

Wednesday, 10 April 2024

(10.29 am)

LADY HALLETT: We'll wait until on the dot of 10.30.

(Pause)

It may not be on the dot, but good morning, everybody.

This is the third preliminary hearing into Module 3, an investigation of the impact on the healthcare systems during the pandemic, and we have a huge amount to get through, so I shall say no more and ask Ms Jacqueline Carey King's Counsel, who is Lead Counsel to the Inquiry for this module as well as for the care module, to outline the issues that I have to consider today.

Ms Carey.

MS CAREY: Thank you, my Lady.

Statement by LEAD COUNSEL TO THE INQUIRY for MODULE 3

MS CAREY: As you have just made clear, this is the third preliminary hearing in Module 3, and of the 36 core participants in this module, 20 I think are present in the room today at Dorland House and a number of others are attending online.

I know that in advance of today's hearing you've received written submissions from a number of core participants, many of whom I know wish to expand

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For the avoidance of confusion, it may be helpful for me to clarify that, contrary to the submissions of some of the core participants, these were not late requests but were as a result of a deliberate decision by the Inquiry legal team to await the receipt of the bulk of the corporate statements, some of which have been delayed, and I'll come back to that in a moment, and for some of the witnesses to have been -- given evidence in Modules 2, 2A and 2B.

As you might imagine, my Lady, the Module 3 team has been keen to ensure that all relevant information and evidence was taken into account when drafting focused Rule 9 requests for those individuals, and accordingly, in our submission, it would have been premature and inefficient for those Rule 9s to have been issued sooner.

The deadlines for those Rule 9 statements are mid to late May of this year, so four months before the start of the hearing, and if there are any requests for extensions from those individuals, then those applications will be scrutinised to ensure that their timely onward disclosure to the core participants is not hampered.

Over the course of the Rule 9 process the Inquiry has provided recipients of Rule 9 requests with

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upon but not repeat those submissions orally today.

It is not practical or necessary for me to respond to all of the matters raised, but as we go through the agenda there are various aspects that I will seek to address from Counsel to the Inquiry's perspective.

I think the agenda has been put up on the screens at Dorland House. There are updates in relation to Rule 9s, expert witnesses, disclosure, Every Story Matters, and the timetable for the public hearings in due course.

So may I turn, please, to an update in relation to Rule 9 requests.

As at the start of this month, Module 3 has sent over 190 Rule 9 requests to individuals, organisations and government bodies across the UK, and we have received back 91 signed statements, of which 69 have been disclosed.

The Module 3 solicitor team monthly update note provides details of the recipients of those requests and indeed an overview of the topics which they have been asked about. Recent Rule 9 requests have been sent to the respective health ministers and cabinet secretaries during the relevant period, namely Matt Hancock and Sajid Javid, Robin Swann, Jeane Freeman, Humza Yousaf, Vaughan Gething and Eluned Morgan.

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a deadline by which the draft statements should be submitted. Now, some recipients have asked the Inquiry for an extension by which to file their response and, in appropriate cases, reasonable extensions have been granted. However, since the last preliminary hearing, your Ladyship has considered it necessary to issue what are called section 21 Inquiries Act notices to a number of government department/agencies, to ensure that all matters raised in the Rule 9 requests are properly addressed and that the evidence is provided in time to allow the Inquiry legal team to progress its work.

By way of background, the department and agencies in question received their Rule 9 requests in the spring of 2023, they were issued between March and May of last year, and applications for extensions for deadlines were often granted. However, the Inquiry became increasingly concerned to hear that some delays in receiving evidence was said to have been a result of the work required on other modules, whether preparing statements or preparing for public hearings, even in circumstances when many months had elapsed between the Rule 9 requests being issued by Module 3 and the draft statement or parts thereof being received.

In deciding to issue section 21 notices you were cognisant not only of the demands placed on those

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1 departments by other Inquiry modules, and indeed by
2 other public inquiries, but also of the everyday
3 pressures of the respective department's normal work,
4 particularly over the winter, and I know that you took
5 this into account when setting and, where necessary,
6 varying section 21 deadlines.

7 Those section 21 notices have been issued to four
8 government bodies and departments: UKHSA, Department of
9 Health and Social Care, the Welsh Government Health and
10 Social Services Group, and the Department of Health
11 Northern Ireland.

12 All deadlines have been met. In some instances the
13 statements provided do not adequately address all
14 matters set out in the Rule 9 request or indeed in the
15 section 21 notice. That has been the case with
16 a question to the Welsh Chief Medical Officer, some
17 questions in one part of the Department of Health's
18 response, some questions in the revised draft corporate
19 statement by the Welsh Government, and some questions in
20 the Department of Health Northern Ireland corporate
21 statement. So consequently, further Rule 9 requests
22 and/or varied section 21 notices have been issued with
23 a short deadline for a response to ensure that all
24 topics are fully answered.

25 In addition to the Rule 9 requests sent by the

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1 respond, how the hospitals responded to the challenges
2 faced, and we sought practical examples of their
3 response.

4 The focus of the requests was therefore very much
5 from the perspectives of the people working in the
6 hospitals rather than from the perspectives of the
7 patients or their families.

8 Now, my Lady, whether the use of the phrase
9 "spotlight hospitals" is the correct terminology to
10 describe the evidence-gathering exercise perhaps might
11 be debatable, but the aim of this work is to gather
12 evidence from the hospitals themselves as to how the
13 pandemic affected them and the staff working in them.

14 While a number of core participants have welcomed
15 the Inquiry's approach to the spotlight evidence, others
16 have expressed concerns about the number of hospitals
17 involved or the methodology behind the selection of the
18 hospitals, and so it might assist this morning if I set
19 out a little more detail about those matters.

20 The purpose of the spotlights is not to identify
21 hospitals most severely affected by the pandemic, nor is
22 it to conduct an examination nation by nation, region by
23 region, or hospital by hospital. It is not
24 a comparative exercise comparing one hospital's response
25 against another, nor could it be. As was made clear in

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1 Module 3 team, the Inquiry is grateful for the
2 suggestions made by core participants as to which
3 additional individuals or bodies should receive a Rule 9
4 request and/or be sent a supplemental Rule 9 request.
5 These suggestions are actively being considered in
6 particular to ensure that any further requests are
7 proportionate and sufficiently focused on assisting the
8 Inquiry with any future recommendations your Ladyship
9 may make. Where the module already has a body of
10 evidence covering a particular topic or the request does
11 not fall within a key area that is within scope, it is
12 unlikely the Inquiry will consider it necessary to issue
13 a Rule 9 request or a supplemental Rule 9.

14 Now, my Lady, within the Rule 9 requests there are
15 a number of discrete topics to which I'd like to return.
16 The first is what is known as the "spotlight hospitals".
17 As you may appreciate, one of the challenges for
18 a module of this size is to obtain evidence about the
19 impact of national decision-making upon those operating
20 within the healthcare system, including how hospitals
21 responded, if I can put it like this, "on the ground" to
22 the Covid pandemic; and so in this regard, in December
23 of last year Module 3 sent Rule 9 requests to
24 22 hospitals across the length and breadth of the UK.
25 The requests focused on examples of the steps taken to

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1 the update note sent out in January but covering the
2 December work, and in accordance with the Inquiry's
3 terms of reference, it is not the Inquiry's intention to
4 examine or compare the circumstances surrounding the
5 treatment of individual patients or the outcomes of
6 their treatment. The intention of requesting the
7 information from the spotlight hospitals is to assist
8 my Lady in identifying recurring themes and particular
9 issues that arose with respect to the healthcare
10 system's response.

11 The themes that will emerge inevitably will not be
12 considered as an exhaustive list nor necessarily
13 representative of the experiences in each and every
14 hospital across the UK, but as the evidence comes in it
15 will come to form part of the Inquiry's broader
16 investigation into the operational and healthcare
17 pressures or challenges faced by the healthcare systems
18 across the UK during the relevant period.

19 The number and location of the spotlight hospitals
20 were chosen so as to gain evidence from across the
21 four nations, taking into account matters including
22 respective populations within each nation, covering some
23 rural and urban areas. And accordingly, two spotlight
24 hospitals were selected from each of Northern Ireland,
25 Scotland and Wales, with the remaining 16 spotlights

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1 being selected from England. The number of spotlights
 2 is inevitably limited, given that this exercise is but
 3 one aspect of Module 3's work and the need to be
 4 proportionate, not just within Module 3 but across
 5 the Inquiry's work as a whole. In our submission, this
 6 would be consistent with your Ladyship's obligations
 7 under section 17 of the Inquiries Act, to act with
 8 fairness and with regard to the need to avoid
 9 unnecessary cost, whether to the public or to the
 10 witnesses.

11 The Inquiry has been asked to send spotlight Rule 9
 12 requests to a hospital in each of the seven healthcare
 13 boards in Wales, and the five health and social care
 14 trusts in Northern Ireland. I note that were the
 15 Inquiry to adopt that approach across the entire UK, it
 16 would result in spotlight requests being sent to
 17 hospitals in each of the 14 territorial NHS boards in
 18 Scotland, and potentially to nearly 230 NHS trusts in
 19 England, so a total of 250 hospitals across the UK, in
 20 our submission a course of action that would be
 21 disproportionate and contrary to your commitment to run
 22 this Inquiry efficiently.

23 My Lady, as you will have appreciated from the
 24 written submissions, the Covid-19 Bereaved Families for
 25 Justice Cymru raised specific concerns amongst their
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1 to be made, but those statements taken as a whole help
 2 to establish how hospital-acquired transmission was
 3 identified, understood and addressed in Wales throughout
 4 the relevant period.

5 Now, clearly I appreciate, given that much of this
 6 disclosure is to come, it's understandable that the
 7 core participants are yet unaware of the evidence that
 8 is available and the totality of that evidence. But in
 9 addition, the infection prevention and control experts
 10 are being asked to summarise and critically analyse
 11 official estimates of hospital-acquired infection, in
 12 all four nations, as well as the alternative estimates
 13 published in the scientific literature.

14 When selecting the spotlight hospitals, the Inquiry
 15 considered a number of different factors, including the
 16 questionnaire responses provided by some trusts, health
 17 boards and health and social care trusts, and
 18 identifying from those responses hospitals which may be
 19 able to provide practical information and evidence to
 20 the Inquiry.

21 Module 3 also selected some hospitals where the
 22 trust or board did not provide a response to the
 23 Inquiry's questionnaire, and we also sought out publicly
 24 available information about particular issues arising in
 25 hospitals, and the Rule 9 requests were sent to the
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1 members about nosocomial infection rates, or
 2 hospital-acquired infection, in Wales. They submit that
 3 in the absence of a separate Welsh Covid-19 public
 4 inquiry, Module 3 should spotlight a hospital in each of
 5 the seven boards in order to obtain an accurate and/or
 6 reflective picture of what happened in Welsh hospitals.

7 My Lady, in my submission, this request
 8 misunderstands the aim behind this part of the Inquiry's
 9 work, which is to provide a UK-wide perspective on
 10 recurring themes regarding the healthcare systems, and
 11 importantly it is not to investigate particular issues
 12 in Wales. The request that this Inquiry reflect
 13 sufficiently and broadly the dominant and distinct
 14 issues which arose in Wales risks, in our submission,
 15 falling into the kind of comparative exercise that is
 16 not appropriate.

17 In relation to hospital-acquired infection rates in
 18 Wales, Module 3 has already obtained a large amount of
 19 evidence on this issue, including in the statements and
 20 exhibits provided by the Welsh CMO, Frank Atherton,
 21 Public Health Wales, and the Welsh Government Health and
 22 Social Services Group.

23 Now, my Lady, one of those statements was disclosed
 24 in a tranche of disclosure made yesterday. Two of the
 25 statements are due for disclosure in the coming tranches
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1 medical or clinical director or chief medical officer or
 2 equivalent at each of the 22 hospitals across the UK.

3 The requests specifically asked that the statement
 4 be provided by an appropriate individual or individuals
 5 who were able to provide evidence about events during
 6 the relevant period rather than a corporate statement
 7 from the senior management team at the trust or the
 8 board responsible for that hospital.

9 The requests themselves sent to each hospital
 10 covered the same topic areas and questions. In
 11 addition, the Inquiry asked some hospitals about
 12 specific issues that were raised either in the
 13 questionnaire responses or were revealed in open source
 14 research on the hospital in question where those issues
 15 might have indicated systemic problems in response to
 16 Covid-19.

17 All 22 hospitals have now responded. The draft
 18 statements have had feedback provided on them, and they
 19 are now in the process of being finalised ready for
 20 disclosure. Initial analysis of the statements suggest
 21 that some common themes are emerging, and, my Lady, this
 22 is just a small snapshot of some of the evidence, but
 23 there are themes emerging such as staff shortages prior
 24 to the pandemic and/or shortages -- to workers isolating
 25 and becoming ill during the pandemic.
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1 A number have raised relaxation in nursing fixed
2 ratios of care. Other responses reveal the numbers of
3 workers suffering from Long Covid and the varying
4 methods of support offered by hospitals for staff with
5 Long Covid. Issues raised include practical problems
6 with the physical condition of the estate, particularly
7 in older hospital buildings, which presented challenges
8 implementing IPC guidance, for example narrow corridors
9 or poor ventilation.

10 There is evidence in those statements about
11 variations in approaches to visiting restrictions. Also
12 evidence, particularly from the English spotlights,
13 about the impact of vaccination as a condition of
14 deployment, or VCOD as it's known, not just in terms of
15 ascertaining numbers of workers who were or weren't
16 vaccinated, but also often the damaging effect of the
17 proposal on staff relations and morale. A number of the
18 spotlights speak of the impact on workers from ethnic
19 minority backgrounds.

20 There were some innovative practices adopted by some
21 of the hospitals. May I just give you one or two
22 examples. There were booking systems for visitors,
23 family liaison officers to aid virtual communications,
24 there were virtual follow-up of antenatal and postnatal
25 Covid-positive women.

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1 already has.

2 My Lady, some core participants have expressed
3 a concern that the signatory to the spotlight statement
4 might provide a rose-tinted view or that the statement
5 has been written from an unduly corporate perspective.
6 In fact, having reviewed a number of the draft
7 statements myself, overall we do not consider this
8 concern has materialised, and in fact there is now
9 a body of evidence attesting to how the pandemic
10 affected the hospitals and their staff, including those
11 working on the frontline.

12 My Lady, three of the core participants have
13 submitted that spotlights should be extended to include
14 other services, for example primary care, pharmacies and
15 ambulances. Module 3 has considered this suggestion
16 carefully but considers that the evidence received from
17 the relevant royal colleges, ambulance trusts and other
18 associations and bodies, properly and proportionately
19 examines issues affecting these parts of the healthcare
20 system.

21 May I turn to a different aspect of the Rule 9 work
22 that is going on, and deal with some research that has
23 recently been commissioned, because, in addition to the
24 spotlights, the Inquiry has commissioned a research
25 survey on escalation of care decisions made by frontline

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1 There were examples of the lengths to which some of
2 those working in hospitals went to provide care. Just
3 one example, in Altnagelvin in Northern Ireland workers
4 placed little wooden hearts in the pockets of patients
5 who were approaching death as a small connection to
6 their loved ones that could not be with them in
7 hospital. There are some painful accounts of the impact
8 on staff working in hospital, for example in Manchester
9 Royal Infirmary, one of the elderly wards in wave 2
10 experienced seven patient deaths within 24 hours,
11 whereas outside of the pandemic it was death every one
12 to two weeks.

13 As I say, they are but just some examples of the
14 evidence obtained by the spotlight hospitals. The
15 hospitals were not asked about any plans they had in
16 place for dealing with the pandemic, this evidence being
17 more appropriately obtained from the respective
18 Department of Healths, but, that said, a number of the
19 spotlights provided evidence of the plans they put in
20 place as the pandemic took hold. And in our submission
21 the totality of this evidence, combined with the Rule 9s
22 sent to the government departments, means it's not
23 necessary to instruct an expert to consider the question
24 of preparedness separately to the consideration of
25 preparedness in the existing reports that the Inquiry

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1 healthcare workers, and the primary issue being
2 considered is how frontline clinicians made decisions
3 about escalation of care during the extreme
4 circumstances of the pandemic, and whether thresholds
5 for escalating a patient's care were altered based on
6 resource availability rather than clinical need. That
7 includes decisions about the assessment of patients in
8 the community and escalating them to hospital and then,
9 once in hospital, escalation to critical care.

10 The project aims to hear from a wide range of
11 healthcare professionals involved in decisions about
12 escalation of care, including paramedics, 111 call
13 handlers, clinical advisers, GPs, A&E doctors and
14 doctors based on general wards and doctors and nurses
15 based on critical wards. The Inquiry has commissioned
16 IFF Research to conduct this project. IFF Research is
17 a company with significant experience and technical
18 expertise in running large-scale surveys of healthcare
19 professionals, and further information on the project
20 will be provided in the monthly update notes in due
21 course.

22 The final matter I wish to raise in relation to the
23 Rule 9 update is in relation to impact evidence.
24 Module 3's scope makes clear that it will examine the
25 impact of the pandemic on people's experiences of

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1 healthcare during the pandemic, including through
 2 illustrative accounts, and so in addition, therefore, to
 3 the accounts given by those individuals who have
 4 contributed to the Inquiry's listening exercise, Every
 5 Story Matters, Module 3 has invited 21 of the
 6 core participant groups in Module 3 from across the UK
 7 to provide short summary accounts from a specified
 8 number of individual members of those groups or
 9 individuals supported by those groups during the
 10 relevant period about their experience of the healthcare
 11 system.

12 The core participant groups include all of the
 13 bereaved family groups, charities, other groups such as
 14 the clinically vulnerable, those with Long Covid,
 15 professional membership organisations, and it's hoped
 16 that in this way a range of experiences during the
 17 pandemic will be captured.

18 The summaries are designed to help the Inquiry
 19 identify those witnesses who may be able to speak to
 20 systemic issues, including, for example, individuals
 21 working on the frontline, such as healthcare workers,
 22 cleaners, porters, ambulance staff, paramedics,
 23 pharmacists, doctors and nurses. And they will be able
 24 to speak to concerns about, for example, PPE and about
 25 the sheer physical, mental and emotional toll that the

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1 My Lady, that's all I wish to say about the Rule 9
 2 update. May I just deviate slightly from the agenda and
 3 actually deal with expert witnesses now before going on
 4 to disclosure, which might in fact make more sense in
 5 relation to a number of the submissions that you are to
 6 receive this morning.

7 The Inquiry has identified eight areas for expert
 8 evidence and seven of the reports are progressing well
 9 and are on track. I know that some core participants
 10 have repeated their request to have sight of the letters
 11 of instruction. This remains an unnecessary step, in
 12 our submission. Sight of the draft report and the
 13 option to comment on the draft report provides ample
 14 opportunity for core participants to contribute to the
 15 final expert report. I can confirm that the expert
 16 reports are all addressing matters affecting the UK and
 17 not just looking at the position in the country in which
 18 the expert is based.

19 The first of those reports is a report in relation
 20 to Long Covid, and the report of Professor Chris
 21 Brightling and Dr Rachael Evans was disclosed yesterday
 22 in the tranche of disclosure made. They also, I think
 23 you'll recall, prepared a report for Module 2, and that
 24 has been disclosed to the Module 3 core participants.
 25 Whilst addressing you on the topic of Long Covid, some

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1 pandemic took.

2 A small number of these witnesses will be formally
 3 asked to provide statements and some of those will be
 4 asked to give oral evidence at the public hearing. That
 5 will be in addition to other evidence about the impact
 6 of the pandemic on individuals, as set out in some of
 7 the other statements the Inquiry has received, as well
 8 as in Every Story Matters.

9 My Lady, the Inquiry legal team has started to
 10 review the summaries with a view to identifying those
 11 individuals who may receive a Rule 9 request. Where
 12 a witness is not called to give evidence, we anticipate
 13 inviting you to adduce that written statement into
 14 evidence by publishing it on the Inquiry website.

15 It follows from what I have said that, in addition
 16 to Every Story Matters, some impact evidence will be
 17 called at the public hearing and some statements are
 18 likely to be published, but I know that a number of the
 19 core participants urge the Inquiry to hear from a larger
 20 selection of impact witnesses. My Lady, in our
 21 submission, it's not about calling any set or specific
 22 number of witnesses but rather about ensuring you hear
 23 from a range of individuals who are best placed to
 24 convey the impact of the pandemic based on their
 25 respective experiences.

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1 core participants repeat their request for Module 3 to
 2 look at whether Long Covid should be designated as
 3 a disability or an occupational disease, and for you to
 4 look at the financial support for those diagnosed with
 5 Long Covid. My Lady, I know, will not be assisted by
 6 repetition, and you have already ruled that this is not
 7 a matter falling within the scope of Module 3, so unless
 8 any new information is brought to your attention in the
 9 course of this preliminary hearing, I would invite you
 10 to confirm your earlier ruling.

