

Wednesday, 4 October 2023

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(10.00 am)

LADY HALLETT: My list has disappeared. The next speaker?
Thank you. Thank you very much. Ms Twite. There you are.

Submissions on behalf of Save the Children UK, Just for Kids Law and the Children's Rights Alliance for England by MS TWITE

MS TWITE: Good morning, my Lady. Can you hear me now?

LADY HALLETT: I can, thank you.

MS TWITE: Thank you.

My Lady, I want to start in 1924, when the League of Nations adopted the Declaration of the Rights of the Child in Geneva. That declaration was drafted by Eglantyne Jebb, who had founded Save the Children Fund in London in 1919 along with her sister Dorothy Buxton, to provide relief to children suffering poverty and starvation following the First World War.

That declaration was drafted in recognition that children have rights that are important and distinct from adults. That declaration later inspired the 1989 United Nations Convention on the Rights of the Child, itself a landmark international agreement that enshrines the civil, political, social, economic and cultural rights of children, and has become the most widely

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We recognise that this will be a focus, and rightly so, of this Inquiry. Yet the impact of the pandemic, and the political and administrative decisions which are the subject of this Inquiry too, also touch the lives of millions in many other ways. In particular, we want to emphasise to the Inquiry how children were also negatively impacted and continue to be negatively impacted in a plethora of ways which were unique to them.

Some will carry that negative impact forever, for many they will be the Covid generation. Many were isolated at critical times in their lives. They missed more than just school, they missed chunks of their childhood.

You will, of course, be hearing from witnesses on impact and I cannot hope to do justice to all the different issues that faced children over the course of the pandemic in the 15 minutes I have this morning. But we also say to you that there is no need for this Inquiry to reinvent the wheel when considering the harm done to children in the pandemic.

Since March 2020 there have been numerous reports and studies done by civil society organisations, government bodies, academics, setting out the negative impacts the pandemic and the decision-making had and

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ratified human rights treaty in history.

Nearly a century on, Save the Children Fund are now core participants to this Inquiry, along with Just for Kids Law and the Children's Rights Alliance England. And nearly a century on, we must ask this Inquiry again to consider the necessity of children's rights, sadly, we say, so neglected in this pandemic, and ask that you, my Lady, take action when you come to consider your recommendations from this Inquiry.

We know that on the eve of the pandemic the state of children's rights in the UK was bleak. Among almost a third of the more than 14 million children in the UK lived in poverty following a decade of austerity.

We know that following the pandemic that poverty has increased for children, and inequalities have widened, the gap in educational attainment between wealthier and poorer children has increased by 46%.

It is difficult to speak today of anything after the heartbreaking tales we heard yesterday, and we wanted to acknowledge and recognise the huge amount of suffering experienced by those who have died and their families and friends, which included children, as well as those who were directly affected by bereavement and loss. There are also many whose health continues to be impacted by the impact of long Covid.

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continue to have on children. This, we say, shows that government decision-making caused educational and psychological harm that in many ways disproportionately impacted children.

In particular we wish to commend *What About The Children?*, a report written on behalf of the children's rights organisations who are core participants today. This was published last week. We hope that you will read it and give it the consideration it merits.

We also wish to highlight that there have been many other important reports examining the impact of the pandemic, by well over 20 different organisations I don't have time to list now, but we would be happy to provide a list to your Inquiry team.

The UK Government's own website concludes that the quality and quantity of learning students undertook declined as a result of the pandemic. Disadvantage and deprivation appeared to be most associated with less effective learning and overall learning losses, and disadvantaged primary school students were disproportionately behind expectations.

It is, therefore, undeniable, we say, that the pandemic disproportionately impacted children, and we say because the UK Government did not sufficiently consider children's rights and wellbeing in their

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1 political and administrative decision-making.
 2 You, my Lady, have already concluded that it is not
 3 necessary for the then Secretary of State for Education,
 4 Gavin Williamson, to be called during Module 2 hearings
 5 and asked about high level decision-making processes,
 6 because it appears he was largely excluded from those
 7 decisions. This, we say, effectively proves our very
 8 point.

9 Consequently, the key decision in respect of
 10 children which the Inquiry will wish to ask itself and
 11 ask the witnesses being called are: how does such
 12 a serious, inexcusable and avoidable failure of
 13 governance and policy making happen? What needs to be
 14 done to learn the lessons so this never happens again?
 15 And what needs to be done to repair the harm that was
 16 caused?

17 The core proposition that we put forward for
 18 the Inquiry to consider is that children's needs are
 19 different from adults', and that that difference has to
 20 be recognised and embedded in decision-making, and they
 21 weren't.

22 My Lady, to say that children are different from
 23 adults is an embarrassingly simple and depressingly
 24 obvious submission to have to make, but sadly it is
 25 a necessary one. In March 2020, when we were all told

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1 when you might have thought the government had had time
 2 to plan for children, when children were actually the
 3 most isolated, because it was in that lockdown that the
 4 combination of school closures and the rules against
 5 household mixing meant that most children only saw their
 6 siblings, if they were lucky enough to have them, and
 7 that therefore many children went over two and a half
 8 months without seeing another child.

9 During this time a number of parents provided their
 10 concerns as part of a joint letter written by charities
 11 to the Prime Minister pleading for a change in the
 12 rules. Some of those comments are as follows.

13 "My 5-year old daughter is an only child and she has
 14 been badly affected by lack of socialising with other
 15 children since lockdown. She is far less cheerful and
 16 motivated than she was before this isolation. She
 17 especially looks for video games with other children to
 18 watch or pretend, which she used not to do. Her sleep
 19 has also become disturbed."

20 Another mother wrote how her 8-year-old child, also
 21 an only child, had become irritable, sad, prone to
 22 outbursts of crying and then bedwetting.

23 A different parent wrote:

24 "My happy, sociable 7-year old has developed chronic
 25 anxiety since the start of this, and all he wants to see

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1 to stay at home, we were told we were allowed to go out
 2 to exercise. Examples were given in the guidance of
 3 jogging and yoga. My Lady, I don't need to tell you
 4 that very few young children go jogging or do yoga. But
 5 despite frequent calls from those who work with
 6 children, from psychologists and academics, to clarify
 7 that guidance and tell the population, and tell
 8 the police, that play for children would constitute
 9 exercise, to tell the parents that supervising their own
 10 children whilst their children exercised or played was
 11 within the rules, that guidance and those regulations
 12 were not updated, and those calls were still being made
 13 in 2021.

14 The result was that parents kept their children in
 15 for fear of breaking the rules. The result was that
 16 children skateboarding, climbing trees and paddling in
 17 streams were told off by the police and sent home.

18 When adults were allowed to meet one other adult
 19 from another household for the jogging and the yoga that
 20 they were allowed to do, their young children could not
 21 meet any of their friends, because the need for
 22 a supervising adult would constitute a breach of the
 23 lockdown regulations.

24 It was, in fact, in the third lockdown, some
 25 nine months after that fateful day on 23 March 2020,

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1 is his friends, to race around the playground non-stop
 2 and for life to feel normal."

3 "My 7-year old hasn't seen anyone since
 4 December 16th. He has started to withdraw and become
 5 moody and aggressive. He is angry with me and his mam
 6 because he is an only child and has no-one to play with.
 7 I am so worried about him it's unreal."

8 And finally:

9 "I have an 8-year-old who, like yours, hasn't seen
 10 any other children since mid-December. He sits having
 11 literal conversations with himself about football, not
 12 just talking out loud but having a discussion, in lieu
 13 of being able to chat to his friends."

14 Like so many aspects of the pandemic, this impact
 15 was not uniform. It was exacerbated in deprived areas.
 16 A project worker in an area of high deprivation in
 17 Bristol described their concerns at seeing the children
 18 there:

19 "Over the last two weeks we've been at school and
 20 met parents one by one, handing over art packs we bought
 21 for children at home. Unlike the more affluent area
 22 where we live, which is busy with children and parents
 23 outside, we saw no children at all outside or in green
 24 spaces. Parents said that collecting the art pack was
 25 the one valid reason they could take their children out,

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1 as if they did not feel this was the case otherwise."

2 But, my Lady, what makes these stories particularly
3 heartbreaking was that whilst this was the experience in
4 early 2021 for so many children in England, at the same
5 time children in Scotland and Wales could meet up and
6 were spending time with their friends. According to
7 BBC News, Scottish children were going sledding and
8 having snowball fights. Because while Scotland and
9 Wales were still in lockdown, they had amended their
10 rules for children.

11 Not only did this and many other examples, some of
12 which are set out in more detail in our written
13 submissions, mean that lockdown rules were, in reality,
14 stricter for children than their parents, stricter for
15 English and Northern Irish children than Scottish and
16 Welsh, but the impact on children was different.
17 Children experience time differently. Two and a half
18 months for an 8-year old is not the same as two and a
19 half months for a 30-year old. Childhood is a crucial
20 development time which impacts all of later life.

21 It is why, for some, Mr Johnson's being ambushed by
22 a birthday cake in lockdown touched a particular nerve.
23 It reminded us all of the birthday parties missed by the
24 nation's children. There is something about missing
25 your sixth birthday which frankly isn't the same as

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1 in June 2020 to open non-essential retail, but not most
2 schools. We then had the decision in July 2020 to open
3 pubs, hairdressers, theme parks, but not most schools.

4 It is not just about whether those decisions were
5 correct, although of course that is also important. It
6 is about how they were made. Why did Scotland and Wales
7 take different approaches? Was it perhaps related to
8 the child's rights impact assessments that those
9 governments carried out on children? Assessments that
10 referenced children's rights that are enshrined in the
11 United Nations Convention on the Rights of the Child.
12 Were assessments carried out by the UK Government? Did
13 the UK scientists, policy makers and politicians analyse
14 the situation in Scotland and decide that there was
15 a good reason for having different rules for children in
16 England?

17 We focus on how those decisions were made because
18 you might consider that any decision-maker might make
19 the wrong call sometimes, but we are scared they didn't
20 even ask the right questions.

21 Finally, my Lady, if you agree with us that
22 the questions weren't asked, we ask you to consider why
23 not. Because, importantly, we fear that the answer does
24 not simply lie in the erratic decision-making and
25 the failures of Mr Johnson or the distractions of

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1 missing your 57th. Childhood is sacrosanct and lost
2 childhood cannot be given back.

3 This is not merely rhetoric, my Lady, we know from
4 the expert report of David Taylor-Robinson, who will
5 give evidence to you later this week, that there are
6 important developmental stages in childhood and that
7 some of these, once missed, cannot be simply returned or
8 caught back up on, and it is that difference that we ask
9 you, the Inquiry, to consider. It is for these reasons
10 that we say some of that impact evidence is vital for
11 your considerations. We ask the Inquiry to consider it
12 and we ask the Inquiry to ask whether those in
13 government considered it when they made the important
14 decisions.

15 So we ask the Inquiry to start by recognising
16 the distinct needs for children, and then we ask
17 the Inquiry to ask whether the government considered
18 those needs.

19 To do that, we ask you look both at how those
20 decisions were made. Did they carry out any impact
21 assessments for children? Were modelling and analysis
22 done about different rules for children? Were children
23 mentioned in their discussions?

24 But also the sort of decisions that they made. In
25 addition to the ones I've mentioned, we had the decision

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1 Brexit, some of which we heard about yesterday, although
2 we accept those are unlikely to have helped. We ask you
3 to imagine what would have happened if we had had
4 Cabinet meetings that did involve better debate, and
5 whether or not thought had gone into considering
6 the social implications of non-pharmaceutical
7 interventions. Would that have resulted in children
8 being properly considered? Because we say this is not
9 just about the individuals, it is about systemic
10 failings within the system.

11 We say that because even in that scenario, even if
12 we had had non-erratic decision-making, we still don't
13 know the answer to a fundamental question that we pose:
14 whose role was it to consider the interests of children
15 and make sure that their needs were not forgotten in
16 a crisis? We know from the disclosure that Playing Out
17 wrote to the children's minister and Undersecretary of
18 State because they were seriously concerned about the
19 rules about children playing out of doors. He wrote
20 back to say that outdoor play was not in his remit,
21 because the children's minister role sits in the
22 Department of Education. We know that Gavin Williamson
23 was so incidental to decision-making that it is the
24 current position of this Inquiry not even to call him to
25 give evidence in this module.

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1 So who was there to consider the rights for children
2 in England, and perhaps more importantly, who should
3 have been there?

4 We ask you to consider not just whether there is
5 someone making the decision but how that decision should
6 be made. Some of the evidence we will hear examines the
7 need for diversity of people in the room. For example,
8 Alex Thomas from the Institute for Government expresses
9 concern that the circle of advisers in Number 10 was not
10 diverse, which led to a narrowness of experiences, and
11 we hear from other witnesses about the advantages of
12 diverse groups of scientists that may have led to the
13 changes for parents of young children to be able to meet
14 up with each other.

15 But there is a fundamental problem here when you
16 consider the importance of diverse groups. A laudable
17 aim, we accept, but however diverse your group, it is
18 unlikely to include children. And that is why, coming
19 back to the United Nations Convention on the Rights of
20 the Child, that that enshrines the right for children to
21 be heard, because children are not routinely heard, they
22 are not and are never going to be members of SPI-B or
23 the Cabinet. And however much adults think that they
24 know the interests of children, no one knows that as
25 much as children themselves, and so it is all the more

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1 pandemic; to ensure the government fully takes
2 children's rights and best interests into account before
3 and during future crises; and thirdly, to ensure that
4 children's rights are embedded in decision-making.

5 On the last one, my Lady, this is quite a general
6 proposal.

7 **LADY HALLETT:** I'm sorry, Ms Twite, we're going to have to
8 bring it to an end. It's not fair on everybody else,
9 I'm really sorry.

10 **MS TWITE:** I'm grateful, my Lady.

11 **LADY HALLETT:** I have read your written submissions and
12 I will read them again, I promise.

13 **MS TWITE:** Thank you very much.

14 **LADY HALLETT:** Thank you.

15 **Submissions on behalf of Solace Women's Aid and Southall
16 Black Sisters by MS DAVIES KC**

17 **MS DAVIES:** My Lady, thank you very much. I appear for
18 Southall Black Sisters, SBS we call them, and Solace
19 Women's Aid, together with Marina Sergides, Fatima Jichi
20 and Angharad Monk, and we are instructed by Public
21 Interest Law Centre.

22 My clients want to start by paying tribute to the
23 pain experienced by the bereaved families and to their
24 courage in speaking out and articulating their pain and
25 grief. We heard powerful voices yesterday.

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1 important that that right to be heard is given to
2 children. And it is why we call for specific impact
3 assessments for children. It is why they need
4 a distinct set of rights such as the United Nations
5 Convention on the Rights of the Child, that is used and
6 embedded in the decision-making processes.

7 My Lady, in our written submissions --

8 **LADY HALLETT:** I'm afraid I'm going to have to ask you to
9 wind up now.

10 **MS TWITE:** I am, my Lady, I apologise for the matter. I am
11 making concluding remarks, thank you.

12 My Lady, I'm not reading out and wasn't intending to
13 read out the recommendations that we ask the Inquiry to
14 consider in our written submissions. What I did want to
15 say is that we accept that it may seem to be jumping the
16 gun to start this Inquiry with already putting forward
17 recommendations, but we do so in the hope of being
18 helpful, we do so because we hope that this will allow
19 the Inquiry to test whether or not those sort of
20 solutions are the ones that could have made matters
21 better in the pandemic.

22 My Lady, you have our written submissions where they
23 are set out in full. They are, in brief, arguing for
24 three things: to support the Covid generation to thrive
25 and honouring children's contributions to overcoming the

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1 My clients have been providing direct services for
2 women experiencing domestic abuse for over 40 years, and
3 they are significant voices advocating for those women's
4 rights. SBS is also a leading, by and for, provider of
5 services for black and ethnic minority women, and has
6 a specific project for migrant women. Both
7 organisations have submitted witness statements, Solace
8 from its head of partnership and public affairs,
9 Rebecca Goshawk, who will give oral evidence before you
10 on Friday, and SBS from its head of policy, campaigns
11 and research, Hannana Siddiqui.

12 My Lady, there were many consequences of Covid and
13 of the government's response. One of those consequences
14 was a rise in domestic abuse as a result of isolation
15 rules and lockdown. We say that rise was both
16 well known and obvious. It was known from research into
17 other disasters, and from media reports from countries
18 who had entered lockdown earlier than the UK. And it
19 was obvious and, we say, a matter of common sense
20 because individuals were trapped together in the same
21 home.

22 Although government did not anticipate that rise,
23 a number of prominent politicians and the police did,
24 and shortly before lockdown, on 19 March, both the
25 Domestic Abuse and the Victims Commissioners wrote to

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1 respectively the Chancellor of the Exchequer and the
2 Prime Minister raising concerns.

3 When we refer to an inevitable rise in domestic
4 abuse, we don't just mean that more people would
5 experience domestic abuse for the first time, we also
6 mean that the frequency of domestic abuse incidents
7 increases and that the severity of that abuse increases.
8 So women were and still are presenting to the violence
9 against women and girls sector with more complex needs
10 and with more trauma. Those effects of lockdown
11 continue right up to the present day and we anticipate
12 into the future.

13 My Lady, I need to deal with language. Domestic
14 abuse is experienced by men as well as by women. But
15 twice as many women than men experience it. Women are
16 more likely to endure repeated domestic abuse and they
17 are more likely to be seriously hurt, and for that
18 reason my clients and their representatives say "women",
19 or "women and girls", to refer to victims and survivors
20 of domestic abuse, because we emphasise the gender
21 dimension, and we take an intersectional approach,
22 recognising that women's experience of abuse and
23 misogyny can be exacerbated when they also face
24 discrimination because of other characteristics such as
25 race, sexuality, gender identity, disability or age.

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1 for a coffee or a play date, so those best friends or
2 mother or sister could not do what friends and family
3 normally do, which is offer a spare room or a sofa as
4 the temporary respite where a woman, perhaps with her
5 children, could stay in a safe space, to gather her
6 thoughts, take a breath, make some decisions. Staying
7 with another household, even with your mother or sister,
8 was not permitted. And I've not even addressed the
9 additional and obvious complications of trying to find
10 support in a safe space with children.

11 Migrant women, particularly those who have no
12 recourse to public funds, NRPF, attached to their leave
13 to remain are in an even worse position. They face what
14 is known as immigration abuse. Not only are they
15 trapped because of domestic abuse and during the
16 pandemic because of lockdown, they are also fearful and
17 their abuser often threatens them with being reported to
18 the Home Office for breach of immigration conditions.
19 So they fear that leaving abuse risks deportation.
20 Their abuser is usually their sponsor, so if they leave
21 they also face destitution.

22 There is provision for women fleeing domestic abuse
23 to apply for indefinite leave to remain, and for them to
24 be eligible for public funds for three months while
25 their application is considered, but that is only

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1 At the same time as domestic abuse increased, women
2 seeking help found that options normally available to
3 them had significantly diminished. First, they did not
4 always know that they could leave home. The regulations
5 permitted people to leave in order to access critical
6 public services or to escape a risk of harm, so clearly
7 someone seeking to leave because of domestic abuse fell
8 within that, but that message was not clearly delivered
9 by government.

10 Second, many existing sources of support closed down
11 completely or were difficult to access without placing
12 oneself in danger. A woman experiencing domestic abuse
13 was no longer engaging with people outside her
14 household, such as work colleagues, friends or
15 professional services. Finding the time and privacy to
16 obtain advice from home in the same space as the abuser
17 was challenging.

18 Yvette Cooper MP made the point in Parliament. She
19 said:

20 "The social worker is not dropping by, the bruises
21 will not be visible at the school gate the next morning,
22 and the GP will not be asking questions at the next
23 appointment."

24 Family and friends were not around, women were not
25 meeting their best friends, their sisters, their mother

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1 available to women on a spousal or partner visa, so not
2 for women here on student visas, work visas or other
3 family relationships. So while women experiencing
4 domestic abuse were facing a double threat of domestic
5 abuse and coronavirus, migrant women, particularly those
6 subject to NRPF, were living through the triple threat
7 of domestic abuse, coronavirus and fear of destitution
8 and deportation.

9 We do not suggest that self-isolation regulations or
10 lockdown were unnecessary, nor do we suggest that
11 government could have entirely prevented domestic abuse
12 rising during lockdown, but we do say that the
13 inevitable increase was far from government's mind when
14 considering NPIs, that government failed to plan for
15 that rise, and failed to put in place remedial measures
16 in advance of lockdown. Government failed to consult
17 the violence against women and girls sector, who would
18 have told them what was needed. Government failed to
19 provide clear and consistent public messaging, and it
20 failed to resource the violence against women and girls
21 sector, who experienced unprecedented demands for their
22 services, and it failed to learn any lessons from
23 the first lockdown, so that those failings continued
24 into second lockdown and beyond. And we add that
25 planning to tackle domestic abuse is a legal obligation

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1 on government and other public authorities under
2 the section 149 public sector equality duty.

3 My Lady, as the UK approached lockdown, violence
4 against women and girls services and public services
5 were already significantly underfunded following
6 ten years of austerity. Your expert on gender,
7 Dr Clare Wenham, makes the point that between 2010 and
8 2020, demand for services from the violence against
9 women and girls sector had increased while funding had
10 significantly decreased, and that demand was about to
11 rocket.

12 The first lockdown message was the Prime Minister's
13 address to the nation on the evening of 23 March. He
14 said:

15 "... people will only be allowed to leave their home
16 for the following very limited purposes:

17 "- shopping ...

18 "- one form of exercise a day ...

19 "- any medical need, to provide care or to help
20 a vulnerable person; and.

21 "- traveling to and from work, but only where this
22 is absolutely necessary ...

23 "That's all [he said] - these are the only reasons
24 you should leave your home."

25 And, my Lady, you will immediately see that this

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1 needed urgent and direct funding. And it was only then,
2 on 2 May, after the public campaign, political criticism
3 and the threat of legal action, that resources of
4 £76 million were announced for the sector.

5 At the same time the Mayor of London, not central
6 government, stepped up to fund a crisis project
7 in London, offering 70 emergency refuge spaces run by my
8 clients. And there is a dispute that will be explored
9 in evidence about whether earlier funding for the
10 charitable sector reached the violence against women and
11 girls sector.

12 We note the irony that during this period the
13 Home Office was steering the Domestic Abuse Bill now the
14 Domestic Abuse Act 2021 through Parliament. Overall we
15 expect the evidence to show that the Home Office's
16 response and that of government generally was too
17 little, too late, and that government was not consistent
18 in its messaging.

