

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

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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 Metzger 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

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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

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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

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

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

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

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

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1 which I will return to shortly. And almost all of the  
2 36 core participants in Module 3 have received a Rule 9  
3 request, and indeed many have already supplied draft  
4 statements for which the legal team is very grateful for  
5 their prompt response. Those who have not yet received  
6 a Rule 9 will be getting one in the next phase of  
7 Module 3's work.

8 Out of the 127 requests, 66 statements are currently  
9 being reviewed and finalised, and in addition last week  
10 five statements were disclosed and there are a further  
11 16 statements that have been signed and are being  
12 progressed for disclosure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 NHS Wales Microsoft 365 email service. In short, at the  
2 beginning of August this year, the Inquiry was informed  
3 that Digital Healthcare Wales, DHCW, had in February of  
4 2023 discovered that email mailboxes and all the  
5 contents stored in those mailboxes, so not just the  
6 emails but calendars, contacts, notes and the like, for  
7 people who had left an NHS organisation or had left  
8 an NHS organisation to join another NHS organisation  
9 within Wales, were deleted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 Is my Lady struggling to find it?

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

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

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

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1 systems in other countries responded to the pandemic.

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

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

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

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1 services, CAMHS or CYMPHS for short, is too narrow.  
 2 Mind submits that the module should include  
 3 consideration of CAMHS within the community.  
 4 Now, amongst other issues, Module 3 will examine  
 5 the impact of the pandemic on referrals and admissions  
 6 to in-patient CAMHS, including the reasons for those  
 7 changes, and that will encompass the consequences of  
 8 reduced access in the community for children and young  
 9 people, and so, to that extent, CAMHS within the  
 10 community will be considered within Module 3.  
 11 Mind also submits that Module 3 should look at  
 12 mental health services more widely. My Lady, whilst  
 13 undoubtedly important, we submit that this is one of  
 14 those areas where a difficult decision has had to have  
 15 been made not to look at broader issues of children's  
 16 mental health in the community or wider mental health  
 17 services within the UK's healthcare system. We submit  
 18 that Module 3 should focus on a discrete section of  
 19 acute mental health services for children in the  
 20 four nations, which will enable a suitably detailed  
 21 examination of this area of mental health, whilst  
 22 ensuring a proportionate focus on non-Covid conditions  
 23 is maintained. But, again, I know that you'll want to  
 24 consider any supplementary oral submissions about that  
 25 topic.

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1 not asked to assist in this task, but once the report is  
 2 prepared in draft, the draft copy will be sent to  
 3 core participants for their observations so that content  
 4 that needs either amplifying or clarifying can be  
 5 incorporated before the final version is disclosed.  
 6 So, in addition to the Rule 9s and the disclosure  
 7 that's been made to date, and dealing with each of the  
 8 experts in turn, in relation to long Covid the Inquiry  
 9 has instructed Professor Chris Brightling and  
 10 Dr Rachael Evans, experts in long Covid, to prepare  
 11 a report in relation to both Module 2 and Module 3. The  
 12 report was divided into topics of general applicability,  
 13 such as understanding the emergence of long Covid, and  
 14 topics which are more specific to Module 3, such as the  
 15 treatment of long Covid.  
 16 Given the imminent start of Module 2, the first part  
 17 of the report has already been sent to the  
 18 core participants in Module 2 and will be disclosed to  
 19 Module 3 core participants. The Module 3 section is  
 20 nearing completion, and will be sent to Module 3  
 21 core participants for their input, queries and comments  
 22 to be considered.  
 23 The second expert report is in relation to critical  
 24 care for patients with Covid-19, and in this regard  
 25 the Inquiry has instructed Dr Ganesh Suntharalingam and

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

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

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

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

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

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

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

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

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

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

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

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

25

1 an associate professor at the Radcliffe Department of  
2 Medicine.

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

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

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

27

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

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

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

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

26

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

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

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

28

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

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

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

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

29

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

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

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

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

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

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

30

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

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

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

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

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

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

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

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

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

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

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

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

35

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

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

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

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

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

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

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

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

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

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

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

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

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1 preliminary hearing.

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

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

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

39

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

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

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

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

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

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

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

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

14 **MS MUNROE:** Yes.

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

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

40

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

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

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

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

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

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

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

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

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

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

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1 they will add value to this module.