11 The second report that has been commissioned is in
 12 relation to intensive care. The draft report by
 13 Dr Ganesh Suntharalingam and Professor Charlotte Summers
 14 has been sent to core participants and I know that they
 15 will be working on that and their comments are due by
 16 16 April.

17 Four non-Covid conditions are being looked at within
 18 the scope of Module 3: ischaemic heart disease,
 19 colorectal cancer, hip replacements, and in-patient
 20 children and young people's mental health services.
 21 There are expert reports on all four conditions that
 22 have been commissioned. All four reports will examine
 23 from a healthcare systems perspective the impact of the
 24 pandemic on diagnosis, care and treatment of the
 25 respective non-Covid conditions, and the reports are

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1 looking at how diagnostic and treatment pathways were
2 maintained during the pandemic, and the outcome of
3 delays to diagnosis and/or care and treatment on patient
4 outcomes.

5 So taking each in turn, in relation to ischaemic
6 heart disease, Professor Christopher Gale, who is
7 a professor of cardiovascular medicine at the University
8 of Leeds, and his colleague, Dr Ramesh Nadarajah, who is
9 a cardiology speciality registrar, have prepared a draft
10 report and that was shared with core participants
11 earlier this week.

12 The reports in relation to elective hip replacement
13 surgery and on in-patient children and young people's
14 mental health services, the drafts are due to be
15 received by the Inquiry in May. And in relation to
16 colorectal cancer, Professor Aneel Bhangu and his
17 colleague, Dr Dmitri Nepogodiev, who are based in the
18 University of Birmingham, have been instructed in
19 relation to colorectal cancer, and their draft report is
20 likely to be sent to core participants for their
21 comments in May.

22 There is an expert report commissioned in relation
23 to primary care and emergency pre-hospital care.
24 Professor Helen Snooks, who is a professor of health
25 services research at Swansea University, and

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1 system, including clinically vulnerable and clinically
2 extremely vulnerable children.

3 Now, that draft report is likely to be sent to core
4 participants in May. I know that the John's Campaign
5 core participant group submits that this report should
6 cover healthcare provision in people's homes, care
7 settings, mental health units and other community
8 settings. My Lady, as you are aware, access to
9 healthcare in some care settings is a matter being
10 examined in Module 6. Moreover, as you already made
11 clear in your ruling following the second preliminary
12 hearing in this module, the other settings are not
13 referred to within the scope of Module 3, and in the
14 November monthly update note you confirmed that the
15 impact on mental health services would not be examined
16 in Module 3.

17 In light of those matters, the Inquiry does not
18 intend to expand the areas that this expert report will
19 cover. May I make it clear, however, that the impact of
20 the pandemic on the mental health of healthcare workers
21 is a matter about which evidence has been and is being
22 gathered, and I hope that that allays any
23 misunderstanding on the part of some core participants
24 that this module is not looking at the harm caused to
25 the mental health of those working in the healthcare

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1 Professor Adrian Edwards, who is a professor of general
2 practice at Cardiff University, have been instructed to
3 provide a draft report examining a number of aspects of
4 healthcare outside of hospitals, and their report will
5 comment on changes to primary care, the way in which it
6 was accessed, including the transition to remote primary
7 care, such as the use of either telephone triage or
8 video calls, oximetry at home, other remote monitoring.
9 They are going to look at emergency pre-hospital care,
10 including changes to 999 and 111 calls, and impact on
11 ambulance services, including response time by category,
12 handover time, outcome, whether related to likely
13 Covid-19 or not. They are going to look at the
14 escalation from community care to hospital care.

15 They are also going to look at the shielding
16 programme, including how the shielding criteria evolved
17 over time, a summary of relevant published academic
18 research on some of the positive and negative impacts of
19 the shielding programme, and an evaluation of any known
20 qualitative or quantitative differences between England,
21 Wales, Northern Ireland and Scotland in the outcomes of
22 the shielding programme, if that is available.

23 It is not the Inquiry's present intention to ask the
24 experts to provide their opinion on the impact of
25 Covid-19 on children's experiences of the healthcare

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1 sector.

2 Finally, the final report that is being commissioned
3 by the Inquiry is that in relation to infection
4 prevention and control (IPC).

5 My Lady, in my note to the core participants last
6 month, I explained that progress in relation to the
7 expert report on IPC is not as Module 3 anticipated or
8 would have wished. In short, of the original five
9 experts identified in September 2023, only two are now
10 available to continue with this work. Those two are
11 Clive Beggs and Hajo Grundmann. Clive Beggs' draft
12 report will shortly be ready to be disclosed to
13 core participants. That report focuses on the mechanism
14 of transmission of Covid-19, the role of ventilation and
15 air cleaning systems in hospitals, and the role of
16 respiratory protective equipment (RPE) in mitigating the
17 transmission of Covid-19.

18 Although the Inquiry had initially envisaged
19 producing an overarching IPC report to which all IPC
20 experts contributed, rather than delay the provision of
21 feedback on this report, the Inquiry intends to ask
22 core participants to comment on Professor Beggs' draft
23 report so that this aspect of IPC expert evidence can be
24 progressed.

25 In relation to the other aspects of IPC, and in

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1 particular to changing clinical guidelines, testing and
2 other IPC interventions and experiences on the
3 frontline, the Inquiry has devoted considerable time to
4 identify suitable replacements.

5 Dr Gee Yen Shin, a consultant virologist and
6 director of IPC at University College London Hospitals
7 NHS Foundation Trust, Professor Dinah Gould, an
8 independent IPC consultant and an honorary professor of
9 nursing at City University London, and Dr Ben Warne, an
10 academic clinical lecturer and speciality registrar in
11 infectious disease and general internal medicine, have
12 all now confirmed that they are willing and able to
13 write a report covering the remaining IPC issues within
14 scope, and so I anticipate and very much hope that the
15 IPC expert report is now very much back on track.

16 A number of core participants invite you to consider
17 other areas for expert evidence. The Covid Bereaved
18 Families for Justice UK and the Northern Irish Covid
19 Bereaved Families for Justice submit that Module 3 needs
20 to obtain further evidence about the disproportionate
21 outcomes on black and minority ethnic healthcare workers
22 and discrimination, whether that's on the basis of age,
23 sex, gender, disability, and on people suffering
24 different types of mental health conditions.

25 They suggest that the experts in previous modules
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1 submission, one of those areas where the module simply
2 cannot accede to every request, no matter how important
3 the topic is for those people who suffer with those
4 disabilities.

5 Three of the core participants have submitted that
6 an expert should be appointed to comment on the use of
7 private sector contracting and outsourcing during the
8 pandemic. Module 3 has requested and/or already
9 received evidence relating to the use of private
10 hospitals during the pandemic. And I emphasise the
11 phrase "use of private hospitals" as that is the phrase
12 that appears within Module 3's scope. Accordingly,
13 the Inquiry legal team does not consider that the expert
14 evidence is required on this topic.

15 My Lady, the Royal Pharmaceutical Society submit
16 that an expert should be appointed who has expertise in
17 pharmacists and pharmacy to consider matters including
18 the impact of IPC guidance on pharmacy teams and the
19 adequate provision of PPE to pharmacists. Module 3 has
20 sought evidence on these and other topics from a number
21 of witnesses and so it does not consider that an expert
22 in addition to that evidence is necessary.

23 Turning to, my Lady, the next matter on the agenda,
24 and that is disclosure.

25 In addition to the 12 tranches of disclosure already
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1 who considered these matters should produce, where
2 necessary, Module 3 specific addenda. In our
3 submission, this is not necessary. Those reports
4 provide you with the necessary context and background to
5 a number of different disproportionate impacts, and
6 those reports will therefore complement the statements
7 and evidence obtained by Module 3 which examine
8 disproportionate impacts, including, to name just one
9 statement, in the statement from the NHS Race and Health
10 Observatory.

11 The John's Campaign core participant group ask that
12 Module 3 obtains expert evidence on the use and, it is
13 said, misuse of DNACPR notices. My Lady, a large number
14 of the Rule 9 requests sent by Module 3 have asked about
15 the use of DNACPR notices, so we do not consider it is
16 necessary to instruct an expert on this topic.

17 I think, as I may have said at an earlier
18 preliminary hearing, it would not be possible to
19 instruct experts on every area within the scope of
20 Module 3, or indeed on every impact felt and suffered,
21 and so the John's Campaign group also requests that
22 Module 3 obtain expert evidence on how those with
23 learning disabilities accessed healthcare services and
24 the impact on the learning disabled and those with
25 cognitive impairments, and my Lady, that is, in our
26

1 made by Module 3, there are over 80 draft statements
2 that are either being reviewed and feedback prepared or
3 where the Inquiry has given feedback and requested that
4 the statements be finalised.

5 Recent tranches of disclosure in March and April
6 this year contain a significant proportion of corporate
7 witness evidence from organisations and departments such
8 as NHS England, DHSC, the Office of the Chief Medical
9 Officer, UKHSA, the Health and Safety Executive, Public
10 Health Scotland and NHS services, Scotland. Those
11 statements are lengthy and detailed and cover a wide
12 range of topics relevant to Module 3's scope.

13 In addition, there have been and there will be
14 disclosure of statements of some of Module 3's
15 core participant groups, which highlight specific areas
16 of concerns relevant to their members. It's inevitable
17 that reading and assimilating all that material will
18 take some time, and therefore the Inquiry legal team
19 considers that, in order to have a more meaningful and
20 detailed second draft of the list of issues, the second
21 draft of the list of issues should be circulated once
22 the disclosed material has been analysed.

23 The Inquiry currently holds 14,000 documents,
24 totalling around 157,000 pages which will be disclosed
25 on Module 3 in due course. I see my Lady's eyes raised.
28

1 **LADY HALLETT:** I'm just thinking, not much for me to do
2 then.

3 **MS CAREY:** That doesn't include the statements and
4 associated exhibits which are not yet signed or provided
5 to the Inquiry.

6 Now, I provide those figures so that
7 core participants know the scale of disclosure that will
8 be forthcoming, and I hope that it will assist them in
9 their resourcing arrangements for reviewing those
10 documents. It's not meant to scare, but to try to
11 assist with what is coming in the next few months.

12 A number of core participants have requested that
13 disclosure or the majority thereof is completed by the
14 end of June of this year. Now, the Inquiry is working
15 hard to review and disclose material in Module 3, but it
16 must be acknowledged that much of the disclosure work is
17 still going on Module 2C, which I think starts at the
18 end of this month, and goes into May, and so
19 consequently some of the Inquiry's resources are
20 diverted to that module, and indeed to later modules
21 which have public hearings in 2025.

22 The Inquiry's resources, like those of material
23 providers, are not unlimited and difficult decisions
24 must be made. But may I make it plain, Module 3 is
25 equally keen to complete the better part of disclosure

29

1 Some core participant material providers are still
2 engaging in protracted and evolving correspondence about
3 the redaction of senior officials' names. To give one
4 example, UKHSA has recently changed the list of
5 individuals it considers to be senior officials, which
6 is causing ongoing redaction issues. It's also asked
7 Module 3 to redact the names of people from other
8 government departments, such as Clara Swinson, who is
9 a director general at DHSC, Graham Medley, a member of
10 SAGE, and Ruth May, who is the Chief Nursing Officer in
11 England.

12 The Inquiry's established position is that it will
13 only redact the names and email addresses of those whom
14 it considers to be junior officials, and in our
15 submission those three individuals, for example, are
16 clearly not junior.

17 Engaging in correspondence about these matters at
18 the material provider review stage of course takes time
19 for the Inquiry's legal team to respond to and resolve,
20 all of which diverts resources from the actual review,
21 redaction and disclosure task. Material providers are
22 therefore urged to assist the Inquiry in this important
23 task where they can and respond as swiftly as possible
24 to queries and not repeatedly raise the same issue where
25 the Inquiry has made its position clear, not change the

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1 by the end of June or early July, and that ambition may
2 be all the more achievable as the Inquiry is currently
3 prioritising the disclosure of the statements and
4 exhibits provided to Module 3 directly, as this is of
5 particular relevance. The Inquiry recognises that the
6 quantities of material being disclosed each week must
7 increase significantly from the current rate and so we
8 will be increasing the amount of paralegal resource
9 available to Module 3 and anticipate that that will
10 double the current rate at which disclosure is being
11 made.

12 There are also a number of ways in which
13 core participants and material providers can assist the
14 Inquiry to speed up the rate of current disclosure.
15 A number of material providers are seeking significant
16 extensions of time in which to review provision or
17 redactions to material beyond the standard three working
18 days, including extensions of up to two weeks. Going
19 forward, Module 3 is unlikely to be able to grant any
20 significant extensions; as I have said, we need to
21 double the quantities of material being disclosed each
22 week, and material providers may wish to bear this in
23 mind when deciding who will review the material for
24 redactions and how to seek instructions from clients who
25 may be on leave.

30

1 names they asked to redact, and not to seek redactions
2 on publicly available material.

3 So, taking that as a whole, with a renewed ambition
4 from the Inquiry's perspective and the co-operation,
5 I know, from the core participant material providers and
6 other material providers, it is hoped that we will be in
7 a position to complete the bulk of that disclosure by
8 the end of June or early July.

9 In addition, Module 3 has reviewed the transcripts
10 of evidence from Modules 1 and 2, and the relevant
11 transcripts and statements will be disclosed in
12 a separate discrete tranche of disclosure. Work is
13 ongoing reviewing the transcripts of evidence from
14 Modules 2A and B. That has commenced, and 2C module
15 will be reviewed in due course.

16 My Lady, the penultimate matter on the agenda is
17 Every Story Matters.

18 Over 11,000 experiences of healthcare services
19 during the pandemic have been shared with Every Story
20 Matters via the online web form, with many more sharing
21 their experiences of having had Covid-19, bereavement
22 and Long Covid. The Inquiry has heard from people
23 around the UK directly as part of Every Story Matters
24 events programmes, including members of the public,
25 bereaved families, Long Covid survivors and healthcare

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1 staff.

2 In addition, 450 individuals have participated in
3 the research interviews for Every Story Matters,
4 including 212 patients and 238 healthcare workers and
5 other professionals in healthcare roles.

6 All those experiences are being analysed and brought
7 together in the first Every Story Matters report for
8 the Inquiry, and that report is due to be provided to
9 the Inquiry in the middle of this month, following which
10 it will be reviewed by the Inquiry legal team, feedback
11 provided, and it will be finalised and formatted. Those
12 matters take a little time and we anticipate that the
13 report will be shared with the core participants by the
14 end of June.

15 Finally, my Lady, the public hearings.

16 Module 3 public hearings will commence on
17 9 September this year and take place in two phases, each
18 lasting five weeks. The Inquiry is not planning to hold
19 hearings in the weeks of 14 and 21 October, and so the
20 second phase will begin on 28 October. Requests have
21 been made to move the two-week break, but I understand
22 that this cannot be accommodated. The Inquiry does not
23 currently anticipate holding a further preliminary
24 hearing for Module 3 before the start of the public
25 hearings in September. However, I know that the Inquiry

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1 considered in full the written statements and evidence
2 contained therein.

3 So in preparation for the public hearings, as I've
4 already alluded to, the second draft of the list of
5 issues we hope to circulate by the end of May, along
6 with a provisional list of witnesses, and we will invite
7 the core participants' submissions on those documents in
8 due course.

9 The monthly update notes will provide detail about
10 the process for evidence proposals to be sent to
11 core participants, and the precise pre-Rule 10 procedure
12 to be adopted by Module 3, but at the outset I must
13 observe, with 36 separate core participant groups and
14 organisations, suggestions for pre-Rule 10 questions
15 need to be proportionate and focused. Not every
16 question or point can be raised or needs to be put to
17 every witness, and core participants are asked to
18 reflect carefully on this before making any pre-Rule 10
19 applications in Module 3.

20 Module 3 will adopt the process used in earlier
21 modules and accordingly ask that pre-Rule 10 requests
22 are limited to key and significant matters, and to
23 matters that the core participants does not anticipate
24 CTI will cover. It assists no one and it's not
25 conducive to an efficient process for the Inquiry legal

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1 will keep this under review and will inform all

2 core participants if it considers a further preliminary
3 hearing to be necessary.

4 A number of the core participants submit that
5 a ten-week hearing time is insufficient to examine the
6 matters within Module 3 and have asked that additional
7 hearing time be allocated. My Lady, you have already
8 allocated ten weeks of hearing time to Module 3, making
9 this the longest public hearing to date, but even so you
10 may think that it is simply not possible to include more
11 than is already envisaged.

12 Moreover, you have been clear that the Inquiry will
13 not run on and on and that you want to hear evidence and
14 make recommendations in a timely manner. Given the
15 Inquiry's programme of work, including, for example,
16 preparation for hearings in 2025 and the publication of
17 reports, it will not be possible to extend the hearing
18 time, nor will it be possible to move the two-week
19 break.

20 The Inquiry legal team notes that a number of
21 written submissions have repeated core participants'
22 offers to assist the Inquiry in its work, and we will
23 hope this will be extended to being focused on those
24 matters that require examination and exploration in the
25 public hearing, knowing that your Ladyship will have

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1 teams, nor indeed for the core participant legal teams,
2 for pre-Rule 10 applications to be made in respect of
3 questions that Counsel to the Inquiry are obviously
4 going to ask.

5 Moreover, the Inquiry legal team considers that the
6 contents of any pre-Rule 10 applications may be better
7 focused on questions in areas that might lead you to
8 making meaningful recommendations for the future.

9 My Lady, I make those observations knowing that all
10 core participants have repeatedly assured your Ladyship
11 of their desire and willingness to assist the Inquiry in
12 its work, and we hope that that renewed focus will help
13 the public hearings run smoothly and efficiently and
14 ensure that core participants' particular interests in
15 a witness or a topic are advanced either by Counsel to
16 the Inquiry's questions or by the core participants'
17 questions themselves.

18 Further guidance on the evidence proposals and the
19 pre-Rule 10 process will be provided in the monthly
20 update notes in due course.

21 My Lady, that's all I propose to say by way of
22 Counsel to the Inquiry's submissions to your Ladyship.
23 Can I invite you, please, to publish the written
24 submissions on the website later today, and I think the
25 first core participant to address you is Mr Weatherby

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1 King's Counsel.

2 **LADY HALLETT:** Thank you.

3 Submissions will be published.

4 **MS CAREY:** Thank you very much, my Lady.

5 **LADY HALLETT:** Mr Weatherby.

6 **Submissions on behalf of Covid-19 Bereaved Families for**

7 **Justice by MR WEATHERBY KC**

8 **MR WEATHERBY:** Good morning, my Lady. As you know, I appear

9 for Covid Bereaved Families for Justice UK.

10 As we hope we have done consistently so far, our

11 submissions are made in the spirit of assisting the

12 Inquiry in fulfilling its terms of reference.

13 Can I say at the outset that we have looked

14 carefully at the submissions of other, particularly the

15 non-state, core participants, and we support many

16 perhaps most of the points so clearly made by them and

17 I'll try not to overlap too much, treading on their

18 lawns.

19 In particular, we support the submissions of Mind,

20 urging the Inquiry to include adult mental health within

21 Module 3. Our submissions, which I will say a little

22 bit more about in due course, resonate with FEMHO and

23 others regarding the need for further discrimination

24 evidence. And we specifically endorse submissions made

25 about the issue of the downgrading of Covid as an HCID,

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1 The answer, the simple answer, is that document

2 providers must do as the Inquiry requests within the

3 timescales set, and we respectfully urge you to use

4 section 20 perhaps more liberally in terms of ensuring

5 that happens. Additional resources have to be allocated

6 if necessary. And if they're not, the consequent delays

7 will result in at least three effects, in our

8 submission: one, the wasting of substantial amounts of

9 public money; two, further untold stress to families,

10 witnesses, all directly involved; and, three, impeding

11 the reaching of your conclusions and recommendations

12 which are so vital.

13 I'm sorry if all that sounds so obvious, but it

14 needed saying, in my submission.

15 Moving on to spotlight hospitals, we note the

16 explanation of how example facilities have been

17 selected. We raise no objection in principle to this

18 sort of approach, but we have raised a number of points

19 in the written submissions from paragraphs 6 onwards.

20 We would have raised these earlier had there been

21 consultation about the spotlights and we might have been

22 in a position to have assisted the Inquiry earlier and

23 better had that happened.

24 The points we raise are in four categories. One,

25 selection itself. Two, the evidence gathering from the

39

1 high-consequence infectious disease, in March 2020, made

2 by, I think, the BMA and the Covid-19 Airborne

3 Transmission Alliance, and no doubt you will recall this

4 is an issue that we raised in questioning of Professor

5 Van-Tam in Module 2.

6 So, turning swiftly to the issues on the agenda,

7 Rule 9s and evidence gathering. We're grateful for the

8 updates. We've raised a number of issues. I'll raise

9 them orally in two short sections, if I may, firstly,

10 evidence gathering generally and, secondly, spotlight.

