Wednesday, 27 September 2023

(10.28 am)

LADY HALLETT: Good morning, everyone. This is the second preliminary hearing into Module 3 of the Covid-19 UK Inquiry, the one that is focusing on the healthcare systems in Wales, Scotland, Northern Ireland and England. Without further ado, I shall hand over to Ms Jacqueline Carey King's Counsel, who will tell us what progress has been made and whether we have faced any difficulties as we are making our way through investigating for the module hearings next autumn. Yes.

Statement by COUNSEL TO THE INQUIRY

MS CAREY: My Lady, good morning. As you have just said, this is the second preliminary hearing held in relation to Module 3, in which I appear as lead counsel.

As you know, Module 3 will examine the impact of the Covid-19 pandemic on the healthcare systems, namely the NHS in England, Wales, Scotland and Northern Ireland. Since the last preliminary hearing, on 28 February earlier this year, a great deal of work has been undertaken by the Inquiry and by Module 3 in particular, and so much of my address today will be providing an update on that work and outlining some of the work to be undertaken in the coming months.

I should say at the outset that the Inquiry has

confirmed, as your Ladyship just mentioned, that it expects Module 3 substantive hearings to begin in autumn 2024. Now, whilst to many observers that will doubtless sound a long way off, that timetable is set to ensure that those witnesses, whether they are corporate or otherwise, who are being asked to provide evidence have sufficient time to prepare their statements, an item to which I'm going to return on today's agenda, and the timetable takes into account the Inquiry's plan for other modules. That includes the Module 2 hearings examining UK core decision-making and political governance, which are due to start next week on 3 October, in early 2024 and throughout the spring you will be conducting public hearings in Scotland, Wales and Northern Ireland looking at the core decision-making in those countries, and in July 2024 there will be the public hearing in the vaccines and therapeutics module.

In addition to those public hearings, the Inquiry aims to publish its report setting out the findings and recommendations following the conclusion of the Module 1 hearings into the UK's resilience and preparedness for the pandemic.

In addition, the Inquiry has also announced that Module 5, looking at government procurement, and Module 6, examining the impact of the pandemic on the

care sector, are due to open before the end of this year.

Before I turn to the agenda, may I introduce the parties, whether in person or virtual. There are 30 core participants either present in the hearing room today or attending via the live link, and there are a number of them who wish to address you in oral submissions.

During the course of my address, I will respond to some but by no means all of the matters raised in the written submissions that you have received.

Dealing with the instructions in turn, Ms Munroe King's Counsel appears for the Covid Bereaved Families for Justice; Ms McDermott for the Northern Ireland Covid-19 Bereaved Families for Justice.

Ms Mitchell King's Counsel is remotely with us for the Scottish Bereaved; Ms Gowman for the Covid-19 Bereaved Families for Justice Cymru.

On behalf of the long Covid groups (Long Covid Kids, Long COVID Physio, Long Covid SOS and Long Covid Support), Mr Metzer King's Counsel, who is remotely.

Mr Wagner is here for both the Clinically Vulnerable Families and the 13 Pregnancy, Baby and Parent Organisations; Mr Straw King's Counsel for the John's Campaign, Care Rights UK and the

Patients Association.

Mind is represented by Ms Davies; the Trades Union Congress by Mr Jacobs; Ms Fenella Morris King's Counsel for the Royal College of Nursing; Mr Stanton for the British Medical Association, the National Pharmacy Association and the Royal Pharmaceutical Society.

Mr Dayle is present for the Federation of Ethnic Minority Healthcare Organisations; Mr Simblet King's Counsel for the COVID-19 Airborne Transmission Alliance; the Frontline Migrant Health Workers Group is by Ms Sen Gupta King's Counsel. Mr Jory is with us, I hope, remotely for the Independent Ambulance Association.

There are also a number of legal representatives who have indicated they do not wish to make oral submissions but are in attendance at the hearing:
Ms Grey King's Counsel for NHS England; Ms Peters and Ms Broad for the UK Health Security Agency; Ms Haghpanah for the Secretary of State for Health and Social Care; Mr Bowie King's Counsel for Public Health Scotland; the Academy of Medical Royal Colleges, Mr Mattar and Mr Henderson are present; Ms Doherty King's Counsel for NHS National Services Scotland; the Scottish Health Boards by Mr Pugh King's Counsel; the Scottish Ministers by Ms Nicholson and Mr Way; the group of Welsh NHS

bodies by Mr Hyam King's Counsel; Mr Kinnier King's Counsel for the Welsh Government; Mr Booth King's Counsel for the Welsh Ambulance Services NHS Trust; and Ms Smith for His Majesty's Treasury.

Notwithstanding that list, there are six core participants unable to attend today's hearing. Each has written to the Inquiry explaining why they cannot attend and has indicated they mean no discourtesy to your Ladyship by their absence, and in fact some may be able to follow by the livestream.

As to that, these proceedings are of course being recorded and livestreamed. As is routine in public inquiries where there may be, from time to time, matters raised of a potentially sensitive nature, the broadcasting of the hearing will be conducted with a three-minute delay. That, my Lady, provides the opportunity for the feed to be paused if anything unexpected is aired which should not be. We do not expect such matters to arise over the course of today, but I mention it in case those who are following the proceedings from further afield understand the reasons for any short delay.

I know that your Ladyship will have seen the agenda for today's preliminary hearing, and I'll address each of the seven topics, if I may, in turn.

The first of those relates to the evidence requests and an update in relation to the Rule 9 statements that have been requested by Module 3.

My Lady, Module 3 has sent out 127 Rule 9 requests. The number and range of topics and issues referred to in those requests is quite frankly vast, and certainly it would not be a good use of today's hearing time for me to rehearse each and every request made.

The core participants are aware of the broad topics covered in each request, as the monthly update notes provides that information. However, it is appropriate for me to provide a summary in public, outlining just some of the groups of recipients from whom requests have been made.

They include the government departments, including the departments of health in each nation, NHS England, His Majesty's Treasury, the Cabinet Office, the UK Health Security Agency, or UKHSA as it's known, and the public health bodies in each of the nations.

Requests have been made of each of the Chief Medical Officers, of a number of the Royal Colleges, trade unions and the Health and Safety Executive. The healthcare regulators and the Medicines and Healthcare products Regulatory Agency have been written to. A number of charities. All 14 ambulance trusts, more of

which I will return to shortly. And almost all of the 36 core participants in Module 3 have received a Rule 9 request, and indeed many have already supplied draft statements for which the legal team is very grateful for their prompt response. Those who have not yet received a Rule 9 will be getting one in the next phase of Module 3's work.

Out of the 127 requests, 66 statements are currently being reviewed and finalised, and in addition last week five statements were disclosed and there are a further 16 statements that have been signed and are being progressed for disclosure.

As will be appreciated from the update I have just given, some of the statements have been or are in the process of being finalised, and that's particularly true for those recipients who received their Rule 9s early on in the process. So, my Lady, by way of example, and as an introduction to just some of the issues raised in those earlier responses, I'm just going to give a very brief overview of four areas of responses, to outline some of the issues that are being raised in those areas.

So in relation to ambulances, a review of the evidence on the ambulance trusts and associated Rule 9 recipients raises concern about the frequency of changes to guidance produced by Public Health England, now the

UK Health Security Agency, and NHS England. They raise the fact that it was not, that guidance, specific to the ambulance sector. Their evidence also raises concerns about access to and the quality of personal protective equipment (PPE), and respiratory protective equipment (RPE) that ambulance staff required. A number of the ambulance trusts have stated that they were able to access Covid-19 testing for their staff before it became available as part of a government testing programme in the summer of 2020, but not all of them had the benefit of that, and where it did not exist they have stated that it impacted negatively on their trusts' resources and capacity.

Evidence from Rule 9 recipients who were involved in pharmacies and pharmacists, such as the independent regulators and the professional membership bodies, have also identified some key themes, and they have told us about the impact of reduced access to GPs and the resultant surge in demand for community pharmacy services. The evidence attests to the impact of inconsistent or late designation of pharmacy staff as key workers or frontline healthcare workers. They raise issues related to the sustainable access to adequate PPE for pharmacy staff and the feasibility of implementing other IPC guidance in community pharmacy settings, the

delivery of medicines to patients and the cost to pharmacies, the role of pharmacists in responding to shortages of specific medicines used to treat Covid-19. They speak of the delays to individual Covid-19 risk assessments for pharmacy staff, and state that this is of particular significance given the high proportion of pharmacy sector staff from black and minority ethnic backgrounds.

Another aspect of Module 3 is to look at and examine the quality of care and patient safety during the pandemic, and so the Inquiry has sought evidence from the Healthcare Safety Investigations Branch, HSIB for short. HSIB is an independent body funded by the Department of Health and Social Care, and it undertakes independent safety investigations into NHS funded care across England and they provide reports to the Department of Health and NHS England.

Now, HSIB has provided a witness statement to the Inquiry which is in the process of being reviewed and signed, but has also provided a number of other investigation reports to the Inquiry on topics that are within the scope of Module 3, including reports related to the NHS's 111 response to callers with Covid-19-related symptoms, a report on the use of early warning scores to detect deterioration in the Covid-19

in-patients. There is a report in relation to prospective safety investigations concerning management of risk of Covid-19 transmission in hospitals. They have looked at surgical care of NHS patients in independent hospitals during the pandemic, oxygen issues during the pandemic, access to what they call critical patient information at the bedside, and that includes, my Lady, information relating to Do Not Attempt Cardiopulmonary Resuscitation notices, or DNACPRs as they are known, and they have prepared reports in relation to stillbirths and maternal death investigations during the pandemic.

Finally, just by way of overview, and really allied to that last report from HSIB, the Module 3 team has received a number of statements relating to maternity issues in the pandemic, and the evidence there already attests to the distressing impact of Covid-19 restrictions on pregnant women and their partners. There's evidence in relation to limitations on choice during childbirth, affecting home births, birthing centres, water births, caesareans being denied.

The evidence received has covered issues relating to access to health visitors, which are considered to be particularly important to the physical health of the newborn, but also the physical and mental health of

mothers, where some women have suffered increased postpartum maternal depression and anxiety during the pandemic, and that in turn may have exacerbated existing health inequalities.

The evidence received to date raises concerns about access to suitable and sufficient PPE for health visiting practitioners and mixed views about virtual health visits.

They also raise the identification and categorisation of pregnant women as clinically vulnerable at the start of the pandemic and a concern that that decision was made without consultation or prior warning, leading therefore to contradictory advice and guidance being given to colleagues and confusion amongst pregnant women.

As I say, those matters that I've just outlined are very much by way of example to give you and those following the hearing a flavour of some of the initial themes and concerns raised in the evidence received thus far.

It will be appreciated that the Rule 9 requests to date have primarily been addressed to organisations and institutions. One aspect of Module 3's work this autumn will be to start issuing Rule 9 requests to the individuals relevant to Module 3, including the

respective Secretaries of State and ministers for Health, the deputy chief medical officers, the chief nursing officers, along with a number of other individuals who played a key role in advising the governments.

In the written submissions that you have received, a number of the core participants have named individuals that they propose that we should Rule 9, and we will be considering those suggestions as we embark on this next phase of the module's work.

There is one other matter that we would wish to raise in relation to Rule 9s. There are some recipients of Rule 9 requests that were sent in March, April and early May of this year where Module 3 is becoming concerned about slippage in deadline for responses and the impact that that will have not just on Module 3 but for other modules as well.

This includes the chief medical officers in England and Northern Ireland, the Department of Health and Social Care, the Department of Health in Northern Ireland, and the UK Health Security Agency.

My Lady should know, for example, that in relation to the Department of Health and Social Care, the department informed the Inquiry they wish to provide their statement in five sections. That is a request

that has been made by other Rule 9 recipients and which has invariably been granted, but it is disappointing to note, however, the Inquiry has not received any section of statement from the Department of Health and Social Care, either in draft or otherwise, when the Rule 9 was sent to them in March of this year.

Now, Module 3, my Lady, is not unrealistic about the demands that other Inquiry modules have placed on recipients such as the Department of Health, the chief medical officers and the UKHSA, and nor are we blind to the demands that these organisations and individuals face in their day job, if I can put it like that. But we are concerned about these delays and the detrimental effect that these will inevitably have on Module 3.

My Lady, it cannot be the case that some recipients need over six months to respond to Rule 9 requests or acceptable that they miss agreed deadlines for statements to be provided in smaller, more discrete sections.

In relation to the chief medical officers, the CMO for Northern Ireland has indicated they will answer the Rule 9 by the end of October. The Office of the Chief Medical Officer informed the Inquiry yesterday that the office is on track to provide a statement before the end of the year. My Lady, we appreciate that the chief

medical officers have smaller offices and legal teams than some of the other organisations I have named, and that they have been heavily involved in earlier modules, and have also commitments to Module 4, but these proposed dates are five and seven months respectively after the request was made, and so we look forward to receiving this important evidence at the earliest opportunity, and certainly by no later than the dates I've just outlined.

If it is not obvious, these statements are needed so that we can identify further lines of enquiry and areas that we will need to ask individual witnesses about. So delays now risk holding up the next phase of Module 3's work, and that in turn may also impact on other modules' ability to progress their investigations in a timely way.

I hope it won't come to this, but in the event of further delays we may invite your Ladyship to consider whether it is necessary to issue a notice under section 21 of the Inquiries Act to the Department of Health, and/or any other bodies, requiring the evidence to be provided within a specified time.

Now I turn to disclosure as the next item on the agenda.

Last week, on 21 September, Module 3 made its first

tranche of disclosure to core participants. In total, the 136 documents were disclosed, including some statements and exhibits from the disabilities charities consortium, St John's Ambulance, West Midlands ambulance healthcare trust, Public Health and the Independent Healthcare Providers Network. Also disclosed were documents from the British Medical Association and the Department of Health and Social Care.

In addition, Module 3 has disclosed the expert reports of Professors Marmot and Bambra, and Professor Heymann, and the relevant parts of the evidence given in the Module 1 hearings, and Module 3 will be disclosing the expert report of Dr Claas Kirchhelle and the transcript of his evidence given in Module 1.

In addition to the disclosure already made, we are progressing the Rule 9 statements and exhibits for disclosure, and will continue to review the evidence provided to other modules and make disclosure of relevant material in the coming months.

There is one discrete matter in relation to disclosure requests that I wish to update the core participants and your Ladyship about. In my note on 29 August, the core participants were made aware of an issue relating to the retention of emails within the

NHS Wales Microsoft 365 email service. In short, at the beginning of August this year, the Inquiry was informed that Digital Healthcare Wales, DHCW, had in February of 2023 discovered that email mailboxes and all the contents stored in those mailboxes, so not just the emails but calendars, contacts, notes and the like, for people who had left an NHS organisation or had left an NHS organisation to join another NHS organisation within Wales, were deleted.

The Inquiry has been informed that some accounts were not affected. Two health boards, Cardiff and Cym Taf, had separate back-up mail for staff who have left those organisations so they were not affected.

Now, upon learning of that issue, the Inquiry wrote to DHCW requesting an explanation as to why that issue was not brought to the Inquiry's attention at an earlier date and to ascertain the scale and potential impact of that issue. In response, DHCW apologised for not informing the Inquiry sooner and explained that it did not consider the deletion of some accounts to be a material factor in relation to DHCW's ability to respond to the Inquiry. That was because some key documentation was stored in document repositories and was not solely in mailboxes. However, DHCW told us that as the Covid Inquiry progressed and they were more

involved in helping the health organisations to find copies of emails from affected mailboxes, they considered they should notify the Inquiry of the potential problem.

Now, my Lady, in relation to Module 3 in particular to date, no Welsh Rule 9 recipient has told the Inquiry the mailbox deletion issue has affected their ability to respond to Module 3's Rule 9 requests.

Unconnected to the Microsoft mailbox deletion issue, Cardiff and Vale University Health Board have recently told us that the mailbox of Professor Stuart Walker, who was the executive medical director between July 2019 and September 2021 and then the interim chief executive until February 2022, cannot be accessed from the period from 5 December. Now, Cardiff and Vale University Health Board are still investigating the reasons for this, but it does not appear to be connected from the move to Microsoft 365.

I should say that that aside, no other recipient of Rule 9 requests outside of Wales has indicated that their mailboxes are affected, and we would expect of course them to bring this to their attention if they had suffered a similar fate.

Turning to the next item on the agenda, my Lady, behind your tab 7, will find what is called the

provisional list of issues. Now, as was made clear when that list was circulated to core participants, the list is very much an initial draft of issues that are emerging from the material provided to the Inquiry to date.

It is not intended to be exhaustive or prescriptive or final, nor could it be, given that there is more evidence to come from the Rule 9 requests that are issued to date and the Rule 9 requests that are going to be issued in the coming months.

Inevitably, some issues may come into greater or lesser focus as the module progresses, and some may drop away and others may emerge.

Is my Lady struggling to find it?

LADY HALLETT: No, no, it's all right, I've found it. There is a curious system of filing today but, don't worry, I'm there.

MS CAREY: A number of core participants have made submissions about additional matters and topics that should be included in that list. Some of those matters are already within Module 3's contemplation, and so, where appropriate, they'll be added into version 2 of the list.

For example, there is reference in the current list to clinical support staff. Now, that was intended to

refer to non-clinicians working in clinical settings, and to include healthcare workers and non-healthcare staff, and that can be clarified in the later version.

Rule 9 questions have also asked about, for example, individual risk assessments and the use of the private sector by the NHS, and so again version 2 of the list can provide clarification where needed, and there'll obviously be an expanded version of the issues as the evidence is received by the module.

There were some topics, however, that were proposed, such as more capacity, lack of bereavement support or counselling, comparisons of treatment between people who live in one country but received treatment in another, impact on adults detained under the Mental Health Act, they are all just examples of topics that we submit either are not within the scope of Module 3 or, in our submission, are topics that it is not proportionate or necessary to focus on within the course of this module, examining as it does the impact on the healthcare system.

There were joint submissions to your Ladyship from the Covid Bereaved Families for Justice and the Northern Ireland Covid Bereaved Families for Justice core participant groups, inviting the Inquiry to consider instructing an expert to look at how healthcare

systems in other countries responded to the pandemic.

At present, Module 3 does not invite your Ladyship to instruct such an expert, given that you'll already be looking at the responses within the four nations and that some of the draft statements may touch on an international response or on scientific knowledge as it developed around the world during the pandemic. I've no doubt you'll want to keep that request under review, though.

The John's Campaign core participant group submits that Module 3 is too focused on hospitals and GPs, and that the module should include healthcare provided in the home, or in residential care, or in supported living, or in mental health units. My Lady, in our submission, to cover all of those topics would broaden the already wide scope of Module 3 too far, and in any event it may be that an examination of the impact of the pandemic in some of those settings would sit better in later modules, particularly within M6 looking at the care sector.

Mind submits that Module 3 should include a greater examination of the impact of the pandemic on mental health services, and contend that focusing on in-patient children and adolescent mental health services, now referred to as children and young people's mental health

services, CAMHS or CYMPHS for short, is too narrow. Mind submits that the module should include consideration of CAMHS within the community.

Now, amongst other issues, Module 3 will examine the impact of the pandemic on referrals and admissions to in-patient CAMHS, including the reasons for those changes, and that will encompass the consequences of reduced access in the community for children and young people, and so, to that extent, CAMHS within the community will be considered within Module 3.

Mind also submits that Module 3 should look at mental health services more widely. My Lady, whilst undoubtedly important, we submit that this is one of those areas where a difficult decision has had to have been made not to look at broader issues of children's mental health in the community or wider mental health services within the UK's healthcare system. We submit that Module 3 should focus on a discrete section of acute mental health services for children in the four nations, which will enable a suitably detailed examination of this area of mental health, whilst ensuring a proportionate focus on non-Covid conditions is maintained. But, again, I know that you'll want to consider any supplementary oral submissions about that topic.

I hope it follows from all that I have just said that where core participants have invited Module 3 to broaden its scope we have taken very great care to ensure that we do so in a way that is necessary and proportionate. Where evidence is being called on a topic, we submit that you do not need to receive each and every available piece of evidence on that issue, only that will which will enable you to come to fair conclusions and enable you to make meaningful recommendations.

Item 3 on the agenda deals with the topic of experts.

Module 3 has currently identified a number of areas within the scope of Module 3 where the Inquiry would benefit from expert evidence. Those areas are in relation to long Covid, intensive care and critical care for patients with Covid-19, infection prevention and control in healthcare settings, and the four non-Covid conditions.

By way of introduction and explanation, when instructing the experts, the Module 3 legal team has been greatly assisted by the Inquiry's research team to identify those witnesses with the expertise, independence and capacity to assist the Inquiry. Some core participants I know will be disappointed they were

not asked to assist in this task, but once the report is prepared in draft, the draft copy will be sent to core participants for their observations so that content that needs either amplifying or clarifying can be incorporated before the final version is disclosed.

So, in addition to the Rule 9s and the disclosure that's been made to date, and dealing with each of the experts in turn, in relation to long Covid the Inquiry has instructed Professor Chris Brightling and Dr Rachael Evans, experts in long Covid, to prepare a report in relation to both Module 2 and Module 3. The report was divided into topics of general applicability, such as understanding the emergence of long Covid, and topics which are more specific to Module 3, such as the treatment of long Covid.

Given the imminent start of Module 2, the first part of the report has already been sent to the core participants in Module 2 and will be disclosed to Module 3 core participants. The Module 3 section is nearing completion, and will be sent to Module 3 core participants for their input, queries and comments to be considered.