19 That lack of clarity in messaging is best
20 illustrated by noting that the Prime Minister throughout
21 the whole of 2020, while announcing various lockdowns,
22 tiers, and the different regulations for Christmas,
23 which is of course a time when there is traditionally
24 a spike in domestic abuse, did not once mention domestic
25 abuse as a permitted reason to leave home. His first

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1 does not convey to someone experiencing or anticipating
2 abuse at home that she can leave.

3 A few days after 23 March the Home Office did start,
4 too late we say, to take some steps. The Home Secretary
5 wrote an article in the Mail on Sunday on 28 March which
6 was headlined, "Priti Patel pledges to help vulnerable
7 people stuck at home with domestic abusers during the
8 lockdown", and on 11 April, two and a half weeks into
9 lockdown, the Home Office launched its "You Are Not
10 Alone" campaign. But even then there was no increase in
11 resources to the violence against women and girls
12 sector, so the sector was forced to lobby for more
13 resources at a time when it was experiencing
14 unprecedented demand for its services. There were
15 private meetings with the Home Office, there were open
16 letters, there was press coverage, and my clients were
17 even forced to resort to a threat of legal action.

18 The most devastating contemporaneous account of
19 government failure is in the House of Commons Home
20 Affairs Committee report which was published on 27 April
21 on the Home Office's preparedness for Covid-19, *Domestic
22 abuse and risks of harm within the home*. It found that
23 government had not been prepared, that an action plan
24 was needed immediately, during lockdown and after it,
25 and services for domestic abuse and vulnerable children

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1 mention of it came on 4 January 2021 when he announced
2 the third lockdown.

3 When it comes to migrant women, government did not
4 just fail to act, it took a positive decision not to
5 help. Government was extensively lobbied not just by
6 the violence against women and girls sector but also by
7 the Local Government Association, the Mayor of London,
8 various MPs, to suspend the NRPF condition and extend
9 the destitution domestic violence concession for the
10 duration of the pandemic. That step would have been
11 a humanitarian and public health focused approach,
12 similar to the government's "Everyone In" scheme for
13 rough sleepers. Instead, government took a decision not
14 to extend any more protection to women subject to NRPF
15 fleeing domestic abuse. The government's position was
16 put by the Minister for Safeguarding in the
17 House of Commons. She said:

18 "... lifting restrictions for all migrant victims
19 would enable any migrant, including those here
20 illegally, to ... [secure leave to remain] if they
21 claimed to be a victim of domestic abuse."

22 We say that this refusal to help continued to trap
23 women subject to NRPF in the homes of their abusers.

24 My Lady, my final section is on the reality of life
25 under lockdown for women victims of domestic abuse.

24

1 That reality can partly be gleaned from the statistics
2 contained in the witness statement on the increase in
3 demand for my clients' services. In March 2020 in
4 anticipation of lockdown calls to Solace's advice line
5 were up by a staggering 117% in comparison with the
6 previous year, and in September 2020 up by 138%.

7 For SBS, in the three months of April to June 2020,
8 their enquiries rose by 138% from the previous year, and
9 over the two years of the pandemic between March 2020
10 and March 2022 the rate of annual enquiries that they
11 have received has more than tripled. Those are
12 compelling figures and there are similar figures from
13 other organisations in the witness statements.

14 But even more compelling are the personal stories
15 which appear in the witness statements, and some of the
16 reports before you. Can I give you just three examples.

17 A woman interviewed by Solace said:

18 "They [the perpetrator] are not going to the gym,
19 they're not going to work, nothing, so essentially they
20 will use whoever is there at home as their punchbag."

21 Rachel, a pseudonym, in Siddiqui's statement, had
22 been abused by her husband and threatened by her
23 stepchildren, and said:

24 "For months I was so isolated, everything was closed
25 because of Covid and I was in the worst state ever.

25

1 that is exactly what they are, providing necessary
2 public services.

3 Four, government failed to provide clear messages
4 consistently replicated across government, and so failed
5 to give women the reassurance they needed that leaving
6 was permitted.

7 Five, government took a deliberate decision not to
8 suspend NRPF or take other steps to support migrant
9 women during the pandemic, leaving those women in
10 the triple bind of lockdown, domestic abuse and fear of
11 destitution and deportation.

12 Sixth, after the first lockdown, from summer 2020,
13 government failed to learn the lessons from the first
14 lockdown so that inconsistent messaging and pressure on
15 resources continued.

16 My Lady, the lessons from lockdown are well summed
17 up, not only in the witness statements, but in Solace's
18 publication in March 2021 examining the effects of
19 lockdown which is aptly titled "*When I needed you to
20 protect me, you gave him more powers instead*". We say
21 that is exactly what happened: that government failed to
22 recognise that for many women and girls home is not
23 a safe place and that lockdown made an unsafe home even
24 more dangerous. We hope that the outcome of this
25 Inquiry will be that government prioritises tackling

27

1 I did not know who to speak to or where to go to get
2 help. I could not contact my GP as the appointments
3 were shut. I did not have any friends that I could talk
4 to. I felt so trapped. The strict Covid rules made it
5 difficult for me to go out of my house or reach out to
6 anyone."

7 And Joy, also a pseudonym, in Siddiqui's statement,
8 was abused by her partner. She was too scared to call
9 the police as she feared she would be deported. When
10 her partner kicked her out of her home, she was sleeping
11 rough until she managed to contact SBS.

12 So in conclusion, my Lady, we expect the evidence to
13 show this:

14 One, that government failed to recognise in advance
15 that a rise in domestic abuse was an impact of isolation
16 rules and lockdown, failed to plan for additional
17 resources to an already underfunded and overstretched
18 sector, and failed to consult the violence against women
19 and girls sector to establish what was needed.

20 Two, government failed to recognise the specific
21 needs of by and for services for marginalised women
22 facing domestic abuse, black and ethnic minority women,
23 LGBTQ+ services.

24 Three, government failed to treat violence against
25 women and girls frontline workers as key workers, when

26

1 domestic abuse and working with the violence against
2 women and girls sector, both in normal times and in
3 times of pandemic so that when, as you have said,
4 my Lady, we face the next pandemic, women and girls are
5 not doubly or triply at risk.

6 Thank you very much, my Lady.

7 **LADY HALLETT:** Thank you very much indeed, Ms Davies.

8 Mr Jacobs.

9 **Submissions on behalf of the Trades Union Congress by**
10 **MR JACOBS**

11 **MR JACOBS:** Good morning, my Lady. This is the opening
12 statement on behalf of the Trades Union Congress.
13 I appear with Ms Ruby Peacock and we are instructed by
14 Thompsons Solicitors.

15 The TUC brings together over 5 million working
16 people who make up its 48 member unions, and in this
17 module this is working in partnership with the
18 Wales TUC, the Scottish TUC, and the Northern Ireland
19 Committee of the Irish Congress of Trade Unions.

20 My Lady, we will address five topics, the first of
21 which is truth and candour.

22 In any public inquiry, the demand for truth and
23 candour is a heavy one, all the more so we say in the
24 context of this Inquiry. In the moving impact film
25 shown yesterday, a bereaved husband, Alan, said

28

1 powerfully is that what was needed was accountability
2 and ownership of what went wrong.

3 The TUC is disheartened to see that so many witness
4 statements of the key decision-makers are striking only
5 for how utterly anodyne they are. There is very little
6 ownership of what went wrong. Much is at odds with what
7 the public has already seen and already knows. Many of
8 the witness statements in this module would have the
9 public believe that the government's response to the
10 pandemic was a wholly unique reversal of the swan
11 analogy. What the public witnessed was the furious
12 flapping of feet under water, but what is now being
13 portrayed to this Inquiry is a serene gliding through
14 the pandemic that happened behind closed doors.

15 My Lady, it will persuade no one.

16 The Cabinet Office in its written opening has
17 described this Inquiry as an unprecedented moment of
18 transparency about the government of this country.
19 There is more than a little irony in that observation,
20 given the intransigence of the Cabinet Office in
21 refusing to provide the requested disclosure to this
22 Inquiry and judicially reviewing a notice requiring
23 disclosure.

24 The TUC hopes that the glare of these Inquiry
25 hearings will bring more openness to the oral evidence

29

1 Inquiry has heard. Many of these occupations intersect
2 with a number of vulnerable and protected groups.

3 My Lady, our third topic is not loss but avoidable
4 loss, and in particular the apparent dysfunction in
5 government decision-making which resulted in avoidable
6 loss of life.

7 The emerging evidence suggests that there was
8 dysfunction rather than coherence, with decision-making
9 flip-flopping between myopically serving one interest
10 before giving in to serve another.

11 Eat Out to Help Out is a striking example. The aim
12 of supporting the hospitality industry was a perfectly
13 valid and important one, but there needed to be some
14 careful thought as to how the scheme fitted within
15 the overall strategy. What we find is that it was
16 a Treasury scheme about which neither SAGE nor
17 the Department of Health and Social Care were even
18 consulted. That is a microcosm of repeated failures to
19 make decisions which pursued a coherent plan with
20 support across government.

21 So decision-making flitted between resisting certain
22 NPIs, including lockdowns, at all costs before
23 eventually accepting their inevitability.

24 In a WhatsApp message Simon Case described
25 a particular decision as "A classic of the Johnson

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1 than some of the witness statements. The Inquiry will
2 no doubt continue in its rigorous approach to
3 questioning.

4 Our second topic is to acknowledge loss and
5 sacrifice in the workplace. Over 15,000 people of
6 working age have died of Covid-19. From March 2020 to
7 the end of the first year of the pandemic, there were at
8 least 8,000 deaths of working age people involving the
9 virus. Many who contracted Covid-19 in places of work
10 suffered or continue to suffer the prolonged and
11 debilitating effects of long Covid.

12 We were grateful yesterday to hear
13 Mr Keith King's Counsel in his opening refer to those in
14 a variety of occupations who played a key role in
15 keeping the country going and faced the greatest risk in
16 doing so. Of course those in health and social care
17 were truly on the frontline, but there were so many
18 others: those who continued to work in the supermarkets,
19 in transport, in food processing, in education, in
20 communications, and many more.

21 It was in the workplace that many of the uneven
22 impacts of the pandemic were felt. Many who continued
23 to attend work were in lower paid jobs and many in
24 insecure work. They were already suffering from
25 the structural health disadvantages about which this

30

1 era -- go fast, no go slower, listen to me, no agree it
2 with Rishi ...!"

3 That may ultimately prove to be an apt summary for
4 much of the core political decision-making in response
5 to the pandemic.

6 Our fourth topic is decision-making that served the
7 economics of work but not its safety. The UK Government
8 took a bold approach to supporting jobs and the economy,
9 but the TUC is concerned that Westminster failed to show
10 the same endeavour in supporting safety in the
11 workplace, particularly in respect of those in lower
12 income jobs.

13 That manifested in the approach to supporting
14 self-isolation for those who continued to attend work.
15 The consequence of not supporting those on low income to
16 self-isolate is a perfectly obvious one. For someone on
17 low income who needs to attend work in person and who
18 does not have the benefit of adequate sick pay,
19 foregoing income for two weeks while self-isolating may
20 be extraordinarily difficult. The existing mechanism of
21 statutory sick pay offered only £94.25 per week, and so
22 was far too low to meaningfully incentivise
23 self-isolation. Around 2 million workers who earned
24 below the lower earnings limit were not eligible at all.

25 The problematically affected a number of vulnerable

32

1 and protected groups working in higher risk occupations.

2 My Lady, if there was to be more than lip service to
3 ameliorating uneven impacts, it was an area for action.
4 It was also a problem very well known to the government.
5 It was raised on numerous occasions by the TUC,
6 including by way of a report of 3 March 2020. It was
7 raised by the Behavioural Insights Team, who pointed to
8 evidence that care homes that paid sick leave saw lower
9 infection rates.

10 It was also raised by MPs. A letter to Matt Hancock
11 from Conservative MP George Freeman referenced
12 an outbreak at Banham Poultry stating "the current
13 statutory sick pay doesn't provide enough to live on".
14 He went on to describe the problem of food processing
15 plants being closed due to outbreaks but workers without
16 incomes or financial support for self-isolation being
17 compelled to obtain employment in other plants, thus
18 pushing the problem down the road.

19 It was also raised by SAGE. The minutes of the SAGE
20 meeting of 1 May 2020 advised that an accessible offer
21 of financial support to those in need could reduce the
22 risk of non-adherence.

23 Sir Patrick Vallance, in his evening diary, recorded
24 on 21 August 2020:

25 "[Chief Medical Officer] said clearly that financial
33

1 supporting the effectiveness of self-isolation and
2 supporting a low-income, high-risk workforce which
3 intersected with a number of vulnerable groups. It
4 should not have been any surprise to see mass outbreaks
5 at clothing factories in Leicester, at meat packing
6 factories, at the Bakkavor sandwich making factory, and
7 many others.

8 It is far from the only example of low income
9 workers in high-risk workplaces being a low priority.
10 Another example is care workers. From early in the
11 pandemic, it was known that staff moving between homes
12 in a highly fragmented sector was a problem. It was
13 raised with the UK Government externally and, we now
14 know, internally. Restricting staff from attending one
15 place of work but not others required a scheme of
16 financial support, but there was a reluctance to provide
17 it.

18 The context was a lack of robust response to safety
19 in the workplaces generally. Lack of PPE, inadequate
20 use of general and individual risk assessments for
21 particularly vulnerable workers, poor social distancing,
22 unnecessary journeys, were all issues commonly reported
23 to the TUC and its unions.

24 Government engagement with sectoral partners
25 including unions was ad hoc and haphazard. Consultation
35

1 support for people self-isolating is key.

2 [Cabinet Office] working through mechanisms (very
3 slowly)."

4 On 7 September 2020 he wrote:

5 "[Chancellor] blocking all notion of paying to get
6 people to isolate despite all the evidence that this
7 will be needed."

8 So it was that the UK Government response was
9 meagre. At the very end of September 2020, months into
10 the pandemic, the self-isolation support scheme was
11 established. Local authorities were given £50 million
12 to fund the scheme. To give that some perspective,
13 my Lady, £70 billion was spent on the furlough scheme
14 and £840 million was spent in the month of August 2020
15 encouraging the public to use restaurants.

16 The TUC subsequently reported that local authorities
17 were rejecting 70% of applications and only a fifth of
18 workers had even heard of the scheme. It was far too
19 little, far too late. The scheme really was tokenistic
20 and devoid of any real commitment to supporting low
21 income workers in high-risk workplaces.

22 In this module, the Inquiry should ask whether all
23 of the professed anxiety for vulnerable groups
24 translated into action. Support for self-isolation was
25 a practical, concrete and entirely obvious way of
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1 on key guidance documents was often late or
2 non-existent. Just by way of example, key guidance
3 produced by the Department of Business, Energy and
4 Industrial Strategy on the return to work after the
5 first lockdown was provided to the TUC on a Sunday
6 morning, with a 12-hour response time. The TUC did
7 respond with a number of concerns raised but the
8 consultation was for too late to be meaningful.

9 All of this reflects an approach which values
10 the economics of work but neglected its safety. That
11 impacted particularly low income and often vulnerable
12 workers who worked in occupations with exposure to the
13 virus.

14 My Lady, our fifth and final topic is
15 decision-making concerning school attendance. The
16 central theme is similar to the general dysfunction in
17 decision-making we described a few moments ago. After
18 the first lockdown, the mantra was to keep schools open.
19 That was a worthy imperative, but the mantra resulted in
20 a pursuit of that objective until it became impossible
21 to continue. It led to hiding from the science rather
22 than being guided by it, until ignoring it was
23 impossible.

24 Unions supported a return to unrestricted school
25 attendance in September 2020 but called for further NPIs
36

1 in schools and also a contingency plan. The government
2 refused.

3 Sir Patrick Vallance noted the Prime Minister saying
4 in a Covid-S meeting on 6 August 2020:

5 "Don't want to hear about plan B and C for failure.
6 I just want pupils back at school."

7 My Lady, the methodology of "don't have a plan B
8 because you might end up using it" is, in the face of
9 a virus such as Covid-19, indefensible.

10 Decision-making through the autumn of 2020, whilst
11 the R rate moved upwards, equivocated. In
12 December 2020, the London Borough of Greenwich was
13 threatened with legal action if it closed school doors
14 in the face of the surging R rate in its area.

15 Ultimately there was the farcical scenario of
16 thousands of primary school children returning to school
17 and mixing for a single day on 4 January 2021 before
18 a U-turn was announced and schools closed again. It is
19 one of the most striking examples of the bullish pursuit
20 of one particular objective, founded on hope against
21 hope, until such pursuit becomes impossible.

22 Education unions were frequently concerned by a lack
23 of government transparency about school attendance and
24 transmission, so it is a concern to see reference in the
25 Vallance diaries to the Department of Education

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1 of applause. We clapped for our carers, we clapped for
2 those putting their lives on the line day in, day out,
3 to keep us safe, to keep our loved ones breathing, to
4 keep our hopes alive.

5 The initiative wasn't just an expression of
6 gratitude, it was an acknowledgement of the sacrifices
7 being made by our healthcare workers, many of whom
8 hailed from black, Asian and minority ethnic
9 backgrounds.

10 Yet there is an unsettling juxtaposition here. As
11 the echoes of the applause rang out, the evidence was
12 mounting, silently and devastating, of the
13 disproportionate impact of Covid-19 that it was having
14 on our healthcare workers of colour.

15 A painful irony was unfolding. While we were
16 clapping for all, were all being cared for in return?
17 While our hands came together in appreciation, was there
18 a parallel commitment from our government to ensure that
19 every healthcare worker, irrespective of their racial or
20 ethnic background, was being equally protected?

21 Sadly, the heartbreaking reality suggests otherwise.
22 The very workers we cheered for, the faces of many of
23 our doctors, nurses and support staff from diverse
24 backgrounds, faced systemic challenges that made them
25 more vulnerable.

39

1 declining to raise questions of SAGE because the minutes
2 would be published.

3 These are important issues which fall within the
4 scope of this module. That Sir Gavin Williamson is not
5 on the witness list appears to the education unions to
6 be an omission, however incidental his role may in fact
7 have been, and the Inquiry is invited to rectify it.

8 My Lady, that is our opening statement. Thank you.

9 **LADY HALLETT:** Thank you very much indeed, Mr Jacobs.
10 Mr Thomas King's Counsel.

11 **Submissions on behalf of the Federation of Ethnic Minority
12 Healthcare Organisations by PROFESSOR THOMAS KC**

13 **PROFESSOR THOMAS:** My Lady, I appear on behalf of the
14 Federation of Ethnic Minority Healthcare Organisations,
15 and I'm instructed by Saunders Law.

16 At the heart of this Inquiry, beneath the layers of
17 documents, data and decisions, lies a deeply human
18 story, one of resilience, adversity and a quest for
19 justice. So, my Lady, I implore you not just to hear
20 but truly listen to the narrative I'm about to give,
21 because it's a testament to those who have given their
22 all in the face of unprecedented challenges.

23 At the height of the pandemic, do you remember every
24 Thursday evening the nation paused? Streets, usually
25 filled with the hum of daily life, echoed with the sound

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1 How can we reconcile the public's heartfelt
2 gratitude with the alleged indifference or oversight of
3 a system tasked with protecting them?

4 You see, it's not enough to clap, it's not enough to
5 express gratitude. True appreciation, true respect,
6 lies in addressing the structural disparities that put
7 our healthcare workers of colour at higher risk. We owe
8 them that much. If we are to clap, let us also commit.
9 Let us commit to understanding, to changing, to
10 rectifying.

11 In our journey for answers, three guiding principles
12 beckon us forward: acknowledgement where there has been
13 ignorance, action in place of inertia, and advocacy in
14 face of silence.

15 FEHMO invokes those principles.

16 Three truths stand unwavering: injustice, if left
17 unchallenged, festers; silence in the face of oppression
18 is complicity; and the power to change is vested in
19 those who dare to speak.

20 FEHMO dares to speak.

21 This pandemic touched each and every one of us in
22 ways we could never have imagined, but as we shall see,
23 it has not touched us all equally.

24 Hearing critiques, especially those anchored in
25 historical and systemic biases, can be a challenging and

40

1 bitter pill to swallow for any institution, including
2 government. This is particularly the case when such
3 critiques target the very foundations upon which
4 an establishment's decisions are based.

5 For the Westminster government, listening to these
6 narratives from organisations such as FEHMO will
7 inevitably stir feelings of discomfort, defensiveness,
8 and perhaps even disbelief. This discomfort emerges not
9 just from the weight of the criticisms, but also from
10 the realisations of serious failings, of not having
11 adequate safeguards for the most vulnerable, despite
12 having the power and resources to do so.

13 However, it is precisely in this discomfort that
14 the potential for genuine growth and change resides. By
15 actively listening to and understanding the concerns of
16 organisations such as FEHMO, the government can embark
17 on a journey of introspection and reform. Avoiding or
18 downplaying these narratives would be a disservice not
19 only to the affected communities but also to the
20 nation's commitment to justice, inclusivity and
21 progress.

22 So let's turn to the government's unpreparedness.
23 The very foundation of good governance is rooted in the
24 ability to anticipate challenges, prepare effectively,
25 and respond decisively. Yet, my Lady, when confronted

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1 of a system that needs drastic re-evaluation and
2 restructuring to truly serve all segments of a society
3 equitably.

4 My Lady, Module 2 will focus on decisions taken by
5 the highest echelons of power. The Prime Minister, the
6 Cabinet, advisers in the civil service, and a coterie of
7 other advisers. This is crucial because it is an apex
8 of where national strategies are formulated.

9 However, to understand the present, one must be
10 acutely aware of the past. The UK's history of racial
11 inequities remains imprinted in the very structures of
12 our institutions, thus decisions that emerge from
13 a system, if not consciously evaluated, can perpetuate
14 those very inequalities. It is imperative that
15 the Inquiry in its probing of these decisions recognises
16 and critiques the underlying dynamics that may have
17 either inadvertently or explicitly sidelined the needs
18 of minoritised communities.

19 I don't need to tell you, my Lady, that structural
20 discrimination is neither new nor unfamiliar. It is
21 deeply entrenched in systems of biases and inequalities
22 that manifest across various facets of society. Black,
23 Asian and other minority ethnic healthcare workers often
24 bear the brunt of this discrimination, facing challenges
25 that range from reduced access to resources, to subtle

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1 with the unfolding catastrophe of this pandemic there
2 was an alarming void in strategic planning specifically
3 addressing the needs of/vulnerabilities of many minority
4 communities.

