1 **Tuesday, 28 February 2023**
2 **(10.20 am)**
3 **LADY HALLETT:** Welcome everyone, including those attending
4 remotely, to the first preliminary hearing into
5 Module 3: heath systems across the United Kingdom.
6 May I begin with an apology for the fact that some
7 Core Participants were sent to the wrong venue. I am
8 genuinely sorry. It was a human error. People
9 attempted to correct it as soon as possible but,
10 obviously, the message didn't get through in time.
11 There will be representatives of the Inquiry team
12 available during the breaks to make sure that nobody is
13 out of pocket so please let them know if you have been
14 incurred additional expense. I hope that everyone's had
15 a chance to get their breath from having rushed from one
16 venue to the next.
17 I am also grateful to everybody from the Core
18 Participants who has taken the time and trouble to
19 submit written submissions. They have been extremely
20 helpful and I look forward to hearing from those Core
21 Participants who wish to speak today, highlighting the
22 main aspects of those submissions.
23 In a moment, lead counsel to the Inquiry for this
24 module, Ms Jacqueline Carey, King's Counsel, will
25 explain in more detail the areas that Module 3 will be

1 covering. May I just say this at the outset.
2 Module 3, healthcare, is obviously at the heart of
3 an inquiry into the Covid-19 pandemic. It is a huge
4 topic and, as I've said before, my aim in conducting
5 this Inquiry is to provide reports, interim reports,
6 throughout the Inquiry and to make timely
7 recommendations where possible in the hope of reducing
8 the suffering that we witnessed during the pandemic.
9 That means that we've had to break down the vast
10 array of issues that healthcare systems in the UK could
11 cover into manageable chunks. So what you might at
12 first have thought would be covered in Module 3 may well
13 be covered in other modules. So, for example, there
14 will be other modules dedicated to examining health
15 inequalities and the impact of Covid-19 on mental health
16 and particular groups such as the elderly, the disabled,
17 the poor and minorities. Some aspects of the impact
18 will be covered in this module and, obviously, the
19 sooner we can make it clear to all the Core Participants
20 what module will be covering what issues, the better.
21 There's bound to be some overlap so there will be
22 a module, as people know, dedicated to the care sector,
23 and one obvious example of an overlap is the discharge
24 of hospital patients into care homes.
25 So I know how frustrating it is and all I can do

1 is undertake to ensure that as soon as we are able to
2 provide you with more detail, so, for example, Ms Carey
3 may speak about providing the Core Participants with
4 a list of issues for this module as soon as possible,
5 then we will give that detail.
6 But as everybody again, I hope, knows by now, the
7 Inquiry team is working extraordinarily hard and at such
8 a pace that these things are not proving easy. We're
9 doing our very best, I can assure you.
10 I hope that some of what Ms Carey will have to say
11 today may allay some of the concerns, because I fear
12 there may still be some misunderstanding amongst some
13 members of the public and possibly some Core
14 Participants.
15 Finally, may I say this in relation to the
16 Listening Exercise, Every Story Matters. The aim of the
17 listening exercise is to ensure that we reach as many
18 people as possible across the United Kingdom, from the
19 seldom heard and from those who are more often heard, to
20 find out from them directly what their experience of the
21 pandemic was.
22 That is our aim, so that that material can be fed
23 into the Inquiry and can inform all the findings and
24 recommendations that I make.
25 Some Core Participants, but not all, and some

1 members of the public, have complained that they do not
2 yet have enough detail of the exercise. Again, may
3 I say it is a huge project, probably one of the biggest
4 of its kind to date, and the Inquiry team with the task
5 of designing and developing it have also been working
6 extremely hard and doing their best to consult and
7 explain as they go along.
8 But having heard some of the complaints, I have
9 asked them to redouble their efforts to explain what
10 they are doing to all those who wish to know.
11 To that end, the latest Inquiry newsletter, which
12 will be published this week, sets out in clear terms
13 what has been happening, and the team will be holding
14 a webinar shortly for interested organisations at which
15 they will attempt to answer any further questions.
16 Could I invite all those who have concerns about the
17 listening exercise to read the newsletter and/or to
18 ensure that they find out from a representative
19 organisation what happens at the webinar. It may help
20 them to understand, and that, in turn, may encourage
21 people across the United Kingdom to participate in the
22 Listening Exercise because that is what the Inquiry
23 needs: it needs to hear from people, and we can only do
24 that if the millions of people across the
25 United Kingdom, enough of them, decide to contribute to

the exercise.

I will now just conclude my remarks by saying that during the break we are going to display a short series of images from the early days of the pandemic. The reasons are twofold. One, so that we recognise the work done by the healthcare sector in response to the pandemic, and some of the images show that in a moving way, and the other, of course, is that we don't forget the impact of the pandemic on so many people.

So, with those comments, I will turn to Ms Carey, please, to outline more about Module 3.

Opening statement by MS CAREY, KC

MS CAREY: Thank you, my Lady.

Module 3 is primarily concerned with the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Ireland. As I know my Lady knows, the majority of healthcare in the UK is provided by the National Health Service, a Health Service that was established over 70 years ago to meet the needs of everyone. It was free at the point of use and would provide care based on need rather than ability to pay. It is a matter, therefore, that affects us all, and so the scale of this module, and indeed the Inquiry as a whole, should not be underestimated.

By way of example, as at December 2019 the

National Health Service employed over 1.43 million full-time equivalent staff and it is the biggest employer in the UK. There were approximately 35,000 full-time GPs, an average of nearly 158,000 in-patient beds, and by March 2020, when the UK went into lockdown, there were just under 5.3 million people on waiting lists for routine elective care.

My Lady, these proceedings are, of course, being recorded and live streamed to other locations. In doing so, your Ladyship is fulfilling the obligation pursuant to section 18 of the Inquiries Act 2005 to take such steps as you consider reasonable to ensure that members of the public are able to attend or see and hear a simultaneous transmission of these proceedings.

Live streaming this hearing also allows the hearing to be followed by a greater number of people than would otherwise be accommodated even within this large hearing room or people that can be accommodated in the overspill rooms.

In addition to the Inquiry's counsel and solicitors teams today there are 27 Core Participants in the hearing room with a further four Core Participants in remote attendance, and five Core Participants are unable to attend today, each of those has written to the Inquiry explaining why they cannot attend and has

indicated they mean no discourtesy to your Ladyship by their absence.

As is routine in public inquiries where there may from time to time be matters mentioned of a potentially sensitive nature, although they are unlikely to arise today, the broadcasting of the hearing will be conducted with a three-minute delay. This provides the opportunity for the feed to be paused if anything unexpected is aired which should not be. As I said, we do not expect any such matters to arise over the course of today but I mention this feature so that those who are following from further afield understand the reasons for the short delay.

My Lady, may I turn firstly to the designation of Core Participants. Pursuant to Rule 5 of the Inquiries Rules, 36 applicants, some involving joint applications, were designated as Core Participants in Module 3. They are the Covid-19 Bereaved Families for Justice, the Northern Ireland Covid-19 Bereaved Families for Justice, Scottish Covid Bereaved, Covid-19 Bereaved Families for Justice Cymru, the Secretary of State for Health and Social Care, Department of Health in Northern Ireland, the Welsh Government, the Scottish Ministers, Office of the Chief Medical Officer, NHS England, NICE (the National Institute for Health and Care Excellence).

There are those representing the Scottish Health Boards, the group of Welsh NHS bodies, the Welsh Ambulance Services NHS Trust, the National Health Services Scotland, the Public Health Agency (Northern Ireland), Public Health Scotland, the British Medical Association, the Academy of Medical Royal Colleges, the Royal College of Nursing.

There are those representing the Royal College of Anaesthetists, the Faculty of Intensive Care Medicine and the Association of Anaesthetists, the Royal Pharmaceutical Society, [National Pharmacy Association], Core Participant group representing Long Covid Kids, Long COVID Physio, Long Covid SOS and Long Covid Support.

The Disability Charities Consortium, the Trades Union Congress (known as the TUC), the Covid-19 Airborne Transmission Alliance, the Federation of Ethnic Minority Healthcare Organisations, John's Campaign and the Relatives & Residents Association, and the Patients Association, those representing clinically vulnerable families, the 13 pregnancy, parenting and baby charities, the Frontline Migrant Health Workers Group, the UK Health Security Agency, Independent Ambulance Association, His Majesty's Treasury, and Mind.

A list of the Core Participants that you have

1 designated for Module 3 has now been published on the
2 Inquiry website.
3 My Lady, for those who were either not granted
4 Core Participant status or for those who did not apply
5 to be a designated Core Participant, I wish to reiterate
6 that not being a Core Participant in Module 3 in no way
7 precludes any person or entity or group from applying
8 for CP status in a later module, from bringing any
9 matter to the attention of the Inquiry, from providing
10 evidence and information and, where appropriate and
11 relevant, giving evidence at a hearing.
12 As my Lady has just referred to, if an individual
13 affected by the pandemic is nonetheless not granted Core
14 Participant status, they are welcome to take part in the
15 Inquiry's Listening Exercise.
16 Having made the introductions to all of you today,
17 can I turn now to the agenda for today's hearing, which
18 has been published on the website, and firstly dealing
19 with the scope of Module 3.
20 I should say at the outset that the relevant
21 period being examined during Module 3 is 1 March 2020 to
22 28 June 2022. That end date is set out in the Terms of
23 Reference and so, although one Core Participant group
24 asked you to consider the impact of ongoing
25 restrictions, in our submission you have no legal power

1 to do so. Section 5(5) of the Inquiries Act makes plain
2 that your functions are exercisable only within those
3 terms of reference.
4 I should also say that we are aware that the names
5 of some of the organisations and bodies have changed
6 since the start, indeed, of this Inquiry and, indeed,
7 changed during the course of the pandemic. We will
8 endeavour to use the terminology that was in use during
9 the relevant period.
10 I know, my Lady, that everyone will have seen the
11 document setting that provisional outline of scope for
12 Module 3. That provisional outline states that this
13 module will consider the impact of the Covid-19 pandemic
14 on healthcare systems in England, Wales, Scotland and
15 Northern Ireland. This will include consideration of
16 the healthcare consequences of how the governments and
17 the public responded to the pandemic. It will examine
18 the capacity of healthcare systems to respond to
19 a pandemic and how that evolved during the Covid-19
20 pandemic.
21 It will consider the primary, secondary and
22 tertiary healthcare sectors and services and people's
23 experience of healthcare during a pandemic. That
24 includes through illustrative accounts.
25 It will also examine healthcare-related

1 inequalities such as in relation to death rates, PPE and
2 oximeters, and there will be further detailed
3 consideration given to a separate designated module.
4 But in particular this module will examine the
5 impact of Covid-19 on people's experience of healthcare,
6 the core decision-making and leadership within
7 healthcare systems during the pandemic, staffing levels
8 and critical care capacity, the establishment and the
9 use of Nightingale hospitals and the use of private
10 hospitals.
11 The module will look at 111 and 999 and ambulance
12 services, GP surgeries and hospitals, and
13 cross-sectional co-operation between services.
14 The healthcare provision and treatment for
15 patients with Covid-19, the healthcare system's response
16 to clinical trials and research during the pandemic is
17 within the scope of Module 3.
18 The allocation of staff and resources, the impact
19 on those requiring care for reasons other than Covid-19,
20 and the quality and treatment of both those with
21 Covid-19 and indeed non-Covid-19 patients.
22 The delays in treatment, waiting lists and the
23 reasons for people not seeking or receiving treatment
24 are within Module 3, is as palliative care and the
25 discharge of patients from hospital.

1 The decision-making about the nature of healthcare
2 to be provided for patients with Covid-19, its
3 escalation, and the provision of cardiopulmonary
4 resuscitation, including the use of do not attempt
5 cardiopulmonary resuscitation instructions, is within
6 the scope, and we will refer to that in future, my Lady,
7 as DNACPRs.
8 The impact of the pandemic on doctors, nurses and
9 other healthcare staff, including those in training and
10 specific groups of healthcare workers, for example by
11 reference to their ethnic background, is within
12 Module 3. The availability of healthcare staff, the
13 NHS surcharge for non-UK healthcare staff and the
14 decision to remove the surcharge is also within the
15 scope.
16 Preventing the spread of Covid-19 within
17 healthcare settings, including infection control, the
18 adequacy of PPE, and rules about those in hospital will
19 be examined.
20 Communication with patients with Covid-19 and
21 their loved ones about the patient's condition and
22 treatment, including discussions about DNACPRs, is
23 a matter that will be looked at.
24 The deaths caused by Covid-19 pandemic, in terms
25 of the numbers, classification and recording of deaths,

including the impact on specific groups of healthcare workers, for example by reference to their ethnic background and/or their geographical location, will be in the scope.

Pausing there, my Lady, official statistics indicate that there were over 850 Covid-related deaths of healthcare workers throughout the UK over the time with which this Inquiry is concerned.

Module 3 will examine shielding and the impact on the clinically vulnerable, including those referred to as clinically extremely vulnerable, and the module will consider the characterisation and identification of post Covid conditions, including the condition referred to as "Long Covid" and its diagnosis and treatment.

My Lady, the Inquiry team are already actively working to identify key topics and themes which are likely to be the focus of requests for evidence, and which may in due course provide a structure for the hearing. Given the breadth of care provided under the umbrella of primary care, for the purposes of Module 3 the Inquiry considers it appropriate to focus on GPs and community pharmacy. However, areas in particular that Module 3 will consider within the scope include the impact of Government decision-making on healthcare systems across the United Kingdom, how the treatments

available to those suffering from Covid-19 developed and changed over the course of the pandemic. As I said earlier, the quality of care provided to both Covid-19 patients and non-Covid-19 patients.

Module 3 will consider the protocols and policies relating to the discharge of patients as they affected hospitals and those being treated and working in the hospitals, and the care sector module will deal with the availability of care and/or the processes about setting up care packages and the impact of patient discharge on the care sector.

Module 3 will consider the effect of national guidance on infection control within healthcare settings. It includes the redeployment of healthcare staff from one area to another, the use of technology to conduct appointments and meetings, cancellation of surgery and the creation of surgical hubs in which the risk of Covid-19 infection was minimised, and the emergence of what is known as Long Covid and the treatments for that condition.

My Lady, further detail about this will be provided in the monthly updates provided by the Module 3 solicitors to the Inquiry.

By way of background, may I say this: as part of the scoping for Module 3, an initial request for

information questionnaire was sent out to over 550 recipients across the UK. It comprised over 200 non-NHS organisations and over 300 NHS organisations. The purpose of those questionnaires was to assist the Inquiry to gather information and to identify areas for investigation in advance of sending Rule 9 requests.

Rule 9 requests are made pursuant to the Inquiry Rules 2006 and are formal requests for written statements.

The recipients of the questionnaires were asked to provide information about what they considered to be the key issues relevant to the provisional outline of scope, and they were asked questions, including in relation to responses to the pandemic, what went well and what did not go so well. They were asked to provide examples of how the particular healthcare system's organisation operated and worked effectively and efficiently, and they were also asked how their organisation delivered and/or ranged examples of healthcare services that were adversely affected.

They were asked how particular groups of the individual organisations, local population, patients, staff or members were adversely affected.

The responses received to date have enabled the Inquiry to identify themes and issues arising and other

matters that will be considered for inclusion in the Rule 9 requests, and they have assisted the Inquiry to identify who should receive the Rule 9 requests.

The decision whether to respond to the pre-Rule 9 questionnaires has been entirely voluntary. I know that submissions are made on behalf of the TUC for disclosure of the initial questionnaire and a list of the recipients. As I hope I outlined a moment ago, the general nature of the questions asked in those questionnaires covered the responses and examples of what worked well and what didn't and how people were affected.

On behalf of the counsel to the Inquiry team, we do not consider that the provision of a list of recipients would, in reality, be of any assistance to the Core Participants, particularly given the voluntary nature of the questionnaire.

As at the middle of this month, the Inquiry had received 269 responses, and an initial analysis of those responses has identified a number of common themes and topics, which include but are not limited to: the authority and capacity of healthcare leaders to make decisions and deal with crisis management; the consequences of cancelling or pausing routine and non-urgent care on patients, and any inequalities,

cross-conditions or indeed groups of people; the responses raised mutual co-operation between trusts and co-ordination across local organisations, including the accelerated implementation of what is known as integrated care systems.

My Lady, they are partnerships bringing together NHS organisations, local authorities and others to plan and deliver joined-up health and care services and to improve the lives of people who live and work in their area.

The responses identified issues relating to the measures used to manage the healthcare system capacity, including co-ordination with the private sector and staffing, mental health and well-being of healthcare staff and patients was raised, the adoption of new ways of working in the healthcare system such as the shift to technological delivery and online working featured and, my Lady, whilst a later module will consider Government procurement of PPE, Module 3 will consider the impact within the healthcare systems of access to and the suitability of PPE and the infection prevention and control measures put in place to manage patient and staff safety.

These matters are just some of the issues likely to feature in Module 3. Some Core Participants have

requested they be provided with a list of issues. The Module 3 team considers this is an entirely sensible request and we unhesitatingly undertake to provide a list, which will no doubt be refined and updated as the module progresses.

A number of Core Participants have made suggestions for other matters that should be included in the provisional outline of scope. It is not practical for me to address all of those today. They all require careful consideration and it may be that some of those areas, for example the impact of the pandemic on some aspects of the mental healthcare system and indeed the impact on the mental health of nurses, doctors and healthcare staff, are intended to be covered by the scope and are already within our contemplation, albeit they have not been expressly referred to within the provisional outline.

There are, however, some specific matters relating to scope I would like to address today. The Covid Bereaved Families for Justice Cymru submit that Module 3 should be subdivided so that in addition to Module 3 there are Modules 3A, 3B, 3C, looking at the healthcare systems in Scotland, Wales and Northern Ireland respectively. This, it is said, would not only reflect the constitutional situation, given that the health is a

devolved matter, but also reflect the fact the healthcare systems are different in each country and that different decisions were taken in the countries at different times.

In our submission, no such division is necessary. The themes and topics identified in the provisional outline of scope enable the Inquiry to take account of any structural differences in the way each country's healthcare system is set up without the need for individual hearings.

At the same time, the hearing of a health-related matters in an overarching module such as Module 3 allows comparisons between all four nations to be more easily evidenced and drawn.

Moreover, your Ladyship has made plain that this Inquiry must be conducted efficiently and the addition of further hearings, in our submission, would be contrary to your clear intentions in this regard. It is further suggested that the scope should be reworded so that there are specific sub-paragraphs for each nation, essentially repeating each part of the scope three more times. My Lady, in our submission, this is an unnecessary amendment. As the opening line of the scope makes clear, and I make no apology for repeating, this module will consider the impact of the pandemic on

healthcare systems in England, Wales, Scotland and Northern Ireland.

As part of their submissions on scope, the Royal College of Nursing submits that Module 3 should examine recruitment, retention, pay and conditions of nurses throughout the pandemic and beyond its lockdown stages, and the impact on nurses and patient care and the provision of death in service benefits.

Whilst the impact of the pandemic on nurses and other healthcare staff is very firmly within the scope of this module, in our submission, consideration of financial matters relating to pay, recruitment and retention are matters that are not specific to the pandemic but are areas of more general concern, and it is not, in my submission, for this Inquiry to seek to examine or resolve those more wide-ranging concerns.

My Lady has received submissions on behalf of the Core Participant group John's Campaign, the Patients Association and the Relatives & Residents Association. They ask that Module 3 considers the experience of people at home and living in care settings who had healthcare needs. I have already referred to the fact that the Inquiry's care sector module is the appropriate module for looking at the impact on those who live in and work in care settings. The Inquiry's aware that

many people are cared for at home but, in our submission, the capacity of the healthcare systems to respond to the pandemic is most appropriately and proportionately viewed through the lens of the National Health Service.

It may be helpful for those listening to know where Module 3 sits in the overall framework of the Covid-19 Inquiry. By way of background, on 12 May 2021 the then Prime Minister made a statement in the House of Commons in which he announced that there would be a public inquiry under the Inquiries Act 2005. He stated it would examine the UK preparedness for and response to Covid-19 panic and learn lessons for the future. That is this Inquiry.

Following your appointment as chair in December 2021, the draft terms of reference were consulted upon and were published on 10 March 2022. It also included -- sorry, that consultation period included consulting with the devolved administrations and it included your Ladyship's recommendation to the Prime Minister that you would be able to publish interim reports so as to ensure that any urgent recommendations could be published and considered in a timely manner.

I mention this because, as my Lady will be aware, the Clinically Vulnerable Families Core Participant

group urges you to consider producing an interim report and make recommendations to improve the safety of those who are at higher risk of severe disease from Covid-19.

Whilst the topics and areas for inclusion in any interim report or reports are a matter for you to consider, I am sure this is precisely what you had in mind when you made this recommendation to the Prime Minister.

In addition, during your consultation, your Ladyship expressed the view that the Inquiry would gain greater public confidence if it was open to the accounts that many people, including those who were bereaved, would wish to give. Therefore, you suggested an explicit acknowledgement of the need to hear about people's experience and that the Inquiry's remit should consider any disparities in the impact of the pandemic.

A public consultation process on the Inquiry's draft terms of reference was launched and your Ladyship consulted widely across all four nations and spoke in particular to a number of bereaved families. In parallel, the team met with -- the Inquiry team met with representatives of more than 150 organisations, covering themes such as equality and diversity, healthcare, business and education and young people, amongst others.

In total, the Inquiry received over 20,000

responses to the consultation and an independent research consultancy was commissioned to analyse the responses and produce a comprehensive independent report on respondents' views. It was following that, on 12 May 2022, that your Ladyship recommended a number of significant changes to the draft terms of reference, which was subsequently accepted by the Prime Minister in full.

The set-up date of the Inquiry was confirmed to be 28 June 2022, and on 21 July the Inquiry was formally opened. A fuller exposition of the background to the Inquiry has been provided to the Core Participants in a note by counsel to the Inquiry and, for those following today's proceedings, that information is available in the video recording and the transcript of the Module 1 preliminary hearing which was held on 4 October.

Your Ladyship announced the decision to conduct the Inquiry in modules which would be announced and opened in sequence, and those wishing to take a formal role in the Inquiry were invited to apply to become Core Participants for each module rather than for the Inquiry as a whole.

Module 1 is primarily concerned with whether the UK was properly prepared for the pandemic, and will

consider the high-level systems that were in place for the pandemic resilience, preparedness and planning across all four nations.

Module 2 will consider the core political and administrative governance and decision-making in the UK, concerning again the high-level response to the pandemic in March 2020 and thereafter.

Module 2 will pay particular scrutiny to the decisions taken by the Prime Minister and the Cabinet, as advised by the Civil Service, senior political scientific and medical advisers and relevant Cabinet subcommittees and, having considered the picture from a UK-wide and also English perspective in Module 2, Modules 2A, 2B and 2C will address the same overarching and strategic issues from the perspectives of Scotland, Wales and Northern Ireland.

As my Lady has already alluded to, other modules will consider vaccines, therapeutics and antiviral treatment, the care sector, Government procurement and PPE, testing and tracing, the Government's business and financial responses, health inequalities and the impact of Covid-19, education, children and young persons, and other public services including frontline delivery by key workers.

