

1 Q. So would it be fair to assume that, in terms of any
2 medical advice within this document, either you're the
3 source of it or effectively you've agreed with it?
4 A. Yes.
5 Q. Now that's July 1999. What's your recollection of how
6 it came about that the minister decided to commission an
7 internal investigation?
8 A. Well, it's a long time ago, but my recollection is that,
9 as the submission indicates, post-devolution there was
10 intense lobbying of MSPs through the Parliamentary
11 process, particularly by The Haemophilia Society, and
12 that the new minister, obviously it was in receipt of
13 all that lobbying, and that, I suspect -- I mean, you
14 are interviewing her, I believe, later this week?
15 Q. Yes.
16 A. She's better placed to answer than I. But my impression
17 was that post-devolution, increased lobbying, and she
18 was persuaded that we needed to drill down further into
19 the allegations of The Haemophilia Society that Scottish
20 blood products, principally Factor VIII, were less safe
21 than those coming from England at the time, and she was
22 very keen to get to the bottom of that.
23 Q. And the ambit of the investigation essentially became
24 the question over Scotland lagging behind England in
25 terms of producing hepatitis-safe heat-treated

5

1 Mrs Towers, Mrs Falconer and Mr Palmer. There is also
2 someone attending from the Central Legal Office and then
3 three from SNBTS.

4 Then if we look at the first paragraph we can see
5 it references to the minister being due to meet The
6 Haemophilia Society on 14 September:

7 "... to hear their concerns about the infection of
8 haemophiliacs with HCV through treatment with SNBTS
9 products ... explained that the Minister had requested
10 a report analysing what had happened at that time with
11 an assessment of whether SNBTS' position could be said
12 to have been negligent. After the investigation the
13 Minister would brief the Parliament's Health Committee
14 on its findings."

15 Now, bearing in mind that the focus of the
16 investigation is to determine whether SNBTS had been
17 negligent, is there any particular reason why the
18 investigation process seems to have commenced with
19 a meeting with representatives of SNBTS before even the
20 minister has met with The Haemophilia Society?

21 A. Well, the meeting was clearly to prepare for that
22 ministerial meeting and make sure that the minister was
23 briefed as accurately as possible in advance of
24 14 September. So I don't find it surprising in any way
25 that we would want to meet with SNBTS to discuss the

7

1 concentrate in a period between 1985 and 1987; is that
2 broadly correct?

3 A. Indeed.

4 Q. And is it right to understand that ambit is a reflection
5 of the particular focus of The Haemophilia Society's
6 lobbying, is that right?

7 A. That's correct.

8 Q. And the investigation was not widened to look, for
9 example, at the position of those should be infected
10 through blood transfusion?

11 A. No, The Haemophilia Society were very focused on the
12 haemophiliac community, understandably, and the remit of
13 the internal inquiry was framed absolutely around what
14 they wanted to be looked at, and was agreed by them.

15 Q. And was there any lobby group or other group
16 representing the interests or position of those who had
17 been infected through transfusion at that point in time
18 in Scotland?

19 A. I can't recall.

20 Q. If we pick matters up in August 1999, just to establish
21 some of the chronology.

22 It's SBTS0000379_040, please, Lawrence.

23 So this is a meeting held on 30 August 1999 to
24 discuss the investigation. We can see that from the
25 Scottish Executive there are four in attendance: you,

6

1 lines of the Inquiry and get preliminary feedback from
2 them on the issues that might arise.

3 Q. It was presumably never going to be very likely that
4 SNBTS would put their hands up and say, "Yes, we were
5 negligent" or "Yes, we were at fault". To what extent
6 in the course of the investigation was the submissions
7 made by, material provided by SNBTS subjected to any
8 kind of rigorous scrutiny?

9 A. My recollection is that what was sought from SNBTS was
10 a factual, chronological account of the measures that we
11 had taken in the mid-1980s to ensure that hepatitis C
12 Factor VIII (*sic*) was available.

13 Q. If we turn then -- so that was 30 August. If we turn to
14 a meeting on 1 September.

15 That's PRSE0000978.

16 So this is the second meeting that we see being
17 held, and this is with Professor Ludlam and
18 Professor Lowe, and again you're in attendance,
19 Mrs Falconer and Mr Palmer, also from the Scottish
20 Executive.

21 The purpose of the meeting in the first paragraph
22 is explained by you as being to clarify the validated
23 information that would be needed from each of the
24 Haemophilia Centres for the planned ministerial briefing
25 on 9 September.

8

1 Now, bearing in mind this was looking at -- or
 2 this was an investigation which was to look at SNBTS's
 3 actions, why had it seemed particularly important to
 4 speak to Professor Ludlam and Professor Lowe at the
 5 outset, of the investigation?
 6 **A.** Well, they, each of them, headed up the two biggest
 7 Haemophilia Centres in Scotland, so therefore they were
 8 the two main prescribers of Factor VIII, so clearly
 9 their recollection of events in the mid-1980s was
 10 material to the internal investigation.
 11 **Q.** Can you assist us in understanding why the focus of the
 12 investigation was negligence, which would ordinarily be
 13 a matter determined by the courts, rather than perhaps
 14 a broader question of whether there was fault or things
 15 that could or should have been done differently or
 16 better?
 17 **A.** As I said earlier, the remit was that requested by
 18 The Haemophilia Society. I imagine that that word --
 19 the use of that word emanated from them.
 20 **Q.** If we go towards the bottom of the page, please,
 21 paragraph 4, this records a further contribution from
 22 you:
 23 "Dr Keel pointed out that it would be necessary to
 24 fully investigate the circumstances and events during
 25 that time and to cost, based on a range of scenarios,

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1 least one plant coming up with a breakthrough. PFC did
 2 so for HIV and BPL then did so (in retrospect
 3 unwittingly) for HCV."
 4 Was it your understanding, therefore, that the
 5 different heat treatment strategies adopted by BPL and
 6 PFC were in some way coordinated so as to be
 7 complementary?
 8 **A.** I think there was a degree of complementarity. Whether
 9 it was serendipitous or -- there definitely was a degree
 10 of complementarity, whether that was deliberate or
 11 serendipitous evades me at this time. It's so long ago.
 12 **Q.** We can see, if we then pick it up at paragraph 6, this:
 13 "Professor Lowe and Professor Ludlam confirmed
 14 that it was normal practice within their centres to
 15 inform patients of the result of a test if they were
 16 found to be HCV positive. Dr Keel would confirm that
 17 this was the procedure within the other Haemophilia
 18 Centres. In particular, she was concerned about the
 19 case of a Dundee patient highlighted in the press
 20 coverage, who had claimed not to have been informed of
 21 his infection for a year after he was tested."
 22 Now, why was it that this issue about informing
 23 patients or the failure to inform patients of test
 24 results, why was this issue being ventilated in the
 25 meeting, given that the ambit of the investigation was

11

1 the different types of assistance which might be
 2 awarded."
 3 Just pausing there, does that reflect the fact
 4 that one of the underlying purposes of the investigation
 5 was to inform a decision about whether or not to provide
 6 financial support?
 7 **A.** Not directly. The purpose of the investigation was to
 8 understand, as I said earlier, the facts and the
 9 chronology of events during the period in question. But
 10 it would have been remiss of any Government department
 11 not to be anticipating that The Haemophilia Society,
 12 which was already lobbying hard for financial redress,
 13 would increase those efforts during and after the
 14 production of the report.
 15 **Q.** Then continuing on with paragraph 4:
 16 "It was therefore essential to estimate how many
 17 people would be eligible. Any follow-up action taken by
 18 the Department would be in consultation with the other
 19 territorial departments on a UK-wide basis."
 20 Then this:
 21 "She advised that the chronologies of events
 22 provided by BPL and SNBTS were revealing. PFC and BPL
 23 had deliberately chosen to pursue different paths in the
 24 development of heat treatment methods, in order to cover
 25 more than one option and increase the likelihood of at

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1 focusing upon the '85-'87 period and SNBTS?
 2 **A.** The remit of the investigation also covered, at
 3 The Haemophilia Society's request, the information
 4 provided to patients. So that's why this discussion was
 5 material.
 6 **Q.** Was what Professor Lowe and Professor Ludlam there said,
 7 and the use of the word "confirmed", was that simply
 8 accepted as face value, "That's what they've told us so
 9 that must be correct"?
 10 **A.** Well, I am struggling to know what other investigation
 11 we could have undertaken to confirm that what they said
 12 was correct. So yes. It was taken at face value. But
 13 I also knew from my own clinical practice in Glasgow,
 14 which we touched on yesterday, doing clinics with
 15 Professor Lowe and others, that that was the practice in
 16 Glasgow. I had no reason to believe that it was
 17 different in Edinburgh.
 18 **Q.** In relation to Glasgow, you were there between 1983 and
 19 1986 and, of course, hepatitis C was not known at that
 20 point in time, and there was no test available. So you
 21 couldn't, I think, have been familiar with
 22 Professor Lowe's practices in relation to hepatitis C,
 23 could you?
 24 **A.** Only insofar as liver enzymes were taken at every visit
 25 and discussed at the following visit. So the

12

1 non-A, non-B context was discussed in those clinics.
 2 **Q.** You have, I think, said in response to my question about
 3 whether this information was essentially taken at face
 4 value -- and I'm paraphrasing your answer,
 5 Professor Keel -- what else could be done? The
 6 Executive could have asked The Haemophilia Society to
 7 provide details of patients who claimed otherwise, could
 8 it not? It could have asked to see patient records?
 9 **A.** Well, it -- The Haemophilia Society and many patients'
 10 views were taken into account. Patients wrote in to the
 11 Department in the process of the Inquiry, and aired
 12 their views. So they were given that opportunity. I'm
 13 not sure that going through patients' notes -- well, it
 14 would have been a very lengthy and laborious process,
 15 particularly going back so far, over 15 years by this
 16 point, to try to -- I don't think looking at the notes
 17 would have been a very fruitful exercise in trying to
 18 determine what the practice was around informing
 19 patients of their results.
 20 **Q.** It might be said, professor, that if you have
 21 an investigation, one aspect of which is to look at what
 22 patients were told, but if all you're going to do is
 23 accept a doctor's assurance that they did tell patients,
 24 that's not much of an investigation. If that submission
 25 were to be made, what would be your comment?

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1 formulation from the previous one. Previously, there
 2 was no reference to the state of knowledge at the time,
 3 but the words were, "which was essential for their
 4 survival".
 5 **MS RICHARDS:** Yes, this picks up more the wording of the
 6 briefing we looked at yesterday afternoon.
 7 **SIR BRIAN LANGSTAFF:** Yes, which was, as is set out here.
 8 **MS RICHARDS:** Yes. Then paragraph 6 says:
 9 "Agreeing no-fault compensation for haemophiliacs
 10 with HCV would have major policy implications in that it
 11 would promote the elastic concept of 'a moral liability'
 12 on government to compensate individuals who have been
 13 damaged, however inadvertently, by its actions ..."
 14 Now, this is Mr Palmer's briefing, professor, not
 15 yours, but do you recall what your thoughts were at the
 16 time about the concept of a moral liability or moral
 17 responsibility?
 18 **A.** Well, at the time, my view was that there had been
 19 no fault attributed to SNBTS or the NHS and that that
 20 was the justification there had been for many, many
 21 years of the Government's position, with the exception
 22 of the precedent we discussed yesterday for HIV.
 23 So my view was -- I mean, Mike Palmer's language
 24 is slightly difficult to interpret, but I suppose what
 25 he's trying to say is that, where patients had been

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1 **A.** Well, it wasn't -- that element of the investigation
 2 wasn't limited to what clinicians had told patients; it
 3 was also related to information provided in the form of
 4 leaflets, et cetera, and I think we laid hands on
 5 a number of those publications in the course of the
 6 Inquiry. So it was more of a holistic approach to
 7 information provided rather than just practices around
 8 informing patients of results.
 9 **Q.** If we pick matters up next in September, about a week or
 10 so later, at SCGV0000043_047. So this is a briefing
 11 provided by Mr Palmer, who we saw in attendance at those
 12 two meetings, to the Minister, 8 September 1999, copied
 13 to you, amongst obviously a number of others. The
 14 purpose is described in paragraph 1 as:
 15 "To provide initial briefing to the Minister prior
 16 to her meeting with the Haemophilia Society on
 17 14 September ..."
 18 If we go over the page, we can see paragraph 5
 19 sets out what the Government's position has been,
 20 essentially if there's no fault there should be no
 21 compensation and the assertion is made there again that
 22 patients received the best treatment available given the
 23 state of knowledge at the time.
 24 Then paragraph 6 says this --
 25 **SIR BRIAN LANGSTAFF:** That's a slightly different

14

1 damaged but no negligence has been proved on the part of
 2 the NHS, then for the Government to embark on
 3 an open-ended no-fault compensation scheme would be
 4 a very major change in policy with major implications
 5 further down the route on the amount of money to be
 6 spent and, therefore, by definition, the amount of money
 7 then available for direct patient care.
 8 I think that's probably what he's trying to get
 9 at. Of course, it's his words, as you said, not mine.
 10 **Q.** Then under the heading "Recent developments" paragraph 7
 11 sets out the background in terms of the Society's
 12 campaigning, and then says:
 13 "Their key concerns seemed to be that ..."
 14 And then there were a number, or three
 15 subparagraphs. (a) is concerned with the issue that
 16 we've already touched on, the difference between
 17 Scotland and England in terms of an HCV-safe product.
 18 Then (b) and (c), (b) is:
 19 "assurances were given at the time that the SNBTS
 20 product was safe from infection, when in fact it was
 21 known that it was not safe from hepatitis C;
 22 "(c) some patients who were tested HCV-positive in
 23 the early 1990s ... were not told that they were
 24 infected until long after the test results were known,
 25 during which time they ran a higher risk of infecting

16

1 close family members because their ignorance."
 2 So I just draw attention to that so we can make
 3 sense of what we see a couple of pages further on. So
 4 that's paragraph 7(b) and (c) of the briefing.
 5 If we go to the next page, the bottom of the page
 6 has the heading "Current investigations", and
 7 paragraph 14 refers to the Department being:
 8 "... engaged in an investigation of events and
 9 circumstances surrounding the introduction of
 10 heat-treated Factor VIII blood products in the
 11 mid-1980s."
 12 Then paragraph 15 refers to paragraph 7(a), so
 13 that's the issue about the heat-treated product, and
 14 says:
 15 "... we have prepared an initial overview of the
 16 events in the mid-1980s, arising from our enquiries so
 17 far."
 18 If we go over the page, paragraphs 16 and 17 deal
 19 with the charge at paragraph 7(b), so that's the
 20 question of the extent to which information about
 21 infectivity of the product was provided to patients.
 22 Paragraph 18 refers to the charge at
 23 paragraph 7(c), and it's said to be a claim currently
 24 investigating, and that's the issue of people not being
 25 told of their positive test results.

17

1 go back to page 4, please, and paragraph 20 of the
 2 briefing. Again, I'm conscious this is not a document
 3 authored by you, Professor Keel, but the suggestion
 4 there, wanting to "probe the basis" for
 5 The Haemophilia Society's statement in relation to the
 6 second indent, which is about little or no information
 7 being provided to patients about HCV, it might be said
 8 that the Scottish Executive Health Department was taking
 9 an approach towards The Haemophilia Society's
 10 assertions, wanting to probe the basis for them, that it
 11 wasn't taking towards the Haemophilia Centre Directors,
 12 accepting at face value what they told the Health
 13 Department.
 14 Do you have any comment on that?
 15 **A.** I think what we were looking for from The Haemophilia
 16 Society was as much intelligence to inform the Inquiry
 17 that ultimately took place as possible. I think it was
 18 a genuine desire to know what lay behind their
 19 allegations rather than subjecting them to a grilling
 20 that we weren't subjecting the Haemophilia Directors to.
 21 **Q.** And then Annex B of the briefing, which Mr Palmer had
 22 described as an overview -- an "initial overview arising
 23 from our enquiries so far", that starts on page 7.
 24 And if we go over the page to page 8, we've got
 25 the heading "Protection from Hepatitis" towards the top

19

1 Then if we go to the heading "Draft agenda for the
 2 meeting on 14 September", reference is made to an
 3 attached draft agenda at Annex C.
 4 Then paragraph 20 says this:
 5 "With regard to Section 3 of the agenda we will
 6 wish to probe the basis for the statements made at the
 7 second and third indents of that section."
 8 Now, to understand that, I want to look at the
 9 draft agenda with you. So if we could go, please, to
 10 page 11. This is the draft agenda, and if we look at
 11 paragraph 3, which is the paragraph being referred to in
 12 Mr Palmer's briefing:
 13 "Why were Scottish people with haemophilia exposed
 14 to the risk of HCV for longer than those treated with
 15 English product?"
 16 The second and third indents are:
 17 "Little or no information provided to patients at
 18 the time about HCV risks although evidence of
 19 non-A, non-B hepatitis transmitted through blood
 20 products was being accumulated through the 70s and early
 21 80s."
 22 And:
 23 "By 1985 risks of HIV were very well documented
 24 and research well advanced into heat treatment."
 25 So those are the second and third indents. If we

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1 of the page, and then paragraph 8 says this:
 2 "Our consultations suggest that from the late
 3 1970s (when NANBH first surfaced) to the mid-1980s,
 4 there was very little evidence that NANBH produced
 5 adverse symptoms, and that it was generally regarded as
 6 mild and non-progressive. For example, as late as
 7 February 1987 Dr Forrester (Medical Adviser at the
 8 Scottish Office) reported that: 'Non-A, non-B Hepatitis
 9 would appear to be relatively benign, despite some risk
 10 of cirrhosis of the liver in the long term, unless the
 11 recipient is pregnant when the effects can be very
 12 serious'. "
 13 Now, again, I appreciate that this is some time
 14 ago, but are you able to assist in understanding what's
 15 referred to as "our consultations" there? In other
 16 words, what was the evidence-gathering exercise that led
 17 to the conclusions that are being recorded in
 18 paragraph 8? Do you know?
 19 **A.** No, I don't, but I infer from the mention of
 20 Dr Forrester that at least part of that consultation was
 21 looking through the files to see -- to gather references
 22 to non-A, non-B hepatitis which had been collected by
 23 Government. But I don't know what else it means, in
 24 terms of consulting.
 25 **Q.** Was there any form of review of the medical literature

20

1 from the '70s and '80s undertaken?
 2 A. That was part of the internal report, yes.
 3 Q. Who would have undertaken that review of the medical
 4 literature? Was that you or was that somebody else?
 5 A. Christine Dora was the administrator in the lead
 6 drafting the report, so it was principally down to her.
 7 But I would -- I can't remember but probably have drawn
 8 attention, her attention, to key articles that had
 9 appeared in the medical press around about this time.
 10 Q. Do you know whether any consideration was given, whether
 11 by Ms Dora or you or by other colleagues within the
 12 Health Department, to making any contact with the civil
 13 servants in the Scottish Office who'd been dealing with
 14 this issue in the course of the 1980s?
 15 A. I've no recollection of that happening.
 16 Q. If we go just then to page 10, paragraph 18 is headed
 17 "Initial conclusions", and says:
 18 "Our initial impressions from this outline of
 19 events, which has been gathered from our preliminary
 20 investigations, are:
 21 "that SNBTS did all they could at the time to
 22 develop a Factor VIII product which was safe from HCV,
 23 given the state of knowledge at the time and the key
 24 objective of combatting HIV."
 25 Then, secondly:

21

1 "In line with our discussions with the Minister
 2 yesterday, we recommend that she closes the meeting on
 3 14 September by outlining the following way forward:
 4 "a) The Department have commenced investigations
 5 into Scotland's efforts to make blood products HCV-safe
 6 in the mid-1980s, and the concerns articulated by the
 7 Society today will be followed up in carrying those
 8 investigations forward. I want to emphasise that the
 9 Department is at the arm's length from SNBTS and is
 10 engaged in an impartial and objective analysis of the
 11 events and circumstances surrounding this issue."
 12 Do you consider it's right to say that the
 13 Department is at arm's length from SNBTS? Obviously,
 14 they are different bodies but we've seen that there was
 15 a close -- perfectly understandably -- working
 16 relationship between the Department and SNBTS, and there
 17 had been regular meetings over the years with SNBTS
 18 representatives, again for perfectly proper reasons.
 19 Was the Department really in a position to engage
 20 in an impartial and objective analysis of SNBTS's
 21 actions?
 22 A. I believe that it was. We had no direct involvement in
 23 directing SNBTS's operations, so I think that the
 24 Department was in a perfectly reasonable position to
 25 conduct this investigation of events that had happened

23

1 "there is no evidence that SNBTS lagged without
 2 good reason behind England ..."

3 Now, those are described as initial impressions
 4 and initial conclusions and preliminary investigations,
 5 but they're expressed in fairly strong and decided terms
 6 at a point in time in which The Haemophilia Society
 7 meeting hasn't even taken place yet. It may be
 8 submitted to the Inquiry in due course that this was
 9 an investigation undertaken essentially with a closed
 10 mind or pre-determined position. Do you have any
 11 observations in relation to that submission if it were
 12 made?

13 A. I disagree. I think it's absolutely consistent with
 14 providing ministers with all the facts that were known
 15 at the time and, indeed, the preliminary conclusions
 16 that were being drawn from those facts in preparation
 17 for a meeting with The Haemophilia Society.

18 Q. If we turn to SCGV0000170_164, this is a further
 19 briefing from Mr Palmer, 10 September 1999, to the
 20 Minister, the purpose is said:

21 "To outline a way forward which the Minister can
 22 offer the Haemophilia Society at her meeting with them
 23 on 14 September."

24 Then if we just go down the page, the
 25 "Recommendation" is:

22

1 many years before, based on evidence gathering from
 2 SNBTS but also from Haemophilia Directors, as well as
 3 The Haemophilia Society.

4 Q. If we turn to the next page, we can see in paragraph (b)
 5 the link being made with the possibility of
 6 compensation. Then on paragraph (c) says this:

7 "The Department aims to report on its
 8 investigations within a month ..."

9 Now, as it happened, it took over a year, it's
 10 late October 2000, I think, when the report was
 11 published. What's your understanding of why it took
 12 that length of time?

13 A. Well, my recollection of this is hazy, but at least part
 14 of it, I think, relates to the fact that I was trying
 15 to, from the UKHCDO registry, get accurate figures on
 16 how many Scottish patients had been treated with what
 17 might be described as at-risk products, during the
 18 period in question and that proved a very difficult
 19 task, and I can't remember now whether we ever finally
 20 got that data that we were seeking. That, at least, was
 21 part of the reason that the report took a year rather
 22 than month.

23 Q. I haven't gone to it but I will give a reference for the
 24 transcript. It's right to note that you wrote to
 25 Dr Colvin, chair of UKHCDO, I don't think the date of

24

1 the letter is clear, but it's LOTH0000011_007, and then
 2 we will I think see some further documents in early 2000
 3 which report that you've not had a response or that
 4 you're chasing for a response.
 5 Can we then just go to SCGV0000170_232. Can we
 6 just go to the bottom of the page, please.
 7 I'm sorry, can we take that down. There's
 8 something which hasn't been redacted, which I think
 9 possibly ought to have been redacted.
 10 I'll come back to that document at a later stage
 11 if we need to. That is the note of the meeting. Yes,
 12 we do have another version of that document but not at
 13 present. My apologies Professor Keel.
 14 In any event, there was a meeting on 14 September
 15 with representatives of The Haemophilia Society. The
 16 document that we looked at a few minutes ago that was
 17 appended to Mr Palmer's briefing that Annex B which set
 18 out the initial investigations and initial impressions,
 19 do you know whether that document was provided to
 20 The Haemophilia Society in the course of the
 21 investigation, so that they could see the Department's
 22 thinking and comment on and respond to it?
 23 **A.** I don't remember but I think it's highly unlikely it
 24 would have been provided to them. It was internal
 25 briefing for ministers, so I think we can conclude it

25

1 the annex to the briefing, Annex B, which set out what
 2 it was the Department had obtained by way of information
 3 and evidence so far.
 4 **A.** Well, I don't know whether it was shared but, as I said
 5 earlier, I think it's highly unlikely.
 6 **Q.** Can we then just pick up on a point of detail in your
 7 witness statement, please. WITN5736003. If we go to
 8 page 47, in paragraph (d), if we just -- thank you.
 9 I just want to pick up on a point that's made in
 10 the second half of the paragraph. So you're talking
 11 here about the different approaches taken by BPL and PFC
 12 to viral inactivation and, halfway down the paragraph,
 13 you say this:
 14 "In the event, the PFC was ahead of BPL with an
 15 HIV-safe product ..."
 16 Then:
 17 "BPL was ahead of the PFC in developing an
 18 HCV-safe product in 1985 ..."
 19 Then it's this phrase:
 20 "... (although this was not proven until 1988)."
 21 Now, the Inquiry has seen documents from 1985 and
 22 1986, which suggest that there was a basis for optimism
 23 about the BPL product: the initial results and findings
 24 were good. That's not something which is referred to
 25 here. You use the phrase "although not proven until

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1 wouldn't have been shared.
 2 **Q.** The reason I ask that, professor, in particular is the
 3 document I asked to be taken down, I'm just going to
 4 read a sentence from it. It's paragraph 10 of that note
 5 of the meeting on 14 September and it records the
 6 Minister pointing out that she wished the examination to
 7 be carried out in an open and transparent manner, and it
 8 might be said, again, that conducting the investigation
 9 in an open and transparent manner might include
 10 providing your initial findings -- when I say "your",
 11 the Department's initial findings -- or impressions to
 12 the Society for it to be able to respond on an informed
 13 basis.
 14 **A.** Well, again, I beg to differ. I think that when it came
 15 to the report, that final report being produced, it was
 16 issued in draft form to the main stakeholders, if you
 17 like, including The Haemophilia Society, so that they
 18 could comment on the more refined conclusions that we'd
 19 arrived at, at that point. I don't think that not
 20 sharing the ministerial briefing with
 21 The Haemophilia Society means that the Inquiry wasn't
 22 conducted in an open and transparent way.
 23 **Q.** Yes, I should say, for the sake of clarity, I wasn't
 24 suggesting that the briefing itself was something that
 25 ought to be shared with the Haemophilia Society. It was

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1 1988". Can you help us in understanding why and whether
 2 you were aware that there was evidence that the BPL
 3 product didn't transmit hepatitis C, that was available
 4 in '85/'86?
 5 **A.** Well, I think having a basis for optimism is not the
 6 same as proof that the product was HCV safe and that
 7 only emerged in 1988. So that's what I was trying to
 8 reflect. There were preliminary, of course, findings
 9 along the way, but the nature of hepatitis C is that you
 10 have to, in the absence of a test, which was not in
 11 existence at that point, you have to let some time
 12 elapse to determine whether patients had indeed been
 13 infected with non-A, non-B hepatitis.
 14 **Q.** Do you recall whether you were aware of the preliminary
 15 evidence that was available before 1988, which indicated
 16 or pointed to the likelihood of this being safe, in
 17 terms of transmission of non-A, non-B hepatitis?
 18 **A.** I don't recall whether I was aware or not. To me, the
 19 material point is that it wasn't definitively proved
 20 until three years later.
 21 **SIR BRIAN LANGSTAFF:** May I just ask a question here? By
 22 1988, there wasn't, as yet, a test for the actual virus
 23 itself because one hadn't yet been developed; that
 24 didn't take place until 1989. So what one is looking
 25 for here is a product being administered to recipients

28

1 and seeing whether any of them then showed the signs
2 which clinically indicated that they had non-A, non-B.
3 Those signs would be what were repeated liver function
4 tests on more than one occasion which showed elevation,
5 and the absence of any positive test for hepatitis B and
6 hepatitis A. It was really a diagnosis of exclusion,
7 wasn't it?

8 **A.** Indeed, yes.

9 **SIR BRIAN LANGSTAFF:** So the proof of the pudding is the
10 absence of any infection demonstrated by those tests.
11 You just need one person or two people to say, "Well,
12 I had this product, I have this result, the result is
13 positive, I've got non-A, non-B", and you'd be able to
14 say, well, the product doesn't work.

15 The proof of the negative is what you have to have
16 to show that the English BPL product actually worked.
17 It's not going to come quickly, but by 1988 you regard
18 it as proven. In other words, there'd been sufficient
19 product out there without any report of any infection.

20 The steps along the way to that are seeing whether
21 anyone checks at intervals and sees if there's any
22 infection and, progressively, my impression would be
23 with those tests nobody produces a positive result, that
24 goes on, and the groundswell develops to an extent where
25 you can say that yes, this is absolutely proven. Is

29

1 other products.

2 **Q.** Now you observe, as I understand it correctly, that at
3 this point in time, BPL wasn't producing sufficient
4 quantities of product for everybody in England or
5 England and Wales to be treated. Did the Department's
6 investigation look at what might be thought to be the
7 separate but important question of whether BPL might
8 have sufficient quantities of 8Y in order to be able to
9 spare some for that smaller cohort of patients in
10 Scotland who were previously untreated or had been
11 minimally treated? In other words, the very cohort most
12 at risk? Was that something the investigation
13 looked at?

14 **A.** I think there is mention in the investigation report, or
15 I've seen it in some document, that a small amount
16 of 8Y, the BPL product, was indeed obtained, I think by
17 Edinburgh, but that was obviously on the basis of
18 clinician-to-clinician approach. I mean, I was working
19 in London during this period in the mid-'80s and
20 I recall that at the Middlesex, where I worked for
21 a bit, that 8Y was often in short supply, even in that
22 major Centre.

23 So BPL were not hanging on to loads of that
24 product that could have been accessed by Scotland. So
25 I think it highly unlikely that, other than the small

31

1 that a fair summary of the process?

2 **A.** That's absolutely what I was trying to convey but much
3 more fluently, thank you.

4 **SIR BRIAN LANGSTAFF:** Thank you.

5 **MS RICHARDS:** The penultimate sentence in that paragraph
6 makes the point that the BPL product was not produced in
7 sufficient quantities to make England self-sufficient.

8 Was it your understanding that the cohort of
9 patients who might be particularly at risk in this
10 period that you were looking at, that the Department was
11 looking at, '85 to '87, would be likely to be patients
12 who had been either previously untreated or minimally
13 treated? They were those who were most likely to be at
14 risk from treatment with a product that transmitted
15 hepatitis C; is that correct?

16 **A.** Yes, because we know, with hindsight, that prior to an
17 HCV-safe product being produced, that 100 per cent of
18 haemophilia patients would have contracted
19 non-A, non-B hepatitis. So the clinical trials -- and
20 of course this long pre-dates any involvement or any of
21 my involvement through the Government -- the clinical
22 trials that would have been conducted in the mid-1980s
23 would have, I think, exclusively been in previously
24 untreated patients, so that the effects could be
25 determined in them who had never been exposed to any

30

1 amount that came in, as I said, I think to Edinburgh,
2 there would have been excess product available for north
3 of the border.

4 **Q.** It's an issue that this Inquiry has been investigating,
5 Professor Keel, as to whether requests could and should
6 have been made earlier to BPL for a small supply but
7 sufficient to enable the smaller number of Scottish
8 patients most at risk to be treated.

9 If you don't recall, please say so, and we can
10 obviously look and will look with Mrs Deacon in due
11 course at the final Inquiry report, but do you recall
12 that coming up as an issue in the course of the
13 investigation, whether requests could and should have
14 been made to BPL for a supply earlier than they were?

15 **A.** I don't remember that being a subject that was
16 discussed, but I -- as I said a minute ago, I think
17 there is reference in the document that a small amount
18 had found its way north. I imagine that it was
19 understood at the time that BPL were not able to produce
20 enough product to cover England, and therefore that the
21 prospect of them, even if they had been formally
22 approached -- of releasing any for Scotland were low.

23 **Q.** If we go to SCGV0000170_152.

24 This is still in September 1999. If we look at
25 the top of the page, it's an email sent on behalf of the

32

1 First Minister, 23 September. And again, it's copied to
 2 you, amongst others, and it says this:
 3 "The First Minister has seen your minute of
 4 17 September to the Minister for Health outlining a way
 5 forward following the meeting with the
 6 Haemophilia Society. He was a little concerned about
 7 the possible financial implications and fears that an
 8 open mind could be taken to mean an open cheque book.
 9 He would be grateful for information on the likely
 10 exposure if compensation were to be awarded."
 11 Now, before we look at anything else on this
 12 document, do you have any recollection of your thoughts
 13 when you saw this email, and the fear about an open
 14 mind?

15 A. No, I don't recall what I thought when I saw the email,
 16 but clearly, any administration would want to be able to
 17 quantify the amount associated with the compensation if
 18 that were to be rewarded -- awarded. And as we've seen
 19 from earlier documents, in preparation for this kind of
 20 response from ministers, the Department had already
 21 begun to try to scope the numbers, so that from -- who
 22 might be eligible -- from those numbers we could build
 23 scenarios around the possible financial implications of
 24 such a scheme if it were adopted.

25 Q. Could we look at the bottom part of the page, please.

33

1 Society -- whether what The Haemophilia Society were
 2 alleging was true or not. So the use of this term does
 3 not tally with my recollection of that period around the
 4 investigation.

5 Q. Moving on, then, through the course of the investigation
 6 to November '99, WITN2287019, please.

7 WITN2280719, we don't have it. Ah, okay, I'll
 8 pick that up after the break, in that case.

9 My apologies, professor, for the document issues
 10 this morning.

11 We'll come back to that, so I'll take the
 12 investigation slightly out of chronological order.

13 If we then move to SCGV0000170_078, this
 14 a meeting, 14 January 2000, and I draw attention to this
 15 just to see what's set out in paragraph 2, and this,
 16 I think, confirms the point you made earlier,
 17 Professor Keel. It refers in paragraph 2 to the lack of
 18 information received so far from the Haemophilia
 19 Directors, and then it sets out that you had written in
 20 September, written again in mid-December, and sent
 21 another reminder in early January, and that the
 22 information received didn't answer all the questions.
 23 So I think that reflects what you already told us and
 24 put some dates on it.

25 Can we then pick up ARCH0003312_031. Now, this is

35

1 There's a note on the right-hand side which I think says
 2 this:

3 "Ms Deacon's office advises that this is very much
 4 a PR exercise and that there is unlikely to be any
 5 compensation paid."

6 Now, this is nine days after the meeting with The
 7 Haemophilia Society where the Minister has said to The
 8 Haemophilia Society "We're going to be open and
 9 transparent". Obviously, this is a matter that
 10 Ms Deacon will no doubt be asked about in the course of
 11 the week but do you maintain the answer you gave earlier
 12 that, from your perspective, this was an independent and
 13 impartial investigation in light of, what's said to be
 14 here, the advice from the Minister that it was very much
 15 a PR exercise?

16 A. Well, as I said in my written statement, I certainly
 17 don't agree with the use of the term "PR exercise".
 18 Undoubtedly, ministers were under great pressure to
 19 further investigate this area and The Haemophilia
 20 Society undoubtedly had in mind compensation at the end
 21 of that period. However, I don't think that means that
 22 the investigation -- the internal investigation was not
 23 conducted in an entirely proper way, as I said, earlier,
 24 finding out the facts, detailing the chronology, so that
 25 we could really understand what The Haemophilia

34

1 a letter from you dated 17 January 2000, and we can see
 2 it's Scottish Haemophilia Directors. Paragraph 1 refers
 3 to the meeting that we just briefly looked at.
 4 Paragraph 2 of the letter says this:

5 "You may recall that The Haemophilia Society are
 6 also particularly interested in pursuing the issue of
 7 what patients were told at the time of Hepatitis C
 8 testing, including the clinical implications of
 9 a positive diagnosis, in addition, the Society allege
 10 that Scottish patients were often completely unaware of
 11 possible adverse effects resulting from plasma derived
 12 blood products, and of other potential treatment
 13 options."

14 So that's one of the issues that have been flagged
 15 up by the Society, and then we can see that, in the
 16 third paragraph, you want to discuss these important
 17 issues in more depth and so you're inviting the
 18 Haemophilia Centre Directors to a meeting.

19 We can see the meeting itself at ARCH0003312_020.
 20 So meeting on 10 February 2000, we can see again the
 21 attendees from the Scottish Executive and then on this
 22 occasion we have Professor Ludlam and Professor Lowe
 23 again but we also have directors from Dundee, Aberdeen,
 24 Inverness and Yorkhill.

25 If we go towards the bottom of the page, we can

36

1 see -- and I'm not going to go through the detail of it
2 but we can see reference there to figures of HCV
3 positive patients said to be currently alive.

4 Then if we go over the page, there's further
5 information about the figures.

6 If we can pick it up at the bottom of the page,
7 please, paragraph 3:

8 "Dr Keel reported that a major concern of
9 The Haemophilia Society was that members alleged they
10 were not given a clear explanation of the risks of
11 treatment or the therapeutic options. Patients were
12 tested without their knowledge and were not told of the
13 results for some time and that during that time their
14 partners were exposed to the unnecessary risk of
15 infection."

16 So you're there recording
17 The Haemophilia Society's complaint from members as to
18 what they were not being told and what was happening
19 without their knowledge.

20 Then Mrs Towers is then recorded as contributing.
21 Now, Mrs Towers was who?

22 **A.** She was a legal adviser to Government.

23 **Q.** What she then says is:

24 "... explained that it was therefore necessary to
25 try to establish whether there was a general policy on

37

1 the medical literature? Do you know?

2 **A.** The latter.

3 **Q.** Then if we go down to paragraph 7, we can see it said:

4 "Professor Lowe pointed out that there was an
5 awareness of Hepatitis at that time and every patient
6 was treated with great care because of the risks of
7 transmission. He explained that the policy was that
8 patients would be informed they were being tested ...
9 and that the results would be discussed at their next
10 appointment."

11 Then he refers to a publication in '85 and British
12 Liver Trust leaflets.

13 Was this information provided by Professor Lowe at
14 this meeting again essentially accepted at face value by
15 the investigation, as far as you can recall?

16 **A.** Yes, I think it was.

17 **Q.** Then if we go over the page, paragraph 9 says this:

18 "Professor Lowe pointed out that most patients
19 would have been infected whilst their predecessors were
20 in post and asked whether it was necessary to contact
21 them to make them aware of the situation. Mrs Towers
22 explained that this was a factual information gathering
23 exercise but that it should be borne in mind that the
24 information might be used in future Court actions.

25 Professor Ludlam also sought advice on whether HDs

39

1 what patients were told and whether there [I think the
2 word 'was' is missing] an assessment of risk and if
3 patients were given a choice."

4 Now, it might be said that Mrs Towers is there
5 identifying a narrower issue so, rather than looking at
6 what, as a matter of fact, did or didn't happen, looking
7 to see whether there was a general policy about the
8 provision of information to patients. What, if any,
9 comment would you make in relation to that?

10 **A.** Not sure I have any comment. She was clearly probing
11 one aspect of this area of the Inquiry.

12 **Q.** We can then see a response from Professor Ludlam
13 describing non-A, non-B hepatitis as a mild
14 non-progressive condition -- sorry, in terms of the
15 perceptions until the late 1980s, the first serious
16 study on liver biopsy having been undertaken in 1985.
17 Then this:

18 "Dr Keel confirmed that this was also her
19 understanding, and Dr Watson advised the only tests for
20 the virus at the time would have been via surrogate
21 markers."

22 Was your understanding of this important issue,
23 about what was known regarding non-A, non-B hepatitis,
24 essentially based upon what Dr Ludlam was saying to you,
25 or was it based upon your own knowledge and review of

38

1 [Haemophilia Directors] should be looking back to try to
2 identify what had happened to patients whose whereabouts
3 and status were unknown. Mrs Towers confirmed that
4 Central Legal Office was representing the Trusts and
5 SNBTS and that the HDs should therefore follow CLO
6 advice on whether any further investigation or the
7 tracking down of patients was necessary."

8 Now obviously this paragraph doesn't record any
9 contribution or expression of view from you,
10 Professor Keel. But as a medical practitioner as well,
11 obviously, as medical advisor to the Government, do you
12 have any concerns about the discussion that's recorded
13 here? We have Professor Lowe asking about whether
14 contact should be made with patients who might have been
15 infected, and Mrs Towers saying, "Well, that information
16 might be used in future court actions and you should
17 take legal advice."

18 **A.** I don't recollect this part of the discussion. I mean,
19 legal advice is clearly very important. SNBTS were
20 already in touch with CLO, so I think it's probably
21 reasonable that Lynda Towers advised them to speak to
22 CLO before doing anything further.

23 **Q.** As a matter -- I'm sorry.

24 **A.** If I may. I'm not quite sure what Professor Lowe had in
25 mind in terms of tracking the patients down. I don't

40

1 know what was in his mind. I mean, was he going to ask
 2 them about what information they'd been given? They
 3 would presumably be under the care of another
 4 Haemophilia Director or centre somewhere else, who was
 5 looking after them from a non-A, non-B infection point
 6 of view, and monitoring them. So -- and in due course,
 7 the report was going to be produced and indeed, as
 8 subsequently happened, there was publicity around
 9 awareness raising. So I'm really a bit mystified as to
 10 what was in Gordon Lowe's mind.

11 **Q.** Yes. Whatever Professor Lowe had in mind, it's I think
 12 tolerably clear what Professor Ludlam had in mind, which
 13 was the question of whether Haemophilia Directors should
 14 be looking back to try to identify what had happened to
 15 patients whose whereabouts and status were unknown. The
 16 Inquiry has heard evidence, Professor Keel, in
 17 particular in relation to mild haemophiliacs who may not
 18 be in contact with Haemophilia Centres from one year to
 19 the next, and so there may be cohorts of patients not
 20 attending regularly at their Haemophilia Centre who
 21 might have been infected and were unaware of their
 22 infection.

23 As a medical professional, whatever this
 24 particular paragraph does or doesn't mean, as a medical
 25 professional, would it have been, in your view,

41

1 investigation, and it's her fact-finding exercise and
 2 her conclusions that we see in the investigation report,
 3 is it not?

4 **A.** Yes.

5 **Q.** Then we see her saying this:

6 "Dr Keel, Mrs Towers

7 "I have now waded through the papers you got from
 8 Prof Cash, relating to SNBTS, and the only things I can
 9 say are:

10 "a) I don't understand half of them!

11 "b) as far as I can make out, 'we' (in Scotland)

12 were only getting around to seriously thinking about
 13 ALT testing of donations in March 1988 -- after the
 14 period in question. I suppose we could try to emphasise
 15 about how unreliable it was -- but that in itself is
 16 a big dollop of hindsight."

17 "The Haemophilia Society are not going to let it
 18 rest if we put nothing in about testing. Can you give
 19 me any advice in relation to the sequence of events as
 20 they might relate to our investigation? Even something
 21 demonstrating that by the time adequate testing of
 22 donations was available, heat treatment was already
 23 protecting people? Or something demonstrating that the
 24 testing available at the time was inadequate?"

25 Now, again, it may be submitted to the Inquiry in

43

1 important that -- bearing in mind we're now in 2000 and
 2 there's a possibility of patients infected through blood
 3 products not knowing of their infection, would it be
 4 important for those patients to be identified and tested
 5 and informed?

6 **A.** Well, it would be, but I suspect that even the mild
 7 haemophiliacs who, as you say, would probably have
 8 little contact with the Centre, would have been aware,
 9 in the preceding decade, of the existence of
 10 a hepatitis C test, and there certainly were great
 11 efforts -- and we discussed some of these yesterday --
 12 in raising awareness of the availability of an HCV test
 13 for anybody who'd received blood transfusion or blood
 14 products.

15 **Q.** Just one further document before we break, and this now
 16 moves to March 2000. It's SCGV0000171_052.

17 This is an email from Christine Dora, dated
 18 28 March 2000, and I'm looking not at the very top of
 19 the page but at the -- which is I think forwarding the
 20 email on -- but to the next -- thank you -- to what is
 21 now on top of the screen.

22 So it's from Christine Dora to you and to
 23 Mrs Towers, subject "help! haemophilia and hepatitis C".

24 Just to understand, Mrs Dora or Ms Dora was the
 25 person who was primarily charged with undertaking the

42

1 due course that this is not a reassuring email to read,
 2 in terms of the reliability of the conclusions set out
 3 in the investigation report, bearing in mind that the
 4 lead fact finder is apparently struggling to understand
 5 some of the issues. Do you have any observations in
 6 relation to that?

7 **A.** Well, first of all, I don't think we know the content of
 8 Professor Cash's papers. In my experience of his
 9 *modus operandi*, many of them possibly didn't relate to
 10 the subject of the Inquiry, so I don't think it's
 11 surprising that Christine Dora and the administrator
 12 would not be able to understand medical communications.
 13 But what I think we do not know, as I said a minute ago,
 14 is what was in those papers from Professor Cash, they
 15 may not even have been about hepatitis C, they may have
 16 covered other areas.

17 And the other element, of course, is that anything
 18 that Christine Dora was going to put in the report
 19 relating to the medical facts, then I was there to
 20 cross-check them.

21 **Q.** Now, we can see there being identified a concern arising
 22 from Professor Cash's papers about ALT testing, and that
 23 not having been considered, the inference may be,
 24 sufficiently timelessly. We see Ms Dora commenting
 25 that:

44

1 "The Haemophilia Society are not going to ... rest
2 if we put nothing in about testing."
3 Then if we can just go to the top of the page
4 there's a handwritten note, is that your handwriting,
5 where it says, "X is a balance between"?

6 **A.** I can't actually be sure. It may be, but I don't think
7 it is.

8 **Q.** In any event, it says:
9 "X [and that's the paragraph about The Haemophilia
10 Society not resting 'if we put nothing in about
11 testing'] is a balance between sticking to what we were
12 asked to do & anticipating further demands. I am still
13 inclined not to cover testing in the body of the
14 report."
15 Regardless of what the remit of the report was,
16 and whether testing fell within the existing remit or
17 not, was the concern about what Scotland had or hadn't
18 done in relation to ALT testing, something that was
19 identified and flagged up as an issue for the minister
20 to consider, as far as you can recall?

21 **A.** I can't recall, and we spent some time on ALT testing
22 yesterday, and I gave you my views on its lack of
23 sensitivity and specificity, in particular, in terms of
24 picking up non-A, non-B hepatitis. So I think we
25 probably regarded ALT testing as an irrelevance in the

45

1 a meeting between SNBTS and the Haemophilia Society was
2 something which arose out of one of the earlier meetings
3 as an idea that this might be a good thing to do.

4 **A.** Yes.

5 **Q.** If we go to the third page, there's just a couple of
6 points I wanted to pick up. So the bottom half of the
7 page refers to a presentation by PF, so that's
8 Peter Foster, and then paragraph 3.1 we see PD, that's
9 Philip Dolan, for The Haemophilia Society, raising the
10 question of who determined the operating policies for
11 haemophilia provision.
12 I just wanted to ask you about what you say here
13 and on the following page. In the third bullet point
14 it's:
15 "AK [that's you] also advised that national policy
16 in matters relating to donor testing were the
17 responsibility of UK ministers. They took advice from
18 a UK advisory committee the Advisory Committee for the
19 Virological Safety of Blood, ACVSB."
20 Then there's reference to the membership of ACVSB.
21 Then if we go over the page, if we look again at
22 the bottom half of the page, about halfway through the
23 paragraph that's on the screen it says:
24 "Several questions were asked on why ALT testing
25 was not introduced in the UK."

