

UK COVID-19 PUBLIC INQUIRY

Second Witness Statement of Professor Philip Banfield

I, Professor Philip Banfield, of the British Medical Association (the BMA or the Association), will say as follows:

1. I am chair of the BMA's UK council, chair of the BMA's board of directors and a member of the chief officer team of the BMA. I am a Consultant Obstetrician and Gynaecologist based in North Wales and am honorary professor in the Cardiff University School of Medicine. Before being appointed as chair of council, I spent several years as a representative of BMA Cymru Wales, as chair of both Welsh council and the Welsh consultants committee. I have sat on the UK council since 2012.
2. I provide this statement in response to a request for evidence made on 18 January 2023 by the UK Covid-19 Public Inquiry (the Inquiry) under Rule 9 of the Inquiry Rules 2006 in connection with Module 1 of the Inquiry.
3. I provided an earlier witness statement to the Inquiry in connection with Modules 2, 2A, 2B and 2C of the Inquiry on 28 February 2023.
4. I took on the role of chair of council of the BMA in July 2022, after the period identified by the Inquiry as having particular relevance to the Rule 9 request (namely, 11 June 2009 to 21 January 2020). In providing this corporate statement to the Inquiry, I have therefore sought input and assistance from colleagues in BMA Northern Ireland, BMA Scotland and BMA Cymru Wales, as well as from relevant UK policy and communications teams across the Association. The information contained within this statement is true to the best of my knowledge and belief.

A. Overview of the BMA

5. The BMA is a professional association and trade union for doctors in the UK. It is a leading voice advocating for outstanding healthcare and a healthy population, providing members with individual services and support throughout their lives.

6. The BMA was originally founded in 1832 as the Provincial Medical and Surgical Association, a collective organisation for doctors, changing its name to the British Medical Association in 1855.
7. As a trade union, the BMA is formally recognised for collective bargaining purposes at a UK, national and local level. It represents, supports and negotiates on behalf of all doctors and medical students in the UK and has a membership of approximately 184,000 (over half of practising doctors).
8. Members of the BMA come from all branches of medical practice and specialities, for example GPs, consultants, junior doctors, public health, occupational medicine, medical academics and students.
9. The BMA's current mission statement is 'We look after doctors so they can look after you'. Its vision is 'a profession of valued doctors delivering the highest quality health services, where all doctors:
 - a. Have strong representation and expert guidance whenever they need it.
 - b. Have their individual needs responded to, through career-long support and professional development.
 - c. Are championed by the BMA and their voices are sought, heard and acted upon.
 - d. Can connect with each other as a professional community.
 - e. Can influence the advancement of health and the profession.'
10. Staff and elected members work to support, protect and represent BMA members across all four UK nations. This includes:
 - a. Negotiating on pay, terms and conditions at a UK, national and local level, and supporting the safeguarding of health, safety and wellbeing at work.
 - b. Providing individualised employment support and advice for members, including through the BMA's First Point of Contact service.
 - c. Providing wellbeing support services, with free confidential counselling and peer support available to all doctors and medical students.
 - d. Providing other services for members, including advice related to immigration, ethics, equality and diversity, and specialist HR and employment law advice for GP partners.

- e. Ensuring doctors' voices are heard by policymakers across the UK's governments and healthcare systems. To do this the BMA conducts research, produces policy recommendations, runs campaigns and makes representations to governments and decision makers. The BMA also works with a range of European partners and makes representations at a global level as part of the World Medical Association.

B. Research undertaken as part of the BMA's COVID-19 Review

11. In order to inform and shape the UK's current and future pandemic response, the BMA conducted its own lessons learned exercise, the "BMA COVID-19 Review" in consultation with its members. The views, findings and recommendations of the BMA and its members are set out within five published reports:

- a. BMA Covid Review Report 1 (published 19 May 2022): How well protected was the medical profession from Covid-19? (PB/13 - INQ000118474)
- b. BMA Covid Review Report 2 (published 19 May 2022): The impact of the pandemic on the medical profession (PB/14 - INQ000118475)
- c. BMA Covid Review Report 3 (published 26 June 2022): Delivery of healthcare during the pandemic (PB/15 - INQ000185355)
- d. BMA Covid Review Report 4 (published 28 July 2022): The public health response by UK governments to COVID-19 (PB/16 - INQ000185356)
- e. BMA Covid Review Report 5 (published 28 July 2022): The impact of the pandemic on population health (PB/17 - INQ000185357)

12. The Review drew in part from 12 Covid Tracker and five Viewpoint surveys of BMA members¹. These surveys were undertaken fortnightly between 6 April and 18 June 2020, before moving to monthly and then bi-monthly. In total, the BMA's surveys during this period received approximately 192,000 responses.

¹ The BMA undertook regular research with its members throughout the pandemic. This began in 2020 with Covid Tracker surveys which were mostly UK wide and dedicated specifically to issues of the pandemic. Later in 2021, Viewpoint surveys were introduced, which replaced these Covid Tracker surveys and supported research on a wider range of subjects, albeit they retained a strong focus on Covid. Additionally, during the initial vaccine roll out at the start of 2021, the BMA conducted 10 vaccine surveys of members to monitor access to the new vaccines among the medical profession, in the absence of published national data.

13. Specifically, to inform the BMA COVID-19 Review, the BMA also conducted an additional and wide-ranging call for evidence from its members. The call for evidence was held online between 10 November and 17 December 2021 and received 2,484 responses from across the profession. A copy of each of the surveys conducted by the BMA (Covid Tracker, Viewpoint and Call for Evidence) are exhibited to this witness statement as PB/18 – INQ000116820 to PB/36 - INQ000116838.
14. In preparing the evidence for the COVID-19 Review, the BMA also engaged with other stakeholder organisations between November 2021 and January 2022, including unions representing healthcare workers, Medical Royal Colleges and think tanks, to ensure that the Review reports would be comprehensive and properly informed by others with a significant role in shaping the healthcare environment during the pandemic. The BMA hosted two round table events in March and April 2022 attended by some of these stakeholders, to obtain further information for the BMA's COVID-19 Review.

C. The UK entered the Covid-19 pandemic significantly underprepared and lacking resilience

15. It is the BMA's view that the UK entered the Covid-19 pandemic significantly underprepared in a multitude of ways, with dire consequences when Covid-19 arrived. A failure to learn and/or implement the lessons from previous pandemic exercises was compounded by a failure to invest adequately in the public health and healthcare systems and ensure they had the capacity, staff and infrastructure to respond to the emerging threat of the Covid-19 pandemic.
16. Further details of the BMA's views on the state of the UK's emergency and pandemic planning, preparedness and resilience are set out below.

