

Monday, 9 September 2024

(10.30 am)

Opening remarks by THE CHAIR

LADY HALLETT: Good morning.

Today we begin the public hearings into Module 3, investigating the impact of the Covid-19 pandemic on the healthcare systems of the four nations of the United Kingdom.

The hearings will last for ten weeks in all, divided into two sessions. We shall take a two-week break in mid-October. This will allow Counsel to the Inquiry and for the core participants to ensure they are as fully prepared as they can be for the second session.

We have a huge amount to get through, and the only way we can do that in the time I have allowed is by strict adherence to the timetable. I apologise in advance to those who would like us to spend more time examining particular issues in these hearings. I understand their concerns. But, as I've said before, the longer any set of hearings take, the longer the delay in making recommendations, and the longer the delay in investigating other important modules such as the impact on the care sector and children and young people.

In all our modules, we start the hearings with

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and Ms Jac Carey King's Counsel, Counsel to the Inquiry for this module, will begin her opening submissions. She will set the scene, provide some background, and explain the issues we shall be examining in this module.

So if those who would like to leave the hearing room or press pause, please do so now.

(Pause)

(Video played)

LADY HALLETT: Thank you very much.

Could we alert the people watching who have left the hearing room, please, to come back. Sorry, I think I said 20 minutes. I gave the wrong time estimate. Apologies to everybody.

(Pause)

I'm sorry, I gave the wrong time estimate, for those who are returning.

Thank you. Ms Carey King's Counsel.

**Opening statement by LEAD COUNSEL TO THE INQUIRY for
MODULE 3**

MS CAREY: Thank you, my Lady.

On 23 March of 2020, when the then Prime Minister, Boris Johnson, told the country to lock down, the broadcast included the following phrase: Stay at Home, Protect the NHS, Save Lives. The focus of the Inquiry's Module 3 hearings will be on some of those words, and

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an impact film to remind everyone why we are here. We decided for this module to divide a longer film into two, because, with a break in the middle, we wish to ensure that those following our proceedings do not lose sight of the fact of why we are here.

We shall show one part of the film at the start of each session. I wish to emphasise that the fact the first part to be shown today features predominantly healthcare workers rather than the bereaved does not in any way undermine the importance of the second part of the film. The order was chosen simply as a way of introducing the evidence we are about to hear, and that evidence, I emphasise, will include as the first two witnesses bereaved family members.

I am very grateful to all those who contributed to making the films. I can only imagine how difficult it must have been for them.

As with the previous impact films, these two are extremely moving, and there will be those who will find them too distressing to watch. I will pause in a moment to allow those who are in the hearing room who wish to do so to leave for a few minutes -- the film lasts about 20 minutes -- and those who are following online to press mute or exit the livestream.

After the film has been played, we shall reassemble

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the ultimate questions: did we protect the NHS? Did we save lives? And perhaps as importantly, why did we need to protect the NHS and at what cost? What cost, for example, to those people who did not have Covid, but rely on healthcare systems to treat non-Covid conditions? What cost to the physical and mental toll on health care workers? What cost to those who could not visit loved ones, who had to shield, to those now living with Long Covid? And what cost, my Lady, to the families of all those patients and healthcare workers who died?

As my Lady knows, between March 2020 and February of 2022, death certificates show that there were 186,668 deaths involving Covid registered in the UK. The death certificates record the place of death across all four nations, and it is in fact between 60 and 70% of people who died from Covid did so in hospital. The first healthcare workers who died were on 25 March of 2020.

The impact of dealing with so many deaths is just one of the many topics covered by Module 3's Every Story Matters healthcare record. That report analyses and brings together over 32,000 stories related to UK healthcare systems and includes contributions gathered from 450 interviews conducted across the UK

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1 with people impacted by the pandemic, along with hearing
2 from those who engaged with the discussion groups.

3 That report includes quotations which powerfully
4 depict the daily realities of life and death within the
5 healthcare systems.

6 My Lady, I will just quote two at the outset.

7 A hospital porter said this:

8 "The fact that people were in ITU and they were
9 alone was horrible, because you could just see it in
10 their eyes, you could see it in the eyes of the staff,
11 the nurses, the doctors. At the height, it was a really
12 horrible place to be. That was probably the thing that
13 will stick with me the most, is that so many people died
14 on their own, or so many people died with only one
15 family member around them, which was horrific."

16 A hospital cleaner said this to Every Story Matters:

17 "I was cleaning her room, and I remember, she took
18 off her mask, to me, she was, like, only 24, 25,
19 I'll never forget her, and she says 'I thought Covid-19
20 wasn't a real thing', she went, 'but honestly, it's
21 killing me'. That cleaner broke down when he spoke to
22 Every Story Matters and said this: 'It makes me quite
23 emotional, actually it was sad'."

24 It is not possible or practical for me to reflect in
25 this address the many thousands of stories that people

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1 that usually takes place in hospital, the emergency and
2 urgent care. It includes 999, ambulance services,
3 emergency departments, acute hospital admissions and
4 some mental health services.

5 Tertiary care, my Lady, includes highly specialist
6 care provided to patients who have been referred from
7 primary or secondary care. In the context of this
8 module, this may include treatment for more complex
9 cases of colorectal cancer, inpatient children's mental
10 health, and specialist intensive care.

11 You can see set out there, and it's on the Inquiry's
12 website, the 12 different areas that the module will
13 examine over the next ten weeks. Whilst formal in its
14 drafting, at its heart you may think at a more
15 fundamental and human level, the sorts of questions that
16 may need to be considered in Module 3 include these:

17 Why couldn't I see my GP? How was I protected from
18 getting Covid-19? Where was my ambulance? Why was my
19 treatment delayed? Did I receive the type of care
20 I needed? Did my loved one? Why couldn't I visit my
21 loved one in hospital? Were healthcare staff protected,
22 looked after? Or perhaps more simply: was I safe at
23 work? What was done to help with the long-term
24 consequences of Covid?

25 These will all be aspects of the evidence heard in

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1 have shared with Every Story Matters, but the report
2 itself will be published today at noon on the Inquiry's
3 website, and it is hoped that it is a lasting account of
4 the very real human impact that the pandemic had. There
5 will be similar reports for other modules, and I know
6 my Lady would wish to encourage as many people as
7 possible to participate in this vital part of the
8 Inquiry's work.

9 So to Module 3. This opening is an introduction to
10 just some of the topics and issues that you will be
11 asked to consider in Module 3, and can I ask, please,
12 that the scope of Module 3, ending INQ000474319, is put
13 up on screen. Time doesn't allow me to go through each
14 and every one of the particular aspects of Module 3 that
15 will be examined. It is necessarily broad. It is
16 undoubtedly ambitious, covering as it does the impact on
17 primary, secondary and tertiary care in all four nations
18 of the UK. The timeframe for the examination of this
19 module's purposes is 1 March 2020 to 28 June 2022. We
20 have called it "the relevant period" and you may hear me
21 refer to it as such throughout.

22 Primary care, as you know, includes but is not
23 limited to general medical practice and community
24 pharmacy.

25 Secondary care includes planned or elective care

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1 Module 3, which may overlap with and indeed complement
2 work being done by other modules, in particular
3 Module 6, examination of the pandemic on the adult
4 social care sector. To take an obvious but hugely
5 important example, issues relating to the discharge
6 decisions of hospital patients into care homes without
7 testing, well, they are matters important to both
8 modules, and Module 3 will look at the impact of the
9 decision as it affected hospital capacity, module 6 will
10 look at the impact of the decision on the care sector.

11 In order to examine these matters, Module 3 has
12 requested over 250 witness statements, obtained ten
13 separate expert reports, commissioned an independent
14 research project looking at decisions made by health
15 workers about escalation decisions, I'll return to that
16 in a moment.

17 The Inquiry's also gathered evidence from a number
18 of spotlight hospitals across the UK to help examine
19 what was going on on the ground. Taken as a whole,
20 spotlight statements provide evidence about matters such
21 as the impact of significant staff shortages on staff to
22 patient ratios, the physical and emotional toll on
23 staff, the significant efforts made by those hospitals
24 to increase their capacity for intensive care unit beds
25 at pace, and the serious and wide-ranging issues with

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1 the suitability and reliability of PPE that was
2 supplied.
3 And my Lady may hear of some innovative ways that
4 staff and management filled those gaps.
5 In total, over 16,500 documents have been disclosed.
6 It amounts to over 225,000 pages of evidence. That work
7 has resulted in a huge body of evidence. Many of the
8 statements run to hundreds of pages, from which you will
9 be able to draw your conclusions and, importantly, make
10 recommendations to help the healthcare system's response
11 in the future. I know that you will be assisted by the
12 36 core participants and their questions and
13 submissions.

14 The reasonableness or otherwise of actions and of
15 decisions taken by those responsible for the healthcare
16 systems will be an important consideration for
17 your Ladyship, and I know that you will not be judging
18 decisions made with the benefit of hindsight. Hindsight
19 is invariably 20/20 and so would not be an accurate or
20 fair way to consider unprecedented decisions that had to
21 be made quickly in highly pressurised environments.

22 Many of the witnesses will tell you that there were
23 no good decisions, rather it was a case of: what is the
24 least bad decision?

25 At the outset, it should be noted that when the
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1 As health is a devolved matter, there are four distinct
2 health systems within the UK, and whilst it may be
3 an oversimplification, and the names and terminology may
4 vary between the nations, it may be helpful to think of
5 the structure in each nation in this way: the government
6 minister sets the strategy, the respective government
7 department devises the policy to deliver that strategy,
8 and then each nation has its own body, bodies,
9 organisations to put that policy into practice.

10 This map, and I'm going to ask, please, that
11 INQ000474319, page 3 -- thank you -- is put on screen,
12 may help give an overview of the landscape of the
13 healthcare systems during the pandemic. Now, some of
14 the names have changed and indeed some of the numbers,
15 in particular the clinical commissioning group numbers
16 have changed. You will see that in England there are
17 135 -- or there were, I should say -- 135 clinical
18 commissioning groups representing the figure in 2022 to
19 2021; there were seven local health boards; there are
20 five health and social care trusts -- there is in fact
21 a sixth trust, the Northern Irish ambulance trust, but
22 we haven't depicted that on the map; and there are
23 14 geographical health boards in Scotland.

24 So turning briefly to England, in England the
25 Department of Health and Social Care, the HSC, supports

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1 government departments were asked to provide statements,
2 they were asked to identify which individual would be
3 best placed to provide the statement and who was able to
4 speak knowledgeably about the matters set out.
5 Accordingly, the Inquiry is able to draw upon a wide
6 range of witnesses, some of whom were in post throughout
7 the relevant period, some of whom may have been in post
8 for only part of the relevant period, and some who have
9 now taken up the role heading up the organisation and so
10 can bring a slightly different perspective as to where
11 we are now in 2024.

12 Irrespective of which camp the witness falls into,
13 witnesses have been asked to reflect on what worked
14 well, as well as what did not. And for those giving
15 evidence may I make this plea: please be prepared to
16 assist in real practical terms when asked about
17 recommendations that your Ladyship may wish to consider.
18 Whilst it's clearly important that in Module 3
19 the Inquiry considers what decisions were taken and why
20 so that lessons can be learnt, Module 3 has an important
21 forward-looking perspective, as will be reflected in
22 many of the questions during this public hearing.

23 At the outset, it may assist if I briefly outline
24 the structure of the healthcare systems in each nation,
25 and the key individuals from whom you will be hearing.

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1 and advises ministers and the Secretary of State for
2 Health and Social Care. Now, the pre-Covid
3 understanding of roles and responsibilities regarding
4 pandemics in DHSC and a number of bodies is undoubtedly
5 a matter you're going to be hearing about, and it might
6 be more easily understood by reference to the diagram on
7 page 4, please. If we could just enlarge it, these are
8 terms with which my Lady will be familiar and will
9 become more familiar throughout.

10 One can see DHSC sits at the top, there was the
11 Pandemic Influenza Preparedness Board and Programme and,
12 underneath that, Public Health England, NHS England and
13 NHS Improvement, then down to the CCGs, the NHS
14 providers, and a number of expert advisory committees,
15 and I know you'll be familiar with the work,
16 for example, of NERVTAG and the other committees set out
17 there.

18 DHSC is headed by its permanent secretary,
19 Sir Christopher Wormald, who I know has given evidence
20 in earlier modules, and the permanent secretary supports
21 the government minister who is the head of the
22 department, who is, in turn, accountable to the Prime
23 Minister and others in Parliament for the department's
24 performance.

25 During the pandemic, the secretaries of state were

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1 Matt Hancock, until his resignation in June 2021, when
2 he was succeeded by Sir Sajid Javid, and the Secretary
3 of State has a statutory duty to take such steps as he
4 considers appropriate for the purpose of protecting the
5 public in England from disease or other dangers to
6 health, and he has a power to take such steps as he
7 considers appropriate for improving the health of people
8 of England.

9 The principal way he does that is through Public
10 Health England, with both the department and Public
11 Health England having responsibilities for planning for
12 and indeed managing the response to emergencies and
13 health protection incidents.

14 On 1 October in 2021, Public Health England was
15 replaced by the UK Health Security Agency, UKHSA, as
16 it's sometimes referred to, as a part of wider
17 government restructuring, and you will be hearing from
18 UKHSA's CEO, Professor Dame Jenny Harries and its Chief
19 Medical Advisor, Professor Susan Hopkins.

20 One can see on the screen there reference to NHS
21 England. NHSE, as it's often shortened to, commissions
22 healthcare services and has responsibility for arranging
23 the provision of services for the purposes of health
24 service in England. For the majority of the pandemic,
25 NHSE worked together with NHS Improvement, and so many

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1 different levels set out there, and the incident level
2 informs how the EPRR framework will respond.

3 Throughout the relevant period, the NHS in England
4 was either at a level 3 or level 4 and, in fact, the NHS
5 in England spent 421 days at level 4 between 30 January
6 2020 and 28 June 2022, and you can see there that
7 level 4 essentially means that NHS England National
8 Command and Control support the NHS response and it's
9 NHSE's job to co-ordinate the NHS response in
10 collaboration with local Commissioners.

11 This, my Lady, is a framework specific to England.
12 You will hear that each nation had a different approach
13 to EPRR frameworks and/or had different frameworks, so
14 the England framework is very much just to give you
15 an example of how an EPRR framework might work.

16 You will hear how the Department of Health and
17 Social Care developed a Covid-19 action plan in early
18 March 2020, to provide the public with information about
19 what the government knew, had planned for and was
20 planning for, and the department devised an internal
21 battle plan, to use their phrase.

22 Can we look at page 6, please. There is the
23 Covid-19 battle plan from March 2020. It split the work
24 into various workstreams, which are set out underneath
25 the "Contain", "Delay", "Research", "Mitigate" phases,

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1 of the documents we will look at will make reference to
2 both NHSE and NHSI.

3 The chief executive officers of NHSE were Sir Simon
4 Stevens, until July 2021, and then Amanda Pritchard who
5 was, in fact, the chief executive of NHSI, and its board
6 members include Professor Stephen Powis, who is the
7 National Medical Director. You will be hearing from the
8 latter two witnesses both of whom have provided lengthy
9 and comprehensive witness statements.

10 My Lady may recall that the map referred to 135
11 CCGs, they are responsible for planning and
12 commissioning health services in local areas using the
13 funds allocated to them by NHS England. There are then
14 a number of services provided by the NHS trusts and
15 a trust indeed can run multiple hospitals and community
16 sites.

17 It is NHS England who is responsible for setting
18 an emergency preparedness resilience response strategy,
19 or EPRR, for the NHS. For the purposes of this relevant
20 period NHS England's EPRR framework from 2015 applied,
21 and that framework describes in terms the level of
22 response and co-ordination required which may change as
23 the incident evolves.

24 So can we call on screen, please, page 5. This is
25 the EPRR framework in place in England, various

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1 and my Lady will see there that workstream 1 was to:

2 "Sustain health and social care resilience --
3 especially critical care capacity and workforce."

4 It was to "ensure supplies to the NHS -- [including]
5 PPE and ventilators"; there was a workstream delivering
6 widespread testing and workstreams in relation to
7 accelerating technology, social distancing and
8 shielding.

9 My Lady, the effectiveness or otherwise of this plan
10 will doubtless be something that you will wish to
11 consider as the evidence progresses.

12 May I turn to the structure in Northern Ireland.
13 Since 1973 there has been an integrated health and
14 social care system in Northern Ireland, the Northern
15 Ireland Executive is composed of nine departments, each
16 with a ministerial lead. The Department of Health is
17 one of those nine and is responsible for health and
18 social care legislation and policy.

19 Until April 2022 there was a single Health and
20 Social Care Board that worked in conjunction with the
21 Public Health Agency in Northern Ireland, which
22 commissioned services to meet need and promote general
23 health and wellbeing.

24 The health and social care services that are
25 provided are provided by five health and social care

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1 trusts. Can we have a look, please, at page 7. There
2 are the five trusts: one in Belfast, and then North;
3 South Eastern, Southern and Western. As I said, the
4 sixth trust provides ambulance services for the region.

5 My Lady, the health and social care structure is
6 different in Northern Ireland, given that in England,
7 Scotland and Wales, provision of social services remains
8 the responsibility of local authorities.

9 Robin Swann was the minister at the time Module 3 is
10 examining and, in terms of the structure, there is what
11 is known as the top management group and the
12 departmental board who have responsibility for overall
13 corporate governance of the Department of Health. They
14 also ensure that the minister's policies and priorities
15 are implemented.

16 In Northern Ireland, the emergency response plan
17 2019 was the plan that was used in response to the
18 emergence of Covid-19. Now, that response operated
19 under a gold, silver and bronze model, with the
20 Department of Health operating as a gold command,
21 setting the broader and longer term responses to the
22 pandemic via a strategic cell and emergency operations
23 centre.

24 It was the emergency operations centre that was
25 responsible for managing the flow of information into

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1 for example, attendances at emergency departments,
2 number of people being admitted to hospital, number of
3 cancellations of elective admissions and others.

4 The then Health and Social Care Board also
5 co-ordinated a range of groups to support regional
6 communication across Northern Ireland, including among
7 frontline staff, such as the critical care network for
8 Northern Ireland, which also developed a daily situation
9 report informing the system of bed availability and
10 demand by unit.

11 My Lady, of course, in relation to Northern Ireland,
12 although the Republic of Ireland and Northern Ireland
13 are separate jurisdictions, from early on in the
14 pandemic there was collaboration with the Republic on
15 public health policy, including arrangements for the
16 sharing of information on infectious diseases.

17 To Scotland. The government in Scotland is
18 structured into a number of directorates of which the
19 Health and Social Care Directorate is one. The
20 directorates and their related public health bodies are
21 responsible for putting government policy into practice.
22 The Scottish ministers, health boards and local
23 authorities are all under a legal duty to continue to
24 make provision to protect public health in Scotland and,
25 indeed, the Cabinet Secretary for Health is under

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1 and out of the strategic cell and between the Department
2 of Health and Social Care sector, and indeed across the
3 wider Northern Ireland Executive departments and the UK
4 Government.

5 Under that was silver command, or the bodies such as
6 Public Health Agency in Northern Ireland, known as PHA,
7 whose responsibilities include health protection.

8 During the pandemic this entailed Public Health Agency
9 providing sit rep data -- situation reports -- to the
10 department, they maintained surveillance systems of
11 Covid-19 cases and they looked at outbreaks, and they
12 adapted guidance on the management of cases, to name
13 just a few of their responsibilities.

14 At bronze level, which is essentially the
15 operational level, were the health and social care
16 trusts themselves.

17 So although I've referred to gold, silver and bronze
18 structure by reference to the position in Northern
19 Ireland, there is a similar command structure operated
20 in a number of places including, for example, in the
21 Welsh health boards.

22 The Department of Health in Northern Ireland was
23 responsible for the development and management of the
24 Covid-19 dashboard, which included data from the trusts,
25 and analysed trends in pandemic related data, including,

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1 a similar statutory duty to promote a comprehensive and
2 integrated health service.

3 Those Cabinet Secretaries during the relevant period
4 were Jeane Freeman until May 2021 and thereafter
5 Humza Yousaf, both of whom will be giving evidence.

6 Very early on in the pandemic on 17 March 2020,
7 Ms Freeman advised the Scottish Parliament that the NHS
8 would be placed on an emergency footing for at least
9 three months and she set out that she was giving
10 instruction to the NHS and the individual health boards
11 to do all that was necessary to manage the expected
12 increase in the number of cases of Covid-19. In short,
13 my Lady, this meant the strategic direction was
14 determined by Ms Freeman and all of the Scottish NHS
15 boards would follow the same set of actions, albeit that
16 operationalisation of them may differ according to local
17 circumstances such as geography.

18 You will hear from the director general of the
19 directorate, Caroline Lamb, who has been in post since
20 January 2021 and the director general has a number of
21 roles including having oversight of all of the health
22 boards in Scotland and during the pandemic new
23 directorates were established such as the Directorate
24 for Covid Health Response and the Directorate for Covid
25 Public Health and there was a Directorate for PPE.

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1 The Health and Social Care Directorate in Scotland
2 provides a policy and a delivery function, as well as
3 oversight of the NHS. The Health and Social Care
4 Management Board is the main decision-making body of the
5 directorate and its remit is to be collectively
6 responsible for strategy and performance.

7 During the first three months of the pandemic,
8 between March and May 2020, that board was briefly
9 reconstituted to become known as the Planning and
10 Insurance Group, which was collectively and individually
11 accountable for the strategy, before reverting in due
12 course back to the board.

13 My Lady may recall from Module 2A that the Scottish
14 Government's approach to decision-making during the
15 pandemic was set out in its framework document published
16 in April 2020. That included suppression of the virus
17 to the lowest level possible whilst seeking to minimise
18 the broader harms, and that framework identified in
19 broad terms four main ways Covid caused harm, direct and
20 indirect health harms and, indeed, social and economic
21 harms and, whilst that framework was not a hierarchy,
22 you will hear that preventing direct harm, namely the
23 mortality and morbidity associated with Covid, was the
24 Scottish Government's paramount concern.

25 There are 14 geographical health boards and seven
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1 Healthcare Associated Infection service, or ARHAI for
2 short. ARHAI provides national expertise for infection
3 prevention and control. ARHAI's IPC guidance was
4 published in what is called the *National Infection*
5 *Prevention and Control Manual*, NIPCM, and that manual
6 was first published in Scotland in 2012 and it's
7 important because it now forms what I may call the
8 backbone of much of the IPC guidance used across the UK
9 today.

10 ARHAI played an important role in the UK-wide
11 Covid-19 IPC guidance, and in particular one of ARHAI's
12 former members, Lisa Ritchie, became the Head of
13 Infection Prevention and Control at NHS England, as she
14 initially chaired the UKIPC cell and it was the UKIPC
15 cell that made the infection prevention and control
16 recommendations that underpinned the UKIPC Covid-19
17 guidance.

18 My Lady, may I just say one thing about that cell.
19 That cell brought together IPC leads of the NHS and the
20 public health bodies from all four nations. Each
21 national representative on the cell was responsible for
22 taking the cell's recommendation back to its respective
23 country for approval, usually either by the Chief
24 Nursing Officer or the Chief Medical Officer. It was
25 not technically a decision-making body. However, you
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1 non-geographical special boards that are all supported
2 by NHS National Services Scotland, or NSS, and indeed by
3 Healthcare Improvement Scotland.

4 Can I just put up on screen page 8, please. There
5 you can see the geographical boards set out and you will
6 notice immediately, my Lady, the very wide spread of
7 regions that they cover, territory that is covered,
8 indeed numbers of people within each of those regions,
9 and the special NHS boards are set out there.

10 The boards are delegated responsibilities by the
11 Cabinet Secretary to plan, commission and deliver
12 healthcare services and take overall responsibility for
13 health and wellbeing.

14 NHS NSS provides strategic support, for example
15 during the pandemic they provided services relating to
16 national screening programmes, many of which in fact
17 were paused during the pandemic in common with the
18 position across the UK, and NHS NSS was also responsible
19 for procuring and delivering PPE.

20 NHS NSS had a public health and intelligence unit,
21 but on 1 April 2020 Public Health Scotland was
22 established and most of the unit's functions were
23 transferred to Public Health Scotland.

24 There's one important exception to that and that was
25 the service provided by the Antimicrobial Resistance and
22

1 will want to consider the extent to which, if at all,
2 the UKIPC cell's recommendations were altered and/or
3 overturned, as there may be little evidence of that.
4 Thus you may come to the conclusion that it's likely
5 that the cell was de facto the body making the decisions
6 in respect of the IPC guidance.

7 The structure in Wales has the Welsh ministers who
8 set the high level policy framework and the targets for
9 the health service, which are then delivered by the
10 local health boards and NHS trusts in Wales. There is
11 a Health and Social Services Group, HSSG, which sets out
12 the ministers' expectations in respect of planning and
13 performance and the assurance it seeks from NHS
14 organisations through its planning, delivery and
15 compliance frameworks. The NHS in Wales is principally
16 made up of different types of statutory bodies, the
17 seven local health boards, there are three trusts and
18 two special health authorities.

19 Now, in Wales, the healthcare services are primarily
20 delivered by the seven local health boards, who are
21 responsible for planning, securing and delivering
22 healthcare services for the benefit of their resident
23 population within their geographical area.

24 The term NHS Wales is commonly used to refer
25 collectively to the local health boards and indeed the
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1 special health authorities but, unlike in NHS England,
2 there is no central legal entity of this name.

3 The ministers in post during the relevant period
4 were Vaughan Gething until May 2021, followed by
5 Eluned Morgan thereafter. While delivery of the
6 healthcare services is the responsibility of the NHS
7 bodies, the Welsh ministers are responsible for
8 monitoring the financial duties of the NHS bodies and
9 each board has to submit plans to the minister setting
10 out how they will use the funds, and those plans are
11 then approved by the Welsh minister.

12 At the start of the pandemic, Dr Andrew Goodall was
13 the Director General of Health and Social Services, also
14 the Chief Executive of NHS Wales until September 2021
15 when he became the government's permanent secretary.
16 Judith Paget took the role of general thereafter and
17 that of Chief Executive of NHS Wales.

