Wednesday, 4 October 2023

(10.00 am)

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

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

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

LADY HALLETT: I can, thank you.

MS TWITE: Thank you.

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

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

ratified human rights treaty in history.

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

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

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

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

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

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

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

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

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

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

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

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

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

political and administrative decision-making.

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

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

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

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

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

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

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

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

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

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

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

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

A different parent wrote:

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

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

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

And finally:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

My Lady, in our written submissions --

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

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

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

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

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

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

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

MS TWITE: I'm grateful, my Lady.

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

MS TWITE: Thank you very much.

LADY HALLETT: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"- shopping ...

"- one form of exercise a day ...

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

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

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

And, my Lady, you will immediately see that this

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A woman interviewed by Solace said:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much, my Lady.

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

Mr Jacobs.

Submissions on behalf of the Trades Union Congress by MR JACOBS

MR JACOBS: Good morning, my Lady. This is the opening statement on behalf of the Trades Union Congress.

I appear with Ms Ruby Peacock and we are instructed by Thompsons Solicitors.

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

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

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

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

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

My Lady, it will persuade no one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The problematically affected a number of vulnerable

and protected groups working in higher risk occupations.

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

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

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

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

"[Chief Medical Officer] said clearly that financial

support for people self-isolating is key. [Cabinet Office] working through mechanisms (very slowly)."

On 7 September 2020 he wrote:

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

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

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

In this module, the Inquiry should ask whether all of the professed anxiety for vulnerable groups translated into action. Support for self-isolation was a practical, concrete and entirely obvious way of

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

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

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

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

on key guidance documents was often late or non-existent. Just by way of example, key guidance produced by the Department of Business, Energy and Industrial Strategy on the return to work after the first lockdown was provided to the TUC on a Sunday morning, with a 12-hour response time. The TUC did respond with a number of concerns raised but the consultation was for too late to be meaningful.

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you very much indeed, Mr Jacobs.

Mr Thomas King's Counsel.

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

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

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

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

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

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

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

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

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

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

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

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

FEHMO invokes those principles.

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

FEHMO dares to speak.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But it is essential to recognise that this isn't

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

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

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

Meanwhile, the very essence of public health

communications during this period lacked accessibility. For many, my Lady, the language of guidance was exclusively in English, erecting barriers in accessing crucial information.

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

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

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

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

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

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

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

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

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

Thank you.

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

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

(11.10 am)

(A short break)

(11.25 am)

LADY HALLETT: Mr Stanton.

Submissions on behalf of the British Medical Association by MR STANTON

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

for an urgent investigation.

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

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

Thank you, my Lady.

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

Mr Allen King's Counsel.

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

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

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

authorities; and councils played an absolutely major role in bringing the country through the pandemic.

During Module 1 it was widely acknowledged the nation's preparedness and resilience plans were ill focused and inadequate, and in this module the Inquiry will look at how those preparations were deployed and how government at all levels made policy under pressure and then operationalised it.

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

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

sharing between central and local government.

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

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

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

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

virus.

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

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

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

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

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

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

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

Secondly, in the early stages, there was

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

This delay affected the design of schemes of very great importance to the community at large. For example, in relation to shielding the clinically extremely vulnerable and contact tracing, as well as to aspects of the legislation that was introduced and supporting guidance.

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

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

Fourthly on this aspect, particularly at the

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

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

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

Again, there are four subpoints to this.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you very much, Mr Allen.

Mr Phillips, there you are.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the last resort.

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

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

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

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

That's all I wish to say at this stage, my Lady. The NPCC will continue to assist the Inquiry in any way it can.

LADY HALLETT: Thank you very much indeed, Mr Phillips.

Mr Sheldon, I think you're over there.

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

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

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

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

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

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

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

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

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

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

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

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

into account by decision-makers.

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

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

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

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

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

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

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

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

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

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

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

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

The analysis must also ensure, we submit, that

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

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

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

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

The technical report on the Covid-19 pandemic in

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

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

Thank you, my Lady.

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

Mr Howells.

Submissions on behalf of the Welsh Government by MR HOWELLS

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

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

to learn lessons for the future."

