

Monday, 6 December 2021

(10.00 am)

SIR BRIAN LANGSTAFF: Good morning, Dr Entwistle, can you hear me?

THE WITNESS: Good morning, Sir Brian. Yes, I can.

SIR BRIAN LANGSTAFF: Good. Obviously you can see me?

THE WITNESS: Yes.

SIR BRIAN LANGSTAFF: Good. You are at home, are you?

THE WITNESS: I am indeed, yes.

SIR BRIAN LANGSTAFF: I think it is just your wife who is there in the house with you or ...

THE WITNESS: No. In the house, yes, but I have -- next to me I have my step-daughter, Dr Sara Kundu.

SIR BRIAN LANGSTAFF: Thank you. In a moment or two after you have been sworn you will be asked questions by Ms Scott. You are talking to an audience here, a select audience, which is quite small but there is a much larger audience, well over 100 probably, who will be listening to you online. So bear that in mind, that's who you are talking to, people who want to hear what you have to say.

But first I'm going to ask Oliver to ask you to take the oath. Oliver.

DR COLIN CARRUTHERS ENTWISTLE (sworn)

Questions from MS SCOTT

1

SIR BRIAN LANGSTAFF: Ms Scott.

MS SCOTT: Dr Entwistle, can you see and hear me?

A. Yes, I can indeed. Thank you.

Q. I'm going to start with a brief overview of your career. So, you qualified in 1958, is that right?

A. Yes, indeed.

Q. You then had various junior doctor roles in Bristol, moving into pathology in 1959?

A. Correct.

Q. By 1963, you had been appointed a lecturer in pathology at the Welsh National School of Medicine, which was a post you held until 1968.

A. Yes.

Q. That post was part time teaching, was it, and part time clinical work?

A. It was mostly laboratory and with some clinical involvement, yes.

Q. Your witness statement tells us that during that period you were -- you ran the routine 24-hour blood transfusion service for the Welsh National School of Medicine?

A. Yes, I did.

Q. Can you tell us what that entailed?

A. The School of Medicine was based at what was then the Cardiff Royal Infirmary. My role was, in fact,

2

looking after the blood bank of the Royal Infirmary, although I had a dual role, in that it was also part of the Welsh National School of Medicine.

Q. Then in 1968 you were appointed consultant haematologist and deputy director of the Cambridge Regional Transfusion Centre?

A. That is right, yes.

Q. I will come and ask you some more detailed questions about that in due course. Then between 1974 and 1980 you were the deputy director of the National Tissue Typing and Research Laboratory in Bristol?

A. Yes.

Q. Then in May 1980 until September 1995 when you retired, you were the director of the Oxford Blood Transfusion Centre?

A. Yes, indeed.

Q. I'm just going to run through with you some of the committees and working groups and some of the meetings, and so on, that you attended during your career. So from 1980, when you were appointed the director of Oxford, you were a regular attender of regional -- the Regional Transfusion Director meetings, is that right?

A. Yes.

Q. Again, as the director of the Oxford Regional

3

Transfusion Centre you also attended the regional meetings of the Western division?

A. Yes.

Q. In March 1981, you were elected to serve on the care and selection of donors working party by the Western division of the Regional Transfusion Centres, is that correct?

A. Yes.

Q. In March 1990 you were elected again by the Western division to be the representative on the -- to be their representative on the committee considering the retention of records?

A. Yes.

Q. Then you were elected the chair of the Western division of the regional meetings in July 1991?

A. Yes.

Q. You also sat on the National Blood Transfusion Service and the CBLA liaison committee from 1991 to 1994?

A. Yes, I did.

Q. You were also part of the National Directorate's National Management Committee between 1991 and 1992?

A. Yes.

Q. Then you became a member of the NBA, the National Blood Authority's, executive from its first meeting in October 1993 until around July 1994, is that correct?

4

- 1 A. Yes.
- 2 Q. We also have a record of you attending a handful of
3 liaison committee meetings between the Regional
4 Transfusion Centres and BPL in 1993, which was
5 a committee which was badged as an NBA committee, is
6 that right?
- 7 A. Yes.
- 8 Q. Your CV also tells us that you were a member of the
9 British Society for Immunology, the British Society
10 for Histocompatibility and Immunology (*sic*) and
11 a founder member of the British Blood Transfusion
12 Society?
- 13 A. That is correct.
- 14 Q. Turning then to your time in Cambridge as deputy
15 director between 1968 and 1974, when you arrived
16 there, was Dr Darnborough the director --
- 17 A. Yes.
- 18 Q. -- or did he arrive just after you arrived?
- 19 A. No, he had been made director of the Cambridge centre
20 two years before I was appointed and in fact because
21 of that he had not had a holiday and I was dropped in
22 it, in my first week in Cambridge, because
23 Dr Darnborough took a holiday and left me there to
24 look after things.
- 25 Q. So do we understand from that that the Deputy Director

5

- 1 was a new post?
- 2 A. Yes, it was.
- 3 Q. Your witness statement tells us that you were
4 primarily responsible for donors and running donor
5 sessions. Is that right?
- 6 A. Yes.
- 7 Q. If we just look at your witness statement, Paul,
8 please, it is WITN6917001.
- 9 If we go, please, to page 4, we can see what you
10 say there in paragraph 8, about a third of the way
11 down that paragraph:
- 12 "My main role concerned practical organisation
13 of blood donor sessions, including the training of
14 session directors (including conducting many donor
15 sessions myself), helping the Head Nurse with
16 recruiting and training of donor attendants, dealing
17 with donors who had medical problems (mostly actual or
18 suspected anaemia), and responding as well as possible
19 to any complaints received."
- 20 Then you say:
- 21 "I also took part in on-call rotas dealing with
22 management of out-of-hours provision of blood and
23 blood products to hospitals in the East Anglian
24 hospitals."
- 25 A. That is correct.

6

- 1 Q. In relation to your work on on-call rotas, can you
2 tell us a little bit about what that involved?
- 3 A. At that stage, the arrangement was that there would be
4 a night porter on duty for out-of-hours services and
5 he would call whoever was the doctor on call for out
6 of hours consultation and that meant most of the time
7 I did not have to go into the centre but at least
8 authorise the provision of what was needed or what had
9 been requested, provided we had it, which we nearly
10 always did, and authorise, if necessary, the emergency
11 transmission using a blue light.
- 12 Q. So, this was requests from hospital blood banks for
13 products or components that the transfusion centre
14 held?
- 15 A. Yes.
- 16 Q. Is it -- at that stage, did the transfusion centre
17 have regular deliveries to the hospitals that it
18 served?
- 19 A. Oh yes, we did.
- 20 Q. So this was on top of, if they'd run out of something
21 or they needed something special?
- 22 A. If they had run out of -- something special perhaps
23 was required which was not held in stock in the
24 hospital.
- 25 Q. If we then look at a document DHSC0101582.

7

- 1 This is a Department of Health document, and it
2 is actually page 7 that is of interest. It is
3 a chart -- table rather, entitled "Hospital blood bank
4 serviced by Regional Blood Transfusion Centres in
5 England and Wales". And if we go down the left-hand
6 column to East Anglia, we can see there it says:
- 7 "No. of NHS blood banks serviced: 12
8 "No. of private hospitals serviced direct: 0"
9 Then it has a star next to that saying "plus 2
10 Armed services hospitals".
- 11 Now this document is dated May 1982 but does
12 that accord with your recollection of the number of
13 blood banks that the Cambridge RTC was servicing
14 during your time?
- 15 A. Would you excuse me a moment, while I do some mental
16 calculations.
- 17 (Pause)
- 18 Yes, that seems a fair approximation, I think.
- 19 Q. Can you describe for us what the facilities were like
20 at the Cambridge Regional Transfusion Centre during
21 the time that you were there, what the Centre itself
22 was actually like and the laboratory services and so
23 on.
- 24 A. The building itself was relatively new because the
25 Addenbrooke's -- the new Addenbrooke's Hospital had

8

1 only been opened a couple of years beforehand, and the
2 transfusion centre was within the grounds of the new
3 Addenbrooke's.

4 It was a two-storey building with laboratories
5 on the upstairs section and also the director's room
6 and my own room and secretary's room, and there was
7 also a small lecture theater.

8 Downstairs there were further laboratories
9 concerned with the processing of blood components and
10 also storage facilities for the mobile blood teams.

11 **Q.** What use was put to the lecture theater by the
12 transfusion centre?

13 **A.** It was used, when needed, for training purposes
14 mainly.

15 **Q.** And training of internal staff or was there training
16 of --

17 **A.** Yes, training of internal staff. Yes.

18 **Q.** Was any training undertaken of haematologists or other
19 clinicians in transfusion medicine at that stage?

20 From -- by --

21 **A.** No, not that I can recall.

22 **Q.** Turning then to the donor sessions themselves. Again,
23 probably best way to take this is to look back at your
24 witness statement, WITN6917001.

25 And if we could turn, please, to page 6 at

9

1 paragraph 9. You say this:

2 "Blood collections by EARTC ..."

3 And EARTC is East Anglian Regional Transfusion
4 Centre, is it? Was that the proper name for Cambridge
5 Regional Transfusion Centre?

6 **A.** Well, originally it was the Blood Transfusion
7 Immunohaematology Centre. That was the title it had
8 been given.

9 **Q.** "Blood collection by EARTC were organised on the basis
10 of collection teams. Each team comprised a Team
11 Leader and up to eight Donor attendants, a clerk from
12 the Donor Registry department and two drivers.
13 A doctor attended [the] session independently."

14 Pausing there, you say in your witness statement
15 that that doctor was sometimes you; is that correct?

16 **A.** Correct, yes.

17 **Q.** And:

18 "The teams went out from Mondays to Fridays.

19 Teams would travel to prearranged venues throughout
20 the region where the RTC Donor Organiser had recruited
21 volunteer local donor organisers and had secured
22 suitable premises and publicity. Teams under the
23 control of a senior (more experienced) donor attendant
24 set up usually eight beds for actual blood collection
25 and a comparable number of couches for donors to rest

10

1 after donation. The clerk was responsible for
2 implementing questioning of incoming donors and one of
3 the drivers undertook the donors' simple copper
4 sulphate-based finger-prick blood tests for possible
5 anaemia. The doctor performed all venepunctures and
6 managed any medical problems (such as donors fainting,
7 etc). As part of this pattern, donor sessions were
8 usually held in a Cambridge venue on Monday mornings
9 to provide fresh blood to be sent to the Papworth
10 hospital for heart operations."

11 Is it right to understand from that that there
12 were no donor sessions in the transfusion centre
13 itself? They were all out in the community?

14 **A.** As a routine, that is correct. Very occasionally,
15 over long bank holidays, we did have the facilities
16 with a few beds which could -- we could call donors in
17 especially to come into the centre. But that was not
18 a routine procedure.

19 **Q.** Was that usually as a response to low stock?

20 **A.** No. As I said, particularly for long bank holidays,
21 where we anticipated there would be difficulties in
22 having fresh products over several days without
23 routine collections coming in.

24 **Q.** And is it also right to understand that during your
25 time at the East Anglia or Cambridge Transfusion

11

1 Centre there was no plasmapheresis programme?

2 **A.** No, not at that stage, not as I recall.

3 **Q.** Do you recall whether or not there were any sessions
4 in which military donors were bled? So we saw in that
5 chart that there was -- you were providing components
6 and blood to military hospitals. Were there any
7 specific military donor sessions held?

8 **A.** There were, yes. We visited two military
9 establishments. And in fact I personally attended one
10 of those sessions, which proved incredibly beneficial
11 to the Service.

12 **Q.** And were those sessions undertaken, do you recall,
13 throughout your time at -- in Cambridge?

14 **A.** As far as I can recall, yes.

15 **Q.** And did you hold any sessions in prisons?

16 **A.** No, none at all.

17 **Q.** And did you or any of your colleagues at the blood
18 transfusion centre give any consideration to whether
19 or not the military donors may pose a higher risk of
20 transfusion-transmitted infections than the general
21 donor population? Was that part of the thinking at
22 that stage?

23 **A.** At that particular time, as far as I can recall, they
24 were not perceived to impose particular extra risks,
25 whatever people might have thought subsequently.

12

1 **Q.** Just one last issue to ask you about in relation to
 2 your time in Cambridge, and that's in relation to
 3 hepatitis B. You tell us in your statement that while
 4 you were there you devised a detection method for
 5 hepatitis B antigen which you used personally on
 6 donations six months prior to it being adopted for all
 7 incoming donations at the Cambridge Centre.
 8 I'm just going to ask you a handful of questions
 9 in relation to that. Can you recall whenabouts it was
 10 that you developed the detection method for
 11 hepatitis B antigen?
 12 **A.** I can't remember the exact date but I was -- first of
 13 all, I was aware that there was a phenomenon which was
 14 described then as the Australian antigen, and that was
 15 what subsequently was known as the hepatitis B
 16 antigen.
 17 And I got in touch with a Japanese gentleman who
 18 had made the possibility of providing me with some of
 19 this -- the antibody to that antigen.
 20 Now, I won't go into the details how we got
 21 round to getting in touch with this Japanese
 22 gentleman, but he did actually let me have some serum,
 23 which I collected from him when he came into
 24 Heathrow Airport, and I used that to try to see
 25 whether I could identify any donors who may have

13

1 carried the actual virus antigen itself. And for
 2 quite a long time in my earlier struggles with this,
 3 no, there was nothing. And then, sure enough,
 4 inevitably, I did find a serum which did react with
 5 this Japanese antibody, and that was my first
 6 experience of finding the hepatitis B antigen in
 7 a donor.
 8 **Q.** So is it right to understand from what you have just
 9 said that this was at a time before there was
 10 screening for hepatitis B within the centre?
 11 **A.** Yes -- oh, yes, this was long before there was any
 12 screening anywhere in this country.
 13 **Q.** And what kind of test was it that you were using?
 14 **A.** I used to prepare petri dishes and there would be rows
 15 of holes made in agar sitting in the petri dish. In
 16 one row of holes would be the antibody from the
 17 Japanese gentleman, and in the centre hole of the
 18 three would be the donor plasma. There was also
 19 a third row which I won't go into. But if there was
 20 a positive reaction, there would be a little line
 21 developing between the donor plasma and the Japanese
 22 plasma when an electric current had been applied
 23 across the gel -- I hope this isn't too complicated --
 24 but it would take about 20 to 30 minutes for the
 25 electric current to do what it required to do. And

14

1 because of the different electrical properties of the
 2 virus itself and of the antibody, the two would be
 3 encouraged to join and that would produce a line in
 4 the agar gel and that would indicate a positive
 5 reaction.
 6 **Q.** And we have heard evidence about different kinds of
 7 tests over different periods of time, ELISA tests, RIA
 8 tests, PCR tests and so on. Would the test that you
 9 are describing be described as one of those kinds of
 10 tests or is it a different kind of test?
 11 **A.** It was different to the others. It was electro --
 12 I can't remember the title now.
 13 **SIR BRIAN LANGSTAFF:** Electrophoresis --
 14 **A.** Electrophoresis was the procedure used, as opposed to
 15 by radioimmunoassay or ELISA test.
 16 **SIR BRIAN LANGSTAFF:** Just so that I understand, the
 17 acronym for that is IEOP? Am I right?
 18 **A.** Yes, that is correct.
 19 **SIR BRIAN LANGSTAFF:** Thank you.
 20 **MS SCOTT:** And how did that test compare to the later
 21 tests that were rolled out throughout -- as we
 22 understand it -- the regional transfusion centres for
 23 hepatitis B in terms of specificity and sensitivity?
 24 **A.** In terms of specificity it was totally accurate.
 25 In terms of sensitivity I cannot tell you because

15

1 I did not do a comparative study. All I do know is
 2 that I had developed a test which did indeed pick up
 3 some positives. Whether it would pick up all, I do
 4 not know. But at least it would pick up some.
 5 **Q.** And did -- you say in your witness statement that you
 6 personally were using it for about six months before
 7 it was used on all donations within the centre. Why
 8 was that? Were you testing it for yourself during
 9 those six months -- that six-month period?
 10 **A.** Yes, I was doing it out of -- purely as a personal
 11 research project.
 12 **Q.** If you picked up a donation that was positive at that
 13 stage, what steps would you take?
 14 **A.** The immediate thing would be to remove that donation
 15 from any possibility of it being issued. And
 16 obviously I could have considered sending it away for
 17 further tests if further tests were available but of
 18 course initially they were not. So all I could do, at
 19 that stage, was to remove it from circulation and make
 20 sure that nobody got it.
 21 **Q.** And was anything said to the donor?
 22 **A.** We had no choice but to say, "Yes, we have a problem
 23 here, it appears that you may have picked up
 24 an infection", and we had to undertake initial
 25 counselling at that stage and refer them on to,

16

1 firstly, their general practitioner, and he or she in
2 turn would consider the necessity of referring further
3 to a specialist.

4 **Q.** That was the case, was it, even though there were no
5 confirmatory tests?

6 **A.** Correct.

7 **Q.** So, even in those early days, those were the steps
8 that were taken?

9 **A.** All we could say was that this person appeared to have
10 a problem which -- for which there was no treatment at
11 that stage, anyway, and we had no way of doing
12 anything further.

13 **Q.** Did you take any steps yourself to share the work that
14 you had done, the research that you had done, and your
15 findings and the test with other centres?

16 **A.** Not initially no, I didn't.

17 **Q.** You, of course, weren't a director at that stage, so
18 you weren't attending the Regional Transfusion
19 Director meetings but do you know whether
20 Dr Darnborough informed his colleagues, and so on,
21 that this work was being done in the Cambridge centre?

22 **A.** I don't think he would do it in the early months when
23 I was doing this purely for myself. Whether he did
24 afterwards, I think he probably must have done because
25 after I had been doing this work for a few months, he

17

1 arranged for that same procedure to be extended to
2 become a routine procedure, and it would have been
3 more than sensible to alert his colleagues in other
4 centres.

5 **Q.** So you say it would be more than sensible. Do you
6 know whether he did alert his colleagues?

7 **A.** I do not know.

8 **Q.** So you don't know whether or not it was adopted by
9 other centres?

10 **A.** I do not, no.

11 **Q.** If it had been adopted by other centres, do you think
12 you would know?

13 **A.** Very possibly but, on the other hand, I was also aware
14 that other tests were being developed and came into
15 more routine use in other centres. I'm not sure
16 whether any other centre, actually, adopted the
17 technique that I had used.

18 **Q.** Was your test then replaced by a different test in the
19 around about 1972 or was your test used, as far as you
20 recall, for the whole period that you were -- well up
21 until you left the Cambridge centre?

22 **A.** Yes, as far as I can recall, that was the only test
23 being used for hepatitis B.

24 **Q.** Until you left in 1974?

25 **A.** Yes.

18

1 **SIR BRIAN LANGSTAFF:** Could you help me with this, there
2 was something which I have picked up, the acronym
3 CIEOP, counter-immunoelectro-osmophoresis. Can you
4 explain that to me and how that works in comparison
5 with ICOP -- IEOP?

6 **A.** Yes, I did refer very briefly to a third row of holes
7 in the agar gel and the idea of that was that in the
8 middle row would be the donor serum, the plasma, in
9 one row would be the Japanese antibody serum, and in
10 the third row, ultimately, when we had a positive,
11 known sample, that could be put into the third row.
12 The reason being then that when you apply the electric
13 current, if there was a positive antibody at all in
14 the donor plasma, that would react with the antigen in
15 the third row, which, if you like, is going in the
16 opposite direction to the little precipitation line
17 that I referred to first of all. So, in that sense,
18 hence, counterelectrophoresis.

19 **SIR BRIAN LANGSTAFF:** Thank you very much.

20 **MS SCOTT:** I'm going to move on now to ask you some
21 questions about your time in Oxford. So you, as we
22 know, became the director of the Oxford Blood
23 Transfusion Centre in May 1980. You took over from
24 Dr Gunson, is that right?

25 **A.** Correct.

19

1 **Q.** You tell us in your witness statement that when you
2 arrived you had a staff of about 120 --

3 **A.** As far as I can recall, that is correct.

4 **Q.** -- and that you were accountable to the Oxford
5 Regional Health Authority, is that right?

6 **A.** Correct.

7 **Q.** That remained the case throughout your tenure at
8 Oxford?

9 **A.** No. Once the National Blood Authority was formed,
10 they took over -- I was responsible to them, rather
11 than to the Regional Health Authority.

12 **Q.** That was right at the end of your time there, wasn't
13 it --

14 **A.** Yes.

15 **Q.** -- 1993?

16 **A.** Correct.

17 **Q.** Just to get an idea --

18 **SIR BRIAN LANGSTAFF:** I thought it was 1995 you said
19 earlier, retirement?

20 **MS SCOTT:** Yes, retirement 1995. Sorry.

21 **SIR BRIAN LANGSTAFF:** You mean 1993 for the
22 accountability?

23 **MS SCOTT:** Exactly.

24 **SIR BRIAN LANGSTAFF:** When the NBA began?

25 **MS SCOTT:** Exactly.

20

1 Can we look please at NHBT0006265. This is to
 2 get a snapshot of the work being done by Oxford
 3 Regional Transfusion Centre. If we look at the bottom
 4 of that page, we can see it is a document dated
 5 10 May 1990. If we look at the top of that page we
 6 can see that it is a Department of Health Medicines
 7 Inspector's summary of the Oxford Regional Blood
 8 Transfusion Centre.

9 If we look, then, over the page at page 3,
 10 please, under "Introduction":

11 "Oxford [Regional Transfusion Centre], opened in
 12 1979, is connected to the John Radcliffe Hospital."

13 Just pausing there. Is it right to understand
 14 that, in fact, what happened in 1979 is that the
 15 transfusion centre moved to new premises in John
 16 Radcliffe Hospital? It had existed before but in the
 17 Churchill Hospital?

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

19 **Q.** Then it goes on:

20 "Although the Centre has its own self-contained
 21 area on a single floor, there are security problems
 22 arising from access to the main hospital on one side
 23 and to the engineering/plant rooms to the other.

24 "The RTC serves a population of 2.69 million,
 25 collected around 114,000 donations in 1989 and

1 employees 202 staff."

2 Again, just pausing there on the 202 staff, does
 3 it sound from -- is it right that there was
 4 a significant increase in staff during your time
 5 there?

6 **A.** No. I said earlier I thought it was about 120, I may
 7 be completely wrong. I honestly can't remember.

8 **Q.** It is likely that your estimate in your witness
 9 statement was a bit too low but the staffing remained
 10 about the same during your time there?

11 **A.** Yes, as far as I can recall, it was. There certainly
 12 was no significant increase or decrease.

13 **Q.** Then if we go down to paragraph 3, we can see the
 14 senior staff list. We can see you there as medical
 15 director. Then you have a scientific services manager
 16 or deputy director, a quality manager -- what was the
 17 responsibility of the quality manager?

18 **A.** When I was appointed director there was very little,
 19 generally, in the way of quality management in the
 20 transfusion service that I was aware of and we
 21 certainly did not have a quality department as such
 22 within the Oxford Transfusion Centre. However, as
 23 time went by -- and this is not a document from the
 24 earlier part. I forget what date this document was.

25 **Q.** This is May 1990.

1 **A.** That's quite a bit later. And there was no quality
 2 department, as such, to start with but it felt later
 3 on that it became imperative and someone had to run it
 4 and, initially, my colleague, Dr David Collins, was
 5 involved as quality manager.

6 **Q.** Then we see there donor services manager and you tell
 7 us in your witness statement that that post was
 8 brought into being by you as a result of
 9 a restructuring arising out of poor practice.

10 Can you just tell us a little bit about what you
 11 were referring to in terms of poor practices?

12 **A.** I suspect what had happened is that, over the course
 13 of time, the system in place was possibly not as tight
 14 as it should have been and it was necessary to make
 15 sure that things were done better for everybody's
 16 sake, not only to make sure that the staff knew better
 17 what they were doing but also, and more particularly,
 18 to make sure that the donors were dealt with in
 19 an appropriate manner.

20 **Q.** Then running back down the list of senior staff, we
 21 can see there is donor organiser, blood collection
 22 manager, two laboratory managers and then the heads of
 23 the four different laboratories: standard reagents,
 24 donor grouping, microbiology and blood products.

25 Then if we go over the page we can see what the

1 list of products that were provided by the centre in
 2 1990 --

3 **SIR BRIAN LANGSTAFF:** 1989.

4 **MS SCOTT:** Sorry, 1989. Thank you, sir. We have got
 5 whole blood, plasma reduced red cells, SAG-M red
 6 cells. So we can see there that that is the largest
 7 most significant number of units issued at that time.
 8 Was that something that increased during your time
 9 there, the number of SAG-M red cells?

10 **A.** Yes, it was. Initially we didn't have any but
 11 developments took place that a different additive
 12 could be put in with the anticoagulant to make sure
 13 the blood doesn't clot and the additive was SAG, which
 14 is abbreviation for some chemicals which enable the
 15 red cells to last healthily for rather longer in
 16 storage, as a consequence of which the expiry time for
 17 red cells was extended from three weeks to five weeks.

18 **Q.** Was another benefit of SAG-M that you could remove
 19 more of the plasma and so you were able to send more
 20 plasma or use more plasma, send more plasma for
 21 fractionation?

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

23 **Q.** Then we have filtered red cells, platelet concentrates
 24 from two different methods, and then we have there
 25 a number of cryoprecipitate 50 units issued. Just

1 pausing there, you tell us in your statement that
 2 Oxford had stopped making cryoprecipitate when it
 3 moved to the new centre in 1979. Was that a decision
 4 that was made -- that decision, was it, made before
 5 you arrived at the centre?
 6 **A.** Can I make a correction please? At the time I wrote
 7 my statement -- you will realise that this was over
 8 26 years ago, in fact it was over 30 years since
 9 I arrived at the centre and I honestly could not
 10 remember cryoprecipitate being made during my time at
 11 Oxford. That may sound very bizarre but that is the
 12 fact and that is the -- I made that statement in true
 13 faith. So obviously small amounts, small numbers of
 14 cryoprecipitates were being made but, as I said,
 15 I have no recollection of that.
 16 **Q.** It may be obvious, the answer to this question, given
 17 what you have just said, but do you recall having any
 18 discussions with the clinicians at the Oxford
 19 Haemophilia Centre, for example, about provision of
 20 cryoprecipitate?
 21 **A.** I have no recollection of any such discussions at all.
 22 **Q.** You say that -- and looking at this -- borne out by
 23 looking at this, that only small amounts of
 24 cryoprecipitate were issued by the Regional
 25 Transfusion Centre. Would it have been possible to

25

1 increase the issue of cryoprecipitate, had there been
 2 a demand for it and had you been asked for it?
 3 **A.** Obviously, if it had been required and we were the
 4 centre producing them, yes, we would naturally have
 5 done what we could to meet that requirement.
 6 **Q.** Would that -- would you have been able to increase
 7 cryoprecipitate, the production and issue of
 8 cryoprecipitate -- well, how quickly would you have
 9 been able to increase the production of
 10 cryoprecipitate? If you had been asked, would the
 11 time be measured in weeks or in months?
 12 **A.** Depending on how much of an increase you are talking
 13 about, it would be very quick because it could be done
 14 literally in a matter of a day or so, if it was
 15 required.
 16 I may add, if I may, one further document which
 17 I was sent, which I read last week, which showed in
 18 1988 there were 140 units of cryoprecipitate being
 19 issued in the course of the whole year. So you can
 20 see that it is not a massive charge on the
 21 requirements from the laboratory.
 22 **Q.** Turning back then to the document we were just looking
 23 at, the 1990 inspection report, NHBT0006265. If we
 24 look then, so we have "Blood Collection and Receipt":
 25 "Standard blood donations are collected at

26

1 mobile donor sessions throughout the Region, all teams
 2 being based at the Centre."
 3 Sorry, this is 6.1:
 4 "There is also a donor apheresis clinic in the
 5 RTC."
 6 Then some detail is given about that in the
 7 following paragraphs: equipped with eight machines;
 8 560 donors on the panel; about 105 being bled per week
 9 and plans to increase the numbers so that platelet
 10 concentrates will be produced by apheresis.
 11 Can you recall how long donors on the apheresis
 12 panel were bled?
 13 **A.** As far as I can recall, it was certainly three
 14 monthly, may well have been less than that, because
 15 one is only taking plasma off and not taking off the
 16 red cells. So they are not at risk of anaemia which
 17 an ordinary donor would. Because of that one could
 18 actually quite safely take plasma and plated donations
 19 off monthly, if that was deemed necessary.
 20 **Q.** Can you recall how those donors were recruited?
 21 **A.** I cannot remember the practical details. I would
 22 imagine that, because we had donors living within
 23 reasonable striking distance of the John Radcliffe
 24 Hospital, they may well have been invited through
 25 donor sessions to look at documents which would allow

27

1 for the possibility of their coming into the
 2 transfusion centre for considering apheresis.
 3 **Q.** Can you recall whether there were any additional
 4 checks or steps taken in selecting those donors to
 5 ensure that they were healthy and free from infection
 6 and -- viral infection?
 7 **A.** I think there was very little in the way of additional
 8 medical supervision. I do know that there were tests
 9 of liver function introduced at a later stage and for
 10 very good reason but, initially, they were really
 11 virtually the same inspection as routine donors. But
 12 times did change over the course of my being in
 13 Oxford --
 14 **Q.** Then if we go, we see that in -- if we go back to that
 15 document and NHBT0006265. At the bottom of that page
 16 there:
 17 "Donor records are now computerised [so we are
 18 in 1990] and have been since 1988. The records for
 19 the following week's donors are printed out each week
 20 and held in the Clinic. When a donor attends and has
 21 signed the consent form, the Session Sheet is manually
 22 filled in with the name, donation number and group",
 23 and so on.
 24 Then if we go over the page, just one more
 25 reference I want to pick up, "Mobile Session", 6.1.2:

28

1 "Donors at mobile sessions are mainly 'called',
2 the pre-printed computer-generated record sheets being
3 taken to the session. Typically, around 200 donors
4 would be called to a session, with an attendance rate
5 of about 50%. For new donors and 'walk-ins', yellow
6 record sheets are used, the appropriate information
7 being hand-written in."

8 Does that accord with your recollection that you
9 got about a 50 per cent turn out rate for donors who
10 were pre-called to sessions?

11 **A.** That seems a reasonable figure, yes.

12 **Q.** How common were walk-ins, can you recall?

13 **A.** On average, I would say that the walk-ins, as you call
14 them, would be about 10 per cent of the total
15 attendance at a donor session.

16 **Q.** I'm going to come back to this document a little later
17 on today but we can take that down for now, Paul. So,
18 in relation to donor sessions, you say in your
19 statement that there were no donor sessions held in
20 prisons during your time in Oxford, is that right?

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

22 **Q.** And --

23 **A.** The decision had been taken nationally not to use
24 prisons quite some time before I came to Oxford.

25 **Q.** Is it right to understand then that, by the time you

29

1 were a director in 1980, were you aware -- sorry, were
2 you aware of any other centres undertaking donor
3 sessions in prisons, by the time you were a director
4 in 1980?

5 **A.** No, I was not aware of any. More than that, I was
6 aware that it was a national policy not to use prisons
7 by that time.

8 **Q.** Did you have any sessions bleeding military donors
9 while you were at Oxford?

10 **A.** Not that I can recall.

11 **Q.** I'm going to turn now to the issue of your targets.
12 Is it right to understand that there were, in
13 effect -- your targets, in terms of how you decided
14 how many donations you needed to collect, were made up
15 of three separate elements, the first of which was
16 your target that was provided to you by either BPL or
17 the National Directorate, as to the amount of plasma
18 that you needed to provide to send for fractionation
19 to either BPL or PFL?

20 **A.** That was one of the targets, yes.

21 **Q.** In relation to that, I will just run through the three
22 and then I will go back and ask you some questions
23 about them. Another part of the target was made up,
24 was it, of your estimation as to the amount of blood
25 you would need to meet the needs of the local

30

1 hospitals that you served?

2 **A.** That is correct, yes, and that was obviously very much
3 based on past record of the likely requirements and
4 that, by and large, really worked very well.

5 **Q.** Again, I will come back and ask you a couple of
6 questions about that. Then was there also -- we heard
7 from Professor Contreras last week that there was
8 a contract between the Oxford centre and her centre in
9 North London to supply them with blood and components.

10 Did that also form part of your target setting
11 or did you simply provide them with whatever you had
12 spare?

13 **A.** I would imagine this was probably happening on the
14 latter basis before I got there but, by the time
15 I arrived, we provided Edgware with -- Dr Contreras's
16 centre, we provided them with blood on a regular
17 basis --

18 **Q.** So is it right, then, that that would have also
19 formed -- you would have factored that into your
20 targets for the year?

21 **A.** Correct, yes.

22 **Q.** So just --

23 **A.** And I think -- if I can expand a little on that, it is
24 only fair to say that because we in the Oxford region
25 did have the resource we could easily or relatively

31

1 easily find the donations that Dr Contreras wanted,
2 whereas obviously Edgware was having a problem.

3 **Q.** Why was that? Why was it that you could find the
4 donations relatively easily?

5 **A.** I suspect purely population demographics.

6 **Q.** So you never had -- throughout your time there you
7 would have always been able to collect more donations
8 had they been required?

9 **A.** Yes, I think we probably could.

10 **Q.** Just turning then to the first of your targets, the
11 national target, the target set by BPL and/or the
12 National Directorate. What input did you have into
13 that target? And by "you", I mean the centre.

14 **A.** We didn't have an input in deciding how much was
15 required. I think it is fair to say that the BPL was
16 challenged with finding sufficient raw material to
17 provide for products needed, and they devise -- sorry,
18 divided up the total requirement into proportions
19 provided by each of the transfusion centres. So a big
20 centre, for instance, would provide a lot more plasma
21 than a small centre. And consequently we were given
22 a target by BPL: this is what was felt appropriate
23 from -- to be provided by the Oxford centre if
24 possible.

25 **Q.** And so was there a check in with you to establish

32

1 whether or not that was a target you could meet? Or
 2 were you simply just provided it and expected to get
 3 on with it?
 4 **A.** Not really. Not really. We did just that. We got
 5 along with it.
 6 **Q.** Then, turning then to the second target, the target
 7 that you set for the -- to meet the local needs.
 8 I think you already said that that worked quite well,
 9 that it was based on previous years' experience. Was
 10 it also based -- or, did you have discussions with
 11 your haematological colleagues in the blood banks that
 12 you served as to what the needs of their particular
 13 hospitals were?
 14 **A.** Not in specific detail, but I think it is fair to
 15 point out that totally outside our normal routines,
 16 both us or the haematologists, the haematologists of
 17 the whole region used to meet every three months or so
 18 in a -- or in a semi-domestic arrangement, maybe talks
 19 or discussions, and that gave good opportunity for
 20 face-to-face discussions to raise questions, to ask
 21 questions, and so on. But apart from that there was
 22 no formal review.
 23 **Q.** I have seen reference to the regional blood club
 24 meeting four times a year in the area?
 25 **A.** That is right.

33

1 NHBT0111632. So this is a record of a meeting of the
 2 heads of department, and I understand that to mean the
 3 heads of department within the Regional Transfusion
 4 Centre, is that right?
 5 **A.** Correct.
 6 **Q.** We see some of the names that we just looked at on the
 7 senior staff list in the inspection report. If we
 8 look at the bottom of that first page,
 9 "Rationalisation of Sessions", at 3:
 10 "Dr Entwistle had met with Dr Contreras and
 11 a representative from NW Thames BTS to sort out the
 12 requirements for Edgware. It had become apparent that
 13 although fresh whole blood would be very nice, what
 14 they really wanted was platelets. The RHA had agreed
 15 that it was not ethical to bleed donors and discard
 16 all the red cells.
 17 "As a result, there was now no justification for
 18 Oxford to think of increasing red cell collection and
 19 Dr Entwistle pointed out that there was no therefore
 20 justification for retaining the 5th team. Ideally
 21 there should be a 4 full teams, ie 48 DAs on the
 22 road."
 23 Then you go on to discuss what the four sessions
 24 would look like.
 25 So, is it right to understand that, at that

35

1 **Q.** Is that what you are describing?
 2 **A.** That is correct. That's correct.
 3 **Q.** And I will come on to ask you some questions about
 4 your interactions with colleagues later on this
 5 morning.
 6 Turning then to the contract you had with
 7 North London, just to ask you a little bit more detail
 8 about that. You have told us that that was
 9 an arrangement that started before your time. In your
 10 witness statement you link the ability to collect
 11 donations from the Slough area with the arrangement to
 12 provide blood to the Edgware Centre. Why is that?
 13 What's the relevance of the collections in Slough?
 14 **A.** Well, the Slough area was geographically a part of the
 15 Oxford region, and we were, therefore -- the Oxford
 16 Centre was therefore bleeding donors from that area
 17 and it seems in some senses logical that, if you like,
 18 those donations could go back home, as it were, to the
 19 Edgware Centre.
 20 In fact, there was a discussion between
 21 Dr Contreras and myself on more than one occasion; she
 22 asked if there would be any possibility of them taking
 23 over the Slough area. But, in fact, we left things as
 24 they were.
 25 **Q.** Can we look then at a document on this issue, which is

34

1 stage, there was no ability on the part of Oxford to
 2 collect platelets by apheresis?
 3 **A.** That is correct, yes. (Unclear).
 4 **Q.** So while you had the ability to collect whole blood
 5 donations which would have met the needs of Edgware,
 6 because that would have required you to get rid of the
 7 red blood cells that were needed that was unethical
 8 and so you couldn't help out?
 9 **A.** Correct.
 10 **Q.** Can we look at another document, please,
 11 DHSC0038579_016. This is another document on the
 12 issue of feast, if I can put it that way, in one area,
 13 yours, and famine in others.
 14 This is an issue which seems to have made its
 15 way into the press. So we have here two articles
 16 date stamped 12 September 1987. One, on the left,
 17 from the Daily Telegraph and, on the right, from
 18 The Guardian. It is the one from The Guardian that
 19 I'm going to turn to, and it is entitled "Minister
 20 denies blood 'shambles'". And these were articles
 21 that were written in the wake of then Dr Cash's
 22 article in the British Medical Journal in which he
 23 described the Blood Transfusion Services as
 24 a fragmented and disorganised shambles.
 25 We have looked at this article in previous

36

1 hearings so we are not going to turn that up, but you
2 were contacted by and spoke to The Guardian
3 journalist, and we can see what you say on the
4 right-hand column. So if we can pick it up sort of
5 a third of the way down where it starts:

6 "One of Professor Cash's central criticisms --
7 that coordination is so bad that one region is cutting
8 blood supplies while another faces shortages -- was
9 confirmed yesterday."

10 Then:

11 "Oxford has cut back despite a shortage of more
12 than 100 pints a day in the south London region.
13 Oxford's regional director, Dr Colin Entwistle said:
14 'There was no way we could justify collecting vast
15 excesses of blood that nobody wanted. That is why we
16 cut back'."

17 So this article, in 1987, is picking up on
18 a slightly different point to the one we looked at
19 previously, which was that you were cutting back on
20 donor sessions even though you could have collected
21 more donations at a time when there was a shortage,
22 apparently, according to this article, in the south
23 London region.

24 Were you aware during your tenure, and
25 particularly in 1987 when you were cutting back on

37

1 donor sessions, that there were shortages in other
2 regions?

3 **A.** You connect two issues there. Two issues there. One
4 was cutting back. We only decided not to move on to
5 a fifth blood collection team. We could have -- if it
6 had been required obviously it would have gone ahead.
7 So we were not actively cutting back in that sense, we
8 maintained our normal collection, which included some
9 going to Edgware. We were not aware that south London
10 was that desperately short and we hadn't been
11 approached by them to see whether we could help them
12 as well.

13 So even though they may have been short we were
14 not involved in that.

15 **Q.** Do you think, looking at it now, that that -- the fact
16 that you weren't even aware that there were shortages
17 in another area -- was a product of the
18 regionalisation of the transfusion service? Had there
19 been a national -- had it been a truly national body,
20 with one body overseeing all of the centres, that that
21 may not have occurred?

22 **A.** Certain. And I think this did underline the need for
23 proper rationalisation of the service which ultimately
24 led to the formation of the National Blood Authority.

25 **Q.** Moving off the issue of targets then, on to the issue

38

1 of what you did with your plasma in Oxford, is it
2 right to understand that Oxford provided plasma to PFL
3 in Oxford, which was a historic arrangement in place
4 when you arrived at the centre?

5 **A.** Correct.

6 **Q.** And the plasma that was fractionated by PFL was
7 provided directly by the Oxford Haemophilia Centre as
8 Factor VIII or Factor IX or whatever products they
9 were making, that those products did not make their
10 way back to the Regional Transfusion Centre?

11 **A.** That is correct. At no time did the transfusion
12 centre hold stocks of Factor VIII.

13 **Q.** What about Factor IX?

14 **A.** Or any of the coagulation products.

15 **Q.** Is this also correct, that Oxford also provided plasma
16 to BPL at Elstree. And again, the products that were
17 made out of that plasma, Factor VIII, Factor IX, went,
18 again, direct to the Oxford Haemophilia Centre and did
19 not come to the transfusion centre?

20 **A.** Correct.

21 **Q.** And did that remain the case throughout your tenure at
22 the --

23 **A.** It did indeed. PFL, so the plasma fractionation
24 branch in Oxford, in fact relinquished its role to the
25 BPL.

39

1 **Q.** So is it the case that in fact the Oxford Transfusion
2 Centre didn't hold any PFL or BPL or commercial
3 products?

4 **A.** Correct.

5 **Q.** So the only blood products or blood components that
6 their centre held were those made at the centre
7 themselves?

8 **A.** Sorry?

9 **Q.** The cryoprecipitate -- so --

10 **A.** The cryoprecipitate is the only product which the
11 Oxford Transfusion Centre made available to the
12 haemophilia centre.

13 **Q.** So all the -- if I can call them -- products, all the
14 products that were held by the transfusion centre were
15 those that were made at the transfusion centre?

16 **A.** Yes.

17 **Q.** Did the centre have any input or any discussions or
18 have any discussions or any input into the decisions
19 made by the haemophilia centre about purchasing
20 commercial blood products?

21 **A.** No, we had no part in that at all.

22 **Q.** Moving on then to look at supply of blood and
23 components from the transfusion centre. We are going
24 to go back to the document we looked at earlier,
25 DHSC0101582.

40

1 If we look at the table we looked at, which
2 I think was on page 7 -- thank you.
3 If we look down the left-hand column we can see
4 Oxford, "No. of NHS [hospitals served]: 11", and no
5 private hospitals, but we have got there two RAF and
6 one USAF hospital. Does that accord with your
7 recollection?
8 **A.** That is not correct. There were a number of private
9 hospitals in the Oxford region which we also -- to
10 which we also provided small quantities of blood.
11 **Q.** So this is a document from 1982. In 1982 do you think
12 this was incorrect?
13 **A.** As far as I can remember there were private hospitals.
14 Whether they were there 1982, I'm not sure.
15 **Q.** Certainly we have a document --
16 **A.** I certainly --
17 **Q.** I don't want to --
18 **SIR BRIAN LANGSTAFF:** Can you let him finish?
19 **MS SCOTT:** Yes, absolutely.
20 **A.** Certainly towards the end of my time, I was very well
21 aware of there being private hospitals because we had
22 to negotiate with them for contract purchases. But
23 I was also aware that at least some of them had been
24 there prior to that and I'm very surprised to see this
25 figure 0 in that chart.

41

1 **Q.** Certainly we have a document from 1992 which is from
2 a medical audit visit by Drs Robinson and Hewitt, to
3 the Oxford Centre, which I do not think we need to go
4 to but, for the benefit of the transcript, it is
5 NHBT0009748_001. It is a medical audit from 1992 in
6 which it is said that the centre served ten district
7 general hospitals, two RAF hospitals, one US Air Force
8 hospital and 14 private hospitals. So by 1992 it
9 looks like 14 private hospitals, does that sound more
10 accurate to you?
11 **A.** That accords with my recollection, yes.
12 **Q.** Can you recall whether there was a period, as you went
13 through your tenure, that you picked up more and more
14 private hospitals or do you recall always having
15 private hospitals?
16 **A.** Initially, there was very little in the way of private
17 hospitals and, in any case, even at the end, they did
18 not figure largely in the demands made on our service.
19 **Q.** Did you provide any blood or components to any other
20 NHS services, such as dentists?
21 **A.** No.
22 **Q.** So just hospitals?
23 **A.** Yes.
24 **MS SCOTT:** Sir, I'm about to move topics and it is going
25 to take me, I think, more than three minutes.

42

1 I wonder whether is now a good time to break?
2 **SIR BRIAN LANGSTAFF:** Yes. We normally take a break,
3 mid-morning, about now, Dr Entwistle, for about half
4 an hour to allow people to have a cup of coffee, for
5 those who are at home to make some refreshment or
6 indeed just have a break.
7 We will take a break now. We'll come back at
8 11.45, if that's okay. Let me tell you what I tell
9 every witness at this stage and it is this, you are
10 giving evidence, what you must not do is discuss the
11 evidence you have given or, for that matter, any
12 evidence which you think you might be asked to give
13 with anyone, whoever that person is, whether family,
14 lawyer, anyone at all, but you can talk about anything
15 else you like. So I look forward to seeing you at
16 11.45.
17 **(11.14 am)**
18 **(A short break)**
19 **(11.45 am)**
20 **SIR BRIAN LANGSTAFF:** Ms Scott, just before we begin
21 again, I think some people may have noticed you have
22 a slight hoarseness of voice and slight cough but
23 I understand, just for their reassurance, you took
24 a PCR test over the weekend and it was entirely --
25 well, it is either negative or positive -- it was

43

1 negative.
2 **MS SCOTT:** Indeed, that is correct, yes sir.
3 **SIR BRIAN LANGSTAFF:** So you are not suffering from Covid,
4 whatever else you may have seasonally affecting your
5 voice?
6 **MS SCOTT:** That is right, sir.
7 Dr Entwistle, I'm going to start this session
8 asking you about your knowledge of risk of hepatitis
9 and I will come on later to deal with HIV. I think
10 perhaps the best way to start us off is to go back to
11 your witness statement, WITN6917001, and to page 24,
12 please, Paul.
13 This is what you say at paragraph 87:
14 "I had been aware since the 1970s after the
15 identification of hepatitis B that there was
16 a condition given the title 'Non-A, Non-B' (for want
17 of a better name). I was also aware that throughout
18 most of my time at Oxford, there was no specific tests
19 for it. It was acknowledged that this condition posed
20 a risk of blood transmission."
21 Then if we pick it up again at paragraph 90,
22 please. You were asked questions about your
23 understanding of how serious hepatitis C or non-A,
24 non-B could be, and you say:
25 "My understanding was that hepatitis B was the

44

1 most aggressive infection, but that the other forms
2 including hepatitis C could nonetheless lead to
3 chronic liver disease possibly with ultimately fatal
4 consequences in some cases."

5 I'm just going to show you a document to see if
6 we can nail down the date or thereabouts by which you
7 would have -- which you knew that hepatitis C could
8 lead to chronic liver disease and, ultimately, could
9 be fatal in some cases.

10 Can we have, please, Paul, PRSE0004766.

11 This is a document called *Notes on Transfusion*.
12 We can see there it is the revised version of 1984.
13 Sorry, I have got the wrong document up in front of
14 me, which isn't very helpful. Let me find the right
15 document. If we turn please to page 3 of that
16 document -- in fact, can we go back to page 2. It is
17 rather small writing there, if we can enlarge that.

18 We can see that this is a document issued by the
19 Department of Health and Social Security with the
20 Scottish Home and Health Department and the Welsh
21 Office for the National Blood Transfusion Service and
22 the Scottish National Blood Transfusion Service.

23 If we go to page 3, we can see on the left-hand
24 side, if we can enlarge that bit:

25 "This edition of 'Notes on Transfusion', like

45

1 other viruses including the so-called 'non-A non-B'
2 viruses. The latter are also transmissible by
3 transfusion, but as yet no specific laboratory tests
4 have been developed to identify them. The incubation
5 period is also variable extending up to 70 days or
6 more. The clinical course may be acute, or chronic
7 leading to cirrhosis."

8 Is it fair to assume that, even if you weren't
9 involved in the drafting of this particular document,
10 you would have known what the contents of it were?

11 A. Yes, certainly.

12 Q. So if we are trying to pin down a date by which you
13 would have known about the chronic cause of
14 hepatitis C, non-A, non-B in some cases, and the
15 seriousness of it --

16 A. I was aware of that even before this document came
17 out.

18 Q. Were you aware of it, do you think, by the time you
19 arrived at the Oxford Blood Transfusion Centre as the
20 director?

21 A. Yes.

22 Q. So by 1980 you were aware of the seriousness of non-A,
23 non-B hepatitis?

24 A. Yes.

25 Q. Can you recall what -- how you became aware of that

47

1 its predecessors, has been prepared by a Committee of
2 the Regional Transfusion Directors."

3 Can you recall whether or not you were on that
4 committee?

5 A. You say that was 1983?

6 Q. Yes. It is the revised 1984 version.

7 A. I can't recall offhand when I was involved in that
8 committee.

9 Q. So you were, at some point, involved in drafting --

10 A. At some point but I can't -- unfortunately, I can't
11 remember exactly when.

12 Q. Can we -- we heard -- we have heard some evidence last
13 week that this document was the definitive publication
14 from the Transfusion Service to be used by those
15 carrying out transfusions, transfusion medicine in
16 hospitals, so for clinicians on the frontline. Is
17 that how you understood it to be used?

18 A. It could well have been. Obviously, anyone who is
19 involved in transfusion should have pretty good
20 knowledge of what they are doing.

21 Q. Can we turn to page 19 of this document, please. We
22 have got a section there on the right, "Post
23 Transfusion Hepatitis", and it is the bottom paragraph
24 that I wish to draw your attention to:

25 "Very similar illnesses can also be caused by

46

1 information, what it was that led you to understand
2 that?

3 A. I don't think there was any specific article or
4 information which I gleaned on that subject but I was
5 certainly aware of it from my general reading and
6 knowledge of the subject.

7 Q. I'm going to ask you some questions about your view of
8 your role as a director of the Regional Transfusion
9 Centre --

10 SIR BRIAN LANGSTAFF: Before you do that could I just come
11 back to that document that you had on screen, that is
12 PRSE0004766, and go back to page 2, the page which you
13 passed over reasonably quickly. Can we just highlight
14 that, please, Paul. Thank you.

15 I just wanted to ask you about this, really,
16 I think, for confirmation, more than for information.
17 *Notes on Transfusion* is:

18 "Issued by the Department of Health and Social
19 Security with the Scottish Home and Health Department
20 and the Welsh Office for the National Blood
21 Transfusion Service and the [SNBTS]."

22 The words "for the" could be interpreted in one
23 of two ways. One could mean that it is intended to be
24 given to the National Blood Transfusion Service and
25 those who work in it, the other could be that it is

48

1 done on behalf of. I had read this and I want you to
 2 know -- I want to know whether I'm right or not, as
 3 essentially being issued on behalf, and it may be
 4 a reflection of the fact that the NBTS had no direct
 5 funding from Regional Health Authorities of its own
 6 but had to rely upon central finance, for anything
 7 which it was going to publish and send round. Am
 8 I right or am I wrong?

9 **A.** I don't recall.

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

11 In that case, it is something which is open for
 12 comment in due course by others. It had seemed to me
 13 it might be a reflection of the fact that the NBTS
 14 was, in name, though not necessarily in control and
 15 organisation.

16 **MS SCOTT:** I'm going to ask you now about your view about
 17 whether or not you considered you had a role in
 18 educating your clinical colleagues about the risk of
 19 transmission of viruses via blood and blood products.

20 So did you consider that was part of your role?

21 **A.** To be fair, no, I don't think I did.

22 **Q.** What about -- did you consider it to be part of your
 23 role to educate your clinical colleagues more
 24 generally about best practice and transfusion
 25 medicine?

49

1 basis -- say annual or 6 monthly -- between the
 2 medical staff or Director at the Centre and the
 3 hospital based haematologist in charge of the blood
 4 bank is considered with a view to sharing problems and
 5 good practice experienced in blood banking."

6 Then if we go over the page, please, to 160 and
 7 then this is a recommendation for haematologists in
 8 charge of blood banks that they are:

9 "... asked to ensure that they discuss with
 10 their medical colleagues economies in blood usage."

11 That takes the chain through. That is not for
 12 Regional Transfusion Centre directors.

13 So, just pausing there, is this -- in fact
 14 I will show you another document before I ask you the
 15 question.

16 So if we could then turn, please, to
 17 NHBT0000476, and we can see here this is a DHSS
 18 circular from 28 February 1983 to regional
 19 administrators, district administrators and so on, and
 20 it refers to the "Blood transfusion: record keeping
 21 stock control arrangements".

22 Then if we go over the page. We can see that
 23 that's the circular itself. It is entitled "(Draft)"
 24 and it is again to Regional Health Authorities. And
 25 the summary:

51

1 **A.** That is something which hadn't really figured in my
 2 thinking.

