

1 Thursday, 17 October 2024
 2 (10.00 am)
 3 LORD HUGHES: Yes, good morning. Morning,
 4 Mr O'Connor.
 5 MR O'CONNOR: Morning, sir. Our first witness this
 6 morning is Mr Wayne Darch. Perhaps you could be sworn ,
 7 please.
 8 MR WAYNE MARK DARCH (sworn)
 9 Questioned by MR O'CONNOR
 10 MR O'CONNOR: Thank you, Mr Darch. Do take a seat.
 11 Could you give us your full name please?
 12 A. Certainly. Wayne Darch.
 13 Q. Mr Darch, you have kindly prepared a witness
 14 statement for the Inquiry. It is -- if we could bring
 15 it up on screen -- INQ006058. I know you have a hard
 16 copy in front of you. Thank you. Do you see it on the
 17 screen there?
 18 A. I do.
 19 Q. If we just go forward to the last page of the
 20 statement, which is page 26, we see that it is dated
 21 7 October of this year.
 22 A. Correct.
 23 Q. There is a signature there, although of course
 24 it is concealed on the published version of the
 25 statement, but can you confirm that that is your

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1 Response for the same organisation; is that right?
 2 A. I was the head of Emergency Preparedness,
 3 Resilience and Response.
 4 Q. With that small correction, that was your
 5 role?
 6 A. Yes.
 7 Q. In total, I think we see from your statement
 8 that you have been in the Ambulance Service for very
 9 nearly 28 years.
 10 A. That's correct.
 11 Q. The roles we have just mentioned that you have
 12 been undertaking for the last few years and currently
 13 are strategic management type roles, is it right that
 14 you spent some of those 28 years as an ambulance
 15 emergency technician?
 16 A. I started off as a control assistant working
 17 in our 999 control centres. I undertook a number of
 18 different roles over the course of my career, including
 19 training as a technician. I responded in that capacity
 20 as a responding officer, rather than on a double crewed
 21 ambulance, which would be the traditional route, but
 22 nonetheless that was the case.
 23 I didn't continue down a clinical route and, as you
 24 will see in my statement, I am not a registered
 25 clinician because I took other opportunities through the

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1 statement?
 2 A. I can confirm that is my statement.
 3 Q. Have you read through it in preparation for
 4 coming today?
 5 A. I have.
 6 Q. Are the contents of that statement true to the
 7 best of your knowledge and belief?
 8 A. They are.
 9 Q. Thank you very much.
 10 Mr Darch, I'm going to ask you some questions,
 11 first of all a little bit about your career history. We
 12 have quite a lot of detail about that in your statement
 13 and, sir, may I invite you to adduce the entirety of
 14 Mr Darch's statement into evidence?
 15 LORD HUGHES: Yes.
 16 MR O'CONNOR: Thank you.
 17 I will simply touch on a few points about your
 18 career history, Mr Darch. Your current role, is this
 19 right, is as Deputy Director Operations of the South
 20 Western Ambulance Service NHS Foundation Trust?
 21 A. That is correct.
 22 Q. Referred to for brevity as SWASFT, yes?
 23 A. SWASFT.
 24 Q. In 2018, of course the time with which we're
 25 concerned, you were head of Preparedness, Resilience and

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1 leadership and management route.
 2 Q. Yes. Just give us an idea. We have in our
 3 minds the 28 years of your total service, how many of
 4 those years were spent as an emergency responder?
 5 A. Six or seven.
 6 Q. Right. But presumably much earlier in your
 7 career --
 8 A. Much earlier, yes.
 9 Q. -- and for a large part of that more recent
 10 time you have been occupying the type of management and
 11 strategic roles that you have mentioned?
 12 A. That's correct, yes.
 13 Q. Thank you. Now, as you know, Mr Darch, and
 14 certainly some people in this room know, we will be
 15 hearing in the days ahead -- in fact , today and tomorrow
 16 and then further when we resume our hearings in
 17 London -- from a number of ambulance staff who actually
 18 attended Dawn Sturgess, Charlie Rowley and Sergei and
 19 Yulia Skripal, and of course we will be asking them
 20 about the details of what they did on those occasions
 21 and we will be taking them to the contemporaneous
 22 documents and so on. That's not what I want to do with
 23 you today of course. The purpose of you coming to give
 24 evidence today is to give us some insight into the
 25 management, policy, and training content of the

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1 Ambulance Service over the period with which we're
2 concerned. Do you understand?
3 **A.** I do. Thank you.
4 **Q.** I want to start, if I may, with the question
5 of what understanding or training ambulance staff had of
6 or for nerve agent, organophosphate poisoning before the
7 Skripal poisoning in March 2018, and we will work then
8 forward in the chronology, okay?
9 **A.** Okay.
10 **Q.** I think it's important for me to ask you right
11 at the start about the rarity of this type of poisoning,
12 organophosphate/nerve agent poisoning. We will be
13 hearing in due course from an expert witness,
14 Mr Faulkner -- and I know you have read his report -- he
15 will be giving evidence about pre-accident -- sorry,
16 pre-hospital care generally and he asserts in his
17 statement that -- something to the effect of the vast
18 majority of ambulance technicians, clinicians would
19 never see an organophosphate poisoning case in their
20 entire career and he says that in his long career he had
21 only seen one.
22 Obviously I'm not asking for an exact answer, but,
23 roughly speaking, does that chime with you or do you
24 think he's got it way out?
25 **A.** No, absolutely, I agree with Mr Faulkner's

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1 **MR O'CONNOR:** I'm going to ask you in a moment
2 about the training that ambulance staff had for this
3 type of incident, but before we do, just help us
4 generally, is it -- are there other examples of
5 extremely rare but if they do happen high consequence
6 incidents that ambulance staff are trained for, or is
7 this an outlier?
8 **A.** No, it's not an outlier. We train for
9 marauding terrorist attacks and other high consequence
10 incidents, so high consequence infectious disease, for
11 example, and we have specialist resources that respond
12 to those, but there is a baseline level of training and
13 education that is provided to all of our responding
14 crews, as well as staff within our emergency operation
15 centres who take the 999 calls and then coordinate the
16 response thereon in.
17 **Q.** Thank you. If we can go to page 8 of your
18 statement, please. We will bring it up on the screen.
19 This is a part of your statement -- we can see from
20 the heading at the top -- where you describe the
21 guidance that's been issued to ambulance staff for
22 organophosphate/nerve agent poisoning and you refer
23 further down the page to the treatment, the DuoDote pen,
24 which administers atropine, does it not?
25 **A.** It does.

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1 assessment of that. A number of our clinicians will go
2 a whole career without witnessing or attending an
3 organophosphate or nerve agent poisoning, whether
4 accidental or deliberately. In contrast to that, our
5 clinicians will regularly attend opiate overdoses, but,
6 yes, I mean, the incidences of nerve agent or
7 organophosphate poisoning I absolutely agree with
8 Mr Faulkner's assessment.
9 **Q.** In the six or seven years that you were --
10 **LORD HUGHES:** Forgive me, Mr O'Connor. Had there
11 ever been a nerve agent poisoning experience in this
12 country?
13 **A.** Not that's recorded since the Second World
14 War, as far as I understand it, sir.
15 **LORD HUGHES:** Right. But you bracket it with
16 organophosphate poisoning.
17 **A.** Yes.
18 **LORD HUGHES:** Which is what, fertilisers basically?
19 **A.** Yes, that's right.
20 **LORD HUGHES:** And that happens occasionally, does
21 it?
22 **A.** Occasionally but extremely rare. Again, as
23 Mr Faulkner states within his statement, almost unlikely
24 that our clinicians would attend such a scenario.
25 **LORD HUGHES:** Right, thank you very much.

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1 **Q.** That is the sort of basis or the vehicle for
2 the training that was given prior to 2018?
3 **A.** That is correct.
4 **Q.** You refer to a clinical note issued by the --
5 by SWASFT that was circulated, from memory, I think in
6 2017. Let's bring it up on screen, please. It's
7 INQ000627.
8 Mr Darch, this is a clinical notice and it goes
9 with a medicines protocol which I'm going to take you
10 onto in a moment. Just describe in a sentence or so,
11 will you, what this document is, who it went to, why it
12 was circulated.
13 **A.** Okay, so I will start with the why it was
14 circulated first, if I may. Late 2016, NHS England
15 National Emergency Preparedness, Resilience and Response
16 team --
17 **LORD HUGHES:** Sorry, say that slowly, will you,
18 Mr Darch?
19 **A.** In late 2016, the national NHS England EPRR
20 team, Emergency Preparedness, Resilience and Response
21 team, wrote to all English NHS ambulance services
22 confirming that they had accepted a recommendation
23 through the national clinical reference group for
24 DuoDote, which is the atropine that's been described, to
25 be carried on all frontline emergency vehicles and there

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1 is a breakdown within that communication which is
2 further detailed within the clinical notice, as is
3 presented on the screen.

4 The purpose of the clinical notice is to confirm
5 internally our intention to follow that direction and is
6 a direction to operations officers who are our
7 frontline, first line supervisory level officers, and to
8 all clinical staff that this is being distributed and
9 that they should familiarise themselves with the
10 medicines protocol which describes the circumstances in
11 which the DuoDote should be administered.

12 **LORD HUGHES:** Now, it goes to -- so this goes to or
13 went to, did it, the people at the bottom of the page?

14 **A.** That's right, that's correct.

15 **LORD HUGHES:** What does "All clinical staff" mean?

16 **A.** All clinical staff are paramedics and their
17 colleagues that work operationally on the frontline,
18 regardless of whether that's on a double crewed
19 ambulance, a rapid response vehicle, which is a car, our
20 command vehicles and it is also of relevance to our
21 clinicians that work within our emergency operation
22 centres.

23 **LORD HUGHES:** Right.

24 **MR O'CONNOR:** Thank you, Mr Darch. We can see just
25 underneath the table there the instruction, as you have

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1 devices, and this would have been available on our
2 intranet, but publicised well, that it was there to be
3 referred to.

4 **Q.** Having sent out the instruction, do you have
5 a method for monitoring whether staff have actually done
6 what they have been told to do, that is to read the
7 clinical notice and the protocol?

8 **A.** With regards to that specific question, at the
9 time we didn't have that technology available and the
10 app didn't allow us to do that. However, since then we
11 do now have the ability to be able to do that.

12 What I would say is that once we issue updates or
13 new protocols, there are arrangements for training for
14 our colleagues which happens over a period of time. So,
15 for example, if this protocol was issued today, some
16 colleagues may be on a training programme tomorrow that
17 would have access to training in that respect, some may
18 receive that further down the line in 11 months' time,
19 for example.

20 **Q.** Thank you.

21 **LORD HUGHES:** Do they come in for training every
22 now and then; is that what you're telling us?

23 **A.** Annually, yes, sir.

24 **LORD HUGHES:** How often?

25 **A.** Annually.

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1 said, to people who receive this document to refer to
2 the separate medicines protocol. Let's turn that up if
3 we may. That is INQ000623. Staff who follow that
4 instruction would have seen this document; is that
5 right?

6 **A.** That is correct.

7 **Q.** Before we look at the detail, can you give us
8 an idea of -- if you were a -- in those years when you
9 were a first responder, how many documents like this
10 would you have been receiving? How much training of
11 this sort do you expect staff to undertake?

12 **A.** We receive regular updates at the time.
13 They -- I mean, in terms of the frequency, I don't
14 recall, if I'm honest, but I would have had time to have
15 accessed and referred to this particular document.

16 **Q.** Presumably these documents get circulated by
17 email. Do they receive them sort of every day, every
18 week, every month?

19 **A.** Maybe a few a week at the time. It depends on
20 other circumstances with regards to other medicines or
21 clinical guidelines that are needing to be refreshed or
22 issued. This was clearly a new medicine. We circulated
23 it through email at the time, but we had also just gone
24 live with an application that our colleagues can access
25 through their mobile phones or iPads or other forms of

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1 **LORD HUGHES:** Annually?

2 **A.** Yes.

3 **MR O'CONNOR:** Mr Darch, let's just look at the
4 content of the protocol, if we may, and we see, don't
5 we, towards the bottom of the page that we're looking
6 at, where it says "Clinical situation", there are
7 three -- there are a series of, in fact, three sort of
8 signs, symptoms that are said to be indicative --
9 clinical features that are indicative of organophosphate
10 poisoning and the instruction says that at least one of
11 those must be present in order to justify using this
12 treatment and we will see similar lists in other
13 documents: bronchorrhea, bronchospasm, that's
14 a respiratory difficulty; is that right?

15 **A.** As I understand it.

16 **Q.** Also severe bradycardia, low heart rate.

17 Then if we follow it down onto the other side of
18 the page, other signs may include excess secretions,
19 respiratory depression and altered level of
20 consciousness.

21 As I say, we will see similar lists of the way in
22 which patients with organophosphate poisoning present in
23 other documents and so some of those symptoms are
24 familiar. It's right also, isn't it -- and you have
25 already made the point -- that some of those symptoms

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1 overlap with the way in which people suffering from
 2 opiate overdose present?
 3 **A.** Mm-hm.
 4 **Q.** In particular, respiratory depression, altered
 5 levels of consciousness and so on.
 6 **A.** Correct.
 7 **Q.** While we're on this second page, can we just
 8 cast our eyes down, if we see the heading on the left
 9 "Cautions" and the second bullet point, do you see that,
 10 it starts:
 11 "When symptoms of poisoning are not severe ..."
 12 Then:
 13 "DuoDote should be used with extreme caution in
 14 people with heart disease, arrhythmia, recent myocardial
 15 infarctions ..."
 16 And so on.
 17 An indication there that -- well, you tell us your
 18 understanding of that?
 19 **A.** It's not quite a contra-indication, but
 20 clinicians should use extreme caution when considering
 21 DuoDote for patients with those clinical conditions.
 22 **Q.** It's not -- with generically heart problems,
 23 the instruction is not saying "Don't ever use it" but it
 24 is saying --
 25 **A.** Use it with caution.

13

1 that right?
 2 **A.** That's correct.
 3 **Q.** They were showing symptoms that, broadly
 4 speaking, were consistent with both nerve agent
 5 poisoning, organophosphate poisoning on the one hand,
 6 and an opiate overdose on the other, for example
 7 respiratory collapse and also miosis, pin prick
 8 eyeballs, correct?
 9 **A.** Correct.
 10 **Q.** Also, they were seen to be suffering excess
 11 secretions, so sort of salivation, foaming at the mouth,
 12 that type of symptom, which we often see referred to as
 13 a symptom which is a distinguishing point because it is
 14 a symptom of organophosphate poisoning but not seen with
 15 opiate overdose, correct?
 16 **A.** Correct.
 17 **Q.** It was also the case that atropine was, in
 18 fact, administered to Sergei Skripal by one of the
 19 ambulance staff present by accident. He intended to
 20 give an administration of naloxone but picked up the
 21 wrong bottle and in fact gave him some atropine; is that
 22 right?
 23 **A.** Correct.
 24 **Q.** We will hear from Mr Faulkner, the expert, who
 25 says that that actually -- that that would clearly have

15

1 **Q.** -- use with caution. According to your
 2 statement, that is the training, the guidance that was
 3 in play relating to this type of condition prior to
 4 March 2018?
 5 **A.** That's correct, so if I can just expand on
 6 that, if I may. All new staff coming into the
 7 organisation and at the time through the training that
 8 I have already described, clinicians undergo a period of
 9 training which covers the clinical symptoms of
 10 organophosphate poisoning, nerve agent poisoning, and
 11 also the detail around the medicines protocol that we
 12 have just reviewed, as well as the application of the
 13 DuoDote itself. So that at the time was the baseline
 14 standard training.
 15 **Q.** Yes. Now, I want to move forward in the
 16 chronology then to March 2018 and the Skripal poisoning.
 17 As I have said, we will be calling evidence from
 18 ambulance technicians and indeed others who were
 19 present, so I don't want to ask you about the detail of
 20 exactly what happened, but perhaps you will agree or
 21 disagree with this summary. Both Yulia and Sergei
 22 Skripal were attended to and were, in fact, assessed by
 23 the ambulance crews there to be suffering from an opiate
 24 overdose, and so they were both given naloxone, which is
 25 a drug intended to combat that sort of condition; is

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1 helped Mr Skripal and may even have saved his life.
 2 But it is also fair to say that we will hear from
 3 Mr Faulkner that he is not critical of the fact that the
 4 ambulance staff on that occasion didn't diagnose
 5 organophosphate poisoning, but instead diagnosed opiate
 6 poisoning for the very reason we have been discussing,
 7 because it is so rare and there is an overlap of
 8 symptoms.
 9 **A.** That is correct.
 10 **Q.** With that summary in mind, I want to move on
 11 and ask you some questions about how the
 12 Ambulance Service, your own trust, responded to the
 13 Skripal poisoning and what guidance and learning took
 14 place after March or during and after March 2018 and
 15 let's go, if we may, to page 18 of your witness
 16 statement.
 17 We can see, just about a third of the way down,
 18 there's a headline "Reviews, learning and changes to
 19 policy/procedures" and then a little bit further down
 20 a heading "Guidance disseminated following the Salisbury
 21 incident"; do you see that?
 22 **A.** I do.
 23 **Q.** In fact, it is at paragraph 105.1, so
 24 immediately underneath that heading, that you refer to
 25 something that took place on 9 March, so the week

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1 after -- I think that was the Friday after the Sunday
2 poisoning, a step taken by you to circulate throughout
3 your organisation a piece of advice that had come in
4 from the NHS and Public Health England about nerve agent
5 poisoning. Let's have that document up on screen
6 please, it's INQ000660.

7 You refer to two documents in your statement. They
8 are very similar, aren't they? One was intended,
9 I think, for GPs and one for hospitals?

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

11 **Q.** This is the slightly shorter version.

12 **A.** This is the GP version.

13 **LORD HUGHES:** This is which?

14 **MR O'CONNOR:** This is the GP version, sir. One
15 might think that's more appropriate, the detail that's
16 added for hospitals would not necessarily be something
17 that ambulance technicians would find useful; is that
18 fair?

19 **A.** There is crossover between the two documents,
20 so there are aspects of the emergency department
21 guidance that would be relevant to the ambulance
22 pre-hospital environment.

23 **Q.** Well, let's just look at this for now in any
24 event, Mr Darch. What we see there -- we see
25 the headline "Diagnosis and early management in

17

1 **Q.** This was a document which you received and is
2 it right that you, on your own initiative, decided to
3 send it to everyone in the trust, or at least was it all
4 clinical people within the trust?

5 **A.** No, it wasn't all clinical people. I did
6 circulate this, along with the guidance that was issued
7 for emergency departments as well because, as I say,
8 there were aspects within that guidance that were
9 applicable to particularly paramedics within our
10 workforce, and that document makes reference to the
11 significant crossover of the symptoms between opiate
12 overdose and organophosphate or nerve agent overdose and
13 describes the stepped approach to the treatment of those
14 patients.

15 In the absence of any guidance forthcoming that was
16 specific to the Ambulance Service or to the pre-hospital
17 environment, I took the decision to circulate the
18 guidance that was available.

19 **Q.** Yes. I mean, that was a point I wanted to
20 come onto because, as I mentioned, that was a key
21 learning point from the Skripal incident, wasn't it --

22 **A.** Yes.

23 **Q.** -- the risk of misdiagnosing which would lead,
24 other than by the fortunate accident of Mr Skripal
25 getting the atropine, to not using the DuoDote pen when

19

1 organophosphate chemical incidents". There are a series
2 of visual indicators. "Step 1, 2, 3 plus triggers", can
3 you just explain what that means?

4 **A.** Yes, absolutely. So safety triggers for
5 emergency personnel, "Step 1, 2, 3". Essentially, if it
6 we're responding to an incident that has one patient, we
7 would deal with that as normal essentially; two patients
8 we would approach with caution; and with three patients
9 we would essentially respond with specialist responders
10 and seek specialist advice and then there are a number
11 of plus triggers which include evacuation and accessing,
12 as I say, specialist support and advice.

13 **Q.** Those are generic considerations, they're not
14 specific to this type of case?

15 **A.** No, they're generic and they're applied across
16 the emergency service spectrum.

17 **Q.** Then I won't read them out, but a series of
18 again fairly -- I don't want to use the word "obvious"
19 but signs of something that's gone seriously wrong: dead
20 or distressed people and animals, obvious presence of
21 hazardous materials, unexplained vapours or mists.

22 Then immediately below that, clinical symptoms, as
23 I say, similar although not quite identical to the types
24 of symptoms that we saw on that medicines protocol.

25 **A.** Yes.

18

1 it was needed?

2 **A.** That's correct.

3 **Q.** Did you consider not just circulating the
4 hospital guidance which mentioned the risk of that
5 confusion, but circulating a sort of internal specific
6 piece of guidance, drawing your staff's attention to
7 that very aspect of the Skripal case?

8 **A.** We didn't issue new guidance. We reminded
9 colleagues of the existing guidance that was in place at
10 that time, which, as we have seen from the other
11 documents we have referred to this morning, were
12 consistent.

13 **LORD HUGHES:** I'm sorry, Mr Darch, you will have to
14 forgive me, you circulated this; is that right?

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

16 **LORD HUGHES:** Along with, you said, some other
17 documents which particularly referred to the overlap of
18 symptoms between, on the one hand, opiate poisoning and
19 organophosphate poisoning.

20 **A.** That's --

21 **LORD HUGHES:** What was that document?

22 **A.** That document was a Public Health England
23 document and it was the diagnosis and early management
24 of organophosphate chemical incidents, but specific for
25 hospital emergency departments and I understand that

20

1 that's Inquiry reference 000659 --
 2 **MR O'CONNOR:** Let's bring it up on screen.
 3 Mr Darch is right, it's 000659.
 4 **LORD HUGHES:** That's a PHE document -- or NHS
 5 document, is it?
 6 **A.** PHE.
 7 **MR O'CONNOR:** What we will see is it's similar --
 8 it starts in a very -- I think almost identical way to
 9 the document we have just been looking at, but then it
 10 goes on to provide more detail; is that right, Mr Darch?
 11 **A.** It does from recollection.
 12 **LORD HUGHES:** So where does it --
 13 **MR O'CONNOR:** It's not up yet, sir, I don't think.
 14 **LORD HUGHES:** I'm sorry, wrong document.
 15 **MR O'CONNOR:** We're waiting for 659. That's still
 16 660.
 17 **LORD HUGHES:** Yes, that's 660.
 18 **MR O'CONNOR:** We see, as I said, Mr Darch, the
 19 first page or so of this document are very similar if
 20 not identical to the document we were just looking at,
 21 but I think you -- will you take us to a later page in
 22 the document which makes the point about overlapping
 23 symptoms of opiate overdose?
 24 **A.** It may not be that document.
 25 *(Pause)*

21

1 that was circulated not between the Skripal and the
 2 Amesbury incident, but after the Amesbury incident?
 3 **A.** That's correct, yes.
 4 **LORD HUGHES:** Well, you were being asked
 5 originally, you see, Mr Darch, about what, if anything,
 6 went out to people after the Salisbury incident --
 7 **A.** Yes, that's my --
 8 **LORD HUGHES:** -- and it must be obvious to you
 9 before the Amesbury incident.
 10 **A.** Absolutely, sir. That's my error.
 11 **LORD HUGHES:** Don't worry.
 12 **A.** The two documents that we were referring to
 13 were the documents that were published on 10 March.
 14 **LORD HUGHES:** Don't worry. Those are, 660, is that
 15 right, the public health document about nerve
 16 agent/organophosphate poisoning.
 17 **A.** Correct.
 18 **LORD HUGHES:** And?
 19 **MR O'CONNOR:** 659, which was the similar document
 20 which went to hospitals.
 21 **A.** That's right.
 22 **Q.** But is it right, Mr Darch, that in fact
 23 neither of those documents refer to the misdiagnosis
 24 point?
 25 **A.** Correct.

23

1 It may have been the wrong -- just bear with me,
 2 I just need to refer to a further Public Health England
 3 document, which, if I may, give you an alternative
 4 Inquiry reference number.
 5 **Q.** Yes. I must say I had read this document and
 6 I hadn't seen the point you wanted to make about it so
 7 it may be that we're at cross-purposes.
 8 **A.** It's in 657.
 9 **LORD HUGHES:** Oh, not 659? Right, let's have 657
 10 then.
 11 **MR O'CONNOR:** Shall we pull that up on the screen?
 12 **A.** The document that I'm referring to was issued
 13 in July 2018, but that was an update --
 14 **LORD HUGHES:** In when?
 15 **A.** In July 2018 but that --
 16 **LORD HUGHES:** Dr Darch, just take it gently,
 17 please. I need to know exactly who got what, when?
 18 **MR O'CONNOR:** Can I suggest, if we could go back to
 19 Mr Darch's witness statement, please, and go to page 20.
 20 If we look at paragraph 108.2, is that the sub-paragraph
 21 which refers to the document you're describing,
 22 Mr Darch?
 23 **A.** It is, yes, that's correct.
 24 **Q.** We can see from the title just above it, and
 25 also from the date, that this was, in fact, guidance

22

1 **Q.** In fact, you refer in your witness statement
 2 to a number of other generic documents relating to
 3 organophosphate poisoning that were circulated around
 4 this time, but my suggestion is that in fact none of
 5 them refer to the misdiagnosis point. Do you agree with
 6 that?
 7 **A.** I do agree with that, yes.
 8 **LORD HUGHES:** Right. So who got the two documents
 9 that they did get after the Skripal event, that is to
 10 say 660 and 659, which describe the symptoms of
 11 organophosphate/nerve agent?
 12 **A.** They went to all staff as listed within my
 13 statement, sir.
 14 **LORD HUGHES:** Meaning?
 15 **A.** Meaning all staff, all of our colleagues.
 16 **LORD HUGHES:** Right.
 17 **A.** It was issued across the organisation.
 18 **LORD HUGHES:** If I'm an ambulance man I will have
 19 had it, will I?
 20 **A.** Yes.
 21 **LORD HUGHES:** Thank you.
 22 **MR O'CONNOR:** So they will have had that high level
 23 document describing the symptoms, but they wouldn't have
 24 had their attention drawn to the risk of misdiagnosis in
 25 that document.

24

1 **A.** In that document, that's correct.
 2 **Q.** I would like to take you to another document ,
 3 please. If we could have INQ000724. Now, this
 4 document, Mr Darch, is the debrief that your
 5 organisation conducted, it's the report of the debrief
 6 into Operation Fairline which was the name given to the
 7 response to the Skripal poisoning, yes?
 8 **A.** Correct.
 9 **Q.** We know that this document itself wasn't
 10 published until quite a lot later, it was October 2018.
 11 **A.** The first edition was published prior
 12 to October, but the final version was published
 13 in October 2018, having concluded Operation Fortis and
 14 the multi-agency debriefs that we heard earlier on in
 15 the week.
 16 **Q.** Certainly this document though, much later?
 17 **A.** That's right.
 18 **Q.** Let's go, if we may, to page 18 of this
 19 document. This is annex A to the document, Mr Darch.
 20 We can see it is headed "Mike Killoran debrief report".
 21 We don't need to go there, but I will just record that
 22 we see that this debrief report was, in fact, dated
 23 27 March 2018, so it was much more rapid?
 24 **A.** That's right.
 25 **Q.** We assume that when that was undertaken the

25

1 management aspects of the response to the initial
 2 Operation Fairline.
 3 This was shared with our command teams and tactical
 4 advisors, who this particular document was specifically
 5 relevant to.
 6 **LORD HUGHES:** Right, and, Mr O'Connor, do you want
 7 us to look at this because it contains something
 8 material to the point you were dealing with before, or
 9 not?
 10 **MR O'CONNOR:** Yes, there's one part of it I would
 11 like to ask you about, so if we can go back to page 18,
 12 please. Obviously I have heard what you say, Mr Darch,
 13 that this wasn't aimed at frontline staff, but if we
 14 just look at the last of those paragraphs, please. This
 15 is the executive summary. We see Mr Killoran says:
 16 "At the time of the incident the crews were
 17 completely unaware of the cause of injury/illness ..."
 18 This is the Skripal incident, isn't it?
 19 "... and this was not revealed until some 15 hours
 20 later. The debrief will detail the staff concerns and
 21 suggest some changes to working practice in incidents
 22 such as this."
 23 This is a reference to the fact that the staff on
 24 the ground didn't diagnose organophosphate/nerve agent
 25 poisoning, but my suggestion is that it doesn't then

27

1 results of it were circulated within the organisation?
 2 **A.** They were indeed.
 3 **LORD HUGHES:** I'm sorry, Mr O'Connor, you've lost
 4 me. I've got a document in front of me, it hasn't got
 5 a date on it.
 6 **MR O'CONNOR:** No, well --
 7 **LORD HUGHES:** But it has it somewhere else, has it?
 8 **MR O'CONNOR:** We can look, sir, it's internal
 9 page 23 of this document.
 10 **LORD HUGHES:** Thank you.
 11 **MR O'CONNOR:** At the bottom. Do you see there,
 12 Mr Darch?
 13 **LORD HUGHES:** So Mr Killoran's report, 27 March .
 14 **MR O'CONNOR:** It's an earlier report annexed to the
 15 final report; is that fair?
 16 **A.** That's correct.
 17 **LORD HUGHES:** What happened to that? Did people
 18 see it or not?
 19 **A.** Yes, they did.
 20 **LORD HUGHES:** Who, who saw it?
 21 **A.** The contents of this report are largely not
 22 concerning clinical matters --
 23 **LORD HUGHES:** No.
 24 **A.** -- but are concerning policy, process and
 25 procedural issues as a result of the consequence

26

1 take that issue forward and recommend any further
 2 training, any guidance, there's no action point to try
 3 and deal with that problem within this debrief
 4 from March 2018.
 5 **A.** I think -- on reflection I think that's a fair
 6 comment. There was also a significant delay in
 7 ourselves within the Ambulance Service being aware that
 8 the issue that our colleagues had attended on the Sunday
 9 was indeed of, you know, organophosphate or nerve agent
 10 related incident, which is what that also refers to.
 11 **Q.** Just drawing this together, Mr Darch, do you
 12 think it's fair to say that more could have been done in
 13 that period between March and June to draw your staff's
 14 attention -- not just refreshing their guidance on
 15 organophosphate poisoning, but drawing their attention
 16 to this particular learning point from the Skripal
 17 poisoning?
 18 **A.** We shared as much information as we could, as
 19 I have described, and there are a number of documents
 20 there that were disseminated following the Salisbury
 21 incident, but of course we could always do more and if
 22 the Inquiry considers that we should have done more,
 23 then clearly we will take action to address that.
 24 **LORD HUGHES:** Well, I think you're being asked
 25 whether you think you should have done more.

28

1 **A.** I think we --
 2 **LORD HUGHES:** Or whether at the time it was as best
 3 you could do.
 4 **A.** My perspective is at the time we did the best
 5 that we could with what we had available to us.
 6 **MR O'CONNOR:** Are you saying that you didn't know
 7 before the Amesbury incident that the staff in Salisbury
 8 had misdiagnosed the Skripals?
 9 **A.** Sir, I refer to my earlier comment, if I may.
 10 The incidents of nerve agent poisoning that crews would
 11 be -- you know, would come across is extremely,
 12 extremely rare and, as you will know from witness
 13 statements from colleagues that you will speak to in the
 14 coming days, we responded to the symptoms that we
 15 believed were of an opiate overdose nature.
 16 It was some hours later, indeed well into the
 17 Monday, that it was known that this was not an opiate
 18 related incident, but as I think Mr Faulkner makes
 19 reference to in his statement, he is not critical of the
 20 diagnosis or the action that our crews took at the time
 21 and I would support that.
 22 **Q.** I'm sorry to interrupt you, but I want to come
 23 to the point. We have all agreed that Mr Faulkner --
 24 and it may be in due course the Chair -- is not critical
 25 of the misdiagnosis at the time, but very shortly

29

1 departments and GPs, to our colleagues.
 2 We also -- or I also re-issued the initial
 3 Operational Response Guidance, again on 10 March, and
 4 there was guidance that was received into our
 5 organisation that was specifically intended for
 6 ambulance services that used NHS pathways as a triage
 7 system. We're a MPDS service, medical priority dispatch
 8 triage service, but again, in the absence of guidance or
 9 additional information for MPDS services, I took the
 10 information that was available and circulated that.
 11 In terms of being aware of potential or -- either
 12 secondary or tertiary incidents, I don't recall specific
 13 discussions regarding that. However, I was made aware
 14 yesterday evening of some emails that were circulated on
 15 15 March which I was not in possession of -- and over
 16 the course of last night I have rechecked to confirm
 17 that position -- but the actions that were contained
 18 within the documents that were shared with me yesterday
 19 evening were the actions that I took on 10 March, some
 20 five days earlier.
 21 **Q.** Well, you have mentioned that email, so let me
 22 ask you about it. If we could have, please, INQ004704
 23 on screen. This is an email -- it's not easy to work
 24 out exactly who sent it or received it for obvious
 25 reasons, but we can see that it is dated Thursday,

31

1 afterwards you, as an organisation, were aware that
 2 there had been a misdiagnosis and my question is: should
 3 you have done more to circulate that particular learning
 4 point within your organisation because we haven't been
 5 able to find a single document where that's done in the
 6 three or four months before the Amesbury incident?
 7 **A.** We did share as much information as we
 8 possibly could, but to answer your specific question,
 9 no, we didn't, and we could have done better there.
 10 **Q.** All right. Let me move on to a slightly
 11 different topic. Of course one of the reasons why
 12 spreading this knowledge would have been a good idea was
 13 because of the risk that it might happen again. That
 14 must be right, mustn't it?
 15 **A.** Yes.
 16 **Q.** In particular, if that risk crystallised, if
 17 there was another nerve agent incident, then your staff
 18 very likely would be at the sharp end of that?
 19 **A.** Correct.
 20 **Q.** Was that risk something that you as an
 21 organisation were made aware of or considered?
 22 **A.** We did consider it and that's in part the
 23 reason that I circulated the guidance that was
 24 available, notwithstanding that it was not addressed or
 25 intended for the Ambulance Service, but for emergency

30

1 15 March, so ten days or so after the Skripal poisoning.
 2 It would appear that it's an internal DHSC email and if
 3 we can go over to the second page, please, we can see
 4 that it's -- the title is "Salisbury nerve agent attack:
 5 Risk of secondary incident" and just underneath that,
 6 "Reasonable worst case scenarios ... and mitigation".
 7 And a list underneath, a numbered list, the first number
 8 being a second, targeted attack, so in other words
 9 another targeted attack like the Skripals, but then
 10 second and third:
 11 "Accidental discovery of discarded agent by ..."
 12 Either humans, or third, animals.
 13 If we cast our eyes down towards the bottom of the
 14 page, we can see that the analysis of the second type of
 15 incident, that is in an accidental discovery of
 16 a discarded source of material by humans, and we can see
 17 what is being anticipated is up to six members of the
 18 public being exposed to source material used and then
 19 discarded after the Salisbury incident, up to four
 20 emergency services personnel exposed to the nerve agent?
 21 **LORD HUGHES:** This is all someone's stab at
 22 a hypothetical possibility, is it?
 23 **MR O'CONNOR:** It's a reasonable worst case
 24 scenario.
 25 **LORD HUGHES:** Worst case scenario.

32

1 **MR O'CONNOR:** A scenario against which to plan.
 2 **LORD HUGHES:** Right.
 3 **MR O'CONNOR:** One fatality, nine other casualties
 4 requiring prolonged hospital treatment, and so on.
 5 Then if we go over the page again, please, we see
 6 further analysis in a grid and consideration being given
 7 to what first responders need to know in planning for
 8 that sort of scenario.
 9 My question, Mr Darch, is perhaps an obvious one,
 10 which is in your sort of managerial/strategic role
 11 within the Ambulance Service that must have been the
 12 most likely to have been involved in this sort of
 13 secondary incident, coming across a discarded container,
 14 do you think you ought to have seen this sort of
 15 planning document so that you could have been involved
 16 in that planning?
 17 **A.** Absolutely, yes.
 18 **LORD HUGHES:** You didn't see this at the time?
 19 It's an internal departmental document somewhere, is it?
 20 **A.** That's correct. The first time I saw this
 21 document was yesterday evening.
 22 **LORD HUGHES:** Right, and you say now that you would
 23 like to have done?
 24 **A.** I would have, yes.
 25 **MR O'CONNOR:** If we can go back to the first page

33

1 actions, is it, it's about what the worst case scenario
 2 is?
 3 **MR O'CONNOR:** I think it's the next -- it's the
 4 grid that Mr Darch is referring to.
 5 **LORD HUGHES:** It's the grid. Yes.
 6 **A.** Yes, so if you look at the actions that are
 7 required in terms of reinforcing initial operational
 8 response with regard to remove, remove, remove,
 9 protocols, we did that on 10 March and the learning from
 10 the 4th was disseminated, as I said earlier on,
 11 following the distribution of the Public Health England
 12 guidance that I previously referred to.
 13 **MR O'CONNOR:** You have referred to that second
 14 bullet point:
 15 "Learning from 4 March should be rapidly
 16 disseminated ..."
 17 Do you think, if you had seen this sort of
 18 document, which I assume would have made the risks feel
 19 much more real to you --
 20 **A.** Yes.
 21 **Q.** -- you might have thought again about, for
 22 example, disseminating the learning point about the
 23 crossover symptoms between opiates and nerve agents?
 24 **A.** Yes, absolutely. This would have been
 25 extremely helpful.

35

1 of the document, just the text of the email please, we
 2 can see that whoever it was that wrote it, says:
 3 "Please find attached a first stab at the
 4 [reasonable worst case scenario] for a secondary nerve
 5 agent incident ..."
 6 There's then in brackets "For health sector only".
 7 Were you the health sector?
 8 **A.** We are part of the health sector, yes.
 9 **Q.** Then:
 10 "Suggest that this is not forwarded further than
 11 necessary ..."
 12 I think you have made your position clear, but do
 13 you regard yourself as having been one of the necessary
 14 recipients of this analysis?
 15 **A.** Absolutely.
 16 **Q.** If you had, what would you have done
 17 differently?
 18 **A.** We would have -- we would have followed the
 19 action that it describes on page 2, I think it was, but
 20 in terms of the actions -- could we possibly go to
 21 page 2? But in terms of the actions around reaffirming
 22 initial operational response and dissemination of
 23 guidance, we -- that's the action that we undertook on
 24 10 March.
 25 **LORD HUGHES:** Well, actually this page isn't about

34

1 **Q.** Thank you, Mr Darch. I want to move finally
 2 on to two other topics, which I think I can ask you
 3 about quite briefly, and they relate first to the
 4 treatment of Dawn Sturgess and, second, to the treatment
 5 of Charlie Rowley. As I have said with my earlier
 6 questions, of course we will be coming to the paramedics
 7 who themselves undertook that treatment, so we will ask
 8 them the detailed questions. I want to fore shadow some
 9 of the sort of larger issues that will come up with you
 10 now.
 11 In terms of the treatment of Dawn Sturgess, one of
 12 the features of her case was that while the paramedics
 13 were treating her, they were told, by her boyfriend,
 14 Charlie Rowley, that Dawn didn't take drugs and that was
 15 inconsistent with the views they were forming about what
 16 might have caused her condition because they were
 17 working on the basis that this may well be an opiate
 18 poisoning case.
 19 As I say, we will ask them about exactly who heard
 20 what and what they were thinking, but from your sort of
 21 managerial perspective, what guidance or training is
 22 there within the Ambulance Service about how paramedics
 23 treating a patient should sort of feed into their
 24 analysis information like that that's given by family
 25 members or people who are with the victim?

36

1 **A.** I think the first thing that's important to
2 say is clearly Dawn was in cardiac arrest at the point
3 at which we arrived and therefore the treatment of the
4 cardiac arrest is first and foremost in -- one, in
5 achieving a return of spontaneous circulation and
6 secondly, sustaining it stably.

7 Clearly, any information that is available to
8 ambulance crews at the scene are important and should be
9 taken into consideration. There are a number of
10 causative clinical conditions which, as I have mentioned
11 I'm not a registered clinician so I'm not able to go
12 into, that they would be considering in terms of
13 addressing the potential causes of the cardiac arrest
14 and therefore that -- those principles, but at the same
15 time taking into account any observations that they make
16 of the scene, but also information that they are given
17 from either, you know, witnesses, relatives, friends,
18 other bystander, clearly they will take into
19 consideration. But as you have already mentioned, my
20 colleagues that attended the incident will be able to
21 detail that.

22 **Q.** Just to pick you up on that though, you say
23 "clearly" they would take that into consideration. Of
24 course we will ask them whether they did or not, but you
25 from your standpoint, is your position that they should

37

1 frequent.

2 **Q.** Knowing what you know about what happened that
3 night, is that something that you understand and that
4 you think was reasonable, or do you think -- or not?

5 **A.** From my perspective, I think it's evident that
6 there was a breakdown in the application of the JESIP,
7 the Joint Emergency Services Interoperability
8 Principles, which essentially are where you have
9 a multi-agency response to an incident, the three blue
10 light services in particular, should co-locate, they
11 should communicate, which allows them then to jointly
12 coordinate the response, having a shared situational
13 awareness and a joint understanding of the risk, which
14 allows the multi-agency partnership to develop a joint
15 plan to respond to the circumstances that they are
16 facing.

17 On that particular evening, I think there was
18 a breakdown of the application of those principles on
19 this occasion.

20 **Q.** Thank you. Mr Darch, thank you. Those are
21 all the questions I have for you. There will be some
22 other questions, sir.

23 **LORD HUGHES:** Yes, and I have one first, please.

24 In relation to Dawn Sturgess, you have been asked
25 about the impact of being told by a partner present that

39

1 have taken that into consideration?

2 **A.** Yes.

3 **Q.** Is that their training?

4 **A.** That's their training, yes.

5 **Q.** Right. Then lastly, Mr Darch, Charlie Rowley,
6 who of course became ill later on the day, different
7 paramedics and ambulance staff attended him. We will
8 hear that there was a rather different sequence of
9 events there and in fact the paramedics who attended
10 Charlie Rowley did form the view that he was suffering
11 from nerve agent poisoning, but there was then
12 a difference of opinion with police officers who
13 attended and, in very brief summary, the police officers
14 did not accept the diagnosis, the views of the
15 paramedics, and proceeded essentially on the basis that
16 they were content that this was an opiate poisoning and
17 there were various steps that followed as a result.

18 We will get into all of the detail of that with the
19 people who were there, but again from your sort of
20 managerial perspective -- first of all, let me ask this:
21 is that something that happens very often, that
22 police officers or, for that matter, a different
23 emergency service, override the clinical views of the
24 attending paramedics?

25 **A.** It is possible, but in my experience not

38

1 she wasn't a drug taker. Your ambulance people are
2 dealing with a woman in cardiac arrest. Supposing that
3 it had never occurred to them that any drugs might have
4 been involved, would it make any difference to the way
5 that she is managed?

6 **A.** As I have said, sir, I'm not able to answer
7 the clinical specifics, but the priority is, in dealing
8 with the cardiac arrest, to achieve a return of
9 spontaneous circulation.

10 **LORD HUGHES:** Which eventually they did.

11 **A.** They did, yes.

12 **LORD HUGHES:** As it were artificially. Yes, all
13 right. Thank you very much indeed.

14 Mr Mansfield. Mr Mansfield, there are clearly some
15 questions which you will need to ask. I have seen the
16 request to do so. I rely on you, with all your
17 experience, to confine them to the things that need to
18 be asked, and to bear in mind the difference between
19 requests for information which will help me, and comment
20 which will come later.

21 **MR MANSFIELD:** Yes, I will make that distinction.
22 I'm grateful.

23 **LORD HUGHES:** You will bear in mind the timetable,
24 but I'm not proposing to break until 11.15; you have
25 until then.

40

1 **MR MANSFIELD:** I think that's within the time
2 framework you have in mind.
3 **LORD HUGHES:** So be it.
4 **Questioned by MR MANSFIELD**
5 **MR MANSFIELD:** Good morning. I represent the
6 family of Dawn Sturgess and the first thing just -- this
7 is an observation, it's not a question, just so you see
8 the context. The family do appreciate what the
9 paramedics did to help her, even though in the end, of
10 course, we know how it -- what the outcome was, but they
11 do appreciate that and want that known to you.
12 However, they also -- and I think you know this
13 from other sources --
14 **LORD HUGHES:** Mr Mansfield, forgive me, we're on
15 questions.
16 **MR MANSFIELD:** Coming now.
17 **LORD HUGHES:** Sooner rather than later, please.
18 **MR MANSFIELD:** Yes. They also would like to think
19 of the future. The questions that I have -- it's the
20 context for the question, so you know.
21 The first question is really the one we have just
22 finished with. I want to follow that up, if I may, for
23 a minute. Because if we're thinking about the future,
24 we don't want a situation in which two emergency
25 services say one thing, in this case that in fact it's

41

1 understood, works well when it is utilised.
2 **Q.** In that context, are there practical exercises
3 in this which you can monitor whether the understanding
4 is being implemented? In other words, the situation
5 that was confronted in this case might arise again in
6 the same way?
7 **A.** Yes, both through table top and live
8 exercises.
9 **Q.** Because one of the things -- and this is
10 another general question which reflects back -- it's
11 quite clear that after the Salisbury attack there
12 were -- and they're in the documents, I am not asking
13 for them to be brought up -- numerous references to
14 debriefs, are there not?
15 **A.** Yes.
16 **Q.** Throughout March, a whole set of dates, then
17 another lot in June. You recall that?
18 **A.** I do.
19 **Q.** Now, in relation to those debriefs -- this is
20 another aspect, the key learning curve -- in any of
21 those debriefs were the points that have been put to you
22 about the key learning, namely distinguishing between
23 symptoms, signs and causes; were they discussed? Was
24 training discussed in any of them?
25 **A.** Yes.

43

1 another Novichok, putting it shortly, and another
2 emergency service, if you like, saying "no", overriding
3 it, as you have just heard, saying it's drug related.
4 Now, has there been discussions in order to ensure
5 that this sort of situation doesn't arise at the command
6 level, or any other level for that matter?
7 **A.** Yes.
8 **Q.** Right. Is there provision now -- I would ask,
9 for the public benefit, basically how is that going to
10 be resolved? At command level, ground level; how is it
11 going to be done?
12 **A.** We're six years down the line now and the
13 principles of JESIP are, as I understand it, embedded in
14 all of the blue light emergency services, but also
15 across the wider partnership of the Local Resilience
16 Forum which we heard about earlier on in the week.
17 The national JESIP team routinely undertake
18 assessments of all blue light services, periodically
19 throughout the calendar year, which assess whether the
20 principles are embedded or not. My understanding is
21 that the principles of JESIP are now firmly embedded in
22 blue light organisations and in my experience working at
23 the tactical and the strategic level, particularly in
24 response to the incidents in which we're discussing, and
25 other incidents, that is my experience, that JESIP is

42

1 **LORD HUGHES:** Hang on, Mr Mansfield. That's two or
2 three questions. Are you on the question of the
3 possible overlap between opiate --
4 **MR MANSFIELD:** Yes, I am.
5 **LORD HUGHES:** Right. That's what he wants to know,
6 Mr Darch: did any of the debrief documents address the
7 overlap in symptoms and the risk, therefore, of
8 mistaking one for the other?
9 **A.** Yes, they did and since the Salisbury and
10 Amesbury incidents there has been a number of changes to
11 national guidance that addresses those which are
12 detailed within my statement.
13 **MR MANSFIELD:** In relation to that, as well as what
14 was happening at the time in March and June, it's
15 a question of compliance and monitoring whether it's
16 actually happening, because you can have a lot of
17 documents, nothing actually happens on the ground. How
18 is the monitoring of this documented information being
19 carried out?
20 **A.** Could you clarify the question? Are you
21 referring to the implementation of the learning from the
22 debriefs?
23 **Q.** Yes, that's right.
24 **A.** Yes. From my organisation's perspective, we
25 declared both incidents to our commissioners and to our

44

1 regional NHS England team as a serious incident. What
2 that means is that we have external oversight and
3 scrutiny of ensuring that the learning is taken forward,
4 is implemented and is embedded and we are not able to
5 only internally sign off the implementation of that
6 learning, that requires external overview and assurance
7 that that has indeed been taken forward.

8 **Q.** One of the key points after Salisbury, which
9 obviously was a shock for everybody's system at that
10 time -- I want to ask you about this point, namely
11 a secondary -- not necessarily a secondary incident, but
12 Novichok having been left somewhere, discarded. Now,
13 was that a talking point amongst these briefings that
14 you had?

15 **A.** I recall some conversation at the SCG around
16 the search for potentially missing substance, but
17 I wasn't specifically into the detail of that and, as
18 I have mentioned, with regards to the document that we
19 have just reviewed from the Department of Health,
20 I think it was, that wasn't shared with me either.

21 **Q.** Were you provided with any advice on this
22 topic, namely the real risk that some has been left,
23 either in the Salisbury area or even a little wider than
24 that, because Novichok was found in London?

25 **A.** No --

45

1 saying it's your responsibility, but whether you, given
2 your situation right here, whether you thought that that
3 was a priority, that there might be more in the city
4 somewhere and the sooner it's found, the better, but
5 people doing the looking, as well as the public, need to
6 have -- and your first responders -- need to be aware
7 there could be another incident in that sense?

8 **A.** Of course it was a consideration and I recall
9 it being a consideration, which is why we circulated the
10 guidance that we did, which I have already discussed
11 today.

12 However, my considerations were in the context of
13 advice at the time from public health experts that the
14 risk was extremely low.

15 **Q.** Right. Well, I want to deal with that because
16 I'm going to suggest one of the problems after the
17 Salisbury attack was a mindset that because Novichok was
18 rare or virtually unknown, or because nerve agent
19 poisoning was rare, there was a mindset that it wouldn't
20 happen again, wasn't there?

21 **A.** I don't know if there was a mindset that it
22 wouldn't happen again, but I think in the context of the
23 public health advice that the risk was low, you know --

24 **Q.** But then -- I'm sorry to interrupt, but at
25 that time, straight after the Salisbury attack, was it

47

1 **Q.** Traces of it.

2 **A.** Not that I recall.

3 **Q.** Well, I want to ask you -- in a sense it's
4 a key learning aspect of this. Is it right that at the
5 time we're talking about, that's between the Skripal and
6 the Amesbury events, there were a large number of
7 organisations at your level which had a function of
8 sharing important information in order to inform public
9 and inform first responders, weren't you?

10 **A.** Yes.

11 **Q.** A large number of groups, about seven
12 altogether.

13 **A.** Yes.

14 **Q.** Yes. I can run through them, but I don't want
15 to take up a lot of time, but if you agree there's about
16 seven of them.

17 The question I have is: can you explain then how it
18 was then, hopefully not in the future, that the
19 discussion about discarded Novichok which could affect
20 the local population wasn't a matter of prioritisation
21 or discussion? Can you explain that?

22 **A.** No, simply because I wasn't involved in those
23 specific conversations and information, as I have
24 already alluded to, wasn't shared with me.

25 **Q.** Did it occur to you personally -- I'm not

46

1 really being considered that the risk of more being
2 found -- not another attack, but being found in
3 Salisbury -- was regarded by public health authorities
4 as low risk?

5 **LORD HUGHES:** Well, you must tell us about what you
6 understood for your people, Mr Darch. Public health may
7 have had to think about all manner of things, including,
8 one would have thought, the fact that some of the
9 Novichok which had affected the Skripals might well be
10 around in the area.

11 **MR MANSFIELD:** Yes.

12 **LORD HUGHES:** But what's the answer to the
13 question: were you applying your people's minds to the
14 risk of not just the stuff being -- having contaminated
15 other bits of Salisbury or beyond, but the specific risk
16 of discarded material?

17 **A.** Okay, so I don't -- I don't recall considering
18 specific risk as a result of discarded material, but
19 I did consider the importance of ensuring that
20 responding crews were aware of the signs, symptoms and
21 how to treat as such.

22 **LORD HUGHES:** Thank you.

23 **MR MANSFIELD:** In terms of organophosphate
24 poisoning, of course in terms of that there are numerous
25 other ways in which -- the Chair has mentioned

48

1 fertiliser, but pesticides can give rise to it and also
 2 flammable retardants can give rise to it, plastics can
 3 give rise to it. There's a wide range of sources for
 4 poisoning of that kind, is there not?
 5 **A.** That's my understanding, yes.
 6 **Q.** What I want to ask you, backing on to that, is
 7 in relation to making distinctions and understanding
 8 signs and symptoms, to your understanding is there one
 9 distinctive feature or sign or symptom that relates to
 10 Novichok poisoning as opposed to any of the others, or
 11 are they all very similar?
 12 **A.** I think there's significant crossover, as we
 13 have previously discussed.
 14 **Q.** Yes, well, I'm only wanting to ask if the
 15 documentation that has been made available to first
 16 responders from now on gives them a clear indication
 17 that "If you see X, then that is Novichok, but if you
 18 see Y it may not be". In other words, making
 19 a significant distinctive feature so that somebody can
 20 tell on the spot, or at least have a notion?
 21 **LORD HUGHES:** Is this a question specifically about
 22 Novichok or about nerve agents generally?
 23 **MR MANSFIELD:** Well, I will make it about nerve
 24 agents generally.
 25 **LORD HUGHES:** Right, so the question is, is it: Is

49

1 been actually on the ground? Did that happen?
 2 **A.** There were a number of sessions that happened
 3 that did involve some, not all, of those individuals,
 4 yes.
 5 **Q.** Did you attend those? Do you know what
 6 actually happened when they did them?
 7 **A.** I didn't in person, no.
 8 **Q.** Was a record kept of what happened on those
 9 occasions?
 10 **A.** There should be, yes.
 11 **Q.** Now, in relation to one particular meeting --
 12 I think you went to it -- there was a meeting held at
 13 Porton Down. That's important, is it not?
 14 **A.** It is. I know the meeting you're referring
 15 to, sir. I didn't attend it in person.
 16 **Q.** I'm sorry, I didn't catch that?
 17 **A.** I didn't attend that in person, but I'm aware
 18 of the meeting you're referring to.
 19 **Q.** You're aware of it. There are two questions
 20 arising out of that. One is that the meeting took place
 21 on 19 April 2018, but the report indicating what had
 22 been discussed at Porton Down wasn't published until the
 23 day after Dawn's death. Did you know that?
 24 **A.** I was aware of that.
 25 **Q.** Can you help as to why that was delayed for

51

1 there any reliable means of distinguishing on the spot
 2 between Novichok or other nerve agents on the one hand,
 3 and organophosphates and some other sources on the
 4 other? Is that it?
 5 **MR MANSFIELD:** Yes, that's it.
 6 **A.** Yes is the answer and that's contained in
 7 updated JRCALC guidelines for clinicians. In 2018,
 8 a terminology called CRESS, which looks at conscious
 9 levels and a number of other symptoms, were not included
 10 in the clinical guidance at the time. It now is and it
 11 assists clinicians to be able to diagnose and
 12 differentiate between different types of toxidrome.
 13 **Q.** To make it clear, it wasn't available at the
 14 time of Amesbury, but it is now available?
 15 **A.** That's correct.
 16 **Q.** Now, part of the situation after Salisbury was
 17 a number of members of your organisation, in other words
 18 paramedics, as well as doctors and others, were at
 19 Salisbury as well as at Amesbury, were they not?
 20 **A.** They were.
 21 **Q.** They were in a very strong position, since it
 22 had been established by then that it was Novichok,
 23 a particular version at Salisbury -- was there
 24 an attempt by you to organise internally gatherings,
 25 seminars and practicals involving the people who had

50

1 that period of time?
 2 **A.** I'm afraid I can't. I wasn't involved in the
 3 meeting and it wasn't my document to publish.
 4 **Q.** No, I appreciate --
 5 **A.** So I'm unable to help you, I'm afraid.
 6 **Q.** I'm only asking for information just so we can
 7 put it together, as it were.
 8 Were you aware of what, in fact, was discussed at
 9 Porton Down in that period?
 10 **A.** No.
 11 **Q.** Did you become aware -- once the report was
 12 published, did you read it then?
 13 **A.** Yes.
 14 **Q.** Right. Now, one of the things I want to ask
 15 you, because of a witness that's coming, to see whether
 16 you know anything about it, there seems to have been for
 17 some a reticence to reveal details about Novichok
 18 poisoning. Did you run into that difficulty yourself?
 19 A reservation about either talking about it or certainly
 20 making it public?
 21 **A.** Yes, I did.
 22 **Q.** You did? Now, where did you run into it? At
 23 Porton Down or somewhere else?
 24 **A.** No, it was at the SCG, so on the Tuesday, I
 25 was informed of an organophosphate poisoning, but the

52

1 details surrounding Novichok was not shared with me.
 2 **Q.** Was not shared --
 3 **LORD HUGHES:** Sorry, the details surrounding what,
 4 the type of material?
 5 **A.** The type of material, so I knew it was an
 6 organophosphate, but I didn't know that it was Novichok.
 7 **MR MANSFIELD:** Yes, I understand that. Well,
 8 I think one can understand the materials point, but what
 9 about -- I'm going to put it this way: the presentation
 10 of the symptoms and signs, the treatment which needs to
 11 be urgent and so on, that sort of thing, was that
 12 discussed at Porton Down?
 13 **LORD HUGHES:** He wasn't there.
 14 **A.** I wasn't there, so I don't know.
 15 **MR MANSFIELD:** No, but he read the report.
 16 **LORD HUGHES:** Mr Mansfield, I'm sorry, there's
 17 a limit to how far you can take this with this witness.
 18 Moreover, you need to keep an eye on the clock.
 19 **MR MANSFIELD:** Do you also accept, therefore, just
 20 in this context, that since you were dealing with this
 21 between the two situations, that is Salisbury and
 22 Amesbury, that protection of the public is important?
 23 **A.** Yes, I agree.
 24 **Q.** I appreciate it's not your responsibility, but
 25 you are sitting on seven different organisations which

53

1 **LORD HUGHES:** No, please don't argue the point,
 2 Mr Mansfield.
 3 **MR MANSFIELD:** All right, I won't.
 4 May I just have one moment?
 5 **LORD HUGHES:** Of course.
 6 **MR MANSFIELD:** Most of the other questions have
 7 already been asked by counsel that we submitted, so
 8 I don't think there's anything else I wish to ask.
 9 **LORD HUGHES:** Just check.
 10 **MR MANSFIELD:** Yes, thank you very much.
 11 **LORD HUGHES:** Thank you very much indeed,
 12 Mr Mansfield.
 13 Have we finished with Mr Darch, Mr O'Connor?
 14 **MR O'CONNOR:** Yes, we have, sir.
 15 **LORD HUGHES:** Thank you for your help, Mr Darch.
 16 You need not stay. 11.30, please.
 17 (11.17 am)
 18 (Short Break)
 19 (11.29 am)
 20 **LORD HUGHES:** Yes, Mr O'Connor.
 21 **MR O'CONNOR:** Sir, Deputy Chief Constable Mills is
 22 in the witness box and you will recall that he has
 23 already sworn and already --
 24 **DEPUTY CHIEF CONSTABLE PAUL MILLS (still under oath)**
 25 **LORD HUGHES:** Yes, you are still on oath, Mr Mills,

55

1 have a responsibility, each of them, towards the public.
 2 Was there any discussion --
 3 **LORD HUGHES:** Mr Mansfield, he isn't sitting on any
 4 of them. Please confine the questions to material
 5 that -- information that this witness can give. We
 6 don't need --
 7 **MR MANSFIELD:** It does.
 8 **LORD HUGHES:** I don't know -- it is whether it
 9 helps me that matters. I do not need repetition of the
 10 assertions that have been contained in your questions.
 11 I have understood them.
 12 **MR MANSFIELD:** I do understand.
 13 The question I would seek to ask is for the future
 14 if we have a number of organisations such as this and
 15 that protection of the public, as you have agreed, is
 16 important, these are matters that need to be discussed
 17 at the level of the organisations I haven't read out in
 18 detail, it does need to be discussed; do you agree?
 19 **A.** I do.
 20 **LORD HUGHES:** It is not for him to say. It is for
 21 me -- it might be for me to say, but it certainly isn't
 22 for him to say.
 23 **MR MANSFIELD:** Well, he is a leader in the field.
 24 That's the only reason I'm asking. He is a leader and
 25 an influential one.