18 In Wales, in addition to the UK pandemic flu
19 strategy 2011, Wales also followed a number of other
20 plans. There are three in particular. The Pan-Wales
21 Operational Response Plan from 2019, the Wales Health
22 and Social Care Influenza Pandemic Preparedness Response
23 Guidance issued in February 2014, and then there was the
24 Pandemic Influenza Extreme Surge Guidance for the NHS in
25 Wales. Now, that latter guidance had been in draft form

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1 consider any disparities evidence in the impact of the
2 pandemic on different categories of people, including
3 but not limited to those relating to protected
4 characteristics under the Equality Act 2010 and the
5 equality categories under the Northern Ireland Act 1998.

6 I know that in previous modules you have heard from
7 a number of experts who provided your Ladyship with
8 evidence about some of the many inequalities that
9 existed pre-pandemic which were exacerbated by the
10 pandemic. You will recall the evidence given by
11 Professors Marmot and Bambra who in Module 1 spoke,
12 for example, of the socioeconomic inequalities such that
13 the more deprived local authorities in the UK have worse
14 health than the less deprived and that those in more
15 deprived areas have shorter lives and live more years in
16 ill health compared to people living in less deprived
17 areas.

18 The experts spoke of ethnic inequalities in health,
19 where, notwithstanding the concerns about the
20 reliability of data, there was some evidence that ethnic
21 minority people may have much poorer health than white
22 people.

23 Those ethnic inequalities have particular
24 significance, in my submission, for the NHS. Amongst
25 all the staff employed by the NHS, and there are

27

1 at the start of the pandemic, was updated for Covid-19
2 by the Covid-19 Health and Social Services Planning and
3 Response Group, and that planning and response group's
4 role was to consider the reasonable worst-case scenarios
5 for Covid risk assessment and co-ordinate the response
6 of planning across Wales.

7 Public Health Wales was part of that planning and
8 response group and you'll be hearing from Public Health
9 Wales' national director.

10 So that, my Lady, was a very quick and summary
11 attempt to set out some of the structures in place at
12 the highest level of planning and preparedness across
13 the four nations.

14 At a more local level, the spotlight evidence
15 attests to some of the plans put in place by the trusts
16 and hospitals and the considerable efforts they went to
17 as the pandemic struck.

18 May I deal, my Lady, with one other topic, perhaps
19 before we turn to our mid-morning break and it's, at the
20 outset, the issue of inequalities.

21 Laws across the UK require public authorities to
22 have due regard to certain equality considerations when
23 exercising their functions, and I refer to these legal
24 duties because, as my Lady knows, the Inquiry's terms of
25 reference specifically set out that the Inquiry will

26

1 1.3 million in England as of March 2020, approximately
2 21% are from a Black, Asian and ethnic minority
3 background, or to put it another way, 270,000 people.
4 That includes a quarter of nurses and over 40% of
5 doctors. My Lady will hear about the evidence of the
6 disproportionate number of black, Asian and minority
7 ethnic healthcare workers. You will hear concerns that
8 those group of healthcare workers were often deployed to
9 the frontline roles, so that they were there with direct
10 contact with Covid-19 patients, and so needed PPE that
11 not only fit them but took account of religious dress,
12 facial characteristics, such as hijabs or beards.

13 You will hear, my Lady, that risk assessments for
14 Black, Asian and minority ethnic healthcare workers
15 happened too late or not at all. You will hear that
16 some staff in non-clinical roles, such as porters or
17 cleaners, were not provided with PPE at all. There is
18 concern about the lack of engagement with groups set up
19 to represent Black, Asian and minority ethnic healthcare
20 workers, and that communications with that group were
21 not tailored or sufficiently tailored to those
22 communities.

23 Many witnesses will attest to the efforts they made
24 to bring these matters to the attention of the
25 respective governments and key decision-makers,

28

1 for example the ministers, chief medical officers, the
2 heads of the departments, and indeed what steps were
3 taken in response.

4 You will hear about some specific examples of
5 potential racial inequalities. May I just give two
6 examples. During the pandemic, there were concerns
7 about the use of pulse oximetry for Covid-19 patients
8 being managed at home. Pulse oximeters can identify
9 a drop in someone's blood oxygen level, which can be
10 an indication, amongst others, that the person's
11 condition is deteriorating. From November 2020 pulse
12 oximeters were used in England to monitor patients who
13 were well enough to stay at home but who were most at
14 risk of becoming seriously unwell, and concerns emerged
15 that suggested that inaccurate and variable readings
16 when the device was used on a darker skin were not
17 appropriate. So, put another way, the reading was
18 inaccurate because it would suggest that oxygen levels
19 were okay when in fact they weren't, and it resulted in
20 delays in those people potentially being taken to
21 hospital and being treated.

22 The NHS Race and Health Observatory conducted
23 a rapid review of the evidence of inaccuracies in pulse
24 oximeters, and you will hear more about that and the
25 observatory's other work when Mr Naqvi, their CEO, gives

29

1 PPE, masks and the like, made spoken communication
2 more challenging, particularly for patients who have
3 additional communication needs such as the deaf and
4 hearing impaired who couldn't lip-read when people were
5 wearing masks. Some autistic people depended on facial
6 expressions to aid communication, and clearly the masks
7 impeded them.

8 The increased use of remote consultations impacted
9 many people. For example, the move to remote
10 consultations was difficult for people who spoke no
11 English or for whom English was their second language,
12 for older people, for those who lacked confidence in
13 their ability to accurately self-test. In the context
14 of maternity care there is some evidence to suggest that
15 early in the pandemic remote support did not work well
16 for those who were breastfeeding.

17 My Lady, you will hear from witnesses called on
18 behalf of Mencap and the Disability Charities
19 Consortium. Mencap's CEO will tell you about Mencap's
20 concerns that visiting guidance had on those with
21 learning disabilities and its concerns about Do Not
22 Attempt CPR, and I will return to that topic later.

23 The Disability Charities Consortium raised similar
24 concerns and they rhetorically ask this, to use their
25 words: they want to know whether disabled people were

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1 evidence.

2 During an Every Story Matters listening event,
3 healthcare professionals from ethnic minority
4 backgrounds recalled their own heightened concerns about
5 personal safety and the risk of Covid-19 after learning
6 that people from those backgrounds were more at risk.

7 You will hear, my Lady, particularly at the start of
8 the pandemic, that formal equality impact assessments
9 were not always carried out. A consequence of this was
10 that health inequalities, defined as "avoidable, unfair
11 and systematic differences in health between different
12 groups of people", were not properly taken into account
13 when measures to address the pandemic were designed.
14 This gives rise to the risk that measures would fail to
15 mitigate health inequalities, or worse, the risk they
16 would exacerbate them.

17 The pandemic brought other inequalities to the fore.
18 In their witness statement, for example, Age UK
19 highlighted that age is the single biggest risk factor
20 for experiencing severe illness and dying from Covid-19.
21 Age UK point to data which suggests that, even after
22 accounting for people's health, sex and ethnicity and
23 other characteristics, when compared to someone aged 60
24 the risk of dying was about doubled for someone aged 70
25 and almost quadrupled for someone aged 80.

30

1 treated "as an afterthought" during the pandemic.

2 My Lady, these are just some of the disparities and
3 inequalities that emerge from the evidence in Module 3
4 and I know my Lady will be keen to hear more about these
5 matters as the public hearing progresses.

6 Might that be a convenient moment for a break?

7 **LADY HALLETT:** Certainly, if that suits you, Ms Carey.

8 I shall return at 11.40.

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

10 (11.28 am)

(A short break)

12 (11.40 am)

13 **LADY HALLETT:** Ms Carey.

14 **MS CAREY:** My Lady, may I deal with the plan for the
15 hearing. The plan for calling the evidence during the
16 hearing will be to follow the patient journey through
17 the healthcare system insofar as practically possible,
18 hearing from those directly affected, although it may
19 not always be possible, given witness availability, to
20 follow strictly each and every stage of the journey.

21 Running throughout that journey will be the need to
22 understand some of the basics of how Covid-19 is
23 transmitted and the infection prevention and control
24 measures (IPC) needed to try to stop people becoming
25 infected. And inevitably when considering IPC measures,

32

1 we will be need to be familiar with terminology such as
 2 PPE, personal protective equipment, that's clothing,
 3 for example, that is designed to protect the wearer, and
 4 respiratory protective equipment, normally a mask type
 5 of PPE designed to protect the wearer from breathing in
 6 the harmful substance.

7 Professor Beggs, an expert in the transmission of
 8 infectious diseases in hospitals, will help us to
 9 understand the routes of transmission of Covid-19 and
 10 the ways to prevent and control transmission of the
 11 virus.

12 Now, it should be noted that, in relation to the
 13 transmission of Covid, as with many things in life,
 14 there was and perhaps remains a lack of scientific
 15 consensus. There are diverging views, each of which may
 16 be supported by a reasonable body of scientific
 17 evidence, and so anything I say or, more importantly,
 18 anything the Module 3 experts say about infection,
 19 transmission and consequential IPC measures, cannot be
 20 taken as gospel. It can't be considered to be the only
 21 view on those matters. And importantly, and perhaps
 22 unhelpfully you may think, there does not always appear
 23 to be consistent and agreed terminology.

24 In addition to Professor Beggs, the Inquiry has
 25 instructed a trio of IPC experts to consider the

33

1 for a viral infection to be transmitted in humans,
 2 viable virus particles must be transported from
 3 an infectious individual to a susceptible individual.
 4 However, when the virus particles eventually reach
 5 a susceptible individual, they may not cause
 6 any infection, simply because they might not come into
 7 contact with the receptors in the nose, throat, eyes and
 8 lungs that facilitate infection. That means that in
 9 order for an infection to spread, infectious individuals
 10 must shed virus particles into the environment in such
 11 numbers that eventually some of those reach the
 12 receptors of the susceptible person.

13 Now, there are various ways that a respiratory virus
 14 can be transmitted, including and often in combination
 15 with each other, and it may help us to have this simple
 16 diagram on screen.

17 Thank you.

18 There are three main routes. Firstly, droplet
 19 transmission. They are the larger particles from
 20 an infected person's respiratory tract which reaches the
 21 eyes, nose and mouth of the person, and on this diagram
 22 they're represented by the larger orange circles.

23 There is airborne transmission, ie via the air, and
 24 where the infection is spread by the dissemination of
 25 the smaller particles, the smaller orange dots, from the

35

1 guidance and IPC in practice. Dr Gee Yen Shin,
 2 Professor Dinah Gould and Dr Ben Warne will give
 3 evidence about topics and issues including IPC measures
 4 taken to protect both patients and indeed staff in NHS
 5 hospitals. They will speak to the evolution of the
 6 Covid-19 guidelines, and to patient and staff testing.
 7 I anticipate that you will be assisted by other expert
 8 and indeed other witness evidence, for example from the
 9 public health agencies, the chief medical officers, the
 10 chief nursing officers and others who will be able to
 11 assist on this topic.

12 I do however need to cover some background at the
 13 outset in relation to transmission and IPC. The need
 14 for the Inquiry to consider what was known about how
 15 Covid was transmitted arises because of the consequences
 16 for the types of infection and IPC measures which were
 17 needed to be adopted and the PPE that should be worn.

18 Covid-19 as you know was a pathogen known as
 19 SARS-CoV-2. It's an organism that causes the disease.
 20 That became known, as the WHO named it in February
 21 of 2020, as Covid-19. It's a respiratory disease
 22 transmitted through respiratory particles that contain
 23 the virus. Now, for ease, I'm going to refer to both
 24 the virus and indeed the disease as Covid-19.

25 As to transmission, in very basic terms, in order

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1 respiratory tract.

2 There is contact transmission, whether that's
 3 direct, ie from one person to another, for example
 4 sneezing in someone's face, or indirectly, via contact
 5 with a contaminated object or surface, such as the door
 6 handle that is depicted here, a light switch, surgical
 7 equipment or instruments that haven't been cleaned
 8 properly. Where the surface is contaminated, that is
 9 often known as fomite transmission.

10 Now, in the case of respiratory infections, the size
 11 of the infected particle may be of significance when
 12 considering transmission. The larger size particles,
 13 known as droplets, are generally thought to fall to the
 14 ground or the surface within about 1 metre from the
 15 source. The smaller particles are known as aerosols.
 16 And the reason that the size is important is because
 17 whilst the larger droplets are considered to settle
 18 rapidly, the smaller droplets, the aerosols, can remain
 19 in the air for longer, travel longer distances, and so
 20 are considered to be transmitted by the airborne route.

21 When considering airborne transmission,
 22 Professor Beggs will provide you with a background to
 23 what he considers to be an historical confusion
 24 surrounding the size and behaviour of respiratory
 25 particles that are exhaled. In part, the problem is

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1 said to arise from the terminology used by different
2 scientific disciplines to describe these particles, and
3 the language used by the medical community is not always
4 the same as that used by physicists and engineers.

5 This, he states, is not merely a question of
6 semantics. Rather, it has important implications for
7 the IPC measures adopted, including the PPE that is
8 used, when responding to a respiratory virus.

9 You will hear that because respiratory viruses such
10 as Covid have, save for when particular medical
11 procedures are being carried out, been deemed not to be
12 transmitted via aerosols, the result is that the IPC
13 advice issued in the UK and indeed overseas, including
14 that during 2020 and much of 2021, focused on prevention
15 via the droplet and contact routes. The clarification
16 of Covid as a droplet-borne virus also affected the
17 ventilation requirements in healthcare facilities.

18 Early in the pandemic, it was thought by many that
19 droplet transmission was the dominant route. Now, that
20 in part may have been due to the fact that the
21 overarching strategy was set out in the UK pandemic
22 influenza strategy from 2011, and there is an initial
23 infection prevention guidance adapted from that flu
24 strategy, and flu has historically been considered to be
25 a droplet-borne disease rather than an airborne one.

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1 The extent to which the World Health Organisation
2 (WHO) guidance on the subject may have informed or
3 coloured the UK's position on transmission: at the start
4 of the pandemic, the WHO stated categorically that Covid
5 was not airborne. By July of 2021, WHO partially
6 accepted that airborne transmission occurred, and it was
7 not until December of 2021 the WHO changed its stance
8 and acknowledged that Covid could be transmitted via
9 aerosol particles that could remain suspended in the
10 air.

11 That is a very brief overview of the issues that
12 arise in relation to transmission. Underpinning what
13 PPE needs to be worn is reference to health and safety
14 requirements and the legal framework.

15 Employers, as I think my Lady knows, are under
16 various legal duties to provide and maintain a safe
17 working environment insofar as is reasonably
18 practicable. That includes preventing and controlling
19 employees' exposure to hazardous substances, including
20 infection at work.

21 There is a framework known as the hierarchy of
22 controls which should be considered by employers to help
23 eliminate the risk.

24 And can I call up page 10, please.

25 There is the hierarchy of controls, the most

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1 You may hear that although a review in 2011
2 concluded that aerosols probably played more of
3 an important role in transmission than previously
4 thought, droplets were still considered to be the
5 principal route by which flu was transmitted, and the
6 epidemiological evidence in support of aerosol
7 transmission was considered inconclusive.

8 The medical community's understanding of SARS, not
9 to be confused with SARS-CoV-2 which became Covid, may
10 have been equally influential in shaping early guidance,
11 given the similarity between the two viruses. A belief
12 that SARS was predominantly droplet-based,
13 notwithstanding evidence that suggested it was
14 potentially airborne, may also have influenced a view
15 that Covid would behave in the same way.

16 Now, my Lady, that's not to say that the airborne
17 route was not recognised as a possible route of
18 transmission for Covid. The Inquiry is in possession of
19 numerous statements and documents that show that the
20 scientists, experts and advisers were aware that Covid
21 could be spread by aerosols, but those witnesses suggest
22 that what was not clear was the extent to which aerosols
23 transmitted the disease, the circumstances in which this
24 occurred, and the relative contribution of droplet,
25 aerosol and contact transmission.

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1 effective at the top, down to the least effective.

2 Elimination. In reality it was always going to be
3 difficult for Covid-19 to be eliminated entirely,
4 although clearly there was efforts made to reduce the
5 number of people attending hospitals, GPs and the like.

6 You will see that PPE (personal protective
7 equipment) is the final measure in the hierarchy and
8 it's obvious that, given that the risk of Covid could
9 not be entirely eliminated from healthcare settings and
10 the need to provide close quarter care to patients, PPE
11 was always going to play a significant part in
12 preventing the spread of the virus.

13 It's likely to be uncontroversial, therefore, to
14 state that PPE is one of the most important IPC measures
15 that can be put in place to help prevent people becoming
16 effected. So Module 3 will be looking at what kinds of
17 PPE were recommended, the legalities, the practicalities
18 of this guidance and, in particular, the role of
19 surgical face masks and respirators in protecting
20 healthcare workers.

21 My Lady is going to hear much about fluid-resistant
22 surgical face masks. I'm holding one up, but they are
23 the blue masks many of us wore at various times. FRSM,
24 to give them their acronym, provide a barrier to
25 splashes and droplets impacting on the wearer's nose,

40

1 mouth and respiratory tract, and you will see that they
2 are not designed to closely fit the wearer's face and
3 the poor fit means that aerosols can be inhaled passing
4 through the gap between the mask and the face. Because
5 FRSM are not only worn to protect the wearer but to
6 prevent the wearer from infecting someone else, you may
7 hear them also referred to as "source control".

8 Now, protection against aerosol particles requires
9 the use of respirators which remove the contaminant from
10 the air before they're breathed in. There are many
11 different types of respirators used in healthcare
12 settings but one that your Ladyship will hear about most
13 is FFP3, the filtering face piece, and I have one
14 example here.

15 FFP3 offers the highest level of protection and is
16 ordinarily, by which I mean in non-pandemic times, the
17 only FFP class acceptable to the Health and Safety
18 Executive for use against infectious aerosols in the UK.
19 It's of a different quality of material and it fits the
20 face with a much closer fit.

21 The health and safety regulations require that those
22 required to use respirators are fit tested by
23 a competent person, results are satisfactory and those
24 results are recorded and available for inspection.

25 Now, the IPC trio of experts will note that, for
41

1 with staff of white ethnicity, including in particular
2 those with beards. One of the core participants in this
3 module, FMHWG, report that, where fit tests were failed,
4 this did not necessarily result in more suitable PPE
5 being provided.

6 So, my Lady, I just want to briefly summarise what
7 PPE was recommended for healthcare workers and when,
8 this is by no means a reference to all of the guidance
9 that was issued but it's to give you an indication of
10 some of the issues that will arise in the evidence.

11 May I start with the position as at January 2020.
12 As you heard in Module 2, in January 2020 Covid-19 was
13 designated as a high-consequence infectious disease or
14 HCID. HClDs are highly transmissible infections and
15 defined according to a set criteria, which includes the
16 fact that they typically have a high case fatality rate.
17 The CFR, the case fatality rate, is the proportion of
18 those with symptoms and an infection who die.

19 You will hear that, because of the mode of
20 transmission for an HCID it is often unknown at the
21 early stages and because certain procedures that
22 generate aerosols are often required to be performed on
23 HCID patients, HClDs require a high level of PPE to be
24 worn, but it should be noted that the mode of
25 transmission does not determine whether the disease is
43

1 many NHS staff, this was their first experience of using
2 respirators and of fit testing because, prior to the
3 pandemic, hospitals would not have tended to fit test
4 workers who are unlikely to use FFP3 masks in their
5 day-to-day roles.

6 So at the outset of the pandemic, there were staff
7 trained to perform fit testing, they were few and far
8 between and more NHS staff had to be rapidly trained.
9 This resonates with evidence from some of the spotlight
10 hospitals from whom the Inquiry obtained evidence. Some
11 of those spotlight hospitals told us they abandoned fit
12 testing in favour of what's called "fit checking", with
13 one hospital stating it moved at one point to fit
14 checking to avoid "being overwhelmed". A fit test is
15 not the same as a fit check, the latter of which is
16 simply regarded as good practice to ensure the mask is
17 being correctly worn, and fit checking is not
18 a regulatory requirement, it is not a substitute for fit
19 testing.

20 The British Medical Association note, for example,
21 that across a range of their surveys, female respondents
22 consistently reported slightly higher rates of failing
23 fit tests compared to males. Other research also
24 suggests that failure rates for fit testing are higher
25 in staff from ethnic minority backgrounds when compared
42

1 an HCID or not.

2 By 13 March, so two and a half months on, Covid-19
3 was declassified as an HCID by the Advisory Committee on
4 Dangerous Pathogens and indeed NERVTAG, and that advice
5 was accepted by the Government a few delays later.
6 Therefore, Covid was subsequently to be managed like
7 other contagious diseases. Now, that decision was based
8 on the evidence about Covid that emerged between January
9 and March and, in particular, the fact that mortality
10 rates were considered to be low.

11 May I just pause there to make this observation,
12 though, about a relatively low mortality rate compared
13 to other HClDs because, whilst the proportion of those
14 infected who die of Covid was known to be about
15 approximately 1%, which is higher than seasonal flu but
16 lower than, for example, SARS, Covid is highly
17 transmissible. So if lots of people get infected, even
18 if the fatality rate is relatively low, you will still
19 get high numbers of deaths. Indeed, as you know from
20 the ONS statistics, a number of people did get infected,
21 leading to that over 186,000 deaths that I referred you
22 to at the beginning.

23 When considering the evidence relating to HClDs, it
24 is important not to elide issues of what PPE was
25 recommended whilst Covid was classified as an HCID with
44

1 what PPE should have been recommended once it was
2 declassified. They are two separate issues.

3 Two points may arise for your Ladyship's
4 consideration. Whilst it may be that the
5 declassification of Covid as an HCID was a reasonable
6 decision, this did not signify that Covid-19 was not
7 transmitted via airborne route and, equally, just
8 because a higher level of PPE was used whilst Covid was
9 classified, that doesn't automatically mean that the
10 higher level of PPE for healthcare workers was no longer
11 appropriate once the disease had been declassified.

12 By March 2020, on the 13th of that month, the IPC
13 guidance stated that the following PPE should be worn:
14 FFP3 masks and disposable eye protection should be worn
15 at all times in high risk areas where AGPs -- and I'll
16 come back to those in a moment -- are being conducted.
17 That included intensive care units, high dependency
18 units, where they were managing the Covid-19 patients.

19 The blue mask, the FRSM, were to be worn by general
20 ward staff, community staff, ambulance, social care
21 staff, for close patient contact, unless an AGP was
22 being performed. AGPs, another acronym -- aerosol
23 generating procedures -- are procedures that are thought
24 to have a high risk of aerosol generation and
25 an increased risk of transmission from patients with

45

1 I jump forward to June 2021, on 1 June. By this
2 stage IPC guidance recommended an enhanced role for
3 local risk assessments. The guidance stated that, if
4 an unacceptable risk of transmission remains following
5 the risk assessment, it may be necessary to consider the
6 extended use of RPE for patient care. The risk
7 assessment should include evaluation of the ventilation
8 in the area and the prevalence of infections or new
9 variants of concern in a local area.

10 By March 2022, the guidance now stated that FFP3
11 should be used for AGPs and when dealing with cases of
12 suspected or confirmed infection spread predominantly
13 via the airborne route.

14 My Lady, you will hear that other iterations of the
15 IPC guidance used phrases such as "spread wholly",
16 "spread predominantly by the airborne route". Not only
17 were they considered confusing but you may want to
18 consider how practically useful words such as "wholly"
19 and "predominantly" were to those to had to assimilate
20 this guidance at short notice and disseminate it
21 accurately to healthcare workers on the frontline.

22 You may hear evidence from some witnesses that the
23 changes in 2022, to which I have just alluded, were, to
24 paraphrase, too little too late because it appears that,
25 for much of the pandemic and certainly up to the end of

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1 a known or suspected infection.

2 So during AGPs healthcare workers should wear the
3 FFP3 respirator, they have eye protection, the
4 disposable long sleeved gown, gloves. You will hear
5 that there are issues relating to what procedures were
6 designated as AGPs and, in particular, concern that
7 cardiopulmonary resuscitation, or CPR, was not listed as
8 an AGP. That led to a divergence in approach from some
9 bodies, including the Resuscitation Council in the UK
10 and the College of Paramedics and ambulance trusts who
11 recommended that FFP3 was worn when conducting CPR, in
12 contrast to the UKIPC guidance, which didn't make that
13 recommendation.

14 A month on, in April 2020, the IPC guidance
15 recommended re-use and sessional use of PPE, in effect
16 prolonged use of specific PPE items during a single
17 period of time when working in a specific setting, so to
18 give you an example, wearing the same mask and goggles
19 throughout a ward round but still changing apron and
20 gloves every time physical contact was made with
21 a patient. That guidance was brought in because there
22 were concerns about supplies of gowns, in particular,
23 which resulted in specific guidance being issued,
24 recommending that sessional use and re-use where there
25 were severe shortages of supply.

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1 2021, the position was that, if a healthcare worker was
2 working in an ICU or an HDU or a Covid hotspot, or they
3 were performing AGPs, they had a higher level of PPE
4 throughout.

5 But for the remaining healthcare workers, who made
6 up the vast majority of the workforce, it was simply the
7 blue FRSM masks that were recommended.

8 You will hear that there was concern amongst the
9 medical community that the IPC guidance did not
10 sufficiently protect healthcare workers, particularly
11 before vaccinations became available, and a belief that
12 the FFP3 masks were not being recommended, save for the
13 hotspots and the AGPs, because there were insufficient
14 supplies of those respirators.

15 It is argued by some that the IPC guidance was
16 influenced by supply rather than safety. It failed to
17 adopt what is called the precautionary principle, and
18 there may also be disagreements about the precise
19 definition of the precautionary principle but, in short,
20 the precautionary principle describes an approach that
21 should be adopted for addressing hazards, subject to
22 high scientific uncertainty and rules out lack of
23 scientific certainty as a reason for not taking
24 preventative action.

25 During the course of the evidence, my Lady will

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1 doubtless hear the phrase "the absence of evidence is
2 not evidence of absence", and you will need to consider
3 whether the government agencies and those that advise
4 them were more pragmatic than precautionary when it came
5 to the IPC guidance that was issued.

