Tuesday, 18 July 2023

(10.00 am)

MR KEITH: Good morning, my Lady. The first witness today is Matt Fowler, the co-founder of Covid Bereaved Families for Justice. Could you be sworn, please.

MR MATT FOWLER (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

LADY HALLETT: Mr Fowler, thank you so much for contributing to the Inquiry, and if at any stage you need a break, please just say.

THE WITNESS: Thank you very much.

MR KEITH: Could you give the Inquiry, please, your full name.

A. My name is Matthew Ian Fowler.

Q. Mr Fowler, thank you for attending this morning to give evidence, and thank you also for the provision of a number of statements that you and your group have provided this Inquiry.

I would like to ask you, please, some questions about the loss of your father, Ian Fowler, and then ask you some questions about the nature of the group that you co-founded, and also then to set out the concerns expressed by you and your group about the areas of the public response to the Covid pandemic where you believe things went wrong, in order to be able to properly found

the future work of this Inquiry.

Your father was a retired engineer from Jaguar Land Rover, is that correct?

A. That's correct. He worked for Jaguar Land Rover for 29 years. At the time of his -- by the end of his career he was working in the design offices at Gaydon, having been an employee for, you know, most of his working life. He had started as a welder engineer as a young man.

Actually the story about his interview is quite significant, it says a lot about him as a person. He turned up for his interview as a welder for Solihull, working on Defender. At the time there were a number of people that had been -- were being interviewed. However, the MIG welder machine they were supposed to be using to carry out the trial, if you like, wasn't working, and when my dad arrived he saw it wasn't working, repaired it, and was the only man on the day to put down a weld. He was the sort of guy that was very practical, very hard working and he was always the sort of guy to, you know, get the work done no matter what.

Unsurprisingly, he progressed very quickly in his time at Jaguar Land Rover. He was promoted to group leader, a job that I'm now doing myself, and eventually

moved into engineering, first in reverse engineering, he then moved into design, and was responsible for introducing rapid prototyping to the company, was key to getting the first 3D printers there. The latter part of his career was spent on SVO, which is special vehicle operations, where they were doing sort of one-off builds and things like that, one of which was Project 7, which was a D-type inspired car.

Q. It's lovely to hear --

A. Yeah.

Q. -- everything about the nature of the work he did at Jaguar Land Rover. Can I bring you forward --

A. Sure.

Q. -- to 2019, though, and ask you: did the time come when he retired from his job?

A. Well, this is what I was going to say. Towards the end of his career, he worked on these special vehicles and that wound him down to taking voluntary redundancy.

Q. Was that in March 2019?

A. March 2019.

Q. From your statement, Mr Fowler, it appears that he was in good health. He was a man who loved sport --

A. Yeah.

Q. -- he seemed to have played everything that he possibly could, and no doubt loved a round of golf with you.

In March of 2020, was he in generally quite good health?

A. Yeah. Dad had been quite an active guy for most of his life. You're right in saying that he did play many sports, everything, football, boxing, cricket, from a young age. He maintained an active lifestyle through his sort of 30s and 40s and, as he got older, took a more -- interest in a more sedate sport, being golf, but he would play frequently, several times a week. You know, I've always said that golf's a good way to ruin a good walk, but he enjoyed it a lot and that was something that he took a lot of pleasure in.

Q. That --

A. He also had two dogs that he used to walk frequently, and he was -- at the time of his death he was working on landscaping a garden. He was a very active -- active guy.

Q. But did there come a time in March of 2020 when he appeared to have caught the disease Covid?

A. Yes.

Q. Just if you could just give us the timeframe, Mr Fowler: do you know when he caught Covid, either generally or specifically?

A. Generally, yes. This is quite -- again, this is quite significant.

Q. Mr Fowler, will you allow me to develop the account?

It's very important that there are areas which we develop and which you can give evidence about to my Lady, and areas which I can't ask you about, because of the rulings that we have in this case.

A. Sure.

Q. So he caught Covid at some point in March 2020. Do you know when that was specifically?

A. So dad started showing symptoms of Covid around the 18th or 19th of March, where around there. So he would have been infected some time around -- well, between the 14th and then.

Q. Was he able to cope with the infection in the early days, at the start, or did there come a time when he began to struggle and needed hospital attention?

A. He tried not to make a fuss for quite some time. He put off seeking any help until it got to the point that he was struggling to breathe significantly, and on 22 March rang the emergency services and was admitted to hospital on 23 March, which was the day of the first lockdown.

Q. When he was taken into the hospital, was he tested for whether or not he had Covid?

A. He was.

Q. What was the result?

A. It was a positive result.

Q. May we take it that the hospital staff cared for him and

looked after him as best they could?

A. I have got nothing bad to say about the George Eliot Hospital in Nuneaton where he was admitted. They worked really hard to do whatever they could for him for the entire time that he spent in the hospital.

So the first five days on a nebuliser, with steroids, and oxygen to try and do the best that they could. But eventually his condition swan dived, he could no longer breathe without the assistance of the nebuliser, and they made the choice to intubate him. That was about five days into his hospital stay.

Then they fought daily for him for about two and a half weeks, by which point his major organs started to fail and the hospital contacted us and said that there was no longer anything they could do for him and they made the decision to withdraw his life support and allow him to pass peacefully.

Q. So he had been on life support towards the end. The hospital contacted you, did they, to tell you that they were going to withdraw life support?

A. Yeah, a few days before they'd said that if his condition wasn't -- didn't start to improve, then there would be nothing more they could do for him. So we were -- we were notified in advance, and we hoped beyond hope that something would change, but it wasn't the

case, and sadly dad didn't make it.

Q. And did he die on April 13?

A. April 13.

Q. Your statement recounts how, because of the regulations and the procedures which were then in force, the arrangements for his funeral were extremely difficult.

A. They were.

Q. Could you just briefly confirm to my Lady that your father's funeral took place under those restrictions that you identify in the statement, that is to say there were terrible limits on the number of persons from the family who could attend, the procedure and the course of the service and the ceremony and the burial were markedly affected by the rules, effectively denying your father considerable dignity in death?

A. Dad was an incredibly popular man, and it was a source of great pain for everybody that knew him that they would not be able to attend his funeral. Only ten people were allowed there on the day, all had to be socially distanced, due to those limitations, and as an illustration of how popular my dad was and the impact that he had on the people around him, over 300 people lined the streets for the procession. It was -- it was quite moving. And my uncle actually commented on the day that he felt like he'd accidentally joined Elvis's

procession instead.

But, yeah, dad couldn't be viewed. It was closed casket, obviously. Due to the restrictions and the possibility of contagion, dad actually had to be cremated in his hospital gown. And to anybody that's spent any time in hospital, the gowns aren't very dignified at any point and certainly not something that you would consider to be dignified for somebody making their final journey.

The funeral director, who was also family, my uncle David, he had to lay an outfit on top of the casket, to try and give us something. There was no opportunity to display the body, as had been in previous funerals that I'd been to, to, you know, say your final goodbyes or anything like that. It was very much a, he was -- he was there, I remember spending time with him on his birthday in January, and then he disappeared off the face of the planet and I never saw him again.

Q. About a month or so after your father passed away, did you read an article about a person called Jo Goodman who had lost her dad as well?

A. I did.

Q. Was that in May of 2020?

A. That was towards the end of April.

Q. Did you contact her?

A. What happened was the article spoke about Jo's dad, Stuart, who had also passed away from Covid, and talked about her feelings about what had happened. The comment section, as these things were prone to be at the time, were filled with some quite negative and unpleasant comments from people at the time, that of Covid deniers and -- and some very negative people.
Q. Can I pause you there?
A. Sure.
Q. Mr Fowler, from your statement, it appears that, both at that time and later, when you had started and -- you had founded and you had started to run the group, Covid Bereaved Families for Justice, appallingly you received a considerable amount, perhaps a vast amount of criticism, of vitriolic attacks on social media, people challenging the aims of your group and what you were trying to achieve, attacking you personally.

Is that something that happened throughout this whole time? And give us, please, some indication of the level of such material.
A. This is something that I think all of the bereaved have been subjected to over the course of the last three years. It's certainly --
Q. When you say bereaved, bereaved in your group or bereaved generally?

A. Yeah. Bereaved in our group.
Q. Is this on social media?
A. Largely, although it hasn't been exclusively on social media. There has also been -- it's happened in person as well in some cases.
Q. All right.
A. But, yes, that attitude of Covid denial, or Covid scepticism, anti-mask protesters, vaccine sceptics, those people have often targeted me and members of the group that I represent. Sometimes they have gone out of the way to seek people out. We've had people that have made media appearances talking about their loss who have then been stalked via social media and abused, and in some cases threatened.

One of the things that I would like to point out is that had my dad died from something else, say cancer, people wouldn't be coming to me and saying, "Well, was it really cancer?" It's something that has been very unique to our loss to be targeted in that way.
Q. Coming back to May of 2020, yourself and Ms Goodman decided to co-found the group, and did you become and are you now chair of the board of directors as the co-founder of the group?
A. Yeah, so after commenting on that particular article in The Independent, Jo had seen my comment and reached out

to me, and we struck up a conversation where we talked about our feelings about it and what we would like to do about what had happened. Specifically, our view has always been that we should be trying to do whatever we could to prevent other people from going through what we have.
Q. What did you have in mind in terms of how you would be able to prevent other people suffering what you and Ms Goodman had?
A. We wanted systemic change. We wanted there to be a change in the attitude towards how things had been managed.
Q. Do you mean in terms of the care and support to people suffering from the disease, or the government and structural systems in place for the maintenance and care of our elderly and our ill? Describe something about how you saw change as being possible and how you intended it to be made.
A. Well, it's all of the above, for a start, and I think one of the things that needs to be mentioned is that some time earlier in the year, while I was still working, I can remember seeing what was happening on the news in China, and then Italy, and then Spain, as Covid crept ever closer to the UK, and wondering why nothing was being done about it.

Q. All right. So you have identified there possible inaction on the part of the government.
A. There certainly was inaction.
Q. Looking prospectively, looking to the future, though, has your group formed a view as to particular areas where you feel there was an inadequacy of protection, where people were let down in terms of the way in which they were looked after, either as members of society or having caught the disease? Where are the main areas of concern as you and your group see it?
A. So, first and foremost, it's certainly to do with that element of not proactively having plans in place for this sort of world event.
Q. So the planning and preparedness, if you like, for a future pandemic or health emergency, the subject matter, in fact, of Module 1?
A. Yeah.
Q. What about in relation to hospitals and care homes? Have your members expressed concerns to you about the way in which, for example, in hospitals there were problems concerning infection control, communication between medical staff and family members of persons who were ill or dying?
A. Yeah. There have been a number of things that have been -- that have been brought up. So obviously my own

personal experience was to do with lockdowns. However, I'll point out that, although I'm grateful for the opportunity to have this conversation, the -- my experience doesn't encompass the experience of everybody, all of the bereaved, from Covid, experience. So there are many people that have many different things that they would like to add to this.

Q. Of course.

A. So --

Q. Well, let's run through them.

A. Sure.

Q. So your group have expressed concerns to you about dealing, firstly, with hospitals, those aspects that I've mentioned, so --

A. Yeah, so --

Q. -- problems concerning testing for persons in hospital, infection control, the provision of PPE to hospital staff, the practices concerning ensuring that in-patients don't become infected, and the risks of infection, so nosocomial infection. Concerns about how, when persons were being treated in hospital, they're allowed access to, I don't know, workers and other people coming through wards and becoming infected. How procedures were put in place to stop them becoming infected if they were then discharged.

A. Yeah.

Q. Other aspects of hospital care.

A. So things that I have brought with me, so what I have been told is that hospital protocol at early stages was hand washing only, and patients were moved frequently between wards, which obviously increased exposure to infection. Often PPE was out of date, and not fit for purpose.

I have been told that at times some NHS workers were staying in tents in their gardens to try to avoid spreading infection to their loved ones. It sounds utterly tragic to me. It's not something that I think anybody should be -- had to have gone through.

There was poor communication generally between sort of central and hospitals. Often that was contradictory, it changed frequently, and a lot of the time apparently it made no sense to NHS workers.

Q. What about medical treatment? Have your members expressed concerns about aspects of treatment such as the availability of CPAP, continuous pressurised air devices, the use of and the apparently widespread use of DNACPR, do not attempt cardiopulmonary resuscitation orders, or notices, and availability generally of respirators and ventilators in order to be able to maintain treatment? Are those also areas in which

concern has been expressed?

A. Over the course of the organisation's existence, we've had obviously -- almost 7,000 people have come to us, who've joined us, and these are the sort of stories that we hear all of the time, and alarmingly these are stories that we were hearing right at the start of Covid and we were seeing repeated again and again as time went on. Seeing the same horror stories that people had experienced in April of 2020 then also happening at Christmas, and then happening again after Christmas, was frankly traumatic to all of us that are involved.

Q. I want to make it plain, Mr Fowler, your group has not jumped on a bandwagon, these were concerns being expressed to you and Ms Goodman from the very beginning, the beginning of the pandemic, and they're concerns which you then sought to highlight to become known more generally --

A. Yeah.

Q. -- from then on?

A. To begin with, Jo and I, when with started the organisation, we knew that we wanted to try and do something for change. At the time it was difficult to work out exactly what form that was going to take. People were coming to us, they felt that they had been abandoned by the government and left to deal with their

bereavement on their own.

Q. Were you approached not just by patients who had been ill but had recovered, but family members who had lost loved ones, but also key workers, members of society who regarded themselves as being vulnerable or marginalised, also members of the ethnic communities, so from all walks of life?

A. Yeah, so we have the organisation of -- by the structure of the organisation, if you like, we have regional branches for devolved nations, we have regional branches for different areas of the UK, and then we have sub-groups. We have several sub-groups that look at health and social care, key workers, people from other ethnic minorities that have been affected, which were disproportionately affected, and several other groups. We try to encompass as much of the pandemic's effect as we can, because it's important that all -- everything is looked at, we can't be allowing anybody to be left behind or anything that fall through the gaps.

Q. Therefore. Does your group also -- has it also concerned itself with other hospital-related issues such as inappropriate discharge without testing?

A. Yeah.

Q. Then, in relation to care homes, all the same issues again concerning PPE, medical support, the issue --

A. There have been --
Q. -- of movement of staff and patients between hospitals and care homes and between care homes?
A. There have been a lot of stories about care homes, and obviously it should come as no surprise that it was deeply traumatic to be told that apparently there was a protective ring thrown around the most vulnerable when it seemed in practicality that wasn't actually true.

There have been many differences between how some care homes have operated and others. In some, they had protocols in place to protect residents from pandemic flu, and lockdown two weeks before the national lockdown was announced, and provided private minibuses for staff. However, in other care homes they didn't seem to have any guidance at all and couldn't react because they genuinely didn't know what to do and how to go about it.

Clearly this is also affected by the way that agency workers were treated, whether or not they had the ability to take time away from work, and --
Q. And whether they were forced to work in multiple homes and therefore --
A. Exactly.
Q. -- vehicles, if you like, of infection cross-sector between homes?
A. Yeah, and that's without --

Q. Well, what about --
A. -- talking about the way that test and trace had been abandoned very early on and, as you quite rightly said, in some cases Covid-positive patients were discharged to care homes or discharged to home without testing.
Q. What about the guidance then in place for visiting in care homes and hospitals and also the arrangements -- as you've described so terribly in relation to your own father, the arrangements for dealing with mortuary arrangements and burials and the like?
A. In many cases visiting was prohibited in care homes, and I do know there are many of our members who are traumatised by the fact that they didn't get to see their loved ones in their last days, some of which -- I mean, I've heard some truly heartbreaking stories about loved ones with, like, dementia and things like that who would not have understood why suddenly they weren't being visited, and, I mean, that has been such a -- it's been heartbreaking for me to hear of these stories and it's been traumatic for the people that experienced them.