54

1 of course.
 2 **A.** Thank you, sir.
 3 **Questioned by MR O'CONNOR**
 4 **MR O'CONNOR:** Mr Mills, you have already given
 5 outline evidence this week about Wiltshire Police
 6 structures, about the response of the constabulary to
 7 the 2018 poisonings, Operations Fairline and Fortis and
 8 so on, and we will return in due course, in London in
 9 fact, for you to provide some detailed evidence about
 10 Wiltshire Police's response to the Skripal poisonings.
 11 The purpose of asking you to come and give evidence
 12 today is for you to provide some context, as I said to
 13 Mr Darch, to the evidence we will hear today and
 14 tomorrow and early on in our hearings in London about
 15 the emergency services' response to Dawn Sturgess'
 16 poisoning and also Charlie Rowley's poisoning, and some
 17 sort of policy level context into which we can put that
 18 evidence.
 19 As I said to Mr Darch, of course we will ask the
 20 witnesses themselves who were there, and we're very
 21 conscious that you weren't, about what they did, what
 22 they were thinking, what decisions they made. We won't
 23 trouble you with those matters.
 24 I would like to start then, if I may, with the
 25 general issue of the training, guidance available, the

56

1 preparedness, if you like, of Wiltshire Police to face
 2 an organophosphate poisoning after the Skripal
 3 poisoning.
 4 **LORD HUGHES:** Which of the statements would you
 5 like me to have open, Mr O'Connor?
 6 **MR O'CONNOR:** Sir, I'm going to be referring
 7 Mr Mills to his third statement, the sort of
 8 compendious -- the summary statement of his earlier two.
 9 **LORD HUGHES:** Is that 6117?
 10 **MR O'CONNOR:** Yes, it is.
 11 In fact, Mr Mills, I would like to start by taking
 12 you back to some questions you were asked when you gave
 13 evidence earlier this week and I hope that we're going
 14 to be able to bring the transcript up on screen. It was
 15 Tuesday, 15 October, and if we could have the internal
 16 pages, the small internal pages, 21 and following, on
 17 screen.
 18 This is just -- you were asked some questions by
 19 Ms Whitelaw on this topic, Mr Mills, and I think it's
 20 fair if we just remind ourselves of what you said then
 21 and then I will ask you some further questions.
 22 You see that -- yes, the small page numbers at the
 23 bottom of the pages -- at the bottom of page 21,
 24 Ms Whitelaw said:
 25 **"Question:** Importantly, the item or items used to

57

1 **"Answer:** From a local level, yes, I absolutely
 2 reflect that we didn't put anything further out.
 3 Clearly police officers are trained in relation to
 4 generic responses, but I do believe in hindsight it
 5 would have been sensible just to have put some advice
 6 and guidance out, just confirming that which was already
 7 there."
 8 That was the evidence you gave earlier this week.
 9 Thank you, we can take that down.
 10 Now, I said that I would bring up what I thought
 11 was probably the CBRN document you were referring to in
 12 the course of that answer, so could we have on screen,
 13 please, INQ006069. Mr Mills, I know you had a look at
 14 this document earlier this morning. Is this either the
 15 very document you had in mind or a close relation of it?
 16 **A.** I believe, sir, this is the source document
 17 and what I have seen is a secondary document which in
 18 essence is a PowerPoint presentation which covers the
 19 main points which are made in this document.
 20 **Q.** Just to be clear, this was in -- we know from
 21 other evidence that this document was circulated
 22 March/April, I think it was, 2018, certainly between the
 23 Skripal poisoning and the Amesbury incident. Do you
 24 think you would have seen it during that period?
 25 **A.** I hadn't seen it up until recently, sir.

59

1 deliver the poison in the Skripal poisoning had not been
 2 located at the time of --"
 3 You said:
 4 **"Answer:** No, they hadn't."
 5 She went on to say:
 6 **"Question:** ... Dawn Sturgess' poisoning. Indeed,
 7 you didn't know in June/July 2018 whether there was
 8 a vessel or container that had been discarded still in
 9 or around Salisbury or in Wiltshire or in the country?"
 10 You said: "We did not know".
 11 Ms Whitelaw put it to you whether you agreed that in
 12 those circumstances Wiltshire Police ought to have been
 13 advised to be particularly alert to any signs of nerve
 14 agent poisoning from March 2018 onwards. Then we can
 15 read your answer. You gave some context. You referred
 16 to a CBRN document and I'm going to show you in a minute
 17 the CBRN document which I think was the one you were
 18 referring to.
 19 You said that that document said that this was an
 20 isolated incident. You referred to the fact that the
 21 intelligence -- and that there wasn't believed to be
 22 a further risk.
 23 Then I'm just casting my eyes down. If we can go to
 24 page 23, which is at the bottom of the page, picking it
 25 up a couple of lines in you said:

58

1 However, what I can say to be more precise is that the
 2 version I have seen, the PowerPoint presentation, was
 3 dated in March, sir.
 4 **Q.** Right, so --
 5 **LORD HUGHES:** Not the document, but a PowerPoint
 6 presentation of the same material?
 7 **A.** Same material, sir, and that was dated
 8 in March.
 9 **MR O'CONNOR:** 2018?
 10 **A.** 2018.
 11 **Q.** The substance wasn't known to you in 2018 at
 12 the time?
 13 **A.** No, it was not.
 14 **Q.** No.
 15 **A.** And I was -- sorry, forgive me, I may have
 16 misunderstood that question, sorry.
 17 **Q.** Perhaps I will try that again. We have agreed
 18 that you hadn't seen this very document until, I think,
 19 this morning, but you said that you had seen the
 20 substance of it in a PowerPoint demonstration?
 21 **A.** Yes, that is recently in the preparations for
 22 the Public Inquiry, sir. Certainly between the material
 23 period of the Skripal attack, before the attack in
 24 Amesbury, I had not seen this document.
 25 **Q.** I'm grateful. That's now clear.

60

1 But just to look briefly at this document, because
 2 you did pick out some aspects of it in the answer you
 3 gave to Ms Whitelaw, first of all there is the -- in red
 4 at the top, there is the restricted handling. It's only
 5 to go to certain tactical commanders. Perhaps that's
 6 why you didn't see it at the time, I don't know.

7 **A.** Yes, certainly in my witness statement, sir,
 8 I do tell at the time I was not what's called a CBRN
 9 commander. My apologies, sir, in relation to again all
 10 of the acronyms, so chemical biological radiological and
 11 nuclear commander in policing, similar to the other
 12 emergency services, what you have is a specialism in
 13 relation to such events and that follows what we call
 14 the gold, silver and bronze model. So gold is
 15 strategic, silver is tactical and bronze is operational.
 16 Officers are trained specifically within that discipline
 17 and there's also, of course, what's called tactical
 18 advisors who actually assist commanders. That's what
 19 exists and this is who this information was meant to be
 20 for and circulated to.

21 **Q.** Moving on to the paragraph below the red words
 22 at the top -- and again this was -- you gave us
 23 a flavour of this in your answer to Ms Whitelaw earlier
 24 this week, we see the assertion that:
 25 "Whilst we are aware of no intelligence or

61

1 trying to condense what the signs and symptoms that
 2 might be obvious to responders are.

3 **A.** Yes, I can see that, sir.

4 **Q.** I don't want to ask you about the detail of
 5 that because you're not a medic, but when you said to
 6 Ms Whitelaw earlier in the week that on reflection it
 7 would have been a good idea to circulate to Wiltshire
 8 Police some further guidance just perhaps refreshing and
 9 emphasising training that they had already had, is it
 10 something like this that you would have had in mind or
 11 not?

12 **A.** So obviously -- I will go back to the top of
 13 this document which is in red that obviously talks about
 14 it not being circulated further without express
 15 authority and obviously then goes on to talk about the
 16 symptoms, what I was referring to at that point in time
 17 are really sort of three pieces of what I would call
 18 core training doctrine. There's, firstly, as was
 19 alluded to by Mr Darch, there's the JESIP principles;
 20 secondly, there is the initial operational response, 1,
 21 2, 3, plus, which we heard about from Mr Darch, that's
 22 to assist first responders who may come across a CBRN
 23 incident in terms of their decision-making; and then
 24 there is what I would call a more command level document
 25 and that is -- it was issued in 2016, it's the CBRN,

63

1 information to suggest that this incident ..."
 2 That's the Skripal incident:
 3 "... is anything other than isolated to the
 4 identified victims, the National CBRN Centre has a duty
 5 to support, strengthen and assure UK capability and
 6 resilience to respond to CBRN events."
 7 Now, you have made it clear now that you didn't see
 8 this document back in March 2018, but does that
 9 description of the existing intelligence match what you
 10 understood to be the case then or not?

11 **A.** Yes, it was my understanding at that point in
 12 time that this was an isolated incident, that the
 13 Skripals, or indeed Mr Skripal, had been targeted and
 14 there was no more information intelligence that I was
 15 aware of, notwithstanding the need to know basis, which
 16 indicated there was a wider potential threat of
 17 a further attack.

18 **Q.** Thank you. Then just looking down the page
 19 a little more, if we may, do you see that there's
 20 a grid, a sort of ready reckoner of signs/symptoms of
 21 nerve agent poisoning? As I said to Mr Darch earlier
 22 this morning, one comes across repeatedly in it these
 23 documents little summaries of the types of symptoms to
 24 look out for, not always identical, but there's a common
 25 theme to most of them and here we see another go at

62

1 it's JOP, sir, but the JOP stands for joint operating
 2 principles and there are 24 of those and again they
 3 come, together with the JESIP principles, to help the
 4 emergency services work together if there is a potential
 5 CBRN incident to help guide the response.

6 **Q.** Is your evidence now, Mr Mills -- we have
 7 understood that no guidance was sent to police officers
 8 between March and June 2018. Is your evidence now that
 9 looking back you don't think it was a good idea to send
 10 out some guidance to police officers on what to look out
 11 for in terms of signs and symptoms of nerve agent
 12 poisoning?

13 **A.** No, I'm not saying that, sir. I think there's
 14 firstly three fundamental core pieces of training
 15 doctrine which we should have reminded our officers and
 16 staff of. However, what I reflected on Tuesday was in
 17 hindsight it would have been helpful for us,
 18 notwithstanding as we have heard this morning this
 19 crossover with symptoms with opiate poisoning, to have
 20 put these out as well to help and assist decision-makers
 21 if they were to come across such an incident in the
 22 future.

23 **LORD HUGHES:** First, you needed to and did
 24 emphasise the joint operational features, JESIP, JOP and
 25 so on, but you're being asked about advice to your

64

1 frontline policemen, wherever they may be, about
 2 symptoms; do you follow?
 3 **A.** Yes, I do, two points, if I may --
 4 **LORD HUGHES:** Did you have this information about
 5 the likely symptoms?
 6 **A.** It was in the CBRN community, so as
 7 I explained the gold, silver, bronze commanders who are
 8 specialist in this area and the tactical advisors.
 9 Building on my evidence from Tuesday, in hindsight
 10 I think we should have pushed back against the element
 11 which is in red there to provide some advice and
 12 guidance around signs and symptoms that may assist
 13 officers or staff who had to attend such a potential
 14 incident in the future, notwithstanding that the
 15 likelihood was considered low.
 16 **MR O'CONNOR:** Tell us if you can't answer this
 17 question, Mr Mills, but there's nothing sensitive about
 18 the signs and symptoms of organophosphate poisoning, is
 19 there?
 20 **A.** No, there's not. Looking at those, sir, not
 21 at all.
 22 **Q.** Thank you. We can take that down. Can I go
 23 now to your witness statement, please, Mr Mills, and
 24 it's the 6117 reference. It is page 29 of that
 25 statement, if we may. We see at the head of that

65

1 a unique incident, in the sense it had happened, it was
 2 very rare and that nothing like that was going to happen
 3 again?
 4 **A.** If I may, sir -- and sorry to depart from the
 5 statement -- but I do think in my first statement, at
 6 page 51, paragraph 182, it is worthwhile me just setting
 7 out again nationally what happened in policing further
 8 to the attack on the Skripals because I think it goes to
 9 some of the elements you have spoken about.
 10 **Q.** Mr Mills, do you mind if you would just answer
 11 my question first. You have used the word "unique"
 12 about the Skripal incident in that statement that we're
 13 just looking at. Was it the understanding and the
 14 approach of Wiltshire Police during this period that the
 15 Skripal poisoning was a one-off, not to be repeated
 16 event, or not?
 17 **A.** It was my understanding at that point in time
 18 this was targeted against the Skripals and again, the
 19 information that I was talking about was circulated to
 20 policing, which says it should be made clear there is no
 21 information to indicate any further threat from the
 22 agent at this time. This was circulated by Deputy
 23 Assistant Lucy Dorsey to all 43 police forces in England
 24 and Wales.
 25 Clearly further to what we have been discussing in

67

1 page -- it's headed "Policies and guidance" and at
 2 paragraph 124, you record that you have been asked:
 3 "If any internal policies or guidance were
 4 distributed within Wiltshire Police advising on the
 5 symptoms of nerve agent poisoning and how to respond to
 6 them."
 7 Then at paragraph 125, you say this:
 8 "Due to the unique and exceptional circumstances
 9 relating to the targeted attack on the Skripals and the
 10 absence of any intelligence or information to indicate
 11 the likelihood of any further nerve agent related
 12 incidents, Wiltshire Police did not proactively provide
 13 any advice to officers and staff who may attend any
 14 subsequent reported future incidents which could be
 15 linked to the symptoms of Novichok or a wider
 16 poisoning."
 17 A statement there, we have already established, no
 18 guidance sent out and further down the page, we will
 19 come to it, there's a passage where you describe, as you
 20 said to Ms Whitelaw, you wish you had.
 21 **A.** Yes.
 22 **Q.** Just coming back to paragraph 125, if we may,
 23 I want to ask you about that word "unique". Was the
 24 Wiltshire Police understanding after the Skripal
 25 poisoning that it was properly to be regarded as

66

1 the last couple of days, what that doesn't talk about is
 2 the potential for a discarded item in terms of the
 3 administration of the poison to be picked up.
 4 **Q.** Yes, and you make a similar point, just
 5 further on in that same paragraph. You talk about an
 6 absence of intelligence or information to indicate the
 7 likelihood of any further nerve agent related incidents.
 8 I'm going to come to ask you about the discarded
 9 container in due course.
 10 We have also heard, Mr Mills, that at this
 11 time, March/April, there was a great activity in
 12 Salisbury working on what you describe as consequence
 13 management, looking for scenes that were contaminated,
 14 decontamination when those scenes were discovered.
 15 Doesn't it follow from all of that, leaving aside any
 16 intelligence about future targeted attacks, but surely
 17 it follows from all of the activity that was going on in
 18 relation to suspected and actual contaminated scenes,
 19 there must have been a possibility of another incident,
 20 mustn't there?
 21 **A.** Clearly there was and hence the tragic death
 22 of Ms Sturgess. In relation to my role -- and I can
 23 only talk about my role, firstly as the corporate
 24 witness of Wiltshire Police and then secondly as the
 25 Strategic Coordination Group chair -- we didn't have

68

1 specific information to indicate there was a likelihood
2 of another attack -- and I think "attack" is the
3 important word -- at that point in time.

4 Then, in relation to my role in the partnership
5 setting as the multi-agency Chair, again clearly there
6 is a degree of foreseeability, as we look back at this
7 now, that that was not something that we were actively
8 discussing within the Strategic Coordination Group.

9 The final element of that, I would say, sir, is
10 around that role of working with different colleagues,
11 so very early on we established that working with public
12 health colleagues they would inform us of the risk and
13 the appropriate communications to put out relative to
14 that risk which was assessed and, forgive me, my final
15 point on this would be I would take us back to what
16 I said on Tuesday around that local meets national
17 structures. At a local level I had the scientific
18 advisory cell assisting me, but they were receiving help
19 and assistance from what's called SAGE, sir, which you
20 will remember is the Scientific Advisory Group in an
21 Emergency, and really you have two elements going on
22 there in consideration of the here and now risk, but
23 also potential future risk.

24 **Q.** Can I move to a related subject and we need to
25 go back to the witness statement, please? We were just

69

1 going to call the crossover point.

2 **A.** By definition, sir, incident number 1 was
3 initially assessed as a fentanyl incident in relation to
4 the Skripals, and then subsequently over the course of
5 that four-day period then went from that initial
6 hypothesis to Novichok. I was aware at that level that
7 it was quite difficult to identify in the early stages
8 of this what somebody had actually been infected with.

9 **LORD HUGHES:** I see.

10 **MR O'CONNOR:** Just to be clear, no one is -- or
11 could possibly expect, well, even paramedics and
12 certainly not police officers as first responders,
13 accurately to diagnose these things. The learning, as
14 you say from the Skripal incident, is that to be aware
15 of the risk that something that looks like it might be
16 an opioid poisoning could be something else.

17 **A.** 100 per cent, sir.

18 **Q.** Is that something that -- well, I think --
19 just let me ask you this: is that something -- that
20 learning something that was disseminated to Wiltshire
21 Police officers in March, April, May, 2018?

22 **A.** I return to my previous point, no, it wasn't,
23 sir.

24 **Q.** Do you think it ought to have been?

25 **A.** Again, I return to my previous responses on

71

1 looking at paragraph 125 and if we could go on to the
2 next paragraph, paragraph 126. In the first sentence
3 there you refer to JESIP principles, HAZMAT and so on.
4 Then, picking it up in the second sentence, three lines
5 down, you say:

6 "In relation to identifying specific Novichok
7 symptoms, as detailed in the expert medical reports to
8 the Inquiry, there are a number of similarities and
9 crossovers between the medical signs and symptoms of
10 a Novichok poisoning versus that of an opioid drug
11 poisoning."

12 We're back in territory that we have heard about
13 already this morning. Can I ask you this: was that
14 something that you were aware of in March/April 2018?

15 **A.** Not -- it's difficult, sir, with the passage
16 of time. These are six years' worth of incidences.
17 What I was aware of, as I put within my statement, that
18 the only place at that point in time that it could be
19 identified that someone had been subject of a nerve
20 agent attack was in a hospital setting. This is
21 conclusively further to drugs work which had been
22 undertaken --

23 **LORD HUGHES:** That's where you can make a diagnosis
24 in a particular case. The question is whether you were,
25 at that time, March/April, aware of what I'm loosely

70

1 this. In hindsight, I think we should have put some
2 advice and guidance out to staff, reaffirming their
3 training, as I have spoken about, in relation to IOR
4 specifically, steps 1, 2, 3, because that is the
5 doctrine that's in place and it would have been sensible
6 to additionally have put something out, high level as we
7 saw in the document you showed me earlier, which
8 details -- notwithstanding they are not medically
9 trained -- the types of symptoms that may present in
10 a secondary incident.

11 **Q.** Well, yes, but there's something else, isn't
12 there? There's the symptoms of organophosphate
13 poisoning, such as that grid we saw a moment ago. That
14 is existing training, if you like, certainly for
15 paramedics, but there's the specific learning point
16 which emerged from the Skripal case very clearly that
17 there is a risk of crossover.

18 Now, that's not something we find in the CBRN
19 document, my question to you is whether that is an
20 additional thing that ought to have been, with
21 hindsight, disseminated to Wiltshire officers?

22 **A.** I'm cautious in relation to that, sir, I have
23 to say, and I go back to the doctrine which is in place
24 and the IOR doctrine because what it doesn't do -- and
25 specifically now as a CBRN commander I'm aware of

72

1 this -- is start talking about symptoms.
 2 When you read it, what it starts talking about is
 3 the number of people actually presenting and it's
 4 unclear why they potentially have become unwell and
 5 I think that's helpful for frontline responders because
 6 what it's asking them to do is to work through the steps
 7 to consider how many people are presenting and whether
 8 or not it's unexplained and then gives them advice
 9 around how they should actually proceed going forward .
 10 I think for the Police Service that is appropriate.
 11 When you start getting much further than that, you're
 12 going outside of what actually policing is there to
 13 actually do.
 14 **Q.** Well, we will come a little bit later in my
 15 questioning to what actually happened with Charlie
 16 Rowley and the actions of the Police there and we may
 17 come back to the question then of whether they would
 18 have benefited from being told about the risks of
 19 confusing opiate poisoning with nerve agent poisoning,
 20 but we will come back to that, Mr Mills.
 21 I would like now to show you some documents
 22 about -- I said I would come back to the issue of the
 23 discarded container, and the context for these questions
 24 is the evidence we will recall that you gave to
 25 Ms Whitelaw earlier in the week about your role in the

73

1 practice around how you would look to respond to
 2 anything where there is a particular scientific or
 3 technical considerations -- is I appointed at a local
 4 level the STAC. Just to remind all of us, it's the
 5 Science Technological Advisory Cell. Sits locally, was
 6 chaired by the local representative from Public Health
 7 England, with some other members on there as well, and
 8 the role at a local level was to assist me in terms of
 9 scientific considerations and understanding.
 10 Just to put that into context, the closure report
 11 for Operation Fairline I asked for a summary report from
 12 the Chair and it detailed that they had considered over
 13 50 thematic issues and subdivided down to 125 thematic
 14 scientific issues as a result of the response, so in
 15 normal circumstances, sir -- this was isolated and
 16 I will perhaps take it outside of what we're dealing
 17 with today.
 18 Let's say a fire, there's a big fire in the centre
 19 of Salisbury, there may be issues in relation to the
 20 plume from the fire. What I would look to do is I would
 21 call on the local STAC and I would ask them for advice
 22 around do we need to evacuate, those sorts of things.
 23 That's at the local level in what I would call a normal
 24 major incident response. We will obviously go on to
 25 then talk about the levels due to the uniqueness of this

75

1 follow-up, if I can put it that way, to the Skripal
 2 poisoning, Chair of the SCG, consequence management was
 3 a term that you used, was it not?
 4 **A.** Yes, it was, sir.
 5 **Q.** Let's look, first of all, if we may, at
 6 document INQ004837. We will see here -- this is the
 7 minutes of SAGE on 9 March, so the Friday after the
 8 poisoning on the Sunday.
 9 **A.** Yes.
 10 **Q.** Now, just to be clear, you weren't on this
 11 occasion or ever, I think, someone who attended SAGE?
 12 **A.** I never attended SAGE.
 13 **Q.** In this period that we're talking about, did
 14 you receive SAGE minutes?
 15 **A.** No, I did not.
 16 **Q.** When you were giving evidence to Ms Whitelaw
 17 earlier in the week, you talked about your own
 18 Scientific Advisory Group, which I think had the acronym
 19 STAC?
 20 **A.** That's correct.
 21 **Q.** In general terms, can you remind us of what
 22 the relationship -- first of all what STAC was and what
 23 its relationship to SAGE was.
 24 **A.** Yes, certainly. One of the first things that
 25 I did in both incidences -- and this is standard

74

1 that had to be put in above that.
 2 **Q.** With that in mind, let's look at this document
 3 and we can see then at a meeting really within days of
 4 the Skripal poisoning, we see from the minutes, at point
 5 2, under the heading "Public health issues", point (c)
 6 below that -- or, rather, perhaps I will just read
 7 paragraph 2:
 8 "It was agreed that there are currently 3 public
 9 health areas of risk that need to be addressed as
 10 initial priorities for police and others ..."
 11 Then the third of those is:
 12 "Where the substance has been deliberately placed,
 13 but as yet undiscovered."
 14 Now, Salisbury and the surrounding area may, of
 15 course, not have been the only location in which
 16 Novichok could have been deliberately placed, but will
 17 you agree it was certainly a leading contender?
 18 **A.** Yes, absolutely.
 19 **Q.** Perhaps the most obvious place, if we go to
 20 the principles --
 21 **A.** Go to the principles of searching, you start
 22 from the point of the crime scene and work outwards .
 23 **Q.** You have described your public health
 24 consequence management role, both in the SCG and also
 25 just now with the STAC, were you aware that the week

76

1 after the poisoning SAGE identified as one of the three
 2 public health issues questions around where the
 3 substance had been deliberately placed?
 4 **A.** No, I was not.
 5 **Q.** Did you work it out for yourself?
 6 **A.** I have reflected on this, sir. I think very
 7 much the work that we were doing at the local level was
 8 focused on the consequence management around the impact
 9 of this incident. Just to give an example -- and it's
 10 at number 1 -- we had to do things like contact tracing
 11 whereby there is over, I think it was, 350-odd people
 12 that we had to contact trace around people that may have
 13 come into contact with this. But in terms of that
 14 forward facing element, no, we did not discuss anything
 15 in relation to the forward facing risk which is
 16 identified there at points 2(b) and (c).
 17 **Q.** I'm going to come to --
 18 **A.** 2(c), should I say.
 19 **LORD HUGHES:** It's (c), isn't it?
 20 **MR O'CONNOR:** Yes.
 21 **LORD HUGHES:** We can label it "Discard"?
 22 **A.** Yes.
 23 **MR O'CONNOR:** I'm going to come in a moment and
 24 show you the reasonable worst case scenario document
 25 that I showed Mr Darch and I think you were in the room

77

1 "If you didn't drop it, don't pick it up". Again, our
 2 job at the local level was then to what I would call
 3 operationalise that and get it out into the community.
 4 **Q.** Do you think if you had been aware of this
 5 sort of thinking as early as a week after the first
 6 incident, that type of advice, "If you didn't drop it,
 7 don't pick it up", might have come earlier and in fact
 8 before the Amesbury incident?
 9 **A.** Yes, and I sit here six years later and, yes,
 10 I now think it's -- it's an obvious question, isn't it?
 11 You go through the search activity which has been
 12 undertaken. If you get to the point then that you
 13 exhaust that and you can't reasonably find it, then it
 14 is absolutely an obvious question, is it not, around
 15 "Okay, what is the risk here now to the public and what
 16 can we reasonably do to try and mitigate that risk".
 17 **LORD HUGHES:** Did you just say "search activity"?
 18 **A.** Yes, which was undertaken by Counter Terrorism
 19 Policing, sir.
 20 **LORD HUGHES:** Not your force, but it was going on,
 21 was it, all around you?
 22 **A.** So just to give you some further detail on
 23 that, sir. You have heard from Mr Murphy -- and you
 24 will hear from Mr Murphy again -- he was leading an
 25 investigation, a criminal investigation. Within that he

79

1 at the time, so you will know what's coming. Just
 2 before we leave this document, do you think it would
 3 have helped you performing your duties on the SCG
 4 have been kept in the loop on SAGE's thinking on this
 5 matter?
 6 **A.** Yes, I do, sir, and I think there's
 7 a contextual bit here as well around the dates, 9 March.
 8 Again in my first big statement, if I can call it that,
 9 probably poor terminology, what I talk about is early on
 10 trying to get this connection from what normally is just
 11 a localised STAC, up into SAGE, around incredibly
 12 difficult scientific advice. One of the reasons that
 13 the Health Emergency Response Cell was put in place --
 14 I believe I'm correct around the dates here, sir, but
 15 I believe it is around 12 March -- was to try and get
 16 that join up. This meeting had obviously already taken
 17 place before that, but yes, absolutely, I'm sat there as
 18 the SCG Chair. One of my responsibilities locally is
 19 around working with partners around the public health
 20 risk, to have known that that thinking was going on
 21 would have been very, very helpful.
 22 Indeed, you can see that in incident number 2
 23 where, sadly, the events in relation to Ms Sturgess and
 24 Mr Rowley have taken place. We then very quickly put in
 25 place, through public health nationally, advice around

78

1 would have had, talking on his behalf, a search strategy
 2 and Wiltshire Police's job -- and you can see it from my
 3 strategic objectives -- is to assist him in terms of the
 4 delivery of that.
 5 What did that look like in practice? I believe we
 6 did give him what's called a -- sorry, again acronyms,
 7 a POLSA, which is a police search advisor to assist him
 8 and his team, and we also have trained people that can
 9 do searching. We would have assisted in terms of
 10 providing some resource to assist him around what that
 11 strategy was and how he delivered that.
 12 **LORD HUGHES:** If there's a search going on, what
 13 are you searching for?
 14 **A.** I think it goes to point 2(c), doesn't it,
 15 sir? 100 per cent --
 16 **LORD HUGHES:** It does. Well, it sounds like it
 17 anyway.
 18 **A.** Obviously clearly a question for Mr Murphy,
 19 but we're searching for what has been brought into the
 20 United Kingdom, has been placed, ultimately what we
 21 understand, on the door handle and then potentially, as
 22 one of the hypotheses, has been disposed of or discarded
 23 of before the individuals left the country.
 24 **MR O'CONNOR:** I suppose the question is what -- you
 25 said that you would have been assisted -- we will come

80

1 onto the reasonable worst case scenario document, but
 2 you said you would have been assisted to have known
 3 about SAGE's thinking as demonstrated in these minutes.
 4 Would it actually have added to your knowledge or
 5 understanding of the situation, given that you knew
 6 there were searches going on?

7 **A.** I think it's quite a difficult one to answer,
 8 but my responsibility, working with all of the different
 9 partners, is to think through the risk. The reason that
 10 I asked for a summary closure report at the end of the
 11 Operation Fairline from the STAC Chair was they had, as
 12 I have touched on, these 125 sort of different thematic
 13 issues that were dealt with, or sub-thematic issues.
 14 What I wanted to assure myself of at that point in time
 15 was we hadn't left any of those -- we hadn't completed
 16 the loop on any of them.

17 Absolutely, if I had been aware of that and that
 18 would have featured locally, that would have been
 19 a question to ask ourselves quite early on: what are we
 20 doing to actually mitigate this risk?

21 **Q.** Well, let's move to look at this other
 22 document which we have already seen once this morning.
 23 If we may, it's INQ004704. You were watching, as we
 24 looked at this, Mr Mills, so we can take it fairly
 25 briefly. If we go to the second page, we will remind

81

1 "The following consequence management issues are
 2 identified for the health sector for both scenarios",
 3 which includes accidental discovery of a discarded
 4 container by a human.

5 First of all, the same question again, or two
 6 questions: did you see this document at the time?

7 **A.** I've never seen this document up until the
 8 last 24 hours.

9 **Q.** Do you think that in performing your duties in
 10 the SCG and more generally in consequence management in
 11 Wiltshire after the Skripal poisoning, it would have
 12 been helpful to see this document?

13 **A.** Yes, I believe that it would because again it
 14 comes back to risk assessment, doesn't it: what is the
 15 risk which is presented, both in terms of the initial
 16 response, but also a potential forward facing risk?

17 **Q.** It is fair to say that this document focuses
 18 itself on health provision and health support, so not
 19 a police piece of analysis, but is it right that your
 20 SCG group covered health considerations?

21 **A.** Yes, it is, at a local level.

22 **Q.** Just looking at the top line, or set of lines,
 23 on this table against "First response", we looked with
 24 Mr Darch at the "Action required" bullet points on the
 25 right-hand side:

83

1 ourselves that this was described as a "reasonable worst
 2 case scenario". Are you familiar with that -- with the
 3 term "reasonable worst case scenario"?

4 **A.** High level, sir, yes, not in the context of
 5 the response to this incident.

6 **Q.** Have you seen before a situation in which
 7 someone comes up with a hypothetical set of events which
 8 are to be used as a basis for planning for an incident
 9 in the future?

10 **A.** Not in my training, sir, but I'm aware of the
 11 concept.

12 **Q.** You are aware of the concept. You have seen
 13 this document and we looked this morning with Mr Darch,
 14 towards the bottom of this page, against number 2, the
 15 "Accidental discovery of discarded source material by
 16 humans" and the details of the scenario then, quite
 17 alarming:

18 "... six members of the public exposed ... up to
 19 four emergency services personnel are also exposed ... 1
 20 fatality; nine other casualties ..."

21 And so on. Obviously that is just a scenario, but
 22 that is what these analysts came up with.

23 Then if we go to the next page, we see the grid and
 24 at the top, underneath there where it says -- well, it
 25 says "Consequence management" and then again:

82

1 "Learning from 4 March should be rapidly
 2 disseminated to ensure effective and safe first
 3 response."

4 The police -- your police force would be likely to
 5 be a frontline responder in any second event, just as
 6 much as the Ambulance Service, would it not?

7 **A.** Yes, agreed.

8 **Q.** I ask, had you seen this document, would it
 9 perhaps have given you thought about providing some
 10 further guidance of the type we were discussing
 11 ten minutes ago to your officers, drawing on the
 12 learning from the Skripal incident?

13 **A.** Sorry, sir, I interrupted you. I think what
 14 we see here is a read-across, so we see a read-across to
 15 the national CBRN advice which came out that we looked
 16 at, one of the first documents this morning in my
 17 session, which talks about reinforcing the IOR, which is
 18 the steps 1, 2, 3, plus, and remove, remove, remove,
 19 which again is protocols that come from the CBRN world.
 20 That did take place limited to the CBRN community, but
 21 again, returning to the point that I have spoken about,
 22 yes, in relation to Wiltshire Police as an entity,
 23 thinking about what more could we have done to actually
 24 have informed our first responders, then absolutely
 25 I reiterate that in hindsight it would have been

84

1 sensible for us to have provided in addition to IOR and
2 remove, remove, remove some advice around
3 signs/symptoms.

4 **Q.** Just generally, before I move on, Mr Mills,
5 perhaps you could go back to the first page of this
6 document. This is the email which attached the
7 reasonable worst case scenario and the grid that we have
8 just been looking at, but we can see, if we just zoom in
9 on the text of the email, that whoever it was in the
10 Department of Health and social care who put this
11 together and then sent it to someone says:

12 "Suggest that this is not forwarded further than
13 necessary ..."

14 Now, I think you have already made it clear that
15 you would have been helped by this document. In due
16 course, the Chair is going to have to think about any
17 recommendations that he might want to make. In general
18 terms, do you think that there was a problem in the
19 response to the Skripal poisoning that information
20 within all the different organisations that were
21 responding wasn't shared as widely and as fully as it
22 should have been?

23 **A.** So I touch on in my first statement that --
24 I'm going to use hopefully not poor terminology, but
25 I would describe it, in that first sort of ten days, the

85

1 impact on things such as the economy in terms of local
2 businesses, et cetera, and they subsequently became the
3 work of the recovery group which I set out earlier on in
4 this week to try and pick up some of those issues.

5 Before that, what we certainly have in policing is
6 we have something that's called a Community Impact
7 Assessment, sir, and that's looking at actually what is
8 the impact here in the local community and what can we
9 do to try and assess what that is, but also bridge the
10 gap.

11 To give you some practicalities with that, what we
12 were doing through the police Gold Commander was putting
13 in place visibility, things like mobile police stations,
14 we also did joint patrols with local public health
15 officials. We had leaflets made up and we had all of
16 these officers that were on cordons who could actually
17 be not just standing there, but actively providing
18 information to the public. Those sorts of things were
19 the types of things that we tried to do to mitigate the
20 impact of this.

21 **LORD HUGHES:** Right. Was there or was there not --
22 I have absolutely no idea -- any discussion about where
23 the balance lay between warning members of the public on
24 the one hand and reassuring them on the other?

25 **A.** In terms of discussion around that, sir, no,

87

1 responsibility of the local STAC around providing
2 scientific advice meets actually the national advice
3 which was being considered, or national considerations
4 that were considered at SAGE, felt a little bit clunky.
5 You can see me proactively raise that as an issue and
6 certainly over the course of the first weekend, what
7 I looked to do is work with partners from
8 the Home Office to try and bring together something
9 which will try and bridge this gap which ultimately ends
10 up being the HERC.

11 **Q.** Thank you. I would like to move on --

12 **LORD HUGHES:** Just before you leave that topic,
13 Mr Mills. This is something that, for all I know, may
14 be addressed subsequently, but you were there.

15 What was the effect on the public in Salisbury of
16 the events of 4 March?

17 **A.** Significant, sir, at a number of levels.

18 I think, firstly, I would use the word fear around what
19 they were seeing because this was very visual around the
20 number of sites that we had to lock down, the resources
21 that we then needed to lock those down, and then the
22 activity which needed to take place within those in
23 terms of visual CBRN response.

24 I think fear is the first one and then there's
25 probably some wider ones around actually the wider

86

1 but absolutely a consideration. What we also held was
2 a number of public meetings where we had representatives
3 from the emergency services, from Public Health England,
4 from Wiltshire Council, and I sat on a number of those.

5 It is a balance and it also became a balance around
6 scenes as well, when you're shutting scenes down. Every
7 scene that you shut down you have to do on a basis of
8 what's the information and intelligence around a threat
9 because the more scenes that you have -- notwithstanding
10 it wouldn't have stopped us -- the impact on the public
11 at that point in time in terms of the fear factor grows
12 every single time that you take that activity.

13 Back to your point, sir, around balance, absolutely
14 there was a balance in that regard.

15 **LORD HUGHES:** When, after the Amesbury incident,
16 you issued the warning, homely warning to people "If you
17 haven't dropped it, don't pick it up", you have told us
18 that that hadn't been considered before the Amesbury
19 incident; that's right, is it?

20 **A.** That's right, sir.

21 **LORD HUGHES:** It wasn't a question of it having
22 been thought about and decided it might be alarmist, or
23 anything like that?

24 **A.** Certainly not at the local level, sir.
25 I can't account for the national level.

88

1 **LORD HUGHES:** No, right.
 2 After Amesbury, was there any discussion about
 3 the -- any, as it were, the pluses and minuses of giving
 4 that advice, or was it all plus?
 5 **A.** Sorry, could you just reframe that for me?
 6 **LORD HUGHES:** Certainly, yes. When, after
 7 Amesbury, you issued that homely advice, was the
 8 thinking that there was no difficulty about it, it was
 9 obvious, or was there any discussion about possible
 10 pluses and possible minuses in doing it?
 11 **A.** There wasn't a discussion about pluses or
 12 minus, sir. You can see --
 13 **LORD HUGHES:** There was or wasn't?
 14 **A.** There wasn't, sir, no.
 15 **LORD HUGHES:** No, that's what I thought. Thank you
 16 very much.
 17 **MR O'CONNOR:** Thank you. I want, Mr Mills, to move
 18 on to two last issues. They are related. The first is
 19 the question of Wiltshire Police's understanding in sort
 20 of June 2018 of Charlie Rowley's involvement in drugs.
 21 I can do this, I think, by going to your statement
 22 please, the same statement, 6117, and starting on
 23 page 8. I'm just going to direct your attention to
 24 certain paragraphs and ask if they are accurate,
 25 Mr Mills.

89

1 "Between January 2017 and July 2018 ... 17 separate
 2 intelligence reports relating to Charlie Rowley and the
 3 purchase, supply and consumption of controlled class A
 4 drugs, namely heroin and crack cocaine."
 5 Not things that had been established in court, but
 6 intelligence that you had received?
 7 **A.** Yes, that's correct.
 8 **Q.** Thank you. Now, as I said, relatedly I now --
 9 and I think finally -- want to ask you some questions
 10 about the Wiltshire Police response to the Amesbury
 11 event and in particular to Charlie Rowley becoming
 12 unwell. If we can go, please, to page 10 of your
 13 witness statement, we will recall that you were asked
 14 some questions again about this incident by Ms Whitelaw
 15 and she took you up to a certain point in the narrative
 16 and you looked with her at some of the logs that were
 17 created that evening.
 18 **A.** Yes.
 19 **Q.** Again, I will try and go through the witness
 20 statement and summarise the position and then ask you
 21 about them. If we can pick it up at paragraph 37,
 22 please, we see that at 18:58 Wiltshire Police received
 23 a call from the Fire Service asking if it they were
 24 going to attend what appeared to be a HAZMAT incident,
 25 and the police's position was that they weren't being

91

1 Before we do this, we will recall your clear
 2 statement in evidence to Ms Whitelaw that we are talking
 3 about Charlie Rowley. As far as Dawn Sturgess was
 4 concerned, you indicated that the suggestion at the time
 5 that she was a known drugs user was inaccurate and
 6 shouldn't have been made.
 7 **A.** That is correct, sir.
 8 **Q.** But let's now focus on Charlie Rowley and at
 9 paragraph 27 of the witness statement you deal, do you
 10 not, with his criminal record in relation to drugs and
 11 you say he had numerous convictions for possession of
 12 class A and C drugs?
 13 **A.** That's correct, sir.
 14 **Q.** Then at paragraph 28 -- I'm not going to read
 15 it out -- the point made there is that two of the
 16 officers who were, in fact, involved in the events, in
 17 fact both of them will come and give evidence
 18 themselves, in slightly different ways were aware -- had
 19 a background knowledge of Charlie Rowley's involvement
 20 in drugs.
 21 **A.** That's correct, sir.
 22 **Q.** Then if we look down to paragraph 30 you refer
 23 to intelligence reports, in other words not convictions,
 24 but pieces of information that had come into
 25 the police's possession, you say:

90

1 asked to attend at that stage.
 2 **A.** That was our understanding.
 3 **Q.** Then if we look down at paragraph 38, a few
 4 minutes later, at 19:02 hours, police communications
 5 centre received a call from the Ambulance Service. This
 6 was the one about the special job, talking about two
 7 patients displaying excess drooling, sweating,
 8 unresponsive and the Ambulance Service, we see at the
 9 bottom of that paragraph, at that point saying there was
 10 going to be a significant response from them and the
 11 Fire Service?
 12 **A.** That's correct.
 13 **Q.** If we can look over, please, at paragraph 39,
 14 a few minutes after that, so seven minutes after that,
 15 this is 19:09, the Fire Service on this occasion called
 16 again. They are talking about this incident. At that
 17 stage, police attendance was not required, yes?
 18 **A.** That's correct.
 19 **Q.** Then, at paragraph 40, you refer to the fact
 20 that the Force Incident Manager that evening, Inspector
 21 Andy Noble, who we infer was in that headquarters and
 22 was aware of the calls that had been coming in,
 23 undertook a background search, or maybe asked others to
 24 undertake a background search on the address which
 25 revealed recent intelligence relating to drugs connected

92

1 to the occupant of that property, that is Charlie
 2 Rowley. As a result he, that is Inspector Noble,
 3 directed that Police should attend and officers were
 4 dispatched?
 5 **A.** That's correct.
 6 **Q.** Then, I think that may have been as far as you
 7 got with the story with Ms Whitelaw, so let's take it
 8 on, please, to paragraph 41, a few minutes after that,
 9 the Ambulance Service this time made further contact
 10 with the communications centre and stated that the
 11 patients were presenting with similar symptoms to the
 12 Salisbury incident, so for the first time, I think,
 13 raising a concern about nerve agent expressly.
 14 "The Fire Service were now in attendance and were
 15 treating the incident as if there was a suspicious
 16 substance at the location. The Ambulance Service
 17 requested that cordons were put in place and for
 18 a police commander to lead with the fire/ambulance
 19 a JESIP response. The police call handler stated that
 20 this would be added to the log and passed to their
 21 boss ..."
 22 That's Inspector Noble?
 23 **A.** Yes, that's correct.
 24 **Q.** Then we see his response in the next
 25 paragraph:

93

1 I suggest is that really Inspector Noble simply seems to
 2 have countermanded the concerns of the Ambulance Service
 3 and the Fire Brigade without doing any of those things,
 4 he simply formed a view, having read some intelligence
 5 reports, and didn't engage or discuss or really make any
 6 attempt jointly to understand the situation with the
 7 other services involved. Is that fair or not?
 8 **A.** There are elements within the log, the police
 9 log on this, which refers to the summary that we're
 10 talking about. He talks about the use of IOR1, 2, 3 and
 11 safety advice to first responders. He talks about
 12 considering a site survey and then after that
 13 potentially looking at fire undertaking a site survey
 14 and then CBRN tactical advice.
 15 I'm in agreement with you around the application of
 16 the JESIP principles. Really, for me, that's the first
 17 part of what kicked in there with Inspector Noble was,
 18 it was right for him to have a hypothesis --
 19 **LORD HUGHES:** Sorry, say that again? Say that
 20 again, that last bit?
 21 **A.** It was right for him to have a hypothesis
 22 based upon the intelligence which he had read, sir, and
 23 at that point in time we have resources that are going
 24 to the scene that have further information over and
 25 above what we have spoken about to date in the

95

1 "Based on the intelligence, ... Inspector Noble
 2 formed the opinion that this incident was most likely
 3 owing to drugs. [He] noted the apparent nervousness of
 4 the other emergency services but remained of the opinion
 5 that this was drug related and was to be treated as
 6 such."
 7 **A.** Correct.
 8 **Q.** Mr Mills, I'm very well aware that the story
 9 continued and we will be hearing all about it from those
 10 who were involved, DS McKerlie, the officers at the
 11 hospital, Dr Jukes and so on, but I just want to ask you
 12 about this stage of the decision-making process and in
 13 particular Inspector Noble's decision at that point not
 14 to treat this incident as a suspected nerve agent
 15 incident, but simply to instruct that it be treated as
 16 a drugs incident. I want to ask you about the JESIP
 17 principles and if we can go back in your statement,
 18 please, to page 5, you have set them out there.
 19 What I want to suggest to you is that that
 20 decision, which we have just seen by Inspector Noble,
 21 really didn't comply with any of the JESIP principles
 22 because what JESIP requires is first of all co-location,
 23 Inspector Noble took his decision from his headquarters,
 24 communication, coordination, a joint understanding of
 25 the risk and shared situational awareness. What

94

1 chronology. If I deal with the respective elements of
 2 it, so -- and I do deal with this in my supplementary
 3 statement.
 4 The co-location bit for me, that would be at the
 5 scene. It's often called what's referred to as a blue
 6 light huddle. I know we're not going much further than
 7 Inspector Noble here, but what you would have expected
 8 at the scene was this blue light huddle to come together
 9 and that would have been the fire commander on the
 10 scene, it would have been Acting Police Sergeant
 11 McKerlie because he was the most senior one on the scene
 12 at that point, and it would have been the ambulance
 13 commander, and they would have co-located together. So
 14 moving on from that they would have --
 15 **MR O'CONNOR:** Well, just pausing there, if I may.
 16 What your expectation would have been that, when
 17 Sergeant McKerlie arrived at the scene, he would have
 18 sought out the ambulance and fire brigade commanders,
 19 discussed with them, tried to understand their concerns
 20 and attempted to reach a joint decision of the risk.
 21 **A.** Yes, and I'm just briefly going to refer to
 22 what I would call a triangle of considerations in
 23 relation to JESIP. The first one is, as absolutely set
 24 out at 16, those are the main principles of JESIP.
 25 The second, what they call core component, is

96

1 something called METHANE, which I would say that's
2 a descriptive -- I can say what it is, if you wish,
3 sir -- if I perhaps describe it as it's a descriptor
4 early on around shared situational awareness around lots
5 of major incidents. If so, what the type of incident
6 is, number of casualties, types of emergency services
7 that are required. But really, really critical to
8 this -- and I think this is critical throughout
9 everything that you will consider from this point
10 onwards -- is the joint decision-making model.

11 That has five elements which I will briefly run
12 through and it comes back to this
13 co-location/communication element that you consider
14 what's the information and intelligence that we have
15 available? So that would have been from the initial
16 incident in relation to Ms Sturgess, it would have been
17 in relation to what the police were aware of in terms of
18 the drugs intelligence and it would have been the
19 assessment of the commanders from fire and ambulance at
20 the scene and then latterly, as we go through this
21 chronology, what we were hearing from the hospital.

22 For me that was the critical information
23 intelligence which was available to actually jointly
24 come together to consider how do we actually move
25 forward in this circumstance.

97

1 information it has to inform that joint understanding
2 and joint situational awareness. It is only through --
3 many of this guidance around JESIP is brought about from
4 the learning of other major incidences. It is only by
5 having that shared situational awareness that
6 collectively what the guidance says is commanders should
7 come together and agree what steps should actually be
8 taken.

9 **Q.** I'm going to just make one last -- I'm going
10 to ask you one last question because we will hear from
11 the officers who were there and the paramedics about how
12 the situation developed and whether there was that joint
13 discussion or not, but what we know now, with hindsight,
14 is that the paramedics were right --

15 **A.** Yes.

16 **Q.** -- and that this was a nerve agent incident
17 and that, in fact, the police officers who, as we may
18 hear, insisted that it be dealt with as a drugs incident
19 were wrong. We know that, don't we?

20 **A.** Yes, we do, yes.

21 **Q.** We also know that, as a result of that state
22 of affairs, police officers from your force, Wiltshire
23 Police officers, were instructed to and did go into that
24 flat and undertake a search of it and, as we know from
25 the evidence we heard yesterday, that was a flat which

99

1 **MR O'CONNOR:** If, in due course, we hear evidence
2 from the paramedics who had formed their clinical
3 judgment that this was a nerve agent case, if we hear
4 evidence that the police officers who arrived on the
5 scene were dismissive of their concerns, your view would
6 be that that was quite wrong, would it?

7 **A.** What I refer to in my statement -- I think
8 I used the term that the police officers were overly
9 confident -- I don't believe it was wrong for them to
10 have a hypothesis based upon the recent intelligence
11 that they were aware of through the single lens of the
12 Police Service in Wiltshire, that this potentially could
13 have been a drugs-related incident.

14 However, applying JESIP, if we look back at the
15 principles, back to the blue light huddle, they needed
16 to communicate with their fellow first responders to
17 understand what was the other information and
18 intelligence which was available.

19 **Q.** Not just other intelligence that is available,
20 but if a police officer meets a clinician who has
21 reached a clinical judgment in a case, that's something
22 that they are bound to give great weight to, isn't it?

23 **A.** It's certainly a consideration for them but
24 I think it is a two-way process whereby it is also
25 contingent upon the Police Service to share what

98

1 not only contained a bottle of Novichok inside it but
2 had been contaminated in various areas by Novichok, yes?

3 **A.** Absolutely, sir, and --

4 **Q.** In fact, what took place was something just as
5 dangerous, if not more dangerous, than the search of
6 Christie Miller Road four months earlier, except that on
7 that occasion, that recent occasion, the police officers
8 had actually been warned that it was a nerve agent scene
9 but went ahead anyway.

10 **A.** Two elements to that, sir. At the centre of
11 the joint decision-making model is the principle of
12 working together to save lives and reduce harm. That is
13 absolutely why, in terms of that scene element, that
14 co-location, the blue light huddle, was really important
15 that that took place and because we also have to overlay
16 the initial operational response. That talks about 1,
17 2, 3 that I spoke about. Number 2, so what do we have
18 at this point in time? We have two casualties, one in
19 the morning, one in the evening. What the IOR actually
20 says is, based upon that, to proceed with normal
21 protocols but with caution. Again this comes back to
22 the centre of this around the communication element. It
23 is only by the respective commanders having that
24 conversation and communicating that we agree
25 collectively how we should proceed and actually move

100

1 forward.
 2 **Q.** That's what should happen?
 3 **A.** That's what my statement refers to, yes.
 4 **MR O'CONNOR:** Thank you very much, Mr Mills. Thank
 5 you, sir.
 6 **LORD HUGHES:** Mr Mansfield.
 7 **Questioned by MR MANSFIELD**
 8 **MR MANSFIELD:** Good afternoon, officer.
 9 I represent the family of Dawn Sturgess and I want to,
 10 if I may, just some follow up points arising from the
 11 matters you have mentioned.
 12 Can I deal with the last one first as I did with
 13 the last witness. This is for the purposes of the
 14 future. It's one thing to have a hypothesis -- you
 15 mentioned that Police are entitled to have
 16 a hypothesis -- the problem is if that hypothesis
 17 becomes set in concrete and determines a situation, it
 18 can be very dangerous, can't it?
 19 **A.** Well, I would agree, sir.
 20 **Q.** I want to see whether a position that was
 21 faced in here -- if you have a police officer or senior
 22 officers forming a view, a strong view that it is drug
 23 related but you've got two other emergency services
 24 thinking otherwise, particularly as they were certainly
 25 the paramedics, they had been at Salisbury so they knew

101

1 for CBRN one of the first ones -- and it says any of the
 2 emergency services can consider that they are dealing
 3 with a potential CBRN incident and then the IOR should
 4 be put in place. That really should have then led to
 5 everything --
 6 **MR MANSFIELD:** That becomes the priority?
 7 **A.** Yes. Yes.
 8 **Q.** Takes precedence over the other, because there
 9 are risks if you don't do it; is that right?
 10 **A.** Absolutely.
 11 **Q.** Because of cordons, other people, the public
 12 being involved, people going in the flat?
 13 **A.** Yes.
 14 **Q.** If there's a possibility that it's a chemical
 15 incident -- and I'm putting it shortly -- then that
 16 takes precedence from now on, so this situation that
 17 occurred in this case won't occur again.
 18 **A.** Since then we have continued, as you heard
 19 from Mr Darch, across the emergency services and the
 20 Local Resilience Forum, to embed JESIP. Some of the
 21 learning coming out of the learning report was around
 22 further embedding that not only across the emergency
 23 services, but the Local Resilience Forum, but also
 24 across other partner agencies.
 25 We have done a lot of that and again, as Mr Darch

103

1 what it would look like -- if you have a disagreement of
 2 that kind, then you have a discussion. How is this
 3 resolved? In other words, the Police stick to their
 4 view that, in fact, it's drug related and the others
 5 stick to their view; what happens in the protocols for
 6 the future?
 7 **A.** In relation to what we were dealing with at
 8 the time, that was the importance of JESIP, the joint
 9 decision-making model. At this point in time, we were
 10 only dealing with hypotheses because we could have
 11 nothing more than hypotheses at that point, plus the
 12 clinical diagnosis.
 13 **LORD HUGHES:** Yes, but come on, what he is asking
 14 is this: JESIP requires consultation on the spot --
 15 **A.** Yes.
 16 **LORD HUGHES:** -- joint decision-making. What
 17 happens if you have two irreconcilable views?
 18 **A.** Then that comes back to the heart of JESIP.
 19 It's around actually communicating, it's AROUND
 20 commanders being together and using the
 21 information/intelligence. What comes after that is
 22 a threat assessment and also considers what's the powers
 23 and policies in place here?
 24 The key powers and policies that should have been
 25 considered was that under the joint operating principles

102

1 referred to, again looking to embed JESIP. I mean, it's
 2 really the heartbeat of a civil contingencies response,
 3 to embed it such that it becomes second nature to not
 4 only first responders but also commanders.
 5 **Q.** Right, that's one matter. Another matter,
 6 please. It relates to this situation and the use of
 7 intelligence. May I just ask you this: since that day,
 8 has there been a review conducted by Wiltshire Police on
 9 the whole of this incident in relation to the use of
 10 intelligence, its reliability, robust approach, those
 11 sort of questions? Has there been a discussion along
 12 those lines?
 13 **A.** Not that I'm aware of, sir.
 14 **Q.** Why not?
 15 **A.** Because in relation to intelligence and
 16 information in the Police Service, it basically has
 17 a grading structure which is set nationally. So let's
 18 say you get a piece of information or intelligence in,
 19 it's given that grading, and then really the mechanisms
 20 exist in relation to the JDM. Number 1 is information
 21 intelligence. It's to consider what potential
 22 information/intelligence you have, set against what
 23 other information/intelligence is available. So we
 24 haven't undertaken a review. I don't believe there's
 25 a requirement to undertake such a review.

104

1 **Q.** Yes, the question really is whether you have
2 reviewed it in the light of the fact that intelligence
3 can be and was in this case, as far as Dawn is
4 concerned, you have apologised for it, wrong?

5 **A.** The intelligence wasn't wrong. The assessment
6 that it led to was wrong for that first period of time
7 in terms of the response.

8 **Q.** There was no intelligence about Dawn Sturgess,
9 was there?

10 **LORD HUGHES:** He has always said that,
11 Mr Mansfield. There's no question of there being bad
12 intelligence about Dawn. There was intelligence about
13 the house and about Rowley's friends and relations, and
14 a deduction was made that applied to Dawn.

15 **MR MANSFIELD:** The question really is: has a review
16 been made that that is a risky approach to the situation
17 where the officers concerned are not medics?

18 **A.** No, there hasn't, sir. They are not medics
19 and officers every single day we happily now have to
20 consider information/intelligence to help inform
21 a response.

22 **Q.** Yes, I understand. The position now -- and
23 I'm going to ask this as a general question -- are
24 Wiltshire Police officers being trained and informed
25 about the presentation and treatment of Novichok cases?

105

1 **MR MANSFIELD:** Does it follow from your answer that
2 you yourself have not been trained or informed about the
3 presentation and treatment of Novichok cases?

4 **A.** Through my lived experience I'm aware of what
5 that looks like, but in relation to specifically have
6 I had anything that has come centrally from the national
7 CBRN centre as a -- not only as a police commander but
8 also a CBRN Gold Commander, no, I have not.

9 **Q.** A different topic, but it relates further
10 back, as it will, within the narrative here. I want to
11 deal with -- you have dealt with it in some detail, I'm
12 not going over it -- the question of discarded Novichok.

13 The simple question is this: during this time, just
14 after, if you can put yourself back into Salisbury just
15 after the Skripal attack, did it occur to you
16 personally, as a senior police officer, that there might
17 be more Novichok left over or discarded or however you
18 describe it?

19 **A.** In relation to my role in the SCG and my work
20 with the STAC, no, it didn't. Yes, was it always there
21 in terms of a potential risk at the back of my mind when
22 you go through the search activity --

23 **Q.** Yes, but --

24 **A.** -- and when you don't find it, then clearly it
25 is a risk -- I guess two hypotheses again: they have

107

1 **A.** No, they're not, sir.

2 **Q.** Whose decision is that?

3 **A.** I will return to my evidence earlier. If we
4 look at the structure of policing nationally, we have
5 the national CBRN centre that sits across the Police
6 Service, the Ambulance Service and Fire Service. Part
7 of the review, or the various reviews that took place,
8 was for the CBRN centre to consider whether or not there
9 was a requirement for any specific further information,
10 further to the learning coming out of this, and as it
11 stands at this moment in time, what is available to
12 the Police Service is still the IOR1, 2, 3 plus steps
13 and also the CBRN joint operating principles. They
14 still exist today.

15 **Q.** Is that matter being reviewed in the light of
16 the MI5 indication last week of what's going to happen
17 on the streets of the United Kingdom? Is that matter
18 being reviewed, that police officers on the frontline
19 need training in these matters?

20 **LORD HUGHES:** That's well beyond this Inquiry,
21 Mr Mansfield.

