Witness Name: Andrea Beveney
Statement No.: WITN7690002
Exhibits: WITN7690003 - WITN7690044
Dated: 18 July 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF ANDREA BEVENEY

I provide this statement on behalf of the Government Legal Department in response to the request under Rule 9 of the Inquiry Rules 2006 dated 26 April 2023.

I, ANDREA BEVENEY, will say as follows:

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1. Introduction

1.1. My name is Andrea Beveney. My professional address is 102 Petty France, London, SW1H 9GL.

1.2. I am a Deputy Director in the Government Legal Department (GLD) and have been the Team Leader for the GLD team representing the Department of Health and Social Care (the Department) in the Infected Blood Inquiry team since July 2021. This is my second statement to the Inquiry.

1.3. I am duly authorised to make this statement on behalf of the Department. The contents of this statement are true to the best of my knowledge, information and belief.

1.4. This statement addresses criticisms made of the Department in a statement dated 31 August 2022 from the Inquiry's witness **WITN5244001**; I understand that the statement was brought to the Department's attention on 22 March 2023. W5244's statement explains that she is the niece of GRO-B Mr GRO-B was a haemophiliac who was infected with both HIV and HCV through contaminated blood products and died on GRO-B 2012. Mr GRO-B death was the subject of an inquest conducted by HM Senior Coroner for Milton Keynes, Mr Thomas Osborne.

1.5. In her statement, W5244 is critical of the inquest process, of the Coroners involved (in both Northamptonshire and Milton Keynes), of the Coroner Service in both Coroner areas, and of Dr Brian Colvin who had treated Mr GRO-B GLD does not act for these individuals and organisations and this statement does not seek to address those matters.

1.6. In her statement, W5244 also makes the following criticisms of the Department:

(1) That she does not feel that the Department or the Coroner were very helpful in that they asked Mr GRO-B family to obtain documents which were not in the family's remit to obtain and should have been obtained by the Coroner / the Department (paragraph 108).

(2) That the family did not consider that the Coroner was independent in his final analysis, with the suggestion that it was clear from conversations between the Coroner and the Department of Health that they had been having private communications, that the family were not party to and have not since been shared with the family (paragraph 142).

(3) That the Coroner worked together with the Department to provide a narrative on GRO-B death certificate which the family consider is not the truth (paragraph 143).

1.7. It can be seen from the summary above that the issues raised critically by W5244 concerning the Department principally involve how the inquest was handled. I am providing this statement to the Inquiry, rather than an official from the Department because I can confirm that The Treasury Solicitor and the Government Legal Department (as TSol became) was instructed by the Department in Mr GRO-B inquest. I should make clear however, that I was not personally involved in the Inquest and the matters set out in this statement are drawn principally from GLD's case management system, and to a lesser extent from material and information provided by Counsel instructed in the case.

2. Chronology of procedural issues in Mr GRO-B inquest

2.1. To give context to the Department's approach to Mr GRO-B inquest, I have set out below a chronology of the main events, drawn from the documents located on GLD's case management system and documents provided to me from the Department.

2.2. On 25 March 2014 the Senior Coroner for Milton Keynes, Mr Osborne, wrote to DH Legal Services **[WITN7690003]**. The Coroner explained that Mr GRO-B inquest had been transferred to him from the Northampton coroner area. The letter attached submissions on behalf of Mr GRO-B family dated 3 March 2014 together with the file of evidence put together by the Coroner as it then stood. At this stage, Mr GRO-B family were legally represented. Submissions on their behalf by Dan Squires of Matrix Chambers (instructed by Public Law Solicitors) argued that the enhanced investigative obligation under Article 2 ECHR was engaged and would require either a full public inquiry (as had been established in Scotland, *i.e.* the Penrose Inquiry) or an inquest fully looking into the systemic issue (reference was made by analogy to the Hillsborough Inquests). The Coroner requested submissions from the Department by 15 June 2014.