In my dad's case, we were offered the chance to have a phone call -- I say a phone call, a video call with my dad in hospital to say our goodbyes, which is something that I didn't take the hospital up on, as that's not how

I want to remember my dad. Some of the last photos I had of him are him sitting in his hospital bed wearing his oxygen mask and I would prefer not to remember him like that and instead to remember him how he was in life.
Q. Many of your members expressed concerns about the way in which, when it came to take their departure from their loved ones, there were restrictions on the number of persons who could attend funerals and burials, and, of course, the aspect which you have already identified, of the way in which loved ones were dressed and cared for right up to the end?
A. Yeah. Those that we lost, we lost without dignity.
Q. All right. Mr Fowler, that's very clear, thank you.

Finally, also, I should note and ask you to confirm that one of the matters into which your group as devoted itself and indeed campaigned long and hard for, here, was, of course, the setting up of this public inquiry, which --
A. Yeah.
Q. -- was announced and formally opened, as we know, to Parliament and then this arena last June last year.
A. Once it was established that this was a way to get the change that we wanted, we have campaigned relentlessly for it. It's been something that has been

all-encompassing, it's taken up most of my life over the last three years. And don't get me wrong, it's not something I regret and I would do it again in a heartbeat if required.

Right from the get-go, Jo and I said that the important thing is change. We need to learn lessons, we need to learn about things that went wrong, and we need to put something in place to prevent those mistakes from being carried out again in the future. And those mistakes are many, ones that we've talked about here.
MR KEITH: Mr Fowler, thank you very much indeed for your help.

My Lady, those are all the questions that I wanted to ask.
LADY HALLETT: Mr Fowler, I cannot understand the mentality of people who abused and threatened bereaved people like you. It is just -- it's plain cruel, it piles trauma on trauma, and I'm sorry there are people like that in the world.

Your father was obviously a very special man and his death a great loss to you, your family and by the sounds of it the local community. So you've done him honour in the work that you've done, and I promise that I will answer as many of the questions, and learn any lessons, as I can in the course of this Inquiry.

I see you have a number of notes, you have also written a full statement, and I promise -- don't worry on the way home if you haven't said something. I will make sure I take very much into account everything you said in your witness statement and of course anything that will be said in closing submissions by your counsel. So thank you very much for your help.

THE WITNESS: Thank you, my Lady.

(The witness withdrew)

LADY HALLETT: I have been asked to break for ten minutes between the witnesses.

MR KEITH: Yes, the next witness will be giving evidence by video.

LADY HALLETT: Thank you very much.

Ten minutes, please.

(10.30 am)

(A short break)

(10.40 am)

LADY HALLETT: Mr Keith.

MR KEITH: My Lady, the next witness is Jane Morrison from the Scottish Covid Bereaved group.

MRS JANE MORRISON (affirmed)

(Evidence via videolink)

Questions from LEAD COUNSEL TO THE INQUIRY

MR KEITH: Good morning. Could you give the Inquiry your

full name, please.

A. Jane Morrison.

LADY HALLETT: Sorry, could I just interrupt. As I said to Mr Fowler, and as you may have seen, I do understand how difficult this must be for you, so if at any stage you need a break, please just say.

THE WITNESS: Thank you, my Lady.

LADY HALLETT: Thank you.

MR KEITH: Mrs Morrison, I understand from having spoken to you earlier that you wish to commence your evidence by saying a short statement about the condolences that you've received. Would you like to do that now?

A. Yes, please.

It's for those who have offered their condolences with genuine sincerity, I'd like to thank you, and more importantly to all those individuals from the ranks of all key workers out there who took that extra, often small, compassionate step, you may not even be aware of the difference it made and the impact it had, and it's a moment of kindness in a dark world. So thank you to all of you.

Q. Mrs Morrison, in October of 2020, your wife, Jacky Morrison-Hart, died from Covid, having caught it in hospital through what is called nosocomial infection. Is that right?

A. That's correct.

Q. Had she, in the weeks preceding her death, developed an illness, jaundice in fact, which had required her to go into hospital for tests?

A. That's correct, yes.

Q. Was she an in-patient thereafter?

A. Yes, she was, yes. She was in for two weeks and she caught Covid on the 15th day.

Q. Throughout that time, the 14 days that she was in prior to catching Covid, was she in hospital because the tests which she was required to undertake took rather longer than usual?

A. That's correct, because the scans, for example, after somebody had been in the scanner the whole thing had to be disinfected completely and then left for a further 20 minutes before anybody else could go in, so the whole process took much, much longer.

Q. Was the early sign of her having caught something in hospital the fact that her temperature went up but it wasn't at all clear at the beginning what it was that she might have caught?

A. That's correct. They were monitoring her very closely, and they detected the temperature rise in the small hours of that morning, and they thought it might have been from biopsies she'd had, so they started giving her

antibiotics straightaway, and then when that made no difference, they did a whole raft of tests and they included a Covid test in it, and sadly that came back positive.

Q. It is obvious from the fact that she had been in hospital for the prior 14 days that she couldn't have caught Covid outside. It's therefore clear to you, isn't it, that that was a nosocomial infection?

A. Correct, yes.

Q. She went downhill very fast thereafter, did she not?

A. She did indeed. It was actually five days from the onset of Covid until she died.

Q. So that there can be no illusion about the way in which Covid can strike, her major organs and her health deteriorated very, very sharply indeed under the onset of the Covid virus?

A. That's correct. From the onset, in that time the Covid destroyed her lungs, her kidneys, her liver and her pancreas. They tried to give her dialysis, but the Covid had made her blood so thick and sticky that it actually blocked the dialysis machine.

Q. Due to the organ damage that she suffered, was she a candidate for intensive care or for intubation?

A. No, she wasn't, because once especially the liver had failed there was nothing they could do and they told her

and myself that she wasn't a candidate for ICU and intubation and told us both that she was dying, and there was nothing, sadly, that they could do to help her.

Q. So the hospital told you that the end was near, did it?

A. Yes, it did, yes.

Q. Were you given an opportunity to get to hospital to say goodbye?

A. Yes, I thought initially I wasn't going to be able to, and they thought I wasn't going to be able to, and they had initially arranged a phone call with her, but of course she was on CPAP so I couldn't hear anything that she said, but they very kindly managed to arrange for me to be there, so I went up.

Q. Following her passing away, were you forced to be in isolation thereafter and, if so, for how long?

A. Yes, I was told that I had to go into immediate isolation for 14 days.

Q. Which you no doubt did?

A. I did, yes.

Q. May I ask, and forgive me for asking, did that period of isolation merely extend and aggravate your agony?

A. It did indeed, and there was other traumas going on at the same time, if you don't mind me digressing slightly, because I also had to deal with Jacky's guide dog going

back to Guide Dogs for the Blind, and our border terrier had to be put to sleep, and our remaining wee dog, who was Jacky's shadow, had effectively a doggy breakdown, because 75% of her pack had disappeared. So all this was going on at the same time. I mean, this was just in the space of a week, so it was very difficult to be isolated during that time.

Q. A few months after Jacky died, did you come across on Facebook a group of like-minded people with whom you began to discuss what could be done to bring support to those who needed it as well as to start raising the concerns which you all shared about the way in which your loved ones had died, in particular of course, in your case, from a nosocomial infection?

A. That's correct, yes.

Q. Was that the group that became, or maybe it was already in existence, Covid Bereaved Families for Justice?

A. That's correct.

Q. What were the aims of that group -- we'll come to Scottish Covid Bereaved in a moment, but what were the aims of that group, as you saw it, when you joined them later in that year 2020?

A. Their main aim was to get a UK public inquiry.

Q. They also had, we've heard, the aims of making things better, of holding people to account, of making sure

that lessons are learned and so on. That was all part of the group as well of course?

A. Yes.

Q. There came a time when an autonomous group, Scottish Covid Bereaved, was formed from Covid Bereaved Families for Justice. Can you just tell the Inquiry when that happened? When did you set up Scottish Covid Bereaved?

A. We started off initially it would be about March 2021 as a branch, a Scottish branch of Covid Bereaved Families for Justice, and as time went on we decided it was better to have a completely autonomous group, and -- it came about quite gradually, really, but by October last year we were completely separate and an autonomous group then.

Q. October 2022?

A. Yes.

Q. Whilst you were concerned with the management and the running of the Scottish branch of Covid Bereaved Families for Justice, were its aims broadly similar to the aims of the overarching group? And when you formed Scottish Covid Bereaved, again, did the aims generally reflect the aims of the prior group of which you had been part?

A. Yes, they did, but of course we were focusing at that stage on the Scottish public inquiry as well as the

UK one.

Q. Has Scottish Covid Bereaved, and the Scottish branch of Covid Bereaved Families for Justice before it, had a significant number of meetings with the Scottish Government, including the then First Minister, and consistently raised the issue of a public inquiry in Scotland as well as pursuing the broad aims of which you've already spoken?

A. That is correct, yes. We managed to have a meeting with Nicola Sturgeon, who was then First Minister, in March 2021, and we got her commitment then to the Scottish public inquiry, and thereafter we had several meetings with John Swinney, who was the deputy First Minister, and Humza Yousaf, who by that time was Health Secretary, and of course he is now the First Minister, and we were accompanied to those meetings with Aamer Anwar, who was our lawyer for the Scottish public inquiry.

Q. Does Scottish Covid Bereaved represent persons from all walks of life?

A. Very much so, yes.

Q. Is it just concerned with those persons who have suffered bereavement, or does it also have members from the healthcare and the care home sectors, teachers, key workers, and other people who have suffered in different

ways from the pandemic?
A. Yes, that's correct. We've got quite a range of people who have had other consequences apart from bereavement, just as you've said: traumatised healthcare workers; teachers, who also had to buy their own disinfectant to keep classrooms safe; those struggling with long Covid; those dealing with the financial consequences of the pandemic; and quite a lot of people with post-traumatic stress.
Q. Do you all share the concern, the fear that in multiple areas in the response to the pandemic things went wrong, both in Scotland and in the United Kingdom more generally?
A. That is correct, yes.
Q. What is the aim, now, of Scottish Covid Bereaved in relation to dealing with or seeking answers as to what you believe went wrong?
A. Yes, there's two aspects to it, because, oh, we definitely want to find the answers as to what went wrong, but also we want to help as much as we can, because, in addition to things going wrong, we also have examples of things that went well, and it's important to recognise those.
Q. Could you identify for us, please, Mrs Morrison, those areas where your members believe things did go wrong

insofar as there may have been a lack of protection? So just in a very general sense, that they perceived that they were let down by the system or the way in which they were treated.

Starting with hospitals, is a very major concern, perhaps the greatest concern in relation to hospitals, perceived breakdowns in proper infection control?
A. That is correct, and obviously it's particularly close to my heart.

Within our group, if I could just say, when we last did a survey within the group, and in relation to -- everybody focuses on care home deaths, and we've got about 9% of people lost a relative in care home deaths. 26% of people have lost someone through nosocomial infection in hospital, on that.

But since I have been widowed I've looked at quite a lot of infection control plans, which are very extensive to what the hospital staff have to do, but the only reference I've ever seen in relation to patients and visitors is that they're invited to use alcohol hand gel upon entering the ward. Admittedly the procedures were beefed up for Covid.

But to myself and others in the group who have commented on this, there is one glaring flaw, and I witnessed with my own eyes on several occasions:

patients who had left the wards and were meeting up with friends and family groups in the hospital grounds with no social distancing and no masks, and then they returned to the ward without even using the hand gel, and in many cases not even wearing masks once back in the ward, because some wards were more relaxed about patients wearing masks. Everybody else had to but not always the patients.
Q. So that's a good example of an incidence in which there may have been a breakdown in proper infection control by virtue of patients in the hospital leaving the ward and going outside and coming back in.

Have your members also expressed concerns about the movement of patients between wards, and also the movement of persons visiting hospitals, visitors and workmen and the like, who may also have contributed to a breakdown in infection control?
A. That is correct. I mean, there's vast differences between different health boards on infection control and sometimes different hospitals within health boards had different procedures. But what is really surprising is different wards within a hospital had different procedures, and if they're moving patients around because of lack of beds and so on, some patients were being taken to wards where infection control levels were

less, for example visitors weren't made to wear PPE when they entered the ward, and so on. And often they were wheeled through the hospital and, because they were a patient, they didn't have to wear a mask.
Q. Your statement refers, Mrs Morrison, to another area of hospital treatment, and this is the communication between medical staff and the relatives of patients.

Is this an area which your members have raised significant concern about, and in particular the perception, rightly or wrongly, that the communication between themselves and the various hospitals was deficient: they simply didn't know what was going on, and if they were told they were not told about it in the most appropriate way? Is that a fair summary?
A. That is correct, yes. There were -- it is probably one of the major areas of concern with that. I mean, I was very fortunate, the communication I had between Jacky's consultant and myself was excellent. So we know it can be done well. But there are far too many people who were left very upset and confused as to why, for example, their loved one was not eligible for intubation or CPR, because those conversations either weren't held or if they were held they were very brief, over the phone, and patient -- sorry, the relatives did not feel able to ask questions because it was all just

happening at once and all seemed to be very, very hurried, and we have even an example where the next of kin was told immediately on admission that her husband was not a candidate for ICU or (inaudible) and she doesn't know why.

Q. Turning to care homes, you mentioned a few moments ago that the procedures in place for dealing with infection control were, of course, different in care homes. Have many of your members expressed concern about the degree to which there were proper procedures in place for dealing generally with infection control in care and nursing homes, but also the degree to which they were regulated and tested and checked to make sure there were appropriate procedures in place?

A. Yes, a lot of our members actually think there weren't any procedures in place in care homes. This is fully understanding the difference between a nursing home and a care home. And without any nursing input, many care homes probably would not have understood the level of infection control required for dealing with Covid, because these are not skills they are required to have and they didn't have the skills for basic monitoring and that.

So it really felt that people were just, "Ah, what do I do now?" sort of thing. There was no clear

evidence that there were set procedures in place. And of course Covid symptoms are quite different in the elderly. But there was no inspectorate visits during that time or visits from GPs, and of course the relatives themselves weren't visiting, so there was no checks and balances on the care homes.

Q. Have many of your members expressed concern that, as a result, there were difficulties in their loved ones who were in care homes in particular getting proper medical treatment and attention when it was required? So you give the example in your statement of the practical restrictions on having GPs visiting care homes. Was there a perception that the necessary degree of medical care was just not available?

A. Very much so, and in many care homes the GPs were just refusing to visit at all. The only response people -- care home managers then had was to try phoning 111, and they were told -- if they did that, the response from 111 was, "We don't take Covid-positive patients to hospital, order the end of life pack."

And, I mean, if you're a manager of a care home, and you keep getting that response, what are you going to do?

Q. Turning to a different area, do you raise in your statement, as many others have done, the general

concerns that your members have expressed about the lack of available testing, diagnostic testing, in the public sphere, the lack of mass contact tracing, and also the well known difficulties concerning the availability of PPE? I don't think we need to go into it in greater detail, but are those all areas which are also identified in your statement?

A. That's correct, yes.

Q. Shielding --

A. May I just --

Q. Yes.

A. -- emphasise one thing? This thing about the three cardinal symptoms for -- you'd only get a test if you had the high fever with continuous cough or loss of sense and taste and smell. Yet as early as March 2020 it was recognised in the elderly they will not necessarily present with those symptoms. I mean, only 20% of elderly people would present with a fever, and all the symptoms were very, very different from them. So they wouldn't get a test normally because they would not meet the criteria for testing.

Q. Thank you for that.

Shielding. Is that another area in which your members have expressed concern, in particular over the generic overarching decision-making as to when people

would be expected to be shielded and what general arrangements were put in place to shield them whilst the rest of the population were either in lockdown or coming out of it?

A. Yes, that's correct. I think particularly so when people were starting to come out of lockdown, because to take restrictions off people who were shielding at the same time everything was opening up, I would suggest was not the most sensible option to follow.

Q. Then finally, and certainly not least, many of your members have expressed to you how they faced terrible difficulties when holding funerals and saying goodbye to their loved ones. Is that an area which it seems to the Scottish Covid Bereaved is a very significant and wide-ranging problem insofar as, across the board, everybody had to deal with that terrible time in the most appalling of circumstances?