The UK's preparations focused on an influenza-style pandemic

17. The UK's pandemic planning exercises predominantly focused on an influenza-style pandemic. This narrow focus was an oversight, particularly considering that we had already seen serious outbreaks/epidemics of two coronaviruses in the 21st century: SARS (Severe Acute Respiratory Syndrome) and MERS (Middle Eastern Respiratory Syndrome). While SARS and MERs did not progress to become global pandemics, they drew attention to the possibility and risks of a non-influenza epidemic or pandemic. The UK did carry out planning exercises (Exercise Alice, 2016) based on a

SARs/MERs outbreak, but it was not the prime focus and when the pandemic began it did not implement the lessons from these coronavirus exercises.

18. Little consideration was given within pandemic planning policies of strategies to detect and contain the spread of disease, but rather the emphasis was on how to respond in a situation where there was already significant mortality and morbidity. For pandemic planning policies to be comprehensive and effective, both strategies need full consideration. This relatively limited focus on disease containment within the UK's pandemic preparations may explain why the UK Government was slow to implement public health and occupational hygiene measures when Covid-19 arrived.
19. The predominant focus on an influenza-style pandemic meant that the UK's response failed to properly consider the potential for aerosol transmission of the virus as influenza was understood to be spread primarily by droplets or contact. This in turn impacted the protections available to healthcare workers and the public health measures put in place, including the focus on hand washing in public information campaigns, the delay in mandating mask wearing for the public and the quality of masks recommended. For example, the limitations of surgical masks (also known as fluid resistant surgical masks (FRSM) in preventing aerosol infection were well known prior to the pandemic (as highlighted, for example, in a research report by the Health and Safety Executive in 2008 (PB/107 - INQ000145893)). Equally it was well known that Filtering Face Piece Respirators (FFP2/3 respirators) were more effective at preventing the spread of infections via the air. Yet, for the majority of the pandemic and even to this day, Infection Prevention and Control (IPC) guidance for healthcare settings states that only a small number of 'aerosol generating procedures' (AGPs) require access to respiratory protective equipment (RPE) such as a FFP2/3 respirator and that FRSM is appropriate protection for a healthcare worker caring for patients with confirmed or suspected Covid-19. This fails to take account of the fact that daily actions such as coughing, talking and breathing generate more aerosol than so-called AGPs (PB/108 - INQ000145858).
20. The BMA raised its concerns about these matters with the Health and Safety Executive (HSE) directly, as the regulator entrusted with the protection of worker health and the enforcement of the law. However, the response received from the HSE was inadequate and left staff and patients at risk.

- a. On 25 November 2021, the BMA wrote a joint letter to the HSE alongside the Royal College of Nursing, the British Occupational Hygiene Society, Fresh Air

NHS and the Covid Airborne Protection Alliance (CAPA) (PB/109 - INQ000118441). This letter requested the HSE to undertake an urgent review of the IPC guidelines on respiratory infection risk to determine their appropriateness and compatibility with Health and Safety law, to make the review public and to issue further guidance to NHS leaders.

b. The response the BMA received on 15 December 2021 (PB/110 - INQ000118447) was that HSE would “*not be undertaking a review of this guidance as this has already been done by DHSC, UKHSA and the DAs [devolved administrations].*” The BMA regards the HSE response as highly notable and regrettable, given that:

- i. The HSE covers all sectors and has produced guidance or approved codes of practice to protect workers from all manner of hazards including Legionnaire’s disease and other biological agents.
- ii. The HSE’s own laboratories had conducted research confirming the inadequacy of surgical masks to protect against viral aerosols and the corresponding high effectiveness of FFP respirators (PB/107 - INQ000145893).
- iii. The 2008 HSE report acknowledged “*challenges to the healthcare sector. The widespread use of respirators might be difficult to sustain during a pandemic unless provision is made for their use in advance*” (PB/107 - INQ000145893).

c. In the face of this evidence generated by the HSE itself, it is of great concern to the BMA that the HSE endorsed the guidance from Public Health England, which the BMA believes refers to the IPC guidance issued by the IPC Cell in relation to Covid-19, as providing “*effective control measures*” to protect workers from contracting Covid-19 (PB/111 - INQ000145872). This had the dual detriment of both undermining risk assessments conducted by employers under health and safety law, which may have suggested stronger worker protection, and also discouraging employers from reporting Covid-19 infections acquired as a result of work.

Key recommendations from pandemic planning exercises were ignored

21. Despite the predominant focus on an influenza-style pandemic, pandemic planning exercises still made a number of recommendations that were directly relevant to the

handling of a coronavirus type pandemic. However, key recommendations from these exercises were ignored rather than acted upon. These include recommendations in relation to:

- a. **PPE:** A review of current PPE stocks; creation of pandemic stockpiles of PPE; ensuring staff have clear instruction/training in the use of PPE and infection control; development of a whole system approach to distribute PPE to health and care staff (Exercise Alice 2016, Exercise Cygnus 2016, Exercise Iris 2018).
- b. **Surge arrangements and surge capacity:** Further work to manage surge arrangements in health and social care (Exercise Cygnus 2016, Exercise Pica 2018).
- c. **Contact tracing capacity:** Further work to ensure the resource impact of extensive contact tracing is considered (Exercise Iris, 2018).
- d. **Risk assessments:** The importance of employers continuing to undertake risk assessments for their staff (UK Influenza Pandemic Preparedness Strategy 2011).
- e. **Ethical frameworks:** Further work to inform consideration of the issues related to the possible use of population-based triage (Exercise Cygnus 2016).

22. The consequences of ignoring these vital recommendations are outlined in paragraphs 30 to 41.

Public health systems lacked vital capacity

23. Major reforms to the UK's public health structures, particularly in England, alongside a decade of underfunding, meant that public health systems across the UK entered the pandemic without the resources, workforce, capacity, structures, or voice they needed to shape and influence governments' responses to Covid-19. For example:

- a. The decade preceding the pandemic saw a decline in the funding available to many public health bodies across the UK, leaving them less able to respond effectively to any public health crisis, let alone a pandemic (PB/16 - INQ000185356 and PB/112 - INQ000145868). The BMA believes this hampered pandemic preparedness across the UK and the initial public health response to the onset of Covid-19.
- b. The widespread deterioration of public health funding occurred in concert with an equally concerning decline in the size of the public health workforce. To

meet the Faculty of Public Health's recommended number of full-time equivalent public health specialists per capita, the workforce would need to increase by 59% (England), 32% (Scotland), 18% (Wales) and 97% (Northern Ireland).