6 Can I deal with symptoms and asymptomatic infection.
7 Once a person becomes infected with Covid it takes
8 several days, normally, before symptoms start to appear
9 and it is during this presymptomatic period, which could
10 be hours, it could be days, where a person becomes
11 infectious before symptoms appear. This is when the
12 virus is incubating and individuals are most contagious.
13 There may therefore be a period of time where
14 an individual is infected with the virus, capable of
15 spreading the virus without them feeling ill or
16 realising that they are infected and infectious.

17 Some of the terminology that you're likely to hear
18 about will resonate from earlier modules, asymptomatic
19 in particular, the person never develops any symptoms,
20 and you will want to draw a distinction between
21 asymptomatic infection, where the person has the virus
22 and does not have the symptoms, and asymptomatic
23 transmission, where the person has the virus and passes
24 it on.

25 You can be asymptotically infectious and not
49

1 examined during this module.

2 Testing is obviously important and initially focused
3 on tested symptomatic in-patients to determine whether
4 they had the disease and, if so, what treatment they
5 should be given. But it wasn't just important for that,
6 testing has an important IPC function as, for example,
7 it enables Covid-19 positive patients to be isolated.
8 The testing of healthcare workers was rolled out on
9 various dates across the UK from the end of March 2020,
10 thereby enabling infected healthcare workers to be
11 isolated and those who had a negative test returned to
12 work.

13 The dates for asymptomatic testing of staff also
14 varied across the UK and Dr Warne will explain the
15 challenges in determining where and how Covid-19 was
16 acquired, as this too can affect IPC measures. In
17 particular, it can be important to determine whether
18 Covid-19 was acquired in hospital and, if so, the extent
19 to which it was patients infecting healthcare workers
20 and vice versa, patients infecting other patients,
21 healthcare workers infecting other healthcare workers.

22 There are challenges in determining all of those
23 things but, notwithstanding those challenges, Dr Warne
24 considers it likely that the number of patients across
25 the UK who contracted a hospital acquired infection, or
51

1 necessarily pass the virus on. Put another way, just
2 because you have it doesn't mean you transmit it.

3 Now, you've already heard in earlier modules some
4 evidence about what was and was not known about the
5 extent to which Covid-19 was transmitted
6 asymptotically but it appears to be accepted in the UK
7 that the possibility of asymptomatic transmission was
8 acknowledged early on in the pandemic, by the end of
9 January 2020.

10 The fact and degree of asymptomatic transmission,
11 however, was challenging for the healthcare system's
12 response to the pandemic. For example, it caused
13 difficulties in accurately ascertaining the number of
14 people infected with Covid because asymptomatic people
15 often went untested because they didn't realise they had
16 the virus and therefore were undiagnosed.

17 The relatively long incubation period of the virus,
18 which for the Wuhan variant, the first variant, was four
19 to six days, and so high rates of asymptomatic infection
20 meant that it was difficult to identify infected
21 patients and staff and understand the networks of
22 transmission.

23 I just referred to testing and so it may help to set
24 the scene for consideration of this by summarising the
25 roll-out and some of the matters that will need to be
50

1 nosocomial infection as it is called, to be well over
2 100,000 people.

3 The age of the hospital estate is also important
4 when considering IPC. It affects the ability of the
5 hospital to implement IPC measures. It also affects,
6 for example, oxygen provision and that is a matter that
7 did come to the fore during the pandemic.

8 Can I deal firstly with ventilation. In England
9 alone, the NHS estate encompasses some 17,000 buildings
10 and, whilst not all of those are hospitals, 12% of the
11 total estate pre-dates the founding of the NHS, that was
12 in 1948; around 17% is over 60 years old; and about 44%
13 is 30 to 60 years old. If one thinks about it in
14 relation to implementing IPC measures, the number of
15 single-occupancy patient rooms, the ability to socially
16 distance in wards, to open the windows, to separate
17 Covid and non-Covid patients are all important and in
18 this regard good ventilation is key.

19 Can I put up on screen, please, INQ000474319,
20 page 11, thank you. I just want to say a couple of
21 things about ventilation. That's the process where
22 clean outside air is introduced into a room space to
23 flush out any virus and other pollutants. It doesn't
24 completely remove all infectious aerosols in the room.
25 Its aim is to dilute and reduce the concentration of
52

1 aerosols to a safe level. So, generally speaking, the
2 better the ventilation, the lower the concentration of
3 Covid in the room.

4 If one looks at this diagram that Professor Beggs
5 will speak to, one can see there that it set out the
6 position. The virus is the blue dots but, clearly,
7 an infectious person has left the room at 2.30, in
8 looking at the top brown row, at 2.30 when they've left,
9 in a poorly ventilated room there is a large
10 concentration of the virus and, even one hour later,
11 continuing to the top right side of the page, there is
12 still a fair concentration of the virus in that room.

13 Contrast that, if your Ladyship will, with the good
14 ventilation at the bottom, it includes there the ceiling
15 fan, a window that can be opened, a portable air cleaner
16 in this case, there is less of it even just shortly
17 after the infected person has left and, by 3.30,
18 a significantly different picture painted.

19 Now, my Lady, that is obviously a simplistic diagram
20 but if one pauses to think about an old hospital ward
21 with multiple beds and windows that don't open and
22 ageing ventilation systems, one can see how important
23 ventilation is in healthcare settings.

24 Professor Beggs will tell you that ventilation in
25 English healthcare settings is governed by health

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1 days before the critical incident, there were warning
2 signs when, on the morning of 1 April, the alarm panels
3 at Watford General were triggered, indicating there was
4 high pressure in the oxygen delivery system.

5 That matter was raised over the course of the next
6 few days with various bodies who tried to assist in
7 having, for example, a mobile unit delivered to Watford
8 Hospital. But, come the 4th, as a result of the
9 critical incident being declared, approximately 60
10 ambulances were diverted and seven in-patients were
11 transferred to other hospitals out from Watford General.
12 I should add that, by the end of the day, oxygen
13 capacity had been increased and seven days later new
14 evaporators were delivered. But that is a snapshot of
15 the types of problems caused by an ageing estate that
16 couldn't supply the requisite amount of oxygen to the
17 hospitals.

18 Now, I turn now to some of the other matters set out
19 in Module 3's scope and, firstly, the position in
20 relation to GPs. For many of us, the GP is the first
21 port of call and, at the onset of the pandemic, there
22 were approximately 35,000 full-time equivalent GPs in
23 the UK but, as Dr Michael Mulholland, the Honorary
24 Secretary of the RCGP, will tell you, there were
25 concerns pre-pandemic that there were simply not enough

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1 technical memoranda. Those memoranda give advice and
2 guidance on the design, installation and operation of
3 specialised building and engineering technology for use
4 in healthcare settings. There are similar HTMs in
5 Scotland and the HTMs were written before the Covid-19
6 pandemic, and Professor Beggs will tell you that
7 ordinarily they prioritise comfort and energy efficiency
8 over infection. He considers the HTMs to be outdated,
9 based on the current understanding of airborne
10 transmission and in urgent need of updating.

11 I mentioned oxygen supply issues. The impact of the
12 ageing NHS estate on pandemic response was also seen in
13 the capacity of the piped oxygen supply system in many
14 hospitals and that was a matter about which a number of
15 the spotlight hospitals were asked. By way of example,
16 you may have recalled seeing reports in the news about
17 oxygen supply issues in Watford General. That was one
18 of the Inquiry's spotlight hospitals.

19 Now, back on 4 April 2020 the hospital declared
20 a critical incident due to oxygen supply issues. In
21 short, the previous month they had wanted to undertake
22 an urgent upgrade of their ability to supply oxygen but,
23 unbeknownst to the hospital's trust, the Department of
24 Health had instructed that work is stopped on bulk
25 oxygen systems that had not been prior approved. A few

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1 GPs to meet the level of demand.

2 Pre-pandemic the RCGP also called for investment to
3 increase an enhanced digital infrastructure, and you may
4 think that recommendation was rather prescient given
5 that the pandemic saw a significant increase in remote
6 consultations. Module 3 has instructed Professor Adrian
7 Edwards to prepare an expert report on the impact of the
8 pandemic on general medical practice. One of the
9 matters he highlights is the rise in the number of
10 telephone appointments during the pandemic. To give one
11 example, in England in March 2020 there were 6.6 million
12 telephone appointments; one year on there are
13 11.4 million.

14 It should be noted, however, that both
15 Professor Edwards and, indeed, the RCGP consider that
16 remote consultations are not appropriate for all
17 patients. This echoes the sentiments of many
18 contributors to Every Story Matters, who spoke of how
19 difficult it was to assess patients without seeing them
20 in person. They described remote consultations as risky
21 and worrying. Contributors said they lost valuable
22 insights they would usually gain from in-person
23 appointments. There were significant fluctuations in
24 GPs' workloads during the onset of the different waves
25 of the infection and across different parts of the

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1 country. During later stages of the pandemic, there was
2 a need for GP staff to support the vaccination effort,
3 alongside their usual care, and there was a significant
4 impact on GPs in relation to shielding.

5 Staff in every general practice had to go through
6 their systems identifying patients who should be advised
7 to shield. Those systems were imperfect. Not all
8 illnesses were recorded that would have correctly coded
9 in a patient's records; mitigations, again, which would
10 have influenced assessment weren't necessarily recorded
11 in the records; and you may hear concerns that from the
12 outset it was unclear who should be in the shielding
13 group and should not. Practices report receiving
14 a significant number of calls from patients asking for
15 advice on this.

16 Professor Edwards considers that the evidence
17 suggests that overall people's experience of accessing
18 a GP is deteriorating. The pandemic exacerbated the
19 problems with access. He considers there to have been
20 a lack of pre-pandemic planning for primary care and
21 points to a stark contrast between the lack of plans
22 pre-pandemic with what he describes as a deluge of
23 guidance which was then issued, I think a matter that
24 was referred to in the video that we saw this morning.
25 That deluge was described by one GP nurse who told Every

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1 for community pharmacy services. It included
2 a substantial increase in the number of patients seeking
3 advice for more serious conditions or mental health
4 issues, and it led to a rise in the number of
5 prescriptions being issued. There were demands placed
6 on pharmacists when the vaccine was rolled out,
7 alongside the sector's own struggles with pharmacists
8 becoming ill with Covid-19 and self-isolating.

9 An indication of some of those pressures on
10 pharmacists may be gleaned from Every Story Matters
11 where one community pharmacist said this:

12 "Because doctors shut down, oh my God, it became
13 hysteria. We had days where there was 80 or 90 people
14 queuing outside the pharmacy."

15 You will hear there is concern amongst pharmacists
16 that they were overlooked and that community pharmacy
17 was not considered alongside other NHS service
18 providers. It led to community pharmacy not having the
19 support it needed throughout the pandemic. To just give
20 you two examples, pharmacy teams were initially excluded
21 from the life assurance scheme announced in England in
22 April 2020, which guaranteed a £60,000 life assurance
23 payout to families of, I quote, "eligible frontline
24 health and care staff in England who died from the
25 virus".

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1 Story Matters:

2 "I had probably on average about 20 different
3 guidelines to read on a daily basis at work. At the end
4 of the day, we were focusing more on reading these
5 guidelines than we were on actually actioning for our
6 patients. It took away a lot of precious clinical time
7 and patient experience."

8 Professor Edwards will also explain some of the data
9 relating to face-to-face versus virtual appointments
10 but, as he points out, it is not all about statistics
11 but the potential effect on patient care. To quote him,
12 if I may:

13 "General practice care is not transactional in
14 nature, it is relational."

15 Pharmacists are a matter that Module 3 will
16 consider. Data suggests that in 2022 there were over
17 14,000 registered pharmacies and community pharmacies
18 across the UK and you will hear that those figures are
19 lower when compared with pharmacy data published in 2019
20 in August. Whether that decrease is as a direct result
21 of the pressures brought to bear on pharmacies by the
22 pandemic may be difficult to establish, but the pandemic
23 undoubtedly had a number of impacts on pharmacies and
24 pharmacists.

25 The reduced access to GPs led to a surge in demand
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1 As originally planned, the scheme would only extend
2 to pharmacists in exceptional circumstances. However,
3 the government soon changed its mind and included
4 pharmacists in the scheme and it is worth noting, for
5 example, that a similar scheme in Wales included
6 pharmacists from the outset.

7 Pharmacists consider they were overlooked in
8 relation to PPE, where community pharmacy initially had
9 to source its own PPE, and in May 2020, when the
10 Department of Health launched a portal to provide access
11 to PPE, it was only made available to GP surgeries and
12 small care homes. It took many months, until the late
13 summer of 2020, for pharmacists to be finally allowed
14 access to the portal. You will hear, by contrast, that
15 different arrangements for supply of PPE to pharmacies
16 in Scotland, for example, led to fewer problems
17 accessing PPE.

18 My Lady, the feasibility of implementing IPC
19 guidance in pharmacy settings is likely to be another
20 feature of the evidence, along with that issue of PPE.

21 In April, so just a month into the pandemic, 34% of
22 pharmacists responding to a Royal Pharmaceutical Society
23 survey said they were unable to source continuous
24 supplies of PPE, 94% of respondents said they were
25 unable to maintain 2 metres social distancing from other

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1 staff and 40% of respondents said they were unable to
2 maintain social distancing from patients.

3 Risk assessments appear to be an issue in the
4 pharmacy sector. There are results from a survey from
5 the RPS and the UK Black Pharmacist Association in June
6 2020 that found that more than two-thirds of pharmacists
7 and preregistration pharmacists from ethnic minorities,
8 across primary and secondary care, had not yet had
9 access to a Covid-19 risk assessment. That was nearly
10 two months after the NHS said they should take place.

11 Can I turn to 999, 111 and ambulances. Across the
12 UK, there are ten ambulance trusts in England, a Welsh
13 ambulance trust, a Northern Ireland Ambulance Service
14 Health and Social Care Trust and there is a Scottish
15 Ambulance Service. All the ambulance trusts are
16 responsible for provision of 999 services in England and
17 Wales. They also are responsible for 111 services. In
18 Scotland it's called NHS 24 that covers the 111 service
19 and in Northern Ireland, although they don't usually
20 operate 111, they did have that service during the
21 pandemic.

22 The Inquiry has statements from all these
23 organisations from which a number of issues emerge.
24 First, there was the obvious increase in calls to 111
25 and 999, and an inevitable impact on response times to

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1 pandemic, temporary changes were made to the pathway for
2 a patient who contacted the service with confirmed or
3 suspected Covid. This was known as protocol 36 and, in
4 short, if protocol 36 applied, the patient was triaged
5 into a lower category and had to wait longer for an
6 ambulance response. Professor Snooks, the Inquiry's
7 expert, looked at prehospital care and will take you
8 through the details of the changes and the impact in
9 more detail.

10 NHS 111 in England and Wales and Northern Ireland,
11 and NHS 24, provide initial assessment and triage for
12 those needing urgent but not emergency advice and care.
13 Unsurprisingly, demand on those services significantly
14 and rapidly increased and, again, Professor Snooks
15 considered the efficacy of the initiatives and the
16 impact on the safety and quality of care provided for
17 those ringing that service. She found a high number of
18 calls went unanswered and considers that, in summary,
19 although there was some merit in the use of triage
20 tools, they were not always accurate in identifying
21 calls that did and did not need immediate care.

22 There are issues related to the appropriateness or
23 otherwise of IPC guidance and, in particular, which type
24 of mask was recommended for people working in
25 ambulances. There are also concerns about access to and

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1 calls and an ambulance arriving. To take just one
2 example, the London Ambulance Service took 214,000 calls
3 in March 2020, which was an increase on the previous
4 month. The average time to answer rose from four
5 seconds in January 2020 to 200 seconds -- that's
6 3 minutes 20 -- in March 2020 and, on 26 March 2020,
7 there was a peak where it took nearly ten minutes to
8 answer a call.

9 The increase in demand on London Ambulance Service
10 coincided with a spike in sickness of their staff, with
11 up to 20% of their staff off sick in March of that year.
12 There was an increase in demand for ambulances and so
13 the module will consider how patients were prioritised
14 to receive an ambulance and for escalation by way of
15 conveyance to hospital and the impact this had on the
16 paramedics and indeed the call handlers.

17 The prioritisation of calls received by 999
18 ambulance call handlers -- this is not specific to the
19 pandemic -- there are, as you will hear, two triage
20 systems used across the UK, which categorise calls by
21 colour or number, depending on the nation, and that
22 dictates the severity of the patient's condition and
23 therefore the target response time in which they should
24 receive an ambulance response, if one is sent at all.
25 Those targets vary between each nation but, during the

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1 the suitability of PPE. Can I pause there and ask
2 my Lady to think about some of the realities faced by
3 paramedics attending a patient's home and then taking
4 them to hospital.

5 Paramedics did not necessarily know whether the
6 patient, or indeed anyone else in the address, had
7 Covid-19. It was not possible to socially distance in
8 the back of an ambulance. The patient's condition might
9 mean that it was not appropriate for the patient to wear
10 a mask. There were often long delays outside hospitals
11 while waiting for the patient to be admitted. As the
12 College of Paramedics told the Inquiry, in January 2021
13 they experienced handover delays at hospitals of
14 sometimes between 10 and 12 hours, sometimes more. When
15 you think about that time of year, coupled with
16 temperatures of minus 2 degrees, that was not
17 an environment where a door for ventilation could be
18 opened without compromising the environment for the
19 patient.

20 There were the additional burdens caused by the need
21 to clean and decontaminate the vehicles and the College
22 of Paramedics, and indeed a number of ambulance trust
23 members, reported that the disposable aprons they were
24 provided as PPE were completely impractical and that,
25 once outside, any spillages or pathogens that might be

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1 on them were blown into the paramedic's face by gusts of
2 wind.

3 I touch there on the issue of handover delays and
4 your Ladyship will hear from Katherine Henderson, the
5 President of the Royal College of Emergency Medicine,
6 who speaks about the impact of handover delays on the
7 emergency departments. She notes the harmful effects on
8 patient care that are caused by delays in the emergency
9 department in assessing, treating and then deciding to
10 admit patients.

11 That brings me on in the patient journey to the
12 hospital and it hardly needs saying that, for some
13 people, Covid took a devastating toll on their physical
14 health, attacking, as it did, vital organs, the heart,
15 the lungs, the kidneys, such that there was
16 a significant increase in the need for more intensive
17 care beds and staff. Now, you will hear about the
18 attempts to increase intensive care capacity. There is
19 no doubt that it did increase but you will nonetheless
20 need to consider whether there was still an inability to
21 care for some patients in an ICU setting with the amount
22 and type of care that they needed.

23 Two experts, Professor Charlotte Summers and
24 Dr Ganesh Suntharalingam have provided an expert report
25 and the headlines from the report are as follows. The

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1 was not enough capacity. They will tell you that the
2 transfers are regarded as the last resort.

3 Then if we look, please, though at this graph on
4 screen, this is the mean daily inter-hospital transfers
5 between critical care units across the UK, and you have
6 set out there the position as it was in the two years of
7 the run-up to the pandemic, the dotted line roughly
8 representing when the pandemic started. You can see
9 there the rise, particularly for example in early 2021,
10 where the number of people being transferred out to
11 a bed elsewhere rose dramatically.

12 I just say one thing about the graph. It is one of
13 a suite of graphs prepared for the Inquiry thanks to the
14 joint efforts of two organisations, ICNARC and SICSAG.
15 ICNARC is the Intensive Care National Audit and Research
16 Centre. It collects data from intensive care units and
17 high dependency units across England, Wales and
18 Northern Ireland. And SICSAG is the Scottish Intensive
19 Care Society Audit Group, performing a similar role in
20 Scotland. At the Inquiry's request, ICNARC and SICSAG
21 worked together to produce a combined report of
22 comparable ICU statistics that will be looked at and we
23 are extremely grateful to both organisations for their
24 considerable assistance.

25 During the pandemic, there was great concern amongst

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1 UK entered the pandemic with less ICU capacity, by which
2 I mean fewer staff equipped ICU beds than other
3 developed countries and healthcare systems. Figures
4 provided by the Intensive Care Society indicate the UK
5 entered the pandemic with just 7.3 critical care beds
6 per 100,000. By contrast, Germany had 28.2 beds per
7 100,000 and the Czech Republic had 43.2 critical care
8 beds per 100,000.

9 The experts will tell you patients were looked after
10 in ways that were stretched and diluted compared to
11 usual critical care, sometimes in makeshift ICUs,
12 sometimes far from home, and much of the time with no or
13 limited access to their families. Think about the
14 impact on ICU staff caring for the most seriously ill
15 patients. Results of surveys indicate that many staff
16 would meet the criteria for being diagnosed with
17 a mental health disorder, including post-traumatic
18 stress disorder.

19 An indication of the strain that ICU was under can
20 be seen through the lens of what is called
21 inter-hospital critical care transfers. Now, they rose
22 dramatically during the pandemic and that was not
23 because ICU patients were being transferred to perhaps
24 more specialist care or being moved nearer to home but,
25 as you will hear from the experts, simply because there

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1 the medical profession that frontline doctors would be
2 called upon to make ethically and legally challenging
3 decisions about which patients should be escalated to
4 critical care in the event there was no more critical
5 care capacity. We will hear that for a brief period of
6 time the Department of Health convened a working group
7 to consider and develop a clinical prioritisation tool
8 to be used in the event that saturation of critical care
9 resources was reached.

10 One of the experts, Dr Suntharalingam, was a member
11 of that working group and he will explain its work and
12 the tool itself in more detail. In fact, the tool was
13 stopped very shortly after it was asked to be worked on
14 because it was considered that critical care resources
15 would not in fact be so stretched that the tool was
16 needed.

17 Now, irrespective of whether that assessment of
18 critical care resource was correct, there are parts of
19 the profession that felt adrift in the absence of any
20 national guidance about how to prioritise patients in
21 need of critical care. To many, the idea that the UK
22 even needs to consider drafting such a tool would be
23 unpalatable but, as, for example, the British Medical
24 Association point out, had workable guidance been
25 available then, in the BMA's view, this would have gone

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1 a considerable way to addressing doctors' concerns about
2 personal or legal liability and would have helped manage
3 moral distress.

4 Moral distress occurs when you believe you know the
5 ethically correct action to take but you're constrained
6 from taking it. It would have meant, had there been
7 such a tool, that all healthcare professionals would
8 have been following the same guidance and it is clear
9 that in the absence of a national decision-making tool
10 some hospitals, including for example one of the
11 spotlights, developed their own policies for level of
12 care decisions where there were limited resources.

13 My Lady, I referred to diluted care a moment ago,
14 and one aspect of diluted care is reduced staffing
15 ratios. Intensive care units are overseen by dedicated
16 teams. Ordinarily, ICUs have one nurse with specialist
17 critical care training per patient. During the
18 pandemic, in some places the ratios were stretched to
19 one critical care nurse to four or even six patients,
20 with some additional support being provided by nurses
21 and support workers who did not have critical care
22 skills.

23 The chief nursing officers in the UK and other
24 witnesses will provide evidence about the impact of
25 those changes on the nursing profession, and the impact

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1 merely to hear directly from a number of frontline staff
2 about the challenges they faced when dealing with
3 escalation decisions.

4 And can I ask, please, that we call up the survey.

5 Can I invite your Ladyship to publish the entire
6 survey later today.

7 If we go, please, to page 3 in the survey, this is
8 just from the executive summary, but it sets out there
9 that of the 1,683 healthcare professionals from the mix
10 of roles that were spoken to, over half of those
11 healthcare professionals reported some patients could
12 not be escalated to the next level of care due to lack
13 of resources during either wave.

14 And if you look, A&E doctors and paramedics were
15 more likely to have been unable to escalate care due to
16 a lack of resources. The primary reasons: the lack of
17 available beds, lack of staff. And finally, in the
18 bottom box there, four fifths (81%) of healthcare
19 professionals agreed that more patients were unable to
20 be escalated during the pandemic compared to before.
21 Over two-thirds agreed that patients who were unable to
22 be escalated were more severely ill.

23 That resonates, you may think, your Ladyship, with
24 the paramedic on the video this morning who spoke about
25 the difficult decisions that he had to make.

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1 of the pressures on ICU on patient care and outcomes.
2 Whilst that may be difficult to ascertain and quantify,
3 there is evidence that suggests that the pandemic
4 resulted in a rationing of care and/or poorer outcomes.

5 Can I pick two examples. You may wish to consider
6 what ICNARC call "ICU capacity strain", that is
7 a mismatch between supply and demand, with availability
8 of beds, staff and/or other resources, and the need to
9 admit and provide care for critically ill patients, the
10 demand. Pre-pandemic, ICNARC reported that higher
11 strain was associated with higher hospital mortality, so
12 ICNARC sought to determine whether patients admitted to
13 an ICU during times of strain experienced a higher risk
14 of death. The short answer is that they did. The
15 greater the mismatch between the supply and the demand,
16 the more likely it was that a patient who was admitted
17 to intensive care would die.

18 As part of its work the Inquiry commissioned
19 a research company to conduct a survey of healthcare
20 professionals. It included GPs, A&E staff, general
21 hospital wards, doctors, and it was asking those
22 healthcare workers about the decisions about escalation
23 of care in waves 1 and 2.

24 Now, I stress it was not intended to be
25 a representative survey, nor could it be, but it was

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1 Taking those pieces of evidence as a whole, you may
2 think there is a picture being painted not only of
3 a healthcare system creaking at the seams but a sense of
4 the scale of the hugely difficult decisions being
5 repeatedly made by healthcare workers which affected who
6 was escalated for treatment and who was not.

7 Let me deal briefly, please, if I may, with those
8 efforts to increase hospital capacity. There were
9 nearly 900,000 admissions of Covid patients to hospital
10 across the UK. Measures taken to increase capacity
11 included suspending elective care, that's planned
12 surgery, a decision that was taken by in each of the
13 four nations just before the UK went into lockdown.
14 It's an undoubted indirect harm, you may think.

