## Thursday, 5 October 2023

| (10.00 am) | 2 |
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| LADY HALLETT: Mr Keith. | 3 |
| MR KEITH: My Lady, may I call, please, Catriona Myles. | 4 |
| MRS CATRIONA MYLES (sworn) | 5 |
| Questions from LEAD COUNSEL TO THE INQUIRY | 6 |
| LADY HALLETT: Please say if at any stage you need just to pause. I appreciate how difficult it is. | 7 8 |
| A. Thank you. | 9 |
| MR KEITH: Could you commence, please, by giving us your full name. | 10 11 |
| A. I'm Mrs Catriona Leanna Myles. | 12 |
| Q. Thank you very much, Mrs Myles. You have kindly provided the Inquiry already with a statement, INQ000282334. Is that a statement that you recall signing in fact on 25 September of this year? | 13 14 15 16 |
| A. It is. | 17 |
| Q. Thank you. In that statement, Mrs Myles, you describe how you are a member of Northern Ireland Covid Bereaved Families for Justice. Is that a branch of the UK-wide Covid Bereaved Families for Justice group? | 18 19 20 21 |
| A. It is. | 22 |
| Q. I'm going to ask you in a moment some more detail about the aims of the group, what it seeks to achieve, what it's done, and what it hopes still to do. Before I do | 23 24 25 | 1

actually -- one of the strands to our campaign is that we want more services in place for those that have had their lives destroyed by Covid.
Q. Is it the view of your members, to which your organisation provides a collective voice, that mistakes were made and that where it is possible to correct those mistakes, mainly to make sure that they never happen again, you've sought to campaign for change?
A. Absolutely. I mean, we are very well represented here by our legal team, but the group -- it would be a travesty if what happened to us and our loved ones was allowed to happen again. So really, the main thing that we want from this Inquiry is accountability and reform.
Q. By accountability, do you mean an exploration of what went wrong? Is that what is meant by accountability?
A. I mean, obviously we have got a very negative experience of the pandemic --
Q. Of course.
A. -- but we're not saying everything went wrong, but we just want the truth -- the truth to be out there, and to know that if and when something like this hits our shores again -- not that Covid in itself has actually gone away, like some people think -- that we will be better prepared, and that there will be nowhere for those in power to hide.
that, could you give us just a brief overview of what the general aims of the group are?

Does it, for example, focus its attention on providing support to the bereaved in Northern Ireland, campaigning for change where change is possible, and also holding decision-makers to account for decisions that the group believes contributed in any way towards the bereavements which your members have suffered?
A. Absolutely. Our group, obviously, we look at it from a Northern Ireland perspective. We are a little bit different, a little bit out there, but we are very much under the umbrella of the UK group, and we have a fantastic working relationship with them also.
Q. Does your group provide, firstly, bereavement support to its members?
A. Yeah, we -- we're a group who never thought we would ever come together. We have a shared loss. Unfortunately shared trauma. But we support each other. We source bereavement support for members. The leads of the group are fantastic guides. They're there for us 24/7. In that respect, we're very lucky.
Q. Is that bereavement support in terms of psychological, financial, emotional or all those areas?
A. The group will signpost, but as you -- I'm sure you're aware the services are extremely limited, and that is 2
Q. Do you know whether your group has sought to take up the battle with the government, for example writing to it, pointing out areas where you believe mistakes were made, where things could be improved, and where, for the future, things could be done better? Is it a -- has it been a campaign waged by correspondence and meetings or through the press? How has it worked?
A. Unlike your witnesses yesterday, I am a member of Northern Ireland Covid Bereaved, I'm not actually one of the founders, but our two leads have been involved with the government, liaising with the government from early, early days of the pandemic, actually before the inception of our group, to ensure that vulnerable people in care homes and hospitals have a voice. And really, I think that's one of the reasons that they decided to form our group, because obviously our -- we're governed very differently in Northern Ireland, when we have a sitting government, and our leads have been chipping away at this since April of 2020, and they continue to do so.
Q. Is that when --
A. And hold down full-time careers.
Q. Forgive me. Is that when the group then commenced, around about April --
A. No. We had all kind of linked up on Facebook as and
when our relatives died. The group really -- and we also, most of us, had joined the UK group at its inception. As time went on, we realised that with the devolved situation that we kind of needed our own representation, because really unless you're there on the ground in Northern Ireland you don't really get how a lot of things work. So our group came about around the January of 2021.
Q. Thank you.

Now may I please ask you about your own father, because of course you suffered a bereavement as well. He was a teacher, was he not, and, we gather, a very talented popular musician?
A. He was.
Q. Prior to his death, in fact for some years before his death, did he suffer from a gallstone condition which then changed into something known as necrotising pancreatitis?
A. That's right.
Q. Which is a very unpleasant and painful condition which will lead to the sufferer then developing severe diabetes?
A. Correct.
Q. At the beginning of the pandemic, with the restrictions that were then placed upon everybody, was it extremely 5

Mrs Myles, you said his medication -- I'm sorry, I didn't catch the word.
A. Titrated. So maybe the dosages changed, you know, or --

LADY HALLETT: Oh, I see. Titrated is the word, thank you.
A. Yes, yes.

LADY HALLETT: Thank you.
MR KEITH: Perhaps due to the difficulty in getting medical attention, being able to get the appointments, to get the consultations, did there come a time when he was given a diagnosis of secondary liver cancer, effectively --
A. Yes.
Q. -- which turned out, in fact, to be a wrongful diagnosis, he was then diagnosed with, in effect, primary liver cancer?
A. That's right. By the September of 2020, Dad had been rushed into Antrim Area Hospital. There they found a lesion on his liver. It took a few weeks to get a diagnosis because there was issues this in that every time Daddy needed to attend a hospital appointment, he had to isolate for two weeks, get a Covid test at an acute hospital setting, wait for the results, wait for the appointment, attend the appointment, whereby he had broken his isolation, and then go home and wait another two weeks to get -- to be able to go back to get 7
hard for him to be able to manage the treatment that he was receiving, in terms of being able to see consultants and medics and so on, because of the practical difficulties associated with isolating himself before he could see any medic or consultant or so on?
A. Just very quickly before I go on to that, you have to remember that Northern Ireland's healthcare system is in the worst state of all the UK healthcare systems, our waiting times are ridiculous, and this was prior to the pandemic. So by the time we locked down, Daddy I think had maybe a dozen to 15 attempts to get a face-to-face appointment with a GP. They all failed. He just was -had his medication titrated, his dosages titrated --
Q. Mrs Myles, I'm just go to ask you to slow down a wee bit, if you'd be so kind. It's quite difficult for our stenographer to be able to keep up.
A. Okay, sorry. And maybe new prescriptions added into his regime. So we -- you know, as a family, we very much feel that the scaling back of GP face-to-face appointments led Daddy down a path that potentially, if he had gotten to see his GP, it might not have ended up the way it ended up.
Q. In the event --

LADY HALLETT: Sorry, just before you do, sorry to interrupt.

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the results of said appointment.
So when Daddy was told that he had a rare, aggressive liver cancer, we didn't have many two weeks to play with.
Q. And of course all the time the cancer was growing all the more aggressively?
A. Absolutely. And the -- sorry, the really sad thing is at the outset we were told Daddy could be cured, but unfortunately, by the time he met his oncologist, and weeks and weeks had lapsed due to policy and protocol and procedure within the hospital system in Northern Ireland, Daddy was then deemed terminal.
Q. Was that on 27 November of 2020?
A. That's right.
Q. Because he was by then, and he had been told for the first time on that day, terminally ill, and because his condition was extremely poorly, did he have to go -- in fact was he dropped off at A\&E very shortly thereafter?
A. Yes, the next morning we got a call to say that his bloods were through the roof and that he was -- his liver was beginning to fail and we needed to get him to the nearest A\&E department immediately.
Q. What hospital was he made an in-patient in?
A. So my brother dropped him off at Antrim Area A\&E department, and my brother tells me that he remembers 8

Daddy waving back at him with his little bag like a scared schoolboy.
Q. Did he leave the hospital again?
A. In a box.
Q. Do you know whether he moved wards when he was in hospital?
A. Daddy was moved three times, and whenever I -- after Daddy had passed, I got his hospital notes, and in his records it clearly states in the nursing notes "Gerry has been moved wards due to possible exposure".
Q. From Covid?
A. That's right.
Q. Do you know whether or not he was tested for Covid?
A. Daddy was in a ward with symptomatic patients, I'm not sure which of the wards and at what time, but on day nine he tested positive for Covid.
Q. He was given what is called end of life care?
A. That's correct.
Q. And your brother was the only member of your family who was permitted to see him, to the extent that he was, and I'll come on to that in a moment. Did you see him when he was in hospital?
A. No, I didn't see my father from the day that he was told he was terminally ill, 27 November, and my brother -- we were given the option that one family member could come 9
lucky. We were allowed to invite 30 people to our church. But Daddy died on 23 December, and I still have -- had a young family at the time, and on 23 December we were preparing for Santa Claus arriving. I remember waking up on the 24 th, and bringing the turkey out of my fridge and thinking about my father lying alone in a fridge in a dirty hospital gown on his own on Christmas Eve.

Christmas Day went by in a blur, all our family separated. The funeral plans had to happen over the phone, with three separate households not even able to come together to plan the small funeral.

I checked out. I just felt that if it wasn't going to be a funeral worthy of my father's life, I didn't really want any part in it. We went to visit him in the chapel of rest, and in Northern Ireland wakes are -wakes happen before funerals in Northern Ireland, and they're a massive part of our culture, and they're a massive part of a grieving ritual. That didn't happen. And when I visited Daddy in the chapel of rest, whereby I felt he should never have had to have been -he should have been in his own home, although deceased -- I just remember looking at that coffin and thinking to myself: that could be a bag of potatoes in that coffin, how do I know what's in that coffin?
and say goodbye through a tiny slit of glass in a six-bay ward, where my father was three beds down, and the person would be wearing full hazmat protection. So by my reckoning that meant that this area here (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 anybody saw him.
Q. None of you were present, therefore, at the time of his death. Do you know even the time of his death?
A. 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 8 pm .
Q. Was there a funeral?
A. We were lucky, in the second wave, if you can call it 10

It was one of the most detached, surreal experiences of my life, and that was on Boxing Day. So
Christmas Day was the weirdest experience. I can barely explain it.
Q. 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?
A. There are wide-ranging concerns, and there are themes and strands to lots of those concerns.
Q. 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 a big area of concern?
A. That has been a theme. And I'm very conscious that when I finish today you're going to hear from people with 12
lots of letters to their names and things, experts in their field, but our group and the people I represent, we're the experts on what happens when it all goes very wrong, and one of the opinions in our group is that Stormont basically did what Westminster told them to do.
Q. None of us are necessarily privy to government decisions behind the scenes, how they're made, at least until there's an Inquiry of this sort. From your perspective, and the perspective of your members, was there a degree of clarity? Were you, do you feel, properly informed as to the developments which flowed from the decisions that were being made? Were you kept, in essence, in the loop, do you feel?
A. There certainly wasn't clarity. If anything,
the opposite. Very often you would watch the reports in the evening and the updates, and it wasn't clear whether we were following what Westminster were saying or waiting to hear what the devolved government would tell us to do. There needed to be more cohesion and more communication, in our eyes, with the two governments, and it seemed, particularly in hindsight, that Northern Ireland didn't really have a seat at the table with the big boys, they were just told: this is how much money you're getting, this is what you should do. You know, and that's what happened. 13
people, it was very hard for normal people to work out 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?
Q. And would more people have survived?
A. Absolutely.
Q. 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 levels of medical care that they were absolutely entitled to receive?
A. Absolutely. Within my statement, we had a case whereby

And generally there was a two-week lag, we found, with Northern Ireland, so that if a new rule came in here, we were sort of made to feel that our guys were going to go away and think about it, but in reality two weeks later they just stood up and told us to do what had been said here two weeks prior.
Q. So has concern also been expressed about the timings of the decisions that were made? So, for example, the timings of decisions in relation to travel restrictions or social restrictions or society-wide interventions such as the lockdowns?
A. Absolutely. One standout is the fact that, of course, there's no denying -- doesn't matter what political persuasion you are, we share an island with the Republic of Ireland and the rules and legislation set out in Westminster didn't really allow for the fact that we had a land border that -- whereby meant that in some cases, on, for example, the Derry and Donegal border, you could have a house on one side of a fence having to abide by one set of rules and legislations and yet the neighbours on the other side of that fence had a completely different set of rules. And then because of that you had people that were moving about through the two different regions for work purposes, social purposes, et cetera. It got so confusing at times for 14
a lady felt her mother was being telephone triaged with some sort of form, and because of her age was deemed not worthy of any life-saving treatment.

I remember reading an article by Sandy Toksvig, and in it she said there shouldn't be a hierarchy for life, and it seemed very much like, nearly a fatalistic approach, that if you had underlying issues, if you're an ethnic minority, if you were aged, whatever that is, in society -- you know, at what age do you become aged, I don't know -- that those lives were more expendable and weren't worthy of the same interventions.
Q. Is palliative or end of life care also another issue, another area about which a great deal of concern has been expressed?
A. It's an issue that's extremely triggering for our families. Lots of families, including my own, feel that the end of life pathway, even the structure that they were using, the Liverpool Pathway, years ago was deemed inappropriate, and that the medications used really hastened death in lots of cases.
Q. Did many of your members lose loved ones in the care sector?
A. Absolutely. We have massive concerns with -- that we now know that the care sector was flooded with non-tested residents at the beginning of the Covid 16
outbreak. But we also had a situation whereby maybe someone was being transferred from a care home to a hospital, the families weren't maybe being told that that person was symptomatic of Covid, that person unfortunately maybe passed away in hospital, but the care home were never informed by the hospital that that person had Covid, therefore the other residents had been exposed.

And another issue is the isolation for residents in care homes. You know, it must have just been like prison to those poor people at that time, you know, being basically locked in tiny square boxes for many hours of the day, you know, and having zero autonomy.
Q. You've described your own father's funeral. Are the restrictions that were placed on funerals and wakes and social rituals associated with the passing, is that also another area about which a great deal of concern has been expressed?
A. Yes, and in Northern Ireland particularly it's of such importance to us within our culture. I mean, from my perspective, we were actually one of the -- being wave 2 -- one of the luckier families, in that we did get to have a small -- pathetic -- funeral, but at the very start -- and some people might say, well, the government didn't know what was coming down the track. 17
people think, you know, "Christmas parties, it was Christmas", we have a family that when their parent was dying, alone, and it was May of 2020, we now know, and it's in the public realm, that one of these parties was going on. And it's just disgusting. It's galling that the same people that were making these draconian rules thought, "Rules for some", but were above the rules and, "Sure, what they don't know will never hurt them". But the thing about the modern day is the truth will always come out. And for us, we get very angry about it, and we don't -- you know, public that haven't been touched by this, I get it, if it doesn't visit your door, you don't really get it, but we're still living through this.

And so many people have so many opinions. We have the Covid deniers, the arguments about vaccinations, we have all that, and we still have to try to live our lives, process our grief, and hold our loved ones' memory in our heart against the backdrop of all the politics that are going around, you know, surrounding Covid. So when there are likes of these parties going on, it just adds insult to injury for the bereaved families.
MR KEITH: Mrs Myles, thank you very much.
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 l'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 so traumatised, having described the circumstances of your father's death, and I'm truly sorry, and I will remember all the people you've described. As you know, I've met some of them and I hope to meet some more during the course of this Inquiry, but I will remember 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.
LADY HALLETT: It must have been particularly difficult with them.
THE WITNESS: Yeah. And, sorry, my youngest son has autism, which played a factor, and I had meant to mention that as one of the vulnerabilities as well. You know,

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special needs people were really impacted terribly.
LADY HALLETT: Yes. Well, thank you very much indeed, you have been extremely brave.
THE WITNESS: Thank you, my Lady.
(The witness withdrew)
LADY HALLETT: Right, I think the idea is that we have 6
a quick break.
MR KEITH: Please.
LADY HALLETT: Five minutes, please.
(10.34 am)

## (A short break)

(10.40 am)

MR KEITH: Professor Nazroo, please.

## PROFESSOR JAMES NAZROO (affirmed)

 Questions from LEAD COUNSEL TO THE INQUIRYMR KEITH: Please be seated. Could you commence, please, by giving us your full name.
A. Yes, my name is James Nazroo.
Q. You are in fact Professor Nazroo, so that's how I'm going to call you, if I may.

Professor, whilst you give evidence, could you please remember to keep your voice up so that we may clearly hear what you have to say, and also speak as clearly as you can so that the microphone can pick up your evidence. And also, lastly, due to the complexity
A. Indeed.
Q. Thank you.

That report is at INQ000280057.
Did you in fact sign that report as being a report that was prepared based on facts within your knowledge and obviously true to the best of your knowledge and belief and in accordance with your professional expert views?
A. I did.
Q. And you did, I think, on 15 September of 2023.

Remaining on that front page, could we start, please, with your professional qualifications. Are you a fellow of the Academy of Social Sciences, a fellow of the British Academy and professor of sociology at the University of Manchester?
A. I am.
Q. For many years, and this is the area in which you are one of the world's leading experts, you've conducted research on issues of inequality, social justice and health, with a focus on ethnicity and race, ageing, gender, and the interrelationships, intersectionality, between these topics or these areas?
A. That's correct.
Q. At the end of that paragraph, you say that you're a member of the governing board of the NHS Race and 23
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?
A. It is.
Q. Was that report prepared by both of you?
A. It was.
Q. 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 the views of both of you?
A. It will reflect the views of both of us. We've worked together for many years and have reached this position together.
Q. And of course you debated the many issues raised in your report when you compiled it together?

Health Observatory and co-chair of its academic reference group. What is the NHS Race and Health Observatory?
A. 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 well as evidence.
Q. How long has that observatory been in existence and how long have you been a member of the governing board?
A. 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.
Q. Post-pandemic, in fact?
A. Post-pandemic, yes, indeed.
Q. All right.

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

I want to commence the examination of your report, 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 reference later in your report.

