RULING FOLLOWING THE MODULE 3 PRELIMINARY HEARING ON 10 APRIL 2024

Background

1. On 10 April 2024 I held the third Preliminary Hearing in relation to Module 3 of this Inquiry.

2. Prior to the hearing, 16 of the 36 designated Core Participant groups filed written submissions (one was a joint submission) and oral submissions were made during the hearing on behalf of 15 of the Core Participant groups. I am grateful to all those who addressed me, whether in writing or orally, for the care they took in making their submissions. I have considered the matters raised with equal care. I have already directed that the written submissions be published on the Inquiry's website.

3. In this ruling I set out my decisions on those issues that I consider require determination.

Scope of Module 3

4. A number of Core Participants sought confirmation that Module 3 will address areas of particular interest or concern to them. Those matters included preparedness within the healthcare systems, regulation and oversight of healthcare, palliative care, the impact of vaccines on long Covid, variations in long Covid services and racial inequalities and discrimination within healthcare settings.

5. The issues to be investigated in Module 3 continue to develop as the evidence is received and analysed, with some topics inevitably coming into greater focus than others. However, I am satisfied that each of the issues mentioned above will be

considered to an appropriate extent by Module 3 (whether through oral testimony, expert evidence, the Inquiry's research project or the Inquiry's listening exercise, Every Story Matters). It is neither necessary nor desirable at this stage to set out the extent to which these issues will be examined during the public hearing, though I will keep the submissions made as to the importance of each topic in mind as the Module progresses.

Mental Health

6. As set out in my Ruling following the Second Preliminary hearing into Module 3, this Module will examine the impact of the pandemic on healthcare for conditions other than Covid-19. It will do so by focussing on specific conditions and healthcare services, namely ischaemic (coronary) heart disease, colorectal cancer, elective hip replacement surgery and in-patient Children and Young People's Mental Health Services. Matters relating to ante-natal, post-natal and maternity care will also be explored. Mind, supported by other Core Participants, submitted that adult mental health services should also be included as a key area of examination given the significant number of adults affected by mental health conditions and the scale of mental health concerns during the Covid-19 pandemic.

7. I have carefully considered what has been said, particularly by Mind, but I do not intend to widen the scope of Module 3. Module 3 will directly examine in-patient Children and Young People's Mental Health Services and, in this regard, evidence has already been obtained and an expert report commissioned. The Module will also consider the impact of the Covid-19 pandemic on the mental health and wellbeing of those working within the healthcare system. However, it is simply not possible or necessary to examine all areas of non Covid-19 care in detail. I am not able to broaden the investigation into mental health or mental health services in Module 3 while ensuring that the existing timetable for this Module and future Modules is adhered to and my commitment to providing prompt recommendations is met.

8. I note that the Inquiry's Terms of Reference include the *"impact on the mental health and wellbeing of the population*". This connotes a wider remit than access to and the impact on services for adult mental health. Other modules will assist in exploring this. Additionally, as I made clear during the preliminary hearing, oral evidence is just one of the ways in which the Inquiry can gather evidence. The Inquiry has commissioned

independent research and continues to progress Every Story Matters - as of April, 39% of all the stories people have shared with us online have related to mental health - such as feeling sad, anxious or stressed. I intend to utilise a combination of approaches to address this aspect of the Inquiry's Terms of Reference.

Rule 9 requests - "Spotlight" hospitals

9. Module 3 has sent Rule 9 requests to the Chief Medical Officers / Medical Directors of 22 hospitals across the United Kingdom in order to obtain first-hand evidence from those operating within healthcare systems. Those hospitals who have received Rule 9 requests have been referred to by the Inquiry as the "Spotlight" hospitals. I heard from a number of Core Participants who supported this approach. Others encouraged me to expand or amend the approach taken. The submissions in this respect included:

    a. A submission from the Covid-19 Bereaved Families for Justice Cymru that Module 3 should send further "Spotlight" Rule 9 requests to a hospital in each of the seven Welsh Health Boards or at least to one or two further hospitals across Wales. This is said to be necessary to obtain a full picture of what occurred across hospitals in Wales, most significantly because the existing Welsh "Spotlights" are situated in South Wales despite there being particular issues, such as high nosocomial infection rates, in North Wales.

    b. A submission from the Northern Ireland Covid-19 Bereaved Families For Justice that at least one further hospital from Northern Ireland should be issued with a "Spotlight" Rule 9 request in order to account for the variety of experiences across each of the five Health and Social Care Trusts within Northern Ireland.

    c. A submission from various Core Participants that the Inquiry's approach of seeking witness statements from specific hospitals should be expanded to include other services, such as ambulances and primary care providers.

    d. A concern expressed by several Core Participant groups that the signatory to the "Spotlight" witness statements might provide a "rose-tinted view" of events during the pandemic, given their seniority within the relevant hospitals. They suggest that evidence should also be requested from other members of staff within the hospitals and from patients and bereaved families with experience of those

hospitals.