15 There was the discharge decisions of those medically
16 fit. There was the rearranging of the layout of
17 hospitals to increase the number of beds. There was the
18 building of the Nightingales and field hospitals,
19 increasing to staffing capacity by redeploying others to
20 work on acute and critical wards, by introducing
21 a temporary register for returning healthcare workers by
22 using trainee doctors, student nurses, trainee
23 paramedics to help bolster the staffing capacity. And
24 there was the use of private hospitals across the
25 healthcare system. Those arrangements are not new but

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1 during the pandemic how private hospitals were used
2 varied from nation to nation. Those measures will be
3 examined in more detail throughout the hearing.

4 Let me just say something about Nightingales,
5 please, if I may.

6 Can I call up on screen, please, page 19 of
7 INQ000474319.

8 During the pandemic there were the Nightingale
9 hospitals in England and Northern Ireland, the
10 Louisa Jordan as it was known in Scotland, and in Wales
11 the use of planned and actual field hospitals often used
12 as step-down facilities. They were all set up to
13 provide extra capacity as modelling suggested that
14 demand for hospital beds might be exceeded.

15 My Lady, I'm not going to take you through what can
16 be seen on the map. There are: one in Scotland, two
17 hospitals in Northern Ireland, a number of planned and
18 actual hospitals in Wales, and seven in England.

19 We have obtained evidence from all of those who can
20 speak to why they were set up, how they were used. It
21 was not all that were used for Covid patients. They
22 were not all critical care capacity. They were used in
23 a variety of ways: to carry on elective surgery, used as
24 vaccination centres in due course; and the evidence that
25 we will consider will look at that.

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1 impact on infection control measures and on the ability
2 of the NHS and care sector to 'surge up' capacity during
3 a pandemic ... The health and social care services in
4 Wales and Scotland confronted similar challenges to
5 England."

6 My Lady, may I pause there and invite you to
7 consider taking an early lunch? I have a few matters
8 that I would like to address afterwards, but if
9 your Ladyship is content, and indeed the stenographer
10 is, I'm happy to carry on for another few minutes. I'm
11 in your Ladyship's hands.

12 **LADY HALLETT:** Perhaps carry on just for a few more minutes.

13 **MS CAREY:** Certainly.

14 Can I turn then to matters relating to death, end of
15 life and DNACPRs. This is an undoubtedly distressing
16 and painful topic when considering the numbers of people
17 who died. The first Covid death in England was on
18 5 March. It was a little bit later in Scotland, on the
19 13th, three days later in Wales, and two days after that
20 in Northern Ireland.

21 You know at the outset I said there were 186,668
22 deaths involving Covid-19.

23 Can I just look briefly, please, at page 20 of the
24 document, thank you.

25 Can I ask your Ladyship to look at the second column

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1 Staffing capacity is clearly a matter of concern.
2 There were high vacancy rates across all sectors of
3 the UK going into the pandemic. Nursing levels were low
4 and nursing vacancy rates were high. And clearly Covid
5 caused additional staffing pressures. For example, in
6 England in April 2020, figures provided by the BMA
7 suggest that 30% of recorded NHS staff absences were
8 Covid-related. In Scotland, there were absences that
9 were highest in April and June 2020. In Wales, absences
10 peaked in April 2020. And in Northern Ireland, absence
11 due to Covid-19 was actually highest in January and
12 March 2022. If one stands back, it appears that the UK
13 entered the pandemic with not enough staff, it was then
14 compounded by staff absence through illness, staff being
15 absent through shielding, staff lost because they had
16 Long Covid, and that's before one even considers the
17 long-term impact on the morale and wellbeing of
18 healthcare workers who were simply burnt out.

19 It is little wonder, therefore, as you stated in the
20 Module 1 report:

21 "The Inquiry also heard that there were severe staff
22 shortages and that a significant amount of the hospital
23 infrastructure in England was not fit for purpose ..."

24 You said this, my Lady:

25 "This combination of factors had a directly negative

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1 that refers to age-standardised mortality rates per
2 100,000. It will be appreciated that England has by far
3 the largest population in the UK and so, as you would
4 expect, it has a higher number of recorded deaths, but
5 the age-standardised mortality rates allows comparisons
6 to be made against the different population sizes,
7 different age distributions, and you will see there that
8 Scotland, towards the bottom of the table, in fact had
9 the lowest rate of deaths per 100,000, at 124.9, England
10 has 145, Wales was slightly less than that at 144, and
11 indeed Northern Ireland slightly less at 130.

12 As is often the case when looking at statistics,
13 there needs to be a degree of caution as there are
14 inevitably caveats and qualifications. There were
15 differences in the way that the Department of Health
16 recorded deaths. It was initially there had to be
17 a positive test. That was changed in due course.
18 Again, in August 2020, it was changed and deaths were
19 counted as Covid deaths if the patient died within
20 60 days of testing positive.

21 The availability of testing will also have an effect
22 on how Covid was recorded on a death certificate, and of
23 course there was limited testing capacity at the start
24 of the pandemic, which may mean that some patients died
25 who may have had Covid but were not tested and therefore

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1 not recorded as a Covid death whether by any of the
2 health authorities or statistical agencies.

3 Ascertaining how many healthcare workers died of
4 Covid-19, and of that number those who caught the
5 infection at work, is not straightforward due to
6 competing estimates and incomplete information. Figures
7 from the statistics authorities across the UK indicate
8 there have been 904 deaths involving Covid-19 of
9 healthcare workers.

10 Now, that figure only includes those aged between 20
11 and 64 and covers slightly varying time periods.
12 Contrast that with data provided by NHS England who, as
13 at 3 July 2023, had recorded 559 NHS staff as having
14 died of Covid-19. It will immediately be seen that the
15 ONS has a higher count than the figures provided by
16 NHSE, and that is a matter of concern to some of the
17 core participant groups.

18 In Scotland, the health boards reported 97 staff to
19 have died. The Welsh Government does not hold or
20 publish official or verified data on the number of NHS
21 staff who died. In Northern Ireland the Department of
22 Health asked the trusts to provide the daily number of
23 deaths of health and social care workers, but the
24 department has told the Inquiry it does not hold any
25 collated data.

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1 Evidence from the HSE notes that RIDDOR was drafted
2 to capture single one-off unexpected events and was not
3 intended to be used in a pandemic involving thousands of
4 incidences of infection, where an employer may be
5 required to make a judgement as to whether the worker
6 caught it at work as a result of workplace exposure or
7 from the wider community.

8 My Lady will hear from a witness from the HSE who
9 will go into this in more detail, but the HSE itself
10 looked at the data, which was collected from
11 10 April 2020. RIDDOR reporting indicates there were
12 12,330 non-fatal occupational disease reports, and
13 170 fatal reports between their reporting in April 2020
14 and March 2022. The HSE unsurprisingly have noted there
15 appeared to be both under-reporting and overreporting of
16 Covid-19 by employers in healthcare settings.

17 Now, on any view, the fatal reports are lower than
18 one might have expected given the ONS and indeed the
19 NHS England figures that I outlined relating to
20 healthcare worker deaths. And you will hear from
21 Kevin Rowan, the head of organisational services at the
22 TUC, which sets out their concerns about the
23 under-reporting of Covid-19. That's a topic likely to
24 be touched on by other witnesses as well.

25 **LADY HALLETT:** Thank you very much, Ms Carey. We'll take

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1 I'm told I have misread. I said 97 Scottish staff
2 died. It's 27, forgive me. Thank you.

3 We have obtained evidence about the deaths of
4 healthcare workers from the 22 spotlights, six of whom
5 reported no deaths. Some of those numbers vary because
6 sometimes they have included the data from hospitals or
7 trusts, not always separating each.

8 There are regulations, which may be a good point to
9 deal with just before lunch and then leave some other
10 matters to just after.

11 There are regulations in place that may be a way of
12 ascertaining the number of healthcare workers' deaths.
13 They are called the RIDDOR regulations: the Reporting of
14 Injuries, Diseases and Dangerous Occurrence Regulations
15 2013. RIDDOR requires, in this context, employers to
16 report specified workplace incidents to the Health and
17 Safety Executive. In the context of healthcare workers
18 in a healthcare setting, the HSE considers that those
19 reportable incidents includes cases of disease or deaths
20 arising from Covid only when the employee has been
21 infected with the virus through deliberately working
22 with it, such as in a laboratory or being incidentally
23 exposed to the virus. Incidental exposure can occur
24 within a healthcare setting where people are known to
25 have Covid, known as occupational exposure.

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1 the luncheon break now. I shall return at 1.50.

2 **(12.50 pm)**

3 **(The short adjournment)**

4 **(1.50 pm)**

5 **LADY HALLETT:** Ms Carey.

6 **MS CAREY:** My Lady, I know you've heard about DNACPRs from
7 your meetings with the bereaved groups, and so I turn to
8 this topic next. It is undoubtedly a highly emotive
9 topic, and have I would like to spend a moment
10 explaining DNACPRs. Some of the people following this
11 may find some of the detail distressing, so there may be
12 people that either wish to leave the hearing room or
13 rejoin the link in a moment or two.

14 Cardiopulmonary resuscitation, or CPR, is an
15 emergency procedure that aims to restart a person's
16 heart if their heart stops beating or they stop
17 breathing. It can involve chest compressions, delivery
18 of high voltage electric shocks across the chest,
19 attempts to ventilate the lungs and injection of drugs.

20 It is, as you will hear, an invasive and traumatic
21 medical intervention, and most CPR, sadly, is
22 unsuccessful. The survival rates are relatively low.
23 In hospitals the average proportion who survive is 15%
24 to 20%. Out of hospital, the survival rate is lower.

25 Due to the nature of the treatment, in some

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1 circumstances CPR can do more harm than good and can
2 cause physical injury to the patient, in particular to
3 their lungs and ribs.

4 A DNACPR notice sets out a decision not to attempt
5 CPR. They are designed to protect people from
6 unnecessary suffering by receiving CPR that they don't
7 want or that won't work or where the harm outweighs the
8 benefits.

9 May I make this clear: it is a specific decision
10 made in respect of CPR alone and it is not a decision
11 not to treat. It should not and must not be confused or
12 elided with an advance care plan, which is commonly the
13 umbrella term used for a document which records
14 individuals' preferences and decisions about their
15 future care and treatment.

16 DNACPR decisions are made or should be made based
17 only on clinical judgement, usually by the clinician
18 responsible for the person's care, and wherever possible
19 and appropriate a decision about CPR should be agreed
20 with the whole care team involved in the person's care,
21 and wherever possible made in consultation with the
22 person. A person can state that they do not want CPR to
23 be attempted as part of their advance care planning, and
24 that will be taken into consideration by the clinicians
25 who are making decisions.

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1 start of the pandemic, and a sense of providers being
2 overwhelmed.

3 CQC found there was evidence of unacceptable and
4 inappropriate DNACPRs being made, but they did note
5 there was a quick response from multiple agencies to
6 highlight the issue. They remained concerned, however,
7 that there were some cases where inappropriate DNACPRs
8 remained in place.

9 The CQC's final report in March 2021 found what the
10 CQC described as a worrying picture of poor involvement,
11 poor record-keeping and a lack of oversight and scrutiny
12 of the decisions being made. CQC considered there was
13 significant impact and distress caused where discussions
14 about DNACPR decisions did not take place at
15 an appropriate time. Every Story Matters has heard
16 accounts of how some people only discovered a DNACPR
17 being put in place after their loved one had died or
18 after they were discharged from hospital.

19 To quote just one contributor, they said this to
20 Every Story Matters:

21 "We didn't know he had a DNR ... and my mum
22 had power of attorney ... The only reason we know is
23 because when he was discharged, it was in his pack. But
24 the fact that we weren't involved in the decision and
25 knowing that dad's got Alzheimer's, it kind of felt like

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1 The General Medical Council has issued guidance that
2 makes it clear that if the patient lacks capacity to
3 make a decision, a legal proxy, for example a power of
4 attorney, may in fact make the decision for the patient,
5 but they must be consulted unless it is not practicable
6 or appropriate to do so. If there is no legal proxy,
7 the matter then must be discussed with those closest to
8 the patient and with the healthcare team.

9 Now, during the course of the pandemic, there were
10 reports of blanket DNACPRs being imposed. For example,
11 the BMA heard reports of GP practices sending blank
12 DNACPR forms to patients over 65 or to those with
13 a disability. There are also reports of DNACPRs being
14 used inappropriately.

15 The four nations' departments communicated with
16 healthcare professionals in a variety of ways and at
17 various times to remind healthcare professionals or to
18 reiterate that any DNACPR decision must be made on the
19 particular and individual circumstances of each patient
20 and that it was unacceptable to apply DNACPRs to
21 particular groups.

22 I think you may have heard that the DHSC
23 commissioned the CQC to look at DNACPR decisions. Their
24 interim report found that there was confusion and
25 miscommunication about the application of DNACPRs at the

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1 they were throwing away old people. It was like they're
2 not a priority because they're old."

3 That lack of communication, plus the concerns about
4 blanket and inappropriate applications of these notices,
5 are matters raised by the representatives from the Covid
6 bereaved core participant groups, who will give evidence
7 about the DNACPRs and a whole range of their other
8 concerns at the beginning and indeed at the end of the
9 public hearings.

10 I mentioned there that the bereaved core participant
11 groups are the first witnesses to be called across the
12 UK, and you will hear about the circumstances in which
13 their loved one died and the impact this had and
14 continues to have on them and their families.

15 Every Story Matters report includes a chapter on
16 end-of-life care and bereavement and it records the
17 pain, upset, guilty and often anger expressed by those
18 who could not be with their loved ones in their final
19 days. To quote just one contributor who said this:

20 "My mother was lying on a bed with something out of
21 space standing by her [a reference to staff in PPE], she
22 was being told to wave to her family on an iPad she
23 waved like a child and the zoom call ended. The doctor
24 told her she's not going to wake up again, so she waved
25 so hard to say goodbye to her family. I couldn't

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1 believe the doctors told her that, that she wouldn't
2 wake up after the ventilator. We watched our mother on
3 an iPad on a ventilator dying."

4 My Lady, whilst the need to prevent the spread of
5 infection in hospitals was clearly a very key
6 consideration in not allowing visitors, not being at the
7 bedside of a dying loved one, it has caused the most
8 immense pain and harm. Many of the witnesses you will
9 hear from do not suggest anything other than this was
10 a difficult balancing act, but, my Lady, this is one
11 area you may feel that the UK may need to act
12 differently if there were to be future pandemic. You
13 may think it cannot be beyond the capabilities of our
14 society to provide dignity in death, to facilitate
15 visitors at the end of life, and these may be matters
16 that you'll wish to consider, both in this and indeed in
17 future modules.

18 Protecting the vulnerable was clearly an aspect to
19 the shielding programme. There is both the clinically
20 vulnerable, the clinically extremely vulnerable, and
21 those at highest risk (as they were renamed in Scotland
22 in June 2021). This was a priority for the healthcare
23 systems across the UK, and it was the chief medical
24 officers who decided the initial groups that they
25 considered to be at highest risk, and groups were added

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1 concern at the lack of support and advice they received.

2 My Lady, the decision to require large numbers of
3 the population to shield is not without its supporters
4 and indeed its critics, and whilst the role of
5 non-pharmaceutical interventions was something you've
6 already examined in Module 2, there are particular
7 aspects of the shielding programme which Module 3 will
8 examine.

9 Some of those issues include: the decision-making
10 process to identify those deemed as clinically extremely
11 vulnerable, clinically vulnerable and at highest risk,
12 how that was communicated to those groups; how it was
13 decided to pause the programme, restart it again,
14 finally stop it, the dates of those decisions varied
15 across the UK and not every nation restarted the
16 programme; and you will want to consider how those who
17 were shielding accessed healthcare and more generally
18 the impact of the shielding programme on those who were
19 shielding.

20 Many people have spoken of the significant and
21 deleterious impact shielding had, including to Every
22 Story Matters, on their physical and mental health.
23 Indeed you will hear impact evidence from
24 Dr Catherine Finnis on behalf of the core participant
25 group Clinically Vulnerable Families. She will be able

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1 as the pandemic progressed.

2 Initial shielding advice was issued across the UK
3 from about 21 March onwards in 2020, and those who were
4 deemed to be clinically extremely vulnerable were
5 advised to shield for at least 12 weeks by staying at
6 home as much as possible, except for attending essential
7 medical appointments or for exercise, and they were
8 advised to avoid face-to-face contact with people
9 outside their household.

10 Now, that created real practical difficulties for
11 those who required medical appointments, required repeat
12 prescriptions, conditions that needed monitoring, as
13 well, of course, as going about one's daily life and the
14 usual routines of going to the shops.

15 That 12-week period was extended and then overlapped
16 with periods of lockdown over the following 18 months
17 with local variations. People identified as being
18 clinically vulnerable included those over 70, pregnant
19 women and those with a chronic condition or morbid
20 obesity. They were also told to stay at home as much as
21 possible and to be strict in social distancing, but the
22 clinically vulnerable were not included in the shielded
23 patient list and did not receive letters or support to
24 self-isolate through the shielding initiative. That
25 created, you may hear, a degree of additional stress and

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1 to attest to the ways in which group members were
2 affected, and indeed Professor Snooks will speak to
3 a number of aspects of the shielding programme and of
4 the difficulties in evaluating its efficacy.

5 One other matter you have heard about is Long Covid,
6 Long Covid is the term used to describe the ongoing
7 symptoms caused by Covid-19. Sometimes it's referred to
8 as the post-Covid-19 syndrome but I'm going to use the
9 phrase Long Covid if I may.

10 During the course of the Module 2 you will recall
11 hearing from Professor Brightling and Dr Evans, and
12 they've prepared an addendum report for Module 3. They
13 explain that Long Covid is frequently characterised by
14 fatigue, breathlessness, brain fog, joint and muscle
15 pain, but there are in fact over 200 symptoms that have
16 been reported, and studies have shown the reduction in
17 quality of life and significant impacts on the
18 sufferer's ability to continue to do the job they did
19 before developing Long Covid, in some cases their
20 ability to do a job at all.

21 It is not easy to diagnose, as you know. Evidence
22 provided by the Long Covid core participant group
23 attests to concerns about the length of time taken for
24 their members to have their symptoms taken seriously and
25 their members report having their symptoms disbelieved

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1 and/or minimised. That echoes accounts given to Every
2 Story Matters.

3 The experts will tell you that any adult is at risk
4 of developing Long Covid, although it is more common and
5 more likely to be more severe in females and those with
6 pre-existing health conditions. People who are not
7 hospitalised during their Covid infection can suffer
8 from Long Covid symptoms. They are just as severe as
9 those experienced by people who had been hospitalised.

10 Access to healthcare for Long Covid has been and
11 remains variable within and across the four nations of
12 the UK. There are Long Covid clinics in October started
13 in England. In Northern Ireland there was funding
14 granted in November 2021 for a dedicated assessment and
15 treatment centre. And whilst there don't appear to be
16 Long Covid clinics in Wales and Scotland, there was
17 funding allocated in both countries for Long Covid care
18 and rehabilitation. ONS data suggests that the
19 vaccination prior to infection reduces the likelihood of
20 developing Long Covid.

21 My Lady, clearly healthcare workers were at higher
22 risk of exposure to Covid-19 infection throughout the
23 pandemic, with early studies highlighting the risk of
24 severe disease associated with certain ethnic minority
25 backgrounds.

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1 fields and, in particular, to look at the impact of
2 Covid on diagnosis, care and treatment of the non-Covid
3 conditions and how treatment and diagnosis are
4 maintained during the pandemic, the impact of the delays
5 on diagnosis and treatment, on patient outcomes and on
6 the patient's health.

7 The first of those conditions is ischaemic heart
8 disease. That is the most common form of heart and
9 circulatory disease, affecting over 2 million people in
10 the UK. Often it manifests itself as a heart attack or
11 angina, when the heart does not receive enough blood and
12 oxygen.

13 Professor Gale, the module's expert, states that the
14 pandemic witnessed a substantial decline in people being
15 admitted to hospital with heart attack. He notes that
16 the onset of the decline in admission was before the
17 first UK lockdown and states that, although it's not
18 known why this occurred, he considers it may be because
19 the public were fearful of coming to the hospital and/or
20 wanted to protect essential clinical services for people
21 with Covid-19 and/or sadly they died in the community.
22 That is a theme I suspect you will hear running
23 throughout the non-Covid conditions and indeed other
24 evidence.

25 He states that during the pandemic there were more

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1 According to the chief medical officers' technical
2 report, the precise number of people who have
3 experienced longer-term symptoms after Covid is likely
4 to be substantial but remains unclear. In July 2022 the
5 ONS estimated it was 1.4 million people in the UK. By
6 February 2023 the ONS estimated the prevalence to be
7 over 2 million people in the UK.

8 In my submission, those estimates are a powerful
9 reminder why considering the long-term consequences of
10 pandemic diseases need to not only be recognised at the
11 start of the pandemic but planned for wherever possible.
12 I know you will want to examine the extent to which
13 long-term consequences of Covid were considered as part
14 of core decision-making in those early days.

15 Module 3 has within its scope reference to non-Covid
16 conditions. The decision to suspend all non-urgent and
17 elective surgery has had and continues to have
18 a significant effect on non-Covid related healthcare.
19 Now, clearly it would not be practical or realistic for
20 the Inquiry to look at the impact on every single
21 illness or treatment that was stopped, and so Module 3
22 has selected some common and important health conditions
23 to examine in more detail. There are four in total and
24 I will briefly deal with them.

25 Instructed to help in this task are experts in those

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1 deaths from acute cardiovascular causes than expected
2 and, whilst hospital remained the most frequent place of
3 death, there were proportionately fewer deaths in
4 hospital and more deaths at home. He considers that the
5 data suggests the public either did not seek help for
6 suspected heart attacks or were not referred to hospital
7 for suspected heart attack and he warns that the
8 consequences of delay will lead to many more adverse
9 health consequences.

10 He considers that during the early part of the
11 pandemic there was a deficit of public information about
12 the importance of attending hospital with symptoms of
13 a heart attack.

14 The Inquiry is also going to look at colorectal
15 cancer, also called bowel cancer. That is the fourth
16 most common cancer in the UK. The two experts
17 instructed consider that there was a substantial
18 reduction in the number of patients diagnosed with bowel
19 cancer during the first wave of the pandemic across all
20 referral pathways, except for emergency presentations
21 which remained constant.

22 In the first phase of the pandemic there was a sharp
23 fall in referrals for suspected colorectal cancer and
24 subsequent diagnostic tests. The experts consider that
25 in the order of 3,000 to 4,000 patients from England,

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1 750 to 1,000 patients from Scotland, 500 patients from
2 Wales and 150 from Northern Ireland missed a diagnosis.

3 The experts' critical recommendation is to keep the
4 pathway of cancer services, meaning from diagnosis
5 through to treatment, open during the next pandemic and
6 they consider that ringfenced elective surgery hubs
7 should be more widely used to provide Covid-free
8 pathways.

9 The Inquiry is also considering hip replacement
10 surgery. Now, whilst the suspension of hip replacement
11 surgery was not life-threatening, evidence suggests that
12 delaying hip replacement surgery was life limiting. The
13 Inquiry's experts will tell you that the most common
14 reason for hip replacement is painful osteoarthritis and
15 that hip arthritis is very common. About 8% of the UK
16 population over 45 have sought treatment for
17 osteoarthritis of the hip. Professor Metcalfe and
18 Ms Chloe Scott will tell you that, where patients have
19 worse hip pain and function, they have worse
20 health-related quality of life prior to their hip
21 replacements but they also achieve worse patient
22 reported outcomes after surgery.

23 They will tell you that the pandemic led to
24 an increase in patients attending orthopaedic clinics
25 for the first time in wheelchairs, who had already lost
93

1 with severe eating disorders.

2 The experts instructed in this area will tell you
3 that the pandemic affected the provision of inpatient
4 treatment in a number of ways, it increased the waiting
5 time between referral and admission, there was
6 a substantial increase in time taken from the decision
7 to admit to actually being admitted onto a psychiatric
8 inpatient ward, the self-isolation rules resulted in new
9 patients who were admitted requiring varying lengths of
10 self-isolation. The experts will tell you that all of
11 these issues are likely to have increased the length of
12 stays and delayed the recovery of the young person.

13 They are just some of the impacts set out in the
14 experts' report and it may be that the consequences of
15 the pandemic on the mental health of children and young
16 people will be matters that will resonate with the
17 evidence that's gathered in Module 8, which is
18 specifically looking at the impact on children and young
19 people.

20 My Lady, Module 3 will also consider the impact of
21 the pandemic on pregnant women seeking maternity care,
22 including access to antenatal and postnatal care. The
23 prospect of attending maternity appointments, going into
24 labour and sadly, in some cases, receiving devastating
25 news about a pregnancy alone whilst IPC measures were in
95

1 their mobility and who had missed the opportunity to
2 have a hip replacement in a timely fashion and who are
3 now not suitable for hip replacement due to their
4 frailty.

5 One of the recommendations they ask you to consider
6 is that, in the event of a future pandemic requiring
7 suspension of elective surgery, there should be a body
8 committed to planning the prompt restoration of safe
9 elective care.

10 They consider that such planning needs to include
11 specific recovery targets with incentives for regions
12 and trusts to deliver them.

13 The final non-Covid condition is the Inquiry
14 considers it is important to consider the impact of the
15 pandemic on inpatient mental health services for
16 children and young people. The deterioration in the
17 mental health of children and young people during the
18 pandemic was stark. A statement from the chair of the
19 Royal College of Psychiatrists Faculty of Child and
20 Adolescent Psychiatry makes clear that the rates of
21 probably mental health disorders rose during the
22 relevant period. There is particular concern for
23 children and young people with eating disorders and
24 demand for those services increased substantially, as
25 did the number of children and young people presenting
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1 place were the reality for those seeking and providing
2 maternity care.

3 You will hear there was a reluctance by some
4 pregnant women to seek medical attention whether that's
5 through fear of themselves and/or their baby catching
6 Covid, or concerns about not overwhelming the NHS or
7 both.