2.3. On 16 June 2014, Dr Ailsa Wight (the Department's Deputy Director, Infectious Disease and Blood Policy) wrote to the Coroner attaching a submission **[WITN7690004]**. In her covering letter, Dr Wight stated,

> *"The key events in question covered roughly a 15 year period and are quite complex. Those events are set out as a factual chronology of events, attached to this letter. Our submission is therefore a relatively high level summary that covers the main issues and key decisions to assist you in your understanding of events, but does not include all of the details of what transpired.*
>
> *We do not accept the assertion that an Article 2 compliant inquest is necessary on the grounds of systematic failure. As the attached chronology makes clear, the actions of DHSS were based on the state of scientific knowledge at the relevant time and upon advice taken from the relevant scientific authorities.*

However, should a fully argued narrative response in rebuttal of the arguments made by Public Law Solicitors and counsel on behalf of Mr GRO-B *family be required in addition to the above, or if there is further specific information you require, please let me know."*

2.4. The attached submission was described as providing

"… a factual chronology of developing scientific knowledge together with events in the period from the mid-1970s to 1991 during which some patients were infected with HIV and/or hepatitis c as a result of treatment with NHS supplied blood or blood products."

2.5. On 25 June 2014, the Coroner replied to Dr Wight, thanking her for the detail provided but inviting the Department to provide its detailed submissions with regard to the arguments advanced by Mr GRO-B family **[WITN7690005].**

2.6. On 31 July 2014, Dr Wight responded to the Coroner with the Department's position on the Article 2 issue and matters for investigation in the Inquest **[WITN7690006]**. The Department's position was summarised in paragraph (1) of the response:

"(1) We note the position adopted by Mr GRO-B *family that the State has an obligation to ensure that* GRO-B *death is subject to an independent, effective, public and prompt investigation. The Department accepts that if there are systemic issues relating to the provision of contaminated blood products of potentially causative relevance to the death of* GRO-B GRO-B *and if those systemic issues have not been adequately addressed by other independent investigations into the provision of contaminated blood products, then it would be necessary to include any such issues in the scope of your inquest into the death of Mr* GRO-B *As matters stand, however, it appears to us that the systemic issues identified in the submissions on behalf of the family have already been investigated by Lord Archer as part of the "Archer Inquiry" and/or are being dealt with in the Penrose Inquiry." (underlined text emphasised in italics in original)*

2.7. On 13 August 2014, Eleanor Goodfield of the Treasury Solicitor's Department wrote to the Coroner noting that the Treasury Solicitor was now acting for the Department **[WITN7690007]**. She asked that the Department should be represented at the Pre-Inquest Review listed for 12 September 2014. She provided the Coroner with contact details for the Penrose Inquiry Secretariat

and a copy of the HIV litigation settlement which appeared to have been omitted from the earlier submissions. On 29 August 2014 Eleanor Goodfield wrote to Public Law Solicitors, confirming instruction by the Department and enclosing a copy of their submissions **[WITN7690008]**.

2.8. On 27 August 2014, the Coroner wrote to Mr GRO-B family's legal representatives with an agenda with provisional views:

"1 . Penrose Report

The preliminary view of the Coroner is that he will wait until the final publication of the Penrose Enquiry Report in Scotland before listing the full inquest.

2. Whether the findings set out in the Penrose Report are admissible at the inquest.

The preliminary view taken by the Coroner is that they are admissible under Rule 24, The Coroner's Inquest Rules 2013.

3. Whether Article 2 is engaged.

The Coroner will decide whether Article 2 is engaged after hearing any further submissions on behalf of the properly interested persons.

4. Whether the Coroner should sit with a jury.

The preliminary view of the Coroner is that no jury is required.

5. Further disclosure

6. Preliminary list of witnesses.

7. Time estimate

8. Date and venue"

The letter was then forwarded to the Department **[WITN7690009].**

2.9. On 8 September 2014 Mr GRO-B family's legal representatives filed further submissions **[WITN7690010]**. They agreed with the Senior Coroner's preliminary view that the listing of the full inquest should await the Penrose Inquiry report, but argued that the Archer Inquiry had not, and the Penrose report once completed would not, discharge the Article 2 investigative obligation.