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

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

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

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

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

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

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

benefits of effective devolved decision-making.

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

Firstly, the decision-making structures.

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

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

preparations.

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

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

The second main point is the funding of a health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Diolch yn fawr.

LADY HALLETT: Thank you very much.

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

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

MR HOWELLS: My Lady, I'm grateful.

LADY HALLETT: Thank you.

Ms Drysdale.

Submissions on behalf of Scottish Ministers by MS DRYSDALE KC

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

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

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

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

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

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

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

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

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

Devolved control of the public health response was

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

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

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

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

Scottish Government took the approach of tailoring restrictions to local circumstances.

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

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

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

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

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

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

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

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

The Scottish Government took the approach of

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

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

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

occurred in the future.

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

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

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

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

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

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

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

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

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

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

Thank you.

LADY HALLETT: Thank you very much, Ms Drysdale.

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

Submissions on behalf of the Cabinet Office by MS STUDD KC

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

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

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

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

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

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

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

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

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

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

the planning could reflect the advantage of that testing ability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In responding to Covid-19, the government sought to

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

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

LADY HALLETT: Thank you very much, Ms Studd.

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

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

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

LADY HALLETT: I so order. Thank you.

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

MR KEITH: Yes, very well, thank you.
LADY HALLETT: Very well, 2 o'clock.
(12.48 pm)
(A short break)
(2.00 pm)
MR KEITH: My Lady, may I please call Joanna Goodman.
MS JOANNA GOODMAN (affirmed)
Questions from LEAD COUNSEL TO THE INQUIRY
LADY HALLETT: Ms Goodman, I appreciate this could be difficult for you, so please just say if it gets too much. All right?
A. Thank you very much.
MR KEITH: May I please ask you to start by giving us your full name.
A. Yes, it's Joanna Sophie Goodman.
Q. Ms Goodman, whilst you give evidence, could you try to keep your voice up as much as you can, so that we may all hear you as clearly as possible.
A. Yes.
Q. Also because your voice needs to be clearly received by the microphone so it can be recorded.
If I ask you a question that isn't clear, which may be quite possible, please ask me to repeat it.
A. Yes.
Q. Ms Goodman, you have been good enough to provide this

Inquiry with a statement signed in fact on 27 September of this year. We don't need to bring it up, but it's INQ000281297. Is that your statement? And it is of course true.
And my Lady, perhaps that could be published in due course.
We heard in Module 1 from Matt Fowler. Was he, is he, the co-founder, with you, of Covid-19 Bereaved Families for Justice?
A. He is.
Q. I'm going to ask you some questions about your father Stuart in a moment or two, but did the group Covid Bereaved Families for Justice come into being at the end of April 2020 soon after you had lost your own father on 2 April?
A. Yes.
Q. Could you just say something about why you instituted the group, why you commenced it, and what was it about the circumstances of your father's death which caused you to have to set up, as you saw it, that group?
A. Yes. So my father Stuart, he was someone who, from very early on, we knew was likely to be vulnerable to Covid-19. He was 72, he had a number of health issues, and at the time he was undergoing diagnosis for cancer.
When the risk factors for Covid-19 were published,

they looked pretty much like a shopping list of his health conditions, and I still have a message that I sent to him on 3 March telling him that I wished I was able to wrap him up in a giant ball of cotton wool.
At the time I was actually in India, and in India it was already very clear that the virus was something to be feared, that -- for instance, in my statement I gave the example of the festival of Holi on 10 March, festivities were very, very much scaled down. And people were actually approaching me and saying, "Oh, you know, it's really worrying to see how quickly cases are rising in the UK", and I was very, very anxious about my own father. So I was on the phone to my parents most days in March 2020 to say, you know, "Oh it's really worrying, you know, there are more cases", and my family -- effectively we made the decision to shield my father from long before the first lockdown.
Q. Can I just pause you there.
A. Yes.
Q. There's quite a lot to take in there from that.
Your father had had, I think, a number of health issues in the years before the pandemic, including two heart attacks, and therefore was it the position that a considerable amount of care had to be taken to ensuring that he remained healthy thereafter, and