NHS England have asked the Inquiry identify not

1 just the later modules but also set the provisional
2 scope for each of those modules and explain how
3 cross-cutting themes will be addressed. Whilst the
4 Inquiry understands why Core Participants and interested
5 parties are keen to know more about the details about
6 future modules, the Inquiry needs to retain flexibility
7 about the precise timetable and adjust its plans in
8 light of the evidence being gathered. I can, however,
9 inform everyone that the Inquiry aims to announce the
10 next phase of the Inquiry in early summer this year.
11 My Lady, may I turn to deal with evidence requests
12 and provide everyone with a Rule 9 update as relates to
13 Module 3.
14 The Inquiry has already issued or is about to
15 issue formal requests for evidence to the following
16 Government organisations which appear to the Inquiry to
17 have played a central or significant role in Module 3.
18 As one would expect, the requests for the Department of
19 Health and Social Care, the Welsh Government Health and
20 Social Services Group and the Department of Health in
21 Northern Ireland are wide ranging.
22 The requests include questions relating to the
23 structure of the healthcare system in each country,
24 including roles and responsibilities and funding
25 arrangements at the start of the relevant period and

1 indeed throughout the pandemic. They include questions
2 about the capacity of healthcare systems in terms of
3 staffing levels and the numbers, for example, of
4 GP appointments, of ambulances, of critical care beds,
5 ventilators. There are questions relating to infection
6 prevention and control and the availability and
7 suitability of PPE. There are questions in relation to
8 guidance about shielding, about DNACPR policies, about
9 the creation, funding and use of Nightingale hospitals,
10 or temporary field hospitals and surge facilities as
11 they were known in Wales.
12 My Lady, in drafting those Rule 9 requests, the
13 Module 3 team has reviewed Rule 9 requests made by
14 earlier modules, and where a Rule 9 response has already
15 been received, that has also been reviewed. In adopting
16 that approach, we have been careful to try to avoid,
17 where possible, duplicating requests previously made.
18 In relation to the Rule 9 request for Health and
19 Social Care in Scotland, this request will be sent
20 slightly after the Rule 9s to the other three nations
21 for this reason. My Lady is aware both this Inquiry and
22 the Scottish Covid-19 Inquiry are keen to avoid
23 duplication, so the Module 3 team is checking not only
24 requests made by Module 2A but also requests made by the
25 Scottish Inquiry. That process means inevitably that

1 this takes a little more time to issue the Rule 9 but it
2 is hoped that in the long run that approach will be of
3 assistance in minimising unnecessary repetition.
4 In that regard I should add that last week, on
5 23 February, the Inquiry published a memorandum of
6 understanding setting out how this Inquiry and the
7 Scottish Covid-19 Inquiry intend to work together. I am
8 also aware that your Ladyship recently met with the
9 chair of the Scottish Inquiry, Lord Brailsford, to
10 discuss the constructive ways the inquiries can
11 collaborate and co-operate.
12 In addition, where appropriate, joint requests for
13 documents that may be relevant across a number of
14 modules are being sent. For example, Audit Scotland
15 will be sent a Rule 9 request on behalf of Module 2A but
16 which also includes requests for material that may be
17 relevant to Module 3.
18 Rule 9 requests are also being made of the
19 13 ambulance trusts in the UK, focused on 999 and 111
20 calls, emergency ambulance provision and patient
21 transport services, and those requests include questions
22 about funding, capacity and response times. There were
23 also requests for information about how the patients
24 were prioritised for a 999 emergency ambulance response,
25 and questions relating to policies about which patients

1 were conveyed to hospital or who should be left at home.
2 The Inquiry has already made requests to those
3 involved in palliative care, including requests for
4 information about how palliative care changed throughout
5 the pandemic, the key policies and/or guidance relating
6 to palliative care, and for evidence as to whether there
7 was any distinction or differences in the way Covid-19
8 and non-Covid-19 patients received palliative care.
9 Rule 9 requests have also been made to the
10 Commissioner for Older People in Northern Ireland and
11 the Older People's Commissioner for Wales and to Age UK,
12 asking about a number of matters contained within the
13 provisional outline of scope.
14 My Lady, questions in relation to healthcare
15 inequalities in respect of both patients and those
16 working in the NHS have featured in our Rule 9 requests
17 made to date and will continue to do so.
18 The joint submissions of the Covid Bereaved
19 Families for Justice and the Northern Ireland Covid-19
20 Bereaved Families for Justice, and submissions on behalf
21 of the Federation of Ethnic Minority Healthcare
22 Organisations, invite you to consider including
23 an investigation into structural racism and
24 discrimination in Module 3, whether through expert
25 evidence or otherwise.

My Lady, those are obviously important matters within society today but they are also matters with a far broader reach than this module or indeed the terms of reference of this Inquiry.

Inequalities are very much at the forefront of our minds in Module 3 and, in our submission, including these matters is neither necessary nor proportionate, although I have no doubt that it may be a matter you will wish to keep under review as the Inquiry progresses.

Finally in relation to Rule 9 requests, Rule 9 requests relating to maternity care and services will include requests for information and evidence about antenatal and postnatal care. Over the coming weeks and months the Inquiry intends to issue further Rule 9 requests to organisations including but not limited to the Chief Medical Officers, NHS bodies across the four nations, the Academy of Medical Royal Colleges and some specific Royal Colleges, the professional bodies representing those working within healthcare systems, and to those Core Participant groups representing specific areas of interest within the scope of Module 3.

My Lady, in line with the determination made in Module 1, the Inquiry's submission is the Core Participants will not be provided with copies of Rule 9

requests made by the Inquiry. Disclosure to the Core Participants of the Rule 9 requests themselves, as opposed to the relevant documents and material generated by them, is neither required by the rules nor generally established by past practice.

Furthermore, in our submission, it would serve little practical purpose given the wide scope and detailed nature of the Rule 9 requests that are being made.

Turning to disclosure, in common with the approach taken in the preceding modules, Module 3 will adopt the following approach:

All CPs will receive all documents disclosed in Module 3, not just those documents relevant to them. Disclosure will be subject to three things: a relevance review, so that only relevant documents are disclosed; a de-duplication exercise; and redactions in accordance the Inquiry's redactions protocol. There is a significant team of solicitors and barristers and paralegals already in place to review for relevance once material is received.

Module 3 will make disclosure in tranches on a rolling basis. Disclosure will be made by the electronic data management and disclosure system Relativity, and there will be disclosure updates

provided by the Module 3 solicitors' team informing Core Participants of the progress which has been made in obtaining relevant documents and we will, of course, also do so at the next preliminary hearing or hearings.

The Inquiry will be asking document providers to provide a signed statement explaining how they have secured the preservation of documents, how they have conducted their searches and how they've satisfied themselves that they have complied in full with their duties. Each provider has been asked or will be asked to provide an account setting out in detail how the documents were originally stored, search terms used, or other processes used to locate documents and the nature of any review carried out by the document provider.

Where the Inquiry has concerns or queries about a provider's processes for locating relevant documents, it will raise them and pursue them and, of course, as documents are reviewed and gaps identified, further documents will be sought.

I should also add that the Inquiry has already taken steps to ensure the preservation of documents. In January 2022, the director of the UK Covid-19 Inquiry set-up team wrote to the Director General of Propriety and Ethics at the Cabinet Office to request retention of records across Government, and the following month, in

February 2022, the Director General replied indicating that steps were being taken to ensure records relevant to the Inquiry were retained across Government.

Should it be necessary, my Lady, you have the power to compel the production of documents under section 21 of the Inquiries Act. There are also provisions in section 35 of the Inquiries Act which make it an offence if, during the course of an inquiry, a person does anything to alter or distort a relevant document or to prevent any relevant document being produced to the inquiry or intentionally destroys, suppresses or conceals a document.

May I turn to the issue of experts. Module 3 has, already identified two areas where expert evidence is likely to be of assistance. The first area of expert evidence relates to the treatment given to Covid-19 patients in intensive care, including an overview of how treatment changed during the various waves of the pandemic, and the quality of care provided.

Secondly, Module 3 has also identified an expert in relation to the diagnosis of and treatment for Long Covid. It is an emerging area, my Lady, but it is something that we consider will be of assistance to you.

The identities of these two experts and, indeed, any other expert will be contained in the solicitor to

1 the Inquiry's update notes, and these notes will also
2 provide the topics on which experts are instructed,
3 thereby updating the Core Participants and enabling the
4 Core Participants to comment on those matters.
5 My Lady, in the course of the written submissions
6 a number of Core Participants have included suggestions
7 for areas of expert evidence, for example, the Covid-19
8 Airborne Transmission Alliance has suggested that the
9 effectiveness of PPE might be a potential area.
10 I have no doubt that you will wish to consider
11 that and, indeed, all of those suggestions after the
12 conclusion of today's hearing.
13 My Lady, in relation to pen portraits, in rulings
14 made in earlier modules you stated that you were not
15 persuaded that pen portrait evidence should be admitted
16 a general rule in this Inquiry. However, you indicated
17 and ruled that the terms of reference make clear that
18 the Inquiry will not consider in detail individual cases
19 of harm or death but will consider evidence of the
20 circumstances of individual deaths where it is
21 illustrative and probative of systemic failure.
22 The Covid, Bereaved Families for Justice Cymru
23 have asked you to consider hearing some evidence about
24 the particular circumstances of some deaths.
25 Module 3 wishes to explore the ways of hearing

1 evidence about the devastating impact of the pandemic in
2 a way that highlights or exposes systemic issues within
3 the healthcare systems. Careful thought is needed about
4 how best to present this evidence but this is already
5 a matter under active consideration and we anticipate
6 the number of the Module 3 Core Participants
7 representing the bereaved families and those working
8 within healthcare systems and other interest groups will
9 be in a position to help us with that matter.
10 My Lady, in your opening remarks you already
11 referred to the Listening Exercise, Every Story Matters.
12 The terms of reference make clear that although the
13 Inquiry will not investigate individual cases of harm or
14 death in detail, listening to the accounts and
15 experiences of the bereaved families and others who
16 suffered hardship or loss will inform the Inquiry's
17 understanding of the impact of the pandemic and the
18 response and of the lessons to be learnt.
19 Every Story Matters is the process by which the
20 public can contribute to the Inquiry, so that the
21 Inquiry will be able not just to hear the voices of the
22 people and to reflect upon their experiences but to also
23 incorporate their accounts into its work.
24 It is anticipated that the Inquiry's ability to
25 consider those accounts will be particularly important

1 when it comes to Module 3 and indeed those modules which
2 will consider the impact of Covid-19 and the decisions
3 made about it. It will give individuals the opportunity
4 to contribute to the Inquiry in a way which requires no
5 formality nor any need to attend the hearing. It is
6 open to all whose lives have been affected, whether by
7 bereavement, illness, poor mental health or because
8 their prospects, their education or their work has been
9 affected, and to people whose family lives or
10 relationships suffered.
11 No one person's experience or loss will be the
12 same as another's. The listening anything exercise
13 enables this Inquiry to capture the full breadth of
14 human experience across the UK, including from those who
15 might not otherwise come forward or otherwise have
16 a forum to say what happened to them.
17 Every Story Matters will support the Inquiry's
18 legal process but it is not a legal process in and of
19 itself. The experiences which people share will not be
20 filed in the hearings by way of direct evidence or as
21 individual testimony, and accounts will be anonymised,
22 but there will be a set of comprehensive reports
23 prepared that will be disclosed to Core Participants and
24 may be admitted into evidence.
25 In November 2022 an initial pilot was launched by

1 way of an online platform which enabled some people to
2 share their experiences. As far as Module 3 is
3 concerned, work has now commenced on gathering accounts
4 from patients and relatives directly and indirectly
5 affected by Covid-19, and from healthcare workers and
6 support staff. The Inquiry is keen to hear from
7 individuals who are seldom heard and so we are grateful
8 for the submissions by Mind and the John's Campaign Core
9 Participant groups on the issues of capacity and the
10 participation of individuals who are non-verbal. I know
11 that the listening exercise will want to consider those
12 submissions.
13 More information about Every Story Matters will be
14 provided in the coming weeks, including by way of the
15 webinar to which you referred, and there will be further
16 updates of this part of the Inquiry's work provided in
17 the solicitor team note update in due course.
18 May I deal with commemoration. My Lady, you have
19 made clear your wish to recognise the human suffering
20 arising from the pandemic, including the loss of loved
21 ones. It is important that is reflected throughout
22 entirety of the Inquiry's work, and the Inquiry, I know,
23 is exploring ways in which this can be done, including
24 by way of a commemorative memorial in the future hearing
25 centre, through the Inquiry's public hearings and indeed

on the Inquiry's website.

Finally, my Lady, some Core Participants have invited you to consider the way in which applications for funding are made and determined prior to the first preliminary hearing in a module. For practical reasons it is not possible to consider these applications in advance of that preliminary hearing. However, the Inquiry is taking steps through the pre-authorisation process to make sure that Core Participants who successfully applied for section 40 funding when invited to do so after the preliminary hearing can retrospectively cover their reasonable legal costs associated with preparing for and attending that hearing.

My Lady, I know that once you have had an opportunity to consider the written submissions, and indeed those that are already being made today, you will publish any appropriate directions. One matter that counsel to the Inquiry asks you to consider is whether you wish to publish any written submissions on the Inquiry's website. That is a matter entirely for your creche.

There will be a further preliminary hearing for Module 3 held later in 2023 in London on a date and a venue to be confirmed, and it is anticipated that the

hearing in Module 3 will commence on a date to be confirmed in 2023.

My Lady, that concludes all the submissions I wish to make to you on behalf of counsel to the Inquiry.

LADY HALLETT: Thank you very much indeed, Ms Carey.

If we could turn, please, to -- is it Ms Munroe, King's Counsel? Careful as you make your way to the lectern. It is a bit of an obstacle course, I am afraid.

Submission by MS MUNROE, KC

MS MUNROE: Good morning, my Lady, and thank you for the opportunity to make some further oral submissions to the written submissions that have been filed on behalf of Covid-19 Bereaved Families for Justice and Northern Ireland Covid-19 Bereaved Families for Justice.

They are detailed submissions, my Lady, and I am aware that we have a very full room and we have a lot of speakers today, and we are very aware -- and I am very aware -- of the constraints of time.

What I hope to do in making these oral submissions, my Lady, is to offer some constructive ideas and thoughts which we hope will enhance the Inquiry both in terms of its investigative process but also outcomes and recommendations. Because whatever position people in this room have, I think we all agree

that this is an opportunity that should be grappled with and grasped with both hands so that the outcomes and recommendations are fulsome, are effective and that they are heard.

This was a pandemic that affected every strata in society. It was no respecter of class, race, gender, economic power, or anything. It therefore is important that the recommendations and outcomes are ones that are taken seriously and it is for that reason, my Lady, that we in our detailed submissions offer, as I say, I hope, constructive ideas and thoughts.

Any matters that I do not emphasise in oral submissions now it is not because we resile from them or that we think they are no longer important but, as I say, my Lady, I am mindful of the time and I seek, therefore, to highlight perhaps the most pressing matters which require some expansion in oral submissions.

Perhaps a thread that runs through all our submissions that we make is the issue of effective participation and ensuring that voices of the bereaved are heard and that they are heard by the right people and that they are acted upon.

Whilst of course our families welcome and are moved by commemorations and the Listening Exercises,

expressions of sympathy, there also has to be a recognition that effective participation is key, that the families should not feel disconnected or that they are bystanders to what is going on and that experts speak on their behalf and their own lived experiences are perhaps not heard.

So it is with that in mind, my Lady, that we do revisit, and we set it out in our document, some of the matters that have been already submitted in Module 1 submissions before the Inquiry. In particular I will highlight the Rule 9 point, as it was one of the last matters that was dealt with on behalf of counsel to the Inquiry.

We repeat our concerns about the lack of disclosure of Rule 9s, which we say impedes our ability to assist the Inquiry. We don't seek this disclosure for the sake of seeking disclosure. As I say, it is because of the need and the desire to assist the Inquiry. We hear what is said by counsel to the Inquiry but we believe that it will serve a very practical purpose. It may not be required in strict accordance with the Rules but we want to work in partnership with the Inquiry team.

This Inquiry is a mammoth task. No one team can or should be expected to have all the answers on how

best to proceed. Collaboration and co-operation is key. As I said earlier, my Lady, it will lead to better outcomes and, importantly, our families will feel that they are in fact being heard and seen as an essential part of this Inquiry.

We therefore remain concerned that, in the absence of disclosure of the Rule 9 requests themselves, we are unable to assist the Inquiry with relevant lines of investigation that may be pursued. So we renew that request.

Rule 10s, my Lady, again we note the observations following the Module 1 hearing and the concessions that were made in respect of questioning of witnesses. In relation to Module 3, we submit that facilitating CPs' questioning ensures, again, effective participation of the bereaved and others. This is central to their confidence in the Inquiry, cathartic, and forms some sort of resolution.

Full and effective participation on their behalf, we say, will engender wider public confidence as well.

If modules have limited direct evidence from CPs of their lived experience, questioning is the next best thing. It will allow and ensure a greater diversity of questioners and that will be beneficial to the Inquiry, but also questions from different CPs will, of course,

be coming from different perspectives, and they may, in fact almost inevitably will, elicit different answers.

That is also something that can be extremely beneficial to the Inquiry.

My Lady, there's always a concern if one allows CPs and their advocates to ask questions there will be a proliferation of issues, matters will be expanded, time will be expanded. However, I am certain, and on behalf of those that I represent we are certain, that with the strict case management that I am sure you will bring to bear on proceedings, permitting questioning in and of itself will not lead to those worries of expansion and time being expanded. Questions will be focused and relevant to the instructions and issues relevant to the particular CPs.

The Listening Exercise. What I say in relation to that, my Lady, is this. The companies and delivery of the listening exercise process and the issue of conflict of interest, again we revisit that simply to say this: fairness and the perception of fairness and transparency is important. There should be, we say, a proper public explanation from both the Inquiry and the companies involved as to why they say there is no conflict of interest. We note that even if there is no conflict of interest, the involvement of such companies may

potentially do real damage to the whole project because of the perceptions of the families and others and that is then compounded by the lack of disclosure of precisely what these companies have been contracted to do and the results.

So really, my Lady, it's a question, as I said, of perceptions, fairness and transparency.

I now turn to the issue of discrimination and racism. We have already addressed those previously in the Module 1 submissions. I hear both what is said by counsel to the Inquiry and, my Lady, your helpful remarks this morning in opening this session. But it is important that we do revisit this issue.

It is a hallmark of any society in terms of how it functions and what kind of society we live in how it treats its most disadvantaged, vulnerable and marginalised members and communities. It is vital to acknowledge that and it is vital, as I said earlier, to acknowledge that whilst the pandemic did affect every strata of society, regardless of race, class, socio-economic background, gender, physical or mental vulnerability or disability, nonetheless certain groups were differently and disproportionately affected.

It is said by the Counsel to the Inquiry that this matter, this issue of discrimination and structural

racism, is at the forefront of its mind, however it is unnecessary and not proportionate.

We have to say that those words do not necessarily fill our clients with a great deal of confidence. Why is it not necessary? Why is it disproportionate? We say it is important. Inequalities and discrimination affect those who are affected by it in every aspect of their lives, maybe on a micro level, maybe on a macro level. Sometimes, it's an irritant or a situation they can deal with. Sometimes it is a matter of life and death. It is therefore vitally important.

This module specifically looks at the impact of inequalities on healthcare staff. We say it is important that the topic also considers and looks at the ethnic background of NHS patients and their families who were impacted by the pandemic.

Structural racism exists. We are not asking the Inquiry to examine it as an abstract concept and embark upon a detailed investigation as to what is structural racism. It exists. It is the uncomfortable truth that we have to grapple with. It is not something that can or should be considered in isolation or in silos. It intersects and impacts, we say, on all modules.

We therefore say that the issue of structural discrimination and racism should be investigated as

a key issue in each and every module.

If the Inquiry and if this Inquiry, my Lady, is to properly investigate the issue of systemic failings and failures, particularly looking at this module, not to consider structural discrimination would be a glaring omission.

We had set out in, I think it was, paragraph 14 of our Module 1 submissions, dated in January of this year, detailed submissions on this point and I don't wish to repeat them all again here. But we say this: structural racism is not a new concept and, in the context of this public inquiry, structural racism has hitherto been recognised by many of the institutions that we are dealing with, such as the NHS. We've set out in our written document for this hearing today, my Lady, an article, *Occupational Medicine*, volume 72, issue 2, from March of this year, in which the author looks at the issue of structural racism and how it affected BAME workers and their risk to Covid-19. So I won't repeat that. It's there.

But I will say this in addition. New ONS data outlining Covid-19 mortality rates by ethnicities shows that, despite the gap closing in recent months, almost all minority groups who died died disproportionately from Covid-19. From January 2020 to November 2022, the

death rate is 3.1 times greater for Bangladeshi men than for white British men, following by Pakistani men, 2.3 times, black Caribbean men, 1.8 times. Meanwhile, the rate for Bangladeshi women is 2.4 times greater than that for white women, white British women, followed by Pakistani women, 2.1, gypsy and Irish traveller women, 1.8 times, and for black Caribbean women the mortality rate is 1.5 times greater than for white British women.

Those we represent, my Lady, call upon the Inquiry to look at this, to look at these disproportionate figures, those disproportionately affected by the pandemic, and centre that within the Inquiry.

We also raise concern that there are groups, including groups representing migrants and the gypsy and Roma traveller community, who are not represented as Core Participants and appear to have been somewhat siloed off from issues which deeply impacted their own communities.

It is argued that until we dismantle those factors which enabled the pandemic to be racialised in its impact, we cannot mitigate a similar outcome from any future crisis and crisis responses.

We therefore call upon the Inquiry to investigate structural racism as a key in every module; secondly, to instruct an expert in the field of structural racism to

shed light on the state of the UK's preparedness in the lead up to the pandemic; thirdly, to rethink the Listening Exercise and centre those most impacted in a supportive and accessible way to enable full trust and participation in the process; and, fourthly, to ensure that migrant groups, such as the gypsy and Roma traveller communities, are represented as Core Participants.

My Lady, I'm looking at the time so I'm moving on now to two further points. Firstly, in relation to matters that we are revisiting: experts. Again, it's set out in full in our written document but we do reiterate our point about letters of instructions and why it is important to see those. The letter of instruction to any expert is a basis upon which that expert finds out what exactly he or she is being asked to do. It is important, obviously, why they are such important documents and we submit that it is both extremely helpful but also just good practice for other CPs to have sight of and some input into letters of instructions so that we can ensure that it is comprehensive, it covers all issues and all relevant matters. So again it is not simply out of curiosity that we make this request; it is, we say, to assist the Inquiry.

My Lady, you will see at paragraph 28 through to 31 of our submissions we raise the issue of devolved issues generally and we set out there our position. Those will be expanded upon by my colleagues from Northern Ireland in due course, so I will not tread on any toes and say anything further and will leave that for them to expand.

Finally then, turning to the scope of Module 3. My Lady, I again am very mindful of your opening observations about the module being an evolving module. What it will eventually look like may be very different to what it looks like now in terms of the framework and certain matters that are not there now may be there and others may be moved. We can completely understand that.

So where we set out from our paragraph 32 onwards in our document specifically addressing scope, again, these points that we raise, my Lady, are really to look at areas that perhaps the Inquiry would like to consider as being important and should be within Module 3, why we say they should be within Module 3, and certain questions that we say they can answer. I certainly don't have the time but without going through each at every one of them, for example, at paragraph 32 where we talk about therapeutics, we simply posit the question that it is unclear whether therapeutics are within the

1 scope of Module 3 or not. So we put that out there
2 effectively as a question for consideration.
3 There are other aspects of our discussion on scope
4 (such as testing) however, where we have set out at
5 paragraph 36 a set of questions that we say in our
6 submissions the Inquiry should be investigating in
7 relation to testing. Again, I won't repeat them here
8 because they are there in writing. But you can see, my
9 Lady, I hope, why we say those particular questions
10 would be relevant and germane to the investigation.
11 Likewise, with inspection and monitoring, in
12 particular at paragraph 39, we say that in the absence
13 of inspectors on the ground the Inquiry should consider
14 what alternative arrangements were put in place and
15 whether any interim provisions effectively monitored
16 hospitals' compliance with guidelines, shared emerging
17 best practice on infection prevention and control, and
18 made rapid recommendations for hospitals with high
19 numbers of hospital-acquired infections to take
20 corrective actions.
21 Again, that is the context in which we are putting
22 forward these suggestions. Triage likewise,
23 ventilation. Some of the others, such as patient
24 vulnerability, other CPs specifically will be dealing
25 with those, and I simply say on our behalf that we would

1 add and complement those submissions.
2 On the issue of mental health in particular, we
3 are very clear, my Lady, that certainly our clients feel
4 that the scope of Module 3 should look at the adequacy
5 and effectiveness of the NHS mental health services, not
6 just to staff obviously, but also to those people
7 affected by the pandemic itself. It is important, we
8 say, to not having a narrow focus on that because mental
9 health is an issue that is almost like a ripple effect;
10 it starts with one person in the family, it affects
11 other members of the family, other members of the
12 community. So we ask that the Inquiry is mindful of
13 that and it would seem to us that Module 3 would be the
14 best place for such an investigation to take place.
15 My Lady, I suspect my time is now coming to an end
16 so I simply would commend to you our written document.
17 I hope that the submissions I have made have been, as
18 I said at the outset, suggestive of constructive ideas
19 and thoughts that we believe will assist the Inquiry.
20 It will allow those we represent to feel fully
21 participants in this Inquiry.
22 The phrase "front and centre" is often used about
23 the bereaved and it is easy to say that; it's more
24 difficult to actually effect it. We know that the
25 Inquiry and we know, my Lady, that you are mindful of

1 these points. It is something that you have said on
2 a number of occasions, and we are extremely grateful for
3 those, but we do wish the Inquiry really seriously
4 consider these submissions that are made and consider
5 the points, particularly in respect of structural racism
6 and how it overarches this Inquiry in its entirety.
7 My Lady, unless I can be of any further assistance
8 to the Inquiry.
9 **LADY HALLETT:** Ms Monroe, you have been extremely helpful.
10 Excellent timekeeping, which bodes well for the future.
11 Thank you very much indeed.
12 Just in case anybody is concerned, the written
13 submissions that you and the rest of your team submitted
14 are very comprehensive and I assure you that I will read
15 them all extremely carefully. Thank you for your very
16 constructive approach. Thank you.
17 I think it is only fair to the stenographer to
18 break now.
19 Sorry, Mr -- I thought that was Mr Lavery, wasn't
20 it? Yes, I was going to say, I think it is Mr McCaffery
21 next. Is it? Anyway, whoever it is, we can work it out
22 while we take a break and I shall return at 11.55.
23 Thank you.
24 **(11.36 am)**
25 **(A short break)**.