3 **Q.** Can I take you to a few documents and see if that
 4 prompts any recollection. The first is
 5 DHSC0002221_011.

6 Now, this is a report from the Central
 7 Management Services for the Department of Health, for
 8 the DHSS, in 1982, and it is called "Blood: Record
 9 keeping and stock control".

10 It is a review of, unsurprisingly perhaps,
 11 record keeping and stock control in the transfusion
 12 services and indeed in hospitals. And the report
 13 concludes by making a number of recommendations, and
 14 if we can turn, please, to page 30, we can have a look
 15 at three of those. Recommendation 148:

16 "It is recommended that Centres ..."

17 And by that they mean Regional Transfusion
 18 Centres.

19 "... consider as part of their role a formal
 20 process to enable the exchange of ideas and good
 21 practice at operational level for hospitals to whom
 22 they supply substantial quantities of blood and blood
 23 products."

24 149:

25 "It is recommended that discussion on a formal

50

1 "This Circular asks health authorities to review
 2 arrangements for the supply of blood and blood
 3 products, and to review concurrently record-keeping
 4 and stock control arrangements in Regional Transfusion
 5 Centres (RTCs) and hospital blood banks. Its contents
 6 have been endorsed by the Advisory Committee on the
 7 National Blood Transfusion Service."

8 Then if we go down to the bottom of that page:
 9 "Regional review of policies:

10 "2. To facilitate a Regional review of
 11 policies, it is suggested that RMOs should convene
 12 regular meetings between their Regional Transfusion
 13 Directors (RTDs) and the consultants responsible for
 14 the hospital blood banks in their Regions to consider
 15 matters such as current and future requirements for
 16 blood, the scope for economies in blood usage, the
 17 proportion of plasma-reduced blood to be supplied, the
 18 use of ad hoc deliveries and the amount of stock which
 19 becomes time-expired in blood banks. The meetings
 20 should also provide the forum for the exchange of
 21 ideas as to what constitutes 'good practice' in the
 22 Region with regard to blood supplies."

23 So, first of all, do you recall seeing either
 24 the report that we looked at first or this circular?
 25 Are those documents that came to your attention, do

52

1 you recall?

2 **A.** I must be honest, they did not come to my attention.

3 **Q.** Do you recall whether or not the Regional Health

4 Authority took any steps to arrange regular meetings

5 between yourself and the consultants responsible for

6 the hospital blood banks?

7 **A.** Not that I'm aware of, no.

8 **Q.** You are mentioned earlier the meeting of the regional

9 blood club?

10 **A.** Yes.

11 **Q.** How did that come about? Was that as a response to

12 these recommendations or this circular do you think?

13 **A.** I don't know because that system of regular meetings

14 was already in place by the time I came to Oxford.

15 **Q.** So it couldn't, just by the dint of the chronology, be

16 a response to what was happening in 1982 and 1983?

17 **A.** That's my imagination, yes.

18 **Q.** So, in terms of meetings between yourself and your

19 clinical colleagues running the blood banks and indeed

20 carrying out transfusion practice, you have the

21 regional meeting of the Blood Club. Were there any

22 other forums in which best practice or exchange of

23 information took place?

24 **A.** Not as such, no. The only other thing I could mention

25 is that we had very informal but regular discussions

53

1 over the phone with my haematological colleagues in

2 hospitals as necessary.

3 **Q.** Would that arise where you might be rung up for

4 advice, in relation to a difficult case, for example?

5 **A.** That is one possibility, yes, or if there was some new

6 development or some new recommendation that I was

7 aware of and needed to pass on.

8 **Q.** Might that have included information about viral

9 infections in blood and blood products?

10 **A.** I am sure that must have been discussed. I can't say

11 more than that.

12 **Q.** In terms of the regional Blood Club, what was the

13 purpose of those meetings and what actually occurred

14 during those meetings?

15 **A.** It was a forum for discussion primarily but sometimes

16 with a specific topic being discussed in more detail.

17 **Q.** Can you recall whether transfusion-transmitted

18 infections were discussed at those meetings?

19 **A.** Offhand, I can't recall.

20 **Q.** I'm going to move now to ask you some questions about

21 your work on the Working Party on the Care and

22 Selection of Donors which reported to the Regional

23 Transfusion Directors meetings.

24 It is right, isn't it, that that working party

25 was responsible for drafting the guidance document

54

1 entitled "Care and Selection of Donors"?

2 **A.** Correct.

3 **Q.** If we just turn the 1984 version up, we find that at

4 NHBT0053225. Is it right to understand that this 1984

5 version was a revision of the previous 1977 version?

6 **A.** As I understand it, yes, it was.

7 **Q.** So, again, by dint of the chronology, you wouldn't

8 have been involved in the drafting of the 1977 version

9 because --

10 **A.** No.

11 **Q.** -- you were not in the Blood Transfusion Service at

12 that time. Just looking then at the title of this

13 document and we can see it is "Guidance for the

14 Selection Medical Examination and Care of Blood

15 Donors". Given the autonomy that each Regional

16 Transfusion Centre had, do you know the extent to

17 which this document was followed by other Regional

18 Transfusion Centres?

19 **A.** No, I don't. I have no reason to know what they were

20 doing.

21 **Q.** In terms of your own centre, so in terms of the centre

22 at Oxford, would you expect those working at donor

23 sessions -- so both the administrative clerk and the

24 medical officer -- to have followed the guidance in

25 this document?

55

1 **A.** Yes.

2 **Q.** Would they have received training on and received

3 a copy of this document?

4 **A.** I can't recall whether they would have had that

5 document, they might well have done but, certainly,

6 there was some training at the start of their

7 undertaking sessional work for us.

8 **Q.** So if we look then at the detail of the document and

9 then I'll ask you some questions about how -- what

10 your understanding of the donor sessions and how they

11 ran and how donors were selected.

12 We can see in the first page that there is,

13 under paragraph 1, there is some general guidance

14 about the age of donors, the weight of donors, and so

15 on. Then at paragraph 2, again, general guidance

16 about intervals between donations, and then

17 paragraph 4 looks at hazardous occupations, and

18 general guidance and more specific guidance in

19 relation to that.

20 If we then turn over the page, we get to

21 "Section II -- Medical Examination of Donors", and it

22 says under "Medical History":

23 "A donor is the best judge of his or her

24 fitness, and truthful answers to simple questions

25 about his or her medical history and general health

56

1 form a large part of the assessment.
 2 "The donor session clerk should specifically
 3 question the donor about the conditions listed on form
 4 NBTS 110A and request the donor's signature on form
 5 NBTS 110. Any conditions declared should be recorded
 6 by the Clerk or preferably by the Medical Officer,
 7 most conveniently in the 'medical history box' on the
 8 NBTS 101 donor record card or other equivalent
 9 document."

10 So, just pausing there then. Is it right to
 11 understand that the first -- well, that the system
 12 relied on the donor disclosing whether or not they had
 13 suffered from the conditions listed in the form
 14 mentioned there?

- 15 **A.** Yes, that is correct, and it was inevitable that if
 16 they failed to disclose, for whatever reason, there is
 17 no way that we could pre-judge.
 18 **Q.** So, was any training given or was there any
 19 expectation that either the donor session clerk or,
 20 indeed, the medical officer would carry out some kind
 21 of assessment themselves of the donor and whether or
 22 not they were a suitable candidate for donation? So
 23 setting to one side what had or hadn't been disclosed
 24 by the donor, was there any other kind of check by
 25 those individuals?

- 1 **A.** No, not really.
 2 **Q.** So, if a donor discloses a relevant condition on the
 3 form, then is it right to understand that that would
 4 trigger a referral to the medical officer for
 5 consideration?
 6 **A.** Yes.
 7 **Q.** Of whether or not that donor should be deferred or
 8 whether or not that donor could donate?
 9 **A.** That is correct, yes.
 10 **Q.** And the medical officer would then turn to this
 11 document for guidance as to how to deal with that
 12 particular donor?
 13 **A.** Yes.
 14 **Q.** And is it also right to understand that the medical
 15 officer would ask questions -- would effectively
 16 interview a donor who had been referred to him or her,
 17 in order to get more information about the condition?
 18 **A.** I think it would be fair to say they would ask further
 19 questions. They wouldn't necessarily interrogate them
 20 but I think have sufficient information to say, "Yes,
 21 okay, we can forget that for today", or, "Perhaps we
 22 had better not give blood today", or even take the
 23 matter further.
 24 **Q.** So you would expect there to be some exchange of
 25 information once something had been disclosed?

- 1 **A.** Some exchange of information, yes.
 2 **Q.** Was there an opportunity for that discussion to take
 3 place in private during a session in the community or
 4 would there have been sessions, at least some
 5 sessions, where that discussion would have had to take
 6 place in the large room that was where all the other
 7 donors and staff were?
 8 **A.** It would almost inevitably be in what you might call
 9 open forum, yes. But obviously one would try to --
 10 shall we say, try and take the patient slightly to one
 11 side so they are not sort of right next to somebody.
 12 **Q.** Was that a concern, that given how reliant the system
 13 was on donors being honest about what might be rather
 14 embarrassing or difficult matters to talk about, that
 15 that was being done without much privacy?
 16 **A.** It is a consideration which perhaps should have been
 17 dealt with differently, but it wasn't.
 18 **Q.** So let's look then at what was available by 1984 in
 19 relation to those who may be considered to be
 20 high-risk donors for Aids. So, in 1984, the donor
 21 would have been provided with the NBTS 110A. Is that
 22 right? We just looked at the guidance and it said the
 23 donor session clerk should specifically question the
 24 donor about the conditions listed on form NBTS 110A
 25 and request the donor's signature on form NBTS 110.

- 1 Would the donor have been given the form
 2 NBTS 110A or is that something that the donor clerk
 3 would have had?
 4 **A.** The donor clerk would have had it but other copies of
 5 that leaflet would be available for them to have read
 6 prior to seeing the clerk.
 7 **Q.** So if we look at NBTS 110A, which is at page 18 of the
 8 document we were just looking at, the guidance,
 9 NHBT0053225, we can see that this is appended to
 10 the 1984 guidelines. And if we see right at the top
 11 there, I think it says "NBTS" -- or the bottom of --
 12 "NBTS 110A (Rev 1983)". So we understand that that
 13 form was revised in 1983. Does that accord with your
 14 recollection?
 15 **A.** Mm.
 16 **Q.** Then you say:
 17 "This is very important -- please read carefully
 18 each time you attend."
 19 That would suggest, would it, that this was
 20 a leaflet provided for the donor?
 21 **A.** Yes.
 22 **Q.** We know from the guidance that the donor session clerk
 23 must ask specifically whether or not the donor has
 24 suffered from any of the matters set out there, which
 25 includes:

1 "Hepatitis (jaundice), or been in contact with
 2 a case in the last 6 months."
 3 Doesn't include AIDS, which seems to have been
 4 handwritten in there with a question mark. Is that,
 5 again, how you remember it in 1984?
 6 **A.** Well, this looks to me like a possible draft rather
 7 than the official document.
 8 **Q.** And by 1984 there was the separate Aids leaflet which
 9 had been produced by the Department of Health, and
 10 that would have been available at donor sessions,
 11 would it?
 12 **A.** Yes, there would be separate leaflets which
 13 specifically listed risk of Aids.
 14 **Q.** And I will come on to ask you some questions about
 15 that in due course. So just sticking then with this
 16 and the point in the session at which the donor clerk
 17 is asking the donor questions. Again, that would be
 18 an open session, would it? Those questions would be
 19 being asked orally and they were being asked orally in
 20 open session?
 21 **A.** That is correct.
 22 **Q.** Then turning back then to page 2 of this document, we
 23 see there, it says -- the last paragraph there:
 24 "A more detailed list follows of conditions
 25 which may affect actions taken with a particular

1 donor, whether to accept a donation, to refer the
 2 donor to the Medical Officer or to decline their offer
 3 permanently. Any donor not accepted because one of
 4 the conditions listed will, if they ask, be referred
 5 to the Medical Officer."
 6 Then there is set out a list of conditions.
 7 These are conditions that both the donor clerk and the
 8 medical officer will be taking into account, is that
 9 right?
 10 **A.** Yes, I mean if any -- if the donor admitted to any of
 11 those, he or she could be referred to the doctor for
 12 consideration.
 13 **Q.** Then we see there "AIDS, Disqualify, See appendix 1".
 14 We can see appendix 1 is at page 10:
 15 "Notes on Certain Diseases.
 16 "Acquired Immune Deficiency Syndrome ...
 17 "Practising homosexual and bisexual men, drug
 18 abusers both men and women, persons from Haiti and
 19 Central Africa, particularly Zaire and Chad,
 20 haemophiliacs and the sexual contacts of all those
 21 mentioned must not be accepted as donors."
 22 So that wording comes from, does it not, the
 23 first leaflet on AIDS?
 24 **A.** Yes.
 25 **Q.** We can look at that in due course, if necessary.

1 Then, if we go back then, please, to page 3 of this
 2 document, and down to "Hepatitis". We know that the
 3 donor clerk will have asked specifically about
 4 hepatitis or jaundice, "refer" -- and if that's
 5 disclosed we can see here that it is referred to the
 6 MO and, again, it says "See appendix 1".
 7 So if we turn back to appendix 1 and to page 11,
 8 please, we can see there the guidance that's given to
 9 the medical officer:
 10 "Individuals who give a history of jaundice or
 11 hepatitis or in whose blood anti-HBs is present may be
 12 accepted as donors providing that they have not
 13 suffered from jaundice or hepatitis in the previous
 14 twelve months, have not been in close contact with
 15 hepatitis or received a transfusion of blood or blood
 16 products in the previous six months, and providing
 17 their blood gives a negative reaction for the presence
 18 of HBsAG when tested by an accepted sensitive method
 19 (eg RIA). An approved test for hepatitis B surface
 20 antigen should be performed each time a donor is bled;
 21 donors whose blood is shown to carry [hepatitis B
 22 surface antigen] shall be excluded from the ordinary
 23 donor panel. They may only be considered for
 24 reinstatement under special circumstances and if they
 25 have been subsequently demonstrated by appropriately

1 sensitive tests to be persistently negative for known
 2 viral markers, (HBc, HBe) for at least twelve months
 3 and have an adequate level ... of anti-HBs antibody."
 4 **A.** May I comment on that if I may?
 5 **Q.** Yes.
 6 **A.** Quite honestly, if a donor presented with a history as
 7 presented there, whatever the subsequent
 8 microbiological tests were, as specified there, the
 9 odds are that donor would not be accepted anyway.
 10 **Q.** Are you talking there about somebody who has
 11 a positive test for hepatitis B surface antigen?
 12 Because there are two different categories here,
 13 aren't there? One is somebody who gives a history of
 14 jaundice and then those that are shown to carry the
 15 antigen?
 16 **A.** Those who have a history of jaundice we would not have
 17 accepted anyway, and those who certainly have tested
 18 positive, they would be excluded without question.
 19 **Q.** So, am I right in understanding that what you are
 20 saying is that, despite what this says in terms of
 21 accepting those with a history of hepatitis or
 22 jaundice, as long as it was more than 12 months ago,
 23 in practice, in Oxford, that's not what happened. In
 24 practice, in Oxford, if one disclosed that had history
 25 you would not be accepted as a donor.

1 A. Yes, we would not accept them.
 2 Q. So is it right to understand that, in fact, you
 3 departed, Oxford departed from these guidelines?
 4 A. Perhaps we were overly restrictive.
 5 Q. Do you recall whether or not you discussed that with
 6 any of your fellow Regional Transfusion Directors and
 7 explained that that was your practice?
 8 A. No.
 9 Q. Why not?
 10 A. Well, I would personally have thought that
 11 reinstatement of those donors was questionable. And
 12 if they had got hepatitis B, who knows whether they
 13 might have something else as well, which we have not
 14 tested for. So I was personally less happy to accept
 15 those sort of donors in the future.
 16 Q. And were you also concerned that if you accepted
 17 somebody with a history of jaundice, then, in fact, it
 18 may be somebody who was infected with non-A, non-B
 19 hepatitis and, applying this guidance, you may be
 20 letting such a person onto the panel to donate?
 21 A. Well, that's precisely what I was thinking. I was
 22 unhappy with that particular recommendation.
 23 I am also aware, of course, that long before
 24 the discovery of hepatitis B, the Service was aware of
 25 jaundice being a possible marker for trouble. What we

65

1 have subsequently found out was, of course, most of
 2 those were not hepatitis A or B or hepatitis C but
 3 might well have been so-called infectious jaundice,
 4 which is a different disease altogether. And it
 5 wasn't until specific tests became available that we
 6 could define exactly what was what.
 7 Q. How is it that these guidelines came out in the terms
 8 that they did in relation to hepatitis, given that
 9 you, as I understand it, were the chair of the working
 10 committee that was drawing up these guidelines and
 11 didn't, in fact, agree with one of the key
 12 recommendations within it?
 13 A. I felt it was over-generous, shall we say. But
 14 nonetheless there were others on that committee whose
 15 advice was respected and I think one has to be
 16 cautious in trying to draw up a common agreed policy
 17 which everyone can agree to even though some people
 18 might feel slightly different within that.
 19 Q. And so is it right to understand that you would have
 20 trained your staff to take a rather more cautious
 21 approach than that set out in the guidelines?
 22 A. In general terms, yes.
 23 Q. And do you think there was a danger that because this
 24 was the written guidelines that in fact some of your
 25 staff would have applied the guidelines and not

66

1 applied the more cautious test that you thought was
 2 appropriate?
 3 A. I honestly can't say.
 4 Q. Can I then -- picking up on a slightly different
 5 issue, on the issue of consent which you seemed to
 6 have raised in a meeting of July 1984, can we turn,
 7 please, to DHSC0002245_002.
 8 This is a meeting of the Regional Transfusion
 9 Directors in July 1984 at which you were present. And
 10 if we can turn, please, to page 3, there is an entry
 11 at the top there, "Care and selection of donors", and
 12 it is the second paragraph:
 13 "Discussion took place on the format of the blue
 14 form signed by donors and whether this can be regarded
 15 as consent. Dr Entwistle is pursuing this with the
 16 protection society and will inform RTDs of his
 17 findings."
 18 I'm just going to take you to one more document
 19 before I ask you about this. It is NHBT0090316.
 20 This, we can see, has a compliment slip on page 1 from
 21 you. If we go then, please, over to page 2, we can
 22 see a memorandum to the Medical Protection Society
 23 dated 1 August 1984 from a firm of solicitors,
 24 Le Brasseur & Bury.
 25 It says:

67

1 "Dr CC Entwistle
 2 "Re: Consent and Blood Donors"
 3 It sets out some advice and at the bottom there
 4 is a signature.
 5 Is it right to understand that this memorandum
 6 was provided by you to the Regional Transfusion
 7 Directors meeting -- if we go back over the page, the
 8 previous page -- for the meeting on 10 October 1984?
 9 A. I can't imagine that that was not referred back -- in
 10 fact, I think it was referred back to the directors
 11 meeting. I was also aware that there had been some
 12 difficulties, not in our region but elsewhere, with
 13 regard to consent being acceptable or not. But the
 14 Medical Protection Society felt that the consent was
 15 actually implied, yes.
 16 Q. So is this right, you raised it as a concern at the
 17 meeting we just looked at because you were
 18 concerned -- it had been raised with you and you
 19 wanted to understand what the position was. You
 20 then --
 21 A. Yes.
 22 Q. -- went off and got some advice from the Medical
 23 Protection Society, and they appear to have provided
 24 you with the advice that they themselves received --
 25 A. Yes.

68

1 Q. -- and you provided that advice back to the Regional
 2 Transfusion Directors meeting?
 3 A. I am sure I would have done but I cannot recall today
 4 whether I did or not. I am sure I must have.
 5 Q. All I'm inviting you to consider is that that's what
 6 it looks like, because you have got a compliment slip
 7 suggesting that --
 8 A. Yes.
 9 Q. -- attached to the memorandum from the Medical
 10 Protection Society.
 11 A. It is likely that I would have referred it back.
 12 Q. Then if we look at the detail, then, if we go back to
 13 page 2, please, Paul, if we look at the detail of what
 14 the Medical Protection Society were told, the second
 15 paragraph:
 16 "Your member refers at the end of this
 17 letter ..."
 18 I think that's you.
 19 "... to 'the apparent loophole in our present
 20 arrangements', but we do not think there is in fact
 21 any loophole. Have Dr Entwistle or his fellow
 22 directors in other centres ever experienced any
 23 complaint by a donor alleging lack of consent? It is
 24 difficult to conceive how any such complaint could be
 25 sustained.

1 a look at the forms that we do have that the donor
 2 would have been provided with to sign during the
 3 session. If we can look, please, first of all, at
 4 NHBT0010861_004.
 5 So this is, we can see halfway down, the form
 6 NBTS 110. If we look on the left-hand side under
 7 "Birthplace" it says NBTS 1011 revised 1965, in very
 8 small --
 9 **SIR BRIAN LANGSTAFF:** I think it is "101/P".
 10 **MS SCOTT:** Yes, I think that must be right. It suggests
 11 there "Rev 1965". I haven't found, not to say it
 12 doesn't exist, a form between then and 1985. Is that
 13 a form that you recognise? It is from significantly
 14 before your time, 1965, but is that a form that you
 15 recognise or do you think there would have been
 16 revisions subsequent to that?
 17 A. I suspect -- I'm pretty certain there would have been
 18 revisions to that.
 19 Q. So the next one that I have been able to find is at
 20 DHSC0002277_068.
 21 So this is the 1985 version and -- revised 1985
 22 and then it says "To blood donors", so this seems to
 23 be a later version than the one we looked at, at the
 24 back of the guidance, the 1983 version. Again, it
 25 doesn't appear in the 1985 version to have any

1 "As we understand it, the prospective donor
 2 takes the initiative in contacting the Blood
 3 Transfusion Service and expressing a willingness to
 4 give blood, and is then sent an appointment to attend
 5 a session. Before any blood is taken the donor is
 6 asked to read and sign a form ... which is addressed
 7 to 'Blood Donors'. In our view all the circumstances
 8 point clearly and unequivocally to implied consent.
 9 The consent is implied not only by the signing of the
 10 document ... but from all the circumstances, ie the
 11 initial volunteering, the attendance at the session,
 12 the signing of the form, and the permitting of blood
 13 to be taken without raising any objection."
 14 Did that put to bed, as it were, the concerns
 15 that had been raised with you about whether or not
 16 there was sufficient consent by the blood donors?
 17 A. Yes, it did, because there had been a case referred to
 18 the medical directors meeting from another region
 19 where a donor queried whether consent was valid. But,
 20 obviously, you will see from what the Medical
 21 Protection Society have just quoted there, they
 22 thought it was perfectly valid.
 23 Q. Then for the sake of completeness, which I probably
 24 should have taken you to before looking at the issue
 25 of consent but I will take you to now, just have

1 reference to AIDS but it does -- in the list of
 2 conditions, but it does say:
 3 "Please read the leaflet ... about AIDS."
 4 So the donor is directed to the AIDS leaflet and
 5 then tells the donor that all donations will be tested
 6 for the AIDS antibody. Then the donor is asked to
 7 sign below on this form to show that they have read
 8 the notice and they agree to their blood being tested.
 9 Then, lastly, the 1990 version, which is at
 10 NHBT0006682_008. It is in a slightly different form
 11 here and it is entitled "Declaration by Donors", and
 12 they are asked to declare various different matters,
 13 including that they haven't had an infectious disease
 14 in the last two years or been in contact with
 15 an infectious disease, haven't lived abroad other than
 16 in Europe, one about inoculations or vaccinations, and
 17 then they haven't had any of a list of the following,
 18 which includes jaundice, doesn't include AIDS, but
 19 then again directed to the AIDS leaflet and say "I am
 20 not at risk", and then agree lastly that the donation
 21 can be tested for AIDS antibody and other infections.
 22 Certainly from 1985 to 1990 were those the forms
 23 in use at the Oxford Centre --
 24 A. Yes, they are.
 25 Q. Moving on then to deal specifically with AIDS. You

1 have told us in your statement that you first became
 2 aware AIDS was a medical problem in 1982. Can you
 3 recall the circumstances in which you first became
 4 aware of AIDS?
 5 **A.** From general press and medical press.
 6 **Q.** When did you first become aware that AIDS or HTLV-III
 7 was caused or could be caused by blood or blood
 8 products?
 9 **SIR BRIAN LANGSTAFF:** Which is it, could be or is?
 10 **MS SCOTT:** Is.
 11 **SIR BRIAN LANGSTAFF:** Was caused as opposed to might be
 12 caused?
 13 **MS SCOTT:** Well, let's start with might be caused.
 14 **A.** I was aware right from the start that the question of
 15 infection with the AIDS virus was associated with
 16 transmission via blood in some form, whether it was
 17 through transfusion, which is only one form, but
 18 through other unusual practices, and through cuts and
 19 whatever, but blood seemed to be required for
 20 transmission to occur by whatever means.
 21 **Q.** So is it right then that from 1982 that was your
 22 understanding?
 23 **A.** Yes.
 24 **Q.** Given that fact, were you concerned at the length of
 25 time it took for the Department of Health to produce

1 the first AIDS leaflet? We know from other evidence
 2 that we have heard that that was produced for
 3 distribution by the Department of Health on
 4 1 September 1983. Do you recall whether or not that
 5 period of time, between you knowing about AIDS and
 6 understanding that it required blood for transmission,
 7 and having available to you a leaflet to provide to
 8 your donors, whether that caused you any concern?
 9 **A.** I think one has to remember that 1982 was a very
 10 different social situation to what we have today. We
 11 are looking back with hindsight which is a different
 12 matter altogether. The public conception of AIDS, as,
 13 it came to be known as AIDS, was that it was
 14 a condition which was primarily linked to persons with
 15 certain practices, which we needn't go into details,
 16 and was not a matter involving the general public and,
 17 although blood was necessarily involved, yes,
 18 that's -- the transmission seemed to be within
 19 restricted groups.
 20 And it was only as time went by that it realised
 21 that there were other possibilities to be considered,
 22 that in fact AIDS was transmissible, as was evidenced
 23 particularly from the populations in Africa, and it
 24 was realised that AIDS was becoming a more serious
 25 problem and that the general public, which included

1 blood donors, would have to take this on board.
 2 But we could not do that -- bearing in mind the
 3 public fear of AIDS, which there was at that time, we
 4 could not do that until we knew exactly what we were
 5 up against, which of course in those days we didn't,
 6 and we had to draw up guidelines for donors which
 7 would not scare them rigid.
 8 So this is one of the reasons why it took a long
 9 time for an approved document to be produced which
 10 would address this situation and would give the
 11 opportunity for those people in the dangerous
 12 activities to withdraw themselves as potential donors,
 13 while, at the same time, giving donors the opportunity
 14 of disclosing those risks.
 15 **Q.** So is it right to understand from what you have just
 16 said that, in fact, that length of time between when
 17 you knew about AIDS and the association with blood, or
 18 it being caused by blood, and the leaflet in
 19 September '83 didn't at the time cause you any
 20 concern?
 21 **A.** What, the long time between the two you mean?
 22 **Q.** Yes.
 23 **A.** I think initially, 1982 onwards, people used to
 24 think: oh, it is only going to be happening in these
 25 at-risk groups, which isn't going to be the general

1 public, it's not going to be donors. But that's
 2 an attitude which obviously had to be challenged in
 3 due course.
 4 **Q.** And so was that your view then, in those -- in that
 5 period '82 to September '83?
 6 **A.** I think it is fair to say yes because, initially, not
 7 an awful lot was known as to who actually could be
 8 involved, apart from the so-called at-risk groups.
 9 **Q.** So is it also right to understand then from what you
 10 have said that before the leaflet became available in
 11 September 1983, Oxford was not taking any steps to
 12 screen out high-risk donors from donating?
 13 **A.** The Oxford Centre was following the recommendations
 14 agreed by the directors that we would all -- all the
 15 transfusion centres would follow the same system in
 16 terms of dealing with the advice requesting
 17 information about at-risk activities. It was felt
 18 very strongly that we should all go by the same rules.
 19 **Q.** We have heard evidence that it was left to the
 20 discretion of the Regional Transfusion Directors as to
 21 how to distribute the first leaflet to donors. So
 22 there were three choices: the choice of sending out
 23 with the call-out card, handing to donors in sessions
 24 or having them available in sessions. I'm just going
 25 to turn to a document, NHBT0020746, and just ask you

1 about the practice in Oxford.
 2 So this is a letter from you, if we go over to
 3 the second page, to Dr Wagstaff, dated 14 June 1983.
 4 If I turn, first of all, to paragraph 6:
 5 "The leaflet being prepared should be made
 6 freely available at donor sessions along with other
 7 BTS literature. We consider it should not be handed
 8 to each and every donor at the clerking desk for the
 9 reasons given in 3 above."
 10 So there we can see, is this right, that you
 11 took, as it were, the least invasive, if I can put it
 12 that way, option of leaving it available at donor
 13 sessions. Is that right?
 14 **A.** That is correct. And the reason why we chose that
 15 route is that bearing in mind public attitudes at that
 16 time, we felt that if each and every donor was given
 17 the AIDS leaflet, there would be some at least who
 18 would take exception to being, as they might see it,
 19 threatened, and it was felt more acceptable to adopt
 20 what we did.
 21 **Q.** Would you also accept that, by taking the course that
 22 you did, that there may be some high-risk donors who
 23 never read the leaflet?
 24 **A.** Quite possible.
 25 **Q.** And --

1 **A.** But, on the other hand, you are never going to stop
 2 some high-risk donors failing to declare what they've
 3 done.
 4 **Q.** But equally, there may be some high-risk donors who
 5 ended up donating simply because they didn't realise
 6 that they were, in fact, high-risk donors who should
 7 be deferred, would you accept that?
 8 **A.** If they didn't risk it, they are not going to disclose
 9 that, are they?
 10 **Q.** Can we look back at that letter then, because you also
 11 give some -- you set out your views about a question
 12 you were being asked -- you were being asked
 13 a question about whether donors should be questioned
 14 about matters that might identify AIDS at sessions.
 15 So you say there:
 16 "In response to your letter of 7th June, we have
 17 reconsidered our approach to blood donor questioning
 18 with AIDS in mind. We do not consider the aggressive
 19 approach is justified ..."
 20 Are you there referring to the aggressive
 21 approach as oral questioning of donors? Is that what
 22 you were referring to?
 23 **A.** Yes. Indeed, yes, because it was felt -- not only me
 24 but others too, felt that what we might call
 25 aggressive questioning in an open session like that

1 would cause far more trouble than was warranted.
 2 **Q.** Why was it thought that questions about, for example,
 3 sexual practices or lifestyle, would be necessarily
 4 aggressive? Is there not a way of doing that that
 5 isn't aggressive, that is neutral and for information
 6 purposes only?
 7 **A.** Well, we could not see how that could practicably be
 8 done in an open-donor session.
 9 **Q.** Do you think it would have made a difference if there
 10 had been the ability at donor sessions for there to be
 11 privacy? Would that have made a difference, do you
 12 think, to your view?
 13 **A.** No, I don't think it would, on balance.
 14 **Q.** Then you set out your reasons in that letter, so if we
 15 can just have a quick look at that:
 16 "There are no specific medical questions, the
 17 answers to which indicate presence of, or liability to
 18 develop AIDS. Answers to non-specific questions about
 19 loss of weight, enlarged glands, night sweats, etc.
 20 Are thought to be too vague, misleading and possibly
 21 frankly unhelpful."
 22 Paragraph 2:
 23 "Even if specific questions were available, it
 24 is likely that the correct answers may not be offered
 25 where necessary, indeed the truth may be positively

1 concealed."
 2 Just pausing there, that is something you
 3 referred to in your earlier answer. What was your
 4 view about the extent to which donors were, in fact,
 5 positively concealing risk factors when being asked
 6 questions generally about their medical condition and
 7 specifically in relation to AIDS?
 8 **A.** I'm not saying in any way that that was the norm, I'm
 9 just saying it is possible.
 10 **Q.** Had you come across instances where that had occurred?
 11 **A.** Me personally, no, but nonetheless the possibility
 12 remained.
 13 **Q.** Then you carry on at 3:
 14 "The evidence to date suggests that those
 15 would-be UK donors most likely to develop AIDS come
 16 into the category of two of the 'Hs' namely
 17 homosexuals (especially the more promiscuous ones) and
 18 heroin or other drug abusers. The other Hs probably
 19 do not apply for practical purposes. Routine
 20 questioning of donors in the open forum of a clerking
 21 desk to seek information on their personal habits of
 22 this sort is considered to lead to:
 23 "a) rare disclosure of the truth, or
 24 "b) deliberate withholding of information, or
 25 "c) a very large number of

1 annoyed/irritated/puzzled/upset donors to whom the
2 questions do not apply. The resulting loss of donors
3 as well as the aggro, could be awful."

4 I think that's what you have just told us. Then
5 you say in 4:

6 "A sense of perspective should be maintained.
7 The infections known to be associated with AIDS are
8 far more prevalent in the USA even in their so-called
9 normal healthy donor populations. The incidence of
10 donors with past hepatitis B, Herpes simplex, CMV,
11 Syphilis etc in the UK population is so much at
12 variance with the USA experience that the ill-defined
13 questionnaire designed for American donors is
14 considered inappropriate for the UK, at least on
15 present evidence and at the present time."

16 I think you told us that you considered that the
17 incidence of AIDS in the donor population was thought
18 to be low but here you are saying something slightly
19 different, that, actually, in the population in the UK
20 as a whole was also much lower than in America. Was
21 that your understanding and belief in June 1983?

22 **A.** That was the belief at the time and most of the
23 information coming in about AIDS was arising at that
24 time from the States and it was not seen as a massive
25 problem in this country, at that time. Obviously,

81

1 things changed quite drastically over the next few
2 years.

3 **Q.** Then if we can go over the page, please, just to pick
4 up on the last penultimate paragraph, and then you
5 say:

6 "If an inordinate fuss were made about AIDS,
7 then possibly important other donor information may be
8 at risk of being overlooked, ignored, not disclosed
9 etc. There are already very many conditions about
10 which information is already sought. It seems most
11 reasonable and appropriate that at least as far as
12 this country is concerned, AIDS should be dealt with
13 by so many other disorders, and be covered by the
14 blanket ruling that should there be ANY MEDICAL DOUBTS
15 about the fitness to donate, then that donor should
16 discuss the matter with the Medical Officer in charge
17 of the session."

18 So what was your concern there, that if one
19 elevated the question of AIDS by particular questions
20 about lifestyle and practices, and so on, one might be
21 at risk of losing the other important information
22 about other infections?

23 **A.** That was one of the concerns, yes. And I felt -- as
24 I said there, we felt try to keep things in
25 a reasonable perspective, bearing in mind what was

82

1 known at the time.

2 **Q.** And so those matters that you have just set out at
3 paragraphs 1 to 5 go, really, primarily, don't they,
4 to the question of whether or not donors should be
5 orally questioned in a donation session.

6 What was your rationale for taking the approach
7 you did in terms of the handing out and dissemination
8 of the leaflets? Why was it that you took the view
9 that they should only be available at sessions rather
10 than either being provided in call-up cards or
11 individually to donors as they arrived at the session?

12 **A.** We felt that call-up cards was not the most
13 appropriate way, not least because that would not
14 cater for the walk-in donors.

15 Secondly, we felt that if the leaflets were
16 available on display for donors to read before coming
17 to the clerk, that was probably the most private or
18 discreet way that could be addressed without causing
19 too much anxiety, and they would give the donor the
20 opportunity of disclosing or not as appropriate when
21 they finally got to the clerk.

22 **Q.** So if we then look at another document to see what was
23 happening in 1984. Can we go, please, to
24 DHSC0002241_002.

25 So we have here a letter to the DHSS dated

83

1 28 March 1984, from you, entitled "AIDS LEAFLET". You
2 are replying to a request for information from the
3 DHSS about how the leaflet is going in the region.
4 You say you have stock of approximately 13,000 and you
5 have issued approximately 1,000.

6 What does that mean? What does "issued" mean?

7 **A.** 1,000 leaflets were used at donor sessions.

8 **Q.** Right. And then you say the rate of usage per month
9 is now negligible. Then you set out:

10 "Method of distribution ... leaflets are
11 displayed with other BTS leaflets at sessions at the
12 clerking-in table and at the tea table."

13 And then you say:

14 "5. The effect on donor attendance: none as far
15 as we can see.

16 "6. Feedback ... none for practical purposes."

17 Picking up a couple of those points. Is it
18 right to understand that by March 1984, donors were
19 not picking up and removing from the tea table, the
20 clerking table, the leaflet. Is that what "now
21 negligible" means?

22 **A.** Yes. I think one has to remember, again going back to
23 the fact that this is now March 1984, which is a very
24 different situation already from the situation in 1982
25 when there was so much public worry. By 1984 things

84

1 were beginning to settle down somewhat and most of --
2 the vast majority of the donors did not perceive that
3 AIDS was quite as bad a problem as was first thought.

4 **Q.** But of course at this time there is no screening in
5 place so the only, sort of, line of defence against
6 high-risk donors is via the leaflet.

7 **A.** Correct.

8 **Q.** Was it a concern to you that actually having them
9 available didn't seem to mean that they were being
10 read?

11 **A.** That's the one. That could be argued, but I don't
12 know whether that was the truth or not.

13 **Q.** And then moving on then to the effect on donors of the
14 leaflet, it is right to understand that your concerns
15 about the impact of the leaflet, in terms of putting
16 donors off and the consequence that would have for the
17 blood supply, hadn't, in fact, been borne out in your
18 area and the donors didn't seem to be bothered one way
19 or the other about the presence of the leaflet?

20 **A.** I think that is a very fair assessment, yes.

21 **Q.** Moving on then to the second AIDS leaflet, and then
22 that will bring us to lunchtime I think, can I take
23 you first of all to a meeting of the Western division
24 of the region -- of the Blood Transfusion Service, of
25 7 December 1984, which we find at NHBT0113565.

85

1 We can see there you in attendance, and if we
2 turn over, please, to the second page of that
3 document, we can see at "AIDS":

4 "The general problems of Regional Transfusion
5 Centres relating to AIDS was discussed. It appears
6 that Centres will not be able to test for HTLV III
7 antibodies for at least six months. The promised DHSS
8 AIDS leaflet was not yet available. Four Centres have
9 produced their own version for the time being.
10 Concern was expressed at the lack of information from
11 the DHSS, particularly in relation to heat treatment
12 of Factor VIII."

13 Two matters arising from this, were you, can you
14 recall, concerned about the fact that the promised
15 AIDS -- second version of the AIDS leaflet was not yet
16 available?

17 **A.** I do not recall exactly what the situation was at that
18 time. I don't think we produced our leaflet
19 independently. Because I felt the -- and I think
20 I was not alone in feeling, that we should go by
21 whatever was agreed nationally. And so --

22 **Q.** So you don't -- I'm sorry.

23 **A.** So I don't think we would have set out to produce
24 an independent leaflet of our own, which might --

25 **Q.** So you don't think -- sorry --

86

1 **A.** So it varied. Sorry.

2 **Q.** I spoke over you, sorry. I interrupted you. You
3 said: it might ...

4 **A.** I don't think it would be right -- didn't think it
5 would be right for us to produce a leaflet which might
6 be at variance with what was ultimately thought as
7 being correct elsewhere or might conflict, perhaps,
8 with the Department of Health document when it finally
9 came.

10 **Q.** So is it right then that you think it is unlikely or
11 you weren't one of the four centres to have produced
12 their own versions -- second versions of the AIDS
13 leaflet?

14 **A.** I don't recall our -- I don't recall the Oxford Centre
15 producing a leaflet independently, no.

16 **Q.** Then if we turn then to two more documents before we
17 break for lunch, DHSC0002159. This is a Department of
18 Health circular issued in January 1985 and it is to
19 Regional Health Authorities, and if we go down,
20 please, to paragraph 4 revised distribution
21 arrangements. We can see there:

22 "Ministers have decided that it is essential
23 that the revised leaflet be brought to the attention
24 of each donor on an *individual basis*. This would
25 normally be achieved by sending each donor a copy of

87

1 the leaflet with his next call-up notification. It is
2 realised that this may not be practicable for
3 industrial sessions (or for new donors presenting at
4 sessions) -- in these cases alternative arrangements
5 should be made to ensure that each donor is
6 individually given the leaflet before any blood is
7 taken. Displays of leaflets, while continuing to be
8 useful, will not meet these new distribution
9 requirements. Because the advice has changed
10 significantly, the revised leaflet should be sent even
11 to those who received the 1983 version."

12 Just pausing there. Do you recall whether or
13 not that circular made its way to you and you were
14 aware that there was an instruction from the
15 Department of Health as to how leaflets -- how the
16 second version of the leaflet should be distributed?

17 **A.** I must be honest, I don't recall that document. If
18 I did see it, I presumably would have been required to
19 act upon it but I don't recall it, I'm sorry.

20 **Q.** Then last document then, which -- before we break for
21 lunch -- is NHBT0000745. This is a letter dated
22 20 October 1989 to Dr Gunson from the deputy director
23 at the Oxford Centre. It says:

24 "Colin [that's you] has left to attend
25 [a] meeting in New Orleans. In his absence I have

88

1 obtained a copy of his reply to Bill Wagstaff's letter
2 of 7th June. He does not appear to have replied to
3 the second letter dated 6th July."

4 He says this:

5 "I can find no evidence that the AIDS leaflet
6 made available to Blood Transfusion Centres in 1984
7 was formally issued to donors. Indeed the first time
8 the AIDS leaflet was sent to donors individually with
9 their call up card or as a hand-out at sessions was in
10 March 1985."

11 So there seems to be a gap, Dr Entwistle between
12 the instruction coming from the Department of Health
13 in January 1985, that the leaflet should be provided
14 individually to donors, and that being put in place at
15 Oxford in March 1985. Do you know why that was?

16 **A.** No, I'm sorry, I don't.

17 **MS SCOTT:** Sir, I'm slightly over time. I'm going to move
18 on now to a slightly different topic in relation to
19 HIV and AIDS. Now might be a good time for a break.

20 **SIR BRIAN LANGSTAFF:** Yes, the only thing which arises
21 possibly out of that last exchange is the health
22 circular was addressed to Regional Health Authorities,
23 I think. It was not addressed to Regional Transfusion
24 Centres, as such.

25 **MS SCOTT:** Yes, that is correct.

89

1 **SIR BRIAN LANGSTAFF:** So, presumably, the route would be
2 that it goes to the Regional Health Authority and if
3 they think that it is of sufficient importance, as
4 they ought to, in the case of a circular, they would
5 pass on the information to whoever needed to know.
6 Would that be the way that it came to you?

7 **A.** That's the way it should have come to me but, as
8 I said just now, I do not recall seeing that document.

9 **SIR BRIAN LANGSTAFF:** But obviously that might take
10 a short while but that's something which I shall have
11 to consider.

12 At the moment, I'm considering when we should
13 come back after lunch, and we will make it 2.00,
14 I think.

15 So 2.00, if you please. 2.00.

16 **(1.03 pm)**

(The short adjournment)

17 **(2.00 pm)**

18 **SIR BRIAN LANGSTAFF:** Yes.

19 **MS SCOTT:** Good afternoon, Dr Entwistle.

20 **A.** Hello.

21 **Q.** Just a couple of points to pick up from this morning's
22 session. First of all, just to make a correction.
23 I was showing you the forms before lunch and suggested
24 that I hadn't found a form between 1965 and 1985. It
25

90

1 has been pointed out to me that we do have a form
2 from 1977. I don't think we need to go to it but just
3 to correct the transcript, the URN for that is
4 DHSC0003734_066, and it was pointed out to me that
5 Dr Napier was taken to that form.

6 The other, second point I wanted to pick up,
7 before I ask you about arrangements in Oxford for HIV
8 testing, was a follow-up question from the question
9 Sir Brian put to you before we broke for lunch and
10 that was to just ask you what your relationship was
11 like with the Regional Health Authority, what the
12 communications were like and how often you met, and so
13 on?

14 **A.** Well, not so much with the RMO, Regional Medical
15 Officer, but with others in the Health Authority
16 communication was pretty regular and very good
17 relation with HR and with the gentleman who was
18 overseeing the Blood Transfusion Service.

19 **Q.** We were looking earlier at a circular and you thought
20 that that hadn't made its way to you. You certainly
21 couldn't recall seeing it. Was the health authority
22 fairly good at disseminating information to you that
23 they had you ought to see or were they not so
24 reliable?

25 **A.** I don't think I'm in a position to comment on that.

91

1 I think one of the big problems one might be up
2 against, as I am sure you must have found too, is
3 sometimes when you get a massive document it is
4 awfully easy to overlook a paragraph.

5 **Q.** So turning then to the arrangements in Oxford for HIV
6 testing. Can we turn first to NHBT0004521. So, this
7 is -- so NHBT0004251.

8 **SIR BRIAN LANGSTAFF:** I think we may be drawing a blank on
9 that one.

10 **MS SCOTT:** Perhaps I can deal with this without going to
11 the documents. We will see how we do. Maybe we can
12 come back to it if we don't get very far. Is this
13 right, that initially when you were being asked --
14 when planning for HTLV-III testing was being
15 undertaken, the initial view from your centre -- from
16 you and your centre, was that you would need to do
17 some building work before you would be able to start
18 screening donations for HTLV-III, is that right?

19 **A.** That was our original thought. However, because it
20 was apparent, very readily apparent that the rest of
21 the centres were going to start screening as from --
22 I think it was the middle of October '85, we had
23 a duty of obligation to get going by that date so we
24 had a radical re-think of the arrangements in our
25 microbiology section of the laboratory, and we were

92

1 actually able to start HIV screening on time.
 2 **Q.** The reason you were able to do that is because, as you
 3 say, you had a radical rethink and you reorganised the
 4 space, did you?
 5 **A.** Yes.
 6 **Q.** Did you ever get your building work?
 7 **A.** No, we didn't do that. Our original thought was we
 8 would possibly take over part of the store which was
 9 next door but, in the end, that was not necessary,
 10 thank goodness.
 11 **Q.** Then, let's try this document, DHSC0000177. So this
 12 is "AIDS, Booklet 2, Information for Doctors
 13 Concerning the Introduction of the HTLV-III Antibody
 14 Test", dated October 1985.
 15 If we turn over the page we can see that this is
 16 a letter to "All Doctors in England", from -- and if
 17 we turn over to page 3, we can see that it is from
 18 Dr Acheson, the Chief Medical Officer.
 19 If you turn back please to page 2., I want to
 20 ask you about what arrangements were in place in
 21 Oxford when HTLV-III screening was brought in.
 22 So we can see that it says, at the beginning of
 23 this letter, that:
 24 "From a date in mid October [second paragraph]
 25 to be announced, all blood donations will be

1 screened ..."
 2 And:
 3 "At the same time, alternative facilities for
 4 providing antibody tests on a confidential basis will
 5 become available --
 6 "a. at [GUM] clinics.
 7 "b. by arrangement with the patients' general
 8 practitioner at certain other clinics as arranged and
 9 publicised by the District Health Authority."
 10 We have heard and seen evidence that there was
 11 a concern on the part of the Regional Transfusion
 12 Directors that there should be alternative venues for
 13 screening, so as to avoid high-risk donors coming to
 14 donate in order to get a HTLV-III screening test; is
 15 that right?
 16 **A.** Certainly, we did not want high-risk donors coming in
 17 just to have the benefit of the test.
 18 **Q.** So can you recall whether, when you started screening
 19 in Oxford, there were these alternative arrangements
 20 for those that wanted to get an HTLV-III test to go
 21 and have one?
 22 **A.** I understood that they were actually in place, yes.
 23 **Q.** Then we go down to the bottom of that second page:
 24 "It is essential that all individuals who are
 25 found to have positive antibody tests receive

1 counselling both in order that they may understand the
 2 meaning of the results and to advise them how to avoid
 3 transmitting the infection to others."
 4 Then, if we go over to page 11, we see under
 5 "Counselling", it says:
 6 "Within [GUM]/Sexually Transmitted Disease
 7 clinics multidisciplinary collaboration involving
 8 social workers, clinical psychologists and health
 9 advisers is usually available to assist the proper
 10 counselling and support of AIDS sufferers and their
 11 contacts. Support is also available from some
 12 community based groups ..."
 13 And some details are provided.
 14 On the question of counselling, what counselling
 15 arrangements were in place and were the donors who
 16 tested positive able to access?
 17 **A.** Well, I personally was only involved in one
 18 (inaudible) came, and in fact I was the person who
 19 initiated counselling. I arranged to meet the lady,
 20 who lived in Reading. I met her at the Royal Barts
 21 Hospital and explained the situation as best I could.
 22 I had had the benefit of going to a meeting in St
 23 Mary's, Paddington, on how to counsel patients who
 24 might have HIV, and I was able to sort out a probable
 25 mode of acquisition of infection and point her in the

1 direction of her GP, who might then point her further
 2 for appropriate further management and possible
 3 treatment, bearing in mind that at that stage there
 4 was no specific treatment available for HIV.
 5 **Q.** So it wasn't -- and I appreciate you are talking about
 6 the practice of counselling one individual, but as far
 7 as you -- there wasn't a practice of trying to access
 8 these multidisciplinary-type team approaches of
 9 counselling for donors?
 10 **A.** No, we were not involved in that at all.
 11 **Q.** Then if we can just go to page 8 of this document to
 12 look at the confidentiality provisions:
 13 "The strictest confidentiality must be
 14 maintained when an HTLV III antibody positive
 15 individual is identified. Where a person is tested
 16 for HTLV III infection or for its complications and it
 17 is thought to have been sexually transmitted, health
 18 authorities have an obligation to maintain
 19 confidentiality of information under the terms of the
 20 National Health Service (Venereal Diseases)
 21 Regulations ... Unless the patient has given his
 22 consent, personal health data relating to him must not
 23 be disclosed to anyone for any purpose other than the
 24 health care of that patient, except where the
 25 disclosure is necessary to prevent the spread of

1 infection. Disclosure of this information for
 2 purposes other than medical or public health reasons
 3 could lead to serious consequences for the informant.
 4 Adequate safeguards to protect individuals against
 5 unauthorised disclosure must be adopted."
 6 One could read that there are two different
 7 levels of confidentiality in relation to the results
 8 of HTLV-III tests depending on how the person became
 9 infected, but is that the way that it was read by you
 10 and your colleagues at Oxford or were all donors
 11 treated in the same way in terms of confidentiality?
 12 **A.** As far as I'm aware, they were all treated the same
 13 way. Confidentiality was maintained in that no
 14 information was passed on to anybody except with the
 15 specific consent of the individual concerned.
 16 **Q.** And that would include, would it, passing on test
 17 results to GPs or to other clinicians for further
 18 treatment?
 19 **A.** Indeed.
 20 **Q.** And would that also include passing on information to
 21 family members or partners of the donor, infected
 22 donor?
 23 **A.** We would not do that, but obviously we would stress to
 24 the individual concerned that they would be the ones
 25 to pass on the information as appropriate. But

1 stored red cells was also considered. It might have
 2 to be accepted that current stocks cannot be tested --
 3 many donations were in fact collected before the
 4 prevailing epidemic. The washing and reconstitution
 5 might also reduce the risk of virus transmission. New
 6 donations obtained from past contributors could be
 7 tested and when found negative their preceding
 8 donations be certified as being safe."
 9 Now, just with that prompt, if I can put it that
 10 way, can you recall what the practice was in the
 11 Oxford Centre for any stocks that the centre had
 12 themselves that had been harvested prior to testing
 13 that might perhaps be frozen, whether or not those
 14 were released post the testing date as untested
 15 components and products?
 16 **A.** Well, we had no frozen red cells at all. So that can
 17 be forgotten about and I wasn't -- I can't recall
 18 offhand what other products you might be thinking of.
 19 **Q.** Well, would you have, for example -- what long life
 20 products, products with a long shelf life was the
 21 centre -- would the centre or could the centre have
 22 been holding in October 1985?
 23 **A.** There could have been fresh frozen plasma, which would
 24 have been in store, yes. And that's all I think we
 25 would have held.

