b>trolley</b> [1] 89/15</p> <p><b>trouble</b> [1] 91/7</p> <p><b>truly</b> [2] 59/8 87/12</p> <p><b>trust</b> [11] 76/23 97/25 111/13 116/10</p>	<p>116/11 131/5 131/13 162/10 162/15 171/18 180/22</p> <p><b>trusts</b> [8] 110/20 129/2 131/5 156/21 159/6 159/6 162/6 163/17</p> <p><b>truth</b> [6] 31/16 31/17 32/12 57/2 100/1 169/18</p> <p><b>try</b> [11] 14/16 20/9 48/17 49/16 62/5 66/18 68/5 76/12 90/12 96/9 105/8</p> <p><b>trying</b> [19] 6/2 31/24 44/17 51/24 61/23 62/8 65/18 65/24 72/5 85/22 96/7 103/1 103/9 107/6 107/9 108/25 139/14 139/16 149/10</p> <p><b>tube</b> [1] 78/5</p> <p><b>Tuesday</b> [1] 1/1</p> <p><b>tumour</b> [1] 119/23</p> <p><b>turn</b> [6] 73/25 112/25 139/3 140/25 141/17 144/20</p> <p><b>turned</b> [2] 66/18 97/6</p> <p><b>turning</b> [5] 145/24 172/8 173/20 175/3 179/25</p> <p><b>turns</b> [1] 104/14</p> <p><b>TV</b> [2] 98/5 99/22</p> <p><b>twice</b> [2] 24/6 116/25</p> <p><b>Twitter</b> [1] 2/25</p> <p><b>two</b> [26] 10/4 11/5 14/9 18/1 31/6 34/13 35/19 36/5 41/5 55/6 59/15 65/23 81/18 92/7 95/10 103/15 113/6 117/2 119/8 124/18 130/7 133/14 133/19 147/14 159/6 165/5</p> <p><b>two days</b> [1] 55/6</p> <p><b>two weeks</b> [5] 31/6 34/13 117/2 133/14 133/19</p> <p><b>two years</b> [2] 10/4 14/9</p> <p><b>type</b> [1] 180/4</p> <p><b>types</b> [2] 110/25 111/24</p> <p><b>typical</b> [1] 81/23</p>	<p>108/20</p> <p><b>UKHSA</b> [12] 143/15 143/17 143/24 145/25 146/10 150/14 151/6 151/11 152/18 152/21 153/1 153/24</p> <p><b>UKHSA's</b> [4] 143/20 144/2 146/14 150/12</p> <p><b>ultimately</b> [1] 53/2</p> <p><b>Um</b> [1] 134/17</p> <p><b>unanswered</b> [1] 16/1</p> <p><b>unaware</b> [3] 40/23 126/1 173/4</p> <p><b>unbelievable</b> [1] 136/12</p> <p><b>uncle</b> [1] 126/13</p> <p><b>unclear</b> [5] 8/6 8/7 55/3 145/15 178/1</p> <p><b>uncontaminated</b> [2] 21/14 21/18</p> <p><b>under</b> [7] 66/7 84/16 86/2 105/20 114/22 132/22 175/5</p> <p><b>undergarments</b> [1] 17/24</p> <p><b>underlying</b> [1] 54/12</p> <p><b>underneath</b> [1] 95/9</p> <p><b>underpin</b> [2] 151/3 169/21</p> <p><b>underpinned</b> [1] 162/9</p> <p><b>underpinning</b> [1] 43/8</p> <p><b>understand</b> [25] 11/14 13/8 16/5 30/20 33/23 36/8 40/4 40/13 42/13 42/13 43/16 43/19 44/25 44/25 45/8 45/9 45/15 62/4 104/5 123/21 130/13 139/20 174/9 179/10 182/10</p> <p><b>understanding</b> [11] 24/17 27/10 42/8 66/4 105/15 131/4 144/14 144/15 145/10 172/2 176/17</p> <p><b>understood</b> [7] 14/6 38/24 43/16 44/21 56/14 81/7 117/10</p> <p><b>undertaken</b> [3] 15/9 146/23 162/5</p> <p><b>unequivocal</b> [1] 176/14</p> <p><b>unequivocally</b> [1] 175/9</p> <p><b>unerring</b> [1] 164/7</p> <p><b>unflinching</b> [1] 164/17</p> <p><b>unforgivable</b> [1] 72/23</p> <p><b>unfortunately</b> [6] 61/9 63/25 68/25 72/19 97/19 126/17</p>