- c. Reforms to the public health system, in England in particular, led to a fragmented system with the 2012 Health and Social Care Act fracturing, in many places, the links between public health specialists and NHS colleagues, which impacted on the pandemic response. It also meant that local public health services were hindered by cuts in local authority spending settlements in the years preceding the pandemic.

24. The BMA welcomes the Inquiry's confirmation within the Module 1 Provisional List of Issues that the state of pandemic readiness and preparedness of the UK's public health bodies will be covered within the scope of Module 1.

Chronic underinvestment left healthcare systems lacking resilience

25. The overall state of health and care systems in the years leading up to the Covid-19 pandemic played a major role in the inability of these systems to weather the storm when Covid-19 arrived. In the decade prior to the pandemic, the UK's health services experienced chronic underinvestment, a lack of workforce planning, acute staffing shortages, reduced bed stock, unsafe bed occupancy levels, year-round capacity issues, growing waiting lists, neglected infrastructure and deteriorating equipment² (see for example PB/15 - INQ000185355, PB/113 - INQ000145849 to PB/116 – INQ000145865).

26. These fault lines were brutally exposed over the course of the pandemic and were key aspects of the UK's significant lack of preparedness and resilience. The extent of these pre-existing capacity constraints meant that there was little slack in the system when the pandemic hit and many elective procedures, diagnostic tests and routine outpatient services had to be suspended in order for staff, resources and beds to be utilised for Covid care. Existing staff shortages were also exacerbated by Covid-related absences and meant that doctors worked in intense and often unsafe conditions for much of the

² The BMA produces regular analysis of the main pressure points within the NHS in England: <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/an-nhs-under-pressure>

pandemic. Doctors reported feeling overworked, exhausted, and with no option but to take on ever increasing workloads.

27. The BMA welcomes the Inquiry's recent clarification in its ruling dated 09 March 2023 following the first Module 3 preliminary hearing that "*Module 3 will seek to ascertain the state of the healthcare systems as at March 2020, for example by considering the numbers of hospital beds, staffing capacity, availability of respiratory equipment and PPE*". For this reason, the BMA's response to this Module 1 Rule 9 request will make reference to these issues where relevant, with more substantial detail and documents to be provided to the Inquiry in relation to Module 3.

D. The UK's emergency and pandemic planning and preparedness did not adequately consider inequalities

28. It is the BMA's view that pre-existing inequalities and the vulnerabilities of different groups were not adequately taken into account in the UK's emergency and pandemic planning and preparedness. Where these were considered, ineffective implementation led to increased harm for certain groups.

29. The BMA includes healthcare workers as a vulnerable group due to their greater exposure to the virus through their work. As the trade union and professional association for doctors, they were the BMA's main focus during the pandemic, but the majority of the concerns and issues raised by the Association also applied to other frontline health and social care workers.

The UK failed, and continues to fail, to adequately consider aerosol transmission which impacted the protection available in health and care settings

30. The failure to properly prepare for an airborne virus pandemic (as set out above in paragraphs 19 to 20) impacted the protections available to healthcare workers. As a result, IPC guidance for the vast majority of the pandemic, and still to this day, puts staff and patients at risk by recommending the wearing of FSRMs rather than respirators, such as FFP2/3, for the routine care of patients likely to be infected with Covid-19.

PPE shortages further increased the risk to healthcare workers

31. A lack of domestic PPE manufacturing and the failure to implement recommendations from previous pandemic planning exercises (for example in relation to PPE stockpiles)

increased the UK's urgent dependence on PPE from global supply chains and a complex web of private providers. This left the UK Government less able to respond in an agile and rapid way to the dramatic increase in demand for PPE caused by Covid-19.

32. As a result, health and social care staff experienced severe shortages of PPE, particularly during the first wave, with UK stockpiles lasting only two weeks into the pandemic. Staff on the frontline often had to go without PPE, buy their own, reuse single-use items or use homemade, donated or expired items. In a BMA survey as part of its COVID-19 Review, 81% of respondents reported not feeling fully protected during the first wave of the pandemic.
33. The government's actions also meant that PPE was not available to suit a diverse range of physiologies, including for smaller, often female, face shapes, and for staff who wear a beard or hair covering for religious reasons. The need to ensure sufficient supplies of PPE to fit a wide range of face shapes and sizes was not adequately considered as part of pandemic planning prior to Covid-19.

A lack of testing capacity further increased exposure to the virus in health and care settings

34. Failure to adequately prepare for the testing capacity needed, for example through increased manufacturing or earlier imports of testing kits, left healthcare workers and their patients at increased exposure to Covid-19, particularly at the beginning of the pandemic.
35. The first wave of the Covid-19 pandemic saw high levels of nosocomial³ spread. Tests were not available for incoming patients or staff themselves. This meant healthcare workers were often in contact with Covid-19 positive patients without the recommended PPE and may have unwittingly transmitted the virus to their patients and colleagues.
36. This initial lack of preparedness was then compounded by UK Government decisions made during the Covid-19 pandemic in relation to testing and contact tracing, including the decision to make relatively little use of existing NHS laboratory capacity (see paragraph 42c).

³ Nosocomial infection, also called healthcare-associated infection, is an infection that is acquired while receiving medical treatment or from being in contact with healthcare services.

The guidance on risk assessments prior to the pandemic was inadequate

37. Employers are by law required to carry out risk assessments of their work activity and act upon them. The UK Government failed to adequately remind employers of this responsibility during the Covid-19 pandemic and did not provide sufficient explicit guidance and other support for employers to undertake risk assessments in a timely manner.
38. On multiple occasions the BMA raised concerns that legally required risk assessments were not being undertaken in healthcare settings, for example on 20 May 2020 the BMA wrote to NHS England highlighting that over half of BMA survey respondents were not aware of any risk assessment in their place of work (PB/57 - INQ000097908). It was not until 24 June 2020, three months into the pandemic, that NHS England issued a letter reminding local employers to undertake risk assessments for their staff (PB/117 - INQ000145891). Yet a BMA survey in October 2020 found that risk assessments had still not been rolled out fully, and the BMA raised its concerns again in a letter to NHS England in November 2020 (PB/118 - INQ00118181).
39. As a result healthcare staff, including those more vulnerable to Covid-19, for example due to factors such as age, ethnicity, sex or underlying health conditions, did not receive timely and adequate risk assessments which could have prevented the death and long-term illness of some workers.