1 **(11.57 am)**
2 **LADY HALLETT:** Mr Lavery, I apologise, I hadn't realised you
3 were next. While you are making your way to the
4 lectern, could I apologise to the National Pharmacy
5 Association -- Mr Stanton, I don't know where you are --
6 I fear that when Ms Carey read out the list of Core
7 Participants she forgot -- I did notice at the time,
8 I promise you. I didn't want to interrupt her flow.
9 But I'm sorry about that and I know Ms Carey's already
10 apologised to me for having missed you out. But we will
11 be sure the transcript is amended so that the National
12 Pharmacy Association appears there.
13 Yes, Mr Lavery. Sorry to --
14 **MR LAVERY:** In fact, my Lady, Mr McCaffery was next but he
15 has kindly head to swap with me.
16 **LADY HALLETT:** That's what the confusion was.
17 **Submission by MR LAVERY, KC**
18 **MR LAVERY:** Yes, because we thought -- well, certainly
19 I thought that, because we had made a joint submission
20 with the Bereaved Families for Justice for England and
21 Wales, that it would more naturally follow on that
22 I would endorse those written submissions, my Lady,
23 first of all, and of course the oral submissions from
24 Ms Munroe.
25 I don't intend to be very long because of all of

the reasons that have been set out already. Your Ladyship has those submissions.

There are three areas really that I just wanted to look at very briefly. The first is the permission of questioning and Rule 10 requests. Your Ladyship will know, and I say it for the benefit of anybody else listening, that there are quite a number of Core Participants now, and the role of the bereaved families, of our families, is, we say, key, and it is important that that key role is not diminished.

One way in which the importance of the role of the bereaved families may be looked at in due course is whenever and -- if we make requests for permission of questioning, because what we would say about that is that we have a direct connection with those most affected by the pandemic, we are speaking to them and our clients come from a broad range of backgrounds, ethnicity, as do the lawyers that represent those people, and from diverse practices that represent individuals largely in, very often, the human rights context.

The diversity, the difference of approach is something which we think would be of value in due course in terms of not only the type of questions that might be asked but also the perception that people are having

questions asked by people who represent them and represent their interests.

The second issue I wanted to deal with was this listening project, and you have referred to that already in your opening remarks this morning. What I wanted to make clear about our submissions about that was we're not really suggesting a replacement of the listening project. What we are suggesting is something which I understand now the Inquiry is open to, and that is if there are personal accounts which are illustrative and probative that that is something which may be of benefit to the Inquiry.

We say that, and I reminded your Ladyship of this on previous occasions and I know we are in a different modules, but the Listening Exercise that you carried out in Belfast and the first-hand accounts of the victims, and I say it once again, I don't apologise for that, my Lady, in many ways the public who will be watching this Inquiry have a right to experience that as well. They have a right to encounter those individuals, they've a right to be informed of a very personal account and the right to share it.

We think that that can only enhance the Inquiry's role and the outcome, which is what we're looking at. It will maintain a sense of humanity and proportion in

the whole context of this Inquiry. But as I say, that is not suggested as a replacement of the Listening Exercise, which, as you have pointed out, will involve a much broader section of those people affected.

The third issue I wanted to deal with then was a uniquely Northern Irish perspective on this scope. It is not clear from the scope how exactly the Inquiry will look at the impact on the Northern Ireland healthcare system and again I've said this in previous submissions, about the uniqueness of that. Briefly, first of all, that we have a combined health and social care model; secondly, that there are cross-border elements to the healthcare service which is provided. We say that in that context it is essential that a Northern Ireland expert on health and social care be appointed who will fully understand that complex relationship and who will fully understand the impact of the pandemic on the healthcare system.

As part of the impact on the healthcare system, one has to understand how dire the prevailing healthcare system was in Northern Ireland before the pandemic, and it was described by an academic in a recent judicial review as "catastrophic", "appalling performance", and "in a state of functional collapse".

In June 2021, for instance, the proportion of

people in England and Wales who were on a waiting list for over a year was 9 per cent and in Northern Ireland it was 57 per cent.

So we say that it must be understood what the prior state of the healthcare system was before the pandemic hit.

Lastly, looking at the model of Northern Ireland in that health and social care are combined, it's very different from the England and Wales model and, in looking at the Module 3 and the scope of that, it's going to be difficult, we say, in a Northern Irish context to completely separate social care from healthcare. It may even be that one of the findings of the Inquiry is that there was a better response in Northern Ireland because of the combined nature and that there are lessons that the other parts of the United Kingdom might learn from that.

That's all that I would like to say, my Lady.

LADY HALLETT: That's very helpful, Mr Lavery. As I said to Ms Munroe, I have read, obviously, the submissions with great care. So thank you very much indeed.

MR LAVERY: Thank you.

LADY HALLETT: Mr McCaffery.

Submission by MR McCAFFERY

MR MCCAFFERY: Thank you. Good afternoon, my Lady.

My Lady, Scottish Covid Bereaved are grateful to counsel to the Inquiry for once again providing a detailed note of the background to the setting up of the Inquiry, also the input which your Ladyship has had in recommending the inclusion of an express mandate within the draft terms of reference to allow for the provision of interim reports and the publication of recommendations for consideration before the end of the Inquiry and which it is hoped will avoid any unnecessary delay and their potential implementation.

We also particularly welcome your Ladyship's recommendation that the Inquiry be open to the accounts of the many people, including those members of the Scottish Covid Bereaved, of their experiences during the pandemic and any disparities on the impact which it had on them and/or relatives.

Module 3 will of course consider the entirety of the United Kingdom albeit there are different healthcare structures across the four nations. This obviously has the potential to duplicate matters, which will be explored within Module 2A, relating to the strategic and overarching issues from the perspective of Scotland and indeed matters which are bound to be considered by the separate Scottish Inquiry.

We note and welcome the intention to minimise any

duplication of matters, not only with the Scottish Inquiry but it is also assumed in relation to Module 2A.

It will be useful, my Lady, to get further detail of how Module 3 will interplay with Module 2A in due courses.

Scottish Covid Bereaved particularly welcome the Inquiry's stated intention to draw on information provided to the Listening Exercise, Every Story Counts, when examining the general impact of governmental and societal responses is the pandemic, and many within Scottish Covid Bereaved look forward to contributing to that exercise.

The scope of Module 3 is obviously wide, and members of Scottish Covid Bereaved appreciate that many of the issues which are of critical importance to them have been included in the 12 stated areas to be explored within this module: the restriction on visiting relatives in hospital, provision for end of life contact, isolation of elderly patients, issues around testing, availability and suitability of PPE, the arbitrary imposition of do not attempt cardiopulmonary resuscitation instructions, to mention but a few of these.

We also acknowledge that this list is not exhaustive and remains provisional at this stage.

Rule 9 letters and disclosure. My Lady, while Scottish Covid Bereaved accept that Core Participants will not be provided with copies of the Rule 9 requests made by the Inquiry, we do look forward to receiving and will welcome the monthly updates which will be provided by the solicitor to Module 3, together with the disclosure to Core Participants of the recoveries subsequently to intimation of the Rule 9 letters.

Further we hope to be and will certainly aim to be of assistance to counsel to the Inquiry in identifying any additional and appropriate avenues of investigation, any other organisations and witnesses on whom letters ought to be served, or further topics to be included in the Module 3 hearings.

Expert witnesses, my Lady, we look forward to receiving further information on the identities of the experts who will be instructed to prepare reports on the issues to be considered in Module 3. Also to have the opportunity to provide observations on those reports prior to their finalisation.

We also welcome the opportunity to provide suggestions as to who might be instructed to provide expert evidence and areas in which they might be required to give such evidence.

In relation to the Listening Exercise, Every Story

Counts, commemoration and pen portrait material, Scottish Covid Bereaved particularly acknowledge the interest expressed by the Inquiry in hearing of the specific and very individual experience of the families involved in Scottish Covid Bereaved. They look forward to those experiences being included in reports which will be fed into modules where appropriate and relevant, and appreciate the fact that these will be formally included as part of the Inquiry's record.

It will of course be obvious to the Inquiry that those members of Scottish Covid Bereaved have a particular interest in the opportunity to participate in the commemoration exercise, Every Story Counts, and they look forward to taking part in that process and the Inquiry's recognition of the suffering of all those concerned.

They acknowledge that arrangements are being made for the commemorative memorial and the ability to view that in due course at the hearing centre during the public hearings and online on the Inquiry's website, and again await with interest further details of progress with that.

Those members of Scottish Covid Bereaved who wish to provide evidence on systemic failings which they consider relevant to their own individual circumstances

and how they were impacted by these will endeavour to provide such evidence for the Inquiry's consideration and potential inclusion in Module 3., for example, and it was referred to in counsel to the Inquiry's note, bereaved family members, those shielding, those suffering from post Covid conditions such as Long Covid sufferers and healthcare workers.

They will all have relevant experience or evidence to provide in relation to such issues and will be able to provide lived experience of the issues as they were affected by them and their relatives.

I'd also like, my Lady, to acknowledge the submissions in respect of ethnicity and structural racism made by our friends, the Covid-19 Bereaved Families for Justice, and we would ally ourselves with those submissions.

Finally, further acknowledge the fact that the experience of the bereaved families are central to the Inquiry and will be at the core in assisting the Inquiry in arriving at its stated aims.

That completes the submissions on behalf of Scottish Covid Bereaved in respect of Module 3 of the Inquiry and we look forward to discussions and further discoveries and hearing updates of the further hearings in due course, my Lady.

Unless I can be of any further assistance, my Lady.

LADY HALLETT: Thank you very much indeed, Mr McCaffery. Extremely helpful. As far as the Scottish Inquiry is concerned, as you know, and as counsel to the Inquiry outlined earlier, we had a meeting last week and I was very encouraged by the very positive approach both Inquiry teams are taking. They seem to be working well together and Lord Brailsford and I expressed exactly the same aim, which is we wanted to work together to avoid duplication wherever we can and give clarity to the Scottish people.

So I was -- I hope -- I'm optimistic -- it may not be straightforward in every respect but I am optimistic that we can achieve our aims. So thank you very much.

MR MCCAFFERY: Thank you.

LADY HALLETT: I think it is Mr Williams next.

Submission by MR WILLIAMS, KC

MR WILLIAMS: I think it is now good afternoon, my Lady.

My name is Lloyd Williams, King's Counsel. I am instructed, as you know, my Lady, by Harding Evans on behalf of the Covid-19 Bereaved Families for Justice Cymru.

I am pleased to say that as a result of the comprehensive submissions and remarks made by your

counsel and the remarks we have had so far it enables me to reduce a little the submissions I was going to make, which were not in any event going to be lengthy.

I am going to go through the issues raised by your counsel in the order in which she's raised them, and the first matter is scope and structure of Module 3.

We're grateful, my Lady, for assurances that have been received from you in hearings to date that you fully intend to ensure that the interests of the people who live in Wales are properly recognised during the Inquiry.

CBFJ Cymru wishes to raise that the structure and scope of Module 3 should have regard to the need for sufficient attention to the impact of Covid-19 pandemic on the healthcare system in Wales. As you know, my Lady, because I've told you on three or more occasions, although Wales receives funding from the UK Government responsibility for health is devolved to the Welsh Government. Wales has its own healthcare system. NHS Wales is not a legal entity and instead is comprised of local health boards, NHS Trusts and Public Health Wales. Relevant offices and agencies, such the Office of the Chief Medical Officer and Care Inspectorate Wales are specific to Wales.

This means that key decisions made in Wales were

largely separate to and often quite different, my Lady, from those taken by the UK Government.

This module necessarily covers wide ranging and complex matters. Moreover, investigation of impact on healthcare lies at the heart of the investigation of the response to and impact of the pandemic.

It is particularly important to CBFJ Cymru. A high proportion of those in the group lost loved ones due to hospital-acquired Covid-19. It is a fundamental concern to CBFJ Cymru that the Inquiry understands why hospital-acquired Covid-19 was such an acute problem in Wales and how and whether other regions in the UK adopted a better or simply a different approach.

We are grateful to the Chair for confirming that Wales will be properly considered and not simply as a poor relative of the UK Government.

However, in order for there to be a proportionate and effective investigation in this important devolved matter, CBFJ Cymru asks you, my Lady, to consider subdividing Module 3 into parts. I listened carefully to the remarks made by your counsel this morning but nonetheless I will, with some temerity, make short submissions on that.

The group asks that the Chair adopt a consistent approach for Module 3 as has been taken in respect of

Module 2, namely for Modules 3, 3A, 3B and 3C to address the impact of the Covid-19 pandemic on the healthcare in Wales, Scotland and Northern Ireland. We submit this for the following reasons. Such subdivision reflects the constitutional position in the UK. Health is devolved in Wales, Scotland and Northern Ireland. There are very real differences between healthcare in Wales and the rest of the UK. The structure is different, the general nature of healthcare is different, access to primary care, prescriptions and out-of-hours care all operate differently in Wales.

There are differences in the decisions taken by Wales. For example, in Wales there was no Nightingale hospitals but rather temporary field hospitals and surge facilities. There are also different decisions taken in respect of masks and when they should be made mandatory. Decisions taken in respect of asymptomatic testing of healthcare workers were different.

We therefore urge you to consider once again the issue of separate sub-modules within this.

As an alternative to having four separate sub-modules, we urge you to consider an alternative, which is to have the evidence in relation to, for example, Wales or Scotland, an attempt is made that evidence is heard all in one go. So we have a week of

Welsh or two weeks of Welsh evidence and so on with Northern Ireland. We appreciate that that may not be possible in respect of all witnesses but to get a larger group will make it more understandable to those listening.

My Lady, the issues that are particularly important to CBFJ Cymru include healthcare resources, lack of investment in IT infrastructure and digitisation of NHS Wales, ICU and more capacity, differences experienced by many of our clients' relatives and loved ones in relation to the quality of treatment received, and differences in palliative and end-of-life care received.

They want to know how infection control was managed in hospitals, including ventilation, testing, segregation and PPE. Want to know the extent of testing for Covid-19 hospital patients prior to discharge, whether the correct PPE was used and the scientific basis for choosing one type of PPE over another. Wish to know whether the belief that Covid-19 was fomite based led to the incorrect type of PPE being used.

My Lady, we wish to know whether the Welsh Government paid sufficient regard to the fact that Covid-19 was airborne and the date of knowledge for relevant facts about Covid-19 and who provided that

information. We would like to know whether the local health boards adhered to a mandatory trading and whether there was sufficient education of staff.

My Lady, you can see there are many differences that we have identified. Our list of issues goes on for a page or two longer than I have read out. I am going to stop there because it gives an indication of the particular matters which concern Wales.

The final issue I want to raise on this particular topic is we seek confirmation of resourcing and preparedness for infection control in hospitals, resourcing for PPE availability being within this particular scope. These are matters as to the existing state of affairs when the pandemic struck, which we submit require to be considered in order to understand how the pandemic impacted on the Welsh and other healthcare systems.

We note the CTI's comments during the second preliminary hearing in respect of Module 1 as to the scope of that module, including the separate consideration of overarching factors and also then specific issues in relation to particular problems which arose.

We have set out there at page 14, line 20 of those remarks -- I am not going to read that out now -- that

CBFJ Cymru seeks confirmation of the matters of preparedness in respect of hospitals being prepared for infection control, including the state of the hospital stock so as to have the capacity to implement it, resourcing for infection control measures in hospitals, and the extent of preparedness by way of appropriate stockpiles of PPE will be covered in Module 3.

If to an extent it is proposed they are not covered in Module 3, CBFJ Cymru would be grateful to know in which module it is proposed that those particular areas would be covered.

Update on Rule 9 requests. We noted it is intended that to ensure the Core Participants are kept properly informed the Inquiry will ensure that the Module 3 lead solicitor provides monthly updates to Core Participants on the progress of Rule 9 work.

As yet, however, we've not received sufficient detailed summaries. A recent example is that the ILT had received seven draft witness statements and associated disclosure and that there was outstanding disclosure which had been delayed.

While these updates are helpful, they're not sufficiently detailed to enable CPs to understand the full extent of the request. What we want to avoid, my Lady, is a position where we discover the true extent of

1 the Rule 9 requests in the weeks immediately before the
2 listed hearing for Module 3 and are then unable to raise
3 any challenge or speak to the ILT about key witnesses
4 who have not been approached or key issues that have not
5 been explored with witnesses.
6 In that regard, CBFJ Cymru looks forward to
7 receiving a Rule 9 request directed to it where the
8 issues that are important to the bereaved families can
9 be set out. We hope this input will assist with the
10 Inquiry's development of the list of issues to be
11 covered by this module.
12 Rule 10 procedure. In keeping with our
13 submissions made at Module 1 preliminary hearing on
14 14 February we request that consideration is given to
15 adopting the same informal procedure in respect of
16 Module 3, namely that an opportunity is afforded to meet
17 with the CTI, either remotely or in person, following
18 submission of Core Participants' observations on CTI's
19 evidence proposals and prior to CTI providing
20 a finalised evidence proposal. Therefore, we request
21 a short amount of time set aside after CTI's questions
22 so that further follow-up questions arising from the
23 evidence can be considered with the Core Participants.
24 Disclosure to Core Participants. I suspect, my
25 Lady, you are getting a little tired now of hearing

1 submissions on disclosure. I will simply make this
2 point. It is fairly obvious. We don't have any
3 submissions save we request disclosures given in good
4 time for us to have sufficient time to adequately
5 prepare for the substantive hearing.
6 Instruction of expert witnesses. At this stage we
7 don't have any submissions to make in respect this
8 issue, save in respect of timing once again. It is
9 noted that it is not proposed to disclose letters of
10 instruction but we will be informed of the identity of
11 witnesses, questions and the issues they will be asked
12 to address before the expert reports are finalised. We
13 will welcome that CPs will receive that information as
14 early as possible so that we have the opportunity to
15 make observations in what we hope will be a constructive
16 and meaningful way.
17 My Lady, approach to evidence of circumstances of
18 individual death and pen portrait material, we note the
19 matters set out in paragraph 65 and 66 of CTI's note.
20 CBFJ Cymru request that the Chair give consideration as
21 to whether hearing the circumstances of particular
22 deaths would be permissible in respect of this module.
23 Individual bereaved family members within the group have
24 relevant evidence to give in respect of the way in which
25 their loved ones became infected, often in hospital

1 settings, and how they were treated thereafter.
2 We note the mention of paragraph 66 of the calling
3 of evidence regarding individual deaths or experience of
4 Covid-19 may be considered so as to introduce a systemic
5 issue. CBFJ Cymru welcomes the acknowledgement from the
6 CTI in its note that to include this type of evidence
7 would be in keeping with the Inquiry's express intention
8 to keep those affected by the pandemic at the heart of
9 the Inquiry and submits that such evidence would assist
10 the investigation and cast a spotlight on the issues
11 concerned.
12 My Lady, listening exercise. You have heard
13 extensive submissions on that already. I am not going
14 to repeat it save to say that CBFJ Cymru offers its
15 commitment to working with the Inquiry team to assist in
16 the development of the Listening Exercise.
17 My Lady, these are my submissions.
18 **LADY HALLETT:** Thank you very much indeed, Mr Williams. As
19 constructive as ever. As you know, I began the UK-wide
20 consultation on terms of reference in Cardiff and
21 I remember vividly the accounts given by bereaved family
22 members at the meeting in Cardiff and, therefore,
23 I understand just how important healthcare is to the
24 people you represent. So thank you very much indeed.
25 **MR WILLIAMS:** Thank you, my Lady.

1 **Submission by MR METZER, KC**
2 **MR METZER:** My Lady, I appear on behalf of the four Long
3 Covid groups, together with my learned friends Ms Iengar
4 and Ms Sivakumaran who are instructed by Bhatt Murphy
5 Solicitors.
6 As you are aware, my Lady, three of the four Long
7 Covid group organisations are also Core Participants in
8 Module 2, on administrative and Government
9 decision-making, and have been introduced to you at the
10 Module 2 preliminary hearing last October.
11 However, the full composition of the Long Covid
12 groups before you today is different. Long COVID Physio
13 is a new Core Participant to the Inquiry and of course
14 we also have different representation in attendance
15 today than for the previous module.
16 I therefore propose to introduce briefly the four
17 Long Covid organisations before setting out their
18 interest in Module 3, and then provide an overview of
19 our position on the procedural matters under
20 consideration today.
21 The Long Covid groups. The Long Covid groups
22 comprise Long Covid Support, Long Covid SOS, Long Covid
23 Kids and Long COVID Physio. Long Covid Support began as
24 a peer support Facebook group in March 2020 and has
25 quickly grown. It has over 57,000 members globally,

with 23,000 in the UK. The charity provides support and information and campaigns for equitable access to high quality healthcare, employment, welfare rights and research into treatment.

Long Covid SOS was established in June 2020 as a volunteer-run patient advocacy and campaign group. Almost 5,000 individuals have signed up to their website. Long Covid SOS provides recognition, research and rehabilitation for people with Long Covid by providing informed and lived experience perspective in Long Covid.

Long Covid Kids was formed in September 20 by a group of families whose children became victims of Long Covid. The organisation has grown to provide support services to 11,000 families and represents those families' interests in relevant national stakeholder forums.

Long COVID Physio is a patient-led association of physiotherapists that began in November 2020 to provide peer support, education and advocacy for physiotherapists and allied healthcare professionals living with Long Covid. The organisation has 393 Facebook members and a website with more than 30,000 monthly page views. It provides free educational resources and advocates for safe and effective

rehabilitation.

Long Covid and interest in Module 3. The four Long Covid organisations were all formed in the first year of the pandemic. Their professional membership spans all aspects of health and education sectors as well as occupational health and research. They have played a direct and significant role in the characterisation, identification, diagnosis and treatment of Long Covid, and are all committed to assisting the Inquiry by sharing their lived experience and involvement with advocating for recognition, treatment and research or Long Covid.

Turning then to their interest in Module 3, the Long Covid groups taken together represent the collective interest of at least 2 million adult and child victims of Long Covid who have suffered from life changing and disabling illness following infection from SARS-Cov-2.

As almost 3 per cent of the population, it is clearly a significant cohort of the population directly affected by Covid-19 and living with it. They welcome the Chair's recognition that Long Covid groups will assist the Inquiry to understand "the experiences and perspectives of those suffering from Long Covid in the UK, as well as the response of healthcare systems in

characterising, diagnosing and treating the condition".

A unique characteristic of Long Covid is that it is a patient-derived term. Individuals suffering from Long Covid struggle in many ways to access the healthcare system during the pandemic. They struggled to receive a diagnosis, their symptoms were often disbelieved, they were discredited and they experienced difficulty in accessing appropriate care and treatment.

The dissonance between their lived experience of Long Covid as a severely disabling, life-altering chronic illness and the pervasive public perception of the illness, even once generally recognised, as mild, brief and easily treated at home, meant they had a very different experience of the healthcare system to patients of other diseases.

The Long Covid sufferers, many of whom were healthcare workers, came together online and established peer support organisations who: (1) advocated for the proper recognition of Long Covid; (2) called for more effective access to healthcare system, including to safe and effective care, diagnosis and treatments; and (3) were proponents for research into Long Covid and its underlying biological mechanisms.

It was this collective advocacy of patients that led to the formal recognition of Long Covid as

a clinical illness. The WHO developed a clinical case definition of Long Covid for adults by the Delphi methodology in October 2021 and developed a separate clinical case definition of Long Covid in children and adolescents more recently, as on 16 February 2023.

We anticipate that central to Module 3 is the investigation of how and why patient advocacy outside formal clinical channels was required to refine the clinical recognition and understanding of the condition that affects such a sizeable proportion of the population.

Scope. My Lady, I now turn to our substantive procedural submissions. I began by explaining the Long Covid groups' interest in Module 3 to contextualise the following points. We are very grateful to your indication this morning that the nature of future modules will be shared with Core Participants and your recognition that there will be areas of overlap, for example health inequalities. We agree, respectfully, that this is vitally important to be shared with Core Participants at an early stage.

We also welcome my Lady's commitment to providing interim reports during the course of these proceedings. In terms of the lessons being learned, several of the concerns investigated by the Inquiry are not confined to

the past, their ongoing concerns and interim recommendations are welcomed.

Further on the issue of scope we make three short points. The 12-point provisional outline of scope contains only one express reference to Long Covid, which appears in the final paragraph. The areas of particular focus highlighted this morning also contained one reference to Long Covid. Whilst the express investigation of Long Covid's characterisation, diagnosis and treatment are, we say, correctly included within the remit of Module 3, we would like to respectfully remind the Inquiry that Long Covid must not be consigned to a mere footnote. It is a central threat to the Inquiry's assessment of healthcare consequences.