A. Yes, that is a very, very big area of concern, because I think it affected everybody in the group, and it was the terrible decisions you had to make about who could go and who couldn't, and of course if someone had been with their loved one at the end, they were often told by some hospitals, "You have a choice: you can either come in and be with them at the end or you can go to the funeral, but you can't do both, because you have to be

in isolation."

And one thing I think people found particularly traumatic was, because the bodies were deemed to be contaminated, there were then specific rules: it was sealed body bags, many funeral homes would not undo the body bags, wouldn't open them up, so people couldn't put on -- you know, give their loved one the smart suit to wear or whatever. And people found that very distressing as well as the restrictions on the numbers of funerals.

Q. Mrs Morrison, thank you for your assistance in identifying those areas of concern. They provide a helpful foundation, of course, for the Inquiry's further work.

Finally, it's right to note that Scottish Covid Bereaved has participated fully in this module, and you're already fully engaged and continue to engage in Module 2A in Edinburgh, and you've also, of course, called for and you are now participating in the Scottish Inquiry under the chair of Lord Brailsford?

A. That's correct, yes, and can I thank this Inquiry for also the depth it's going into on dealing with Scotland as well as the rest of the UK. It's appreciated, thank you.

MR KEITH: Thank you, Mrs Morrison.

LADY HALLETT: Thank you very much indeed, Mrs Morrison , and thank you for your thanks.

I can't imagine how distressing it must have been for you to lose Jacky. To lose a loved one in any circumstances is bad enough, but to lose a loved one in the circumstances you describe is truly awful. But you've shown great courage and I do thank you for doing your best that ensure that others don't suffer as you have suffered in the future. So thank you very much indeed.

THE WITNESS: Thank you, my Lady.

(The witness withdrew)

LADY HALLETT: Right, I've been asked to break for ten minutes.

MR KEITH: Thank you, my Lady.

LADY HALLETT: So I will now adjourn -- oh, Mrs Morrison has gone, right -- and I shall return at 20 past.

(11.08 am)

(A short break)

(11.20 am)

MR KEITH: My Lady, the next witness is Anna-Louise Marsh-Rees of Covid Bereaved Families for Justice Cymru.

MS ANNA-LOUISE MARSH-REES (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

LADY HALLETT: Ms Marsh-Rees, if at any stage you want to break, you've heard what I've said to other people, I do understand how difficult this must be for all of you, so just say and we'll stop immediately. All right?

THE WITNESS: Thank you very much.

MR KEITH: Could you commence your evidence, please, by giving the Inquiry your full name.

A. My name is Anna-Louise Marsh-Rees.

Q. Ms Marsh-Rees, thank you for the assistance that you have already given. You are of course the representative for Covid Bereaved Families for Justice Cymru, and you've afforded assistance in that role, and you've also provided us with your witness statement and a number of written submissions.

I'd like to commence your evidence, please, by asking you some questions about your father Ian, who we believe returned to his beloved Wales to retire after many years of working abroad as an electrical engineer.

When Covid and the pandemic struck in February to March of 2020, did you shelter him by keeping him at home and protected in those early weeks and months?

A. Absolutely. We kept him at home. We, you know, had -- we delivered shopping to him. We made sure they were safe and well.

Q. He was living on his own or with your mother, Valerie?

What was the position?

A. With my mother Valerie, yes.

Q. Did there come a time when, terribly, as it turned out, he developed an infection later in the year?

A. He did, he had a gallbladder infection, for which he was hospitalised, for -- at the beginning of October 2020.

Q. Was that hospital in Abergavenny in Wales?

A. It was, Nevill Hall Hospital.

Q. When he went into hospital as an in-patient, were you aware of the steps that were being taken to protect him from Covid infection and to make sure that he remained infection-free?

A. That's a very good question. We knew he'd been tested on admission. He had a temperature, so he's moved into an assessment area, and then he was moved beds six times in eight days.

Q. Between different wards or in a single ward?

A. Between different wards, yeah.

Q. Do you know whether or not the wards to which he was moved were declared to be non-Covid wards?

A. Yes, when he tested negative after the initial test, and obviously they were treating him for the gallbladder infection, eventually he ended up on a particular ward which was a non-Covid ward.

Q. But did there come a day when you were told -- or at

least he was told that he had Covid, or was he released from hospital not knowing that he had picked up Covid in hospital?

A. Yes, so on day 8 he was sent, he was discharged. We subsequently found out that the ward had been closed down due to an outbreak, but we weren't informed that he had been exposed.

Q. So was he discharged because his ward had been exposed to Covid, was that why he was taken out of the ward and discharged home? Or was he discharged because the hospital had been able to deal with the original infection for which he had been treated?

A. That's debatable. I mean, he was definitely, you know, on the mend, but, you know, he was sent home without a test. We subsequently found out after many, many letters that there were actually 21 people with Covid on his non-Covid ward, 12 of whom died.

Q. So you weren't told and he wasn't told that he was positive for Covid. Did you and your --

A. Well, he wasn't tested, so we don't know.

Q. You just don't know?

A. No, no.

Q. Did you or your mother subsequently get Covid from, it would seem, him or not?

A. Yes, my mother wasn't told that he had been exposed at

all, so she -- you know, he came home and she stayed with him, in the same room, and she subsequently got Covid, as did my sister. And she suffers from long Covid now.

Q. Was your father then re-admitted to hospital suffering from Covid itself?

A. Yes. So during that week he deteriorated almost from the minute he was discharged, he got sicker and sicker. He was falling asleep in his -- while eating. He had severe diarrhoea. One of -- I think Jane from the Scotland team also mentioned that the three symptoms aren't always prevalent in older people, and these were obviously overlooked.

He had -- my mum made 13 calls to the GP and they had four out-of-hours doctor's visits, none of whom ever suggested he might have Covid, despite, we now know, that it was on his discharge notes that he'd been exposed to Covid.

Q. So let's be clear about this. So when he was discharged from hospital the first time he was discharged with discharge notes, and your examination of those notes, perhaps much later, showed that actually he had been tested and was tested positive for Covid prior to his initial --

A. He wasn't tested but they just said he'd been exposed to

it.

Q. He'd been exposed to it?

A. Yeah. So I think that's --

Q. By virtue of the ward on which he had been placed?

A. Absolutely, with -- yeah. And three of the people on his bay had already tested positive for Covid.

LADY HALLETT: So on his notes it said "exposed", but to you, the family --

A. Nothing.

LADY HALLETT: Not informed?

A. Not informed.

MR KEITH: So when he was re-admitted, suffering from the symptoms he was, you couldn't have known or wouldn't have known whether or not that was Covid or anything else?

A. Not at all. It was -- when he was re-tested that evening we were incredibly surprised to find out he had Covid, even more surprised to find out that his oxygen levels were -- were decreasing quite rapidly. Yes, it was a real shock.

Q. Then did his condition deteriorate rapidly, having been re-admitted to hospital?

A. It did. You know, we would be calling almost, you know, hourly, it seemed. I mean, it wasn't, but, you know, it would be 5 litres -- "He needs 5 litres of oxygen", "He

needs 10 litres of oxygen". By the Wednesday it was 15 litres, "You need to be prepared" conversation. You know, we -- we just -- completely in shock.

Q. Was he placed on a CPAP?

A. He wasn't, no, no.

Q. Then did you find out at some point, terribly, that a DNACPR had been placed on him?

A. Yeah, it wasn't until we saw his notes some months later that we saw the DNACPR that had been placed on him. And this was without consultation with us. Apparently they tried to call us but we were eating dinner. How they knew that I've no idea, but we were not aware of that.

Q. So you never knew at the time and no one told you that a DNACPR had been placed on him or given you any opportunity at all to challenge that or to ask brutally and simply what was going on?

A. Not at all.

Q. Tragically then he died.

A. He died.

Q. I don't want to go into the detail of it all, but, as a result of the things which you've raised, have you been engaged in a long course of dealing with the hospital and with the health services in Wales in order to try to find out some of the answers to the questions which you've posed?

A. Absolutely. It's in fact two years nine months today since we first complained -- or not complained, asked questions of his health board. There have been a series of letters and responses and subsequently a nosocomial investigation by the Welsh Government into all hospital-acquired Covid deaths, and I've been told, even now, responses are inaccurate, incomplete and inconsistent.

It's almost like -- I say it's almost like an Agatha Christie mystery, that we -- you have to find out bits, you know, new information all the time. I've been told that my final response, it's been sitting on the CEO of the Aneurin Bevan Health Board now for two months, but I've still not received anything.

Q. All right.

Was it as a result of your father's death and the way in which it came to light that he had been exposed to Covid that you formed or joined, perhaps, if it was already formed, Covid Bereaved Families for Justice Cymru?

A. Absolutely. So I think first of all you're -- you're in shock that it happened to you, but I think it's only happened to you, and then you find out, you know, through various social media groups, that there are other people maybe in the area that sort of have

a similar story, and then you find out there's other people from other health boards, and the picture builds to: this wasn't an isolated incident, this was, you know, quite a regular occurrence of people going into hospital with one thing and not coming out, or -- or subsequently dying from Covid.

Q. Were these all persons to whom you spoke because you had already joined the group Covid Bereaved Families for Justice, or were they people that you met having formed Covid Bereaved Families for Justice Cymru?

A. So both, really. So our group, the Cymru group, emanated from the UK group. Obviously we've got different objectives, different governments. Health and social care are devolved in Wales. But, you know, also people -- once I started to do some media interviews we'd get a huge amount of, you know, interest from others that had, you know, suffered a similar experience.

Q. Is the same of Bereaved Families for Justice Cymru, as you see it, to try to find answers to the questions and the concerns which had been raised by members of your group, and also to campaign in a wider sense for things to be done, for procedures and decision-making processes to be changed?

A. Absolutely. Of course we want to find out what happened

and why it happened, you know, who was responsible, who was accountable. I mean, that's been one of our major areas of -- challenging areas, is that we have different health boards and different care homes, all with different processes and ways of doing things, almost devolved amongst themselves. But not -- but we do want change and we have -- I think we've been very successful at not just being a campaign group to get answers, but also trying to change things already.

So we've been introduced to the National Bereavement Steering Group of Wales, and through that we have -- because we got zero bereavement support from any hospitals in Wales, we've now set up working groups with each of the health boards, so we are trying to -- trying to channel that grief, frustration, heartbreak into -- into areas where we can really make change and using our lived experience to do that.

Q. From what you've said then, the main, the overarching aims and concerns of the group appeared to be to continue to provide bereavement support, because of the absence of bereavement support, as your members saw it, at the time, and, in terms of the hospital care which your members or rather their loved ones received, infection control and nosocomial infection appears to be at the heart of many of the concerns expressed by your

members?

A. Absolutely. Most of our members were impacted by hospital or care home acquired --

Q. Infection?

A. -- infection -- yeah. And infection control is obviously key to that: where was it? What guidelines were being followed? Was anyone -- how were they being communicated? How were they being embedded, monitored, iterated upon?

We have yet to find out what happened, and, you know, it kind of haunts us all that, you know, people go to a hospital -- you know, people used to say, "Well, they're in the right place", when they go to hospital. I'm not sure they would say that anymore.

Q. One of the areas in which your campaign has been successful insofar as the Welsh Government is concerned is that you've campaigned successfully for there to be at least the start of an official inquiry into nosocomial infection in Welsh hospitals; is that correct?

A. That's correct, that's been running for a year and they are investigating each of those cases.

I guess the key thing is what comes out from that, and we've had the first -- it's running for two years, so after that first year there's an interim report.

Our -- what we want to ensure now is that it's not just a report on a dusty shelf that -- but they are being implemented so this does not happen again.

Q. Is your group also campaigning, and do its primary aims also include other aspects of hospital and care home and nursing home treatment? So the availability of PPE and respirators, ventilators and so on and so forth for the purposes of the health and social care staff, the broad issue of communications between hospitals and care homes and the loved ones of patients and those being cared for, and also importantly, as we've heard from other evidence, the whole issue of the arrangements which were then put into place for dealing with loved ones at the end, the way in which there were communications from hospital staff and care homes, the way in which they were buried, the way in which they had their funerals conducted, and so on.

So not just the hospital and the care home setting --

A. No.

Q. -- but, as you describe it in your statement, the aftermath as well?

A. Yeah, and I think that's very important for us. You know, the preparedness is -- in terms of response and controlling an infection, obviously we've covered --

it's been covered quite extensively over the last few weeks. What I think we're very interested in to ensure is that it's the at death and after death impacts of a pandemic are considered as well. So, you know, end of life care, dignity in death, the sort of palliative care. You know, being kind of crude, what happens to bodies.

I think Jane mentioned as well, something that was not communicated to us was that once somebody with Covid dies, they are almost treated like toxic waste. They are zipped away and you -- nobody told us that you can't wash them, you can't dress them, you can't do any of those things, the funerals, the ceremonies, you just can't do any of those. You couldn't sing at a funeral. You know, we're Welsh, that's something you have to do.

And it's to ensure that all of those factors are considered in preparedness as well as the sort of more practical things.

And also the psychological effects. So, again, I said we're working with various people on, like, Hospice UK, et cetera, to, you know, understand what a good death is. You know, my dad did not have a good death. Most of our members' loved ones did not have a good death.

Q. I understand. And presumably, and not least of course

on account of your father Ian's death, this issue of the way in which DNA cardiopulmonary resuscitation notices are given, end of life care is an absolutely vital topic?

A. Absolutely. You know, there's very valid reasons for putting a DNACPR on someone, and it's a medical decision, but it's the way it's communicated, and we're really campaigning for the whole process to be much more formal -- you know, if it needs a signature from a loved one or from the patient themselves if they are -- you know, if they have the capacity to do that. It's simple things like that.

You know, some of the other things -- I know this sounds really silly, but when we left the hospital, my dad -- we were given my dad's stuff in a Tesco carrier bag. Some people were given somebody else's clothes that were in a pretty awful state. It's those things like that that don't often get considered, and yet one wonderful lady, who is in the bereavement team, I can't remember which health board, but she has designed paper bags, carrier bags, for -- you know, for all deaths in hospitals, so that there is dignity all round for someone that has died, whatever the circumstances.

And I do think as -- if there's one good thing that kind of came out of this, is that we are maybe able to

talk about death more openly, more realistically, and talk about it more. Because there's one thing that is definitely going to happen to all of us. So, you know, we want the whole piece around death and a good death -- because there is such a thing as a good death, and I think that was very overlooked during the pandemic.

Q. And to better prepare for it and to make it happen --

A. Absolutely, 100%, yeah.

Q. -- in the event of a future health emergency?

A. Absolutely.

MR KEITH: Thank you very much.

THE WITNESS: Can I say one thing?

LADY HALLETT: Of course you may.

THE WITNESS: First of all, I want to say thank you very much for the Inquiry to date, and all of the people involved. We have been treated, you know, hugely respectfully and sensitively and we thank you for that.

Just one more thing: there is a whole generation, my mum's generation, who haven't got the mechanisms like maybe I have to complain and question, and they are heartbroken and really in shock. You know, my mum cries daily and -- even though it's nearly three years. But we'd like some change to happen in their lifetime, and, you know -- and I know -- I know, you know -- we're all doing our best, but that's something we would really

appreciate, because if it doesn't then, you know, they ... it's just -- they're just left with that feeling of nobody cared, and if that can be expedited in any way, we will really appreciate that.

LADY HALLETT: We'll do our very best, I promise.

THE WITNESS: Thank you so much.

LADY HALLETT: I know how much you've contributed to the Inquiry, and since the very first day of the consultation exercise when we met in Cardiff, so I'm extremely grateful for everything that you've done. As I said to Mrs Morrison, it takes great courage to channel your obvious grief into trying to help others and to reduce the suffering of others in the future.

I'm really sorry to hear about your mother and about the long Covid, and she's obviously still grieving, and that's something I did learn during the consultation exercise, and you may have heard me say it before, that grief is bad enough in normal circumstances but grief during times of lockdown and isolation and the circumstances you've described is just dreadful. So thank you very much for everything you're done.

THE WITNESS: Thank you.

MR KEITH: Thank you.

(The witness withdrew)

LADY HALLETT: So I'm asked to take another break?

MR KEITH: Yes, please.