A lack of preparedness significantly impacted on vulnerable groups in the wider population

40. In addition to healthcare workers, the BMA has been proactive in highlighting particular at-risk or vulnerable groups within the wider population. The UK's significant pre-existing health inequalities profoundly impacted outcomes for certain groups; those who were most at risk of infection, severe symptoms and death were those with the worst health outcomes prior to the pandemic suggesting more could have been done to protect these groups. This was a particular issue for those from ethnic minority backgrounds who experienced disproportionate mortality from the virus. Equally, had inequalities been addressed before March 2020, the impact of Covid-19 in the UK is likely to have been less severe.
41. The unequal impact of decisions made by governments during the Covid-19 pandemic can be seen as indicative that pandemic preparations prior to March 2020 did not give sufficient consideration to inequalities and accessibility. Examples include:

- a. Clearer public health messaging which emphasised the role of aerosol transmission could have equipped the public, including those more vulnerable to the virus, such as those from ethnic minority groups, with more accurate information on how to keep themselves safe. The UK Government did not launch public health messaging which emphasised ventilation until November 2021.
- b. Adequate consideration of aerosol transmission should have ensured that FFP2/3 respirators were available for vulnerable people rather than lower grade masks, thereby offering greater protection from infection.
- c. Public health guidance was not accessible to all. This includes a lack of translations for public health guidance into languages other than English and Welsh, the failure to provide sign language interpreters on UK Government television briefings, and the difficulties experienced by some people categorised as Clinically Extremely Vulnerable (CEV) in relation to shielding letters (outlined further in paragraph 42f.iii).

E. A number of government decisions should have been made differently, with key lessons to be learned for the future

Government decisions in response to the Covid-19 pandemic that should have been made differently

42. The BMA's response to the Inquiry's Rule 9 request for Module 2 provides a detailed outline of its views on the UK's core political and administrative decision making during the pandemic. Key government decisions made in response to the Covid-19 pandemic that the BMA believes should have been made differently include:

- a. Aerosol transmission:
 - i. The UK's response failed, and continues to fail, to properly consider and openly acknowledge that Covid-19 is spread by aerosol transmission.
 - ii. This failure had wide implications for decisions about what non-pharmaceutical interventions (NPIs) were implemented, for example a greater focus on indoor ventilation air quality monitoring and clearer

public health messaging about aerosol spread could all have reduced transmission of the virus.

- iii. It also had direct implications for healthcare workers and patients, as the IPC guidance issued by the four nation IPC cell continues to put staff and patients at risk by recommending the wearing of FRSMs rather than respirators such as FFP2/3 for routine care of patients likely to be infected with Covid-19.

b. PPE supplies:

- i. As a result of government decisions made prior to the pandemic, the UK entered the Covid-19 pandemic with significant shortages of PPE, especially RPE (outlined in more detail in paragraphs 31 to 33).
- ii. The UK Government failed to recognise early enough that its existing supplies of PPE would be insufficient. In March 2020, NHS England assured the Health and Social Care Committee that the stockpile would last the whole of the pandemic, despite it containing less than two weeks' worth of most equipment (PB/119 - INQ000145899).
- iii. PPE procurement processes lacked transparency and were often flawed, leading to PPE being delivered that did not meet the Government's specifications and was unsuitable for use (PB/120 - INQ000145895), putting health and care staff at risk. Frontline health and care organisations with relevant PPE knowledge were unable to recommend leads to the high-priority lane for PPE contracts, while leads from ministers and lords were more actively pursued (PB/119 - INQ000145899).

c. Testing and contact tracing:

- i. The UK Government made the decision to abandon initial contact tracing, which was run by local and national public health services, in all UK nations on 12 March 2020. England's deputy chief medical officer later admitted that this decision was at least partly due to a lack of capacity (PB/121 - INQ000145860).
- ii. During the early months of the pandemic, a lack of testing capacity meant there were not enough tests for all patients who needed one, despite the virus beginning to circulate widely. As a result, tests in

healthcare settings were limited to those entering intensive care which left little capacity available for other patients in hospital, or those being discharged into social care settings, which had severe implications for many living in care homes.

- iii. The shortfall in testing capacity is partly due to the UK Government's failure to utilise the 44 pre-existing NHS laboratories and an overreliance on both the private sector and the seven Lighthouse Laboratories. The expense and effort of using these alternative laboratories, which operated independently of public health and NHS infrastructures and used different software and systems, was unnecessary and created unhelpful fragmentation.
- iv. In contrast to the approaches taken in Scotland, Wales and Northern Ireland, the UK Government's decision to outsource contact tracing and testing in England, and make relatively little use of existing public capacity, remains opaque and is widely regarded as a critical and costly failure. The decision to outsource to external organisations had implications for the contact tracing success rate, with reports of inexperienced and inadequately trained staff. Despite its cost and the size of its staff, England's NHS Test and Trace was unable to reach a large number of Covid-19 cases and their contacts, particularly in its first two months. Although direct comparisons with publicly run models are difficult to make, some (see for example PB/122 - INQ000145859 and PB/123 - INQ000145894) have pointed to these being both more effective in limiting transmission and cheaper to run.
- v. There were repeated calls for England's contact tracing system to be run at a local authority level. This gradually started to happen from August 2020, three months after the launch of NHS Test and Trace, with indications that local teams had higher success rates. However, this shift towards local authority involvement was slow, with only one third of England's local authorities having local contact tracing systems in place by October 2020. The initial decision to outsource contact tracing, followed by a slow transition to involve local authority teams, resulted in an ineffective system that put lives at risk – bolstering local

teams from the start rather than abandoning contact tracing would have likely been a better decision.

d. Use of public health expertise:

- i. The decision not to ensure adequate independent specialist public health and occupational health expertise at the highest levels of decision making, including on SAGE, had a critical impact on other decisions made by the UK Government during the pandemic. It is the BMA's view that this lack of public health expertise may have led to delays in implementing lockdowns or introducing other NPIs. Corresponding lack of occupational health expertise led to inadequate guidance on the protection of staff, as well as the protection of patients from health care associated infections.
- ii. Public health measures during Covid-19 were decided using a relatively centralised process. Local public health teams struggled to access the data they needed to interpret or explain government decisions, to constructively scrutinise and challenge national guidance, and to effectively manage local lockdown restrictions.

e. Legislative preparedness and speed of introducing public health measures:

- i. Despite publishing its Coronavirus action plan on 3 March 2020, and then abandoning contact tracing nine days later on 12 March 2020, the UK Government decided to wait a further 11 days before implementing a nationwide lockdown on 23 March 2020.
- ii. Prior to the nationwide lockdown the UK Government decided to pursue a strategy from 16 March 2020 of encouraging, but not requiring, the public to change their behaviour. The rationale behind this decision, rather than implementing the lockdown earlier, is unclear and may be partly due to a lack of legislative and fiscal preparedness in relation to the Coronavirus Act and the funding for the furlough scheme.
- iii. A number of other public health measures were introduced too late, lifted too early, and lacked clarity in the way they were communicated. The requirements around face masks, for example, changed on a frequent basis with all four UK nations taking an approach of requiring masks to be worn on public transport first, before a series of

announcements over a number of weeks, then introduced this requirement in other settings.