47

1 context of trying to understand what efforts were made by
2 SNBTS to produce a non-A, non-B safe product in the
3 mid-1980s.

4 **MS RICHARDS:** Sir, I trespassed into break territory, so
5 perhaps we could take our morning break now.

6 **SIR BRIAN LANGSTAFF:** Yes, well, we'll take a break until
7 11.50. 11.50.

8 **(11.19 am)**
9 **(A short break)**
10 **(11.50 am)**
11 **MS RICHARDS:** Professor Keel, I'm going to go back to
12 a document which I had wanted to look at earlier, and we
13 didn't have it and it's entirely my fault because I gave
14 the wrong reference. So the correct reference is
15 WITN2287021.
16 And if we go to the second page, top half of the
17 page, we can see these are the notes of a meeting
18 between The Haemophilia Society and the Scottish
19 National Blood Transfusion Service, 25 November 1999,
20 and then we can see a number of attendees on behalf of
21 The Haemophilia Society, and then on behalf of SNBTS,
22 and then you and Thea Teale there on behalf of the
23 Scottish Office.
24 This was taking place in the course of the
25 investigation and, as I understand it, the suggestion of

46

1 There's a response from BMCC [that's
2 Brian McClelland] and then you're recorded as saying:
3 "AK advice that the ACVSB had considered this
4 issue over a number of years. On each occasion, they
5 agreed that ALT testing should not be introduced because
6 of the poor specificity of this test."
7 Now, Professor Keel, the ACVSB only met for the
8 first time in 1989, in April 1989. So it would appear
9 that what you're setting out at the bottom of that page
10 may not be correct. What was the basis of your
11 understanding that the issue of ALT testing had been
12 considered over a number of years by ACVSB?

13 **A.** Well, if they met for the first time in 1989, then 1999
14 we're talking about ten years later. So I think my
15 statement could be considered accurate.

16 **Q.** Do you know or did you know in 1999 what consideration
17 had been given and by whom to the question of surrogate
18 testing in Scotland in the 1980s? It wasn't the ACVSB
19 in the '80s, because it -- unless you're just talking
20 about 1989. Did you have any knowledge of what other
21 bodies or organisations or individuals had considered
22 that issue?

23 **A.** No, I can't recall having any knowledge of them.

24 **Q.** And this deals with ALT testing, and of course that may
25 be the specific issue that had been raised by those

48

1 present. But another aspect of surrogate testing is HBc
2 testing. Was that something which was thought about in
3 the course of the investigation at all as far as you can
4 recall?

5 **A.** Well, it had been -- the remit of the investigation
6 agreed by The Haemophilia Society didn't cover surrogate
7 testing. So I think the answer to your question is no.

8 **Q.** I don't know what independent recollection you have of
9 this meeting at this distance of time, Professor Keel,
10 but if we go back to the second page --

11 **SIR BRIAN LANGSTAFF:** Just before we do, can we come back to
12 that, the page we were on, please? And let me ask you
13 just a couple of questions, Professor, about the last
14 bullet point on the page.

15 ACVSB, having met for the first time in 1989, by
16 which time a test was being promoted by the Chiron
17 Corporation in the United States, and rapidly was
18 becoming available in the UK, albeit a second
19 generation, ultimately, can you help at all with why the
20 ACVSB might have been considering ALT testing in the
21 first place? After all, if there was a specific --
22 a test specific to the virus in question, why would you
23 want a surrogate test?

24 That's the first question.

25 **A.** Yes, well, you'll forgive me because, of course, this
49

1 consider it a false positive. It's elevated for other
2 reasons, and I've already referred to them on a number
3 of occasions, you know, other hepatitis viruses, other
4 affections, alcohol, obesity, et cetera.

5 So that would be considered a false positive in
6 the context of a screening test aimed at identifying
7 non-A, non-B hepatitis.

8 **SIR BRIAN LANGSTAFF:** I understand. So what you are
9 summarising here, or at least -- it's a minute, of
10 course, so may not represent everything that you said,
11 but what you are summarising here was the problem of
12 confirming, as it were, a positive test, of eliminating
13 false positives --

14 **A.** Yes.

15 **SIR BRIAN LANGSTAFF:** -- albeit they'd been screened out,
16 the -- you're left with the donor who is told they're
17 positive when they're not, and that may cause problems.
18 I understand. Right, thank you very much.

19 **MS RICHARDS:** If we go back to the second page, please, and
20 the list of attendees. You'll see, Professor Keel, that
21 the list of attendees for the Haemophilia Society
22 includes B Wright, Bill Wright, and Mr Wright has told
23 the Inquiry of his recollection of this meeting, of
24 surprise being expressed by SNBTS representatives that
25 someone could be infected as late as 1986, and with the
51

1 comment, and ACVSB's first meeting of course pre-date my
2 Government employment, so I have no direct knowledge of
3 what exactly discussions were in ACVSB. You're
4 absolutely right, there must have been other bodies.

5 There would have been other bodies in the departments of
6 health which preceded ACVSB who considered issues of
7 surrogate testing, and I guess that my comment here was
8 not as precise as it might have been. I should have
9 said ACVSB and predecessor committees, have considered
10 this issue over a number of years.

11 **SIR BRIAN LANGSTAFF:** I see. That explains that, thank you.

12 The second question is that what is being
13 envisaged for ALT testing here, I think, is use as
14 a form of screening test. That would be right, would
15 it?

16 **A.** Yes.

17 **SIR BRIAN LANGSTAFF:** If one's having a screening test, the
18 object of the test is to screen out anything which might
19 be the infection in question, am I right about that?

20 **A.** You are.

21 **SIR BRIAN LANGSTAFF:** So why does the poor specificity of
22 the test, rather than the poor sensitivity, matter
23 directly?

24 **A.** Well, if the test is positive, not because of non-A,
25 non-B hepatitis or whatever organism, then you could
50

1 response being, "Well, he's sitting here". Because that
2 was Mr Wright's own situation.

3 Do you have any recollection of that, or of being
4 aware that somebody infected in the very period that you
5 were investigating was there?

6 **A.** I've no recollection, and I may point out this is
7 Mr Wright's recollection of the meeting. I don't recall
8 that being discussed.

9 **Q.** Can we turn, then, to March 2000 just to complete
10 a chronology of events in relation to the investigation.
11 SCGV0000171_053.

12 This a minute from you, 23 March 2000 to Ms Dora,
13 and you're providing your comments on the draft report
14 that she's produced.

15 If we could just go down the page to paragraph 4.
16 You say in paragraph 4:

17 "As far as the Conclusion is concerned, I agree
18 with John that this should be made for definite."

19 "John" I think is Mr John Aldridge; is that right?

20 **A.** Yes.

21 **Q.** What was his role?

22 **A.** I think he was director offer finance at that point.

23 **Q.** Then you suggest that the paragraph could "refer to the
24 fact that comparable developments in the commercial
25 sector usually take significantly longer than SNBTS's
52

1 development".

2 I'll come back to that in a moment but if we just

3 go over the page, you then say this:

4 "Finally, as far as financial help is concerned,

5 you will need no reminding that DH are very nervous

6 about this. Mike McGovern made a point of bringing the

7 issue up with me during a recent unrelated telephone

8 conversation, during which I reassured him that we

9 recognised that compensation in this area would set

10 a very difficult precedent for the Government, given the

11 many claims for compensation that it receives."

12 Now, bearing in mind Ms Dora's role was to

13 investigate whether there had been fault on the part of

14 SNBTS or negligence on the part of SNBTS, and to reach

15 conclusions, why was it relevant for you to remind her

16 that the Department of Health was very nervous about the

17 possibility of financial help?

18 **A.** Well, because it was a material issue that was

19 discussed -- being discussed at that time. I mean, it's

20 not directly relevant to the investigation but clearly

21 from previous documents we have seen that the

22 Scottish Office, Scottish Executive subsequently, had

23 over the years already done some pre-planning around the

24 impact that setting up a compensation scheme would have.

25 Not expecting that that would be the case, but in

53

1 **A.** I think -- I think the retyped text probably came from

2 me.

3 **Q.** I'm not going to go through the detail of the suggested

4 amendments. It was just to try to understand who was

5 amending what.

6 In terms of the conclusion that you'd wanted

7 strengthening, if we go to page 11, bottom of the page,

8 so the "Conclusion":

9 "The episode of HCV infection of haemophiliacs is

10 devastating for the individuals infected and their

11 families, and is a matter of public distress and regret.

12 While ..."

13 And I'm just going to read out the amended text:

14 "While the facts suggest that those involved in

15 the manufacture of blood products made every effort to

16 develop products free of viral risk, it is undeniable

17 that these efforts took some time to come to fruition.

18 However, to talk in terms of people being exposed

19 'longer than they should have been' is not accurate."

20 Then there's a reference to that being "expanded

21 in the light of comment in covering minute". And then

22 at the bottom of the page there's a reference to:

23 "Scientific knowledge ... developing rapidly

24 during the period in question. From the available

25 evidence, SNBTS appear to have acted ..."

55

1 preparation for that, should it be an eventuality.

2 **Q.** If we turn to the draft report, it starts on page 3., we

3 can see that there are -- and this continues through the

4 draft -- a number of -- if we go to the bottom of the

5 page, please, Lawrence -- a number of handwritten

6 comments and then there are deletions and additions that

7 have been suggested in typewritten form, and we see an

8 example of that in paragraph 4.

9 Just so that we can understand who's providing

10 what comments, were your comments the handwritten ones

11 or the typed ones, do you know? We can go over the page

12 if it might help.

13 **A.** Yes, please.

14 **Q.** Yes, so if we go over the page, there's some -- and can

15 we have a look at the next page as well? Can we put

16 this page and the following one on screen at the same

17 time? It might help Professor Keel.

18 So I don't know whether that assists in working

19 out which comments you authored or not.

20 **A.** Could you show me page 3 in large, please. I can't

21 really see it clearly.

22 **Q.** Yes, of course.

23 It's page 3 internally, so if you go to page 5

24 electronically, Lawrence.

25 Does that assist at all, Professor Keel?

54

1 And then there's text "as quickly as possible",

2 somebody else has crossed that out and suggested

3 "reasonably":

4 "... under the circumstances."

5 And then I think the suggestion is the words "as

6 quickly as they could" go in there:

7 "... to develop a Factor VIII product free of the

8 risk of Hepatitis C."

9 Can you recall why it was you wanted that

10 paragraph strengthened?

11 **A.** Well, the context in which this investigation was taking

12 place, the period that it was looking at was one of

13 fairly frenetic activity in the protein -- in the

14 fractionation of blood products world. You know, there

15 is evidence which is cited in the report from the US and

16 other European countries of fractionators really

17 struggling to understand what processes could be safely

18 applied to factor concentrates to render them virus

19 free, without making them unsafe or reducing the active

20 ingredient by such an amount that, you know, there

21 wouldn't be enough product to go round.

22 So I wanted this paragraph in, to make sure that

23 everybody knew that it wasn't just the UK that was

24 struggling to achieve safety, viral safety, in blood and

25 blood products at this point; it was a worldwide issue.

56

1 Q. Then if we turn to SCGV0000171_077, this is a minute
2 from Christine Dora, 4 April 2000 -- that appears on
3 page 4 but we don't need to go to that -- to the
4 Minister for Health and Community Care. We can see, if
5 we just look at the purpose of the minutes, so if we go
6 a little further down the page, it's to "let the
7 Minister see and comment on a draft report", and then
8 various matters in which the minister's approval was
9 sought in terms of the process of publishing the report,
10 and so on.

11 I just want to ask you about something that's on
12 page 2 of the minute, which was copied to you. It's
13 paragraph 7., so towards the bottom of the page, where
14 Ms Dora says this:

15 "The second part of our remit was:
16 "to examine evidence about the information given
17 to patients with haemophilia in the 1980s about the
18 risks of contracting HCV from blood products'."

19 Then Ms Dora says this:

20 "This was much more difficult to research than the
21 first part, since we could not find many papers from so
22 long ago. However, Haemophilia Centre directors told us
23 verbally that what they could remember, and we have
24 detailed this in the report. I believe some of them are
25 worried about possible litigation, and we have been

57

1 Q. You've told us already that the Department essentially
2 accepted at face value what the Haemophilia Centre
3 Directors said about their approach to providing
4 information to patients. We have here Ms Dora setting
5 out her belief that some of them were worried about
6 possible litigation. Would that not ring alarm bells as
7 to whether the Department could safely simply rely upon
8 what the directors were saying on this particular issue?

9 A. Why would it ring alarm bells?

10 Q. Because if they're worried about possible litigation
11 they may be less than forthcoming about what information
12 was or wasn't provided to patients.

13 A. Well, that may or may not be the case, but I think they
14 could be worried about possible litigation and still
15 disclose all of the information available to them. The
16 two are not mutually exclusive.

17 Q. The report itself, in final form, was published in
18 October 2000 but I'm not going to take time going
19 through that with you, Professor Keel, and we can pick
20 that up with Ms Deacon later in the week.

21 I want, then, to look at some documentation and
22 decision making from 2000 onwards on the issue of
23 financial support for hepatitis C. Some of it overlaps
24 with the time period of the investigation. So if we
25 start with DHSC0032292_045.

59

1 unable to obtain some of the papers they have mentioned.
2 I am willing however to accept that there was no
3 evidence that clinicians had a policy to deliberately
4 mislead their patients about the risks of using
5 Factor VIII."

6 Now, Professor Keel, would you accept that the
7 issue that Ms Dora addresses in that final sentence of
8 paragraph 7, whether there's a policy of deliberately
9 misleading patients, is a narrower issue than the
10 broader question contained within the remit, which was
11 to look at what information was given to patients; it's
12 a significantly narrower issue, isn't it?

13 A. Yes, I agree.

14 Q. Why was it, do you know, that the remit having been that
15 this broader issue, reflecting what

16 The Haemophilia Society was saying to the Department,
17 that only the narrower issue was answered?

18 A. Well, I think that the broader issue is perhaps better
19 addressed in the report but, in relation to this
20 paragraph, I think Christine Dora is reflecting the
21 difficulty that we had in obtaining the papers that the
22 Haemophilia Directors said were available during the
23 period in question, and it's not surprising that there
24 was that difficulty, given the gap between the activity
25 we're talking about and the report in 2000.

58

1 This is an email chain in April 2000, so it's
2 after the first draft of the report has been produced
3 and it's while the report is being finalised. If we go
4 to the second page, we can pick up the email chain. So
5 the bottom half of the page we have, if we go just up
6 a few lines, please, Lawrence, further up, so I can see
7 who the email -- thank you, perfect.

8 So we can see Ms Dora is sending an email on
9 19 April to you and to a number of others and she says
10 in the body of the email:

11 "Thanks to those of you who have commented up to
12 now on my attempts to draft a report. Please find
13 attached what I hope is now a pretty final draft
14 Ministerial submission with recommendations on
15 handling."

16 Then if we go to the top of the page, we've got
17 an email from John Aldridge, and we can pick it up in
18 the third paragraph of the email, where he says this:

19 "I note the issues on which you are seeking the
20 Minister's views. I think she should be pointed very
21 firmly in the direction of not agreeing to compensation
22 or special priority treatment for Hep C sufferers who
23 may have been infected by NHS treatment. That would
24 have huge implications for other areas of NHS activity,
25 and would, I am sure be resisted strongly by colleagues

60

1 in the other parts of the UK and the Treasury as well as
2 by me!"

3 Then if we go to the first page, we can see
4 there's a name there about a third of the way down the
5 page, Francis Gibb. What was the role of Francis Gibb
6 within the Department?

7 **A.** He wasn't in the Department, he was chief exec of the
8 Common Services Agency.

9 **Q.** We can see, if we just look -- I'm sorry.

10 **A.** Sorry, I was just going to add: within which SNBTS was
11 situated.

12 **Q.** Then we can see the comment from Mr Gibb, so just below
13 the list of attendees, is this:

14 "I agree with these sentiments as they are in tune
15 with the advice we gave at the meeting. Beware of going
16 down a path which could have serious repercussions for
17 the future. We could open the floodgates if we are not
18 careful."

19 Do the views there expressed by Mr Gibb and
20 Mr Aldridge reflect the general thinking in the
21 Department in Scotland at the time, which was,
22 essentially, fundamentally opposed to financial support
23 or compensation for those infected with hepatitis C?

24 **A.** Yes, for the reasons that we discussed in some detail
25 yesterday, setting yet another precedent, which would

61

1 don't need to look at the detail of it, but this is part
2 of the same email chain, so we've got Christine Dora's
3 email at the bottom, John Aldridge's response at the
4 top.

5 If we go back to the first page, we can see, at
6 the bottom half of the page, Ms Dora's response to
7 Mr Aldridge. She says this:

8 "I note what you say about pointing the Minister
9 away from compensation. I'm intending to leave the
10 arguments about compensation and other possible action
11 to a future minute, for the sake of digestibility.
12 I agree that the arguments tend against the award of
13 compensation (or hardship payments). The
14 Macfarlane Trust for people infected with HIV is an
15 uncomfortable precedent in this respect, so we'll need
16 to marshal the arguments carefully. I also understand
17 that Lord Hunt at the Dept of Health has been reflecting
18 on the idea of a possible hardship fund for Hepatitis C
19 victims ..."

20 Then this:

21 "... I really think it would be wise to have both
22 Ministers discuss and at least decide whether to operate
23 in step with each other (although I am hoping they will
24 decide the same thing and it won't be compensation)."

25 Now this is the author of the investigation

63

1 mean that other groups -- and I mentioned some of them
2 yesterday -- who felt that they would be entitled to
3 compensation would not being allowed access to it. So,
4 yes, this was the general feeling in the Department at
5 that point.

6 **Q.** If we go to your statement, WITN5736003, page 44, you
7 were referred to that email exchange and then we can see
8 your answer at A76. You say:

9 "These views were held in SE [so Scottish
10 Executive] and the health department around this time
11 ..."

12 Then in paragraph (b) you set out your view:

13 "I agreed that the establishment of a scheme for
14 compensation of HCV infected patients would set
15 a dangerous precedent."

16 Then you go on to explain about other possible
17 categories of patients, and (c) says your:

18 "... advice to Ministers would have been along the
19 lines outlined above ..."

20 Now "dangerous precedent" is, it might be said,
21 quite a strong way of putting it. Does that reflect
22 your own strength of feeling at the time?

23 **A.** Yes.

24 **Q.** Then if we could go, please, to SCGV0000171_031.

25 If we look at the second page, we'll see -- we

62

1 report. Why is it part of the role -- or is it part of
2 the role of a civil servant to hope that people infected
3 with a serious potentially fatal virus do not get
4 compensation? Does it concern you the way in which
5 Ms Dora, the author of the report, expressed herself?

6 **A.** No, I can't say I'm concerned by it. You have to
7 remember, compensation was not part of the remit of this
8 internal investigation. However, it was foreseen, and
9 had been for many years, that compensation was an issue,
10 and could become an even bigger issue following the
11 publication of the report. I think Christine Dora was
12 merely sharing in the general sentiment around the
13 Departments of Health up until that point that going
14 down the route of a compensation scheme, where no
15 negligence had been demonstrated, would be ill advised.

16 **Q.** If we move forward from April 2000 to February 2001, and
17 go to SCGV0000174_068, this is an email from
18 Christine Dora, again 19 February 2001, to a number of
19 recipients, including you, and it says -- records
20 a conversation she's had with Charles Lister from the
21 Department of Health in London, and then the first
22 paragraph says this:

23 "Lord Hunt has apparently agreed to meet
24 Lord Morris (President of the Haemophilia Society) and
25 others tomorrow ... to revisit the idea of compensation

64

1 for Hep C positive haemophiliacs. I understand this may
2 be prompted by political considerations; I also however
3 understand that Lord Hunt inclines naturally towards
4 sympathy for the plight of the affected haemophiliacs.
5 Officials' advice has not changed, but they have been
6 asked to put together costings for various options and
7 to offer an assessment of the extent of any precedent
8 which might be created."

9 Then this:

10 "Charles and I acknowledged that if one of the 4
11 administrations should crack, it becomes
12 presentationally much more difficult for the others not
13 to, and he said he would keep us informed."

14 Now, of course, this is two years into -- or
15 more -- into devolution by this point in time, and
16 Scotland has responsibility for its own health issues
17 and is free to take its own course. What, if anything,
18 do you recall about the concern of holding a common line
19 between the four administrations and the presentational
20 difficulty referred to there? Do you recall that being
21 discussed?

22 A. Well, I can't specifically recall the discussions, but
23 reading this and other papers has reminded me that it
24 was indeed a matter of concern as to whether Lord Hunt
25 was going to deviate from the previously agreed position

65

1 she commented that it gave her enormous concern",
2 et cetera.

3 Which is why I inferred that that handwriting is
4 by or on behalf of the minister.

5 If we just go to the top of this email, just to
6 see where we get to within February 2001, we can see
7 Sandra, presumably Sandra Falconer, to Karen saying:

8 "I have been informed by colleagues in DH(E) that
9 Lord Hunt made it clear to Lord Morris and Eddie O'Hara
10 MP that the Government had decided against compensating
11 haemophiliacs with HCV when Frank Dobson held his
12 review ..."

13 Which we know was 1998.

14 "... and that the subject is now closed."

15 Then the response at the top of the page:

16 "The Minister will be vvv relieved!"

17 Would it be right to understand that as at
18 February 2001, the position in Scotland is still set
19 firmly against financial support for those infected with
20 hepatitis C from their treatment?

21 A. Yes.

22 Q. Now as you'll recall, Professor, the Health and
23 Community Care Committee of the Scottish Parliament
24 undertook their own inquiry of forms and produced
25 a report into 2001.

67

1 across the UK that there would not be a compensation
2 scheme. So I recall that element of it, but specific
3 discussions, no.

4 Q. Then just for the sake of completeness in relation to
5 this document, the bottom -- we can see some handwriting
6 there, and then the bottom half of the page includes
7 some other that handwriting:

8 "This gives me enormous concern. Please arrange
9 for urgent contact to be made with Philip Hunt's office
10 ... emphasising that we have withstood enormous pressure
11 on this issue -- not least after discussions directly
12 with him -- any movement from the previous position,
13 without discussion with other administrations, would, in
14 my view be quite unacceptable.

15 "Happy to have conversation directly if
16 [necessary]."

17 I think there's another email from this time which
18 might suggest that's coming from the minister or the
19 minister's office. In any event, that is not your
20 handwriting?

21 A. No.

22 Q. If we go to SCGV0000174_066, we can pick it up in the
23 middle of the page with an email addressed to Christine
24 from Karen which summarises those handwritten comments:

25 "The Minister was grateful for this -- although

66

1 That's at MACK0001929_001.

2 I don't propose to go through the detail of it.

3 We can see the title of the report there.

4 If we just go to page 23, we can pick up what the
5 Committee said about financial assistance. So you'll
6 see, Professor, the heading "Targeted financial and
7 other assistance regardless of negligence". Then the
8 report reads, in paragraph 83:

9 "The more that we as a Committee have investigated
10 the issues raised in the two petitions, the more our
11 conviction has grown that what lies behind both is
12 a fundamental question of fairness and consistency.

13 "84. The individuals who petitioned us contracted
14 a serious and incurable virus many years ago as a result
15 of medical treatment, or are relatives of those people.
16 Understandably, they feel wronged, and have campaigned
17 over many years for recognition and redress. To these
18 individuals the relatively narrow question of whether or
19 not any particular agency or individual within the NHS
20 has been legally negligent, while important and worthy
21 of exploration, is of secondary importance. What it
22 they consider more important is that the Executive
23 recognise what they would classify as the moral case for
24 providing support, and that it provides the concrete
25 practical assistance that they consider would be fair

68

1 and appropriate."
 2 Then the paragraphs go on to set out in 85 and 86
 3 the general principle about not paying out unless
 4 there's negligence and then referring to exceptions
 5 within that, the Consumer Protection Act, and then in
 6 paragraph 86 the Macfarlane Trust.
 7 If we go over the page, and pick it up at the
 8 bottom half of the page -- no, in fact, I'm sorry, could
 9 we pick it up at paragraph 88, first of all, towards the
 10 top of the page:
 11 "The example cited by [and the name is redacted
 12 but it's someone on behalf of The Haemophilia Society]
 13 is a simple and striking one. It is difficult to
 14 disagree that it highlights the inconsistency of the
 15 current position, especially given that the effects of
 16 hepatitis C can, when severe, be practically as
 17 devastating as those of HIV."
 18 Then paragraph 90 says this:
 19 "Having considered the issues raised in the
 20 petitions, the Committee has become persuaded by what we
 21 classified as the 'moral' case for providing financial
 22 assistance to those individuals infected with
 23 hepatitis C through blood transfusions."
 24 Then the Committee goes on to say that they're not
 25 advocating a transition to a complete no-fault

69

1 a mechanism for providing financial and other
 2 appropriate practical support to all hepatitis C
 3 sufferers who have contracted the virus as a result of
 4 blood transfusions provided by the NHS in Scotland, or
 5 which involve blood or blood products produced by the
 6 SNBTS."
 7 Then if we go to the next page, I won't read the
 8 recommendations in full, but paragraphs 2, 3 and 4
 9 provide as follows:
 10 "2. We recommend that this mechanism for
 11 providing financial and other support comes into
 12 operation within a period of twelve months.
 13 "3. The level of financial assistance awarded to
 14 any claimant should be determined on the basis of need,
 15 having regard to the physical or psychological loss
 16 individually suffered, and should include redress for
 17 practical difficulties such as the inability to obtain
 18 an affordable mortgage or life insurance."
 19 Then:
 20 "4. In determining an appropriate package of
 21 assistance, and in particular in clarifying what
 22 practical help can be offered, the Executive should
 23 consult hepatitis C sufferers -- both haemophiliac and
 24 non-haemophiliac."
 25 Now, before I ask you about that, can I just show

71

1 compensation scheme.
 2 At paragraph 91, they say this:
 3 "The Committee therefore wishes to stress the
 4 narrowness of the view to which it has come. We are not
 5 advocating the principle that all injury caused through
 6 NHS treatment should be compensated. Nor are we asking
 7 the Executive to establish any new, wide-ranging
 8 precedent on the management of risk in clinical
 9 decision-making. Instead we simply seek to correct
 10 an inconsistency in the operation of an already created
 11 and narrow precedent; namely the precedent create when
 12 the Macfarlane Trust was set up. We do not envisage
 13 that any ad hoc decision to provide financial or other
 14 help to individuals infected with hepatitis C through
 15 NHS treatment, would necessarily require the NHS to
 16 change any of its current medical policies and practices
 17 on risk arising from treatment."
 18 So, professor, it's right, isn't it, that the
 19 Committee did not share your view and the Department's
 20 view that this would establish a dangerous precedent?
 21 A. Yes, I think you can certainly conclude that from their
 22 report.
 23 Q. Then if we just go to the "Recommendations" on page 26,
 24 we can pick it up at the bottom of the page:
 25 "We recommend that the Executive set up

70

1 you an email you sent in response. It's at
 2 SCGV0000247_094. This is from you, 3 October 2001, to
 3 Mrs Falconer, copied to others. Paragraph 1:
 4 "You were right to emphasise in our initial
 5 response to this that we will require time to consider
 6 its recommendations! No surprises in the sense that we
 7 were expecting the Committee to recommend compensation
 8 for those who have contracted Hep C through blood
 9 transfusion and fall outside the terms of the Burton
 10 Judgment."
 11 Then you go on to make number of points. I don't
 12 think I need to take you through those. You suggest in
 13 paragraph 2 that the Committee has underestimated the
 14 difficulty in determining levels of compensation based
 15 on need.
 16 What do you recall of your response to and your
 17 thoughts about the Committee's report? I don't mean
 18 some of the finer points of detail, but the broad thrust
 19 of it, which is the Executive should set up a scheme for
 20 compensation and recommending something which went
 21 directly against the policy which the Executive and its
 22 predecessor had maintained for a number of years?
 23 A. Well, a number of observations if I may. First of all,
 24 going back to the report, it talks about haemophiliacs
 25 and probably recipients of blood transfusion feeling

72

1 wronged. As I pointed out yesterday and again today:
 2 those groups were not unique. There were other groups
 3 which we were aware of, and doubtless others that we're
 4 not aware of, who were interested in pursuing
 5 compensation. So the report, in using that phrase,
 6 doesn't acknowledge the wider context and possibility --
 7 nay, reality -- that others would come forward if
 8 a compensation scheme was set up for this group of
 9 individuals.

10 I've commented in my -- in paragraph 2 here on how
 11 you would go about setting up the difficulties in going
 12 about setting up such a scheme based on need. How would
 13 you define physical or psychological loss at individual
 14 level? I could already envisage real difficulties in
 15 defining categories of patients and the level of their
 16 suffering to be compensated.

17 So I guess my reading of the report was that it
 18 was slightly naive in its assumption that you could just
 19 set up a scheme and that would be very straightforward.

20 And I also think that their conclusion that they
 21 didn't want to compensate everybody who had been injured
 22 at the hands of the NHS, in their view -- they didn't
 23 want a compensation scheme that covered everybody, and
 24 that seemed to me rather illogical in singling out
 25 hepatitis C infected individuals as a special category

73

1 group. Part of it certainly was, as far as I could
 2 recollect, to get a better handle on the difficulties
 3 I've already mentioned, and are covered in paragraph 2
 4 here, of defining levels of compensation and I think at
 5 least part of the expert group's task was to try to
 6 better understand those difficulties.

7 **Q.** Can I ask you then to look at something you say in your
 8 witness statement more broadly on the question of
 9 compensation.

10 It's WITN5736003, and if we could go to page 60
 11 and it's the bottom half of the page.

12 You were asked in question 105 about some emails
 13 regarding the costs of a scheme. I'm not going to ask
 14 you about that. But you say in paragraph A105, third
 15 line:

16 "I regretted that the Burton judgment had forced
 17 a move away from the previous principal [*sic*] that no
 18 compensation was due where there was no negligence
 19 proven on the part of NHS."

20 Now the expression of regret about the Burton
 21 judgment is not, I think, a view that the Inquiry has
 22 heard from others so far in the course of its hearings.
 23 Why did you feel that way about a judgment of the High
 24 Court?

25 **A.** Because it seemed logical to me that the previous

75

1 for compensation when there were other groups of
 2 patients out there who would feel equally wronged and
 3 equally eligible for such compensation.

4 **Q.** And as far as you can recall, were your views about
 5 the Committee's report shared by your colleagues within
 6 the Scottish Executive and in particular within the
 7 Health Department?

8 **A.** As far as I can recollect, yes.

9 **Q.** Now the Government, as we know, the Scottish Government,
 10 didn't proceed to implementation of the Committee's
 11 recommendations. Instead, it set up what's been
 12 referred to in the Inquiry's hearings as the Ross Group
 13 or the Ross Committee. So the expert group under the
 14 chairmanship of Lord Ross.

15 Do you know why the Government went down that
 16 route rather than simply proceeding to implement the
 17 recommendations of the Health and Community Care
 18 Committee? And in particular, are you able to comment
 19 on a submission that may be made to the Inquiry that
 20 that was a delaying tactic?

21 **A.** My recollection of the setting up of the Lord Ross
 22 expert group is I really had very little to do with it.
 23 This was a matter for officials and legal advisers to be
 24 fully involved in. You would need to ask ministers what
 25 was in their minds in terms of setting up the expert

74

1 principle, that no compensation was due if there had
 2 been no negligence proven, was a sound one. And the
 3 Burton judgment clearly opened -- or exposed the NHS to
 4 much wider, a much wider range of liabilities ie,
 5 providing compensation where no negligence had been
 6 proven.

7 **Q.** Now, the Ross Committee or the Ross Group produced its
 8 preliminary report in, I think, September 2002 and it's
 9 HSOC00033499. I'm not going to take you through the
 10 detail of either the preliminary or the final reports,
 11 Professor Keel, but is it likely that you would have
 12 read these reports at the time?

13 **A.** Yes.

14 **Q.** What was, as far as you can recall, your view about what
 15 was being recommended by the Expert Group, in terms of
 16 compensation/financial support?

17 **A.** Well, I have no direct memory from that time. I mean,
 18 I've obviously read papers referring to the Expert Group
 19 and, certainly, the levels of compensation being
 20 proposed were perceived as rather high and therefore
 21 unaffordable. But I can't say that was my original
 22 thought. It's been derived from reading the papers.

23 **Q.** If we look at SCGV0000251_018, and we go to the second
 24 page, this is from Bob Stock, 29 January 2003, to the
 25 Minister who, by now, is, I think, Malcolm Chisholm.

76

1 It's copied to you, your name is on a long list of
2 recipients on fourth page. We can see what it records
3 in paragraph 1 is:

4 "To record and confirm the decision taken today to
5 inform the Health and Community Care Committee that the
6 Executive would be prepared to fund a scheme that would
7 make lump sum payments to those who now have Hepatitis C
8 as the result of receiving blood, blood products or
9 tissue from the NHS in Scotland."

10 Then reference is made in paragraph 3 and 4 to
11 there having been a brief discussion at Cabinet, and the
12 costing of a scheme, this is paragraph 4:

13 "On the basis of making lump sum payments of
14 £20,000 to all those who now have Hepatitis C -- with
15 a further £25,000 to those who have cirrhosis, liver
16 cancer or liver failure."

17 It's said:

18 "This was put forward, with the agreement of the
19 First Minister, to the Committee today."

20 So in terms of the chronology of events,
21 Professor Keel, we have the preliminary report in
22 September 2002 and then, whilst the final report is
23 awaited -- and it was published in, I think,
24 March 2003 -- the Minister makes an announcement along
25 the lines that we see referred here of a willingness to

77

1 Community Care Committee report.

2 So bearing in mind that decision to settle
3 outstanding legal actions brought under the Consumer
4 Protection Act, can I now ask you to look at a different
5 document which I hope you were provided with overnight,
6 Professor Keel. It's a very short document.

7 SBTS0000357_059.

8 This is from Bob Stock to Susan Murray, you,
9 Steve Lindsay, Brian McClelland, copied to Lynda Towers
10 and Angus Macmillan Douglas. The date is 29 June 2001,
11 and it's then headed "Scrutiny of Outstanding claims",
12 and it says:

13 "I propose primary recipients of this message
14 [which would include you] meet on Monday [2 July] to go
15 through the list of court actions which has been
16 prepared by CLO/SNBTS. The main purpose will be to
17 endorse the proposed categorisation into those where CLO
18 will enter into discussions with the legal
19 representatives of claimants -- and those where they
20 will not.

21 "Hopefully this will be a straightforward matter
22 but the Minister was anxious that the list is thoroughly
23 scrutinised (particularly by [Scottish Executive]
24 solicitors) before any letters are sent out."

25 It's a limited piece of material upon which to

79

1 fund a scheme that would make payments along these
2 lines.

3 Do you have any recollection of what your
4 involvement in that decision-making process was and in
5 what was obviously a change of position on the part of
6 the Scottish Executive?

7 **A.** I think my involvement was minimal. Clearly this was
8 a political decision made in Cabinet, and I don't
9 recollect being involved in any of the discussions
10 around it.

11 **Q.** Can I ask you to look at a document at DHSC0020742_071,
12 please. I think that's the right reference, Lawrence.

13 This is to take you back in time to 2001. If we
14 go to page 3, this picks up on the Burton judgment, and
15 we can see the first paragraph reads:

16 "In March 2001, the High Court in [England]
17 awarded damages", et cetera.

18 That's a reflection of Mr Justice Burton's
19 judgment. Then the second paragraph says this:

20 "Following the CPA High Court ruling, the Scottish
21 Executive announced in August [August 2001] a decision
22 to settle outstanding legal actions brought under the
23 Act by Scottish blood recipients infected with
24 hepatitis C."

25 Then there's a reference to the Health and

78

1 prompt your memory, Professor Keel, but do you have any
2 recollection of your involvement with the process
3 referred to here of deciding how outstanding claims
4 should be dealt with?

5 **A.** No, I don't and clearly I was only going to be at the
6 meeting for half an hour. So I think I infer from that
7 that my involvement was minimal, and not particularly
8 material to the discussion around eligibility of these
9 litigants under CPA to have a claim settled.

10 **Q.** Leaving aside this particular document, do you know
11 whether you had any broader involvement with providing
12 advice from a medical perspective about how individual
13 claims should be assessed and what approach should be
14 taken to the payment of compensation or otherwise?

15 **A.** No, I suspect that this discussion around whether they
16 should be settled or not was entirely on legal grounds
17 and not medical.

18 **Q.** We can take that down, thank you.

19 Now, in relation to events in 2003,
20 Professor Keel, we've looked at that document that
21 refers to the announcement in January 2003 of two levels
22 of financial support, the payment of £20,000 and the
23 payment of £25,000. I'm not going to take you through
24 lots of documents relating to 2003 but if I just give
25 you a very brief chronology and then I'll ask you about

80

1 it.
2 The Inquiry knows from other evidence that there
3 were discussions between Mr Chisholm and the Secretary
4 of State for Health within the UK Government, at that
5 point Alan Milburn. Advice was sought from Law Officers
6 as to whether Scotland could set up a financial support
7 scheme using its devolved powers or whether this was
8 a reserved matter.

9 Then in June 2003, Mr Milburn was succeeded by
10 Dr Reid, John Reid, as Secretary of State for Health in
11 the UK Government, and he took a different view in
12 relation to what the position should be in England,
13 resulting in a press announcement at the end of
14 August 2003 that England would be setting up a scheme.

15 Did you, as far as you can recall, have any
16 involvement with that process, so the process of going
17 to the Law Officers for advice, or discussions as to
18 what might be the position in England and the effect
19 that might have upon the schemes or a scheme in
20 Scotland?

21 A. I'm afraid I've no recollection of being involved in
22 those -- in that particular part of the chronology.

23 Q. Did you have any understanding in 2003 as to whether
24 that announcement we looked at, in January 2003 of the
25 20,000 and the 25,000, was it your understanding that

81

1 a highly invasive medical procedure, which carries
2 with it the risk of haemorrhage, which clearly in
3 haemophilia patients would be extremely serious. So it
4 was -- would not be a routine -- or an investigation
5 routinely embarked on in that group of patients.

6 So I had discussions with, I recall,
7 Professor Peter Hayes, who was the departmental adviser
8 in hepatology at that point, to see if there was any
9 other non-invasive test that might act as the trigger
10 for that second payment.

11 My recollection is that discussions with
12 Peter Hayes and more widely failed to yield any real
13 substitute for liver biopsy. So I think ultimately the
14 conclusion was that any diagnosis of cirrhosis would
15 have to be based on the available clinical information
16 from the consultants involved in that patient's care,
17 and their feeling, based on other, less specific tests,
18 as to whether the individual did indeed have cirrhosis.

19 So it was not a clear-cut trigger point,
20 particularly for haemophilia patients.

21 Q. I think we can see an example of the discussions that
22 were held at SCGV0001034_014. There's certainly some
23 earlier exchange with Dr Hayes in February 2003. This
24 now is, I think, October 2003 and it's reference to
25 a meeting on 10 October 2003.

83

1 that was -- fixed the parameters of a scheme in
2 Scotland, or was the position about what the payments
3 might be still -- still flexible and open for the
4 further consideration?

5 A. I don't recall. I mean, I imagine I thought that that
6 was broadly the framework with which we were going to
7 proceed. But with John Reid's change of direction south
8 of the border, I suspect the figures were further
9 discussed and refined.

10 Q. But you don't recall being party to those discussions?

11 A. I don't recall being part of that.

12 Q. You did, however, I think, have some involvement in
13 discussions about the medical trigger for the second
14 stage payment. We can look at two or three documents in
15 that regard, but before we do so, what do you recall
16 about the decision-making process in relation to that?

17 A. Well, clearly the second payment of £25,000 on the
18 diagnosis of cirrhosis was a key point in determining
19 the level of payment.

20 Now, the gold standard -- there is no other test
21 other than liver biopsy that really meets the criteria
22 for a definitive test to diagnose liver cirrhosis. And
23 I think I say in my written statement -- or highlight
24 the issues that that would have given rise to for the
25 haemophilia patients in particular. Liver biopsy is

82

1 If we go over the page, if we pick it up at the
2 bottom of the page -- this is a general meeting about
3 hepatitis C but then an issue is picked up at the bottom
4 of the page where it says:

5 "Aileen Keel acknowledged that in line with
6 David Goldberg's previous modelling work, the Executive
7 was working on an estimate of [and then '400' has been
8 crossed out and '253' put in] persons who may be
9 eligible for the higher level of ex-gratia payment of
10 compensation, having contracted their infection through
11 infection [*sic*] blood or blood products. Dr Keel
12 explained that she and Bob Stock were to meet with
13 colleagues in DH to work out a trigger for the 2nd level
14 of payment which could include up to 580 patients with
15 30% of these being paid in the first year. She
16 explained that it was not going to be easy to define the
17 trigger and that whatever was agreed would need to be
18 agreeable to the Haemophilia Society."

19 Then if we go to just, I think, one further
20 document, SCGV0000265_004, we've got here a meeting
21 which is then specifically focused on the ex gratia
22 payment scheme. This is 14 October 2003. It refers to
23 a number of people being present and the purpose of the
24 meeting is to discuss the medical trigger point for the
25 proposed higher payment.

84

1 Now, I'm not going to go through the detail of
2 what was discussed, but do you recall whether there was,
3 at this point in time, a series of meetings to discuss
4 issues relating to the parameters and the working out of
5 the ex gratia payment scheme or whether there were just
6 one or two such encounters?

7 A. I honestly can't remember.

8 Q. One of the issues regarding the scope of the ex gratia
9 payment scheme was the inclusion or otherwise of natural
10 clearers. Do you recall any involvement with that
11 decision-making process?

12 A. Well, I would have been involved because clearly it's
13 a clinical matter but, I mean, a lot of my recollection
14 in this area is -- has been jogged by reading the
15 papers, rather than actual recollection of the events
16 themselves.

17 Q. If we just look at one document, or possibly two, on
18 natural clearers, DHSC0004510_080, "Meetings of Skipton
19 Fund Teleconference -- 29 September 2004", and we can
20 see there are a number of attendees from different
21 departments, so you're there on behalf of the Scottish
22 Executive, as is Mr Stock. There are representatives
23 from the Welsh Assembly and from the Department of
24 Health in England, with an apology from the Department
25 of Health and Social Services in Northern Ireland.

85

1 first payment of 20,000.

2 Q. If we just look at -- so that I can finish this topic
3 before we break -- one further document.
4 DHSC0006798_072. This is from Mr Gutowski, so
5 Department of Health in London, 19 November 2004. It's
6 not copied to you, although it is copied to Mr Stock in
7 the Scottish Executive, and it's dealing with the issue
8 of spontaneous clearance.

9 If I could ask you to look at paragraph 3, and the
10 italicised passage below that. So Mr Gutowski records
11 in paragraph 3 that Claimants had made claims to the
12 Skipton Fund "outside the stated eligibility criteria"
13 and that the Skipton Fund had "held on to those claim
14 forms rather than reject them", and had asked for
15 further clarification.

16 Then he says this:

17 "We have asked them to include the following
18 explanatory paragraph in the letter:

19 "patients would only be eligible for the first
20 payment if (i) there was evidence they had developed
21 chronic hepatitis C infection but this had resolved
22 spontaneously (thought to be a reasonably rare
23 situation) or (ii) had developed chronic hepatitis C
24 infection but subsequently cleared the virus as a result
25 of treatment. Patients who had, or were thought to

87

1 If we go to the heading "2. 'Natural Clearers'",
2 we can see reference to Professor Lee being invited to
3 speak, and that's obviously Professor Christine Lee at
4 the Royal Free Hospital, regarding her concerns about
5 inconsistency in the reviewing of natural clearers by
6 clinicians.

7 The issue I have been asked, in particular, to
8 raise with you, Professor Keel, is why it was that
9 Professor Lee, a haemophilia clinician, not
10 a hepatologist or virologist, was being invited to
11 address the meeting on this particular issue, and what
12 weight was given to her views on the question of whether
13 natural clearers should receive payments or not --
14 sorry, in deciding whether natural clearers should
15 receive payments or not?

16 A. Well, again, I infer this from reading the document that
17 Christine Lee was concerned about inconsistencies,
18 I think, which related to the fact that, yes, further
19 down at 2.4, very, very late clearance of hepatitis C.
20 The 20 per cent who naturally clear the virus usually do
21 so within the first six months. So this case that she
22 was describing is very unusual and I imagine that she
23 was concerned about that and wondered whether such
24 an individual should be compensated or not, because the
25 majority of natural clearers were not eligible for the

86

1 have, eliminated the virus in the acute stage, when they
2 would most likely have been asymptomatic or when any
3 symptoms that did occur would have been short lived
4 because of the transient nature of the infection, would
5 not be eligible for this payment. It should be assumed
6 that the virus has been cleared in the acute phase
7 unless a robust medical evidence is cited that proves,
8 on the balance of probabilities, that the patient
9 experienced chronic infection ie infection that extended
10 after the first six months of illness."

11 The question I have been asked to ask you,
12 Professor Keel, is whether that requirement that there
13 be an assumption that the virus has been cleared in the
14 acute phase unless robust medical evidence is cited was
15 based on your advice?

16 A. I'm not at all sure that that's the case, but I think
17 this part about (ii) the Christine Lee issue, where
18 clearly she wanted to know whether her patient, who had
19 cleared the virus after 20 years, was eligible for
20 treatment, and the -- for payment. The conclusion was
21 yes, because obviously during that lengthy period, the
22 patient was suffering from chronic hepatitis, even
23 though eventually he or she -- well, he cleared it.

24 So I think that whoever crafted this, and I don't
25 think it was me, would be drawing on that earlier

88

1 meeting with Christine Lee and ensuring that those
 2 unusual patients who experienced chronic infection but
 3 eventually cleared the virus, were given payment, first
 4 stage payment, because they'd been suffering from
 5 a chronic infection over a long period of time.

6 **Q.** If we just look at DHSC0004520_057 -- I'm sorry for
 7 trespassing into lunch but I probably should have taken
 8 you to this first, and that's my fault, Professor Keel.
 9 This is a series of emails, and if we go to the
 10 third page there's an email from Bob, Bob Stock, to
 11 "Zubeda", and that's Zubeda Seedat in the Department of
 12 Health, London, and it says:
 13 "I have discussed this with Aileen and offer the
 14 following amendments."
 15 I don't think we can tell from this email exchange
 16 exactly what the amendments are, and then we see the
 17 passage set out and reference in that last sentence to
 18 "robust medical evidence".
 19 So it would appear from this that you had had some
 20 discussion with Mr Stock --

21 **A.** Yes --
 22 **Q.** -- and provided some advice on this issue?
 23 **A.** It would definitely appear that I contributed to the
 24 paragraph that we looked at previously. I don't think
 25 I wrote the whole thing ab initio, and it was an attempt

89

1 "We met with you last week to discuss and plan the
 2 arrangements for the second Better Blood Transfusion
 3 conference now set for 29 October 2001."
 4 If we just go to paragraph 2, under the heading
 5 "Discussion", the first sentence refers to what that day
 6 is going to focus on. Then picking it up in the third
 7 line of paragraph 2:
 8 "Despite work over the last three years, local
 9 audits still suggest that the use of blood components
 10 remains highly variable between clinicians and
 11 hospitals, and needed to be explored as a marker of
 12 surgical/clinical practice. Most importantly, and in
 13 the aftermath of the recent HCV ruling [obviously
 14 a reference to Mr Justice Burton's judgment], the risk
 15 of blood transfusion would need to be recognised up
 16 front and put in clear perspective for the public,
 17 patients and clinicians."
 18 Then paragraph 3:
 19 "The main issue therefore was about risk --
 20 scoping the risk of receiving blood components risk
 21 against effectiveness, communicating this to patients
 22 and the service in the context of the benefits, and
 23 reducing the risk through best clinical practice. This
 24 approach would require a full and honest partnership
 25 between the blood services and the public. It would

91

1 to clarify what was a confused situation, certainly in
 2 the context of Christine Lee's experience.