22 **A.** To help the Inquiry --

23 **LORD HUGHES:** No, Mr Mills, you need not answer
24 that.

25 **A.** Okay, thank you, sir.

106

1 either taken it with them or they have discarded it
2 locally or somewhere else in the United Kingdom or --

3 **Q.** You see this is not the same question as being
4 advised, being told, being kept in the loop, getting
5 lots of paperwork. This is you as a straightforward
6 police officer, if you don't mind me putting it that
7 way. Are you -- were you not aware that it would be
8 possible for, therefore, a member of the public to be
9 seriously damaged by this?

10 **A.** Clearly, as I look back in hindsight now,
11 hence why we are sat here today, yes, I have to concede
12 that in relation to the model that I was operating in.
13 In terms of the advice I was getting from the STAC and
14 from Public Health England and above, that was not
15 articulated in terms of a risk in the investigation.

16 **Q.** Yes, looking back now, again with a view to
17 the future, does that surprise you that you didn't and
18 no one else seemed to have broached it with you either?

19 **A.** Looking back now, sir, yes. Yes.

20 **Q.** Sir, there's one document that I would just
21 like -- I have notified of all the documents, but this
22 is one that's just come up this morning, so it's
23 INQ004745, I think it is.

24 **LORD HUGHES:** 4745?

25 **MR MANSFIELD:** Yes. Sorry, they have been

108

1 notified.
 2 **LORD HUGHES:** We've got it, that's all that
 3 matters.
 4 **MR MANSFIELD:** Yes. I just want to ask you about
 5 this document. Would you like a second just to look at
 6 it?
 7 **A.** I have certainly taken in the front of it,
 8 sir.
 9 **Q.** They are minutes of a meeting and you will see
 10 the date is 9 March 2018, so it's between Salisbury and
 11 Amesbury, if I can put it that way.
 12 **LORD HUGHES:** It's very soon after Salisbury,
 13 isn't it, it's within the week?
 14 **MR MANSFIELD:** Yes, within a week.
 15 **LORD HUGHES:** It's Public Health England meeting of
 16 some kind.
 17 **MR MANSFIELD:** It is SRG, which is the response
 18 group. Are you familiar with the SRG?
 19 **A.** No, that's new terminology to me, sir.
 20 **Q.** No. I'm not suggesting it doesn't suggest
 21 that you are there, but were you ever shown any
 22 information according to this -- the point about the
 23 document is it records that the investigation by police
 24 has identified other potential sites for discarded
 25 Novichok.

109

1 imagine -- and I'm surmising -- that this relates to his
 2 investigation and hypotheses around potential
 3 depositions --
 4 **Q.** Yes, can I ask this then. What at that time,
 5 that is between Salisbury and Amesbury, in that period,
 6 with Counter Terrorism being involved, did you have
 7 a close working relationship with them?
 8 **A.** As outlined in my statement, yes, I had
 9 periodic calls with the head of Counter Terrorism
 10 Policing, Senior National Coordinator across both
 11 incidences and we also had somebody from the
 12 investigation who would sit on the SCG meetings and
 13 provide updates relative to what that audience was.
 14 **Q.** Yes, so would you describe it as a close
 15 relationship?
 16 **A.** I would describe it as an effective
 17 relationship, yes, where we had good relations with
 18 them.
 19 **MR MANSFIELD:** Right. Thank you very much.
 20 **LORD HUGHES:** Thank you very much indeed,
 21 Mr Mansfield. Anything else?
 22 Where would you like me to go now, Mr O'Connor?
 23 Somewhere else?
 24 **MR O'CONNOR:** I think lunch would be a good place
 25 for us all to go, sir.

111

1 **LORD HUGHES:** Well, you will have to take us,
 2 Mr Mansfield -- you will have to take him, won't you, to
 3 the bit you want him to look at. Come on.
 4 **MR MANSFIELD:** Page 4, please, at the top.
 5 I wanted him to just see if he had seen the document
 6 first of all.
 7 **LORD HUGHES:** Of course.
 8 **A.** I can confirm I haven't seen the document.
 9 Are you referring to the top box, sir?
 10 **MR MANSFIELD:** Yes. If you look at the top, this
 11 should be page 4:
 12 "Police have identified ..."
 13 The first few words. You see that?
 14 **A.** Yes.
 15 **Q.** From what you are saying you haven't seen this
 16 document before; is that right? The second question is
 17 have you been -- were you informed on around 9 March,
 18 10 March, somewhere in that region, about the fact
 19 the Police had identified potentially, I don't put it
 20 higher than that, sites?
 21 **A.** No, sir. Again, my reading, if I can put some
 22 context around the word "Police" there, that would be
 23 the Counter Terrorism Policing investigation.
 24 I referred earlier to the search strategy. I can't
 25 speak on behalf of Commander Murphy, but I would

110

1 **LORD HUGHES:** All right. How full is this
 2 afternoon?
 3 **MR O'CONNOR:** Full.
 4 **LORD HUGHES:** Pretty full? Then we had better say
 5 2 o'clock, hadn't we? I'm so sorry, 1.45.
 6 **(12.46 pm)**
 7 **(The lunch break)**
 8 **(1.46 pm)**
 9 **LORD HUGHES:** Yes, Ms Whitelaw.
 10 **MS WHITELAW:** Good afternoon, sir.
 11 Good afternoon, my name is Francesca Whitelaw and
 12 I ask questions on behalf of the Inquiry, as I think you
 13 know. Thank you for attending today to give evidence.
 14 **MR MARK ALAN MARRIOTT (affirmed)**
 15 **LORD HUGHES:** Now, Mr Marriott, either stand or sit
 16 as convenient, but most people are sitting.
 17 **Questioned by MS WHITELAW**
 18 **MS WHITELAW:** Could you give us your full name,
 19 please?
 20 **A.** Mark Alan Marriott.
 21 **Q.** You should have in front of you a 13-page
 22 witness statement dated 19 July 2018, the reference for
 23 the transcript is INQ005000.
 24 **A.** Yes, I have that.
 25 **Q.** Have you had an opportunity to read that

112

1 witness statement?
 2 **A.** I have.
 3 **Q.** Are you able to confirm that the contents are
 4 true to the best of your knowledge and belief?
 5 **A.** I can.
 6 **Q.** Thank you. Sir, with your permission, the
 7 whole statement will be adduced in evidence and appear
 8 on the Inquiry's website.
 9 **LORD HUGHES:** Yes.
 10 **MS WHITELAW:** May I, before we start, just make
 11 a similar warning to the one I gave previously for the
 12 benefit of Dawn Sturgess' family in particular. This
 13 evidence is going to be dealing with the emergency
 14 response and the treatment of Dawn. It may well be
 15 distressing for some to listen to or to read and the
 16 opportunity to leave if anybody wants to, or not to
 17 watch the proceedings, is now.
 18 **LORD HUGHES:** You will have the point. Don't feel
 19 obliged to stay unless you want to, but it will have to
 20 be detailed. Right.
 21 **MS WHITELAW:** Mr Marriott, were you, in June 2018,
 22 a paramedic employed by the South Western Ambulance
 23 Service.
 24 **A.** Yes.
 25 **Q.** Is that still your job?

113

1 training and if you do need to refer to your witness
 2 statement, please do.
 3 You say that around seven years prior to the date
 4 of the statement, so about 2011, you completed
 5 a chemical biological radiological and nuclear training
 6 in a location, we don't need to say the name of the
 7 location, but that this consisted of casualty retrieval
 8 from hazardous areas; is that correct?
 9 **A.** That's correct, yes. It was just for
 10 a casualty retrieval programme. It was a volunteer
 11 scheme. They asked for staff if they wanted to be
 12 involved within that retrieval programme and I uptook it
 13 and was shown how to don protective suits and how to
 14 retrieve patients from hot zones and so forth.
 15 **Q.** Did that training include recognition of nerve
 16 agent or other hazardous chemical poisoning symptoms?
 17 **A.** I can't fully remember because it's such
 18 a long time ago what the content of it was, so I can't
 19 remember. It was such a long time ago.
 20 **Q.** When you were working for the South Western
 21 Ambulance Service prior to the time of these events, you
 22 indicated in your witness statement that you completed
 23 local based training updates relating to changes of
 24 procedures, equipment updates, new techniques and
 25 clinical updates. How was that training delivered?

115

1 **A.** Yes.
 2 **Q.** We can perhaps tell from the uniform. At the
 3 time that you made your statement, had you been employed
 4 by the South Western Ambulance Service for about
 5 10 years?
 6 **A.** Approximately, yes, I think it was.
 7 **Q.** Prior to that, I think you had ten years'
 8 experience working as an intensive care paramedic in the
 9 northern territory in Australia; is that correct?
 10 **A.** That's correct, yes.
 11 **Q.** Prior to that, 11 years' experience with the
 12 London Ambulance Service; is that right?
 13 **A.** That's correct, yes.
 14 **Q.** In what role or roles did you work for the
 15 London Ambulance Service?
 16 **A.** Initially, when I joined the London Ambulance
 17 Service, it was prior to there being a paramedic
 18 programme within the UK, so initially I was just
 19 employed as a qualified ambulance person and until the
 20 introduction of the paramedic programme which came about
 21 in the very early 90s, and so I was a very early uptaker
 22 of the UK paramedic programme and I qualified with the
 23 London Ambulance Services and trained with the London
 24 Ambulance Service as a paramedic.
 25 **Q.** Thank you. I'm going to move on to your

114

1 **A.** A lot of it was -- in the early days, it was
 2 face-to-face and we would go up to one of the training
 3 centres and, depending on what the content was, whether
 4 it be a two or three-day course, but a lot of it was
 5 face-to-face. Generally they did send down some
 6 literature which was prior learning so that we could
 7 update ourselves prior to being there what the content
 8 of it would be, and we also have an online -- what we
 9 call ESR, which is electronic staff records, where we
 10 can log on to a training account and it will show us
 11 what areas we need to keep ourselves updated on.
 12 More recently, that has been the way things have
 13 been done. So yes, that's how I update --
 14 **Q.** Do you receive email briefings as well?
 15 **A.** What, sorry?
 16 **Q.** Do you receive email briefings as well?
 17 **A.** Yes, we do periodically, to say that there has
 18 been a clinical or procedure update and it would ask
 19 staff to update themselves with whatever was being
 20 updated, and we do have access to an application which
 21 is on particular types of electronic devices that we can
 22 read the latest updates and keep ourselves updated with
 23 that.
 24 **Q.** Thank you. I think we will come back to that
 25 in a moment. You say in your witness statement that

116

1 since the Salisbury incident you received new guidance.
 2 First of all, by "the Salisbury incident" presumably you
 3 mean the poisoning of the Skripals in March 2018; is
 4 that correct?
 5 **A.** Yes, I believe that after the Salisbury
 6 incident that we did receive some information on
 7 station. It would generally come -- if I remember, it
 8 came in a paper type format which was --
 9 **LORD HUGHES:** Sorry, in what kind of format?
 10 **A.** Sorry?
 11 **LORD HUGHES:** You said it came in a particular
 12 format.
 13 **A.** A paper format. A printed paper format.
 14 **LORD HUGHES:** Thank you.
 15 **A.** I think normally what happened is the
 16 particular officers who were on duty at that time, they
 17 would be informed that there was an update. That
 18 officer would then print-out that document and would
 19 place it on the station information table, and it would
 20 generally be a document attached to it that would say:
 21 "All staff please read and update yourselves" and there
 22 was quite often a little document attached to that
 23 where -- with the staff names' members on so they could
 24 sign to say they had received and updated themselves on
 25 that document.

117

1 **A.** Okay:
 2 "I have received new guidance since the previous
 3 incident in Salisbury, and the effects, signs and
 4 symptoms of a Novichok exposure, and the 1-2-3 step
 5 approach to dealing with casualties, this is, in basic
 6 terms, when you are dealing with a patient that is
 7 unresponsive, take caution, in the event of two patients
 8 being unresponsive, exercise extreme caution, and where
 9 there are three patients unresponsive, evacuate the area
 10 and seek guidance ..."
 11 So that would be pretty much what I already knew
 12 anyway.
 13 **LORD HUGHES:** What, the 1, 2, 3 mantra? The 1, 2,
 14 3 rule?
 15 **A.** Yes.
 16 **LORD HUGHES:** Yes, well, I think we have heard
 17 that. But what you say there is that you had new
 18 guidance dealing with the 1, 2, 3 rule, but also with
 19 the effects, signs and symptoms of Novichok exposure.
 20 Now, is that -- do you remember getting that or not?
 21 **A.** Yes, I mean, as I say, that's what I would
 22 have known already and I think the document probably
 23 come out to remind staff to be aware of that again.
 24 **MS WHITELAW:** Do you think your memory was probably
 25 better in 2018 than it is now in relation to those

119

1 **MS WHITELAW:** Thank you. Can I ask you
 2 specifically in relation to this new guidance that you
 3 were talking about post Salisbury? First of all, can
 4 you tell us what that guidance broadly was and if you
 5 need to refer to your statement --
 6 **A.** Yes, I'm sorry I can't remember what the
 7 particular document was, but I do remember after the
 8 Salisbury incident that there was an update, and what
 9 the content of it was I cannot remember at this stage,
 10 but I think it probably would have been advising staff
 11 to perhaps --
 12 **Q.** Well, perhaps I can help you. If you've got
 13 your statement in front of you -- have you? Do you want
 14 to just look at it, and page 4. We appreciate you made
 15 this statement some time ago, so just -- do you want to
 16 read the first paragraph to yourself just to refresh
 17 your memory?
 18 **A.** What page, sorry?
 19 **Q.** Page 4 of the statement. There's a page
 20 number at the top right-hand corner and in fact probably
 21 the bottom right-hand corner as well. Just read the
 22 first paragraph to yourself.
 23 **A.** Sorry, what paragraph?
 24 **Q.** The top paragraph. It starts: "I have
 25 received new guidance ..."

118

1 documents?
 2 **A.** Yes, yes.
 3 **LORD HUGHES:** Forgive me, Mr Marriott, have you
 4 just said that everything there is something that you
 5 would have known beforehand in any event?
 6 **A.** Sorry, I didn't quite hear you. Can you say
 7 it again?
 8 **LORD HUGHES:** Yes. Did you just tell us that the
 9 things that were in the guidance were all things that
 10 you knew already?
 11 **A.** Yes.
 12 **LORD HUGHES:** Including the symptoms of Novichok?
 13 **A.** Yes.
 14 **LORD HUGHES:** Where had you got that from
 15 beforehand?
 16 **A.** Well, I knew the signs and symptoms of
 17 organophosphate poisoning and Novichok poisoning which
 18 we would have received -- they may have not called it
 19 Novichok, they may have just said that there will be
 20 a chemical attack, or what type of symptoms somebody
 21 would have got had they have been poisoned by
 22 a particular substance.
 23 **MS WHITELAW:** You think you knew about hazardous
 24 chemical poisoning symptoms --
 25 **A.** Yes.

120

1 Q. -- before March 2018 even?
 2 A. Yes, yes. We would have known -- we would
 3 have had information -- we would have had training to
 4 say, you know, what could happen or what the signs and
 5 symptoms of some of those things would be.
 6 Q. Well, you say perhaps -- if we look at the
 7 next paragraph, there's just two lines in the next
 8 paragraph, where you say:
 9 "I am trained, that with any suspected exposure to
 10 hazardous material, to seek guidance for safety
 11 purposes, it is not specific to Novichok in isolation,
 12 it is relevant to all chemicals."
 13 A. Yes, yes, it would be relevant to all
 14 chemicals because, obviously at the point when
 15 I received that training, Novichok wasn't the word we
 16 were familiar with, but we were aware that there were
 17 particular nerve agents.
 18 Q. But once we get to March 2018, there's an
 19 awareness of Novichok arising out of the Skripal
 20 poisoning, so do you think when you got that guidance
 21 after Salisbury there was specific mention of Novichok?
 22 A. I don't remember thinking that. It's always
 23 in the back of your mind, but ...
 24 Q. So you don't actually remember now --
 25 A. No.

121

1 I was -- yes, I mean, there's always the 1, 2, 3 step
 2 approach, yes, certainly, yes.
 3 Q. In your statement -- and you have also
 4 mentioned it just now -- you say that "Within the past
 5 month", so that was within a month of July 2018:
 6 "... all South Western Ambulance Service have
 7 access to an online mobile phone application, which
 8 essentially gives an aide memoire for clinical
 9 guidelines on various topics, including CBRN ..."
 10 Do you know if you had that at the time of Dawn
 11 Sturgess' poisoning?
 12 A. I think I probably did have it, yes, and
 13 I also think it was available on our electronic patient
 14 care record as well. I believe it was available on
 15 there that we could pull up those guidelines.
 16 Q. Did you have occasion to use it when you
 17 attended Dawn Sturgess?
 18 A. I -- I mean, I -- yes, I used it all the time,
 19 that particular app.
 20 LORD HUGHES: That wasn't the question, I don't
 21 think, Mr Marriott. I think what the lady would like to
 22 know is whether you consulted it when you went to
 23 Muggleton Road.
 24 A. I don't think I did use it when I went to
 25 Muggleton Road, no.

123

1 Q. -- whether it was a specific. Do you remember
 2 now -- we know the Salisbury poisoning were in March,
 3 Dawn Sturgess was poisoned at the end of the June. Do
 4 you recall when in that period you received this new
 5 guidance that you mention in your statement?
 6 A. No, I can't remember.
 7 Q. Do you recall if the guidance you received
 8 after March 2018 included the potential for confusion of
 9 symptoms between drug overdose and nerve agent
 10 poisoning?
 11 A. No, I don't remember.
 12 Q. Do you remember guidance identifying how you
 13 should treat suspected nerve agent poisoning?
 14 A. Yes.
 15 Q. Was that specific to Novichok after
 16 March 2018?
 17 A. Well, I would say not specifically Novichok,
 18 but any nerve agent or organophosphate poisoning. Had
 19 I have attended a patient who were presenting with those
 20 symptoms, I would probably have been alerted that there
 21 was potential for a poisoning.
 22 Q. When you say you knew how to treat it, are you
 23 referring there to the 1, 2, 3 step approach or
 24 something else?
 25 A. Yes, yes, I would do, yes. I mean, if

122

1 MS WHITELAW: I'm going to bring up on screen
 2 INQ00623 please. Sorry 000623. A document which we saw
 3 this morning. Were you watching the evidence this
 4 morning?
 5 A. I was.
 6 Q. So you will have seen this. This is a South
 7 Western Ambulance Service medicines protocol. Page 1,
 8 it says 5 January 2017 is the issue date. Were you
 9 aware of this protocol prior to June 2018?
 10 A. Yes.
 11 Q. If we look at the clinical situation, again we
 12 have seen that this morning, it sets out a number of
 13 symptoms there. Can you see that on the screen in front
 14 of you?
 15 A. I have only got page 1 at the moment.
 16 Q. Yes, page 1. We will then go over to page 2.
 17 Can you see page 2? Are those symptoms that you were
 18 aware of in June 2018?
 19 A. Yes.
 20 Q. If we go to page 5, please, if we could make
 21 the bottom step 1, 2, 3, bigger.
 22 LORD HUGHES: What number is this one, Ms Whitelaw?
 23 MS WHITELAW: This is 000623.
 24 LORD HUGHES: This is still 623, is it?
 25 MS WHITELAW: Yes, it is just page 5 of that

124

1 document.
 2 **LORD HUGHES:** I do beg your pardon.
 3 **MS WHITELAW:** Is that the step 1, 2, 3 that you
 4 were referring to previously?
 5 **A.** It is.
 6 **Q.** If we could make that smaller again and the
 7 DuoDote auto-injector, were you aware of that as well
 8 in June 2018?
 9 **A.** Yes, it's something that we carry on the
 10 vehicles.
 11 **LORD HUGHES:** Sorry? What did you say?
 12 **A.** It's something we carry on the --
 13 **LORD HUGHES:** You had them on the vehicles?
 14 **A.** Yes, we carry more than one. I think there's
 15 four on the ambulances we carry.
 16 **MS WHITELAW:** Thank you. We can take that down
 17 now, please. We're now going to move to what happened
 18 on 30 June. You deal with this in your statement from
 19 page 4. If you need to refer to it, please do.
 20 What shift were you working on Saturday, 30 June?
 21 **A.** I believe it was 06:00 to 18:00 day shift.
 22 **Q.** What vehicle, what type of vehicle were you
 23 scheduled to work in?
 24 **A.** It was a Skoda Scout RRV. I believe the
 25 number was -- our call sign was 303.

125

1 days called a Panasonic Toughbook and it had a handle on
 2 and it was very similar to a mobile tablet/laptop
 3 which we would carry in onto a call, where we would
 4 enter all the electronic patient care report on.
 5 **Q.** Thank you. You were on shift 6 until 6. Was
 6 the call to Muggleton Road your first call of the day?
 7 **A.** I believe it was. It was an unusually quiet
 8 day, so I think that was my first call of the day.
 9 **Q.** Thank you. Could we go to INQ000653 please.
 10 Do you recognise this as the call log?
 11 **A.** I'm not familiar with call logs because
 12 I don't really ever see these, but I have only seen it
 13 very briefly in a printed format. There's lots of
 14 numbers and things on there. I'm not completely
 15 familiar how it flows.
 16 **LORD HUGHES:** This is back at HQ, is it, somewhere;
 17 is that right?
 18 **A.** Yes.
 19 **LORD HUGHES:** Okay.
 20 **MS WHITELAW:** If you could sit slightly forward.
 21 I think the microphone is having some difficulty picking
 22 you up. Thank you very much.
 23 Just a couple -- we tried to decipher -- sir, this
 24 isn't easy to read and for your reference, sir, the
 25 report of Mr Mark Faulkner does give a summary of the

127

1 **Q.** Thank you. I think you said RRV; is that
 2 rapid response vehicle?
 3 **A.** Rapid response vehicle.
 4 **Q.** Was that single crewed?
 5 **A.** It was, it was just myself.
 6 **LORD HUGHES:** What is it, a car, Mr Marriott?
 7 **A.** Yes.
 8 **MS WHITELAW:** In your vehicle was there a mobile
 9 data terminal?
 10 **A.** There was.
 11 **Q.** I think you refer to that as MDT?
 12 **A.** Yes.
 13 **Q.** Can you just tell us what that is, please?
 14 **A.** A mobile data terminal is where we receive all
 15 the information of the particular incident we're being
 16 deployed on. It has a screen which is situated in front
 17 of the driver on the dashboard. When a call comes in,
 18 we receive notification on our handheld radio and it
 19 will also simultaneously alert on the screen. Do you
 20 want me to carry on?
 21 **Q.** Well, I'm going to ask you next if there was
 22 an EPCR, an electronic patient care record as well?
 23 **A.** Yes, that's a separate device, that's where
 24 we -- that's located in the back, in the boot space, and
 25 it's something that we -- it's called -- it was in those

126

1 call log, that's INQ005942, page 37. Sir, you may in
 2 slower time find it easier to refer to that, but I will
 3 just try and pick out some key timings.
 4 It looks at though at 10.14, if you look on the
 5 screen in front of you, there was a 999 call. Could you
 6 just look at the screen and just tell me if you agree
 7 with that.
 8 **LORD HUGHES:** I'm sure you're right, Ms Whitelaw,
 9 and I have seen the time cited as 10.14 elsewhere, but
 10 where is it on this document?
 11 **MS WHITELAW:** Yes, sorry, page 1. We're on page 4.
 12 Could we just skip back to page 1 first. My fault.
 13 **LORD HUGHES:** No, no.
 14 **MS WHITELAW:** At the top we see 10.14.25.
 15 **LORD HUGHES:** 10.14 "New call".
 16 **MS WHITELAW:** 999, and that's the date as well.
 17 Then if we go to 10.16 -- sorry, I should say
 18 page 4 to get to 10.16 and I'm looking for 10.16.04
 19 "Resource allocation 303". The highlighting is very
 20 helpful for this document, thank you. Do you see that
 21 there? You mentioned your call sign was 303, so does it
 22 look like --
 23 **A.** Yes, I think I'm looking at the right place,
 24 yes, 303 RRV.
 25 **Q.** It looks as if you are allocated there at

128

1 10.16 and then do we also see there, just below that:
 2 "43-year old. Female. Conscious. Breathing.
 3 Caller statement ... fitting."
 4 Then page 5, please, we should see "Crew 1" at the
 5 top, a few lines down, "Marriott Mark". That's your
 6 name. "Qualifications (P)"; does that mean paramedic?
 7 **A.** It would be, yes.
 8 **Q.** Then "Resource 303 - time dispatch MDT ...
 9 10.16.08". Just below that for the -- thank you. A bit
 10 further down:
 11 "RRV SALN 208 10.16 now allocated."
 12 **A.** I think that means Salisbury North. That
 13 would indicate the location where I was at the time.
 14 **Q.** Thank you. Does this suggest that you
 15 initially received the call at about 10.16?
 16 **A.** Yes.
 17 **Q.** In your witness statement, you said it was
 18 about 11.10, but you couldn't be sure without checking
 19 for the log.
 20 **A.** Yeah, I do believe I got the time wrong
 21 because I couldn't remember the time of day, for
 22 whatever reason, but obviously this doesn't lie and this
 23 is the correct information so that was a mistake by me.
 24 **Q.** No, and you do say in your witness statement
 25 you must check the call log to be sure, so that's fine.

129

1 "43-year old female. Conscious. Breathing.
 2 Caller statement ... fitting."
 3 Is that the information you would have received on
 4 your MDT?
 5 **A.** That would initially be the information that
 6 would come on the screen, but that is periodically
 7 updated, so I would expect this being the type of the
 8 call it was, the operator would have continued on the
 9 line with the caller and as more information would be
 10 coming in, they would update us accordingly. So it
 11 would update as more information would come in.
 12 **Q.** Thank you. You say in your witness statement
 13 that you received the call as a category 1 call. That
 14 was a top priority with an immediate response?
 15 **A.** That's correct.
 16 **Q.** Which means life at risk without an immediate
 17 response, does it?
 18 **A.** Yes. It was immediate response.
 19 **Q.** Do you remember if you received any other
 20 information before you attended the call?
 21 **A.** Possibly I may have received some verbal
 22 communication. I do believe possibly I may have been
 23 told that it was a new build and that the location
 24 wasn't completely verified.
 25 **Q.** In your witness statement, you said you

131

1 **A.** Okay.
 2 **Q.** If we could go to page 11, please. I think we
 3 should see 303 on scene at 10.23. It's only a few lines
 4 down. 10.23.35:
 5 "At scene: resource 303 now 199.0 metres from
 6 scene".
 7 Then time arrived at -- a few lines down:
 8 "303 time arrived scene ... 10.23.35".
 9 It looks as though you received the call about
 10 10.16 and you were there by 10.23?
 11 **A.** I think that time is what they call an auto at
 12 scene time, so when you're within a certain distance to
 13 the job, I think it does say there 199.0 metres, it
 14 would automatically put us at scene even though
 15 theoretically we may be, for instance, in the car park.
 16 There may be several flights of stairs or somewhere to
 17 find. So I think it generalises, it just puts us
 18 approximately in that area.
 19 **Q.** Yes, of course. Thank you.
 20 **LORD HUGHES:** It rather looks, Mr Marriott, as if
 21 this log picks up some of the transmissions from what
 22 I think you called your mobile data terminal in the car.
 23 They're linked, are they?
 24 **A.** Yes, they are.
 25 **MS WHITELAW:** We have seen on the call log it said:

130

1 received a call on the radio from your ambulance
 2 control --
 3 **A.** Yes.
 4 **Q.** -- where you were advised the call is believed
 5 to be a query cardiac arrest?
 6 **A.** Yes, so it may well have -- yeah, I think that
 7 is correct, I would have done. As I say, sometimes it
 8 would be verbal and then another time it may just be
 9 a text update.
 10 **Q.** Also in your statement you say when you
 11 received the call you were at one of your designated
 12 standby points in Fountain Way Campus, Wilton Road
 13 Salisbury. Was that about seven miles away from
 14 Muggleton Road? If you don't know, that's fine.
 15 **A.** Yeah, I'll have to take your word for it,
 16 yeah, but it --
 17 **Q.** You say you responded within about 30 seconds
 18 of the call?
 19 **A.** I believe -- when the nature of a category 1
 20 call does come in, yes, we're pretty much up straight
 21 away and out the door as quickly as possible. That's
 22 the whole purpose of being a rapid response vehicle.
 23 **Q.** I think there was a slight delay finding the
 24 property, you indicate in your witness statement,
 25 because of a problem with the sat nav and you asked

132

1 somebody who was outside if they knew where number 9
 2 was. Do you remember that?
 3 **A.** Yes. It is a problem because when a new build
 4 does occur, we don't get the updates -- our mapping
 5 system isn't updated and incidents in the past I have
 6 found I couldn't find properties because it wasn't
 7 mapping. So I've known it take six months before we
 8 actually get the updates on the mapping --
 9 **Q.** Is that better now; you said in the past?
 10 **A.** I think it probably is similar today. Quite
 11 often now we get additional information on what3words we
 12 use and we use Google Maps as well as the SWASFT system
 13 and one may be more ahead than the other, but when
 14 you're working solo, you don't -- you cannot do that
 15 because you're driving, so it can be problematic.
 16 **Q.** Well, we know from the log you at least in
 17 that area 199 metres away by 10.23 and it looks like
 18 that's the time that you also got to the scene. I want
 19 to ask you a few questions about when you first arrived.
 20 You described it in your statement, you have
 21 indicated new build property, appeared to be a one
 22 storey flat.
 23 You said:
 24 "The door was open on my attendance and I could see
 25 the door was open."

133

1 replied "She collapsed". That was the end of the verbal
 2 conversation at that point.
 3 I looked down at the female patient. I noticed she
 4 was cyanosed, that means her skin is very blue which
 5 would indicate a lack of or no blood supply.
 6 **Q.** What was your assessment of her condition at
 7 that point?
 8 **A.** When I looked -- at that point I thought it's
 9 probably -- I noticed she wasn't breathing and, as I say
 10 further in my statement, I would have bent down or
 11 kneeled down besides her and I would have felt for
 12 a pulse. But my initial assessment was that she was in
 13 cardiopulmonary arrest.
 14 **Q.** You said you knelt down and felt for a pulse.
 15 Was that in her neck?
 16 **A.** That's correct. It would have been what we
 17 call her carotid pulse.
 18 **Q.** Was that present or absent?
 19 **A.** It was absent.
 20 **Q.** What did you do next?
 21 **A.** I then commenced what we would call basic life
 22 support because even though I had advanced skills ,
 23 I couldn't give those advanced skills because I had to
 24 focus on just chest compressions and the importance is
 25 just to continually press down on the -- on somebody's

135

1 Is that right?
 2 **A.** That's correct, yes.
 3 **Q.** Could you describe what happened when you
 4 arrived at the front door and you deal with this at
 5 page 6 of your witness statement because I appreciate it
 6 was a long time ago.
 7 **A.** Can I just refer to my statement?
 8 **Q.** Of course you can, at page 6, and it's the
 9 second paragraph, the larger paragraph at the top of the
 10 page.
 11 *(Pause)*
 12 **A.** So as I have indicated here, I collected my
 13 equipment as I arrived at the door and then, as I say,
 14 the door was open. I shouted "Hello". I heard a male
 15 voice say "Up here". I walked up the stairs. I turned
 16 to the right. I didn't -- as I state here, I didn't
 17 smell anything in the air and at the top of the stairs
 18 I turned right. I stood in the hallway looking at the
 19 bathroom and I saw a female patient who was laying
 20 supine on the floor and that means she is on her back,
 21 within the bathroom. Her head was towards the door, the
 22 bathroom door that would have been. There was a male
 23 partner who was in the hallway directly outside the
 24 door. He had what I believe to be a mobile phone in his
 25 hand and then I said to him "What's happened?" and he

134

1 chest, on their sternum, on their heart, approximately
 2 100 times a minute, to restart the circulation and that
 3 is the important -- so that's initially what I started
 4 to do.
 5 **Q.** What else did you do at the same time?
 6 **A.** Say again, sorry?
 7 **Q.** What else did you do? Do you remember making
 8 a request to speak?
 9 **A.** Yes, I would have -- at that point I would
 10 have called for back up, or updated my control and said
 11 words to the effect of "Yes, this is a confirmed cardiac
 12 arrest, I need back up", which I think they would have
 13 automatically sent anyway, and other resources would
 14 have been also advised, like aerial support, advanced
 15 life support.
 16 **Q.** You say in your statement the operator advised
 17 you that a crew would be with you shortly?
 18 **A.** Yes.
 19 **Q.** While you were giving basic life support , what
 20 conversation did you have with the male partner who we
 21 now know to be Charlie?
 22 **A.** Again, I will just refer back to my statement.
 23 **Q.** Yes, of course, page 6, and it's the big
 24 paragraph three paragraphs up from the bottom.
 25 **A.** So:

136

1 "While doing the compressions, I said to the male
2 partner 'Are you the partner?' he replied 'yes'. I said
3 'What happened?' he replied 'She was complaining of
4 a headache, said she was going to have a bath, I heard
5 a noise that sounded like she was gurgling. I went in
6 and found her collapsed in the bathroom, she was foaming
7 at the mouth.' I asked the male partner 'When did she
8 collapse?' he replied 'Ten fifteen minutes ago', he was
9 a bit flustered, he seemed a bit jiddery, [and quite]
10 muddled in himself."

11 He didn't really give me much of a clear history as
12 to what the events were or what the reason was for the
13 cause of the collapse.

14 **Q.** What was your assessment of what he told you
15 and in terms of the description of Dawn Sturgess?

16 **A.** What was -- sorry, say again?

17 **Q.** You said he told you she was complaining of
18 a headache, was going to have a bath and he had heard
19 gurgling and found her collapsed in the bathroom and
20 foaming at the mouth, so that information, what did that
21 tell you, if anything, about her condition or --

22 **A.** My initial thoughts -- yes, I mean, again you
23 go in with an open mind because it could be anything,
24 you don't know what you're going into, so as the
25 information comes in, you make your assessment and at

137

1 can't give me information because I have been to calls
2 before where patients can't tell me anything because of
3 their mental state at that particular time. So that's
4 why I considered that -- I didn't think he was unwell.
5 I just think he was very muddled because of what was
6 going on.

7 **Q.** Did it occur to you he might be under the
8 influence of something or not?

9 **A.** Not at that point, no.

10 **Q.** I think there came a point when you broke away
11 from doing chest compressions; is that right?

12 **A.** Yes.

13 **Q.** What was the next step of the treatment you
14 applied?

15 **A.** Well, I carried on with the -- if I could just
16 refer to my statement, sorry.

17 **Q.** Yes, of course. It's page 7 we're on now at
18 the top.

19 **A.** So I broke away from the chest compressions,
20 as I said, and turned on what we commonly call the shock
21 box, which basically is a very portable defibrillator.
22 Everybody used to just call it a shock box. I exposed
23 the chest. I remember that she had, I think, a very
24 light fitting top on, so I exposed her chest by --
25 I believe I must have cut the dress off and then

139

1 that point I considered that she had a headache, it was
2 acute by the sounds of it, that means it was sudden, she
3 collapsed and lost consciousness and I believe she would
4 have been foaming at the mouth. So my initial thoughts
5 were this was a cerebral incident in terms of a brain
6 injury or something. So I thought maybe she'd had
7 a stroke or something like that which maybe would cause
8 her to lose consciousness, and that cerebral irritation
9 probably would have caused a seizure. That was my
10 initial thought, that I thought this was a cerebral
11 retail incident causing a cardiopulmonary arrest.

12 **Q.** Did you also ask Charlie Rowley, as we now
13 know him to be, the male partner, what her medical
14 history was?

15 **A.** I did but he couldn't tell me.

16 **Q.** Just going back to what you said about Charlie
17 Rowley being a bit flustered and juddery and a bit
18 muddled, did it appear to you that he was unwell in any
19 way at that point?

20 **A.** I had never met Charlie before, I wouldn't
21 know what his normal demeanour was, but no, I think to
22 me I looked at it from the perspective that this was his
23 loved one or his partner who collapsed and I assumed
24 that he was very distressed because of that. And having
25 seen this many a time, I thought perhaps this is why he

138

1 I attached the paddle to her chest, or the pads, the
2 adhesive gel pads to the chest. Then I followed the
3 prompts on the machine that gave me a verbal indication
4 of no shock indicated. This would only occur if there
5 was not a shockable rhythm and in that case there was no
6 shockable rhythm which would generally mean that it was
7 cardiac standstill or what we call asystole; it was just
8 a flat line at that point.

9 I carried on when chest compressions and at some
10 point a little bit later that's when my colleagues
11 arrived.

12 **Q.** Can I just ask you, you said you cut the top
13 dress off. What was she wearing; do you remember?

14 **A.** I think it was just a dress. I don't think
15 she had a bra on. I think it was just -- I think it was
16 just a dress that we removed, yes.

17 **Q.** Do you remember trousers underneath, or not?

18 **A.** She did have some trousers on, yes.

19 **Q.** So there came a point when your colleagues
20 arrived. Was that ambulance colleagues in the first
21 instance?

22 **A.** Yes.

23 **Q.** We won't go back to the log, but we're going
24 to hear some evidence from one of your colleagues, but
25 at 10.33, I think ten minutes later, they arrived. Was

140

1 that Keith Coomber and Glen Davies; do you remember?
 2 **A.** Say again, sorry?
 3 **Q.** Was it Keith Coomber and Glen Davies?
 4 **A.** Yes, it was. Keith and Glen, yeah.
 5 **Q.** You knew both of them, did you?
 6 **A.** Yes, I did.
 7 **Q.** I think they are lead paramedics; is that
 8 correct? Or they were at the time lead paramedics?
 9 **A.** Glen was the lead paramedic.
 10 **Q.** Does that mean any advanced clinical skills?
 11 **A.** No.
 12 **Q.** Is it a management role?
 13 **A.** No, exactly the same, it was purely for
 14 administrative type of duties and things and maybe they
 15 do something like advise new starters and things like
 16 that, but it was really administrative, but clinically
 17 we were both the same level.
 18 **Q.** Thank you. What did you tell them by way of
 19 handover? Do refer to your statement if you need to.
 20 I think we're still on page 7 here, about paragraph 3.
 21 **A.** I gave Keith and Glen a handover of
 22 essentially what had been disclosed to me by the male
 23 partner Charlie and the present clinical symptoms the
 24 female was presenting with, and that is her being in
 25 cardiopulmonary arrest and asystole, meaning a flat

141

1 paragraph -- it's on page 7 still, halfway down.
 2 **A.** Yes, Keith and I were -- yes, completed
 3 standard chest compressions. So what that means is
 4 a ratio of 15 to 2, so Keith would do 15 compressions
 5 and on the 15th compression I would do two inflations
 6 and then Keith would carry on with 15. So that is
 7 a national guideline standard of the ratio that you
 8 should adopt when doing cardiopulmonary resuscitation.
 9 **Q.** I think Keith Coomber inserted a cannula into
 10 Dawn Sturgess' hand; is that correct? Hand/arm it says
 11 in the statement?
 12 **A.** Sorry, what was that you said?
 13 **Q.** Did Keith insert a cannula into her hand/arm?
 14 **A.** Yes, that's right. Keith put a cannula into
 15 Dawn's hand.
 16 **Q.** Did you notice if her hand was sweaty at all?
 17 If you don't remember, do say.
 18 **A.** I don't recall. I mean, it was a very hot
 19 day. Environmentally it was a very hot day and we were
 20 hot. So no, I didn't notice.
 21 **Q.** What was she given in terms of treatment then
 22 and again do refer to the statement if you need to?
 23 **A.** We would then give adrenaline, 1 in 100,000, 1
 24 milligram of adrenaline for every 10,000 mls of saline.
 25 So that is basically what we would give first of all to

143

1 line. So that's what I had told them. At that point,
 2 I didn't know the cause of what the cardiac arrest was.
 3 **Q.** Did Keith Coomber take over the chest
 4 compressions?
 5 **A.** Yes, he did.
 6 **Q.** What did you do then?
 7 **A.** This is when I started doing some airway
 8 maintenance, so this would have involved me tilting
 9 Dawn's head back and lifting her jaw forward so to try
 10 and obtain a patent airway. By patent we mean try and
 11 clear it by stopping any obstruction from the tongue.
 12 Then we have a tube, what we call an i-gel, and
 13 that's lubricated and then put into Dawn's mouth and it
 14 lifts the tongue and enables a patent airway so that we
 15 can then ventilate her.
 16 **Q.** Was she then connected to oxygen?
 17 **A.** Yes, it would be -- well, it would be -- we
 18 would have attached a bag up to that, an oxygen bag, or
 19 not an oxygen bag, but a silicon bag that we would
 20 squeeze. Initially it would be at atmospheric air, but
 21 we would attach an oxygen cylinder which has a reservoir
 22 bag on the back which would then push 100 per cent
 23 oxygen into Dawn.
 24 **Q.** Did you help Keith Coomber complete standard
 25 chest compressions? If you can't recall, it's

142

1 try and reverse the effects of the cardiac arrest.
 2 **Q.** That's part of normal advanced life support;
 3 is that correct?
 4 **A.** Yes, that would be the initial drug of choice
 5 first of all to try and restart a heart and I think
 6 I have also noted here that a saline drip of sodium
 7 chloride was also administered. That would be purely
 8 there to keep a patent intravenous flow so we can keep
 9 referring back to that intravenous access for more drug
 10 therapy.
 11 **Q.** Did there come a stage when the shock box, the
 12 defibrillator, indicated that the patient was shockable?
 13 **A.** Again, I'll just refer to my statement here.
 14 **Q.** Yes, do.
 15 **A.** At this point, I think we had -- looking at my
 16 note -- the shock box indicated via verbal command that
 17 the battery was low and Glen obtained an additional
 18 shock box which was then connected to the pads which
 19 were already on Dawn, so it was just a matter of
 20 swapping them over. Periodically the batteries do
 21 deplete over a period of time.
 22 **Q.** Does it tell you immediately when the battery
 23 is going low? You said a verbal command.
 24 **A.** Yes, there is a verbal command on there.
 25 Because it was an old system, an old type of

144

1 defibrillator, it wasn't always a completely accurate
2 gauge. You would have a LCD display that may say that
3 it was completely full and then it may just deplete very
4 quickly. These devices weren't left on permanent charge
5 at all, they just had batteries in them and periodically
6 they would change, I believe, when the vehicle went for
7 servicing and that. But the vehicle --

8 It would have been checked at the start of the
9 shift when we just turned the shock box on and it would
10 indicate that the battery was full or half, but within
11 a useable level, but, as I say, they weren't completely
12 very accurate, the older devices.

13 **Q.** You say you changed the shock box to
14 a different one that Glen Davies got hold of and then
15 was there a verbal command that the patient was
16 shockable?

17 **A.** Yes, it was. I believe what we -- we had to
18 do to make a heart shockable, it has to fibrillate
19 before we can defibrillate it and the only way to
20 fibrillate the heart is to oxygen it. So that's why we
21 were doing the aggressive chest compressions to get the
22 blood flow going through the heart and that's what we
23 done, along with the adrenaline as well. That would be
24 working to get that flowing through Dawn's blood system
25 because we have to make sure that by doing those

145

1 details from the male partner, Charlie Rowley; is that
2 correct?

3 **A.** Yes, at that point we were happy that we had
4 stabilised Dawn to the level that we could then try and
5 engage with Charlie a little bit more to find out what
6 the lead-up of the events were and why Dawn had
7 collapsed and try and obtain as much history as we
8 could.

9 **Q.** Could you just by reference to the bottom of
10 page 7, the last paragraph and going on to page 8, tell
11 us what it was you asked and found out from Charlie
12 Rowley?

13 **A.** I broke away:
14 "I broke away, and left Glen Davies and Keith One,
15 who continued ALS, I then spoke to the male partner, he
16 was standing in the hall, at the lounge/kitchen area
17 end, I said ['Can you tell me what her name is or her]
18 date of birth [or] any information on why she is like
19 this?'"

20 He did reply her name was Dawn Sturgess and it's
21 a name that I hadn't heard before and I was just trying
22 to get some clarity on how it was spelled.

23 Charlie replied "No, I'm dyslexic, I can't do
24 numbers".

25 "I looked on the window sill and saw a letter, it

147

1 compressions that blood does flow through, and at that
2 point she was shockable and a shock was delivered as per
3 the instructions on the --

4 **Q.** What was the result of that?

5 **A.** We got what we called ROSC, or return of
6 spontaneous circulation. Again, you can have an active
7 heart rate on the machine, but sometimes there's an
8 electrical mechanical dissociation between the two, so
9 you can have an electrical activity, but there won't
10 actually be any physical movement. So I have to make
11 sure that we did actually have a pulse and I felt again
12 for a carotid pulse and I could actually see a pulse as
13 well, I could see a pulsating in Dawn's neck. So I was
14 happy that we had got return of spontaneous circulation.

15 **Q.** You say the monitor attached to the female
16 patient also confirmed sinus rhythm. What does that
17 mean?

18 **A.** Sinus rhythm indicates that the -- the
19 pacemaker site is a sinus pacemaker which is on the top
20 of the heart. So that would indicate that the rhythm
21 there is coming from the top of the heart and working
22 its way down through the middle of the heart to the base
23 of the heart, so it's what we call NSR or normal sinus
24 rhythm.

25 **Q.** I think you then tried to obtain some more

146

1 had a name [on] it, I said to [Charlie 'Is it] Dawn
2 Sturgess? Is that her?' referring to the name on the
3 letter, he replied 'Yes'. I said 'Does [Dawn] have any
4 medical condition?' he replied 'Not as far as I'm aware
5 of.'

6 He said she had some tablets. He pointed to some
7 tablets on the window sill. I can't remember what those
8 tablets were. The conversation lasted about 15 seconds.

9 **Q.** Did you look at what the tablets were at the
10 time?

11 **A.** I can't remember. They may -- they may have
12 been completely irrelevant.

13 **Q.** Did you return to assist the ambulance crew at
14 that point?

15 **A.** Yes. I carried on with the crew and I believe
16 that we lost -- Dawn's pulse stopped again and again we
17 continued with CPR. I checked the machine. More
18 adrenaline was given as per our guidelines and again we
19 got return of spontaneous circulation and that's --
20 yeah, we got return of spontaneous circulation back
21 again.

22 **Q.** Then you deal with in your statement what we
23 have already spoken about, you have already explained
24 the battery -- sorry, no, this was the -- you said you
25 previously replaced your shock box with Glen Davies'

148

1 because of the battery pack and --
 2 **A.** Yes, this --
 3 **Q.** Sorry, go on.
 4 **A.** Glen Davies, he's had his EPCR, electronic
 5 patient care record, and what we call the brick. In
 6 those days we had an electronic patient care -- it was
 7 different on the ambulances as to the cars. If you were
 8 on an ambulance, your electronic patient care record is,
 9 as it says, an electronic patient care record, but it
 10 also doubles as a patient monitoring device for
 11 monitoring their vital signs, which wasn't the greatest
 12 situation because it was very difficult to flick between
 13 the two sometimes. And we had a device what we used to
 14 call "the brick" because it would look like a square
 15 house brick and that connected to the electronic patient
 16 care record via a cable. On the side of this brick we
 17 had a connector, one would be for blood pressure, one
 18 would be for saturations -- oxygen saturations, and we
 19 also had -- we could monitor patient's carbon dioxide
 20 levels as well. So that's what we were referring to
 21 there.
 22 **Q.** So, sorry, let's -- just to be clear about
 23 this point, so now what I think you say in your
 24 statement is that Glen Davies' electronic patient care
 25 record and brick, the communication box between the

149

1 grabbed mine quite quickly, so then we continued to
 2 monitor --
 3 **Q.** What did that tell you in relation to the ECG
 4 monitor?
 5 **A.** It would tell me -- well, I could monitor the
 6 blood pressure, I could monitor the CO2 levels --
 7 **Q.** But in terms of what you actually saw, I think
 8 halfway down your statement you say there was nothing
 9 remarkable on the readings on the ECG; is that right?
 10 **A.** Yes, I think that's right. Let me just refer
 11 to that.
 12 **Q.** Yes, halfway down page 8 --
 13 **A.** Yes, I would have done an ECG.
 14 **Q.** What about Dawn Sturgess' condition you
 15 address there?
 16 **A.** Sorry, say again?
 17 **Q.** You address Dawn Sturgess' condition at that
 18 point, when you say halfway down:
 19 "I got back to airway management ..."
 20 **A.** Yes, so we got back to airway management and
 21 I was bagging Dawn, that means that I was squeezing the
 22 bag that had the oxygen in -- I mean, this would have
 23 been continuous anyway, but we generally do take turns
 24 so we don't get fatigued in doing one particular
 25 treatment continuously. She was nice and pink in colour

151

1 medical monitoring devices and the electronic patient
 2 care record, was faulty, so you had to go and get --
 3 **A.** Yes, yes.
 4 **Q.** So you couldn't monitor the patient's CO2
 5 levels, so you had to go and get another device; is that
 6 correct?
 7 **A.** That's correct, yes.
 8 **Q.** Is that two devices you had to replace, first
 9 of all the defib and then --
 10 **A.** Yeah, because -- because there was only one
 11 ambulance there, there was nowhere else to replace that
 12 device with, so effectively he could do no monitoring
 13 through his electronic patient care record because that
 14 brick wasn't working for whatever reason.
 15 **Q.** But it was a monitoring device rather than
 16 a device delivering treatment.
 17 **A.** Yes, it was a monitoring device. So what
 18 I done at that point, if I just refer to my statement.
 19 **Q.** Yes, it's about four paragraphs down on
 20 page 8.
 21 **A.** Yes, I returned back to my car and took what
 22 we call a life pack 12, which is again a defibrillator,
 23 cardiac defibrillator, and it has the capabilities to do
 24 all the necessary patient monitoring devices on it, so
 25 because Glen's connection had failed, I went down and

150

1 and, as I say, we could see her chest was rising well.
 2 I noticed her right-hand -- my right-hand glove had
 3 split at the top, the thumb, and I had some mucus which
 4 had come from Dawn's mouth onto my hand/glove. This
 5 would have occurred when I was doing some airway
 6 management.
 7 **Q.** Did you change your glove?
 8 **A.** I believe I did.
 9 **Q.** Did you experience any symptoms of being
 10 unwell in the days after treating Dawn Sturgess?
 11 **A.** Myself?
 12 **Q.** Yes.
 13 **A.** Not that I can remember.
 14 **Q.** Thank you. Then I think there next came
 15 a point -- and we will hear subsequent evidence it was
 16 about 11.05 I think -- that critical care paramedics
 17 arrived; is that correct?
 18 **A.** That's correct. The critical care crew
 19 arrived. Again, this consisted of another Keith, which
 20 I referred to as "Keith 2" in my statement, and another
 21 unknown paramedic who I hadn't met before and a female
 22 which I later learned was a -- I believe a critical care
 23 nurse who was there on an observer capacity that
 24 particular day.
 25 **Q.** Did they take over the ROSC care, the return

152

1 of spontaneous circulation?
 2 **A.** Yeah, initially I would have given them
 3 a handover, a clinical handover, and I would have told
 4 them what had occurred or what we thought had occurred
 5 and what we had done to -- what treatment we had done
 6 for Dawn in terms of we had put a IV in, she has had
 7 several shocks, what drugs she had, what airway
 8 maintenance she had and probably what are the baseline
 9 observations in terms of ECG, whether she had blood
 10 pressure, oxygen levels and what happened (*unclear*) we
 11 would have noted which would have been important for
 12 them to know.
 13 **Q.** Yes. When -- were you aware of the critical
 14 care paramedics giving naloxone?
 15 **A.** I think -- I believe they may -- yeah,
 16 possibly. I cannot remember. But I do know that if --
 17 part of our protocol, when we get a patient who is in
 18 cardiopulmonary arrest, we always have to consider
 19 whether there is an opiate possibly. If we don't know,
 20 if we didn't know whether it was an opiate involved or
 21 not, we could give that drug because if there was an
 22 opiate involved, it would -- it would stop the effects
 23 of that opiate. But if there wasn't an opiate involved,
 24 it would have no detrimental effects on the patient.
 25 But I never thought that there was any -- my initial

153

1 whether there was a hospital letter or something, or
 2 even a prescription to see whether there was any
 3 particular medication Dawn was taking.
 4 **Q.** But you didn't find anything?
 5 **A.** I didn't find anything.
 6 **Q.** Did you see any drug paraphernalia?
 7 **A.** No.
 8 **Q.** Were you aware of Charlie Rowley saying
 9 anything to Keith Coomber about Dawn not taking drugs?
 10 **A.** No, I never knew -- I never -- no.
 11 **Q.** Did Charlie Rowley tell you at any point that
 12 Dawn had not taken any drugs?
 13 **A.** No, and I don't think I ever asked that
 14 question either.
 15 **Q.** Just to cover the treatment once the critical
 16 care paramedics had arrived, you said at the end of
 17 page 8 that we connected a ET CO2 probe to check her
 18 oxygen levels checked her blood glucose nothing
 19 remarkable.
 20 And I think you noticed a suction unit being
 21 brought in; is that right?
 22 **A.** I believe so, yes.
 23 **Q.** What's that used for?
 24 **A.** The suction would be to maintain a patent
 25 airway because 90 per cent -- I would say in my

155

1 thoughts were that I always thought this was a cerebral
 2 episode or a neurological episode, and I thought it may
 3 possibly have been a seizure caused by a brain injury or
 4 something.
 5 **Q.** Once the critical care paramedics arrived,
 6 I think you had an opportunity to speak to Charlie
 7 Rowley again and you deal with this at page 9. Halfway
 8 down page 9. What did you ask him at that stage?
 9 **A.** On page 9?
 10 **Q.** The paragraph starting: "I changed my
 11 gloves ..."
 12 **A.** Yes:
 13 "I changed my gloves, at this point there was a lot
 14 of involvement in treating [Dawn], I said to The Male
 15 Partner 'Are there any prescriptions, or hospital
 16 details?' and Charlie replied 'I don't know', I said 'do
 17 you mind if I have a look around for something?' ..."
 18 Because part of our job is trying to investigate,
 19 find out what has occurred.
 20 Again, Charlie didn't reply and he did look
 21 a little bit confused at that time which again I think
 22 possibly may have been down to how he was feeling.
 23 I looked around and I could only see a letter from
 24 Wiltshire Council, but that only gave me her name and
 25 nothing else. Initially, I was looking around to see

154

1 experience 90 per cent of patients who are in
 2 cardiopulmonary arrest have some fluid coming out of
 3 their mouth or their nose.
 4 **Q.** So secretions are common in cardiac arrest
 5 then?
 6 **A.** Yes, yes.
 7 **Q.** Very common if it's 90 per cent.
 8 **A.** It's very common having fluid loss, yes.
 9 **Q.** Do you remember noticing excess secretions in
 10 Dawn's case?
 11 **A.** I do remember fluid coming out of Dawn's
 12 mouth, yes.
 13 **Q.** I think you helped take her on a scoop
 14 stretcher to the ambulance?
 15 **A.** That's right, yes.
 16 **Q.** I think you noticed that she lost control of
 17 her bowels at that point?
 18 **A.** That's correct, yes.
 19 **Q.** I think you suggest she was wearing trousers
 20 at that point?
 21 **A.** Yes.
 22 **Q.** Once she was taken into the ambulance, you
 23 say:
 24 "I had no further contact with her at that point."
 25 So is it right you weren't involved in her care in

156

1 the ambulance?
 2 **A.** Yes, I handed over to the other team, the
 3 critical care team, they took over from there.
 4 **Q.** When you helped to transfer her into the
 5 ambulance, were you aware that she was bradycardic and
 6 hypotensive?
 7 **A.** Sorry, she was?
 8 **Q.** Bradycardic and hypotensive, if I pronounced
 9 that correctly?
 10 **A.** No, I don't think so.
 11 **Q.** Did you notice a white frothy liquid rising in
 12 the i-gel?
 13 **A.** Possibly, but it wouldn't have been abnormal
 14 to have a white frothy type of fluid in an i-gel because
 15 again probably 90 per cent of the cardiac arrests that
 16 we go to would have fluid in an airway. That's the
 17 whole idea of us having a suction unit, to remove that.
 18 **Q.** You have explained that when you first came
 19 you thought it might be a stroke and you thought it was
 20 a brain seizure of some sort and by the time you put her
 21 in the ambulance, what were your thoughts as to what
 22 might have caused the arrest?
 23 **A.** Again, I was still thinking on the basis of --
 24 we didn't know, none of us knew and I think I did say
 25 that it was an unknown cause, but there was nothing with

157

1 a poisoning.
 2 **MS WHITELAW:** Thank you very much. Those are all
 3 my questions. There will be some more questions for
 4 you.
 5 **LORD HUGHES:** Do you have anything, Mr Mansfield?
 6 **MR MANSFIELD:** Yes.
 7 **Questioned by MR MANSFIELD**
 8 Good afternoon. I represent the family of Dawn
 9 Sturgess. Just a couple of questions.
 10 First of all, before you went on this particular
 11 day, were you ever alerted to the fact that Novichok
 12 might still be present in the Salisbury area?
 13 **A.** Not by my ambulance control, but it was always
 14 at the back of my mind being a healthcare professional
 15 and because of events prior to meeting -- attending
 16 Dawn, it was -- anything could be possible, so I was --
 17 I would have been, as I say, maybe a little bit more
 18 guarded, I would consider those things.
 19 **Q.** From what you're saying then there hadn't been
 20 any official training or information about Novichok
 21 before you went, or the presence of it?
 22 **A.** Only the update that we had received after the
 23 Salisbury incident, just to the update that we've got to
 24 remind staff of the procedures of hazardous chemicals.
 25 **Q.** One final question on that and that is: was

159

1 clearly indicating what the cause of it was because
 2 Charlie couldn't give us much information at all, or
 3 couldn't find any medical notes to say that Dawn had
 4 a pre-existing medical condition. My personal thoughts
 5 were again I always thought it was a neurological
 6 episode and I thought, as I say, she possibly could have
 7 had a stroke which could have precipitated a seizure and
 8 also collapse.
 9 **Q.** Did you consider any of her symptoms to be
 10 particularly unusual in the context of cardiac arrest?
 11 **A.** Did I -- say again?
 12 **Q.** Any of her symptoms to be particularly
 13 unusual, given that cardiac arrest obviously unusual,
 14 but in the context of cardiac arrest, anything in her
 15 symptoms that you thought was particularly unusual in
 16 your experience?
 17 **A.** No, there was nothing which was really red
 18 flagging to me at all.
 19 **Q.** It may be obvious from what you have said, but
 20 presumably then you didn't consider that organophosphate
 21 poisoning was a possible cause at all?
 22 **A.** Anything is a possible cause. You know, when
 23 we get on scene it's -- you have to find as much
 24 information as you can and think -- but there was
 25 nothing at that point saying to me that this was

158

1 the issue about a possible crossover or misdiagnosis of
 2 a nerve agent reaction with an overdose of drug, was
 3 that something that you had been discussing at all?
 4 **A.** No, I don't think so.
 5 **Q.** No. One final question altogether and that is
 6 you came to the conclusion, and you maintained that
 7 throughout, that you thought it was a neurological
 8 episode?
 9 **A.** That's correct.
 10 **Q.** Now, was that an instinctive reaction or was
 11 there a feature of this one that you thought led to that
 12 conclusion?
 13 **A.** I think it was a feature because the
 14 information I got from Charlie was that it was acute, it
 15 was sudden, she was complaining of a headache, again
 16 which was acute, and that she had been foaming at the
 17 mouth, so those are factors which can be indicative of
 18 a neurological episode.
 19 **MR MANSFIELD:** All right. Yes, thank you very
 20 much.
 21 **LORD HUGHES:** Thank you, Mr Mansfield.
 22 **MS WHITELAW:** Sir, I don't know if this would be
 23 time for an afternoon break?
 24 **LORD HUGHES:** Yes, it would.
 25 Mr Marriott, we are grateful. Thank you very much

160

1 indeed. There's no need to stay unless you want to and
 2 of course you are free to do so.
 3 3.15, please.
 4 **(2.58 pm)**
 5 **(Short Break)**
 6 **(3.16 pm)**
 7 **LORD HUGHES:** Yes, Ms Pottle.
 8 **MS POTTLE:** Sir, the next witness to be called is
 9 Keith Coomber.
 10 **MR KEITH COOMBER (affirmed)**
 11 **LORD HUGHES:** Thank you, Mr Coomber. Yes, by all
 12 means sit down if that's comfortable.
 13 **Questioned by MS POTTLE**
 14 **MS POTTLE:** Good afternoon, Mr Coomber. My name is
 15 Émilie Pottle and I ask questions on behalf of the
 16 Inquiry. Thank you for attending to give your evidence
 17 this afternoon.
 18 Could you give your full name, please?
 19 **A.** Yes, my name is Keith Coomber.
 20 **Q.** Mr Coomber, you have made two witness
 21 statements in this case, I believe. The first is dated
 22 6 July 2018 and the second is dated 13 July 2018. The
 23 references for those statements are INQ4550 and 4560.
 24 If we can bring up -- yes, 4550 and 4560 on the screen,
 25 you should see that, Mr Coomber, on the screen in front

161

1 **A.** Yes.
 2 **Q.** And you can make amendments that you feel are
 3 necessary, but just before we do that, the second
 4 statement is -- if we can just pull that up -- 4560.
 5 It's just a single page and it just corrects a typo,
 6 confirms that the date is 30 July 2018.
 7 **A.** Mm-hm.
 8 **Q.** Sir, if you are content, could both of those
 9 statements be adduced into evidence?
 10 **LORD HUGHES:** Yes, it is "June" for "July",
 11 isn't it? Yes, of course, both statements.
 12 **MS POTTLE:** Mr Coomber, before I ask you about the
 13 poisoning of Dawn Sturgess and your role, I would just
 14 like to ask you a bit about your qualifications, if
 15 I could. In 2018, when you responded to the call at
 16 Muggleton Road, you were an advanced technician working
 17 for South Western Ambulance Service; is that right?
 18 **A.** That's correct, yes.
 19 **Q.** Can you just tell us in a few words what the
 20 role of an advanced technician is?
 21 **A.** I have just got additional skills than
 22 a normal technician, sort of cannulation.
 23 **Q.** Okay. In relation to a paramedic --
 24 **A.** I'm not registered --
 25 **Q.** What would you say -- pardon me?

