1		Thursday, 5 October 2023	1	
2	•		2	
3		DY HALLETT: Mr Keith.	3	
4	MR	KEITH: My Lady, may I call, please, Catriona Myles.	4	
5			5	
6		Questions from LEAD COUNSEL TO THE INQUIRY	6 7	
7 8	LA	DY HALLETT: Please say if at any stage you need just to pause. I appreciate how difficult it is.	8	
9	Α.		0 9	,
9 10		Thank you. • KEITH: Could you commence, please, by giving us your	9 10	
10	WIN	full name.	10	
12	Α.	l'm Mrs Catriona Leanna Myles.	12	
13	Q.	Thank you very much, Mrs Myles. You have kindly	13	
14	ч.	provided the Inquiry already with a statement,	14	c
15		INQ000282334. Is that a statement that you recall	15	
16		signing in fact on 25 September of this year?	16	A
17	A.	It is.	17	-
18	Q.	Thank you. In that statement, Mrs Myles, you describe	18	
19		how you are a member of Northern Ireland Covid Bereaved	19	
20		Families for Justice. Is that a branch of the UK-wide	20	
21		Covid Bereaved Families for Justice group?	21	
22	Α.	It is.	22	C
23	Q.	I'm going to ask you in a moment some more detail about	23	
24		the aims of the group, what it seeks to achieve, what	24	ŀ
25		it's done, and what it hopes still to do. Before I do	25	
1		actually one of the strands to our campaign is that	1	C
2		we want more services in place for those that have had	2	
3		their lives destroyed by Covid.	3	
4	Q.	Is it the view of your members, to which your	4	
5		organisation provides a collective voice, that mistakes	5	
6		were made and that where it is possible to correct those	6	
7		mistakes, mainly to make sure that they never happen	7	
8		again, you've sought to campaign for change?	8	ŀ
9	Α.	Absolutely. I mean, we are very well represented here	9	
10		by our legal team, but the group it would be	10	
11		a travesty if what happened to us and our loved ones was	11	
12		allowed to happen again. So really, the main thing that	12	
13		we want from this Inquiry is accountability and reform.	13	
14	Q.	By accountability, do you mean an exploration of what	14	
15		went wrong? Is that what is meant by accountability?	15	
16	Α.	I mean, obviously we have got a very negative experience	16	
17	~	of the pandemic	17	
18	Q.	Of course.	18	
19 20	Α.	but we're not saying everything went wrong, but we	19 20	
20 21		just want the truth the truth to be out there, and to know that if and when something like this hits our	20 21	,
21		shores again not that Covid in itself has actually	21	
22		gone away, like some people think that we will be	22	, (
23		better prepared, and that there will be nowhere for	23	`
25		those in power to hide.	25	A
		3	20	

uir	У	5 October 2023
1		that, could you give us just a brief overview of what
2		the general aims of the group are?
3		Does it, for example, focus its attention on
4		providing support to the bereaved in Northern Ireland,
5		campaigning for change where change is possible, and
6		also holding decision-makers to account for decisions
7		that the group believes contributed in any way towards
-		the bereavements which your members have suffered?
8		-
9 10	Α.	Absolutely. Our group, obviously, we look at it from
10		a Northern Ireland perspective. We are a little bit
11		different, a little bit out there, but we are very much
12		under the umbrella of the UK group, and we have
13	_	a fantastic working relationship with them also.
14	Q.	Does your group provide, firstly, bereavement support to
15		its members?
16	Α.	Yeah, we we're a group who never thought we would
17		ever come together. We have a shared loss.
18		Unfortunately shared trauma. But we support each other.
19		We source bereavement support for members. The leads of
20		the group are fantastic guides. They're there for us
21		24/7. In that respect, we're very lucky.
22	Q.	Is that bereavement support in terms of psychological,
23		financial, emotional or all those areas?
24	Α.	The group will signpost, but as you I'm sure you're
25		aware the services are extremely limited, and that is
		2
4	~	Do you know whather your group has sought to take up the
1	Q.	Do you know whether your group has sought to take up the
2		battle with the government, for example writing to it,
3		pointing out areas where you believe mistakes were made,
4		where things could be improved, and where, for the
5		future, things could be done better? Is it a has it
6		been a campaign waged by correspondence and meetings or
7		through the press? How has it worked?
8	Α.	Unlike your witnesses yesterday, I am a member of
9		Northern Ireland Covid Bereaved, I'm not actually one of
10		the founders, but our two leads have been involved with
11		the government, liaising with the government from early,
12		early days of the pandemic, actually before the
13		inception of our group, to ensure that vulnerable people
14		in care homes and hospitals have a voice. And really,
15		I think that's one of the reasons that they decided to
16		form our group, because obviously our we're governed
17		very differently in Northern Ireland, when we have
18		a sitting government, and our leads have been chipping
19		away at this since April of 2020, and they continue to
20		do so.
21	Q.	Is that when
22	Α.	And hold down full-time careers.
23	Q.	Forgive me. Is that when the group then commenced,
24		around about April

around about April -A. No. We had all kind of linked up on Facebook as and

4

3

(1) Pages 1 - 4

1		when our relatives died. The group really and we
2		also, most of us, had joined the UK group at its
3		inception. As time went on, we realised that with
4		the devolved situation that we kind of needed our own
5		representation, because really unless you're there on
6		the ground in Northern Ireland you don't really get how
7		a lot of things work. So our group came about around
8		the January of 2021.
9	Q.	Thank you.
10		Now may I please ask you about your own father,
11		because of course you suffered a bereavement as well.
12		He was a teacher, was he not, and, we gather, a very
13		talented popular musician?
14	Α.	He was.
15	Q.	Prior to his death, in fact for some years before his
16		death, did he suffer from a gallstone condition which
17		then changed into something known as necrotising
18		pancreatitis?
19	Α.	That's right.
20	Q.	Which is a very unpleasant and painful condition which
21		will lead to the sufferer then developing severe
22		diabetes?
23	Α.	Correct.
24	Q.	At the beginning of the pandemic, with the restrictions
25		that were then placed upon everybody, was it extremely 5
		0
1		Mrs Myles, you said his medication I'm sorry,
2		I didn't catch the word.
3	A.	Titrated. So maybe the dosages changed, you know, or
4	-	DY HALLETT: Oh, I see. Titrated is the word, thank you.
5	A.	
6		DY HALLETT: Thank you.
7	WR	KEITH: Perhaps due to the difficulty in getting medical
8 9		attention, being able to get the appointments, to get
		the consultations, did there come a time when he was
10 11		given a diagnosis of secondary liver cancer, effectively
12	Α.	Yes.
13	Q.	which turned out, in fact, to be a wrongful
14	ω.	diagnosis, he was then diagnosed with, in effect,
15		primary liver cancer?
16	Α.	That's right. By the September of 2020, Dad had been
17		rushed into Antrim Area Hospital. There they found
18		a lesion on his liver. It took a few weeks to get
19		a diagnosis because there was issues this in that every
20		time Daddy needed to attend a hospital appointment, he
20		had to isolate for two weeks, get a Covid test at
21		an acute hospital setting, wait for the results, wait
23		for the appointment, attend the appointment, whereby he
23		had broken his isolation, and then go home and wait
25		
25		another two weeks to get to be able to go back to get 7

2		was receiving, in terms of being able to see consultants
3		and medics and so on, because of the practical
4		difficulties associated with isolating himself before he
5		could see any medic or consultant or so on?
6	Α.	Just very quickly before I go on to that, you have to
7		remember that Northern Ireland's healthcare system is in
8		the worst state of all the UK healthcare systems, our
9		waiting times are ridiculous, and this was prior to the
10		pandemic. So by the time we locked down, Daddy I think
11		had maybe a dozen to 15 attempts to get a face-to-face
12		appointment with a GP. They all failed. He just was
13		had his medication titrated, his dosages titrated
14	Q.	Mrs Myles, I'm just go to ask you to slow down a wee
15		bit, if you'd be so kind. It's quite difficult for our
16		stenographer to be able to keep up.
17	Α.	Okay, sorry. And maybe new prescriptions added into his
18		regime. So we you know, as a family, we very much
19		feel that the scaling back of GP face-to-face
20		appointments led Daddy down a path that potentially, if
21		he had gotten to see his GP, it might not have ended up
22		the way it ended up.
23	Q.	In the event
24	LA	DY HALLETT: Sorry, just before you do, sorry to
25		interrupt.
		6
1		the results of said appointment.
2		So when Daddy was told that he had a rare,
3		aggressive liver cancer, we didn't have many two weeks
4		to play with.
5	Q.	And of course all the time the cancer was growing all
6		the more aggressively?
7	Α.	Absolutely. And the sorry, the really sad thing is
8		at the outset we were told Daddy could be cured, but
9		unfortunately, by the time he met his oncologist,
10		and weeks and weeks had lapsed due to policy and
11		protocol and procedure within the hospital system in
12		Northern Ireland, Daddy was then deemed terminal.
13	Q.	Was that on 27 November of 2020?
14	Α.	That's right.
15	Q.	Because he was by then, and he had been told for the
16		first time on that day, terminally ill, and because his

hard for him to be able to manage the treatment that he

bloods were through the roof and that he was -- his liver was beginning to fail and we needed to get him to

condition was extremely poorly, did he have to go -- in

fact was he dropped off at A&E very shortly thereafter?

22 the nearest A&E department immediately.

17

18

19 20

21

- 23 Q. What hospital was he made an in-patient in?
- 24 A. So my brother dropped him off at Antrim Area A&E

A. Yes, the next morning we got a call to say that his

25 department, and my brother tells me that he remembers 8

and say goodbye through a tiny slit of glass in

by my reckoning that meant that this area here

anybody saw him.

Was there a funeral?

8 pm.

explain it.

a six-bay ward, where my father was three beds down, and the person would be wearing full hazmat protection. So

(indicated) through a window quite far away. And again, my brother is traumatised by the fact that he was -he'd only arrived and he had sort of said -- he made up a story that he was bringing daddy some music to listen to on an MP3 player rather than scare Daddy by saying, you know, "We're here to say goodbye", so he was making sign language at my father and the nurse came to the door, and said, "Right, that's it, the man in the next bay needs to use the commode". So the door was closed, and the nurse explained to my dad, and the curtain was pulled round for the man beside for to use the toilet, and my daddy saluted my brother, and that was the last

None of you were present, therefore, at the time of his death. Do you know even the time of his death?

We were lucky, in the second wave, if you can call it 10

of my life, and that was on Boxing Day. So

It was one of the most detached, surreal experiences

Christmas Day was the weirdest experience. I can barely

From your own terrible experience and the experiences of the members of the group of which you're a member, have

you raised -- has your group raised -- a number of concerns, expressed across large numbers of people, relating to the deaths of their loved ones which form the basis of the campaign which your group has pursued? There are wide-ranging concerns, and there are themes

Picking up some of those themes, Mrs Myles, in your statement you turn firstly to the high level issue of the differences in decision-making between

Northern Ireland and Westminster. Has it appeared to many of your members that there's a lack of clarity or understanding as to the extent to which Northern Ireland made decisions for itself and for its own people, as opposed to Westminster being the driver behind the imposition of society-wide restrictions and

decisions on Northern Ireland society? Has that been

and strands to lots of those concerns.

Daddy had none of his family with him, Daddy had nobody with him. We don't know what time my father expired, he was found dead on 23 December, we suggest between 7 and

1		Daddy waving back at him with his little bag like	1		
2		a scared schoolboy.	2		
3	Q.	Did he leave the hospital again?	3		
4	Α.	In a box.	4		
5	Q.	Do you know whether he moved wards when he was in	5		
6		hospital?	6		
7	Α.	Daddy was moved three times, and whenever I after	7		
8		Daddy had passed, I got his hospital notes, and in his	8		
9		records it clearly states in the nursing notes "Gerry	9		
10		has been moved wards due to possible exposure".	10		
11	Q.	From Covid?	11		
12	Α.	That's right.	12		
13	Q.	Do you know whether or not he was tested for Covid?	13		
14	Α.	Daddy was in a ward with symptomatic patients, I'm not	14		
15		sure which of the wards and at what time, but on day	15		
16		nine he tested positive for Covid.	16		
17	Q.	He was given what is called end of life care?	17		
18	Α.	That's correct.	18	Q.	
19	Q.	And your brother was the only member of your family who	19		
20		was permitted to see him, to the extent that he was, and	20	Α.	
21		I'll come on to that in a moment. Did you see him when	21		
22		he was in hospital?	22		
23	Α.	No, I didn't see my father from the day that he was told	23		
24		he was terminally ill, 27 November, and my brother we	24	Q.	
25		were given the option that one family member could come 9	25	Α.	
1		lucky. We were allowed to invite 30 people to our	1		
2		church. But Daddy died on 23 December, and I still	2		
3		have had a young family at the time, and on	3		
4		23 December we were preparing for Santa Claus arriving.	4		
5		I remember waking up on the 24th, and bringing the	5	Q.	
6		turkey out of my fridge and thinking about my father	6		
7		lying alone in a fridge in a dirty hospital gown on his	7		
8		own on Christmas Eve.	8		
9		Christmas Day went by in a blur, all our family	9		
10		separated. The funeral plans had to happen over the	10		
11		phone, with three separate households not even able to	11	Α.	
12		come together to plan the small funeral.	12		
13		I checked out. I just felt that if it wasn't going	13	Q.	
14		to be a funeral worthy of my father's life, I didn't	14		
15		really want any part in it. We went to visit him in the	15		
16		chapel of rest, and in Northern Ireland wakes are	16		
17		wakes happen before funerals in Northern Ireland, and	17		
18		they're a massive part of our culture, and they're	18		
19		a massive part of a grieving ritual. That didn't	19		
20		happen. And when I visited Daddy in the chapel of rest,	20		
21		whereby I felt he should never have had to have been	21		
22		he should have been in his own home, although	22		
23		deceased I just remember looking at that coffin and	23		
24		thinking to myself: that could be a bag of potatoes in	24	Α.	

Daddy waving back at him with his little bag like

1

- 24 A. That has been a theme. And I'm very conscious that when
 - 25 I finish today you're going to hear from people with 12

a big area of concern?

11

that coffin, how do I know what's in that coffin?

25

(3) Pages 9 - 12

1		lots of letters to their names and things, experts in
2		their field, but our group and the people I represent,
3		we're the experts on what happens when it all goes very
4		wrong, and one of the opinions in our group is that
5		Stormont basically did what Westminster told them to do.
6	Q.	None of us are necessarily privy to government decisions
7		behind the scenes, how they're made, at least until
8		there's an Inquiry of this sort. From your perspective,
9		and the perspective of your members, was there a degree
10		of clarity? Were you, do you feel, properly informed as
11		to the developments which flowed from the decisions that
12		were being made? Were you kept, in essence, in the
13		loop, do you feel?
14	Α.	There certainly wasn't clarity. If anything,
15		the opposite. Very often you would watch the reports in
16		the evening and the updates, and it wasn't clear whether
17		we were following what Westminster were saying or
18		waiting to hear what the devolved government would tell
19		us to do. There needed to be more cohesion and more
20		communication, in our eyes, with the two governments,
21		and it seemed, particularly in hindsight, that
22		Northern Ireland didn't really have a seat at the table
23		with the big boys, they were just told: this is how much
24		money you're getting, this is what you should do.
25		You know, and that's what happened.
		13
1		people, it was very hard for normal people to work out
1		people, it was very hard for normal people to work out
2		if they were abiding by the rules, which rules they were
2 3		if they were abiding by the rules, which rules they were abiding by.
2 3 4		if they were abiding by the rules, which rules they were abiding by. And another thing I think is relevant is that we
2 3 4 5		if they were abiding by the rules, which rules they were abiding by. And another thing I think is relevant is that we found in hindsight that Northern Ireland actually seemed
2 3 4 5 6		if they were abiding by the rules, which rules they were abiding by. And another thing I think is relevant is that we found in hindsight that Northern Ireland actually seemed to be two weeks behind in the curve at most times from
2 3 4 5 6 7		if they were abiding by the rules, which rules they were abiding by. And another thing I think is relevant is that we found in hindsight that Northern Ireland actually seemed to be two weeks behind in the curve at most times from the mainland, and I wonder this is personal if we
2 3 4 5 6 7 8		if they were abiding by the rules, which rules they were abiding by. And another thing I think is relevant is that we found in hindsight that Northern Ireland actually seemed to be two weeks behind in the curve at most times from the mainland, and I wonder this is personal if we had enacted what was said here at the beginning of the
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Α.	if they were abiding by the rules, which rules they were abiding by. And another thing I think is relevant is that we found in hindsight that Northern Ireland actually seemed to be two weeks behind in the curve at most times from the mainland, and I wonder this is personal if we had enacted what was said here at the beginning of the two weeks, rather than having the lag, would our curve have been slightly dampened? And would more people have survived? Absolutely. Looking at the healthcare structures generally, and of course hospitals and your father of course died in the Antrim Hospital is I mean, it's obvious, nosocomial infection is a huge issue for many of your members, the catching of Covid in hospital. But do the concerns of your members go wider than that? Have some of them expressed concern about whether or not, due to age or vulnerability, their loved ones were given up on, or, because of the demands being placed on the system, they simply didn't receive the
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inquiry		5 October 2023
1		And generally there was a two-week lag, we found,
2		with Northern Ireland, so that if a new rule came in
3		here, we were sort of made to feel that our guys were
4		going to go away and think about it, but in reality
5		two weeks later they just stood up and told us to do
6		what had been said here two weeks prior.
7	Q.	So has concern also been expressed about the timings of
8		the decisions that were made? So, for example, the
9		timings of decisions in relation to travel restrictions
10		or social restrictions or society-wide interventions
11		such as the lockdowns?
12	Α.	Absolutely. One standout is the fact that, of course,
13		there's no denying doesn't matter what political
14		persuasion you are, we share an island with the
15		Republic of Ireland and the rules and legislation set
16		out in Westminster didn't really allow for the fact that
17		we had a land border that whereby meant that in some
18		cases, on, for example, the Derry and Donegal border,
19		you could have a house on one side of a fence having to
20		abide by one set of rules and legislations and yet the
21		neighbours on the other side of that fence had
22		a completely different set of rules. And then because
23		of that you had people that were moving about through
24		the two different regions for work purposes, social
25		purposes, et cetera. It got so confusing at times for
		14
1		a lady felt her mother was being telephone triaged with
2		some sort of form, and because of her age was deemed not
3		worthy of any life-saving treatment.
4		I remember reading an article by Sandy Toksvig, and
5		in it she said there shouldn't be a hierarchy for life,
6		and it seemed very much like, nearly a fatalistic
7		approach, that if you had underlying issues, if you're
8		an ethnic minority, if you were aged, whatever that is,
9		in society you know, at what age do you become aged,
10		I don't know that those lives were more expendable
11		and weren't worthy of the same interventions.
12	Q.	Is palliative or end of life care also another issue,
13		another area about which a great deal of concern has
14		been expressed?
15	Α.	It's an issue that's extremely triggering for our
16		families. Lots of families, including my own, feel that
17		the end of life pathway, even the structure that they
18		were using, the Liverpool Pathway, years ago was deemed
19		inappropriate, and that the medications used really
20		hastened death in lots of cases.
21	Q.	Did many of your members lose loved ones in the
22		care sector?
23	Α.	Absolutely. We have massive concerns with that we
24		now know that the care sector was flooded with

24 now know that the care sector was flooded with25 non-tested residents at the beginning of the Covid

1 1 outbreak. But we also had a situation whereby maybe 2 2 someone was being transferred from a care home to 3 3 a hospital, the families weren't maybe being told that 4 4 that person was symptomatic of Covid, that person 5 unfortunately maybe passed away in hospital, but the 5 6 care home were never informed by the hospital that that 6 7 person had Covid, therefore the other residents had been 7 8 8 exposed. 9 9 And another issue is the isolation for residents in 10 care homes. You know, it must have just been like 10 prison to those poor people at that time, you know, 11 11 12 being basically locked in tiny square boxes for many 12 13 hours of the day, you know, and having zero autonomy. 13 14 Q. You've described your own father's funeral. Are the 14 15 restrictions that were placed on funerals and wakes and 15 16 social rituals associated with the passing, is that also 16 17 another area about which a great deal of concern has 17 18 18 been expressed? 19 Α. Yes, and in Northern Ireland particularly it's of such 19 20 importance to us within our culture. I mean, from my 20 21 21 perspective, we were actually one of the -- being 22 22 wave 2 -- one of the luckier families, in that we did 23 get to have a small -- pathetic -- funeral, but at the 23 very start -- and some people might say, well, the 24 24 25 government didn't know what was coming down the track. 25 17 1 people think, you know, "Christmas parties, it was 1 2 Christmas", we have a family that when their parent was 2 3 dying, alone, and it was May of 2020, we now know, and 3 4 it's in the public realm, that one of these parties was 4 5 going on. And it's just disgusting. It's galling that 5 6 the same people that were making these draconian rules 6 7 7 thought, "Rules for some", but were above the rules and, 8 "Sure, what they don't know will never hurt them". But 8 9 the thing about the modern day is the truth will always 9 10 come out. And for us, we get very angry about it, and 10 11 we don't -- you know, public that haven't been touched 11 12 12 by this, I get it, if it doesn't visit your door, you 13 don't really get it, but we're still living through 13 14 this. 14 15 And so many people have so many opinions. We have 15 16 the Covid deniers, the arguments about vaccinations, we 16 17 have all that, and we still have to try to live our 17 18 lives, process our grief, and hold our loved ones' 18 19 memory in our heart against the backdrop of all 19 20 the politics that are going around, you know, 20 21 surrounding Covid. So when there are likes of these 21 22 parties going on, it just adds insult to injury for the

- 23 bereaved families.
- 24 **MR KEITH:** Mrs Myles, thank you very much.
- 25 THE WITNESS: Could I very, very briefly, because I know

I don't think that's true. I think they just didn't act quick enough. But some people -- I have a cousin who got a phone call to say, "Your daddy will be buried at such and such a time if you would like to say a prayer in your home", and four men in hazmat suits just placed that coffin in the ground at a certain time on a certain day, with masses of open graves around. That was in 2020. And then the step up from that was the six-person funeral. And I can only imagine, if you have an immediate family of more than six people, how could you ever choose which six people went to your loved one's funeral? Q. Finally, Mrs Myles, your statement identifies another big area of concern, which is the damage done to public trust in government by virtue of the revelations of the behaviour in Downing Street and elsewhere during particularly the middle and later parts of the pandemic. Why is that an issue of such great concern to your members? I don't want you to answer by virtue, please, of the merits or demerits of partying, but in terms of the damage that was done to society's belief and trust in government. A. Yeah. Yes. This is an area I've been very vocal about, and I'm not here -- I'm not an expert, I haven't got all the details, but one thing I will say is that some 18 you're under pressure. I just wanted to say what a privilege it is that my father's story was heard today, but I am a corporate witness for every family in Northern Ireland, and I hope that today you will remember every mother, father, brother, sister, husband, wife, that are feeling how I feel or have suffered and lost, and the -- ultimately I am telling my father's story because he's not here to tell it, and we want to know why our loved ones aren't here.

LADY HALLETT: Thank you very much indeed, Mrs Myles.
 I'm in no way surprised that you and your family are

- 2 so traumatised, having described the circumstances of
- 3 your father's death, and I'm truly sorry, and I will
- 14 remember all the people you've described. As you know,
- 15 I've met some of them and I hope to meet some more
- 6 during the course of this Inquiry, but I will remember
- 7 them, I promise.
 - How old were your children when your father died?

THE WITNESS: My son was almost 8 and then I had one in her
 teens and one of 19 at that time.

21 LADY HALLETT: It must have been particularly difficult with22 them.

- 23 THE WITNESS: Yeah. And, sorry, my youngest son has autism,
- 24 which played a factor, and I had meant to mention that
- 25 as one of the vulnerabilities as well. You know,

of the subject matter in which you are expert, and for the rest of us who will be hearing your evidence, could you please try to keep your answers as short and succinct as you can, whilst obviously doing credit, giving sufficient credit to the subject matter.

You have been good enough to prepare for her Ladyship an expert report. Is that a report that you wrote with a professional colleague, a professor, herself, of social science and health at the Department of Global Health and Social Medicine at King's College

London, Professor Laia Bécares?

the views of both of you?

Was that report prepared by both of you?

Now, she's not giving evidence today with you, on account of the fact that she was unavailable to give evidence today. But when you give evidence about the

subject matter of your report, will you be giving evidence in a way that's reflective of you own views or

report when you compiled it together?

It will reflect the views of both of us. We've worked together for many years and have reached this position

22

Health Observatory and co-chair of its academic reference group. What is the NHS Race and Health

And of course you debated the many issues raised in your

The NHS Race and Health Observatory is an independent organisation located within the NHS that focuses, as its name suggests, on the relationship between race and health, and focuses on policy in relation to that, as

How long has that observatory been in existence and how long have you been a member of the governing board? I have been a member of the governing board since it started, and I'm now trying to remember, I think it's about 18 months that it's been in existence.

If we could then move over the page, please, to the preamble, so over two pages in fact, thank you very

I want to commence the examination of your report,

It is.

It was

together.

Observatory?

well as evidence.

Post-pandemic, in fact? Post-pandemic, yes, indeed.

reference later in your report.

All right.

much.

1		special needs people were really impacted terribly.	1					
2	LAI	LADY HALLETT: Yes. Well, thank you very much indeed, you 2						
3		have been extremely brave.	3					
4	THE	E WITNESS: Thank you, my Lady.	4					
5		(The witness withdrew)	5					
6	LAI	DY HALLETT: Right, I think the idea is that we have	6					
7		a quick break.	7					
8	MR	KEITH: Please.	8					
9	LAI	DY HALLETT: Five minutes, please.	9					
10	(10	34 am)	10					
11		(A short break)	11					
12	(10	.40 am)	12	A				
13	MR	KEITH: Professor Nazroo, please.	13	Q				
14		PROFESSOR JAMES NAZROO (affirmed)	14	A				
15		Questions from LEAD COUNSEL TO THE INQUIRY	15	Q				
16	MR	KEITH: Please be seated. Could you commence, please, by	16					
17		giving us your full name.	17					
18	Α.	Yes, my name is James Nazroo.	18					
19	Q.	You are in fact Professor Nazroo, so that's how I'm	19					
20		going to call you, if I may.	20					
21		Professor, whilst you give evidence, could you	21	A				
22		please remember to keep your voice up so that we may	22					
23		clearly hear what you have to say, and also speak as	23					
24		clearly as you can so that the microphone can pick up	24	Q				
25		your evidence. And also, lastly, due to the complexity 21	25					
1	A.	Indeed.	1					
2	Q.	Thank you.	2					
3		That report is at INQ000280057.	3					
4		Did you in fact sign that report as being a report	4	A				
5		that was prepared based on facts within your knowledge	5					
6		and obviously true to the best of your knowledge and	6					
7		belief and in accordance with your professional expert	7					
8		views?	8					
9	Α.	l did.	9	Q				
10	Q.	And you did, I think, on 15 September of 2023.	10					
11		Remaining on that front page, could we start,	11	A				
12		please, with your professional qualifications. Are you	12					
13		a fellow of the Academy of Social Sciences, a fellow of	13					
14		the British Academy and professor of sociology at the	14	Q				
15		University of Manchester?	15	A				
16	Α.	l am.	16	Q				
17	Q.	For many years, and this is the area in which you are	17					
18		one of the world's leading experts, you've conducted	18					
19		research on issues of inequality, social justice and	19					
20		health, with a focus on ethnicity and race, ageing,	20					
21		gender, and the interrelationships, intersectionality,	21					
22		between these topics or these areas?	22					
23	Α.	That's correct.	23					
24	Q.	At the end of that paragraph, you say that you're	24					
25		a member of the governing board of the NHS Race and	25					

23

24

please, Professor, by setting out some of the basic building blocks, the legislation that applies to the area of race equality, the comparative evidence upon which you draw, and the sources to which you make

(6) Pages 21 - 24

22

23

24

25

Q. After the time that in fact you were asked to look at,

which was the dawn of the pandemic, preceding the

pandemic, in December 2020, did the ONS carry out

a survey or report called "Coronavirus and the social

28

		UK	Covid-19 Inquir	у	5 October 2023
1		Your report in general terms addresses ethnic	1		reducing ethnic inequalities in health". As it says in
2		inequalities in the areas or the fields of health,	2		the title, that was a report concerned with health
3		society and the economy.	3		inequalities, but has government generally sought to try
4		What is meant by ethnic inequality? Is that	4		to address the issue of ethnic inequality across
5		a general compendious term that refers to all the many	5		society?
6		ways in which there may be an inequality in day-to-day	6	Α.	So there have been a number of inquiries and
7		life, in that particular person's existence, in the	7		investigations by government into ethnic inequalities.
8		resources to which they have access, the services that	8		Many of those have focused on very specific areas like
9		they receive from the state, based in some way upon	9		employment or policing, more recently there has been the
10		their ethnic grouping?	10		Commission on Race and Ethnic Disparities, chaired by
11	Α.	Yes, on the ethnic category within which they belong.	11		Dr Sewell, which reported in 2021 and did look across
12	Q.	This is, of course, an issue that government has paid	12		the spectrum of society, so it looked at a range of
13		attention to, with varying degrees of success or not,	13		features of society.
14		over the years. Is there in place legislation to try to	14	Q.	What other areas of research have been carried out, or
15		promote ethnic equality?	15		what other government bodies or non-governmental
	Α.	There is, and the most recent legislation is the	16		organisations have carried out research into the state
17		Equality Act of 2010.	17		of play of ethnic inequality? So the ONS, SAGE, of
18	Q.	Over time, and particularly since 2010, have a variety	18		which we've heard of course a lot in this Inquiry, the
19		of government bodies, including Public Health England,	19		government's own Race Disparity Unit, can you list or
20		tried to assess, tried to carried out research upon	20		identify the main players in this field of research?
21		and tried to assess the actual state of ethnic	21	Α.	
22		inequality in the United Kingdom?	22		endeavours examining ethnic inequalities. The Race
		They have.	23		Disparity Unit, set up within the Cabinet Office, is one
	Q.	Public Health England prepared a report in 2018 called	24		example of that. In fact, perhaps a prominent example
25		"Local action on health inequalities. Understanding and 25	25		of that. Established by Theresa May, I believe, when 26
1		she was Prime Minister, but had a precursor when	1		that. I think that's the correct date.
2		David Cameron was Prime Minister. And that collated	2	Q.	
3		data from across government departments on the extent of	3	ч.	sometimes year by year, on other occasions less
4		ethnic disparity. So including education, employment,	4		frequently, surveys across the United Kingdom to try to
5		housing and so on, health.	5		evaluate or identify and evaluate the state of play?
	Q.	5	6	Α.	It does indeed, yeah.
7		derived from its own research on publicly accessible	7	Q.	
8		websites?	8		time?
	Α.	Yes, absolutely. So the Race Disparity Unit has	9	A.	
10		a publicly accessible website where it presents headline	10	Q.	
11		figures, but also allows access to more detailed	11		are more specific? So, for example, focused on social
12		reporting on those headline figures.	12		impacts and, we'll come to this in a minute, coronavirus
13	Q.	Are those figures in fact or are they published under	13		or ethnicity?
4		headings such as the government's Ethnicity facts and	14	A.	It carries out the annual population survey, which is
15		figures website, and the government Race Disparity Audit	15		a very large survey, so enables data users to say to
16		website?	16		examine and to say something about ethnic differences
7	Α.	Indeed, yeah.	17		across a range of outcomes. And it carries out a number
18	Q.	So that's the government's own internal research, if you	18		of other very important surveys, like the Labour Force
19		like.	19		Survey that we use to examine ethnicity inequalities in
20		SAGE, which we know is the Scientific Advisory Group	20		the labour market.