8 There was a healthcare services safety investigation
9 branch who undertook an independent investigation. They
10 investigated 19 maternal deaths in England between March
11 2020 and May 2020 and they found that the families were
12 concerned about their health and the risks of exposing
13 their unborn baby to Covid-19. Because of those
14 concerns, they put off going to hospital for longer than
15 they may otherwise have done.

16 The evidence provided to the Inquiry overwhelmingly
17 suggests that having to attend appointments and being
18 given unexpected and/or upsetting news was one of the
19 most distressing aspects of the pandemic. The
20 Miscarriage Association conducted a survey and amongst
21 many of the quotations from that survey were these two:

22 "It was heartbreaking to lose my baby, the only
23 child I conceived in a three-year ongoing infertility
24 journey, confused, masked, distraught and without my
25 partner to hold my hand and grieve with me."
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1 Another lady said this:

2 "It was one thing being completely alone in hospital
3 and having my miscarriage confirms and having to decide
4 how to manage things, but knowing that the government
5 were having parties at the same time is disgusting and
6 fills me with so much anger. I remember meeting my
7 husband at the entrance to the hospital to decide on how
8 to manage things. I'll never forget the group of men
9 standing there, waiting for their partners to come out
10 from appointments and scans. It was so inhumane and
11 a memory I'll never forget."

12 It echoes an account given to Every Story Matters
13 where one contributor said this:

14 "I went to a routine midwife appointment but she was
15 worried about the baby and said she couldn't hear
16 a heartbeat. She said I needed an emergency ambulance
17 or to make my way to hospital quickly. We drove to the
18 hospital where they were expecting me. At the doors
19 I was told I was the only one allowed in. We thought
20 that the baby had died at 32 weeks gestation yet I had
21 to go in alone. This was one of the scariest moments of
22 my entire life. Meanwhile my partner had to wait
23 outside the hospital, waiting to be told if his baby was
24 alive or not."

25 There appears to have been inconsistency about the
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1 a GP mythbuster published which sought to reinforce that
2 GPs were still open, and in Wales there were similar
3 messages put by the Welsh Government and through local
4 partners and authorities to highlight the NHS was there
5 for people who needed urgent care.

6 The success or otherwise of those campaigns will be
7 explored as the hearing progresses. As I mentioned
8 earlier, Module 3's requests for evidence have asked the
9 recipients about the lessons they and their
10 organisations have already learned. That includes the
11 systemic issues that arose. They were asked to provide
12 your Ladyship with recommendations for you to consider
13 and, as the evidence unfolds, witnesses may be asked
14 about possible recommendations not because the Inquiry
15 has prejudged matters but so that those who may be
16 responsible for implementing them can assist as to how
17 workable they are, how efficacious they might be. That
18 a recommendation is not asked about does not mean it has
19 been dismissed or not been considered, simply that it's
20 not possible to ask every witness about every
21 recommendation.

22 So may I turn to where I started and the impact of
23 the pandemic on those receiving and providing care.
24 There is a further impact that deserves to be
25 highlighted. Many of the witnesses who speak on behalf
99

1 rules for visitors attending appointments throughout
2 labour and indeed afterwards. The pandemic affected
3 decisions about where to give birth and the types of
4 birth that women would have liked. In some areas, for
5 example, home births were suspended and midwifery led
6 units were closed. There were concerns about staff
7 shortages and PPE and concerns about the impact of the
8 pandemic on pregnant black, Asian and minority ethnic
9 women, where evidence emerges that they were of higher
10 risk of experiencing severe Covid symptoms.

11 Having considered the Module 3 non-Covid conditions
12 and maternity care, my Lady will now see that however
13 necessary it was to tell the public to stay at home,
14 protect the NHS, there was an undoubted impact on people
15 who needed care for non-Covid conditions, in a way that
16 may not necessarily have been intended. Indeed, there
17 is evidence that, irrespective of the condition there
18 was a reluctance by many to attend hospital. Across the
19 UK, there were public health campaigns to address any
20 perception by the public that they should not present
21 themselves to the NHS for fear of catching Covid or
22 because they didn't want to be a burden.

23 The Scottish Government launched "NHS is Open". In
24 England there were campaigns such as "Help Us Help You"
25 and "Open for Business". In Northern Ireland there was
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1 of those working in healthcare systems have attested in
2 their statements to the gratitude to the staff who
3 worked tirelessly to look after us all, often at the
4 detriment of their own physical and mental health.

5 I know that in previous modules you have heard and
6 indeed condemned the abuse that public servants were
7 subjected to for the decisions they made and sadly you
8 may hear more of that within these hearings. It is
9 nothing short of an outrage that there are some members
10 of our society that think it is appropriate to insult
11 and, in some instances, physically threaten individuals
12 and their families who were doing their jobs to try and
13 protect us all. Now, that is not to say that decisions
14 should not be scrutinised and there will undoubtedly be
15 legitimate arguments and differing points of view about
16 the reasonableness or otherwise of the decisions made
17 but I know that your Ladyship will wish to denounce the
18 increase in personal attacks and abuse that is meted out
19 by those who are often ill-informed and may be ignorant
20 to the additional harm they have caused.

21 Although the public health emergency phase of the
22 pandemic has ended, the myriad effects of the pandemic
23 are still keenly felt by those providing healthcare and
24 those receiving healthcare in the UK today. They are
25 felt by those who are suffering from Long Covid, whose
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1 treatment was delayed, the many thousands of healthcare
2 workers left feeling completely and utterly exhausted
3 and burnt out by the work they undertook and the efforts
4 they went to to look after us, and by those who deeply
5 miss and mourn the friends, family and colleagues that
6 died. That, my Lady, is why, in my submission,
7 Module 3's findings and recommendations are of such
8 significance to each and every one of us who has the
9 benefit of access to healthcare which is available to
10 all based on clinical need and not on an individual's
11 ability to pay.

12 **LADY HALLETT:** Thank you very much indeed, Ms Carey,
13 I'm extremely grateful to you.

14 I've also received written submissions from the core
15 participants and I'm very grateful to all of them.
16 They're extremely constructive and helpful but, as
17 a result, I'm afraid I'm going to have to ask the core
18 participants to highlight only the most essential issues
19 in their oral submissions. We have submissions from 29
20 core participants to get through before we call evidence
21 from bereaved witnesses tomorrow afternoon.

22 So to be fair to other core participants and to be
23 fair to the bereaved witnesses, whom I do not wish to
24 keep waiting, I'm afraid I must be very strict on
25 timings.

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1 decisions and policy affecting Wales, where the
2 population is older, poorer and sicker than in England.
3 There were higher levels of nosocomial infection in
4 Wales than in England or Scotland, at least in the first
5 wave. This group has questioned how the responses of
6 the Welsh Government, the NHS in Wales, seven regional
7 health boards, Public Health Wales and many other groups
8 are to be scrutinised in this extensive Inquiry and to
9 what extent that is a realisable ambition. The Chair
10 may no doubt recall that our request for a split module
11 by nation, as with Module 2, was refused.

12 The Module 1 report has already highlighted that
13 there was in Wales a very complicated array committees,
14 teams, groups and subgroups. It was "labyrinthine".
15 Although Wales had its own expert medical and scientific
16 advice, the Inquiry has concluded that they were not
17 central to pandemic preparedness and resilience. So
18 health services in Wales were unprepared for a pandemic,
19 and this is despite a series of exercises from as long
20 ago as 2003 modelling emergency health responses in
21 Wales.

22 Even leaving actual science aside for a moment we
23 say the Inquiry has available to it overwhelming
24 evidence of catastrophic failures of common sense and
25 pragmatism, which had devastating consequences for the

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1 Right, I think Ms Aswini Weereratne KC, would you
2 like to go first on behalf of the Welsh bereaved.

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

5 **MS WEERERATNE:** Thank you, my Lady.

6 Covid Bereaved Families for Justice Cymru is a group
7 that consists of a spectrum of families bereaved by
8 Covid in Wales. They are reluctant campaigners for
9 truth, justice and accountability. It's heartbreaking
10 to remember that there have been well over 12,500 deaths
11 from Covid in Wales, yet a Welsh-specific public inquiry
12 has been refused by the Welsh Government, so that this
13 group is committed to securing scrutiny of all
14 decision-making relevant to Wales in this Inquiry. It's
15 axiomatic that lessons must be learned, errors publicly
16 acknowledged and recommendations made for improvement in
17 Wales. We appreciate the reassurances from the Inquiry
18 that the experiences of all four nations will be
19 addressed and we acknowledge that this is not a small
20 undertaking.

21 For this group, it is vital that the Inquiry
22 reflects that there are important features specific to
23 Wales. Wales has complete responsibility for its own
24 healthcare and the Welsh Government remained responsible
25 and accountable throughout the pandemic for strategic

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1 people of Wales. Was it rocket science to practise
2 caution in the face of a rapidly rising global death
3 rate, rolling towards Wales like a tsunami? What is the
4 cost of caution in the face of death? Is it rocket
5 science to provide the most effective PPE in the face of
6 uncertainty, to cascade clear IPC guidance that does not
7 overwhelm or disenfranchise overworked healthcare
8 workers, to provide protection and dignity to the
9 vulnerable and the elderly?

10 Or is the Welsh experience the consequence of
11 serious and serial incompetence on the part of the Welsh
12 Government and its counterparts in the UK. Is this the
13 tail of incompetence wagging the dog of a nation's
14 health and safety or is the appropriate cliché that of
15 a headless chicken?

16 This group want accountability for failures of
17 government and leadership on critical healthcare
18 provision, in particular from the Welsh Government.
19 Blaming the UK will not be an adequate response in light
20 of the proliferation of dedicated Welsh committees and
21 experts.

22 On evidence, the group is struggling to see how the
23 Welsh experience can be thoroughly examined by this
24 Inquiry. Apart from this group witness statements have
25 been provided by a range of Welsh-specific witnesses

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1 though only a small handful are being called to give
 2 oral evidence to have their accounts tested through
 3 questioning. This leaves the rest to be taken as read.
 4 How then can our criticisms of Welsh pandemic healthcare
 5 be properly explored with all Welsh witnesses?
 6 A quick illustration is that the Inquiry has
 7 directed us to ask our questions about, for example, the
 8 TUC to a relevant Welsh witness but Adam Morgan who has
 9 provided a Rule 9 witness statement from the TUC in
 10 Wales is not being called, so we have to turn elsewhere.
 11 We will of course be pursuing Welsh evidence with all
 12 witnesses as appropriate but it is an indirect process
 13 of challenge or inquiry that defies reliable aim or
 14 answers.
 15 The Welsh government testimony will come from on
 16 high: Frank Atherton, Vaughan Gething, Baroness Eluned
 17 Morgan and similar. The group do not consider that
 18 a high level gloss on what was happening in Wales will
 19 adequately discharge the commitment to enquire into
 20 Welsh processes.
 21 The shield of hindsight must not be wielded once
 22 more by Welsh Government witnesses and there are issues
 23 of credibility to surmount. The Inquiry has already
 24 encountered this with the deletion of Welsh Government
 25 WhatsApp communications and now iMessages which remain

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1 been an easy task because every issue is a key issue for
 2 one or other member of the group.
 3 Across Wales and across all four nations, ordinary
 4 folks needlessly lost their lives. Their stories are
 5 a central part of this Inquiry. The accounts you will
 6 hear from this group chime across Wales with systematic
 7 failures of healthcare at their heart through waves 1
 8 and 2. Some of the stories frankly beggar belief. They
 9 bring into graphic relief the passive, disjointed and
 10 technocratic responses from the Welsh Government,
 11 leaving hospitals and staff floundering in the face of
 12 an unfolding disaster.
 13 A common theme in these stories is that Covid was
 14 acquired in hospital, sometimes a week or more after
 15 admission for non-Covid-related reasons, for a minor leg
 16 operation, a kidney infection or serious heart condition
 17 and suspected sepsis, or after a negative Covid test.
 18 That the source of the infection lay within the
 19 hospital is clear in many stories. One member's loved
 20 one was moved from ward to ward, an infection control
 21 technique criticised by the Welsh government's
 22 nosocomial investigation recently published. He caught
 23 Covid and died in ICU. There are many such stories.
 24 Vulnerable people at high risk through existing health
 25 conditions were at more risk in hospital than when

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1 under investigation. The Welsh Government has also been
 2 slow to provide its evidence in this module
 3 necessitating the use of section 21 notices by the
 4 Inquiry.
 5 In relation to expert evidence, as far as we can
 6 tell none, bar one -- Professor Edwards of Cardiff
 7 Hospital on primary care -- is able within their
 8 professional expertise to opine on what happened in
 9 Wales. It's not considered proportionate continually to
 10 ask experts: what about Wales? Yet that is usually the
 11 first question on this group's lips.
 12 We consider it imperative that the Inquiry is alert
 13 to probe the experience in Wales with all witnesses.
 14 Any gap in expert evidence, in particular, will, we
 15 fear, make it difficult for the Inquiry to draw
 16 conclusions and make recommendations on untested Welsh
 17 evidence, save to the extent that it does not appear on
 18 paper to comply with experiences in other devolved
 19 nations and especially England, to which the
 20 preponderance of expert evidence applies. There is
 21 danger, we say, that conclusions will be skewed towards
 22 England and risk not being applicable to the different
 23 systems in Wales for the future.
 24 On issues, our written submission is a distillation
 25 of some of our main areas of concern and this has not

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1 shielding in the community.
 2 One member's loved one with an autoimmune disorder
 3 was placed on a main ward after a negative test on
 4 admission. Members recall seeing nurses wearing
 5 inadequate PPE or failing to renew PPE as they moved
 6 from one part of a hospital to another, and nurses
 7 walking around with face masks on their chins. A member
 8 recalls being asked to wear full PPE when visiting
 9 relatives, yet nurses wore none.
 10 Elderly and frail people were refused or had
 11 treatment delayed or were coerced into accepting do not
 12 resuscitate notices. One member was told her mother was
 13 being refused oxygen therapy based on her frailty score.
 14 There are scores of stories of failed contact with GPs
 15 out of hours or on 999 services. There was no dignity
 16 in death. One health board authorised staff to move
 17 around hospitals taking photos of those who were
 18 suffering and dying and also after death. This group
 19 says it is clear that the evidence in this module will
 20 show that hospital-acquired or nosocomial infection was
 21 not inevitable, it was a result of a basic
 22 misunderstanding of IPC.
 23 During the first wave the First Minister and health
 24 minister in Wales said that there was no value in
 25 regular testing of healthcare workers without symptoms,

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1 even as WHO advice in June 2020 was to the contrary.
 2 There was good evidence available early in 2020 that
 3 Covid is an airborne virus transmissible
 4 asymptotically. It will not be enough for the Welsh
 5 Government to be allowed to say they were simply
 6 following or collaborating with the UK Government in
 7 these critical matters. They had their own experts,
 8 their own version of SAGE, their own nosocomial
 9 transmission group. No buck passing is the key message.

10 Finally, in summary, the group requests this that
 11 Inquiry: listens to Welsh voices; scrutinises care in
 12 Wales from GPs, ambulance services, in hospitals and
 13 after death; ensures there is accountability in Wales
 14 for the catastrophic rate of hospital-acquired
 15 infections; ensures accountability for the IPC guidance
 16 that we say did not follow available science; ensures
 17 accountability for the delay in rolling out the regular
 18 testing of healthcare workers to March 2021; scrutinises
 19 the use of clinical frailty scores, treatment escalation
 20 plans and do not resuscitate notices for the vulnerable,
 21 including the elderly in Wales; fully explores the
 22 consequences of IPC, of ageing infrastructure and
 23 buildings in the NHS in Wales; finally, ensures that
 24 lessons are learned from Welsh experiences so
 25 recommendations can be made for Wales to ensure safe

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1 have identified areas of concern amongst their members
 2 and have shared these concerns with politicians at this
 3 Inquiry and its Scottish counterpart. The group has
 4 repeatedly raised the issue of deaths of patients with
 5 hospital-acquired Covid-19 infections. They have raised
 6 issues around NHS services and the suitability of
 7 testing criteria focusing on the three cardinal
 8 symptoms. The group has also proposed that the Crown in
 9 Scotland investigate deaths in care homes and should
 10 also consider the issue of nosocomial deaths.

11 As well as this, the Scottish Covid Bereaved has and
 12 have supported their members. Groups have been set up
 13 to support members who were bereaved as a result of
 14 Covid in care homes and through nosocomial infection.
 15 Mutual support is offered to members through the closed
 16 Facebook group. The group holds online meetings which
 17 not only allow for members to be kept up to date in
 18 relation to the ongoing inquiries, but allows them to
 19 share their stories and ask for help.

20 Turning then to module 3. In Module 1 the bereaved
 21 learned that despite the existence of pandemic planning
 22 exercises and various expert groups, neither Scotland
 23 nor the wider UK were in any way prepared for the
 24 pandemic which struck. In Modules 2 and 2A the Inquiry
 25 examined the core political and administrative

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1 health systems for the future.

2 That completes our opening statement.

3 **LADY HALLETT:** Thank you very much, Ms Weeraratne, very
 4 grateful.

5 I think Ms Mitchell.

6 **Submissions on behalf of Scottish Covid Bereaved by**
 7 **MS MITCHELL KC**

8 **MS MITCHELL:** My Lady, I appear as instructed by Aamer Anwar
 9 & Company on behalf of the Scottish Covid Bereaved.

10 The Scottish Covid Bereaved is a group of bereaved
 11 individuals with a common goal, wanting lessons to be
 12 learned from the deaths of their loved ones to stop
 13 others having to suffer in the same way that they have.

14 They hope that in sharing their experiences they
 15 will be of assistance to the Inquiry, and indeed
 16 the Inquiry has heard this morning from one of our
 17 members, Carole Anne Stewart and will hear from others
 18 later in the module. Their experiences and the
 19 experiences of others in the UK provide a visceral
 20 reminder of the pandemic's devastating impact, and we
 21 are grateful to them for sharing these very difficult,
 22 emotional and sensitive details of their life so that we
 23 may learn from them.

24 The group has been a consistent and positive media
 25 presence and has political campaigning. The bereaved

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1 decision-making in Scotland and Westminster.

2 A spotlight was turned on our politicians, civil
 3 servants and advisers. Those we trusted with our health
 4 and our lives were often found lacking. It is hoped
 5 that the Inquiry light being shone on the topics in
 6 Module 3 will be the disinfectant required to place
 7 Scotland and the United Kingdom's healthcare systems in
 8 a better place in the future.

9 As the bereaved have previously submitted to this
 10 Inquiry, and as the World Health Organisation sets out
 11 in its constitution, the enjoyment of the highest
 12 attainable standard of health is one of the fundamental
 13 rights of every human being without distinction of race,
 14 religion, political belief, economic or social
 15 condition.

16 Of course the Scottish Covid Bereaved's focus is on
 17 Scotland. Each and every one of us in the
 18 United Kingdom was affected in some way by the decisions
 19 taken in relation to healthcare. Whether that be those
 20 like the bereaved who lost loved ones, those who risked
 21 their life to staff hospitals and care homes, and those
 22 who watched family and friends struggle through
 23 treatment, or those whose care for non-Covid-related
 24 conditions was affected.

25 In the course of this hearing, the bereaved hope

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1 that they can find answers to questions, some of which
 2 have been asked since those devastating early days
 3 of 2020, and those watching online and present here
 4 today will have noted with great interest the details
 5 and helpful opening statement by Senior Counsel to the
 6 Inquiry setting out all the areas that are to be
 7 considered. This is very helpful in putting at ease the
 8 minds of the bereaved, who are keen to ensure that all
 9 issues are dealt with, and this opening statement will
 10 no doubt go a long way in that regard.

11 The bereaved are particularly interested in
 12 the Inquiry's examination of a number of issues and
 13 I will give my Lady a short following list, which is not
 14 exhaustive or set out in any area of importance, and
 15 of course my Lady will have heard these already in much
 16 greater detail:

17 The healthcare provisions and treatments for
 18 patients with Covid; decision-making about the nature of
 19 healthcare to be provided for patients with Covid;
 20 do not attempt cardiopulmonary resuscitation;
 21 communication with patients with Covid-19 and their
 22 loved ones about patients' conditions and treatments,
 23 again including discussions about DNACPRs; the impact of
 24 those requiring care for reasons other than Covid;
 25 issues impacting upon palliative care; the discharge of

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1 decisions made an unprecedented impact on the health and
 2 lives of the nation and is of huge importance to us all.

3 Finally, the bereaved appreciate that this module
 4 and the Inquiry cannot change their experiences and the
 5 experiences suffered by their loved ones. The bereaved
 6 hope that the evidence that they will hear over the
 7 forthcoming weeks as well as giving them the answers
 8 they seek will help to ensure that our vital healthcare
 9 system and those who risked so much to staff it are in
 10 the best possible position when the next pandemic comes.

11 These are the submissions of the Scottish Covid
 12 Bereaved.

13 **LADY HALLETT:** Thank you very much indeed, Ms Mitchell, very
 14 grateful.

15 Mr Wilcock, I think you're next.

16 **Submissions on behalf of the Northern Ireland Covid-19
 17 Bereaved Families for Justice by MR WILCOCK KC**

18 **MR WILCOCK:** I make these opening remarks on behalf of the
 19 Northern Ireland Covid Bereaved Families for Justice
 20 and, in doing so, can I say that we are grateful for the
 21 thorough overview of this module that we have heard this
 22 morning from Ms Carey King's Counsel. We also
 23 appreciate that you have the benefit of assistance from
 24 over 30 core participants, all of whom you will want to
 25 hear in opening, to help you in this module.

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1 patients from hospital; infection prevention and control
 2 measures; the adequacy of PPE; nosocomial infection;
 3 restrictions on visiting patients; and shielding and the
 4 impact on the clinically vulnerable.

5 The Scottish Covid Bereaved have heard and
 6 understood the need for focus to be brought on questions
 7 for witnesses, and hope only to pose questions where it
 8 is thought necessary to obtain evidence to assist the
 9 Chair in making recommendations.

10 The group of course has equal interest in all the
 11 UK-relevant witnesses. The bereaved do have other
 12 issues in relation to this module, including questions
 13 for the former CMO, Dr Catherine Calderwood, and the
 14 purpose of the foregoing list was not to list every area
 15 of concern, rather it's hoped these examples provide to
 16 the Chair an example of the breadth and depth of the
 17 issues which the bereaved hope can be covered in the
 18 forthcoming weeks.

19 It's been clear to the Scottish Covid Bereaved that
 20 the political machinations and decision-making processes
 21 highlighted in the previous modules attracted a great
 22 deal of media attention. It's hoped that those in the
 23 press maintain this interest when the Inquiry looks at
 24 the sometimes technical and complex healthcare decisions
 25 that were made during the course of the pandemic. The

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1 Many of these core participants represent
 2 organisations or individuals with huge scientific,
 3 technical or professional knowledge of the issues you
 4 will be considering. However, those whose loved ones
 5 died because of or for want of access to healthcare and
 6 those who were providing the actual frontline care can
 7 tell you about the tragic truth of that experience, thus
 8 demonstrating that, throughout the topics you will be
 9 investigating, the healthcare system choices being made
 10 directly or indirectly were not just theoretical but had
 11 real consequences upon untold numbers of real people.

12 To that end, we adopt the representations we have
 13 previously made in writing and which have been made by
 14 other bereaved family groups today on individual topics
 15 included in this module, such as visiting restrictions,
 16 DNACPRs, and the all too frequent lack of communication
 17 which continue to cause those that we represent great
 18 anguish.

19 The campaign that I represent are particularly
 20 anxious to assist this Inquiry in ensuring that the
 21 response of the Northern Irish healthcare system to
 22 Covid, and the dreadful impact that that pandemic has
 23 had on the Northern Irish healthcare system, patients
 24 and healthcare workers, are as fully dissected in this
 25 module as we have been repeatedly assured that they will

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1 be.
2 To this end you will hear from two of our members,
3 Catherine Todd and Martina Ferguson, who will describe
4 the suffering and feelings of loss surrounding the
5 deaths of their newborn child and elderly mother
6 respectively, as well as providing an overview of the
7 experiences of other bereaved families in our group in
8 order that the Inquiry can best assess the high level
9 evidence before it about the impact of Covid-19 on
10 people's experience of healthcare in Northern Ireland,
11 against the real experience of those who were at the
12 mercy of that healthcare system during the pandemic.

13 My Lady, impressions matter. This morning we
14 watched some powerful and moving testimonies in the
15 impact video prepared for this module, all of which must
16 be heard and heeded. I'm bound to say that members of
17 the group I represent quickly noticed that the video
18 contained no Northern Irish voices, whether bereaved or
19 frontline workers in the healthcare system. It may be
20 that the Inquiry intends to redress that balance when
21 the second impact video is shown in the second half of
22 this series.

23 However, this is not just about including different
24 accents. As you will have seen from your journey around
25 the UK earlier this year, whilst many of the experiences

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1 longer, people waited in pain and distress and we are
2 still not in a position where we can recover."

3 So that answer came at 4.15 in the afternoon, and
4 pressure of time meant that Sir Michael was unable to
5 say more. He is, however, I think, one of the few --
6 I think it's only five -- professional or political
7 Northern Irish witnesses being called in this module of
8 the Inquiry who can provide you with the further detail
9 you may feel you now require in this module.

10 One of these witnesses will tell you about
11 Altnagelvin Hospital, in one of the poorest areas in
12 Northern Ireland, where many staff live a short distance
13 way in the Republic of Ireland, in Donegal, and which
14 has staffing problems partly, she says, as a result of
15 more attractive terms and conditions for healthcare
16 professionals in the Republic of Ireland.

17 Others will tell you that, even before the pandemic
18 struck, the health service in Northern Ireland was
19 operating at high capacity with steadily increasing
20 waiting lists for the elective care that Professor
21 McBride referred to as being turned off in response to
22 the pandemic.

23 In this context, we anticipate that the then
24 Northern Ireland Minister for Health, Robin Swann MP,
25 will repeat his evidence that:

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1 during Covid are universal, there were and are distinct
2 differences between the health systems in the four
3 nations of this country and between Northern Ireland and
4 Great Britain in particular.