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<p><b>U</b></p> <p><b>unhelpful [2]</b> 176/16 177/9</p> <p><b>uniformly [1]</b> 159/14</p> <p><b>unifying [1]</b> 61/10</p> <p><b>union [1]</b> 178/23</p> <p><b>unique [5]</b> 5/23 38/14 38/16 38/17 94/7</p> <p><b>unit [1]</b> 83/10</p> <p><b>United [5]</b> 38/15 38/17 143/14 148/14 168/24</p> <p><b>United Kingdom [5]</b> 38/15 38/17 143/14 148/14 168/24</p> <p><b>University [1]</b> 59/24</p> <p><b>unknown [2]</b> 21/5 49/25</p> <p><b>unless [2]</b> 8/16 130/3</p> <p><b>unlocked [3]</b> 97/6 97/14 97/16</p> <p><b>unnecessary [1]</b> 167/8</p> <p><b>unpicking [1]</b> 67/10</p> <p><b>unrestricted [1]</b> 180/23</p> <p><b>unselfish [1]</b> 164/7</p> <p><b>until [13]</b> 14/9 16/24 20/16 23/24 26/1 26/13 40/24 62/6 109/3 113/7 145/23 161/25 182/16</p> <p><b>until April 2020 [1]</b> 145/23</p> <p><b>until January 2021 [1]</b> 26/13</p> <p><b>until March [1]</b> 23/24</p> <p><b>unusual [1]</b> 97/9</p> <p><b>unwell [13]</b> 4/24 8/1 48/11 49/23 52/16 52/19 55/7 55/14 66/14 66/18 68/22 96/24 122/7</p> <p><b>up [44]</b> 22/16 28/8 29/9 38/11 39/10 46/21 53/3 54/5 54/13 56/3 58/8 69/13 73/25 77/9 77/16 78/11 79/4 85/9 87/7 90/16 97/20 100/4 101/24 103/18 104/12 106/18 106/19 109/19 109/21 109/25 116/2 116/18 119/6 119/17 128/7 131/18 131/24 136/15 139/13 143/4 152/13 156/6 160/4 178/24</p> <p><b>update [3]</b> 101/10 127/7 127/16</p> <p><b>updated [1]</b> 162/11</p> <p><b>updates [2]</b> 16/2 31/8</p> <p><b>upon [3]</b> 81/1 166/7 179/1</p>	<p><b>upset [1]</b> 92/8</p> <p><b>upsetting [2]</b> 127/14 169/10</p> <p><b>upskilling [1]</b> 30/1</p> <p><b>urban [3]</b> 62/15 62/17 65/24</p> <p><b>urge [2]</b> 137/4 138/2</p> <p><b>urgent [5]</b> 61/24 85/8 172/17 173/25 181/18</p> <p><b>urine [1]</b> 17/24</p> <p><b>urine-soaked [1]</b> 17/24</p> <p><b>urology [2]</b> 102/13 102/15</p> <p><b>us [69]</b> 2/8 7/19 14/8 14/9 15/7 16/22 16/23 17/6 17/9 18/24 19/19 24/11 25/8 30/25 30/25 31/3 31/13 35/11 35/20 44/2 44/13 44/20 44/21 45/14 46/7 48/22 52/5 55/24 55/24 57/1 58/1 58/17 60/3 62/9 65/12 68/2 68/2 71/23 73/24 76/2 76/7 78/14 78/19 78/21 81/14 82/10 84/19 85/8 86/12 87/15 89/16 90/3 91/19 92/16 93/3 94/7 104/3 107/12 107/17 109/10 111/3 114/10 126/3 128/3 131/3 132/13 134/9 141/7 181/2</p> <p><b>use [33]</b> 17/13 22/2 27/2 27/16 31/22 39/24 47/21 48/4 48/15 48/15 48/23 50/13 50/20 50/22 50/25 51/4 54/16 64/3 71/9 147/9 147/19 148/1 149/19 150/9 151/25 152/8 153/15 154/21 155/6 155/8 177/22 177/25 180/12</p> <p><b>used [19]</b> 21/21 27/7 41/13 43/2 43/3 43/7 47/24 48/24 49/3 49/4 50/5 51/9 52/10 132/12 133/25 147/13 155/1 177/10 181/16</p> <p><b>useful [2]</b> 51/12 144/13</p> <p><b>useless [1]</b> 31/17</p> <p><b>uses [1]</b> 151/10</p> <p><b>using [4]</b> 48/18 124/24 147/18 148/24</p> <p><b>usually [1]</b> 18/4</p> <p><b>utilisation [2]</b> 19/19 151/13</p> <p><b>UUP [1]</b> 111/21</p>	<p><b>V</b></p> <p><b>vaccination [1]</b> 158/25</p> <p><b>vaccine [1]</b> 181/4</p> <p><b>valuable [1]</b> 168/11</p> <p><b>value [3]</b> 31/14 180/19 180/21</p> <p><b>values [6]</b> 155/17 169/21 169/22 170/1 170/6 170/7</p> <p><b>variable [3]</b> 48/2 48/6 52/1</p> <p><b>variation [3]</b> 43/2 171/20 175/22</p> <p><b>varied [3]</b> 24/9 92/21 146/22</p> <p><b>various [2]</b> 157/11 166/21</p> <p><b>vast [1]</b> 66/1</p> <p><b>Vaughan [1]</b> 29/4</p> <p><b>vehicle [1]</b> 52/25</p> <p><b>ventilate [1]</b> 14/5</p> <p><b>ventilated [1]</b> 15/11</p> <p><b>ventilation [8]</b> 20/25 21/7 57/7 57/14 145/3 152/3 152/3 177/3</p> <p><b>ventilators [1]</b> 46/3</p> <p><b>verbal [1]</b> 122/24</p> <p><b>Verrall [1]</b> 143/19</p> <p><b>versus [1]</b> 62/17</p> <p><b>very [97]</b> 1/13 3/9 3/12 5/23 13/9 14/15 15/14 19/2 26/5 26/15 28/12 28/13 28/14 29/8 30/10 32/3 32/17 32/19 32/25 33/21 39/25 40/9 41/6 41/6 41/7 46/19 48/11 49/20 52/1 53/15 53/24 57/16 57/17 58/4 58/7 58/14 58/21 59/11 62/17 63/10 65/13 68/23 68/23 69/9 73/16 77/3 81/12 81/12 88/12 91/15 91/15 91/25 92/7 100/25 101/17 102/25 103/25 104/18 106/23 107/1 107/4 107/22 109/15 109/22 112/6 114/13 120/15 121/5 124/8 134/11 134/13 134/13 135/16 136/21 136/23 137/8 137/14 139/20 139/21 139/22 140/4 140/21 141/10 142/17 143/8 153/10 153/25 154/1 154/7 154/23 164/8 164/9 164/10 168/13 168/13 182/7 182/8</p> <p><b>via [9]</b> 2/25 2/25 3/1 3/6 10/7 38/5 49/5</p>	<p>144/18 176/6</p> <p><b>viability [1]</b> 163/1</p> <p><b>video [4]</b> 4/17 11/24 50/5 53/25</p> <p><b>view [9]</b> 31/16 40/10 53/13 115/2 146/6 155/4 156/10 163/3 167/10</p> <p><b>views [5]</b> 23/2 69/19 151/22 151/23 165/5</p> <p><b>viral [3]</b> 26/8 73/18 96/1</p> <p><b>virus [8]</b> 43/17 112/15 137/20 144/14 144/15 150/21 171/16 176/17</p> <p><b>viruses [3]</b> 144/17 144/18 180/2</p> <p><b>visit [13]</b> 11/22 23/7 23/10 43/14 46/6 51/25 54/18 64/25 64/25 66/25 113/11 132/3 132/6</p> <p><b>visiting [22]</b> 10/9 22/24 23/2 23/3 36/13 43/10 43/11 43/21 45/5 46/5 46/16 47/4 47/22 47/24 50/14 51/1 51/3 82/10 115/23 128/5 137/5 167/15</p> <p><b>visiting hours [1]</b> 10/9</p> <p><b>visitor [1]</b> 92/17</p> <p><b>visitors [2]</b> 46/7 69/17</p> <p><b>visits [4]</b> 4/12 5/3 53/18 53/24</p> <p><b>visor [1]</b> 82/20</p> <p><b>visors [1]</b> 94/20</p> <p><b>visually [1]</b> 9/14</p> <p><b>vital [5]</b> 13/7 15/22 26/6 49/7 150/10</p> <p><b>vitality [2]</b> 35/19 50/1</p> <p><b>voice [4]</b> 12/3 16/9 117/7 117/12</p> <p><b>voiced [1]</b> 17/17</p> <p><b>volition [1]</b> 19/1</p> <p><b>volume [1]</b> 180/4</p> <p><b>voluntary [1]</b> 148/15</p> <p><b>vomiting [1]</b> 112/12</p> <p><b>vulnerable [17]</b> 32/9 56/11 73/23 102/3 102/10 102/25 113/22 148/18 148/18 149/5 150/4 153/5 158/8 169/15 173/24 175/20 179/15</p>	<p>84/21</p> <p><b>waiting [4]</b> 7/15 74/23 74/24 75/5</p> <p><b>waits [1]</b> 81/15</p> <p><b>Wales [48]</b> 2/16 2/19 3/8 3/10 3/13 3/21 5/14 5/18 5/23 7/15 8/8 8/9 10/23 11/3 11/9 16/12 20/3 23/21 26/4 26/11 26/14 