- f. Accessibility of public health messaging:
 - i. The UK Government failed to provide adequate translations of public health guidance in a timely manner. The few translations that were produced were then not updated as guidance changed. Accessible and up-to-date information on how to protect themselves from a fast-spreading disease such as Covid-19 likely would have allowed ethnic minority groups, whose first language was not English or Welsh, to better protect themselves.
 - ii. Similarly, the UK Government failed to provide sign language interpreters during live Covid-19 briefings, unlike Scotland which had provisions from the start. By not doing so, the UK Government put deaf and disabled people at risk by not providing access to the information they would need to protect themselves. In July 2021, the High Court ruled that the UK Government's failure to provide British Sign Language interpreters was discriminatory and breached equality legislation.
 - iii. Accessibility was also lacking in relation to the shielding letters for people categorised as CEV. Not everyone who received a shielding letter could read and understand its contents, with an initial lack of available translations and easy-read versions.
- g. Ethical guidance on triage and decision making should capacity become overwhelmed:
 - i. The urgent need for clinical staff to have guidance on decision making, triage and resource allocation in the event that resources became overwhelmed was discussed with the Moral and Ethics Advisory Group (MEAG) set up by the Department of Health and Social Care (DHSC), and draft guidance was discussed (PB/124 - INQ000145835).
 - ii. However, by 30 March 2020 the UK Government decided not to issue this guidance in order to avoid raising public anxiety unnecessarily (PB/125 - INQ000117809).

- iii. Healthcare professionals were asking for this guidance and needed it to be issued urgently to enable them to be properly prepared and supported, even if the situation never realised and the guidance was not ultimately put to use. As a result of the UK Government's decision not to issue guidance, the BMA issued its own guidance for the profession, as did a number of other organisations. However, having multiple sets of guidance, instead of a central source, creates the risk of different interpretations and a lack of clarity for staff.
- h. Disbanding Public Health England (PHE) in the middle of the Covid-19 pandemic:
 - i. Public health services in England were affected by PHE being disbanded during the pandemic. Although this is an example of change being enacted swiftly when there is a political will to act, the timing was inappropriate and caused disruption and uncertainty for the organisation's staff, who were forced to spend time and resources arranging a restructure – rather than on Covid-19.
 - ii. It is also possible that this very public reorganisation of PHE may have had an impact on the public's and healthcare staff's trust in the public health system, in pandemic response measures more widely and in the ability of the newly structured system to respond to future pandemics. The BMA raised its concerns with the new Chief Executive of UKHSA in April 2021 (PB/126 - INQ000097953).

Lessons to be learned for future pandemics and other whole-system emergencies

43. In addition to the key decisions outlined above, it is vital that governments learn the lessons from the Covid-19 pandemic to ensure a tragedy on this scale is not repeated.

44. As part of its COVID-19 Review, the BMA has identified a number of lessons for future pandemics and other whole-system emergencies. These include:

- a. **Implement recommendations from pandemic planning exercises:** Governments should conduct proper pandemic planning and readiness exercises for future pandemics and must implement their recommendations transparently.
- b. **Highlight existing responsibilities under health and safety law:** A key part of pandemic preparedness is that the spread of disease can be controlled in

work settings and that the most vulnerable can be protected. Employers are by law required to carry out risk assessments and act upon them. Ensuring that employers are well aware of and reminded of these responsibilities should be prioritised in all stages of a pandemic response, and public sector employers should lead by example in this area. This includes ensuring that IPC guidance is updated rapidly in response to fast-changing situations and evidence. The level of health and safety guidance should be at least as detailed as that produced by HSE for other hazards. In addition, responsibilities to report occupationally acquired infections as required by law must be publicised and enforced.

- c. **Maintain an adequate rotating stockpile of PPE and have plans to quickly scale up procurement and manufacturing if required:** PPE stockpiles need to be suitable to different face and body shapes, varying hair textures, head coverings, and facial hair so all workers can access adequate protection. They should also be rotated regularly to ensure PPE stockpiles do not become out of date. Regular inspections and safety testing of PPE are also important. Regular staff training and fit testing of RPE should be implemented together with the provision of further 'surge capacity' supplies to be activated during whole-system emergencies.
- d. **Improve health and care data:** To support a quick and effective response to whole-system emergencies, UK and devolved nation governments should make sure data collected is comparable and easily available. Data are currently not always collected in a comparable way across all four UK nations, which creates significant data limitations by preventing comparisons and the ability to build a full picture of emergency situations as they develop.
- e. **Improve public health infrastructure and capacity:** Governments should adequately fund public health infrastructure and services wherever they are located to enable the UK to better respond at a rapid pace during future emergencies. This includes reversing any cuts made in recent years, ensuring public health systems have adequate contact tracing capacity that can be rapidly scaled up for future pandemics, urgently increasing the number of public health staff at a local and national level, and increasing the number of training places provided. All UK governments should also review their public health structures to ensure expertise is located where it is needed and is

included as part of government decision making – particularly at times of national crisis.