The second expert report is in relation to critical care for patients with Covid-19, and in this regard the Inquiry has instructed Dr Ganesh Suntharalingam and

Professor Charlotte Summers, both of whom are expert intensivists, with extensive practical experience of matters affecting patients and staff in intensive care units and high dependency units.

Their report will cover topics including how Covid-19 affects the body's systems, a summary of the Covid-19 treatments given to critically ill patients, the numbers and roles of staff involved per patient in treating critically ill patients. They have been asked to report on details of any geographical variations in the treatments across the UK or difference in treatments by reference to patients' age, sex, ethnicity or other characteristics of the patient, including those with pre-existing health conditions, disabilities or other inequalities.

They are giving a summary of the clinical guidance disseminated about how to treat Covid-19 patients, including how people who are less critically ill were treated in hospital or in the community, and they are going to report on the extent to which decisions about treatment, particularly escalation of care, or affected by the existence of a DNACPR order. They are looking at end of life care in intensive care, resourcing in intensive care, including staff, beds and equipment.

It is by no means a short report, but their report

is expected in late autumn of this year, and I can confirm that both experts have been asked to address all four nations when drafting their report.

In relation to those experts, the joint submissions of the Covid Bereaved Families for Justice and the Northern Ireland Covid Bereaved Families for Justice have, notwithstanding what is accepted to be Dr Suntharalingam's significant expertise and Dr Summers' imminent qualifications, queried whether those doctors are sufficiently independent because of their involvement in developing clinical guidance.

My Lady, when instructing any expert, the Inquiry undertakes a comprehensive background check for any potential or actual conflicts of interest, and we were already aware of their roles in professional society guidelines, but we have concluded that this does not materially impact their independence and there will be a section in the report setting out any areas of potential conflict.

My Lady will have gleaned from the overview I gave in relation to the ambulances, pharmacists, maternity care and the HSIB reports that preventing the spread of Covid within healthcare settings is clearly a matter of significance within Module 3, and to that end and in order to assist matters relating to infection prevention

and control measures, a multidisciplinary panel of experts has been identified to prepare an expert report into IPC.

That report will assist with matters including how Covid-19 is transmitted, whether IPC guidance followed the scientific community's contemporaneous understanding of transmission, it's going to include a chronological summary of that IPC guidance including where there were changes in guidance implemented in the devolved administrations and the reasons for any variations. It will consider the minimum standard of PPE required for healthcare workers and visitors as IPC measures. Matters relating to IPC within care settings though are not within the scope of Module 3 and so the experts have not been asked to address this.

My Lady, the IPC experts, who bring a diversity of experience and have been involved "on the ground" dealing with outbreaks of infections in hospitals are a panel of five experts.

Stephanie Dancer is a consultant medical microbiologist at NHS Lanarkshire and a professor of microbiology at Edinburgh Napier University. Assisting her will be Katie Jeffery, the director of IPC and a consultant microbiologist at Oxford University Hospitals NHS Trust. Director Jeffery is

an associate professor at the Radcliffe Department of Medicine.

The third expert is Hajo Grundmann. Professor Grundmann will bring an international perspective to these issues as he is based in the University of Freiburg in the Institute for Infection Prevention and Hospital Epidemiology, and he is considered to be a world leading expert on hospital transmission, with experience in both nursing and in medicine in England as well as in Europe.

The fourth member of the panel is David Eyre. He is a professor of infectious diseases and an honorary consultant at the University of Oxford. He has particular expertise in testing and genomics, which is the study of genetic material, and how that information is applied in IPC.

The fifth expert is Clive Beggs. He is an emeritus professor of applied physiology at Leeds Beckett University and he has expertise in medical engineering and biology, which includes understanding and preventing the transmission of infectious diseases in hospitals, and the application of what are called biophysical or engineering interventions, such as UV disinfection, HEPA filtration, to mitigate the transmission of infection.

So we submit, my Lady, that across those five experts they are bringing a range of expertise and experience to the issue of IPC within Module 3.

The Inquiry will be, over the course of the autumn, continuing its work to instruct experts in relation to the four non-Covid conditions, namely colorectal cancer, ischaemic heart disease, hip replacements and the in-patients' CAMHS. The monthly update notes to CPs will keep them informed as to the Inquiry's progress on this, and any other topic where expert evidence would assist your Ladyship. We anticipate that those experts will consider matters such as delays in diagnosing and treating people with those conditions, and the impact of any such delays on patients' health. It follows, therefore, that the experts will be asked to look at the available data and, where there is an absence of data or a gap in the data, to make reference to that in the report.

It is anticipated that the experts will be asked where possible to comment on broader systemic issues relating to the impact of the pandemic on healthcare provision for conditions other than Covid-19 rather than add further detailed examinations of the impact on specific health problems beyond those four non-Covid conditions.

In the written submissions, there were requests made for expert evidence in relation to the impact of the pandemic on maternity care and a statistical expert to look at deaths of healthcare workers and, my Lady, the Inquiry will consider those requests this autumn.

There is one other matter in relation to experts. In relation to those four areas, your Ladyship will be aware that Module 2 has instructed a number of experts to consider inequalities across a variety of areas. Now, those reports are being finalised but the drafts contain matters that are relevant to Module 3 and so those reports will be disclosed to Module 3 core participants in due course.

Given the centrality of inequalities to the Inquiry's work as a whole as well as to Module 3 in particular, it may be appropriate at this stage and by way of example only, just to outline some of the areas that those draft reports have commented upon.

There is a report from Professor James Nazroo reporting on ageing that refers at the outset to the increased vulnerability of older people to a pandemic caused by a respiratory virus. Now, Professor Nazroo states that older people are at greater risk of flu-related complications and mortality as a consequence of a combination of factors, including the greater

prevalence of chronic illness, reduced immunity and more generally frailty in older people.

The report notes that an analysis from Public Health England in 2020 showed that once infected, those aged 80 and over were seventy times more likely to die than those aged 40. The report also considers that older people who are social distancing are especially at risk of social isolation, and whilst they may benefit from being able to use digital technologies to carry out their daily lives, including remote consultations with healthcare, they are in fact the people least likely to be able to use remote digital technologies.

Professor Nazroo, along with his colleague, Professor Laia Bécares, have provided a report on ethnicity, and they noted, for example, that morbidity and mortality data demonstrates higher, though variable, levels of chronic diseases, including ischaemic heart disease, in ethnic groups. They argue that explanations for ethnic inequalities in health that focus on cultural or genetic health differences should be rejected, and they submit that genetic and cultural explanations for ethnic inequalities are a form of racism denial, as they lead to a minimising and sometimes a denial of the role of racism in shaping ethnic inequalities in health, social and economic outcomes.

Professors Nick Watson and Tom Shakespeare's report on disability references the fact that disabled people in the UK could and should have been foreseen to be at higher risk from a Covid-19-type virus due to factors including the fact that some disabled people are at higher risk of Covid-19 due to intrinsic vulnerability to infection. They are higher risk as a result of societal, structural and institutional failings. And that disabled people in 2020 were in a weakened socio-economic situation compared to their non-disabled peers, particularly, they submit, due to changes experienced since 2010. And they, thirdly, say they are at higher risk because many disabled people are dependent on health and social care services which were themselves weakened as a result of the pandemic.

The report on gender by Dr Clare Wenham highlights the disproportionate impact of epidemics and pandemics on women that existed prior to Covid-19, and the report looks at the impact of austerity measures, which, it is argued, have exacerbated gender inequalities.

There are two other reports which Module 3 proposes to disclose: Professor Bécares' report on LGBTQ+ notes that evidence suggests that LGBTQ+ inequalities are stark and long-standing, with worse health, healthcare and social outcomes for those groups when compared with

heterosexual and cisgender populations. Cisgender meaning those whose gender corresponds with their sex assigned at birth.

The report on child health inequalities by Professor Taylor-Robinson includes an analysis of the causes of those inequalities, such as poverty, obesity and experiences during pregnancy and the early years, which are important for a child's physical and mental health. The report also notes that there is growing concern in the UK over the rising prevalence of mental health problems in children and young people, which will no doubt resonate with that non-Covid condition that Module 3 will be examining.

We anticipate disclosing those reports to Module 3 core participants in the very near future. Given that the Rule 9 requests we have made to date have included questions relating to inequalities and there is this body of expert evidence, we submit that, contrary to the submissions of one of the core participants groups, it is not necessary to reinstruct and reissue letters of instruction to these experts.

May I turn to the non-Covid conditions to be examined.

Your Ladyship will be aware that there are some submissions that, in addition to the four non-Covid

conditions that I've outlined, Mind submits that the Inquiry should consider the impacts of the pandemic on those with dementia. I have no doubt that your Ladyship will wish to consider the submissions made, but to date Module 3 has indicated it does not intend to examine dementia, not because it's not important but because the size of this module is already such that the Inquiry needs to keep a tight focus on the matters to be examined, and in any event it may be that if your Ladyship wishes to look at that topic, you will consider that later modules are better placed to do so.

The Clinically Vulnerable Families core participant group raises a concern that the Inquiry is not looking at any underlying long-term conditions that would lead a patient to become immunosuppressed. However, shielding and the impact on the clinically vulnerable is explicitly referred to at paragraph 11 in the provisional outline of scope and so the experiences of immunosuppressed people will be covered within Module 3.

The next matter on the agenda relates to Every Story Matters, the Inquiry's name for the Inquiry's listening exercise.

In my note to the core participants for this hearing, I outlined that ESM, Every Story Matters, will be holding community events across the UK to enable

people to tell the Inquiry about their experiences in person in their own communities. The Inquiry will be piloting the approach to events in late 2023 but prior to this the Inquiry's secretariat are running events at interested organisations, pre-existing events, to encourage participation in ESM. They have already attended the TUC congress in Liverpool and a virtual Royal College of Midwives event earlier this month, and will shortly be attending the Northern Ireland Bereaved Families for Justice conference, and I know that the secretariat are very grateful for being invited along to explain more about ESM.

Within Module 3 in particular, accompanying my update note was a document setting out the key lines of enquiry relevant to Every Story Matters which will help inform a bespoke report to Module 3 on the human impact of the pandemic.

Now, those key lines of enquiry will be explored through what is called targeted qualitative research which aims to gather the experiences of individuals from underrepresented, seldom heard and/or vulnerable communities, and from those where there are significant barriers existing to engagement. It will also gather the experiences of individuals who experienced particular impacts related to matters within Module 3,

including those directly affected by the pandemic, including bereaved individuals, their families, the patients who were hospitalised with Covid, and long Covid patients, those indirectly affected by the pandemic, such as people who used NHS 111, those who were advised to shield, and the healthcare workers and staff. The findings of that research will be brought together with findings from the analysis of people's experiences which have been shared online through those accessible participation routes or through the events.

Taking all of those matters together, those insights will be turned into an anonymised thematic report which will be disclosed to core participants as evidence in good time for the hearing. It is anticipated that that report will be available to support the Inquiry legal team ahead of the hearings and will be a source of evidence for the final module report and its recommendations, and importantly, my Lady, it will form a part of the formal record of the Inquiry.

May I just turn to one matter that's not on the agenda but didn't fit into the agenda items, and whilst I'm doing so, I may have, I'm afraid, inadvertently said that we have disclosed a Public Health statement. It's actually the Parliamentary and Health Service Ombudsman statement that we have been disclosed, and I'm sorry if

I didn't give the right information earlier this morning.

The one matter that doesn't fit into any of those agenda items is in relation to a submission from the Covid Bereaved Families for Justice and Northern Ireland Covid Bereaved Families groups. They have asked how treatment of Covid-19, which is within the provisional scope of Module 3, is different to paragraph 2 of Module 4's provisional scope.

Now, paragraph 2 of Module 4's provisional outline of scope states that Module 4 will examine the development, trials and use of new therapeutics during the pandemic, in addition to the use of existing medications. Now, it may be that this query was answered in part during the Module 4 preliminary hearing which was heard earlier this month on 13 September, during which Mr Wald King's Counsel, who is the lead counsel to Module 4, explained that Module 4 will consider the way in which new therapeutics were developed and existing medicines were repurposed to treat Covid-19, and he made clear that Module 3 will therefore examine the use of therapeutics in practice, by which we mean how therapeutics were used once effective treatments had been identified and improved.

My Lady, by way of example, the intensivist experts'

report have been asked to set out how treatments for Covid-19 developed and changed over the course of the pandemic.

It may be that your Ladyship will hear this morning submissions from the CVF core participant about the Inquiry's investigation into therapeutics and the division of this topic across Module 3 and Module 4. The thrust of the submission is that whilst not precluding examination of therapeutics in Module 3, Module 4 should also consider the use of therapeutics, and it's clearly not appropriate for me to trespass on or speak for the Module 4 legal team, and so that is a submission for them.

My Lady, I know that you have had an opportunity already to consider the written submissions and will be considering those submissions alongside any oral submissions made today, and you will publish any appropriate directions. Can we ask you to consider whether you wish to publish any written submissions on the Inquiry's website. That's a matter entirely for your discretion in due course.

So may I turn or return to where I first started by looking at the next steps for Module 3.

It is anticipated that the hearings will run for ten weeks with two short breaks and will be heard here

at Dorland House. In their joint submissions, the Covid Bereaved Families for Justice and the Northern Ireland Covid Bereaved Families for Justice submit that the Inquiry will need up to 31 weeks of hearing time set aside for Module 3.

Putting aside the sheer impracticality of holding a six-month long public hearing given the Inquiry's other modules and your Ladyship's stated intention in your opening statement to run the Inquiry as thoroughly and as efficiently as possible, in our submission, Module 3 does not need to set aside that amount of hearing time. The multitude of ways in which evidence can be placed before you means it will not be necessary to call each and every witness who can provide evidence on any given topic.

Moreover, I anticipate that where a witness is called live, there will be a laser-like focus on the key issues, and I know that those with a speaking role will do their utmost to ensure that questions do not deviate from those essential issues.

In the written submissions, your Ladyship has also been asked to consider bringing Module 3 forward to start after Module 2C, which is being heard in Northern Ireland. Indeed, I think you received submissions on this topic during the Module 4

preliminary hearing.

Bringing Module 3 forward will not be possible, not least because it is likely that not all of the evidence Module 3 needs will be available by then. You have also been asked by the John's Campaign core participant group to consider moving the care sector module, Module 6, to start straight after Module 3. Again, the logistics of timetabling an inquiry as large as this one means that is not possible either. And it goes without saying that the order of modules is not intended to reflect a hierarchy of importance. All the modules are important and the Inquiry has taken great care to devise a sensible order that allows the Inquiry to progress its work.

The Module 3 public hearing will include hearing evidence from the bereaved, patients and those working within the healthcare system. Identifying those witnesses who can shine a light on systemic issues, including issues of disparities and unequal impacts, is another aspect of this autumn's work, and we are grateful for the offers of help from the core participants in selecting the individuals who we can approach to provide this evidence.

My Lady, there will be a further preliminary hearing in the spring of 2024, and unless I'm told otherwise,

that brings to a close the submissions I wish to make on behalf of the Module 3 legal team. I know there are many core participants who wish to address you during the course of this hearing, but can I invite you first to hear from Ms Munroe King's Counsel, and your Ladyship will find the order of speaking behind tab 3 in your bundle.

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

Ms Munroe, I think we can fit you in before the break.

Submissions on behalf of Covid-19 Bereaved Families for Justice by MS MUNROE KC

MS MUNROE: Yes.

Good morning, my Lady. As you know, I represent Covid Bereaved Families for Justice UK, instructed by Broudie Jackson Canter solicitors, and today I'm gratefully and ably assisted by counsel, Mr Oliver Lewis and solicitor Ms Clare Fletcher.

My Lady, I'm grateful to you and your team for taking the time to read and digest our detailed submissions. I'm mindful of the number of CPs that wish to make oral submissions to you, so I intend simply to, I hope, augment the written submissions we have provided, with an emphasis on certain points and matters

which are of particular importance to our families, and which we hope to persuade the Inquiry to consider further and, where necessary, to adopt.

Where I do not mention orally matters that are in our written submissions, we still of course consider those to be important.

My Lady, I essentially have five short topics to comment on: one, effective participation of our families; second, health inequalities and discrimination; thirdly, sequencing and timetable; fourth, experts; and finally, Rule 9 and disclosure.

Effective participation. My Lady, you will find at paragraphs 10 to 13 of our written document our detailed submissions in this regard, but you will of course recall from Module 1 the impact of hearing from the families. It changed the dynamics in the room. It was visceral, it was real, but it was very, very powerful. It showed the value of hearing from those and their lived experiences of losing loved ones, and the aftermath and the ongoing impact on their lives of the pandemic.

Hearing their voices will be particularly relevant, we say, in Module 3. We say that, my Lady, not from a maudlin sense of wanting to hear more suffering and personal tragedies, but in a very real sense because

they will add value to this module.

We within our group are fortunate that we have a wide and diverse group of individuals. We have a number of people who are healthcare professionals, doctors, nurses, paramedics, ambulance workers, those who have held managerial positions within the healthcare organisations, worked in care homes, those who have managed trusts. They have and they are able to see things from a dual perspective, both as bereaved family members who have lost children, partners, parents, loved ones, but also as healthcare professionals who were at the sharp end, who were on the frontline.

When assessing how well and how prepared and how effective healthcare systems in this country were in facing the pandemic, these are the very individuals who are actually and who can provide actual factual evidence in terms of what was happening. This, we say, will add immense value to the Inquiry.

Secondly, healthcare, health inequalities and discrimination. My Lady, this is found at paragraphs 24 to 25 of our written submissions. We say it needs repeating and it benefits from repeating that those who suffered issues of discrimination and inequalities as explored in Module 1 and will be explored in Module 2, cannot be seen in isolation. These are recurring

threads that will flow throughout all the modules, my Lady, that you will be hearing. Sadly, Covid-19 was not an equal opportunities pandemic, and it exposed the existing fault lines and discrimination and inequality within society.

We urge the Inquiry, when considering the response of the healthcare systems, to look carefully at the effects upon persons who have historically faced discrimination in healthcare, and also to expand upon that which was discussed in Module 1 and to consider individuals such as neurodivergent people, those with intellectual disabilities and those with mental health conditions.

My Lady, we note what was said a moment ago about adults detained under the Mental Health Act, but repeat and emphasise our submissions that those with mental health conditions, both in the community and facilities, need to be fully addressed in Module 3.

This is not a niche area. Those suffering from poor mental health make up a large section of our population. How they experienced the pandemic must be a significant aspect to be considered.

The Module 1 experts on issues of discrimination and the many other witnesses that we heard who provided a wealth of evidence was indeed detailed and

comprehensive. It was perhaps some of the clearest, most erudite and most eloquently delivered evidence that we heard in Module 1 from those various witnesses.

We note that Professors Marmot and Bambra, Professor Heymann and Dr Kirchhelle have -- their reports and transcripts have been disclosed and will be disclosed into Module 3.

We also note paragraph 30 of CTI's note of 29 August of this year that the Inquiry will also be disclosing discrimination reports from Module 2. I'm grateful for the indication that we received this morning, and a broad outline of those, the nature of some of those reports.

However, my Lady, we still submit that Module 3 will perhaps require reports, not new reports per se, but reports perhaps with a different focus. If the same experts are effectively reinstructed, fresh letters of instruction could be drafted that direct those experts to address matters pertaining and pertinent to the scope of Module 3. It's important, we say, not to have the mindset that "Well, we've done discrimination, let's move on", and reports can seamlessly be slotted into different modules. Matters are more nuanced than that, as I'm sure, my Lady, you appreciate.

Three, scheduling and timetable. We addressed these

at paragraphs 31 to 40 of our written document.
My Lady, I've heard what has just been said about timetable, and of course there's a balance to be struck between having an Inquiry of an appropriate length, but also concluding and reporting as swiftly as possible, because there is a pressing need to make changes. This country must prepare itself for the next and sadly inevitable pandemic, and we need this Inquiry to report as soon as possible.
Against that, however, we say it is also vital that the Inquiry has sufficient time to examine and scrutinise those relevant matters and answer, as far as it is possible, the questions it poses itself. To do that effectively, it will be necessary to consider matters in as much depth and in as much detail as necessary. It is important that the conclusions and recommendations are informed and evidence based. The better the evidence, the better the conclusions, the better the recommendations.
The families are at the front and centre of this Inquiry, as has been said many times. It was their campaigning that in many respects brought about this Inquiry. They want to make sure that it has teeth, and that it has a lasting legacy. We, on their behalf, likewise, want to make sure that the integrity of this

Inquiry is at its highest. We do not want to see a situation whereby post-publication the recommendations are kicked into the long grass by the government, or that the Inquiry, like many before it, is consigned to be known by the name of its Chair rather than by the contents of its work and the changes it can make.
So that is why we say it is so important to have sufficient time to hear the evidence and that it is done with sufficient detail. We want there to be a realistic timetable, and we simply say -- and we set out very detailed calculations, but we simply say, to put it simply, that ten weeks is not enough, and we would invite you, my Lady, and the Inquiry team to carefully consider both the oral and written submissions we make about the time.
In terms of sequence, even if Module 4 takes place before Module 3, we do urge the Inquiry to list Module 6, social care, to be directly after Module 3, thereby effectively leapfrogging Module 5, on procurement.
Our submission in that respect is simple. Waiting four or perhaps five years after what our families see as the scandal of the care homes of spring 2020 would be a failure to ensure speedy justice, and it would be letting the families down. Also, to put it bluntly, and

sadly, many of the survivors of the care homes may not be with us in four to five years' time.
LADY HALLETT: Ms Munroe, I'm entirely sympathetic to that. Of course I appreciate and understand it, but one of the problems that I think maybe some people haven't really considered is the demands that the Inquiry is making on material providers, and when you have modules that are health related or care related, the demands are going to be on the same providers, and it's really a case of what's doable. But, I mean, obviously I always bear in mind your submissions, they're always helpful, but it is extraordinarily difficult. We have heard this morning the difficulty in getting material from some providers. So I do understand, of course I do, and I have looked into it several times, but there are restrictions on me that I haven't placed there.
MS MUNROE: My Lady, yes.
LADY HALLETT: But obviously I will bear everything you say in mind with great care.
MS MUNROE: I'm grateful, thank you.
Fourth topic point, experts. Again, we set out in our written submissions at paragraphs 16 to 17 in detail what we say about that. Suffice to say this: given that healthcare is a devolved matter, we say there is also a need for independent experts who understand the state

of individual healthcare systems before and during the pandemic and that they should be instructed by the Inquiry.
Our colleagues from Northern Ireland will be making further submissions in due course, generally and specifically on this point, I defer to them, but in advance I also endorse and adopt their submissions.
My Lady, you will remember perhaps another thing that came out very starkly from Module 1 was Northern Ireland, as a nation, how that nation is treated, how that nation is perceived, and the different treatment of the people of Northern Ireland, and the different systems that operate. It's complicated, but it's important to bear that in mind, and, as I say, my colleagues will in due course make further submissions.
In terms of the critical care experts, we set out at paragraphs 18 to 21 of the written submissions our thoughts there.
My Lady, I'm grateful for what has been said this morning about those two experts, who of course are hugely experienced and have great expertise in their areas. We make the simple point that independence of expert witnesses is obviously a crucial aspect of ensuring that their reports have integrity and value, and one doesn't want there to be the perception that any

expert witness would lack independence as an expert.