27/3 27/11 28/1 28/2 28/12 29/8 29/18 31/11 65/8 65/9 72/9 74/3 74/9 74/11 74/14 76/24 78/8 79/18 79/22 81/18 83/24 92/18 93/3 164/18 165/22 166/3 167/1</p> <p><b>walk [2]</b> 7/22 41/9</p> <p><b>walked [2]</b> 124/5 130/6</p> <p><b>wall [4]</b> 36/3 60/23 131/17 131/25</p> <p><b>want [42]</b> 3/10 13/4 15/21 27/13 27/16 31/10 31/18 31/19 39/13 43/10 47/21 54/21 66/10 67/8 76/10 78/18 82/6 90/4 90/5 90/18 92/3 94/2 96/15 101/16 101/21 113/24 114/19 118/11 118/12 121/9 124/13 125/12 125/18 129/17 130/11 135/24 137/10 138/3 138/15 140/13 140/13 144/6</p> <p><b>wanted [15]</b> 3/5 32/5 32/8 36/12 61/13 74/14 75/20 80/22 104/13 110/3 112/8 117/19 121/23 127/25 130/13</p> <p><b>wants [2]</b> 116/22 151/7</p> <p><b>ward [58]</b> 4/23 5/6 10/16 11/18 19/17 20/10 20/12 20/13 20/16 20/18 25/16 37/15 37/15 43/25 46/20 46/22 47/12 47/13 47/16 48/6 48/7 56/14 56/15 81/5 82/7 83/9 86/5 86/18 86/24 86/24 86/25 87/1 87/6 120/11 123/12 125/15 125/19 127/22 128/4 128/6 128/8 128/10 128/12 128/16 130/3 130/4 130/14 130/20 130/22 131/16 132/17 133/9 133/12 133/14 133/18 133/23 135/21 136/6</p>
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<b>W</b>	146/8 170/2 181/12	10/18 12/2 14/12	133/5	<b>when [136]</b> 4/19 4/22
<b>ward-based [1]</b> 86/5	<b>we [335]</b>	14/22 15/3 18/15	<b>what [176]</b> 7/16 9/19	6/9 6/13 7/16 11/22
<b>wards [9]</b> 12/11	<b>we'd [7]</b> 19/24 20/22	19/24 23/6 28/12	10/5 10/8 10/9 10/9	12/5 12/18 13/22
19/14 19/15 37/20	85/9 88/21 88/22	29/17 29/18 30/19	13/7 13/12 15/7 15/9	14/10 14/10 14/11
46/17 48/23 56/10	141/9 156/1	31/11 32/23 36/18	15/10 15/21 16/3 18/3	15/24 16/6 16/11 20/8
57/21 116/2	<b>we'll [6]</b> 58/22 77/10	37/4 37/13 37/16	19/22 22/10 23/2 24/8	20/15 23/4 23/13
<b>Warne [2]</b> 147/10	77/12 77/12 94/11	39/11 41/6 41/15	25/17 27/25 28/1	24/10 24/15 24/25
177/23	182/10	47/25 49/9 49/9 53/5	29/11 29/12 30/12	26/6 26/7 27/16 27/19
<b>was [704]</b>	<b>we're [31]</b> 6/24 14/18	53/10 56/1 56/2 56/2	31/14 31/24 32/8	28/14 30/3 30/23
<b>was a [1]</b> 42/6	31/5 31/24 41/10 46/1	67/12 70/22 73/11	33/19 36/8 38/9 38/23	30/24 35/6 35/16
<b>was February [1]</b>	49/7 50/3 57/16 65/13	75/9 77/24 80/13	39/15 40/4 40/4 40/6	39/24 40/3 40/5 44/6
78/7	73/16 75/2 75/2 75/7	83/24 87/2 88/12	40/12 40/13 41/7	44/8 45/2 46/1 47/1
<b>wash [2]</b> 135/9	75/14 75/14 77/19	91/22 93/20 94/6	41/20 42/1 42/22	47/24 48/23 49/3
136/21	77/20 87/18 93/9 94/3	95/19 97/8 97/16	44/18 44/21 46/8	49/10 49/22 50/23
<b>washing [3]</b> 134/1	100/1 102/14 102/15	100/9 102/4 103/1	49/17 49/21 51/10	50/23 52/21 54/10
136/18 148/1	112/25 127/6 135/17	104/16 106/13 106/18	51/11 54/25 55/9	54/16 55/9 56/19
<b>wasn't [51]</b> 5/14 5/20	138/3 139/15 139/16	107/22 112/20 113/18	55/15 55/19 56/12	63/12 64/5 66/20 69/6
6/4 6/5 6/18 7/8 8/16	139/18	114/13 115/9 118/1	56/13 58/11 61/5 62/8	70/8 73/13 73/13 74/6