- 21 for Emergencies, which was stood up, to use a terrible
- 22 modern idiom, during the pandemic, did that have
- 23 a subgroup which focused on ethnicity?
- 24 Α. It did. So there was a SAGE Ethnicity subgroup that
- 25 I believe was established autumn 2020, something like 27

impacts on different ethnic groups in the UK"?

1	Α.	It did.
2	Q.	And did it in 2021 carry out a census entitled "Ethnic
3		group consensus"?
4	Α.	Sorry, entitled?
5	Q.	"Ethnic group consensus 2021"?
6	Α.	I don't know of that report.
7	Q.	I can say with absolute certainty, Professor, that is
8		probably my fault, not yours. It may be that I have
9		misled myself. But are you aware of any ONS work done
10		by way of a census specifically focusing on ethnicity?
11	Α.	So in 2021 a census was carried out which includes
12		collection of data on people's ethnicity.
13	Q.	Ah, it just may not therefore have been entitled as
14		I read it out.
15	Α.	No, so the census covers the whole population. ONS are
16		responsible for the England and Wales census, and within
17		that they collect data on people's ethnicity.
18	Q.	The ONS also prepared a report on mortality, did it not?
19	Α.	It did.
20	Q.	Again, was that a report that postdated the time that
21		you were looking at, so 2021 in fact?
22	Α.	It did. So that report grew out of their work around
23		ethnic differences in death rates from coronavirus,
24		where they did some very innovative work linking death
25		certificates to census records to estimate differences 29
		20
1		practices, racism, the lack of access of those in ethnic
2		groups to social and economic resources, the prejudice
3		which they encounter and so on? So it was a very
4		wide-ranging report?
5	Α.	It was a very wide-ranging report that looked across
6	_	the board in terms of ethnic disparity.
7	Q.	Now, you've introduced a number of reports, the majority
8		of which in fact postdate 2020. You were asked, were
9		
10		you not, to look specifically at what material was
		available at the commencement of the pandemic in order
11		available at the commencement of the pandemic in order to be able to ascertain what decision-makers, what
12		available at the commencement of the pandemic in order to be able to ascertain what decision-makers, what government would have understood the position to be when
12 13		available at the commencement of the pandemic in order to be able to ascertain what decision-makers, what government would have understood the position to be when it commenced making the momentous decisions which are
12 13 14		available at the commencement of the pandemic in order to be able to ascertain what decision-makers, what government would have understood the position to be when it commenced making the momentous decisions which are the subject of this Inquiry; is that correct?
12 13 14 15	А.	available at the commencement of the pandemic in order to be able to ascertain what decision-makers, what government would have understood the position to be when it commenced making the momentous decisions which are the subject of this Inquiry; is that correct? Indeed.
12 13 14 15 16	A. Q.	available at the commencement of the pandemic in order to be able to ascertain what decision-makers, what government would have understood the position to be when it commenced making the momentous decisions which are the subject of this Inquiry; is that correct? Indeed. To what extent, therefore, do the later reports assist
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12 13 14 15 16 17 18 19 20 21 22 23 24	Q.	 available at the commencement of the pandemic in order to be able to ascertain what decision-makers, what government would have understood the position to be when it commenced making the momentous decisions which are the subject of this Inquiry; is that correct? Indeed. To what extent, therefore, do the later reports assist you in providing the snapshot of the position at 2020? For example, do any of those reports contain backward-looking conclusions which might be reflective in part on the position at 2020? Yes, so inevitably those reports look at the evidence across a wide period of time, and so therefore do contain backward-looking evidence. I did not incorporate them into my and Laia's report because they
12 13 14 15 16 17 18 19 20 21 22 23	Q.	available at the commencement of the pandemic in order to be able to ascertain what decision-makers, what government would have understood the position to be when it commenced making the momentous decisions which are the subject of this Inquiry; is that correct? Indeed. To what extent, therefore, do the later reports assist you in providing the snapshot of the position at 2020? For example, do any of those reports contain backward-looking conclusions which might be reflective in part on the position at 2020? Yes, so inevitably those reports look at the evidence across a wide period of time, and so therefore do contain backward-looking evidence. I did not

qui		
1		in the provelence of rick of death or you know of
		in the prevalence of risk of death or, you know, of
2		death, and then they extended that work to examine
3		the period prior to the coronavirus pandemic. Though,
4	~	as you say, published in 2021.
5	Q.	And importantly, that report or that survey of facts and
6		figures addressing mortality rates was a survey or
7		a report that focused on the links between ethnicity and
8		mortality, so that is to say which ethnic group suffered
9		the highest rates of mortality, whether, therefore, it
10		would impact or whether you were white or whether you
11		were a member of an ethnic group would affect the risk
12		of mortality?
13	Α.	Yes, exactly, they estimated mortality rates by ethnic
14		group.
15	Q.	We'll come back to that report in greater detail later,
16		because I know you have some views on the methodology
17		behind that report and therefore the weight which can be
18		placed upon it.
19		You have mentioned Dr Sewell's report. Was that
20		a report from 2022, March 2022, or was it March 2021?
21	Α.	March 2021.
22	Q.	March 2021. And again, that's obviously a report that
23		postdates the pandemic or the commencement of the
24		pandemic. Was that a report which looked at, in very
25		general terms, not just mortality but discriminatory
		30
1	•	pandemic began.
2	Q.	Because of course the government wouldn't have known of
2 3	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced.
2 3 4	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express
2 3 4 5	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what
2 3 4 5 6	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice,
2 3 4 5 6 7	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which
2 3 4 5 6 7 8	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social
2 3 4 5 6 7 8 9	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality
2 3 4 5 6 7 8 9	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated
2 3 4 5 6 7 8 9 10 11	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair
2 3 4 5 6 7 8 9 10 11 12		Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary?
2 3 4 5 6 7 8 9 10 11 12 13	Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be
2 3 4 5 6 7 8 9 10 11 12 13 14		Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports,
2 3 4 5 6 7 8 9 10 11 12 13 14 15	A.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16		Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	A.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much. Because you were asked to look at what surveys were
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much. Because you were asked to look at what surveys were in existence and what material existed in front of
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much. Because you were asked to look at what surveys were in existence and what material existed in front of decision-makers in January 2020, did you go back and look and see what material was available?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A. Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much. Because you were asked to look at what surveys were in existence and what material existed in front of decision-makers in January 2020, did you go back and look and see what material was available? I did.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much. Because you were asked to look at what surveys were in existence and what material existed in front of decision-makers in January 2020, did you go back and look and see what material was available? I did. If we look at the top, please, of, I think it's page 4,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much. Because you were asked to look at what surveys were in existence and what material existed in front of decision-makers in January 2020, did you go back and look and see what material was available? I did. If we look at the top, please, of, I think it's page 4, did you find that, and of course you were aware already,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A. Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much. Because you were asked to look at what surveys were in existence and what material existed in front of decision-makers in January 2020, did you go back and look and see what material was available? I did. If we look at the top, please, of, I think it's page 4, did you find that, and of course you were aware already, that the last health survey for England to oversample
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q.	Because of course the government wouldn't have known of them, they hadn't yet been produced. But to the extent to which, if at all, you express any views on what the reality was at 2020, what the state of racism was, what the state of prejudice, the levels of prejudice were at, and the way in which members of ethnic groups were denied access to social and economic resources, any view as to what the reality was would have to be assessed in light of postdated material, because it's backward looking; is that a fair summary? Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed. Thank you very much. Because you were asked to look at what surveys were in existence and what material existed in front of decision-makers in January 2020, did you go back and look and see what material was available? I did. If we look at the top, please, of, I think it's page 4, did you find that, and of course you were aware already,

1		Department for Communities and Local Government's
2		citizenship survey, which oversampled ethnic minority
3		people and has been a key source of data, had its final
4		round of funding in 2011?
5		So although there were reports, they were, at least
6		by comparison to the post-pandemic position, fewer and
7		further between, in part because of a lack of investment
8		in funding?
9	Α.	Yeah, that is correct. The health survey for England,
10		just to clarify, is perhaps the most important annual
11		monitoring of the health of the population. A standard
12		survey does not contain because of the relatively low
13		numbers of ethnic minority people in the population,
14		a standard survey does not contain enough ethnic
15		minority people to be able to examine ethnic
16		differences. So the last time we were able to do
17		that or the last time we had data to enable us to do
18		that was in 2004. And a similar story goes with the
19		citizenship survey. Neither of those surveys have been
20		resourced to include ethnic minority oversamples since
21		then.
22	Q.	For good reasons of fairness, is it right to say that,
23		since the pandemic, funding has become somewhat more
24		available? I believe that more funding has been
25		provided by the NIHR and by government and, therefore,
		33
1		and made recommendations for how we might approach
2		addressing ethnic inequalities in health.
3	Q.	If we turn over the page, to "Topic 1: Definitions",
4		could you please assist us with some of the basic
5		terminology, Professor.
6		"Ethnicity" and "race" are words that, of course,
7		are in extremely common use and it's not altogether
8		clear what we always mean by them when we refer to them.
9		What is, in a sentence, if you can do it, ethnicity?
10	Α.	So ethnicity is collective identity, an affiliation to
11		a grouping, based on ancestry, culture, religion,
12	~	geographical origins, and so on.
13	Q.	So in essence, if you'll forgive me, who they are?
14 15	A.	One dimension of who they are.
15	Q.	One dimension of who they are.
16 17		By contrast, is "race" a word which refers to shared
17 18	^	physical features, most often skin colour?
18 10	A. 0	Yes. This is how I use the term "race".
19 20	Q.	Is that why racism, the social scourge that it is, is
20 21		a reflection of behaviour which is outrageously and
21 22		unfairly based upon, in the main, the colour of someone's skin?
22	Α.	Not just the colour of someone's skin. So racism also
23 24	д.	incorporates notions of cultural inferiority as well.
24 25	Q.	Yes, I said in the main, but yes, thank you.
20	٩.	35

1	that in part is why there have been more surveys since
2	the pandemic than there were before?

- the pandemic than there were before?
- 3 A. Yes, that's correct. Just to add one additional bit of 4 clarification.

5	Q.	Please.
6	Α.	There is also the UK Longitudinal Household Study, known
7		as Understanding Society, which has been running
8		throughout the period that we're talking about, so from
9		2010, I think, onwards, and that oversamples ethnic
10		minority people. So that has been a very important
11		source of data, funded by the Economic and Social
12		Research Council.
13	Q.	And in fact you refer to that household survey in this
14		same paragraph, alongside the references to the census
15		in 2021, to which you've already made reference?
16	Α.	Yeah. And as you asked, there has been additional
17		funding since the beginning of the Covid pandemic to
18		investigate ethnic differences.
19	Q.	Finally, in paragraph 8, further down the page, you
20		refer to the Public Health England report of 2018. How
21		important in the general scheme of things, was that

- 21 important, in the general scheme of things, was that 22 report?
- 23 A. I believe that report was very important. It brought
- 24 together existing evidence on the patterning of ethnic
- 25 inequalities in health, it examined underlying causes, 34

1		At paragraph 11, you refer to racism, and you say
2		one of the elements of racism, one of its, perhaps its
3		most pernicious, elements, is a racist approach to
4		a person often entails the placing of them and their
5		cultural group on a hierarchical scale. What is meant
6		by hierarchical scale?
7	Α.	So it's how we evaluate each other on the basis of our
8		ethnicity and the notion that some ethnicities are more
9		valued than others.
10	Q.	And by implication, some are considered inferior to
11		others and are therefore marginalised and excluded?
12	Α.	Yep.
13	Q.	All right.
14		What then are inequalities?
15	Α.	Inequalities are unfair outcomes as a consequence of
16		processes related to inferiority, superiority and access
17		to resources.
18	Q.	The consequences?
19	Α.	The consequences.
20	Q.	And in order to aid the study of this area, is racism
21		conceptually separated into three different areas:
22		structural, institutional and interpersonal?
23	Α.	Yeah, so this is the approach that I take in order to
24		understand how racism operates in our society. If we
25		consider these three dimensions of highly interrelated

1		processes of racism, we can then begin to identify how	1		all see as the most obvious, through our personal
2		racism leads to unfair outcomes, how it leads to	2		experiences, is personal prejudice, hence interpersonal?
3		inequalities.	3	Α.	Yes, and this is how most of us see and recognise
	Q.	And what is structural racism?	4		racism.
5	Α.	So structural racism is the uneven distribution of	5	Q.	
6		access to resources as a result of people's ethnicity or	6		Now, paragraph 14, please, page 7.
7		race. So by that I include things like economic	7		You then turn to the heart of the report, which is
8		resources, geographical location, cultural resources,	8		what was the position relating to ethnic inequalities in
9		access to political resources and so on.	9		health prior to January 2020, for the purposes of
	Q.	It's structural because it focuses upon the way in which	10		setting, of course, the building block for what
11		society and its structures, governmental, commercial,	11		the position was that confronted government
12		and otherwise, fail to give proper access?	12		decision-makers on the cusp of the pandemic.
	A.	It's structural because of the ways in which social	13		Do you conclude, in very general terms, in
14		structures constrain access to certain resources. These	14		paragraph 15, that ethnic inequalities in health have
15		aren't necessarily the direct actions of particular	15		been long-standing and persistent? Have they been
16		organisations or individuals.	16		documented, for example, for many years?
	0	But it's across society?	10	Α.	
		It's across society.	18	Q.	Was there a greater amount of documentation and survey
		Right.	19	۰.	and research in the years leading up to January 2020 or
20	α.	Institutional racism, is that a reflection of the	20		less?
21		processes and procedures within institutional settings?	20	Α.	In the decade or so leading up to January 2020, there
	A.	Indeed.	22	Λ.	was less total population examination of ethnic
		And is interpersonal racism, as would appear to be the	23		inequalities in health.
24	α.	case from the word "interpersonal", a reference to	20	Q.	Was that in the main because, as you've said earlier,
25		everyday encounters of racism? Which, as what we might	25	હ.	the last health survey hadn't been there hadn't been
		37			38
1		one since 2004, and there had been an underinvestment in	1		across ethnic groups. The bottom line of this is that
2		data generally with regards to ethnic minority	2		for the two crucial questions in the census, they both
3		monitoring?	3		correlate very well with risk of mortality and with risk
4	Α.	Indeed. And as I've argued earlier, or as I said	4		of having a diagnosed disease, and that correlation does
5		earlier, the Health Survey for England I think is	5		not appear to vary dramatically across ethnic groups or
6		an absolutely crucial resource for documenting	6		meaningfully across ethnic groups.
7		inequalities in health.	7	Q.	If I may say so, I think that's admirably clear. I'll
8 (Q.	Is that the report you refer to at paragraph 17 and	8		probably bring confusion in where it's not warranted,
9		which you've already spoken of already?	9		but in essence, therefore, what you're saying is the
10	Α.	That's the Health Survey for England I refer to in	10		figures which are self-reported by people who contribute
11		paragraph 16. The Public Health England report brought	11		to a census and respond to a census, they're consistent
12		together evidence from a range of sources.	12		with objectively verifiable levels of mortality,
13 (Q.	You've referred to the census carried out by the ONS and	13		the risk of death, in ethnic grouping, and also with
14		in particular the 2011 census which preceded the	14		the objectively verifiable information relating to
15		pandemic, the 2021 was later, of course. A census	15		disease?
16		depends, of course, on every recipient or contributor	16	Α.	They are.
17		self-reporting information. To what extent does	17	Q.	What that census material shows is that over time ethnic
18		the information that can be extracted from a census have	18		inequalities in health have been persistent, and
19		to be assessed in light of the fact that it's	19		therefore that some ethnic groups, Pakistani,
20		self-reported? Putting it another way, can the same	20		Bangladeshi and black Caribbean groups and , among wome
21		weight be placed on self-reported data as objectively	21		the Indian group, have higher rates of long-term illness
		observed data?	22		than the white ethnic group?
22		So, this is a very important topic. There has been some	23	Α.	Yes, that's correct.
	Α.		20		
	Α.	investigation into how far measured disease correlates	24	Q.	Can I bring you back to the post-pandemic ONS data of
23	Α.			Q.	

(10) Pages 37 - 40

1 focused on mortality rates?

- 2 A. It was, and subsequently on life expectancy.
- 3 **Q.** And was that report, post-pandemic as it was,
- 4 consistent, in your opinion, with the pre-pandemic
- 5 material, the census material, the Public Health England
- 6 material, the Longitudinal survey and so on, in terms of
- 7 the persistency of ethnic inequality in health?
- 8 **A.** Yes, so that report covered a period prior to
- 9 the pandemic, so the period that we're talking about in
- 10 terms of the evidence that we've presented in the
- 11 document, and again the bottom line is it was not
- 12 consistent with that evidence.
- 13 **Q.** So the post-pandemic ONS survey, although it was
- backward facing in terms of relying upon data from 2012
 to 2019, reached a different general conclusion from
 the earlier material?
- 17 A. That's correct, the conclusion it reached was that
- 18 the life expectancy of white people was lower than the
- 19 life expectancy of ethnic minority people, suggesting
- 20 white people had worse health, and that the mortality
- 21 risk for white people, consistent with what I've just
- said about life expectancy, were higher for white peoplecompared with ethnic minority people.
- 24 **Q.** The conclusion of that report was that the white group
- 25 had a statistically significantly elevated all-cause 41

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1 My concerns with this really began when I saw 2 the inconsistency between the mortality rates and what 3 we knew about morbidity or health levels. When I looked 4 a little bit closer, I saw that some of the estimates of 5 life expectancy and of mortality rates were rather 6 unusual. For example, the life expectancy of an 80-year 7 old Pakistani or Bangladeshi woman is considerably 8 longer than the life expectancy of a Japanese woman of 9 a similar age. And I use Japan as the example because 10 Japan has long life expectancies, considerably longer. 11 So when you see that, you begin to wonder whether 12 the data are correct. 13 The reason why the data may not be correct is 14 because of the linkage of administrative records, so 15 that some deaths may not be accurately linked to census 16 records, so then deaths become undercounted. And that 17 means that some people become statistically immortal, 18 they never die, in the statistical record. 19 We are working with -- or "we", me and colleagues 20 are working with ONS to explore the consequences of 21 that, but we believe that that does raise questions 22 about the conclusions that they reach. 23 The data themselves are also published as 24 experimental statistics, which means that 25 the statistical underpinnings of the analysis have not

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- mortality when compared to all other ethnic groups, so
- 2 in practice, in reality, because of the prevalence of
- 3 dementia, Alzheimer's and cancer in white groups, they
- 4 concluded or the ONS concluded that the risk of death
- 5 was higher, generally speaking, across the white group
- 6 than it was for ethnic minority groups; is that the sum
- 7 of it?
- 8 A. That's the conclusion of the report.
- 9 **Q.** But you have concerns about the methodology of that
- 10 report; is that right?
- 11 A. Indeed.

- 12 Q. Could you just briefly summarise what concerns you have13 and therefore what concerns you have about the validity
- 14 of the conclusions that the ONS reached?
- 15 A. Yes. So the report itself was based on very innovative
- 16 analysis. I'm not sure whether people are aware, but on
- 17 death certificates we do not record ethnicity. So we
- 18 know whether people have died but we don't know their
- 19 ethnicity. So what the ONS did, and they did this as
- 20 part of pandemic research that they conducted, was to
- 21 link death certificate data to census data and to NHS
- 22 records. Census data and NHS records do contain data on
- 23 ethnicity, so they were then able to estimate risk of
- 24 death by ethnicity. This is incredibly innovative work,
 - and -- yeah, and difficult work to do.
 - 42

All right. We need to treat them with some caution. So, quite properly, there are issues raised about the methodology and the statistical validity of the material, which you in fact, and I think you're looking at this for the ONS, will no doubt research and opine upon in due course. Is it the position that therefore the conclusions from the ONS post-pandemic may
So, quite properly, there are issues raised about the methodology and the statistical validity of the material, which you in fact, and I think you're looking at this for the ONS, will no doubt research and opine upon in due course. Is it the position that therefore the conclusions from the ONS post-pandemic may
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opine upon in due course. Is it the position that therefore the conclusions from the ONS post-pandemic may
therefore the conclusions from the ONS post-pandemic may
or may not prove in the fullness of time to be accurate,
we just don't know?
We don't know.
All right.
But what that shows is there is at least an issue as
to whether or not there had been changes both in
the levels of access to health services amongst ethnic
groups, levels of mortality and health inequalities,
over time, perhaps, before the pandemic, we just don't
know to what extent, if at all, there were?
So the data on morbidity, on health, on disease and so
on suggests consistency over time, that the inequalities
have persisted over time. The data on mortality are
backward looking, as you've described them, which means
that they are also consistent over time. So that
backward look is also consistent with a more recent

1		analysis that was conducted using data since the 2021	1
2		census.	2
3	Q.	On mortality?	3
4	Α.	On mortality.	4
5	Q.	Right.	5
6	Α.	But, as I have suggested, my opinion is that there are	6
7		statistical problems with those analyses.	7
8	Q.	At paragraphs 21 and 22, you conclude, as a result of	8
9		your examination, that ethnic inequalities in health are	9
10		also more pronounced at older ages, and you give some	10
11		details or some examples of why that is so, and you also	11
12		say, in paragraph 22, that:	12
13		"Inequalities across ethnic groups begin to emerge	13
14		in middle adulthood and for three [particular] groups -	14
15		Bangladeshi, Pakistani and Black Caribbean people"	15
16	Α.	Yes.	16
17	Q.	You produced a chart on the following page, please,	17
18		if we could just scroll in, please, on that chart	18
19		does this show ethnic differences in fair or poor	19
20		self-reported health by age? So these are	20
21		the recipients of the surveys and the contributors	21
22		indicating themselves where they have fair or poor	22
23		health?	23
24	Α.	That is correct, yeah.	24
25	Q.	And we can see Bangladeshi at the top, Pakistani second	25
		45	
		45	
		45	
1		45 the risk of chronic conditions are higher the risk of	1
1 2			1 2
		the risk of chronic conditions are higher the risk of	
2		the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst	2
2 3	Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in	2 3
2 3 4	Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms.	2 3 4
2 3 4 5	Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic	2 3 4 5
2 3 4 5 6	Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic	2 3 4 5 6
2 3 4 5 6 7	Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic	2 3 4 5 6 7
2 3 4 5 6 7 8	Q. A.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical	2 3 4 5 6 7 8
2 3 4 5 6 7 8 9		the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care?	2 3 4 5 6 7 8 9
2 3 4 5 6 7 8 9 10	A.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct.	2 3 4 5 6 7 8 9 10
2 3 4 5 6 7 8 9 10 11	A.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how	2 3 4 5 6 7 8 9 10 11
2 3 4 5 6 7 8 9 10 11 12	A. Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not?	2 3 4 5 6 7 8 9 10 11 11
2 3 4 5 6 7 8 9 10 11 12 13	A. Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and	2 3 4 5 6 7 8 9 10 11 12 13
2 3 4 5 6 7 8 9 10 11 12 13 14	A. Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and Irish traveller group, ethnic minority people are more likely to use a GP than white British people. And how indicative is that of the need for medical	2 3 4 5 6 7 8 9 10 11 12 13 13
2 3 4 5 6 7 8 9 10 11 12 13 14 15	A. Q. A.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and Irish traveller group, ethnic minority people are more likely to use a GP than white British people.	2 3 4 5 6 7 8 9 10 11 12 13 14 15
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	A. Q. A.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and Irish traveller group, ethnic minority people are more likely to use a GP than white British people. And how indicative is that of the need for medical	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 77	A. Q. A.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and Irish traveller group, ethnic minority people are more likely to use a GP than white British people. And how indicative is that of the need for medical treatment as opposed to a propensity or a disinclination	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A. Q. A. Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and Irish traveller group, ethnic minority people are more likely to use a GP than white British people. And how indicative is that of the need for medical treatment as opposed to a propensity or a disinclination to want to seek help?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	А. Q. A. Q. А.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and Irish traveller group, ethnic minority people are more likely to use a GP than white British people. And how indicative is that of the need for medical treatment as opposed to a propensity or a disinclination to want to seek help? It at least in part reflects the need for more	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	А. Q. A. Q. А.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and Irish traveller group, ethnic minority people are more likely to use a GP than white British people. And how indicative is that of the need for medical treatment as opposed to a propensity or a disinclination to want to seek help? It at least in part reflects the need for more treatment. But not wholly? It's a very difficult statistical exercise to be able to	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A. Q. A. Q. A. Q.	the risk of chronic conditions are higher the risk of a diagnosis with a chronic condition is higher amongst ethnic minority people than white British people, in general terms. Topic 3, on the following page, page 10, "Ethnic inequalities in access to healthcare", is this the topic of the extent to which members of any particular ethnic group might go to a GP or a hospital and seek medical care? That's correct. Are there differences between ethnic groups as to how likely it is that people use GP services than not? Apart from the Chinese group and the white Gypsy and Irish traveller group, ethnic minority people are more likely to use a GP than white British people. And how indicative is that of the need for medical treatment as opposed to a propensity or a disinclination to want to seek help? It at least in part reflects the need for more treatment. But not wholly?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21

25 can, it explains some of the difference, some of the

- there, underneath, and then -- my eyesight will probably betray me -- black Caribbean third and white British at the bottom?
 A. White British not quite at the bottom, white British are the yellow line in the chart, and you can there are two or three lines that are not much different from them.
 Q. They are at the bottom, they're just not very far from the bottom from the other two above them.
 A. Yeah, so the black African and Chinese levels of self-reported health are pretty similar to those for white British people across the age range.
 Q. Right. You then went on to look at the position in
- 3 relation to specific diseases, and obviously in
- 14 the population at large there are a number of chronic
- 15 conditions such as diabetes, ischaemic heart disease,
- hypertension and stroke and so on and so forth. What,
- 7 in very general terms, did you conclude in relation to
- 18 specific disease outcomes? And by "outcomes" I mean the
- 19 extent to which people self-reported the existence of
- and the suffering from specific diseases.
- A. Yeah, so the picture does become complicated because
 specific diseases have specific -- have differences in
 prevalence across ethnic groups that don't immediately
- 4 parallel -- each disease doesn't immediately parallel
- the other. But in general terms, in high-level terms,46

1		higher rate, which suggests that need is at least one of
2		the drivers of this.
3	Q.	Yes. In essence, it must be a factor?
4	Α.	It is a factor.
5	Q.	Yes. All right.
6		You also referred to a Public Health report in 2018
7		which expresses the view that ethnic minority groups
8		report lower satisfaction with primary and secondary
9		healthcare, and you also refer to the particular field
10		of maternal and neonatal healthcare, where ethnic
11		minority women experience less good communication with
12		providers and also delays in antenatal care?
13	Α.	That is correct, the Public Health England report, in
14		paragraph 28, brings together evidence from a large
15		number of studies. The work on maternal and neonatal
16		morbidity has been done by a handful of studies.
17	Q.	Lastly under this section, at 31 and 33, you deal with
18		the issue of access to mental health services. 31:
19		" ethnic minority people are more likely than
20		White people to experience high rates of admissions
21		involving the police, less likely to be referred to by
22		a GP"
23		For mental health services.
24		And, 33, there are ethnic inequalities in relation
25		to young people in addition, particularly black young 48

1		people, who are more likely to be referred through
2		education, mental health services, social care, relative
3		to primary care?
4	Α.	That is correct.
5	Q.	All right. Well, I'm not going to ask you any more
6		questions about that, because, if I may say so, you've
7		set it out very clearly and your conclusions are
8		self-evident in those paragraphs.
9		Topic 4, social and economic resources. What is,
10	_	what are social and economic resources?
11	Α.	
12	_	employment, education, yeah, et cetera.
13	Q.	
14		terms of those resources?
15	Α.	The evidence we summarise strongly suggests that that
16		inequality has been persistent. Is present and has been
17 18	^	persistent. And that's across the whole range of economic activity,
10 19	Q.	so employment, income, educational outcomes, housing,
20		area deprivation, discrimination and so on, this is
20		a huge area.
22	Α.	
23	7.1	persistent. There is variation in the detail,
24		of course, but those inequalities are persistent.
25	Q.	
		49
1		groups, not all of them, but it is higher in ethnic
1 2		groups, not all of them, but it is higher in ethnic minority groups, and that higher rate has largely
2	Q.	minority groups, and that higher rate has largely remained persistent over time.
2 3	Q.	minority groups, and that higher rate has largely remained persistent over time.
2 3 4	Q.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent
2 3 4 5	Q.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are
2 3 4 5 6 7 8	Q.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might
2 3 4 5 6 7 8 9		minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects?
2 3 4 5 6 7 8 9	Q. A.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over
2 3 4 5 6 7 8 9 10 11		minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment
2 3 4 5 6 7 8 9 10 11 12		minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as
2 3 4 5 6 7 8 9 10 11 12 13		minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources
2 3 4 5 6 7 8 9 10 11 12 13 14		minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and
2 3 4 5 6 7 8 9 10 11 12 13 14 15	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16		minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to your report, by way of what's called a Rule 10(4)
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to your report, by way of what's called a Rule 10(4) submission, that since the pandemic and again
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to your report, by way of what's called a Rule 10(4) submission, that since the pandemic and again emphasising that you were looking at the position as
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to your report, by way of what's called a Rule 10(4) submission, that since the pandemic and again emphasising that you were looking at the position as at 2020 here since the pandemic there is some
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to your report, by way of what's called a Rule 10(4) submission, that since the pandemic and again emphasising that you were looking at the position as at 2020 here since the pandemic there is some material, in particular an annual population survey
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to your report, by way of what's called a Rule 10(4) submission, that since the pandemic and again emphasising that you were looking at the position as at 2020 here since the pandemic there is some material, in particular an annual population survey in 2021, which suggests that the risk of unemployment or
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to your report, by way of what's called a Rule 10(4) submission, that since the pandemic and again emphasising that you were looking at the position as at 2020 here since the pandemic there is some material, in particular an annual population survey
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Α.	minority groups, and that higher rate has largely remained persistent over time. Do you reach the view that it's remained persistent because the rates of unemployment in ethnic groups are still there, despite the fact that ethnic minority populations now have a large proportion of second and third generation people within them and therefore might otherwise be expected to have enjoyed better prospects? Indeed, we would expect I would have expected over time for ethnic inequalities in things like employment to have diminished because the resources that we sell as we apply for jobs, the inequalities in those resources should have reduced over time, across generations and over time. The government has made the point in the response to your report, by way of what's called a Rule 10(4) submission, that since the pandemic and again emphasising that you were looking at the position as at 2020 here since the pandemic there is some material, in particular an annual population survey in 2021, which suggests that the risk of unemployment or the levels of unemployment are narrowing. Would you