1 certainly we did not feel that it was either other
 2 obligation to pass it on nor should we pass it on.
 3 **Q.** Moving on then to a slightly different HIV-related
 4 topic, if I can put it that way. If we could have,
 5 please, NHBT0092851.
 6 If we could go, please, to page 2 of this
 7 document, you can see that this is the minutes of
 8 a Western division of the N BTS consultants meeting of
 9 4 October 1985, and we can see a third down that you
 10 were present at that meeting.
 11 If we could go to the bottom, please, of this
 12 page. We see at paragraph (c):
 13 "It was agreed that absolute confidentiality
 14 should apply to donors found to be HTLVIII antibody
 15 positive. A proposal from Dr Moss, Consultant in GUM
 16 that GUM specialists be notified was not accepted."
 17 So that bears out the evidence you just gave us.
 18 Then it is (e) that I wanted to ask you questions
 19 about:
 20 "Aids update. It was accepted that there would
 21 be substantial amounts of untested long life frozen
 22 components in circulation (mainly in hospitals) at the
 23 time of the general announcement on testing. Centres
 24 were operating different policies for the use of this
 25 material. The [over the page] testing of frozen

1 **Q.** So can you recall whether you tested that fresh frozen
 2 plasma and then released it or whether you would have
 3 released it post-7 October 1985, despite the fact that
 4 it was untested, because it had been collected before
 5 that date.
 6 **A.** I see what you are getting at and I can't recall
 7 exactly what did happen. It would have been nice to
 8 have withdrawn it before testing it, which we couldn't
 9 do anyway.
 10 But I suspect -- I may be proved wrong, but
 11 I suspect it would have been issued. Even though it
 12 had not been tested, it would have been collected for
 13 introduction of testing.
 14 **Q.** When you say you couldn't have tested it anyway, why
 15 was that?
 16 **A.** Because we would not have had separate samples from
 17 that frozen plasma.
 18 **Q.** So you would have had to test the whole batch?
 19 **A.** Indeed.
 20 **Q.** Would that not have been possible?
 21 **A.** Not really. I think we would probably have to have
 22 abandoned any frozen stocks.
 23 **Q.** Then, turning to the stocks that were in hospital,
 24 which was given specific regard in the meeting minute
 25 we just looked at. So the expectation of the Western

1 division was that there would be, at the time that
 2 testing came in, substantial amounts of untested long
 3 life frozen components in circulation. Can you recall
 4 what the practice was at Oxford in terms of that
 5 material? Do you think Oxford recalled those products
 6 and tested them and then released them or do you think
 7 they were left in circulation to be used post-testing
 8 but as untested products?

9 **A.** I can't recall but I suspect they would have been
 10 issued in the normal way, even though they had not
 11 been tested prior to screening.

12 **Q.** So you can't recall but you think it is likely that
 13 there would have been some products both issued by the
 14 Blood Transfusion Centre and issued by the hospital
 15 blood banks, after the date on which testing for
 16 HTLV-III came in and those products would have been
 17 untested. Is that a fair summary of your evidence.

18 **A.** Would be untested, yes.

19 **Q.** Can we then turn, please, to NHBT0019630_003. Now,
 20 I wonder if you can, first of all, help us to
 21 understand what this document is and how it came into
 22 being. We can see it is a witness statement from you
 23 and it goes over several pages and then, if we go,
 24 please, to page 7, we can see the date of it,
 25 4 January 1990. Can you remember what this witness

101

1 statement was produced for, why it was produced?

2 **A.** I have no recollection what that was for.

3 **Q.** The paragraph I wanted to take you to starts at
 4 page 6. You talk there about testing and then, in the
 5 second and third paragraph, you talk about
 6 counselling, and then it is at the end of the last
 7 paragraph I want to pick up. It starts about halfway
 8 down there:

9 "Should a donor become HIV infected, the
 10 corresponding antibody does not develop and become
 11 detectable until after a timelag which varies from
 12 a few weeks to perhaps several months. The risk of
 13 a donor giving blood during such a timelag or 'window'
 14 of infection has been calculated to be in the order of
 15 about 1 in a million, that risk being less in the UK
 16 than some other countries who accept donations more
 17 than twice a year from the average donor.
 18 Consequently, if a donor were to become infected there
 19 is a good chance of there being only one previous
 20 possibly virus-containing plasma donation which would
 21 be most probably still held in quarantine anyway
 22 before being pooled and fractionated."

23 We will go on to look at the situation in
 24 relation to plasmapheresis donors.
 25 Just pausing there, was it the practice of

102

1 Oxford -- at Oxford to keep back donations of new
 2 donors until a second HTLV-III test had been carried
 3 out, to guard against the risk of them donating during
 4 that window period?

5 **A.** Not as I recall, and I don't recall any recommendation
 6 coming that we should have done either.

7 **Q.** So that presumably would be both in relation to new
 8 donors and in relation to established donors, there
 9 was no policy?

10 **A.** Indeed.

11 **Q.** Then if we pick up then where we left off in that
 12 document and look at the situation in relation to
 13 plasmapheresis donors:

14 "The situation could potentially be slightly
 15 different in respect to donations given by pheresis,
 16 in view of the much greater frequency of donation, and
 17 also in view of the rapidly expanding role of pheresis
 18 in meeting plasma demand."

19 So then you go on to say what the new code of
 20 practice says in relation to frequency of donation.
 21 You say there:

22 "In Oxford, most of our approximately 400
 23 pheresis panel donors arrange to come monthly.
 24 Although this frequency of donations could be
 25 a possible problem if a donor were to become infected,

103

1 safeguards are provided by our knowing the donors
 2 concerned very well, by undertaking rather more
 3 rigorous health checks on them before embarking on
 4 pheresis and at regular intervals thereafter, by
 5 routinely screening every donation, and by keeping
 6 their donations in quarantine, frozen both at the
 7 Centre prior to shipping to BPL, and for several
 8 months at BPL before fractionation. Although we have
 9 no proof for our impression, we believe that pheresis
 10 donations may possible if anything, constitute
 11 a lesser risk from HIV 'window' infection of plasma
 12 for fractionation than conventional donations."

13 Looking at that, does that accord with your
 14 recollection that there was a different system for
 15 pheresis donations?

16 **A.** Yes.

17 **Q.** And you kept donations in quarantine until another
 18 test, effectively, had been taken to guard against
 19 the risk of a donation being taken during the window
 20 period?

21 **A.** Yes, that is a fair comment. The risk we felt would
 22 be significantly less.

23 **Q.** What was the position in Oxford in relation to
 24 products such as platelets, which needed to be used
 25 within a few hours of the donation being taken?

104

1 Was it possible to always test the platelets for
2 HTLV-III?

3 **A.** Yes, because the platelets would be collected on
4 day 0. The test would be done first thing next
5 morning, or even that same afternoon of day 0, then
6 they would be available for issue after testing had
7 been completed. There is a window of using platelets
8 for up to three days, possibly more.

9 **Q.** Was there any practice of putting warning labels or
10 providing any kind of warning on products that, for
11 example, the blood or the product may still contain
12 viruses because of this risk of donations being made
13 in the window period? Because clinicians would be
14 expecting, wouldn't they, post-HTLV-III testing coming
15 in, that the product would be free from HTLV-III, but
16 in fact there remained a risk, didn't there, that the
17 product may still contain HTLV-III?

18 **A.** There remained an exquisitely small risk, yes, but
19 I don't think any such warning was ever put onto
20 a product itself.

21 **Q.** Can we turn to a document just to get your evidence as
22 to whether or not you were aware of this document and,
23 if so, what you understood it to mean. It is
24 SHPL0000163_033.
25 It is a WHO Expert Committee on Biological

105

1 Standardisation, 29th report, and the date at the
2 bottom is not very clear -- 1978, I think it says.
3 Then if we turn over to the second page. We get the
4 more detailed title of the report which is
5 "Requirements for the Collection, Processing and
6 Quality Control of Human Blood and Blood Products".
7 If we can turn over, please, to page 18, the
8 particular that I wanted to ask you about is on the
9 right-hand side, B.3.6.

10 Can we go over to the next page. Perhaps we
11 will come back to that, we seem to be having a little
12 difficulty with getting that page up.

13 I can ask you the general question: was that
14 a publication that you were aware of and that was
15 something that you were familiar with?

16 **A.** No, I can't recall having ever seen that before until
17 a copy was sent to me recently.

18 **Q.** Can we try this document then, PRSE0001355. We have
19 an original Transfusion Directors meeting with you in
20 attendance on 20 January 1988. If we can turn,
21 please, to page 6 of that document.

22 We can see halfway down a title "Package insert
23 from Platelets":
24 "Dr Entwistle questioned the need to provide
25 a package insert for platelet preparations.

106

1 Discussions on this centred on the need for up-to-date
2 Notes on Transfusion (to which general package insert
3 might refer) and appropriate training of staff. It
4 was recalled that at the Product Liability Meeting,
5 Mr Evans, (Solicitor) had pointed out that it was also
6 necessary to anticipate what people may do wrong. The
7 Chairman asked Dr Moore to approach the DHSS
8 Solicitors for further advice."

9 Can you recall what this was about and why you
10 were questioning the need to provide a package insert?

11 **A.** At this time, I can't recall what that was about,
12 sorry.

13 **Q.** Do you think it was -- could it have been in order to
14 warn of contra -- in trajectories or risks of
15 platelets, in relation to platelets?

16 **SIR BRIAN LANGSTAFF:** There are two questions which
17 emerge. I thought you were asking about could he
18 recall why he was questioning the need for the insert.
19 Your question now seems to be what an insert might
20 have been there to do.

21 **MS SCOTT:** Yes.

22 **SIR BRIAN LANGSTAFF:** I think we may take it that
23 a package insert will say whatever a package insert
24 says. If Dr Entwistle can't remember then I don't
25 think he can probably help us further on this.

107

1 **MS SCOTT:** Okay, Thank you, sir.
2 I have a handful more questions to ask you in
3 relation to HIV.
4 Can we turn now to BPLL0010773. So this is
5 a letter from you to Dr Snape, dated 13 January 1986,
6 and you are answering various questions that have been
7 put to you. Paragraph 1, you explain that donations
8 at Oxford were tested from 7 October 1985. Then you
9 say this at paragraph 3:
10 "Retrospective investigation of any positives
11 that turn up will obviously be pursued up to six years
12 if possible."
13 I just wanted to ask you about the systems in
14 place in Oxford for, effectively, look back. So when
15 a donor tested positive, what action was taken by
16 Oxford to investigate whether any previous donations
17 had been used by patients?
18 So was there a system in place for carrying out
19 those investigations?

20 **A.** There was what I could best describe as an ad hoc
21 system, insofar as this was not a regular routine
22 activity. On the other hand, obviously, when
23 a positive case turned up, it would be necessary to go
24 back and see what we can find by way of further
25 information about that same donor.

108

1 Q. And do you know what the reference to six years -- why
 2 you were limiting it to going back six years?
 3 A. I was puzzled when I saw that this last few weeks.
 4 And I can only imagine it is because it was a general
 5 feeling that there was no risk of HIV in this country
 6 prior to about six years before the testing had
 7 started. In other words, the late 70s.
 8 Q. And do you recall whether, as part of the
 9 retrospective investigations you would have taken
 10 steps to try to ensure that the eventual recipient of
 11 a donation was informed that they may have HTLV-III?
 12 A. That is an obvious corollary why there was a positive,
 13 but I don't recall there ever being one.
 14 Q. And equally, would the retrospective investigations
 15 have included informing BPL or PFL that they had
 16 received infected or potentially infected donations?
 17 A. I think it was something they would need to know about
 18 in case they still had material in the system.
 19 Q. So that is something they should have known about.
 20 Can you recall whether or not that was something they
 21 were told about?
 22 A. No, I can't offhand, I'm sorry.
 23 Q. And were there any circumstances or do you have any
 24 recollection of whether or not information would have
 25 been provided to the haemophilia centre about the fate

1 of any infected donations?
 2 A. No, I don't recall any such information being passed
 3 on.
 4 Q. And then, just a further document on HIV look-back.
 5 NHBT0015108.
 6 It is a letter from Dr Gunson to all RTDs
 7 saying:
 8 "[He has] been asked by the Department of Health
 9 to contact you with respect to the identification of
 10 any possible blood donations which may be implicated
 11 of transmitting HIV to patients as a result of blood
 12 transfusion.
 13 "Could you please identify the blood donors that
 14 you have found to be confirmed HIV antibody positive
 15 since the commencement of testing and send a list of
 16 the donation numbers of the previous donations (if
 17 any) from these donors, together with the dates of
 18 delivery, to the Consultant Haematologist at the
 19 hospital concerned. Some of you may already have this
 20 information available from 'look-back' programmes.
 21 "The Department of Health are anxious that no
 22 potential beneficiaries are over-looked ..."
 23 This is some six years later than the letter we
 24 saw from you to Terry Snape, and you are being asked
 25 by Dr Gunson to carry out look-back. Can you recall

1 what action was taken as a result of this letter?
 2 A. Frankly, no, I can't.
 3 Q. Then last issue in relation to HIV, can we look,
 4 please, at NHBT0019630_003.
 5 So this is the witness statement that we looked
 6 at earlier, and if we can turn, please, to page 3 of
 7 that document. The second and third paragraphs you
 8 are talking about the stockpile of plasma that had
 9 built up at BPL as a result of the rebuilding of BPL,
 10 and the reduction in their ability to fractionate.
 11 It is at the third paragraph I want to pick it
 12 up. You say at the beginning of that paragraph that
 13 the problem with having the stockpile was that
 14 the HTLV-III testing came in and the stockpile was
 15 untested, and you say that the stockpile was
 16 affectionately referred to as the "iceberg". You go
 17 on to say this:
 18 "All Centres had to examine the records of all
 19 donations sequestered in the iceberg to see whether
 20 their corresponding donors had donated blood more
 21 recently, had been screened and had perhaps had proved
 22 positive for HIV 1. In Oxford we traced about
 23 two thirds of the many thousands of donors concerned
 24 and were able to confirm that they had subsequently
 25 been bled, tested and were found clear. We understand

1 that the remaining donations, from donors for whom no
 2 further information was available, could not be used,
 3 and have not been processed."
 4 So is it right to understand that the two-thirds
 5 of the donors that you did find, that was because they
 6 had subsequently come back to the centre to donate and
 7 had been -- their donations had been tested because
 8 HTLV-III screening had been introduced by that stage?
 9 A. That was my understanding, yes.
 10 Q. And then the third that you couldn't identify, that
 11 was because they hadn't returned to the centre to
 12 donate and so there were no tested donations for that
 13 third --
 14 A. That is correct.
 15 Q. Were any steps taken to try to get in touch with that
 16 cohort of donors, to see whether or not they would be
 17 willing to come back to the centre and have their --
 18 A. Not that I'm aware of.
 19 Q. I'm going to pick up now then with HCV and hepatitis C
 20 and look first at a document from October 1990.
 21 NHBT009472_050.
 22 We looked at some documents last week with the
 23 witnesses who gave oral evidence last week, and
 24 I don't intend to put you to the same documents that
 25 they looked at but I just want to show you a handful

1 of documents to get your evidence on what you can
2 recall about your thinking at the time.
3 It is NHBT009472_050.
4 No? Okay. Let me come back to that if we have
5 better luck with the system in relation to that one.
6 Can we try this document, NHBT0000074_030.
7 This is a letter you wrote to Dr Lloyd from the
8 northern -- Newcastle transfusion centre. We have
9 heard evidence that Dr Lloyd began testing at his
10 centre prior to the date that had been set for all
11 Regional Transfusion Centres to begin their HCV
12 testing.
13 It is a response to a letter to Dr Lloyd
14 informing Regional Transfusion Directors of this plan.
15 We have looked at it before so I don't propose to go
16 to it now, but for the transcript it is
17 NHBT0000073_014 and this is your response to that
18 letter. We can see here that you say:
19 "I am utterly dismayed at your proposal to break
20 ranks from the rest of the BTS of England and Wales by
21 embarking on HCV testing in the way you have
22 described.
23 "I know you already realise that we have
24 a National Directorate who have striven hard to try
25 and generate so cohesion into our Service and your

113

1 proposal can be viewed as nothing less than
2 destructive, when other Centres are aiming to
3 introduce their testing not so long afterwards.
4 I would have thought commonsense would have indicated
5 that we should all introduce testing for this reagent
6 from the same agreed date.
7 "I would fervently ask you to reconsider."
8 If I could ask you some questions about your
9 thinking in the light up to writing this letter. We
10 have heard evidence that the UK was -- introduced
11 testing rather later than a lot of other developed
12 countries. Was that something that you were aware of
13 at this time?
14 **A.** I know other countries were introducing it at
15 different rates but, on the other hand, that is not
16 surprising because we all have different resources
17 available at our disposal, but I was very firmly of
18 the opinion, as you will have gathered from this
19 letter, that, having got a National Directorate with
20 its own policy for the service as a whole, that we
21 should follow the directorate's policy and not break
22 ranks in this way. It could be argued that Dr Lloyd
23 was providing the additional benefit of having some
24 extra donations screened before, whereas others not,
25 but on the other hand I still think that the tone of

114

1 that letter was right, that it should have been done
2 as from the agreed date.
3 **Q.** Would you accept that, by introducing screening for
4 HCV earlier, Dr Lloyd was producing a safer product
5 for the patient?
6 **A.** That was not the issue. I would not disagree with
7 that in principle but that was not the issue which
8 I was referring to.
9 **Q.** But it was an issue, wasn't it? Wasn't that an issue
10 that needed to be weighed in the balance against the
11 issue that you have just spoken about, the issue of
12 cohesion and all centres beginning testing together,
13 would you agree with that?
14 **A.** I would agree it is another view but, on the other
15 hand, I felt then, and I still feel, that we had
16 an approximation to a national service, in this case
17 a National Directorate, and that we should have
18 followed the Directorate's guidelines. Potentially
19 that could lead to chaos if we all did things
20 differently.
21 **Q.** What was the concern about that? What chaos would
22 ensue if different -- testing was brought in at
23 different times at different centres?
24 **A.** Would it mean that some centres who were not testing
25 would have donors who might say this is unfair because

115

1 those people up the road have got blood which has been
2 tested and yet you can't do that for me. That is
3 an argument that could be put forward. I quite agree
4 with that. But I was concerned to establish the
5 screening in the approved manner in accordance with
6 the directorate view.
7 **Q.** So for you it was more important, was it, that there
8 should be cohesion amongst the Regional Transfusion
9 Centres than that the blood donations should be tested
10 for hepatitis C in some areas several months early?
11 **A.** I have already answered that question.
12 **SIR BRIAN LANGSTAFF:** I wonder if I may ask a question
13 arising out of this. Could we just have the letter
14 back up, please?
15 **MS SCOTT:** NHBT0000074_014.
16 **SIR BRIAN LANGSTAFF:** If we have got it, it is the last
17 sentence of the second paragraph:
18 "I would have thought commonsense would have
19 indicated we should all introduce testing for this
20 reagent from the same agreed date."
21 What were the particular aspects that make it
22 commonsense? "Commonsense" is a very misused word, it
23 often means "thinking as I do as opposed to you do".
24 So what were the particular aspects of commonsense
25 that you thought led to the same conclusion as you

116

1 were reaching?
 2 **A.** Well, this is another example of what had been amiss
 3 with the Blood Transfusion Service over the years.
 4 That people were doing things differently in different
 5 places. There wasn't commonality, and there were
 6 efforts being made, and the National Directorate was
 7 a first step in that direction, to try to get some
 8 commonality and uniformity throughout the system, so
 9 we all had the benefit of doing things in a cohesive
 10 manner.
 11 **SIR BRIAN LANGSTAFF:** So, in effect, the commonsense is
 12 the same point as the cohesion point?
 13 **A.** Yes.
 14 **SIR BRIAN LANGSTAFF:** Thank you.
 15 **MS SCOTT:** Is it right to understand that in relation
 16 to -- I think I will come back to that point. We will
 17 see if we can get the other document up that we were
 18 unable to see earlier.
 19 I'm going to turn now to the question of the
 20 arrangements in Oxford for counselling for
 21 hepatitis C. I think the best way to do that is
 22 through looking at the documents. Can we look at
 23 OXUH0001862_004.
 24 This is a letter, "Dear [blank]". Then if we go
 25 over the page we can see that it is from Dr Dike, the

1 associate specialist at the Regional Blood Transfusion
 2 Service. Dr Dike was leading, was she, I believe it
 3 is -- it is a female doctor, is that right? Was
 4 leading on the issue of donor counselling for
 5 hepatitis C, is that right?
 6 **A.** Correct.
 7 **Q.** And this letter appears to be to a blood donor who has
 8 tested positive for hepatitis C as a result of
 9 screening of the donation, and so -- the first
 10 paragraph just sets out some background and picking it
 11 up at the second paragraph:
 12 "I am writing to let you know that our newly
 13 introduced routine test for hepatitis C antibody has
 14 given positive results on your recent blood donation.
 15 This indicates that you have had an infection with the
 16 hepatitis C virus at some time, and therefore might be
 17 able to transmit this infection to a patient being
 18 transfused with your blood. I am sure you will
 19 appreciate that we cannot accept blood donations which
 20 might cause illness, and therefore I regret that we
 21 shall now have to remove your name permanently from
 22 the donor panel."
 23 Then it sets out some information about
 24 hepatitis C and the risk to the liver.
 25 And you say it usually causes a mild

1 inflammation of the liver -- or Dr Dike does, but
 2 a small proportion can become quite ill and have
 3 long-term effects. Then this:
 4 "I think we should inform your own doctor of the
 5 results as he may wish to discuss with you the
 6 possible need for other tests. I would be grateful if
 7 you could complete the enclosed form and return it to
 8 me. Your answers will be treated confidentially, and
 9 the information you give may be helpful in tracing
 10 cases of hepatitis and sources of infection. After
 11 I have received your reply I will send your doctor the
 12 results of our tests on your blood. I suggest you
 13 arrange to see your doctor about a week after you
 14 write back to me."
 15 Then over the page:
 16 "Your doctor should be able to answer any
 17 questions you may have in mind after reading this
 18 letter, but if you need further assistance please
 19 contact me."
 20 Then, again, making the point that they should
 21 never donate blood again.
 22 So is it right to understand that your practice
 23 for those donors that were HCV positive was not to
 24 make an appointment at the centre but to inform them
 25 of their infection by letter and seek permission to

1 share the diagnosis with the GP and for the GP to pick
 2 up the baton in terms of counselling and decisions
 3 about further treatment?
 4 **A.** Yes, that's fair.
 5 **Q.** And were you aware that other centres were carrying
 6 out different practice, that they were counselling
 7 donors themselves?
 8 **A.** I was not aware what other centres were doing. I had
 9 no occasion to ask.
 10 **Q.** And why was it that you took that route rather than
 11 having -- calling the donors in yourself? When I say
 12 "yourself", I mean calling the donor into the centre
 13 and the centre counselling the donors, at least
 14 initially?
 15 **A.** I can't recall what the thinking was behind that but
 16 that was the thinking that we adopted at that time.
 17 **Q.** And do you know -- there was an offer made by Dr Dike
 18 in this letter to the infected donor to call for
 19 a further information should the donor want to. Do
 20 you know whether or not such phone calls were received
 21 by the centre from donors for further information?
 22 **A.** I don't know offhand.
 23 **Q.** Then if we look, to complete the picture, at the
 24 letter then sent to the clinician, the GP rather, if
 25 we look at NHBT0053158.

1 Again, we have another letter here, "Dear
2 [blank]", from Dr Dike. This appears to be the letter
3 sent to the GP:
4 "Your patient is a new blood donor, and routine
5 testing of a blood donation taken on [blank] is
6 positive for hepatitis C antibody ... The donor has
7 been informed of this and has been given this
8 information to bring to you. We have further tested
9 [blank] blood for Hepatitis B, Syphilis and HIV 1 and
10 2 antibody and I enclose those results."
11 Then the letter goes on to give some information
12 about hepatitis C and encloses some information about
13 hepatitis C which the doctor may use to counsel the
14 patient with. And then some information about sending
15 samples to a virologist at Public Health Laboratory
16 Service.
17 So presumably this is the letter, is it, that
18 was sent to the GP if the infected donor gave consent
19 to the transfusion centre to get in contact with their
20 GP?
21 **A.** Indeed.
22 **Q.** I'm going to just ask you a couple of questions about
23 surrogate testing for what was then non-A, non-B.
24 I understand from your statement that surrogate
25 testing wasn't implemented at Oxford on whole blood

1 donations but it was implemented on -- or at least ALT
2 testing was implemented on plasmapheresis donations;
3 is that right?
4 **A.** Correct.
5 **Q.** What was the reason for that?
6 **A.** Well, for -- the main reason was that we were going to
7 see the plasmapheresis donors much more regularly,
8 much more frequently than we felt it was appropriate,
9 that we ought to try and take a closer look at them
10 for that reason. Even though we were well aware the
11 ALT test by itself is deeply flawed in terms of its
12 relevance to hepatitis C.
13 **Q.** But the thinking was, was it, that for a donor that
14 donated, and we saw in a previous document, once
15 a month, more stringent testing should -- or some
16 testing to -- even though imperfect, it was better to
17 have ALT testing than nothing at all?
18 **A.** It might help.
19 **Q.** How in practice did it actually work? If there was
20 a raised ALT reading on a plasmapheresis donation,
21 what would happen? Would the donor be deferred?
22 Would it be kept in quarantine? What would happen?
23 **A.** That donation would be quarantined, but -- and the
24 donor would be re-tested shortly afterwards -- well,
25 within the next month, and very frequently the ALT

1 test might be back down, normal, or whatever. The ALT
2 was a very unreliable test.
3 **Q.** So if the reading was then back to normal, would the
4 assumption be that this wasn't a non-A, non-B, this
5 was -- the ALT was raised for some other reason and
6 the donor could continue to donate and the donations
7 could continue be used?
8 **A.** That was our thinking at the time, bearing in mind
9 that there was no actual specific test for hepatitis C
10 at that time.
11 **Q.** And if the ALT reading continued to be elevated, what
12 would happen? If it was elevated in the second test
13 what would happen then?
14 **A.** We would seriously have to consider removing that
15 donor from the pheresis panel.
16 **Q.** And what would the donor be told?
17 **A.** They would be told that there appeared to be something
18 which was not quite normal but we did not know what it
19 meant. It is unlikely to be serious but we did not
20 know any more details at that time and subsequently
21 other tests might be able to confirm a different story
22 but that's all we could do at that time.
23 **Q.** And what impact did the introduction of ALT testing on
24 plasmapheresis donations have on the amount of
25 donations available from plasmapheresis donations,

1 were many quarantined?
2 **A.** No, they were not. There were very few.
3 **Q.** Did that tell you anything about the concerns that had
4 been raised about introducing ALT testing, the whole
5 blood donations?
6 **A.** It just raised another unknown, which didn't really
7 help in some respects. It helped only in the respect
8 that, well, perhaps this donor would be put to one
9 side for the time being, and then reviewed maybe a few
10 months down the line. But as I say, it was not
11 a reliable test, and most elevations of ALT are due to
12 other causes.
13 **Q.** Given the experience of plasmapheresis donations,
14 ie that the introduction of ALT testing had not had
15 an impact on the amount of donations available, was
16 there any re-thinking about the position, about the
17 decision to introduce ALT testing and surrogate
18 testing for whole blood donations?
19 **A.** Not really, for two reasons. One is that it was
20 a practical consideration of getting the test actually
21 done. And secondly, once again we had this question
22 of: what was the national policy? What was the
23 directorate thinking? Should we not be following in
24 the agreed pattern of behaviour?
25 **Q.** Is this right, even if you had been a supporter of ALT

1 testing, because of your views on the national policy,
2 you wouldn't have introduced it in any event?

3 **A.** I think that is true. What would have been the
4 obvious thing to do, if one has sufficient evidence to
5 be really dogmatic about it, is to go back to the
6 Directorate and say, "Look, this is the situation we
7 found, how about re-thinking your national policy?"

8 **Q.** I'm just going to ask you a handful of questions on
9 hepatitis B.

10 **SIR BRIAN LANGSTAFF:** Before you do that, this question of
11 whether to introduce surrogate testing is one which
12 arose before the National Directorate. So presumably
13 you were taking the same approach, before the National
14 Directorate itself was formed, to the way in which the
15 National Blood Service -- Transfusion Service was
16 actually operating?

17 **A.** Indeed. We were trying to do our best to treat people
18 much the same way if we possibly could, even though it
19 was sometimes very difficult.

20 **SIR BRIAN LANGSTAFF:** Part of the reasoning for
21 introducing a greater degree of cohesion was that
22 people were doing different things, to an extent?

23 **A.** To an extent they were, yes.

24 **SIR BRIAN LANGSTAFF:** Yes.

25 **A.** I don't think any other centre had seriously

125

1 that plasma?

2 **A.** I don't, except that some people may have thought it
3 was potentially safer. I don't know. But we were
4 getting a better price for it, that is true.

5 **Q.** I'm just going to ask you a handful of questions about
6 hepatitis B, NHBT0081007. This is a letter from
7 Dr Dike to Dr Barbara, enclosing the annual returns
8 for Oxford's HBsAg positive donors "as requested by
9 you".

10 Do you know why that information was being
11 provided to Dr Barbara by Oxford, other than obviously
12 he had asked for it?

13 **A.** I think, at that stage, which was relatively early, it
14 was only three years after screening was introduced,
15 Dr Barbara was very much involved in a programme of
16 collecting national data to try to determine what was
17 the exact national prevalence of HBsAg.

18 **Q.** I think it is three years after HTLV-III or HIV
19 testing has been introduced but I don't think it is --
20 it's quite a few years after HBsAg testing had been
21 introduced?

22 **A.** He was keeping the system going.

23 **Q.** Then the second paragraph there:

24 "On our computer system the donor number is more
25 permanent than the donation number. The latter gets

127

1 introduced surrogate testing.

2 **SIR BRIAN LANGSTAFF:** Do you know how many other centres
3 were ALT testing their plasma?

4 **A.** I just said, I don't know whether anyone else was
5 doing surrogate testing.

6 **MS SCOTT:** In fact, before we leave the question of ALT
7 testing plasma, can we just look at BPLL0010787.
8 Sorry, I have given you the wrong reference,
9 NHBT0000077_092. It is just the first paragraph of
10 that letter from your administrator to Dr Gunson,
11 13 March 1990:

12 "Dr Entwistle has advised me that we are going
13 to receive an increased sum for fresh frozen plasma
14 collected by plasma pheresis, which has been ALT
15 tested."

16 Do you know why that was?

17 **A.** Well, this follows on from what I was saying just now
18 about doing surrogate testing, such as it was, for
19 pheresis donors and the fresh frozen plasma collected
20 that way was part of that procedure.

21 **Q.** So --

22 **A.** So we were aiming to do ALT testing on -- to procure
23 fresh frozen plasma.

24 **Q.** Do you know why -- my question wasn't perhaps very
25 clear -- do you know why a higher price was paid for

126

1 lost in the archives once we have clocked up the
2 donation number '999,999FN'. I have now made sure
3 that all our HBsAg positive donors can be referred to
4 on our computer by their donor numbers ..."

5 What was the consequence of the problem with the
6 donation numbers? Did that make it difficult for you
7 to trace through donation numbers when you were
8 doing -- carrying out tasks like look-back?

9 **A.** It could make a difference in time for when the
10 donation numbers have exceeded that magic figure of
11 all the 9s. Hence that is why my colleague had to
12 devise a modification to the computer system to make
13 sure that those suspect donors would be picked up if
14 they came again.

15 **Q.** So, are you describing there a problem with the
16 computer system but that Dr Dike actually established
17 a workaround which meant that you could in fact trace
18 donors and their donation numbers, despite the problem
19 with the computer?

20 **A.** Yes, it was obviously imperative that we had to be
21 able to trace them if they turned up again.

22 **Q.** I'm just looking through my notes to see how much
23 longer I have got. I have probably got another 20 or
24 30 minutes, depending on whether or not we can get
25 those documents back up on the system. I don't know

128

1 whether now would be a good time for a break?
 2 **SIR BRIAN LANGSTAFF:** It depends whether it is 20 or 30.
 3 If you think it is more likely to be 20, let's go
 4 ahead and allow Dr Entwistle his tea break at 3.30 pm
 5 or thereabouts and come back with the questions which
 6 Core Participants may have.

7 If it is going to be half an hour, well, let's
 8 do it in two stages, have a break now and there will
 9 have to be a further break later on, doctor, to allow
 10 Core Participants to field -- to send their questions
 11 into counsel and for counsel to then ask you what
 12 others think would be helpful.

13 **MS SCOTT:** I think 20 minutes but I'm conscious that some
 14 of my -- I haven't asked some of my questions because
 15 the documents haven't come up on the screen.

16 **SIR BRIAN LANGSTAFF:** Let's try it. Shall we go ahead.

17 **MS SCOTT:** Yes, I think that's -- because I'm just going
 18 to ask you Dr Entwistle now some questions about
 19 records.

20 We have looked at *Notes on Transfusion*. We can
 21 come back to that document if necessary but there is
 22 a clear recommendation within that document for
 23 reports of transfusion-transmitted infections to be
 24 made by clinicians in hospitals to Regional
 25 Transfusion Centres. Was that something that the

129

1 clinicians in your area complied with? Did you get
 2 regular and timely information about
 3 transfusion-transmitted infections from the blood
 4 coming from your centre?

5 **A.** Frankly no. I had very few reports of any sort like
 6 that.

7 **Q.** Why do you think that was?

8 **A.** I don't know.

9 **Q.** Did you take any steps to try and improve that
 10 situation?

11 **A.** No, I don't think I did. I wasn't even aware that
 12 that was a problem, otherwise I would have taken
 13 steps.

14 **Q.** How is it you are aware of that now?

15 **A.** You are asking the questions about it.

16 **Q.** So it may be that, in fact, there wasn't a problem
 17 because there weren't any transfusion transmitted
 18 infections you just simply don't know?

19 **A.** There were very few that I ever heard of. There was
 20 one that I put in my witness statement, in fact, which
 21 may have been a transfusion-transmitted infection,
 22 although it was never finally proved, and that was the
 23 only one that I can recall.

24 **Q.** Again, we can go to the document if necessary but we
 25 looked earlier at the report on record keeping and

130

1 stock control, the report made to the Department of
 2 Health and Social -- the DHSS. I think you said you
 3 hadn't seen that report before but, in there, there is
 4 a recommendation for blood banks, hospital blood banks
 5 to make monthly returns to the Regional Transfusion
 6 Centre for reasons of stock control. So is that
 7 a system that was in place in Oxford when you were
 8 there?

9 **A.** Yes, it was.

10 **Q.** So how did that work? Was it a monthly return from
 11 each hospital blood bank, is that what you would
 12 expect?

13 **A.** I think it was nominally once a year, let's put it
 14 that way.

15 **Q.** So it was supposed to be monthly but it may be rather
 16 less frequently? What information was supposed to be
 17 and was, in fact, as a matter of generality, provided
 18 to the centre in those returns?

19 **A.** I'm sorry what was the question?

20 **Q.** What information was supposed to be provided in those
 21 returns and was, as a matter of general practice,
 22 provided?

23 **A.** Blood received and blood returned in date, if
 24 necessary. In other words, could not be used in time
 25 and that was an obvious thing which had to be done.

131

1 **Q.** So you would have a record of any unused blood?

2 **A.** Yes.

3 **Q.** So then you would assume, would you, that anything
 4 that had not been returned to you as unused had been
 5 given to a patient?

6 **A.** Yes, it is a fair comment.

7 **Q.** Did that system work quite well? As a matter of
 8 generality, was that complied with?

9 **A.** As far as I was aware, yes, it was but, as I say,
 10 I didn't personally look into the details of that so
 11 I can't answer any further questions than that.

12 **Q.** You were the Western division of the Blood Transfusion
 13 Service's representative on the retention of records
 14 working party, reporting to the National Directorate,
 15 is that right?

16 **A.** As far as I was aware, yes.

17 **Q.** You -- there was a piece of work done, is this right,
 18 by the working party about the number of years the
 19 Blood Transfusion Service should retain their records?

20 **A.** There was discussion about that but no firm
 21 conclusions were ever reached.

22 **Q.** So there is discussion about there being a 30 year
 23 retention period being appropriate, is that right?

24 **A.** There were discussions about different lengths of
 25 period for it to be retained and there was also

132

1 a suggestion that perhaps we should follow the
2 pharmaceutical industry, but then the question was
3 raised, "well, why, is it essential?" And I don't
4 recall there being a definitive decision taken as to
5 what the period of retention of records should
6 actually be or even which records. Different periods
7 could perhaps be kept for different records.

8 **Q.** Do you recall what the retention period for records in
9 the pharmaceutical industry was?

10 **A.** I think the figure of 30 years had been suggested.

11 **Q.** Just in relation to your practice in Oxford, you tell
12 us in your witness statement that the paper donor
13 record cards were kept indefinitely, as far as you
14 were aware; is that right?

15 **A.** Yes.

16 **Q.** Did you, at any time during your tenure in Oxford,
17 order the destruction of any records?

18 **A.** No.

19 **Q.** So is it right to say then that, during the period of
20 1980 to 1985, any records that were created in Oxford
21 would have been in Oxford until you left?

22 **A.** They should have been there, yes, either in the
23 written form on donor cards or on the computer records
24 and that was still ongoing.

25 **Q.** In relation to donors who were found positive for any

133

1 viral infection, what was the position in relation to
2 their records? Were they held indefinitely to ensure
3 that they didn't come back and donate again?

4 **A.** Correct.

5 **Q.** Were there any arrangements for sharing information
6 between Regional Transfusion Centres about such donors
7 to ensure that they didn't, for example, go and donate
8 in a different area?

9 **A.** Not that I was aware of, neither had we been asked to
10 do so.

11 **Q.** Can I just ask you to look at a document we looked at
12 this morning which is NHBT0006265, which is the 1990
13 Medicines Inspectorate Report.

14 If we turn, please, to page 9 of that document,
15 I just want to draw your attention to some of the
16 problems with the recordkeeping that were identified
17 in that 1990 visit. It says, second paragraph down:
18 "The procedure for dealing with donations which
19 test microbiologically positive is inadequate."
20 It goes on to give details, and then skipping
21 the next paragraph down to:
22 "The records kept in Microbiology of the
23 withdrawal and disposal of positive products are
24 totally inadequate. There is no list of the products
25 made, just the donation number. There is no record of

134

1 the final fate of the packs concerned, eg autoclaving
2 or held in the laboratory. The records, such as they
3 are, are incompletely maintained. There is no
4 procedure for follow-up if packs are not delivered to
5 Microbiology. There is no signed 'receipt' given to
6 Blood Products staff when packs are delivered to
7 Microbiology."

8 Then the next paragraph:
9 "The flaws in the procedure were highlighted
10 with case of the SAG-M red cell pack in the Grouping
11 Laboratory fridge ... It transpired that the donation
12 had been identified as TPHA positive but instead of
13 withdrawal and disposal, it had been put into Grouping
14 fridge. In order that a Group label could be issued
15 for it, the donation was entered as 'clear' on the
16 computer record. However, although the red cells were
17 held (albeit in the wrong fridge and the wrong
18 laboratory), the effect of altering the computer entry
19 was to enable the plasma to be cleared for issue.
20 Investigations during the inspection revealed that the
21 plasma had, in fact, been dispatched to Elstree some 3
22 weeks previously. (Steps were taken at the time of
23 inspection to have the pack recalled from Elstree.)"

24 So there in 1990 there are some quite serious
25 concerns raised about recordkeeping, and so on. I see

135

1 you shaking your head, what do you say about that?

2 **A.** It was a damning indictment of a totally inadequate
3 situation and, obviously, things had to be done to put
4 things right.

5 **Q.** And --

6 **A.** We could not go on that way.

7 **Q.** How long would you say that that inadequate situation
8 had been in place?

9 **A.** I have no idea. It is obviously something which was
10 recorded at the time but there is no evidence as to
11 how long that had been going on or why. But, plainly,
12 lack of supervision was very evident. And I plead
13 humble pie for that.

14 **Q.** Were steps taken by the centre to remedy the
15 inadequate system that was revealed in that report, in
16 that inspection?

17 **A.** Yes, we revised the system of the supervision
18 laboratories and my deputy, Dr Marlene Fisher, became
19 overall manager of the laboratory side of things. She
20 was a very bright girl and very efficient and things
21 looked up considerably after that.

22 **Q.** Turning then to hepatitis C look-back. Again, I'm
23 going to do this via reference to the documents. So
24 NHBT0087333. So this is a letter from 21 October 1986
25 to somebody from Dr Dike, and it says:

136

1 "We have been told by the Public Health
2 Department that you have had hepatitis recently. I am
3 sorry to hear this and do hope you are feeling better
4 now.

5 "If you are or have been a blood donor please
6 will you let me know when and where you last gave
7 blood. I should be most grateful if you could also
8 let me have details of any close contacts of yours if
9 they are blood donors."

10 Is it right to understand that, certainly in
11 1986, you were being informed by the Public Health
12 Department of cases of viral hepatitis in your area,
13 so that you could do investigations to see whether or
14 not they were blood donors?

- 15 **A.** This was not a regular feature and this is an odd one.
16 **Q.** So it is not, as far as you can recall -- it wasn't
17 a common occurrence that every time there was a case
18 of viral hepatitis you were informed and you did
19 investigations?
20 **A.** Yes, something like this was an odd occurrence.
21 **Q.** If we turn over the page to page 3, you can see that
22 that letter is dated 21 October. We can see on
23 page 3 -- it is a handwritten date the day before,
24 "Searched -- no trace as donor". So it looks like you
25 are notified, you do a search, there is no trace of

1 the person being a blood donor but, nevertheless, you
2 write to them to ask whether or not they have been
3 a blood donor. Does that sound -- I think you said
4 this was an odd one. It wasn't something that you
5 think happened regularly?

- 6 **A.** -- (Overspeaking) --
7 **Q.** Can we turn then to NHBT0057093_002. So this is
8 Standard Operating Procedure in relation to
9 transfusion-transmitted hepatitis. It says there, we
10 can see it under "Edition", date effective
11 6 July 1992. It replaces a previous one from -- is
12 that from 1991? Is that what we understand that
13 number there, 1003/02 91 01?
14 **A.** I believe so, yes.
15 **Q.** Can you recall whether or not you had standing
16 operating procedures in relation to
17 transfusion-transmitted hepatitis from -- well, it
18 certainly looks like from 2001. Do you think there
19 could have been such procedures earlier than 2001 --
20 sorry, 1991?
21 **A.** I would think if it wasn't -- I couldn't tell you the
22 precise date when they were introduced but by the
23 time -- 1991/1992, I would think that is likely.
24 I can't think of a precise date.
25 **Q.** So then is this fair, there may have been earlier

- 1 versions but you are not sure, but 1991 --
2 **A.** I'm not sure.
3 **Q.** -- certainly there were?
4 This seems to deal with the situation whereby
5 you are informed by a clinician that there has been
6 an infection of transfusion-transmitted hepatitis in
7 a patient. So if we look over at page 2, you can see
8 what's supposed to happen on receipt of paragraph 1 --
9 well, the aim is to trace donors who may have
10 transmitted hepatitis in order to prevent a recurrence
11 and, if possible, to prevent any other components of
12 the current blood donation from being used, and it
13 sets out there what you have to do on receipt of
14 a verbal or written report that a patient is suspected
15 of having TTH, a full inquiry is to be made.
16 Then paragraph 3:
17 "All the blood donations involved must be
18 retested ..."
19 Just pausing there. Can you recall when the
20 centre started keeping serum samples of blood
21 donations? How far back would you have been able to
22 test?
23 **A.** I can't tell you offhand, I don't recall.
24 **Q.** Do you think that was something that was introduced
25 during your tenure or something that you inherited?

- 1 **A.** It probably was, but it's a practical detail that
2 I wasn't involved in and I can't recall when it was
3 introduced.
4 **Q.** Then:
5 "All the blood donors involved must be suspended
6 from the donor panel. Each one is sent a standard
7 letter and questionnaire ... together with an
8 addressed box and sample tubes ..."
9 For further tests to be able to be undertaken,
10 or they are asked to visit the doctor.
11 Then if we go over the page to paragraph 6:
12 "When all the results of the donors'
13 questionnaires and blood tests and the patient's
14 clinical details are known, an assessment is made ...
15 to resolve the questions:
16 "a) Did the patients have the TTH?
17 "and if so
18 "b) Which donor transmitted the infection?
19 "Letters are written to all the donors involved,
20 telling them whether or not they are thought to have
21 transmitted infection, and explaining that they have
22 now been either reinstated or withdrawn."
23 If we then turn on to the position in 1994, the
24 national look-back programme, if we look at
25 NHBT0055409_001.

1 Just before I do ask you questions about the
2 national look-back, in relation to the standard
3 operating procedure in 1991 and 1992, have you -- do
4 you know how common it was for look-back to be
5 undertaken under those standing operating procedures
6 at Oxford?

7 **A.** I honestly don't know because I personally wasn't
8 involved in that part of the centre's activities. And
9 I can't answer the question I'm sorry.
10 **Q.** If we look then on 20 September 1994, there's
11 a handwritten letter from you to Dr Ala, "Re: HCV
12 look-back". You say in the first paragraph:
13 "We agree in principle that look-back to
14 recipients of blood from donors now found HCV positive
15 is something which should be pursued. Those
16 recipients who have survived so far could be
17 identified and counselled and some will need further
18 investigation and treatment. The scale of clinical
19 involvement here needs to be assessed, and costs of
20 treatment determined, and money found! Not easy.
21 Hepatologists should be on board."

22 If you carry on down:

23 "We think around 150 patients may exist on our
24 patch. We don't have the resources at this stage to
25 undertake this extra work."

141

1 Do you know how you came to an estimate of
2 150 patients who may exist on your patch?
3 **A.** Yes. Well, we were aware by that stage that the
4 likely incidence of hepatitis C in the population as
5 a whole was going to be a lot less than the number of
6 screen test positives. We knew that the screen test
7 positive rate was in the order of one in every 200,
8 which means the number of genuine positives is perhaps
9 1 in every 2,000. And on that basis we would see
10 somewhere in the order of one every week during the
11 first year of screening.

12 So there would be -- we had something like
13 120,000 donors a year, which would mean something
14 like -- sorry, donations a year, which would mean
15 there would be about six -- about 50,000 coming twice
16 a year, on average, and about 10,000 new donors in
17 a given year.

18 At the rate of 0.1% we would see somewhere in
19 the order of possibly 300 or so cases a year, not 150,
20 which is our first guess.

21 **SIR BRIAN LANGSTAFF:** Can you just help me with the
22 figures there. One in 200 is a figure of 0.5 of a
23 percent, I think, and the rate that you have just
24 quoted is 0.1 of a per cent. Can you help with what
25 I'm comparing there?

142

1 **A.** I'm sorry, Sir Brian, can I correct myself, please?

2 **SIR BRIAN LANGSTAFF:** Yes, of course.

3 **A.** I think the figures should read 0.1% screen positive
4 and 0.01 genuine positive.

5 **SIR BRIAN LANGSTAFF:** Very well. Thank you.

6 **MS SCOTT:** Now, the instructions on the national look-back
7 from Dr Robinson were promulgated in January 1995 with
8 further guidance provided in April 1995, and we can
9 look at those documents if necessary. You had
10 an opportunity to look at those prior to giving your
11 evidence. But conscious as I am that you retired in
12 September 1995, and given that the evidence you have
13 given so far is that Dr Dike was leading, as
14 I understand it, on look-back and donor counselling,
15 are you able to help us with the steps that were taken
16 at Oxford in order to comply with the national HCV
17 look-back programme in 1995 before your retirement?

18 **A.** I hate to have to say this but I think I must be
19 perfectly honest. The National Blood Authority had
20 instituted independent assessors to look at all
21 transfusion centres and the Service as a whole, and
22 this took place during 1994.

23 The message was coming across loud and clear in
24 Oxford that the Oxford Centre was vulnerable to the
25 possibility of being closed. No decision was taken

143

1 until during 1995.

2 Now, in the June of 1995, beginning of June,
3 I was summoned to the National Blood Authority
4 premises in Watford and I was told point blank that
5 the Oxford Centre was indeed going to be, and I quote,
6 "closed". So you can imagine that over the course of
7 the preceding months our attention was not exactly
8 focused where it should have been. And indeed I was
9 told, as I said, that the centre was going to
10 effectively close, my own personal position was going
11 to disappear, and that is why I opted to take early
12 retirement. And I must be quite honest, I almost lost
13 interest.

14 **Q.** And so I think -- am I right in understanding that the
15 answer to my question, in terms of can you help us
16 with what steps, if any, given your answer, were taken
17 at Oxford in order to put into place the HCV
18 look-back, you are not able to help us with that?

19 **A.** Well, I can tell you something, if I may be allowed to
20 advise you on something which happened after
21 I retired. Is that allowed?

22 **Q.** Absolutely, yes.

23 **A.** Dr Dike in fact, who was looking after the HCV
24 situation, did look at the number of people who were
25 positive, identified them, and indeed -- but didn't

144

1 have enough staffing resources to be able to do
 2 the appropriate chasing up for look-back, going into
 3 the hospitals and looking up the patients. She did do
 4 that after I retired, when she got some additional
 5 help, and in fact I think she looked at some
 6 350 donors who had been positive. And if I recall
 7 correctly, about two-thirds of those were still
 8 available and still alive.

9 **MS SCOTT:** Sir, that, subject to working on whether I need
 10 to ask anything arising from the documents we couldn't
 11 get on the system beforehand -- I will just have
 12 a think about that -- concludes my questioning.

13 **SIR BRIAN LANGSTAFF:** Well, it was certainly a lot nearer
 14 to 20 than 30 minutes, so thank you.

15 We will take a break now. You are going to
 16 field questions from Core Participants?

17 **MS SCOTT:** Yes.

18 **SIR BRIAN LANGSTAFF:** Shall we give you until 4.00 to do
 19 that?

20 **MS SCOTT:** Yes, Thank you, sir.

21 **SIR BRIAN LANGSTAFF:** 4.00, if you don't mind, doctor.
 22 What happens now, as I have described earlier, is that
 23 a number of questions are suggested to counsel to ask,
 24 I don't know how many that will be, maybe a lot, maybe
 25 a few, but if you would come back at 4.00, then

1 counsel will ask those questions.
 2 It won't then take very much longer, I suspect,
 3 but I can't be absolutely certain before your
 4 testimony is finished.

5 **A.** Thank you, Sir Brian.

6 **SIR BRIAN LANGSTAFF:** 4.00.
 7 (3.37 pm)

8 (A short break)

9 (4.00 pm)

10 **SIR BRIAN LANGSTAFF:** Yes.

11 **MS SCOTT:** Dr Entwistle, I have a handful of questions to
 12 ask you on topics from Core Participants and their
 13 legal representatives.

14 You gave some evidence about having informal
 15 discussions with clinical colleagues in local
 16 hospitals and the question is whether during those
 17 discussions or otherwise you discussed the need to
 18 minimise the use of blood or blood products, given
 19 your awareness of the unavoidable risk that they
 20 carry?

21 **A.** I don't think we specifically discussed that but
 22 I think one of the take-home messages, which I will
 23 try to convey, is that transfusion, just like any
 24 other medical intervention, is a form of treatment
 25 which may have risks, maybe small, maybe big, whatever

1 those risks are the clinician using transfusion should
 2 do so bearing in mind the need and the possible
 3 alternatives that could be used.

4 The need, bearing in mind the risks.

5 **Q.** We looked at a document which referred to making
 6 a visit to New Orleans. Did you visit any blood banks
 7 when you were in America?

8 **A.** No, I didn't, because I was privileged to have a very
 9 brief visit to go to the American Association of Blood
 10 Banks meeting but it didn't allow me time to divert on
 11 to local blood banks, which would have been very
 12 interesting, yes, I have no doubt, but I just didn't
 13 have the time to do that, I'm afraid.

14 **Q.** Now, I have been asked to ask you a question about the
 15 arrangements with BPL for pro rata or whether you got
 16 back a pro rata amount for the plasma that you
 17 provided. I have got a couple of documents I can take
 18 you to to prompt your memory about that unless you are
 19 able to answer it without going to documents.

20 **A.** Well, I think I can. At one stage in the early '80s,
 21 we were a bit behind in terms of what we were required
 22 to produce, but from about mid-'80s onwards we had no
 23 problem, we were well on track.

24 **Q.** Can I -- I will, in fact, I think, take you to
 25 a couple of documents just to make sure we have got

1 the full picture.
 2 The first one is CBLA0001380.
 3 So this is a letter from -- if we go over to the
 4 second page, it is from Dr Lane to you, dated
 5 12 June 1981, and if we go back to the first page,
 6 Dr Lane says:
 7 "As you know, Oxford and Wessex are the only
 8 regions that do not appear on the pro rata league
 9 table for factor VIII supply, the reason being that
 10 all Oxford plasma and half Wessex plasma is
 11 fractionated at PFL and the system of fractionation
 12 vis a vis data collection does not appear to
 13 correspond with that at BPL."
 14 Then if we go down to the big paragraph
 15 starting:
 16 "I have requested that Oxford plasma and Wessex
 17 plasma be brought into line with other regions ..."
 18 Then he sets out the advantages and
 19 disadvantages of that and the arguments.
 20 Then if we go over the page he concludes by
 21 saying -- the arguments either way, sorry -- "Removing
 22 this final irregularity", I think he means there
 23 Oxford and Wessex not being involved in the pro rata
 24 system:
 25 "... will not create difficulties but in the

1 long run is a much better guarantee of improved
 2 service and supply of factor VIII to Oxford and Wessex
 3 than at present. I hope to obtain your agreement with
 4 the points set out in this letter, and would ask you
 5 to obtain mutual agreement on these matters with
 6 Dr Rizza at the Oxford Haemophilia Centre."
 7 Then if we look then at CBLA0001389, we can see
 8 your reply, which is 23 June 1981, and you say:
 9 "Thank you for your letter of 12th June ...
 10 "I set up a meeting yesterday with Ethel
 11 Bidwell, Jim Smith, Terry Snape, Dr Rizza and myself
 12 to discuss this whole matter. We all agree that the
 13 proposed new arrangements are probably not a great
 14 deal more than a paper exercise in terms of accounting
 15 for what goes where. It appears that the practices
 16 relating to distribution will remain unchanged, and
 17 that any Factor VIII produced either at PFL or Elstree
 18 from Oxford material will continue to be issued direct
 19 to the Oxford Haemophilia Centre. We are satisfied
 20 that it would be proper for the Oxford Centre to come
 21 in line with the others, and it is right that we
 22 should contribute to the Lord Mayor Treloar School.
 23 We also appreciate the advantages of Oxford production
 24 being buffered in the event of unforeseen hiccups with
 25 their batches."