3 **MS RICHARDS:** Thank you.
 4 Sir, my apologies for running over beyond
 5 one o'clock. If we could take lunch now.

6 **SIR BRIAN LANGSTAFF:** Let's take lunch then and come back
 7 at 2.05. 2.05.

8 **MS RICHARDS:** Thank you.
 9 (1.05 pm)
 10 (The Luncheon Adjournment)
 11 (2.05 pm)
 12 **SIR BRIAN LANGSTAFF:** Yes.
 13 **MS RICHARDS:** Professor Keel, I wanted to ask you now about
 14 a separate topic the issue of Better Blood Transfusion
 15 and clinical practice relating to the use of blood and
 16 blood components.
 17 If we pick it up at DHNI0000013_052.
 18 This is a document dated 2 July 2001 from
 19 Mike McGovern, who was in the Department of Health in
 20 London. We can see who it's addressed to on the
 21 left-hand side, so I think that's a range of CMOs or
 22 DCMOs and page 4, we don't need to go to it, but shows
 23 that you were copied in on this document.
 24 It's headed "Better Blood Transfusion: Note of
 25 meeting with UK CMOs":

90

1 need to be based on an agreed recognition of the risks,
 2 a policy that did not promote blood transfusion as safe,
 3 and fully governed by informed consent."
 4 Then paragraph 4, just the first sentence:
 5 "The overall purpose of the day would be to
 6 publicise a new open up-front partnership between the UK
 7 NHS blood services and the public."
 8 Now, before we look at what happened following on
 9 from this discussion, and in particular the second
 10 Better Blood Transfusion conference, what can you tell
 11 us about any steps taken by SHHD in the 1990s to promote
 12 the better or safer use of blood and blood components?

13 **A.** Well, I recall that Brian McClelland and I -- he was
 14 a consultant with SNBTS based in Edinburgh -- we
 15 co-edited a report which came from CRAG, the Clinical
 16 Resource and Audit Group, which was a predecessor of the
 17 Clinical Standards Board for Scotland, on optimal use of
 18 blood. Now, unfortunately, I haven't revisited that
 19 report for years. I think it came out in the mid-'90s,
 20 and it was very much focused on reducing inappropriate
 21 use of blood and blood components.
 22 So that is one piece of work that was
 23 Government-sponsored, and would have been publicised
 24 through the Boards.

25 **Q.** In paragraph 2 of this minute which I referred to,

92

1 Dr McGovern says that local audits still suggest highly
2 variable use of blood components as between clinicians
3 and hospitals. Was that the case in Scotland as well as
4 the rest of the United Kingdom, that there was still
5 a problem here about the way in which blood and blood
6 components were being used?

7 **A.** Indeed. Yes.

8 **Q.** Then the other matter which this touches on in the
9 passages which I read out is the importance of ensuring
10 a clear and common understanding about the risks of
11 blood transfusion, and that might suggest that there had
12 not been such an understanding, a public understanding
13 at least previously. Again, would it be fair to say
14 that that was as applicable to Scotland as it was to the
15 rest of the United Kingdom?

16 **A.** Yes, it would be.

17 **Q.** Can I then ask you to look at a couple of documents,
18 then, which post-date the Better Blood Transfusion
19 conference referred to here.
20 SCGV0000096_014.
21 This is a minute from you to Mr Stock dated
22 28 June 2002, and it's obviously in anticipation of
23 a meeting of the MSBT. We don't need to look at most of
24 the material. If we just go to the third page, we can
25 see the last paragraph is headed "Better Blood

93

1 Health Service circular, SCGV0000098_179.
2 This is towards the middle of the following year,
3 we can see the date, 19 May 2003, and it's issued by the
4 Scottish Executive.

5 If we look down the right-hand side, bottom half
6 of the page, it says:

7 "General enquiries to:

8 "Dr Aileen Keel.

9 "Deputy Chief Medical Officer ..."

10 Then we can see the text of it:

11 "Dear Colleague

12 "1. Better Blood Transfusion Programme;

13 "2. Availability of imported fresh frozen plasma
14 from [SNBTS]; and

15 "3. SNBTS information leaflets on blood
16 products."

17 And the second of those obviously is in relation
18 to vCJD risks.

19 But the first paragraph refers to an annex
20 providing details of the Better Blood Transfusion
21 Programme now being progressed across NHS Scotland.

22 I'm not proposing to go to any further
23 documentation but can you tell us in very general terms,
24 the kind of steps that were taken in Scotland in
25 relation to the Better Blood Transfusion Programme at

95

1 Transfusion", and it says:

2 "Apparently the HSC on this is to issue during the
3 first week in July."

4 That's Health Service circular, I assume.

5 "Clearly we will have to think about producing
6 a Scottish equivalent, which hopefully will be able to
7 point to proper funding for the effective use of blood
8 project!"

9 Now, I'll show you in a minute the circular that
10 was produced in Scotland, but can you assist us in
11 understanding the reference to "the effective use of
12 blood project" and "proper funding" for that project?
13 What was that?

14 **A.** What ultimately transpired was a Better Blood
15 Transfusion Programme, which needed a programme manager
16 and people to implement its recommendations in the
17 Service. So clearly funding would be needed, because
18 this was additional work for the Service. So I can't
19 remember whether that funding was ultimately found from
20 within the SNBTS allocation or whether additional
21 funding was provided from the centre for the project,
22 but I suspect it was the former. But whatever the
23 funding mechanism was, it was clearly identified as
24 a need and found.

25 **Q.** Then just to complete the picture in relation to the

94

1 this time?

2 **A.** Yes. Well, as I say, a proper program was set out,
3 programme manager appointed, and I say in my written
4 submission I recall him as a very energetic and
5 effective programme manager. And reporting to him,
6 there were 18 nurses appointed throughout the country to
7 lead small teams within hospitals to spread the word
8 about the need for more appropriate use of blood and
9 blood products.

10 We also established our steering group, which was
11 chaired by a cardiac surgeon actually from Aberdeen,
12 which oversaw the programme over a period of years.

13 **Q.** For the benefit of others, I won't take time going to it
14 but there's a newsletter from the Better Blood
15 Transfusion Programme towards the end of 2003 which
16 gives some details of the programme, and it's at
17 SCGV0000098_124.

18 Professor Keel, you'd been obviously working in
19 the field of haematology clinically throughout the
20 1980s. Do you have any recollection on clinical
21 practice -- or, sorry, reflection on clinical practice
22 in relation to the use of blood and blood products
23 during that time, in the context of the kind of issues
24 then later explored through the effective use of blood
25 project in the Better Blood Transfusion Programme?

96

1 A. Yes, I think broadly, the perception of blood amongst
2 non-specialists was that it was a very safe product and,
3 of course, it was and is, but not 100 per cent safe, as
4 this Inquiry knows very, very well. But amongst
5 clinicians, I think the perception in general was that
6 it was an entirely safe thing to do to transfuse
7 a patient. So for example, in contrast to today's
8 practice, patients would often be "chalked up" following
9 surgery in a way that wouldn't be done now unless the
10 haemoglobin level had really fallen much lower than the
11 trigger points used in those days.

12 So perceptions amongst the general clinical
13 professionals have changed radically over the last 20 or
14 30 years. When I was training and practising as
15 a junior doctor, blood was used much -- well, much more
16 widely, particularly in the area of surgery, or even,
17 for example, patients coming into the general medical
18 wards with anaemia. I mean, nowadays we would withhold
19 blood. We'd identify the cause of the anaemia, treat
20 it, and only if the haemoglobin was very low would blood
21 transfusion be used as a means of getting it up.

22 Q. I'm going to turn now to the issue of vCJD. Now, you
23 were provided with a lot of documents in relation to
24 vCJD and you referred to a significant number of them in
25 your statement, and I'm not going to take time going

97

1 colleagues at this time in the late 1990s; do you have
2 any recollection of that?

3 A. Well, I think the way that I thought about it, and
4 I think I was not alone by any means in this view, is
5 that the patient's right to know, which is extremely
6 important, nonetheless needs to be set in context. But
7 what we're talking about here was an absolutely
8 devastating diagnosis for anybody to be given:
9 universally fatal, no diagnostic test apart from [audio
10 disruption] treatment. And what we were dealing with in
11 the context of blood transfusion was a highly
12 theoretical risk.

13 The evidence here was -- well, there was no
14 evidence, it was a theory that blood transfusion might
15 be a means of transmitting the variant CJD organism.

16 So, against that background, I agreed with
17 Ian Kennedy's advice that we shouldn't be burdening
18 individuals with the worry or concern -- those aren't
19 adequate words. I mean, I can imagine myself being
20 given that news that I'd received an implicated blood
21 donation, it would have been one of great distress. So
22 that was the thinking behind my views and, obviously,
23 Ian Kennedy's views.

24 Q. Now, we know that as matters proceeded, there were
25 certain notification exercises, as I think they've been

99

1 through those, not least because in terms of the
2 national UK-wide picture in relation to vCJD, the
3 Inquiry has already received quite a lot of evidence.
4 I just want to ask you about, really, a couple of
5 issues.

6 The first arises from your statement, WITN5736003,
7 page 27. It's the bottom half of the page. You were
8 asked a question at question 50 about an MSBT meeting,
9 in fact a meeting that you were not at, and advice from
10 Professor Kennedy that recipients of blood from a CJD
11 patient should not be informed. You were asked your
12 view and you say this -- you weren't at that meeting
13 you, as far as you can remember, you were unaware of
14 Professor Kennedy's advice until reading the minutes --
15 but then you say this:

16 "I agreed with his view. It seemed to me that
17 telling individuals that they **might** be at risk of
18 an infection which had a universally fatal outcome, but
19 no diagnostic test and certainly no treatment, would not
20 be the right thing to do."

21 Now, set against that might be the idea that
22 that's -- and I don't mean this pejoratively -- but
23 a paternalistic approach: there's the patient's right to
24 know, issues of autonomy. To what extent was that
25 weighed as part of your thinking or the thinking of your

98

1 termed elsewhere. Again, I'm not proposing to go
2 through the detail of them. Some of the documentation
3 is referred to in your statement and the Inquiry has
4 a wealth of information on that issue.

5 But do you again recall your own views as time
6 went on, about some categories of patients, at least in
7 due course, being notified of the possibility of having
8 received implicated products? In other words, did your
9 views change?

10 A. Well, I think you may be referring to a question that
11 I was asked further on in this statement around the
12 names of individuals being on a central registry without
13 their consent.

14 It seems to me, as in so many other areas relating
15 to blood transfusion, the thinking involved over
16 a period of time between 1996, when variant CJD was
17 first identified, through the following decade or so,
18 and part of that thinking evolution was thinking around
19 the ethics of retaining data centrally on individuals
20 who had received implicated products and whether that
21 was the right thing to do or not.

22 And I think my -- I think my thinking was along
23 the lines of: they should at least be given the
24 opportunity to know more about the situation.

25 Q. Can we turn to the next page, and this is a slightly

100

1 different topic in relation to vCJD. We can pick it up
2 in the bottom half of the page. So we can see in that
3 first paragraph on screen reference to plans in relation
4 to the introduction of leukodepletion of blood donations
5 and then, in 1999, the use of UK plasma in the
6 manufacture of blood products being abandoned. Then you
7 say this:

8 "In December 1997 a policy of withdrawal/recall of
9 blood components and tissues from patients who had gone
10 on to develop vCJD was instituted. Over subsequent
11 years, additional precautionary measures were
12 introduced, including deferral of previously transfused
13 donors in 2004."

14 Now, you've referred there to precautionary
15 measures and certainly that's the concept that appears
16 throughout a lot of the documentation relating to the
17 decision making regarding vCJD in the material that
18 you've been supplied with. Did you, at the time, as far
19 as you can recall, have any particular views about
20 whether the precautionary approach, in introducing the
21 kind of measures that you've referred to here, whether
22 that was the right approach or whether too precautionary
23 an approach was being adopted?

24 **A.** I certainly had supported a precautionary approach. But
25 I do think that the risks, such as they were, were

101

1 plasma, its operations had changed radically, but it was
2 still fractionating plasma, albeit from abroad. So
3 I don't think, in my memory, there was ever any ruled
4 out as to the future of the PFC and, you know, that
5 would not anyway, or should not anyway have stood in any
6 way in the path of precautionary measures.

7 **Q.** The last issue in relation to vCJD I wanted to ask you
8 about is this: the Inquiry has heard evidence from
9 individuals who had been informed that they may be at
10 risk, having received an implicated product experiencing
11 difficulties in accessing medical and surgical
12 treatment, being put to the bottom of lists, issues
13 relating to the sourcing of surgical equipment for the
14 purposes of medical procedures and the like, and
15 I should say that's not specific to Scotland. That,
16 again, appears to have been a concern UK-wide.

17 Were you aware of that difficulty, and do you know
18 whether any particular steps were taken by the Scottish
19 Executive to try to address that problem?

20 **A.** Well, I was very aware of the issues arising from the
21 need to manage patients who were considered at risk of
22 variant CJD because they'd had human growth hormone
23 treatment or dura mater patch or whatever. I mean,
24 there was really a dual system set up to deal with them
25 in terms of surgery, in that special surgical sets were

103

1 perceived as greater, for example, in relation to whole
2 blood and blood components than to fractionated blood
3 products. And albumin comes to mind. I think as part
4 of the raft of measures to abandon use of UK plasma, of
5 which albumin is a product, a very frequently used
6 product in the NHS, in that -- the suggestion was that
7 we should stop using UK-sourced albumin.

8 Now, albumin has, because of the way it's
9 manufactured, an incredibly safe track record, had never
10 been known to transmit anything in the way of viruses or
11 other infections. So I felt that the precautionary
12 principle was entirely appropriate in relation to whole
13 blood and blood components but perhaps could be more
14 nuanced in relation to fractionated products.

15 **Q.** Is it right to understand from the documentation that
16 there was a particular concern in Scotland about the
17 implications of this raft of precautionary measures for
18 the future of the PFC, and from time to time it appears
19 those concerns were voiced with you and you were asked
20 to raise them, albeit, as I understand it, decision
21 making effectively was on a UK-wide basis, so Scotland
22 didn't take, in practice, a different course. Was that
23 an issue that you recall coming to the fore at all?

24 **A.** I don't recall ever being concerned about the future of
25 the PFC. Certainly in the light of the ban on UK

102

1 used for those patients clearly identified and sent for
2 sterilisation separately.

3 There was a greatly increased emphasis on use of
4 single-use instruments, disposable instruments, rather
5 than re-sterilisation, because even the sterilisation
6 processes were certainly not, from the beginning,
7 adequate to get rid of the prime protein that was
8 associated with vCJD transmission. So, in parallel with
9 all that was happening in hospitals, there was loads and
10 loads of research going on in terms of decontamination
11 of surgical instruments.

12 So it certainly added to the operational burden on
13 the NHS having to manage these patients in very specific
14 and -- in a way that enhanced the safety of the whole
15 system.

16 **Q.** I'm going to move now to a separate topic, which is the
17 question of public inquiries. It's right, I think, to
18 understand that throughout the 1990s and into the 2000s
19 the policy of the Scottish Home and Health Department,
20 continued by the Scottish Executive, was that there
21 should not be a public inquiry into the circumstances by
22 which people had come to be infected through blood and
23 blood products; that's right, isn't it?

24 **A.** Yes.

25 **Q.** What was your understanding, in broad terms, of the

104

- 1 reasoning for the maintenance of that line?
- 2 **A.** I think, in the main, that there had been examination in
3 various fora, including the internal departmental report
4 that we talked about earlier, there'd been examination
5 of the issues in some depth, and no new evidence had
6 emerged which ministers felt merited a public inquiry.
- 7 **Q.** It could be said that there's a degree of circularity to
8 that position, because it may only be through the
9 holding of a public inquiry, with its powers to call for
10 evidence from a wide range of sources and scrutinise it,
11 that such evidence might come to light. Do you have any
12 observation on that?
- 13 **A.** Of course you're right, it could be that additional
14 information would have emerged in the course of a public
15 inquiry. But the view held at that point was that it
16 wouldn't be appropriate, because the evidence as
17 available at the time that the calls for public
18 inquiries were being generated had been examined, and
19 that it would only be if additional evidence emerged
20 that a public inquiry might augment, improve or enhance
21 that evidence gathering?
- 22 **Q.** Leaving aside the internal investigation that we looked
23 at before lunch, in what other ways had these issues
24 been examined in Scotland?
- 25 **A.** I'm not sure I quite understand the question.

105

- 1 Minister of State for Public Health in England] was
2 particularly concerned that this issue should not be
3 forced in England because of decisions in Scotland.
4 "7. We have consulted Dr Aileen Keel DCMO in
5 Scotland. Advice from SE officials to Scottish
6 Ministers continues to be very strongly against holding
7 a public inquiry. The Executive is examining the
8 validity of a vote in the Scottish Parliament Health
9 Committee in support of a public inquiry. It is
10 understood that the casting vote of the Chairman may be
11 disallowed."
- 12 First of all, do you know anything about that
13 latter issue there, about the voting issue?
- 14 **A.** No, I don't.
- 15 **Q.** So it is, I think, clear from this document that as at
16 mid-2006, the Scottish Executive position and your own
17 views on the issue remained the same: strongly or very
18 strongly against holding a public inquiry; is that fair?
- 19 **A.** Yes.
- 20 **Q.** Was the question of holding a public inquiry at this
21 time or any earlier time ever looked at from the
22 perspective of wanting to understand how it could be
23 that so many people were infected and dying, or had
24 died? In other words, did the sheer scale of what had
25 happened not give rise to sufficient public concern to

107

- 1 **Q.** You referred to there having been examination in various
2 fora, including the internal departmental report, and
3 you said there'd been an examination of the issues in
4 some depth.
5 If we leave aside the internal investigation
6 report, because of course that had a very specific
7 scope, what other fora do you have in mind in giving
8 that evidence?
- 9 **A.** Well, I suppose there's reference in an earlier
10 document, which I think you called up, to DH having
11 looked at such issues over the years. You know, the
12 Advisory Committee structure, ACVSB, latterly MSBT, had
13 also examined -- well, had looked at all of the issues
14 over the years. I think that's what I had in mind. But
15 obviously the internal inquiry on the specific issues of
16 Factor VIII safety had gone into that in some detail.
- 17 **Q.** Then if we look at DHSC0041159_205.
18 This is an internal Department of Health minute,
19 not copied to you, dated 20 May 2006, and it's from
20 Gerard Hetherington. I just want to ask you about
21 something on the second page which refers to you. So if
22 we look at the bottom of the second page, we have the
23 heading "Demand for a Public Inquiry":
24 "6. Ministers pointed out that demands for
25 a public inquiry were intensifying. MS(PH) [the

106

- 1 justify the establishment of an inquiry?
- 2 **A.** I don't know what the criteria are for setting up public
3 inquiries but I guess maybe scale of problem might be
4 one of them but, again, I'm not sure that the scale of
5 the issue here, while of course absolutely horrendous
6 for those who contracted viruses through blood and blood
7 products, I'm not sure that I agree that it was on
8 a massive scale.
- 9 **Q.** We know, of course, that in due course in Scotland the
10 Penrose Inquiry was instituted and we saw yesterday that
11 you'd given evidence to the Penrose Inquiry. Did you
12 have any role in giving advice in the decision-making
13 process that led up to the decision to establish that
14 Inquiry?
- 15 **A.** Well ...
- 16 **Q.** As far as you can recall?
- 17 **A.** I can't recall clearly, but I'm sure my advice would
18 have been sought.
- 19 **Q.** I don't think we've got any particular documentation
20 that answers that or provides any further information in
21 regard to that.
22 Once the Penrose Inquiry was established and up
23 and running, obviously you gave evidence, as we saw, on
24 the issue of look-back. Did you have any other role in
25 relation to the Inquiry in the course of it, in terms of

108

1 giving advice on matters related to the Inquiry?
 2 A. Not that I recollect.
 3 Q. One of the issues that's been explored with other
 4 witnesses is the difficulties that might arise if a body
 5 that might itself be criticised if there were to be
 6 a public inquiry is the body charged with deciding if
 7 there should be a public inquiry, and an issue that's
 8 been explored with other witnesses is whether there
 9 should be an independent body or independent position
 10 that might be able to either take the decision as to
 11 whether there should be a public inquiry or provide
 12 advice, at least, in that regard. Do you have any views
 13 on that suggestion?
 14 A. Well, I haven't thought about it before now but I guess
 15 that such a body would have to draw up the criteria
 16 that I mentioned earlier around what would trigger
 17 a public inquiry. So I suppose there might be some
 18 benefit in that.
 19 Q. Just a couple of then miscellaneous issues -- I don't
 20 mean to undermine their importance by describing them in
 21 those terms -- that I wanted to ask you about now.
 22 If we go, please, to SCGV0000246_051. This is
 23 a minute from you, 18 June 2001, to the Chief Medical
 24 Officer. It's triggered by, again, I think, the Burton
 25 judgment but I'm not going to ask you about that case

109

1 I think that probably -- not probably, definitely -- in
 2 years gone by, led to a lack of openness with the
 3 patient about what exactly, you know, was happening.
 4 And certainly it's only in, I would say, the last
 5 20 years or so that we've begun to talk about coming to
 6 joint decisions with the patient, rather than the doctor
 7 handing down on high to the patient what is going to be
 8 done.
 9 Now, I think that is exactly the way things should
 10 be but, nonetheless, it is still not an infrequent
 11 occurrence that a doctor will have a conversation with
 12 a patient and say, "Well, we could do course A or
 13 course B, what do you think?" and for the patient to
 14 turn round and say, "Doctor, you know best, so you
 15 decide".
 16 However, that doesn't take away from the fact that
 17 having the conversation, giving the patient the option
 18 to share more fully in the implications of their
 19 diagnosis and what treatment or treatments are on offer
 20 is absolutely the right thing to do.
 21 So I think that this comment here about more
 22 openness in general in the NHS, and that trend, is just
 23 consistent with the trend in general society.
 24 Q. The next topic I want to ask you about relates to
 25 documentation and issues about what files were retained

111

1 itself. But paragraph 1 says:
 2 "As you can see from the attached, I raise the
 3 issue of the possible need for a public education
 4 campaign arising from this judgment ..."
 5 Then if we go to paragraph 3:
 6 "I think I am fairly clear in my own mind that
 7 while public education campaigns will not remove
 8 liability in such cases, they may well reduce it. In
 9 any case, such a policy is consistent with the trend
 10 towards greater openness in general in the NHS."
 11 I wanted to ask you about that general issue that
 12 you referred to there: the trend towards greater
 13 openness in the NHS. Now, that might suggest that there
 14 had not previously been as much openness in the NHS as
 15 perhaps there could or should be, would that be a fair
 16 inference to draw?
 17 A. Yes, I think the NHS in, let's say, the first 50 years
 18 of its existence, was a thing of its time. Society was
 19 much less open in those days than it is nowadays. So
 20 the NHS was simply a reflection of society. Our
 21 thinking, as I said a while ago, of course, has evolved
 22 immensely over the decades. You use the word
 23 "paternalistic" in reference to a comment that had been
 24 made earlier by somebody, I think a non-medical but the
 25 medical profession is often accused of paternalism, and

110

1 and by whom. I don't know whether you're going to be able
 2 to cast much light on the issue in light of the limited
 3 material available but I just want to ask you about it.
 4 If we go, first of all, to SCGV0000170_150, please.
 5 So this is from you to Mrs Towers, 24 September
 6 1999. And so, in terms of timing, it's whilst the
 7 internal investigation is ongoing and you say this:
 8 "In the course of our investigations in this area
 9 it has emerged that Professor John Cash ... took him on
 10 his retreat some files which may be relevant, which he
 11 has 'gifted' to the Royal College of Physicians in
 12 Edinburgh. Both Angus Macmillan Douglas and I have
 13 tried without success to persuade him that it would be
 14 much more convenient to allow SNBTS and Departmental
 15 staff access to the files in another location, eg
 16 St Andrew's House. Professor Cash is extremely
 17 resistant to this idea, for reasons best known to
 18 himself. In the course of our conversation he actually
 19 said to me that the files now belong to the College!
 20 I said that I did not see how that could be, but that
 21 I could seek your advice on the question of ownership."
 22 We saw from a document that we looked at earlier
 23 that obviously some files from Professor Cash did become
 24 available because we saw Christine Dora's comments on
 25 them, but what, if anything, do you recall about the

112

1 issue thrown up by this minute, the documentation that
2 had been retained by Professor Cash and your ability to
3 access that?

4 **A.** At the risk of sounding flippant, what it really reminds
5 me of is John Cash's desire always to be mysterious and
6 to hold in his ownership something that others don't
7 know about and I think the files are an example of that.

8 Again, my recollection, although it's hazy, is
9 that the files, actually, when we finally got our hands
10 on them, added nothing to the sum total of knowledge
11 here. But of course we had to try to get hold of them
12 and actually it should have been much more
13 straightforward than it was because the files did not
14 belong to Professor Cash, they were not in his gift to
15 give to the College of Physicians, and he should just
16 have handed them over to us.

17 **Q.** And as I say, I think it's right to understand from
18 later documents -- I don't think we need to put them on
19 screen but I'll just read an example into the
20 transcript, SCGV0000173_044 -- that there were then
21 files handed over by Professor Cash which were looked at
22 in the course of the investigation.

23 Then I'd asked you earlier about your involvement
24 in the Penrose Inquiry. When the Penrose final report
25 was produced, I think you were still, just, the Acting

113

1 of CSA did conduct needs assessment. However, I can't
2 be confident that the needs of those affected by this
3 virus were part of that collective endeavour. However,
4 I do recall that in terms of practical support short of
5 providing financial support, that we did engage with the
6 ABPI over the difficulty that some individuals with
7 hepatitis C were encountering in relation to life
8 insurance and mortgages, and I know that we also
9 explored with the NHS their access to whatever
10 treatments -- it would have been interferon at the
11 beginning -- were available to treat the condition.

12 **Q.** Then, Professor Keel, looking back now, is there any
13 aspect of the Scottish Government's response to those
14 infected and affected that you consider was misjudged or
15 wrong?

16 **A.** While notwithstanding the existence of this Inquiry and
17 certainly notwithstanding the compen -- or the financial
18 support that has been provided for these patients, and
19 fully recognising the fact that they have been through
20 significant physical and mental problems arising from
21 their infection, I still believe that the logic here
22 would have been not to set up a financial assistance
23 scheme specifically with this group of patients, because
24 it elevated their problems to a higher level than many
25 other groups, who were pursuing -- equally justifiably,

115

1 Chief Medical Officer. April 2015 was when you ended
2 that role. Were you involved in advising the Scottish
3 Government about the Inquiry report and its one
4 recommendation and how that should be implemented, as
5 far as you can recall?

6 **A.** Yes, I think I was, before I moved out of Government.

7 **Q.** And in broad terms, do you recall the nature of the
8 advice that you provided in relation to the Penrose
9 Inquiry report?

10 **A.** Well, the only thing that sticks in my mind is the one
11 recommendation, and the advice would have been that that
12 was already or had already been implemented, ie the
13 offering of an HCV test to anyone who was concerned that
14 they may have contracted the virus through blood
15 transfusion.

16 **Q.** Two final questions, Professor Keel, from me. The first
17 is this: during the time you worked in your governmental
18 position, so from 1992 through to 2015, was any
19 assessment ever undertaken by Scottish Home and Health
20 Department, Scottish Executive, Scottish Government,
21 into the needs of the infected and affected communities
22 in Scotland?

23 **A.** I'm not absolutely sure. However, needs assessments
24 were conducted by various other agencies, if you like.
25 For example, Health Protection Scotland and other bits

114

1 seeking compensation for other ills that the NHS
2 allegedly had inflicted on them. I didn't see the logic
3 in that.

4 And in terms of public inquiries, well, I mean,
5 I hope this one will indeed shed further light on the
6 issues but, at the time that the public inquiry was
7 being resisted in Scotland, I believed and I still
8 believe that, at that stage, no additional evidence had
9 emerged that would have merited a public inquiry and,
10 therefore, I think that, at that stage anyway, it would
11 not have been appropriate for Scotland.

12 **MS RICHARDS:** Those are the questions I am proposing to ask
13 Professor Keel, sir. We obviously need to give
14 an opportunity to Core Participants through their legal
15 representatives to suggest any further lines of
16 questioning.

17 Could I ask that we take a slightly longer break,
18 having finished earlier than our normal break time.
19 Could we take 45 minutes?

20 **SIR BRIAN LANGSTAFF:** Yes, certainly.

21 Let me explain. Those who are participating in
22 the Inquiry have a right, through their Recognised Legal
23 Representatives, to put questions through counsel to
24 you. Plainly, they have to be given an opportunity to
25 formulate those questions in the light of everything

116

1 that you have said and, since you have only just
 2 finished, they have to be given time to do that.
 3 I don't know how long that will be, I don't know how
 4 many questions there will be, but your evidence has been
 5 of such interest I wouldn't be surprised if there are
 6 quite a lot. We'll find out.
 7 But we won't sit again until 3.40. We may not sit
 8 then if there are questions coming in still or questions
 9 coming in late, so we won't sit before 3.40, in other
 10 words you're free completely until then, and then
 11 I can't tell you how long you'll be detained after that.
 12 It depends how long it takes for the various issues
 13 raised by the questions to be properly ventilated. But
 14 that's what we'll do.
 15 3.40, not before 3.40. You'll be told, of course,
 16 if it's going to be any later.
 17 **MS RICHARDS:** Thank you, sir.
 18 **A.** Thank you.
 19 **(2.56 pm)**
 20 **(A short break)**
 21 **(3.44 pm)**
 22 **SIR BRIAN LANGSTAFF:** Yes.
 23 **MS RICHARDS:** Professor Keel, the questions I'm going to ask
 24 now, because they've been suggested on behalf of
 25 Core Participants, may dot around from topic to topic

117

1 Scottish Executive's position was that those patients
 2 were misremembering or providing the investigation with
 3 unreliable information?
 4 **A.** We certainly didn't disbelieve them, but there seemed no
 5 easy way of proving that they hadn't been told -- double
 6 negative there, sorry -- but I can see where you're
 7 heading. You're suggesting that we were inconsistent in
 8 our approach to the evidence or the allegation that
 9 the -- the evidence that the consultants presented,
 10 which I have already acknowledged was patchy because of
 11 the lapse of time between the mid-'80s and 2000 when the
 12 Inquiry was taking place.
 13 They said, and we believed them, that there was
 14 patient literature available in the mid-'80s which
 15 patients had access to, but we weren't able really to
 16 lay our hands on that.
 17 So there was a lack of confirmatory evidence,
 18 really, on both sides, I suppose. But we certainly
 19 didn't disbelieve the patients.
 20 **Q.** The next question requires you to cast your mind back to
 21 the time you were working in Glasgow with
 22 Professors Forbes and Lowe. Were you involved in the
 23 testing of immune function deficiencies in bleeding
 24 disorder patients in Glasgow in 1983 or 1984?
 25 **A.** No.

119

1 rather than following a single thread at any one time.
 2 The first question arises out of the issues of
 3 Better Blood Transfusion and educating clinicians on the
 4 better use of blood. Was there resistance from
 5 clinicians to the Scottish initiative to ensure the
 6 better use of blood?
 7 **A.** Not that I recollect.
 8 **Q.** And then turning next to the internal investigation
 9 report, we explored the question of whether, for
 10 example, patient records could have been looked at.
 11 Would it be your expectation that it would be recorded
 12 in patient records that a patient had been informed of
 13 a positive test result?
 14 **A.** Certainly in the case of HIV I would expect that to be
 15 recorded in the notes, because explicit consent was
 16 needed for taking blood for HIV. As far as HCV is
 17 concerned, I can't be confident that it would uniformly
 18 be recorded that the patient knew the result.
 19 **Q.** And then I explored with you when we were considering
 20 the internal investigation the Scottish Executive's
 21 acceptance of the evidence provided by consultants, in
 22 terms of the information that was provided to patients.
 23 Does it follow from that acceptance that the Scottish
 24 Executive disbelieved the patients who said that they
 25 had not been provided with information, or that the

118

1 **Q.** And did you have any awareness at that time of the
 2 thinking that immune deficiencies might be indicative of
 3 HTLV-III positivity due to exposure to factor
 4 concentrates?
 5 **A.** No, that was not something that crossed my mind.
 6 **Q.** I asked you, when we were looking at the look-back,
 7 about the request that had been made by Dr Ludlam
 8 regarding DEFIX. Over what time period, roughly, as far
 9 as you know, was DEFIX used for reversing the effects of
 10 warfarin?
 11 **A.** Gosh, um, I can't even remember when DEFIX was first
 12 produced. In the '80s, I guess. Over a period of many,
 13 many years. I mean, it was -- my recollection was it
 14 was still being used in -- certainly in the '90s I don't
 15 know about current practices because I'm not up to date
 16 on that.
 17 **Q.** Would SNBTS not have records of the hospitals to which
 18 DEFIX had been supplied for this purpose?
 19 **A.** Yes, they would. However, that doesn't mean that there
 20 was a record of which patients received the DEFIX
 21 because I think I mentioned yesterday there was no
 22 prescribing database which was set up for DEFIX
 23 prescriptions to ascertain whether the DEFIX that had
 24 come from SNBTS to a particular hospital had gone into
 25 a particular patient. It would have meant trawling

120

1 through patient records, probably many thousands, tens
2 of thousands of them.

3 **Q.** In relation to I think your earlier evidence that there
4 might be tens of thousands of patients treated in that
5 way, as DEFIX was a pooled product and not heat treated
6 until October 1985, does this mean that there are
7 potentially thousands of patients who were HCV-infected
8 as a result of this treatment, and some who may have
9 been infected with HIV as a result of that treatment?

10 **A.** I guess those possibilities can't be excluded.

11 **Q.** And was that issue ever investigated by the Scottish
12 Health Service or the Scottish Health Department, to
13 your knowledge?

14 **A.** Not on a population basis, but I suspect that if
15 a patient treated with non-heat treated DEFIX appeared
16 to be suffering from hepatitis, then the clinician
17 looking after them would have been monitoring them, and
18 then, maybe when the test appeared, testing them for
19 HCV.

20 **Q.** Can I ask you next about the line to take, or the policy
21 position that we see articulated in the various
22 briefings about the best available treatment in the
23 light of medical knowledge at the time.

24 Now as I think I may have mentioned,
25 Professor Keel, when I asked you about that first of

121

1 that it didn't transmit non-A, non-B, it wouldn't have
2 been available in sufficient quantities to supply
3 Scotland. So clearly NY transmitted HCV. There's no
4 doubt about that. Anybody who got it, got hepatitis C.
5 But the risks of transmission of that virus, which
6 hadn't even been identified at the time, were, in the
7 views of clinicians, outweighed by the benefits from
8 using that product, which, as I've already said on more
9 than one occasion, were potentially life saving.

10 **Q.** You told us your understanding that the mean age of
11 haemophiliacs in the '60s was 37. To what severity of
12 haemophilia patients --

13 **A.** Of death.

14 **Q.** I'm sorry?

15 **A.** Mean age of death.

16 **Q.** Yes, I'm sorry, you're absolutely right. To what
17 severity of haemophilia patients did that statistic
18 apply in your understanding?

19 **A.** It would have been severe haemophiliacs, maybe some
20 moderate were in that. I don't know how the number was
21 calculated.

22 **Q.** And can you recall what the source of your knowledge was
23 in relation to that issue?

24 **A.** No, I can't, sorry.

25 **Q.** And is there any evidence that you can point to

123

1 all, that is a line that we've seen in Department of
2 Health material as well, as in the Department of Health
3 in London. Do you know what the origin, from the
4 Scottish perspective, was of that particular line to
5 take?

6 **A.** No, I don't know what the origin was.

7 **Q.** Were the commercial factor concentrates given to the
8 children at Yorkhill the best available treatment in
9 light of medical knowledge at the time?

10 **A.** I suppose with hindsight the answer is no. That was
11 Dr Willoughby's preferred clinical practice, and he
12 would definitely have had views on the relative safety
13 of those products compared with the SNBTS products. But
14 he also had views, I think I mentioned this yesterday,
15 on the ease of administration to paediatric patients of
16 the PFC product, and my recollection is he felt that the
17 commercial products were easier to make up in volumes
18 appropriate for children.

19 **Q.** Was the PFC product NY the best available treatment in
20 light of medical knowledge at the time for a previously
21 untreated or minimally treated patient in 1986?

22 **A.** Well, again with hindsight, clearly not. But in that
23 chronology, the only safer product would have been 8Y,
24 which, as we discussed this morning, was not available
25 in sufficient quantities. Even if we had known for sure

122

1 demonstrate that haemophiliacs would have died if they
2 did not receive Factor VIII concentrates as opposed to
3 treatment with cryoprecipitate?

4 **A.** Again, I think we partially covered this this morning.
5 In the event of a potentially life-threatening bleed,
6 such as intracranial bleeding, then cryoprecipitate
7 would definitely not have been the best treatment for
8 these patients to receive. You would have to give
9 enormous volumes of cryo to try to stop the bleeding.
10 So absolutely clear in my own mind that giving
11 coagulation factor concentrates in the event of
12 a life-saving bleed was potentially life saving.

13 **Q.** If the severity of non-A, non-B hepatitis testing was
14 not appreciated in the first half of the 1980s or the
15 mid-1980s, why was so much time, effort and money put
16 into research at BPL and PFC to produce a product that
17 did not transmit non-A, non-B hepatitis?

18 **SIR BRIAN LANGSTAFF:** I'm not sure that's really a question
19 which she can answer. That really is a comment.

20 **MS RICHARDS:** It's a -- (overspeaking) --

21 **SIR BRIAN LANGSTAFF:** A question dressed up as a comment,
22 which I think is ultimately for me to evaluate.

23 **MS RICHARDS:** I absolutely take that point, sir.
24 Surrogate testing, Professor Keel, and we touched
25 on this earlier. We saw from the documentation

124

1 references to ALT testing and not anti-HBc testing.
 2 When you were providing advice on these issues in the
 3 various respects in which we looked at in the course of
 4 your evidence, was it your understanding that only ALT
 5 testing was a possibility?

6 **A.** I think at that time that ALT was the main factor under
 7 consideration. Now, I -- my recollection, again, is
 8 very unclear in this. But I think probably that the
 9 anti-HB core testing issue had been put to bed before
 10 I came into post. So the ALT issue was still current in
 11 a way, and it was the one that cropped up rather than
 12 HBc testing.

13 **Q.** Does it follow then that it was your understanding that
 14 in the 1980s, the question of using anti-HBc testing as
 15 a form of surrogate testing was not a live issue in the
 16 1980s?

17 **A.** I'm not -- I didn't say it was not a live issue. It
 18 wasn't the forefront of the issues raised with me when
 19 I came into post.

20 **Q.** Then, in your evidence earlier about what might be done
 21 if donors had elevated ALTs, your evidence was to the
 22 effect that what would you tell them about the reason
 23 for the elevated ALTs, as it might be drinking or being
 24 overweight or other matters.

25 The question arising from that is this,
 125

1 haemophilia patients would have contracted
 2 non-A, non-B hepatitis. Was that advice that you
 3 provided to ministers, as far as you can recall?
 4 **A.** I think it does appear in some of the briefings, maybe
 5 earlier on. And the reason for saying that is -- well,
 6 it's a fact, because of the large donor pools that
 7 were -- from which the factor concentrates were made.
 8 It only took one positive donation amidst the 3,000 --
 9 I think was what SNBTS were dealing with -- commercial
 10 producers were dealing with [live stream froze] of
 11 30,000. So you therefore "contaminate", I use that word
 12 in inverted commas, an enormous plasma pool that is then
 13 being made into various products, all of which carry the
 14 virus.

15 **Q.** The Inquiry has heard evidence about a paper from 1983
 16 by Fletcher and others, which suggested that -- the fact
 17 that you've just referred to -- 100 per cent of
 18 haemophilia patients contracting non-A, non-B hepatitis.
 19 I'm hesitant to ask you about a paper that you haven't
 20 been provided with in advance of your evidence but, in
 21 any event, do you know whether that was a paper that you
 22 were aware of? Does it ring any bells at this stage?

23 **A.** No, I'm afraid not.

24 **Q.** The next question moves to 2003. The announcement in
 25 January 2003 of the potential figures of 20,000 and
 127

1 Professor Keel: why would that be a bad thing or
 2 a reason not to do the testing and telling a donor that
 3 they have a deranged liver function which might be due
 4 to non-A, non-B hepatitis infection or might be due to
 5 one of those other factors would then enable a donor to
 6 make good choices for their health as a consequence?

7 **A.** Well, certainly telling them that they had deranged
 8 liver function which might be the result of a virus as
 9 yet unidentified, I think, would have been pretty
 10 unsatisfactory from that individual's point of view.

11 Yes, of course you could say you could screen for
 12 elevated ALT and tell people to lose weight, stop
 13 drinking, but that really is not the function of our
 14 blood screening test. The blood screening test is to
 15 protect the population from donors who might be carrying
 16 viruses.

17 So allied to the issue of how you deal with donors
 18 with elevated ALT levels, theoretically speaking, is the
 19 issue of what that would mean for the Blood Service.
 20 What proportion of the population might fall into that
 21 category could be very significant and, therefore, erode
 22 the blood supply available to the population.

23 **Q.** You said in your evidence earlier that we know with
 24 hindsight that, prior to the introduction of successful
 25 viral inactivation, et cetera, 100 per cent of
 126

1 25,000 for stage 1 and stage 2. Now, you've told us
 2 about the extent of your involvement with that earlier.
 3 We touched in your earlier evidence on interactions you
 4 had with Peter Hayes about the stage 2 issues, and the
 5 documentation referred to in your statement suggested
 6 that you made contact with Peter Hayes in February 2003.
 7 At that stage, was it your understanding that there
 8 would be a Scotland-specific scheme or did you
 9 anticipate that there would be a UK-wide scheme?

10 **A.** I can't recall. I'm not really sure of the relevance to
 11 the issue of deciding on a trigger point or not. I did
 12 further, of course, discuss that matter with colleagues
 13 in the Department of Health. So it wasn't -- it wasn't
 14 confined to Peter Hayes. So I suppose that fully
 15 reflects the desire, at that stage, to see the scheme
 16 implemented on a UK-wide basis.

17 **Q.** The next question relates to natural clearers. Do you
 18 know when and by whom it was decided that acute natural
 19 clearers would be excluded from the scheme?

20 **A.** I think we decided that fairly early on, on the grounds
 21 that those who cleared the virus within six months of
 22 acquiring certainly had not suffered any long-term harm,
 23 and most of them would have been asymptomatic anyway,
 24 even during the first six months.

25 **Q.** So is it your understanding that that had already been
 128

1 effectively decided by the time of the January 2003
 2 announcement?
 3 A. I can't recollect the timing of it.
 4 Q. And did you provide, as far as you can recall, any
 5 medical advice about the possible impact, in particular
 6 psychological impacts, of hepatitis C infection on such
 7 patients?
 8 A. I can't specifically recall but I'm sure the
 9 psychological -- potential psychological distress would
 10 have been discussed. But if you're talking about
 11 natural clearers, as I've already said, most of them
 12 wouldn't have known that they had a virus during that
 13 period before they cleared it. Many were totally
 14 asymptomatic. I think most were asymptomatic.
 15 Q. And then still on the topic of natural clearers, given
 16 that chronic clearance of hepatitis C was unusual, how
 17 would the typical transfusion patient who did not,
 18 unlike bleeding disorder patients, potentially, have the
 19 benefit of previous regular results of blood testing,
 20 prove that they had cleared at the chronic and not the
 21 acute stage?
 22 A. I think that would have been very difficult unless they
 23 were being monitored by some other clinician, and their
 24 LFTs tested on a regular basis.
 25 Q. Moving to a different issue entirely. You referred to

129

1 A. Well, there have been many other treatment disasters.
 2 Thalidomide comes to mind. I think it's very difficult
 3 to categorise such events by degree of severity and
 4 I don't think I'm in a position so to do.
 5 Q. In terms of the issue of precedent setting, and
 6 financial assistance, are you aware of any group other
 7 than those infected through blood and blood products,
 8 relying on the financial assistance given to recipients
 9 of infected blood or blood products as a precedent for
 10 wider no-fault compensation?
 11 A. Am I now relying on -- is that your question?
 12 Q. Yes. Were you at any time aware or are you now aware of
 13 any groups pointing to the provision of financial
 14 support to the cohorts of individuals with whom this
 15 Inquiry is concerned in saying: well, they've had
 16 financial support, so too should we?
 17 A. Well, I've been seconded out of Government for 7 years,
 18 so I certainly can't comment on current thinking in that
 19 area. But as I said, I've said many times, the concern
 20 around introducing the HCV assistance scheme was that it
 21 would activate other groups that we knew were already
 22 out there, others unknown to us, to make claims.
 23 I mean, I'm not in principle against a no-fault
 24 compensation scheme. Many countries have them. But
 25 most of the payments arising from some such schemes are

131

1 engagement by the Scottish Government with the ABPI on
 2 life insurance and mortgages. Was any assistance
 3 ultimately offered to the infected as a result of that
 4 engagement, and if so, what?
 5 A. I can only remember one meeting, and I can picture the
 6 room that we were in, in the new Parliament, with the
 7 insurance industry, at which these concerns were voiced.
 8 But I really have no recollection of further follow-up
 9 or what the outcomes of those discussions were.
 10 Q. Next question is about look-back again. Was part of the
 11 rationale for requiring a UK-wide introduction of HCV
 12 look-back influenced by who might be expected to pay for
 13 it? In other words, would it assist in looking to
 14 Westminster to fund the look-back if it was UK-wide?
 15 A. I don't remember that being a factor. I think the main
 16 issues driving a UK approach were to avoid confusion of
 17 patients who were potentially identified through the
 18 exercise, and also to avoid confusion of clinicians
 19 who'd be involved. So doing it across the UK was seen
 20 as the best way forward.
 21 Q. The infection of thousands with hepatitis and HIV from
 22 blood and blood products has been described, I think
 23 first by Lord Winston, as the worst treatment disaster
 24 in NHS history. Is that a characterisation that you
 25 disagree with?