Let us take point 1 of the provisional scope as one example. The delays in formally recognising Long Covid, in publishing the wider range of symptoms associated with Covid-19 and in reporting the vast numbers of people affected by the condition, all caused Long Covid sufferers to have an entirely distinct experience of healthcare provision and treatment than those who experienced acute infections of Covid-19.

Disbelief, dismissal and denial characterised many Long Covid sufferers' experience of the healthcare system. They struggled to receive a diagnosis, to

access a care pathway and to receive treatment. Through this process individuals reported being disbelieved by healthcare providers, having their physiological symptoms minimised and dismissed as a mental health syndrome, and being denied effective treatment.

We highlight this one point of the provisional scope to illustrate that Long Covid should not be artificially separated and siloed to a separate consideration within this module. It is an important central thread to the Inquiry's understanding of the pandemic's impact on the healthcare system and we respectfully hope will be properly factored into the Inquiry's scrutiny of all points under investigation in this module.

Secondly, in respect of the scope itself, we note at paragraph 33 of the CTI's note, introduces a narrow revised list of 9 areas "of particular interest" in Module 3. We are concerned by this revised list Strikingly, there is no explicit reference to Long Covid in the area identified as being "of particular interest". We greatly hope that this is not an oversight by the Inquiry and that Long Covid is intended to be read in as included in all aspects of the revised list. We will seek express clarification that that is correct and that Long Covid has not once more been

overlooked.

Finally in respect of Covid we are grateful that counsel to the Inquiry will publish a list of issues developed from analysis of the evidence and responses to Rule 9 requests, as has been indicated for Modules 1 and 2. The Long Covid groups welcome this approach and plan to assist the Inquiry in identifying areas of concern for Long Covid.

Disclosure. We are grateful to counsel to the Inquiry's update on the disclosure method for Module 3 today. We understand and accept the need to avoid duplication of Rule 9 requests. Whether Module 3 team is considering responses to Rule 9 from previous modules, we are unclear how Core Participants who have not been granted status in previous modules will be made aware of those responses, but we respectfully ask will the Inquiry consider disclosure of Rule 9 responses for earlier modules as they relate to Module 3.

Experts and witnesses. In relation to the issue of lay and expert witnesses, we wish to provide three observations. The Inquiry is already alert to the difficulty of instructing experts from previous modules. In the case of Module 3, several of the prominent experts may also be involved in the issues being investigated. They may be called as witnesses of fact

and they may have expressed opinions publicly on matters being probed in this module. We respectfully suggest that these difficulties could well be overcome by providing Core Participants with an early opportunity to input on the expert witnesses that have been identified and on the scope of their instructions.

We understand and underscore the importance of early disclosure in this regard for two key reasons. Any objection raised by Core Participants of the experts or to their expertise when reports are already well underway will only serve to delay the Inquiry's work. We seek to avoid such delay by providing early input in identifying suitable experts.

Similarly, the early disclosure of letters of instruction where work by experts remains at an initial or an early stage will ensure that Core Participants can identify any missing subject matter to be opined upon within the context of the overall report itself. This is, of course, particularly important in respect of the expert on Long Covid.

We respectfully submit that will avoid delay and maximise the meaningful participation of Core Participants.

Our second point in relation to experts concerns the proposed areas of expertise. The Long Covid groups

welcome counsel to the Inquiry's indication this morning that expertise on post Covid sequelae for Long Covid and its recognition will be included. We agree that this is central to the Inquiry's investigation in this module.

Finally, on the point of lay and expert witnesses, we invite the Inquiry team to hear formal evidence from members of the Long Covid groups. Members of those groups are uniquely placed to provide the expert evidence on how and why patient advocacy led to the public and clinical recognition of Long Covid and the systemic implications this had on long Covid sufferers, key points for investigation in Module 3.

Many members of the Long Covid organisations are also well placed to provide testimony from the dual perspective of being patients and healthcare workers in this pandemic.

Healthcare workers were and continue to be important patient advocates for Long Covid. They are doctors, nurses, physiotherapists and other allied health professionals who have the twin experience of being Long Covid patients as well as frontline workers in the pandemic, or parents or caregivers of a child with Long Covid. Their experience can speak to multiple issues under investigation in this module, such as how adequately the spread of Long Covid was prevented -- of

Covid-19 was prevented within healthcare settings, their insight in the accessibility of care and treatment for Long Covid on both sides of the wall, and the impact that Long Covid had on the employment of healthcare workers.

We respectfully submit that the evidence of Long Covid groups is highly relevant to a proper assessment of the matters under investigation in Module 3.

The listening exercise and commemoration. In relation to the Listening Exercise, Every Story Matters, the Long Covid groups recognise and support its function as a separate non-legal process for the Inquiry to capture a wide range of experiences. We welcome the Chair's commitment to providing further clarity and detail on its design and implementation.

The Long Covid groups welcome STI's recent update that the Inquiry will hear from seldom heard groups and that its staff will be trained on trauma-informed approaches. In this regard specifically we invite the Inquiry team to provide further detail on what reasonable adjustments will be put into place to ensure that people living with disability and the clinically vulnerable are able to participate meaningfully in the exercise, how seldom heard groups will be identified and approached, and what training staff members will be

equipped with.

At present the online web form under the "Share your experience" specifically excludes anyone under the age of 18 from providing their perspectives. We reiterate the submissions we made ahead of Module 2 preliminary hearing and urge the Inquiry to consider safe and inclusive ways to incorporate children's experiences into the Listening Exercise.

The Inquiry has the benefit of Core Participants, including the Long Covid groups, who have a wealth of experience and disability inclusion, working with children and young people and handling trauma survivors, which we consider the Inquiry team are likely to benefit hearing from.

We strongly recommend that the listening exercise is developed in open consultation with the Core Participants. The Long Covid groups continue to offer their assistance in this regard. It is hoped that the Inquiry team will maximise the experience and expertise that Core Participants bring in order to develop an effective and accessible Listening Exercise that captures the full breadth of perspectives.

In relation to the commemoration, the Long Covid groups were pleased to be consulted on this in December '22. The Chair's decision to include video

content at the start of each module is welcomed. It is hoped that this will appropriately represent the experience of Long Covid sufferers who remain surviving victims of the pandemic. As with the Listening Exercise, Long Covid groups continue to offer their assistance to progress the commemorative tapestry and video content.

Reasonable adjustments. The Long Covid group raised the topic of reasonable adjustments at the preliminary hearing of Module 2 and are grateful for my Lady's recognition of her statutory obligation under section 19(2) of the Inquiries Act 2005 to take reasonable steps to ensure that members of the public can follow the proceedings and obtain or view a record of the evidence.

We take this opportunity to respectfully remind my Lady that reasonable adjustments ought to be accommodated for the entire process of the Inquiry, including for Core Participants' preparation, as well as for the venue proceedings and publication of evidence. The Long Covid groups are concerned about the time-frames Core Participants are given to provide their input. They recognise that the Inquiry is working at pace. However, the Core Participants have only six working days from provision of CTI's note for Module 3

and the deadline to lodge written submissions in response.

The Long Covid groups represent individuals who were previously fit and healthy but have suffered profound and often disabling changes to their health and to their lives caused by the effects of Long Covid 19. As Long Covid sufferers themselves, the groups found that this time-frame was too tight and offered inadequate time for disabled clients to review written submissions once drafted. This severely impairs their ability to meaningfully contribute and provide input into as Core Participants. It is respectfully requested disabled participants be provided with adequate time to sufficiently review documents and provide instructions in order to properly assist the Inquiry and fulfil their role as Core Participants.

Covid-19 safety measures, last topic.

The Long Covid groups would like to raise one final important point in relation to the Inquiry's safety measures. The Inquiry team will appreciate that safeguarding attendees' health, safety and welfare at the Inquiry's hearing venue is of utmost importance and this naturally extends to adopting measures to minimise the spread of Covid-19 transmission in order to avoid disruption and potential harm to all participants during

the hearing process. For this reason, the Long Covid groups have invited the Inquiry to ensure that HEPA filters, adequate ventilation and CO2 monitors are used in all of the Inquiry venues. Studies show that air filtration using HEPA filters and installing CO2 monitors that access levels of ventilation successfully reduce the transmission of airborne pathogens including SARS-CoV-2.

The Long Covid groups continue to recommend strongly that the Inquiry team consider these simple, effective and relatively cost-efficient methods of infection prevention.

These are all the points I wish to raise at this time unless I can assist my Lady any further.

LADY HALLETT: No, thank you very much indeed, Mr Metzer. I am very grateful.

As far as making sure that the interests of the groups you represent are properly recognised, and that's obviously, as you know, one of the reasons I gave the groups Core Participant status, but I'm sure that with your help and the help of your team and with the help of counsel to the Inquiry we can achieve that aim.

Can I just mention one point, you talked about Listening Exercise and children under 18. When we first launched the online form there was a reason why we

couldn't include children under the age of 18 at that time, but I have always said to the team we must capture the experiences of children and we need to get on with it because, from my experience in another life as a judge and a barrister, I know that we need to capture the experience of children before their memories fade, though I suspect that for some of your lay clients who are suffering from Long Covid sadly the memories are still with them.

But we will do our very best to make sure that children are properly recognised too.

MR METZER: Thank you very much.

LADY HALLETT: Mr Wagner, I think, is next.

Submission by MR WAGNER

MR WAGNER: Good afternoon, my Lady.

My name is Adam Wagner and I act for two Core Participants in Module 3. First, the Clinically Vulnerable Families and, second, a group of 13 pregnancy, baby and parent organisations. I am instructed by Kim Harrison and Shane Smith of Slater & Gordon lawyers for both Core Participants.

You have our detailed written submissions on behalf of both Core Participants and I do not intend to refer to them in detail, and I'm of course conscious that I now stand between 150 people in this room and

their lunches so I really will try not to be longer than I need to be!

The way I am going to set out my submissions is first I will make submissions on behalf of the Clinically Vulnerable Families and then move on to pregnancy, baby and parent organisations.

LADY HALLETT: You may have to break in the middle if that is all right with you.

MR WAGNER: That is --

LADY HALLETT: So maybe we will deal with the Clinically Vulnerable Families' submissions first and then come back to the other ones. Then you haven't got to rush.

MR WAGNER: That makes perfect sense. I do intend at the end to make some very brief submissions on behalf of both Core Participants but I will save that until after lunch.

So, beginning with the Clinically Vulnerable Families, which I will refer to as CVF going forward, CVF were designated as a Core Participant on 16 January, and they are keen to assist the Inquiry and the very grateful for the opportunity, my Lady.

I'm going to give a brief introduction to the group and their reasons for being involved in Module 3. CVF was founded in August 2020. They represent those who are clinically vulnerable, clinically extremely

1 vulnerable and the severely immuno-suppressed, as well
2 as their households, and they represent them across all
3 four nations.
4 CVF has a significant online presence, including
5 thousands of members of a private Facebook group and
6 over 10,000 followers on Twitter. CVF estimates its
7 reach is over 30,000 people.
8 The people CVF represent are at a higher risk of
9 severe outcomes from the Covid-19 disease. They have
10 a greater risk of mortality, around 7.5 times more
11 likely to die than the general population, and they have
12 a greater risk of Long Covid, around 5.2 times more
13 likely.
14 For many vulnerable individuals, the pandemic is
15 by no means over. Many continue to shield to this day.
16 Indeed, they still face as significant a risk from
17 contracting Covid-19 as they did in early 2020. The
18 clinically vulnerable are, for this reason, the
19 forgotten half million.
20 Life has moved on for the vast majority of the
21 population and yet the clinically vulnerable continue to
22 have to shield. They are denied free treatments, such
23 as Evusheld, and timely antivirals. They are also
24 denied basic public health protections, such as HEPA
25 filters in public buildings and reasonable adjustments

1 at work, which would make them able to live more
2 fulfilling lives out and about rather than locked in
3 their homes.
4 CVF agree with the Covid Bereaved Families for
5 Justice that society is judged on how it treat its most
6 vulnerable and marginalised. Clinically vulnerable
7 people are in both of these groups.
8 CVF is keen to ensure that the Inquiry considers
9 the full impact of the pandemic on the clinically
10 vulnerable, the clinically extremely vulnerable
11 (sometimes shown as the shielded), and the severely
12 immuno-suppressed, their families and their households.
13 Such individuals not only face, but continue to
14 face, greater risks to their lives than any other
15 category of person. As such, any planning for future
16 pandemics or consideration of the effectiveness of
17 public health services need to take place with the
18 impact of the clinically vulnerable as a key
19 consideration.
20 So moving on to submissions, I will make four on
21 behalf of CVF.
22 First, on scope. CVF has proposed in the written
23 submissions four relatively modest changes to the
24 Module 3 scope. I will begin with paragraph 11 as that
25 is the paragraph which currently mentions the clinically

1 vulnerable and clinically extremely vulnerable. It
2 currently reads:
3 "Shielding and the impact on the clinically
4 vulnerable, including those referred to as clinically
5 extremely vulnerable."
6 CVF are concerned that the paragraph as currently
7 drafted is potentially misleading as only the clinically
8 extremely vulnerable were told to shield. The larger
9 group of clinically vulnerable were not told to shield
10 unless they fell within the subcategory of clinically
11 extremely vulnerable. Therefore, we have proposed an
12 amendment to paragraph 11, which reads:
13 "Shielding, as it impacted on those referred to as
14 clinically extremely vulnerable, and the impact of not
15 including all of those referred to as clinically
16 vulnerable in shielding."
17 I just pause there to say in relation to
18 terminology -- I'll come back to this point -- but the
19 terminology "clinically vulnerable" and "clinically
20 extremely vulnerable" has, as I'm sure your Ladyship is
21 aware, moved on quite significantly since the pandemic
22 and this Inquiry will have to think carefully about
23 which terminology it uses in its different elements.
24 The other three proposals are at paragraph 8 to 11
25 on our written submissions and I don't refer to them in

1 detail. Just in short, we propose an amendment to
2 paragraph 6 and this is to add the words -- it currently
3 reads "decision-making about the nature of healthcare to
4 be provided for patients with Covid-19" and we propose
5 adding the words "including the use of decision support
6 tools to determine patients' pre-morbid states and their
7 treatment options for Covid-19".
8 The reason we say this is important is that the
9 Covid-19 decision support tool was used to determine the
10 treatment pathway of patients with Covid-19 and
11 particularly their level of vulnerability and the
12 adequacy, and otherwise, of that tool, and indeed other
13 tools, is critically important in determining how well
14 the clinically vulnerable and clinically extremely
15 vulnerable people were protected when being treated for
16 Covid-19.
17 The third amendment is to paragraph 8 and this is
18 currently drafted about preventing the spread of
19 Covid-19 within healthcare settings. We propose an
20 addition of not just the adequacy of PPE but the
21 information given in relation to PPE. That's because,
22 in CVF's submission, there was insufficient information
23 provided to clinically vulnerable people about what PPE
24 they should use: for example, what kind of face mask in
25 order to mitigate risks in healthcare settings.

But also at the end of that paragraph, we request that the following words are added: "to include the impact on clinically vulnerable frontline staff and social care staff and clinically vulnerable patients, including those who are immune compromised." The reason we propose adding those words is, although clinically vulnerable people are mentioned in paragraph 11, currently that wouldn't cover necessarily -- because it refers to "shielding", that wouldn't necessarily cover the impact on clinically vulnerable people in the healthcare settings themselves.

We make one final point in relation to paragraph 9, which is in our written submissions. The second submission, producing an interim report: for many clinically vulnerable people, there has been no freedom day. The Covid-19 pandemic is not over. They still remain at serious risk from contracting the virus, which is still of course at large and we are subject to a series of waves in each year.

One of the key tasks for this Inquiry is to ensure that lessons are learned. However, the focus should not be solely on saving lives during future pandemics or epidemics but also on urgently addressing the ongoing risks to people who have a higher risk of severe disease from Covid-19 and their families, and also their

reintegration into society. This could be achieved through, for example, improved health and safety and access to health service provision to mitigate against their ongoing risk arising from Covid-19.

In this regard, CVF respectfully requests, my Lady, that you consider using your power under the Inquiry's terms of reference to produce an interim report on measures which can be taken to improve the safety of persons who have high risk of severe disease from Covid-19 in the here and now.

We're very grateful to counsel to the Inquiry for her indication earlier that she assured an interim report on improving the safety of those at high risk of severe disease from Covid-19 is precisely what your Ladyship has in mind, and we hope that is correct. But the indication is of great reassurance to the Clinically Vulnerable Families.

Just a point on jurisdiction. CTI made submissions earlier about the terms of reference limiting consideration of matters which occurred after 22 June 2022, which is obviously correct. But we assume that Ms Carey did not by this mean that your Ladyship cannot consider matters up-to-date when considering recommendations, which is what we are requesting in relation to the current impact on Clinically Vulnerable

Families. Indeed, if you were artificially prevented from looking at the current position in relation to recommendations, that would be counter-productive because you might be making recommendations which were already in place.

My third submission relates to the Listening Exercise and just a note on terminology. CVF very much welcomes the Listening Exercise and the references in there to the clinically vulnerable. It is important, in my submission, that the Inquiry's Listening Exercise team understands there are different vulnerable groups who have had, and who continue to have, notably different experiences of the pandemic.

The solicitor to the Inquiry's note mentions "data collection" and we submit that it's important for data collection and subsequent thematic analysis that these groups are given due regard. The risk of simply using the "clinically vulnerable" category is that within that group there is a very wide range of experiences of the pandemic. Just the most basic example: there were people who had some risk from their underlying condition but for whom vaccination has been effective, and for them they may have been able to return to some sort of normal life. But there are conversely a group of immune-suppressed who have remained particularly

vulnerable, despite vaccination, and CVF recommends that careful thought is given to potential subcategories of those who are in the generality clinically vulnerable.

Also in relation to the terminology point, which I said I'd come back to, when analysing historic periods in the pandemic it will sometimes obviously make sense to use terms such as "clinically vulnerable", "clinically extremely vulnerable". But, going forward, we propose that the terminology of "higher risk of severe disease from Covid-19" is considered for use by the Inquiry because that matches the current Government terminology being utilised. Indeed, "clinically vulnerable" and "clinically extremely vulnerable" as terms have become historic in terms of how they are used, although you, my Lady, will have the complication of the fact that the public still understand those terms. But we just raise the matter now.

Relatedley on pen portraits or illustrative cases, we are very grateful for the indication that those will be used, and CVF would be very happy to assist the Inquiry in identifying individual case histories of those who are clinically vulnerable.

My final submission relates to adjustments for the upcoming Module 3 hearings. An inquiry into Covid-19, with Core Participants and witnesses who are extremely

clinically vulnerable, should in our submission ensure that the final venue has robust Covid-19 safety measures in place. I have no doubt that's in your Ladyship's mind.

We agree, of course, with the Long Covid groups' submissions at paragraphs 53 to 55 of their written submissions on safety measures. We emphasise that for higher risk of Covid individuals, it is imperative that the venue takes due regard of any risk assessment for Covid-19 that includes its airborne nature and adjust the venue and requirements accordingly. In particular, CVF asks for air filtration using HEPA filters or ventilation measured by CO2 proxy, and ensuring high quality masks are available (such as FFP2 or 3), as well as lateral flow test requirements for all participants at the in-person inquiry.

We note, just as a relatively small point, that the guidance for those who were in the alternative room for today was not as clear as it was for the people in this room that they should take Covid-19 tests.

But, fundamentally, the key request I am making on behalf of CVF is that they and other CPs are consulted well in advance of the next hearing on the safety arrangements for that hearing because we've all learnt from being here for the first time a lot and we can

offer a lot in terms of our experiences and expertise.

So those are my submissions on a behalf of CVF.

LADY HALLETT: Thank you very much, Mr Wagner, and a number of very interesting points you make certainly as far as the preparations for the hearing centre are concerned. It would be a good time to make them because, obviously, the work is going on at the moment for what we hope will be the permanent hearing centre.

As far as terminology is concerned, I do understand it changes all the time and I welcome any expert advice on terminology we should use.

So thank you very much and I shall see you after lunch. We shall return please at 2.05.

(1.04 pm)

(Luncheon Adjournment).

(2.03 pm)

MR WAGNER: My Lady, just on the topic of safety measures, I've been told by my clients that they brought a CO2 monitor today along with a number of other air filtration machines and they said that the level in this room is very good; so that's -- they're very pleased with that. I am pleased to say also they have already begun conversations with the Inquiry team, who have been very receptive to all of the different issues that might arise. So we're grateful for that.

LADY HALLETT: You frightened me there for a minute, Mr Wagner, so thank you for that.

MR WAGNER: It's good news.

So I will now move on to submissions on behalf of the 13 pregnancy, baby and parent organisations. Those are organisations are: Aching Arms, Baby Lifeline, Bliss, The Ectopic Pregnancy Trust, Group B Strep Support, ICP Support, The Lullaby Trust, the Miscarriage Association, the National Childbirth Trust (NCT), the Pelvic Partnership, Pregnancy Sickness Support, Tommy's, and Twins Trust.

I won't attempt to summarise all of the amazing work that those organisations do but I have done so in the annex to our written submissions and I encourage members of the public to look there.

Each of the 13 organisations has a unique focus. However, all of them agree that there are a number of key themes and concerns that the Inquiry should investigate, and this list is very much provisional but I will just give a precis.

There are seven points. The first is, during pregnancy. During pregnancy women and birthing people faced challenges during the pandemic in accessing adequate antenatal care including but not limited to accessing information, and having to attend clinics,

scans and hospital appointments alone.

For multiple and other high-risk pregnancies where people attend more appointments and longer stays, the impact was compounded.

Secondly, during childbirth. Because of visitor restrictions in healthcare settings, women and birthing people faced giving birth alone or with too little support. This was often traumatic, particularly so in the case of complex and multiple births. Many hospital trusts suspended services such as home births and midwife-led units due to, in particular, staff shortages, which resulted in restricted and reduced choice for women and birthing people about how and where they were able to give birth.

Third, postnatal care and after childbirth. Families faced challenges in accessing postnatal medical care and infant feeding support. There was a lack of care in the form of the usual visits from midwives and health visitors, as well as limited provision through support groups for new parents. This negatively impacted both parents who were unable to obtain adequate support when they were vulnerable and babies who had limited interactions inside and particularly outside the home during lockdowns.

Fourth, neonatal care for newborn babies. Most

neonatal units heavily restricted parental presence, for example only allowing one parent to attend or banning fathers or non-birthing parents altogether. This negatively impacted the short and long-term health of babies and developmental outcomes, as well on family attachment and bonding. There were devastating restrictions on parents being able to be with their premature and sick babies in neonatal care units, some of which would have been compounded by multiple births.

The absence of this close parental presence and care will have affected the early days and weeks of tens of thousands of babies, had a significant impact on parents' mental health and wellbeing, their ability to be involved in care and their ability to parent together.

Fifth, death and bereavement. Many women in birthing people received the devastating news that their pregnancy had ended, for example by miscarriage, whilst they were alone. They would sometimes have to share this news with their partners in hospital car parks rather than in the presence of medical professionals. Parents were denied compassionate bereavement care and some were even denied the right to be with their baby until their baby's death.

Sixth, vaccination. There was confused and

conflicting messaging around vaccination, which led to a number of pregnant women and birthing people remaining unvaccinated, resulting in unnecessary increased hospitalisation and deaths in this clinically vulnerable group that could have been avoided.

So those are the very brief key provisional themes, and now I will move on to submissions.

The first submission I make on behalf of this group is that the Module 3 scope should be expanded to include issues which relate to antenatal and postnatal care. This is, of course, part of the terms of reference and should be included in the scope.

The Inquiry's draft terms of reference, as you know, my Lady, published on 11 March last year, did not include any reference to maternity services or babies. As a part of the public consultation which followed, the Pregnancy and Baby Charities Network, of which all 13 organisations I represent are members, although they do not comprise the entire group, wrote to you requesting the impact upon new and expectant parents and their babies during the pandemic was added to the terms of reference.

This was ultimately reflected in the final terms of reference, and indeed in the consultation document which the Inquiry produced -- this was seen as a very

important added element -- and it's now one of the 11 issues to be investigated in relation to the response of the health and care sectors across the UK. The Inquiry must of course investigate all the issues in the terms of reference in order to fulfil its statutory obligation.

The pregnancy baby and parent organisations are therefore extremely concerned to see that the provisional scope for Module 3 makes no reference to antenatal and postnatal care.

Counsel to the Inquiry referred in her oral submissions to a number of proposals by other CPs in relation to the scope which had been rejected and we hope the fact that our request was not mentioned either as being accepted or rejected means that it remains under consideration.