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

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

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

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

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

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

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

25 Three, scheduling and timetable. We addressed these

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1 at paragraphs 31 to 40 of our written document.  
 2 My Lady, I've heard what has just been said about  
 3 timetable, and of course there's a balance to be struck  
 4 between having an Inquiry of an appropriate length, but  
 5 also concluding and reporting as swiftly as possible,  
 6 because there is a pressing need to make changes. This  
 7 country must prepare itself for the next and sadly  
 8 inevitable pandemic, and we need this Inquiry to report  
 9 as soon as possible.

10 Against that, however, we say it is also vital that  
 11 the Inquiry has sufficient time to examine and  
 12 scrutinise those relevant matters and answer, as far as  
 13 it is possible, the questions it poses itself. To do  
 14 that effectively, it will be necessary to consider  
 15 matters in as much depth and in as much detail as  
 16 necessary. It is important that the conclusions and  
 17 recommendations are informed and evidence based. The  
 18 better the evidence, the better the conclusions, the  
 19 better the recommendations.

20 The families are at the front and centre of this  
 21 Inquiry, as has been said many times. It was their  
 22 campaigning that in many respects brought about this  
 23 Inquiry. They want to make sure that it has teeth, and  
 24 that it has a lasting legacy. We, on their behalf,  
 25 likewise, want to make sure that the integrity of this

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1 sadly, many of the survivors of the care homes may not  
 2 be with us in four to five years' time.

3 **LADY HALLETT:** Ms Munroe, I'm entirely sympathetic to that.

4 Of course I appreciate and understand it, but one of the  
 5 problems that I think maybe some people haven't really  
 6 considered is the demands that the Inquiry is making on  
 7 material providers, and when you have modules that are  
 8 health related or care related, the demands are going to  
 9 be on the same providers, and it's really a case of  
 10 what's doable. But, I mean, obviously I always bear in  
 11 mind your submissions, they're always helpful, but it is  
 12 extraordinarily difficult. We have heard this morning  
 13 the difficulty in getting material from some providers.  
 14 So I do understand, of course I do, and I have looked  
 15 into it several times, but there are restrictions on me  
 16 that I haven't placed there.

17 **MS MUNROE:** My Lady, yes.

18 **LADY HALLETT:** But obviously I will bear everything you say  
 19 in mind with great care.

20 **MS MUNROE:** I'm grateful, thank you.

21 Fourth topic point, experts. Again, we set out in  
 22 our written submissions at paragraphs 16 to 17 in detail  
 23 what we say about that. Suffice to say this: given that  
 24 healthcare is a devolved matter, we say there is also  
 25 a need for independent experts who understand the state

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1 Inquiry is at its highest. We do not want to see  
 2 a situation whereby post-publication the recommendations  
 3 are kicked into the long grass by the government, or  
 4 that the Inquiry, like many before it, is consigned to  
 5 be known by the name of its Chair rather than by the  
 6 contents of its work and the changes it can make.

7 So that is why we say it is so important to have  
 8 sufficient time to hear the evidence and that it is done  
 9 with sufficient detail. We want there to be a realistic  
 10 timetable, and we simply say -- and we set out very  
 11 detailed calculations, but we simply say, to put it  
 12 simply, that ten weeks is not enough, and we would  
 13 invite you, my Lady, and the Inquiry team to carefully  
 14 consider both the oral and written submissions we make  
 15 about the time.

16 In terms of sequence, even if Module 4 takes place  
 17 before Module 3, we do urge the Inquiry to list  
 18 Module 6, social care, to be directly after Module 3,  
 19 thereby effectively leapfrogging Module 5, on  
 20 procurement.

21 Our submission in that respect is simple. Waiting  
 22 four or perhaps five years after what our families see  
 23 as the scandal of the care homes of spring 2020 would be  
 24 a failure to ensure speedy justice, and it would be  
 25 letting the families down. Also, to put it bluntly, and

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1 of individual healthcare systems before and during  
 2 the pandemic and that they should be instructed by  
 3 the Inquiry.

4 Our colleagues from Northern Ireland will be making  
 5 further submissions in due course, generally and  
 6 specifically on this point, I defer to them, but in  
 7 advance I also endorse and adopt their submissions.

8 My Lady, you will remember perhaps another thing  
 9 that came out very starkly from Module 1 was  
 10 Northern Ireland, as a nation, how that nation is  
 11 treated, how that nation is perceived, and the different  
 12 treatment of the people of Northern Ireland, and the  
 13 different systems that operate. It's complicated, but  
 14 it's important to bear that in mind, and, as I say, my  
 15 colleagues will in due course make further submissions.