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Your report in general terms addresses ethnic inequalities in the areas or the fields of health, society and the economy.
What is meant by ethnic inequality? Is that a general compendious term that refers to all the many ways in which there may be an inequality in day-to-day life, in that particular person's existence, in the resources to which they have access, the services that they receive from the state, based in some way upon their ethnic grouping?
A. Yes, on the ethnic category within which they belong.
Q. This is, of course, an issue that government has paid attention to, with varying degrees of success or not, over the years. Is there in place legislation to try to promote ethnic equality?
A. There is, and the most recent legislation is the Equality Act of 2010.
Q. Over time, and particularly since 2010, have a variety of government bodies, including Public Health England, tried to assess, tried to -- carried out research upon and tried to assess the actual state of ethnic inequality in the United Kingdom?
A. They have.
Q. Public Health England prepared a report in 2018 called "Local action on health inequalities. Understanding and 25
she was Prime Minister, but had a precursor when David Cameron was Prime Minister. And that collated data from across government departments on the extent of ethnic disparity. So including education, employment, housing and so on, health.
Q. Does the government publish facts and figures that it's derived from its own research on publicly accessible websites?
A. Yes, absolutely. So the Race Disparity Unit has a publicly accessible website where it presents headline figures, but also allows access to more detailed reporting on those headline figures.
Q. Are those figures in fact -- or are they published under headings such as the government's Ethnicity facts and figures website, and the government Race Disparity Audit website?
A. Indeed, yeah.
Q. So that's the government's own internal research, if you like. for Emergencies, which was stood up, to use a terrible modern idiom, during the pandemic, did that have a subgroup which focused on ethnicity?
A. It did. So there was a SAGE Ethnicity subgroup that I believe was established autumn 2020, something like 27

SAGE, which we know is the Scientific Advisory Group
reducing ethnic inequalities in health". As it says in the title, that was a report concerned with health inequalities, but has government generally sought to try to address the issue of ethnic inequality across society?
A. So there have been a number of inquiries and investigations by government into ethnic inequalities. Many of those have focused on very specific areas like employment or policing, more recently there has been the Commission on Race and Ethnic Disparities, chaired by Dr Sewell, which reported in 2021 and did look across the spectrum of society, so it looked at a range of features of society.
Q. What other areas of research have been carried out, or what other government bodies or non-governmental organisations have carried out research into the state of play of ethnic inequality? So the ONS, SAGE, of which we've heard of course a lot in this Inquiry, the government's own Race Disparity Unit, can you list or identify the main players in this field of research?
A. Yes. So prior to the pandemic, there were a number of endeavours examining ethnic inequalities. The Race Disparity Unit, set up within the Cabinet Office, is one example of that. In fact, perhaps a prominent example of that. Established by Theresa May, I believe, when 26
that. I think that's the correct date.
Q. You've mentioned the ONS. Does the ONS carry out sometimes year by year, on other occasions less frequently, surveys across the United Kingdom to try to evaluate or identify and evaluate the state of play?
A. It does indeed, yeah.
Q. So does it carry out, for example, a census from time to time?
A. Every ten years.
Q. Every ten years. Does it carry out any censuses that are more specific? So, for example, focused on social impacts and, we'll come to this in a minute, coronavirus or ethnicity?
A. It carries out the annual population survey, which is a very large survey, so enables data users to say -- to examine and to say something about ethnic differences across a range of outcomes. And it carries out a number of other very important surveys, like the Labour Force Survey that we use to examine ethnicity inequalities in the labour market.
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 impacts on different ethnic groups in the UK"?

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A. It did.
Q. And did it in 2021 carry out a census entitled "Ethnic group consensus"?
A. Sorry, entitled?
Q. "Ethnic group consensus 2021"?
A. I don't know of that report.
Q. I can say with absolute certainty, Professor, that is probably my fault, not yours. It may be that I have misled myself. But are you aware of any ONS work done by way of a census specifically focusing on ethnicity?
A. So in 2021 a census was carried out which includes collection of data on people's ethnicity.
Q. Ah, it just may not therefore have been entitled as I read it out.
A. No, so the census covers the whole population. ONS are responsible for the England and Wales census, and within that they collect data on people's ethnicity.
Q. The ONS also prepared a report on mortality, did it not?
A. It did.
Q. Again, was that a report that postdated the time that you were looking at, so 2021 in fact?
A. It did. So that report grew out of their work around ethnic differences in death rates from coronavirus, where they did some very innovative work linking death certificates to census records to estimate differences 29
practices, racism, the lack of access of those in ethnic groups to social and economic resources, the prejudice which they encounter and so on? So it was a very wide-ranging report?
A. It was a very wide-ranging report that looked across the board in terms of ethnic disparity.
Q. Now, you've introduced a number of reports, the majority of which in fact postdate 2020. You were asked, were you not, to look specifically at what material was 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?
A. Indeed.
Q. 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?
A. 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 were not available at the time that the coronavirus
in the prevalence of risk of death or, you know, of death, and then they extended that work to examine the period prior to the coronavirus pandemic. Though, as you say, published in 2021.
Q. And importantly, that report or that survey of facts and figures addressing mortality rates was a survey or a report that focused on the links between ethnicity and mortality, so that is to say which ethnic group suffered the highest rates of mortality, whether, therefore, it would impact -- or whether you were white or whether you were a member of an ethnic group would affect the risk of mortality?
A. Yes, exactly, they estimated mortality rates by ethnic group.
Q. We'll come back to that report in greater detail later, because I know you have some views on the methodology behind that report and therefore the weight which can be placed upon it.

You have mentioned Dr Sewell's report. Was that a report from 2022, March 2022, or was it March 2021?
A. March 2021.
Q. March 2021. And again, that's obviously a report that postdates the pandemic or the commencement of the pandemic. Was that a report which looked at, in very general terms, not just mortality but discriminatory 30
pandemic began.
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?
A. Certainly the evidence that we produce should be considered in the light of the more recent reports, indeed.
Q. 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?
A. I did.
Q. 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 ethnic minority people had been in 2004, and the 32

Department for Communities and Local Government's citizenship survey, which oversampled ethnic minority people and has been a key source of data, had its final round of funding in 2011?

So although there were reports, they were, at least by comparison to the post-pandemic position, fewer and further between, in part because of a lack of investment in funding?
A. Yeah, that is correct. The health survey for England, just to clarify, is perhaps the most important annual monitoring of the health of the population. A standard survey does not contain -- because of the relatively low numbers of ethnic minority people in the population, a standard survey does not contain enough ethnic minority people to be able to examine ethnic differences. So the last time we were able to do that -- or the last time we had data to enable us to do that was in 2004. And a similar story goes with the citizenship survey. Neither of those surveys have been resourced to include ethnic minority oversamples since then.
Q. For good reasons of fairness, is it right to say that, since the pandemic, funding has become somewhat more available? I believe that more funding has been provided by the NIHR and by government and, therefore, 33
and made recommendations for how we might approach addressing ethnic inequalities in health.
Q. If we turn over the page, to "Topic 1: Definitions", could you please assist us with some of the basic terminology, Professor.
"Ethnicity" and "race" are words that, of course, are in extremely common use and it's not altogether clear what we always mean by them when we refer to them.

What is, in a sentence, if you can do it, ethnicity?
A. So ethnicity is collective identity, an affiliation to a grouping, based on ancestry, culture, religion, geographical origins, and so on.
Q. So in essence, if you'll forgive me, who they are?
A. One dimension of who they are.
Q. One dimension of who they are.

By contrast, is "race" a word which refers to shared physical features, most often skin colour?
A. Yes. This is how 1 use the term "race".
Q. Is that why racism, the social scourge that it is, is a reflection of behaviour which is outrageously and unfairly based upon, in the main, the colour of someone's skin?
A. Not just the colour of someone's skin. So racism also incorporates notions of cultural inferiority as well.
Q. Yes, I said in the main, but yes, thank you.
that in part is why there have been more surveys since the pandemic than there were before?
A. Yes, that's correct. Just to add one additional bit of clarification.
Q. Please.
A. There is also the UK Longitudinal Household Study, known as Understanding Society, which has been running throughout the period that we're talking about, so from 2010, I think, onwards, and that oversamples ethnic minority people. So that has been a very important source of data, funded by the Economic and Social Research Council.
Q. And in fact you refer to that household survey in this same paragraph, alongside the references to the census in 2021, to which you've already made reference?
A. Yeah. And as you asked, there has been additional funding since the beginning of the Covid pandemic to investigate ethnic differences.
Q. Finally, in paragraph 8 , further down the page, you refer to the Public Health England report of 2018. How important, in the general scheme of things, was that report?
A. I believe that report was very important. It brought together existing evidence on the patterning of ethnic inequalities in health, it examined underlying causes,

At paragraph 11, you refer to racism, and you say one of the elements of racism, one of its, perhaps its most pernicious, elements, is a racist approach to a person often entails the placing of them and their cultural group on a hierarchical scale. What is meant by hierarchical scale?
A. So it's how we evaluate each other on the basis of our ethnicity and the notion that some ethnicities are more valued than others.
Q. And by implication, some are considered inferior to others and are therefore marginalised and excluded?
A. Yep.
Q. All right.

What then are inequalities?
A. Inequalities are unfair outcomes as a consequence of processes related to inferiority, superiority and access to resources.
Q. The consequences?
A. The consequences.
Q. And in order to aid the study of this area, is racism conceptually separated into three different areas: structural, institutional and interpersonal?
A. Yeah, so this is the approach that I take in order to understand how racism operates in our society. If we consider these three dimensions of highly interrelated 36
processes of racism, we can then begin to identify how racism leads to unfair outcomes, how it leads to inequalities.
Q. And what is structural racism?
A. So structural racism is the uneven distribution of access to resources as a result of people's ethnicity or race. So by that I include things like economic resources, geographical location, cultural resources, access to political resources and so on.
Q. It's structural because it focuses upon the way in which society and its structures, governmental, commercial, and otherwise, fail to give proper access?
A. It's structural because of the ways in which social structures constrain access to certain resources. These aren't necessarily the direct actions of particular organisations or individuals.
Q. But it's across society?
A. It's across society.
Q. Right.

Institutional racism, is that a reflection of the processes and procedures within institutional settings?
A. Indeed.
Q. And is interpersonal racism, as would appear to be the case from the word "interpersonal", a reference to everyday encounters of racism? Which, as what we might
one since 2004, and there had been an underinvestment in data generally with regards to ethnic minority monitoring?
A. Indeed. And as I've argued earlier, or as I said earlier, the Health Survey for England I think is an absolutely crucial resource for documenting inequalities in health.
Q. Is that the report you refer to at paragraph 17 and which you've already spoken of already?
A. That's the Health Survey for England I refer to in paragraph 16. The Public Health England report brought together evidence from a range of sources.
Q. You've referred to the census carried out by the ONS and in particular the 2011 census which preceded the pandemic, the 2021 was later, of course. A census depends, of course, on every recipient or contributor self-reporting information. To what extent does the information that can be extracted from a census have to be assessed in light of the fact that it's self-reported? Putting it another way, can the same weight be placed on self-reported data as objectively observed data?
A. So, this is a very important topic. There has been some investigation into how far measured disease correlates with self-reported health, and how far that varies 39

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all see as the most obvious, through our personal experiences, is personal prejudice, hence interpersonal?
A. Yes, and this is how most of us see and recognise racism.
Q. All right.

Now, paragraph 14, please, page 7.
You then turn to the heart of the report, which is what was the position relating to ethnic inequalities in health prior to January 2020, for the purposes of setting, of course, the building block for what the position was that confronted government decision-makers on the cusp of the pandemic.

Do you conclude, in very general terms, in paragraph 15, that ethnic inequalities in health have been long-standing and persistent? Have they been documented, for example, for many years?
A. They have been documented for several decades.
Q. Was there a greater amount of documentation and survey and research in the years leading up to January 2020 or less?
A. In the decade or so leading up to January 2020, there was less total population examination of ethnic inequalities in health.
Q. Was that in the main because, as you've said earlier, the last health survey hadn't been -- there hadn't been 38
across ethnic groups. The bottom line of this is that for the two crucial questions in the census, they both correlate very well with risk of mortality and with risk of having a diagnosed disease, and that correlation does not appear to vary dramatically across ethnic groups or meaningfully across ethnic groups.
Q. If I may say so, I think that's admirably clear. I'll probably bring confusion in where it's not warranted, but in essence, therefore, what you're saying is the figures which are self-reported by people who contribute to a census and respond to a census, they're consistent with objectively verifiable levels of mortality, the risk of death, in ethnic grouping, and also with the objectively verifiable information relating to disease?
A. They are.
Q. What that census material shows is that over time ethnic inequalities in health have been persistent, and therefore that some ethnic groups, Pakistani, Bangladeshi and black Caribbean groups and, among women, the Indian group, have higher rates of long-term illness than the white ethnic group?
A. Yes, that's correct.
Q. Can I bring you back to the post-pandemic ONS data of 2021, which I said I would, was that a report that 40
focused on mortality rates?
A. It was, and subsequently on life expectancy.
Q. And was that report, post-pandemic as it was, consistent, in your opinion, with the pre-pandemic material, the census material, the Public Health England material, the Longitudinal survey and so on, in terms of the persistency of ethnic inequality in health?
A. Yes, so that report covered a period prior to the pandemic, so the period that we're talking about in terms of the evidence that we've presented in the document, and again the bottom line is it was not consistent with that evidence.
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?
A. That's correct, the conclusion it reached was that the life expectancy of white people was lower than the life expectancy of ethnic minority people, suggesting white people had worse health, and that the mortality risk for white people, consistent with what l've just said about life expectancy, were higher for white people compared with ethnic minority people.
Q. The conclusion of that report was that the white group had a statistically significantly elevated all-cause 41

My concerns with this really began when I saw the inconsistency between the mortality rates and what we knew about morbidity or health levels. When I looked a little bit closer, I saw that some of the estimates of life expectancy and of mortality rates were rather unusual. For example, the life expectancy of an 80-year old Pakistani or Bangladeshi woman is considerably longer than the life expectancy of a Japanese woman of a similar age. And I use Japan as the example because Japan has long life expectancies, considerably longer.

So when you see that, you begin to wonder whether the data are correct.

The reason why the data may not be correct is because of the linkage of administrative records, so that some deaths may not be accurately linked to census records, so then deaths become undercounted. And that means that some people become statistically immortal, they never die, in the statistical record.

We are working with -- or "we", me and colleagues are working with ONS to explore the consequences of that, but we believe that that does raise questions about the conclusions that they reach.

The data themselves are also published as experimental statistics, which means that the statistical underpinnings of the analysis have not 43
mortality when compared to all other ethnic groups, so in practice, in reality, because of the prevalence of dementia, Alzheimer's and cancer in white groups, they concluded or the ONS concluded that the risk of death was higher, generally speaking, across the white group than it was for ethnic minority groups; is that the sum of it?
A. That's the conclusion of the report.
Q. But you have concerns about the methodology of that report; is that right?
A. Indeed.
Q. Could you just briefly summarise what concerns you have and therefore what concerns you have about the validity of the conclusions that the ONS reached?
A. Yes. So the report itself was based on very innovative analysis. I'm not sure whether people are aware, but on death certificates we do not record ethnicity. So we know whether people have died but we don't know their ethnicity. So what the ONS did, and they did this as part of pandemic research that they conducted, was to link death certificate data to census data and to NHS records. Census data and NHS records do contain data on ethnicity, so they were then able to estimate risk of death by ethnicity. This is incredibly innovative work, and -- yeah, and difficult work to do. 42
yet been gold standard.
Q. All right.
A. We need to treat them with some caution.
Q. 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 or may not prove in the fullness of time to be accurate, we just don't know?
A. We don't know.
Q. 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?
A. 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
analysis that was conducted using data since the 2021 census.
Q. On mortality?
A. On mortality.
Q. Right.
A. But, as I have suggested, my opinion is that there are statistical problems with those analyses.
Q. At paragraphs 21 and 22 , you conclude, as a result of your examination, that ethnic inequalities in health are also more pronounced at older ages, and you give some details or some examples of why that is so, and you also say, in paragraph 22, that:
"Inequalities across ethnic groups begin to emerge in middle adulthood and for three [particular] groups Bangladeshi, Pakistani and Black Caribbean people ..."
A. Yes.
Q. You produced a chart -- on the following page, please, if we could just scroll in, please, on that chart -does this show ethnic differences in fair or poor self-reported health by age? So these are the recipients of the surveys and the contributors indicating themselves where they have fair or poor health?
A. That is correct, yeah.
Q. And we can see Bangladeshi at the top, Pakistani second
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.
Q. 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?
A. That's correct.
Q. Are there differences between ethnic groups as to how likely it is that people use GP services than not?
A. 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.
Q. And how indicative is that of the need for medical treatment as opposed to a propensity or a disinclination to want to seek help?
A. It at least in part reflects the need for more treatment.
Q. But not wholly?
A. It's a very difficult statistical exercise to be able to take into account the whole of need in terms of healthcare. When you take it into account as far as you can, it explains some of the difference, some of the

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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 relation to specific diseases, and obviously in the population at large there are a number of chronic conditions such as diabetes, ischaemic heart disease, hypertension and stroke and so on and so forth. What, in very general terms, did you conclude in relation to specific disease outcomes? And by "outcomes" I mean the 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 parallel -- each disease doesn't immediately parallel the other. But in general terms, in high-level terms, 46
higher rate, which suggests that need is at least one of the drivers of this.
Q. Yes. In essence, it must be a factor?
A. It is a factor.
Q. Yes. All right.

You also referred to a Public Health report in 2018 which expresses the view that ethnic minority groups report lower satisfaction with primary and secondary healthcare, and you also refer to the particular field of maternal and neonatal healthcare, where ethnic minority women experience less good communication with providers and also delays in antenatal care?
A. That is correct, the Public Health England report, in paragraph 28, brings together evidence from a large number of studies. The work on maternal and neonatal morbidity has been done by a handful of studies.
Q. Lastly under this section, at 31 and 33 , you deal with the issue of access to mental health services. 31:
"... ethnic minority people are more likely than White people to experience high rates of admissions involving the police, less likely to be referred to by a GP ..."

For mental health services.
And, 33, there are ethnic inequalities in relation to young people in addition, particularly black young 48
people, who are more likely to be referred through education, mental health services, social care, relative to primary care?
A. That is correct.
Q. All right. Well, I'm not going to ask you any more questions about that, because, if I may say so, you've set it out very clearly and your conclusions are self-evident in those paragraphs.

Topic 4, social and economic resources. What is, what are social and economic resources?
A. So here I -- or we refer to things like housing, employment, education, yeah, et cetera
Q. Over time, has there been a persistent inequality in terms of those resources?
A. The evidence we summarise strongly suggests that that inequality has been persistent. Is present and has been persistent.
Q. And that's across the whole range of economic activity so employment, income, educational outcomes, housing, area deprivation, discrimination and so on, this is a huge area.
A. It is a huge area, but those inequalities are persistent. There is variation in the detail, of course, but those inequalities are persistent.
Q. To what extent does an individual or have individual 49
groups, not all of them, but it is higher in ethnic minority groups, and that higher rate has largely remained persistent over time.
Q. 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?
A. 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.
Q. 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 agree or not?
A. So I would qualify the statement. The levels of
surveys or censuses tried to unpick the individual areas which are grouped in the area of social and economic resources? So are there specific surveys dealing with just housing, for example, or just employment, or is this information which has to be extracted from a much larger body of data?
A. There are specific studies around housing, specific studies around employment, specific studies around health and so on, but the census, perhaps one of the most useful tools or one of the most useful sources of data, does cover a number of these dimensions jointly.
Q. Of particular importance to this Inquiry is, of course, employment, because the figures appear to indicate, and they're very clear, that certain people in certain jobs were more at risk of being infected, depended of course on whether they were on the frontline of healthcare or whether they were delivering public services which required them to come into contact with other people who might be infected, so employment and the nature of employment, whether it's part or full-time and what sort of employment it is, is of great importance.