149

1 Then you say at the next paragraph:
 2 "One point which I think should not be forgotten
 3 is that about half of the patients that come to the
 4 Oxford Haemophilia Centre are referred from outside
 5 the Region, and this very often is because they are
 6 the more difficult cases to deal with. This point
 7 will not be lost when I put my next submission to the
 8 RHA for funds to increase our plasma collection."
 9 Is it right to understand that, prior to this
 10 exchange of correspondence, you weren't in the
 11 pro rata system but following this exchange of
 12 correspondence Oxford was brought into line with the
 13 other Regional Transfusion Centres?
 14 **A.** Yes, that was my understanding, and I think this was
 15 largely a historical phenomenon, in that, of course,
 16 the Churchill Hospital is also the location of where
 17 the Oxford Haemophilia Centre is and that's how PFL
 18 got involved with that in the first place. As time
 19 went by and the demand for products went up, and up,
 20 and up PFL could no longer cope anyway and BPL had to
 21 assume the fractionation for everybody.
 22 So, in fact, the redistribution was actually
 23 simplified.
 24 **Q.** Were you aware that Dr Contreras in the Edgware Centre
 25 had a leaflet that was supplemental to the nationally

150

1 agreed material provided to donors? A supplemental
 2 questionnaire which donors could fill in
 3 confidentially to identify whether or not they were in
 4 high-risk groups. Was that something that was brought
 5 to your attention?
 6 **A.** Not that I can recall, no. And was she the only one
 7 to have that?
 8 **Q.** The evidence that she gave last week was that that was
 9 something that she and Dr Barbara came up with after
 10 visiting America, and that was something that they
 11 instituted in the Edgware Centre. I do not think she
 12 gave evidence about whether or not that was put in
 13 place in other centres. That is not something you
 14 were aware of?
 15 **A.** No.
 16 **Q.** You were asked questions this morning about donations
 17 sessions undertaken with military personnel, and you
 18 said they were extremely beneficial. I have been
 19 asked to ask you what you mean by that.
 20 **A.** Well, normally we reckoned to have about 100 to
 21 120 donors at a session. One particular one at
 22 a military establishment, they rang up during the
 23 course of the morning, "Could we keep going over
 24 lunchtime?"
 25 "All right. If you must."

151

1 We finished up with 240-odd donations that day.
 2 Which was -- well, all I can say is that the staff
 3 concerned were brilliant.
 4 **MS SCOTT:** Those are all the questions I'm going to ask
 5 from the Core Participants and the legal
 6 representatives.
 7 **SIR BRIAN LANGSTAFF:** I have none of my own.
 8 **MS SCOTT:** Dr Entwistle, is there anything that you would
 9 like to say at this stage?
 10 **A.** Yes, if I may.
 11 Firstly, can I say what a tremendous amount of
 12 work, Ms Scott, that you and your colleagues must have
 13 done to sort out these documents. You have done
 14 a tremendous job. And coming from a non-transfusion
 15 background, I think you are to be congratulated. And
 16 I think that all I have to say. But thank you all
 17 very much for your attention and I wish you well with
 18 whatever the outcome may be.
 19 **SIR BRIAN LANGSTAFF:** Thank you, from my perspective, and
 20 my congratulations to you, if I may, for the careful
 21 way you have given your evidence. You have given,
 22 clearly, evidence which, when you have been asked
 23 a question, you have actually thought about the answer
 24 in order to try to get it right. And that gives one
 25 confidence that you are telling us what you know and

152

1 what you don't know as best you now recollect it, and
 2 given us the insight you have into the position that
 3 the Oxford Centre took, that is the transfusion
 4 centre, and its slight remove from the Oxford
 5 Haemophilia Centre, which got its supplies elsewhere.
 6 But thank you for that and also for giving us
 7 another view on when a director of a Regional
 8 Transfusion Centre first knew of the various
 9 particular challenges to blood. It was a fascinating
 10 account, in particular to listen to how you had, in
 11 effect, been the first person in our blood transfusion
 12 system to start a test for hepatitis B. It is a pity
 13 that you didn't have -- of it is perhaps a credit to
 14 you that you had the humility not to claim rather more
 15 forcefully than you did the credit for that but thank
 16 you.
 17 **A.** Thank you, sir.
 18 **MS SCOTT:** Tomorrow, sir, we have the evidence of
 19 Dr Galea.
 20 **SIR BRIAN LANGSTAFF:** Yes, so tomorrow, 10.00, Dr Galea.
 21 (4.12 pm)
 22 (Adjourned until 10.00 am on Tuesday, 7 December 2021)
 23
 24
 25

1 **INDEX**

2 DR COLIN CARRUTHERS ENTWISTLE 1
 (sworn)

3 Questions from MS SCOTT 1
 4
 5
 6
 7
 8
 9
 10
 11
 12
 13
 14
 15
 16
 17
 18
 19
 20
 21
 22
 23
 24
 25

<p>MS SCOTT: [34] 2/2 15/20 19/20 20/20 20/23 20/25 24/4 41/19 42/24 44/2 44/6 49/16 71/10 73/10 73/13 89/17 89/25 90/20 92/10 107/21 108/1 116/15 117/15 126/6 129/13 129/17 143/6 145/9 145/17 145/20 146/11 152/4 152/8 153/18 SIR BRIAN LANGSTAFF: [52] 1/3 1/6 1/8 1/10 1/14 2/1 15/13 15/16 15/19 19/1 19/19 20/18 20/21 20/24 24/3 41/18 43/2 43/20 44/3 48/10 49/10 71/9 73/9 73/11 89/20 90/1 90/9 90/19 92/8 107/16 107/22 116/12 116/16 117/11 117/14 125/10 125/20 125/24 126/2 129/2 129/16 142/21 143/2 143/5 145/13 145/18 145/21 146/6 146/10 152/7 152/19 153/20 THE WITNESS: [4] 1/5 1/7 1/9 1/12</p> <hr/> <p>'80s [2] 147/20 147/22 '82 [1] 76/5 '83 [2] 75/19 76/5 '85 [1] 92/22 '999,999FN' [1] 128/2 'Blood [1] 70/7 'called' [1] 29/1 'clear' [1] 135/15 'good' [1] 52/21 'Hs' [1] 80/16 'look [1] 110/20 'look-back' [1] 110/20 'medical [1] 57/7 'Non [2] 44/16 47/1 'Non-A [2] 44/16 47/1 'Notes [1] 45/25 'receipt' [1] 135/5 'shambles' [1] 36/20 'the [1] 69/19 'There [1] 37/14 'walk [1] 29/5 'walk-ins' [1] 29/5 'window' [2] 102/13 104/11</p> <hr/> <p>/Sexually [1] 95/6</p>	<p>0 0.01 [1] 143/4 0.1 [2] 142/18 143/3 0.1 of [1] 142/24 0.5 [1] 142/22 001 [2] 42/5 140/25 002 [3] 67/7 83/24 138/7 003 [2] 101/19 111/4 004 [2] 71/4 117/23 008 [1] 72/10 01 [1] 138/13 011 [1] 50/5 014 [2] 113/17 116/15 016 [1] 36/11 030 [1] 113/6 033 [1] 105/24 050 [2] 112/21 113/3 066 [1] 91/4 068 [1] 71/20 092 [1] 126/9</p> <hr/> <p>1 1 August 1984 [1] 67/23 1 September 1983 [1] 74/4 1,000 [2] 84/5 84/7 1.03 pm [1] 90/16 10 [2] 29/14 62/14 10 May 1990 [1] 21/5 10 October 1984 [1] 68/8 10,000 [1] 142/16 10.00 [3] 1/2 153/20 153/22 100 [2] 1/18 151/20 100 pints [1] 37/12 1003/02 91 01 [1] 138/13 101 [1] 57/8 101/P [1] 71/9 1011 [1] 71/7 105 [1] 27/8 11 [3] 41/4 63/7 95/4 11.14 [1] 43/17 11.45 [3] 43/8 43/16 43/19 110 [3] 57/5 59/25 71/6 110A [6] 57/4 59/21 59/24 60/2 60/7 60/12 114,000 [1] 21/25 12 [1] 8/7 12 June 1981 [1] 148/5 12 months [1] 64/22 12 September 1987 [1] 36/16 120 [2] 20/2 22/6 120 donors [1] 151/21</p>	<p>120,000 [1] 142/13 12th June [1] 149/9 13 January 1986 [1] 108/5 13 March 1990 [1] 126/11 13,000 [1] 84/4 14 [2] 42/8 42/9 14 June 1983 [1] 77/3 140 [1] 26/18 148 [1] 50/15 149 [1] 50/24 150 [2] 141/23 142/19 150 patients [1] 142/2 160 [1] 51/6 18 [2] 60/7 106/7 19 [1] 46/21 1958 [1] 2/5 1959 [1] 2/8 1963 [1] 2/10 1965 [4] 71/7 71/11 71/14 90/25 1968 [3] 2/12 3/4 5/15 1970s [1] 44/14 1972 [1] 18/19 1974 [3] 3/9 5/15 18/24 1977 [3] 55/5 55/8 91/2 1978 [1] 106/2 1979 [3] 21/12 21/14 25/3 1980 [8] 3/9 3/13 3/20 19/23 30/1 30/4 47/22 133/20 1981 [3] 4/4 148/5 149/8 1982 [11] 8/11 41/11 41/11 41/14 50/8 53/16 73/2 73/21 74/9 75/23 84/24 1983 [11] 46/5 51/18 53/16 60/12 60/13 71/24 74/4 76/11 77/3 81/21 88/11 1984 [20] 45/12 46/6 55/3 55/4 59/18 59/20 60/10 61/5 61/8 67/6 67/9 67/23 68/8 83/23 84/1 84/18 84/23 84/25 85/25 89/6 1985 [16] 71/12 71/21 71/21 71/25 72/22 87/18 89/10 89/13 89/15 90/25 93/14 98/9 99/22 100/3 108/8 133/20 1986 [3] 108/5 136/24 137/11 1987 [3] 36/16 37/17 37/25 1988 [3] 26/18 28/18</p>	<p>106/20 1989 [4] 21/25 24/3 24/4 88/22 1990 [14] 4/9 21/5 22/25 24/2 26/23 28/18 72/9 72/22 101/25 112/20 126/11 134/12 134/17 135/24 1991 [7] 4/15 4/18 4/21 138/12 138/20 139/1 141/3 1991/1992 [1] 138/23 1992 [7] 4/21 42/1 42/5 42/8 138/11 138/23 141/3 1993 [4] 4/25 5/4 20/15 20/21 1994 [5] 4/18 4/25 140/23 141/10 143/22 1995 [9] 3/13 20/18 20/20 143/7 143/8 143/12 143/17 144/1 144/2</p> <hr/> <p>2 2,000 [1] 142/9 2.00 [3] 90/13 90/15 90/15 2.00 pm [1] 90/18 2.69 million [1] 21/24 20 [6] 14/24 128/23 129/2 129/3 129/13 145/14 20 January 1988 [1] 106/20 20 October 1989 [1] 88/22 20 September 1994 [1] 141/10 200 [3] 29/3 142/7 142/22 2001 [2] 138/18 138/19 202 [2] 22/1 22/2 2021 [2] 1/1 153/22 21 October [1] 137/22 21 October 1986 [1] 136/24 23 June 1981 [1] 149/8 24 [1] 44/11 24-hour [1] 2/19 240-odd [1] 152/1 26 years [1] 25/8 28 February 1983 [1] 51/18 28 March 1984 [1] 84/1 29th [1] 106/1</p> <hr/> <p>3 3.30 pm [1] 129/4</p>	<p>3.37 pm [1] 146/7 30 [2] 50/14 129/2 30 minutes [3] 14/24 128/24 145/14 30 years [2] 25/8 133/10 300 [1] 142/19 350 donors [1] 145/6</p> <hr/> <p>4 4 January 1990 [1] 101/25 4 October 1985 [1] 98/9 4.00 [4] 145/18 145/21 145/25 146/6 4.00 pm [1] 146/9 4.12 pm [1] 153/21 400 [1] 103/22 48 [1] 35/21</p> <hr/> <p>5 50 [3] 24/25 29/5 29/9 50,000 [1] 142/15 560 [1] 27/8 5th [1] 35/20</p> <hr/> <p>6 6 December 2021 [1] 1/1 6 July 1992 [1] 138/11 6.1 [1] 27/3 6.1.2 [1] 28/25 6th July [1] 89/3</p> <hr/> <p>7 7 December 1984 [1] 85/25 7 December 2021 [1] 153/22 7 October 1985 [1] 108/8 70 [1] 47/5 70s [1] 109/7 7th [1] 78/16 7th June [1] 89/2</p> <hr/> <p>8 87 [1] 44/13</p> <hr/> <p>9 90 [1] 44/21 9s [1] 128/11</p> <hr/> <p>A abandoned [1] 100/22 abbreviation [1] 24/14 ability [5] 34/10 36/1 36/4 79/10 111/10 able [22] 24/19 26/6</p>	<p>26/9 32/7 71/19 86/6 92/17 93/1 93/2 95/16 95/24 111/24 118/17 119/16 123/21 128/21 139/21 140/9 143/15 144/18 145/1 147/19 about [146] 3/9 6/10 7/2 13/1 14/24 15/6 16/6 18/19 19/21 20/2 22/6 22/10 23/10 25/19 26/13 27/6 27/8 29/5 29/9 29/14 30/23 31/6 34/3 34/8 39/13 40/19 42/24 43/3 43/3 43/14 44/8 44/22 47/13 48/7 48/15 49/16 49/16 49/18 49/22 49/24 53/11 54/8 54/20 56/9 56/14 56/16 56/25 57/3 58/17 59/13 59/14 59/24 61/14 63/3 64/10 67/19 70/15 72/3 72/16 74/5 75/17 76/17 77/1 78/11 78/13 78/14 79/2 79/18 80/4 80/6 81/23 82/6 82/9 82/15 82/20 82/22 84/3 85/15 85/19 86/14 91/7 93/20 96/5 98/19 99/17 102/4 102/5 102/7 102/15 106/8 107/9 107/11 107/17 108/13 108/25 109/6 109/17 109/19 109/21 109/25 111/8 111/22 113/2 114/8 115/11 115/21 118/23 119/13 120/3 121/12 121/12 121/14 121/22 124/3 124/4 124/16 124/16 125/5 125/7 126/18 127/5 129/18 130/2 130/15 132/18 132/20 132/22 132/24 134/6 135/25 136/1 141/1 142/15 142/15 142/16 145/7 145/12 146/14 147/14 147/18 147/22 150/3 151/12 151/16 151/20 152/23 above [1] 77/9 abroad [1] 72/15 absence [1] 88/25 absolute [1] 98/13 absolutely [3] 41/19 144/22 146/3 abusers [2] 62/18 80/18 accept [8] 62/1 65/1 65/14 77/21 78/7</p>
---	--	---	---	--	---

<p>A</p> <p>accept... [3] 102/16 115/3 118/19</p> <p>acceptable [2] 68/13 77/19</p> <p>accepted [11] 62/3 62/21 63/12 63/18 64/9 64/17 64/25 65/16 98/16 98/20 99/2</p> <p>accepting [1] 64/21</p> <p>access [3] 21/22 95/16 96/7</p> <p>accord [5] 8/12 29/8 41/6 60/13 104/13</p> <p>accordance [1] 116/5</p> <p>according [1] 37/22</p> <p>accords [1] 42/11</p> <p>account [2] 62/8 153/10</p> <p>accountability [1] 20/22</p> <p>accountable [1] 20/4</p> <p>accounting [1] 149/14</p> <p>accurate [2] 15/24 42/10</p> <p>Acheson [1] 93/18</p> <p>achieved [1] 87/25</p> <p>acknowledged [1] 44/19</p> <p>Acquired [1] 62/16</p> <p>acquisition [1] 95/25</p> <p>acronym [2] 15/17 19/2</p> <p>across [3] 14/23 80/10 143/23</p> <p>act [1] 88/19</p> <p>action [2] 108/15 111/1</p> <p>actions [1] 61/25</p> <p>actively [1] 38/7</p> <p>activities [3] 75/12 76/17 141/8</p> <p>activity [1] 108/22</p> <p>actual [4] 6/17 10/24 14/1 123/9</p> <p>actually [19] 8/2 8/22 13/22 18/16 27/18 54/13 68/15 76/7 81/19 85/8 93/1 94/22 122/19 124/20 125/16 128/16 133/6 150/22 152/23</p> <p>acute [1] 47/6</p> <p>ad [2] 52/18 108/20</p> <p>add [1] 26/16</p> <p>Addenbrooke's [3] 8/25 8/25 9/3</p> <p>additional [4] 28/3 28/7 114/23 145/4</p> <p>additive [2] 24/11</p>	<p>24/13</p> <p>address [1] 75/10</p> <p>addressed [5] 70/6 83/18 89/22 89/23 140/8</p> <p>adequate [2] 64/3 97/4</p> <p>Adjourned [1] 153/22</p> <p>adjournment [1] 90/17</p> <p>administrative [1] 55/23</p> <p>administrator [1] 126/10</p> <p>administrators [2] 51/19 51/19</p> <p>admitted [1] 62/10</p> <p>adopt [1] 77/19</p> <p>adopted [6] 13/6 18/8 18/11 18/16 97/5 120/16</p> <p>advantages [2] 148/18 149/23</p> <p>advice [9] 54/4 66/15 68/3 68/22 68/24 69/1 76/16 88/9 107/8</p> <p>advise [2] 95/2 144/20</p> <p>advised [1] 126/12</p> <p>advisers [1] 95/9</p> <p>Advisory [1] 52/6</p> <p>affect [1] 61/25</p> <p>affecting [1] 44/4</p> <p>affectingly [1] 111/16</p> <p>afraid [1] 147/13</p> <p>Africa [2] 62/19 74/23</p> <p>after [22] 1/14 3/1 5/18 5/24 11/1 17/25 44/14 90/13 101/15 102/11 105/6 119/10 119/13 119/17 127/14 127/18 127/20 136/21 144/20 144/23 145/4 151/9</p> <p>afternoon [2] 90/20 105/5</p> <p>afterwards [3] 17/24 114/3 122/24</p> <p>again [27] 3/25 4/9 9/22 22/2 31/5 39/16 39/18 43/21 44/21 51/24 55/7 56/15 61/5 61/17 63/6 71/24 72/19 84/22 119/20 119/21 121/1 124/21 128/14 128/21 130/24 134/3 136/22</p> <p>against [7] 75/5 85/5 92/2 97/4 103/3 104/18 115/10</p> <p>agar [3] 14/15 15/4</p>	<p>19/7</p> <p>age [1] 56/14</p> <p>aggressive [6] 45/1 78/18 78/20 78/25 79/4 79/5</p> <p>aggro [1] 81/3</p> <p>ago [2] 25/8 64/22</p> <p>agree [9] 66/11 66/17 72/8 72/20 115/13 115/14 116/3 141/13 149/12</p> <p>agreed [10] 35/14 66/16 76/14 86/21 98/13 114/6 115/2 116/20 124/24 151/1</p> <p>agreement [2] 149/3 149/5</p> <p>ahead [3] 38/6 129/4 129/16</p> <p>Aids [53] 59/20 61/3 61/8 61/13 62/13 62/23 72/1 72/3 72/4 72/6 72/18 72/19 72/21 72/25 73/2 73/4 73/6 73/15 74/1 74/5 74/12 74/13 74/22 74/24 75/3 75/17 77/17 78/14 78/18 79/18 80/7 80/15 81/7 81/17 81/23 82/6 82/12 82/19 84/1 85/3 85/21 86/3 86/5 86/8 86/15 86/15 87/12 89/5 89/8 89/19 93/12 95/10 98/20</p> <p>aim [1] 139/9</p> <p>aiming [2] 114/2 126/22</p> <p>Air [1] 42/7</p> <p>Airport [1] 13/24</p> <p>Ala [1] 141/11</p> <p>albeit [1] 135/17</p> <p>alert [2] 18/3 18/6</p> <p>alive [1] 145/8</p> <p>all [69] 11/5 11/13 12/16 13/6 13/13 16/1 16/3 16/7 16/18 17/9 19/13 19/17 25/21 27/1 35/16 38/20 40/13 40/13 40/21 43/14 52/23 59/6 62/20 69/5 70/7 70/10 71/3 72/5 76/14 76/14 76/18 77/4 85/23 90/23 93/16 93/25 94/24 96/10 97/10 97/12 99/16 99/24 101/20 110/6 111/18 111/18 113/10 114/5 114/16 115/12 115/19 116/19 117/9 122/17 123/22 128/3 128/11</p>	<p>139/17 140/5 140/12 140/19 143/20 148/10 149/12 151/25 152/2 152/4 152/16 152/16</p> <p>alleging [1] 69/23</p> <p>allow [5] 27/25 43/4 129/4 129/9 147/10</p> <p>allowed [2] 144/19 144/21</p> <p>almost [2] 59/8 144/12</p> <p>alone [1] 86/20</p> <p>along [2] 33/5 77/6</p> <p>already [8] 33/8 53/14 82/9 82/10 84/24 110/19 113/23 116/11</p> <p>also [48] 3/2 4/1 4/17 4/20 5/2 5/8 6/21 9/5 9/7 9/10 11/24 14/18 18/13 23/17 27/4 31/6 31/10 31/18 33/10 39/15 39/15 41/9 41/10 41/23 44/17 46/25 47/2 47/5 52/20 58/14 65/16 65/23 68/11 76/9 77/21 78/10 81/20 95/11 97/20 99/1 99/5 103/17 107/5 132/25 137/7 149/23 150/16 153/6</p> <p>ALT [18] 122/1 122/11 122/17 122/20 122/25 123/1 123/5 123/11 123/23 124/4 124/11 124/14 124/17 124/25 126/3 126/6 126/14 126/22</p> <p>altering [1] 135/18</p> <p>alternative [4] 88/4 94/3 94/12 94/19</p> <p>alternatives [1] 147/3</p> <p>although [8] 3/2 21/20 35/13 74/17 103/24 104/8 130/22 135/16</p> <p>altogether [2] 66/4 74/12</p> <p>always [4] 7/10 32/7 42/14 105/1</p> <p>am [21] 1/2 1/9 15/17 43/17 43/19 49/7 49/8 54/10 64/19 65/23 69/3 69/4 72/19 92/2 113/19 118/12 118/18 137/2 143/11 144/14 153/22</p> <p>America [3] 81/20 147/7 151/10</p> <p>American [2] 81/13 147/9</p> <p>amiss [1] 117/2</p> <p>amongst [1] 116/8</p>	<p>amount [7] 30/17 30/24 52/18 123/24 124/15 147/16 152/11</p> <p>amounts [4] 25/13 25/23 98/21 101/2</p> <p>an accepted [1] 63/18</p> <p>an ad [1] 108/20</p> <p>an adequate [1] 64/3</p> <p>an appointment [1] 119/24</p> <p>an appropriate [1] 23/19</p> <p>an approved [2] 63/19 75/9</p> <p>an approximation [1] 115/16</p> <p>an argument [1] 116/3</p> <p>an arrangement [1] 34/9</p> <p>an attendance [1] 29/4</p> <p>an attitude [1] 76/2</p> <p>an audience [1] 1/16</p> <p>an awful [1] 76/7</p> <p>an electric [1] 14/22</p> <p>an entry [1] 67/10</p> <p>an estimate [1] 142/1</p> <p>an exquisitely [1] 105/18</p> <p>an extent [2] 125/22 125/23</p> <p>an hour [1] 43/4</p> <p>an HTLV III [1] 96/14</p> <p>an HTLV-III [1] 94/20</p> <p>an idea [1] 20/17</p> <p>an impact [1] 124/15</p> <p>an increase [1] 26/12</p> <p>an increased [1] 126/13</p> <p>an independent [1] 86/24</p> <p>an individual [1] 87/24</p> <p>an infection [3] 16/24 118/15 139/6</p> <p>an infectious [2] 72/13 72/15</p> <p>an inordinate [1] 82/6</p> <p>an input [1] 32/14</p> <p>an insert [1] 107/19</p> <p>an instruction [1] 88/14</p> <p>an issue [3] 36/14 115/9 115/9</p> <p>an NBA [1] 5/5</p> <p>an obligation [1] 96/18</p> <p>an obvious [2] 109/12 131/25</p> <p>an odd [3] 137/15 137/20 138/4</p>	<p>an offer [1] 120/17</p> <p>an open [2] 61/18 78/25</p> <p>an open-donor [1] 79/8</p> <p>an opportunity [2] 59/2 143/10</p> <p>an ordinary [1] 27/17</p> <p>an original [1] 106/19</p> <p>anaemia [3] 6/18 11/5 27/16</p> <p>Anglia [2] 8/6 11/25</p> <p>Anglian [2] 6/23 10/3</p> <p>announced [1] 93/25</p> <p>announcement [1] 98/23</p> <p>annoyed [1] 81/1</p> <p>annoyed/irritated/puz zled/upset [1] 81/1</p> <p>annual [2] 51/1 127/7</p> <p>another [16] 24/18 30/23 36/10 36/11 37/8 38/17 51/14 70/18 83/22 104/17 115/14 117/2 121/1 124/6 128/23 153/7</p> <p>answer [9] 25/16 80/3 119/16 132/11 141/9 144/15 144/16 147/19 152/23</p> <p>answered [1] 116/11</p> <p>answering [1] 108/6</p> <p>answers [5] 56/24 79/17 79/18 79/24 119/8</p> <p>anti [2] 63/11 64/3</p> <p>anti-HBs [2] 63/11 64/3</p> <p>antibodies [1] 86/7</p> <p>antibody [19] 13/19 14/5 14/16 15/2 19/9 19/13 64/3 72/6 72/21 93/13 94/4 94/25 96/14 98/14 102/10 110/14 118/13 121/6 121/10</p> <p>anticipate [1] 107/6</p> <p>anticipated [1] 11/21</p> <p>anticoagulant [1] 24/12</p> <p>antigen [12] 13/5 13/11 13/14 13/16 13/19 14/1 14/6 19/14 63/20 63/22 64/11 64/15</p> <p>anxiety [1] 83/19</p> <p>anxious [1] 110/21</p> <p>any [94] 6/19 9/18 11/6 12/3 12/6 12/15 12/17 12/18 13/25 14/11 16/15 17/13 18/16 24/10 25/17</p>
--	--	---	--	---	--

(41) accept... - any

<p>A</p> <p>any... [79] 25/21 28/3 30/2 30/5 30/8 34/22 39/14 40/2 40/17 40/17 40/18 40/18 42/17 42/19 42/19 43/11 48/3 50/4 53/4 53/21 57/5 57/18 57/18 57/24 60/24 62/3 62/10 62/10 65/6 69/21 69/22 69/24 70/5 70/13 71/25 72/17 74/8 75/19 76/11 80/8 82/14 88/6 96/23 99/11 100/22 103/5 105/9 105/10 105/19 108/10 108/16 109/23 109/23 110/1 110/2 110/10 110/17 112/15 119/16 123/20 124/16 125/2 125/25 130/5 130/9 130/17 132/1 132/11 133/16 133/17 133/20 133/25 134/5 137/8 139/11 144/16 146/23 147/6 149/17</p> <p>any loophole [1] 69/21</p> <p>anybody [1] 97/14</p> <p>anyone [5] 43/13 43/14 46/18 96/23 126/4</p> <p>anything [9] 16/21 17/12 43/14 49/6 104/10 124/3 132/3 145/10 152/8</p> <p>anyway [7] 17/11 64/9 64/17 100/9 100/14 102/21 150/20</p> <p>anywhere [1] 14/12</p> <p>apart [2] 33/21 76/8</p> <p>apheresis [5] 27/4 27/10 27/11 28/2 36/2</p> <p>apparent [4] 35/12 69/19 92/20 92/20</p> <p>apparently [1] 37/22</p> <p>appear [5] 68/23 71/25 89/2 148/8 148/12</p> <p>appeared [2] 17/9 123/17</p> <p>appears [5] 16/23 86/5 118/7 121/2 149/15</p> <p>appended [1] 60/9</p> <p>appendix [4] 62/13 62/14 63/6 63/7</p> <p>appendix 1 [4] 62/13 62/14 63/6 63/7</p> <p>applied [3] 14/22</p>	<p>66/25 67/1</p> <p>apply [4] 19/12 80/19 81/2 98/14</p> <p>applying [1] 65/19</p> <p>appointed [5] 2/10 3/4 3/20 5/20 22/18</p> <p>appointment [2] 70/4 119/24</p> <p>appreciate [3] 96/5 118/19 149/23</p> <p>approach [7] 66/21 78/17 78/19 78/21 83/6 107/7 125/13</p> <p>approached [1] 38/11</p> <p>approaches [1] 96/8</p> <p>appropriate [13] 23/19 29/6 32/22 67/2 82/11 83/13 83/20 96/2 97/25 107/3 122/8 132/23 145/2</p> <p>appropriately [1] 63/25</p> <p>approved [3] 63/19 75/9 116/5</p> <p>approximately [3] 84/4 84/5 103/22</p> <p>approximation [2] 8/18 115/16</p> <p>April [1] 143/8</p> <p>April 1995 [1] 143/8</p> <p>archives [1] 128/1</p> <p>are [95] 1/8 1/8 1/16 1/20 15/9 21/21 26/12 26/25 27/16 28/17 28/17 28/19 29/1 29/6 34/1 37/1 40/23 43/5 43/9 44/3 46/20 47/2 47/12 51/8 52/25 53/8 59/11 62/7 64/9 64/10 64/12 64/14 64/19 72/12 72/24 74/11 78/1 78/8 78/9 78/20 79/16 79/20 81/7 81/18 82/9 84/2 84/10 94/24 95/13 96/5 97/6 100/6 104/1 107/16 108/6 110/21 110/22 110/24 111/8 114/2 124/11 126/12 128/15 130/14 130/15 134/23 135/3 135/3 135/4 135/6 135/24 137/3 137/5 137/9 137/25 139/1 139/5 140/10 140/14 140/19 140/20 143/15 144/18 145/15 145/23 147/1 147/18 148/7 149/13 149/19 150/4 150/5 152/4 152/15 152/25</p> <p>area [12] 21/21 33/24 34/11 34/14 34/16</p>	<p>34/23 36/12 38/17 85/18 130/1 134/8 137/12</p> <p>areas [1] 116/10</p> <p>aren't [1] 64/13</p> <p>argued [2] 85/11 114/22</p> <p>argument [1] 116/3</p> <p>arguments [2] 148/19 148/21</p> <p>arise [1] 54/3</p> <p>arises [1] 89/20</p> <p>arising [6] 21/22 23/9 81/23 86/13 116/13 145/10</p> <p>Armed [1] 8/10</p> <p>arose [1] 125/12</p> <p>around [5] 4/25 18/19 21/25 29/3 141/23</p> <p>arrange [3] 53/4 103/23 119/13</p> <p>arranged [3] 18/1 94/8 95/19</p> <p>arrangement [6] 7/3 33/18 34/9 34/11 39/3 94/7</p> <p>arrangements [15] 51/21 52/2 52/4 87/21 88/4 91/7 92/5 92/24 93/20 94/19 95/15 117/20 134/5 147/15 149/13</p> <p>arrangements' [1] 69/20</p> <p>arrive [1] 5/18</p> <p>arrived [9] 5/15 5/18 20/2 25/5 25/9 31/15 39/4 47/19 83/11</p> <p>article [5] 36/22 36/25 37/17 37/22 48/3</p> <p>articles [2] 36/15 36/20</p> <p>as [177] 13/1 13/8 19/20 30/22 31/5 33/20 34/3 34/7 48/7 48/15 49/16 51/14 54/20 56/9 58/15 58/18 60/23 61/14 62/4 67/19 76/25 91/7 91/10 93/20 98/18 106/8 106/13 108/2 108/13 114/7 114/8 116/12 120/9 121/22 125/8 127/5 129/11 129/18 134/11 138/2 141/1 145/10 145/23 146/1 146/12 147/14 149/4 151/19 152/4</p> <p>asked [28] 1/15 26/2 26/10 34/22 43/12</p>	<p>44/22 51/9 61/19 61/19 63/3 70/6 72/6 72/12 78/12 78/12 80/5 92/13 107/7 110/8 110/24 127/12 129/14 134/9 140/10 147/14 151/16 151/19 152/22</p> <p>asking [4] 44/8 61/17 107/17 130/15</p> <p>asks [1] 52/1</p> <p>aspects [2] 116/21 116/24</p> <p>assessed [1] 141/19</p> <p>assessment [4] 57/1 57/21 85/20 140/14</p> <p>assessors [1] 143/20</p> <p>assist [1] 95/9</p> <p>assistance [1] 119/18</p> <p>associate [1] 118/1</p> <p>associated [2] 73/15 81/7</p> <p>association [2] 75/17 147/9</p> <p>assume [3] 47/8 132/3 150/21</p> <p>assumption [1] 123/4</p> <p>attached [1] 69/9</p> <p>attend [3] 60/18 70/4 88/24</p> <p>attendance [5] 29/4 29/15 70/11 86/1 106/20</p> <p>attendance: [1] 84/14</p> <p>attendance: none [1] 84/14</p> <p>attendant [1] 10/23</p> <p>attendants [2] 6/16 10/11</p> <p>attended [4] 3/19 4/1 10/13 12/9</p> <p>attender [1] 3/21</p> <p>attending [2] 5/2 17/18</p> <p>attends [1] 28/20</p> <p>attention [8] 46/24 52/25 53/2 87/23 134/15 144/7 151/5 152/17</p> <p>attitude [1] 76/2</p> <p>attitudes [1] 77/15</p> <p>audience [3] 1/16 1/17 1/18</p> <p>audit [2] 42/2 42/5</p> <p>August [1] 67/23</p> <p>Australian [1] 13/14</p> <p>authorise [2] 7/8 7/10</p> <p>authorities [6] 49/5 51/24 52/1 87/19 89/22 96/18</p> <p>authority [12] 20/5 20/9 20/11 38/24 53/4</p>	<p>90/2 91/11 91/15 91/21 94/9 143/19 144/3</p> <p>Authority's [1] 4/24</p> <p>autoclaving [1] 135/1</p> <p>autonomy [1] 55/15</p> <p>available [29] 16/17 40/11 59/18 60/5 61/10 66/5 74/7 76/10 76/24 77/6 77/12 79/23 83/9 83/16 85/9 86/8 86/16 89/6 94/5 95/9 95/11 96/4 105/6 110/20 112/2 114/17 123/25 124/15 145/8</p> <p>average [3] 29/13 102/17 142/16</p> <p>avoid [2] 94/13 95/2</p> <p>aware [46] 13/13 18/13 22/20 30/1 30/2 30/5 30/6 37/24 38/9 38/16 41/21 41/23 44/14 44/17 47/16 47/18 47/22 47/25 48/5 53/7 54/7 65/23 65/24 68/11 73/2 73/4 73/6 73/14 88/14 97/12 105/22 106/14 112/18 114/12 120/5 120/8 122/10 130/11 130/14 132/9 132/16 133/14 134/9 142/3 150/24 151/14</p> <p>awareness [1] 146/19</p> <p>away [1] 16/16</p> <p>awful [2] 76/7 81/3</p> <p>awfully [1] 92/4</p>	<p>143/6 143/14 143/17 144/18 145/2 145/25 147/16 148/5</p> <p>back' [2] 37/16 110/20</p> <p>background [2] 118/10 152/15</p> <p>bad [2] 37/7 85/3</p> <p>badged [1] 5/5</p> <p>balance [2] 79/13 115/10</p> <p>bank [6] 3/1 8/3 11/15 11/20 51/4 131/11</p> <p>banking [1] 51/5</p> <p>banks [16] 7/12 8/7 8/13 33/11 51/8 52/5 52/14 52/19 53/6 53/19 101/15 131/4 131/4 147/6 147/10 147/11</p> <p>Barbara [4] 127/7 127/11 127/15 151/9</p> <p>Barts [1] 95/20</p> <p>based [8] 2/24 11/4 27/2 31/3 33/9 33/10 51/3 95/12</p> <p>basis [7] 10/9 31/14 31/17 51/1 87/24 94/4 142/9</p> <p>batch [1] 100/18</p> <p>batches [1] 149/25</p> <p>baton [1] 120/2</p> <p>be [267]</p> <p>bear [1] 1/19</p> <p>bearing [7] 75/2 77/15 82/25 96/3 123/8 147/2 147/4</p> <p>bears [1] 98/17</p> <p>became [10] 4/23 19/22 23/3 47/25 66/5 73/1 73/3 76/10 97/8 136/18</p> <p>because [48] 5/20 5/22 8/24 15/1 15/25 17/24 26/13 27/14 27/17 27/22 31/24 36/6 41/21 53/13 55/9 62/3 64/12 66/23 68/17 69/6 70/17 76/6 78/5 78/10 78/23 83/13 86/19 88/9 92/19 93/2 100/4 100/16 105/3 105/12 105/13 109/4 112/5 112/7 112/11 114/16 115/25 125/1 129/14 129/17 130/17 141/7 147/8 150/5</p> <p>become [9] 18/2 35/12 73/6 94/5 102/9 102/10 102/18 103/25 119/2</p> <p>becomes [1] 52/19</p>
--	---	---	---	--	--

(42) any... - becomes

<p>B</p> <p>becoming [1] 74/24</p> <p>bed [1] 70/14</p> <p>beds [2] 10/24 11/16</p> <p>been [134] 1/15 2/10 5/19 7/9 9/1 10/8 14/22 17/25 18/2 18/11 23/14 25/25 26/1 26/2 26/3 26/6 26/9 26/10 27/14 27/24 28/18 29/23 32/7 32/8 38/6 38/10 38/13 38/19 38/19 41/23 44/14 46/1 46/18 47/4 52/6 54/10 55/8 57/23 58/16 58/25 59/4 59/16 59/21 60/1 61/1 61/3 61/9 61/10 63/14 63/25 66/3 68/11 68/18 70/15 70/17 71/2 71/15 71/17 71/19 72/14 79/10 85/17 88/18 91/1 96/17 99/12 99/22 99/23 99/24 100/4 100/7 100/11 100/12 100/12 100/20 101/9 101/11 101/13 101/16 102/14 103/2 104/18 105/7 107/13 107/20 108/6 108/17 109/25 110/8 111/21 111/25 112/3 112/7 112/7 112/8 113/10 115/1 116/1 117/2 121/7 121/7 124/4 124/25 125/3 126/14 127/19 127/20 130/21 132/4 132/4 133/10 133/21 133/22 134/9 135/12 135/13 135/21 136/8 136/11 137/1 137/5 138/2 138/19 138/25 139/5 139/21 140/22 144/8 145/6 147/11 147/14 151/18 152/22 153/11</p> <p>before [46] 5/20 14/9 14/11 16/6 21/16 25/4 29/24 31/14 34/9 43/20 47/16 48/10 51/14 65/23 67/19 70/5 70/24 71/14 76/10 83/16 87/16 88/6 88/20 90/24 91/7 91/9 92/17 99/3 100/4 100/8 102/22 104/3 104/8 106/16 109/6 113/15 114/24 125/10 125/12 125/13 126/6</p>	<p>131/3 137/23 141/1 143/17 146/3</p> <p>beforehand [2] 9/1 145/11</p> <p>began [2] 20/24 113/9</p> <p>begin [2] 43/20 113/11</p> <p>beginning [5] 85/1 93/22 111/12 115/12 144/2</p> <p>behalf [2] 49/1 49/3</p> <p>behaviour [1] 124/24</p> <p>behind [2] 120/15 147/21</p> <p>being [65] 13/6 16/15 17/21 18/14 18/23 19/12 21/2 23/8 25/10 25/14 26/18 27/2 27/8 28/12 29/2 29/7 41/21 49/3 54/16 59/13 59/15 61/19 61/19 65/25 68/13 72/8 75/18 77/5 77/18 78/12 78/12 80/5 82/8 83/10 85/9 86/9 87/7 89/14 92/13 92/14 99/8 101/22 102/15 102/19 102/22 104/19 104/25 105/12 109/13 110/2 110/24 117/6 118/17 124/9 127/10 132/22 132/23 133/4 137/11 138/1 139/12 143/25 148/9 148/23 149/24</p> <p>belief [2] 81/21 81/22</p> <p>believe [3] 104/9 118/2 138/14</p> <p>below [1] 72/7</p> <p>beneficial [2] 12/10 151/18</p> <p>beneficiaries [1] 110/22</p> <p>benefit [6] 24/18 42/4 94/17 95/22 114/23 117/9</p> <p>best [10] 9/23 44/10 49/24 53/22 56/23 95/21 108/20 117/21 125/17 153/1</p> <p>better [9] 23/15 23/16 44/17 58/22 113/5 122/16 127/4 137/3 149/1</p> <p>between [19] 3/9 4/21 5/3 5/15 14/21 31/8 34/20 51/1 52/12 53/5 53/18 56/16 71/12 74/5 75/16 75/21 89/11 90/25 134/6</p> <p>Bidwell [1] 149/11</p> <p>big [4] 32/19 92/1</p>	<p>146/25 148/14</p> <p>Bill [1] 89/1</p> <p>Biological [1] 105/25</p> <p>Birthplace [1] 71/7</p> <p>bisexual [1] 62/17</p> <p>bit [7] 7/2 22/9 23/1 23/10 34/7 45/24 147/21</p> <p>bizarre [1] 25/11</p> <p>blank [1] 92/8 117/24 121/2 121/5 121/9 144/4</p> <p>blanket [1] 82/14</p> <p>bled [5] 12/4 27/8 27/12 63/20 111/25</p> <p>bleed [1] 35/15</p> <p>bleeding [2] 30/8 34/16</p> <p>blood [176]</p> <p>Blood: [1] 50/8</p> <p>Blood: Record [1] 50/8</p> <p>blue [2] 7/11 67/13</p> <p>board [2] 75/1 141/21</p> <p>body [2] 38/19 38/20</p> <p>Booklet [1] 93/12</p> <p>borne [2] 25/22 85/17</p> <p>both [8] 33/16 55/23 62/7 62/18 95/1 101/13 103/7 104/6</p> <p>bothered [1] 85/18</p> <p>bottom [10] 21/3 28/15 35/8 46/23 52/8 60/11 68/3 94/23 98/11 106/2</p> <p>box [1] 140/8</p> <p>box' [1] 57/7</p> <p>BPL [17] 5/4 30/16 30/19 32/11 32/15 32/22 39/16 39/25 40/2 104/7 104/8 109/15 111/9 111/9 147/15 148/13 150/20</p> <p>BPLL0010773 [1] 108/4</p> <p>BPLL0010787 [1] 126/7</p> <p>branch [1] 39/24</p> <p>Brasseur [1] 67/24</p> <p>break [16] 43/1 43/2 43/6 43/7 43/18 87/17 88/20 89/19 113/19 114/21 129/1 129/4 129/8 129/9 145/15 146/8</p> <p>Brian [4] 1/5 91/9 143/1 146/5</p> <p>brief [2] 2/4 147/9</p> <p>briefly [1] 19/6</p> <p>bright [1] 136/20</p> <p>brilliant [1] 152/3</p> <p>bring [2] 85/22 121/8</p>	<p>Bristol [2] 2/7 3/11</p> <p>British [4] 5/9 5/9 5/11 36/22</p> <p>broke [1] 91/9</p> <p>brought [7] 23/8 87/23 93/21 115/22 148/17 150/12 151/4</p> <p>BTS [4] 35/11 77/7 84/11 113/20</p> <p>buffered [1] 149/24</p> <p>building [4] 8/24 9/4 92/17 93/6</p> <p>built [1] 111/9</p> <p>Bury [1] 67/24</p> <p>but [144] 1/12 1/17 1/22 7/7 8/11 11/17 13/12 13/22 14/19 14/24 16/4 16/17 16/22 17/19 18/13 21/16 22/9 23/2 23/17 24/10 25/11 25/14 25/17 28/10 28/11 29/17 31/14 33/14 33/21 34/23 37/1 41/5 41/22 42/4 43/14 43/22 45/1 46/10 47/3 48/4 49/6 53/25 54/15 56/5 58/20 59/9 59/17 60/4 66/2 66/13 68/12 68/13 69/3 69/20 70/10 70/19 70/25 71/14 72/1 72/2 72/18 73/17 73/19 75/2 76/1 78/1 78/4 78/24 80/11 81/18 85/4 85/11 88/19 90/7 90/9 90/10 91/2 91/15 93/9 96/6 97/9 97/23 97/25 100/10 100/10 101/8 101/9 101/12 105/15 105/18 109/13 112/25 113/16 114/15 114/17 114/25 115/7 115/9 115/14 116/4 119/1 119/18 119/24 120/15 122/1 122/13 122/23 123/18 123/19 123/22 124/10 127/3 127/19 128/16 129/13 129/21 130/24 131/3 131/15 132/9 132/20 133/2 135/12 136/10 136/11 138/1 138/22 139/1 139/1 140/1 143/11 143/18 144/25 145/25 146/3 146/21 147/10 147/12 147/22 148/25 150/11 152/16 153/6 153/15</p> <p>by [126] 1/15 2/10 4/5 4/9 8/4 9/11 9/20 10/2 10/9 15/15 18/8 18/11</p>	<p>18/18 21/2 22/23 23/8 24/1 25/22 25/24 27/10 29/25 30/3 30/7 30/16 31/4 31/14 32/11 32/13 32/19 32/22 32/23 36/2 37/2 38/11 39/6 39/7 40/14 40/19 42/2 42/8 45/6 45/18 46/1 46/14 46/25 47/2 47/12 47/18 47/22 48/18 49/12 50/13 50/17 52/6 53/14 53/15 55/7 55/17 57/6 57/6 57/24 57/24 59/18 61/8 61/9 63/18 63/25 67/14 68/6 69/23 70/9 70/16 72/11 73/7 73/20 74/3 74/20 75/18 76/14 76/18 77/21 82/13 82/13 82/19 84/18 84/25 86/20 87/25 92/23 94/7 94/9 97/9 101/13 101/14 103/15 104/1 104/2 104/4 104/5 108/15 108/17 108/24 110/8 110/25 112/8 113/20 115/3 119/25 120/17 120/21 122/11 126/14 127/8 127/11 128/4 129/24 132/18 136/14 137/1 137/11 138/22 139/5 142/3 148/20 150/19 151/19</p>	<p>101/2 101/16 101/21 111/14 128/14 142/1 151/9</p> <p>can [174]</p> <p>can't [28] 13/12 15/12 22/7 46/7 46/10 46/10 54/10 54/19 56/4 67/3 68/9 99/17 100/6 101/9 101/12 106/16 107/11 107/24 109/22 111/2 116/2 120/15 132/11 138/24 139/23 140/2 141/9 146/3</p> <p>candidate [1] 57/22</p> <p>cannot [5] 15/25 27/21 69/3 99/2 118/19</p> <p>card [3] 57/8 76/23 89/9</p> <p>Cardiff [1] 2/25</p> <p>cards [4] 83/10 83/12 133/13 133/23</p> <p>care [6] 4/4 54/21 55/1 55/14 67/11 96/24</p> <p>career [2] 2/5 3/20</p> <p>careful [1] 152/20</p> <p>carefully [1] 60/17</p> <p>carried [2] 14/1 103/2</p> <p>CARRUTHERS [2] 1/24 154/2</p> <p>carry [7] 57/20 63/21 64/14 80/13 110/25 141/22 146/20</p> <p>carrying [5] 46/15 53/20 108/18 120/5 128/8</p> <p>case [15] 17/4 20/7 39/21 40/1 42/17 49/11 54/4 61/2 70/17 90/4 108/23 109/18 115/16 135/10 137/17</p> <p>cases [8] 45/4 45/9 47/14 88/4 119/10 137/12 142/19 150/6</p> <p>Cash's [2] 36/21 37/6</p> <p>categories [1] 64/12</p> <p>category [1] 80/16</p> <p>cater [1] 83/14</p> <p>cause [4] 47/13 75/19 79/1 118/20</p> <p>caused [8] 46/25 73/7 73/7 73/11 73/12 73/13 74/8 75/18</p> <p>causes [2] 118/25 124/12</p> <p>causing [1] 83/18</p> <p>cautious [3] 66/16 66/20 67/1</p> <p>CBLA [1] 4/18</p> <p>CBLA0001380 [1] 148/2</p>
---	---	--	--	--	--