obviously that he was protected to whatever degree was required?
A. Yes. I think it was very clear to myself and my family very early on that should my dad contract Covid-19 the chances of him surviving were very low, and so that was why, I guess, it was a no-brainer for us that we needed to do everything we could to keep him safe, and that included -- for instance, my mum works as a music therapist in schools, she stopped into going schools, they scaled back their social contact and then eventually stopped their social contact before the first lockdown. My brother stopped going to visit my parents because he also worked in a school and was coming into contact with a lot of people.
So --
Q. Was the problem, the immediate problem at that time, that your father had had a scan the previous autumn, around about November 2019, which had required him to go into hospital to get the results of that scan?
A. Yes. So my dad was no longer going out in public in general. On 18 March 2020 he had an appointment at the Norfolk & Norwich Hospital to receive his cancer diagnosis. I was very anxious about that appointment, and I actually called him on the morning of the appointment begging him not to go, because I felt

that no testing was taking place, there was no treatment taking place. As far as I was concerned that appointment could have happened over the phone.

Q. Just pausing there, which part of the country was the hospital that your father was required to attend?

A. It was in Norwich, in the East of England.

LADY HALLETT: I think the clue was in the name.

MR KEITH: Did she say Norfolk?

LADY HALLETT: Norfolk & Norwich.

MR KEITH: Yes, I should know that.

Did your mother and father go to hospital together?

A. They did go to hospital together. My dad was of the view that he wouldn't be invited to attend an appointment if it wasn't safe, and he had a huge amount of faith in the NHS. He never liked to be a burden, particularly to public services, and he felt that it was -- he want didn't want to kick up a fuss and ask for an appointment to happen over the phone. So they went --

Q. They were together?

A. They were together. And they spent the day in crowded waiting rooms with no mitigations in place, no face masks, no social distancing, no ventilation.

Q. Just pause there. They recounted this to you, presumably?

A. Yes.

Q. Did your father receive his diagnosis that day?

A. He did, yes.

Q. He did, and that was of, I think, non-Hodgkin lymphoma?

A. Yeah.

Q. He came back home. Were you still abroad at that stage or were you by then travelling back?

A. I was still abroad when I was notified of the diagnosis. So previously we'd been led to believe that the cancer was likely to be slow moving and non-aggressive. It then became clear it was aggressive and required immediate treatment, so I made the decision to travel home as soon as I was able.

Q. And because of your father's condition, and because of Covid, did you and your brother decide to self-isolate for the whole period that you believed was appropriate, in order that you could then see your father and of course your mother thereafter?

A. Yes, so this was prior to the first lockdown, and the plan myself and my brother had come up with was that we would isolate at his home and then -- with the intention to move home with our parents while my dad was undergoing chemotherapy.

So I came home from India having not seen my parents for four months and knowing that my dad had just been

diagnosed with cancer, and I had to wheel my suitcase at a distance to my mum as we both sobbed in the street, I think, at about 8 am on a Sunday, probably much to the bemusement of the neighbours. But yeah, the intention was that myself and my brother would isolate in order to keep him safe.

And it's worth saying, actually, that I landed at Heathrow on the morning of, I believe, 22 March, if that was the Sunday, and --

Q. You might have landed on the 21st.

A. I might have landed on the 21st, yeah.

Q. I don't think there's any disagreement on the date.

A. Yes. And I was very anxious about what I needed to do to keep my father safe, having been on a busy flight. The only sign of any guidance there was to me at Heathrow was a single person with a leaflet who I asked, you know, "I'm planning to isolate for two weeks, is that the best course of action?" And they just said, "You don't need to isolate unless you've got symptoms, here's a leaflet", and it just very basically said if you have symptoms to isolate then. But, yeah, I was quite shocked, actually that there was no testing, no -- yeah, no --

Q. No measures in place.

A. -- proper guidance, no distancing. I was actually told

by a flight attendant on my flight, because I was wearing a face mask at the time, I was told, "Oh, you haven't been taken in by all this, have you?" And that was very much the -- the mood, it felt, at the time.