10. Before addressing the individual submissions, it is worth explaining the purpose of seeking evidence from the "Spotlight" hospitals. It is to obtain evidence of specific issues experienced within hospitals across the United Kingdom during the pandemic, with a view to identifying, in a proportionate manner, any recurring challenges or systemic issues that hospitals experienced. This evidence is intended to supplement evidence that has already been received from corporate and professional bodies and interest groups to form part of the overall body of evidence to which Module 3 will have regard.

11. I consider it would be disproportionate and impractical to obtain this sort of evidence from several hundred NHS/HSC hospitals operating across the United Kingdom. Selection of the "Spotlight" hospitals was guided by a desire to obtain a broad spread of evidence including from rural and urban areas, as well as seeking to ensure that the number of hospitals from whom evidence is obtained in each of the four nations is broadly commensurate to the size of their population. These hospitals have not been selected because they were deemed to have been most acutely affected by the Covid-19 pandemic or with the view to undertaking a comparative exercise.

12. A process such as this could never be an exact science. I have listened carefully to the submissions detailed above. However, given the stated purpose behind this evidence gathering process, I am not persuaded that it would be appropriate, at this stage, to issue any further "Spotlight" Rule 9 requests to other hospitals. I also bear in mind that were I to accede to the requests of the Bereaved Families for Justice Cymru and the Northern Ireland Covid-19 Bereaved Families for Justice to issue further requests to hospitals in Wales and Northern Ireland, this would create a significant imbalance in terms of the number of hospitals per capita from whom evidence has been obtained when compared with England and Scotland.

13. With respect to the request to expand the approach to include other services, including ambulances and primary care, I am satisfied that the evidence obtained by Module 3 in these areas is sufficient to allow me to investigate the relevant issues without the need for a similar approach. Module 3 has already obtained witness statements from each of the Ambulance Trusts across the United Kingdom, as well as from the Independent Ambulance Association. Evidence has also been obtained from

various organisations, including but not limited to the Royal College of General Practitioners, the British Medical Association, the Royal Pharmaceutical Association and the National Pharmacy Association addressing specific issues within primary care. The structure of primary care, with thousands of individual providers operating across the United Kingdom, means that it would also be far more difficult to conduct a similar exercise fairly and proportionately.

14. Finally, with respect to the submission that other front-line members of staff, as well as patients and bereaved family members with experiences of specific hospitals should be sent a "Spotlight" Rule 9 request, I do not consider that the process should be expanded in this way. As has been made clear previously, the purpose of this evidence is not to conduct a series of mini inquiries into experiences within the "Spotlight" hospitals. That is not to say that I do not wish to hear evidence from individuals with direct experiences of working within healthcare, receiving care or supporting those receiving care within the healthcare system. Module 3 has already invited several Core Participant groups to provide short summaries from proposed witnesses able to provide relevant evidence about the impact of the Covid-19 pandemic, some of whom will be asked to give evidence to the Inquiry. I understand the initial concern expressed that some of those in senior positions within the relevant hospitals may give a "rose tinted" view. I note, however, that those making submissions have not yet seen the witness statements obtained by the Inquiry. I am encouraged by what I have heard about the detail and level of candour within the "Spotlight" witness statements.

15. I will keep all of those points raised with respect to "Spotlight" evidence under review. I do so with regard to my obligations under section 17(3) of the Inquiries Act 2005 to act with fairness and avoid any unnecessary cost. I am conscious that deciding to issue further "Spotlight" Rule 9 requests would involve incurring further legal expense in the preparation and issuing of further Rule 9 requests, the reviewing of the witness statements by both the Inquiry's legal team and Core Participants, as well as the public cost in the preparation of witness statements by NHS/HSC hospitals.

Impact evidence

16. As previously mentioned, Module 3 has invited several Core Participant groups to provide short summaries from potential witnesses able to provide relevant evidence

about the impact of the Covid-19 pandemic. Those contacted include bereaved families, groups including the clinically vulnerable, those with long Covid, charity groups, workers' organisations and professional membership organisations. The Inquiry will consider each of the summaries received in order to identify witnesses who will be formally asked to provide witness statements, some of whom will then be asked to give oral evidence at the public hearing.

17. The Frontline Migrant Health Workers Group and the Federation of Ethnic Minority Healthcare Organisations ("FEMHO") Core Participants asked me to consider the use of Restriction Orders under Section 19 of the Inquiries Act 2005 to prevent potentially vulnerable individuals or those in lower band roles whose employment may be precarious from being exposed to the risk of repercussions as a result of the content of their evidence. I will consider any application for specific restrictions or special measures to assist a witness in giving evidence on its individual merits. Any Core Participant wishing to make such an application should have regard to the Inquiry's Protocol on Applications for Restriction Orders in relation to the process for making any such applications and may wish to contact the Module 3 solicitors team prior to making an application. They may also wish to discuss the potential ways in which the Inquiry may be able to support witnesses giving evidence to the Inquiry before making an application for a restriction order.