16 In terms of the critical care experts, we set out at  
 17 paragraphs 18 to 21 of the written submissions our  
 18 thoughts there.

19 My Lady, I'm grateful for what has been said this  
 20 morning about those two experts, who of course are  
 21 hugely experienced and have great expertise in their  
 22 areas. We make the simple point that independence of  
 23 expert witnesses is obviously a crucial aspect of  
 24 ensuring that their reports have integrity and value,  
 25 and one doesn't want there to be the perception that any

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1 expert witness would lack independence as an expert.

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

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

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

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

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

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

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

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

17 **MS MUNROE:** Thank you.

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

21 (11.41 am)

(A short break)

23 (11.55 am)

24 **LADY HALLETT:** Yes, Ms McDermott.

25 **Submissions on behalf of Northern Ireland Covid Bereaved**

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

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

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

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

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#### **Families for Justice by MS McDERMOTT**

2 **MS McDERMOTT:** Good morning, my Lady.

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

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

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

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

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

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

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

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

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

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1 instructions on how and when it should be used.

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

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

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

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

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

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

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

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

4 By way of examples, two sisters have shared their  
5 account of how their mother tested positive for Covid on  
6 31 March and died on 7 April 2020. They comment:

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

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

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

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

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

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

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

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

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

25 Unless, my Lady, there are any matters on which

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

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

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

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

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

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

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

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

8 **Submissions on behalf of Scottish Covid Bereaved by**  
9 **MS MITCHELL KC**

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

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

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

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

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

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

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

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

25 Number two, disclosure. We have now started to  
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1 that Microsoft 365 email system may have had some kind  
2 of issue with the retention of emails.

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

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

21 The Scottish Covid Bereaved members of course have  
22 family members that were impacted by other matters than  
23 the pandemic per se, and of course we appreciate  
24 the Inquiry cannot examine every distinct non-Covid  
25 condition. However, we are heartened to hear this  
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1 receive disclosure, as of last week, in relation to this  
2 module, and we are disappointed this morning to  
3 understand that the reason that there is perhaps so  
4 little disclosure to date is because of the delays in  
5 respect of the Rule 9s.

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

23 Three, the issue of the retention of evidence. The  
24 Scottish Covid Bereaved note that it's been identified  
25 in relation to the retention of emails within NHS Wales  
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1 morning that the request from the Scottish Covid-19  
2 Inquiry that the issues of maternity and antenatal care  
3 may be expanded to include those issues in relation to  
4 women who suffered miscarriage, and we would urge  
5 the Inquiry to consider that in some detail, including  
6 the care and the services provided to women at that time  
7 and how that was impacted by the pandemic.

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

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

18 There may be differences between the healthcare  
19 systems and how matters are dealt with between Scotland  
20 and England, of course Scotland having its own  
21 healthcare system. We note that Counsel to the Inquiry  
22 has stated that the reports will address all  
23 four nations, but we flag up at this stage that  
24 the Inquiry may benefit from the expertise of those in  
25 Scotland. If it may be that Dr Suntharalingam and  
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1 Dr Summers are not in a position to comment on certain  
2 matters as they arose in NHS Scotland, we would ask that  
3 the Inquiry consider instructing a report from suitably  
4 qualified people with experience of practice in Scotland  
5 to produce reports to assist the Inquiry.

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

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

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

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

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

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

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

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

10 Thank you very much.

11 **MS MITCHELL:** I'm obliged, my Lady.

12 **LADY HALLETT:** Right.

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

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

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

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

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1 staff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Diolch am wrando. Those are my submissions,

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1 my Lady.

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

4 Mr Metzger, I think you're attending remotely.

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

7 **MR METZER:** Yes, thank you, my Lady.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 Do I need to repeat anything?

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

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

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

14 **MR METZER:** Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 **LADY HALLETT:** No, thank you very much indeed, Mr Metzger,  
2 very grateful.

3 **MR METZER:** Very grateful, my Lady.

4 **LADY HALLETT:** Right, Mr Wagner.

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

8 **MR WAGNER:** Thank you, and good afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Second on the list of issues, we submit that

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

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

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

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

25 We note the helpful suggestion from the Scottish

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

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

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

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

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

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

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

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

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

25 Thirdly, we agree with the submissions of

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

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

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

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

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

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

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

24 Those are my submissions for the PBPOs.

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

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

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

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

9 (12.58 pm)

10 (The short adjournment)

11 (1.50 pm)

12 **LADY HALLETT:** Mr Wagner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 As you know, Chair, the Inquiry produced

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

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

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

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

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

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

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

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

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

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

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

19 **LADY HALLETT:** Thank you very much. Understood.