What general conclusions did you reach in relation to the risk of unemployment, firstly?
A. So the risk of unemployment is higher in ethnic minority 50
unemployment are reducing, the gap between ethnic minority people and white British people has remained. And it's also important to recognise that one of the crucial dimensions of employment is not just having a job but the type of job you have, and so that actual -- those data do not tell us much about part-time employment, for example, and the dramatic move of some ethnic minority groups into part-time employment from full-time employment.
Q. So in essence, that proposition, whilst it might well be right in part, doesn't tell the full story, that's what you would say?
A. Doesn't tell the full story and I think the headline conclusion, that ethnic inequalities are diminishing, is not the correct conclusion.
Q. Yes. I think to be fair to them, I actually put it in a different way, Professor, I said they suggest that the gap in levels of unemployment is lowering or reducing, which isn't what you've described it as.
A. Okay.
Q. Paragraph 36 , you then deal with the point which you've just raised, which is the type of work. So are there ethnic differences in the employment profile of ethnic minority people? That is to say, are they employed in sectors that may increase the risk of exposure to 52
an infectious agent, such as transport, delivery jobs, healthcare assistants, hospital cleaners, social care workers, nursing and medical jobs and the like?
A. That is correct.
Q. Can you give us any figures or a closer indication of the proportion of employment undertaken by ethnic minority people which is in those sectors?
A. I'm sorry, I don't have those figures off the top of my head, and I don't have a note in relation to those figures, but I think it has been very well documented in a number of sources that these are the locations where ethnic minority people are more concentrated and ... yeah.
Q. Housing. Relevant to this Inquiry because of the greater risk of infection in a multigenerational household, and that's obviously relevant to the governmental decision-making as to how restrictions and lockdowns were imposed and what the impact would be on such housing. Are there conclusions that you can draw in relation to the proportion of people in ethnic minority groups who live in multigenerational households or overcrowded households, or households which are seen as deprived because of lack of central heating and so on and so forth?
A. So that is the case for some ethnic minority groups, 53
featuring at the lowest point, the percentage points, or are we talking about different ones?
A. Yes, my Lady, there are three groups that are particularly vulnerable, according to the general data we have, which are the Pakistani, Bangladeshi and black Caribbean group. You have less coverage of a very vulnerable group, which is the white Gypsy/traveller/Roma group.
LADY HALLETT: Is that in any way related to the difficulty in getting data from them because they don't always have a permanent base, or ...
A. I think it -- my view is that it relates to our willingness to reach out, to get to those people. But I accept it's more complicated.
MR KEITH: The evidence, in part your own evidence, indicates that there is another group of people who are digitally excluded, and that is the elderly.

Are you in a position to draw any view, to express an opinion as to comparatively what the levels of digital exclusion are between some ethnic minority groups and the elderly?

You will look in vain at that paragraph, Professor, I'm afraid I've bowled you a difficult ball, it's not in that paragraph.
A. So the evidence we have in terms of older ethnic
they're more likely to be in poor quality housing, more likely to be in the private rental sector, which runs the risk of poorer quality housing, and more precarious housing, and more likely to be in overcrowded houses than white British people. This is not across all ethnic minority groups, but it's the case for some ethnic minority groups
LADY HALLETT: Mr Keith, I don't know how your timing is going?
MR KEITH: That's a very good moment.
LADY HALLETT: Very well, I shall return at quarter to. (11.30 am)

## (A short break)

## (11.45 am)

MR KEITH: Professor, higher pollution levels, are ethnic minority groups more likely than white majority groups to live in deprived neighbourhoods with higher pollution levels?
A. Yes.
Q. And are ethnic minority groups more likely than the general population to experience digital exclusion?
A. Some ethnic minority groups, not all.
Q. Yes.

LADY HALLETT: You said "some" more than once. Are we always talking about the same minority groups that are 54
minority people and digital exclusion cannot be easily derived from survey data, simply because of the very small number of older ethnic minority people who appear in surveys. Qualitative research suggests that older ethnic minority people are particularly at risk of digital exclusion. But, as you say, I haven't reported ...
Q. And that's not a surprising conclusion at all?
A. It's not a surprising conclusion.
Q. All right.

Topic 5 , the role of racism. Bearing in mind what you said earlier about the definitional differences between structural, institutional and interpersonal racism, do you conclude that ethnicity remains strongly associated with social location, status and power, leading to inequalities in access to the resources that you've described, because of ongoing structural racism?
A. That is my opinion.
Q. In essence, at its most basic, access to resources is more limited for members of its groups because they are members of those groups; is that it?
A. Because of the way society is organised and the consequences of that for members of those ethnic groups.
Q. In relation to interpersonal racism, that is to say acts 56
of racism in everyday life, everyday lives, can you say anything about the level of interpersonal racism over time in the United Kingdom?
A. Measuring the level of interpersonal racism is extremely complicated. The ways in which we phrase questions, the ways in which they're interpreted makes it difficult to capture all dimensions of interpersonal racism. But the headline response to your question is that it appears that levels of interpersonal racism on average have remained consistent over time.
Q. Now, there are a number of different ways in which levels of racism might be surveyed or monitored, the most important is the self-reported surveys where members of the ethnic minorities report on the degree to which they have experienced racist abuse, assault or vandalism; is that correct?
A. That's correct, that's the measure has been used quite consistently over time.
Q. From what time period do those sorts of reports date upon which you place reliance for your conclusion that there had been a persistence of racism over time?
A. So they were first used on a national level in 1993/4, the survey was carried out in 1993/4, and were repeated in a few surveys subsequently.
Q. What dates were those subsequent surveys? 57
figure 3, what the impact is of those reports in the surveys, which is that -- if you could scroll into the charts, thank you very much.

The solid line indicates self-reported acts of racism. That is to say, members of the ethnic groups that you identify, Pakistani, black Caribbean and Irish, have experienced racism, and they're the solid groups. And we can see in the bottom right-hand half of the page a fairly persistent line, because the lines are horizontal, perhaps less persistent in the case of the Irish, but over time from 1991 to 2008, which is the last survey you mentioned. Those figures have remained 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.

What is the top line, starting on the left at 1983, by comparison to fear of racism or experience of racism?
A. The top line reflects the general population's responses to a question asking whether they are prejudiced against ethnic minority people, and it shows how that rate has changed from 1983 through to 2013. Each square is the period when the data were collected, and you can see it was collected quite frequently in the early phase of
Q. You properly identify, and we can go to the next page, 58
this and less frequently in the later phase, and it basically shows, in my view, a fairly consistent level of reporting that you are prejudiced, that ranges between $30 \%$ and $40 \%$ over this time period.
Q. Now, it's obvious that the figures must to some extent, because they're -- the asking of anybody the question "Are you prejudiced?" of course may not elicit an entirely truthful answer, so is that an issue which is taken into account in this survey or this approach?
A. It's an issue that needs to be taken account of in terms of the interpretation of responses to this question.
LADY HALLETT: Because an awful lot of people don't know that they're prejudiced when they are?
A. And the willingness to admit you're prejudiced in front of an interviewer is also going to vary.
MR KEITH: So the figures of actual prejudice could be higher because of under-reporting, or if you ask the question to what degree do they know that they're prejudiced the figure could be lower because of a failure to identify that they are prejudiced?
A. That's correct, and it's also important to bear in mind how those issues may change over time.
Q. Indeed.

What survey does the blue block in 2013 for prejudice signify? What survey is that? Because that's 60

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in 2013, but the earlier surveys for all the other indices, indicia, are different.
A. Yeah, so the data for each of these lines comes from a range of surveys. The only consistent line is the blue line at the top on prejudice, which comes from the British Social Attitudes Survey, which is repeated every year, although the question on prejudice is not repeated every year.
Q. And was the last year in which that question was contained in the survey 2013, which is why there's a block on the chart?
A. At the time we did this analysis, that was the last --
Q. Right.

So the last objective or quantifiable data underpinning your conclusions is from 2013?
A. Indeed.
Q. All right.

The reason I ask, Professor, as you know, is that in the submissions put forward to the Inquiry
the government says: well, what about other surveys or data from 2013 to 2020, and also what about surveys post-pandemic which may be reflective of levels of prejudice pre-pandemic?

Do you follow?
A. Yes.
group.
That is a comparative survey, we don't know on what it was based, and it obviously says something to the general advantage of the United Kingdom.
LADY HALLETT: Sorry, is that they would wish to live next door or they wouldn't?
MR KEITH: $1 \%$ say they would not like to -- sorry, did I miss out the "not"?
LADY HALLETT: Yes, you did.
MR KEITH: I do apologise.
Did it say anything about the levels of prejudice, objective levels of prejudice in the United Kingdom, as opposed to saying something, and perhaps not very much, about the comparative position of the United Kingdom?
A. So the World Values Survey is actually a very important survey, that enables us to explore attitudes across the globe. It includes very many countries, and so enables us to position attitudes held in the United Kingdom alongside attitudes held in other countries. So for that purpose it's a very valuable survey.

That question is a very specific question that captures just one dimension of people's experiences, or people's prejudicial views. So to generalise from that one question to a broader dimension of prejudice against
Q. Is there really an absence of data 2013 to 2020? Was the research and the surveys simply not done?
A. As I mentioned earlier, there is this crucial survey called Understanding Society which has continued throughout this period and over that period has intermittently asked questions on racism and discrimination. Those questions are different from the questions that I charted in this figure, which is why they're not included in this figure, because the way you ask the question is crucial. But what it shows is that ethnic minority people continue to report experiences of racism and discrimination up to the period of the pandemic, and the levels at which they report this doesn't change very much over that period.

Post-pandemic there have been additional surveys conducted on this question.
Q. The government refers in particular to something called the World Values Survey, I think it's April 2023, earlier this year, but in any event that survey suggests that of 18 countries, one of the least prejudiced -- and I'll come to the significance of this in a moment, of course -- one of the least prejudiced is the United Kingdom. The survey reports that only $1 \%$ of the United Kingdom public say that they would wish to live next door to a neighbour of a different ethnic 62
ethnic minorities I think is a bit of a stretch, but there are important conceptual and methodological issues related to that, but I would not use that as an indicator that levels of prejudice have decreased.
Q. Finally, the issue of institutional racism, upon which we have not touched in this context, is there a difficulty in separating out the degree of racism that comes from individuals on an interpersonal basis and the extent to which racism is perhaps baked into the institutions of which those individuals form part?
A. Yes. So although l've talked about the difficulties of measuring interpersonal experiences of racism, these are straightforward experiences, therefore you can design questions to capture that. In terms of institutional racism and structural racism, you can't ask people questions about this in a direct way, you have to ask about the consequences of racism. So in terms of structural racism, you can see the consequences, in terms of the resources that people have access to. In terms of institutional racism, you can see it operating in terms of the processes and outcomes of the actions of institutions.
Q. Topic 6, the role of cultural and genetic difference. In this chapter, do you investigate the argument put forward by some that differences in access to health 64
resources and, on a wider sense, ethnic inequality in health, that is to say the risk of disease, mortality rates and so on, are in some way connected to the cultural or genetic characteristics of that person? So, putting it another way, saying a Chinese person is more likely to have a worse health outcome in general terms because genetically he or she is more prone to cancer, that sort of argument. Is that the argument which underpins this argument about cultural and genetic differences and their impact?
A. Yes, we felt it very important to discuss this topic, for perhaps very obvious reasons. Genetics and health behaviours, culturally informed health behaviours, inevitably impact on our health. And we assume, we make the assumption in everyday thinking, that health is a biological outcome and therefore genetic and cultural differences across ethnic groups may lead to ethnic differences in health.

It's a common lay approach to thinking about why ethnic groups might have a higher risk of poor health, so we felt it important to discuss this.
Q. And is the problem here that the argument, as l've so defined it, is insufficiently nuanced? It's too bold, too broad brush an approach? Plainly there may be some ethnic groups who do suffer more widely from particular 65
risk of infection and mortality during a pandemic. Do you conclude in paragraph 62 that because of the inequalities that you've described, including the stress generated by experiences of and knowledge of racism, higher levels of chronic disease, which, as we've explored, is prevalent or is present in some ethnic groups, and early onset of biological ageing, ethnic minority people are more at risk?
A. Indeed, including the social and economic inequalities faced by ethnic minority people.
Q. Just picking apart that proposition in part, are there any figures showing the degree of stress or are there figures other than self-reported stress upon which you have been able to rely for the purposes of assessing that degree of stress?
A. There have been studies that have examined biological stress responses to experiences of racism which show the rise in those biological responses when people are exposed to narratives of racism.
Q. Do we presume that it is not possible to delineate the degree to which any one of those factors may be a greater contributory factor than any of the others? So, for example, are the pre-existing social, economic and health inequalities that you've described likely to be the greater contributory factor to the risk of
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?
A. 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.
Q. 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?
A. Indeed.
Q. 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?
A. Indeed.
Q. Right.

Topic 7, implications of ethnic inequalities for 66
serious illness and mortality rather than stress or biological ageing?
A. 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.
Q. 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 is that all these issues, all these indicia of inequality, have a direct bearing on the impact of any 68
particular non-pharmaceutical intervention that any 1 government might impose?
A. Indeed, the pre-existing inequalities mean that those interventions are likely to have a more adverse impact on ethnic minority people.
Q. You then go on to deal with two particular examples of where clinical interventions have a different outcome because of ethnicity. Firstly, pulse oximetry. What is pulse oximetry?
A. Pulse oximetry is a convenient device that can be used to measure the level of oxygen saturation in the blood, and therefore an indicator of the beginnings of respiratory failure.
Q. And do pulse oximeters rely upon, mechanically, the transmission of light through the skin?
A. Exactly.
Q. On account of ethnicity, are there differences in the way in which pulse oximetry may work?
A. So there is extensive evidence, some from before the pandemic and since the pandemic occurred, which demonstrates that pulse oximeters do not work as well on darker skin, they're more inaccurate.
Q. Because in the health service pulse oximetry is a particularly valuable indicator for people who are older, there is an impact insofar as the cut-off date 69
you mean by that reference in fact the position as at 2020 ?
A. Indeed.
Q. 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?
A. She did, once government became aware that this was an issue.
Q. 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?
A. 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.
Q. To what extent -- are you aware, you may not know, but to what extent did various parts of the government, for example SAGE, Public Health England, the UKHSA, or the Health and Safety Executive, or the Faculty of
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?
A. 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 devices or take that into account.

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

The second area that you address in terms of clinical intervention is the roll-out of vaccines. You say at paragraph 82:
"Given the existing evidence on vaccine hesitancy ..."

More dedicated effort should be made to "address the concerns of ethnic minority people".

Although you say "given the existing evidence", did 70

Occupational Medicine, attempt to address any of these issues as the pandemic rolled on?
A. So once it became apparent that ethnic minority people were dying at higher rates from Covid infection --
Q. Can I just pause you there, can you express a view as to when that generally became understood?
A. So it became visible in the general media in March and April, if I remember correctly, March and April 2020.
Q. Thank you.
A. 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 that.
Q. You say "public health responses"; do you mean bodies within and without government?
A. Yes.
Q. So across the whole range, in fact, of this field.

So when you express your views as to what more could have been done, do you express those views in light of 72
what was done or do you restrict yourself to identifying conceptually where the problem areas were, as at the position in 2020 ?
A. So this is where the problem areas were at the outset of the pandemic, and the issues that should have been considered when things like non-pharmaceutical interventions were put in place.
Q. Regardless of the extent to which they were thereafter considered, if they were considered at all?
A. Regardless of whether they were considered afterwards.
Q. Right, thank you, that's very clear.

So you identify the broad areas in which these inequalities of outcomes should have been addressed or should be addressed or the extent to which the government should have started addressing them in 2020: economic safety nets for the circumstances of ethnic minority people, precarious work -- who were in precarious work, self-employed in sole trading or small business.

Of course there were schemes, not for determination in this module, for self-employed and so on and so forth, and we'll have to look in due course at the extent to which the schemes that were put in place did address your concerns.

There is the link between the development of 73

## to which it was:

"... attention should be paid to the risk of an increase in prejudicial sentiment leading to a blaming of ethnic minority people ..."

And such racist behaviour was required to be addressed?
A. Indeed.

MR KEITH: Professor Nazroo, thank you very much.
Now, there will be some further questions for you.
LADY HALLETT: I have the list, Mr Keith, thank you.
May I just explain to those who haven't followed this process before, before the witness gives evidence, I'm given a list of questions that core participants would like to ask. I direct which questions they may ask and I set time limits, and I'm afraid I have to be fairly strict with those time limits.
MR KEITH: My Lady, may I also explain that you give permission for those areas to be explored once, of course, you've heard the extent of the evidence already given, so may I invite you to give permission for the three areas that Covid Bereaved Families for Justice and Covid Bereaved Families for Justice Northern Ireland have raised within their ten-minute time allotment for Professor Nazroo?
LADY HALLETT: Certainly.
lockdown rules and their surveillance on the fact that those in ethnic minorities suffer from overcrowded, poor-quality housing, lack of access to outside and green spaces and reduced access to the internet.

Hugely important to the lockdowns; yes?
A. Yes
Q. Social distancing and lockdown measures are linked to the degree of digital exclusion, because of isolation and the inability to be able to receive information about what the government has in mind for us all next.

Clinical interventions were required to be developed in partnership with ethnic minority people and trials of their effectiveness and side effects.

My Lady will be hearing a bit about that in a moment from Professor Banfield of the BMA.

For NPIs and clinical interventions there was a requirement to use the strength and cohesiveness of ethnic minority communities, that is to say to speak to them, to communicate with them, and to address how their needs and concerns could be more properly and carefully met, in the development of the intervention?
A. Indeed, to work in partnership.
Q. Then lastly, in paragraph 91, you say that part of the government's obligation as at 2020 should have been -- again, I emphasise, we don't yet know the extent 74

## Mr Weatherby.

## Questions from MR WEATHERBY KC

MR WEATHERBY: Professor, I am going to ask you a handful of questions on behalf of bereaved families who are part of the Covid Bereaved Families for Justice UK group, a significant number of whom are from ethnic minority communities.