163

1 of you.
 2 **A.** Yes.
 3 **Q.** Okay. If we begin with 4550, if we just turn
 4 to the last page, yes, so we can see this is the main
 5 statement, if I can put it that way. It is four pages
 6 long. Do you recognise that statement, Mr Coomber?
 7 **A.** Yes, I do.
 8 **Q.** Have you had a chance to review this
 9 statement --
 10 **A.** Yes.
 11 **Q.** -- before giving your evidence?
 12 **A.** Yes.
 13 **Q.** Is it true to the best of your knowledge and
 14 belief?
 15 **A.** Yes, it is true.
 16 **Q.** Is there one correction you would like to
 17 make?
 18 **A.** No, I would just like to state that I was in
 19 sort of a state of shock at the time of the statement.
 20 **Q.** I see.
 21 **A.** Just through going to a cardiac arrest and
 22 a few days later being told it's a major incident of
 23 Novichok.
 24 **Q.** I see. Well, we will go through the statement
 25 in detail in a moment.

162

1 **A.** I'm not registered.
 2 **Q.** Not registered, okay. So would your level of
 3 training be the same as a paramedic or a bit lower?
 4 **A.** A little bit lower.
 5 **Q.** A bit lower, okay. So would you normally --
 6 we know that on the date in question you were crewed
 7 with Glen Davies who was a paramedic?
 8 **A.** Yes.
 9 **Q.** Would you normally be crewed with a paramedic,
 10 if you --
 11 **A.** Not normally -- well, it changes, whoever --
 12 I've been doing shifts along with ECAs. They even put
 13 technicians on the car as well.
 14 **Q.** Okay, so not always with a paramedic?
 15 **A.** No.
 16 **Q.** How long have you been an advanced technician?
 17 **A.** I have been with the Ambulance Service since
 18 about 2005.
 19 **Q.** So nearly 20 years?
 20 **A.** About 20 years.
 21 **Q.** Yes, okay.
 22 If I can ask you then -- before we move on to the
 23 events in question -- I want to ask you a bit about your
 24 training and guidance that was given to you on
 25 organophosphate poisoning.

164

1 **A.** Mm-hm.
 2 **Q.** We heard this morning from Wayne Darch that
 3 a clinical notice regarding DuoDote auto-injectors was
 4 emailed to all paramedics, he says, prior to the Skripal
 5 poisoning and all clinical staff were asked to
 6 familiarise themselves with it. The clinical notice
 7 itself asks clinicians to look at the medicines protocol
 8 for a DuoDote auto-injectors and if we can just pull up
 9 that medicines protocol now. Thank you very much. For
 10 the transcript that's INQ623.
 11 We have looked at this document twice already
 12 today, but Mr Coomber, could I ask you: do you recognise
 13 that document?
 14 **A.** Yes, I do.
 15 **Q.** Did you see it prior to June 2018?
 16 **A.** Yes.
 17 **Q.** You did, okay. I'm just going to take you
 18 through it in a bit more detail now. So if we look at
 19 page 1, it sets out the clinical diagnosis of nerve
 20 agent poisoning and sets out a number of features,
 21 including bronchorrhea, which is the production of
 22 excess watery sputum. Chronic spasm, which is
 23 difficulties with breathing; is that right?
 24 **A.** Yes.
 25 **Q.** And severe bradycardia, so that's a slow heart

165

1 Here we have quite a clear exposition of the signs
 2 and symptoms of the poisoning, so for breathing, chest
 3 tightness, wheezing, respiratory arrest, bradycardia,
 4 pinpoint pupils, miosis, seizures or unconsciousness,
 5 sweating, fasciculations. Can you help us with what
 6 fasciculations are?
 7 **A.** That I'm not sure.
 8 **Q.** We will hear, sir, from an expert in
 9 pre-hospital care in due course.
 10 Then also finally other nausea, vomiting, faecal
 11 and urinary incontinence are the other signs and
 12 symptoms.
 13 I know that I'm asking you about events that
 14 occurred quite a long time ago, but you recognise the
 15 document. Do you think, before you attended to Dawn
 16 Sturgess at 9 Muggleton Road, you were familiar with the
 17 signs and symptoms of nerve agent and organophosphate
 18 poisoning?
 19 **A.** Yes, because I would have read the notice and
 20 signed for it.
 21 **Q.** You did, okay.
 22 **A.** Yes.
 23 **Q.** I see. Now, I want to ask you about
 24 information received after the Skripals' poisoning but
 25 before the poisoning of Dawn Sturgess. So, you know,

167

1 rate?
 2 **A.** Slow heart rate, yes.
 3 **Q.** Then it says "Other signs may include", and if
 4 we can move on then to page 2, so the other signs are
 5 excess secretions, for example, tears, respiratory
 6 depression and altered level of consciousness and
 7 convulsions.
 8 Then the protocol says that:
 9 "Toxic doses may cause CNS ..."
 10 That's central nervous system; is that right?
 11 **A.** Yes.
 12 **Q.** "... CNS stimulation ..." which can cause, for
 13 example, restlessness and confusion, but that can give
 14 way to depression, so central nervous system depression,
 15 which would cause coma, circulatory and respiratory
 16 failure and death. So if we're considering Dawn
 17 Sturgess' case, she had, we now know, circulatory and
 18 respiratory failure caused by that poisoning.
 19 If I can then ask to move to page 5 of
 20 the protocol, so this is the final page of the protocol
 21 which I think we saw just a moment ago with your
 22 colleague, Mr Marriott, and if we can just focus in on
 23 the bottom of that page, the grid. Yes, sorry, that's
 24 a little too focused, if we can zoom out just a little.
 25 I want both grids, I should have said. Perfect.

166

1 you weren't involved in these events, but of course
 2 in March, Sergei and Yulia Skripal had been poisoned in
 3 Salisbury and we heard this morning from Mr Darch that
 4 some guidance which had been intended for emergency
 5 departments had been emailed through, he says to all
 6 staff, and I just want to show that to you and ask if
 7 you remember seeing it. That is -- the reference is
 8 INQ659. Perfect, thank you very much.
 9 We need not take a long time with this, but it is
 10 a document which sets out a reminder for clinicians for
 11 recognising the signs of organophosphate poisoning, and
 12 it begins on the first page with recognising the release
 13 of the chemical and the step 1, 2, 3 plus triggers.
 14 Just to spend a little time on that, the step 1, 2,
 15 3 plus triggers, those numbers refer, don't they, to the
 16 casualties?
 17 **A.** The number of patients, yes.
 18 **Q.** Number of patients, exactly. So in your case
 19 when you were responding to Dawn Sturgess, you only had
 20 one patient?
 21 **A.** Yes, step 1.
 22 **Q.** Yes, exactly, okay. If you had had three
 23 patients at that address, then this sort of protocol,
 24 the step 1, 2, 3 protocol, would have required you to
 25 seek specialist responders; is that right?

168

1 **A.** Yes, that's right.
 2 **Q.** Okay, but you weren't there obviously when you
 3 were attending to Dawn on her own.
 4 Then the other sort of indicators would be dead
 5 people and animals, unexplained signs of irritation on
 6 the skin and the eyes and the airway, the presence of
 7 hazardous materials and unexplained vapour, mist and
 8 clouds.
 9 Then the clinical symptoms -- they begin on page 1
 10 and if I can take us now to page 3, which just sets out
 11 the acute effect of exposure, and we need not take
 12 a long time because they are the same as the ones that
 13 we saw on the DuoDote protocol. Yes, there we go, so
 14 increased salivation, chest tightness, rhinorrhea.
 15 Rhinorrhea, is that secretions from the nose?
 16 **A.** Yes.
 17 **Q.** Bronchorrhea, bronchospasm, miosis, so the
 18 pupils that are constricted. We also see as the acute
 19 effects you can have hypoxic -- this is the very last
 20 bullet point:
 21 "Late complications ... may result from aspiration
 22 or hypoxic brain injury from early loss of consciousness
 23 and respiratory failure."
 24 Which we know is what happened in the case of
 25 Ms Sturgess.

169

1 **A.** Yes.
 2 **Q.** Partnered with Glen Davies. He was driving.
 3 **A.** Yes.
 4 **Q.** Your ambulance was call sign 312; is that
 5 right?
 6 **A.** That's correct.
 7 **Q.** I'm going to take you now not to the call log,
 8 because it can be a little difficult to make sense of,
 9 for me anyway, but I'm going to take you instead to the
 10 distillation of the call log by the expert, the
 11 pre-hospital expert, Mr Faulkner, and that is INQ5942?
 12 **LORD HUGHES:** 5942?
 13 **MS POTTLE:** Yes, 5942, page 37. It should come up
 14 on your screen in just a moment.
 15 **A.** Yes.
 16 **Q.** You were call sign 312, so we can see here at
 17 10.16, it says:
 18 "Resource call sign 312 ... allocated to incident."
 19 **A.** Yes.
 20 **Q.** Actually at the very top, we can see the call
 21 was received at 10.14, so you were allocated two minutes
 22 later?
 23 **LORD HUGHES:** No, that's -- sorry, 312, yes.
 24 **MS POTTLE:** Yes, so 303 is Mr Marriott, who we just
 25 heard from.

171

1 Okay, so do you recall getting this by email?
 2 **A.** I don't recall it, no.
 3 **LORD HUGHES:** You don't recall having it or don't
 4 recall how you got it?
 5 **A.** As I say, it was six years ago. A lot has
 6 sort of happened in that time, but it would have been on
 7 the table, I would have read it and signed for it.
 8 **LORD HUGHES:** Okay.
 9 **MS POTTLE:** In any event you confirmed that with
 10 the DuoDote protocol you remember that you knew the
 11 signs and symptoms at the time.
 12 **A.** Yeah, the DuoDote that's on the ambulance
 13 along with the card as well.
 14 **Q.** With the card?
 15 **A.** With the card.
 16 **Q.** You could refer to that at any time when you
 17 were out on a call?
 18 **A.** Yes.
 19 **Q.** Great. Then I will move now to the events on
 20 30 June and please refer to your statement if you need
 21 to --
 22 **A.** Yes.
 23 **Q.** -- because it was some time ago. On that
 24 date, you were on duty as part of a double crewed
 25 ambulance?

170

1 **LORD HUGHES:** That's right, yes.
 2 **MS POTTLE:** Actually at the same time you were
 3 allocated to the incident and we can also see at the top
 4 of the page that it was a category 1 call, that's the
 5 highest level of priority; is that right?
 6 **A.** That's correct.
 7 **Q.** At that time, the complaint is given as
 8 "fitting". Then we can move down the page. At 10.23,
 9 it says "Call recorded as cardiac arrest", so it is
 10 still a category 1.
 11 Do you remember on the date in question whether you
 12 were receiving that information as it came through?
 13 **A.** It had initially come through as a fitting,
 14 but en route to Amesbury it went down to a cardiac
 15 arrest.
 16 **Q.** Okay. Did you -- Mr Marriott told us that he
 17 had a mobile data terminal in his RRV. Do you have
 18 a similar set up in the double crewed ambulance?
 19 **A.** Yeah, we have radio plus the MDT.
 20 **Q.** Okay, and then as the information changes,
 21 does that new information come through on the MDT?
 22 **A.** I think that came through via radio --
 23 **Q.** Okay.
 24 **A.** -- to confirm cardiac arrest.
 25 **Q.** That is dispatches from the control room

172

1 keeping you informed of what's happening ; is that right?
 2 **A.** Yes.
 3 **Q.** Okay, I see. If we continue down the page, we
 4 can see at -- it says 10.29:
 5 "Notes added stating 'cardiac arrest confirmed by
 6 RRV'.
 7 That would be Mr Marriott?
 8 **A.** Yes.
 9 **Q.** He confirmed it and then you -- it says your
 10 call sign arrives four minutes later at the scene. Does
 11 that accord with what you remember? You arrived after
 12 Mr Marriott was there?
 13 **A.** Oh, he was first on scene, yes.
 14 **Q.** Okay. Then before we go into a bit more
 15 detail, can I ask, the call log also sets out when the
 16 first set of observations are recorded, when adrenaline
 17 was given and when other medical interventions happened.
 18 How does that information end up on the call log? Are
 19 you in control -- are you in contact with the control
 20 room?
 21 **A.** I don't --
 22 **Q.** -- on the scene or --
 23 **A.** No, that doesn't make no sense to me.
 24 **Q.** If you can't help us with that --
 25 **A.** We just arrived at 10.33, so I can't see any

173

1 actions to help him?
 2 **A.** To get the heart going, cardiac arrest.
 3 **Q.** Did you start bagging her or were you doing
 4 compressions?
 5 **A.** No, I was on the chest.
 6 **Q.** You were on the chest.
 7 **A.** Freeing up for the -- to get the airway.
 8 **Q.** I see. Mr Marriott told us that when he was
 9 on his own he could only do basic life support?
 10 **A.** That's correct.
 11 **Q.** But then, when you arrived, you and Glen, that
 12 it was possible to do advanced life support?
 13 **A.** Yes.
 14 **Q.** Can you just help us with what the difference
 15 is between basic and advanced?
 16 **A.** Basic is applying pressure to the heart, onto
 17 the chest. You're acting as the heart, keeping the
 18 heart going, and also you've got a bag where you're
 19 giving oxygen as well -- well, oxygen as well, yes.
 20 With advance that's giving the drugs.
 21 **Q.** I see, okay. You cannulated Dawn Sturgess,
 22 that's right, isn't it?
 23 **A.** That's correct.
 24 **Q.** Was that to her hand?
 25 **A.** No, into the ACF, up into her arm.

175

1 drugs being given at that time.
 2 **Q.** No, okay. Don't worry, if you can't help us
 3 with the call log, that's -- you must simply tell us
 4 what you yourself saw and what you know about.
 5 **A.** Yes.
 6 **Q.** So then you arrived at the scene. Mark was
 7 already there. Can you just paint the picture for us.
 8 When you arrived at the address we know you went up the
 9 stairs, you went into the bathroom. What did you see at
 10 that stage?
 11 **A.** I went up the stairs, turned right. Mark was
 12 at the head on his knees, doing CPR. He give me a quick
 13 handover. I squeezed through the doorway and I went --
 14 moved her left arm to give me some room. I knelt down
 15 on her left-hand side and commenced with CPR to give
 16 Mark a rest, as per protocol.
 17 **Q.** If I can just pause you there. When you say
 18 he gave you a quick handover, do you remember what he
 19 told you?
 20 **A.** Collapsed, query cause and she was in cardiac
 21 arrest.
 22 **Q.** So you knelt next to her, you moved her arm so
 23 there was space for you?
 24 **A.** Yes.
 25 **Q.** And you started to help him. What were your

174

1 **Q.** I see. Sort of her elbow area?
 2 **A.** Yes, that's correct.
 3 **Q.** Did you notice when you were doing that
 4 whether her skin was sweaty at all?
 5 **A.** No, no.
 6 **LORD HUGHES:** No, you didn't notice or no --
 7 **A.** No, I didn't notice.
 8 **LORD HUGHES:** There's no reason why you should,
 9 I just want to know what the "No" means, that's all.
 10 **A.** Yes.
 11 **MS POTTLE:** Okay. Can we pull up Inquiry reference
 12 655. Mr Coomber, I'm going to take you in a moment to
 13 this document which is -- I believe it's the electronic
 14 patient record.
 15 **A.** Yes.
 16 **Q.** Is that right?
 17 **A.** Yes.
 18 **Q.** If we could -- can you help us, how is this
 19 document completed?
 20 **A.** I didn't do this one, but normally at the top
 21 you just write in explaining what you did, what you have
 22 seen on the scene, and the next one is sort of like
 23 a primary survey --
 24 **Q.** Can we just -- sorry, I know I said page 2,
 25 but can we begin just at page 1, just to help. Yes, so

176

1 this is what you were talking about, I think, the
 2 primary survey.
 3 **A.** Yes, on arrival, with the free text.
 4 **Q.** Can I just ask, before we get into the details
 5 of what's included in the form, because it's called an
 6 electronic patient record, that suggests that it's not
 7 done by hand?
 8 **A.** No, not anymore. It's all electronic now.
 9 **Q.** Yes, exactly. Mr Marriott was, in his
 10 evidence, telling us about an electronic patient record
 11 which was like a sort of tablet?
 12 **A.** Yes.
 13 **Q.** Is this something that's completed that you
 14 type up when you're on the scene, or is there
 15 automatic --
 16 **A.** Depending on the condition of the patient. If
 17 the patient needs all your help, you're concentrating on
 18 the patient and you do the paperwork later.
 19 **Q.** Of course. In Dawn's case, when you were
 20 assisting Dawn, I think the expert notes that there's
 21 some inconsistencies in the record, he hypothesises it's
 22 because you were probably helping Dawn rather than
 23 filling in --
 24 **A.** That's correct, yes.
 25 **Q.** Is that what happened?

177

1 morning --
 2 **A.** Right.
 3 **Q.** -- so I don't think -- I'm not going to
 4 trouble you too much more, Mr Coomber, with this
 5 document, but just to say that we can see here on
 6 examination underneath that box on page 2 they say that
 7 the pupils were sluggish, left size 1mm, right side 1mm,
 8 so that would be miosis; is that right?
 9 **A.** Yes, pinpoint.
 10 **Q.** Yes, so 1mm is quite small?
 11 **A.** Yes.
 12 **Q.** There are some indication of the drugs given,
 13 that's on page 3, and then the treatment. If I can just
 14 ask you then to put that document to one side -- we can
 15 take it down now. If we can get back then to the
 16 medical treatment that you remember giving her, so you
 17 cannulated her to give her some drugs, that would be
 18 part of the advance life support. You had been helping
 19 with compressions. You did eventually achieve
 20 a resumption of spontaneous circulation?
 21 **A.** Yes.
 22 **Q.** That's right, isn't it? Okay. Can you help
 23 us with -- you might not be able to, but with the time
 24 that that happened because the patient record says that
 25 it was about 10.51. Does that sound right to you?

179

1 **A.** Yes.
 2 **Q.** Okay, I see. We had the primary survey here
 3 which says that the presenting condition is cardiac and
 4 it says "OOH cardiac arrest". Can you help us with
 5 that, what does that mean? Is it out of hospital?
 6 **A.** Out of hospital cardiac arrest, cardiac arrest
 7 before ambulance arrival.
 8 **Q.** Okay. Then if we turn to page 2, it says:
 9 "Collapsed in toilet went into arrest. RRV on
 10 scene. B(i)s commenced ..."
 11 What's Bls?
 12 **A.** I think that's meant to be BL, basic life
 13 support.
 14 **Q.** I see:
 15 "... ambulance arrived ... ASU in attendance ..."
 16 Who is ASU?
 17 **A.** That I'm not sure.
 18 **Q.** Then "Extricated on scoop. ALS continued ..."
 19 ALS is advanced life support; is that right?
 20 **A.** That's what -- yeah, as I say, I did not write
 21 this one, so the abbreviations are going to be a bit
 22 different.
 23 **Q.** Of course. It says actually Fred Thompson
 24 completed the EPCR.
 25 Sir, we're going to hear from him tomorrow

178

1 **A.** That's about right, yes.
 2 **Q.** I would ask you now to look at document
 3 INQ5294, page 3. This is a debrief that was conducted
 4 by SWASFT of the incident. It took place -- the debrief
 5 took place shortly after. You attended this debrief; is
 6 that right?
 7 **A.** Yes.
 8 **Q.** Yes, Okay. The incident 12043565, that's the
 9 response to Dawn Sturgess at 9 Muggleton Road.
 10 We can see that they record your ambulance, 312,
 11 was second to arrive on the scene. You enter the
 12 property wearing gloves, and then there's the equipment
 13 that you brought, including the suction kit and the
 14 i-gel unit was placed by Mr Marriott.
 15 Then if we look at the fourth paragraph, it is what
 16 I'm interested in, it says:
 17 "Once [double crewed ambulance 312] were in scene,
 18 advanced life support was commenced. The patient was
 19 cannulated in the left arm. Medicines were administered
 20 via this route. The patient then had a return of
 21 spontaneous circulation. However, after a while the
 22 patient had a VF cardiac arrest. After one shock, the
 23 patient's rhythm went to ..."
 24 How do I pronounce that?
 25 **A.** Asystole.

180

1 Q. So:
2 "... after one shock, the patient's rhythm went to
3 asystole, but after further advanced life support there
4 was a further return of spontaneous circulation."
5 Does that accord with your memory of what happened?
6 A. No, I can't quite remember that. I remember
7 her having one shock and went back into -- she went into
8 ROSC, return of spontaneous circulation.
9 Q. Okay.
10 A. But we had HEMS arrived, critical care. When
11 the critical care arrived, I went down to get the
12 ambulance ready for extrication.
13 Q. I see. So you continued providing care until
14 the critical care team arrived?
15 A. That's correct.
16 Q. I would just like to ask you now about the
17 interactions you had with Ms Sturgess' partner, Charlie
18 Rowley. Do you remember speaking to him about Dawn
19 Sturgess' condition?
20 A. I think that went all through Mark.
21 Q. I see.
22 A. I didn't see much of Mark -- not Mark,
23 Charlie. If I did, it was only for a fleeting few
24 seconds because I was busy on Dawn.
25 Q. I see. Do you recall Charlie Rowley

181

1 ambulance ready.
2 Q. Okay, so you don't remember that?
3 A. No, but suction was used on her in the back of
4 the ambulance, but I don't remember it being used up in
5 the bathroom.
6 Q. Okay. Mr Marriott told us that it's very
7 common for there to be excess secretions. Is that your
8 experience?
9 A. Yes, it's boiling down to sort of fight or
10 flight syndrome. Your body is trying to concentrate on
11 providing energy, blood circulation to the important
12 organs of the body, so you vomit, you lose secretions,
13 faecal matter.
14 Q. So the systems that you would have been aware
15 of when you're treating Dawn Sturgess, the excess
16 secretions, the incontinence of faecal matter, and the
17 miosis, did you consider that those were an unusual
18 constellation of symptoms or not?
19 A. No, no.
20 Q. Can you help us as a working paramedic of
21 20 years' experience now, how -- whether those are
22 symptoms that you would expect to find in somebody who
23 was in cardiac arrest or not?
24 A. Everybody's different, but I have been to
25 cardiac arrests where there's been huge amounts of

183

1 confirming that Dawn Sturgess did not take drugs? Do
2 you recall that?
3 A. I don't recall that, but if I did ask, it was
4 just a rule of elimination because it was just trying to
5 find out why she collapsed.
6 Q. Okay. Did you form a view, while you were
7 treating her, what the cause of her symptoms was?
8 A. Again, I was going down the neurological
9 route.
10 Q. When you say neurological route, what kind of
11 conditions were you considering?
12 A. Sort of -- like Mark said, it's sort of like
13 seizure type, brain injury.
14 Q. Okay. Do you recall noting that she had
15 miosis?
16 A. Yes, pinpoint pupils.
17 Q. And that didn't cause you to think that it
18 could be a drugs overdose?
19 A. It goes through your mind, loads of things are
20 going through your mind all at once and you have just
21 got to eliminate things, hence why we have given
22 naloxone.
23 Q. Do you remember the suction machine being used
24 to remove excess secretions in her airway?
25 A. I might have been downstairs then getting the

182

1 vomiting. With Dawn there was no vomiting. Everybody
2 sort of portrays differently.
3 Q. I see. You mentioned a moment ago that
4 naloxone was given to Dawn.
5 A. Mm-hm.
6 Q. Did you notice whether that had any effect on
7 her?
8 A. I don't know. We were too busy then trying to
9 get her out of the house and into the next level of
10 care.
11 Q. I see. Just help me with this, the naloxone,
12 was that given by you before the critical care team
13 arrived or was that given afterwards?
14 A. I give it as they arrived because I put it
15 past them. I said "Is it all right to give her that?"
16 and they said yes.
17 Q. Okay, I see. You gave that to her for what
18 reason?
19 A. If it was opiate.
20 Q. I see. If it wasn't opiates, was your
21 understanding that there would be any negative
22 consequences for her?
23 A. It's not going to do anything bad, but it will
24 help reverse the causes if it was.
25 Q. Okay, and you didn't notice whether there was

184

1 any impact on her?
 2 **A.** No.
 3 **Q.** Okay. Arrangements were made eventually to
 4 move Dawn onto a scoop stretcher so that she could be
 5 put into the ambulance; that's right, isn't it?
 6 **A.** Yes.
 7 **Q.** What was your role in that part of her care?
 8 **A.** HEMS, the critical care, they took over the
 9 care for Dawn then. I was just assisting with lifting
 10 and assistance in the back of the ambulance.
 11 **Q.** Did you help carry her down the stairs?
 12 **A.** Yes.
 13 **Q.** Then when the ambulance -- when she was put
 14 into the ambulance were you in the back of the ambulance
 15 with her?
 16 **A.** Yes.
 17 **Q.** Did you stay with her until she arrived at
 18 hospital?
 19 **A.** Yes.
 20 **Q.** Okay. When she was in the back of the
 21 ambulance, she was intubated; is that right? Do you
 22 recall?
 23 **A.** Vaguely I can recall, but Fred, he was up at
 24 the head end and I was bandaging the -- because she
 25 started sweating and losing the vasofix for the cannula,

185

1 **Q.** Okay. At that stage at the end, what was your
 2 thinking as to the cause of her symptoms?
 3 **A.** I was still going down a neurological event.
 4 **Q.** I see. Thank you very much. I have no
 5 further questions for you, but there will be some
 6 questions.
 7 **A.** Thank you.
 8 **LORD HUGHES:** Thank you, Ms Pottle. Are there
 9 any -- yes, Mr Mansfield.
 10 **Questioned by MR MANSFIELD**
 11 **MR MANSFIELD:** Good afternoon. I represent the
 12 family of Dawn Sturgess. I just want to ask you about
 13 a document that was on the screen a moment ago. I don't
 14 ask for it to come up again. This is the debrief that
 15 we have just seen.
 16 Can you help on this, that when you get back to the
 17 hospital with Dawn, can you recall how long after your
 18 arrival back at the hospital that the debrief is carried
 19 out and who carries it out?
 20 **A.** No, I can't remember that one.
 21 **Q.** Can you give us an idea of how long after you
 22 returned? Is it something that's done fairly soon?
 23 **A.** It depends on the trauma.
 24 **Q.** You mean how serious it is?
 25 **A.** Yes.

187

1 so I was bandaging the cannula in place.
 2 **Q.** Okay. At that stage, when she was in the back
 3 of the ambulance you noticed that she was sweating?
 4 **A.** Yes.
 5 **Q.** That's why she lost the cannula that you had
 6 put in earlier?
 7 **A.** She didn't lose the cannula, but she was
 8 losing the vasofix.
 9 **Q.** That's the adhesive, is it?
 10 **A.** It's just like a sticky plaster sort of thing.
 11 **Q.** Would it be unusual for somebody to be
 12 sweating after cardiac arrest?
 13 **A.** No, not really.
 14 **Q.** Mr Coomber, I can say that the Inquiry is
 15 going to hear expert evidence from an expert paramedic,
 16 Mr Mark Faulkner, and I can say that he has concluded
 17 that the care given to Dawn by paramedics on that day
 18 was of a reasonable standard and he doesn't criticise
 19 the care provided, but I would like to ask you that by
 20 the time you were in the back of the ambulance and you
 21 noticed the sweating and the miosis, the respiratory
 22 arrest and the cardiac arrest, did you think at that
 23 stage that her symptoms might be caused by
 24 organophosphate poisoning?
 25 **A.** No. No.

186

1 **Q.** Right, well, this is pretty serious, so is the
 2 likelihood that those dealing with Dawn would want to
 3 know from you and obviously anyone else, all of you, the
 4 crew, as much as you could tell them about the
 5 circumstances?
 6 **A.** They will only give us the information as they
 7 receive it back from the hospital.
 8 **LORD HUGHES:** What's the purpose of the debrief,
 9 Mr Coomber, as you understand it?
 10 **A.** It's sort of welfare really, keep you in the
 11 picture, to make sure you're okay and because of the
 12 seriousness of this, it just wanted to put everything
 13 together.
 14 **LORD HUGHES:** Right, and is there always a debrief
 15 when you get back with a patient?
 16 **A.** Not always, no.
 17 **LORD HUGHES:** When there is -- well, was this one
 18 that same -- where are we -- morning, I think, or some
 19 time later in the day?
 20 **A.** This was not -- no, it wasn't the same day.
 21 **LORD HUGHES:** Not the same day?
 22 **A.** No. I think you will find there's a date on
 23 the debrief.
 24 **MR MANSFIELD:** 4th, at 6.30, apparently this one.
 25 **LORD HUGHES:** 4 July?

188

1 **MR MANSFIELD:** Yes.
 2 **LORD HUGHES:** So a few days later.
 3 **MR MANSFIELD:** Yes.
 4 **LORD HUGHES:** Thank you.
 5 **MR MANSFIELD:** Does -- the reason I'm asking you is
 6 obviously information you had could have been important
 7 for the doctors. Does any doctor come and see you , or
 8 consultant come and see you, or registrar come and see
 9 you saying, you know, "What happened?" and so on, to get
 10 information because they're dealing with --
 11 **A.** Again, that would be boiling down to the
 12 person who handed over and I believe it was Fred
 13 Thompson who handed over the patient.
 14 **Q.** Right, so it's part of the handover.
 15 **A.** Yes.
 16 **Q.** Because we saw on the -- again I'm not asking
 17 for that sheet to come back. On that same sheet, the
 18 debrief sheet, that's where it also shows that Charlie
 19 Rowley had been saying and telling people that -- more
 20 than just you, two other people -- that Dawn had not
 21 taken drugs, but can you help any more about that?
 22 **A.** It's just asked for a role of elimination. As
 23 Dawn collapsed, it's just a question asked to find out
 24 why she collapsed.
 25 **MR MANSFIELD:** Yes, I understand. Yes, thank you

1 very much.
 2 **LORD HUGHES:** Thank you, Mr Mansfield.
 3 Mr Coomber, thank you very much for your help.
 4 There's no need to stay unless you wish to. Thank you.
 5 Where do we go from there, Ms Pottle? Is that the
 6 end of the day?
 7 **MS POTTLE:** Yes, that is the end of the witness
 8 testimony for today.
 9 **LORD HUGHES:** Well, we will have to put up with
 10 that as best we can. Tomorrow morning at 10 o'clock
 11 please.
 12 **(3.57 pm)**
 13 **(The Inquiry adjourned until 10.00 am on Friday,**
 14 **18 October 2024)**

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6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

INDEX		PAGE
1	MR WAYNE MARK DARCH (sworn)	1
2	Questioned by MR O'CONNOR	1
3	Questioned by MR MANSFIELD	41
4	DEPUTY CHIEF CONSTABLE PAUL MILLS (still	55
5	under oath)	
6	Questioned by MR O'CONNOR	56
7	Questioned by MR MANSFIELD	101
8	MR MARK ALAN MARRIOTT (affirmed)	112
9	Questioned by MS WHITELAW	112
10	Questioned by MR MANSFIELD	159
11	MR KEITH COOMBER (affirmed)	161
12	Questioned by MS POTTLE	161
13	Questioned by MR MANSFIELD	187
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

LORD HUGHES: [165] 1/3 2/15 6/10 6/15 6/18 6/20 6/25 8/17 9/12 9/15 9/23 11/21 11/24 12/1 17/13 20/13 20/16 20/21 21/4 21/12 21/14 21/17 22/9 22/14 22/16 23/4 23/8 23/11 23/14 23/18 24/8 24/14 24/16 24/18 24/21 26/3 26/7 26/10 26/13 26/17 26/20 26/23 27/6 28/24 29/2 32/21 32/25 33/2 33/18 33/22 34/25 35/5 39/23 40/10 40/12 40/23 41/3 41/14 41/17 44/1 44/5 48/5 48/12 48/22 49/21 49/25 53/3 53/13 53/16 54/3 54/8 54/20 55/1 55/5 55/9 55/11 55/15 55/20 55/25 57/4 57/9 60/5 64/23 65/4 70/23 71/9 77/19 77/21 79/17 79/20 80/12 80/16 86/12 87/21 88/15	88/21 89/1 89/6 89/13 89/15 95/19 101/6 102/13 102/16 105/10 106/20 106/23 108/24 109/2 109/12 109/15 110/1 110/7 111/20 112/1 112/4 112/9 112/15 113/9 113/18 117/9 117/11 117/14 119/13 119/16 120/3 120/8 120/12 120/14 123/20 124/22 124/24 125/2 125/11 125/13 126/6 127/16 127/19 128/8 128/13 128/15 130/20 159/5 160/21 160/24 161/7 161/11 163/10 170/3 170/8 171/12 171/23 172/1 176/6 176/8 187/8 188/8 188/14 188/17 188/21 188/25 189/2 189/4 190/2 190/9 MR MANSFIELD: [39] 40/21 41/1 41/5 41/16 41/18 44/4 44/13 48/11 48/23	49/23 50/5 53/7 53/15 53/19 54/7 54/12 54/23 55/3 55/6 55/10 101/8 103/6 105/15 107/1 108/25 109/4 109/14 109/17 110/4 110/10 111/19 159/6 160/19 187/11 188/24 189/1 189/3 189/5 189/25 MR O'CONNOR: [45] 1/5 1/10 2/16 7/1 9/24 12/3 17/14 21/2 21/7 21/13 21/15 21/18 22/11 22/18 23/19 24/22 26/6 26/8 26/11 26/14 27/10 29/6 32/23 33/1 33/3 33/25 35/3 35/13 55/14 55/21 56/4 57/6 57/10 60/9 65/16 71/10 77/20 77/23 80/24 89/17 96/15 98/1 101/4 111/24 112/3 MS POTTLE: [9] 161/8 161/14 163/12 170/9 171/13 171/24 172/2 176/11 190/7 MS WHITELAW: [20] 112/10 112/18	113/10 113/21 118/1 119/24 120/23 124/1 124/23 124/25 125/3 125/16 126/8 127/20 128/11 128/14 128/16 130/25 159/2 160/22 ' 'Are [2] 137/2 154/15 'Can [1] 147/17 'cardiac [1] 173/5 'do [1] 154/16 'Does [1] 148/3 'I [1] 154/16 'I don't [1] 154/16 'Is [1] 148/1 'Not [1] 148/4 'She [1] 137/3 'Ten [1] 137/8 'What [1] 137/3 'When [1] 137/7 'yes' [2] 137/2 148/3 ' ... [6] 27/19 62/3 82/18 166/12 178/15 181/2 ... after [1] 181/2 ... ambulance [1] 178/15 ... and [1] 27/19 ... CNS [1] 166/12	... is [1] 62/3 ... six [1] 82/18 0 000623 [2] 124/2 124/23 000659 [2] 21/1 21/3 06:00 [1] 125/21 1 1-2-3 [1] 119/4 1.45 [1] 112/5 1.46 pm [1] 112/8 10 [1] 91/12 10 March [6] 23/13 31/3 31/19 34/24 35/9 110/18 10 o'clock [1] 190/10 10 years [1] 114/5 10,000 [1] 143/24 10.00 [2] 1/2 190/13 10.14 [4] 128/4 128/9 128/15 171/21 10.14.25 [1] 128/14 10.16 [7] 128/17 128/18 129/1 129/11 129/15 130/10 171/17 10.16.04 [1] 128/18 10.16.08 [1] 129/9 10.23 [4] 130/3 130/10 133/17 172/8 10.23.35 [2]	130/4 130/8 10.29 [1] 173/4 10.33 [2] 140/25 173/25 10.51 [1] 179/25 100 [1] 136/2 100 per cent [3] 71/17 80/15 142/22 100,000 [1] 143/23 105.1 [1] 16/23 108.2 [1] 22/20 11 [2] 11/18 130/2 11 years' [1] 114/11 11.05 [1] 152/16 11.10 [1] 129/18 11.15 [1] 40/24 11.17 [1] 55/17 11.29 [1] 55/19 11.30 [1] 55/16 12 [1] 150/22 12 March [1] 78/15 12.46 pm [1] 112/6 12043565 [1] 180/8 124 [1] 66/2 125 [5] 66/7 66/22 70/1 75/13 81/12 126 [1] 70/2 13 July 2018 [1] 161/22 15 [4] 143/4 143/4 143/6 148/8 15 hours [1]	27/19 15 March [2] 31/15 32/1 15 October [1] 57/15 15th [1] 143/5 16 [1] 96/24 17 [1] 91/1 17 October 2024 [1] 1/1 18 [3] 16/15 25/18 27/11 18 October 2024 [1] 190/14 182 [1] 67/6 18:00 [1] 125/21 18:58 [1] 91/22 19 April 2018 [1] 51/21 19 July 2018 [1] 112/22 199 metres [1] 133/17 199.0 metres [2] 130/5 130/13 19:02 hours [1] 92/4 19:09 [1] 92/15 1mm [3] 179/7 179/7 179/10 2 2 o'clock [1] 112/5 2.58 pm [1] 161/4 20 [1] 22/19 20 years [2] 164/19 164/20 20 years' [1] 183/21 2005 [1] 164/18 2011 [1]
---	--	--	---	---	---	--

2	28 years [3] 3/9 3/14 4/3 29 [1] 65/24	161/24 162/3 4560 [3] 161/23 161/24 163/4	156/1 156/7 157/15 90s [1] 114/21 999 [4] 3/17 7/15 128/5 128/16	67/19 68/1 68/5 68/8 68/16 68/23 70/12 72/3 73/1 73/2 73/18 73/22 73/25 74/13 74/17 75/25 78/9 81/3 84/9 84/17 84/21 84/23 85/16 87/22 88/22 89/2 89/8 89/9 89/11 90/3 91/10 91/14 91/21 92/6 92/6 92/16 93/13 94/9 94/12 94/16 95/10 95/10 95/11 95/25 99/3 99/11 100/16 100/17 105/8 105/12 105/12 105/13 105/25 107/2 109/4 109/22 110/18 114/4 114/20 115/4 118/3 120/23 129/15 129/18 130/9 132/13 132/17 133/19 137/21 138/16 141/20 148/8 148/23 149/22 150/19 151/14 152/16 155/9 159/20 160/1 163/12 163/14 164/18 164/20 164/23	167/13 167/23 174/4 177/1 177/10 179/25 180/1 181/16 181/18 187/12 188/4 189/21 above [4] 22/24 76/1 95/25 108/14 absence [4] 19/15 31/8 66/10 68/6 absent [2] 135/18 135/19 absolutely [20] 5/25 6/7 18/4 23/10 33/17 34/15 35/24 59/1 76/18 78/17 79/14 81/17 84/24 87/22 88/1 88/13 96/23 100/3 100/13 103/10 accept [2] 38/14 53/19 accepted [1] 8/22 access [5] 10/24 11/17 116/20 123/7 144/9 accessed [1] 10/15 accessing [1] 18/11 accident [3] 5/15 15/19 19/24 accidental [5] 6/4 32/11 32/15 82/15 83/3 accord [2] 173/11 181/5 according [2] 14/1 109/22	accordingly [1] 131/10 account [3] 37/15 88/25 116/10 accurate [3] 89/24 145/1 145/12 accurately [1] 71/13 ACF [1] 175/25 achieve [2] 40/8 179/19 achieving [1] 37/5 acronym [1] 74/18 acronyms [2] 61/10 80/6 across [15] 18/15 24/17 29/11 33/13 42/15 62/22 63/22 64/21 84/14 84/14 103/19 103/22 103/24 106/5 111/10 acting [2] 96/10 175/17 action [6] 28/2 28/23 29/20 34/19 34/23 83/24 actions [8] 31/17 31/19 34/20 34/21 35/1 35/6 73/16 175/1 active [1] 146/6 actively [2] 69/7 87/17 activity [8] 68/11 68/17 79/11 79/17 86/22 88/12 107/22 146/9 actual [1] 68/18	
2011... [1] 115/4 2016 [3] 8/14 8/19 63/25 2017 [3] 8/6 91/1 124/8 2018 [45] 2/24 5/7 8/2 14/4 14/16 16/14 22/13 22/15 25/10 25/13 25/23 28/4 50/7 51/21 56/7 58/7 58/14 59/22 60/9 60/10 60/11 62/8 64/8 70/14 71/21 89/20 91/1 109/10 112/22 113/21 117/3 119/25 121/1 121/18 122/8 122/16 123/5 124/9 124/18 125/8 161/22 161/22 163/6 163/15 165/15 2024 [2] 1/1 190/14 208 [1] 129/11 21 [2] 57/16 57/23 23 [2] 26/9 58/24 24 [1] 64/2 24 hours [1] 83/8 26 [1] 1/20 27 [1] 90/9 27 March [1] 26/13 27 March 2018 [1] 25/23 28 [1] 90/14	3 3.15 [1] 161/3 3.16 pm [1] 161/6 3.57 pm [1] 190/12 30 [2] 90/22 132/17 30 July 2018 [1] 163/6 30 June [3] 125/18 125/20 170/20 303 [8] 125/25 128/19 128/21 128/24 130/3 130/5 130/8 171/24 303 - time [1] 129/8 312 [6] 171/4 171/16 171/18 171/23 180/10 180/17 350-odd [1] 77/11 37 [3] 91/21 128/1 171/13 38 [1] 92/3 39 [1] 92/13	4 4 July [1] 188/25 4 March [3] 35/15 84/1 86/16 40 [1] 92/19 41 [1] 93/8 43 [1] 67/23 43-year [2] 129/2 131/1 4550 [2]	5 5 January 2017 [1] 124/8 50 [1] 75/13 51 [1] 67/6 5942 [2] 171/12 171/13	6 6 July 2018 [1] 161/22 6.30 [1] 188/24 6117 [3] 57/9 65/24 89/22 623 [1] 124/24 655 [1] 176/12 657 [2] 22/8 22/9 659 [4] 21/15 22/9 23/19 24/10 660 [4] 21/16 21/17 23/14 24/10	7 7 October [1] 1/21	9 9 March [4] 16/25 74/7 78/7 110/17 9 March 2018 [1] 109/10 90 per cent [4] 155/25	A abbreviations [1] 178/21 ability [1] 11/11 able [10] 11/11 30/5 37/11 37/20 40/6 45/4 50/11 57/14 113/3 179/23 abnormal [1] 157/13 about [158] 2/11 2/12 2/17 4/20 5/11 5/15 7/2 14/19 16/11 16/17 17/4 21/22 22/6 23/5 23/15 27/11 31/22 34/25 35/1 35/21 35/22 36/3 36/15 36/19 36/22 39/2 39/25 41/23 42/16 43/22 45/10 46/5 46/11 46/15 46/19 48/5 48/7 49/21 49/22 49/23 52/16 52/17 52/19 52/19 53/9 56/5 56/6 56/9 56/14 56/21 63/4 63/13 63/15 63/21 64/25 65/1 65/4 65/17 66/23 67/9 67/12

A	addressing	75/21 78/12	93/8 95/12	107/25	94/14 98/3	142/14
actually [38]	[1] 37/13	78/25 79/6	102/21	108/16	99/16 100/8	151/19
4/17 11/5	adduce [1]	84/15 85/2	107/14	110/21	115/16 122/9	151/20 152/5
15/25 34/25	2/13	86/2 86/2	107/15	119/23 120/7	122/13	153/7 155/25
44/16 44/17	adduced [2]	89/4 89/7	109/12 117/5	124/11 125/6	122/18 160/2	157/16 169/6
51/1 51/6	113/7 163/9	95/11 95/14	118/7 121/21	136/6 136/22	165/20	175/7 182/24
61/18 71/8	adhesive [2]	108/13	122/8 122/15	137/16	167/17	ALAN [3]
73/3 73/9	140/2 186/9	advise [1]	152/10	137/22 141/2	agent/organo	112/14
73/12 73/13	adjourned [1]	141/15	159/22	143/22	phosphate [1]	112/20
73/15 81/4	190/13	advised [5]	167/24	144/13 146/6	23/16	192/10
81/20 84/23	administered	58/13 108/4	173/11 180/5	146/11	agents [5]	alarming [1]
86/2 86/25	[4] 9/11	132/4 136/14	180/21	148/16	35/23 49/22	82/17
87/7 87/16	15/18 144/7	136/16	180/22 181/2	148/16	49/24 50/2	alarmist [1]
97/23 97/24	180/19	advising [2]	181/3 186/12	148/18	121/17	88/22
99/7 100/8	administers	66/4 118/10	187/17	148/21	aggressive	alert [2]
100/19	[1] 7/24	advisor [1]	187/21	150/22	[1] 145/21	58/13 126/19
100/25	administratio	80/7	after March	151/16	ago [12]	alerted [2]
102/19	n [2] 15/20	advisors [3]	[1] 16/14	152/19 154/7	72/13 84/11	122/20
121/24 133/8	68/3	27/4 61/18	after March	154/20	115/18	159/11
146/10	administrativ	65/8	2018 [2]	154/21	115/19	all [85] 2/11
146/11	e [2] 141/14	advisory [4]	16/14 122/8	157/15	118/15 134/6	7/13 8/21
146/12 151/7	141/16	69/18 69/20	afternoon [9]	157/23 158/5	166/21	8/25 9/8 9/15
171/20 172/2	adopt [1]	74/18 75/5	101/8 112/2	158/11	167/14 170/5	9/16 14/6
178/23	143/8	aerial [1]	112/10	160/15 182/8	170/23 184/3	19/3 19/5
acute [5]	adrenaline [5]	136/14	112/11 159/8	187/14	187/13	24/12 24/15
138/2 160/14	143/23	affairs [1]	160/23	189/11	ago' [1] 137/8	24/15 29/23
160/16	143/24	99/22	161/14	189/16	agree [13]	30/10 32/21
169/11	145/23	affect [1]	161/17	against [6]	5/25 6/7	38/18 38/20
169/18	148/18	46/19	187/11	33/1 65/10	14/20 24/5	39/21 40/12
added [4]	173/16	affected [1]	afterwards [2]	67/18 82/14	24/7 46/15	40/16 42/14
17/16 81/4	advance [2]	48/9	30/1 184/13	83/23 104/22	53/23 54/18	42/18 48/7
93/20 173/5	175/20	affirmed [4]	again [73]	agencies [1]	76/17 99/7	49/11 51/3
addition [1]	179/18	112/14	6/22 18/18	103/24	100/24	55/3 61/3
85/1	advanced	161/10	30/13 31/3	agency [4]	101/19 128/6	61/9 65/21
additional [5]	[13] 135/22	192/10	31/8 33/5	25/14 39/9	agreed [6]	67/23 68/15
31/9 72/20	135/23	192/13	35/21 38/19	39/14 69/5	29/23 54/15	68/17 74/5
133/11	136/14	afraid [2]	43/5 47/20	agent [43]	58/11 60/17	74/22 75/4
144/17	141/10 144/2	52/2 52/5	47/22 60/17	5/6 5/12 6/3	76/8 84/7	79/21 81/8
163/21	163/16	after [49]	61/9 61/22	6/6 6/11 7/22	agreement [1]	83/5 85/20
additionally	163/20	16/14 16/14	64/2 67/3	14/10 15/4	95/15	86/13 87/15
[1] 72/6	164/16	17/1 17/1	67/7 67/18	17/4 19/12	ahead [3]	89/4 94/9
address [7]	175/12	23/2 23/6	69/5 71/25	23/16 24/11	4/15 100/9	94/22 108/21
28/23 44/6	175/15	24/9 32/1	78/8 79/1	27/24 28/9	133/13	109/2 110/6
92/24 151/15	178/19	32/19 43/11	79/24 80/6	29/10 30/17	aide [1] 123/8	111/25 112/1
151/17	180/18 181/3	45/8 47/16	82/25 83/5	32/4 32/11	aide memoire	117/2 117/21
168/23 174/8	advice [25]	47/25 50/16	83/13 84/19	32/20 34/5	[1] 123/8	118/3 120/9
addressed [3]	17/3 18/10	51/23 57/2	84/21 91/14	38/11 47/18	aimed [1]	121/12
30/24 76/9	18/12 45/21	66/24 74/7	91/19 92/16	58/14 62/21	27/13	121/13 123/6
86/14	47/13 47/23	77/1 79/5	95/19 95/20	64/11 66/5	air [2] 134/17	123/18
addresses [1]	59/5 64/25	83/11 88/15	100/21	66/11 67/22	142/20	126/14 127/4
44/11	65/11 66/13	89/2 89/6	103/17	68/7 70/20	airway [12]	143/16
	72/2 73/8	92/14 92/14	103/25 104/1	73/19 93/13	142/7 142/10	143/25 144/5

A	165/11 174/7	28/21 62/24	164/17	Andy [1]	87/22 89/2	app [2] 11/10
all... [22]	ALS [3]	105/10	170/12	92/21	89/3 89/9	123/19
145/5 150/9	147/15	107/20	170/25 171/4	animals [3]	94/21 95/3	apparent [1]
150/24 158/2	178/18	121/22 123/1	172/18 178/7	18/20 32/12	95/5 103/1	94/3
158/18	178/19	145/1 153/18	178/15	169/5	106/9 109/21	apparently [1]
158/21 159/2	also [63] 9/20	154/1 158/5	180/10	annex [1]	120/5 121/9	188/24
159/10 160/3	10/23 12/16	159/13	180/17	25/19	122/18	appear [3]
160/19	12/24 14/11	164/14	181/12 183/1	annex A [1]	131/19	32/2 113/7
161/11 165/4	15/7 15/10	188/14	183/4 185/5	25/19	138/18	138/18
165/5 168/5	15/17 16/2	188/16	185/10	annexed [1]	141/10	appeared [2]
176/4 176/9	22/25 28/6	am [8] 1/2	185/13	26/14	142/11	91/24 133/21
177/8 177/17	28/10 31/2	3/24 43/12	185/14	Annually [3]	146/10	applicable [1]
181/20	31/2 37/16	44/4 55/17	185/14	11/23 11/25	147/18 148/3	19/9
182/20	41/12 41/18	55/19 121/9	185/21 186/3	12/1	152/9 153/25	application
184/15 188/3	42/14 49/1	190/13	186/20	another [18]	154/15 155/2	[7] 10/24
allocated [5]	53/19 56/16	ambulance	Ambulance	25/2 30/17	155/6 155/11	14/12 39/6
128/25	61/17 68/10	[84] 2/20 3/8	Service [16]	32/9 42/1	155/12 158/3	39/18 95/15
129/11	69/23 76/24	3/14 3/21	3/8 5/1 16/12	42/1 43/10	158/9 158/12	116/20 123/7
171/18	80/8 82/19	4/17 5/1 5/5	19/16 28/7	43/17 43/20	159/20 170/9	applied [3]
171/21 172/3	83/16 87/9	5/18 7/2 7/6	30/25 33/11	47/7 48/2	170/16	18/15 105/14
allocation [1]	87/14 88/1	7/21 8/21	36/22 84/6	62/25 68/19	173/25 184/6	139/14
128/19	88/5 98/24	9/19 14/18	92/5 92/8	69/2 104/5	184/21 185/1	applying [3]
allow [1]	99/21 100/15	14/23 15/19	93/9 93/16	132/8 150/5	187/9 189/7	48/13 98/14
11/10	102/22	16/4 16/12	95/2 106/6	152/19	189/21	175/16
allows [2]	103/23 104/4	17/17 17/21	164/17	152/20	anybody [1]	appointed [1]
39/11 39/14	106/13 107/8	19/16 24/18	ambulances	answer [15]	113/16	75/3
alluded [2]	111/11 116/8	28/7 30/25	[2] 125/15	5/22 30/8	anymore [1]	appreciate [6]
46/24 63/19	119/18 123/3	31/6 33/11	149/7	40/6 48/12	177/8	41/8 41/11
almost [2]	123/13	36/22 37/8	amendments	50/6 58/4	anyone [1]	52/4 53/24
6/23 21/8	126/19 129/1	38/7 40/1	[1] 163/2	58/15 59/12	188/3	118/14 134/5
along [6]	132/10	84/6 92/5	Amesbury	61/2 61/23	anything [22]	approach [8]
19/6 20/16	133/18	92/8 93/9	[21] 23/2	65/16 67/10	23/5 52/16	18/8 19/13
104/11	136/14	93/16 93/18	23/2 23/9	81/7 106/23	55/8 59/2	67/14 104/10
145/23	138/12 144/6	95/2 96/12	29/7 30/6	107/1	62/3 75/2	105/16 119/5
164/12	144/7 146/16	96/18 97/19	44/10 46/6	anticipated	77/14 88/23	122/23 123/2
170/13	149/10	106/6 113/22	50/14 50/19	[1] 32/17	107/6 111/21	appropriate
already [24]	149/19 158/8	114/4 114/12	53/22 59/23	any [70]	134/17	[3] 17/15
12/25 14/8	167/10	114/15	60/24 79/8	17/23 19/15	137/21	69/13 73/10
37/19 46/24	169/18 172/3	114/16	88/15 88/18	28/1 28/2	137/23 139/2	approximatel
47/10 55/7	173/15	114/19	89/2 89/7	37/7 37/15	155/4 155/5	y [3] 114/6
55/23 55/23	175/18	114/23	91/10 109/11	40/3 40/4	155/9 158/14	130/18 136/1
56/4 59/6	189/18	114/24	111/5 172/14	42/6 43/20	158/22 159/5	April [5]
63/9 66/17	altered [3]	115/21 123/6	amongst [1]	43/24 44/6	159/16	51/21 59/22
70/13 78/16	12/19 13/4	124/7 132/1	45/13	45/21 49/10	184/23	68/11 70/14
81/22 85/14	166/6	140/20	amounts [1]	50/1 54/2	anyway [6]	70/25
119/11	alternative [1]	148/13 149/8	183/25	54/3 58/13	80/17 100/9	April, [1]
119/22	22/3	150/11	analysis [5]	66/3 66/10	119/12	71/21
120/10	although [2]	156/14	32/14 33/6	66/11 66/13	136/13	are [129] 2/6
144/19	1/23 18/23	156/22 157/1	34/14 36/24	66/13 67/21	151/23 171/9	2/8 3/13 7/4
148/23	altogether [2]	157/5 157/21	83/19	68/7 68/15	apologies [1]	7/6 9/6 9/16
148/23	46/12 160/5	159/13	analysts [1]	81/15 81/16	61/9	10/21 11/13
	always [14]	163/17	82/22	84/5 85/16	apologised	12/6 12/7
					[1] 105/4	