Q. Your father started the chemotherapy on the first day of lockdown. Did he go back to the same hospital for the chemotherapy where he had received his diagnosis?

A. He did. None of us were able to attend with him, so my mum took him there and then needed to leave him. He wasn't tested prior to starting the course of chemotherapy, and I think what's worth saying is that we believe that he contracted Covid when he attended that appointment on 18 March --

Q. When he received his diagnosis --

A. When he received his --

Q. -- rather than when he went in for his first dose of chemotherapy?

A. Yes. And so we believe that he would probably already have tested positive for Covid-19 on the day he began his chemotherapy treatment, but no test was offered. And, as you will know, chemotherapy, it compromises your immune system, so any hope that he would have had of surviving Covid, I think the chemotherapy --

Q. Would have disposed of that?

A. Yeah.

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

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

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

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

LADY HALLETT: Just take your time.

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

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

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

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

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

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

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

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

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

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

Q. Right.

After your father passed away, do we presume that

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

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

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

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

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

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

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

Q. You felt that --

A. -- I could go on.

Q. -- that were contributory features?

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

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

Q. All right.

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

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

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

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

Q. Shared your views?

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

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

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

A. Yeah.

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

A. Yes.

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

A. Yes.

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

A. Yeah. So --

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

then they couldn't be gravely ill, despite their families describing very, very significant other symptoms.

There were people who were asked if their loved ones' lips had turned blue, which is a presentation that might be present in someone with a caucasian skin tone that might not be present in someone with a darker skin tone.

There were people who were asked about symptoms which weren't present but the symptoms which were present were kind of disregarded.

There didn't seem to be any element to the assessment process which took into account people's pre-existing health conditions, so a lot of people had existing vulnerabilities which made their symptoms significantly more concerning.

Q. Ms Goodman, may I just pause you there, I do apologise.

A. Yeah.

Q. I want to try to elicit some of the other areas in which your group --

A. Yeah, could I just add two brief points there?

Q. Yes, please do.

A. The other things was about the accessibility of the 111 service. So I know that one of our members in Wales was told by the GP that they couldn't deal with a Covid case

and that they needed to go through 111. When they were trying to get through to 111 repeatedly for, I think, days and eventually it turned out that 111 didn't cover that part of Wales, and the GP didn't even know.

There were people who -- English was their second language, and they weren't able to communicate effectively their symptoms and their families were concerned. And in these instances the results were either people going into hospital very significantly too late, by which point there was nothing that could be done, or in some circumstances actually people dying at home before they were able to access any real medical attention.

Q. Thank you.

Two other areas from your statement appear to be of particular importance and particularly prevalent. One is the amount of persons who acquired Covid in hospital, so nosocomial infection. Did a very large number and do a very large number of the members of your group say that their loved ones acquired Covid in hospital? So that's the first issue. To what extent has that been an issue that has been raised by your members?

A. Yes, I think at the time there was -- there was a lot of coverage of issues around care homes in the press, although it didn't cover all of the detail --

Q. I'll come on to care homes in a moment. Could --

A. That was one of the starkest things that it felt like it was coming up with in our group, but --

Q. Can I come on to care homes in a moment, because I want to ask you some questions about that, but in terms of hospital-acquired Covid, hospital-acquired infection --

A. Yes.

Q. -- to what degree has that been a very major issue raised by your --

A. A very significant issue. A lot of people who were in hospital for the entire period, so it was very clear that they contracted Covid. A number of people who also believed that their loved ones had contracted Covid, like we believed my dad did --

Q. Yes?

A. -- at an outpatient appointment. Also people not being tested on discharge from hospital, and often then going home, becoming ill, being re-admitted. Or actually going home to someone else who was vulnerable in the household. So particularly you can imagine elderly couples whereby one of them would have been in hospital, wasn't tested, and on arriving home became ill.

Q. Right.

A. And then their partner then went on to become ill. And, yeah, I think it's one of the saddest things that --

there are a number of people in our group who lost both parents to Covid-19.