LADY HALLETT: Ten minutes, and I shall be back at 11.50.

(11.41 am)

(A short break)

(11.50 am)

MR KEITH: My Lady, the fourth witness from this group of witnesses is Brenda Doherty, from the Northern Ireland Covid Bereaved Families for Justice branch of Covid Bereaved Families for Justice Group.

MS BRENDA DOHERTY (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY

LADY HALLETT: Ms Doherty, if at any stage you want a break -- I know you're helping us by telling your story several times, so you may not need one, but I do assure you that if you do need one, please just say.

THE WITNESS: Thank you. It might be the stenographer that needs a break, but I will try -- I will try.

LADY HALLETT: You have been following proceedings, haven't you?

THE WITNESS: I will try.

MR KEITH: We're going to start with your name, please. Could you give your full name to the Inquiry.

A. My name's Brenda Doherty.

Q. It's my sad duty to ask you questions about your mother.

A. Yes.

Q. On the morning of 11 March of 2020, did she have a regular checkup scheduled by the district nurse to check on warfarin levels in her blood?

A. Yes, she did. Mummy would have had regular checkups due to medication and that she was on to keep an eye on her warfarin levels. Sorry, yes, okay. There we go.

Q. The afternoon of the same day, did she have an appointment for an x-ray on her back at a local hospital?

A. She did. That had been arranged following a bit of a cough that she had had.

Q. Did she attend that x-ray or did something happen when she was being examined or having her blood levels examined in the course of that initial appointment?

A. No, she attended that x-ray and then when she got home, I received a phone call from the GP to say that mum's warfarin levels were through the roof and that I needed to get her immediately to a hospital.

I did say that mum had already been at an appointment that day for her x-ray, and the doctor's words were, "Even if you need to fold her up, get her immediately to the hospital, this is dangerous."

Q. Was she told to go to the same hospital where she'd had the x-ray or a different hospital?

A. It was different. The hospital that she had the x-ray

really only does that, it wouldn't take in-patients.

Q. When she went to the hospital, therefore, in response to that phone call saying that she had to get to hospital immediately, did you know what sort of treatment she would then receive or what sort of process would be applied or were you essentially in the hands of the hospital to work out what would need to be done?

A. Well, we were essentially in the hands of the hospital, because when mum went in, as far as we were concerned, it was for the warfarin levels. The consultant did actually advise us that the checks, test x-ray was clear, and even though they thought there was a bit of an infection, they couldn't deem where that was, and we've never found out what that was.

So they decided to admit mum.

Q. When she was admitted, was there at that stage any general understanding on your part or in fact on the part of the hospital as to what changes in procedure would be required in light of what was then the developing pandemic?

A. Absolutely not. When we took mummy up into the hospital, there was very limited -- just a plastic apron on staff, and my sister actually asked about Covid, and we were told not to worry, it would be a flash in the pan and gone by the summer.

Q. That was 11 March?
A. 11 March.
Q. For those first few days were you allowed to visit your mother in hospital?
A. We were, and then restrictions went that only one person was allowed to go in, and then on 17 March I went up to visit and I was told then that they had stopped all visiting due to the fact that unfortunately not everybody was following the one person guidance, and actually some people were trying to get four -- three or four members in during the day, so therefore the trust felt that all visiting should stop.
Q. Were you able nonetheless to see your mother on that occasion, because of the state in which she was then in?
A. Well, that night I just got to leave a plastic bag in with clothing in it, and actually the -- on the Thursday, the 19th of March, was the evening that I got up to leave clothing in and the nurse said that, "Your mum is a bit distressed tonight, do you want to come in and see if you can settle her", so she says, "I'll give you five minutes". So I went in and found mum rocking on her chair. And I always say this, because it just says it as it was for me, that mum had one tear on her cheek, and I says to her, "Mummy dear, what's wrong, don't be panicking", and she says, "I just want to go

home."
At that stage, as far as we were concerned, mummy would be coming home, so I told her not to worry, that on a Monday evening -- we all took turns, since my dad died, to stay with mum. Monday evening was my night and we had our knitting club, we watched movies and we watched things like girl flicks, you know, things that my husband wouldn't watch with me. So I said, "You and I'll be sitting on Monday night watching (inaudible)". I took her face in my hands, I gave her a kiss and told her I loved her and not to worry, that I would see her hopefully the next day, which was the Friday, that we hoped to bring her home. I waved bye bye and told her I loved her, and that was the last I seen my mum.
Q. The next day were you told that it was likely that she would be discharged, in fact?
A. Yes, I got a phone call to say that they were trying to arrange a care package and, providing they got that put in place, that mum would be coming home. Later on in the day, I got a phone call to say that mum -- because of mum's swallow that they weren't going to let her home, because they needed her tablets to be crushed and unfortunately the care workers in the morning weren't able to do that. Now, mum has had an issue with her swallow since 2016 and we were actually waiting on

a scan from 2018 to see what the issue was, but unfortunately that never happened.
Q. So she came within a hair breadth of being discharged and would have been that discharged that day, the Friday, were it not for the fact that there was a last minute complication with the care package which had to be in place?
A. Yes.
Q. That complication meant that she stayed in the hospital one further night?
A. Yes.
Q. What happened on the Saturday?
A. On the Saturday, I had rang just to ask about how mum was doing, and she says, "Oh, well, we have moved her to another ward", and I said, "Is she not getting home?" And they said, "Somebody will ring you later."
In my head I thought maybe mummy was moved to a discharge ward, so I was waiting on the call, and then that night I got a phone call and the first words I heard were, "Hi Brenda, I'm sorry, your mum has tested positive."
And I said, "Positive for what?"
And they said Covid-19. I'll not repeat my response, but you can imagine that there was a swear word there, because I didn't expect to hear that,

because, as far as I was concerned, mum was medically fit to be discharged and only the care package was keeping her in.
Q. And there has been no suggestion that she was, for example, on any sort of Covid ward?
A. No.
Q. Did they tell you that the whole of her ward had been tested?
A. Yes.
Q. And, therefore, that is how she came to have a test, which proved to be positive?
A. Yes, one person on the ward displayed symptoms, so they tested the whole ward and mum tested positive.
Q. On the Sunday, you attended the hospital to take in to your mother some clothing, a nightdress I think, and some personal items. Were you able to see her?
A. No, I took up -- it was Mothering Sunday so I took up one of her presents that I'd bought her, which was a nightdress that says, "Mum, you are my world".
At one point the nurse was actually leading me down the corridor, and at that point another member of staff came and said, "She can't be here, you need to take her out."
And the nurse said, "She wants to know about her mum."

So they took me out and later another nurse came and said, "Your mum is doing well, and if she keeps this up we actually might get her home during the week."

So I went home thinking "Happy days".

Q. But on the Monday night, or in the evening, did you receive a call telling you that her condition had gone significantly downwards?

A. Prior to that, I had made a phone call, on the Monday, to check to see how mum was doing, and I was told unfortunately they couldn't give me any information on the phone, and I says, "Well, I can't get up so you have to give me information on the phone or else how am I going to know how mum's doing", and they said somebody will be in touch later.

So it was just after the Prime Minister had made his lockdown speech that I got a phone call, and again it was, "Hi Brenda, I'm contacting you to find out do you agree to no unnecessary intervention in your mum's care?"

Q. Did you, of course, say, "What do you mean?"

A. Yes. I said, "What are you asking me?"

And the doctor at that point started talking about mum's liver failure, kidney failure, her heart rate, her blood pressure, and they deemed that any intervention would be unkindly to mum.

So I said, "Are you telling me that this is a battle that mum's not going to win?"

And the doctor said, "Yes."

And I said, "So do I ring my siblings and tell them?"

And he said, "Yes."

At that point then I asked could I come and see mum, could anybody be with her, and I was told no, unfortunately not, that they would ring me when mum had passed.

Q. And she did?

A. And she did, 12 hours later. The longest 12 hours of our lives.

Q. So you never got to see her again?

A. No.

Q. And she never came home?

A. Never.

Q. Was the funeral for her subject to the restrictions of which we are all now only too familiar?

A. It was, and --

Q. On the number of people who could attend?

A. I suppose -- you know, there were so many things that, as a family, we accepted at the start because we believed that's what was to happen. You know, so we didn't get mum's clothing back from the hospital. It

was incinerated. Thanks to the kindness of a nurse we got a cross back. And, you know, I've heard earlier from other witnesses about how their loved ones were treated, you know. I like to pretend mum was in the nightdress that I bought her, but the reality is I know she was double bagged, like toxic waste.

So we met mum at the cemetery gates -- at first we were advised that only two people can attend. My brothers had agreed that it would be my sister and I. And then, thankfully, the night before they told us that a total of ten could attend but only my sister and I could be at the graveside and the other eight would have to stand back, red and white tape.

We met mum at the cemetery gates. We walked in behind her, there was no carrying of the coffin. We had -- it wasn't a funeral, it was a 10 to 15-minute committal. We were timed. I went to walk to touch mum's coffin and I was told I wasn't allowed at the graveside until mummy was in the hole in the ground.

You know, Anna-Louise talked about singing. I played Amazing Grace on my phone. And then I could see the cemetery attender putting the watch up and telling me that the time was up. So then we as a family all went our separate ways, my two brothers and my sister all went home to their own house, as did my sons,

and my nephew, and there was no coming together for us until the August, really, of 2020.

Q. Were you able to visit your mother there in the weeks thereafter?

A. No. The cemetery gates were closed. And I had a brother who died when he was 16, of cancer, and when my daddy died we would have took some rose of one of the wreaths and put it in a Bible, and I didn't get that for mum, because by the time we got to the cemetery the flowers were decayed and unfortunately just fit for the bin.

Q. Thereafter, did you become involved in, with other like-minded people, raising your general concerns and some of the events which had befallen you with state bodies, state organisations, raising the profile of all these matters --

A. Yes.

Q. -- in order to try to bring about significant change?

A. We did.

Q. Was that part of the Covid Bereaved Families group or was this within the Northern Irish branch of which you've spoken?

A. Initially I became a member of Covid Bereaved Families for Justice UK in the summer of 2020. I had been very vocal about mum's death. I was quite determined that

mum would not be a statistic. My sister had already said, you know, mum's going to be a statistic and I said, "No, everyone will know Ruth Burke, and everybody will know who she was, the life she had and not just how she died."

And because of being vocal, other family members started reaching out to me and sharing with me their experiences. So we knew that we had to start doing something.

I actually became involved in another project called Memory Stones of Love, and -- with another family member who lost both his parents within 12 hours.

Because sometimes in Northern Ireland we feel like we're the poor relation, and I was quite determined that at this time we wouldn't be the poor relation. Our loved ones deserved the same as everybody else.

Other members within the group were contacting the relevant bodies to try and get access to loved ones in the residential care -- in care homes, trying to get access into loved ones in hospitals. And I suppose one of the most frustrating things for me was the inconsistency in the trusts across Northern Ireland, because, you know, since mum's passing I've found that other ones got to be with their loved ones and that had led me to question why, and people will say, "Well, your

mummy died so early on", but, you know, people who died within the week of mum got to be with their loved ones. You know there is ways it can happen.

Q. So did it become apparent to you that there may be failings across the board? As opposed to just failings and a failure to protect your own mother, there was a wider more general issue?

A. 100%. You know, one of the things that I was quite struck by was the things that were going to come out from the families. We had -- you know, once the Memory Stones came together, then myself and my co-lead, Martina, we connected, and we started with, you know, looking at: how can we ensure that our loved ones and the people of Northern Ireland can be represented as a group? And that's actually how we branched off. So we're still very much part of the Covid Bereaved Families for Justice UK, we are another branch of them, which is great because we benefit from great input from our legal team as well as the English team.

Q. Does the branch, the Northern Ireland branch, represent just bereaved or does it represent others and provide support to them, for example key workers or public sector workers or those who have suffered in other ways in the course of the pandemic?

A. Generally in the Covid Bereaved Northern Ireland group

it is bereaved, but what I would say is anybody who reaches out to us, like recently I had a gentleman who suffered from long Covid, so I've linked him into another group, we would always try and support.

Our focus very much is finding out what changes need to be made to ensure this doesn't happen again.

Q. In addition to trying to ensure accountability, to use the word from your statement, that is to say trying to find out what went wrong, what happened and to try to find answers and therefore to make improvements, do you also continue to provide support for bereaved as well as those other people who have reached out to you?

A. We do. We provide support and actually, through the other project, Memory Stones of Love, we are now linking in with Cruse Bereavement, looking at how we can work in partnership to provide support, and it's very, very important -- you know, you have watched the impact statements, which are very powerful, and I am so grateful to have had an opportunity to be part of it, my Lady. It meant a lot to have a voice. And that was very important, because there is so many themes here, within our group, that we need change within Northern Ireland.

And I have been practising a word all week, and I hope that I get it out: legislative -- yes -- change.

We need legislative change in Northern Ireland.

There is so much that happens. I have heard today you talk about DNRs. That is so representative within our group. We done a lot of work to get the themes.

My Lady, when you were in Belfast you would have been struck by how many families had DNRs on them without any consultation. Families will question the use of medication, the visitation rights that were not allowed, even though there's the Care Partners' guidance, that was just being totally and utterly ignored.

Q. Can I just pause you there, Ms Doherty.

The DNRs, medication, visiting rights, also in the hospital sphere, communication with --

A. Totally.

Q. -- patients and their loved ones and their families.

End of life care, is that another important area?

A. And the lack of PPE.

Q. The lack of PPE.

A. And especially in community. And I think -- you know, one of the other things is we can put things in place, but there is a level of responsibility on people to follow them, and earlier we've heard, you know, from Matt about some of the hateful messages he got sent, and unfortunately I had swastikas, stuff sent to me via

messages, saying that I was colluding.

And, you know, not everybody wanted to wear PPE. Some people were afraid of their glasses steaming up. Not everybody who was going into homes were sanitising properly. You know, we have a member who lost both her parents and she believed it was because of poor -- you know, not following the guidelines, not sanitising, not wearing PPE.

You know, that -- unfortunately, whilst we want change, I think one of the other big things is the fact of how Covid has been responded to, left unfortunately a lot of questions over how real -- I even had a comment the other day when I said I was coming to the Inquiry, some idiot, I shall say, said that, "Well, sure I saw Michael Jackson. Covid's as real as Michael Jackson is walking around."

So it's still out there and this is still what we are dealing with when we are trying to bring about change to protect society.

Q. What about care homes and nursing homes? Have many of your members expressed concerns about the treatment, the access to medical treatment in care and nursing homes, similarly the issue of communication with families --

A. Yes.

Q. -- and also end of life care, so the same broad and very

significant issues arise also in the context of care and nursing homes?

A. Yes, we -- at the start of the pandemic we have one member, her father and her uncle, and actually her cousin is also a member, they received a phone call to say that all residents would not be receiving end of life resuscitation if required. There was being a DNR put on all the residents should they contract Covid. Which I just find extremely upsetting. And I suppose this is the one thing -- I know from the very large group that we have that Covid didn't just take -- and I don't mean that "just" the way it comes out -- but didn't just take the lives of elderly. One of our youngest was 28 weeks in gestation, so hadn't yet been born.

You talked about communication and the lack of it. One of the other issues that I have was the failure to communicate how Covid evolved, and it wasn't just about the guidance at the start, of the temperature and the cough and the loss of taste and smell. We have a 23-year old man who was experiencing vomiting and diarrhoea. He didn't need a test because he wasn't experiencing symptoms. That 23-year old man called on his mummy, and my Lady, you met this lady.

LADY HALLETT: I remember very well.

A. And unfortunately that young man lost his life. So, you know, communication is a big thing.

You know, there were so many people -- not only were there not being communication, but things were being communicated wrongly. We have another family member who they were told to -- that their loved one was doing well. Five minutes later somebody different rang and said, "You need to come up", and when they arrived there unfortunately they were two minutes late, their loved one had passed away.

So, I mean, I know in my work how important communication is. I think communication throughout what I'm hearing over these last lot of weeks, the breakdown in communication has been powerful in a lot of issues and unfortunately, you know, in the application to apply some of the guidelines I think the communication hasn't been there.