A	130/24 141/7	77/12 78/7	arrhythmia	81/19 84/8	46/4	assure [2]
are... [118]	153/8 156/1	78/11 78/14	[1] 13/14	89/24 91/9	aspects [4]	62/5 81/14
12/8 12/9	156/4 159/2	78/15 78/19	arrival [3]	91/20 94/11	17/20 19/8	ASU [2]
12/23 13/11	160/17	78/19 78/25	177/3 178/7	94/16 99/10	27/1 61/2	178/15
17/8 17/20	160/25 161/2	79/14 79/21	187/18	104/7 105/23	aspiration [1]	178/16
18/1 18/10	161/23 163/2	80/10 85/2	arrive [1]	109/4 111/4	169/21	asystole [4]
18/13 21/19	163/8 166/4	86/1 86/18	180/11	112/12	assertion [1]	140/7 141/25
23/14 26/21	167/6 167/11	86/19 86/25	arrived [27]	116/18 118/1	61/24	180/25 181/3
26/24 28/19	169/12	87/25 88/5	37/3 96/17	126/21	assertions [1]	atmospheric
29/6 34/8	169/18	88/8 88/13	98/4 130/7	133/19	54/10	[1] 142/20
35/6 36/25	173/16	95/15 97/4	130/8 133/19	138/12	asserts [1]	atropine [5]
37/8 37/9	173/18	97/4 99/3	134/4 134/13	140/12 154/8	5/16	7/24 8/24
37/16 39/8	173/19	100/22	140/11	161/15	assess [2]	15/17 15/21
39/15 39/20	178/21	102/19	140/20	163/12	42/19 87/9	19/25
40/1 40/14	179/12	102/19	140/25	163/14	assessed [3]	attach [1]
42/13 42/20	182/19	103/21	152/17	164/22	14/22 69/14	142/21
42/21 43/2	183/21 187/8	110/17	152/19 154/5	164/23	71/3	attached [7]
43/14 44/2	188/18	110/22 111/2	155/16	165/12	assessment	34/3 85/6
44/11 44/20	area [10]	115/3 154/17	173/11	166/19	[11] 6/1 6/8	117/20
45/4 48/24	45/23 48/10	154/23	173/25 174/6	167/23 168/6	83/14 87/7	117/22 140/1
49/11 51/19	65/8 76/14	154/25	174/8 175/11	173/15 177/4	97/19 102/22	142/18
53/25 54/16	119/9 130/18	arrangement	178/15	179/14 180/2	105/5 135/6	146/15
55/25 59/3	133/17	s [2] 11/13	181/10	181/16 182/3	135/12	attack [17]
59/19 61/16	147/16	185/3	181/11	186/19	137/14	32/4 32/8
61/25 63/2	159/12 176/1	arrest [36]	181/14	187/12	137/25	32/9 43/11
63/17 64/2	areas [4]	37/2 37/4	184/13	187/14	assessments	47/17 47/25
65/7 70/8	76/9 100/2	37/13 40/2	184/14	asked [22]	[1] 42/18	48/2 60/23
70/16 72/8	115/8 116/11	40/8 132/5	185/17	23/4 28/24	assist [9]	60/23 62/17
73/7 76/8	aren't [1]	135/13	arrives [1]	39/24 40/18	61/18 63/22	66/9 67/8
80/13 81/19	17/8	136/12	173/10	55/7 57/12	64/20 65/12	69/2 69/2
82/2 82/8	argue [1]	138/11	articulated [1]	57/18 64/25	75/8 80/3	70/20 107/15
82/12 82/19	55/1	141/25 142/2	108/15	66/2 75/11	80/7 80/10	120/20
83/1 89/18	arise [2] 42/5	144/1 153/18	artificially [1]	81/10 91/13	148/13	attacks [2]
89/24 90/2	43/5	156/2 156/4	40/12	92/1 92/23	assistance	7/9 68/16
92/16 95/8	arising [3]	157/22	as [242]	115/11	[2] 69/19	attempt [2]
95/23 96/24	51/20 101/10	158/10	aside [1]	132/25 137/7	185/10	50/24 95/6
97/7 98/22	121/19	158/13	68/15	147/11	assistant [2]	attempted [1]
101/15 103/2	arm [6]	158/14	ask [67] 2/10	155/13 165/5	3/16 67/23	96/20
103/9 105/17	143/10	162/21 167/3	5/10 7/1	189/22	assisted [3]	attend [10]
105/18	143/13	172/9 172/15	14/19 16/11	189/23	80/9 80/25	6/5 6/24 51/5
105/23 108/7	174/14	172/24 173/5	27/11 31/22	asking [12]	81/2	51/15 51/17
108/11 109/9	174/22	174/21 175/2	36/2 36/7	4/19 5/22	assisting [3]	65/13 66/13
109/18	175/25	178/4 178/6	36/19 37/24	43/12 52/6	69/18 177/20	91/24 92/1
109/21 110/9	180/19	178/6 178/9	38/20 40/15	54/24 56/11	185/9	93/3
110/15	around [49]	180/22	42/8 45/10	73/6 91/23	assists [1]	attendance
112/16 113/3	14/11 24/3	183/23	46/3 49/6	102/13	50/11	[4] 92/17
113/3 119/6	34/21 45/15	186/12	49/14 52/14	167/13 189/5	assume [2]	93/14 133/24
119/9 122/22	48/10 58/9	186/22	54/13 55/8	189/16	25/25 35/18	178/15
124/17	65/12 69/10	186/22	56/19 57/21	asks [1]	assumed [1]	attended [14]
128/25	69/16 73/9	arrests [2]	63/4 66/23	165/7	138/23	4/18 14/22
130/23	75/1 75/22	157/15	68/8 70/13	aspect [3]	assurance [1]	28/8 37/20
	77/2 77/8	183/25	71/19 75/21	20/7 43/20	45/6	38/7 38/9

A	30/21 31/11	107/14	88/14	17/16 17/21	121/13 129/7	19/20 27/7
attended... [8]	31/13 47/6	107/21	bandaging [2]	21/24 22/7	129/18	30/4 30/13
38/13 74/11	48/20 51/17	108/10	185/24 186/1	23/8 29/11	129/25	36/16 41/23
74/12 122/19	51/19 51/24	108/16	base [1]	29/24 30/14	130/15	43/9 44/16
123/17	52/8 52/11	108/19	146/22	30/18 35/15	130/16 131/5	45/24 46/22
131/20	61/25 62/15	116/24	based [5]	36/6 36/17	131/9 132/5	47/15 47/17
167/15 180/5	70/14 70/17	121/23	94/1 95/22	37/8 37/12	132/8 132/8	47/18 52/15
attending [6]	70/25 71/6	126/24	98/10 100/20	37/20 39/21	133/13	61/1 63/5
6/2 38/24	71/14 72/25	127/16	115/23	40/18 41/3	133/15	67/8 72/4
112/13	76/25 79/4	128/12	baseline [3]	42/10 42/11	133/21	72/24 73/5
159/15	81/17 82/10	134/20	7/12 14/13	43/13 47/3	134/24	83/13 86/19
161/16 169/3	82/12 90/18	136/10	153/8	47/6 47/7	136/17	88/9 94/22
attention [5]	92/22 94/8	136/12	basic [7]	48/9 49/18	136/21	96/11 99/10
20/6 24/24	97/17 98/11	136/22	119/5 135/21	50/11 51/10	137/23	100/15
28/14 28/15	104/13 107/4	138/16	136/19 175/9	53/11 54/16	138/13 139/7	102/10 103/8
89/23	108/7 119/23	140/23 142/9	175/15	54/18 54/21	142/17	103/11
audience [1]	121/16 124/9	142/22 144/9	175/16	57/6 57/14	142/17	104/15
111/13	124/18 125/7	148/20	178/12	58/13 58/21	142/20 144/4	115/17
Australia [1]	148/4 153/13	150/21	basically [5]	59/20 60/1	144/7 145/23	121/14
114/9	155/8 157/5	151/19	6/18 42/9	61/19 62/10	146/10	127/11
authorities	183/14	151/20	104/16	63/2 65/1	149/17	129/21
[1] 48/3	awareness	159/14	139/21	66/14 66/25	149/18	132/25 133/3
authority [1]	[6] 39/13	179/15 181/7	143/25	67/15 67/20	149/22	133/6 133/15
63/15	94/25 97/4	183/3 185/10	basis [7] 8/1	68/3 69/15	155/24	134/5 135/22
auto [4]	99/2 99/5	185/14	36/17 38/15	70/18 71/10	157/19 158/9	135/23
125/7 130/11	121/19	185/20 186/2	62/15 82/8	71/14 71/15	158/12	137/23
165/3 165/8	away [7]	186/20	88/7 157/23	71/16 74/10	158/19 159/3	138/24 139/1
auto-injector	132/13	187/16	bath [2]	75/19 76/1	159/12	139/2 139/5
[1] 125/7	132/21	187/18 188/7	137/4 137/18	76/9 82/8	159/16	144/25
auto-injector	133/17	188/15	bathroom [7]	84/1 84/4	160/17	145/25 149/1
s [2] 165/3	139/10	189/17	134/19	84/5 86/14	160/22 161/8	149/12
165/8	139/19	background	134/21	87/17 88/22	163/9 164/3	149/14
automatic [1]	147/13	[3] 90/19	134/22 137/6	91/24 92/10	164/9 169/4	150/10
177/15	147/14	92/23 92/24	137/19 174/9	93/20 94/5	171/8 173/7	150/10
automatically	B	backing [1]	183/5	94/9 94/15	178/12	150/13
[2] 130/14	back [65]	49/6	batteries [2]	96/4 98/6	178/21 179/8	150/25
136/13	22/18 27/11	bad [2]	144/20 145/5	99/7 99/18	179/17	153/21
available [19]	33/25 43/10	105/11	battery [5]	101/18 103/4	179/23	154/18
11/1 11/9	57/12 62/8	184/23	144/17	105/3 107/17	182/18 183/7	155/25
19/18 29/5	63/12 64/9	bag [7]	144/22	108/7 108/8	184/21 185/4	157/14 158/1
30/24 31/10	65/10 66/22	142/18	145/10	110/11	186/11	159/15
37/7 49/15	69/6 69/15	142/18	148/24 149/1	110/22	186/11	160/13
50/13 50/14	69/25 70/12	142/19	be [176] 1/6	111/24 113/7	186/23 187/5	167/19
56/25 97/15	72/23 73/17	142/19	3/21 4/14	113/13	189/11	169/12
97/23 98/18	73/20 73/22	142/22	4/19 4/21	113/14	bear [3] 22/1	170/23 171/8
98/19 104/23	83/14 85/5	151/22	5/12 5/15	113/20	40/18 40/23	177/5 177/22
106/11	88/13 94/17	175/18	8/25 9/11	115/11 116/4	became [3]	179/24
123/13	97/12 98/14	bagging [2]	10/21 11/2	116/8 117/17	38/6 87/2	181/24 182/4
123/14	98/15 100/21	151/21 175/3	11/11 11/16	117/20	88/5	184/14
aware [43]	102/18	balance [5]	12/8 12/11	119/11	because [81]	185/24
28/7 30/1	107/10	87/23 88/5	13/13 14/17	119/23	3/25 15/13	188/11
		88/5 88/13	14/23 15/10	120/19 121/5	16/7 19/7	189/10

B	96/16 97/15	147/21	155/20	20/18 23/1	145/24 146/1	149/25 179/6
because... [1]	97/16 97/18	152/21	159/14	28/13 35/23	149/17 151/6	boyfriend [1]
189/16	98/13 100/2	159/10	162/22 174/1	40/18 43/22	153/9 155/18	36/13
become [2]	100/8 101/25	159/21	182/23 183/4	44/3 46/5	183/11	bra [1]
52/11 73/4	102/24 104/8	162/11 163/3	belief [3] 2/7	50/2 50/12	blue [9] 39/9	140/15
becomes [3]	104/11	163/12	113/4 162/14	53/21 59/22	42/14 42/18	bracket [1]
101/17 103/6	105/16 107/2	164/22	believe [29]	60/22 64/8	42/22 96/5	6/15
104/3	108/25	167/15	59/4 59/16	70/9 87/23	96/8 98/15	brackets [1]
becoming [1]	110/17 114/3	167/25	78/14 78/15	91/1 109/10	100/14 135/4	34/6
91/11	116/12	173/14 177/4	80/5 83/13	111/5 122/9	body [2]	bradycardia
been [135]	116/13	178/7 184/12	98/9 104/24	146/8 149/12	183/10	[3] 12/16
3/8 3/12 4/10	116/18	before March	117/5 123/14	149/25	183/12	165/25 167/3
6/11 7/21	118/10	2018 [1]	125/21	175/15	boiling [2]	bradycardic
8/24 10/10	120/21	121/1	125/24 127/7	Between	183/9 189/11	[2] 157/5
11/1 11/6	122/20	beforehand	129/20	January	boot [1]	157/8
16/6 21/9	131/22	[2] 120/5	131/22	2017 [1] 91/1	126/24	brain [5]
22/1 28/12	134/22	120/15	132/19	between	boss [1]	138/5 154/3
30/2 30/4	135/16	beg [1] 125/2	134/24 138/3	March [2]	93/21	157/20
30/12 33/11	136/14 138/4	begin [3]	139/25 145/6	28/13 64/8	both [16]	169/22
33/12 33/15	139/1 141/22	162/3 169/9	145/17	beyond [2]	14/21 14/24	182/13
34/13 35/24	145/8 148/12	176/25	148/15 152/8	48/15 106/20	15/4 43/7	break [5]
39/24 40/4	151/23	begins [1]	152/22	big [3] 75/18	44/25 74/25	40/24 55/18
42/4 43/21	153/11 154/3	168/12	153/15	78/8 136/23	76/24 83/2	112/7 160/23
44/10 45/7	154/22	behalf [4]	155/22	bigger [1]	83/15 90/17	161/5
45/12 45/22	157/13	80/1 110/25	161/21	124/21	111/10 141/5	breakdown
49/15 50/22	159/17	112/12	176/13	biological [2]	141/17 163/8	[3] 9/1 39/6
51/1 51/22	159/19 160/3	161/15	189/12	61/10 115/5	163/11	39/18
52/16 54/10	160/16	being [49]	believed [3]	birth [1]	166/25	breathing [5]
55/7 58/1	164/12	9/8 23/4 28/7	29/15 58/21	147/18	bottle [2]	129/2 131/1
58/8 58/12	164/16	28/24 31/11	132/4	Bls [1]	15/21 100/1	135/9 165/23
59/5 62/13	164/17 168/2	32/8 32/17	below [5]	178/11	bottom [14]	167/2
63/7 64/17	168/4 168/5	32/18 33/6	18/22 61/21	bit [25] 2/11	9/13 12/5	breavity [1]
66/2 67/25	170/6 179/18	39/25 43/4	76/6 129/1	16/19 73/14	26/11 32/13	2/22
68/19 70/19	182/25	44/18 47/9	129/9	78/7 86/4	57/23 57/23	brick [6]
70/21 71/8	183/14	48/1 48/1	benefit [2]	95/20 96/4	58/24 82/14	149/5 149/14
71/24 72/5	183/24	48/2 48/14	42/9 113/12	110/3 129/9	92/9 118/21	149/15
72/20 76/12	183/25 189/6	63/14 64/25	benefited [1]	137/9 137/9	124/21	149/16
76/15 76/16	189/19	73/18 86/3	73/18	138/17	136/24 147/9	149/25
77/3 78/4	before [40]	86/10 91/25	bent [1]	138/17	166/23	150/14
78/21 79/4	5/6 7/3 10/7	102/20	135/10	140/10 147/5	bound [1]	bridge [2]
79/11 80/19	23/9 27/8	103/12	besides [1]	154/21	98/22	86/9 87/9
80/20 80/22	29/7 30/6	105/11	135/11	159/17	bowels [1]	brief [1]
80/25 81/2	60/23 78/2	105/24	best [6] 2/7	163/14 164/3	156/17	38/13
81/17 81/18	78/17 79/8	106/15	29/2 29/4	164/4 164/5	box [12]	briefings [3]
83/12 84/25	80/23 82/6	106/18 108/3	113/4 162/13	164/23	55/22 110/9	45/13 116/14
85/8 85/15	85/4 86/12	108/4 108/4	190/10	165/18	139/21	116/16
85/22 88/18	87/5 88/18	111/6 114/17	better [5]	173/14	139/22	briefly [6]
88/22 90/6	90/1 110/16	116/7 116/19	30/9 47/4	178/21	144/11	36/3 61/1
91/5 92/22	113/10 121/1	119/8 126/15	112/4 119/25	bits [1] 48/15	144/16	81/25 96/21
93/6 96/9	131/20 133/7	131/7 132/22	133/9	BL [1] 178/12	144/18 145/9	97/11 127/13
96/10 96/12	138/20 139/2	138/17	between [26]	blood [9]	145/13	brigade [2]
	145/19	141/24 152/9	17/19 19/11	135/5 145/22	148/25	95/3 96/18

B	63/24 71/1	131/9	92/13 94/17	187/16	37/13 40/2	2/11 2/18
bring [9] 1/14	75/21 75/23	calling [1]	97/2 101/12	187/17	40/8 132/5	3/18 4/7 5/20
7/18 8/6 21/2	78/8 79/2	14/17	101/18 103/2	187/21	136/11 140/7	5/20 6/2
57/14 59/10	91/23 92/5	calls [4] 7/15	105/3 107/14	189/21	142/2 144/1	carotid [2]
86/8 124/1	93/19 96/22	92/22 111/9	109/11 110/8	190/10	150/23 156/4	135/17
161/24	96/25 116/9	139/1	110/21 111/4	can't [21]	157/15	146/12
broached [1]	125/25	came [12]	113/5 114/2	52/2 65/16	158/10	carried [6]
108/18	126/17 127/3	82/22 84/15	116/10	79/13 88/25	158/13	8/25 44/19
broadly [2]	127/6 127/6	114/20 117/8	116/21 118/1	101/18	158/14	139/15 140/9
15/3 118/4	127/8 127/10	117/11	118/3 118/12	110/24	162/21 172/9	148/15
broke [4]	127/11 128/1	139/10	120/6 124/13	115/17	172/14	187/18
139/10	128/5 128/15	140/19	124/17	115/18 118/6	172/24	carries [1]
139/19	128/21	152/14	125/16	122/6 139/1	174/20 175/2	187/19
147/13	129/15	157/18 160/6	126/13	139/2 142/25	178/3 178/4	carry [8]
147/14	129/25 130/9	172/12	133/15 134/7	147/23 148/7	178/6 178/6	125/9 125/12
bronchorrhea	130/11	172/22	134/8 140/12	148/11	180/22	125/14
[3] 12/13	130/25 131/8	Campus [1]	142/15 144/8	173/24	183/23	125/15
165/21	131/13	132/12	145/19 146/6	173/25 174/2	183/25	126/20 127/3
169/17	131/13	can [151]	146/9 152/13	181/6 187/20	186/12	143/6 185/11
bronchospas	131/20 132/1	1/25 2/2 7/17	158/24	cannot [3]	186/22	cars [1]
m [2] 12/13	132/4 132/11	7/19 9/24	160/17	118/9 133/14	cardiopulmon	149/7
169/17	132/18	10/7 10/24	161/24 162/4	153/16	ary [6]	case [33]
bronze [3]	132/20	13/7 14/5	162/5 163/2	cannula [7]	135/13	3/22 5/19
61/14 61/15	135/17	16/17 18/2	163/4 163/19	143/9 143/13	138/11	15/17 18/14
65/7	135/21	22/18 22/24	164/22 165/8	143/14	141/25 143/8	20/7 32/6
brought [5]	139/20	25/20 26/8	166/4 166/12	185/25 186/1	153/18 156/2	32/23 32/25
43/13 80/19	139/22 140/7	27/11 31/25	166/13	186/5 186/7	care [35]	34/4 35/1
99/3 155/21	142/12	32/3 32/3	166/19	cannulated	5/16 85/10	36/12 36/18
180/13	146/23 149/5	32/14 32/16	166/22	[3] 175/21	114/8 123/14	41/25 43/5
build [3]	149/14	33/25 34/2	166/24 167/5	179/17	126/22 127/4	62/10 70/24
131/23 133/3	150/22	36/2 43/3	169/10	180/19	149/5 149/6	72/16 77/24
133/21	163/15	44/16 46/14	169/19 171/8	cannulation	149/8 149/9	81/1 82/2
Building [1]	170/17 171/4	46/17 46/21	171/16	[1] 163/22	149/16	82/3 85/7
65/9	171/7 171/10	49/1 49/2	171/20 172/3	capabilities	149/24 150/2	98/3 98/21
bullet [4]	171/16	49/2 49/19	172/8 173/4	[1] 150/23	150/13	103/17 105/3
13/9 35/14	171/18	51/25 52/6	173/15 174/7	capability [1]	152/16	140/5 156/10
83/24 169/20	171/20 172/4	53/8 53/17	174/17	62/5	152/18	161/21
businesses	172/9 173/10	54/5 56/17	175/14	capacity [2]	152/22	166/17
[1] 87/2	173/15	58/14 58/23	176/11	3/19 152/23	152/25	168/18
busy [2]	173/18 174/3	59/9 60/1	176/18	car [6] 9/19	153/14 154/5	169/24
181/24 184/8	called [17]	63/3 65/22	176/24	126/6 130/15	155/16	177/19
bystander [1]	50/8 61/8	65/22 68/22	176/25 177/4	130/22	156/25 157/3	cases [2]
37/18	61/17 69/19	69/24 70/13	178/4 179/5	150/21	167/9 181/10	105/25 107/3
C	80/6 87/6	70/23 74/1	179/13	164/13	181/11	cast [2] 13/8
	92/15 96/5	74/21 76/3	179/14	carbon [1]	181/13	32/13
cable [1]	97/1 120/18	77/21 78/8	179/15	149/19	181/14	casting [1]
149/16	126/25 127/1	78/22 79/16	179/22	card [3]	184/10	58/23
calendar [1]	130/22	80/2 80/8	180/10	170/13	184/12 185/7	casualties [6]
42/19	136/10 146/5	81/24 85/8	183/20	170/14	185/8 185/9	33/3 82/20
call [64]	161/8 177/5	86/5 87/8	185/23	170/15	186/17	97/6 100/18
61/13 63/17	caller [3]	89/12 89/21	186/14	cardiac [31]	186/19	119/5 168/16
	129/3 131/2	91/12 91/21	186/16	37/2 37/4	career [7]	casualty [2]

C	106/8 106/13	162/8	chemicals [3]	148/19	12/6 12/9	CO2 [3]
casualty... [2]	107/7 107/8	change [2]	121/12	148/20 153/1	13/21 14/9	150/4 151/6
115/7 115/10	123/9	145/6 152/7	121/14	179/20	18/22 19/4	155/17
catch [1]	cell [3] 69/18	changed [3]	159/24	180/21 181/4	19/5 26/22	cocaine [1]
51/16	75/5 78/13	145/13	chest [19]	181/8 183/11	37/10 38/23	91/4
category [4]	cent [7]	154/10	135/24 136/1	circulatory	40/7 50/10	collapse [4]
131/13	71/17 80/15	154/13	139/11	[2] 166/15	98/2 98/21	15/7 137/8
132/19 172/4	142/22	changes [6]	139/19	166/17	102/12	137/13 158/8
172/10	155/25 156/1	16/18 27/21	139/23	circumstance	115/25	collapsed
causative [1]	156/7 157/15	44/10 115/23	139/24 140/1	[1] 97/25	116/18 123/8	[11] 135/1
37/10	central [2]	164/11	140/2 140/9	circumstance	124/11	137/6 137/19
cause [15]	166/10	172/20	142/3 142/25	s [7] 9/10	141/10	138/3 138/23
27/17 137/13	166/14	charge [1]	143/3 145/21	10/20 39/15	141/23 153/3	147/7 174/20
138/7 142/2	centrally [1]	145/4	152/1 167/2	58/12 66/8	165/3 165/5	178/9 182/5
157/25 158/1	107/6	Charlie [35]	169/14 175/5	75/15 188/5	165/6 165/19	189/23
158/21	centre [9]	4/18 36/5	175/6 175/17	cited [1]	169/9	189/24
158/22 166/9	62/4 75/18	36/14 38/5	Chief [3]	128/9	clinically [1]	colleague [1]
166/12	92/5 93/10	38/10 56/16	55/21 55/24	city [1] 47/3	141/16	166/22
166/15	100/10	73/15 89/20	192/6	civil [1] 104/2	clinician [3]	colleagues
174/20 182/7	100/22 106/5	90/3 90/8	chime [1]	clarify [1]	3/25 37/11	[16] 9/17
182/17 187/2	106/8 107/7	90/19 91/2	5/23	44/20	98/20	10/24 11/14
caused [6]	centres [4]	91/11 93/1	chloride [1]	clarity [1]	clinicians	11/16 20/9
36/16 138/9	3/17 7/15	136/21	144/7	147/22	[11] 5/18 6/1	24/15 28/8
154/3 157/22	9/22 116/3	138/12	choice [1]	class [2]	6/5 6/24 9/21	29/13 31/1
166/18	cerebral [4]	138/16	144/4	90/12 91/3	13/20 14/8	37/20 69/10
186/23	138/5 138/8	138/20	Christie [1]	class A [2]	50/7 50/11	69/12 140/10
causes [3]	138/10 154/1	141/23 147/1	100/6	90/12 91/3	165/7 168/10	140/19
37/13 43/23	certain [4]	147/5 147/11	Chronic [1]	clear [16]	clock [1]	140/20
184/24	61/5 89/24	147/23 148/1	165/22	34/12 43/11	53/18	140/24
causing [1]	91/15 130/12	154/6 154/16	chronology	49/16 50/13	close [3]	collected [1]
138/11	certainly [20]	154/20 155/8	[4] 5/8 14/16	59/20 60/25	59/15 111/7	134/12
caution [8]	1/12 4/14	155/11 158/2	96/1 97/21	62/7 67/20	111/14	collectively
13/13 13/20	25/16 52/19	160/14	circulate [5]	71/10 74/10	closure [2]	[2] 99/6
13/25 14/1	54/21 59/22	181/17	17/2 19/6	85/14 90/1	75/10 81/10	100/25
18/8 100/21	60/22 61/7	181/23	19/17 30/3	137/11	clouds [1]	colour [1]
119/7 119/8	71/12 72/14	181/25	63/7	142/11	169/8	151/25
Cautions [1]	74/24 76/17	189/18	circulated	149/22 167/1	clunky [1]	coma [1]
13/9	86/6 87/5	check [3]	[18] 8/5 8/12	clearly [17]	86/4	166/15
cautious [1]	88/24 89/6	55/9 129/25	8/14 10/16	10/22 15/25	CNS [2]	combat [1]
72/22	98/23 101/24	155/17	10/22 20/14	28/23 37/2	166/9 166/12	14/25
CBRN [25]	109/7 123/2	checked [3]	23/1 24/3	37/7 37/18	co [6] 39/10	come [48]
58/16 58/17	cetera [1]	145/8 148/17	26/1 30/23	37/23 40/14	94/22 96/4	11/21 17/3
59/11 61/8	87/2	155/18	31/10 31/14	59/3 67/25	96/13 97/13	19/20 29/11
62/4 62/6	chair [9]	checking [1]	47/9 59/21	68/21 69/5	100/14	29/22 36/9
63/22 63/25	29/24 48/25	129/18	61/20 63/14	72/16 80/18	co-locate [1]	40/20 56/11
64/5 65/6	68/25 69/5	chemical [9]	67/19 67/22	107/24	39/10	63/22 64/3
72/18 72/25	74/2 75/12	18/1 20/24	circulating [2]	108/10 158/1	co-located [1]	64/21 66/19
84/15 84/19	78/18 81/11	61/10 103/14	20/3 20/5	clinical [38]	96/13	68/8 73/14
84/20 86/23	85/16	115/5 115/16	circulation	3/23 8/4 8/8	co-location	73/17 73/20
95/14 103/1	chaired [1]	120/20	[13] 37/5	8/23 9/2 9/4	[3] 94/22	73/22 77/13
103/3 106/5	75/6	120/24	40/9 136/2	9/8 9/15 9/16	96/4 100/14	77/17 77/23
	chance [1]	168/13	146/6 146/14	10/21 11/7	co-location/c	79/7 80/25
					ommunicatio	
					n [1] 97/13	

C	3/10 4/12 8/3	59/12 66/14	127/23 159/9	7/14 14/23	108/9	43/16 78/7
convenient	9/14 10/6	70/1 70/18	course [40]	27/16 29/10	dangerous	78/14
[1] 112/16	13/6 14/5	71/11 71/16	1/23 2/24	29/20 37/8	[3] 100/5	Davies [7]
conversation	15/2 15/8	76/16 84/23	3/18 4/19	48/20	100/5 101/18	141/1 141/3
[5] 45/15	15/9 15/15	85/5 87/16	4/23 5/13	crime [1]	Darch [48]	145/14
100/24 135/2	15/16 15/23	89/5 98/12	28/21 29/24	76/22	1/6 1/8 1/10	147/14 149/4
136/20 148/8	16/9 17/10	102/10	30/11 31/16	criminal [2]	1/12 1/13	164/7 171/2
conversations [1]	20/2 20/15	112/18 116/6	36/6 37/24	79/25 90/10	2/10 2/18	Davies' [2]
convictions	22/23 23/3	117/23 121/4	38/6 41/10	critical [18]	4/13 8/8 8/18	148/25
[2] 90/11	23/17 23/25	123/15	47/8 48/24	16/3 29/19	9/24 12/3	149/24
90/23	25/1 25/8	124/20 125/6	55/5 56/1	29/24 97/7	17/24 20/13	Dawn [65]
convulsions	26/16 30/19	127/9 127/20	56/8 56/19	97/8 97/22	21/3 21/10	4/18 36/4
[1] 166/7	33/20 50/15	128/5 128/12	59/12 61/17	152/16	21/18 22/16	36/11 36/14
Coomber [22]	74/20 78/14	130/2 133/24	68/9 71/4	152/18	22/22 23/5	37/2 39/24
141/1 141/3	90/7 90/13	134/3 137/23	76/15 85/16	152/22	23/22 25/4	41/6 56/15
142/3 142/24	90/21 91/7	139/15	86/6 98/1	153/13 154/5	25/19 26/12	58/6 90/3
143/9 155/9	92/12 92/18	146/12	110/7 116/4	155/15 157/3	27/12 28/11	101/9 105/3
161/9 161/10	93/5 93/23	146/13 147/4	130/19 134/8	181/10	33/9 35/4	105/8 105/12
161/11	94/7 114/9	147/8 147/9	136/23	181/11	36/1 38/5	105/14
161/14	114/10	149/19	139/17 161/2	181/14	39/20 44/6	113/12
161/19	114/13 115/8	150/12 151/5	163/11 167/9	184/12 185/8	48/6 55/13	113/14 122/3
161/20	115/9 117/4	151/6 152/1	168/1 177/19	criticise [1]	55/15 56/13	123/10
161/25 162/6	129/23	153/21	178/23	cross [1]	56/19 62/21	123/17
163/12	131/15 132/7	154/23 158/6	court [1] 91/5	22/7	63/19 63/21	137/15
165/12	134/2 135/16	158/7 159/16	cover [1]	cross-purposes [1]	77/25 82/13	142/23
176/12 179/4	141/8 143/10	161/18 163/8	155/15	22/7	83/24 103/19	143/10
186/14 188/9	144/3 147/2	163/15	covered [1]	crossover [8]	103/25 165/2	144/19 147/4
190/3 192/13	150/6 150/7	165/12	83/20	17/19 19/11	168/3 192/3	147/6 147/20
coordinate	152/17	170/16 175/9	covers [2]	35/23 49/12	Darch's [2]	148/1 148/3
[2] 7/15	152/18	176/18	14/9 59/18	64/19 71/1	2/14 22/19	151/14
39/12	156/18 160/9	182/18 185/4	CPR [3]	72/17 160/1	dashboard	151/17
coordination	163/18 171/6	188/4 189/6	148/17	crossovers	[1] 126/17	151/21
[3] 68/25	172/6 175/10	couldn't [8]	174/12	[1] 70/9	data [4]	152/10 153/6
69/8 94/24	175/23 176/2	129/18	174/15	crystallised	126/9 126/14	154/14 155/3
Coordinator	177/24	129/21 133/6	crack [1]	[1] 30/16	130/22	155/9 155/12
[1] 111/10	181/15	135/23	91/4	current [1]	172/17	158/3 159/8
copy [1] 1/16	correction [2]	138/15 150/4	created [1]	2/18	date [13]	159/16
cordons [3]	3/4 162/16	158/2 158/3	91/17	currently [2]	22/25 26/5	163/13
87/16 93/17	correctly [1]	Council [2]	CRESS [1]	3/12 76/8	95/25 109/10	166/16
103/11	157/9	88/4 154/24	50/8	curve [1]	115/3 124/8	167/15
core [3]	corrects [1]	counsel [1]	crew [6]	43/20	128/16	167/25
63/18 64/14	163/5	55/7	129/4 136/17	cut [2]	147/18 163/6	168/19 169/3
96/25	could [74]	Counter [4]	148/13	139/25	164/6 170/24	175/21
corner [2]	1/6 1/11 1/14	79/18 110/23	148/15	140/12	172/11	177/20
118/20	22/18 25/3	111/6 111/9	152/18 188/4	cyanosed [1]	188/22	177/22 180/9
118/21	28/12 28/18	countermand	crewed [8]	135/4	dated [8]	181/18
corporate [1]	28/21 29/3	ed [1] 95/2	3/20 9/18	cylinder [1]	1/20 25/22	181/24 182/1
68/23	29/5 30/8	country [3]	126/4 164/6	142/21	31/25 60/3	183/15 184/1
correct [69]	30/9 31/22	6/12 58/9	164/9 170/24	D	60/7 112/22	184/4 185/4
1/22 2/21	33/15 34/20	80/23	172/18	damaged [1]	161/21	185/9 186/17
	44/20 46/19	couple [4]	180/17		161/22	187/12
	47/7 57/15	58/25 68/1	crews [7]		dates [3]	187/17 188/2

D	113/13 119/5 119/6 119/18 188/2 189/10	150/9 defibrillate [1] 145/19	126/16 depositions [1] 111/3	113/20 details [9] 4/20 52/17	51/1 51/3 51/5 51/6 51/23 52/11	178/20 179/19 181/23 182/1
Dawn... [2] 189/20 189/23	dealt [3] 81/13 99/18 107/11	defibrillator [5] 139/21 144/12 145/1	depression [5] 12/19 13/4 166/6	53/1 53/3 72/8 82/16 147/1 154/16 177/4	52/12 52/18 52/21 52/22 52/22 56/21 58/10 61/2	182/3 182/6 183/17 184/6 185/11 185/17
Dawn's [11] 51/23 142/9 142/13 143/15 145/24 146/13 148/16 152/4 156/10 156/11 177/19	death [3] 51/23 68/21 166/16	150/22 150/23 definition [1] 71/2	166/14 166/14 Deputy [5] 2/19 55/21	determines [1] 101/17	64/23 65/4 66/12 74/13 74/15 74/25 77/5 77/14	186/22 didn't [46] 3/23 11/9 11/10 16/4
104/7 105/19 116/4 125/21 127/6 127/8 127/8 129/21 143/19 143/19 152/24 159/11 186/17 188/19 188/20 188/21 190/6	death [3] 25/4 25/5 25/20 25/22 27/20 28/3 44/6 180/3 180/4 180/5 187/14 187/18 188/8	degree [1] 69/6 delay [2] 28/6 132/23 delayed [1] 51/25	55/24 67/22 192/6 describe [11] 7/20 8/10 24/10 66/19 68/12 85/25 97/3 107/18 111/14 111/16 134/3	detrimental [1] 153/24 develop [1] 39/14 developed [1] 99/12	79/17 80/5 80/6 83/6 84/20 87/14 99/23 101/12 107/15 111/6 114/14 115/15 116/5 117/6 120/8	20/8 27/24 29/6 30/9 33/18 36/14 51/7 51/15 51/16 51/17 53/6 58/7 59/2 61/6 62/7 68/25 79/1 79/6 94/21 95/5 107/20 108/17 120/6 134/16 134/16 137/11 139/4 142/2 143/20 153/20
day [21] 10/17 38/6 51/23 71/5 104/7 105/19 116/4 125/21 127/6 127/8 127/8 129/21 143/19 143/19 152/24 159/11 186/17 188/19 188/20 188/21 190/6	debrief [16] 25/4 25/5 25/20 25/22 27/20 28/3 44/6 180/3 180/4 180/5 187/14 187/18 188/8	deliberately [4] 6/4 76/12 76/16 77/3 deliver [1] 58/1	82/1 133/20 describes [3] 9/10 19/13 34/19 describing [2] 22/21 24/23	device [8] 126/23 149/10 149/13 150/5 150/12 150/15 150/16 150/17	123/12 123/16 123/24 125/11 135/20 136/5 136/7 136/20 137/7 137/20 138/12 138/15 138/18 139/7 140/18 141/5 141/6 141/18 142/3 142/5 142/6 142/24	134/16 134/16 137/11 139/4 142/2 143/20 153/20 154/20 155/4 155/5 157/24 158/20 176/6 176/7 176/20 181/22 182/17 184/25 186/7 difference [4] 38/12 40/4 40/18 175/14
10/17 38/6 51/23 71/5 104/7 105/19 116/4 125/21 127/6 127/8 127/8 129/21 143/19 143/19 152/24 159/11 186/17 188/19 188/20 188/21 190/6	decided [2] 19/2 88/22 decipher [1] 127/23 decision [13] 19/17 63/23 64/20 94/12 94/13 94/20 94/23 96/20 97/10 100/11 102/9 102/16 106/2	delivered [3] 80/11 115/25 146/2 delivering [1] 150/16 delivery [1] 80/4 demeanour [1] 138/21 demonstrate d [1] 81/3 demonstratio n [1] 60/20 depart [1] 67/4 department [3] 17/20 45/19 85/10 departmental [1] 33/19 departments [4] 19/7 20/25 31/1 168/5 depending [2] 116/3 177/16 depends [2] 10/19 187/23 deplete [2] 144/21 145/3 deployed [1]	described [6] 8/24 14/8 28/19 76/23 82/1 133/20 describes [3] 9/10 19/13 34/19 describing [2] 22/21 24/23 description [2] 62/9 137/15 descriptive [1] 97/2 descriptor [1] 97/3 designated [1] 132/11 detail [17] 2/12 10/7 14/11 14/19 17/15 21/10 27/20 37/21 38/18 45/17 54/18 63/4 79/22 107/11 162/25 165/18 173/15 detailed [7] 9/2 36/8 44/12 56/9 70/7 75/12	devices [7] 11/1 116/21 145/4 145/12 150/1 150/8 150/24 DHSC [1] 32/2 diagnose [4] 16/4 27/24 50/11 71/13 diagnosed [1] 16/5 diagnosis [7] 17/25 20/23 29/20 38/14 70/23 102/12 165/19 did [120] 4/20 9/13 19/5 20/3 24/9 26/17 26/19 29/4 30/7 30/22 35/9 37/24 38/10 38/14 40/10 40/11 41/9 44/6 44/9 46/25 47/10 48/19	125/11 135/20 136/5 136/7 136/20 137/7 137/20 138/12 138/15 138/18 139/7 140/18 141/5 141/6 141/18 142/3 142/5 142/6 142/24 143/13 143/16 144/11 146/11 147/20 148/9 148/13 151/3 152/7 152/8 152/9 152/25 154/8 154/20 155/6 155/11 157/11 157/24 158/9 158/11 165/15 165/17 167/21 172/16 174/9 175/3 176/3 176/21	154/20 155/4 155/5 157/24 158/20 176/6 176/7 176/20 181/22 182/17 184/25 186/7 difference [4] 38/12 40/4 40/18 175/14 different [17] 3/18 30/11 38/6 38/8 38/22 50/12 53/25 69/10 81/8 81/12 85/20 90/18 107/9 145/14 149/7 178/22 183/24 differentiate [1] 50/12 differently [2] 34/17 184/2
10/17 38/6 51/23 71/5 104/7 105/19 116/4 125/21 127/6 127/8 127/8 129/21 143/19 143/19 152/24 159/11 186/17 188/19 188/20 188/21 190/6	decisions [1] 56/22 declared [1] 44/25 decontaminat ion [1] 68/14 deduction [1] 105/14 defib [1]	depart [1] 67/4 department [3] 17/20 45/19 85/10 departmental [1] 33/19 departments [4] 19/7 20/25 31/1 168/5 depending [2] 116/3 177/16 depends [2] 10/19 187/23 deplete [2] 144/21 145/3 deployed [1]	described [6] 8/24 14/8 28/19 76/23 82/1 133/20 describes [3] 9/10 19/13 34/19 describing [2] 22/21 24/23 description [2] 62/9 137/15 descriptive [1] 97/2 descriptor [1] 97/3 designated [1] 132/11 detail [17] 2/12 10/7 14/11 14/19 17/15 21/10 27/20 37/21 38/18 45/17 54/18 63/4 79/22 107/11 162/25 165/18 173/15 detailed [7] 9/2 36/8 44/12 56/9 70/7 75/12	diagnosed [1] 16/5 diagnosis [7] 17/25 20/23 29/20 38/14 70/23 102/12 165/19 did [120] 4/20 9/13 19/5 20/3 24/9 26/17 26/19 29/4 30/7 30/22 35/9 37/24 38/10 38/14 40/10 40/11 41/9 44/6 44/9 46/25 47/10 48/19	143/13 143/16 144/11 146/11 147/20 148/9 148/13 151/3 152/7 152/8 152/9 152/25 154/8 154/20 155/6 155/11 157/11 157/24 158/9 158/11 165/15 165/17 167/21 172/16 174/9 175/3 176/3 176/21	181/22 182/17 184/25 186/7 difference [4] 38/12 40/4 40/18 175/14 different [17] 3/18 30/11 38/6 38/8 38/22 50/12 53/25 69/10 81/8 81/12 85/20 90/18 107/9 145/14 149/7 178/22 183/24 differentiate [1] 50/12 differently [2] 34/17 184/2
10/17 38/6 51/23 71/5 104/7 105/19 116/4 125/21 127/6 127/8 127/8 129/21 143/19 143/19 152/24 159/11 186/17 188/19 188/20 188/21 190/6	decisions [1] 56/22 declared [1] 44/25 decontaminat ion [1] 68/14 deduction [1] 105/14 defib [1]	depart [1] 67/4 department [3] 17/20 45/19 85/10 departmental [1] 33/19 departments [4] 19/7 20/25 31/1 168/5 depending [2] 116/3 177/16 depends [2] 10/19 187/23 deplete [2] 144/21 145/3 deployed [1]	described [6] 8/24 14/8 28/19 76/23 82/1 133/20 describes [3] 9/10 19/13 34/19 describing [2] 22/21 24/23 description [2] 62/9 137/15 descriptive [1] 97/2 descriptor [1] 97/3 designated [1] 132/11 detail [17] 2/12 10/7 14/11 14/19 17/15 21/10 27/20 37/21 38/18 45/17 54/18 63/4 79/22 107/11 162/25 165/18 173/15 detailed [7] 9/2 36/8 44/12 56/9 70/7 75/12	diagnosed [1] 16/5 diagnosis [7] 17/25 20/23 29/20 38/14 70/23 102/12 165/19 did [120] 4/20 9/13 19/5 20/3 24/9 26/17 26/19 29/4 30/7 30/22 35/9 37/24 38/10 38/14 40/10 40/11 41/9 44/6 44/9 46/25 47/10 48/19	143/13 143/16 144/11 146/11 147/20 148/9 148/13 151/3 152/7 152/8 152/9 152/25 154/8 154/20 155/6 155/11 157/11 157/24 158/9 158/11 165/15 165/17 167/21 172/16 174/9 175/3 176/3 176/21	181/22 182/17 184/25 186/7 difference [4] 38/12 40/4 40/18 175/14 different [17] 3/18 30/11 38/6 38/8 38/22 50/12 53/25 69/10 81/8 81/12 85/20 90/18 107/9 145/14 149/7 178/22 183/24 differentiate [1] 50/12 differently [2] 34/17 184/2

D	discussed	distinction [1]	97/24 99/20	176/20	81/1 81/22	130/13
difficult [6]	[10] 43/23	40/21	100/17 103/9	177/18	82/13 83/6	131/17
70/15 71/7	43/24 47/10	distinctions	115/1 115/2	180/24	83/7 83/12	132/20 133/4
78/12 81/7	49/13 51/22	[1] 49/7	116/14	181/18	83/17 84/8	141/10
149/12 171/8	52/8 53/12	distinctive [2]	116/16	181/25 182/1	85/6 85/15	144/22 146/1
difficulties [1]	54/16 54/18	49/9 49/19	116/17	182/14	108/20 109/5	146/16
165/23	96/19	distinguishin	116/20 118/7	182/23	109/23 110/5	172/21
difficulty [4]	discussing	g [3] 15/13	118/13	184/23	110/8 110/16	173/10
12/14 52/18	[6] 16/6	43/22 50/1	118/15	185/21 190/5	117/18	173/18 178/5
89/8 127/21	42/24 67/25	distressed [2]	119/20	doctor [1]	117/20	179/25 181/5
dioxide [1]	69/8 84/10	18/20 138/24	119/24	189/7	117/22	189/5 189/7
149/19	160/3	distressing	121/20 122/1	doctors [2]	117/25 118/7	doesn't [11]
direct [1]	discussion	[1] 113/15	122/3 122/7	50/18 189/7	119/22 124/2	27/25 42/5
89/23	[11] 46/19	distributed	122/12	doctrine [5]	125/1 128/10	68/1 68/15
directed [1]	46/21 54/2	[2] 9/8 66/4	122/25	63/18 64/15	128/20	72/24 80/14
93/3	87/22 87/25	distribution	123/10 125/2	72/5 72/23	165/11	83/14 109/20
direction [2]	89/2 89/9	[1] 35/11	125/19	72/24	165/13	129/22
9/5 9/6	89/11 99/13	do [155] 1/10	126/19	document	167/15	173/23
directly [1]	102/2 104/11	1/16 1/18	127/10	[103] 8/11	168/10	186/18
134/23	discussions	4/22 5/2 5/3	128/20 129/1	10/1 10/4	176/13	doing [18]
Director [1]	[2] 31/13	5/23 7/3 7/5	129/20	10/15 17/5	176/19 179/5	47/5 77/7
2/19	42/4	10/11 10/17	129/24	19/1 19/10	179/14 180/2	81/20 87/12
disagree [1]	disease [2]	11/4 11/6	131/19	20/21 20/22	187/13	89/10 95/3
14/21	7/10 13/14	11/10 11/11	131/22 133/2	20/23 21/4	documentatio	137/1 139/11
disagreement	dismissive	11/11 11/21	133/14	21/5 21/9	n [1] 49/15	142/7 143/8
[1] 102/1	[1] 98/5	13/9 16/21	135/20 136/4	21/14 21/19	documented	145/21
Discard [1]	dispatch [2]	16/22 24/5	136/5 136/7	21/20 21/22	[1] 44/18	145/25
77/21	31/7 129/8	24/7 26/11	136/7 140/13	21/24 22/3	documents	151/24 152/5
discarded	dispatched	27/6 28/11	140/17 141/1	22/5 22/12	[24] 4/22	164/12
[19] 32/11	[1] 93/4	28/21 29/3	141/15	22/21 23/15	10/9 10/16	174/12 175/3
32/16 32/19	dispatches	33/14 34/12	141/19 142/6	23/19 24/23	12/13 12/23	176/3
33/13 45/12	[1] 172/25	35/17 39/4	143/4 143/5	24/25 25/1	17/7 17/19	don [1]
46/19 48/16	display [1]	40/16 41/8	143/17	25/2 25/4	20/11 20/17	115/13
48/18 58/8	145/2	41/11 43/18	143/22	25/9 25/16	23/12 23/13	don't [67]
68/2 68/8	displaying [1]	51/5 53/19	144/14	25/19 25/19	23/23 24/2	10/13 12/4
73/23 80/22	92/7	54/9 54/12	144/20	26/4 26/9	24/8 28/19	13/23 14/19
82/15 83/3	disposed [1]	54/18 54/19	145/18	27/4 30/5	31/18 43/12	18/18 21/13
107/12	80/22	59/4 59/23	147/23	33/15 33/19	44/6 44/17	23/11 23/14
107/17 108/1	disseminated	61/8 62/19	150/12	33/21 34/1	62/23 73/21	25/21 31/12
109/24	[7] 16/20	65/2 65/3	150/23	35/18 45/18	84/16 108/21	41/24 46/14
discipline [1]	28/20 35/10	67/5 67/10	151/23	52/3 58/16	120/1	47/21 48/17
61/16	35/16 71/20	71/24 72/24	153/16 156/9	58/17 58/19	does [33]	48/17 53/14
disclosed [1]	72/21 84/2	73/6 73/13	156/11 159/5	59/11 59/14	5/23 6/20	54/6 54/8
141/22	disseminatin	75/20 75/22	161/2 162/6	59/15 59/16	7/24 7/25	55/1 55/8
discovered	g [1] 35/22	77/10 78/2	162/7 163/3	59/17 59/19	9/15 21/11	61/6 63/4
[1] 68/14	disseminatio	78/6 79/4	165/12	59/21 60/5	21/12 54/7	64/9 79/1
discovery [4]	n [1] 34/22	79/16 80/9	165/14	60/18 60/24	54/18 62/8	79/7 88/17
32/11 32/15	dissociation	83/9 85/18	167/15 170/1	61/1 62/8	80/16 107/1	98/9 99/19
82/15 83/3	[1] 146/8	86/7 87/9	172/11	63/13 63/24	108/17	103/9 104/24
discuss [2]	130/12	87/19 88/7	172/17	72/7 72/19	127/25	107/24 108/6
77/14 95/5	distillation [1]	89/21 90/1	174/18 175/9	74/6 76/2	128/21 129/6	110/19
	171/10	90/9 96/2	175/12	77/24 78/2	129/14	113/18 115/6

D	67/23	28/13	7/23 8/24	economy [1]	eliminate [1]	101/23 103/2
don't... [32]	doses [1]	drawing [4]	9/11 13/13	87/1	182/21	103/19
121/22	166/9	20/6 28/11	13/21 14/13	edition [1]	elimination	103/22
121/24	double [5]	28/15 84/11	19/25 125/7	25/11	[2] 182/4	113/13 168/4
122/11	3/20 9/18	drawn [1]	165/3 165/8	education [1]	189/22	emphasise
123/20	170/24	24/24	169/13	7/13	else [15] 26/7	[1] 64/24
123/24	172/18	dress [4]	170/10	effect [5]	52/23 55/8	emphasising
127/12	180/17	139/25	170/12	5/17 86/15	71/16 72/11	[1] 63/9
132/14 133/4	doubles [1]	140/13	during [4]	136/11	108/2 108/18	employed [3]
133/14	149/10	140/14	16/14 59/24	169/11 184/6	111/21	113/22 114/3
137/24	down [59]	140/16	67/14 107/13	effective [2]	111/23	114/19
140/14	3/23 7/23	drip [1] 144/6	duties [3]	84/2 111/16	122/24 136/5	en [1] 172/14
143/17	11/18 12/17	driver [1]	78/3 83/9	effectively [1]	136/7 150/11	enables [1]
143/18	13/8 16/17	126/17	141/14	150/12	154/25 188/3	142/14
151/24	16/19 32/13	driving [2]	duty [3] 62/4	effects [6]	elsewhere [1]	end [12]
153/19	42/12 51/13	133/15 171/2	117/16	119/3 119/19	128/9	30/18 41/9
154/16	51/22 52/9	drooling [1]	170/24	144/1 153/22	email [11]	81/10 122/3
155/13	52/23 53/12	92/7	dyslexic [1]	153/24	10/17 10/23	135/1 147/17
157/10 160/4	58/23 59/9	drop [2] 79/1	147/23	169/19	31/21 31/23	155/16
160/22	62/18 65/22	79/6	E	either [11]	32/2 34/1	173/18
168/15 170/2	66/18 70/5	dropped [1]	each [1] 54/1	31/11 32/12	85/6 85/9	185/24 187/1
170/3 170/3	75/13 86/20	88/17	earlier [25]	37/17 45/20	116/14	190/6 190/7
173/21 174/2	86/21 88/6	drug [13]	4/6 4/8 25/14	45/23 52/19	116/16 170/1	ends [1] 86/9
179/3 182/3	88/7 90/22	14/25 40/1	26/14 29/9	59/14 108/1	emailed [2]	energy [1]
183/2 183/4	92/3 116/5	42/3 70/10	31/20 35/10	108/18	165/4 168/5	183/11
184/8 187/13	125/16 129/5	94/5 101/22	36/5 42/16	112/15	emails [1]	engage [2]
done [21]	129/10 130/4	102/4 122/9	57/8 57/13	155/14	31/14	95/5 147/5
11/5 28/12	130/7 135/3	144/4 144/9	59/8 59/14	elbow [1]	embed [3]	England [12]
28/22 28/25	135/10	153/21 155/6	61/23 62/21	176/1	103/20 104/1	8/14 8/19
30/3 30/5	135/11	160/2	63/6 72/7	electrical [2]	104/3	17/4 20/22
30/9 33/23	135/14	drugs [25]	73/25 74/17	146/8 146/9	embedded [4]	22/2 35/11
34/16 42/11	135/25 143/1	36/14 40/3	79/7 87/3	electronic	42/13 42/20	45/1 67/23
84/23 103/25	146/22	70/21 89/20	100/6 106/3	[17] 116/9	42/21 45/4	75/7 88/3
116/13 132/7	150/19	90/5 90/10	110/24 186/6	116/21	embedding	108/14
145/23	150/25 151/8	90/12 90/20	early [13]	123/13	[1] 103/22	109/15
150/18	151/12	91/4 92/25	17/25 20/23	126/22 127/4	emerged [1]	English [1]
151/13 153/5	151/18 154/8	94/3 94/16	56/14 69/11	149/4 149/6	72/16	8/21
153/5 177/7	154/22	97/18 98/13	71/7 78/9	149/8 149/9	emergency	ensure [2]
187/22	161/12 172/8	99/18 153/7	79/5 81/19	149/15	[35] 3/2 3/15	42/4 84/2
door [10]	172/14 173/3	155/9 155/12	97/4 114/21	149/24 150/1	4/4 7/14 8/15	ensuring [2]
80/21 132/21	174/14	174/1 175/20	114/21 116/1	150/13	8/20 8/25	45/3 48/19
133/24	179/15	179/12	169/22	176/13 177/6	9/21 17/20	enter [2]
133/25 134/4	181/11 182/8	179/17 182/1	easier [1]	177/8 177/10	18/5 18/16	127/4 180/11
134/13	183/9 185/11	182/18	128/2	element [6]	19/7 20/25	entire [1]
134/14	187/3 189/11	189/21	easy [2]	65/10 69/9	30/25 32/20	5/20
134/21	downstairs	DS [1] 94/10	31/23 127/24	77/14 97/13	38/23 39/7	entirety [1]
134/22	[1] 182/25	due [9] 5/13	ECAs [1]	100/13	41/24 42/2	2/13
134/24	Dr [2] 22/16	29/24 56/8	164/12	100/22	42/14 56/15	entitled [1]
doorway [1]	94/11	66/8 68/9	ECG [4]	elements [6]	61/12 64/4	101/15
174/13	Dr Jukes [1]	75/25 85/15	151/3 151/9	67/9 69/21	69/21 78/13	entity [1]
Dorsey [1]	94/11	98/1 167/9	151/13 153/9	95/8 96/1	82/19 88/3	84/22
	draw [1]	DuoDote [13]		97/11 100/10	94/4 97/6	environment
						[2] 17/22

E	91/17 92/20	64/6 64/8	existing [4]	expressly [1]	faecal [3]	171/11
environment..	100/19	65/9 73/24	20/9 62/9	93/13	167/10	186/16
. [1] 19/17	event [9]	74/16 90/2	72/14 158/4	external [2]	183/13	Faulkner's [2]
Environment	17/24 24/9	90/17 98/1	exists [1]	45/2 45/6	183/16	5/25 6/8
ally [1]	67/16 84/5	98/4 99/25	61/19	extreme [3]	failed [1]	fault [1]
143/19	91/11 119/7	106/3 112/13	expand [1]	13/13 13/20	150/25	128/12
EPCR [3]	120/5 170/9	113/7 113/13	14/5	119/8	failure [3]	faulty [1]
126/22 149/4	187/3	124/3 140/24	expect [4]	extremely [6]	166/16	150/2
178/24	events [16]	152/15	10/11 71/11	6/22 7/5	166/18	fear [3] 86/18
episode [5]	38/9 46/6	161/16	131/7 183/22	29/11 29/12	169/23	86/24 88/11
154/2 154/2	61/13 62/6	162/11 163/9	expectation	35/25 47/14	fair [8] 16/2	feature [4]
158/6 160/8	78/23 82/7	177/10	[1] 96/16	Extricated [1]	17/18 26/15	49/9 49/19
160/18	86/16 90/16	186/15	expected [1]	178/18	28/5 28/12	160/11
EPRR [1]	115/21	evident [1]	96/7	extrication [1]	57/20 83/17	160/13
8/19	137/12 147/6	39/5	experience	181/12	95/7	featured [1]
equipment [3]	159/15	exact [1] 5/22	[13] 6/11	eye [1] 53/18	Fairline [5]	81/18
115/24	164/23	exactly [8]	38/25 40/17	eyeballs [1]	25/6 27/2	features [4]
134/13	167/13 168/1	14/20 22/17	42/22 42/25	15/8	56/7 75/11	12/9 36/12
180/12	170/19	31/24 36/19	107/4 114/8	eyes [4] 13/8	81/11	64/24 165/20
error [1]	eventually [3]	141/13	114/11 152/9	32/13 58/23	fairly [3]	feed [1]
23/10	40/10 179/19	168/18	156/1 158/16	169/6	18/18 81/24	36/23
ESR [1]	185/3	168/22 177/9	183/8 183/21	F	187/22	feel [3] 35/18
116/9	ever [7] 6/11	examination	expert [9]	face [5] 57/1	familiar [7]	113/18 163/2
essence [1]	13/23 74/11	[1] 179/6	5/13 15/24	116/2 116/2	12/24 82/2	feeling [1]
59/18	109/21	example [8]	70/7 167/8	116/5 116/5	109/18	154/22
essentially	127/12	7/11 11/15	171/10	faced [1]	121/16	fellow [1]
[7] 18/5 18/7	155/13	11/19 15/6	171/11	101/21	127/11	98/16
18/9 38/15	159/11	35/22 77/9	177/20	facing [4]	127/15	felt [4] 86/4
39/8 123/8	every [8]	166/5 166/13	186/15	39/16 77/14	167/16	135/11
141/22	10/17 10/17	examples [1]	186/15	77/15 83/16	familiarise [2]	135/14
established	10/18 11/21	7/4	experts [1]	fact [31] 4/15	9/9 165/6	146/11
[4] 50/22	88/6 88/12	except [1]	47/13	12/7 14/22	family [7]	female [7]
66/17 69/11	105/19	100/6	explain [3]	15/18 15/21	36/24 41/6	129/2 131/1
91/5	143/24	exceptional	18/3 46/17	16/3 16/23	41/8 101/9	134/19 135/3
et [2] 87/2	Everybody	[1] 66/8	46/21	22/25 23/22	113/12 159/8	141/24
155/17	[2] 139/22	excess [9]	explained [3]	24/1 24/4	187/12	146/15
et cetera [1]	184/1	12/18 15/10	65/7 148/23	25/22 27/23	far [6] 6/14	152/21
87/2	everybody's	92/7 156/9	157/18	38/9 41/25	53/17 90/3	fentanyl [1]
evacuate [2]	[2] 45/9	165/22 166/5	explaining [1]	48/8 52/8	93/6 105/3	71/3
75/22 119/9	183/24	182/24 183/7	176/21	56/9 57/11	148/4	fertiliser [1]
evacuation	everyone [1]	183/15	exposed [6]	58/20 79/7	fasciculation	49/1
[1] 18/11	19/3	executive [1]	32/18 32/20	90/16 90/17	s [2] 167/5	fertilisers [1]
even [9] 16/1	everything [4]	27/15	82/18 82/19	92/19 99/17	167/6	6/18
41/9 45/23	97/9 103/5	exercise [1]	139/22	100/4 102/4	fatality [2]	few [15] 2/17
71/11 121/1	120/4 188/12	119/8	139/24	105/2 110/18	33/3 82/20	3/12 10/19
130/14	evidence [34]	exercises [2]	exposition [1]	118/20	fatigued [1]	92/3 92/14
135/22 155/2	2/14 4/24	43/2 43/8	167/1	159/11	151/24	93/8 110/13
164/12	5/15 14/17	exhaust [1]	exposure [4]	factor [1]	Faulkner [9]	129/5 130/3
evening [7]	56/5 56/9	79/13	119/4 119/19	88/11	5/14 6/23	130/7 133/19
31/14 31/19	56/11 56/13	exist [2]	121/9 169/11	factors [1]	15/24 16/3	162/22
33/21 39/17	56/18 57/13	104/20	express [1]	160/17	29/18 29/23	163/19
	59/8 59/21	106/14	63/14		127/25	181/23 189/2