The letters of instructions have not been provided for these or indeed any of the experts, and that may be something that can be of assistance, help to allay any fears, and we would ask that the letters of instructions are circulated.

CTI's note of 29 August lists topics by bullet points which form the two experts' reports and what they have been asked to comment upon. We simply suggest that "resourcing within ICU/CCU" should also include surge capacity of ICU beds as well as staffing resource within ICU units, and we also suggest that the list includes development and dissemination to clinicians of guidance on Covid care and treatment.

Finally, five, Rule 9 and disclosure. That's at paragraph 14, particularly, of our written submissions.

My Lady, we note and we share the frustration of CTI that in terms of the tardiness, we'll put it no higher than that, and in some instances complete lack of response to the Rule 9 requests, that is extremely unhelpful. It has a knock-on effect, not only on the investigative work that the Inquiry has to do, but then disclosure. That has a knock-on effect on the core participants in preparing for their own questions, and preparing generally.

It's also extremely worrying, to say the least, that there has been destruction of any documents, and, my Lady, I'm sure you will want full and proper explanations from the relevant parties as to why that happened, how it happened, and to ensure it doesn't happen, because this module is some many months ahead, and there are undoubtedly many other documents that will need to be considered.

Accessing mailboxes, that's not an insurmountable problem. It may cost a little bit of money, it may require some technical assistance, but I'm sure that that can be rectified, and that shouldn't be a reason why, again, emails, et cetera, are not disclosed.

Disclosure has now begun for Module 3, and we welcome that, and we hope that it continues in a timely fashion. Whilst inevitably there may still be some disclosure once we begin Module 3, we hope we're not in the situation that unfortunately we found ourselves in Module 1, where disclosure was still ongoing for particular witnesses after they gave their evidence, which is extremely frustrating for everyone but also means that potentially areas that may have been explored further were not and we could not do that.

So that is obviously a problem that we hope we don't encounter in Module 3, and we would simply urge and hope

that, as far as possible, all disclosure can be made before the commencements of the hearings.

My Lady, as I mentioned at the start of these brief oral submissions, if there are matters in our document that I haven't mentioned, we do nonetheless say that they are all of importance and we would ask you to consider them carefully and, where appropriate, to adopt them.

My Lady, those are our submissions for today's preliminary hearing.

LADY HALLETT: Thank you very much indeed, Ms Munroe, and thank you for taking the trouble to focus. I know sometimes it takes more time to shorten submissions than it does just to read out one's written submissions, so thank you very much indeed, both for the content and for the trouble you've taken.

MS MUNROE: Thank you.

LADY HALLETT: I think we will break now, if you can wait, Ms McDermott, until after the break. It's now 20 to, I shall be back at five to.

(11.41 am)

(A short break)

(11.55 am)

LADY HALLETT: Yes, Ms McDermott.

Submissions on behalf of Northern Ireland Covid Bereaved Families for Justice by MS McDERMOTT

MS McDERMOTT: Good morning, my Lady.

As you know, I represent the Northern Ireland Covid Bereaved Families for Justice, led by Brenda Campbell KC, Peter Wilcock KC and instructed by PA Duffy Solicitors.

May I start by thanking you for the opportunity to address you on Module 3.

Many of our group will, like me, be doing their best to avoid Storm Agnes today and will be following remotely or catching up online, and I would like to welcome and recognise their unfailing commitment to this Inquiry.

They will have listened intently to the observations we've just heard and will no doubt have strong feelings about the lack of response to Rule 9 requests by the Department of Health in Northern Ireland and the Chief Medical Officer for Northern Ireland.

We share the concern that these delays and the detrimental effect that they will have on Module 3. Of course, my Lady, we will keep under review the possibility of a section 21 order as the hearing date hurtles closer.

Now, as your Ladyship has already observed in the last preliminary hearing for this module, Module 3

is huge. The core issues have been carefully set out by my learned friend Ms Carey this morning, and on behalf of the Northern Ireland Covid Bereaved Families for Justice, whom I shall refer to as the Northern Ireland Covid Bereaved, we lean into those submissions and welcome the observations made, which we will reflect upon further.

I'm aware that there are a lot of speakers today and I will try to be concise and focus on only a couple of points. That does not mean to say that by doing so I am abandoning or pushing down the priority list those matters as set out in our written submissions. Rather, I make these submissions to emphasise and complement those that have already been placed before you in writing, as well as outlined this morning by Ms Munroe KC in her characteristically skilled oral submissions.

Firstly, and in sharp focus for the Northern Ireland Covid Bereaved, are the experiences of the bereaved families. In both Module 1 and Module 2, the accounts of the families have been limited by the argument that they do not have first-hand witness evidence in respect of the high-level political decision making, preparedness or political response. That refrain holds no traction in Module 3. For your Ladyship to have

a real understanding of what the impact of policies and procedures within the healthcare meant for patients and their loved ones, you must view the outcomes through the prism of real experience of real people.

It is a matter of fact that the families are well placed to inform the issues under consideration in this module. Indeed, the very first paragraph of Module 3's scope states that this module will examine the impact of Covid-19 on people's experience of the healthcare.

Many of our members strongly believed that their loved ones were allowed to be exposed to Covid-19 and that the health and social care structures in Northern Ireland were so devoid of resilience in the pandemic that it was inevitable their loved ones would contract Covid-19. In short, they believe their loved ones were effectively given Covid-19 because nothing was done to prevent it. We've many examples of bereaved families attending healthcare settings for relatively routine treatments only to be infected with the virus which proved to be fatal.

Within the hospital setting, many of the Northern Ireland Covid Bereaved give accounts of apparent failures to use PPE in hospital. These issues naturally give rise to the concern either there were inadequate supplies of PPE or that there were inadequate

instructions on how and when it should be used.

One of our members recounts how her father reported staff were wearing masks around their chins, with one individual putting the mask on after leaving the ward, or how other patients moved freely in and out of hospital buildings with no masks at all. He and his family continually raised this and enquired about the potential exposure to Covid-19. On 1 October 2021 he tested positive for Covid-19 and died less than three weeks later.

In a similar vein are the concerns about the suitability and availability of the much needed equipment in Northern Ireland. One Northern Ireland Covid Bereaved discovered following the death of her loved one and an investigation that the ventilation system on the ward was faulty and inadequate prior to the outbreak.

Other Northern Ireland group members have expressed anxiety regarding the perceived use or misuse of palliative care in hospital. This includes use such as midazolam and/or morphine in end of life care, and the use of risperidone to sedate patients, as well as issues around withholding of water. Many members have painted very distressing portraits of coming upon their loved ones in a state of dehydration.

There is sadly a belief amongst some of our members that in some cases their loved ones' lives were, in effect, actively ended by healthcare professionals.

By way of examples, two sisters have shared their account of how their mother tested positive for Covid on 31 March and died on 7 April 2020. They comment:

"They gave her sedation, midazolam and morphine, and they ultimately believed that they knew they were going to need the beds for younger people and giving sedation drugs were simply a form of euthanasia."

It is common case that people were discharged from the NHS estate into care homes, ostensibly to protect the NHS. In many cases, GPs refused to visit care homes and care home residents requiring hospital care were denied it. Many of our group believe that the care homes were flooded with patients who were discharged from hospitals to home settings without being tested or in isolation, despite the awareness of the risks of asymptomatic transmission from the early stages of the pandemic.

Before the pandemic hit our shores, Northern Ireland's healthcare system was in a state of functional collapse. The health and social care system was unfit to withstand the necessary additional surge capacity that was required for the pandemic to be fought

on any proper footing. Surge capacity came about due to the redirecting and standing down of other services. It did not have additionality. The waiting lists were, as your Ladyship has heard, far worse in Northern Ireland than in any other part of the UK. For the people of Northern Ireland, that meant 57% of those on a waiting list have been on there for a year compared to 9% of the waiting list population in England.

In Module 1, Mr Robin Swann MLA, the Minister for Health, gave evidence and expressed the view that Stormont had let down the healthcare system in Northern Ireland because it had not looked after the health and social care services as well as it could and that vital services had been underfunded, short-term decisions preferred over long-term planning, and difficult choices were ducked and staff were left to feel unappreciated, with social care being particularly neglected.

Michelle O'Neill, his predecessor and First Minister for Northern Ireland, noted to your Ladyship in July this year that it was evident to her, in her previous tenure in a health minister post, that the system demanded transformation on how healthcare was delivered. She described "report fatigue" in the Department of Health from day one and that an action plan was needed

to transform and fix the healthcare service and tackle health inequalities.

Unfortunately, the reforms envisaged had not been employed, such that Sir Michael McBride, the Chief Medical Officer for Northern Ireland, stated in his evidence that the Department of Health was inadequately resourced to respond to the multiple and competing demands of an emergency.

My Lady, that emergency came, and it came in the form of the Covid-19 pandemic. The well-documented failure to invest undoubtedly adversely impacted on how Northern Ireland and the social care system responded, and undoubtedly those who work in healthcare came up with a response plan, with policies and procedures that stemmed from emergency care to access to general practitioners.

However, in order for you to really understand where there were failings and to come to conclusions that are likely to result in real and much needed change, you must hear the direct experiences of those who bore the brunt, who lost loved ones, and have much to say about where lessons are to be learned and how the changes must be implemented.

This module will not serve its core purpose if it does not move on from a paper-based reporting and

consider real people, real experiences and the very real and heartbreaking outcomes.

For those reasons, my Lady, Northern Ireland is reliant on this module in combination with M2, 2C and M6 in particular, to provide a report that goes a long way to fixing a broken health and social care system, so that when the next pandemic comes, fewer families will be bereaved. In order to do so meaningfully, the Inquiry should call upon an expert's evidence on the Northern Ireland health and social care system to assist as a guide to you through our unique system within the UK. Pertinently, Northern Ireland has a fully integrated system of healthcare and processing(?) around social services, referred to health and social care.

We acknowledge that a single expert might provide sufficient expertise across the modules, given that many and much overlap. Without that expert evidence, however, we contend that when it comes to understanding the impact of Covid-19 on the Northern Ireland health and social care services, the Inquiry will be much the poorer. We urge communication between the modules and -- in this module and M2C and with the Northern Ireland core participants in order to identify and instruct a suitable expert.

Unless, my Lady, there are any matters on which

I can particularly assist you with, those are the submissions on behalf of the Northern Ireland Covid Bereaved Families for Justice.

LADY HALLETT: Thank you very much indeed, Ms McDermott, I'm very grateful to you.

I think Ms Mitchell's also attending remotely, I think. Ms Mitchell King's Counsel.

Submissions on behalf of Scottish Covid Bereaved by MS MITCHELL KC

LADY HALLETT: I can see you. Can you see us, Ms Mitchell?

MS MITCHELL: I can -- good morning, my Lady -- thank you very much.

My Lady, I've listened with care to what's been said beforehand and I think the Scottish Covid Bereaved aren't known for their lengthy submissions but I shall endeavour to make this perhaps one of our shortest yet, given the number of people that are speaking today, and also given the fact that, in relation to this particular module, we really are at the foothills of our enquiries, given that we will not be hearing until next August.

Perhaps, if I may move to my first issue, that is the timing of the hearings. We're grateful to Counsel to the Inquiry for providing a detailed note and update this morning. We note that the proposed date for this module is going to be autumn next year, and of course we

would have hoped that would have been sooner, but given what we know already about the preparation and presentation of the Inquiry, we appreciate that there is an enormous amount of information that has to be in-gathered, assessed, disclosed, et cetera, and of course witnesses obtained.

The Scottish Covid Bereaved don't want to sacrifice thoroughness for speed, and we hope that the proposed timing reflects the detail in which this module will be dealt with.

Given that's the case, a ten-week period does seem a very ambitious timescale and, given that disclosure is in its early stages, it may be that in the course of time greater time is needed. We would only ask at this stage that, whilst it's good to plan, the hearing timing of ten weeks ought not to dictate the number of witnesses to be called within it, and rather that period of time should be kept under review and expanded if and when necessary.

So, my Lady, we would simply urge that a degree of flexibility be built into the proposed timescale for these hearings in order that, perhaps closer to the time, a further assessment can be given as to whether or not that period of ten weeks is in fact realistic.

Number two, disclosure. We have now started to

receive disclosure, as of last week, in relation to this module, and we are disappointed this morning to understand that the reason that there is perhaps so little disclosure to date is because of the delays in respect of the Rule 9s.

We hope that this hearing serves as an opportunity for the Inquiry to stress the importance of observing the time limits when set. We, of course, are kept to strict time limits, and we do understand that sometimes we need to understand the size and scale of the requests being asked for. However, as this Inquiry has said repeatedly, it is vitally important that we are able to proceed with speed in respect of these hearings in order that we do not find ourselves in perhaps another pandemic before we would be ready to find out what we need to learn from the last pandemic. Therefore, it's absolutely vital that as much emphasis is put by those parties that have been asked to provide information to provide it as soon as possible, because it's not only in the interests of the Inquiry but it's in the interests of everyone in the UK that they try and observe these time limits.

Three, the issue of the retention of evidence. The Scottish Covid Bereaved note that it's been identified in relation to the retention of emails within NHS Wales

that Microsoft 365 email system may have had some kind of issue with the retention of emails.

We are of course concerned to hear that is the case, albeit that it would not affect, it would appear, interests directly in Scotland. We are of course seized of the view that it is of the utmost importance to have the best and primary evidence given to this Inquiry, and as a result we would urge all other key governmental and NHS organisations to be clear that they are able to retain all primary evidence that is going to be available, because that is how best we will be able to recreate what happened during the pandemic, and we hope that this issue having been raised today by Counsel to the Inquiry will allow other holders of information perhaps to reflect upon that situation and to ensure that that doesn't happen elsewhere.

Four, it's noted that the Inquiry has identified four areas which it proposes to examine in more detail to assess the impact of the pandemic on those requiring healthcare for reasons other than Covid-19.

The Scottish Covid Bereaved members of course have family members that were impacted by other matters than the pandemic per se, and of course we appreciate the Inquiry cannot examine every distinct non-Covid condition. However, we are heartened to hear this

morning that the request from the Scottish Covid-19 Inquiry that the issues of maternity and antenatal care may be expanded to include those issues in relation to women who suffered miscarriage, and we would urge the Inquiry to consider that in some detail, including the care and the services provided to women at that time and how that was impacted by the pandemic.

We look forward to hearing more about this in future hearings.

Five, it's noted that the Inquiry has instructed a number of experts for Module 3, as we would have come to expect. We understand that the expert witnesses in relation to intensive care and critical care are both based in England. No issue, perhaps -- although it's taken elsewhere, no issue is taken on behalf of the Scottish Covid Bereaved with independence or expertise of these witnesses, but we do strike a note of caution.

There may be differences between the healthcare systems and how matters are dealt with between Scotland and England, of course Scotland having its own healthcare system. We note that Counsel to the Inquiry has stated that the reports will address all four nations, but we flag up at this stage that the Inquiry may benefit from the expertise of those in Scotland. If it may be that Dr Suntharalingam and

Dr Summers are not in a position to comment on certain matters as they arose in NHS Scotland, we would ask that the Inquiry consider instructing a report from suitably qualified people with experience of practice in Scotland to produce reports to assist the Inquiry.

This observation of course applies to all the expert reports. It's not being suggested that we simply have to have a Scottish report in respect of every matter, but we would respectfully submit it might be helpful to ask the experts whether or not they consider that giving the same information or similar information into Scotland -- sorry, similar information about Scotland is appropriate or whether or not they feel they would benefit from perhaps speaking to a Scottish colleague or having a Scottish expert involved, and we would respectfully submit, given NHS Scotland is a separate entity, that that is considered by this Inquiry.

Unless there's anything further, my Lady, those are the submissions at this stage on behalf of the Scottish Covid Bereaved.

LADY HALLETT: Thank you very much indeed, Ms Mitchell. As ever, directly on point and you raise some interesting matters that I obviously will consider.

In relation to disclosure, can I just say this to supplement what Ms Carey said earlier: I am acutely

conscious of the burdens that this Inquiry has placed on some material providers and of course the demands placed on them by what Ms Carey called the "day job". Having said that, I am also acutely conscious of the duty that I have to the public of the United Kingdom, and therefore I have to say I will use all the powers at my disposal, where necessary, to ensure adherence to the timetable that I have set, and I would therefore issue the reminder that Ms Mitchell asked me to do.

Thank you very much.

MS MITCHELL: I'm obliged, my Lady.

LADY HALLETT: Right.

Now I think it's Ms Gowman, and I think you've moved so I can see you.

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

MS GOWMAN: Yes, I have, your Ladyship. Prynhawn da, good afternoon. I represent Covid-19 Bereaved Families for Justice Cymru, and will refer to the group as the Cymru group.

A significant proportion of the group's members died as a result of hospital-acquired Covid. Accordingly, the group believes that it has a real standing on the issue of the impact of Covid-19 on healthcare systems in Wales.

Your Ladyship has received written submissions from the group and I don't propose to repeat the same in detail. These oral submissions will therefore seek to supplement the Cymru group's written position in respect of the following topics: the provisional list of issues, Rule 9 requests, expert evidence, disclosure, and Every Story Matters.

Dealing firstly with the provisional list of issues. Your Ladyship will have read from the written submission the key areas of concern for the Cymru group. Overall, the group considers that the provisional list is sufficiently broad to encompass its areas of concern. However, there are several lines of enquiry that the group would invite the Inquiry to confirm will be explored in detail within Module 3. I will focus on elaborating upon six particular lines of enquiry.

First, the Cymru group agrees with the joint submission of Covid Bereaved Families for Justice and the Northern Ireland group that, given that preparedness of the health system fell outside of the scope of Module 1, that number 1 on the list of issues in Module 3 should be preparedness. In particular this should include pandemic preparedness at NHS trust health board level in Wales, including the readiness of the infrastructure, provisions, management and frontline

staff.

Secondly, in respect of decision-making and leadership, the Cymru group is focused on how matters were dealt with in Wales. The group seeks confirmation that the Inquiry will explore what information was or should have been available to decision-makers at the time decisions were made. And this in particular should include an exploration of whether Welsh bodies paid sufficient regard to the fact that Covid-19 was airborne and, if not, why not.

In this regard, the Cymru group supports the points raised in the written submission of COVID-19 Airborne Transmission Alliance.

Third, the Inquiry will be aware that many of the Cymru group lost loved ones due to hospital-acquired Covid, in the context of perceived inadequate infection control and a lack of adequate PPE in Welsh hospitals, many of which were known to have inadequate ventilation.

In relation to the issue of preventing the spread of Covid-19 in healthcare settings, the Cymru group submits that the Inquiry should also clarify and confirm that the matter of segregation will be explored as part of the exploration of inspection control measures in hospitals. This is a matter of deep concern for the Cymru group, particularly given that many lost loved

ones because they contracted Covid in hospitals, having been placed on wards with other Covid patients.

Fourthly, the Cymru group is keen to champion the rights of the elderly in Wales, and welcomes the Inquiry's proposed examination of Do Not Attempt Cardiopulmonary Resuscitation notices. To add to the written submission, many of the group's loved ones were placed on DNACPRs as soon as they tested positive for Covid, without due process we say.

From the group's experience, often neither the patient nor the family were consulted about their decisions. Many members, some of whom held power of attorney or deputyship for health and welfare for their loved ones, only discovered that they were placed on DNACPR notices after they had requested copies of their medical records post death. Upon review, often forms were completely incomplete or inaccurate, and the group urges the Inquiry to robustly examine whether those forms were completed in accordance with due process.

Fifth, many in the Cymru group report that after they had lost loved ones they found that morgues simply did not have the capacity to deal with the excess deaths arising from Covid. At least four members of the group experienced the bodies of loved ones going missing in morgues, which understandably made after-death and

funeral arrangements, together with the grieving process, even more distressing. As such, the Cymru group urges the Inquiry to add more capacity to its lines of enquiry for Module 3.