We submit that the provisional scope should reflect and, where necessary, expand on the issues in the terms of reference and it seems that the only issue which appears under paragraph 1(b) in the terms of reference which is not covered in the provisional scope of Module 3 is antenatal and post natal care. This must be rectified so that the Inquiry fulfils its terms of reference.

Secondly, it's clear to person and organisations

who have relevant information and evidence that they have to commence their preparations, and I appreciate counsel to the Inquiry's note in her oral submissions that Rule 9 requests would include antenatal and postnatal care. However, those are private documents which won't be seen by the public and, in my respectful submission, it is important that the key public facing document for Module 3 includes direct reference to antenatal and postnatal care because otherwise individuals and groups who proactively want to come to the Inquiry and give evidence may not realise that this is the module to do it in.

Finally, in the consultation document which you, my Lady, produced it was said that the overwhelming weight of opinion was that antenatal and post care must be added to the terms of reference, but at present, and we don't understand why, there is no obvious plan for the voices of those who experienced trauma and loss as identified earlier will be heard in Module 3.

So we have proposed some wording in our written submissions, which I will read out briefly, and this is: pregnancy, antenatal before childbirth, intra-partum, during childbirth, postnatal, after childbirth and neonatal newborn baby care, parent support, baby loss and bereavement, in particular the

impact of that care on babies and parents caused by, for example, the limits on visiting those in hospital, such as parents and premature and sick babies, the reduction of in-person care and the information given in relation to vaccination during pregnancy.

We note finally on this point that a number of other CPs agree with us that antenatal and postnatal care need to be included in the scope, including NHS England, Covid Bereaved and Northern Ireland Covid Bereaved and the TUC. So we respectfully respect that consideration is given to including it directly and not just on the list of issues.

The second submission, which I can make very briefly because it has already been well discussed earlier today, considering the entirety of the United Kingdom in Module 3., and I'll put it very simply, we don't propose there is a Module 3A, B and C necessarily but simply that in good time the Inquiry explains to the Core Participants how Module 3 will be structured to ensure that the different parts of the UK are fully taken into account, and I'm sure that is all I have to say on that.

I said at the outset that I would come at the end to some joint submissions on behalf of both Core Participants I represent. I can take them very shortly.

First is in relation to expert material. This is set out in detail in the written submissions and I know it's already been referred to by a number of Core Participants. Our simple points are, first of all, that the specialist areas are identified soon and we note the indication that will be in the solicitor to the Inquiry's newsletter and we're grateful for that.

Secondly, that identities of experts are identified early.

Finally, that the questions and issues experts have to address are disclosed to the CPs before they are finalised and not before the report itself is finalised, as in not very late in the process.

I submit that this interacts with the issue of whether Rule 9 requests will be shown to the Core Participants. Ultimately, there is no requirement in the rules and there's no consistent practice across other public inquiries, although the practice varies, but in my submission the overarching point is that the more information that Core Participants can see, not just as individuals with interest but as experts in particular areas, the better for transparency and also the better for the Inquiry in making sure that nothing is missed. So that's my submission on that.

Then, finally, submissions of the other CPs which

we support. We agree with the TUC in paragraph 37 of their written submissions that the Inquiry should consider giving more time between counsel to the Inquiry's notes and the deadline for submissions and there's good reasons for this. There's lots of good reasons for this but in relation to CVF, they represent a group who have serious underlying pre-existing conditions, many of which cause fatigue, and in my submission a reasonable adjustment would be to allow for more time because it's really practically impossible for them to digest lots and lots of material in a short amount of time, even allowing for the fact that does happen in inquiries.

In relation to the Long Covid group's submission that the most number of voices possible should be included in the Listening Exercise, we agree wholeheartedly that consideration should be given to inviting younger voices into this exercise. We note your Ladyship's indication, too, that that would occur but we make a slightly more general submission which is that in the healthcare module there isn't any reference to children in the scope.

Now, this may be because it's generally assumed that children didn't suffer the same or anywhere near the level of morbidity and mortality from Covid-19.

However, children were very significantly affected by the changes in healthcare, for example not being able to have visitors in hospital, those children who were clinically vulnerable and clinically extremely vulnerable who did suffer from severe reactions to Covid, including Long Covid. So we do ask that you consider, my Lady, adding more reference to children, both in the Listening Exercise, in the scope.

The final point is that we agree with NHS England's submission from paragraph 28 to 23 *(sic)* of their submissions that it would be extremely useful to see a road map of the future modules, and again, the point on consultation and transparency, the earlier and more detailed the better.

Unless I can assist you further, those are my submissions.

LADY HALLETT: No, you have been very helpful, Mr Wagner, thank you very much indeed. I promise to bear very much in mind all the submissions you have made. You have made some interesting points. Thank you.

It is now Mr Straw, I think.

Submission by MR STRAW, KC

MR STRAW: My Lady, good afternoon. I represent John's Campaign, the Relatives and Residents Association and the Patients Association. Broadly they act on behalf of

1 service users, relatives and carers in health and care
2 settings and their reach is roughly 100,000 people.
3 I would first like to look at provisional scope.
4 We respectfully invite the Inquiry to make clear that it
5 will investigate six matters. I anticipate that most of
6 these will be investigated, and that's the intention,
7 but it's important that this is made clear in writing at
8 this stage, we submit. So the six matters are as
9 follows.
10 Firstly, the situation of people who were outside
11 hospital who had healthcare needs, in particular those
12 who were at home or in care. Ms Carey earlier indicated
13 that this issue would be investigated in the care homes
14 module. I hope it helps for me to clarify the issue of
15 concern for my clients and ask the Inquiry to reconsider
16 whether the appropriate module is the care homes module.
17 So the real issue of concern for us is people who
18 had healthcare needs where those needs weren't met due
19 to the Covid response, so denial of access to non-Covid
20 healthcare, things like cancer treatment, treatment for
21 life threatening illnesses, due to the restrictions
22 imposed by the Covid response. It does appear to us
23 that this fits better in this module and we would
24 respectfully ask the Inquiry to reconsider that.
25 The second issue is we submit that it's important

1 that the Inquiry investigates, in respect of each of the
2 issues within the provisional scope, the impact of the
3 pandemic and responses to it on people, including on
4 service users and others, as well as on institutions.
5 Now, the need to do that is clear from the Inquiry's
6 terms of reference, but an example of where this
7 previously wasn't clear is in CTI's note for the
8 purposes of this hearing at paragraph 33(c). That
9 indicated that the inability to discharge patients would
10 be investigated, and in particular the impact of that
11 inability on hospitals. Ms Carey has clarified this
12 morning that that will also include the impact on
13 patients who are receiving healthcare, and we welcome
14 that, but we press on the Inquiry to really ensure at
15 every level of the issues that are being investigated
16 that it's the impact on people that will be centre of
17 the Inquiry's attention.
18 The third issue is people's experience of
19 healthcare during the pandemic, not only in terms of
20 clinical treatment but in a more holistic sense. There
21 are issues of serious public concern that don't solely
22 relate to clinical treatment, and one particular example
23 that my clients are concerned about is the isolation of
24 vulnerable parents from their loved ones and their
25 carers. This often had a severe adverse impact on both

1 the individual patient themselves and also the carers,
2 for example on the patient's care, which was very much
3 undermined when the essential carers weren't present,
4 the quality of the remainder of the patient's life if
5 they are completely isolated from their carers and their
6 family, and indeed the family themselves.
7 The fourth issue is end-of-life care. We invite
8 the Inquiry to include in the list of issues end-of-life
9 care as a distinct line of inquiry. This is or at least
10 may be defined differently from palliative care. It is
11 a separate care pathway. It raises additional issues of
12 real public concern, for example how end-of-life care
13 was defined, in what circumstances people were moved on
14 to that care pathway, how patients and their families
15 were supported once they are looking down that pathway,
16 and how decisions were made to refuse life-sustaining
17 treatment.
18 The fifth issue is the exclusion of non-NHS
19 carers, so, in particular, essential or family carers,
20 from healthcare settings. We submit that this is
21 a major issue. The majority of care, including
22 healthcare, is provided by the unpaid sector. The
23 exclusion of these unpaid or non-NHS carers often had
24 a serious impact on the service users' care, their
25 ability to communicate while in healthcare, and on their

1 quality of life more generally. It also made the work
2 of NHS staff that much more difficult.
3 The sixth and final issue which we invite the
4 Inquiry to include within its scope is current relevant
5 healthcare policies and systems so far as they are
6 relevant to paragraph 2 of the terms of reference.
7 Paragraph 2 being the requirement to identify lessons
8 that will be learnt.
9 We submit that it's necessary to understand the
10 current systems and policies in order for the Inquiry to
11 identify lessons to be learnt. Mr Wagner has already
12 touched upon this, but just to give an example, in order
13 to understand where the changes need to be made in the
14 future, for example, on the policy on preventing contact
15 with family or essential carers, it's necessary for
16 the Inquiry to understand what the position is now,
17 otherwise it may not be clear whether or not changes
18 need to be made.
19 So at least for that purpose we invite the Inquiry
20 to include the current situation within its scope.
21 So in summary we invite the Inquiry to confirm in
22 writing that the issues that I've gone through will be
23 investigated, either in another module or, if it forms
24 part of this module, then they should be identified
25 within the list of issues.

The reasons it is important that that is clearing in writing I'm sure are obvious but, just to put it briefly, the decisions about which documents will be obtained, which questions will be asked of witnesses and even, perhaps, the results of the Listening Exercise may be informed by the written list of issues.

Evidence gathering. A number of CPs have invited the Inquiry to disclose Rule 9 letters. If that's not going to be done -- we support that submission but, in the alternative, if that's not going to be done, then we would ask the Inquiry at least to consider on a case-by-case basis whether to disclose those letters. I've seen a number of occasions when it's not possible to understand the contents of the witness statement unless one sees the letter of questions that -- the Rule 9 letter. For example, witness statements might say, "My response to question 6 is no". So we would ask the Inquiry at least to consider that on a case-by-case basis.

The Listening Exercise. We look forward to reading the newsletter and listening to the webinar that, my Lady, you mentioned earlier, but within that we invite the Inquiry to give further information on two issues.

Firstly, how will the individual responses feed in

to the relevant module? Many people we have contact with are discouraged from being involved in the Listening Exercise because they are not convinced there's any point to being involved at this stage. Three practical suggestions we have for what further detail may be given to people as to how the outcome of that exercise may inform the rest of the Inquiry are as follows.

Firstly, although it's going to be anonymised, can summaries of individual cases or quotes from individual cases find their way into reports? Secondly, can a qualitative analysis of responses be done in respect of particular themes? It may be that those themes come from the list of issues in each of the relevant modules or it may be that those themes will develop as time goes on.

A couple of examples of things which may be relevant in this module are as follows: isolation of loved ones from carers in the healthcare context; the types of problems that that leads to, and what lessons may be learned.

The third suggestion we have for the Listening Exercise is a statistical exercise. There may be problems doing that in a number of contexts but, in respect of topics such as discrimination, it may be that

the data that comes back from the Listening Exercise can properly inform a statistical analysis.

The second area in respect of the Listening Exercise which we invite further information from the Inquiry on is how the Inquiry will involve those who have difficulties communicating in the exercise. We reiterate Long Covid groups' submissions on this. My clients and a number of other Core Participants are in a good position to try to help the Inquiry with the best way to try to involve those individuals, and so we very much welcome consultation with our clients as to how that's best done.

The final issue I would like to address is the point about an interim report. CVF invited the Inquiry earlier to produce an interim report and we would reiterate that invitation. We agree that there's a pressing need for an interim report in respect of certain topics. In addition to that one that was mentioned by Mr Wagner, a number of people in the healthcare context are still subject to very serious restrictions on their contact with family members with carers and so on, with the serious adverse impact that I've mentioned already.

Interim recommendations will be of real value to improving the very difficult current circumstances that

those people face.

Unless there's anything else I can assist you on, those are my submissions.

LADY HALLETT: No, thank you very much indeed, Mr Straw. Many of the points you made were made to me during the consultation exercise and I see considerable validity in them -- things like the end-of-life care -- and there were some very distressing accounts that I heard in the consultation exercise. So I shall try to ensure that we make explicit, if it is not already explicit, that these matters will be investigated.

Thank you for your help.

Submission by MR BURTON, KC

MR BURTON: Good afternoon, my Lady. I appear today on behalf of the Disability Charities Consortium, instructed by Anne-Marie Irwin at Rook Irwin Sweeney, a firm with a long established reputation for representing disabled people. The Consortium is a coalition of disability charities in the UK, consisting of: the Business Disability Forum, Leonard Cheshire, MENCAP, Mind, the National Autistic Society, Royal National Institute of Blind People, Royal National Institute for Deaf People, Scope and Sense.

The Consortium, the DCC I shall call it, has been in existence for over 15 years, reaches a large majority

with 14 million disabled people in the UK. Its member organisations address the broad range of issues that disabled people face and, indeed, during the pandemic the DCC met regularly with the disability minister, the Disability Unit in the Cabinet Office, and indeed with the Prime Minister's office.

I'm also very recently instructed by one particular member of the DCC, which is Mind, who have been given CP status in their own right.

When in my submissions I refer to the DCC, my Lady, that includes Mind, and if I do mention Mind specifically it does not mean the DCC does not agree, it is just that was a point specifically taken by Mind.

My submissions will cover four topics: (1) why is the DCC involved in the Inquiry, from its perspective; (2) three overarching points made by the DCC; (3) the agenda items for today, which I will take very briefly; and then finally, cross-cutting issues.

My Lady, by combining the submissions of the DCC and Mind I hope to take only 15 of my allotted 20 minutes, and, as we all know, counsel's self-proclaimed time estimates are always reliable ...

So why is the DCC involved in this Inquiry? Well, of course, disabled people's healthcare needs and their access to appropriate and necessary healthcare during

the pandemic would have been of high level importance to the DCC in any event. But what we know is this, that one in five people in the UK are disabled, 14 million people as I mentioned a moment ago, but astonishingly three in five of those people who sadly died because of Covid-19 were disabled people. Three in five, my Lady.

Moreover, the disparate impact on the pandemic on disabled people was not limited to mortality, restrictions generally and specifically restrictions on healthcare services for non-Covid related health needs had a particular adverse impact on those with physical and mental impairments. By way of one example, Mind state in their written submissions that it provided a helpline during the pandemic -- indeed, throughout the pandemic and before and since -- during which they supported nearly 130,000 people in one year alone, a record amount of contacts, that had been rising rapidly during that period. There was a marked increase in the level of distress displayed by the beneficiaries of the hotline, including many citing that they had been unable to access services.

My Lady, there are doubtless other examples, myriad examples indeed, of disparate impact on disabled people during the pandemic, and it will be one of the main purposes of your Inquiry to understand the extent

of those disparate impacts, and indeed their causes, a matter to which I shall return at the end of my submissions.

Topic 2, my Lady, the DCC's overarching points. Now, there are three of these. They are made in our written submissions, but if I may I am going to briefly touch on them orally now because they are of such significance we say.

First, without detracting from its significant role and representative capacity described above, the DCC and its members do not purport to speak exclusively on behalf of all disabled people. Indeed, it would be a mistake to treat disabled people as a single homogeneous group with the same interests and points of view. The DCC therefore promotes as equally valid the autonomous voices of individual disabled people, and believes that their experiences should be prominent in the Inquiry. Similarly, the DCC recognises the distinct perspective and important role of disabled people's organisations.

My Lady, you will know that for the purposes of indirect and disability discrimination outlawed by the Equality Act 2010, to share the protective characteristic of disability is to share the particular disability of the person discriminated against.

Conversely, the duty on public authorities to make reasonable adjustments to remove disadvantages is an anticipatory duty and applies to all mental and physical impairments. That's an important distinction that this Inquiry must be sensitive to during its work and in particular when looking at inequalities.

I just take that moment also to agree with the submission made by other CPs that it would be preferable if the Inquiry could use person-first nouns in its work, so, for example, "disabled people" rather than "the disabled" or "older people" rather than "the elderly".

The second overarching point is that there is a risk in the Inquiry and in Module 3 in particular of eliding disability with ill health or medical vulnerability, and thereby assuming that because Module 3 is concerned with healthcare it is *ipso facto* addressing the needs of disabled people.

This would obscure the necessary focus on the social model of disability which holds that people are disabled by barriers in society and not by impairments or medical needs, and narrow unduly the scope of the module to the exclusion of the rights of disabled people? Even in a pandemic the interests of disabled people are broader than the universal right to

healthcare.

My Lady, the finally overarching point concerns reasonable adjustments and accessibility for the Inquiry generally. I can take this very briefly. The DCC has previously set out recommendations to your team in relation to reasonable adjustments. I know that similar ones have been made by other groups, including the Long Covid group, and I endorse the comments made by Mr Metzer King's Counsel this morning in that regard and also welcome Ms Carey's indication that the Inquiry team have looked at the suggestion about people who are incapacitous being able to participate in the Listening Exercise, in particular.

My Lady, then moving to my third topic, the agenda items, which I hope to take fairly briefly. Like all the other CPs, of course the DCC intends to work as hard and as quick as the Inquiry team, as best it can, and as a friend to the Inquiry, if albeit a critical friend at times. If I can just take, though, the particular topics that have been raised and just make a couple of observations. The first is designation of Core Participants. Mind, in particular, highlights the lack of any representation of gypsy, Roma and traveller groups in this module and regrets that. It's a particular concern for Mind because the evidence, such

as it is, is that the health disparities for that particular group are particularly acute. For example, they have a much higher rate of suicide than non-GRT groups.

On the question of scope, there are, we now count, at least three as soon as possibles. We are going to have clarity regarding future modules, a list of issues for Module 3, and doubtless further information about the specialist areas that have been identified by your team in the provision of expert advice. Of course we look forward to all of those. We just make two related points about scope at this stage.

Mind say that mental health specifically should be mentioned within the scope for Module 3. Mental health services have been long recognised as Cinderella services in comparison to those addressing physical impairments, and indeed Mind has suggested that Covid-19 has created a secondary pandemic of poor mental health. They point out that mental health services are provided in a multitude of different settings not limited to hospitals or GPs and "as such the generic reference to healthcare may simply not be recognised by many people as including mental health or psychiatric care".

Related to that is Mind's astute observation -- I can call it that because I didn't draft their

submissions -- is that particularly when looking at the impact of Covid-19 it will be important for this Inquiry to understand how voluntary services fared. We heard from counsel the Inquiry this morning that Module 3 will only be looking at the NHS as the provider of mental health services. We believe that would be a relevant and significant omission. Mental health services, in particular, are very reliant on third party provision, not least because of the dearth of provision available in the mental health system. It wouldn't take a lot of time but it would be a very important facet of the overall investigation of the impact of Covid-19 on the provision of healthcare in the UK.

The next topic is evidence. On this issue I can't really improve on the submissions of my learned friends this morning or indeed in their written submissions. A number of just very short observations. We note that NHS England has taken a rather optimistic view about how experts and letters of instruction will work. I'm sure that's not intended as a form of reverse psychology on the team, but we very much endorse that observation and hope it transpires to be correct. It's premised on CPs having enough time to consider experts, albeit that they won't actually be able to input on the letters of instruction.

On the Rule 9 issue, we are again aligned with the other CPs in terms of our view that the concerns about micromanagement effectively by a committee of CPs in terms of Rule 9s is probably overstated and it's very difficult to see how participants can assist the Inquiry adequately without sight of the Rule 9s, and I can't, as I say, really improve on Mr Straw's observation that he made a moment ago. If we have to spend time deducing what has been asked from what has been said then that, of course, is time not spent otherwise helping the Inquiry.

There is also the point made by a number of others that we should perhaps have more time to make submissions for hearings. That's something again the DCC would agree with. My Lady, it won't be lost on you that there's a common theme to all of these, which is time. It's true, of course, that lawyers always want more time, but please ignore their pleas, or put them to one side. It's really about the clients here and, in particular, the DCC is nine large institutions trying to formulate responses to these very important issues that are raised. A bit more time would help the DCC provide a more focused response and thereby assist the Inquiry further.

So moving on then, finally, to my last topic,

which is cross-cutting or overlapping issues. I had initially considered it necessary to address you on three of those. I'm still going to do that but I think the first two can now be taken very quickly because it does seem that the DCC is largely -- well, CTI and DCC largely see matters in the same way. The first is about the care sector and care homes and the question should Module 3 examine the highly controversial and tragic handling of the discharge of patients from hospitals to care homes, an issue you will understand, my Lady, of very considerable importance to DCC.

It is plainly right that discharge decisions, as they were being made by healthcare providers and not social care providers, should be squarely within the scope of Module 3. But the Inquiry should probably stop at that point.

We agree with the submissions made by bereaved families that we mustn't allow, as it were, inadvertently the issue of care homes to be dealt partially in Module 3 and then partially in Module 4. It must be given its proper place in Module 4. What we have to do obviously is just have a clear and logical division between Module 3 and Module 4.

I am calling it Module 4. That might be somewhat optimistic, maybe it's not going to be Module 4! But

insofar as care homes is the next module or another module, then of course ensuring we've got that clarity is important, and we were encouraged by counsel to the Inquiry's submissions this morning about how that delineation between healthcare and social care should work.

Second one, similarly on devolved issues, Bereaved Families Cymru made a submission. You have already heard responses to it this morning. We agree with counsel to the Inquiry, it is not necessary to have separate modules to look at the devolved nations and indeed the capacity to make comparisons may lost by a sequential examination of the devolved areas. You would then have to come back and have some kind of wrapping-up further module. We don't think that's necessary.

I would just highlight, however, that the DCC has raised in its written submissions a concern about where and at what point the Inquiry will consider "poor co-ordination of healthcare services across the borders of the devolved administrations". And if necessary that might be something that we would seek to raise as an addition to the scope of Module 3 if it wasn't otherwise clear that that would be dealt with during Module 3 subject to its current delineation and scope.

So that just leaves me to the last point, which is, in my submission, the chief cross-cutting issue in the Inquiry, which concerns discrimination. My Lady, you have placed equality issues that forefront of your Inquiry. It's easy to understand why. It's incontrovertible and, to a certain extent, well known, although perhaps not as well known as one might expect, that Covid-19 had disparate impacts on people who share particular protected characteristics. True it is that the impact of Covid-19 on those people who share that protected characteristics is to be the subject of a future module, and doubtless the specific disparate impact on disabled people, for which my clients are concerned, and people of specific ethnic backgrounds, again an issue raised specifically by Mind, will be identified, measured and explored extensively within that module.

But, my Lady, what of the causes of those disparate impacts? Why did they happen is the critical question for this Inquiry. The impacts themselves may be reasonably well known but they are not well understood. To the extent that the cause or causes of those disparate impacts is to be found in our healthcare systems, then those must be firmly within scope in Module 3. The Inquiry must therefore be vigilant to

ensure that when seeking, commissioning and listening to evidence in Module 3, it has its eyes and ears wide open and proactively seeks to justify potential causes of disparate impacts.

The imperative to come back to the causes after we have heard of the impact in a later module may be compelling but the opportunity to do so effectively may have been lost by then.

A related point on this concerns the state of healthcare systems at the outset of the pandemic. Identifying causes will inevitably involve the question of whether those disparate impacts were the result of decisions or failures to act that pre-dated the pandemic or acts or omissions made in the face of the pandemic, or perhaps as is more likely a combination of the two.

This must mean that the comment made by counsel to the Inquiry at paragraph 34 of the written submissions must be treated with caution. It is said there it is not part of the Inquiry's terms of reference to consider the state of healthcare systems in the United Kingdom prior to the pandemic save where necessary to understand how the pandemic impacted on healthcare systems.

It's our view that that exception is so large as to almost eliminate the first premise. It will be necessary, in our submission, for the Inquiry to

understand what the state of play was coming into the pandemic.

Ms Munroe this morning on behalf of the bereaved families set out very eloquently, in our submission, the relevance of structural racism. We would endorse those submissions and repeat them and make the same in relation to structural ableism. You may have noted, my Lady, it took a very well known Radio 1 DJ, Jo Whiley, to highlight, for example, the clear discrimination against the learning disabled in the context of healthcare in 2020 and 2021. It really does beg the question, why did it require a high profile celebrity and a media campaign to bring that issue to the attention of the public and eventually, indeed, policy makers?

Just finally on that point about the state of healthcare pre-pandemic, the DCC agrees with the submissions made by the TUC and NHS England that, in fact, the premise is probably incorrect. Preparedness, initial capacity and resilience are all within the terms of reference for the Inquiry and, as such, the state of healthcare systems at the outset of the pandemic are squarely within scope and should remain there.

My Lady, just by way of reassurance, this would involve no radical departure from what we intend to

consider in Module 3 in any event. Two examples: first, triaging of care, which has been identified by bereaved families; and the identification of the clinically vulnerable, which Mr Wagner has just been addressing. Two matters already within scope but clearly questions arise: what role did triage and the identification of clinically vulnerable people have on the demographic break down of those affected by the virus?