9/13 10/17 11/16	<b>we've [35]</b> 12/7 13/5	119/10 120/4 120/10	62/10 64/17 65/10	74/17 75/19 76/19
11/22 11/23 15/5 15/6	17/7 19/1 24/8 29/7	120/21 122/4 124/2	65/18 66/3 66/5 66/12	77/18 78/8 78/24 79/1
15/25 16/6 24/13 25/1	29/19 30/11 31/7 32/5	126/15 128/21 130/8	67/8 67/9 67/10 67/11	79/4 81/2 83/5 84/4
25/2 26/13 28/7 35/6	32/22 38/3 39/6 42/25	130/9 132/16 143/7	68/4 69/2 70/7 72/11	84/24 89/18 89/25
43/3 43/17 46/10	44/16 44/23 51/6 55/2	143/22 158/20 160/1	73/5 73/9 73/12 73/22	90/16 90/17 91/12
53/17 61/23 65/16	57/8 57/14 57/16	160/1 160/1 160/2	73/22 74/15 74/16	92/2 92/2 92/17 92/18
68/8 69/4 81/10 83/12	57/17 61/10 61/12	160/4 160/6 160/20	74/16 74/17 74/21	92/20 92/23 92/25
83/22 88/20 94/7	61/14 62/23 77/7 83/7	<b>well-being [4]</b> 56/1	75/2 75/2 75/7 75/9	93/16 93/21 94/2 95/8
100/5 100/5 102/16	91/4 101/19 105/5	56/2 73/11 160/20	75/16 75/19 76/6 76/7	95/20 95/24 96/2
104/10 111/9 111/21	109/22 138/7 144/9	<b>well-established [1]</b>	76/18 76/18 77/7	105/4 105/17 106/9
117/22 117/23 118/6	169/9	41/15	77/11 78/1 78/13	109/25 111/5 111/9
120/19 122/13 124/3	<b>wear [11]</b> 8/10 46/6	<b>well-known [1]</b> 10/18	78/19 79/1 79/2 79/8	111/17 112/11 114/7
129/16 129/22 132/20	48/12 48/13 82/15	<b>well-loved [1]</b> 49/9	79/13 79/14 79/25	114/12 115/22 122/3
137/11	93/4 94/20 115/23	<b>Welsh [33]</b> 2/20 3/18	82/10 82/24 83/16	122/12 122/18 122/24
<b>wasn't free [1]</b> 5/20	116/1 116/19 178/9	3/19 3/22 5/24 9/13	83/18 84/14 84/14	123/16 123/18 123/19
<b>watched [1]</b> 101/1	<b>wearers [1]</b> 21/25	9/16 18/23 19/6 21/3	84/19 85/23 86/12	124/5 125/3 126/24
<b>watching [3]</b> 46/1	<b>wearing [22]</b> 21/23	21/4 21/21 26/21	87/13 87/14 89/11	128/5 128/7 129/14
48/21 75/14	70/4 70/10 70/24	28/11 28/22 29/6	89/24 90/23 92/8	131/15 131/23 132/2
<b>Waterton [6]</b> 33/15	82/11 82/13 82/24	31/20 164/11 164/12	92/11 92/17 92/18	132/3 132/6 133/13
33/17 33/25 58/4	82/25 93/10 94/25	164/15 165/5 165/15	93/1 93/4 93/9 95/12	135/5 136/8 136/10
139/11 183/6	116/3 116/17 116/20	166/2 166/24 167/1	96/13 97/16 98/7	136/13 138/17 139/21
<b>wave [19]</b> 19/21 72/8	117/4 122/16 122/18	167/7 167/10 167/14	98/18 100/8 100/11	140/9 147/13 152/13
72/8 72/11 72/22	122/19 128/3 128/5	167/23 168/3 168/5	101/1 101/16 101/19	152/15 152/17 159/13
72/24 72/25 74/4	132/13 132/14 133/5	168/9 183/20	102/3 103/12 103/23	169/14 173/18 178/8
92/22 94/24 99/11	<b>weary [1]</b> 35/5	<b>went [43]</b> 15/25 36/2	104/2 104/2 104/3	<b>whenever [4]</b> 75/23
99/17 99/18 100/17	<b>website [2]</b> 10/7	39/25 48/24 67/9	104/7 104/13 105/8	123/3 124/17 137/14
104/6 104/7 122/11	128/23	67/11 76/15 77/14	105/9 109/16 111/3	<b>where [55]</b> 5/17 7/6
134/20 162/13	<b>Wednesday [2]</b>	78/24 80/17 81/12	111/23 112/1 113/3	8/18 16/7 16/8 22/12
<b>wave 2 [1]</b> 134/20	114/16 182/17	84/2 84/4 85/15 86/23	114/10 116/1 117/20	25/3 41/6 44/16 46/4
<b>waves [5]</b> 16/12	<b>week [22]</b> 37/24 49/1	90/17 97/2 112/25	117/21 117/24 117/25	54/22 55/15 56/8