2.10. The outcome of the Pre-Inquest Review ("PIR") hearing of 12 September 2014[1] was a ruling with further directions from the Senior Coroner dated the same day, **[WITN7690011]**. GLD does not hold a copy of a recording of the PIR hearing or a transcript of it.[2] From the directions it is apparent that, before reaching a final view on the issues to be investigated in the final inquest, the Senior Coroner wished to obtain further evidence, including the final Penrose report (once published); evidence from Mr GRO-B treating clinicians; and – as directed at paragraphs 3.3 and 3.4, the Coroner also directed that the Department should produce two witness statements. Those statements were to address:

(1) a brief overview of which body (in England and in Scotland) was responsible for the decisions material to the policy issues from 1975-1991 set out in paragraph 1 of the ruling; and

(2) a brief overview of what system, policy or training was in place for the type of professionals involved in Mr GRO-B case, concerning the risks of treatment and consent to it, and what system was now in place.

The Coroner indicated that he would receive further submissions once the Penrose Report and other evidence was available, and listed areas on which he would be further assisted by submissions.

2.11. In response to these directions, Ben Cole of the Department's Blood Policy Team submitted two statements to the Coroner dated 28 November 2014 **[WITN7690012]**.

2.12. On 19 January 2015 Eleanor Goodfield wrote to the Coroner noting that the Penrose Report had publicly announced its publication date of 25 March 2015 **[WITN7690013]**. On 20 February 2015 Eleanor Goodfield wrote again to the Coroner, essentially agreeing with the request that had been made by the family

[1] While GLD would be able to apply for a copy of the recording of the PIR, this typically takes time to obtain from any Coroner's Court and is not practicable within the R9 timescales for this statement.
[2] While GLD would be able to apply for a copy of the recording of the PIR, this typically takes time to obtain from any Coroner's Court and is not practicable within the R9 timescales for this statement.

legal representatives that some time would be required to consider to the Penrose Report **[WITN7690014]**. A copy of this letter was also sent to Public Law Solicitors **[WITN7690015]**. The final report of the Penrose Inquiry was published on 25 March 2015.

2.13. Public Law Solicitors wrote to the Treasury Solicitor on 19 June 2015 **[WITN7690016]**. Owing to illness to a member of Mr GRO-B family, they had asked for *"…a further extension of time for the provision of the family's written submissions following the publication of the Penrose Report."* The extension sought was to the end of the first week of August. They asked Eleanor Goodfield to confirm there was no objection to this. On 23 June 2015 Eleanor Goodfield wrote to the Coroner confirming that GLD had no objection to an extension of time **[WITN7690017]**. However, she noted that GLD may not then be in a position to respond to the family's submissions until the end of September.

2.14. Mr GRO-B family's legal representatives filed further submissions on 5 August 2015 **[WITN7690018]**. Irwin Mitchell had taken over as solicitors instructed for the family. They maintained the position that there remained systemic issues requiring investigation and argued that it was hard to see how these could be addressed by an 'ordinary inquest' rather than a public inquiry or at least an inquiry similar in scale to the Hillsborough inquests. They argued that the Penrose Inquiry had not answered some relevant issues, and that in relation to others, issues had not been addressed for England & Wales. The Coroner's Office sent the submissions to Eleanor Goodfield by email on 11 August 2015 **[WITN7690019]**.

2.15. On 25 September 2015, GLD wrote to the Coroner asking for an extension to file submissions until 9 October 2015 **[WITN7690020]**. On 28 September 2015 the Coroner wrote to GLD granting the requested extension **[WITN7690021]**.

2.16. On 9 October 2015, GLD filed submissions in response to those of the family; the submissions were settled by Neil Sheldon (now KC but then a senior junior) and Dominic Ruck Keene of counsel **[WITN7690022 and WITN7690023]**. The submissions continued to accept that the circumstances of Mr GRO-B death gave rise to wider, systemic issues concerning the provision of blood products to haemophiliacs which were likely to require investigation in the course of the inquest. However, it was argued that the relevant question was whether there were systemic issues of potentially causative relevance to Mr GRO-B death which had not been substantially investigated by, in particular, the Penrose Inquiry, and which, if further investigated, could lead to further useful information being obtained and/or useful lessons learned. It was submitted that that the wider systemic issues material to Mr GRO-B death had been fully addressed by the Penrose Inquiry; the submission set out the key areas raised and how the Penrose Inquiry had addressed them. It was accepted that the inquest may well need to consider the question of whether the advice that Mr GRO-B and his family were given by the treating clinicians was in accordance with current medical knowledge, and whether there were alternative treatments available that could have been offered. In the alternative, it was submitted that if the Coroner identified that some further investigation of the wider systemic issues concerning the provision of contaminated products to haemophiliacs such as Mr GRO-B was required, that could be addressed in the inquest, and it did not follow that a statutory inquiry was required.