Those are points developed further in our written submissions but I make them now just to point out that really it's not a radical departure to examine causation of disparate impacts in Module 3 if we're already looking at those issues.

We are reassured that this morning counsel to the Inquiry, Ms Carey, said that the Inquiry will look that impact of cancellations and delays on patient care and any equality issues that arise therefrom. That does appear to be an indication that the submission I've just outlined a moment ago is likely to be endorsed by the Inquiry and, if that is so, of course the DCC and Mind would be very happy.

There is just one final point to make about this, another compelling reason why equality should remain squarely in scope and causation in Module 3. Sir Martin Moore-Bick in the Grenfell Inquiry decided to

reverse his previous decision, or previous course, and resolve the question of whether or not the refurbishment of Grenfell Tower had been compliant with building control in his phase 1 report. He did that partly because it was an issue of such importance that an opportunity to consider it early was too important to miss, and it could be done. We say exactly the same thing here about equalities and causation.

Indeed, my Lady, you have identified and reaffirmed your commitment to making interim recommendations where appropriate. This may be an area in which the use of that power could be of very great effect. If you identify causes in our healthcare systems of disparate impacts, then necessarily you will wish to consider whether something should be done about that now rather than waiting until later.

That may, of course, benefit many people who have otherwise been the unremitting victims of this terrible virus and pandemic.

My Lady, those are my submissions on behalf of the DCC and Mind, unless I can assist further at this stage.

LADY HALLETT: No, thank you very much indeed, Mr Burton. I welcome very much the offer from your lay clients of being a friend, albeit on occasions a critical one.

Can I just ask that any criticism, should it be

forthcoming, is as constructive as your submissions have been today. Thank you very much.

MR BURTON: Thank you.

LADY HALLETT: Right, Ms Gallagher.

Submission by MS GALLAGHER, KC

MS GALLAGHER: My Lady, as you know, I represent the Trades Union Congress, the TUC, along with my colleague Mr Jacobs, instructed by Thompsons. We have made detailed written submissions in advance. We are mindful that you and your counsel have seen those considered them before today's hearing and so many of the points I don't need to deal with orally.

In addition, my Lady, we stand by our submissions made in previous modules concerning the centrality of effective representation and effective participation for Core Participants, a topic on which we and the four bereaved family groups, in particular, have repeatedly made submissions in prior modules in one voice albeit with our many varied accents.

I intend to address the following four points today including responding to points made by counsel to the Inquiry this morning in her opening where necessary.

Number 1, I intend to introduce the TUC's role and interest in this module and set the context for our submissions.

Second, I'm going to return briefly to that issue of effective participation but also early participation. I can take this shortly because we strongly support the submissions made this morning by Ms Munroe concerning the vital importance of effective participation of Core Participants. We've got some short supplementary further points to make under that head.

Third, and this will be a longer topic, and it arises from oral submissions this morning, we want to deal with matters that are said to have a broader reach than Module 3 and, my Lady, it's a response to counsel to the Inquiry's submissions this morning regarding why she counsels against you investigating in this module two specific matters which she says have a far broader reach than this module or indeed the terms of reference for this Inquiry and so should not be the subject of specific investigation here. They are (a) structural racism and (b) recruitment/retention issues concerning healthcare staff.

We're very grateful to counsel to the Inquiry for the work that they've done and the position they have taken on many issues. This topic, I'm afraid, is one on which we take issue with CTI's reasoning. We urge you to adopt a different approach. We say they are two vitally important issues. They must be at the heart of

what you do in Module 3.

Fourth, very briefly, my Lady, we've got some specific additional matters concerning scope for this module which does include the relevance of pre-pandemic and post pandemic matters and both of which we say are not excluded from your terms of reference and indeed are vital to fulfilling your statutory role.

On post pandemic matters, I can take this briefly because we agree with Mr Wagner's point. We were going to make it, he has made it and made it did very well this morning -- or this afternoon, regarding post pandemic matters being of vital importance to your recommendation power.

So first, my Lady, the TUC's role and interest. The TUC brings together 5.5 million working people who make up its 48 member unions across all parts of the UK. They span a wide range of industries profoundly affected by the Covid-19 pandemic. But it's 11 of the TUC's affiliated unions, representing collectively many hundreds of thousands of members, who have a particular interest in this module. I know you have them from paragraph 8 of our written submissions, my Lady, but given the importance of open justice and the importance to those unions, I name them here. They are:

The Royal College of Midwives, representing over

50,000 midwives, student midwives and maternity support workers and you will know from our written submissions that indeed we echo many of the submissions made by Mr Wagner for the groups he represents today.

We also include the Chartered Society of Physiotherapy, representing over 63,000 physiotherapists, support workers and students.

The Hospital Consultants and Specialists Association, the UK's only professional association and trade union focused solely on hospital doctors, representing over 3,000 members.

The Society of Radiographers.

Unison, a general union whose representation includes a very broad range of medical, clinical, administrative and support staff in the healthcare sector and the NHS.

Unite, similarly a general union with large representation of a broad range of people working in the healthcare sector.

The GMB, a general union representing over 35,000 members across the NHS and ambulance services across the UK, a broad range of other medical related staff.

The British Dietetic Association, representing 10,000 dietitians and support workers.

The Royal College of Podiatry, representing over

50,000 NHS and other chiropodists and podiatrists.

The British Orthoptic Society Trade Union, representing orthoptists.

And the Prison Officers Association, representing staff in secure psychiatric settings, who of course we must not forget when considering healthcare.

Now as that list makes abundantly clear, the TUC and its affiliated unions include a very wide range of healthcare workers who worked in the sector during the pandemic, from consultants to hospital porters, midwives to patient transport service drivers. Those hundreds of thousands of people who are represented by those 11 affiliated unions to the TUC were on the front line. Hundreds of them, as you have heard from Ms Carey this morning, died whilst working during the pandemic, with a disproportionate and devastating toll upon healthcare workers from a black minority ethnic background, including many migrant workers on whom the NHS depends.

Many more healthcare workers contracted Covid-19 at rates far in excess of those in the general population. Once infected, the statistics show us that they experienced severe infection, again at a rate far in excess of the general population. Many suffered debilitating and long-term effects of Long Covid, having contracted Covid in an unsafe workplace, and all have

worked in extremely stressful and traumatic conditions, experiencing the loss of their own loved ones, family members and colleagues.

Often, indeed we believe the evidence will show in the vast majority of cases, those workers were exposed to risk of infection with inadequate provision of PPE or other workplace mitigations.

The reality on the ground for healthcare workers, my Lady, and the persisting reality of workers being expected to shoulder unacceptable risk during the pandemic, contrasts sharply with the public mood at the time and, indeed, performative actions from Government ministers at the time. You will recall that Government ministers joined millions of members of the public standing on their door steps every Thursday night at 8pm banging pots and pans to show our united public affection for those in the NHS and carers saving lives.

The UK showed its appreciation in highly visible ways, rainbow pictures in windows, public buildings being lit up in the blue of the NHS. Boris Johnson, then Prime Minister, stated on his hospital release that the NHS was, and I quote, "powered by love". And in April 2020 Matt Hancock, then Secretary of State for Health and Social Care, announced that critical care workers during Covid-19 who had put their lives on the

line would be issued with a blue badge to mark their commitment and to show the Government's gratitude.

But in reality, healthcare key workers were seeing, every day, fundamental failings by their employers and by the Government placing them at serious risk. Within weeks of the first lockdown it was widely known that healthcare staff had inadequate PPE, were having to risk their own lives, their loved one's lives and their patients' lives in flimsy paper masks and inadequate plastic aprons.

Doctors and nurses we knew within weeks were having to source their own PPE, buying it from B&Q, adapting sports equipment, relying on local charities. One doctor reported to the Times in March 2020 that she had been coughed on all day by an extremely ill Covid-19 patient whilst not wearing a visor or any other protective covering and she said she had to borrow and adapt her 9-year old's safety specs that she got in a science birthday party bag.

The reality is that many of those rightly lauded key workers died because their own employers, their own Government failed in its most basic duty to protect them. The cheers, the clapping, the pots and pans and the blue badge can't drown out that terrible truth and, indeed, the meagreness of the blue badge gesture, in

a context where the NHS had, by the start of the pandemic, been subject to a decade of austerity policies, is at the heart of the TUC's concerns in this module.

That's indeed why academics professor, Professor Helen Wood, and Beverley Skeggs as early as April 2020 called for a move from care gratitude to care justice. They said, within weeks of the pandemic starting, the irony of a Government that voted against a pay rise for nurses numerous times, most recently in 2017, and that withdrew nursing bursaries while charging nursing students £9,000 a year in tuition fees, leading to a drastic reduction in nurse applications, now declaring their love for the NHS and very publicly applauding it, is not lost on us.

That mismatch for the TUC is at the heart of their work in this module and also at the heart of the TUC's work is the grossly disparate impact in terms of race for healthcare workers, an issue on which we appreciate we have considerable impact with a number of the other CPs.

My Lady, may I give you one statistic at the outset and then I will move on to the other points.

Of the 1.2 million people employed by the NHS, 20.7 belong to black, Asian or minority ethnic

background. About one fifth. Yet analysis conducted as early as April 2020 showed that of the 119 NHS staff known to have died in the pandemic by that time, 64 per cent were from a BAME background, more than two thirds. It's critical that when the next pandemic arrives, the healthcare sector is better equipped to transform the numbered of deaths downwards, minimise the many challenges and traumas of providing healthcare through a pandemic. We say at the outset that cannot be done unless those two key underpinning systemic issues, the undervaluing of healthcare workers (including retention and recruitment strategies) and structural racism, are at the heart of the Inquiry's work, otherwise Module 3 cannot do its job and will not be fit for purpose.

The second point I can take very quickly, on effective participation and early participation. We agree with the submissions made by others. We commend to you in particular the submissions made by Ms Munroe this morning and Mr Burton. We say effective participation must mean early participation at a time that can make a difference to the direction of travel of this module.

We noted a reference today to the next phase of the Inquiry being revealed in the summer, and it sounds

to us as if that may coincide with the substantive hearings in Module 1 commencing in relation to preparedness. We urge again -- I appreciate, my Lady, you have heard our submissions on this and we are conscious on what you said after our submissions at the end of the Module 1 hearing most recently. We appreciate that the Inquiry's thinking is evolving. We ask that we are part of that process rather than having a *fait accompli* at a stage when the preparedness module is already starting.

We're all subject to the confidentiality undertaking. We ask that we're brought within the Inquiry's circle of trust and we can contribute to their thinking in its development phase rather than hearing about it later.

We also under this heading -- and I am very grateful to Ms Carey for indicating that there will indeed be a hearing later in 2023. You have seen our submissions at paragraph 20. We're grateful for that indication because it is a vital importance that distilling and developing the list of key issues for this module includes Core Participants, and we think autumn 2023 is a sensible time given the timeline for disclosure.

My Lady, our third point on broader issues. This

is the one issue on which we take issue with Ms Carey's approach this morning. So on both systemic racism and recruitment retention, our understanding of the submission made to you this morning by Ms Carey was essentially: these are both broader issues than the pandemic only and so should not be looked at here.

In our submission, that is not persuasive. The fact that those issues run broader than Module 3 and indeed run broader than your terms of reference is not a reason to disregard them. Now, of course, we're not asking you to conduct a role which steps on the toes of others, who would look at much of the detail, for example, about the precision of nurses' pay, for example, but those issues must be on the table and, in particular in relation to structural racism, it's essential in our view that we do have expert input.

On structural racism, the answer in essence, as we understand it, was: we're aware of this, it's running through everything we're doing, we don't need to have an expert. But being aware of the impact and those devastating figures, of which we heard from Ms Munroe earlier, some of the figures which I have just given you, being aware of the impact, the differential outcome, doesn't mean understanding the why and the only way in which we can understand the why is to engage with

the substantial academic expert work which has been undertaken on those issues and, we say, cost effectively and resource effectively to engage an expert to deal with those issues.

Our submission is that the argument to the contrary is not persuasive. Similarly on recruitment and retention, it's essential that we look at those issues. We're in a position where just last week the TUC had evidence that one in three healthcare workers is actively considering leaving their role because they feel undervalued. There's evidence very recently from the TUC that hundreds of thousands of NHS workers have lost at least a year's worth of salary as a result of their pay not keeping pace with inflation since 2010. That includes, for example, midwives suffering a cumulative pay real terms loss of £48,000 since 2010, equivalent to 14 months' worth of salary. We don't expect those issues to be delved into in a way that the National Audit Office or another body would, but it is, we say, not going to be feasible to proceed with Module 3 if you are not looking at those realities, about what was fuelling recruitment and retention crisis across the NHS, and, indeed, when we had those deaths, what was then done about filling those gaps.

Fourth point concerns scope.

We recognise that the provisional scope document is high level; specific issues will crystallise and be developed at a later stage. We just make some short points. At first we've proposed one modest but, we say, important amendment to the provisional scope outline. We didn't hear a response to that earlier from Ms Carey, not quite as optimistic as Mr Wagner that that means it's definitely included, because when reference was made to this sentence it wasn't referred to. It just is the addition of two words, my Lady, as follows, in paragraph 10, the reference to "deaths caused by the Covid-19 pandemic in terms of the numbers, classification and recording of deaths" be amended to instead read "deaths caused by the Covid-19 pandemic in terms of the numbers, classification, recording and investigation of deaths".

We want to avoid a situation where the key issue about regulatory and investigative responses to reported deaths at the time, which raises Article 2 and, indeed, Article 3 ECHR issues, that that's not overlooked. So it's two additional words, and we suggest it be included.

That doesn't prevent you having the Lewis type function later of deciding that actually applying the funnel approach. This is not an issue you will look at

in detail for the hearing. But we suggest in the high level document it should be included.

Second, we support Mr Wagner relating to antenatal and postnatal care. You have our written submissions on that.

Third, in our written submissions we've raised concerns about paragraph 34 and we echo Mr Burton's submissions just now. That's the reference, save where necessary, to understand how the pandemic impacted on healthcare systems. Because that's such a critical issue.

Finally, in relation to scope you have our submissions in writing which we echo again, that it refers already in the provisional outline of scope document to issues such as staffing levels and critical care capacity, availability of healthcare staff. That must require direct evidence as to the state of healthcare systems at the time and it must involve looking at some of the underlying issues concerning recruitment and retention as raised by the RCN.

Now, those structural and funding deficiencies in the healthcare sector impacted severely upon the resilience of healthcare services. The perspective of our unions is that these sorts of issues are central to understanding how the pandemic impacted on healthcare

systems and also it's going to be a vital importance to recommendations.

We're very mindful, my Lady, of the fact that recommendations and early recommendations are at the heart of what you wish to do. We consider this issue must be at the heart of Module 3.

Unless I can assist further, my Lady, those are our submissions.

LADY HALLETT: Thank you very much indeed, Ms Gallagher. I will bear in mind very much indeed, obviously, the submissions you have made, and I continue to review previous submissions that you have made as well. Thank you.

Ms Morris, please.

I apologise to all those who merit the initials KC after their name, I haven't been using them. I should have done. Partly I'm not used to it yet. Still in the QC mode.

Submission by MS MORRIS, KC

MS MORRIS: Good afternoon, my Lady, I represent the Royal College of Nursing. I have a few observations to make which are relatively high level and then one or two more specific points arising out of the points which have been made by my colleagues.

The Royal College of Nursing has a membership of

almost half a million registered nurses and more than 300,000 of those work in the NHS. Members are also midwives, health visitors, nursing students, healthcare assistants and nurse cadets, and so the College is the voice of nursing across different jurisdictions of the UK and the largest professional union of nursing staff in the world.

The College of Nursing is both the professional body for nursing and a trade union and campaigns on the issues of concern to nursing staff and patients, including pay and terms and conditions. It influences health policy and it promotes excellence in nursing practice.

Of central importance, with a view to the Royal College of Nursing's role in the Inquiry, is that nursing is the largest safety-critical profession in healthcare. It's vital to patient safety that there are the right nurses and other members of the nursing family with the right skills in the right place at the right time and the pandemic highlighted the critical role that nursing plays in protecting, improving and sustaining health.

So throughout the pandemic nurses worked in hospitals, schools, care homes, GP surgery, prisons and homes, and the College of Nursing supported their

members there.

Just to give a few examples of its work that have particular materiality for the work of the Inquiry, the RCN provided support services and ran a call centre where nursing staff from across the UK sought advice and accessed specialist representation. Since the start of the pandemic it's received 25,500-odd calls to do with issues on Covid-19, and the Inquiry will see the vividness of what those calls show.

It's also given the Royal College of Nursing a particular insight into the day-to-day frontline experiences of nurses and other allied healthcare professionals, the challenges they faced and the pressures that they were under.

In order to support nurses, the RCN also compiled extensive guidance and advice both in anticipation of and in response to key emerging issues to support nurses through the pandemic in relation to their clinical roles, employment and, to pick up a thread from my learned friend who just preceded me, their mental health and well-being.

This included a Covid-19 workplace risk assessment toolkit to support healthcare professionals consider and manage risks associated with the transmission of respiratory infections, specifically Covid-19, and aid

local decision-making as to the level of PPE required to protect them whilst at work.

The RCN also undertook influencing and campaigning. For example, it led a coalition of health experts to demand that the Prime Minister urgently tackle the inadequate protection of nursing staff from Covid-19. It undertook engagement with its members in order to inform its work and also it developed research and compiled data, and therefore played a key role in furthering scientific understanding, through research, to inform UK health guidance. For example, the RCN commissioned an independent review of guidelines for the prevention and control of Covid-19 in healthcare settings in the UK and in evaluation and messages for future infection-related emergency planning.

In this way, the Royal College of Nursing represents the voice of nursing and its members have unique story to tell of their experiences working during the pandemic. They are the largest staff group in the NHS, they are predominantly women, and nearly 25 per cent of them are from a black and minority ethnic background. They were and remain the frontline response.

Of the College's hopes for the Inquiry, there is a particular focus on the future. It is imperative for

the nursing profession, its leaders and its patients, that the failures of Government and other agencies must be identified and reported on and lessons learned.

Nurses and healthcare workers will be on the front line of the next pandemic, and the RCN has a responsibility to ensure anything that went wrong, things that could be improved, are reported on and acted upon in the interests of nurses and the patients to whom they provide care.

The Royal College of Nursing has identified a number of issues as being critically relevant to Module 3. It's not an exhaustive list but it reflects the state of its evidence gathering.

First of all, the obtaining, provision and supply of PPE.

Secondly, the transfer of patients from hospitals to care homes. Now, a number of things have been said about this today but the position of the Royal College of Nursing is that it's not easy to sever the issue of those in care homes from those in hospitals because, certainly, nurses were present in both locations and also that that movement didn't mean that somebody suddenly changed their status in a way which meant either the previous one or the later one became irrelevant and, therefore, we would ask the Inquiry to

think carefully about whether it wishes to move that issue out of this module.

The other area where we make a particular submission is in relation to recruitment, retention, pay and conditions of nursing, and we adopt that which was said by Ms Gallagher KC just now, in that it is particularly, given the critical condition of healthcare services today and given the need for the Inquiry to focus on the future, an issue which requires to be addressed in this module, not only in the interests of consistency and its inclusion but also because it is such an urgent contemporary imperative.

The other issues which the Royal College of Nursing would highlight are the infection and death rates for nurses and healthcare workers, and particularly those from particular minority communities; the provision of death in service benefits and the removal of the NHS surcharge for non-UK healthcare staff; and the requirement for RIDDOR reporting, Covid-19 related occupational illness and death; the patient experience of healthcare throughout the pandemic and recovery planning; and the impact of the pandemic on the mental and physical health of the nursing and healthcare workforce, including professionals who were pregnant, clinically vulnerable, or redeployed.

The Royal College of Nursing hopes that the Covid-19 Inquiry will increase awareness of the need for proper staffing to ensure safe and effective patient care and promote its provision. The Royal College of Nursing's principles for staffing for safe and effective care are as follows. Accountability: we want it to be clear whose job it is to make sure there are enough nurses to meet patients' needs. Numbers: we want the right number of nurses with the right skills to be in the right place at the right time, so patients' needs are met. Strategy: we want a vision for tackling nurse shortages and making sure nursing helps meet the whole country's health needs. Plans: we want clear plans for getting the right numbers and skill mix of nursing staff, and we want checks to make sure it really happens. Finally, education: we want governments to educate enough nursing students and develop its existing staff so that they can meet patients' needs.

That's the conclusion of my submissions.

LADY HALLETT: Thank you very much indeed, Ms Morris. We share the same hope, which is looking to the future, and it is why I came out of retirement to accept this role. So I hope, with the assistance of the Royal College of Nursing, we can make some sensible recommendations for the future. Thank you.

1 It is now time to take a break. I shall return at
2 3.35, please.
3 **(3.20 pm)**
4 **(A short break)**
5 **(3.37 pm)**
6 **LADY HALLETT:** Mr Stanton.
7 **Submission by MR STANTON**
8 **MR STANTON:** My Lady, thank you for this opportunity to
9 address you. I appear on behalf of the British Medical
10 Association and the National Pharmacy Association.
11 These organisations are represented separately and
12 I will be delivering their submissions separately,
13 starting with the British Medical Association, which
14 I will refer to throughout as the BMA.
15 The BMA is a trade union and professional
16 association that represents the interests of doctors in
17 the UK. It has more than 176,000 members, which is over
18 half of all registered doctors. This is the first time
19 the BMA has sought to address you at a hearing and it
20 does so now to emphasise the tremendous impact on the
21 pandemic on doctors and their patients, to offer some
22 observations on areas for inclusion within the scope
23 Module 3., and to request clarification about the
24 Inquiry's intended approach in respect of issues that
25 are common to multiple modules.

1 I would like to preface these submissions by
2 making clear that the overwhelming priority of the BMA's
3 members is to ensure that they provide the best possible
4 care and treatment for their patients. During the
5 pandemic, doctors and other healthcare staff worked
6 tirelessly to safeguard the nation's health and care for
7 those in need, often at great personal cost to their
8 physical and mental health.
9 As you will be aware, the BMA conducted its own
10 review into the pandemic and published its finding
11 within five significant reports. The second report,
12 published in May 2022, explores the impact of the
13 pandemic on the medical profession and includes the
14 following passages within the introduction. They read:
15 "At the beginning of 2020 the medical profession
16 in the UK was struggling. Doctors were overworked and
17 overstretched, with many considering leaving the Health
18 Service altogether. Stress-related sickness absence
19 rates were high and workforce planning was inadequate.
20 The idea of having to work harder still and in more
21 dangerous conditions seemed impossible, and yet that is
22 exactly what doctors have had to do for the past two
23 years since the Covid-19 pandemic arrived.
24 "The experience of the pandemic among medical
25 professionals remains varied. Some have had their

1 livelihoods affected, many their health, and most their
2 morale. Each experience has been unique and, in some
3 cases, influenced by their ethnicity, gender or
4 disability status.
5 "There is one word, however, which is used
6 repeatedly by the medical professionals to describe the
7 last two years: devastating.
8 "Doctors have been left exhausted, demoralised and
9 unwell. UK health services will never be quite the
10 same. While we may be out of the acute phase of the
11 pandemic, largely due to the successful roll-out of the
12 national vaccination programme, doctors' jobs are not
13 becoming any easier, as they begin to address the
14 mountain backlog of care. Burnout, exhaustion and poor
15 mental health are therefore unlikely to improve
16 overnight, and the intention to leave is high.
17 "Against this context, a key challenge for health
18 services over the coming weeks, months and years is to
19 ensure that there are enough staff to ensure every
20 patient who needs help receives it promptly."
21 My Lady, regarding the scope of Module 3, the
22 BMA's written submissions identifies some 45 issues for
23 inclusion, and in the time available I will simply
24 highlight four broad areas of concern that recur
25 throughout the issues identified.