MR KEITH: And I think you would say that, drawing those various threads together, the failings or the lack of protection in relation to treatment in hospitals, care homes, infection control, communication, as well as the terrible restrictions after death in relation to funerals and the like, across the board, institutionally, there was a broad swathe of, you would say, matters that went wrong?

A. Yeah. I'll be diplomatic -- which isn't like me, so it really takes a lot --

Q. Well, you are giving evidence under oath.

A. Yes, that's why I'm being diplomatic and that's why I kept the bible beside me.

The apparent lack of ability to apply, you know, the guidance and the things are out here is just shocking, and I suppose one of the things that I'm really struck by -- and, you know, you mentioned care homes and one of the things I think that's very important, because it has been highlighted here today and it happened in Northern Ireland too, was the lack of testing. And I'm thinking of one family member in particular who herself has health issues, and she would talk about her brother, who she cared for until he couldn't go in -- until she couldn't care for him anymore and he had to go into a care home, and she will talk about how the care home was flooded with people who unfortunately, due to lack of testing, were positive.

Q. From hospitals?

A. From hospitals, you know. And again, for me, I'm not the most logical person, I have been told recently, but there's things that I think common sense should be applied, and that to me is common sense, and my Lady, you know, I'm not going to digress, but I just -- as

a Northern Ireland person you know that I've been very vocal in saying that I don't want to be a footnote, and one of the things that I feel I have to say here today, if you don't mind, Mr Keith --

Q. Well, it's not for me, it's for my Lady.

A. Yes, but I'm just saying because I'm interrupting you -- is that in Northern Ireland I didn't feel the need to know about Civil Contingencies Act 2004, I didn't need to know about the civil contingency hub or all the different sub-groups. I have never in my life heard so many sub-groups. There is far too many links in the chain, which means no communication. No communication whatsoever. And I am just astounded.

You know, again, that's where the legislative change needs to come in.

When I have been reading Civil Contingencies Act -- I'm not saying, being menopausal, I retain it, but I have been reading it, and we are so far apart.

And I'm going to get a bit emotional here, and emotion's good, because I am here to remind everybody of the human cost that we paid as bereaved people. My mummy was not cannon fodder. My mummy was a wonderful wee woman who had the spirit of Goliath, and I know she's standing here with me today, because she would want me to be here, because she knows that she lived

a life, as did all our loved ones, and it's very important that we remember the human cost, because there are too many people out there now that think Covid has gone away. People are still losing their life to Covid. And I have now trained myself to ignore those individuals as best I can and focus now on the living, because it's us here that are bereaved that have to live the legacy.

I've got my tree of life earrings on. We may have lost a branch but that branch left a legacy which I will continue to live on.

MR KEITH: Ms Doherty, thank you very much.

LADY HALLETT: There's nothing I can say, Ms Doherty.

THE WITNESS: Thank you.

LADY HALLETT: Extremely moving, you have been moving throughout, so thank you very much indeed for all your you've done and I promise to answer as many questions as I can.

THE WITNESS: Thank you.

And please, if there's an opportunity to hear for more, here. Thank you very much.

LADY HALLETT: Thank you.

So Ms Doherty started our hearings with the impact film, and you're our last witness.

THE WITNESS: Thank you.

LADY HALLETT: Very appropriate, if I may say so.

(The witness withdrew)

LADY HALLETT: I'm told in fact that, apart the fact that I would take a break anyway, I'm asked not to hear closing submissions until 1.30.

MR KEITH: My Lady, yes. We have been unable to bring them forward, so if we could have -- if you could rise now and then sit again at 1.30, we can start the closing submissions at that point.

LADY HALLETT: I shall. 1.30, please.

(12.21 pm)

(The short adjournment)

(1.30 pm)

LADY HALLETT: Mr Weatherby.

Submissions on behalf of Covid Bereaved Families for Justice by MR WEATHERBY KC

MR WEATHERBY: Thank you very much.

Woefully inadequate was the assessment of Matt Hancock, former Health Secretary, of the state of preparedness of the United Kingdom at the outset of the pandemic. Wholly inadequate was the phrase used by Bruce Mann and Professor Alexander, the experts chosen to assist the Inquiry. The 2019 National Security Risk Assessment assessed the likelihood of the emergence of a dangerous newly emerging infectious disease as

moderate, with a reasonable worst-case scenario of 200 deaths and 2,000 casualties.

But as we noted in opening, in 2015 then Prime Minister David Cameron warned in a major speech to the G7 that the world needed to consider the possibility of the emergence of a new disease with a fatality rate of Ebola and the transmissibility of measles. It's difficult to square that with a reasonable worst-case scenario of 200 deaths.

Way beyond the headlines, we know this was not the stuff of science fiction to epidemiologists and virologists. Professor Whitty told the Inquiry he was involved in drafting so-called "golden hour" SAGE guidance, produced at some point between 2013 and 2017, which dealt with an emergency involving a non-flu emerging disease. That guidance recognised the following nine points:

One, that such a disease might have a range of characteristics affecting the mode and rate of transmission.

Two, it was unlikely that existing antivirals would be effective.

Three, there had been multiple cases of emergent infectious diseases with pandemic potential which had arisen within the previous century, and that they were

usually zoonotic, jumping to humans from other animal species.

Four, the most likely scenario was based on SARS, which was contained by barrier nursing, isolation and contact tracing, and Ebola, which was not airborne. But the reasonable worst-case scenario was based upon smallpox, a respiratory virus, with a fatality rate of 40%.

Five, the possibility of asymptomatic transmission was clearly flagged.

Six, that it might be possible to prevent an emerging disease pandemic from entering the UK, and there were possible measures to slow its spread if it did, including restrictions on assemblies, school closures and home isolation.

Seven, the availability of diagnostic testing including for the asymptomatic.

Eight, that the capacity of the healthcare system was an important resilience factor.

Nine, the need to identify particularly vulnerable groups and to recognise that transport systems would be a likely source of exposure to infection and that transport workers would be particularly vulnerable.

That was pre-2017. None of the national risk assessments or any plans addressed the need to try to

prevent or slow the spread of an emerging disease hitting the UK. None of them referred to the likely different characteristics of the new disease or the mitigating measures mentioned to combat it. None of them reflected the reasonable worst-case scenario used in the golden hour guidance.

The purpose of the golden hour guidance was to assist SAGE once it was set up as the emergency happened. All rather too late, shutting the stable door. The thinking was all there but not within the risk assessments or any planning.

Professor Whitty also said that he had warned of the possibility of a dangerous non-flu pandemic in a seminar in 2018. In evidence Professor Woolhouse noted, somewhat alarmingly, that, bad as Covid was, that it could have been worse and that the next pandemic may well be.

Dr Horton from *The Lancet* produced the 2004 Institute of Medicine report from the United States that warned of the real threat of new coronaviruses, and he confirmed that this was a subject well trodden within the scientific community globally.

Coronaviruses were no longer just the common cold but were becoming increasingly dangerous, with SARS and, later, MERS being examples and warnings.

The real question for the Inquiry is therefore not if the United Kingdom was as prepared as could reasonably be expected, but why it was so catastrophically unprepared, given the warnings.

Plainly the failure to prepare and plan for Covid is not just a matter of history, because all of those warnings remain as prescient today as they ever were. In considering recommendations we urge the Inquiry not to consider this the post Covid age but the relative calm before the next pandemic. That prospect calls for swift and bold recommendations. Big changes need to be made. Or as Bruce Mann and Professor Alexander agreed with Mr Keith, there is a need for a wholesale rewriting of the United Kingdom's strategic approach to pandemics.

The Inquiry should make recommendations as soon as possible and in tune with other recent successful Inquiries, including the Manchester Arena Inquiry, it should return to its recommendations as it deals with other aspects of its work, and it should call witnesses back to make sure recommendations have been fully considered in a timely way and implemented where appropriate. To some of the people we've heard from, carrying learning into practice will be a novel experience.

We've heard evidence that there were ministers

involved in resilience, and there were many civil servants in the Cabinet Office and beyond whose duties related to civil emergencies. We have seen the spaghetti charts entitled "Pandemic preparedness and response structures in the UK" and similar charts for each of the devolved nations and jurisdictions. There was no shortage of committees, teams, partnerships, divisions, authorities and groups. Indeed, acronyms too.

We've heard evidence from a range of very eminent scientists and there were a number of scientific advisory groups, and of course SAGE. So the Inquiry might conclude that there was no lack of effort expended in this area, but efforts which resulted in this woefully inadequate level of preparedness.

So what was missing?

Firstly, although there were ministers involved, there was no single point of responsibility in central government for civil emergencies or resilience or preparedness. The captain wasn't so much missing from the wheelhouse as there simply was no captain.

Secondly, what appears to have been the hub of central government preparedness, the Civil Contingencies Secretariat, had no actual responsibilities and no actual organisational role or powers. It operated on

an ad hoc basis, in a liaison role between disparate parts of government.

Despite its industry, what did it actually achieve? If it had been paused or abolished, what difference would it have made to the state of pandemic planning as at January 2020?

The legal framework, as we have seen, contained duties only on first and second responders. There were and remain no central government duties save insofar as the Department of Health is classed as a responder. Yes, ministers had regard to some aspects of preparedness or resilience, but none bore significant responsibility.

The senior Cabinet Office managers were at pains to emphasise that no actual responsibilities fell on them. Oh no. The reason, we were told, because the system was based on localism and subsidiarity. A convenient and alluring Get Out of Jail Free card when things go wrong, based on a concept most of us would probably applaud.

We certainly do not suggest that there should be anything other than a strong emphasis on the local delivery of any emergency response. Although there may be many valid criticisms of the way in which this happens in practice, and in the lack of resourcing, localism is not the problem in principle. The problem

is the absence of national responsibility and a national framework to make the system work, to ensure resourcing, training, guidance are in place, to ensure central government departments work in tandem with localism and, perhaps above all, to assure the system.

Assurance means an evidence-based scheme whereby minimum standards and consistency and compliance can be audited and proven. With respect to pandemics, there is a need for national and international collaboration on many fronts. To pretend that responsibility can be left to individual local responders and local resilience forums is and always was a dangerous nonsense.

To pretend that the Civil Contingencies Secretariat or its 2023 replacement is a body that can fill the gap through liaison and co-ordination is equally dangerous.

To suggest that voluntary standards and the self-assessment of local bodies provides some kind of assurance is a pure fiction. It does no such thing. There remains no auditing or assurance of civil emergency preparedness at either local or national level. That must change.

The national element of the civil emergencies framework appears to have consisted of two key elements: the formulation of national risk assessments or national security risk assessments and the National Risk Register

signed off by the National Security Adviser and the National Security Council; and the ownership of each of the assessed threats and hazards by different lead government departments. Ownership in this context meaning responsibility.

With respect to both pandemic flu and outbreaks of dangerous emerging diseases, it's far from clear how these hazards were assessed either in terms of the likelihood of their occurrence or, indeed, their impact.

Given the warnings about the threat of new coronaviruses, the experience of some of them and the golden hour guidance I've already referred to, it is perhaps more than perplexing that the National Risk Assessment system came to the conclusion that the threat from a newly emerging disease was only moderate. It is more than remarkable that it repeatedly concluded that the reasonable worst-case scenario was 200 deaths, and I remind that this was not the most likely impact for the reasonable worst-case scenario.

We know that this was hopelessly wrong by a factor of well over 1,000. As we all well know, there were not 200 deaths, but officially well over 228,000 deaths. And counting. 184 people died of Covid across the UK during the week ending 13 July.

There are really two possibilities here: either the

pandemic was a black swan event which no one could have foreseen or the basis for the risk assessments requires the closest of scrutiny and change.

The experts expressly discounted any suggestion of Covid being a black swan event. The evidence shows that it was not only foreseeable but actually foreseen.

So far as we can see, there is no document, no significant witness evidence as to the evidential basis for the series of risk assessments, so it's not clear why all the warnings and evidence were not heeded. Perhaps those who did the assessments were fixated on what had gone before: Ebola, which had largely been confined to Western and Central Africa, and SARS and MERS, which had largely been contained elsewhere. If that is the explanation, it was predicting the last war, not the next one.

What we do know is that the Hine review questioned the basis of reasonable worst-case scenario. What is the concept based on? A decade or more later, the Cabinet Office commissioned a Royal Academy of Engineers' report and the Mann and Alexander evidence has repeated the point: risk assessments need a range of scenarios, not a guess as to what the worst reasonable outcome might be.

Similarly, the Blackett report of 2011 emphasised

that the focus should be on impact, not likelihood, a point seemingly adopted by Mr Letwin. Once a threat is identified as one which is likely to occur at some indeterminate point, what's the relevance of guessing whether it will be next year or next decade, and how can you ever do so? The point is the identification of a threat must lead to action now because it might happen next year or next decade.

Then there's the evidence of Sir Mark Walport that in 2013 he was arguing that the UK needed to concentrate on prevention and mitigation, not just responding to the dire impacts seen on risk assessments.

Going forward, these three points need to change the way risk assessments are considered.

We've heard from a variety of eminent scientists, we're told that the UK is a country of scientific excellence. We have no reason to disagree. If it's accepted that the National Risk Assessment was hopelessly wrong concerning the impact of a newly emerging disease pandemic, and it must, if it's accepted that the UK is a centre of scientific excellence, and we do, and if it's accepted that Covid was not a black swan event, then the inevitable conclusion is that there was a disconnect between scientific advice and foresight and the national risk assessments.

Much has been said about SAGE and its efficacy. SAGE is not a standing committee, it's an emergency process to stand up whatever bespoke panel of experts is required to respond to an emergency as it arises. It's not designed to advise government on risk assessment.

There are, of course, a myriad of other scientific advisory groups which might be able to contribute to the assessment of threats and hazards. NERVTAG, for example. However, none of them appear to have responsibilities regarding the national risk assessments as a core role or term of reference, nor specific responsibility for advising or critiquing plans devised to meet the threats. Why not?

It's worth noting that NERVTAG, to stay with that pertinent example, because it advises on newly merging respiratory virus threats, has what is described in its terms of reference as a "responsive role", and therefore meets only on an ad hoc basis, albeit at least annually, and its members are volunteers and unpaid.

Since the pandemic, as we heard from Professor Woolhouse, amongst others, the Scottish Government has established its Standing Committee on Pandemic Preparedness, SCoPP. Its role is to respond to commissions from the devolved government but also to act on its own initiative and highlight

matters which it considers should be dealt with. The evidence shows that it meets regularly and autonomy is written into its terms of reference. Isn't this a common sense approach to dealing with scientific advice and scientific monitoring needed for identifying threats and hazards, that is national risk assessments, and for informing resilience planning and preparedness?

If there had been such a dedicated scientific advisory body advising on and challenging the national risk assessments, would the threat of emerging diseases have been assessed as it was? Would the fact that 2011 pandemic flu strategy was so deficient, or the fact that there was no whole-system plan or plan for non-flu pandemics, have been allowed to persist for nearly a decade? Would the fact that such planning as there was did not address prevention or mitigation measures to contain or slow the spread of a pandemic disease have been ignored? We think not.

If the first task of the national framework is identification of threats and hazards through national risk assessments, what about the other side of the coin, planning and preparedness to meet those challenges? We know from the Cabinet Office evidence that the model or doctrine for planning for identified National Risk Assessment threats and hazards was, and appears to

remain, ownership of them by lead government departments.

Yes, of course the department with responsibility for health must be expected to play a leading role in preparedness for a pandemic, but in our view it's a flawed model to delegate responsibility or ownership of a civil emergency threat to a particular department on the basis that the context of the emergency falls within the remit of the department.

The pandemic threat, like other national emergencies, requires a whole-system approach to both planning and response. Yes, that will include a substantial role for hospitals, the social care sector, public health bodies, but a threat assessed to kill 800,000 citizens on a reasonable worst-case scenario was very obviously going to require a fully co-ordinated, cross-government, intergovernment, vertical and horizontal series of plans. It hardly bears repeating, because it has been a constant theme of the evidence, but there was no whole-system plan, there was an out of date single department plan for pandemic flu which contained no more than a cursory nod to the role of other departments. There was no plan for other pandemics beyond a vague hope expressed within the flu plan that it could be adaptable with no further guidance

as to how that could be done.