2.17. A copy of the submissions was sent to Central England Law Centre, the new legal representatives for Mr GRO-B family **[WITN7690024]**.

2.18. On 10 November 2015 Central England Law (the family's solicitor, Ms Ashton, had moved firms) wrote to the Coroner requesting that the PIR be reconvened so as to enable a decision to be taken about the nature and scope of the inquest, and for the family to be able to respond to the Department's submissions **[WITN7690025]**. On 17 November 2015 Eleanor Goodfield wrote

to the Coroner requesting that if the PIR were to be reconvened then counsel's availability be taken into account **[WITN7690026]**.

2.19. On 18 December 2015, counsel for Mr GRO-B family settled submissions in reply to those of the Department **[WITN7690027]**. On 21 December 2015 Central England Law Centre wrote to GLD enclosing the submissions in reply as served on the Coroner that day **[WITN7690028]**.

2.20. On 1 April 2016 Central England Law Centre wrote to the Coroner to ask for an agenda for the PIR which had been listed for 12 April 2016 and pressing for determination of the issue of whether Article 2 was engaged, and whether the Penrose Inquiry had addressed the wider systemic issues. The letter also suggested Basingstoke Haemophilia Unit, Basingstoke Hospital as a possible location of Mr GRO-B Treloar College medical records **[WITN7690029]**.

2.21. At the PIR on 12 April 2016[3] the Coroner issued a written decision dated 11 April 2016 **[WITN7690030].** The Coroner's decision was that:

(1) He did not have the power to conduct a Penrose-like inquiry.

(2) He considered that the Penrose inquiry had substantially inquired into the systemic issues that arose, with most of the inquiry's conclusions being applicable to England and Wales as well as Scotland.

(3) The enhanced investigative obligation under Article 2 was engaged.

(4) The Penrose inquiry had substantially discharged the Article 2 investigative obligation.

(5) He would accept the Penrose inquiry report as evidence of the wider issues.

(6) He would explore the circumstances of Mr GRO-B death by calling the clinicians involved at the time.

[3] Again, GLD does not hold a copy of a recording of this PIR hearing or a transcript of it.

2.22. In addition to this decision, at the PIR the Coroner requested the attendance of a witness from the Department of Health to address and update the issues covered in Ben Cole's statements. By this stage Ben Cole had left the team and the Department agreed to ensure that another suitable witness was provided. At the PIR, the Coroner also noted that he was still trying to obtain Mr GRO-B medical records from the Lord Mayor Treloar College, the Royal London and Royal Portsmouth Hospital, and would keep the Interested Persons updated. The Treloar records had so far not been located, and the Coroner raised the prospect of summonsing the Chief Executive if necessary.

2.23. On 23 June 2016, the Coroner listed the resumed inquest for 22 February – 28 February 2017.

2.24. Having had some issues obtaining the medical records, on 5 July 2016 the Coroner emailed GLD and Mr GRO-B family's legal representatives with a chronology and an index of the notes and medical records **[WITN7690031].** He stated that there were 7 volumes of notes and records and he would arrange for these to be copied and forwarded.

2.25. On 7 July 2016 Central England Law Centre emailed the Coroner and GLD **[WITN7690032]**. Karen Ashton wrote that Mr GRO-B family were no longer legally represented because of financial constraints, and asked that the family be communicated with directly.