11 On the general level, we note the Inquiry has had to

12 resort, as Ms Carey has set out this morning, to

13 section 21 notices because document producers hadn't

14 responded or hadn't responded sufficiently to requests

15 made as long ago as last spring, and although that has

16 achieved progress, as one would expect, much does remain

17 from the updates outstanding.

18 We're not unsympathetic to the amount of work that

19 goes into providing disclosure, we're not unsympathetic

20 to the fact that many of the evidence providers are also

21 engaged in providing services. However, the work that

22 needs to be done doesn't get less if it's not attended

23 to expeditiously, non-compliance makes things worse for

24 the evidence providers themselves, and delay just causes

25 problems elsewhere in the process.

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1 chosen facilities. Three, whether the approach should

2 be adopted for other healthcare facilities. And four,

3 the issue of preparedness.

4 In respect of selection, we note what had been

5 carefully set out in terms of the selection of hospitals

6 across the four nations and jurisdictions and across

7 population spread. We understand the approach, that

8 it's designed to get a spread of evidence from across

9 the UK, and we understand the questionnaire approach

10 that was adopted to it, although we haven't had

11 disclosure of those questionnaires as of yet.

12 No method of selection is going to be perfect, but,

13 as we've set out in our written submissions, there are

14 key issues that we would urge further consideration on.

15 For example, and only by way of example, at paragraph 7,

16 we've noted the choice of hospitals in Northern Ireland

17 includes the main cities but not rural areas. We'll

18 leave that to the Northern Ireland team to develop. And

19 we've noted that both of the hospitals selected in Wales

20 are in South Wales, which rather excludes the healthcare

21 experience from across the rest of the country and the

22 other health boards there, many of which are very

23 different from the South Wales metropolises, and we note

24 the Cymru team's written submissions on that too and we

25 won't trespass on those.

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1 Again, a minded-to approach might have allowed us to
2 have assisted on that issue earlier.

3 Similarly, we've raised the point about whether the
4 demographics of the areas of the hospitals were
5 considered as well as the more straightforward issue of
6 population spread.

7 In our submission, the different racial and ethnic
8 minority communities served by hospitals is of great
9 importance, and should have been part of the selection
10 criteria.

11 We hope that the Inquiry will seek evidence from
12 healthcare workers and bereaved families with experience
13 from the spotlight hospitals, and also from further
14 afield than the spotlight hospitals as well. As you've
15 heard, we've submitted a schedule of summaries which we
16 hope will help in that selection. I'll deal with that
17 in a moment, freestanding as a topic, if I may. But
18 just on this section of the spotlight hospitals, I note
19 that one of the accounts by way of example that we've
20 put forward is a bereaved family member who was also
21 a frontline doctor during the pandemic and who in fact
22 worked in a hospital in North Wales. So the selection
23 of individuals such as that might help in dealing with
24 some of the perceived deficiencies in the approach.

25 Secondly with respect to spotlight hospitals,

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1 there need to be innovative ways presented of dealing
2 with that.

3 We have raised, maybe too persistently, the issue of
4 position statements. I'm not going to raise that issue
5 again generally, but, with respect to spotlight
6 hospitals, this is an area where seeking a corporate
7 summary of what happened at particular institutions and
8 trusts of what went right and wrong through their own
9 lens may well be an effective way of, again, honing the
10 ambit of the evidence. Position statements allow that
11 to happen so that Rule 9s can then drill down into the
12 detail, and there are a number of inquiries where that
13 approach has been taken successfully.

14 Thirdly, on spotlights, we urge that a similar
15 approach is taken with respect to other healthcare
16 facilities and services, we've raised 111, 999,
17 ambulance trusts, healthcare centres, GP surgeries and
18 mental health facilities. Again, we're well recognising
19 of the imperatives of time, but in order to do justice
20 to the terms of reference for Module 3, a concentration
21 primarily on hospitals is, in our submission, not taking
22 the issues far enough.

23 Fourthly and finally, with respect to spotlights,
24 preparedness. From paragraph 12 we've highlighted
25 a concern that the Inquiry appears to be overlooking

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1 evidence gathering. We note what's been said about
2 seeking evidence from chief medical officers. We
3 recognise and absolutely agree with the intention to go
4 beyond the corporate view, but we do maintain our
5 concerns that this isn't likely to achieve that, because
6 CMOs are themselves members of health trusts and boards
7 and they may have their own motivations to present what
8 we've suggested might be a rose-tinted view.

9 So we urge the Inquiry to take a much wider view and
10 seek evidence from patient groups, patient advice and
11 liaison services, where that applies, trade unions and
12 professional bodies, for example.

13 At paragraph 11 we've indicated our concerns that
14 the timetable's ambitious to consider such a wide set of
15 issues and evidence across four healthcare systems. We
16 repeat an earlier submission that to make the spotlight
17 approach work that it may be of assistance to commission
18 a panel of experts to assist in analysing and honing the
19 evidence so that only that which is important to
20 the Inquiry need be called or can be collated by people
21 with expertise in that kind of area.

22 We again indicate that we would be very much open,
23 we would encourage a collaborative approach to this with
24 your team. Calling evidence over 22 hospitals in such
25 a short period of weeks is going to be challenging, and

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1 preparedness in this module. The examination of
2 preparedness in Module 1 related to a high level only,
3 not to the healthcare or social care sectors. We've set
4 out in writing to remind the Inquiry what was said
5 earlier by Counsel to the Inquiry in the earlier
6 hearings, and in particular in the preliminary hearing
7 for Module 1 where it was asserted that preparedness for
8 healthcare and social care would be dealt with within
9 their own modules, and we'd urge a rethink on that.

10 It's imperative, in our submission, that this is
11 done. It's not sufficient that the position is
12 restricted to staff shortages just prior to pandemic, as
13 asserted in the CTI note. In our submission, the
14 Inquiry should look at the plans from each of the
15 22 spotlight hospitals and health boards for a pandemic,
16 what their understanding was of the applicable national
17 planning related in particular to IPC, infection
18 prevention and control, isolation, testing, visitation,
19 resilience, staffing, bed capacity, surge capacity,
20 triage systems, stockpiling, medical equipment, oxygen
21 and PPE.

22 Moving on, evidence from bereaved witnesses. We've
23 heard what's been said this morning. We're pleased that
24 the Inquiry has decided to call a proportionate number
25 of individuals with direct knowledge or experience of

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1 topics within Module 3. Many of our families have such
2 experience of systemic themes. We urge a calling of
3 a proportionate number of them to that end. The voices
4 of bereaved family members and others are powerful
5 within hearings themselves, and hearing the lived
6 experience is of obvious importance to this Inquiry, as
7 in just about all others.

8 We've provided a schedule. Again, we would be
9 grateful for collaboration and co-operation with your
10 team about where that's taken.

11 In selecting witnesses, we note that the Inquiry
12 has, entirely properly, sought similar evidence from
13 other CP groups. In the selection of the witnesses we
14 ask you to have consideration of the central position of
15 the bereaved, the substantial number of families CBFFJ
16 represents across the four nations, we urge you to
17 consider diversity, and we urge you to consider how the
18 evidence is relevant to the systemic issues of Module 3.

19 We've raised the issue of discrimination. We've set
20 this out in some detail in writing. We've addressed it
21 regularly in each module. With respect, you have
22 listened to us on those issues. But disparities of
23 outcome for racialised minorities and issues relating to
24 the treatment of disabled people amongst others are
25 well known not just to the Inquiry but also there's

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1 by Ms Carey this morning will lead to an earlier
2 disclosure of the bulk of the material.

3 We're experienced enough to know that of course
4 disclosure continues and so you can't put a stop date on
5 it, but if there is a concentration, a real
6 concentration, on the date that we've suggested and
7 Ms Carey has mentioned this morning, the end of June,
8 then that will help all of us. We are nervous about it,
9 given the amount of disclosure that has been made to
10 date, and the fact that we are only five months away,
11 but we do hear that we're being listened to on this
12 subject.

13 Experts. We've made submissions regarding
14 consultation around experts and letters of instructions
15 before, we don't resile from them but we're not going to
16 repeat them again, they're in our written submissions
17 again.

18 We would note that where we have been involved in
19 putting forward experts, then our perception is that
20 that has assisted the Inquiry, and therefore we would
21 hope going forward that that would be borne in mind by
22 your teams.

23 In our written submission we have raised one further
24 particular note that hasn't been noted this morning, no
25 reason it should have been, it's at paragraph 34 of our

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1 a real importance to those issues within this module.

2 Issues of institutional discrimination within the
3 health services, plural, are very much live issues, and
4 we would absolutely encourage the Inquiry to rely on the
5 evidence so far called but also to look carefully at it
6 as to what other issues could be assisted by addendum
7 reports from those experts or, indeed, possibly further
8 reports from others. And those would include issues as
9 to the disproportionate number of deaths of BAME
10 healthcare workers compared to the demographics of the
11 workforce, issues as to whether persons of particular
12 minorities were disproportionately on the frontline and,
13 if so, why, and issues of preparedness regarding
14 protection with regard to particular characteristics or
15 needs, PPE, but it goes beyond that of course.

16 In terms of disclosure, we're grateful for the
17 update that's been provided. We note that there was
18 very late disclosure in both Modules 1 and 2. On our
19 analysis, by one month before the hearings we had
20 received 42%, and 61% of the disclosure which ultimately
21 came to us, that was one month before the hearings.
22 Now, of course that was due certainly in part to the
23 pace of the Inquiry and that it was working. There has
24 been a longer period for preparation of Module 3, and
25 therefore we hope that the recognition of these issues

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1 submissions, and we've asked you to consider instructing
2 an expert to provide evidence of how healthcare systems
3 of other countries fared.

4 We don't want to be misunderstood about this. We're
5 not seeking wide-ranging evidence from across the globe,
6 we're not seeking evidence to show where the UK should
7 be positioned on some sort of international league
8 table, that issue arose out of unevidenced assertions by
9 the former Prime Minister, and we don't intend to go
10 back to it.

11 The purpose of commissioning such a report here
12 would be to look to lessons from elsewhere which might
13 assist your analysis of what happened in the UK, but,
14 more importantly, may inform recommendations, and we've
15 suggested two countries, simply to keep the issue in
16 proportion, in perspective. An expert report would not
17 significantly affect the timetable. In our submission,
18 countries should be selected in consultation with
19 a suitable expert, and be of similar economic profile to
20 the United Kingdom, countries perhaps such as
21 South Korea and Germany, or perhaps Norway. But that,
22 we say, should be a matter for discussion between
23 the Inquiry and experts.

24 In the absence of such evidence, you'll be assessing
25 what happened and what recommendations to make rather in

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1 the abstract. The Inquiry needs all the help it can
2 get, and it appears to us that learning from elsewhere
3 might be particularly helpful.

4 Finally, with respect to hearing dates, we've heard
5 what Ms Carey has said. We simply note that there are
6 two weeks of half term that covers most of the country;
7 if the period of break of two weeks was pushed back by
8 one week, it would cover both of those. We're not aware
9 of what the problems with doing that are, but we would
10 urge you to have a further look at that.

11 Those are our submissions, unless there's anything
12 else I can assist with.

13 **LADY HALLETT:** No, thank you very much indeed for your help,
14 Mr Weatherby, very helpful.

15 I think, Mr Bindman, you're going to go next before
16 we take a break.

17 **Submissions on behalf of the Northern Ireland Covid-19**
18 **Bereaved Families for Justice by MR BINDMAN**

19 **MR BINDMAN:** My Lady, I appear on behalf of the
20 Northern Ireland Covid Bereaved Families for Justice.
21 You've received our written submissions and I propose to
22 use the short time that I have to bring to the fore some
23 key topics on behalf of the Northern Ireland Covid
24 Bereaved.

25 As you are aware, uniquely in the United Kingdom,
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1 2022 is important as it lays the foundation for many
2 matters which I seek to bring to your attention today.
3 Specifically in the context that many of our clients
4 believe that each of the trusts or the trust areas
5 functioned inadequately during the pandemic, none more
6 so than in hospital settings and care homes. Our
7 clients have genuine concerns about the trusts'
8 guidance, standard of care, implementation of
9 visitation, family liaison, end of life care and DNR and
10 DNACPR protocols and the stark lack of consistency on
11 these issues across the trusts.

12 Much if not all of the inconsistency across the
13 trusts stems from the fragmented and complex health and
14 social care structure operating for a relatively small
15 population. This granulated structure has led to the
16 existence of different policies and procedures and thus
17 differing standards of care and treatment across the
18 trusts.

19 I lay out that background, my Lady, to give some
20 context to the submissions that I intend to make.

21 The Northern Ireland Covid Bereaved Families for
22 Justice feel strongly that there should, if possible, be
23 a forensic examination as to how each health and social
24 care trust responded to the pandemic, with emphasis on
25 the compelling differences in standards of care and

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1 Northern Ireland has a fully integrated system of
2 personal social services with healthcare, referred to as
3 "health and social care". The Health and Social Care
4 (Reform) Act 2009 created a single regional Health and
5 Social Care Board. This single regional Health and
6 Social Care Board, working in conjunction with the
7 Public Health Agency, commissioned services to meet
8 assessed need and promote general health and wellbeing.
9 These services were provided by six newly established
10 health and social care trusts: Belfast's, Northern,
11 South Eastern, Southern, Western and the
12 Northern Ireland Ambulance Service HSC Trust; along with
13 other HSE arm's length bodies.

14 Each health and social care trust was accountable
15 for its performance and for ensuring that appropriate
16 assurance mechanisms were in place. This obligation
17 rested with the Health and Social Care trusts' board of
18 directors. It was the responsibility of the Health and
19 Social Care trust board to manage local performance and
20 to manage emerging issues in the first instance. The --
21 and I'll call them HSCT boards for short, the HSCT
22 boards remain responsible for performance management and
23 assurance in respect of all of the HSCT's activities.

24 There has been further modification in the Health
25 and Social Care Act 2022 but the background prior to
50

1 approaches taken.

2 To this end, as you will have noted from
3 correspondence from PA Duffy Solicitors on behalf of the
4 Northern Ireland Covid Bereaved Families for Justice to
5 the Inquiry, we implore it to send Rule 9 requests for
6 information to the chief executives of each of the five
7 health trusts in Northern Ireland.

8 In light of the division of the trust areas, and on
9 the eve of Module 2C, tranches of disclosure support the
10 commonly held view amongst our group that there were
11 different care and treatment standards employed across
12 the HSC trusts due to different policies and procedures
13 being employed. The result, we say, was a postcode
14 lottery.

15 Examples from our client base include patients who
16 were unable to receive IV antibiotic treatment at home
17 outside the Belfast trust. This particular client's
18 mother had to be admitted to hospital for this treatment
19 and subsequently went on to contract Covid-19 in
20 hospital. The family were told that if she was in the
21 Belfast trust, IV antibiotics could have been
22 administered at home, meaning that there was clearly
23 an unnecessary exposure of the vulnerable or
24 a vulnerable person to the virus.

25 Another example of obvious divergence of approach
52

1 concerns the expectations, rules and protocol for
2 testing of trust staff. Many of our clients have
3 flagged this as a matter of particular concern,
4 particularly in relation to domiciliary care. Our
5 clients observe the screening of staff providing
6 domiciliary care was not prioritised to the same extent
7 as it was for staff in clinical or care settings.

8 Many of our clients reasonably believe that
9 domiciliary staff members brought Covid-19 into their
10 vulnerable family member's home with little or no
11 precautions taken to prevent the spread of infection,
12 including not wearing PPE and giving inadequate
13 responses as to why they were not wearing the same.

14 In our submission, the trust executives ought to be
15 called to the Inquiry to answer and to explain who was
16 responsible for overseeing the drawing up and
17 implementation of preventative standards for domiciliary
18 care. It is only with first-hand accounts given by the
19 relevant heads of the trust divisions that there can
20 being a full and proper examination of the
21 decision-making employed, the reasons for the same and
22 an assessment of the outcomes, both intended and
23 unintended, if not obvious, of those decisions.

24 What is not clear to our client base is whether
25 there was any effective collaboration between trust

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1 pressures of time this module already faces and that
2 a considered decision has been made to choose the two
3 largest hospitals in Northern Ireland, the
4 Northern Ireland Covid-19 Bereaved Families for Justice
5 are apprehensive that the focus on these hospitals will
6 inevitably be at the exclusion of other hospitals,
7 particularly given that the hospitals chosen are
8 situated in the two largest cities in Northern Ireland
9 whereas 37% of the population in Northern Ireland live
10 in rural areas, such that there are other hospitals that
11 serve those communities. The product of the current
12 spotlight hospitals information may not be
13 representative of the experience faced by our clients.
14 Of the six health and social care trusts I have referred
15 to, the current identified spotlight hospitals will only
16 come under the umbrella of the Belfast and
17 Western Trusts and do not examine the decision-making
18 and, importantly, the impact of those decisions on three
19 other trusts.

20 Because of the differences in decisions made by
21 different trusts, a one-size-fits-all approach simply
22 cannot apply.

23 For example, the Inquiry may well be interested in
24 a serious incident which was declared in the Southern
25 Health and Social Care Trust as a result of three

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1 executives, it appears on the face of it there was not,
2 and if not, why not. We are keen to understand the
3 level of communication between each of the five chief
4 executives and their relationships. What were their
5 reasons for employing certain decisions over others?
6 Were experiences and lessons pooled and shared or did
7 the trusts work in silo? The resultant effect, as
8 referred to previously, was a postcode lottery.

9 By way of example of some of the experiences of our
10 group, they query why some trusts employed liaison
11 officers to keep families updated and others did not.
12 Communication or the lack thereof is a key theme for the
13 Northern Ireland Covid Bereaved Families for Justice,
14 whose friends and family were not properly and
15 adequately appraised of the care and even deaths of
16 their loved ones and, as a consequence, are left to
17 suffer the purgatory of the unknown.

18 This has understandably added to the trauma of their
19 loved ones' passing. One of our group, Sarah Todd(?),
20 lost her mother in 2021, her mother died in hospital.
21 Ms Todd was not informed that her mother's condition had
22 deteriorated. Ms Todd was not informed that her mother
23 had even passed away.

24 So I turn then, my Lady, to deal with the issue of
25 spotlighting hospitals. Whilst recognising the enormous

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1 clusters of the Covid-19 virus at Craigavon and Daisy
2 Hill Hospital between August and October 2020. In the
3 three outbreaks a total of 15 of 32 patients with Covid
4 died. These included specifically the haematology ward
5 outbreak at Craigavon, where seven of the 14 patients
6 with the virus died, in the male medical ward outbreak
7 at Daisy Hill, six of the 13 patients died, and in the
8 4S ward outbreak at Craigavon, two of the five patients
9 with Covid died.

10 A serious adverse incident report was published in
11 September 2023 and found that the lack of regular
12 screening of in-patients or healthcare workers hampered
13 early detection of hospital-acquired Covid infections.
14 It also cited insufficient and inadequate isolation
15 facilities, overcrowding and inadequate space for social
16 distancing in the emergency department of Craigavon
17 Hospital.

18 Naturally, questions arise as to how the outbreak
19 compared to the decision-making and outworkings in other
20 trust areas. If there were other systems in place that
21 protected other hospitals, why were they not adopted in
22 the Southern health trust? Were the systems that were
23 adopted different to the other trusts? Can it be said
24 that the differences led to this significant incident?

25 It follows, in our submission, that without some

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1 flexibility there is a danger that the unique healthcare
2 structure in Northern Ireland may result in the Inquiry
3 being unable to sufficiently contrast the differing
4 approaches made by health and social care trusts. For
5 that reason, we ask that consideration is given to
6 adding spotlight hospitals to the current list and
7 potentially considering three or four hospitals in total
8 across the five different health and social care trusts.
9 We've identified those in Antrim and Craigavon as being
10 the appropriate hospitals.

11 Finally, my Lady, and on a more general note, we
12 seek some clarification regarding matters raised about
13 the crossover of issues in earlier modules.

14 At the preliminary hearing for Module 1 on
15 25 April 2023, Mr Keith King's Counsel clarified that
16 preparedness in hospitals and care homes was not
17 an issue which would be explored beyond general terms in
18 respect of the UK Government and the devolved
19 administrations declaring how hospitals and care homes
20 should prepare for civil emergencies and pandemics.
21 Principally:

22 "... [a] more detailed examination of preparedness
23 in hospitals and care homes, especially at
24 an operational level, must be for healthcare and
25 care sector modules."