Mr Keith's already touched on my first point. At paragraph 6 of your report, you comment on the lack of data in the ten years leading up to January 2020 relating to ethnic inequalities because of underinvestment or contributed to by underinvestment.

Is it right that the effect of the lack of such data is to reduce the ability to identify and mitigate foreseeable pre-existing ethnic inequalities?
A. That is correct.
Q. Would you agree, therefore, that the underinvestment in data for the understanding and monitoring of ethnic inequalities over this period is itself, therefore, an example of structural racism?
A. I would argue -- I'm sorry to be kind of definitional, but I would argue that this is institutional racism within --
Q. Okay.
A. -- within the process of commissioning --

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Q. Right, so you would classify it -- I don't think it probably matters, but that's very helpful -institutional racism.

My second point, at paragraphs 26 to 33, you highlight the reported poor experiences of members of its ethnic groups with primary and secondary healthcare historically.

Are these negative experiences likely to have reduced access to healthcare when needed in the eye of the crisis?
A. It's hard to make that extrapolation in terms of the eye of the crisis because of the nature of the crisis --
Q. Yes.
A. -- where the risk that we were all under was very obvious, but it is possible.
Q. Yes, and perhaps then, for example, language difficulties, with the 111 service, it would be more difficult for accessing of that; yes?
A. Yes, so this is a -- language interpretation is a major issue. It affects a relatively small minority of ethnic minority people but it is absolutely crucial for them.
Q. Okay, perhaps a wider one then is a reduced trust. Through negative experience there's a reduced trust in guidance and such matters?
A. Exactly. And this is, I think, something that in our 77
the sources of that, which include the issues that you
have raised. And we had reasonable evidence on how that might be addressed.
Q. Yes, and so having had this problem highlighted in the 2018 report, at least, is there anything you're aware of that was in fact done to address this problem of engagement, particularly in relation to vaccine hesitancy, before the pandemic?
A. Before the pandemic, there was not.

MR WEATHERBY: Thank you very much, Professor.
LADY HALLETT: Thank you very much, Mr Weatherby.
Now, I don't think I'm saying goodbye, Professor, am I? I think you're returning this afternoon.
THE WITNESS: I am.
LADY HALLETT: You won't need to take the oath again. Thank you very much.
(The witness withdrew)
MR KEITH: Thank you, my Lady.
Once the Professor has gone, could we perhaps turn to another eminent professor, Professor Philip Banfield.
LADY HALLETT: Just so people understand, the reason Professor Nazroo is coming and going is we were trying to do it in specific areas, but I don't think it's worked totally because of the availability of some witnesses.
.
A. I think prior to the pandemic we had good evidence that there would be higher levels of vaccine hesitancy amongst ethnic minority people. We had good evidence on 78

## PROFESSOR PHILIP BANFIELD (affirmed) Questions from LEAD COUNSEL TO THE INQUIRY

MR KEITH: Could you give the Inquiry your full name, please.
A. Yes, I'm Professor Philip James Banfield.
Q. Professor Banfield, are you the chair of the BMA's UK council?
A. Yes, lam.
Q. 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 described as frontline and key workers.

But are many of the workers and the members whom you represent also members of the ethnic minorities?
A. Yes, they are.
Q. So are you giving evidence now in relation to this theme, ethnicity, because the subject matter of your 80
witness statement covers not just frontline and
key worker impact evidence but also the impact on ethnic minority members of the BMA?
A. Yes, indeed.
Q. All right, thank you, that's very clear.

You prepared a statement, INQ000228384.
We'll have it up, thank you.
Did you sign it on 21 July 2023 and declare its truthfulness?
A. Yes, I did.
Q. We'll come back to the statement in due course.

Could we start, please, Professor Banfield, with
just a few questions about the structure of the BMA and your place in the general scheme of things. This is an area that we've covered, of course, because you gave evidence in Module 1, but it's important to set it out again for this module.

Is the BMA a professional association and trade union?
A. Yes, it is.
Q. Does its membership come from the whole breadth of medicine, from academics, students, general practice, consultants, junior doctors, public health, and no doubt many other areas?
A. Yes, it does, and retired members. 81
Q. And you are its chair, as I've said.

Are there also within the BMA structure a number of regional councils?
A. Yes, there are in England.
Q. Eight?
A. Indeed.
Q. And a number of divisions?
A. So these are our local structures at this point in time, and they cross over between primary and secondary care.
Q. 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?
A. 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.
Q. Because you took on the role of chair of the council in July 2022 in fact after, of course, the pandemic was over?
A. Yes, prior to that I was chair of the consultants committee in Wales.
Q. But you had been on the UK council as well since 2012, alongside your practice as a consultant obstetrician and gynaecologist in North Wales?
A. Yes, so I was working on the frontline during the pandemic.
Q. And retired members.

Are there of course in your organisation different committees, bodies and areas that reflect the many different specialities of medicine?
A. Yes, there are.
Q. So you have committees which feed into the central structure of the BMA and committees that feed into the general structure of BMA committees in England and in Scotland and in Wales and Northern Ireland, reflective of those different specialities?
A. So the UK council represents all four nations, the devolved nations have their own separate council to deliberate on matters that are devolved purely to those nations.
Q. But there is a BMA UK council, of which you are chair --
A. Correct
Q. -- and information and political leadership and the degree to which there are particular issues that each committee wants to raise are fed through the UK council, are they not?
A. For matters that affect the whole UK.
Q. Of course.

The BMA UK council is the principal executive committee of the BMA, is it not?
A. It is.

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Q. For the purposes of giving evidence today, have you gone 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?
A. Yes, to the best of my ability.
Q. 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?
A. 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 what the state of play was in Europe, and that was very worrying because that was going to come to our shores with an inevitability that we felt we weren't prepared for.
Q. At what time did this battle rhythm within the BMA commence?
A. Just towards the end of March.

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Q. So at the time, in fact, that the government was first imposing, mid-March, social restrictions of a society-wide nature or latterly towards the lockdown period?
A. No, we had started our deliberations. It was very quickly apparent to the profession the seriousness of what was due to happen. There was a recognition that services were likely to be overwhelmed. A number of us went about writing our wills and making sure that our life insurance was up to date, because we had no doubts that we were facing something that was completely unprecedented.
Q. In general terms, focusing on the BMA's role and function, are there a number of areas that the BMA focuses on? So, firstly, providing individual support to members, because they are members of your body and association; secondly, providing guidance to doctors and their employers; thirdly, and this is the area upon which we'll be focusing today, seeking to influence decision-makers on a wide range of matters related to Covid through meetings, letters and correspondence, engagement with the media, and issuing of press statements, and giving evidence in Parliament. Are those the broad areas?
A. Yes, we advocate for excellence in healthcare and for 85
other areas, but Covid remained on the agenda.
Q. May we presume that, because you're the BMA, you were raising issues not just to do with the mechanics of Covid and the government's response, but including many other wider public health issues, all related in one form or other to the pandemic?
A. Yes.
Q. Did the BMA have regular meetings with the CMO for England, Sir Chris Whitty?
A. Not regular, but we were able to contact the CMO as and when we felt it was appropriate to. He made himself readily available at the point at which we had any specific questions.
Q. So he said if you wish to raise concerns with him, in effect, you were free to do so, and he made himself available to meet you if you wished to do so?
A. Correct. We didn't always agree, but he was there to listen.
Q. Were there a number of meetings held to discuss a range of issues, the government's approach to lockdown, PPE, the impact on your members and so on, a huge range of issues?
A. Yes, there were.
Q. Public Health England, did you have regular meetings with it?
A. Yes, there were. They started off about Covid specifically and then after a period of time went into 86
A. No.
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 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.
Q. As for the Department of Health and Social Care more generally, did you receive updates from the civil servants in the DHSC and also their representatives on a body called the SPF, is it social policy forum?
A. The Social Partnership Forum.
Q. Social Partnership Forum, Covid-19 engagement forum?
A. Yes, and, you know, there were a number of meetings set up to impart information and share it between multiple organisations and bodies, and we were part of that, either as elected members or members of staff of the BMA.
Q. Did the government set up what are called stakeholder meetings between the DHSC and other bodies, including Professor Sir Jonathan Van-Tam, the Deputy CMO, and the BMA, at which issues of general concern could be ventilated?
A. Yes. It tended to be that we were listening rather than 88
giving information
Q. Finally, did the BMA have significant engagement with senior officials from NHS England?
A. Yes, there was regular and full engagement to discuss operational matters, so the chair of consultants
committee, Dr Vish Sharma, used to meet with Professor Stephen Powis, as did the GP chair at that time.
Q. My Lady, may I just make plain that much of Professor Banfield's statement does deal with engagement between the BMA and the devolved administrations, but of course that is an issue which will be for later consideration in Modules A, B and C.

Just at this stage, at a very general level, what were the sorts of issues, what were the themes, what were the general areas that the BMA raised with NHS England? PPE?
A. So PPE and a lack of testing were the two immediate issues between ourselves and NHS England. We felt that the guidance was inadequate. We had stories very early on about not being able to have PPE, so there was a lack of aprons, a lack of visors. A number of us had -- our local schools were 3D printing visors for us. A number of people had to source masks themselves, especially in general practice, for example.
rapidly tailed off. So, for example, people were either treating patients with no masks or with fluid-resistant surgical masks, which don't protect from an airborne virus.
Q. Was another area of general concern to the BMA the disproportionate impact on ethnic minority communities?
A. Yes, there were quite early data from the intensive care community showing a disproportionate number of intensive care admissions from black, Asian and minority ethnic groups. Alarmingly, the first ten doctors who died of Covid were all in that black and Asian and minority ethnic group, and that was spotted very quickly by a number of organisations, including BAPIO, and the BMA, and the BMA then wrote immediately to raise concerns.
Q. So were there three areas, in fact, touching upon the issue of your ethnic minorities: one, the disproportionate impact of the virus on them; two, the disproportionate impact of the virus on members of your association who were from ethnic minorities; and, three, was there then the issue of the efficacy or suitability of particular types of PPE for those members of your organisation who were drawn from ethnic minorities?
A. That is true, because PPE needs to be particularly well fit tested, and it doesn't suit people with beards, for example, for religious purposes. But people from
Q. Just pausing there, can I just delineate the scope of what you've just said. So in relation to PPE, there were in fact three areas of concern, very broadly putting it, as I say: firstly, the shortages; secondly, the guidance in relation to the use of PPE; and then thirdly, the impact of the, in cases, deficient PPE on your members?
A. That's true, yes.
Q. All right.
A. There's a fourth aspect, which is actually have to work in that kind of PPE. That has a -- had a huge impact on people's health and wellbeing.
Q. Is that the topic of risk assessment? So, because of the impact or because of the consequences of your members having to wear PPE that may not have been adequate or proper, that gave rise to very difficult debates about the extent to which they would have been placed at risk, the need for risk assessments, as well as the objective impact upon them individually of having to wear deficient PPE?
A. Yes, because there was a shortage of PPE, the very high-risk areas, like intensive care units, were using respiratory protection throughout the pandemic, but once you got beyond an intensive care unit, with people who were Covid positive, the amount and degree of PPE very 90
ethnic minorities are less likely to stick up and speak up when there is insufficient PPE, and they -- we found that they were much less likely to have had an adequate risk assessment.

By the end of the first wave, two out of three doctors still hadn't felt that they'd been adequately risk assessed.
Q. Could we now turn in a little more detail to the particular areas and issues of concern that you raised from time to time with various parts of the government, the parts of the government that you've now identified.

Starting -- if we could have on the screen -paragraph 77 on page 20.

The BMA first became aware of the Covid-19 emergence via the media, when it was still confined to China. Did you, as a result, send in January a letter -- in fact it was your predecessor who sent a letter -- to the Secretary of State and to NHS England and Public Health England, offering the BMA's support and expertise?
A. Yes, we did.
Q. In that period up to the end of March, the period you've already identified, did you have a number of meetings or phone calls or did the BMA have a number of meetings or phone calls with senior officials in the UK Government? 92
A. Yes, we did. It was to find out and to highlight the exchange of information that we were receiving both from our own experts and from our colleagues abroad.
Q. If you could go, please, to page 22, paragraph 86.

At the ministerial meetings, that's to say meetings with the Secretary of State or his ministers -- as you've said, the meetings invariably covered many aspects of the pandemic, but have you drawn out in your witness statement in that paragraph 86 , reflective of the same areas that you were raising in fact with the NHS, the broad areas of PPE, testing and contact tracing, shielding, social distancing and other lockdowns?
A. Yes, I have.
Q. Now, as at that time, mid to late March, to what extent did the BMA have a view on the particularity, the specifics of what the government was proposing by way of social distancing and then ultimately, from 23 March, lockdown? Were you focusing in your engagement with the government upon the impact of whatever it is the government might then have been proposing, or were you focusing on the efficacy of whatever was being proposed, would it work?
A. Well, the biggest issue really started one step back from that, was our lack of understanding as to why the 93
Q. Just a couple of features around that, please,

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?
A. Yes.
Q. Secondly, you were concerned on behalf of the BMA that the government had abandoned contact tracing; to what extent was the BMA aware of the physical or the practical limits on the testing structures that were then available?
A. Well, that came out, I think, in discussions and communications afterwards, and there was an admission that part of the decision to do that was a lack of testing.
Q. Now, you know that there is in place or there was in place, of course, a system by which, whenever a disease emerges or there is an infectious viral outbreak, a data set can be prepared, a structure can be put in place whereby the first few hundred cases are tracked, contacted, tested, traced, isolated, but there was a distinct limit on how many cases that First Few 100 system could accommodate.

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government was apparently abandoning basic public health protection measures. Our local public health teams, our 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?
A. 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.

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?
A. I mean, that was known quite early on, because public 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 control the outbreak, and because they were then sitting within different systems, the data didn't reach the frontline. We saw that -- a good example of that later on when there was a local lockdown in Leicester, where there was detailed information about the test results but not about the results and prevalence in the local population. And that made it really difficult to control it.
Q. Is that because at the beginning one of the other features of the First Few 100 system is that that's a nationally-run system, it's not run by local authorities or public health directors?
A. Well, normally it would be, you would expect it to be run locally for a local outbreak and have it co-ordinated by the regional directors, who would then 96
be feeding up to the centre. What happened here was the centre gave public health policy from the top downwards.
Q. What about the absence of or the very limited number of PCR tests that were then available? You can't run a testing system, even at a basic level, unless you've got the testing kits, then, all that there was after the initial diagnostic tests were prepared, a PCR test. To what extent did the BMA become aware that there was a very distinct limit on the physical number of tests, testing kits available?
A. Well, that happened very quickly, because we were relying on the availability of the PCR tests to keep people in work. In the absence of the PCR tests, we were having to isolate for 14 days, isolate if we were contacts. We were already short of staff and we ended up in that first wave with huge numbers of staff not being in work when they potentially could have been if there were tests to test both them and the patients around. And of course the consequence of not having sufficient tests in those early days were that we were admitting patients to unsuitable areas with patients who hadn't got Covid. So the chance of passing Covid around a hospital was very high.
Q. Was there a general difference of view between the BMA and the government in relation to the level of 97
service as well, because the number of admissions soared during that time, the number of people who caught Covid and had been affected by it soared during that time, and we did feed back both to government and then publicly in the media that we thought that this was an unnecessary delay.
Q. Can we just unpick some aspects of that answer. So on 12 March the government announced that there would no longer be testing in the community and such PCR test as there was would be kept for healthcare workers.

By that time, the First Few 100 dataset, the analysis of index cases and the pursuit of their contacts and the isolation of their contacts, had given up the ghost, it stopped at 415 ?
A. They'd lost control.
Q. They lost control. So are you saying that thereafter, from 12 March to the lockdown day of 23 March, there was in practice no way of assessing the degree of spread of the infections through the community at large?
A. That's what it seemed like to our members.
Q. And if you don't know how the virus is spreading, other than by way of estimate or modelling, what means of control have you got to suppress it?
A. Very little. We were seeing the results of that actually on the frontline.
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 we could 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 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.
Q. As 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 contact tracing was abandoned. That 11-day delay until the lockdown, and given that there was already a plan in place, 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 98
Q. There were a number of areas where the BMA's entreaties to the government had greater degrees of success, were there not?
A. Yes, indeed.
Q. So could you turn, please, to page 34, paragraph 139. 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 testing and contact tracing, and the exiting of lockdowns safely, did your lobbying meet with some, if not always completely unalloyed, success?
A. Indeed, yes. It's difficult to actually put a cause and effect onto that, but eventually the measures that we were calling for came into play.
Q. In relation to exiting lockdowns safely, at paragraph 142, did you publish documents in July and November 2020 setting out what you believed the government should do to ease restrictions that would keep control upon the virulence, the level of virus in the community?
A. Yeah, it was really important to us, because we had a sense across that summer that we were failing to prepare for the inevitable second wave, and therefore we took it into our own hands to try to give guidance into 100
the public domain, that we shared with various parts of government, as to how to keep the levels of virus low enough to be able to get through the following winter.
Q. In the summer of 2020, was there a general concern being expressed that, because the virus -- the levels of virus in the community had not been brought down low enough, too great a degree of relaxation in restrictions, or complete freedom, would allow it to unspring, uncoil itself like a spring, back out into the community violently?
A. Yeah, I'm advised by my public health colleagues that you need a rate of around 10 per 100,000, which is around 100,000 cases per day, and the UK was above that.

So, you know, the data were suggesting that it was unsafe to ease lockdowns at that point. We were advocating mandatory use of face protection, face masks for the public. We were advocating later for a higher degree of protection from vulnerable people, as the shielding came out of play.
Q. Just finally before lunch, then, and just identifying certain aspects of the face mask debate, the government did impose a mandatory face covering order, firstly in relation to public transport and then latterly shops and supermarkets, but relatively speaking you were calling for mandatory face masks across the population at 101
still hiding away from society.
MR KEITH: My Lady, that a convenient moment?
LADY HALLETT: Certainly.
Are you okay to come back this afternoon, Professor?

## Thank you.

2 o'clock, please.
( 1.02 pm )

## (The short adjournment)

( 2.00 pm )
MR KEITH: Professor Banfield, at paragraph 145 you say this:
"While not a specific [non-pharmaceutical intervention], the BMA contends that a key failure of the Government was, and continues to be, the failure to properly acknowledge (and at an early enough stage), that Covid-19 was spread by aerosol transmission and to adapt their public messaging, guidance to health services or the focus of their NPIs appropriately."

