IN THE UK COVID-19 PUBLIC INQUIRY

BEFORE BARONESS HEATHER HALLETT

IN THE MATTER OF:

THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

Submissions on behalf of Covid-19 Bereaved Families for Justice UK and NI Covid-19 Bereaved Families for Justice for the Module 3 preliminary hearing on 27 September 2023

---

1. These submissions are provided on behalf of Covid-19 Bereaved Families for Justice UK (CBFFJ UK) and NI Covid-19 Bereaved Families for Justice (NI CBFFJ) in advance of the Inquiry's M3 preliminary hearing on 27 September 2023.

2. These submissions build on those previously made dated 21 February 2023 in advance of the first preliminary hearing on 14 February 2023 and the information received on 29 August 2023 from the Inquiry in relation to M3.

Overarching Issues

3. By the time M3 begins in autumn 2024, the inquiry will have completed M1, M2, M2A, M2B and M2C and possibly M4 too (we will return to the sequence of the modules later in these submissions). However, there will be a wealth of evidence having been heard by the inquiry orally, as well as the disclosure received and written evidence filed within the proceedings. In many instances the evidence will overlap from one module to the next and have a cumulative effect. We have identified a number of overarching evidential issues which are pertinent to every module. These include:

   (a) Health inequalities;

   (b) Structural discrimination; and

   (c) Data collation, analysis and data-informed decision-making implementation.

4. It will be important to ensure that these overarching issues are built up consistently and augmented by each module.

5. Our submissions follow the agenda of the preliminary hearing on 27 September 2023.

(a) Rule 9 requests

6. We note at §6 of CTI's note of 29 August 2023 that the inquiry is in the process of "identifying Trusts and [Health] Boards that can provide direct evidence of how issues and concerns within

Module 3's scope affected hospitals and those being treated and working within them." It will be important to understand not only how Covid impacted on those Trusts and Health Boards, but also to understand why it was that some hospitals fared much better than others in terms of rates of Covid-19 infections and deaths.

7. To this end, we suggest that after consultation with CPs, the Inquiry selects a panel of experts who are tasked to produce a report examining two selected Trusts / Health Boards (in each nation) that had a low rate of infection and death, and two others (in each nation) that had high rates. This will allow the inquiry to explore the inequitable distribution of the burden of Covid-19 across settings, as well as the variance of (for example), visiting policies, access to ICU, spread of infections, and death rates. It will be important for learning lessons to analyse the factors that caused or contributed to the variance.

8. Without knowing what information has been sought by the Inquiry, it is difficult for us to assist the Inquiry by raising other topics or avenues of investigation, or identifying particular material which may exist. In light of this, we again invite the Inquiry to disclose r.9 requests and to direct that position statements should be made by state and organisational CPs and material providers.

9. In view of the difficulties with gathering evidence in M1 and M2 and the apparent late production of material to the Inquiry by various providers, and the consequent very late disclosure of relevant material to CPs, we invite the Inquiry to reconsider the use of Position Statements in M3 (and other modules). Position statements are an effective way of placing the onus of signalling what is relevant - and what may not be - onto providers, expediting the process. Evidence gathering through the r.9 process alone tends to lead to delay and defensive statements, necessitating much more work from the Inquiry itself in identifying issues and materials which may not be apparent to anyone other than those who were directly involved - the provider. A position statement requires the provider to proactively assist the Inquiry, the r.9 process generally calls for them to address particular questions and issues, rather than identify where the Inquiry should be looking.

Testimonies of bereaved families

10. At the conclusion of M1, the Inquiry heard from representatives from the family groups for UK, Scotland, Wales and Northern Ireland. The court heard powerful and emotional testimonies from people who not only told their own stories but throughout their own experience of loss had become experts who were able to provide insights and information relevant to the scope of M1. The impact their evidence had on those in the Inquiry room and those in the wider audience listening and watching online was profound. There was much media attention of these testimonies. Not only was it in the public interest for the bereaved to have been heard directly by the Inquiry in M1, but their testimony marked an important moment across the four nations and, it is submitted, went some way in assisting those still grieving, and for the public to continue to process the collective loss felt by so many people. It is a matter of real regret to the families that having seen the importance of calling representatives of the bereaved family group, the Inquiry declined to hear any of the other bereaved witnesses proposed.

11. As to the r.9 request made to our clients, we would urge upon the Inquiry the importance of calling a proportionate number of bereaved family witnesses from diverse backgrounds and locations across the UK, who can speak to a range of systemic issues relevant to M3 . Whatever the utility of the parallel Every Story Matters project, the voices of those most affected need to be heard within the Inquiry room and be part of the evidence before it. Their voices and lived experiences are as important as any expert, clinician or politician who gives evidence to the inquiry.