5 When we addressed you in Belfast last May, we
6 observed that the political similarities in Northern
7 Ireland then and at the outbreak of Covid in March 2020
8 were obvious. Unfortunately, we can say exactly the
9 same about the state of the healthcare system, which
10 just ten days ago was described by the Northern Ireland
11 director of the Royal College of Surgeons as remaining
12 "in a precarious state with huge pressures on a depleted
13 and stretched workforce".

14 But, my Lady, you knew this already because, on
15 10 July last year Sir Michael McBride, the Northern
16 Irish CMO, told you when giving evidence that:

17 "In Northern Ireland the health service struggles on
18 a day-in, daily basis to deliver what it should be
19 delivering. Notwithstanding the additional pressures
20 created by the pandemic and surge, where really what we
21 had to do was to turn off, to a large extent, all of
22 that elective capacity, which had huge impacts right
23 across the public leading to ... people waiting
24 excessive periods of time, even longer than they were
25 before. The worst waiting times in the UK got even

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1 "Underfunding and persistent single year budgets saw
2 healthcare in Northern Ireland surviving hand to mouth
3 with a limited ability to plan strategically and deliver
4 better services and which inevitably had an adverse
5 effect on the readiness of public services to prepare
6 for a whole system emergency."

7 Now, Altnagelvin is the only one of the 40 or so
8 hospitals in Northern Ireland about which you will hear
9 live evidence, but you will no doubt consider the
10 entirety of the written materials available to you on
11 the extent to which the healthcare system in Northern
12 Ireland was and is sufficiently resourced. You will
13 consider, for example, whether, as an official report
14 concluded, one of the reasons that Altnagelvin had the
15 lowest number of nosocomial infections in the region was
16 because they could provide greater single-room occupancy
17 as a result of pre-pandemic funding, fortuitously
18 enabling the opening of a new wing in the spring of 2020
19 as the pandemic struck.

20 Other sites in Northern Ireland were not so
21 fortunate. Old and poorly-ventilated hospital
22 buildings, wards filled to capacity and staff shortages
23 meant that for far too many of our families the
24 environments which ought to have nursed them back to
25 health became the places of greatest risk to them.

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1 My Lady, of course we recognise that difficult
2 decisions about who to call to give evidence have had to
3 be made so this Inquiry can produce a report at a time
4 when its recommendations will still have relevance, but
5 the personal experiences of the many people I represent,
6 certainly too many to tell every story or even name now,
7 in the absence of a Northern Ireland equivalent witness,
8 are to some extent reflected in what a London-based
9 doctor, from whom you will hear in a week or so,
10 Dr Tilakkumar, described as the disorganised nature of
11 the initial emergency monitoring and isolation of
12 patients, the confused decisions that were made in
13 relation to what infection prevention measures or staff
14 personal protective equipment were required and the
15 heartbreaking experiences of patients acutely or
16 terminally ill because of a pandemic for which we were
17 ill prepared.

18 Take Samuel Patterson, who was admitted to hospital
19 in Belfast on 25 March 2020. He was 75, frail and
20 totally dependent on care from others. When his family
21 contacted the GP about repeated recent episodes of
22 falling, they were told that the GP was not attending
23 homes and that he was probably suffering from a UTI or
24 mini-stroke. When an ambulance came to collect Sam,
25 they were told that the local hospital would not accept
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1 them to contemplate horrendous questions such as why was
2 Samuel placed on a Covid ward in the first place and had
3 the hospital unilaterally imposed what the family
4 describe as a DNR, perhaps because of Samuel's age or
5 disability.

6 My Lady, as Sir Michael McBride observed, the damage
7 Covid wreaked was not just to individuals and families
8 and loved ones, the whole Northern Irish healthcare
9 system continues to feel the aftershocks of its
10 consequences. In addition to the written statistical
11 evidence available to the Inquiry, the same press
12 reports which announced the recent remarks I quoted of
13 the Northern Ireland director of the Royal College of
14 Surgeons also reported that in June of this year
15 available figures from the Department of Health showed
16 that Northern Irish waiting lists for people waiting for
17 a first consultant-led outpatient appointment across
18 just four of its five trust areas now total 340,000;
19 340,000, in a population of 1.8 million, around one in
20 five, and more than half of those patients have been
21 waiting for more than one year. It is quite frankly
22 obscene.

23 Finally, Sir Michael has told this Inquiry that it
24 is incumbent on all that we use the opportunity of this
25 Inquiry to learn those lessons of what happened, hear
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1 him, simply because he had a temperature and so he was
2 diverted to the recently re-designated Covid unit at the
3 Mater Hospital.

4 His family's concerns about this decision were
5 obvious. They were also borne out by subsequent events,
6 Samuel was fine for the first couple of days but then
7 for the first time tested positive for Covid while in
8 hospital. The family were told that Samuel was not
9 a candidate for a ventilator. On the Sunday the
10 hospital advised that his oxygen levels were down and he
11 was struggling for breath. On the Monday and Tuesday
12 they were told that he had deteriorated further and,
13 despite this, only one family member was allowed to see
14 Samuel and even then the hospital thought it appropriate
15 to emphasis the high risk on the ward, the need to
16 remove PPE personally and the fact that any attendee
17 would be quarantined after the visit.

18 At 11.00 am the next day, on the Wednesday, the
19 family were allowed a short phone call with Samuel
20 during which they told him how much they loved him, and
21 he, even though he wasn't characteristically someone who
22 showed his emotions, replied "I know".

23 The family were told that Samuel would be sedated to
24 make him more comfortable, only to discover later that
25 day that he had died with only a nurse present, leaving
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1 the experience of those most directly affected, and to
2 ensure we are as prepared as we can be for the next,
3 because there will be a next, pandemic.

4 On behalf of all of those who died or lost loved
5 ones in Northern Ireland, we will do all we can within
6 the confines of this module to help the Inquiry achieve
7 that aim and, in doing so, we echo the call of the
8 United Kingdom campaign Bereaved Families for Justice
9 that this Inquiry must not shy away from reflecting the
10 fundamental reality that increased funding of the
11 healthcare system in Northern Ireland will be required
12 to ensure that it not only meets the needs of the next
13 pandemic but meets the needs of its citizens in the here
14 and now.

15 My Lady, thank you very much.

16 **LADY HALLETT:** Thank you, Mr Wilcock.

17 Mr Weatherby.

18 **Submissions on behalf of Covid-19 Bereaved Families for
19 Justice by MR WEATHERBY KC**

20 **MR WEATHERBY:** My Lady, Dr Saleyha Ahsan is a member of the
21 Royal College of Emergency Medicine EPRR committee
22 (emergency preparedness, response and resilience). She
23 is an emergency medicine doctor and an academic
24 researcher at the University of Cambridge. In
25 February 2020, Dr Ahsan undertook a PHE-related medical
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1 role at Heathrow Airport dealing with travellers who
2 arrived with Covid-type symptoms, but her primary role
3 was in critical care in a hospital in North Wales, where
4 she subsequently managed patients with Covid on ITU and
5 HDU wards.

6 In addition to her practice, Dr Ahsan is an
7 accomplished filmmaker and has made a number of
8 documentaries and programmes for Channel 4 and the BBC
9 concerning healthcare in the pandemic from her own
10 experience.

11 Dr Ahsan is also one of the family members
12 I represent, as sadly her father, Ahsan-ul-Haq Chaudry,
13 succumbed to the virus in December 2020. She will be
14 the last witness you hear from in Module 3, as the group
15 witness for Covid Bereaved Families for Justice UK,
16 which as you know is the group that represents
17 7,000 family members spread across the four
18 jurisdictions of the United Kingdom.

19 Dr Ahsan has five siblings, four of whom are
20 doctors, all of whom had worked at the hospital where
21 her father died, and one pharmacist. Dr Ahsan is
22 therefore particularly well placed to assist you with
23 many aspects of healthcare and Covid as a bereaved
24 daughter and a frontline NHS medic.

25 In the course of her evidence, Dr Ahsan will tell
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1 hundreds of thousands of healthcare workers who
2 valiantly and selflessly put themselves on the line to
3 care for all those ill and dying, and we do too, not
4 least because we represent healthcare workers themselves
5 bereaved and bereaved families of many healthcare
6 workers who died, but their efforts, their sacrifice
7 must not become a cloak for the austerity and
8 underfunding and lack of planning which put them in such
9 an untenable position. The families do not want to clap
10 for healthcare workers, they want their services
11 properly funded and they want proper staffing levels and
12 bed capacity before it's too late for the next time.

13 I started with a simple example of lack of critical
14 care capacity, but in fact, as you've heard, the
15 evidence of overwhelmed healthcare services started well
16 before hospital care, the government messaging from the
17 outset advising people to stay at home and to seek
18 medical help only if really necessary, the strength of
19 which, according to not me but from the Healthcare
20 Safety Investigation Branch, is said to have put off
21 many of those who really needed healthcare.

22 As you heard this morning, the Inquiry's own primary
23 care experts will give evidence that there was little if
24 any pandemic planning in GP services and health services
25 at all. There was a funding crisis, too few primary
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1 you that her sister had a senior clinical position at
2 the hospital where her father was, and that it was
3 "overwhelmed by Covid". She will also tell you that the
4 ITU consultant responsible for her father candidly
5 explained that he could not be admitted to critical care
6 or HDU because there were no available beds, and indeed
7 that was the picture for much younger patients too.
8 This was a capacity and not a clinical decision, a point
9 that chimes with comments made by Ms Carey earlier.

10 A very different picture painted by Boris Johnson,
11 Matt Hancock and others, who have brazenly asserted that
12 one of the key successes of the Covid response was that
13 the NHS was never overwhelmed.

14 True enough, we did not see scenes from a dystopian
15 disaster film, with empty ransacked hospitals, but the
16 fact that hospitals and healthcare facilities continued
17 to operate at some level must not be allowed to point to
18 a dangerously misleading conclusion that things went
19 reasonably well. Where acute demand for emergency and
20 critical care services outstripped supply, those
21 services were indeed overwhelmed and unable to function
22 as they should. This is not a metric measured in missed
23 targets, it's not a matter of semantics. Overwhelmed
24 services cost lives.

25 We have no doubt that you will want to honour the
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1 care doctors and healthcare staff, and a consequent
2 retention problem.

3 In earlier submissions we have referred to evidence
4 from family members of their experience of the
5 111 services.

6 Rivka Gottlieb has told of the extreme difficulty in
7 her father getting through to the service at all, and
8 even when successful the advice was to remain at home.
9 Only when, having taken advice from a doctor friend,
10 were they able to express the symptoms in such a way to
11 trigger a response did they get a paramedic attendance,
12 immediately determining that her father needed
13 hospitalisation. Admitted too late, he unfortunately
14 died in hospital.

15 Likewise Mary Rogan(?), who asked for an ambulance
16 for her 52-year old husband, who had severe and classic
17 Covid symptoms, but who was refused because his
18 temperature had not reached a particular benchmark. He
19 died at home.

20 James Yates, who lived in Scotland, again told to
21 remain home despite serious symptoms and relevant
22 comorbidities. He succumbed too.

23 According to the HSIB, there was a general problem
24 with no questions being asked and no regard paid to
25 pre-existing conditions by 111 algorithms. And
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1 distressing though these individual accounts are,
2 the Inquiry will want to look to whether they are just
3 isolated examples or whether they're more general
4 problems.

5 In that regard, can I add two details to the ones
6 you heard about earlier. Firstly, the HSIB found that
7 in March 2020 only 50% of 111 calls were answered at
8 all. Secondly, that there is evidence of further
9 problems in those that were answered in passing them on
10 to expert clinical advisers. So no surprise, then, that
11 the Inquiry expert Professor Snooks has concluded that
12 both of those services, 111 and 999, were at times
13 overwhelmed. She also says that existing inequalities
14 may have been exacerbated.

15 In that vein, we've examples of where it appears
16 that algorithmic questioning failed to take account of
17 racial characteristics -- you already heard about
18 oximeters. But Lobby Akinola's father sought
19 assistance from the 111 service. He was asked whether
20 his lips had turned blue, a question which might well
21 have been appropriate for a white person. Were services
22 such as 111 equipped to deal with patients from
23 different backgrounds or was there institutional racism
24 which led to the failure to consider the needs of large
25 sections of our communities?

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1 her to hospital because they stated that earlier they'd
2 waited seven hours outside a hospital with a frail
3 elderly person, and Dr Fulop died at home the next day.

4 Whether this evidence of overwhelmed services was
5 simply because of the extreme seriousness of Covid or
6 whether overwhelmed services were a result of no proper
7 planning, no adequate resilience, chronic underfunding,
8 austerity, is a matter for you, but either way the
9 narrative that the health services coped without
10 becoming overwhelmed is a false one and needs to be
11 called out at such. Pretending nothing is wrong means
12 nothing changes. From ambulances to hospitals, like
13 critical care bed capacity referred to earlier. But we
14 already heard evidence in earlier modules that the UK
15 had the lowest number of doctors and nurses per capita
16 than any other comparable OECD country. Bed capacity
17 regularly a problem even with seasonal flu spikes.

18 The evidence suggests that there were real problems
19 with the physical estate, as we heard earlier, about
20 ventilator systems in particular. In each area
21 the Inquiry delves into, we urge it to consider
22 carefully the level of planning. We anticipate it will
23 find precious little beyond the 2011 flu plan, and if
24 that's right it's a shocking dereliction of duty by
25 those responsible over many years.

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1 Patrick McManus had multiple sclerosis. He was an
2 NHS deputy ward manager, honoured in February 2020 by
3 the City of Derry and Strabane for services to nursing.
4 Weeks after, he contracted Covid and sent home from
5 work. His condition worsened but the 111 service told
6 him that he could leave the house simply because he had
7 passed a 7-day marker, presumably acting on
8 an algorithm. Subsequently taken into hospital,
9 a DNACPR put on his record, apparently without
10 consultation, and sadly he died.

11 Telephone services to ambulances. When patient care
12 progressed beyond telephone advice, during March 2020,
13 as you've heard, a protocol was activated for ambulance
14 services whereby those who merited a category 1 urgent
15 response would be treated as category 2.

16 It appears that the times for expected ambulance
17 arrivals were vastly increased at peak Covid times. The
18 evidence disclosed so far suggests that in March 2020
19 the average arrival times for category 2 ambulance
20 dispatchers in London -- I repeat, the average time --
21 was well over three times the normal standard. Evidence
22 from our families resonates on this each.
23 Sarah Choudhury waited 12 hours for an ambulance for her
24 mother. She sadly died two days later. When paramedics
25 attended on Dr Christina Fulop, they declined to take

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1 I note what's been said about DNACPRs. No less than
2 422 of our families have raised with us issues relating
3 to DNACPR. The concerns relate to a range of matters,
4 but the sheer volume indicates serious problems with
5 this part of the system.

6 Were there proper plans in place for consultations
7 with patients and their loved ones? Many of our
8 families report that records indicate there were family
9 consultations when they had not in fact occurred. Was
10 there inappropriate use of DNACPR as a means of managing
11 or prioritising care capacity despite its real purpose?
12 As Ms Carey told you, that inappropriate and
13 unacceptable DNACPRs were made at the start of the
14 pandemic was an early finding of the CQC.

15 There is evidence, as you have heard, that a triage
16 tool was developed, essentially a policy to determine
17 who would and would get scarce care resources and who
18 would not, perhaps on the basis of age or underlying
19 conditions, even disability. But the evidence also
20 suggests that this approach was abandoned and there was,
21 in fact, no such formal policy established.

22 But did this leave hard pressed clinicians and
23 hospital managers in an invidious position of choosing
24 who got admitted to ITU, whether critical care was
25 provided at all, simply because there weren't available

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1 beds or equipment or doctors? These are uncomfortable
2 issues and ones the Inquiry must address.

3 **LADY HALLETT:** I'm afraid I must ask you to bring it to
4 a close, Mr Weatherby, I'm sorry.

5 **MR WEATHERBY:** I'll leave it there.

6 **LADY HALLETT:** I mean, carry on for a sentence or two if
7 you --

8 **MR WEATHERBY:** I've got about 90 seconds left, I think.

9 **LADY HALLETT:** Carry on.

10 **MR WEATHERBY:** Tomorrow you will hear from John Sullivan
11 about his 56-year old daughter Susan. He raises
12 a number of highly disturbing issues. He relates
13 serious delay in an ambulance arriving. Susan's medical
14 records indicate that her Down's Syndrome was recorded
15 as a reason for the decision not to admit her to ITU.
16 She struggled with tolerating an oxygen mask, yet the
17 learning disability team was apparently not deployed to
18 help her, nor were her family allowed to attend to help,
19 which could have made a critical difference. Again,
20 there is an issue of DNACPR.

21 Did an overstretched health system discriminate on
22 the basis of her disability because it was overwhelmed?

23 Finally this, recent reports in the media this week
24 suggest that too little has changed in healthcare since
25 the pandemic, despite the shocking loss of life,

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1 My Lady, in this module you will hear evidence from
2 two members of the Long Covid groups, first
3 Nicola Ritchie from Long Covid Physio and Natalie Rogers
4 from Long Covid Support. Both will speak to the
5 devastation that Long Covid has wrought on their lives
6 and on the lives of members of their organisations.
7 They describe confusion and uncertainty about what was
8 happening to them, a lack of publicly available
9 information and a lack of concern from general
10 practitioners.

11 They are not alone, surveys carried out by the Long
12 Covid groups document the widespread disbelief that
13 members have faced and the lack of recognition of their
14 symptoms. Even after diagnosis, many have struggled to
15 access suitable care and support.

16 Their experiences are at odds with NHSE's opening
17 statement that treatment for Long Covid was an example
18 of what worked, neither do the Long Covid groups
19 recognise in their personal experiences the suggestion
20 from the Welsh Government that programmes and services
21 were developed to respond to the need for rehabilitation
22 services for people who had been affected by Covid-19
23 from spring 2020.

24 Further, whilst the Long Covid groups welcome the
25 Scottish Government's commitment to ensuring that every

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1 Long Covid, all sorts of other damage -- as the
2 narrative that the NHS was not overwhelmed, that the UK
3 did okay, prevented a clamour for proper resourcing and
4 revitalised health services and proper pandemic
5 preparedness and planning. In our submission, if that's
6 so, the central mission of Module 3 must be to address
7 that fiction before another emergency comes upon us.

8 Those are our submissions.

9 **LADY HALLETT:** Thank you very much, Mr Weatherby, very
10 grateful.

11 Ms Hannett, would you like to take us up to the
12 break?

13 **Submissions on behalf of Long Covid Groups by MS HANNETT KC**

14 **MS HANNETT:** Thank you, my Lady.

15 I appear with Ms Iengar, Ms Sivakumaran and
16 Ms Johnson on behalf of the Long Covid groups,
17 instructed by Ms Jane Ryan of Bhatt Murphy Solicitors.

18 The Long Covid groups are Long Covid Kids, Long
19 COVID Physio, Long Covid SOS and Long Covid Support.
20 They are grassroots advocacy organisations whose members
21 came together in the early days of the pandemic to
22 achieve recognition of Long Covid and to obtain the care
23 and support that their members need. Their members
24 suffered and continue to suffer the devastation
25 inflicted by the symptoms of Long Covid.

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1 person with Long Covid is supported with access to the
2 care that they need, they note that, as implicitly
3 acknowledged, this does not reflect the current
4 position.

5 The Long Covid groups invite the Inquiry to
6 investigate why, despite Long Covid being foreseeable,
7 noting that SARS and MERS had caused long-term morbidity
8 like that seen with Long Covid, there was such a delay
9 in recognising and providing any response to Long Covid.

10 Further, they have questions about why they, as
11 patient advocates, had to fight for recognition of their
12 illness and disability and for the provision of services
13 by the healthcare system.

14 The Long Covid groups ask the Inquiry to recognise
15 that the response to Long Covid by the UK healthcare
16 system has been and remains inadequate and that these
17 inadequacies have led to real and substantial suffering.

18 The United Kingdom cannot effectively prepare for
19 the long-term morbidities of a future, as yet unknown
20 pandemic, without understanding the deficiencies of the
21 response to Long Covid in this pandemic.

22 The Covid-19 pandemic is ongoing. People continue
23 to contract Covid and to develop the long-term disabling
24 symptoms of Long Covid. As such, the findings we say
25 should be drawn from the evidence resonate today.

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1 The written opening submissions on behalf of the
2 Long Covid groups have focused on ten key areas where
3 the Inquiry is invited to make findings of fact to
4 inform strong, instructive recommendations on the
5 current response to Long Covid, in addition to a future
6 response to long-term sequelae of a novel virus. In
7 making these brief opening observations on behalf of the
8 Long Covid groups, I propose to focus on six overarching
9 themes drawn from our written submissions.

10 The first issue, which I've touched on already, is
11 the ongoing impact of Long Covid. Those impacts are
12 felt on an individual level on a patient's long-term
13 mental, social, education and financial wellbeing.
14 Adults are unable to work and earn an income; Long Covid
15 has deprived children and young people of ordinary
16 aspects of childhood, such as attending school or
17 playing with their friends. Further, the UK healthcare
18 system itself feels the adverse effect of Long Covid, as
19 resources must be allocated to its diagnosis, care and
20 support. Long Covid places an unquantified indirect
21 impact on the healthcare system itself due to the
22 disproportionate effect of Long Covid on the ability of
23 healthcare workers to carry out their jobs.

24 Further still, the prevalence of Long Covid, the
25 most recent statistics saying that Long Covid affects

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1 inform the provision of the assessment, care and support
2 services for Long Covid, much of the current provision
3 is inadequate, variable in its quality and overall can
4 be addressed to fall a long way short of those criteria.

5 Long Covid in children and young people has been and
6 continues to be an inconvenient truth. The reluctance
7 to accept that Covid-19 could have a more profound
8 effect on some children led to even greater delays in
9 recognising, diagnosing and responding to Long Covid in
10 children and young people. When finally established in
11 England, dedicated children and young person Long Covid
12 hubs were sparse. Such dedicated clinics in Wales,
13 Scotland and Northern Ireland were either absent or too
14 slow to be established.

15 Fourth, the healthcare system has not committed even
16 now to preventing Long Covid, there is no treatment for
17 Long Covid. The only way to avoid contracting it is to
18 prevent Covid-19 infections and yet practitioners,
19 patients and the public were not and are not adequately
20 warned about the risk of Long Covid. Further, there was
21 no communication of the risk of Long Covid as part of
22 the drive to encourage vaccine take-up.

23 Fifth, Long Covid exacerbates pre-existing
24 inequalities whilst creating further health
25 inequalities. Those inequalities relate to

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1 2 million adults and children, as already indicated by
2 Senior Counsel to the Inquiry this morning, means that
3 it has a wider financial cost borne by the national
4 economy.

5 Second, the understanding of Long Covid has been and
6 continues to be impeded by delayed and then inadequate
7 and now abandoned data gathering and research on both
8 the prevalence and degree of impact of Long Covid.
9 There has been no publicly recorded data on the
10 prevalence of Long Covid since the ONS winter infection
11 study was closed in March 2024. NHS England cannot
12 feasibly model current and future demand for Long Covid
13 services in the absence of any current data on the need
14 for such services. Research into Long Covid has been
15 insufficient and delayed with consequential adverse
16 effects on clinical care.

17 Third, despite it being foreseeable, the healthcare
18 system overlooked Long Covid in adults and children.
19 The failure to plan for the long-term effects led to
20 inequalities of access to Long Covid services across and
21 within the four nations, as each country adopted
22 haphazard responses which did not address the complex
23 multisystem nature of Long Covid.

24 The Long Covid groups have set out at paragraph 23
25 of their written submissions those factors that should

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1 socioeconomic status, sex, ethnicity and disability.
2 The inadequacies of data limit the ability to understand
3 both aspects of health inequalities related to Long
4 Covid. What can be observed, however, is that there
5 continues to be unwarranted geographical variation in
6 access to services and the most deprived areas are
7 significantly under-served.

8 Finally, sixth, Covid-19 and Long Covid affected
9 healthcare workers disproportionately, yet the
10 occupational protections offered were wholly inadequate.
11 Healthcare workers were not offered adequate respiratory
12 protective equipment, the guidance on infection
13 prevention and control measures and PPE guidance was and
14 remains inadequate for preventing the transmission of
15 Covid-19, Healthcare employers failed to discharge their
16 statutory duties under the COSHH regulations, employers
17 did not always undertake risk assessments to safeguard
18 healthcare workers or employees from the risk of
19 occupational exposure to Covid-19.

20 This had the knock-on effect of employers failing to
21 monitor and conduct ongoing health surveillance of the
22 risks of the virus. The disproportionate impact of Long
23 Covid on healthcare workers was not accurately captured
24 in either RIDDOR reporting or any other systematic data
25 collection. For example, as of October 2023, the Health

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1 and Safety Executive report that only 36 RIDDOR reports
2 relating to Long Covid across all sectors have been
3 received.

4 My Lady, the Long Covid groups look forward to
5 assisting the Inquiry with its important work in
6 Module 3. Those are the submissions on their behalf.

7 **LADY HALLETT:** Thank you very much indeed, Ms Hannett,
8 I'm very grateful.

9 We shall break now and I shall return at 3.25.
10 I would like to get as far as Mr Thomas this afternoon,
11 if we can. I doubt, Ms Sen Gupta, if we're going to get
12 to you, wherever you are, waiting patiently, but we'll
13 get through what we can.

14 Thank you.

15 **(3.13 pm)**

(A short break)

17 **(3.25 pm)**

18 **LADY HALLETT:** All right, yes, Mr Wolfe.

19 **Submissions on behalf of John's Campaign, Care Rights UK and**
20 **the Patients Association by MR WOLFE KC**

21 **MR WOLFE:** Good afternoon, my Lady, I lead a team which
22 speaks on behalf of John's Campaign --

23 **LADY HALLETT:** Are you on the microphone?

24 **MR WOLFE:** Thank you, apologies. I lead a team, my Lady,
25 which speaks on behalf of John's Campaign, Care Rights
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1 rest of the population. In far too many cases, their
2 existing conditions actually worsened, sometimes to the
3 point of hastening their deaths.