<p>C</p> <p>CBLA0001389 [1] 149/7</p> <p>CC [1] 68/1</p> <p>cell [2] 35/18 135/10</p> <p>cells [12] 24/5 24/6 24/9 24/15 24/17 24/23 27/16 35/16 36/7 99/1 99/16 135/16</p> <p>cent [3] 29/9 29/14 142/24</p> <p>central [4] 37/6 49/6 50/6 62/19</p> <p>centre [121] 3/6 3/15 4/1 5/19 7/7 7/13 7/16 8/20 8/21 9/2 9/12 10/4 10/5 10/7 11/12 11/17 12/1 12/18 13/7 14/10 14/17 16/7 17/21 18/16 18/21 19/23 21/3 21/8 21/11 21/15 21/20 22/22 24/1 25/3 25/5 25/9 25/19 25/25 26/4 27/2 28/2 31/8 31/8 31/16 32/13 32/20 32/21 32/23 34/12 34/16 34/19 35/4 39/4 39/7 39/10 39/12 39/18 39/19 40/2 40/6 40/6 40/11 40/12 40/14 40/15 40/17 40/19 40/23 42/3 42/6 47/19 48/9 51/2 51/12 55/16 55/21 55/21 72/23 76/13 87/14 88/23 92/15 92/16 99/11 99/11 99/21 99/21 99/21 101/14 104/7 109/25 112/6 112/11 112/17 113/8 113/10 119/24 120/12 120/13 120/21 121/19 125/25 130/4 131/6 131/18 136/14 139/20 143/24 144/5 144/9 149/6 149/19 149/20 150/4 150/17 150/24 151/11 153/3 153/4 153/5 153/8</p> <p>centre's [1] 141/8</p> <p>centred [1] 107/1</p> <p>centres [41] 4/6 5/4 8/4 15/22 17/15 18/4 18/9 18/11 18/15 30/2 32/19 38/20 50/16 50/18 52/5 55/18 69/22 76/15 86/5 86/6 86/8 87/11 89/6 89/24 92/21 98/23 111/18</p>	<p>113/11 114/2 115/12 115/23 115/24 116/9 120/5 120/8 126/2 129/25 134/6 143/21 150/13 151/13</p> <p>certain [6] 38/22 62/15 71/17 74/15 94/8 146/3</p> <p>certainly [19] 22/11 22/21 27/13 41/15 41/16 41/20 42/1 47/11 48/5 56/5 64/17 72/22 91/20 94/16 98/1 137/10 138/18 139/3 145/13</p> <p>certified [1] 99/8</p> <p>Chad [1] 62/19</p> <p>chain [1] 51/11</p> <p>chair [2] 4/14 66/9</p> <p>Chairman [1] 107/7</p> <p>challenged [2] 32/16 76/2</p> <p>challenges [1] 153/9</p> <p>change [1] 102/19</p> <p>change [1] 28/12</p> <p>changed [2] 82/1 88/9</p> <p>chaos [2] 115/19 115/21</p> <p>charge [4] 26/20 51/3 51/8 82/16</p> <p>chart [3] 8/3 12/5 41/25</p> <p>chasing [1] 145/2</p> <p>check [2] 32/25 57/24</p> <p>checks [2] 28/4 104/3</p> <p>chemicals [1] 24/14</p> <p>Chief [1] 93/18</p> <p>choice [2] 16/22 76/22</p> <p>choices [1] 76/22</p> <p>chose [1] 77/14</p> <p>chronic [4] 45/3 45/8 47/6 47/13</p> <p>chronology [2] 53/15 55/7</p> <p>Churchill [2] 21/17 150/16</p> <p>CIEOP [1] 19/3</p> <p>circular [10] 51/18 51/23 52/1 52/24 53/12 87/18 88/13 89/22 90/4 91/19</p> <p>circulation [4] 16/19 98/22 101/3 101/7</p> <p>circumstances [5] 63/24 70/7 70/10 73/3 109/23</p> <p>cirrhosis [1] 47/7</p> <p>claim [1] 153/14</p> <p>clear [5] 106/2 111/25 126/25 129/22 143/23</p> <p>cleared [1] 135/19</p>	<p>clearly [2] 70/8 152/22</p> <p>clerk [16] 10/11 11/1 55/23 57/2 57/6 57/19 59/23 60/2 60/4 60/6 60/22 61/16 62/7 63/3 83/17 83/21</p> <p>clerking [4] 77/8 80/20 84/12 84/20</p> <p>clerking-in [1] 84/12</p> <p>clinic [2] 27/4 28/20</p> <p>clinical [10] 2/15 2/16 47/6 49/18 49/23 53/19 95/8 140/14 141/18 146/15</p> <p>clinician [3] 120/24 139/5 147/1</p> <p>clinicians [7] 9/19 25/18 46/16 97/17 105/13 129/24 130/1</p> <p>clinics [3] 94/6 94/8 95/7</p> <p>clocked [1] 128/1</p> <p>close [3] 63/14 137/8 144/10</p> <p>closed [2] 143/25 144/6</p> <p>closer [1] 122/9</p> <p>clot [1] 24/13</p> <p>club [4] 33/23 53/9 53/21 54/12</p> <p>CMV [1] 81/10</p> <p>coagulation [1] 39/14</p> <p>code [1] 103/19</p> <p>coffee [1] 43/4</p> <p>cohesion [5] 113/25 115/12 116/8 117/12 125/21</p> <p>cohesive [1] 117/9</p> <p>cohort [1] 112/16</p> <p>COLIN [4] 1/24 37/13 88/24 154/2</p> <p>collaboration [1] 95/7</p> <p>collage [2] 23/4 128/11</p> <p>colleagues [14] 12/17 17/20 18/3 18/6 33/11 34/4 49/18 49/23 51/10 53/19 54/1 97/10 146/15 152/12</p> <p>collect [5] 30/14 32/7 34/10 36/2 36/4</p> <p>collected [10] 13/23 21/25 26/25 37/20 99/3 100/4 100/12 105/3 126/14 126/19</p> <p>collecting [2] 37/14 127/16</p> <p>collection [11] 10/9 10/10 10/24 23/21 26/24 35/18 38/5 38/8 106/5 148/12 150/8</p>	<p>collections [3] 10/2 11/23 34/13</p> <p>Collins [1] 23/4</p> <p>column [3] 8/6 37/4 41/3</p> <p>come [30] 3/8 11/17 29/16 31/5 34/3 39/19 43/7 44/9 48/10 53/2 53/11 61/14 80/10 80/15 90/7 90/13 92/12 103/23 106/11 112/6 112/17 113/4 117/16 129/5 129/15 129/21 134/3 145/25 149/20 150/3</p> <p>comes [1] 62/22</p> <p>coming [13] 11/23 28/1 81/23 83/16 89/12 94/13 94/16 103/6 105/14 130/4 142/15 143/23 152/14</p> <p>commencement [1] 110/15</p> <p>comment [5] 49/12 64/4 91/25 104/21 132/6</p> <p>commercial [2] 40/2 40/20</p> <p>committee [13] 4/11 4/18 4/21 5/3 5/5 5/5 46/1 46/4 46/8 52/6 66/10 66/14 105/25</p> <p>committees [1] 3/18</p> <p>common [4] 29/12 66/16 137/17 141/4</p> <p>commonality [2] 117/5 117/8</p> <p>commonsense [6] 114/4 116/18 116/22 116/22 116/24 117/11</p> <p>communication [1] 91/16</p> <p>communications [1] 91/12</p> <p>community [3] 11/13 59/3 95/12</p> <p>comparable [1] 10/25</p> <p>comparative [1] 16/1</p> <p>compare [1] 15/20</p> <p>comparing [1] 142/25</p> <p>comparison [1] 19/4</p> <p>complaint [2] 69/23 69/24</p> <p>complaints [1] 6/19</p> <p>complete [2] 119/7 120/23</p> <p>completed [1] 105/7</p> <p>completely [1] 22/7</p> <p>completeness [1] 70/23</p> <p>complicated [1] 14/23</p> <p>complications [1]</p>	<p>96/16</p> <p>complied [2] 130/1 132/8</p> <p>compliment [2] 67/20 69/6</p> <p>comply [1] 143/16</p> <p>components [11] 7/13 9/9 12/5 31/9 40/5 40/23 42/19 98/22 99/15 101/3 139/11</p> <p>comprised [1] 10/10</p> <p>computer [9] 29/2 127/24 128/4 128/12 128/16 128/19 133/23 135/16 135/18</p> <p>computer-generated [1] 29/2</p> <p>computerised [1] 28/17</p> <p>concealed [1] 80/1</p> <p>conceive [1] 69/24</p> <p>concentrates [2] 24/23 27/10</p> <p>conception [1] 74/12</p> <p>concern [9] 59/12 68/16 74/8 75/20 82/18 85/8 86/10 94/11 115/21</p> <p>concerned [15] 6/12 9/9 65/16 68/18 73/24 82/12 86/14 97/15 97/24 104/2 110/19 111/23 116/4 135/1 152/3</p> <p>Concerning [1] 93/13</p> <p>concerns [5] 70/14 82/23 85/14 124/3 135/25</p> <p>concludes [3] 50/13 145/12 148/20</p> <p>conclusion [1] 116/25</p> <p>conclusions [1] 132/21</p> <p>concurrently [1] 52/3</p> <p>condition [6] 44/16 44/19 58/2 58/17 74/14 80/6</p> <p>conditions [10] 57/3 57/5 57/13 59/24 61/24 62/4 62/6 62/7 72/2 82/9</p> <p>conducting [1] 6/14</p> <p>confidence [1] 152/25</p> <p>confidential [1] 94/4</p> <p>confidentiality [7] 96/12 96/13 96/19 97/7 97/11 97/13 98/13</p> <p>confidentially [2] 119/8 151/3</p>	<p>confirm [2] 111/24 123/21</p> <p>confirmation [1] 48/16</p> <p>confirmatory [1] 17/5</p> <p>confirmed [2] 37/9 110/14</p> <p>conflict [1] 87/7</p> <p>congratulated [1] 152/15</p> <p>congratulations [1] 152/20</p> <p>connect [1] 38/3</p> <p>connected [1] 21/12</p> <p>conscious [2] 129/13 143/11</p> <p>consent [15] 28/21 67/5 67/15 68/2 68/13 68/14 69/23 70/8 70/9 70/16 70/19 70/25 96/22 97/15 121/18</p> <p>consequence [3] 24/16 85/16 128/5</p> <p>consequences [2] 45/4 97/3</p> <p>consequently [2] 32/21 102/18</p> <p>consider [10] 17/2 49/20 49/22 50/19 52/14 69/5 77/7 78/18 90/11 123/14</p> <p>considerably [1] 136/21</p> <p>consideration [5] 12/18 58/5 59/16 62/12 124/20</p> <p>considered [10] 16/16 49/17 51/4 59/19 63/23 74/21 80/22 81/14 81/16 99/1</p> <p>considering [3] 4/11 28/2 90/12</p> <p>constitute [1] 104/10</p> <p>constitutes [1] 52/21</p> <p>consultant [3] 3/4 98/15 110/18</p> <p>consultants [3] 52/13 53/5 98/8</p> <p>consultation [1] 7/6</p> <p>contact [6] 61/1 63/14 72/14 110/9 119/19 121/19</p> <p>contacted [1] 37/2</p> <p>contacting [1] 70/2</p> <p>contacts [3] 62/20 95/11 137/8</p> <p>contain [2] 105/11 105/17</p> <p>contained [1] 21/20</p> <p>containing [1] 102/20</p> <p>contents [2] 47/10 52/5</p>
--	--	--	---	--	--

<p>C</p> <p>continue [3] 123/6 123/7 149/18</p> <p>continued [1] 123/11</p> <p>continuing [1] 88/7</p> <p>contra [1] 107/14</p> <p>contract [3] 31/8 34/6 41/22</p> <p>Contreras [5] 31/7 32/1 34/21 35/10 150/24</p> <p>Contreras's [1] 31/15</p> <p>contribute [1] 149/22</p> <p>contributors [1] 99/6</p> <p>control [9] 10/23 49/14 50/9 50/11 51/21 52/4 106/6 131/1 131/6</p> <p>convene [1] 52/11</p> <p>conveniently [1] 57/7</p> <p>conventional [1] 104/12</p> <p>convey [1] 146/23</p> <p>coordination [1] 37/7</p> <p>cope [1] 150/20</p> <p>copies [1] 60/4</p> <p>copper [1] 11/3</p> <p>copy [4] 56/3 87/25 89/1 106/17</p> <p>Core [5] 129/6 129/10 145/16 146/12 152/5</p> <p>corollary [1] 109/12</p> <p>correct [46] 2/9 4/7 4/25 5/13 6/25 10/15 10/16 11/14 15/18 17/6 19/25 20/3 20/6 20/16 21/18 24/22 29/21 31/2 31/21 34/2 34/2 35/5 36/3 36/9 39/5 39/11 39/15 39/20 40/4 41/8 44/2 55/2 57/15 58/9 61/21 77/14 79/24 85/7 87/7 89/25 91/3 112/14 118/6 122/4 134/4 143/1</p> <p>correction [2] 25/6 90/23</p> <p>correctly [1] 145/7</p> <p>correspond [1] 148/13</p> <p>correspondence [2] 150/10 150/12</p> <p>corresponding [2] 102/10 111/20</p> <p>costs [1] 141/19</p> <p>couches [1] 10/25</p> <p>cough [1] 43/22</p> <p>could [90] 9/25 11/16 11/16 13/25 16/16 16/18 17/9 19/1 19/11</p>	<p>24/12 24/18 25/9 26/5 26/13 27/17 31/25 32/3 32/9 33/1 34/18 37/14 37/20 38/5 38/11 44/24 45/2 45/7 45/8 46/18 48/10 48/22 48/23 48/25 51/16 53/24 57/17 58/8 62/11 66/6 69/24 73/7 73/9 75/2 75/4 76/7 79/7 79/7 81/3 83/18 85/11 95/21 97/3 97/6 98/4 98/6 98/11 99/6 99/21 99/23 103/14 103/24 107/13 107/17 108/20 110/13 112/2 114/8 114/22 115/19 116/3 116/13 119/7 123/6 123/7 123/22 125/18 128/9 128/17 131/24 133/7 135/14 136/6 137/7 137/13 138/19 141/16 147/3 150/20 151/2 151/23</p> <p>couldn't [8] 36/8 53/15 91/21 100/8 100/14 112/10 138/21 145/10</p> <p>counsel [6] 95/23 121/13 129/11 129/11 145/23 146/1</p> <p>counselled [1] 141/17</p> <p>counselling [16] 16/25 95/1 95/5 95/10 95/14 95/14 95/19 96/6 96/9 102/6 117/20 118/4 120/2 120/6 120/13 143/14</p> <p>counter [1] 19/3</p> <p>counter-immunoelect ro-osmophoresis [1] 19/3</p> <p>counterelectrophores is [1] 19/18</p> <p>countries [3] 102/16 114/12 114/14</p> <p>country [4] 14/12 81/25 82/12 109/5</p> <p>couple [7] 9/1 31/5 84/17 90/22 121/22 147/17 147/25</p> <p>course [20] 3/9 16/18 17/17 23/12 26/19 28/12 47/6 49/12 61/15 62/25 65/23 66/1 75/5 76/3 77/21 85/4 143/2 144/6 150/15 151/23</p> <p>covered [1] 82/13</p> <p>Covid [1] 44/3</p> <p>create [1] 148/25</p>	<p>created [1] 133/20</p> <p>credit [2] 153/13 153/15</p> <p>criticisms [1] 37/6</p> <p>cryoprecipitate [12] 24/25 25/2 25/10 25/20 25/24 26/1 26/7 26/8 26/10 26/18 40/9 40/10</p> <p>cryoprecipitates [1] 25/14</p> <p>cup [1] 43/4</p> <p>current [6] 14/22 14/25 19/13 52/15 99/2 139/12</p> <p>cut [2] 37/11 37/16</p> <p>cuts [1] 73/18</p> <p>cutting [5] 37/7 37/19 37/25 38/4 38/7</p> <p>CV [1] 5/8</p> <p>D</p> <p>Daily [1] 36/17</p> <p>Daily Telegraph [1] 36/17</p> <p>damning [1] 136/2</p> <p>danger [1] 66/23</p> <p>dangerous [1] 75/11</p> <p>Darnborough [3] 5/16 5/23 17/20</p> <p>DAs [1] 35/21</p> <p>data [3] 96/22 127/16 148/12</p> <p>date [23] 13/12 22/24 36/16 45/6 47/12 80/14 92/23 93/24 99/14 100/5 101/15 101/24 106/1 107/1 113/10 114/6 115/2 116/20 131/23 137/23 138/10 138/22 138/24</p> <p>date stamped [1] 36/16</p> <p>dated [11] 8/11 21/4 67/23 77/3 83/25 88/21 89/3 93/14 108/5 137/22 148/4</p> <p>dates [1] 110/17</p> <p>daughter [1] 1/13</p> <p>David [1] 23/4</p> <p>day [6] 26/14 37/12 105/4 105/5 137/23 152/1</p> <p>day 0 [1] 105/4</p> <p>days [5] 11/22 17/7 47/5 75/5 105/8</p> <p>deal [7] 44/9 58/11 72/25 92/10 139/4 149/14 150/6</p> <p>dealing [4] 6/16 6/21 76/16 134/18</p> <p>dealt [3] 23/18 59/17</p>	<p>82/12</p> <p>Dear [2] 117/24 121/1</p> <p>decease [1] 22/12</p> <p>December [3] 1/1 85/25 153/22</p> <p>decided [3] 30/13 38/4 87/22</p> <p>deciding [1] 32/14</p> <p>decision [6] 25/3 25/4 29/23 124/17 133/4 143/25</p> <p>decisions [2] 40/18 120/2</p> <p>Declaration [1] 72/11</p> <p>declare [2] 72/12 78/2</p> <p>declared [1] 57/5</p> <p>decline [1] 62/2</p> <p>deemed [1] 27/19</p> <p>deeply [1] 122/11</p> <p>defence [1] 85/5</p> <p>deferred [3] 58/7 78/7 122/21</p> <p>Deficiency [1] 62/16</p> <p>define [1] 66/6</p> <p>defined [1] 81/12</p> <p>definitive [2] 46/13 133/4</p> <p>degree [1] 125/21</p> <p>deliberate [1] 80/24</p> <p>delivered [2] 135/4 135/6</p> <p>deliveries [2] 7/17 52/18</p> <p>delivery [1] 110/18</p> <p>demand [3] 26/2 103/18 150/19</p> <p>demands [1] 42/18</p> <p>demographics [1] 32/5</p> <p>demonstrated [1] 63/25</p> <p>denies [1] 36/20</p> <p>dentists [1] 42/20</p> <p>departed [2] 65/3 65/3</p> <p>department [24] 8/1 10/12 21/6 22/21 23/2 35/2 35/3 45/19 45/20 48/18 48/19 50/7 61/9 73/25 74/3 87/8 87/17 88/15 89/12 110/8 110/21 131/1 137/2 137/12</p> <p>depending [3] 26/12 97/8 128/24</p> <p>depends [1] 129/2</p> <p>deputy [7] 3/5 3/10 5/14 5/25 22/16 88/22 136/18</p> <p>describe [2] 8/19 108/20</p> <p>described [5] 13/14 15/9 36/23 113/22</p>	<p>145/22</p> <p>describing [3] 15/9 34/1 128/15</p> <p>designed [1] 81/13</p> <p>desk [2] 77/8 80/21</p> <p>desperately [1] 38/10</p> <p>despite [4] 37/11 64/20 100/3 128/18</p> <p>destruction [1] 133/17</p> <p>destructive [1] 114/2</p> <p>detail [8] 27/6 33/14 34/7 54/16 56/8 69/12 69/13 140/1</p> <p>detailed [3] 3/8 61/24 106/4</p> <p>details [9] 13/20 27/21 74/15 95/13 123/20 132/10 134/20 137/8 140/14</p> <p>detectable [1] 102/11</p> <p>detection [2] 13/4 13/10</p> <p>determine [1] 127/16</p> <p>determined [1] 141/20</p> <p>develop [3] 79/18 80/15 102/10</p> <p>developed [5] 13/10 16/2 18/14 47/4 114/11</p> <p>developing [1] 14/21</p> <p>development [1] 54/6</p> <p>developments [1] 24/11</p> <p>devise [2] 32/17 128/12</p> <p>devised [1] 13/4</p> <p>DHSC0000177 [1] 93/11</p> <p>DHSC0002159 [1] 87/17</p> <p>DHSC0002221 [1] 50/5</p> <p>DHSC0002241 [1] 83/24</p> <p>DHSC0002245 [1] 67/7</p> <p>DHSC0002277 [1] 71/20</p> <p>DHSC0003734 [1] 91/4</p> <p>DHSC0038579 [1] 36/11</p> <p>DHSC0101582 [2] 7/25 40/25</p> <p>DHSS [8] 50/8 51/17 83/25 84/3 86/7 86/11 107/7 131/2</p> <p>diagnosis [1] 120/1</p> <p>did [80] 2/22 4/19 5/18 7/7 7/10 7/16</p>	<p>7/19 11/15 12/15 12/17 13/22 14/4 14/4 15/20 16/1 16/2 16/5 17/13 17/23 18/6 19/6 22/21 28/12 30/8 31/10 31/11 31/25 32/12 33/4 33/10 38/22 39/1 39/9 39/11 39/18 39/21 39/23 40/17 42/17 42/19 49/20 49/21 49/22 53/2 53/11 66/8 69/4 70/14 70/17 73/6 77/20 77/22 83/7 85/2 88/18 93/4 93/6 94/16 98/1 100/7 112/5 115/19 122/19 123/18 123/19 123/23 124/3 128/6 130/1 130/9 130/11 131/10 132/7 133/16 137/18 140/16 144/24 145/3 147/6 153/15</p> <p>didn't [23] 17/16 24/10 32/14 40/2 66/11 75/5 75/19 78/5 78/8 85/9 85/18 87/4 93/7 105/16 124/6 132/10 134/3 134/7 144/25 147/8 147/10 147/12 153/13</p> <p>difference [3] 79/9 79/11 128/9</p> <p>different [39] 15/1 15/6 15/7 15/10 15/11 18/18 23/23 24/11 24/24 37/18 64/12 66/4 66/18 67/4 72/10 72/12 74/10 74/11 81/19 84/24 89/18 97/6 98/3 98/24 103/15 104/14 114/15 114/16 115/22 115/23 115/23 117/4 120/6 123/21 125/22 132/24 133/6 133/7 134/8</p> <p>differently [3] 59/17 115/20 117/4</p> <p>difficult [6] 54/4 59/14 69/24 125/19 128/6 150/6</p> <p>difficulties [3] 11/21 68/12 148/25</p> <p>difficulty [1] 106/12</p> <p>Dike [10] 117/25 118/2 119/1 120/17 121/2 127/7 128/16 136/25 143/13 144/23</p> <p>dint [2] 53/15 55/7</p> <p>direct [4] 8/8 39/18 49/4 149/18</p> <p>directed [2] 72/4</p>
--	---	--	--	---	--

(45) continue - directed

<p>D</p> <p>directed... [1] 72/19</p> <p>direction [3] 19/16 96/1 117/7</p> <p>directly [1] 39/7</p> <p>director [24] 3/5 3/10 3/14 3/21 3/22 3/25 5/15 5/16 5/19 5/25 17/17 17/19 19/22 22/15 22/16 22/18 30/1 30/3 37/13 47/20 48/8 51/2 88/22 153/7</p> <p>director's [1] 9/5</p> <p>directorate [12] 30/17 32/12 113/24 114/19 115/17 116/6 117/6 124/23 125/6 125/12 125/14 132/14</p> <p>directorate's [3] 4/20 114/21 115/18</p> <p>directors [17] 6/14 46/2 51/12 52/13 54/23 65/6 67/9 68/7 68/10 69/2 69/22 70/18 76/14 76/20 94/12 106/19 113/14</p> <p>disadvantages [1] 148/19</p> <p>disagree [1] 115/6</p> <p>disappear [1] 144/11</p> <p>discard [1] 35/15</p> <p>disclose [2] 57/16 78/8</p> <p>disclosed [6] 57/23 58/25 63/5 64/24 82/8 96/23</p> <p>discloses [1] 58/2</p> <p>disclosing [3] 57/12 75/14 83/20</p> <p>disclosure [4] 80/23 96/25 97/1 97/5</p> <p>discovery [1] 65/24</p> <p>discreet [1] 83/18</p> <p>discretion [1] 76/20</p> <p>discuss [6] 35/23 43/10 51/9 82/16 119/5 149/12</p> <p>discussed [7] 54/10 54/16 54/18 65/5 86/5 146/17 146/21</p> <p>discussion [8] 34/20 50/25 54/15 59/2 59/5 67/13 132/20 132/22</p> <p>discussions [12] 25/18 25/21 33/10 33/19 33/20 40/17 40/18 53/25 107/1 132/24 146/15 146/17</p> <p>disease [6] 45/3 45/8 66/4 72/13 72/15 95/6</p> <p>Diseases [2] 62/15</p>	<p>96/20</p> <p>dish [1] 14/15</p> <p>dishes [1] 14/14</p> <p>dismayed [1] 113/19</p> <p>disorders [1] 82/13</p> <p>disorganised [1] 36/24</p> <p>dispatched [1] 135/21</p> <p>display [1] 83/16</p> <p>displayed [1] 84/11</p> <p>Displays [1] 88/7</p> <p>disposal [3] 114/17 134/23 135/13</p> <p>Disqualify [1] 62/13</p> <p>disseminating [1] 91/22</p> <p>dissemination [1] 83/7</p> <p>distance [1] 27/23</p> <p>distribute [1] 76/21</p> <p>distributed [1] 88/16</p> <p>distribution [5] 74/3 84/10 87/20 88/8 149/16</p> <p>district [3] 42/6 51/19 94/9</p> <p>divert [1] 147/10</p> <p>divided [1] 32/18</p> <p>division [8] 4/2 4/6 4/10 4/15 85/23 98/8 101/1 132/12</p> <p>do [100] 5/25 8/15 12/3 12/12 14/25 14/25 16/1 16/1 16/3 16/18 17/19 17/22 18/5 18/7 18/10 18/11 25/17 28/8 38/15 41/11 42/3 42/14 43/10 47/18 48/10 52/23 52/25 53/3 53/12 55/16 65/5 66/23 69/20 71/1 71/15 74/4 75/2 75/4 78/18 79/9 79/11 80/19 81/2 86/17 88/12 89/15 90/8 91/1 92/11 92/16 93/2 93/7 97/23 100/9 101/5 101/6 107/6 107/13 107/20 109/1 109/8 109/23 116/2 116/23 116/23 117/21 120/17 120/19 123/22 125/4 125/10 125/17 126/2 126/16 126/22 126/24 126/25 127/10 129/8 130/7 133/8 134/10 136/1 136/23 137/3 137/13 137/25 138/18 139/13 139/24 141/1 141/3 142/1 145/1 145/3 145/18 147/2</p>	<p>147/13 148/8 151/11</p> <p>doctor [15] 2/7 7/5 10/13 10/15 11/5 62/11 118/3 119/4 119/11 119/13 119/16 121/13 129/9 140/10 145/21</p> <p>Doctors [2] 93/12 93/16</p> <p>document [74] 7/25 8/1 8/11 21/4 22/23 22/24 26/16 26/22 28/15 29/16 34/25 36/10 36/11 40/24 41/11 41/15 42/1 45/5 45/11 45/13 45/15 45/16 45/18 46/13 46/21 47/9 47/16 48/11 51/14 54/25 55/13 55/17 55/25 56/3 56/5 56/8 57/9 58/11 60/8 61/7 61/22 63/2 67/18 70/10 75/9 76/25 83/22 86/3 87/8 88/17 88/20 90/8 92/3 93/11 96/11 98/7 101/21 103/12 105/21 105/22 106/18 106/21 110/4 111/7 112/20 113/6 117/17 122/14 129/21 129/22 130/24 134/11 134/14 147/5</p> <p>documents [18] 27/25 50/3 52/25 87/16 92/11 112/22 112/24 113/1 117/22 128/25 129/15 136/23 143/9 145/10 147/17 147/19 147/25 152/13</p> <p>does [17] 8/11 22/2 29/8 41/6 42/9 60/13 62/22 72/1 72/2 84/6 84/6 89/2 102/10 104/13 119/1 138/3 148/12</p> <p>doesn't [5] 24/13 61/3 71/12 71/25 72/18</p> <p>dogmatic [1] 125/5</p> <p>doing [15] 16/10 17/11 17/23 17/25 23/17 46/20 55/20 79/4 117/4 117/9 120/8 125/22 126/5 126/18 128/8</p> <p>domestic [1] 33/18</p> <p>don't [49] 17/22 18/8 41/17 48/3 49/9 49/21 53/13 55/19 79/13 83/3 85/11 86/18 86/22 86/23 86/25 87/4 87/14 87/14 88/17 88/19 89/16</p>	<p>91/2 91/25 92/12 103/5 105/19 107/24 109/13 110/2 112/24 113/15 120/22 125/25 126/4 127/2 127/3 127/19 128/25 130/8 130/11 130/18 133/3 139/23 141/7 141/24 145/21 145/24 146/21 153/1</p> <p>donate [10] 58/8 65/20 82/15 94/14 112/6 112/12 119/21 123/6 134/3 134/7</p> <p>donated [2] 111/20 122/14</p> <p>donating [3] 76/12 78/5 103/3</p> <p>donation [31] 11/1 16/12 16/14 28/22 57/22 62/1 72/20 83/5 102/20 103/16 103/20 104/5 104/19 104/25 109/11 110/16 118/9 118/14 121/5 122/20 122/23 127/25 128/2 128/6 128/7 128/10 128/18 134/25 135/11 135/15 139/12</p> <p>donations [60] 13/6 13/7 16/7 21/25 26/25 27/18 30/14 32/1 32/4 32/7 34/11 34/18 36/5 37/21 56/16 72/5 92/18 93/25 99/3 99/6 99/8 102/16 103/1 103/15 103/24 104/6 104/10 104/12 104/15 104/17 105/12 108/7 108/16 109/16 110/1 110/10 110/16 111/19 112/1 112/7 112/12 114/24 116/9 118/19 122/1 122/2 123/6 123/24 123/25 123/25 124/5 124/13 124/15 124/18 134/18 139/17 139/21 142/14 151/16 152/1</p> <p>done [23] 17/14 17/14 17/21 17/24 21/2 23/15 26/5 26/13 49/1 56/5 59/15 69/3 78/3 79/8 103/6 105/4 115/1 124/21 131/25 132/17 136/3 152/13 152/13</p> <p>donor [134] 6/4 6/13 6/14 6/16 9/22 10/11 10/12 10/20 10/21 10/23 11/7 11/12 12/7 12/21 14/7 14/18</p>	<p>14/21 16/21 19/8 19/14 23/6 23/21 23/24 27/1 27/4 27/17 27/25 28/17 28/20 29/15 29/18 29/19 30/2 37/20 38/1 55/22 56/10 56/23 57/2 57/3 57/8 57/12 57/19 57/21 57/24 58/2 58/7 58/8 58/12 58/16 59/20 59/23 59/24 60/1 60/2 60/4 60/20 60/22 60/23 61/10 61/16 61/17 62/1 62/2 62/3 62/7 62/10 63/3 63/20 63/23 64/6 64/9 64/25 69/23 70/1 70/5 70/19 71/1 72/4 72/5 72/6 77/6 77/8 77/12 77/16 78/17 79/8 79/10 81/9 81/17 82/7 82/15 83/19 84/7 84/14 87/24 87/25 88/5 97/21 97/22 102/9 102/13 102/17 102/18 103/25 108/15 108/25 118/4 118/7 118/22 120/12 120/18 120/19 121/4 121/6 121/18 122/13 122/21 122/24 123/6 123/15 123/16 124/8 127/24 128/4 133/12 133/23 137/5 137/24 138/1 138/3 140/6 140/18 143/14</p> <p>donor's [2] 57/4 59/25</p> <p>donors [128] 4/5 6/4 6/17 10/25 11/2 11/6 11/16 12/4 12/19 13/25 23/18 27/8 27/11 27/20 27/22 28/4 28/11 28/19 29/1 29/3 29/5 29/9 30/8 34/16 35/15 54/22 55/1 55/15 56/11 56/14 56/14 56/21 59/7 59/13 59/20 62/21 63/12 63/21 65/11 65/15 67/11 67/14 68/2 70/16 71/22 72/11 74/8 75/1 75/6 75/12 75/13 76/1 76/12 76/21 76/23 77/22 78/2 78/4 78/6 78/13 78/21 80/4 80/15 80/20 81/1 81/2 81/10 81/13 83/4 83/11 83/14 83/16 84/18 85/2 85/6 85/13 85/16 85/18 88/3 89/7 89/8 89/14 94/13</p>	<p>94/16 95/15 96/9 97/10 98/14 102/24 103/2 103/8 103/8 103/13 103/23 104/1 110/13 110/17 111/20 111/23 112/1 112/5 112/16 115/25 119/23 120/7 120/11 120/13 120/21 122/7 126/19 127/8 128/3 128/13 128/18 133/25 134/6 137/9 137/14 139/9 140/5 140/19 141/14 142/13 142/16 145/6 151/1 151/2 151/21</p> <p>donors' [3] 11/3 70/7 140/12</p> <p>door [1] 93/9</p> <p>doubt [1] 147/12</p> <p>DOUBTS [1] 82/14</p> <p>down [24] 6/11 8/5 22/13 23/20 29/17 37/5 41/3 45/6 47/12 52/8 63/2 71/5 85/1 87/19 94/23 98/9 102/8 106/22 123/1 124/10 134/17 134/21 141/22 148/14</p> <p>Downstairs [1] 9/8</p> <p>Dr [71] 1/3 1/13 1/24 2/2 5/16 5/23 17/20 19/24 23/4 31/15 32/1 34/21 35/10 35/10 35/19 36/21 37/13 43/3 44/7 67/15 68/1 69/21 77/3 88/22 89/11 90/20 91/5 93/18 98/15 106/24 107/7 107/24 108/5 110/6 110/25 113/7 113/9 113/13 114/22 115/4 117/25 118/2 119/1 120/17 121/2 126/10 126/12 127/7 127/17 127/11 127/15 128/16 129/4 129/18 136/18 136/25 141/11 143/7 143/13 144/23 146/11 148/4 148/6 149/6 149/11 150/24 151/9 152/8 153/19 153/20 154/2</p> <p>Dr Acheson [1] 93/18</p> <p>Dr Ala [1] 141/11</p> <p>Dr Barbara [4] 127/7 127/11 127/15 151/9</p> <p>Dr Cash's [1] 36/21</p> <p>Dr CC [1] 68/1</p> <p>Dr Colin Entwistle [1] 37/13</p> <p>Dr Contreras [4] 32/1 34/21 35/10 150/24</p>
--	--	---	--	---	---

D	duty [2] 7/4 92/23	elevations [1] 124/11	94/24 133/3	105/11 117/2 134/7	68/10 69/20 73/24
Dr Contreras's [1] 31/15	E	ELISA [2] 15/7 15/15	essentially [1] 49/3	exceeded [1] 128/10	74/22 75/16 78/6 80/4
Dr Darnborough [3] 5/16 5/23 17/20	each [13] 10/10 28/19	ELISA test [1] 15/15	establish [2] 32/25	except [3] 96/24	84/23 85/17 86/14
Dr David [1] 23/4	32/19 55/15 60/18	else [4] 43/15 44/4	116/4	97/14 127/2	95/18 99/3 100/3
Dr Dike [9] 117/25	63/20 77/8 77/16	65/13 126/4	established [2] 103/8	exception [1] 77/18	105/16 126/6 128/17
118/2 120/17 121/2	87/24 87/25 88/5	elsewhere [3] 68/12	128/16	excesses [1] 37/15	130/16 130/20 131/17
127/7 128/16 136/25	131/11 140/6	87/7 153/5	establishment [1]	exchange [8] 50/20	135/21 144/23 145/5
143/13 144/23	earlier [15] 14/2 20/19	Elstree [4] 39/16	151/22	52/20 53/22 58/24	147/24 150/22
Dr Entwistle [16] 1/3	22/6 22/24 40/24 53/8	135/21 135/23 149/17	establishments [1]	59/1 89/21 150/10	factor [10] 39/8 39/8
2/2 35/10 35/19 43/3	80/3 91/19 111/6	embarking [2] 104/3	12/9	150/11	39/12 39/13 39/17
44/7 67/15 89/11	115/4 117/18 130/25	113/21	estimate [2] 22/8	excluded [2] 63/22	39/17 86/12 148/9
90/20 106/24 107/24	138/19 138/25 145/22	embarrassing [1]	142/1	64/18	149/2 149/17
126/12 129/4 129/18	early [6] 17/7 17/22	59/14	estimation [1] 30/24	excuse [1] 8/15	Factor VIII [1] 149/17
146/11 152/8	116/10 127/13 144/11	emerge [1] 107/17	etc [4] 11/7 79/19	executive [1] 4/24	factored [1] 31/19
Dr Galea [2] 153/19	147/20	emergency [1] 7/10	81/11 82/9	exercise [1] 149/14	factors [1] 80/5
153/20	EARTC [3] 10/2 10/3	employees [1] 22/1	Ethel [1] 149/10	exist [3] 71/12 141/23	failed [1] 57/16
Dr Gunson [5] 19/24	10/9	enable [3] 24/14	ethical [1] 35/15	142/2	failing [1] 78/2
88/22 110/6 110/25	easily [3] 31/25 32/1	50/20 135/19	Europe [1] 72/16	existed [1] 21/16	fainting [1] 11/6
126/10	32/4	enclose [1] 121/10	Evans [1] 107/5	expand [1] 31/23	fair [14] 8/18 31/24
Dr Lane [2] 148/4	East [4] 6/23 8/6 10/3	enclosed [1] 119/7	even [22] 17/4 17/7	expanding [1] 103/17	32/15 33/14 47/8
148/6	11/25	encloses [1] 121/12	37/20 38/13 38/16	expect [3] 55/22	49/21 58/18 76/6
Dr Lloyd [5] 113/7	East Anglia [1] 8/6	enclosing [1] 127/7	42/17 47/8 47/16	58/24 131/12	85/20 101/17 104/21
113/9 113/13 114/22	easy [2] 92/4 141/20	encouraged [1] 15/3	58/22 66/17 79/23	expectation [2] 57/19	120/4 132/6 138/25
115/4	economies [2] 51/10	end [6] 20/12 41/20	81/8 88/10 100/11	100/25	fairly [1] 91/22
Dr Moore [1] 107/7	52/16	42/17 69/16 93/9	101/10 105/5 122/10	expected [1] 33/2	faith [1] 25/13
Dr Moss [1] 98/15	Edgware [9] 31/15	102/6	122/16 124/25 125/18	expecting [1] 105/14	familiar [1] 106/15
Dr Napier [1] 91/5	32/2 34/12 34/19	ended [1] 78/5	130/11 133/6	experience [4] 14/6	family [2] 43/13 97/21
Dr Rizza [2] 149/6	35/12 36/5 38/9	endorsed [1] 52/6	event [2] 125/2	33/9 81/12 124/13	famine [1] 36/13
149/11	150/24 151/11	engineering [1] 21/23	149/24	experienced [3] 10/23	far [22] 12/14 12/23
Dr Robinson [1]	edition [2] 45/25	engineering/plant [1]	eventual [1] 109/10	51/5 69/22	18/19 18/22 20/3
143/7	138/10	21/23	ever [7] 69/22 93/6	Expert [1] 105/25	22/11 27/13 41/13
Dr Sara [1] 1/13	educate [1] 49/23	England [3] 8/5 93/16	105/19 106/16 109/13	expired [1] 52/19	79/1 81/8 82/11 84/14
Dr Snape [1] 108/5	educating [1] 49/18	113/20	130/19 132/21	expiry [1] 24/16	92/12 96/6 97/12
Dr Wagstaff [1] 77/3	effect [6] 30/13 84/14	enlarge [2] 45/17	every [9] 33/17 43/9	explain [2] 19/4 108/7	132/9 132/16 133/13
draft [2] 51/23 61/6	85/13 117/11 135/18	45/24	77/8 77/16 104/5	explained [2] 65/7	137/16 139/21 141/16
drafting [4] 46/9 47/9	153/11	enlarged [1] 79/19	137/17 142/7 142/9	95/21	143/13
54/25 55/8	effective [1] 138/10	enough [2] 14/3 145/1	142/10	explaining [1] 140/21	fascinating [1] 153/9
drastically [1] 82/1	effectively [4] 58/15	ensue [1] 115/22	everybody [1] 150/21	expressed [1] 86/10	fatal [2] 45/3 45/9
draw [4] 46/24 66/16	104/18 108/14 144/10	ensure [6] 28/5 51/9	everybody's [1] 23/15	expressing [1] 70/3	fate [2] 109/25 135/1
75/6 134/15	effects [1] 119/3	88/5 109/10 134/2	everyone [1] 66/17	exquisitely [1] 105/18	fear [1] 75/3
drawing [2] 66/10	efficient [1] 136/20	134/7	evidence [28] 15/6	extended [2] 18/1	feast [1] 36/12
92/8	efforts [1] 117/6	entailed [1] 2/23	43/10 43/11 43/12	24/17	feature [1] 137/15
drivers [2] 10/12 11/3	eg [2] 63/19 135/1	entered [1] 135/15	46/12 74/1 76/19	extending [1] 47/5	February [1] 51/18
dropped [1] 5/21	eight [3] 10/11 10/24	entirely [1] 43/24	80/14 81/15 89/5	extent [4] 55/16 80/4	Feedback [1] 84/16
Drs [1] 42/2	27/7	entitled [6] 8/3 36/19	94/10 98/17 101/17	125/22 125/23	feel [3] 66/18 98/1
drug [2] 62/17 80/18	either [12] 30/16	51/23 55/1 72/11 84/1	105/21 112/23 113/1	extra [3] 12/24 114/24	115/15
dual [1] 3/2	30/19 43/25 52/23	84/1 69/21 89/11	113/9 114/10 125/4	141/25	feeling [3] 86/20
due [6] 3/9 49/12	57/19 83/10 98/1	90/20 106/24 107/24	136/10 143/11 143/12	extremely [1] 151/18	109/5 137/3
61/15 62/25 76/3	103/6 133/22 140/22	126/12 129/4 129/18	146/14 151/8 151/12	F	fellow [2] 65/6 69/21
124/11	148/21 149/17	146/11 152/8 154/2	152/21 152/22 153/18	face [2] 33/20 33/20	felt [17] 23/2 32/22
during [27] 2/18 3/19	4/14	epidemic [1] 99/4	evidenced [1] 74/22	face-to-face [1] 33/20	66/13 68/14 76/17
8/14 8/20 11/24 16/8	electric [3] 14/22	99/4	evident [1] 136/12	faces [1] 37/8	77/16 77/19 78/23
22/4 22/10 24/8 25/10	14/25 19/12	equally [2] 78/4	exact [2] 13/12	facilitate [1] 52/10	78/24 82/23 82/24
29/20 37/24 54/14	electrical [1] 15/1	109/14	exactly [8] 20/23	facilities [4] 8/19 9/10	83/12 83/15 86/19
59/3 71/2 102/13	electro [1] 15/11	equipped [1] 27/7	20/25 46/11 66/6 75/4	11/15 94/3	104/21 115/15 122/8
103/3 104/19 133/16	Electrophoresis [2]	equivalent [1] 57/8	86/17 100/7 144/7	fact [43] 2/25 5/20	female [1] 118/3
133/19 135/20 139/25	15/13 15/14	especially [2] 11/17	Examination [2]	12/9 21/14 25/8 25/12	fervently [1] 114/7
142/10 143/22 144/1	elements [1] 30/15	80/17	55/14 56/21	34/20 34/23 38/15	few [13] 11/16 17/25
146/16 151/22	elevated [3] 82/19	essential [3] 87/22	examine [1] 111/18	39/24 40/1 45/16 49/4	50/3 82/1 102/12
	123/11 123/12		example [7] 25/19	49/13 51/13 65/2	104/25 109/3 124/2
			54/4 79/2 99/19	65/17 66/11 66/24	124/9 127/20 130/5
					130/19 145/25

<p>F</p> <p>field [2] 129/10 145/16</p> <p>fifth [1] 38/5</p> <p>figure [6] 29/11 41/25 42/18 128/10 133/10 142/22</p> <p>figured [1] 50/1</p> <p>figures [2] 142/22 143/3</p> <p>fill [1] 151/2</p> <p>filled [1] 28/22</p> <p>filtered [1] 24/23</p> <p>final [2] 135/1 148/22</p> <p>finally [3] 83/21 87/8 130/22</p> <p>finance [1] 49/6</p> <p>find [10] 14/4 32/1 32/3 45/14 55/3 71/19 85/25 89/5 108/24 112/5</p> <p>finding [2] 14/6 32/16</p> <p>findings [2] 17/15 67/17</p> <p>finger [1] 11/4</p> <p>finger-prick [1] 11/4</p> <p>finish [1] 41/18</p> <p>finished [2] 146/4 152/1</p> <p>firm [2] 67/23 132/20</p> <p>firmly [1] 114/17</p> <p>first [41] 1/22 4/24 5/22 13/12 14/5 19/17 30/15 32/10 35/8 50/4 52/23 52/24 56/12 57/11 62/23 71/3 73/1 73/3 73/6 74/1 76/21 77/4 85/3 85/23 89/7 90/23 92/6 101/20 105/4 112/20 117/7 118/9 126/9 141/12 142/11 142/20 148/2 148/5 150/18 153/8 153/11</p> <p>first of [1] 32/10</p> <p>firstly [2] 17/1 152/11</p> <p>Fisher [1] 136/18</p> <p>fitness [2] 56/24 82/15</p> <p>five [1] 24/17</p> <p>flawed [1] 122/11</p> <p>flaws [1] 135/9</p> <p>floor [1] 21/21</p> <p>focused [1] 144/8</p> <p>follow [5] 76/15 91/8 114/21 133/1 135/4</p> <p>follow-up [1] 135/4</p> <p>followed [3] 55/17 55/24 115/18</p> <p>following [6] 27/7 28/19 72/17 76/13</p>	<p>124/23 150/11</p> <p>follows [2] 61/24 126/17</p> <p>Force [1] 42/7</p> <p>forcefully [1] 153/15</p> <p>forget [2] 22/24 58/21</p> <p>forgotten [2] 99/17 150/2</p> <p>form [28] 28/21 31/10 57/1 57/3 57/4 57/13 60/13 67/14 70/6 70/12 71/5 71/12 71/13 71/14 72/7 72/10 73/16 73/17 90/25 91/1 91/5 119/7 133/23 146/24</p> <p>formal [3] 33/22 50/19 50/25</p> <p>formally [1] 89/7</p> <p>format [1] 67/13</p> <p>formation [1] 38/24</p> <p>formed [3] 20/9 31/19 125/14</p> <p>forms [4] 45/1 71/1 72/22 90/24</p> <p>forum [4] 52/20 54/15 59/9 80/20</p> <p>forums [1] 53/22</p> <p>forward [2] 43/15 116/3</p> <p>found [13] 66/1 71/11 90/25 92/2 94/25 98/14 99/7 110/14 111/25 125/7 133/25 141/14 141/20</p> <p>founder [1] 5/11</p> <p>four [5] 23/23 33/24 35/23 86/8 87/11</p> <p>fractionate [1] 111/10</p> <p>fractionated [3] 39/6 102/22 148/11</p> <p>fractionation [7] 24/21 30/18 39/23 104/8 104/12 148/11 150/21</p> <p>fragmented [1] 36/24</p> <p>frankly [3] 79/21 111/2 130/5</p> <p>free [2] 28/5 105/15</p> <p>freely [1] 77/6</p> <p>frequency [3] 103/16 103/20 103/24</p> <p>frequently [3] 122/8 122/25 131/16</p> <p>fresh [8] 11/9 11/22 35/13 99/23 100/1 126/13 126/19 126/23</p> <p>Fridays [1] 10/18</p> <p>fridge [3] 135/11 135/14 135/17</p> <p>from [151] 1/25 3/20</p>	<p>4/18 4/24 5/25 7/12 9/20 10/11 10/18 11/11 13/23 14/8 14/16 16/15 16/19 19/23 21/22 22/3 22/23 24/17 24/24 26/21 28/5 31/7 32/23 33/21 34/11 34/16 35/11 36/17 36/17 36/18 40/23 41/11 42/1 42/1 42/5 44/3 46/14 48/5 49/5 50/6 51/18 57/13 60/22 60/24 62/18 62/22 63/13 63/22 65/3 67/20 67/23 68/22 69/9 70/10 70/18 70/20 71/13 72/22 73/5 73/14 73/21 74/1 74/23 75/15 76/8 76/9 76/12 77/2 81/24 84/1 84/2 84/19 84/24 86/10 86/13 88/14 88/22 89/12 90/22 91/2 91/8 92/15 92/15 92/21 93/16 93/17 93/24 95/11 98/15 99/6 100/16 101/22 102/11 102/17 104/11 105/15 106/23 108/5 108/8 110/6 110/17 110/20 110/24 112/1 112/20 113/7 113/20 114/6 114/18 115/2 116/20 117/25 118/21 120/21 121/2 121/24 123/15 123/25 126/10 126/17 127/6 130/3 130/4 131/10 135/23 136/24 136/25 138/11 138/12 138/17 138/18 139/12 140/6 141/11 141/14 143/7 145/10 145/16 146/12 147/22 148/3 148/4 149/18 150/4 152/5 152/14 152/19 153/4 154/3</p> <p>from 1977 [1] 91/2</p> <p>front [1] 45/13</p> <p>frontline [1] 46/16</p> <p>frozen [13] 98/21 98/25 99/13 99/16 99/23 100/1 100/17 100/22 101/3 104/6 126/13 126/19 126/23</p> <p>full [3] 35/21 139/15 148/1</p> <p>function [1] 28/9</p> <p>funding [1] 49/5</p> <p>funds [1] 150/8</p> <p>further [26] 9/8 16/17 16/17 17/2 17/12</p>	<p>26/16 58/18 58/23 96/1 96/2 97/17 107/8 107/25 108/24 110/4 112/2 119/18 120/3 120/19 120/21 121/8 129/9 132/11 140/9 141/17 143/8</p> <p>fuss [1] 82/6</p> <p>future [2] 52/15 65/15</p> <p>G</p> <p>Galea [2] 153/19 153/20</p> <p>gap [1] 89/11</p> <p>gathered [1] 114/18</p> <p>gave [8] 33/19 98/17 112/23 121/18 137/6 146/14 151/8 151/12</p> <p>gel [3] 14/23 15/4 19/7</p> <p>general [20] 12/20 17/1 42/7 48/5 56/13 56/15 56/18 56/25 66/22 73/5 74/16 74/25 75/25 86/4 94/7 98/23 106/13 107/2 109/4 131/21</p> <p>generality [2] 131/17 132/8</p> <p>generally [3] 22/19 49/24 80/6</p> <p>generate [1] 113/25</p> <p>generated [1] 29/2</p> <p>generous [1] 66/13</p> <p>gentleman [4] 13/17 13/22 14/17 91/17</p> <p>genuine [2] 142/8 143/4</p> <p>geographically [1] 34/14</p> <p>get [23] 20/17 21/2 33/2 36/6 56/20 58/17 92/3 92/12 92/23 93/6 94/14 94/20 105/21 106/3 112/15 113/1 117/7 117/17 121/19 128/24 130/1 145/11 152/24</p> <p>gets [1] 127/25</p> <p>getting [5] 13/21 100/6 106/12 124/20 127/4</p> <p>girl [1] 136/20</p> <p>give [12] 12/18 43/12 58/22 63/10 70/4 75/10 78/11 83/19 119/9 121/11 134/20 145/18</p> <p>given [34] 10/8 25/16 27/6 32/21 43/11 44/16 48/24 55/15 57/18 59/12 60/1 63/8</p>	<p>66/8 73/24 77/9 77/16 88/6 96/21 100/24 103/15 118/14 121/7 124/13 126/8 132/5 135/5 142/17 143/12 143/13 144/16 146/18 152/21 152/21 153/2</p> <p>gives [3] 63/17 64/13 152/24</p> <p>giving [5] 43/10 75/13 102/13 143/10 153/6</p> <p>glands [1] 79/19</p> <p>gleaned [1] 48/4</p> <p>go [61] 6/9 7/7 8/5 13/20 14/19 22/13 23/25 28/14 28/14 28/24 30/22 34/18 35/23 40/24 42/3 44/10 45/16 45/23 48/12 51/6 51/22 52/8 63/1 67/21 68/7 69/12 74/15 76/18 77/2 82/3 83/3 83/23 86/20 87/19 91/2 94/20 94/23 95/4 96/11 98/6 98/11 101/23 102/23 103/19 106/10 108/23 111/16 113/15 117/24 125/5 129/3 129/16 130/24 134/7 136/6 140/11 147/9 148/3 148/5 148/14 148/20</p> <p>goes [6] 21/19 90/2 101/23 121/11 134/20 149/15</p> <p>going [55] 1/22 2/4 3/17 13/8 19/15 19/20 29/16 30/11 36/19 37/1 38/9 40/23 42/24 44/7 45/5 48/7 49/7 49/16 54/20 67/18 75/24 75/25 76/1 76/24 78/1 78/8 84/3 84/22 89/17 92/10 92/21 92/23 95/22 109/2 112/19 117/19 121/22 122/6 125/8 126/12 127/5 127/22 129/7 129/17 136/11 136/23 142/5 144/5 144/9 144/10 145/2 145/15 147/19 151/23 152/4</p> <p>gone [1] 38/6</p> <p>good [16] 1/3 1/5 1/6 1/8 28/10 33/19 43/1 46/19 50/20 51/5 89/19 90/20 91/16 91/22 102/19 129/1</p> <p>goodness [1] 93/10</p> <p>got [25] 13/17 13/20 16/20 24/4 29/9 31/14</p>	<p>33/4 41/5 45/13 46/22 65/12 68/22 69/6 83/21 114/19 116/1 116/16 128/23 128/23 145/4 147/15 147/17 147/25 150/18 153/5</p> <p>GP [7] 96/1 120/1 120/1 120/24 121/3 121/18 121/20</p> <p>GPs [1] 97/17</p> <p>grateful [2] 119/6 137/7</p> <p>great [1] 149/13</p> <p>greater [2] 103/16 125/21</p> <p>grounds [1] 9/2</p> <p>group [2] 28/22 135/14</p> <p>grouping [3] 23/24 135/10 135/13</p> <p>groups [6] 3/18 74/19 75/25 76/8 95/12 151/4</p> <p>guarantee [1] 149/1</p> <p>guard [2] 103/3 104/18</p> <p>Guardian [3] 36/18 36/18 37/2</p> <p>guess [1] 142/20</p> <p>guidance [15] 54/25 55/13 55/24 56/13 56/15 56/18 56/18 58/11 59/22 60/8 60/22 63/8 65/19 71/24 143/8</p> <p>guidelines [9] 60/10 65/3 66/7 66/10 66/21 66/24 66/25 75/6 115/18</p> <p>GUM [4] 94/6 95/6 98/15 98/16</p> <p>Gunson [5] 19/24 88/22 110/6 110/25 126/10</p> <p>H</p> <p>habits [1] 80/21</p> <p>had [155]</p> <p>hadn't [8] 38/10 50/1 57/23 85/17 90/25 91/20 112/11 131/3</p> <p>haematological [2] 33/11 54/1</p> <p>haematologist [3] 3/5 51/3 110/18</p> <p>haematologists [4] 9/18 33/16 33/16 51/7</p> <p>haemophilia [11] 25/19 39/7 39/18 40/12 40/19 109/25 149/6 149/19 150/4 150/17 153/5</p>
--	---	---	--	---	---