20 **MR WAGNER:** I'm grateful.

21 **LADY HALLETT:** Thank you, Mr Wagner.

22 Mr Straw, I think you're over there.

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

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

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

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

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

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

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1 **MR STRAW:** Thank you.

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

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

- 8 A. The list of issues.
- 9 B. The overlap of this module with Module 6.
- 10 C. Evidence.

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

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

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

25 Now, many people received very important healthcare

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

8 The importance of healthcare outside the clinical  
9 setting might be illustrated by statistics. So,  
10 for example, the King's Fund identified excess home  
11 deaths, so the number of home deaths additional to what  
12 would normally be expected, in the period from  
13 14 March 2020 to July 2022 as being 100,000, but only 3%  
14 of those were from Covid. What that suggests is that  
15 the restrictions put in place as a response to Covid  
16 were responsible for some 97,000 additional home deaths  
17 during that period.

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

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

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

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

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

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

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

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

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

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

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

5 So that's issue A.

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

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

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

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

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

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

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1 submissions, makes clear, care and healthcare for  
 2 dementia are inseparable, they are the same thing.  
 3 Pick the example of infection control. Infections  
 4 for dementia sufferers are one of the biggest causes of  
 5 death. How infection control is effectively delivered  
 6 is a mixture of care and healthcare. So checking the  
 7 patient for sores, communicating with the patient  
 8 effectively, in particular those who lack capacity,  
 9 moving the patient to prevent sores developing, applying  
 10 treatment and medication. Again, they're part and  
 11 parcel of the same thing.

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

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

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

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

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

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

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

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

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1 care.

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

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

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

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

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

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

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

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

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

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

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

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

25 My Lady, topic C, and this is a short topic, is  
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1 investigation of the additional issues which we have  
 2 identified in our submissions is critical to the proper  
 3 examination of the pandemic on healthcare.

4 Those are my submissions.

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

15 **MR STRAW:** Thank you.

16 **LADY HALLETT:** Thank you.

17 Ms Davies.

18 **Submissions on behalf of Mind by MS DAVIES**

19 **MS DAVIES:** Thank you.

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

25 I want to divide my submissions into three points:  
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1 evidence. In our written submissions we've invited  
 2 the Inquiry to instruct an expert about the critical  
 3 role of carers in healthcare, and in particular the  
 4 impact of the pandemic and the response on healthcare  
 5 provided by carers and on the carers themselves. We'd  
 6 be very happy to identify particular experts if that  
 7 would help.

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

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

23 So, in conclusion, my Lady, we readily recognise  
 24 the Inquiry has a huge amount of work to do in this  
 25 module, but we respectfully submit that the  
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1 the general importance of the treatment of mental health  
 2 problems, the weight of mental health services within  
 3 the NHS estate; why you cannot study CYP in patients,  
 4 even in detail, and then extrapolate that to understand  
 5 what happened in the rest of mental health services; and  
 6 addressing Rule 9 and experts to the Inquiry.

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

13 So to put things in context I think, you know,  
 14 I myself have worked in the mental health service for  
 15 32 years, equally split between being a clinician and  
 16 a lawyer, and we have always been called the Cinderella  
 17 service. But public attitudes have moved on enormously  
 18 in just the space of a generation. Just recently  
 19 a retiring director told us the story of companies who  
 20 would donate to Mind as long as their names didn't  
 21 appear in the annual report and that people did not  
 22 associate them with mental health problems. But on  
 23 5 September, The Times reported that only one in five  
 24 people felt that mental health services were performing  
 25 well, and the majority of those under 40 considered  
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1 mental health as a higher political priority than crime,  
 2 climate change or the war in Ukraine.  
 3 Not just Mind but the British public are at risk of  
 4 being left feeling short changed by the Inquiry if it  
 5 does not investigate what happened to the mental health  
 6 of the nation and why mental health services, much  
 7 weakened since 2010, were not near to meet the needs of  
 8 the population.

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

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

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

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

24 So we say, even with a detailed look at in-patients,  
 25 where you're fundamentally working on a community care  
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1 under 18s. That figure now stands at over 2 million.