Q. In relation to care homes, which you've mentioned, are there two main areas about which the members of your group have expressed the greatest concern? One is, of course, the acquisition of infection in the care home sector, but the other is the related but slightly different area of the restrictions, the way in which, their last days in the particular care home, they were subject to isolation, to absence of contact from their family and loved ones, and the way in which they were treated. Is that a second major area of concern?

A. Yes. I think it's also a bit broader than that. So I think the -- obviously the discharge of untested hospital patients into care homes was a big concern and -- but also issues around, for example, agency workers and sickness absence and --

Q. Yes, that all goes to the issue of why there was Covid in the care sector.

A. But also actually concerns around access to healthcare for care home residents. So a lot of members reporting that their loved ones contracted Covid-19 and having concerns about how it had come into the care home, but also feeling as though, because their loved one was a care home resident and had a number of health

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

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

A. Yeah.

Q. Inside the care home sector?

A. Yeah.

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

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

So they deal with areas such as: pre-existing health vulnerabilities, the absence of masks, 111 service (which you've addressed already), nosocomial infection

(which you've addressed already), the lack of PPE for key workers, the lack of isolation at work from other people who may have become infected, the lack of financial provision for those who were unable to go to work, and also the general way in which you and they believe that the way in which the government sought to impose non-pharmaceutical interventions was an improper and an inadequate way of getting on top of the control of the virus.

A. Absolutely.

Q. Are those the broad themes?

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

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

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

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

A. It was formed during the pandemic.

Q. Therefore, as the pandemic rolled on, did the group have an opportunity of giving evidence, for example, to the

All Parliamentary Group, of communicating its concerns to ministers and officials in government, or did you take up the baton of campaigning on these issues after the pandemic was over?

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

And I think none of us felt able to grieve because we felt this sense of -- it was like, you know, we were bereaved but we knew that there were families who were still to be bereaved, and they didn't know that this was

the most important thing that they needed to do, to prevent -- I can't really articulate it properly, but it felt like there were families who would one day be us, and we didn't want them to be, and we wanted to do whatever we could do to -- we always said, you know, even if we could save one life, it will have been worth all of it, so ...

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

Q. All right.

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

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

A. Yes, I'll be very succinct.

Q. No, no, it's of the greatest importance to her Ladyship --
A. Yeah.
Q. -- that we understand what befell your members and where the greatest areas of concern are, because that is where, of course, she'll make her recommendations.

Your engagement with the government in all its shape and forms is of, I'm sorry to say, slightly less importance. So I'm going to have to leave it there. You've described the group's campaign and its aims extremely adequately indeed.

A. If I could, I just -- so what I wanted to say I was just coming to, I think over that summer we sought to influence the trajectory of the pandemic as much as we could, and we were very concerned and our members were very concerned and this -- so I've talked really about the concerns from the first wave. I think what then proceeded to happen was those of us who were bereaved in the first wave were very concerned about decisions like Eat Out to Help Out, decisions which seemed to be antithetical to efforts to protect life, and so it felt very strongly to us that the government were repeating the same mistakes, and I think what was very traumatic, particularly over the kind of second and third waves for those of us who were bereaved early on, was that it felt

like --
Q. Seeing it happen again?
A. -- those missed opportunities had happened. And we had people joining the group, you know, the day after or even the same day that they'd lost a loved one, and they'd recount their story and they'd recount the same experience of 111 that had happened before, and it was very demoralising and very depressing. I think all of us were very, very low at this point.
MR KEITH: I think you used the word that you were re-traumatised by seeing it all happen again and again.

Ms Goodman, we must leave it there, but thank you very much indeed, you've been very clear in what you've said.

LADY HALLETT: Thank you very much indeed, Ms Goodman. You couldn't have done more to protect your father and also to support others who had lost a loved one. Maybe between us -- you've raised so many issues of legitimate concern, between us maybe we can fulfil that aim of saving lives in the future.
A. Thank you. Could I make just a small plea and could I say a few words about --
LADY HALLETT: I'm sorry, Ms Goodman, I'm going to have to stop you, because you have a very experienced and very able advocate, and I think you have been told that this

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

United Kingdom meeting bereaved families, the suffering has been at the heart of everything I've considered, so please rest assured that every time I hear a witness I am thinking about the impact on people of decisions that were made and also will be considering whether the impact on people was taken into account. So don't worry, you'll always be at the heart of everything we do.
A. Thank you very much.
LADY HALLETT: Thank you.