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1 there was absent because they too were suffering from
2 Covid. When the health trust were challenged about
3 this, the family were offered an anecdote about another
4 person who was discharged on the same care package.
5 This was cold comfort to the family, who knew that the
6 arrangements were demonstrably inadequate, and put
7 Ms Reynolds' aunt at serious risk. Whilst failings of
8 this nature may have been present prior to the pandemic,
9 the impact of the reduced oversight of mechanisms during
10 the pandemic compounded the problem and elevated the
11 risk.

12 So, my Lady, it's for those reasons that we ask
13 the Inquiry to consider our request in respect of the
14 health and social care trusts and the spotlighting
15 hospitals.

16 Unless, my Lady, there are any matters which I can
17 assist with, those are the submissions.

18 **LADY HALLETT:** Thank you very much, Mr Bindman.

19 We shall break now. I shall resume at 12.10 to hear
20 from Mr Henry.

21 (11.54 am)

(A short break)

23 (12.10 pm)

24 **LADY HALLETT:** Mr Henry, I think it is, next, isn't it?

25

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1 That is a quote.

2 We welcome that clarification, but now, on the cusp
3 of Module 3, seek further explanation as to how the
4 close interplay that Module 3, the impacts on healthcare
5 systems in the four nations of the UK, and the
6 outworkings of particular decisions made by respective
7 healthcare systems, cross or span into issues that come
8 under the rubric for Module 6, the care sector.

9 By way of example, in a letter dated 3 April 2020,
10 the health trusts wrote to the care home registered
11 providers clarifying the hospital discharge protocol
12 regarding testing, making clear that there was no
13 expectation that patients are tested for Covid-19 before
14 discharge from hospital to a care home. Less than
15 three weeks later, and by 22 April 2020, there were
16 297 confirmed cases of Covid-19 in 60 care homes in
17 Northern Ireland.

18 In respect of the lived experiences of our client
19 base, in the witness statement prepared by
20 Marian Reynolds(?) for Module 2C, she recounts how her
21 aunt was discharged from hospital in poor health with
22 effectively the same care package that had been in place
23 before she was admitted to hospital, with no adaptation
24 for the significant deterioration in her aunt's health,
25 or that the family support that had previously been

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1 **Submissions on behalf of Scottish Covid Bereaved by MR HENRY**
2 **MR HENRY:** Yes, good morning, my Lady.

3 I appear on behalf of the Scottish Covid Bereaved as
4 instructed by the Inquiries team at Aamer Anwar &
5 Company.

6 Your Ladyship has received our written submissions
7 and I adopt those submissions. I propose to use my time
8 this morning to make brief further submissions in
9 relation to disclosure, expert reports, other witnesses
10 and timetabling.

11 Turning first to the issue of disclosure, the
12 Scottish bereaved note all that has been said by Counsel
13 to the Inquiry in relation to that this morning. It is
14 hoped that your Ladyship's notices under section 21 of
15 the 2005 Act allow for the all the matters in the
16 relevant Rule 9 requests to be addressed and for
17 evidence to be provided to the Inquiry timeously.

18 Your Ladyship has submissions from a number of
19 core participants in relation to the issue of
20 disclosure. I don't intend to rehearse those
21 submissions, save to repeat our submission that,
22 standing the volume of disclosure, it is hoped that all
23 possible steps are taken to allow for the disclosure
24 process to be finalised in good time to allow for all
25 matters to be finalised in advance of the substantive

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1 hearings.

2 Moving on, my Lady, to expert reports, your Ladyship
3 has the Scottish bereaved's comments in relation to the
4 report concerning Long Covid and we will provide our
5 comments on other reports in due course.

6 Scottish Covid Bereaved note that in relation to
7 primary care and emergency pre-hospital care,
8 Professors Snooks and Edwards have been instructed to
9 provide a report in that regard. We note what has been
10 said this morning by Counsel to the Inquiry about these
11 reports covering all four nations of the UK, but, given
12 the different healthcare system in Scotland, it may be
13 that we have additional submissions about the need for
14 a discrete report in relation to Scotland, but we await
15 the disclosure of that report, my Lady, and we will make
16 any submissions required in due course.

17 We note the submissions of the UK and Northern Irish
18 bereaved about the need for reports to cover issues of
19 structural and institutional discrimination. That is
20 an approach that the Scottish Covid Bereaved would
21 welcome, although we do note all that has been said by
22 Counsel to the Inquiry this morning.

23 Turning, my Lady, to other witnesses, the Scottish
24 bereaved consider that the Inquiry requires to hear the
25 evidence of the former Scottish Chief Medical Officer,

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1 Mr Henry, I'm very grateful.

2 Right, Ms Weereratne. You're hiding back there.

3 **Submissions on behalf of Covid-19 Bereaved Families for**
4 **Justice Cymru by MS WEERERATNE KC**

5 **MS WEERERATNE:** Trying to make myself seen and heard.

6 Good morning, my Lady.

7 **LADY HALLETT:** Good morning.

8 **MS WEERERATNE:** Aswini Weereratne, I appear on behalf of
9 Cymru Covid Bereaved Families for Justice. You have our
10 written submissions on which we rely this morning, and
11 I'd like to address four points in addition.

12 Firstly, on section 21 notices, we note that
13 a section 21 notice has been served on the Welsh
14 Government Health and Social Services Group.
15 Non-compliance and lateness have been ongoing issues
16 throughout this Inquiry, and on previous modules as well
17 with the Welsh Government. In submissions for the last
18 preliminary hearing in September 2023 on this module,
19 the Welsh Government stated its commitment to co-operate
20 fully with the Inquiry and that two detailed responses
21 to Rule 9 requests had already been provided.

22 Our clients are disappointed, therefore, and angered
23 to hear that, in spite of reassures given, the Welsh
24 Government's compliance has necessitated a section 21
25 notice from my Lady.

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1 Dr Catherine Calderwood, during the substantive
2 hearings. We are of course aware of the issues
3 surrounding securing Dr Calderwood's evidence which
4 arose in Module 2A, and it is hoped that steps can be
5 taken to allow for Dr Calderwood to give evidence, even
6 if that is outwith the hearings currently set.

7 Finally, my Lady, moving to the issue of
8 timetabling, the Scottish Covid Bereaved understand that
9 a great many issues will require to be addressed during
10 the substantive hearings. We have concerns about
11 whether this can be done in the assigned hearings and we
12 would welcome a further preliminary hearing to address
13 the issue of the witness list and timetabling. We do,
14 however, welcome Counsel to the Inquiry's confirmation
15 this morning that the two-week break in the hearings
16 will not be pushed back. Although I understand that
17 other core participants have submissions on this matter,
18 my Lady, were the two-week break to be pushed back it
19 would no longer coincide with the October week school
20 holiday in Scotland and we'd have issues for those in
21 Scotland who have childcare responsibilities.

22 So, my Lady, those are my submissions, unless there
23 are any matters which your Ladyship requires to be
24 addressed.

25 **LADY HALLETT:** No, thank you very much for your help,

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1 Secondly, then, I would like to turn to spotlight
2 evidence and spotlight hospitals, and this is a very
3 important issue and of some concern to our clients. We
4 have had lengthy correspondence on this issue with
5 the Inquiry legal team since early February. Our
6 clients are grateful for the time that the Inquiry has
7 given them on this issue, and also grateful for
8 Ms Carey's submissions this morning and in her note.
9 They address some, though not all, of our concerns. Our
10 clients have expressed their extreme unhappiness with
11 the selection of two hospitals in Wales for this task,
12 and our concerns and our clients' unhappiness will be
13 repeated and amplified today.

14 Regrettably, there has been no shift in
15 the Inquiry's position, as we've heard, and our clients
16 feel heard but not listened to. We will consider
17 carefully what we have heard today, but our clients do
18 remain somewhat uncertain as to how this proposal is
19 intended to actually work. From our understanding of
20 this task, there are still a number of shortcomings in
21 the proposal, which lead us to question its value.

22 The operation of and responses in Welsh hospitals
23 are of course a key focus for Cymru bereaved families,
24 and our clients are anxious that their concerns are
25 properly aired and interrogated in this Inquiry, and

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1 this anxiety underlines our submissions on this point
2 today.

3 Also I want to echo that in Module 1 Mr Keith
4 King's Counsel created an expectation that the detail of
5 preparedness on healthcare would be featured in this
6 module, and it's very important to our clients that this
7 is done with regard to Wales.

8 My Lady may recall that a significant proportion of
9 the membership of this group lost their loved ones as
10 a result of hospital-acquired Covid-19 or in the
11 care home following discharge of hospital patients
12 without testing.

13 The first point I'd like to make is on location, and
14 it arises from the fact that in her note Ms Carey notes
15 that the spotlight evidence is intended to cover both
16 rural and urban areas, but in fact only hospitals from
17 two areas of South Wales have been selected, and that's
18 been commented on by others as well. Large swathes of
19 Wales, the rest of South Wales, for example, North Wales
20 and rural areas, are not covered by the selection made.
21 While it may be reasonable not to actively seek
22 information from the areas worst affected, in our
23 submission it makes little sense, where evidence points
24 to a particular problem in a particular area, to ignore
25 that during this exercise or not to seek to build on it.

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1 evidence may be sought. One of the stated aims of the
2 spotlight process is to identify key themes and
3 particular issues. We would question again whether two
4 hospitals from South Wales can adequately identify the
5 key themes and issues of the whole country, in which
6 different regions had different demands placed on them.

7 So the point we make is that each health board faced
8 unique challenges and responded differently to common
9 challenges, so that key themes in Wales need broader
10 scrutiny. Understanding the range of issues within
11 Wales is surely critical and crucial to add to the
12 Inquiry's understanding of UK-wide issues.

13 Looking at the rationale and criteria applied as set
14 out in counsel's note, at paragraph 9 it's stated that:

15 "The purpose ... was to obtain evidence [of] the
16 impact of national decision-making and leadership upon
17 those operating within healthcare systems, including how
18 hospitals responded 'on the ground' to the ...
19 pandemic."

20 We agree, it's a laudable and proper aim, and we
21 focus in particular on the words "on the ground",
22 because we struggle to see how these aims are in fact
23 satisfied by evidence from a Chief Medical Officer,
24 a point that's already been made, but if I may, we also
25 say that this will be inevitably at too high a level to

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1 For example, the National Nosocomial COVID-19
2 Programme report was provided by the Welsh Government
3 earlier this year for a period ending 31 January 2024.
4 This showed that the highest rate of nosocomial
5 infection was in North Wales, within Betsi Cadwaladr
6 health board, and that the rates of nosocomial infection
7 varied greatly across Wales. Hence our reference to the
8 postcode lottery in Wales and Wales' particular
9 geographical and demographic characteristics in our
10 written submissions.

11 Failure to consider this variance in our submission
12 not only limits the voice of those bereaved in other
13 areas of Wales, but also leaves a gap in understanding
14 of the UK-wide issues, which we now understand is what
15 this evidence is directed at.

16 There are a number of relevant issues raised by our
17 members which we have already brought to the Inquiry's
18 attention, and these arise across the health boards, and
19 examples are also at annex A of our written submissions,
20 which have been provided for context.

21 We raised concerns with the Inquiry legal team in
22 correspondence about the rates of nosocomial infection,
23 healthcare facilities and access to healthcare
24 facilities in North Wales as an example, based on the
25 experiences of our clients, of an area where useful

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1 be useful and, in our submission, will be unlikely to
2 convey a true and vivid sense of what it was like to
3 battle with the pandemic on a daily basis in the wards
4 of the chosen hospitals, whether in Wales or elsewhere.

5 From the topic list in paragraph 13 of counsel's
6 note, at (a), for example, on staff shortages, is it not
7 relevant also to hear from staff on the ground how staff
8 shortages impacted on their work within those hospitals?
9 Would that not provide a more rounded picture of any
10 problems? This will again, we submit, bring to life --
11 and this is important -- for the public, the Inquiry and
12 CPs what it was actually like for the frontline staff at
13 the chosen hospital, a crucial level of understanding,
14 in our submission, for the crafting of meaningful
15 recommendations.

16 At paragraph 9 counsel's note states that spotlight
17 evidence is not the only way by which Module 3 will
18 examine the impact of the pandemic on those working and
19 being treated in hospitals. Whilst that was not
20 elaborated on in the note, we did hear this morning that
21 impact evidence requested from CPs and the accounts in
22 the Every Story Matters process will be used in this
23 regard.

24 The questions in our submission that still arise
25 are: how will it fit with and make sense of the

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1 spotlight evidence? Will core participants be given
2 an opportunity to respond to that evidence?
3 If the intention is to use expert evidence to fill
4 any gaps, for example on analysing the rates of
5 nosocomial infection across the UK, then we would make
6 the following observations: experts are not able to
7 cover the actual experiences of staff on the ground, and
8 counsel has alerted us to a problem with the infection
9 prevention and control expert evidence at paragraph 31
10 of her note, though of course we do note her submissions
11 on that this morning.

12 So our concerns about gaps in evidence more
13 generally about the Welsh experience are underlined by
14 the expert draft intensive care evidence which has
15 recently been circulated and the responses are formally
16 due on 16 April. For now we can say that our view is
17 that the draft report does not adequately deal with
18 devolved issues and would be responding with details on
19 this by the deadline set. That is a lacuna which raises
20 for our clients the concern that the Welsh experience is
21 not being sufficiently addressed in this module.

22 Further, on gaps in the evidence, we heard that
23 other evidence on nosocomial infection rates,
24 for example, is available from the Chief Medical Officer
25 of Wales, Public Health Wales, and Welsh Government

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1 We do acknowledge the burdens on the Inquiry and we
2 do raise concerns as to how this is a proportionate use
3 of the Inquiry's resources in relation to Wales.

4 So we do ask once more that this is reviewed and
5 that if statements from each of the seven health boards
6 cannot be taken, then at least that one or two of the
7 other health boards are considered from other parts of
8 Wales and are included in this exercise, and also that
9 consideration is given to including staff and clinicians
10 from the chosen hospitals.

11 My third point was on delay in listing. Our
12 experience in other modules is that disclosure has been
13 late and sometimes comes after the event. It's not
14 unusual. In Module 1, crucial evidence of risk
15 registers was disclosed on 12 and 13 July last year,
16 when the Welsh witnesses had already given evidence and
17 we had no longer the opportunity to put these documents
18 to those witnesses. Similar issues were encountered in
19 Module 2B. We understand that delays are unavoidable
20 but repeatedly CPs are having to play catch-up. It
21 inevitably impacts on effective participation, and in
22 particular where lay participants are concerned, who
23 need more time to absorb what is disclosed even with
24 legal advice.

25 With respect, we say it's not sufficient to say it's

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1 Health and Social Services Group. Again, and I'm sorry
2 I'm being repetitive on this, our point is that this is
3 high-level evidence and unlikely to throw light on the
4 impact on the ground of decisions and leadership for
5 healthcare workers interpreting guidelines from on high.
6 On some issues, as noted in the draft intensive care
7 report, guidance differed from area to area, leaving
8 clinicians to decide how best to respond.

9 Lastly, we say that there is no indication as to
10 whether or how evidence gathered by the spotlight
11 process is to be tested. Is its reliability to be taken
12 as read, or will CPs be given an opportunity to
13 interrogate it, and if so on what basis? If it's not
14 tested, we would question its value to the Inquiry, or
15 even how useful or proportionate an exercise this
16 actually is. This may be a particular concern to
17 devolved nations. It's definitely a concern to the
18 understanding of issues in Wales.

19 I do offer my apologies for sounding so disgruntled
20 and negative about this process, but this is what our
21 clients feel. It's a very important strand of the
22 Inquiry and, without fully explained reassurances as to
23 how else the key issues and themes will be elicited, the
24 mantra that "the experience in Wales will be thoroughly
25 examined" begins to sound somewhat hollow.

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1 a knock-on effect of the late production of disclosure
2 by other state bodies. It doesn't really help our
3 clients. We are concerned that the balance between
4 timing, resources, CP participation, could be struck
5 better and that more time for hearings and also for
6 Rule 10 questions is necessary.

7 We are anxious that there should be no delays in the
8 timetabling, but added to the woes already referred to
9 is the listing of hearings virtually back-to-back. In
10 general written submissions are due one to two weeks
11 before a hearing and three to four weeks after the
12 conclusion of a hearing, so the overlap and demands on
13 the work is clear, and especially where there is, say,
14 six weeks between hearings. This is onerous and
15 potentially impacts on the fairness for CPs and their
16 ability to respond adequately.

17 I was going to make a fourth point on expert points,
18 but I have already made the points I wanted to make on
19 that.

20 So just on Rule 9 requests, we have heard what
21 Counsel to the Inquiry has said and we've raised in our
22 written submissions at paragraph 4 the requests that we
23 have already made, which we have repeated in our written
24 submissions.

25 So, with the greatest of respect and repeating the

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1 understanding that time and resources are not
2 a bottomless pit, Cymru families feel that they must
3 record their disappointment and frustrations at this
4 point, but we do look forward to continuing to work and
5 collaborate with the Inquiry in the work of this module.

6 My Lady, thank you very much, and unless there's
7 anything further I can assist you with, those are my
8 submissions.

9 **LADY HALLETT:** No, thank you.

10 Mr Straw.

11 **Submissions on behalf of John's Campaign, Care Rights UK and
12 the Patients Association by MR STRAW KC**

13 **MR STRAW:** Thank you. My Lady, I'd like to address eight
14 topics this morning.

15 First, the need for people to be central to this
16 questions. The very first line of the NHS Constitution
17 for England is "The NHS belongs to the people". The
18 reason why the constitution repeatedly makes clear that
19 the patient will be at the heart of everything the NHS
20 does is that this is the most effective way of
21 organising a health system. In the same way we submit
22 that the most effective way that this module can examine
23 the impact of Covid-19 on the health system is to place
24 people at its heart. It is only by focusing on the
25 lived experiences of individual patients or staff that

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1 should not be given disproportionate attention in this
2 module. It's important to also investigate the impact
3 of Covid and the response to it on healthcare outside
4 hospitals and to consider healthcare holistically across
5 the range of relevant contexts. Healthcare is provided
6 in hospitals, but also in GP surgeries, by community
7 care, at home, in residential care, in hospices and in
8 a number of other settings. As the NHS Constitution for
9 England states, at 5:

10 "The NHS works across organisational boundaries ...
11 The NHS is an integrated system of organisations and
12 services bound together by the principles and values
13 reflected in the Constitution. The NHS is committed to
14 working jointly with other local authority services,
15 other public sector organisations and a wide range of
16 private and voluntary sector organisations to provide
17 and deliver improvements in health and wellbeing."

18 We submit that that approach again should be
19 reflected in the Inquiry. An investigation which
20 encompasses healthcare outside the hospital is important
21 for two key reasons.

22 Firstly, non-hospital healthcare involves critical
23 services which are provided to a very large number of
24 people. For example, the NHS provides some 95 million
25 contacts in community services each year. Restricted

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1 this Inquiry will fully understand and learn from the
2 pandemic and from its response.

3 In consequence, we warmly welcome the indications
4 from the Inquiry in this module that it will focus on
5 individuals. However, we are concerned with the
6 approach that appears to be taken to spotlight hospitals
7 in this respect, and I'll come back to that in a moment,
8 if I may.

9 The second topic is the issues to be investigated.
10 We made some submissions about the Inquiry's provisional
11 list of issues previously, for the purpose of the last
12 preliminary hearing. There has been no specific
13 response to those submissions, and the timescale for
14 a revised list of issues is now said to be the end of
15 May. We would invite the Inquiry, if possible, to
16 produce the revised list of issues sooner than the end
17 of May, if it can do, because this would provide
18 assurance to core participants that their submissions
19 are being addressed and it's also very important to
20 guide future preparation.

21 In light of recent developments, the CPs, our CPs,
22 have further submissions about what issues should be
23 investigated.

24 So, firstly, healthcare outside hospital. The
25 hospital setting, while of course is very important,

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1 access to community services for many meant that
2 non-Covid-related health needs were left unidentified
3 and untreated and this led to serious illnesses and
4 deaths.

5 The second reason is that healthcare outside
6 hospital raises specific and different issues with
7 respect to Covid and the response. To take some broad
8 and basic examples, the risks of Covid infection were
9 different outside hospital. Effective infection
10 prevention and control measures were different, and the
11 dangers of not providing non-Covid healthcare and
12 treatment were also different.

13 We note that a number of other CPs have made similar
14 submissions to this for the purpose of this hearing,
15 including the British Medical Association at
16 paragraph 28, and CATA, paragraphs 3.1 to 3.2, which we
17 endorse.

18 The next additional issue is regulation and
19 oversight. Issue 2 in this module's provisional list of
20 issues is core decision-making and leadership. We urge
21 the Inquiry to include within this the way in which
22 systems for complaints, regulation and oversight of
23 healthcare operated during the pandemic. Those systems
24 were suspended or otherwise hugely disrupted. It's
25 difficult to see that that was appropriate, since

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1 regulation and oversight were no less important during
2 a pandemic and this ought to be examined.