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

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

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

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

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

19 So far the Disabilities Charities Consortium has  
 20 been asked for a statement on mental health which, for  
 21 the purposes of this Inquiry, does not contain a mental  
 22 health charity. We are the only mental health charity  
 23 that is a core participant in this Inquiry, and  
 24 therefore we say we can assist the Inquiry by providing  
 25 a Rule 9 statement.  
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1 This is why we also say that an expert is needed on  
2 mental health. We understand you can't look into every  
3 corner, but an expert on mental health services would be  
4 precisely there to guide the Inquiry as to the pertinent  
5 places that would be most useful to the Inquiry in the  
6 matter of mental health care.

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

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

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

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

23 **LADY HALLETT:** I can see you're not going to give up,  
24 Ms Davies, and the mental health services are very  
25 fortunate to have you as an advocate, so thank you very  
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1 practice, and what needs to be learnt.

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

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

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

25 It was a burden that may not have been distributed  
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1 much indeed.

2 **MS DAVIES:** Thank you.

3 **LADY HALLETT:** Right.

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

6 **Submissions on behalf of the Trades Union Congress by**  
7 **MR JACOBS**

8 **MR JACOBS:** Maybe not quite as fortunate.

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

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

23 My Lady, that is very welcome indeed. Such evidence  
24 frames the perspective of the Inquiry. It illuminates  
25 which policies were effective and which floundered in  
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1 equally amongst the workforce. Significantly, the NHS  
2 did not have the preparedness to make those changes in  
3 a fair or equitable way across trusts and the  
4 uncertainty compounded the challenges faced by staff.

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

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

20 The experience of the TUC unions was that outsourced  
21 services were beyond the effective control of system  
22 leaders, with implications for infection prevention. We  
23 note that some of the practical experiences of that are,  
24 in our view, powerfully articulated in the submissions  
25 of the Frontline Migrant Health Workers Group.  
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1 My Lady, thirdly, disparities in death rates. The  
2 list of issues includes the numbers of patients and  
3 staff who died from Covid-19. We ask that the list of  
4 issues includes reference to disparities in death rates  
5 in protected and vulnerable groups, and the reasons for  
6 those disparities, including the extent to which they  
7 were contributed to by individual and structural racism.

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

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

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

5 My Lady, unless I can assist further.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 Those are my submissions, my Lady.

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

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

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

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

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

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

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

6 **MR STANTON:** Thank you, my Lady.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Evidence has also emerged of the serious impact of

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

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

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

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

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1 to prepare for the future.

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

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

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

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

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

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

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

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1 inclusion, both of which are supported by the RPS.

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

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

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

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

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

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1 who die in service to our nation and are doing  
 2 everything we can to protect them.  
 3 "Financial worries should be the last thing on the  
 4 minds of their families so in recognition of these  
 5 unprecedented circumstances we are expanding financial  
 6 protection to NHS and social care workers delivering  
 7 publicly funded care on the frontline.

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

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

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

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

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1 the following ways:

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

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

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

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1 service benefits."

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

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

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

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

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

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

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

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

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

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

24 My Lady, finally the British Medical Association.

25 **LADY HALLETT:** You're getting close to your allotted time,  
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1 departments and agencies, including the Department of  
2 Health and Social Care, NHS England and the Health and  
3 Safety Executive, to consider whether they should have  
4 done more to support employing organisations to both  
5 understand and fulfil their obligations in the context  
6 of Covid-19.

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

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

20 Regarding the failure to adequately stockpile  
21 respiratory protective equipment, RPE, the BMA welcomes  
22 the Inquiry's intention to examine the availability and  
23 adequacy of protective equipment within issue 8, and is  
24 pleased to note the clear distinction drawn within  
25 the provisional list of issues between personal  
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1 Mr Stanton.

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

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

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

23 This legal obligation to undertake risk assessment  
24 rests with employers. However, in the BMA's view, it is  
25 important to also investigate the role of key government  
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1 protective equipment and respiratory protective  
2 equipment.

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

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

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

22 This is because it's the BMA's position that  
23 the stockpile of RPE and the supplies that healthcare  
24 workers relied upon were not properly constituted in  
25 accordance with scientific understanding from at  
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1 least 2008. That is, we started off from a point that  
2 was not in accordance with the scientific understanding  
3 about how healthcare workers should be protected from  
4 aerosol transmission.