As a general comment, although many witnesses have come to this Inquiry with candour and to assist its purpose, others have shown a single-minded determination to protect their legacy, their reputation and to pretend that any shortcomings in the state of preparedness and resilience as at January 2020 made little difference to outcome, or that other countries did not do any better.

The lack of frankness was nowhere so apparent as with issues of capacity and austerity. Without an overall plan, with a dysfunctional civil emergencies framework, with no one at the helm, and with little evidence of meaningful joined-up collaboration between national officials and local responders, with zero responsibility on the former and zero assurance on the latter, and little evidence of planning co-ordination between the United Kingdom Government and the three devolved administrations, at least in terms of structures, this was a system which was never going to be effective.

But further to problems with the system itself, the issue of capacity was critical to the success of any planning. A number of the experts and eminent witnesses who worked within the system have highlighted that the lack of capacity in health and social care and public

health, with huge cuts to devolved and local authority budgets over the relevant period, underpinned systemic failures. A lack of capacity means less resilience. A shortage of healthcare staff and full bed occupancy in normal times is not an NHS which can easily surge and pivot into emergency mode. How was that allowed to happen in one of the most wealthy countries on the planet?

Mr Cameron and Mr Osborne were happy to tell us their views on austerity, but somewhat less forthcoming on its effects. Mr Hunt was keen to tell us that the number of doctors and nurses went up under his stewardship, but less keen to talk about overall capacity. The really revealing statistic had in fact already been given by his Chief Medical Officer, Dame Sally Davies, who told us that the UK was bottom of the table of comparable countries with regard to the numbers of doctors and nurses.

Witness after witness has stressed the capacity issues in health and social care. Professors Marmot and Bambra have noted the reductions in funding for health and social care were concurrent with widening health inequalities. Others have stressed that the resilience relies on a proper base, a proper functioning health service and social care sector. Witnesses have referred

to the fact that the NHS struggles to survive each winter. In 2018 routine operations were cancelled to protect essential emergency healthcare services, and it regularly runs at over 95% bed occupancy.

The structural problems in social care are well known, and in that sector there was even a lack of understanding of the number of care facilities at the outset of the pandemic, and the interface between hospitals and care homes will be a major issue in forthcoming modules.

Major cuts to local authority funding during the relevant period had affected adult social care and early days nursery provision. If our services struggle to maintain business as usual, what chance do we have when there's a looming disaster like a pandemic?

The rights and wrongs of austerity, whether Mr Osborne really did fix the roof while the sun was shining, are not for this Inquiry. Resource allocation is for the democratic institutions of state and elections. But the degrading of capacity through the relevant period, major budget cuts to local and devolved authorities, are for this Inquiry, because they are directly relevant to resilience. The Inquiry should say so.

Mr Letwin's evidence was different, more reflective,

and it did seek to address some of the issues before the Inquiry, rather than defending a position or legacy of office. No doubt his views will assist you regarding the need for responsibility for resilience and preparedness at the centre of government, but also the need to concentrate on preparing for foreseeable adverse impact rather than the probability of an event happening. That is a simple but important point I mentioned earlier.

It's perhaps regrettable that Mr Letwin had not driven those changes and spoken out when he was a senior figure in government during the relevant period.

Then there was Mr Gove. He highlighted the successes of the preparations for no-deal Brexit and he was asked about the fact that it brought to light supply chain issues which were or might have been relevant to Covid. He emphasised that there was a knock-on positive effect in providing a rehearsal for another major civil emergency. We do not doubt that there were positives to come out of the near miss no-deal civil emergency, but the trade-off was that most of the work started on refreshing pandemic preparedness after Cygnus was paused and attention was deflected from it in a period where multiple problems and deficits could have been remedied.

One further comment on the evidence of ministers is

the striking feature of a collective abdication of their responsibility as leaders to ensure pandemic preparedness during the relevant decade, and the failure to acknowledge even now that austerity and the spectre of no-deal Brexit had severe adverse consequences on resilience in particular but also pandemic preparedness as a whole.

I have already alluded to the Marmot and Bambra evidence regarding widening health inequalities during the austerity years. As you know, there is real and widespread concern not only amongst bereaved families regarding the disproportionate number of Covid deaths within black and ethnic minority communities and the failure to recognise structural and institutional racism within pandemic planning. Given that structural and institutional discrimination, now so well recognised, and given that health inequalities are so well known, why was so little attention paid to the disproportionate effects of pandemics and disease on particular ethnic communities or particular vulnerable sections of society?

The fact that a virus does not respect borders or the colour of your football team or your politics is a given, but it does not follow that the statistical chance of contracting a virus or the severity of its

impact is equally indiscriminate. The uncomfortable reality is that race, class, disability, sexual orientation and other characteristics are all matters which may affect impact. This is not inevitable. It is the product of structures not individual choice.

As such, they must be considered as an integral part of planning.

Further to that, Marmot and Bambra highlight the lack of data regarding disparities in health outcomes and longevity on ethnic lines. Without data, empirical evidence, it's difficult to understand the causes and granular effects of discrimination and plan to combat it. It was obvious that in some highly vulnerable sectors, frontline healthcare and transport being prominent amongst them, the proportion of ethnic minority workers was far higher than in the general population, and it's well documented that many black and brown communities are more socially disadvantaged than the average.

It's a shocking fact that most doctors, nurses and other healthcare staff who died from Covid were from ethnic minorities, not only a disproportionate number but an actual majority.

Other factors relating to vaccine take-up, including trust in authority within ethnic minority communities,

plainly required to be planned for and managed too. In so-called excess death management, there was little regard and no guidance for the dignity needs of particular communities. There's scant evidence of planning to combat structural disability discrimination or to combat disproportionate impacts on people with other protected characteristics. In the light of the evidence regarding the failure to combat the disproportionate effect of pandemic on particular ethnic minority communities, there is a need for specific responsibility for all local and national pandemic planning to set out action plans as to how such discrimination is to be challenged.

Furthermore, there is a need to recognise the failure of specialist equality units and the Equality and Human Rights Commission to make an impact in this regard. It is not that there was insufficient regard to discrimination and inequalities within pandemic planning, it is much worse than that. There is hardly any reference to these issues in the plans, guidance or exercises.

Turning to the devolved administrations, Mr Lavery will deal with the complex and different issues relating to Northern Ireland, and I know what he is to say and endorse it in advance.

It appears to us that there are at least three key and common themes regarding pandemic planning and the relationship with the UK administration.

Firstly, there are differing accounts of personal relationships between ministers in particular, no doubt driven by political differences and imperatives, and a lack of structures to fully involve the devolved administrations in UK planning.

Secondly, there are constraints on the ability of the devolved systems to ensure resilience by the limited central resources allocated to them.

Thirdly, there appears to have been a reliance on both the UK threat assessments and the pandemic flu plan in all the devolved jurisdictions rather than a critical consideration of them. The planning assumptions were not challenged, there was no plan B on flu, and what planning there was related to consequences, not prevention.

We will expand on these themes in our written closing submissions, but the overarching learning from the Module 1 evidence with respect to the devolved administrations is the need for better and more formal structures within which intergovernmental civil emergency planning can take place with a genuine spirit of collaboration and dialogue, rather than diktat from

Westminster.

If there was a UK civil emergencies minister, the single point of responsibility might also aid this cross-administration collaboration, but without such structures the evidence indicates that some UK ministers saw co-operation with the devolved administrations as of limited importance, and saw meetings as an opportunity to communicate decisions taken rather than to reach consensus and agreement.

The current approach of tagging on general intergovernmental ministerial responsibility to the Department for Levelling Up portfolio is manifestly insufficient. From the evidence, it's plain that the UK administration can itself gain much from collaboration with the devolved administrations. The SCoPP in Scotland may well be an important example.

Finally, we urge this Inquiry to make the following nine recommendations:

One, that there should be a senior minister within government who is the single point of responsibility for civil emergency resilience and planning. The buck stops with them, and that is an important driver to making sure things are done and optimised.

Two, there should be a whole-system plan for each group of threats or hazards identified on the National

Risk Assessment.

Three, the legal framework should be reformed so that the duties on first and second responders are mirrored by duties at national level. This would mean that a central government department responsible to the minister would have actual responsibility for national risk assessments, for the whole-system plan, and to co-ordinate individual, departmental and other plans which are necessary to the whole-system approach. This department should also have responsibility for clear intergovernmental structures with the devolved administrations and for policies and guidance necessary to support local resilience forums and other local responders, and for setting national standards and training competencies and for assuring local performance. It should be responsible for a running programme of exercises to rehearse and challenge plans against foreseen scenarios, together with a clear programme to analyse real emergencies and exercises and an audited programme of putting learning into practice.

Four, there should be an independent UK standing scientific committee on pandemics, with terms of reference to advise those formulating the National Risk Assessment and to challenge where necessary, and to advise government on resilience and preparedness for

pandemics. The Scottish model would appear to be a good starting point.

Five, there should be a duty on all who hold responsibilities regarding resilience and planning or advising on the same to raise with the minister any issues of capacity or resourcing which might impact on the ability of the UK to optimise its response to a pandemic. Civil emergency plans should expressly deal with the issue of resourcing and capacity, given the importance these issues have assumed in the evidence in this Inquiry.

Six, there should be a people-first approach, with duties placed on both local responders and at the national level to require the integration of community and voluntary groups into civil emergency plans, to require positive community engagement with transparent public communication, and public consultation regarding threats and planned mitigations.

Seven, all civil emergency plans should incorporate clear statements indicating how they will combat the effects of structural and institutional racism, other forms of structural discrimination relating to protected characteristics, the effects of health inequalities, and how they will protect vulnerable persons.

Eight, there should be a clear national policy

regarding data gathering and analysis relating to civil emergency planning and response, addressing and resolving the perceived barriers arising from regulation.

And, nine, openness and candour. The default position should be that national risk assessments, together with their methodology and the evidence base behind them, and all civil emergency plans, should be published unless there are clear national security reasons why they must remain closed. Risk assessments and plans can only be challenged and improved if there's transparency, a point powerfully made by Professor Alexander.

As we heard with respect to Exercise Cygnus and Alice, only the threat of judicial review proceedings by a doctor brought the shortcomings in the system into the public domain, and only well after Covid had arrived. Mark Lloyd was frustrated that the culture of secrecy prevented the Local Government Association from knowing of the learning from exercises. Secrecy hides failure. In this context, failure is and was measured in lost lives.

Those are our submissions.

LADY HALLETT: Extremely helpful, Mr Weatherby, thank you very much indeed.

Mr Lavery.

Submissions on behalf of the Northern Ireland Covid Bereaved Families for Justice by MR LAVERY KC

MR LAVERY: Thank you, my Lady.

As your Ladyship knows, but for the benefit of everybody else, I appear for the Northern Ireland Covid-19 Bereaved Families for Justice and I make these submissions on behalf of those families, but I also endorse and commend the submissions that Mr Weatherby made to your Ladyship.

My Lady, you've heard all of the evidence now, and you've heard the evidence of Brenda Doherty today, who started off this module and finished this module as well, and in many ways she -- and I say this because of what I'm going to go on to say about Northern Ireland -- embodies what people in Northern Ireland can be proud of in terms of her means of articulation, her strength and her intelligence and her humanity.

My Lady, it was upsetting to hear how people in her position and the position of the other bereaved families have been vilified, but here, my Lady, and today they have been treated with the respect and dignity that they deserve.

Because these are articulate, reasonable, intelligent people, and they are typical of the group of

people that we represent. And, like all of us, and like you, my Lady, we want the Inquiry to succeed in its task.

In many ways, Module 1 is the most important module. It's when we look at the resilience and preparedness. But in other ways, it's a work in progress, because it's really -- we are unable to see at this stage whether whatever plans were in place, however meagre they were, whether they were capable even of being implemented effectively, and that's what your Ladyship will look at in due course.

We are looking at this mainly from a Northern Ireland perspective in terms of preparedness and resilience, but there, of course, is a clear overlap with the themes that Mr Weatherby spelt out earlier. But by far -- and your Ladyship heard it from Brenda Doherty earlier -- what we want to impress upon you is the need for, and I'll try and say this properly, legislative change.

We say that the UK as a whole needs a new civil contingency legislative framework, but -- and we've heard Northern Ireland described as the poor relation -- we say whenever that's been formulated that that legislative scheme can't rely, unfortunately, on the devolved administration to either perform a legislative

function or indeed to implement anything which is part of a legislative scheme. And the reasons for that are obvious: we've recurring and lengthy periods of no government, and the legislation which was supposed to be brought in in 2004 simply wasn't brought in in Northern Ireland.

We say, my Lady, that if legislation is brought in, there's a need for it to contemplate periods of time when no minister is in place, lengthy periods of time.

One solution might be an automatic reversion of these devolved powers, if they are devolved powers, to Westminster for civil contingencies generally and pandemic and resilience in particular. But so far, my Lady, the need for, in Northern Ireland, legislation has been summarised as that the duties of public authorities would be clearly set out. Accordingly, then, planning would be properly resourced, and there would be budgetary requirements which would follow that, and that there would be a plan, perhaps some kind of plan, for long periods of no government.

But we also say, and this mirrors in some respect what Mr Weatherby said earlier but we say that in a Northern Ireland specific context, that legislation should include binding obligations on the government minister, and accordingly a department, a corresponding

department. This would lead to that department performing two key roles: firstly, ensuring that the minister is briefed in a proper and timely way; and, secondly, the department would then be obliged to seek the scientific advice which was so glaringly absent in Northern Ireland. We say as part of that scheme or otherwise that Northern Ireland should have an overall Chief Scientific Adviser, somebody like Sir Patrick Vallance, who performs that UK-wide role.

My Lady, your Ladyship heard in the evidence that the politicians said that they weren't briefed and the scientists said that they weren't asked, and that's where the department should and could step in.

Dr Kirchhelle, in his evidence, talked of the fluctuations in terms of resources and interest in pandemic planning, and we say, my Lady, that this points to a need for specifically designating by statute a minister with specific responsibility for civil contingency planning. We say that everybody should know who that person is. They should be easily identifiable, as easily as, for instance, the Finance Minister or the Health Minister, and we say this would go straight to transparency and accountability.

This, in Northern Irish terms, may well be the Executive Office, they already have responsibility under

the current guidance, but it should be set out in statute and the people of Northern Ireland should know who they are, what department is responsible.

During the course of the evidence, it did become clear, and was accepted by Dr McMahon and others, including Michelle O'Neill, that Northern Ireland was at a disadvantage because of the legislative gaps.

My Lady, the value of this Inquiry we say is already demonstrated by the open and stated changes in position of some of the officials, for example, and if I dare mention it, the EU exit position, and there seems to be a clear consensus that that did have an overall negative impact, despite how it was initially put.

But, my Lady, in terms of legislative change and the legislative gaps in Northern Ireland, we say that putting Northern Ireland on the same level as the rest of the UK is now wouldn't be enough, and that's clear from what I've said already.

Mr Keith said to Dr McMahon that there were amber and red warning lights coming from the Cygnus report about care homes, and there was no legislation, no government, no accountable official or minister. We suggest, my Lady, that exercises like Cygnus should have a statutory footing so that they are carried out regularly, that they're comprehensive, and that there is

at the very least a statutory obligation to have due regard to its findings.

The Department of Health and its inefficacy in the absence of ministers or statutory obligations has been sadly demonstrated by its inability to progress the Bengoa report. It's difficult to say whether that is just a failure on the part of the politicians or whether it points to a more structural problem.

My Lady, I've said this previously, the scale of the waiting list problem in Northern Ireland is mammoth, and one talks about waiting lists in Northern Ireland being longer than they are in other parts of the UK, but in some instances they are 50 times longer. This is a combination, I suppose, of UK-imposed austerity measures and a dysfunctional government in Northern Ireland.

Baroness Foster in her evidence suggested that the UK should intervene during periods of no government. Michelle O'Neill said that she was prioritising the implementation of Bengoa.