The Cymru group also invites the Inquiry at this stage to consider the lack of bereavement support offered by Welsh health boards as a line of inquiry. It's understood that none of the Cymru group's bereaved members were made aware of any Welsh health board that had bereavement support during the first 18 months of the pandemic.

The final point in respect of the provisional list of issues is this: the Cymru group is aware from the preliminary hearing on Module 4 on 13 September that it's envisaged that this module will review healthcare systems' response to clinical trials and research during the pandemic, together with the use of therapeutics in practice once effective treatments had been identified and approved, and that I'm grateful has been reiterated today.

The Cymru group considers that at the very least the proposed approach demands a close interplay between Modules 3 and 4 and the Cymru group implores close collaboration in this regard to ensure that nothing falls between the gaps.

It goes without saying perhaps that the Cymru group is also particularly keen to understand what therapeutics were available and used to treat Covid patients in Wales specifically and how their efficacy was recorded and disseminated.

At this juncture I make an observation on the timetable. The Cymru group also invites the Inquiry to reflect upon the viability of covering all of these issues in the envisaged ten weeks. The list of issues is vast and covers important matters which vary amongst the devolved administrations, and the Cymru group agrees with the other bereaved groups that it appears necessary and proportionate to provisionally allow, at the very least, some further time for the hearing in order to ensure that the issues are explored without avoidable limitations.

Within the context of the list of issues, I now turn to Rule 9s. The Cymru group submits that in order to properly examine the Module 3 issues in Wales, Rule 9 statements must be received from relevant individuals and organisations operating in Wales.

The group seeks confirmation, for the avoidance of doubt, that requests have or will be sent to organisations and institutions whose members work within the healthcare sector in Wales, the Welsh divisions of

the Royal Colleges, and charities, groups and non-governmental organisations operating in Wales.

Within its written submission, the Cymru group has suggested 24 individuals and/or organisations that the Inquiry should seek to obtain Rule 9 statements from. The list includes NHS Wales, the seven local health boards and the three NHS trusts which operate in Wales, together with relevant regulators, and the group is grateful for the indication given today that these suggestions will be considered by the Inquiry team as it embarks on the next phase.

The Cymru group further agrees with the submissions advanced by the Trades Union Congress that evidence from frontline staff in Wales will be crucial to understanding how policies, procedures and guidance were implemented in practice, their effectiveness and what lessons can be learnt moving forward.

Finally, the Cymru group supports the Inquiry's indicated robust approach to ensuring that deadlines for Rule 9 statements are maintained to avoid delay, and reiterate its request for statements to be released to core participants as soon as possible thereafter.

I move on to the instruction of expert witnesses. In a similar vein to the submissions made in respect of Rule 9 requests, the Cymru group submits that in order

to properly examine the Module 3 issues in Wales, experts instructed must have sufficient expertise and experience of practice in Wales to be able to provide evidence dealing with Wales specifically.

Further, experts must search for, document and analyse the Welsh data and scrutinise the position in Wales. Unfortunately it has not always been the case that expert reports provided to the Inquiry to date have demonstrated sufficient Welsh expertise or analysed sufficient Welsh data. More generally, the Cymru group is grateful for the Inquiry's assurance that all experts instructed to date are considered sufficiently independent to provide an objective view and is grateful for the Inquiry's clarification that the expert reports will set out any potential or perceived conflict in order that the Inquiry team may take a further view in respect of whether further expert evidence is warranted.

Next I will deal with the issue of disclosure. The Cymru group is deeply concerned about the issue of retention of emails within --

LADY HALLETT: I appreciate you're trying to get through in the time, but just looking at ...

MS GOWMAN: Ah, slow down? Yes, certainly.

The retention of emails within NHS Wales Microsoft 365 email service, which has resulted in all

content from mailboxes of inactive users being deleted. The group is particularly concerned that the deletions will impact on the ability of relevant individuals and organisations to respond to Rule 9 requests, on the Inquiry team's ability to further develop the list of issues for consideration, and on the Inquiry team and core participants' ability to put relevant matters to witnesses in evidence.

The position the Inquiry finds itself in, in my submission, is unacceptable, and Digital Healthcare Wales must be held to account. The explanation provided by them to date is, in the Cymru group's view, inadequate and underplays the scale and potential impact of this issue. The Cymru group considers that this is a very real problem, as highlighted by the written submission made by the group of Welsh NHS bodies, which suggests that this may be an issue which is widespread across its constituent members and is likely to present, at the very least, practical difficulties in responding to Rule 9 requests.

It is of concern to the Cymru group that the NHS bodies themselves have not sought to work with the Inquiry to raise the potential of delay, notwithstanding the submission made by the group of Welsh NHS bodies.

The group is particularly concerned that any mitigating steps to obtain the deleted emails will be time consuming and will not ensure in any event the recovery of all information lost, and for those reasons the Cymru group supports the Inquiry in its continued robust approach to exploration of this matter.

Aside from the deletion issue, on the issue of disclosure, the Cymru group agrees with the submission made on behalf of the Royal College of Nursing that the Inquiry should endeavour to compose a complete suite of infection prevention and control guidance, by seeking from relevant bodies a full suite of the iterations of the guidance and a clear chronology as to when, by whom, and how the guidance was varied and disseminated. And the group makes the simple point that this should of course include IPC guidance applicable to Wales.

Turning finally to Every Story Matters and participation of the bereaved in Module 3, which are very important issues for those whom I represent. Within its written submission, the Cymru group has suggested additions to the key lines of enquiry for Every Story Matters, and the group hopes that your Ladyship will find this of assistance. The Cymru group endorses the submissions made on behalf of the other bereaved groups that bereaved families have and

will continue to provide powerful and valuable information in respect of their experiences. The Cymru group further agrees that the process in itself will be cathartic not only for the bereaved families but also for society as a whole in its efforts to come to terms with the shared sense of grief.

To this end the Cymru group also asks that members of the group be given the opportunity to give evidence in the Inquiry, particularly where their evidence can also speak to systemic issues.

Some of the issues that the Cymru group members can provide valuable evidence on are healthcare decision-making and resources, testing, segregation in hospitals and end of life care.

In closing, the Cymru group experienced first-hand the consequences of the catastrophic impact of the pandemic on healthcare provision in Wales. Its members experienced and continue to experience suffering and trauma due to the devastation of Covid-19 in this regard. The group will continue to work proactively with the Inquiry to robustly explore key decisions made and to understand what went wrong and why, so that lessons can be learned in Wales to minimise the potential for further suffering.

Diolch am wrando. Those are my submissions,

my Lady.

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

Mr Metzer, I think you're attending remotely.

Submissions on behalf of Long Covid Kids, Long Covid SOS and Long Covid Support by MR METZER KC

MR METZER: Yes, thank you, my Lady.

My Lady, as you're aware, I address you on behalf of the long Covid groups. I have two preliminary points to make, followed by some procedural points. Overarching my submissions is this one simple point: long Covid is a direct consequence of Covid-19 and must not be siphoned off into a separate investigation. To investigate the pandemic is to investigate long Covid. With this overarching point in mind, I make these short points which I hope assist my Lady.

Vaccines and therapeutics. First, the long Covid groups raise with concern a topic that appears to have been raised by other core participants, that is the division of the topic of vaccines and therapeutics over Modules 3 and 4. The long Covid groups are concerned specifically about the issue of vaccines and therapeutics insofar as they are significant to the incidence and severity of long Covid. There is evidence that vaccines are efficient at reducing the impact of

long Covid on the overall population and in reducing the harm felt by individuals suffering from long Covid; matters to be considered within Module 3.

Specifically, there is evidence that vaccinated individuals are less likely to develop long Covid from an acute infection, that vaccines alleviate pre-existing symptoms of long Covid, and that vaccines reduce the overall severity of long Covid symptoms, thereby reducing the overall prevalence of long Covid in the UK's population.

The long Covid groups, as my Lady is aware, have not been granted core participant status in Module 4 and have expressed their concern to you in that regard. Module 4 covers this topic as a whole and it is noted that the decision letter refusing them core participant status suggests that the "diagnosis and treatment of long Covid falls within the provisional outline scope for Module 3". The long Covid groups wish to ensure, therefore, that the scope for Module 3 will accommodate the use of pharmaceutical interventions, that is vaccines and therapeutics, for the prevention and treatment of long Covid. It is both necessary and proportionate that this issue is investigated during the course of the Inquiry. People are continuing to suffer from long Covid. It endures. The long Covid groups

seek to understand when and how the Inquiry will investigate how vaccines and therapeutics can best be used to prevent and treat this illness.

Children and young people. Turning to my second submission, my Lady, I'm mindful that the experiences of children and young people is one that is close to your heart and you have on several occasions raised the importance of hearing and understanding the experiences of children and young people to your Inquiry.

The Inquiry needs to grapple with the roulette of Covid-19. Whilst most children suffer short mild illness, some do not. It is very important that the experiences of children and young people that suffered from and, in some cases, continue to suffer from long Covid are not forgotten.

As we have said, those children suffered the dual harms that the general impact of isolation and the loss of education had during the pandemic, as well as the physiological harms of long Covid.

I refer you to the public testimonies of families, children and young people shared on the Long Covid Kids website. I have two brief examples to share, one from the perspective of a child and one from the perspective of their family.

(a) C, a child aged 8, said:

"On big days out I now have to use my wheelchair because otherwise I get too tired and I would have an energy crash."

(b) The family of J, aged 12, said:

"His life is unrecognisable now compared to pre-Covid. He has spent the last two years seeing doctors, visiting hospitals, taking supplements and medication, having physiotherapy and pacing. Covid literally knocked him off his feet."

I'm sure you're cognisant of the profound impact that the sudden loss of health and enduring disability have on previously healthy children and young people. We have three requests on behalf of children with long Covid: (a) that there is proper paediatric evidence; (b) that the list of issues is amended to reflect the investigation into adults and children with long Covid; and (c) concerns Every Story Matters.

Turning to the first point, the expert report of Professor Brightling and Dr Evans, whilst recognising the harm caused by Covid to children that developed into long Covid, it is candid in its acceptance that those experts are not paediatricians and are not expert clinicians who are hands-on and treat children with long Covid.

My Lady, this leaves a gap in the evidence for this

module of the Inquiry, which is the absence of a properly resourced paediatric expert opinion. Children cannot and should not be compared to adults. Their experience is unique, as is their physiology.

It is over a year until Module 3 starts and we would reiterate our request on behalf of our clients that the Inquiry instructs a paediatric expert on long Covid. I note that this is likely to assist your investigation in the future module on children and education. My instructing team remain very open to meeting the Inquiry team to discuss this constructively and offer suggestions.

Secondly, the list of issues should be amended at paragraph 12(a) to include "definition and diagnosis of long Covid in adults and children". As suggested, it is important to specify the unique experience of children.

Thirdly, in relation to Every Story Matters, long Covid groups are concerned that the current plan to research and review the experiences of children and young people will dilute and depersonalise the experiences of children and young people with long Covid. As matters stand, children and young people will not be heard either in the hearings or through Every Story Matters. The long Covid groups are concerned that those children with long Covid will be

hidden in plain sight as a minority group under the crushing weight of the experience of other children and young people. Our client, Long Covid Kids, has proposed that the listening exercise collects accounts from children in a personal manner. As my Lady recognised, children's memories fade, but it seems taking children's accounts, whether that is individualised or otherwise, has still not yet happened.

Long Covid Kids have further noted that younger children may not have the language to express their experiences and artwork could be submitted instead. Our clients continue to work with the listening exercise team and would invite consideration of these proposals.

Procedural matters, my Lady, I will now turn to them. I have four submissions in regard to the list of issues, expert evidence and witness evidence.

On the list of issues we propose some amendments at paragraphs 6 and 7 of our written submissions, which we hope are of assistance to the Inquiry and will ensure that there is no misunderstanding of the scope of investigation.

We understand from Ms Carey King's Counsel's submissions this morning that the list of issues is iterative and we welcome this approach. At this stage I raise only this: long Covid is at the end of the list

of issues, and I take no point with this other than to simply ask the Inquiry legal team to ensure long Covid is not treated as a standalone discrete issue but as an important thread underlying the investigation in this module. This is borne out by the submissions for other core participants, the RCN, the TUC, CVF, that all refer to their members with long Covid.

The centrality of long Covid as being a direct harm requires the following specific amendments to the list of issues: first, that the investigation of long Covid under paragraph 12 includes "the recognition of long Covid as a disability", as called for by the TUC and the Royal College of Nursing, and "recognition of long Covid as an occupational health disease". This is in line with the approach in other countries, like the USA, where long Covid was recognised as a disability under the Americans with Disabilities Act as early as July 2021.

That paragraph 4(b), access to and use of primary care, be amended to include long Covid sufferers' access to primary care, especially in the early stages of the pandemic, and that paragraph 7(a), impact of the pandemic on doctors, nurses and other healthcare staff, be expanded to expressly include the impact of long Covid. I note and commend to your team that

compelling reports from the British Medical Association, overexposed and underprotected the long-term impact of Covid-19 on doctors, which sets out the brutal impact of long Covid on doctors as just one example.

LADY HALLETT: Mr Metzer, could I ask you to speak more slowly too, please, for the sake of the stenographer.

MR METZER: Of course, I'm so sorry, my Lady.

Do I need to repeat anything?

LADY HALLETT: No, she's coping magnificently as ever, but struggling.

MR METZER: Of course I shall slow down, thank you.

LADY HALLETT: It's all right, I share the same failing, I speak too quickly too.

MR METZER: Thank you.

I complete this by saying I invite detailed consideration of the amendments proposed at paragraph 6 of our written submissions regarding further lines of enquiry with long Covid which we trust are of assistance to you and the Inquiry legal team.

My final point on the list of issues circles back to my first submission, that there has been no confirmation that Module 3 will consider treatments, antivirals and impact of vaccines in reducing the incidence and severity of long Covid. The long Covid groups invite the Inquiry to confirm that these pressing issues will

be investigated in Module 3 or to confirm that they will be investigated in Module 4.

We are grateful for the update on the long Covid expert report outlined earlier this morning and look afford to receiving the Module 3-part of the expert report.

In regard to Professor Brightling and Dr Evans' further report on long Covid for Module 3, we understand that this will address the treatment of long Covid, research and long-term management of the illness, their role in advising healthcare systems across the United Kingdom on their response to the Covid-19 pandemic and any further lessons, that's at page 47.

Whilst it is understood that the Module 3 sections are in the process of being finalised, we ask that the Inquiry ensure the following points will also be covered by the long Covid expert reports.

First, interventions, to prevent the incidence of long Covid, (a) being impact of vaccinations on the incidence of and severity of long Covid and effect of vaccinations on existing long Covid patients, and (b) impact of treatment for acute Covid-19 infections such as antivirals on the incidence of long Covid.

Secondly, surveillance systems for long Covid in patient electronic health records.

We agree with the Bereaved Families for Justice that there is a need for appropriate witness evidence in this module from those with lived experience. We note that the BFFJ proposed to provide a schedule of families to provide evidence. Our clients have provided an extensive composite statement reflecting the experiences of their members and supporters of thousands representing the estimated 2 million people that have suffered from long Covid. We would urge that our clients are also called to give oral evidence. They reflect the diverse experiences of accessing healthcare systems as an individual with Covid, from ordinary working families to frontline healthcare workers, as represented by Long COVID Physios.

Every Story Matters. We would ask that the Every Story Matters lines of enquiry are amended to include experiences of having long Covid. One, the impact of lack of recognition of long Covid on people suffering with long Covid, and secondly, experiences of accessing healthcare for long Covid, including primary and secondary care and the differential experiences of those who were hospitalised for Covid-19 and those who experienced infections in the community.

Finally, practical suggestions. The long Covid groups note with concern the delays outlined by Ms Carey

King's Counsel this morning of certain key government bodies responding to Rule 9 requests, specifically the significant delays by the Department of Health -- DHSC and UKHSA, key to this module. At this stage, we simply share the Inquiry team's observation that this delay is unreasonable and is unnecessarily delaying the important work of this Inquiry.

The long Covid groups also note the submissions advanced by other core participants, namely the Bereaved Families for Justice, in regard to the hearing timetable. The long Covid groups have one simple observation in this regard, which is that the timetable be agile enough to adequately accommodate the number of issues listed as being investigated in the scope and that there is sufficient time allocated to hear impact evidence from those affected. The long Covid groups note that the timetabling of impact evidence was strained in Module 2 and hope that Module 3 will allot sufficient time to properly accommodate the hearing of this important evidence. At this stage and without the clear sense of the number of witnesses to be called, that is all the long Covid groups wish to raise about the final hearings.

My Lady, that is all I wish to say, unless I can assist you further.

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

MR METZER: Very grateful, my Lady.

LADY HALLETT: Right, Mr Wagner.

Submissions on behalf of the 13 Pregnancy, Baby and Parenting Organisations and Clinically Vulnerable Families by MR WAGNER

MR WAGNER: Thank you, and good afternoon.

I make submissions on behalf of two core participants, the 13 Pregnancy, Baby and Parent Organisations, which I'll refer to as the PBPOs, and the Clinically Vulnerable Families.

I act together with Mary-Rachel McCabe and Rosa Polaschek of Doughty Street Chambers, and we are instructed by Kim Harrison and Shane Smith, who sit either side of me, of Slater & Gordon.

I will make submissions first on behalf of the PBPOs, which I assume will take us to the lunch adjournment, and then, with your permission, continue after that.

I have four submissions to make on behalf of the PBPOs.

First, requesting that the Inquiry supplement its definition of maternity and antenatal care for the non-Covid conditions as they have been described.

Secondly, why we say that an expert should be instructed in relation to antenatal, intrapartum and postnatal care.

Third, some comments on the key lines of enquiry for Every Story Matters, and fourth, some short points of response to CTI's and the other CPs' submissions that have been made today.

So, starting with the submission about the Inquiry's plan for investigating non-Covid conditions, the PBPOs very much welcome the Counsel to the Inquiry's confirmation that, in addition to the four identified non-Covid conditions to be examined in more detail, the Inquiry will also examine maternity and antenatal care. This, we say, is extremely important, and we are very grateful to the Inquiry for doing it. The PBPOs of course have extensive experience in these areas, from a range of perspectives, and are keen to offer the benefit of that experience and expertise to assist the Inquiry.

We appreciate the regular confirmation that the list of issues remains provisional, and in that respect we make a few short comments on those list of issues.

First, and overall, the PBPOs submit that the phrases "maternity and antenatal care" and "antenatal and postnatal care", which have been

variously used in the list of issues and CTI's notes, are a little bit too narrowly expressed, because the language doesn't capture the range of issues which face pregnant women and birthing people in the healthcare systems during their pregnancies, birth and post-birth care as a result of Covid-19, nor those experienced by non-birthing parents and babies, as we have highlighted in the draft Rule 9 evidence which has now been provided to the Inquiry.

Just to give a couple of examples, amongst our group, The Ectopic Pregnancy Trust and the Miscarriage Association both support women and pregnant people who suffer ectopic pregnancies, usually before 12 weeks' gestation, and whose care is through specialist early pregnancy units rather than maternity care, and that may well not be considered under the current definition that the Inquiry's proposed.

Equally, Bliss supports babies born needing neonatal care, which is distinct from maternity care both in terms of its patient population and how it's commissioned and run.

Third, the Miscarriage Association also supports those experiencing miscarriage and molar pregnancy, which is also falling outside maternity care.

We note the helpful suggestion from the Scottish

Covid Bereaved in their written submissions that the Inquiry may want to widen the scope of their enquiries in relation to maternity and antenatal care and consider the care and services provided to women who had suffered miscarriages and how this was impacted by the pandemic.

We also note their helpful point of information this morning that the Scottish Covid Inquiry may well be expanding its own definition of maternity and antenatal care to include miscarriage, and we entirely agree with all of that.

For those reasons we submit that the following broader phrase should be used in the list of issues: "early pregnancy, pregnancy, maternity, antenatal, neonatal, and postnatal care", which we say captures the full spectrum of issues which was experienced by women and birthing people and their families during the pandemic, and really would give the Inquiry a very full and holistic view on these issues.

It's also important that postnatal care is properly understood as extending beyond the hospital and into the community. It's typically understood to mean the minimum of six weeks' post-birth care, and again that's part of the broader picture.

Second on the list of issues, we submit that

the Inquiry would also benefit from considering additional aspects of care as follows: firstly, a reference to guidance or advice for pregnant women in paragraph 21(d) of CTI's note should be expanded to include pregnant people and new parents for reasons of inclusivity, and this is the language that we have been using in our submissions from the beginning, and we ask that the Inquiry consider adopting that more inclusive language.

Secondly, we do understand CTI's rationale for using the catch-all phrase "visitor restrictions" in paragraph 21(e) in the note in the context of maternity care, but we submit that birthing partners of any kind, for example partners, mothers or friends, are much more than a mere visitor and in fact are an essential part of the caregiving team for the pregnant women or birthing person, and in our experience birthing partners provide essential care, such as helping to monitor the person giving birth, providing them with food or water, and helping them to go to the toilet, et cetera. Put simply, family members and supporters are not simply visitors, they are primary caregivers whose involvement in care delivery and decision-making is crucial to the baby's short-term and long-term developmental outcomes, as well as supporting good attachment and bonding. We

say that it's important the language the Inquiry uses reflects that these categories are not viewed as an optional extra, and we therefore propose that a new phrase is used, "restrictions on visitors and other people supporting an individual's care".

A third point on the list of issues, we submit that there are other issues which the Inquiry should fully investigate under the umbrella of maternity and antenatal care, and we've listed them in our written submissions, but they are: guidance and care for neonatal babies and their families, provision and use of PPE in relation to babies and their families, access to bereavement care services for losses at all stages of pregnancy, including mental health care, access to treatment for women and pregnant people experiencing pregnancy complications and loss, and maternal deaths from Covid-19.