H	128/3	13/5 13/11 13/15 14/6 14/10 15/23 18/23 44/8 44/15 44/23 44/25 45/2 45/7 46/23 47/14 47/23 61/1 63/2 63/4 63/11 63/13 63/15 63/19 63/21 64/11 64/21 65/12 65/19 65/24 66/2 66/2 66/8 81/10 112/19 116/10 117/21 118/5 118/8 118/13 118/16 118/24 119/10 121/6 121/9 121/12 121/13 122/12 123/9 125/9 127/6 136/22 137/2 137/12 137/18 138/9 138/17 139/6 139/10 142/4 153/12	his [13] 17/20 18/3 18/6 56/23 56/25 67/16 69/21 88/1 88/25 89/1 96/21 113/9 129/4 Histocompatibility [1] 5/10 historic [1] 39/3 historical [1] 150/15 history [10] 56/22 56/25 57/7 63/10 64/6 64/13 64/16 64/21 64/24 65/17 HIV [19] 44/9 89/19 91/7 92/5 93/1 95/24 96/4 98/3 102/9 104/11 108/3 109/5 110/4 110/11 110/14 111/3 111/22 121/9 127/18 HIV 1 [1] 111/22 HIV-related [1] 98/3 hoarseness [1] 43/22 hoc [2] 52/18 108/20 hold [3] 12/15 39/12 40/2 holding [1] 99/22 hole [1] 14/17 holes [3] 14/15 14/16 19/6 holiday [2] 5/21 5/23 holidays [2] 11/15 11/20 home [6] 1/8 34/18 43/5 45/20 48/19 146/22 homosexual [1] 62/17 homosexuals [1] 80/17 honest [5] 53/2 59/13 88/17 143/19 144/12 honestly [5] 22/7 25/9 64/6 67/3 141/7 hope [3] 14/23 137/3 149/3 hospital [23] 7/12 7/24 8/3 8/25 11/10 21/12 21/16 21/17 21/22 27/24 41/6 42/8 51/3 52/5 52/14 53/6 95/21 100/23 101/14 110/19 131/4 131/11 150/16 hospitals [29] 6/23 6/24 7/17 8/8 8/10 12/6 31/1 33/13 41/4 41/5 41/9 41/13 41/21 42/7 42/7 42/8 42/9 42/14 42/15 42/17 42/22 46/16 50/12 50/21 54/2 98/22 129/24 145/3 146/16	hour [3] 2/19 43/4 129/7 hours [4] 6/22 7/4 7/6 104/25 house [2] 1/11 1/12 how [48] 13/20 15/20 19/4 26/8 26/12 27/11 27/20 29/12 30/13 30/14 32/14 44/23 46/17 47/25 53/11 56/9 56/10 56/11 58/11 59/12 61/5 66/7 69/24 76/21 79/7 84/3 88/15 88/15 91/12 92/11 95/2 95/23 97/8 101/21 122/19 125/7 126/2 128/22 130/14 131/10 136/7 136/11 139/21 141/4 142/1 145/24 150/17 153/10 However [3] 22/22 92/19 135/16 HR [1] 91/17 Hs [1] 80/18 HTLV [21] 73/6 86/6 92/14 92/18 93/13 93/21 94/14 94/20 96/14 96/16 97/8 101/16 103/2 105/2 105/14 105/15 105/17 109/11 111/14 112/8 127/18 HTLV III [2] 86/6 96/16 HTLV-III [13] 73/6 92/14 92/18 93/13 93/21 101/16 103/2 105/2 105/15 105/17 109/11 112/8 127/18 HTLVIII [1] 98/14 Human [1] 106/6 humble [1] 136/13 humility [1] 153/14	12/14 12/23 18/22 20/3 22/11 27/13 30/10 31/23 40/13 41/13 77/11 89/5 92/10 98/4 99/9 106/13 109/4 130/23 144/19 147/17 147/20 151/6 152/2 I can't [23] 13/12 15/12 46/7 46/10 46/10 54/10 54/19 56/4 68/9 99/17 100/6 101/9 106/16 107/11 109/22 111/2 120/15 132/11 138/24 139/23 140/2 141/9 146/3 I cannot [3] 15/25 27/21 69/3 I collected [1] 13/23 I comment [1] 64/4 I correct [1] 143/1 I could [7] 13/25 16/16 16/18 53/24 95/21 108/20 114/8 I couldn't [1] 138/21 I did [10] 2/22 4/19 7/7 14/4 16/1 19/6 49/21 69/4 88/18 130/11 I didn't [2] 132/10 147/8 I do [12] 8/15 16/1 16/3 18/7 18/10 28/8 42/3 86/17 90/8 116/23 141/1 151/11 I don't [38] 17/22 41/17 48/3 49/9 49/21 53/13 55/19 79/13 85/11 86/18 86/23 87/4 87/14 88/17 88/19 89/16 91/2 91/25 103/5 105/19 107/24 109/13 110/2 112/24 113/15 120/22 125/25 126/4 127/2 127/3 127/19 128/25 130/8 130/11 133/3 139/23 145/24 146/21 I enclose [1] 121/10 I ever [1] 130/19 I felt [4] 66/13 82/23 86/19 115/15 I forget [1] 22/24 I gleaned [1] 48/4 I got [2] 13/17 31/14 I had [9] 3/2 16/2 17/25 18/17 44/14 49/1 95/22 120/8 130/5 I hadn't [1] 90/25 I hate [1] 143/18 I have [27] 1/12 19/2
haemophiliacs [1] 62/20 Haiti [1] 62/18 half [4] 43/3 129/7 148/10 150/3 halfway [3] 71/5 102/7 106/22 hand [14] 8/5 18/13 29/7 37/4 41/3 45/23 71/6 78/1 89/9 106/9 108/22 114/15 114/25 115/15 hand-out [1] 89/9 hand-written [1] 29/7 77/7 handed [1] 77/7 handful [7] 5/2 13/8 108/2 112/25 125/8 127/5 146/11 handing [2] 76/23 83/7 handwritten [3] 61/4 137/23 141/11 happen [6] 100/7 122/21 122/22 123/12 123/13 139/8 happened [5] 21/14 23/12 64/23 138/5 144/20 happening [4] 31/13 53/16 75/24 83/23 happens [1] 145/22 happy [1] 65/14 hard [1] 113/24 harvested [1] 99/12 has [27] 8/9 21/20 28/20 37/11 46/1 60/23 64/10 66/15 67/20 74/9 84/22 88/9 88/24 91/1 96/21 102/14 110/8 116/1 118/7 118/13 121/6 121/7 125/4 126/12 126/14 127/19 139/5 hate [1] 143/18 have [305] haven't [6] 71/11 72/13 72/15 72/17 129/14 129/15 having [15] 11/22 25/17 32/2 42/14 74/7 76/24 85/8 106/11 106/16 111/13 114/19 114/23 120/11 139/15 146/14 hazardous [1] 56/17 HBc [1] 64/2 HBe [1] 64/2 HBs [2] 63/11 64/3 HBsAG [5] 63/18 127/8 127/17 127/20	HCV [10] 112/19 113/11 113/21 115/4 119/23 141/11 141/14 143/16 144/17 144/23 he [26] 5/18 5/19 5/21 7/5 13/22 13/23 17/1 17/22 17/23 17/24 17/25 18/6 36/22 62/11 89/2 89/4 107/17 107/18 107/25 110/8 119/5 127/12 127/22 148/18 148/20 148/22 head [2] 6/15 136/1 heads [3] 23/22 35/2 35/3 health [42] 8/1 20/5 20/11 21/6 45/19 45/20 48/18 48/19 49/5 50/7 51/24 52/1 53/3 56/25 61/9 73/25 74/3 87/8 87/18 87/19 88/15 89/12 89/21 89/22 90/2 91/11 91/15 91/21 94/9 95/8 96/17 96/20 96/22 96/24 97/2 104/3 110/8 110/21 121/15 131/2 137/1 137/11 healthily [1] 24/15 healthy [2] 28/5 81/9 hear [4] 1/4 1/21 2/2 137/3 heard [10] 15/6 31/6 46/12 46/12 74/2 76/19 94/10 113/9 114/10 130/19 hearings [1] 37/1 heart [1] 11/10 heat [1] 86/11 Heathrow [1] 13/24 Heathrow Airport [1] 13/24 held [14] 2/12 7/14 7/23 11/8 12/7 28/20 29/19 40/6 40/14 99/25 102/21 134/2 135/2 135/17 Hello [1] 90/21 help [13] 19/1 36/8 38/11 101/20 107/25 122/18 124/7 142/21 142/24 143/15 144/15 144/18 145/5 helped [1] 124/7 helpful [3] 45/14 119/9 129/12 helping [1] 6/15 hence [2] 19/18 128/11 hepatitis [61] 13/3	hepatitis B [18] 13/3 13/5 13/11 13/15 14/6 14/10 15/23 18/23 44/15 44/25 64/11 65/12 65/24 81/10 121/9 125/9 127/6 137/12 137/18 138/9 138/17 139/6 139/10 142/4 153/12 hepatitis C [17] 45/2 45/7 47/14 112/19 116/10 117/21 118/5 118/8 118/13 118/16 118/24 121/6 121/12 121/13 122/12 136/22 142/4 Hepatologists [1] 141/21 her [8] 31/8 56/23 56/25 58/16 95/20 95/25 96/1 96/1 here [12] 1/16 16/23 36/15 51/17 63/5 64/12 72/11 81/18 83/25 113/18 121/1 141/19 heroin [1] 80/18 Herpes [1] 81/10 Hewitt [1] 42/2 hiccups [1] 149/24 high [10] 59/20 76/12 77/22 78/2 78/4 78/6 85/6 94/13 94/16 151/4 high-risk [10] 59/20 76/12 77/22 78/2 78/4 78/6 85/6 94/13 94/16 151/4 higher [2] 12/19 126/25 highlight [1] 48/13 highlighted [1] 135/9 him [4] 13/23 41/18 58/16 96/22 hindsight [1] 74/11	hour [3] 2/19 43/4 129/7 hours [4] 6/22 7/4 7/6 104/25 house [2] 1/11 1/12 how [48] 13/20 15/20 19/4 26/8 26/12 27/11 27/20 29/12 30/13 30/14 32/14 44/23 46/17 47/25 53/11 56/9 56/10 56/11 58/11 59/12 61/5 66/7 69/24 76/21 79/7 84/3 88/15 88/15 91/12 92/11 95/2 95/23 97/8 101/21 122/19 125/7 126/2 128/22 130/14 131/10 136/7 136/11 139/21 141/4 142/1 145/24 150/17 153/10 However [3] 22/22 92/19 135/16 HR [1] 91/17 Hs [1] 80/18 HTLV [21] 73/6 86/6 92/14 92/18 93/13 93/21 94/14 94/20 96/14 96/16 97/8 101/16 103/2 105/2 105/14 105/15 105/17 109/11 111/14 112/8 127/18 HTLV III [2] 86/6 96/16 HTLV-III [13] 73/6 92/14 92/18 93/13 93/21 101/16 103/2 105/2 105/15 105/17 109/11 112/8 127/18 HTLVIII [1] 98/14 Human [1] 106/6 humble [1] 136/13 humility [1] 153/14		
I			I almost [1] 144/12 I also [1] 6/21 I am [11] 1/9 54/10 65/23 69/3 69/4 72/19 92/2 113/19 118/12 118/18 143/11 I appreciate [1] 96/5 I arranged [1] 95/19 I arrived [2] 25/9 31/15 I ask [3] 51/14 67/19 91/7 I believe [2] 118/2 138/14 I came [2] 29/24 53/14 I can [26] 1/5 2/3 9/21		

<p>I</p> <p>I have... [25] 25/15 25/21 33/23 45/13 55/19 71/19 88/25 102/2 108/2 116/11 119/11 126/8 128/2 128/23 128/23 136/9 145/22 146/11 147/12 147/14 147/17 148/16 151/18 152/7 152/16</p> <p>I haven't [2] 71/11 129/14</p> <p>I honestly [4] 22/7 25/9 67/3 141/7</p> <p>I hope [1] 14/23</p> <p>I interrupted [1] 87/2</p> <p>I just [8] 48/10 48/15 108/13 112/25 126/4 134/11 134/15 147/12</p> <p>I know [2] 113/23 114/14</p> <p>I look [1] 43/15</p> <p>I made [1] 25/12</p> <p>I make [1] 25/6</p> <p>I may [9] 22/6 26/16 26/16 64/4 100/10 116/12 144/19 152/10 152/20</p> <p>I mean [3] 32/13 62/10 120/12</p> <p>I met [1] 95/20</p> <p>I must [5] 53/2 69/4 88/17 143/18 144/12</p> <p>I need [1] 145/9</p> <p>I opted [1] 144/11</p> <p>I personally [3] 12/9 95/17 141/7</p> <p>I plead [1] 136/12</p> <p>I presumably [1] 88/18</p> <p>I probably [1] 70/23</p> <p>I put [1] 130/20</p> <p>I quite [1] 116/3</p> <p>I quote [1] 144/5</p> <p>I read [1] 26/17</p> <p>I recall [3] 12/2 103/5 145/6</p> <p>I referred [1] 19/17</p> <p>I regret [1] 118/20</p> <p>I retired [2] 144/21 145/4</p> <p>I right [4] 15/17 49/8 64/19 144/14</p> <p>I said [6] 11/20 22/6 25/14 82/24 90/8 144/9</p> <p>I saw [1] 109/3</p> <p>I say [4] 120/11 124/10 132/9 152/11</p> <p>I see [2] 100/6 135/25</p> <p>I set [1] 149/10</p>	<p>I shall [1] 90/10</p> <p>I should [1] 137/7</p> <p>I spoke [1] 87/2</p> <p>I still [2] 114/25 115/15</p> <p>I suggest [1] 119/12</p> <p>I suspect [7] 23/12 32/5 71/17 100/10 100/11 101/9 146/2</p> <p>I take [2] 50/3 85/22</p> <p>I tell [1] 43/8</p> <p>I then [1] 67/4</p> <p>I think [63] 1/10 17/24 28/7 31/23 32/9 32/15 33/8 38/22 41/2 43/21 44/9 48/16 58/18 58/20 60/11 66/15 68/10 69/18 71/9 71/10 74/9 75/23 76/6 81/4 81/16 84/22 85/20 85/22 86/19 89/23 90/14 92/1 92/8 92/22 99/24 100/21 106/2 107/22 109/17 117/21 119/4 125/3 127/13 127/18 129/13 129/17 131/2 131/13 133/10 138/3 142/23 143/3 143/18 144/14 145/5 146/22 147/20 147/24 148/22 150/2 150/14 152/15 152/16</p> <p>I thought [3] 20/18 22/6 107/17</p> <p>I turn [1] 77/4</p> <p>I understand [7] 15/16 35/2 43/23 55/6 66/9 121/24 143/14</p> <p>I understood [1] 94/22</p> <p>I used [2] 13/24 14/14</p> <p>I want [6] 28/25 49/1 49/2 93/19 102/7 111/11</p> <p>I wanted [4] 91/6 98/18 102/3 106/8</p> <p>I was [42] 5/20 5/21 13/12 13/13 16/10 17/23 18/13 20/10 22/18 22/20 26/17 30/5 30/5 41/20 41/23 44/17 46/7 47/16 48/4 54/6 65/14 65/21 65/21 68/11 73/14 86/20 90/24 95/18 95/24 109/3 114/17 115/8 116/4 120/8 126/17 132/9 132/16 134/9 144/3 144/4 144/8 147/8</p> <p>I wasn't [2] 130/11 140/2</p>	<p>I will [13] 3/8 30/21 30/22 31/5 34/3 44/9 51/14 61/14 70/25 117/16 145/11 146/22 147/24</p> <p>I wish [2] 46/24 152/17</p> <p>I won't [2] 13/20 14/19</p> <p>I wonder [3] 43/1 101/20 116/12</p> <p>I would [15] 27/21 29/13 31/13 65/10 69/3 69/11 114/4 114/7 115/6 115/14 116/18 119/6 130/12 138/21 138/23</p> <p>I wrong [1] 49/8</p> <p>I wrote [1] 25/6</p> <p>I'll [1] 56/9</p> <p>I'm [51] 1/22 2/4 3/17 13/8 18/15 19/20 29/16 30/11 36/19 41/14 41/24 42/24 44/7 45/5 48/7 49/2 49/16 53/7 54/20 67/18 69/5 71/17 76/24 80/8 80/8 86/22 88/19 89/16 89/17 89/17 90/12 91/25 97/12 109/22 112/18 112/19 117/19 121/22 125/8 127/5 128/22 129/13 129/17 131/19 136/22 139/2 141/9 142/25 143/1 147/13 152/4</p> <p>iceberg [2] 111/16 111/19</p> <p>ICOP [1] 19/5</p> <p>idea [3] 19/7 20/17 136/9</p> <p>Ideally [1] 35/20</p> <p>ideas [2] 50/20 52/21</p> <p>identification [2] 44/15 110/9</p> <p>identified [5] 96/15 134/16 135/12 141/17 144/25</p> <p>identify [6] 13/25 47/4 78/14 110/13 112/10 151/3</p> <p>ie [3] 35/21 70/10 124/14</p> <p>ie that [1] 124/14</p> <p>IEOP [2] 15/17 19/5</p> <p>if [183]</p> <p>ignored [1] 82/8</p> <p>II [1] 56/21</p> <p>III [21] 73/6 86/6 92/14 92/18 93/13 93/21 94/14 94/20 96/14 96/16 97/8 101/16</p>	<p>103/2 105/2 105/14 105/15 105/17 109/11 111/14 112/8 127/18</p> <p>ill [2] 81/12 119/2</p> <p>ill-defined [1] 81/12</p> <p>illness [1] 118/20</p> <p>illnesses [1] 46/25</p> <p>imagination [1] 53/17</p> <p>imagine [5] 27/22 31/13 68/9 109/4 144/6</p> <p>immediate [1] 16/14</p> <p>Immune [1] 62/16</p> <p>immuno-electro [1] 19/3</p> <p>Immunohaematology [1] 10/7</p> <p>Immunology [2] 5/9 5/10</p> <p>impact [3] 85/15 123/23 124/15</p> <p>imperative [2] 23/3 128/20</p> <p>imperfect [1] 122/16</p> <p>implemented [3] 121/25 122/1 122/2</p> <p>implementing [1] 11/2</p> <p>implicated [1] 110/10</p> <p>implied [3] 68/15 70/8 70/9</p> <p>importance [1] 90/3</p> <p>important [4] 60/17 82/7 82/21 116/7</p> <p>impose [1] 12/24</p> <p>impression [1] 104/9</p> <p>improve [1] 130/9</p> <p>improved [1] 149/1</p> <p>inadequate [5] 134/19 134/24 136/2 136/7 136/15</p> <p>inappropriate [1] 81/14</p> <p>inaudible [1] 95/18</p> <p>incidence [3] 81/9 81/17 142/4</p> <p>include [4] 61/3 72/18 97/16 97/20</p> <p>included [4] 38/8 54/8 74/25 109/15</p> <p>includes [2] 60/25 72/18</p> <p>including [5] 6/13 6/14 45/2 47/1 72/13</p> <p>incoming [2] 11/2 13/7</p> <p>incompletely [1] 135/3</p> <p>incorrect [1] 41/12</p> <p>increase [8] 22/4 22/12 26/1 26/6 26/9 26/12 27/9 150/8</p>	<p>increased [2] 24/8 126/13</p> <p>increasing [1] 35/18</p> <p>incredibly [1] 12/10</p> <p>incubation [1] 47/4</p> <p>indeed [22] 1/9 2/3 2/6 3/16 16/2 39/23 43/6 44/2 50/12 53/19 57/20 78/23 79/25 89/7 97/19 100/19 103/10 121/21 125/17 144/5 144/8 144/25</p> <p>indefinitely [2] 133/13 134/2</p> <p>independent [2] 86/24 143/20</p> <p>independently [3] 10/13 86/19 87/15</p> <p>INDEX [1] 153/24</p> <p>indicate [2] 15/4 79/17</p> <p>indicated [2] 114/4 116/19</p> <p>indicates [1] 118/15</p> <p>indictment [1] 136/2</p> <p>individual [5] 87/24 96/6 96/15 97/15 97/24</p> <p>individually [4] 83/11 88/6 89/8 89/14</p> <p>individuals [4] 57/25 63/10 94/24 97/4</p> <p>industrial [1] 88/3</p> <p>industry [2] 133/2 133/9</p> <p>inevitable [1] 57/15</p> <p>inevitably [2] 14/4 59/8</p> <p>infected [11] 65/18 97/9 97/21 102/9 102/18 103/25 109/16 109/16 110/1 120/18 121/18</p> <p>infection [20] 16/24 28/5 28/6 45/1 73/15 95/3 95/25 96/16 97/1 102/14 104/11 118/15 118/17 119/10 119/25 130/21 134/1 139/6 140/18 140/21</p> <p>infections [9] 12/20 54/9 54/18 72/21 81/7 82/22 129/23 130/3 130/18</p> <p>infectious [3] 66/3 72/13 72/15</p> <p>Infirmary [2] 2/25 3/1</p> <p>inflammation [1] 119/1</p> <p>inform [3] 67/16 119/4 119/24</p> <p>informal [2] 53/25</p>	<p>146/14</p> <p>informant [1] 97/3</p> <p>information [46] 29/6 48/1 48/4 48/16 53/23 54/8 58/17 58/20 58/25 59/1 76/17 79/5 80/21 80/24 81/23 82/7 82/10 82/21 84/2 86/10 90/5 91/22 93/12 96/19 97/1 97/14 97/20 97/25 108/25 109/24 110/2 110/20 112/2 118/23 119/9 120/19 120/21 121/8 121/11 121/12 121/14 127/10 130/2 131/16 131/20 134/5</p> <p>informed [6] 17/20 109/11 121/7 137/11 137/18 139/5</p> <p>informing [2] 109/15 113/14</p> <p>inherited [1] 139/25</p> <p>initial [3] 16/24 70/11 92/15</p> <p>initially [10] 16/18 17/16 23/4 24/10 28/10 42/16 75/23 76/6 92/13 120/14</p> <p>initiated [1] 95/19</p> <p>initiative [1] 70/2</p> <p>inoculations [1] 72/16</p> <p>inordinate [1] 82/6</p> <p>input [4] 32/12 32/14 40/17 40/18</p> <p>inquiry [1] 139/15</p> <p>ins [2] 29/12 29/13</p> <p>ins' [1] 29/5</p> <p>insert [8] 106/22 106/25 107/2 107/10 107/18 107/19 107/23 107/23</p> <p>insight [1] 153/2</p> <p>insofar [1] 108/21</p> <p>inspection [6] 26/23 28/11 35/7 135/20 135/23 136/16</p> <p>Inspector's [1] 21/7</p> <p>Inspectorate [1] 134/13</p> <p>instance [1] 32/20</p> <p>instances [1] 80/10</p> <p>instead [1] 135/12</p> <p>instituted [2] 143/20 151/11</p> <p>instruction [2] 88/14 89/12</p> <p>instructions [1] 143/6</p> <p>intend [1] 112/24</p> <p>intended [1] 48/23</p> <p>interactions [1] 34/4</p> <p>interest [2] 8/2 144/13</p>
---	---	--	---	---	--

(50) I have... - interest

<p>I</p> <p>interesting [1] 147/12</p> <p>internal [2] 9/15 9/17</p> <p>interpreted [1] 48/22</p> <p>interrogate [1] 58/19</p> <p>interrupted [1] 87/2</p> <p>intervals [2] 56/16 104/4</p> <p>intervention [1] 146/24</p> <p>interview [1] 58/16</p> <p>into [29] 2/8 7/7 11/17 13/20 13/23 14/19 18/14 19/11 23/8 28/1 31/19 32/12 32/18 36/15 40/18 62/8 74/15 80/16 101/21 113/25 120/12 129/11 132/10 135/13 144/17 145/2 148/17 150/12 153/2</p> <p>introduce [5] 114/3 114/5 116/19 124/17 125/11</p> <p>introduced [12] 28/9 112/8 114/10 118/13 125/2 126/1 127/14 127/19 127/21 138/22 139/24 140/3</p> <p>introducing [4] 114/14 115/3 124/4 125/21</p> <p>introduction [5] 21/10 93/13 100/13 123/23 124/14</p> <p>invasive [1] 77/11</p> <p>investigate [1] 108/16</p> <p>investigation [2] 108/10 141/18</p> <p>investigations [6] 108/19 109/9 109/14 135/20 137/13 137/19</p> <p>invited [1] 27/24</p> <p>inviting [1] 69/5</p> <p>involved [20] 7/2 23/5 38/14 46/7 46/9 46/19 47/9 55/8 74/17 76/8 95/17 96/10 127/15 139/17 140/2 140/5 140/19 141/8 148/23 150/18</p> <p>involvement [2] 2/17 141/19</p> <p>involving [2] 74/16 95/7</p> <p>irregularity [1] 148/22</p> <p>irritated [1] 81/1</p> <p>isn't [5] 14/23 45/14 54/24 75/25 79/5</p> <p>issue [22] 13/1 26/1 26/7 30/11 34/25</p>	<p>36/12 36/14 38/25 38/25 67/5 67/5 70/24 105/6 111/3 115/6 115/7 115/9 115/9 115/11 115/11 118/4 135/19</p> <p>issued [18] 16/15 24/7 24/25 25/24 26/19 45/18 48/18 49/3 84/5 84/6 87/18 89/7 100/11 101/10 101/13 101/14 135/14 149/18</p> <p>issues [2] 38/3 38/3</p> <p>it's [3] 76/1 127/20 140/1</p> <p>its [14] 4/24 21/20 36/14 39/24 46/1 49/5 52/5 88/13 91/20 96/16 114/20 122/11 153/4 153/5</p> <p>itself [9] 8/21 8/24 11/13 14/1 15/2 51/23 105/20 122/11 125/14</p> <p>IX [3] 39/8 39/13 39/17</p> <p>J</p> <p>January [6] 87/18 89/13 101/25 106/20 108/5 143/7</p> <p>January 1985 [2] 87/18 89/13</p> <p>January 1995 [1] 143/7</p> <p>Japanese [6] 13/17 13/21 14/5 14/17 14/21 19/9</p> <p>jaundice [11] 61/1 63/4 63/10 63/13 64/14 64/16 64/22 65/17 65/25 66/3 72/18</p> <p>Jim [1] 149/11</p> <p>job [1] 152/14</p> <p>John [3] 21/12 21/15 27/23</p> <p>join [1] 15/3</p> <p>Journal [1] 36/22</p> <p>journalist [1] 37/3</p> <p>judge [2] 56/23 57/17</p> <p>July [6] 4/15 4/25 67/6 67/9 89/3 138/11</p> <p>July 1984 [2] 67/6 67/9</p> <p>July 1991 [1] 4/15</p> <p>July 1994 [1] 4/25</p> <p>June [9] 77/3 78/16 81/21 89/2 144/2 144/2 148/5 149/8 149/9</p> <p>June 1983 [1] 81/21</p>	<p>junior [1] 2/7</p> <p>just [94] 1/10 3/17 5/18 6/7 13/1 13/8 14/8 15/16 20/17 21/13 22/2 23/10 24/25 25/17 26/22 28/24 30/21 31/22 32/10 33/2 33/4 34/7 35/6 42/22 43/6 43/20 43/23 45/5 48/10 48/13 48/15 51/13 53/15 55/3 55/12 57/10 59/22 60/8 61/15 67/18 68/17 70/21 70/25 75/15 76/24 76/25 79/15 80/2 80/9 81/4 82/3 83/2 88/12 90/8 90/22 90/23 91/2 91/10 94/17 96/11 98/17 99/9 100/25 102/25 105/21 108/13 110/4 112/25 115/11 116/13 118/10 121/22 124/6 125/8 126/4 126/7 126/9 126/17 127/5 128/22 129/17 130/18 133/11 134/11 134/15 134/25 139/19 141/1 142/21 142/23 145/11 146/23 147/12 147/25</p> <p>justification [2] 35/17 35/20</p> <p>justified [1] 78/19</p> <p>justify [1] 37/14</p> <p>K</p> <p>keep [3] 82/24 103/1 151/23</p> <p>keeping [8] 50/9 50/11 51/20 52/3 104/5 127/22 130/25 139/20</p> <p>kept [5] 104/17 122/22 133/7 133/13 134/22</p> <p>key [1] 66/11</p> <p>kind [5] 14/13 15/10 57/20 57/24 105/10</p> <p>kinds [2] 15/6 15/9</p> <p>knew [6] 23/16 45/7 75/4 75/17 142/6 153/8</p> <p>know [48] 16/1 16/4 17/19 18/6 18/7 18/8 18/12 19/22 28/8 49/2 49/2 53/13 55/16 55/19 60/22 63/2 74/1 85/12 89/15 90/5 109/1 109/17 113/23 114/14 118/12 120/17 120/20 120/22 123/18</p>	<p>123/20 126/2 126/4 126/16 126/24 126/25 127/3 127/10 128/25 130/8 130/18 137/6 141/4 141/7 142/1 145/24 148/7 152/25 153/1</p> <p>knowing [2] 74/5 104/1</p> <p>knowledge [3] 44/8 46/20 48/6</p> <p>known [11] 13/15 19/11 47/10 47/13 64/1 74/13 76/7 81/7 83/1 109/19 140/14</p> <p>knows [1] 65/12</p> <p>Kundu [1] 1/13</p> <p>L</p> <p>label [1] 135/14</p> <p>labels [1] 105/9</p> <p>laboratories [4] 9/4 9/8 23/23 136/18</p> <p>laboratory [12] 2/16 3/11 8/22 23/22 26/21 47/3 92/25 121/15 135/2 135/11 135/18 136/19</p> <p>lack [3] 69/23 86/10 136/12</p> <p>lady [1] 95/19</p> <p>Lane [2] 148/4 148/6</p> <p>large [4] 31/4 57/1 59/6 80/25</p> <p>largely [2] 42/18 150/15</p> <p>larger [1] 1/18</p> <p>largest [1] 24/6</p> <p>last [19] 13/1 24/15 26/17 31/7 46/12 61/2 61/23 72/14 82/4 88/20 89/21 102/6 109/3 111/3 112/22 112/23 116/16 137/6 151/8</p> <p>lastly [2] 72/9 72/20</p> <p>late [1] 109/7</p> <p>later [11] 15/20 23/1 23/2 28/9 29/16 34/4 44/9 71/23 110/23 114/11 129/9</p> <p>latter [3] 31/14 47/2 127/25</p> <p>lawyer [1] 43/14</p> <p>Le [1] 67/24</p> <p>Le Brasseur [1] 67/24</p> <p>lead [5] 45/2 45/8 80/22 97/3 115/19</p> <p>Leader [1] 10/11</p> <p>leading [4] 47/7 118/2 118/4 143/13</p> <p>leaflet [39] 60/5 60/20</p>	<p>61/8 62/23 72/3 72/4 72/19 74/1 74/7 75/18 76/10 76/21 77/5 77/17 77/23 84/1 84/3 84/20 85/6 85/14 85/15 85/19 85/21 86/8 86/15 86/18 86/24 87/5 87/13 87/15 87/23 88/1 88/6 88/10 88/16 89/5 89/8 89/13 150/25</p> <p>leaflets [8] 61/12 83/8 83/15 84/7 84/10 84/11 88/7 88/15</p> <p>league [1] 148/8</p> <p>least [13] 7/7 16/4 41/23 59/4 64/2 77/11 77/17 81/14 82/11 83/13 86/7 120/13 122/1</p> <p>leave [1] 126/6</p> <p>leaving [1] 77/12</p> <p>lecture [2] 9/7 9/11</p> <p>lecturer [1] 2/10</p> <p>led [3] 38/24 48/1 116/25</p> <p>left [14] 5/23 8/5 18/21 18/24 34/23 36/16 41/3 45/23 71/6 76/19 88/24 101/7 103/11 133/21</p> <p>left-hand [4] 8/5 41/3 45/23 71/6</p> <p>legal [2] 146/13 152/5</p> <p>length [2] 73/24 75/16</p> <p>lengths [1] 132/24</p> <p>less [7] 27/14 65/14 102/15 104/22 114/1 131/16 142/5</p> <p>lesser [1] 104/11</p> <p>let [8] 13/22 41/18 43/8 45/14 113/4 118/12 137/6 137/8</p> <p>let's [7] 59/18 73/13 93/11 129/3 129/7 129/16 131/13</p> <p>letter [41] 69/17 77/2 78/10 78/16 79/14 83/25 88/21 89/1 89/3 93/16 93/23 108/5 110/6 110/23 111/1 113/7 113/13 113/18 114/9 114/19 115/1 116/13 117/24 118/7 119/18 119/25 120/18 120/24 121/1 121/2 121/11 121/17 126/10 127/6 136/24 137/22 140/7 141/11 148/3 149/4 149/9</p> <p>Letters [1] 140/19</p> <p>letting [1] 65/20</p>	<p>level [2] 50/21 64/3</p> <p>levels [1] 97/7</p> <p>liability [2] 79/17 107/4</p> <p>liaison [2] 4/18 5/3</p> <p>life [4] 98/21 99/19 99/20 101/3</p> <p>lifestyle [2] 79/3 82/20</p> <p>light [2] 7/11 114/9</p> <p>like [22] 8/19 8/22 19/15 34/17 35/24 42/9 43/15 45/25 61/6 69/6 78/25 91/11 91/12 128/8 130/5 137/20 137/24 138/18 142/12 142/14 146/23 152/9</p> <p>likely [9] 22/8 31/3 69/11 79/24 80/15 101/12 129/3 138/23 142/4</p> <p>limiting [1] 109/2</p> <p>line [8] 14/20 15/3 19/16 85/5 124/10 148/17 149/21 150/12</p> <p>link [1] 34/10</p> <p>linked [1] 74/14</p> <p>list [10] 22/14 23/20 24/1 35/7 61/24 62/6 72/1 72/17 110/15 134/24</p> <p>listed [5] 57/3 57/13 59/24 61/13 62/4</p> <p>listen [1] 153/10</p> <p>listening [1] 1/19</p> <p>literally [1] 26/14</p> <p>literature [1] 77/7</p> <p>little [11] 7/2 14/20 19/16 22/18 23/10 28/7 29/16 31/23 34/7 42/16 106/11</p> <p>lived [2] 72/15 95/20</p> <p>liver [5] 28/9 45/3 45/8 118/24 119/1</p> <p>living [1] 27/22</p> <p>Lloyd [5] 113/7 113/9 113/13 114/22 115/4</p> <p>local [5] 10/21 30/25 33/7 146/15 147/11</p> <p>location [1] 150/16</p> <p>logical [1] 34/17</p> <p>London [5] 31/9 34/7 37/12 37/23 38/9</p> <p>long [18] 11/15 11/20 14/2 14/11 27/11 64/22 65/23 75/8 75/21 98/21 99/19 99/20 101/2 114/3 119/3 136/7 136/11 149/1</p> <p>long-term [1] 119/3</p>
---	--	---	--	--	--

(51) interesting - long-term

<p>L</p> <p>longer [4] 24/15 128/23 146/2 150/20</p> <p>look [67] 5/24 6/7 7/25 9/23 21/1 21/3 21/5 21/9 26/24 27/25 34/25 35/8 35/24 36/10 40/22 41/1 41/3 43/15 50/14 56/8 59/18 60/7 62/25 69/12 69/13 71/1 71/3 71/6 78/10 79/15 83/22 96/12 102/23 103/12 108/14 110/4 110/25 111/3 112/20 117/22 120/23 120/25 122/9 125/6 126/7 128/8 132/10 134/11 136/22 139/7 140/24 140/24 141/2 141/4 141/10 141/12 141/13 143/6 143/9 143/10 143/14 143/17 143/20 144/18 144/24 145/2 149/7</p> <p>look-back [14] 110/4 110/25 128/8 136/22 140/24 141/2 141/4 141/12 141/13 143/6 143/14 143/17 144/18 145/2</p> <p>looked [21] 35/6 36/25 37/18 40/24 41/1 52/24 59/22 68/17 71/23 100/25 110/22 111/5 112/22 112/25 113/15 129/20 130/25 134/11 136/21 145/5 147/5</p> <p>looking [15] 3/1 25/22 25/23 26/22 38/15 55/12 60/8 70/24 74/11 91/19 104/13 117/22 128/22 144/23 145/3</p> <p>looks [6] 42/9 56/17 61/6 69/6 137/24 138/18</p> <p>loophole [2] 69/19 69/21</p> <p>Lord [1] 149/22</p> <p>losing [1] 82/21</p> <p>loss [2] 79/19 81/2</p> <p>lost [3] 128/1 144/12 150/7</p> <p>lot [6] 32/20 76/7 114/11 142/5 145/13 145/24</p> <p>loud [1] 143/23</p> <p>low [3] 11/19 22/9 81/18</p>	<p>lower [1] 81/20</p> <p>luck [1] 113/5</p> <p>lunch [5] 87/17 88/21 90/13 90/24 91/9</p> <p>lunchtime [2] 85/22 151/24</p> <p>M</p> <p>machines [1] 27/7</p> <p>made [34] 5/19 13/18 14/15 25/4 25/4 25/10 25/12 25/14 30/14 30/23 36/14 39/17 40/6 40/11 40/15 40/19 42/18 77/5 79/9 79/11 82/6 88/5 88/13 89/6 91/20 105/12 117/6 120/17 128/2 129/24 131/1 134/25 139/15 140/14</p> <p>magic [1] 128/10</p> <p>main [3] 6/12 21/22 122/6</p> <p>mainly [3] 9/14 29/1 98/22</p> <p>maintain [1] 96/18</p> <p>maintained [5] 38/8 81/6 96/14 97/13 135/3</p> <p>majority [1] 85/2</p> <p>make [17] 16/19 23/14 23/16 23/18 24/12 25/6 39/9 43/5 90/13 90/23 116/21 119/24 128/6 128/9 128/12 131/5 147/25</p> <p>making [5] 25/2 39/9 50/13 119/20 147/5</p> <p>managed [1] 11/6</p> <p>management [5] 4/21 6/22 22/19 50/7 96/2</p> <p>manager [7] 22/15 22/16 22/17 23/5 23/6 23/22 136/19</p> <p>managers [1] 23/22</p> <p>manner [3] 23/19 116/5 117/10</p> <p>manually [1] 28/21</p> <p>many [9] 6/14 30/14 82/9 82/13 99/3 111/23 124/1 126/2 145/24</p> <p>March [8] 4/4 4/9 84/1 84/18 84/23 89/10 89/15 126/11</p> <p>March 1981 [1] 4/4</p> <p>March 1984 [2] 84/18 84/23</p> <p>March 1985 [2] 89/10 89/15</p> <p>March 1990 [1] 4/9</p> <p>mark [1] 61/4</p>	<p>marker [1] 65/25</p> <p>markers [1] 64/2</p> <p>Marlene [1] 136/18</p> <p>Mary's [1] 95/23</p> <p>massive [3] 26/20 81/24 92/3</p> <p>material [6] 32/16 98/25 101/5 109/18 149/18 151/1</p> <p>matter [10] 26/14 43/11 58/23 74/12 74/16 82/16 131/17 131/21 132/7 149/12</p> <p>matters [8] 52/15 59/14 60/24 72/12 78/14 83/2 86/13 149/5</p> <p>may [65] 3/13 8/11 12/19 13/25 16/23 19/23 21/5 22/6 22/25 25/11 25/16 26/16 26/16 27/14 27/24 38/13 38/21 43/21 44/4 47/6 49/3 59/19 61/25 63/11 63/23 64/4 64/4 65/18 65/19 77/22 78/4 79/24 79/25 82/7 88/2 92/8 95/1 100/10 104/10 105/11 105/17 107/6 107/22 109/11 110/10 110/19 116/12 119/5 119/9 119/17 121/13 127/2 129/6 130/16 130/21 131/15 138/25 139/9 141/23 142/2 144/19 146/25 152/10 152/18 152/20</p> <p>May 1980 [2] 3/13 19/23</p> <p>May 1982 [1] 8/11</p> <p>May 1990 [1] 22/25</p> <p>maybe [7] 33/18 92/11 124/9 145/24 145/24 146/25 146/25</p> <p>Mayor [1] 149/22</p> <p>me [32] 1/4 1/6 1/13 2/2 5/23 8/15 13/18 13/22 19/1 19/4 42/25 43/8 45/14 45/14 49/12 61/6 78/23 80/11 90/7 91/1 91/4 106/17 113/4 116/2 119/8 119/14 119/19 126/12 137/6 137/8 142/21 147/10</p> <p>mean [16] 20/21 32/13 35/2 48/23 50/17 62/10 75/21 84/6 84/6 85/9 105/23 115/24 120/12 142/13 142/14 151/19</p>	<p>meaning [1] 95/2</p> <p>means [5] 73/20 84/21 116/23 142/8 148/22</p> <p>meant [3] 7/6 123/19 128/17</p> <p>measured [1] 26/11</p> <p>medical [40] 6/17 11/6 22/14 28/8 36/22 42/2 42/5 51/2 51/10 55/14 55/24 56/21 56/22 56/25 57/6 57/20 58/4 58/10 58/14 62/2 62/5 62/8 63/9 67/22 68/14 68/22 69/9 69/14 70/18 70/20 73/2 73/5 79/16 80/6 82/14 82/16 91/14 93/18 97/2 146/24</p> <p>medicine [7] 2/11 2/21 2/24 3/3 9/19 46/15 49/25</p> <p>Medicines [2] 21/6 134/13</p> <p>meet [7] 26/5 30/25 33/1 33/7 33/17 88/8 95/19</p> <p>meeting [24] 4/24 33/24 35/1 53/8 53/21 67/6 67/8 68/7 68/8 68/11 68/17 69/2 70/18 85/23 88/25 95/22 98/8 98/10 100/24 103/18 106/19 107/4 147/10 149/10</p> <p>meetings [15] 3/19 3/23 4/2 4/15 5/3 17/19 52/12 52/19 53/4 53/13 53/18 54/13 54/14 54/18 54/23</p> <p>member [4] 4/23 5/8 5/11 69/16</p> <p>members [1] 97/21</p> <p>memorandum [3] 67/22 68/5 69/9</p> <p>memory [1] 147/18</p> <p>men [2] 62/17 62/18</p> <p>mental [1] 8/15</p> <p>mention [1] 53/24</p> <p>mentioned [3] 53/8 57/14 62/21</p> <p>message [1] 143/23</p> <p>messages [1] 146/22</p> <p>met [4] 35/10 36/5 91/12 95/20</p> <p>method [4] 13/4 13/10 63/18 84/10</p> <p>methods [1] 24/24</p> <p>microbiological [1] 64/8</p>	<p>microbiologically [1] 134/19</p> <p>microbiology [5] 23/24 92/25 134/22 135/5 135/7</p> <p>mid [3] 43/3 93/24 147/22</p> <p>mid-'80s [1] 147/22</p> <p>mid-morning [1] 43/3</p> <p>middle [2] 19/8 92/22</p> <p>might [38] 12/25 43/12 49/13 54/3 54/8 56/5 59/8 59/13 65/13 66/3 66/18 73/11 73/13 77/18 78/14 78/24 82/20 86/24 87/3 87/5 87/7 89/19 90/9 92/1 95/24 96/1 99/1 99/5 99/13 99/18 107/3 107/19 115/25 118/16 118/20 122/18 123/1 123/21</p> <p>mild [1] 118/25</p> <p>military [8] 12/4 12/6 12/7 12/8 12/19 30/8 151/17 151/22</p> <p>million [2] 21/24 102/15</p> <p>mind [11] 1/20 75/2 77/15 78/18 82/25 96/3 119/17 123/8 145/21 147/2 147/4</p> <p>minimise [1] 146/18</p> <p>Minister [1] 36/19</p> <p>Ministers [1] 87/22</p> <p>minute [1] 100/24</p> <p>minutes [6] 14/24 42/25 98/7 128/24 129/13 145/14</p> <p>misleading [1] 79/20</p> <p>misused [1] 116/22</p> <p>Mm [1] 60/15</p> <p>MO [1] 63/6</p> <p>mobile [4] 9/10 27/1 28/25 29/1</p> <p>mode [1] 95/25</p> <p>modification [1] 128/12</p> <p>moment [3] 1/14 8/15 90/12</p> <p>Monday [2] 1/1 11/8</p> <p>Mondays [1] 10/18</p> <p>money [1] 141/20</p> <p>month [4] 16/9 84/8 122/15 122/25</p> <p>monthly [7] 27/14 27/19 51/1 103/23 131/5 131/10 131/15</p> <p>months [18] 13/6 16/6 16/9 17/22 17/25 26/11 33/17 61/2 63/14 63/16 64/2</p>	<p>64/22 86/7 102/12 104/8 116/10 124/10 144/7</p> <p>Moore [1] 107/7</p> <p>more [56] 3/8 10/23 18/3 18/5 18/15 23/17 24/19 24/19 24/20 24/20 28/24 30/5 32/7 32/20 34/7 34/21 37/11 37/21 42/9 42/13 42/13 42/25 47/6 48/16 49/23 54/11 54/16 56/18 58/17 61/24 64/22 66/20 67/1 67/18 74/24 77/19 79/1 80/17 81/8 87/16 102/16 104/2 105/8 106/4 108/2 111/20 116/7 122/7 122/8 122/15 123/20 127/24 129/3 149/14 150/6 153/14</p> <p>morning [8] 1/3 1/5 34/5 43/3 105/5 134/12 151/16 151/23</p> <p>morning's [1] 90/22</p> <p>mornings [1] 11/8</p> <p>Moss [1] 98/15</p> <p>most [16] 7/6 24/7 44/18 45/1 57/7 66/1 80/15 81/22 82/10 83/12 83/17 85/1 102/21 103/22 124/11 137/7</p> <p>mostly [2] 2/16 6/17</p> <p>move [5] 19/20 38/4 42/24 54/20 89/17</p> <p>moved [2] 21/15 25/3</p> <p>moving [7] 2/8 38/25 40/22 72/25 85/13 85/21 98/3</p> <p>Mr [1] 107/5</p> <p>Mr Evans [1] 107/5</p> <p>Ms [6] 1/16 1/25 2/1 43/20 152/12 154/3</p> <p>Ms Scott [6] 1/16 1/25 2/1 43/20 152/12 154/3</p> <p>much [20] 1/18 19/19 26/12 31/2 32/14 59/15 81/11 81/20 83/19 84/25 91/14 103/16 122/7 122/8 125/18 127/15 128/22 146/2 149/1 152/17</p> <p>multidisciplinary [2] 95/7 96/8</p> <p>multidisciplinary-type [1] 96/8</p> <p>must [19] 17/24 43/10 53/2 54/10 60/23</p>
---	---	---	---	---	---

<p>M</p> <p>must... [14] 62/21 69/4 71/10 88/17 92/2 96/13 96/22 97/5 139/17 140/5 143/18 144/12 151/25 152/12</p> <p>mutual [1] 149/5</p> <p>my [36] 1/13 2/25 5/22 6/12 9/6 14/2 14/5 23/4 25/7 25/10 28/12 41/20 42/11 44/18 44/25 48/5 50/1 53/2 53/17 54/1 112/9 126/24 128/11 128/22 129/14 129/14 130/20 136/18 144/10 144/15 145/12 150/7 150/14 152/7 152/19 152/20</p> <p>myself [5] 6/15 17/23 34/21 143/1 149/11</p> <p>N</p> <p>nail [1] 45/6</p> <p>name [5] 10/4 28/22 44/17 49/14 118/21</p> <p>namely [1] 80/16</p> <p>names [1] 35/6</p> <p>Napier [1] 91/5</p> <p>national [42] 2/11 2/20 3/3 3/10 4/17 4/20 4/21 4/23 20/9 30/6 30/17 32/11 32/12 38/19 38/19 38/24 45/21 45/22 48/20 48/24 52/7 96/20 113/24 114/19 115/16 115/17 117/6 124/22 125/1 125/7 125/12 125/13 125/15 127/16 127/17 132/14 140/24 141/2 143/6 143/16 143/19 144/3</p> <p>National Health Service [1] 96/20</p> <p>nationally [3] 29/23 86/21 150/25</p> <p>naturally [1] 26/4</p> <p>NBA [3] 4/23 5/5 20/24</p> <p>NBTS [15] 49/4 49/13 57/4 57/5 57/8 59/21 59/24 59/25 60/2 60/7 60/11 60/12 71/6 71/7 98/8</p> <p>NBTS 101 [1] 57/8</p> <p>NBTS 1011 [1] 71/7</p> <p>NBTS 110 [3] 57/5 59/25 71/6</p> <p>NBTS 110A [6] 57/4 59/21 59/24 60/2 60/7 60/12</p>	<p>nearer [1] 145/13</p> <p>nearly [1] 7/9</p> <p>necessarily [4] 49/14 58/19 74/17 79/3</p> <p>necessary [14] 7/10 23/14 27/19 54/2 62/25 79/25 93/9 96/25 107/6 108/23 129/21 130/24 131/24 143/9</p> <p>necessity [1] 17/2</p> <p>need [17] 30/25 38/22 42/3 91/2 92/16 106/24 107/1 107/10 107/18 109/17 119/6 119/18 141/17 145/9 146/17 147/2 147/4</p> <p>needed [11] 7/8 7/21 9/13 30/14 30/18 32/17 36/7 54/7 90/5 104/24 115/10</p> <p>needn't [1] 74/15</p> <p>needs [5] 30/25 33/7 33/12 36/5 141/19</p> <p>negative [5] 43/25 44/1 63/17 64/1 99/7</p> <p>negligible [2] 84/9 84/21</p> <p>negotiate [1] 41/22</p> <p>neither [1] 134/9</p> <p>neutral [1] 79/5</p> <p>never [5] 32/6 77/23 78/1 119/21 130/22</p> <p>nevertheless [1] 138/1</p> <p>new [20] 6/1 8/24 8/25 9/2 21/15 25/3 29/5 54/5 54/6 88/3 88/8 88/25 99/5 103/1 103/7 103/19 121/4 142/16 147/6 149/13</p> <p>New Orleans [2] 88/25 147/6</p> <p>Newcastle [1] 113/8</p> <p>newly [1] 118/12</p> <p>next [14] 1/12 8/9 59/11 71/19 82/1 88/1 93/9 105/4 106/10 122/25 134/21 135/8 150/1 150/7</p> <p>NHBT0000073 [1] 113/17</p> <p>NHBT0000074 [2] 113/6 116/15</p> <p>NHBT0000077 [1] 126/9</p> <p>NHBT0000476 [1] 51/17</p> <p>NHBT0000745 [1] 88/21</p> <p>NHBT0004251 [1] 92/7</p>	<p>NHBT0004521 [1] 92/6</p> <p>NHBT0006265 [4] 21/1 26/23 28/15 134/12</p> <p>NHBT0006682 [1] 72/10</p> <p>NHBT0009748 [1] 42/5</p> <p>NHBT0010861 [1] 71/4</p> <p>NHBT0015108 [1] 110/5</p> <p>NHBT0019630 [2] 101/19 111/4</p> <p>NHBT0020746 [1] 76/25</p> <p>NHBT0053158 [1] 120/25</p> <p>NHBT0053225 [2] 55/4 60/9</p> <p>NHBT0055409 [1] 140/25</p> <p>NHBT0057093 [1] 138/7</p> <p>NHBT0081007 [1] 127/6</p> <p>NHBT0087333 [1] 136/24</p> <p>NHBT0090316 [1] 67/19</p> <p>NHBT0092851 [1] 98/5</p> <p>NHBT009472 [2] 112/21 113/3</p> <p>NHBT0111632 [1] 35/1</p> <p>NHBT0113565 [1] 85/25</p> <p>NHS [3] 8/7 41/4 42/20</p> <p>nice [2] 35/13 100/7</p> <p>night [2] 7/4 79/19</p> <p>no [94] 1/12 5/19 8/7 8/8 9/21 11/12 11/20 12/1 12/2 12/16 14/3 16/22 17/4 17/10 17/11 17/16 18/10 20/9 22/6 22/12 23/1 25/15 25/21 29/19 30/5 33/22 35/17 35/19 36/1 37/14 39/11 40/21 40/21 41/4 41/4 42/21 44/18 47/3 49/4 49/21 53/7 53/24 55/10 55/19 55/19 57/17 58/1 65/8 79/13 79/16 80/11 85/4 87/15 89/5 89/16 93/7 96/4 96/10 97/13 99/16 102/2 103/9 104/9 106/16 109/5</p>	<p>109/22 110/2 110/21 111/2 112/1 112/12 113/4 120/9 123/9 124/2 130/5 130/11 132/20 133/18 134/24 134/25 135/3 135/5 136/9 136/10 137/24 137/25 143/25 147/8 147/12 147/22 150/20 151/6 151/15</p> <p>nobody [2] 16/20 37/15</p> <p>nominally [1] 131/13</p> <p>non [16] 44/16 44/23 44/24 47/1 47/14 47/14 47/22 47/23 65/18 65/18 79/18 121/23 121/23 123/4 123/4 152/14</p> <p>non-A [5] 44/23 47/14 47/22 65/18 121/23</p> <p>non-B [6] 44/24 47/14 47/23 65/18 121/23 123/4</p> <p>non-B' [2] 44/16 47/1</p> <p>non-specific [1] 79/18</p> <p>none [4] 12/16 84/14 84/16 152/7</p> <p>nonetheless [3] 45/2 66/14 80/11</p> <p>nor [1] 98/2</p> <p>norm [1] 80/8</p> <p>normal [7] 33/15 38/8 81/9 101/10 123/1 123/3 123/18</p> <p>normally [3] 43/2 87/25 151/20</p> <p>North [2] 31/9 34/7</p> <p>North London [1] 34/7</p> <p>northern [1] 113/8</p> <p>not [206]</p> <p>notes [6] 45/11 48/17 62/15 107/2 128/22 129/20</p> <p>nothing [3] 14/3 114/1 122/17</p> <p>notice [1] 72/8</p> <p>noticed [1] 43/21</p> <p>notification [1] 88/1</p> <p>notified [2] 98/16 137/25</p> <p>now [45] 8/11 13/20 15/12 19/20 28/17 29/17 30/11 35/17 38/15 43/1 43/3 43/7 49/16 50/6 54/20 70/25 84/9 84/20 84/23 89/18 89/19 90/8 99/9 101/19 107/19 108/4 112/19 113/16 117/19 118/21</p>	<p>126/17 128/2 129/1 129/8 129/18 130/14 137/4 140/22 141/14 143/6 144/2 145/15 145/22 147/14 153/1</p> <p>number [19] 8/12 10/25 24/7 24/9 24/25 28/22 41/8 50/13 80/25 127/24 127/25 128/2 132/18 134/25 138/13 142/5 142/8 144/24 145/23</p> <p>numbers [8] 25/13 27/9 110/16 128/4 128/6 128/7 128/10 128/18</p> <p>Nurse [1] 6/15</p> <p>NW [1] 35/11</p> <p>O</p> <p>oath [1] 1/23</p> <p>objection [1] 70/13</p> <p>obligation [3] 92/23 96/18 98/2</p> <p>obtain [2] 149/3 149/5</p> <p>obtained [2] 89/1 99/6</p> <p>obvious [4] 25/16 109/12 125/4 131/25</p> <p>obviously [20] 1/6 16/16 25/13 26/3 31/2 32/2 38/6 46/18 59/9 70/20 76/2 81/25 90/9 97/23 108/11 108/22 127/11 128/20 136/3 136/9</p> <p>occasion [2] 34/21 120/9</p> <p>occasionally [1] 11/14</p> <p>occupations [1] 56/17</p> <p>occur [1] 73/20</p> <p>occurred [3] 38/21 54/13 80/10</p> <p>occurrence [2] 137/17 137/20</p> <p>October [13] 4/25 68/8 88/22 92/22 93/14 93/24 98/9 99/22 100/3 108/8 112/20 136/24 137/22 93/14 99/22</p> <p>October 1985 [2] 93/14 99/22</p> <p>October 1990 [1] 112/20</p> <p>October 1993 [1] 4/25</p> <p>odd [4] 137/15 137/20 138/4 152/1</p> <p>odds [1] 64/9</p> <p>of: [1] 124/22</p> <p>of: what [1] 124/22</p> <p>off [8] 27/15 27/15 27/19 38/25 44/10</p>	<p>68/22 85/16 103/11</p> <p>offer [2] 62/2 120/17</p> <p>offered [1] 79/24</p> <p>offhand [6] 46/7 54/19 99/18 109/22 120/22 139/23</p> <p>Office [2] 45/21 48/20</p> <p>officer [13] 55/24 57/6 57/20 58/4 58/10 58/15 62/2 62/5 62/8 63/9 82/16 91/15 93/18</p> <p>official [1] 61/7</p> <p>often [3] 91/12 116/23 150/5</p> <p>oh [3] 7/19 14/11 75/24</p> <p>okay [4] 43/8 58/21 108/1 113/4</p> <p>Oliver [2] 1/22 1/23</p> <p>once [6] 20/9 58/25 122/14 124/21 128/1 131/13</p> <p>one [79] 11/2 12/9 13/1 14/16 15/9 19/9 21/22 26/16 27/15 27/17 28/24 30/20 34/21 36/12 36/16 36/18 37/6 37/7 37/18 38/3 38/20 41/6 42/7 48/22 48/23 54/5 57/23 59/9 59/10 62/3 64/13 64/24 66/11 66/15 67/18 71/19 71/23 72/16 73/17 74/9 75/8 82/18 82/20 82/23 84/22 85/11 85/18 87/11 92/1 92/1 92/9 94/21 95/17 96/6 97/6 102/19 109/13 113/5 124/8 124/19 125/4 125/11 130/20 130/23 137/15 138/4 138/11 140/6 142/7 142/10 142/22 146/22 147/20 148/2 150/2 151/6 151/21 151/21 152/24</p> <p>ones [2] 80/17 97/24</p> <p>ongoing [1] 133/24</p> <p>online [1] 1/19</p> <p>only [28] 9/1 18/22 23/16 25/23 27/15 31/24 38/4 40/5 40/10 53/24 63/23 70/9 73/17 74/20 75/24 78/23 79/6 83/9 85/5 89/20 95/17 102/19 109/4 124/7 127/14 130/23 148/7 151/6</p> <p>onto [2] 65/20 105/19</p> <p>onwards [2] 75/23</p>
--	---	--	---	--	---