2.26. Kypros Menicou of the blood policy team at the Department was selected as an appropriate witness to give evidence instead of Ben Cole. Mr Menicou provided an updating witness statement dated 29 July 2016 **[WITN7690033].**

2.27. A letter was sent to the Coroner on 18 August 2016 supplying Mr Menicou's witness statement in duplicate, the second copy being one to be sent on to Mr

GRO-B family **[WITN7690034]**. The Coroner was asked to consider whether live evidence from Mr Menicou was required in light of his earlier ruling.

2.28. On the same day, Eleanor Goodfield emailed Kypros Menicou to confirm that GLD had received from the Coroner a copy of Mr GRO-B medical records (amounting to a box of records) **[WITN7690035]**.

2.29. In an email dated 30 August 2016 the Coroner requested that Counsel for the Department produced a schedule of the findings of the Penrose Inquiry as relevant to Mr GRO-B **[WITN7690036].**

2.30. On 12 December 2016 GLD sent an email to the Coroner **[WITN7690037],** attached was a report summary **[WITN7690038]** and two schedules **[WITN7690039 and WITN7690040]**[4]. These were also sent to Mr GRO-B family on 12 December 2016 **[WITN7690041]**.

2.31. On 7 February 2017, GLD wrote to the Coroner raising the question of the attendance of Mr Menicou and whether this was necessary; and also seeking sight of the report of Dr Colvin, and requesting a witness list, running order and hearing bundle index **[WITN7690042]**. By now, GLD had been provided with the address for Mr GRO-B family and a copy of this letter was forwarded to them. See further example **[WITN7690043]**.

2.32. The inquest had originally been notified to resume on 22 February, this seems to have been pushed back a day by the Coroner / Coroner's Office and the inquest in fact resumed on 23 February 2017. The inquest took place over two days concluding on 24 February 2017. Instructions on the inquest were

[4] As explained in the covering letter, the documents provided comprised "*1. A full schedule addressing the issues in the order in which they appear in the original [Penrose] report; 2. A schedule containing the same information, but organised thematically by issue; 3. A summary containing the key conclusions.*"

transferred from Neil Sheldon to Oliver Sanders KC[5] because the inquest was listed for dates when Mr Sheldon was not available. Accordingly, Mr Sanders represented the Department at the Inquest.

2.33. As with the PIRs, GLD does not hold a copy of the recording of the inquest or a transcript of it, but Mr Sanders' notes of the hearing are at **[WITN7690044]**. Statements from a number of clinicians were read (Drs Ojoo, GRO-B Nasimudeen and Hardwick). Mr Menicou gave oral evidence. The family gave oral evidence. Dr Colvin gave oral evidence on the second day of the hearing. The Coroner then announced his findings before giving a narrative conclusion. The Coroner was not uncritical. Counsel's notes included that the Coroner's findings / summing in the context of the Penrose Inquiry report included that there was, "…*a material failure to anticipate demand & become self-sufficient"*.

2.34. The Record of Inquest and narrative conclusion dated 24 February 2017 were included at the end of W5244's witness statement so I need not further exhibit these (see: **WITN5244001** at pg 23*ff*). The medical cause of death was given as:

"Ia Multi Organ Failure
b Pneumocystis jiroveci (PCP) pneumonia
c HIV positive
II Haemophilia
Hepatitis C"

The narrative conclusion was as follows:

> *"The deceased died* GRO-B *2012 at Northampton General Hospital. He was diagnosed with haemophilia as a child that contributed to his death. He also died as a result of HIV and hepatitis C infection that he contracted after receiving contaminated blood products given for the treatment of his haemophilia. In particular the HIV infection resulted from the administration of imported blood products from the United States of America administered between June 1981 and April 1982. At the time that the blood products were given to him the risks of infection were not*

[5] At the time of his instruction, Oliver Sanders was a member of the AG's A Panel of civil counsel, but had in fact taken Silk by the time of the substantive inquest hearing.

known and the benefit of such products far outweighed the risks of infection.

The circumstances of the use and contamination of the blood products were dealt with fully in the Penrose Report following a public inquiry under the Inquiries Act 2005 published in March 2015."

3. Response to the issues raised by W5244

3.1. Having set out the chronology of the main procedural events, I turn to address the issues raised in relation to the Department by W5244.