(The witness withdrew)

MR KEITH: My Lady, would you consider please rising just for a couple of minutes, five minutes, whilst we make arrangements for the next witness?
LADY HALLETT: Right.
(2.37 pm)

(A short break)

(2.43 pm)
MR KEITH: May I please call Dr Wightman.
LADY HALLETT: Dr Wightman, can you hear us?
MR KEITH: It would seem not.
LADY HALLETT: I know a member of the team was talking to Dr Wightman just a few moments ago.
MR KEITH: Yes, somehow we seem to be able to -- we've got ourselves in a position we have to speak to Dr Wightman

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

DR ALAN WIGHTMAN (affirmed)

(Evidence via videolink)

Questions from LEAD COUNSEL TO THE INQUIRY

MR KEITH: Could you give the court, please, your full name.
A. My name is Dr Alan Wightman.
Q. Dr Wightman, whilst you give evidence, could you please remember to keep your voice up and speak as clearly as you can.
A. Okay.
Q. Because of the Zoom it's a bit hard to hear sometimes and it's very important that we can all hear what you have to say. If I ask a question the meaning of which is not clear then please ask me to put it again.

You have very kindly assisted the Inquiry by providing a statement. We needn't put it up on the screen but it's INQ000279972. Is that a statement that you recall signing on 27 September of this year?
A. Yes, it is.

Q. Thank you very much.

Now, Dr Wightman, I want to start, if I may, by asking you about your mother, Helen Wightman, and the bereavement that you suffered towards the beginning of the pandemic in May 2020.

At that time, in early 2020, was your mother living in a care home?
A. She was, yes.
Q. In Fife?
A. That's right.
Q. When the virus began to spread in early March, did the care home where your mother was resident put into place any sort of restrictions on visiting, as far as you were aware?
A. Yes, they proactively contacted us, I think the first time was 11 March, to say they were not quite going into a lockdown but they were asking everyone to please only visit if really essential. And five days later, they sent a second communication saying they were effectively now in lockdown. So that was on the 16th, which was a whole week before the Prime Minister saw fit to call a national lockdown.
Q. What impact did that have on your ability to visit your mother? When you say they imposed practically a full lockdown, does that mean that they denied access to all

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

care home?
A. It did. And -- and we don't understand the route by which it got in -- how can anyone be certain? -- but it did. It was circulating in the local community. I presume someone asymptomatically took it in, completely unaware of the risk they were putting everyone under, but it got in.
Q. And she fell ill?
A. She fell ill and she was the fourth of the residents to die. There were 35 residents, and she was number four. They lost -- they lost four people. So they lost 10% of the residents to Covid.
Q. Did she receive medical care prior to her death from outside the care home or was she treated wholly within the care home?
A. She was treated wholly within the care home, but, in contrast to many other homes, the GP responsible for that care home did actually go in on a daily basis to tend the needs of the residents. Though -- both for Covid reasons and other reasons, which I think is quite a noble act on his part, because he was not a young man himself and he was probably in the risky category too, but he carried on, he did his duty.

And when it got to a point where mum needed care, I was asked: did I want her to go to hospital? And

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

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

Q. Did she pass away on 6 May?

A. Yes, 6 May.

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

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

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

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

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

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

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

A. Yeah.

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

A. Yes, she is, yes.

Q. Right.

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

the areas on which your group has campaigned.

A. Right.

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

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

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

A. Yes.

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

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

they're not. They're not designed to hold people in isolation. They are designed to encourage older, predominantly older residents to mix and to not be isolated, not stay in their rooms. And yet at a certain point in time they were treated as if they were isolation hospitals, and that went against what the care staff had been trying to achieve in normal business.

Q. What about the receipt of medical care within the care sector? Have some, perhaps a large number of your members raised the issue of whether or not their loved ones received proper or adequate medical care whilst being resident in a care home?