Those were my points on issues in the list of issues.

Moving on to expert evidence, the simple point is that we submit an expert should be instructed by the Inquiry in relation to the non-Covid condition, or however the Inquiry is describing it, of antenatal, intrapartum and postnatal care. We have provided a couple of suggestions in our written submission,

Professor Marian Knight and Dr Helen Mactier. We have a number of other suggestions which we can provide in writing after these submissions, but we do say that expert evidence will be hugely helpful to the Inquiry's investigation.

My third area to address is key lines of enquiry for Every Story Matters. Now, the categories that have been laid out by the Inquiry are obviously broadly drawn to cover a wide range of potentially affected persons, but we say Every Story Matters must draw out the experience of a wide range of people who needed to access early pregnancy, pregnancy, maternity, antenatal, neonatal and postnatal care during the relevant period.

In respect of bereavement, the PBPOs submit it would be appropriate to add a subparagraph addressing the experience of accessing bereavement support and the availability of bereavement support, including mental health care, and under the second bullet point we propose a subparagraph addressing the experiences of family members who were unable to be involved in decision-making and communication around end of life care or disposal of pregnancy remains. This reflects the experience of PBPO members and constituents who were sometimes prevented from being at crucial discussions due to visitor restriction rules.

Finally some brief points relating to CTI's and other core participants' submissions which the PBPOs support.

First, we note CTI's helpful submission this morning of the Healthcare Safety Investigation Branch evidence on pregnancy, antenatal and maternity care. We are very grateful that this was one of the issues that was picked out to be summarised this morning. It very much reflects the evidence provided by the PBPOs in our submissions so far.

Second, in relation to Mind, we are pleased to see that Mind have been given CP status in Module 3. A significant number of pregnant women and birthing people, as well as those who experienced bereavements, experienced mental health issues during the pandemic. We strongly support Mind's submission that a Rule 9 request should be provided to them, and also that an expert on mental health issues should be instructed. And of course we hear the Inquiry's points that they made a number of times that decisions have to be made and dividing lines, as difficult as they are, have to be drawn, but we do say that mental health is a hugely important issue for our groups and therefore we support more focus being placed upon it.

Thirdly, we agree with the submissions of

John's Campaign and the other groups represented by that core participant at paragraphs 4 to 9 of their written submissions that healthcare in locations other than hospitals and GP surgeries should not be forgotten.

Many women and birthing people prefer their maternity care to take place as much as possible outside of a hospital, especially during Covid but also at other times, and they may choose a freestanding midwife-led unit or home birth for the healthcare they're receiving.

We've already highlighted in our submissions before this that the fact -- the suspension of these services, which was designed to compel healthy women to go into hospitals for their care, drove some to choosing wholly unassisted births and others into reluctantly spending time in a location with a high risk of infection. So we therefore support John's Campaign's submission, and I will also make that point in a different context in relation to CVF later.

Fourth, we support the submission which has been made by a number of CPs across modules that it's important for the Inquiry to set out in detail how it intends to build the information gained from Every Story Matters into each relevant module.

Those are my submissions for the PBPOs.

LADY HALLETT: Thank you, Mr Wagner. And if you were

struggling over the acronym, you've only got yourself to blame.

MR WAGNER: We did work through a number and, if you'll believe it, that was the best.

LADY HALLETT: Thank you very much. We'll break now and I'll come back -- given how many we have to go, I think is 1.50 pm all right? I'm looking at my wonderful stenographer. 1.50 pm, please.

(12.58 pm)

(The short adjournment)

(1.50 pm)

LADY HALLETT: Mr Wagner.

MR WAGNER: Thank you, and good afternoon. I now make submissions on behalf of the Clinically Vulnerable Families, CVF, which is easy to say.

First, safety at the hearings, my regular update on this issue, which you will be pleased to hear will be short. We want to express our thanks to the Inquiry team, who have been highly responsive to our requests, and we can report that to date they have been following both the letter and the spirit of the Equality Act, in our opinion, and we are very grateful for that, and we appreciate how much time and resource this has taken, but we know that you, Chair, and your team understand how important it is that the Covid-19 Inquiry, of all

inquiries, gets this right, and it is an ongoing discussion.

We know that at least one person who was in the room for the Module 4 hearing two weeks ago likely had Covid during the hearing, and my lay clients who sit beside me, and who are clinically vulnerable, were concerned to hear this, but also not at all surprised; given the current Covid rates, it would be statistically expected that there would at least be one person in the room with Covid.

My lay clients, who are clinically vulnerable, say it's hugely important that they and the people that they represent are able safely to attend these hearings, not as separate but equal, having to observe the hearings online in a different space, but as full and equal participants.

There is a wider point here. Air quality and ventilation are hugely important issues for the clinically vulnerable people across the country. Currently 1.8 million of them, according to the National Institute of Clinical Excellence. If ventilation in buildings such as schools and hospitals was better, viruses such as Covid would not spread so easily. And if we don't address this, we will be facing more absences, more disease, and potentially even more

restrictions going forward. For that reason, on both the narrow point about safety here and the wider point about safety in the country, we will continue to work with the Inquiry on this important issue.

My second submission is about the division of the respective scopes of Module 3 and Module 4 as it relates to therapeutics. Now, I did hear the point that Ms Carey KC made in relation to the scope, saying that the scope of Module 4 is for the Module 4 team, and in that respect you have my detailed written submissions on the points, and given that indication I won't press them in any detail, but I do make one point which I say is important for Module 3.

The Inquiry's current plan, as we understand it, is to divide consideration of therapeutics across Modules 4 and 3, in that sequence. And you ruled, Chair, after the Module 4 preliminary hearing that the scope of Module 4 will be amended to the development, trials and steps taken to enable the use of new therapeutics and repurposed medications during the pandemic.

Module 3, as we understand it, will consider the use of therapeutics, which will not be considered in Module 4. However, our concern is that the provisional scope for Module 3 makes no reference to therapeutics, despite being a very detailed document. It does mention

treatment for patients with Covid-19 in general in paragraph 5, and the provisional list of issues is the same. This highlights a problem, we say, that Module 3 will not consider properly and fully the use of therapeutics.

CTI this morning mentioned that intensivists have been asked for evidence on therapeutics, which is entirely understandable because the use of therapeutics in hospitals to treat patient with severe Covid-19 or Covid-19 generally is obviously important in this module. But some of the key therapeutics, in fact many of the key therapeutics, are accessed only in the community. The process is structurally similar to vaccination rather than being similar to other kinds of treatment, such as being put on a ventilator, that's received in hospitals.

We therefore ask the Module 3 team to consider this question: will the use of therapeutics in the community be considered in Module 3? Because it's not in the scope and it's not in the issues list, and it wouldn't obviously come under the treatment of Covid-19 when considered in relation to a Rule 9 statement to a doctor. Treatment of Covid-19 would not necessarily encompass treatment in the community, but that's where most therapeutics are accessed.

So if the answer is no to that question, there needs to be some clarification in the respective scopes of Modules 3 and 4, because the risk is that that point, which really gets to the heart of the provision of therapeutics, will fall between the cracks and will not be considered by either.

So that's the single point that I make in relation to that issue.

My second submission is on the provisional list of issues. The first thing to say is CVF strongly welcomes paragraph 11 and considers the Inquiry has correctly identified the key issues affecting shielding and the impact on the clinically vulnerable in that paragraph. We are grateful for that.

As to provisional paragraph 6, CVF note the change to paragraph 6(b) to explicitly include the reference to blanket decision-making on DNACPRs, Do Not Attempt Resuscitation orders or notices, which the Inquiry will appreciate is a particular concern of our members.

CVF still consider that the decision about healthcare should include a specific review of the Covid-19 decision support tool. It's an extremely important issue for the clinically vulnerable.

This was a tool that was developed during the pandemic to assist decision-making in people with

underlying conditions who were infected with Covid-19. CVF respectfully suggests that the Inquiry should investigate how widely it was accepted and used in healthcare, even if not formally used, the psychological effect of this tool being publicised nationally, including in the media, and to both healthcare professionals and clinically vulnerable people, and we proposed a new subparagraph or extra words:

"The use and potential effects of decision support tools to determine patients' pre-morbid states and their treatment options for Covid-19."

The third submission I make is about the inclusion of the clinically vulnerable and clinically extremely vulnerable as an equality group. The Inquiry's terms of reference include an obligation to consider any disparities evident in the impact of the pandemic on different categories of people, including but not limited to those relating to the protected characteristics under the Equality Act and equality categories under the Northern Ireland Act 1998.

Evidently the scope of the categories identified is within the Inquiry's discretion, and certainly -- obviously doesn't end with the protected characteristics in the Equality Act.

As you know, Chair, the Inquiry produced

an equalities and human rights statement in July which currently mentions groups with protected characteristics within the meaning of the Equality Act, geographical differences, social economic background, occupation and immigration status. Those are all extremely important groups.

We are disappointed, however, to see that the clinically vulnerable, who were and remain particularly vulnerable to Covid-19, are not identified as a relevant group or characteristic. The clinically vulnerable, as a definition, as a category, was in effect invented by Covid, or at least it's a reaction to Covid, because it's the people who are most at risk of Covid. As a category, there are lots of people who would have considered themselves clinically vulnerable before Covid. However, Covid brought in a wide range of different conditions.

Covid itself and the associated decision-making, including in healthcare, had a very specific impact on the clinically vulnerable, the people that we represent, and at present, regrettably, they feel they have been practically been forgotten. CVF is keen to ensure that this oversight is not repeated by the Inquiry.

We therefore submit and request that the Inquiry consider adding to the equalities and human rights

statement "clinical vulnerability to Covid-19" as an extra bullet point, which would allow the clinically vulnerable as a category -- to pick up, I think it was, Mr Metzer KC's terminology this morning -- to be a thread which runs through the Inquiry.

This is particularly important to CVF because we will not be there during Module 2, not having been designated a core participant, and it's extremely important that somewhere along the line the Inquiry embed consideration of the clinically vulnerable, because we are concerned that otherwise they may be lost or subsumed into people with disabilities. Now, of course, not every clinically vulnerable person has a disability under the Equality Act, and not every person who has a disability is clinically vulnerable. They are cross-cutting but not the same categories.

So we would ask that the Inquiry consider adding the clinically vulnerable to the equalities and human rights statement.

Finally, I'll make some brief points on the other core participants' submissions.

First, we are deeply concerned, and this relates to CTI's oral submissions, that the Department for Health and Social Care has failed to provide any Rule 9 statements six months after they were requested, and we

certainly endorse your statement earlier, Chair, that if that issue continues to be an issue, you will consider using the powers available to you, because ultimately those statements have to be provided in good time.

Secondly, we support and are pleased to see Mind has CP status in Module 3. We support their submission that the Inquiry should hear from them by way of Rule 9 and that the Inquiry should commission an expert in mental health. Mental health was a hugely important issue for many clinically vulnerable and particularly -- well, not particularly but including those who had to shield for very long periods of time. In fact, some are shielding to this day. And we certainly support Mind's submission that the Inquiry find a way of increasing its focus on mental health.

On the expert panel for IPC, we're grateful that the identities of the experts have now been revealed in CTI's oral submissions, and we intend to make some submissions on the identities of those experts in due course.

Fourth, we heard, and took note, of the discussions around the length of the ten-week hearing, and do not attempt to propose an additional amount of time that is needed, because we haven't seen the witness list and we don't know what the Inquiry's plans are in any

specificity. However, just to go back to that point about therapeutics, we are concerned that in the tight hearing -- on anyone's view it's going to be tight to fit this module into ten weeks -- we are concerned that if the use of therapeutics in its full extent is included in Module 3, that will take some time, and that should be considered.

Then finally we support the inclusion of carers, including unpaid carers, into the issues list, and that's from paragraph 11 of John's Campaign's written submissions.

We thank you, Chair, and especially your team for your continuing work and engagement with CVF. Those are my submissions.

LADY HALLETT: Thank you very much, Mr Wagner. A couple of points. On the use of therapeutics, I've obviously been considering carefully what you and others have said and the overlap with Modules 3 and 4, and I will discuss that further with both teams to see what we can do to ensure that everyone's concerns are met.

In relation to participation in the hearing, obviously we'll continue to try to ensure that everybody who wishes to attend a hearing in person can do so safely, and as you've already acknowledged the team have been working hard with those whom you represent to

ensure that's possible. But I just want to say, I don't -- these are hybrid proceedings and I don't consider participation remotely to be in any way second class, just in case any of those following online thought there was something second class about that participation. As you know, many people make their submissions online, and these are intended to be, throughout, hybrid proceedings. I just wanted to make that clear, that nothing derogatory is intended if someone appears online.

MR WAGNER: No, and I didn't intend to imply that either. I suppose the point is that while there is an option to attend either in person or online, if reasonably possible, my lay clients would prefer to have both options available to them, and they will use both options and have been using both options in different contexts. So it's really more about ensuring access to both options than privileging one or the other.

LADY HALLETT: Thank you very much. Understood.

MR WAGNER: I'm grateful.

LADY HALLETT: Thank you, Mr Wagner.

Mr Straw, I think you're over there.

Submissions on behalf of John's Campaign, Care Rights UK (formerly the Relatives and Residents Association) and the Patients Association by MR STRAW KC

MR STRAW: Thank you.

Good afternoon. I represent John's Campaign, the Patients Association and Care Rights UK. I act alongside Jessica Jones and I'm instructed by Leigh Day and Carolin Ott in particular is here today.

My Lady, there are three topics I hope to address today:

A. The list of issues.

B. The overlap of this module with Module 6.

C. Evidence.

So topic A, the list of issues. This is an extremely helpful document and the Inquiry clearly has a huge amount of work to do for this module.

However, there are two topics which we would respectfully invite you to include within the list of issues. Those are broadly, firstly, healthcare outside the clinical setting and, secondly, unpaid and family carers. I'll take those in turn now.

So the first topic, the list of issues is focused on the clinical setting, and by that I mean in hospital, GP surgeries and ambulances and so on. What it omits is healthcare provided outside that setting, at so home, in the care home, community, mental health treatment and so on.

Now, many people received very important healthcare

outside the clinical setting, so that may be because they were disabled or vulnerable and therefore unable to get to hospital or otherwise, and in some respects the biggest impact the pandemic had on healthcare was on those outside the clinical setting. And that's partly because in a lot of cases restrictions completely cut off access to healthcare for long periods.

The importance of healthcare outside the clinical setting might be illustrated by statistics. So, for example, the King's Fund identified excess home deaths, so the number of home deaths additional to what would normally be expected, in the period from 14 March 2020 to July 2022 as being 100,000, but only 3% of those were from Covid. What that suggests is that the restrictions put in place as a response to Covid were responsible for some 97,000 additional home deaths during that period.

Another reason why we submit non-clinical setting healthcare should be investigated is that this setting raises different but discrete issues. So the policies or restrictions that were imposed in this area were different. The impact of those policies and restrictions was different. The withdrawal of healthcare was more extreme, as I've indicated. The availability, for example, of PPE was different. The

appropriate response in this context was also different, reflecting, for example, the fact that people at home or in care homes have different healthcare needs, they often have mobility and communication problems, they're often particularly vulnerable.

So for those reasons we respectfully submit that the list of issues should add a number of specific issues concerning non-clinical setting healthcare, and we've set those out in more detail in our written submissions.

Finally on this topic, our clients support the submissions which have been made by Mind to the effect that this module should look in more detail into mental health community services.

The second area which we submit should be added to the list of issues concerns unpaid and family carers. Unpaid and family carers played a vital role in healthcare now and during the pandemic. There are more than 5 million carers in the UK. They are estimated to contribute to the UK economy a figure of about the same as the budget of the NHS, so some £162 billion a year in recent estimates.

Unpaid and family carers play an essential role in healthcare, for example they provide healthcare, they administer medication, treatment and care plans, they

monitor and assess conditions, and they also communicate with professionals for those patients who are unable to communicate for themselves.

We strongly support the PBPOs' submissions that loved ones play a key role in care. Again, a reason why we submit that the role of unpaid and family carers should be included in the list of issues is that different and discrete issues again arise in this context for investigation. Policies and decisions concerning unpaid and family carers were different, for example little thought was given to PPE. These workers were not designated as key workers. The impact of the pandemic was different on unpaid and family workers. Again, in many cases restrictions completely cut off access to care and healthcare provided by those individuals. And the nature of healthcare in this context is also different, so it's more daily, long-term monitoring and treatment rather than sort of one-off or isolated appointments.

Adding unpaid and family carers to the list of issues would be consistent with the introduction to the list of issues which recognised that this module should look at the unequal impact of the pandemic on vulnerable healthcare workers. This army of unpaid and family healthcare workers were vulnerable and the

pandemic had an unequal impact on them. But the remainder of the list of issues does not include them.

Again, we make specific suggestions for changes in our written submissions in paragraph 11.

So that's issue A.

Issue B, the overlap of this module with Module 6, and the Module 6 is the care module.

Care and healthcare, my Lady, in many contexts are inseparable. This has been repeatedly recognised by the government and the health service. Just to pick two examples, in the 2022 White Paper*, Health and Social Care Integration*, the foreword said:

"We have been reminded, once more, of the inextricable link between health services and social care."

Similarly a 2021 policy paper on this issued by the Department of Health and Social Care said:

"... the case couldn't be clearer for joining up and integrating care around people rather than around institutional silos ..."

The overlap between the two might be illustrated by the particular example of dementia. Dementia is, of course, a critical healthcare issue. My Lady, it is the leading cause of death in the UK. But as the national dementia strategy, which we have quoted in our

submissions, makes clear, care and healthcare for dementia are inseparable, they are the same thing.

Pick the example of infection control. Infections for dementia sufferers are one of the biggest causes of death. How infection control is effectively delivered is a mixture of care and healthcare. So checking the patient for sores, communicating with the patient effectively, in particular those who lack capacity, moving the patient to prevent sores developing, applying treatment and medication. Again, they're part and parcel of the same thing.

This inextricable link between care and healthcare, we respectfully submit, should have five implications for the Inquiry.

Firstly, it's important that the Inquiry takes a holistic approach and does not create the institutional silos which the government warned against. Investigation of the impacts of Covid on healthcare will have to examine the impact on care, where there is this overlap.

To put the point slightly differently, it's not possible in a number of contexts to properly answer whether the response to Covid, whether the restrictions imposed, were appropriate, unless one considers the impact of those restrictions on both healthcare and

care.

Take the example of visits out of a care home to a hospital. For a long period those were prohibited and then they were prohibited other than in exceptional cases, when the returning patient would have to completely isolate for 14 days. This meant that the patient couldn't access healthcare or care, and both of those were dangerous and potentially fatal in some cases.

Now, returning to my point, one can't really answer the question as to whether those restrictions were appropriate unless one considers both the impact that they had on the healthcare and also the impact that they had on care.

The second implication is we would respectfully invite the Inquiry to ensure that Module 3 and Module 6 run in tandem, so evidence from each should be shared and should be available to inform the other.

Similarly, implication 3, issues which overlap, so the issues which both fall into the healthcare and the care camps, it would be extremely helpful if the Inquiry could clarify at an early stage which of the two modules will investigate overlapping issues, and how it will do so. That's because if we know, for the purposes of this module, that Module 6 will be investigating an issue,

then that will inform the submissions we make on things like list of issues and witnesses.

Again, I'd like to illustrate that with the example of dementia. In this module, the list of issues at 5C lists four conditions which be investigated as focused conditions. We made submissions that dementia should be added to that list as a fifth condition. The Inquiry's response to that included that Module 6 would be better placed to investigate dementia.

Now, it would be, as I say, very helpful if that could be confirmed, so if it could be confirmed in particular that Module 6 will investigate the impact of the pandemic on healthcare and care of those with dementia. And the reasons, just briefly, why it should be investigated are as follows:

Firstly, the importance of dementia. It's, as I said, the biggest cause of death in the UK, a million people suffer from it, but secondly, that particular and discrete issues are raised about dementia which otherwise won't be investigated.

So the national dementia strategy explains home and family care for dementia sufferers are the most important services. Dementia sufferers often lack the ability to communicate or lack capacity. Care and treatment is of a particular sort, it's daily, intensive

and over the long term, and many dementia sufferers are clinically vulnerable.

So the issues that will arise in the investigation of dementia aren't covered by the other four conditions in 5C of the list of issues.

However, those issues are not just limited to dementia, they cover a number of other conditions such as degenerative conditions, and so the investigation of dementia would have broader importance.

My Lady, the fourth implication of this overlap is about timing, and you've already had an exchange with Ms Munroe KC about this this morning, and I'll try not to repeat that, but we have two points really about timing. Firstly, given the overlap, it would be very helpful if the hearings in Modules 3 and 6 could take place closely together, and if final reports from both could be delayed until the end of the hearings of both, so that evidence from the hearings can inform both reports.

The second point about timing is, of course, urgency. We readily appreciate the huge amount the Inquiry has to do and the difficulty in preparing for these hearings, but if any way can be found to prioritise the care module and this module in particular, then there are very strong reasons why that

should be done.

Some of those were canvassed in the last hearing and I won't repeat those other than to say the restrictions remain in place and they remain onerous. But another reason, which Ms Munroe touched upon, is that evidence from the people affected by the pandemic, the patients and so on in particular, will be critical for the Inquiry and the Inquiry's made it clear that that's very important to them. But by spring 2025, to put it bluntly, most care home residents from 2020 will be dead or will at least have forgotten what happened. So if the Inquiry wants to hear from them, something will need to be done very quickly.