- f. **Take action to reduce health inequalities:** Governments must develop a cross-government strategy to improve population health and reduce health inequalities in order to reduce the disproportionate impact of future pandemics on certain groups. The impact that government actions have on physical and mental health must be central to all government decision-making, following a 'health in all policies' approach – something which will be implemented for public bodies in Wales when the Public Health Wales Act (2017) comes into force. Action must also be taken to tackle institutional racism within the NHS and reduce levels of mistrust and hesitancy amongst ethnic minority communities when engaging with health services.
- g. **A consideration of inequalities must be central to pandemic preparations:** Governments must ensure that pandemic planning includes full consideration of inequalities, with tangible systems in place to mitigate disparities. This includes improving systems for up-to-date public health communications that are inclusive and accessible.
- h. **Increase health service capacity and ensure health services are prepared for the next pandemic:** Governments must ensure that health services are able to respond effectively to future pandemics. Key elements of this includes:
 - i. Undertaking continuous and transparent assessments of workforce shortages and future staffing requirements, with Governments taking accountability for providing safe staffing levels and fully resourcing health services. This will include expanding all aspects of the medical training pipeline to increase capacity for domestic training of doctors in the UK.
 - ii. Developing a credible plan to meaningfully increase hospital capacity, growing core bed stock to a level that will cope with year-round demand and is able to rapidly scale up capacity in case of a future pandemic, as well as avoiding a reliance on costly private sector capacity.

- iii. Improving capital investment, modernising physical and digital infrastructure, and improving ventilation of the NHS estate by implementing clear standards, with funding and equipment to meet them.

F. The BMA's communication and engagement with governments on the state of the UK's emergency and pandemic planning, preparedness, resilience and lessons learned

45. To identify relevant information related to the BMA's communication and engagement with governments, the BMA has conducted document searches and sought input and assistance from staff and elected members across the organisation. However, given the extensive time period covered by this Rule 9 request, there have been numerous staff and member changes as well as changes to electronic systems and archiving processes. These factors have posed significant challenges to fully identify all of the BMA's relevant engagement with governments on this issue. The following information outlines the BMA's engagement to the best of its knowledge.
46. The BMA's review has identified that the Association engaged with governments on a number of occasions in relation to pandemic preparedness. This was usually linked to specific planning exercises or the development of guidance, often related to preparation for an influenza style pandemic. The BMA's ethics team in particular had closer engagement with the UK Government during this time on the ethical issues related to pandemic planning.
47. The BMA's direct engagement in pandemic planning (planning exercises, guidance and consideration of ethical issues) was primarily conducted by UK central teams. However, the BMA offices across the UK regularly engaged with and sought to influence governments in relation to wider preparedness of health care and public health systems to withstand emergency situations and shocks.

Engagement with pandemic planning guidance

48. During the 2009 swine flu pandemic, senior representatives from the BMA were closely involved with UK Government planning both in anticipation of the pandemic and during the pandemic itself. The BMA's engagement included:
 - a. Representation on the Department of Health's Emergency Preparedness Clinical Liaison Action Group (EPCLAG) and on the Committee on the Ethical Aspects of Pandemic Influenza (CEAPI) (PB/127 - INQ000145863 to PB/128 - INQ000145864).

- b. Development of advice on ethical issues arising during a pandemic. This was developed in advance of the pandemic and fed into both national and international guidance.
 - c. Providing input into operational guidance for healthcare settings. This included joint guidance for primary care settings with the Royal College of General Practitioners (PB/129 - INQ000145836) and providing input through the Social Partnership Forum (SPF) into draft guidance from the Department of Health regarding workforce issues and pandemic flu preparations (PB/130 - INQ000145877 to PB/131 – INQ000145876).
 - d. Providing comments on the Department of Health's review of a flu algorithm to be used to assess flu symptoms and authorise antivirals in the event of a pandemic being declared.
49. In April 2011 the Department of Health shared the draft UK Influenza Pandemic Preparedness Strategy with the BMA for comment. The BMA's response (PB/132 - INQ000145842) highlighted concerns that some of the key lessons from the H1N1 (2009) influenza pandemic had not been learnt, including in relation to plans for: how 'hot spots' were handled, PPE, staff redeployment, the prioritisation of scarce resources and surveillance data. The response also warned that the current reorganisation of healthcare and public health systems in England jeopardised a coordinated and integrated UK approach.
50. At least one elected BMA member was also a stakeholder in Exercises Cygnet (pre-exercise event) and Cygnus in 2016, and Exercise Pica in 2018. The role of this stakeholder was in a personal capacity as a member of NHS England's Emergency Preparedness, Resilience and Response team (EPRR), albeit they were likely appointed because of their expertise and role within the BMA.

Ethics

51. Throughout the period of time covered by this Rule 9 request, the BMA's medical ethics team was engaged in a variety of ways in providing input and advice to government on pandemic planning. The BMA's ethics team is highly respected for their expertise on ethical issues and individual members were often invited to sit on committees or groups due to their personal knowledge and expertise, and not as a representative of the BMA with authority to sign off decisions on behalf of the BMA.

52. While engagement on these issues continued throughout the period, it was more concentrated around 2009, before, during and after the H1N1 (swine flu) pandemic (PB/133 – INQ000145878) as well as later periods when the government was consulting on pandemic planning guidance or undertaking pandemic planning exercises, including around the time of Operation Cygnus in 2016. Key engagements with Government are set out below.

53. In particular a senior member of the BMA's ethics team sat on the Department of Health's EPCLAG and on CEAPI, which was responsible for developing an ethical framework for pandemic influenza in 2007.

54. An elected member of the BMA also sat on the EPCLAG.

2009–2011

55. Between February and September 2009, a senior member of the BMA's ethics team was asked to input, from a medical ethics perspective, into various documents via email, including:

- a. Department of Health - 'Pandemic Influenza - Managing demand and increasing capacity in health and social care setting'. Concerns were raised with how the draft dealt with issues concerning withdrawing and withholding medical treatment in circumstances where resources were overwhelmed (PB/134 - INQ000145875). Subsequently, the BMA submitted a document 'Withdrawing and Withholding treatment during pandemic flu' (PB/135 - INQ000145911) to the EPCLAG for consideration and recommended it be used as the basis to re-write chapter 10 of the document relating to these issues.
- b. Department of Health - Review of a flu algorithm, to be used to assess flu symptoms and authorise antivirals in the event of a pandemic being declared in the near future (PB/136 - INQ000145880 and INQ000145881).
- c. Department of Health - Workforce issues and Pandemic Flu draft guidance (PB/130 - INQ000145877 to PB/131 – INQ000145876).

56. The same senior staff member was also invited to several external meetings to discuss pandemic preparedness issues both during and after the swine flu pandemic, including a follow up meeting after EPCLAG with the Department of Health to discuss views on how the UK could improve pandemic preparedness for any future pandemic and also ensure that there is consistency in clinical information (February 2010) (PB/137 -

INQ000145874). The BMA does not have minutes or any records of what was discussed at these meetings.