1		surveys or censuses tried to unpick the individual areas
2		which are grouped in the area of social and economic
3		resources? So are there specific surveys dealing with
4		just housing, for example, or just employment, or is
5		this information which has to be extracted from a much
6		larger body of data?
7	Α.	There are specific studies around housing, specific
8		studies around employment, specific studies around
9		health and so on, but the census, perhaps one of
10		the most useful tools or one of the most useful sources
11		of data, does cover a number of these dimensions
12		jointly.
13	Q.	Of particular importance to this Inquiry is, of course,
14		employment, because the figures appear to indicate, and
15		they're very clear, that certain people in certain jobs
16		were more at risk of being infected, depended of course
17		on whether they were on the frontline of healthcare or
18		whether they were delivering public services which
19		required them to come into contact with other people who
20		might be infected, so employment and the nature of
21		employment, whether it's part or full-time and what
22		sort of employment it is, is of great importance.
23		What general conclusions did you reach in relation
24		to the risk of unemployment, firstly?
25	Α.	So the risk of unemployment is higher in ethnic minority
		50
1		unemployment are reducing, the gap between ethnic
2		minority people and white British people has remained.
3		And it's also important to recognise that one of
4		the crucial dimensions of employment is not just having
5		a job but the type of job you have, and so that
6		actual those data do not tell us much about part-time
7		employment, for example, and the dramatic move of some
8		ethnic minority groups into part-time employment from
9		full-time employment.
10	Q.	So in essence, that proposition, whilst it might well be
11		right in part, doesn't tell the full story, that's what
12		you would say?
13	Α.	Doesn't tell the full story and I think the headline
14		conclusion, that ethnic inequalities are diminishing, is
15		not the correct conclusion.
16	Q.	Yes. I think to be fair to them, I actually put it in
17		a different way, Professor, I said they suggest that
18		the gap in levels of unemployment is lowering or
19		reducing, which isn't what you've described it as.
20	Α.	Okay.
21	Q.	Paragraph 36, you then deal with the point which you've
21 22	Q.	Paragraph 36, you then deal with the point which you've just raised, which is the type of work. So are there
	Q.	
22	Q.	just raised, which is the type of work. So are there

25 sectors that may increase the risk of exposure to 52

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1		an infectious agent, such as transport, delivery jobs,	1		they're more likely to be in poor quality housing, more
2		healthcare assistants, hospital cleaners, social care	2		likely to be in the private rental sector, which runs
3		workers, nursing and medical jobs and the like?	3		the risk of poorer quality housing, and more precarious
	Α.	That is correct.	4		housing, and more likely to be in overcrowded houses
	Q.	Can you give us any figures or a closer indication of	5		than white British people. This is not across all
6		the proportion of employment undertaken by ethnic	6		ethnic minority groups, but it's the case for some
7	_	minority people which is in those sectors?	7		ethnic minority groups.
	Α.	I'm sorry, I don't have those figures off the top of my	8	LA	DY HALLETT: Mr Keith, I don't know how your timing is
9		head, and I don't have a note in relation to those	9		going?
10		figures, but I think it has been very well documented in	10		KEITH: That's a very good moment.
11		a number of sources that these are the locations where	11		DY HALLETT: Very well, I shall return at quarter to.
12		ethnic minority people are more concentrated and	12	(11	.30 am)
13		yeah.	13		(A short break)
	Q.	Housing. Relevant to this Inquiry because of the	14		.45 am)
15		greater risk of infection in a multigenerational	15	MR	KEITH: Professor, higher pollution levels, are ethnic
16		household, and that's obviously relevant to the	16		minority groups more likely than white majority groups
17		governmental decision-making as to how restrictions and	17		to live in deprived neighbourhoods with higher pollution
18		lockdowns were imposed and what the impact would be on	18		levels?
19		such housing. Are there conclusions that you can draw	19	Α.	Yes.
20		in relation to the proportion of people in ethnic	20	Q.	And are ethnic minority groups more likely than the
21		minority groups who live in multigenerational households	21		general population to experience digital exclusion?
22		or overcrowded households, or households which are seen	22	Α.	Some ethnic minority groups, not all.
23		as deprived because of lack of central heating and so on	23	Q.	Yes.
24		and so forth?	24	LAI	DY HALLETT: You said "some" more than once. Are w
25	Α.	So that is the case for some ethnic minority groups, 53	25		always talking about the same minority groups that are 54
1		featuring at the lowest point, the percentage points, or	1		minority people and digital exclusion cannot be easily
2		are we talking about different ones?	2		derived from survey data, simply because of the very
3	A.	Yes, my Lady, there are three groups that are	3		small number of older ethnic minority people who appe
4		particularly vulnerable, according to the general data	4		in surveys. Qualitative research suggests that older
5		we have, which are the Pakistani, Bangladeshi and	5		ethnic minority people are particularly at risk of
6		black Caribbean group. You have less coverage of a very	6		digital exclusion. But, as you say, I haven't
7		vulnerable group, which is the white	7		reported
8		Gypsy/traveller/Roma group.	8	Q.	And that's not a surprising conclusion at all?
	LA	DY HALLETT: Is that in any way related to the difficulty	9	Α.	It's not a surprising conclusion.
10		in getting data from them because they don't always have	10		All right.
11		a permanent base, or	11		Topic 5, the role of racism. Bearing in mind what
	Α.	I think it my view is that it relates to our	12		you said earlier about the definitional differences
13		willingness to reach out, to get to those people. But	13		between structural, institutional and interpersonal
14		I accept it's more complicated.	14		racism, do you conclude that ethnicity remains strongly
	MR	KEITH: The evidence, in part your own evidence,	15		associated with social location, status and power,
16	NII V	indicates that there is another group of people who are	16		leading to inequalities in access to the resources that
17		digitally excluded, and that is the elderly.	10		you've described, because of ongoing structural racism
18		Are you in a position to draw any view, to express	18	Α.	That is my opinion.
19		an opinion as to comparatively what the levels of	10	Q.	In essence, at its most basic, access to resources is
			20	ω.	
20 21		digital exclusion are between some ethnic minority	20 21		more limited for members of its groups because they a members of those groups; is that it?
21 22		groups and the elderly?	21	٨	
		You will look in vain at that paragraph, Professor,		Α.	
23		I'm afraid I've bowled you a difficult ball, it's not in	23		the consequences of that for members of those ethnic
24	Α.	that paragraph. So the evidence we have in terms of older ethnic	24 25	Q.	groups. In relation to interpersonal racism, that is to say acts

- 1 of racism in everyday life, everyday lives, can you say
- 2 anything about the level of interpersonal racism over
- 3 time in the United Kingdom?
- 4 A. Measuring the level of interpersonal racism is extremely
- 5 complicated. The ways in which we phrase questions, the
- 6 ways in which they're interpreted makes it difficult to
- 7 capture all dimensions of interpersonal racism. But the
- 8 headline response to your question is that it appears
- 9 that levels of interpersonal racism on average have
- 10 remained consistent over time.
- 11 Q. Now, there are a number of different ways in which
- 12 levels of racism might be surveyed or monitored,
- 13 the most important is the self-reported surveys where
- 14 members of the ethnic minorities report on the degree to
- which they have experienced racist abuse, assault orvandalism; is that correct?
- 17 A. That's correct, that's the measure has been used quite18 consistently over time.
- 19 Q. From what time period do those sorts of reports date
- 20 upon which you place reliance for your conclusion that21 there had been a persistence of racism over time?
- 22 A. So they were first used on a national level in 1993/4,
- the survey was carried out in 1993/4, and were repeatedin a few surveys subsequently.
- 25 **Q.** What dates were those subsequent surveys?

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- figure 3, what the impact is of those reports in the
 surveys, which is that -- if you could scroll into the
- 3 charts, thank you very much.

4

- The solid line indicates self-reported acts of
- 5 racism. That is to say, members of the ethnic groups
- 6 that you identify, Pakistani, black Caribbean and Irish,
- 7 have experienced racism, and they're the solid groups.
- 8 And we can see in the bottom right-hand half of the page
- 9 a fairly persistent line, because the lines are
- 10 horizontal, perhaps less persistent in the case of
- 11 the Irish, but over time from 1991 to 2008, which is
- the last survey you mentioned. Those figures haveremained fairly constant.
- Then there's self-reported fear of racism, which has
 remained constant in the case of black Caribbean people.
 In the case of Pakistani people, the fear of racism has
 gone up.
- 18 What is the top line, starting on the left at 1983,
 19 by comparison to fear of racism or experience of racism?
 20 A. The top line reflects the general population's responses
 21 to a question asking whether they are prejudiced against
 22 ethnic minority people, and it shows how that rate has
 23 changed from 1983 through to 2013. Each square is the
 24 period when the data were collected, and you can see it
- 25 was collected quite frequently in the early phase of
 - 59

- A. I'd need to look at my chart here, 2001 and 2008,
 I believe, those ...
 - **Q.** Then were there further reports or further surveys
- 4 thereafter, or is the last survey upon which you place5 reliance that year in 2008?
- 6 A. The last survey that used that wording of the question.7 There have been other surveys that have continued to
- 8 collect data on experiences of racism and
- 9 discrimination, most notably the survey I referred to
- 10 earlier, Understanding Society: The UK Household
- 11 Longitudinal Study.
- 12 Q. And when was the longitudinal household survey?
- 13 A. That started I believe in 2010, and it's an annual
- survey, but it doesn't collect the measures of racismevery year.
- 16 Q. It does?
- 17 A. It does not. It does it every few years.
- 18 Q. So would it be fair to say that the primary material,
- 19 the primary surveys upon which you've placed reliance --
- 20 and it is of course because that is all that there is --
- 21 is a little dated by the viewpoint of 2020?
- A. The pattern over time is a little dated. The patternover time that I present in the report is a little
- 24 dated.
- 25 Q. You properly identify, and we can go to the next page, 58
- 1 this and less frequently in the later phase, and it 2 basically shows, in my view, a fairly consistent level 3 of reporting that you are prejudiced, that ranges 4 between 30% and 40% over this time period. 5 Q. Now, it's obvious that the figures must to some extent, 6 because they're -- the asking of anybody the question 7 "Are you prejudiced?" of course may not elicit 8 an entirely truthful answer, so is that an issue which 9 is taken into account in this survey or this approach? 10 A. It's an issue that needs to be taken account of in terms 11 of the interpretation of responses to this question. 12 LADY HALLETT: Because an awful lot of people don't know 13 that they're prejudiced when they are? 14 A. And the willingness to admit you're prejudiced in front 15 of an interviewer is also going to vary. MR KEITH: So the figures of actual prejudice could be 16 higher because of under-reporting, or if you ask the 17 18 question to what degree do they know that they're 19 prejudiced the figure could be lower because of a failure to identify that they are prejudiced? 20 21 A. That's correct, and it's also important to bear in mind 22 how those issues may change over time. 23 Q. Indeed. 24 What survey does the blue block in 2013 for 25 prejudice signify? What survey is that? Because that's

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(15) Pages 57 - 60

1		in 2013, but the earlier surveys for all the other
2		indices, indicia, are different.
3	Α.	Yeah, so the data for each of these lines comes from
4		a range of surveys. The only consistent line is
5		the blue line at the top on prejudice, which comes from
6		the British Social Attitudes Survey, which is repeated
7		every year, although the question on prejudice is not
8		repeated every year.
9	Q.	And was the last year in which that question was
10		contained in the survey 2013, which is why there's
11		a block on the chart?
12	Α.	At the time we did this analysis, that was the last
13	Q.	Right.
14		So the last objective or quantifiable data
15		underpinning your conclusions is from 2013?
16	Α.	Indeed.
17	Q.	All right.
18		The reason I ask, Professor, as you know, is that in
19		the submissions put forward to the Inquiry
20		the government says: well, what about other surveys or
21		data from 2013 to 2020, and also what about surveys
22		post-pandemic which may be reflective of levels of
23		prejudice pre-pandemic?
24		Do you follow?
25	Α.	Yes.
		61
1		group.
2		That is a comparative survey, we don't know on what
3		it was based, and it obviously says something to the
4		general advantage of the United Kingdom.
5	LAI	DY HALLETT: Sorry, is that they would wish to live next
6		door or they wouldn't?
7	MR	KEITH: 1% say they would not like to sorry, did
8		I miss out the "not"?
9	LA	DY HALLETT: Yes, you did.
10		KEITH: I do apologise.
11		Did it say anything about the levels of prejudice,
12		objective levels of prejudice in the United Kingdom, as
13		opposed to saying something, and perhaps not very much,
14		about the comparative position of the United Kingdom?
15	Α.	So the World Values Survey is actually a very important
16		survey, that enables us to explore attitudes across
17		the globe. It includes very many countries, and so
18		enables us to position attitudes held in
19		the United Kingdom alongside attitudes held in other
20		countries. So for that purpose it's a very valuable
21		survey.
		That question is a very specific question that
- 22		
22 23		
22 23 24		captures just one dimension of people's experiences, or people's prejudicial views. So to generalise from that

25 one question to a broader dimension of prejudice against

quir	У	5 October 2023
1	Q.	Is there really an absence of data 2013 to 2020? Was
2		the research and the surveys simply not done?
3	Α.	As I mentioned earlier, there is this crucial survey
4		called Understanding Society which has continued
5		throughout this period and over that period has
6		intermittently asked questions on racism and
7		discrimination. Those questions are different from the
8		questions that I charted in this figure, which is why
9		they're not included in this figure, because the way you
10		ask the question is crucial. But what it shows is that
11		ethnic minority people continue to report experiences of
12		racism and discrimination up to the period of
13		the pandemic, and the levels at which they report this
14		doesn't change very much over that period.
15		Post-pandemic there have been additional surveys
16		conducted on this question.
17	Q.	The government refers in particular to something called
18		the World Values Survey, I think it's April 2023,
19		earlier this year, but in any event that survey suggests
20		that of 18 countries, one of the least prejudiced and
21		I'll come to the significance of this in a moment, of
22		course one of the least prejudiced is the
23		United Kingdom. The survey reports that only 1% of
24		the United Kingdom public say that they would wish to
25		live next door to a neighbour of a different ethnic
		62
1		ethnic minorities I think is a bit of a stretch, but
2		there are important conceptual and methodological issues
3		related to that, but I would not use that as
4		an indicator that levels of prejudice have decreased.
5	Q.	Finally, the issue of institutional racism, upon which
6		we have not touched in this context, is there
7		a difficulty in separating out the degree of racism that
8		comes from individuals on an interpersonal basis and the
9		extent to which racism is perhaps baked into
10		the institutions of which those individuals form part?
11	Α.	Yes. So although I've talked about the difficulties of
12		measuring interpersonal experiences of racism, these are
13		straightforward experiences, therefore you can design
14		questions to capture that. In terms of institutional

- questions to capture that. In terms of institutionalracism and structural racism, you can't ask people
- 16 questions about this in a direct way, you have to ask
- 17 about the consequences of racism. So in terms of
- 18 structural racism, you can see the consequences, in
- 19 terms of the resources that people have access to. In
- 20 terms of institutional racism, you can see it operating
- in terms of the processes and outcomes of the actions ofinstitutions.
- 23 **Q.** Topic 6, the role of cultural and genetic difference.
- 24 In this chapter, do you investigate the argument put
- 25 forward by some that differences in access to health

			UK Covia-19 inquir	У	
1		resources and, on a wider sense, ethnic inequality in	1		
2		health, that is to say the risk of disease, mortality	2		
3		rates and so on, are in some way connected to	3		ſ
4		the cultural or genetic characteristics of that person?	4		1
5		So, putting it another way, saying a Chinese person is	5		,
6		more likely to have a worse health outcome in general	6		
7		terms because genetically he or she is more prone to	7		
8		cancer, that sort of argument. Is that the argument	8		
9		which underpins this argument about cultural and genetic			
10		differences and their impact?	10	Α.	,
11	Α.	Yes, we felt it very important to discuss this topic,	11		ł
12		for perhaps very obvious reasons. Genetics and health	12		(
13		behaviours, culturally informed health behaviours,	13	Q.	
14		inevitably impact on our health. And we assume, we mal	ke 14		í
15		the assumption in everyday thinking, that health is	15		ſ
16		a biological outcome and therefore genetic and cultural	16	Α.	
17		differences across ethnic groups may lead to ethnic	17	Q.	
18		differences in health.	18	ч.	,
19		It's a common lay approach to thinking about why	19		ſ
20		ethnic groups might have a higher risk of poor health,	20		
21		so we felt it important to discuss this.	21		
22	Q.	·	22		,
23	_ .	defined it, is insufficiently nuanced? It's too bold,	23	Α.	
_0 24		too broad brush an approach? Plainly there may be som		Q.	
25		ethnic groups who do suffer more widely from particular 65	25		
1		risk of infection and mortality during a pandemic. Do	1		;
2		you conclude in paragraph 62 that because of	2		ļ
3		the inequalities that you've described, including	3	Α.	;
4		the stress generated by experiences of and knowledge o	f 4		;
5		racism, higher levels of chronic disease, which, as	5		ł
6		we've explored, is prevalent or is present in some	6		ł
7		ethnic groups, and early onset of biological ageing,	7		ļ
8		ethnic minority people are more at risk?	8		t
9	Α.	Indeed, including the social and economic inequalities	9		i
10		faced by ethnic minority people.	10	Q.	I
11	Q.	Just picking apart that proposition in part, are there	11		t
12		any figures showing the degree of stress or are there	12		(
13		figures other than self-reported stress upon which you	13		j
14		have been able to rely for the purposes of assessing	14		ļ
15		that degree of stress?	15		ļ
16	Α.	There have been studies that have examined biological	16		
17		stress responses to experiences of racism which show	17		ł
18		the rise in those biological responses when people are	18		ł
19		exposed to narratives of racism.	19		,
20	Q.	Do we presume that it is not possible to delineate	20		,
21		the degree to which any one of those factors may be	21		,
22		a greater contributory factor than any of the others?	22		
23		So, for example, are the pre-existing social, economic	23		2
24		and health inequalities that you've described likely to	24		į

- and health inequalities that you've described likely tobe the greater contributory factor to the risk of
 - 67

- diseases.
- The fallacy or the flaw in this approach is to make broad or to draw broad conclusions about differences between ethnic groups in the hope, foolishly, that that will assist in identifying health treatment, for example saying, "Well, why don't we give vitamin D to particular segments of the population because they are drawn from particular ethnic groups", is that the fallacy, is that the wrongful approach? Yeah, the fallacy is to look at an association and to take a common sense approach to understanding the causes of that association without investigating it. Right. So in fact it's in that category of proposition, equally flawed, to the effect of, for example, the sole driver of worse health outcome is ethnicity? Indeed. The truth is it is a far more sophisticated and complex debate, ethnicity is related to deprivation, geography, housing, exposure to risk and racism, and as a result of all those features, based in part upon ethnicity, you can say ethnic grouping is relevant to the health outcome? Indeed. Right. Topic 7, implications of ethnic inequalities for 66 serious illness and mortality rather than stress or biological ageing? So these processes are intimately related to each other, so pre-existing social and economic inequalities are the driver of higher levels of chronic disease and also a driver of earlier onset of biological ageing. And racism is part of the set of processes that lead to the social and economic inequalities, as well as having a direct effect on people's biology. Now, beginning to draw the threads together, topic 8, the implications of ethnic inequalities for adverse outcomes resulting from non-pharmaceutical interventions, that is to say government steps that are not drug or vaccine-related, so social restrictions, lockdowns and so on. You set out some of the indicia of inequality: poorer quality and overcrowded housing, lack of access to digital devices, broadband, dislocation from education, the types of employment, the greater levels of unemployment and so on. All the features that you've described already. Do you set them out here in order to make, if I may say so, the relatively straightforward proposition which 24 is that all these issues, all these indicia of inequality, have a direct bearing on the impact of any 25 68

for age under which the NHS won't therefore generally use pulse oximetry ought to be re-examined in the case of its groups because, as you say, there are differences of outcome on account of differences in skin colour? So that's not quite the proposition that we -- or the opinion that we express in this document. The opinion is two-fold. One is that pulse oximeters are less accurate in darker skin, so if you use them to make clinical judgments then you need to either design new

The other argument is that if you have an age cut-off for the use of an intervention, then you need to take into account the earlier biological ageing of

ethnic minority people. So, as we documented, a 50-year old Bangladeshi is not the same as a 50-year old white

The second area that you address in terms of clinical intervention is the roll-out of vaccines. You

More dedicated effort should be made to "address the

Although you say "given the existing evidence", did

Occupational Medicine, attempt to address any of these

So once it became apparent that ethnic minority people were dying at higher rates from Covid infection --Can I just pause you there, can you express a view as to

So it became visible in the general media in March and April, if I remember correctly, March and April 2020.

Research began under way around that time, with a number of non-government agencies doing research, including Professor Bécares and myself. Data was difficult but we and others did some work to illustrate the extent of ethnic inequality and risk of mortality, and then ONS began to gear up to do this in a much more robust way. But I think from those early days, public health responses recognised the higher risk amongst ethnic minority people and began to try and do things about

"Given the existing evidence on vaccine

70

concerns of ethnic minority people".

issues as the pandemic rolled on?

when that generally became understood?

devices or take that into account.

British person on average. Right, that's very clear, thank you.

say at paragraph 82:

hesitancy ..."

Thank you.

that.

Yes

1		particular non-pharmaceutical intervention that any	1	
2		government might impose?	2	
3	Α.	Indeed, the pre-existing inequalities mean that those	3	
4		interventions are likely to have a more adverse impact	4	
5		on ethnic minority people.	5	Α.
6	Q.	You then go on to deal with two particular examples of	6	
7		where clinical interventions have a different outcome	7	
8		because of ethnicity. Firstly, pulse oximetry. What is	8	
9		pulse oximetry?	9	
10	Α.	Pulse oximetry is a convenient device that can be used	10	
11		to measure the level of oxygen saturation in the blood,	11	
12		and therefore an indicator of the beginnings of	12	
13		respiratory failure.	13	
14	Q.	And do pulse oximeters rely upon, mechanically, the	14	
15		transmission of light through the skin?	15	
16	Α.	Exactly.	16	
17	Q.	On account of ethnicity, are there differences in the	17	Q.
18		way in which pulse oximetry may work?	18	
19	Α.	So there is extensive evidence, some from before the	19	
20		pandemic and since the pandemic occurred, which	20	
21		demonstrates that pulse oximeters do not work as well on	21	
22		darker skin, they're more inaccurate.	22	
23	Q.	Because in the health service pulse oximetry is	23	
24		a particularly valuable indicator for people who are	24	
25		older, there is an impact insofar as the cut-off date 69	25	
		03		
1		you mean by that reference in fact the position as at	1	
1 2		you mean by that reference in fact the position as at 2020?	1 2	
		2020? Indeed.		А.
2		2020?	2	A.
2 3		2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to	2 3	A. Q.
2 3 4		2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did	2 3 4	
2 3 4 5		2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact	2 3 4 5	
2 3 4 5 6 7 8		2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address	2 3 4 5 6 7 8	Q. A.
2 3 4 5 6 7 8 9	Q.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy?	2 3 4 5 6 7 8 9	Q. A. Q.
2 3 4 5 6 7 8 9		2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was	2 3 4 5 6 7 8 9 10	Q. A.
2 3 4 5 6 7 8 9 10 11	Q. A.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue.	2 3 4 5 6 7 8 9 10	Q. A. Q.
2 3 4 5 6 7 8 9 10 11 12	Q.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed	2 3 4 5 6 7 8 9 10 11 12	Q. A. Q.
2 3 4 5 6 7 8 9 10 11 12 13	Q. A.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the	2 3 4 5 6 7 8 9 10 11 12 13	Q. A. Q.
2 3 4 5 6 7 8 9 10 11 12 13 13	Q. A.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the areas in which you believe the government should have	2 3 4 5 6 7 8 9 10 11 12 13 14	Q. A. Q.
2 3 4 5 6 7 8 9 10 11 12 13 14 15	Q. A.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the areas in which you believe the government should have done more to try to tailor its interventions and its	2 3 4 5 6 7 8 9 10 11 12 13 14 15	Q. A. Q.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	Q. A.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the areas in which you believe the government should have done more to try to tailor its interventions and its responses taking into account the inequalities that	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	Q. A. Q.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Q. A. Q.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the areas in which you believe the government should have done more to try to tailor its interventions and its responses taking into account the inequalities that you've described in your report?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Q. A. Q.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	Q. A.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the areas in which you believe the government should have done more to try to tailor its interventions and its responses taking into account the inequalities that you've described in your report? Yes, this is an attempt to provide a high-level summary	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	Q. A. Q.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Q. A. Q.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the areas in which you believe the government should have done more to try to tailor its interventions and its responses taking into account the inequalities that you've described in your report? Yes, this is an attempt to provide a high-level summary of the considerations that government and	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Q. A. Q. A.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Q. A. Q. A.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the areas in which you believe the government should have done more to try to tailor its interventions and its responses taking into account the inequalities that you've described in your report? Yes, this is an attempt to provide a high-level summary of the considerations that government and decision-makers generally could have taken in the light of evidence that was available prior to the pandemic.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Q. A. Q. A.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. A. Q. A.	2020? Indeed. All right. May we take it I mean, I think we're all aware that a great deal of work was done in relation to addressing vaccine hesitancy during the pandemic. Did the Minister for Equalities, Kemi Badenoch MP, in fact produce a number of reports trying to address the problem of vaccine hesitancy? She did, once government became aware that this was an issue. The last topic in your report is topic 10, missed opportunities. Do you set out in that paragraph the areas in which you believe the government should have done more to try to tailor its interventions and its responses taking into account the inequalities that you've described in your report? Yes, this is an attempt to provide a high-level summary of the considerations that government and decision-makers generally could have taken in the light of evidence that was available prior to the pandemic. To what extent are you aware, you may not know, but	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. A. Q. A. Q.

71

You say "public health responses"; do you mean bodies

So across the whole range, in fact, of this field.

72

within and without government?