(53) must... - onwards

<p>O</p> <p>onwards... [1] 147/22</p> <p>open [7] 49/11 59/9 61/18 61/20 78/25 79/8 80/20</p> <p>opened [2] 9/1 21/11</p> <p>operating [6] 98/24 125/16 138/8 138/16 141/3 141/5</p> <p>operational [1] 50/21</p> <p>operations [1] 11/10</p> <p>opinion [1] 114/18</p> <p>opportunity [6] 33/19 59/2 75/11 75/13 83/20 143/10</p> <p>opposed [3] 15/14 73/11 116/23</p> <p>opposite [1] 19/16</p> <p>opted [1] 144/11</p> <p>option [1] 77/12</p> <p>or [182]</p> <p>oral [2] 78/21 112/23</p> <p>orally [3] 61/19 61/19 83/5</p> <p>order [14] 58/17 94/14 95/1 102/14 107/13 133/17 135/14 139/10 142/7 142/10 142/19 143/16 144/17 152/24</p> <p>ordinary [2] 27/17 63/22</p> <p>organisation [2] 6/12 49/15</p> <p>organised [1] 10/9</p> <p>organiser [2] 10/20 23/21</p> <p>organisers [1] 10/21</p> <p>original [3] 92/19 93/7 106/19</p> <p>originally [1] 10/6</p> <p>Orleans [2] 88/25 147/6</p> <p>osmophoresis [1] 19/3</p> <p>other [71] 9/18 17/15 18/3 18/9 18/11 18/13 18/14 18/15 18/16 21/23 30/2 38/1 42/19 45/1 47/1 48/25 53/22 53/24 55/17 57/8 57/24 59/6 60/4 69/22 72/15 72/21 73/18 74/1 74/21 77/6 78/1 80/18 80/18 82/7 82/13 82/21 82/22 84/11 85/19 91/6 94/8 96/23 97/2 97/17 98/1 99/18 102/16 108/22 109/7 114/2 114/11 114/14 114/15 114/25 115/14 117/17 119/6</p> <p>120/5 120/8 123/5 123/21 124/12 125/25 126/2 127/11 131/24 139/11 146/24 148/17 150/13 151/13</p> <p>others [10] 15/11 36/13 49/12 66/14 78/24 91/15 95/3 114/24 129/12 149/21</p> <p>otherwise [2] 130/12 146/17</p> <p>ought [3] 90/4 91/23 122/9</p> <p>our [30] 33/15 38/8 42/18 68/12 69/19 70/7 78/17 86/18 86/24 87/14 92/19 92/24 93/7 103/22 104/1 104/9 113/25 114/17 118/12 119/12 123/8 125/17 127/24 128/3 128/4 141/23 142/20 144/7 150/8 153/11</p> <p>out [57] 6/22 7/4 7/5 7/20 7/22 10/18 11/13 15/21 16/10 23/9 25/22 28/19 29/9 33/15 35/11 35/19 36/8 39/17 46/15 47/17 53/20 57/20 60/24 62/6 66/1 66/7 66/21 68/3 76/12 76/22 76/23 78/11 79/14 83/2 83/7 84/9 85/17 86/23 89/9 89/21 91/1 91/4 95/24 98/17 103/3 107/5 108/18 110/25 116/13 118/10 118/23 120/6 128/8 139/13 148/18 149/4 152/13</p> <p>outside [1] 152/18</p> <p>outside [2] 33/15 150/4</p> <p>over [49] 1/18 11/15 11/22 15/7 19/23 20/10 21/9 23/12 23/25 25/7 25/8 28/12 28/24 34/23 43/24 48/13 51/6 51/22 54/1 56/20 66/13 67/21 68/7 77/2 82/1 82/3 86/2 87/2 89/17 93/8 93/15 93/17 95/4 98/25 101/23 106/3 106/7 106/10 110/22 117/3 117/25 119/15 137/21 139/7 140/11 144/6 148/3 148/20 151/23</p> <p>over-generous [1]</p>	<p>66/13</p> <p>over-looked [1] 110/22</p> <p>overall [1] 136/19</p> <p>overlook [1] 92/4</p> <p>overlooked [1] 82/8</p> <p>overly [1] 65/4</p> <p>overseeing [2] 38/20 91/18</p> <p>Overspeaking [1] 138/6</p> <p>overview [1] 2/4</p> <p>own [11] 9/6 21/20 49/5 55/21 86/9 86/24 87/12 114/20 119/4 144/10 152/7</p> <p>Oxford [97] 3/14 3/21 3/25 19/21 19/22 20/4 20/8 21/2 21/7 21/11 22/22 25/2 25/11 25/18 28/13 29/20 29/24 30/9 31/8 31/24 32/23 34/15 34/15 35/18 36/1 37/11 39/1 39/2 39/3 39/7 39/15 39/18 39/24 40/1 40/11 41/4 41/9 42/3 44/18 47/19 53/14 55/22 64/23 64/24 65/3 72/23 76/11 76/13 77/1 87/14 88/23 89/15 91/7 92/5 93/21 94/19 97/10 99/11 101/4 101/5 103/1 103/1 103/22 104/23 108/8 108/14 108/16 111/22 117/20 121/25 127/11 131/7 133/11 133/16 133/20 133/21 141/6 143/16 143/24 143/24 144/5 144/17 148/7 148/10 148/16 148/23 149/2 149/6 149/18 149/19 149/20 149/23 150/4 150/12 150/17 153/3 153/4</p> <p>Oxford's [2] 37/13 127/8</p> <p>OXUH0001862 [1] 117/23</p>	<p>P</p> <p>pack [2] 135/10 135/23</p> <p>package [6] 106/22 106/25 107/2 107/10 107/23 107/23</p> <p>packs [3] 135/1 135/4 135/6</p> <p>Paddington [1] 95/23</p> <p>page [67] 6/9 8/2 9/25</p>	<p>21/4 21/5 21/9 21/9 23/25 28/15 28/24 35/8 41/2 44/11 45/15 45/16 45/23 46/21 48/12 48/12 50/14 51/6 51/22 52/8 56/12 56/20 60/7 61/22 62/14 63/1 63/7 67/10 67/20 67/21 68/7 68/8 69/13 77/3 82/3 86/2 93/15 93/17 93/19 94/23 95/4 96/11 98/6 98/12 98/25 101/24 102/4 106/3 106/7 106/10 106/12 106/21 111/6 117/25 119/15 134/14 137/21 137/21 137/23 139/7 140/11 148/4 148/5 148/20</p> <p>page 1 [1] 67/20</p> <p>page 10 [1] 62/14</p> <p>page 11 [2] 63/7 95/4</p> <p>page 18 [2] 60/7 106/7</p> <p>page 19 [1] 46/21</p> <p>page 2 [8] 45/16 48/12 61/22 67/21 69/13 93/19 98/6 139/7</p> <p>page 24 [1] 44/11</p> <p>page 3 [9] 21/9 45/15 45/23 63/1 67/10 93/17 111/6 137/21 137/23</p> <p>page 30 [1] 50/14</p> <p>page 4 [1] 6/9</p> <p>page 6 [3] 9/25 102/4 106/21</p> <p>page 7 [3] 8/2 41/2 101/24</p> <p>page 8 [1] 96/11</p> <p>page 9 [1] 134/14</p> <p>pages [1] 101/23</p> <p>paid [1] 126/25</p> <p>panel [8] 27/8 27/12 63/23 65/20 103/23 118/22 123/15 140/6</p> <p>paper [2] 133/12 149/14</p> <p>Papworth [1] 11/9</p> <p>paragraph [41] 6/10 6/11 10/1 22/13 44/13 44/21 46/23 56/13 56/15 56/17 61/23 67/12 69/15 77/4 79/22 82/4 87/20 92/4 93/24 98/12 102/3 102/5 102/7 108/7 108/9 111/11 111/12 116/17 118/10 118/11 126/9 127/23 134/17 134/21 135/8 139/8</p>	<p>139/16 140/11 141/12 148/14 150/1</p> <p>paragraph 1 [3] 56/13 108/7 139/8</p> <p>paragraph 2 [2] 56/15 79/22</p> <p>paragraph 3 [3] 22/13 108/9 139/16</p> <p>paragraph 4 [2] 56/17 87/20</p> <p>paragraph 6 [2] 77/4 140/11</p> <p>paragraph 8 [1] 6/10</p> <p>paragraph 87 [1] 44/13</p> <p>paragraph 9 [1] 10/1</p> <p>paragraph 90 [1] 44/21</p> <p>paragraphs [3] 27/7 83/3 111/7</p> <p>paragraphs 1 [1] 83/3</p> <p>part [23] 2/14 2/14 3/2 4/20 6/21 11/7 12/21 22/24 30/23 31/10 34/14 36/1 40/21 49/20 49/22 50/19 57/1 93/8 94/11 109/8 125/20 126/20 141/8</p> <p>Participants [5] 129/6 129/10 145/16 146/12 152/5</p> <p>particular [14] 12/23 12/24 33/12 47/9 58/12 61/25 65/22 82/19 106/8 116/21 116/24 151/21 153/9 153/10</p> <p>particularly [6] 11/20 23/17 37/25 62/19 74/23 86/11</p> <p>partners [1] 97/21</p> <p>party [5] 4/5 54/21 54/24 132/14 132/18</p> <p>pass [5] 54/7 90/5 97/25 98/2 98/2</p> <p>passed [3] 48/13 97/14 110/2</p> <p>passing [2] 97/16 97/20</p> <p>past [3] 31/3 81/10 99/6</p> <p>patch [2] 141/24 142/2</p> <p>pathology [2] 2/8 2/11</p> <p>patient [10] 59/10 96/21 96/24 115/5 118/17 121/4 121/14 132/5 139/7 139/14</p> <p>patient's [1] 140/13</p> <p>patients [8] 95/23 108/17 110/11 140/16 141/23 142/2 145/3</p>	<p>150/3</p> <p>patients' [1] 94/7</p> <p>pattern [2] 11/7 124/24</p> <p>Paul [6] 6/7 29/17 44/12 45/10 48/14 69/13</p> <p>Pause [1] 8/17</p> <p>pausing [10] 10/14 21/13 22/2 25/1 51/13 57/10 80/2 88/12 102/25 139/19</p> <p>PCR [2] 15/8 43/24</p> <p>penultimate [1] 82/4</p> <p>people [14] 1/20 12/25 43/4 43/21 66/17 75/11 75/23 107/6 116/1 117/4 125/17 125/22 127/2 144/24</p> <p>per [5] 27/8 29/9 29/14 84/8 142/24</p> <p>perceive [1] 85/2</p> <p>perceived [1] 12/24</p> <p>percent [1] 142/23</p> <p>perfectly [2] 70/22 143/19</p> <p>performed [2] 11/5 63/20</p> <p>perhaps [18] 7/22 44/10 50/10 58/21 59/16 65/4 87/7 92/10 99/13 102/12 106/10 111/21 124/8 126/24 133/1 133/7 142/8 153/13</p> <p>period [15] 2/19 16/9 18/20 42/12 47/5 74/5 76/5 103/4 104/20 105/13 132/23 132/25 133/5 133/8 133/19</p> <p>periods [2] 15/7 133/6</p> <p>permanent [1] 127/25</p> <p>permanently [2] 62/3 118/21</p> <p>permission [1] 119/25</p> <p>permitting [1] 70/12</p> <p>persistently [1] 64/1</p> <p>person [8] 17/9 43/13 65/20 95/18 96/15 97/8 138/1 153/11</p> <p>personal [4] 16/10 80/21 96/22 144/10</p> <p>personally [9] 12/9 13/5 16/6 65/10 65/14 80/11 95/17 132/10 141/7</p> <p>personnel [1] 151/17</p> <p>persons [2] 62/18 74/14</p> <p>perspective [3] 81/6 82/25 152/19</p>
---	--	---	---	--	---

<p>P</p> <p>petri [2] 14/14 14/15</p> <p>PFL [10] 30/19 39/2 39/6 39/23 40/2 109/15 148/11 149/17 150/17 150/20</p> <p>pharmaceutical [2] 133/2 133/9</p> <p>phenomenon [2] 13/13 150/15</p> <p>pheresis [9] 103/15 103/17 103/23 104/4 104/9 104/15 123/15 126/14 126/19</p> <p>phone [2] 54/1 120/20</p> <p>pick [14] 16/2 16/3 16/4 28/25 37/4 44/21 82/3 90/22 91/6 102/7 103/11 111/11 112/19 120/1</p> <p>picked [5] 16/12 16/23 19/2 42/13 128/13</p> <p>picking [5] 37/17 67/4 84/17 84/19 118/10</p> <p>picture [2] 120/23 148/1</p> <p>pie [1] 136/13</p> <p>piece [1] 132/17</p> <p>pin [1] 47/12</p> <p>pints [1] 37/12</p> <p>pity [1] 153/12</p> <p>place [21] 23/13 24/11 39/3 53/14 53/23 59/3 59/6 67/13 85/5 89/14 93/20 94/22 95/15 108/14 108/18 131/7 136/8 143/22 144/17 150/18 151/13</p> <p>places [1] 117/5</p> <p>plainly [1] 136/11</p> <p>plan [1] 113/14</p> <p>planning [1] 92/14</p> <p>plans [1] 27/9</p> <p>plant [1] 21/23</p> <p>plasma [43] 14/18 14/21 14/22 19/8 19/14 24/5 24/19 24/20 24/20 24/20 27/15 27/18 30/17 32/20 39/1 39/2 39/6 39/15 39/17 39/23 52/17 99/23 100/2 100/17 102/20 103/18 104/11 111/8 126/3 126/7 126/13 126/14 126/19 126/23 127/1 135/19 135/21 147/16 148/10 148/10 148/16 148/17 150/8</p>	<p>plasma-reduced [1] 52/17</p> <p>plasmapheresis [9] 12/1 102/24 103/13 122/2 122/7 122/20 123/24 123/25 124/13</p> <p>plated [1] 27/18</p> <p>platelet [3] 24/23 27/9 106/25</p> <p>platelets [9] 35/14 36/2 104/24 105/1 105/3 105/7 106/23 107/15 107/15</p> <p>plead [1] 136/12</p> <p>please [46] 6/8 6/9 9/25 21/1 21/10 25/6 36/10 44/12 44/22 45/10 45/15 46/21 48/14 50/14 51/6 51/16 60/17 63/1 63/8 67/7 67/10 67/21 69/13 71/3 72/3 82/3 83/23 86/2 87/20 90/15 93/19 98/5 98/6 98/11 101/19 101/24 106/7 106/21 110/13 111/4 111/6 116/14 119/18 134/14 137/5 143/1</p> <p>plus [1] 8/9</p> <p>pm [6] 90/16 90/18 129/4 146/7 146/9 153/21</p> <p>point [16] 33/15 37/18 46/9 46/10 61/16 70/8 91/6 95/25 96/1 117/12 117/12 117/16 119/20 144/4 150/2 150/6</p> <p>pointed [4] 35/19 91/1 91/4 107/5</p> <p>points [3] 84/17 90/22 149/4</p> <p>policies [3] 52/9 52/11 98/24</p> <p>policy [8] 30/6 66/16 103/9 114/20 114/21 124/22 125/1 125/7</p> <p>pooled [1] 102/22</p> <p>poor [2] 23/9 23/11</p> <p>population [7] 12/21 21/24 32/5 81/11 81/17 81/19 142/4</p> <p>populations [2] 74/23 81/9</p> <p>porter [1] 7/4</p> <p>pose [1] 12/19</p> <p>posed [1] 44/19</p> <p>position [8] 68/19 91/25 104/23 124/16 134/1 140/23 144/10 153/2</p>	<p>positive [33] 14/20 15/4 16/12 19/10 19/13 43/25 64/11 64/18 94/25 95/16 96/14 98/15 108/15 108/23 109/12 110/14 111/22 118/8 118/14 119/23 121/6 127/8 128/3 133/25 134/19 134/23 135/12 141/14 142/7 143/3 143/4 144/25 145/6</p> <p>positively [2] 79/25 80/5</p> <p>positives [4] 16/3 108/10 142/6 142/8</p> <p>possibilities [1] 74/21</p> <p>possibility [7] 13/18 16/15 28/1 34/22 54/5 80/11 143/25</p> <p>possible [18] 6/18 11/4 25/25 32/24 61/6 65/25 77/24 80/9 96/2 100/20 103/25 104/10 105/1 108/12 110/10 119/6 139/11 147/2</p> <p>possibly [11] 18/13 23/13 45/3 79/20 82/7 89/21 93/8 102/20 105/8 125/18 142/19</p> <p>post [9] 2/12 2/14 6/1 23/7 46/22 99/14 100/3 101/7 105/14</p> <p>post-7 October 1985 [1] 100/3</p> <p>post-HTLV-III [1] 105/14</p> <p>post-testing [1] 101/7</p> <p>potential [2] 75/12 110/22</p> <p>potentially [4] 103/14 109/16 115/18 127/3</p> <p>practicable [1] 88/2</p> <p>practically [1] 79/7</p> <p>practical [6] 6/12 27/21 80/19 84/16 124/20 140/1</p> <p>practice [22] 23/9 49/24 50/21 51/5 53/20 53/22 64/23 64/24 65/7 77/1 96/6 96/7 99/10 101/4 102/25 103/20 105/9 119/22 120/6 122/19 131/21 133/11</p> <p>practice' [1] 52/21</p> <p>practices [6] 23/11 73/18 74/15 79/3 82/20 149/15</p> <p>Practising [1] 62/17</p> <p>practitioner [2] 17/1 94/8</p>	<p>pre [3] 29/2 29/10 57/17</p> <p>pre-called [1] 29/10</p> <p>pre-judge [1] 57/17</p> <p>pre-printed [1] 29/2</p> <p>prearranged [1] 10/19</p> <p>preceding [2] 99/7 144/7</p> <p>precipitation [1] 19/16</p> <p>precise [2] 138/22 138/24</p> <p>precisely [1] 65/21</p> <p>predecessors [1] 46/1</p> <p>preferably [1] 57/6</p> <p>premises [3] 10/22 21/15 144/4</p> <p>preparations [1] 106/25</p> <p>prepare [1] 14/14</p> <p>prepared [2] 46/1 77/5</p> <p>presence [3] 63/17 79/17 85/19</p> <p>present [7] 63/11 67/9 69/19 81/15 81/15 98/10 149/3</p> <p>presented [2] 64/6 64/7</p> <p>presenting [1] 88/3</p> <p>press [3] 36/15 73/5 73/5</p> <p>presumably [5] 88/18 90/1 103/7 121/17 125/12</p> <p>pretty [3] 46/19 71/17 91/16</p> <p>prevailing [1] 99/4</p> <p>prevalence [1] 127/17</p> <p>prevalent [1] 81/8</p> <p>prevent [3] 96/25 139/10 139/11</p> <p>previous [11] 33/9 36/25 55/5 63/13 63/16 68/8 102/19 108/16 110/16 122/14 138/11</p> <p>previously [2] 37/19 135/22</p> <p>price [2] 126/25 127/4</p> <p>prick [1] 11/4</p> <p>primarily [4] 6/4 54/15 74/14 83/3</p> <p>principle [2] 115/7 141/13</p> <p>printed [2] 28/19 29/2</p> <p>prior [10] 13/6 41/24 60/6 99/12 101/11 104/7 109/6 113/10 143/10 150/9</p> <p>prisons [5] 12/15</p>	<p>29/20 29/24 30/3 30/6</p> <p>privacy [2] 59/15 79/11</p> <p>private [12] 8/8 41/5 41/8 41/13 41/21 42/8 42/9 42/14 42/15 42/16 59/3 83/17</p> <p>privileged [1] 147/8</p> <p>pro [5] 147/15 147/16 148/8 148/23 150/11</p> <p>pro rata [4] 147/15 148/8 148/23 150/11</p> <p>probable [1] 95/24</p> <p>probably [14] 1/18 9/23 17/24 31/13 32/9 70/23 80/18 83/17 100/21 102/21 107/25 128/23 140/1 149/13</p> <p>problem [15] 16/22 17/10 32/2 73/2 74/25 81/25 85/3 103/25 111/13 128/5 128/15 128/18 130/12 130/16 147/23</p> <p>problems [7] 6/17 11/6 21/21 51/4 86/4 92/1 134/16</p> <p>procedure [10] 11/18 15/14 18/1 18/2 126/20 134/18 135/4 135/9 138/8 141/3</p> <p>procedures [3] 138/16 138/19 141/5</p> <p>process [1] 50/20</p> <p>processed [1] 112/3</p> <p>processing [2] 9/9 106/5</p> <p>procure [1] 126/22</p> <p>produce [5] 15/3 73/25 86/23 87/5 147/22</p> <p>produced [10] 27/10 61/9 74/2 75/9 86/9 86/18 87/11 102/1 102/1 149/17</p> <p>producing [3] 26/4 87/15 115/4</p> <p>product [8] 38/17 40/10 105/11 105/15 105/17 105/20 107/4 115/4</p> <p>production [3] 26/7 26/9 149/23</p> <p>products [37] 6/23 7/13 11/22 23/24 24/1 32/17 39/8 39/9 39/14 39/16 40/3 40/5 40/13 40/14 40/20 49/19 50/23 52/3 54/9 63/16 73/8 99/15 99/18 99/20 99/20 101/5 101/8 101/13 101/16</p>	<p>104/24 105/10 106/6 134/23 134/24 135/6 146/18 150/19</p> <p>Professor [2] 31/7 37/6</p> <p>Professor Cash's [1] 37/6</p> <p>Professor Contreras [1] 31/7</p> <p>programme [4] 12/1 127/15 140/24 143/17</p> <p>programmes [1] 110/20</p> <p>project [1] 16/11</p> <p>promiscuous [1] 80/17</p> <p>promised [2] 86/7 86/14</p> <p>prompt [2] 99/9 147/18</p> <p>prompts [1] 50/4</p> <p>promulgated [1] 143/7</p> <p>proof [1] 104/9</p> <p>proper [4] 10/4 38/23 95/9 149/20</p> <p>properties [1] 15/1</p> <p>proportion [2] 52/17 119/2</p> <p>proportions [1] 32/18</p> <p>proposal [3] 98/15 113/19 114/1</p> <p>propose [1] 113/15</p> <p>proposed [1] 149/13</p> <p>prospective [1] 70/1</p> <p>protect [1] 97/4</p> <p>protection [7] 67/16 67/22 68/14 68/23 69/10 69/14 70/21</p> <p>proved [4] 12/10 100/10 111/21 130/22</p> <p>provide [11] 11/9 30/18 31/11 32/17 32/20 34/12 42/19 52/20 74/7 106/24 107/10</p> <p>provided [30] 7/9 24/1 30/16 31/15 31/16 32/19 32/23 33/2 39/2 39/7 39/15 41/10 59/21 60/20 68/6 68/23 69/1 71/2 83/10 89/13 95/13 104/1 109/25 127/11 131/17 131/20 131/22 143/8 147/17 151/1</p> <p>providing [7] 12/5 13/18 63/12 63/16 94/4 105/10 114/23</p> <p>provision [3] 6/22 7/8 25/19</p> <p>provisions [1] 96/12</p>
---	--	--	--	---	--

<p>P</p> <p>PRSE0001355 [1] 106/18</p> <p>PRSE0004766 [2] 45/10 48/12</p> <p>psychologists [1] 95/8</p> <p>public [11] 74/12 74/16 74/25 75/3 76/1 77/15 84/25 97/2 121/15 137/1 137/11</p> <p>publication [2] 46/13 106/14</p> <p>publicised [1] 94/9</p> <p>publicity [1] 10/22</p> <p>publish [1] 49/7</p> <p>purchases [1] 41/22</p> <p>purchasing [1] 40/19</p> <p>purely [3] 16/10 17/23 32/5</p> <p>purpose [2] 54/13 96/23</p> <p>purposes [5] 9/13 79/6 80/19 84/16 97/2</p> <p>pursued [2] 108/11 141/15</p> <p>pursuing [1] 67/15</p> <p>put [22] 9/11 19/11 24/12 36/12 70/14 77/11 89/14 91/9 98/4 99/9 105/19 108/7 112/24 116/3 124/8 130/20 131/13 135/13 136/3 144/17 150/7 151/12</p> <p>putting [2] 85/15 105/9</p> <p>puzzled [2] 81/1 109/3</p>	<p>questionable [1] 65/11</p> <p>questioned [3] 78/13 83/5 106/24</p> <p>questioning [8] 11/2 78/17 78/21 78/25 80/20 107/10 107/18 145/12</p> <p>questionnaire [3] 81/13 140/7 151/2</p> <p>questionnaires [1] 140/13</p> <p>questions [51] 1/15 1/25 3/8 13/8 19/21 30/22 31/6 33/20 33/21 34/3 44/22 48/7 54/20 56/9 56/24 58/15 58/19 61/14 61/17 61/18 79/2 79/16 79/18 79/23 80/6 81/2 82/19 98/18 107/16 108/2 108/6 114/8 119/17 121/22 125/8 127/5 129/5 129/10 129/14 129/18 130/15 132/11 140/15 141/1 145/16 145/23 146/1 146/11 151/16 152/4 154/3</p> <p>quick [2] 26/13 79/15</p> <p>quickly [2] 26/8 48/13</p> <p>quite [17] 1/17 14/2 23/1 27/18 29/24 33/8 64/6 77/24 82/1 85/3 116/3 119/2 123/18 127/20 132/7 135/24 144/12</p> <p>quote [1] 144/5</p> <p>quoted [2] 70/21 142/24</p>	<p>rate [6] 29/4 29/9 84/8 142/7 142/18 142/23</p> <p>rates [1] 114/15</p> <p>rather [14] 8/3 20/10 24/15 45/17 59/13 61/6 66/20 83/9 104/2 114/11 120/10 120/24 131/15 153/14</p> <p>rationale [1] 83/6</p> <p>rationalisation [2] 35/9 38/23</p> <p>raw [1] 32/16</p> <p>re [6] 68/2 92/24 122/24 124/16 125/7 141/11</p> <p>re-tested [1] 122/24</p> <p>re-think [1] 92/24</p> <p>re-thinking [2] 124/16 125/7</p> <p>reached [1] 132/21</p> <p>reaching [1] 117/1</p> <p>react [2] 14/4 19/14</p> <p>reaction [3] 14/20 15/5 63/17</p> <p>read [13] 26/17 49/1 60/5 60/17 70/6 72/3 72/7 77/23 83/16 85/10 97/6 97/9 143/3</p> <p>readily [1] 92/20</p> <p>reading [6] 48/5 95/20 119/17 122/20 123/3 123/11</p> <p>reagent [2] 114/5 116/20</p> <p>reagents [1] 23/23</p> <p>realise [3] 25/7 78/5 113/23</p> <p>realised [3] 74/20 74/24 88/2</p> <p>really [13] 28/10 31/4 33/4 33/4 35/14 48/15 50/1 58/1 83/3 100/21 124/6 124/19 125/5</p> <p>reason [11] 19/12 28/10 55/19 57/16 77/14 93/2 122/5 122/6 122/10 123/5 148/9</p> <p>reasonable [4] 27/23 29/11 82/11 82/25</p> <p>reasonably [1] 48/13</p> <p>reasoning [1] 125/20</p> <p>reasons [6] 75/8 77/9 79/14 97/2 124/19 131/6</p> <p>reassurance [1] 43/23</p> <p>rebuilding [1] 111/9</p> <p>recall [74] 9/21 12/2 12/3 12/12 12/14 12/23 13/9 18/20 18/22 20/3 22/11 25/17 27/11 27/13</p>	<p>27/20 28/3 29/12 30/10 42/12 42/14 46/3 46/7 47/25 49/9 52/23 53/1 53/3 54/17 54/19 56/4 65/5 69/3 73/3 74/4 86/14 86/17 87/14 87/14 88/12 88/17 88/19 90/8 91/21 94/18 99/10 99/17 100/1 100/6 101/3 101/9 101/12 103/5 103/5 106/16 107/9 107/11 107/18 109/8 109/13 109/20 110/2 110/25 113/2 120/15 130/23 133/4 133/8 137/16 138/15 139/19 139/23 140/2 145/6 151/6</p> <p>recalled [3] 101/5 107/4 135/23</p> <p>receipt [3] 26/24 139/8 139/13</p> <p>receive [2] 94/25 126/13</p> <p>received [10] 6/19 56/2 56/2 63/15 68/24 88/11 109/16 119/11 120/20 131/23</p> <p>recent [1] 118/14</p> <p>recently [3] 106/17 111/21 137/2</p> <p>recipient [1] 109/10</p> <p>recipients [2] 141/14 141/16</p> <p>reckoned [1] 151/20</p> <p>recognise [2] 71/13 71/15</p> <p>recollect [1] 153/1</p> <p>recollection [11] 8/12 25/15 25/21 29/8 41/7 42/11 50/4 60/14 102/2 104/14 109/24</p> <p>recommendation [7] 50/15 51/7 54/6 65/22 103/5 129/22 131/4</p> <p>recommendations [4] 50/13 53/12 66/12 76/13</p> <p>recommended [2] 50/16 50/25</p> <p>reconsider [1] 114/7</p> <p>reconsidered [1] 78/17</p> <p>reconstitution [1] 99/4</p> <p>record [15] 5/2 29/2 29/6 31/3 35/1 50/8 50/11 51/20 52/3 57/8 130/25 132/1 133/13 134/25 135/16</p> <p>record keeping [1]</p>	<p>50/11</p> <p>record-keeping [1] 52/3</p> <p>recorded [2] 57/5 136/10</p> <p>recordkeeping [2] 134/16 135/25</p> <p>records [17] 4/12 28/17 28/18 111/18 129/19 132/13 132/19 133/5 133/6 133/7 133/8 133/17 133/20 133/23 134/2 134/22 135/2</p> <p>recruited [2] 10/20 27/20</p> <p>recruiting [1] 6/16</p> <p>recurrence [1] 139/10</p> <p>red [14] 24/5 24/5 24/9 24/15 24/17 24/23 27/16 35/16 35/18 36/7 99/1 99/16 135/10 135/16</p> <p>redistribution [1] 150/22</p> <p>reduce [1] 99/5</p> <p>reduced [2] 24/5 52/17</p> <p>reduction [1] 111/10</p> <p>refer [5] 16/25 19/6 62/1 63/4 107/3</p> <p>reference [6] 28/25 33/23 72/1 109/1 126/8 136/23</p> <p>referral [1] 58/4</p> <p>referred [14] 19/17 58/16 62/4 62/11 63/5 68/9 68/10 69/11 70/17 80/3 111/16 128/3 147/5 150/4</p> <p>referring [5] 17/2 23/11 78/20 78/22 115/8</p> <p>refers [2] 51/20 69/16</p> <p>reflection [2] 49/4 49/13</p> <p>refreshment [1] 43/5</p> <p>regard [3] 52/22 68/13 100/24</p> <p>regarded [1] 67/14</p> <p>region [15] 10/20 27/1 31/24 33/17 34/15 37/7 37/12 37/23 41/9 52/22 68/12 70/18 84/3 85/24 150/5</p> <p>regional [64] 3/6 3/22 3/22 3/25 4/1 4/6 4/15 5/3 8/4 8/20 10/3 10/5 15/22 17/18 20/5 20/11 21/3 21/7 21/11 25/24 33/23 35/3 37/13 39/10 46/2 48/8</p>	<p>49/5 50/17 51/12 51/18 51/24 52/4 52/9 52/10 52/12 53/3 53/8 53/21 54/12 54/22 55/15 55/17 65/6 67/8 68/6 69/1 76/20 86/4 87/19 89/22 89/23 90/2 91/11 91/14 94/11 113/11 113/14 116/8 118/1 129/24 131/5 134/6 150/13 153/7</p> <p>regionalisation [1] 38/18</p> <p>regions [4] 38/2 52/14 148/8 148/17</p> <p>Registry [1] 10/12</p> <p>regret [1] 118/20</p> <p>regular [12] 3/21 7/17 31/16 52/12 53/4 53/13 53/25 91/16 104/4 108/21 130/2 137/15</p> <p>regularly [2] 122/7 138/5</p> <p>Regulations [1] 96/21</p> <p>reinstated [1] 140/22</p> <p>reinstatement [2] 63/24 65/11</p> <p>related [1] 98/3</p> <p>relating [3] 86/5 96/22 149/16</p> <p>relation [32] 7/1 13/1 13/2 13/9 29/18 30/21 54/4 56/19 59/19 66/8 80/7 86/11 89/18 91/17 97/7 102/24 103/7 103/8 103/12 103/20 104/23 107/15 108/3 111/3 113/5 117/15 133/11 133/25 134/1 138/8 138/16 141/2</p> <p>relationship [1] 91/10</p> <p>relatively [4] 8/24 31/25 32/4 127/13</p> <p>released [4] 99/14 100/2 100/3 101/6</p> <p>relevance [2] 34/13 122/12</p> <p>relevant [1] 58/2</p> <p>reliable [2] 91/24 124/11</p> <p>reliant [1] 59/12</p> <p>relied [1] 57/12</p> <p>relinquished [1] 39/24</p> <p>rely [1] 49/6</p> <p>remain [2] 39/21 149/16</p> <p>remained [5] 20/7 22/9 80/12 105/16</p>
<p>Q</p> <p>qualified [1] 2/5</p> <p>quality [7] 22/16 22/17 22/19 22/21 23/1 23/5 106/6</p> <p>quantities [2] 41/10 50/22</p> <p>quarantine [4] 102/21 104/6 104/17 122/22</p> <p>quarantined [2] 122/23 124/1</p> <p>queried [1] 70/19</p> <p>question [30] 25/16 51/15 57/3 59/23 61/4 64/18 73/14 78/11 78/13 82/19 83/4 91/8 91/8 95/14 106/13 107/19 116/11 116/12 117/19 124/21 125/10 126/6 126/24 131/19 133/2 141/9 144/15 146/16 147/14 152/23</p>	<p>R</p> <p>Radcliffe [3] 21/12 21/16 27/23</p> <p>radical [2] 92/24 93/3</p> <p>radioimmunoassay [1] 15/15</p> <p>RAF [2] 41/5 42/7</p> <p>raise [1] 33/20</p> <p>raised [10] 67/6 68/16 68/18 70/15 122/20 123/5 124/4 124/6 133/3 135/25</p> <p>raising [1] 70/13</p> <p>ran [2] 2/19 56/11</p> <p>rang [1] 151/22</p> <p>ranks [2] 113/20 114/22</p> <p>rapidly [1] 103/17</p> <p>rare [1] 80/23</p> <p>rata [5] 147/15 147/16 148/8 148/23 150/11</p>				

<p>R</p> <p>remained... [1] 105/18</p> <p>remaining [1] 112/1</p> <p>remedy [1] 136/14</p> <p>remember [12] 13/12 15/12 22/7 25/10 27/21 41/13 46/11 61/5 74/9 84/22 101/25 107/24</p> <p>remove [5] 16/14 16/19 24/18 118/21 153/4</p> <p>removing [3] 84/19 123/14 148/21</p> <p>reorganised [1] 93/3</p> <p>replaced [1] 18/18</p> <p>replaces [1] 138/11</p> <p>replied [1] 89/2</p> <p>reply [3] 89/1 119/11 149/8</p> <p>replying [1] 84/2</p> <p>report [13] 26/23 35/7 50/6 50/12 52/24 106/1 106/4 130/25 131/1 131/3 134/13 136/15 139/14</p> <p>reported [1] 54/22</p> <p>reporting [1] 132/14</p> <p>reports [2] 129/23 130/5</p> <p>representative [4] 4/10 4/11 35/11 132/13</p> <p>representatives [2] 146/13 152/6</p> <p>request [3] 57/4 59/25 84/2</p> <p>requested [3] 7/9 127/8 148/16</p> <p>requesting [1] 76/16</p> <p>requests [1] 7/12</p> <p>required [12] 7/23 14/25 26/3 26/15 32/8 32/15 36/6 38/6 73/19 74/6 88/18 147/21</p> <p>requirement [2] 26/5 32/18</p> <p>requirements [6] 26/21 31/3 35/12 52/15 88/9 106/5</p> <p>research [3] 3/11 16/11 17/14</p> <p>resolve [1] 140/15</p> <p>resource [1] 31/25</p> <p>resources [3] 114/16 141/24 145/1</p> <p>respect [3] 103/15 110/9 124/7</p> <p>respected [1] 66/15</p> <p>respects [1] 124/7</p> <p>responding [1] 6/18</p>	<p>response [6] 11/19 53/11 53/16 78/16 113/13 113/17</p> <p>responsibility [1] 22/17</p> <p>responsible [6] 6/4 11/1 20/10 52/13 53/5 54/25</p> <p>rest [3] 10/25 92/20 113/20</p> <p>restricted [1] 74/19</p> <p>restrictive [1] 65/4</p> <p>restructuring [1] 23/9</p> <p>result [6] 23/8 35/17 110/11 111/1 111/9 118/8</p> <p>resulting [1] 81/2</p> <p>results [8] 95/2 97/7 97/17 118/14 119/5 119/12 121/10 140/12</p> <p>retain [1] 132/19</p> <p>retained [1] 132/25</p> <p>retaining [1] 35/20</p> <p>retention [5] 4/12 132/13 132/23 133/5 133/8</p> <p>retested [1] 139/18</p> <p>rethink [1] 93/3</p> <p>retired [4] 3/14 143/11 144/21 145/4</p> <p>retirement [4] 20/19 20/20 143/17 144/12</p> <p>retrospective [3] 108/10 109/9 109/14</p> <p>return [2] 119/7 131/10</p> <p>returned [3] 112/11 131/23 132/4</p> <p>returns [4] 127/7 131/5 131/18 131/21</p> <p>Rev [2] 60/12 71/11</p> <p>revealed [2] 135/20 136/15</p> <p>review [6] 33/22 50/10 52/1 52/3 52/9 52/10</p> <p>reviewed [1] 124/9</p> <p>revised [9] 45/12 46/6 60/13 71/7 71/21 87/20 87/23 88/10 136/17</p> <p>revision [1] 55/5</p> <p>revisions [2] 71/16 71/18</p> <p>RHA [2] 35/14 150/8</p> <p>RIA [2] 15/7 63/19</p> <p>rid [1] 36/6</p> <p>right [80] 2/5 3/7 3/23 5/6 6/5 11/11 11/24 14/8 15/17 19/24 20/5 20/12 21/13 22/3 29/20 29/25 30/12</p>	<p>31/18 33/25 35/4 35/25 36/17 37/4 39/2 44/6 45/14 46/22 49/2 49/8 54/24 55/4 57/10 58/3 58/14 59/11 59/22 60/10 62/9 64/19 65/2 66/19 68/5 68/16 71/10 73/14 73/21 75/15 76/9 77/10 77/13 84/8 84/18 85/14 87/4 87/5 87/10 92/13 92/18 94/15 106/9 112/4 115/1 117/15 118/3 118/5 119/22 122/3 124/25 132/15 132/17 132/23 133/14 133/19 136/4 137/10 144/14 149/21 150/9 151/25 152/24</p> <p>right-hand [2] 37/4 106/9</p> <p>rigid [1] 75/7</p> <p>rigorous [1] 104/3</p> <p>risk [37] 12/19 27/16 44/8 44/20 49/18 59/20 61/13 72/20 75/25 76/8 76/12 76/17 77/22 78/2 78/4 78/6 78/8 80/5 82/8 82/21 85/6 94/13 94/16 99/5 102/12 102/15 103/3 104/11 104/19 104/21 105/12 105/16 105/18 109/5 118/24 146/19 151/4</p> <p>risks [6] 12/24 75/14 107/14 146/25 147/1 147/4</p> <p>Rizza [2] 149/6 149/11</p> <p>RMO [1] 91/14</p> <p>RMOs [1] 52/11</p> <p>road [2] 35/22 116/1</p> <p>Robinson [2] 42/2 143/7</p> <p>role [10] 2/25 3/2 6/12 39/24 48/8 49/17 49/20 49/23 50/19 103/17</p> <p>roles [1] 2/7</p> <p>rolled [1] 15/21</p> <p>room [4] 9/5 9/6 9/6 59/6</p> <p>rooms [1] 21/23</p> <p>rotas [2] 6/21 7/1</p> <p>round [2] 13/21 49/7</p> <p>route [3] 77/15 90/1 120/10</p> <p>routine [11] 2/19 11/14 11/18 11/23 18/2 18/15 28/11 80/19 108/21 118/13</p>	<p>121/4</p> <p>routinely [1] 104/5</p> <p>routines [1] 33/15</p> <p>row [8] 14/16 14/19 19/6 19/8 19/9 19/10 19/11 19/15</p> <p>rows [1] 14/14</p> <p>Royal [3] 2/25 3/1 95/20</p> <p>RTC [4] 8/13 10/20 21/24 27/5</p> <p>RTCs [1] 52/5</p> <p>RTDs [3] 52/13 67/16 110/6</p> <p>rules [1] 76/18</p> <p>ruling [1] 82/14</p> <p>run [6] 3/17 7/20 7/22 23/3 30/21 149/1</p> <p>rung [1] 54/3</p> <p>running [3] 6/4 23/20 53/19</p> <hr/> <p>S</p> <p>safe [1] 99/8</p> <p>safeguards [2] 97/4 104/1</p> <p>safely [1] 27/18</p> <p>safer [2] 115/4 127/3</p> <p>SAG [5] 24/5 24/9 24/13 24/18 135/10</p> <p>SAG-M [4] 24/5 24/9 24/18 135/10</p> <p>said [20] 11/20 14/9 16/21 20/18 22/6 25/14 25/17 33/8 37/13 42/6 59/22 75/16 76/10 82/24 90/8 126/4 131/2 138/3 144/9 151/18</p> <p>said: [1] 87/3</p> <p>said: it [1] 87/3</p> <p>sake [2] 23/16 70/23 28/11 75/13 76/15 76/18 94/3 97/11 97/12 105/5 108/25 112/24 114/6 116/20 116/25 117/12 125/13 125/18</p> <p>sample [2] 19/11 140/8</p> <p>samples [3] 100/16 121/15 139/20</p> <p>Sara [1] 1/13</p> <p>sat [1] 4/17</p> <p>satisfied [1] 149/19</p> <p>saw [4] 12/4 109/3 110/24 122/14</p> <p>say [63] 1/21 6/10 6/20 10/1 10/14 16/5 16/22 17/9 18/5 25/22 29/13 29/18 31/24</p>	<p>32/15 37/3 44/13 44/24 46/5 51/1 54/10 58/18 58/20 59/10 60/16 66/13 67/3 71/11 72/2 72/19 76/6 78/15 81/5 82/5 84/4 84/8 84/13 93/3 100/14 103/19 103/21 107/23 108/9 111/12 111/15 111/17 113/18 115/25 118/25 120/11 124/10 125/6 132/9 133/19 136/1 136/7 141/12 143/18 149/8 150/1 152/2 152/9 152/11 152/16</p> <p>saying [8] 8/9 64/20 80/8 80/9 81/18 110/7 126/17 148/21</p> <p>says [20] 8/6 56/22 60/11 61/23 63/6 64/20 67/25 71/7 71/22 88/23 89/4 93/22 95/5 103/20 106/2 107/24 134/17 136/25 138/9 148/6</p> <p>scale [1] 141/18</p> <p>scare [1] 75/7</p> <p>School [5] 2/11 2/20 2/24 3/3 149/22</p> <p>scientific [1] 22/15</p> <p>scope [1] 52/16</p> <p>Scott [6] 1/16 1/25 2/1 43/20 152/12 154/3</p> <p>Scottish [3] 45/20 45/22 48/19</p> <p>screen [6] 48/11 76/12 129/15 142/6 142/6 143/3</p> <p>screened [3] 94/1 111/21 114/24</p> <p>screening [18] 14/10 14/12 85/4 92/18 92/21 93/1 93/21 94/13 94/14 94/18 101/11 104/5 112/8 115/3 116/5 118/9 127/14 142/11</p> <p>search [1] 137/25</p> <p>Searched [1] 137/24</p> <p>seasonally [1] 44/4</p> <p>second [23] 33/6 67/12 69/14 77/3 85/21 86/2 86/15 87/12 88/16 89/3 91/6 93/24 94/23 102/5 103/2 106/3 111/7 116/17 118/11 123/12 127/23 134/17 148/4</p> <p>secondly [2] 83/15 124/21</p> <p>secretary's [1] 9/6</p>	<p>section [4] 9/5 46/22 56/21 92/25</p> <p>Section II [1] 56/21</p> <p>secured [1] 10/21</p> <p>security [3] 21/21 45/19 48/19</p> <p>see [83] 1/6 2/2 6/9 8/6 13/24 21/4 21/6 22/13 22/14 23/6 23/21 23/25 24/6 26/20 28/14 35/6 37/3 38/11 41/3 41/24 45/5 45/12 45/18 45/23 50/3 51/17 51/22 55/13 56/12 60/9 60/10 61/23 62/13 62/13 62/14 63/5 63/6 63/8 67/20 67/22 70/20 71/5 77/10 77/18 79/7 83/22 84/15 86/1 86/3 87/21 88/18 91/23 92/11 93/15 93/17 93/22 95/4 98/7 98/9 98/12 100/6 101/22 101/24 106/22 108/24 111/19 112/16 113/18 117/17 117/18 117/25 119/13 122/7 128/22 135/25 137/13 137/21 137/22 138/10 139/7 142/9 142/18 149/7</p> <p>seeing [5] 43/15 52/23 60/6 90/8 91/21</p> <p>seek [2] 80/21 119/25</p> <p>seem [3] 85/9 85/18 106/11</p> <p>seemed [4] 49/12 67/5 73/19 74/18</p> <p>seems [10] 8/18 29/11 34/17 36/14 61/3 71/22 82/10 89/11 107/19 139/4</p> <p>seen [5] 33/23 81/24 94/10 106/16 131/3</p> <p>select [1] 1/17</p> <p>selected [1] 56/11</p> <p>selecting [1] 28/4</p> <p>selection [5] 4/5 54/22 55/1 55/14 67/11</p> <p>self [1] 21/20</p> <p>self-contained [1] 21/20</p> <p>semi [1] 33/18</p> <p>send [7] 24/19 24/20 30/18 49/7 110/15 119/11 129/10</p> <p>sending [4] 16/16 76/22 87/25 121/14</p> <p>senior [4] 10/23 22/14 23/20 35/7</p>
--	---	---	--	---	--