Was that because there was an issue in the very early days as to whether or not Covid was transmitted by droplet or aerosol or both, and when it became apparent that it could be spread by both vectors, or both forms of transmission, the government didn't sufficiently tailor its messaging?
A. That's true in some ways. We have always advocated 103
an earlier time?
A. Yes, we were. It didn't make sense to us that there would be -- and if you're going to ask the public to wear face masks, then why not do it all in one go rather than this phased approach, which seemed to us to be sustaining the transmission unnecessarily.
Q. Did you at the same time call for ways in which the government could ameliorate, make better, the position of people who were subject to restrictions? There were some people, of course, a lot of people, who were subject to continuing shielding restrictions, and during the lockdowns themselves, of course, people who required better financial support, help with combatting the effects of isolation, and so on.

At the top of page 36, for all these particular issues, did you go into bat against the government?
A. Yes, we did. The best phrase that l've heard about that situation was that we were all in the same storm, but not in the same boat. There were clear discrepancies about how the pandemic was affecting different parts of our society, the poorest, the homeless, those who were already vulnerable. And that stayed with us. So when the country came out of lockdown, in inverted commas, right at the end in 2022, we've still got a situation in which very vulnerable people feel very exposed and are 102
a precautionary approach to public health measures, and it was known that similar coronaviruses are transmitted by aerosol, you know, airborne spread rather than droplets, so it seemed sensible from a professional point of view to consider that possibility. There became more emerging evidence across that summer, and it became unequivocal, and at the point at which it became unequivocal, there were temporary changes to the advice from Public Health England that then got reversed after the vaccination programme came into play.
Q. So relatively late?
A. Yes.
Q. Now, earlier in the course of your evidence you described a number of areas in relation to which the BMA had not met with much success of persuading 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 you made in relation to the exact manner in which the first lockdown was eased in the summer of 2021 had an impact?
A. So I do beg your pardon, there is a typographical error in paragraph 154 in that that refers to us having 104
influence in the lockdown of 2021.
Q. You mean 2020?
A. No, it's listed as 2020, which is the first year, and it actually is 2021.
LADY HALLETT: Oh, the headline is 2020.
MR KEITH: Right.
A. And the delay was, we feel, four weeks at that point.

LADY HALLETT: Sorry, the delay in what?
MR KEITH: Oh, is that because in the summer of 2021, pre-Omicron, the government, having announced a final exit date, the complete lifting of restrictions in that summer --
A. Yes.
Q. -- put the date of the lifting of the restrictions back by two weeks?
A. By four weeks, it was, actually. So --
Q. But you asked for a delay of two or four weeks or just a delay?
A. A delay.
Q. All right, okay. So there's a typo in relation to the two weeks and also the year?
A. Yes, I beg your pardon.
Q. All right.

At paragraph 155, you met with some success in relation to calling for further work to be done on 105
reflected on the face of the final report?
A. As put to me, people felt hugely let down and as if it had been watered down.
Q. So it went beyond the mere lack of replication of their submissions on the face of the report; it went to the issue of whether or not the report properly reflected the -- that -- the conclusions that had to be drawn from their material?
A. Correct.

LADY HALLETT: It's a very non-specific criticism, Mr Keith.
MR KEITH: Yes.
LADY HALLETT: Are we dealing with anybody else, or ...
MR KEITH: No, that's all that I was going to ask about
that, because it doesn't seem to me to be particularly specific.

Paragraph 158, there's another important point. You raise the issue of what you say is the lack of independent public health expertise informing and supporting the public health response to the pandemic.

Now, obviously a large number of members of the BMA work in the public health field. Was a general concern raised that the government was not receiving sufficient advice from public health experts, experts perhaps in pandemic management or the delivery of appropriate healthcare facilities at local level, as opposed to the
the impact of the pandemic on people from ethnic minority backgrounds, because in April of 2020 the government announced that they would be conducting a review led by Public Health England?
A. Yes.
Q. Was that the disparity review that PHE carried out?
A. It was indeed, yes.
Q. You say there that you did have some concerns about the findings, though. What were those concerns?
A. Well, we knew that a large number of stakeholders had been interviewed, and there seemed to be a large amount of evidence missing from the original report. Furthermore, the report didn't have any recommendations in it, so we were suspicious, and later had it confirmed to us, that pieces had been removed. At that point we wrote and asked for the report to be reissued.
Q. And was it?
A. It was modified in that the stakeholder engagement was then published later, and there were then recommendations.
Q. So it wasn't, though, that their conclusions were for some unknown reason omitted, it was that the report had the ability to be able to cite passages of material submitted by stakeholders and a lot of the material or some of the material submitted by stakeholders wasn't 106
epidemiological aspect of this affair?
A. Our public health members who have expertise in this 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.
Q. 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?
A. Correct.
Q. All right.

At the same time, was concern raised about the over-reliance on behavioural expertise?
A. It was. There was a lot of concern about how the necessary measures for public health protection would be received by the public, whether the public 108
would agree to lockdown and, if so, for how long. And, you know, as it turned out, the public responded very well, but that seemed to drive the narrative in, for example, mask wearing. So instead of bringing it in in one go, they staggered it. It seemed to be based on what was a political imperative to engage with the public rather than a public health narrative. The public health narrative seemed lacking, actually all the way across the pandemic.
LADY HALLETT: Is that fair, Professor? Because if you do have concerns about how the public will respond, it's not necessarily a political imperative so much as an imperative trying to ensure people will comply with the guidance or advice. Is that really fair to accuse it of being a political imperative?
A. I think some of the messaging became confused --

LADY HALLETT: I'm not denying that. What I'm saying is you called it a political imperative when I'm just saying maybe it was a "We need to keep the public onside so they will comply" imperative.
A. I think I'm suggesting that there were economic and other factors that lay outside public health necessities in deciding what the messaging to the public was.
MR KEITH: So not political, but just not public health --
A. Political with a small $p$.

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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.

In general terms, did those reviews conclude that there had been failings by the government in the same way as -- or, rather, the same failings had taken place on the part of the government as those areas of concern or failings which you had identified in your engagement 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 debrief.

It was very clear that the profession was traumatised, not only from within itself, but what it had seen happen to its patients. And we felt that because there was likely to be a delay with the Covid Inquiry, that this should be collated, you know, as quickly as possible with a view to providing evidence to this Inquiry.
Q. So may we summarise it on this basis: if you look at page 45 , l've referred to the fourth report, the public
Q. Right. I'm going to go in for the double punch, Professor, because in your witness statement you actually say that the concerns were expressed about behavioural expertise having too great a prominence rather than that the decision-making was infected by overtly political considerations.
A. That's true. But what that means by that is that it wasn't necessarily driven by the public health measures themselves that would be expected to contain and stop the spread of the virus.
Q. But that's just simply a reflection of the fact that the BMA's view was that behavioural expertise was valuable, shouldn't be given too great a prominence against other public health-related considerations?
A. Correct.
Q. All right.

Now, the final part of your statement deals with the BMA Covid review. Between January 2020 and May 2022, did the BMA carry out a number of reviews, five published reports, in fact, the first one concerned with how well protected the medical profession from Covid was, and the fourth one, the public health response by the UK Government?
A. Yes, it did.
Q. And I think the BMA drew those reviews from a number of 110
health response by the UK governments -- in fact, I apologise, could you go back, please, one page, to the bottom of page 44. The general points made in that fourth report are reflective of the points you've already raised: (a), the government was slow to react to the emergence of Covid-19 globally; (b), there was an absence of a sufficiently strong independent public health presence on SAGE; a slowness in introducing face masks to the public; the decision to shift capacity away from contact tracing on 12 March whilst not controlling the population for a further 11 days; the public messaging consequences of Eat Out to Help Out; the cost of outsourcing contact tracing and testing away from local public health capacity; the chopping and changing particularly in relation to the tier 3 structure concerning the imposition of enhanced restrictions; the clarity and simplicity of early pandemic messaging giving way to the more ambiguous instructions later; and the increasing public rhetoric concerning easing restrictions.

Those were the themes in that fourth report?
A. Yes, they were.
Q. Likewise, in a further report published in March 2021, entitled "Mitigating the impact of Covid-19 on health inequalities" -- could we have page 64 -- the BMA went 112
in to bat on the subject of a number of aspects of the way in which the pandemic had affected members of the ethnic minorities, and it asked for or it identified several key priorities for the government: reducing the overall transmission of the virus; ensuring vaccine access; improving financial security; protecting the long-term health outcomes of children; and investing in a strong public mental health response.

You set out at paragraph 232 onwards, page 68, how the pandemic had highlighted disparities within society, widened health inequalities, and impacted groups differently, and you sought to make a number of recommendations about how to ameliorate that position?
A. Yes, we did.

MR KEITH: Thank you very much.
My Lady, there have been a number of applications for Rule 10(4) questions to be put by core participants. You've declined some of them. In light of Professor Banfield's evidence, would you please grant --

LADY HALLETT: It's Mr Thomas, I think.
MR KEITH: -- permission -- yes -- to
Mr Thomas King's Counsel.
LADY HALLETT: Mr Thomas.
I'm afraid, Professor, Mr Thomas is behind you, don't get a crick in your neck. 113
more likely to have been posted to the frontline and 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.
Q. 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?
A. Yes, they are, and they have been found in multiple reports.
Q. 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?
A. 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 shaped faces or for the presence of beards. But getting hold of that at the beginning of the pandemic was very difficult. So what has been done is that that has been

## Questions from PROFESSOR THOMAS KC

## PROFESSOR THOMAS: Professor, I've only got a few questions

 for you, some of which you have touched upon already this morning, but if I can just put the question to you, and you can amplify if necessary. Yes?A. Yes.
Q. So the first question that l've got for you is: we've looked at the experience of black, Asian and minority ethnic healthcare workers in the profession; I would be interested to know what insights that you have and whether you can elaborate on what you think the key concerns posed were relating to those healthcare workers in terms of the virus and their vulnerabilities?
A. There were a number of issues that arose going into the pandemic. Firstly, the NHS is acknowledged to be institutionally racist; there are discrepancies both in the way that staff are treated and the experiences that staff have at the NHS as well as patients. So, taking the disproportionate physical effect on them, the ability to protect staff during the pandemic was affected by the biases and discrimination. People from an ethnic background are less likely to seek out and be upheld with their risk assessments, they are less likely to be forthright about saying, "I need to have appropriate respiratory protective equipment", they are 114
now, largely, rectified.
Q. Next, what tangible steps could government institutions take to tackle some of those healthcare disparities that you've told us about amongst ethnic minority communities, particularly in the context of the pandemic?
A. Well, I mean, there's a greater recognition of the need for cultural competency. You know, we went into this pandemic with one set of health messages and made no attempt or little attempt to adapt those for different recipients. So it took a long time, for example, for videos to be -- and messaging to be worked up with the BBC World Service, for example, into different languages and to become culturally competent to the communities that were actually subjected to huge discrepancy and bias.
Q. Sorry, just to be clear, so you're saying, if I can paraphrase, it was only being looked at through one lens, a white lens?
A. I'm going to say that it was looking, to start off with, as that as the default.
Q. Yes.
A. I would say that it became very apparent very quickly that that was the wrong lens, and I think that enormous efforts have gone -- been made since then to recognise 116
and correct that. And that's part of our longer term wish, to make sure that inequalities, both inside the health service and in our communities, are narrowed and resolved. Because, you know, this country cannot go on like this.
Q. Can I ask my final question: what suggestions would you propose, you know, being in the BMA, for moving beyond our established understanding, you know, to effectively address these health disparities?
A. Well, I mean, the first thing to do is to acknowledge that they exist, and then to work to eliminate them, and I think that there is work that's going on. I've talked about NHS England, for example. We've talked about the institutional discrimination within the NHS. So we are working together and want to work with whoever to make sure that this is improved and changes, because we have to have change out of this.
Q. So acknowledgement. What else, if anything?
A. Listening. Listening to what the needs are of the communities and how best to address them, and then tailoring our health service and the way that we work with people to that.

PROFESSOR THOMAS: Thank you, that's all I ask.
LADY HALLETT: Thank you very much, Mr Thomas. MR KEITH: My Lady, there are two further points, if I may. 117

MR KEITH: That's all, in fact, that I have for
Professor Banfield, my Lady, unless there are any questions that you --

## Questions from THE CHAIR

LADY HALLETT: Just following up on that,
Professor Banfield, one of the problems I've noticed with other conditions which l've dealt with in the course of my career is when there's no objective test it can sometimes be difficult to persuade, dare I say it, your colleagues of the existence of a condition.

So how do you -- this is obviously a very real condition and we've heard from several people who have suffered.
A. That is true, but one of the advantages of having the academic committee and the broader science is that I do know that there are tests on the horizon that would help us with that as a positive diagnosis.

What's really difficult about all of this is that a large number of doctors with long Covid caught this in the first wave before testing and acknowledgement and any kind of PPE was in place, but at a time that they were self-isolating from their families. At the start of this, we all used to go in in scrubs, we used to get to our front doors, switch our clothes off, go and shower, keep ourselves away from the rest of our

Firstly, we gave an assurance to the long Covid groups that I would ask a question about long Covid of Professor Banfield, which, I apologise, I omitted to do. May I put that question?
LADY HALLETT: Of course.

## Further questions from LEAD COUNSEL TO THE INQUIRY

MR KEITH: Professor, is it the position that the BMA has long advocated the issue of long Covid and the impact of long Covid on its members, so doctors and other healthcare workers, and has published a number of reports concerning and addressing the healthcare challenges of long Covid in the medical profession?
A. Yes, it is.
Q. You've made representations to government and during the pandemic, because of the impact of long Covid and the prevalence of that syndrome, you in fact made arguments to the government as to why there should be delay in the lifting of restrictions because the greater incidence of the virus would lead to an increased number in long Covid cases?
A. Yes. I mean, we've had feedback from over 600 doctors with long Covid, and their stories are horrible. It's disrupted their lives, it's stopped their careers. And there's still a lack of acknowledgement that this could and is most likely to have been gained at work.
families. So it's difficult to see how they could have caught Covid any other way.
LADY HALLETT: Thank you very much.
MR KEITH: My Lady, thank you. That concludes the evidence of Professor Banfield.
LADY HALLETT: Thank you, Professor, very grateful for your help.

## (The witness withdrew)

MR KEITH: Lastly, my Lady, in relation to the theme of ethnicity, you will recall that you ordered that a large number of questionnaires be sent out to groups and organisations, bereaved, impact and voluntary organisations, asking them for their views on this area, this theme. We've drawn together just a very high-level summary of what those responses amount to.

I don't propose to read out the questionnaires or indeed to put them up on the screen. I just wanted to summarise them in this way, that they make absolutely plain that there are a number of themes dealing with ethnicity, which are actually largely reflective of the evidence of Professor Nazroo and Banfield. Respondents highlighted in particular: the lack of consultation and involvement in decision-making, resulting in a lack of influence over the decisions that affected them; the fact, secondly, that the Covid pandemic and some of 120
the measures implemented exacerbated pre-existing inequalities; thirdly, that the government communications were unclear and failed to consider the impact on disadvantaged groups.

Many of the questionnaires -- much of the material and many of the questionnaires make plain that members of ethnic minorities are disproportionately affected by long-term chronic diseases and therefore that there were comorbidities in place and therefore they were disproportionately impact by the pandemic, they were at greater risk because of exposure to the virus in key worker roles, and children and older people from minority groups faced specific challenges.

The Runnymede Trust in particular says the BAME communities and their disparities were not fully considered by the government when making decisions about the response to Covid, and the Traveller Movement noted the contrast between the response in the Republic of Ireland and Northern Ireland and the United Kingdom. In the Republic of Ireland travellers were supported whilst in isolation or quarantine through the provision of food, phone helplines and mental health support.

Lastly, some respondents noted that the disproportionate rates of Covid deaths from 121

MR O'CONNOR: Professor, as my Lady indicated before you
A. Yes.
A. Yes.
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?
Q. This report you prepared on your own, not with, as in the case of the ethnicity report, Professor Bécares?
A. That's correct.
Q. 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".
Q. We see your name at the bottom, and the date of 19 September this year. Is that your report?
A. That is my report.
Q. Have you had a chance to read it through before giving evidence today and are the contents of it true?
A. They are.
Q. Thank you.

It's right, I think, Professor, that very broadly speaking, the subject of this report is inequalities faced at the outset of the pandemic by older people in this country?
the minority communities was both inequality and a safety work issue. Because so many key workers from minority communities faced greater risks and were placed at greater levels of exposure.
LADY HALLETT: Just to add -- thank you, Mr Keith, for that -- we do have one more witness, I think, from the organisation Mr Thomas represents, who is tomorrow afternoon.
MR KEITH: Indeed.
LADY HALLETT: And I assume will be dealing with this too. MR KEITH: Absolutely.
LADY HALLETT: Thank you.

## Mr O'Connor.

MR O'CONNOR: My Lady, as Mr Keith indicated, the witnesses you have heard so far today have been addressing the issue of ethnicity. We now move to another area, that of later life, and for that reason may I invite you to re-call Professor Nazroo.

PROFESSOR JAMES NAZROO (recalled)
LADY HALLETT: Professor. Thank you.
Don't worry, you don't need to take the oath again, I don't think anything's happened over lunch that I know of.
THE WITNESS: Thank you.

## Questions from COUNSEL TO THE INQUIRY

 122A. Correct.
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 paragraph 5 of your report. Well, perhaps you can tell us in your own words: for the purposes of this report, what do you mean when you use the term "older people"? 124
A. So "older people", the term -- I use the term in an entirely pragmatic way in the context of this report. So the report primarily focuses on those aged 65 and older. This is a pragmatic division in order to be able to collate evidence. In some places I do talk about people who are a bit younger, so those aged 50 and over.

The importance of that -- or the important consequence of that pragmatic decision, though, is that there is great variation amongst the 65 and older population in terms of the range of things that I discuss in the report.
Q. Yes. So exactly as you say, although the age gives one a cohort, much of what we will go on to discuss will be about sub-groups within that larger cohort?
A. Yes.
Q. In particular those who are vulnerable within the cohort, for example those who are economically disadvantaged; yes?
A. Yes.
Q. Older people from ethnic minorities?
A. Yes.
Q. And older people living in care homes?
A. Yes.
Q. Thank you. the HAGIS study is that it's relatively immature, so it's not detailed enough to do this kind of work yet, though it will over time be able to do that.

The other sources of data really rely on surveys that have large enough samples of older people within them, and many surveys, most surveys, do not have large enough samples of older people within them, hence the specialist nature of the English Longitudinal Study of Ageing.

There are variations in circumstances across the different four nations of the UK, of course there are, including in relation to health. The points I'm making in this report are really about the level of inequality. So it's not about the absolute level, it's about the level of inequality. There is no evidence to suggest that the nature of inequality varies across the four nations.

I take some reassurance in making that claim, drawing that opinion, because there are a range of international studies that I can look to, to examine inequality in later life, and find that across a variety of national contexts very similar conclusions can be drawn to those that I draw here.
Q. Thank you.