5 The absence of a structured response targeted to
6 these communities was not just an oversight, it was
7 a glaring omission that stands as a testament to
8 a system ill prepared for the magnitude of the crisis at
9 hand.

10 Yesterday we heard from your counsel to this Inquiry
11 about the numerous early warning signs and data points
12 that should have prompted a more calibrated response
13 from the government. The information was there
14 indicating the communities most at risk and the mounting
15 challenges they faced, yet there seemed to have been
16 a lack of urgency or tangible action in formulating
17 interventions to protect vulnerable populations.

18 You see, the failure to consider systemic
19 discrimination and its impact on these communities'
20 resilience to healthcare crises was particularly
21 concerning. The neglect to connect the dots between
22 historical inequalities and present vulnerabilities
23 revealed a significant lapse in holistic understanding
24 and governance. There was a dual failure: a failure to
25 anticipate and a failure to respond. This, indicative

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1 yet persuasive workplace bias. These systemic
2 disparities compromise not only the wellbeing and
3 professional development of these individuals, but also
4 the overall resilience of our healthcare system.

5 So what are the facts and the lived experiences of
6 the disproportionate impact on communities of colour?
7 Let me share some of them with you.

8 65% to 76% of the Covid-related deaths reported in
9 clinical healthcare workers, despite only making up 20%
10 of the NHS workforce.

11 On 10 April 2020, less than three weeks after the
12 national lockdown was declared, the British Medical
13 Association warned that the first ten NHS doctors to die
14 from the virus were from black, Asian or from minority
15 ethnic backgrounds. The numbers are alarmingly shocking
16 and speak for themselves. The disproportionate impact
17 of Covid on communities of colour is not just
18 statistical, it is deeply human.

19 High infection and mortality rates, coupled with
20 limited access to timely medical care, underscored
21 a troubling reality, for these communities pre-existing
22 health conditions, socio-economic challenges and limited
23 access to resources created the perfect storm,
24 amplifying the ravages of the virus.

25 But it is essential to recognise that this isn't

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1 about biology, but about a system that has historically
2 marginalised certain communities, making them more
3 vulnerable to healthcare crises. Accordingly, it's
4 imperative to first acknowledge a fundamental
5 observation: Covid-19 did not create health
6 inequalities. Instead, the pandemic unmasked and
7 accentuated long-standing disparities that have plagued
8 black, Asian and minority ethnic people and groups
9 within the UK.

10 While recommendations were made for more culturally
11 appropriate occupational risk assessment tools,
12 the realtime implementation of such tools was
13 inconsistent at best, leaving a significant proportion
14 of our healthcare workers exposed and vulnerable.

15 A decision of note was the downgrading of
16 the Covid-19 from a high-consequence infectious disease
17 status, which dictated the type of protective equipment
18 that would be used. This decision, we say, contradicted
19 robust scientific evidence at the time and adversely
20 impacted on the safety of FEHMO members. Whilst some
21 initiatives were launched, such as the FFP3 fit testing
22 project aimed at accommodating diverse facial profiles,
23 they lacked urgency, were inconsistently implemented
24 across healthcare settings.

25 Meanwhile, the very essence of public health

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1 understanding of how these structures adversely impacted
2 our society. For the sake of our shared future, we must
3 ensure that lessons learned from this crisis are deeply
4 embedded in the national consciousness and structural
5 governance. It's not just a question of human rights,
6 but of public health and trust. It's incumbent on all
7 of us to confront these difficult truths of structural
8 racism and health inequality and their reflection in
9 decision-making.

10 My Lady, James Baldwin once said not everything that
11 is faced can be changed, but nothing can be changed
12 until it is faced.

13 You see, this quote encapsulates the essence of our
14 dialogue today. It underscores the urgency, the
15 necessity of confronting hard truths regardless of the
16 discomfort as a precursor to meaningful change.
17 Baldwin's wisdom compels us to be brave, to acknowledge
18 the shortcomings and to relentlessly pursue a future
19 imbued with hope and justice.

20 I end, my Lady, with this, with words from one of
21 FEHMO's members. When asked in conversation with the
22 legal team what, if anything, they think was done
23 adequately and what could have been done better during
24 the pandemic, they said this:

25 "Very honestly, it was too little, too late. From

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1 communications during this period lacked accessibility.

2 For many, my Lady, the language of guidance was
3 exclusively in English, erecting barriers in accessing
4 crucial information.

5 FEHMO members, along with other organisations, rose
6 to the challenge to bridge this communication gap,
7 ensuring that public health messages reached communities
8 in need. In the midst of a crisis, FEHMO's members
9 continued to educate, raise awareness and engage at all
10 levels of governance and administration. Their
11 objective: to highlight very real and often overlooked
12 challenges such as inadequate PPE and heightened
13 exposure to risk faced by ethnic minority healthcare
14 workers.

15 The question then arises: were these issues given
16 due consideration as part of the public sector equality
17 duty under the Equality Act 2010? Our collective
18 responsibility is to probe and ascertain if there were
19 a suspension, even inadvertently, of the fundamental
20 statutory obligation towards the elimination of
21 discrimination.

22 So let me come to the end. By critically examining
23 the impact of structural racism on decision-making by
24 acknowledging the missteps and oversights rooted in
25 systemic biases, this Inquiry can foster greater

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1 an institutional point of view, I'm afraid to say, not
2 enough was done. There was a lack of understanding of
3 the risks faced by vulnerable groups. To put it mildly,
4 I would say it was a lack of awareness or ignorance.
5 Being more blunt, it was apathy and indifference.
6 Without mincing words, systemic racism and institutional
7 discrimination at the heart of structures. Part of it,
8 and it's only an answer, but some of it having
9 representative and leadership at senior levels. At the
10 start of the pandemic there was little diversity of
11 thinking, background and perspective in decision-makers.
12 They were very removed from those on the ground facing
13 the impacts. Being able to understand the extra risks
14 faced by vulnerable people is very important. This must
15 be built in when making pathways and plans. Also to
16 think about people and value them. Their lives were
17 worth safeguarding. People felt like tools that were
18 being used, not lives that were being valued."

19 Thank you.

20 **LADY HALLETT:** Thank you very much indeed, Mr Thomas.

21 Mr Stanton, you'll have to wait until after the
22 break, please. I shall return at 11.25. Thank you.

23 (11.10 am)

(A short break)

24 (11.25 am)

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1 **LADY HALLETT:** Mr Stanton.

2 **Submissions on behalf of the British Medical Association by**
3 **MR STANTON**

4 **MR STANTON:** The British Medical Association, the BMA,
5 believes that the United Kingdom Government's response
6 to the pandemic was categorised by a failure to take
7 a sufficiently precautionary approach and by missed
8 opportunities to learn lessons as the pandemic
9 progressed.

10 These failures placed healthcare workers at greater
11 risk of infection and death, put extra pressure on
12 already stretched and stressed healthcare and public
13 health systems, and caused moral distress and injury for
14 doctors and healthcare workers, who felt unable to
15 provide the right level of care, including for non-Covid
16 patients.

17 This statement highlights the BMA's key concerns
18 regarding matters within the scope of Module 2 under
19 three broad, categories. First, decisions affecting
20 public health.

21 The UK Government's actions to reduce the spread of
22 Covid-19 were too slow, with non-pharmaceutical
23 interventions, NPIs, implemented too late and lifted too
24 early. Examples include the failure to cancel mass
25 gatherings and large sporting events in March 2020,

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1 missed a key opportunity in the summer of 2020 to better
2 prepare for the second wave of Covid-19.

3 In respect of test and trace, there was a failure to
4 adopt a strategy to detect and contain the spread of
5 Covid-19 at scale. The decision to abandon contact
6 tracing on 12 March 2020, 11 days before the UK went
7 into lockdown, left the UK without any effective
8 measures for controlling the pandemic at a critical
9 time, and likely fuelled the number of infections as
10 well as deaths.

11 This decision was ostensibly because the UK was
12 moving from the contain to the delay stage of the
13 pandemic, although it later emerged that it was at least
14 partly due to a lack of testing capacity.

15 Contact tracing was not reinstated for several
16 months, and when it resumed it was delivered via
17 an outsourced national test and trace programme. The
18 rationale for this decision and the failure to properly
19 utilise existing public sector testing infrastructure
20 and contact tracing expertise in favour of expensive
21 private sector alternatives and new systems which
22 yielded poor results will require careful consideration.

23 The UK Government failed to provide clear,
24 consistent and visible public health messaging.
25 For example, there was unclear messaging between 16 and

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1 which undoubtedly led to higher cases, hospitalisations
2 and, very likely, deaths, and the first UK wide
3 lockdown, which only began on 23 March 2020, 11 days
4 after contact tracing was abandoned.

5 The mandating of face masks for the general public
6 was also introduced far too late, and much later than in
7 many other countries. Since 25 April the BMA had been
8 calling for the introduction of face coverings for
9 the public. However, in England they only became
10 mandatory on public transport and for outpatients and
11 hospital visitors from 15 June, and it was not until
12 24 July that they were required in shops and
13 supermarkets.

14 From June 2020 the BMA published its position on
15 what was needed for the safe easing of restrictions,
16 including an effective test and trace system, ongoing
17 surveillance of Covid-19, the use of certain NPIs,
18 including mask wearing, reduced household mixing and
19 better ventilation, and the need for greater support for
20 vulnerable groups and action to reduce health
21 inequalities.

22 In the same period, the BMA also highlighted
23 the need to prepare for the coming winter and to learn
24 lessons from the first wave. However, in its
25 determination to ease restrictions, the UK Government

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1 23 March 2020, when the public were encouraged but not
2 required to change their behaviour. The Eat Out to Help
3 Out initiative encouraged social mixing and confused
4 public health messaging during 2020, suggesting that it
5 was safe for people to socialise before vaccines were
6 available and when the risks of Covid-19 remained high.

7 In 2020 alone, the government campaign around
8 working from home initially encouraged it, then required
9 it, then encouraged it again, then strongly discouraged
10 it, then encouraged it again and then required it again.
11 This pattern continued throughout 2021, and into 2022.

12 This lack of clarity and consistency undermined
13 the public's understanding of and confidence in core
14 public health messaging.

15 Further, high profile failures of MPs, senior
16 advisers and civil servants to adhere to the rules
17 fuelled mistrust and misinformation and further impacted
18 the effectiveness of public health messaging.

19 My Lady, the second category is the safety of
20 healthcare workers. 81% of respondents to the BMA's
21 call for evidence as part of its Covid-19 review said
22 that they did not feel fully protected during the first
23 wave of the pandemic. While recognising the overlap
24 with issues to be considered within Module 3, the BMA
25 believes that central decision-making in this area,

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1 including around the supply of PPE, Covid testing,
2 workplace risk assessments, and infection prevention and
3 control guidance require consideration in Module 2.

4 There can be no doubt that the provision of PPE to
5 healthcare workers during the pandemic was hopelessly
6 inadequate. In the early weeks and months of
7 the pandemic, shortages of vital PPE were especially
8 acute, and the BMA heard from many of its members that
9 they either did not have the right protective equipment
10 or enough of it.

11 The Inquiry was told by several witnesses in
12 Module 1 that the UK never ran out of PPE nationally,
13 but the fact is that doctors and other healthcare staff
14 did not have the PPE they needed. This not only put
15 them at physical risk from Covid-19, but also affected
16 their mental health and wellbeing. In correspondence to
17 the Prime Minister, Public Health England and
18 NHS England, the BMA highlighted the discrepancy between
19 levels of PPE recommended by the World Health
20 Organisation and other nations, with the inadequate
21 provision in the UK.

22 A key failure of government decision-making was and
23 continues to be the failure to properly consider and
24 acknowledge that Covid-19 is an airborne virus. This
25 impacted on the protections available to healthcare

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1 employees are safe and protected at work, yet these were
2 often not performed or were inadequate, particularly
3 during the first wave of Covid-19.

4 In response to these failures, the BMA asked
5 NHS England in April 2020 to develop a national risk
6 profiling framework to assist employers in conducting
7 risk assessments. However, it was not until
8 24 June 2020, three months into the pandemic, that
9 NHS England issued a letter reminding employers of their
10 legal responsibilities to undertake risk assessments.

11 The third and final category is inequalities. The
12 pandemic highlighted disparities within society, widened
13 health inequalities, and impacted groups differently.
14 People from some ethnic minority backgrounds were more
15 likely to become infected with and die from Covid-19.
16 Shockingly, analysis by the Health Service Journal found
17 that 94% of doctors who died up to April 2020 were from
18 ethnic minority backgrounds, even though this group
19 makes up only 44% of NHS medical staff.

20 The BMA was one of the first organisations to raise
21 concerns about this issue. On 9 April 2020, the BMA's
22 chair of council wrote to the CEO of NHS England raising
23 concerns about the disproportionate impact of Covid-19
24 on people from ethnic minority backgrounds and the high
25 rates of Covid-19 deaths amongst this group and called

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1 workers. Deficiencies in IPC guidance meant that
2 respiratory protective equipment, or RPE, which provides
3 the greatest protection against aerosols, was not always
4 provided to staff who were treating patients with
5 confirmed or suspected Covid-19, and that
6 fluid-resistant surgical masks were wrongly deemed to be
7 suitable protection.

8 There is also evidence before the Inquiry that
9 the lack of availability of respirators was because cost
10 considerations were prioritised ahead of safety.

11 The failure to provide healthcare workers with
12 the right level of protection has caused serious harm to
13 many BMA members and the wider healthcare workforce,
14 many of whom are still suffering today with long Covid
15 acquired in their workplace.

16 There was also an initial lack of testing capacity
17 which meant that there were not enough tests for all
18 patients and healthcare workers who needed one, leading
19 to the unwitting transmission of Covid. The lack of
20 testing also had a significant impact on workforce
21 capacity, with many NHS staff unnecessarily required to
22 self-isolate which exacerbated frontline staff
23 shortages, especially at the outset of the pandemic.

24 Risk assessments are mandatory under health and
25 safety law and are an important tool in ensuring that

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1 for an urgent investigation.

2 The BMA also raised concerns about other groups who
3 were disproportionately impacted by the pandemic, such
4 as those who were clinically vulnerable, due to
5 pre-existing medical conditions or other factors, older
6 people and those living in care settings and disabled
7 people.

8 The BMA suggests that central to the Inquiry's
9 Module 2 investigation should be an examination of
10 the likely impact of NPIs and other government decisions
11 on particular groups, the extent to which early warnings
12 about disproportionate impacts were adequately taken
13 into account and the extent to which action was taken to
14 mitigate disproportionate impacts.

15 Thank you, my Lady.

16 **LADY HALLETT:** Thank you very much indeed, Mr Stanton.

17 Mr Allen King's Counsel.

18 **Submissions on behalf of the Local Government Association by**
19 **MR ALLEN KC**

20 **MR ALLEN:** Good morning, my Lady. As in Module 1 of this
21 Inquiry, I represent the Local Government Association.

22 Scrutinising when the pandemic was at its height,
23 the LGA applied to become a core participant for two
24 reasons: it represents the collected voice of local
25 government, with over 99% of the English principal local

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1 authorities; and councils played an absolutely major
2 role in bringing the country through the pandemic.
3 During Module 1 it was widely acknowledged the
4 nation's preparedness and resilience plans were ill
5 focused and inadequate, and in this module the Inquiry
6 will look at how those preparations were deployed and
7 how government at all levels made policy under pressure
8 and then operationalised it.

9 Some things are already quite clear. Policy
10 decisions had to be made very quickly and then revisited
11 as events unfolded. Central government did not always
12 utilise all the sources of advice and information, and
13 sometimes, as Mr Keith discussed yesterday, because of
14 internal disorganisation.

15 Now, the LGA emphasises that these tasks were not
16 for central government alone. Whatever policies were
17 announced centrally, they had to be delivered locally.
18 And if central government policy making ignored
19 partnership with local government, its delivery was
20 likely to flounder. These short points contextualise
21 the most important issues for local government in this
22 module. In summary, these are: subsidiarity and
23 decision-making, local tiering and local lockdowns, key
24 decision-making regarding both adult social care and
25 care at home, test and trace and isolate, and data

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1 virus.

2 Mobilisation within local government occurred well,
3 with everyone determined to make a positive
4 contribution. Thousands of workers volunteered
5 overnight to change roles temporarily to contribute to
6 the emergency effort. Very quickly, both unilaterally
7 and where necessary in response to the national
8 emergency legislation, local authorities redesigned and
9 re-prioritised essential local services, and in some
10 cases suspended services and introduced new operating
11 models.

12 My Lady, the LGA's chief executive has submitted two
13 witness statements setting out this work and that of
14 the LGA. It is happy that those witness statements
15 should be published as soon as the Inquiry thinks
16 appropriate.

17 This evidence shows how councils were able to devise
18 solutions that were effective on the ground precisely
19 because they knew best how things could be made to work
20 in their communities. They restructured around
21 essential services to deliver novel support services
22 such as shielding, supporting vaccination roll-out, and
23 the rapid distribution of business support, whilst also
24 ensuring the continued delivery of critical core council
25 services. And this flexible and engaged response of

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1 sharing between central and local government.

2 Why are these so important? To answer that, I need
3 only sketch some of the roles that local authority
4 officers and elected members had in this period.

5 Firstly, social workers continued to support those
6 already drawing on their support. Social care
7 commissioners continued to work closely with care
8 provider partners to ensure people had access to the
9 services they needed. Public health teams continued to
10 control outbreaks. Emergency planners organised the
11 local response. Revenue and benefit teams administered
12 business support grants. Customer service teams
13 contacted millions of clinically extremely vulnerable
14 people. Bereavement services supported relatives in the
15 most stressful of circumstances. And employees across
16 the councils delivered emergency food parcels.

17 More could be said about roles like environmental
18 health, health visitors, refuse workers. They kept the
19 usual services running as normal, while hundreds of
20 thousands of employees were re-deployed to frontline
21 Covid response roles.

22 So the LGA very much hopes that the Inquiry will
23 recognise that, from the very start, the goodwill,
24 experience and expertise of local government was there
25 to be harnessed to the task of overcoming the Covid

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1 local authorities we say demonstrates the great
2 importance of subsidiarity and localism, and also the
3 contribution that elected members and officers rooted in
4 their local communities bring to civil society on
5 occasions such as this.

6 I will now emphasise some key points that are
7 important both for the public to know and to provide, we
8 say, focus for this module.

9 First, the LGA invites the Inquiry to recognise
10 explicitly that there could not have been any success in
11 addressing this emergency if local government had not
12 been fully engaged from the outset. It asks you to note
13 how local government was able to act flexibly and take
14 early decisive action, officers reacting positively to
15 requests to change roles and patterns with little
16 notice, consultation or discussion.

17 But also, so much more could have been done. For
18 instance, as has been mentioned already this morning,
19 the NHS Test and Trace system in England was
20 commissioned centrally and designed and created
21 independently from local government. The LGA considers
22 that this significantly impeded effective collaboration
23 and slowed down the ability to actually effectively
24 speedily test, trace and isolate people with the virus.

25 Secondly, in the early stages, there was

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1 a regrettable delay in central government's engagement
2 with local government, and thus a failure to benefit
3 from councils' understanding of their communities. We
4 emphasise four aspects of this.

5 This delay affected the design of schemes of very
6 great importance to the community at large.

7 For example, in relation to shielding the clinically
8 extremely vulnerable and contact tracing, as well as to
9 aspects of the legislation that was introduced and
10 supporting guidance.

11 Secondly, consistent concerns were raised with the
12 LGA by its member councils from an operational
13 perspective. These concerned the timeliness of
14 government decision-making and communication to
15 councils, and decisions about funding and workforce
16 issues. We acknowledge, over time, engagement did
17 improve.

18 Thirdly, many aspects of the response demonstrated
19 the problems in trying to design, control and manage
20 from the centre activities which must be delivered
21 locally to tackle local challenges. Local government
22 was simply not often enough a partner in co-designing
23 the response to the pandemic, despite its critical
24 operational role in managing this.

25 Fourthly on this aspect, particularly at the

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1 My Lady, you've already heard much, important
2 submissions, about inequality this morning.

3 Now, the fourth main point we want to make is that
4 there is no doubt that the crisis required the best use
5 of all available data. This issue is of great
6 importance, since it was relevant at so many levels,
7 from the implications of the infection rates for
8 particular groups to the identification of the
9 clinically vulnerable during lockdown. It is highly
10 likely that initial delays in providing local
11 authorities with quality granular data meant that the
12 pandemic response was not as effective as it might have
13 been. These delays had particular impact on efforts to
14 support the clinically extremely vulnerable, on test and
15 trace and on vaccination rates.

16 The Local Government Association is clear that
17 the rules for data sharing in an equivalent crisis
18 require review. Efficiency requires greater
19 harmonisation, with: one, timely access across all
20 national public health agencies and other relevant data
21 generating institutions; two, a code of conduct for data
22 producers and data users relevant to such circumstances;
23 and three, an acceptance that local authorities
24 routinely use personally identifiable data in
25 a professional and safe way and can be trusted to do so.

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1 beginning, the disconnect between national policy
2 formation and its local implementation meant that
3 councils spent much effort trying to stitch together
4 different elements of the pandemic response on issues
5 such as PPE and volunteering and test and trace.

6 The LGA acknowledges the pressure on civil servants
7 and government politicians, but really this does not
8 excuse it, those failures to make the best use of local
9 government.

10 Now, the third main aspect that we want to raise
11 with you is the government's introduction of
12 checkerboard tier systems and the localised lockdowns
13 approach, because this was very confusing.

14 Again, there are four subpoints to this.

15 The top-down approach inadequately considered local
16 challenges such as overcrowded housing or
17 intergenerational living.

18 Secondly, there were also communication issues. In
19 some areas local leaders learnt about new restrictions
20 literally merely hours before the public.

21 Thirdly, councils sometimes even had to support
22 residents in multiple different tiers within their local
23 area.

24 And fourthly, this kind of confusion about rules and
25 engagement led to an increasing sense of inequality.

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1 The LGA is particularly pleased to see the expert
2 evidence from Gavin Freeguard and it hopes his
3 contribution can help the Inquiry to see what needed to
4 be done and how this could be achieved.

5 My Lady, the fifth and last aspect I want to mention
6 concerns social care both at home and in care homes.
7 There were many issues about this. In normal times,
8 careful consideration, prioritisation and planning for
9 care homes and domiciliary care is critical, and this
10 was equally true, if not more so, during the pandemic.