3(I) Requests for documents from Mr GRO-B family

3.2. From the records of Mr GRO-B inquest that are available, I have not been able to identify any occasions on which the Department, directly or through GLD as its legal representatives, asked Mr GRO-B family to obtain documents which were for the Department itself to obtain.

3.3. It is apparent from the case records that the Coroner had some difficulties in obtaining Mr GRO-B full medical records, an issue with which I am aware the inquiry is very familiar. Mr GRO-B family may understandably have considered that Mr GRO-B medical records were within the power of the Department to obtain, whereas the individual health providers are responsible for the provision of relevant records to Coroners. The case records suggest that the Coroner pursued this matter in the conventional way, with the Coroner himself seeking to obtain those records from the relevant health providers. GLD was supplied with a copy of the medical records by the Coroner, see paragraph 2.27. Similarly, it was the Coroner who sought and obtained a report from Dr Colvin as well as statements from other clinicians.

3.4. As would be expected, for the period when Mr GRO-B family were legally represented, the Department and GLD corresponded via their legal

representatives. Once Mr GRO-B family were acting in person, as set out in the chronology above, GLD initially did not have contact details for his family and so provided an extra copy of Mr Menicou's statement. By February 2017, GLD did have an address for Mr GRO-B family and so forwarded them a copy of the letter sent to the Coroner on 7 February 2017.

3.5. None of this correspondence suggests that GLD / the Department were requesting Mr GRO-B family to obtain documents; it is therefore difficult for me to comment further on the experiences that lie behind the family's criticisms in this regard.

3(II) The family's view that the Coroner was not independent and had conversations with the Department to which the family were not party.

3.6. GLD does not act for the Coroner and neither the Department nor GLD seek to address the criticisms made of the Coroners involved or the Coroner's Service in either Coroner Area. However, GLD is not aware of any basis to impugn the independence of the Coroners' conduct.

3.7. From the case records for Mr GRO-B inquest, the Department and (once instructed) GLD corresponded with the Coroner's Office in an entirely conventional way. The Department's position on the substantive and procedural legal issues, in particular the scope of the inquest and how to address the wider systemic issues, were made either:

(1) in writing:

- The Department's written submissions were made available to Mr GRO-B family;

- Relevant correspondence tended to be either circulated by the Coroner or forwarded by the interested persons to each other / their legal representatives[6].

(2) orally in open Court at the PIRs.

3.8. There is nothing in the case records to suggest that GLD entered into any kind of inappropriate private communications with the Coroner. Both counsel engaged in the case have confirmed that they are not aware of any such communication taking place, nor did they did engage in any such communication.

3(III) The family's view that the Coroner worked together with the Department to provide a narrative on Mr GRO-B Record of Inquest

3.9. Through GLD and Counsel, the Department had argued that the wider systemic issues had been addressed by the Penrose Inquiry, and the Coroner adduced that Report in evidence.

3.10. As with the issues raised under 3(II) above,

- The evidence presented by the Department was exchanged in advance in writing by the Coroner and, in the case of Mr Menicou's oral evidence, given in open Court.
- The Department's legal arguments were made in writing as exchanged with Mr GRO-B family prior to the resumed Inquest, or in open Court. As is conventional, the Coroner gave both the family and the Department the opportunity to make brief legal representations at the end of the evidence.

[6] See for example the representations made in writing to the Coroner on 7 February 2017, a copy of which was forwarded to Mr GRO-B family on the same date.

3.11. The Coroner made his own assessment of the evidence and the legal arguments and having taken time on the second day of the hearing, gave a summing up / findings in open court, together with his conclusions on the Record of Inquest. As I have indicated, the Coroner's summing up / findings announced in Court were not uncritical. In the narrative conclusion, the Coroner addressed the wider issues by reference to the findings of the Penrose Inquiry.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 18 July 2023