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

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

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

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

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

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

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

19 My Lady, it bears saying, as an introduction, that  
20 the first ten doctors to die from coronavirus were from  
21 black, Asian and minority ethnic backgrounds. In  
22 an article entitled "UK Government urged to investigate  
23 coronavirus of BAME doctors" in The Guardian on  
24 10 April 2020, the head of the British Medical  
25 Association called on the government to urgently

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1 because issues of costs were prioritised over safety.

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

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

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

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

23 (3.15 pm)

(A short break)

24 (3.30 pm)

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

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

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

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

25 FEHMO welcomes the provisional list of issues

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

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

25 "Historic racism and poorer experiences of  
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1 the pandemic, we submit that it is imperative, my Lady,  
2 that oral evidence is elicited from this cohort about  
3 their lived experience during that time.

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

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

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

21 FEHMO invites the Inquiry in Module 3, my Lady, to  
22 pay close attention to the period of the early stages of  
23 the pandemic. Again, we wish to point out that it is  
24 not sentimentality for the Inquiry to pay focused  
25 attention to this period, but instead it's  
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1 healthcare or at work may mean that individuals in  
2 [black, Asian and minority ethnic] groups are less  
3 likely to seek care when needed or as NHS staff are less  
4 likely to speak up when they have concerns about  
5 Personal Protective Equipment (PPE) or risks."

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

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

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

24 So given the disproportionate death rate of BAME  
25 healthcare workers in the earliest stages of  
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1 an opportunity to examine what occurred within  
2 the healthcare system during that time, and reflect on  
3 what might be corrected for the future.

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

19 FEHMO is also keen for there to be focus on the  
20 following matters related to acute treatment and care:  
21 how staffing challenges impacted on members' delivery of  
22 healthcare and how this contributed to general access to  
23 critical care, and I think at this juncture I must  
24 acknowledge and support Ms Morris, on behalf of the  
25 Royal College of Nursing, who called for a compensation  
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1 scheme to meet the need of those workers made  
2 chronically ill by their service during the pandemic.

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

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

24 My Lady, this Inquiry must focus on whether there  
25 was any data sharing among NHS organisations about risk  
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1 these communities.

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

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

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

24 Secondly, we repeat our calls for the instructed  
25 experts on structural racism for Module 2, Professors  
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1 assessment. There appears to have been a massive amount  
2 of inconsistency between NHS trusts as to whether  
3 ethnicity was even included as a risk factor in the  
4 first place. Was there guidance on how to conduct risk  
5 assessments in relation to race and ethnicity? And if  
6 so, was there any consultation with BAME leaders within  
7 the NHS in the development of such guidance? And when  
8 risk assessments were in fact done, it was often at the  
9 level of a peer, and not by managers who had the  
10 authority to make reasonable adjustments.

11 Another area of high importance, we say, that  
12 the Inquiry must directly hear from BAME healthcare  
13 workers in is in relation to cultural competency,  
14 engagement, representation and leadership. FEHMO  
15 contends that a productive healthcare relationship must  
16 be one that is based on trust, and the development of  
17 such trust is assisted by cultural competency and  
18 leadership. In a pandemic, assertions about science and  
19 evidence, often touted as the Holy Grail, are considered  
20 through the prism of health inequality and structural  
21 racism. Public health communications and guidance  
22 during this time were not consistently provided in  
23 accessible formats. BAME communities were unhelpfully  
24 branded "hard to reach", which frankly reflected the  
25 failure of NHS leadership to effectively engage with  
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1 James Nazroo and Ms Laia Bécares, to be further  
2 instructed in Module 3, and for them to be invited to  
3 give oral as well as written evidence, affording you,  
4 my Lady, the opportunity for a more dynamic exploration  
5 of the subject matter.

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

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

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

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

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

23 **MR SIMBLET:** Thank you, my Lady.

24 Well, my Lady, I make these submissions along with  
25 Mr Dayle, from whom you have just heard for FEHMO, and  
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1 instructed by Saunders Law, on behalf of the COVID-19  
2 Airborne Transmission Alliance, or CATA.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 It seems to CATA that all of this likely arose from  
25 a lack of resources. CATA's very concerned about this,  
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1 Workers Group that Covid and measures to combat it  
2 impacted different racial groups differentially.

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

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

19 The Inquiry has agreed to investigate this, and CATA  
20 considers that an important area of investigation  
21 because, in its experience, there was a gross  
22 under-reporting under RIDDOR of healthcare worker  
23 contracted Covid-19 illnesses and deaths; and this  
24 under-reporting was not due to the healthcare workers  
25 themselves not raising it, it is to do with the  
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1 as is a large percentage of those who worked in the  
2 healthcare centre during the pandemic, and CATA asks  
3 that this issue is fully, rigorously and courageously  
4 explored.