11 Yet while such a mutual relationship seems to have
12 operated between the government and the NHS, the
13 relationship between central and local government in
14 respect of the responsibilities for social care, both at
15 home and in care homes, was in no sense comparable. In
16 short, it seems that central government did not really
17 know how to address the 18,000 providers and 150 local
18 authorities concerned with social care. Thus, adult
19 social care settings suffered severe problems from lack
20 of PPE, from cross-infection, and from high morbidity.

21 Thus the arrangements for the funding, organisation
22 and deployment of PPE for social care were far slower
23 for social care than for the NHS. And thus
24 consideration and treatment of the social care sector
25 was at times late and piecemeal, with an overall

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1 governmental failure to offer those involved in this
2 sector, whether staff or care recipients, equality of
3 esteem with the NHS.

4 The LGA urges this Inquiry to highlight
5 the importance in any future similar crisis of
6 addressing the needs of and the risks in the social care
7 sector on a basis of equality with its approach to the
8 NHS. Protecting those in social care must never be
9 an afterthought. It is a matter of absolutely equal
10 priority.

11 My Lady, thank you, we look forward to assisting
12 during this module.

13 **LADY HALLETT:** Thank you very much, Mr Allen.

14 Mr Phillips, there you are.

15 **Submissions on behalf of the National Police Chiefs' Council**
16 **by MR PHILLIPS KC**

17 **MR PHILLIPS:** My Lady, the National Police Chiefs' Council
18 is a national co-ordinating body which represents all UK
19 police forces, and in this Inquiry it's
20 a core participant not just in this module but also in
21 Modules 1, 2A, 2B and C, and in that capacity it
22 represents UK policing; no individual police force or
23 police officer is a core participant.

24 The functions of the NPCC include the co-ordination
25 of national operations, the co-ordination of

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1 policing's response to the pandemic. It was established
2 in March 2020 when, in the early stages of the crisis,
3 the NPCC recognised that the police's strategy for
4 the pandemic would require a co-ordinated national
5 approach.

6 As everyone in this room knows, the pandemic created
7 challenges in every aspect of public and private life.
8 Policing and police officers faced many such challenges
9 as the pandemic affected every part of the service.
10 Police officers and their leaders had to adjust to novel
11 conditions, without any idea of how long they would
12 last, of how far police resources would be diminished
13 through isolation or infection, and do what they could
14 to ensure they were able, so far as possible, to
15 discharge their usual duties and functions whilst also
16 paying proper regard to their responsibilities for the
17 safety and welfare of officers and staff.

18 My Lady, Operation Talla was an unprecedented
19 national response to this unprecedented situation.
20 During the course of the pandemic, the work of
21 Operation Talla covered just about every area of
22 policing and deployed all available resources of
23 the NPCC.

24 As you know, the police were one of the key
25 frontline organisations dealing with the day-to-day

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1 the national police response to national emergencies,
2 the co-ordination of the mobilisation of resources
3 across force borders, and the national operational
4 implementation of standards and policy as set by the
5 College of Policing and government.

6 The NPCC is led by a full-time chair elected by
7 the organisation's membership. Its primary
8 decision-making body is the Chief Constables' Council,
9 which is made up of the chief constable or a chief
10 officer representative of each member organisation. It
11 allows member forces to reach agreement on issues of
12 national application, to ensure best practice, and the
13 adoption of a joined-up approach.

14 However, the chief officers of each force retain
15 their operational power and independence and may
16 derogate from Council's decisions, and this reflects
17 the fundamental point that the NPCC has no operational
18 directive powers in relation to forces. It cannot
19 instruct a force or an individual officer to take action
20 or to refrain from acting. Operational policing
21 decisions remain the responsibility of force leads and
22 individual officers, including in the context of
23 a national emergency.

24 Now turning to the issues with which this Inquiry is
25 concerned, Operation Talla was the name given to the UK

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1 impacts of the pandemic on members of the public and on
2 local communities, whilst also dealing with its impact
3 on the police workforce and on normal policing activity,
4 as well, of course, as on their own families and
5 households.

6 Now, in this module, the Inquiry has decided to
7 focus on the enforcement of Covid-19 regulations.
8 However, at all stages of the pandemic, the work of
9 the NPCC and of Operation Talla encompassed far more
10 than that in terms of the co-ordination of the national
11 policing effort.

12 Moreover, the NPCC played no direct role in
13 the enforcement of the regulations. As I've explained,
14 the NPCC has no operational command or directive powers
15 in relation to forces or individual officers.
16 Enforcement remained at all times the responsibility of
17 individual officers and forces.

18 However, a vital aspect of the NPCC's work during
19 the pandemic was the drawing up and dissemination of
20 guidance and of clear and accurate operational briefings
21 on a wide range of issues to all forces and, through
22 forces, to police officers and staff. As part of that
23 work, the NPCC worked with the college to produce and
24 circulate briefings on the practical application and
25 effect of the Covid-19 regulations.

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1 My Lady, the key guidance issued by the NPCC and
2 the college in March 2020 for achieving compliance with
3 these regulations was the four Es approach: engage,
4 explain, encourage, enforce. The message was simple:
5 enforcement was the last resort, after the first three
6 Es had been undertaken.

7 This guidance of course reflected another
8 fundamental point, which is that in this country we have
9 policing by consent. The task faced by the police in
10 the pandemic was to encourage the public to comply with
11 regulations which were judged by government to be in
12 everyone's best interests and which were also designed
13 for their protection, whilst at the same time retaining
14 their trust. That was a formidable assignment.

15 The four Es guidance remained in place throughout
16 the pandemic and was regularly referred to in
17 operational briefings and in public statements.
18 However, it did not include specific details on how to
19 approach each of the steps or on how, when or at what
20 stage or speed to move from one step to the next. Those
21 questions were always for individual officers on the
22 frontline.

23 That said, the guidance reflected the core
24 recognition that compliance with restrictions optimised
25 public safety and, as I've noted, that enforcement was

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1 **LADY HALLETT:** Thank you very much indeed, Mr Phillips.
2 Mr Sheldon, I think you're over there.

3 **Submissions on behalf of the Government Office for Science**
4 **by MR SHELDON KC**

5 **MR SHELDON:** My Lady, on behalf of the Government Office for
6 Science, we wish to start by expressing our sincere
7 sympathy for the enduring loss suffered by those
8 affected by the pandemic. It is also right to
9 acknowledge the wider public and the altruism they
10 showed in countering Covid. We also wish to reaffirm
11 our commitment to what we understand to be the common
12 goal of those participating in this Inquiry, namely to
13 examine what happened in order to inform and improve the
14 country's collective response to future pandemics,
15 whatever form they take.

16 The Government Office for Science, GO-Science, is
17 a small organisation. At its head is the Government
18 Chief Scientific Adviser, the GCSA, who reports to the
19 Cabinet Secretary. During the pandemic, the GCSA was
20 Sir Patrick Vallance, and the director of GO-Science was
21 Dr Stuart Wainwright OBE. The current GCSA is
22 Dame Angela McLean. All have provided witness
23 statements and all will be giving oral evidence.

24 Together GO-Science and the GCSA provide science
25 advice to the Prime Minister and the Cabinet and promote

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1 the last resort.

2 But there was in this one important constant, namely
3 that it was and remained the duty of the police to
4 enforce the law. It was no part of their remit to
5 enforce government policy per se, still less to enforce
6 government guidance.

7 My Lady, the provisions of the Coronavirus Act and
8 the related regulations led the police service into the
9 area of public health policing, which was largely
10 uncharted territory, and brought with it a recognised
11 risk of impact on the perception of and on public trust
12 in policing.

13 Moreover, as is well known, there were frequent
14 changes to the legal framework in which the police had
15 to operate by way of the introduction of new or amended
16 regulations, often at very short notice.

17 Meeting all these challenges required and received
18 an exceptional response from policing. For the duration
19 of the health emergency presented by the pandemic,
20 flexibility and resilience were needed throughout the
21 service as it adapted to the novel responsibilities
22 conferred on it and sought to keep the public safe.

23 That's all I wish to say at this stage, my Lady.

24 The NPCC will continue to assist the Inquiry in any way
25 it can.

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1 and support the provision of science advice in all
2 government departments. Their remit covers the whole of
3 science, and whilst Sir Patrick happens to have had
4 a background in medicine and medical research, which was
5 plainly of considerable value, that was a matter of
6 fortunate chance.

7 During government-wide emergencies, GO-Science
8 convenes and provides secretariat support for SAGE, the
9 Scientific Advisory Group for Emergencies. During the
10 pandemic SAGE was co-chaired by Sir Patrick and the CMO,
11 Sir Chris Whitty. SAGE is not a permanent standing
12 committee and it does not have members. It exists only
13 when it is activated by COBR in response to
14 an emergency.

15 Its role is to provide science advice to COBR and to
16 ministers, bringing together experts relevant to that
17 particular emergency to inform science advice in a way
18 that is co-ordinated, comprehensive and comprehensible.

19 Those who participate in SAGE and its sub-groups are
20 experts drawn from inside and outside government to give
21 independent advice drawn from their expertise and
22 experience. It is vitally important to a proper
23 understanding of the role of SAGE and the GCSA that the
24 distinction between the giving of advice and the taking
25 of decisions is properly understood.

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1 The As in GCSA and SAGE stand for adviser and
 2 advisory respectively, and it is the clearly defined
 3 role of both to provide advice on relevant scientific
 4 matters and not to make policy.

5 Nothing, including, we would suggest, the mantra of
 6 "following the science", should be permitted to blur
 7 that fundamental distinction.

8 The GCSA and SAGE provided advice to the government
 9 on scientific issues relating to the pandemic. The
 10 policy decisions that were taken in light of that advice
 11 were taken by ministers and officials. Operational
 12 implementation of those policies was undertaken by
 13 specialist bodies and services. The advice provided by
 14 the GCSA and SAGE was restricted to matters of science.
 15 The S in both acronyms stands for scientific, and again
 16 accurately defines their respective remits.

17 The fact that science advice given to the government
 18 during the pandemic was delivered in a more transparent
 19 manner than other forms of advice may have led it to be
 20 accorded a disproportionate prominence in relation to,
 21 for example, economic, political or operational advice,
 22 which was delivered far less transparently. This may
 23 contribute to an inaccurate impression that science
 24 advice was directing policy making when it was in
 25 reality only one of the relevant considerations taken

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1 individuals and structures was enormous. There were
 2 105 SAGE meetings during the two years of the pandemic.
 3 The next highest total for any event in which SAGE has
 4 been called is 22. The range and breadth of scientific
 5 issues addressed was also unprecedented.

6 SAGE's role is to deliver a clear and accessible
 7 account of the current state of scientific understanding
 8 on the issue in question to government decision-makers.
 9 This includes communicating degrees of certainty, causes
 10 of uncertainty, and gaps in the evidence base.

11 The questions addressed by SAGE were often complex,
 12 novel, multifaceted and impossible to answer with
 13 certainty. There will inevitably be a tension between
 14 a desire for clear answers and decisive action on the
 15 one hand and the communication of uncertainty and the
 16 need for further investigation on the other. Both
 17 imperatives are understandable in the context of
 18 a public health emergency when the stakes are at their
 19 highest, and a difficult balance must be struck.

20 Sir Patrick explains in his statement how he sought
 21 to communicate advice developed by SAGE to ministers in
 22 this context. He asked himself four questions:

23 First, is the evidence that is available sufficient
 24 to address the issue, and if not, what should be done to
 25 develop more evidence or reduce uncertainty?

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1 into account by decision-makers.

2 One benefit of the transparency, including the
 3 publication of the minutes of all SAGE meetings, is that
 4 the Inquiry now has a comprehensive and contemporaneous
 5 account of the totality of the science advice given to
 6 the government. In addition, Sir Patrick has provided
 7 a witness statement running, as you know, to almost
 8 250 pages which sets out a full chronological account of
 9 the science advice he provided, when it was provided,
 10 and to whom.

11 However, it is important to keep in mind that SAGE
 12 and GO-Science were not the only sources of science
 13 advice. Individual departments drew upon their own
 14 network of science advisers. The DHSC and the public
 15 health agencies are responsible for the provision of
 16 science advice on health matters, including health
 17 emergencies, in most situations. They provided the
 18 clinical and operational advice that lies outside SAGE's
 19 remit. So it should not be thought that if something
 20 was not considered at SAGE it was not considered at all.

21 The evidence submitted by GO-Science demonstrates,
 22 we would suggest, that the challenges of providing
 23 the government with timely and authoritative scientific
 24 advice during the pandemic were unprecedented in their
 25 scale and complexity. The strain they placed on

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1 Second, has the advice, including the uncertainties,
 2 been expressed clearly so that it has been understood by
 3 the policymakers, bearing in mind they may have no
 4 science background?

5 Third, has the science advice been presented in
 6 a way to make it relevant and useful in formulating
 7 policy?

8 Fourth, has the decision-maker understood the ways
 9 in which science can be used going forward to update
 10 the advice and monitor the impact and effect of
 11 the relevant policy?

12 Now, my Lady, it will be for you and the Inquiry to
 13 assess whether those objectives were met, although we
 14 would respectfully suggest that on a fair and objective
 15 analysis of the evidence they were. But the point for
 16 present purposes is that they illustrate the challenges
 17 inherent in delivering scientific advice in a complex
 18 and long-running national emergency such as the
 19 pandemic. Formulating an account of the current state
 20 of scientific knowledge on the difficult questions posed
 21 by the pandemic is hard enough. Communicating that
 22 advice in a manner that will be useful to
 23 decision-makers when making difficult policy choices is
 24 harder still.

25 The analysis must also ensure, we submit, that

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1 the pandemic is considered over its full duration.
 2 Countries are affected differently at different stages
 3 of a pandemic, depending upon a variety of demographic,
 4 environmental, economic, societal and health factors,
 5 and that was certainly the case with Covid as it swept
 6 across the world.

7 The UK was seeded with infection across the country
 8 in February and March 2020, largely from importation
 9 from Europe rather than directly from China. In the UK,
 10 the first and second waves caused the most damage, with
 11 the second causing more death and illness than the
 12 first. In other countries, infection started locally
 13 rather than nationally, and in some others the deadliest
 14 waves came significantly later.

15 A disproportionate focus on specific periods,
 16 particularly in the early stages of the pandemic, will
 17 inevitably produce a distorted and potentially
 18 misleading picture of decision-making and the role
 19 played by scientific advice in the formulation of policy
 20 across the whole period of the pandemic.

21 My Lady, this module will inevitably be valuable in
 22 identifying ways in which decision-making and the
 23 provision of science advice to decision-makers can be
 24 improved in a national emergency such as this.

25 The technical report on the Covid-19 pandemic in

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1 Thank you, my Lady.

2 **LADY HALLETT:** Thank you very much indeed, Mr Sheldon.

3 Mr Howells.

4 **Submissions on behalf of the Welsh Government by MRHOWELLS**

5 **MR HOWELLS:** My Lord, on behalf of the Welsh Government, may
 6 I begin by quoting the First Minister of Wales in his
 7 statement in this module:

8 "The pandemic touched the lives of everyone: my own,
 9 my colleagues, our communities, but none more so that
 10 the many families who lost loved ones. I want to
 11 acknowledge this loss ... and take this opportunity to
 12 express my personal sympathies and sincere condolences,
 13 to those affected, and to all who sadly lost loved ones
 14 across the nations. The pain and sadness of their
 15 losses will last a lifetime and I will continue to
 16 recognise this at every opportunity. Sadly, too many
 17 families have lost loved ones. This cruel virus has
 18 stolen lives and it has left their loved ones with
 19 questions, which they rightly want answered. I would
 20 also like to take an opportunity to recognise the
 21 suffering of those who continue to live with the
 22 debilitating after-effects of the virus. We continue to
 23 learn not only of the impacts on our health but on our
 24 society as a whole. I, and the Welsh Government, are
 25 committed and will remain committed to this Inquiry and

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1 the UK published last December, to which Sir Patrick
 2 contributed, provides a helpful starting point. But the
 3 effectiveness of the UK's response to future pandemics
 4 can only be improved by subjecting the core
 5 decision-making to further scrutiny. Covid-19 was
 6 ruthless in exposing those systems and structures that
 7 were particularly challenged by an emergency of this
 8 complexity, speed and duration. In a pandemic, the
 9 speed of implementation of the measures has to be fast,
 10 faster than the doubling time of the infective agent,
 11 and clear lines of accountability and responsibility are
 12 vital. In some areas, improvements were made as the
 13 response evolved, and we hope and expect the Inquiry
 14 will identify others.

15 Finally, GO-Science and the GCSAs would wish to
 16 restate their acknowledgement of the extraordinary
 17 efforts of the many scientists, academics and clinicians
 18 who assisted SAGE and its sub-groups, including
 19 colleagues from overseas. The workload was formidable
 20 and the pressure was intense. They stepped forward
 21 voluntarily and often at a cost to personal and family
 22 lives. They did so not for personal advancement or
 23 financial gain, but to help. Their work saved many
 24 lives, and the country was fortunate to be able to call
 25 on them.

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1 to learn lessons for the future."

2 As the Inquiry recognises, an important part of
 3 examining the effectiveness of the UK Government's
 4 response is to examine how it conducted
 5 inter-governmental relations with the devolved
 6 governments. The Welsh Government made decisions it
 7 considered were in the best interests of the people of
 8 Wales. Of course it considered what was being done
 9 elsewhere across the UK, but its primary objective was
 10 to make the right decisions for the people of Wales
 11 based on the scientific and medical advice for the
 12 circumstances that prevailed in Wales, which differed to
 13 what was happening in the rest of the UK.

14 The actions of the devolved governments should not
 15 be judged by ascertaining what the UK Government did
 16 first and then asking why the devolved governments
 17 diverged. Decision-making in Wales was undertaken in
 18 accordance with its legal responsibilities.

19 The Welsh Government is reassured by my Lady's
 20 statement that there is an obvious value in assessing
 21 decision-making across the four nations and the
 22 interactions between them. The Welsh Government in
 23 particular welcomes the confirmation that your current
 24 intention is to publish one report which considers
 25 the decision-making in all four governments, having

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1 considered the evidence in Modules 2, 2A, 2B, and 2C.

2 The First Minister has provided two statements for
3 Module 2 which he hopes will assist and inform
4 the Inquiry's investigation. Mr Drakeford would also
5 like to repeat in public his offer to give oral evidence
6 in this module so that his perspective as head of
7 government can be heard and, importantly, examined.

8 The Welsh Government knows that the Inquiry's
9 investigation will follow the evidence. That is why,
10 given the matters that will be examined in Module 2, and
11 how modern UK is governed, we hope that you will keep
12 under review the decision not to call evidence from the
13 heads of devolved governments in this module. They will
14 provide an invaluable perspective on core
15 decision-making in the UK, without which there is a risk
16 that the full and complex picture of governance will not
17 be heard and an opportunity for much needed reform will
18 be lost.

19 The Welsh Government invites your Ladyship to
20 consider three particular issues: firstly, the nature
21 and effectiveness of the UK Government's dealings with
22 the Welsh Government in relation to non-pharmaceutical
23 interventions; secondly, the funding arrangements
24 governing the response to health emergencies between the
25 Treasury and the devolved governments; and thirdly, the

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1 preparations.

2 Mr Johnson did not attend a single Joint Ministerial
3 Committee meeting with the First Ministers. Until COBR
4 was re-engaged in October 2020, when the circumstances
5 across the UK were deteriorating badly, he did not meet
6 them once. Boris Johnson's reason for not meeting the
7 First Ministers was his belief that, to avoid the
8 impression that the UK was a federal state, he should
9 not be seen to be doing so. His concern with
10 appearances did not recognise and so did not meet the
11 scale of the events confronting the four nations. As
12 a reflection of the UK Government's attitude to close
13 and effective co-ordination between the four
14 governments, this evidence is telling.

15 The First Minister regularly asked for regular
16 meetings with the Prime Minister to discuss the path out
17 of lockdown and then to discuss circuit breakers. Those
18 requests were ignored. The UK ministers and former
19 UK ministers that the Inquiry will hear from seek to
20 highlight the importance of consistent decision-making
21 across the UK. However, the reality is that
22 the UK Government made consistency difficult to achieve
23 in practice, because it failed to support the means
24 which might have secured those ends.

25 The second main point is the funding of a health

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1 benefits of effective devolved decision-making.

2 Those issues have been addressed in our written
3 submissions but I wish to focus on a few key points this
4 morning.

5 Firstly, the decision-making structures.

6 Until May 2020 the then Prime Minister Boris Johnson
7 engaged with the First Ministers of the devolved
8 governments via COBR. It can be seen from the minutes
9 of COBR that all four governments were alive to
10 the benefits of a common approach, but they were also
11 alive to the reality that the pace and implementation
12 would be different in each country depending on
13 the scientific and medical advice upon which decisions
14 had to be based.

15 However, in May 2020 the UK Government decided
16 unilaterally to reorganise its Cabinet committee
17 structures. It ceased holding COBR meetings. Instead
18 it implemented Covid-S, strategy, and Covid-O,
19 operations, to reflect the structures which had been
20 adopted as part of the Brexit preparations. When that
21 change was made, Mr Johnson accepted a recommendation
22 that COBR was to be replaced with the Joint Ministerial
23 Committee meetings, to ensure that the Prime Minister
24 met the First Ministers. This was a decision-making
25 structure used to good effect as part of the Brexit

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1 emergency. The First Ministers dealt very clearly with
2 the barriers that were created by the Treasury to
3 the devolved governments implementing restrictions they
4 considered necessary on the scientific and medical
5 advice available to them. The length of the firebreak
6 in Wales was influenced by the refusal of Mr Sunak to
7 bring forward the enhanced job support scheme, which
8 came into force on 1 November 2020, in time for the
9 lockdown in England.

10 The effect is powerfully explained by the
11 First Minister in his statement:

12 "On 23 October 2020, the Welsh Firebreak came into
13 effect. Had we had the confidence that the
14 UK Government would provide the money needed to support
15 people during the firebreak we probably would have
16 implemented the lockdown sooner. However, it was hard
17 for Wales to take the initiative, because that meant we
18 had to take the decision without financial support
19 provided by the UK Government. Nevertheless, I felt
20 strongly that we needed to implement the fire break to
21 delay the spread of the virus, because that was what the
22 science was telling us.

