IN THE UK COVID-19 PUBLIC INQUIRY
BEFORE BARONESS HEATHER HALLETT
IN THE MATTER OF:
THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

On behalf of Covid-19 Bereaved Families for Justice UK

MODULE THREE OPENING SUBMISSIONS

[These submissions should be read together with those of NICBFFJ, which we fully endorse]

INTRODUCTION

1. This inquiry was established as a result of campaigning by our families. As Matt Fowler, a co-founder of CBFFJ UK, explained to the Inquiry:

> *"Once it was established that this was a way to get the change that we wanted, we have campaigned relentlessly for it... We need to learn lessons, we need to learn about things that went wrong, and we need to put something in place to prevent those mistakes from being carried out again in the future."*[1]

2. Our families continue to believe that the Inquiry is uniquely placed to bring truth to light, provide accountability and to secure the changes that are obviously imperative. Key issues in M3 must start with the absence of preparedness. Not only was there a wholesale failure to plan, but fewer doctors and nurses per capita than any other comparable country, a lack of bed and ICU capacity, and a crumbling healthcare infrastructure. Whereas public law proceedings are constrained by the separation of powers – resourcing is pre-eminently for the democratic arena – a statutory Public Inquiry is not. An Inquiry is under a duty to consider all matters within its terms of reference and to make appropriate findings and recommendations. If public resourcing and funding is at the heart of those matters then inquiries not only ***can***, but ***must*** address issues concerning the allocation of public funds: *R (Smith) v Asst Dep Coroner for Oxfordshire* [2011] 1 AC 1, at [127].

3. The current Inquiry is under such a duty. The families we represent have carefully listened to the evidence in Modules 1 and 2. That evidence, and the evidence that has been disclosed so far in Module 3 has made one truth abundantly clear: the resilience, preparedness and capacity of our public health, health and social care and civil contingencies infrastructure was fatally undermined by chronic underfunding and, in particular, the decade of austerity that preceded the pandemic. That policy of underfunding continues. Whereas some of the failures of planning can be addressed at minimal cost, without proper provision for increased staffing and infrastructure, such changes will not meet the needs of the next pandemic. We call on the Inquiry to reflect this fundamental truth in its findings and recommendations. It is then for politicians to act, or not, on those recommendations, against the backdrop of an informed public.

SECTION ONE: THE MYTH OF SUCCESS

4. The UK's overall response to Covid-19 is a story of failure. The UK, one of wealthiest countries in the world, said to have a 'world leading' health system, also ranks as one of the top 20 countries in the world in terms of deaths from Covid-19 per 100,000 people.[2]

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[1] M1:D22:P19-20:L23-10
[2] John Hopkins Coronavirus Resource Centre; Mortality Analyses

5. Despite this, by 30 April 2020 Boris Johnson had concluded that the UK had *"succeeded in the first and most important task we set ourselves as a nation. ... Because at no stage has our NHS been overwhelmed."*[3] This hubris echoes through many of the witness statements we have received so far from key decision makers and high-level corporate witnesses. Indeed, Matt Hancock believes that the *"single most important fact about the NHS in the pandemic is that it was never overwhelmed."* [INQ*421858/1§4]

6. The reality on the ground was very different. The valiant and selfless efforts of healthcare workers, many of whom needlessly died, must not be allowed to be used to obscure the truth. Healthcare and hospital access were restricted, and the burden of responding to the pandemic was pushed into the community setting, masking the true performance of the healthcare system as a whole. A lack of data and monitoring of primary care, NHS 111 and 999 services makes assessment of the extent of this difficult,[4] but it is clear many people did not reach the services they needed. Those that did, often encountered insufficient IPC measures and the effects of shortages of PPE and medical equipment, and access to ICU.

7. Messaging from government in the early stages of the pandemic emphasised that those with Covid-19 symptoms should stay at home. Government advice was to try to avoid calling NHS 111(**'111'**) and to use online tools instead.[5] The script for those who called 111 with Covid-19 symptoms reinforced the message that "*In the current situation the NHS needs the problem to be managed at home."* [INQ*320204/43] The Healthcare Safety Investigation Branch (**'HSIB'**) found that the strength of this messaging resulted in some people being reluctant to contact 111 or to re-contact 111 when their condition deteriorated.

8. Even with this negative messaging, 111 services were completely overwhelmed. At peak points in the pandemic, half of all 111 calls went unanswered. [INQ*474285/16] Those whose 111 calls were answered and who were assessed to have Covid-19 symptoms were supposed to be routed through to a specialist service (the Covid-19 Response Service, **'CRS'**), but in many cases this did not happen. [INQ*320204/7]

9. The evidence disclosed so far suggests that the triage protocol at the 111 stage, failed to facilitate access to healthcare services for many of those who were most in need.

10. There was no assessment within the protocol of co-morbidities at all, and the only path to assessment by a clinician was for the caller to report that they were *"so ill that ... [they've] stopped doing all of [their] usual daily activities."* (emphasis added) [INQ*320204/7] Medical history was not considered and there was no process by which the call handler could see previous calls and track a deterioration in symptoms.