(57) remained... - senior

<p>S</p> <p>sense [3] 19/17 38/7 81/6</p> <p>senses [1] 34/17</p> <p>sensible [2] 18/3 18/5</p> <p>sensitive [2] 63/18 64/1</p> <p>sensitivity [2] 15/23 15/25</p> <p>sent [10] 11/9 26/17 70/4 88/10 89/8 106/17 120/24 121/3 121/18 140/6</p> <p>sentence [1] 116/17</p> <p>separate [4] 30/15 61/8 61/12 100/16</p> <p>September [8] 3/13 36/16 74/4 75/19 76/5 76/11 141/10 143/12</p> <p>September '83 [2] 75/19 76/5</p> <p>September 1983 [1] 76/11</p> <p>September 1995 [2] 3/13 143/12</p> <p>sequestered [1] 111/19</p> <p>serious [5] 44/23 74/24 97/3 123/19 135/24</p> <p>seriously [2] 123/14 125/25</p> <p>seriousness [2] 47/15 47/22</p> <p>serum [5] 13/22 14/4 19/8 19/9 139/20</p> <p>serve [1] 4/4</p> <p>served [5] 7/18 31/1 33/12 41/4 42/6</p> <p>serves [1] 21/24</p> <p>service [30] 2/20 4/17 12/11 22/20 38/18 38/23 42/18 45/21 45/22 46/14 48/21 48/24 52/7 55/11 65/24 70/3 85/24 91/18 96/20 113/25 114/20 115/16 117/3 118/2 121/16 125/15 125/15 132/19 143/21 149/2</p> <p>Service's [1] 132/13</p> <p>serviced [3] 8/4 8/7 8/8</p> <p>services [9] 7/4 8/10 8/22 22/15 23/6 36/23 42/20 50/7 50/12</p> <p>servicing [1] 8/13</p> <p>session [26] 6/14 10/13 28/21 28/25 29/3 29/4 29/15 44/7</p>	<p>57/2 57/19 59/3 59/23 60/22 61/16 61/18 61/20 70/5 70/11 71/3 78/25 79/8 82/17 83/5 83/11 90/23 151/21</p> <p>sessional [1] 56/7</p> <p>sessions [41] 6/5 6/13 6/15 9/22 11/7 11/12 12/3 12/7 12/10 12/12 12/15 27/1 27/25 29/1 29/10 29/18 29/19 30/3 30/8 35/9 35/23 37/20 38/1 55/23 56/10 59/4 59/5 61/10 76/23 76/24 77/6 77/13 78/14 79/10 83/9 84/7 84/11 88/3 88/4 89/9 151/17</p> <p>set [14] 10/24 32/11 33/7 60/24 62/6 66/21 78/11 79/14 83/2 84/9 86/23 113/10 149/4 149/10</p> <p>sets [5] 68/3 118/10 118/23 139/13 148/18</p> <p>setting [2] 31/10 57/23</p> <p>settle [1] 85/1</p> <p>several [5] 11/22 101/23 102/12 104/7 116/10</p> <p>sexual [2] 62/20 79/3</p> <p>sexually [2] 95/6 96/17</p> <p>shaking [1] 136/1</p> <p>shall [7] 59/10 63/22 66/13 90/10 118/21 129/16 145/18</p> <p>shambles [1] 36/24</p> <p>share [2] 17/13 120/1</p> <p>sharing [2] 51/4 134/5</p> <p>she [12] 17/1 34/21 62/11 118/2 136/19 145/3 145/4 145/5 151/6 151/8 151/9 151/11</p> <p>Sheet [1] 28/21</p> <p>sheets [2] 29/2 29/6</p> <p>shelf [1] 99/20</p> <p>shipping [1] 104/7</p> <p>short [6] 38/10 38/13 43/18 90/10 90/17 146/8</p> <p>shortage [2] 37/11 37/21</p> <p>shortages [3] 37/8 38/1 38/16</p> <p>shortly [1] 122/24</p> <p>should [61] 23/14 35/21 46/19 52/11 52/20 57/2 57/5 58/7 59/16 59/23 63/20</p>	<p>70/24 76/18 77/5 77/7 78/6 78/13 81/6 82/12 82/14 82/15 83/4 83/9 86/20 88/5 88/10 88/16 89/13 90/7 90/12 94/12 98/2 98/14 102/9 103/6 109/19 114/5 114/21 115/1 115/17 116/8 116/9 116/19 119/4 119/16 119/20 120/19 122/15 124/23 132/19 133/1 133/5 133/22 137/7 141/15 141/21 143/3 144/8 147/1 149/22 150/2</p> <p>show [4] 45/5 51/14 72/7 112/25</p> <p>showed [1] 26/17</p> <p>showing [1] 90/24</p> <p>shown [2] 63/21 64/14</p> <p>SHPL0000163 [1] 105/24</p> <p>sic [1] 5/10</p> <p>side [8] 21/22 45/24 57/23 59/11 71/6 106/9 124/9 136/19</p> <p>sign [3] 70/6 71/2 72/7</p> <p>signature [3] 57/4 59/25 68/4</p> <p>signed [3] 28/21 67/14 135/5</p> <p>significant [3] 22/4 22/12 24/7</p> <p>significantly [3] 71/13 88/10 104/22</p> <p>signing [2] 70/9 70/12</p> <p>similar [1] 46/25</p> <p>simple [2] 11/3 56/24</p> <p>simplex [1] 81/10</p> <p>simplified [1] 150/23</p> <p>simply [4] 31/11 33/2 78/5 130/18</p> <p>since [4] 25/8 28/18 44/14 110/15</p> <p>single [1] 21/21</p> <p>sir [14] 1/5 24/4 42/24 44/2 44/6 89/17 91/9 108/1 143/1 145/9 145/20 146/5 153/17 153/18</p> <p>Sir Brian [3] 1/5 91/9 143/1</p> <p>sitting [1] 14/15</p> <p>situation [15] 74/10 75/10 84/24 84/24 86/17 95/21 102/23 103/12 103/14 125/6 130/10 136/3 136/7 139/4 144/24</p>	<p>six [12] 13/6 16/6 16/9 16/9 63/16 86/7 108/11 109/1 109/2 109/6 110/23 142/15</p> <p>six months [2] 16/9 86/7</p> <p>six years [2] 109/2 109/6</p> <p>six-month [1] 16/9</p> <p>skipping [1] 134/20</p> <p>slight [3] 43/22 43/22 153/4</p> <p>slightly [10] 37/18 59/10 66/18 67/4 72/10 81/18 89/17 89/18 98/3 103/14</p> <p>slip [2] 67/20 69/6</p> <p>Slough [4] 34/11 34/13 34/14 34/23</p> <p>small [12] 1/17 9/7 25/13 25/13 25/23 32/21 41/10 45/17 71/8 105/18 119/2 146/25</p> <p>Smith [1] 149/11</p> <p>Snake [3] 108/5 110/24 149/11</p> <p>snapshot [1] 21/2</p> <p>SNBTS [1] 48/21</p> <p>so [206]</p> <p>so-called [4] 47/1 66/3 76/8 81/8</p> <p>social [5] 45/19 48/18 74/10 95/8 131/2</p> <p>society [10] 5/9 5/9 5/12 67/16 67/22 68/14 68/23 69/10 69/14 70/21</p> <p>Solicitor [1] 107/5</p> <p>solicitors [2] 67/23 107/8</p> <p>some [83] 2/16 3/8 3/17 3/18 8/15 13/18 13/22 16/3 16/4 19/20 24/14 27/6 29/24 30/22 34/3 34/17 35/6 38/8 41/23 43/5 43/21 45/4 45/9 46/9 46/10 46/12 47/14 48/7 54/5 54/6 54/20 56/6 56/9 56/13 57/20 58/24 59/1 59/4 61/14 66/17 66/24 68/3 68/11 68/22 73/16 77/17 77/22 78/2 78/4 78/11 92/17 95/11 95/13 101/13 102/16 110/19 110/23 112/22 114/8 114/23 115/24 116/10 117/7 118/10 118/16 118/23 121/11 121/12 121/14 122/15 123/5</p>	<p>124/7 127/2 129/13 129/14 129/18 134/15 135/21 135/24 141/17 145/4 145/5 146/14</p> <p>somebody [6] 59/11 64/10 64/13 65/17 65/18 136/25</p> <p>someone [1] 23/3</p> <p>something [34] 7/20 7/21 7/22 19/2 24/8 49/11 50/1 58/25 60/2 65/13 80/2 81/18 90/10 106/15 109/17 109/19 109/20 114/12 123/17 129/25 136/9 137/20 138/4 139/24 139/25 141/15 142/12 142/13 144/19 144/20 151/4 151/9 151/10 151/13</p> <p>sometimes [4] 10/15 54/15 92/3 125/19</p> <p>somewhat [1] 85/1</p> <p>somewhere [2] 142/10 142/18</p> <p>sorry [23] 20/20 24/4 27/3 30/1 32/17 40/8 45/13 86/22 86/25 87/1 87/2 88/19 89/16 107/12 109/22 126/8 131/19 137/3 138/20 141/9 142/14 143/1 148/21</p> <p>sort [9] 35/11 37/4 59/11 65/15 80/22 85/5 95/24 130/5 152/13</p> <p>sought [1] 82/10</p> <p>sound [4] 22/3 25/11 42/9 138/3</p> <p>sources [1] 119/10</p> <p>south [3] 37/12 37/22 38/9</p> <p>space [1] 93/4</p> <p>spare [1] 31/12</p> <p>special [3] 7/21 7/22 63/24</p> <p>specialist [2] 17/3 118/1</p> <p>specialists [1] 98/16</p> <p>specific [15] 12/7 33/14 44/18 47/3 48/3 54/16 56/18 66/5 79/16 79/18 79/23 96/4 97/15 100/24 123/9</p> <p>specifically [8] 57/2 59/23 60/23 61/13 63/3 72/25 80/7 146/21</p> <p>specificity [2] 15/23 15/24</p>	<p>specified [1] 64/8</p> <p>spoke [2] 37/2 87/2</p> <p>spoken [1] 115/11</p> <p>spread [1] 96/25</p> <p>St [1] 95/22</p> <p>staff [17] 9/15 9/17 20/2 22/1 22/2 22/4 22/14 23/16 23/20 35/7 51/2 59/7 66/20 66/25 107/3 135/6 152/2</p> <p>staffing [2] 22/9 145/1</p> <p>stage [20] 7/3 7/16 9/19 12/2 12/22 16/13 16/19 16/25 17/11 17/17 28/9 36/1 43/9 96/3 112/8 127/13 141/24 142/3 147/20 152/9</p> <p>stages [1] 129/8</p> <p>stamped [1] 36/16</p> <p>standard [5] 23/23 26/25 138/8 140/6 141/2</p> <p>Standardisation [1] 106/1</p> <p>standing [2] 138/15 141/5</p> <p>star [1] 8/9</p> <p>start [11] 2/4 23/2 44/7 44/10 56/6 73/13 73/14 92/17 92/21 93/1 153/12</p> <p>started [4] 34/9 94/18 109/7 139/20</p> <p>starting [1] 148/15</p> <p>starts [3] 37/5 102/3 102/7</p> <p>statement [23] 2/18 6/3 6/7 9/24 10/14 13/3 16/5 20/1 22/9 23/7 25/1 25/7 25/12 29/19 34/10 44/11 73/1 101/22 102/1 111/5 121/24 130/20 133/12</p> <p>States [1] 81/24</p> <p>step [2] 1/13 117/7</p> <p>step-daughter [1] 1/13</p> <p>steps [14] 16/13 17/7 17/13 28/4 53/4 76/11 109/10 112/15 130/9 130/13 135/22 136/14 143/15 144/16</p> <p>sticking [1] 61/15</p> <p>still [9] 102/21 105/11 105/17 109/18 114/25 115/15 133/24 145/7 145/8</p> <p>stock [10] 7/23 11/19 50/9 50/11 51/21 52/4</p>
---	---	--	--	---	--

<p>S</p> <p>stock... [4] 52/18 84/4 131/1 131/6</p> <p>stockpile [4] 111/8 111/13 111/14 111/15</p> <p>stocks [5] 39/12 99/2 99/11 100/22 100/23</p> <p>stop [1] 78/1</p> <p>stopped [1] 25/2</p> <p>storage [2] 9/10 24/16</p> <p>store [2] 93/8 99/24</p> <p>stored [1] 99/1</p> <p>storey [1] 9/4</p> <p>story [1] 123/21</p> <p>stress [1] 97/23</p> <p>strictest [1] 96/13</p> <p>striking [1] 27/23</p> <p>stringent [1] 122/15</p> <p>striven [1] 113/24</p> <p>strongly [1] 76/18</p> <p>struggles [1] 14/2</p> <p>study [1] 16/1</p> <p>subject [3] 48/4 48/6 145/9</p> <p>submission [1] 150/7</p> <p>subsequent [2] 64/7 71/16</p> <p>subsequently [7] 12/25 13/15 63/25 66/1 111/24 112/6 123/20</p> <p>substantial [3] 50/22 98/21 101/2</p> <p>such [19] 11/6 22/21 23/2 25/21 42/20 52/15 53/24 65/20 69/24 89/24 102/13 104/24 105/19 110/2 120/20 126/18 134/6 135/2 138/19</p> <p>suffered [3] 57/13 60/24 63/13</p> <p>sufferers [1] 95/10</p> <p>suffering [1] 44/3</p> <p>sufficient [5] 32/16 58/20 70/16 90/3 125/4</p> <p>suggest [2] 60/19 119/12</p> <p>suggested [4] 52/11 90/24 133/10 145/23</p> <p>suggesting [1] 69/7</p> <p>suggestion [1] 133/1</p> <p>suggests [2] 71/10 80/14</p> <p>suitable [2] 10/22 57/22</p> <p>sulphate [1] 11/4</p> <p>sulphate-based [1] 11/4</p> <p>sum [1] 126/13</p>	<p>summary [3] 21/7 51/25 101/17</p> <p>summoned [1] 144/3</p> <p>supervision [3] 28/8 136/12 136/17</p> <p>supplemental [2] 150/25 151/1</p> <p>supplied [1] 52/17</p> <p>supplies [3] 37/8 52/22 153/5</p> <p>supply [7] 31/9 40/22 50/22 52/2 85/17 148/9 149/2</p> <p>support [2] 95/10 95/11</p> <p>supporter [1] 124/25</p> <p>supposed [4] 131/15 131/16 131/20 139/8</p> <p>sure [18] 14/3 16/20 18/15 23/15 23/16 23/18 24/12 41/14 54/10 69/3 69/4 92/2 118/18 128/2 128/13 139/1 139/2 147/25</p> <p>surface [3] 63/19 63/22 64/11</p> <p>surprised [1] 41/24</p> <p>surprising [1] 114/16</p> <p>surrogate [7] 121/23 121/24 124/17 125/11 126/1 126/5 126/18</p> <p>survived [1] 141/16</p> <p>suspect [8] 23/12 32/5 71/17 100/10 100/11 101/9 128/13 146/2</p> <p>suspected [2] 6/18 139/14</p> <p>suspended [1] 140/5</p> <p>sustained [1] 69/25</p> <p>sweats [1] 79/19</p> <p>sworn [3] 1/15 1/24 154/2</p> <p>Syndrome [1] 62/16</p> <p>Syphilis [2] 81/11 121/9</p> <p>system [25] 23/13 53/13 57/11 59/12 76/15 104/14 108/18 108/21 109/18 113/5 117/8 127/22 127/24 128/12 128/16 128/25 131/7 132/7 136/15 136/17 145/11 148/11 148/24 150/11 153/12</p> <p>systems [1] 108/13</p> <p>T</p> <p>table [7] 8/3 41/1 84/12 84/12 84/19 84/20 148/9</p> <p>take [33] 1/23 9/23</p>	<p>14/24 16/13 17/13 27/18 29/17 42/25 43/2 43/7 50/3 58/22 59/2 59/5 59/10 66/20 67/18 70/25 75/1 77/18 85/22 90/9 93/8 102/3 107/22 122/9 130/9 144/11 145/15 146/2 146/22 147/17 147/24</p> <p>take-home [1] 146/22</p> <p>taken [25] 17/8 28/4 29/3 29/23 61/25 70/5 70/13 70/24 88/7 91/5 104/18 104/19 104/25 108/15 109/9 111/1 112/15 121/5 130/12 133/4 135/22 136/14 143/15 143/25 144/16</p> <p>takes [2] 51/11 70/2</p> <p>taking [8] 27/15 27/15 34/22 62/8 76/11 77/21 83/6 125/13</p> <p>talk [4] 43/14 59/14 102/4 102/5</p> <p>talking [6] 1/16 1/20 26/12 64/10 96/5 111/8</p> <p>talks [1] 33/18</p> <p>target [10] 30/16 30/23 31/10 32/11 32/11 32/13 32/22 33/1 33/6 33/6</p> <p>targets [6] 30/11 30/13 30/20 31/20 32/10 38/25</p> <p>tasks [1] 128/8</p> <p>tea [3] 84/12 84/19 129/4</p> <p>teaching [1] 2/14</p> <p>team [5] 10/10 10/10 35/20 38/5 96/8</p> <p>teams [7] 9/10 10/10 10/18 10/19 10/22 27/1 35/21</p> <p>technique [1] 18/17</p> <p>Telegraph [1] 36/17</p> <p>tell [15] 2/23 7/2 13/3 15/25 20/1 23/6 23/10 25/1 43/8 43/8 124/3 133/11 138/21 139/23 144/19</p> <p>telling [2] 140/20 152/25</p> <p>tells [4] 2/18 5/8 6/3 72/5</p> <p>ten [1] 42/6</p> <p>tenure [6] 20/7 37/24 39/21 42/13 133/16 139/25</p> <p>term [1] 119/3</p> <p>terms [23] 15/23</p>	<p>15/24 15/25 23/11 30/13 53/18 54/12 55/21 55/21 64/20 66/7 66/22 76/16 83/7 85/15 96/19 97/11 101/4 120/2 122/11 144/15 147/21 149/14</p> <p>Terry [2] 110/24 149/11</p> <p>test [39] 14/13 15/8 15/10 15/15 15/20 16/2 17/15 18/18 18/18 18/19 18/22 43/24 63/19 64/11 67/1 86/6 93/14 94/14 94/17 94/20 97/16 100/18 103/2 104/18 105/1 105/4 118/13 122/11 123/1 123/2 123/9 123/12 124/11 124/20 134/19 139/22 142/6 142/6 153/12</p> <p>tested [26] 63/18 64/17 65/14 72/5 72/8 72/21 95/16 96/15 99/2 99/7 100/1 100/12 100/14 101/6 101/11 108/8 108/15 111/25 112/7 112/12 116/2 116/9 118/8 121/8 122/24 126/15</p> <p>testimony [1] 146/4</p> <p>testing [51] 16/8 91/8 92/6 92/14 98/23 98/25 99/12 99/14 100/8 100/13 101/2 101/7 101/15 102/4 105/6 105/14 109/6 110/15 111/14 113/9 113/12 113/21 114/3 114/5 114/11 115/12 115/22 115/24 116/19 121/5 121/23 121/25 122/2 122/15 122/16 122/17 123/23 124/4 124/14 124/17 124/18 125/1 125/11 126/1 126/3 126/5 126/7 126/18 126/22 127/19 127/20</p> <p>tests [25] 11/4 15/7 15/7 15/8 15/8 15/10 15/21 16/17 16/17 17/5 18/14 28/8 44/18 47/3 64/1 64/8 66/5 94/4 94/25 97/8 119/6 119/12 123/21 140/9 140/13</p> <p>Thames [1] 35/11</p> <p>than [41] 12/20 18/3 18/5 20/11 27/14 30/5 32/21 34/21 37/12</p>	<p>42/25 48/16 54/11 61/7 64/22 66/21 71/23 72/15 79/1 81/20 83/10 96/23 97/2 102/16 102/17 104/12 110/23 114/1 114/11 116/9 120/10 122/8 122/17 127/11 127/25 132/11 138/19 142/5 145/14 149/3 149/14 153/15</p> <p>thank [21] 1/14 2/3 15/19 19/19 24/4 41/2 48/14 49/10 93/10 108/1 117/14 143/5 145/14 145/20 146/5 149/9 152/16 152/19 153/6 153/15 153/17</p> <p>that [959]</p> <p>that's [25] 1/20 13/2 23/1 34/2 43/8 51/23 53/17 63/4 63/8 64/23 65/21 69/5 69/18 74/18 76/1 81/4 85/11 88/24 90/7 90/10 99/24 120/4 123/22 129/17 150/17</p> <p>theater [2] 9/7 9/11</p> <p>their [40] 4/11 17/1 28/1 33/12 39/9 40/6 43/23 50/19 51/10 52/12 52/14 56/6 62/2 63/17 72/8 80/6 80/21 81/8 86/9 87/12 89/9 95/10 99/7 104/6 111/10 111/20 112/7 112/17 113/11 114/3 119/25 121/19 126/3 128/4 128/18 129/10 132/19 134/2 146/12 149/25</p> <p>them [32] 16/25 20/10 26/4 29/14 30/23 31/9 31/11 31/16 34/22 38/11 38/11 40/13 41/22 41/23 47/4 58/19 60/5 65/1 75/7 76/24 85/8 95/2 101/6 101/6 103/3 104/3 119/24 122/9 128/21 138/2 140/20 144/25</p> <p>themselves [7] 9/22 40/7 57/21 68/24 75/12 99/12 120/7</p> <p>then [175]</p> <p>there [241]</p> <p>there's [1] 141/10</p> <p>thereabouts [2] 45/6 129/5</p> <p>thereafter [1] 104/4</p> <p>therefore [5] 34/15 34/16 35/19 118/16</p>	<p>118/20</p> <p>these [14] 36/20 53/12 62/7 65/3 66/7 66/10 75/24 88/4 88/8 94/19 96/8 110/17 149/5 152/13</p> <p>they [116] 7/21 7/22 11/13 12/23 16/18 20/10 23/17 27/16 27/24 28/5 28/10 32/8 32/17 34/24 35/14 38/13 39/8 41/14 42/17 46/20 50/17 50/22 51/8 51/9 53/2 55/19 56/2 56/4 56/5 56/10 57/12 57/16 57/22 58/18 58/19 59/11 61/19 62/4 63/12 63/23 63/24 64/18 65/12 65/12 66/8 68/23 68/24 70/21 72/7 72/8 72/12 72/13 72/17 72/24 77/18 78/5 78/6 78/8 78/8 78/9 83/3 83/9 83/11 83/19 83/21 85/9 90/3 90/4 90/4 91/23 91/23 94/22 95/1 97/12 97/24 101/7 101/9 101/10 105/6 105/14 109/11 109/15 109/17 109/18 109/19 109/20 111/24 112/5 112/11 112/16 112/25 119/20 120/6 123/17 124/2 125/23 128/14 128/21 133/22 134/2 134/3 134/7 135/2 137/9 137/14 138/2 138/22 140/10 140/20 140/21 146/19 150/5 151/3 151/10 151/18 151/22</p> <p>they'd [1] 7/20</p> <p>they've [1] 78/2</p> <p>thing [6] 16/14 53/24 89/20 105/4 125/4 131/25</p> <p>things [14] 5/24 23/15 34/23 82/1 82/24 84/25 115/19 117/4 117/9 125/22 136/3 136/4 136/19 136/20</p> <p>think [117] 1/10 8/18 17/22 17/24 18/11 28/7 31/23 32/9 32/15 33/8 33/14 35/18 38/15 38/22 41/2 41/11 42/3 42/25 43/12 43/21 44/9 47/18 48/3 48/16 49/21 53/12 58/18</p>
--	---	--	---	---	--

<p>T</p> <p>think... [90] 58/20 60/11 66/15 66/23 68/10 69/18 69/20 71/9 71/10 71/15 74/9 75/23 76/6 79/9 79/12 79/13 81/4 81/16 84/22 85/20 85/22 86/18 86/19 86/23 86/25 87/4 87/4 87/10 89/23 90/3 90/14 91/2 91/25 92/1 92/8 92/22 92/24 99/24 100/21 101/5 101/6 101/12 105/19 106/2 107/13 107/22 107/25 109/17 114/25 117/16 117/21 119/4 125/3 125/25 127/13 127/18 127/19 129/3 129/12 129/13 129/17 130/7 130/11 131/2 131/13 133/10 138/3 138/5 138/18 138/21 138/23 138/24 139/24 141/23 142/23 143/3 143/18 144/14 145/5 145/12 146/21 146/22 147/20 147/24 148/22 150/2 150/14 151/11 152/15 152/16</p> <p>think: [1] 75/24 think: oh [1] 75/24 thinking [14] 12/21 50/2 65/21 99/18 113/2 114/9 116/23 120/15 120/16 122/13 123/8 124/16 124/23 125/7</p> <p>third [13] 6/10 14/19 19/6 19/10 19/11 19/15 37/5 98/9 102/5 111/7 111/11 112/10 112/13</p> <p>thirds [3] 111/23 112/4 145/7</p> <p>this [205] those [63] 12/10 12/12 15/9 16/9 17/7 17/7 27/20 28/4 34/18 39/9 40/6 40/15 43/5 46/14 48/25 50/15 52/25 54/13 54/14 54/18 55/22 57/25 59/19 61/18 62/11 62/20 64/14 64/16 64/17 64/21 65/11 65/15 66/2 72/22 75/5 75/11 75/14 76/4 80/14 83/2 84/17 88/11 94/20 99/13 101/5 101/16 108/19</p>	<p>116/1 119/23 121/10 128/13 128/25 131/18 131/20 141/5 141/15 143/9 143/10 145/7 146/1 146/16 147/1 152/4</p> <p>though [10] 17/4 37/20 38/13 49/14 66/17 100/11 101/10 122/10 122/16 125/18</p> <p>thought [22] 12/25 20/18 22/6 65/10 67/1 70/22 79/2 79/20 81/17 85/3 87/6 91/19 92/19 93/7 96/17 107/17 114/4 116/18 116/25 127/2 140/20 152/23</p> <p>thousands [1] 111/23</p> <p>threatened [1] 77/19</p> <p>three [12] 14/18 24/17 27/13 30/15 30/21 33/17 42/25 50/15 76/22 105/8 127/14 127/18</p> <p>three days [1] 105/8</p> <p>through [11] 3/17 27/24 30/21 42/13 51/11 73/17 73/18 73/18 117/22 128/7 128/22</p> <p>throughout [9] 10/19 12/13 15/21 20/7 27/1 32/6 39/21 44/17 117/8</p> <p>tight [1] 23/13</p> <p>time [91] 2/14 2/15 5/14 7/6 8/14 8/21 11/25 12/13 12/23 13/2 14/2 14/9 15/7 19/21 20/12 22/4 22/10 22/23 23/13 24/7 24/8 24/16 25/6 25/10 26/11 29/20 29/24 29/25 30/3 30/7 31/14 32/6 34/9 37/21 39/11 41/20 43/1 44/18 47/18 52/19 53/14 55/12 60/18 63/20 71/14 73/25 74/5 74/20 75/3 75/9 75/13 75/16 75/19 75/21 77/16 81/15 81/22 81/24 81/25 83/1 85/4 86/9 86/18 89/7 89/17 89/19 93/1 94/3 98/23 101/1 107/11 113/2 114/13 118/16 120/16 123/8 123/10 123/20 123/22 124/9 128/9 129/1 131/24 133/16 135/22</p>	<p>136/10 137/17 138/23 147/10 147/13 150/18</p> <p>time-expired [1] 52/19</p> <p>timelag [2] 102/11 102/13</p> <p>timely [1] 130/2</p> <p>times [3] 28/12 33/24 115/23</p> <p>Tissue [1] 3/10</p> <p>title [6] 10/7 15/12 44/16 55/12 106/4 106/22</p> <p>to [982]</p> <p>to 20 [1] 145/14</p> <p>today [5] 29/17 58/21 58/22 69/3 74/10</p> <p>together [3] 110/17 115/12 140/7</p> <p>told [11] 34/8 69/14 73/1 81/4 81/16 109/21 123/16 123/17 137/1 144/4 144/9</p> <p>tomorrow [2] 153/18 153/20</p> <p>tone [1] 114/25</p> <p>too [6] 14/23 22/9 78/24 79/20 83/19 92/2</p> <p>took [16] 5/23 6/21 19/23 20/10 24/11 43/23 53/4 53/23 67/13 73/25 75/8 77/11 83/8 120/10 143/22 153/3</p> <p>top [4] 7/20 21/5 60/10 67/11</p> <p>topic [3] 54/16 89/18 98/4</p> <p>topics [2] 42/24 146/12</p> <p>total [2] 29/14 32/18</p> <p>totally [4] 15/24 33/15 134/24 136/2</p> <p>touch [3] 13/17 13/21 112/15</p> <p>towards [1] 41/20</p> <p>TPHA [1] 135/12</p> <p>trace [6] 128/7 128/17 128/21 137/24 137/25 139/9</p> <p>traced [1] 111/22</p> <p>tracing [1] 119/9</p> <p>track [1] 147/23</p> <p>trained [1] 66/20</p> <p>training [11] 6/13 6/16 9/13 9/15 9/15 9/17 9/18 56/2 56/6 57/18 107/3</p> <p>trajectories [1] 107/14</p> <p>transcript [3] 42/4 91/3 113/16</p>	<p>transfused [1] 118/18</p> <p>transfusion [121] 2/20 3/6 3/15 3/22 4/1 4/6 4/17 5/4 5/11 7/13 7/16 8/4 8/20 9/2 9/12 9/19 10/3 10/5 10/6 11/12 11/25 12/18 12/20 15/22 17/18 19/23 21/3 21/8 21/11 21/15 22/20 22/22 25/25 28/2 32/19 35/3 36/23 38/18 39/10 39/11 39/19 40/1 40/11 40/14 40/15 40/23 45/11 45/21 45/22 46/2 46/14 46/15 46/19 46/23 47/3 47/19 48/8 48/17 48/21 48/24 49/24 50/11 50/17 51/12 52/4 52/7 52/12 53/20 54/17 54/23 55/11 55/16 55/18 63/15 65/6 67/8 68/6 69/2 70/3 73/17 76/15 76/20 85/24 86/4 89/6 89/23 91/18 94/11 101/14 106/19 107/2 110/12 113/8 113/11 113/14 116/8 117/3 118/1 121/19 125/15 129/20 129/23 129/25 130/3 130/17 130/21 131/5 132/12 132/19 134/6 138/9 138/17 139/6 143/21 146/23 147/1 150/13 152/14 153/3 153/8 153/11</p> <p>Transfusion* [1] 45/25</p> <p>transfusion-transmitted [7] 12/20 54/17 129/23 130/3 138/9 138/17 139/6</p> <p>transfusion: record [1] 51/20</p> <p>transfusions [1] 46/15</p> <p>transmissible [2] 47/2 74/22</p> <p>transmission [8] 7/11 44/20 49/19 73/16 73/20 74/6 74/18 99/5</p> <p>transmit [1] 118/17</p> <p>transmitted [14] 12/20 54/17 95/6 96/17 129/23 130/3 130/17 130/21 138/9 138/17 139/6 139/10 140/18 140/21</p> <p>transmitting [2] 95/3</p>	<p>110/11</p> <p>transpired [1] 135/11</p> <p>travel [1] 10/19</p> <p>treat [1] 125/17</p> <p>treated [3] 97/11 97/12 119/8</p> <p>treatment [9] 17/10 86/11 96/3 96/4 97/18 120/3 141/18 141/20 146/24</p> <p>Treloar [1] 149/22</p> <p>tremendous [2] 152/11 152/14</p> <p>trigger [1] 58/4</p> <p>trouble [2] 65/25 79/1</p> <p>true [3] 25/12 125/3 127/4</p> <p>truly [1] 38/19</p> <p>truth [3] 79/25 80/23 85/12</p> <p>truthful [1] 56/24</p> <p>try [17] 13/24 59/9 59/10 82/24 93/11 106/18 109/10 112/15 113/6 113/24 117/7 122/9 127/16 129/16 130/9 146/23 152/24</p> <p>trying [4] 47/12 66/16 96/7 125/17</p> <p>TTH [2] 139/15 140/16</p> <p>tubes [1] 140/8</p> <p>Tuesday [1] 153/22</p> <p>turn [37] 9/25 17/2 29/9 30/11 36/19 37/1 45/15 46/21 50/14 51/16 55/3 56/20 58/10 63/7 67/6 67/10 76/25 77/4 86/2 87/16 92/6 93/15 93/17 93/19 101/19 105/21 106/3 106/7 106/20 108/4 108/11 111/6 117/19 134/14 137/21 138/7 140/23</p> <p>turned [2] 108/23 128/21</p> <p>turning [10] 5/14 9/22 26/22 32/10 33/6 34/6 61/22 92/5 100/23 136/22</p> <p>twelve [2] 63/14 64/2</p> <p>twice [2] 102/17 142/15</p> <p>two [27] 1/14 5/20 9/4 10/12 12/8 15/2 23/22 24/24 36/15 38/3 38/3 41/5 42/7 48/23 64/12 72/14 75/21 80/16 86/13 87/16 97/6 107/16 111/23 112/4 124/19 129/8 145/7</p> <p>two thirds [1] 111/23</p>	<p>two-thirds [2] 112/4 145/7</p> <p>type [1] 96/8</p> <p>Typically [1] 29/3</p> <p>Typing [1] 3/11</p> <hr/> <p>U</p> <p>UK [6] 80/15 81/11 81/14 81/19 102/15 114/10</p> <p>ultimately [5] 19/10 38/23 45/3 45/8 87/6</p> <p>unable [1] 117/18</p> <p>unauthorised [1] 97/5</p> <p>unavoidable [1] 146/19</p> <p>unchanged [1] 149/16</p> <p>Unclear [1] 36/3</p> <p>under [10] 10/22 21/10 56/13 56/22 63/24 71/6 95/4 96/19 138/10 141/5</p> <p>underline [1] 38/22</p> <p>understand [41] 5/25 11/11 11/24 14/8 15/16 15/22 21/13 29/25 30/12 35/2 35/25 39/2 43/23 48/1 55/4 55/6 57/11 58/3 58/14 60/12 65/2 66/9 66/19 68/5 68/19 70/1 75/15 76/9 84/18 85/14 95/1 101/21 111/25 112/4 117/15 119/22 121/24 137/10 138/12 143/14 150/9</p> <p>understanding [10] 44/23 44/25 56/10 64/19 73/22 74/6 81/21 112/9 144/14 150/14</p> <p>understood [3] 46/17 94/22 105/23</p> <p>undertake [2] 16/24 141/25</p> <p>undertaken [6] 9/18 12/12 92/15 140/9 141/5 151/17</p> <p>undertaking [3] 30/2 56/7 104/2</p> <p>undertook [1] 11/3</p> <p>unequivocally [1] 70/8</p> <p>unethical [1] 36/7</p> <p>unfair [1] 115/25</p> <p>unforeseen [1] 149/24</p> <p>unfortunately [1] 46/10</p> <p>unhappy [1] 65/22</p> <p>unhelpful [1] 79/21</p> <p>uniformity [1] 117/8</p>
--	--	--	---	--	---

<p>U</p> <p>units [3] 24/7 24/25 26/18</p> <p>unknown [1] 124/6</p> <p>unless [2] 96/21 147/18</p> <p>unlikely [2] 87/10 123/19</p> <p>unreliable [1] 123/2</p> <p>unsurprisingly [1] 50/10</p> <p>untested [8] 98/21 99/14 100/4 101/2 101/8 101/17 101/18 111/15</p> <p>until [15] 2/12 3/13 4/25 18/21 18/24 66/5 75/4 102/11 103/2 104/17 106/16 133/21 144/1 145/18 153/22</p> <p>unused [2] 132/1 132/4</p> <p>unusual [1] 73/18</p> <p>up [72] 10/11 10/24 16/2 16/3 16/4 16/12 16/23 18/20 19/2 28/25 30/14 30/23 32/18 37/1 37/4 37/17 42/13 44/21 45/13 47/5 54/3 55/3 66/10 66/16 67/4 75/5 75/6 78/5 82/4 83/10 83/12 84/17 84/19 88/1 89/9 90/22 91/6 91/8 92/1 102/7 103/11 105/8 106/12 107/1 108/11 108/11 108/23 111/9 111/12 112/19 114/9 116/1 116/14 117/17 118/11 120/2 128/1 128/13 128/21 128/25 129/15 135/4 136/21 145/2 145/3 149/10 150/19 150/19 150/20 151/9 151/22 152/1</p> <p>up-to-date [1] 107/1</p> <p>update [1] 98/20</p> <p>upon [2] 49/6 88/19</p> <p>upset [1] 81/1</p> <p>upstairs [1] 9/5</p> <p>URN [1] 91/3</p> <p>us [31] 2/18 2/23 5/8 6/3 7/2 8/19 13/3 20/1 23/7 23/10 25/1 33/16 34/8 42/7 44/10 56/7 73/1 81/4 81/16 85/22 87/5 98/17 101/20 107/25 133/12 143/15 144/15 144/18 152/25 153/2 153/6</p> <p>USA [2] 81/8 81/12</p>	<p>USAF [1] 41/6</p> <p>usage [3] 51/10 52/16 84/8</p> <p>use [10] 9/11 18/15 24/20 29/23 30/6 52/18 72/23 98/24 121/13 146/18</p> <p>used [23] 9/13 13/5 13/24 14/14 15/14 16/7 18/17 18/19 18/23 29/6 33/17 46/14 46/17 75/23 84/7 101/7 104/24 108/17 112/2 123/7 131/24 139/12 147/3</p> <p>useful [1] 88/8</p> <p>using [5] 7/11 14/13 16/6 105/7 147/1</p> <p>usually [5] 10/24 11/8 11/19 95/9 118/25</p> <p>utterly [1] 113/19</p> <p>V</p> <p>vaccinations [1] 72/16</p> <p>vague [1] 79/20</p> <p>valid [2] 70/19 70/22</p> <p>variable [1] 47/5</p> <p>variance [2] 81/12 87/6</p> <p>varied [1] 87/1</p> <p>varies [1] 102/11</p> <p>various [4] 2/7 72/12 108/6 153/8</p> <p>vast [2] 37/14 85/2</p> <p>venepunctures [1] 11/5</p> <p>Venereal [1] 96/20</p> <p>venue [1] 11/8</p> <p>venues [2] 10/19 94/12</p> <p>verbal [1] 139/14</p> <p>version [15] 45/12 46/6 55/3 55/5 55/5 55/8 71/21 71/23 71/24 71/25 72/9 86/9 86/15 88/11 88/16</p> <p>versions [3] 87/12 87/12 139/1</p> <p>very [50] 11/14 18/13 19/6 19/19 22/18 25/11 26/13 28/7 28/10 31/2 31/4 35/13 41/20 41/24 42/16 45/14 46/25 53/25 60/17 71/7 74/9 76/18 80/25 82/9 84/23 85/20 91/16 92/12 92/20 104/2 106/2 114/17 116/22 122/25 123/2 124/2 125/19 126/24 127/15 130/5</p>	<p>130/19 136/12 136/20 136/20 143/5 146/2 147/8 147/11 150/5 152/17</p> <p>via [4] 49/19 73/16 85/6 136/23</p> <p>view [14] 48/7 49/16 51/4 70/7 76/4 79/12 80/4 83/8 92/15 103/16 103/17 115/14 116/6 153/7</p> <p>viewed [1] 114/1</p> <p>views [2] 78/11 125/1</p> <p>VIII [7] 39/8 39/12 39/17 86/12 148/9 149/2 149/17</p> <p>viral [6] 28/6 54/8 64/2 134/1 137/12 137/18</p> <p>virologist [1] 121/15</p> <p>virtually [1] 28/11</p> <p>virus [6] 14/1 15/2 73/15 99/5 102/20 118/16</p> <p>virus-containing [1] 102/20</p> <p>viruses [4] 47/1 47/2 49/19 105/12</p> <p>vis [2] 148/12 148/12</p> <p>visit [6] 42/2 134/17 140/10 147/6 147/6 147/9</p> <p>visited [1] 12/8</p> <p>visiting [1] 151/10</p> <p>voice [2] 43/22 44/5</p> <p>volunteer [1] 10/21</p> <p>volunteering [1] 70/11</p> <p>vulnerable [1] 143/24</p> <p>W</p> <p>Wagstaff [1] 77/3</p> <p>Wagstaff's [1] 89/1</p> <p>wake [1] 36/21</p> <p>Wales [2] 8/5 113/20</p> <p>walk [3] 29/12 29/13 83/14</p> <p>walk-in [1] 83/14</p> <p>walk-ins [2] 29/12 29/13</p> <p>want [13] 1/20 28/25 41/17 44/16 49/1 49/2 93/19 94/16 102/7 111/11 112/25 120/19 134/15</p> <p>wanted [11] 32/1 35/14 37/15 48/15 68/19 91/6 94/20 98/18 102/3 106/8 108/13</p> <p>warn [1] 107/14</p> <p>warning [3] 105/9</p>	<p>105/10 105/19</p> <p>warranted [1] 79/1</p> <p>was [520]</p> <p>washing [1] 99/4</p> <p>wasn't [19] 20/12 59/17 66/5 96/5 96/7 99/17 115/9 115/9 117/5 121/25 123/4 126/24 130/11 130/16 137/16 138/4 138/21 140/2 141/7</p> <p>Watford [1] 144/4</p> <p>way [40] 6/10 9/23 17/11 22/19 28/7 36/12 36/15 37/5 37/14 39/10 42/16 44/10 57/17 77/12 79/4 80/8 83/13 83/18 85/18 88/13 90/6 90/7 91/20 97/9 97/11 97/13 98/4 99/10 101/10 108/24 113/21 114/22 117/21 125/14 125/18 126/20 131/14 136/6 148/21 152/21</p> <p>ways [1] 48/23</p> <p>we [418]</p> <p>We'll [1] 43/7</p> <p>week [11] 5/22 26/17 27/8 28/19 31/7 46/13 112/22 112/23 119/13 142/10 151/8</p> <p>week's [1] 28/19</p> <p>weekend [1] 43/24</p> <p>weeks [6] 24/17 24/17 26/11 102/12 109/3 135/22</p> <p>weighed [1] 115/10</p> <p>weight [2] 56/14 79/19</p> <p>well [49] 1/18 6/18 10/6 18/20 26/8 27/14 27/24 31/4 33/8 34/14 38/12 41/20 43/25 46/18 56/5 57/11 61/6 65/10 65/13 65/21 66/3 73/13 79/7 81/3 91/14 95/17 99/16 99/19 104/2 117/2 122/6 122/10 122/24 124/8 126/17 129/7 132/7 133/3 138/17 139/9 142/3 143/5 144/19 145/13 147/20 147/23 151/20 152/2 152/17</p> <p>Welsh [5] 2/11 2/20 3/3 45/20 48/20</p> <p>went [8] 10/18 22/23 39/17 42/12 68/22 74/20 150/19 150/19</p> <p>were [239]</p>	<p>weren't [7] 17/17 17/18 38/16 47/8 87/11 130/17 150/10</p> <p>Wessex [5] 148/7 148/10 148/16 148/23 149/2</p> <p>Western [8] 4/2 4/5 4/9 4/14 85/23 98/8 100/25 132/12</p> <p>what [150] 1/21 2/23 2/24 6/9 7/2 7/8 7/8 8/19 8/21 9/11 13/15 14/8 14/13 14/25 16/13 21/14 22/16 22/24 23/10 23/12 23/17 23/25 25/17 26/5 32/12 32/22 33/12 34/1 35/13 35/23 37/3 39/1 39/13 43/8 43/10 44/13 46/20 47/10 47/25 48/1 49/22 52/21 53/16 54/12 54/13 55/19 56/9 57/23 59/8 59/13 59/18 64/19 64/20 64/23 65/21 65/25 66/6 66/6 68/19 69/5 69/13 70/20 74/10 75/4 75/15 75/21 76/9 77/20 78/2 78/21 78/24 80/3 81/4 82/18 82/25 83/6 83/22 84/6 84/6 84/20 86/17 87/6 91/10 91/11 93/20 95/14 99/10 99/18 99/19 100/6 100/7 101/4 101/21 101/25 102/2 103/19 104/23 105/23 107/6 107/9 107/11 107/19 108/15 108/20 108/24 109/1 111/1 113/1 115/21 115/21 116/21 116/24 117/2 120/8 120/15 121/23 122/5 122/21 122/22 123/11 123/13 123/16 123/18 123/23 124/22 124/22 125/3 126/17 127/16 128/5 129/11 131/11 131/16 131/19 131/20 133/5 133/8 134/1 136/1 138/12 139/13 142/24 144/16 145/22 147/21 149/15 151/19 152/11 152/25 153/1</p> <p>what's [2] 34/13 139/8</p> <p>whatever [13] 12/25 31/11 39/8 44/4 57/16 64/7 73/19 73/20 86/21 107/23 123/1</p>	<p>146/25 152/18</p> <p>when [54] 3/13 3/20 5/15 9/13 13/23 14/22 17/22 19/10 19/12 20/1 20/24 22/18 25/2 28/20 37/21 37/25 39/4 46/7 46/11 63/18 73/6 75/16 80/5 83/20 84/25 87/8 90/12 92/3 92/13 92/14 93/21 94/18 96/14 99/7 100/14 108/14 108/22 109/3 114/2 120/11 128/7 128/9 131/7 135/6 137/6 138/22 139/19 140/2 140/12 145/4 147/7 150/7 152/22 153/7</p> <p>whenabouts [1] 13/9</p> <p>where [16] 10/20 11/21 37/5 54/3 59/5 59/6 70/19 79/25 80/10 96/15 96/24 103/11 137/6 144/8 149/15 150/16</p> <p>whereas [2] 32/2 114/24</p> <p>whereby [1] 139/4</p> <p>whether [67] 12/3 12/18 13/25 16/3 17/19 17/23 18/6 18/8 18/16 28/3 33/1 38/11 41/14 42/12 43/1 43/13 46/3 49/2 49/17 53/3 54/17 56/4 57/12 57/21 58/7 58/8 60/23 62/1 65/5 65/12 67/14 69/4 70/15 70/19 73/16 74/4 74/8 78/13 83/4 85/12 88/12 94/18 99/13 100/1 100/2 105/22 108/16 109/8 109/20 109/24 111/19 112/16 120/20 125/11 126/4 128/24 129/1 129/2 137/13 138/2 138/15 140/20 145/9 146/16 147/15 151/3 151/12</p> <p>which [145] 1/17 2/12 5/4 5/5 7/9 7/23 11/16 12/4 12/10 13/5 13/13 13/23 14/4 14/19 16/2 17/10 17/10 19/2 19/15 24/13 24/14 24/16 26/16 26/17 26/17 27/16 27/25 30/15 34/25 36/5 36/14 36/22 37/19 38/8 38/23 39/3 40/10 41/1 41/9 41/10 42/1 42/3 42/6 43/12 45/6</p>
--	---	--	---	---	---

<p>W</p> <p>which... [100] 45/7 45/14 47/12 48/4 48/12 49/7 49/11 50/1 52/18 53/22 54/22 55/17 59/16 60/7 60/24 61/3 61/8 61/12 61/16 61/25 65/13 66/4 66/17 67/5 67/9 70/6 70/23 72/9 72/18 73/3 73/9 73/17 74/11 74/14 74/15 74/25 75/3 75/5 75/6 75/9 75/25 76/2 79/17 80/4 82/10 84/23 85/25 86/24 87/5 88/20 89/20 90/10 93/8 99/23 100/8 100/24 101/15 102/11 102/20 104/24 106/4 107/2 107/16 110/10 115/7 116/1 118/19 121/13 123/18 124/6 125/11 125/14 126/14 127/13 128/17 129/5 130/20 131/25 133/6 134/12 134/12 134/18 136/9 140/18 141/15 142/8 142/13 142/14 142/20 144/20 146/22 146/25 147/5 147/11 149/8 150/2 151/2 152/2 152/22 153/5</p> <p>while [8] 8/15 13/3 30/9 36/4 37/8 75/13 88/7 90/10</p> <p>who [47] 1/10 1/18 1/20 1/20 6/17 13/17 13/25 29/9 43/5 46/18 48/25 58/16 59/19 63/10 64/10 64/13 64/16 64/17 65/12 65/18 76/7 77/17 77/22 78/4 78/6 88/11 91/17 94/24 95/15 95/18 95/20 95/23 96/1 102/16 105/25 112/23 113/24 115/24 115/25 118/7 133/25 139/9 141/16 142/2 144/23 144/24 145/6</p> <p>whoever [3] 7/5 43/13 90/5</p> <p>whole [15] 18/20 24/5 26/19 33/17 35/13 36/4 81/20 100/18 114/20 121/25 124/4 124/18 142/5 143/21 149/12</p> <p>whom [3] 50/21 81/1 112/1</p>	<p>whose [3] 63/11 63/21 66/14</p> <p>why [27] 16/7 32/3 32/3 34/12 37/15 65/9 75/8 77/14 79/2 83/8 89/15 100/14 102/1 107/9 107/18 109/1 109/12 120/10 126/16 126/24 126/25 127/10 128/11 130/7 133/3 136/11 144/11</p> <p>wife [1] 1/10</p> <p>will [50] 1/15 1/19 3/8 25/7 27/10 30/21 30/22 31/5 34/3 43/7 44/9 51/14 61/14 62/4 62/8 63/3 67/16 70/20 70/25 72/5 85/22 86/6 88/8 90/13 92/11 93/25 94/4 102/23 106/11 107/23 108/11 114/18 117/16 117/16 118/18 119/8 119/11 129/8 137/6 141/17 145/11 145/15 145/24 146/1 146/22 147/24 148/25 149/16 149/18 150/7</p> <p>willing [1] 112/17</p> <p>willingness [1] 70/3</p> <p>window [4] 103/4 104/19 105/7 105/13</p> <p>wish [3] 46/24 119/5 152/17</p> <p>with [167]</p> <p>withdraw [1] 75/12</p> <p>withdrawal [2] 134/23 135/13</p> <p>withdrawn [2] 100/8 140/22</p> <p>withholding [1] 80/24</p> <p>within [13] 9/2 14/10 16/7 22/22 27/22 35/3 66/12 66/18 74/18 95/6 104/25 122/25 129/22</p> <p>without [7] 11/22 59/15 64/18 70/13 83/18 92/10 147/19</p> <p>WITN6917001 [3] 6/8 9/24 44/11</p> <p>witness [17] 2/18 6/3 6/7 9/24 10/14 16/5 20/1 22/8 23/7 34/10 43/9 44/11 101/22 101/25 111/5 130/20 133/12</p> <p>witnesses [1] 112/23</p> <p>women [1] 62/18</p> <p>won't [3] 13/20 14/19 146/2</p> <p>wonder [3] 43/1</p>	<p>101/20 116/12</p> <p>word [1] 116/22</p> <p>wording [1] 62/22</p> <p>words [3] 48/22 109/7 131/24</p> <p>work [17] 2/15 7/1 17/13 17/21 17/25 21/2 48/25 54/21 56/7 92/17 93/6 122/19 131/10 132/7 132/17 141/25 152/12</p> <p>workaround [1] 128/17</p> <p>worked [2] 31/4 33/8</p> <p>workers [1] 95/8</p> <p>working [9] 3/18 4/5 54/21 54/24 55/22 66/9 132/14 132/18 145/9</p> <p>works [1] 19/4</p> <p>worry [1] 84/25</p> <p>would [215]</p> <p>would-be [1] 80/15</p> <p>wouldn't [4] 55/7 58/19 105/14 125/2</p> <p>write [2] 119/14 138/2</p> <p>writing [3] 45/17 114/9 118/12</p> <p>written [6] 29/7 36/21 66/24 133/23 139/14 140/19</p> <p>wrong [8] 22/7 45/13 49/8 100/10 107/6 126/8 135/17 135/17</p> <p>wrote [2] 25/6 113/7</p> <p>Y</p> <p>year [12] 26/19 31/20 33/24 102/17 131/13 132/22 142/11 142/13 142/14 142/16 142/17 142/19</p> <p>years [17] 5/20 9/1 25/8 25/8 72/14 82/2 108/11 109/1 109/2 109/6 110/23 117/3 127/14 127/18 127/20 132/18 133/10</p> <p>years' [1] 33/9</p> <p>yellow [1] 29/5</p> <p>yes [138] 1/5 1/7 1/9 1/12 2/3 2/6 2/13 2/17 2/22 3/7 3/12 3/16 3/24 4/3 4/8 4/13 4/16 4/19 4/22 5/1 5/7 5/17 6/2 6/6 7/15 7/19 8/18 9/17 9/17 10/16 12/8 12/14 14/11 14/11 15/18 16/10 16/22 18/22 18/25 19/6 20/14 20/20 21/18 22/11 24/10 24/22</p>	<p>26/4 29/11 29/21 30/20 31/2 31/21 32/9 36/3 40/16 41/19 42/11 42/23 43/2 44/2 46/6 47/11 47/21 47/24 53/10 53/17 54/5 55/6 56/1 57/15 58/6 58/9 58/13 58/20 59/1 59/9 60/21 61/12 62/10 62/24 64/5 65/1 66/22 68/15 68/21 68/25 69/8 70/17 71/10 72/24 73/23 74/17 75/22 76/6 78/23 78/23 82/23 84/22 85/20 89/20 89/25 90/19 93/5 94/22 99/24 101/18 104/16 104/21 105/3 105/18 107/21 112/9 117/13 120/4 125/23 125/24 128/20 129/17 131/9 132/2 132/6 132/9 132/16 133/15 133/22 136/17 137/20 138/14 142/3 143/2 144/22 145/17 145/20 146/10 147/12 150/14 152/10 153/20</p> <p>yesterday [2] 37/9 149/10</p> <p>yet [4] 47/3 86/8 86/15 116/2</p> <p>you [657]</p> <p>your [146] 1/10 2/4 2/18 3/19 5/8 5/14 6/3 6/7 7/1 8/12 8/14 9/23 10/14 11/24 12/13 12/17 13/2 13/3 16/5 17/14 18/18 18/19 19/21 20/1 20/7 20/12 22/4 22/8 22/8 22/10 23/7 24/8 25/1 29/8 29/18 29/20 30/11 30/13 30/16 30/24 31/10 31/19 32/6 32/10 33/11 34/4 34/9 34/9 37/24 39/1 39/21 41/6 42/13 44/4 44/8 44/11 44/22 46/24 48/7 48/8 49/16 49/18 49/20 49/22 49/23 52/25 53/18 54/21 55/21 56/10 60/13 65/6 65/7 66/20 66/24 69/16 71/14 73/1 73/21 74/8 76/4 78/11 78/16 79/12 79/14 80/3 80/3 81/21 82/18 83/6 85/14 85/17 91/10 92/15 92/16 93/6 97/10 101/17</p>	<p>104/13 105/21 107/19 113/1 113/2 113/17 113/19 113/25 114/8 118/14 118/18 118/21 119/4 119/8 119/11 119/11 119/12 119/13 119/16 119/22 121/4 121/24 125/1 125/7 126/10 130/1 130/4 133/11 133/12 133/16 134/15 136/1 137/12 139/25 142/2 143/10 143/17 144/16 146/3 146/19 147/18 149/3 149/8 149/9 151/5 152/12 152/17 152/21</p> <p>your haematological [1] 33/11</p> <p>yours [2] 36/13 137/8</p> <p>yourself [6] 16/8 17/13 53/5 53/18 120/11 120/12</p> <hr/> <p>Z</p> <p>Zaire [1] 62/19</p>
--	--	---	---	--