23 "The Chancellor of the Exchequer refused to fund the
24 consequences of a public health decision taken in Wales.
25 That decision was, in my view, one of the most misguided

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1 decisions of the whole pandemic. It demonstrated that
2 the four nations of the UK were to be treated
3 differently by HM Treasury. It was, in effect, acting
4 as a Treasury for England, not as a Treasury for the UK.
5 This was vividly illustrated when, within a few days of
6 the Welsh firebreak a similar set of measures were
7 adopted for England. Funds to support that cause of
8 action were then released by the UK Treasury. Those
9 funds extended to Wales, but only because of decisions
10 taken in response to the public health position in
11 England, not because of the public health needs in
12 Wales."

13 The issue of the availability of financial levers
14 was raised time and again and by the First Ministers,
15 but as of today it remains unresolved.

16 My Lady, the third main point is the reality and
17 benefits of devolved decision-making. Both Mr Johnson
18 and Mr Gove suggest that in any future response to
19 a health emergency, the UK should be treated as one
20 epidemiological unit and that the UK Government's
21 backstop powers should be strengthened. There are three
22 fundamental problems with that course.

23 Firstly, both Mr Johnson and Mr Gove accept that
24 the decisions taken by the Welsh Government were
25 reasonable and were based on local circumstances. In

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1 decisions would have a practical impact. So the idea
2 that the UK Government could swing in and make effective
3 or in some way better decisions for Wales is
4 misconceived.

5 The Welsh Government looks forward to contributing
6 to and supporting the Inquiry's work. This module
7 provides a unique and valuable opportunity to assess
8 critically but fairly how intergovernmental
9 relationships work and to make recommendations for
10 improvement.

11 Diolch yn fawr.

12 **LADY HALLETT:** Thank you very much.

13 Can I just say this in relation to the point about
14 not calling the First Ministers in Module 2. I do
15 understand the concerns, of course I do, and I know that
16 Mr Drakeford has expressed his concern to the Inquiry
17 team. But can I assure everybody, we will of course be
18 falling the First Ministers in the specific Modules 2A,
19 2B and 2C, where appropriate, but also I've told
20 the Inquiry team I want to ensure that nothing falls
21 between the cracks, so if there's anything that
22 Mr Drakeford has raised in his witness statements for
23 this module that needs to be put to the UK ministers,
24 they will be put. And similarly, if the UK ministers
25 raise anything, it will be put to Mr Drakeford when we

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1 particular, they accept the decision to impose the
2 firebreak in Wales ahead of England was reasonable as
3 infections were rising and tiering was not working.
4 That recognition of the effectiveness of devolved
5 decision-making is inconsistent with the call for
6 greater centralised power.

7 Secondly, the devolved decision-making under health
8 protection legislation was the consequence of
9 the UK Government's own decision not to use UK-wide
10 legislation such as the Civil Contingencies Act or
11 the Coronavirus Act. It is not a proper basis for
12 criticising the devolved settlements that have now
13 existed for nearly a quarter century.

14 Thirdly, the sectors most affected by the public
15 health emergency, health, education, social care and
16 local government, had been devolved for more than
17 two decades when Covid-19 struck. None of these policy
18 areas have been the responsibility of the UK Government
19 for that length of time, and by 2020 each of them
20 operated under different legislative, policy and funding
21 arrangements from England and the rest of the UK.

22 The UK Government was not only unfamiliar with those
23 arrangements, but it lacked any practical presence on
24 the ground. It simply lacked the means to implement any
25 decisions which it might make far from where those

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1 get to 2B. So please rest assured and assure
2 Mr Drakeford and the other First Ministers or former
3 First Ministers that we will ensure that all the matters
4 they are concerned about will be taken into account.

5 **MR HOWELLS:** My Lady, I'm grateful.

6 **LADY HALLETT:** Thank you.

7 Ms Drysdale.

8 **Submissions on behalf of Scottish Ministers by**

9 **MS DRYSDALE KC**

10 **MS DRYSDALE:** Good afternoon, my Lady. I appear with
11 Julie McKinlay advocate, on behalf of the
12 Scottish Government.

13 My Lady, the Scottish Government wish to acknowledge
14 the scale of the loss and suffering of those in Scotland
15 and the rest of the United Kingdom during the pandemic
16 and recognise the central importance of the bereaved and
17 all those affected by the pandemic to the Inquiry
18 process.

19 In this context, the Scottish Government wish to
20 emphasise their full commitment to the Inquiry to ensure
21 that the response to the pandemic is properly
22 scrutinised.

23 The Scottish Government wishes to assist
24 the Inquiry, to participate fully in it, to listen to
25 the evidence and to learn lessons for the future.

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1 My Lady, I wish to address you on five key themes,
2 which are: devolution, intergovernmental relations,
3 data, public health communications, and inequalities.

4 Turning to the first of these, my Lady, devolution.
5 The Scottish Government's decisions and actions in
6 relation to its devolved responsibilities will be
7 examined, of course, in Module 2A. However, devolution
8 forms the context for the decision-making of governments
9 in the UK and is therefore also relevant to Module 2.

10 My Lady, devolution does not necessarily imply
11 difference, nor does a reserved or centralised
12 decision-making necessarily imply uniformity.

13 The Scottish Government's strategic objective in
14 responding to the pandemic was to contain and suppress
15 the virus, to minimise the overall harm it could do,
16 taking into consideration the available scientific,
17 clinical and public health advice. Its engagement with
18 the UK Government was undertaken with that objective.

19 My Lady, the Scottish Government recognised
20 the harms caused by the impact of the pandemic and
21 the government response. A key part of that was
22 consideration of the four interrelated harms which were:
23 direct Covid-19 health harm, other health harm caused by
24 the pandemic, societal harm, and economic harm.

25 Devolved control of the public health response was
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1 Scottish Government took the approach of tailoring
2 restrictions to local circumstances.

3 The Scottish Government took decisions at all times
4 based on its best assessments combining evidence and
5 judgement of what were the most appropriate actions to
6 minimise the harm of the pandemic to the Scottish
7 population.

8 Naturally the Scottish Government recognises that
9 devolution must be accompanied by effective arrangements
10 for co-operation between the four nations of the UK, and
11 the Scottish Government's objective in engagement with
12 the UK Government and the other devolved governments was
13 not uniformity of approach, which would not have been
14 appropriate or proportionate, but rather co-operation on
15 matters of mutual interest and where there was
16 an interface with devolved decisions.

17 Overall, the Scottish Government considers that
18 there were benefits of devolution in the context of
19 the pandemic response due to subsidiarity, with
20 decisions taken at the lowest possible level, reflecting
21 regional variations and promoting trust and compliance
22 with restrictions.

23 Turning to my second theme, my Lady,
24 intergovernmental relations, where devolution allows all
25 four UK administrations to take decisions having regard

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1 crucial to the effective handling of the pandemic in
2 Scotland. The Scottish Government respectfully submits
3 that the Inquiry should exercise caution in considering
4 the merits of devolution as a political concept, which
5 is a constitutional settlement.

6 The issue of the operation of devolution is relevant
7 to the pandemic and response, but the merits of
8 devolution are an issue that is collateral to the
9 pandemic. Devolution allows the people of Scotland to
10 choose political representatives that reflect their
11 views, and the Scottish Ministers are accountable to
12 the Scottish Parliament rather than to the UK ministers.

13 There is a close connection in Scotland between the
14 devolved powers and the administrative benefits of
15 a cohesive and efficient system. The close connection
16 ensures clear lines of democratic accountability which
17 are essential to good government.

18 My Lady, it was for the devolved governments rather
19 than for the UK Government to take decisions about
20 devolved matters, including NPIs, and to be accountable
21 to their respective legislatures and electorates. Given
22 the widely varying geographical and epidemiological
23 circumstances across Scotland, and conscious of the need
24 to balance the impact on social and economic activity of
25 measures necessary to suppress virus transmission, the

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1 to the circumstances within their areas of
2 responsibility, effective intergovernmental relations
3 allow each to align with others to the extent necessary
4 to meet the needs of the people they serve. Devolution
5 requires effective intergovernmental relations both
6 routinely and in exceptional circumstances.

7 Generally it is the view of the Scottish Government
8 that intergovernmental arrangements worked effectively.
9 COBR was a well tested mental mechanism enabling
10 effective intergovernmental relations when necessary.

11 A range of Covid-specific groups then evolved to
12 meet the needs of intergovernmental relations in
13 the pandemic, and as the pandemic developed
14 the four nations took different decisions, particularly
15 in relation to NPIs that differed in timing and nature.

16 An effective response does require the ability to
17 tailor approaches to geographical circumstances, and it
18 would be incorrect to consider that the approach
19 followed by the UK Government for England was
20 the orthodox approach from which other UK nations
21 diverged. Across the UK, there is a wide range of
22 geographical and social circumstances, and a uniform
23 approach would not have been able to take account of
24 such variation.

25 The Scottish Government took the approach of

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1 tailoring measures to circumstances within different
2 parts of Scotland using the Scottish levels system. The
3 government considered different Scottish circumstances
4 and its own responsibilities to the Scottish population.
5 The Scottish Government invites the Inquiry to recognise
6 that where circumstances were justified,
7 a geographically tailored approach was appropriate.

8 The arrangements for intergovernmental liaison
9 evolved during the pandemic from an initial focus on
10 emergency mechanisms such as COBR to a range of Covid
11 specific groups, but throughout the pandemic there were
12 mechanisms for regular and frequent communication across
13 the response and the development of strong working
14 relationships between governments.

15 My Lady, it's been suggested that the Civil
16 Contingencies Act 2004 should have been used rather than
17 public health legislation to bind the UK together due to
18 the risk of divergence. The implication is that in
19 a future pandemic the UK Government should lead
20 the response using its emergency powers under
21 the 2004 Act. The Scottish Government submits that this
22 should remain as devolved decision-making rather than
23 using emergency legislation, that the 2004 Act was not
24 an appropriate vehicle for the government response to
25 the pandemic, and would not be if a similar pandemic

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1 My Lady, turning to my fourth theme, public health
2 communications. Communicating information about
3 the government response and the actions of
4 the population was critical. Therefore a priority for
5 the Scottish Government from the outset was to ensure
6 the most effective public communication possible.
7 Generally, information sharing between the UK and
8 Scottish Governments about public health communications
9 enabled both governments to plan, but trust in
10 the Scottish Government was consistently higher than
11 trust in the UK Government throughout the pandemic.
12 This is possibly a reflection on the effect of
13 devolution on communication.

14 As the public health advice and response to the
15 pandemic between England and Scotland started to differ,
16 communications had to differ, and
17 the Scottish Government submits that UK Government
18 public health communications could have been clearer as
19 to their territorial scope.

20 My Lady, turning to my final theme, inequalities,
21 the Scottish Government welcomes the Inquiry's
22 commitment to learning the detailed lessons on
23 inequalities and welcomes the expert evidence on
24 the effect that existing structural inequalities in
25 society had on vulnerable and at-risk groups during the

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1 occurred in the future.

2 The Scottish Government refutes any suggestion that
3 its decisions were at times politically motivated.
4 Justification of divergence was set out
5 contemporaneously and the Scottish Government's shared
6 intention with the UK Government was to save lives and
7 minimise the harm from the pandemic.

8 Turning to my third theme, my Lady, data. The
9 Scottish Government recognises the importance of
10 efficient communication between the UK Government and
11 the other devolved governments about data. It worked
12 collaboratively with the other governments of
13 the United Kingdom. The core structures at
14 UK Government level were COBR, SAGE and its
15 subcommittees, and the Scottish Government participated
16 constructively in these to the extent that it was
17 invited to do so. It also participated in various
18 four nations meetings and liaised extensively with
19 four nations counterparts.

20 Overall, the Scottish Government was impressed by
21 the quality of the advice that emerged from
22 the four nations processes but there was often
23 an English focus. This prompted the establishment of
24 a new advisory group, the Covid-19 Advisory Group in
25 Scotland.

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1 pandemic. The Scottish Government recognises that we
2 have an opportunity to make fundamental and lasting
3 changes to address these issues.

4 The Scottish Government has been committed to
5 the eradication of inequalities in health and social
6 care for years. During the pandemic, consideration of
7 inequalities and the principle of fairness were integral
8 parts of the four harms decision-making approach.

9 The Scottish Government commits to listening
10 carefully to the evidence of witnesses in respect of
11 structural inequalities and to learning lessons for
12 the future.

13 My Lady, in conclusion, the Scottish Government will
14 examine and consider closely the recommendations that
15 the Inquiry makes in relation to Module 2. It
16 understands that the most important way to recognise
17 the loss and suffering of the people of Scotland and
18 the wider UK population during the pandemic is to learn
19 from the evidence, to identify what could have been done
20 better, and to improve government decision-making in
21 a pandemic to save lives and to prevent future
22 suffering.

23 Thank you.

24 **LADY HALLETT:** Thank you very much, Ms Drysdale.

25 Ms Studd, sorry you've had to wait so long.

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1 **Submissions on behalf of the Cabinet Office by MS STUDD KC**

2 **MS STUDD:** My Lady, the Cabinet Office has provided
3 the Inquiry with a written opening which undoubtedly you
4 will read in due course.

5 This is an abridged version to comply with the time
6 constraints required to permit all those
7 core participants who wish to speak the opportunity of
8 doing so.

9 The period between January 2020 and February 2022
10 presented challenges to our country that were
11 unprecedented in peacetime.

12 The government is committed to ensuring that lessons
13 are learned and recognises the importance of this module
14 in ensuring that the country is prepared for future
15 risks and threats. You will be aware, my Lady, that
16 the Cabinet Office has already implemented a number of
17 lessons learned which we do not have time to deal with
18 in this abridged opening statement, but which we have
19 set out in our written opening.

20 My Lady, the strategic response to the pandemic was
21 prepared with input from experts and other departments
22 and was agreed by the Prime Minister and other
23 ministers. Particularly in the early period,
24 the Cabinet Office, including Number 10, sought to lead
25 the response at a time of exceptional pressure on

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1 the planning could reflect the advantage of that testing
2 ability.

3 Similarly, the vaccine roll-out provided a further
4 opportunity to revise the strategy. The vaccines, along
5 with the lessons learned over 2020, were at the heart of
6 the February 2021 roadmap for the lifting of the third
7 and final lockdown, as well as the strategy for living
8 with the virus published at the end of February 2022.

9 Underpinning the structural framework of
10 decision-making is the Cabinet system of government,
11 based on the principle of collective responsibility.
12 Individual Cabinet committees are established to
13 consider a particular area of government business.
14 Cabinet committee decisions have the same authority as
15 Cabinet decisions. Of course departments also routinely
16 take many decisions that do not require collective
17 agreement.

18 Following the emergence of the outbreak in Wuhan in
19 January 2020, the Cabinet Office worked closely with
20 the Department of Health and Social Care to monitor
21 the situation and set out trigger points for escalation.
22 It convened the first ministerial COBR meeting on
23 24 January to discuss the government's response.

24 The COBR process, as you have heard, is intended to
25 respond to short-term crises. So as the pandemic

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1 the centre of government, including during the illness
2 of the Prime Minister, for whom Dominic Raab, the then
3 first Secretary of State, deputised.

4 A key role of the Cabinet Office throughout
5 the relevant period was to seek to ensure that
6 the Prime Minister and other ministers were equipped
7 with strategic advice which balanced the different
8 impacts of the pandemic between health, the economy and
9 society.

10 The Cabinet Office co-ordinated a strategic response
11 across government, bringing together the range of
12 departmental views and helping to ensure that
13 ministerial decisions were implemented effectively.

14 Particularly in the early phases, strategic plans
15 were developed in an environment of significant
16 uncertainty, about both the characteristics of the virus
17 and the path of the pandemic, and against the backdrop
18 of catastrophic reasonable worst-case scenarios.

19 As the scientific understanding of the virus
20 developed, and as lessons arising from the response were
21 learned, strategic planning too had to develop and
22 adapt. Strategic planning was also influenced by
23 the tools that were or were not available at any given
24 stage. For example, once the Department of Health and
25 Social Care had built a testing architecture,

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1 escalated and the response developed, correspondingly so
2 did the structures required to meet it.

3 From 16 March 2020 ministerial implementation groups
4 were introduced to lead the government's key lines of
5 operation, running alongside COBR and Cabinet meetings.
6 The ministerial operation groups reported in to
7 a 9.15 am strategy meeting chaired by the
8 Prime Minister.

9 In early May 2020, the government published a phased
10 roadmap out of lockdown. It became clear that
11 the governance structure, less complex and more
12 sustainable for the longer term, was required. From
13 28 May 2020 the ministerial implementation groups were
14 replaced by the Covid Strategy Committee, Covid-S, and
15 the Covid Operations Committee, Covid-O.

16 Throughout this evolution of governance structures,
17 the government sought to maintain the principle of
18 Cabinet collective responsibility despite the speed of
19 events. By way of example, Covid-O met over 200 times
20 during this Module 2 period to help ensure that
21 the significant decisions were made collectively and
22 rapidly.

23 To support decision-making, the Covid-19 Taskforce
24 was established in May 2020 and increased in size over
25 the subsequent months.

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1 This was the unit at the centre of government which
2 joined together strategy, analysis and co-ordination
3 with departments across Whitehall, working closely with
4 the Chief Medical Officer and the Government Chief
5 Scientific Adviser.

6 I turn now to deal with data. As many witnesses
7 made clear in their written submissions to the Inquiry,
8 they were working with a novel coronavirus, and
9 consequently with imperfect information, particularly
10 during the early period. Collecting and synthesising
11 data in the initial and critical stages of the pandemic
12 was not a challenge unique to the UK Government but
13 rather a global issue.

14 Nevertheless, the government sought to develop
15 the structures required to collect the necessary data
16 and evidence and integrate it into a single analytical
17 picture. The Covid dashboard, operated by
18 Cabinet Office, brought together a wide range of
19 information provided by an analytical community across
20 government. It was used frequently to present updates
21 to the Prime Minister and inform ministerial meetings.

22 Over time, the availability of data across a broad
23 range of indicators significantly improved, enabling
24 better formed decisions to be made, with a higher degree
25 of certainty.

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1 government in the United Kingdom. The spread of
2 the virus across the country and the measures in place
3 in different parts of the country were not always
4 uniform. The Cabinet Office endeavoured to engage
5 constructively with the devolved administrations. From
6 the start of the pandemic, for example,
7 the First Ministers of Scotland, Wales and
8 Northern Ireland were regularly invited to COBR
9 meetings. The Chancellor of the Duchy of Lancaster also
10 had regular calls with the First Ministers to support
11 co-ordination between the devolved administrations and
12 the UK Government.

13 There is significant evidence of data sharing
14 between the UK Government and the devolved
15 administrations throughout the pandemic, and where
16 concerns were raised, efforts were made to address them.
17 Provision of data to local authorities and regional
18 mayors improved substantially over the period.

19 To conclude, this Inquiry is an unprecedented moment
20 of transparency about the government of this country.
21 Many thousands of documents have been provided to
22 the Inquiry, and you will hear from dozens of witnesses
23 who had direct involvement in decisions and
24 decision-making.

25 In responding to Covid-19, the government sought to

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1 There remained, of course, many unknowns, such as
2 whether and when a vaccine might be available and
3 delivered at scale. This meant that the government had
4 to make its best judgments based on assumptions of risk
5 and trade-offs without certainty.

6 Equality concerns were also an important part of
7 understanding and responding to the virus. The
8 taskforce had analytical and policy teams dedicated to
9 understanding the impact of the pandemic on
10 disproportionately impacted groups. They conducted
11 a broad range of analysis, which informed policy making
12 across government, ministerial meetings and equality
13 impact assessments.

14 The Equality Hub provided data and evidence to
15 assist the Cabinet Office and government more widely,
16 including on the prevalence and impact of Covid-19 on
17 communities who were considered to be at greater risk.

18 The Race Disparity Unit, which became part of the
19 Equality Hub in September 2020, informed the
20 government's understanding of the prevalence and impact
21 of Covid-19 on different communities, helping to shape
22 the government's response throughout the relevant
23 period.

24 The pandemic also posed novel challenges to
25 frameworks for decision-making across all levels of

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1 balance the impacts of the virus on health, on
2 the economy and on society. The response began in the
3 context of acute uncertainty and evolved over time as
4 the virus was better understood, as more tools were
5 developed to combat it, and as lessons were learned.

6 The Cabinet Office can assure you, my Lady, that it
7 welcomes the opportunity to further improve its
8 capabilities to be able to respond in the event of any
9 future pandemic.

10 **LADY HALLETT:** Thank you very much, Ms Studd.

11 Right, well, that completes the opening statements
12 of those who wish to make oral submissions, as
13 I understand it. So we're now moving to evidence, which
14 I think will be ready at 2 o'clock this afternoon,
15 Mr Keith.

16 **MR KEITH:** My Lady, yes, we'll be hearing at 2 o'clock from
17 Ms Goodman on behalf of Covid-19 Bereaved Families for
18 Justice.

19 May I before that, however, invite you to give
20 permission to publish the written submissions filed
21 before you by the core participants.

22 **LADY HALLETT:** I so order. Thank you.

23 Right, well, I know that some have quite a lot to do
24 this lunchtime, so a little extended lunch will probably
25 go down quite well.

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1 **MR KEITH:** Yes, very well, thank you.

2 **LADY HALLETT:** Very well, 2 o'clock.

3 (12.48 pm)

4 (A short break)

5 (2.00 pm)

6 **MR KEITH:** My Lady, may I please call Joanna Goodman.

7 **MS JOANNA GOODMAN (affirmed)**

8 **Questions from LEAD COUNSEL TO THE INQUIRY**

9 **LADY HALLETT:** Ms Goodman, I appreciate this could be
10 difficult for you, so please just say if it gets too
11 much. All right?

12 **A.** Thank you very much.

13 **MR KEITH:** May I please ask you to start by giving us your
14 full name.

15 **A.** Yes, it's Joanna Sophie Goodman.

16 **Q.** Ms Goodman, whilst you give evidence, could you try to
17 keep your voice up as much as you can, so that we may
18 all hear you as clearly as possible.

19 **A.** Yes.

20 **Q.** Also because your voice needs to be clearly received by
21 the microphone so it can be recorded.

22 If I ask you a question that isn't clear, which may
23 be quite possible, please ask me to repeat it.

24 **A.** Yes.

25 **Q.** Ms Goodman, you have been good enough to provide this
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1 they looked pretty much like a shopping list of his
2 health conditions, and I still have a message that
3 I sent to him on 3 March telling him that I wished I was
4 able to wrap him up in a giant ball of cotton wool.