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

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

21 So on the topic, you've heard other submissions  
22 today which are welcomed by CATA from, for instance, the  
23 Royal College of Nursing, the TUC, FEHMO and others,  
24 about RPE and its suitability, and of course CATA agrees  
25 with Mind, FEHMO and the Frontline Migrant Health  
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1 circumstances created by situations in the health  
2 service and attitudes taken to the relevant law.

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

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

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

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

24 CATA has serious concerns about maladministration at  
25 the highest levels of public health and policy apparatus  
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1 in the application or disapplication of health and  
2 safety legislation during the pandemic. Some of those  
3 have in fact already been aired during a BBC Panorama  
4 investigation, but CATA submits that the Inquiry will  
5 need further to investigate whether health and safety  
6 standards were ditched and, if so, why, if it is to  
7 discharge its function sufficiently.

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

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

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

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

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

6 Right, Diya Sen Gupta KC. There you are.

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

9 **MS SEN GUPTA:** Good afternoon, my Lady.

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

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

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

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

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

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

13 **LADY HALLETT:** Thank you.

14 **MR SIMBLET:** Thank you, my Lady.

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

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

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

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

11 Kanlungan members work across the healthcare sector  
12 as nurses, cleaners and domestic healthcare staff. In  
13 May 2020, about 20,000 Filipinos worked for the NHS.  
14 They were the largest national group after British and  
15 Indian workers. Despite comprising only 3.8% of the  
16 nursing workforce, by May 2020 Filipinos accounted for  
17 22% of Covid-19 deaths among nurses.

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

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1 precarious employment.

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

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

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

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

25 All three organisations thank your Ladyship for  
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1 pandemics across the UK. It is against that background  
2 that we make our submissions.

3 Topic 1, scope and provisional list of issues.

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

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

16 We submit that this will need to be reflected  
17 throughout version 2, including at issues 1, 3, 7, 8 and  
18 10 of the current draft.

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

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

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

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

23 We submit that a thorough and critical examination  
24 of those systemic issues is essential for the Inquiry to  
25 fulfil its aim of informing preparations for future  
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1 we had raised the issue of migrant domestic healthcare  
2 workers being considered in Module 3. We understand  
3 from CTI's opening this morning that they will be  
4 considered as part of Module 6. We shall be grateful  
5 for confirmation of this. Our clients' main concern is  
6 ensuring that these domestic workers and the crucial  
7 role they played are not overlooked as part of this  
8 Inquiry.

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

16 As your Ladyship has already recognised, all  
17 individuals who contribute to the work of the NHS,  
18 whether directly employed or outsourced workers, are  
19 essential to its efficacy. When considering the impact  
20 of the pandemic, it is vital that the Inquiry considers  
21 and reports on the impact on all those working in  
22 a healthcare setting, and we should be grateful for  
23 clarity in version 2 of the list of issues to ensure  
24 that it expressly includes outsourced workers, as we  
25 understand is intended.  
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1 Those are our submissions on scope and the  
 2 provisional list of issues. My remaining topics are  
 3 much shorter.  
 4 Topic 2, expert evidence.  
 5 My Lady, we're grateful to CTI for the information  
 6 provided thus far with regard to expert evidence in this  
 7 module, and we understand that the scope of expert  
 8 evidence is still under review. We take this  
 9 opportunity to submit that this Inquiry would be greatly  
 10 assisted in Module 3 by expert evidence on outsourcing  
 11 and the impact of privatisation in the NHS, and the  
 12 impact of hostile environment immigration policies on  
 13 healthcare services. These are complex areas of law and  
 14 policy that require significant technical understanding  
 15 to properly assess their impacts, and we submit that  
 16 these matters cannot properly be considered without the  
 17 benefit of expert evidence. Your Ladyship may already  
 18 be in the process of instructing experts in these areas,  
 19 but if not, we invite consideration on the subject by  
 20 your Ladyship.  
 21 Topic 3, Rule 9 requests.  
 22 As your Ladyship will be aware, we have responded to  
 23 the Inquiry's Rule 9 request and await any comments from  
 24 the Inquiry team on our draft response.  
 25 Topic 4, witness evidence.