3 The third additional issue is end of life healthcare
4 or other care. Palliative care for patients with
5 Covid-19 in acute hospitals is issue 5(b) within the
6 list of issues for this module. It's unclear whether
7 other forms of end of life or palliative care are
8 covered. These are important topics that were
9 overlooked during the pandemic and which ought, we say,
10 to be covered at some stage by this Inquiry.

11 There are a number of issues of public concern in
12 this area, which include the following four:

13 First, the lack of end-of-life care for non-Covid
14 conditions, a lack of end-of-life care for any condition
15 outside of acute hospitals. This left many people to
16 die alone and without support.

17 The second issue of concern, the reasons for the
18 lack of end-of-life care, these may include entrenched
19 systemic inadequacies and that older and disabled people
20 were considered to be expendable.

21 The third issue, restrictions on visits from carers
22 and loved ones.

23 And fourthly, whether those delivering palliative
24 care outside hospitals were provided with sufficient PPE
25 and other support.

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1 this led to serious harm. Some examples of this are set
2 out in our witness statement, paragraphs 37 to 39.

3 Now, while this might be examined to a degree by the
4 spotlight hospital process, it's unlikely to be fully
5 understood by that route, so we submit other evidence is
6 necessary in order to fully investigate it.

7 Now, this morning Ms Carey King's Counsel appeared
8 to suggest that evidence will not be taken from patients
9 or their families in respect of the spotlight hospitals,
10 only staff. Now, if I've interpreted that correctly,
11 then we would object to that approach. For the reasons
12 I gave at the start, we submit that it's very important
13 that evidence is taken from patients. Without that
14 lived experience, the perspective from spotlight
15 hospitals will be one-sided and will overlook key
16 issues.

17 The next topic is mental health. As to the
18 investigation of adult mental health by this Inquiry,
19 the November 2023 update note stated that, while this
20 won't be examined in this module, Module 3, it will be
21 investigated in another module or other modules.

22 It's not clear which module will examine this
23 important issue, or why it doesn't fit most obviously
24 within this module, and that's why I'm raising this
25 again now.

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1 So we invite the Inquiry to make clear that it will
2 investigate these issues at some point and we also
3 invite it to consider calling expert evidence on
4 end-of-life care. This may be obtained from the Cicely
5 Saunders Institute at King's College London, and in
6 particular from Professor Irene Higginson, and we'll
7 forward a copy of her CV to the Inquiry so it may be
8 considered.

9 The fourth and final additional issue is that we
10 agree with Mr Weatherby King's Counsel in urging you to
11 include preparedness for health and social care within
12 this module.

13 The next topic is spotlight hospitals. While this
14 is a potentially useful aspect of this investigation, we
15 submit that it should not be exclusive and should not
16 preclude a full and proper investigation of the relevant
17 systemic issues by other means.

18 CTI's note for this hearing at paragraph 9 appears
19 to recognise this and that this won't be exclusive, but
20 to give an example, topic (h) in paragraph 13 of CTI's
21 note is visiting restrictions. One of the concerns of
22 the CPs who I represent is that visiting guidelines were
23 interpreted and applied very differently between
24 different hospitals and other healthcare settings. In
25 some places they were applied very restrictively and

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1 We respectfully submit that it is important that
2 adult mental health is investigated. The pandemic
3 response restrictions on visits, for example, had a very
4 severe impact on those with psychiatric problems in
5 hospitals or otherwise. Mind's submissions for this
6 hearing give some examples of this at paragraph 19, and
7 our witness statement gives other examples. Mental
8 health healthcare is an integral part of the broader
9 healthcare system and we agree with Mind that, as
10 a consequence, it should fall within this module. In
11 any event, we respectfully invite the Inquiry to confirm
12 in which module this will be investigated.

13 The next topic is further evidence. We make six
14 suggestions for further evidence, whether this comes
15 from experts or from other witnesses who are able to
16 help. This is set out in detail in our written
17 submissions, so I'll just briefly summarise and add
18 a few additional points, if I may.

19 So firstly, the use of do not resuscitate or do not
20 attempt CPR notices. This is issue 6(b) within the
21 provisional list of issues for this module. There is
22 evidence that these notices were issued on a very wide
23 scale on an inappropriate basis, that is without
24 consulting the person and/or their representative, and
25 it's arguable that there were broad systemic issues

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1 behind this, for example age, disability or other
2 discrimination, or at least that there were inadequate
3 local or national guidelines. The examination of this
4 issue we say would benefit from a witness, again not
5 necessarily an expert witness, but someone who can
6 digest and summarise the complex evidence as to how
7 these notices were used inappropriately across a broad
8 range of settings and can help identify whether there
9 were systemic flaws behind that misuse.

10 The second new area of evidence is access to
11 healthcare outside NHS premises. CTI's note indicates
12 that Professors Snooks and Edwards will examine a number
13 of aspects of healthcare outside hospitals and we
14 welcome that. Ms Carey King's Counsel has partly dealt
15 with this earlier today concerning mental health, but we
16 invite this Inquiry to make clear that it has instructed
17 the professors to include healthcare provision in as
18 full a range of settings as possible outside hospital,
19 so including community settings, in people's homes, care
20 settings and so on. As touched upon above, there were
21 specific and different issues of concerns applicable to
22 healthcare outside NHS premises.

23 The third area of evidence, the clinically extremely
24 vulnerable population. This population is covered by
25 issue 11 on the Inquiry's list of issues. We invite

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1 adjustments to ensure that this group of people could
2 access healthcare. We therefore invite the Inquiry to
3 consider investigating this issue and with that in mind
4 we suggest an expert who would be able to help do so,
5 Dr Emma Wolverson, clinical psychologist and reader in
6 ageing and dementia at the University of Hull, and again
7 we'll forward a copy of her CV to the Inquiry.

8 The fifth area of evidence, carers in healthcare, we
9 submit that this module ought to examine the critical
10 and inseparable role of carers, including family carers
11 in healthcare. Given the specific and often overlooked
12 role that they played, this module may benefit from
13 expert evidence about unpaid carers in the NHS.

14 Then the sixth area of additional evidence is
15 nosocomial transmission in hospitals. This falls within
16 issue 8 in the Inquiry's list of issues, and we invite
17 the Inquiry to consider whether expert evidence would
18 assist in respect of this issue, particularly in
19 relation to certain specific topics that are set out in
20 our written submissions.

21 The final two areas of -- topics I'd like to cover
22 are, firstly, cross-module issues, so issues which cut
23 across two different modules or more. NHS have invited
24 the Inquiry to clarify how issues which cut across more
25 than one module will be examined and where the dividing

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1 the Inquiry to obtain evidence, potentially expert
2 evidence, about certain subissues within this point,
3 namely (i) whether the conditions which were considered
4 to be extremely vulnerable were appropriately
5 categorised as such; (ii) whether the restrictions on
6 access to healthcare and other matters which resulted
7 from this categorisation were proportionate; and (iii)
8 whether alternative but less onerous means of protecting
9 these individuals from Covid should have been adopted.

10 The fourth area of additional evidence is access to
11 and impact on healthcare services for those with
12 learning disabilities and cognitive impairments. Again,
13 Ms Carey has touched upon this this morning. The
14 pandemic response had a particular and severe impact on
15 people with learning disabilities and cognitive
16 impairments, for example with dementia, not least in
17 accessing healthcare. People with learning disabilities
18 were around eight times more likely to die during the
19 pandemic. This isn't a peripheral healthcare issue; it
20 is central.

21 There are a number of specific and discrete issues
22 of concern which govern this group which, we
23 respectfully submit, ought to be investigated in this
24 module. They include lack of access to familiar
25 caregivers and widespread failure to make reasonable

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1 lines are. An example is the DNACPR issue.

2 Now, if the Inquiry will do as NHS England asks, we
3 invite it to bear in mind that in a number of ways
4 health and social care are inseparable, and this means
5 that for some cross-cutting issues it's not proper to
6 investigate the issue in isolation in each setting. Do
7 not attempt CPR as an example, it appears that the
8 bodies/systems and other factors that are responsible
9 for the widespread misuse of these forms are inseparable
10 and it's therefore necessary in order to properly
11 understand this issue to consider it across the whole
12 range of health and social care settings.

13 Some other issues, however, might be investigated
14 separately in more than one module. End-of-life care is
15 an example. It appears that this Inquiry intends to
16 investigate it in both Module 3 and Module 6, and we
17 endorse that approach, given that those who are
18 responsible for it and for the issues are broadly
19 separable. However, we would invite the Inquiry to
20 maintain a degree of flexibility in light of the
21 evidence which is obtained.

22 The last brief point, if I may, is that in --
23 concerns expert questions and instructions. In Module 6
24 this Inquiry has decided that it will provide to
25 core participants the questions it gives to experts.

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1 There are obvious good reasons for doing so, which we've
2 set out in the past. We respectfully invite this module
3 to reconsider its position and to take the same approach
4 as will Module 6.

5 My Lady, unless there is anything else, those are
6 our submissions.

7 **LADY HALLETT:** Thank you very much, Mr Straw, very grateful.
8 Ms McCabe.

9 **Submissions on behalf of Clinically Vulnerable Families and
10 13 Pregnancy, Baby and Parent Organisations by MS McCABE**

11 **MS McCABE:** My Lady, yes, thank you very much.

12 I act with Adam Wagner and Rosa Polaschek on behalf
13 of two core participants. The first is Clinically
14 Vulnerable Families and the second is 13 Pregnancy,
15 Birthing and Parent Organisations. We are instructed by
16 Slater and Gordon solicitors on behalf of both, and
17 I have Shane Smith in attendance with me today.

18 My Lady, on behalf of the 13 Pregnancy, Birthing and
19 Parent Organisations I have no substantive submissions
20 to make at this hearing, save to say we're very grateful
21 for the updates from Ms Carey King's Counsel this
22 morning, in particular the Inquiry's aim for disclosure
23 to be complete by the end of June or early July, bearing
24 in mind the school holidays, and also to say that the
25 Pregnancy, Birthing and Parent Organisations are working

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1 practically been forgotten, within the healthcare system
2 but also in wider society.

3 CVF are therefore keen to ensure that this very
4 serious oversight is not repeated in the Inquiry, and
5 so, in that context, CVF's overarching submission is
6 that the Inquiry must consider clinically vulnerable
7 people with an appreciation of their distinct interests
8 in this module and that it must specifically bear
9 clinically vulnerable people in mind when investigating
10 the healthcare response to Covid-19.

11 Now, your Ladyship will recall that the Inquiry's
12 terms of reference include an obligation to consider any
13 disparities evident in the impact of the pandemic on
14 different categories of people, and the terms of
15 reference make clear that those categories include but
16 are not limited to those relating to protected
17 characteristics under the Equality Act. So evidently
18 the scope of the categories of people is within
19 the Inquiry's discretion.

20 My Lady, the Inquiry's equalities and human rights
21 statement on the website currently states that when
22 investigating unequal impact among different groups, the
23 characteristics which will be considered are: groups
24 with protected characteristics, geographical
25 differences, social economic background, occupation and

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1 hard to identify suitable individuals to provide impact
2 evidence to the Inquiry, and they were very grateful to
3 be asked to do so.

4 My Lady, on behalf of Clinically Vulnerable
5 Families, who I will refer to as CVF, there are five
6 topics I wish to address today.

7 The first, my Lady, is the inclusion of the
8 clinically vulnerable and clinically extremely
9 vulnerable as a separate equality group.

10 My Lady, this is a submission which was made by
11 Mr Wagner at the last preliminary hearing, but it's
12 an issue that CVF feel particularly strongly about, and
13 no ruling was made on it, so they have asked me to
14 repeat the submission today.

15 My Lady, the pandemic, as you'll be aware, had and
16 continues to have a distinct impact on clinically
17 vulnerable people. They remain at higher risk of severe
18 disease from Covid-19 and they've had to make difficult
19 choices about the extent to which they can participate
20 in all facets of public life since public health
21 measures have been withdrawn.

22 CVF's core concern, my Lady, is that the distinct
23 impact on the clinically vulnerable was insufficiently
24 considered throughout the pandemic, and at present they
25 feel that the clinically vulnerable as a group have

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1 immigration status.

2 While those are all hugely important groups, CVF
3 were disappointed to see that the clinically vulnerable
4 are not identified as a relevant group or characteristic
5 within that statement, notwithstanding the submissions
6 made on their behalf at the last hearing.

7 So CVF therefore repeat their submission that the
8 equalities and human rights statement should be amended
9 to add clinical vulnerability to Covid-19 to the list of
10 characteristics which will be considered by the Inquiry
11 when investigating unequal impact among different groups
12 or populations.

13 Whilst this may appear to be a fairly small step by
14 the Inquiry, CVF submit that amending that statement
15 would be a tangible demonstration of the clinically
16 vulnerable's important place within this Inquiry and
17 will ensure that the mistake of overlooking this group
18 is not repeated in the Inquiry as it too often was
19 during the main phases of the pandemic.

20 My Lady, my second topic is reasonable adjustments
21 at the substantive hearing in the autumn. CVF are
22 exceptionally grateful to the Inquiry's operations team
23 for the steps taken to enable their in-person
24 participation at preliminary hearings to date.

25 Your Ladyship may be aware that CVF has been engaged in

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1 correspondence with the operations team in respect of
2 appropriate reasonable adjustments which will allow CVF
3 members to attend and fully participate in the
4 substantive hearings.

5 CVF does acknowledge that online attendance at those
6 hearings is possible. However, they're very keen for
7 CVF members to have safe access to the physical space if
8 at all possible and they remain concerned that this will
9 not be possible as matters stand.

10 CVF will continue to liaise with the operations team
11 in respect of this, and they sincerely hope that
12 a creative solution will be identified to enable their
13 full participation in the substantive hearing.

14 My Lady, my third topic, expert evidence.

15 From CVF's perspective, the Inquiry must ensure that
16 it has the evidence necessary to properly consider the
17 impact of the pandemic on clinically vulnerable people
18 as a key demographic. With that in mind, they have two
19 brief points to raise.

20 The first is a point of clarification on the current
21 expert evidence. CVF are very grateful for the
22 Inquiry's confirmation that some of the experts already
23 instructed will address the challenges faced by the
24 clinically vulnerable. In particular, Professor Snooks
25 and Professor Edwards' report on primary care and

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1 airborne hospital-acquired transmission. So CVF ask
2 that the Inquiry seriously considers those requests.

3 My fourth and penultimate topic, my Lady, is the
4 importance of Module 3 addressing the impact of Covid-19
5 on children's experiences of healthcare. CVF have
6 already noted that there is no explicit reference to
7 children in the provisional scope of Module 3, and they
8 are of course aware that there is a separate module
9 upcoming on education and children. However, that does
10 not, in CVF's submission, distract from the need to
11 consider children's particular and distinctive
12 experiences of healthcare as part of Module 3.

13 We note what was said by Ms Carey King's Counsel
14 this morning in respect of Professor Edwards and
15 Professor Snooks' report specifically, but
16 notwithstanding that, CVF submit that the impact of
17 Covid-19 on children's experiences of healthcare,
18 including clinically vulnerable children, and the impact
19 of shielding or not shielding on clinically vulnerable
20 children, fall within the scope of Module 3, and would
21 be grateful for confirmation of that from the Inquiry.

22 If the Inquiry does not propose to consider those
23 issues within the purview of Module 3, then CVF seek
24 confirmation of whether they'll be considered in the
25 forthcoming separate module on children.

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1 emergency pre-hospital care will address issues around
2 the shielding programme. They were very pleased to
3 learn that.

4 But in addition to the points which were summarised
5 today, which will be addressed by Professor Snooks and
6 Professor Edwards, the Inquiry is invited, if it has not
7 already done so, to instruct those experts to
8 specifically consider the long-term effects of shielding
9 on all shielding people, but in particular, my Lady, the
10 psychosocial effects of shielding. CVF's very strong
11 view, which is supported by its members' lived
12 experience, is that the psychosocial impact of shielding
13 is just as important as any other long-term effect, and
14 that must be addressed in that evidence for the Inquiry
15 to have a full understanding of the shielding programme.

16 My second point on expert evidence is simply to
17 endorse the submissions made by -- some of the
18 submissions made by the John's Campaign core participant
19 group, and specifically on the instruction of a specific
20 expert in respect of the clinically extremely vulnerable
21 population, albeit if that request is granted CVF would
22 want to feed into the contents of the instructions, and
23 CVF also endorse John's Campaign's submissions in
24 respect of obtaining an expert in respect of
25 hospital-acquired transmission of Covid-19, especially

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1 My Lady, finally, some brief observations on the
2 submissions made by other core participants in respect
3 of spotlight hospitals. CVF hear what was said in
4 respect of that this morning. They do echo the concerns
5 about a rose-tinted corporate view, but they will review
6 the statements with interest when they are disclosed.
7 And, briefly, CVF endorse a specific submission made by
8 Covid Bereaved UK at paragraph 13 of their written
9 submissions, which is that -- the concern that a focus
10 on a very limited number of spotlight hospitals may be
11 at the expense of consideration of wider systemic issues
12 that were faced by the population, for example
13 differences between NHS trusts in respect of their
14 approach to DNACPR and the Covid-19 decision support
15 tool, which is of particular concern to CVF.

16 My Lady, unless I can assist further, at 3 minutes
17 to 1, those are my submissions on behalf of CVF.

18 **LADY HALLETT:** Excellent timing, Ms McCabe. Thank you very
19 much indeed for your submissions.

20 Break now? Right, we shall break now and I shall
21 return at 2 o'clock.

22 **(12.57 pm)**

23 **(The short adjournment)**

24 **(2.00 pm)**

25 **LADY HALLETT:** Right, Ms Hannett? Ah, you're there.

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1 **Submissions on behalf of Long Covid Kids, Long Covid Physio,**
 2 **Long Covid SOS and Long Covid Support by MS HANNETT KC**

3 **MS HANNETT:** I appear on behalf of the four Long Covid
 4 groups, Long Covid Kids, Long Covid SOS,
 5 Long COVID Physio and Long Covid Support.

6 I'm assisted by Ms Iengar and Ms Sivakumaran, and
 7 I'm instructed by Jane Ryan of Bhatt Murphy Solicitors.

8 The Inquiry has our written submissions. I propose
 9 to focus on key issues for our clients. That focus is
 10 not intended to diminish the importance of the remaining
 11 points raised in our submissions, but the Inquiry has
 12 them and will no doubt consider them with care.

13 With that in mind, I propose to make submissions on
 14 five broad topics: first, the scope of Module 3; second,
 15 the Rule 9 process to date; third, disclosure; fourth,
 16 the length of the hearing; and fifth, the timetable for
 17 the Inquiry's recommendations.

18 The first topic, my Lady, is a request for
 19 clarification as to the scope of Module 3 in three
 20 respects. These points are set out in paragraphs 5 to
 21 16 of our written submissions, but in summary are as
 22 follows.

23 The first point of scope is that the Long Covid
 24 groups seek a clarificatory ruling as to where the
 25 impact of vaccines on Long Covid will be investigated,

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1 confirmation that the Inquiry will consider the economic
 2 impact of Long Covid on healthcare workers, in
 3 particular on their ability to continue working and the
 4 consequential financial impacts and, further, that
 5 the Inquiry will investigate the impact on healthcare
 6 workers of the decision not to designate Long Covid as
 7 an occupational disease.

8 My Lady, you ruled at the last preliminary hearing
 9 that issues relating to the designation of Covid-19 as
 10 a disability and the creation of a compensation scheme
 11 were out of scope, but these are two separate points,
 12 my Lady. As to the economic impacts, the Long Covid
 13 groups maintain that a proper focus on the physical
 14 health and wellbeing of healthcare staff, as required by
 15 issue 7(a), necessarily includes an examination of the
 16 wider economic impacts for healthcare workers who
 17 contracted Covid-19 and who developed Long Covid.

18 Similarly, that Long Covid was not recognised as
 19 an occupational disease has implications for issue 8(d),
 20 namely RIDDOR reporting requirements for healthcare
 21 workers. The RIDDOR regulations prescribe the
 22 occupational diseases which must be reported.
 23 Long Covid is not one of them. There is evidence as to
 24 the under-reporting of workplace Covid-19 via RIDDOR
 25 already before the Inquiry, both from the Scottish TUC

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1 and whether that is to be in Module 3 or in Module 4.

2 There is evidence that vaccines both reduce the severity
 3 of existing Long Covid and reduce, albeit not wholly
 4 prevent, new cases of Long Covid developing. These are
 5 matters that must be explored by the Inquiry, not least
 6 because people continue to suffer from Long Covid and
 7 its effects.

8 My clients made submissions at the last preliminary
 9 hearing asking for confirmation that these issues would
 10 be considered in Module 3, given the Inquiry's decision
 11 to refuse them core participant status in Module 4, and
 12 that the reasons for that refusal included the point
 13 that the characterisation and identification of
 14 post-Covid condition, including Long Covid, and its
 15 diagnosis and treatment, falls within Module 3.