12. To that end we will provide the Inquiry team with a list of families from whom we consider the Inquiry would benefit from hearing oral evidence. These are bereaved family members some of whom also have experience as healthcare staff both at front line level as health care workers, but also in some instances as management. They have a unique perspective on the pandemic and their evidence will provide considerable value to the Inquiry.

13. It has always been understood that it is both beyond the scope of the Inquiry to consider individual cases and that it would be impossible given the scale of deaths. With that in mind, we are currently conducting an exercise with our families to identify a proportionate number who would wish to give oral evidence and whose accounts will assist the Inquiry on matters within the scope of M3. We will submit a spreadsheet of summaries of the evidence of those families as soon as that exercise is completed. The list will include proposed family witnesses from across the UK and the evidence will cover a diverse range of issues.

(b) Disclosure to CPs

14. We welcome efficient and early disclosure of material for M3 to enable proper preparation and exploration of the issues and to assist in effective preparation of questions to witnesses. We note that there have been serious problems with disclosure relating to both M1 and M2. We urge the Chair to direct the Inquiry team to ensure that all disclosure is made as early possible and substantially completed no later than four weeks before the start of the M3 hearings, to prevent a repetition of the experience of Module 1 wherein disclosure was sent during the hearing period, including after CPs had made final submissions. Given the breadth of the topics within Module 3, and that it spans all four nations, we anticipate that the number of documents disclosed in M3 will far exceed those disclosed in M1 which was 19,020 documents amounting to 304,096 pages.

(c) Expert witnesses

15. We are concerned that the inquiry is proceeding on the basis that CPs have nothing useful to contribute as to which experts are required or the identity of the experts. The inquiry's approach of ignoring the knowledge base of the CPs is uncollaborative and unhelpful.

16. We have emphasised in previous submissions and do so again the need for independent experts to understand the state of the healthcare system in Northern Ireland *before* the pandemic, given its specific and unique makeup which differs from Trusts and Health Boards in all other parts of the UK. Witnesses with specific expertise on the state of the healthcare system in NI would be best placed to assist the Inquiry. Given that healthcare is a devolved matter, there is also a need for independent experts who understand the state of the healthcare systems in Scotland and Wales before and during the pandemic to be instructed by the Inquiry. Accordingly, we request that the Inquiry ensures it hears from witnesses with specific expertise on the state of the healthcare system in all four nations of the UK. While there may be some overlap with evidence to be heard in Modules 2, 2A, 2B and 2C, it is outside the scope of those modules to conduct review of the impact of the pandemic on healthcare systems. It follows that M3 must thoroughly examine the impact of the pandemic on the all four nations of the UK.

17. Further, the inquiry has afforded very little time between receiving CTI's note on 29 August 2023 and requiring written submissions to be filed by 12 September 2023. We are consulting with our clients and the below are their preliminary observations.

Critical care experts

18. We note that the inquiry has appointed Dr Ganesh Suntharalingam and Dr Charlotte Summers as independent experts on critical care. We repeat our concern about the lack of engagement with CPs about identity of experts. We note that Dr Suntharalingam was president of the Intensive Care Society during ("ICS") the relevant period. The Society is an association of ICU clinicians that, among other activities, produced guidance for clinicians during the pandemic. Working with the Association of Anaesthetists, the ICS published a multidisciplinary website containing information, guidance and resources to tackle Covid-19, and Dr Suntharalingam is reported to have said, "*The Society is delighted to work with partner organisations to provide a common hub for key information. It is essential that we show consistency and simplicity under the current circumstances.*"[1] The publication urged Trusts to participate in cross-skilling between ICU and anaesthetic departments. It is not known whether this approach was useful or effective. Dr Suntharalingam clearly has significant expertise, but CBFFJ-UK and NI-CBFFJ are concerned that as he was so involved in the development of clinical guidance, he lacks sufficient independence to be an expert.

19. We note that Dr Charlotte Summers led the ICU surge response at Addenbrooke's hospital in Cambridge and sat on national advisory committees on Covid treatment and research. Again, while Dr Summers is eminently qualified, it appears that she was at the frontline of developing policy and guidance.

20. CTI's note of 29 August 2023 lists topics in bullet points form that these two people have been asked to comment on. We suggest that "*resourcing within ICU/CCU*" should include surge capacity of ICU beds as well as staffing resource within ICU units. We also suggest that the list include development and dissemination to clinicians of guidance on Covid care and treatment.