1	what was done or do you restrict yourself to identifying	1		lockdown rules and their surveillance on the fact that
2	conceptually where the problem areas were, as at	2		those in ethnic minorities suffer from overcrowded,
3	the position in 2020?	3		poor-quality housing, lack of access to outside and
4 A	A. So this is where the problem areas were at the outset of	4		green spaces and reduced access to the internet.
5	the pandemic, and the issues that should have been	5		Hugely important to the lockdowns; yes?
6	considered when things like non-pharmaceutical	6	Α.	Yes.
7	interventions were put in place.	7	Q.	Social distancing and lockdown measures are linked to
8 C	2. Regardless of the extent to which they were thereafter	8		the degree of digital exclusion, because of isolation
9	considered, if they were considered at all?	9		and the inability to be able to receive information
10 A	A. Regardless of whether they were considered afterwards.	10		about what the government has in mind for us all next.
11 C	2. Right, thank you, that's very clear.	11		Clinical interventions were required to be developed
2	So you identify the broad areas in which these	12		in partnership with ethnic minority people and trials of
3	inequalities of outcomes should have been addressed or	13		their effectiveness and side effects.
4	should be addressed or the extent to which	14		My Lady will be hearing a bit about that in a moment
15	the government should have started addressing them	15		from Professor Banfield of the BMA.
16	in 2020: economic safety nets for the circumstances of	16		For NPIs and clinical interventions there was
17	ethnic minority people, precarious work who were in	10		a requirement to use the strength and cohesiveness of
18	precarious work, self-employed in sole trading or small	18		ethnic minority communities, that is to say to speak to
19		10		them, to communicate with them, and to address how their
	Of acurac there were achieved, not for determination			
20	Of course there were schemes, not for determination	20		needs and concerns could be more properly and carefully
21	in this module, for self-employed and so on and	21		met, in the development of the intervention?
22	so forth, and we'll have to look in due course at	22	Α.	Indeed, to work in partnership.
23	the extent to which the schemes that were put in place	23	Q.	Then lastly, in paragraph 91, you say that part of
24	did address your concerns.	24		the government's obligation as at 2020 should have
25	There is the link between the development of 73	25		been again, I emphasise, we don't yet know the extent 74
1	to which it was:	1		Mr Weatherby.
2	" attention should be paid to the risk of	2		Questions from MR WEATHERBY KC
3	an increase in prejudicial sentiment leading to	3	MR	WEATHERBY: Professor, I am going to ask you a handful
4	a blaming of ethnic minority people"	4		questions on behalf of bereaved families who are part of
5	And such racist behaviour was required to be	5		the Covid Bereaved Families for Justice UK group,
6	addressed?	6		a significant number of whom are from ethnic minority
7 A	A. Indeed.	7		communities.
8 N	IR KEITH: Professor Nazroo, thank you very much.	8		Mr Keith's already touched on my first point. At
9	Now, there will be some further questions for you.	9		paragraph 6 of your report, you comment on the lack of
10 L	ADY HALLETT: I have the list, Mr Keith, thank you.	10		data in the ten years leading up to January 2020
1	May I just explain to those who haven't followed	11		relating to ethnic inequalities because of
2	this process before, before the witness gives evidence,	12		underinvestment or contributed to by underinvestment.
3	I'm given a list of questions that core participants	13		Is it right that the effect of the lack of such data
4	would like to ask. I direct which questions they may	14		is to reduce the ability to identify and mitigate
15	ask and I set time limits, and I'm afraid I have to be	15		foreseeable pre-existing ethnic inequalities?
16	fairly strict with those time limits.	16	Α.	That is correct.
	IR KEITH: My Lady, may I also explain that you give	17	Q.	Would you agree, therefore, that the underinvestment in
18	permission for those areas to be explored once,	18		data for the understanding and monitoring of ethnic
19	of course, you've heard the extent of the evidence	10		inequalities over this period is itself, therefore,
20	already given, so may I invite you to give permission	20		an example of structural racism?
			٨	
21	for the three areas that Covid Bereaved Families for	21	Α.	I would argue I'm sorry to be kind of definitional,
22	Justice and Covid Bereaved Families for	22		but I would argue that this is institutional racism
23	Justice Northern Ireland have raised within their	23		within
	to a minute time all the ant fan Draft and Name a	0.4	~	Okay
24	ten-minute time allotment for Professor Nazroo? ADY HALLETT: Certainly.	24 25	Q.	Okay. within the process of commissioning

75

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76

1	Q.	Right, so you would classify it I don't think it
2		probably matters, but that's very helpful
3		institutional racism.
4		My second point, at paragraphs 26 to 33, you
5		highlight the reported poor experiences of members of
6		its ethnic groups with primary and secondary healthcare
7		historically.
8		Are these negative experiences likely to have
9		reduced access to healthcare when needed in the eye of
10		the crisis?
11	Α.	It's hard to make that extrapolation in terms of the eye
12		of the crisis because of the nature of the crisis
13	Q.	Yes.
14	Α.	where the risk that we were all under was very
15		obvious, but it is possible.
16	Q.	Yes, and perhaps then, for example, language
17		difficulties, with the 111 service, it would be more
18		difficult for accessing of that; yes?
19	Α.	Yes, so this is a language interpretation is a major
20		issue. It affects a relatively small minority of ethnic
21		minority people but it is absolutely crucial for them.
22	Q.	Okay, perhaps a wider one then is a reduced trust.
23		Through negative experience there's a reduced trust in
24		guidance and such matters?
25	Α.	Exactly. And this is, I think, something that in our 77
		11
1		the sources of that, which include the issues that you
2		have raised. And we had reasonable evidence on how that
3		might be addressed.
4	Q.	
5		the 2018 report, at least, is there anything you're
6		aware of that was in fact done to address this problem
7		of engagement, particularly in relation to vaccine
8		hesitancy, before the pandemic?
9	Α.	Before the pandemic, there was not.
10		WEATHERBY: Thank you very much, Professor.
11	LAI	DY HALLETT: Thank you very much, Mr Weatherby.
12		Now, I don't think I'm saying goodbye, Professor,
13		am I? I think you're returning this afternoon.
14		EWITNESS: I am.
15	LAI	DY HALLETT: You won't need to take the oath again.
16		Thank you very much.
17		(The witness withdrew)
18	MR	KEITH: Thank you, my Lady.
19		Once the Professor has gone, could we perhaps turn
20		to another eminent professor, Professor Philip Banfield.
21	LA	DY HALLETT: Just so people understand, the reason
22 23		Professor Nazroo is coming and going is we were trying to do it in specific areas, but I don't think it's
1.5		

1		conclusions we suggest should have been paid attention
2		to.
3	Q.	Yes. Therefore, would the reported poor experiences
4		likely have impacted on the rate of infection and,
5		therefore, mortality in ethnic minority groups?
6	Α.	That's very hard to judge. It's unlikely, in my view,
7		to have impacted on risk of infection. It may have
8		impacted on poor outcomes and certainly may have
9		impacted on vaccine hesitancy.
10	Q.	Right. That's my last point that I'm just coming on to.
11		So the lower satisfaction with primary and secondary
12		healthcare services reported by ethnic minority groups,
13		and generally the poor experience of ethnic minority
14		women within maternal and neonatal healthcare, which was
15		asserted in the 2018 report that you have been referred
16		to, the PHE report, should they have raised the issue
17		for policymakers that future engagement with ethnic
18		minority communities may be negatively impacted?
19	Α.	That is my opinion.
20	Q.	Yes. That brings me on to the point of vaccine
21		hesitancy. So was it likely to have been a factor in
22		lowering vaccine take-up amongst ethnic minority groups?
23	Α.	I think prior to the pandemic we had good evidence that
24		there would be higher levels of vaccine hesitancy
25		amongst ethnic minority people. We had good evidence on
		78
1		PROFESSOR PHILIP BANFIELD (affirmed)
2		Questions from LEAD COUNSEL TO THE INQUIRY
3	MR	KEITH: Could you give the Inquiry your full name,
4		please.
5	Α.	Yes, I'm Professor Philip James Banfield.
6	Q.	
	ч.	Professor Banfield, are you the chair of the BMA's UK
7	ч.	Professor Banfield, are you the chair of the BMA's UK council?
7 8	A.	, ,
	-	council?
8	Α.	council? Yes, I am.
8 9	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of
8 9 10	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad
8 9 10 11	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes,
8 9 10 11 12	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes, in very broad terms, the role of the BMA in the pandemic
8 9 10 11 12 13	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes, in very broad terms, the role of the BMA in the pandemic and the way in which, firstly, the members of the BMA,
8 9 10 11 12 13 14	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes, in very broad terms, the role of the BMA in the pandemic and the way in which, firstly, the members of the BMA, those who you represent, suffered under the pandemic,
8 9 10 11 12 13 14 15	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes, in very broad terms, the role of the BMA in the pandemic and the way in which, firstly, the members of the BMA, those who you represent, suffered under the pandemic, and secondly, the way in which you engaged with
8 9 10 11 12 13 14 15 16	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes, in very broad terms, the role of the BMA in the pandemic and the way in which, firstly, the members of the BMA, those who you represent, suffered under the pandemic, and secondly, the way in which you engaged with government on behalf of the BMA.
8 9 10 11 12 13 14 15 16 17	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes, in very broad terms, the role of the BMA in the pandemic and the way in which, firstly, the members of the BMA, those who you represent, suffered under the pandemic, and secondly, the way in which you engaged with government on behalf of the BMA. You were asked, I think, to focus on the impact upon
8 9 10 11 12 13 14 15 16 17 18	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes, in very broad terms, the role of the BMA in the pandemic and the way in which, firstly, the members of the BMA, those who you represent, suffered under the pandemic, and secondly, the way in which you engaged with government on behalf of the BMA. You were asked, I think, to focus on the impact upon those who you represent of the pandemic and the
8 9 10 11 12 13 14 15 16 17 18 19	Α.	council? Yes, I am. You were asked by the Inquiry to provide, by way of Rule 9, a witness statement addressing in very broad terms, at least descriptively now, for present purposes, in very broad terms, the role of the BMA in the pandemic and the way in which, firstly, the members of the BMA, those who you represent, suffered under the pandemic, and secondly, the way in which you engaged with government on behalf of the BMA. You were asked, I think, to focus on the impact upon those who you represent of the pandemic and the government decision-making because they might broadly be

- 23 A. Yes, they are.
- 24 Q. So are you giving evidence now in relation to this
- 25 theme, ethnicity, because the subject matter of your 80

worked totally because of the availability of some

to do it in specific areas, but I don't think it's

23

24

25

witnesses.

1		witness statement covers not just frontline and	1	Q.	And retired members.
2		key worker impact evidence but also the impact on ethnic	2	·	Are there of course in your organisation different
3		minority members of the BMA?	3		committees, bodies and areas that reflect the many
4	Α.	Yes, indeed.	4		different specialities of medicine?
5		All right, thank you, that's very clear.	5	Δ	Yes, there are.
6	ч.	You prepared a statement, INQ000228384.	6	Q.	So you have committees which feed into the central
7		We'll have it up, thank you.	7	ч.	structure of the BMA and committees that feed into
, 8		Did you sign it on 21 July 2023 and declare its	8		the general structure of BMA committees in England and
9		truthfulness?	9		in Scotland and in Wales and Northern Ireland.
10	Α.	Yes, I did.	10		reflective of those different specialities?
11	Q.	We'll come back to the statement in due course.	10	Α.	So the UK council represents all four nations, the
12	ч.	Could we start, please, Professor Banfield, with	12		devolved nations have their own separate council to
13		just a few questions about the structure of the BMA and	12		deliberate on matters that are devolved purely to those
			13		nations.
14		your place in the general scheme of things. This is		^	
15		an area that we've covered, of course, because you gave	15	Q. A.	But there is a BMA UK council, of which you are chair
16		evidence in Module 1, but it's important to set it out	16		Correct.
17		again for this module.	17	Q.	and information and political leadership and
18		Is the BMA a professional association and trade	18		the degree to which there are particular issues that
19		union?	19		each committee wants to raise are fed through the UK
20	Α.	Yes, it is.	20		council, are they not?
21	Q.	Does its membership come from the whole breadth of	21		For matters that affect the whole UK.
22		medicine, from academics, students, general practice,	22	Q.	Of course.
23		consultants, junior doctors, public health, and no doubt	23		The BMA UK council is the principal executive
24		many other areas?	24		committee of the BMA, is it not?
25	Α.	Yes, it does, and retired members. 81	25	Α.	It is. 82
					-
1	0	And you are its chair, as I've said	1	0	For the purposes of giving evidence today, have you gone
1	Q.	And you are its chair, as I've said.	1	Q.	For the purposes of giving evidence today, have you gone
2	Q.	Are there also within the BMA structure a number of	2	Q.	back through the BMA's paperwork and informed yourself
2 3		Are there also within the BMA structure a number of regional councils?	2 3	Q.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with
2 3 4	А.	Are there also within the BMA structure a number of regional councils? Yes, there are in England.	2 3 4	Q.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of
2 3 4 5	A. Q.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight?	2 3 4 5		back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic?
2 3 4 5 6	A. Q. A.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight? Indeed.	2 3 4	A.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic? Yes, to the best of my ability.
2 3 4 5 6 7	A. Q. A. Q.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight? Indeed. And a number of divisions?	2 3 4 5 6 7	A.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic? Yes, to the best of my ability. All right, thank you very much.
2 3 4 5 6 7 8	A. Q. A.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight? Indeed. And a number of divisions? So these are our local structures at this point in time,	2 3 4 5 6 7 8	A.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic? Yes, to the best of my ability. All right, thank you very much. In general terms, from late March 2020, within
2 3 4 5 6 7 8 9	A. Q. A. Q.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight? Indeed. And a number of divisions? So these are our local structures at this point in time, and they cross over between primary and secondary care.	2 3 4 5 6 7 8 9	A.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic? Yes, to the best of my ability. All right, thank you very much. In general terms, from late March 2020, within the BMA, did you have daily virtual meetings in order to
2 3 4 5 6 7 8 9 10	A. Q. A. Q.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight? Indeed. And a number of divisions? So these are our local structures at this point in time, and they cross over between primary and secondary care. When dealing with the UK Government, which part of	2 3 4 5 6 7 8 9 10	A.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic? Yes, to the best of my ability. All right, thank you very much. In general terms, from late March 2020, within the BMA, did you have daily virtual meetings in order to inform the leadership, namely your predecessor, and to
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2 3 4 5 6 7 8 9 10 11 12	A. Q. A. Q. Q.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight? Indeed. And a number of divisions? So these are our local structures at this point in time, and they cross over between primary and secondary care. When dealing with the UK Government, which part of the BMA provides the political leadership of the BMA and leads the engagement with the UK Government?	2 3 4 5 6 7 8 9 10 11 12	A.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic? Yes, to the best of my ability. All right, thank you very much. In general terms, from late March 2020, within the BMA, did you have daily virtual meetings in order to inform the leadership, namely your predecessor, and to identify key emerging evidence and what the government's position on various issues was for the purposes of
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2 3 4 5 6 7 8 9 10 11 12 13 14	A. Q. A. Q. Q.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight? Indeed. And a number of divisions? So these are our local structures at this point in time, and they cross over between primary and secondary care. When dealing with the UK Government, which part of the BMA provides the political leadership of the BMA and leads the engagement with the UK Government? That was mainly done at UK level by the chair of UK council, at that point Dr Chaand Nagpaul, but also	2 3 4 5 6 7 8 9 10 11 12 13 14	A.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic? Yes, to the best of my ability. All right, thank you very much. In general terms, from late March 2020, within the BMA, did you have daily virtual meetings in order to inform the leadership, namely your predecessor, and to identify key emerging evidence and what the government's position on various issues was for the purposes of working out what the BMA's response would be? Yes, there were daily meetings. It was really important
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A. Q. Q. A. Q. A.	Are there also within the BMA structure a number of regional councils? Yes, there are in England. Eight? Indeed. And a number of divisions? So these are our local structures at this point in time, and they cross over between primary and secondary care. When dealing with the UK Government, which part of the BMA provides the political leadership of the BMA and leads the engagement with the UK Government? That was mainly done at UK level by the chair of UK council, at that point Dr Chaand Nagpaul, but also the chairs of the UK branch practice committees. Because you took on the role of chair of the council in July 2022 in fact after, of course, the pandemic was over?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A. Q.	back through the BMA's paperwork and informed yourself as to the degree to which the BMA engaged with the government, the UK Government, during the time of the pandemic? Yes, to the best of my ability. All right, thank you very much. In general terms, from late March 2020, within the BMA, did you have daily virtual meetings in order to inform the leadership, namely your predecessor, and to identify key emerging evidence and what the government's position on various issues was for the purposes of working out what the BMA's response would be? Yes, there were daily meetings. It was really important because things were happening so quickly, and we were getting conflicting advice, both coming down from governments, but also from clinicians on the shop floor, who had a feed in from international colleagues as to
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pandemic.

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25 A. Just towards the end of March.

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- 1 Q. So at the time, in fact, that the government was first
- 2 imposing, mid-March, social restrictions of
- a society-wide nature or latterly towards the lockdownperiod?
- 5 A. No, we had started our deliberations. It was very
 6 quickly apparent to the profession the seriousness of
 7 what was due to happen. There was a recognition that
- 8 services were likely to be overwhelmed. A number of us
- 9 went about writing our wills and making sure that our
- 10 life insurance was up to date, because we had no doubts
- 11 that we were facing something that was completely
- 12 unprecedented.

13 Q. In general terms, focusing on the BMA's role and

- 14 function, are there a number of areas that the BMA
- 15 focuses on? So, firstly, providing individual support
- 16 to members, because they are members of your body and
- 17 association; secondly, providing guidance to doctors and
- 18 their employers; thirdly, and this is the area upon
- 19 which we'll be focusing today, seeking to influence
- 20 decision-makers on a wide range of matters related to
- 21 Covid through meetings, letters and correspondence,
- 22 engagement with the media, and issuing of press
- 23 statements, and giving evidence in Parliament. Are
- 24 those the broad areas?
- 25 **A.** Yes, we advocate for excellence in healthcare and for 85
- 1 other areas, but Covid remained on the agenda.
- 2 Q. May we presume that, because you're the BMA, you were
- 3 raising issues not just to do with the mechanics of
- 4 Covid and the government's response, but including many
- 5 other wider public health issues, all related in one
- 6 form or other to the pandemic?
- 7 A. Yes.
- 8 Q. Did the BMA have regular meetings with the CMO for9 England, Sir Chris Whitty?
- 10 A. Not regular, but we were able to contact the CMO as and
- when we felt it was appropriate to. He made himselfreadily available at the point at which we had any
- 13 specific questions.
- 14 Q. So he said if you wish to raise concerns with him, in
 15 effect, you were free to do so, and he made himself
 16 available to meet you if you wished to do so?
- 17 A. Correct. We didn't always agree, but he was there to18 listen.
- 19 Q. Were there a number of meetings held to discuss a range20 of issues, the government's approach to lockdown, PPE,
- the impact on your members and so on, a huge range of
 issues?
- 23 **A.** Yes, there were.

25

- 24 Q. Public Health England, did you have regular meetings
 - with it?

healthy populations.

- 2 Q. The engagement with government presumably required
 3 the BMA to meet with and speak to and write to or
- 4 correspond with a significant number of different moving
 - governmental parts?
- 6 A. Correct.
- 7 Q. In general terms, does the BMA consider that it had good
- 8 access to the Secretary of State for the Department of
- 9 Health and Social Care and ministers during the10 pandemic?
- 11 A. Yes, it does. There was already an existing
- relationship between Chaand Nagpaul as chair and theSecretary of State, Matt Hancock.
- 14 Q. Did he have regular meetings with Mr Hancock whilst he15 was Secretary of State, and did he and other senior
- 16 staff have regular meetings with ministers of state,
- 17 for example Ed Argar MP, Helen Whately MP and others
- 18 throughout the currency of the pandemic?
- 19 A. Yes, they did.
- 20 Q. Were there also meetings between the BMA's general
- 21 practitioners committee for England and the
- 22 Parliamentary Under Secretary of State for Public Health
- and Primary Care, Jo Churchill MP?
- 24 A. Yes, there were. They started off about Covid
- 25 specifically and then after a period of time went into 86
- 1 **A.** No.

- 2 Q. Was there written communication?
- A. Yes. It was more specific. When we had concerns, or
 wanted to query a specific piece of advice, we would
 write formally about that. Our public health committee
- 6 does have a number of, and a range of public health
 - clinicians, so a lot of information for the general BMA was coming to us through that committee.
- 8 was coming to us through that committee.9 Q. As for the Department of Health and Social Care more
- 10 generally, did you receive updates from the civil
- 11 servants in the DHSC and also their representatives on
- 12 a body called the SPF, is it social policy forum?
- 13 A. The Social Partnership Forum.
- 14 **Q.** Social Partnership Forum, Covid-19 engagement forum?
- 15 A. Yes, and, you know, there were a number of meetings setup to impart information and share it between multiple
- 17 organisations and bodies, and we were part of that,
- either as elected members or members of staff ofthe BMA.
- 20 Q. Did the government set up what are called stakeholder
- 21 meetings between the DHSC and other bodies, including
- 22 Professor Sir Jonathan Van-Tam, the Deputy CMO, and
- the BMA, at which issues of general concern could beventilated?
- 25 **A.** Yes. It tended to be that we were listening rather than 88

1		giving information.	1	Q.	Just pausing there, can I just delineate the scope of
2 C	Q.	Finally, did the BMA have significant engagement with	2		what you've just said. So in relation to PPE, there
3		senior officials from NHS England?	3		were in fact three areas of concern, very broadly
4 A	۹.	Yes, there was regular and full engagement to discuss	4		putting it, as I say: firstly, the shortages; secondly,
5		operational matters, so the chair of consultants	5		the guidance in relation to the use of PPE; and then
6		committee, Dr Vish Sharma, used to meet with	6		thirdly, the impact of the, in cases, deficient PPE on
7		Professor Stephen Powis, as did the GP chair at that	7		your members?
8		time.	8	Α.	That's true, yes.
9 C	Q.	My Lady, may I just make plain that much of	9	Q.	All right.
0		Professor Banfield's statement does deal with engagement	10	Α.	There's a fourth aspect, which is actually have to work
1		between the BMA and the devolved administrations, but	11		in that kind of PPE. That has a had a huge impact on
2		of course that is an issue which will be for later	12		people's health and wellbeing.
3		consideration in Modules A, B and C.	13	Q.	Is that the topic of risk assessment? So, because of
4		Just at this stage, at a very general level, what	14		the impact or because of the consequences of your
5		were the sorts of issues, what were the themes, what	15		members having to wear PPE that may not have been
6		were the general areas that the BMA raised with	16		adequate or proper, that gave rise to very difficult
7		NHS England? PPE?	17		debates about the extent to which they would have been
8 A	۹.	So PPE and a lack of testing were the two immediate	18		placed at risk, the need for risk assessments, as well
9		issues between ourselves and NHS England. We felt that	19		as the objective impact upon them individually of having
20		the guidance was inadequate. We had stories very early	20		to wear deficient PPE?
21		on about not being able to have PPE, so there was a lack	21	Α.	Yes, because there was a shortage of PPE, the very
22		of aprons, a lack of visors. A number of us had our	22		high-risk areas, like intensive care units, were using
23		local schools were 3D printing visors for us. A number	23		respiratory protection throughout the pandemic, but once
24		of people had to source masks themselves, especially in	24		you got beyond an intensive care unit, with people who
25		general practice, for example.	25		were Covid positive, the amount and degree of PPE very
		89			90
4			4		
1 ว		rapidly tailed off. So, for example, people were either	1		ethnic minorities are less likely to stick up and speak
2		treating patients with no masks or with fluid-resistant	2		up when there is insufficient PPE, and they we found
3 4		surgical masks, which don't protect from an airborne	3		that they were much less likely to have had an adequate risk assessment.
4 5 6	~	virus.	4		
	Q.	Was another area of general concern to the BMA the	5		By the end of the first wave, two out of three
6	•	disproportionate impact on ethnic minority communities?	6		doctors still hadn't felt that they'd been adequately
	Α.	Yes, there were quite early data from the intensive care	7	~	risk assessed.
8		community showing a disproportionate number of intensive	8	Q.	Could we now turn in a little more detail to
9		care admissions from black, Asian and minority ethnic	9		the particular areas and issues of concern that you
0		groups. Alarmingly, the first ten doctors who died of	10		raised from time to time with various parts of the
1		Covid were all in that black and Asian and minority	11		government, the parts of the government that you've now
2		ethnic group, and that was spotted very quickly by	12		identified.
3		a number of organisations, including BAPIO, and the BMA,	13		Starting if we could have on the screen
4	_	and the BMA then wrote immediately to raise concerns.	14		paragraph 77 on page 20.
	Q.	So were there three areas, in fact, touching upon	15		The BMA first became aware of the Covid-19 emergen
6		the issue of your ethnic minorities: one, the	16		via the media, when it was still confined to China. Did
7		disproportionate impact of the virus on them; two, the	17		you, as a result, send in January a letter in fact it
8		disproportionate impact of the virus on members of your	18		was your predecessor who sent a letter to the
9		association who were from ethnic minorities; and, three,	19		Secretary of State and to NHS England and Public Health
20		was there then the issue of the efficacy or suitability	20		England, offering the BMA's support and expertise?
21		of particular types of PPE for those members of your	21	Α.	Yes, we did.
		organisation who were drawn from ethnic minorities?	22	Q.	In that period up to the end of March, the period you've
22	Δ	That is true, because PPE needs to be particularly well	23		already identified, did you have a number of meetings or
22 23 4					phone calls or did the BMA have a number of meetings or
22	-	fit tested, and it doesn't suit people with beards,	24 25		phone cans of the the DMA have a number of meetings of

(23) Pages 89 - 92

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1	Α.	Yes, we did. It was to find out and to highlight
2		the exchange of information that we were receiving both
3		from our own experts and from our colleagues abroad.
4	Q.	If you could go, please, to page 22, paragraph 86.
5		At the ministerial meetings, that's to say meetings
6		with the Secretary of State or his ministers as
7		you've said, the meetings invariably covered many
8		aspects of the pandemic, but have you drawn out in your
9		witness statement in that paragraph 86, reflective of
10		the same areas that you were raising in fact with the
11		NHS, the broad areas of PPE, testing and contact
12		tracing, shielding, social distancing and other
13		lockdowns?
14	Α.	Yes, I have.
15	Q.	Now, as at that time, mid to late March, to what extent
16		did the BMA have a view on the particularity, the
17		specifics of what the government was proposing by way of
18		social distancing and then ultimately, from 23 March,
19		lockdown? Were you focusing in your engagement with
20		the government upon the impact of whatever it is the
21		government might then have been proposing, or were you
22		focusing on the efficacy of whatever was being proposed,
23		would it work?
24	Α.	Well, the biggest issue really started one step back
25		from that, was our lack of understanding as to why the
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1	Q.	Just a couple of features around that, please,
1 2	Q.	Just a couple of features around that, please, Professor. Firstly, when you say, when you refer to
	Q.	
2	Q.	Professor. Firstly, when you say, when you refer to
2 3	Q.	Professor. Firstly, when you say, when you refer to local public health systems, do you mean the local
2 3 4	Q.	Professor. Firstly, when you say, when you refer to local public health systems, do you mean the local authority health protection teams, the directors of
2 3 4 5	Q.	Professor. Firstly, when you say, when you refer to local public health systems, do you mean the local authority health protection teams, the directors of public health, the local structures which were already
2 3 4 5 6	Q.	Professor. Firstly, when you say, when you refer to local public health systems, do you mean the local authority health protection teams, the directors of public health, the local structures which were already in place for dealing with infectious disease outbreaks
2 3 4 5 6 7		Professor. Firstly, when you say, when you refer to local public health systems, do you mean the local authority health protection teams, the directors of public health, the local structures which were already in place for dealing with infectious disease outbreaks and environmental risks?
2 3 4 5 6 7 8	А.	Professor. Firstly, when you say, when you refer to local public health systems, do you mean the local authority health protection teams, the directors of public health, the local structures which were already in place for dealing with infectious disease outbreaks and environmental risks? Yes.
2 3 4 5 6 7 8 9	А.	Professor. Firstly, when you say, when you refer to local public health systems, do you mean the local authority health protection teams, the directors of public health, the local structures which were already in place for dealing with infectious disease outbreaks and environmental risks? Yes. Secondly, you were concerned on behalf of the BMA that
2 3 4 5 6 7 8 9	А.	Professor. Firstly, when you say, when you refer to local public health systems, do you mean the local authority health protection teams, the directors of public health, the local structures which were already in place for dealing with infectious disease outbreaks and environmental risks? Yes. Secondly, you were concerned on behalf of the BMA that the government had abandoned contact tracing; to what
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local public health doctors were prepared for a pandemic, this is their bread and butter subject, and we seemed to have abandoned that first principle of control of an infectious outbreak by trying to control and contain through testing and isolating and making sure that you can support people to do that. Q. Sorry, just pause there, can I just come back to something you said at the start of that sentence. You say there was an abandonment of basic public health protection measures, and you've referred to testing and isolating. Was test and trace and isolation, TTI, the primary or perhaps the only way by which an infection could be controlled or can be controlled on its emergence? Α. Well, you need to identify it, you need to contain it, and you need to then help people to isolate, but that needs local knowledge and local efforts, and there was a disconnect between the central control -- and this seemed to be the message that we were trying to get across to government, was the need to involve local health protection teams as early as they could. So we couldn't understand the decision to abandon contact tracing that was made on 11 or 12 March. 94 To what extent did the BMA become aware that that basic system for test and trace and contact for high-consequence infectious disease was lamentably inadequate for dealing with the demands of a massive viral outbreak? health had already -- or our public health colleagues had already highlighted the risks of the disconnect between local health protection teams and the NHS, and it meant that possession of data was essential to

government was apparently abandoning basic public health

protection measures. Our local public health teams, our

- 4 5 6 A. I mean, that was known guite early on, because public 7 8 9 10 11 control the outbreak, and because they were then sitting 12 within different systems, the data didn't reach 13 the frontline. We saw that -- a good example of that 14 later on when there was a local lockdown in Leicester, 15 where there was detailed information about the test 16 results but not about the results and prevalence in the 17 local population. And that made it really difficult to 18 control it. Is that because at the beginning one of the other 19 Q. 20 features of the First Few 100 system is that that's 21 a nationally-run system, it's not run by local 22 authorities or public health directors? 23 A. Well, normally it would be, you would expect it to be 24 run locally for a local outbreak and have it
- 25 co-ordinated by the regional directors, who would then 96

	be feeding up to the centre. What happened here was the	1
	centre gave public health policy from the top downwards.	2
Q.	What about the absence of or the very limited number of	3
	PCR tests that were then available? You can't run	4
	a testing system, even at a basic level, unless you've	5
	got the testing kits, then, all that there was after	6
	the initial diagnostic tests were prepared, a PCR test.	7
	To what extent did the BMA become aware that there was	8
	a very distinct limit on the physical number of tests,	9
_	testing kits available?	10
Α.	Well, that happened very quickly, because we were	11
	relying on the availability of the PCR tests to keep	12
	people in work. In the absence of the PCR tests, we	13
	were having to isolate for 14 days, isolate if we were	14
	contacts. We were already short of staff and we ended	15
	up in that first wave with huge numbers of staff not	16
	being in work when they potentially could have been if there were tests to test both them and the patients	17
		18 19
	around. And of course the consequence of not having sufficient tests in those early days were that we were	19
	admitting patients to unsuitable areas with patients who	20
	hadn't got Covid. So the chance of passing Covid around	21
	a hospital was very high.	22
Q.	Was there a general difference of view between the BMA	23
હ.	and the government in relation to the level of	25
	97	25
	service as well, because the number of admissions soared	1
	during that time, the number of people who caught Covid	2
	and had been affected by it soared during that time, and	3
	we did feed back both to government and then publicly in	4
	the media that we thought that this was an unnecessary	5
	delay.	6
Q.	Can we just unpick some aspects of that answer. So on	7
	12 March the government announced that there would no	8
	longer be testing in the community and such PCR test as	9
	there was would be kept for healthcare workers.	10
	By that time, the First Few 100 dataset, the	11
	analysis of index cases and the pursuit of their	12
	contacts and the isolation of their contacts, had given	13
	up the ghost, it stopped at 415?	14
Α.	They'd lost control.	15
Q.	They lost control. So are you saying that thereafter,	16
	from 12 March to the lockdown day of 23 March, there was	17
	in practice no way of assessing the degree of spread of	18
	the infections through the community at large?	19
Α.	That's what it seemed like to our members.	20
Q.	And if you don't know how the virus is spreading, other	21
	than by way of estimate or modelling, what means of	22
	control have you got to suppress it?	23
Α.	Very little. We were seeing the results of that	24
	actually on the frontline.	25
	99	

 government intervention in terms of the robustness, if you like, of the way in which the government was taking action? Was that a subject of concern and of debate? A. It was a subject of concern. There wasn't very much that the would do about it, because a lot of public health policy that was announced was announced in the daily briefings, and that caused a problem for a public health teams on the ground, because the first that they might have known of a change of tack or a change of policy would be at that meeting, and yet they would then be on call that evening trying to find out as to what the implications were for the local population. A. Se the clock turned through those dark days of the end of March, to what extent did the BMA seek to engage with the government on the primary decisions to, firstly, throughout mid-March, impose social restrictions, and then, on 23 March, announce the lockdown? A. Well, we had been advocating for strengthened measures, these non-pharmaceutical interventions, as soon as constact tracing was abandoned. That 11-day delay until the lockdown, and given that there was already a plan in piace, just seemed to be increasing the number of infections unnecessarily. And that had a huge consequence not only to the public but to the health You were obviously trying to influence the government on multiple issues at any one time, but going over the page, to page 35, in relation to the wearing of face coverings, later systems for tasting and contact tracing, and the extiling of lockdowns safely, di your lobbying meet with some, if not always completely unalloyed, success? A. Indeed, yes. It's difficult to actually put a cause and effect not bat, but eventually the measures that would <			
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took it into our own hands to try to give guidance into	23		
, , , ,	24		prepare for the inevitable second wave, and therefore we
100	25		, , ,
			100
(25) Pages 97 - 100			(25) Pages 97 - 100

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19 20

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23

24 25 an impact?