Let me ask you, again by way of introduction, about 125

The issue with the data from the NICOLA study and
the geographical reach of your report. You explain in paragraph 6 of your report that the data which allows you to opine on these issues is much more detailed, much more reliable, relating to England than it is to the other nations of the UK; is that a fair summary?
A. That's correct, yeah.
Q. But you go on to say, and I'm not going to take you to the paragraphs of the report, perhaps we can deal with this by way of summary, but you go on to say that, in your expert view, the patterns, if you like, of inequality and the risks that may have been present probably are replicated or were replicated in Scotland, Wales, Northern Ireland?
A. Indeed. So --
Q. Can you explain that?
A. Yeah. So for England we have a very rich data source that allows us to examine later life in a great detail. That's the English Longitudinal Study of Ageing, which has been running for more than 20 years, and so you can see how things unfold for older people as they grow older.

There are parallel studies in some of the other nations of the UK, so there's the NICOLA study in Northern Ireland, there's the HAGIS study in Scotland, there is not such a study in Wales at the moment. 126

Perhaps we can just go over the page and zoom in on paragraph 9 to finish off this point. When you say in your report is, despite the imbalance in data, if we can put it that way, you say:
"... in [your] considered opinion it is very
unlikely that there will be meaningful differences across the nations of the UK in relation to the issues discussed in this report, and that the ... conclusions [you draw] are relevant for [all those four] nation[s] ..."
A. That is my opinion, and in some places I do draw on evidence from other nations as well.
Q. Yes, thank you.

I want to move on, then, Professor, and talk about the first of the topics that you address in your report, and that is the question of the vulnerability of older people to a pandemic caused by a respiratory virus.

You say, perhaps we can go over to the next page, at paragraph 10 of your report, that it is well documented that older people have increased vulnerability to a respiratory virus such as flu, which would of course have been the obvious benchmark if we are thinking of the position as at 2020 before the pandemic; is that fair?
A. Yes, exactly, and flu is the archetypal pandemic virus. 128
Q. You refer, for example, to the well-known fact that older people are encouraged to have a flu jab?
A. Indeed.
Q. Just before we move on, can you perhaps make it clear, the vulnerability that you're talking about of older people to these types of respiratory diseases, is it a vulnerability to catching the disease or to experiencing severe symptoms and complications having caught it?
A. It's to experiencing severe complications, illness, mortality, having caught it.
Q. You explain, and l'm looking at paragraph 14 now, that there are three factors, albeit that they work in combination, to explain why it is that older people have this increased vulnerability to a respiratory virus or to experiencing severe symptoms of such a virus.

I'll list them and then perhaps we can talk briefly about each of them in turn.

First of all, a greater prevalence of chronic illness amongst that group. Secondly, reduced immunity. And thirdly, the term "frailty".

So can I ask you first of all just to expand
a little on the point about greater prevalence of chronic illness, or I think as it's sometimes referred to comorbidity?

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So those factors, then, are the building blocks, if
you like, the overlapping causes of this well known vulnerability of older people to catching respiratory viruses like flu or, as we shall see, Covid.

You go on to refer to the fact, and I'm now looking at paragraphs 17 and 18 of your report, that precisely that vulnerability which was known to exist in relation to flu demonstrated itself equally applicable to Covid within a fairly short period of the pandemic commencing.
A. Indeed, as soon as we had data from China, which was reasonably early in February, mid-February maybe, we saw very clearly that the risk of infection was not age-related, amongst the adult population, but the risk of mortality was very strongly age-related.
Q. We see in paragraph 18 of your report the type of statistic that Mr Keith referred to in his opening a couple of days ago, ONS figures between March 2020 and June 2023: that of the deaths classified as being due to Covid-19, $59.6 \%$ of them occurred in the age group of 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 less than $1 \%$ of those deaths occurring for people younger than 40 .
A. Indeed.
Q. Quite striking statistics.
A. Yes, so I think it's very thoroughly established that the risk of illness is higher amongst older people, the risk of diagnosed disease is higher amongst older people, and the risk of chronic disease is higher among 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.

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Let's move, then, if we may, to the second of the topics in your report, and this, as we said, we move from the general issues relating to the whole cohort of people of a certain age to vulnerable groups within that cohort.

You describe it as the patterning of inequality
within the older population in your report.
A. Yes.
Q. You refer in this section of your report to two segments of the older population that suffered greater ethnic inequality than others, first of all economically disadvantaged; yes?
A. Yes.
Q. Secondly, older people from ethnic minorities?
A. Yes.
Q. The issue that you are exploring in this part of your report is whether there were data available and research available in 2020 to suggest that those groups might be at greater risk to a pandemic --
A. Yes.
Q. -- such as occurred?
A. Yes.
Q. I'll start and in fact spend more time asking you questions about the first of those categories, the socioeconomic inequalities. Of course you have 132
already touched this morning with Mr Keith on ethnicity. I'll come back to it but more briefly.
A. Yes.
Q. So as far as the economically disadvantaged cohort is concerned, you make the point, I'm looking at paragraphs 20 and 21 of your report, that in the period up to 2020 broadly speaking socioeconomic inequality amongst older people was marked, and in fact was growing; is that a fair summary?
A. That's correct, yeah.
Q. Then looking at paragraph 22, and perhaps we can bring this up on screen, you say:
"Socioeconomic position is strongly related to health, even in older ages, and consequently socioeconomic position is related to risk of complications and mortality in the context of a pandemic."
A. Yes.
Q. Can you perhaps expand on that a little?
A. Yes. So if you look at the patterning of health within the older population you see it's strong correlated to markers of socioeconomic position such as wealth and education and so on, and as a consequence poorer older people are more likely to have the underlying diseases, comorbidities, that then lead to greater risk of death 133
Q. I see, all right.

But what we see, then -- I mean, let's look at the women, the graph on the left, first. Over though 72-month, six-year period, what we are seeing is essentially how many of them survive?
A. Yes, correct.
Q. The different colour lines reflect the different quartiles of socioeconomic advantage, wealth?
A. The different quintiles of wealth, yes.
Q. Sorry. The high level point to be made, if we're looking at the left-hand table, is that we see the dark blue line, so that is the bottom, the poorest quintile, far more of those people die than the highest quintile, the green line at the top?
A. That is correct.
Q. So what we see is that over those 72 months, the least affluent, only $84 \%$ of the cohort survive, whereas with the most affluent it's 96 ?
A. That is correct.
Q. So a marked difference over that six-year period?
A. Indeed.
Q. And the right-hand table reflects the experiences of men, otherwise it's the same?
A. The same pattern but --
Q. The --
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 l'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.

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A. -- 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
available in 2020?
A. Indeed.
Q. I'm sure there was lots of data addressing issues like this or closely related issues; is that fair?
A. Indeed, there were a number of papers, reports and policy documents reporting this kind of evidence.
Q. So is this, are these tables, these graphs that you've produced, reflective of what the mainstream data was showing --
A. They are.
Q. -- in the period prior to the pandemic?
A. They are.
Q. Then towards the end of your report, you refer -- we don't need to go to it -- to early SAGE meetings that took place in the very first weeks of 2020 and discussion there about trying to identify who might be the sections of society who were most vulnerable to a pandemic such as was at that stage developing, and looking at those graphs, is your view that that would have been relevant to answering that question?
A. I think it would have been relevant to answering that question. My report refers to my reading of minutes of those early meetings. I don't know the full extent of how these issues were discussed in the SAGE committee of course.
A. Yes.
Q. You have included it in your Later Life report because of its relevance to that as well as to ethnicity, intersectionality?
A. Indeed.
Q. For our purposes, we are interested in the sort of right-hand corner of this graph, are we not?
A. Indeed.
Q. Because that's the sort of end of this table which informs us about, on the face of it at any rate, disparity in health outcomes or self-reported health towards the end of people's lives?
A. Indeed.
Q. As we saw this morning, the disparities widen generally as the age of the individuals increases?
A. They do.
Q. So by the end of the -- by the far right-hand side of the table, one sees some quite marked differences, with the Bangladeshi, Pakistani and black Caribbean cohorts really quite distinct from some of the others, including the white British?
A. Yes.
Q. Now, on its face, and this is the point you make in your report, does that type of information also feed into the question of who might be vulnerable to a pandemic 139
Q. Yes, I'm not trying to -- perhaps I can make myself clearer. I'm certainly not trying to ask you to put yourself into the minds of those at SAGE and I'm not even asking really for you to comment on what SAGE did or didn't do. It's simply to address that very high-level question. If one was asking oneself from a position of knowledge and expertise at the outset of the pandemic "Who do we need to look out for?" would these graphs have given you part of the answer to that?
A. So this was not only -- this kind of evidence was not only publicly available, it actually was present in government departments and very widely circulated.
Q. Thank you.

I mentioned a few minutes ago that there were two segments or particularly vulnerable segments of society that I was going to ask you about. One was the socioeconomic disadvantage, which we've covered. The other was older people within ethnic minorities. As I said, this is an issue that you have already touched on with Mr Keith this morning, but can we go, please, it's paragraph -- if we can go to figure 4 in your report, which is just above paragraph 31. That's it. If we could zoom in on that graph, please.

Now, Professor, this is a graph that you looked at with Mr Keith this morning, isn't it?
such as Covid?
A. It does. Just to divert very slightly to illustrate the point, l'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.
Q. 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?
A. 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 140

Covid.
Q. As you explained this morning, we can see that these figures are drawn from the results of the 2011 census?
A. Yes.
Q. And no doubt it takes a while for all of that information to feed through into the research. But similarly to the questions I was asking you about your own socioeconomic data, are you able to help us whether this type of table shows the general understanding amongst the academic community of these types of issues as at 2020?
A. It does. These analyses are not unique, there have been earlier analyses that have a very, very similar pattern. Using data that are earlier, of course. So these are the most recent available, but ...
Q. As at 2020?
A. Yeah.
Q. But we then have to ask ourselves the question that you were addressing with Mr Keith, because we know that since the pandemic the ONS have produced further data, backward-looking data, which relates to this pre-pandemic period --
A. Yes.
Q. -- which gives different results. That data relates not to morbidity, which is a subject of this graph, but 141
analyses are, in my view, not credible.
LADY HALLETT: Do we not also have a problem -- sorry to interrupt, Mr O'Connor.

The graph that you showed us first, that's based on self-reporting. That's got problems too, hasn't it?
A. Yes, so the graph that we have in front of us, figure 4, is self-reported health. As I described earlier, there is now a considerable body of evidence that shows that self-reported health does predict mortality. There does not appear to be a variation in that across different ethnic groups, even though of course it is a self-report. And I haven't included it in this report, but I have similar graphs from other data periods which show something similar for things like diagnosed diabetes.
LADY HALLETT: Thank you.
MR O'CONNOR: Thank you.
Professor, I'm going to move on, and turn to another section of society again, one of those which I mentioned at the outset, one of those I mentioned as being vulnerable, which is older people living in care homes.

I'm now looking at topic 3 in your report, and in the broadest of terms -- and we'll look at this in a little more detail -- I think the headline points that you're making are that those in care homes or 143
mortality. But in fact do those later figures at least cast doubt on the accuracy of the lines we see on this page?
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 people at older ages have a shorter life expectancy than ethnic minority people at older ages.
Q. So, on the basis of that data, one would identify different groups of society as being at particular risk of a pandemic?
A. If those data were available prior to the pandemic, those analyses were available prior to the pandemic, and I would also qualify and say if those data had also received the approval as a national statistic, then they would suggest that the white British group were most at risk.
Q. You had a debate with Mr Keith this morning about the reliability of that ONS data. I don't want to go back over that territory, but maybe I can simply ask you this: do the same considerations then that you expressed this morning apply to this question of the reliability of this data as compared with the ONS data?
A. They do. The estimations of life expectancy for ethnic minority people at older ages according to the ONS 142
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 illness, that's why they're there; and secondly, the environmental considerations associated with care homes, the proximity of other people, the risks from the staff and so on.

So is that a fair summary of the very bald aspects of that type of vulnerability?
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.
A. Yes.
Q. It's been helpfully brought up on the screen. First of all, the title "Influenza in long-term care facilities";
yes?
A. Yes.
Q. 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 144
that?
A. Yes.
Q. Can you help us, I couldn't actually find it on this sheet, what was the name of the journal that it appeared in? Or perhaps you can't help us with that?
A. I can. I'm just looking it up, apologies. It's called "Influenza and other respiratory viruses".
Q. I see. In fact we do see that. If anyone's interested it's at the bottom right-hand corner of this page.
A. Yeah.
Q. Do you see it?
A. Yes.
Q. So I hadn't appreciated, that's actually the name of the journal itself, is it?
A. Yes.
Q. Thank you.

We can see the rest of the page now, because the next point to note about this article is who wrote it. Could we zoom out, please, and look at the top again. Yes. So we see three names listed along the top: Louise Lansbury, Caroline Brown and Jonathan Van-Tam. Perhaps it's the third of those names which draws the eye: Professor Van-Tam as he was then, is now. I think I'm right in saying that at the time that this article was published, that's June 2017, he was a professor of 145
and $B$ viruses are well documented in LTCFs, and may be
explosive, with high mortality, highlighting the need
for early recognition and prompt initiation of control measures."

Then two other passages, if I may. If we can go over to the next full page, and it's the left-hand column starting at "Transmission", about halfway down:
"Transmission of influenza from healthcare workers ... to hospital patients, including those in geriatric facilities, has been well documented using epidemiological linkage, nucleotide sequence analysis and contact tracking data and case reports of outbreaks of influenza-like illness in care facilities indicate that staff can transmit the virus to residents."

There is then a passage which goes into some detail about various studies and test reports and so on, but picking it up about eight or nine lines up from the bottom:
"The observed variability ..."
That's in these test results, of healthcare workers.
"... might be explained by [healthcare workers] being at higher risk of asymptomatic or subclinical infection, indicating that [healthcare workers] may act as an infective pool to transmit influenza to frail elderly people."
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.
A. Yes.
Q. With that in mind, what I want to do is just look at a few passages of this report and then ask you some questions about it.

Could we start, please, by just zooming in on the bottom right-hand corner where it says "The impact of influenza". So we see the article says:
"Persons residing in LTCFs [long-term care facilities] present a population very susceptible to the acquisition and spread of infectious diseases and for whom the consequences of infection may be serious. Nursing home residents are at greatest risk due to their overall frailty, close quarter living arrangements, shared caregivers, and opportunities for introduction of healthcare associated infections and the spread of pathogens to other facilities through resident transfers and the movement of staff and visitors in and out of the home."

I'm not sure we've got -- yes, sorry, we have got the right part:
"Outbreaks of influenza caused by both influenza A 146

Finally, if I can pick it up at the very bottom of that column and going on to the next column:
"Although the role of asymptomatic people and those with only mild symptoms in spreading influenza is uncertain, [healthcare workers] often continue to work despite having symptoms and may act as a source of infection to those in their care. Nursing home aides in particular have been shown in one Swedish study to be the occupational group at significantly greatest risk of continuing to work despite the feeling that, in the light of their perceived state of health, they should have taken sick leave. However, in reality the employment status of many LTCF staff is often precarious and taking unpaid sick leave may result in adverse economic consequences."

One might think -- thank you very much -- Professor, that in that article in 2017 Professor Van-Tam was flagging certain risks, risks that in fact, as we shall hear, transpired with terrible results, very clearly?
A. I think the paper flagged those risks very clearly, yes.
Q. First of all, he was flagging the basic vulnerability of nursing and care home occupants to a flu-like virus on account of their own frailty and their close living arrangements?
A. Yes.
Q. He was also flagging the risk that healthcare staff might themselves transmit the disease --
A. Yes.
Q. -- firstly by moving themselves between different care facilities, secondly the risk in asymptomatic transmission --
A. Yes.
Q. -- by healthcare workers. Why is that of interest?
A. Because even though you are asymptomatic you could still carry infection and therefore can pass the infection on to other people.
Q. And so --
A. If you're in intimate contact with someone, caring for them, then that risk of transmission is very high.
Q. The risk then, as with any asymptomatic transmission, is that the people who are doing the transmitting don't even realise that they have the virus, there's no reason for them to shield or to isolate, and therefore the risk of them spreading it is that much worse?
A. That's correct.
Q. Then also flagged is what's described in the report as the precarious nature of healthcare workers' employment, which in fact leads to the risk that even if they do know that they're ill they might still carry on working.
They don't want to take sick leave, they're worried 149
an infectious diseases epidemiologist, but the example would be that one person becomes infected within the care home and, without adequate protections within the care home, then the illness will spread rapidly.
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 ...
A. Infection prevention control, I believe.
Q. That's right. Again, it would seem in this article to be rather prophetic as to what was needed in 2020; is that fair?
A. Indeed.
Q. So just finally then before we leave this part of it, for the reasons really summarised in that article, that segment of the older population who were resident in
about whether they're going to keep their job; is that fair?
A. They're worried about income in the context of having to take sick leave.
Q. Finally, and perhaps bringing it all together, these risks generate risks of outbreaks of infectious disease in nursing homes, in care homes, that can be, to use the words of the report, explosive and involve high mortality?
A. They carry the risk of high mortality, indeed.
Q. The word in the report was "explosive"; is that a word you're not comfortable with?
A. I probably would not choose to use such an emotive word, but certainly a high risk of mortality.
Q. One wonders, one doesn't know, of course, but one wonders what the authors of the report meant by that word. Might they have meant that those -- if you like, it's a sort of tinder box, the coming together of frail people, living in close proximity to each other, and these transient workers who may have an asymptomatic virus and who may not be inclined to isolate even if they know they are ill, a risk of a sudden and extreme outbreak, would that be one way of understanding the word explosive perhaps?
A. So I initially qualified my response by saying I'm not

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nursing homes, in care homes, and in fact in your report you say similar considerations would apply to those who were in hospital awaiting discharge, were they another identifiable vulnerable group who were vulnerable, particularly vulnerable, to experiencing serious symptoms from Covid?
A. 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.
Q. 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 very much on the research that was available in 2020.

We will be hearing, my Lady, later this afternoon 152
from a witness from Age UK who will tell us more about the impact that was in fact experienced by older people as a result of NPIs.

But at the moment l'm going to ask you questions, as I say, about what was known, what data, what research was available before the pandemic started.