19/21 42/2 73/2	72/19 77/4 77/14	113/3 113/6 113/8	118/1 118/11 120/6	56/15 58/13 62/16
161/18	77/19 78/14 79/20	113/15 113/16 114/7	120/6 123/15 124/21	62/18 69/3 70/10
<b>waves 1 [1]</b> 19/21	80/7 84/3 87/25 93/5	114/12 115/11 115/11	125/11 125/18 125/24	74/15 74/25 75/21
<b>way [36]</b> 3/9 10/6	93/9 93/10 93/12	115/21 116/24 117/20	131/9 132/13 134/9	77/24 78/1 79/2 79/6
14/19 14/19 21/20	93/13 94/3 94/12	119/5 120/14 121/12	137/22 138/3 140/6	80/22 83/18 84/10
22/4 22/19 22/20	111/7 111/10 111/22	122/5 124/6 124/9	142/22 146/15 146/22	84/12 84/23 85/3
23/10 28/7 29/21	112/18	125/9 125/16 129/13	153/18 155/24 170/4	87/18 92/23 94/15
44/22 45/17 47/15	<b>weekly [1]</b> 24/6	132/3 134/7 139/21	<b>what's [6]</b> 57/4 64/5	94/18 95/4 99/12
50/4 50/13 51/14 61/4	<b>weeks [8]</b> 24/2 31/6	181/4	75/15 101/10 130/8	101/12 105/20 106/6
66/10 71/9 73/4 84/25	34/13 84/4 99/4 117/2	<b>were [338]</b>	136/14	116/9 119/6 128/13
86/16 88/4 88/9 91/2	133/14 133/19	<b>weren't [20]</b> 12/24	<b>whatever [7]</b> 25/13	133/3 135/1 136/5
91/3 92/2 93/3 97/12	<b>weeping [1]</b> 36/7	14/5 15/9 15/10 16/19	43/6 48/4 50/21 78/3	141/8 145/6 165/13
103/17 103/18 105/11	<b>weighed [1]</b> 175/15	20/19 20/20 22/7 22/8	135/24 137/9	167/15 171/10 177/11
139/10 149/24 177/11	<b>weight [1]</b> 90/9	26/17 31/2 31/2 41/22	<b>WhatsApp [1]</b> 48/25	179/6 181/22
<b>ways [5]</b> 8/12 69/14	<b>weird [1]</b> 99/16	44/17 52/14 55/15	<b>whatsoever [2]</b> 52/15	<b>Whereas [1]</b> 135/25
	<b>well [79]</b> 1/11 9/23	88/17 98/9 126/17	75/4	<b>whereby [1]</b> 175/23



<b>W</b>	98/22 99/1 99/7 101/13 101/18 102/1 102/13 102/22 103/5 104/20 113/3 113/23 119/1 121/15 126/2 126/11 127/3 128/17 135/9 135/9 136/1 140/10 141/3 147/25 148/11 151/24 163/21 166/7 169/8 169/8 169/9 169/23 176/14 177/20 178/4 179/14 181/17 181/25 182/1	<b>willingly [1]</b> 157/1 <b>win [1]</b> 25/7 <b>window [1]</b> 133/6 <b>winner [1]</b> 110/8 <b>winter [1]</b> 63/16 <b>wiping [1]</b> 114/9 <b>wise [1]</b> 182/9 <b>wish [5]</b> 51/2 58/18 107/2 142/15 154/8 <b>wished [3]</b> 83/15 83/17 150/8 <b>wishes [4]</b> 154/11 155/16 158/15 161/25 <b>wit [1]</b> 12/8 <b>withdrew [4]</b> 33/10 58/24 107/21 140/23 <b>Withers [1]</b> 143/19 <b>within [37]</b> 4/5 11/2 11/17 13/20 28/4 46/16 59/20 61/20 63/9 63/11 63/18 63/20 63/21 66/8 68/9 69/22 71/1 76/12 76/17 76/23 76/24 77/16 78/14 84/18 85/1 94/17 95/19 97/17 99/10 101/16 111/22 112/18 146/1 147/2 151/13 152/23 156/12 <b>within a [1]</b> 71/1 <b>without [13]</b> 21/15 24/23 41/3 41/3 66/19 73/21 85/4 85/5 91/17 91/18 106/20 130/25 163/25 <b>witness [22]</b> 1/19 1/22 1/24 3/15 4/9 4/19 8/2 13/18 18/9 19/9 28/16 33/10 58/24 59/4 59/15 60/24 107/21 108/1 133/13 139/1 140/23 175/8 <b>witnessed [6]</b> 19/15 45/12 45/14 91/23 103/12 170/5 <b>witnesses [4]</b> 73/23 108/8 126/19 154/19 <b>witnessing [3]</b> 66/5 