5 At the time I was actually in India, and in India it
6 was already very clear that the virus was something to
7 be feared, that -- for instance, in my statement I gave
8 the example of the festival of Holi on 10 March,
9 festivities were very, very much scaled down. And
10 people were actually approaching me and saying, "Oh,
11 you know, it's really worrying to see how quickly cases
12 are rising in the UK", and I was very, very anxious
13 about my own father. So I was on the phone to my
14 parents most days in March 2020 to say, you know, "Oh
15 it's really worrying, you know, there are more cases",
16 and my family -- effectively we made the decision to
17 shield my father from long before the first lockdown.

18 **Q.** Can I just pause you there.

19 **A.** Yes.

20 **Q.** There's quite a lot to take in there from that.

21 Your father had had, I think, a number of health
22 issues in the years before the pandemic, including two
23 heart attacks, and therefore was it the position that
24 a considerable amount of care had to be taken to
25 ensuring that he remained healthy thereafter, and
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1 Inquiry with a statement signed in fact on 27 September
2 of this year. We don't need to bring it up, but it's
3 INQ000281297. Is that your statement? And it is
4 of course true.

5 And my Lady, perhaps that could be published in due
6 course.

7 We heard in Module 1 from Matt Fowler. Was he, is
8 he, the co-founder, with you, of Covid-19 Bereaved
9 Families for Justice?

10 **A.** He is.

11 **Q.** I'm going to ask you some questions about your father
12 Stuart in a moment or two, but did the group Covid
13 Bereaved Families for Justice come into being at the end
14 of April 2020 soon after you had lost your own father on
15 2 April?

16 **A.** Yes.

17 **Q.** Could you just say something about why you instituted
18 the group, why you commenced it, and what was it about
19 the circumstances of your father's death which caused
20 you to have to set up, as you saw it, that group?

21 **A.** Yes. So my father Stuart, he was someone who, from very
22 early on, we knew was likely to be vulnerable to
23 Covid-19. He was 72, he had a number of health issues,
24 and at the time he was undergoing diagnosis for cancer.

25 When the risk factors for Covid-19 were published,
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1 obviously that he was protected to whatever degree was
2 required?

3 **A.** Yes. I think it was very clear to myself and my family
4 very early on that should my dad contract Covid-19
5 the chances of him surviving were very low, and so that
6 was why, I guess, it was a no-brainer for us that we
7 needed to do everything we could to keep him safe, and
8 that included -- for instance, my mum works as a music
9 therapist in schools, she stopped into going schools,
10 they scaled back their social contact and then
11 eventually stopped their social contact before the first
12 lockdown. My brother stopped going to visit my parents
13 because he also worked in a school and was coming into
14 contact with a lot of people.

15 So --

16 **Q.** Was the problem, the immediate problem at that time,
17 that your father had had a scan the previous autumn,
18 around about November 2019, which had required him to go
19 into hospital to get the results of that scan?

20 **A.** Yes. So my dad was no longer going out in public in
21 general. On 18 March 2020 he had an appointment at
22 the Norfolk & Norwich Hospital to receive his cancer
23 diagnosis. I was very anxious about that appointment,
24 and I actually called him on the morning of
25 the appointment begging him not to go, because I felt
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1 that no testing was taking place, there was no treatment
 2 taking place. As far as I was concerned that
 3 appointment could have happened over the phone.
 4 **Q.** Just pausing there, which part of the country was the
 5 hospital that your father was required to attend?
 6 **A.** It was in Norwich, in the East of England.
 7 **LADY HALLETT:** I think the clue was in the name.
 8 **MR KEITH:** Did she say Norfolk?
 9 **LADY HALLETT:** Norfolk & Norwich.
 10 **MR KEITH:** Yes, I should know that.
 11 Did your mother and father go to hospital together?
 12 **A.** They did go to hospital together. My dad was of
 13 the view that he wouldn't be invited to attend
 14 an appointment if it wasn't safe, and he had a huge
 15 amount of faith in the NHS. He never liked to be
 16 a burden, particularly to public services, and he felt
 17 that it was -- he want didn't want to kick up a fuss and
 18 ask for an appointment to happen over the phone. So
 19 they went --
 20 **Q.** They were together?
 21 **A.** They were together. And they spent the day in crowded
 22 waiting rooms with no mitigations in place, no
 23 face masks, no social distancing, no ventilation.
 24 **Q.** Just pause there. They recounted this to you,
 25 presumably?

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1 diagnosed with cancer, and I had to wheel my suitcase at
 2 a distance to my mum as we both sobbed in the street,
 3 I think, at about 8 am on a Sunday, probably much to the
 4 bemusement of the neighbours. But yeah, the intention
 5 was that myself and my brother would isolate in order to
 6 keep him safe.
 7 And it's worth saying, actually, that I landed at
 8 Heathrow on the morning of, I believe, 22 March, if that
 9 was the Sunday, and --
 10 **Q.** You might have landed on the 21st.
 11 **A.** I might have landed on the 21st, yeah.
 12 **Q.** I don't think there's any disagreement on the date.
 13 **A.** Yes. And I was very anxious about what I needed to do
 14 to keep my father safe, having been on a busy flight.
 15 The only sign of any guidance there was to me at
 16 Heathrow was a single person with a leaflet who I asked,
 17 you know, "I'm planning to isolate for two weeks, is
 18 that the best course of action?" And they just said,
 19 "You don't need to isolate unless you've got symptoms,
 20 here's a leaflet", and it just very basically said if
 21 you have symptoms to isolate then. But, yeah, I was
 22 quite shocked, actually that there was no testing, no --
 23 yeah, no --
 24 **Q.** No measures in place.
 25 **A.** -- proper guidance, no distancing. I was actually told

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1 **A.** Yes.
 2 **Q.** Did your father receive his diagnosis that day?
 3 **A.** He did, yes.
 4 **Q.** He did, and that was of, I think, non-Hodgkin lymphoma?
 5 **A.** Yeah.
 6 **Q.** He came back home. Were you still abroad at that stage
 7 or were you by then travelling back?
 8 **A.** I was still abroad when I was notified of the diagnosis.
 9 So previously we'd been led to believe that the cancer
 10 was likely to be slow moving and non-aggressive. It
 11 then became clear it was aggressive and required
 12 immediate treatment, so I made the decision to travel
 13 home as soon as I was able.
 14 **Q.** And because of your father's condition, and because of
 15 Covid, did you and your brother decide to self-isolate
 16 for the whole period that you believed was appropriate,
 17 in order that you could then see your father and
 18 of course your mother thereafter?
 19 **A.** Yes, so this was prior to the first lockdown, and
 20 the plan myself and my brother had come up with was that
 21 we would isolate at his home and then -- with the
 22 intention to move home with our parents while my dad was
 23 undergoing chemotherapy.
 24 So I came home from India having not seen my parents
 25 for four months and knowing that my dad had just been

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1 by a flight attendant on my flight, because I was
 2 wearing a face mask at the time, I was told, "Oh, you
 3 haven't been taken in by all this, have you?" And that
 4 was very much the -- the mood, it felt, at the time.
 5 **Q.** Your father started the chemotherapy on the first day of
 6 lockdown. Did he go back to the same hospital for the
 7 chemotherapy where he had received his diagnosis?
 8 **A.** He did. None of us were able to attend with him, so my
 9 mum took him there and then needed to leave him. He
 10 wasn't tested prior to starting the course of
 11 chemotherapy, and I think what's worth saying is that we
 12 believe that he contracted Covid when he attended that
 13 appointment on 18 March --
 14 **Q.** When he received his diagnosis --
 15 **A.** When he received his --
 16 **Q.** -- rather than when he went in for his first dose of
 17 chemotherapy?
 18 **A.** Yes. And so we believe that he would probably already
 19 have tested positive for Covid-19 on the day he began
 20 his chemotherapy treatment, but no test was offered.
 21 And, as you will know, chemotherapy, it compromises your
 22 immune system, so any hope that he would have had of
 23 surviving Covid, I think the chemotherapy --
 24 **Q.** Would have disposed of that?
 25 **A.** Yeah.

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1 Q. Did he start to show symptoms on the Thursday, the 26th,
2 and the Friday, 27 March when you were speaking to him?
3 You were obviously still self-isolating, so we presume
4 that was on a phone or video?

5 A. Yeah. So we did a Zoom call with him on the Thursday,
6 and -- my dad always had a bit of a cough, but he had
7 a real kind of coughing fit on this video call, and
8 I was quite worried and asked him if he was okay but he
9 insisted he was. He then went on to deteriorate, become
10 very lethargic over the next few days, and overnight on
11 the Saturday into the Sunday, he lost his lucidity,
12 yeah, forgot who my mum was, was vomiting, was very,
13 very unwell, and she called an ambulance and he was
14 taken into hospital.

15 Q. So he was taken to hospital on the Sunday, 29 March. On
16 the Monday were you told that he had been tested or at
17 least told that he had Covid?

18 A. Yeah. So I think that was the hardest moment of all of
19 it, and -- I'm sorry, I will get emotional, but to
20 quote --

21 **LADY HALLETT:** Just take your time.

22 A. No, but I was just going say, to quote Brenda Doherty
23 from the first Module, I think emotion is good and it's
24 important that we don't hide it, because this is,
25 you know, real life trauma.

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1 a lower number of cases in Norfolk at the time, and my
2 dad was on the early side of those cases, they allowed
3 us to visit him, we were able to spend time with him one
4 by one. But it was just the hardest time.

5 So we were able to go in, I think, on the Tuesday
6 morning and he passed away on the Thursday morning in
7 the early hours. And just to watch, across that 48-hour
8 period, one of the people that you loved most in
9 the world just being absolutely taken apart by this
10 virus, you know, and -- yeah, I feel very, very lucky
11 that I was able to be with him, but I will also always
12 have those images of my dad in his dying days.

13 And I think, you know, we talk a lot about what is
14 a good death, and I think, you know, this wasn't that,
15 but my dad was lucky that he had I think as good -- as
16 good a death as was afforded to anyone during Covid, in
17 that he was able to have his family around him.

18 Q. Did the hospital allow you back in a second time, on the
19 Wednesday, the day in fact before he died, after they
20 told you that he was -- that it was time?

21 A. Yes. So on the Wednesday evening the hospital called us
22 and said that we should come, because he -- they didn't
23 think he was going to make the night.

24 Q. Right.

25 After your father passed away, do we presume that

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1 Yeah, so I received a phone call from my mum to tell
2 me -- at the time we'd been very worried because he had
3 a fever, which we thought was perhaps an infection
4 following on from the chemotherapy, but we knew that he
5 was in a Covid assessment bay, which we were very
6 worried about, because at the time we didn't think he
7 had Covid.

8 And, yeah, my mum phoned on the Monday evening and
9 she said, "Are you sitting down? It's Covid". And
10 I think I just howled. Like, I don't know what my
11 brother's neighbours thought, but that was the
12 worst moment, because it felt as though we had done
13 everything in our power to protect him, and yet, as I'll
14 go on to discuss, it felt that the fact that
15 the government had failed to keep their end of
16 the bargain in that regard meant that he had still been
17 exposed to it. And the person that I least wanted to --
18 you know, the person that I most wanted to protect in
19 the world had Covid, and we knew at that point that
20 there was no hope of him surviving.

21 **MR KEITH:** Were you allowed on the Tuesday to go into
22 hospital to see him?

23 A. Yeah. So this is where I have to say that myself and my
24 family were immensely privileged, because this wasn't
25 afforded to all families. But because there were

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1 the funeral was not -- that it was a funeral that was
2 subject to the restrictions which were then in place and
3 therefore you were denied the ability to have any more
4 than ten people there, there was no proper wake and it
5 was one of those appalling, dreadful events --

6 A. Yes, that's correct, only ten of us at the graveside.

7 Q. -- as a result of the Covid restrictions?

8 What aspect of the infection of your father with
9 Covid or the hospital treatment or the way in which you
10 were denied the ability to attend a proper funeral
11 afterwards led you to set up the Covid Bereaved Families
12 for Justice group?

13 A. I think I immediately found it very difficult to grieve.
14 Not in the kind of traditional sense, in terms of
15 the funeral, obviously that was not available to us, but
16 I found it very hard emotionally to feel the -- to go
17 through the natural emotional process of grieving,
18 because I think what was blocking me was that I felt
19 very strongly that his death was not an inevitability.
20 I felt that as a family we had taken decisions, with
21 very limited access to information, to protect him. It
22 was clear to us that we needed to protect him, and it
23 felt as though the government had done absolutely
24 nothing.

25 So I think when we look at 18 March, the date where

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1 we believe he contracted Covid, up until that date
 2 I don't think there's a meaningful tangible action that
 3 I could point to that the government had done to protect
 4 my father. So, you know, there hadn't been the border
 5 control or testing that had happened in other countries,
 6 community testing wasn't happening, infection control in
 7 hospitals wasn't being looked at. Clearly, from his
 8 experience. There were just so many things that I could
 9 point to, you know --

10 **Q.** You felt that --

11 **A.** -- I could go on.

12 **Q.** -- that were contributory features?

13 **A.** That were contributory features to the prevalence of
 14 Covid-19 in the community at that time.

15 And we received my dad's shielding letter nine days
 16 after he passed away, and I think that was a real
 17 trigger for me. I just felt like that was -- you know,
 18 how did we know that we needed to shield him from early
 19 to mid-March when the government didn't, you know,
 20 didn't take any action to reduce transmission in the
 21 community until much later? And didn't take action to
 22 protect him individually until nine days after he died.

23 **Q.** All right.

24 Did you see this, of course, befalling hundreds,
 25 thousands of other people? So one presumes, of course,

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1 had people from all across England, Scotland, Wales,
 2 Northern Ireland, a range of backgrounds, all sharing
 3 different concerns about the specific circumstances of
 4 their loved ones' deaths, but --

5 **Q.** May I just pause you there, because I want to ask you
 6 about what those themes were.

7 **A.** Yeah.

8 **Q.** As you talked to more and more bereaved people, certain
 9 themes undoubtedly emerged?

10 **A.** Yes.

11 **Q.** And I just want to ask you, please, to identify
 12 the broad themes. Presumably they are the themes, in
 13 part, that your group then commenced campaigning about?

14 **A.** Yes.

15 **Q.** Looking for accountability, looking for explanations,
 16 and where appropriate, because some events had already
 17 passed, of course, looking for change?

18 **A.** Yeah. So --

19 **Q.** So let's identify some of the broad themes.

20 From your statement, and you describe it as possibly
 21 the most stark theme that first emerged when you spoke
 22 to other bereaved people, was that the 111 system?

23 **A.** Yes. So that was something that started to -- because
 24 I think instinctively when people found this community
 25 of other bereaved people who shared their concerns,

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1 that you looked around and you saw that, as you describe
 2 in your statement, the same mistakes, the same errors,
 3 the same flaws were occurring again and again and again
 4 and in the cases of everybody else?

5 **A.** I think that came a bit later. So initially for me it
 6 was very much a personal sense that my dad's life had
 7 been treated as expendable and I really questioned
 8 whether decisions had been made by government on
 9 the basis that people like him needed to be protected,
 10 and I at the time I didn't really know what to do with
 11 all of these feelings.

12 I ended up actually speaking to a journalist from
 13 The Independent newspaper the day after his funeral, so
 14 you can imagine the kind of emotional state that I was
 15 in, and I shared with them that I felt strongly that the
 16 government was responsible for my father's death. And
 17 that was how I initially made contact with Matt Fowler,
 18 and he -- I found him in the Facebook comments section,
 19 and he said that he'd lost his dad and, you know, felt
 20 exactly the same as me. So I think that was the first
 21 sense I got that anyone else shared those sentiments.

22 **Q.** Shared your views?

23 **A.** But I think we very quickly agreed that what we needed
 24 to do was see if there were other people that felt
 25 similarly, and it very quickly became evident that we

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1 people shared their stories, and I think that was
 2 probably the quickest pattern to emerge, that there were
 3 a lot of people who were sharing stories of their loved
 4 ones who had become very unwell at home, had done what
 5 they had been asked to do and made contact with
 6 the 111 service and had been asked about their symptoms,
 7 and despite the fact that they themselves and their
 8 families were hugely concerned about them and felt that
 9 they were very, very seriously unwell, the triage
 10 questions were indicating that they should stay at home.

11 **Q.** So just pausing there, it became apparent that there
 12 were a number of questions being raised about the way in
 13 which the triage system, so the way in which people were
 14 assessed to see whether they would be allowed to have
 15 hospital treatment, was being undertaken?

16 **A.** Yes.

17 **Q.** So issues about whether or not the correct symptoms were
 18 being identified?

19 **A.** Yes.

20 **Q.** Whether or not there was some pre-existing policy in
 21 place which denied some people medical care but not
 22 others, for wrongful reasons; is that the gist of it?

23 **A.** Yes. So, for example, I think there were people who
 24 were asked if their loved one could make a cup of tea,
 25 and it was considered if they could make a cup of tea

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1 then they couldn't be gravely ill, despite their
 2 families describing very, very significant other
 3 symptoms.
 4 There were people who were asked if their loved
 5 ones' lips had turned blue, which is a presentation that
 6 might be present in someone with a caucasian skin tone
 7 that might not be present in someone with a darker skin
 8 tone.
 9 There were people who were asked about symptoms
 10 which weren't present but the symptoms which were
 11 present were kind of disregarded.
 12 There didn't seem to be any element to the
 13 assessment process which took into account people's
 14 pre-existing health conditions, so a lot of people had
 15 existing vulnerabilities which made their symptoms
 16 significantly more concerning.
 17 **Q.** Ms Goodman, may I just pause you there, I do apologise.
 18 **A.** Yeah.
 19 **Q.** I want to try to elicit some of the other areas in which
 20 your group --
 21 **A.** Yeah, could I just add two brief points there?
 22 **Q.** Yes, please do.
 23 **A.** The other things was about the accessibility of the 111
 24 service. So I know that one of our members in Wales was
 25 told by the GP that they couldn't deal with a Covid case

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1 **Q.** I'll come on to care homes in a moment. Could --
 2 **A.** That was one of the starkest things that it felt like it
 3 was coming up with in our group, but --
 4 **Q.** Can I come on to care homes in a moment, because I want
 5 to ask you some questions about that, but in terms of
 6 hospital-acquired Covid, hospital-acquired infection --
 7 **A.** Yes.
 8 **Q.** -- to what degree has that been a very major issue
 9 raised by your --
 10 **A.** A very significant issue. A lot of people who were in
 11 hospital for the entire period, so it was very clear
 12 that they contracted Covid. A number of people who also
 13 believed that their loved ones had contracted Covid,
 14 like we believed my dad did --
 15 **Q.** Yes?
 16 **A.** -- at an outpatient appointment. Also people not being
 17 tested on discharge from hospital, and often then going
 18 home, becoming ill, being re-admitted. Or actually
 19 going home to someone else who was vulnerable in the
 20 household. So particularly you can imagine elderly
 21 couples whereby one of them would have been in hospital,
 22 wasn't tested, and on arriving home became ill.
 23 **Q.** Right.
 24 **A.** And then their partner then went on to become ill. And,
 25 yeah, I think it's one of the saddest things that --

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1 and that they needed to go through 111. When they were
 2 trying to get through to 111 repeatedly for, I think,
 3 days and eventually it turned out that 111 didn't cover
 4 that part of Wales, and the GP didn't even know.
 5 There were people who -- English was their second
 6 language, and they weren't able to communicate
 7 effectively their symptoms and their families were
 8 concerned. And in these instances the results were
 9 either people going into hospital very significantly too
 10 late, by which point there was nothing that could be
 11 done, or in some circumstances actually people dying at
 12 home before they were able to access any real medical
 13 attention.
 14 **Q.** Thank you.
 15 Two other areas from your statement appear to be of
 16 particular importance and particularly prevalent. One
 17 is the amount of persons who acquired Covid in hospital,
 18 so nosocomial infection. Did a very large number and do
 19 a very large number of the members of your group say
 20 that their loved ones acquired Covid in hospital? So
 21 that's the first issue. To what extent has that been an
 22 issue that has been raised by your members?
 23 **A.** Yes, I think at the time there was -- there was a lot of
 24 coverage of issues around care homes in the press,
 25 although it didn't cover all of the detail --

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1 there are a number of people in our group who lost both
 2 parents to Covid-19.
 3 **Q.** In relation to care homes, which you've mentioned, are
 4 there two main areas about which the members of your
 5 group have expressed the greatest concern? One is,
 6 of course, the acquisition of infection in the care home
 7 sector, but the other is the related but slightly
 8 different area of the restrictions, the way in which,
 9 their last days in the particular care home, they were
 10 subject to isolation, to absence of contact from their
 11 family and loved ones, and the way in which they were
 12 treated. Is that a second major area of concern?
 13 **A.** Yes. I think it's also a bit broader than that. So
 14 I think the -- obviously the discharge of untested
 15 hospital patients into care homes was a big concern
 16 and -- but also issues around, for example, agency
 17 workers and sickness absence and --
 18 **Q.** Yes, that all goes to the issue of why there was Covid
 19 in the care sector.
 20 **A.** But also actually concerns around access to healthcare
 21 for care home residents. So a lot of members reporting
 22 that their loved ones contracted Covid-19 and having
 23 concerns about how it had come into the care home, but
 24 also feeling as though, because their loved one was
 25 a care home resident and had a number of health

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1 conditions, it was almost assumed that what they would
2 need was palliative care and that that should be
3 provided in the care home rather than it being possible
4 for them to be admitted to hospital for treatment.

5 **Q.** Just pause there. So a very real concern about whether
6 or not they were afforded access to proper medical care
7 when they became infected with Covid?

8 **A.** Yeah.

9 **Q.** Inside the care home sector?

10 **A.** Yeah.

11 **Q.** We are aware, and her Ladyship is aware, that you've
12 sent to the Inquiry a list, around about 23 in fact,
13 a list of 23 people who are members of your group who
14 have set out in terrible and stark terms the details
15 surrounding the way in which they lost their loved ones.

16 I just want to identify for you, if I may, the sorts
17 of themes and issues which emerge from that list, not to
18 give you -- I'm sorry to say -- an opportunity to
19 describe the ways in which their loved ones died, but to
20 identify that some of the broad themes that you've
21 identified already re-occur in that list of other
22 persons.