Infection prevention and control

21. We note that the intention is to appoint a panel of experts to comment on IPC. We invite the Inquiry to circulate a longlist of suggestions to CPs for their views.

22. On behalf of NI-CBFFJ, it is submitted that the instructed panel of experts should, amongst their other duties, examine the issue of the only open land-border within the UK and in particular examine steps taken to address IPC in border regions in NI.

Non-Covid conditions

23. Again, we invite the Inquiry to circulate a longlist of suggestions to CPs for their views. We suggest that the scope includes delayed diagnosis in addition to delayed treatment.

Equality and discrimination

[1] Taken from this website.

24. The M2 discrimination experts have now reported. While we consider that these experts may be relevant to M3, and we hope the inquiry will keep this under review. With regard to the effects of structural and institutional racism on healthcare provision and protection of healthcare staff, we have the benefit of a large cohort of clients for whom this is a crucial topic and who can also give evidence on the topic.

25. We urge the Inquiry to consider the response of health services effects on persons who have historically faced discrimination in healthcare such as neurodiverse people, those with intellectual disabilities and those with mental health conditions. We note §30 of CTI's note of 29 August 2023 that the Inquiry is considering disclosing the discrimination reports from M2 into M3. The reports are too general on their own and respond to letters of instruction in relation to M2 (we note that the Inquiry has not yet disclosed the LOIs to the Module 2 CPs). If the same experts are to be re-instructed, fresh LOIs should be drafted that direct the experts to address matters pertinent to the scope of Module 3.

Comparative review

26. We invite the Inquiry to commission an expert to provide comparative report on how healthcare systems in other countries dealt with the pandemic. Our clients can make suggestions as to the identity of such an expert in due course.

(d) Non-Covid conditions

27. We note the inquiry has suggested colorectal cancer, coronary disease, hip replacement, inpatient CAMHS as the four non-Covid conditions plus maternity care. We note that these are 5 substantial areas of medicine, and that M3 concerns all 4 nations. Consideration should also be given to whether the private sector could have been utilized in a meaningful way. We return to feasibility of covering all issues in 10 hearing weeks below.

(e) Provisional list of issues

28. We make the following suggestions on the provisional list of issues in Annex A to CTI's note of 29 August 2023.

    a. Given that preparedness of the health system fell outside the scope of Module 1, we suggest that issue Number 1 of M3 becomes preparedness. This should include pandemic preparedness at NHS Trust / Health Board level, including readiness of management and training of staff.

    b. §3: With reference to capacity, NI-CBFFJ draw particular attention to the prevailing healthcare system in NI *before* the pandemic, where, as was indicated in previous submissions on behalf of CBFFJ-UK and NI-CBFFJ dated 28 February 2023, the waiting lists as of June 2021 were equivalent to 57% of the population, as compared with 9% in England. The Inquiry will recall the evidence from NI witnesses in M1 in relation to the Bengoa report and the inadequate state of readiness of the NI healthcare system as a result of lack of reform and cuts to funding. That evidence provided a starting point upon which the Inquiry should build in M3.

c. §4(c): This should include GPs carrying out domiciliary visits to patients' homes, including care homes. We note that while M6 will examine the impact of the pandemic on social care there has been no suggestion that M6 will cover healthcare provision in social care settings. GP services are within scope of M3 so should be dealt with here.

d. §5: The inquiry is invited to clarify what is meant by "treatment of Covid-19" and how it is different from "The development, trials and use of new therapeutics during the pandemic, in addition to the use of existing medications" which is paragraph 2 of the Module 4 Provisional Outline of Scope.

e. §5(c): This should include delays in diagnosis.

f. §6(b): This should include an examination into the underlying legal basis for DNACPRs and a review about whether the law in this area should be reformed.

g. §8: This is vast in scope and should be split up. §8(c) on visiting is not just about IPC; it is also about patients' and families' rights to see loved ones who were critically ill and dying. We suggest it is removed from §8 and that the Inquiry examines "*Visiting*" as a separate issue.

h. §10: This should include the availability of bereavement counselling to those who lost loved ones, and for healthcare staff who had to cope with an enormous numbers of suffering patients, deaths and grieving families.

i. §10: This should also include examination of the guidance issued by medical bodies such as the GQC and GMC on death certification, as well as the accuracy of the recording on death certificates of cause of death.

j. §23: (b) and (c) should include provision of equipment (PPE, ventilators, relevant pharmaceuticals) and training/exercising. §23(c) should include isolation provisions and policies, and the interface with social care facilities.

k. Missing from the scope document is the impact of the pandemic on those who were detained under the Mental Health Act 1983 in healthcare settings.

l. A final concern for our collective client group, at this juncture, is whether there were set criteria for all aspects of medical treatment within the NHS during the pandemic. This is not within the scope of the document but something we invite the inquiry to consider, given its importance to our collective client group.