4 We also speak, my Lady, for the forgotten section of
5 the healthcare system: the unpaid family carers whose
6 value to the economy has been calculated to outweigh the
7 entire NHS budget. Their value to the individuals who
8 support it and in supporting professional carers is
9 inestimable. The single and persistent failure to
10 understand their importance was deeply damaging and
11 entirely avoidable.

12 During the pandemic period, all three of our
13 organisations helped support people denied treatment by
14 including policies of separation, by isolation and other
15 non-pharmaceutical interventions. We also undertook
16 surveys, collected first-hand experiences and tried to
17 make those in authority aware of the consequences of
18 their decisions.

19 For instance, we shared Rachel's experience. Rachel
20 is a former nurse, her brother suffered depression and
21 was taken to hospital after an overdose. Rachel
22 explained how visiting restrictions during the pandemic
23 prevented her from supporting him in hospital, she said
24 this:

25 "When in A&E Chris was still saying he wanted to
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1 UK and the Patients Association.

2 Between them, these organisations have a significant
3 understanding of how patients experienced healthcare
4 provision during the pandemic. From its surveys and
5 helpline, the Patients Association can take an overview
6 of the issues faced by all users of NHS services.
7 Meanwhile, Care Rights UK and John's Campaign focus
8 particularly, but not exclusively, on those patients
9 rendered additionally vulnerable by disability,
10 especially cognitive impairments by age or by complex
11 and rare conditions.

12 Just pausing on one particular cognitive impairment,
13 pre-pandemic one in four hospital patients was
14 a dementia patient. Those dementia patients greatly
15 suffered through that additional factor.

16 We also have particular concern, my Lady, for people
17 whose first language was not English, for people
18 suffering mental health conditions and for those already
19 approaching the end of life period. These were all
20 people whose characteristics should have entitled them
21 to individual consideration under the law but their
22 human needs and individual choices were often
23 disregarded.

24 They were not always protected from harm. They were
25 placed at a significant disadvantage compared to the
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1 die. We asked if one of us could stay with him to be
2 his voice but this was dismissed due to Covid. He said
3 he didn't trust himself to be left alone yet, despite
4 requesting admission to a psychiatric hospital, he was
5 discharged with no follow-up care and with no
6 communication with his family. He died by suicide in
7 February 2021."

8 We also shared Clare's experience. Clare's father
9 Bruce had Parkinson's and was admitted to hospital
10 following a serious fall. Clare was his registered
11 carer and was initially able to be with him every day,
12 continuing her care and particularly focusing on his
13 Parkinson's needs. He was recovering well and they are
14 very confused. When he contracted Covid he was moved to
15 a different ward. Clare was forbidden to visit despite
16 the fact that she'd recently had Covid herself and had
17 the vaccinations. His Parkinson's treatment came to
18 an end because the nurses had no time and she was not
19 there to support them.

20 His Covid infection passed but his overall decline
21 was rapid and irreversible. His official cause of death
22 was pneumonia. Clare says:

23 "I fear that the sudden and dramatic separation from
24 us caused him distress and despair, potentially resulted
25 in him giving up hope of recovering."
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1 She spoke of her own distress and added:
 2 "I feel that my father should have had a right to
 3 our loving presence and care during the last weeks of
 4 his life. If I had been given permission to wear PPE
 5 and care for him on the isolation ward, the risk to me
 6 would have been minimal and it would have been greatly
 7 outweighed by the benefit to my father and to all of
 8 us."

9 Against that background, we draw the Inquiry's
 10 attention to some broad themes.

11 Theme 1, access to basic healthcare during the
 12 pandemic was restricted across the whole range of
 13 settings.

14 Theme 2, there were widespread problems with
 15 communication in healthcare at every level that affected
 16 both access to healthcare and its quality.

17 Theme 3, the role of family and friends in
 18 healthcare was not well understood and was severely
 19 disrupted with discernible adverse effects and
 20 irreversible damage.

21 Theme 4, care staff didn't always have training to
 22 undertake healthcare tasks when professional health
 23 carers would not visit.

24 Finally, theme 5, people with disabilities and
 25 complex conditions suffered the most severe restrictions

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1 during the pandemic on infection control at the expense
 2 of many other healthcare issues, and so we would like
 3 the Inquiry particularly to bear in mind the following
 4 things.

5 Firstly, healthcare is not just delivered by medical
 6 professionals in hospital settings. Secondly, the
 7 failure to treat family carers as part of a healthcare
 8 team damaged the quality of and access to healthcare for
 9 individuals who relied on family carers to advocate for
 10 them, interpret their needs and ensure they received the
 11 healthcare they needed and, of course, it also made the
 12 job of the professional carers harder.

13 The decision to discharge patients from hospital
 14 into residential healthcare settings without testing for
 15 Covid-19 had a devastating impact on individuals who
 16 live in those settings.

17 Next, guidance and regulations across the UK was
 18 often conflicting, confusing and lacking in clarity.
 19 Clear guidance would have obviated some of the harm
 20 caused to vulnerable groups. Next, there were serious
 21 issues with the provision of palliative and end-of-life
 22 care. Next, human rights of individuals and the need
 23 for individualised assessments are more, rather than
 24 less, important in times of crisis.

25 Can we then give some thoughts on what we say needs

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1 and were given the least support.

2 My Lady, in our written submissions, we describe our
 3 concerns about the exclusion of people living in care
 4 homes from the mainstream healthcare system. We
 5 describe our concerns about inappropriate and
 6 occasionally coercive DNACPRs directives. We describe
 7 our concerns about poor quality arrangements for end of
 8 life support and family access and we describe our
 9 concerns about conflicting and inconsistent regulations
 10 and the damage done through overhasty (unclear) of
 11 hospitals without care and testing.

12 All of those things were obvious and foreseeable
 13 consequences of the restrictions introduced to address
 14 the pandemic but the government failed to take steps to
 15 mitigate them or to commute how patients rights and
 16 access to essential healthcare should be protected,
 17 consistent with the need for infection control.

18 Turning then to the Inquiry process itself, our
 19 written submission also explains how proper analysis of
 20 the impact of the pandemic on healthcare systems will
 21 require the Inquiry to take specific account of the
 22 broad range of settings in which individuals receive
 23 healthcare from their own homes to hospitals and care
 24 homes and other residential healthcare settings. The
 25 Inquiry will also need to scrutinise the intense focus

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1 to happen. First, the NHS must ensure that patients
 2 receive a comprehensive service, even in times of
 3 crisis. Second, we must focus on protecting the people
 4 most at risk, not on protecting institutions. Third,
 5 lives must not be devalued in times of crisis. Fourth,
 6 systems must be in place to safeguard rights and ensure
 7 that the voices of people using services are always
 8 heard. Fifth, essential caregivers including family
 9 members and friends must be treated as key workers.
 10 Sixth, the right to family life must be respected by all
 11 those in all settings with duties under the Human Rights
 12 Act. Seventh, consent is and must remain a key aspect
 13 of the provision of healthcare, particular attention
 14 must be given to the needs of people with protected
 15 characteristics and those approaching the end of life.
 16 Eighth, respect for individual dignity and
 17 responsibility should always be maintained; infection
 18 control should not override personal consent.

19 I would like to come towards the end by sharing the
 20 experience of Pam, if I may. She wrote about her
 21 daughter Jen, who died at the age of 38. Jen had
 22 a complex medical condition which meant that she lived
 23 at home with both of her parents for most of her life.
 24 When she was admitted to hospital pre-pandemic, her
 25 parents would continue to accompany her, continuing

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1 providing her complex and specialist care alongside the
2 professionals.

3 At the beginning of the pandemic they were given
4 a letter from the hospital CEO to say that this
5 arrangement should not only continue but was essential.
6 However, that letter was then not accepted by the ward.
7 Jen, separated from her parents, wrote to the CEO,
8 saying she didn't feel safe; she never got a reply. He
9 mothers describes how she felt when she watched her
10 daughter, via FaceTime, struggling and uncared for:

11 "Every day I was phoning up to ask if I could go and
12 look after Jen. Every day I was given a different
13 reason why not, mostly interested on PPE. I was told
14 that gold command and later silver command were making
15 the decisions. I asked if I could come in and discuss
16 it with them. I was told by the matron that, if I came
17 to the hospital, security would be called."

18 Jen's condition worsened. She said she wanted to
19 kill herself. No one understood what was happening to
20 her. Even when she had suffered a serious of epileptic
21 fits her parents were denied access. This was on the
22 grounds of reducing footfall and a lack of PPE. Pam
23 offered to pay for PPE, she offered to pay for Jen to
24 have a nurse but she was told there weren't enough
25 staff. Jen and her parents were told that the ICU would

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1 Shane Smith of Slater & Gordon.

2 I begin with the PBPOs.

3 The group brings together 13 organisations working
4 in early pregnancy, pregnancy, maternity, antenatal,
5 neonatal and postnatal care. Aching Arms,
6 Baby Lifeline, Bliss, the Ectopic Pregnancy Trust,
7 Group B Strep Support, ICP Support, the Lullaby Trust,
8 the Miscarriage Association, the National Childbirth
9 Trust, or NCT, Pelvic Partnership, Pregnancy Sickness
10 Support, Tommy's and the Twins Trust.

11 One message from their collective experience is
12 clear, the reactive healthcare response to Covid-19
13 failed to properly value the care of women, pregnant
14 people and newborn babies and failed the women, pregnant
15 people and babies who were supposed to be at the heart
16 of that care.

17 These failures have left many women and pregnant
18 people traumatised. They led to partners and fathers
19 being wrongly excluded from the first hours, days and
20 weeks with their children. They resulted in unbearable
21 choices, such as the parents of neonatal twins who had
22 to choose which parent could visit and divide the
23 one-hour of allocated visiting time between both
24 children. The mother, who had to call her partner after
25 emergency surgery to explain that both their babies had

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1 not accept her. A DNR notice was forced on them.

2 On 21 January 2021, the consultant said that Jen
3 would die during that day. Her parents were finally
4 told they could have an hour with her and could split it
5 if they liked. The 30 minutes in the morning went well
6 but by the time they called back in the afternoon their
7 daughter was dead.

8 My Lady, finally, perhaps the most difficult
9 question before this Inquiry is what caused some people
10 during the pandemic to behave in that way and how the
11 basic rights of patients and their families might be
12 better protected in future.

13 Thank you, my Lady.

14 **LADY HALLETT:** Thank you very much, Mr Wolfe.

15 Mr Wagner, I think you're hiding over that side
16 today.

17 **MR WAGNER:** No longer hiding.

18 **Submissions on behalf of 13 Pregnancy, Baby and Parent
19 Organisations and Clinically Vulnerable Families by
20 MR WAGNER**

21 **MR WAGNER:** Thank you and good afternoon. I act for the
22 pregnancy, baby and parent organisations, or the PBPOs
23 for short. I also act for the Clinically Vulnerable
24 Families and I am assisted by Daniella Waddoup and
25 Rosa Polaschek. We are instructed by Kim Harrison and

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1 died and due to poor phone signal had to decide what to
2 do with the embryos' remains alone. And those who
3 simply lost the ability to choose how, when, where and
4 with whom they would deliver their babies.

5 These failures were not merely missed opportunities
6 to provide preferable or ideal care. As the Royal
7 College of Obstetricians and Gynaecologists has
8 identified, some women received maternity services that
9 were inadequate.

10 Devastatingly, some pregnant women died in
11 potentially avoidable circumstances. These errors
12 appear to have been the result of structural failures to
13 pay attention to, prioritise and provide sufficient
14 resources to the safety of pregnant women and people and
15 their babies, and the failures were not quickly
16 identified nor remedied. Visiting restrictions
17 continued to affect pregnant women and people for
18 prolonged periods, including when public restrictions
19 had eased and even while the public were being
20 encouraged to Eat Out to Help Out. So did restrictions
21 on parents being able to spend time with their sick
22 newborn babies in neonatal intensive care.

23 Against that background, Chair, our submissions are
24 divided into four main themes.

25 First, restrictions on access to services for

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1 pregnancy and baby-related care. A major study on
2 maternal deaths and morbidity, MBRRACE-UK, found that
3 Covid-19 was the leading cause of maternal death in the
4 UK and this disproportionately affected Black and Asian
5 ethnic minority women. It found that improvements in
6 care may have made a difference in 76% of those maternal
7 deaths from Covid-19. These were failures to ensure
8 adequate care was given to pregnant women and people,
9 amplified by an already under-resourced system in which
10 women and minorities' voices were routinely dismissed.

11 These failures were also not merely a result of
12 an inevitable struggle to respond to a novel virus. The
13 study found that clear guidance was either not known
14 about or not applied.

15 Chair, the PBPOs invite the Inquiry to investigate
16 whether the lack of attention and prioritisation of
17 maternity and related services was indicative of
18 structural failures to recognise the importance of
19 continued care for women, pregnant people and children.

20 Staff shortages also had a major impact on the
21 provision of services and notably on the choices
22 pregnant women and people could make about where and how
23 to give birth. As early as 23 March 2020, the day that
24 lockdown was announced, the Chief Nursing Officer from
25 England was informed that London ambulance services had

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1 friends and family, women and their partners could not
2 access effective bereavement care.

3 We submit the Inquiry should treat bereavement and
4 postnatal support as a crucial form of pregnancy-related
5 healthcare provision.

6 The PBPOs have submitted evidence which shows that
7 women and pregnant people expressed consistent fear of
8 Covid-19 and that this discouraged some who ought to
9 have sought early pregnancy or maternity care. We
10 request, Chair, that the Inquiry investigates how
11 information was communicated during the course of the
12 pandemic and how this contributed to confusion and
13 misunderstanding of how pregnant women should engage and
14 seek care.

15 Our second theme is visitor restrictions or, another
16 way of putting it, preventing pregnant women, people and
17 babies from receiving essential support.

18 Infection prevention and control or IPC measures
19 were a necessary part of promoting safety in healthcare
20 settings but decisions to impose restrictions on
21 visitation and support caused disruption and distress to
22 pregnant women, pregnant people, babies and their
23 families. It was eventually recognised across the UK in
24 various iterations of visiting guidance that birthing
25 partners are an essential part of the care giving team

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1 advised it could no longer guarantee ambulances would be
2 available to attend to home births or women giving birth
3 in a standalone birth centre if an obstetric emergency
4 occurred.

5 She was also informed that epidurals may not be
6 available if anaesthetists were required to attend
7 Covid-19 patients. In April 2020, 57% of home birth
8 services were closed in England. In late November 2020,
9 24 NHS trusts across England were reporting that
10 Covid-19 was impacting on the maintenance of safe
11 staffing levels in maternity services and this did not
12 improve in the second wave of the pandemic.

13 For ectopic pregnancies, access to non-surgical
14 treatments and to laparoscopic surgery was reduced due
15 to Covid-19 related restrictions and that meant some
16 women were forced to have more invasive procedures than
17 they would have wanted if they had the choice.

18 Another major impact of Covid-19 was the limited,
19 ability to provide face-to-face care, particularly in
20 the community, including once people were discharged
21 home. There was reduced access to midwives and health
22 visitors, exacerbated by the absence of contact with
23 direct family due to the lockdown restrictions. This
24 left many new mothers and families isolated. Without
25 either face-to-face support from specialists or from

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1 for the pregnant women or birthing people.

2 The PBPOs remain concerned however that visiting
3 restrictions were imposed without sufficient care and
4 without appropriate weight being afforded to the harms
5 caused by isolating women and birthing people and/or
6 their babies.

7 By 16 July 2020, only 19% of units allowed partners
8 to attend antenatal scans and, although 97% of units
9 were allowing partners to attend births, that is
10 a slightly misleading statistic because half of those
11 units only allowed partners in once active labour was
12 confirmed. How individual trusts applied that was
13 inconsistent. One result was that some women and
14 pregnant people felt coerced into vaginal examinations
15 to determine if labour was sufficiently established so
16 that their partners could finally enter the room.

17 Other women's care suffered because they had no
18 family or support people available to them to help to
19 understand what was being said by staff. The health
20 services safety investigations body reports a rise in
21 stillbirths during Covid-19 and identified that around
22 43% of the birth incidents they investigated involved
23 a mother who did not speak English as their first
24 language. The PBPOs submit that the Inquiry should
25 closely scrutinise decision-makers' understanding of the

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1 IPC risks in early pregnancy, maternity and neonatal
2 care, the proportionality of the restrictions imposed
3 and centrally the impacts of those restrictions.

4 Could alternative IPC measures to blanket visiting
5 restrictions have been considered and used? We invite
6 the Inquiry to examine the clinical justifications for
7 and proportionality of the restrictions placed on
8 allowing pregnant women and people a support person
9 during all forms of care, and also the delay until
10 December 2020 in providing national guidance on visiting
11 in maternity services.

12 Our third theme is inequalities in care of pregnant
13 women and babies. The PBPOs are concerned about areas
14 of inequality which emerged in the delivery of early
15 pregnancy, maternity care and neonatal services during
16 the pandemic. We submit the Inquiry should consider the
17 long-term impact on future generations of the
18 inequalities in maternity and neonatal care which were
19 further baked in through the pandemic.

20 Our final and fourth theme is PPE care and contact
21 with babies and impact on families. One woman whose
22 baby was in the neonatal ward said PPE made her feel cut
23 off from her baby:

24 "She is 8 weeks old and I haven't kissed her yet."

25 There were extraordinary and upsetting experiences
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1 I stood up to make my submissions, I held up my client's
2 CO2 monitor, which I have again here, and I asked on
3 their behalf: what about the air quality? What about
4 ventilation? Covid is airborne; what, I asked, was the
5 Inquiry doing to ensure that the air in the hearing
6 centre was well-ventilated and cleaned?

7 Over the months that followed, my clients had
8 extensive discussions with the Inquiry staff, who, to
9 their credit, have been diligent and accommodating.
10 Air filters, the machine which is behind me, were
11 provided, and a CO2 monitor sits on top of it.

12 Why do I start here? To use fashionable language,
13 the Inquiry and CVF have been on a journey together, and
14 that journey illustrates the journey which the UK has
15 been on too, towards understanding and accepting that
16 Covid is airborne. It doesn't just exist in large
17 droplets which fall onto surfaces, it floats through the
18 air. Covid is airborne. Three of the most important
19 words in this Inquiry.

20 A number of questions arise: who knew? When did
21 they know? When should they have known? Those are
22 classic questions for lawyers. But finding out who knew
23 what and where and who should have known when and when
24 will not bring back a single life of the over 200,000
25 who have died, the vast majority of them clinically
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1 for many parents and there seems to have been a failure
2 to consider the wider health consequences of imposing
3 blanket rules, such as mask wearing for new parents in
4 the name of general public health and at the expense of
5 skin-to-skin contact.

6 In conclusion, the PBPOs call for the Inquiry to
7 make sure that pregnant women, new parents and infants
8 are not overlooked in future pandemic responses and
9 public emergencies, the inequalities are highlighted and
10 that the care of pregnant women, pregnant people and
11 newborn babies is properly resourced so that
12 fundamentally they are safe.

13 I'm moving on now to the Clinically Vulnerable
14 Families.

15 CVF is a grassroots organisation born of the
16 pandemic. It represents the clinically vulnerable, the
17 clinically extremely vulnerable, the immunosuppressed
18 and their families.

19 I start with this point, Chair: some 18 months ago,
20 on 28 February last year, you held the first preliminary
21 hearing in this module. As you know, we were not in
22 this hearing room but in a cavernous function suite in
23 a hotel. After each advocate spoke, from the same
24 lectern, and before the next one could begin, a gloved
25 employee painstakingly wiped the lectern down. When
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1 vulnerable, including many healthcare workers and people
2 who caught Covid-19 in hospitals, which were supposed to
3 be places of safety.

4 A crucial question, we say, is: what are the
5 implications of what we know now? Ms Carey this morning
6 referred to the Inquiry's important forward-looking
7 perspective. That is music to the ears of CVF. The
8 fact that Covid is airborne is an inconvenient truth,
9 because it undermines many of the major messages given
10 out during the pandemic to the public. Hands, Face,
11 Space. What about air? It undermines much of the
12 guidance which was the foundation of how patients and
13 healthcare workers were protected or, as it turned out,
14 unprotected.

15 For many of the pandemic the clinically vulnerable
16 and clinically extremely vulnerable were told: if you
17 follow some simple rules you'll be protected, you will
18 be shielded. But as the evidence in this module will
19 show, there was a paradox. The people who were given
20 the strictest precautionary advice at home were the same
21 people who were most likely to have to spend time at GP
22 practices and in hospitals, and there they were exposed
23 to a serious risk of contracting Covid-19. The
24 clinically vulnerable were told to take personal
25 responsibility, wash their hands and keep their
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1 distance. But by focusing on personal responsibility,
2 public authorities may at the same time have been
3 washing their hands of their own responsibility.

4 Patients cannot be responsible for the environments
5 in healthcare settings. Institutions are responsible
6 for those environments. The realisation that Covid-19
7 is airborne requires a paradigm shift in our
8 understanding of how to protect everyone from the virus,
9 and any airborne pathogen, including the flu. We need
10 better ventilation, air filters, high quality masks.
11 Good ventilation is key, as Ms Carey said this morning.
12 In one sense the pandemic has been the greatest ever
13 missed opportunity to educate the public on those simple
14 mitigations. Improving air quality would be the
15 simplest improvement in infection prevention and control
16 since hand washing. Improving conditions for the
17 clinically vulnerable means improving conditions for
18 all.

19 We trust, Chair, that now you have such high quality
20 and conclusive evidence, not just me holding up an air
21 monitor, for example from Professor Beggs, that your
22 Inquiry will not squander the same opportunity, or we
23 will be back to square one now and when the next
24 pandemic hits.

25 Against that background, I'll briefly summarise some
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1 A second focus: the decision-making process used to
2 decide when to start, pause and stop the shielding
3 programme. CVF submits the shielding programme began
4 too late, meaning too many vulnerable people were put at
5 unjustified risk. CVF also has serious concerns about
6 the abruptness with which the shielding programme ended.
7 In CVF's factual evidence from Dr Catherine Finnis,
8 which reflects many members' concerns, she describes
9 stopping shielding as like falling off a cliff. When
10 national shielding advice and associated support came to
11 an end on 31 March 2021, around 30% of the 3.8 million in
12 the shielding list had still not received a first dose
13 of the vaccine, and for some clinically extremely
14 vulnerable the vaccine was not particularly effective
15 for them in any event.

16 Chair, we invite you to investigate whether the
17 shielding programme should have ended at that stage and
18 whether transitional or rehabilitative support after the
19 end of the shielding programme was fit for purpose.

20 Third, communication and advice for people shielding
21 and designated as clinically vulnerable. People
22 shielding and those designated as clinically vulnerable
23 and at the highest risk had the right to expect timely,
24 evidence-based and sensitive communications and advice,
25 yet they frequently felt as if they had been forgotten

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1 key points we make in our written submissions.

2 First, the decision-making process used to identify
3 the clinically vulnerable. CVF accepts that, to
4 an extent, an iterative process was unavoidable.
5 Clinical criteria for shielding was adapted as more
6 evidence about the nature of the disease emerged, but
7 this does not explain some key omissions. For example,
8 why were learning disabled adults not added to the
9 shielded patients list until 19 February 2021 despite
10 evidence being published in November of 2020 that people
11 with learning disabilities were 3.6 times more likely to
12 die from Covid-19?

13 Inconsistencies and delays meant some very
14 vulnerable people were unaware of the need to shield and
15 those who were clinically vulnerable, as opposed to
16 clinically extremely vulnerable, were not actively
17 contacted or informed of their risk status until they
18 were called for their first vaccines in 2021.

19 Clinically vulnerable people were not advised to
20 shield, nor were they offered protections such as
21 entitlement to sick pay or priority access to essential
22 medications and food. Unless individuals had educated
23 themselves, they were left unaware of their increased
24 risk, and we ask the Inquiry to investigate the factors
25 which led to the distinction of these two groups.

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1 or as if their needs and concerns did not matter. On
2 the most basic level, vital communications, such as
3 those advising people to shield, did not always reach
4 the right people or reach them in good time, and we
5 invite you to scrutinise, Chair, the underlying reasons
6 for these problems, the effect of which has been to
7 leave clinically vulnerable people exposed, unsafe and,
8 as a result of widespread public misunderstanding, at
9 a risk of discrimination and abuse.

10 Fourth, the impacts of the shielding programme.
11 Shielding undoubtedly protected some of the most
12 vulnerable, but it also had negative psychological and
13 social effects, as well as practical limitations. There
14 were mental health impacts, impacts on family and
15 household members of those shielding, restrictions on
16 receiving care at home, financial implications -- many
17 of who shielded lost businesses and jobs -- and, more
18 broadly, social isolation and stigma.

19 CVF requests that the Inquiry investigates whether
20 these impacts could have been mitigated by support that
21 was targeted, meaningful and more long term.

22 Fifth, access to healthcare for people shielding and
23 for the clinically vulnerable. As a result of the
24 failure to implement basic protective measures across
25 healthcare, many clinically vulnerable people have felt

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1 and continue to feel that they cannot access healthcare
2 safely. Two issues are of particular importance: the
3 lack of clean air and adequate ventilation; and the lack
4 of evidence-based guidance in relation to face masks.

5 CVF submits that both of these shortcomings have
6 contributed to an avoidably high level of
7 hospital-acquired infection, which have put vulnerable
8 people at particular high risk. And I say again,
9 hospitals are supposed to be safe places, not places
10 where you contract further illnesses.

11 CVF invites the Inquiry to conclude that meaningful
12 and urgent changes are needed to ensure the air in
13 healthcare settings is clean and safe to breathe, and we
14 also ask you to investigate the difficulties many
15 clinically vulnerable people have experienced in
16 accessing their usual care for their underlying
17 conditions.

18 Sixth, decision-making about healthcare provided to
19 Covid patients. CVF considered there should be
20 an urgent systemic review of DNACPRs put in place during
21 the height of the pandemic, and also support should be
22 put in place for those affected by decisions forced on
23 them.