130

1 relatively modest, and they take a great deal of
 2 designing. So I mean, my mind was open as to whether we
 3 explored that possibility. During my time in
 4 Government, I think it was always in the 'too difficult'
 5 box to really pursue and come out the other end with
 6 a scheme that would fit with the NHS.
 7 Q. You were in Government for approximately 12 years
 8 following the announcement in 2003 that there would be
 9 an ex gratia payment scheme for those infected with
 10 hepatitis C.
 11 In those 12 years, did the establishment of the
 12 Skipton Fund create the dangerous precedent that you'd
 13 feared?
 14 A. No, it didn't, but that doesn't mean that there aren't
 15 disgruntled groups of people out there who have not been
 16 able to bring the lobbying power that, for example,
 17 The Haemophilia Society got to this area. So I think
 18 the concern was valid. The fact that it hasn't actually
 19 come to pass doesn't mean it wasn't a valid concern.
 20 MS RICHARDS: Sir, those are the questions I'm proposing to
 21 ask from those put forward on behalf of
 22 Core Participants. I'm just going to turn and see
 23 whether there's anything -- no, there's nothing from
 24 Dr Keel's legal representatives.
 25 Do you have any questions for Professor Keel?

132

1 **SIR BRIAN LANGSTAFF:** Only one question, which arises out of
 2 the questions you've just been asked on behalf of
 3 Core Participants. You were asked why the look-back
 4 exercise needed to be conducted on a UK basis, and you
 5 said that otherwise the patients might become confused
 6 and clinicians might be confused. Can you help me,
 7 starting with clinicians, why would clinicians
 8 practising in Scotland be confused that the Scottish
 9 Government, Scottish Health Service, the NHS in
 10 Scotland, was saying, "We want you to have a look-back
 11 for those involved in Scotland"? What would be the
 12 source of their confusion?

13 **A.** Well, it would have been perfectly feasible to proceed
 14 on the basis of Scotland going it alone, if you like.
 15 But you have to remember that patients cross the border
 16 between Scotland and England, and vice versa, so that
 17 there was that. It was just seen as desirable that in
 18 such an important area, that the whole of the UK did it
 19 roughly at the same time.

20 Now, the starting gun was fired but by no means
 21 everybody was at the same place in terms of preparation.
 22 So the time courses that were run across the UK, between
 23 the different transfusion services, varied a bit, but
 24 they all started roughly at the same time -- well, at
 25 the same time, some had done more preparation before

133

1 introduced. Before it was introduced my understanding
 2 is, at least the understanding of the Inquiry is, that
 3 there were a number of pilot schemes operated, certainly
 4 in England, which -- in which areas everyone was being
 5 screened, whereas in other areas they weren't.

6 Do you recollect there being any particular
 7 concern or confusion amongst patients and clinicians as
 8 to why that was happening "there" when it wasn't
 9 happening "here"?

10 **A.** No, I don't recollect. I suspect that that kind of
 11 local testing was not visible to the wider patient
 12 community.

13 **SIR BRIAN LANGSTAFF:** So the difference is the degree of
 14 publicity, is it?

15 **A.** In part, yes. Those centres that were ahead of the rest
 16 of the country in introducing testing, were of course
 17 using the first generation HCV test, which, for reasons
 18 that I'm sure have been explained already, and I think
 19 I mentioned yesterday, were not considered satisfactory
 20 enough for screening the whole donor population, and
 21 being able to absolutely depend on the results that were
 22 emerging, and there were no confirmatory tests at the
 23 beginning.

24 So I imagine that those places that were using, in
 25 the early days, HCV tests were using the first

135

1 that starting date than others. But given that, you
 2 know, public awareness was going to be raised around the
 3 exercise, that was another reason for wanting to do it,
 4 as far as possible, starting at the same time.

5 **SIR BRIAN LANGSTAFF:** So are you really describing confusion
 6 or an element of "Why are they doing it there and not
 7 here?"

8 **A.** I'm sure that question would have been raised, yes.

9 **SIR BRIAN LANGSTAFF:** Do you still want to maintain the word
 10 "confusion"? It's your word. I'm just asking about
 11 what gave rise to it and I'm not sure you've really
 12 explained it to me so far.

13 **A.** Well, I think clinicians would have said -- well, if
 14 we'd gone ahead in Scotland with our own exercise,
 15 I think clinicians south of the border would have said,
 16 "Why are we not doing it here?" Indeed, some small
 17 areas in England had already, as Jack Gillon had done,
 18 begun their own little exercises in various places.

19 So it didn't come as a bombshell to England that
 20 this was going to happen, but I definitely think if we'd
 21 gone it alone, so to speak, English clinicians would
 22 have been a bit bemused as to why they weren't being
 23 asked to do it at the same time.

24 **SIR BRIAN LANGSTAFF:** Now this leads on to the question,
 25 really, about testing for HCV, hepatitis C, when it was

134

1 generation tests.

2 **SIR BRIAN LANGSTAFF:** Yes, well, that's all that I'm going
 3 to ask. Thank you very much.

4 **MS RICHARDS:** Professor Keel, was there anything further
 5 that you wanted to add?

6 **A.** No, I don't think so. Thanks, Ms Richards.

7 **SIR BRIAN LANGSTAFF:** Well, can I thank you. You'll have
 8 understood from the number of questions and the length
 9 of time that it took to assimilate them the considerable
 10 degree of interest which your evidence has given us.
 11 I know it's taken two days, which is a long-ish time
 12 compared to some of the evidence which we've heard, but
 13 I'm sure that anyone listening will have thought the
 14 two days entirely justified by the questions and answers
 15 that have been asked and given. So thank you very much.

16 **A.** Thank you.

17 **SIR BRIAN LANGSTAFF:** Tomorrow?

18 **MS RICHARDS:** Tomorrow, sir, we have the evidence of
 19 Jeremy Hunt, Secretary of State for Health in the
 20 UK Government, 2012 to 2018.

21 **SIR BRIAN LANGSTAFF:** So Jeremy Hunt MP tomorrow.

22 **MS RICHARDS:** Yes.

23 **SIR BRIAN LANGSTAFF:** 10.00.

24 (4.21 pm)

25 (The hearing adjourned until 10.00 am the following day)

136

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2	PROFESSOR AILEEN KEEL (continued)	1
3	Questioned by MS RICHARDS (continued)	1
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<p>MS RICHARDS: [19] 1/8 15/5 15/8 30/5 46/4 46/11 51/19 90/3 90/8 90/13 116/12 117/17 117/23 124/20 124/23 132/20 136/4 136/18 136/22 SIR BRIAN LANGSTAFF: [30] 1/5 1/7 14/25 15/7 28/21 29/9 30/4 46/6 49/11 50/11 50/17 50/21 51/8 51/15 90/6 90/12 116/20 117/22 124/18 124/21 133/1 134/5 134/9 134/24 135/13 136/2 136/7 136/17 136/21 136/23 THE WITNESS: [1] 1/6</p>	<p>'was' [1] 38/2 'we' [1] 43/11</p> <hr/> <p>0</p> <p>001 [1] 68/1 004 [1] 84/20 007 [1] 25/1 014 [2] 83/22 93/20 018 [1] 76/23 020 [1] 36/19 031 [2] 35/25 62/24 040 [1] 6/22 044 [1] 113/20 045 [1] 59/25 047 [1] 14/10 051 [1] 109/22 052 [2] 42/16 90/17 053 [1] 52/11 057 [1] 89/6 059 [1] 79/7 066 [1] 66/22 068 [1] 64/17 071 [1] 78/11 072 [1] 87/4 077 [1] 57/1 078 [1] 35/13 080 [1] 85/18 094 [1] 72/2</p> <hr/> <p>1</p> <p>1 September [1] 8/14 1.05 [1] 90/9 10 [2] 21/16 26/4 10 February 2000 [1] 36/20 10 October 2003 [1] 83/25 10 September 1999 [1] 22/19 10.00 [3] 1/2 136/23 136/25 100 per cent [4] 30/17 97/3 126/25 127/17 105 [1] 75/12 11 [2] 18/10 55/7 11.19 [1] 46/8 11.50 [3] 46/7 46/7 46/10 118 [1] 1/12 12 years [2] 132/7 132/11</p>	<p>124 [1] 96/17 14 [1] 17/7 14 January 2000 [1] 35/14 14 October 2003 [1] 84/22 14 September [8] 7/6 7/24 14/17 18/2 22/23 23/3 25/14 26/5 15 [1] 17/12 15 July 1999 [1] 1/14 15 years [1] 13/15 150 [1] 112/4 152 [1] 32/23 16 [1] 17/18 164 [1] 22/18 17 [1] 17/18 17 January 2000 [1] 36/1 17 September [1] 33/4 179 [1] 95/1 18 [2] 17/22 21/16 18 June 2001 [1] 109/23 18 nurses [1] 96/6 19 April [1] 60/9 19 February 2001 [1] 64/18 19 May 2003 [1] 95/3 19 November 2004 [1] 87/5 1970s [1] 20/3 1980s [17] 8/11 9/9 17/11 17/16 20/3 21/14 23/6 30/22 38/15 46/3 48/18 57/17 96/20 124/14 124/15 125/14 125/16 1983 [3] 12/18 119/24 127/15 1984 [1] 119/24 1985 [6] 6/1 18/23 27/18 27/21 38/16 121/6 1986 [4] 12/19 27/22 51/25 122/21 1987 [2] 6/1 20/7 1988 [7] 27/20 28/1 28/7 28/15 28/22 29/17 43/13 1989 [6] 28/24 48/8</p>	<p>48/8 48/13 48/20 49/15 1990s [4] 16/23 92/11 99/1 104/18 1992 [1] 114/18 1996 [1] 100/16 1997 [1] 101/8 1998 [1] 67/13 1999 [15] 1/10 1/11 1/14 2/2 5/5 6/20 6/23 14/12 22/19 32/24 46/19 48/13 48/16 101/5 112/6</p> <hr/> <p>2</p> <p>2 July [1] 79/14 2 July 2001 [1] 90/18 2.05 [3] 90/7 90/7 90/11 2.4 [1] 86/19 2.56 [1] 117/19 20 [3] 18/4 19/1 97/13 20 May 2006 [1] 106/19 20 per cent [1] 86/20 20 years [2] 88/19 111/5 20,000 [5] 77/14 80/22 81/25 87/1 127/25 2000 [18] 1/10 24/10 25/2 35/14 36/1 36/20 42/1 42/16 42/18 52/9 52/12 57/2 58/25 59/18 59/22 60/1 64/16 119/11 2000s [1] 104/18 2001 [13] 64/16 64/18 67/6 67/18 67/25 72/2 78/13 78/16 78/21 79/10 90/18 91/3 109/23 2002 [3] 76/8 77/22 93/22 2003 [20] 76/24 77/24 80/19 80/21 80/24 81/9 81/14 81/23 81/24 83/23 83/24 83/25 84/22 95/3 96/15 127/24 127/25 128/6 129/1 132/8 2004 [3] 85/19 87/5</p>	<p>101/13 2006 [2] 106/19 107/16 2012 [1] 136/20 2015 [2] 114/1 114/18 2018 [1] 136/20 2022 [1] 1/1 205 [1] 106/17 23 [1] 68/4 23 March 2000 [1] 52/12 23 September [1] 33/1 232 [1] 25/5 24 September [1] 112/5 25 November 1999 [1] 46/19 25,000 [5] 77/15 80/23 81/25 82/17 128/1 26 [1] 70/23 26 July 2022 [1] 1/1 27 [1] 98/7 28 June 2002 [1] 93/22 28 March 2000 [1] 42/18 29 [1] 91/3 29 January 2003 [1] 76/24 29 June 2001 [1] 79/10 29 September 2004 [1] 85/19 2nd level [1] 84/13</p> <hr/> <p>3</p> <p>3 October 2001 [1] 72/2 3,000 [1] 127/8 3.1 [1] 47/8 3.40 [4] 117/7 117/9 117/15 117/15 3.44 [1] 117/21 30 [1] 84/15 30 August [1] 8/13 30 August 1999 [1] 6/23 30 years [1] 97/14 30,000 [1] 127/11 37 [1] 123/11</p>
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<p>A</p> <p>agreed [11] 5/3 6/14 48/5 49/6 62/13 64/23 65/25 84/17 92/1 98/16 99/16</p> <p>agreeing [2] 15/9 60/21</p> <p>agreement [1] 77/18</p> <p>Ah [1] 35/7</p> <p>ahead [4] 27/14 27/17 134/14 135/15</p> <p>AILEEN [6] 1/3 84/5 89/13 95/8 107/4 137/2</p> <p>Aileen Keel [1] 84/5</p> <p>aimed [1] 51/6</p> <p>aims [1] 24/7</p> <p>aired [1] 13/11</p> <p>AK [2] 47/15 48/3</p> <p>Alan [1] 81/5</p> <p>Alan Milburn [1] 81/5</p> <p>alarm [2] 59/6 59/9</p> <p>albeit [4] 49/18 51/15 102/20 103/2</p> <p>albumin [4] 102/3 102/5 102/7 102/8</p> <p>alcohol [1] 51/4</p> <p>Aldridge [4] 52/19 60/17 61/20 63/7</p> <p>Aldridge's [1] 63/3</p> <p>alive [1] 37/3</p> <p>all [30] 2/20 2/23 3/3 3/4 5/13 13/22 21/21 22/14 35/22 44/7 49/3 49/19 49/21 54/25 59/15 69/9 70/5 71/2 72/23 77/14 88/16 102/23 104/9 106/13 107/12 112/4 122/1 127/13 133/24 136/2</p> <p>allegation [1] 119/8</p> <p>allegations [2] 5/19 19/19</p> <p>allege [1] 36/9</p> <p>alleged [1] 37/9</p> <p>allegedly [1] 116/2</p> <p>alleging [1] 35/2</p> <p>allied [1] 126/17</p> <p>allocation [1] 94/20</p> <p>allow [2] 3/6 112/14</p> <p>allowed [1] 62/3</p>	<p>alone [3] 99/4 133/14 134/21</p> <p>along [6] 28/9 29/20 62/18 77/24 78/1 100/22</p> <p>already [22] 10/12 16/16 33/20 35/23 40/20 43/22 51/2 53/23 59/1 70/10 73/14 75/3 98/3 114/12 114/12 119/10 123/8 128/25 129/11 131/21 134/17 135/18</p> <p>also [20] 3/13 7/1 8/19 12/2 12/13 14/3 24/2 36/6 36/23 38/18 39/25 47/15 63/16 65/2 73/20 96/10 106/13 115/8 122/14 130/18</p> <p>ALT [17] 43/13 44/22 45/18 45/21 45/25 47/24 48/5 48/11 48/24 49/20 50/13 125/1 125/4 125/6 125/10 126/12 126/18</p> <p>ALT testing [1] 43/13</p> <p>although [7] 18/18 27/20 27/25 63/23 66/25 87/6 113/8</p> <p>ALTs [2] 125/21 125/23</p> <p>always [2] 113/5 132/4</p> <p>am [13] 1/2 12/10 45/12 46/8 46/10 50/19 58/2 60/25 63/23 110/6 116/12 131/11 136/25</p> <p>ambit [3] 5/23 6/4 11/25</p> <p>amended [1] 55/13</p> <p>amending [1] 55/5</p> <p>amendments [3] 55/4 89/14 89/16</p> <p>amidst [1] 127/8</p> <p>amongst [7] 1/15 14/13 33/2 97/1 97/4 97/12 135/7</p> <p>amount [7] 16/5 16/6 31/15 32/1 32/17 33/17 56/20</p>	<p>an absolutely [1] 99/7</p> <p>an affordable [1] 71/18</p> <p>an already [1] 70/10</p> <p>an amount [1] 56/20</p> <p>an announcement [1] 77/24</p> <p>an apology [1] 85/24</p> <p>an approach [1] 101/23</p> <p>an appropriate [1] 71/20</p> <p>an element [1] 134/6</p> <p>an email [5] 60/1 60/8 60/17 72/1 89/10</p> <p>an enormous [1] 127/12</p> <p>an entirely [1] 34/23</p> <p>an example [1] 83/21</p> <p>an impartial [2] 23/10 23/20</p> <p>an implicated [1] 99/20</p> <p>an important [1] 133/18</p> <p>an inconsistency [1] 70/10</p> <p>an independent [2] 34/12 109/9</p> <p>an individual [1] 86/24</p> <p>an infection [1] 98/18</p> <p>an informed [1] 26/12</p> <p>an infrequent [1] 111/10</p> <p>an investigation [3] 13/21 13/24 22/9</p> <p>an irrelevance [1] 45/25</p> <p>an issue [3] 45/19 84/3 109/7</p> <p>an MSBT [1] 98/8</p> <p>an open [3] 26/7 26/9 26/22</p> <p>an open-ended [1] 16/3</p> <p>an opportunity [2] 116/14 116/24</p> <p>anaemia [2] 97/18 97/19</p> <p>analysing [1] 7/10</p>	<p>analysis [2] 23/10 23/20</p> <p>Andrew's [1] 112/16</p> <p>Angus [2] 79/10 112/12</p> <p>Angus Macmillan Douglas [1] 79/10</p> <p>annex [6] 18/3 19/21 25/17 27/1 27/1 95/19</p> <p>Annex B [3] 19/21 25/17 27/1</p> <p>Annex C [1] 18/3</p> <p>announced [1] 78/21</p> <p>announcement [8] 3/22 77/24 80/21 81/13 81/24 127/24 129/2 132/8</p> <p>another [8] 25/12 35/21 41/3 49/1 61/25 66/17 112/15 134/3</p> <p>answer [8] 5/16 13/4 34/11 35/22 49/7 62/8 122/10 124/19</p> <p>answered [1] 58/17</p> <p>answers [2] 108/20 136/14</p> <p>anti [3] 125/1 125/9 125/14</p> <p>anti-HB [1] 125/9</p> <p>anti-HBc [2] 125/1 125/14</p> <p>anticipate [1] 128/9</p> <p>anticipating [2] 10/11 45/12</p> <p>anticipation [1] 93/22</p> <p>anxious [1] 79/22</p> <p>any [92] 2/1 5/1 6/15 7/17 7/24 8/7 10/10 10/17 19/14 20/25 21/10 21/12 22/10 25/14 29/1 29/5 29/10 29/19 29/19 29/21 30/20 30/20 30/25 32/22 33/12 33/16 34/4 38/8 38/10 40/6 40/8 40/12 43/19 44/5 45/8 48/20 48/23 52/3 65/7 66/12 66/19 68/19 70/7 70/13 70/16 71/14 78/3 78/9 79/24 80/1 80/11 81/15 81/23 83/8</p>	<p>83/12 83/14 85/10 88/2 92/11 95/22 96/20 99/2 99/4 101/19 103/3 103/5 103/18 105/11 107/21 108/12 108/19 108/20 108/24 109/12 110/9 114/18 115/12 116/15 117/16 118/1 120/1 123/25 127/21 127/22 128/22 129/4 130/2 131/6 131/12 131/13 132/25 135/6</p> <p>anybody [3] 42/13 99/8 123/4</p> <p>anyone [3] 29/21 114/13 136/13</p> <p>anything [10] 33/11 40/22 44/17 50/18 65/17 102/10 107/12 112/25 132/23 136/4</p> <p>anyway [4] 103/5 103/5 116/10 128/23</p> <p>apart [1] 99/9</p> <p>apologies [3] 25/13 35/9 90/4</p> <p>apology [1] 85/24</p> <p>apparently [3] 44/4 64/23 94/2</p> <p>appear [6] 20/9 48/8 55/25 89/19 89/23 127/4</p> <p>appeared [3] 21/9 121/15 121/18</p> <p>appears [5] 4/2 57/2 101/15 102/18 103/16</p> <p>appended [1] 25/17</p> <p>applicable [1] 93/14</p> <p>applied [1] 56/18</p> <p>apply [1] 123/18</p> <p>appointed [2] 96/3 96/6</p> <p>appointment [1] 39/10</p> <p>appreciate [1] 20/13</p> <p>appreciated [1] 124/14</p> <p>approach [13] 14/6 19/9 31/18 59/3 80/13 91/24 98/23 101/20 101/22 101/23 101/24 119/8 130/16</p>
--	--	---	--	--

<p>A</p> <p>approached [1] 32/22</p> <p>approaches [1] 27/11</p> <p>appropriate [8] 69/1 71/2 71/20 96/8 102/12 105/16 116/11 122/18</p> <p>approval [1] 57/8</p> <p>approximately [1] 132/7</p> <p>April [6] 48/8 57/2 60/1 60/9 64/16 114/1</p> <p>April 1989 [1] 48/8</p> <p>April 2000 [2] 60/1 64/16</p> <p>April 2015 [1] 114/1</p> <p>ARCH0003312 [2] 35/25 36/19</p> <p>are [53] 2/20 2/23 2/25 5/14 6/25 18/16 18/25 20/14 20/17 21/20 22/3 23/14 29/20 36/5 43/9 43/17 45/1 46/17 50/20 51/8 51/11 53/5 54/3 54/6 57/24 59/16 60/19 61/14 61/17 68/15 70/4 70/6 74/18 75/3 79/24 85/20 85/22 89/16 108/2 111/19 113/7 116/12 116/21 117/5 117/8 121/6 131/6 131/12 131/25 132/20 134/5 134/6 134/16</p> <p>area [9] 34/19 38/11 53/9 85/14 97/16 112/8 131/19 132/17 133/18</p> <p>areas [6] 44/16 60/24 100/14 134/17 135/4 135/5</p> <p>aren't [2] 99/18 132/14</p> <p>arguments [3] 63/10 63/12 63/16</p> <p>arise [2] 8/2 109/4</p> <p>arises [3] 98/6 118/2 133/1</p> <p>arising [9] 17/16 19/22 44/21 70/17</p>	<p>103/20 110/4 115/20 125/25 131/25</p> <p>arm's [2] 23/9 23/13</p> <p>arm's length [2] 23/9 23/13</p> <p>arose [1] 47/2</p> <p>around [20] 6/13 13/18 14/7 21/9 33/23 35/3 41/8 43/12 53/23 62/10 64/12 78/10 80/8 80/15 100/11 100/18 109/16 117/25 131/20 134/2</p> <p>arrange [1] 66/8</p> <p>arrangements [1] 91/2</p> <p>arrived [1] 26/19</p> <p>articles [1] 21/8</p> <p>articulated [2] 23/6 121/21</p> <p>as [200]</p> <p>ascertain [1] 120/23</p> <p>aside [3] 80/10 105/22 106/5</p> <p>ask [34] 1/8 2/13 26/2 28/21 41/1 47/12 49/12 57/11 71/25 74/24 75/7 75/13 78/11 79/4 80/25 87/9 88/11 90/13 93/17 98/4 103/7 106/20 109/21 109/25 110/11 111/24 112/3 116/12 116/17 117/23 121/20 127/19 132/21 136/3</p> <p>asked [24] 13/6 13/8 26/3 34/10 39/20 45/12 47/24 65/6 75/12 86/7 87/14 87/17 88/11 98/8 98/11 100/11 102/19 113/23 120/6 121/25 133/2 133/3 134/23 136/15</p> <p>asking [3] 40/13 70/6 134/10</p> <p>aspect [4] 13/21 38/11 49/1 115/13</p> <p>Assembly [1] 85/23</p> <p>assertion [1] 14/21</p> <p>assertions [1] 19/10</p> <p>assessed [1] 80/13</p>	<p>assessment [5] 7/11 38/2 65/7 114/19 115/1</p> <p>assessments [1] 114/23</p> <p>assimilate [1] 136/9</p> <p>assist [5] 9/11 20/14 54/25 94/10 130/13</p> <p>assistance [13] 4/11 10/1 68/5 68/7 68/25 69/22 71/13 71/21 115/22 130/2 131/6 131/8 131/20</p> <p>assists [1] 54/18</p> <p>associated [2] 33/17 104/8</p> <p>assume [2] 5/1 94/4</p> <p>assumed [1] 88/5</p> <p>assumption [2] 73/18 88/13</p> <p>assurance [1] 13/23</p> <p>assurances [1] 16/19</p> <p>asymptomatic [4] 88/2 128/23 129/14 129/14</p> <p>attached [5] 4/2 4/15 18/3 60/13 110/2</p> <p>attempt [1] 89/25</p> <p>attempts [1] 60/12</p> <p>attendance [3] 6/25 8/18 14/11</p> <p>attendees [6] 36/21 46/20 51/20 51/21 61/13 85/20</p> <p>attending [2] 7/2 41/20</p> <p>attention [4] 17/2 21/8 21/8 35/14</p> <p>attributed [1] 15/19</p> <p>audio [1] 99/9</p> <p>Audit [1] 92/16</p> <p>audits [2] 91/9 93/1</p> <p>augment [1] 105/20</p> <p>August [6] 6/20 6/23 8/13 78/21 78/21 81/14</p> <p>August 2001 [1] 78/21</p> <p>August 2003 [1] 81/14</p> <p>author [2] 63/25 64/5</p> <p>authored [2] 19/3</p>	<p>54/19</p> <p>autonomy [1] 98/24</p> <p>availability [2] 42/12 95/13</p> <p>available [26] 2/8 8/12 12/20 14/22 16/7 28/3 28/15 32/2 43/22 43/24 49/18 55/24 58/22 59/15 83/15 105/17 112/3 112/24 115/11 119/14 121/22 122/8 122/19 122/24 123/2 126/22</p> <p>avoid [2] 130/16 130/18</p> <p>awaited [1] 77/23</p> <p>award [1] 63/12</p> <p>awarded [5] 10/2 33/10 33/18 71/13 78/17</p> <p>aware [14] 28/2 28/14 28/18 39/21 42/8 52/4 73/3 73/4 103/17 103/20 127/22 131/6 131/12 131/12</p> <p>awareness [5] 39/5 41/9 42/12 120/1 134/2</p> <p>away [3] 63/9 75/17 111/16</p> <p>B</p> <p>B Wright [1] 51/22</p> <p>back [25] 4/16 13/15 19/1 25/10 35/11 40/1 41/14 46/11 49/10 49/11 51/19 53/2 63/5 72/24 78/13 90/6 108/24 115/12 119/20 120/6 130/10 130/12 130/14 133/3 133/10</p> <p>background [2] 16/11 99/16</p> <p>bad [1] 126/1</p> <p>balance [3] 45/5 45/11 88/8</p> <p>ban [1] 102/25</p> <p>based [11] 9/25 24/1 38/24 38/25 72/14 73/12 83/15 83/17 88/15 92/1 92/14</p> <p>basis [18] 2/12 10/19</p>	<p>18/6 19/4 19/10 26/13 27/22 28/5 31/17 48/10 71/14 77/13 102/21 121/14 128/16 129/24 133/4 133/14</p> <p>be [236]</p> <p>bearing [6] 7/15 9/1 42/1 44/3 53/12 79/2</p> <p>became [1] 5/23</p> <p>because [36] 17/1 28/23 30/16 39/6 46/13 48/5 48/19 49/25 50/24 52/1 53/18 59/10 75/25 85/12 86/24 88/4 88/21 89/4 94/17 98/1 102/8 103/22 104/5 105/8 105/16 106/6 107/3 112/24 113/13 115/23 117/24 118/15 119/10 120/15 120/21 127/6</p> <p>become [4] 64/10 69/20 112/23 133/5</p> <p>becomes [1] 65/11</p> <p>becoming [1] 49/18</p> <p>bed [1] 125/9</p> <p>been [152]</p> <p>been' [1] 55/19</p> <p>before [23] 1/11 2/1 7/19 24/1 28/15 33/11 40/22 42/15 49/11 71/25 79/24 82/15 87/3 92/8 105/23 109/14 114/6 117/9 117/15 125/9 129/13 133/25 135/1</p> <p>beg [1] 26/14</p> <p>beginning [3] 104/6 115/11 135/23</p> <p>begun [3] 33/21 111/5 134/18</p> <p>behalf [10] 32/25 46/20 46/21 46/22 67/4 69/12 85/21 117/24 132/21 133/2</p> <p>behind [5] 5/24 19/18 22/2 68/11 99/22</p> <p>being [63] 2/17 7/5 8/16 8/22 11/24 17/7 17/24 18/11 18/20 19/7 20/17 22/16 24/5</p>
--	--	--	--	---

(39) approached - being

<p>B</p> <p>being... [50] 26/15 28/16 28/25 30/17 32/15 37/18 39/8 44/21 49/16 50/12 51/24 52/1 52/3 52/8 53/19 55/18 55/20 60/3 62/3 65/20 76/15 76/19 78/9 81/21 82/10 82/11 84/15 84/23 86/2 86/10 93/6 95/21 99/19 100/7 100/12 101/6 101/23 102/24 103/12 105/18 116/7 120/14 125/23 127/13 129/23 130/15 134/22 135/4 135/6 135/21</p> <p>belief [1] 59/5</p> <p>believe [8] 2/16 3/17 5/14 12/16 23/22 57/24 115/21 116/8</p> <p>believed [2] 116/7 119/13</p> <p>Bell [1] 1/13</p> <p>bells [3] 59/6 59/9 127/22</p> <p>belong [2] 112/19 113/14</p> <p>below [2] 61/12 87/10</p> <p>bemused [1] 134/22</p> <p>benefit [3] 96/13 109/18 129/19</p> <p>benefits [2] 91/22 123/7</p> <p>benign [1] 20/9</p> <p>best [10] 2/7 14/22 91/23 111/14 112/17 121/22 122/8 122/19 124/7 130/20</p> <p>better [21] 5/16 9/16 58/18 75/2 75/6 90/14 90/24 91/2 92/10 92/12 93/18 93/25 94/14 95/12 95/20 95/25 96/14 96/25 118/3 118/4 118/6</p> <p>between [20] 1/10 6/1 12/18 16/16 23/16 45/5 45/11 46/18 47/1 58/24 65/19 81/3</p>	<p>91/10 91/25 92/6 93/2 100/16 119/11 133/16 133/22</p> <p>Beware [1] 61/15</p> <p>beyond [1] 90/4</p> <p>big [1] 43/16</p> <p>bigger [1] 64/10</p> <p>biggest [1] 9/6</p> <p>Bill [1] 51/22</p> <p>biopsy [4] 38/16 82/21 82/25 83/13</p> <p>bit [4] 31/21 41/9 133/23 134/22</p> <p>bits [1] 114/25</p> <p>bleed [5] 3/4 3/5 3/7 124/5 124/12</p> <p>bleeding [4] 119/23 124/6 124/9 129/18</p> <p>bleeds [1] 2/25</p> <p>blood [103] 1/19 1/19 5/20 6/10 17/10 18/19 23/5 36/12 42/2 42/13 42/13 46/19 47/19 55/15 56/14 56/24 56/25 57/18 69/23 71/4 71/5 71/5 72/8 72/25 77/8 77/8 78/23 84/11 84/11 90/14 90/15 90/16 90/24 91/2 91/9 91/15 91/20 91/25 92/2 92/7 92/10 92/12 92/12 92/18 92/21 92/21 93/2 93/5 93/5 93/11 93/18 93/25 94/7 94/12 94/14 95/12 95/15 95/20 95/25 96/8 96/9 96/14 96/22 96/22 96/24 96/25 97/1 97/15 97/19 97/20 98/10 99/11 99/14 99/20 100/15 101/4 101/6 101/9 102/2 102/2 102/2 102/13 102/13 104/22 104/23 108/6 108/6 114/14 118/3 118/4 118/6 118/16 126/14 126/14 126/19 126/22 129/19 130/22 130/22 131/7 131/7 131/9 131/9</p> <p>BMcC [1] 48/1</p>	<p>Board [1] 92/17</p> <p>Boards [1] 92/24</p> <p>Bob [5] 76/24 79/8 84/12 89/10 89/10</p> <p>Bob Stock [4] 76/24 79/8 84/12 89/10</p> <p>bodies [4] 23/14 48/21 50/4 50/5</p> <p>body [6] 45/13 60/10 109/4 109/6 109/9 109/15</p> <p>bombshell [1] 134/19</p> <p>book [1] 33/8</p> <p>border [4] 32/3 82/8 133/15 134/15</p> <p>borne [1] 39/23</p> <p>both [6] 3/12 63/21 68/11 71/23 112/12 119/18</p> <p>bottom [29] 5/22 9/20 17/5 25/6 33/25 36/25 37/6 47/6 47/22 48/9 54/4 55/7 55/22 57/13 60/5 63/3 63/6 66/5 66/6 69/8 70/24 75/11 84/2 84/3 95/5 98/7 101/2 103/12 106/22</p> <p>box [1] 132/5</p> <p>BPL [19] 10/22 10/22 11/2 11/5 27/11 27/14 27/17 27/23 28/2 29/16 30/6 31/3 31/7 31/16 31/23 32/6 32/14 32/19 124/16</p> <p>BPL product [1] 31/16</p> <p>break [10] 35/8 42/15 46/4 46/5 46/6 46/9 87/3 116/17 116/18 117/20</p> <p>breakthrough [1] 11/1</p> <p>Brian [3] 48/2 79/9 92/13</p> <p>Brian McClelland [3] 48/2 79/9 92/13</p> <p>brief [4] 1/16 7/13 77/11 80/25</p> <p>briefed [1] 7/23</p> <p>briefing [16] 1/16 8/24 14/10 14/15 15/6 15/14 17/4 18/12 19/2</p>	<p>19/21 22/19 25/17 25/25 26/20 26/24 27/1</p> <p>briefings [2] 121/22 127/4</p> <p>briefly [1] 36/3</p> <p>bring [1] 132/16</p> <p>bringing [1] 53/6</p> <p>British [1] 39/11</p> <p>broad [3] 72/18 104/25 114/7</p> <p>broader [5] 9/14 58/10 58/15 58/18 80/11</p> <p>broadly [4] 6/2 75/8 82/6 97/1</p> <p>brought [2] 78/22 79/3</p> <p>build [1] 33/22</p> <p>bullet [5] 2/1 2/6 2/22 47/13 49/14</p> <p>burden [1] 104/12</p> <p>burdening [1] 99/17</p> <p>Burton [6] 72/9 75/16 75/20 76/3 78/14 109/24</p> <p>Burton's [2] 78/18 91/14</p> <p>but [144]</p> <p>by [103] 1/4 2/25 3/23 4/14 5/11 6/14 8/7 8/7 8/22 9/13 9/17 10/17 10/22 11/5 13/15 14/11 15/13 16/6 18/23 19/3 20/22 21/11 21/11 23/3 23/6 27/2 27/11 28/21 29/10 29/17 31/16 31/24 36/15 39/13 39/14 43/21 46/1 47/7 48/12 48/17 48/25 49/6 49/15 49/16 51/24 56/20 60/23 60/25 61/2 61/19 64/6 65/2 65/15 67/4 67/8 69/11 69/20 71/4 71/5 74/5 76/15 76/25 78/23 79/16 79/23 81/9 85/14 86/5 92/3 92/11 95/3 96/11 99/4 103/18 104/20 104/21 109/20 109/24 110/24</p>	<p>111/2 112/1 113/1 113/2 113/21 114/19 114/24 115/2 117/13 118/21 120/7 121/11 123/7 127/16 128/18 129/1 129/23 130/1 130/12 130/23 131/3 133/20 136/14 137/3</p> <p>By 1985 [1] 18/23</p> <p>C</p> <p>Cabinet [2] 77/11 78/8</p> <p>calculated [1] 123/21</p> <p>call [1] 105/9</p> <p>called [1] 106/10</p> <p>calls [1] 105/17</p> <p>came [8] 5/6 26/14 32/1 55/1 92/15 92/19 125/10 125/19</p> <p>campaign [3] 1/17 1/22 110/4</p> <p>campaigned [1] 68/16</p> <p>campaigning [1] 16/12</p> <p>campaigns [1] 110/7</p> <p>can [114] 1/14 2/6 3/18 6/24 7/4 9/11 11/12 14/18 17/2 20/11 22/21 24/4 25/5 25/5 25/7 25/25 27/6 28/1 29/25 32/9 35/25 36/1 36/15 36/19 36/20 36/25 37/2 37/6 38/12 39/3 39/15 43/8 43/11 43/18 44/21 45/3 45/20 46/17 46/20 49/3 49/11 49/19 52/9 54/3 54/9 54/11 54/14 54/15 56/9 57/4 59/19 60/4 60/6 60/8 60/17 61/3 61/9 61/12 62/7 63/5 66/5 66/22 67/6 68/3 68/4 69/16 70/21 70/24 71/22 71/25 74/4 74/8 75/7 76/14 77/2 78/11 78/15 79/4 80/18 81/15 82/14 83/21 85/19 86/2 87/2 89/15 90/20 92/10</p>
---	--	--	--	---

<p>C</p> <p>can... [26] 93/17 93/24 94/10 95/3 95/10 95/23 98/13 99/19 100/25 101/1 101/2 101/19 108/16 110/2 114/5 119/6 121/20 123/22 123/25 124/19 127/3 129/4 130/5 130/5 133/6 136/7</p> <p>can't [23] 6/19 21/7 24/19 45/6 45/21 48/23 54/20 64/6 65/22 76/21 85/7 94/18 108/17 115/1 117/11 118/17 120/11 121/10 123/24 128/10 129/3 129/8 131/18</p> <p>cancer [1] 77/16</p> <p>cardiac [1] 96/11</p> <p>care [10] 1/13 16/7 39/6 41/3 57/4 67/23 74/17 77/5 79/1 83/16</p> <p>careful [1] 61/18</p> <p>carefully [1] 63/16</p> <p>carried [1] 26/7</p> <p>carries [1] 83/1</p> <p>carry [1] 127/13</p> <p>carrying [2] 23/7 126/15</p> <p>case [12] 11/19 35/8 53/25 59/13 68/23 69/21 86/21 88/16 93/3 109/25 110/9 118/14</p> <p>cases [1] 110/8</p> <p>Cash [8] 43/8 44/14 112/9 112/16 112/23 113/2 113/14 113/21</p> <p>Cash's [3] 44/8 44/22 113/5</p> <p>cast [2] 112/2 119/20</p> <p>casting [1] 107/10</p> <p>categories [3] 62/17 73/15 100/6</p> <p>categorisation [1] 79/17</p> <p>categorise [1] 131/3</p> <p>category [2] 73/25 126/21</p>	<p>cause [2] 51/17 97/19</p> <p>caused [1] 70/5</p> <p>cent [5] 30/17 86/20 97/3 126/25 127/17</p> <p>central [3] 7/2 40/4 100/12</p> <p>centrally [1] 100/19</p> <p>centre [9] 19/11 31/22 36/18 41/4 41/20 42/8 57/22 59/2 94/21</p> <p>centres [6] 8/24 9/7 11/14 11/18 41/18 135/15</p> <p>certain [1] 99/25</p> <p>certainly [24] 34/16 42/10 70/21 75/1 76/19 83/22 90/1 98/19 101/15 101/24 102/25 104/6 104/12 111/4 115/17 116/20 118/14 119/4 119/18 120/14 126/7 128/22 131/18 135/3</p> <p>cetera [5] 14/4 51/4 67/2 78/17 126/25</p> <p>chain [3] 60/1 60/4 63/2</p> <p>chair [1] 24/25</p> <p>chaired [1] 96/11</p> <p>Chairman [1] 107/10</p> <p>chairmanship [1] 74/14</p> <p>chalked [1] 97/8</p> <p>change [5] 16/4 70/16 78/5 82/7 100/9</p> <p>changed [3] 65/5 97/13 103/1</p> <p>characterisation [1] 130/24</p> <p>charge [2] 17/19 17/22</p> <p>charged [2] 42/25 109/6</p> <p>Charles [2] 64/20 65/10</p> <p>Charles Lister [1] 64/20</p> <p>chasing [1] 25/4</p> <p>check [1] 44/20</p> <p>checks [1] 29/21</p> <p>cheque [1] 33/8</p>	<p>chief [5] 4/24 61/7 95/9 109/23 114/1</p> <p>children [2] 122/8 122/18</p> <p>Chiron [1] 49/16</p> <p>Chisholm [2] 76/25 81/3</p> <p>choice [1] 38/3</p> <p>choices [1] 126/6</p> <p>chosen [1] 10/23</p> <p>Christine [17] 21/5 42/17 42/22 44/11 44/18 57/2 58/20 63/2 64/11 64/18 66/23 86/3 86/17 88/17 89/1 90/2 112/24</p> <p>Christine Dora [9] 21/5 42/17 42/22 44/11 44/18 57/2 58/20 64/11 64/18</p> <p>Christine Dora's [2] 63/2 112/24</p> <p>Christine Lee [3] 86/17 88/17 89/1</p> <p>Christine Lee's [1] 90/2</p> <p>chronic [8] 87/21 87/23 88/9 88/22 89/2 89/5 129/16 129/20</p> <p>chronological [2] 8/10 35/12</p> <p>chronologies [1] 10/21</p> <p>chronology [8] 6/21 10/9 34/24 52/10 77/20 80/25 81/22 122/23</p> <p>circular [3] 94/4 94/9 95/1</p> <p>circularity [1] 105/7</p> <p>circumstances [5] 9/24 17/9 23/11 56/4 104/21</p> <p>cirrhosis [6] 20/10 77/15 82/18 82/22 83/14 83/18</p> <p>cited [4] 56/15 69/11 88/7 88/14</p> <p>civil [2] 21/12 64/2</p> <p>CJD [4] 98/10 99/15 100/16 103/22</p> <p>claim [4] 4/10 17/23</p>	<p>80/9 87/13</p> <p>claimant [1] 71/14</p> <p>claimants [2] 79/19 87/11</p> <p>claimed [2] 11/20 13/7</p> <p>claims [7] 1/24 53/11 79/11 80/3 80/13 87/11 131/22</p> <p>clarification [1] 87/15</p> <p>clarify [2] 8/22 90/1</p> <p>clarifying [1] 71/21</p> <p>clarity [1] 26/23</p> <p>classified [1] 69/21</p> <p>classify [1] 68/23</p> <p>clear [11] 25/1 37/10 41/12 67/9 83/19 86/20 91/16 93/10 107/15 110/6 124/10</p> <p>clearance [3] 86/19 87/8 129/16</p> <p>cleared [9] 87/24 88/6 88/13 88/19 88/23 89/3 128/21 129/13 129/20</p> <p>clearers [10] 85/10 85/18 86/5 86/13 86/14 86/25 128/17 128/19 129/11 129/15</p> <p>Clearers' [1] 86/1</p> <p>clearly [23] 3/2 4/19 7/21 9/8 33/16 38/10 40/19 53/20 54/21 76/3 78/7 80/5 82/17 83/2 85/12 88/18 94/5 94/17 94/23 104/1 108/17 122/22 123/3</p> <p>clinical [16] 12/13 30/19 30/21 36/8 70/8 83/15 85/13 90/15 91/12 91/23 92/15 92/17 96/20 96/21 97/12 122/11</p> <p>clinically [2] 29/2 96/19</p> <p>clinician [5] 31/18 31/18 86/9 121/16 129/23</p> <p>clinician-to-clinician [1] 31/18</p> <p>clinicians [18] 14/2 58/3 86/6 91/10 91/17</p>	<p>93/2 97/5 118/3 118/5 123/7 130/18 133/6 133/7 133/7 134/13 134/15 134/21 135/7</p> <p>clinics [2] 12/14 13/1</p> <p>CLO [5] 40/5 40/20 40/22 79/16 79/17</p> <p>CLO/SNBTS [1] 79/16</p> <p>close [2] 17/1 23/15</p> <p>closed [2] 22/9 67/14</p> <p>closes [1] 23/2</p> <p>CMOs [2] 90/21 90/25</p> <p>co [1] 92/15</p> <p>co-edited [1] 92/15</p> <p>coagulation [2] 2/21 124/11</p> <p>cohort [3] 30/8 31/9 31/11</p> <p>cohorts [2] 41/19 131/14</p> <p>Colleague [1] 95/11</p> <p>colleagues [7] 21/11 60/25 67/8 74/5 84/13 99/1 128/12</p> <p>collected [1] 20/22</p> <p>collective [1] 115/3</p> <p>College [3] 112/11 112/19 113/15</p> <p>Colvin [1] 24/25</p> <p>combatting [1] 21/24</p> <p>come [16] 3/7 25/10 29/17 35/11 49/11 53/2 55/17 70/4 73/7 90/6 104/22 105/11 120/24 132/5 132/19 134/19</p> <p>comes [4] 4/1 71/11 102/3 131/2</p> <p>coming [9] 5/21 11/1 32/12 66/18 97/17 102/23 111/5 117/8 117/9</p> <p>commas [1] 127/12</p> <p>commenced [2] 7/18 23/4</p> <p>comment [17] 13/25 19/14 25/22 26/18 38/9 38/10 50/1 50/7 55/21 57/7 61/12 74/18 110/23 111/21 124/19 124/21 131/18</p> <p>commented [3] 60/11</p>
---	---	---	--	---