103/24 104/3 <b>wits' [1]</b> 111/8 <b>woman [2]</b> 100/12 126/11 <b>women [2]</b> 119/9 179/4 <b>won't [3]</b> 58/10 91/6 141/5 <b>wonder [1]</b> 44/16 <b>wondered [1]</b> 142/24 <b>wondering [2]</b> 46/5 134/19 <b>word [3]</b> 17/13 20/22 49/3	<b>words [8]</b> 14/18 14/19 14/20 17/11 30/17 40/14 161/6 174/21 <b>wore [4]</b> 82/15 82/23 92/16 94/23 <b>work [28]</b> 8/23 24/6 29/17 46/14 50/23 53/8 54/3 56/24 65/24 70/22 84/5 87/23 99/14 102/11 103/9 107/5 107/6 109/4 110/24 140/13 146/15 149/17 150/12 154/16 162/5 164/19 168/11 179/19 <b>worked [7]</b> 74/4 84/17 85/6 85/10 170/3 170/12 173/9 <b>worker [4]</b> 24/20 59/20 64/2 104/20 <b>workers [28]</b> 21/22 23/20 24/6 39/2 42/11 42/12 50/7 76/3 100/7 101/23 102/1 102/24 103/7 150/18 150/24 157/11 158/10 164/2 164/16 169/3 177/20 177/25 178/4 178/9 178/16 178/25 179/14 179/23 <b>workforce [10]</b> 57/8 57/12 93/17 165/18 166/5 169/2 169/14 170/12 172/21 182/4 <b>working [24]</b> 20/4 22/13 37/12 37/13 46/13 69/3 72/9 74/3 76/24 80/23 85/4 85/5 92/18 92/20 94/22 99/9 99/10 99/12 99/22 109/22 146/8 146/9 151/12 171/24 <b>world [3]</b> 12/25 36/10 36/10 <b>worn [10]</b> 21/21 21/24 22/7 22/8 22/9 96/3 132/20 132/22 132/24 133/4 <b>worried [4]</b> 49/24 66/23 81/14 120/18 <b>worry [3]</b> 6/13 69/4 69/5 <b>worse [3]</b> 34/22 66/15 139/25 <b>worsens [1]</b> 52/5 <b>worst [2]</b> 73/1 171/3 <b>worst-case [1]</b> 171/3 <b>worth [2]</b> 98/13 171/6 <b>would [134]</b> 1/12 3/8 3/11 4/16 8/15 8/23 13/16 15/12 15/15 17/12 17/14 18/2 23/7 23/8 23/9 23/9 23/11	23/14 27/22 27/22 29/3 34/16 40/17 44/20 46/21 47/2 47/5 47/10 48/4 48/11 48/23 49/20 50/4 50/16 50/17 50/23 53/3 54/15 62/6 64/10 64/11 64/24 65/1 66/9 66/11 66/15 71/1 73/4 77/5 77/8 78/18 79/20 81/15 83/10 84/7 84/7 84/11 84/11 85/20 86/6 86/10 86/13 86/13 87/13 87/16 87/17 88/5 89/2 89/2 89/3 89/5 89/8 90/12 93/2 93/4 93/19 93/20 94/18 94/19 94/19 95/24 95/25 99/2 102/7 104/10 105/2 105/21 105/22 107/2 109/13 109/17 112/12 117/7 117/8 117/11 117/12 121/2 124/15 126/21 131/20 132/4 136/1 137/11 137/13 137/16 137/17 137/25 138/8 141/21 142/24 146/17 152/4 152/10 152/22 153/2 154/15 158/19 162/20 163/3 163/6 163/10 164/17 165/15 166/5 166/10 173/7 175/10 175/14 175/18 175/21 176/1 176/21 177/23 177/25 <b>wouldn't [11]</b> 17/14 21/15 21/16 35/17 52/25 114/4 114/5 117/9 117/10 122/24 129/12 <b>wrapped [1]</b> 135/11 <b>writing [2]</b> 98/14 131/18 <b>written [10]</b> 5/5 14/19 25/11 37/3 56/22 142/18 146/10 151/17 164/20 168/3 <b>wrong [5]</b> 31/18 91/16 103/17 103/18 130/24 <b>wrote [1]</b> 132/5
			<b>X</b>	
			<b>x-ray [1]</b> 81/23	
			<b>Y</b>	
			<b>yeah [41]</b> 5/18 9/18 15/17 18/18 36/14 65/4 68/13 74/19 78/5 80/19 81/6 81/8 82/1 82/5 82/20 86/4 86/6 86/15 86/24 88/25 95/3 95/16 99/24	