1 They are, first, resourcing capacity and staffing
2 shortages. Prior to the pandemic, the UK's public
3 health and healthcare systems were understaffed and
4 under-resourced and barely able to cope with pre-Covid
5 levels of demand. Compared to many other OECD nations,
6 the UK entering the pandemic with fewer doctors,
7 hospital beds and critical care beds per 1,000 people,
8 alongside high staff vacancy rates and frequently unsafe
9 bed occupancy levels.
10 This lack of pre-pandemic resilience and
11 preparedness exacerbated the severe disruption to
12 healthcare delivery during the pandemic and resulted in
13 calls for retired doctors and nurses to return to
14 service, medical students joining the workforce early,
15 and the use of volunteers.
16 Staff had to be redeployed, often starting new
17 roles without training or adequate supervision. Many
18 elective procedures, diagnostic tests and routine
19 out-patient services were suspended so that staff
20 resources and beds could be utilised for Covid-19 care.
21 For the BMA it is critical that there is an
22 appreciation and understanding of the lack of capacity
23 and resource within the NHS, public health and social
24 care systems, and of the repeated failures to address
25 the long-standing problem of staff recruitment and

1 retention, which meant that the UK's health systems were
2 desperately under-prepared, with no spare capacity to
3 deal with the pandemic.
4 Higher absences among healthcare workers due to
5 Covid-19, self-isolation and Long Covid have compounded
6 workforce shortages, which unsurprisingly impacted
7 patient care and forced remaining staff to take on even
8 more work.
9 The consequences of these failures are still
10 impacting health services today and there are now over
11 8.9 million people in the UK on waiting lists for
12 treatment. This figure is from September 2022.
13 In this context, we heard from counsel to the
14 Inquiry that in March 2020 there were 5.3 million on
15 waiting lists. That's an almost doubling over the
16 period of the pandemic.
17 Second, PPE and infection prevention and control.
18 The lack of stock and supply of appropriate PPE to
19 protect doctors and healthcare workers who were exposed
20 to a deadly virus while treating patients is an
21 appalling failure. Even now healthcare workers still do
22 not have access to adequate PPE as a result of
23 continuing inadequate infection prevention and control
24 guidance.
25 In the early days of the pandemic, shockingly,

1 doctors who purchased their own face masks were
2 prevented from using them, and on some occasions even
3 had them physically removed. Other doctors and
4 healthcare workers were required to use bin bags as
5 protective gowns, had to rely on homemade PPE, or were
6 being offered expired masks, masks they had to reuse or
7 masks that did not fit correctly.
8 This lack of protection had a profound impact on
9 the medical workforce, including healthcare workers
10 acquiring Covid or Long Covid, and a significant number
11 are still affected now and limited in their ability to
12 work.
13 Infection prevention and control guidance
14 continues to fail to properly recognise the fact that
15 Covid spreads via the air, and this means doctors and
16 healthcare workers have not and are still not being
17 provided with the right level of protection.
18 The third area is equalities issues. The BMA
19 encourages the Inquiry to consider inequalities both in
20 respect of the impact on patients and the health and
21 social care worker force. Information collected by the
22 BMA indicates that over 80 per cent of doctors who died
23 of Covid-19 were from an ethnic minority background, and
24 analysis by the Health Service journal made a similar
25 finding, that 94 per cent of doctors who died up to

1 April 2020 were from ethnic minority backgrounds.
2 In relation to patients, relevant equalities
3 issues will include the impact of pre-existing
4 inequalities on the health outcomes of patients, how
5 inequalities impacted on people's access to and
6 experience of healthcare, for example, those living in
7 areas of higher deprivation, the impact on people from
8 ethnic minority groups, those without official
9 immigration status, and people categorised as clinically
10 extremely vulnerable.
11 Fourth area, health and safety issues. All
12 employers are legally required to conduct suitable and
13 sufficient risk assessments to identify risks to which
14 employees are exposed and to identify steps to mitigate
15 these risks and put them into practice. However, during
16 the pandemic doctors and healthcare workers were subject
17 to a catalogue of failures in this area, including the
18 failure to carry out adequate risk assessments, working
19 without adequate protection from infection, inadequate
20 occupational health support, often as a result of lack
21 of capacity, poor testing infrastructure and capacity,
22 inadequate infection and prevention control policies, as
23 highlighted earlier, and working within ageing estates
24 ill-suited to modern needs and without proper
25 ventilation.

1 Many of these health and safety failures will also
2 be relevant to the Inquiry's consideration of equalities
3 issues, for example, whether adequate risk assessments
4 would have prevented or mitigated the disproportionate
5 impact of the pandemic on doctors and healthcare workers
6 from an ethnic minority background.
7 My Lady, the breadth of scope of these issues just
8 outlined means inevitably that the Inquiry will have to
9 examine them across multiple modules and the BMA would
10 be grateful for guidance and clarification from the
11 Inquiry about its intended approach.
12 In saying this, the BMA fully appreciates the
13 enormity of the task that is faced by you and your team
14 and is in no way critical of the approach taken. The
15 BMA fully appreciates the difficult task of balancing
16 determination of scope, needing to consider sources of
17 evidence against providing direction, and the
18 observations I am about to make will hopefully feed into
19 your considerations in this area.
20 Taking PPE as an example, which is an issue of
21 various significant and ongoing concern within the
22 medical profession, the clarification provided by
23 counsel to the Inquiry about the extent to which PPE
24 will be examined within Module 3 is welcomed and has
25 provided BMA with some assurance in this area. However,

you will be aware that the BMA has also proposed within its written submissions on Module 1 that the lack of adequate and suitable PPE stock and supply should be specifically included within the scope of Module 1 because it is so integral to the issues of resilience and preparedness.

The provisional outline of scope for Module 1 specifically includes consideration of whether lessons were learned from earlier simulations, and the Inquiry will be aware that the recommendations of the simulation exercises, Exercise Alice in 2016 and Exercise Cygnus, also in 2016, included a review of stocks of PPE, the need for pandemic stockpiles in order to ensure availability of sufficient and appropriate PPE, and the development of a whole system approach to the distribution of PPE to health and care staff.

In these circumstances, the BMA's position is that there needs to be detailed consideration within Module 1 of the apparent failure to implement these recommendations and of the failure to ensure sufficient stock and supply of appropriate PPE more generally.

However, if it is not the intention of the Inquiry to examine these issues within Module 1 then the BMA would be grateful to understand at what stage it is envisaged the failure to ensure sufficient and

appropriate stock and supply of PPE and the consequences of this failure will receive detailed consideration, for example, within Module 3 or within a later Government procurement and PPE module.

Similarly, on the issue of resourcing, capacity and staffing shortages, the BMA has noted the recent clarification within the note of counsel to the Inquiry of 14 February, and it has also noted the Inquiry's earlier indications that Module 3 will investigate healthcare systems, governance and NHS backlogs, that staffing levels and the allocation of staff and resources are within scope, and that Module 3 will be a UK system module and will include consideration of the capacity of healthcare systems to respond to a pandemic.

Notwithstanding these helpful assurances, the BMA would still wish to make clear its position as an organisation that is expert in the delivery of healthcare and public health and one which represents the interests of over half of all practising doctors in the UK, that the lack of resource, capacity and staffing within health services prior to and during the pandemic meant that the adverse impact of the pandemic on patients, doctors and other healthcare workers was and continues to be more severe, including worse outcomes for patients and more serious physical and mental health

impacts for doctors and other healthcare workers, than would have been the case had there been better resourcing, capacity and staffing.

The BMA considers that these issues are fully within the Inquiry's terms of reference and also that they will require some consideration within Modules 1 and 2, because health systems were desperately under-prepared and had no spare capacity to deal with the pandemic and, to a significant degree, this necessitated the national lockdowns.

My Lady, those are the submissions on behalf of the BMA.

LADY HALLETT: Thank you very much.

MR STANTON: In respect of the National Pharmacy Association, which I will refer to as the NPA, the NPA is a not for profit membership body which represents the vast majority of independent community pharmacies in the UK. Community pharmacy is part of primary care, together with GPs, opticians and dentists, and it is most well known as a dispenser of medicines.

However, its role is much broader and includes other NHS and public services, for example the provision of health advice, including sexual health services, advice on substance misuse and travel medicines and health checks.

Community pharmacy also administers millions of flu vaccines every winter, the delivery of over 20 million Covid-19 vaccinations since 2021, and the provision of lateral flow tests.

The type of pharmacies represented by the NPA are family-owned, community-focused businesses, ranging from single outlets to regional chains, as distinct from national chains. Over 50,000 people, including approximately 15,000 pharmacists, work in the NPA's approximately 5,500 member pharmacies.

The members of the NPA elect members to sit on the national board, with many NPA board members recognised nationally as leading clinical practitioners. The current NPA chair is an officer of the World Pharmacy Council, and other NPA sit on working groups of the NHS and the General Pharmaceutical Council.

Throughout the pandemic, community pharmacies demonstrated great resilience. They not only maintained the core service of the supply of medicines, which involves the supply of around 1 billion prescriptions every year, but they also increase the provision of expert medicines advice, with 98 per cent of community pharmacies reporting increased any enquiries about serious health conditions.

The NPA has collected extensive testimony from its

members about the impact of Covid-19, and the following account is typical of the commitment, sacrifice and resilience of NPA members in the delivery of their essential services. It reads:

"My wife and I are co-owners of a single independent pharmacy. We are both pharmacists. When the pandemic hit, it occurred to us that if one of the team became ill or got Covid there was the potential for the whole team to go down and that would mean closure, leaving patients without medication, putting them in turmoil. Our big fear was letting people down. The solution we came up with to keep running and safe was to split the team in half. My wife led one half of the team while the other half of the team isolated at home. Whichever one of myself or my wife was working stayed in a hotel for that week. At the end of the week when I was working, I checked I was symptom-free before going home. Even then the family would go to a separate room and I would go straight to have a shower and put my clothes in a bag. Only then would I come down to the family. We'd spend a day together, then we'd swap. We did that for ten weeks. In 23 years of pharmacy, this has been the most challenging time of my career. It has also been the most rewarding. We've not let our patients down. We've come through it."

However, despite this central role in the delivery of NHS care, community pharmacy was often overlooked during the pandemic and it was not given the support that it needed, including pharmacies initially having to source and fund their own PPE, with the NPA and others in the sector having to intervene to secure reimbursement of the cost. Pharmacy workers were not initially recognised as key workers so as to enable their children to attend school while they worked, which again required intervention from the NPA to rectify. There are delays in the provision of Covid test availability for pharmacy teams, which amplified resourcing challenges and, perhaps most inexplicably, community pharmacy was initially excluded from the scheme announced by the Department of Health and Social Care in April 2020 to pay £60,000 when a health or social care worker died from Covid-19 in the course of frontline work. It was only following challenge from the NPA that the scheme was extended to community pharmacy.

Regarding the scope of Module 3, the NPA has suggested within its written submissions over 20 issues including in the following broad areas. First, health inequalities and the needs of vulnerable patients. Here, the NPA suggests that this should include

difficulties in accessing medication and the role played by community pharmacy in delivering medicines to large numbers of vulnerable patients in self-isolation.

Community pharmacies have unique insights into the challenges facing vulnerable patients because they are disproportionately located within deprived communities. They deliver health services to communities that need them most, and by doing so community pharmacies play an important role in reducing health inequalities.

In addition, over 50 per cent of the NPA's membership are from an ethnic minority background, and the NPA as an organisation reflects the diverse background of its membership through a board composition that is generally representative, with eight out of 15 board members coming from an ethnic minority background.

Specific actions taken by the NPA around equalities issues include making the case to the Department of Health and Social Care and to NHS England in March 2020 for the delivery of medicines to vulnerable patients who were shielding. This subsequently led to community pharmacies delivering a significant scheme to support shielding patients through home delivery of their medicines, which required the employment and training of additional staff during the already extremely challenging circumstances of the

pandemic.

The NPA also worked closely with the Home Office on the introduction of the Ask for ANI scheme, which gave victims of domestic abuse a way to seek help through their local pharmacy when other services were unavailable, which was voluntary and included providing access to private consultation rooms and undertaking additional training, again on top of already difficult and challenging working conditions, and it collaborated with charities and NHS England to provide Covid-19 vaccines to those with insecure NHS status, such as people without settled immigration status.

The NPA will also suggest in this area that there is consideration within Module 3 of the contribution made by community pharmacy and other primary care providers during the pandemic to the health and social capital of the communities they serve. For example, the extent to which their role as a hub of the community was enhanced during lockdowns when other social contact was unavailable.

The second area relevant to scope to highlight is the impact of medicine shortages and medicine price increases. NPA members had to overcome challenges in the medicine supply chain, including price rises and a shortage as the global medicine supply chain adjusted

to the pandemic. There were also local supply challenges as large numbers of patients were transferred on to longer prescriptions, for example a three-month supply versus the previous usual one month's supply which put acute pressure on supplies.

In Northern Ireland, the Northern Ireland Protocol led to additional difficulties in the sourcing and supply of medicines, including higher costs than in the rest of the UK.

The third area to highlight is the challenge that community pharmacy faced in responding to the pandemic in maintaining staff services following long-term underinvestment.

Here, the NPA suggests that Module 3 should include the circumstances in which pharmacy staff were required to work long hours in extreme conditions with inadequate PPE provision in order to maintain services, and how these conditions were exacerbated by staff needing to self-isolate and workforce shortages across the UK following the UK's departure from the EU. In many cases the experience of working in these challenging conditions has given rise to stress, fatigue and mental health issues.

The UK's community pharmacies were in the front line of efforts to limit the impact of corona virus and

to keep people well and, as well as handling a massive increase in demand for healthcare advice and medicines, they also continued to provide urgent care and vital support to people with long-term medical conditions.

However, there are now very many at risk of closure due to underfunding and, when the Inquiry turns to its recommendations, the NPA would encourage you to consider how resilience can be built into future plans.

My Lady, those are the submissions on behalf of the NPA.

LADY HALLETT: Thank you very much indeed Mr Stanton. Very helpful.

Mr Thomas. I'm sorry you have had to wait and your colleagues have had to wait so long to get on today.

Submission by MR THOMAS, KC

MR THOMAS: Not a problem at all.

My Lady, someone once said racism is not a problem of the oppressed, it's a problem of the oppressor, who cannot understand the lived experience of those who have been discriminated against.

I appear on behalf of FEMHO, the Federation of Ethnic Minority Healthcare workers (sic). It's a body of some 55,000 healthcare professionals. I'm part of a team. Ms Banton, Mr Dayle, Mr Odogwu and Ms Morris,

and we are instructed by Saunders Law.

My Lady, your Inquiry has a very heavy burden but it's one that must be shouldered in order to achieve justice, accountability and closure to those affected by the events in question. The weight of this burden stems not only from the gravity of the situation -- lives lost, long-term illnesses sustained -- but also from the sheer complexity of the issues at hand.

Nonetheless, the importance of a thorough and unbiased investigation cannot be overstated, as it is essential for upholding the integrity of our justice system and ensuring that the events we lived through do not occur again in the future. Therefore, it is imperative that is the Inquiry proceeds with the utmost diligence and care, taking into account all relevant evidence and perspectives, and remaining committed to uncovering the truth no matter how difficult or uncomfortable that may be.

You see, the Covid-19 pandemic has laid bare deep-seated inequalities in our healthcare system, and it's imperative that we address these issues head on. FEMHO's members and their minority communities have been unfairly affected by this pandemic, with higher rates of deaths, hospitalisations and exposure to the virus. This isn't an opinion. It's arithmetic.

The figures speak for themselves. Black and brown individuals in the UK have proportionately higher likelihood of death and hospitalisation due to Covid compared to other ethnic groups. Black and brown people in the UK are disproportionately overrepresented in frontline essential jobs, putting them at greater risk of exposure. The disproportionate impact of Covid on black and brown healthcare workers, doctors, nurses, frontline workers, the evidence shows that these people in these professions were at greater risk from exposure to the virus, as well as suffering higher rates of illness, death, compared to their white colleagues.

We've heard about the access or the lack of access to adequate PPE to provide protection against this exposure.

My Lady given the data, it is clear that there is a pressing need to investigate not just the surface but to dig deep and scrutinise the root causes of these disparities and to take action to address them. What happened during the pandemic particularly to communities of colour was unacceptable. The obvious question is: why? We believe that a comprehensive investigation into Government's decision-making processes and policies is necessary to uncover any systemic failures that may have contributed to the disproportionate impact on minority

healthcare workers. Such an investigation should explore the wider socio-economic consequences of the pandemic on these communities.

The failure to protect workers not only undermined their fundamental human rights but also posed a serious threat to the health and well-being of the wider community. We believe that a thorough fearless exploration of these issues is central for the public inquiry to fulfil its mandate and to restore trust in the Government's response to the pandemic.

In failing to fully explore these issues, this public inquiry risks not only perpetuating structural inequalities that have plagued healthcare deliveries to minority communities and their workers but also failing to address and identify underlying causes of the pandemic's disproportionate impact.

We urge the Inquiry to take this matter seriously and to demonstrate its commitment to justice and equality for all. It is time for change. We urge you to take up that challenge. So, please, examine the evidence, please hear the voices of those who have been affected, and please work towards solutions that will ensure that everyone has access to quality healthcare and is protected against the future spread of infectious diseases.

We submit, my Lady, that it may well be that various human rights may have been breached.

Article 2, the right to life. This right protects an individual's right to life and requires the state to take appropriate measures to protect the lives of its citizens. Did the state fulfil this obligation?

Article 14, prohibition against discrimination. This right prohibits discrimination in the enjoyment of any of the other rights and freedoms set forth in the Convention, and we invite this Inquiry to examine whether the state's response to the pandemic was discriminatory. For example, if communities of colour were disproportionately affected by the virus due to policies, action or inaction.

If your Inquiry ever needed good reasons, well, here's ten for starters:

1. Any failure to address the disproportionate impact on black and brown healthcare workers and communities will perpetuate existing inequalities in the healthcare system, undermining trust and confidence that they have in the system.

2. Addressing the concerns of black and brown healthcare workers will help ensure their well-being, reduce absenteeism, increase productivity, which are all essential for a functioning healthcare system.

3. The impact of the pandemic on black and brown healthcare workers is a reflection of long-standing structural inequalities and systemic racism in the healthcare system that needs to be addressed for the long-term.

4. The failure to address the concerns of black and brown healthcare workers is a violation of the Government's obligations to protect and promote the right of health for all.

5. Any failure to address the concerns of black and brown healthcare workers undermines the ability of the healthcare system to respond effectively to future pandemics.

6. The experience of black and brown healthcare workers has been documented, widely reported, indicating there's as strong basis for this Inquiry to investigate these concerns.

7. Addressing the concerns of black and brown healthcare workers will send a message that this Inquiry is committed to protecting the health and well-being of all, irrespective of race, ethnicity or social status.

8. The UK Government has a legal obligation under the Human Rights Act 1998 to protect the right to life of all individuals within its jurisdiction. Failure to address these concerns, particularly the concerns of

black and brown healthcare workers, would seem to be a breach of this obligation.

9. The disproportionate impact of Covid on black and brown communities and healthcare workers has been acknowledged by the World Health Organization and other international bodies. The UK Government should take this seriously, as should this Inquiry, and investigate the reasons for this impact.

10. Addressing the concerns of black and brown healthcare workers will help to ensure that the healthcare system is more resilient, better prepared to respond to future crises.

My Lady, learned counsel to the Inquiry, Ms Carey KC, stated regarding structural racism the following, quote:

"... those are obviously important matters within society today but they are also matters with a far broader reach than this module or indeed the terms of reference of this Inquiry.

"Inequalities are very much at the forefront of our minds in Module 2 and, in our submission, including these matters is neither necessary nor proportionate, although I have no doubt that it may be a matter you will wish to keep under review as the Inquiry progresses."

My Lady, this, with the greatest of respect to Ms Carey and your team, would be a wrong move for the Inquiry to take, and I hope I will be able to persuade you not to follow that course.

You see, it's imperative that a public inquiry into a tragedy of this magnitude leaves no stone unturned in the pursuit of the truth. To shy away from investigating the possibility of structural racism is to ignore one of the most pressing issues facing our society today and risks overlooking the crucial factor in the events that led up to and exacerbated the scale of the tragedy. Ms Munroe KC is absolutely right when she says that structural racism is not some abstract concept or some standalone issue to be investigated. Rather, it is a necessary consideration for examining all the central issues of the Inquiry. The Inquiry has committed to examining inequalities, but you cannot diagnose, fully diagnose, understand and address those inequalities without looking at the deep root causes. It's like trying to examine why a tree is diseased without looking or examining the rotten roots.

As such, it's crucial that this Inquiry takes a comprehensive approach and considers all possible contributing factors, including those relating to systemic race and inequality structural racism.

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So here are ten hopefully compelling reasons why failing to investigate would be a grave mistake for this Inquiry to make.

1. A failure to examine structural racism would undermine the incredibility of this Inquiry's findings as it would ignore a key factor that contributed to a disproportionate impact of Covid on certain communities.

2. Structural racism is a fundamental issue and it's relevant to the terms of reference of the Inquiry as it relates to the role of the Government's policies, institutions in perpetuating inequality and potential discrimination.

3. Failing to consider structural racism would be inconsistent with the duty of the Inquiry to examine all factors that contributed to the outcome of the pandemic.

4. The exclusion of structural racism from the Inquiry scope would perpetuate the very same inequalities and injustices that the Inquiry is seeking to address.

5. Ignoring structural racism would leave important questions unanswered, including why certain communities have been historically marginalised and vulnerable to the impact of public health crises.

6. The failure to address structural racism would

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prevent the Inquiry from fulfilling its mandate to make recommendations that can help to prevent future pandemics and mitigate their impact on vulnerable communities.

7. The exclusion of structural racism would be contrary to the principles of equity, fairness and justice that underpin the terms of reference of this Inquiry.

8. Structural racism is not a minor peripheral issue but a fundamental factor that shapes the social, economic and political conditions affecting people's lives.

9. Ignoring structural racism would be inconsistent with the duty of the Inquiry to uphold human rights and promote social justice.

10. Finally, failing to address structural racism would be a missed opportunity to promote positive change and address long-standing social and economic inequalities that have been exposed by the Covid-19 pandemic.

So, my Lady, I am nearly there. What must be done in terms of scope? Let me suggest a 16-point plan.

1. Institutional structural racism. Examine the historic and structural factors that contribute to health inequalities. The Inquiry must take into account

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the impact of institutional structural racism on health outcomes. Why the disproportionate impact? You've got to look at poverty, discrimination, social exclusion.

2. Access to adequate PPE. Investigate the specific challenges faced by black and brown communities regarding inadequate access. Examine whether the Government's decisions and policies effectively addressed the needs of minority ethnic workers.

3. You need to take an intersectional approach to analysing the impact of the pandemic on racially minoritised healthcare workers and, in that you need to look at their multiple identities, how it intersects with race, gender, social conditioning, disadvantage.

4. Investigate the disproportionate impact of the pandemic on communities of colour and examine how this was exacerbated. Was the public sector equality duty, the requirement -- was there proper regard to it? If not, why?

5. Health inequalities. Consider the impact of health inequalities on communities of colour and the Government's response to that. How was this effectively addressed?

6. Look at pre-existing conditions. You have to respectfully examine the impact of pre-existing health conditions on the vulnerability of communities of colour

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to the pandemic and investigate whether those particular vulnerabilities added to the risk that communities of colour may have risked.

7. Communication and engagement. How did the Government and senior management within the healthcare system communicate with communities of colour during the pandemic?

8. Language barriers. Examine the impact of language barriers on communities of colour. Access to information and services during the pandemic and investigate whether policies effectively addressed these barriers.

9. Employment and financial support. Consider the impact of this on communities of colour in relation to their ability to respond to the pandemic and investigate whether Government policies effectively addressed these issues.

10. Discrimination in the workplace. Did this impact on this question?

11. Mental health. Consider the impact of the pandemic on the mental health of communities of colour in the community and investigate whether Government policies effectively addressed these issues.

12. Education and awareness. Examine the impact of educational awareness campaigns on communities of colour

again in relation to responses to the pandemic.

13. Data collection and analysis. Investigate whether collection and analysis of data on the impact of the pandemic was adequate and sufficient, taken timely.

14. International comparisons. Compare the impact of the pandemic on communities of colour in the UK to the impact in other countries. Are there lessons to be learnt from an international perspective?

15. Policy implementation. Examine the implementation of Government policies and guidance aimed at addressing the impact of the pandemic on communities of colour, specifically within the healthcare system.

16. Engage with and listen to the voices of those affected to ensure that this Inquiry's investigation is grounded in the experience and perspective of those most affected by the pandemic. It must engage with, listen to the voices of the ethnic minority healthcare workers, their representative bodies and other organisations that represent the interests of vulnerable groups.

My Lady, I am going to finish by saying this: you have our written submissions. I don't need to tell you that -- we take them as read. So in summary we say this, if this Inquiry is truly committed to placing possible inequalities -- I take that from your terms of reference -- at the forefront -- I take that from your

terms of reference -- of its investigation, it must be fearless and thorough in exploring the impact of institutional and structural racism and inequality on the pandemic response and its impact on vulnerable groups in the healthcare system across the UK.

By taking the arguments into account as outlined, this Inquiry can demonstrate it's serious, its commitment to this goal, and ensure that this investigation is grounded in the experience and perspectives of those affected by the pandemic.

Finally, we ask you to remember throughout this process that despite the fact that so many lives have been lost to this virus -- and FEMHO's members, along with so many other people who are still suffering today -- nevertheless this Inquiry has a golden opportunity to make a positive change to ensure that the negative impact of Covid-19 never repeats itself and that communities are treated equally and with dignity, regardless of their colour.

My Lady, pick up the gauntlet. Take the opportunity, use your influence and power that you have been entrusted with to bring about real change and leave a lasting legacy for future generations. Thank you.

LADY HALLETT: Quite a challenge, Mr Thomas. Thank you. Thank you for your written and oral submission. Very

grateful.