11. The impact of this is starkly illustrated in the experience of Rivka Gottlieb. Her father, Michael, was 73 years old, suffered from Rheumatoid Arthritis and previously had lymphoma. Despite this, he was relatively fit and well before becoming infected with Covid-19. She describes her father's experience as follows:

> *"My father started having symptoms of Covid-19 on 22.03.20. He was told to phone NHS 111 for advice, not the GP surgery. Over the 9 days or so that he was ill at home, he tried phoning the NHS 111 service several times. Each time took hours to get through. Once he got through to someone, he was told to take paracetamol and stay at home, every time, regardless of any changes in his symptoms and regardless of his medical history... A family friend who is a doctor told my father what to say to get medical attention – he coached him on what key things to mention which resulted in an ambulance being sent. On examining him, the paramedics took him straight to hospital, where he was put on a ventilator 3 days later."*

12. Similarly, Alison Saunders describes the experience of her partner, 58-year-old James Yeats who passed away on 7 April 2020. James was generally fit and healthy and worked as a factory manager, in Scotland. He was particularly vulnerable to Covid-19, however, as he suffered from asthma and a compromised immune system. Despite this, when he became increasingly ill and called 111 he was advised to stay at home, less than a week

[3] Prime Minister's statement, 30.04.20
[4] CQC, 12.05.22, How we monitor urgent care services
[5] Boris Johnson statement, 12.03.20

before he died. Alison obtained a recording of the 111 call from which it is clear that James sounded unwell and distressed.

13. Calls that were triaged as requiring clinician assessment were to be transferred to a Clinical Safety Net ('**CSN**') service: in March the length of wait for this service was such that over 35% of calls were abandoned before being answered. [INQ*474285/21§56]

14. Even where a 111 health advisor reached the conclusion that a patient required Category 3 (urgent not life threatening) ambulance dispatch, this was subject to a further stage of clinician validation. HSIB examined one 'indicative' reference incident where a caller was so categorised. The clinician decided that the ambulance response should be cancelled and further home management was appropriate. Later that day, the caller collapsed. An ambulance was dispatched and he was declared dead on arrival at hospital. HSIB concluded that the design of the system may have resulted in the clinician being unable to appreciate how unwell the caller was, resulting in a lack of action to prevent his further deterioration. [INQ*320204/31§3.1.29]

15. This occurred in a context where ambulance services were overwhelmed, with response vehicles often not available for dispatch. [INQ*474285*25§78] In late March, triage Protocol 36 was implemented, as at that point it was recognised that *"UK Ambulance services will soon be in a position where demand outstrips supply."* [INQ*281180/1§4] Under this protocol, patients who in ordinary circumstances would receive the most urgent 'Category 1' ambulance response, would instead receive a 'Category 2' response *if* their symptoms were assessed as diagnostic of Covid-19. The impact of this was that a Covid-19 patient suffering from severe breathing difficulties such that they were *"fighting for breath"* would be allocated a 'Category 2' response. [INQ*281180/4§21] An emergency service where 'demand outstrips supply', is by definition overwhelmed.

16. Individuals triaged as Category 1 should receive an ambulance within 7 minutes and those in Category 2 should receive one within 18 minutes. However, in March 2020 the ambulance service was overwhelmed to the extent that the ***average*** wait for a Category 2 ambulance in major cities such as London and Cardiff exceeded 1 hour, with 10% of Category 2 responses in London exceeding 2 hours 20 minutes. [INQ*474285/26-27] The implication of such a wait for somebody who is fighting for breath is clear. The Inquiry will have to investigate whether this 'overwhelm' was an inevitable result of the Covid-19 emergency or whether it was exacerbated by underfunding. In doing so, it is noted that such shortcomings were not present to the same extent in Scotland.

17. While Protocol 36 was 'de-escalated' in August 2020 so that ineffective breathing qualified for a Category 1 response, it would be re-escalated several times throughout the pandemic. [INQ*485652/164-169]

18. Ambulance response times continued to worsen throughout the period, rather than improve.[6] Sarah Choudhury lost her mother, Khudeza, as a result of Covid-19 on 25.10.21. Two days earlier Khudeza had waited for 12 hours for an ambulance to arrive, despite reporting that she was severely ill with oxygen levels dropping.

19. The impact of overwhelmed services should not be measured only in formal restrictions of access to care. The understanding of frontline workers that the system was overwhelmed impacted their day-to-day decision making in a way which was never captured by formal DHSC policy making.

20. This reality is amply reflected in the experiences of our families. For example, when an ambulance was called for Dr Christina Fulop on 05.01.21, the paramedics who arrived said they did not think it was a good idea to take her to hospital as they had previously waited with an elderly frail lady for 7 hours outside the hospital. She was not taken to hospital and was found unresponsive by her carer on the following day.

21. IFF research commissioned by the Covid-19 Inquiry indicates that such experiences were not the exception. 58% of the healthcare professionals ('**HCP**'s) surveyed reported that some patients could not be escalated to the next level of care due to a lack of resources, with the primary reasons being a lack of beds and a lack of staff. [INQ*499523/3] A&E doctors and paramedics were the more likely cohorts to have been unable to escalate care. 1 in 3 HCPs, including a majority of paramedics stated that they had received instructions from their employer

[6] See for example response times in England in January 2022 compared to March 2020 [INQ*474285/26]

on which group should not be escalated. As the Inquiry will hear from John Sullivan, the medical records for his daughter Susan starkly reflect that a decision not to admit her to ICU was due to her having Down Syndrome.

22. Despite the reorientation of the healthcare system to protect critical care capacity, it is a gross oversimplification to suggest that even in this aspect the NHS was never overwhelmed.