1		the public domain, that we shared with various parts of
2		government, as to how to keep the levels of virus low
3		enough to be able to get through the following winter.
4	Q.	In the summer of 2020, was there a general concern being
5		expressed that, because the virus the levels of virus
6		in the community had not been brought down low enough,
7		too great a degree of relaxation in restrictions, or
8		complete freedom, would allow it to unspring, uncoil
9		itself like a spring, back out into the community
10		violently?
11	Α.	Yeah, I'm advised by my public health colleagues that
12		you need a rate of around 10 per 100,000, which is
13		around 100,000 cases per day, and the UK was above that.
14		So, you know, the data were suggesting that it was
15		unsafe to ease lockdowns at that point. We were
16		advocating mandatory use of face protection, face masks
17		for the public. We were advocating later for a higher
18		degree of protection from vulnerable people, as the
19		shielding came out of play.
20	Q.	Just finally before lunch, then, and just identifying
21		certain aspects of the face mask debate, the government
22		did impose a mandatory face covering order, firstly in
23		relation to public transport and then latterly shops and
24		supermarkets, but relatively speaking you were calling
25		for mandatory face masks across the population at
		101
1		still hiding away from society.
2	MR	KEITH: My Lady, that a convenient moment?
3		DY HALLETT: Certainly.
4		Are you okay to come back this afternoon, Professor?
5		Thank you.
6		2 o'clock, please.
7	(1.0	12 pm)
8		(The short adjournment)
9	(2.0	(pm)
10	MR	KEITH: Professor Banfield, at paragraph 145 you say
11		this:
12		"While not a specific [non-pharmaceutical
13		intervention], the BMA contends that a key failure of
14		the Government was, and continues to be, the failure to
15		properly acknowledge (and at an early enough stage),
16		that Covid-19 was spread by aerosol transmission and to
17		adapt their public messaging, guidance to health
18		services or the focus of their NPIs appropriately."
19		Was that because there was an issue in the very
20		early days as to whether or not Covid was transmitted by
21		droplet or aerosol or both, and when it became apparent
22		that it could be spread by both vectors, or both forms
23		of transmission, the government didn't sufficiently
24		tailor its messaging?
25	Α.	That's true in some ways. We have always advocated
-		103

1		an earlier time?
2	Α.	Yes, we were. It didn't make sense to us that there
3		would be and if you're going to ask the public to
4		wear face masks, then why not do it all in one go rather
5		than this phased approach, which seemed to us to be
6		sustaining the transmission unnecessarily.
7	Q.	Did you at the same time call for ways in which
8		the government could ameliorate, make better,
9		the position of people who were subject to restrictions?
10		There were some people, of course, a lot of people, who
11		were subject to continuing shielding restrictions, and
12		during the lockdowns themselves, of course, people who
13		required better financial support, help with combatting
14		the effects of isolation, and so on.
15		At the top of page 36, for all these particular
16		issues, did you go into bat against the government?
17	Α.	Yes, we did. The best phrase that I've heard about that
18		situation was that we were all in the same storm, but
19		not in the same boat. There were clear discrepancies
20		about how the pandemic was affecting different parts of
21		our society, the poorest, the homeless, those who were
22		already vulnerable. And that stayed with us. So when
23		the country came out of lockdown, in inverted commas,
24		right at the end in 2022, we've still got a situation in
25		which very vulnerable people feel very exposed and are
		102
1		a precautionary approach to public health measures, and
2		it was known that similar coronaviruses are transmitted
2		by aerosol, you know, airborne spread rather than
4		droplets, so it seemed sensible from a professional
5		point of view to consider that possibility. There
6		became more emerging evidence across that summer, and it
7		became unequivocal, and at the point at which it became
, 8		unequivocal, there were temporary changes to the advice
9		from Public Health England that then got reversed after
10		the vaccination programme came into play.
11	Q.	So relatively late?
12	Q. A.	Yes.
12	A. Q.	Now, earlier in the course of your evidence you
13	ખ.	described a number of areas in relation to which the BMA
14		had not met with much success of persuading the
15		nau normer with much success of persuaulity the

government of the merits of its own views, but in

relation to some other areas, starting on page 39, did

you have a greater degree of success as a result of your interventions in influencing government decision-making?

So firstly, do you believe that the interventions

the first lockdown was eased in the summer of 2021 had

you made in relation to the exact manner in which

A. So I do beg your pardon, there is a typographical error

in paragraph 154 in that that refers to us having 104

(26) Pages 101 - 104

1	influence in the lockdown of 2021.	
2	Q. You mean 2020?	:
3	A. No, it's listed as 2020, which is the first year, and it	:
4	actually is 2021.	
5	LADY HALLETT: Oh, the headline is 2020.	:
6	MR KEITH: Right.	
7	A. And the delay was, we feel, four weeks at that point.	
8	LADY HALLETT: Sorry, the delay in what?	
9	MR KEITH: Oh, is that because in the summer of 2021,	
10	pre-Omicron, the government, having announced a final	1
11	exit date, the complete lifting of restrictions in that	1
12	summer	1
13	A. Yes.	1
14	Q put the date of the lifting of the restrictions back	1
15	by two weeks?	1
16	A. By four weeks, it was, actually. So	1
17	Q. But you asked for a delay of two or four weeks or just	1
18	a delay?	1
19	A. A delay.	1
20	Q. All right, okay. So there's a typo in relation to the	2
21	two weeks and also the year?	2
22	A. Yes, I beg your pardon.	2
23	Q. All right.	2
24	At paragraph 155, you met with some success in	2
25	relation to calling for further work to be done on	2
	105	
1	reflected on the face of the final report?	
2	A. As put to me, people felt hugely let down and as if it	
3	had been watered down.	
4	Q. So it went beyond the mere lack of replication of their	
5	submissions on the face of the report; it went to	
6	the issue of whether or not the report properly	
7	reflected the that the conclusions that had to be	
8	drawn from their material?	
9	A. Correct.	
10	LADY HALLETT: It's a very non-specific criticism, Mr Keith.	1
11	MR KEITH: Yes.	1
12	LADY HALLETT: Are we dealing with anybody else, or	1
13	MR KEITH: No, that's all that I was going to ask about	1
14	that, because it doesn't seem to me to be particularly	1
15	specific.	1
16	Paragraph 158, there's another important point. You	1
17	raise the issue of what you say is the lack of	1
18	independent public health expertise informing and	1
19	supporting the public health response to the pandemic.	1
20	Now, obviously a large number of members of the BMA	2
20	work in the public health field. Was a general concern	2
21	raised that the government was not receiving sufficient	2
23	advice from public health experts, experts perhaps in	2
23 24	pandemic management or the delivery of appropriate	2
24	healthcare facilities at local level, as opposed to the	2
20	107	2

1		the impact of the pandemic on people from ethnic
2		minority backgrounds, because in April of 2020 the
3		government announced that they would be conducting
4		a review led by Public Health England?
5	Α.	Yes.
6	Q.	Was that the disparity review that PHE carried out?
7	Α.	It was indeed, yes.
8	Q.	You say there that you did have some concerns about the
9		findings, though. What were those concerns?
10	Α.	Well, we knew that a large number of stakeholders had
11		been interviewed, and there seemed to be a large amount
12		of evidence missing from the original report.
13		Furthermore, the report didn't have any recommendations
14 15		in it, so we were suspicious, and later had it confirmed
15 16		to us, that pieces had been removed. At that point we wrote and asked for the report to be reissued.
17	Q.	And was it?
18	A.	It was modified in that the stakeholder engagement was
19		then published later, and there were then
20		recommendations.
21	Q.	So it wasn't, though, that their conclusions were for
22		some unknown reason omitted, it was that the report had
23		the ability to be able to cite passages of material
24		submitted by stakeholders and a lot of the material or
25		some of the material submitted by stakeholders wasn't
		106
1		epidemiological aspect of this affair?
2 3	Α.	O_{1} where h_{1} is a state we can be used as the state state of the state of
		Our public health members who have expertise in this
		field felt deeply disrespected and that their views and
4		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions
4 5		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not
4		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the
4 5 6		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not
4 5 6 7		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health
4 5 6 7 8		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise.
4 5 6 7 8 9		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government
4 5 6 7 8 9		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise
4 5 7 8 9 10		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite
4 5 6 7 8 9 10 11 12		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt
4 5 7 8 9 10 11 12 13	Q.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge
4 5 6 7 8 9 10 11 12 13 14 15 16	Q.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the
4 5 6 7 8 9 10 11 12 13 14 15 16 17	Q.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly expert in that field?
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Α.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly expert in that field? Correct.
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20		field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly expert in that field? Correct. All right.
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Α.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly expert in that field? Correct. All right. At the same time, was concern raised about
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly expert in that field? Correct. All right. At the same time, was concern raised about the over-reliance on behavioural expertise?
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Α.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly expert in that field? Correct. All right. At the same time, was concern raised about the over-reliance on behavioural expertise? It was. There was a lot of concern about how
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly expert in that field? Correct. All right. At the same time, was concern raised about the over-reliance on behavioural expertise? It was. There was a lot of concern about how the necessary measures for public health protection
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A. Q.	field felt deeply disrespected and that their views and expertise was being ignored. It was felt that decisions were being made at governmental level and were not seeking the expert views and opinions of people on the frontline with local and contemporary public health expertise. It's difficult if you are in a government environment to stand up and openly criticise a government, and our public health colleagues are quite good at saying when something isn't right, and they felt that that ability to criticise or push back or challenge was missing. And you should make plain, of course, that that is in no way an attack on the expertise of the Chief and the Deputy Chief Medical Officers, who were undoubtedly expert in that field? Correct. All right. At the same time, was concern raised about the over-reliance on behavioural expertise? It was. There was a lot of concern about how

(27) Pages 105 - 108

1	would agree	to lockdown	and if so	for how long.	And
	would agree	to lockdown	ana, n 30,	for now long.	And,

- 2 you know, as it turned out, the public responded very
- 3 well, but that seemed to drive the narrative in,
- 4 for example, mask wearing. So instead of bringing it in
- 5 in one go, they staggered it. It seemed to be based on
- 6 what was a political imperative to engage with the
- 7 public rather than a public health narrative. The
- 8 public health narrative seemed lacking, actually all the9 way across the pandemic.
- 10 LADY HALLETT: Is that fair, Professor? Because if you do
- 11 have concerns about how the public will respond, it's
- 12 not necessarily a political imperative so much as
- 13 an imperative trying to ensure people will comply with
- 14 the guidance or advice. Is that really fair to accuse
- 15 it of being a political imperative?
- 16 A. I think some of the messaging became confused --
- 17 LADY HALLETT: I'm not denying that. What I'm saying is you
- 18 called it a political imperative when I'm just saying
- 19 maybe it was a "We need to keep the public onside so
- 20 they will comply" imperative.
- A. I think I'm suggesting that there were economic and
 other factors that lay outside public health necessities
- 23 in deciding what the messaging to the public was.
- 24 MR KEITH: So not political, but just not public health --
- 25 A. Political with a small p.
 - 109
- Covid tracker surveys, five Viewpoint surveys, some
 190,000 responses in fact in total from members of the
 BMA, and, we'll come to this later, also another
 specific survey carried out.
- 5 In general terms, did those reviews conclude that 6 there had been failings by the government in the same 7 way as -- or, rather, the same failings had taken place 8 on the part of the government as those areas of concern 9 or failings which you had identified in your engagement 10 with the government as the pandemic moved on?
- A. Yes. They reflected and they formalised and codified
 much of the information that we had been receiving
 across the pandemic. We felt it important that doctors
 were able to tell what had happened. We felt that there
 was a need for them to undergo a kind of grieving
- 16 debrief.
- 17 It was very clear that the profession was
- 18 traumatised, not only from within itself, but what it
- 19 had seen happen to its patients. And we felt that
- 20 because there was likely to be a delay with the
- 21 Covid Inquiry, that this should be collated, you know,
- as quickly as possible with a view to providing evidenceto this Inquiry.
- 24 Q. So may we summarise it on this basis: if you look at
- 25 page 45, I've referred to the fourth report, the public 111

- Q. Right. I'm going to go in for the double punch,
- 2 Professor, because in your witness statement you
- 3 actually say that the concerns were expressed about
- 4 behavioural expertise having too great a prominence
- rather than that the decision-making was infected byovertly political considerations.
- 7 A. That's true. But what that means by that is that it
- 8 wasn't necessarily driven by the public health measures9 themselves that would be expected to contain and stop
- 10 the spread of the virus.
- 11 Q. But that's just simply a reflection of the fact that
- 12 the BMA's view was that behavioural expertise was
- 13 valuable, shouldn't be given too great a prominence
- 14 against other public health-related considerations?
- 15 A. Correct.
- 16 Q. All right.
- 17 Now, the final part of your statement deals with the
- 18 BMA Covid review. Between January 2020 and May 2022,
- 19 did the BMA carry out a number of reviews, five
- 20 published reports, in fact, the first one concerned with
- 21 how well protected the medical profession from Covid
- 22 was, and the fourth one, the public health response by
- 23 the UK Government?
- 24 A. Yes, it did.
- 25 **Q.** And I think the BMA drew those reviews from a number of 110
- 1 health response by the UK governments -- in fact, 2 I apologise, could you go back, please, one page, to the 3 bottom of page 44. The general points made in that 4 fourth report are reflective of the points you've 5 already raised: (a), the government was slow to react to 6 the emergence of Covid-19 globally; (b), there was 7 an absence of a sufficiently strong independent public 8 health presence on SAGE; a slowness in introducing face 9 masks to the public; the decision to shift capacity away 10 from contact tracing on 12 March whilst not controlling 11 the population for a further 11 days; the public 12 messaging consequences of Eat Out to Help Out; the cost 13 of outsourcing contact tracing and testing away from 14 local public health capacity; the chopping and changing 15 particularly in relation to the tier 3 structure 16 concerning the imposition of enhanced restrictions; the 17 clarity and simplicity of early pandemic messaging 18 giving way to the more ambiguous instructions later; and 19 the increasing public rhetoric concerning easing 20 restrictions. 21 Those were the themes in that fourth report? 22 A. Yes, they were. 23 Q. Likewise, in a further report published in March 2021, 24 entitled "Mitigating the impact of Covid-19 on health 25 inequalities" -- could we have page 64 -- the BMA went

1		in to bat on the subject of a number of aspects of
2		the way in which the pandemic had affected members of
3		the ethnic minorities, and it asked for or it identified
4		several key priorities for the government: reducing the
5		overall transmission of the virus; ensuring vaccine
6		access; improving financial security; protecting the
7		long-term health outcomes of children; and investing in
8		a strong public mental health response.
9		You set out at paragraph 232 onwards, page 68, how
10		the pandemic had highlighted disparities within society,
11		widened health inequalities, and impacted groups
12		differently, and you sought to make a number of
13		recommendations about how to ameliorate that position?
14	Α.	Yes, we did.
15		KEITH: Thank you very much.
16		My Lady, there have been a number of applications
17		for Rule 10(4) questions to be put by core participants.
18		You've declined some of them. In light of
19		Professor Banfield's evidence, would you please grant
20	ΙΔ	DY HALLETT: It's Mr Thomas. I think.
21		KEITH: permission yes to
22		Mr Thomas King's Counsel.
23	LA	DY HALLETT: Mr Thomas.
 24		I'm afraid, Professor, Mr Thomas is behind you,
25		don't get a crick in your neck.
		113
1		more likely to have been posted to the frontline and
1		more likely to have been posted to the frontline and
2		exposed to high-risk cases. And the recognition that
2 3		exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has
2 3 4		exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active
2 3 4 5		exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active steps being put to correct that, both driven by us and
2 3 4 5 6	0	exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active steps being put to correct that, both driven by us and by NHS England.
2 3 4 5 6 7	Q.	exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active steps being put to correct that, both driven by us and by NHS England. And so, if I can just follow up on that, so to be
2 3 4 5 6 7 8	Q.	exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active steps being put to correct that, both driven by us and by NHS England. And so, if I can just follow up on that, so to be absolutely crystal clear, these aren't imagined
2 3 4 5 7 8 9	_	exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active steps being put to correct that, both driven by us and by NHS England. And so, if I can just follow up on that, so to be absolutely crystal clear, these aren't imagined concerns, these are very real concerns, are they?
2 3 4 5 6 7 8 9	Q. A.	exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active steps being put to correct that, both driven by us and by NHS England. And so, if I can just follow up on that, so to be absolutely crystal clear, these aren't imagined concerns, these are very real concerns, are they? Yes, they are, and they have been found in multiple
2 3 4 5 6 7 8 9 10 11	Α.	exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active steps being put to correct that, both driven by us and by NHS England. And so, if I can just follow up on that, so to be absolutely crystal clear, these aren't imagined concerns, these are very real concerns, are they? Yes, they are, and they have been found in multiple reports.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q.	exposed to high-risk cases. And the recognition that that was the case emerged across the pandemic and has been recognised by the NHS, and there are very active steps being put to correct that, both driven by us and by NHS England. And so, if I can just follow up on that, so to be absolutely crystal clear, these aren't imagined concerns, these are very real concerns, are they? Yes, they are, and they have been found in multiple reports. Thank you. Can I move on, then. I think you've dealt with that fully. What considerations were made regarding PPE that could cater for the needs of black, Asian and minority ethnic healthcare workers and communities? So you told us what the difficulties were, but what considerations were made in fact? Well, I mean, firstly you can help people to work in safer environments. There is PPE and respiratory protective equipment that is available for different

nquir	y 5 October 2023			
1		Questions from PROFESSOR THOMAS KC		
2	PRO	DFESSOR THOMAS: Professor, I've only got a few questions		
3		for you, some of which you have touched upon already		
4		this morning, but if I can just put the question to you,		
5		and you can amplify if necessary. Yes?		
6	Α.	Yes.		
7	Q.	So the first question that I've got for you is: we've		
8		looked at the experience of black, Asian and minority		
9		ethnic healthcare workers in the profession; I would be		
10		interested to know what insights that you have and		
11		whether you can elaborate on what you think the key		
12		concerns posed were relating to those healthcare workers		
13		in terms of the virus and their vulnerabilities?		
14	Α.	There were a number of issues that arose going into		
15		the pandemic. Firstly, the NHS is acknowledged to be		
16		institutionally racist; there are discrepancies both in		
17		the way that staff are treated and the experiences that		
18		staff have at the NHS as well as patients. So, taking		
19		the disproportionate physical effect on them, the		
20		ability to protect staff during the pandemic was		
21		affected by the biases and discrimination. People from		
22		an ethnic background are less likely to seek out and be		
23		upheld with their risk assessments, they are less likely		
24		to be forthright about saying, "I need to have		
25		appropriate respiratory protective equipment", they are 114		
		114		
1		now, largely, rectified.		
2	Q.	Next, what tangible steps could government institutions		
3		take to tackle some of those healthcare disparities that		
4		you've told us about amongst ethnic minority		
5		communities, particularly in the context of the		
6		pandemic?		
7	Α.	Well, I mean, there's a greater recognition of the need		
8		for cultural competency. You know, we went into this		
9		pandemic with one set of health messages and made no		
10		attempt or little attempt to adapt those for different		
11		recipients. So it took a long time, for example, for		
12		videos to be and messaging to be worked up with the		
13		BBC World Service, for example, into different languages		
14		and to become culturally competent to the communities		
15		that were actually subjected to huge discrepancy and		
16		bias.		
17	Q.	Sorry, just to be clear, so you're saying, if I can		
40		non-selence is used as by being looked at the surple and		

- paraphrase, it was only being looked at through onelens, a white lens?
- 20 A. I'm going to say that it was looking, to start off with,
- as that as the default.
- 22 **Q.** Yes.
- 23 A. I would say that it became very apparent very quickly
- 24 that that was the wrong lens, and I think that enormous
- 25 efforts have gone -- been made since then to recognise 116

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1	and correct that. And that's part of our longer term	1 Firstly, we gave an assurance to the long Covid
2	wish, to make sure that inequalities, both inside the	2 groups that I would ask a question about long Covid of
3	health service and in our communities, are narrowed and	3 Professor Banfield, which, I apologise, I omitted to do.
4	resolved. Because, you know, this country cannot go on	4 May I put that question?
5	like this.	5 LADY HALLETT: Of course.
6	Q. Can I ask my final question: what suggestions would you	6 Further questions from LEAD COUNSEL TO THE INQUIRY
7	propose, you know, being in the BMA, for moving beyond	7 MR KEITH: Professor, is it the position that the BMA has
8	our established understanding, you know, to effectively	8 long advocated the issue of long Covid and the impact of
9	address these health disparities?	9 long Covid on its members, so doctors and other
10	A. Well, I mean, the first thing to do is to acknowledge	10 healthcare workers, and has published a number of
11	that they exist, and then to work to eliminate them, and	11 reports concerning and addressing the healthcare
12	I think that there is work that's going on. I've talked	12 challenges of long Covid in the medical profession?
13	about NHS England, for example. We've talked about	13 A. Yes, it is.
14	the institutional discrimination within the NHS. So we	14 Q. You've made representations to government and during the
15	are working together and want to work with whoever to	15 pandemic, because of the impact of long Covid and the
16	make sure that this is improved and changes, because we	16 prevalence of that syndrome, you in fact made arguments
17	have to have change out of this.	17 to the government as to why there should be delay in
18	Q. So acknowledgement. What else, if anything?	18 the lifting of restrictions because the greater
19	A. Listening. Listening to what the needs are of	19 incidence of the virus would lead to an increased number
20	the communities and how best to address them, and then	20 in long Covid cases?
21	tailoring our health service and the way that we work	21 A. Yes. I mean, we've had feedback from over 600 doctors
22	with people to that.	22 with long Covid, and their stories are horrible. It's
23	PROFESSOR THOMAS: Thank you, that's all I ask.	23 disrupted their lives, it's stopped their careers. And
20	LADY HALLETT: Thank you very much, Mr Thomas.	24 there's still a lack of acknowledgement that this could
25	MR KEITH: My Lady, there are two further points, if I may.	and is most likely to have been gained at work.
20	117	118
1 2 3	MR KEITH: That's all, in fact, that I have for Professor Banfield, my Lady, unless there are any questions that you	 families. So it's difficult to see how they could have caught Covid any other way. LADY HALLETT: Thank you very much.
4	Questions from THE CHAIR	4 MR KEITH: My Lady, thank you. That concludes the evidence
5	LADY HALLETT: Just following up on that,	5 of Professor Banfield.
6	Professor Banfield, one of the problems I've noticed	6 LADY HALLETT: Thank you, Professor, very grateful for your
7	with other conditions which I've dealt with in the	7 help.
8	course of my career is when there's no objective test it	8 (The witness withdrew)
9	can sometimes be difficult to persuade, dare I say it,	9 MR KEITH: Lastly, my Lady, in relation to the theme of
10	your colleagues of the existence of a condition.	10 ethnicity, you will recall that you ordered that a large
11	So how do you this is obviously a very real	11 number of questionnaires be sent out to groups and
12		
12	condition and we've heard from several people who have	
	suffered.	13 organisations, asking them for their views on this area,
14 15	A. That is true, but one of the advantages of having the academic committee and the broader science is that	this theme. We've drawn together just a very high-levelsummary of what those responses amount to.
16	I do know that there are tests on the horizon that would	 15 summary of what those responses amount to. 16 I don't propose to read out the questionnaires or
17	help us with that as a positive diagnosis.	17 indeed to put them up on the screen. I just wanted to
18	What's really difficult about all of this is that	18 summarise them in this way, that they make absolutely
19	a large number of doctors with long Covid caught this in	 19 plain that there are a number of themes dealing with
20	the first wave before testing and acknowledgement and	20 ethnicity, which are actually largely reflective of the
20	any kind of PPE was in place, but at a time that they	20 evidence of Professor Nazroo and Banfield. Respondents
21	were self-isolating from their families. At the start	22 highlighted in particular: the lack of consultation and
~~		
23 24	of this, we all used to go in in scrubs, we used to get to our front doors, switch our clothes off, go and	 involvement in decision-making, resulting in a lack of influence over the decisions that affected them; the

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1		the measures implemented exacerbated pre-existing	1	the minority communities was both inequality and
2		inequalities; thirdly, that the government	2	a safety work issue. Because so many key workers from
3		communications were unclear and failed to consider	3	minority communities faced greater risks and were placed
4		the impact on disadvantaged groups.	4	at greater levels of exposure.
5		Many of the questionnaires much of the material	5	LADY HALLETT: Just to add thank you, Mr Keith, for
6		and many of the questionnaires make plain that members	6	that we do have one more witness, I think, from the
7		of ethnic minorities are disproportionately affected by	7	organisation Mr Thomas represents, who is tomorrow
8		long-term chronic diseases and therefore that there were	8	afternoon.
9		comorbidities in place and therefore they were	9	MR KEITH: Indeed.
10		disproportionately impact by the pandemic, they were at	10	LADY HALLETT: And I assume will be dealing with this too.
11		greater risk because of exposure to the virus in	11	MR KEITH: Absolutely.
12		key worker roles, and children and older people from	12	LADY HALLETT: Thank you.
13		minority groups faced specific challenges.	13	Mr O'Connor.
14		The Runnymede Trust in particular says the BAME	14	MR O'CONNOR: My Lady, as Mr Keith indicated, the witnesses
15		communities and their disparities were not fully	15	you have heard so far today have been addressing the
16		considered by the government when making decisions about	16	issue of ethnicity. We now move to another area, that
17		the response to Covid, and the Traveller Movement noted	17	of later life, and for that reason may I invite you to
18		the contrast between the response in	18	re-call Professor Nazroo.
19		the Republic of Ireland and Northern Ireland and the	19	PROFESSOR JAMES NAZROO (recalled)
20		United Kingdom. In the Republic of Ireland travellers	20	LADY HALLETT: Professor. Thank you.
21		were supported whilst in isolation or quarantine through	21	Don't worry, you don't need to take the oath again,
22		the provision of food, phone helplines and mental health	22	I don't think anything's happened over lunch that I know
23		support.	23	of.
24		Lastly, some respondents noted that	24	THE WITNESS: Thank you.
25		the disproportionate rates of Covid deaths from	25	Questions from COUNSEL TO THE INQUIRY
		121		122
1	MR	O'CONNOR: Professor, as my Lady indicated before you	1	A. Correct.
1 2	MR	O'CONNOR: Professor, as my Lady indicated before you left that chair this morning, you're still here because	1 2	Q. We can perhaps put a little more detail there. If we
	MR			
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q. A. Q. A. Q. A.	left that chair this morning, you're still here because you have in fact prepared a second report to help the Inquiry, this one relating to the subject of later life; is that right? Yes. This report you prepared on your own, not with, as in the case of the ethnicity report, Professor Bécares? That's correct. Can we call it up on screen, please. It's at INQ000280058. We can see there, Professor, the report is in fact entitled "Inequality, Later Life and Ageism". Yes. We see your name at the bottom, and the date of 19 September this year. Is that your report? That is my report. Have you had a chance to read it through before giving evidence today and are the contents of it true? They are. Thank you. It's right, I think, Professor, that very broadly	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 Q. We can perhaps put a little more detail there. If we can go to the next page of the report and look at the very first paragraph, in fact I think it's two pages on, sorry, and zoom in on paragraph 1, please, you say that in the report you summarise evidence produced prior to January 2020 on inequalities in health, social and economic factors experienced by older people and how that varies across the older population. A. Yes. Q. So it is, if you like, a snapshot taken prior to the pandemic of the research that was available, the issues that might or perhaps should have been known to those who were going to go on and take decisions during the pandemic? A. This is the evidence that was available as the pandemic emerged. Q. Thank you. Now, you apologised this morning during your evidence for being definitional, I think was the word you used. I want to ask you very briefly about what we mean by "older people" or "age". You address it at
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1	A.	So "older people", the term I use the term in	
2	А.	an entirely pragmatic way in the context of this report.	
2		So the report primarily focuses on those aged 65 and	
4		older. This is a pragmatic division in order to be able	
5		to collate evidence. In some places I do talk about	
6		people who are a bit younger, so those aged 50 and over.	
7		The importance of that or the important	
8		consequence of that pragmatic decision, though, is that	
9		there is great variation amongst the 65 and older	
10		population in terms of the range of things that	1
11		I discuss in the report.	1
12	Q.	Yes. So exactly as you say, although the age gives one	1
13		a cohort, much of what we will go on to discuss will be	1
14		about sub-groups within that larger cohort?	1
15	Α.	Yes.	1
16	Q.	In particular those who are vulnerable within	1
17		the cohort, for example those who are economically	1
18		disadvantaged; yes?	1
19	Α.	Yes.	1
20	Q.	Older people from ethnic minorities?	2
21	Α.	Yes.	2
22	Q.	And older people living in care homes?	2
23	Α.	Yes.	2
24	Q.	Thank you.	2
25		Let me ask you, again by way of introduction, about 125	2
1		The issue with the data from the NICOLA study and	
2		the HAGIS study is that it's relatively immature, so	:
3		it's not detailed enough to do this kind of work yet,	:
4		though it will over time be able to do that.	
5		The other sources of data really rely on surveys	:
6		that have large enough samples of older people within	
7		them, and many surveys, most surveys, do not have large	
8		enough samples of older people within them, hence the	
9		specialist nature of the English Longitudinal Study of	
10		Ageing.	1
11		There are variations in circumstances across	1
12		the different four nations of the UK, of course there	1
13 14		are, including in relation to health. The points I'm making in this report are really about the level of	1
14		inequality. So it's not about the absolute level of	1
16		about the level of inequality. There is no evidence to	1
17		suggest that the nature of inequality varies across	1
18		the four nations.	1
19			
20		I take some reassurance in making that claim, drawing that opinion, because there are a range of	1
20 21		international studies that I can look to, to examine	2
21		inequality in later life, and find that across a variety	2
22		of national contexts very similar conclusions can be	2
23 24		drawn to those that I draw here.	2
24 25	Q.	Thank you.	2
20	ω.	127	2

127

1		the geographical reach of your report. You explain in
2		paragraph 6 of your report that the data which allows
3		you to opine on these issues is much more detailed, much
4		more reliable, relating to England than it is to
5		the other nations of the UK; is that a fair summary?
6	Α.	That's correct, yeah.
7	Q.	But you go on to say, and I'm not going to take you to
8		the paragraphs of the report, perhaps we can deal with
9		this by way of summary, but you go on to say that, in
10		your expert view, the patterns, if you like, of
11		inequality and the risks that may have been present
12		probably are replicated or were replicated in Scotland,
13		Wales, Northern Ireland?
14	Α.	Indeed. So
15	Q.	Can you explain that?
16	Α.	Yeah. So for England we have a very rich data source
17		that allows us to examine later life in a great detail.
18		That's the English Longitudinal Study of Ageing, which
19		has been running for more than 20 years, and so you can
20		see how things unfold for older people as they grow
21		older.
22		There are parallel studies in some of the other
23		nations of the UK, so there's the NICOLA study in
24		Northern Ireland, there's the HAGIS study in Scotland,
25		there is not such a study in Wales at the moment. 126
		120
1		Perhaps we can just go over the page and zoom in on
2		paragraph 9 to finish off this point. When you say in
3		your report is, despite the imbalance in data, if we can
4		put it that way, you say:
5		" in [your] considered opinion it is very
6		unlikely that there will be meaningful differences
7		across the nations of the UK in relation to the issues
8		discussed in this report, and that the conclusions
9		[you draw] are relevant for [all
10		those four] nation[s]"
11	Α.	That is my opinion, and in some places I do draw on
12	~	evidence from other nations as well.
13 14	Q.	Yes, thank you. I want to move on, then, Professor, and talk about
14		the first of the topics that you address in your report,
16		and that is the question of the vulnerability of older
17		people to a pandemic caused by a respiratory virus.
18		You say, perhaps we can go over to the next page, at
19		paragraph 10 of your report, that it is well documented
20		that older people have increased vulnerability to
20		a respiratory virus such as flu, which would of course
22		have been the obvious benchmark if we are thinking of
22		the position as at 2020 before the pandomic: is that

23the position as at 2020 before the pandemic; is that24fair?