There's obviously a political overlay to any of these comments, my Lady, but we say that legislation could and should look at emergency planning on a five jurisdiction, two-island basis. This would ensure that there were no legislative inconsistencies or anomalies

between the two jurisdictions. Anomalies or inconsistencies that might prevent partnership and co-operation which would be in the common good.

In terms of partnership with the Republic of Ireland, it doesn't need a treaty, the structures are already there within the rubric of the Good Friday -- Belfast Good Friday Agreement, Strand 2 are north-south bodies, co-operation Strand 3 is east-west. So structures are already in place to discuss and make sure that legislative schemes for contingencies are coherent.

We say, my Lady, that legislation would mitigate the impact of factors which prevented proper preparedness and resilience.

It would, through the legislative process and the legislative workstream, examine risks and preparedness. There would be an obligation, we say, as part of such legislation, on the department which was responsible to seek advice from scientists. Next, there should be an obligation to ensure that ministers are properly briefed. There would flow from that proper resourcing of the responsible public authorities, which would minimise the impact of austerity policies.

There would be proper designation of the responsible public authorities, and there would be a contingency for

no government being in place in Northern Ireland.

We say that a proper legislative workstream would ensure that the human impact of a pandemic is contemplated and built into the response plan. We say that there should be a formal structure to ensure that Northern Ireland is properly plugged in to the all-UK science network, that meetings aren't a tick box exercise, nor a simple communication of what is to be done coming from London.

Legislative framework should incorporate exercises like Cygnus into legislative obligations, first of all to make sure that such exercises are carried out, and, secondly, that the recommendations are properly taken into account.

Perhaps not part of that, but certainly in terms of legislative change, this will come as no surprise, the lack of regulation of care homes is a matter of utmost concern to our families, my Lady, and, as you heard today, regulation of end of life care, whether it's appropriate or not to regulate that, whether it's within the statutory framework and how the whole question of communication is dealt with in that context.

My Lady, we will face another pandemic, and we say that the work needs to start now. And when I say "now", I mean after Module 1. That is clearly necessary to

prevent a lack of protection of the most vulnerable in society, a lack of containment, a lack of ability to prevent the spread of disease and death and, my Lady, to prevent the suffering and the indignity and, to use a phrase I used in my opening, the dehumanisation and re-traumatisation that happened in the circumstances of lockdown.

Those are my closing submissions, my Lady, and they'll be amplified in due course and be more detailed in terms of our written submissions.

Thank you, my Lady.

LADY HALLETT: Very grateful, Mr Lavery, and obviously, as with anybody's written closing submissions, I'll read them all with great care. I'm very grateful to you.

MR LAVERY: Thank you.

LADY HALLETT: I think I've been asked to break now before we turn to, I think it's Ms Heaven next -- I can't see her -- wherever she is. I shall return at 25 to.

(2.20 pm)

(A short break)

(2.35 pm)

LADY HALLETT: Right. Now, Ms Heaven, I'm told you've moved.

MS HEAVEN: Yes, I'm here. Thank you.

(Pause)

Submissions on behalf of Covid Bereaved Families for Justice Cymru by MS HEAVEN

MS HEAVEN: Thank you, good afternoon, my Lady.

As you know, I represent the Covid Bereaved Families for Justice for Cymru. They experienced first-hand the failures in Wales to prepare for a pandemic, and you've just heard very powerful testimony from Anna-Louise which reflects the experience of very many people in Wales. Loved ones were lost in traumatic circumstances and the pain and suffering continues.

It has been very difficult for the Welsh bereaved to listen to the evidence heard in this Inquiry over recent weeks. It is now beyond doubt that the Welsh Government and Welsh institutions tasked with protecting the people of Wales not only failed to prepare for a pandemic in Wales but they also failed to build resilience in Wales.

The Welsh people have been profoundly let down by their government and it's now time for lessons to be learnt and for there to be accountability.

It was very disappointing to the Cymru group to hear that some of the witnesses giving evidence before this Inquiry still do not appear to accept all the criticisms that were put to them and that appear in the documents before the Inquiry.

The Inquiry has heard that a more severe and devastating pandemic is an inevitability. There needs to be a fundamental change in approach to preparedness for the next pandemic in Wales, and a willingness to be candid about what went wrong and why. If this does not happen, Wales will not be prepared and more Welsh people will lose their lives.

Pandemic planning in Wales was flawed in the same fundamental way as planning in the United Kingdom, Northern Ireland and Scotland, in that the focus was solely on planning for an influenza pandemic. The consequences of this failure were stark. The focus was not on halting community transmission, as it should have been, or thinking about non-pharmaceutical interventions. This had devastating consequences when Covid-19 arrived in Wales and around the UK. PPE was not available for healthcare professionals, there was a failure to understand the importance of mask wearing and the need for large-scale contact tracing and testing, mass gatherings were not cancelled, and there was no awareness of the need for quarantining and social distancing.

These failures in planning assumptions were unjustifiable. The world had already experienced two coronavirus pandemics, major epidemics, in the

21st century, SARS and MERS. Both had profound effects in East Asian countries, and as a result those countries had learnt lessons about pandemic planning and preparedness. The lessons learned by the East Asian countries were readily available in the World Health Organisation literature, and could and should have been in the UK and used in the United Kingdom, including in Wales' pandemic planning.

The Inquiry heard evidence from Professor Heymann and Dr Richard Horton, who gave poignant evidence of how since 2004 the global community knew that coronaviruses were a major threat, yet there was a general groupthink in the United Kingdom to focus only on the threat of influenza.

Witnesses were prisoners of their own ill-informed assumptions, and did not even consider looking to the East Asian countries for guidance. In the words of Quentin Sandifer of Public Health Wales:

"... on lockdowns, I think it's fair to say from my own professional experience, I hadn't envisaged circumstances where we would have locked down a whole society or, indeed, a whole country in the way that we did in March 2020."

Mr Drakeford was asked whether, in his capacity as health minister or First Minister for Wales, whether

he'd asked about the risk of a novel virus or a Disease X breaking out and whether Wales was prepared, to which he responded that he had not. Mr Drakeford had first-hand experience of the response to SARS, MERS and Ebola during his political career in Wales. The Cymru group considers that the threat of a pandemic requires a much more robust spirit of political enquiry.

Mr Drakeford was not the only minister who did not ask the questions that needed to be asked. There needs to be an across-the-board change in mindset as regards thinking about and discussing scientific opinion on pandemic risk.

But was it really the case that no one in Wales as asking the right questions? As far back as 2013 the Inquiry can see that Wales' own Health Emergency Preparedness Unit's annual pandemic planning conference included a talk by Dr John Watkins, now Professor Watkins, and of note he has provided you, my Lady, with a very interesting witness statement to this Inquiry.

In 2013, Professor Watkins was a consultant epidemiologist in Public Health Wales and he can be seen talking publicly about how current threats included a novel virus and that planning assumptions in Wales must consider that it could see the emergence of such

novel virus with a possibility of little background immunity and no vaccine available with transmissibility akin to the Spanish influenza pandemic.

The Cymru group asked the Inquiry to get to the bottom of whether the Welsh Government was in fact warned about the risks of a novel virus, and if so why such warnings were not heeded.

Aside from being fundamentally flawed because of narrow planning assumptions, pandemic preparedness in Wales was not a sufficiently high priority within the Welsh Government. This failure to prioritise pandemic planning is perfectly illustrated by the flawed approach in Wales to understanding and managing Tier 1 pandemic risk. As the Inquiry has heard, the United Kingdom held a UK National Risk Register which identified pandemic influenza as a Tier 1 risk. However, in Wales, pandemic risk was downgraded by virtue of it being taken out of the Welsh Government Corporate Risk Register and only then included, under a general heading on the 2019 register, under "Disruption Event[s]".

The risk remained in the health and social services group risk register, but this simply did not give it the overall prominence that it quite clearly warranted.

Of note, the health and social services risk register was not disclosed to the Inquiry by the

Welsh Government until the Thursday before the Welsh witnesses gave evidence at this Inquiry, and so there was insufficient time to provide this document to core participants.

The risk rating of a pandemic was also downgraded in Wales. This was despite there apparently being limited resources to implement devolved civil contingency powers, a failure to implement recommendations from Exercise Taliesin and Cygnus, and a failure to complete task workstreams on pandemic planning.

The risk of a pandemic in Wales had been downgraded but they had simply not been mitigated.

Mr Drakeford now recognises that Wales should have had its own national risk assessment process. However, immediately after devolution there was a need to ensure a Welsh-specific assessment of risk that honestly reflected the vulnerabilities in Wales in respect of a pandemic. This did not happen.

I now turn to pandemic planning in Wales. As the Inquiry has heard, formal pandemic planning was woefully inadequate. Wales did not formally plan for the impact of lockdown measures, but tested them only after Covid-19 arrived in the United Kingdom. There was no testing for surge capacity, no evidence of a plan or strategy to deal with excess deaths or the consequences

of adequate planning in relation to post death procedures or to protect dignity and support the Welsh bereaved in the event of a pandemic.

The witnesses to this Inquiry have not given a satisfactory explanation for these failures.

Wales participated in Exercise Cygnus 2014 and the national Exercise Cygnus in 2016. This 2016 exercise, as you know, gave rise to a finding that the United Kingdom's preparedness and response "in terms of its plans, policies and capabilities was not sufficient to cope with the extreme demands of a severe pandemic that would have a nationwide impact across all sectors". There were four key learning outcomes and 22 detailed lessons, with 12 recommendations applying to Wales.

Sir Frank Atherton, Chief Medical Officer, stated that he was aware of HEPU maintaining a log of progress on the outcomes of Cygnus 2016, but the Inquiry heard that workstreams were not completed, and whilst it was recognised that the Welsh strategic documents required updating, this did not happen. For example, the Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance and the Wales Framework for Managing Infectious Disease Emergencies remained in their 2014 versions and were not updated in light of the 2016 Cygnus report. The local resilience forum

pandemic -- of 2013 -- guidance was also not updated.

A concern was raised, as you heard, by Reg Kilpatrick in July 2018 regarding the Welsh Government's level of engagement and provision of resource to the progress of pandemic influenza preparedness. Notwithstanding the concerns raised, no further resource was committed to pandemic planning and no further work was completed in respect of the guidance.

Now, the Inquiry has learnt that after Cygnus in 2016, the Welsh Government also set up the Wales Pandemic Flu Preparedness Group to progress tasks but this group for the last time in September to October 2018 and, as the Inquiry has established, there were many tasks but they were not finished.

The Inquiry heard evidence that the work in Wales was in effect shadowing the UK-wide group, however there were no impediments to the Welsh Government getting on with drawing up plans and guidance. This work could and should have been progressed to fruition with greater urgency.

The failure to do this meant that when Covid-19 hit Wales' health and social care infrastructure, it was simply not able to cope. This was an unforgivable failure, not least because in 2014 Exercise Taliesin

raised a concern about capacity in the adult social care sector and that it could not cope with the demands of a pandemic. This had not been resolved in 2016, and it was still not resolved when Covid-19 hit.

The Cymru group experienced the consequences of these shocking failures on preparation and planning. Many loved ones lost their lives in hospitals and care homes in traumatic circumstances with inadequate means of protection.

The Cymru group consider that preparing for a no-deal EU exit was simply not a sufficient reason to justify significantly interrupting all the preparations for the Tier 1 risk of a pandemic in Wales.

The Welsh people were not told that such life and death choices were being made for them. They should have been.

From the evidence before the Inquiry, a clear picture emerges of a lack of adequate attention paid to pandemic preparedness at all levels of government over many, many years. The Inquiry has heard deeply concerning evidence from Mr Vaughan Gething, who has served as Deputy Minister for Health, the Cabinet Secretary for Health, Well-being and Sport, and, latterly, Minister for Health and Social Services until May 2021. He told the Inquiry that before October 2016

pandemic risk for Wales "wasn't, as it were, brought to my direct attention that it was something that I needed to be particularly prepared for". He said that whilst he became aware that a pandemic was a priority in Wales in the run-up to Exercise Cygnus, before then he'd simply not understood that pandemic risk was in the Tier 1 risk register. He did not read the risk register. He candidly admitted that pandemic preparedness:

"... [did not] have the same priority as those headline issues that ... take up lots of life and energy of the government ..."

And that there is a learning lessons point arising from the challenge of dealing with "what comes up" and "longer term priorities". Mr Gething stated that he was advised that Cygnus learning points had been identified and would be implemented, and he assumed, absent any advice to the contrary, or questions in the Senedd, that the lessons of Cygnus had been applied. Mr Gething did not read the report of the outcome of Cygnus and admits that had he read the conclusion about lack of preparedness he would almost certainly have asked extra questions and asked for more assurances about implementation.

Mr Gething accepted that it was fair to say that if

he'd put more time into this work then he may well have sped up preparedness.

It is shocking that ministerial political oversight needed for such an important issue was simply absent from someone in the position of Mr Gething. This was a catastrophic and indefensible failure.

The failure continues. The Welsh Government were warned eight years before Covid-19 hit that there was a fragmented labyrinthine system dealing with pandemic resilience in Wales, in which accountabilities were unclear. No action was taken.

A Wales audit report of December 2012 on civil emergencies in Wales noted that "too many emergency planning groups and unclear accountabilities add efficiency to the already complex resilience framework and that the complexity risks fragmentation of resilience activity with potential overlap or collapse in the arrangements for resilience".

This structure did not significantly change prior to the Transfer of Functions Order under the Civil Contingencies Act 2004 in 2018. Mr Drakeford accepted in oral evidence that a review of civil contingencies arrangements remained outstanding going into the pandemic. This was yet another indefensible failure on the part of the Welsh Government.

Now, a matter of real significance to the Cymru group is hospital-acquired Covid-19. Many people in Wales died because they caught Covid-19 in Welsh hospitals with inadequate ventilation and poor infection control.

It has been deeply concerning and upsetting to learn about the extent to which this issue was simply not a priority for the Welsh Government and NHS Wales.

The Welsh Government's key pandemic preparedness guidance of 2014 identified the importance of infection control and control arrangements, the need for meticulous use of infection control, isolation and cohort nursing, and the need to be able to care for large numbers of infectious patients on a scale outside their normal experience.

This was not new news. Since 2004, in the wake of SARS, the Welsh Government and those responsible for pandemic planning and preparedness in Wales had known about the lack of facilities to deal with high-consequence infectious diseases in Wales and the need for general improvement in infection control in Welsh hospitals.

However, inadequate action was taken over many years. When Covid-19 struck, Welsh hospitals could not cope with infection prevention and control. In

addition, it was known over many years that microbiology and infection services were fragile and struggling to deliver on a day-to-day basis the prevention, early diagnosis and frontline support that professionals and the public require.

Wales could not even deal with one high-consequence infectious disease when the pandemic hit. Since 2006 NHS Wales has surveyed and produced annual reports on all airborne isolation rooms in major hospitals across Wales. Every year the reports concluded that many of these isolation rooms were inadequate. In 2017 the Airborne Isolation Rooms Review Working Group produced a report to inform policy on airborne isolation rooms in major acute hospitals. The report concluded that building structures did not support safe management of patients with infectious disease.

It is again important to say that it's staggering to learn that there was no one single health board in Wales capable of dealing with a high-consequence infectious disease.

Frank Atherton, Chief Medical Officer, and Quentin Sandifer, Public Health Wales, knew about this state of affairs. In the early days, Covid-19 was classified as a high-consequence infectious disease. The Cymru group consider that there was a systemic

failure in Wales to improve infection control in Welsh hospitals and the lack of urgency around the high-consequence infectious disease issue is merely illustrative of a general lack of focus on infection control from devolution onwards.

The Cymru group ask the Inquiry to robustly examine the state of infection control in Welsh hospitals in Module 2B.

Turning to PPE, Audit Wales have been damning in their April 2021 report on PPE, and have clearly illustrated that PPE stockpiles were inadequate, not just for a coronavirus pandemic but for the pandemic planned for, namely influenza with waves lasting 15 weeks. The same applies to the arrangements to distribute the PPE in a timely manner. These were also inadequate. More work could and should have been done in advance of the Covid-19 pandemic to ensure both a sufficient stockpile of PPE in terms of the amounts, the expiry dates, the correct types and ensuring a robust distribution system.