57. A senior staff member and a BMA Council member were interviewed by Dame Deirdre Hine in her capacity as Chair of the Independent Review of the Government Response to the 2009 H1N1 Pandemic (April 2010) (PB/138 - INQ000145887 to PB/139 - INQ000145888). The BMA holds no records of these meetings, or the issues discussed, but both individuals are mentioned as contributors in Dame Hine's report (PB/140 - INQ000145901).

2016

58. A member of the BMA medical ethics team provided ad hoc ethical advice to EPRR before, during and slightly after Operation Cygnus. This included being on standby during Operation Cygnus to provide ethics advice as required. The member of staff, who is still employed by the BMA, does not recall being called upon during the Operation itself and has no emails to that effect.

59. In September 2016, the BMA hosted a meeting of ethics experts and NHS England to help review their pandemic influenza guidance and draw out ethical issues.

60. Members of NHS England's EPRR group attended a routine meeting of the BMA's Medical Ethics Committee (MEC) in December 2016 (PB/141 - INQ000145866 and INQ000145867). This was for the purpose of exchanging professional views and to discuss and debate ethical issues which would arise during any future pandemic. The meeting discussed the vital need for clear protocols and decision-making processes to be put in place to identify when the threshold to move from resource allocation on the basis of clinical need to 'population triage' had been reached and it was highlighted that this should ideally be covered by anticipatory legislation. The meeting also recommended that public awareness-raising and debate should take place well before any pandemic occurred in order to maintain public confidence. The MEC was not asked to, nor did it, provide a formal report or response to the EPRR group subsequent to the discussion at the MEC.

Post 21 January 2020

61. Members of the BMA Medical Ethics team sat on MEAG formed in October 2019. This group pivoted to focus on ethical issues relating to the Covid-19 pandemic in March 2020.

62. Early in the pandemic, the BMA, along with other organisations, called on the UK Government to urgently publish guidance on ethical decision making when healthcare

resources, particularly critical care, were overwhelmed. The BMA argued that it was important to provide clear guidance to healthcare professionals to enable them to be properly prepared and supported, even if this situation was never realised.

63. At the same time, as a matter of urgency, the BMA was working to develop its own guidance for medical professionals and a set of FAQs.

64. As the BMA was finalising this guidance, the Chair of the MEC was approached by the Medical Director for NHS England and informed of plans for pan-professional guidance to be developed, overseen by a clinical advisory group. This was commissioned by the four Chief Medical Officers across the UK. In an email to the Medical Director of NHS England (23 March 2020) (PB/142 - INQ000117785) following a telephone call of the same day, the Chair of the MEC welcomed the plans and set out the BMA's three principles for any such guidance:

- It must be urgently issued, that week.
- It must be honest, truthful and transparent and be frank in guiding healthcare professionals and in informing the public about the immensely difficult resource allocation and prioritisation decisions which lay ahead.
- It must be applicable throughout the UK.

65. The guidance was never published and, therefore, given the urgent need for clear guidance to the medical profession, the BMA published its own ethical framework and guidance on triage (PB/143 - INQ000117773) and a set of FAQs (PB144 - INQ00011772 and PB/145 - INQ000117774) which were published on the BMA website on 20 March 2020. On 8 April 2020, the BMA published a clarifying statement on its website about how the guidance applied to age and disability (PB/146 - INQ000145862). Other organisations, including the Intensive Care Society also published guidance for their members.

66. In September 2022, the DHSC team that provided secretariat support for MEAG asked the group's members for feedback as part of a review of MEAG after three years of operation. In responding to this request, a BMA staff member, who had attended MEAG most often during the pandemic, provided reflections via email (29 September 2022) on how it had worked (PB/147 - INQ000145907). It was noted that while they found many of the discussions were helpful and informative and they appreciated the breadth of expertise and representation on the group, there were two main frustrations from the BMA's perspective, namely:

- a. The impossibility of achieving consensus on the ethics of triage in the face of possible pandemic-induced shortages of critical health supplies. This failure left the profession (including the BMA) to take on this work.
- b. The inability of the group to address ethical challenges in real-time, either because they were not timetabled for discussion or, if they were, relevant decisions had already been made. As a result, the primary purpose of the group was not clear.

State of public health and healthcare systems

67. Throughout the period covered by this Rule 9 request, the BMA regularly raised concerns with governments in relation to the state of public health and healthcare systems, their lack of capacity and resilience and the consequences for patients, staff and the public. The BMA did not always directly frame these concerns in relation to pandemic preparedness, however the BMA’s communications ensured governments were fully aware that public health and health systems were struggling to provide adequate services even in normal times and that action needed to be taken.

68. Since the start of the Covid-19 pandemic, the BMA regularly raised concerns with governments about the issues experienced by its members during the pandemic. It is the BMA’s view that many of these issues were a result of the UK’s lack of pandemic preparedness and resilience. Extensive details of these communications can be found in the BMA’s response to the Inquiry’s Rule 9 request for Module 2.

G. Key articles, reports and evidence given by the BMA regarding the UK’s emergency and pandemic planning, preparedness and resilience

69. The BMA has commented and published widely on the preparedness of UK healthcare systems. It recognises that these issues will be considered more directly in Module 3 of the Inquiry. However, to assist the Module 1 investigation, the statement identifies below a small selection of documents of relevance. The BMA is happy to provide any further documents the Inquiry may find useful.

BMA articles and reports

Year	Date	Item	Exhibit number
2016	19 February 2016	NHS Funding and Efficiency Savings	(PB/148 - INQ000145834)