25 **A.** Yes, exactly, and flu is the archetypal pandemic virus. 128

1	Q.	You refer, for example, to the well-known fact that	1	Α.	Yes, so I think it's very thoroughly established that
2		older people are encouraged to have a flu jab?	2		the risk of illness is higher amongst older people, the
3	Α.	Indeed.	3		risk of diagnosed disease is higher amongst older
4	Q.	Just before we move on, can you perhaps make it clear,	4		people, and the risk of chronic disease is higher am
5		the vulnerability that you're talking about of older	5		older people. And alongside that, as you indicated,
6		people to these types of respiratory diseases, is it	6		there is a greater risk of having more than one disea
7		a vulnerability to catching the disease or to	7	Q.	That's the first component, then. What about "reduc
8		experiencing severe symptoms and complications having	8		immunity", what do you mean by that term?
9		caught it?	9	Α.	So this is a consequence of biological ageing where
10	Α.	It's to experiencing severe complications, illness,	10		immune system performs less effectively and conse
11		mortality, having caught it.	11		people have reduced immunity and therefore are less
12	Q.	You explain, and I'm looking at paragraph 14 now, that	12		to combat an infection.
13		there are three factors, albeit that they work in	13	Q.	Then frailty, and that's a word of course we're all
14		combination, to explain why it is that older people have	14		familiar with, but I think you use it as something of
15		this increased vulnerability to a respiratory virus or	15		a term of art here?
16		to experiencing severe symptoms of such a virus.	16	Α.	Yes, so "frailty" within gerontology has a set of
17		I'll list them and then perhaps we can talk briefly	17		specific definitions. Here I refer to one in
18		about each of them in turn.	18		particular, produced by Ken Rockwood, who is an er
19		First of all, a greater prevalence of chronic	19		gerontologist in Canada, and it basically talks about
20		illness amongst that group. Secondly, reduced immunity.	20		decline in biological systems across the spectrum, s
21		And thirdly, the term "frailty".	21		physical, psychological and cognitive. And involves
22		So can I ask you first of all just to expand	22		like multimorbidity, involves many things occurring
23		a little on the point about greater prevalence of	23		together and reduces vulnerability to subsequent ad
24		chronic illness, or I think as it's sometimes referred	24		events.
25		to comorbidity?	25	Q.	Thank you.
		129			130
1		So those factors, then, are the building blocks, if	1		Let's move, then, if we may, to the second of th
2		you like, the overlapping causes of this well known	2		topics in your report, and this, as we said, we move
3		vulnerability of older people to catching respiratory	3		from the general issues relating to the whole cohort
4		viruses like flu or, as we shall see, Covid.	4		people of a certain age to vulnerable groups within t
5		You go on to refer to the fact, and I'm now looking	5		cohort.
6		at paragraphs 17 and 18 of your report, that precisely	6		You describe it as the patterning of inequality
7		that vulnerability which was known to exist in relation	7		within the older population in your report.
8		to flu demonstrated itself equally applicable to Covid	8	Α.	Yes.
9		within a fairly short period of the pandemic commencing.	9	Q.	
10	Α.	Indeed, as soon as we had data from China, which was	10	_ .	of the older population that suffered greater ethnic
11	7.1	reasonably early in February, mid-February maybe, we saw	10		inequality than others, first of all economically
12		very clearly that the risk of infection was not	12		disadvantaged; yes?
13		age-related, amongst the adult population, but the risk	12	Α.	Yes.
14		of mortality was very strongly age-related.	13	Q.	Secondly, older people from ethnic minorities?
15	Q.	We see in paragraph 18 of your report the type of	14	Q. A.	Yes.
16	ખ.	statistic that Mr Keith referred to in his opening	15	A. Q.	The issue that you are exploring in this part of your
17		· -	10	પ.	
		a couple of days ago, ONS figures between March 2020 and			report is whether there were data available and rese
18		June 2023: that of the deaths classified as being due to	18		available in 2020 to suggest that those groups migh
19		Covid-19, 59.6% of them occurred in the age group of	19		at greater risk to a pandemic

older people. And alongside that, as you indicated, there is a greater risk of having more than one disease. Q. That's the first component, then. What about "reduced immunity", what do you mean by that term? A. So this is a consequence of biological ageing where the immune system performs less effectively and consequently people have reduced immunity and therefore are less able to combat an infection. Q. Then frailty, and that's a word of course we're all familiar with, but I think you use it as something of a term of art here? A. Yes, so "frailty" within gerontology has a set of specific definitions. Here I refer to one in particular, produced by Ken Rockwood, who is an eminent gerontologist in Canada, and it basically talks about decline in biological systems across the spectrum, so physical, psychological and cognitive. And involves -like multimorbidity, involves many things occurring together and reduces vulnerability to subsequent adverse events. Q. Thank you. 130

people, and the risk of chronic disease is higher among

1		Let's move, then, if we may, to the second of the
2		topics in your report, and this, as we said, we move
3		from the general issues relating to the whole cohort of
4		people of a certain age to vulnerable groups within that
5		cohort.
6		You describe it as the patterning of inequality
7		within the older population in your report.
8	Α.	Yes.
9	Q.	You refer in this section of your report to two segments
10		of the older population that suffered greater ethnic
11		inequality than others, first of all economically
12		disadvantaged; yes?
13	Α.	Yes.
14	Q.	Secondly, older people from ethnic minorities?
15	Α.	Yes.
16	Q.	The issue that you are exploring in this part of your
17		report is whether there were data available and research
18		available in 2020 to suggest that those groups might be
19		at greater risk to a pandemic
20	Α.	Yes.
21	Q.	such as occurred?
22	Α.	Yes.
23	Q.	I'll start and in fact spend more time asking you
24		questions about the first of those categories,

25 the socioeconomic inequalities. Of course you have 132

24 A. Indeed.

20

21

22

23

25 Q. Quite striking statistics.

younger than 40.

131

less than 1% of those deaths occurring for people

80 and over, 22.4% the cohort between 70 and 79, at

10.6% 60 to 69, and 6.6% in the age group 40 to 59, with

(33) Pages 129 - 132

	already touched this morning with Mr Keith on ethnicity.	1	
	I'll come back to it but more briefly.	2	(
Α.	Yes.	3	
Q.	So as far as the economically disadvantaged cohort is	4	ŀ
	concerned, you make the point, I'm looking at	5	(
	paragraphs 20 and 21 of your report, that in the period	6	ŀ
	up to 2020 broadly speaking socioeconomic inequality	7	(
	amongst older people was marked, and in fact was	8	
	growing; is that a fair summary?	9	
Α.	That's correct, yeah.	10	
Q.	Then looking at paragraph 22, and perhaps we can bring	11	
	this up on screen, you say:	12	
	"Socioeconomic position is strongly related to	13	
	health, even in older ages, and consequently	14	
	socioeconomic position is related to risk of	15	(
	complications and mortality in the context of	16 17	
A.	a pandemic." Yes.	17	
A. Q.	Can you perhaps expand on that a little?	10	,
Q. А.	Yes. So if you look at the patterning of health within	20	ſ
	the older population you see it's strong correlated to	20	
	markers of socioeconomic position such as wealth and	22	(
	education and so on, and as a consequence poorer older	23	
	people are more likely to have the underlying diseases,	24	1
	comorbidities, that then lead to greater risk of death	25	
	133		
~		4	
Q.	I see, all right. But what we see, then I mean, let's look at the	1 2	4
	women, the graph on the left, first. Over though	3	(
	72-month, six-year period, what we are seeing is	4	`
	essentially how many of them survive?	5	
Α.	Yes, correct.	6	
Q.	The different colour lines reflect the different	7	(
	quartiles of socioeconomic advantage, wealth?	8	1
Α.	The different quintiles of wealth, yes.	9	(
Q.	Sorry. The high level point to be made, if we're	10	
	looking at the left-hand table, is that we see the dark	11	
	blue line, so that is the bottom, the poorest quintile,	12	
	far more of those people die than the highest quintile,	13	ŀ
	the green line at the top?	14	
Α.	That is correct.	15	(
Q.	So what we see is that over those 72 months, the least	16	
	affluent, only 84% of the cohort survive, whereas with	17	
	the most affluent it's 96?	18	ŀ
Α.	That is correct.	19	
Q.	So a marked difference over that six-year period?	20	(
Α.	Indeed.	21	
Q.	And the right-hand table reflects the experiences of	22	4
	men, otherwise it's the same?	23	,
Α.	The same pattern but	24	(
Q.	The	25	

2

3 Α.

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10 Α.

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19 Q.

20 Α.

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6 Α.

7 Q.

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14

15 Α.

16 Q.

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19 Α.

20 Q.

21 Α.

22 Q.

23

24 Α. Th

25 Q.

- in the context of a pandemic.
- Q. Perhaps even, thinking of those other factors, lower
- immunity?
- A. Indeed.
- Q. More frailty?
- A. Yeah, indeed.
- Q. You have provided us with a graph which is actually on the next page of the report and I wonder if we can bring that up.
- Tell me if I'm wrong, Professor, but I think the two
- graphs, first of all, they reflect women on the
- left-hand side and men on the right-hand side, you
- describe this in your report; is that right?
- A. Yes, apologies, I should have put that on the graph.
- Q. Don't worry. What they show, each of them, they
- represent a period of ageing between, you've got it in
- months at the bottom there, but it's actually between
- the ages of 50 and 56?
- A. No, no, so it's people who are aged 50 and over and it's
- a process of observing them over a six-year period, so over 72 months, sorry.
- Q. Yes, but would that not -- if they started at 50, would that not be between --
- A. Yes, but some of them are older than 50, so it's 50 and older.

134

- Α. -- different because of differences in mortality risk
- for men and women.
- Q. Yes, so rather more of the men die, that's 80 -- sorry, 93% for the most advantaged and 80% for the poorest quintile?
- A. Yes.
- Q. But a similar pattern nonetheless?
- A. Yeah.
- Q. Is that then a reflection of what you were saying about
- a very marked relationship between affluence or economic
- advantage on the one hand and health outcomes and ultimately mortality on the other?
- A. Indeed, this is a high-level summary of that
- relationship.
- Q. Just before we take that down, I think it's actually on the previous page, but these were statistics I think
- that appeared in a report that you yourself wrote?
- A. Indeed, using data from the English Longitudinal Study of Ageing.
- Q. Yes. So just remind us of the date of that study, or roughly the date.
- A. I think these were published probably 2012, I'm not 100% certain.
- Q. No, well, we don't need to worry about the exact date.
- The point I'm after is that this was data that was 136

1	Q.	Yes, I'm not trying to perhaps I can make myself
2	ω.	clearer. I'm certainly not trying to ask you to put
2		yourself into the minds of those at SAGE and I'm not
4		even asking really for you to comment on what SAGE did
5		or didn't do. It's simply to address that very
6		high-level question. If one was asking oneself from
7		a position of knowledge and expertise at the outset of
8		the pandemic "Who do we need to look out for?" would
9		these graphs have given you part of the answer to that?
9 10	Α.	So this was not only this kind of evidence was not
11	A.	only publicly available, it actually was present in
12		government departments and very widely circulated.
12	Q.	Thank you.
13	Q.	-
14		I mentioned a few minutes ago that there were two segments or particularly vulnerable segments of society
16		that I was going to ask you about. One was the
17		
18		socioeconomic disadvantage, which we've covered. The
10		other was older people within ethnic minorities. As I said, this is an issue that you have already touched
20		on with Mr Keith this morning, but can we go, please,
21		it's paragraph if we can go to figure 4 in your
22		report, which is just above paragraph 31. That's it.
23		If we could zoom in on that graph, please.
24		Now, Professor, this is a graph that you looked at
25		with Mr Keith this morning, isn't it? 138
		100
1		such as Covid?
1 2	А.	such as Covid? It does. Just to divert very slightly to illustrate
	A.	
2	A.	It does. Just to divert very slightly to illustrate
2 3	A.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that
2 3 4	A.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and
2 3 4 5	А.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross
2 3 4 5 6	Α.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them
2 3 4 5 6 7	Α.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's
2 3 4 5 6 7 8	Α.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability
2 3 4 5 6 7 8 9	Α.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and
2 3 4 5 6 7 8 9	A.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups.
2 3 4 5 6 7 8 9 10 11		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups
2 3 4 5 6 7 8 9 10 11 12		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you
2 3 4 5 6 7 8 9 10 11 12 13		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those
2 3 4 5 6 7 8 9 10 11 12 13 14		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable,
2 3 4 5 6 7 8 9 10 11 12 13 14 15		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to come to ask you whether we need to qualify it or not,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to come to ask you whether we need to qualify it or not, but on its face does this graph tell us something
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20		It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to come to ask you whether we need to qualify it or not, but on its face does this graph tell us something separate about those who might have been identified as
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Q.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to come to ask you whether we need to qualify it or not, but on its face does this graph tell us something separate about those who might have been identified as being at risk from Covid? Yes, apologies, I didn't answer that correctly, but,
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to come to ask you whether we need to qualify it or not, but on its face does this graph tell us something separate about those who might have been identified as being at risk from Covid?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to come to ask you whether we need to qualify it or not, but on its face does this graph tell us something separate about those who might have been identified as being at risk from Covid? Yes, apologies, I didn't answer that correctly, but, yes, that's what this graph tells us, that there are
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Q.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to come to ask you whether we need to qualify it or not, but on its face does this graph tell us something separate about those who might have been identified as being at risk from Covid? Yes, apologies, I didn't answer that correctly, but, yes, that's what this graph tells us, that there are certain ethnic minority groups that were particularly
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Q.	It does. Just to divert very slightly to illustrate the point, I'd encourage you to look at the line that cuts across at 20% on the chart, the orange line, and see where the different ethnic minority groups cross that line, and that's the age at which 20% of them report having not good health, and you can see that it's much younger for some groups than for other groups, and that gives you a sense of how health vulnerability happens at a younger age for some ethnic minority groups than for white British groups. Going back to my question, I was asking you the hypothetical or the high-level question about those people within society who might have been identified at an early stage as those who were vulnerable, particularly vulnerable, to Covid. We talked about the less affluent groups. On its face, and I'm going to come to ask you whether we need to qualify it or not, but on its face does this graph tell us something separate about those who might have been identified as being at risk from Covid? Yes, apologies, I didn't answer that correctly, but, yes, that's what this graph tells us, that there are certain ethnic minority groups that were particularly vulnerable or appear to be particularly vulnerable to

1		available in 2020?
2	Α.	Indeed.

- 3 Q. I'm sure there was lots of data addressing issues like 4 this or closely related issues; is that fair?
- 5 Indeed, there were a number of papers, reports and Α. 6 policy documents reporting this kind of evidence.
- 7 Q. So is this, are these tables, these graphs that you've 8 produced, reflective of what the mainstream data was
- 9 showing --
- 10 A. They are.
- Q. -- in the period prior to the pandemic? 11
- A. They are. 12
- 13 Q. Then towards the end of your report, you refer -- we
- 14 don't need to go to it -- to early SAGE meetings that 15 took place in the very first weeks of 2020 and
- 16 discussion there about trying to identify who might be
- 17 the sections of society who were most vulnerable to
- 18 a pandemic such as was at that stage developing, and
- 19 looking at those graphs, is your view that that would
- 20 have been relevant to answering that question?
- 21 A. I think it would have been relevant to answering that 22 question. My report refers to my reading of minutes of
- 23 those early meetings. I don't know the full extent of
- how these issues were discussed in the SAGE committee 24
- 25 of course.

- 1 Α. Yes.
- 2 You have included it in your Later Life report because Q. 3 of its relevance to that as well as to ethnicity, 4 intersectionality? 5 A. Indeed. 6 Q. For our purposes, we are interested in the sort of 7 right-hand corner of this graph, are we not? 8 A. Indeed. 9 Q. Because that's the sort of end of this table which informs us about, on the face of it at any rate, 10 11 disparity in health outcomes or self-reported health 12 towards the end of people's lives? 13 Α. Indeed. 14 Q. As we saw this morning, the disparities widen generally 15 as the age of the individuals increases? A. They do. 16 17 Q. So by the end of the -- by the far right-hand side of 18 the table, one sees some quite marked differences, with the Bangladeshi, Pakistani and black Caribbean cohorts 19 20 really quite distinct from some of the others, including 21 the white British? 22 A. Yes. 23 Q. Now, on its face, and this is the point you make in your 24 report, does that type of information also feed into 25 the question of who might be vulnerable to a pandemic

Α.

Α.

and so on.

A. Yes.

Α. Yes.

Q.

yes?

of that type of vulnerability?

risk.

page?

of a pandemic?

mortality. But in fact do those later figures at least

A. The mortality data published as experimental statistics by the Office for National Statistics show the opposite

pattern to these data. So in those data, white British

different groups of society as being at particular risk

If those data were available prior to the pandemic,

I would also qualify and say if those data had also received the approval as a national statistic, then they

Q. You had a debate with Mr Keith this morning about

the reliability of that ONS data. I don't want to go

this morning apply to this question of the reliability

They do. The estimations of life expectancy for ethnic

residential care were at an elevated risk of respiratory diseases essentially for two reasons: one, because they

were very likely already to have some form of chronic

the proximity of other people, the risks from the staff

environmental considerations associated with care homes,

So is that a fair summary of the very bald aspects

illness, that's why they're there; and secondly, the

minority people at older ages according to the ONS 142

of this data as compared with the ONS data?

those analyses were available prior to the pandemic, and

would suggest that the white British group were most at

back over that territory, but maybe I can simply ask you this: do the same considerations then that you expressed

ethnic minority people at older ages.

Q. So, on the basis of that data, one would identify

people at older ages have a shorter life expectancy than

cast doubt on the accuracy of the lines we see on this

1	Covid.	1
2	Q. As you explained this morning, we can see that these	2
3	figures are drawn from the results of the 2011 census?	3
4	A. Yes.	4
5	Q. And no doubt it takes a while for all of that	5
6	information to feed through into the research. But	6
7	similarly to the questions I was asking you about your	7
8	own socioeconomic data, are you able to help us whether	8
9 10	this type of table shows the general understanding amongst the academic community of these types of issues	9 10
11	as at 2020?	10
12	A. It does. These analyses are not unique, there have been	12
13	earlier analyses that have a very, very similar pattern.	12
14	Using data that are earlier, of course. So these are	13
15	the most recent available, but	15
16	Q. As at 2020?	16
17	A. Yeah.	17
18	Q. But we then have to ask ourselves the question that you	18
19	were addressing with Mr Keith, because we know that	19
20	since the pandemic the ONS have produced further data,	20
21	backward-looking data, which relates to this	21
22	pre-pandemic period	22
23	A. Yes.	23
24	Q which gives different results. That data relates not	24
25	to morbidity, which is a subject of this graph, but	25
	141	
4		4
1 2	analyses are, in my view, not credible. LADY HALLETT: Do we not also have a problem sorry to	1 2
3	interrupt, Mr O'Connor.	3
4	The graph that you showed us first, that's based on	4
5	self-reporting. That's got problems too, hasn't it?	5
6	A. Yes, so the graph that we have in front of us, figure 4,	6
7	is self-reported health. As I described earlier, there	7
8	is now a considerable body of evidence that shows that	8
9	self-reported health does predict mortality. There does	9
10	not appear to be a variation in that across different	10
11	ethnic groups, even though of course it is	11
12	a self-report. And I haven't included it in this	12
13	report, but I have similar graphs from other data	13
14	periods which show something similar for things like	14
15	diagnosed diabetes.	15
16	LADY HALLETT: Thank you.	16
17	MR O'CONNOR: Thank you.	17
18	Professor, I'm going to move on, and turn to another	18
19	section of society again, one of those which I mentioned	19
20	at the outset, one of those I mentioned as being	20
21	vulnerable, which is older people living in care homes.	21
22	I'm now looking at topic 3 in your report, and in	22
23	the broadest of terms and we'll look at this in	23
24	a little more detail I think the headline points that	24
25	you're making are that those in care homes or 143	25

A. That is a fair summary: increased risk of infection because of the environment in which they were living, and, once having an infection, increased risk of serious illness and mortality. **Q.** You have drawn our attention to an article in a learned scientific journal which addressed exactly these points, going back to 2017, which therefore perhaps is a useful benchmark to see how these risks were understood by the scientific community prior to the pandemic. Q. It's been helpfully brought up on the screen. First of all, the title "Influenza in long-term care facilities"; The date, we can see right at the top, I mean, the exact date doesn't matter, but it's June 2017. Do you see

(36) Pages 141 - 144

1		that?	1		public h
2	Α.	Yes.	2		been ap
3	Q.	Can you help us, I couldn't actually find it on this	3		with him
4		sheet, what was the name of the journal that it appeared	4		appoint
5		in? Or perhaps you can't help us with that?	5	Α.	Yes.
6	Α.	I can. I'm just looking it up, apologies. It's called	6	Q.	With tha
7		"Influenza and other respiratory viruses".	7		a few pa
8	Q.	I see. In fact we do see that. If anyone's interested	8		question
9		it's at the bottom right-hand corner of this page.	9		Cou
10	Α.	Yeah.	10		the bott
11	Q.	Do you see it?	11		of influe
12	Α.	Yes.	12		"Pe
13	Q.	So I hadn't appreciated, that's actually the name of the	13		facilities
14		journal itself, is it?	14		acquisit
15	Α.	Yes.	15		whom th
16	Q.	Thank you.	16		Nursing
17		We can see the rest of the page now, because the	17		overall f
18		next point to note about this article is who wrote it.	18		shared
19		Could we zoom out, please, and look at the top again.	19		healthca
20		Yes. So we see three names listed along the top:	20		pathoge
21		Louise Lansbury, Caroline Brown and Jonathan Van-Tam.	21		and the
22		Perhaps it's the third of those names which draws the	22		home."
23		eye: Professor Van-Tam as he was then, is now. I think	23		l'm
24		I'm right in saying that at the time that this article	24		the righ
25		was published, that's June 2017, he was a professor of	25		"Ou
		145			
1		and B viruses are well documented in LTCFs, and may be	1		Fin
2		explosive, with high mortality, highlighting the need	2		that col
3		for early recognition and prompt initiation of control	3		"Alt
4		measures."	4		with onl
5		Then two other passages, if I may. If we can go	5		uncerta
6		over to the next full page, and it's the left-hand	6		despite
7		column starting at "Transmission", about halfway down:	7		infectior
8		"Transmission of influenza from healthcare	8		particula
9		workers to hospital patients, including those in	9		the occu
10		geriatric facilities, has been well documented using	10		continui
11		epidemiological linkage, nucleotide sequence analysis	11		light of t
12		and contact tracking data and case reports of outbreaks	12		have ta
13		of influenza-like illness in care facilities indicate	13		employ
14		that staff can transmit the virus to residents."	14		and taki
15		There is then a passage which goes into some detail	15		econom
16		about various studies and test reports and so on, but	16		On
17		picking it up about eight or nine lines up from the	17		that in t
18		bottom:	18		flagging
19		"The observed variability"	19		hear, tra
20		That's in these test results, of healthcare workers.	20	Α.	I think th
21		" might be explained by [healthcare workers]	21	Q.	First of
22		being at higher risk of asymptomatic or subclinical	22		nursing
23		infection, indicating that [healthcare workers] may act	23		account
24		as an infective pool to transmit influenza to frail	24		arrange
25		elderly people."	25	Α.	Yes.
		147			

1 2 3 4 5	А.	public health at Nottingham University, he hadn't yet been appointed to the role that we will become familiar with him in, as the Deputy Chief Medical Officer; he was appointed to that role later in 2017, I think. Yes.
6	Q.	With that in mind, what I want to do is just look at
	ω.	
7		a few passages of this report and then ask you some
8		questions about it.
9		Could we start, please, by just zooming in on
10		the bottom right-hand corner where it says "The impact
11		of influenza". So we see the article says:
12		"Persons residing in LTCFs [long-term care
13		facilities] present a population very susceptible to the
14		acquisition and spread of infectious diseases and for
15		whom the consequences of infection may be serious.
16		Nursing home residents are at greatest risk due to their
17		overall frailty, close quarter living arrangements,
18		shared caregivers, and opportunities for introduction of
19		healthcare associated infections and the spread of
20		pathogens to other facilities through resident transfers
21		and the movement of staff and visitors in and out of the
22		home."
23		I'm not sure we've got yes, sorry, we have got
24		the right part:
25		"Outbreaks of influenza caused by both influenza A 146
1		Finally, if I can pick it up at the very bottom of
2		that column and going on to the next column:
3		"Although the role of asymptomatic people and those
4		with only mild symptoms in spreading influenza is
5		uncertain, [healthcare workers] often continue to work
6		despite having symptoms and may act as a source of
7		infection to those in their care. Nursing home aides in
, 8		particular have been shown in one Swedish study to be
9		the occupational group at significantly greatest risk of
		continuing to work despite the feeling that, in the
10 11		light of their perceived state of health, they should
12		have taken sick leave. However, in reality the
13		employment status of many LTCF staff is often precarious
14		and taking unpaid sick leave may result in adverse
15		economic consequences."
16		One might think thank you very much Professor,
17		that in that article in 2017 Professor Van-Tam was
18		flagging certain risks, risks that in fact, as we shall
19		hear, transpired with terrible results, very clearly?
20	Α.	I think the paper flagged those risks very clearly, yes.
21	Q.	First of all, he was flagging the basic vulnerability of
22		nursing and care home occupants to a flu-like virus on
23		account of their own frailty and their close living
24		arrangements?
25	Α.	Yes.
		148

1 Q.		1		about whether they're going to keep their job; is that
2	might themselves transmit the disease	2		fair?
3 A .	Yes.	3	Α.	They're worried about income in the context of having to
4 Q .	firstly by moving themselves between different care	4		take sick leave.
5	facilities, secondly the risk in asymptomatic	5	Q.	Finally, and perhaps bringing it all together, these
6	transmission	6		risks generate risks of outbreaks of infectious disease
7 A .	Yes.	7		in nursing homes, in care homes, that can be, to use
8 Q .	by healthcare workers. Why is that of interest?	8		the words of the report, explosive and involve high
9 A .	Because even though you are asymptomatic you could still	9		mortality?
0	carry infection and therefore can pass the infection on	10	Α.	They carry the risk of high mortality, indeed.
1	to other people.	11	Q.	The word in the report was "explosive"; is that a word
12 Q .	And so	12		you're not comfortable with?
13 A .	If you're in intimate contact with someone, caring for	13	Α.	I probably would not choose to use such an emotive word
4	them, then that risk of transmission is very high.	14		but certainly a high risk of mortality.
15 Q .	The risk then, as with any asymptomatic transmission, is	15	Q.	One wonders, one doesn't know, of course, but one
6	that the people who are doing the transmitting don't	16		wonders what the authors of the report meant by that
17	even realise that they have the virus, there's no reason	17		word. Might they have meant that those if you like,
8	for them to shield or to isolate, and therefore the risk	18		it's a sort of tinder box, the coming together of frail
9	of them spreading it is that much worse?	19		people, living in close proximity to each other, and
20 A .	That's correct.	20		these transient workers who may have an asymptomatic
21 Q .	Then also flagged is what's described in the report as	21		virus and who may not be inclined to isolate even if
22	the precarious nature of healthcare workers' employment,	22		they know they are ill, a risk of a sudden and extreme
23	which in fact leads to the risk that even if they do	23		outbreak, would that be one way of understanding the
24	know that they're ill they might still carry on working.	24		word explosive perhaps?
25	They don't want to take sick leave, they're worried 149	25	Α.	So I initially qualified my response by saying I'm not 150
1 2	an infectious diseases epidemiologist, but the example would be that one person becomes infected within	1		nursing homes, in care homes, and in fact in your report you say similar considerations would apply to those who
3	the care home and, without adequate protections within	3		were in hospital awaiting discharge, were they another
4	the care home, then the illness will spread rapidly.	4		identifiable vulnerable group who were vulnerable,
5 Q .	Yes.	4 5		particularly vulnerable, to experiencing serious
	Yes. Then finally with this document, could we have to	4		particularly vulnerable, to experiencing serious symptoms from Covid?
5 Q . 6 7	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph	4 5 6 7	А.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were
5 Q. 6 7 8	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see	4 5 6 7 8	A.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is
5 Q . 6 7 8 9	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the	4 5 7 8 9	A.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're
5 Q . 6 7 8 9	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the sentence starting at the end of one of the lines:	4 5 7 8 9 10	A.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're awaiting discharge into care homes or into their own
5 Q. 6 7 8 9 10	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the sentence starting at the end of one of the lines: "The prevention and control of influenza in LTCFs	4 5 7 8 9 10 11	A.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're awaiting discharge into care homes or into their own homes if appropriate packages can be put in place, which
5 Q . 6 7 8 9 10 11	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the sentence starting at the end of one of the lines: "The prevention and control of influenza in LTCFs requires a multifaceted approach; vaccination and	4 5 7 8 9 10 11 12	Α.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're awaiting discharge into care homes or into their own homes if appropriate packages can be put in place, which means they have a similar level of morbidity, frailty
5 Q . 6 7 8 9 10 11 12 13	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the sentence starting at the end of one of the lines: "The prevention and control of influenza in LTCFs requires a multifaceted approach; vaccination and antiviral policies form an important part of this, but	4 5 7 8 9 10 11	Α.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're awaiting discharge into care homes or into their own homes if appropriate packages can be put in place, which
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5 Q. 6 7 8 9 10 11 12 13 14 15 16 17 18 A.	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the sentence starting at the end of one of the lines: "The prevention and control of influenza in LTCFs requires a multifaceted approach; vaccination and antiviral policies form an important part of this, but strong managerial leadership, outbreak planning, and a well-trained, educated and engaged workforce are pivotal to the successful implementation of IPC policies." IPC, infection Infection prevention control, I believe.	4 5 7 8 9 10 11 12 13 14 15 16 17 18	A. Q.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're awaiting discharge into care homes or into their own homes if appropriate packages can be put in place, which means they have a similar level of morbidity, frailty and so on, and then in addition because they are in hospital they are at a heightened risk of infection. Thank you. Finally, one more topic to address with you, Professor, and that is the risk of adverse outcomes resulting from non-pharmaceutical interventions during
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5 Q. 6 7 8 9 10 11 12 13 14 15 16 17 18 A. 19 Q. 20 21 22 A.	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the sentence starting at the end of one of the lines: "The prevention and control of influenza in LTCFs requires a multifaceted approach; vaccination and antiviral policies form an important part of this, but strong managerial leadership, outbreak planning, and a well-trained, educated and engaged workforce are pivotal to the successful implementation of IPC policies." IPC, infection Infection prevention control, I believe. That's right. Again, it would seem in this article to be rather prophetic as to what was needed in 2020; is that fair? Indeed.	4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're awaiting discharge into care homes or into their own homes if appropriate packages can be put in place, which means they have a similar level of morbidity, frailty and so on, and then in addition because they are in hospital they are at a heightened risk of infection. Thank you. Finally, one more topic to address with you, Professor, and that is the risk of adverse outcomes resulting from non-pharmaceutical interventions during the pandemic, and how that relates to these inequality issues that we have been addressing together. I'm now looking at paragraphs 46 and following of your report, and perhaps it's worth me saying that, as
5 Q . 6 7 8 9 10 11 12 13 14 15 16 17 8 8 A . 19 Q . 20 21 22 A . 23 Q .	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the sentence starting at the end of one of the lines: "The prevention and control of influenza in LTCFs requires a multifaceted approach; vaccination and antiviral policies form an important part of this, but strong managerial leadership, outbreak planning, and a well-trained, educated and engaged workforce are pivotal to the successful implementation of IPC policies." IPC, infection Infection prevention control, I believe. That's right. Again, it would seem in this article to be rather prophetic as to what was needed in 2020; is that fair? Indeed. So just finally then before we leave this part of it,	4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're awaiting discharge into care homes or into their own homes if appropriate packages can be put in place, which means they have a similar level of morbidity, frailty and so on, and then in addition because they are in hospital they are at a heightened risk of infection. Thank you. Finally, one more topic to address with you, Professor, and that is the risk of adverse outcomes resulting from non-pharmaceutical interventions during the pandemic, and how that relates to these inequality issues that we have been addressing together. I'm now looking at paragraphs 46 and following of your report, and perhaps it's worth me saying that, as with previous sections of your report, this is focused
5 Q. 6 7 8 9 10 11 12 13 14 15 16 17 18 A. 19 Q. 20 21 22 A.	Yes. Then finally with this document, could we have to the seventh page of it, please. It's the paragraph headed "Conclusion" but the last few lines of it, we see about four or five lines up from the bottom, the sentence starting at the end of one of the lines: "The prevention and control of influenza in LTCFs requires a multifaceted approach; vaccination and antiviral policies form an important part of this, but strong managerial leadership, outbreak planning, and a well-trained, educated and engaged workforce are pivotal to the successful implementation of IPC policies." IPC, infection Infection prevention control, I believe. That's right. Again, it would seem in this article to be rather prophetic as to what was needed in 2020; is that fair? Indeed.	4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q.	particularly vulnerable, to experiencing serious symptoms from Covid? So my opinion is that the profile of the people who were medically fit, awaiting discharge, was very similar, is very similar to those who are in care homes, they're awaiting discharge into care homes or into their own homes if appropriate packages can be put in place, which means they have a similar level of morbidity, frailty and so on, and then in addition because they are in hospital they are at a heightened risk of infection. Thank you. Finally, one more topic to address with you, Professor, and that is the risk of adverse outcomes resulting from non-pharmaceutical interventions during the pandemic, and how that relates to these inequality issues that we have been addressing together. I'm now looking at paragraphs 46 and following of your report, and perhaps it's worth me saying that, as