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1 **MS SEN GUPTA:** Thank you, my Lady.  
 2 **LADY HALLETT:** Right, Mr Jory, are you still there? You've  
 3 been waiting patiently all day. I'm really sorry about  
 4 the length of time you have had to wait. The order of  
 5 speakers is nothing to do with the order of importance,  
 6 I promise you.  
 7 **Submissions on behalf of the Independent Ambulance**  
 8 **Association by MR JORY KC**  
 9 **MR JORY:** Well, I understood they were saving the best to  
 10 last, so I'm not offended, thank you. That's what  
 11 I like to think, anyway.  
 12 My Lady, briefly, I can address you briefly in terms  
 13 of our representations. I represent or act on behalf of  
 14 the Independent Ambulance Association. We've made  
 15 written submissions, which you will have. I'm going to  
 16 refer to the IAA, rather than the longer term.  
 17 I confine my brief submissions to the provisional list  
 18 of issues.  
 19 Now, I'm aware that not many people know or perhaps  
 20 have heard of the IAA. It is a not for profit trade  
 21 association which represents independent ambulance  
 22 providers across the UK. They are regulated by the Care  
 23 Quality Commission. There are currently 50 member  
 24 organisations within the IAA. They range from small  
 25 companies, some with fewer than ten employees, some

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1 Where possible, our Rule 9 statement has addressed  
 2 the concerns of members using those members' own  
 3 accounts of their frontline experiences during the  
 4 pandemic. Like the TUC, we emphasised the importance of  
 5 the Inquiry hearing directly from individuals who worked  
 6 on the frontline. We're grateful to CTI for confirming  
 7 that the public hearings will include hearing evidence  
 8 from those working within the healthcare system.  
 9 My Lady, in conclusion, the Frontline Migrant Health  
 10 Workers Group regard this Inquiry as vitally important  
 11 to their members and to the future of the NHS. Many of  
 12 the systemic issues that the group's members faced  
 13 during the relevant period still persist.  
 14 Your Ladyship's report will include an essential  
 15 analysis of these issues. Your Ladyship's  
 16 recommendations will be crucial in addressing them so  
 17 that our healthcare system is prepared for future  
 18 pandemics.  
 19 We're very grateful to your Ladyship and the Inquiry  
 20 team for all your work, and will continue to assist  
 21 the Inquiry in whatever ways we can.  
 22 My Lady, those are our submissions, unless I can be  
 23 of any further assistance.  
 24 **LADY HALLETT:** Extremely helpful, thank you very much  
 25 indeed.

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1 employing over 500 staff.  
 2 Now, each year the NHS funds the transport of  
 3 between 11 to 12 million patients. More than half of  
 4 all those patients -- patient transfers are provided by  
 5 independent ambulance providers.  
 6 So, just to repeat, more than half of all NHS  
 7 patient transfers are provided by independent ambulance  
 8 providers.  
 9 Now, during the Covid-19 pandemic, the NHS's  
 10 reliance on those independent ambulance providers  
 11 increased dramatically. There was a significant and  
 12 wholly unforeseen increase in demand for non-emergency  
 13 transport service providers to pivot to prioritise Covid  
 14 patients and emergency services. As a consequence of  
 15 this, the IAA members have gained extensive first-hand  
 16 experience of the impact of Covid-19 on patients and  
 17 staff, and the many issues this presented.  
 18 My Lady, we've provided you with a written document.  
 19 Can I just highlight, please, the two discrete areas we  
 20 wish to draw your attention to, and I'm going to  
 21 paragraph 6 of our submissions. We invite the Inquiry  
 22 team to consider the following amendments to the  
 23 provisional list of issues.  
 24 If you go to issue or provisional issue 4A, we make  
 25 a suggestion:

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

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

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

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

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

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1 and I'm sorry to both core participant groups.

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

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

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

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1 extension of that category.

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

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

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

19 Ms Carey, any remarks by way of reply?

20 **Reply statement by COUNSEL TO THE INQUIRY**

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

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

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

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

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

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

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1 **MS CAREY:** No, we wouldn't object to that at all.  
 2 **LADY HALLETT:** Very well, I so order.  
 3 Thank you, Ms Carey. Thank you very much, everybody  
 4 else. As ever, submissions have been extraordinarily  
 5 helpful and a great deal of food for thought, and I will  
 6 give very careful consideration to these issues, along  
 7 with seeking advice from my team.  
 8 So, thank you, until we meet again.

9 **(4.25 pm)**  
 10 **(The hearing concluded)**

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