23 So they deal with areas such as: pre-existing health
24 vulnerabilities, the absence of masks, 111 service
25 (which you've addressed already), nosocomial infection
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1 All Parliamentary Group, of communicating its concerns
2 to ministers and officials in government, or did you
3 take up the baton of campaigning on these issues after
4 the pandemic was over?

5 **A.** No, we very much began campaigning almost immediately.
6 So you mentioned that the group was formed the same
7 month that both myself and Matt had lost our fathers.
8 We and the other people -- I mean, we always say we're
9 the co-founders, but there are so many people who have
10 given so much of their time and energy at the hardest
11 time of their lives to run this campaign, and our goal
12 has always been to ensure that lessons could be learnt
13 and lives could be saved. And I think we never felt
14 that more keenly than in those early days of
15 the formation of the group, because we all felt very
16 strongly that we couldn't do anything to bring our loved
17 ones back, but we could do what we could do to try to
18 prevent further deaths, and what we wanted to do more
19 than anything was to influence the trajectory of the
20 Covid pandemic, because obviously we were still very,
21 very much in the thick of it at that point.

22 And I think none of us felt able to grieve because
23 we felt this sense of -- it was like, you know, we were
24 bereaved but we knew that there were families who were
25 still to be bereaved, and they didn't know that this was
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1 (which you've addressed already), the lack of PPE for
2 key workers, the lack of isolation at work from other
3 people who may have become infected, the lack of
4 financial provision for those who were unable to go to
5 work, and also the general way in which you and they
6 believe that the way in which the government sought to
7 impose non-pharmaceutical interventions was an improper
8 and an inadequate way of getting on top of the control
9 of the virus.

10 **A.** Absolutely.

11 **Q.** Are those the broad themes?

12 **A.** Yes. And I think -- I would like to speak a little bit
13 to the experience of running the group in that period,
14 if I may.

15 **Q.** Would you forgive me if I invited you to decline that
16 self-imposed invitation? The running of the group is
17 not central to the underlying problems --

18 **A.** No, sorry, I'm saying -- so I suppose the way that we
19 tried to influence those decisions is what I would like
20 to speak to, because I think --

21 **Q.** Can I ask you this, an alternative way: was the group
22 formed pre-pandemic or during the pandemic?

23 **A.** It was formed during the pandemic.

24 **Q.** Therefore, as the pandemic rolled on, did the group have
25 an opportunity of giving evidence, for example, to the
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1 the most important thing that they needed to do, to
2 prevent -- I can't really articulate it properly, but it
3 felt like there were families who would one day be us,
4 and we didn't want them to be, and we wanted to do
5 whatever we could do to -- we always said, you know,
6 even if we could save one life, it will have been worth
7 all of it, so ...

8 But in those early days we were kind of desperately
9 trying to get the government to engage with us. So we
10 sought a meeting with the Prime Minister and then
11 Health Secretary, we wrote to various ministers, we got
12 a lot of responses basically saying they were very busy
13 handling the pandemic and couldn't speak to us. And at
14 the same time I think very often Boris Johnson would be
15 doing a press trip in a hard hat, which didn't feel to
16 us as pressing as engaging with bereaved families on
17 what needed to happen in relation to the pandemic.

18 **Q.** All right.

19 **A.** So we began pushing for the Inquiry very, very early on
20 and we sought other opportunities to try to create
21 change. So I provided evidence that we gave to --

22 **Q.** Ms Goodman, I'm very sorry, I'm going to have to pause
23 you there, because there's a limit on the time that we
24 have.

25 **A.** Yes, I'll be very succinct.
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1 Q. No, no, it's of the greatest importance to
 2 her Ladyship --
 3 A. Yeah.
 4 Q. -- that we understand what befell your members and where
 5 the greatest areas of concern are, because that is
 6 where, of course, she'll make her recommendations.
 7 Your engagement with the government in all its shape
 8 and forms is of, I'm sorry to say, slightly less
 9 importance. So I'm going to have to leave it there.
 10 You've described the group's campaign and its aims
 11 extremely adequately indeed.
 12 A. If I could, I just -- so what I wanted to say I was just
 13 coming to, I think over that summer we sought to
 14 influence the trajectory of the pandemic as much as we
 15 could, and we were very concerned and our members were
 16 very concerned and this -- so I've talked really about
 17 the concerns from the first wave. I think what then
 18 proceeded to happen was those of us who were bereaved in
 19 the first wave were very concerned about decisions like
 20 Eat Out to Help Out, decisions which seemed to be
 21 antithetical to efforts to protect life, and so it felt
 22 very strongly to us that the government were repeating
 23 the same mistakes, and I think what was very traumatic,
 24 particularly over the kind of second and third waves for
 25 those of us who were bereaved early on, was that it felt

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1 is a time for you to give evidence rather than advocacy.
 2 But if there's any submission you want Mr Weatherby to
 3 make on your behalf, then please do so. I'm sorry to
 4 cut you short, but if I don't do it with you and I do it
 5 with other people --
 6 A. Can I say something for 30 seconds, it's just really
 7 a plea to say obviously I'm one member of one family,
 8 and you've alluded to it, Hugo, that you weren't able to
 9 hear from other families, and I really just would say
 10 over the coming weeks, as you're going to hear a lot of
 11 evidence, it's just to really keep families at the
 12 forefront of your minds and think about the kinds of
 13 decisions that families up and down the country were
 14 taking to try to keep loved ones safe, and really to
 15 look at -- you know, I think we'll hear a lot of
 16 arguments that it's the benefit of hindsight, and
 17 I think -- hopefully I've made clear that my family and
 18 many other families up and down the country were making
 19 decisions at that time and throughout the pandemic and
 20 I just would really encourage you to consider: were
 21 those decisions being made on the right basis to protect
 22 life and to protect people like my father and so many
 23 tens of thousands like him.
 24 LADY HALLETT: I absolutely take on board everything you've
 25 just said then. Ever since I went around the

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1 like --
 2 Q. Seeing it happen again?
 3 A. -- those missed opportunities had happened. And we had
 4 people joining the group, you know, the day after or
 5 even the same day that they'd lost a loved one, and
 6 they'd recount their story and they'd recount the same
 7 experience of 111 that had happened before, and it was
 8 very demoralising and very depressing. I think all of
 9 us were very, very low at this point.
 10 MR KEITH: I think you used the word that you were
 11 re-traumatised by seeing it all happen again and again.
 12 Ms Goodman, we must leave it there, but thank you
 13 very much indeed, you've been very clear in what you've
 14 said.
 15 LADY HALLETT: Thank you very much indeed, Ms Goodman. You
 16 couldn't have done more to protect your father and also
 17 to support others who had lost a loved one. Maybe
 18 between us -- you've raised so many issues of legitimate
 19 concern, between us maybe we can fulfil that aim of
 20 saving lives in the future.
 21 A. Thank you. Could I make just a small plea and could
 22 I say a few words about --
 23 LADY HALLETT: I'm sorry, Ms Goodman, I'm going to have to
 24 stop you, because you have a very experienced and very
 25 able advocate, and I think you have been told that this

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1 United Kingdom meeting bereaved families, the suffering
 2 has been at the heart of everything I've considered, so
 3 please rest assured that every time I hear a witness
 4 I am thinking about the impact on people of decisions
 5 that were made and also will be considering whether the
 6 impact on people was taken into account. So don't
 7 worry, you'll always be at the heart of everything we
 8 do.
 9 A. Thank you very much.
 10 LADY HALLETT: Thank you.
 11 (The witness withdrew)
 12 MR KEITH: My Lady, would you consider please rising just
 13 for a couple of minutes, five minutes, whilst we make
 14 arrangements for the next witness?
 15 LADY HALLETT: Right.
 16 (2.37 pm)
 17 (A short break)
 18 (2.43 pm)
 19 MR KEITH: May I please call Dr Wightman.
 20 LADY HALLETT: Dr Wightman, can you hear us?
 21 MR KEITH: It would seem not.
 22 LADY HALLETT: I know a member of the team was talking to
 23 Dr Wightman just a few moments ago.
 24 MR KEITH: Yes, somehow we seem to be able to -- we've got
 25 ourselves in a position we have to speak to Dr Wightman

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1 from two rooms simultaneously but differently.
 2 **LADY HALLETT:** Dr Wightman, can you hear us?
 3 **THE WITNESS:** I can hear you and see you.
 4 **LADY HALLETT:** Sorry, we had problems. We were talking to
 5 you and you couldn't hear us, but you're there now. If
 6 you would like to listen to our lovely usher, she will
 7 take you through the oath.

8 **DR ALAN WIGHTMAN (affirmed)**

9 **(Evidence via videolink)**

10 **Questions from LEAD COUNSEL TO THE INQUIRY**

11 **MR KEITH:** Could you give the court, please, your full name.
 12 **A.** My name is Dr Alan Wightman.
 13 **Q.** Dr Wightman, whilst you give evidence, could you please
 14 remember to keep your voice up and speak as clearly as
 15 you can.
 16 **A.** Okay.
 17 **Q.** Because of the Zoom it's a bit hard to hear sometimes
 18 and it's very important that we can all hear what you
 19 have to say. If I ask a question the meaning of which
 20 is not clear then please ask me to put it again.
 21 You have very kindly assisted the Inquiry by
 22 providing a statement. We needn't put it up on the
 23 screen but it's INQ000279972. Is that a statement that
 24 you recall signing on 27 September of this year?
 25 **A.** Yes, it is.

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1 relatives and loved ones and prevented them from
 2 visiting the residents?
 3 **A.** No, it was not a blanket ban, it was really a request
 4 for voluntary compliance with such a ban, for the
 5 obvious reasons of protecting all of the residents in
 6 the home from becoming infected.
 7 **Q.** Did you become aware of any other arrangements which the
 8 home took to try to restrict the spread of the virus in
 9 terms of staff and PPE and so on?
 10 **A.** Yes, although some of this I only found out subsequently
 11 by communicating with the chief executive after -- after
 12 mum had passed. But I was reassured that they had
 13 sourced their own PPE. They were part of a group that
 14 was actually based in Cheltenham, so the group was
 15 buying PPE for its care home group throughout the UK.
 16 And they hadn't sat and waited, they had seen what was
 17 coming and been proactive. And they also avoided taking
 18 in untested residents, although some homes were put
 19 under some pressure to do so, but they didn't do it, and
 20 they did not use agency staff. So they did what they
 21 could, in my opinion --
 22 **Q.** In spite of --
 23 **A.** -- reasonable.
 24 **Q.** I'm so sorry. In spite of their best endeavours, did
 25 Covid manage to gain entrance to your mother's

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1 **Q.** Thank you very much.
 2 Now, Dr Wightman, I want to start, if I may, by
 3 asking you about your mother, Helen Wightman, and the
 4 bereavement that you suffered towards the beginning of
 5 the pandemic in May 2020.
 6 At that time, in early 2020, was your mother living
 7 in a care home?
 8 **A.** She was, yes.
 9 **Q.** In Fife?
 10 **A.** That's right.
 11 **Q.** When the virus began to spread in early March, did the
 12 care home where your mother was resident put into place
 13 any sort of restrictions on visiting, as far as you were
 14 aware?
 15 **A.** Yes, they proactively contacted us, I think the first
 16 time was 11 March, to say they were not quite going into
 17 a lockdown but they were asking everyone to please only
 18 visit if really essential. And five days later, they
 19 sent a second communication saying they were effectively
 20 now in lockdown. So that was on the 16th, which was
 21 a whole week before the Prime Minister saw fit to call
 22 a national lockdown.
 23 **Q.** What impact did that have on your ability to visit your
 24 mother? When you say they imposed practically a full
 25 lockdown, does that mean that they denied access to all

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1 care home?
 2 **A.** It did. And -- and we don't understand the route by
 3 which it got in -- how can anyone be certain? -- but it
 4 did. It was circulating in the local community.
 5 I presume someone asymptotically took it in,
 6 completely unaware of the risk they were putting
 7 everyone under, but it got in.
 8 **Q.** And she fell ill?
 9 **A.** She fell ill and she was the fourth of the residents to
 10 die. There were 35 residents, and she was number four.
 11 They lost -- they lost four people. So they lost 10% of
 12 the residents to Covid.
 13 **Q.** Did she receive medical care prior to her death from
 14 outside the care home or was she treated wholly within
 15 the care home?
 16 **A.** She was treated wholly within the care home, but, in
 17 contrast to many other homes, the GP responsible for
 18 that care home did actually go in on a daily basis to
 19 tend the needs of the residents. Though -- both for
 20 Covid reasons and other reasons, which I think is quite
 21 a noble act on his part, because he was not a young man
 22 himself and he was probably in the risky category too,
 23 but he carried on, he did his duty.
 24 And when it got to a point where mum needed care,
 25 I was asked: did I want her to go to hospital? And

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1 I said no, because that's -- it's circulating even more
2 in hospitals than in care homes, so no. And what they
3 did, they -- they had sent a unit called Hospital at
4 Home from Victoria General Hospital in Kirkcaldy to the
5 care home on a daily basis to administer what mum
6 needed, which was something that is beyond the
7 capabilities of the ordinary care staff. It was a care
8 home and not a nursing home.

9 So she was given -- she was given support. A lot of
10 people weren't that fortunate. But in spite of all the
11 best efforts it was too much for her and we lost her.

12 **Q.** Did she pass away on 6 May?

13 **A.** Yes, 6 May.

14 **Q.** Following her passing, Dr Wightman, did you join a group
15 then known as the Facebook group Covid Bereaved Families
16 for Justice?

17 **A.** Yes. And as near as I can work it back, because I don't
18 have a note of the actual date, but I believe it was
19 sometime in July, because -- the reason I know that is
20 they had a press officer at the time, a lady called
21 Fiona Kirton, who put out a call for people -- members
22 in Scotland to speak to the BBC in Scotland, and
23 I answered that, and I had a -- my first meeting with
24 the press on 27 July, with a reporter called
25 Marc Ellison, who turned out to be a very, very good

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1 But as time went on -- and we had the meeting with
2 the First Minister, who had promised us either
3 a UK Inquiry or, failing that, if she couldn't persuade
4 the Prime Minister, a Scottish Inquiry. We'd secured
5 that by kind of May time 2021. And she'd furthermore
6 asked us if we would be involved in defining the scope
7 of said Scottish Inquiry, and at that point we decided,
8 well, we really need some legal support here, and we
9 asked her for a Scottish solicitor and they very kindly
10 brought Amer Anwar to the table, which we're quite
11 happy about, and Amer became our representative first
12 in Scotland. And then, as things progressed, it became
13 obvious that it didn't make sense to have two legal
14 teams, one for the UK Inquiry and one for the
15 Scottish Inquiry, what about the overlaps and the cracks
16 between, and we decided that we really would like Amer
17 to be our legal representative for both inquiries.

18 **Q.** And now you're still happily seated at that table with
19 your legal team?

20 **A.** Yeah.

21 **Q.** And is Dr Jane Morrison, from whom her Ladyship heard in
22 Module 1, also a core member of Scottish Covid Bereaved?

23 **A.** Yes, she is, yes.

24 **Q.** Right.

25 I want to now ask you, please, about some of

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1 contact for me because he was following the care home
2 story from the beginning, and ultimately he and his
3 colleague produced quite a lot of data on deaths by
4 care home and through time, which is something that
5 I know my -- my -- other members of the Covid Bereaved
6 Families for Justice group had to fight tooth and nail
7 to get that kind of information south of the border from
8 the Care Quality Commission, but this BBC team was
9 already on the case in Scotland and -- and were of great
10 help to me.

11 **Q.** Then, perhaps as a result of the different needs of your
12 members in Scotland from the then UK-wide group, did the
13 Scottish members become an autonomous group, a subgroup,
14 if you like, within the overall group, and then
15 subsequently did you split away and become Scottish
16 Covid Bereaved?

17 **A.** Yes, we did, and I was largely responsible for trying to
18 make contact with fellow Scots in the group, and at one
19 point the administrators in the UK group, if they got
20 a Scottish member joining they would give me their
21 contact details and I would go and find out their story,
22 and built what I initially -- you're quite correct,
23 I called it a Scottish subgroup, but then subsequently
24 became the first branch, the Scotland branch, of that
25 organisation.

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1 the areas on which your group has campaigned.

2 **A.** Right.

3 **Q.** It's self-evident that its members have suffered,
4 of course, terrible bereavement, but in the course of
5 speaking to your members, have certain themes arisen?
6 Have general areas of concern been brought to your
7 attention which has led you to campaign on change, where
8 change is possible, or accountability where it's not,
9 through your dealings with the Scottish Government in
10 particular and also your approach to this Inquiry? Are
11 there a number of broad areas that you've become
12 concerned with?

13 **A.** There are. And the first one, because it happened
14 first, of course, in the sequence of things, was what
15 went on in the care homes, particularly in wave 1.

16 **Q.** So by that, Dr Wightman, are you referring to the
17 ability of Covid to spread within the care homes?

18 **A.** Yes.

19 **Q.** Of course the restrictions which were placed on
20 care homes generally, in terms of trying to keep them
21 safe, but of course with the terrible consequences on
22 the loved ones and relatives of residents, are those
23 the two broad themes relating to care homes?

24 **A.** They are, but also the fact that care homes seemed to
25 have been regarded almost as isolation hospitals. Which

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- 1 they're not. They're not designed to hold people in
2 isolation. They are designed to encourage older,
3 predominantly older residents to mix and to not be
4 isolated, not stay in their rooms. And yet at a certain
5 point in time they were treated as if they were
6 isolation hospitals, and that went against what the care
7 staff had been trying to achieve in normal business.
- 8 **Q.** What about the receipt of medical care within
9 the care sector? Have some, perhaps a large number of
10 your members raised the issue of whether or not their
11 loved ones received proper or adequate medical care
12 whilst being resident in a care home?
- 13 **A.** Yes. As I said earlier, we were fortunate that the GP
14 kept going into the care home. That was not the case in
15 many, many instances throughout Scotland, that these --
16 the GPs basically stopped going in. And so even normal
17 care was not provided, but also, of course, the -- you
18 know, the question of: were care home residents to be
19 permitted to go to hospital? Would hospitals accept
20 them?
- 21 **Q.** Outside the care sector, like Ms Goodman before you,
22 have a lot of your members, a significant proportion of
23 your members, raised the issue of the 111 medical
24 service, the phone system --
- 25 **A.** Yes.

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- 1 the care homes, also through the hospitals, and
2 of course the major concern with hospitals is you go in
3 for one reason, which isn't Covid, and you get a free
4 issue of Covid whilst you're in there, and then you
5 don't come out again. You know, it's -- it's the spread
6 in the healthcare settings that is the number one, by
7 far. 25% of our members have been affected by losing
8 somebody who went into hospital for one reason and
9 didn't come out again.
- 10 **Q.** So like your mother who received Covid whilst in
11 a care home --
- 12 **A.** Yes.
- 13 **Q.** -- these members, their loved ones received Covid as
14 part of -- well, a nosocomial infection in hospital?
- 15 **A.** It is, yes, yeah.
- 16 **Q.** What about palliative care and end of life care, is that
17 an issue which is raised by your members?
- 18 **A.** Quite frequently it is raised about -- it's not getting
19 the care they perhaps deserved whilst in hospital, and
20 maybe not surviving it. But we've also got instances of
21 where people appear to have been discharged because they
22 were in their early 80s, they were sent home, knowingly
23 having Covid. I mean, we've got an example of
24 a gentleman, 84, sent home to his 82-year old wife, and
25 known to be infected with Covid, but there was nothing

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- 1 **Q.** -- for receiving medical help, and in a related way the
2 triage process or the identification of symptoms that
3 went alongside the immediate provision of care to
4 persons who phoned the 111 line?
- 5 **A.** Indeed, that was a main theme, and I can illustrate it
6 with perhaps something that's not heard too often
7 elsewhere. It wasn't just about old people being denied
8 care. We have two young men who were lost, one aged 28
9 and one aged 31, because when they phoned up for help,
10 having isolated at home and suffering with Covid and
11 they phoned up on day seven, I think day eight in one
12 case, were told they had to stay at home, because of
13 their age, tough it out until you get to day ten, and in
14 both cases they didn't make it as far as day ten. So
15 the triaging was abysmal in those two instances.
- 16 **Q.** Turning to hospitals and the general provision of
17 medical care, is, firstly, the nature of the hospital or
18 the medical care that your members received in hospital,
19 secondly, the issue of Do Not Resuscitate orders, and,
20 thirdly, the issue of restrictions in visiting and
21 the ability to be able to see loved ones in hospital,
22 are those the three main issues which arise in relation
23 to hospitals?
- 24 **A.** I would say they indeed are, and the concern with
25 the Do Not Resuscitate or DNACPR notices runs through

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- 1 more the hospital felt they could do for him, sent him
2 home, she got Covid as well, and they both died because
3 of it.
- 4 And that's happened to -- there are a couple of
5 families where that same story applies, they lost both
6 elderly parents because they didn't get the treatment in
7 hospital and they were sent home.
- 8 **Q.** Restrictions on funerals and memorial services, is that
9 an issue which is raised in a large number of the cases?
- 10 **A.** It does come up quite frequently, about the disruption
11 to normal funeral rituals, and the impact it has on the
12 family long term, and in many cases they just feel --
13 it's a feeling of guilt, I think, that a lot of them
14 speak about, that they weren't able to do and honour the
15 person who had died in the way that would have been
16 fitting. It's kind of letting them down right at the
17 end of their life. And of course it's not -- it's not
18 their fault, you know.
- 19 **Q.** Dr Wightman, the Inquiry wrote to you and asked you to
20 give, furthermore, your views on the extent to which
21 your members had been telling you terrible stories about
22 the impact of the pandemic and the government
23 decision-making on those who were, in a general sense,
24 less able to look after themselves, so those prone to
25 unequal treatment. You give the example in your

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1 statement of those with pre-existing chronic diseases --

2 **A.** Yes.

3 **Q.** -- the elderly and those who are disabled. So I want to

4 ask you: to what extent do your members say that their

5 loved ones received, for whatever reason, a degree of

6 unequal treatment and, perhaps as a result of that, paid

7 the ultimate price, either because, as elderly people,

8 they didn't receive the care that they were, of course,

9 expected to receive, and likewise if they were disabled,

10 or suffering from some other form of chronic condition?

11 **A.** There are a couple of stories which come to mind

12 regarding those. And again, it's not necessarily

13 elderly people, but it's disabled people who really

14 should have been given -- given better care, and in one

15 instance should arguably have been vaccinated because he

16 was by far the most vulnerable person in the hospital,

17 being a stroke victim and having locked-in syndrome and

18 having to have everything done basically for him, but

19 was denied the vax because he wasn't 60 yet.