1		from a witness from Age UK who will tell us more about	1
2		the impact that was in fact experienced by older people	2
3		as a result of NPIs.	3
4		But at the moment I'm going to ask you questions, as	4
5		I say, about what was known, what data, what research	5
6		was available before the pandemic started.	6
7		But in summary, is it fair to say, Professor, that	7
8		the evidence, the research that was available indicated	8
9		that older people would suffer more than most from,	9
10		for example, a lockdown, first of all because, because	10
11		of the greater vulnerability, they would be more likely	11
12		to have to isolate themselves, and that they would be	12
13		more affected once they were isolating; is that a fair	13
14		summary?	14
15	Α.	That's a fair summary of the on-average situation	15
16		amongst older people.	16
17	Q.	Focusing a little on various areas. First of all, the	17
18		question of social exclusion. You refer in your report	18
19		to the risk of social exclusion being higher for	19
20		particular groups of older people. Can you expand on	20
21		that a little?	21
22	Α.		22
23		exclusion might be, but in effect it means poor access	23
23 24		to services, facilities, community and so on, and the	23
24 25		evidence suggests that people who are poorer or people	24
25		153	23
1		wellbeing, social distancing and lockdown measures have	1
2		a particularly negative impact on those who do not have	2
3		access to digital devices and high quality broadband,	3
4		because they can be used to maintain connections"	4
5		And so on.	5
6		I think it's fair to say that not just maintaining	6
7		connections with family but, in a distancing situation,	7
8		necessary for much more than that?	8
9	Α.	Indeed, for connections with community networks and	9
10		connections with services, amenities and so on.	10
11	Q.	At paragraph 57 of your report you indicate that in	10
12	ч.	the years prior to 2020 there had been a lot of	12
12		, ,	12
		progress, if one wants to call it progress, in moving	
14		many of the sort of essential services online?	14
15	Α.	Yes.	15
16	Q.	Then if we can look at paragraph 58, please, you say	16
17		this:	17
18		"However, older people are more likely not to be	18
		using the internet."	19
19		Then you have produced this data from 2020,	20
20			
		an estimate that 13% of adults in the UK do not use	21
20		an estimate that 13% of adults in the UK do not use the internet, so that's a global figure, but then if one	21 22
20 21			
20 21 22		the internet, so that's a global figure, but then if one	22

1		who are living in more deprived areas are more likely to
2		not only be socially excluded at a particular point in
3		time but over time they are more likely to move into
4		social exclusion than richer people, and much less
5		likely to move out of social exclusion if they're
6		already in it.
7	Q.	And those considerations are clearly of great relevance
8		to the question of lockdown and how older people would
9		fare in that situation?
10	A.	Yes, absolutely.
11	Q.	I want to move to the question of digital exclusion.
12		DY HALLETT: I don't know how much longer you have to go.
13		We do have, I think, about 15 minutes of other
14		questions.
15	MR	O'CONNOR: Yes. I probably only have another two or
16	WILL.	three minutes with the Professor, and perhaps if
17		I finish with him and then we have a break before my
18		learned friends can go to their questions.
19	1 /1	DY HALLETT: Of course.
20		O'CONNOR: It's in fact well, I've got two more
20	IVIT	
21 22		topics. The first of those is digital exclusion,
		Professor, and I'm now looking at paragraph 56 of your
23		report.
24 25		You say: "Also relevant to social and psychological
25		Also relevant to social and psychological
1		64, 200% in the breeket 65 to 74, and $540%$ for these area
1 2		64, 30% in the bracket 65 to 74, and 51% for those aged 75 and older.
2		You say an ONS survey also from 2020 found that
3 4		nearly 40% of those aged 75 and older had never used the
5		internet, and Age UK report that many of those who had
6 7	^	used the internet no longer do so.
7	A.	Yes.
8 9	Q.	So 13% of the adult population but, as you say, a very sharp gradient when one gets to the older cohorts
9 10		Yes.
10	A. Q.	of people who don't use the internet.
12	ω.	
13		You then go on to, as it were, focus more precisely. You say at paragraph 60 in effect that the wealthier
14		elderly, and I take it you mean of all of those cohorts,
14		
15 16		are more likely than the poorer elderly to use the internet?
	٨	
17 10	A.	Yes.
18	Q.	So this digital exclusion is something, therefore,
19 20		that's more keenly felt by the poorer elderly cohorts?
20	A.	Yes.
21 22	Q.	You also indicate or suggest that poor health also
22 23	^	shapes the trajectory of internet use?
∠ 0	Α.	That's correct.

- 24 Q. So in summary, are you saying that these sort of
- 5 intersections, older, poorer and those with ill health, 156

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1	putting those all together, are the least likely to have	1	that is not covered in your report, is the question of
2	or to be able to use, to be familiar with the internet?	2	domestic abuse.
2	A. Yeah. So socioeconomic position and health are related,	3	Was there in 2020 evidence showing any particular
4	as I described, as we discussed earlier, but over and	4	patterning or risks of domestic abuse within the older
5	above socioeconomic inequality, deteriorating health	5	population?
6	leads to less use of the internet.	6	So domestic abuse I think we need to define broadly,
7	Q. That was the data that was available in 2020, and	7	need to think about physical abuse, sexual abuse,
8	of course one might think that, if you like, those	8	psychological abuse, neglect and financial abuse I think
9	people you're describing who are least likely to use	9	are the main dimensions that are studied when people
10	the internet might have been amongst those who would	10	study domestic abuse of older people.
11	most need it once the pandemic started?	11	The evidence is intermittent. There was a large
12	A. That's certainly possible. And the data were available	12	study done 2006/7, something around then, on domestic
13	before 2020, so much of this work was done before 2020.	13	abuse amongst older people, that was a large
14	Q. Just finally on this, are you able to help us this is	14	representative study, which I can't remember the
15	not something that's covered in your report, and you may	15	exact number, but something like 2% or 3% of older
16	not be able to help us, but are you able to help us	16	people reported experiencing abuse.
17	whether there was yet another variation in the sense of	17	I think we have to put that estimate in the context
18	whether older women were more digitally excluded than	18	of how easy it is to tell someone that you're being
19	older men?	19	abused, particularly when various dimensions of elder
20	A. Older women are more digitally excluded than older men.	20	abuse are seen as normal, routine and so on. But
21	Q. Was that something that was there on the research prior	21	nevertheless, a significant proportion.
22	to the pandemic?	22	In relation to your earlier question about gender,
23	A. Indeed, it was available prior to the pandemic.	23	it seems that most of the elder abuse is conducted by
24	Q. Thank you.	24	partners. Well, maybe not most, but at least half of
25	The last subject then, again, which is something	25	elder abuse is conducted by partners.
	157		158
1	MR O'CONNOR: Thank you.	1	the early onset of age-related illnesses compared with
2	My Lady, those are all the questions that I had. LADY HALLETT: Thank you, Mr O'Connor.	2	the white British group; thirdly, the significant
3	•	3	presence of ethnic minority workers in the social care
4	Are you all right?	4	sector; and fourthly, the missed opportunities in treating older people as a monolithic group.
5 6	A. I am indeed.	5 6	
7	LADY HALLETT: Thank you very much. I shall return at	0 7	Here's the question: given the above, can you share with us what your views are on the appropriateness of
	25 to. Thank you.	8	
8 9	(3.20 pm)	o 9	inviting older and/or retired health and social care
	(A short break)		workers from ethnic minority communities to return to active service during the pandemic?
10	(3.35 pm) LADY HALLETT: Mr O'Connor.	10 11	
11 12	MR O'CONNOR: My Lady, as I said, I have finished my	11	I'll speak into the microphone, sorry. I presume that's appropriate, rather than
12	questioning of Professor Nazroo, but there were two	12	Okay, so this is an important question, I think.
13	representatives, Mr Thomas from FEHMO, and Ms Gowman	13	I think it's right to summarise my evidence as
14	from Covid Bereaved Families for Justice Cymru, who you	14	suggesting that older ethnic minority people are
16	had indicated you might be prepared to grant permission	16	particularly vulnerable, and this will apply of course
17	to ask questions of this witness.	10	to former as well as current healthcare workers.
18	LADY HALLETT: Yes, I do grant permission.	18	So for me the question then would be what kind of
19	Mr Thomas.	10	risk assessments should you put in place if you were
20	Questions from PROFESSOR THOMAS KC	20	asking those people to return to the frontline in
21	PROFESSOR THOMAS: Thank you, Professor, I've only got one	20	the context of the need for additional labour. So the
22	question for you, and it's this: in your report you	22	risk assessments would be crucial here.
23	note, firstly, the complexity of the age and ethnicity	23	Y HALLETT: Thank you, Mr Thomas.
24	intersecting; secondly, in particular heightened	24	 Now, you're going to have the same problem I have in
25	vulnerabilities of older ethnic minority people, notably	25	seeing the next questioner.
	159		160

(40) Pages 157 - 160

1	Ms Gowman, there you are, I can see you.	1		SI
2	THE WITNESS: I can.	2	Q.	Y
3	Questions from MS GOWMAN	3	Α.	Т
4	MS GOWMAN: Professor Nazroo, I represent Covid Bereaved	4	Q.	N
5	Families for Justice Cymru. I'm going to ask you	5		S
6	questions on four topics, time permitting.	6		u:
7	The first topic is the use of blanket policies and	7	Α.	Т
8	tools in healthcare. My Lady has granted permission for	8	Q.	D
9	the Cymru group to ask a set of reformulated questions	9		SI
10	on this topic, having liaised with Covid Bereaved	10		th
11	Families for Justice UK and Northern Ireland, and it is	11		di T
12 13	on behalf of all three groups that I ask questions on	12 13	Α.	Т
13 14	this topic.	13		re
14	At paragraph 77 of your report, you say that many			U: th
15 16	hospitals used some form of triage to restrict intensive	15 16	Q.	th Y
17	care for those aged 60 and over, modelled on a disseminated but not implemented NHS Covid-19 decision	10	Q.	I
18	support tool.	18		th
19	It's right, isn't it, that the decision support tool	10		tr
20	was a points-based system, using a combination of four	20	Α.	S
20	constituent scores across the domains of age, gender,	20	ς.	tr
22	level of frailty and medical conditions, that then	22		ra
23	subsequently recommended patients into particular	23		a
24	treatment pathways?	24		0
25	 A. That's correct, though, as you said, this decision 	25		th
	161			
1	people who need treatment is appropriate to identify	1		di
2	those as people who are not worth treating, I think is	2		s
3	the wrong use of such tools.	3	Α.	A
4	Q. So they should be used to identify effectively the most	4		n
5	vulnerable and deserving of treatment as opposed to	5		П
6	eliminate treatment being given to those vulnerable	6		u
7	individuals; is that fair?	7	Q.	F
8	A. The people who most need treatment.	8		o
9	Q. Yes. And it's also correct that there has been	9		d
10	a long-standing concern about poor practices regarding	10		a
11	the blanket use of Do Not Attempt Resuscitation notices.	11	Α.	A
12	Is that your understanding?	12		tc
13	A. Sorry, I'm afraid I haven't seen detailed evidence of	13		0
14	this, so all I can observe is the anecdotal evidence	14		р
15	that has appeared in various reporting suggesting that	15		re
16	that was the case.	16		e
17	LADY HALLETT: Don't worry, we're going to deal with it in	17		p
18	some detail at some stage. It's one of those issues	18	Q.	Т
19	that I'm very conscious of.	19		
20	MS GOWMAN: If there is a blanket use of such notices, it	20		in
21	follows, doesn't it, that that would disproportionate	21		w
22	affect the older population?	22		le
23	A. It would disproportionately affect the older, iller	23		
24	population, yeah.	24		re
25	Q. From your perspective, based on the anecdotal evidence, 163	25		a

support tool was never implemented.

Yes.

Though it may have influenced decision-making.

- When assessing levels of frailty, the clinical frailty
- score, also known as the Rockwood frailty score, is also
- used as a prognostic indicator; is that right?
- That's correct.
- Do you agree that the blanket use of the decision
- support tool and the clinical frailty score, insofar as
- they were used, and other similar tools, are potentially
- discriminately, and if so why?
- They are discriminatory, in my view, so long as they
- restrict entry into care. My opinion is that they are
- useful tools for identifying those who need care, rather
- than the opposite.
- Yes.
 - Insofar as the scoring systems are concerned, could
- they be used to impact on the prioritisation of
- treatment, and in turn mortality rates?
- So my opinion is that they could be used to encourage
- treatment of people who are particularly vulnerable
- rather than to discourage the treatment of people who are particularly vulnerable. So my view is that the use
- of something like an age threshold or a frailty
- threshold or a multimorbidity threshold to identify 162

1		did the pandemic expose and exacerbate issues
2		surrounding the Do Not Attempt Resuscitation process?
3	Α.	Anecdotal evidence suggests that the Do Not Resuscitate
4		notices were not used, in my view, appropriately. But
5		I haven't done research in this area, this is my
6		understanding of the anecdotal evidence.
7	Q.	Finally on this topic, Professor Nazroo, are you aware
8		of any alternative approaches to clinical
9		decision-making that reduces the risk of discrimination
10		against older and/or disabled people in particular?
11	Α.	As I've tried to identify in my report and in response
12		to your earlier questions, there are clearly groups of
13		older people who are more in need of treatment, of
14		protection against infection and treatment once they
15		receive infection. I think those groups we had
16		evidence on how to identify those groups prior to the
17		pandemic.
18	Q.	Thank you.
19		The next topic is the vulnerability of older people
20		in care homes and awaiting discharge from hospital,
21		which you've already covered to some extent with my
22		learned friend.
23		At paragraph 89 of your report, you identify, in
24		respect of those living in care homes and medically fit
25		and awaiting discharge, that there was a missed

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1		opportunity to implement recommendations of the review
2		paper that we have already referred to. You have been
3		taken to the risks in respect of those residing in
4		long-term care facilities, but I want to ask you about
5		the recommendations that emanated from that article.
6		It's right, isn't it, that the article makes several
7		recommendations in respect of control measures in
8		respect of long-term care facilities?
9	Α.	That's correct.
10	Q.	If I summarise them in the following way, you can tell
11		me if that represents your understanding: firstly, it
12		recommends routine and pre-outbreak prevention measures
13		comprising of planning, training and education,
14		vaccination of residents and staff.
15		Secondly, it emphasises the need for early
16		recognition, including by way of testing.
17		And, thirdly, it makes recommendations for outbreak
18		control measures comprising respiratory etiquette,
19		appropriate use of PPE, isolation of infected residents,
20		and the minimisation of transmission opportunities.
21		closure of care homes to new admissions, limitation of
22		visitors, rostering vaccinated staff to care for
23		residents, and hand hygiene and enhanced environmental
24		cleaning.
25		Do you agree that those represent a summary of
		165
1		impression is that it was not, but that strictly is
1 2		impression is that it was not, but that strictly is an impression.
	Q.	
2	Q.	an impression.
2 3	Q. A.	an impression. So when you cite in your report that there was a missed
2 3 4		an impression. So when you cite in your report that there was a missed opportunity
2 3 4 5	Α.	an impression. So when you cite in your report that there was a missed opportunity Indeed.
2 3 4 5 6	A. Q.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie
2 3 4 5 6 7	A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed.
2 3 4 5 6 7 8	A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear
2 3 4 5 6 7 8 9	A. Q. A. Q.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article?
2 3 4 5 6 7 8 9	A. Q. A. Q.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this
2 3 4 5 6 7 8 9 10 11	A. Q. A. Q.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days
2 3 4 5 6 7 8 9 10 11 12	A. Q. A. Q.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't
2 3 4 5 6 7 8 9 10 11 12 13	A. Q. A. Q.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days
2 3 4 5 6 7 8 9 10 11 12 13 13	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented.
2 3 4 5 6 7 8 9 10 11 12 13 14 15	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented. The next topic is the fragility of the domiciliary
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented. The next topic is the fragility of the domiciliary care sector. Within your report you identify that the social care system, in particular the care home
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented. The next topic is the fragility of the domiciliary care sector. Within your report you identify that the social care system, in particular the care home sector, was in a fragile state on going into
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented. The next topic is the fragility of the domiciliary care sector. Within your report you identify that the social care system, in particular the care home sector, was in a fragile state on going into the pandemic. What comment, if any, can you make in
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented. The next topic is the fragility of the domiciliary care sector. Within your report you identify that the social care system, in particular the care home sector, was in a fragile state on going into the pandemic. What comment, if any, can you make in respect of vulnerability and fragility of the
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented. The next topic is the fragility of the domiciliary care sector. Within your report you identify that the social care system, in particular the care home sector, was in a fragile state on going into the pandemic. What comment, if any, can you make in respect of vulnerability and fragility of the domiciliary care sector in particular on going into
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A. Q. A. Q. A. Q.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented. The next topic is the fragility of the domiciliary care sector. Within your report you identify that the social care system, in particular the care home sector, was in a fragile state on going into the pandemic. What comment, if any, can you make in respect of vulnerability and fragility of the domiciliary care sector in particular on going into the pandemic?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. A.	an impression. So when you cite in your report that there was a missed opportunity Indeed. is that what you mean, ie Indeed. a missed opportunity to implement clear recommendations emanating from the article? Indeed, and missed opportunity in the sense that this was well established evidence and could have been considered in the early days of the pandemic. I don't know to what extent it was considered in the early days of the pandemic. But your impression was that it was not? My impression is that it was not implemented. The next topic is the fragility of the domiciliary care sector. Within your report you identify that the social care system, in particular the care home sector, was in a fragile state on going into the pandemic. What comment, if any, can you make in respect of vulnerability and fragility of the domiciliary care sector in particular on going into

1		the primary recommendations made in that article?
2	Α.	I agree. I would add perhaps one more, which was around
3		the staffing of long-term care facilities.
4	Q.	To ensure that there was effectively sufficient levels
5		of staffing; is that right?
6	Α.	To ensure that staffing was sufficiently secure that the
7		risks of precarity in the labour force, working in more
8		than one care home and so on, were minimised.
9	Q.	You have already indicated in response to questions by
10		my learned friend in respect of the impact on such
11		patients, but is it right that the recommendations also
12		represented the thrust of scientific thought on control
13		measures at the time?
14	Α.	Sorry, I missed the: also represent?
15	Q.	The thrust of scientific thought?
16	Α.	They do, yes.
17	Q.	So this wasn't a minority view?
18	Α.	No, no, this was an important review paper.
19	Q.	Can I ask, was the article publicly available?
20	Α.	Yes.
21	Q.	To your knowledge, it may be that you can't assist with
22		this, were the recommendations ever noted and
23		implemented by any policymakers in advance of or going
24		into the pandemic?
25	Α.	I cannot answer that question, I don't know. The 166
		100
1		domiciliary care, but the papers that I have seen
2		suggest that there are very similar issues around
3 4		underfunding and security of employment, and so on, that mean that there was a substantial risk of domiciliary
4 5		care failure within the context of a pandemic.
6	1 11	DY HALLETT: Just so people understand, domiciliary means
7		care in the home.
, 8	Α.	Indeed.
9		GOWMAN: Thank you, my Lady, I was about to ask that
10		follow-up question to clarify.
11		In terms of the issues that you identify with social
12		care more generally that may have direct applicability
13		to domiciliary care, your report identifies low pay and
14		lack of resilience, carers moving from setting to
15		setting, dependence on private agencies, problems
16		sustaining packages of care and lack of PPE, and I think
17		your evidence is that those issues applied equally to
18		domiciliary care provision?
19	Α.	I understand that they did.
20	Q.	Do you consider that there were missed opportunities by
21		decision-makers in relation to the domiciliary
22		care sector specifically?
23	Α.	Yes. I think the issues that you have just raised could
24		have been considered at the beginning of the pandemic.
25		The extent to which they were is not clear to me. That 168

1		they did not lead to action does seem to be the case.	1	Q. And or
2	Q.	And should have been considered?	2	LADY HALI
3	Α.	Should have been should have been considered and	3	you're
4		should, in my opinion, have led to action.	4	find that
5	Q.	The final topic, I think I have time, namely	5	going
6		the disparities between the devolved nations. At	6	MS GOWM
7		paragraph 9 of your report, you state that it's very	7	Tł
8		unlikely there will have been meaningful differences	8	LADY HALI
9		across the nations, and you were taken to this section	9	Tł
10		of your report earlier in your evidence.	10	MR O'CON
11		The nature of inequalities may be similar across the	11	LADY HALI
12		four nations, but do you agree that the impact and	12	today.
13		extent of the health inequalities might differ between	13	THE WITNE
14		nations depending on the population make-up?	14	opport
15	Α.	So I think the for me the crucial point is that	15	
16		the level of risk of illness will vary across	16	LADY HALI
17		the four nations. I think that's very well established,	17	until it
18		that it varies across the four nations.	18	MR O'CON
19	Q.	Yes.	19	l wond
20	Α.	It also varies within the nations as well	20	for a m
21		geographically. And so in terms of planning, you may	21	one ot
22		well want to consider the absolute level of risk within	22	is the r
23		the nation, but the inequality in risk, which is what	23	Mr Kei
24		I focus on here, I believe did not vary particularly	24	LADY HALI
25		across the four nations.	25	MR O'CON
		169		
1		distracted. But even before I do that, and just while	1	before
2		Professor Nazroo's evidence is fresh in our minds,	2	afterwa
3		perhaps just for the record I can make it clear to	3	eviden
4		everyone who's listening and who may read the transcript	4	take m
5		that the terms of Professor Nazroo's instructions did	5	As
6		not extend for us either showing him the evidence that	6	respor
7		has been provided to you about the government response	7	the fiel
8		or inviting him to provide any evidence, far less expert	8	helpful
9		evidence, on what should or shouldn't have been done,	9	in fact
10		but I think in answering questions he made it clear that	10	the org
11		he was really speaking from his own sort of	11	and the
12	LAI	DY HALLETT: Yes, I was getting a little concerned at that	12	"It
13		stage.	13	beginn
14	MR	O'CONNOR: impression. But to be clear, that wasn't	14	storm.
15		part of his formal function in either drafting his	15	factor
16		report or providing his views.	16	living v
17	LAI	DY HALLETT: I think when you're talking about expert	17	or care
18		evidence, we have got to be pretty clear.	18	the ma
19	MR	O'CONNOR: Yes.	19	extrem
20		Summary of questionnaire responses	20	greate
21	MR	O'CONNOR: As I say, I wonder I'm sorry, it's going to	21	exclus
22		take a few minutes, but I think it's since I'm going	22	intensi
23		to, as Mr Keith did, just summarise the questionnaire	23	risk of
24		responses that we received relating to the issue of	24	functio
25		later life, I think it would be more sensible to do that 171	25	among

they did not lead to action does seem to be the case.

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- Q. And one final question on --1
 - LETT: No, I'm afraid not, Ms Gowman. I'm afraid e out of time. Apart from anything else, I can't
- hat I had given approval for these. Anyway, we're
- to stop there.
- IAN: Certainly.
 - hank you, Professor. Thank you, my Lady.
- **LETT:** Thank you very much indeed, Professor.
- hose are all the questions, Mr O'Connor, for --
- NOR: No, no further questions, I'm very grateful --
- **LETT:** And thank you for being so patient with us
- ESS: No, thank you, my Lady, I appreciate the rtunity to give evidence.
- (The witness withdrew)
- LETT: We've just got a wait a second, I'm afraid, t's all cleaned.
- NOR: My Lady, just before the witness is sworn,
- der if I could just invite the witness to sit down
- moment, because I was in fact intending to take
- other matter before I invite you to call her, which
- narrative, similar to the narrative that
- eith --
- LETT: Of course, yes, absolutely, the summary.
- **INOR:** It's useful for her to be -- I'm sorry, I was 170
- e Ms Abrahams gives evidence rather than vards, so that we have them in mind when she gives nce. So I'm just going to read those out. It will me two or three minutes. As Mr Keith explained, we sought questionnaire onses from a range of interest groups within eld, in this case of later life, and received very ul responses. Amongst them were -- I'll start with t a passage from Age UK's questionnaire, which is rganisation we'll hear that Ms Abrahams is part of, heir response included this passage: It should have been apparent from the very ning that older people would be at the eye of the . Age was identified early on as a major risk for critical illness and mortality. The risk of with pre-existing health conditions, disability re need rises directly in line with age, including ajority of people advised they were clinical or mely clinical vulnerable. Older people have er likelihood of social isolation and digital sion. Older carers are more likely to be providing sive informal care and there was a predictably high f losing and not regaining mobility, cognitive on, strength and balance or cardiovascular fitness igst older people. In addition, the experiences of 172

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1	other countries that were ahead of us during the
2	pandemic, such as Italy, demonstrated the vulnerability
3	of older people, especially those living in residential
4	settings."
5	Then we have identified two broad themes that were
6	addressed in these questionnaire responses, the first of
7	which was a lack of understanding of the sector by those
8	making decisions.
9	The National Care Forum stated this:
10	"One key overarching theme spans our submission,
11	which is the lack of understanding of the care and
12	support sector and those who are supported through it.
13	This lack of understanding can be compared to the
14	absolute primacy given to the NHS in all aspects of the
15	government's response to the pandemic, which is a far
16	better understood institution for policy and
17	decision-makers."
18	Care England said this:
19	"Decisions were made during the pandemic,
20	particularly within or during the first wave, that
21	protected the NHS with little or no regard for the adult
22	social care sector. Decision-makers did not have
23	a clear and sufficient understanding of the social care
24	sector, lack of central understanding of the diversity
25	of the adult social care sector, particularly for those 173
	175
1	likely they are to have ill health, increased loneliness
2	and isolation as well as financial hardship."
3	Then, finally, Homecare Association Wales stated
4	that:
5	"Recovery did not end in spring 2022. Workforce
6	wellbeing continues to be important. The Welsh
7	Government began discussions about recovery in 2020 and
8	produced a Covid-19 recovery framework in July 2021.
9	However, the guidance [they say] for social care only
10	really reached a new normal during the spring 2023 when
11	testing was finally stepped down."
12	My Lady, those are the summary of the questionnaire
13	responses, and may I now invite you to call Ms Abrahams.
14 15	Thank you.
15 16	LADY HALLETT: Thank you for being patient.
17	Questions from COUNSEL TO THE INQUIRY
18 10	MR O'CONNOR: Can you give us your full name, please.
19 20	 A. Yes, Caroline Susan Abrahams. A. Yeu are the charity director of Are LWs in that right?
20	 Q. You are the charity director of Age UK; is that right? A. Correct
21	A. Correct.
22	 Q. I think that's a post you've held for some time? A. Yook I've hear there for shout 11 years
23	 A. Yeah, I've been there for about 11 years. So during the pendemia?
24 25	Q. So during the pandemic?A. Indeed.
25	A. Indeed. 175

with learning disabilities and/or autism. Care England members operating within the younger adult sector found themselves having to rewrite guidance as a result of its predominant focus on older people living in residential care homes." The second theme is of longer term impacts. Age UK said this: "Research suggests that older people who previously did not need support to maintain their independence are now requiring care and support for the first time, and much earlier than would otherwise have been the case. Those who were already struggling to carry out activities of daily living such as walking, eating, showering and getting dressed, are now finding things harder. The significant drop in activity levels amongst over 50s, and only a third of people aged 75 and over have been active during the pandemic, this has impacted on older people's mobility, strength and balance and left them at greater risk of frailty and falls. The Carers UK survey in 2021 said that 72% of unpaid carers had not had a break since the pandemic began. The 2021 census shows the number of unpaid carers providing over 20 hours of care per week increased by 260,050 hours by 152,000. The more care provided, the more likely it is that someone will have to give up work to care, the more 174 Q. You have helpfully provided the Inquiry with a witness statement which we can see on the screen. It's dated 27 September 2023. A. Yeah. Q. It's concealed on the screen, but I can tell you, because I'm looking at it, that you signed that statement. Δ Yes.