(41) can... - commented

<p>C</p> <p>commented... [2] 67/1 73/10</p> <p>commenting [1] 44/24</p> <p>comments [7] 52/13 54/6 54/10 54/10 54/19 66/24 112/24</p> <p>commercial [4] 52/24 122/7 122/17 127/9</p> <p>commission [1] 5/6</p> <p>committee [20] 7/13 47/18 47/18 67/23 68/5 68/9 69/20 69/24 70/3 70/19 72/7 72/13 74/13 74/18 76/7 77/5 77/19 79/1 106/12 107/9</p> <p>Committee's [3] 72/17 74/5 74/10</p> <p>committees [1] 50/9</p> <p>common [3] 61/8 65/18 93/10</p> <p>communicating [1] 91/21</p> <p>communications [1] 44/12</p> <p>communities [1] 114/21</p> <p>community [7] 6/12 57/4 67/23 74/17 77/5 79/1 135/12</p> <p>comparable [1] 52/24</p> <p>compared [2] 122/13 136/12</p> <p>compen [1] 115/17</p> <p>compensate [2] 15/12 73/21</p> <p>compensated [3] 70/6 73/16 86/24</p> <p>compensating [1] 67/10</p> <p>compensation [47] 1/18 14/21 15/9 16/3 24/6 33/10 33/17 34/5 34/20 53/9 53/11 53/24 60/21 61/23 62/3 62/14 63/9 63/10 63/13 63/24 64/4 64/7 64/9 64/14 64/25 66/1 70/1 72/7 72/14 72/20</p>	<p>73/5 73/8 73/23 74/1 74/3 75/4 75/9 75/18 76/1 76/5 76/16 76/19 80/14 84/10 116/1 131/10 131/24</p> <p>compensation/financial [1] 76/16</p> <p>complaint [1] 37/17</p> <p>complementarity [2] 11/8 11/10</p> <p>complementary [1] 11/7</p> <p>complete [3] 52/9 69/25 94/25</p> <p>completely [2] 36/10 117/10</p> <p>completeness [1] 66/4</p> <p>components [10] 90/16 91/9 91/20 92/12 92/21 93/2 93/6 101/9 102/2 102/13</p> <p>concentrate [1] 6/1</p> <p>concentrates [7] 3/14 56/18 120/4 122/7 124/2 124/11 127/7</p> <p>concept [3] 15/11 15/16 101/15</p> <p>concern [16] 37/8 44/21 45/17 64/4 65/18 65/24 66/8 67/1 99/18 102/16 103/16 107/25 131/19 132/18 132/19 135/7</p> <p>concerned [14] 2/7 11/18 16/15 33/6 52/17 53/4 64/6 86/17 86/23 102/24 107/2 114/13 118/17 131/15</p> <p>concerns [7] 7/7 16/13 23/6 40/12 86/4 102/19 130/7</p> <p>conclude [2] 25/25 70/21</p> <p>conclusion [6] 52/17 55/6 55/8 73/20 83/14 88/20</p> <p>conclusions [9] 4/13 20/17 21/17 22/4 22/15 26/18 43/2 44/2 53/15</p> <p>concrete [1] 68/24</p>	<p>condition [3] 2/24 38/14 115/11</p> <p>conduct [2] 23/25 115/1</p> <p>conducted [5] 26/22 30/22 34/23 114/24 133/4</p> <p>conducting [1] 26/8</p> <p>conference [3] 91/3 92/10 93/19</p> <p>confident [2] 115/2 118/17</p> <p>confined [1] 128/14</p> <p>confirm [3] 11/16 12/11 77/4</p> <p>confirmatory [2] 119/17 135/22</p> <p>confirmed [4] 11/13 12/7 38/18 40/3</p> <p>confirming [1] 51/12</p> <p>confirms [1] 35/16</p> <p>confused [4] 90/1 133/5 133/6 133/8</p> <p>confusion [6] 130/16 130/18 133/12 134/5 134/10 135/7</p> <p>conscious [1] 19/2</p> <p>consent [3] 92/3 100/13 118/15</p> <p>consequence [1] 126/6</p> <p>consider [7] 23/12 45/20 51/1 68/22 68/25 72/5 115/14</p> <p>considerable [1] 136/9</p> <p>consideration [4] 21/10 48/16 82/4 125/7</p> <p>considerations [1] 65/2</p> <p>considered [11] 44/23 48/3 48/12 48/15 48/21 50/6 50/9 51/5 69/19 103/21 135/19</p> <p>considering [2] 49/20 118/19</p> <p>consistency [1] 68/12</p> <p>consistent [4] 3/22 22/13 110/9 111/23</p> <p>consult [1] 71/23</p>	<p>consultant [1] 92/14</p> <p>consultants [3] 83/16 118/21 119/9</p> <p>consultation [2] 10/18 20/20</p> <p>consultations [2] 20/2 20/15</p> <p>consulted [1] 107/4</p> <p>consulting [1] 20/24</p> <p>Consumer [2] 69/5 79/3</p> <p>contact [7] 21/12 39/20 40/14 41/18 42/8 66/9 128/6</p> <p>contained [1] 58/10</p> <p>contaminate [1] 127/11</p> <p>content [1] 44/7</p> <p>context [10] 13/1 46/1 51/6 56/11 73/6 90/2 91/22 96/23 99/6 99/11</p> <p>continued [5] 1/3 1/4 104/20 137/2 137/3</p> <p>continues [2] 54/3 107/6</p> <p>continuing [2] 1/17 10/15</p> <p>contracted [8] 30/18 68/13 71/3 72/8 84/10 108/6 114/14 127/1</p> <p>contracting [2] 57/18 127/18</p> <p>contrast [1] 97/7</p> <p>contributed [1] 89/23</p> <p>contributing [1] 37/20</p> <p>contribution [2] 9/21 40/9</p> <p>convenient [1] 112/14</p> <p>conversation [6] 53/8 64/20 66/15 111/11 111/17 112/18</p> <p>convey [1] 30/2</p> <p>conviction [1] 68/11</p> <p>coordinated [1] 11/6</p> <p>copied [11] 1/15 14/12 33/1 57/12 72/3 77/1 79/9 87/6 87/6 90/23 106/19</p> <p>core [5] 116/14</p>	<p>117/25 125/9 132/22 133/3</p> <p>Core Participants [4] 116/14 117/25 132/22 133/3</p> <p>Corporation [1] 49/17</p> <p>correct [8] 6/2 6/7 12/9 12/12 30/15 46/14 48/10 70/9</p> <p>correctly [1] 31/2</p> <p>correspondence [1] 4/3</p> <p>cost [1] 9/25</p> <p>costing [1] 77/12</p> <p>costings [1] 65/6</p> <p>costs [1] 75/13</p> <p>could [61] 7/11 9/15 12/11 12/23 13/5 13/6 13/7 13/8 18/9 21/21 25/21 26/18 30/24 31/24 32/5 32/13 33/8 33/22 33/25 34/25 43/14 46/5 48/15 50/25 51/25 52/15 52/23 54/20 56/6 56/17 57/21 57/23 59/7 59/14 61/16 61/17 62/24 64/10 69/8 73/14 73/18 75/1 75/10 81/6 84/14 87/9 90/5 102/13 105/7 105/13 107/22 110/15 111/12 112/20 112/21 116/17 116/19 118/10 126/11 126/11 126/21</p> <p>couldn't [1] 12/21</p> <p>counsel [1] 116/23</p> <p>countries [2] 56/16 131/24</p> <p>country [2] 96/6 135/16</p> <p>couple [6] 17/3 47/5 49/13 93/17 98/4 109/19</p> <p>course [48] 8/6 12/19 14/5 16/9 21/14 22/8 25/20 28/8 30/20 32/11 32/12 34/10 35/5 41/6 44/1 44/17 46/24 48/24 49/3 49/25 50/1 51/10 54/22 65/14 65/17</p>
---	---	---	--	---

<p>C</p> <p>course... [23] 75/22 97/3 100/7 102/22 105/13 105/14 106/6 108/5 108/9 108/9 108/25 110/21 111/12 111/13 112/8 112/18 113/11 113/22 117/15 125/3 126/11 128/12 135/16</p> <p>course B [1] 111/13</p> <p>courses [1] 133/22</p> <p>court [6] 39/24 40/16 75/24 78/16 78/20 79/15</p> <p>courts [1] 9/13</p> <p>cover [4] 10/24 32/20 45/13 49/6</p> <p>coverage [1] 11/20</p> <p>covered [5] 12/2 44/16 73/23 75/3 124/4</p> <p>covering [1] 55/21</p> <p>CPA [2] 78/20 80/9</p> <p>crack [1] 65/11</p> <p>crafted [1] 88/24</p> <p>CRAG [1] 92/15</p> <p>create [2] 70/11 132/12</p> <p>created [2] 65/8 70/10</p> <p>criteria [4] 82/21 87/12 108/2 109/15</p> <p>criticised [1] 109/5</p> <p>cropped [1] 125/11</p> <p>cross [2] 44/20 133/15</p> <p>cross-check [1] 44/20</p> <p>crossed [3] 56/2 84/8 120/5</p> <p>cryo [1] 124/9</p> <p>cryoprecipitate [2] 124/3 124/6</p> <p>CSA [1] 115/1</p> <p>current [6] 17/6 69/15 70/16 120/15 125/10 131/18</p> <p>currently [2] 17/23 37/3</p> <p>cut [1] 83/19</p>	<p>D</p> <p>damaged [2] 15/13 16/1</p> <p>damages [1] 78/17</p> <p>dangerous [4] 62/15 62/20 70/20 132/12</p> <p>data [2] 24/20 100/19</p> <p>database [1] 120/22</p> <p>date [7] 24/25 50/1 79/10 93/18 95/3 120/15 134/1</p> <p>dated [5] 36/1 42/17 90/18 93/21 106/19</p> <p>dates [2] 30/20 35/24</p> <p>David [1] 84/6</p> <p>David Goldberg's [1] 84/6</p> <p>day [3] 91/5 92/5 136/25</p> <p>days [6] 34/6 97/11 110/19 135/25 136/11 136/14</p> <p>DCMO [1] 107/4</p> <p>DCMOs [1] 90/22</p> <p>Deacon [4] 4/19 32/10 34/10 59/20</p> <p>Deacon's [1] 34/3</p> <p>deal [4] 17/18 103/24 126/17 132/1</p> <p>dealing [5] 21/13 87/7 99/10 127/9 127/10</p> <p>deals [1] 48/24</p> <p>dealt [1] 80/4</p> <p>Dear [1] 95/11</p> <p>death [4] 2/21 3/4 123/13 123/15</p> <p>decade [2] 42/9 100/17</p> <p>decades [1] 110/22</p> <p>December [2] 35/20 101/8</p> <p>December 1997 [1] 101/8</p> <p>decide [3] 63/22 63/24 111/15</p> <p>decided [6] 5/6 22/5 67/10 128/18 128/20 129/1</p> <p>deciding [4] 80/3 86/14 109/6 128/11</p> <p>decision [19] 1/11</p>	<p>4/14 4/18 10/5 59/22 70/9 70/13 77/4 78/4 78/8 78/21 79/2 82/16 85/11 101/17 102/20 108/12 108/13 109/10</p> <p>decision-making [5] 70/9 78/4 82/16 85/11 108/12</p> <p>decisions [2] 107/3 111/6</p> <p>decontamination [1] 104/10</p> <p>deferral [1] 101/12</p> <p>deficiencies [2] 119/23 120/2</p> <p>define [2] 73/13 84/16</p> <p>defining [2] 73/15 75/4</p> <p>definite [1] 52/18</p> <p>definitely [7] 3/5 11/9 89/23 111/1 122/12 124/7 134/20</p> <p>definition [1] 16/6</p> <p>definitive [1] 82/22</p> <p>definitively [1] 28/19</p> <p>DEFIX [9] 120/8 120/9 120/11 120/18 120/20 120/22 120/23 121/5 121/15</p> <p>degree [6] 11/8 11/9 105/7 131/3 135/13 136/10</p> <p>delaying [1] 74/20</p> <p>deletions [1] 54/6</p> <p>deliberate [1] 11/10</p> <p>deliberately [3] 10/23 58/3 58/8</p> <p>Demand [1] 106/23</p> <p>demands [2] 45/12 106/24</p> <p>demonstrate [1] 124/1</p> <p>demonstrated [2] 29/10 64/15</p> <p>demonstrating [2] 43/21 43/23</p> <p>department [42] 4/7 4/25 10/10 10/18 13/11 17/7 19/8 19/13 21/12 23/4 23/9 23/13 23/16 23/19 23/24 24/7 27/2 30/10 33/20</p>	<p>53/16 58/16 59/1 59/7 61/6 61/7 61/21 62/4 62/10 64/21 74/7 85/23 85/24 87/5 89/11 90/19 104/19 106/18 114/20 121/12 122/1 122/2 128/13</p> <p>Department's [4] 25/21 26/11 31/5 70/19</p> <p>departmental [4] 83/7 105/3 106/2 112/14</p> <p>departments [5] 3/21 10/19 50/5 64/13 85/21</p> <p>depend [1] 135/21</p> <p>depends [1] 117/12</p> <p>Dept [1] 63/17</p> <p>depth [3] 36/17 105/5 106/4</p> <p>Deputy [1] 95/9</p> <p>deranged [2] 126/3 126/7</p> <p>derived [2] 36/11 76/22</p> <p>described [5] 14/14 19/22 22/3 24/17 130/22</p> <p>describing [4] 38/13 86/22 109/20 134/5</p> <p>designing [1] 132/2</p> <p>desirable [1] 133/17</p> <p>desire [3] 19/18 113/5 128/15</p> <p>despite [2] 20/9 91/8</p> <p>detail [11] 27/6 37/1 55/3 61/24 63/1 68/2 72/18 76/10 85/1 100/2 106/16</p> <p>detailed [1] 57/24</p> <p>detailing [1] 34/24</p> <p>details [3] 13/7 95/20 96/16</p> <p>detained [1] 117/11</p> <p>determine [3] 7/16 13/18 28/12</p> <p>determined [5] 9/13 22/10 30/25 47/10 71/14</p> <p>determining [3] 71/20 72/14 82/18</p> <p>devastating [3] 55/10</p>	<p>69/17 99/8</p> <p>develop [4] 21/22 55/16 56/7 101/10</p> <p>developed [3] 28/23 87/20 87/23</p> <p>developing [2] 27/17 55/23</p> <p>development [2] 10/24 53/1</p> <p>developments [2] 16/10 52/24</p> <p>develops [1] 29/24</p> <p>deviate [1] 65/25</p> <p>devolution [3] 5/9 5/17 65/15</p> <p>devolved [2] 2/3 81/7</p> <p>DH [4] 53/5 67/8 84/13 106/10</p> <p>DHNI0000013 [1] 90/17</p> <p>DHSC0004510 [1] 85/18</p> <p>DHSC0004520 [1] 89/6</p> <p>DHSC0006798 [1] 87/4</p> <p>DHSC0020742 [1] 78/11</p> <p>DHSC0032292 [1] 59/25</p> <p>DHSC0041159 [1] 106/17</p> <p>diagnose [1] 82/22</p> <p>diagnosis [6] 29/6 36/9 82/18 83/14 99/8 111/19</p> <p>diagnostic [2] 98/19 99/9</p> <p>did [36] 11/1 11/2 13/23 21/21 31/5 38/6 48/16 48/20 70/19 75/23 81/15 81/23 82/12 83/18 88/3 92/2 100/8 101/18 107/24 108/11 108/24 112/20 112/23 113/13 115/1 115/5 120/1 123/17 124/2 124/17 128/8 128/11 129/4 129/17 132/11 133/18</p> <p>didn't [18] 28/3 28/24 35/22 38/6 44/9 46/13</p>
--	--	---	--	--

(43) course... - didn't

<p>D</p> <p>didn't... [12] 49/6 73/21 73/22 74/10 102/22 116/2 119/4 119/19 123/1 125/17 132/14 134/19</p> <p>die [1] 2/23</p> <p>died [3] 2/18 107/24 124/1</p> <p>differ [1] 26/14</p> <p>difference [2] 16/16 135/13</p> <p>different [14] 10/1 10/23 11/5 12/17 14/25 23/14 27/11 79/4 81/11 85/20 101/1 102/22 129/25 133/23</p> <p>differently [1] 9/15</p> <p>difficult [8] 15/24 24/18 53/10 57/20 65/12 69/13 129/22 131/2</p> <p>difficult' [1] 132/4</p> <p>difficulties [7] 71/17 73/11 73/14 75/2 75/6 103/11 109/4</p> <p>difficulty [6] 58/21 58/24 65/20 72/14 103/17 115/6</p> <p>digestibility [1] 63/11</p> <p>direct [4] 16/7 23/22 50/2 76/17</p> <p>directing [1] 23/23</p> <p>direction [2] 60/21 82/7</p> <p>directly [6] 10/7 50/23 53/20 66/11 66/15 72/21</p> <p>director [2] 41/4 52/22</p> <p>directors [13] 19/11 19/20 24/2 35/19 36/2 36/18 36/23 40/1 41/13 57/22 58/22 59/3 59/8</p> <p>disagree [3] 22/13 69/14 130/25</p> <p>disallowed [1] 107/11</p> <p>disaster [1] 130/23</p> <p>disasters [1] 131/1</p>	<p>disbelieve [2] 119/4 119/19</p> <p>disbelieved [1] 118/24</p> <p>disclose [1] 59/15</p> <p>discuss [8] 6/24 7/25 36/16 63/22 84/24 85/3 91/1 128/12</p> <p>discussed [17] 2/9 12/25 13/1 15/22 32/16 39/9 42/11 52/8 53/19 53/19 61/24 65/21 82/9 85/2 89/13 122/24 129/10</p> <p>discussion [10] 12/4 40/12 40/18 66/13 77/11 80/8 80/15 89/20 91/5 92/9</p> <p>discussions [15] 23/1 50/3 65/22 66/3 66/11 78/9 79/18 81/3 81/17 82/10 82/13 83/6 83/11 83/21 130/9</p> <p>disgruntled [1] 132/15</p> <p>disorder [2] 119/24 129/18</p> <p>disposable [1] 104/4</p> <p>disruption [1] 99/10</p> <p>distance [1] 49/9</p> <p>distress [3] 55/11 99/21 129/9</p> <p>Division [1] 1/14</p> <p>do [71] 4/18 13/22 15/15 19/14 20/18 21/10 22/10 23/12 25/12 25/19 28/14 32/11 33/12 34/11 39/1 40/11 44/5 44/13 45/12 47/3 48/16 49/11 52/3 54/11 58/14 61/19 64/3 65/18 65/20 70/12 72/16 74/15 74/22 78/3 80/1 80/10 82/15 82/15 85/2 85/10 86/20 96/20 97/6 98/20 99/1 100/5 100/21 101/25 103/17 105/11 106/7 107/12 109/12 111/12 111/13 111/20 112/25 114/7</p>	<p>115/4 117/2 117/14 122/3 126/2 127/21 128/17 131/4 132/25 134/3 134/9 134/23 135/6</p> <p>Dobson [1] 67/11</p> <p>Dobson's [1] 3/22</p> <p>doctor [5] 4/24 97/15 111/6 111/11 111/14</p> <p>doctor's [1] 13/23</p> <p>document [29] 2/14 5/2 19/2 25/10 25/12 25/16 25/19 26/3 31/15 32/17 33/12 35/9 42/15 46/12 66/5 78/11 79/5 79/6 80/10 80/20 84/20 85/17 86/16 87/3 90/18 90/23 106/10 107/15 112/22</p> <p>documentation [10] 59/21 95/23 100/2 101/16 102/15 108/19 111/25 113/1 124/25 128/5</p> <p>documented [1] 18/23</p> <p>documents [9] 25/2 27/21 33/19 53/21 80/24 82/14 93/17 97/23 113/18</p> <p>does [12] 10/3 35/2 41/24 50/21 54/25 62/21 64/4 118/23 121/6 125/13 127/4 127/22</p> <p>Does it [3] 64/4 118/23 125/13</p> <p>doesn't [9] 2/23 29/14 40/8 41/24 73/6 111/16 120/19 132/14 132/19</p> <p>doing [5] 12/14 40/22 130/19 134/6 134/16</p> <p>Dolan [1] 47/9</p> <p>dollop [1] 43/16</p> <p>don't [62] 3/2 3/15 3/16 4/19 7/24 13/16 20/19 20/23 24/25 25/23 26/19 27/4 28/18 32/9 32/15 33/15 34/17 34/21</p>	<p>35/7 40/18 40/25 43/10 44/7 44/10 45/6 49/8 52/7 54/18 57/3 63/1 68/2 72/11 72/17 78/8 80/5 82/5 82/10 82/11 88/24 89/15 89/24 90/22 93/23 98/22 102/24 103/3 107/14 108/2 108/19 109/19 112/1 113/6 113/18 117/3 117/3 120/14 122/6 123/20 130/15 131/4 135/10 136/6</p> <p>donation [2] 99/21 127/8</p> <p>donations [3] 43/13 43/22 101/4</p> <p>done [9] 9/15 13/5 45/18 53/23 97/9 111/8 125/20 133/25 134/17</p> <p>donor [6] 47/16 51/16 126/2 126/5 127/6 135/20</p> <p>donors [4] 101/13 125/21 126/15 126/17</p> <p>Dora [20] 21/5 21/11 42/17 42/22 42/24 42/24 44/11 44/18 44/24 52/12 57/2 57/14 57/19 58/7 58/20 59/4 60/8 64/5 64/11 64/18</p> <p>Dora's [4] 53/12 63/2 63/6 112/24</p> <p>dot [1] 117/25</p> <p>double [1] 119/5</p> <p>doubt [2] 34/10 123/4</p> <p>doubtless [1] 73/3</p> <p>Douglas [3] 4/4 79/10 112/12</p> <p>Douglas-Hamilton [1] 4/4</p> <p>down [20] 5/18 16/5 21/6 22/24 25/7 26/3 27/12 39/3 40/7 40/25 52/15 57/6 61/4 61/16 64/14 74/15 80/18 86/19 95/5 111/7</p> <p>Dr [22] 4/23 4/23 4/24 9/23 11/16 20/7 20/20</p>	<p>24/25 37/8 38/18 38/19 38/24 43/6 81/10 83/23 84/11 93/1 95/8 107/4 120/7 122/11 132/24</p> <p>Dr Aileen Keel [2] 95/8 107/4</p> <p>Dr Colvin [1] 24/25</p> <p>Dr Forrester [2] 20/7 20/20</p> <p>Dr Hayes [1] 83/23</p> <p>Dr Keel [5] 11/16 37/8 38/18 43/6 84/11</p> <p>Dr Keel's [1] 132/24</p> <p>Dr Ludlam [2] 38/24 120/7</p> <p>Dr McGovern [1] 93/1</p> <p>Dr Reid [1] 81/10</p> <p>Dr Watson [1] 38/19</p> <p>Dr Willoughby's [1] 122/11</p> <p>Dr Woods [3] 4/23 4/23 4/24</p> <p>draft [12] 18/1 18/3 18/9 18/10 26/16 52/13 54/2 54/4 57/7 60/2 60/12 60/13</p> <p>drafting [1] 21/6</p> <p>draw [5] 4/12 17/2 35/14 109/15 110/16</p> <p>drawing [1] 88/25</p> <p>drawn [2] 21/7 22/16</p> <p>dressed [1] 124/21</p> <p>drill [1] 5/18</p> <p>drinking [2] 125/23 126/13</p> <p>driving [1] 130/16</p> <p>dual [1] 103/24</p> <p>due [12] 7/5 22/8 32/10 41/6 44/1 75/18 76/1 100/7 108/9 120/3 126/3 126/4</p> <p>Dundee [2] 11/19 36/23</p> <p>dura [1] 103/23</p> <p>during [18] 9/24 10/9 10/13 16/25 24/17 31/19 37/13 53/7 53/8 55/24 58/22 88/21 94/2 96/23 114/17 128/24 129/12 132/3</p> <p>dying [1] 107/23</p>
---	---	--	--	---

(44) didn't... - dying

E	44/17 66/2 134/6 elevated [6] 51/1 115/24 125/21 125/23 126/12 126/18 elevation [1] 29/4 eligibility [2] 80/8 87/12 eligible [8] 10/17 33/22 74/3 84/9 86/25 87/19 88/5 88/19 eliminated [1] 88/1 eliminating [1] 51/12 else [6] 13/5 20/23 21/4 33/11 41/4 56/2 elsewhere [1] 100/1 email [23] 32/25 33/13 33/15 42/17 42/20 44/1 60/1 60/4 60/7 60/8 60/10 60/17 60/18 62/7 63/2 63/3 64/17 66/17 66/23 67/5 72/1 89/10 89/15 emails [2] 75/12 89/9 emanated [1] 9/19 embark [1] 16/2 embarked [1] 83/5 emerged [6] 28/7 105/6 105/14 105/19 112/9 116/9 emerging [1] 135/22 emphasis [1] 104/3 emphasise [3] 23/8 43/14 72/4 emphasising [1] 66/10 employment [1] 50/2 enable [2] 32/7 126/5 encountering [1] 115/7 encounters [1] 85/6 end [4] 34/20 81/13 96/15 132/5 endeavour [1] 115/3 ended [2] 16/3 114/1 endorse [1] 79/17 endorsed [1] 3/23 endorses [1] 4/14 energetic [1] 96/4 engage [2] 23/19 115/5 engaged [2] 17/8 23/10	engagement [2] 130/1 130/4 England [19] 5/21 5/24 16/17 22/2 30/7 31/4 31/5 32/20 78/16 81/12 81/14 81/18 85/24 107/1 107/3 133/16 134/17 134/19 135/4 English [3] 18/15 29/16 134/21 enhance [1] 105/20 enhanced [1] 104/14 enormous [5] 66/8 66/10 67/1 124/9 127/12 enough [3] 32/20 56/21 135/20 enquiries [3] 17/16 19/23 95/7 enquiry [1] 4/3 ensure [2] 8/11 118/5 ensuring [2] 89/1 93/9 enter [1] 79/18 entirely [7] 34/23 46/13 80/16 97/6 102/12 129/25 136/14 entitled [1] 62/2 envisage [2] 70/12 73/14 envisaged [1] 50/13 enzymes [1] 12/24 episode [1] 55/9 equally [3] 74/2 74/3 115/25 equipment [1] 103/13 equivalent [1] 94/6 erode [1] 126/21 especially [1] 69/15 essential [4] 2/10 2/14 10/16 15/3 essentially [8] 5/23 13/3 14/20 22/9 38/24 39/14 59/1 61/22 establish [5] 6/20 37/25 70/7 70/20 108/13 established [2] 96/10 108/22 establishment [3] 62/13 108/1 132/11	estimate [2] 10/16 84/7 et [5] 14/4 51/4 67/2 78/17 126/25 et cetera [5] 14/4 51/4 67/2 78/17 126/25 ethics [1] 100/19 European [1] 56/16 evades [1] 11/11 evaluate [1] 124/22 even [15] 7/19 22/7 31/21 32/21 42/6 43/20 44/15 64/10 88/22 97/16 104/5 120/11 122/25 123/6 128/24 event [8] 3/4 25/14 27/14 45/8 66/19 124/5 124/11 127/21 events [15] 9/9 9/24 10/9 10/21 17/8 17/16 21/19 23/11 23/25 43/19 52/10 77/20 80/19 85/15 131/3 eventuality [1] 54/1 eventually [2] 88/23 89/3 ever [6] 24/19 102/24 103/3 107/21 114/19 121/11 every [4] 2/18 12/24 39/5 55/15 everybody [5] 31/4 56/23 73/21 73/23 133/21 everyone [1] 135/4 everything [2] 51/10 116/25 evidence [50] 4/10 18/18 20/4 20/16 22/1 24/1 27/3 28/2 28/15 41/16 55/25 56/15 57/16 58/3 81/2 87/20 88/7 88/14 89/18 98/3 99/13 99/14 103/8 105/5 105/10 105/11 105/16 105/19 105/21 106/8 108/11 108/23 116/8 117/4 118/21 119/8 119/9 119/17 121/3 123/25 125/4	125/20 125/21 126/23 127/15 127/20 128/3 136/10 136/12 136/18 evidence-gathering [1] 20/16 evolution [1] 100/18 evolved [1] 110/21 ex [5] 84/9 84/21 85/5 85/8 132/9 ex gratia [4] 84/21 85/5 85/8 132/9 ex-gratia [1] 84/9 exactly [4] 50/3 89/16 111/3 111/9 examination [6] 4/12 26/6 105/2 105/4 106/1 106/3 examine [1] 57/16 examined [4] 4/8 105/18 105/24 106/13 examining [1] 107/7 example [13] 6/9 20/6 54/8 69/11 83/21 97/7 97/17 102/1 113/7 113/19 114/25 118/10 132/16 exception [1] 15/21 exceptions [1] 69/4 excess [1] 32/2 exchange [3] 62/7 83/23 89/15 excluded [2] 121/10 128/19 exclusion [1] 29/6 exclusive [1] 59/16 exclusively [1] 30/23 exec [2] 4/24 61/7 Executive [29] 1/9 6/25 8/20 13/6 19/8 36/21 53/22 62/10 68/22 70/7 70/25 71/22 72/19 72/21 74/6 77/6 78/6 78/21 79/23 84/6 85/22 87/7 95/4 103/19 104/20 107/7 107/16 114/20 118/24 Executive's [2] 118/20 119/1 exercise [11] 13/17 20/16 34/4 34/15 34/17 39/23 43/1
----------	--	--	--	--

(45) each - exercise

<p>E</p> <p>exercise... [4] 130/18 133/4 134/3 134/14</p> <p>exercises [2] 99/25 134/18</p> <p>exercising [1] 2/4</p> <p>existence [4] 28/11 42/9 110/18 115/16</p> <p>existing [1] 45/16</p> <p>expanded [1] 55/20</p> <p>expect [1] 118/14</p> <p>expectation [1] 118/11</p> <p>expected [1] 130/12</p> <p>expecting [2] 53/25 72/7</p> <p>experience [2] 44/8 90/2</p> <p>experienced [2] 88/9 89/2</p> <p>experiencing [1] 103/10</p> <p>expert [6] 74/13 74/22 74/25 75/5 76/15 76/18</p> <p>explain [2] 62/16 116/21</p> <p>explained [9] 7/9 8/22 37/24 39/7 39/22 84/12 84/16 134/12 135/18</p> <p>explains [3] 1/22 3/19 50/11</p> <p>explanation [1] 37/10</p> <p>explanatory [1] 87/18</p> <p>explicit [1] 118/15</p> <p>exploration [1] 68/21</p> <p>explored [8] 91/11 96/24 109/3 109/8 115/9 118/9 118/19 132/3</p> <p>exposed [5] 18/13 30/25 37/14 55/18 76/3</p> <p>exposure [2] 33/10 120/3</p> <p>expressed [4] 22/5 51/24 61/19 64/5</p> <p>expression [2] 40/9 75/20</p> <p>extended [1] 88/9</p>	<p>extent [6] 8/5 17/20 29/24 65/7 98/24 128/2</p> <p>extremely [3] 83/3 99/5 112/16</p> <p>F</p> <p>face [6] 12/8 12/12 13/3 19/12 39/14 59/2</p> <p>fact [16] 4/7 10/3 16/20 24/14 38/6 43/1 44/4 52/24 69/8 86/18 98/9 111/16 115/19 127/6 127/16 132/18</p> <p>fact-finding [1] 43/1</p> <p>factor [17] 2/21 5/20 8/12 9/8 17/10 21/22 56/7 56/18 58/5 106/16 120/3 122/7 124/2 124/11 125/6 127/7 130/15</p> <p>Factor VIII [7] 5/20 8/12 9/8 17/10 58/5 106/16 124/2</p> <p>factors [1] 126/5</p> <p>facts [6] 10/8 22/14 22/16 34/24 44/19 55/14</p> <p>factual [2] 8/10 39/22</p> <p>failed [1] 83/12</p> <p>failure [2] 11/23 77/16</p> <p>fair [6] 5/1 30/1 68/25 93/13 107/18 110/15</p> <p>fairly [4] 22/5 56/13 110/6 128/20</p> <p>fairness [1] 68/12</p> <p>Falconer [4] 7/1 8/19 67/7 72/3</p> <p>fall [2] 72/9 126/20</p> <p>fallen [1] 97/10</p> <p>false [3] 51/1 51/5 51/13</p> <p>familiar [1] 12/21</p> <p>families [1] 55/11</p> <p>family [1] 17/1</p> <p>far [27] 13/15 17/17 19/23 27/3 35/18 39/15 43/11 45/20 49/3 52/17 53/4 74/4 74/8 75/1 75/22 76/14 81/15 98/13 101/18</p>	<p>108/16 114/5 118/16 120/8 127/3 129/4 134/4 134/12</p> <p>fatal [3] 64/3 98/18 99/9</p> <p>fault [13] 1/25 8/5 9/14 14/20 15/9 15/19 16/3 46/13 53/13 69/25 89/8 131/10 131/23</p> <p>fear [1] 33/13</p> <p>feared [1] 132/13</p> <p>fears [1] 33/7</p> <p>feasible [1] 133/13</p> <p>February [8] 20/7 36/20 64/16 64/18 67/6 67/18 83/23 128/6</p> <p>February 1987 [1] 20/7</p> <p>February 2001 [3] 64/16 67/6 67/18</p> <p>February 2003 [2] 83/23 128/6</p> <p>feedback [1] 8/1</p> <p>feel [3] 68/16 74/2 75/23</p> <p>feeling [4] 62/4 62/22 72/25 83/17</p> <p>fell [1] 45/16</p> <p>felt [4] 62/2 102/11 105/6 122/16</p> <p>few [2] 25/16 60/6</p> <p>field [1] 96/19</p> <p>figures [5] 24/15 37/2 37/5 82/8 127/25</p> <p>files [10] 20/21 111/25 112/10 112/15 112/19 112/23 113/7 113/9 113/13 113/21</p> <p>final [9] 26/15 32/11 58/7 59/17 60/13 76/10 77/22 113/24 114/16</p> <p>finalised [1] 60/3</p> <p>finally [3] 24/19 53/4 113/9</p> <p>finance [1] 52/22</p> <p>financial [27] 4/11 10/6 10/12 33/7 33/23 53/4 53/17 59/23 61/22 67/19 68/5 68/6</p>	<p>69/21 70/13 71/1 71/11 71/13 76/16 80/22 81/6 115/5 115/17 115/22 131/6 131/8 131/13 131/16</p> <p>find [4] 7/24 57/21 60/12 117/6</p> <p>finder [1] 44/4</p> <p>finding [2] 34/24 43/1</p> <p>findings [5] 7/14 26/10 26/11 27/23 28/8</p> <p>finer [1] 72/18</p> <p>finish [1] 87/2</p> <p>finished [2] 116/18 117/2</p> <p>fired [1] 133/20</p> <p>firmly [2] 60/21 67/19</p> <p>first [50] 2/6 4/16 7/4 8/21 20/3 33/1 33/3 38/15 44/7 48/8 48/13 49/15 49/21 49/24 50/1 57/21 60/2 61/3 63/5 64/21 69/9 72/23 77/19 78/15 84/15 86/21 87/1 87/19 88/10 89/3 89/8 91/5 92/4 94/3 95/19 98/6 100/17 101/3 107/12 110/17 112/4 114/16 118/2 120/11 121/25 124/14 128/24 130/23 135/17 135/25</p> <p>fit [1] 132/6</p> <p>fixed [1] 82/1</p> <p>flagged [2] 36/14 45/19</p> <p>Fletcher [1] 127/16</p> <p>flexible [1] 82/3</p> <p>flippant [1] 113/4</p> <p>floodgates [1] 61/17</p> <p>fluently [1] 30/3</p> <p>focus [4] 6/5 7/15 9/11 91/6</p> <p>focused [3] 6/11 84/21 92/20</p> <p>focusing [2] 4/5 12/1</p> <p>follow [5] 10/17 40/5 118/23 125/13 130/8</p> <p>follow-up [2] 10/17 130/8</p> <p>followed [1] 23/7</p>	<p>following [16] 12/25 23/3 33/5 47/13 54/16 64/10 78/20 87/17 89/14 92/8 95/2 97/8 100/17 118/1 132/8 136/25</p> <p>follows [1] 71/9</p> <p>fora [3] 105/3 106/2 106/7</p> <p>Forbes [1] 119/22</p> <p>forced [2] 75/16 107/3</p> <p>fore [1] 102/23</p> <p>forefront [1] 125/18</p> <p>foreseen [1] 64/8</p> <p>forgive [1] 49/25</p> <p>form [7] 14/3 20/25 26/16 50/14 54/7 59/17 125/15</p> <p>formally [1] 32/21</p> <p>former [1] 94/22</p> <p>forms [2] 67/24 87/14</p> <p>formulate [1] 116/25</p> <p>formulation [1] 15/1</p> <p>Forrester [2] 20/7 20/20</p> <p>forthcoming [1] 59/11</p> <p>forward [9] 22/21 23/3 23/8 33/5 64/16 73/7 77/18 130/20 132/21</p> <p>forwarding [1] 42/19</p> <p>Foster [1] 47/8</p> <p>found [4] 11/16 32/18 94/19 94/24</p> <p>four [3] 3/21 6/25 65/19</p> <p>fourth [1] 77/2</p> <p>fractionated [2] 102/2 102/14</p> <p>fractionating [1] 103/2</p> <p>fractionation [1] 56/14</p> <p>fractionators [1] 56/16</p> <p>framed [1] 6/13</p> <p>framework [1] 82/6</p> <p>Francis [2] 61/5 61/5</p> <p>Francis Gibb [2] 61/5 61/5</p>
---	---	--	--	--

F	24/1 39/22 105/21 gave [7] 34/11 45/22 46/13 61/15 67/1 108/23 134/11 general [16] 37/25 38/7 61/20 62/4 64/12 69/3 84/2 95/7 95/23 97/5 97/12 97/17 110/10 110/11 111/22 111/23 generalisation [2] 3/12 3/16 generally [1] 20/5 generated [1] 105/18 generation [3] 49/19 135/17 136/1 genuine [1] 19/18 Gerard [1] 106/20 Gerard Hetherington [1] 106/20 get [9] 5/22 8/1 16/8 24/15 64/3 67/6 75/2 104/7 113/11 getting [2] 43/12 97/21 Gibb [4] 61/5 61/5 61/12 61/19 gift [1] 113/14 Gillon [1] 134/17 give [7] 24/23 43/18 80/24 107/25 113/15 116/13 124/8 given [30] 11/25 13/12 14/22 16/19 21/10 21/23 37/10 38/3 41/2 48/17 53/10 57/16 58/11 58/24 69/15 82/24 86/12 89/3 99/8 99/20 100/23 108/11 116/24 117/2 122/7 129/15 131/8 134/1 136/10 136/15 gives [2] 66/8 96/16 giving [5] 106/7 108/12 109/1 111/17 124/10 Glasgow [5] 12/13 12/16 12/18 119/21 119/24 go [77] 1/21 3/18 4/16 9/20 14/18 17/5 17/18	18/1 18/9 19/1 19/24 21/16 22/24 25/5 25/6 27/7 32/23 36/25 37/1 37/4 39/3 39/17 45/3 46/11 46/16 47/5 47/21 49/10 51/19 52/15 53/3 54/4 54/11 54/14 54/23 55/3 55/7 56/6 56/21 57/3 57/5 60/3 60/5 60/16 61/3 62/6 62/16 62/24 63/5 64/17 66/22 67/5 68/2 68/4 69/2 69/7 70/23 71/7 72/11 73/11 75/10 76/23 78/14 79/14 84/1 84/19 85/1 86/1 89/9 90/22 91/4 93/24 95/22 100/1 109/22 110/5 112/4 goes [2] 29/24 69/24 going [50] 2/23 8/3 13/13 13/15 13/22 26/3 29/17 34/8 37/1 41/1 41/7 43/17 44/18 45/1 46/11 55/3 55/13 59/18 59/18 61/10 61/15 64/13 65/25 72/24 73/11 75/13 76/9 80/5 80/23 81/16 82/6 84/16 85/1 91/6 96/13 97/22 97/25 97/25 104/10 104/16 109/25 111/7 112/1 117/16 117/23 132/22 133/14 134/2 134/20 136/2 gold [1] 82/20 Goldberg's [1] 84/6 gone [7] 24/23 101/9 106/16 111/2 120/24 134/14 134/21 good [6] 1/5 1/6 22/2 27/24 47/3 126/6 Gordon [1] 41/10 Gordon Lowe's [1] 41/10 Gosh [1] 120/11 got [12] 19/24 24/20 29/13 43/7 60/16 63/2 84/20 108/19 113/9 123/4 123/4 132/17 governed [1] 92/3	government [26] 2/4 10/10 15/12 16/2 20/23 30/21 37/22 40/11 50/2 53/10 67/10 74/9 74/9 74/15 81/4 81/11 92/23 114/3 114/6 114/20 130/1 131/17 132/4 132/7 133/9 136/20 Government's [3] 14/19 15/21 115/13 Government-sponsor ed [1] 92/23 governmental [1] 114/17 grateful [2] 33/9 66/25 gratia [5] 84/9 84/21 85/5 85/8 132/9 great [5] 34/18 39/6 42/10 99/21 132/1 greater [3] 102/1 110/10 110/12 greatly [1] 104/3 grilling [1] 19/19 grounds [3] 1/25 80/16 128/20 groundswell [1] 29/24 group [15] 6/15 6/15 73/8 74/12 74/13 74/22 75/1 76/7 76/15 76/18 83/5 92/16 96/10 115/23 131/6 group's [1] 75/5 groups [8] 62/1 73/2 73/2 74/1 115/25 131/13 131/21 132/15 grown [1] 68/11 growth [1] 103/22 guess [6] 50/7 73/17 108/3 109/14 120/12 121/10 gun [1] 133/20 Gutowski [2] 87/4 87/10	15/25 19/21 20/22 21/8 23/17 23/22 23/25 24/16 25/3 27/2 28/12 29/2 29/12 30/12 30/25 31/10 32/18 32/21 33/20 34/20 35/19 40/2 40/24 41/11 41/12 41/14 45/17 46/12 48/3 48/11 48/17 48/21 48/25 49/5 53/13 53/22 58/3 58/21 64/9 64/15 64/20 67/10 72/22 73/21 74/22 75/16 76/1 76/5 80/11 83/6 87/11 87/13 87/14 87/20 87/21 87/23 87/25 88/18 89/19 89/19 93/11 97/10 98/18 100/20 101/9 101/24 102/9 103/1 103/9 103/22 104/22 105/2 105/5 105/18 105/23 106/6 106/12 106/13 106/14 106/16 107/23 107/24 110/14 110/23 113/2 113/11 114/12 116/2 116/8 118/12 118/25 119/15 120/7 120/18 120/23 120/24 122/12 122/14 122/25 125/9 125/21 126/7 128/4 128/22 128/25 129/12 129/20 131/15 133/25 134/17 134/17 hadn't [4] 28/23 45/17 119/5 123/6 haematology [1] 96/19 haemoglobin [2] 97/10 97/20 haemophilia [81] 1/17 1/22 4/4 4/9 5/11 5/19 6/5 6/11 7/6 7/20 8/24 9/7 9/18 10/11 11/17 12/3 13/6 13/9 14/16 18/13 19/5 19/9 19/11 19/15 19/20 22/6 22/17 22/22 24/2 24/3 25/15 25/20
G	Galbraith [1] 3/23 gap [1] 58/24 gather [1] 20/21 gathered [1] 21/19 gathering [4] 20/16			
		H		
		had [124] 1/11 6/16 7/9 7/10 7/16 8/11 9/3 10/23 11/20 12/16 14/2 15/18 15/20		

<p>H</p> <p>haemophilia... [49] 26/17 26/21 26/25 30/18 33/6 34/7 34/8 34/19 34/25 35/1 35/18 36/2 36/5 36/18 37/9 37/17 40/1 41/4 41/13 41/18 41/20 42/23 43/17 45/1 45/9 46/18 46/21 47/1 47/9 47/11 49/6 51/21 57/17 57/22 58/16 58/22 59/2 64/24 69/12 82/25 83/3 83/20 84/18 86/9 123/12 123/17 127/1 127/18 132/17</p> <p>Haemophilia Society [23] 4/4 4/9 5/11 5/19 6/11 7/6 7/20 10/11 13/6 13/9 14/16 22/6 22/17 22/22 25/15 26/17 33/6 34/7 36/5 46/21 49/6 64/24 69/12</p> <p>Haemophilia Society's [3] 1/17 6/5 19/9</p> <p>haemophiliac [4] 2/18 6/12 71/23 71/24</p> <p>haemophiliacs [15] 1/18 2/20 2/25 7/8 15/9 41/17 42/7 55/9 65/1 65/4 67/11 72/24 123/11 123/19 124/1</p> <p>haemorrhage [2] 3/1 83/2</p> <p>half [15] 27/10 43/10 46/16 47/6 47/22 60/5 63/6 66/6 69/8 75/11 80/6 95/5 98/7 101/2 124/14</p> <p>halfway [2] 27/12 47/22</p> <p>Hamilton [1] 4/4</p> <p>hand [3] 34/1 90/21 95/5</p> <p>handed [2] 113/16 113/21</p> <p>handing [1] 111/7</p> <p>handle [1] 75/2</p>	<p>handling [1] 60/15</p> <p>hands [5] 8/4 14/4 73/22 113/9 119/16</p> <p>handwriting [7] 4/17 4/18 45/4 66/5 66/7 66/20 67/3</p> <p>handwritten [4] 45/4 54/5 54/10 66/24</p> <p>hanging [1] 31/23</p> <p>happen [2] 38/6 134/20</p> <p>happened [8] 7/10 23/25 24/9 40/2 41/8 41/14 92/8 107/25</p> <p>happening [6] 21/15 37/18 104/9 111/3 135/8 135/9</p> <p>Happy [1] 66/15</p> <p>hard [1] 10/12</p> <p>hardship [2] 63/13 63/18</p> <p>harm [1] 128/22</p> <p>has [42] 3/20 7/20 14/19 16/1 17/6 21/19 27/21 32/4 33/3 34/7 41/16 51/22 56/2 60/2 63/17 64/23 65/5 65/16 65/23 68/11 68/20 69/20 70/4 72/13 75/21 79/15 84/7 85/14 88/6 88/13 98/3 100/3 102/8 103/8 110/21 112/9 112/11 115/18 117/4 127/15 130/22 136/10</p> <p>hasn't [3] 22/7 25/8 132/18</p> <p>have [199]</p> <p>haven't [4] 24/23 92/18 109/14 127/19</p> <p>having [19] 1/21 28/5 38/16 44/23 48/23 49/15 50/17 58/14 69/19 71/15 77/11 84/10 100/7 103/10 104/13 106/1 106/10 111/17 116/18</p> <p>Hayes [6] 83/7 83/12 83/23 128/4 128/6 128/14</p> <p>hazy [2] 24/13 113/8</p> <p>HB [1] 125/9</p>	<p>HBc [4] 49/1 125/1 125/12 125/14</p> <p>HCV [31] 7/8 11/3 11/16 15/10 16/17 16/22 18/14 18/18 19/7 21/22 23/5 27/18 28/6 30/17 37/2 42/12 55/9 57/18 62/14 67/11 91/13 114/13 118/16 121/7 121/19 123/3 130/11 131/20 134/25 135/17 135/25</p> <p>HCV-infected [1] 121/7</p> <p>HCV-positive [1] 16/22</p> <p>HCV-safe [4] 16/17 23/5 27/18 30/17</p> <p>HDs [2] 39/25 40/5</p> <p>he [24] 4/24 11/21 33/6 33/9 39/7 39/11 41/1 52/22 60/18 61/7 61/7 65/13 65/13 81/11 87/16 88/23 88/23 92/13 112/10 112/18 113/15 122/11 122/14 122/16</p> <p>he's [3] 15/25 16/8 52/1</p> <p>headed [5] 9/6 21/16 79/11 90/24 93/25</p> <p>heading [9] 16/10 17/6 18/1 19/25 68/6 86/1 91/4 106/23 119/7</p> <p>health [45] 1/13 3/21 3/24 4/8 7/13 19/8 19/12 21/12 33/4 50/6 53/16 57/4 62/10 63/17 64/13 64/21 65/16 67/22 74/7 74/17 77/5 78/25 81/4 81/10 85/24 85/25 87/5 89/12 90/19 94/4 95/1 104/19 106/18 107/1 107/8 114/19 114/25 121/12 121/12 122/2 122/2 126/6 128/13 133/9 136/19</p> <p>Health Service [3] 95/1 121/12 133/9</p> <p>healthcare [1] 2/4</p>	<p>hear [1] 7/7</p> <p>heard [5] 41/16 75/22 103/8 127/15 136/12</p> <p>hearing [1] 136/25</p> <p>hearings [2] 74/12 75/22</p> <p>heat [9] 5/25 10/24 11/5 17/10 17/13 18/24 43/22 121/5 121/15</p> <p>heat-treated [3] 5/25 17/10 17/13</p> <p>held [7] 6/23 8/17 62/9 67/11 83/22 87/13 105/15</p> <p>help [10] 28/1 42/23 49/19 53/4 53/17 54/12 54/17 70/14 71/22 133/6</p> <p>Hep [3] 60/22 65/1 72/8</p> <p>Hep C [3] 60/22 65/1 72/8</p> <p>hepatitis [61] 1/18 5/25 8/11 12/19 12/22 16/21 18/19 19/25 20/8 20/22 28/3 28/9 28/13 28/17 29/5 29/6 30/15 30/19 36/7 38/13 38/23 39/5 42/10 42/23 44/15 45/24 50/25 51/3 51/7 56/8 59/23 61/23 63/18 67/20 69/16 69/23 70/14 71/2 71/23 73/25 77/7 77/14 78/24 84/3 86/19 87/21 87/23 88/22 115/7 121/16 123/4 124/13 124/17 126/4 127/2 127/18 129/6 129/16 130/21 132/10 134/25</p> <p>hepatitis A [1] 29/6</p> <p>hepatitis B [1] 29/5</p> <p>hepatitis C [35] 1/18 8/11 12/19 12/22 16/21 28/3 28/9 30/15 36/7 42/23 44/15 56/8 59/23 61/23 63/18 67/20 69/16 69/23 70/14 71/2 71/23</p>	<p>73/25 77/7 77/14 78/24 84/3 86/19 87/21 87/23 115/7 123/4 129/6 129/16 132/10 134/25</p> <p>hepatitis-safe [1] 5/25</p> <p>hepatologist [1] 86/10</p> <p>hepatology [1] 83/8</p> <p>her [16] 4/14 5/14 14/16 21/6 21/8 22/22 38/18 43/1 43/2 43/5 53/15 59/5 67/1 86/4 86/12 88/18</p> <p>here [32] 2/2 15/7 27/11 27/25 28/21 28/25 34/14 40/13 47/12 50/7 50/13 51/9 51/11 52/1 59/4 73/10 75/4 77/25 80/3 84/20 93/5 93/19 99/7 99/13 101/21 108/5 111/21 113/11 115/21 134/7 134/16 135/9</p> <p>herself [1] 64/5</p> <p>hesitant [1] 127/19</p> <p>Hetherington [1] 106/20</p> <p>high [5] 75/23 76/20 78/16 78/20 111/7</p> <p>higher [4] 16/25 84/9 84/25 115/24</p> <p>highlight [1] 82/23</p> <p>highlighted [1] 11/19</p> <p>highlights [1] 69/14</p> <p>highly [7] 25/23 27/5 31/25 83/1 91/10 93/1 99/11</p> <p>him [6] 53/8 66/12 96/4 96/5 112/9 112/13</p> <p>himself [1] 112/18</p> <p>hindsight [5] 30/16 43/16 122/10 122/22 126/24</p> <p>his [11] 11/21 16/9 41/1 44/8 51/23 52/21 67/11 98/16 112/10 113/6 113/14</p> <p>history [1] 130/24</p> <p>HIV [11] 11/2 15/22</p>
---	---	---	--	--