20 **Q.** He wasn't 16?

21 **A.** He wasn't 60 years of age, but he was --

22 **Q.** He was not 60. So this was a -- I'm sorry, forgive

23 me -- clinical decision, it would seem, taken in that

24 case to deny him the vaccine?

25 **A.** If you think about this, this is a man who was totally

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1 **A.** We could indeed.

2 **LADY HALLETT:** I just wanted to thank you, just as I thanked

3 Ms Goodman and others. What you've done to support

4 other people is extraordinary, especially as you don't

5 seem to have too many criticisms of the care or the

6 care home where your mother sadly died. So it's very

7 impressive that you've taken so much time and trouble to

8 look after other people. So thank you very much indeed

9 for your help.

10 **THE WITNESS:** Thank you.

11 **(The witness withdrew)**

12 **LADY HALLETT:** Right, I think you want me to break?

13 **MR KEITH:** Yes, please.

14 **(3.07 pm)**

15 **(A short break)**

16 **(3.15 pm)**

17 **MR KEITH:** My Lady, could we please welcome back

18 Anna-Louise Marsh-Rees of Covid-19 Bereaved Families for

19 Justice Cymru.

20 **MS ANNA-LOUISE MARSH-REES (affirmed)**

21 **Questions from LEAD COUNSEL TO THE INQUIRY**

22 **MR KEITH:** Could you please commence by giving the Inquiry

23 your full name.

24 **A.** It's Anna-Louise Marsh-Rees.

25 **Q.** Thank you very much, Ms Marsh-Rees, for coming back.

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1 dependent on others. He'd clearly survived the first

2 year or so of the pandemic because they had -- the

3 vaccine had arrived. But he was denied it because

4 the guidance said you have to be 60 and over to get

5 the vax, and he was not yet 60, but he was completely

6 dependent on others. And of course he did catch Covid

7 and he did not survive it.

8 So that's one example, but other examples of

9 people -- a lady had a sister who was non-verbal,

10 learning difficulties, and there's a harrowing story

11 about her sister basically being kept in hospital, her

12 being sent home, not able to assist, and an overwhelming

13 feeling on her part that the medical profession simply

14 gave up on her, on her sister.

15 **MR KEITH:** Dr Wightman, thank you very much indeed. That's

16 been enormously helpful.

17 **A.** Thank you.

18 **LADY HALLETT:** Dr Wightman, thank you very much.

19 Just for the avoidance of any doubt, what kind of

20 doctor are you?

21 **A.** Ah, I was going to say that at the beginning. Yes, for

22 the avoidance of doubt, I am not a medical man, and I am

23 not an epidemiologist, I'm a polymer chemist.

24 **LADY HALLETT:** Right, I won't ask you what that involves,

25 because we could be here for some time.

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1 You gave evidence of course in Module 1, and I'm going

2 to ask you to repeat in part some of the evidence that

3 you gave on that occasion.

4 You have, for the purposes of this module, kindly

5 produced a further statement, INQ000273792. Is that

6 a statement that you signed, if you take it from me, on

7 19 September 2023?

8 **A.** I did.

9 **Q.** Thank you very much.

10 Ms Marsh-Rees, when you gave evidence before

11 her Ladyship in Module 1, you told us about your father,

12 Ian, who was a retired electrical engineer, and how he

13 was hospitalised in Nevill Hall Hospital in Abergavenny,

14 where he became exposed to Covid and returned home

15 without any of you knowing that he had been exposed to

16 Covid. There was no positive test and you didn't know.

17 **A.** That's correct.

18 **Q.** How did you find out that he had become exposed to

19 Covid?

20 **A.** That was some months after, when we asked for his

21 hospital notes, and we also raised some complaints about

22 the health board. When I say complaints, we asked

23 questions at that point, because we couldn't understand

24 how that was possible.

25 **LADY HALLETT:** So what was on his notes that alerted you to

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1 the fact he had been exposed to Covid?
 2 **A.** It says on his discharge summary "The patient has been
 3 potentially exposed to Covid".
 4 **LADY HALLETT:** It actually says those words?
 5 **A.** Actually says those words.
 6 **MR KEITH:** But there was no test, you didn't know --
 7 **A.** They did not test him, no.
 8 **Q.** There was no testing --
 9 **A.** They did -- apologies. They not test him. They missed
 10 two opportunities to test him because there was a mass
 11 outbreak on his ward.
 12 **Q.** Did you subsequently discover that 21 people in what was
 13 supposedly or what was meant to be a non-Covid ward,
 14 12 of whom subsequently died from Covid?
 15 **A.** They did.
 16 **Q.** So your father was sent home, he developed Covid or he
 17 developed the disease from the virus. Was he then
 18 re-admitted back to the same hospital --
 19 **A.** He was.
 20 **Q.** -- where tragically he subsequently died?
 21 **A.** Yes, in that week where he was discharged he became ill
 22 from that evening. My mother made 13 calls to his GP,
 23 they had four out-of-hours doctors to visit, not one
 24 person mentioned that he potentially had Covid. Even
 25 though his oxygen levels were below 95, no one suggested

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1 **A.** No access at all.
 2 **Q.** No access at all?
 3 **A.** No.
 4 **Q.** So effectively a full lockdown?
 5 **A. (Witness nods)**
 6 **Q.** Were you able to say goodbye?
 7 **A.** We were, fortunately. Very traumatic.
 8 And, you know, one of the things I wanted to say is
 9 to anyone that says Covid isn't a thing, I just
 10 wanted -- and apologies if this is going to be
 11 triggering. But when you die of Covid pneumonia, it's
 12 not like you're out of breath from running for the bus
 13 or walking up stairs, it's like you're trying to take
 14 six breaths a second. He was almost quivering. It's
 15 incredibly distressing to watch him literally gasping
 16 for breath.
 17 But can I just say, he was such a lovely positive
 18 man. Even when they were giving him the morphine drug,
 19 he was barely coherent but he asked the nurse what her
 20 name was and where she lived. I mean, it was barely
 21 coherent, but just -- that just shows how, just, warm,
 22 lovely person he was.
 23 **Q.** The mark of the man.
 24 Subsequently, you were instrumental in the setting
 25 up of Covid Bereaved Families for Justice Cymru. When

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1 he have a test.
 2 **Q.** How long was he at home for after being discharged from
 3 Nevill Hall, having been exposed to Covid, and having to
 4 go back to hospital, being re-admitted --
 5 **A.** It was just under seven days.
 6 **Q.** Seven days.
 7 **A.** But we took him, it wasn't on -- we weren't told --
 8 **Q.** They didn't direct you to do it?
 9 **A.** No, no.
 10 **Q.** You just did it.
 11 Before he died, were you aware of whether or not
 12 there was any decision or order in place for
 13 the possibility of resuscitation?
 14 **A.** Again, we found out some months after, only by accessing
 15 his hospital notes, that a DNACPR had been placed on
 16 him. It wasn't filled out accurately or completely. We
 17 had not been consulted, which they have acknowledged.
 18 They say my father was consulted but if you would have
 19 seen him when my sister took him to the hospital, there
 20 was no way that was -- in any way he would have
 21 understood what was being told to him.
 22 **Q.** What was the position during those last few days on your
 23 ability to visit and the ability of your family to
 24 visit? Were you denied access to him? Were you allowed
 25 to visit? What were the restrictions in place?

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1 was that started?
 2 **A.** In July 2021.
 3 **Q.** Plainly the group was started after some of the first
 4 major decisions in the pandemic had been taken by the
 5 government, and whilst the pandemic was of course still
 6 raging. What was the primary aim of the group, as you
 7 saw it, when you first commenced it?
 8 **A.** The aim was to get answers. It wasn't to have
 9 an Inquiry for the sake of an Inquiry; it was genuinely
 10 because we didn't know -- I didn't understand what had
 11 happened, and then I spoke to other people from Wales
 12 that didn't understand and, you know, you start to build
 13 that picture. Predominantly it was because we didn't
 14 understand about the nosocomial, the hospital-acquired
 15 Covid but, as I met other people, you know, that
 16 extended to concerns about care homes. One of our
 17 members ran a care home in Wrexham in the first wave
 18 where she lost 12 patients, there was no oxygen, no PPE,
 19 nothing, and yet nine miles over the border in England
 20 they had all of that.
 21 So it was quite a differentiation from a Wales
 22 perspective.
 23 **Q.** I'm going to come back in a moment to the issue of
 24 cross-border travel, particularly in the context of
 25 local lockdowns. But, from the beginning, did your

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1 group focus on the decision-making which had taken place
2 insofar as it affected Wales? Was the group always and
3 does it remain Welsh-centric?

4 **A.** Absolutely. Once we'd formed, our objective was very
5 much calling for a Wales-specific Inquiry because, as
6 you know, healthcare and social care, which were our
7 main concerns, are devolved in Wales and therefore under
8 the control of the Welsh Government.

9 So, absolutely, we were born out of wanting
10 Welsh Government decisions to be understood, and still
11 remain of that view. But clearly, as we're in the
12 UK Inquiry, we want the context of how Wales performed
13 against all of the UK nations.

14 **Q.** And of course the UK decision-making had direct impacts
15 on Wales?

16 **A.** Absolutely.

17 **Q.** You've no doubt heard the evidence which has just been
18 given by Ms Goodman and Dr Wightman about the areas, the
19 broad themes or areas which have been the subject of the
20 greatest concern on the part of the next of your
21 respective groups. So may I introduce that topic and
22 start to identify the main themes through you, if you
23 may.

24 Hospitals obviously are at the forefront of any
25 pandemic response, and appear to be right at the heart

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1 **A.** Absolutely, I think you need to go back to, you know,
2 back to Module 1, preparedness and resilience. We've
3 got reports from NHS Wales that identify, even after
4 SARS-1, that hospitals need to be built with looking at
5 ventilation, filtration, looking at South East Asian
6 public healthcare as a blueprint. And then, you know,
7 I guess from a personal perspective I was very surprised
8 that -- you know, my father was infected in the second
9 wave -- it didn't appear that there had been any kind of
10 progress or lessons learnt from that first phase, and
11 yet we'd had, looking back now, almost a sort of Halcyon
12 period of -- you know, on that summer between wave 1 and
13 wave 2 where it felt there could have been, you know,
14 more science, as we keep hearing about, you know, that
15 could have been put in place.

16 **Q.** Halcyon unless, as you yourself rightly say in your
17 statement, you happened to be shielding or you suffered
18 from a pre-existing chronic disease or if you suffered
19 from a disability.

20 **A.** Absolutely.

21 **Q.** But for everybody else, they were unusual days.

22 You mentioned a few moments ago infection control
23 more generally. The issue of infection control in
24 hospitals and the care sector has a clinical element to
25 it, of course, but where do your members say the main

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1 of the greatest area of concerns expressed by members of
2 all the groups. What is it about the hospital care that
3 your members in general terms received, or rather their
4 loved ones received, that's given rise to the greatest
5 concern?

6 **A.** I would say segregation, or lack of, is one of the
7 primary concerns.

8 **Q.** You mean the infection control in hospitals?

9 **A.** Yeah, in the broader sense infection control in general
10 but within that, you know, the lack of the right PPE,
11 RPE, the lack of segregation, the lack of testing of
12 both healthcare workers and patients, or having any
13 regular testing. Wales were very late introducing
14 masks, and even then not the right ones, and four months
15 later than England in testing asymptomatic healthcare
16 workers. We'd very much like to understand what the
17 science was driving that.

18 **Q.** You are no doubt aware that the figures now show that
19 the levels of nosocomial infection in hospital were,
20 across the United Kingdom, extremely high. The
21 infection was rampant across the healthcare sector.

22 Is it the view of your members that more could have
23 been done by way of infection control to stop the rage
24 of the virus through the places where their loved ones
25 were most vulnerable?

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1 failings, as it appears to them, if there were any,
2 arose in relation to infection control generally?

3 Is there a sense held on the part of your members
4 that there was a failure to get on top of the spread of
5 the virus generally before it impacted on individual
6 hospitals and care homes?

7 **A.** I'm not sure they would specifically say that, though
8 obviously infection -- you know, monitoring Covid out in
9 the community was obviously vital. But it just seemed
10 that so many people went in with, you know, with one --
11 for some specific treatment, but either came out with --
12 were sent home with Covid or back to a care home with
13 Covid, or simply died of Covid, that they did not have
14 100% before they went into that hospital.

15 **Q.** Do many of your members raise the issue of the
16 restrictions on their visiting ability to the hospitals
17 where their loved ones were being looked after, and also
18 the general issue of communications with medical staff?
19 Do many of them say that they simply didn't receive
20 sufficient detail, or the right level of communication,
21 and of course were being denied the ability to visit?

22 **A.** All of the above. There was either no communication or
23 very poor communication, which is one of the things
24 we've, as a group -- because, as I said, I want to
25 reiterate, whilst we do want to know what happened and

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1 why it happened, we very much want to make a difference
2 as a group and use our experiences positively.

3 You know, we're calling for mandatory bereavement
4 training. Nothing major, nothing onerous that takes
5 people off their day-to-day job but, you know, some
6 online training on how -- tone of voice, the right words
7 to use, and the smallest things make the biggest
8 difference in terms of telling someone that their loved
9 one is not going to make it.

10 **Q.** There are a number of places in your statement where you
11 refer to an apparent absence of bereavement support,
12 a lack of financial support, but also structures in
13 place to help people come to terms with the loss of
14 their loved one, as well as dealing in a far better way
15 with funerals and the rights associated with the passing
16 of loved ones.

17 Do your members feel that there is a lot more that
18 can be done in terms of providing support, both
19 emotionally, financially and in terms of the
20 practicalities, returning the clothes from somebody who
21 has died in hospital? Is that a big issue?

22 **A.** That was one of the key issues, in that if you were
23 fortunate enough to be with your loved one when they
24 died, or you were just told about it, that -- you know,
25 it's this kind of silence as you walk through

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1 reiterate that we wanted to say today that we also want
2 to give voice to those that have died as well because
3 know they haven't got a voice any more. So it's not
4 just about us, it's very much about them, and what we
5 don't want is for another Peggy, Betty, Margaret, Phil,
6 to have gone through what our loved ones went through in
7 a room by themselves, with no wifi, no -- if they were
8 even able to use a phone. We've had phones with
9 messages, missed messages.

10 This is a really tragic one: glasses being in the
11 bag or a hearing aid, and whereas they've not been given
12 them, you know. So we're talking about true isolation
13 here and it's particularly if you're, you know, disabled
14 or elderly.

15 Elderly, yeah, you know, your world becomes much
16 smaller naturally as you get older and now, you know,
17 you've had this good, wonderful life and your last few
18 days are truly alone.

19 **Q.** In your statement you refer to a cadre of people, you
20 call them the silent generation, and you do so in the
21 context of how many of your members feel that, because
22 their loved ones were relatively elderly, that they
23 either didn't receive the treatment which they rightly
24 expected to receive, or failed to get the levels of
25 support of which you've spoken so eloquently.

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1 a hospital, it's always in the night for some reason,
2 and you've got your bin liner or plastic bag with the
3 belongings. There's no -- nobody tells you about the
4 practical side of things, no-one contacts you about the
5 psychological help.

6 Many of our members -- I mean, this again might be
7 quite triggering -- couldn't find their loved one, they
8 were moved either to a different hospital before they
9 died or after they'd died. In fact, one of our members
10 actually had to stop her father's body being taken to
11 a supermorgue in Cardiff, which was because they'd
12 obviously run out of morgue space by that time.

13 But, yeah, that whole ... and sort of bereavement
14 starts -- when you know someone's going to die, it
15 starts from the moment you know they're going to die, it
16 doesn't just start once they've died. So it's -- we've
17 been trying to work with Hospices UK and palliative care
18 professors to look at how we can -- because it's not
19 like a long-term palliative care, it's a very sudden
20 pallia ... how we could make that communication, how you
21 can explain to someone the different -- what happens
22 when someone dies, actually what physically happens to
23 them and, you know, and then there's the practical side
24 of it and the psychological side of the bereaved.

25 I know we represent the bereaved, but I also want to

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1 What did you mean by the silent generation? Is this
2 an issue to do with the failure of society to appreciate
3 that there is a generation of people who are less prone
4 to call out for help when they need it and need to be
5 given it?

6 **A.** Absolutely. So I think the expression "silent
7 generation" was coined by TIME Magazine in 1950
8 something, and it's a categorisation of those born
9 between 1928 and 1945, so very much sort of grew up in
10 the Second World War, sort of experienced -- well,
11 probably didn't experience the swinging 60s in Brynmawr
12 as they would have in Woodstock, let's say, but they're
13 very traditionalist, very law-abiding, pragmatic, stoic.

14 You know, my father, when I even suggest -- he had
15 needed his cataracts done, and when I said, "Well, you
16 can't -- there's three years to wait", he went -- and
17 I said, "Let's go private". He was horrified; that is
18 not the thing to do, you wait your turn, you do not --
19 you do not buck the system just because you've got some
20 money.

21 **Q.** And is it the view of yourself and many of your members
22 that more careful attention needs to be paid to ensuring
23 that those who don't want to ask for help do
24 nevertheless receive it?

25 **A.** I think culturally we need to change. There's a choice

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1 to be made here. One thing that's for certain is we
2 will all get old, and I think we have to start to think
3 about giving people a voice. I think it probably was
4 there already, but I think the pandemic has highlighted
5 this, that -- you know, and so many times I've heard
6 "Well, he was old anyway, wasn't he?" Like, well, yes,
7 but that doesn't mean to say their lives are any less
8 valid than anyone else's.

9 Obviously the Inquiry will look at certain aspects
10 of that but, you know, there has to be ways that we
11 don't put old people -- you know, now it's like, "Oh,
12 they're over 70". Well, 70's not old. It's --

13 **LADY HALLETT:** Thank you for that.

14 **A.** Oh, sorry.

15 **LADY HALLETT:** It's all right.

16 **MR KEITH:** So, Ms Marsh-Rees --

17 **A.** To my point.

18 **LADY HALLETT:** Yes.

19 **MR KEITH:** If you'll allow me to move over from a slightly
20 awkward moment --

21 **A.** Yes.

22 **Q.** -- would you accept that essentially what you're railing
23 against is the inequality of age, the fact that because
24 of age some people are treated less equally and
25 therefore need the extra assistance? Is that what --

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1 had different epidemiological tiers associated with
2 them.

3 Has that been a significant issue in the views of
4 your members?

5 **A.** It really has, because it was very unclear, it was very
6 confusing which country had which rules. There was also
7 people being treated, that lived on the borders, being
8 treated in England; there was a lot of healthcare
9 workers that lived in Bristol that were going to Wales,
10 so there's a whole big question around: was it right
11 that different nations had different rules in place, and
12 why, and should that happen again? You know, I'm not
13 here to judge, but it doesn't seem logical, when you've
14 got porous borders to allow that, or ...

15 **Q.** And did it make it extremely hard to adhere to, if there
16 was an unnecessary degree of complexity or confusion?

17 **A.** Absolutely. I mean, I was travelling between England
18 and Wales so I was personally affected and I couldn't --
19 you know, it was difficult, was I wearing a mask here,
20 wasn't I wearing a mask there? You know, going across
21 the Severn Bridge was like going across the Mexican
22 border, you didn't know whether you were going to get
23 stopped. You know, and was I flouting the rules? When
24 my father was ill, possibly I was. But ...

25 **MR KEITH:** Well, that's all right.

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1 **A.** Absolutely, yeah, there's no doubt about it, you know,
2 people that are older are ignored, they -- maybe they're
3 deemed less important, their lives less valuable, and
4 because of this whole reticence to maybe, you know, call
5 out or stand their ground or complain, that exacerbates
6 the situation. And I think that's maybe why I'm here,
7 and our members are here, is to give them the voice.
8 They were the silent generation, they are most certainly
9 silent now, but we thank the Inquiry for giving them
10 that voice now and the platform to discuss some of these
11 things that could impact us culturally, socially for the
12 future.

13 **Q.** Well, if I may say so, you have given the most eloquent
14 of voices.

15 I'd said that I'd come back to the issue of
16 cross-border. In the context of the social restrictions
17 and the NPIs that the government put into place,
18 obviously an issue arose as to whether or not there were
19 differences in application and impact between Wales and
20 England.

21 One other very interesting area in your statement is
22 the level of complaint which appears to have been felt
23 by those people who, in Wales, were aware of people
24 crossing the border into England and thereby
25 circumventing restrictions or moving from areas which

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1 Ms Marsh-Rees, thank you very much.

2 **THE WITNESS:** Thank you very much.

3 **LADY HALLETT:** Ms Marsh-Rees, when you spoke about trying to
4 persuade your father to have private treatment, you
5 reminded me of trying to persuade my mother to get
6 a taxi, "You can't spend money on taxis". Just, you're
7 absolutely right. As Mr Keith said, you've been
8 an excellent and eloquent voice, both for the bereaved
9 and for those who died, and always constructive.

10 So thank you very much indeed.

11 **THE WITNESS:** And that's what we aim to do. We do want to
12 know what happened but we also want to make
13 a positive -- we want to use our negative experiences to
14 a positive future. So ... and apologies for
15 the comment, but I think my point stands that 70 is not
16 old.

17 **LADY HALLETT:** No, no, I consider it to be a compliment.

18 **MR KEITH:** I can't quite believe you've returned to that
19 subject, Ms Marsh-Rees.

20 **THE WITNESS:** It was a compliment, I promise.

21 **LADY HALLETT:** Thank you very much indeed.

22 **THE WITNESS:** Thank you very much.

23 **(The witness withdrew)**

24 **LADY HALLETT:** Right, so that's all we have time for this
25 afternoon.

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1 Obviously we have one more bereaved witness,
 2 Ms Myles, who is going to give evidence tomorrow
 3 morning, and obviously we're looking forward to hearing
 4 from her, and I'm sorry that she has had to wait until
 5 tomorrow morning, but it's just one of those things,
 6 we've done our best to get as much in as we can.

7 I think that's it for today, isn't it?

8 **MR KEITH:** Will you order 10 o'clock tomorrow, my Lady?

9 **LADY HALLETT:** 10 o'clock tomorrow. Well, I think what I'll
 10 say is it's 10 o'clock unless I say to the contrary.

11 Thank you all very much.

12 **(3.41 pm)**

**(The hearing adjourned until 10 am
 on Thursday, 5 October 2023)**

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