G	81/5 84/9	61/5 62/25	126/21 137/4	151/19	19/18 20/4	62/13 63/9
get... [19]	104/19	63/12 65/22	137/18	151/20	20/6 20/8	63/9 63/10
133/8 133/11	143/21	69/25 70/1	137/24	159/23	20/9 22/25	65/13 66/20
145/21	148/18 153/2	72/23 75/24	138/16 139/6	160/14	28/2 28/14	67/1 69/17
145/24	158/13	76/19 76/21	140/23	163/21 170/4	30/23 31/3	70/19 70/21
147/22 150/2	164/24 172/7	79/11 81/25	144/23	175/18	31/4 31/8	71/8 74/18
150/5 151/24	173/17 174/1	82/23 85/5	145/22	182/21	34/23 35/12	75/12 76/1
153/17	179/12	91/12 91/19	147/10	GP [2] 17/12	36/21 44/11	77/3 77/10
158/23 175/2	182/21 184/4	94/17 97/20	162/21	17/14	47/10 50/10	77/12 78/16
175/7 177/4	184/12	99/23 107/22	165/17 171/7	GPs [2] 17/9	56/25 59/6	79/4 80/1
179/15	184/13	111/22	171/9 175/2	31/1	63/8 64/7	81/11 81/17
181/11 184/9	186/17	111/25 116/2	175/18	grabbed [1]	64/10 65/12	84/8 86/20
187/16	gives [3]	124/16	176/12	151/1	66/1 66/3	87/15 87/15
188/15 189/9	49/16 73/8	124/20 127/9	178/21	grading [2]	66/18 72/2	88/2 90/11
getting [7]	123/8	128/17 130/2	178/25 179/3	104/17	84/10 99/3	90/18 90/24
19/25 73/11	giving [9]	137/23	182/8 182/20	104/19	99/6 117/1	91/5 91/6
108/4 108/13	5/15 74/16	140/23 149/3	184/23	grateful [3]	118/2 118/4	92/22 95/22
119/20 170/1	89/3 136/19	150/2 150/5	186/15 187/3	40/22 60/25	118/25 119/2	98/2 100/2
182/25	153/14	157/16	gold [5]	160/25	119/10	100/8 101/25
give [39] 1/11	162/11	162/24	61/14 61/14	great [3]	119/18 120/9	107/6 110/5
4/2 4/23 4/24	175/19	169/13	65/7 87/12	68/11 98/22	121/10	110/19 111/8
10/7 15/20	175/20	173/14 190/5	107/8	170/19	121/20 122/5	111/11
22/3 49/1	179/16	goes [8] 8/8	gone [2]	greatest [1]	122/7 122/12	111/17 112/4
49/2 49/3	Glen [14]	9/12 9/12	10/23 18/19	149/11	164/24 168/4	112/25 114/3
54/5 56/11	141/1 141/3	21/10 63/15	good [13] 1/3	grid [8] 33/6	guide [1]	114/7 117/24
77/9 79/22	141/4 141/9	67/8 80/14	30/12 41/5	35/4 35/5	64/5	119/17
80/6 87/11	141/21	182/19	63/7 64/9	62/20 72/13	guideline [1]	120/14
90/17 98/22	144/17	going [68]	101/8 111/17	82/23 85/7	143/7	120/21 121/3
112/13	145/14	2/10 7/1 8/9	111/24	166/23	guidelines [5]	121/3 122/18
112/18	147/14	42/9 42/11	112/10	grids [1]	10/21 50/7	123/10
127/25	148/25 149/4	47/16 53/9	112/11 159/8	166/25	123/9 123/15	125/13 127/1
135/23	149/24 164/7	57/6 57/13	161/14	ground [4]	148/18	134/24
137/11 139/1	171/2 175/11	58/16 67/2	187/11	27/24 42/10	gurgling [2]	135/22
143/23	Glen's [1]	68/8 68/17	Google [1]	44/17 51/1	137/5 137/19	135/23
143/25	150/25	69/21 71/1	133/12	group [8]	H	137/18 138/1
153/21 158/2	glove [3]	73/9 73/12	Google Maps	8/23 68/25	had [162] 5/5	138/6 138/20
161/16	152/2 152/4	77/17 77/23	[1] 133/12	69/8 69/20	5/20 6/10 7/2	139/23
161/18	152/7	78/20 79/20	got [28] 5/24	74/18 83/20	8/22 10/14	140/15
166/13	gloves [3]	80/12 81/6	22/17 24/8	87/3 109/18	10/23 17/3	141/22 142/1
174/12	154/11	85/16 85/24	26/4 26/4	groups [1]	22/5 24/19	144/15 145/5
174/14	154/13	89/21 89/23	93/7 101/23	46/11	24/22 24/24	145/17
174/15	180/12	90/14 91/24	109/2 118/12	grows [1]	28/8 29/5	146/14 147/3
179/17	glucose [1]	92/10 95/23	120/14	88/11	29/8 30/2	147/6 148/1
184/14	155/18	96/6 96/21	120/21	guarded [1]	34/16 35/17	148/6 149/4
184/15	go [53] 1/19	99/9 99/9	121/20	159/18	40/3 45/14	149/6 149/13
187/21 188/6	6/1 7/17	103/12	124/15	guess [1]	46/7 48/7	149/17
given [25]	16/15 22/18	105/23	129/20	107/25	48/9 50/22	149/19 150/2
8/2 14/24	22/19 25/18	106/16	133/18	guidance [54]	50/25 51/21	150/5 150/8
25/6 33/6	25/21 27/11	107/12	145/14 146/5	7/21 14/2	58/1 58/8	150/25
36/24 37/16	32/3 33/5	113/13	146/14	16/13 16/20	59/13 59/15	151/22 152/2
47/1 56/4	33/25 34/20	114/25 124/1	148/19	17/21 19/6	60/19 60/24	152/3 152/4
	37/11 58/23	125/17	148/20	19/8 19/15		153/4 153/4

H	134/25	189/9	138/24 156/8	175/9 177/21	178/25	176/18
had... [38]	143/10	happening [3]	157/17 170/3	185/23	186/15	176/25
153/5 153/5	143/10	44/14 44/16	181/7	186/16	heard [20]	177/17 178/4
153/6 153/6	143/13	173/1	hazardous [7]	186/18	25/14 27/12	179/22
153/7 153/8	143/15	happens [6]	18/21 115/8	he's [2] 5/24	36/19 42/3	183/20
153/9 154/6	143/16 152/2	6/20 11/14	115/16	149/4	42/16 63/21	184/11
155/12	152/2 152/4	38/21 44/17	120/23	head [8] 2/25	64/18 68/10	184/24
155/16	174/15	102/5 102/17	121/10	3/2 65/25	70/12 79/23	185/11
156/24 158/3	175/24 177/7	happily [1]	159/24 169/7	111/9 134/21	99/25 103/18	187/16
158/7 159/22	hand/arm [2]	105/19	HAZMAT [2]	142/9 174/12	119/16	189/21 190/3
160/3 160/16	143/10	happy [2]	70/3 91/24	185/24	134/14 137/4	helped [5]
162/8 166/17	143/13	146/14 147/3	he [74] 5/14	headache [4]	137/18	16/1 78/3
168/2 168/4	hand/glove	hard [1] 1/15	5/16 5/20	137/4 137/18	147/21 165/2	85/15 156/13
168/5 168/19	[1] 152/4	harm [1]	5/20 15/19	138/1 160/15	168/3 171/25	157/4
168/22	handed [3]	100/12	16/3 29/19	headed [2]	hearing [4]	helpful [6]
168/22	157/2 189/12	has [36] 18/6	38/10 44/5	25/20 66/1	4/15 5/13	35/25 64/17
172/13	189/13	26/7 26/7	53/13 53/15	heading [5]	94/9 97/21	73/5 78/21
172/17 178/2	handheld [1]	42/4 44/10	54/3 54/23	7/20 13/8	hearings [2]	83/12 128/20
179/18	126/18	45/7 45/22	54/24 55/22	16/20 16/24	4/16 56/14	helping [2]
180/20	handle [2]	48/25 49/15	79/24 79/25	76/5	heart [20]	177/22
180/22	80/21 127/1	55/22 62/4	80/11 85/17	headline [2]	12/16 13/14	179/18
181/10	handler [1]	76/12 79/11	90/11 93/2	16/18 17/25	13/22 102/18	helps [1]
181/17	93/19	80/19 80/20	94/3 95/4	headquarters	136/1 144/5	54/9
182/14 184/6	handling [1]	80/22 97/11	95/10 95/11	[2] 92/21	145/18	HEMS [2]
186/5 189/6	61/4	98/20 99/1	95/22 96/11	94/23	145/20	181/10 185/8
189/19	handover [7]	104/8 104/11	96/17 102/13	health [31]	145/22 146/7	hence [3]
189/20	141/19	104/16	105/10 110/5	17/4 20/22	146/20	68/21 108/11
hadn't [11]	141/21 153/3	105/10	134/24	22/2 23/15	146/21	182/21
22/6 58/4	153/3 174/13	105/15 107/6	134/25 137/2	34/6 34/7	146/22	her [73]
59/25 60/18	174/18	109/24	137/3 137/8	34/8 35/11	146/23	36/12 36/13
81/15 81/15	189/14	116/12	137/8 137/9	45/19 47/13	165/25 166/2	36/13 36/16
88/18 112/5	Hang [1] 44/1	116/17	137/11	47/23 48/3	175/2 175/16	41/9 91/16
147/21	happen [9]	126/16	137/14	48/6 69/12	175/17	134/20
152/21	7/5 30/13	142/21	137/17	75/6 76/5	175/18	134/21 135/4
159/19	47/20 47/22	145/18	137/18	76/9 76/23	heartbeat [1]	135/6 135/11
half [1]	51/1 67/2	150/23 153/6	138/15	77/2 78/13	104/2	135/15
145/10	101/2 106/16	154/19 170/5	138/18	78/19 78/25	held [2]	135/17 137/6
halfway [5]	121/4	186/16	138/24	83/2 83/18	51/12 88/1	137/19
143/1 151/8	happened	hasn't [2]	138/25 139/4	83/18 83/20	Hello [1]	137/21 138/8
151/12	[22] 14/20	26/4 105/18	139/5 139/7	85/10 87/14	134/14	138/13
151/18 154/7	26/17 39/2	have [382]	142/5 147/15	88/3 108/14	help [32] 7/3	139/24 140/1
hall [1]	51/2 51/6	haven't [6]	147/20 148/3	109/15	40/19 41/9	141/24 142/9
147/16	51/8 67/1	30/4 54/17	148/4 148/6	healthcare [1]	51/25 52/5	142/15
hallway [2]	67/7 73/15	88/17 104/24	148/6 150/12	159/14	55/15 64/3	143/13
134/18	117/15	110/8 110/15	154/20	hear [15]	64/5 64/20	143/16
134/23	125/17 134/3	having [16]	154/22 165/4	15/24 16/2	69/18 105/20	147/17
hand [19]	134/25 137/3	11/4 25/13	168/5 171/2	38/8 56/13	106/22	147/17
15/5 20/18	153/10	34/13 39/12	172/16 173/9	79/24 98/1	118/12	147/20 148/2
50/2 83/25	169/24 170/6	45/12 48/14	173/13	98/3 99/10	142/24 167/5	152/1 152/2
87/24 118/20	173/17	88/21 95/4	174/12	99/18 120/6	173/24 174/2	154/24
118/21	177/25	99/5 100/23	174/18	140/24	174/25 175/1	155/17
	179/24 181/5	127/21	174/18 175/8	152/15 167/8	175/14	155/18

H	24/22 72/6	Home [1]	122/22	I	161/21	133/24
her... [39]	82/4	86/8	127/15	I absolutely	176/13	139/15
156/13	higher [1]	homely [2]	147/22	[2] 6/7 59/1	189/12	146/12
156/17	110/20	88/16 89/7	154/22	I agree [2]	I broke [3]	146/13 151/5
156/24	highest [1]	honest [1]	164/16 170/4	5/25 53/23	139/19	151/6 154/23
156/25 157/4	172/5	10/14	173/18	I already [1]	147/13	163/15
157/20 158/9	highlighting	hope [1]	176/18	119/11	147/14	I couldn't [3]
158/12	[1] 128/19	57/13	180/24	I also [2] 31/2	I can [26] 2/2	129/21 133/6
158/14 169/3	him [20]	hopefully [2]	183/21	123/13	14/5 36/2	135/23
174/14	15/21 38/7	46/18 85/24	187/17	I always [2]	46/14 60/1	I deal [2] 96/1
174/15	54/20 54/22	hospital [19]	187/21	154/1 158/5	63/3 68/22	101/12
174/22	80/3 80/6	5/16 17/22	187/24	I am [3] 3/24	74/1 78/8	I did [14]
174/22 175/3	80/7 80/10	19/16 20/4	however [9]	43/12 44/4	89/21 97/2	19/5 48/19
175/24	95/18 95/21	20/25 33/4	11/10 31/13	I appointed	109/11 110/8	52/21 74/15
175/25 176/1	110/2 110/3	70/20 94/11	41/12 47/12	[1] 75/3	110/21 113/5	74/25 101/12
176/4 179/16	110/5 134/25	97/21 154/15	60/1 64/16	I appreciate	118/12	123/24
179/17	138/13 154/8	155/1 167/9	98/14 107/17	[3] 52/4	152/13 162/5	138/15 141/6
179/17 181/7	174/25 175/1	171/11 178/5	180/21	53/24 134/5	164/22	152/8 157/24
182/7 182/7	178/25	178/6 185/18	HQ [1]	I arrived [1]	166/19	178/20
182/24 183/3	181/18	187/17	127/16	134/13	169/10	181/23 182/3
184/7 184/9	himself [1]	187/18 188/7	huddle [4]	I ask [9]	174/17	I didn't [16]
184/15	137/10	hospitals [3]	96/6 96/8	70/13 84/8	179/13	3/23 51/7
184/17	hindsight [8]	17/9 17/16	98/15 100/14	111/4 112/12	185/23	51/15 51/16
184/22 185/1	59/4 64/17	23/20	huge [1]	118/1 161/15	186/14	51/17 53/6
185/7 185/11	65/9 72/1	hot [4]	183/25	163/12	186/16	120/6 134/16
185/15	72/21 84/25	115/14	human [1]	165/12	I can't [13]	134/16 139/4
185/17	99/13 108/10	143/18	83/4	173/15	52/2 88/25	142/2 143/20
186/23 187/2	his [25] 5/14	143/19	humans [3]	I asked [3]	110/24	155/5 176/7
HERC [1]	5/16 5/20	143/20	32/12 32/16	75/11 81/10	115/17	176/20
86/10	6/23 16/1	hours [4]	82/16	137/7	115/18 118/6	181/22
here [25]	29/19 57/7	27/19 29/16	hypotensive	I assume [1]	122/6 147/23	I do [22] 1/18
47/2 62/25	57/8 80/1	83/8 92/4	[2] 157/6	35/18	148/7 148/11	5/3 16/22
69/22 74/6	80/8 90/10	house [3]	157/8	I assumed [1]	173/25 181/6	24/7 43/18
78/7 78/14	93/24 94/23	105/13	hypotheses	138/23	187/20	54/9 54/12
79/9 79/15	94/23 111/1	149/15 184/9	[5] 80/22	I attached [1]	I cannot [2]	54/19 59/4
84/14 87/8	134/24	how [41] 4/3	102/10	140/1	118/9 153/16	61/8 65/3
96/7 101/21	138/21	10/9 10/10	102/11	I believe [24]	I carried [3]	67/5 78/6
102/23	138/22	11/24 16/11	107/25 111/2	59/16 78/14	139/15 140/9	96/2 118/7
107/10	138/23 149/4	36/22 41/10	hypothesis	78/15 80/5	148/15	125/2 129/20
108/11	150/13	42/9 42/10	[7] 71/6	83/13 117/5	I changed [2]	131/22
134/12	172/17	44/17 46/17	95/18 95/21	123/14	154/10	153/16
134/15	174/12 175/9	48/21 53/17	98/10 101/14	125/21	154/13	156/11 162/7
134/16	177/9	66/5 73/7	101/16	125/24 127/7	I checked [1]	165/14
141/20 144/6	history [5]	73/9 75/1	101/16	132/19	148/17	I don't [35]
144/13 167/1	2/11 2/18	80/11 97/24	hypothesises	134/24 138/3	I circulated	10/13 14/19
171/16 178/2	137/11	99/11 100/25	[1] 177/21	139/25 145/6	[1] 30/23	18/18 21/13
179/5	138/14 147/7	102/2 112/1	hypothetical	145/17	I collected [1]	31/12 46/14
heroin [1]	hm [4] 13/3	115/13	[2] 32/22	148/15 152/8	134/12	47/21 48/17
91/4	163/7 165/1	115/13	82/7	152/22	I considered	48/17 53/14
high [6] 7/5	184/5	115/25	hypoxic [2]	153/15	[2] 138/1	54/8 55/8
7/9 7/10	hold [1]	116/13	169/19	155/22	139/4	61/6 63/4
	145/14	122/12	169/22		I could [8]	98/9 104/24

I	22/6 59/25	187/12	135/3 135/9	91/8 134/25	134/18	130/11
I don't... [19]	147/21	I knelt [1]	152/2	137/1 137/2	I suggest [2]	130/13
110/19	152/21	174/14	I now [2]	139/20	22/18 95/1	130/17
121/22	I handed [1]	I knew [2]	79/10 91/8	147/17 148/1	I suppose [1]	130/22 132/6
122/11	157/2	53/5 120/16	I perhaps [1]	148/3 154/14	80/24	132/23
123/20	I have [48]	I know [8]	97/3	154/16	I talk [1] 78/9	133/10
123/24	2/5 14/8	1/15 5/14	I previously	176/24	I then [1]	136/12
127/12	14/17 27/12	51/14 59/13	[1] 35/12	184/15	135/21	138/21
140/14	28/19 31/16	86/13 96/6	I probably [1]	I sat [1] 88/4	I think [120]	139/10
143/18	36/5 37/10	167/13	123/12	I saw [2]	3/7 5/10 8/5	139/23
155/13	39/21 39/23	176/24	I pronounce	33/20 134/19	17/1 17/9	140/14
157/10 160/4	40/6 40/15	I later [1]	[1] 180/24	I say [16]	21/8 21/21	140/15
160/22 170/2	41/19 45/18	152/22	I pronounced	12/21 18/12	28/5 28/5	140/15
173/21 179/3	46/17 46/23	I look [1]	[1] 157/8	18/23 19/7	28/24 29/1	140/25 141/7
182/3 183/4	47/10 54/11	108/10	I put [2]	36/19 77/18	29/18 34/12	141/20 143/9
184/8 187/13	59/17 60/2	I looked [6]	70/17 184/14	119/21 132/7	34/19 35/3	144/5 144/15
I done [1]	72/3 72/22	86/7 135/3	I qualified [1]	134/13 135/9	36/2 37/1	146/25
150/18	77/6 81/12	135/8 138/22	114/22	145/11 152/1	39/5 39/17	149/23 151/7
I ever [1]	84/21 87/22	147/25	I recall [3]	158/6 159/17	41/1 41/12	151/10
155/13	107/8 108/11	154/23	45/15 46/2	170/5 178/20	45/20 47/22	152/14
I explained	108/21 109/7	I may [14] 5/4	47/8	I see [18]	49/12 51/12	152/16
[1] 65/7	112/24 113/2	8/14 14/6	I received [1]	71/9 162/20	53/8 57/19	153/15 154/6
I exposed [2]	118/24 119/2	22/3 29/9	121/15	162/24	58/17 59/22	154/21
139/22	122/19	41/22 56/24	I refer [2]	167/23 173/3	60/18 64/13	155/20
139/24	124/15	60/15 65/3	29/9 98/7	175/8 175/21	65/10 67/8	156/13
I felt [1]	127/12 128/9	67/4 96/15	I referred [2]	176/1 178/2	69/2 71/18	156/16
146/11	133/5 134/12	101/10	110/24	178/14	72/1 73/5	156/19
I followed [1]	139/1 144/6	131/21	152/20	181/13	73/10 74/11	157/24
140/2	146/10	131/22	I reflected [1]	181/21	74/18 77/6	160/13
I gave [2]	154/17	I mean [10]	64/16	181/25 184/3	77/11 77/25	166/21
113/11	163/21	6/6 10/13	I reiterate [1]	184/11	78/6 80/14	172/22 177/1
141/21	164/17	19/19 119/21	84/25	184/17	81/7 84/13	177/20
I give [1]	183/24 187/4	122/25 123/1	I rely [1]	184/20 187/4	85/14 86/18	178/12
184/14	I haven't [2]	123/18	40/16	I set [1] 87/3	86/24 89/21	181/20
I go [2] 65/22	54/17 110/8	137/22	I remember	I should [2]	91/9 93/6	188/18
72/23	I heard [2]	143/18	[3] 117/7	128/17	93/12 97/8	188/22
I got [3]	134/14 137/4	151/22	139/23 181/6	166/25	98/7 98/24	I thought [7]
129/20	I hope [1]	I mentioned	I represent	I shouted [1]	108/23	59/10 89/15
151/19	57/13	[1] 19/20	[4] 41/5	134/14	111/24	135/8 138/6
160/14	I interrupted	I might [1]	101/9 159/8	I showed [1]	112/12 114/6	138/25 154/2
I guess [1]	[1] 84/13	182/25	187/11	77/25	114/7 116/24	158/6
107/25	I invite [1]	I move [2]	I responded	I sit [1] 79/9	117/15	I took [4]
I had [12]	2/13	69/24 85/4	[1] 3/19	I spoke [1]	118/10	3/25 19/17
22/5 60/24	I joined [1]	I must [2]	I return [2]	100/17	119/16	31/9 31/19
69/17 81/17	114/16	22/5 139/25	71/22 71/25	I squeezed	119/22	I touch [1]
107/6 111/8	I just [13]	I need [2]	I returned [1]	[1] 174/13	123/12	85/23
135/22	22/2 55/4	22/17 136/12	150/21	I started [3]	123/21	I turned [2]
135/23	94/11 104/7	I never [4]	I said [20]	3/16 136/3	125/14 126/1	134/15
138/20 142/1	109/4 134/7	74/12 153/25	21/18 35/10	142/7	126/11 127/8	134/18
152/3 156/24	139/5 140/12	155/10	56/12 56/19	I state [1]	127/21	I understand
I hadn't [4]	150/18 168/6	155/10	59/10 62/21	134/16	128/23	[7] 6/14
	176/9 177/4	I noticed [3]	69/16 73/22	I stood [1]	129/12 130/2	12/15 20/25

I	154/25	122/20	126/21	87/1 87/6	82/8 84/12	indeed [12]
I	157/23	122/25 131/7	127/11	87/8 87/20	88/15 88/19	14/18 26/2
understand...	159/16	132/7 135/10	127/14 128/8	88/10 185/1	91/14 91/24	28/9 29/16
[4] 42/13	162/18 175/5	135/11 136/9	128/18	implementati	92/16 92/20	40/13 45/7
53/7 105/22	181/24 182/8	136/9 143/5	128/23	on [2] 44/21	93/12 93/15	55/11 58/6
189/25	185/9 185/24	151/13 153/2	147/23 148/4	45/5	94/2 94/14	62/13 78/22
I undertook	186/1 187/3	153/3 155/25	163/24 164/1	implemented	94/15 94/16	111/20 161/1
[1] 3/17	I wasn't [4]	159/17	165/17 167/7	[2] 43/4 45/4	97/5 97/16	INDEX [1]
I update [1]	45/17 46/22	159/18	167/13 171/7	importance	98/13 99/16	191/2
116/13	52/2 53/14	162/18	171/9 176/12	[3] 48/19	99/18 103/3	indicate [9]
I uptook [1]	I went [6]	163/13	178/17 179/3	102/8 135/24	103/15 104/9	66/10 67/21
115/12	123/24 137/5	167/19 170/7	180/16 189/5	important	117/1 117/2	68/6 69/1
I used [2]	150/25	180/2 181/16	189/16	[13] 5/10	117/6 118/8	129/13
98/8 123/18	174/11	186/19	I've [4] 26/4	37/1 37/8	119/3 126/15	132/24 135/5
I walked [1]	174/13	I wouldn't [1]	83/7 133/7	46/8 51/13	138/5 138/11	145/10
134/15	181/11	138/20	164/12	53/22 54/16	159/23	146/20
I want [24]	I were [1]	I'll [2] 132/15	i-gel [3]	69/3 100/14	162/22	indicated [8]
4/22 5/4	143/2	144/13	157/12	136/3 153/11	171/18 172/3	62/16 90/4
14/15 16/10	I will [17]	I'll just [1]	157/14	183/11 189/6	180/4 180/8	115/22
29/22 36/1	2/17 8/13	144/13	180/14	Importantly	incidents [16]	133/21
36/8 41/22	24/18 25/21	I'm [83] 2/10	idea [8] 4/2	[1] 57/25	7/6 7/10 18/1	134/12 140/4
45/10 46/3	40/21 49/23	5/22 7/1 8/9	10/8 30/12	inaccurate [1]	20/24 27/21	144/12
47/15 49/6	57/21 60/17	10/14 20/13	63/7 64/9	90/5	29/10 31/12	144/16
52/14 66/23	63/12 75/16	21/14 22/12	87/22 157/17	incidences	42/24 42/25	indicates [1]
89/17 94/16	76/6 91/19	24/18 26/3	187/21	[5] 6/6 70/16	44/10 44/25	146/18
94/19 101/9	97/11 106/3	29/22 37/11	identical [4]	74/25 99/4	66/12 66/14	indicating [2]
101/20	128/2 136/22	37/11 40/6	18/23 21/8	111/11	68/7 97/5	51/21 158/1
107/10	170/19	40/22 40/24	21/20 62/24	incident [84]	133/5	indication [6]
133/18	I wish [1]	46/25 47/16	identified [8]	7/3 16/21	include [4]	13/17 13/19
164/23	55/8	47/24 49/14	62/4 70/19	18/6 19/21	12/18 18/11	49/16 106/16
166/25	I won't [2]	51/16 51/17	77/1 77/16	23/2 23/2	115/15 166/3	140/3 179/12
167/23	18/17 55/3	52/2 52/5	83/2 109/24	23/6 23/9	included [3]	indicative [3]
I wanted [3]	I would [55]	52/5 52/6	110/12	27/16 27/18	50/9 122/8	12/8 12/9
19/19 81/14	10/14 11/12	53/9 53/16	110/19	28/10 28/21	177/5	160/17
110/5	25/2 27/10	54/24 57/6	identify [1]	29/7 29/18	includes [1]	indicators [2]
I was [36] 3/2	29/21 33/24	58/16 58/23	71/7	30/6 30/17	83/3	18/2 169/4
31/13 31/15	42/8 54/13	60/25 64/13	identifying [2]	32/5 32/15	including [6]	individuals
51/24 52/25	56/24 57/11	68/8 70/25	70/6 122/12	32/19 33/13	3/18 48/7	[2] 51/3
60/15 61/8	59/10 63/17	72/22 72/25	ill [1] 38/6	34/5 37/20	120/12 123/9	80/23
62/14 63/16	63/24 69/9	77/17 77/23	illness [1]	39/9 45/1	165/21	infarctions
67/19 70/17	69/15 73/21	78/14 78/17	27/17	45/11 47/7	180/13	[1] 13/15
71/6 77/4	73/22 75/20	82/10 85/24	imagine [1]	58/20 59/23	inconsistenci	infected [1]
108/12	75/20 75/21	89/23 90/14	111/1	62/1 62/2	es [1] 177/21	71/8
108/13	75/23 79/2	94/8 95/15	immediate [3]	62/12 63/23	inconsistent	infectious [1]
114/18	85/25 86/11	96/21 99/9	131/14	64/5 64/21	[1] 36/15	7/10
114/21 123/1	86/18 96/22	99/9 103/15	131/16	65/14 67/1	incontinence	infer [1]
124/5 129/13	97/1 101/19	104/13	131/18	67/12 68/19	[2] 167/11	92/21
146/13	108/20	105/23 107/4	immediately	71/2 71/3	183/16	inflations [1]
147/21	110/25	107/11	[3] 16/24	71/14 72/10	increased [1]	143/5
151/21	111/16	109/20 111/1	18/22 144/22	75/24 77/9	169/14	influence [1]
151/21 152/5	119/21	112/5 114/25	impact [8]	78/22 79/6	incredibly [1]	139/8
	122/17	118/6 124/1	39/25 77/8	79/8 82/5	78/11	influential [1]

I	information/i	81/23	94/23 95/1	interested [1]	90/19 154/14	issues [12]
influential...	ntelligence	INQ004745	95/17 96/7	180/16	involving [1]	26/25 36/9
[1] 54/25	[4] 102/21	[1] 108/23	instance [2]	internal [7]	50/25	75/13 75/14
inform [5]	104/22	INQ004837	130/15	20/5 26/8	IOR [6] 72/3	75/19 76/5
46/8 46/9	104/23	[1] 74/6	140/21	32/2 33/19	72/24 84/17	77/2 81/13
69/12 99/1	105/20	INQ005000	instead [2]	57/15 57/16	85/1 100/19	81/13 83/1
105/20	informed [7]	[1] 112/23	16/5 171/9	66/3	103/3	87/4 89/18
information	52/25 84/24	INQ005942	instinctive [1]	internally [3]	IOR1 [2]	it [591]
[67] 28/18	105/24 107/2	[1] 128/1	160/10	9/5 45/5	95/10 106/12	it's [104] 5/10
30/7 31/9	110/17	INQ006058	instruct [1]	50/24	iPads [1]	7/8 8/6 12/24
31/10 36/24	117/17 173/1	[1] 1/15	94/15	Interoperabili	10/25	13/19 13/22
37/7 37/16	initial [16]	INQ006069	instructed [1]	ty [1] 39/7	irreconcilable	17/6 21/3
40/19 44/18	27/1 31/2	[1] 59/13	99/23	interrupt [2]	[1] 102/17	21/7 21/13
46/8 46/23	34/22 35/7	INQ00623 [1]	instruction	29/22 47/24	irrelevant [1]	22/8 25/5
52/6 54/5	63/20 71/5	124/2	[5] 9/25 10/4	interrupted	148/12	26/8 26/14
61/19 62/1	76/10 83/15	INQ4550 [1]	11/4 12/10	[1] 84/13	irritation [2]	28/12 31/23
62/14 65/4	97/15 100/16	161/23	13/23	interventions	138/8 169/5	32/2 32/4
66/10 67/19	135/12	INQ5294 [1]	instructions	[1] 173/17	is [479]	32/23 33/19
67/21 68/6	137/22 138/4	180/3	[1] 146/3	intranet [1]	is it [1] 88/19	35/1 35/3
69/1 85/19	138/10 144/4	INQ5942 [1]	intelligence	11/2	isn't [16]	35/3 35/5
87/18 88/8	153/25	171/11	[35] 58/21	intravenous	12/24 27/18	39/5 41/7
90/24 95/24	initially [10]	INQ623 [1]	61/25 62/9	[2] 144/8	34/25 54/3	41/19 41/25
97/14 97/22	71/3 114/16	165/10	62/14 66/10	144/9	54/21 72/11	42/3 43/10
98/17 99/1	114/18	INQ659 [1]	68/6 68/16	introduction	77/19 79/10	44/14 44/15
102/21	129/15 131/5	168/8	88/8 90/23	[1] 114/20	98/22 109/13	46/3 47/1
104/16	136/3 142/20	Inquiry [13]	91/2 91/6	intubated [1]	127/24 133/5	47/4 53/24
104/18	153/2 154/25	1/14 21/1	92/25 94/1	185/21	163/11	57/19 61/4
104/20	172/13	22/4 28/22	95/4 95/22	investigate	175/22	63/25 64/1
104/22	initiative [1]	60/22 70/8	97/14 97/18	[1] 154/18	179/22 185/5	65/24 66/1
104/23	19/2	106/20	97/23 98/10	investigation	isn't it [8]	70/15 73/3
105/20 106/9	injector [1]	106/22	98/18 98/19	[7] 79/25	12/24 27/18	73/6 73/8
109/22 117/6	125/7	112/12	102/21 104/7	79/25 108/15	77/19 79/10	75/4 77/9
117/19 121/3	injectors [2]	161/16	104/10	109/23	98/22 109/13	77/19 79/10
126/15	165/3 165/8	176/11	104/15	110/23 111/2	163/11 185/5	79/10 81/7
129/23 131/3	injury [5]	186/14	104/18	111/12	isolated [4]	81/23 96/5
131/5 131/9	27/17 138/6	190/13	104/21	invite [1]	58/20 62/3	97/3 98/23
131/11	154/3 169/22	Inquiry's [1]	104/22	2/13	62/12 75/15	101/14 102/4
131/20	182/13	113/8	104/23 105/2	involve [1]	isolation [1]	102/19
133/11	injury/illness	insert [1]	105/5 105/8	51/3	121/11	102/19
137/20	[1] 27/17	143/13	105/12	involved [17]	issue [9]	103/14 104/1
137/25 139/1	INQ000623	inserted [1]	105/12	33/12 33/15	11/12 20/8	104/19
147/18 158/2	[1] 10/3	143/9	105/20	40/4 46/22	28/1 28/8	104/21
158/24	INQ000627	inside [1]	intended [6]	52/2 90/16	56/25 73/22	108/22
159/20	[1] 8/7	100/1	14/25 15/19	94/10 95/7	86/5 124/8	109/10
160/14	INQ000653	insight [1]	17/8 30/25	103/12 111/6	160/1	109/12
167/24	[1] 127/9	4/24	31/5 168/4	115/12 142/8	issued [11]	109/13
172/12	INQ000660	insisted [1]	intensive [1]	153/20	7/21 8/4	109/15
172/20	[1] 17/6	99/18	114/8	153/22	10/22 11/15	115/17
172/21	INQ000724	Inspector [10]	intention [1]	153/23	19/6 22/12	121/22 125/9
173/18 188/6	[1] 25/3	92/20 93/2	9/5	156/25 168/1	24/17 31/2	125/12
189/6 189/10	INQ004704	93/22 94/1	interactions	involvement	63/25 88/16	126/25
	[2] 31/22	94/13 94/20	[1] 181/17	[3] 89/20	89/7	126/25 130/3

I	102/8 102/14	125/20	114/18 115/9	176/25	kindly [1]	133/16
it's... [28]	102/18	163/10	118/14	176/25 177/4	1/13	136/21
134/8 135/8	103/20 104/1	165/15	118/15	179/5 179/13	Kingdom [3]	137/24
136/23	jiddery [1]	170/20	118/16	181/16 182/4	80/20 106/17	138/13
139/17	137/9	just [186]	118/21 120/4	182/4 182/20	108/2	138/21 142/2
142/25 143/1	job [6] 79/2	1/19 3/11 4/2	120/8 120/19	184/11 185/9	kit [1] 180/13	153/12
146/23	80/2 92/6	7/3 8/10 9/24	121/7 123/4	186/10	kitchen [1]	153/16
147/20	113/25	10/23 12/3	124/25 126/5	187/12	147/16	153/19
150/19 156/7	130/13	13/7 14/5	126/13	187/15	kneeled [1]	153/20
156/8 158/23	154/18	14/12 16/17	127/23 128/3	188/12	135/11	157/24
162/22 163/5	join [1] 78/16	17/23 18/3	128/6 128/6	189/20	knees [1]	158/22
176/13 177/5	joined [1]	20/3 21/9	128/12 129/1	189/22	174/12	160/22 164/6
177/6 177/8	114/16	21/20 22/1	129/9 130/17	189/23	knelt [3]	166/17
177/21	joint [17]	22/2 22/16	132/8 134/7	justify [1]	135/14	167/13
182/12 183/6	39/7 39/13	22/24 25/21	135/24	12/11	174/14	167/25
183/9 184/23	39/14 64/1	27/14 28/11	135/25	K	174/22	169/24 174/4
186/10	64/24 87/14	28/14 32/5	136/22	keep [6]	knew [13]	174/8 176/9
188/10	94/24 96/20	34/1 37/22	138/16 139/5	53/18 116/11	53/5 81/5	176/24 184/8
189/14	97/10 99/1	41/6 41/7	139/15	116/22 144/8	101/25	188/3 189/9
189/22	99/2 99/12	41/21 42/3	139/22 140/7	144/8 188/10	119/11	know' [1]
189/23	100/11 102/8	45/19 48/14	140/12	keeping [2]	120/10	154/16
it's drug [1]	102/16	52/6 53/19	140/14	173/1 175/17	120/16	Knowing [1]
42/3	102/25	55/4 55/9	140/15	Keith [20]	120/23	39/2
item [2]	106/13	57/18 57/20	140/16	141/1 141/3	122/22 133/1	knowledge
57/25 68/2	jointly [3]	58/23 59/5	144/13	141/4 141/21	141/5 155/10	[6] 2/7 30/12
items [1]	39/11 95/6	59/6 59/20	144/19 145/3	142/3 142/24	157/24	81/4 90/19
57/25	97/23	61/1 62/18	145/5 145/9	143/2 143/4	170/10	113/4 162/13
its [3] 74/23	JOP [3] 64/1	63/8 66/22	147/9 147/21	143/6 143/9	know [70]	known [10]
104/10	64/1 64/24	67/6 67/10	149/22	143/13	1/15 4/13	29/17 41/11
146/22	JRCALC [1]	67/13 68/4	150/18	143/14	4/14 5/14	60/11 78/20
itself [4]	50/7	69/25 71/10	151/10	147/14	22/17 25/9	81/2 90/5
14/13 25/9	juddery [1]	71/19 74/10	155/15 159/9	152/19	28/9 29/6	119/22 120/5
83/18 165/7	138/17	75/4 75/10	159/23 162/3	152/20 155/9	29/11 29/12	121/2 133/7
IV [1] 153/6	judgment [2]	76/6 76/25	162/18	161/9 161/10	33/7 37/17	
	98/3 98/21	77/9 78/1	162/21 163/3	161/19	39/2 41/10	L
J	Jukes [1]	78/10 79/17	163/4 163/5	192/13	41/12 41/20	label [1]
January [2]	94/11	79/22 82/21	163/5 163/13	kept [3] 51/8	44/5 47/21	77/21
91/1 124/8	July [11]	83/22 84/5	163/19	78/4 108/4	47/23 51/5	lack [1] 135/5
jaw [1] 142/9	22/13 22/15	85/4 85/8	163/21 165/8	key [7] 19/20	51/14 51/23	lady [1]
JDM [1]	58/7 91/1	85/8 86/12	165/17	43/20 43/22	52/16 53/6	123/21
104/20	112/22 123/5	87/17 89/5	166/21	45/8 46/4	53/14 54/8	laptop [1]
JESIP [23]	161/22	89/23 94/11	166/22	102/24 128/3	58/7 58/10	127/2
39/6 42/13	161/22 163/6	94/20 96/15	166/24 168/6	kicked [1]	59/13 59/20	large [3] 4/9
42/17 42/21	163/10	96/21 98/19	168/14	95/17	61/6 62/15	46/6 46/11
42/25 63/19	188/25	99/9 100/4	169/10	Killoran [2]	78/1 86/13	largely [1]
64/3 64/24	June [16]	101/10 104/7	171/14	25/20 27/15	96/6 99/13	26/21
70/3 93/19	28/13 43/17	107/13	171/24	Killoran's [1]	99/19 99/21	larger [2]
94/16 94/21	44/14 58/7	107/14	173/25 174/7	26/13	99/24 112/13	36/9 134/9
94/22 95/16	64/8 89/20	108/20	174/17	kind [5] 49/4	121/4 122/2	last [16] 1/19
96/23 96/24	113/21 122/3	108/22 109/4	175/14 176/9	102/2 109/16	123/10	3/12 27/14
98/14 99/3	124/9 124/18	109/5 110/5	176/21	117/9 182/10	123/22	31/16 68/1
	125/8 125/18	113/10	176/24		132/14	83/8 89/18

L	152/22	7/12 9/7	57/11 63/10	list [2] 32/7	location [10]	98/14 102/1
last... [9]	learning [24]	12/19 24/22	67/2 71/15	32/7	76/15 93/16	106/4 108/10
95/20 99/9	16/13 16/18	42/6 42/6	72/14 73/21	listed [1]	94/22 96/4	109/5 110/3
99/10 101/12	19/21 28/16	42/10 42/10	77/10 80/5	24/12	97/13 100/14	110/10
101/13	30/3 35/9	42/23 46/7	80/16 86/11	listen [1]	115/6 115/7	118/14 121/6
106/16	35/15 35/22	54/17 56/17	87/13 88/23	113/15	129/13	124/11 128/4
147/10 162/4	43/20 43/22	59/1 63/24	102/1 107/5	lists [2] 12/12	131/23	128/6 128/22
169/19	44/21 45/3	69/17 71/6	108/21 109/5	12/21	lock [2] 86/20	148/9 149/14
lasted [1]	45/6 46/4	72/6 75/4	111/22	literature [1]	86/21	154/17
148/8	71/13 71/20	75/8 75/23	123/21	116/6	log [17]	154/20 165/7
lastly [1] 38/5	72/15 84/1	77/7 79/2	128/22	little [17]	93/20 95/8	165/18 180/2
late [3] 8/14	84/12 99/4	82/4 83/21	133/17	2/11 16/19	95/9 116/10	180/15
8/19 169/21	103/21	88/24 88/25	136/14 137/5	45/23 62/19	127/10 128/1	looked [12]
later [20]	103/21	141/17	138/7 141/15	62/23 73/14	129/19	81/24 82/13
21/21 25/10	106/10 116/6	145/11 147/4	141/15	86/4 117/22	129/25	83/23 84/15
25/16 27/20	least [4]	164/2 166/6	147/18	140/10 147/5	130/21	86/7 91/16
29/16 38/6	12/10 19/3	172/5 184/9	149/14	154/21	130/25	135/3 135/8
40/20 41/17	49/20 133/16	levels [9]	162/16	159/17 164/4	133/16	138/22
73/14 79/9	leave [3] 78/2	13/5 50/9	162/18	166/24	140/23 171/7	147/25
92/4 140/10	86/12 113/16	75/25 86/17	163/14	166/24	171/10	154/23
140/25	leaving [1]	149/20 150/5	176/22	168/14 171/8	173/15	165/11
152/22	68/15	151/6 153/10	177/11	live [2] 10/24	173/18 174/3	looking [22]
162/22	led [3] 103/4	155/18	181/16	43/7	logs [2]	12/5 21/9
171/22	105/6 160/11	lie [1] 129/22	182/12	lived [1]	91/16 127/11	21/20 47/5
173/10	left [12] 13/8	life [14] 16/1	182/12	107/4	London [9]	62/18 64/9
177/18	45/12 45/22	131/16	186/10	lives [1]	4/17 45/24	65/20 67/13
188/19 189/2	80/23 81/15	135/21	186/19	100/12	56/8 56/14	68/13 70/1
latest [1]	107/17 145/4	136/15	likelihood [5]	loads [1]	114/12	83/22 85/8
116/22	147/14	136/19 144/2	65/15 66/11	182/19	114/15	87/7 95/13
latterly [1]	174/14	150/22 175/9	68/7 69/1	local [21]	114/16	104/1 108/16
97/20	174/15 179/7	175/12	188/2	42/15 46/20	114/23	108/19
lay [1] 87/23	180/19	178/12	likely [5]	59/1 69/16	114/23	128/18
laying [1]	left-hand [1]	178/19	30/18 33/12	69/17 75/3	long [11]	128/23
134/19	174/15	179/18	65/5 84/4	75/6 75/8	5/20 115/18	134/18
LCD [1]	lens [1] 98/11	180/18 181/3	94/2	75/21 75/23	115/19 134/6	144/15
145/2	let [5] 30/10	lifting [2]	limit [1]	77/7 79/2	162/6 164/16	154/25
lead [6] 19/23	31/21 38/20	142/9 185/9	53/17	83/21 86/1	167/14 168/9	looks [8]
93/18 141/7	71/19 151/10	lifts [1]	limited [1]	87/1 87/8	169/12	50/8 71/15
141/8 141/9	let's [17] 8/6	142/14	84/20	87/14 88/24	187/17	107/5 128/4
147/6	10/2 12/3	light [11]	line [7] 9/7	103/20	187/21	128/25 130/9
lead-up [1]	16/15 17/5	39/10 42/14	11/18 42/12	103/23	look [43]	130/20
147/6	17/23 21/2	42/18 42/22	83/22 131/9	115/23	10/7 12/3	133/17
leader [2]	22/9 25/18	96/6 96/8	140/8 142/1	localised [1]	17/23 22/20	loop [3] 78/4
54/23 54/24	74/5 75/18	98/15 100/14	lines [8]	78/11	26/8 27/7	81/16 108/4
leadership [1]	76/2 81/21	105/2 106/15	58/25 70/4	locally [4]	27/14 35/6	loosely [1]
4/1	90/8 93/7	139/24	83/22 104/12	75/5 78/18	59/13 61/1	70/25
leading [2]	104/17	like [48] 10/9	121/7 129/5	81/18 108/2	62/24 64/10	lose [3] 138/8
76/17 79/24	149/22	25/2 27/11	130/3 130/7	locate [1]	69/6 74/5	183/12 186/7
leaflets [1]	letter [4]	32/9 33/23	linked [2]	39/10	75/1 75/20	losing [2]
87/15	147/25 148/3	36/24 41/18	66/15 130/23	located [3]	76/2 80/5	185/25 186/8
learned [1]	154/23 155/1	42/2 56/24	liquid [1]	58/2 96/13	81/21 90/22	loss [2] 156/8
	level [33]	57/1 57/5	157/11	126/24	92/3 92/13	169/22

L	59/19 96/24 162/4	management [18] 3/13 4/1 4/10 4/25 17/25 20/23	23/13 25/23 26/13 28/4 28/13 31/3 31/15 31/19 32/1 34/24 35/9 35/15 43/16 44/14 58/14 59/22 60/3 60/8 62/8 64/8 68/11 70/14 70/25 74/7 78/7 78/15 84/1 86/16 109/10 110/17 110/18 117/3 121/1 121/18 122/2 122/8 122/16 168/2	match [1] 62/9 material [13] 27/8 32/16 32/18 48/16 48/18 53/4 53/5 54/4 60/6 60/7 60/22 82/15 121/10 materials [3] 18/21 53/8 169/7 matter [11] 38/22 42/6 46/20 78/5 104/5 104/5 106/15 106/17 144/19 183/13 183/16 matters [7] 26/22 54/9 54/16 56/23 101/11 106/19 109/3 may [71] 2/13 5/4 8/14 10/3 11/16 11/17 12/4 12/18 14/6 16/1 16/15 21/24 22/1 22/3 22/7 25/18 29/9 29/24 36/17 41/22 48/6 49/18 55/4 56/24 60/15 62/19 63/22 65/1 65/3 65/12 65/25 66/13 66/22 67/4 71/21 72/9 73/16 74/5 75/19 76/14 77/12 81/23 86/13 93/6 96/15 99/17 101/10 104/7 113/10	113/14 120/18 120/19 128/1 130/15 130/16 131/21 131/22 132/6 132/8 133/13 145/2 145/3 148/11 148/11 153/15 154/2 154/22 158/19 166/3 166/9 169/21 maybe [6] 10/19 92/23 138/6 138/7 141/14 159/17 McKerlie [3] 94/10 96/11 96/17 MDT [5] 126/11 129/8 131/4 172/19 172/21 me [58] 5/10 6/10 20/14 22/1 26/4 26/4 30/10 31/18 31/21 38/20 40/19 41/14 45/20 46/24 53/1 54/9 54/21 54/21 57/5 60/15 67/6 69/14 69/18 71/19 72/7 75/8 86/5 89/5 95/16 96/4 97/22 108/6 109/19 111/22 120/3 126/20 128/6 129/23 137/11 138/15 138/22 139/1 139/2 140/3 141/22 142/8	147/17 151/5 151/10 154/24 158/18 158/25 163/25 171/9 173/23 174/12 174/14 184/11 mean [20] 6/6 9/15 10/13 19/19 104/1 117/3 119/21 122/25 123/1 123/18 129/6 137/22 140/6 141/10 142/10 143/18 146/17 151/22 178/5 187/24 meaning [3] 24/14 24/15 141/25 means [12] 18/3 45/2 50/1 129/12 131/16 134/20 135/4 138/2 143/3 151/21 161/12 176/9 meant [2] 61/19 178/12 mechanical [1] 146/8 mechanisms [1] 104/19 medic [1] 63/5 medical [10] 31/7 70/7 70/9 138/13 148/4 150/1 158/3 158/4 173/17 179/16 medically [1] 72/8
lost [5] 26/3 138/3 148/16 156/16 186/5	maintain [1] 155/24	maintained [1] 160/6				
lot [10] 2/12 25/10 43/17 44/16 46/15 103/25 116/1 116/4 154/13 170/5	maintained [1] 160/6	maintenance [2] 142/8 153/8				
lots [3] 97/4 108/5 127/13	major [4] 75/24 97/5 99/4 162/22	majority [1] 5/18				
lounge [1] 147/16	make [23] 22/6 37/15 40/4 40/21 49/23 50/13 68/4 70/23 85/17 95/5 99/9 113/10 124/20 125/6 137/25 145/18 145/25 146/10 162/17 163/2 171/8 173/23 188/11	Manager [1] 92/20	managerial [3] 33/10 36/21 38/20	managerial/st rategic [1] 33/10	manner [1] 48/7	Mansfield [25] 40/14 40/14 41/4 41/14 44/1 53/16 54/3 55/2 55/12 101/6 101/7 105/11 106/21 110/2 111/21 159/5 159/7 160/21 187/9 187/10 190/2 192/5 192/9 192/12 192/15
lounge/kitchen [1] 147/16	loved [1] 138/23	low [7] 12/16 47/14 47/23 48/4 65/15 144/17 144/23	March 2018 [1] 122/16	March, [1] 71/21	March/April [1] 59/22	MARK [15] 1/8 112/14 112/20 127/25 129/5 174/6 174/11 174/16 181/20 181/22 181/22 182/12 186/16 192/3 192/10
lower [3] 164/3 164/4 164/5	lubricated [1] 142/13	Lucy [1] 67/23	March [1] 71/21	March/April [1] 59/22	MARK [15] 1/8 112/14 112/20 127/25 129/5 174/6 174/11 174/16 181/20 181/22 181/22 182/12 186/16 192/3 192/10	may [71] 2/13 5/4 8/14 10/3 11/16 11/17 12/4 12/18 14/6 16/1 16/15 21/24 22/1 22/3 22/7 25/18 29/9 29/24 36/17 41/22 48/6 49/18 55/4 56/24 60/15 62/19 63/22 65/1 65/3 65/12 65/25 66/13 66/22 67/4 71/21 72/9 73/16 74/5 75/19 76/14 77/12 81/23 86/13 93/6 96/15 99/17 101/10 104/7 113/10
lunch [2] 111/24 112/7	M	lunch [2] 111/24 112/7	Mansfield [25] 40/14 40/14 41/4 41/14 44/1 53/16 54/3 55/2 55/12 101/6 101/7 105/11 106/21 110/2 111/21 159/5 159/7 160/21 187/9 187/10 190/2 192/5 192/9 192/12 192/15	MARK [15] 1/8 112/14 112/20 127/25 129/5 174/6 174/11 174/16 181/20 181/22 181/22 182/12 186/16 192/3 192/10	me [58] 5/10 6/10 20/14 22/1 26/4 26/4 30/10 31/18 31/21 38/20 40/19 41/14 45/20 46/24 53/1 54/9 54/21 54/21 57/5 60/15 67/6 69/14 69/18 71/19 72/7 75/8 86/5 89/5 95/16 96/4 97/22 108/6 109/19 111/22 120/3 126/20 128/6 129/23 137/11 138/15 138/22 139/1 139/2 140/3 141/22 142/8	means [12] 18/3 45/2 50/1 129/12 131/16 134/20 135/4 138/2 143/3 151/21 161/12 176/9 meant [2] 61/19 178/12 mechanical [1] 146/8 mechanisms [1] 104/19 medic [1] 63/5 medical [10] 31/7 70/7 70/9 138/13 148/4 150/1 158/3 158/4 173/17 179/16 medically [1] 72/8
machine [4] 140/3 146/7 148/17 182/23	making [10] 49/7 49/18 52/20 63/23 94/12 97/10 100/11 102/9 102/16 136/7	man [1] 24/18	mantra [1] 119/13	man [1] 24/18	man [1] 24/18	man [1] 24/18
made [21] 12/25 30/21 31/13 34/12 35/18 49/15 56/22 59/19 62/7 67/20 85/14 87/15 90/6 90/15 93/9 105/14 105/16 114/3 118/14 161/20 185/3	male [10] 134/14 134/22 136/20 137/1 137/7 138/13 141/22 147/1 147/15 154/14	managed [1] 40/5	many [5] 4/3 10/9 73/7 99/3 138/25	mapping [3] 133/4 133/7 133/8	Maps [1] 133/12	March [44] 5/7 14/4 14/16 16/14 16/14 16/25
main [3]	man [1] 24/18	managed [1] 40/5	mantra [1] 119/13	man [1] 24/18	man [1] 24/18	man [1] 24/18

M	met [2] 138/20 152/21	mils [1] 143/24	missing [1] 45/16	149/19 150/4 151/2 151/4	84/16 100/19 108/22 124/3	20/13 21/3 21/10 21/18
medication [1] 155/3	152/21	mind [16] 16/10 40/18	mist [1] 169/7	151/5 151/6	124/4 124/12	22/19 22/22
medicine [1] 10/22	METHANE [1] 97/1	40/23 41/2	mistake [1] 129/23	monitoring [10] 11/5	165/2 168/3	23/5 23/22
medicines [10] 8/9 9/10 10/2 10/20 14/11 18/24 124/7 165/7 165/9 180/19	method [1] 11/5	59/15 63/10 67/10 76/2	mistaking [1] 44/8	44/15 44/18 149/10	179/1 188/18 190/10	25/4 25/19 26/3 26/12 26/13 27/6
medics [2] 105/17 105/18	metres [3] 130/5 130/13 133/17	107/21 108/6 121/23 137/23	mists [1] 18/21	149/11 150/1 150/12 150/15 150/17 150/24	15/11 137/20 138/4 142/13 152/4 156/3 156/12 160/17	27/12 27/15 28/11 29/18 29/23 33/9 35/4 36/1 38/5 39/20 40/14 40/14 41/4 41/14 44/1 44/6 48/6 53/16 54/3 55/2
meeting [11] 51/11 51/12 51/14 51/18 51/20 52/3 76/3 78/16 109/9 109/15 159/15	MI5 [1] 106/16	154/17 159/14 182/19 182/20	misunderstood [1] 60/16	month [3] 10/18 123/5 123/5	mouth [8] 15/11 137/20 138/4 142/13 152/4 156/3	44/1 44/6 48/6 53/16 54/3 55/2 55/12 55/13 55/13 55/15 55/20 55/25 56/3 56/4 56/13 56/19 57/5 57/7 57/11 57/19 59/13 62/13 62/21 63/19 63/21 64/6 65/17 65/23 67/10 68/10 73/20 77/25 78/24 79/23 79/24 80/18 81/24 82/13 83/24 85/4 86/13 89/17 89/25 94/8 101/4 101/6 101/7 103/19 103/25 105/11 106/21 106/23 110/2 111/21 111/22 112/14 112/15 113/21 120/3 123/21 126/6 127/25 130/20 159/5 159/7 160/21 160/25
meetings [2] 88/2 111/12	microphone [1] 127/21	minds [2] 4/3 48/13	mitigate [3] 79/16 81/20 87/19	months [3] 30/6 100/6 133/7	mouth.' [1] 137/7	
meets [3] 69/16 86/2 98/20	middle [1] 146/22	mindset [3] 47/17 47/19 47/21	mitigation [1] 32/6	months' [1] 11/18	move [19] 14/15 16/10 30/10 36/1 69/24 81/21 85/4 86/11 89/17 97/24 100/25 114/25 125/17 164/22 166/4 166/19 170/19 172/8 185/4	
member [1] 108/8	might [22] 17/15 30/13 35/21 36/16 40/3 43/5 47/3 48/9 54/21 63/2 71/15 79/7 85/17 88/22 107/16 139/7 157/19 157/22 159/12 179/23 182/25 186/23	mine [1] 151/1	Mm [4] 13/3 163/7 165/1 184/5	more [38] 4/9 17/15 21/10 25/23 28/12 28/21 28/22 28/25 30/3 35/19 47/3 48/1 60/1 62/14 62/19 63/24 83/10 84/23 88/9 100/5 102/11 107/17 116/12 125/14 131/9 131/11 133/13 144/9 146/25 147/5 148/17 159/3 159/17 165/18 173/14 179/4 189/19 189/21		
members [7] 32/17 36/25 50/17 75/7 82/18 87/23 117/23	Mike [1] 25/20	minus [1] 89/12	Mm-hm [4] 13/3 163/7 165/1 184/5	mobile [9] 10/25 87/13 123/7 126/8 126/14 127/2 130/22 134/24 172/17		
memoire [1] 123/8	miles [1] 132/13	minuses [2] 89/3 89/10	mobile phones [1] 10/25	model [5] 61/14 97/10 100/11 102/9 108/12		
memory [4] 8/5 118/17 119/24 181/5	Miller [1] 100/6	minute [3] 41/23 58/16 136/2	model [5] 61/14 97/10 100/11 102/9 108/12	moment [14] 7/1 8/10 55/4 72/13 77/23 106/11 116/25 124/15 162/25 166/21 171/14 176/12 184/3 187/13		
mental [1] 139/3	milligram [1] 143/24	minutes [14] 74/7 74/14 76/4 81/3 84/11 92/4 92/14 92/14 93/8 109/9 137/8 140/25 171/21 173/10	moment [14] 7/1 8/10 55/4 72/13 77/23 106/11 116/25 124/15 162/25 166/21 171/14 176/12 184/3 187/13			
mention [2] 121/21 122/5	Mills [23] 55/21 55/24 55/25 56/4 57/7 57/11 57/19 59/13 64/6 65/17 65/23 67/10 68/10 73/20 81/24 85/4 86/13 89/17 89/25 94/8 101/4 106/23 192/6	miosis [7] 15/7 167/4 169/17 179/8 182/15 183/17 186/21	Monday [1] 29/17			
mentioned [14] 3/11 4/11 19/20 20/4 31/21 37/10 37/19 45/18 48/25 101/11 101/15 123/4 128/21 184/3		misdiagnosed [1] 29/8	monitor [8] 43/3 146/15			