16 The Long Covid groups note the distinction drawn in
 17 the second preliminary hearing ruling between the
 18 development of therapeutics up to the point of use,
 19 a matter for Module 4, and the use of therapeutics,
 20 a matter for Module 3, but respectfully ask that it put
 21 be beyond doubt in your ruling on preliminary hearing 3
 22 that Module 3 will include an examination of the impact
 23 of vaccinations on Long Covid.

24 That's the first point of scope, my Lady.

25 The second point of scope is a request for

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1 and the Health and Safety Executive, and indeed the
 2 Health and Safety Executive witness statement notes that
 3 as of 31 October 2023 only 36 RIDDOR reports for
 4 Long Covid had been received.

5 In the absence of a designation of Long Covid as
 6 an occupational disease, trusts are left with
 7 a discretion as to whether to report or not, and we say
 8 it's artificial to look at RIDDOR reporting but not to
 9 look at the decision-making around whether or not
 10 Long Covid should be designated as an occupational
 11 disease, and we say this is key to making proper
 12 recommendations as to the prevention of the spread of
 13 Covid and an understanding of how best to manage
 14 workplace safety.

15 For these reasons we ask that the Inquiry make clear
 16 that both of these points, economic impact and
 17 Long Covid as an occupational disease, are in the scope
 18 of Module 3.

19 The final point of scope concerns the manner in
 20 which the Inquiry will investigate the barriers to
 21 patients, both adults and children, accessing Long Covid
 22 services and clinics and the variation in the quality of
 23 those services.

24 The Long Covid groups will in due course invite the
 25 Inquiry to make findings as to the adequacy of those

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1 services and recommendations as to how they could be
2 improved, and we ask now for clarification as to how
3 evidence to address these issues will be obtained.

4 One possibility, as we suggest in our written
5 submissions, would be to apply an equivalent approach to
6 Long Covid clinics as that being applied to spotlight
7 hospitals. We note the submissions of Counsel to the
8 Inquiry this morning about the lack of need or lack of
9 perceived need to expand the spotlight hospital approach
10 to other services, given the totality of the evidence,
11 but we say that equivalent evidence does not appear
12 presently to be before the Inquiry in respect of
13 Long Covid services and we ask the Inquiry to give that
14 some further consideration.

15 In summary, on the first topic of scope, the
16 Long Covid groups say that all three points are
17 fundamental to the proper investigation of Long Covid in
18 the healthcare system. They ask, first, the Inquiry to
19 confirm that they will be dealt with in Module 3, and if
20 not, for the Inquiry to confirm in which module they
21 will be addressed.

22 My Lady, that's the first topic.

23 The second topic concerns the Rule 9 process and we
24 address this in paragraphs 18 to 21 of our written
25 submissions. Two key points arise on which I wish to

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1 rather reflect a broader need for evidence to be
2 sufficiently detailed in the first place, and indeed we
3 note Counsel to the Inquiry's reminder this morning that
4 pre-Rule 10 questions need to be proportionate and
5 focused.

6 The Long Covid groups do wish to assist the Inquiry
7 in this respect and to this end we will continue the
8 correspondence that has been started directly with
9 the Inquiry's legal team with suggestions of where
10 further detail is required.

11 The second key point, my Lady, on the Rule 9 process
12 concerns Rule 9 statements for the spotlight hospitals.
13 We join cause with many of the other core participants
14 to note that these must go further than just the chief
15 medical officer or equivalent. In particular, my
16 clients invite the Inquiry to seek evidence from a range
17 of frontline healthcare workers, including those
18 privately contracted by the NHS in the spotlight
19 hospitals.

20 My clients welcomed Counsel to the Inquiry's
21 clarification this morning that the evidence sought from
22 spotlight hospitals includes a number of workers
23 suffering from Long Covid and the varying methods of
24 support offered by hospitals, and further we welcome the
25 clarification that the issues raised include problems

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1 address you in oral submissions.

2 First, the Long Covid groups understand that
3 necessarily the Inquiry will focus on the healthcare
4 response at a relatively high level, but the detail
5 does, in our submission, remain important, and we regret
6 to note that the witness statements disclosed to date
7 that address Long Covid provide evidence at such a high
8 level of generality that no meaningful conclusions can
9 be drawn from them.

10 So, for example, it appears that none of the Rule 9
11 recipients have been specifically asked to comment on
12 Long Covid in children. As a result, none of the
13 witness statements disclosed to date make reference to
14 this, even the statement from the Royal College of
15 General Practitioners and the statement from Public
16 Health Scotland, and we also note that morning that
17 Counsel to the Inquiry confirmed that the expert report
18 on pre-hospital care will not comment on children's
19 access to healthcare.

20 For the avoidance of doubt, we don't accept that
21 those kinds of gaps can properly be plugged by the use
22 of the Rule 10 process. There is limited time for the
23 hearings, which will inevitably limit the number and
24 scope of the Rule 10 questions that can be asked.
25 Further, these aren't points of clarification. They

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1 with the physical condition of the estate, infection
2 protection and control guidelines, narrow corridors and
3 poor ventilation.

4 We note Counsel to the Inquiry's assurance that
5 they're satisfied that the evidence obtained is not
6 rose-tinted but we are concerned there's a real risk
7 this approach may lead to not providing a balanced
8 evidential picture of the issues that affect affected
9 healthcare workers. The Inquiry will only have one side
10 of the picture, and it's unclear how that evidence will
11 be tested.

12 So we therefore repeat our request for the Inquiry
13 to expand their request of the spotlight hospitals
14 beyond one individual statement and to seek evidence
15 from a variety of sources, such as patient groups,
16 professional bodies and trade unions, so that
17 core participants may be satisfied that the Inquiry is
18 receiving a balanced picture.

19 Further, in this respect, we endorse the submissions
20 made this morning by Mr Weatherby that the evidence
21 sought from spotlight hospitals should include
22 preparedness. Questions around applicable national
23 planning, infection protection and control, testing,
24 staffing and support for healthcare workers are of
25 central concern.

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1 As we outline in our written submission, the
2 Long Covid groups' experience is that of a healthcare
3 system unprepared to protect healthcare staff from
4 developing Long Covid and unprepared to manage and
5 support healthcare staff who suffered from Long Covid.

6 My Lady, the third topic concerns disclosure. We
7 have dealt with this in paragraphs 22 to 23 of our
8 written submissions. We welcome the significant amount
9 of disclosure that the Inquiry has provided to date,
10 but, again, we join cause with the other
11 core participants in noting that it remains imperative
12 that the reminder of the witness statements are provided
13 with sufficient time to allow the Long Covid groups and
14 the other core participants sufficient time to prepare
15 properly for the Module 3 hearing.

16 To this end we invite the Inquiry to do two things.
17 First, to ensure that most or all of the disclosure is
18 received by the end of June 2024 at the latest, and we
19 welcomed the comments of Counsel to the Inquiry this
20 morning to that end. But, second, to provide
21 a timetable or roadmap now indicating when particular
22 witness statements and underlying material are likely to
23 be provided, to enable both my clients and other
24 core participants to properly prepare and marshal their
25 resources.

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1 Inquiry's recommendations. My clients welcome your
2 recommendation for a monitoring process, including that
3 the institutions responsible for implementing the
4 recommendations should respond within six months. The
5 recommendations are urgent, and have immediate and
6 ongoing relevance, given that people continue to
7 contract Long Covid.

8 In conclusion, the Long Covid groups look forward to
9 assisting the Inquiry in the Module 3 hearing, but
10 unless I can assist you further, my Lady, those are the
11 submissions on behalf of the Long Covid groups.

12 **LADY HALLETT:** Thank you very much for your help.

13 Right, who is next? Ms Sen Gupta. There you are,
14 hiding at the back.

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

17 **MS SEN GUPTA:** My Lady, I am.

18 My Lady, I appear on behalf of the Frontline Migrant
19 Health Workers Group, together with my learned friend
20 Piers Marquis. We are instructed by the Public Interest
21 Law Centre. The group is comprised of United Voices of
22 the World, Independent Workers' Union of Great Britain,
23 and Kanlungan Filipino Consortium.

24 We take this opportunity to highlight briefly some
25 of the points made in our written submissions. We've

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1 My Lady, the fourth topic concerns the length of the
2 hearing. We address this in paragraph 24 of our written
3 submissions. Again, like other core participants, we
4 are concerned about the adequacy of the 40-day
5 allocation for the Module 3 hearing, and in particular
6 the Long Covid groups note the importance of there being
7 a sufficient exploration of Long Covid, not least
8 because people continue to contract Long Covid and
9 suffer its avoidable impacts.

10 We say that the current timetable gives rise to
11 a real risk of there being insufficient time to ensure
12 Long Covid receives the focus it requires, and we
13 respectfully ask the Inquiry to keep the timetable under
14 review and to monitor, in the light of the evidence
15 that's received, whether it remains satisfied that
16 Long Covid issues, amongst others, can be fairly and
17 thoroughly undertaken within Module 3 in the scheduled
18 time period.

19 If Long Covid cannot be dealt with fully in the
20 current Module 3 timetable, including the matters of
21 scope that I began these submissions with, the Inquiry
22 is asked to consider whether Long Covid should be dealt
23 with in a separate freestanding module, as suggested by
24 the Royal College of Nursing.

25 My Lady, my fifth and final topic concerns the

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1 divided up our oral submissions into those on the
2 substance of the evidence your Ladyship ought to hear as
3 part of Module 3, and those on process and procedure in
4 respect of the public hearings listed to begin in
5 September and timely preparation for those hearings.

6 In relation to substance, I address our proposals in
7 relation to, first, the scope of the expert evidence;
8 second, the scope of the evidence from spotlight
9 hospitals; and, third, the scope of the issues in
10 Module 3.

11 In relation to process, we note CTI's helpful update
12 on disclosure, for which we're grateful. I will briefly
13 touch on, first, the need for position statements from
14 state CPs; second, the length of the public hearings;
15 and, third, the need for restriction orders for
16 vulnerable witnesses, as appropriate.

17 My Lady, turning then first to substance and expert
18 evidence.

19 As your Ladyship is aware, one of the systemic
20 issues of particular concern to our clients is the
21 impact of outsourcing on the NHS in the context of the
22 pandemic. This is about the use of contract workers as
23 well as NHS employees within NHS hospitals. For the
24 avoidance of any doubt, it is not about the use of
25 private hospitals. The Inquiry has received our

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1 separate written representations that your Ladyship and
2 CPs would be assisted by the instruction of an expert in
3 this area.

4 There have been significant concerns raised from
5 within the NHS about the impact of this outsourcing on
6 the healthcare system and those working in it, in
7 particular with regard to unfavourable contract terms,
8 working conditions and the overall impact on healthcare
9 efficiency.

10 Clearly, we submit, this is all highly pertinent to
11 Module 3's scope. We submit that your Ladyship and
12 the Inquiry would be greatly assisted by instructing
13 such an expert, and invite your Ladyship's ruling in
14 this regard.

15 Second, spotlight hospitals.

16 We submit that evidence from the spotlight hospitals
17 should not be limited to senior managers. Evidence
18 should also be obtained from frontline staff in both
19 clinical and non-clinical roles, including those in
20 outsourced positions and migrant workers with
21 employment-dependent visas. They ought to be heard,
22 given the crucially important role they played during
23 the pandemic.

24 Further, we have identified in our written
25 submissions some particular points which we submit

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1 as treatment for physical health conditions.

2 My Lady, process.

3 First, position statements from state CPs.

4 We invite your Ladyship to direct that the state CPs
5 prepare and submit position statements in advance of the
6 public hearings in order that CPs have sufficient notice
7 of their respective positions and are able to prepare
8 accordingly.

9 Second, length of the public hearings.

10 Like many other CPs, we are concerned that ten weeks
11 will not be enough for the public hearings, given the
12 breadth of this module, though we note what CTI has said
13 in this regard.

14 Third, and finally, restriction orders for
15 vulnerable witnesses.

16 Many of our groups' members are in precarious
17 employment or have leave to remain directly tied to
18 their employment. They are thereby exposed to potential
19 repercussions should they provide impact evidence to
20 your Ladyship on systemic failures.

21 They have important evidence to give to
22 your Ladyship. By way of example, one staff nurse
23 worked on the Covid and non-Covid wards from the outset
24 of the pandemic, she contracted Covid at work and had to
25 be signed off after developing Long Covid. She raised

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1 should be covered and we have explained why we say that
2 is the case. I need not repeat those submissions
3 orally, and refer your Ladyship to them.

4 Third, on substance, we support the submissions of
5 Mind and FEMHO and the John's Campaign CP group on the
6 need for access to adult mental health services to be
7 included as a key area of examination in Module 3. The
8 impact of the pandemic on mental health generally and
9 the mental health of our clients' members in particular
10 was extremely significant. Your Ladyship and CTI have
11 already reflected this at paragraph 7(b) of the
12 provisional list of issues, for which we're grateful.

13 Our clients' members carried the stress of
14 an understaffed healthcare system and worked through
15 their fear, uncertainty and exhaustion to provide
16 essential services in the pandemic response. The trauma
17 of working on the frontline of a pandemic, unprotected
18 both physically and contractually, cannot be
19 understated. The consequent impact on the ability of
20 the healthcare systems to respond to the pandemic, as
21 a result of health workers' declining mental health, is
22 paramount to the task at hand in this module.

23 Examination of the impact of the pandemic on healthcare
24 ought, we respectfully submit, to include an examination
25 of the impact on access to adult mental health as well

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1 concerns about PPE early in the pandemic and was ignored
2 and reprimanded by senior managers. She witnessed
3 discriminatory treatment of Filipino and other BAME and
4 migrant staff in the hospital. She has not received
5 adequate support from her employer since being diagnosed
6 with Long Covid.

7 By way of further example, we refer to two
8 outsourced cleaners. During the pandemic, they raised
9 concerns that they were being instructed to work on
10 Covid wards without adequate training and without prior
11 warning of contamination risk. There was also a notable
12 lack of PPE, lateral flow tests, and access to
13 vaccinations. They were given no time to wash or
14 disinfect themselves before being sent to clean other
15 non-Covid wards.

16 They raised additional concerns that cleaners who
17 contracted Covid-19 were not paid when self-isolating.
18 This had led to outsourced cleaners who were unable to
19 afford the unpaid sick leave, continuing to work whilst
20 unwell. They did not have access to Covid-19
21 vaccinations, whereas the directly employed NHS hospital
22 cleaners did. The vaccination programme appeared to
23 function as a two-tier system which treated employees as
24 more important than outsourced staff, despite their
25 shared risk of exposure. It was only through pursuing

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1 a grievance process with the hospital that IWGB was able
2 to secure vaccinations for these workers.

3 We request that your Ladyship hears impact evidence
4 from these vulnerable individuals and we request that
5 these vulnerable individuals are suitably protected from
6 their further public service in giving such evidence to
7 your Ladyship's Inquiry by restriction orders as
8 appropriate.

9 My Lady, in conclusion, we're very grateful to
10 your Ladyship and to the Inquiry team for all your
11 considerable dedication to this module. We will
12 continue to assist the Inquiry in whatever ways we can.

13 Those are the submissions of the Frontline Migrant
14 Health Workers Group. My Lady, unless I can be of any
15 further assistance.

16 **LADY HALLETT:** Thank you very much indeed for your help,
17 Ms Sen Gupta, very grateful.

18 I saw the lectern arrive in good time. You're
19 obviously very ready to go, Mr Odogwu, thank you.

20 **Submissions on behalf of the Federation of Ethnic Minority
21 Healthcare Organisations by MR ODOGWU**

22 **MR ODOGWU:** Thank you, my Lady. I represent the Federation
23 of Ethnic Minority Healthcare Organisations and will use
24 the shorthand of FEMHO in my oral submissions.

25 As you will be aware, FEMHO is a large consortium of
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1 made ready for the end of May. Any further delay in the
2 provision of the revised list of issues is likely to be
3 counterproductive, given the tight timeframes we are
4 already under. It is also unnecessary.

5 We say respectfully there are obvious omissions from
6 the provisional list of issues that ought to be
7 immediately addressed. FEMHO stands firmly behind its
8 submissions made at previous preliminary hearings that
9 the examination of race inequality, both in terms of
10 impact and root causes, should be explicit in the list
11 of issues.

12 We know your Ladyship has demonstrated already in
13 this Inquiry a recognition of the importance of the
14 issue of discrimination and inequality. It is therefore
15 surprising to my clients that there has been no direct
16 response from the Inquiry to those submissions.

17 The list of issues as presently drafted make no
18 reference to -- specifically to the issue of race
19 inequality, and this can be contrasted with the specific
20 references to inequalities in relation to other
21 vulnerable groups, for example those relating to age and
22 disability.

23 A comprehensive investigation into the impacts of
24 Covid-19 on the healthcare system must include
25 a thorough consideration of race inequality. It is
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1 black, Asian and minority ethnic healthcare workers.
2 Our members were on the frontline and behind the scenes
3 throughout the pandemic, working tirelessly under brutal
4 pressures and conditions across the UK to support the
5 public health services.

6 A striking feature of the Covid-19 pandemic was the
7 disproportionate impact on healthcare workers. Many of
8 our members lost their own lives, colleagues, friends,
9 family and loved ones whilst suffering from physical and
10 mental burn-out because of the conditions they were
11 required to work in.

12 According, my Lady, FEMHO provides the Inquiry with
13 a unique and pivotal voice on the impact of the pandemic
14 on healthcare systems and staff.

15 Your Ladyship will have received our written
16 submissions and I don't propose to repeat the same in my
17 oral submissions.

18 My submissions today will focus on four main topics:
19 first, scope; second, the Rule 9 requests and
20 disclosure; third, expert and impact witnesses; and
21 fourthly, public hearings.

22 Dealing firstly with scope.

23 The Inquiry had previously indicated that a revised
24 list of issues would be provided in the spring of 2024.

25 It is now being suggested that a second draft will be
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1 important that this is officially acknowledged in the
2 list of issues. In order to assist your Inquiry, we
3 submit the revised list of issues should include the
4 following five issues:

5 (1) Whether and if so how structural inequalities
6 influenced the capacity of the healthcare systems and
7 workers.

8 (2) Socioeconomic factors such as the impact of
9 poverty, discrimination and social exclusion.

10 (3) Specific challenges faced by ethnic minority
11 healthcare workers including inadequate access to PPE
12 and occupational health support, and increased exposure
13 to the virus due to high risk clinical roles.

14 (4) The impact of government policies and decisions
15 or lack of them on black and minority ethnic people in
16 the healthcare system.

17 (5) Engagement and consultation and inclusion with
18 black, Asian and minority ethnic communities and
19 healthcare workers in the development of policies or
20 interventions.

21 We echo calls made by other core participants for
22 greater clarity on the remit of healthcare within
23 Module 3. We urge the Inquiry not to narrow its focus
24 purely on hospitals, and instead take an expansive view
25 that encompasses primary and community care services.
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1 Finally, in respect to scope, we support the
2 submissions made by the Long Covid groups. FEMHO's
3 membership includes a cohort suffering from Long Covid
4 after occupational exposure, some of whom have had
5 profoundly negative consequences and experiences in
6 obtaining support and adjustment from their employers.

7 We share the view that the scope of Module 3 should
8 include an examination of how healthcare staff who
9 developed Long Covid as a result of their occupational
10 exposure have or have not been supported.

11 The second issue is Rule 9 requests and disclosure.

12 FEMHO welcomes the Rule 9 requests to the spotlight
13 hospitals and notes what was said this morning. We
14 have, though, three observations about the gathering of
15 evidence on what was happening on the ground during the
16 pandemic.

17 First, a point that has been advanced by other
18 core participants, we consider that the Inquiry would
19 benefit from carrying out a similar exercise in
20 gathering information from a range of primary care
21 services and not just hospitals. We note CTI's
22 observations that evidence already gathered means this
23 isn't necessary. We would suggest the spotlight
24 approach that we encourage you to adopt would ensure the
25 Inquiry hears from a range of people, including GP

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1 impact of treatment on vulnerable groups, and in
2 particular black and Asian, minority ethnic healthcare
3 workers.

4 In our submission, the Rule 9 requests ought to
5 include topics specifically addressing racial
6 inequalities, including but not limited to whether
7 appropriate and effective risk assessments were carried
8 out in the deployment of black, Asian and minority
9 ethnic healthcare workers, the extent of any diversity
10 within the leadership, disproportionality in decisions
11 regarding re-deployment of staff into red zones or other
12 high clerical(sic) risk areas, and, finally, whether
13 concerns regarding PPE access and suitability were
14 raised and appropriately addressed.

15 In relation to the wider disclosure process, whilst
16 acknowledging the constraints caused by delays in
17 material provider provision to the Inquiry team, we
18 remain concerned as to the progress with onward
19 disclosure of material to the core participants.