23. The Inquiry's intensive care experts concluded that it is likely that Intensive Care Unit ('**ICU**') capacity ***was*** overwhelmed in individual locations at certain times, and that the criteria for ICU admission changed via local informal processes when capacity was stretched, meaning those who might normally be admitted to ICU were not. [INQ*474255/61§156] The ISARIC Clinical Characterisation Group assessed the clinical paths of 142,540 patients with Covid-19 admitted to hospitals between March and December 2020. It found that ICU admission was more likely in periods between surges than during surges. ICU admission was more likely in June and August than in April or October 2020 for the same cohorts of patients. [INQ*474255/64§164]

24. Similarly, as Professor Banfield highlights in his witness statement, while oxygen *"never officially ran out,"* shortages led to clinicians reporting that they needed to ration oxygen, which impacted on the care they could provide to patients, with a fifth of doctors reporting to the BMA, a shortage in oxygen supplies in April 2020. This contrast between the 'official' position and the reality is illustrated by the account of one consultant to the BMA who stated that there was a *"rationalisation of oxygen [...] by lowering the thresholds for oxygen treatment"* and described *"everyone pretending it was OK."* [INQ*477304/147§360] Difficulties with oxygen supply were persistent: for example, ambulance staff at South East ambulance service were urged to conserve oxygen in December 2022. [INQ*397251]

25. In response to an IFF survey commissioned by the Inquiry, 80% of HCPs reported having to act in a way that conflicted with their values, including 92% of critical care nurses and 84% of paramedics. [INQ*499523/4] The Inquiry will have to determine whether these are reports of sensible rationalisations to deal with an unprecedented emergency, or evidence of desperate attempts to manage chronic, historical under-resourcing of a failing system, and austerity.

26. Professors Summers and Suntharalingam warn in their report to the Inquiry that the most important lesson is that *"the overly simple message that "we coped" does not become the prevailing message to the public or a reason for complacency in future planning."* [INQ*474255/9§xii] The statements of key decision makers suggest that this lesson has not been learned.

SECTION TWO: STRUCTURAL INEQUALITY

27. It is now widely accepted that prior to the pandemic and in its early stages there was little or no consideration of inequalities and discrimination. However, there has been a concerning tendency by the Inquiry itself to lump all structural inequality into a catch-all category of 'vulnerability' and by others to make blanket commitments to consider 'vulnerabilities' in decision making. It is vital that the Inquiry's findings and recommendations in M3 counter this tendency by considering different groups separately and identifying distinct structural and institutional issues underlying unequal outcomes.

28. Structural racism made Black people, Asian people and those from other Minoritised ethnic groups more vulnerable to Covid-19: their vulnerability is not inherent.

29. Their over-representation in groups contracted by the NHS (e.g. those engaged by agency banks and outsourced contractors) is an illustration of this. The evidence we have seen so far suggests that agreements reached by unions for directly employed NHS staff covering full pay for Covid-19 sickness and self-isolation, or for staff required to shield and unable to work from home were not properly enforced for such workers. [INQ*471985/25] DHSC was aware of the implications of this regarding increased rates of transmission amongst such groups, which particularly impacted the care sector, but would be equally applicable to other areas such as homecare

support. The evidence so far suggests that an approach was taken to simply rely on outsourced employers to *"do the right thing"* rather than DHSC taking a more proactive role in enforcement.[7]

30. The Inquiry should also examine the extent to which migrant workers were disproportionately affected. For example, in an interview with *Nursing Times*, Francis Fernando, officer of the Filipino Nurses UK Association, said many Filipino nurses felt an *"obligation"* to follow instructions from their employers as immigrants on a visa, even if it meant they were put in harm's way.

31. The Inquiry should carefully examine whether a failure to tackle these structural issues put both the workers affected and the patients at risk.

32. Structural and institutional racism was evident within the NHS employed workforce. Black workers were overly exposed to Covid-19 risks. A UNISON members' survey found that between March and December 2020, 67% of Black workers in NHS bands 1 and 2 said that they had worked in Covid-19 wards, compared with 51% of their white colleagues. [INQ*339477/9] In a 2020 UNISON/ITV Wales survey of Black workers in the Welsh NHS, 67% of respondents had experienced racism. [INQ*339477/6] Further, as one respondent summarised in their response to UNISON's January 2021 survey of Black members: [INQ*339477/7]

> *"All the managers are white. the support workers are Black. It's absurd during training or meetings because the divide is obvious. There's not a single Black member in management."*

33. It is against this context that many of our families have reported feeling that the treatment of their loved one was influenced by discriminatory attitudes.

34. It is therefore important that the Inquiry's findings and recommendations recognise and address not only the *symptom* of inequality but the structural *cause* of that inequality, which is often left unaddressed. For example, prior to the pandemic available PPE in the UK was modelled on Caucasian males. This meant that standard PPE was less likely to be a good fit for those who were not Caucasian males. [INQ*273913/47] As a result, the PPE shortage and fit testing failures had a disproportionate impact on other groups. It is not enough to address only the issue of PPE availability, the Inquiry must address the structural racism which led to this procurement despite the obvious knowledge that the NHS workforce is diverse and not composed of solely Caucasian males, and in disregard of duties imposed by the Equality Act 2010.

35. In contradistinction to racialised groups, older people *are* inherently more vulnerable to Covid-19. Age and race discrimination may intersect, and may have overlapping features, but the relevant issues should not be assumed to be the same, or indeed similar to the clinically vulnerable or the disabled or others who face discrimination and unequal outcomes. Age is the single biggest risk factor for experiencing severe illness and dying from Covid-19. [INQ*319639/3*8] This should have translated into a response that prioritised the needs of older people. In the experience of many of our client group, instead it translated to an attitude that treated them as an inevitable and dispensable casualty of the pandemic.

36. As summarised by Caroline Abrahams of Age UK: [INQ*319639/7*24]

> *"the very fact that older people were seen to be highly vulnerable or at risk led to their needs being deprioritised at times by decision makers or individual services or professionals."*

37. The decision not to take a precautionary approach to Infection Prevention and Control ('**IPC**') measures (as set out below at Section Four) is one such example which predictably and disproportionately affected older people.

38. As a result of their clinical vulnerability, people over 70 were advised to *"try to stay at home as much as possible"* and to be strict in social distancing. However, they were not included in the Shielded Patient List and did not

[7] See: INQ*119088/2§14, 19.03.20, Letter from HCSA to Matt Hancock, INQ*339484, 27.04.20, Letter from HCSA to Matt Hancock, INQ*119070, 02.06.20, DHSC workforce meeting email chain, INQ*119068, 26.06.20, DHSC workforce meeting email chain, INQ*119066, 26.06.20, DHSC workforce meeting email chain

receive letters or support to self-isolate through the shielding initiative. [INQ*474285/114] The Inquiry should consider why older people were not offered any support to shield and whether they should have been.