But in summary, is it fair to say, Professor, that the evidence, the research that was available indicated that older people would suffer more than most from, for example, a lockdown, first of all because, because of the greater vulnerability, they would be more likely to have to isolate themselves, and that they would be more affected once they were isolating; is that a fair summary?
A. That's a fair summary of the on-average situation amongst older people.
Q. Focusing a little on various areas. First of all, the question of social exclusion. You refer in your report to the risk of social exclusion being higher for particular groups of older people. Can you expand on that a little?
A. Yes. So I offer a brief summary of what social exclusion might be, but in effect it means poor access to services, facilities, community and so on, and the evidence suggests that people who are poorer or people 153
wellbeing, social distancing and lockdown measures have a particularly negative impact on those who do not have access to digital devices and high quality broadband, because they can be used to maintain connections ..."

And so on.
I think it's fair to say that not just maintaining connections with family but, in a distancing situation, necessary for much more than that?
A. Indeed, for connections with community networks and connections with services, amenities and so on.
Q. At paragraph 57 of your report you indicate that in the years prior to 2020 there had been a lot of progress, if one wants to call it progress, in moving many of the sort of essential services online?
A. Yes.
Q. Then if we can look at paragraph 58 , please, you say this:
"However, older people are more likely not to be using the internet."

Then you have produced this data from 2020, an estimate that $13 \%$ of adults in the UK do not use the internet, so that's a global figure, but then if one breaks it down, you say there is a sharp age gradient, so it's $17 \%$ of -- and these are figures of people who are not using the internet -- $17 \%$ in the bracket 55 to 155
who are living in more deprived areas are more likely to not only be socially excluded at a particular point in time but over time they are more likely to move into social exclusion than richer people, and much less likely to move out of social exclusion if they're already in it.
Q. And those considerations are clearly of great relevance to the question of lockdown and how older people would fare in that situation?
A. Yes, absolutely.
Q. I want to move to the question of digital exclusion.

LADY HALLETT: I don't know how much longer you have to go.
We do have, I think, about 15 minutes of other questions.
MR O'CONNOR: Yes. I probably only have another two or three minutes with the Professor, and perhaps if I finish with him and then we have a break before my learned friends can go to their questions.
LADY HALLETT: Of course.
MR O'CONNOR: It's in fact -- well, I've got two more
topics. The first of those is digital exclusion,
Professor, and I'm now looking at paragraph 56 of your report.

## You say:

"Also relevant to social and psychological 154
$64,30 \%$ in the bracket 65 to 74 , and $51 \%$ for those aged 75 and older.

You say an ONS survey also from 2020 found that nearly $40 \%$ of those aged 75 and older had never used the internet, and Age UK report that many of those who had used the internet no longer do so.
A. Yes.
Q. So $13 \%$ of the adult population but, as you say, a very sharp gradient when one gets to the older cohorts --
A. Yes.
Q. -- of people who don't use the internet.

You then go on to, as it were, focus more precisely.
You say at paragraph 60 in effect that the wealthier elderly, and I take it you mean of all of those cohorts, are more likely than the poorer elderly to use the internet?
A. Yes.
Q. So this digital exclusion is something, therefore, that's more keenly felt by the poorer elderly cohorts?
A. Yes.
Q. You also indicate or suggest that poor health also shapes the trajectory of internet use?
A. That's correct.
Q. So in summary, are you saying that these sort of intersections, older, poorer and those with ill health, 156
putting those all together, are the least likely to have or to be able to use, to be familiar with the internet?
A. Yeah. So socioeconomic position and health are related, as I described, as we discussed earlier, but over and above socioeconomic inequality, deteriorating health leads to less use of the internet.
Q. That was the data that was available in 2020, and of course one might think that, if you like, those people you're describing who are least likely to use the internet might have been amongst those who would most need it once the pandemic started?
A. That's certainly possible. And the data were available before 2020, so much of this work was done before 2020.
Q. Just finally on this, are you able to help us -- this is not something that's covered in your report, and you may not be able to help us, but are you able to help us whether there was yet another variation in the sense of whether older women were more digitally excluded than older men?
A. Older women are more digitally excluded than older men.
Q. Was that something that was there on the research prior to the pandemic?
A. Indeed, it was available prior to the pandemic.
Q. Thank you.

The last subject then, again, which is something 157

MR O'CONNOR: Thank you. My Lady, those are all the questions that I had.
LADY HALLETT: Thank you, Mr O'Connor.
Are you all right?
A. $I$ am indeed.

LADY HALLETT: Thank you very much. I shall return at
25 to. Thank you.
( 3.20 pm )
( 3.35 pm )
LADY HALLETT: Mr O'Connor.
MR O'CONNOR: My Lady, as I said, I have finished my questioning of Professor Nazroo, but there were two representatives, Mr Thomas from FEHMO, and Ms Gowman from Covid Bereaved Families for Justice Cymru, who you had indicated you might be prepared to grant permission to ask questions of this witness.
LADY HALLETT: Yes, I do grant permission.

## Mr Thomas.

## Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Thank you, Professor, l've only got one question for you, and it's this: in your report you note, firstly, the complexity of the age and ethnicity intersecting; secondly, in particular heightened vulnerabilities of older ethnic minority people, notably
that is not covered in your report, is the question of domestic abuse.

Was there in 2020 evidence showing any particular patterning or risks of domestic abuse within the older population?
A. So domestic abuse I think we need to define broadly, need to think about physical abuse, sexual abuse, psychological abuse, neglect and financial abuse I think are the main dimensions that are studied when people study domestic abuse of older people.

The evidence is intermittent. There was a large study done 2006/7, something around then, on domestic abuse amongst older people, that was a large representative study, which -- I can't remember the exact number, but something like $2 \%$ or $3 \%$ of older people reported experiencing abuse.

I think we have to put that estimate in the context of how easy it is to tell someone that you're being abused, particularly when various dimensions of elder abuse are seen as normal, routine and so on. But nevertheless, a significant proportion.

In relation to your earlier question about gender, it seems that most of the elder abuse is conducted by partners. Well, maybe not most, but at least half of elder abuse is conducted by partners.
the early onset of age-related illnesses compared with the white British group; thirdly, the significant presence of ethnic minority workers in the social care sector; and fourthly, the missed opportunities in treating older people as a monolithic group.

Here's the question: given the above, can you share with us what your views are on the appropriateness of inviting older and/or retired health and social care workers from ethnic minority communities to return to active service during the pandemic?
A. I'll speak into the microphone, sorry. I presume that's appropriate, rather than ...

Okay, so this is an important question, I think. I think it's right to summarise my evidence as suggesting that older ethnic minority people are particularly vulnerable, and this will apply of course to former as well as current healthcare workers.

So for me the question then would be what kind of risk assessments should you put in place if you were asking those people to return to the frontline in the context of the need for additional labour. So the risk assessments would be crucial here.
LADY HALLETT: Thank you, Mr Thomas.
Now, you're going to have the same problem I have in seeing the next questioner.

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Ms Gowman, there you are, I can see you.

## THE WITNESS: I can. <br> Questions from MS GOWMAN

MS GOWMAN: Professor Nazroo, I represent Covid Bereaved Families for Justice Cymru. I'm going to ask you questions on four topics, time permitting.

The first topic is the use of blanket policies and tools in healthcare. My Lady has granted permission for the Cymru group to ask a set of reformulated questions on this topic, having liaised with Covid Bereaved Families for Justice UK and Northern Ireland, and it is on behalf of all three groups that I ask questions on this topic.

At paragraph 77 of your report, you say that many hospitals used some form of triage to restrict intensive care for those aged 60 and over, modelled on a disseminated but not implemented NHS Covid-19 decision support tool.

It's right, isn't it, that the decision support tool was a points-based system, using a combination of four constituent scores across the domains of age, gender, level of frailty and medical conditions, that then subsequently recommended patients into particular treatment pathways?
A. That's correct, though, as you said, this decision
people who need treatment is appropriate to identify those as people who are not worth treating, I think is the wrong use of such tools.
Q. So they should be used to identify effectively the most vulnerable and deserving of treatment as opposed to eliminate treatment being given to those vulnerable individuals; is that fair?
A. The people who most need treatment.
Q. Yes. And it's also correct that there has been a long-standing concern about poor practices regarding the blanket use of Do Not Attempt Resuscitation notices. Is that your understanding?
A. Sorry, I'm afraid I haven't seen detailed evidence of this, so all I can observe is the anecdotal evidence that has appeared in various reporting suggesting that that was the case.
LADY HALLETT: Don't worry, we're going to deal with it in some detail at some stage. It's one of those issues that I'm very conscious of.
MS GOWMAN: If there is a blanket use of such notices, it follows, doesn't it, that that would disproportionate affect the older population?
A. It would disproportionately affect the older, iller population, yeah.
Q. From your perspective, based on the anecdotal evidence, 163

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support tool was never implemented.
Q. Yes.
A. Though it may have influenced decision-making.
Q. 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?
A. That's correct.
Q. 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?
A. 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.
Q. Yes.

Insofar as the scoring systems are concerned, could they be used to impact on the prioritisation of treatment, and in turn mortality rates?
A. 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
did the pandemic expose and exacerbate issues surrounding the Do Not Attempt Resuscitation process?
A. Anecdotal evidence suggests that the Do Not Resuscitate notices were not used, in my view, appropriately. But I haven't done research in this area, this is my understanding of the anecdotal evidence.
Q. Finally on this topic, Professor Nazroo, are you aware of any alternative approaches to clinical decision-making that reduces the risk of discrimination against older and/or disabled people in particular?
A. As l've tried to identify in my report and in response to your earlier questions, there are clearly groups of older people who are more in need of treatment, of protection against infection and treatment once they receive infection. I think those groups -- we had evidence on how to identify those groups prior to the pandemic.
Q. Thank you.

The next topic is the vulnerability of older people in care homes and awaiting discharge from hospital, which you've already covered to some extent with my learned friend.

At paragraph 89 of your report, you identify, in respect of those living in care homes and medically fit and awaiting discharge, that there was a missed 164
opportunity to implement recommendations of the review paper that we have already referred to. You have been taken to the risks in respect of those residing in long-term care facilities, but I want to ask you about the recommendations that emanated from that article. It's right, isn't it, that the article makes several recommendations in respect of control measures in respect of long-term care facilities?
A. That's correct.
Q. If I summarise them in the following way, you can tell me if that represents your understanding: firstly, it recommends routine and pre-outbreak prevention measures comprising of planning, training and education, vaccination of residents and staff.

Secondly, it emphasises the need for early recognition, including by way of testing.

And, thirdly, it makes recommendations for outbreak control measures comprising respiratory etiquette, appropriate use of PPE, isolation of infected residents, and the minimisation of transmission opportunities, closure of care homes to new admissions, limitation of visitors, rostering vaccinated staff to care for residents, and hand hygiene and enhanced environmental cleaning.

Do you agree that those represent a summary of 165
impression is that it was not, but that strictly is an impression.
Q. So when you cite in your report that there was a missed opportunity --
A. Indeed.
Q. -- is that what you mean, ie --
A. Indeed.
Q. -- a missed opportunity to implement clear recommendations emanating from the article?
A. 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.
Q. But your impression was that it was not?
A. My impression is that it was not implemented.
Q. 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?
A. So again I have not reviewed the evidence in relation to 167
A. I cannot answer that question, I don't know. The 166
domiciliary care, but the papers that I have seen suggest that there are very similar issues around underfunding and security of employment, and so on, that mean that there was a substantial risk of domiciliary care failure within the context of a pandemic.
LADY HALLETT: Just so people understand, domiciliary means care in the home.
A. Indeed.

MS GOWMAN: Thank you, my Lady, I was about to ask that follow-up question to clarify.

In terms of the issues that you identify with social care more generally that may have direct applicability to domiciliary care, your report identifies low pay and lack of resilience, carers moving from setting to setting, dependence on private agencies, problems sustaining packages of care and lack of PPE, and I think your evidence is that those issues applied equally to domiciliary care provision?
A. I understand that they did.
Q. Do you consider that there were missed opportunities by decision-makers in relation to the domiciliary care sector specifically?
A. Yes. I think the issues that you have just raised could have been considered at the beginning of the pandemic. The extent to which they were is not clear to me. That 168
they did not lead to action does seem to be the case.
Q. And should have been considered?
A. Should have been -- should have been considered and should, in my opinion, have led to action.
Q. The final topic, I think I have time, namely the disparities between the devolved nations. At paragraph 9 of your report, you state that it's very unlikely there will have been meaningful differences across the nations, and you were taken to this section of your report earlier in your evidence.

The nature of inequalities may be similar across the four nations, but do you agree that the impact and extent of the health inequalities might differ between nations depending on the population make-up?
A. So I think the -- for me the crucial point is that the level of risk of illness will vary across the four nations. I think that's very well established, that it varies across the four nations.
Q. Yes.
A. It also varies within the nations as well geographically. And so in terms of planning, you may well want to consider the absolute level of risk within the nation, but the inequality in risk, which is what I focus on here, I believe did not vary particularly across the four nations.

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distracted. But even before I do that, and just while
Professor Nazroo's evidence is fresh in our minds, perhaps just for the record I can make it clear to everyone who's listening and who may read the transcript that the terms of Professor Nazroo's instructions did not extend for us either showing him the evidence that has been provided to you about the government response or inviting him to provide any evidence, far less expert evidence, on what should or shouldn't have been done, but I think in answering questions he made it clear that he was really speaking from his own sort of --
LADY HALLETT: Yes, I was getting a little concerned at that stage.
MR O'CONNOR: -- impression. But to be clear, that wasn't part of his formal function in either drafting his report or providing his views.
LADY HALLETT: I think when you're talking about expert evidence, we have got to be pretty clear.
MR O'CONNOR: Yes.

## Summary of questionnaire responses

MR O'CONNOR: As I say, I wonder -- I'm sorry, it's going to take a few minutes, but I think it's -- since I'm going to, as Mr Keith did, just summarise the questionnaire responses that we received relating to the issue of later life, I think it would be more sensible to do that 171
Q. And one final question on --

LADY HALLETT: No, I'm afraid not, Ms Gowman. I'm afraid you're out of time. Apart from anything else, I can't find that I had given approval for these. Anyway, we're going to stop there.
MS GOWMAN: Certainly.
Thank you, Professor. Thank you, my Lady.
LADY HALLETT: Thank you very much indeed, Professor.
Those are all the questions, Mr O'Connor, for --
MR O'CONNOR: No, no further questions, I'm very grateful --
LADY HALLETT: And thank you for being so patient with us today.
THE WITNESS: No, thank you, my Lady, I appreciate the opportunity to give evidence.
(The witness withdrew)
LADY HALLETT: We've just got a wait a second, I'm afraid, until it's all cleaned.
MR O'CONNOR: My Lady, just before the witness is sworn, I wonder if I could just invite the witness to sit down for a moment, because I was in fact intending to take one other matter before I invite you to call her, which is the narrative, similar to the narrative that Mr Keith --
LADY HALLETT: Of course, yes, absolutely, the summary.
MR O'CONNOR: It's useful for her to be -- I'm sorry, I was 170
before Ms Abrahams gives evidence rather than afterwards, so that we have them in mind when she gives evidence. So I'm just going to read those out. It will take me two or three minutes.

As Mr Keith explained, we sought questionnaire responses from a range of interest groups within the field, in this case of later life, and received very helpful responses. Amongst them were -- I'll start with in fact a passage from Age UK's questionnaire, which is the organisation we'll hear that Ms Abrahams is part of, and their response included this passage:
"It should have been apparent from the very beginning that older people would be at the eye of the storm. Age was identified early on as a major risk factor for critical illness and mortality. The risk of living with pre-existing health conditions, disability or care need rises directly in line with age, including the majority of people advised they were clinical or extremely clinical vulnerable. Older people have greater likelihood of social isolation and digital exclusion. Older carers are more likely to be providing intensive informal care and there was a predictably high risk of losing and not regaining mobility, cognitive function, strength and balance or cardiovascular fitness amongst older people. In addition, the experiences of 172

| other countries that were ahead of us during the | 1 |
| :--- | :--- |
| pandemic, such as Italy, demonstrated the vulnerability | 2 |
| of older people, especially those living in residential | 3 |
| settings." | 4 |
| Then we have identified two broad themes that were | 5 |
| addressed in these questionnaire responses, the first of | 6 |
| which was a lack of understanding of the sector by those | 7 |
| making decisions. | 8 |
| $\quad$ The National Care Forum stated this: | 9 |
| $\quad$ "One key overarching theme spans our submission, | 10 |
| which is the lack of understanding of the care and | 11 |
| support sector and those who are supported through it. | 12 |
| This lack of understanding can be compared to the | 13 |
| absolute primacy given to the NHS in all aspects of the | 14 |
| government's response to the pandemic, which is a far | 15 |
| better understood institution for policy and | 16 |
| decision-makers." | 17 |
| Care England said this: | 18 |
| "Decisions were made during the pandemic, | 19 |
| particularly within or during the first wave, that | 20 |
| protected the NHS with little or no regard for the adult | 21 |
| social care sector. Decision-makers did not have | 22 |
| a clear and sufficient understanding of the social care | 23 |
| sector, lack of central understanding of the diversity | 24 |
| of the adult social care sector, particularly for those | 25 | 173

likely they are to have ill health, increased loneliness and isolation as well as financial hardship."

Then, finally, Homecare Association Wales stated that:
"Recovery did not end in spring 2022. Workforce wellbeing continues to be important. The Welsh
Government began discussions about recovery in 2020 and produced a Covid-19 recovery framework in July 2021. However, the guidance [they say] for social care only really reached a new normal during the spring 2023 when testing was finally stepped down."

My Lady, those are the summary of the questionnaire responses, and may I now invite you to call Ms Abrahams. Thank you.
LADY HALLETT: Thank you for being patient.
MS CAROLINE ABRAHAMS (sworn)

## Questions from COUNSEL TO THE INQUIRY

MR O'CONNOR: Can you give us your full name, please.
A. Yes, Caroline Susan Abrahams.
Q. You are the charity director of Age UK; is that right?
A. Correct.
Q. I think that's a post you've held for some time?
A. Yeah, l've been there for about 11 years.
Q. So during the pandemic?
A. Indeed.
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.
A. Yes.
Q. Do you recall signing it?
A. I do.
Q. I'm sure you're familiar with the contents of the statement.
A. Yes.
Q. Are they true to the best of your knowledge and belief?
A. Yes.
Q. It's a very lengthy statement, Ms Abrahams, and we won't be able to go into anything like the detail that it contains today, but of course the Inquiry have the statement and we will be adducing it in writing in full. What we will try to do today is simply, in the time we have available, cover some of the key themes that you have identified.