A. Yes. As I said earlier, we were fortunate that the GP kept going into the care home. That was not the case in many, many instances throughout Scotland, that these -- the GPs basically stopped going in. And so even normal care was not provided, but also, of course, the -- you know, the question of: were care home residents to be permitted to go to hospital? Would hospitals accept them?

Q. Outside the care sector, like Ms Goodman before you, have a lot of your members, a significant proportion of your members, raised the issue of the 111 medical service, the phone system --

A. Yes.

Q. -- for receiving medical help, and in a related way the triage process or the identification of symptoms that went alongside the immediate provision of care to persons who phoned the 111 line?

A. Indeed, that was a main theme, and I can illustrate it with perhaps something that's not heard too often elsewhere. It wasn't just about old people being denied care. We have two young men who were lost, one aged 28 and one aged 31, because when they phoned up for help, having isolated at home and suffering with Covid and they phoned up on day seven, I think day eight in one case, were told they had to stay at home, because of their age, tough it out until you get to day ten, and in both cases they didn't make it as far as day ten. So the triaging was abysmal in those two instances.

Q. Turning to hospitals and the general provision of medical care, is, firstly, the nature of the hospital or the medical care that your members received in hospital, secondly, the issue of Do Not Resuscitate orders, and, thirdly, the issue of restrictions in visiting and the ability to be able to see loved ones in hospital, are those the three main issues which arise in relation to hospitals?

A. I would say they indeed are, and the concern with the Do Not Resuscitate or DNACPR notices runs through

the care homes, also through the hospitals, and of course the major concern with hospitals is you go in for one reason, which isn't Covid, and you get a free issue of Covid whilst you're in there, and then you don't come out again. You know, it's -- it's the spread in the healthcare settings that is the number one, by far. 25% of our members have been affected by losing somebody who went into hospital for one reason and didn't come out again.

Q. So like your mother who received Covid whilst in a care home --

A. Yes.

Q. -- these members, their loved ones received Covid as part of -- well, a nosocomial infection in hospital?

A. It is, yes, yeah.

Q. What about palliative care and end of life care, is that an issue which is raised by your members?

A. Quite frequently it is raised about -- it's not getting the care they perhaps deserved whilst in hospital, and maybe not surviving it. But we've also got instances of where people appear to have been discharged because they were in their early 80s, they were sent home, knowingly having Covid. I mean, we've got an example of a gentleman, 84, sent home to his 82-year old wife, and known to be infected with Covid, but there was nothing

more the hospital felt they could do for him, sent him home, she got Covid as well, and they both died because of it.

And that's happened to -- there are a couple of families where that same story applies, they lost both elderly parents because they didn't get the treatment in hospital and they were sent home.

Q. Restrictions on funerals and memorial services, is that an issue which is raised in a large number of the cases?

A. It does come up quite frequently, about the disruption to normal funeral rituals, and the impact it has on the family long term, and in many cases they just feel -- it's a feeling of guilt, I think, that a lot of them speak about, that they weren't able to do and honour the person who had died in the way that would have been fitting. It's kind of letting them down right at the end of their life. And of course it's not -- it's not their fault, you know.

Q. Dr Wightman, the Inquiry wrote to you and asked you to give, furthermore, your views on the extent to which your members had been telling you terrible stories about the impact of the pandemic and the government decision-making on those who were, in a general sense, less able to look after themselves, so those prone to unequal treatment. You give the example in your

statement of those with pre-existing chronic diseases --
A. Yes.
Q. -- the elderly and those who are disabled. So I want to ask you: to what extent do your members say that their loved ones received, for whatever reason, a degree of unequal treatment and, perhaps as a result of that, paid the ultimate price, either because, as elderly people, they didn't receive the care that they were, of course, expected to receive, and likewise if they were disabled, or suffering from some other form of chronic condition?
A. There are a couple of stories which come to mind regarding those. And again, it's not necessarily elderly people, but it's disabled people who really should have been given -- given better care, and in one instance should arguably have been vaccinated because he was by far the most vulnerable person in the hospital, being a stroke victim and having locked-in syndrome and having to have everything done basically for him, but was denied the vax because he wasn't 60 yet.
Q. He wasn't 16?
A. He wasn't 60 years of age, but he was --
Q. He was not 60. So this was a -- I'm sorry, forgive me -- clinical decision, it would seem, taken in that case to deny him the vaccine?
A. If you think about this, this is a man who was totally