39. Older people were also often excluded from access to health services. One senior clinician responsible for overseeing a community hub reported that any older resident with respiratory symptoms was assumed to have contracted Covid-19 and would not be considered for further care. [INQ*319639/17§52]

40. Evidence from the first wave of the pandemic suggests that older people were deprioritised in terms of access to ICU care. A study by ICNARC found that during the first wave patients admitted to ICU were *"younger ... when compared to those admitted pre- and post-peak periods."* [INQ*474239] Summers and Suntharalingham comment that older patients *"will not have disappeared during that time, but fewer will have been admitted to ICU."* [INQ*474255] The ISARIC study (see §23 above) reached a similar conclusion regarding ICU admission for older people. Crucially, the study found that ward mortality was highest when older patients were least likely to be admitted into ICU, suggesting that this group of patients may have benefitted from ICU admission.

41. As we heard in M1, people with disabilities faced structural discrimination throughout the pandemic response. Whilst comprising 16% of population, disabled people may have made up as many as 6 out of 10 deaths. [INQ*280067/12§40] The Learning Disabilities Mortality Review Programme found that Covid-19 was the leading cause of death amongst people with intellectual disabilities, with an excess mortality ratio more than two times higher than for the average population. [INQ*417461/114§300] There is a lack of reliable data in relation to mortality rates of people with autism.

42. One of the issues that the Inquiry should consider is how far confusing and contradictory government advice disproportionately impacted those with autism and learning difficulties. This issue is exemplified by the account of Elizabeth Baxter-Heyes who lost her father, Peter Oddy in October 2021. Peter was autistic and she recounts having real difficulty "*getting through*" to her dad about the dangers of Covid-19 in the light of constantly changing government messaging about risk. She reports *"that was half of what my dad was dealing with. He didn't believe anything after being told everything was fine."*

43. A key issue for the Inquiry to consider is the impact of NICE guidance incorporating a clinical frailty score issued in March 2020 on both people with disabilities and older people. While this guidance was subsequently amended, issues with its use and interpretation both in practice and in local policy appear to have persisted. As outlined by Dr Lade Smith of the Royal College of Psychiatrists [INQ*417461/127-128]:

> *"Members [reported] the clinical frailty scale being incorrectly incorporated into decision trees relating to access to ICU treatment and ventilation. For patients with complex health needs who were at higher risk of Covid-19 mortality, advanced care planning was undertaken with patients - and, where possible, their families - to determine the ceiling of care. This issue had to be repeatedly raised to NHSEI, NHS providers and frontline clinicians by the RCPsych, other professional bodies and third sector agencies."*

44. We have received similar reports from our families, of clinical frailty scores being overemphasised in relation to decisions as to the provision of care.

45. People with disabilities were over-represented in the group of people whom the government identified as Clinically Extremely Vulnerable (CEV) and were therefore part of the shielding programme. The evidence we have seen so far suggests that the shielding programme did not effectively prevent transmission to those whom it was intended to protect.

46. The Inquiry should consider how far this was because of inadequacies in the programme design. Some elements of the programme appear to have been symbolic in nature: an average weekly food box contained a loaf of bread, 2 onions, 2 packets of biscuits and a few tinned goods and few fruits and vegetables. [INQ*260635/10§20] Further, there appears to have been little consideration that those who were shielding also had elevated needs to access healthcare and no provision for their enhanced protection in either transport or in healthcare settings.

47. Our families have also described the impact of the sudden decisions to abandon IPC measures and the closure of the shielding programme. David Garfinkel lost his father, Ivor, on the 11 August 2021. Ivor was extremely vulnerable due to an autoimmune disease and David describes his experience as follows:

> *"After Freedom Day, it was as if the Government threw all the shielders under the bus. It was against scientific advice, there was no winding down, just a full opening. Dad had to attend the hospital to have his arm checked. He wore a mask, although no one else did. There were no precautions in place."*

48. The overwhelm of 999 services also had a disproportionate impact: those without their own cars would have found it very hard to get to hospital themselves with reduced public transport and the moral risk associated with calling a taxi or being driven by a neighbour.

49. Many of our families have reported the inappropriate use of DNACPRs and that this disproportionately affected older people and people with disabilities. While a DNACPR decision should only apply to CPR itself, there is qualitative, pre-pandemic evidence that the presence of a DNACPR may influence other treatments in acute medicine. [INQ*474255/33§70]

50. One explanation for this is a lack of holistic mandatory guidance around treatment escalation planning beyond the DNACPR form. While Wales has its own DNACPR policy, it has not adopted the Recommended Summary Plan for Emergency Care and Treatment ('ReSPECT') that is endorsed by the Resuscitation Council UK, the Care Quality Commission, and the Healthcare Safety Inspection Branch. The use of this policy is optional across England and Scotland.[8]

51. Concerns about the imposition of blanket DNACPRs either because of an individual's characteristics, or to an entire group arose early in the pandemic. [INQ*417461/125] In November 2020, the CQC found evidence of "overwhelmed" providers early in the pandemic amidst confusion and miscommunication making inappropriate DNACPRs decisions. [INQ*235491]

52. There is ample evidence from our families that this practice was far more widespread than is acknowledged by provider organisations or indeed the CQC. Over **422** of the families we represent, from across the four nations, and in relation to experiences throughout the pandemic, report the inappropriate use of DNACPRs. A common experience amongst our client group was finding out from medical notes after the death of a loved one that they had been subject to a DNACPR order and that it was recorded that the family had consented, despite either active opposition or no conversation having taken place. Even where such an order is clinically indicated, proper consultation is imperative.