First of all, may I ask you just a few questions about Age UK itself.
A. Yeah.
Q. You describe the organisation in your statement as being a federated network of organisations across the UK?
A. Yeah.
Q. Can you perhaps explain that in a little detail, please.
A. Certainly. So there's Age UK, the national organisation which I work for, and then we also have about 125 local Age UKs scattered across England, and there's Age Cymru, Age Scotland and Age Northern Ireland, there's also Age International, and we have a commercial arm as well.
Q. Another measure of the size of the organisation is how many people it reaches.
A. Yeah.
Q. And in your statement you say that you believe that, taken together, the organisation reaches about 1 million older people across the UK; is that right?
A. Correct.
Q. In what way?
A. I suppose the bulk of those numbers come to use our information and advice, particularly through our website, but we also operate a free helpline that is rung by hundreds of thousands of people every year.

In addition to that we also have our local Age UKs that provide face-to-face services, and then nationally and locally we provide friendship services for older people as well.

We also -- obviously through our information and advice it covers just about anything any older person ever wants to know about, or indeed their family or carers. We provide friendship services for people who are alone who would like more companionship in their lives, which -- join up a volunteer with somebody who can ring them once a week, that sort of thing.

And locally we provide a wide range of direct services in local communities. Some of it is low-level support in people's homes, there is some personal care delivered, but also things like choirs and pottery classes and keep fit and rambling and all kinds of things you could -- you know, men in sheds and walking football, all sorts of things like that, which give older people the opportunity to come together to sustain their wellbeing, to keep physically fit and mentally fit as well.
Q. Thank you, Ms Abrahams. You will see we have a stenographer who is trying to take a note of what we both say.
A. Yeah
Q. I'm trying to speak slowly and perhaps I can just ask you --
A. I'll slow down, sorry.
Q. -- on her behalf to try to speak a little more slowly as
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 Age UK?
A. Yeah
Q. We see that reference to 1 million people a year and you say that you seek to ensure that older people have enough money, are socially connected, receive high quality health and care, that they're considerable, safe and secure at home, and that they feel valued and able to participate in society.

Then you explain how you seek to achieve those ends, referring to research, advocacy, campaigning, providing information, advice, public information, and so on.
A. Yes.
Q. Can you maybe just expand a little on those various means by which you seek to achieve your aims?
A. Certainly. Yeah, so particularly nationally we research, campaign and advocate, and that's my job, really, with my colleagues, to work with decision-makers, to work with government, the NHS. Very often we're asking the question: what about older people? That's, I guess, our primary role. But also talking in detail with policymakers about emerging policy and practice issues.
you answer our questions. It's very difficult to remember.

You mentioned that your particular role amongst that whole range of activity that you just described is in the campaigning and the advocacy --
A. Yeah.
Q. -- and you mentioned engaging with the NHS and also policymakers --
A. Yeah.
Q. -- more generally. Are there in fact particular sort of liaison points in -- and I'm really, perhaps, asking you about central government now, that you normally engage with?
A. Yes. Very often central government, different government departments, will set up groups, they will bring together officials from a government department and also outsiders, people who work for organisations like mine, who know about issues they're interested in. Of course during the pandemic those largely stopped and for a while that sort of contact became more difficult. But it's also the job for people like me to build strong trusting relationships with ministers, with their advisers, and with senior officials. And the same is true with the NHS.
Q. I want to come on to ask you about the pandemic and your 180
campaigning, advocacy role on behalf of Age UK during that time.

Starting chronologically at the beginning, you
say -- this is in fact in paragraph 9 of your report, so it's the fourth page, l'll read out just a sentence from that paragraph, you say:
"There were clear indications that the virus itself and public health measures taken in response would have a disproportionate impact on older people."
A. Yeah.
Q. How quickly in the course of the spread of the virus did it become clear to you in Age UK that it would have this type of disproportionate effect on older people?
A. Very early on. And I think that was because we knew what your previous witness knew about the evidence, and we could see what was playing out on in the media, particularly from Italy and America, where congregate settings were proving to be places where, once the virus got in, lots of older people were dying or becoming very ill. So that was a very clear warning to us, and I think should have been to everybody else. But of course we also -- it's our job to understand older people in the round, what their lives are like. So we knew that if there were lockdowns or people's movement were restricted or they restricted their own movements 181
then trying to engage with government in a constructive way so that they understood what the issues would be for older people, and we could also act as advocates for government actually back to older people. We felt that was part of our responsibility too, because we know we're a trusted voice by older people and we have really good channels to lots and lots of them.
Q. Did your engagement with government, national government in that period extend to lobbying for particular steps to be taken, for example most obviously perhaps a lockdown, or particular provision being made for older people?
A. Well, at that stage, and I would say probably for the first two or three months, most of our lobbying happened through the media, because we weren't -- no one was reaching out to us from government on the whole, and we were finding it really difficult to reach in. It was as though the wagons had circled and everyone was very internally focused within government. Our usual routes in were no longer there, so that was a problem for us because those groups that we would normally be part of weren't meeting, and of course there were no face-to-face interactions. So people doing my kind of job depend a lot on bumping into people and having that conversation in the corridor and, we couldn't do that. 183
because they were frightened to go out, that that would have a huge impact on older people, particularly older people living alone or who didn't have good family or neighbour support, who really were suddenly in really big trouble.
Q. So in those early, I think you're saying, weeks --
A. Yes, definitely.
Q. -- in 2020, what steps did you take as an organisation --
A. Yes.
Q. -- to try to react to what you understood?
A. Well, local Age UKs situated in communities across England, lots of them dropped what they were doing normally and became emergency outreach organisations, particularly delivering food to older people who were stuck at home, collecting prescriptions, transporting older people around, those sorts of tasks. Sometimes off their own bat and sometimes as part of broader community activity. Some of it formally led by councils or by the emergency forums that were set up in local areas.

Nationally, I think the first thing we did was we were on the media a lot nationally, and locally, trying to reassure older people, because we were conscious how incredibly scary all this news would be for them, and 182

So we were quite cut off, and it meant that on the whole our advice initially was conveyed through the national media.
Q. 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 --
A. Yes.
Q. -- and, secondly, what you mean by those strong words?
A. 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 have dementia, and very often physical health problems 184
as well. So these were very, very vulnerable people.
And many care homes didn't have enough staff, even at the beginning of the pandemic. Even before anyone got sick, they were covering with agency staff who were in and out.

So we could see what was likely to happen, and yet it seemed to take a long time for policymakers to respond to that reality.
Q. I'm going to come back in a moment because, in the subparagraphs underneath paragraph 39, you refer to a few, what you regard as being the sort of crucial --
A. Yes.
Q. -- factors that fed into that --
A. Yeah
Q. -- government response.
A. Yeah.
Q. But before I do, it's fair to say that you also say in that earlier part of paragraph 39 that things got better, as far as you were concerned, in the way that the government responded.
A. Definitely.
Q. The first wave --
A. Yes.
Q. -- was the worst, but --
A. Yes.

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A. Yeah
Q. -- few months, and what you describe as the deeply inadequate government --
A. Yeah.
Q. -- response to the first wave. As I said, you identify, just below paragraph 39, three points --
A. Yes.
Q. -- which you describe as the critical factors --
A. Yeah.
Q. -- and I just want to ask you briefly about --
A. Yes.
Q. -- each of those.

The first point you make is what you describe as a sense of fatalism --
A. Yeah.
Q. -- an underlying assumption that older people with care needs would be unlikely to survive --
A. Yeah.
Q. -- there wasn't much that could be done for them?
A. Yes.
Q. Is that a sense of fatalism that you got from -- that you understood to be present in central government?
A. My colleagues -- this is my colleagues rather than me -but including, for example, our head of research, who is an academic epidemiologist. So they -- people like that 187
Q. -- subsequently matters improved.
A. Very much so.
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 Sir David Pearson, as he now is, to come in as their adviser and to essentially sort out their response to social care, and he was a highly -- he is a highly respected leader in local government and also, crucially for us, a friend; we knew him. And he then became the bridge that had been so obviously lacking, I think, between government on the one hand and the outside world on the other, and David was able to mediate that, and I talked to him a lot. If we saw things we were worried about, we could just ring him up and tell him and he would listen and he would act on them, where appropriate, and he was also able to ask us for help too, and he helped to stimulate the creation of more structured engagement with providers of care and organisations like Mind and Carers UK, who you've also mentioned today.
Q. Thank you.

So that was as things were to develop --
A. Yes.
Q. -- but, as I said, just coming back to those first -186
talked -- eventually were able to talk to some of the scientists and some of the senior public health figures who were trying to manage this disaster, and I think from them they felt a definite sense that there wasn't much that could be done. If the virus did ever get into a care home, there wouldn't be a lot that you could do.

So I think too much -- I mean, of course we saw what happened, to a degree they were right, but actually it was incredibly patchy and some people -- not all older people are the same, I suppose that is the most enormous finding that comes out so far from this evidence -- and some older people were fit and well, they didn't have comorbidities and they were able to withstand it. And even in care homes we saw some older people who caught the virus and were okay, and other care homes that worked incredibly hard and managed to keep the virus out altogether.
Q. Then, perhaps just briefly, if we can go on to the next page, the other two --
A. Yeah.
Q. -- critical factors that you refer to.

First of all, and this is perhaps a consideration of which we heard in the questionnaire responses --
A. Yeah
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.
Q. -- "but to an extent throughout, there was a hesitation on the part of government to intervene or to provide support to services which were predominantly provided by the private or voluntary sector."
A. Correct.
Q. Again with the questionnaire responses there was the contrast noted --
A. Yes.
Q. -- between the consideration that the government --
A. Yeah.
Q. -- appeared to be taking to protecting the NHS --
A. Yes.
Q. -- on the one hand, and the social care --

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disease itself had on older people.
A. Sure.
Q. And then some questions about the impact of NPIs --
A. Yes.
Q. -- on older people.

First of all, you describe in your statement issues relating to infection control --
A. Yeah.
Q. -- in care homes.
A. Yeah.
Q. We've already heard some evidence about that, and we'll be hearing plenty more, so I don't want to take time --
A. Sure.
Q. -- with you today on that.

There was one point, a related point in your statement which is perhaps worth touching on, which is that you draw attention to the fact that really similar issues arose very widely in relation to care being provided not in --
A. Yeah.
Q. -- residential care homes --
A. Yes.
Q. -- but in fact in people's domestic homes.
A. Indeed, and that's absolutely the case, and I know that from Age UK and I know it because I was caring, with 191
A. Yes.
Q. -- sector on the other. Is that the point, perhaps, that's coming here?
A. Definitely and, you know, you could see it play out all the time at that time. A real sense sometimes, I think more from ministers than -- certainly rather than officials, that these were private organisations so, you know, it was up to them to look after themselves, this was not part of the state.

So I think the fact that social care is so fragmented -- and in practice, as you know now, it provides an absolutely crucial public service for very vulnerable people -- but with its fragmented governance it meant there was a reluctance, and actually to begin with an inability really to know how government could help. They didn't have the information, they didn't know who they were, they didn't have a list even of -they couldn't even write to them, to begin with.
Q. Yes. Thank you.

I'm going to move on now, away from the Age UK's liaison with the government and steps taken during the pandemic, and shift focus to more what we talk of as impact evidence.
A. Yes.
Q. First of all, a few questions about the impact that the 190
a care package, for my mum at home at the time. So I saw it from my personal experience as well as from Age UK's. And you may remember that at times it became very difficult to actually even get hold of gloves and masks and things like that, aprons, or they were very, very expensive, and it was difficult, particularly for all those people who fund their own care who aren't part of the state system at all, of whom there are hundreds of thousands, to even be able to get hold of those sorts of things, and because of that reality it faced carers and older people with a difficult decision about whether it might be safer to stop care coming in to the home and to try and manage on their own rather than have someone come in who wasn't properly protected, wasn't able to protect themselves. And over time that improved and those things became more widely available.
Q. Yes.
A. But it was a continuing fear, I think, for many carers.
Q. Moving to another albeit related subject, I'm now looking at page 21 of your report, paragraph 48, end-of-life care.
A. Yes.
Q. You refer to the fact that, particularly perhaps in residential settings but maybe in homes as well --
A. Yeah.
Q. -- the palliative care, the symptomatic relief --
A. Yeah.
Q. -- that would in normal times have been available dried up --
A. Yeah.
Q. -- partly, perhaps principally, because GPs weren't visiting and the care staff weren't able to prescribe this medication.
A. Yes. I mean, that was particularly a problem in care homes where very sadly for a time, again quite early on in the pandemic, it wasn't -- there were lots of people very, very sick and dying in some care homes, but the people working there couldn't access the drugs that make that -- someone feel more comfortable in that situation. And this has to be seen against a context in which palliative care, before the pandemic, during the pandemic and now, is very patchy, and you can be lucky and be in a part of the country where that is available, often through a palliative care team or district nurses or a hospice at home service, or where there are none of those resources.

So -- but after a time they resolved those issues and got over the problem of things like: was there someone with the right qualifications in a care home to be able to dispense what is controlled medicine? These 193
A. Yes, and I don't think this was -- I mean, this is a particularly grave example of what happened to somebody in that situation, but the situation was not unusual, at that time, that people were unable to see 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 with now, which is people who became unwell in different ways during the pandemic but were unable to get the treatment they needed, either for a new condition or for one of those long-term conditions they were managing, and it helps to explain why so many people are unwell today.
Q. I mentioned that I would deal first of all with the impact of the disease itself and regulations and so on --
A. Yeah.
Q. -- and then on the impact of NPIs.

I know that you've seen the impact video --
are powerful drugs that people need at this point.
Q. Yes.
A. But yes, tragically for some people, they died without that help, and I hate to think what some care workers witnessed, and I'm sure they're experiences they will never forget.
Q. Moving on, Ms Abrahams, now I'm looking at page 23 of your report, this is in the section where you deal with, again, a related consequence of the pandemic, which is simply older people not having access to normal, whether it's primary or --
A. Yeah.
Q. -- ongoing care.
A. Yeah.
Q. And you give perhaps a particularly striking example -I'm looking at, as I think I said, paragraph 54 -- of an elderly lady who, on the face of it, was very seriously injured with spinal injuries, but the type of injury that one would normally expect to have --
A. Yeah.
Q. -- hospital treatment.
A. Yeah.
Q. But in fact -- well, perhaps you can tell us, in a few sentences explain, but on the face of it appears to have had very little care indeed.
A. Yes.
Q. -- that was shown at the start of our hearings on Tuesday of this week, and I know that you recall this 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 one who doesn't seem to have had Covid herself --
A. Yeah.
Q. -- or in fact she doesn't mention anyone else she knows --
A. Yeah.
Q. -- or her family having had Covid. But she spoke about the profound impact that simply isolating --
A. Yeah.
Q. -- had had on her. She said, from memory, that she'd been worried about catching Covid, she had some pre-existing health problems.
A. Yes.
Q. She was frightened of having to go to hospital, and she said that she'd been indoors for three years now --
A. Yeah.
Q. -- more or less, she didn't feel she could go out any more.
A. Yeah.
Q. She wasn't the person she had been before, she'd been a sociable person but now --
A. Yeah.
Q. -- she couldn't really get her head round meeting other people.
A. Yeah
Q. Is that a typical story that you hear in the course of your work?
A. I'm not sure it's typical, but we hear from many older people in that position, and so do our local Age UKs.
So one of the new services some of them have created is actually helping older people to get out of their own homes and begin to walk around again, and including using transport, which is a particular fear for some older people. But of course for many it's too late. It was a different -- it was a different lifestyle for sufficiently long time that they're not able now to be able to go back to how they were.

So, yes, I'm afraid there are many older people who lead much, much more constrained lives now than before the pandemic.
Q. Some of the concepts you describe in your statement are physical and mental deconditioning --
A. Yes.
Q. -- as a result of lockdown.
Q. -- of lockdown. I'm now looking at paragraphs 80 and 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 --
A. Yeah.
Q. -- 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.
A. Yeah. Absolutely, and, you know, one's heart goes out to carers and families who found they were -- there was no one to call for help, and they were with somebody who was profoundly unwell for long periods of time. And we have no doubt at Age UK that this will have led to neglect, to abuse, to enormous distress for carers and also for people being cared for. It's difficult enough caring for someone with dementia at the best of times, not like this, and day centres are often a great outlet for people, they give some -- a good safe place for someone -- somewhere to go, and the carer has a few hours off. But, as you've heard, those opportunities often disappeared. Those services had to close during 199
A. Yes.
Q. And also an effect on mental health and much higher rates of depression and self-harming and suicide amongst --
A. Yeah.
Q. -- older people.
A. Yes, we've had to provide new training for some of our helpline staff on how to cope with people who are ringing up in great distress, and that only happened during and after the pandemic. It's undoubtedly exacted a toll on many older people, that anxiety, and also -as in the case of the lady on the film -- a great loss of confidence, coupled with the fact that if you stay still and you don't move around so much, as an older person, then you stiffen up and your muscles tend to waste and then it's physically very, very difficult to be able to get around.
Q. You mentioned earlier in your evidence the great number of people -- I think you were actually referring to care homes, but no doubt generally -- of older people who suffer from dementia.
A. Yeah.
Q. In your statement you do say a little about the particular impact on that group of people --
A. Yeah.

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the pandemic, and actually many of them have not re-opened, so there's an ongoing problem today.
Q. At paragraph 82 of your report, so over on the next page, you give an example of a very particular concern of dementia patients who were at home and wandered off, left the house and their carers, their family being uncertain as to whether they could even go and try and find them because they might be breaking lockdown regulations.
A. Yes.
Q. From the way you put it, it sounds as though that was not an isolated case but something that you heard of more than once?
A. I think we certainly heard of lots of different ways in which ... people trying very hard to stay the right side of the law got in the way of being able to do the things they wanted to for their loved ones, even if that was being afraid to go out for a walk because they read that the police had arrested someone who'd sat on a bench, those sorts of things. And so, you know, none of these things were probably intended, but it was a time when people were very -- and lots of older people -- most older people are very law-abiding and they don't want to do the wrong thing. So these may well have been older carers who were worried about going out, and indeed 200
particularly at a time when they were being told to takeextra precautions.MR O'CONNOR: Yes. Ms Abrahams, thank you very much.
MR O'CONNOR: Yes. Ms Abrahams, thank you very much . 3
As I said at the start, we have your witness statement.
There's far more detail in there than I have been able
to cover today, but those are all the questions I wanted
to ask you. Thank you very much.
THE WITNESS: Thank you.
LADY HALLETT: Extremely grateful, and I suspect we might be
seeing you again during the course of this Inquiry, but
there is a great deal of information in your statement,
and I'll consider it all very carefully.
THE WITNESS: Thank you very much.
LADY HALLETT: Thank you very much for your help.
THE WITNESS: Thank you.
(The witness withdrew)
MR O'CONNOR: My Lady, that concludes our business for
today.
LADY HALLETT: Thank you very much.
So we meet again at 10 o'clock tomorrow. Thank you.
( 4.30 pm )(The hearing adjourned until 10 am
on Friday, 6 October 2023)
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