20 We have our full submissions set out at
21 paragraphs 3.1 to 3.3 in our written submissions and
22 note what was said earlier. We simply stand behind
23 those submissions and echo calls from other
24 core participants on this point.

25 Thirdly, my Lady, expert and impact evidence.

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1 surgeries, mental health facilities, ambulance trusts
2 and other frontline community healthcare centres.

3 Second, we are concerned that the Rule 9 requests
4 have been sent to the chief medical officers or
5 equivalent roles, and we therefore echo the other
6 submissions made by core participants in this regard.

7 We do note Ms Carey's submission this morning that
8 requests specifically ask that the statement be provided
9 by an appropriate person or individual. It is
10 imperative that the spotlight hospitals take an open and
11 transparent approach to their responses, and defensive
12 corporate statements from members boards responsible for
13 particular hospitals would undermine the integrity of
14 this approach.

15 The Inquiry should ensure evidence is obtained from
16 a full range of personnel in the hospital and primary
17 care settings, including frontline workers. The
18 responses should reflect the experiences of healthcare
19 workers across the different levels and areas within the
20 individual hospitals and be candid in acknowledging any
21 issues and negative experiences that were encountered.

22 Third, whilst we are grateful to the Inquiry in
23 sharing the summary of topics that were covered in the
24 spotlight hospital requests, we are concerned about the
25 absence of specific references to evidence regarding the

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1 The Inquiry's commitment to placing possible
2 inequalities at the forefront of this investigation is
3 of particular importance to FEMHO in this module, as
4 this is where we say the impact of inequality cuts the
5 sharpest.

6 In line with that commitment, expert evidence on
7 racial inequality on all aspects of healthcare and
8 disproportionate outcomes should be obtained for
9 Module 3. This should look at both patients and staff.
10 We fully endorse and support the submissions made on
11 behalf of the Bereaved Families for Justice group, that
12 there is a need for further healthcare-specific evidence
13 in this regard.

14 FEMHO implores the Inquiry to go further than merely
15 examining impact, but to investigate the root causes of
16 the underlying inequalities within the healthcare
17 system. It can achieve this by adopting what we say is
18 a three-pronged approach.

19 First, the Inquiry should instruct its existing
20 experts to produce addendum reports and, where
21 necessary, instruct further experts to address the
22 Module 3 specific matters in relation to discrimination
23 and race inequality. We certainly do encourage the use
24 of the existing expert evidence prepared for the
25 purposes of other modules. However, it is inadequate,

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1 in our submission, to examine the Module 3 specific
2 issues by merely adducing those reports.

3 We respectfully do not agree with Counsel to the
4 Inquiry's submission this morning that the background
5 and context of those existing reports provides
6 sufficient evidence in of itself to this module. They
7 do not address the institutional or systemic issues
8 within the healthcare setting which it is imperative
9 that this module investigates.

10 Second, FEMHO urges the Inquiry to prioritise
11 calling a proportionate number of witnesses who are from
12 diverse backgrounds, disciplines and locations across
13 the UK and who can speak to a range of systemic issues
14 relevant to Module 3. FEMHO has many such witnesses who
15 can provide this evidence. Our position is that the
16 experience of FEMHO members speaks directly to the
17 issues of health inequality as workers and users of the
18 healthcare system. Their voice should not be limited to
19 the Every Story Matters reports.

20 We are grateful for and encouraged by the requests
21 for short summaries of impact evidence from a number of
22 our members. We look forward to engaging with
23 the Inquiry and endeavour to assist in this regard. To
24 assist this process, my Lady, Saunders Law, those
25 instructing me, have sent a letter to the Inquiry team

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1 the pandemic and the data indicates that black, Asian
2 and minority ethnic healthcare workers were overly
3 represented within that cohort. Its impact on the
4 healthcare system and its obvious impact on patients in
5 accessing appropriate care should be examined, and we
6 therefore endorse and support the submissions on behalf
7 of Mind.

8 Finally, my Lady, in regards to public hearings,
9 FEMHO shares the genuine concerns advanced on behalf of
10 other core participants regarding the limited duration
11 afforded to evidential hearings for Module 3. Given the
12 breadth of the scope and the issues to be investigated,
13 we are of course keen that progress is made
14 expeditiously but we respectfully invite the Inquiry to
15 allocate more days to Module 3 for it to be meaningful
16 and effective.

17 We also support submissions on behalf of the
18 Bereaved Families for Justice group that a further
19 preliminary hearing is likely to be necessary in
20 preparation for the substantive hearings.

21 Finally, we would also echo the concerns about
22 timetabling and limited time windows before the public
23 hearings are due to commence. We would urge the Inquiry
24 to adopt a pragmatic and sensible timetabling approach,
25 namely prioritising early disclosure, particularly

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1 requesting that consideration is given to providing some
2 protection to those individuals who are coming forward,
3 such as anonymity. We are aligned with
4 Ms Sen Gupta KC's submissions just now in this regard.

5 As your Ladyship will appreciate, many of our junior
6 members and those in lower band and support roles have
7 legitimate concerns about negative consequences and
8 negative repercussions of speaking out.

9 Third, we invite the Inquiry to request evidence
10 from the researchers on the UK-REACH project, which is
11 a study focused on the experiences of minority ethnic
12 healthcare workers during the pandemic. We are grateful
13 for Ms Carey's confirmation that the Inquiry are
14 actively considering requests from core participants for
15 further Rule 9 requests to be made to individuals or
16 bodies. In our submission, it would greatly benefit
17 Module 3 if witness evidence is obtained from UK-REACH,
18 as well as the study reports, which we are happy to
19 provide the Inquiry.

20 We also urge the Inquiry to revisit its
21 consideration of adult mental health services within
22 Module 3. Again, we welcome Ms Carey's confirmation
23 this morning that the mental health of healthcare
24 workers is being examined. Individuals' experiencing
25 mental health problems died disproportionately during

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1 witness statements, allowing more time for EPs by
2 starting this process earlier, aligning timetables with
3 school holidays, and avoiding deadlines during and
4 immediately after August.

5 My Lady, those are our submissions, unless there are
6 any questions.

7 **LADY HALLETT:** No, very grateful to you, thank you very
8 much, Mr Odogwu.

9 Right, who is next? Mr Simblet. Oh, there you are.

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

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

13 As my Lady knows, we represent the Covid-19 Airborne
14 Transmission Alliance, CATA, who you have met in the
15 previous two preliminary hearings. As we said on those
16 occasions, CATA is here to help your Inquiry to conduct
17 an effective investigation, to obtain a proper
18 evidential basis for meaningful and informed
19 recommendations, and to encourage those to be
20 expeditiously implemented before any future pandemic.

21 Today, I wish to build on what I hope are regarded
22 as our constructive written submissions and to emphasise
23 that understanding how Covid-19 is and was transmitted
24 is essential to any assessment of the appropriateness of
25 the UK Government response to the pandemic.

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1 That's particularly so in this module, where it's
2 important to look at health and safety within the
3 healthcare system during the pandemic, and appropriate
4 to raise this at this last preliminary hearing since
5 such proper understanding of Covid transmission should
6 inform fundamentally how you organise this module,
7 including what it covers, managing disclosure and the
8 obtaining and selection of witnesses.

9 So I shall address three points today.

10 First, the implications of airborne transmissibility
11 of the Covid virus in the healthcare system.

12 Secondly, how that informs what should be considered
13 to be healthcare in the context of this module.

14 And, thirdly, the IPC expertise the Inquiry should
15 draw on.

16 So first, my Lady, this being potentially our last
17 opportunity to do so before the substantive Module 3
18 hearings, is: why is the airborne transmissibility of
19 Covid-19 important for an investigation of the
20 healthcare system?

21 Well, CATA submits that there were profound
22 cascading consequences flowing from the initial response
23 to the pandemic within the droplet paradigm and the very
24 slow march to appreciating the virus's airborne nature.

25 The impact on the healthcare system was grave. The
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1 So the UK Government's pandemic response treating
2 SARS-CoV-2 as transmitted primarily by droplets as
3 opposed to being an airborne virus was seriously flawed
4 and remained so.

5 Any uncertainty around the means of transmission
6 should have led on the precautionary principle to the
7 presumption that the virus transmission was airborne and
8 triggered the appropriate protections against this
9 disease, and this serious misstep needs to be considered
10 at all stages of your process.

11 One direct impact upon CATA's membership of this
12 failure was in terms of healthcare workers' safety and
13 the nature of such personal protective equipment as was
14 provided.

15 So why were healthcare workers wearing only surgical
16 masks? The appropriate kit to guard against airborne
17 transmission is respiratory protective equipment such as
18 powered respirators and FFP3 respirators.

19 Or, as the BMA have highlighted in their written
20 submission, why was a stop order placed on FFP3
21 procurement in June 2020? This concerning revelation
22 must be investigated thoroughly by the Inquiry, given
23 the profound impact it may have had on healthcare
24 workers' safety during the pandemic.

25 These issues are not just about healthcare worker
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1 failure to recognise the airborne nature of the Covid-19
2 virus, alongside the departure from existing policies,
3 practices and procedures for dealing with unknown
4 viruses, was disastrous.

5 As CATA has explained previously in its written and
6 oral submissions, there were procedures in place in the
7 healthcare systems for dealing with airborne viruses,
8 and it is a fundamental health and safety principle that
9 airborne precautions should be followed until there is
10 scientific evidence to the contrary. That's referred to
11 as the precautionary principle. And this basic tenet
12 underpinning health and safety legislation and practice
13 should have informed the approaches to disease
14 prevention and control within the healthcare system.

15 In fact, what happened was exactly the opposite. As
16 we've said in our written submissions at 2.6, alert
17 messages were sent to healthcare workers stating that
18 Covid-19 is not airborne in its transmission and is
19 droplet carried. That was seriously misleading and
20 wrong. As we have put it in our written submissions at
21 paragraph 2.1, SARS-CoV-2 is unequivocally an airborne
22 transmitted pathogen, that is to say it is carried in
23 tiny droplets known as aerosols. These are sufficiently
24 small that they remain suspended in air for long periods
25 of time and, when inhaled, initiate disease.
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1 safety, important though that obviously is, they
2 affected the wider public with whom the healthcare
3 workers were dealing, because the public were exposed to
4 greater risks of infection and, of course, suffered
5 an impact on the healthcare system through staff
6 absences.

7 My Lady, the airborne nature of Covid also informs
8 the second matter to be addressed: what should be
9 investigated as healthcare systems in Module 3?

10 CATA's always advocated for an expansive view of
11 healthcare. Our written submissions express the concern
12 that an overly restrictive definition of healthcare in
13 Module 3 will result in a failure to investigate
14 properly or at all healthcare administered within
15 community settings.

16 At the last preliminary hearing in September 2023 we
17 were joined by other core participants, who submitted
18 that Modules 3 and 6 should run in tandem, since what is
19 considered healthcare and social care cannot easily and
20 sufficiently be demarcated.

21 When looking at healthcare systems, the definition,
22 we say, cannot depend on whether care is received in
23 a hospital or not. We support on this point
24 particularly the written submissions from
25 John's Campaign and we say further, first, an airborne
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1 virus does not stop at the door of the hospital; those
2 working in healthcare systems very often do not only
3 work in hospitals, and we've given many examples in our
4 written submissions; and, thirdly, there was conflicting
5 advice, instructions, variations in equipment and
6 practice provided either to the same categories of
7 people in their different places or particularly the
8 same people working in different places who receive
9 conflicting instruction according to where they actually
10 are.

11 So that, we say, cannot properly be examined unless
12 you change what appears to be the approach. We say that
13 the Inquiry can only discharge its proper investigative
14 duties if it interrogates also the impact of Covid-19 on
15 community healthcare during the course of Module 3, and
16 we seek confirmation that this matter will be considered
17 appropriately within this module.

18 So it's important for us to say this is not just
19 simply a lament about hospitals or topics omitted from
20 this module. Rather, our point is: if you don't
21 investigate the conflicting advice, instructions and
22 policies and practices properly, you may end up with
23 incorrect conclusions. You could proceed on a false
24 premise, namely failing to understand how the
25 interdependent nature of healthcare systems -- and that

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1 the pandemic in the formulation of the appropriate IPC
2 guidance, and we support the Royal College of Nursing's
3 call for a clear chronology of when, by whom and how the
4 IPC guidance was varied and then disseminated.

5 The failure of IPC measures and the failure to
6 recognise the fact of airborne transmission is thus key
7 to understanding the significance of other issues that
8 have been raised previously by CATA and other CPs in
9 this Inquiry. For instance, inadequate and unsuitable
10 respiratory protective equipment and why the failures in
11 relation to those were so catastrophic may well inform,
12 for instance, the differential impact on those from
13 a minority ethnic background, as highlighted by FEMHO
14 and the Frontline Migrant Workers, among others.

15 More broadly, and as we and other CPs have submitted
16 briefly, the failure to look after healthcare workers
17 not only caused and still causes the loss of their
18 lives, health and financial security, it still has
19 enduring consequences on healthcare provision now. On
20 this we agree with the submissions of the BMA at
21 paragraphs 10 to 15 and welcome their support in
22 paragraphs 20 to 22 of their submissions for the issues
23 relating to the departure from usual health and safety
24 reporting procedures and the RIDDOR requirements about
25 which we've made submissions previously.

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1 word is important, "systems" -- and the people in them
2 were affected by Covid. You would proceed on a false
3 assumption that the impact in hospitals can be examined
4 as if a hospital is isolated from the rest of the
5 healthcare system. That is simply wrong and would
6 almost inevitably lead to wrong answers.

7 Thirdly, my Lady, the Inquiry's engagement with the
8 appropriate infection prevention and control, IPC,
9 guidance and appropriate expertise.

10 We had provided various materials about that, we are
11 pleased to be told today of the progress that there has
12 been on that. Our submission is that health and safety
13 law such as the COSHH regulations and RPE standards
14 appear to have been ditched in favour of IPC guidance
15 without legitimate or transparent justification, and we
16 submit that the experts must address that issue.

17 It's also, we say, important for the Inquiry to
18 obtain -- well, to utilise such expert evidence on the
19 correct approach to IPC guidance, not just looking back
20 during Covid but to provide clarity ahead of the next
21 pandemic.

22 Again, there were existing procedures in place which
23 were not followed in relation to similar respiratory
24 viruses. There was already substantial learning which
25 could and should have been drawn upon at the outset of

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1 The expert evidence that you hear, my Lady, is
2 important not only for the understanding of past choices
3 but also to frame any recommendations for the future.
4 Lack of access to such expertise was a significant
5 factor that led to the vulnerability of healthcare to
6 this airborne risk, and its lack of appreciation of the
7 significance of an airborne transmission was
8 a significant failure.

9 To conclude, my Lady, after today there are only
10 151 days until the hearings begin. That sounds a lot of
11 time. It's less than six months, and there is
12 an immense amount to organise if this module is to
13 investigate properly.

14 CATA remains, of course, available to provide all
15 possible assistance.

16 **LADY HALLETT:** Thank you very much for your help,
17 Mr Simblet, very grateful.

18 Ms Davies.

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

20 **MS DAVIES:** My name is Ms Davies, I'm head of legal at Mind,
21 the mental health charity. I'm assisted today by Ms --
22 or Mrs Abdul Vincent Nightingale(?) and Ms Nimareng(?),
23 part of the dedicated Mind legal team, and this gives me
24 an opportunity to wish Eid Mubarak to my colleagues who
25 are missing today.

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1 It's probably not well known that Mind was set up by
2 the post-war Labour government, who set up our NHS and
3 modern welfare state and social services. They had
4 recognised in their vision for the country that
5 a separate voice was needed for those with mental health
6 problems, who were even more sorely discriminated
7 against and stigmatised than they are today.

8 Our mission was set then and remains today not to
9 give up until those people with mental health problems
10 are given the support and the respect that they need,
11 and our submission is not set against the historic task
12 of this Inquiry, which is to learn the lessons that can
13 be learnt from the pandemic for the prevention of future
14 suffering. Counsel Ms Carey has said that the Inquiry
15 will look at key and significant issues. It's my job to
16 persuade you that what happened to the nation's mental
17 health during the pandemic and the impact on health
18 services is both key and significant.

19 We appreciate that the Inquiry has to grapple with
20 twin beasts, the scale of the information it has to
21 review and the pace that must be adopted in order that
22 recommendations will be practicable for future
23 generations or indeed this generation, should another
24 pandemic reach our shores.

25 We see the argument that was put at the last
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1 be a public health mental health plan to address what we
2 say were these population health predictable issues.
3 And why is that?

4 You know, I could say -- I could give you a general
5 opinion about the stigma and the status of those with
6 mental health problems, but surely the answer is more
7 nuanced than that, and I say a perfectly proper question
8 for this Inquiry to address.

9 On top of those predictable problems, there were
10 less expected issues. Many people with no prior mental
11 health problems experienced first and very serious
12 episodes of psychosis and found that their lives --
13 actually particularly those who were intubated in ICU,
14 for some reason, and those people found that their lives
15 unravelled as a result of those illnesses. 8 million
16 people sought and were turned away from mental health
17 services because they were deemed not to be sick enough.
18 Recent evidence showed that one in nine children who --
19 are still carrying a mental health disability that
20 started during the pandemic. Recently figures were
21 released that said that people in their 20s were off
22 sick from work more than people in their 40s. The
23 response from the government was not to learn some of
24 the lessons that might have been -- to intervene in that
25 issue, but that mental health culture had gone too far.

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1 preliminary hearing that we cannot examine every
2 condition during this Inquiry or look -- that was
3 affected by the pandemic, and we cannot look in every
4 nook and cranny. However, mental health problems are
5 not every condition. They're a condition that everyone
6 can get. In normal times, however we seek to define
7 that now, one in four people will seek help for their
8 mental health in any given year.

9 During the pandemic, the scale of those mental
10 health problems became gargantuan. Substantial parts of
11 those mental health problems were, we say, predictable.
12 We knew that SARS-1 carried post-viral depression
13 syndrome, and it was reasonable to assume until told
14 otherwise that SARS-2 would do the same. The impact of
15 lockdown and shielding was bound to be detrimental for
16 a significant portion of the population shut off from
17 their social contact and their social support. We saw
18 mass bereavements, often without the chance to say
19 goodbye, and that created an obvious need.

20 Our health service staff were under intolerable
21 stress, and were facing both death and Covid with
22 inadequate PPE. The shutting of schools was bound to
23 affect both parents and children alike, although perhaps
24 the intensity of that was less predicted, according to
25 the parents that I know, and yet there appeared not to

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1 We at Mind would say there's no such thing as mental
2 health culture, there are only people and their families
3 who are suffering.

4 **LADY HALLETT:** I'm sorry to interrupt, Ms Davies, but we do
5 have limited time. Could we go back to the issues
6 I have to decide today in the preliminary hearing,
7 please.

8 **MS DAVIES:** Yes.

9 There was -- also perhaps less predictable were
10 questions such as lack of PPE. That meant that there
11 was rationing and prioritisation. Mental health
12 in-patient and community services were not priorities
13 for PPE, and that had an impact. This meant that during
14 the first few weeks of lockdown, when a quarter of
15 mental health in-patients were discharged early,
16 community services, who were also not a priority, found
17 themselves with what they say were both confusing
18 guidance and inadequate or no PPE. This meant that the
19 people who were meant to look after the discharged
20 patients were simply not there or not knowing what to
21 do.

22 Psychiatric nurses are less trained in infection
23 control, and that and the lack of PPE led to some really
24 dreadful experiences for those that were left in
25 hospitals. So, for example, we have had stories of

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1 people who lost all of their leave, even though they had
2 previously many hours a day, and people who were locked
3 in their rooms for up to five days at a time, in
4 isolation, and who were denied access to basic things
5 like showers.

6 Could this have been handled better? Is there
7 something we could do different? These, we say, are
8 perfectly proper questions that this Inquiry could
9 answer.

10 In terms of staff mental health, I know from my own
11 experience at the Nightingale hospital that they
12 developed a programme of putting on your psychological
13 PPE. Counsellors were available at all shifts. This
14 wasn't rolled out across the NHS. I don't know why.
15 And again, we say this is something the Inquiry can look
16 at.

17 In terms of when mental health might be looked at,
18 we were told that if not here then maybe we'd look in
19 Module 6. There was nothing in Module 6 about mental
20 health, and we say that Module 3 is the best place to
21 look at these issues. Or the Inquiry I suppose could
22 have a separate module, but that's not for me to tell
23 you to do, it's just a suggestion. Or the Inquiry could
24 move some of the children's mental health into looking
25 at children in schools, because the schools are such

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1 **MS MORRIS:** I'm just trying to be quick.