- 9 Q. Do you recall signing it?
- 10 **A.** I do.
- 11 Q. I'm sure you're familiar with the contents of the
- 12 statement.
- 13 **A.** Yes.
- 14 Q. Are they true to the best of your knowledge and belief?
- 15 A. Yes.
- 16 Q. It's a very lengthy statement, Ms Abrahams, and we won't
- 17 be able to go into anything like the detail that it
- 18 contains today, but of course the Inquiry have
- 19 the statement and we will be adducing it in writing in
- 20 full. What we will try to do today is simply, in
- the time we have available, cover some of the key themesthat you have identified.
- 23 First of all, may I ask you just a few questions
- 24 about Age UK itself.
- 25 A. Yeah.

2

3

1	0	You describe the organisation in your statem	ent as heing
	ч.		ient as being

- 2 a federated network of organisations across the UK?
- 3 A. Yeah.
- 4 Q. Can you perhaps explain that in a little detail, please.
- 5 A. Certainly. So there's Age UK, the national organisation
- 6 which I work for, and then we also have about 125 local
- 7 Age UKs scattered across England, and there's Age Cymru,
- 8 Age Scotland and Age Northern Ireland, there's also
- 9 Age International, and we have a commercial arm as well.
- 10 Q. Another measure of the size of the organisation is how 11 many people it reaches.
- A. Yeah. 12
- 13 Q. And in your statement you say that you believe that, 14 taken together, the organisation reaches about 1 million 15 older people across the UK; is that right?
- 16 Α. Correct.
- 17 Q. In what way?
- 18 A. I suppose the bulk of those numbers come to use our 19 information and advice, particularly through our 20 website, but we also operate a free helpline that is 21 rung by hundreds of thousands of people every year. 22 In addition to that we also have our local Age UKs
- 23 that provide face-to-face services, and then nationally
- 24 and locally we provide friendship services for older
- 25 people as well.

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1 We also -- obviously through our information and 2 advice it covers just about anything any older person 3 ever wants to know about, or indeed their family or 4 carers. We provide friendship services for people who 5 are alone who would like more companionship in their 6 lives, which -- join up a volunteer with somebody who 7 can ring them once a week, that sort of thing. 8 And locally we provide a wide range of direct 9 services in local communities. Some of it is low-level 10 support in people's homes, there is some personal care 11

- delivered, but also things like choirs and pottery 12 classes and keep fit and rambling and all kinds of
- 13
- things you could -- you know, men in sheds and walking 14
- football, all sorts of things like that, which give
- 15 older people the opportunity to come together to sustain 16 their wellbeing, to keep physically fit and mentally fit
- 17 as well
- Q. Thank you, Ms Abrahams. You will see we have 18 19 a stenographer who is trying to take a note of what we 20 both say.
- Yeah. 21 Α.
- 22 Q. I'm trying to speak slowly and perhaps I can just ask 23 you --
- 24 A. I'll slow down, sorry.
- 25 Q. -- on her behalf to try to speak a little more slowly as 179

- Q. Perhaps we can turn to the second page on the screen of your statement, and at paragraph 3, if we can zoom in,
- first of all you give a succinct summary of the aims of
- 4 Age UK?
- 5 A. Yeah
- 6 **Q.** We see that reference to 1 million people a year and you 7 say that you seek to ensure that older people have
- 8 enough money, are socially connected, receive high
- 9 quality health and care, that they're considerable, safe 10
 - and secure at home, and that they feel valued and able
- 11 to participate in society.
- 12 Then you explain how you seek to achieve those ends, 13 referring to research, advocacy, campaigning, providing
- 14 information, advice, public information, and so on.
- 15 Α. Yes.

- 16 Q. Can you maybe just expand a little on those various
- 17 means by which you seek to achieve your aims?
- 18 Certainly. Yeah, so particularly nationally we Α.
- 19 research, campaign and advocate, and that's my job,
- 20 really, with my colleagues, to work with
- 21 decision-makers, to work with government, the NHS. Very
- 22 often we're asking the question: what about older
- 23 people? That's, I guess, our primary role. But also
- 24 talking in detail with policymakers about emerging
 - policy and practice issues.
 - 178
- 1 you answer our questions. It's very difficult to 2 remember. 3 You mentioned that your particular role amongst that 4 whole range of activity that you just described is in 5 the campaigning and the advocacy --6 A. Yeah. 7 Q. -- and you mentioned engaging with the NHS and also 8 policymakers --9 A. Yeah. Q. -- more generally. Are there in fact particular sort of 10 11 liaison points in -- and I'm really, perhaps, asking you 12 about central government now, that you normally engage 13 with? 14 A. Yes. Very often central government, different 15 government departments, will set up groups, they will 16 bring together officials from a government department 17 and also outsiders, people who work for organisations 18 like mine, who know about issues they're interested in. 19 Of course during the pandemic those largely stopped and 20 for a while that sort of contact became more difficult. 21 But it's also the job for people like me to build strong 22 trusting relationships with ministers, with their 23 advisers, and with senior officials. And the same is 24 true with the NHS. 25 Q. I want to come on to ask you about the pandemic and your 180

1		campaigning, advocacy role on behalf of Age UK during	1	
2		that time.	2	
3		Starting chronologically at the beginning, you	3	
4		say this is in fact in paragraph 9 of your report, so	4	
5		it's the fourth page, I'll read out just a sentence from	5	
6		that paragraph, you say:	6	Q.
7		"There were clear indications that the virus itself	7	Α.
8		and public health measures taken in response would have	8	Q.
9		a disproportionate impact on older people."	9	
10	Α.	Yeah.	10	Α.
11	Q.	How quickly in the course of the spread of the virus did	11	Q.
12		it become clear to you in Age UK that it would have this	12	Α.
13		type of disproportionate effect on older people?	13	
14	Α.	Very early on. And I think that was because we knew	14	
15		what your previous witness knew about the evidence, and	15	
16		we could see what was playing out on in the media,	16	
17		particularly from Italy and America, where congregate	17	
18		settings were proving to be places where, once the virus	18	
19		got in, lots of older people were dying or becoming	19	
20		very ill. So that was a very clear warning to us, and	20	
21		I think should have been to everybody else. But	21	
22		of course we also it's our job to understand older	22	
23		people in the round, what their lives are like. So we	23	
24		knew that if there were lockdowns or people's movement	24	
25		were restricted or they restricted their own movements	25	
		181		
1		then trying to engage with government in a constructive	1	
2		way so that they understood what the issues would be for	2	
3		older people, and we could also act as advocates for	3	
4		government actually back to older people. We felt that	4	Q.
5		was part of our responsibility too, because we know	5	
6		we're a trusted voice by older people and we have really	6	
7	_	good channels to lots and lots of them.	7	
8	Q.		8	
9		in that period extend to lobbying for particular steps	9	
10		to be taken, for example most obviously perhaps	10	
11		a lockdown, or particular provision being made for older	11	
12		people?	12	
13	Α.		13	A.
14 15		first two or three months, most of our lobbying happened through the media, because we weren't no one was	14 15	Q.
16		reaching out to us from government on the whole, and we	15	Α.
17		were finding it really difficult to reach in. It was as	10	
18		though the wagons had circled and everyone was very	17	
19		internally focused within government. Our usual routes	10	
20		in were no longer there, so that was a problem for us	20	
20		because those groups that we would normally be part of	20	
21		weren't meeting, and of course there were no	21	
23		face-to-face interactions. So people doing my kind of	22	
23 24		job depend a lot on bumping into people and having that	23	
24		conversation in the corridor and, we couldn't do that.	24	
20		183	20	

1		because they were frightened to go out, that that would
2		have a huge impact on older people, particularly older
3		people living alone or who didn't have good family or
4		neighbour support, who really were suddenly in really
5	~	big trouble.
6	Q.	So in those early, I think you're saying, weeks
7	A.	Yes, definitely. in 2020, what steps did you take as
8 9	Q.	an organisation
9 10	A.	Yes.
11	Q.	to try to react to what you understood?
12	A.	Well, local Age UKs situated in communities across
13	7.0	England, lots of them dropped what they were doing
14		normally and became emergency outreach organisations,
15		particularly delivering food to older people who were
16		stuck at home, collecting prescriptions, transporting
17		older people around, those sorts of tasks. Sometimes
18		off their own bat and sometimes as part of broader
19		community activity. Some of it formally led by councils
20		or by the emergency forums that were set up in local
21		areas.
22		Nationally, I think the first thing we did was we
23		were on the media a lot nationally, and locally, trying
24		to reassure older people, because we were conscious how
25		incredibly scary all this news would be for them, and
		182
1		So we were quite cut off, and it meant that on the whole
2		1 7
		our advice initially was conveyed through the national
3		our advice initially was conveyed through the national media.
	Q.	media.
3	Q.	
3 4	Q.	media. I want to skip ahead just a little bit and if we could
3 4 5	Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16
3 4 5 6	Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your
3 4 5 6 7	Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's
3 4 5 6 7 8	Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate.
3 4 5 7 8 9	Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first
3 4 5 6 7 8 9 10	Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response
3 4 5 7 8 9 10 11	Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the
3 4 5 7 8 9 10 11 12		media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector
3 4 5 7 8 9 10 11 12 13	А.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe
3 4 5 6 7 8 9 10 11 12 13 14 15 16	A. Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	A. Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A. Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was just a complete misunderstanding really of what happens
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	A. Q.	 media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was just a complete misunderstanding really of what happens in care homes. You've already heard about how
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was just a complete misunderstanding really of what happens in care homes. You've already heard about how vulnerable older people in care homes are, but I would
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A. Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was just a complete misunderstanding really of what happens in care homes. You've already heard about how vulnerable older people in care homes are, but I would want to emphasise that many of the people in
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q.	media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was just a complete misunderstanding really of what happens in care homes. You've already heard about how vulnerable older people in care homes are, but I would want to emphasise that many of the people in care homes I mean, you're only in a care home
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q.	 media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was just a complete misunderstanding really of what happens in care homes. You've already heard about how vulnerable older people in care homes are, but I would want to emphasise that many of the people in care homes I mean, you're only in a care home generally these days because you have very significant
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A. Q.	 media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was just a complete misunderstanding really of what happens in care homes. You've already heard about how vulnerable older people in care homes are, but I would want to emphasise that many of the people in care homes I mean, you're only in a care home generally these days because you have very significant health issues. At least 80% of people in care homes
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q.	 media. I want to skip ahead just a little bit and if we could go to paragraph 39 of your statement, please, on page 16 of the document. About four lines down, we see your assertion in that statement that the government's response to the first wave was deeply inadequate. Can you expand on that, please, and tell us, first of all, whether you're referring to the general response or, for example, its particular actions relating to the care sector Yes. and, secondly, what you mean by those strong words? Yes. They are strong words, but I think we do believe they are valid. I think we were thinking in particular of what happened in the care sector, where there was just a complete misunderstanding really of what happens in care homes. You've already heard about how vulnerable older people in care homes are, but I would want to emphasise that many of the people in care homes I mean, you're only in a care home generally these days because you have very significant

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2

4 5

1		as well. So these were very, very vulnerable people.
2		And many care homes didn't have enough staff, even at
3		the beginning of the pandemic. Even before anyone got
4		sick, they were covering with agency staff who were in
5		and out.
6		So we could see what was likely to happen, and yet
7		it seemed to take a long time for policymakers to
8	-	respond to that reality.
9	Q.	I'm going to come back in a moment because, in the
10		subparagraphs underneath paragraph 39, you refer to
11		a few, what you regard as being the sort of crucial
12	A.	Yes.
13	Q.	factors that fed into that
14	A.	Yeah.
15	Q. A.	government response. Yeah.
16 17	_	
17	Q.	But before I do, it's fair to say that you also say in that earlier part of paragraph 39 that things got
19		better, as far as you were concerned, in the way that
20		
20 21	A.	the government responded. Definitely.
21	Q.	The first wave
22	Q. A.	Yes.
24	Q.	was the worst, but
25	A.	
20	7.0	185
1	Δ	Yeah
1 2		Yeah. few months, and what you describe as the deeply
2	A. Q.	few months, and what you describe as the deeply
2 3	Q.	few months, and what you describe as the deeply inadequate government Yeah.
2 3 4	Q. A.	few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify,
2 3 4 5	Q. A.	few months, and what you describe as the deeply inadequate government Yeah.
2 3 4 5 6	Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points
2 3 4 5 6 7	Q. A. Q. A.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes.
2 3 4 5 6 7 8	Q. A. Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors
2 3 4 5 6 7 8 9	Q. A. Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah.
2 3 4 5 6 7 8 9	Q. A. Q. A. Q. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about
2 3 4 5 6 7 8 9 10 11	Q. A. Q. A. Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes.
2 3 4 5 6 7 8 9 10 11 12	Q. A. Q. A. Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those.
2 3 4 5 6 7 8 9 10 11 12 13	Q. A. Q. A. Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those. The first point you make is what you describe as
2 3 4 5 6 7 8 9 10 11 12 13 14	Q. A. Q. A. Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those. The first point you make is what you describe as a sense of fatalism
2 3 4 5 6 7 8 9 10 11 12 13 14 15	Q. A. Q. A. Q. A. Q. A.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those. The first point you make is what you describe as a sense of fatalism Yeah.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	Q. A. Q. A. Q. A. Q. A.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those. The first point you make is what you describe as a sense of fatalism Yeah. an underlying assumption that older people with care
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Q. A. Q. A. Q. A. Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those. The first point you make is what you describe as a sense of fatalism Yeah. an underlying assumption that older people with care needs would be unlikely to survive
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	Q. A. Q. A. Q. A. Q. A. Q. A.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those. The first point you make is what you describe as a sense of fatalism Yeah. an underlying assumption that older people with care needs would be unlikely to survive Yeah.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Q. A. Q. A. Q. A. Q. A. Q. A. Q.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those. The first point you make is what you describe as a sense of fatalism Yeah. an underlying assumption that older people with care needs would be unlikely to survive Yeah. there wasn't much that could be done for them?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	Q. A. Q. A. Q. A. Q. A. Q. A. Q. A.	 few months, and what you describe as the deeply inadequate government Yeah. response to the first wave. As I said, you identify, just below paragraph 39, three points Yes. which you describe as the critical factors Yeah. and I just want to ask you briefly about Yes. each of those. The first point you make is what you describe as a sense of fatalism Yeah. an underlying assumption that older people with care needs would be unlikely to survive Yeah. there wasn't much that could be done for them? Yes.
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- A. Very much so.
- 3 **Q.** Can you briefly give us an outline of those points?
 - A. Yes. I think the single biggest reason things got
 - better was because the government appointed
- 6 Sir David Pearson, as he now is, to come in as their
- 7 adviser and to essentially sort out their response to
- 8 social care, and he was a highly -- he is a highly
- 9 respected leader in local government and also, crucially
- 10 for us, a friend; we knew him. And he then became the
- 11 bridge that had been so obviously lacking, I think,
- 12 between government on the one hand and the outside world
- 13 on the other, and David was able to mediate that, and
- 14 I talked to him a lot. If we saw things we were worried15 about, we could just ring him up and tell him and he
- about, we could just ring him up and tell him and hewould listen and he would act on them, where
- 17 appropriate, and he was also able to ask us for help
- 18 too, and he helped to stimulate the creation of more
- 19 structured engagement with providers of care and
- 20 organisations like Mind and Carers UK, who you've also
- 21 mentioned today.
- 22 Q. Thank you.
 - So that was as things were to develop --
- 24 A. Yes.

23

25 Q. -- but, as I said, just coming back to those first -- 186

1		talked eventually were able to talk to some of the
2		scientists and some of the senior public health figures
3		who were trying to manage this disaster, and I think
4		from them they felt a definite sense that there wasn't
5		much that could be done. If the virus did ever get into
6		a care home, there wouldn't be a lot that you could do.
7		So I think too much I mean, of course we saw what
8		happened, to a degree they were right, but actually it
9		was incredibly patchy and some people not all older
10		people are the same, I suppose that is the most enormous
11		finding that comes out so far from this evidence and
12		some older people were fit and well, they didn't have
13		comorbidities and they were able to withstand it. And
14		even in care homes we saw some older people who caught
15		the virus and were okay, and other care homes that
16		worked incredibly hard and managed to keep the virus out
17		altogether.
18	Q.	Then, perhaps just briefly, if we can go on to the next
19		page, the other two
20	Α.	Yeah.
21	Q.	critical factors that you refer to.
22		First of all, and this is perhaps a consideration of
23		which we heard in the questionnaire responses
24	Α.	Yeah.
25	Q.	a feeling that, at least at the outset, the

 government didn't have any knowledge about the realities of the care sector? A. Yeah, exactly. Q. And perhaps that's the point you've already made that, once A. Yeah. Q Sir David Pearson was appointed, that was remedied. A. Yeah. Q. Well, let's move to the final of the factors then where you say: "Especially in the early months of the pandemic" A. Yeah 	 2 of the care sector? 3 A. Yeah, exactly. 4 Q. And perhaps that's the point you've already made that, 5 once 6 A. Yeah. 7 Q Sir David Pearson was appointed, that was remedied. 8 A. Yeah. 9 Q. Well, let's move to the final of the factors then where 10 you say: 	, ,	 2 of the care sector? 3 A. Yeah, exactly. 	1 government didn't have any knowledge about the realities	1 government didn't have any knowledge about the realities	, ,	1 accomment didn't have any knowledge about the realities	5
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1	Α.	Yes.
2	Q.	sector on the other. Is that the point, perhaps,
3		that's coming here?
4	Α.	Definitely and, you know, you could see it play out all
5		the time at that time. A real sense sometimes, I think
6		more from ministers than certainly rather than
7		officials, that these were private organisations so,
8		you know, it was up to them to look after themselves,
9		this was not part of the state.
10		So I think the fact that social care is so
11		fragmented and in practice, as you know now, it
12		provides an absolutely crucial public service for very
13		vulnerable people but with its fragmented governance
14		it meant there was a reluctance, and actually to begin
15		with an inability really to know how government could
16		help. They didn't have the information, they didn't
17		know who they were, they didn't have a list even of
18	_	they couldn't even write to them, to begin with.
19	Q.	Yes. Thank you.
20		I'm going to move on now, away from the Age UK's
21		liaison with the government and steps taken during the
22		pandemic, and shift focus to more what we talk of as
23		impact evidence. Yes.
24 25	A. Q.	First of all, a few questions about the impact that the
25	α.	190
1		a care package, for my mum at home at the time. So
2		I saw it from my personal experience as well as from
3		Age UK's. And you may remember that at times it became
4		very difficult to actually even get hold of gloves and
5		masks and things like that, aprons, or they were very,
6		very expensive, and it was difficult, particularly for
7		all those people who fund their own care who aren't part
8		of the state system at all, of whom there are hundreds
9		of thousands, to even be able to get hold of those sorts
10		of things, and because of that reality it faced carers
11		and older people with a difficult decision about whether
12		it might be safer to stop care coming in to the home and
13		to try and manage on their own rather than have someone
14		come in who wasn't properly protected, wasn't able to
15		protect themselves. And over time that improved and
16		those things became more widely available.
17	Q.	Yes.
18	Α.	But it was a continuing fear, I think, for many carers.
19	Q.	Moving to another albeit related subject, I'm now
20		looking at page 21 of your report, paragraph 48,
21		end-of-life care.
22	Α.	Yes.
23	Q.	You refer to the fact that, particularly perhaps in

- 24 residential settings but maybe in homes as well --
- **A.** Yeah.

1	Q.	the palliative care, the symptomatic relief	1		are powerful drugs that people need at this point.
2	Α.	Yeah.	2	Q.	Yes.
3	Q.	that would in normal times have been available dried	3	Α.	But yes, tragically for some people, they died without
4		up	4		that help, and I hate to think what some care workers
5	Α.	Yeah.	5		witnessed, and I'm sure they're experiences they will
6	Q.	partly, perhaps principally, because GPs weren't	6		never forget.
7		visiting and the care staff weren't able to prescribe	7	Q.	Moving on, Ms Abrahams, now I'm looking at page 23 c
8		this medication.	8		your report, this is in the section where you deal with,
9	Α.	Yes. I mean, that was particularly a problem in	9		again, a related consequence of the pandemic, which is
10		care homes where very sadly for a time, again quite	10		simply older people not having access to normal, wheth
11		early on in the pandemic, it wasn't there were lots	11		it's primary or
12		of people very, very sick and dying in some care homes,	12	Α.	Yeah.
13		but the people working there couldn't access the drugs	13	Q.	ongoing care.
14		that make that someone feel more comfortable in that	14	Α.	Yeah.
15		situation. And this has to be seen against a context in	15	Q.	And you give perhaps a particularly striking example
16		which palliative care, before the pandemic, during the	16		I'm looking at, as I think I said, paragraph 54 of
17		pandemic and now, is very patchy, and you can be lucky	17		an elderly lady who, on the face of it, was very
18		and be in a part of the country where that is available,	18		seriously injured with spinal injuries, but the type of
19		often through a palliative care team or district nurses	19		injury that one would normally expect to have
20		or a hospice at home service, or where there are none of	20	Α.	Yeah.
21		those resources.	21	Q.	hospital treatment.
22		So but after a time they resolved those issues	22	Α.	Yeah.
23		and got over the problem of things like: was there	23	Q.	But in fact well, perhaps you can tell us, in a few
24		someone with the right qualifications in a care home to	24		sentences explain, but on the face of it appears to have
25		be able to dispense what is controlled medicine? These	25		had very little care indeed.
		193			194
1	Α.	Yes, and I don't think this was I mean, this is	1	Α.	Yes.
2		a particularly grave example of what happened to	2		that was shown at the start of our hearings on
		somebody in that situation, but the situation was not	3		Tuesday of this week, and I know that you recall this
3					
3 4		unusual, at that time, that people were unable to see	4		
4		unusual, at that time, that people were unable to see a doctor face-to-face. Sometimes medical services	4 5		because we've discussed it, but many of us who saw the
4 5		a doctor face-to-face. Sometimes medical services	5		because we've discussed it, but many of us who saw th impact video will remember one elderly lady who
4 5 6		a doctor face-to-face. Sometimes medical services used were starting to use video calls and things like	5 6		because we've discussed it, but many of us who saw th impact video will remember one elderly lady who described her condition. I think probably of all of the
4 5 6 7		a doctor face-to-face. Sometimes medical services used were starting to use video calls and things like that, but of course I know you may ask me about the	5 6 7		because we've discussed it, but many of us who saw the impact video will remember one elderly lady who described her condition. I think probably of all of the people who appeared in that video she was the only on
4 5 6 7 8		a doctor face-to-face. Sometimes medical services used were starting to use video calls and things like that, but of course I know you may ask me about the fact that many, many older people do not use digital	5 6 7 8	Α.	because we've discussed it, but many of us who saw the impact video will remember one elderly lady who described her condition. I think probably of all of the people who appeared in that video she was the only on who doesn't seem to have had Covid herself
4 5 6 7 8 9		a doctor face-to-face. Sometimes medical services used were starting to use video calls and things like that, but of course I know you may ask me about the fact that many, many older people do not use digital technology, so they were unable to take advantage of	5 6 7 8 9	A. 0	because we've discussed it, but many of us who saw the impact video will remember one elderly lady who described her condition. I think probably of all of the people who appeared in that video she was the only on who doesn't seem to have had Covid herself Yeah.
4 5 7 8 9		a doctor face-to-face. Sometimes medical services used were starting to use video calls and things like that, but of course I know you may ask me about the fact that many, many older people do not use digital technology, so they were unable to take advantage of that. So they might have a phone call, as here.	5 6 7 8 9 10		because we've discussed it, but many of us who saw the impact video will remember one elderly lady who described her condition. I think probably of all of the people who appeared in that video she was the only on who doesn't seem to have had Covid herself Yeah. or in fact she doesn't mention anyone else she
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4 5 7 8 9 10 11		a doctor face-to-face. Sometimes medical services used were starting to use video calls and things like that, but of course I know you may ask me about the fact that many, many older people do not use digital technology, so they were unable to take advantage of that. So they might have a phone call, as here. But possibly, had a doctor seen this lady straightaway, he would have identified how seriously	5 6 7 8 9 10 11	Q. A.	because we've discussed it, but many of us who saw the impact video will remember one elderly lady who described her condition. I think probably of all of the people who appeared in that video she was the only on who doesn't seem to have had Covid herself Yeah. or in fact she doesn't mention anyone else she knows Yeah.
4 5 7 8 9 10 11 12		a doctor face-to-face. Sometimes medical services used were starting to use video calls and things like that, but of course I know you may ask me about the fact that many, many older people do not use digital technology, so they were unable to take advantage of that. So they might have a phone call, as here. But possibly, had a doctor seen this lady straightaway, he would have identified how seriously unwell she was. And this is one of the things we live	5 6 7 8 9 10 11 12 13	Q. A.	because we've discussed it, but many of us who saw the impact video will remember one elderly lady who described her condition. I think probably of all of the people who appeared in that video she was the only on who doesn't seem to have had Covid herself Yeah. or in fact she doesn't mention anyone else she knows Yeah. or her family having had Covid. But she spoke about
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1	Q.	
2		a sociable person but now
3	Α.	Yeah.
4	Q.	
5		people.
6	A.	Yeah.
7	Q.	Is that a typical story that you hear in the course of
8 9	Α.	your work? I'm not sure it's typical, but we hear from many older
10	ς.	people in that position, and so do our local Age UKs.
11		So one of the new services some of them have created is
12		actually helping older people to get out of their own
13		homes and begin to walk around again, and including
14		using transport, which is a particular fear for some
15		older people. But of course for many it's too late. It
16		was a different it was a different lifestyle for
17		sufficiently long time that they're not able now to be
18		able to go back to how they were.
19		So, yes, I'm afraid there are many older people who
20		lead much, much more constrained lives now than before
21		the pandemic.
22	Q.	Some of the concepts you describe in your statement are
23		physical and mental deconditioning
24	Α.	Yes.
25	Q.	
		197
4	•	of the challeness. These means the challeness second as 0.0 and
1	Q.	
2	Q.	following of your report, so page 32.
2 3	Q.	following of your report, so page 32. Just two points to draw out. One is that you
2 3 4	Q.	following of your report, so page 32. Just two points to draw out. One is that you explain that because some of the clinics, memory clinics
2 3 4 5	Q.	following of your report, so page 32. Just two points to draw out. One is that you explain that because some of the clinics, memory clinics and so on, and activities that they might in normal
2 3 4 5 6		following of your report, so page 32. Just two points to draw out. One is that you explain that because some of the clinics, memory clinics and so on, and activities that they might in normal times have been attending were no longer functioning
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2 3 4 5 6 7	А.	following of your report, so page 32. Just two points to draw out. One is that you explain that because some of the clinics, memory clinics and so on, and activities that they might in normal times have been attending were no longer functioning
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2 3 4 5 6 7 8 9 10 11 12	A. Q.	following of your report, so page 32. Just two points to draw out. One is that you explain that because some of the clinics, memory clinics and so on, and activities that they might in normal times have been attending were no longer functioning Yeah. they had to be in order to control their conditions, they were then either had the doses of their medication increased or were put on medication otherwise they wouldn't have been on, with some quite serious side effects.
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Yes. 1 Α.

2

- Q. And also an effect on mental health and much higher
 - rates of depression and self-harming and suicide
- 4 amongst --
- 5 Yeah. Α.
- . .

6	Q.	older people.
7	Α.	Yes, we've had to provide new training for some of our
8		helpline staff on how to cope with people who are
9		ringing up in great distress, and that only happened
10		during and after the pandemic. It's undoubtedly exacted
11		a toll on many older people, that anxiety, and also
12		as in the case of the lady on the film a great loss
13		of confidence, coupled with the fact that if you stay
14		still and you don't move around so much, as an older
15		person, then you stiffen up and your muscles tend to
16		waste and then it's physically very, very difficult to
17		be able to get around.
18	Q.	You mentioned earlier in your evidence the great number
19		of people I think you were actually referring to
20		care homes, but no doubt generally of older people
21		who suffer from dementia.
22	Α.	Yeah.
23	Q.	In your statement you do say a little about the
24		particular impact on that group of people
25	Α.	Yeah.
		198
1		the pandemic, and actually many of them have not
2		re-opened, so there's an ongoing problem today.
3	Q.	At paragraph 82 of your report, so over on the next
4		page, you give an example of a very particular concern
5		of dementia natients who were at home and wandered off

- 5 of dementia patients who were at home and wandered off, 6 left the house and their carers, their family being
- 7 uncertain as to whether they could even go and try and find them because they might be breaking lockdown 8
- 9 regulations.
- 10 A. Yes.
- **Q.** From the way you put it, it sounds as though that was 11 12 not an isolated case but something that you heard of more than once? 13
- 14 A. I think we certainly heard of lots of different ways in 15 which ... people trying very hard to stay the right side
- 16
 - of the law got in the way of being able to do the things
- 17 they wanted to for their loved ones, even if that was being afraid to go out for a walk because they read that
- 18 19 the police had arrested someone who'd sat on a bench,
- 20 those sorts of things. And so, you know, none of these
- 21 things were probably intended, but it was a time when
- 22 people were very -- and lots of older people -- most
- older people are very law-abiding and they don't want to 23
- 24 do the wrong thing. So these may well have been older
- 25 carers who were worried about going out, and indeed 200

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1	particularly at a time when they were being told to take	1	INDEX
2	extra precautions.	2	PAGE
3	MR O'CONNOR: Yes. Ms Abrahams, thank you very much.	3	MRS CATRIONA MYLES (sworn) 1
4	As I said at the start, we have your witness statement.	4	
5	There's far more detail in there than I have been able	5	Questions from LEAD COUNSEL TO THE INQUIRY 1
6	to cover today, but those are all the questions I wanted	6	
7	to ask you. Thank you very much.	7	PROFESSOR JAMES NAZROO (affirmed) 21
8	THE WITNESS: Thank you.	8	
9	LADY HALLETT: Extremely grateful, and I suspect we might be	9	Questions from LEAD COUNSEL TO THE INQUIRY21
10	seeing you again during the course of this Inquiry, but	10	
11	there is a great deal of information in your statement,	11	Questions from MR WEATHERBY KC
12	and I'll consider it all very carefully.	12	
13	THE WITNESS: Thank you very much.	13	PROFESSOR PHILIP BANFIELD (affirmed) 80
14	LADY HALLETT: Thank you very much for your help.	14	
15	THE WITNESS: Thank you.	15	Questions from LEAD COUNSEL TO THE INQUIRY80
16	(The witness withdrew)	16	
17	MR O'CONNOR: My Lady, that concludes our business for	17	Questions from PROFESSOR THOMAS KC 114
18	today.	18	
19	LADY HALLETT: Thank you very much.	19	Further questions from LEAD COUNSEL TO THE 118
20	So we meet again at 10 o'clock tomorrow. Thank you.	20	INQUIRY
21	(4.30 pm)	21	
22	(The hearing adjourned until 10 am	22	Questions from THE CHAIR 119
23	on Friday, 6 October 2023)	23	
24		24	
25		25	
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