M	55/13 55/15	172/16 173/7	78/23 97/16	multi-agency	136/22	86/2 86/3
Mr... [37]	56/13 56/19	173/12 175/8	169/25	[3] 25/14	137/22 138/4	88/25 106/5
161/10	62/21 63/19	177/9 180/14	Ms Sturgess'	39/14 69/5	138/9 139/16	107/6 111/10
161/11	63/21 77/25	183/6	[1] 181/17	Murphy [4]	140/10	143/7
161/14	82/13 83/24	Mr Mills [20]	Ms Whitelaw	79/23 79/24	144/13	nationally [4]
161/20	103/19	55/25 56/4	[17] 57/19	80/18 110/25	144/15	67/7 78/25
161/25 162/6	103/25 168/3	57/7 57/11	57/24 58/11	must [10]	150/18	104/17 106/4
163/12	Mr Darch's	57/19 59/13	61/3 61/23	12/11 22/5	150/21 152/2	nature [3]
165/12	[2] 2/14	64/6 65/17	63/6 66/20	23/8 30/14	152/4 152/20	29/15 104/3
166/22 168/3	22/19	65/23 67/10	73/25 74/16	33/11 48/5	153/25	132/19
171/11	Mr Faulkner	68/10 73/20	90/2 91/14	68/19 129/25	154/10	nausea [1]
171/24	[7] 5/14 6/23	81/24 85/4	93/7 112/9	139/25 174/3	154/13	167/10
172/16 173/7	15/24 16/3	86/13 89/17	112/17	mustn't [2]	155/25 158/4	nav [1]
173/12 175/8	29/18 29/23	89/25 94/8	124/22 128/8	30/14 68/20	159/3 159/13	132/25
176/12 177/9	171/11	101/4 106/23	192/11	my [90] 2/2	159/14	nearly [2] 3/9
179/4 180/14	Mr Faulkner's	Mr Murphy	much [39]	3/18 3/24	161/14	164/19
183/6 186/14	[2] 5/25 6/8	[3] 79/23	2/9 4/6 4/8	23/7 23/10	161/19	necessarily
186/16 187/9	MR KEITH [2]	79/24 80/18	6/25 10/10	24/4 24/12	myocardial	[2] 17/16
187/10 188/9	161/10	Mr O'Connor	25/16 25/23	27/25 29/4	[1] 13/14	45/11
190/2 190/3	192/13	[12] 1/4 1/9	28/18 30/7	29/9 30/2	myself [3]	necessary [5]
192/3 192/4	Mr Killoran	6/10 26/3	35/19 40/13	33/9 36/5	81/14 126/5	34/11 34/13
192/5 192/8	[1] 27/15	27/6 55/13	55/10 55/11	37/19 38/25	152/11	85/13 150/24
192/9 192/10	Mr Killoran's	55/20 56/3	73/11 77/7	39/5 42/20		163/3
192/12	[1] 26/13	57/5 111/22	84/6 89/16	42/22 42/25	N	neck [2]
192/13	Mr Mansfield	192/4 192/8	96/6 101/4	44/12 44/24	naloxone [6]	135/15
192/15	[25] 40/14	Mr Rowley [1]	111/19	47/12 49/5	14/24 15/20	146/13
Mr Coomber	40/14 41/4	78/24	111/20	52/3 58/23	153/14	need [33]
[12] 161/11	41/14 44/1	Mr Skripal [3]	119/11	61/7 61/9	182/22 184/4	22/2 22/17
161/14	53/16 54/3	16/1 19/24	127/22	62/11 65/9	184/11	25/21 33/7
161/20	55/2 55/12	62/13	132/20	67/5 67/11	name [15]	40/15 40/17
161/25 162/6	101/6 101/7	Mr Wayne [3]	137/11 147/7	67/17 68/22	1/11 25/6	47/5 47/6
163/12	105/11	1/6 1/8 192/3	158/2 158/23	68/23 69/4	112/11	53/18 54/6
165/12	106/21 110/2	Ms [27] 57/19	159/2 160/20	69/14 70/17	112/18 115/6	54/9 54/16
176/12 179/4	111/21 159/5	57/24 58/11	160/25 165/9	71/22 71/25	129/6 147/17	54/18 55/16
186/14 188/9	159/7 160/21	61/3 61/23	168/8 179/4	72/19 73/14	147/20	62/15 69/24
190/3	187/9 187/10	63/6 66/20	181/22 187/4	78/8 78/18	147/21 148/1	75/22 76/9
Mr Darch [42]	190/2 192/5	68/22 73/25	188/4 190/1	80/2 81/8	148/2 154/24	106/19
1/10 1/13	192/9 192/12	74/16 78/23	190/3	82/10 84/16	161/14	106/23 115/1
2/10 2/18	192/15	90/2 91/14	mucus [1]	85/23 96/2	161/18	115/6 116/11
4/13 8/8 8/18	MR MARK [4]	93/7 97/16	152/3	98/7 101/3	161/19	118/5 125/19
9/24 12/3	112/14	112/9 112/17	muddled [3]	106/3 107/4	namely [4]	136/12
17/24 20/13	127/25	124/22 128/8	137/10	107/19	43/22 45/10	141/19
21/3 21/10	186/16	161/7 161/13	138/18 139/5	107/19	45/22 91/4	143/22 161/1
21/18 22/22	192/10	169/25	Muggleton [7]	107/21	names' [1]	168/9 169/11
23/5 23/22	Mr Marriott	181/17 187/8	123/23	110/21 111/8	117/23	170/20 190/4
25/4 25/19	[16] 112/15	190/5 192/11	123/25 127/6	112/11 127/8	narrative [2]	needed [5]
26/12 27/12	113/21 120/3	192/14	132/14	128/12	91/15 107/10	20/1 64/23
28/11 33/9	123/21 126/6	Ms Pottle [5]	163/16	133/24 134/7	national [15]	86/21 86/22
35/4 36/1	130/20	161/7 161/13	167/16 180/9	134/12	8/15 8/19	98/15
38/5 39/20	160/25	187/8 190/5	multi [4]	135/10	8/23 42/17	needing [1]
44/6 48/6	166/22	192/14	25/14 39/9	135/12	44/11 62/4	10/21
	171/24	Ms Sturgess	39/14 69/5	136/10	69/16 84/15	needs [2]
		[4] 68/22				

N	14/6 20/8	89/15 105/8	71/10 108/18	39/4 40/6	121/11	165/6 167/19
needs... [2]	109/19	105/11	Noble [9]	40/24 41/7	122/17	176/3 176/6
53/10 177/17	115/24 117/1	105/18 106/1	92/21 93/2	42/20 43/12	127/11	176/7 184/6
negative [1]	118/2 118/25	106/23 107/8	93/22 94/1	43/14 45/4	127/14 139/8	184/25
184/21	119/2 119/17	107/20	94/20 94/23	45/11 46/2	139/9 140/5	noticed [7]
neither [1]	122/4 128/15	108/18	95/1 95/17	46/18 46/25	140/17	135/3 135/9
23/23	131/23 133/3	109/19	96/7	48/2 48/14	142/19	152/2 155/20
nerve [46]	133/21	109/20	Noble's [1]	49/4 49/18	152/13	156/16 186/3
5/6 5/12 6/3	141/15	110/21	94/13	50/9 50/19	153/21 155/9	186/21
6/6 6/11 7/22	172/21	121/25 122/6	noise [1]	51/3 51/13	155/12	noticing [1]
14/10 15/4	new build [1]	122/11	137/5	53/1 53/2	159/13	156/9
17/4 19/12	133/21	123/25	none [2] 24/4	53/24 54/9	163/24 164/1	notification
23/15 24/11	next [14]	128/13	157/24	54/20 55/16	164/2 164/11	[1] 126/18
27/24 28/9	35/3 70/2	128/13	nonetheless	58/1 58/10	164/14 167/7	notified [2]
29/10 30/17	82/23 93/24	129/24 135/5	[1] 3/22	60/5 60/13	168/9 169/11	108/21 109/1
32/4 32/20	121/7 121/7	138/21 139/9	normal [8]	60/24 61/8	171/7 177/6	noting [1]
34/4 35/23	126/21	140/4 140/5	18/7 75/15	62/10 62/24	177/8 178/17	182/14
38/11 47/18	135/20	141/11	75/23 100/20	63/5 63/11	178/20 179/3	notion [1]
49/22 49/23	139/13	141/13	138/21 144/2	63/14 64/13	179/23	49/20
50/2 58/13	152/14 161/8	143/20	146/23	65/20 65/20	181/22 182/1	notwithstandi
62/21 64/11	174/22	147/23	163/22	66/12 67/15	183/18	ng [6] 30/24
66/5 66/11	176/22 184/9	148/24	normally [6]	67/16 69/7	183/23	62/15 64/18
68/7 70/19	NHS [8] 2/20	150/12	78/10 117/15	70/15 71/12	184/23	65/14 72/8
73/19 93/13	8/14 8/19	153/24 155/7	164/5 164/9	72/8 72/18	186/13	88/9
94/14 98/3	8/21 17/4	155/10	164/11	73/8 74/3	188/16	Novichok [40]
99/16 100/8	21/4 31/6	155/10	176/20	74/15 76/15	188/20	42/1 45/12
115/15	45/1	155/13	North [1]	77/4 77/14	188/21	45/24 46/19
121/17 122/9	nice [1]	156/24	129/12	79/14 79/20	189/16	47/17 48/9
122/13	151/25	157/10	northern [1]	82/4 82/10	189/20	49/10 49/17
122/18 160/2	night [2]	158/17 160/4	114/9	83/18 84/6	note [2] 8/4	49/22 50/2
165/19	31/16 39/3	160/5 161/1	nose [2]	85/12 85/24	144/16	50/22 52/17
167/17	nine [2] 33/3	162/18	156/3 169/15	87/17 87/21	noted [3]	53/1 53/6
nervous [2]	82/20	164/15 170/2	not [176]	88/24 90/10	94/3 144/6	66/15 70/6
166/10	no [110] 5/25	171/23	3/24 4/22	90/14 90/23	153/11	70/10 71/6
166/14	7/8 18/15	173/23	5/22 6/13 7/8	91/5 92/17	notes [3]	76/16 100/1
nervousness	19/5 26/6	173/23 174/2	7/24 13/11	94/13 95/7	158/3 173/5	100/2 105/25
[1] 94/3	26/23 28/2	175/5 175/25	13/19 13/22	96/6 98/19	177/20	107/3 107/12
neurological	30/9 42/2	176/5 176/5	13/23 15/14	99/13 100/1	nothing [10]	107/17
[7] 154/2	45/25 46/22	176/6 176/6	16/3 17/16	100/5 103/22	44/17 65/17	109/25 119/4
158/5 160/7	51/7 52/4	176/7 176/8	18/13 18/23	104/3 104/13	67/2 102/11	119/19
160/18 182/8	52/10 52/24	176/9 177/8	19/25 20/3	104/14	151/8 154/25	120/12
182/10 187/3	53/15 55/1	181/6 183/3	21/13 21/20	105/17	155/18	120/17
never [8]	58/4 60/13	183/19	21/24 22/9	105/18 106/1	157/25	120/19
5/19 40/3	60/14 61/25	183/19 184/1	23/1 26/18	106/8 106/23	158/17	121/11
74/12 83/7	62/14 64/7	185/2 186/13	26/21 27/9	107/2 107/7	158/25	121/15
138/20	64/13 65/20	186/25	27/19 28/14	107/8 107/12	nothing with	121/19
153/25	66/17 67/20	186/25 187/4	29/17 29/19	108/3 108/7	[1] 157/25	121/21
155/10	71/10 71/22	187/20	29/24 30/24	108/14	notice [15]	122/15
155/10	74/15 77/4	188/16	31/15 31/23	109/20	8/8 9/2 9/4	122/17
new [18]	77/14 87/22	188/20	34/10 37/11	113/16	11/7 143/16	159/11
10/22 11/13	87/25 89/1	188/22 190/4	37/11 37/24	119/20	143/20	159/20
	89/8 89/14	no one [2]	38/14 38/25	120/18	157/11 165/3	162/23

O	85/20	50/9 50/17	ourselves [7]	76/22	142/19	124/20
operations	organise [1]	55/6 59/21	28/7 57/20	over [25]	142/21	124/25
[3] 2/19 9/6	50/24	61/11 62/3	81/19 82/1	3/18 5/1	142/23	125/19 128/1
56/7	organophosp	75/7 81/21	116/7 116/11	11/14 31/15	145/20	128/11
operator [2]	hate [36] 5/6	82/20 87/24	116/22	32/3 33/5	149/18	128/11
131/8 136/16	5/12 5/19 6/3	90/23 94/4	out [55] 5/24	71/4 75/12	151/22	128/12
opiate [22]	6/7 6/16 7/22	95/7 98/17	11/4 18/17	77/11 86/6	153/10	128/18 129/4
6/5 13/2	12/9 12/22	98/19 99/4	23/6 31/24	92/13 95/24	155/18	130/2 134/5
14/23 15/6	14/10 15/5	101/23 102/3	44/19 51/20	103/8 107/12	175/19	134/8 134/10
15/15 16/5	15/14 16/5	103/8 103/11	54/17 59/2	107/17	175/19	136/23
19/11 20/18	18/1 19/12	103/24	59/6 61/2	124/16 142/3		139/17
21/23 29/15	20/19 20/24	104/23	62/24 64/10	144/20	P	141/20 143/1
29/17 36/17	23/16 24/3	109/24	64/10 64/20	144/21	pacemaker	147/10
38/16 44/3	24/11 27/24	115/16	66/18 67/7	152/25 157/2	[2] 146/19	147/10
64/19 73/19	28/9 28/15	131/19	69/13 72/2	157/3 185/8	146/19	150/20
153/19	48/23 52/25	133/13	72/6 77/5	189/12	pack [2]	151/12 154/7
153/20	53/6 57/2	136/13 157/2	79/3 84/15	189/13	149/1 150/22	154/8 154/9
153/22	65/18 72/12	166/3 166/4	87/3 90/15	overdose [11]	paddle [1]	155/17 162/4
153/23	120/17	167/10	94/18 96/18	13/2 14/24	140/1	163/5 165/19
153/23	122/18	167/11 169/4	96/24 103/21	15/6 15/15	pads [3]	166/4 166/19
184/19	158/20	173/17	106/10	19/12 19/12	140/1 140/2	166/20
opiates [2]	164/25	189/20	117/18	21/23 29/15	144/18	166/23
35/23 184/20	167/17	others [6]	119/23	122/9 160/2	page [96]	168/12 169/9
opinion [3]	168/11	14/18 49/10	121/19	182/18	1/19 1/20	169/10
38/12 94/2	186/24	50/18 76/10	124/12 128/3	overdoses [1]	7/17 7/23	171/13 172/4
94/4	organophosp	92/23 102/4	132/21 147/5	6/5	9/13 12/5	172/8 173/3
opioid [2]	hate/nerve [4]	otherwise [1]	147/11	overlap [5]	12/18 13/7	176/24
70/10 71/16	5/12 7/22	101/24	154/19 156/2	13/1 16/7	16/15 21/19	176/25 178/8
opportunities	24/11 27/24	ought [4]	156/11	20/17 44/3	21/21 22/19	179/6 179/13
[1] 3/25	organophosp	33/14 58/12	165/19	44/7	25/18 26/9	180/3 192/2
opportunity	hates [1]	71/24 72/20	165/20	overlapping	27/11 32/3	page 1 [8]
[3] 112/25	50/3	our [40] 1/5	166/24	[1] 21/22	32/14 33/5	124/7 124/15
113/16 154/6	organs [1]	3/17 4/2 4/16	168/10	overlay [1]	33/25 34/19	124/16
opposed [1]	183/12	6/1 6/4 6/24	169/10	100/15	34/21 34/25	128/11
49/10	originally [1]	7/13 7/14 9/5	170/17	overly [1]	57/22 57/23	128/12
order [3]	23/5	9/6 9/19 9/20	173/15 178/5	98/8	58/24 58/24	165/19 169/9
12/11 42/4	other [66]	9/21 10/24	178/6 182/5	override [1]	62/18 65/24	176/25
46/8	3/25 7/4 7/9	11/1 11/14	184/9 187/19	38/23	66/1 66/18	page 10 [1]
organisation	10/20 10/20	13/8 19/9	187/19	overriding [1]	67/6 81/25	91/12
[11] 3/1 14/7	10/25 12/12	24/15 27/3	189/23	42/2	82/14 82/23	page 11 [1]
17/3 24/17	12/17 12/18	28/8 29/20	outcome [1]	oversight [1]	85/5 89/23	130/2
25/5 26/1	12/23 15/6	31/1 31/4	41/10	45/2	91/12 94/18	page 18 [3]
30/1 30/4	19/24 20/10	32/13 44/25	outlier [2] 7/7	overview [1]	110/4 110/11	16/15 25/18
30/21 31/5	20/16 24/2	44/25 56/14	7/8	45/6	112/21	27/11
50/17	32/8 33/3	64/15 79/1	outline [1]	owing [1]	118/14	page 2 [8]
organisation'	36/2 37/18	84/24 92/2	56/5	94/3	118/18	34/19 34/21
s [1] 44/24	39/22 41/13	123/13	outlined [1]	own [5] 16/12	118/19	124/16
organisations	42/6 42/25	125/25	111/8	19/2 74/17	118/19 124/7	124/17 166/4
[6] 42/22	43/4 44/8	126/18 133/4	outside [4]	169/3 175/9	124/15	176/24 178/8
46/7 53/25	48/15 48/25	148/18	73/12 75/16	oxygen [12]	124/16	179/6
54/14 54/17	49/18 50/2	153/17	133/1 134/23	142/16	124/16	page 20 [1]
	50/3 50/4	154/18	outwards [1]	142/18	124/17	22/19

P	117/8 117/13 117/13	paragraph 37 [1] 91/21	153/17 154/18	passed [1] 93/20	168/18 168/23	138/25
page 21 [1] 57/23	paperwork [2] 108/5 177/18	paragraph 38 [1] 92/3	170/24 179/18 185/7	past [4] 123/4 133/5 133/9 184/15	patrols [1] 87/14	period [15] 5/1 11/14 14/8 28/13 52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 23 [2] 26/9 58/24	paragraph [37] 16/23 22/20 22/20	paragraph 39 [1] 92/13	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	patent [5] 142/10 142/10 142/14 144/8 155/24	PAUL [2] 55/24 192/6	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 26 [1] 1/20	61/21 66/2 66/7 66/22 67/6 68/5 70/1 70/2	paragraph 40 [1] 92/19	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	pause [3] 21/25 134/11 174/17	pause [3] 21/25 134/11 174/17	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 29 [1] 65/24	70/2 76/7 90/9 90/14 90/22 91/21 92/3 92/9 92/13 92/19	paragraph 41 [1] 93/8	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	pathways [1] 31/6	pathways [1] 31/6	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 3 [3] 169/10 179/13 180/3	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paragraphs [4] 27/14 89/24 136/24 150/19	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	patient [37] 18/6 36/23 119/6 122/19 123/13 126/22 127/4 134/19 135/3 144/12 145/15 146/16 149/5 149/6 149/8 149/9 149/10 149/15 149/24 150/1 150/13 150/24 153/17 153/24 168/20 176/14 177/6 177/10 177/16 177/17 177/18 179/24 180/18 180/20 180/22 188/15 189/13	patient [37] 18/6 36/23 119/6 122/19 123/13 126/22 127/4 134/19 135/3 144/12 145/15 146/16 149/5 149/6 149/8 149/9 149/10 149/15 149/24 150/1 150/13 150/24 153/17 153/24 168/20 176/14 177/6 177/10 177/16 177/17 177/18 179/24 180/18 180/20 180/22 188/15 189/13	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 37 [2] 128/1 171/13	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	pen [2] 7/23 19/25	pen [2] 7/23 19/25	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 4 [7] 110/4 110/11 118/14 118/19 125/19 128/11 128/18	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	people [28] 4/14 9/13 10/1 13/1 13/14 18/20 19/4 19/5 23/6 26/17 36/25 38/19 40/1 47/5 48/6 50/25 73/3 73/7 77/11 77/12 80/8 88/16 103/11 103/12 112/16 169/5 189/19 189/20	people [28] 4/14 9/13 10/1 13/1 13/14 18/20 19/4 19/5 23/6 26/17 36/25 38/19 40/1 47/5 48/6 50/25 73/3 73/7 77/11 77/12 80/8 88/16 103/11 103/12 112/16 169/5 189/19 189/20	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 5 [5] 94/18 124/20 124/25 129/4 166/19	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	people's [1] 48/13	people's [1] 48/13	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 51 [1] 67/6	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	per [10] 71/17 80/15 142/22 146/2 148/18 155/25 156/1 156/7 157/15 174/16	per [10] 71/17 80/15 142/22 146/2 148/18 155/25 156/1 156/7 157/15 174/16	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 6 [3] 134/5 134/8 136/23	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	perfect [2] 166/25 168/8	perfect [2] 166/25 168/8	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 7 [4] 139/17 141/20 143/1 147/10	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	performing [2] 78/3 83/9	performing [2] 78/3 83/9	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 8 [6] 7/17 89/23 147/10 150/20 151/12 155/17	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	perhaps [17] 1/6 14/20 33/9 60/17 61/5 63/8 75/16 76/6 76/19 84/9 85/5 97/3 114/2 118/11 118/12 121/6	perhaps [17] 1/6 14/20 33/9 60/17 61/5 63/8 75/16 76/6 76/19 84/9 85/5 97/3 114/2 118/11 118/12 121/6	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
page 9 [3] 154/7 154/8 154/9	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	phones [1] 10/25	phones [1] 10/25	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
pages [4] 57/16 57/16 57/23 162/5	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	physical [1] 146/10	physical [1] 146/10	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
paint [1] 174/7	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	pick [8] 37/22 61/2 79/1 79/7 87/4 88/17 91/21 128/3	pick [8] 37/22 61/2 79/1 79/7 87/4 88/17 91/21 128/3	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
Panasonic [1] 127/1	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23	picked [2]	picked [2]	52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21
paper [3]	92/3 92/9 92/13 92/19 93/8 93/25 118/16 118/22 118/23 118/24 121/7 121/8 134/9 134/9 136/24 141/20 143/1 147/10 154/10 180/15	paramedic [16] 113/22 114/8 114/17 114/20 114/22 114/24 129/6 141/9 152/21 163/23 164/3 164/7 164/9 164/14 183/20 186/15	particular [28] 10/15 13/4 27/4 28/16 30/3 30/16 39/10 39/17 50/23			52/1 52/9 59/24 60/23 67/14 71/5 74/13 105/6 111/5 122/4 144/21

P	please [46]	45/13 53/8	5/11 5/12	168/11	police's [5]	158/21
picked... [2]	1/7 1/11 7/18	55/1 62/11	5/19 6/3 6/7	186/24	56/10 80/2	158/22
15/20 68/3	8/6 17/6	63/16 67/17	6/11 6/16	poisonings	89/19 90/25	159/16 160/1
picking [3]	22/17 22/19	68/4 69/3	7/22 12/10	[2] 56/7	91/25	175/12
58/24 70/4	25/3 27/12	69/15 70/18	12/22 13/11	56/10	policemen [1]	possibly [11]
127/21	27/14 31/22	71/1 71/22	14/10 14/10	police [63]	65/1	30/8 34/20
picks [1]	32/3 33/5	72/15 76/4	14/16 15/5	38/12 38/13	policies [4]	71/11 131/21
130/21	34/1 34/3	76/5 76/22	15/5 15/14	38/22 56/5	66/1 66/3	131/22
picture [2]	39/23 41/17	79/12 80/14	16/5 16/6	57/1 58/12	102/23	153/16
174/7 188/11	54/4 55/1	81/14 84/21	16/13 17/2	59/3 63/8	102/24	153/19 154/3
piece [4] 17/3	55/16 59/13	88/11 88/13	17/5 20/18	64/7 64/10	policing [9]	154/22
20/6 83/19	65/23 69/25	90/15 91/15	20/19 23/16	66/4 66/12	61/11 67/7	157/13 158/6
104/18	89/22 91/12	92/9 94/13	24/3 25/7	66/24 67/14	67/20 73/12	post [1]
pieces [3]	91/22 92/13	95/23 96/12	27/25 28/15	67/23 68/24	79/19 87/5	118/3
63/17 64/14	93/8 94/18	97/9 100/18	28/17 29/10	71/12 71/21	106/4 110/23	potential [15]
90/24	104/6 110/4	102/9 102/11	32/1 36/18	73/10 73/16	111/10	31/11 37/13
pin [1] 15/7	112/19 115/2	109/22	38/11 38/16	76/10 80/7	policy [4]	62/16 64/4
pink [1]	117/21 124/2	113/18	47/19 48/24	83/19 84/4	4/25 16/19	65/13 68/2
151/25	124/20	121/14 135/2	49/4 49/10	84/4 84/22	26/24 56/17	69/23 83/16
pinpoint [3]	125/17	135/7 135/8	52/18 52/25	87/12 87/13	policy/proced	103/3 104/21
167/4 179/9	125/19	136/9 138/1	56/16 56/16	91/10 91/22	ures [1]	107/21
182/16	126/13 127/9	138/19 139/9	57/2 57/3	92/4 92/17	16/19	109/24 111/2
place [27]	129/4 130/2	139/10 140/8	58/1 58/6	93/3 93/18	POLSA [1]	122/8 122/21
16/14 16/25	161/3 161/18	140/10	58/14 59/23	93/19 95/8	80/7	potentially [6]
20/9 51/20	170/20	140/19 142/1	62/21 64/12	96/10 97/17	poor [2] 78/9	45/16 73/4
70/18 72/5	190/11	144/15 146/2	64/19 65/18	98/4 98/8	85/24	80/21 95/13
72/23 76/19	plume [1]	147/3 148/14	66/5 66/16	98/12 98/20	population [1]	98/12 110/19
78/13 78/17	75/20	149/23	66/25 67/15	98/25 99/17	46/20	Pottle [6]
78/24 78/25	plus [10]	150/18	70/10 70/11	99/22 99/23	portable [1]	161/7 161/13
84/20 86/22	18/2 18/11	151/18	71/16 72/13	100/7 101/15	139/21	161/15 187/8
87/13 93/17	63/21 84/18	152/15	73/19 73/19	101/21 102/3	Porton [5]	190/5 192/14
100/4 100/15	89/4 102/11	154/13	74/2 74/8	104/8 104/16	51/13 51/22	PowerPoint
102/23 103/4	106/12	155/11	76/4 77/1	105/24 106/5	52/9 52/23	[4] 59/18
106/7 111/24	168/13	156/17	83/11 85/19	106/12	53/12	60/2 60/5
117/19	168/15	156/20	115/16 117/3	106/18 107/7	portrays [1]	60/20
128/23 180/4	172/19	156/24	120/17	107/16 108/6	184/2	powers [2]
180/5 186/1	pluses [3]	158/25	120/17	109/23	position [8]	102/22
placed [5]	89/3 89/10	169/20	120/24	110/12	31/17 34/12	102/24
76/12 76/16	89/11	pointed [1]	121/20 122/2	110/19	37/25 50/21	practical [1]
77/3 80/20	pm [5] 112/6	148/6	122/10	110/22	91/20 91/25	43/2
180/14	112/8 161/4	points [9]	122/13	police officer	101/20	practicalities
plan [2] 33/1	161/6 190/12	2/17 43/21	122/18	[2] 107/16	105/22	[1] 87/11
39/15	point [80]	45/8 59/19	122/21	108/6	possession	practicals [1]
planning [4]	12/25 13/9	65/3 77/16	123/11	police	[3] 31/15	50/25
33/7 33/15	15/13 19/19	83/24 101/10	158/21 159/1	officers [13]	90/11 90/25	practice [3]
33/16 82/8	19/21 21/22	132/12	163/13	38/12 38/13	possibility [3]	27/21 75/1
plaster [1]	22/6 23/24	poison [2]	164/25 165/5	38/22 59/3	32/22 68/19	80/5
186/10	24/5 27/8	58/1 68/3	165/20	64/7 64/10	103/14	pre [7] 5/15
plastics [1]	28/2 28/16	poisoned [3]	166/18 167/2	71/12 98/4	possible [11]	5/16 17/22
49/2	29/23 30/4	120/21 122/3	167/18	98/8 99/17	38/25 44/3	19/16 158/4
play [1] 14/3	35/14 35/22	168/2	167/24	99/22 100/7	89/9 89/10	167/9 171/11
	37/2 45/10	poisoning	167/25	106/18	108/8 132/21	pre-accident
		[96] 5/6 5/7				[1] 5/15

P	153/10	priority [6]	114/18	providing [6]	179/7 182/16	114/22
pre-hospital [5]	175/16	31/7 40/7	114/20	80/10 84/9	purchase [1]	query [2]
17/22 19/16	presumably [4]	47/3 103/6	114/22	86/1 87/17	91/3	132/5 174/20
167/9 171/11	4/6 10/16	131/14 172/5	115/10	181/13	purely [2]	question [50]
precedence [2]	117/2 158/20	proactively [2]	115/12	183/11	141/13 144/7	5/4 11/8 30/2
103/8	pretty [4]	66/12	prolonged [1]	provision [2]	purpose [5]	30/8 33/9
103/16	112/4 119/11	86/5	33/4	42/8 83/18	4/23 9/4	41/7 41/20
precipitated [1]	132/20 188/1	probably [15]	prompts [1]	public [39]	56/11 132/22	41/21 43/10
158/7	previous [3]	59/11 78/9	140/3	17/4 20/22	188/8	44/2 44/15
precise [1]	71/22 71/25	86/25 118/10	pronounce [1]	22/2 23/15	purposes [3]	44/20 46/17
60/1	119/2	118/20	180/24	32/18 35/11	22/7 101/13	48/13 49/21
preparation [1]	previously [5]	119/22	pronounced [1]	42/9 46/8	121/11	49/25 54/13
2/3	35/12 49/13	119/24	157/8	47/5 47/13	push [1]	57/25 58/6
preparations [1]	113/11 125/4	122/20	properly [1]	47/23 48/3	142/22	60/16 65/17
60/21	148/25	123/12	66/25	48/6 52/20	pushed [1]	67/11 70/24
prepared [1]	prick [1]	133/10 135/9	properties [1]	53/22 54/1	65/10	72/19 73/17
1/13	15/7	138/9 153/8	133/6	54/15 60/22	put [38]	79/10 79/14
preparedness [5]	primary [3]	157/15	property [4]	69/11 75/6	43/21 52/7	80/18 80/24
2/25 3/2	176/23 177/2	177/22	93/1 132/24	76/5 76/8	53/9 56/17	81/19 83/5
8/15 8/20	178/2	probe [1]	133/21	76/23 77/2	58/11 59/2	88/21 89/19
57/1	principle [1]	155/17	180/12	78/19 78/25	59/5 64/20	99/10 105/1
prescription [1]	100/11	problem [5]	proposing [1]	79/15 82/18	69/13 70/17	105/11
155/2	principles [19]	28/3 85/18	40/24	86/15 87/14	72/1 72/6	105/15
prescriptions [1]	39/8 39/18	101/16	protection [2]	87/18 87/23	74/1 75/10	105/23
154/15	42/13 42/20	132/25 133/3	53/22 54/15	88/2 88/3	76/1 78/13	107/12
presence [3]	42/21 63/19	problematic [1]	protective [1]	88/10 103/11	78/24 85/10	107/13 108/3
18/20 159/21	64/2 64/3	133/15	115/13	108/8 108/14	93/17 103/4	110/16
169/6	70/3 76/20	problems [2]	protocol [21]	109/15	107/14	123/20
present [10]	76/21 94/17	13/22 47/16	8/9 9/10 10/2	publicised [1]	109/11	155/14
12/11 12/22	94/21 95/16	procedural [1]	11/7 11/15	11/2	110/19	159/25 160/5
13/2 14/19	96/24 98/15	26/25	12/4 14/11	publish [1]	110/21	164/6 164/23
15/19 39/25	102/25	procedure [1]	18/24 124/7	52/3	130/14	172/11
72/9 135/18	106/13	116/18	124/9 153/17	published [7]	142/13	189/23
141/23	print [1]	procedures [3]	165/7 165/9	1/24 23/13	143/14 153/6	Questioned [16]
159/12	117/18	16/19	166/8 166/20	25/10 25/11	157/20 162/5	1/9 41/4
presentation [6]	print-out [1]	115/24	166/20	25/12 51/22	164/12	56/3 101/7
53/9	117/18	159/24	168/23	52/12	179/14	112/17 159/7
59/18 60/2	printed [2]	proceed [3]	168/24	pull [5]	184/14 185/5	161/13
60/6 105/25	117/13	73/9 100/20	169/13	123/15 163/4	185/13 186/6	187/10 192/4
107/3	127/13	100/25	170/10	165/8 176/11	188/12 190/9	192/5 192/8
presented [2]	prior [14]	proceeded [1]	174/16	pulsating [1]	puts [1]	192/9 192/11
9/3 83/15	8/2	38/15	protocols [5]	146/13	130/17	192/12
presenting [6]	14/3 25/11	proceedings [1]	11/13 35/9	pulse [7]	putting [4]	192/14
73/3 73/7	114/7 114/11	113/17	84/19 100/21	135/12	42/1 87/12	192/15
93/11 122/19	114/17 115/3	process [3]	102/5	135/14	103/15 108/6	questioning [1]
141/24 178/3	115/21 116/6	26/24 94/12	provide [6]	135/17	Q	73/15
press [1]	116/7 124/9	98/24	21/10 56/9	146/11	qualifications [2]	questions [31]
135/25	159/15 165/4	production [1]	56/12 65/11	146/12	129/6	2/10
pressure [4]	165/15	professional [1]	66/12 111/13	146/12	163/14	16/11 36/6
149/17 151/6	priorities [1]	programme [6]	provided [4]	148/16	qualified [2]	36/8 39/21
	76/10		7/13 45/21	pupils [4]	114/19	39/22 40/15
	prioritisation [1]		85/1 186/19	167/4 169/18		41/15 41/19
	46/20					

Q	rapidly [2] 35/15 84/1	72/2	182/2 182/3	recollection [1] 21/11	151/10	88/14
questions... [22] 44/2	rare [7] 6/22	real [2] 35/19	182/14	recommend [1] 28/1	168/15	regarded [2] 48/3 66/25
51/19 54/4	7/5 16/7	45/22	185/22	recommendat	170/16	regarding [2] 31/13 165/3
54/10 55/6	29/12 47/18	really [23]	185/23	ion [1] 8/22	170/20	regardless [1] 9/18
57/12 57/18	47/19 67/2	41/21 48/1	187/17	recommendat	reference [12]	regards [3] 10/20 11/8
57/21 73/23	rarity [1] 5/11	63/17 69/21	receive [11]	ions [1]	8/23 19/10	45/18
77/2 83/6	rate [4] 12/16	76/3 94/21	10/1 10/12	85/17	21/1 22/4	region [1] 110/18
91/9 91/14	146/7 166/1	95/1 95/5	10/17 11/18	record [19]	27/23 29/19	regional [1] 45/1
104/11	166/2	95/16 97/7	74/14 116/14	25/21 51/8	65/24 112/22	registered [5] 3/24 37/11
112/12	rather [7]	97/7 100/14	116/16 117/6	66/2 90/10	127/24 147/9	163/24 164/1
133/19 159/3	3/20 38/8	103/4 104/2	126/14	123/14	168/7 176/11	164/2
159/3 159/9	41/17 76/6	104/19 105/1	126/18 188/7	126/22 149/5	references [2]	registrar [1] 189/8
161/15 187/5	130/20	105/15	received [25]	149/8 149/9	43/13 161/23	regular [1] 10/12
187/6	150/15	127/12	19/1 31/4	149/16	referred [14]	regularly [1] 6/5
quick [2]	177/22	137/11	31/24 91/6	149/25 150/2	2/22 10/15	reinforcing [2] 35/7
174/12	ratio [2]	141/16	91/22 92/5	150/13	11/3 15/12	84/17
174/18	143/4 143/7	158/17	117/1 117/24	176/14 177/6	20/11 20/17	reiterate [1] 84/25
quickly [4]	re [1] 31/2	186/13	118/25 119/2	177/10	35/12 35/13	relate [1] 36/3
78/24 132/21	re-issued [1]	188/10	120/18	177/21	58/15 58/20	related [11] 28/10 29/18
145/4 151/1	31/2	reason [10]	121/15 122/4	179/24	96/5 104/1	42/3 66/11
quiet [1]	reach [1]	16/6 30/23	122/7 129/15	180/10	110/24	68/7 69/24
127/7	96/20	54/24 81/9	130/9 131/3	recorded [3]	152/20	89/18 94/5
quite [20]	reached [1]	129/22	131/13	6/13 172/9	referring [16]	regularly [1] 10/12
2/12 13/19	98/21	137/12	131/19	173/16	22/12 23/12	6/5
18/23 25/10	reaction [2]	150/14 176/8	131/21 132/1	109/23 116/9	35/4 44/21	reinforcing [2] 35/7
36/3 43/11	160/2 160/10	184/18 189/5	132/11	records [2]	51/14 51/18	84/17
71/7 81/7	read [25] 2/3	reasonable	159/22	109/23 116/9	57/6 58/18	reiterate [1] 84/25
81/19 82/16	5/14 11/6	[10] 32/6	167/24	recovery [1]	59/11 63/16	relate [1] 36/3
98/6 117/22	18/17 22/5	32/23 34/4	171/21	87/3	110/9 122/23	related [11] 28/10 29/18
120/6 133/10	52/12 53/15	39/4 77/24	receiving [3]	red [5] 61/3	125/4 144/9	42/3 66/11
137/9 151/1	81/1 82/1	81/1 82/1	10/10 69/18	61/21 63/13	148/2 149/20	68/7 69/24
167/1 167/14	82/3 85/7	82/3 85/7	172/12	65/11 158/17	refers [4]	89/18 94/5
179/10 181/6	186/18	reasonably	recent [5] 4/9	reduce [1]	22/21 28/10	98/13 101/23
R	84/14 84/14	[2] 79/13	13/14 92/25	100/12	95/9 101/3	102/4
radio [4]	90/14 95/4	79/16	98/10 100/7	refer [31]	reflect [1]	89/18 94/5
126/18 132/1	95/22 112/25	reasons [3]	recently [3]	7/22 8/4 10/1	59/2	98/13 101/23
172/19	113/15	30/11 31/25	59/25 60/21	16/24 17/7	reflected [2]	102/4
172/22	116/22	78/12	116/12	22/2 23/23	64/16 77/6	relatedly [1] 91/8
radiological	117/21	reassuring	rechecked [1]	24/1 24/5	reflection [2]	relates [4] 49/9 104/6
[2] 61/10	118/16	[1] 87/24	31/16	29/9 70/3	28/5 63/6	107/9 111/1
115/5	118/21	recall [26]	recipients [1]	90/22 92/19	reflects [1]	relating [6] 14/3 24/2
raise [1] 86/5	127/24	10/14 31/12	34/14	96/21 98/7	43/10	66/9 91/2
raising [1]	167/19 170/7	43/17 45/15	reckoner [1]	115/1 118/5	reframe [1]	92/25 115/23
93/13	reading [1]	46/2 47/8	62/20	125/19	89/5	relation [35] 39/24 43/19
range [1]	readings [1]	48/17 55/22	recognise [4]	126/11 128/2	refresh [1]	44/13 49/7
49/3	151/9	73/24 90/1	127/10 162/6	134/7 136/22	118/16	51/11 59/3
rapid [5] 9/19	ready [3]	91/13 122/4	165/12	139/16	refreshed [1]	59/15 61/9
25/23 126/2	62/20 181/12	122/7 142/25	167/14	141/19	10/21	
126/3 132/22	183/1	143/18 170/1	recognising	143/22	refreshing [2]	
	reaffirming	170/2 170/3	[2] 168/11	144/13	regard [3]	
	[2] 34/21	170/4 181/25	recognition	150/18	34/13 35/8	
			[1] 115/15			

R	118/6 118/7	replied [8]	resilience [8]	8/15 8/20	retail [1]	146/24
relation... [27]	118/9 119/20	135/1 137/2	2/25 3/3 8/15	9/19 25/7	138/11	180/23 181/2
61/13 68/18	121/22	137/3 137/8	8/20 42/15	27/1 31/3	retardants [1]	right [104]
68/22 69/4	121/24 122/1	147/23 148/3	62/6 103/20	34/22 35/8	49/2	2/19 3/1 3/13
70/6 71/3	122/6 122/11	148/4 154/16	103/23	39/9 39/12	reticence [1]	4/6 5/10 6/15
72/3 72/22	122/12	reply [2]	resolved [2]	42/24 56/6	52/17	6/19 6/25
75/19 77/15	129/21	147/20	42/10 102/3	56/10 56/15	retrieval [3]	9/14 9/23
78/23 84/22	131/19 133/2	154/20	resource [5]	63/20 64/5	115/7 115/10	10/5 12/14
90/10 96/23	136/7 139/23	report [17]	80/10 128/19	75/14 75/24	115/12	12/24 15/1
97/16 97/17	140/13	5/14 25/5	129/8 130/5	78/13 82/5	retrieve [1]	15/22 19/2
102/7 104/9	140/17 141/1	25/20 25/22	171/18	83/16 83/23	115/14	20/14 21/3
104/15	143/17 148/7	26/13 26/14	resources [4]	84/3 85/19	return [15]	21/10 22/9
104/20 107/5	148/11	26/15 26/21	7/11 86/20	86/23 91/10	37/5 40/8	23/15 23/21
107/19	152/13	51/21 52/11	95/23 136/13	92/10 93/19	56/8 71/22	23/22 24/8
108/12 118/2	153/16 156/9	53/15 75/10	respect [1]	93/24 100/16	71/25 106/3	24/16 25/17
119/25 151/3	156/11 168/7	75/11 81/10	11/17	104/2 105/7	146/5 146/14	25/24 27/6
163/23	170/10	103/21 127/4	respective [2]	105/21	148/13	30/10 30/14
relations [2]	172/11	127/25	96/1 100/23	109/17	148/19	33/2 33/22
105/13	173/11	reported [1]	respiratory	113/14 126/2	148/20	38/5 40/13
111/17	174/18	66/14	[10] 12/14	126/3 131/14	152/25	42/8 44/5
relationship	179/16 181/6	reports [4]	12/19 13/4	131/17	180/20 181/4	44/23 46/4
[5] 74/22	181/6 181/18	70/7 90/23	15/7 166/5	131/18	181/8	47/2 47/15
74/23 111/7	182/23 183/2	91/2 95/5	166/15	132/22 180/9	returned [2]	49/25 52/14
111/15	183/4 187/20	represent [4]	166/18 167/3	responses [2]	150/21	55/3 60/4
111/17	remind [6]	41/5 101/9	169/23	59/4 71/25	187/22	83/19 83/25
relative [2]	57/20 74/21	159/8 187/11	186/21	responsibilit	returning [1]	87/21 88/19
69/13 111/13	75/4 81/25	representativ	respond [6]	es [1] 78/18	84/21	88/20 89/1
relatives [1]	119/23	e [1] 75/6	7/11 18/9	responsibility	reveal [1]	95/18 95/21
37/17	159/24	representativ	39/15 62/6	[5] 47/1	52/17	99/14 103/9
release [1]	reminded [2]	es [1] 88/2	66/5 75/1	53/24 54/1	revealed [2]	104/5 110/16
168/12	20/8 64/15	request [2]	responded	81/8 86/1	27/19 92/25	111/19 112/1
relevance [1]	reminder [1]	40/16 136/8	[5] 3/19	rest [1]	reverse [2]	113/20
9/20	168/10	requested [1]	16/12 29/14	174/16	144/1 184/24	114/12
relevant [4]	remove [11]	93/17	132/17	restart [2]	review [6]	118/20
17/21 27/5	35/8 35/8	requests [1]	163/15	136/2 144/5	104/8 104/24	118/21
121/12	35/8 84/18	40/19	responder [3]	restlessness	104/25	127/17 128/8
121/13	84/18 84/18	required [5]	4/4 10/9 84/5	[1] 166/13	105/15 106/7	128/23 134/1
reliability [1]	85/2 85/2	35/7 83/24	responders	restricted [1]	162/8	134/16
104/10	85/2 157/17	92/17 97/7	[14] 18/9	61/4	reviewed [5]	134/18
reliable [1]	182/24	168/24	33/7 46/9	result [8]	14/12 45/19	139/11
50/1	removed [1]	requirement	47/6 49/16	26/25 38/17	105/2 106/15	143/14 151/9
rely [1] 40/16	140/16	[2] 104/25	63/2 63/22	48/18 75/14	106/18	151/10 152/2
remained [1]	repeated [1]	106/9	71/12 73/5	93/2 99/21	reviews [2]	152/2 155/21
94/4	67/15	requires [3]	84/24 95/11	146/4 169/21	16/18 106/7	156/15
remarkable	repeatedly [1]	45/6 94/22	98/16 104/4	results [1]	rhinorrhea [2]	156/25
[2] 151/9	62/22	102/14	168/25	26/1	169/14	160/19
155/19	repetition [1]	requiring [1]	responding	resume [1]	169/15	163/17
remember	54/9	33/4	[6] 3/20 7/13	4/16	rhythm [8]	165/23
[42] 69/20	replace [2]	reservation	18/6 48/20	resumption	140/5 140/6	166/10
115/17	150/8 150/11	[1] 52/19	85/21 168/19	[1] 179/20	146/16	168/25 169/1
115/19 117/7	replaced [1]	reservoir [1]	response [45]	resuscitation	146/18	171/5 172/1
	148/25	142/21	3/1 3/3 7/16	[1] 143/8	146/20	172/5 173/1

R	123/25 127/6	56/16 89/20	134/25	129/11	97/2 104/18	27/15 34/2
right... [17]	132/12	90/19 105/13	135/14	same [19] 3/1	112/4 115/3	67/20 82/24
174/11	132/14	RRV [6]	136/10 137/1	37/14 43/6	115/6 116/17	82/25 85/11
175/22	163/16	125/24 126/1	137/2 137/4	60/6 60/7	116/25	99/6 100/20
176/16	167/16 180/9	128/24	137/17	68/5 83/5	117/20	103/1 124/8
178/19 179/2	robust [1]	129/11	138/16	89/22 108/3	117/24	143/10 149/9
179/7 179/8	104/10	172/17 178/9	139/20	136/5 141/13	119/17	165/4 166/3
179/22	role [17] 2/18	RRV' [1]	140/12	141/17 164/3	119/21 120/6	166/8 168/5
179/25 180/1	3/5 33/10	173/6	143/12	169/12 172/2	121/4 121/6	171/17 172/9
180/6 184/15	68/22 68/23	rule [3]	144/23	188/18	121/8 122/17	173/4 173/9
185/5 185/21	69/4 69/10	119/14	147/17 148/1	188/20	122/22 123/4	178/3 178/4
188/1 188/14	73/25 75/8	119/18 182/4	148/3 148/6	188/21	125/11	178/8 178/23
189/14	76/24 107/19	run [4] 46/14	148/24	189/17	128/17	179/24
right-hand [5]	114/14	52/18 52/22	154/14	sat [4] 78/17	129/24	180/16
83/25 118/20	141/12	97/11	154/16	88/4 108/11	130/13	scenario [14]
118/21 152/2	163/13		155/16	132/25	131/12 132/7	6/24 32/24
152/2	163/20 185/7	S	158/19	saturation	132/10	32/25 33/1
rise [3] 49/1	189/22	sadly [1]	166/25	[2] 149/18	132/17	33/8 34/4
49/2 49/3	roles [5] 3/11	78/23	176/24	149/18	134/13	35/1 77/24
rising [2]	3/13 3/18	safe [1] 84/2	182/12	Saturday [1]	134/15 135/9	81/1 82/2
152/1 157/11	4/11 114/14	safety [3]	184/15	125/20	136/6 136/16	82/3 82/16
risk [40]	room [5] 4/14	18/4 95/11	184/16	save [1]	137/16 141/2	82/21 85/7
19/23 20/4	77/25 172/25	121/10	saline [2]	100/12	143/17 145/2	scenarios [2]
24/24 30/13	173/20	SAGE [9]	143/24 144/6	saved [1]	145/11	32/6 83/2
30/16 30/20	174/14	69/19 74/7	Salisbury [42]	16/1	145/13	scene [31]
32/5 39/13	ROSC [3]	74/11 74/12	16/20 23/6	saw [13]	146/15	37/8 37/16
44/7 45/22	146/5 152/25	74/14 74/23	28/20 29/7	18/24 26/20	149/23 151/8	76/22 88/7
47/14 47/23	181/8	77/1 78/11	32/4 32/19	33/20 72/7	151/16	95/24 96/5
48/1 48/4	roughly [1]	86/4	43/11 44/9	72/13 124/2	151/18 152/1	96/8 96/10
48/14 48/15	5/23	SAGE's [2]	45/8 45/23	134/19	155/25	96/11 96/17
48/18 58/22	route [7] 3/21	78/4 81/3	47/17 47/25	147/25 151/7	156/23	97/20 98/5
69/12 69/14	3/23 4/1	said [63] 10/1	48/3 48/15	166/21	157/24 158/3	100/8 100/13
69/22 69/23	172/14	12/8 14/17	50/16 50/19	169/13 174/4	158/6 158/11	130/3 130/5
71/15 72/17	180/20 182/9	20/16 21/18	50/23 53/21	189/16	159/17	130/6 130/8
76/9 77/15	182/10	35/10 36/5	58/9 68/12	say [94] 8/17	163/25 170/5	130/12
78/20 79/15	routinely [1]	40/6 56/12	75/19 76/14	11/12 12/21	174/17	130/14
79/16 81/9	42/17	56/19 57/20	86/15 93/12	16/2 18/12	178/20 179/5	133/18
81/20 83/14	Rowley [22]	57/24 58/3	101/25	18/23 19/7	179/6 182/10	158/23
83/15 83/16	4/18 36/5	58/10 58/19	107/14	22/5 24/10	186/14	173/10
94/25 96/20	36/14 38/5	58/19 58/25	109/10	27/12 28/12	186/16	173/13
107/21	38/10 73/16	59/10 60/19	109/12 111/5	33/22 36/19	saying [14]	173/22 174/6
107/25	78/24 90/3	62/21 63/5	117/1 117/2	37/2 37/22	13/23 13/24	176/22
108/15	90/8 91/2	66/20 69/16	117/5 118/3	41/25 54/20	29/6 42/2	177/14
131/16	91/11 93/2	73/22 80/25	118/8 119/3	54/21 54/22	42/3 47/1	178/10
risks [3]	138/12	81/2 91/8	121/21 122/2	58/5 60/1	64/13 92/9	180/11
35/18 73/18	138/17 147/1	105/10	129/12	66/7 69/9	110/15 155/8	180/17
103/9	147/12 154/7	117/11 120/4	132/13	70/5 71/14	158/25	scenes [6]
risky [1]	155/8 155/11	120/19 126/1	159/12	72/23 75/18	159/19 189/9	68/13 68/14
105/16	181/18	129/17	159/23 168/3	77/18 79/17	189/19	68/18 88/6
Road [9]	181/25	130/25	salivation [2]	83/17 90/11	says [30]	88/6 88/9
100/6 123/23	189/19	131/25 133/9	15/11 169/14	90/25 95/19	5/20 12/6	SCG [10]
	Rowley's [4]	133/23	SALN [1]	95/19 97/1	12/10 15/25	45/15 52/24

S	76/21 80/9	33/18 34/2	seeing [2]	sensitive [1]	124/7 163/17	36/8
SCG... [8]	80/13 80/19	41/7 49/17	86/19 168/7	65/17	164/17	Shall [1]
74/2 76/24	seat [1] 1/10	49/18 52/15	seek [5]	sent [6] 11/4	services [21]	22/11
78/3 78/18	second [20]	57/22 61/6	18/10 54/13	31/24 64/7	8/21 31/6	share [2]
83/10 83/20	6/13 13/7	61/24 62/7	119/10	66/18 85/11	31/9 32/20	30/7 98/25
107/19	13/9 32/3	62/19 62/25	121/10	136/13	39/7 39/10	shared [12]
111/12	32/8 32/10	63/3 65/25	168/25	sentence [3]	41/25 42/14	27/3 28/18
scheduled [1]	32/14 35/13	71/9 74/6	seemed [2]	8/10 70/2	42/18 61/12	31/18 39/12
125/23	36/4 70/4	76/3 76/4	108/18 137/9	70/4	64/4 82/19	45/20 46/24
scheme [1]	81/25 84/5	78/22 80/2	seems [2]	separate [3]	88/3 94/4	53/1 53/2
115/11	96/25 104/3	82/23 83/6	52/16 95/1	10/2 91/1	95/7 97/6	85/21 94/25
Science [1]	109/5 110/16	83/12 84/14	seen [33]	126/23	101/23 103/2	97/4 99/5
75/5	134/9 161/22	84/14 85/8	5/21 10/4	sequence [1]	103/19	sharing [1]
scientific [8]	163/3 180/11	86/5 89/12	15/10 15/14	38/8	103/23	46/8
69/17 69/20	secondary [8]	91/22 92/8	20/10 22/6	Sergeant [2]	114/23	sharp [1]
74/18 75/2	31/12 32/5	93/24 101/20	33/14 35/17	96/10 96/17	services' [1]	30/18
75/9 75/14	33/13 34/4	108/3 109/9	40/15 59/17	Sergei [4]	56/15	she [57] 40/1
78/12 86/2	45/11 45/11	110/5 110/13	59/24 59/25	4/18 14/21	servicing [1]	40/5 58/5
scoop [3]	59/17 72/10	124/13	60/2 60/18	15/18 168/2	145/7	90/5 91/15
156/13	secondly [3]	124/17	60/19 60/24	series [3]	session [1]	134/20 135/1
178/18 185/4	37/6 63/20	127/12	81/22 82/6	12/7 18/1	84/17	135/3 135/9
Scout [1]	68/24	128/14	82/12 83/7	18/17	sessions [1]	135/12 137/4
125/24	seconds [3]	128/20 129/1	84/8 94/20	serious [3]	51/2	137/5 137/6
screen [23]	132/17 148/8	129/4 130/3	110/5 110/8	45/1 187/24	set [11] 43/16	137/7 137/17
1/15 1/17	181/24	133/24	110/15 124/6	188/1	82/7 83/22	138/1 138/2
7/18 8/6 9/3	secretions	146/12	124/12	seriously [2]	87/3 94/18	138/3 139/23
17/5 21/2	[10] 12/18	146/13 152/1	127/12 128/9	18/19 108/9	96/23 101/17	140/13
22/11 31/23	15/11 156/4	154/23	130/25	seriousness	104/17	140/15
57/14 57/17	156/9 166/5	154/25 155/2	138/25	[1] 188/12	104/22	140/18
59/12 124/1	169/15	155/6 161/25	176/22	service [44]	172/18	142/16
124/13	182/24 183/7	162/4 162/20	187/15	2/20 3/8 4/3	173/16	143/21 146/2
126/16	183/12	162/24	seizure [5]	5/1 16/12	sets [6]	147/18 148/6
126/19 128/5	183/16	165/15	138/9 154/3	18/16 19/16	124/12	151/25 153/6
128/6 131/6	sector [4]	167/23	157/20 158/7	28/7 30/25	165/19	153/7 153/8
161/24	34/6 34/7	169/18	182/13	31/7 31/8	165/20	153/9 156/16
161/25	34/8 83/2	171/16	seizures [1]	33/11 36/22	168/10	156/19
171/14	see [116]	171/20 172/3	167/4	38/23 42/2	169/10	156/22 157/5
187/13	1/16 1/20 3/7	173/3 173/4	seminars [1]	73/10 84/6	173/15	157/7 158/6
scrutiny [1]	3/24 5/19	173/25 174/9	50/25	91/23 92/5	setting [3]	160/15
45/3	7/19 9/24	175/8 175/21	send [3] 19/3	92/8 92/11	67/6 69/5	160/16
search [12]	12/4 12/12	176/1 178/2	64/9 116/5	92/15 93/9	70/20	166/17
45/16 79/11	12/21 13/8	178/14 179/5	senior [4]	93/14 93/16	seven [8] 4/5	174/20 181/7
79/17 80/1	13/9 15/12	180/10	96/11 101/21	95/2 98/12	6/9 46/11	182/5 182/14
80/7 80/12	16/17 16/21	181/13	107/16	98/25 104/16	46/16 53/25	185/4 185/13
92/23 92/24	17/24 17/24	181/21	111/10	106/6 106/6	92/14 115/3	185/17
99/24 100/5	21/7 21/18	181/22	sense [5]	106/6 106/12	132/13	185/20
107/22	22/24 23/5	181/25 184/3	46/3 47/7	113/23 114/4	several [2]	185/21
110/24	25/20 25/22	184/11	67/1 171/8	114/12	130/16 153/7	185/24 186/2
searches [1]	26/11 26/18	184/17	173/23	114/15	severe [3]	186/3 186/5
81/6	27/15 31/25	184/20 187/4	sensible [3]	114/17	12/16 13/11	186/7 186/7
searching [4]	32/3 32/14	189/7 189/8	59/5 72/5	114/24	165/25	189/24
	32/16 33/5	189/8	85/1	115/21 123/6	shadow [1]	she'd [1]