Year	Date	Item	Exhibit number
2017	May 2017	A vote of health: BMA manifesto 2017	(PB/149 - INQ000145838)
2018	05 March 2018	Institute for Public Policy Research Call for Evidence: The Lord Darzi Review of Health and Care	(PB/150 - INQ000145870)
	16 March 2018	Feeling the squeeze: The local impact of cuts to public health budgets in England	(PB/112 - INQ000145868)
	18 June 2018	NHS funding settlement: Is it enough and how should it be spent?	(PB/151 - INQ000145855)
	12 September 2018	Prevention before cure: Securing the long-term sustainability of the NHS	(PB/152 - INQ000145902)
2019	28 March 2019	Prevention before cure: Prioritising population health	(PB/153 - INQ000145903)
	August 2019	A health service on the brink: the dangers of a 'no deal' Brexit	(PB/154 - INQ000145856)
2020	26 November 2020	BMA Cymru Wales: A manifesto for health	(PB/155 - INQ000145857)
2021	19 March 2021	Rest, recover, restore: Getting UK health services back on track	(PB/156 - INQ000118308)
	12 July 2021	Medical staffing in England: a defining moment for doctors and patients	(PB/157 - INQ000145854)
	19 November 2021	Weathering the storm: vital actions to minimise pressure on UK health services this winter	(PB/158 - INQ000118442)
2022	May 2022	Public Health Specialists Manifesto	(PB/159 - INQ000145906)
	19 May 2022	Covid Review Report 1: How well protected was the medical profession from COVID-19?	(PB/13 - INQ000118474)
	19 May 2022	Covid Review Report 2: The impact of the pandemic on the medical profession	(PB/14 - INQ000118475)
	26 June 2022	Covid Review Report 3: Delivery of healthcare during the pandemic	(PB/15 - INQ000185355)
	28 July 2022	Covid Review Report 4: The public health response by UK governments to COVID-19	(PB/16 - INQ000185356)
	28 July 2022	Covid Review Report 5: The impact of the pandemic on population health	(PB/17 - INQ000185357)
	1 August 2022	A manifesto For health: BMA Northern Ireland 2022	(PB/160 - INQ000145840)
	05 December 2022	Building the Future 1: Brick by brick: The case for urgent investment in safe, modern, and sustainable healthcare estates	(PB/114 - INQ000145852)
	05 December 2022	Building the Future 2: Getting IT Right: The case for urgent investment in safe, modern technology and data sharing in the 2 UK's health services	(PB/115 - INQ000145853)

Evidence submissions and consultation responses

Year	Date	Item	Exhibit number
2011	March 2011	Liberating the NHS: Developing the Healthcare Workforce From Design to Delivery	(PB/161 - INQ000145843)
2013	7 November 2013	Health Committee: Public Health England	(PB/162 - INQ000145889)
2015	18 December 2015	Review of the Public Health Act (NI) 1967: BMA Northern Ireland response	(PB/163 - INQ000145908)
2016	13 January 2016	Health Committee: Public health post-2013	(PB/164 - INQ000145905)
	22 January 2016	Health Committee: The impact of the Comprehensive Spending Review on health and social care	(PB/165 - INQ000145890)
	20 July 2016	Programme for Government draft framework: Comments from BMA Northern Ireland	(PB/166 - INQ000145897)
2017	04 January 2017	Public Accounts Committee: Financial Sustainability of the NHS	(PB/167 - INQ000145898)
	12 May 2017	Parliamentary Review of Health and Social Care in Wales, and supplementary response	(PB/168 - INQ000145909 and PB/169 - INQ000145910)
2018	February 2018	Public Accounts Committee: Sustainability and Transformation in the NHS	(PB/170 - INQ000145900)
	23 August 2018	Northern Ireland Affairs Committee inquiry into funding priorities in the 2018-19 Budget: Health	(PB/171 - INQ000145896)
	September 2018	NHS England Long Term Plan	(PB/172 - INQ000145844)
	September 2018	Health and Social Care Committee: Impact of a 'no deal' Brexit on health and social care	(PB/173 - INQ000145851)
	September 2018	UK Government Budget	(PB/174 - INQ000145837)
	October 2018	Public Accounts Committee: Department of Health and Social Care (DHSC) accounts	(PB/175 - INQ000145845)
2019	October 2019	UK Government Green Paper: Advancing our health: prevention in the 2020s	(PB/176 - INQ000145848)
	November 2019	BMA Manifesto for health	(PB/177 - INQ000145839)
2020	February 2020	UK Government Budget 2020	(PB/178 - INQ000145846)
	26 March 2020	Health and Social Care Committee: Preparations for coronavirus	(PB/179 - INQ000117799)
	12 May 2020	National Audit Office: Readyng the NHS and social care for the COVID-19 peak	(PB/180 - INQ000117896)
	22 May 2020	Health, Social Care and Sport Committee (Welsh Parliament): Inquiry	(PB/181 - INQ000118549)

Year	Date	Item	Exhibit number
		into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales	
	29 June 2020	House of Lords Select Committee Inquiry: Public Services - Lessons from Covid-19	(PB/41 - INQ000118011)
	02 July 2020	Health, Social Care and Sport Committee (Welsh Parliament): Covid-19 Evidence Session	(PB/182 - INQ000118573)
	September 2020	UK Government Comprehensive Spending Review 2020	(PB/183 - INQ000145847)
	18 September 2020	Changes to Human Medicine Regulations to support the rollout of Covid-19 vaccines	(PB/184 - INQ000118117)
	07 December 2020	Public Accounts Committee Inquiry: Procurement and supply of PPE	(PB/185 - INQ000118235)
	10 December 2020	Foreign Affairs Committee Inquiry: Global Health Security	(PB/186 - INQ000145871)
2021	20 January 2021	BMA Northern Ireland response to 2021-22 Budget	(PB/187 - INQ000145841)
	22 March 2021	Programme for Government draft outcomes framework: Comments from BMA Northern Ireland	(PB/188 - INQ000145869)
	April 2021	Health and Social Care Committee: White paper on health and social care	(PB/189 - INQ000145892)
	05 April 2021	Department of Health and Social Care (DHSC) consultation: Transforming the public health system: reforming the public health system for the challenges of our times	(PB/190 - INQ000145850)
	10 June 2021	Public Accounts Committee Inquiry: Initial lessons from the government's response to the COVID-19 pandemic	(PB/191 - INQ000118350)
	21 October 2021	Health and Social Care Committee and the Science and Technology Committee Inquiry: Coronavirus: Lessons learnt	(PB/192 - INQ000118424)

Persons, entities or organisations which may hold relevant information or material

70. The BMA notes that Rule 9 requests have already been issued to a number of organisations that the BMA considers relevant to the scope of Module 1.

71. In addition, the BMA suggests that a request for information be made to:

- a. Health and Safety Executive Northern Ireland
- b. All members of the UK-wide IPC Cell
- c. All members of the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG)

- d. All members of the Advisory Committee on Dangerous Pathogens (ACDP)
- e. The British Occupational Hygiene Society
- f. Faculty of Occupational Medicine
- g. Society of Occupational Medicine

72. The BMA seeks clarification that:

- a. The request to NHS England will cover the Emergency Preparedness Resilience and Response (EPRR) group.
- b. Requests to UK Government departments will cover the Scientific Advisory Group for Emergencies (SAGE) and the Environmental Modelling Group (EMG) as a sub-group of SAGE.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signature:

Personal Data

Name: Philip Banfield

Date: 12th April 2023