H	136/19 136/21 Hunt's [1] 66/9	28/18 32/15 33/15 34/21 40/18 40/25 43/10 44/7 44/10 45/6 49/8 52/7 54/18 68/2 72/17 78/8 80/5 82/11 88/24 89/15 89/24 98/22 102/24 103/3 107/14 108/2 108/19 109/19 112/1 113/18 117/3 117/3 120/14 122/6 123/20 130/15 131/4 135/10 136/6 I draw [1] 35/14 I explored [1] 118/19 I felt [1] 102/11 I gave [2] 45/22 46/13 I guess [6] 50/7 73/17 108/3 109/14 120/12 121/10 I had [5] 12/16 29/12 46/12 83/6 106/14 I have [9] 29/12 38/10 43/7 50/2 76/17 86/7 88/11 112/12 119/10 I haven't [3] 24/23 92/18 109/14 I honestly [1] 85/7 I hope [3] 60/13 79/5 116/5 I imagine [2] 32/18 86/22 I infer [3] 20/19 80/6 86/16 I inferred [1] 67/3 I just [10] 17/2 27/9 28/21 47/12 57/11 71/25 80/24 98/4 106/20 112/3 I know [2] 115/8 136/11 I may [4] 40/24 52/6 72/23 121/24 I mean [14] 3/15 5/13 15/23 31/18 40/18 41/1 53/19 76/17 85/13 97/18 103/23 116/4 131/23 132/2 I mentioned [4] 62/1 120/21 122/14 135/19 I moved [1] 114/6 I need [1] 72/12 I note [2] 60/19 63/8	I now [1] 131/11 I pointed [1] 73/1 I probably [1] 89/7 I propose [1] 79/13 I quite [1] 105/25 I raise [1] 110/2 I read [1] 93/9 I reassured [1] 53/8 I recall [5] 31/20 66/2 83/6 92/13 96/4 I referred [1] 92/25 I regretted [1] 75/16 I right [1] 50/19 I said [11] 9/17 10/8 27/4 32/1 32/16 34/16 34/23 44/13 110/21 112/20 131/19 I saw [1] 33/15 I say [5] 26/10 82/23 96/2 96/3 113/17 I see [1] 50/11 I should [3] 26/23 50/8 103/15 I still [2] 115/21 116/7 I suppose [7] 15/24 43/14 106/9 109/17 119/18 122/10 128/14 I suspect [6] 42/6 80/15 82/8 94/22 121/14 135/10 I thank [1] 136/7 I think [111] 2/21 12/21 13/2 14/4 16/8 19/15 19/17 22/13 23/23 24/10 24/14 25/2 25/23 25/25 27/5 28/5 30/23 31/14 31/16 31/25 32/1 32/16 34/1 35/16 35/23 38/1 39/16 40/20 41/11 42/19 44/13 45/24 48/14 49/7 50/13 52/19 52/22 55/1 56/5 58/18 58/20 59/13 60/20 64/11 66/17 70/21 75/4 76/8 76/25 77/23 78/7 78/12 80/6 82/12 82/23 83/13 83/21 83/24 84/19 86/18 88/16 88/24 90/21 92/19 97/1 97/5 99/3	99/4 99/25 100/10 100/22 100/22 102/3 104/17 105/2 106/10 106/14 107/15 109/24 110/6 110/17 110/24 111/1 111/9 111/21 113/7 113/17 113/25 114/6 116/10 120/21 121/3 121/24 122/14 124/4 124/22 125/6 125/8 126/9 127/4 127/9 128/20 129/14 129/22 130/15 130/22 132/4 132/17 134/13 134/15 135/18 I thought [2] 33/15 82/5 I trespassed [1] 46/4 I understand [3] 51/18 65/1 102/20 I understand it [1] 46/25 I use [1] 127/11 I want [3] 1/10 59/21 111/24 I wanted [6] 2/13 47/6 56/22 90/13 103/7 110/11 I was [11] 28/7 28/18 30/2 31/18 44/19 80/5 97/14 99/4 100/11 103/20 114/6 I wasn't [1] 26/23 I will [1] 24/23 I won't [2] 71/7 96/13 I worked [1] 31/20 I would [5] 4/17 21/7 85/12 111/4 118/14 I wrote [1] 89/25 I'd [2] 99/20 113/23 I'll [7] 25/10 35/7 35/11 53/2 80/25 94/9 113/19 I'm [56] 13/4 13/12 19/2 25/7 26/3 37/1 40/23 40/24 41/9 42/18 46/11 55/3 55/13 59/18 61/9 63/9 64/6 69/8 75/13 76/9 80/23 81/21 85/1 88/16 89/6 95/22 97/22 97/25 100/1
----------	---	---	---	--

I	impartial [3] 23/10 23/20 34/13	119/7	88/9 89/2 89/5 98/18 115/21 126/4 129/6 130/21	104/21 105/6 105/9 105/15 105/20 106/15 106/23 106/25 107/7 107/9 107/18 107/20 108/1 108/10 108/11 108/14 108/22 108/25 109/1 109/6 109/7 109/11 109/17 113/24 114/3 114/9 115/16 116/6 116/9 116/22 119/12 127/15 131/15 135/2
I'm... [27] 104/16 105/25 108/4 108/7 108/17 109/25 114/23 117/23 120/15 123/14 123/16 124/18 125/17 127/19 127/23 128/10 129/8 131/4 131/23 132/20 132/22 134/8 134/10 134/11 135/18 136/2 136/13	implement [2] 74/16 94/16	increase [2] 10/13 10/25	infections [1] 102/11	Inquiry's [1] 74/12
I'm paraphrasing [1] 13/4	implementation [1] 74/10	increased [3] 2/20 5/17 104/3	infectivity [1] 17/21	insofar [1] 12/24
I've [14] 2/24 21/15 29/13 31/15 51/2 52/6 73/10 75/3 76/18 81/21 123/8 129/11 131/17 131/19	implemented [3] 114/4 114/12 128/16	incredibly [1] 102/9	infer [3] 20/19 80/6 86/16	Instead [2] 70/9 74/11
Ian [2] 99/17 99/23	implicated [4] 99/20 100/8 100/20 103/10	incurable [1] 68/14	inference [2] 44/23 110/16	instituted [2] 101/10 108/10
Ian Kennedy's [2] 99/17 99/23	implications [8] 15/10 16/4 33/7 33/23 36/8 60/24 102/17 111/18	indeed [11] 6/3 22/15 28/12 29/8 31/16 41/7 65/24 83/18 93/7 116/5 134/16	inferred [1] 67/3	instruments [3] 104/4 104/4 104/11
idea [5] 47/3 63/18 64/25 98/21 112/17	implies [1] 3/3	indent [1] 19/6	inflicted [1] 116/2	insurance [4] 71/18 115/8 130/2 130/7
identified [8] 42/4 44/21 45/19 94/23 100/17 104/1 123/6 130/17	importance [3] 68/21 93/9 109/20	indents [3] 18/7 18/16 18/25	influenced [1] 130/12	intending [1] 63/9
identify [3] 40/2 41/14 97/19	important [11] 9/3 31/7 36/16 38/22 40/19 42/1 42/4 68/20 68/22 99/6 133/18	indicated [2] 28/15 29/2	inform [5] 10/5 11/15 11/23 19/16 77/5	intense [1] 5/10
identifying [2] 38/5 51/6	importantly [1] 91/12	indicates [1] 5/9	information [32] 8/23 12/3 13/3 14/3 14/7 17/20 18/17 19/6 27/2 33/9 35/18 35/22 37/5 38/8 39/13 39/22 39/24 40/15 41/2 57/16 58/11 59/4 59/11 59/15 83/15 95/15 100/4 105/14 108/20 118/22 118/25 119/3	intensifying [1] 106/25
ie [3] 76/4 88/9 114/12	imported [1] 95/13	indicative [1] 120/2	informed [10] 11/20 26/12 39/8 42/5 65/13 67/8 92/3 98/11 103/9 118/12	interactions [1] 128/3
ie infection [1] 88/9	impression [2] 5/16 29/22	individual [5] 68/19 73/13 80/12 83/18 86/24	informing [3] 11/22 13/18 14/8	interest [2] 117/5 136/10
if [145]	impressions [4] 21/18 22/3 25/18 26/11	individual's [1] 126/10	infrequent [1] 111/10	interested [2] 36/6 73/4
ignorance [1] 17/1	improve [1] 105/20	individually [1] 71/16	ingredient [1] 56/20	interests [1] 6/16
ii [2] 87/23 88/17	inability [1] 71/17	individuals [16] 15/12 48/21 55/10 68/13 68/18 69/22 70/14 73/9 73/25 98/17 99/18 100/12 100/19 103/9 115/6 131/14	initial [13] 14/15 17/15 19/22 21/17 21/18 22/3 22/4 25/18 25/18 26/10 26/11 27/23 72/4	interferon [1] 115/10
iii [1] 120/3	inactivation [2] 27/12 126/25	industry [1] 130/7	initial [13] 14/15 17/15 19/22 21/17 21/18 22/3 22/4 25/18 25/18 26/10 26/11 27/23 72/4	internal [16] 5/7 6/13 9/10 21/2 25/24 34/22 64/8 105/3 105/22 106/2 106/5 106/15 106/18 112/7 118/8 118/20
iii [1] 64/15	inadequate [1] 43/24	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9	initiate [1] 118/5	internally [1] 54/23
illness [1] 88/10	inadvertently [1] 15/13	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9	initio [1] 89/25	interpret [1] 15/24
illogical [1] 73/24	include [5] 26/9 71/16 79/14 84/14 87/17	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9	injured [1] 73/21	intervals [1] 29/21
ills [1] 116/1	includes [2] 51/22 66/6	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9	injury [1] 70/5	interviewing [1] 5/14
imagine [6] 9/18 32/18 82/5 86/22 99/19 135/24	including [6] 26/17 36/8 64/19 101/12 105/3 106/2	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9	inquiries [4] 104/17 105/18 108/3 116/4	into [24] 5/18 13/10 18/24 23/5 46/4 65/14 65/15 67/25 71/11 79/17 79/18 89/7 97/17 104/18 104/21 106/16 113/19 114/21 120/24 124/16 125/10 125/19 126/20 127/13
immensely [1] 110/22	inclusion [1] 85/9	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9	inquiry [59] 1/9 1/12 6/13 8/1 13/11 14/6 19/16 22/8 26/21 27/21 32/4 32/11 38/11 41/16 43/25 44/10 51/23 67/24 74/19 75/21 81/2 97/4 98/3 100/3 103/8	intracranial [3] 3/1
immune [2] 119/23 120/2	inconsistencies [1] 86/17	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9		
impact [2] 53/24 129/5	inconsistency [3] 69/14 70/10 86/5	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9		
impacts [1] 129/6	inconsistent [1]	infected [32] 1/18 6/9 6/17 16/24 28/13 39/19 40/15 41/21 42/2 51/25 52/4 55/10 60/23 61/23 62/14 63/14 64/2 67/19 69/22 70/14 73/25 78/23 104/22 107/23 114/21 115/14 121/7 121/9 130/3 131/7 131/9 132/9		

<p>I</p> <p>intracranial... [2] 3/5 124/6</p> <p>introduced [5] 47/25 48/5 101/12 135/1 135/1</p> <p>introducing [3] 101/20 131/20 135/16</p> <p>introduction [4] 17/9 101/4 126/24 130/11</p> <p>invariably [1] 2/17</p> <p>invasive [2] 83/1 83/9</p> <p>Inverness [1] 36/24</p> <p>inverted [1] 127/12</p> <p>investigate [3] 9/24 34/19 53/13</p> <p>investigated [2] 68/9 121/11</p> <p>investigating [3] 17/24 32/4 52/5</p> <p>investigation [58] 5/7 5/23 6/8 6/24 7/12 7/16 7/18 8/6 9/2 9/5 9/10 9/12 10/4 10/7 11/25 12/2 12/10 13/21 13/24 14/1 17/8 22/9 23/25 25/21 26/8 31/6 31/12 31/14 32/13 34/13 34/22 34/22 35/4 35/5 35/12 39/15 40/6 43/1 43/2 43/20 44/3 46/25 49/3 49/5 52/10 53/20 56/11 59/24 63/25 64/8 83/4 105/22 106/5 112/7 113/22 118/8 118/20 119/2</p> <p>investigations [8] 17/6 21/20 22/4 23/4 23/8 24/8 25/18 112/8</p> <p>invited [2] 86/2 86/10</p> <p>inviting [1] 36/17</p> <p>involve [1] 71/5</p> <p>involved [11] 55/14 74/24 78/9 81/21 83/16 85/12 100/15 114/2 119/22 130/19 133/11</p> <p>involvement [13] 23/22 30/20 30/21 78/4 78/7 80/2 80/7</p>	<p>80/11 81/16 82/12 85/10 113/23 128/2</p> <p>Ireland [1] 85/25</p> <p>irrelevance [1] 45/25</p> <p>ish [1] 136/11</p> <p>isn't [3] 58/12 70/18 104/23</p> <p>issue [71] 3/20 4/1 4/8 4/12 11/22 11/24 16/15 17/13 17/24 21/14 23/11 32/4 32/12 36/6 38/5 38/22 45/19 48/4 48/11 48/22 48/25 50/10 53/7 53/18 56/25 58/7 58/9 58/12 58/15 58/17 58/18 59/8 59/22 64/9 64/10 66/11 84/3 86/7 86/11 87/7 88/17 89/22 90/14 91/19 94/2 97/22 100/4 102/23 103/7 107/2 107/13 107/13 107/17 108/5 108/24 109/7 110/3 110/11 112/2 113/1 121/11 123/23 125/9 125/10 125/15 125/17 126/17 126/19 128/11 129/25 131/5</p> <p>issued [2] 26/16 95/3</p> <p>issues [34] 8/2 35/9 36/14 36/17 44/5 50/6 60/19 65/16 68/10 69/19 82/24 85/4 85/8 96/23 98/5 98/24 103/12 103/20 105/5 105/23 106/3 106/11 106/13 106/15 109/3 109/19 111/25 116/6 117/12 118/2 125/2 125/18 128/4 130/16</p> <p>it's [75] 3/15 3/17 5/8 6/22 11/11 16/9 17/23 22/13 23/12 24/9 24/24 25/1 25/23 26/4 27/5 27/19 29/17 32/4 32/25 33/1 36/2 40/20 41/11 42/16 42/22 43/1 44/10 46/13 47/14 51/1 51/9 53/19 54/23 57/6 57/12</p>	<p>58/11 58/23 60/1 60/3 69/12 70/18 72/1 75/10 75/11 76/8 76/22 77/1 77/17 79/6 79/11 79/25 83/24 85/12 87/5 87/7 90/20 90/24 93/22 95/3 96/16 98/7 102/8 104/17 106/19 109/24 111/4 112/6 113/8 113/17 117/16 124/20 127/6 131/2 134/10 136/11</p> <p>italicised [1] 87/10</p> <p>its [21] 4/5 7/14 15/13 24/7 32/18 45/22 65/16 65/17 70/16 72/6 72/21 73/18 75/22 76/7 81/7 94/16 103/1 105/9 110/18 110/18 114/3</p> <p>itself [7] 26/24 28/23 36/19 43/15 59/17 109/5 110/1</p> <p>J</p> <p>Jack [1] 134/17</p> <p>Jack Gillon [1] 134/17</p> <p>James [1] 4/3</p> <p>January [8] 35/14 35/21 36/1 76/24 80/21 81/24 127/25 129/1</p> <p>January 2003 [4] 80/21 81/24 127/25 129/1</p> <p>Jeremy [2] 136/19 136/21</p> <p>Jeremy Hunt [2] 136/19 136/21</p> <p>jogged [1] 85/14</p> <p>John [9] 52/18 52/19 52/19 60/17 63/3 81/10 82/7 112/9 113/5</p> <p>John Aldridge [1] 60/17</p> <p>John Aldridge's [1] 63/3</p> <p>John Cash's [1] 113/5</p>	<p>John Reid [1] 81/10</p> <p>John Reid's [1] 82/7</p> <p>joint [1] 111/6</p> <p>judgment [10] 72/10 75/16 75/21 75/23 76/3 78/14 78/19 91/14 109/25 110/4</p> <p>July [7] 1/1 1/14 2/2 5/5 79/14 90/18 94/3</p> <p>July 1999 [2] 2/2 5/5</p> <p>June [4] 79/10 81/9 93/22 109/23</p> <p>June 2003 [1] 81/9</p> <p>junior [1] 97/15</p> <p>just [69] 4/16 6/20 10/3 14/7 17/2 21/16 22/24 25/5 25/6 26/3 27/6 27/8 27/9 28/21 29/11 35/15 36/3 42/15 42/24 45/3 47/5 47/12 48/19 49/11 49/13 52/9 52/15 53/2 54/9 55/4 55/13 56/23 57/5 57/11 60/5 61/9 61/10 61/12 66/4 67/5 67/5 68/4 70/23 71/25 73/18 80/24 84/19 85/5 85/17 87/2 89/6 91/4 92/4 93/24 94/25 98/4 106/20 109/19 111/22 112/3 113/15 113/19 113/25 117/1 127/17 132/22 133/2 133/17 134/10</p> <p>Justice [2] 78/18 91/14</p> <p>justifiably [1] 115/25</p> <p>justification [1] 15/20</p> <p>justified [1] 136/14</p> <p>justify [1] 108/1</p> <p>K</p> <p>Karen [2] 66/24 67/7</p> <p>KEEL [46] 1/3 1/8 9/23 11/16 13/5 19/3 25/13 32/5 35/17 37/8 38/18 40/10 41/16 43/6 46/11 48/7 49/9 51/20 54/17 54/25 58/6 59/19 76/11 77/21 79/6 80/1 80/20 84/5 84/11 86/8 88/12</p>	<p>89/8 90/13 95/8 96/18 107/4 114/16 115/12 116/13 117/23 121/25 124/24 126/1 132/25 136/4 137/2</p> <p>Keel's [1] 132/24</p> <p>keen [1] 5/22</p> <p>keep [1] 65/13</p> <p>Kennedy [1] 98/10</p> <p>Kennedy's [3] 98/14 99/17 99/23</p> <p>key [4] 16/13 21/8 21/23 82/18</p> <p>kind [6] 8/8 33/19 95/24 96/23 101/21 135/10</p> <p>Kingdom [2] 93/4 93/15</p> <p>knew [4] 12/13 56/23 118/18 131/21</p> <p>know [54] 4/18 12/10 19/18 20/18 20/23 21/10 25/19 27/4 30/16 39/1 41/1 44/7 44/13 48/16 48/16 49/8 51/3 54/11 54/18 56/14 56/20 58/14 67/13 74/9 74/15 80/10 88/18 98/24 99/5 99/24 100/24 103/4 103/17 106/11 107/12 108/2 108/9 111/3 111/14 112/1 113/7 115/8 117/3 117/3 120/9 120/15 122/3 122/6 123/20 126/23 127/21 128/18 134/2 136/11</p> <p>knowing [1] 42/3</p> <p>knowledge [17] 3/10 14/23 15/2 21/23 37/12 37/19 38/25 48/20 48/23 50/2 55/23 113/10 121/13 121/23 122/9 122/20 123/22</p> <p>known [9] 12/19 16/21 16/24 22/14 38/23 102/10 112/17 122/25 129/12</p> <p>knows [2] 81/2 97/4</p>
--	--	---	---	--

<p>L</p> <p>lack [4] 35/17 45/22 111/2 119/17</p> <p>lagged [1] 22/1</p> <p>lagging [1] 5/24</p> <p>laid [1] 14/4</p> <p>language [1] 15/23</p> <p>lapse [1] 119/11</p> <p>large [2] 54/20 127/6</p> <p>last [8] 49/13 89/17 91/1 91/8 93/25 97/13 103/7 111/4</p> <p>late [8] 20/2 20/6 24/10 38/15 51/25 86/19 99/1 117/9</p> <p>later [9] 5/14 14/10 25/10 28/20 48/14 59/20 96/24 113/18 117/16</p> <p>latter [2] 39/2 107/13</p> <p>latterly [1] 106/12</p> <p>Law [2] 81/5 81/17</p> <p>Law Officers [1] 81/5</p> <p>Lawrence [5] 6/22 54/5 54/24 60/6 78/12</p> <p>lay [2] 19/18 119/16</p> <p>lead [4] 2/16 21/5 44/4 96/7</p> <p>leads [1] 134/24</p> <p>leaflets [3] 14/4 39/12 95/15</p> <p>least [14] 11/1 20/20 24/13 24/20 51/9 63/22 66/11 75/5 93/13 98/1 100/6 100/23 109/12 135/2</p> <p>leave [2] 63/9 106/5</p> <p>Leaving [2] 80/10 105/22</p> <p>led [3] 20/16 108/13 111/2</p> <p>Lee [6] 86/2 86/3 86/9 86/17 88/17 89/1</p> <p>Lee's [1] 90/2</p> <p>left [2] 51/16 90/21</p> <p>left-hand [1] 90/21</p> <p>legal [13] 7/2 37/22 40/4 40/17 40/19 74/23 78/22 79/3 79/18 80/16 116/14 116/22 132/24</p>	<p>legally [1] 68/20</p> <p>length [4] 23/9 23/13 24/12 136/8</p> <p>lengthy [2] 13/14 88/21</p> <p>less [4] 5/20 59/11 83/17 110/19</p> <p>let [5] 28/11 43/17 49/12 57/6 116/21</p> <p>let's [2] 90/6 110/17</p> <p>letter [4] 25/1 36/1 36/4 87/18</p> <p>letters [1] 79/24</p> <p>leukodepletion [1] 101/4</p> <p>level [8] 71/13 73/14 73/15 82/19 84/9 84/13 97/10 115/24</p> <p>levels [5] 72/14 75/4 76/19 80/21 126/18</p> <p>LFTs [1] 129/24</p> <p>liabilities [1] 76/4</p> <p>liability [2] 15/16 110/8</p> <p>liability' [1] 15/11</p> <p>lies [1] 68/11</p> <p>life [9] 2/18 2/25 71/18 115/7 123/9 124/5 124/12 124/12 130/2</p> <p>life-saving [1] 2/18</p> <p>life-threatening [2] 2/25 124/5</p> <p>light [12] 4/7 34/13 55/21 102/25 105/11 112/2 112/2 116/5 116/25 121/23 122/9 122/20</p> <p>like [4] 26/17 103/14 114/24 133/14</p> <p>likelihood [2] 10/25 28/16</p> <p>likely [6] 8/3 30/11 30/13 33/9 76/11 88/2</p> <p>limited [3] 14/2 79/25 112/2</p> <p>Lindsay [1] 79/9</p> <p>line [11] 2/9 3/22 23/1 65/18 75/15 84/5 91/7 105/1 121/20 122/1 122/4</p> <p>lines [7] 8/1 60/6</p>	<p>62/19 77/25 78/2 100/23 116/15</p> <p>link [1] 24/5</p> <p>list [6] 51/20 51/21 61/13 77/1 79/15 79/22</p> <p>listening [1] 136/13</p> <p>Lister [1] 64/20</p> <p>lists [1] 103/12</p> <p>literature [4] 20/25 21/4 39/1 119/14</p> <p>litigants [1] 80/9</p> <p>litigation [4] 57/25 59/6 59/10 59/14</p> <p>little [8] 18/17 19/6 20/4 33/6 42/8 57/6 74/22 134/18</p> <p>live [3] 125/15 125/17 127/10</p> <p>lived [1] 88/3</p> <p>liver [13] 12/24 20/10 29/3 38/16 39/12 77/15 77/16 82/21 82/22 82/25 83/13 126/3 126/8</p> <p>loads [3] 31/23 104/9 104/10</p> <p>lobby [1] 6/15</p> <p>lobbying [6] 5/10 5/13 5/17 6/6 10/12 132/16</p> <p>local [3] 91/8 93/1 135/11</p> <p>location [1] 112/15</p> <p>logic [2] 115/21 116/2</p> <p>logical [1] 75/25</p> <p>London [6] 31/19 64/21 87/5 89/12 90/20 122/3</p> <p>long [13] 5/8 11/11 16/24 20/10 30/20 57/22 77/1 89/5 117/3 117/11 117/12 128/22 136/11</p> <p>long-term [1] 128/22</p> <p>longer [3] 18/14 52/25 116/17</p> <p>look [44] 2/1 6/8 7/4 9/2 13/21 18/8 18/10 31/6 32/10 32/10 32/24 33/11 33/25 46/12 47/21 54/15</p>	<p>57/5 58/11 59/21 61/9 62/25 63/1 75/7 76/23 78/11 79/4 82/14 85/17 87/2 87/9 89/6 92/8 93/17 93/23 95/5 106/17 106/22 108/24 120/6 130/10 130/12 130/14 133/3 133/10</p> <p>look-back [6] 108/24 120/6 130/10 130/12 130/14 133/3</p> <p>looked [17] 3/25 6/14 15/6 25/16 31/13 36/3 80/20 81/24 89/24 105/22 106/11 106/13 107/21 112/22 113/21 118/10 125/3</p> <p>looked at [9] 6/14 31/13 36/3 80/20 106/11 106/13 107/21 113/21 118/10</p> <p>looking [19] 2/2 9/1 13/16 19/15 20/21 28/24 30/10 30/11 38/5 38/6 40/1 41/5 41/14 42/18 56/12 115/12 120/6 121/17 130/13</p> <p>Lord [10] 63/17 64/23 64/24 65/3 65/24 67/9 67/9 74/14 74/21 130/23</p> <p>Lord Hunt [5] 63/17 64/23 65/3 65/24 67/9</p> <p>Lord Morris [2] 64/24 67/9</p> <p>Lord Ross [2] 74/14 74/21</p> <p>lose [1] 126/12</p> <p>loss [2] 71/15 73/13</p> <p>lot [5] 85/13 97/23 98/3 101/16 117/6</p> <p>LOTH000011 [1] 25/1</p> <p>lots [1] 80/24</p> <p>low [2] 32/22 97/20</p> <p>Lowe [13] 8/18 9/4 11/13 12/6 12/15 36/22 39/4 39/13 39/18 40/13 40/24 41/11 119/22</p> <p>Lowe's [2] 12/22</p>	<p>41/10</p> <p>lower [1] 97/10</p> <p>Ludlam [10] 8/17 9/4 11/13 12/6 36/22 38/12 38/24 39/25 41/12 120/7</p> <p>lump [2] 77/7 77/13</p> <p>lunch [4] 89/7 90/5 90/6 105/23</p> <p>Luncheon [1] 90/10</p> <p>Lynda [2] 40/21 79/9</p> <p>Lynda Towers [1] 79/9</p> <hr/> <p>M</p> <p>Macfarlane [3] 63/14 69/6 70/12</p> <p>Macfarlane Trust [3] 63/14 69/6 70/12</p> <p>MACK0001929 [1] 68/1</p> <p>Macmillan [2] 79/10 112/12</p> <p>made [27] 8/7 13/25 14/21 18/2 18/6 22/12 24/5 27/9 32/6 32/14 35/16 40/14 46/1 52/18 53/6 55/15 66/9 67/9 74/19 77/10 78/8 87/11 110/24 120/7 127/7 127/13 128/6</p> <p>main [7] 9/8 26/16 79/16 91/19 105/2 125/6 130/15</p> <p>maintain [2] 34/11 134/9</p> <p>maintained [1] 72/22</p> <p>maintenance [1] 105/1</p> <p>major [5] 15/10 16/4 16/4 31/22 37/8</p> <p>majority [1] 86/25</p> <p>make [14] 7/22 17/2 23/5 30/7 38/9 39/21 43/11 56/22 72/11 77/7 78/1 122/17 126/6 131/22</p> <p>makes [2] 30/6 77/24</p> <p>making [12] 2/12 21/12 56/19 59/22 70/9 77/13 78/4 82/16 85/11 101/17 102/21</p>
---	---	---	---	---

M	44/15 44/23 45/6 48/10 48/24 51/10 51/17 52/6 59/11 59/13 59/13 60/23 65/1 72/23 74/19 84/8 95/3 100/10 103/9 105/8 106/19 107/10 110/8 112/10 114/14 117/7 117/25 121/8 121/24 maybe [4] 108/3 121/18 123/19 127/4 McClelland [3] 48/2 79/9 92/13 McGovern [3] 53/6 90/19 93/1 me [24] 11/11 28/18 43/19 49/12 49/25 53/7 54/20 55/2 61/2 65/23 66/8 73/24 75/25 88/25 98/16 100/14 112/19 113/5 114/16 116/21 124/22 125/18 133/6 134/12 mean [31] 2/23 3/15 5/13 15/23 31/18 33/8 40/18 41/1 41/24 53/19 62/1 72/17 76/17 82/5 85/13 97/18 98/22 99/19 103/23 109/20 116/4 120/13 120/19 121/6 123/10 123/15 126/19 131/23 132/2 132/14 132/19 means [8] 3/1 20/23 26/21 34/21 97/21 99/4 99/15 133/20 meant [1] 120/25 measures [7] 8/10 101/11 101/15 101/21 102/4 102/17 103/6 mechanism [3] 71/1 71/10 94/23 medic [1] 110/24 medical [37] 3/9 3/10 4/22 4/24 5/2 20/7 20/25 21/3 21/9 39/1 40/10 40/11 41/23 41/24 44/12 44/19 68/15 70/16 80/12 80/17 82/13 83/1	84/24 88/7 88/14 89/18 95/9 97/17 103/11 103/14 109/23 110/25 114/1 121/23 122/9 122/20 129/5 meet [5] 7/5 7/25 64/23 79/14 84/12 meeting [45] 6/23 7/19 7/21 7/22 8/14 8/16 8/21 11/25 14/16 18/2 22/7 22/17 22/22 23/2 25/11 25/14 26/5 33/5 34/6 35/14 36/3 36/18 36/19 36/20 39/14 46/17 47/1 49/9 50/1 51/23 52/7 61/15 80/6 83/25 84/2 84/20 84/24 86/11 89/1 90/25 93/23 98/8 98/9 98/12 130/5 meetings [5] 14/12 23/17 47/2 85/3 85/18 meets [1] 82/21 members [3] 17/1 37/9 37/17 membership [1] 47/20 memory [3] 76/17 80/1 103/3 mental [1] 115/20 mention [2] 20/19 31/14 mentioned [8] 58/1 62/1 75/3 109/16 120/21 121/24 122/14 135/19 merely [1] 64/12 merited [2] 105/6 116/9 message [1] 79/13 met [5] 7/20 48/7 48/13 49/15 91/1 methods [1] 10/24 mid [15] 8/11 9/9 17/11 17/16 20/3 23/6 30/22 31/19 35/20 46/3 92/19 107/16 119/11 119/14 124/15 mid-'80s [3] 31/19 119/11 119/14 mid-'90s [1] 92/19 mid-1980s [9] 8/11	9/9 17/11 17/16 20/3 23/6 30/22 46/3 124/15 mid-2006 [1] 107/16 mid-December [1] 35/20 middle [4] 1/10 2/2 66/23 95/2 Middlesex [1] 31/20 might [56] 2/16 3/10 8/2 10/1 13/20 19/7 24/17 26/8 26/9 30/9 31/6 31/7 33/22 38/4 39/24 40/14 40/16 41/21 43/20 47/3 49/20 50/8 50/18 54/12 54/17 62/20 65/8 66/18 81/18 81/19 82/3 83/9 93/11 98/17 98/21 99/14 105/11 105/20 108/3 109/4 109/5 109/10 109/17 110/13 120/2 121/4 125/20 125/23 126/3 126/4 126/8 126/15 126/20 130/12 133/5 133/6 might augment [1] 105/20 Mike [3] 15/23 53/6 90/19 Mike McGovern [2] 53/6 90/19 Mike Palmer's [1] 15/23 Milburn [2] 81/5 81/9 mild [4] 20/6 38/13 41/17 42/6 mind [26] 7/15 9/1 22/10 33/8 33/14 34/20 39/23 40/25 41/1 41/10 41/11 41/12 42/1 44/3 53/12 79/2 102/3 106/7 106/14 110/6 114/10 119/20 120/5 124/10 131/2 132/2 minds [1] 74/25 mine [1] 16/9 minimal [2] 78/7 80/7 minimally [3] 30/12 31/11 122/21	minister [37] 1/15 1/16 3/8 3/24 4/14 4/20 5/6 5/12 7/5 7/9 7/13 7/20 7/22 14/12 14/15 22/20 22/21 23/1 26/6 33/1 33/3 33/4 34/7 34/14 45/19 57/4 57/7 63/8 66/18 66/25 67/4 67/16 76/25 77/19 77/24 79/22 107/1 minister's [3] 57/8 60/20 66/19 ministerial [4] 7/22 8/24 26/20 60/14 ministers [12] 22/14 25/25 33/20 34/18 47/17 62/18 63/22 74/24 105/6 106/24 107/6 127/3 minute [15] 32/16 33/3 44/13 51/9 52/12 55/21 57/1 57/12 63/11 92/25 93/21 94/9 106/18 109/23 113/1 minutes [4] 25/16 57/5 98/14 116/19 miscellaneous [1] 109/19 misjudged [1] 115/14 mislead [1] 58/4 misleading [1] 58/9 misremembering [1] 119/2 missing [1] 38/2 modelling [1] 84/6 moderate [1] 123/20 modest [1] 132/1 modus [1] 44/9 modus operandi [1] 44/9 moment [1] 53/2 Monday [1] 79/14 money [3] 16/5 16/6 124/15 monitored [1] 129/23 monitoring [2] 41/6 121/17 month [2] 24/8 24/22 months [5] 71/12 86/21 88/10 128/21
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(53) making... - months

<p>M</p> <p>months... [1] 128/24</p> <p>moral [4] 15/11 15/16 15/16 68/23</p> <p>more [25] 10/25 14/6 15/5 26/18 29/4 30/3 36/17 57/20 65/12 65/15 68/9 68/10 68/22 75/8 83/12 96/8 97/15 100/24 102/13 111/18 111/21 112/14 113/12 123/8 133/25</p> <p>morning [6] 1/5 1/6 35/10 46/5 122/24 124/4</p> <p>Morris [2] 64/24 67/9</p> <p>mortgage [1] 71/18</p> <p>mortgages [2] 115/8 130/2</p> <p>most [12] 3/9 30/13 31/11 32/8 39/18 88/2 91/12 93/23 128/23 129/11 129/14 131/25</p> <p>move [4] 35/13 64/16 75/17 104/16</p> <p>moved [1] 114/6</p> <p>movement [1] 66/12</p> <p>moves [2] 42/16 127/24</p> <p>Moving [2] 35/5 129/25</p> <p>MP [2] 67/10 136/21</p> <p>Mr [29] 1/13 3/22 3/23 7/1 8/19 14/11 15/14 18/12 19/21 22/19 25/17 51/22 52/2 52/7 52/19 61/12 61/19 61/20 63/7 78/18 81/3 81/9 85/22 87/4 87/6 87/10 89/20 91/14 93/21</p> <p>Mr Aldridge [2] 61/20 63/7</p> <p>Mr Bell [1] 1/13</p> <p>Mr Chisholm [1] 81/3</p> <p>Mr Dobson's [1] 3/22</p> <p>Mr Galbraith [1] 3/23</p> <p>Mr Gibb [2] 61/12 61/19</p> <p>Mr Gutowski [2] 87/4 87/10</p>	<p>Mr John [1] 52/19</p> <p>Mr Justice [1] 91/14</p> <p>Mr Justice Burton's [1] 78/18</p> <p>Mr Milburn [1] 81/9</p> <p>Mr Palmer [4] 7/1 14/11 19/21 22/19</p> <p>Mr Palmer's [3] 15/14 18/12 25/17</p> <p>Mr Stock [4] 85/22 87/6 89/20 93/21</p> <p>Mr Wright [1] 51/22</p> <p>Mr Wright's [2] 52/2 52/7</p> <p>Mrs [15] 7/1 7/1 8/19 32/10 37/20 37/21 38/4 39/21 40/3 40/15 42/23 42/24 43/6 72/3 112/5</p> <p>Mrs Deacon [1] 32/10</p> <p>Mrs Dora [1] 42/24</p> <p>Mrs Falconer [3] 7/1 8/19 72/3</p> <p>Mrs Towers [10] 7/1 37/20 37/21 38/4 39/21 40/3 40/15 42/23 43/6 112/5</p> <p>MS [20] 1/4 1/7 21/11 34/3 34/10 42/24 44/24 52/12 53/12 57/14 57/19 58/7 59/4 59/20 60/8 63/6 64/5 106/25 136/6 137/3</p> <p>Ms Deacon [2] 34/10 59/20</p> <p>Ms Deacon's [1] 34/3</p> <p>Ms Dora [10] 21/11 42/24 44/24 52/12 57/14 57/19 58/7 59/4 60/8 64/5</p> <p>Ms Dora's [2] 53/12 63/6</p> <p>Ms Richards [2] 1/7 136/6</p> <p>MSBT [3] 93/23 98/8 106/12</p> <p>MSPs [1] 5/10</p> <p>much [22] 13/24 19/16 30/2 34/3 34/14 51/18 57/20 65/12 76/4 76/4 92/20 97/10 97/15 97/15 110/14</p>	<p>110/19 112/2 112/14 113/12 124/15 136/3 136/15</p> <p>Murray [1] 79/8</p> <p>must [2] 12/9 50/4</p> <p>mutually [1] 59/16</p> <p>my [50] 5/8 5/16 8/9 12/13 13/2 15/18 15/23 24/13 25/13 29/22 30/21 34/16 35/3 35/9 44/8 45/22 46/13 48/14 50/1 50/7 60/12 66/14 73/10 73/17 74/21 76/21 78/7 80/7 82/23 83/11 85/13 89/8 90/4 96/3 99/22 100/22 100/22 103/3 108/17 110/6 113/8 114/10 120/5 120/13 122/16 124/10 125/7 132/2 132/3 135/1</p> <p>myself [1] 99/19</p> <p>mysterious [1] 113/5</p> <p>mystified [1] 41/9</p> <p>N</p> <p>naive [1] 73/18</p> <p>name [3] 61/4 69/11 77/1</p> <p>namely [1] 70/11</p> <p>names [1] 100/12</p> <p>NANBH [2] 20/3 20/4</p> <p>narrow [2] 68/18 70/11</p> <p>narrower [4] 38/5 58/9 58/12 58/17</p> <p>narrowness [1] 70/4</p> <p>national [3] 46/19 47/15 98/2</p> <p>natural [10] 85/9 85/18 86/5 86/13 86/14 86/25 128/17 128/18 129/11 129/15</p> <p>naturally [2] 65/3 86/20</p> <p>nature [3] 28/9 88/4 114/7</p> <p>nay [1] 73/7</p> <p>necessarily [1] 70/15</p> <p>necessary [5] 9/23 37/24 39/20 40/7</p>	<p>66/16</p> <p>necessity [1] 3/13</p> <p>need [24] 3/6 4/17 25/11 29/11 53/5 57/3 63/1 63/15 71/14 72/12 72/15 73/12 74/24 84/17 90/22 91/15 92/1 93/23 94/24 96/8 103/21 110/3 113/18 116/13</p> <p>needed [7] 5/18 8/23 91/11 94/15 94/17 118/16 133/4</p> <p>needs [5] 99/6 114/21 114/23 115/1 115/2</p> <p>negative [2] 29/15 119/6</p> <p>negligence [10] 2/11 9/12 16/1 53/14 64/15 68/7 69/4 75/18 76/2 76/5</p> <p>negligent [4] 7/12 7/17 8/5 68/20</p> <p>nervous [2] 53/5 53/16</p> <p>never [3] 8/3 30/25 102/9</p> <p>new [5] 5/12 70/7 92/6 105/5 130/6</p> <p>news [1] 99/20</p> <p>newsletter [1] 96/14</p> <p>next [18] 1/8 3/18 14/9 17/5 24/4 39/9 41/19 42/20 54/15 71/7 100/25 111/24 118/8 119/20 121/20 127/24 128/17 130/10</p> <p>NHS [30] 1/19 2/11 15/19 16/2 60/23 60/24 68/19 70/6 70/15 70/15 71/4 73/22 75/19 76/3 77/9 92/7 95/21 102/6 104/13 110/10 110/13 110/14 110/17 110/20 111/22 115/9 116/1 130/24 132/6 133/9</p> <p>nine [1] 34/6</p> <p>nine days [1] 34/6</p> <p>no [71] 1/25 2/12 3/1 4/19 4/22 6/11 12/16 12/20 14/20 14/20</p>	<p>15/2 15/9 15/19 16/1 16/3 18/17 19/6 20/19 21/15 22/1 23/22 33/15 34/10 48/23 49/7 50/2 52/6 53/5 58/2 64/6 64/14 66/3 66/21 69/8 69/25 72/6 75/17 75/18 76/1 76/2 76/5 76/17 80/5 80/15 81/21 82/20 98/19 98/19 99/9 99/13 105/5 107/14 116/8 119/4 119/25 120/5 120/21 122/6 122/10 123/3 123/24 127/23 130/8 131/10 131/23 132/14 132/23 133/20 135/10 135/22 136/6</p> <p>no fault [2] 14/20 15/19</p> <p>no-fault [4] 15/9 16/3 69/25 131/10</p> <p>nobody [1] 29/23</p> <p>non [50] 13/1 13/1 18/19 18/19 20/6 20/8 20/22 20/22 28/13 28/13 28/17 28/17 29/2 29/2 29/13 29/13 30/19 30/19 38/13 38/13 38/14 38/23 38/23 41/5 41/5 45/24 45/24 46/2 46/2 50/24 50/25 51/7 51/7 71/24 83/9 97/2 110/24 121/15 123/1 123/1 124/13 124/13 124/17 124/17 126/4 126/4 127/2 127/2 127/18 127/18</p> <p>non-A [3] 45/24 50/24 124/13</p> <p>non-A, non-B [4] 13/1 29/2 29/13 123/1</p> <p>non-A, non-B hepatitis [12] 18/19 20/22 28/13 28/17 30/19 38/13 38/23 51/7 124/17 126/4 127/2 127/18</p> <p>non-B [2] 45/24 50/25</p> <p>non-B hepatitis [1] 124/13</p>
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(54) months... - non-B hepatitis