In that context, it is of course of great concern to hear about the delay from the Department of Health and others in providing witness statements.

The fifth and final implication of this overlap, my Lady, is to really re-emphasise the importance of this Inquiry focusing on the person rather than the setting. To borrow from the Department of Health and Social Care report, the case couldn't be clearer for joining up and integrating the investigation of healthcare and care around people rather than institutional silos.

My Lady, topic C, and this is a short topic, is

evidence. In our written submissions we've invited the Inquiry to instruct an expert about the critical role of carers in healthcare, and in particular the impact of the pandemic and the response on healthcare provided by carers and on the carers themselves. We'd be very happy to identify particular experts if that would help.

On the topic of expert reports, it would be very helpful if we could be given the instructions that experts receive at the same time as the reports, not before so. That's because it can be very difficult to understand opinions or the validity of those opinions in the absence of the instructions. It's done routinely in civil litigation and the reasons why it's done there apply equally here, and it also helps focus our further questions.

Every Story Matters. We would be grateful if the Inquiry could clarify how and when the information from Every Story Matters will be brought into the modules, and it would be helpful if possible if that can be done earlier rather than later so that it can inform the list of issues and the evidence which is obtained.

So, in conclusion, my Lady, we readily recognise the Inquiry has a huge amount of work to do in this module, but we respectfully submit that the

investigation of the additional issues which we have identified in our submissions is critical to the proper examination of the pandemic on healthcare.

Those are my submissions.

LADY HALLETT: Thank you very much, Mr Straw. In relation to Every Story Matters I can only repeat what we've said a number of times, the Inquiry team try to keep all the core participants fully informed of what's happening with Every Story Matters, and Ms Carey this morning went into some detail as to how the reports would be prepared and how they would be used, but obviously I will yet again check with the team if there's anything more we can say, but we are doing out very best to keep everybody fully informed.

MR STRAW: Thank you.

LADY HALLETT: Thank you.

Ms Davies.

Submissions on behalf of Mind by MS DAVIES

MS DAVIES: Thank you.

My Lady, I'm here to persuade you that although we understand that this Inquiry above all others has to cut its cloth if it's to be of use for future generations, that the scope of this module should be broadened to include more about mental health services.

I want to divide my submissions into three points:

the general importance of the treatment of mental health problems, the weight of mental health services within the NHS estate; why you cannot study CYP in patients, even in detail, and then extrapolate that to understand what happened in the rest of mental health services; and addressing Rule 9 and experts to the Inquiry.

I do want to start with a small correction. Counsel said at the beginning that Mind had raised the issue of dementia being included. We have not, because we don't have expertise on that. It's not that we would oppose that, but it's not a submission we made but would support.

So to put things in context I think, you know, I myself have worked in the mental health service for 32 years, equally split between being a clinician and a lawyer, and we have always been called the Cinderella service. But public attitudes have moved on enormously in just the space of a generation. Just recently a retiring director told us the story of companies who would donate to Mind as long as their names didn't appear in the annual report and that people did not associate them with mental health problems. But on 5 September, The Times reported that only one in five people felt that mental health services were performing well, and the majority of those under 40 considered

mental health as a higher political priority than crime, climate change or the war in Ukraine.

Not just Mind but the British public are at risk of being left feeling short changed by the Inquiry if it does not investigate what happened to the mental health of the nation and why mental health services, much weakened since 2010, were not near to meet the needs of the population.

Now, in terms of the weight of mental health in the NHS estate, firstly mental health problems account for 23% of -- these aren't my terms -- disease burden, while receiving 13% of funding. Mental health beds count for 18% to 20% of all overnight inpatient stays. But it's not that we're just considering those half a million people who live with severe mental illness who are more likely to be detained under the Mental Health Act.

I guess that probably by now everyone in this room will know someone who has suffered poor mental health during and after the pandemic. So we're not talking about a niche issue; we're talking about actually a cast of millions. By August 2021 an estimated 8 million people were deemed not ill enough to get specialist mental health help. This was on top of the official waiting list of 1.6 million, 374,000 of those being

under 18s. That figure now stands at over 2 million.

People suffered not just stress, anxiety and depression that you might expect, but psychotic illnesses that they described as life changing, not just because of the illnesses themselves but their experiences in mental health services.

In 2020 psychiatric hospitals were emptied. They did not free up any beds for general medicine or critical care, and that was just the time that community services were also shutting down. Psychiatric professionals have told us that the guidance they received was confusing and they felt they were left to decide on a case-by-case basis who they would visit at home.

This meant that overall, despite greater need for mental health services, that there were less mental health contacts from psychiatric services than previous years. Even to the extent that some patients who did not -- who were on depot medication, long-term injections, they cannot administer themselves, were not seen. Moves to remote appointments were not so successful, many people with severe mental health problems are digitally excluded. And at the end of the pandemic, the medical studies have shown that those with long-term mental health conditions were five times more

likely to die from Covid than the general population.

Now, we do welcome that the Inquiry is looking at CYP in-patients, but we say you can't look at that and then understand what happened in the rest of the mental health system. The model of CAMHS is quite different, it's actually community based. There are disorders in CAMHS, such as behavioural disorders, that don't exist or aren't treated in adult mental health services. There are far less long-term forensic beds, and mental health services are often based in non-hospital settings. So, for example, in schools or other places where young people go. Very few people make it into tier 4, that's the in-patient services, because there is much safeguarding of those beds. Those beds are not commissioned even on a local basis, and young people find themselves, more than others, sent not just out of area but out of their home country.

The stats that we have on inpatient CAMHS are not the same as adult services. So, for example, a majority of girls or young women are admitted into under 18 services, whereas over 18 it's exactly the opposite. The stats that we have on racism are also slightly different.

So we say, even with a detailed look at in-patients, where you're fundamentally working on a community care

model, is really sort of misunderstood.

The other reason that, you know, I think -- we say you should look at mental health services is it's a microcosm of racism and health. There are very stark statistics about people of colour not getting the help they need, then coming into services through uncomfortable routes such as the courts or the police. If you are a black patient, you are 4.5 times more likely to be placed under section 13, and 11 times more likely to be put on a restrictive community order. Racism runs throughout the mental health system and, you know, we think that studying those factors would be instructive to the Inquiry.

Now, we respectfully submit as a friend to the Inquiry that the Inquiry's misunderstood the scope and the weighting of mental health services within the NHS estate, but we think there is actually time for this to be remedied.

So far the Disabilities Charities Consortium has been asked for a statement on mental health which, for the purposes of this Inquiry, does not contain a mental health charity. We are the only mental health charity that is a core participant in this Inquiry, and therefore we say we can assist the Inquiry by providing a Rule 9 statement.

This is why we also say that an expert is needed on mental health. We understand you can't look into every corner, but an expert on mental health services would be precisely there to guide the Inquiry as to the pertinent places that would be most useful to the Inquiry in the matter of mental health care.

You know, since the pandemic, the lesson that has been learnt by government seems to be to deprioritise mental health. Liberty protection safeguards that were passed through Parliament the government has refused to implement. A new mental health act which has been long, long overdue has now been shelved.

We say this is the wrong lesson to learn from the pandemic, that mental health should be re-prioritised, giving the scale of impact that it's had on the nation.

Now, we at Mind have a saying that we will never give up until all those who have a mental health problem have the support and respect that they need, and though we be considered a Cinderella service, we respectfully ask if we can go to that ball.

So that's the end of my submissions, unless I can assist you further.

LADY HALLETT: I can see you're not going to give up, Ms Davies, and the mental health services are very fortunate to have you as an advocate, so thank you very much indeed.

MS DAVIES: Thank you.

LADY HALLETT: Right.

Mr Jacobs. The TUC are very fortunate to have you as an advocate obviously as well.

Submissions on behalf of the Trades Union Congress by MR JACOBS

MR JACOBS: Maybe not quite as fortunate.

Good afternoon, my Lady, these are the submissions of the Trades Union Congress. They are shortened, happily, by some of the helpful indications given this morning by Ms Carey King's Counsel this morning.

Firstly, the submissions we have made on evidence from the frontline. The TUC's written submission raised the importance of the Inquiry hearing directly in oral evidence from those who worked at the sharp end in healthcare. With that in mind, we welcome the assurance given by Ms Carey that the Module 3 hearings will include evidence of individuals and that the next phase of the Module 3 teamwork will include identifying witnesses who can shine a light on systemic issues including issues of unequal impact.

My Lady, that is very welcome indeed. Such evidence frames the perspective of the Inquiry. It illuminates which policies were effective and which floundered in practice, and what needs to be learnt.

We do put on record that it is not to diminish the importance of impact films or Every Story Matters, both are valuable and the TUC was pleased that the Every Story Matters team was at the TUC congress earlier this month. We hope that we can engage perhaps early next year on the breadth and focus of the evidence of individuals, and certainly in advance of the next preliminary hearing.

I'm sure my Lady will have picked up that certainly amongst a number of core participants, there is a real strength of feeling on this issue.

I turn to the provisional list of issues. In broad terms, it is a list that the TUC welcomes, it is a helpful document. We invite consideration of just a few additional matters. Firstly, the Inquiry is committed to examining the impact of the pandemic on doctors, nurses and other healthcare staff. The list of issues should reflect, we think, that one of the very many impacts was huge and demanding changes in working patterns at very short notice. The initial pandemic response saw health workers placed into physically and mentally demanding emergency rotas for weeks on end and with little choice in the hours they worked.

It was a burden that may not have been distributed equally amongst the workforce. Significantly, the NHS did not have the preparedness to make those changes in a fair or equitable way across trusts and the uncertainty compounded the challenges faced by staff.

So we say that it is important that it is explored and understood in this module, in part to provide a platform for consideration as to whether preparedness for a future pandemic or indeed other emergencies should include a national framework for emergency rotas which can be implemented swiftly, consistently and fairly.

Second, we invite the issues relating to infection prevention and control should include those in outsourced services. The point centrally is a simple one: effective infection prevention and control requires a whole hospital or whole healthcare setting approach. Measures on an intensive care ward will be less effective if there is poor infection prevention in the services cleaning the ward or in the corridors, in the cafeteria and so on.

The experience of the TUC unions was that outsourced services were beyond the effective control of system leaders, with implications for infection prevention. We note that some of the practical experiences of that are, in our view, powerfully articulated in the submissions of the Frontline Migrant Health Workers Group.

My Lady, thirdly, disparities in death rates. The list of issues includes the numbers of patients and staff who died from Covid-19. We ask that the list of issues includes reference to disparities in death rates in protected and vulnerable groups, and the reasons for those disparities, including the extent to which they were contributed to by individual and structural racism.

We presumed but we do seek confirmation that the Inquiry will be looking carefully at the unequal death rates and also the likely contributing factors to those inequalities. The Inquiry will be well aware of the widespread concerns. They included black and minority ethnic healthcare workers being far more likely to be put in hot water with Covid patients, more likely to be working in junior or temporary roles, and inherently less supported in a healthcare system with poor black and minority ethnic representation in senior roles. These are the sorts of points that have been made powerfully in the written submissions by FEHMO, and which we endorse.

We do, of course, note the general indication given in the preface to the list of issues that discrimination will be a theme running throughout the module and that is helpful. But we say it is important to be able to focus carefully and to identify on the issues that

the Inquiry is really going to try to penetrate. These are complex issues and they do not simply or easily rise to the surface by themselves. They require an approach which is thoughtful and determined, and we invite that the list of issues identifies which issues precisely are going to attract that focus.

Fourth, we raised the issue of individual risk assessments for at-risk healthcare workers. We note it's also been raised by the Royal College of Nursing and we note this morning that it's a key theme in the early evidence from pharmacists. All I say, my Lady, is we welcome the indication that the list of issues will be amended to include that issue.

Fifthly and finally on the list of issues, in considering long Covid, which is addressed at issue 12, we invite the Inquiry to add the recognition of long Covid as a disability. It is the point made by Mr Metzer King's Counsel this morning, and so I endorse it rather than repeat it, my Lady, simply to note that the confusion has resulted in many workers with long Covid struggling to get the adjustments needed to support them in work. It is an important issue and we invite that it is added.

My Lady, on experts, we invited the Inquiry to consider obtaining an expert statistical analysis of the

available data in respect of deaths of healthcare staff. On that, I simply stand by our written submissions and welcome the indication that it's going to receive some anxious consideration in the coming months.

My Lady, unless I can assist further.

LADY HALLETT: No. Thank you very much indeed, Mr Jacobs, very helpful again. Thank you.

Ms Morris, ah, I thought I had you over on the left.

Submissions on behalf of the Royal College of Nursing by MS MORRIS KC

MS MORRIS: Good afternoon, my Lady. I represent the Royal College of Nursing and they are deeply grateful for the opportunity to provide evidence and make submissions.

As Patricia Cullen, the general secretary of the college, will say in her evidence, nursing staff across the UK carried the heavy burden of the Covid-19 pandemic, and they responded to the crisis in extraordinary ways: coming out of retirement, putting aside their studies, and being redeployed to specialised clinical areas.

As the college is explaining to the Inquiry in its evidence, it has a unique archive of the voices of nurses who contacted the college for advice and support during the pandemic. Key themes that they raised were the fact that they weren't able to see their children

because of their fear of bringing the infection home, that they saw their own colleagues sick and dying in hospital and went to work with a fear of death. They were working in conditions where they were short staffed, so that they were looking after patients with ratios which far exceeded those that were necessary to provide adequate care, and, as my learned friend from the TUC has mentioned again, risk assessments were not always carried out despite them being requested, particularly by those who were especially vulnerable.

This type of experience during the pandemic caused nurses to hit breaking point, and many of them to doubt whether they were able to continue a career in nursing.

Of course all of this impacted disproportionately on nurses from ethnic minorities, and the Royal College of Nursing echoes the submissions of the TUC and others in this regard.

Turning to the topic of long Covid, it is perhaps one of the most serious of the negative impacts of the pandemic on nurses now. A significant body of nurses have been left with chronic ill health, and that is as a result of their committed service to the community at a time of national crisis. It's for this reason that the college adopts the proposals made by the TUC and others that long Covid be designated a disability, and

also that there is consideration for a compensation scheme to meet the needs of those workers who are chronically ill as a result of their service during the pandemic, and that ought not to wait until the end of the Inquiry.

Picking up the thread of staffing levels, it is a key theme of the submissions of the Royal College of Nursing that the recommendations should include a strong legislative underpinning of government accountability for workforce planning and supply across the health and social care service, and a commitment to development of a sustainable nursing workforce if our country is to respond to a future pandemic.

Turning then to two process issues, first of all the scope of Module 6 and the question of how it should address the position of health services that are provided somewhere other than on NHS premises. The Royal College of Nursing gratefully adopts the submissions that were made on behalf of John's Campaign in this regard. It's important that these huge areas of health service provision do not fall through the gaps of this Inquiry.

First of all, one option is that there is an adaptation to the issues of this module to ensure that these matters are considered. The alternative is

to be clear now about the scope of Module 6 so that, as those who represent John's Campaign have suggested, everyone knows where their evidence and submissions should be directed.

That said, the Royal College of Nursing is sensitive to the practical difficulties in terms of trying to run both modules sequentially, and it doesn't support that submission, but we would invite consideration of analysing the terms of reference so that everybody knows now where their efforts should be focused and everyone can feel secure that these important issues aren't overlooked.

The second and final issue in terms of process relates to the topic of infection prevention and control. First of all, the Royal College of Nursing is very grateful that the CTI's statement has acknowledged the need to prepare a chronology of the iterations of IPC guidance over the period, but what the college would seek to reinforce is the point in its written submissions that when it undertook its resource -- researches for the purposes of preparing its statement, it was unable to establish itself a full suite of documentation.

My Lady will recall that at the time guidance was frequently changing and it seems that there is not, even

in the national archive, from our researches, a complete suite of documentation.

If it is to be understood who decided what and when, and then how that information was disseminated, we would encourage the Inquiry to use all its powers to secure a full set of documentation to inform its intended chronology.

The second issue under that heading is as follows: the college welcomes again the identification that we've had today of those who are to be the panel of experts on this topic, but what they would welcome is engagement at this stage on the terms of the letters of instruction.

My Lady may remember the evidence of Rose Gallagher of the Royal College of Nursing under Module 1 and her specialism in infection control, and we would say that it may be that the Royal College of Nursing has some insights which might assist in focusing particular areas of instruction.

If we can't persuade the Inquiry of that, we would also adopt the submission of John's Campaign that it would be of huge assistance to receive the letters of instruction at the same time that we receive the reports for all the reasons that they've advanced.

Those are my submissions, my Lady.

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

Right, Mr Stanton, and then we'll break after you, Mr Stanton.

Submissions on behalf of the Royal Pharmaceutical Society, the National Pharmacy Association and the British Medical Association by MR STANTON

MR STANTON: Thank you, my Lady.

My Lady, I have three submissions to make on behalf of the Royal Pharmaceutical Society, the National Pharmacy Association, and the British Medical Association. In total, the submissions should take approximately 20 minutes.

As the Royal Pharmaceutical Society has not yet previously addressed you, I propose to take them first.

The RPS is the professional body for pharmacists and pharmaceutical scientists in Great Britain. It leads and supports the development of the pharmacy profession, including through postgraduate pharmacy education curricula, professional standards and guidance. Its policy and advocacy work is guided by three elected boards across England, Scotland and Wales. Its members work across all care settings in the health service, including in community pharmacy, hospitals and primary care, as well as in wider roles such as the armed forces, prisons, the pharmaceutical industry and academia.

It offers free membership to students studying for a pharmacy undergraduate degree, working together with the British Pharmaceutical Students' Association, the official student body of the RPS.

Its knowledge business, Pharmaceutical Press, also produces a range of independent pharmaceutical information sources used around the world.

Covid-19 highlighted the essential work of pharmacists, pharmaceutical scientists, pharmacy technicians and wider pharmacy teams in supporting the nation's health by ensuring safe access to medicines and through healthcare research and development.

The pandemic brought unparalleled challenges that stretched personal and professional resilience to the limit. Pharmacists faced a huge surge in demand from patients at the same time as coping with a unique and changing work environment as national policy and guidance evolved. The RPS worked together with the profession to respond to these unprecedented challenges drawing on insights and intelligence from frontline pharmacists, stakeholders, elected members and a wide range of expert advisory groups.

Pharmacists and wider pharmacy teams were on the frontline of Covid-19, working alongside colleagues across the health service, often putting themselves at

risk so they could continue looking after patients in a time of national crisis, and tragically there are pharmacists and pharmacy team members who died after acquiring the Covid-19 infection, some of whom had given decades of service to their communities.

Community pharmacy remained open throughout the pandemic to provide vital care for their communities. Primary care pharmacists changed their ways of working to ensure that patients could continue to access medicines and care, including through video consultations, and academic teams also continued to support students remotely.

Hospital pharmacists cared for the most critically ill patients with Covid-19, transforming services to support colleagues, and made great efforts to source medicines for critical care to ensure supply.

There were also huge challenges for those who supported people living in care homes.

Given this crucial role and the efforts and sacrifices made, it has been hugely disappointing and distressing that the pharmacy profession, and particularly community pharmacy, was often an afterthought in government planning, policy and communications. The difference in treatment between pharmacists who provide NHS contracted services compared

with healthcare workers directly employed by the NHS has been a recurring and systemic issue, and the RPS and others in the profession have repeatedly called for pharmacists to be recognised for the frontline healthcare role they perform.

One of the worst examples of these double standards was the omission of pharmacists from the life assurance scheme announced on 27 April 2020 by the Department of Health and Social Care for the families of frontline health and care workers in England.

The whole pharmacy profession was shocked and dismayed to learn that community pharmacists would only be considered for the scheme in England in exceptional circumstances. It remains unclear how and why this approach was taken by government, and although the decision was quickly reversed following representations by the RPS, NPA and others, it is sadly a decision that has left a bitter taste within the profession.

Other examples of this difference in treatment include the following: the lack of explicit mention of pharmacists in the initial list of key workers, which caused problems for pharmacists around childcare provision, access to supermarkets, and freedom of movement, particularly getting to their place of work. Pharmacists were initially excluded from a national PPE

ordering portal, despite frontline pharmacy teams warning that they were unable to maintain safe social distancing either from colleagues or patients and were struggling to source PPE to protect themselves, their patients and their families.

In March 2020 the Home Office announced that doctors, nurses and paramedics would have their visas extended free of charge for one year as part of the national effort to combat Covid-19. However, this was not initially the case for pharmacists and pre-registration pharmacists, and it required action again by the RPS, British Pharmaceutical Students' Association and others before government changed course.

Regarding the health and wellbeing of pharmacists, the enormous strain that the pandemic placed on staff has showed the importance of wellbeing services, and the RPS has long campaigned for pharmacists to have equal access to these services.

At the start of the pandemic, access to wellbeing services was not universal across the UK, particularly within pharmacy, as the profession works across many different care settings. However, they should all have equal access to wellbeing support, including for long Covid, regardless of where they work.

Evidence has also emerged of the serious impact of

the pandemic on ethnic minority communities. Results from a survey from the RPS and the UK Black Pharmacist Association in June 2020 found that more than two-thirds of pharmacists and pre-registration pharmacists from ethnic minorities across primary and secondary care had not received Covid-19 risk assessments nearly two months after the NHS said they should take place.

The pandemic also exposed the fragility of the medicine supply chain, leading to shortages of many commonly used medicines. But this also led to the empowerment of pharmacists through regulations that supported professional decision-making and allowed pharmacists to take appropriate steps to minimise the impact of medicine shortages on patient care. This increased ability to exercise professional judgement should become more commonplace in the view of the RPS.