dependent on others. He'd clearly survived the first year or so of the pandemic because they had -- the vaccine had arrived. But he was denied it because the guidance said you have to be 60 and over to get the vax, and he was not yet 60, but he was completely dependent on others. And of course he did catch Covid and he did not survive it.

So that's one example, but other examples of people -- a lady had a sister who was non-verbal, learning difficulties, and there's a harrowing story about her sister basically being kept in hospital, her being sent home, not able to assist, and an overwhelming feeling on her part that the medical profession simply gave up on her, on her sister.

MR KEITH: Dr Wightman, thank you very much indeed. That's been enormously helpful.
A. Thank you.
LADY HALLETT: Dr Wightman, thank you very much.

Just for the avoidance of any doubt, what kind of doctor are you?
A. Ah, I was going to say that at the beginning. Yes, for the avoidance of doubt, I am not a medical man, and I am not an epidemiologist, I'm a polymer chemist.
LADY HALLETT: Right, I won't ask you what that involves, because we could be here for some time.

A. We could indeed.
LADY HALLETT: I just wanted to thank you, just as I thanked Ms Goodman and others. What you've done to support other people is extraordinary, especially as you don't seem to have too many criticisms of the care or the care home where your mother sadly died. So it's very impressive that you've taken so much time and trouble to look after other people. So thank you very much indeed for your help.
THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: Right, I think you want me to break?
MR KEITH: Yes, please.
(3.07 pm)

(A short break)

(3.15 pm)
MR KEITH: My Lady, could we please welcome back Anna-Louise Marsh-Rees of Covid-19 Bereaved Families for Justice Cymru.

MS ANNA-LOUISE MARSH-REES (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

MR KEITH: Could you please commence by giving the Inquiry your full name.
A. It's Anna-Louise Marsh-Rees.
Q. Thank you very much, Ms Marsh-Rees, for coming back.

You gave evidence of course in Module 1, and I'm going to ask you to repeat in part some of the evidence that you gave on that occasion.

You have, for the purposes of this module, kindly produced a further statement, INQ000273792. Is that a statement that you signed, if you take it from me, on 19 September 2023?
A. I did.
Q. Thank you very much.

Ms Marsh-Rees, when you gave evidence before her Ladyship in Module 1, you told us about your father, Ian, who was a retired electrical engineer, and how he was hospitalised in Nevill Hall Hospital in Abergavenny, where he became exposed to Covid and returned home without any of you knowing that he had been exposed to Covid. There was no positive test and you didn't know.
A. That's correct.
Q. How did you find out that he had become exposed to Covid?
A. That was some months after, when we asked for his hospital notes, and we also raised some complaints about the health board. When I say complaints, we asked questions at that point, because we couldn't understand how that was possible.
LADY HALLETT: So what was on his notes that alerted you to

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

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

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

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

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

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

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

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

A. Absolutely.

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

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

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

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

Q. You mean the infection control in hospitals?

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

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

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

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

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

A. Absolutely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you for that.

A. Oh, sorry.

LADY HALLETT: It's all right.

MR KEITH: So, Ms Marsh-Rees --

A. To my point.

LADY HALLETT: Yes.

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

A. Yes.

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

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

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

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

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

had different epidemiological tiers associated with them.

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

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

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

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

MR KEITH: Well, that's all right.

Ms Marsh-Rees, thank you very much.

THE WITNESS: Thank you very much.

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

So thank you very much indeed.

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

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

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

THE WITNESS: It was a compliment, I promise.

LADY HALLETT: Thank you very much indeed.

THE WITNESS: Thank you very much.

(The witness withdrew)

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

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

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

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

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

Thank you all very much.

(3.41 pm)

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

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