<p>N</p> <p>non-haemophilic [1] 71/24</p> <p>non-heat [1] 121/15</p> <p>non-invasive [1] 83/9</p> <p>non-progressive [2] 20/6 38/14</p> <p>non-specialists [1] 97/2</p> <p>nonetheless [2] 99/6 111/10</p> <p>Nor [1] 70/6</p> <p>normal [2] 11/14 116/18</p> <p>north [2] 32/2 32/18</p> <p>Northern [1] 85/25</p> <p>Northern Ireland [1] 85/25</p> <p>not [181]</p> <p>note [8] 24/24 25/11 26/4 34/1 45/4 60/19 63/8 90/24</p> <p>notes [4] 13/13 13/16 46/17 118/15</p> <p>nothing [5] 43/18 45/2 45/10 113/10 132/23</p> <p>notification [1] 99/25</p> <p>notified [1] 100/7</p> <p>notwithstanding [2] 115/16 115/17</p> <p>November [3] 35/6 46/19 87/5</p> <p>now [80] 2/3 2/13 4/1 4/4 5/5 7/15 9/1 11/22 15/14 18/8 20/13 22/3 24/9 24/19 27/21 31/2 33/11 34/6 35/25 37/21 38/4 40/8 42/1 42/15 42/21 43/7 43/25 44/21 46/5 48/7 53/12 58/6 60/12 60/13 62/20 63/25 65/14 67/14 67/22 71/25 74/9 75/20 76/7 76/25 77/7 77/14 79/4 80/19 82/20 83/24 85/1 90/5 90/13 91/3 92/8 92/18 94/9 95/21 97/9 97/22 97/22 98/21 99/24 101/14</p>	<p>102/8 104/16 109/14 109/21 110/13 111/9 112/19 115/12 117/24 121/24 125/7 128/1 131/11 131/12 133/20 134/24</p> <p>nowadays [2] 97/18 110/19</p> <p>nuanced [1] 102/14</p> <p>number [22] 14/5 14/13 16/14 32/7 46/20 48/4 48/12 50/10 51/2 54/4 54/5 60/9 64/18 72/11 72/22 72/23 84/23 85/20 97/24 123/20 135/3 136/8</p> <p>numbers [2] 33/21 33/22</p> <p>nurses [1] 96/6</p> <p>NY [2] 122/19 123/3</p> <hr/> <p>O</p> <p>o'clock [1] 90/5</p> <p>O'Hara [1] 67/9</p> <p>obesity [1] 51/4</p> <p>object [1] 50/18</p> <p>objective [3] 21/24 23/10 23/20</p> <p>observation [1] 105/12</p> <p>observations [3] 22/11 44/5 72/23</p> <p>observe [1] 31/2</p> <p>obtain [2] 58/1 71/17</p> <p>obtained [2] 27/2 31/16</p> <p>obtaining [1] 58/21</p> <p>obviously [21] 5/12 14/13 23/13 31/17 32/10 34/9 40/8 40/11 76/18 78/5 86/3 88/21 91/13 93/22 95/17 96/18 99/22 106/15 108/23 112/23 116/13</p> <p>occasion [4] 29/4 36/22 48/4 123/9</p> <p>occasions [1] 51/3</p> <p>occur [1] 88/3</p> <p>occurrence [1] 111/11</p> <p>October [8] 24/10</p>	<p>59/18 72/2 83/24 83/25 84/22 91/3 121/6</p> <p>October 1985 [1] 121/6</p> <p>October 2000 [2] 24/10 59/18</p> <p>October 2003 [1] 83/24</p> <p>offer [5] 22/22 52/22 65/7 89/13 111/19</p> <p>offered [2] 71/22 130/3</p> <p>offering [1] 114/13</p> <p>office [10] 3/23 7/2 20/8 21/13 34/3 40/4 46/23 53/22 66/9 66/19</p> <p>officer [4] 4/22 95/9 109/24 114/1</p> <p>Officers [2] 81/5 81/17</p> <p>officials [2] 74/23 107/5</p> <p>Officials' [1] 65/5</p> <p>often [4] 31/21 36/10 97/8 110/25</p> <p>oh [1] 4/22</p> <p>okay [1] 35/7</p> <p>Once [1] 108/22</p> <p>one [39] 10/4 10/25 11/1 13/21 15/1 28/23 28/24 29/4 29/11 36/14 38/11 41/18 42/15 47/2 54/16 56/12 65/10 69/13 76/2 84/19 85/6 85/8 85/17 87/3 90/5 92/22 99/21 108/4 109/3 114/3 114/10 116/5 118/1 123/9 125/11 126/5 127/8 130/5 133/1</p> <p>one o'clock [1] 90/5</p> <p>one's [1] 50/17</p> <p>ones [2] 54/10 54/11</p> <p>ongoing [1] 112/7</p> <p>only [22] 4/12 4/22 12/24 28/7 38/19 43/8 43/12 48/7 58/17 80/5 87/19 97/20 105/8 105/19 111/4 114/10</p>	<p>117/1 122/23 125/4 127/8 130/5 133/1</p> <p>onwards [1] 59/22</p> <p>open [13] 16/3 26/7 26/9 26/22 33/8 33/8 33/13 34/8 61/17 82/3 92/6 110/19 132/2</p> <p>opened [1] 76/3</p> <p>openness [5] 110/10 110/13 110/14 111/2 111/22</p> <p>operands [1] 44/9</p> <p>operate [1] 63/22</p> <p>operated [1] 135/3</p> <p>operating [1] 47/10</p> <p>operation [2] 70/10 71/12</p> <p>operational [1] 104/12</p> <p>operations [2] 23/23 103/1</p> <p>opportunity [4] 13/12 100/24 116/14 116/24</p> <p>opposed [2] 61/22 124/2</p> <p>optimal [1] 92/17</p> <p>optimism [2] 27/22 28/5</p> <p>option [2] 10/25 111/17</p> <p>options [3] 36/13 37/11 65/6</p> <p>or [152]</p> <p>order [3] 10/24 31/8 35/12</p> <p>ordinarily [1] 9/12</p> <p>organisations [1] 48/21</p> <p>organism [2] 50/25 99/15</p> <p>origin [2] 122/3 122/6</p> <p>original [1] 76/21</p> <p>other [64] 6/15 10/18 11/17 12/10 20/15 21/11 29/18 31/1 31/11 31/25 36/12 44/16 44/17 48/20 50/4 50/5 51/1 51/3 51/3 56/16 60/24 61/1 62/1 62/16 63/10 63/23 65/23 66/7 66/13 68/7 70/13 71/1</p>	<p>71/11 73/2 74/1 81/2 82/20 82/21 83/9 83/17 93/8 100/8 100/14 102/11 105/23 106/7 107/24 108/24 109/3 109/8 114/24 114/25 115/25 116/1 117/9 125/24 126/5 129/23 130/13 131/1 131/6 131/21 132/5 135/5</p> <p>others [16] 1/15 12/15 14/13 33/2 60/9 64/25 65/12 72/3 73/3 73/7 75/22 96/13 113/6 127/16 131/22 134/1</p> <p>otherwise [4] 13/7 80/14 85/9 133/5</p> <p>ought [2] 25/9 26/25</p> <p>our [22] 17/16 19/23 20/2 20/15 21/18 21/19 23/1 43/20 46/5 57/15 68/10 72/4 96/10 110/20 112/8 112/18 113/9 116/18 119/8 119/16 126/13 134/14</p> <p>out [50] 9/23 14/19 15/7 16/11 25/18 26/6 26/7 27/1 29/19 34/24 35/12 35/15 35/19 39/4 39/18 43/11 44/2 47/2 48/9 50/18 51/15 52/6 54/19 55/13 56/2 59/5 62/12 69/2 69/3 73/1 73/24 74/2 79/24 84/8 84/13 85/4 89/17 92/19 93/9 96/2 103/4 106/24 114/6 117/6 118/2 131/17 131/22 132/5 132/15 133/1</p> <p>outcome [1] 98/18</p> <p>outcomes [1] 130/9</p> <p>outline [2] 21/18 22/21</p> <p>outlined [1] 62/19</p> <p>outlining [2] 23/3 33/4</p> <p>outset [1] 9/5</p> <p>outside [2] 72/9 87/12</p> <p>outstanding [4] 78/22</p>
---	---	--	--	--

<p>O</p> <p>outstanding... [3] 79/3 79/11 80/3</p> <p>outweighed [1] 123/7</p> <p>over [37] 1/21 3/12 5/24 13/15 14/18 17/18 19/24 23/17 24/9 37/4 39/17 47/21 48/4 48/12 50/10 53/3 53/23 54/11 54/14 68/17 69/7 84/1 89/5 90/4 91/8 96/12 97/13 100/15 101/10 106/11 106/14 110/22 113/16 113/21 115/6 120/8 120/12</p> <p>over-generalisation [1] 3/12</p> <p>overall [1] 92/5</p> <p>overlaps [1] 59/23</p> <p>overnight [1] 79/5</p> <p>oversaw [1] 96/12</p> <p>overspeaking [1] 124/20</p> <p>overstatement [4] 3/12 3/13 3/15 3/17</p> <p>overview [3] 17/15 19/22 19/22</p> <p>overweight [1] 125/24</p> <p>own [14] 3/10 12/13 38/25 52/2 62/22 65/16 65/17 67/24 100/5 107/16 110/6 124/10 134/14 134/18</p> <p>ownership [2] 112/21 113/6</p>	<p>51/19 52/15 53/3 54/2 54/5 54/11 54/14 54/15 54/16 54/20 54/23 54/23 55/7 55/7 55/22 57/3 57/6 57/12 57/13 60/4 60/5 60/16 61/3 61/5 62/6 62/25 63/5 63/6 66/6 66/23 67/15 68/4 69/7 69/8 69/10 70/23 70/24 71/7 75/10 75/11 76/24 77/2 78/14 84/1 84/2 84/4 89/10 90/22 93/24 95/6 98/7 98/7 100/25 101/2 106/21 106/22</p> <p>page 10 [1] 21/16</p> <p>page 11 [2] 18/10 55/7</p> <p>page 2 [1] 57/12</p> <p>page 23 [1] 68/4</p> <p>page 26 [1] 70/23</p> <p>page 27 [1] 98/7</p> <p>page 3 [4] 54/2 54/20 54/23 78/14</p> <p>page 4 [3] 19/1 57/3 90/22</p> <p>page 44 [1] 62/6</p> <p>page 47 [1] 27/8</p> <p>page 5 [1] 54/23</p> <p>page 60 [1] 75/10</p> <p>page 7 [1] 19/23</p> <p>page 8 [1] 19/24</p> <p>pages [1] 17/3</p> <p>paid [2] 34/5 84/15</p> <p>Palmer [5] 7/1 8/19 14/11 19/21 22/19</p> <p>Palmer's [4] 15/14 15/23 18/12 25/17</p> <p>paper [3] 127/15 127/19 127/21</p> <p>papers [11] 43/7 44/8 44/14 44/22 57/21 58/1 58/21 65/23 76/18 76/22 85/15</p> <p>paragraph [88] 1/22 3/18 4/6 7/4 8/21 9/21 10/15 11/12 14/14 14/18 14/24 15/8 16/10 17/4 17/7 17/12 17/12 17/19 17/22 17/23 18/4 18/11</p>	<p>18/11 19/1 20/1 20/18 21/16 24/4 24/6 26/4 27/8 27/10 27/12 30/5 35/15 35/17 36/2 36/4 36/16 37/7 39/3 39/17 40/8 41/24 45/9 47/8 47/23 52/15 52/16 52/23 54/8 56/10 56/22 57/13 58/8 58/20 60/18 62/12 64/22 68/8 69/6 69/9 69/18 70/2 72/3 72/13 73/10 75/3 75/14 77/3 77/10 77/12 78/15 78/19 87/9 87/11 87/18 89/24 91/4 91/7 91/18 92/4 92/25 93/25 95/19 101/3 110/1 110/5</p> <p>paragraph 1 [5] 14/14 36/2 72/3 77/3 110/1</p> <p>paragraph 10 [1] 26/4</p> <p>paragraph 14 [1] 17/7</p> <p>paragraph 15 [1] 17/12</p> <p>paragraph 18 [2] 17/22 21/16</p> <p>paragraph 2 [9] 35/15 35/17 36/4 72/13 73/10 75/3 91/4 91/7 92/25</p> <p>paragraph 20 [1] 18/4</p> <p>paragraph 3 [7] 18/11 37/7 77/10 87/9 87/11 91/18 110/5</p> <p>paragraph 3.1 [1] 47/8</p> <p>paragraph 4 [8] 1/22 9/21 10/15 52/15 52/16 54/8 77/12 92/4</p> <p>paragraph 5 [1] 14/18</p> <p>paragraph 6 [3] 11/12 14/24 15/8</p> <p>paragraph 7 [8] 3/18 16/10 17/4 17/19 17/23 39/3 57/13 58/8</p> <p>paragraph 8 [2] 20/1 20/18</p> <p>paragraph 83 [1] 68/8</p> <p>paragraph 86 [1] 69/6</p> <p>paragraph 88 [1] 69/9</p> <p>paragraph 9 [2] 4/6</p>	<p>39/17</p> <p>paragraph 90 [1] 69/18</p> <p>paragraph 91 [1] 70/2</p> <p>paragraphs [3] 17/18 69/2 71/8</p> <p>paragraphs 16 [1] 17/18</p> <p>paragraphs 2 [1] 71/8</p> <p>parallel [1] 104/8</p> <p>parameters [2] 82/1 85/4</p> <p>paraphrasing [1] 13/4</p> <p>Parliament [5] 4/2 4/5 67/23 107/8 130/6</p> <p>Parliament's [1] 7/13</p> <p>Parliamentary [1] 5/10</p> <p>part [30] 2/11 3/9 16/1 20/20 21/2 24/13 24/21 33/25 40/18 53/13 53/14 57/15 57/21 63/1 64/1 64/1 64/7 75/1 75/5 75/19 78/5 81/22 82/11 88/17 98/25 100/18 102/3 115/3 130/10 135/15</p> <p>partially [1] 124/4</p> <p>Participants [4] 116/14 117/25 132/22 133/3</p> <p>participating [1] 116/21</p> <p>particular [27] 6/5 7/17 11/18 26/2 41/17 41/24 45/23 59/8 68/19 71/21 74/6 74/18 80/10 81/22 82/25 86/7 86/11 92/9 101/19 102/16 103/18 108/19 120/24 120/25 122/4 129/5 135/6</p> <p>particularly [12] 3/1 3/5 5/11 9/3 13/15 30/9 36/6 79/23 80/7 83/20 97/16 107/2</p> <p>partners [1] 37/14</p> <p>partnership [2] 91/24 92/6</p> <p>parts [1] 61/1</p> <p>party [1] 82/10</p>	<p>pass [1] 132/19</p> <p>passage [2] 87/10 89/17</p> <p>passages [1] 93/9</p> <p>patch [1] 103/23</p> <p>patchy [1] 119/10</p> <p>paternalism [1] 110/25</p> <p>paternalistic [2] 98/23 110/23</p> <p>path [2] 61/16 103/6</p> <p>paths [1] 10/23</p> <p>patient [26] 11/19 13/8 16/7 39/5 88/8 88/18 88/22 97/7 98/11 111/3 111/6 111/7 111/12 111/13 111/17 118/10 118/12 118/12 118/18 119/14 120/25 121/1 121/15 122/21 129/17 135/11</p> <p>patient's [3] 83/16 98/23 99/5</p> <p>patients [92] 2/7 11/15 11/23 11/23 12/4 13/7 13/10 13/19 13/22 13/23 14/2 14/8 14/22 15/25 16/22 17/21 18/17 19/7 24/16 28/12 30/9 30/11 30/18 30/24 31/9 32/8 36/7 36/10 37/3 37/11 38/1 38/3 38/8 39/8 39/18 40/2 40/7 40/14 40/25 41/15 41/19 42/2 42/4 57/17 58/4 58/9 58/11 59/4 59/12 62/14 62/17 73/15 74/2 82/25 83/3 83/5 83/20 84/14 87/25 89/2 91/17 91/21 97/8 97/17 100/6 101/9 103/21 104/1 104/13 115/18 115/23 118/22 118/24 119/1 119/15 119/19 119/24 120/20 121/4 121/7 122/15 123/12 123/17 124/8 127/1 127/18 129/7 129/18 130/17 133/5 133/15 135/7</p>
--	--	---	---	--

(56) outstanding... - patients

P	42/25 persons [1] 84/8 perspective [5] 34/12 80/12 91/16 107/22 122/4 persuade [1] 112/13 persuaded [2] 5/18 69/20 Peter [6] 47/8 83/7 83/12 128/4 128/6 128/14 Peter Foster [1] 47/8 Peter Hayes [4] 83/12 128/4 128/6 128/14 petitioned [1] 68/13 petitions [2] 68/10 69/20 PF [1] 47/7 PFC [12] 10/22 11/1 11/6 27/11 27/14 27/17 102/18 102/25 103/4 122/16 122/19 124/16 PH [1] 106/25 phase [3] 73/5 88/6 88/14 Philip [2] 47/9 66/9 Philip Dolan [1] 47/9 Philip Hunt's [1] 66/9 phrase [2] 27/19 27/25 physical [3] 71/15 73/13 115/20 Physicians [2] 112/11 113/15 pick [20] 6/20 11/12 14/9 27/6 27/9 35/8 35/25 37/6 47/6 59/19 60/4 60/17 66/22 68/4 69/7 69/9 70/24 84/1 90/17 101/1 picked [1] 84/3 picking [2] 45/24 91/6 picks [2] 15/5 78/14 picture [3] 94/25 98/2 130/5 piece [2] 79/25 92/22 pilot [1] 135/3 place [8] 19/17 22/7 28/24 46/24 49/21 56/12 119/12 133/21 placed [1] 5/16	places [2] 134/18 135/24 Plainly [1] 116/24 plan [1] 91/1 planned [1] 8/24 planning [1] 53/23 plans [1] 101/3 plant [1] 11/1 plasma [7] 36/11 95/13 101/5 102/4 103/1 103/2 127/12 please [22] 6/22 9/20 18/9 19/1 25/6 27/7 32/9 33/25 35/6 37/7 49/12 51/19 54/5 54/13 54/20 60/6 60/12 62/24 66/8 78/12 109/22 112/4 plight [1] 65/4 pm [5] 90/9 90/11 117/19 117/21 136/24 point [37] 2/6 2/22 4/25 6/17 12/20 13/16 22/6 26/19 27/6 27/9 28/11 28/19 30/6 31/3 35/16 41/5 47/13 49/14 52/6 52/22 53/6 56/25 62/5 64/13 65/15 81/5 82/18 83/8 83/19 84/24 85/3 94/7 105/15 123/25 124/23 126/10 128/11 pointed [7] 9/23 28/16 39/4 39/18 60/20 73/1 106/24 pointing [3] 26/6 63/8 131/13 points [5] 2/1 47/6 72/11 72/18 97/11 policies [2] 47/10 70/16 policy [15] 1/13 15/10 16/4 37/25 38/7 39/7 47/15 58/3 58/8 72/21 92/2 101/8 104/19 110/9 121/20 political [2] 65/2 78/8 pool [1] 127/12 pooled [1] 121/5 pools [1] 127/6 poor [3] 48/6 50/21 50/22	population [5] 121/14 126/15 126/20 126/22 135/20 position [23] 6/9 6/16 7/11 14/19 15/21 22/10 23/19 23/24 65/25 66/12 67/18 69/15 78/5 81/12 81/18 82/2 105/8 107/16 109/9 114/18 119/1 121/21 131/4 positive [16] 11/16 16/22 17/25 29/5 29/13 29/23 36/9 37/3 50/24 51/1 51/5 51/12 51/17 65/1 118/13 127/8 positives [1] 51/13 positivity [1] 120/3 possibilities [1] 121/10 possibility [7] 24/5 42/2 53/17 73/6 100/7 125/5 132/3 possible [16] 7/23 19/17 33/7 33/23 36/11 56/1 57/25 59/6 59/10 59/14 62/16 63/10 63/18 110/3 129/5 134/4 possibly [3] 25/9 44/9 85/17 post [6] 5/9 5/17 39/20 93/18 125/10 125/19 post-date [1] 93/18 post-devolution [2] 5/9 5/17 potential [3] 36/12 127/25 129/9 potentially [7] 64/3 121/7 123/9 124/5 124/12 129/18 130/17 power [1] 132/16 powers [3] 2/4 81/7 105/9 PR [3] 34/4 34/15 34/17 practical [5] 68/25 71/2 71/17 71/22 115/4 practically [1] 69/16	practice [12] 11/14 12/13 12/15 13/18 90/15 91/12 91/23 96/21 96/21 97/8 102/22 122/11 practices [4] 12/22 14/7 70/16 120/15 practising [2] 97/14 133/8 practitioner [1] 40/10 pre [4] 22/10 30/20 50/1 53/23 pre-date [1] 50/1 pre-dates [1] 30/20 pre-determined [1] 22/10 pre-planning [1] 53/23 precautionary [8] 101/11 101/14 101/20 101/22 101/24 102/11 102/17 103/6 preceded [1] 50/6 precedent [14] 15/22 53/10 61/25 62/15 62/20 63/15 65/7 70/8 70/11 70/11 70/20 131/5 131/9 132/12 preceding [1] 42/9 precise [1] 50/8 predecessor [4] 4/15 50/9 72/22 92/16 predecessors [1] 39/19 preferred [1] 122/11 pregnant [1] 20/11 preliminary [9] 8/1 21/19 22/4 22/15 28/8 28/14 76/8 76/10 77/21 preparation [5] 22/16 33/19 54/1 133/21 133/25 prepare [1] 7/21 prepared [3] 17/15 77/6 79/16 prescribers [1] 9/8 prescribing [1] 120/22 prescriptions [1] 120/23 present [3] 25/13
----------	--	--	---	---

(57) patients' - present

P	83/1	Prof [1] 43/8	116/13 117/23 121/25	proposed [3] 76/20
present... [2] 49/1 84/23	procedures [1] 103/14	profession [1] 110/25	124/24 126/1 132/25	79/17 84/25
presentation [1] 47/7	proceed [3] 74/10	professional [2] 41/23 41/25	136/4	proposing [4] 95/22
presentational [1] 65/19	82/7 133/13	professionals [1] 97/13	Professor Kennedy [1] 98/10	100/1 116/12 132/20
presentationally [1] 65/12	proceeded [1] 99/24	professor [82] 1/3 1/5	Professor Kennedy's [1] 98/14	prospect [1] 32/21
presented [1] 119/9	proceeding [1] 74/16	1/8 8/17 8/18 9/4 9/4	Professor Lee [2] 86/2 86/9	protect [1] 126/15
President [1] 64/24	7/18 13/11 13/14 30/1	11/13 11/13 12/6 12/6	Professor Lowe [12] 8/18 9/4 11/13 12/6	protecting [1] 43/23
press [3] 11/19 21/9 81/13	57/9 78/4 80/2 81/16	12/15 12/22 13/5	12/15 36/22 39/4	Protection [4] 19/25
pressure [2] 34/18 66/10	81/16 82/16 85/11	13/20 15/14 19/3	39/13 39/18 40/13	69/5 79/4 114/25
presumably [3] 8/3 41/3 67/7	108/13	25/13 26/2 32/5 35/9	40/24 41/11	protein [2] 56/13 104/7
pretty [2] 60/13 126/9	processes [2] 56/17 104/6	35/17 36/22 36/22	Professor Lowe's [1] 12/22	prove [1] 129/20
previous [8] 1/24 15/1 53/21 66/12	produce [3] 32/19 46/2 124/16	38/12 39/4 39/13	Professor Ludlam [8] 8/17 9/4 11/13 12/6	proved [3] 16/1 24/18 28/19
75/17 75/25 84/6 129/19	produced [14] 4/10 20/4 26/15 30/6 30/17	39/18 39/25 40/10	36/22 38/12 39/25	proven [7] 27/20 27/25 29/18 29/25
previously [11] 4/13 15/1 30/12 30/23	41/7 52/14 60/2 67/24	40/13 40/24 41/11	41/12	75/19 76/2 76/6
31/10 65/25 89/24	71/5 76/7 94/10	41/12 41/16 44/8	Professor Peter Hayes [1] 83/7	proves [1] 88/7
93/13 101/12 110/14 122/20	113/25 120/12	44/14 44/22 46/11	Professors [1] 119/22	provide [7] 10/5 13/7 14/15 70/13 71/9
primarily [1] 42/25	producers [1] 127/10	48/7 49/9 49/13 51/20	Professors Forbes [1] 119/22	109/11 129/4
primary [1] 79/13	produces [1] 29/23	54/17 54/25 58/6	program [1] 96/2	provided [25] 8/7 10/22 12/4 14/3 14/7
prime [1] 104/7	producing [3] 5/25 31/3 94/5	59/19 67/22 68/6	programme [11] 94/15 94/15 95/12	14/11 17/21 18/17
principal [1] 75/17	product [37] 16/17 16/20 17/13 17/21	70/18 76/11 77/21	95/21 95/25 96/3 96/5	19/7 25/19 25/24
principally [2] 5/20 21/6	18/15 21/22 27/15	79/6 80/1 80/20 83/7	96/12 96/15 96/16	39/13 59/12 71/4 79/5
principle [5] 69/3 70/5 76/1 102/12	27/18 27/23 28/3 28/6	86/2 86/3 86/8 86/9	96/25	89/22 94/21 97/23
131/23	28/25 29/12 29/14	88/12 89/8 90/13	progressed [1] 95/21	114/8 115/18 118/21
prior [3] 14/15 30/16 126/24	29/16 29/19 30/6	96/18 98/10 98/14	progressive [2] 20/6 38/14	118/22 118/25 127/3 127/20
priority [1] 60/22	30/14 30/17 31/4	112/9 112/16 112/23	progressively [1] 29/22	provides [2] 68/24 108/20
probabilities [1] 88/8	31/16 31/24 32/2	113/2 113/14 113/21	project [5] 94/8 94/12 94/12 94/21 96/25	providing [15] 22/14 26/10 52/13 54/9 59/3
probably [12] 16/8 21/7 40/20 42/7 45/25	32/20 46/2 56/7 56/21	114/16 115/12 116/13	promote [3] 15/11 92/2 92/11	68/24 69/21 71/1
55/1 72/25 89/7 111/1 111/1 121/1 125/8	97/2 102/5 102/6	117/23 121/25 124/24	promoted [1] 49/16	71/11 76/5 80/11
probe [3] 18/6 19/4 19/10	103/10 121/5 122/16	126/1 132/25 136/4	prompt [1] 80/1	95/20 115/5 119/2 125/2
probing [1] 38/10	122/19 122/23 123/8 124/16	137/2	prompted [1] 65/2	provision [3] 38/8 47/11 131/13
problem [4] 51/11 93/5 103/19 108/3	production [1] 10/14	PROFESSOR AILEEN KEEL [2] 1/3 137/2	proof [3] 28/6 29/9 29/15	PRSE0000978 [1] 8/15
problems [3] 51/17 115/20 115/24	products [35] 1/20 5/20 7/9 17/10 18/20	Professor Cash [6] 44/14 112/16 112/23	proper [5] 23/18 34/23 94/7 94/12 96/2	psychological [5] 71/15 73/13 129/6 129/9 129/9
procedure [2] 11/17	23/5 24/17 31/1 36/12	113/2 113/14 113/21	properly [1] 117/13	public [31] 55/11 91/16 91/25 92/7
	42/3 42/14 55/15	Professor Cash's [2] 44/8 44/22	proportion [1] 126/20	93/12 104/17 104/21
	55/16 56/14 56/25	Professor Christine Lee [1] 86/3	propose [2] 68/2 79/13	105/6 105/9 105/14
	71/5 77/8 84/11 95/16	Professor John Cash [1] 112/9		105/17 105/20 106/23
	96/9 96/22 100/8	Professor Keel [35] 1/8 13/5 19/3 25/13		106/25 107/1 107/7
	100/20 101/6 102/3	32/5 35/17 40/10		
	102/14 104/23 108/7	41/16 46/11 48/7 49/9		
	122/13 122/13 122/17	51/20 54/17 54/25		
	127/13 130/22 131/7 131/9	58/6 59/19 76/11		
	products' [1] 57/18	77/21 79/6 80/1 80/20		
		86/8 88/12 89/8 90/13		
		96/18 114/16 115/12		

(58) present... - public

<p>P</p> <p>public... [15] 107/9 107/18 107/20 107/25 108/2 109/6 109/7 109/11 109/17 110/3 110/7 116/4 116/6 116/9 134/2</p> <p>publication [2] 39/11 64/11</p> <p>publications [1] 14/5</p> <p>publicise [1] 92/6</p> <p>publicised [1] 92/23</p> <p>publicity [2] 41/8 135/14</p> <p>published [3] 24/11 59/17 77/23</p> <p>publishing [1] 57/9</p> <p>pudding [1] 29/9</p> <p>purpose [10] 1/16 8/21 10/7 14/14 22/20 57/5 79/16 84/23 92/5 120/18</p> <p>purposes [2] 10/4 103/14</p> <p>pursue [2] 10/23 132/5</p> <p>pursuing [3] 36/6 73/4 115/25</p> <p>put [17] 8/4 35/24 43/18 44/18 45/2 45/10 54/15 65/6 77/18 84/8 91/16 103/12 113/18 116/23 124/15 125/9 132/21</p> <p>putting [2] 3/11 62/21</p>	<p>98/8 98/8 100/10 104/17 105/25 107/20 112/21 118/2 118/9 119/20 124/18 124/21 125/14 125/25 127/24 128/17 130/10 131/11 133/1 134/8 134/24</p> <p>Questioned [2] 1/4 137/3</p> <p>questioning [1] 116/16</p> <p>questions [17] 35/22 47/24 49/13 114/16 116/12 116/23 116/25 117/4 117/8 117/8 117/13 117/23 132/20 132/25 133/2 136/8 136/14</p> <p>quickly [3] 29/17 56/1 56/6</p> <p>quite [6] 40/24 62/21 66/14 98/3 105/25 117/6</p>	<p>55/13 71/7 76/12 76/18 93/9 113/19</p> <p>reader [1] 2/16</p> <p>reading [6] 65/23 73/17 76/22 85/14 86/16 98/14</p> <p>reads [2] 68/8 78/15</p> <p>real [2] 73/14 83/12</p> <p>reality [1] 73/7</p> <p>really [25] 3/15 23/19 29/6 34/25 41/9 54/21 56/16 63/21 74/22 82/21 97/10 98/4 103/24 113/4 119/15 119/18 124/18 124/19 126/13 128/10 130/8 132/5 134/5 134/11 134/25</p> <p>reason [9] 7/17 12/16 22/2 24/21 26/2 125/22 126/2 127/5 134/3</p> <p>reasonable [2] 23/24 40/21</p> <p>reasonably [2] 56/3 87/22</p> <p>reasoning [1] 105/1</p> <p>reasons [5] 23/18 51/2 61/24 112/17 135/17</p> <p>reassured [1] 53/8</p> <p>reassuring [1] 44/1</p> <p>recall [50] 6/19 15/15 28/14 28/18 31/20 32/9 32/11 33/15 36/5 39/15 45/20 45/21 48/23 49/4 52/7 56/9 65/18 65/20 65/22 66/2 67/22 72/16 74/4 76/14 81/15 82/5 82/10 82/11 82/15 83/6 85/2 85/10 92/13 96/4 100/5 101/8 101/19 102/23 102/24 108/16 108/17 112/25 114/5 114/7 115/4 123/22 127/3 128/10 129/4 129/8</p> <p>receipt [1] 5/12</p> <p>receive [4] 86/13 86/15 124/2 124/8</p> <p>received [11] 2/7</p>	<p>14/22 35/18 35/22 42/13 98/3 99/20 100/8 100/20 103/10 120/20</p> <p>receives [1] 53/11</p> <p>receiving [2] 77/8 91/20</p> <p>recent [5] 4/3 4/9 16/10 53/7 91/13</p> <p>recipient [1] 20/11</p> <p>recipients [8] 28/25 64/19 72/25 77/2 78/23 79/13 98/10 131/8</p> <p>recognise [1] 68/23</p> <p>recognised [3] 53/9 91/15 116/22</p> <p>recognising [1] 115/19</p> <p>recognition [2] 68/17 92/1</p> <p>recollect [9] 40/18 74/8 75/2 78/9 109/2 118/7 129/3 135/6 135/10</p> <p>recollection [27] 5/5 5/8 8/9 9/9 21/15 24/13 33/12 35/3 49/8 51/23 52/3 52/6 52/7 74/21 78/3 80/2 81/21 83/11 85/13 85/15 96/20 99/2 113/8 120/13 122/16 125/7 130/8</p> <p>recommend [5] 4/13 23/2 70/25 71/10 72/7</p> <p>recommendation [4] 4/6 22/25 114/4 114/11</p> <p>recommendations [7] 60/14 70/23 71/8 72/6 74/11 74/17 94/16</p> <p>recommended [1] 76/15</p> <p>recommending [1] 72/20</p> <p>record [4] 40/8 77/4 102/9 120/20</p> <p>recorded [7] 20/17 37/20 40/12 48/2 118/11 118/15 118/18</p> <p>recording [1] 37/16</p>	<p>records [10] 9/21 13/8 26/5 64/19 77/2 87/10 118/10 118/12 120/17 121/1</p> <p>redacted [3] 25/8 25/9 69/11</p> <p>redress [3] 10/12 68/17 71/16</p> <p>reduce [1] 110/8</p> <p>reducing [3] 56/19 91/23 92/20</p> <p>refer [1] 52/23</p> <p>reference [21] 15/2 18/2 24/23 32/17 37/2 46/14 46/14 47/20 55/20 55/22 77/10 78/12 78/25 83/24 86/2 89/17 91/14 94/11 101/3 106/9 110/23</p> <p>references [3] 7/5 20/21 125/1</p> <p>referred [21] 1/21 18/11 20/15 27/24 51/2 62/7 65/20 74/12 77/25 80/3 92/25 93/19 97/24 100/3 101/14 101/21 106/1 110/12 127/17 128/5 129/25</p> <p>referring [4] 2/22 69/4 76/18 100/10</p> <p>refers [12] 17/7 17/12 17/22 35/17 36/2 39/11 47/7 80/21 84/22 91/5 95/19 106/21</p> <p>refined [2] 26/18 82/9</p> <p>reflect [4] 10/3 28/8 61/20 62/21</p> <p>reflecting [3] 58/15 58/20 63/17</p> <p>reflection [4] 6/4 78/18 96/21 110/20</p> <p>reflects [2] 35/23 128/15</p> <p>regard [6] 18/5 29/17 71/15 82/15 108/21 109/12</p> <p>regarded [2] 20/5 45/25</p> <p>regarding [6] 38/23</p>
(59) public... - regarding				

<p>R</p> <p>regarding... [5] 75/13 85/8 86/4 101/17 120/8</p> <p>regardless [2] 45/15 68/7</p> <p>registry [2] 24/15 100/12</p> <p>regret [2] 55/11 75/20</p> <p>regretted [1] 75/16</p> <p>regular [3] 23/17 129/19 129/24</p> <p>regularly [1] 41/20</p> <p>Reid [2] 81/10 81/10</p> <p>Reid's [1] 82/7</p> <p>reject [1] 87/14</p> <p>rejected [1] 1/24</p> <p>relate [2] 43/20 44/9</p> <p>related [3] 14/3 86/18 109/1</p> <p>relates [3] 24/14 111/24 128/17</p> <p>relating [9] 43/8 44/19 47/16 80/24 85/4 90/15 100/14 101/16 103/13</p> <p>relation [32] 12/18 12/22 19/5 22/11 38/9 41/17 43/19 44/6 45/18 52/10 58/19 66/4 80/19 81/12 82/16 94/25 95/17 95/25 96/22 97/23 98/2 101/1 101/3 102/1 102/12 102/14 103/7 108/25 114/8 115/7 121/3 123/23</p> <p>relationship [1] 23/16</p> <p>relative [1] 122/12</p> <p>relatively [3] 20/9 68/18 132/1</p> <p>relatives [1] 68/15</p> <p>releasing [1] 32/22</p> <p>relevance [1] 128/10</p> <p>relevant [3] 53/15 53/20 112/10</p> <p>reliability [1] 44/2</p> <p>relieved [1] 67/16</p> <p>rely [1] 59/7</p> <p>relying [2] 131/8 131/11</p>	<p>remained [1] 107/17</p> <p>remains [1] 91/10</p> <p>remember [13] 21/7 24/19 25/23 32/15 57/23 64/7 85/7 94/19 98/13 120/11 130/5 130/15 133/15</p> <p>remind [1] 53/15</p> <p>reminded [1] 65/23</p> <p>reminder [1] 35/21</p> <p>reminding [1] 53/5</p> <p>reminds [1] 113/4</p> <p>remiss [1] 10/10</p> <p>remit [11] 4/1 6/12 9/17 12/2 45/15 45/16 49/5 57/15 58/10 58/14 64/7</p> <p>remove [1] 110/7</p> <p>render [1] 56/18</p> <p>repeated [1] 29/3</p> <p>repercussions [1] 61/16</p> <p>reply [1] 4/15</p> <p>report [56] 7/10 10/14 21/2 21/6 24/7 24/10 24/21 25/3 26/15 26/15 29/19 31/14 32/11 41/7 43/2 44/3 44/18 45/14 45/15 52/13 54/2 56/15 57/7 57/9 57/24 58/19 58/25 59/17 60/2 60/3 60/12 64/1 64/5 64/11 67/25 68/3 68/8 70/22 72/17 72/24 73/5 73/17 74/5 76/8 77/21 77/22 79/1 92/15 92/19 105/3 106/2 106/6 113/24 114/3 114/9 118/9</p> <p>reported [2] 20/8 37/8</p> <p>reporting [1] 96/5</p> <p>reports [2] 76/10 76/12</p> <p>represent [1] 51/10</p> <p>representatives [9] 7/19 23/18 25/15 51/24 79/19 85/22 116/15 116/23 132/24</p> <p>representing [2] 6/16 40/4</p> <p>request [2] 12/3</p>	<p>120/7</p> <p>requested [2] 7/9 9/17</p> <p>requests [2] 32/5 32/13</p> <p>require [3] 70/15 72/5 91/24</p> <p>requirement [1] 88/12</p> <p>requires [1] 119/20</p> <p>requiring [1] 130/11</p> <p>research [4] 18/24 57/20 104/10 124/16</p> <p>reserved [1] 81/8</p> <p>resistance [1] 118/4</p> <p>resistant [1] 112/17</p> <p>resisted [2] 60/25 116/7</p> <p>resolved [1] 87/21</p> <p>Resource [1] 92/16</p> <p>respect [1] 63/15</p> <p>respects [1] 125/3</p> <p>respond [2] 25/22 26/12</p> <p>response [14] 13/2 25/3 25/4 33/20 38/12 48/1 52/1 63/3 63/6 67/15 72/1 72/5 72/16 115/13</p> <p>responsibility [3] 15/17 47/17 65/16</p> <p>rest [5] 43/18 45/1 93/4 93/15 135/15</p> <p>resterilisation [1] 104/5</p> <p>resting [1] 45/10</p> <p>result [15] 1/19 11/15 29/12 29/12 29/23 68/14 71/3 77/8 87/24 118/13 118/18 121/8 121/9 126/8 130/3</p> <p>resulting [2] 36/11 81/13</p> <p>results [10] 11/24 13/19 14/8 16/24 17/25 27/23 37/13 39/9 129/19 135/21</p> <p>retained [2] 111/25 113/2</p> <p>retaining [1] 100/19</p> <p>retiral [1] 112/10</p> <p>retrospect [1] 11/2</p> <p>retyped [1] 55/1</p>	<p>revealing [1] 10/22</p> <p>reversing [1] 120/9</p> <p>review [4] 20/25 21/3 38/25 67/12</p> <p>reviewing [1] 86/5</p> <p>revisit [1] 64/25</p> <p>revisited [1] 92/18</p> <p>rewarded [1] 33/18</p> <p>RICHARDS [4] 1/4 1/7 136/6 137/3</p> <p>rid [1] 104/7</p> <p>right [29] 2/3 6/4 6/6 23/12 24/24 34/1 50/4 50/14 50/19 51/18 52/19 67/17 70/18 72/4 78/12 95/5 98/20 98/23 99/5 100/21 101/22 102/15 104/17 104/23 105/13 111/20 113/17 116/22 123/16</p> <p>right-hand [2] 34/1 95/5</p> <p>rigorous [1] 8/8</p> <p>rigorously [1] 4/8</p> <p>ring [3] 59/6 59/9 127/22</p> <p>rise [3] 82/24 107/25 134/11</p> <p>risk [27] 2/20 3/4 16/25 18/14 20/9 24/17 30/9 30/14 31/12 32/8 37/14 38/2 55/16 56/8 70/8 70/17 83/2 91/14 91/19 91/20 91/20 91/23 98/17 99/12 103/10 103/21 113/4</p> <p>risks [11] 18/18 18/23 37/10 39/6 57/18 58/4 92/1 93/10 95/18 101/25 123/5</p> <p>robust [3] 88/7 88/14 89/18</p> <p>role [8] 52/21 53/12 61/5 64/1 64/2 108/12 108/24 114/2</p> <p>room [1] 130/6</p> <p>Ross [6] 74/12 74/13 74/14 74/21 76/7 76/7</p> <p>roughly [3] 120/8 133/19 133/24</p> <p>round [2] 56/21</p>	<p>111/14</p> <p>route [3] 16/5 64/14 74/16</p> <p>routine [1] 83/4</p> <p>routinely [1] 83/5</p> <p>Royal [2] 86/4 112/11</p> <p>ruled [1] 103/3</p> <p>ruling [2] 78/20 91/13</p> <p>run [1] 133/22</p> <p>running [2] 90/4 108/23</p> <hr/> <p>S</p> <p>safe [18] 5/20 5/25 16/17 16/20 16/21 21/22 23/5 27/15 27/18 28/6 28/16 30/17 46/2 92/2 97/2 97/3 97/6 102/9</p> <p>safely [2] 56/17 59/7</p> <p>safer [2] 92/12 122/23</p> <p>safety [6] 47/19 56/24 56/24 104/14 106/16 122/12</p> <p>said [49] 2/24 3/11 7/11 9/17 10/8 12/6 12/11 13/2 13/20 16/9 17/23 19/7 22/20 26/8 27/4 32/1 32/16 34/7 34/13 34/16 34/23 37/3 38/4 39/3 44/13 50/9 51/10 58/22 59/3 62/20 65/13 68/5 77/17 105/7 106/3 110/21 112/19 112/20 117/1 118/24 119/13 123/8 126/23 129/11 131/19 131/19 133/5 134/13 134/15</p> <p>said -- well [1] 134/13</p> <p>sake [3] 26/23 63/11 66/4</p> <p>same [12] 4/12 28/6 54/16 63/2 63/24 107/17 133/19 133/21 133/24 133/25 134/4 134/23</p> <p>Sandra [2] 67/7 67/7</p> <p>satisfactory [1] 135/19</p> <p>saving [4] 2/18 123/9 124/12 124/12</p>
---	---	--	---	--

(60) regarding... - saving

<p>S</p> <p>saw [8] 14/11 33/13 33/15 108/10 108/23 112/22 112/24 124/25</p> <p>say [39] 8/4 15/25 23/12 26/10 26/23 27/13 29/11 29/14 29/25 32/9 42/7 43/9 47/12 52/16 53/3 62/8 63/8 64/6 69/24 70/2 75/7 75/14 76/21 82/23 93/13 96/2 96/3 98/12 98/15 101/7 103/15 110/17 111/4 111/12 111/14 112/7 113/17 125/17 126/11</p> <p>saying [10] 38/24 40/15 43/5 48/2 58/16 59/8 67/7 127/5 131/15 133/10</p> <p>says [35] 4/17 14/24 15/8 16/12 17/14 18/4 20/1 21/17 24/6 33/2 34/1 36/4 37/23 39/17 45/5 45/8 47/23 57/14 57/19 60/9 60/18 62/17 63/7 64/19 64/22 69/18 78/19 79/12 84/4 87/16 89/12 93/1 94/1 95/6 110/1</p> <p>SBTS0000357 [1] 79/7</p> <p>SBTS0000379 [1] 6/22</p> <p>scale [4] 107/24 108/3 108/4 108/8</p> <p>scenarios [2] 9/25 33/23</p> <p>SCGV0000043 [1] 14/10</p> <p>SCGV0000096 [1] 93/20</p> <p>SCGV0000098 [1] 95/1</p> <p>SCGV0000170 [5] 22/18 25/5 32/23 35/13 112/4</p> <p>SCGV0000171 [4] 42/16 52/11 57/1 62/24</p>	<p>SCGV0000173 [1] 113/20</p> <p>SCGV0000174 [2] 64/17 66/22</p> <p>SCGV0000176 [1] 1/12</p> <p>SCGV0000246 [1] 109/22</p> <p>SCGV0000247 [1] 72/2</p> <p>SCGV0000251 [1] 76/23</p> <p>SCGV0000265 [1] 84/20</p> <p>SCGV000098 [1] 96/17</p> <p>SCGV0001034 [1] 83/22</p> <p>scheme [33] 1/25 16/3 33/24 53/24 62/13 64/14 66/2 70/1 72/19 73/8 73/12 73/19 73/23 75/13 77/6 77/12 78/1 81/7 81/14 81/19 82/1 84/22 85/5 85/9 115/23 128/8 128/9 128/15 128/19 131/20 131/24 132/6 132/9</p> <p>schemes [3] 81/19 131/25 135/3</p> <p>Scientific [1] 55/23</p> <p>scope [3] 33/21 85/8 106/7</p> <p>scoping [1] 91/20</p> <p>Scotland [43] 5/24 6/18 9/7 16/17 31/10 31/24 32/22 43/11 45/17 48/18 61/21 65/16 67/18 71/4 77/9 81/6 81/20 82/2 92/17 93/3 93/14 94/10 95/21 95/24 102/16 102/21 103/15 105/24 107/3 107/5 108/9 114/22 114/25 116/7 116/11 123/3 128/8 133/8 133/10 133/11 133/14 133/16 134/14</p> <p>Scotland's [1] 23/5</p> <p>Scottish [52] 1/9 3/23 4/2 5/19 6/25 8/19</p>	<p>18/13 19/8 20/8 21/13 24/16 32/7 36/2 36/10 36/21 46/18 46/23 53/22 53/22 62/9 67/23 74/6 74/9 78/6 78/20 78/23 79/23 85/21 87/7 94/6 95/4 103/18 104/19 104/20 107/5 107/8 107/16 114/2 114/19 114/20 114/20 115/13 118/5 118/20 118/23 119/1 121/11 121/12 122/4 130/1 133/8 133/9</p> <p>Scottish Office [4] 20/8 21/13 46/23 53/22</p> <p>screen [7] 42/21 47/23 50/18 54/16 101/3 113/19 126/11</p> <p>screened [2] 51/15 135/5</p> <p>screening [6] 50/14 50/17 51/6 126/14 126/14 135/20</p> <p>scrutinise [1] 105/10</p> <p>scrutinised [1] 79/23</p> <p>scrutiny [2] 8/8 79/11</p> <p>SD [2] 4/17 4/19</p> <p>SE [2] 62/9 107/5</p> <p>second [24] 8/16 18/7 18/16 18/25 19/6 27/10 46/16 49/10 49/18 50/12 51/19 57/15 60/4 62/25 76/23 78/19 82/13 82/17 83/10 91/2 92/9 95/17 106/21 106/22</p> <p>secondary [1] 68/21</p> <p>seconded [1] 131/17</p> <p>secondly [1] 21/25</p> <p>Secretary [3] 81/3 81/10 136/19</p> <p>section [2] 18/5 18/7</p> <p>sector [1] 52/25</p> <p>see [72] 1/14 2/6 2/14 3/18 6/24 7/4 8/16 11/12 13/8 14/18 17/3 20/21 24/4 25/2 25/21 35/15 36/1 36/15 36/19 36/20 37/1 37/2 38/7 38/12 39/3 43/2</p>	<p>43/5 44/21 44/24 46/17 46/20 47/8 50/11 51/20 54/3 54/7 54/21 57/4 57/7 60/6 60/8 61/3 61/9 61/12 62/7 62/25 63/5 66/5 67/6 67/6 68/3 68/6 77/2 77/25 78/15 83/8 83/21 85/20 86/2 89/16 90/20 93/25 95/3 95/10 101/2 110/2 112/20 116/2 119/6 121/21 128/15 132/22</p> <p>Seedat [1] 89/11</p> <p>seeing [2] 29/1 29/20</p> <p>seek [2] 70/9 112/21</p> <p>seeking [3] 24/20 60/19 116/1</p> <p>seemed [6] 9/3 16/13 73/24 75/25 98/16 119/4</p> <p>seems [2] 7/18 100/14</p> <p>seen [9] 23/14 27/21 31/15 33/3 33/18 53/21 122/1 130/19 133/17</p> <p>sees [1] 29/21</p> <p>self [1] 30/7</p> <p>self-sufficient [1] 30/7</p> <p>sending [1] 60/8</p> <p>sense [2] 17/3 72/6</p> <p>sensitivity [2] 45/23 50/22</p> <p>sent [5] 32/25 35/20 72/1 79/24 104/1</p> <p>sentence [6] 26/4 30/5 58/7 89/17 91/5 92/4</p> <p>sentiment [1] 64/12</p> <p>sentiments [1] 61/14</p> <p>separate [3] 31/7 90/14 104/16</p> <p>separately [1] 104/2</p> <p>September [21] 7/6 7/24 8/14 8/25 14/9 14/12 14/17 18/2 22/19 22/23 23/3 25/14 26/5 32/24 33/1 33/4 35/20 76/8 77/22</p>	<p>85/19 112/5</p> <p>September 1999 [1] 32/24</p> <p>September 2002 [2] 76/8 77/22</p> <p>sequence [1] 43/19</p> <p>serendipitous [2] 11/9 11/11</p> <p>series [2] 85/3 89/9</p> <p>serious [5] 38/15 61/16 64/3 68/14 83/3</p> <p>serious' [1] 20/12</p> <p>seriously [1] 43/12</p> <p>servant [1] 64/2</p> <p>servants [1] 21/13</p> <p>service [9] 46/19 91/22 94/4 94/17 94/18 95/1 121/12 126/19 133/9</p> <p>services [5] 61/8 85/25 91/25 92/7 133/23</p> <p>set [25] 15/7 25/17 27/1 35/15 44/2 53/9 62/12 62/14 67/18 69/2 70/12 70/25 72/19 73/8 73/19 74/11 81/6 89/17 91/3 96/2 98/21 99/6 103/24 115/22 120/22</p> <p>sets [4] 14/19 16/11 35/19 103/25</p> <p>setting [11] 48/9 53/24 59/4 61/25 73/11 73/12 74/21 74/25 81/14 108/2 131/5</p> <p>settle [2] 78/22 79/2</p> <p>settled [2] 80/9 80/16</p> <p>Several [1] 47/24</p> <p>severe [5] 2/20 2/25 3/2 69/16 123/19</p> <p>severity [4] 123/11 123/17 124/13 131/3</p> <p>share [2] 70/19 111/18</p> <p>shared [4] 26/1 26/25 27/4 74/5</p> <p>sharing [2] 26/20 64/12</p> <p>she [20] 5/17 5/21 10/21 11/18 23/2 26/6</p>
--	--	--	---	---