53. It appears from the evidence we have received so far, that there was no actual national policy in relation to changes to the imposition of DNACPRs during the pandemic. However, on 7.04.20, Chief Nursing Officer, Ruth May wrote to the Chief Executives of all NHS Trusts stating that blanket DNACPR policies were inappropriate. [INQ*366245] This would suggest that there was concern that such policies were being operated.

54. The Inquiry should examine to what extent acute resource limitations, national policy including the revoked NICE guidance relating to clinical frailty, or the lack of policy contributed to (a) local informal policies which led to the imposition of inappropriate DNACPRs or (b) practice on the ground. The Inquiry should also consider whether, and the extent to which, the government's approach to the pandemic generally, and its acceptance either by design or default of a 'herd immunity' strategy (as detailed in our Module 2 closing submissions) contributed to a healthcare culture which was permissive of the imposition of such DNACPRs.

55. Structural discrimination also impacted on individuals who suffered from mental health disorders. Mental health settings appear to have been treated as an afterthought, when they were considered at all, in relation to pandemic response. Dr Lade Smith, of the Royal College of Psychiatrists explains that an initial lack of consideration, and

[8] The evidence in relation to this is summarised by Summers and Suntharalingham, see p.29-30 who go on to recommend a UK-wide approach to using a recognised framework (§299)

subsequent urgency, in planning and disseminating guidance for mental health settings, left patients, healthcare systems and professionals to navigate an unknown virus alone. [INQ*417461/43]

56. The impact of this is exemplified by the experience of Katherine Poole's father, who died after acquiring Covid-19 during his stay on a mental health ward. She explains:

> *"It is evident he most likely caught covid from mental health staff, he was kept in his room so had no contacts other than care staff. Staff had no testing, no PPE, they could not treat physical health in their setting, he had no natural ventilation (i.e. couldn't go out, and didn't have the window open) and was stuck in his room. Dad had no choice or option of social distancing. They failed to swab him when he showed covid symptoms a few days before transfer to general hospital and just opened a window, so precious time was wasted."*

SECTION THREE: A PERFECT STORM

57. In our Module 1 and 2 submissions we addressed in detail how underfunding and a lack of resources undermined preparedness. We emphasise in relation to Module 3 that these issues cannot be considered separately: emergency planning either cannot take place or cannot be implemented if resources are stretched to an extent that the healthcare system struggles to deliver business as usual services. A healthcare system which is overstretched therefore creates a perfect storm: a lack of preparation and an inability to adapt to emergency circumstances.

58. These issues underlie all aspects of Module 3, but due to space constraints we deal with the issue briefly, and focus particularly on staffing.

59. The staffing crisis across every area of the health and social care system was well known before the pandemic and has continued since. There were insufficient trained call handlers to run an effective 111 system, insufficient ambulance resources to meet paramedic and transport needs, insufficient doctors and nurses to meet the capacity and IPC needs in hospitals. Nor was this without consequence: IFF research commissioned by the Inquiry found that 69% of health care professionals felt they had insufficient staff at their place of work to provide good quality patient care at least weekly during the pandemic. 43% of health care professionals had experienced this pre-pandemic. [INQ*499523/4]

60. While the pandemic threw into sharp relief the deficiencies in funding of the public health system as a whole, particularly as regard to staffing in the community, this has not been addressed. As set out by the Nuffield Trust in their analysis published in May 2024:

> *"successive governments have not put their money where their mouths are to meet much-touted ambitions of moving more care away from hospitals. Needs-adjusted spending on NHS community health services in 2022/23 was 4.2% below where it was in 2016/17, meaning those services received £6 less per person in 2022/23 - when demand for their services is taken into account - than they did seven years ago."*

61. Nor is the position improved regarding the provision of mental health. As summarised by Dr Lade Smith: [INQ*417461/162]

> *"Just as with public health investment, we cannot say that a greater understanding and appreciation for mental health during the pandemic has translated into priority, resource provision and funding from the Government." Based on NHSE targets to expand the workforce from 2016 onwards, there is a shortfall of 688.1 of FTE consultant psychiatrists across England. The latest NHS vacancy data for the quarter to June 2023 showed that 15.2% of mental health medical posts were vacant, the highest on record dating back to the start of 2018/19, while 6.5% of acute medical posts were vacant in this quarter."*

SECTION 4: THROWING CAUTION TO THE WIND

62. The failure to implement proper Infection Prevention Control measures left a healthcare environment which permitted rampant transmission in health care settings. Rather than seek to mitigate the lacunae in planning and structural barriers to implementing IPC measures, national guidance attempted to justify deficiencies in IPC measures as being scientifically appropriate. Rather than accepting that decision-making was undermined by a lack of preparedness and resourcing, the problems were compounded by fiction.

63. It appears from the evidence that we have seen so far that a combined failure in preparedness and response on both a national and a local level, led to:
    a) A failure to ensure adequate supply of appropriate PPE
    b) A failure to properly consider the IPC measures needed in different healthcare settings
    c) A failure to ensure there was proper ventilation in patient wards and corridors
    d) A failure to ensure that physical settings could allow adequate social distancing
    e) A failure to ensure that social distancing guidelines reflected a distance that was in fact preventative of transmission
    f) A failure in the provision of testing at a level that would allow adequate separation of those infected and those not infected
    g) A failure to ensure adequate levels of staffing to facilitate the implementation of IPC measures
    h) A failure to address the issue of staff rotation between sites
    i) A failure to ensure and monitor the proper implementation of IPC measures, particularly in the context of outsourced services
    j) A failure to treat the ordinary provision of care to Covid-19 positive patients as posing a similar risk as aerosol generating procedures