(f) Every Story Matters

29. We note the update.

(g) Hearings

30. We are concerned both about the sequencing of the modules and the time estimate for M3.

Sequencing

31. We note the confirmation from CTI that the hearings in M4 will take place in summer 2024 and before the public hearings in M3. This is a matter of concern for the bereaved families, who had expected that the impact on healthcare systems would be examined after core political and administrative decision-making. We invite the Inquiry to engage with CPs in respect of the sequencing of future modules and in particular to start M3 directly after M2C, to begin before the summer break next year.

32. We also urge the Inquiry to bring forward M6 on social care, so that it follows directly from M3 on healthcare. The urgent need to examine the impact of the pandemic on the health and care sectors and to identify lessons for the future was highlighted by the evidence heard on this topic in M1 and, we anticipate, will be reinforced in the evidence heard in M2.

Time estimate

33. CTI's note says that M3 is being listed for ten hearing weeks, including two short breaks. This however is a considerable underestimate of the time that will be required for this module, for the following reasons. M3 will consider an enormously wide array of topics, bullet-points of which span five pages of A4 in the Inquiry's list of issues. The issues include 4 non-Covid conditions plus maternity services. M3 will examine each of the UK's nations, given that health in England is governed by the Department of Health and Social Care and NHS England, and that health is a devolved matter in Scotland, Wales and Northern Ireland. Where relevant, the Inquiry will have to look at the communication between the four nations, by healthcare policy-makers and those responsible for clinical guidance (e.g. IPC guidelines for hospitals as the pandemic took hold).

34. In England alone, there are 229 NHS Trusts and 43 Integrated Health Boards which commission healthcare. There are 220 general acute hospitals, 826 community providers and 6,925 GP practices.[2] These are clearly very large numbers, and - as noted above - the Inquiry is encouraged to gain an understanding as to what happened in a small sample to compare healthcare settings that did better (however measured) than elsewhere.

35. Ten weeks amounts to 40 sitting days if the Inquiry sits Monday to Thursday each week. If healthcare preparedness is added to the issues and if visiting becomes its own issue, there will be 14 issues. Clearly some issues are going to take more time than others, and this is a very rough calculation, but dividing 40 days by 14 issues = 2¾ days per issue. If each sitting day is 5 hours, 2¾ sitting days = around 14 hours. There are 4 nations, so there will be 14 issues ÷ 4 = 3½ hours per issue per nation.

36. By way of further example, the 5 non-Covid issues/conditions are grouped together into one issue. Each of them will need to be dealt with separately in the 4 nations. 5 topics x 4 nations = 20 topics to examine in 14 hours = 42 minutes per non-Covid issue per nation.

37. These calculations ignore opening submissions, evidence from the non-state CPs, or closing submissions, so the amount of time per issue is even less than above.

[2] Figures taken from NHS England website: https://www.england.nhs.uk/nhsbirthday/about-the-nhs-birthday/nhs-in-numbers-today.

38. Based upon our estimations, the timescale of ten weeks for this enormous module should at least be doubled. We therefore urge the Inquiry revisit the time estimate to allow for a fuller and fairer investigation of the issues and topics.

39. If the Inquiry is not with us on starting M3 before M4, we further invite the Inquiry to clarify the date on which M3 hearings will start. Presently, there is the rather wide window of "autumn 2024".

40. We suggest M3 starts on Tuesday 10 September 2024 and is listed provisionally for approximately 126 sitting days (around 31 weeks), to consist of, for example:

    a. 112 days for evidence (this allows 2 days for each of the 14 issues x 4 nations);

    b. 5 days for evidence from non-state CPs (including bereaved families);

    c. 4 days for opening; and

    d. 5 days of closing.

12 September 2023

Pete Weatherby KC

Allison Munroe KC

Thalia Maragh

Oliver Lewis

Kate Stone

Jesse Nicholls

Mira Hammad

Thomas Jones

Ciara Bartlam

Christian Weaver

Lily Lewis

Counsel for CBFFJ UK

Brenda Campbell KC

Peter Wilcock KC

Malachy McGowan

Marie-Claire McDermott

Blaine Nugent

Conan Fegan

Counsel for NI CBFFJ

Elkan Abrahamson
Nicola Brook
Broudie Jackson Canter Solicitors
Solicitors for CBFFJ UK

Conal McGarrity
Enda McGarrity
PA Duffy Solicitors
Solicitors for NI CBFFJ