S	93/3 99/6	12/8 12/18	30/5 88/12	160/22 161/8	135/23	57/16 57/22
she'd... [1]	99/7 100/25	18/19 43/23	98/11 105/19	163/8 167/8	141/10	179/10
138/6	101/2 102/24	48/20 49/8	126/4 163/5	178/25	163/21	smaller [1]
sheet [3]	103/3 103/4	53/10 58/13	sinus [4]	sit [5] 79/9	skin [3] 135/4	125/6
189/17	110/11	62/20 63/1	146/16	111/12	169/6 176/4	smell [1]
189/17	112/21	64/11 65/12	146/18	112/15	skip [1]	134/17
189/18	122/13	65/18 70/9	146/19	127/20	128/12	so [201]
shift [4]	128/17 129/4	85/3 119/3	146/23	161/12	Skoda [1]	social [1]
125/20	130/3 143/8	119/19	sir [85] 1/5	site [3] 95/12	125/24	85/10
125/21 127/5	161/25	120/16 121/4	2/13 6/14	95/13 146/19	Skrupal [38]	sodium [1]
145/9	166/25	149/11 166/3	11/23 17/14	sites [3]	4/19 5/7	144/6
shifts [1]	171/13 176/8	166/4 167/1	21/13 23/10	86/20 109/24	14/16 14/22	solo [1]
164/12	shouldn't [1]	167/11	24/13 26/8	110/20	15/18 16/1	133/14
shock [15]	90/6	167/17	29/9 39/22	sits [2] 75/5	16/13 19/21	some [87]
45/9 139/20	shouted [1]	168/11 169/5	40/6 51/15	106/5	19/24 20/7	2/10 3/14
139/22 140/4	134/14	170/11	55/14 55/21	sitting [3]	23/1 24/9	4/14 4/24
144/11	show [5]	signs/symptoms [2] 62/20	56/2 57/6	53/25 54/3	25/7 27/18	11/15 11/17
144/16	58/16 73/21	85/3	59/16 59/25	112/16	28/16 32/1	12/23 12/25
144/18 145/9	77/24 116/10	silicon [1]	60/3 60/7	situated [1]	46/5 56/10	15/21 16/11
145/13 146/2	168/6	142/19	60/22 61/7	126/16	57/2 58/1	20/16 27/19
148/25	showed [2]	sill [2] 147/25	61/9 63/3	situation [16]	59/23 60/23	27/21 29/16
162/19	72/7 77/25	148/7	64/1 64/13	12/6 41/24	62/2 62/13	31/14 31/19
180/22 181/2	showing [1]	silver [3]	65/20 67/4	42/5 43/4	66/24 67/12	36/8 39/21
181/7	15/3	61/14 61/15	69/9 69/19	47/2 50/16	67/15 71/14	40/14 45/15
shockable [6]	shown [2]	65/7	70/15 71/2	81/5 82/6	72/16 74/1	45/22 48/8
140/5 140/6	109/21	similar [15]	71/17 71/23	95/6 99/12	76/4 83/11	50/3 51/3
144/12	115/13	12/12 12/21	72/22 74/4	101/17	84/12 85/19	52/17 56/9
145/16	shows [1]	17/8 18/23	75/15 77/6	103/16 104/6	107/15	56/12 56/16
145/18 146/2	189/18	21/7 21/19	78/6 78/14	105/16	121/19 165/4	57/12 57/18
shocks [1]	shut [1] 88/7	23/19 49/11	79/19 79/23	124/11	168/2	57/21 58/15
153/7	shutting [1]	61/11 68/4	80/15 82/4	149/12	Skripals [9]	59/5 61/2
Short [2]	88/6	93/11 113/11	82/10 84/13	situational [5]	29/8 32/9	63/8 64/10
55/18 161/5	side [6] 12/17	127/2 133/10	86/17 87/7	39/12 94/25	48/9 62/13	65/11 67/9
shorter [1]	83/25 149/16	172/18	87/25 88/13	97/4 99/2	66/9 67/8	72/1 73/21
17/11	174/15 179/7	similarities [1] 70/8	88/20 88/24	99/5	67/18 71/4	75/7 79/22
shortly [5]	179/14	simple [1]	89/12 89/14	situations [1]	117/3	80/10 84/9
29/25 42/1	sign [9] 45/5	107/13	90/7 90/13	53/21	Skripals' [1]	85/2 86/25
103/15	49/9 117/24	simply [6]	90/21 95/22	six [9] 4/5 6/9	167/24	87/4 87/11
136/17 180/5	125/25	2/17 46/22	97/3 100/3	32/17 42/12	slight [1]	91/9 91/14
should [41]	128/21 171/4	94/15 95/1	100/10 101/5	70/16 79/9	132/23	91/16 95/4
9/9 9/11	171/16	95/4 174/3	101/19	82/18 133/7	slightly [4]	101/10
13/13 13/20	171/18	simultaneous ly [1] 126/19	104/13	170/5	17/11 30/10	103/20
28/22 28/25	173/10	since [10]	105/18 106/1	six months [1] 133/7	90/18 127/20	107/11
30/2 35/15	signature [1]	6/13 11/10	106/25	42/12 79/9	slow [2]	109/16
36/23 37/8	1/23	44/9 50/21	108/19	170/5	165/25 166/2	110/21
37/25 39/10	signed [2]	53/20 103/18	108/20 109/8	six years' [1]	slower [1]	113/15 116/5
39/11 51/10	167/20 170/7	104/7 117/1	109/19 110/9	70/16	128/2	117/6 118/15
64/15 65/10	significant [6]	119/2 164/17	110/21	six years' [1]	slowly [1]	121/5 127/21
67/20 72/1	19/11 28/6	single [6]	111/25	179/7	8/17	128/3 130/21
73/9 77/18	49/12 49/19		112/10 113/6	size [1] 179/7	sluggish [1]	131/21 140/9
84/1 85/22	86/17 92/10		127/23	skills [4]	179/7	140/18
	signs [28]		127/24 128/1	135/22	small [4] 3/4	140/24 142/7

S	somewhere	89/19 104/11	specific [18]	165/22	174/10 186/2	2/2 2/6 2/12
some... [17]	[10] 26/7	157/20	11/8 18/14	square [1]	186/23 187/1	2/14 3/7 3/24
146/25	33/19 45/12	162/19	19/16 20/5	149/14	stages [1]	5/17 6/23
147/22 148/6	47/4 52/23	163/22	20/24 30/8	squeeze [1]	71/7	7/18 7/19
148/6 152/3	108/2 110/18	168/23 169/4	31/12 46/23	142/20	stairs [6]	14/2 16/16
152/5 156/2	111/23	170/6 176/1	48/15 48/18	squeezed [1]	130/16	17/7 22/19
157/20 159/3	127/16	176/22	69/1 70/6	174/13	134/15	24/1 24/13
168/4 170/23	130/16	177/11	72/15 106/9	squeezing [1]	134/17 174/9	29/19 44/12
174/14	soon [2]	182/12	121/11	151/21	174/11	57/7 57/8
177/21	109/12	182/12 183/9	121/21 122/1	SRG [2]	185/11	61/7 65/23
179/12	187/22	184/2 186/10	122/15	109/17	stand [1]	65/25 66/17
179/17 187/5	sooner [2]	188/10	specifically	109/18	112/15	67/5 67/5
188/18	41/17 47/4	sorts [2]	[10] 27/4	stab [2]	standard [6]	67/12 69/25
somebody [7]	sorry [43]	75/22 87/18	31/5 45/17	32/21 34/3	14/14 74/25	70/17 78/8
49/19 71/8	5/15 8/17	sought [1]	49/21 61/16	stabilised [1]	142/24 143/3	85/23 89/21
111/11	20/13 21/14	96/18	72/4 72/25	147/4	143/7 186/18	89/22 90/2
120/20 133/1	26/3 29/22	sound [1]	107/5 118/2	stably [1]	standby [1]	90/9 91/13
183/22	47/24 51/16	179/25	122/17	37/6	132/12	91/20 94/17
186/11	53/3 53/16	sounded [1]	specifics [1]	STAC [10]	standing [2]	96/3 98/7
somebody's	60/15 60/16	137/5	40/7	74/19 74/22	87/17 147/16	101/3 111/8
[1] 135/25	67/4 80/6	sounds [2]	spectrum [1]	75/4 75/21	standpoint	112/22 113/1
someone [4]	84/13 89/5	80/16 138/2	18/16	76/25 78/11	[1] 37/25	113/7 114/3
70/19 74/11	95/19 108/25	source [4]	spelled [1]	81/11 86/1	stands [2]	115/2 115/4
82/7 85/11	112/5 116/15	32/16 32/18	147/22	107/20	64/1 106/11	115/22
someone's	117/9 117/10	59/16 82/15	spend [1]	108/13	standstill [1]	116/25 118/5
[1] 32/21	118/6 118/18	sources [3]	168/14	staff [37]	140/7	118/13
something	118/23 120/6	41/13 49/3	spent [2]	4/17 5/5 7/2	start [11] 5/4	118/15
[40] 5/17	124/2 125/11	50/3	3/14 4/4	7/6 7/14 7/21	5/11 8/13	118/19 122/5
16/25 17/16	128/11	South [7]	split [1]	9/8 9/15 9/16	56/24 57/11	123/3 125/18
18/19 27/7	128/17 136/6	2/19 113/22	152/3	10/3 10/11	73/1 73/11	129/3 129/17
30/20 38/21	137/16	114/4 115/20	spoke [2]	11/5 14/6	76/21 113/10	129/24 131/2
39/3 63/10	139/16 141/2	123/6 124/6	100/17	15/19 16/4	145/8 175/3	131/12
69/7 70/14	143/12	163/17	147/15	24/12 24/15	started [5]	131/25
71/15 71/16	148/24 149/3	space [2]	spoken [5]	27/13 27/20	3/16 136/3	132/10
71/18 71/19	149/22	126/24	67/9 72/3	27/23 29/7	142/7 174/25	132/24
71/20 72/6	151/16 157/7	174/23	84/21 95/25	30/17 38/7	185/25	133/20 134/5
72/11 72/18	166/23	spasm [1]	148/23	64/16 65/13	starters [1]	134/7 135/10
86/8 86/13	171/23	165/22	spontaneous	66/13 72/2	141/15	136/16
87/6 97/1	176/24	speak [4]	[11] 37/5	115/11 116/9	starting [2]	136/22
98/21 100/4	sort [42] 8/1	29/13 110/25	40/9 146/6	116/19	89/22 154/10	139/16
120/4 122/24	10/11 10/17	136/8 154/6	146/14	117/21	starts [4]	141/19
125/9 125/12	12/7 14/25	speaking [3]	148/19	117/23	13/10 21/8	143/11
126/25 138/6	15/11 20/5	5/23 15/4	148/20 153/1	118/10	73/2 118/24	143/22
138/7 139/8	33/8 33/10	181/18	179/20	119/23	state [5]	144/13
141/15 154/4	33/12 33/14	special [1]	180/21 181/4	159/24 165/5	99/21 134/16	148/22
154/17 155/1	35/17 36/9	92/6	181/8	168/6	139/3 162/18	149/24
160/3 177/13	36/20 36/23	specialism	spot [3]	staff's [2]	162/19	150/18 151/8
187/22	38/19 42/5	[1] 61/12	49/20 50/1	20/6 28/13	stated [2]	152/20 162/5
sometimes	53/11 56/17	specialist [6]	102/14	stage [10]	93/10 93/19	162/6 162/9
[3] 132/7	57/7 62/20	7/11 18/9	spreading [1]	92/1 92/17	statement	162/19
146/7 149/13	63/17 79/5	18/10 18/12	30/12	94/12 118/9	[92] 1/14	162/24 163/4
	81/12 85/25	65/8 168/25	sputum [1]	144/11 154/8	1/20 1/25 2/1	170/20

T	164/16	74/21 75/8	56/2 59/9	30/5 30/22	157/16 160/9	91/21 92/10
taken... [2]	technicians	77/13 80/3	62/18 65/22	33/20 34/23	161/12	94/18 96/19
156/22	[4] 5/18	80/9 83/15	86/11 89/15	36/24 37/1	163/18	98/9 98/23
189/21	14/18 17/17	85/18 86/23	89/17 91/8	38/4 41/1	165/10	108/1 111/7
taker [1] 40/1	164/13	87/1 87/25	101/4 101/4	44/1 44/5	165/25	111/18
takes [2]	techniques	88/11 97/17	106/25	44/23 46/5	166/10	125/13 141/5
103/8 103/16	[1] 115/24	100/13 105/7	111/19	49/5 50/5	166/23 169/1	141/18 142/1
taking [5]	Technologica	107/21	111/20	50/6 50/15	170/12 171/6	144/20 145/5
4/21 37/15	I [1] 75/5	108/13	112/13 113/6	51/13 52/15	171/23 172/1	153/2 153/4
57/11 155/3	technology	108/15 119/6	114/25	54/24 60/25	172/4 172/6	153/12
155/9	[1] 11/9	137/15 138/5	116/24	61/5 61/18	174/3 175/10	184/15 188/4
talk [6] 63/15	tell [23] 13/17	143/21 151/7	117/14 118/1	62/2 63/21	175/20	thematic [4]
68/1 68/5	48/5 49/20	153/6 153/9	125/16 126/1	70/23 72/5	175/22	75/13 75/13
68/23 75/25	61/8 65/16	territory [2]	127/5 127/9	72/18 73/5	175/23 176/2	81/12 81/13
78/9	114/2 118/4	70/12 114/9	127/22	74/20 75/23	176/9 177/13	theme [1]
talked [1]	120/8 126/13	Terrorism [4]	128/20 129/9	87/6 87/7	177/24	62/25
74/17	128/6 137/21	79/18 110/23	129/14	88/19 88/20	178/12	themselves
talking [14]	138/15 139/2	111/6 111/9	130/19	89/15 90/13	178/20	[7] 9/9 36/7
45/13 46/5	141/18	terrorist [1]	131/12	90/21 91/7	179/13	56/20 90/18
52/19 67/19	144/22	7/9	141/18	92/12 92/18	179/22 180/1	116/19
73/1 73/2	147/10	tertiary [1]	152/14 159/2	93/5 93/22	180/8 181/15	117/24 165/6
74/13 80/1	147/17 151/3	31/12	160/19	93/23 95/16	185/5 186/5	then [149]
90/2 92/6	151/5 155/11	testimony [1]	160/21	97/1 98/21	186/9 187/22	4/16 5/7 7/15
92/16 95/10	163/19 174/3	190/8	160/25	101/2 101/3	189/18	11/10 11/22
118/3 177/1	188/4	text [4] 34/1	161/11	104/5 106/20	their [24]	12/17 13/12
talks [5]	telling [3]	85/9 132/9	161/16 165/9	108/22 109/2	5/19 9/16	14/16 16/19
63/13 84/17	11/22 177/10	177/3	168/8 187/4	109/19	10/25 24/24	18/10 18/17
95/10 95/11	189/19	than [19]	187/7 187/8	114/10	28/14 28/15	18/22 21/9
100/16	ten [5] 32/1	3/20 19/24	189/4 189/25	114/13 115/9	36/23 38/3	22/10 27/25
targeted [6]	84/11 85/25	34/10 41/17	190/2 190/3	116/13	38/4 63/23	28/23 30/17
32/8 32/9	114/7 140/25	45/23 62/3	190/4	119/21	72/2 93/20	32/9 32/18
62/13 66/9	ten minutes	73/11 85/12	that [1124]	126/23	96/19 98/2	33/5 34/6
67/18 68/16	[2] 84/11	96/6 100/5	that you [1]	126/23	98/5 98/16	34/9 38/5
team [10]	140/25	102/11	160/7	126/24 128/1	102/3 102/5	38/11 39/11
8/16 8/20	ten years' [1]	110/20	that's [157]	128/16 129/5	136/1 136/1	40/25 43/16
8/21 42/17	114/7	119/25	3/10 4/12	129/25	139/3 149/11	46/17 46/18
45/1 80/8	term [3] 74/3	125/14	4/22 6/13	131/15	156/3 156/3	47/24 49/17
157/2 157/3	82/3 98/8	133/13	6/19 7/21	132/14	them [48]	50/22 52/12
181/14	terminal [4]	150/15	8/24 9/14	132/21	4/19 4/21	56/24 57/20
184/12	126/9 126/14	163/21	9/14 9/18	133/18 134/2	10/17 18/17	57/21 58/14
teams [1]	130/22	177/22	12/13 14/5	135/16 136/3	24/5 36/8	58/23 62/10
27/3	172/17	189/20	15/2 17/10	139/3 140/10	36/19 37/24	62/18 63/15
tears [1]	terminology	thank [67]	17/15 17/15	142/1 142/13	39/11 40/3	63/23 66/7
166/5	[4] 50/8 78/9	1/10 1/16 2/9	18/19 20/2	143/14 144/2	40/17 43/13	68/24 69/4
technical [1]	85/24 109/19	2/16 4/13 5/3	20/15 20/20	145/20	43/24 46/14	70/4 71/4
75/3	terms [36]	6/25 7/17	21/1 21/4	145/22	46/16 49/16	71/5 73/8
technician [6]	10/13 31/11	9/24 11/20	21/15 21/17	148/19	51/6 54/1	73/17 75/25
3/15 3/19	34/20 34/21	24/21 26/10	22/23 23/3	149/20 150/7	54/4 54/11	76/3 76/11
163/16	35/7 36/11	36/1 39/20	23/7 23/10	151/10	62/25 66/6	78/24 79/2
163/20	37/12 48/23	39/20 40/13	23/21 25/1	152/18	73/6 73/8	79/12 79/13
163/22	48/24 63/23	48/22 55/10	25/17 25/24	156/15	75/21 81/16	80/21 82/16
	64/11 68/2	55/11 55/15	26/16 28/5	156/18	87/24 90/17	82/23 82/25

T	179/15	127/12 145/4	120/18	17/15 21/8	123/24	78/20 79/5
then... [88]	180/12	168/1	120/19	21/13 21/21	125/14 126/1	81/3 84/23
84/24 85/11	180/15	they [124]	120/21	28/5 28/5	126/11 127/8	89/8 101/24
86/21 86/21	180/20	2/8 4/20 7/5	130/11	28/12 28/24	127/21	121/22
86/24 90/14	182/25 184/8	8/22 9/9	130/23	28/25 29/1	128/23	157/23 187/2
90/22 91/20	185/9 185/13	10/13 10/17	130/24	29/18 33/14	129/12 130/2	third [5]
92/3 92/19	theoretically	11/6 11/21	131/10 133/1	34/12 34/19	130/11	16/17 32/10
93/6 93/24	[1] 130/15	14/24 15/3	136/12	35/3 35/17	130/13	32/12 57/7
95/12 95/14	therapy [1]	15/10 17/7	140/25 141/7	36/2 37/1	130/17	76/11
97/20 102/2	144/10	17/8 24/9	141/8 141/14	39/4 39/4	130/22 132/6	this [325]
102/18 103/3	there [220]	24/12 24/22	145/5 145/6	39/5 39/17	132/23	Thompson [2]
103/4 103/15	there's [43]	24/23 26/2	145/11	41/1 41/12	133/10	178/23
103/18	16/18 27/10	26/19 36/3	148/11	41/18 45/20	136/12	189/13
104/19	28/2 34/6	36/13 36/15	148/11	47/22 48/7	138/21 139/4	those [61]
107/24 111/4	46/15 49/3	36/16 36/20	152/25	49/12 51/12	139/5 139/10	3/14 4/4 4/20
112/4 117/18	49/12 53/16	37/12 37/15	153/15 157/3	53/8 55/8	139/23	7/12 10/8
124/16	55/8 61/17	37/16 37/18	164/12	57/19 58/17	140/14	12/11 12/23
128/17 129/1	62/19 62/24	37/23 37/24	168/15 169/9	59/22 59/24	140/14	12/25 13/21
129/4 129/8	63/18 63/19	37/25 38/16	169/12 179/6	60/18 64/9	140/15	18/13 19/13
130/7 132/8	64/13 65/17	39/10 39/15	180/10	64/13 65/10	140/15	23/14 23/23
134/13	65/20 66/19	40/10 40/11	184/14	67/5 67/8	140/25 141/7	27/14 37/14
134/25	72/11 72/12	41/10 41/12	184/16 185/8	69/2 71/18	141/20 143/9	39/18 39/20
135/21	72/15 75/18	41/18 43/23	188/6 188/6	71/24 72/1	144/5 144/15	43/19 43/21
139/25 140/2	78/6 80/12	44/9 49/11	they're [7]	73/5 73/10	146/25	44/11 46/22
142/6 142/12	86/24 103/14	50/19 50/20	18/13 18/15	74/11 74/18	149/23 151/7	51/3 51/5
142/13	104/24	50/21 51/6	18/15 43/12	77/6 77/11	151/10	51/8 56/23
142/15	105/11	56/21 56/22	106/1 130/23	77/25 78/2	152/14	58/12 64/2
142/16	108/20	56/22 58/4	189/10	78/6 79/4	152/16	65/20 68/14
142/22 143/6	118/19 121/7	63/9 64/2	thing [7] 37/1	79/10 80/14	153/15 154/6	75/22 76/11
143/21	121/18 123/1	64/21 65/1	41/6 41/25	81/7 81/9	154/21	81/15 86/21
143/23	125/14	69/12 69/18	53/11 72/20	83/9 84/13	155/13	86/22 87/4
144/18 145/3	127/13 146/7	72/8 73/4	101/14	85/14 85/16	155/20	87/18 88/4
145/14	161/1 176/8	73/9 73/17	186/10	85/18 86/18	156/13	94/9 95/3
146/25 147/4	177/20	75/12 81/11	things [24]	86/24 89/21	156/16	96/24 104/10
147/15	180/12	86/19 87/2	40/17 43/9	91/9 93/6	156/19	104/12
148/22 150/9	183/25	89/18 89/24	48/7 52/14	93/12 97/8	157/10	119/25 121/5
151/1 152/14	188/22 190/4	91/23 91/25	71/13 74/24	98/7 98/24	157/24	122/19
156/5 158/20	therefore [5]	92/16 96/13	75/22 77/10	108/23	158/24 160/4	123/15
159/19	37/3 37/14	96/14 96/25	87/1 87/13	111/24	160/13	124/17
164/22 166/3	44/7 53/19	98/11 98/15	87/18 87/19	112/12 114/6	166/21	126/25
166/4 166/8	108/8	98/22 101/24	91/5 95/3	114/7 116/24	167/15	135/23
166/19	thereon [1]	101/25	116/12 120/9	117/15	172/22 177/1	145/25 148/7
167/10	7/16	101/25 103/2	120/9 121/5	118/10	177/20	149/6 159/2
168/23 169/4	these [17]	105/18	127/14	119/16	178/12 179/3	159/18
169/9 170/19	10/16 45/13	106/13	141/14	119/22	181/20	160/17
172/8 172/20	54/16 62/22	107/25 108/1	141/15	119/24	182/17	161/23 163/8
173/9 173/14	64/20 70/16	108/25 109/9	159/18	120/23	186/22	168/15
174/6 175/11	71/13 73/23	115/11	182/19	121/20	188/18	183/17
178/8 178/18	81/3 81/12	115/11 116/5	182/21	123/12	188/22	183/21 188/2
179/13	82/22 87/16	117/16	think [160]	123/13	thinking [13]	though [7]
179/14	106/19	117/23	3/7 5/10 5/24	123/21	36/20 41/23	25/16 37/22
	115/21	117/24	8/5 17/1 17/9	123/21	56/22 78/4	41/9 128/4

T	162/24	102/8 102/9	47/11 56/12	110/4 110/9	121/9	143/21
though... [3]	165/18 168/5	105/6 106/11	56/13 75/17	110/10	training [40]	150/16
130/9 130/14	172/12	107/13 111/4	106/14	118/20	3/19 4/25 5/5	151/25 153/5
135/22	172/13	114/3 115/18	108/11	118/24	7/2 7/12 8/2	155/15
thought [23]	172/21	115/19	112/13	128/14 129/5	10/10 11/13	179/13
35/21 47/2	172/22	115/21	133/10	131/14 134/9	11/16 11/17	179/16
48/8 59/10	174/13	117/16	165/12 190/8	134/17	11/21 14/2	triage [2]
84/9 88/22	181/20	118/15	together [13]	139/18	14/7 14/9	31/6 31/8
89/15 135/8	182/19	123/10	28/11 52/7	139/24	14/14 28/2	triangle [1]
138/6 138/10	182/20	123/18 128/2	64/3 64/4	140/12	36/21 38/3	96/22
138/10	throughout	128/9 129/8	85/11 86/8	146/19	38/4 43/24	tried [4]
138/25 153/4	[5] 17/2	129/13	96/8 96/13	146/21 152/3	56/25 63/9	87/19 96/19
153/25 154/1	42/19 43/16	129/20	97/24 99/7	171/20 172/3	63/18 64/14	127/23
154/2 157/19	97/8 160/7	129/21 130/7	100/12	176/20	72/3 72/14	146/25
157/19 158/5	Throughout	130/8 130/11	102/20	topic [5]	82/10 106/19	triggers [5]
158/6 158/15	March [1]	130/12 132/8	188/13	30/11 45/22	115/1 115/5	18/2 18/4
160/7 160/11	43/16	133/18 134/6	toilet [1]	57/19 86/12	115/15	18/11 168/13
thoughts [5]	thumb [1]	136/5 138/25	178/9	107/9	115/23	168/15
137/22 138/4	152/3	139/3 141/8	told [16] 11/6	topics [2]	115/25 116/2	trouble [2]
154/1 157/21	Thursday [2]	144/21	36/13 39/25	36/2 123/9	116/10 121/3	56/23 179/4
158/4	1/1 31/25	148/10	73/18 88/17	total [2] 3/7	121/15	trousers [3]
threat [4]	tightness [2]	154/21	108/4 131/23	4/3	159/20 164/3	140/17
62/16 67/21	167/3 169/14	157/20	137/14	touch [2]	164/24	140/18
88/8 102/22	tilting [1]	160/23	137/17 142/1	2/17 85/23	transcript [3]	156/19
three [14]	142/8	162/19	153/3 162/22	touched [1]	57/14 112/23	true [4] 2/6
12/7 12/7	time [103]	167/14 168/9	172/16	81/12	165/10	113/4 162/13
18/8 30/6	2/24 4/10	168/14	174/19 175/8	Toughbook	transfer [1]	162/15
39/9 44/2	10/12 10/14	169/12 170/6	183/6	[1] 127/1	157/4	trust [4] 2/20
63/17 64/14	10/19 10/23	170/11	tomorrow [5]	towards [5]	transmission	16/12 19/3
70/4 77/1	11/9 11/14	170/16	4/15 11/16	12/5 32/13	s [1] 130/21	19/4
116/4 119/9	11/18 14/7	170/23 172/2	56/14 178/25	54/1 82/14	trauma [1]	try [16] 28/2
136/24	14/13 20/10	172/7 174/1	190/10	134/21	187/23	60/17 78/15
168/22	24/4 27/16	179/23	tongue [2]	Toxic [1]	treat [4]	79/16 86/8
three-day [1]	29/2 29/4	186/20	142/11	166/9	48/21 94/14	86/9 87/4
116/4	29/20 29/25	188/19	142/14	toxidrome [1]	122/13	87/9 91/19
through [37]	33/18 33/20	time, [2]	too [3]	50/12	122/22	128/3 142/9
2/3 3/25 8/23	37/15 41/1	68/11 70/25	166/24 179/4	trace [1]	treated [2]	142/10 144/1
10/23 10/25	44/14 45/10	time,	184/8	77/12	94/5 94/15	144/5 147/4
14/7 43/7	46/5 46/15	March/April	took [18]	Traces [1]	treating [7]	147/7
46/14 73/6	47/13 47/25	[2] 68/11	3/25 16/13	46/1	36/13 36/23	trying [7]
78/25 79/11	50/10 50/14	70/25	16/25 19/17	tracing [1]	93/15 152/10	63/1 78/10
81/9 87/12	52/1 58/2	times [1]	29/20 31/9	77/10	154/14 182/7	147/21
91/19 97/12	60/12 61/6	136/2	31/19 51/20	traditional [1]	183/15	154/18 182/4
97/20 98/11	61/8 62/12	timetable [1]	91/15 94/23	3/21	treatment	183/10 184/8
99/2 107/4	63/16 67/17	40/23	100/4 100/15	tragic [1]	[21] 7/23	tube [1]
107/22	67/22 69/3	timings [1]	106/7 150/21	68/21	12/12 19/13	142/12
145/22	70/16 70/18	128/3	157/3 180/4	train [1] 7/8	33/4 36/4	Tuesday [5]
145/24 146/1	78/1 81/14	title [2] 22/24	180/5 185/8	trained [9]	36/4 36/7	52/24 57/15
146/22	83/6 88/11	32/4	top [26] 7/20	7/6 59/3	36/11 37/3	64/16 65/9
150/13	88/12 90/4	today [15]	43/7 61/4	61/16 72/9	53/10 105/25	69/16
162/21	93/9 93/12	2/4 4/15 4/23	61/22 63/12	80/8 105/24	107/3 113/14	turn [3] 10/2
	95/23 100/18	4/24 11/15	82/24 83/22	107/2 114/23	139/13	162/3 178/8

T	U	10/11 42/17 92/24 99/24 104/25	51/22 59/25 60/18 83/7 114/19 127/5	173/18 174/8 174/11 175/7 175/25	75/4 85/1 88/10 88/17 110/1 111/25	utilised [1] 43/1
turned [5] 134/15 134/18 139/20 145/9 174/11	UK [3] 62/5 114/18 114/22	undertaken [5] 25/25 70/22 79/12 79/18 104/24	181/13 185/17 190/13	176/11 177/14 183/4 185/23	112/18 116/10 118/4 120/8 126/13	V
turns [1] 151/23	ultimately [2] 80/20 86/9	undertaking [2] 3/12 95/13	unusual [6] 158/10 158/13 158/13	update [13] 22/13 116/7 116/13 116/18	130/14 130/17 131/10 147/11	Vaguely [1] 185/23
twice [1] 165/11	unable [1] 52/5	undertook [4] 3/17 34/23 36/7 92/23	158/15 183/17 186/11	177/14 183/4 185/23 187/14 190/9	157/17 157/24 158/2 163/19 167/5	vapour [1] 169/7
two [33] 17/7 17/19 18/7 23/12 24/8 36/2 41/24 44/1 51/19 53/21 57/8 65/3 69/21 83/5 89/18 90/15 92/6 98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	unclear [2] 73/4 153/10	undiscovered [1] 76/13	unusually [1] 127/7	116/19 117/17 117/21 118/8 131/10 131/11 132/9 159/22 159/23	169/10 172/16 173/24 174/2 174/3 174/7 175/8 175/14 176/18	vapours [1] 18/21
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	unconsciousness [1] 167/4	unexplained [4] 18/21 73/8 169/5 169/7	unwell [5] 73/4 91/12 138/18 139/4 152/10	117/21 118/8 131/10 131/11 132/9 159/22 159/23	169/10 172/16 173/24 174/2 174/3 174/7 175/8 175/14 176/18	various [4] 38/17 100/2 106/7 123/9
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	under [5] 55/24 76/5 102/25 139/7 192/7	uniform [1] 114/2	upon [68] 1/15 7/18 8/6 10/2 15/20 17/5 21/2 21/13 22/11 32/17 32/19 36/9 37/22 41/22 43/13 46/15 57/14 58/25 59/10 59/25 68/3 70/4 74/1 78/11 78/16 79/1 79/7 82/7 82/18 82/22 83/7 86/10 87/4 87/15 88/17 91/15 91/21 101/10 108/22 116/2 123/15 124/1 127/22 130/21 132/20 134/15 134/15 136/10 136/12 136/24 142/18 147/6 161/24 163/4 165/8 171/13 172/18	117/24 131/7 133/5 136/10 updates [9] 10/12 11/12 111/13 115/23 115/24 115/25 116/22 133/4 133/8 upon [4] 95/22 98/10 98/25 100/20 uptaker [1] 114/21 uptook [1] 115/12 urgent [1] 53/11 urinary [1] 167/11 us [54] 1/11 4/2 4/24 7/3 10/7 11/10 11/22 13/17 21/21 27/7 29/5 48/5 61/22 64/17 65/16 69/12 69/15 74/21	177/10 178/4 179/23 183/6 183/20 187/21 188/6 use [14] 13/20 13/23 13/25 14/1 18/18 85/24 86/18 95/10 104/6 104/9 123/16 123/24 133/12 133/12 useable [1] 145/11 used [15] 13/13 31/6 32/18 57/25 67/11 74/3 82/8 98/8 123/18 139/22 149/13 155/23 182/23 183/3 183/4 useful [1] 17/17 user [1] 90/5 using [3] 12/11 19/25 102/20	vast [1] 5/17
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	undergo [1] 14/8	uniqueness [1] 75/25	unit [3] 155/20 157/17 180/14	133/5 136/10 updates [9] 10/12 11/12 111/13 115/23 115/24 115/25 116/22 133/4 133/8 upon [4] 95/22 98/10 98/25 100/20 uptaker [1] 114/21 uptook [1] 115/12 urgent [1] 53/11 urinary [1] 167/11 us [54] 1/11 4/2 4/24 7/3 10/7 11/10 11/22 13/17 21/21 27/7 29/5 48/5 61/22 64/17 65/16 69/12 69/15 74/21	177/10 178/4 179/23 183/6 183/20 187/21 188/6 use [14] 13/20 13/23 13/25 14/1 18/18 85/24 86/18 95/10 104/6 104/9 123/16 123/24 133/12 133/12 useable [1] 145/11 used [15] 13/13 31/6 32/18 57/25 67/11 74/3 82/8 98/8 123/18 139/22 149/13 155/23 182/23 183/3 183/4 useful [1] 17/17 user [1] 90/5 using [3] 12/11 19/25 102/20	vehicle [10] 8/1 9/19 125/22 125/22 126/2 126/3 126/8 132/22 145/6 145/7
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	underneath [7] 9/25 16/24 32/5 32/7 82/24 140/17 179/6	unit [3] 155/20 157/17 180/14	United [3] 80/20 106/17 108/2	133/5 136/10 updates [9] 10/12 11/12 111/13 115/23 115/24 115/25 116/22 133/4 133/8 upon [4] 95/22 98/10 98/25 100/20 uptaker [1] 114/21 uptook [1] 115/12 urgent [1] 53/11 urinary [1] 167/11 us [54] 1/11 4/2 4/24 7/3 10/7 11/10 11/22 13/17 21/21 27/7 29/5 48/5 61/22 64/17 65/16 69/12 69/15 74/21	177/10 178/4 179/23 183/6 183/20 187/21 188/6 use [14] 13/20 13/23 13/25 14/1 18/18 85/24 86/18 95/10 104/6 104/9 123/16 123/24 133/12 133/12 useable [1] 145/11 used [15] 13/13 31/6 32/18 57/25 67/11 74/3 82/8 98/8 123/18 139/22 149/13 155/23 182/23 183/3 183/4 useful [1] 17/17 user [1] 90/5 using [3] 12/11 19/25 102/20	vehicles [4] 8/25 9/20 125/10 125/13
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	understand [16] 5/2 6/14 12/15 20/25 39/3 42/13 53/7 53/8 54/12 80/21 95/6 96/19 98/17 105/22 188/9 189/25	United Kingdom [3] 80/20 106/17 108/2	unknown [3] 47/18 152/21 157/25	133/5 136/10 updates [9] 10/12 11/12 111/13 115/23 115/24 115/25 116/22 133/4 133/8 upon [4] 95/22 98/10 98/25 100/20 uptaker [1] 114/21 uptook [1] 115/12 urgent [1] 53/11 urinary [1] 167/11 us [54] 1/11 4/2 4/24 7/3 10/7 11/10 11/22 13/17 21/21 27/7 29/5 48/5 61/22 64/17 65/16 69/12 69/15 74/21	177/10 178/4 179/23 183/6 183/20 187/21 188/6 use [14] 13/20 13/23 13/25 14/1 18/18 85/24 86/18 95/10 104/6 104/9 123/16 123/24 133/12 133/12 useable [1] 145/11 used [15] 13/13 31/6 32/18 57/25 67/11 74/3 82/8 98/8 123/18 139/22 149/13 155/23 182/23 183/3 183/4 useful [1] 17/17 user [1] 90/5 using [3] 12/11 19/25 102/20	ventilate [1] 142/15
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	understandin g [19] 5/5 13/18 39/13 42/20 43/3 49/5 49/7 49/8 62/11 66/24 67/13 67/17 75/9 81/5 89/19 92/2 94/24 99/1 184/21	United Kingdom [3] 80/20 106/17 108/2	unless [3] 113/19 161/1 190/4	133/5 136/10 updates [9] 10/12 11/12 111/13 115/23 115/24 115/25 116/22 133/4 133/8 upon [4] 95/22 98/10 98/25 100/20 uptaker [1] 114/21 uptook [1] 115/12 urgent [1] 53/11 urinary [1] 167/11 us [54] 1/11 4/2 4/24 7/3 10/7 11/10 11/22 13/17 21/21 27/7 29/5 48/5 61/22 64/17 65/16 69/12 69/15 74/21	177/10 178/4 179/23 183/6 183/20 187/21 188/6 use [14] 13/20 13/23 13/25 14/1 18/18 85/24 86/18 95/10 104/6 104/9 123/16 123/24 133/12 133/12 useable [1] 145/11 used [15] 13/13 31/6 32/18 57/25 67/11 74/3 82/8 98/8 123/18 139/22 149/13 155/23 182/23 183/3 183/4 useful [1] 17/17 user [1] 90/5 using [3] 12/11 19/25 102/20	verified [1] 131/24
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	understood [5] 43/1 48/6 54/11 62/10 64/7	until [13] 25/10 27/19 40/24 40/25	unlikely [1] 6/23	133/5 136/10 updates [9] 10/12 11/12 111/13 115/23 115/24 115/25 116/22 133/4 133/8 upon [4] 95/22 98/10 98/25 100/20 uptaker [1] 114/21 uptook [1] 115/12 urgent [1] 53/11 urinary [1] 167/11 us [54] 1/11 4/2 4/24 7/3 10/7 11/10 11/22 13/17 21/21 27/7 29/5 48/5 61/22 64/17 65/16 69/12 69/15 74/21	177/10 178/4 179/23 183/6 183/20 187/21 188/6 use [14] 13/20 13/23 13/25 14/1 18/18 85/24 86/18 95/10 104/6 104/9 123/16 123/24 133/12 133/12 useable [1] 145/11 used [15] 13/13 31/6 32/18 57/25 67/11 74/3 82/8 98/8 123/18 139/22 149/13 155/23 182/23 183/3 183/4 useful [1] 17/17 user [1] 90/5 using [3] 12/11 19/25 102/20	version [7] 1/24 17/11 17/12 17/14 25/12 50/23 60/2
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20	undertake [5]			133/5 136/10 updates [9] 10/12 11/12 111/13 115/23 115/24 115/25 116/22 133/4 133/8 upon [4] 95/22 98/10 98/25 100/20 uptaker [1] 114/21 uptook [1] 115/12 urgent [1] 53/11 urinary [1] 167/11 us [54] 1/11 4/2 4/24 7/3 10/7 11/10 11/22 13/17 21/21 27/7 29/5 48/5 61/22 64/17 65/16 69/12 69/15 74/21	177/10 178/4 179/23 183/6 183/20 187/21 188/6 use [14] 13/20 13/23 13/25 14/1 18/18 85/24 86/18 95/10 104/6 104/9 123/16 123/24 133/12 133/12 useable [1] 145/11 used [15] 13/13 31/6 32/18 57/25 67/11 74/3 82/8 98/8 123/18 139/22 149/13 155/23 182/23 183/3 183/4 useful [1] 17/17 user [1] 90/5 using [3] 12/11 19/25 102/20	versus [1] 70/10
98/24 100/10 100/18 101/23 102/17 107/25 116/4 119/7 121/7 143/5 146/8 149/13 150/8 161/20 171/21 189/20				133/5 136/10 updates [9] 10/12 11/12 111/13 115/23 115/24 115/25 116/22 133/4 133/8 upon [4] 95/22 98/10 98/25 100/20 uptaker [1] 114/21 uptook [1] 115/12 urgent [1] 53/11 urinary [1] 167/11 us [54] 1/11 4/2 4/24 7/3 10/7 11/10 11/22 13/17 21/21 27/7 29/5 48/5 61/22 64/17 65/16 69/12 69/15 74/21	177/10 178/4 179/23 183/6 183/20 187/21 188/6 use [14] 13/20 13/23 13/25 14/1 18/18 85/24 86/18 95/10 104/6 104/9 123/16 123/24 133/12 133/12 useable [1] 145/11 used [15] 13/13 31/6 32/18 57/25 67/11 74/3 82/8 98/8 123/18 139/22 149/13 155/23 182/23 183/3 183/4 useful [1] 17/17 user [1] 90/5 using [3] 12/11 19/25 102/20	very [64] 2/9 3/8 6/25 16/6 17/8 20/7 21/8 21/19 29/25 30/18 38/13 38/21 40/13 49/11

V	36/15 38/14 38/23 102/17	167/23 168/6 176/9 187/12	12/21 13/1 16/17 21/8	42/16 56/5 57/13 59/8	145/23 146/13	46/6 47/12 48/13 48/20
very... [50]	virtually [1] 47/18	188/2 wanted [6]	40/4 43/6 53/9 74/1	61/24 63/6 73/25 74/17	149/20 151/5 152/1 162/24	50/9 50/18 50/19 50/20
50/21 55/10 55/11 56/20 59/15 60/18 67/2 69/11 72/16 77/6 78/21 78/21 78/24 86/19 89/16 94/8 101/4 101/18 109/12 111/19 111/20 114/21 114/21 127/2 127/13 127/22 128/19 135/4 138/24 139/5 139/21 139/23 143/18 143/19 145/3 145/12 149/12 156/7 156/8 159/2 160/19 160/25 165/9 168/8 169/19 171/20 183/6 187/4 190/1 190/3	visibility [1] 87/13 visual [3] 18/2 86/19 86/23 vital [1] 149/11 voice [1] 134/15 volunteer [1] 115/10 vomit [1] 183/12 vomiting [3] 167/10 184/1 184/1	188/2 19/19 22/6 81/14 110/5 115/11 188/12 wanting [1] 49/14 wants [2] 44/5 113/16 War [1] 6/14 warned [1] 100/8 warning [4] 87/23 88/16 88/16 113/11 was [526] was October 2018 [1] 25/10 wasn't [37] 19/5 19/21 25/9 27/13 40/1 45/17 45/20 46/20 46/22 46/24 47/20 50/13 51/22 52/2 52/3 53/13 53/14 58/21 60/11 71/22 85/21 88/21 89/11 89/13 89/14 105/5 121/15 123/20 131/24 133/6 135/9 145/1 149/11 150/14 153/23 184/20 188/20 watch [1] 113/17 watching [2] 81/23 124/3 watery [1] 165/22 way [20] 5/24	98/24 108/7 109/11 116/12 132/12 138/19 141/18 145/19 146/22 162/5 166/14 Wayne [5] 1/6 1/8 1/12 165/2 192/3 ways [2] 48/25 90/18 we [484] we start [1] 113/10 we're [31] 2/24 5/1 12/5 13/7 18/6 21/15 22/7 31/7 41/14 41/23 42/12 42/24 46/5 56/20 57/13 67/12 70/12 74/13 75/16 80/19 95/9 96/6 125/17 126/15 128/11 132/20 139/17 140/23 141/20 166/16 178/25 we've [2] 109/2 159/23 wearing [3] 140/13 156/19 180/12 website [1] 113/8 week [18] 10/18 10/19 16/25 25/15	87/4 106/16 109/13 109/14 weekend [1] 86/6 weight [1] 98/22 welfare [1] 188/10 well [76] 7/14 11/2 13/17 14/12 17/23 19/7 23/4 26/6 28/24 29/16 31/21 34/25 36/17 43/1 44/13 46/3 47/5 47/15 48/5 48/9 49/14 49/23 50/18 50/19 53/7 54/23 64/20 71/11 71/18 72/11 73/14 75/7 78/7 80/16 81/21 82/24 88/6 94/8 96/15 101/19 106/20 110/1 113/14 116/14 116/16 118/12 118/21 119/16 120/16 121/6 122/17 123/14 125/7 126/21 126/22 128/16 132/6 133/12 133/16 139/15 142/17	170/13 175/19 175/19 175/19 188/1 188/17 190/9 went [28] 8/11 9/13 23/6 23/20 24/12 51/12 58/5 71/5 100/9 123/22 123/24 137/5 145/6 150/25 159/10 159/21 172/14 174/8 174/9 174/11 174/13 178/9 180/23 181/2 181/7 181/7 181/11 181/20 were [190] 2/25 4/4 6/9 10/8 10/9 14/18 14/22 14/22 14/24 15/3 15/4 15/10 19/8 19/8 20/11 21/20 23/4 23/12 23/13 23/13 24/3 26/1 26/2 27/8 27/16 28/20 29/15 30/1 30/21 31/14 31/17 31/18 31/19 34/7 36/13 36/13 36/15 36/16 36/20 38/16 38/17 38/19 40/12 43/12 43/21 43/23 45/21	50/21 51/2 52/7 52/8 53/20 56/20 56/22 57/12 57/18 58/17 59/11 64/21 66/3 68/13 68/14 69/7 69/18 69/25 70/14 70/24 74/16 76/25 77/7 77/25 81/6 81/13 81/23 84/10 85/20 86/4 86/14 86/19 87/12 87/16 87/18 89/3 90/16 90/18 91/13 91/16 91/23 93/3 93/11 93/14 93/14 93/17 94/10 97/17 97/21 98/5 98/8 98/11 99/11 99/14 99/19 99/23 101/24 102/7 102/9 108/7 109/21 110/17 113/21 115/20 117/16 118/3 120/9 120/9 121/16 121/16 121/16 122/2 122/19 124/3 124/8 124/17 125/4 125/7 125/20 125/22 127/5 130/10 132/4 132/11 136/19 137/12 138/5
vessel [1] 58/8 VF [1] 180/22 via [4] 144/16 149/16 172/22 180/20 victim [1] 36/25 victims [1] 62/4 view [9] 38/10 95/4 98/5 101/22 101/22 102/4 102/5 108/16 182/6 views [4]	waiting [1] 21/15 Wales [1] 67/24 walked [1] 134/15 want [45] 4/22 5/4 14/15 14/19 16/10 18/18 27/6 29/22 36/1 36/8 41/11 41/22 41/24 45/10 46/3 46/14 47/15 49/6 52/14 63/4 66/23 85/17 89/17 91/9 94/11 94/16 94/19 101/9 101/20 107/10 109/4 110/3 113/19 118/13 118/15 126/20 133/18 161/1 164/23 166/25	25/10 was [526] was October 2018 [1] 25/10 wasn't [37] 19/5 19/21 25/9 27/13 40/1 45/17 45/20 46/20 46/22 46/24 47/20 50/13 51/22 52/2 52/3 53/13 53/14 58/21 60/11 71/22 85/21 88/21 89/11 89/13 89/14 105/5 121/15 123/20 131/24 133/6 135/9 145/1 149/11 150/14 153/23 184/20 188/20 watch [1] 113/17 watching [2] 81/23 124/3 watery [1] 165/22 way [20] 5/24	12/21 13/1 16/17 21/8 40/4 43/6 53/9 74/1 98/24 108/7 109/11 116/12 132/12 138/19 141/18 145/19 146/22 162/5 166/14 Wayne [5] 1/6 1/8 1/12 165/2 192/3 ways [2] 48/25 90/18 we [484] we start [1] 113/10 we're [31] 2/24 5/1 12/5 13/7 18/6 21/15 22/7 31/7 41/14 41/23 42/12 42/24 46/5 56/20 57/13 67/12 70/12 74/13 75/16 80/19 95/9 96/6 125/17 126/15 128/11 132/20 139/17 140/23 141/20 166/16 178/25 we've [2] 109/2 159/23 wearing [3] 140/13 156/19 180/12 website [1] 113/8 week [18] 10/18 10/19 16/25 25/15	42/16 56/5 57/13 59/8 61/24 63/6 73/25 74/17 76/25 79/5 87/4 106/16 109/13 109/14 weekend [1] 86/6 weight [1] 98/22 welfare [1] 188/10 well [76] 7/14 11/2 13/17 14/12 17/23 19/7 23/4 26/6 28/24 29/16 31/21 34/25 36/17 43/1 44/13 46/3 47/5 47/15 48/5 48/9 49/14 49/23 50/18 50/19 53/7 54/23 64/20 71/11 71/18 72/11 73/14 75/7 78/7 80/16 81/21 82/24 88/6 94/8 96/15 101/19 106/20 110/1 113/14 116/14 116/16 118/12 118/21 119/16 120/16 121/6 122/17 123/14 125/7 126/21 126/22 128/16 132/6 133/12 133/16 139/15 142/17	145/23 146/13 149/20 151/5 152/1 162/24 164/11 164/13 170/13 175/19 175/19 175/19 188/1 188/17 190/9 went [28] 8/11 9/13 23/6 23/20 24/12 51/12 58/5 71/5 100/9 123/22 123/24 137/5 145/6 150/25 159/10 159/21 172/14 174/8 174/9 174/11 174/13 178/9 180/23 181/2 181/7 181/7 181/11 181/20 were [190] 2/25 4/4 6/9 10/8 10/9 14/18 14/22 14/22 14/24 15/3 15/4 15/10 19/8 19/8 20/11 21/20 23/4 23/12 23/13 23/13 24/3 26/1 26/2 27/8 27/16 28/20 29/15 30/1 30/21 31/14 31/17 31/18 31/19 34/7 36/13 36/13 36/15 36/16 36/20 38/16 38/17 38/19 40/12 43/12 43/21 43/23 45/21	46/6 47/12 48/13 48/20 50/9 50/18 50/19 50/20 50/21 51/2 52/7 52/8 53/20 56/20 56/22 57/12 57/18 58/17 59/11 64/21 66/3 68/13 68/14 69/7 69/18 69/25 70/14 70/24 74/16 76/25 77/7 77/25 81/6 81/13 81/23 84/10 85/20 86/4 86/14 86/19 87/12 87/16 87/18 89/3 90/16 90/18 91/13 91/16 91/23 93/3 93/11 93/14 93/14 93/17 94/10 97/17 97/21 98/5 98/8 98/11 99/11 99/14 99/19 99/23 101/24 102/7 102/9 108/7 109/21 110/17 113/21 115/20 117/16 118/3 120/9 120/9 121/16 121/16 121/16 122/2 122/19 124/3 124/8 124/17 125/4 125/7 125/20 125/22 127/5 130/10 132/4 132/11 136/19 137/12 138/5

W	155/23 173/1	173/16	105/1 106/8	79/11 79/18	61/25	whoever [3]
were... [48]	177/5 178/11	173/17 174/8	116/3 122/1	80/7 81/22	white [2]	34/2 85/9
141/8 141/17	188/8	174/17 175/8	123/22 153/9	82/6 82/7	157/11	164/11
143/2 143/19	what3words	175/11 176/3	153/19	83/3 83/15	157/14	whole [6] 6/2
144/19	[1] 133/11	177/14	153/20 155/1	84/15 84/17	Whitelaw [18]	43/16 104/9
145/21 147/3	whatever [3]	177/19	155/2 172/11	84/17 84/19	57/19 57/24	113/7 132/22
147/6 148/8	116/19	181/10	176/4 183/21	85/6 86/3	58/11 61/3	157/17
148/9 149/7	129/22	182/10	184/6 184/25	86/9 86/9	61/23 63/6	Whose [1]
149/20	150/14	183/15	which [162]	86/22 87/3	66/20 73/25	106/2
153/13 154/1	wheezing [1]	185/13	1/20 2/24	92/24 94/20	74/16 90/2	why [20] 8/11
155/8 157/5	167/3	185/13	3/21 5/1 6/18	95/9 95/22	91/14 93/7	8/13 30/11
157/21 158/5	when [82]	185/20 186/2	7/24 8/9 8/24	97/1 97/11	112/9 112/11	47/9 51/25
159/11	4/16 10/8	187/16	9/1 9/10 9/11	97/23 98/18	112/17	61/6 73/4
163/16 164/6	13/11 13/20	188/15	9/19 11/14	99/25 104/17	124/22 128/8	100/13
165/5 167/16	19/25 22/14	188/17	12/22 13/1	109/17	192/11	104/14
168/19 169/3	22/17 25/25	where [36]	14/9 14/24	114/20 116/6	who [60] 4/17	108/11
170/17	43/1 51/6	7/20 12/6	15/12 15/13	116/9 116/20	7/15 8/11 9/6	138/25 139/4
170/24	57/12 63/5	21/12 30/5	17/13 18/11	117/8 120/17	10/1 10/3	145/20 147/6
171/16	68/14 73/2	39/8 52/22	19/1 19/23	123/7 124/2	14/18 15/24	147/18 176/8
171/21 172/2	73/11 74/16	66/19 70/23	20/4 20/10	126/16 127/3	22/17 24/8	182/5 182/21
172/12	88/6 88/15	75/2 76/12	20/17 21/22	131/16 135/4	26/20 26/20	186/5 189/24
174/25 175/3	89/6 96/16	77/2 78/23	22/3 22/21	136/12 138/7	27/4 31/24	wide [1] 49/3
175/6 176/3	107/21	82/24 87/22	23/19 23/20	139/21 140/6	36/7 36/19	widely [1]
177/1 177/19	107/24	88/2 105/17	24/10 25/6	142/21	36/25 38/6	85/21
177/22 179/7	114/16	111/17	28/10 31/15	142/22	38/9 38/12	wider [6]
180/17	115/20 119/6	111/22 116/9	33/1 33/10	144/18	38/19 50/25	42/15 45/23
180/19 182/6	121/14	117/23 119/8	35/18 36/2	144/18	56/20 61/18	62/16 66/15
182/11	121/20 122/4	120/14 121/8	37/3 37/10	146/19	61/19 63/22	86/25 86/25
183/17 184/8	122/22	126/14	39/8 39/11	149/11	65/7 65/13	will [103]
185/3 185/14	123/16	126/23 127/3	39/13 40/10	150/22 152/3	66/13 74/11	2/17 3/24
186/20	123/22	128/10	40/15 40/19	152/19	85/10 87/16	4/14 4/19
weren't [9]	123/24	129/13 132/4	40/20 41/24	152/22	90/16 92/21	4/21 5/7 5/12
46/9 56/21	126/17	133/1 139/2	42/16 42/19	153/11	94/10 98/2	5/15 6/1 6/5
74/10 91/25	130/12	175/18	42/24 43/3	154/21 158/7	98/4 98/20	7/18 8/11
145/4 145/11	132/10	183/25	43/10 44/11	158/17	99/11 99/17	8/13 8/17
156/25 168/1	132/19 133/3	188/18	45/8 46/7	160/16	111/12	12/12 12/21
169/2	133/13	189/18 190/5	46/19 47/9	160/17	117/16	14/17 14/20
Western [7]	133/19 134/3	whereby [2]	47/10 48/9	165/21	122/19 133/1	15/24 16/2
2/20 113/22	135/8 139/10	77/11 98/24	48/25 50/8	165/22	134/19	20/13 21/7
114/4 115/20	140/9 140/10	wherever [1]	53/10 53/25	166/12	134/23	21/21 24/18
123/6 124/7	140/19 142/7	65/1	56/17 57/4	166/15	136/20	24/19 24/22
163/17	143/8 144/11	whether [36]	58/17 58/24	166/21 168/4	138/23	25/21 27/20
what [274]	144/22 145/6	6/3 9/18 11/5	59/6 59/17	168/10	147/15	28/23 29/12
what's [17]	145/9 151/18	28/25 29/2	59/18 59/19	169/10	152/21	29/13 36/6
48/12 61/8	152/5 153/13	37/24 42/19	62/15 63/13	169/24	152/23	36/7 36/9
61/17 69/19	153/17 157/4	43/3 44/15	63/21 64/15	176/13	153/17 156/1	36/19 37/18
78/1 80/6	157/18	47/1 47/2	65/11 66/14	177/11 178/3	164/7 171/24	37/20 37/24
88/8 96/5	158/22	52/15 54/8	67/20 69/14	while [6] 13/7	178/16	38/7 38/18
97/14 102/22	163/15	58/7 58/11	69/19 70/21	36/12 136/19	183/22	39/21 40/15
106/16	168/19 169/2	70/24 72/19	72/7 72/16	137/1 180/21	187/19	40/19 40/20
134/25	170/16	73/7 73/17	72/23 74/18	182/6	189/12	40/21 40/23
	173/15	99/12 101/20	76/15 77/15	Whilst [1]	189/13	49/23 55/22

W	wish [4] 55/8 66/20 97/2 190/4	woman [1] 40/2	174/2	70/16 114/7 114/11	40/1 40/16 46/7 47/1	152/7 157/21 158/16
will... [55] 56/8 56/13 56/19 57/21 60/17 63/12 66/18 69/20 73/14 73/20 73/24 74/6 75/16 75/24 76/6 76/16 78/1 79/24 80/25 81/25 86/9 90/1 90/17 91/13 91/19 94/9 97/9 97/11 99/10 106/3 107/10 109/9 110/1 110/2 113/7 113/18 113/19 116/10 116/24 120/19 124/6 124/16 126/19 128/2 136/22 152/15 159/3 162/24 167/8 170/19 184/23 187/5 188/6 188/22 190/9	within [38] 6/23 7/14 9/1 9/2 9/21 19/4 19/8 19/9 24/12 26/1 28/3 28/7 30/4 31/18 33/11 36/22 41/1 44/12 61/16 66/4 69/8 70/17 76/3 79/25 85/20 86/22 95/8 107/10 109/13 109/14 114/18 115/12 123/4 123/5 130/12 132/17 134/21 145/10	won't [7] 18/17 55/3 56/22 103/17 110/2 140/23 146/9	worst [10] 32/6 32/23 32/25 34/4 35/1 77/24 81/1 82/1 82/3 85/7	183/21	47/2 47/6 48/6 48/13 49/8 50/17 53/24 54/10 55/15 58/15 61/23 64/6 64/8 64/25 65/23 73/25 74/17 76/23 78/3 79/20 81/4 83/9 83/19 84/4 84/11 88/13 89/21 89/23 90/1 91/12 94/17 96/16 98/5 99/22 107/1 112/18 113/4 113/6 113/25 114/3 114/25 115/1 115/22 116/25 118/5 118/13 118/17 119/24 121/23 122/5 123/3 125/2 125/18 126/8 127/6 127/24 128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	161/16 161/18 162/11 162/13 163/13 163/14 164/2 164/23 166/21 168/18 170/20 171/4 171/14 173/9 174/25 177/17 180/10 181/5 182/19 182/20 183/7 183/10 184/20 185/7 187/1 187/17 190/3
wilts [1] 132/12	without [5] 6/2 63/14 95/3 129/18 131/16	work [15] 5/7 9/17 9/21 31/23 64/4 70/21 73/6 76/22 77/5 77/7 86/7 87/3 107/19 114/14 125/23	worth [1] 70/16	128/8 130/12 133/14 133/15 137/24 159/19 175/17 175/18 177/14 177/17 183/15 188/11	118/13 118/17 119/24 121/23 122/5 123/3 125/2 125/18 126/8 127/6 127/24 128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
Wiltshire [25] 56/5 56/10 57/1 58/9 58/12 63/7 66/4 66/12 66/24 67/14 68/24 71/20 72/21 80/2 83/11 84/22 88/4 89/19 91/10 91/22 98/12 99/22 104/8 105/24 154/24	witness [33] 1/5 1/13 5/13 16/15 22/19 24/1 29/12 52/15 53/17 54/5 55/22 61/7 65/23 68/24 69/25 90/9 91/13 91/19 101/13 112/22 113/1 115/1 115/22 116/25 129/17 129/24 131/12 131/25 132/24 134/5 161/8 161/20 190/7	workforce [1] 19/10	worthwhile [1] 67/6	177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
Wilton [1] 132/12	witnesses [2] 37/17 56/20	working [20] 3/16 27/21 36/17 42/22 68/12 69/10 69/11 78/19 81/8 100/12 111/7 114/8 115/20 125/20 133/14 145/24 146/21 150/14 163/16 183/20	would [236] 24/23 47/19 47/22 88/10 138/20 157/13	177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
Wiltshire [25] 56/5 56/10 57/1 58/9 58/12 63/7 66/4 66/12 66/24 67/14 68/24 71/20 72/21 80/2 83/11 84/22 88/4 89/19 91/10 91/22 98/12 99/22 104/8 105/24 154/24	witnessing [1] 6/2	works [1] 43/1	wouldn't [6] 24/23 47/19 47/22 88/10 138/20 157/13	177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
window [2] 147/25 148/7		world [2] 6/13 84/19	wrote [2] 8/21 34/2	177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
		worry [3] 23/11 23/14	years [14] 3/9 3/12 3/14 4/3 4/4 6/9 10/8 42/12 79/9 114/5 115/3 164/19 164/20 170/5	177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
			years' [4]	177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14 177/17 183/15 188/11	128/21 129/5 129/17 129/24 130/22 131/4 131/12 131/25 132/1 132/10 132/11 132/15 132/24 133/20 134/5 135/6 136/16 137/14 137/25 140/19 140/24 141/19 148/22 148/25 149/8 149/23 151/8	yourself [8] 34/13 52/18 77/5 107/2 107/14 118/16 118/22 174/4
				177/14		