Mr Simblet.

Submission by MR SIMBLET, KC

MR SIMBLET: My Lady, the Covid-19 Airborne Transmission Alliance (CATA) thanks you for granting this application for Core Participant status in Module 3. CATA looks forward to assisting this Inquiry in pursuing an effective investigation, and to that end we've submitted comprehensive and what we hope are helpful written submissions.

We very much hope that those will be published on the Inquiry's website and we hope others will read them.

I asked for 15 to 20 minutes or so to speak to the following six themes:

1. To introduce my clients to you and say a little about how they come before you as Core Participants in this Inquiry.

2. To highlight the centrality of our concerns about airborne transmission and underscore its importance in your investigation of the healthcare system.

3. To highlight the issue of inadequate reporting of events and relevant data collection for the healthcare system.

4. To make some comments about the impact on

healthcare workers.

5. Suggest some approaches in this module as to how the Inquiry might proceed.

6. To reinforce what others have said, that you remain alert to the benefits of interim recommendations and recommending interim measures.

So, (1), who and what is CATA? Well, CATA is a voluntary and collaborative forum, or consortium, made up of professional, scientific and employee organisations and individual representatives from all across the UK.

It was formed in response to the UK Government's failure to recognise and adequately respond to the airborne route of transmission of the Covid-19 virus. The central contention is that UK Government's failure to recognise airborne transmission of Covid-19 in a timely manner put healthcare workers at significant risk of illness and death and caused other serious problems.

For instance, the lack of acceptance of the risk of airborne transmission led to policies, decisions and practices that deprived health workers of the correct respiratory protective equipment, or RPE, to protect them from infection.

Now, CATA, as an umbrella for 12 constituent

bodies and several individual representatives, coincidentally and not intended to be symbolic, now 19 entities, comprises a large number, over 65,000 people. Its members include professional organisations, trade unions and healthcare charities. They provide a representative voice for a wide range of healthcare workers in both institutional and community settings. Its purpose is to ensure that its knowledge of the existing and developing scientific evidence basis for the aerosol transmission of SARS-CoV-2, as well as the lived experience of its members, was made available to this Inquiry.

I say something about airborne transmission and its importance for Module 3. A core submission is the importance of the Inquiry having the correct starting point. Prior to the pandemic, beta coronaviruses, including SARS, were recognised to be transmitted via the airborne route.

We therefore disagree with paragraph 5 of NHS England written submissions where they assert that in early 2020 little was known about the Novel Coronavirus, including -- continuing -- whether, how quickly or in what ways it could be transmitted. We say that's wrong. We say there was already a lot known about these types of viruses, and importantly there was

an appropriate protection and regulatory framework already in existence for tackling them.

So one important issue for your Inquiry is to investigate why there was deviation from these existing policies and procedures, and instead why there wasn't effective implementation of the appropriate framework for response. As we say at paragraph 9 of our written submissions, the prolonged, mistaken focus on a droplet transmission route of Covid-19 misdirected all from proper and effective risk management, undermining both worker protection and measures to manage clinical risk.

Simply put, there was a failure to appreciate the contemporaneous existing science regarding the airborne transmission of Covid-19. There was significant error in seeing Covid-19 as being due to an entirely new virus and, consequently, inappropriate measures were taken to deal with the virus in healthcare and community settings.

So the Inquiry will need to investigate whether promotion of the idea that the virus was spread through droplet rather than airborne transmission might have been because of inadequate available PPE and we note and support the observations from others such as the British Medical Association, the TUC, FEMHO, that this is an important topic for you to consider.

Crucially, CATA submits there was insufficient transparency and inadequate oversight, and the Government was misdirected on scientific decision-making during the pandemic. For example, there was a lack of transparency on the scientific sources and basis for the decisions made. These include, again, the focus on droplet as opposed to airborne transmission, the decision to remove the high consequence infectious disease, or HCID, status of Covid-19, and the decision to downgrade protective equipment for healthcare workers from effective respiratory protection equipment to fluid repellent surgical masks.

Even more specifically, the role of the infection prevention and control cell was not previously identified in the governance of pandemic management and its membership and basis for deliberations are unclear.

Notwithstanding this, the IPC cell was deferred to in all matters of health and safety and transmission control in healthcare settings. So the result was that the Government public bodies and employers failed in legal and public duties to assure public health and safety, particularly in the context of healthcare.

(3), the topic of inadequate reporting and data collection. CATA has raised in paragraph 26 of its written submissions the problem of inadequate reporting

of Covid-19 infections and deaths among healthcare workers. Such reports are required by the reporting of injuries, diseases and dangerous occurrence regulations 2013, or RIDDOR as they have already been referred to. There also appeared to have been almost a policy decision not to investigate Covid deaths at inquests.

So, as an example, Scottish health boards' recently produced statistics appear to suggest that not one single healthcare worker of working age died of Covid between 2020 to 2022. Of course this is incredible in the true sense of the word.

Our submission is that these responses (a) severely undermined the base of data for infectivity in the pandemic; (b) created a gap in accurate public health modelling for case studies and general tracking disease; and (c) impacted on the entitlement of healthcare workers to industrial injuries disablement benefit.

CATA is keen for the Inquiry to make the RIDDOR issue a key part of its investigation and, importantly, explore the implications that such under-reporting might have had for workplace infectivity and our understanding of the death rate.

So (4), impact on healthcare workers. CATA encourages the Inquiry to take an expansive approach to

investigating healthcare. This requires considering not just what went on in the institutional settings but also in community settings. Of course there was a direct personal impact of Covid on CATA members and their families. But that also -- or the impact on them also obviously affected patients and their families. There are significant continuing issues for patient care and provision with ongoing effects. For example, there are children presenting with more complex communication needs as they did not have speech and language therapy and access to services at the height of the pandemic. This is referred to in our paragraph 28.

On this issue, CATA invites the Inquiry to explore why there's not been a long-term illness or disability allocation made available to healthcare workers living with Long Covid similar to the death in service allocation for Covid-19 and, the issue just mentioned, what has been the impact on outcomes for patients who could not access services or treatment in a timely way.

(5) I will make some submissions on a suggested approach to the Inquiry. You will see at paragraphs 29 to 30 of our written submissions that we have made some detailed and comprehensive suggestions. At paragraph 29 CATA identifies various lines of inquiry or issues, and I will come on to the list of issues in a moment, and

30, paragraph 30 of our submissions, identifies various questions that you may want to ask yourself.

We hope that those are focused and considered. I'm not going to read them out but I am going to ask you to reread those when drawing up the future scoping or definition of issues for the Inquiry.

This approach from CATA we submit is scientific and evidence-led. CATA considers it is necessary for the Inquiry to go where the evidence takes it rather than to confine itself and restrict itself by reference to an over-prescriptive list of issues.

There's been submissions both from your counsel and the submissions of others about the benefits of a list of issues, and of course that will be a benefit if it brings focus to the Inquiry. But of course, a list of issues cannot be and must not be allowed to become a device that restricts the pursuit of necessary lines of any enquiry, and CATA is comforted by the observations of your counsel this morning that any list of issues will no doubt be refined.

Our consortium hopes to be able to provide medical and scientific expertise and informed analysis and insights through our suggested questions and through our suggested lines of enquiry. CATA also hopes and expects that the Inquiry will take a suitably robust and

independent approach when identifying, for instance, dissenting voices amongst civil servants and advisers. It will be necessary to hear from some people who are whistleblowers and to protect those people.

CATA has also made submissions at paragraph 34 of its written submissions, which it can summarise orally here, to the effect that the Inquiry is correct to state in paragraph 57 of its counsel's submissions that its selection of its own experts and witnesses will be the subject of discussion and submission. CATA will, by its very nature, be able to assist with this task and we will in due course expect to make informed, detailed and helpful submissions on how this might be done and who can help.

Interim recommendations. Finally, on interim recommendations, we refer you to what we put in our written submissions at paragraph 38. We recognise that many public inquiries have seen fit to make interim recommendations to address a continuing harm, and Covid-19 is still ongoing. It's still causing infection. It's still affecting lives, including through those suffering from Long Covid. So we welcome what was said this morning in relation to interim recommendations.

Finally, my Lady, we hope that this introduction,

1 alongside what has already been said in our written
2 submissions, will explain where we feel this important
3 module in the Inquiry should go. We want to help.
4 I told the Inquiry would speak for 15 to 20
5 minutes or so. I have been speaking for I think 12. We
6 hope the Inquiry will be able to rely on CATA and their
7 representatives to inform its important work in an
8 accurate and efficient way. So unless I can help any
9 further, my Lady.
10 **LADY HALLETT:** No, thank you very much, Mr Simblet. Very
11 interesting, and your submissions from your lay clients
12 were definitely focused and considered. I am very
13 grateful.
14 **MR SIMBLET:** Thank you, my Lady.
15 **LADY HALLETT:** Thank you.
16 Right, Mr Beer, and then Mr Kinnier, you've been
17 waiting so patiently -- well, I hope you have!
18 Mr Beer.
19 **Submission by MR BEER, KC**
20 **MR BEER:** Good afternoon, my Lady. I appear on behalf of
21 NHS England. NHS England welcomes the Inquiry.
22 Responding to the pandemic has been the single biggest
23 challenge the NHS has faced in its history.
24 That challenge has become increasingly complex
25 over time as the NHS has had to manage the pandemic

1 alongside a rebound in demand, elective recovery and
2 vaccine deployment. This Inquiry will allow the facts
3 to be set out and the truth to be told and, through that
4 process, learning and understanding to be identified for
5 the benefit of the future. Consistent with the NHS
6 values and in particular to work together for patients,
7 NHS England looks forward to participating in the
8 Inquiry to help it in its important work.
9 For its own part, NHS England is prepared fully to
10 account for its responsibilities and actions during the
11 pandemic and passionately wishes to learn and implement
12 lessons from the Inquiry. It is a learning organisation
13 which aspires to the highest standards of excellence and
14 professionalism, with the patient at the heart of
15 everything that the NHS does.
16 It's important to note at the outset of this
17 module of the Inquiry that NHS England is not the same
18 as the NHS in England, which is the phrase that's often
19 used to refer collectively to all of the bodies which
20 make up the publicly funded Health Service, excluding
21 public health in England. I should stress, therefore,
22 that the Core Participant who stands before you is not
23 the NHS. By way of illustration, NHS England employees
24 account for only about 1 per cent of the total NHS head
25 count in England of 1.2 5 million NHS hospital and

1 community healthcare staff.
2 This point is a vitally important one and not
3 simply because it will be necessary for the Inquiry in
4 its substantive investigation that it undertakes to
5 understand NHS England's purpose, remit and
6 responsibilities within the complex and recently
7 reorganised healthcare landscape. For reasons that I
8 will explain in a moment, it is important for the point
9 to be grasped now at this stage of the Inquiry's work.
10 So NHS England is a non-departmental arm's length
11 body and is primarily responsible for the co-ordination
12 of the provision of healthcare services in England and
13 oversight of local clinicians and providers of those
14 healthcare services.
15 NHS England's core function and purpose is
16 therefore to arrange for the provision of services for
17 the purposes of the Health Service in England, a duty
18 owed concurrently with the Secretary of State for Health
19 and Social Care. NHS England does not have significant
20 public health functions, albeit the Secretary of State
21 routinely delegates some specific functions to
22 NHS England on an annual basis.
23 It follows that although NHS England has specific
24 statutory functions which are important to the issues
25 being examined within Module 3 of the Inquiry, and to

1 some extent at least informally represents the NHS,
2 NHS England cannot speak directly on behalf of
3 individual healthcare providers, nor on behalf of their
4 employees. As a national body, NHS England cannot
5 account fully for the diversity of actions and
6 initiatives taken at provider level in response to the
7 pandemic, nor indeed comprehensively account for the
8 actions, decisions and experiences of their staff.
9 You will recall that in paragraph 25 of our
10 written submissions we said:
11 "NHS England does not know which, if any, local
12 NHS providers and commissioners or representative bodies
13 of such providers and commissioners have applied for or
14 been granted CP status [Core Participant status]. It is
15 possible on the basis of the information presently known
16 to NHS England that it is the only NHS organisation
17 representing the Health Service in England in Module 3
18 of the Inquiry."
19 Your team has kindly disclosed shortly before this
20 hearing a list of the 36 Core Participants presently
21 designated in Module 3 of the Inquiry. NHS England, we
22 now know, is the only NHS organisation representing the
23 Health Service in England in Module 3 of the Inquiry.
24 There are no other NHS bodies who are Core Participants
25 in Module 3 of the Inquiry. The position is different

1 in Wales and Scotland.
2 Now, given the push within this module to
3 illuminate the issues through the telling of
4 "operational stories", as they are called (i.e. how
5 healthcare was impacted on the ground in hospitals and
6 other care providers), it's even more important, we say,
7 that there should be access to these stories. We know
8 that you are already in contact with some of these
9 organisations because NHS England has already assisted
10 the Inquiry by sending out a questionnaire to NHS Trusts
11 and integrated care boards. We stand ready to continue
12 to assist the Inquiry in working out how it does obtain
13 the full picture.
14 Turning to scope, you will have seen in paragraphs
15 27 to 42 of our written submissions we address three
16 issues relating to the scope of Module 3. I am very
17 conscious you have received a range of submissions on
18 scope -- and it's 4.45 -- and the issues to be addressed
19 in Module 3 have been amongst them. We've not sought in
20 our written submissions to engage in our own red pen
21 exercise and seek to redraft what you and your team have
22 written in terms of scope but, instead, we have sought
23 to address three bigger and broader issues that we think
24 that the Inquiry respectfully needs to grapple with.
25 Firstly, the need by the Inquiry to explain to

1 Core Participants and to the public its plans for later
2 modules in the Inquiry and, in particular, to identify
3 those later modules to set out the issues that will be
4 addressed in later modules, i.e. disclose a provisional
5 scope for each module, and explain how, in the light of
6 that picture, cross-cutting issues will be addressed
7 across the modules.
8 The reasons why we suggest that this is necessary
9 are plainly a number of the issues have relevance across
10 the modules -- we have called them cross-cutting
11 issues -- and indeed the Inquiry needs to explain, we
12 say, its thinking on how these are to be addressed
13 across the life of the Inquiry, so that at these earlier
14 modules of the Inquiry the Core Participants and the
15 public know whether an issue needs to be addressed in
16 evidence in submissions within this module, or whether
17 it is to be addressed later, or whether it is to be
18 addressed in more than one module and, if so, where the
19 demarcation lines are.
20 You will have seen and recognised, I think, that
21 this is a point that's made in the submissions of
22 a number of Core Participants and I would respectfully
23 suggest to you that you should take from that that the
24 recurrence and replication of the issue means that there
25 is a real issue here. All parties will be better able

1 to respond to and work with the Inquiry following
2 identification of the later modules in the Inquiry and
3 the issues that are to be addressed within them.
4 We listened with care to what Ms Carey said this
5 morning in response to the point that we made, which was
6 to the effect that the Inquiry needs to retain
7 flexibility about its precise timetable and have the
8 facility to adjust its plans in the light of the
9 evidence being gathered. As somebody who has sat in
10 Ms Carey's chair, I completely understand what sits
11 behind the reply that she has given.
12 However, we're not asking for a timetable, less
13 still a precise one, and the fact that plans may change
14 in the light of evidence received is not a sufficient
15 reason to make and announce a plan now.
16 If I can take an example to illustrate the point,
17 Ms Carey's note for this hearing states in its
18 paragraph 33(b) that this module, Module 3, will
19 include:
20 "How the treatments available to those suffering
21 from Covid-19 developed and changed over the course of
22 the pandemic."
23 Yet the Inquiry's website states that:
24 "Vaccines, therapeutics and antiviral treatments
25 will be addressed in a future module."

1 So the issue arises for the CPs, the public, and
2 indeed your Inquiry team: what is the position? Where
3 are the demarcation lines?
4 The second issue is related to the first and it's
5 a request for the Inquiry legal team to set out how it
6 proposes to carry its terms of reference into effect in
7 this module by way of the provision of a list of issues.
8 Ms Carey has kindly indicated this morning that such
9 a list will be provided and therefore I say nothing
10 about it, save to say we look forward to receiving it in
11 early course.
12 The third large issue that we identified is the
13 approach to be taken in Module 3 to the obtaining and
14 presentation of evidence from the devolved
15 administrations. By contrast with Module 2, 2A, 2B and
16 2C, the Inquiry has decided not to split Module 3 into
17 sub-modules which address the four nations one by one.
18 As we have explained in our written submissions,
19 NHS England commissions healthcare services in England
20 only. Since 1999, responsibility for health services
21 has been a devolved matter in the other nations and
22 there are significant differences in how healthcare
23 services are paid for and commissioned across the four
24 nations.
25 In the last 20 years, for example, healthcare

1 commissioning in Scotland and Wales has not been
2 characterised by the same split between healthcare
3 purchasers and healthcare providers as it is in England,
4 nor in the devolved nations is there the same separation
5 between Central Government and the NHS.
6 As NHS England sees it, the Inquiry is presented
7 with a choice as to whether it examines the issues
8 presently identified in the scope of Module 3 by either
9 (a) addressing the position of each of the four nations
10 one by one; or (b) addressing the issues that are within
11 the scope of Module 3 sequentially or in groups,
12 examining the position in relation to each of the issues
13 with each of the four nations in mind as that is done
14 and at the same time.
15 We do not adopt a position in relation to which of
16 these choices should be made. There are advantages and
17 disadvantages of each of them. It is a matter for the
18 Inquiry. But we do say that a decision ought to be made
19 and communicated to the Core Participants promptly, if
20 possible, because it will have a substantial impact on
21 the organisation and progress of this Inquiry's work.
22 Those are the short submissions that we make at
23 this stage, hopefully constructively, each designed to
24 assist the Inquiry in the conduct of its future work.
25 **LADY HALLETT:** I'm really grateful, Mr Beer, and I do

1 understand the concern about the lack of detail on
2 future modules and particularly where it comes to
3 cross-cutting issues, and it is something that I shall
4 definitely consider further with counsel to the Inquiry.
5 So thank you very much for your help.
6 **MR BEER:** Thank you, my Lady.
7 **LADY HALLETT:** I think it is now Mr Kinnier, who I thought
8 was the last but I am afraid, Mr Hyam, I had not turned
9 over the page so please forgive me if I have not been
10 referring to you in extending my apologies to you.
11 Mr Kinnier next.
12 **Submission by MR KINNIER, KC**
13 **MR KINNIER:** My Lady, *prynhawn da* -- good afternoon. The
14 Welsh Government is grateful for the opportunity to
15 participate in Module 3. As an all other modules, we
16 offer our full co-operation and support for your
17 Inquiry's work examining how the pandemic affected the
18 healthcare system in Wales.
19 It is also right that at the outset, the Welsh
20 Government makes clear its deep gratitude and respect
21 for the unstinting and selfless dedication of everyone
22 in the NHS in Wales and the wider healthcare system who,
23 faced with the unprecedented challenge of Covid-19,
24 dedicated themselves to the care and support of the
25 people of Wales.

1 An important, if not the defining, feature of the
2 Welsh healthcare system is that it consists of only
3 twelve statutory bodies. That's to say, seven local
4 health boards, each responsible for the provision of
5 health services in their local area; three NHS Trusts,
6 which includes Public Health Wales; and two Welsh
7 special health authorities working across Wales.
8 During the pandemic, the Welsh Government worked
9 closely with all the Welsh NHS bodies and the wider
10 healthcare system in Wales. That closeness had
11 considerable benefits in providing care. But, equally,
12 we can all learn much from our experiences during the
13 pandemic and, in that regard, the Welsh Government looks
14 forward to supporting you in your work and, in
15 particular, an identifying effective recommendations in
16 due course.
17 The Welsh Government firmly supports your clear
18 commitment to consider carefully the experiences of
19 bereaved families and others who have suffered hardship
20 or loss as a result of the pandemic. It welcomes your
21 confirmation that specifically in relation to Module 3
22 the Inquiry will gather the views of people who needed
23 healthcare services during the pandemic, including the
24 relatives and friends of patients in hospital, the
25 bereaved, and people working in healthcare settings

1 during the pandemic.
2 The impact of Covid-19 on these groups was
3 considerable, as were the significant sacrifices that
4 they made during a time of great difficulty, grief and
5 pain.
6 The Welsh Government is also reassured that the
7 report from the Inquiry's Listening Exercise will inform
8 the Inquiry's investigations in Module 3. The Inquiry's
9 approach aligns with the Welsh Government's
10 determination that people's questions are answered fully
11 and transparently. To that end, we are greatly
12 heartened by your assurances that the Inquiry will
13 English that the voices of each of the devolved nations
14 are clearly heard.
15 The people of Wales deserve no less, particularly
16 those patients who endured illness during the pandemic
17 and who may continue to do so; those who lost loved
18 ones, and those who made very great sacrifices to
19 support the healthcare system throughout the pandemic.
20 My Lady, *diolch* -- thank you.
21 **LADY HALLETT:** Thank you very much, Mr Kinnier. Mr Hyam.
22 **NEW SPEAKER:** Mr Hyam.
23 **LADY HALLETT:** Again, apologies for missing you out. You
24 only allotted yourself five minutes as well, so double
25 apologies.

Submission by MR HYAM, KC

MR HYAM: No apology necessary.

My Lady, I appear on behalf of a group of Welsh health bodies. I am instructed by Sarah Watt of NWSSP Legal and Risk. I just have four short observations, if I may.

First, we are very grateful for our designation as a group of Welsh health bodies. We comprise bodies responsible for the majority of primary care, hospital services and other healthcare services in Wales and, to that end, we hope to be able to give significant assistance to the Inquiry.

Secondly, to underline a point already made, that the Welsh Health Boards are responsible for the management and delivery of the Health Service in Wales and act as both commissioner and provider of services, and with a consequent responsibility for the health of their local populations under the NHS Wales Act. These are important structural differences between the NHS in Wales and in England.

Third, that we would endorse NHS England's observation made at paragraph 41 of their written submission to the effect that there should be early identification of issues, but also that there should be early identification of how the Inquiry will deal with

those issues across the four nations. We agree that the options may be limited to two, either sequentially nation-by-nation or as groups of issues. We do not, like NHS England, adopt a particular position but if a grouping of issues is what the route that the Inquiry chooses to go down, the sooner that grouping of issues can be identified the better because it should inform the Rule 9 requests that are made to the various health bodies across the four nations, so that the information provided by them can be usefully digested and made most useful to the Inquiry.

Finally, I just conclude by saying we look forward to assisting the Inquiry with its important work. We hope we can provide significant assistance to it and, consistently with NHS values, working together with the Inquiry for the benefit of patients. Thank you very much.

LADY HALLETT: Thank you very much indeed, Mr Hyam.

Ms Carey, do you have any closing remarks you wish to make?

Closing remarks by MS CAREY, KC

MS CAREY: My Lady, just this, please. You have heard helpful submissions covering a very wide range of topics and both the Inquiry legal team and I know you will want to consider those with great care. In particular, you

want to consider the submissions that you heard about the impact of the pandemic on black, Asian and minority ethnic patients and healthcare workers. So I repeat this is a matter very firmly within the contemplation of Module 3.

It is, however, important that anyone listening to today's hearing understands that an examination of inequalities on patients and those working within healthcare systems undoubtedly includes matters relating to race and ethnicity, but also includes a range of other inequalities such as the impact on disabled people, on blind and deaf people, and that is just by way of two examples.

I just want to reassure Core Participants that Module 3 is committed to examining inequalities throughout the course of this module and I know that the issues raised about the need for expert evidence are matters that you will wish to keep under review and give very real care to. Thank you very much.

LADY HALLETT: Thank you very much, Ms Carey.

Well, it has been a long day but, from my point of view, a very worthwhile one. People have come up with some extremely interesting submissions and ideas for me to think about. As I have said throughout, whenever I have made a decision, everything I keep under review.

Nothing is closed. My mind is never closed. So I undertake to give very careful consideration to all the submissions that were made today.

I am very grateful to everybody who has attended here and stayed with us throughout the day, even those who had to leave early for personal arrangements and I am grateful for those who followed online and those who attended remotely.

So that completes our proceedings today and I will, if I have to make a ruling, issue any written ruling as soon as I can, but obviously I would rather take more time to consider the matter and do it more carefully, but I will get it out as soon as I can. So thank you all very much indeed.

(5.02 pm)

(The Inquiry adjourned)

1 **I N D E X**

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3 Submission by MS MUNROE, KC 38
4 Submission by MR LAVERY, KC 52
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6 Submission by MR WILLIAMS, KC 62
7 Submission by MR METZER, KC 72
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'22 [1] 83/25

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1 billion [1] 164/20
1 March 2020 [1] 9/21
1 per cent [1] 194/24
1,000 [1] 156/7
1.04 pm [1] 98/14
1.2 [1] 194/25
1.2 million [1] 139/24
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