2 We are encouraged by Counsel to the Inquiry's
3 summary of the evidence gleaned from the spotlight
4 hospitals, and the reason for that is that her summary
5 of the content mirrors closely many of the key issues
6 upon which the College itself focuses.

7 We also welcome the indication as to the impact
8 evidence which the Inquiry will take, and in particular
9 that it will be hearing from some nurses who were on the
10 frontline.

11 Finally, we support the proposal made by
12 Ms Hannett KC in relation to healthcare workers with
13 Long Covid, because many of our members are in the
14 situation of having Long Covid, and both because of its
15 materiality for what happened at the time but of course
16 for its materiality for the healthcare system going
17 forward. Staff shortages are a problem which has only
18 intensified and there also will be, we say, potentially
19 greater recruitment problems if healthcare workers
20 perceive that they are not going to be protected or
21 looked after if they sustained such an injury in the
22 course of their work.

23 That concludes my submission, my Lady.

24 **LADY HALLETT:** Oh, they were brief, thank you very much
25 indeed, Ms Morris. In which case I'm going to go to,

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1 an integral part of the mental health referral system.

2 And let me make clear, Baroness Hallett, I'm not
3 disgruntled, I am hopeful. This is one of the most
4 important events that we have taken part in. We want
5 the Covid Inquiry to succeed. We want its legacy to be
6 that of a forward-looking Inquiry that breaks with the
7 tired tradition of excluding those of us with mental
8 health problems because it's often easier to do so.
9 Unless I can assist you further, that's the end of my
10 submissions.

11 **LADY HALLETT:** Thank you very much. Thank you for your
12 help.

13 I think we can take one more before we break, unless
14 I'm told ... yes, Ms Morris.

15 **Submissions on behalf of the Royal College of Nursing by
16 MS MORRIS KC**

17 **MS MORRIS:** My Lady, our submissions are brief and so that's
18 probably a sound choice.

19 I make submissions on behalf of the Royal College of
20 Nursing. We maintain our written submissions and
21 therefore we don't repeat them now.

22 We are encouraged by Counsel to the Inquiry's
23 summary this morning --

24 **LADY HALLETT:** The dance of the lecterns, Ms Morris, you
25 should know about that now.

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1 who is next, Ms Domingo.

2 **Submissions on behalf of the British Medical Association,
3 the National Pharmacy Association and the Royal
4 Pharmaceutical Society by MS DOMINGO**

5 **MS DOMINGO:** Thank you, my Lady. I think my submissions
6 today will also be reasonably brief.

7 My Lady, I will make three sets of submissions this
8 afternoon on behalf of three separate core participant
9 organisations, the BMA, the National Pharmacy
10 Association and the Royal Pharmaceutical Society.

11 The submissions will focus on the key issues and
12 lines of enquiry that each of these organisations
13 consider essential for exploration by the Inquiry within
14 Module 3, and these are the submissions on behalf of the
15 British Medical Association.

16 As the Inquiry has heard in earlier modules, the
17 pandemic had a tremendous impact on healthcare workers
18 and their patients. The UK's health services entered
19 the pandemic significantly understaffed and
20 under-resourced, which severely affected the ability of
21 these systems to weather the storm when Covid arrived.
22 Healthcare staff worked tirelessly to safeguard the
23 nation's health during the pandemic, often at great
24 personal cost to their own physical and mental health.

25 The impacts of the pandemic were not felt equally

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1 for patients or for staff and many impacts continue to
2 this day.

3 Module 3 is a key opportunity for the Inquiry to
4 examine these experiences and ensure crucial lessons are
5 learnt and improvements implemented.

6 The BMA's submissions today are focused on the issue
7 of safety of healthcare workers during the pandemic, and
8 they highlight how a number of critical safety failures
9 placed healthcare workers at unnecessary risk. These
10 include the inadequate provision of appropriate PPE
11 and RPE, coupled with inadequate infection prevention
12 and control guidance, as well as failures to comply with
13 health and safety requirements such as risk assessments
14 and the reporting of occupational death and disease.

15 The BMA has already detailed its very serious
16 concerns about inadequate PPE, RPE and IPC guidance in
17 Modules 1 and 2 and the impact this had on doctors and
18 other healthcare workers on the frontline. However, the
19 BMA considers that Module 3 will be the opportunity to
20 address these issues in more detail. Of particular
21 concern is the recommendation within IPC guidance in
22 favour of the use of fluid-resistant surgical masks
23 (FRSM) for the routine care of patients with confirmed
24 or suspected Covid-19. FRSM masks are not PPE. They do
25 not provide adequate protection against aerosol

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1 employers are subject to a legal duty to undertake
2 suitable and sufficient risk assessments, yet there was
3 a widespread failure to do so within healthcare
4 settings, with 69% of doctors responding to a BMA survey
5 who contracted Covid-19 in 2020 telling the BMA that
6 they had not been individually risk assessed before
7 acquiring Covid.

8 BMA surveys also identified that ethnic minority
9 doctors more commonly went without PPE, felt worried or
10 fearful about speaking out, and felt that risk
11 assessments had been ineffective.

12 Similarly workplace protections are provided within
13 the Reporting of Injuries, Diseases and Dangerous
14 Occurrence Regulations 2013, or RIDDOR, which require
15 the reporting of a disease attributed to occupational
16 exposure to a biological agent.

17 However, despite healthcare workers being at
18 significantly higher risk of Covid-19 infection because
19 of the nature of their work, there was significant
20 under-reporting of cases of Covid-19 in healthcare
21 settings throughout the pandemic.

22 Reporting is crucial to understanding infections at
23 health service staff level, how infection spreads within
24 healthcare settings and how to better protect staff and
25 patients. This is critical information during

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1 transmission, and this particular issue is symptomatic
2 of a wider failure to properly recognise the risk of
3 aerosol transmission and to recommend and implement
4 appropriate measures in response.

5 The evidence of Professor Catherine Noakes in
6 Module 2 offered a number of explanations for the
7 reluctance to fully acknowledge this risk, including the
8 significant resource and operational implications for
9 hospital infection control measures. This same issue is
10 acknowledged within the technical report produced by the
11 chief medical officers and chief scientific advisers,
12 which is fully referenced within the BMA's written
13 submissions, and identifies the management of PPE and
14 best infection control advice as the issue that probably
15 provided the greatest point of tension between medical
16 practitioners and those trying to provide a standard
17 approach to IPC.

18 The BMA submits that this widespread acknowledgement
19 within the profession of the significance of the issue
20 requires thorough consideration by the Inquiry,
21 including the extent to which the safety of healthcare
22 workers was compromised in favour of operational or cost
23 considerations.

24 Connected to inadequate PPE and IPC is the failure
25 to comply with health and safety legislation. All

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1 a pandemic like Covid-19. However, there was
2 considerable under-reporting of disease and death under
3 RIDDOR. This under-reporting has made it even more
4 difficult for staff suffering from Long Covid to access
5 financial recompense, and the BMA asks the Inquiry to
6 consider the adequacy of the RIDDOR guidance produced by
7 the Health and Safety Executive and whether there is any
8 evidence that reporting was discouraged.

9 To conclude, while these submissions contain only
10 brief selected examples of the ways in which the safety
11 of healthcare workers were compromised, they evidence
12 a systemic failure which the BMA asks the Inquiry to
13 fully examine.

14 Sadly, there are doctors and healthcare workers who
15 lost their lives due to inadequate protection at work
16 and others who have suffered and continue to suffer
17 significant physical and mental health impacts from
18 working throughout the pandemic. This includes
19 Long Covid, the impact of which remains, in far too many
20 cases, ongoing and potentially career ending.

21 These are extremely serious issues that require
22 careful scrutiny by the Inquiry, so that meaningful and
23 effective improvement can take place, and the BMA asks
24 that they are examined in detail within the Module 3
25 hearings.

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1 My Lady, shall I move on to --

2 **LADY HALLETT:** Certainly, thank you.

3 **MS DOMINGO:** I shall move on to the submissions on behalf of

4 the National Pharmacy Association.

5 These submissions highlight three principal issues

6 that the NPA considers relevant to the scope of Module 3

7 and that ought to be examined within the Module 3

8 hearings later this year.

9 The first issue is the central role that community

10 pharmacy plays in local communities and in tackling

11 health inequalities across the UK.

12 Community pharmacies are part of primary care and

13 they have a unique understanding of the health needs of

14 the populations and the communities they serve. They

15 are disproportionately located in areas of higher

16 deprivation, delivering health services to communities

17 that need them most, and they play a crucial role in

18 reducing health inequalities. A local pharmacy is one

19 of the few places where patients can walk in off the

20 street and access healthcare advice and treatment

21 without an appointment.

22 During the pandemic, community pharmacies played

23 a core role in maintaining access to healthcare

24 services. They became the first port of call for many

25 patients, and NPA members experienced a huge increase in

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1 community pharmacy into the broader health system and to

2 support effective co-operation across the health

3 service.

4 The second key issue is that community pharmacy was

5 often overlooked and under-recognised. Despite the

6 central role played by community pharmacy in the

7 delivery of NHS care throughout the pandemic, community

8 pharmacists and their teams were not given comparable

9 treatment to other frontline healthcare workers, which

10 meant that often they did not receive the support that

11 they needed.

12 The most significant and demoralising example of the

13 different way in which community pharmacy was treated by

14 government was the initial exclusion of pharmacy workers

15 from the life assurance scheme for frontline workers in

16 England. The NPA asks the Inquiry to fully investigate

17 the circumstances that gave rise to this omission.

18 Another example relates to PPE, which was not

19 initially available to community pharmacy through the

20 NHS, requiring many pharmacy teams to source and fund

21 their own protective equipment.

22 The supply of PPE was a challenge and pharmacy teams

23 put themselves at risk to help patients stay well, often

24 working in close proximity to others and reusing PPE

25 repeatedly for days or even weeks.

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1 demand for healthcare advice and medicines, including

2 an increase in the number of patients seeking advice for

3 more serious health or mental health conditions.

4 NPA members reported a significant increase in the

5 number of prescriptions dispensed from February to

6 March 2020, and phone calls to pharmacies more than

7 tripled during this period. Home deliveries of

8 medication to vulnerable patients more than doubled, and

9 many pharmacies experienced long queues outside their

10 doors.

11 The role played by community pharmacy during the

12 pandemic provided crucial support and resilience to the

13 healthcare system. Pharmacists and their teams worked

14 tirelessly to maintain service provision and ensure the

15 supply of medicines to their local populations. Many

16 medicines became difficult to source, and expensive as

17 demand outstripped supply, and staff spent long hours

18 sourcing medicines.

19 The increased demand on community pharmacy during

20 the pandemic had a significant impact on pharmacists and

21 their teams, resulting in stress, fatigue and mental

22 health issues for many NPA members. Given the essential

23 nature of their frontline role, the Inquiry is asked to

24 consider whether there was sufficient investment by

25 government in the infrastructure needed to integrate

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1 The NPA suggests that the Inquiry examines whether

2 government properly and fairly considered the

3 circumstances of all healthcare workers who contributed

4 to the pandemic response.

5 Thirdly, the Inquiry is asked to consider the

6 resilience of the independent community pharmacy sector

7 in responding to a future pandemic. Community pharmacy

8 entered the pandemic facing financial and workforce

9 crises due to long-term underinvestment in the network.

10 These issues presented significant challenges for

11 community pharmacy in responding to the pandemic and

12 increased the difficulties in providing services to

13 patients and maintaining staffing levels. Even though

14 the pandemic clearly showed that pharmacies are

15 an essential part of health and social care, real-term

16 funding cuts have continued and the independent

17 community pharmacy sector find itself in a worse

18 situation than at the outset of the pandemic, with

19 pharmacies closing at the rate of approximately eight

20 per week.

21 A strong community pharmacy network is an essential

22 element of healthcare services in the UK, and the NPA

23 invites the Inquiry to consider the role of community

24 pharmacy in pandemic planning and in the overall

25 resilience of the UK's healthcare system to respond to

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1 a future pandemic.

2 I have one final set of submissions. Shall
3 I proceed?

4 **LADY HALLETT:** Yes, please.

5 **MS DOMINGO:** My Lady, the third and final set of submissions
6 are made on behalf of the Royal Pharmaceutical Society.
7 They highlight five key areas that the RPS submits
8 should be examined by the Inquiry in Module 3.

9 First, safety at work for pharmacists. Failures to
10 ensure the safety of healthcare workers and pharmacy
11 teams including through appropriate use of risk
12 assessments and the provision of suitable PPE must be
13 considered. The Inquiry is specifically asked to
14 examine whether rules on testing, contact tracing and
15 self-isolation, including infection prevention and
16 control guidance, were appropriate for all healthcare
17 settings, including pharmacies.

18 For example, social distancing in pharmacy settings
19 was often impractical and the RPS received reports of
20 inconsistent approaches to self-isolation rules around
21 the country, which potentially meant that some
22 pharmacies had to close or were no longer able to
23 support patient care.

24 Second, the role played by pharmacists working
25 within hospital settings. The work of pharmacists

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1 government planning, guidance and communications, and
2 this had a hugely detrimental impact on their morale and
3 wellbeing.

4 Fourth, the resilience of pharmacy services in the
5 event of a future pandemic or health emergency.

6 During the Covid pandemic, community pharmacies were
7 easily accessible and provided vital medication, health
8 advice, testing and vaccinations; they played a pivotal
9 role in protecting the health of their communities.

10 However, community pharmacy is under very significant
11 pressure, which is leading to the closure of pharmacies
12 in local communities. There is also a significant
13 concern around the health and wellbeing of pharmacists
14 and their staff and workforce capacity. The pandemic
15 placed enormous strain on staff, and RPS workforce
16 surveys demonstrate that pharmacists are suffering from
17 burn-out and Long Covid. At the start of the pandemic,
18 access to wellbeing services was not universal across
19 the UK and the RPS submits that all pharmacists should
20 have equal access to wellbeing support, including for
21 Long Covid, regardless of where they work.

22 The pandemic exposed the international complexity of
23 the medicines supply chain, leading to shortages of many
24 commonly used medicines such as paracetamol, as well as
25 medicines used in critical care. In the years since, it

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1 within hospitals is sometimes overlooked. During the
2 pandemic, hospital pharmacists cared for the most
3 critically ill patients with Covid-19, transforming
4 services to support colleagues and ensuring the supply
5 of medicines for critical care. Pharmacists also played
6 a key role in rapidly establishing field hospitals, and
7 the RPS submits that these contributions should be
8 examined in Module 3.

9 Third, a significant concern which is shared with
10 the NPA, the repeated and systemic difference in
11 treatments between pharmacists who provided
12 NHS-contracted services compared with healthcare workers
13 directly employed by the NHS.

14 The disparity in treatment can be seen in the
15 exclusion of pharmacists from visa extensions provided
16 to other healthcare workers in March 2020, in the
17 absence of specific mention of pharmacists and their
18 teams in guidance regarding key workers, which impacted
19 childcare provision at school hubs and, perhaps most
20 egregiously, in the omission of pharmacists from the
21 life assurance scheme for the families of frontline
22 health and care workers in England in April 2020.

23 Despite their crucial role providing care throughout
24 the pandemic, the pharmacy profession, and particularly
25 community pharmacy, was often an afterthought in

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1 has become increasingly common to see medicines
2 shortages within fragile supply chains, and the RPS has
3 recently launched a new research project to examine this
4 issue in more detail.

5 The Inquiry is asked to consider the resilience of
6 medication supply and pharmacy services across all care
7 settings in the event of a future pandemic, specifically
8 the current investment and planning in the medicines
9 supply chain, in medicines production facilities,
10 including aseptic pharmacy facilities in hospitals, and
11 in the role of frontline and volunteer workforce in
12 preparation for future pandemics.

13 The fifth point is on lessons learned.

14 The RPS submits that lessons learnt must include
15 longer-term reforms to better manage demand and build
16 resilience across the health service. The pandemic
17 highlighted the need for professional empowerments and
18 regulatory flexibilities to allow all health
19 professionals to put patients first. This included
20 steps to help pharmacists better manage the impact of
21 medicine shortages on patient care, such as enabling the
22 re-use of unused medicines in care homes and hospices.

23 The RPS also wishes to emphasise the importance of
24 early engagement by government and NHS leadership with
25 pharmacy stakeholders. For example, around medicine

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1 delivery services and supporting the planning and
2 roll-out of the mass vaccination programme and the need
3 for pharmacists in all care settings to have read and
4 write access to patient records to support patient care.

5 The RPS encourages the Inquiry to seek to identify
6 lessons such as these so that they can be embedded
7 within working practices going forward, to ensure that
8 we are better prepared in the future.

9 Finally and in relation to experts, it was mentioned
10 earlier this morning by Counsel to the Inquiry that the
11 RPS seeks the appointment of an expert in pharmacy and
12 I wish to clarify that the RPS is not proposing
13 an additional expert witness, rather that the instructed
14 experts -- for example in critical care, primary care,
15 and IPC -- take account of the role played by
16 pharmacists and the impact on pharmacists and pharmacy
17 settings.

18 Thank you, my Lady.

19 **LADY HALLETT:** Thank you very much, Ms Domingo.

20 Anything by way of response, Ms Carey?

21 **MS CAREY:** Nothing from me, my Lady.

22 **Closing remarks by THE CHAIR**

23 **LADY HALLETT:** Well, thank you very much all indeed.

24 I confess that when I was reminded there were 36
25 core participants, 15 of whom wanted to make oral
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1 means that I have to get through the work as soon as
2 possible, and that means that the longer I allow for any
3 one module, the more issues I add to the scope of any
4 one module, then the more delay to other modules.

5 So at the moment 2025 has a whole sequence of
6 modules that hope to have their hearings in 2025,
7 including care and children and young people, and I have
8 to say that if I made Module 3 go longer then I'd ask
9 people: what would they say to the core participants and
10 those interested in care and in children and young
11 people?

12 I also have to say that if I do decide to add to the
13 issues of Module 3, something will have to give, in
14 other words there isn't unlimited time. So although
15 I fully understand why people have made the submissions
16 that they have, and I fully understand the concerns,
17 I'm afraid we have to live with the time and the
18 resources that we have.

19 I also wish people to understand -- and not everyone
20 seems to understand this -- that because an issue is not
21 included in a specific module does not mean the Inquiry
22 will not be considering it at all.

23 As many people will understand, there are a number
24 of ways in which we can gather evidence. Oral hearings
25 is part of it, but also we can -- I can commission

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1 submissions, I was a little concerned, but may
2 I congratulate everybody on the focus of their
3 submissions and the timeliness of them.

4 I shall consider -- I would say consider them all,
5 but I'm going to have to say this in a moment, and
6 I will, having considered them, issue a ruling -- and
7 I'm not going to say "consider them all" because there's
8 one decision that I'm afraid I cannot revisit and
9 I shall not revisit, and I think it's only fair to
10 everybody that I make that plain this afternoon, and
11 that is the decision as to the timetable of this module.

12 For reasons I'll explain in a moment, this module,
13 Module 3, will start in early September. As Ms Carey
14 explained, it will last for ten weeks, with a two-week
15 break in the middle to ensure that everybody is
16 effectively prepared for the second half of the
17 hearings.

18 Let me just give one or two of the reasons that have
19 led me to that decision. As anybody who has ever read
20 my terms of reference, they'll know they are
21 extraordinarily broad. They are the broadest terms of
22 reference any statutory Inquiry has ever faced, and we
23 have a huge amount of work to get through and, because
24 I've set a tight timetable and because I want to get
25 recommendations implemented as soon as possible, that

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1 research, I can commission expert evidence, there are
2 a number of different ways in which I can gather
3 material. Oral hearings are just one part. They are
4 an important part, because they hold people to account
5 in public, but they are only one part of the Inquiry
6 process, and I will not reach any conclusions until
7 I have analysed and been assisted in the analysis of all
8 the relevant written material before me.

9 So please do not think that because you do not see
10 the express words "X, Y, Z" in a specific module that
11 means that X, Y, Z will not be considered. I am
12 exploring all the different ways at the moment with the
13 team and, as soon as I'm able to do, I will make my
14 plans for the future public. And I'm sorry that it
15 takes time but, as I'm sure again those with Inquiry
16 experience will understand, we learn a lot as we go
17 along and there has been a huge amount on the plate of
18 the Inquiry team, but I will make it public as soon as
19 I can, because I know people want to know what's going
20 to happen so they can prepare themselves accordingly.

21 So I will make everything public when I can, I will
22 make the ruling public when I can, and if people want to
23 see the rulings or the written evidence to which I've
24 just referred, they can always access the website.

25 So thank you all very much indeed.

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1 I think the next public hearing is in Belfast,
 2 I think, at the end of April.
 3 So thank you all for your help and for the
 4 constructive nature of the submissions, and that's all
 5 for this afternoon.

6 **MS CAREY:** Thank you, my Lady.

7 **(3.26 pm)**

8 **(The hearing concluded)**

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