I now turn to health inequalities. Health inequalities in Wales were not adequately considered, particularly in the context of pandemic planning. Professors Bambra and Sir Michael Marmot gave compelling evidence of how a whole-system catastrophic shock

exposures and amplifies pre-existing health inequalities. They consider that pre-existing health inequalities were only considered in a minimal way by both the United Kingdom and devolved administrations. The Cymru group agree.

The Inquiry has heard that Public Health Wales' emergency response plan made references to vulnerabilities but that there was no explicit references to those with comorbidities, older people or health inequalities. Again, this is simply inexcusable, not least because the Welsh Government was bound by legal duties under the Equality Act 2010.

The Welsh Government has made a qualified admission in relation to failing to take adequate steps in relation to health inequalities. The Cymru group consider that they need to go much further.

Finally, briefly, lessons to be learned. The Cymru group considers that the headline conclusion of Mann and Alexander that -- there needs to be a radical shift to put in place a single integrated and professional civil protection system which is fit for the future we face, and capable of providing an effective whole-system, whole-of-society response to emergencies on a catastrophic scale, as well as being able to tackle emergencies at a local and regional level.

The group considers that, for Wales, this means a system which is reflective of Welsh data and Welsh risk assessment, supplemented by clear and meaningful arrangements for intergovernmental information sharing and working, and a clear and robust infrastructure for decision-making and leadership across the whole of government on this issue.

Science must play a central role in the system and three short points are made on the science:

First, as Sir Jeremy Farrar described in his evidence, scientific infrastructure must be maintained to ensure the United Kingdom and Wales is prepared for the next pandemic.

Second, scientific advice must be readily available to all decision-makers in a timely way, for example there must be a clear line of communication for information from NERVTAG and SAGE.

Third, scientific advice must be transparent and liable to challenge. Safeguards are required to ensure that the science is less liable to groupthink, less closed and more open to scrutiny and challenge.

Fourth, there must be clear audit trails demonstrating how the science has informed political decision-making.

Within the political arena, the following changes

are required:

First, there is a need for clear leadership on issues of resilience and preparedness. At a UK level there should be a senior Cabinet Minister devoted solely to the resilience and preparedness portfolio; such a function is equally important for Wales.

Whilst in Wales the function has traditionally been carried out by the First Minister, as Reg Kilpatrick acknowledged, the appointment of a dedicated minister for resilience and preparedness could provide a greater impetus in the day-to-day work of preparedness and resilience.

Second, there is a need for clarity and streamlining in respect of preparedness and resilience in Wales, updating and harmonisation of plans, in order to ensure that the system works together as a coherent whole rather than a set of plans.

Third, the development of Wales' specific plans should be informed by a Wales risk register which will look to the UK register but the Welsh Government needs to apply its mind to its own centralised assessment of risk.

Fourth, senior ministers and key personnel must be adequately trained in crisis management and there must be a robust system of audit and assurance to support the

sharing of best practice and drive organisational learning and development, and a clear audit trail to demonstrate how decisions have been made, together with assurance frameworks to ensure plans are stress tested and robust.

Finally, from an operational perspective, there must be adequate investment in infrastructure and workforce resilience, because without those systems no plan will work.

Ultimately, the success of any radical shift can only be ensured if there is accountability and strong leadership in the Welsh Government.

As you know, my Lady, the Cymru group has continuously called upon the Welsh Government to acknowledge its failures and to take responsibility for them. Without such accountability, lessons will not be learnt.

The Cymru group also note that the Welsh Government have at no stage said sorry to Welsh bereaved families. These same families have battled through their own grief to campaign and to shine a light in this Inquiry on the failures of pandemic planning. Given the evidence before the Inquiry, it's right to say that an apology to the Welsh bereaved from the Welsh Government is now long overdue.

So, finally, the Welsh Government must now reflect on the evidence which this Inquiry has heard, acknowledge its failures and provide a strong commitment to the systemic change required to prevent a future loss of life.

Diolch, thank you.

LADY HALLETT: Thank you very much, Ms Heaven, very grateful.

Ms Mitchell.

Submissions on behalf of Scottish Covid Bereaved by MS MITCHELL KC

MS MITCHELL: My Lady, I'm instructed by lead solicitor Aamer Anwar and April Meechan on behalf of the Scottish Covid Bereaved.

This group was set up to ensure Scotland's voice is to be heard both at the UK and Scottish Inquiries.

My learned juniors Kevin McCaffery and Kevin Henry assist me, along with the Inquiry's department and Aamer Anwar & Company.

The Scottish Covid Bereaved wish to thank Jane Morrison and all those who gave evidence this morning on behalf of the four nation groups, and also thank those in the groups themselves. They remind us why we are all here and why the recommendations that you, my Lady, will consider making are vitally important

to the health of everyone in the UK now and in the future.

The right of every person is to the enjoyment of the highest standard of health, as the 1946 Constitution of the World Health Organisation noted when it stated:

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

The right highlights the need for real equality, because discriminated, vulnerable and marginalised groups often share a disproportionate amount of health problems. As Dr Richard Horton stated in his evidence, Covid was not an equal opportunity virus.

Having received disclosure over the past six months and listened to the evidence over the past six weeks, the Scottish Covid Bereaved considers that the UK and Scottish Governments have failed in their obligations to protect the health of those within it by failing to prepare for what they knew was an inevitable pandemic.

The Office of the UN High Commissioner for Human Rights and the World Health Organisation have identified key aspects of the right to health. They include the right to prevention, treatment and control of disease; there was a duty to protect. The right to access to

essential medication, services, goods and facilities that must be available in sufficient quantity, accessible, acceptable and of good quality; that duty existed too. States cannot justify a failure to respect their obligations because of lack of resources. States must guarantee the right to health to the maximum of their available resources.

The Special Rapporteur on the right to health has stated that health systems have to have several components, but two which might be important to consideration in the present case is an adequate system for the collection of data, and that data to be disaggregated, ie to be separated on certain grounds such as sex, age, ethnicity.

Further, it says that national capacity to produce a sufficient number of well trained health workers who enjoy good terms and conditions of employment are part of the right in respect of health.

The Scottish Covid Bereaved see none of these standards were reached pre-pandemic, and therefore it is unsurprising that we invite the Chair to answer the question which she posed at the outset six weeks ago: was the UK prepared for a pandemic? No. Can we learn lessons for the future? Yes, undoubtedly.

We will submit in writing detailed submissions on

the proposed recommendations for you, my Lady, to consider, and in doing so we will take into account the helpful submissions that we heard made today. But for present purposes we just wish to highlight three following issues which were, in part, the reasons for lack of preparation and which recommendations we'll need to address if we are to understand how to be prepared when the next pandemic arrives.

The first of these, perhaps unsurprisingly, is the impact and effect of the ten years of austerity.

My Lady, you have now heard that the policy of austerity led to chronic underfunding of the National Health Service in the decade preceding the pandemic. The National Security Council Threats, Hazards, Resilience and Contingencies committee was set up to scan the horizon and act as an early warning system. This was done at the same time as the National Health Service was being brought to its knees with chronic underfunding. This was wholly counterstrategic, the equivalent of spending money on a tsunami warning system whilst at the same time allowing the sea wall defences to crumble.

David Cameron said it was prudent to fix the roof while the sun is shining, but the weather forecast warned of imminent torrential rainstorms, and those who

worked in the National Health Service and the care sector repeatedly and pointedly warned that the long-term underfunding left the NHS in crisis, barely able to deal with a winter flu, let alone a pandemic.

In 2018, the BMA warned that if funding for the NHS was not increased further there was a very real risk to patient safety, as the NHS would lack the staff and resources to deliver quality patient care. The sustained underfunding of the NHS led doctors to fear for public safety and making medical mistakes. Staff retention, which was already poor before Brexit, worsened. The BMA has contended this has affected well-being and morale of workers.

The effect of ten years of austerity was also felt elsewhere in society, and if I may quote from one of the productions provided to us from the BMA:

"Doctors are concerned about the impact of austerity and associated welfare reform on health and wellbeing, and believe governments need to do more to protect the most vulnerable and disadvantaged in society who suffer a disproportionate burden. They witness first-hand the detrimental effects on their patients' health and wellbeing but are unable to directly address the contributory factors that are beyond their clinical influence. These factors are linked to a range of

economic and social policies that affect wellbeing and welfare, social security, employment, families and communities, health and social care, pensions, living conditions, social housing, and education."

We have heard that the pleas of those involved in the healthcare system remained unanswered by the time Covid reached our shores. Had proper consideration been given to pandemic planning, the first step would have been to make our care services healthy, to prioritise the health service so that when the inevitable pandemic arrived we were ready for it.

Two, the effects of Brexit. In conjunction with underfunding, work on the no-deal exit from the EU was prioritised over pandemic planning. Evidence of this might be most obvious in the fact that the Pandemic Flu Readiness Board didn't meet between November 2018 and November 2019.

It was suggested by Mr Gove that he was not aware of any impact that pausing to work on Brexit had caused. The Chair has evidence from the experts which clearly set out the work preparing for the pandemic had stopped. Vital work had not yet been completed, such as guidance on NHS triage arrangements, the operational plans for adult social care, a revised and updated version of the 2011 pandemic influenza strategy, which by 2020 had

not been updated to include valuable learning which could have been taken from MERS or SARS, the Hine report or Exercise Cygnus.

The effect of leaving the EU, as mentioned above, was also being felt in the inability to retain sufficient staff to work in care facilities and hospitals throughout the NHS. That in turn placed additional stress and workloads on those who were working in those jobs.

Pandemic planning cannot take second place to any other events, and resilience must be found to ensure that, regardless of whatever else might be happening, pandemic planning remains prioritised, and that is a reflection of how serious we understand that the risk is.

Three, failure of experts.

The Inquiry has heard repeated explanation that the focus was placed on a flu pandemic and this was a significant factor in lack of preparedness. It is not clear why this was so. A flu pandemic would still have many similarities to a Covid one and would still have required many of the same preparations. There was also a misplaced confidence in the ability of the UK as a world leader to deal with a pandemic, and a seemingly inexplicable failure to learn valuable lessons from

countries which had and were dealing with pandemic viruses. Groupthink was blamed for lack of scientific enquiry.

The Scottish Covid Bereaved believe that experts must have the time, opportunity and independent funding not only to learn the lessons that this last pandemic has taught us but also have a regulated streamlined way in which scientific advice can be given to governments to allow them to take properly informed decisions to protect health.

These three issues are far from the only ones. Issues such as the myriad groups with reliance on acronyms, lack of joined-up communication, governmental memory being short, the relationship between governments, the engagement or otherwise of the Scottish Ministers in pandemic planning, the way Scottish health groups were organised, and whether the ethos, admirable, that resilience was everyone's business in fact actually worked. These will be addressed in written submissions.

Ultimately we had the science, we had the expertise, but a decade of austerity, focus on planning for a no-deal Brexit, chaotic administration, lack of communication, chronic underfunding of the very services we rely on to protect our health, meant that we were in

no way prepared for the pandemic when it arrived on our shores.

My Lady, at the outset of our submissions we quoted Albert Marrin, emeritus professor of history, who wrote in 2018, writing as he was on the great flu of the influenza pandemic of 1918, that:

"When the next pandemic comes, as it surely will some day, perhaps we will be ready to meet it. If we are not, the outcomes will be very, very, very, dreadful."

Sadly, in the UK we were not ready to meet it, and the outcome, as we'll come to consider in the modules to come, was very, very, very dreadful.

These are the oral submissions on behalf of the Scottish Covid Bereaved.

LADY HALLETT: Thank you very much indeed, Ms Mitchell, extremely helpful.

I think now we have, lastly for today, Mr Ford. Thank you for making your way here at --

MR FORD: Not at all, my Lady. Not at all.

LADY HALLETT: -- rapid response.

Submissions on behalf of the Association of Directors of Public Health by MR FORD KC

MR FORD: Thank you very much.

My Lady, I'm going to be relatively brief on behalf

of the Association of Directors of Public Health. Like others, we're going to put in more comprehensive written submissions which will set out everything we want to say about the issues with which this part of the Inquiry is concerned.

Those will include our views on the part played by the directors of public health in the pandemic response during the Module 1 period; secondly, the views of the members of the Association on the part that they feel they should have played to achieve a more effective response when the pandemic struck; and, thirdly, the reforms that the association suggests should be made in order to hope that such an effective response can be achieved in the future.

The Inquiry has heard the evidence of Professor McManus about the vital role that directors of public health believe they could and should have played in the period leading up to the pandemic and the widely held view amongst directors of public health that they were in effect ignored by central government in the planning for a pandemic and in the early pandemic management.

We mentioned two striking examples of that in opening. The first was that there appeared to be an absence of an up-to-date list of contact details for

the directors of public health in their local authority bases within the Department of Health and Social Care; and, secondly, the fact that the directors were themselves learning about central government plans and initiatives from the televised briefings designed to inform members of the public what was going on.

It is the view of Professor McManus and the directors that the response next time needs to be joined-up, a system-wide plan rather than top-down prescription from central government.

You have heard that Professor McManus's evidence was corroborated, I think by all of the other witnesses from whom the Inquiry has heard who work at the local public health level. Professor Fenton of the Faculty of Public Health, and the English and Welsh representatives of the Local Government Associations, Mark Lloyd and Chris Llewelyn, their evidence referred to the pivotal nature of the local voice, both in public health generally and more specifically in emergency planning.

The message has been a consistent one: of course it was important to protect the NHS capacity so it could fulfil its vital role in treating patients infected by the Covid virus, but if proper use had been made of public health resources at a local level, the National Health Service would have had fewer patients to treat.

As one of the members of the ADPH team put it, it makes more sense to help people give up smoking than focusing all your resources and attentions on treating them for lung cancer.

It's a point made by witnesses outside the public health sector. Matt Hancock said that he had come to believe that the focus at the outset of the pandemic should have been on preventing the spread of Covid rather than on treating those who became infective. That, he said, was a flawed doctrine, and the directors of public health agree with that.

As the Inquiry knows, health protection and improvement at a local level is very much what the public health system is there to deliver, both generally and the directors of public health in particular, and they have significant skills and experiences in that area.

The local role is reflected by the fact that, at least in England, they are placed within local authority homes(?) rather than in health structures, and, as we will elaborate in our written submissions, they are very keen to remain so placed.

Overall, my Lady, when the next pandemic strikes there should be systems and structures in place to ensure that the first thing that happens is that local

public health professionals, directors of public health and others, are mobilised to put health protection measures in place immediately and that they have the powers to do so effectively.

The detail of how they say that should be achieved will appear in our written submissions in more detail, but the broad areas are as follows:

Promoting a better understanding of the role of the directors of public health, both within government and more generally.

Making better use of the directors in local public health planning, including exercise planning.

Reviewing the structures and the functions of the LRFs and the LHRPs.

Drawing on existing local expertise in matters such as test and trace rather than creating parallel structures from scratch.

Ensuring effective communication up and down the system at all levels.

Creating provision for effective data flow by primary legislative changes if necessary.

Encouraging the allocation of sufficient resources so that workforce numbers and training are adequate, and I think every representative who has addressed you so far this afternoon has made the point that they were

not.

And creating national guidance to address health inequalities in emergency planning.

On that last point, my Lady, and finally, in a society which has such regional, economic and cultural diversity, it was a significant mistake, ADPH says, not to take advantage of resources and expertise at the local level. Knowledge of the particular needs of local communities was crucial. Their message is: local matters, and ADPH's members believe that the pandemic response could have been so much better and that, if it had, lives would have been saved.

My Lady, ADPH and its members are very grateful for the opportunity to get these points across to the Inquiry. Thank you.

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

I think that's as far as we can go today.

MR KEITH: My Lady, that is it for today.

LADY HALLETT: So a great deal of food for thought from all the submissions, and I'm really grateful for those. I'm sure there will be yet more food for thought tomorrow.

10 o'clock tomorrow, please.

MR KEITH: Thank you.

(3.18 pm)

(The hearing adjourned until 10 am

on Wednesday, 19 July 2023)

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