64. The Inquiry should consider how far the approach to IPC measures was impacted by the extraordinary decision to downgrade Covid-19 from a High Consequence Infectious Disease (**'HCID'**) made in March 2020, just as the virus was reaching peak transmission and the UK was recording around 1000 deaths per day. [INQ*273913/143]

65. This decision was supported by the Advisory Committee on Dangerous Pathogens (**'ACDP'**) and seems to have been justified by the rationale that (a) more information was available about mortality rates which were considered low (b) there was greater clinical awareness and (c) a specific and sensitive laboratory test. The Inquiry should consider the adequacy of these reasons: especially the mortality rate of Covid-19 in the context of its transmissibility and the actual availability of testing and PPE. [INQ*119091]

66. Crucially, it appears that there would not have been sufficient resources to implement the IPC measures that would have been mandated had Covid-19 remained a HCID. The Inquiry should consider whether, in reality, a lack of resourcing actually drove the decision to declassify Covid-19 as a HCID.

67. Another key issue for the Inquiry to consider will be whether it was reasonable to base IPC guidance on the assumption that Covid-19 was not transmissible via an airborne route.

68. It should have been evident from the beginning of the pandemic that there was a significant possibility that Covid-19 would be transmissible via airborne routes. The most striking indicator of this was the recognition that its close relative SARS-CoV-1 was transmissible via the airborne route, as set out in a paper co-authored by Jonathan Van Tam in 2013 [INQ*130561]. The same paper concluded that as a result, FPP3 respirators were needed for health care workers to ensure proper PPE protection.

69. While Professor Beggs explains that the false assumption that the virus was not airborne was to some extent common, the Inquiry will want to consider whether a precautionary approach should have been taken given (a) that it was well known that this assumption was not based on scientific evidence but rather an absence of evidence (b) that the WHO had based its advice on an expected shortage of global stock and supply (c) DHSC was well aware that other IPC measures such as ventilation were inadequate in the event that Covid-19 did turn

out to be airborne. An absence of evidence should not have led to actions taken on the basis that such factor was not present, where the consequences were so serious and there was a significant possibility that the virus was airborne.

70. This lack of precaution is evident in national guidance related to PPE. The deficiencies in national guidance were repeatedly raised with DHSC and PHE from the start of the pandemic. In a letter to PHE on 1 April 2020, HCSA called for a change of guidance to mandate masks for all areas of hospitals stating: *"Staff and patients may not even be aware they are spreading the virus because the symptoms can be so slight . . . by shifting to a policy where staff and patients are considered potential Covid-19 carriers, we will be cutting the prospect of infection and reducing the chances of crucial NHS staff being taken ill at the worst possible time"*. [INQ*119088] It was not until 15 June 2020 that this warning was heeded and facemasks were introduced in all areas of hospitals. [INQ*471985/33]

71. This approach was echoed in the persistent insistence of PHE, HSE and DHSC that surgical masks were sufficient in the face of scientific evidence and concerns raised repeatedly by health care workers, professional bodies and scientists.[9] The Inquiry should consider this approach in the context of the widespread shortage of PPE. Was guidance based on lack of provision rather than scientific necessity?

72. The rate of transmission within hospital settings (nosocomial transmission) was very high, accounting for up to 40% of cases during the first wave of the pandemic, although a lack of testing imports a high level of variation to study results. [INQ*231451] This had a particular impact on the most vulnerable patient cohorts, with nosocomial rates higher within the shielding cohort than in the general population. [INQ*474285/43]

73. The impact of nosocomial transmission is evident from the experiences of many of our families' loved ones. For example, James Telfer describes how his mother, who had repeatedly tested negative for Covid-19 before admission to I&S A&E in November 2020 for tests for Myeloma, acquired Covid-19 due to transmission from a patient in a nearby ward. He describes the lack of testing during her time on the supposed 'safe ward' where his mother was placed and was started on immunosuppressant therapy.

74. Many of our clients have described a lack of facilities for infection control across different hospital wards, and particularly during long waits at A&E. This was especially damaging in the context of overstretched emergency departments. For example, Clare Farnsworth lost her mother Mary to hospital acquired Covid-19 in January 2021, after a 48 hour wait in A&E.

75. There was also a failure to adequately consider healthcare settings beyond hospitals. The inadequacy of IPC measures and potential for infection spread by and amongst paramedics in the ambulance setting was raised repeatedly with DHSC and PHE. [INQ*28118] It appears that this was never adequately addressed. For example, GMB Union highlighted to Yvonne Doyle in March 2020 that ambulance workers should be considered at highest risk with regard to PPE provision as their work generated the same risk as other Aerosol Generating Procedures. [INQ*425424] Yvonne Doyle simply responded with a link to the government guidance.

SECTION 5: THE PATIENT JOURNEY

76. We set out below some key questions that we submit the Inquiry should address in relation to each area of the healthcare system from the perspective of a Covid-19 patient's journey through the healthcare system.

NHS 111

77. The Inquiry should consider the following questions:
    a) What concerns were raised prior to the pandemic about the capacity, training standards and clinical oversight of the NHS 111 service, and were those concerns adequately addressed?
    b) Were there adequate plans in place for surge capacity, given the obvious foreseeability of increased demand from the onset of a pandemic?