<p><b>Y</b></p> <p><b>yeah... [18]</b> 109/6 109/12 111/4 113/9 114/12 115/4 117/17 118/8 118/18 119/15 120/8 126/7 130/16 133/2 133/3 133/18 134/13 138/3</p> <p><b>year [19]</b> 18/1 29/9 29/10 29/10 63/17 85/21 92/13 99/13 101/24 103/5 104/8 106/3 106/4 113/18 113/18 114/19 119/1 119/17 172/20</p> <p><b>year's [1]</b> 98/13</p> <p><b>years [17]</b> 10/4 14/9 16/25 21/2 42/5 42/7 46/12 63/7 85/6 96/5 97/5 106/18 106/19 118/4 118/7 131/14 140/17</p> <p><b>yes [44]</b> 4/2 4/14 5/23 6/7 7/12 8/7 8/25 14/4 15/2 15/5 17/23 19/13 21/25 21/25 22/5 24/1 26/3 34/9 37/8 41/18 42/12 64/22 67/2 82/22 83/1 89/10 92/14 94/5 95/18 96/11 98/17 106/1 113/12 115/25 116/15 117/10 119/4 119/7 121/11 122/18 130/13 132/17 142/23 154/4</p> <p><b>yesterday [1]</b> 36/2</p> <p><b>yet [9]</b> 10/16 13/1 20/3 21/17 30/13 87/22 89/15 101/11 173/8</p> <p><b>yoghurt [1]</b> 90/15</p> <p><b>you [777]</b></p> <p><b>you know [154]</b> 1/11 6/13 6/23 6/25 8/7 8/9 8/10 9/9 9/24 10/2 10/4 10/7 11/12 11/17 12/4 12/20 12/22 13/2 13/5 13/7 13/15 14/22 15/8 15/19 16/7 17/5 17/23 19/14 19/18 19/23 19/25 20/15 20/20 20/21 20/24 21/4 21/10 21/11 21/12 22/7 25/9 25/15 25/21 26/8 27/19 27/24 30/18 31/8 31/21 45/10 46/2 46/20 53/19 55/13 64/2 66/12 66/20 67/6 69/8 71/3 75/1 77/2 84/23 85/20 85/23 87/3 87/24 88/10 88/11 89/4 89/6 93/1</p>	<p>93/8 93/16 95/25 96/2 97/2 97/20 101/23 103/3 103/15 103/20 106/2 110/5 110/8 110/10 110/11 111/5 111/8 111/10 111/16 111/17 112/9 112/14 112/15 112/23 114/14 114/15 114/21 114/24 116/4 116/5 116/9 116/21 117/21 118/6 118/20 119/8 120/2 120/17 120/21 120/25 122/7 122/9 122/10 122/22 124/1 124/23 124/25 125/7 126/13 126/14 126/22 126/24 126/24 127/1 127/2 127/5 127/9 127/13 131/18 131/21 132/3 133/3 133/3 133/4 133/5 133/9 133/9 133/13 133/20 133/24 135/2 135/5 135/9 135/16 135/20 136/14 136/21 137/10 138/8 138/11 138/17 140/17</p> <p><b>you want [6]</b> 15/21 27/16 114/19 118/11 135/24 137/10</p> <p><b>you wanted [2]</b> 74/14 127/25</p> <p><b>you'd [3]</b> 18/2 138/2 139/4</p> <p><b>you'll [4]</b> 106/7 147/24 148/17 152/12</p> <p><b>you're [34]</b> 1/24 2/1 26/7 29/9 33/24 34/2 34/4 48/13 48/16 52/9 52/16 57/18 59/11 59/17 59/25 62/8 84/24 95/20 105/17 106/12 107/9 107/14 110/12 119/7 120/21 122/12 124/11 125/11 128/14 128/15 129/4 139/13 142/21 142/21</p> <p><b>you've [37]</b> 1/19 3/15 7/13 9/11 11/21 19/4 23/16 25/10 25/15 27/1 28/16 28/21 29/19 29/23 56/17 58/15 58/15 58/16 59/16 62/7 71/22 77/21 77/22 92/16 93/16 96/21 98/4 98/4 100/25 101/4 101/4 107/6 114/1 127/9 128/18 132/13 137/21</p> <p><b>young [1]</b> 126/11</p> <p><b>youngest [1]</b> 103/4</p> <p><b>your [187]</b></p> <p><b>your Ladyship [3]</b> 147/4 150/22 151/18</p>	<p><b>yours [3]</b> 19/12 57/5 139/13</p> <p><b>yourself [7]</b> 42/4 95/17 96/17 96/18 96/20 100/24 107/15</p> <p><b>yourselves [1]</b> 7/20</p> <p><b>Yousaf [4]</b> 37/2 38/18 174/12 174/19</p> <p><b>Yusuf [1]</b> 102/22</p> <hr/> <p><b>Z</b></p> <p><b>zero [2]</b> 11/25 20/18</p>		
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