Regarding communication and stakeholder engagement by government, the RPS found that headline policies would often be announced centrally before the details had been finalised, which left pharmacists and others across the health service looking for clarity in what it meant for them.

Closer co-ordination and engagement with professional bodies at an earlier stage will enable them to keep their members better informed and reassured, to

develop appropriate support, resources and professional guidance, and provide constructive challenge to encourage more effective approximately making.

There were some examples over the pandemic of a more open and collaborative approach from government, however more needs to be done in this area. Community pharmacy teams played a pivotal role in protecting the health of the public over the pandemic, however they're currently under very significant pressure, which is leading to the closure of pharmacies in local communities.

Lessons learned from the pandemic and improvement required include making the most of pharmacists' clinical skills, supporting public health and prevention, reducing hospital admissions and ensuring timely information flow and access to records to better manage demand and build resilience across the health service. This must be backed by workforce planning, sustainable funding, and appropriate investment in pharmacy-led services, education and treatment.

The RPS hopes that the Inquiry will be able to take account of the vital contribution and dedication of pharmacists and pharmacy teams across the whole of the health service and of the impact of Covid-19 on the pharmacy profession and patients, and that the work of the Inquiry will bring about the much needed changes

to prepare for the future.

My Lady, turning to the National Pharmacy Association, you will recall that the NPA addressed you in the first Module 3 preliminary hearing earlier this year, and again in Module 4 a couple of weeks ago, and in these circumstances I don't propose to repeat the nature and scope of its work, save to say that it has similar aims and objectives to the RPS, with the main differences being the RPS membership is comprised of individual students, trainees, and registered pharmacists, whereas the NPA represents community pharmacy businesses, typically family-owned community-focused businesses.

In respect of their geographical reach, RPS membership is available in England, Wales and Scotland, while the NPA is a UK-wide organisation, including pharmacy businesses in Northern Ireland, which of course experienced their own unique challenges because of the Northern Ireland Protocol, including additional difficulties in the sourcing and supply of medicines.

These submissions on behalf of the NPA are focused on the Inquiry's provisional list of issues and the NPA welcomes the inclusion within issue 4 of the changing role of community pharmacy within primary care. The NPA would also like to propose two additional areas for

inclusion, both of which are supported by the RPS.

The first of these areas arises out of the different way in which community pharmacy was treated by government from other frontline healthcare workers, often by omission or afterthought. The deliberate omission of pharmacists from the life assurance scheme for healthcare workers is something that shocked and disappointed the whole profession, as already referenced in the RPS submission. To appreciate the full impact of this decision, it's worth setting out the circumstances in a little detail.

On 27 April 2020 the Department of Health and Social Care announced that the families of frontline health and care workers in England would benefit from a new life assurance scheme during the pandemic. The announcement stated that:

"The scheme is aimed at those who die from coronavirus during the course of their essential and lifesaving work. This includes those providing direct care as well as cleaners and porters who continue to carry out vital duties in these care environments."

The then Health and Social Care Secretary, Matt Hancock, also said:

"Nothing can make up for the tragic loss of a loved one during this pandemic. We owe a huge debt to those

who die in service to our nation and are doing everything we can to protect them.

"Financial worries should be the last thing on the minds of their families so in recognition of these unprecedented circumstances we are expanding financial protection to NHS and social care workers delivering publicly funded care on the frontline.

"We will continue to strive night and day to provide them with the support and protection they need and deserve to keep them safe as they work tirelessly to save lives."

However, despite being part of NHS primary care, risking their lives to treat patients and dealing with a huge surge in demand and increase in working hours, community pharmacy staff were initially excluded from this scheme and they were told they would only be considered in exceptional circumstances.

The NPA and RPS were quick to respond, and the letter of the NPA to Matt Hancock on 29 April 2020 stated:

"Community pharmacists and their staff are risking their lives every day to serve on the frontline alongside their colleagues across the NHS and social care, therefore it is only right and fair that they should also be entitled to the same death in

service benefits."

A swift U-turn by UK Government followed which sought to explain the initial exclusion in a less than convincing fashion, on the grounds that community pharmacy had a different nature of employment from the rest of the NHS. However, the damage to morale was already done, and this divisive decision still rankles within the pharmacy profession.

Other examples of exclusion and/or different treatment include: not being recognised as key workers, the adverse consequences of which have been already been described in the RPS submission; not being given access to the NHS PPE portal in England, to enable PPE to be ordered and supplied, until September 2020, six months into the pandemic; and the lack of availability of testing for community pharmacy staff until November 2020 because community pharmacy was inaccurately categorised as a retail setting rather than a healthcare establishment, which had a very significant adverse impact on the resourcing of community pharmacies as a result of the unnecessary need for staff to self-isolate in circumstances where they were not in fact infected.

The NPA requests that you consider reflecting these issues within the provisional list of issues in

the following ways:

First, in respect of the way healthcare workers are referenced within the list of issues. For example, issue 1, the impact of Covid on people's experience of healthcare refers to healthcare staff including doctors, nurses, paramedics, midwives, medical trainee and clinical support staff, but makes no mention of pharmacists. Similarly, issue 7, which again concerns the impact of the pandemic, refers to the impact on doctors, nurses and other healthcare staff. It is appreciated that these references are expressed inclusively, however to avoid any doubt and to take account of the concerns of community pharmacy about exclusion as just described, one option may be to include a comprehensive list of healthcare workers within a footnoted definition of "healthcare staff" or "healthcare worker".

The second aspect is to consider including within issue 2 core decision-making and leadership, the failures by government to adequately and fairly consider the interests and circumstances of all healthcare workers who contributed to the pandemic response.

The second general area for inclusion within the list of issues is the contribution made by community pharmacy and other primary care providers during

the pandemic to the health and social capital of the communities they serve, thereby reducing health inequalities.

Healthcare services are disproportionately located outside areas of greatest need. However, community pharmacy bucks this trend and the concentration of community pharmacies is higher in deprived areas, which enables pharmacy-based services to play a role in addressing health inequalities between affluent and less well-off areas.

Community pharmacies also have unique insights into the challenges facing vulnerable patients because these patients are disproportionately located within deprived communities.

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

The NPA also worked closely with the Home Office on the introduction of the "Ask for ANI" scheme, which gave victims of domestic abuse a way to seek help through their local pharmacy when other services were unavailable, which was voluntary and included providing access to private consultation rooms and undertaking additional training, again on top of already difficult and challenging working conditions.

It collaborated with charities and NHS England to provide Covid-19 vaccines to those with insecure NHS status and those without a fixed address.

Through actions such as these, the role of community pharmacy as a hub of the community was enhanced during the pandemic, when other social contact was curtailed or unavailable, and the NPA suggests that within issue 5, healthcare provision and treatment, which already includes consideration of inequalities in access to hospital and critical care, a further sub-issue could be added that will allow for the consideration of ways in which healthcare providers sought to reduce inequalities in healthcare provision so that account can be taken of these positive contributions as well as of the barriers and obstacles.

My Lady, finally the British Medical Association.

LADY HALLETT: You're getting close to your allotted time,

Mr Stanton.

MR STANTON: My Lady, I have two issues to address you on. The first relates to risk assessments. I'll aim to cut out some of the content.

In respect of risk assessments, my Lady, you're aware that all employers are subject to a legal duty to undertake suitable and sufficient risk assessments that are proportionate to the nature of the risk, and this includes a requirement to address the protection of groups of individuals who are susceptible to an either risk to health because of factors such as gender, age, comorbidity and ethnicity.

However, despite this legal obligation, the provision of risk assessments for healthcare workers was woefully inadequate over the period of the pandemic. Healthcare workers, including those more susceptible to serious illness from Covid-19, for example due to factors such as age, ethnicity, sex or underlying health conditions, did not receive timely and adequate workplace risk assessments which could, if undertaken and acted upon, have prevented the death and long-term illness of some workers.

This legal obligation to undertake risk assessment rests with employers. However, in the BMA's view, it is important to also investigate the role of key government

departments and agencies, including the Department of Health and Social Care, NHS England and the Health and Safety Executive, to consider whether they should have done more to support employing organisations to both understand and fulfil their obligations in the context of Covid-19.

The BMA's position in this regard, my Lady, is that the absence of timely and adequate risk assessments in response to a new and deadly disease to which healthcare workers were directly exposed, often without adequate protection, requires specific consideration as part of the work of the Inquiry in understanding the impact of the pandemic on the physical and mental health and wellbeing of doctors and other healthcare workers, and the BMA asks that you give careful consideration to its express inclusion within issue 7.

My Lady, the final point I'd like to make is in respect of the stockpile of respiratory protective equipment.

Regarding the failure to adequately stockpile respiratory protective equipment, RPE, the BMA welcomes the Inquiry's intention to examine the availability and adequacy of protective equipment within issue 8, and is pleased to note the clear distinction drawn within the provisional list of issues between personal

protective equipment and respiratory protective equipment.

The BMA also welcomes the indication that the list of issues will continue to develop as the Inquiry's evidence base grows, and in line with this approach we raise now for consideration of express inclusion in the next version of the list of issues the important question of why the stockpile of RPE was so lacking prior to the pandemic.

My Lady, we recognise that this is an issue of preparedness. However, there was not sufficient time within Module 1 to address it, and you may recall within the BMA's closing statement to Module 1 we referred to the need to give further consideration.

Expressly included already within issue 8, at 8B3, is whether the standard of RPE and PPE provided to healthcare workers followed the scientific understanding as the pandemic progressed. However, we ask you to extend this issue to include the scientific understanding of aerosol transmission of viruses prior to the pandemic.

This is because it's the BMA's position that the stockpile of RPE and the supplies that healthcare workers relied upon were not properly constituted in accordance with scientific understanding from at

least 2008. That is, we started off from a point that was not in accordance with the scientific understanding about how healthcare workers should be protected from aerosol transmission.

We set this position out more fully within the BMA's written submissions to Module 1, but, very briefly, in 2008 the Health and Safety Laboratory produced a report for the Health and Safety Executive that evaluated the relative levels of protection afforded by surgical masks and respirators against an airborne virus, and concluded that surgical masks should not be used in situations where close exposure to infectious aerosols is likely.

Best practice was stated to be the use of FFP3 devices. The report concluded with the prescient warning that the widespread use of respirators might be difficult to sustain during a pandemic unless provision is made for their use in advance.

Between 2008 and the outbreak of the pandemic there was scientific consideration of this issue, including within NERVTAG, however stockpile levels of FFP3 respirators remained at a level that was wholly inadequate for the purposes of protecting healthcare staff against an airborne virus. And worse, there is evidence before the Inquiry that suggests that this was

because issues of costs were prioritised over safety.

These are issues of significant importance to healthcare workers who want to know why they were so badly let down and to have assurances that it will not happen again. They are also intrinsically linked to IPC issues.

In the BMA's view, in order to make a full assessment of the protections provided to healthcare workers, it is necessary to consider the interconnecting issues of infection prevention and control and the provision of equipment -- of protective equipment, I beg your pardon, both prior to and during the pandemic, and we suggest that this can easily be achieved by expanding issues 8A and 8B accordingly.

Finally, my Lady, the BMA has recently provided a lengthy draft witness statement which raises a large number of issues for consideration in Module 3. We appreciate that your team will need time to consider them and we look forward to working together in the coming months to develop the list of issues further.

LADY HALLETT: Thank you very much, Mr Stanton. We'll break now. I shall return at 3.30.

(3.15 pm)

(A short break)

(3.30 pm)

LADY HALLETT: Right, Mr Dayle, I think. I've got "on the far right" written down. Yes.

Submissions on behalf of the Federation of Ethnic Minority Healthcare Organisations by MR DAYLE

MR DAYLE: Good afternoon, my Lady. I appear on behalf of the Federation of Ethnic Minority Healthcare Organisations, FEHMO, led by Mr Leslie Thomas KC and instructed by Ms Cyrilia Davies Knight and her Saunders Law team.

My Lady, in addition to the topics I will address today, in our detailed written submissions you can find addressed, among other matters, the key lines of enquiry for the listening exercise, matters dealing with evidential arrangements, the provisional list of issues and the issue of diagnosis of long Covid in minority ethnic people. I do not seek to rehearse those topics in these submissions but nevertheless FEHMO invites the Inquiry to consider them.

My Lady, it bears saying, as an introduction, that the first ten doctors to die from coronavirus were from black, Asian and minority ethnic backgrounds. In an article entitled "UK Government urged to investigate coronavirus of BAME doctors" in The Guardian on 10 April 2020, the head of the British Medical Association called on the government to urgently

investigate if and why black, Asian and minority ethnic people were more vulnerable to Covid-19. The article stated:

"At face value, it seems hard to see how this could be random - to have the first 10 doctors of all being of BAME backgrounds ... Not only that, we also know that in terms of the BAME population, they make up about a third of those in intensive care. There's a disproportionate percentage of BAME people getting ill.

"We have heard the virus does not discriminate between individuals but there's no doubt there appears to be a manifest disproportionate severity of infection in BAME people and doctors. This has to be addressed - the government must act now."

So to put this statement in context, here are some sobering statistics from the British Medical Association for the period between March to April 2020: 21% of all healthcare workers were from minority ethnic backgrounds, yet those groups accounted for 63% of deaths of healthcare workers. 20% of nursing staff were minority ethnic, yet 64% of nurses who died during this period were minority ethnic. 44% of medical staff were minority ethnic, yet 95% of doctors who died during this period were minority ethnic.

FEHMO welcomes the provisional list of issues

provided by CTI's note, and in particular the confirmation that "running throughout the module will be consideration of whether the healthcare decisions to be examined disproportionately affected any particular group in society, the measures put in place to reduce the unequal impact of the pandemic on minorities or vulnerable healthcare workers or patients, and whether any unequal impact was foreseeable".

From our perusal of disclosure in Module 2 to date, it seems that little effort was made at the central governmental level to convene healthcare system leaders to discuss and tackle the causative factors that made BAME healthcare workers the most likely casualty in the early stages of the pandemic. There was an unhelpful state of ambiguity, we call it, within the NHS on how best to protect ethnic minority healthcare staff. It was not until July 2020 that NHS employers provided updated guidance on prioritisation and management of risk, including risk to ethnic minority staff. A report from Public Health England entitled "Beyond the data: Understanding the impact of COVID-19 on BAME groups", dated June 20, 2020, provided what we consider to be an authoritative picture and analysis for this state of affairs, and it found:

"Historic racism and poorer experiences of

healthcare or at work may mean that individuals in [black, Asian and minority ethnic] groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risks."

So the generalising observation of what we may refer to as the Fenton report, for its authorship by Professor Kevin Fenton, accords with the position of FEHMO in its critique of the healthcare system and the exposure of BAME healthcare staff:

"It is clear from discussions with stakeholders that COVID-19 in their view did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting black, Asian and minority ethnic] groups in the UK."

FEHMO notes that in Module 3 the Inquiry proposes to examine as issue 2E core decision-making and leadership, the extent to which healthcare inequalities were considered as part of the core decision-making process -- progress, and we say that there are no specific issues to issues of race or ethnicity but we commend to you, my Lady, these considerations as being obvious and significant areas of investigation for this module.

So given the disproportionate death rate of BAME healthcare workers in the earliest stages of

the pandemic, we submit that it is imperative, my Lady, that oral evidence is elicited from this cohort about their lived experience during that time.

Here I pause to endorse sentiments expressed already by Ms Munroe and Mr Metzer this morning to this effect.

FEHMO contends that the purpose of such evidence taking is not merely to document the fear and hardship wrought by the pandemic, but instead to fill substantive gaps in the understanding of what actually happened within the healthcare system. This is critical from the point of view of impact on healthcare staff, as well as for patient safety.

The oral evidence of BAME healthcare workers will provide an opportunity for the Inquiry to directly interact with the witnesses, ask clarifying questions, and delve deeper into their perspectives and accounts. An interactive and open dialogue, which is only possible through oral testimony, allows for what we consider to be a dynamic exploration of the issues that written statements alone cannot accommodate.

FEHMO invites the Inquiry in Module 3, my Lady, to pay close attention to the period of the early stages of the pandemic. Again, we wish to point out that it is not sentimentality for the Inquiry to pay focused attention to this period, but instead it's

an opportunity to examine what occurred within the healthcare system during that time, and reflect on what might be corrected for the future.

This includes issues such as: the classification and recording of deaths, and here we support Mr Jacobs of the TUC's submissions in his call for an expert on statistical analysis in relation to the death of healthcare staff, and we particularly ask for this to be disaggregated in terms of race and ethnicity; the role of religion and faith within communities of colour in shaping attitudes towards death; the performance of bereavement services, hospices and services in end of life care; the inclusiveness and proportionality of hospital memorialisation efforts; and the racialised impact, we call it, of seemingly facially neutral policies, such as those for hospital visitation, and they played out in an atmosphere of fear, uncertainty and wider concerns about racism.

FEHMO is also keen for there to be focus on the following matters related to acute treatment and care: how staffing challenges impacted on members' delivery of healthcare and how this contributed to general access to critical care, and I think at this juncture I must acknowledge and support Ms Morris, on behalf of the Royal College of Nursing, who called for a compensation

scheme to meet the need of those workers made chronically ill by their service during the pandemic.

The effectiveness of Nightingale hospitals in serving black, Asian and minority ethnic communities, and the adequacy of emergency services in their responses to the needs of BAME communities and the effectiveness of cross-sectional co-operation in managing the crisis.

One area of what we consider to be high importance that the Inquiry must hear directly from BAME healthcare workers in is in matters of risk assessment. It bears repeating that many of our members have frontline patient-facing roles, with exposure to the wider public, with increased risk of infection. Most of our members did not have any risk assessment carried out until later in the pandemic and were not assessed for risks arising from the known disparities in infection and mortality for minority healthcare workers. Outsourced or agency workers were often not given any risk assessment. One of our member organisations, the British Association of Physicians of Indian Origin, called BAPIO, spotted the gap early on and devised its own risk assessment that was rolled out in Wales and parts of England.

My Lady, this Inquiry must focus on whether there was any data sharing among NHS organisations about risk

assessment. There appears to have been a massive amount of inconsistency between NHS trusts as to whether ethnicity was even included as a risk factor in the first place. Was there guidance on how to conduct risk assessments in relation to race and ethnicity? And if so, was there any consultation with BAME leaders within the NHS in the development of such guidance? And when risk assessments were in fact done, it was often at the level of a peer, and not by managers who had the authority to make reasonable adjustments.

Another area of high importance, we say, that the Inquiry must directly hear from BAME healthcare workers in is in relation to cultural competency, engagement, representation and leadership. FEHMO contends that a productive healthcare relationship must be one that is based on trust, and the development of such trust is assisted by cultural competency and leadership. In a pandemic, assertions about science and evidence, often touted as the Holy Grail, are considered through the prism of health inequality and structural racism. Public health communications and guidance during this time were not consistently provided in accessible formats. BAME communities were unhelpfully branded "hard to reach", which frankly reflected the failure of NHS leadership to effectively engage with

these communities.

As some examples, publication of translated guidance was slow and less accessible than English language versions, there were few community specific awareness raising campaigns or materials distributed by local or central government, and slogans often translated poorly across languages.

FEHMO members, along with other voluntary and community sector organisations, and faith leaders, were forced to fill these gaps in leadership to engage with those from ethnic minority groups and ensure that important public health messaging and information was communicated in culturally sensitive and language-appropriate ways.

Finally, my Lady, and this is on some procedural points, and I have three to make, the decision to downgrade Covid-19 from high-consequence infectious disease, or HCID, status on 19 March 2020, thereby permitting the use of PPE and not respiratory protective equipment, or RPE, appears to have been a grave error. My Lady, we thank you for confirming that this will be explored and ask that its impact on loss of life be examined thoroughly.

Secondly, we repeat our calls for the instructed experts on structural racism for Module 2, Professors

James Nazroo and Ms Laia Bécares, to be further instructed in Module 3, and for them to be invited to give oral as well as written evidence, affording you, my Lady, the opportunity for a more dynamic exploration of the subject matter.

Finally, thirdly, FEHMO respectfully reiterates its previous position, shared with many other core participants, Ms Munroe earlier, that the Inquiry reconsiders its decision not to disclose Rule 9 requests to all core participants. Without our sight of these documents, we say, my Lady, it will not be possible for participants in the Inquiry to identify gaps before evidential hearings.

My Lady, unless there are any questions arising, those would be my submissions on behalf of FEHMO at this time.

LADY HALLETT: Thank you very much indeed, Mr Dayle, very helpful.

Mr Simblet King's Counsel, where are you? There you are. You were hiding from me in plain sight.

Submissions on behalf of the COVID-19 Airborne Transmission Alliance by MR SIMBLET KC

MR SIMBLET: Thank you, my Lady.

Well, my Lady, I make these submissions along with Mr Dayle, from whom you have just heard for FEHMO, and

instructed by Saunders Law, on behalf of the COVID-19 Airborne Transmission Alliance, or CATA.

In addition to submitting a detailed Rule 9 statement, CATA's provided its written submissions ahead of this hearing, and obviously I don't propose to repeat those in full, but CATA would want others to be able to read them.

Your counsel referred this morning to your discretion to publish submissions. We invite you in a public inquiry to publish the submissions that you've received.

There are still some particular points to highlight, and to append.

First, we wish to convey CATA's gratitude to the Inquiry for incorporating into the provisional Module 3 list of issues so many of the points that we'd raised earlier as to the appropriate lines of enquiry, and CATA remains cautiously optimistic that the Inquiry will carry out a thorough investigation of these Module 3 issues, and presumably that will include, as you mentioned this morning, my Lady, taking a robust attitude to those who impede the Inquiry by not supplying material when required.