[9] See list of communications set out by Barry Jones INQ*273913/139-194

c) Was NHS 111 capacity during the first wave adequate, if not, why?
d) What was done to improve capacity over the course of the pandemic, and was this adequate, considering the volume of unanswered calls in later waves?
e) Were contracted providers adequately held to account for failures in the 111 system?
f) Was there a reliance on over-the-phone assessment to the exclusion of methods of assessment such as video assessment and oximetry?
g) Did 111 call handlers receive adequate training?
h) Was the threshold for transfer to clinical assessment appropriate, and was it properly supervised?
i) Did the approach of pushing triage onto the NHS 111 service result in individuals who required care not receiving it?
j) Did the standard 111 script serve to discourage callers from contacting, or re-contacting NHS as their symptoms deteriorated?
k) Did the protocol allow for a consideration of the history of the patient, and take account of comorbidities? Should it have done so?
l) Was there a sufficiently flexible approach to risk assessment?
m) Should there have been greater flexibility between the different assessment paths so that callers could be transferred between core 111 and CRS services?
n) Was there a disparity in 111 services between the four nations and between different regions?
o) Were there adequate oversight measures in place, including call recording and dip-testing?
p) Was there sufficient consideration of the full range of Covid-19 symptoms?
q) Did 111 assessments take full and appropriate account of protected characteristics? In particular:
    - Was there a discriminatory approach adopted with regards to the assessment of change of skin colour?
    - Were the needs of those whose first language was not English adequately considered in the design and delivery of 111 services?
    - Were the needs of those who are neuro-diverse adequately considered in the design and delivery of 111 services?
r) Was the 111 system adequately amended and updated as the pandemic progressed?

999 and ambulance services

78. The Inquiry should consider the following questions:
    a) Was there any planning or research done prior to the pandemic regarding infection prevention control in an ambulance setting? Were there sufficient and effective IPC guidelines for ambulance crews?
    b) Did ambulance trusts have in place adequate plans with regard to any type of pandemic?
    c) Were there known issues prior to the pandemic with regard to a lack of ambulance staff and a very high ratio of sickness absence? If so, what action, if any, was taken prior to the pandemic, and what pandemic planning was undertaken to combat this issue? Was there in fact a very high rate of sickness absence amongst ambulance staff? Why, and what was done to address this?
    d) Were there persistent issues with ambulance delays across (a) each nation and (b) in particular regions? What were the reasons for this issue? Were ambulance services overwhelmed and at what points? Was there adequate planning to mitigate this problem in an emergency?
    e) What was known about the differential impact and discriminatory potential of standard algorithm questions regarding respiratory illness prior to the pandemic?
    f) What measures were in place to assist callers whose first language was not English prior to the pandemic?
    g) What systems were in place for surging capacity in relation to (a) 999 call handling and (b) ambulances?
    h) Was adequate training in place for 999 call handlers in relation to pandemics?
    i) In which nations and regions did Trusts utilise AMPDS as compared to NHS Pathways and is there any evidence of comparative outcome?
    j) What was the decision-making process that led to the adoption of Protocol 36? Were these decisions appropriate or initiated because of chronic resource shortages?

k) Did Protocol 36 adequately facilitate triage for those who needed hospital care?
l) Did Protocol 36 have a differential impact on different groups and was this adequately considered by decision makers?
m) Did ambulance delays have different impacts on different groups?
n) Was there a system in place to prioritise dispatch to individuals from different groups where needed, who were assigned to the same Category response?
o) Was video assessment utilised by some Trusts? Should this have been extended to other areas?
p) Were PPE provisions for ambulance crews sufficient?
q) How did these differ between nations and regions?

Other primary care services

79. The Inquiry should address the following questions:
    a) What level of planning and preparation was there within GP services and pharmacies for a pandemic?
    b) What planning was there on a national level regarding IPC measures for GP services and pharmacies? Including the provision of PPE?
    c) If there had been greater planning before the pandemic, would more GP services have been able to remain open?
    d) Were GPs kept up to date in a timely fashion regarding the various symptoms/variants of Covid-19 so they could pass this information on to their patients?
    e) Did primary care services adequately adapt away from face-to-face care?
    f) Should there have been greater incorporation of the primary care structure into national programmes, such as shielding and testing?
    g) Were primary care settings able to continue to offer necessary services?
    h) What was the impact of the closure of primary care settings on different groups?

The hospital setting

80. The Inquiry should address the following questions:
    a) What was the level of planning and preparation for a pandemic nationally in the four health systems, and at the individual Trust and hospital level?
    b) Was staffing adequate to deliver business as usual care prior to the pandemic?
    c) Were hospital facilities adequate from a physical perspective to allow for proper social distancing, and ventilation? Was there adequate oxygen pipework?
    d) If not, had there previously been guidelines regarding the physical design of hospitals? Was the hospital estate sufficiently updated, and if not, why?
    e) To what extent were the issues above able to be resolved or mitigated during the course of the pandemic?
    f) Were IPC guidelines at (a) a national and (b) an individual Trust level adequate?
    g) Were there adequate levels of PPE?
    h) Were IPC guidelines properly followed?
    i) What were the decisions made regarding fit testing? Were they reasonable and what was their impact?
    j) Was there adequate consideration of the spread of Covid-19 in non-ward locations such as kitchens?
    k) Was the safety of patients adequately considered in the formulation of IPC guidance?
    l) Was the spread of Covid-19 (a) between wards and (b) within wards adequately considered?
    m) Were there effective IPC guidelines for the A&E setting?
    n) What impact did overcrowding and waiting times, especially at A&E have on the spread of Covid-19?
    o) What impact did shortages in testing have on IPC measures in the hospital setting?
    p) Was there an over-reliance on the split between 'Covid' and 'non-Covid' wards such that IPC measures were undermined on individual wards?
    q) Were there sufficient plans in place to protect patients who were Clinically Vulnerable or CEV?