Experts

18. A number of Core Participants submitted that the Inquiry should consider instructing further experts in a variety of areas. These included:

    a. A submission from the John's Campaign, Care Rights UK and the Patients Association Core Participant group for expert evidence to examine the use of Do Not Attempt Cardiopulmonary Resuscitation orders ("DNACPRs"), aspects of healthcare outside of hospital, issues surrounding the clinically extremely vulnerable population, the impact on those with learning disabilities, the role of carers in healthcare and nosocomial infections within hospitals.

    b. Submissions from the Clinically Vulnerable Families ("CVF") supporting the above submission with respect to the need for an expert on the impact on the clinically extremely vulnerable and calling for an expert to consider the psychosocial

effects of shielding.

c. A submission from the Frontline Migrant Health Workers Group that an expert should be instructed to address the outsourcing of NHS work and its impact on contract workers.

d. A proposal by the Covid-19 Bereaved Families for Justice for an expert report on the differences between how healthcare systems in the United Kingdom fared when compared with relevant international comparators.

e. A submission from FEMHO that Module 3 should instruct the experts who reported on inequalities in Module 2 to provide addendum reports for Module 3.

19. Module 3 has already identified eight separate areas in which expert evidence is to be obtained. These are: long Covid, intensive care, each of the four Non-Covid conditions/services (ischaemic heart disease, colorectal cancer, elective hip replacement surgery and in-patient Children and Young People's Mental Health Services), infection prevention and control and pre-hospital care. Module 3 will also disclose to Core Participants expert reports obtained for the purposes of other modules which are of relevance to Module 3's investigation.

20. Many of the areas mentioned by Core Participants will be covered by the Inquiry's instructed experts. The pre-hospital care experts, Professor Helen Snooks and Professor Adrian Edwards, will plainly address aspects of healthcare outside of hospital. This also includes use of the shielding policy and the impact on the quality of life of those shielding. Nosocomial infections will be considered by the Infection Prevention and Control experts. Use of DNACPRs will be considered by the intensive care experts. Several of the matters raised, including those already mentioned, will be explored by Module 3 through other witness evidence. Not every aspect of the investigation requires or is suitable for expert evidence.

21. With respect to the instruction of further expert evidence, I keep in mind once again my need to act in accordance with Section 17(3) of the Inquiries Act 2005. Any further instruction of experts carries an inevitable cost and the number and breadth of areas in which Module 3 has instructed experts is already extensive. I am not persuaded, at this stage, that there is a need to commission further expert evidence. This is a matter

which I will keep under close consideration as Module 3 receives finalised reports in the eight areas in which experts have been instructed.

Inquiry's Equalities and Human Rights Statement

22. CVF made a specific submission that the Inquiry's Equalities and Human Rights Statement should be amended to include the clinically vulnerable as a specific group to whom the Inquiry will have regard when investigating the unequal impact of the Covid-19 pandemic among different groups. This is a matter to which I will give further consideration and shall ensure that an update is provided in due course. As this affects the Inquiry as a whole, however, it is not appropriate for me to address this issue within this Module's Ruling.

Timetable / length of hearing

23. The Module 3 public hearing is scheduled for 10 weeks and will commence on 9 September 2024. The hearing will take place in two phases, with no hearings being held during the weeks of 14 and 21 October 2024. The second phase of hearing oral evidence will commence on 28 October 2024 for a further five weeks.

24. There were various submissions made about the length and timetable of the public hearings, in particular the sufficiency of 10 weeks. As I made clear during the preliminary hearing, there are obvious logistical challenges in timetabling an Inquiry of this size given the breadth of the Terms of Reference. I have reiterated on numerous occasions that my intention is to run this Inquiry in a manner which allows me to make prompt recommendations which can be implemented in a timely manner. It is also important that any recommendations made are based upon good quality evidence before memories begin to fade. Any amendment to the timetable would not only affect that aim as far as Module 3 is concerned, but would also have a knock on effect on each of the subsequent Modules. Any extension would also impact the Core Participants and material providers working to separate deadlines in those modules.

25. Taking all these matters into consideration, I do not propose to extend the duration of the Module 3 hearing. I do not currently see a need for a further preliminary hearing, but will keep the need for one in Module 3 under review.

Disclosure

26. The final issue is that of disclosure. Various Core Participants raised concerns about ensuring that disclosure is received as early as possible, to allow time for it to be properly considered and to prepare for the public hearings. I recognise the burden which late disclosure places on Core Participants, as well as those within the Inquiry itself. The Module 3 solicitors team will provide further information about the progress of disclosure in the update notes to be provided to Core Participants over the coming months. I will do all I can to ensure that disclosure is provided to Core Participants in good time before the commencement of this Module in September 2024.

The Right Honourable Baroness Hallett

Chair of the Covid-19 UK Inquiry

25 April 2024