<p>S</p> <p>she... [14] 37/22 37/23 38/10 60/9 60/20 63/7 67/1 84/12 84/15 86/21 86/22 88/18 88/23 124/19 she's [3] 5/16 52/14 64/20 shed [1] 116/5 sheer [1] 107/24 SHHD [1] 92/11 short [6] 31/21 46/9 79/6 88/3 115/4 117/20 should [51] 3/21 6/9 9/15 14/20 26/23 32/5 32/13 39/23 40/1 40/5 40/14 40/16 41/13 48/5 50/8 52/18 54/1 55/19 60/20 65/11 70/6 71/14 71/16 71/22 72/19 80/4 80/13 80/13 80/16 81/12 86/13 86/14 86/24 88/5 89/7 98/11 100/23 102/7 103/5 103/15 104/21 107/2 109/7 109/9 109/11 110/15 111/9 113/12 113/15 114/4 131/16 shouldn't [1] 99/17 show [4] 29/16 54/20 71/25 94/9 showed [2] 29/1 29/4 shows [1] 90/22 sic [3] 8/12 75/17 84/11 side [3] 34/1 90/21 95/5 sides [1] 119/18 significant [3] 97/24 115/20 126/21 significantly [2] 52/25 58/12 signs [3] 4/15 29/1 29/3 simple [1] 69/13 simply [5] 12/7 59/7 70/9 74/16 110/20 since [2] 57/21 117/1 single [2] 104/4 118/1</p>	<p>single-use [1] 104/4 singling [1] 73/24 sir [7] 46/4 90/4 116/13 117/17 124/23 132/20 136/18 sit [3] 117/7 117/7 117/9 sitting [1] 52/1 situated [1] 61/11 situation [5] 39/21 52/2 87/23 90/1 100/24 six [4] 86/21 88/10 128/21 128/24 six months [2] 86/21 88/10 Skipton [4] 85/18 87/12 87/13 132/12 slightly [6] 14/25 15/24 35/12 73/18 100/25 116/17 small [6] 31/15 31/25 32/6 32/17 96/7 134/16 smaller [2] 31/9 32/7 SNBTS [41] 7/3 7/8 7/16 7/19 7/25 8/4 8/7 8/9 10/22 12/1 15/19 16/19 21/21 22/1 23/9 23/13 23/16 23/17 24/2 40/5 40/19 43/8 46/2 46/21 47/1 51/24 53/14 53/14 55/25 61/10 71/6 79/16 92/14 94/20 95/14 95/15 112/14 120/17 120/24 122/13 127/9 SNBTS' [1] 7/11 SNBTS's [4] 9/2 23/20 23/23 52/25 so [179] Social [1] 85/25 society [51] 4/4 4/9 5/11 5/19 6/11 7/6 7/20 9/18 10/11 13/6 13/9 14/16 19/16 22/6 22/17 22/22 23/7 24/3 25/15 25/20 26/12 26/17 26/21 26/25 33/6 34/7 34/8 34/20 35/1 35/1 36/5 36/9 36/15 37/9 43/17 45/1</p>	<p>45/10 46/18 46/21 47/1 47/9 49/6 51/21 58/16 64/24 69/12 84/18 110/18 110/20 111/23 132/17 Society's [8] 1/17 1/22 6/5 12/3 16/11 19/5 19/9 37/17 solicitors [1] 79/24 some [51] 4/16 6/21 11/6 16/22 20/9 20/13 25/2 28/11 31/9 31/15 35/24 37/13 42/11 44/5 45/21 53/23 54/14 55/17 57/24 58/1 59/5 59/21 59/23 61/24 62/1 66/5 66/7 72/18 75/12 82/12 83/22 89/19 89/22 96/16 100/2 100/6 105/5 106/4 106/16 109/17 112/10 112/23 115/6 121/8 123/19 127/4 129/23 131/25 133/25 134/16 136/12 somebody [4] 21/4 52/4 56/2 110/24 someone [3] 7/2 51/25 69/12 something [15] 25/8 26/24 27/24 31/12 43/20 43/23 45/18 47/2 49/2 57/11 72/20 75/7 106/21 113/6 120/5 somewhere [1] 41/4 sorry [13] 25/7 38/14 40/23 61/9 61/10 69/8 86/14 89/6 96/21 119/6 123/14 123/16 123/24 sought [5] 8/9 39/25 57/9 81/5 108/18 sound [1] 76/2 sounding [1] 113/4 source [3] 5/3 123/22 133/12 sourced [1] 102/7 sources [1] 105/10 sourcing [1] 103/13 south [2] 82/7 134/15 spare [1] 31/9</p>	<p>speak [4] 9/4 40/21 86/3 134/21 speaking [1] 126/18 special [3] 60/22 73/25 103/25 specialists [1] 97/2 specific [10] 48/25 49/21 49/22 66/2 83/17 103/15 104/13 106/6 106/15 128/8 specifically [4] 65/22 84/21 115/23 129/8 specificity [3] 45/23 48/6 50/21 spent [2] 16/6 45/21 sponsored [1] 92/23 spontaneous [1] 87/8 spontaneously [1] 87/22 spread [1] 96/7 St [1] 112/16 St Andrew's [1] 112/16 staff [1] 112/15 stage [13] 25/10 82/14 88/1 89/4 116/8 116/10 127/22 128/1 128/1 128/4 128/7 128/15 129/21 stakeholders [1] 26/16 standard [1] 82/20 Standards [1] 92/17 start [2] 1/10 59/25 started [1] 133/24 starting [4] 133/7 133/20 134/1 134/4 starts [2] 19/23 54/2 state [7] 14/23 15/2 21/23 81/4 81/10 107/1 136/19 stated [1] 87/12 statement [12] 19/5 27/7 34/16 48/15 62/6 75/8 82/23 97/25 98/6 100/3 100/11 128/5 statements [1] 18/6 States [1] 49/17 statistic [1] 123/17 status [2] 40/3 41/15 steering [1] 96/10 step [1] 63/23</p>	<p>steps [4] 29/20 92/11 95/24 103/18 sterilisation [2] 104/2 104/5 Steve [1] 79/9 Steve Lindsay [1] 79/9 sticking [1] 45/11 sticks [1] 114/10 still [19] 32/24 45/12 59/14 67/18 82/3 82/3 91/9 93/1 93/4 103/2 111/10 113/25 115/21 116/7 117/8 120/14 125/10 129/15 134/9 Stock [8] 76/24 79/8 84/12 85/22 87/6 89/10 89/20 93/21 stood [1] 103/5 stop [3] 102/7 124/9 126/12 straightforward [3] 73/19 79/21 113/13 strategies [1] 11/5 stream [1] 127/10 strength [1] 62/22 strengthened [1] 56/10 strengthening [1] 55/7 stress [1] 70/3 striking [1] 69/13 strong [3] 3/11 22/5 62/21 strongly [4] 60/25 107/6 107/17 107/18 structure [1] 106/12 struggling [4] 12/10 44/4 56/17 56/24 study [1] 38/16 subject [4] 32/15 42/23 44/10 67/14 subjected [1] 8/7 subjecting [2] 19/19 19/20 submission [6] 5/9 13/24 22/11 60/14 74/19 96/4 submissions [1] 8/6 submitted [2] 22/8 43/25 subparagraphs [1]</p>
---	--	---	---	--

(62) she... - subparagraphs

<p>S</p> <p>subparagraphs... [1] 16/15</p> <p>subsequent [1] 101/10</p> <p>subsequently [3] 41/8 53/22 87/24</p> <p>substantial [1] 3/3</p> <p>substitute [1] 83/13</p> <p>succeeded [1] 81/9</p> <p>success [1] 112/13</p> <p>successful [1] 126/24</p> <p>such [21] 1/25 33/24 56/20 71/17 73/12 74/3 85/6 86/23 93/12 101/25 105/11 106/11 109/15 110/8 110/9 117/5 124/6 129/6 131/3 131/25 133/18</p> <p>suffered [2] 71/16 128/22</p> <p>sufferers [3] 60/22 71/3 71/23</p> <p>suffering [4] 73/16 88/22 89/4 121/16</p> <p>sufficient [9] 29/18 30/7 30/7 31/3 31/8 32/7 107/25 122/25 123/2</p> <p>sufficiently [1] 44/24</p> <p>suggest [11] 20/2 27/22 52/23 55/14 66/18 72/12 91/9 93/1 93/11 110/13 116/15</p> <p>suggested [6] 54/7 55/3 56/2 117/24 127/16 128/5</p> <p>suggesting [2] 26/24 119/7</p> <p>suggestion [5] 19/3 46/25 56/5 102/6 109/13</p> <p>sum [3] 77/7 77/13 113/10</p> <p>summarises [1] 66/24</p> <p>summarising [2] 51/9 51/11</p> <p>summary [1] 30/1</p> <p>supplied [2] 101/18 120/18</p>	<p>supply [5] 31/21 32/6 32/14 123/2 126/22</p> <p>support [17] 4/10 10/6 59/23 61/22 67/19 68/24 71/2 71/11 76/16 80/22 81/6 107/9 115/4 115/5 115/18 131/14 131/16</p> <p>supported [1] 101/24</p> <p>suppose [7] 15/24 43/14 106/9 109/17 119/18 122/10 128/14</p> <p>sure [21] 7/22 13/13 38/10 40/24 45/6 56/22 60/25 88/16 105/25 108/4 108/7 108/17 114/23 122/25 124/18 128/10 129/8 134/8 134/11 135/18 136/13</p> <p>surfaced [1] 20/3</p> <p>surgeon [1] 96/11</p> <p>surgery [3] 97/9 97/16 103/25</p> <p>surgical [5] 91/12 103/11 103/13 103/25 104/11</p> <p>surgical/clinical [1] 91/12</p> <p>surprise [1] 51/24</p> <p>surprised [1] 117/5</p> <p>surprises [1] 72/6</p> <p>surprising [3] 7/24 44/11 58/23</p> <p>surrogate [8] 38/20 48/17 49/1 49/6 49/23 50/7 124/24 125/15</p> <p>surrounding [2] 17/9 23/11</p> <p>survival [4] 2/10 2/15 3/2 15/4</p> <p>Susan [2] 4/19 79/8</p> <p>Susan Murray [1] 79/8</p> <p>suspect [7] 5/13 42/6 80/15 82/8 94/22 121/14 135/10</p> <p>sympathy [1] 65/4</p> <p>symptoms [2] 20/5 88/3</p> <p>system [2] 103/24</p>	<p>104/15</p> <p>T</p> <p>tactic [1] 74/20</p> <p>take [27] 25/7 28/24 35/11 40/17 46/5 46/6 52/25 59/18 65/17 72/12 76/9 78/13 80/18 80/23 90/5 90/6 96/13 97/25 102/22 109/10 111/16 116/17 116/19 121/20 122/5 124/23 132/1</p> <p>taken [19] 1/11 4/14 8/11 10/17 12/12 12/24 13/3 13/10 22/7 26/3 27/11 33/8 77/4 80/14 89/7 92/11 95/24 103/18 136/11</p> <p>takes [1] 117/12</p> <p>taking [6] 19/8 19/11 46/24 56/11 118/16 119/12</p> <p>talk [2] 55/18 111/5</p> <p>talked [1] 105/4</p> <p>talking [6] 27/10 48/14 48/19 58/25 99/7 129/10</p> <p>talks [1] 72/24</p> <p>tally [1] 35/3</p> <p>Targeted [1] 68/6</p> <p>task [2] 24/19 75/5</p> <p>Teale [1] 46/22</p> <p>teams [1] 96/7</p> <p>Teleconference [1] 85/19</p> <p>telephone [1] 53/7</p> <p>tell [7] 13/23 89/15 92/10 95/23 117/11 125/22 126/12</p> <p>telling [3] 98/17 126/2 126/7</p> <p>ten [1] 48/14</p> <p>ten years [1] 48/14</p> <p>tend [1] 63/12</p> <p>tens [2] 121/1 121/4</p> <p>term [4] 20/10 34/17 35/2 128/22</p> <p>termed [1] 100/1</p> <p>terms [33] 3/12 5/1 5/25 16/11 16/17 20/24 22/5 28/17</p>	<p>38/14 40/25 44/2 45/23 55/6 55/18 57/9 72/9 74/25 76/15 77/20 95/23 98/1 103/25 104/10 104/25 108/25 109/21 112/6 114/7 115/4 116/4 118/22 131/5 133/21</p> <p>territorial [2] 3/21 10/19</p> <p>territory [1] 46/4</p> <p>test [32] 11/15 11/23 12/20 16/24 17/25 28/10 28/22 29/5 42/10 42/12 48/6 49/16 49/22 49/23 50/14 50/17 50/18 50/22 50/24 51/6 51/12 82/20 82/22 83/9 98/19 99/9 114/13 118/13 121/18 126/14 126/14 135/17</p> <p>tested [6] 11/21 16/22 37/12 39/8 42/4 129/24</p> <p>testing [40] 36/8 43/13 43/18 43/21 43/24 44/22 45/2 45/13 45/16 45/18 45/21 45/25 47/16 47/24 48/5 48/11 48/18 48/24 49/1 49/2 49/7 49/20 50/7 50/13 119/23 121/18 124/13 124/24 125/1 125/1 125/5 125/9 125/12 125/14 125/15 126/2 129/19 134/25 135/11 135/16</p> <p>testing' [1] 45/11</p> <p>tests [8] 29/4 29/10 29/23 38/19 83/17 135/22 135/25 136/1</p> <p>text [4] 55/1 55/13 56/1 95/10</p> <p>Thalidomide [1] 131/2</p> <p>than [35] 5/16 5/21 9/13 10/25 14/7 18/14 19/19 24/22 29/4 31/25 32/14 38/5 50/22 52/25 55/19</p>	<p>57/20 58/9 59/11 74/16 82/21 85/15 87/14 97/10 102/2 104/5 110/19 111/6 113/13 115/24 116/18 118/1 123/9 125/11 131/7 134/1</p> <p>thank [16] 27/8 30/3 30/4 42/20 50/11 51/18 60/7 80/18 90/3 90/8 117/17 117/18 136/3 136/7 136/15 136/16</p> <p>Thanks [2] 60/11 136/6</p> <p>that [818]</p> <p>that I [9] 24/14 87/2 89/23 99/3 108/7 109/2 109/16 109/21 118/7</p> <p>that immune [1] 120/2</p> <p>that is [8] 4/18 25/11 92/22 111/9 122/1 125/25 127/5 127/12</p> <p>that's [49] 2/9 2/22 3/25 5/5 6/7 8/15 12/4 12/8 13/24 14/25 16/8 17/4 17/13 17/19 17/24 27/9 27/24 28/7 30/2 36/14 40/12 45/9 47/7 47/8 47/15 47/23 48/1 49/24 57/11 66/18 68/1 78/12 78/18 86/3 88/16 89/8 89/11 90/21 94/4 98/22 101/15 103/15 104/23 106/14 109/3 109/7 117/14 124/18 136/2</p> <p>Thea [1] 46/22</p> <p>Thea Teale [1] 46/22</p> <p>their [48] 2/10 2/15 2/24 3/10 4/10 7/7 8/4 9/9 11/14 13/12 13/19 15/3 16/13 17/1 17/25 19/18 37/12 37/13 37/19 39/9 39/19 41/20 41/21 42/3 55/10 58/4 59/3 67/20 67/24 70/21 73/15 73/20 73/22 74/25</p>
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(63) subparagraphs... - their

<p>T</p> <p>their... [14] 83/17 84/10 100/13 109/20 111/18 115/9 115/21 115/24 116/14 116/22 126/6 129/23 133/12 134/18</p> <p>them [57] 2/23 3/3 3/6 6/14 8/2 9/6 9/19 19/10 19/19 22/22 25/24 29/1 30/25 32/21 39/21 39/21 40/21 41/2 41/5 41/6 43/10 44/9 44/20 48/23 51/2 56/18 56/19 57/24 59/5 59/15 62/1 87/14 87/17 97/24 100/2 102/20 103/24 108/4 109/20 112/25 113/10 113/11 113/16 113/18 116/2 119/4 119/13 121/2 121/17 121/17 121/18 125/22 126/7 128/23 129/11 131/24 136/9</p> <p>themselves [2] 3/9 85/16</p> <p>then [142]</p> <p>theoretical [1] 99/12</p> <p>theoretically [1] 126/18</p> <p>theory [1] 99/14</p> <p>therapeutic [1] 37/11</p> <p>there [135] 2/12 5/9 6/15 6/25 7/1 7/17 9/14 10/3 11/8 11/9 12/6 12/18 12/20 14/20 14/21 15/1 15/18 15/20 16/14 19/4 20/4 20/15 20/25 22/1 23/14 23/16 25/14 27/22 28/2 28/8 28/22 29/19 31/14 32/2 32/17 34/4 37/2 37/16 37/25 38/1 38/4 38/7 39/4 41/8 41/19 42/10 44/19 44/21 46/22 49/21 50/4 50/5 52/5 53/13 54/3 54/6 56/6 56/14 56/20 58/2</p>	<p>58/23 61/4 61/19 65/20 66/1 66/6 68/3 73/2 74/1 74/2 75/18 76/1 77/11 81/2 82/20 83/8 85/2 85/5 85/20 85/21 85/22 87/20 88/12 93/4 93/11 96/6 99/13 99/24 101/14 102/16 103/3 103/24 104/3 104/9 104/20 105/2 106/1 107/13 109/5 109/7 109/8 109/11 109/17 110/12 110/13 110/15 113/20 115/12 117/4 117/5 117/8 118/4 119/4 119/6 119/13 119/17 120/19 120/21 121/3 121/6 123/25 128/7 128/9 131/1 131/22 132/8 132/14 132/15 133/17 134/6 135/3 135/6 135/8 135/22 136/4</p> <p>there'd [3] 29/18 105/4 106/3</p> <p>there's [30] 4/16 4/22 14/20 25/7 29/21 34/1 37/4 42/2 45/4 47/5 47/20 48/1 54/14 55/20 55/22 56/1 58/8 61/4 66/17 69/4 78/25 83/22 89/10 96/14 98/23 105/7 106/9 123/3 132/23 132/23</p> <p>therefore [15] 3/23 4/13 9/7 10/16 11/4 16/6 32/20 37/24 40/5 70/3 76/20 91/19 116/10 126/21 127/11</p> <p>these [17] 36/16 42/11 46/17 55/17 61/14 62/9 68/17 76/12 78/1 80/8 84/15 104/13 105/23 115/18 124/8 125/2 130/7</p> <p>they [78] 2/16 3/5 3/6 6/14 9/6 9/7 11/15 12/11 13/12 13/23 16/23 16/25 19/12 21/21 23/14 25/21 26/17 29/2 30/13</p>	<p>32/14 32/21 37/9 37/18 39/8 41/2 43/20 44/14 44/15 47/17 48/4 48/13 55/19 56/6 57/23 58/1 59/11 59/13 61/14 62/2 63/23 65/5 68/16 68/22 68/23 68/25 70/2 73/20 73/22 79/19 80/15 87/20 88/1 98/17 100/23 101/25 103/9 110/8 113/14 114/14 115/19 116/24 117/2 118/24 119/5 119/13 120/19 124/1 126/3 126/7 129/12 129/13 129/20 129/22 132/1 133/24 134/6 134/22 135/5</p> <p>they'd [4] 41/2 51/15 89/4 103/22</p> <p>they're [5] 22/5 51/16 51/17 59/10 69/24</p> <p>they've [4] 12/8 99/25 117/24 131/15</p> <p>thing [10] 47/3 63/24 89/25 97/6 98/20 100/21 110/18 111/20 114/10 126/1</p> <p>things [3] 9/14 43/8 111/9</p> <p>think [141]</p> <p>thinking [13] 25/22 43/12 61/20 98/25 98/25 99/22 100/15 100/18 100/18 100/22 110/21 120/2 131/18</p> <p>third [12] 18/7 18/16 18/25 36/16 47/5 47/13 60/18 61/4 75/14 89/10 91/6 93/24</p> <p>this [241]</p> <p>thoroughly [1] 79/22</p> <p>those [71] 2/1 2/14 5/21 6/9 6/16 10/13 13/1 14/5 14/11 18/14 18/25 22/3 22/16 23/7 29/3 29/10 29/23 30/13 33/22 42/4 44/14 48/25 55/14 60/11 61/23 66/24</p>	<p>67/19 68/15 69/17 69/22 72/8 72/12 73/2 75/6 77/7 77/14 77/15 79/17 79/19 81/22 82/10 87/13 89/1 95/17 97/11 98/1 99/18 102/19 104/1 108/6 109/21 110/19 115/2 115/13 116/12 116/21 116/25 119/1 121/10 122/13 126/5 128/21 130/9 131/7 132/9 132/11 132/20 132/21 133/11 135/15 135/24</p> <p>though [1] 88/23</p> <p>thought [10] 31/6 33/15 49/2 76/22 82/5 87/22 87/25 99/3 109/14 136/13</p> <p>thoughts [3] 15/15 33/12 72/17</p> <p>thousands [5] 121/1 121/2 121/4 121/7 130/21</p> <p>thread [1] 118/1</p> <p>threat [1] 3/2</p> <p>threatening [2] 2/25 124/5</p> <p>three [5] 7/3 16/14 28/20 82/14 91/8</p> <p>three years [2] 28/20 91/8</p> <p>through [47] 3/7 5/10 6/10 6/17 7/8 13/13 18/19 18/20 20/21 30/21 35/5 37/1 42/2 43/7 47/22 54/3 55/3 59/19 68/2 69/23 70/5 70/14 72/8 72/12 76/9 79/15 80/23 84/10 85/1 91/23 92/24 96/24 98/1 100/2 100/17 104/22 105/8 108/6 114/14 114/18 115/19 116/14 116/22 116/23 121/1 130/17 131/7</p> <p>throughout [4] 96/6 96/19 101/16 104/18</p> <p>thrown [1] 113/1</p> <p>thrust [1] 72/18</p>	<p>time [95] 2/8 3/4 5/8 5/21 6/17 7/10 9/25 11/11 12/20 14/23 15/2 15/16 15/18 16/19 16/25 18/18 20/13 21/9 21/21 21/23 22/6 22/15 24/12 28/11 31/3 32/19 36/7 37/13 37/13 38/20 39/5 43/21 43/24 45/21 48/8 48/13 49/9 49/15 49/16 53/19 54/17 55/17 59/18 59/24 61/21 62/10 62/22 65/15 66/17 72/5 76/12 76/17 78/13 85/3 89/5 96/1 96/13 96/23 97/25 99/1 100/5 100/16 101/18 102/18 102/18 105/17 107/21 107/21 110/18 114/17 116/6 116/18 117/2 118/1 119/11 119/21 120/1 120/8 121/23 122/9 122/20 123/6 124/15 125/6 129/1 131/12 132/3 133/19 133/22 133/24 133/25 134/4 134/23 136/9 136/11</p> <p>timelessly [1] 44/24</p> <p>times [1] 131/19</p> <p>timing [2] 112/6 129/3</p> <p>tissue [1] 77/9</p> <p>tissues [1] 101/9</p> <p>title [1] 68/3</p> <p>to [863]</p> <p>today [4] 23/7 73/1 77/4 77/19</p> <p>today's [1] 97/7</p> <p>together [1] 65/6</p> <p>told [20] 2/17 12/8 13/22 14/2 16/23 17/25 19/12 35/23 36/7 37/12 37/18 38/1 51/16 51/22 57/22 59/1 117/15 119/5 123/10 128/1</p> <p>tolerably [1] 41/12</p> <p>tomorrow [4] 64/25 136/17 136/18 136/21</p>
--	--	--	--	---

T	transmission [4] 28/17 39/7 104/8 123/5	43/14 55/4 75/5 103/19 113/11 124/9	unacceptable [1] 66/14	United [3] 49/17 93/4 93/15
too [3] 3/11 101/22 131/16	transmit [4] 28/3 102/10 123/1 124/17	trying [6] 13/17 15/25 16/8 24/14 28/7 30/2	unaffordable [1] 76/21	United Kingdom [2] 93/4 93/15
took [10] 19/17 24/9 24/11 24/21 47/17 55/17 81/11 112/9 127/8 136/9	transmitted [3] 18/19 30/14 123/3	Tuesday [1] 1/1	unaware [3] 36/10 41/21 98/13	United States [1] 49/17
top [11] 19/25 32/25 42/18 42/21 45/3 46/16 60/16 63/4 67/5 67/15 69/10	transmitting [1] 99/15	tune [1] 61/14	unclear [1] 125/8	universally [2] 98/18 99/9
topic [8] 87/2 90/14 101/1 104/16 111/24 117/25 117/25 129/15	transparent [4] 26/7 26/9 26/22 34/9	turn [11] 8/13 8/13 22/18 24/4 52/9 54/2 57/1 97/22 100/25 111/14 132/22	uncomfortable [1] 63/15	unknown [3] 40/3 41/15 131/22
total [1] 113/10	transpired [1] 94/14	turning [1] 118/8	undeniable [1] 55/16	unless [7] 20/10 48/19 69/3 88/7 88/14 97/9 129/22
totally [1] 129/13	trawling [1] 120/25	twelve [1] 71/12	under [10] 16/10 34/18 41/3 56/4 74/13 78/22 79/3 80/9 91/4 125/6	unlike [1] 129/18
touch [1] 40/20	Treasury [1] 61/1	twelve months [1] 71/12	underestimated [1] 72/13	unlikely [5] 3/8 25/23 27/5 31/25 34/4
touched [4] 12/14 16/16 124/24 128/3	treat [2] 97/19 115/11	twice [1] 4/8	underlying [1] 10/4	unnecessary [1] 37/14
touches [1] 93/8	treated [16] 3/20 5/25 17/10 17/13 18/14 24/16 30/13 31/5 31/11 32/8 39/6 121/4 121/5 121/15 121/15 122/21	two [14] 9/6 9/8 14/12 29/11 59/16 65/14 68/10 80/21 82/14 85/6 85/17 114/16 136/11 136/14	undermine [1] 109/20	unrelated [1] 53/7
towards [12] 9/20 19/9 19/11 19/25 36/25 57/13 65/3 69/9 95/2 96/15 110/10 110/12	treatment [37] 1/19 2/8 2/17 2/21 3/6 7/8 10/24 11/5 14/22 18/24 30/14 36/12 37/11 43/22 60/22 60/23 67/20 68/15 70/6 70/15 70/17 87/25 88/20 98/19 99/10 103/12 103/23 111/19 121/8 121/9 121/22 122/8 122/19 124/3 124/7 130/23 131/1	two days [2] 136/11 136/14	understand [28] 2/3 6/4 10/8 18/8 31/2 34/25 42/24 43/10 44/4 44/12 46/1 46/25 51/8 51/18 54/9 55/4 56/17 63/16 65/1 65/3 67/17 75/6 102/15 102/20 104/18 105/25 107/22 113/17	unreliable [2] 43/15 119/3
Towers [12] 7/1 37/20 37/21 38/4 39/21 40/3 40/15 40/21 42/23 43/6 79/9 112/5	treatments [2] 111/19 115/10	two years [1] 65/14	understandably [3] 6/12 23/15 68/16	unsafe [1] 56/19
track [1] 102/9	trend [4] 110/9 110/12 111/22 111/23	tying [1] 46/1	understanding [24] 9/11 11/4 20/14 24/11 28/1 30/8 38/19 38/22 48/11 81/23 81/25 93/10 93/12 93/12 94/11 104/25 123/10 123/18 125/4 125/13 128/7 128/25 135/1 135/2	unsatisfactory [1] 126/10
tracking [2] 40/7 40/25	trespassed [1] 46/4	typed [1] 54/11	understood [3] 32/19 107/10 136/8	until [13] 16/24 27/20 27/25 28/20 28/24 38/15 46/6 64/13 98/14 117/7 117/10 121/6 136/25
training [1] 97/14	trespassing [1] 89/7	types [1] 10/1	undertaken [7] 1/9 12/11 21/1 21/3 22/9 38/16 114/19	unusual [3] 86/22 89/2 129/16
transcript [2] 24/24 113/20	trials [2] 30/19 30/22	typewritten [1] 54/7	undertaking [1] 42/25	unwittingly [1] 11/3
transfuse [1] 97/6	trigger [9] 82/13 83/9 83/19 84/13 84/17 84/24 97/11 109/16 128/11	typical [1] 129/17	undertook [1] 67/24	up [70] 6/20 8/4 9/6 10/17 11/1 11/12 14/9 15/5 23/7 27/6 27/9 32/12 35/8 35/25 36/15 37/6 45/19 45/24 47/6 53/7 53/24 59/20 60/4 60/5 60/6 60/11 60/17 64/13 66/22 68/4 69/7 69/9 70/12 70/24 70/25 72/19 73/8 73/11 73/12 73/19 74/11 74/21 74/25 78/14 81/6 81/14 84/1 84/3 84/14 90/17 91/6 91/15 92/6 97/8 97/21 101/1 103/24 106/10 108/2 108/13 108/22
transfused [1] 101/12	triggered [1] 109/24	UK [30] 3/20 10/19 47/17 47/18 47/25 49/18 56/23 61/1 66/1 81/4 81/11 90/25 92/6 98/2 101/5 102/4 102/7 102/21 102/25 103/16 128/9 128/16 130/11 130/14 130/16 130/19 133/4 133/18 133/22 136/20	undoubtedly [2] 34/18 34/20	unreliable [2] 43/15 119/3
transfusion [29] 6/10 6/17 42/13 46/19 72/9 72/25 90/14 90/24 91/2 91/15 92/2 92/10 93/11 93/18 94/1 94/15 95/12 95/20 95/25 96/15 96/25 97/21 99/11 99/14 100/15 114/15 118/3 129/17 133/23	true [1] 35/2	UK Government [1] 136/20	uniformly [1] 118/17	unrelated [1] 53/7
transfusions [2] 69/23 71/4	Trust [4] 39/12 63/14 69/6 70/12	UK-sourced [1] 102/7	unique [1] 73/2	unreliable [2] 43/15 119/3
transient [1] 88/4	Trusts [1] 40/4	UK-wide [3] 98/2 103/16 130/14		unreliable [2] 43/15 119/3
transition [1] 69/25	try [11] 13/16 33/21 37/25 40/1 41/14	UKHCDO [2] 24/15 24/25		unreliable [2] 43/15 119/3
		ultimately [7] 19/17 49/19 83/13 94/14 94/19 124/22 130/3		unreliable [2] 43/15 119/3
		um [1] 120/11		unreliable [2] 43/15 119/3
		unable [1] 58/1		unreliable [2] 43/15 119/3

U	114/24 117/12 121/21 125/3 127/13 134/18 vCJD [9] 95/18 97/22 97/24 98/2 101/1 101/10 101/17 103/7 104/8 ventilated [2] 11/24 117/13 verbally [1] 57/23 versa [1] 133/16 version [1] 25/12 very [47] 5/22 6/11 8/3 13/14 13/17 16/4 18/23 20/4 20/11 24/18 31/11 34/3 34/14 40/19 42/18 51/18 52/4 53/5 53/10 53/16 60/20 73/19 74/22 79/6 80/25 86/19 86/19 86/22 92/20 95/23 96/4 97/2 97/4 97/4 97/20 102/5 103/20 104/13 106/6 107/6 107/17 125/8 126/21 129/22 131/2 136/3 136/15 via [1] 38/20 vice [1] 133/16 victims [1] 63/19 view [19] 15/18 15/23 40/9 41/6 41/25 62/12 66/14 70/4 70/19 70/20 73/22 75/21 76/14 81/11 98/12 98/16 99/4 105/15 126/10 views [18] 13/10 13/12 45/22 60/20 61/19 62/9 74/4 86/12 99/22 99/23 100/5 100/9 101/19 107/17 109/12 122/12 122/14 123/7 VIII [9] 5/20 8/12 9/8 17/10 21/22 56/7 58/5 106/16 124/2 viral [4] 27/12 55/16 56/24 126/25 Virological [1] 47/19 virologist [1] 86/10 virus [21] 28/22 38/20 49/22 56/18 64/3	68/14 71/3 86/20 87/24 88/1 88/6 88/13 88/19 89/3 114/14 115/3 123/5 126/8 127/14 128/21 129/12 viruses [4] 51/3 102/10 108/6 126/16 visible [1] 135/11 visit [2] 12/24 12/25 voiced [2] 102/19 130/7 volumes [2] 122/17 124/9 vote [2] 107/8 107/10 voting [1] 107/13 vvv [1] 67/16	ways [1] 105/23 we [312] we know [1] 30/16 we'd [4] 26/18 97/19 134/14 134/20 we'll [6] 35/11 46/6 62/25 63/15 117/6 117/14 we're [8] 2/2 2/3 34/8 42/1 48/14 58/25 73/3 99/7 we've [12] 16/16 19/24 23/14 33/18 60/16 63/2 80/20 84/20 108/19 111/5 122/1 136/12 wealth [1] 100/4 week [6] 5/14 14/9 34/11 59/20 91/1 94/3 weighed [1] 98/25 weight [2] 86/12 126/12 well [72] 2/20 5/8 7/21 9/6 12/10 13/9 13/13 14/1 15/18 18/23 18/24 24/2 24/13 26/14 27/4 28/5 29/11 29/14 34/16 40/10 40/15 42/6 44/7 46/6 48/13 49/5 49/25 50/24 52/1 53/18 54/15 56/11 58/18 59/13 61/1 65/22 72/23 76/17 82/17 85/12 86/16 88/23 92/13 93/3 96/2 97/4 97/15 99/3 99/13 100/10 103/20 106/9 106/13 108/15 109/14 110/8 111/12 114/10 116/4 122/2 122/22 126/7 127/5 131/1 131/15 131/17 133/13 133/24 134/13 134/13 136/2 136/7 Welsh [1] 85/23 went [3] 72/20 74/15 100/6 were [175] weren't [5] 19/20 98/12 119/15 134/22 135/5	Westminster [1] 130/14 what [144] what's [6] 5/5 20/14 24/11 34/13 35/15 74/11 whatever [7] 41/11 41/23 50/25 84/17 94/22 103/23 115/9 when [31] 16/20 20/3 20/11 24/10 26/10 26/14 33/13 33/15 51/17 67/11 69/16 70/11 74/1 88/1 88/2 97/14 100/16 113/9 113/24 114/1 118/19 119/11 120/6 120/11 121/18 121/25 125/2 125/18 128/18 134/25 135/8 where [16] 15/25 29/24 31/20 34/7 45/5 57/13 60/18 64/14 67/6 75/18 76/5 79/17 79/19 84/4 88/17 119/6 whereabouts [2] 40/2 41/15 whereas [1] 135/5 whether [66] 7/11 7/16 9/14 10/5 11/8 11/10 13/3 21/10 21/10 24/19 25/19 27/4 28/1 28/12 28/14 28/18 29/1 29/20 31/7 32/5 32/13 35/1 37/25 38/1 38/7 39/20 39/25 40/6 40/13 41/13 45/16 53/13 54/18 58/8 59/7 63/22 65/24 68/18 80/11 80/15 81/6 81/7 81/23 83/18 85/2 85/5 86/12 86/14 86/23 88/12 88/18 94/19 94/20 100/20 101/20 101/21 101/22 103/18 109/8 109/11 112/1 118/9 120/23 127/21 132/2 132/23 which [124] 2/9 2/10 2/14 3/21 4/17 9/2 9/12 10/1 10/12 12/14
V	valid [2] 132/18 132/19 validated [1] 8/22 validity [1] 107/8 value [6] 12/8 12/12 13/4 19/12 39/14 59/2 variable [2] 91/10 93/2 variant [3] 99/15 100/16 103/22 variant CJD [3] 99/15 100/16 103/22 varied [1] 133/23 various [10] 57/8 65/6 105/3 106/1	W waded [1] 43/7 Wales [1] 31/5 want [19] 1/8 1/10 7/25 18/8 23/8 27/9 33/16 36/16 49/23 57/11 59/21 73/21 73/23 98/4 106/20 111/24 112/3 133/10 134/9 wanted [14] 2/13 6/14 46/12 47/6 47/12 55/6 56/9 56/22 88/18 90/13 103/7 109/21 110/11 136/5 wanting [4] 19/4 19/10 107/22 134/3 wards [1] 97/18 warfarin [1] 120/10 was [436] wasn't [18] 14/1 14/2 19/11 26/21 26/23 28/19 28/22 29/7 31/3 48/18 56/23 59/12 61/7 125/18 128/13 128/13 132/19 135/8 Watson [1] 38/19 way [27] 7/24 11/6 22/21 23/3 26/22 27/2 28/9 29/20 32/18 33/4 34/23 61/4 62/21 64/4 75/23 93/5 97/9 99/3 102/8 102/10 103/6 104/14 111/9 119/5 121/5 125/11 130/20	which [124] 2/9 2/10 2/14 3/21 4/17 9/2 9/12 10/1 10/12 12/14	

(66) up... - which

<p>W</p> <p>which... [114] 13/21 15/3 15/7 16/25 17/20 18/11 19/6 19/21 20/22 21/19 21/22 22/6 22/21 25/3 25/8 25/8 25/17 27/1 27/22 27/24 28/10 28/15 29/2 29/4 34/1 41/12 42/19 46/12 47/2 49/2 49/16 50/6 50/18 53/8 54/19 56/11 56/15 57/8 57/12 58/10 60/19 61/10 61/16 61/21 61/25 64/4 65/8 66/17 66/24 67/3 67/13 70/4 71/5 72/19 72/20 72/21 73/3 79/5 79/14 79/15 79/25 82/6 83/1 83/2 84/14 84/21 86/18 92/15 92/16 92/25 93/5 93/8 93/9 93/18 94/6 94/15 96/10 96/12 96/15 98/18 99/5 102/5 104/16 104/22 105/6 106/10 106/21 112/10 112/10 113/21 119/10 119/14 120/17 120/20 120/22 122/24 123/5 123/8 124/19 124/22 125/3 126/3 126/8 127/7 127/13 127/16 130/7 133/1 135/4 135/4 135/17 136/10 136/11 136/12</p> <p>while [8] 55/12 55/14 60/3 68/20 108/5 110/7 110/21 115/16</p> <p>whilst [3] 39/19 77/22 112/6</p> <p>who [66] 3/8 4/23 6/16 11/20 13/7 14/11 15/12 16/22 21/3 30/9 30/12 30/13 30/25 31/10 33/21 37/21 40/14 41/4 41/17 41/20 42/7 42/25 47/10 50/6 51/16 55/4 60/7 60/11 60/22 62/2 68/13 71/3 72/8 73/4</p>	<p>73/21 74/2 76/25 77/7 77/14 77/15 83/7 84/8 86/20 87/25 88/18 89/2 90/19 90/20 100/20 101/9 103/9 103/21 108/6 114/13 115/25 116/21 118/24 121/7 121/8 123/4 126/15 128/21 129/17 130/12 130/17 132/15 who'd [3] 21/13 42/13 130/19</p> <p>who's [1] 54/9</p> <p>whoever [1] 88/24</p> <p>whole [6] 89/25 102/1 102/12 104/14 133/18 135/20</p> <p>whom [5] 4/20 48/17 112/1 128/18 131/14</p> <p>whose [3] 4/18 40/2 41/15</p> <p>why [30] 7/17 9/3 9/11 11/22 11/24 12/4 18/13 24/11 28/1 47/24 49/19 49/22 50/21 53/15 56/9 58/14 59/9 64/1 67/3 74/15 75/23 86/8 124/15 126/1 133/3 133/7 134/6 134/16 134/22 135/8</p> <p>wide [11] 3/20 10/19 70/7 98/2 102/21 103/16 105/10 128/9 128/16 130/11 130/14</p> <p>wide-ranging [1] 70/7</p> <p>widely [2] 83/12 97/16</p> <p>widened [1] 6/8</p> <p>wider [5] 73/6 76/4 76/4 131/10 135/11</p> <p>will [22] 18/5 23/7 24/23 25/2 32/10 34/10 53/5 63/23 67/16 72/5 79/16 79/18 79/20 79/21 94/5 94/6 110/7 111/11 116/5 117/3 117/4 136/13</p> <p>willing [1] 58/2</p> <p>willingness [1] 77/25</p> <p>Willoughby's [1]</p>	<p>122/11</p> <p>Winston [1] 130/23</p> <p>wise [1] 63/21</p> <p>wish [1] 18/6</p> <p>wished [1] 26/6</p> <p>wishes [1] 70/3</p> <p>with [169]</p> <p>with it [3] 5/3 74/22 83/2</p> <p>withdrawal [1] 101/8</p> <p>withdrawal/recall [1] 101/8</p> <p>withhold [1] 97/18</p> <p>within [21] 4/1 5/2 11/14 11/17 21/11 24/8 45/16 58/10 61/6 61/10 67/6 68/19 69/5 71/12 74/5 74/6 81/4 86/21 94/20 96/7 128/21</p> <p>without [10] 2/19 2/21 22/1 29/19 37/12 37/19 56/19 66/13 100/12 112/13</p> <p>withstood [1] 66/10</p> <p>WITN2280719 [1] 35/7</p> <p>WITN2287019 [1] 35/6</p> <p>WITN2287021 [1] 46/15</p> <p>WITN5736003 [4] 27/7 62/6 75/10 98/6</p> <p>witness [2] 27/7 75/8</p> <p>witnesses [2] 109/4 109/8</p> <p>won't [5] 63/24 71/7 96/13 117/7 117/9</p> <p>wondered [1] 86/23</p> <p>Woods [3] 4/23 4/23 4/24</p> <p>word [9] 9/18 9/19 12/7 38/2 96/7 110/22 127/11 134/9 134/10</p> <p>wording [1] 15/5</p> <p>words [12] 2/14 15/3 16/9 20/16 29/18 31/11 56/5 99/19 100/8 107/24 117/10 130/13</p> <p>work [6] 29/14 84/6 84/13 91/8 92/22</p>	<p>94/18</p> <p>worked [3] 29/16 31/20 114/17</p> <p>working [7] 23/15 31/18 54/18 84/7 85/4 96/18 119/21</p> <p>world [1] 56/14</p> <p>worldwide [1] 56/25</p> <p>worried [4] 57/25 59/5 59/10 59/14</p> <p>worry [1] 99/18</p> <p>worst [1] 130/23</p> <p>worthy [1] 68/20</p> <p>would [169]</p> <p>wouldn't [7] 26/1 56/21 97/9 105/16 117/5 123/1 129/12</p> <p>Wright [3] 51/22 51/22 51/22</p> <p>Wright's [2] 52/2 52/7</p> <p>written [5] 34/16 35/19 35/20 82/23 96/3</p> <p>wrong [2] 46/14 115/15</p> <p>wronged [3] 68/16 73/1 74/2</p> <p>wrote [3] 13/10 24/24 89/25</p> <p>Y</p> <p>year [6] 11/21 24/9 24/21 41/18 84/15 95/2</p> <p>years [31] 4/9 13/15 15/21 23/17 24/1 28/20 48/4 48/12 48/14 50/10 53/23 64/9 65/14 68/14 68/17 72/22 88/19 91/8 92/19 96/12 97/14 101/11 106/11 106/14 110/17 111/2 111/5 120/13 131/17 132/7 132/11</p> <p>yes [58] 2/5 4/21 5/4 5/15 8/4 8/5 12/12 15/5 15/7 15/8 21/2 25/11 26/23 29/8 29/25 30/16 39/16 41/11 43/4 46/6 47/4 49/25 50/16 51/14</p>	<p>52/20 54/13 54/14 54/22 58/13 61/24 62/4 62/23 67/21 70/21 74/8 76/13 86/18 88/21 89/21 90/12 93/7 93/16 96/2 97/1 104/24 107/19 110/17 114/6 116/20 117/22 120/19 123/16 126/11 131/12 134/8 135/15 136/2 136/22</p> <p>yesterday [16] 2/9 2/24 3/25 12/14 15/6 15/22 23/2 42/11 45/22 61/25 62/2 73/1 108/10 120/21 122/14 135/19</p> <p>yet [5] 22/7 28/22 28/23 61/25 126/9</p> <p>yield [1] 83/12</p> <p>Yorkhill [2] 36/24 122/8</p> <p>you [326]</p> <p>you'd [5] 29/13 55/6 96/18 108/11 132/12</p> <p>you'll [7] 49/25 51/20 67/22 68/5 117/11 117/15 136/7</p> <p>you're [22] 4/22 5/2 8/18 13/22 25/4 27/10 36/17 37/16 48/2 48/9 48/19 50/3 51/16 52/13 85/21 105/13 112/1 117/10 119/6 119/7 123/16 129/10</p> <p>you've [10] 5/3 25/3 59/1 101/14 101/18 101/21 127/17 128/1 133/2 134/11</p> <p>your [77] 5/5 11/4 13/4 13/25 15/15 24/11 26/10 26/10 27/6 30/8 33/3 33/12 34/12 38/22 38/25 41/25 45/4 48/10 49/7 52/13 54/10 62/6 62/8 62/12 62/17 62/22 66/19 70/19 72/16 72/16 74/4 74/5 75/7 76/14 77/1 78/3 80/1 80/2 81/25 88/15 97/25 98/6 98/11</p>
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Y

your... [34] 98/25
98/25 100/3 100/5
100/8 104/25 107/16
112/21 113/2 113/23
114/17 117/4 118/11
119/20 121/3 121/13
123/10 123/18 123/22
125/4 125/4 125/13
125/20 125/21 126/23
127/20 128/2 128/3
128/5 128/7 128/25
131/11 134/10 136/10
yours [1] 15/15

Z

Zubeda [2] 89/11
89/11
Zubeda Seedat [1]
89/11