Critical Care: the last line of defence

81. The Inquiry should address the following questions:

a) Was there adequate planning for (a) surge capacity both in terms of staff and resources? (b) infection prevention control in the critical care setting?
b) Was there an overestimation of critical care capacity?
c) Did the methods of assessing critical care capacity differ between nations and, if so, were they accurate? In particular, was there a focus in England on the number of beds and ventilators, without assessment of wider capacity, such as staffing?
d) What was the impact of the lack of critical care capacity in Scotland, Wales and Northern Ireland, compared to England?
e) Was critical care capacity across the four nations adequate and how did it change over the course of the pandemic?
f) Was the increase in critical care capacity, such as through Nightingale hospitals, for example, too late, and undermined by a lack of staff to deliver critical care in those settings?
g) Was the surge in critical care capacity achieved by spreading staffing more thinly through dilution of staffing ratios?
h) If so, how did this impact on patient care?
i) Is there evidence of shortages in relation to oxygen (both in relation to its provision and with regard to pipework)? How was this addressed at different stages of the pandemic?
j) Is there evidence of shortages in relation to medicines, and particularly those for the provision of general anesthesia and renal support?
k) Were patients given critical care treatment on non-specialist wards? If so, to what extent did this happen and what was the impact?
l) At what point was triage in relation to critical care considered on a national level and was that guidance ever implemented?
m) Was local guidance considered and implemented with regards to the allocation of critical care resources?
n) Was there a need for greater national guidance regarding the allocation of critical care resources?
o) Is there evidence that in practice triage was implemented with regards to access to critical care, due to a lack of resources?
p) Is there evidence that this impacted particular groups?
q) Have the limitations with regard to critical care capacity and staffing in particular been adequately addressed?

82. The Inquiry should address the following questions in relation to DNACPR:

a) Was there a rise in DNACPRs during the pandemic?
b) Is there evidence of DNACPRs being placed in a 'blanket' or inappropriate fashion on (a) individuals and (b) groups?
c) Is there a gap between the reports of those affected by DNACPRs and the reports of organisations? Why?
d) Was the Mental Capacity Act appropriately followed by decision makers?
e) Was the duty to consult with the patient, or with their family members/carers if the patient lacked capacity, widely breached?
f) What monitoring and oversight was in place to review and track DNACPR decision-making?
g) What pre-pandemic government or hospital guidance was there for DNACPRs? Did this change during the pandemic?
h) Did DNACPR training adequately prepare staff for a mass casualties pandemic? What role did NICE guidance on critical care prioritisation and its application of the clinical frailty scale play in the use of DNACPRs during the pandemic?
i) Did DNACPR policies and guidance and training change between waves?
j) Did relevant bodies (eg DHSC) become aware of inappropriate use of DNACPRs, and if so, when?
k) What role did charities and providers play in raising and mitigating the issue of DNACPRs? Did they work with the Government?

l) Did the Moral and Ethical Advisory Group sufficiently consider DNACPR decision making in their pandemic preparations?
m) Was the clarification and further supplementary guidance issued by the BMA, DHSC, NHS and CQC effective enough?
n) Was the ministerial oversight group effective?

Palliative care

a) Was there consistency of visitation guidelines in different hospitals, and hospices, for patients who were critically ill and deemed to be at the end of their lives? Did the Government or DAs provide guidance to hospitals or hospices on the above?
b) Did workers in palliative care have access to adequate PPE and Covid testing?
c) Were there differences in how hospitals made decisions about which patients needed palliative/end of life care, due to the pandemic?
d) Were there trends in palliative care in relation to protected characteristics?
e) How was end of life care communicated to the families of those with Covid?
f) Was there sufficient staffing for end of life / palliative care wards / private palliative care homes?

SECTION 6: DIGNITY IN DEATH

83. A consistent theme amongst our clients has been a lack of dignity afforded both to families and to their loved ones in their last moments and following their deaths. Tragically, many of our clients were deprived of the chance to say goodbye to their loved one, even over video. Oftentimes, families were not updated about the condition of their loved ones. As Glen Grundle described regarding his mother who died in April 2020:

> *"By not even telling me about the overnight deterioration, they denied me the chance to say goodbye to my mum. I was given my mum's phone, which she spoke to me on less than 24 hours before she died, but not her jewellery.*
>
> *There now appears to be some doubt about the body bag and the preparation of my mum's body. The funeral directors told me they did some preparation, but they were unable to do the embalming process. Yet, the hospital states it was supposed to be a sealed body bag that mortuary or funeral directors could not open."*

84. It appears from the evidence that we have seen that there was little thought given to this issue on a national, regional or local level across all four nations. This is surprising, considering that the one aspect of pandemic planning which had been the focus of so much attention was the handling of hundreds of thousands of deaths. The Inquiry should examine why this was the case, what impact that had and whether this has been adequately addressed since. Was communication between those gravely ill and their loved ones a factor that was deemed low priority due to lack of staff and resources?

CONCLUSION

85. Following the high-level investigation of preparedness in M1, the families hope and trust that the Inquiry will begin and ground all of its examination of M3 issues on the apparent lack of pandemic planning and resilience across healthcare services and settings.

86. The UK healthcare systems across England, Wales, Scotland and Northern Ireland have long since been regarded as a national treasure: high quality comprehensive medical care, free at the point of access.

87. Regrettably, by the point at which Covid-19 arrived at our shores, those systems had been degraded by years of under-resourcing. Staffing levels were inadequate across the board, emergency medical care was often overwhelmed by seasonal flu. Buildings suffered from under-investment, illustrated by widespread poor ventilation systems. PPE and other medical equipment and supplies were inadequate. The whole system

struggled for business-as-usual, and a lack of pandemic planning compounded the problems from the outset of the emergence of the disease.

88. Against that backdrop, the Inquiry should give short shrift to suggestions that the NHS was "not overwhelmed" and should not be deflected from its purpose by the fact that so many healthcare staff went to such lengths to mitigate those deficits. Their commitment and their sacrifice will have been in vain if allowed to obfuscate the huge systemic failures which are apparent on the evidence disclosed to date.

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