It is in the spirit of constructive engagement that I would like first -- a substantive point -- to address

something that we've raised in our paragraph 22 of our written submissions, and to which others have referred, and that is: CATA wants the Inquiry to take an expansive approach in its understanding and investigation of what is termed "healthcare".

CATA has previously pointed out that it's wrong to see healthcare provision as confined to hospital settings, and we commend the submissions of, for example, among several others, those from Mind and those made by the John's Campaign, Patients Association and Care Rights UK, that the healthcare provision is seen as well beyond hospital settings.

It appears from what Ms Carey was submitting this morning that your counsel at least or the Inquiry's position may not be that. But we say that it is essential for a thorough investigation on the impact on healthcare provision during the Covid-19 pandemic and beyond.

Like so many matters pertaining to the proper understanding of Covid-19, the appreciation of systems and their interdependence will first enable the Inquiry to see what went wrong, and secondly, discourage people in the future from departing from practices and procedures without a proper rationale. It is that issue of people departing from already established practices

and procedures that is a particular concern and particular central contention of CATA.

The guidance provided to healthcare workers during the pandemic was erroneous, confused and confusing. One stark example is the UK Government's "Hands, Face, Space" campaign. That phrase initially sidelined the airborne route of transmission of Covid-19 altogether. Indeed, it wasn't until 29 March 2021 that the slogan was modified to "Hands, Face, Space and Fresh Air". But even with that additional "fresh air" component instruction, there was further confusion for healthcare workers because this instruction did not seem to be being applied in healthcare settings.

Although the slogan now recognised the threat of the airborne route of transmission of SARS-CoV-2, healthcare workers were still denied adequate protection against airborne transmission, and this problem was embedded in successive infection prevention and control cell guidance throughout the pandemic. There was a fundamental disconnect between the advice being given to the general public and those working in healthcare settings, and CATA wants to understand why.

At the last preliminary Module 3 hearing, CATA drew attention to the contention in written submissions from NHS England that at the start of the pandemic, to quote

what they said, little was known about the novel coronavirus. CATA submitted and maintains that this is wrong. In fact, the position is the opposite of what NHS England submitted there, as we have previously submitted. A lot was already known about beta coronaviruses, and their transmission via an airborne route. Thus, as we know, SARS CoV-1 was and remains classified as an airborne high-consequence infectious disease. So even if, for the sake of argument, little was known, it nevertheless was known that this was SARS-CoV-2, and that the existing measures to address SARS CoV-1 and its airborne nature, which were known about and in place, we say should have led to obvious and basic scientific approaches in relation to the prediction of a precautionary principle, which essentially means unless there was clear, compelling and indisputable evidence that SARS-CoV-2 was not transmitted via an airborne route, that the proper public health response should have been to take sufficient measures to protect everyone, including healthcare workers, from a virus that could transmit via the air.

In fact there was no clear or sufficient scientific evidence for it to be asserted at the start of the pandemic that SARS-CoV-2 was not spread by the airborne

route, nor sufficient scientific justification to make some of the other consequential decisions.

In that context, it was therefore wrong, we say, in March 2020 to remove SARS-CoV-2's status as a high-consequence infectious disease and, on the very same day, to downgrade protective equipment for healthcare workers from effective respiratory protective equipment, or RPE, to FRSMs, save in relation to some particular specific medical procedures which were arbitrarily classified as aerosol generating procedures.

Essentially, my Lady, the failure either to recognise the airborne route or to apply the precautionary principle in the formulation of infection prevention and control guidance had profound implications for the safety of patients and healthcare workers and the future of the NHS more generally.

This failure is most stark in the context of IPC cell guidance which, contrary to other government and public health bodies' eventual recognition of the airborne route of transmission, has never recognised this route of transmission nor recommended appropriate RPE for healthcare workers caring for infectious patients.

It seems to CATA that all of this likely arose from a lack of resources. CATA's very concerned about this,

as is a large percentage of those who worked in the healthcare centre during the pandemic, and CATA asks that this issue is fully, rigorously and courageously explored.

CATA repeatedly tried to engage with governmental institutions and public bodies on this and other questions throughout the pandemic, but was routinely ignored or treated as an inconvenience, despite a large membership and wealth of expertise, and the lack of transparency and stakeholder engagement in such processes resulted in widespread confusion and frustration in the healthcare sector. It even led to some member organisations having to take it upon themselves to devise their own guidance to assist their concerned members.

So CATA therefore asks the Inquiry to uncover the manner in which the IPC cell guidance was produced. It's a process that until now remains shrouded in secrecy, and the relevant minutes of meetings and so on remain unpublished.

So on the topic, you've heard other submissions today which are welcomed by CATA from, for instance, the Royal College of Nursing, the TUC, FEHMO and others, about RPE and its suitability, and of course CATA agrees with Mind, FEHMO and the Frontline Migrant Health

Workers Group that Covid and measures to combat it impacted different racial groups differentially.

One key issue which we say will need to be looked at carefully was the failure to provide RPE suitable for all persons irrespective of their ethnicity, gender or other characteristics. We've made some submissions in our written submissions at around paragraph 21 in relation to things such as different types of faces and sizes and so on, but essentially CATA's submission is that the procurement and provision of suitable RPE was not properly managed with regard to the diversity of the healthcare workforce.

The inadequacy of protective equipment features along another central concern of CATA, namely the reporting by healthcare workers -- or the non-reporting, as it may be more appropriately described -- under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013, or RIDDOR.

The Inquiry has agreed to investigate this, and CATA considers that an important area of investigation because, in its experience, there was a gross under-reporting under RIDDOR of healthcare worker contracted Covid-19 illnesses and deaths; and this under-reporting was not due to the healthcare workers themselves not raising it, it is to do with the

circumstances created by situations in the health service and attitudes taken to the relevant law.

It is known that there were amendments to the law relating to coroners' inquests for Covid-19 which essentially removed a level of judicial scrutiny for certain deaths.

That approach was also applied in relation to RIDDOR, and there was a radical and, CATA would submit, egregious departure from existing health and safety law. Healthcare workers were told that it was not necessary to report Covid-19 infections for various reasons, for instance, the suggestion that RIDDOR would not apply because their trusts were complying with government guidance, or that workers were being given adequate PPE.

CATA says this was and remains incorrect, both factually and practically, and was not in compliance with the law.

There are also other ways in which Covid-19 illnesses and deaths have been under-reported, for instance, the imposition of an artificially high standard of proof in relation to the source of the infection and the expectation that people would be required to proof that this had been contracted at work.

CATA has serious concerns about maladministration at the highest levels of public health and policy apparatus

in the application or disapplication of health and safety legislation during the pandemic. Some of those have in fact already been aired during a BBC Panorama investigation, but CATA submits that the Inquiry will need further to investigate whether health and safety standards were ditched and, if so, why, if it is to discharge its function sufficiently.

Now, this is an ongoing issue, because the disapplication of health and safety standards has and will continue to have a profound impact on society at large. The lack of data collected about healthcare worker illnesses and deaths contracted at work due to this under-reporting means that the extent of the impact of the pandemic on healthcare workers was hidden. This affected their ability to respond during the pandemic, and hinders planning and preparedness for future pandemics.

Additionally, my Lady, it's also a matter of justice for healthcare workers. Many suffered serious financial detriment from contraction of the Covid-19 virus while working on, essentially, the frontlines to protect the public during the most severe national emergency since the Second World War.

The failure to record healthcare workers' infections with Covid-19 while at work could limit their routes to

potential compensation, and for many healthcare workers this is already a real and present issue. For example, some are struggling to obtain sick pay, or payments under the NHS Injury Allowance insurance scheme, which tops up NHS workers' pay to 85% of their salary for a year where on long-term absence from work due to accident or disease.

LADY HALLETT: Mr Simblet, I appreciate you're speaking really quickly to try and get through it. You're already over time, I'm afraid. I'm going to have to ask you to speak more slowly and to finish now.

MR SIMBLET: Yes, I'm pretty well at the end.

LADY HALLETT: Thank you.

MR SIMBLET: Thank you, my Lady.

CATA endorses the proposal made by the RCN for a compensation scheme and the suggestions that we've heard today about long Covid being recognised as a disability under the Equality Act.

So, finally, if I can make a couple of points in relation to the use of experts. CATA has previously suggested potentially suitable experts. It would be interested in assisting the Inquiry further in relation to the composition of the expert panel and the instructions they are given, and we will be making our own representations after today on those sorts of

topics. But I hope, my Lady, that you will see that CATA engages constructively with the Inquiry and will be keen to assist it as far as it possibly can.

LADY HALLETT: Thank you, Mr Simblet, and thank you for the offer of assistance.

Right, Diya Sen Gupta KC. There you are.

Submissions on behalf of the Frontline Migrant Health Workers Group by MS SEN GUPTA KC

MS SEN GUPTA: Good afternoon, my Lady.

I appear on behalf of the Frontline Migrant Health Workers Group, together with my learned friend Piers Marquis. We are instructed by the Public Interest Law Centre.

Our clients are very grateful to have been granted core participant status by your Ladyship. This is the first occasion on which our clients have made oral submissions as part of this module. Accordingly, we take this opportunity to introduce our clients and to identify their key interests before we make brief submissions on: one, the scope of Module 3 and the provisional list of issues; two, expert evidence; three, Rule 9 requests; and, four, witness evidence.

First, our clients. The Frontline Migrant Health Workers Group is a collective group of two trade unions, United Voices of the World, UVW, and Independent

Workers' Union of Great Britain, IWGB, and a consortium of community organisations, Kanlungan. They have joined together for the purpose of participation in Module 3 of this Inquiry.

Kanlungan is a charitable incorporated organisation representing a consortium of Filipino, South East and East Asian grassroots community organisations. They work closely together for the welfare and interests of migrants, refugees and diaspora communities from those regions living in the UK.

Kanlungan members work across the healthcare sector as nurses, cleaners and domestic healthcare staff. In May 2020, about 20,000 Filipinos worked for the NHS. They were the largest national group after British and Indian workers. Despite comprising only 3.8% of the nursing workforce, by May 2020 Filipinos accounted for 22% of Covid-19 deaths among nurses.

The IWGB is a non-TUC affiliated national trade union founded by Latin American cleaners in 2012. They have membership across a number of sectors, including couriers, cleaners, porters, security officers and private hire drivers. Many of their members work in outsourced positions within the healthcare sector. Members are overwhelmingly working class and from black, Asian and minority ethnic backgrounds, in low paid and

precarious employment.

The IWGB has been at the forefront of organising previously unorganised workers. Over a decade of action, advocacy and campaigning, they have become a leading grassroots trade union.

UVW is a non-TUC affiliated national trade union which organises low paid, migrant and precariously employed workers on short-term contracts or working in the gig economy. Its members include cleaners, security guards, caterers and porters in the NHS across at least ten London hospitals, as well as others across England. Most of their healthcare members are outsourced workers serving the NHS. Where members are employed directly by the NHS, this has often been the result of industrial action organised by the union to bring workers in-house.

All three organisations represent precariously employed, frontline, predominantly migrant workers. Many of those members are outsourced and subcontracted key workers without the contractual protections of NHS employed staff. Their members consist of the unseen and the unheard.

All three organisations campaigned throughout the pandemic in order to protect their members.

All three organisations thank your Ladyship for

acknowledging that as well as doctors and nurses, non-clinical support workers such as outsourced hospital cleaners, porters and medical couriers played an important role in the healthcare response to the Covid-19 pandemic. Your Ladyship's acknowledgement of their importance by granting them CP status is a key first step for the group. As a result of your Ladyship's ruling, our clients' members will be seen and will be heard by this Inquiry.

Second, key areas of interest. We submit that an examination of the key systemic issues that detrimentally impacted on the resilience of the healthcare system is vital to fulfilling the Inquiry's statutory role. Our clients are profoundly concerned about the detrimental impact that systemic issues had and continue to have on healthcare provision and the working conditions of their members.

Those systemic issues of particular concern to our clients are chronic underfunding of the NHS, outsourcing and the impact of privatisation, hostile environment immigration policies, inadequate sick pay provision, and structural racism.

We submit that a thorough and critical examination of those systemic issues is essential for the Inquiry to fulfil its aim of informing preparations for future

pandemics across the UK. It is against that background that we make our submissions.

Topic 1, scope and provisional list of issues.

We're grateful to CTI for providing a provisional list of issues, and also her clarification today regarding scope. We had made some important observations on the list in our written submissions, which seem to have been accepted by CTI.

Crucially, we understand that version 2 of the list will now expressly refer to non-clinical support staff. The words "non-clinical" would include those such as hospital porters, hospital cleaners, catering workers and medical couriers, whose contributions to healthcare are all so vital and who were hugely impacted by the pandemic.

We submit that this will need to be reflected throughout version 2, including at issues 1, 3, 7, 8 and 10 of the current draft.

We were concerned that, without specific reference to non-clinical staff, there was a risk that our clients' members may become an afterthought, as they were during the pandemic. We're grateful to CTI for clarifying that there will be express reference to non-clinical staff in version 2.

Also in relation to the provisional list of issues,

we had raised the issue of migrant domestic healthcare workers being considered in Module 3. We understand from CTI's opening this morning that they will be considered as part of Module 6. We shall be grateful for confirmation of this. Our clients' main concern is ensuring that these domestic workers and the crucial role they played are not overlooked as part of this Inquiry.

Our final observation on the provisional list of issues is its use of the terms "staff", "healthcare staff" and "healthcare workers". We understand the Inquiry team is using these terms interchangeably to include those directly employed by the NHS, as well as those who were not so directly engaged, ie outsourced workers.

As your Ladyship has already recognised, all individuals who contribute to the work of the NHS, whether directly employed or outsourced workers, are essential to its efficacy. When considering the impact of the pandemic, it is vital that the Inquiry considers and reports on the impact on all those working in a healthcare setting, and we should be grateful for clarity in version 2 of the list of issues to ensure that it expressly includes outsourced workers, as we understand is intended.

Those are our submissions on scope and the provisional list of issues. My remaining topics are much shorter.

Topic 2, expert evidence.

My Lady, we're grateful to CTI for the information provided thus far with regard to expert evidence in this module, and we understand that the scope of expert evidence is still under review. We take this opportunity to submit that this Inquiry would be greatly assisted in Module 3 by expert evidence on outsourcing and the impact of privatisation in the NHS, and the impact of hostile environment immigration policies on healthcare services. These are complex areas of law and policy that require significant technical understanding to properly assess their impacts, and we submit that these matters cannot properly be considered without the benefit of expert evidence. Your Ladyship may already be in the process of instructing experts in these areas, but if not, we invite consideration on the subject by your Ladyship.

Topic 3, Rule 9 requests.

As your Ladyship will be aware, we have responded to the Inquiry's Rule 9 request and await any comments from the Inquiry team on our draft response.

Topic 4, witness evidence.

Where possible, our Rule 9 statement has addressed the concerns of members using those members' own accounts of their frontline experiences during the pandemic. Like the TUC, we emphasised the importance of the Inquiry hearing directly from individuals who worked on the frontline. We're grateful to CTI for confirming that the public hearings will include hearing evidence from those working within the healthcare system.

My Lady, in conclusion, the Frontline Migrant Health Workers Group regard this Inquiry as vitally important to their members and to the future of the NHS. Many of the systemic issues that the group's members faced during the relevant period still persist.

Your Ladyship's report will include an essential analysis of these issues. Your Ladyship's recommendations will be crucial in addressing them so that our healthcare system is prepared for future pandemics.

We're very grateful to your Ladyship and the Inquiry team for all your work, and will continue to assist the Inquiry in whatever ways we can.

My Lady, those are our submissions, unless I can be of any further assistance.

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

MS SEN GUPTA: Thank you, my Lady.

LADY HALLETT: Right, Mr Jory, are you still there? You've been waiting patiently all day. I'm really sorry about the length of time you have had to wait. The order of speakers is nothing to do with the order of importance, I promise you.

Submissions on behalf of the Independent Ambulance Association by MR JORY KC

MR JORY: Well, I understood they were saving the best to last, so I'm not offended, thank you. That's what I like to think, anyway.

My Lady, briefly, I can address you briefly in terms of our representations. I represent or act on behalf of the Independent Ambulance Association. We've made written submissions, which you will have. I'm going to refer to the IAA, rather than the longer term. I confine my brief submissions to the provisional list of issues.

Now, I'm aware that not many people know or perhaps have heard of the IAA. It is a not for profit trade association which represents independent ambulance providers across the UK. They are regulated by the Care Quality Commission. There are currently 50 member organisations within the IAA. They range from small companies, some with fewer than ten employees, some

employing over 500 staff.

Now, each year the NHS funds the transport of between 11 to 12 million patients. More than half of all those patients -- patient transfers are provided by independent ambulance providers.

So, just to repeat, more than half of all NHS patient transfers are provided by independent ambulance providers.

Now, during the Covid-19 pandemic, the NHS's reliance on those independent ambulance providers increased dramatically. There was a significant and wholly unforeseen increase in demand for non-emergency transport service providers to pivot to prioritise Covid patients and emergency services. As a consequence of this, the IAA members have gained extensive first-hand experience of the impact of Covid-19 on patients and staff, and the many issues this presented.

My Lady, we've provided you with a written document. Can I just highlight, please, the two discrete areas we wish to draw your attention to, and I'm going to paragraph 6 of our submissions. We invite the Inquiry team to consider the following amendments to the provisional list of issues.

If you go to issue or provisional issue 4A, we make a suggestion:

"We suggest that either issue 4A3 be extended or a further subheading be added to consider systems in place, to address variations in demand for ambulances, including for non-emergency patient transport services."

The reason we suggest this is that one of the main concerns identified by our many thousands of members is the lack of a comprehensive and clear line of communication between stakeholders in advance of significant changes in demand, and that resulted in uncertainty among our members and a simple inability to adjust and adapt effectively.

One suggestion put forward by our group is the introduction of a permanent national team within the NHS to provide oversight and leadership for non-emergency patient transfer services, and we believe that would go some way to providing a remedy for that particular problem.

The second recommendation or suggestion we advance at this stage is to consider a further subheading under issue 4A, namely classification and clarification of key worker status for ambulance/healthcare employees.

Now, what we've found from our discussions with our members is that many of the members faced difficulties arising from the ambiguity in the application of key worker status and the delay in clarification or

extension of that category.

There was a perception the government was slow and possibly reluctant to assign key worker status to non-NHS staff, and that put, frankly, staff employed by IAA members in a very difficult position, because on the one hand they were keen to work to combat the early impact of the pandemic, but they were disadvantaged in terms of accessing the vaccines, PPE, testing and priority shopping, as well as facing a dilemma in making personal choices about what legally they could do, and that inevitably occupied the time and minds of staff who should have been and wanted to be focusing on providing support to healthcare services at an important and worrying time.

So, in summary, at this stage, my Lady, those are my brief submissions.

LADY HALLETT: Thank you very much indeed for your help, and apologies again that you've waited so long.

Ms Carey, any remarks by way of reply?

Reply statement by COUNSEL TO THE INQUIRY

MS CAREY: My Lady, just a few, if I may.

May I start with an apology to Ms Davies for misattributing to Mind the request that Module 3 considers dementia, which should have been correctly attributed to the John's Campaign. That was my fault,

and I'm sorry to both core participant groups.

May I just make two matters clear by way of reply. This is not a case where Module 3 is using inpatient child and adolescent mental health services to extrapolate into a wider look at mental health services, and it may just be worth for a moment me explaining publicly why the four non-Covid conditions were picked.

Colorectal cancer is the second most common cause of cancer death in the UK, and ischaemic heart disease is an example that we thought an appropriate way to look at serious chronic conditions that might require acute medical intervention. Hip replacements is not just a matter that affects the elderly, my Lady, but an example of a common elective surgery which has real debilitating effects for those that can't walk, can't get around, and become generally unable to move about.

My Lady, inpatient child and adolescent mental health services was selected as a way of focusing on the impact of the pandemic on inpatient services; and looking at children and young people who are deemed to be acutely unwell and at the greatest risk of rapidly declining mental health or serious self-harm, we submit, my Lady, that really feeds into your pronounced determination to look at the impact on children and young people. And that is why we are looking at those

mental health conditions and those non-Covid conditions: not to try and extrapolate from that wider learning and understanding, but to allow you to look at a broad spectrum of patients in terms of age, sex and background, and treatment that covers primary, secondary and tertiary care; and I hope that brief explanation makes it clear why we are looking at those matters.

My Lady, finally this: you have heard today a number of submissions that spoke of the powerful evidence that you've already heard by those who experienced the human impact of the pandemic. May I therefore publicly reiterate Module 3's commitment to hearing evidence from the bereaved, from patients and from healthcare workers in the public hearings. We are very grateful and welcome the offers of assistance made to date and those made today to help identify those witnesses.

As to all the other matters that you have been addressed about, they require reflection by the legal team, and so I don't propose to address you about them today. I know there will be particular submissions that you will want to consider carefully, and so I'd ask you to do so, not this afternoon but in the fullness of time.

LADY HALLETT: Save for one. Is there nothing to object to my ordering publication of the submissions online?

MS CAREY: No, we wouldn't object to that at all.

LADY HALLETT: Very well, I so order.

Thank you, Ms Carey. Thank you very much, everybody else. As ever, submissions have been extraordinarily helpful and a great deal of food for thought, and I will give very careful consideration to these issues, along with seeking advice from my team.

So, thank you, until we meet again.

(4.25 pm)

(The hearing concluded)

INDEX