Exhibit table to Second witness statement of Andrea Beveney

	Exhibit #	Date	Description
1.	WITN7690003	25 March 2014	Initial letter from Coroner to DH enclosing GRO-B family submissions
2.	WITN7690004	16 June 2014	DH factual submissions to the Coroner
3.	WITN7690005	25 June 2014	Letter from Coroner to DH asking for submissions
4.	WITN7690006	31 July 2014	Submissions from DH in reply to GRO-B family submissions
5.	WITN7690007	13 August 2014	Letter from Eleanor Goodfield to Coroner asking if DH can be represented at the PIR
6.	WITN7690008	29 August 2014	Letter from Eleanor Goodfield to GRO-B family solicitors confirming instruction by DH and enclosing submissions
7.	WITN7690009	27 August 2014	Letter from the Coroner to the Interested Persons.
8.	WITN7690010	08 September 2014	Further submissions on behalf of Mr GRO-B family
9.	WITN7690011	12 September 2014	Pre-Inquest Report
10.	WITN7690012	28 November 2014	Two statements of Ben Cole plus exhibits
11.	WITN7690013	19 January 2015	Letter from Eleanor Goodfield to Coroner regarding Penrose Report publication date
12.	WITN7690014	20 February 2015	Letter from Eleanor Goodfield to the Coroner regarding time to consider the Penrose Report
13.	WITN7690015	20 February 2015	Letter sending the above to Public Law Solicitors
14.	WITN7690016	19 June 2015	Letter from Public Law Solicitors to GLD regarding an extension of time to file submissions

15.	WITN7690017	23 June 2015	Letter from Eleanor Goodfield to the Coroner confirming no objection to an extension of time
16.	WITN7690018	5 August 2015	Further submissions on behalf of GRO-B family
17.	WITN7690019	11 August 2015	Email from Coroner's Office to Eleanor Goodfield enclosing submissions
18.	WITN7690020	25 September 2015	Letter from Eleanor Goodfield to the Coroner asking for an extension of time to file submissions
19.	WITN7690021	28 September 2015	Letter from the Coroner agreeing an extension of time until 9 October 2015
20.	WITN7690022	9 October 2015	Submissions on behalf of DH
21.	WITN7690023	9 October 2015	Appendix to submissions on behalf of DH
22.	WITN7690024	9 October 2015	Letter from GLD to Central England Law Limited enclosing DH submissions
23.	WITN7690025	10 November 2015	Letter from Central England Law Limited to the Coroner asking for the PIR to be reconvened
24.	WITN7690026	17 November 2015	Letter from Eleanor Goodfield to the Coroner asking for counsel's availability to be taken into account if PIR reconvened
25.	WITN7690027	18 December 2015	Submissions on behalf of GRO-B family
26.	WITN7690028	21 December 2015	Letter from Central England Law Centre to GLD enclosing Mr GRO-B family submissions
27.	WITN7690029	01 April 2016	Letter from Central England Law Centre to the Coroner regarding PIR and medical records
28.	WITN7690030	11 April 2016	Decision on scope document
29.	WITN7690031	5 July 2016	Email from Coroner to Eleanor Goodfield with index and chronology of Mr GRO-B medical records

30.	WITN7690032	7 July 2016	Email from Central England Law Centre to GLD and Coroner confirming GRO-B family no longer legally represented
31.	WITN7690033	29 July 2016	Witness statement of Kypros Menicou and exhibit
32.	WITN7690034	18 August 2016	Letter to Coroner enclosing witness statement
33.	WITN7690035	18 August 2016	Email from Eleanor Goodfield to Kypros Menicou confirming receipt of a box of Mr GRO-B medical records
34.	WITN7690036	30 August 2016	Email from Coroner requesting DH produce a summary of the Penrose findings
35.	WITN7690037	12 December 2016	Email to Coroner with Penrose summary
36.	WITN7690038	12 December 2016	Penrose Report summary
37.	WITN7690039	12 December 2016	Penrose Report schedule
38.	WITN7690040	12 December 2016	Penrose Report schedule
39.	WITN7690041	12 December 2016	Letter to GRO-B family enclosing Penrose documents
40.	WITN7690042	7 February 2017	Letter from Eleanor Goodfield to the Coroner
41.	WITN7690043	7 February 2017	Letter to Mr and Mrs GRO-B enclosing copy of letter to Coroner
42.	WITN7690044	23 February 2023	Handwritten notes of Oliver Sanders from the Inquest