24 Finally, decision support tools. CVF remains
25 concerned about the longer term impact of pandemic

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1 The department wishes again to take the opportunity
2 in this module to extend its condolences to those who
3 lost loved ones during the Covid pandemic. Those who
4 were lost and those who mourn must and will be at the
5 forefront of our minds as we assess the impact of the
6 pandemic on our healthcare systems, healthcare workers
7 and wider society.

8 We must also not forget the efforts of all of those
9 who worked tirelessly across the frontline of healthcare
10 organisations to provide care and support to those sick
11 and dying, working both compassionately and
12 professionally throughout.

13 We remember also those who are still living with the
14 effects of Covid-19, through the condition that has come
15 to be known as Long Covid. There are also people who
16 continue to be affected by the measures introduced
17 during the pandemic to protect people, to protect the
18 healthcare systems and society at large.

19 The department acknowledges that the interventions
20 in response to the Covid-19 threat, whilst necessary,
21 had serious consequences for many parts of society. The
22 department has said previously that the challenge was
23 not to make the right decision, but rather to make the
24 decision that was least wrong.

25 In reaching the least wrong decisions, the

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1 conversations around clinical prioritisation and the use
2 or the putative use of scoring systems.

3 CVF welcomes the Inquiry's scrutiny of this issue
4 and hopes this will bring clarity as to the design of
5 the proposed prioritisation framework by the working
6 group in late March 2020 as well as the Department of
7 Health's decision not to continue with this work.

8 To conclude, CVF's concerns are linked by a common
9 theme: the inescapable reality that the
10 disproportionately severe impact of Covid-19 on the
11 clinically vulnerable and associated decision-making
12 were insufficiently considered and mitigated since the
13 emergence of Covid-19. The clinically vulnerable
14 continue to feel the effects and live in the shadow of
15 the virus today.

16 Thank you.

17 **LADY HALLETT:** Thank you very much, Mr Wagner. Very
18 grateful.

19 Ms Murnaghan, I think you're going next.

20 **Submissions on behalf of the Department of Health Northern
21 Ireland by MS MURNAGHAN KC**

22 **MS MURNAGHAN:** Good afternoon, my Lady.

23 My Lady, I appear on behalf of the Department of
24 Health in Northern Ireland, which I refer to as "the
25 department".

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1 department was acutely aware that those decisions would
2 have ongoing repercussions on the healthcare system, on
3 those working in it and those who required its services.

4 Shielding, for example, was introduced in
5 Northern Ireland with the aim of protecting the most
6 vulnerable in our society and, as our former health
7 minister, Mr Robin Swann, stated in his witness
8 statement to this module, the need for shielding was
9 kept under continuous review.

10 The significant impact that shielding had, both in
11 terms of loneliness, isolation and the deleterious
12 impact on mental health, was shown by the findings of
13 the Patient and Client Council survey. These findings
14 indicated that shielding resulted in a detrimental
15 social and psychological effect on a significant group
16 of those who responded to that survey. It was in light
17 of those findings, once shielding was paused in
18 Northern Ireland on 31 July 2020, that, unlike in
19 England, it was never reintroduced in Northern Ireland.

20 The department's advice to the Northern Ireland
21 Executive ultimately led to the implementation of
22 various measures in response to the pandemic. This
23 response included shielding, the closure of schools,
24 shops, restaurants and hotels, social distancing and the
25 wearing of masks. Whilst the department has previously

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1 acknowledged that these measures imposed a huge cost on
2 society, it remains of the view that the advices given
3 and the decisions taken were the optimum choices at the
4 time, based on the state of knowledge at that time.

5 The department ensured that these measures were
6 reviewed regularly and were intended to only be as
7 restrictive as was strictly necessary. This module has
8 the benefit of an expert report from Dr Gee Yen Shin,
9 Professor Dinah Gould and Dr Ben Warne on infection
10 prevention and control. In respect of visiting
11 guidelines, the learned authors' conclusion was that it
12 was unlikely that any iteration of visiting guidance
13 would satisfy all relevant stakeholders who all have
14 very different priorities and responsibilities.

15 My Lady, the department considers that this is
16 a conclusion which could be drawn in respect of all of
17 the guidelines and measures enacted throughout the
18 pandemic. Visiting guidance applied equally across all
19 healthcare settings, but throughout the pandemic in
20 Northern Ireland it evolved as knowledge of the virus
21 increased, including transmission rates and community
22 prevalence. The department was motivated to keep the
23 most restrictive measures in place for as short a period
24 as was possible.

25 The same approach of minimising restrictions of
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1 to learn from this Inquiry's work.

2 Thank you.

3 **LADY HALLETT:** Thank you very much.

4 Mr Pezzani. Have I pronounced it correctly?

5 **MR PEZZANI:** My Lady, yes.

6 **LADY HALLETT:** I think you need the microphone, though.

7 **Submissions on behalf of Mind by MR PEZZANI**

8 **MR PEZZANI:** My Lady, I make submissions on behalf of Mind,
9 the leading mental health charity in England and Wales.

10 The focus of this module is on, in relation to mental
11 health, children and young person inpatients, but Mind
12 reminds the Inquiry that the pandemic had a profound
13 impact on all people struggling with their mental
14 health. One study found that people with serious or
15 severely mental illness were almost five times more
16 likely to die during the pandemic than people without
17 severe mental illness.

18 On 13 November 2020 the then Chief Executive of Mind
19 issued an urgent communique, warning that the nation was
20 in the grip of a mental health emergency. Mind
21 identified the personal trauma this was causing
22 individuals but also the added strain on the NHS. Mind
23 urged the government to learn from what went wrong in
24 the first wave of Covid-19 and make sure that people
25 could get prompt access to the help they needed in order
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1 non-pharmaceutical interventions was mirrored in a more
2 formal way in the Health Protection (Coronavirus,
3 Restrictions) regulations of 2020. Regulation 2(2) of
4 those regulations required the department to review the
5 need for restrictions at least once every 21 days.

6 Further, regulation 2(3) stated that the department
7 should terminate any restriction as soon as it was
8 considered no longer necessary.

9 The department considers that it carried out these
10 responsibilities with the utmost of concern, and it
11 advised the Northern Ireland Executive in relation to
12 the possibility of relaxing restrictions each time it
13 became apparent, whether from scientific or medical
14 advice and data, that those restrictions were no longer
15 necessary or proportionate.

16 The department acknowledges that the impact of
17 decisions taken by it and the entire Executive were at
18 times understandably difficult to accept by various
19 stakeholders. However, we consider it is a testament to
20 the people of Northern Ireland that the vast majority of
21 them did rise to this challenge and followed the
22 restrictions in a way that ultimately reduced the
23 overall impact of Covid-19. For that, my Lady, the
24 department repeats its thanks to everyone for the
25 sacrifices they made and we confirm that we stand ready
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1 to protect both their mental health and the NHS.

2 Mind's current Chief Executive, Dr Sarah Hughes now
3 finds herself making very similar recommendations today
4 with an emphasis on, first, the need for forward
5 planning for mental health provision in the event of
6 further pandemics; second, the expansion of community
7 alternatives to inpatient admission; third, ending the
8 inappropriate out of area placement of children and
9 young people and ending their admission to adult wards;
10 fourth, on an end to the digital exclusion of
11 disadvantaged children and young people from mental
12 health services; fifth, ensuring children and young
13 people are discharged from hospital only when it is safe
14 to do so and conversely that they are not left
15 languishing in hospital due to under-resourced community
16 aftercare; and, sixth, for there to be urgent
17 improvements to hospital and community mental health
18 staffing levels, which need to be more consistent and
19 with reduced reliance on agency staff who will be
20 unfamiliar with often very complex cases.

21 The pandemic resulted in an increase in mental
22 health problems for children and young people leading to
23 increased demand for services to meet that need.
24 Children and young people are at a higher risk of
25 anxiety and depression caused by lockdown. Notably,
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1 cases of severe eating disorder in children and young
2 people increased significantly during and beyond the
3 pandemic with potentially grave consequences: eating
4 disorders have the highest mortality rate of any mental
5 illness.

6 The pandemic worsened health inequalities within
7 child and adolescent mental health care. At the start
8 of the first lockdown, there was a significant rise in
9 the number of psychiatric admissions to hospital from
10 the most deprived areas of the country. People with
11 protected characteristics all fared disproportionately
12 badly in the deterioration of their mental health during
13 the pandemic but those who suffered most were those
14 people with pre-existing mental health conditions.

15 In its *Not Making the Grade* report from 2021, Mind
16 found that, during the pandemic, existing inequalities
17 in housing, employment and income had a greater impact
18 on the mental health of people from racialised
19 communities than on white people.

20 The Inquiry experts appointed for this aspect of
21 this module, Drs Northover and Evans, confirmed that
22 there were apparently no specific plans in place for
23 mental health inpatient services in the UK's pandemic
24 preparedness planning, despite the predictable and
25 serious mental health toll of social isolation, anxiety,

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1 before the pandemic hit, children and young people's
2 mental health services had been criticised for their
3 failure to meet the needs of the most vulnerable people
4 in our society.

5 In 2017, Sir James Munby described the well-known
6 scandal of the disgraceful and utterly shaming of lack
7 of proper provision in this country of the clinical,
8 residential and other support services so desperately
9 needed by increasing numbers of children and young
10 people.

11 The surge in demand for mental health care in 2020,
12 along with the restrictions imposed by lockdown, led to
13 a further reduction in the availability of mental health
14 services at a time when they were needed more than ever.
15 Mind's report on the consequences of coronavirus for
16 mental health from 2021, which included insights from
17 over 1,700 young people, found that 18% of them
18 experienced mental distress for the first time during
19 the pandemic and nearly 90% reported that loneliness
20 caused by the lockdown worsened their mental health.
21 But 42% of those young people had to wait three or more
22 months to get support and over a quarter had to wait
23 more than four months.

24 A 2022 CQC report found a 32% rise in the number of
25 under 18s being admitted to adult wards due to lack of

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1 financial distress and grief.

2 Nor was there consideration of the mental health
3 impact on children and teenagers, for example from
4 disrupted schooling and social isolation. Mind's
5 research has found that children and young people were
6 particularly vulnerable to the impact of the pandemic,
7 they were the most likely to use negative coping
8 mechanisms with almost a third reporting self-harming to
9 cope with lockdown restrictions, making them more than
10 twice as likely to have coped by self-harming than
11 adults over 25.

12 Young people who were most disadvantaged were also
13 the most likely to face digital exclusion, and children
14 and young people are the least likely to feel
15 comfortable with remote mental health support, which
16 doesn't always enable apt privacy or an accurate
17 assessment of an individual's mental health, nor is it
18 always an effective means of providing treatment, and it
19 should thus not represent a panacea response to the need
20 for infection control.

21 The children and young persons mental health sector
22 is staffed by dedicated individuals, many of whom
23 struggled through the pandemic to provide for the
24 vulnerable people in their care. But a part of that
25 struggle was with inadequate resources. In the years

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1 alternative inpatient or outreach services and warned
2 that the impact of the Covid-19 pandemic on children and
3 young people's mental health services continues to be
4 felt with services struggling to meet rising demand.
5 This is increasing the risk of children and young people
6 ending up in inappropriate environments.

7 Mind continued speaking to people coping with mental
8 health problems throughout the pandemic and one of the
9 most valuable aspects of Mind's evidence is in those
10 voices. They are not typical because there is always
11 nuance in an individual's experience of symptoms and
12 treatment. But there are themes, one of which is
13 a tension between infection control and the management
14 of risks arising from mental disorder, with potentially
15 grave consequences.

16 In one case known to Mind, a young person who was
17 a psychiatric inpatient and an acute risk of suicide
18 needed to travel to A&E for suspected self-harm but she
19 was discharged from the psychiatric hospital and refused
20 readmission there because of the risk of Covid
21 infection. So she went home, and the next day she ran
22 away from the family home with the intention of jumping
23 off a bridge. Thankfully, she did survive.

24 Another young inpatient reported the effects of
25 isolation on the ward:

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1 "The whole ward had Covid, everyone alone in room
2 for two weeks, food left outside door, no conversation
3 at all for the duration, bedroom stripped, so nothing to
4 do, staff not noticing risk behaviour, eg I flushed my
5 food down toilet, was written down I had eaten as plate
6 was empty. Didn't drink for four days towards end of
7 isolation, ended up in critical condition as no-one
8 knew, one day without fluids actually being five,
9 et cetera. No physical health monitoring during the two
10 weeks, no way to monitor the effects my eating disorder
11 was having on my body."

12 It's vital to recognise that mental disorder can
13 itself cause severe risk to the health and the life of
14 those suffering from it. A child or a young person
15 becomes a psychiatric inpatient when there are
16 significant risks associated with their mental disorder.
17 Mind calls for clear recognition in the guidance of the
18 importance of balanced risk assessments, so that the
19 imposition of pandemic control measures does not result
20 in insufficient weight being given to the risks arising
21 from mental disorder.

22 Inpatient services represent one end of a spectrum
23 of treatment strategies that should be available to
24 children and young people when they need them, at the
25 level on that spectrum they that need them. On the

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1 resources to a long under-resourced sector is urgently
2 needed. In the event of further pandemics, all mental
3 health services must be prepared for the foreseeable
4 effects on the psychological wellbeing of the
5 generations that represent our future.

6 Those are the opening submissions of Mind.

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

8 Mr Simblet?

9 **Submissions on behalf of COVID-19 Airborne Transmission**

10 **Alliance by MR SIMBLET KC**

11 **MR SIMBLET:** Good afternoon, my Lady.

12 The Covid Airborne Transmission Alliance, or CATA,
13 is very pleased to be here in this module and welcomes
14 the Inquiry's direction of travel.

15 CATA's helped the Inquiry in this module, we would
16 hope, to make important progress with its fundamental
17 points appearing to have been accepted.

18 First, the Inquiry has, in the Module 1 report,
19 treated Covid as airborne and examined the planning for
20 airborne viruses.

21 Secondly, as Mr Wagner has just said, the Inquiry's
22 own approach to wiping down the lectern between counsel
23 speaking, and so on, is no longer occurring, in fact at
24 one of the earlier preliminary hearings I was stopped by
25 my instructing solicitor from saying that there was no

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1 other side of the ward doors, adequately resourced
2 community resources and mental health services are
3 a vital part of what should be a cohesive system by
4 which to provide children and young people in mental
5 health crisis with timely intervention. This is the
6 only way to ensure that young patients who have been
7 discharged from inpatient services get the aftercare
8 they need to promote sustained recovery and avoid
9 readmission, and prompt community treatment can prevent
10 deterioration and the need for readmission, thus
11 relieving the pressure on inpatient beds.

12 Society has a duty to our children and young people
13 to ensure that mental health services are prepared for
14 the consequences of the next pandemic. If we fail that
15 duty, we fail a generation that now has unprecedented
16 insight into its own mental health and into the need to
17 seek help. That insight represents societal progress.

18 In May 2022 Mr Justice MacDonald reminded us that
19 the development of children and young people and the
20 development of society are intrinsically and inseparably
21 linked. If there is a failure to safeguard and promote
22 the welfare of the children and young people, then
23 society as a whole will suffer.

24 Planning for the mental health effects of a pandemic
25 on children and young people and the allocation of

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1 need to do that because Covid was airborne because she
2 was concerned it would come across as facetious. Now,
3 it's orthodoxy.

4 Thirdly, CATA's evidence will be, we hope, helpful
5 and important in this Inquiry. CATA commends your
6 calling Dr Barry Jones early on and commends that his
7 detailed and considered and authoritative witness
8 statement is being put to other witnesses.

9 My Lady, this is all very refreshing to CATA,
10 compared to how they were treated before because, as you
11 know, CATA's members are healthcare professionals but,
12 importantly, CATA did not exist prior to the pandemic.
13 CATA and its previous incarnations only came into being
14 because experienced knowledgeable healthcare
15 professionals could see in real time the terrible errors
16 being made and were compelled to do something about it.

17 Regrettably, the response from those in authority
18 was to ignore or seek to manage their concerns, and they
19 were marginalised. So it is a relief to them to see
20 that their concerns are being taken seriously by this
21 Inquiry.

22 My Lady, some points on healthcare professionals and
23 the misdirection of them during the pandemic.
24 Healthcare professionals are: one, used to taking
25 serious decisions, informed by evidence, and also

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1 knowing and following procedures; secondly, are people
2 and, in the Covid pandemic, recipients of advice given
3 to the wider public; and, thirdly, people with common
4 sense.

5 One theme in this module is the obvious conflicts
6 between the instructions being given to the wider public
7 to stay apart from other people, minimise interactions,
8 meet only outside or in well ventilated spaces, when
9 contrasted with the instructions and procedures that
10 CATA could see being provided at work and, indeed, what
11 was being said to healthcare workers or what they could
12 see with their own eyes was often obviously
13 contradictory or impossible to implement.

14 Essentially, my Lady, knowledgeable healthcare
15 workers were instructed to suspend their common sense
16 and instructed to follow confused and flawed
17 instructions in relation to their working practice and
18 their dealings with patients. They were instructed to
19 trust in procedures that were not scientifically based
20 and without equipment that was obviously necessary.

21 They were not told that these decisions were based
22 on lack of resources or equipment, though we submit that
23 plainly the evidence will show that to be the reason,
24 and instead were expected to believe that such equipment
25 was not required.

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1 our IPC policy. As staff did not feel adequately
2 protected they felt reluctant to have physical contact
3 with patients and reluctant to spend the time necessary
4 with patients to carry out the best possible treatment.
5 Staff would also be mentally distracted due to the
6 stress and fear of being infected, which even further
7 eroded the level of care provided to patients."

8 Then she continues with a number of specific
9 examples.

10 You're also calling Tracy Nicholls from the College
11 of Paramedics, from whom you'll hear next week. She
12 describes obvious dangers in requiring ambulance
13 personnel to stay in the back of ambulances for
14 extensive periods at hospital. She will tell you about
15 the enduring effects in terms of fear, estrangement and
16 increased staff turnover even after the pandemic.

17 So what we submit is that the context for this
18 module is that what CATA has consistently been saying is
19 supported by the expert evidence marshalled, that
20 SARS CoV-1 was known to pose a particular risk to
21 healthcare workers due to the nature and proximity with
22 which they have to work with patients, and that the
23 scandal -- for that is what it is -- is that Covid's
24 airborne nature was never properly addressed until it
25 was far too late. Indeed, it may still not be being

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1 Among your 250 witness statements is one from
2 Dr Nathalie MacDermott, who is an award winning
3 infection control expert. She describes different
4 colleagues from different healthcare professions having
5 different kit to deal with the same patients, depending,
6 it seemed, on the approach taken by their professional
7 bodies or the particular level of authority of the
8 medical professional involved, such as senior
9 consultants being able to override things.

10 Those failures, as we submit they are, of infection
11 prevention and control often had grave consequences for
12 the clinicians involved. Dr MacDermott herself is now
13 seriously disabled from Long Covid and has become
14 a wheelchair user alongside other problems caused by the
15 pandemic.

16 As that statement also says, there have been very
17 considerable problems even properly reporting that sort
18 of injury under the RIDDOR regulations and what we
19 submit is unreasonable disputation of her Covid
20 infection being work-related.

21 There were serious consequences of course for
22 patient care. That same statement, at paragraph 29,
23 says this:

24 [As read] "I have no doubt that the patients on my
25 ward received a lower standard of care as a result of

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1 properly addressed. Even recently signed statements
2 from the state witnesses do not seem to accept that.

3 The response was never about following the science
4 at all. All of this was compromised for economic and
5 pragmatic reasons. In our written submissions we've
6 highlighted specific matters to look at in relation to
7 the workings of the IPC cell, and we say that's
8 an important matter for your investigation. It's not
9 currently clear that all of the IPC cell minutes are
10 available, and as we go through the Inquiry will need to
11 scrutinise very carefully the workings of that body, and
12 very robustly, because it seems to CATA that the IPC
13 cell towed a line born of expedience, particularly
14 political expedience, rather than actually following the
15 science.

16 So the materials disclosed and the evidence you're
17 calling will show, unfortunately, catastrophic failures
18 to protect healthcare workers and their patients, and
19 those still remain today. Those breaches of trust or,
20 to use the words of John in your opening video this
21 morning, the moral injury to the profession, are not
22 just reprehensible in terms of the treatment of
23 committed staff, but also affect service provision.
24 Failures to inform and protect clinicians damage the
25 provision of healthcare to all.

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1 My Lady, we'd also ask you to keep this in mind.
 2 Although this module is looking at healthcare systems,
 3 those systems comprise people. An inquiry such as this
 4 should also look to hold individuals accountable for
 5 what we submit are serious failures. Dangerous
 6 practices and those responsible for them must be
 7 stopped, and that danger is ongoing.

8 Finally, my Lady, as invited by your counsel in her
 9 opening, CATA is going to be wanting to make submissions
 10 on recommendations, and I'll trail some now because some
 11 are of real urgency.

12 First, in concordance with the expert IPC reports,
 13 CATA wishes to see immediate changes to IPC guidance
 14 reflecting updated aerosol physics and transmission,
 15 together with mitigations including respiratory
 16 protective equipment and ventilation. This should be
 17 UK-wide.

18 Second, a complete overhaul of IPC guidance and
 19 governance with new leadership of a multidisciplinary
 20 body.

21 Pausing there, my Lady, those matters, we would
 22 submit, are of such urgency that you may need to
 23 consider making interim recommendations.

24 Thirdly, that all healthcare workers should be
 25 protected under health and safety law from airborne

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1 On behalf of FEMHO, Federation of Ethnic Minority
 2 Healthcare Organisations, we say we don't have to accept
 3 it. We just don't. Why? It reminds me of that James
 4 Baldwin quote:
 5 "Not everything that is faced can be changed but
 6 nothing can be changed until it is faced."
 7 This is a pivotal moment for your Ladyship's
 8 Inquiry, and we will be hearing from a diverse and
 9 poignant array of voices, from the heart-wrenching
 10 testimonies of those who are bereaved to the invaluable
 11 perspectives shared by others devastatingly impacted by
 12 the pandemic.

13 My Lady, as we explore Module 3, let us remember
 14 this: that this Inquiry is not just a procedural
 15 exercise but an opportunity to confront deep-rooted
 16 injustices and work towards a fairer, more equitable
 17 future.

18 I'm not going to go into the background in any great
 19 detail. Your counsel, Ms Carey KC, really set out the
 20 framework, I say respectfully, in a great way this
 21 morning. But the pandemic has laid bare the deep seated
 22 inequalities within our healthcare system. Professors
 23 James Nazroo and Laia Bécares confirmed the ethnic
 24 inequalities in health in the UK:
 25 "... are long-standing and persistent and have been

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1 pathogens, particularly at close range, and for RIDDOR
 2 reporting to be robust.

3 Next, that there needs to be meaningful stakeholder
 4 end user engagement with full transparency and clear
 5 accountability to restore healthcare worker trust, and
 6 to ensure, in concordance with your recommendation from
 7 Module 1, pandemic planning to ensure adequate supplies
 8 of respiratory protective equipment.

9 Finally, that the precautionary principle and common
 10 sense should always prevail in the face of scientific
 11 uncertainty.

12 So, my Lady, those are my submissions.

13 **LADY HALLETT:** Thank you very much, Mr Simblet.

14 Mr Thomas, last but definitely not least.

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

17 **PROFESSOR THOMAS:** I hope fatigue has not set in.

18 **LADY HALLETT:** Not at all.

19 **PROFESSOR THOMAS:** My Lady, do you remember the video we
 20 watched this morning, the impact video, and there was
 21 that healthcare worker, I believe she was a doctor, who
 22 was saying "We just have to accept the discrimination".

23 **LADY HALLETT:** I think she may even be present or has been
 24 present today.

25 **PROFESSOR THOMAS:** Yes.

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1 researched and documented for several decades."
 2 On this basis, we consider it indisputable that the
 3 disparate impact arising from the pandemic of this
 4 nature was foreseeable. It did not have to be, however,
 5 inevitable, as impactful as it was here.

6 You see, in the missed opportunities for
 7 countermeasures and early mitigation that ethnic
 8 minority health and social care workers and their
 9 communities were so badly failed by those leading the
 10 response, you see from the very outset -- and forgive me
 11 if I repeat what has been said before, but I think it's
 12 necessary to repeat these statistics -- it was evident
 13 that black, Asian and minority ethnic workers were being
 14 disproportionately affected, not least through facing
 15 alarmingly higher rates of infection and mortality. 95%
 16 of doctors and 64% of nurses who succumbed to the virus
 17 in the early stages of the pandemic were from ethnic
 18 minority backgrounds.

19 Here there are chilling parallels with Grenfell.
 20 The disparity and the devastating and direct health
 21 outcomes for ethnic minorities were well known and
 22 widely publicised early in the pandemic. These numbers,
 23 my Lady, are not mere statistics, they are a clarion
 24 call, irrefutable proof that systemic failures
 25 contributed to these tragic outcomes.

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1 My Lady, key questions for this Inquiry remain to be
 2 answered. Why? Why were so many lives impacted and
 3 lost, and how many of those deaths were avoidable?
 4 You see, systemic racism in healthcare is a deeply
 5 entrenched issue and the pandemic exposed it with
 6 unprecedented clarity. Do you remember when former
 7 Health Secretary Matt Hancock openly admitted when being
 8 questioned by myself that he was aware of and agreed
 9 with the assertions that there was systemic racism
 10 prevalent within the NHS prior to the pandemic? Yet no
 11 effective action appears to have been taken by him or
 12 others to address that issue.

13 During the pandemic, FEMHO members faced inadequate
 14 PPE, flawed risk assessments, higher levels of bullying
 15 and harassment, and a range of broader systemic biases
 16 that were systemically disadvantaged and left them more
 17 exposed, less protected, less empowered to speak up and
 18 raise concerns. Quite frankly, my Lady, the law was
 19 flouted: the Human Rights Act 1998 and the Equality Act
 20 2010, which were both pieces of legislation which were
 21 there to protect everyone's rights.

22 So I make the following observations: why is there
 23 no obvious examples of accountability within the NHS
 24 leadership for the appalling issues regarding the
 25 appropriate PPE for black, Asian and minority ethnic

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1 economic hardship and the higher burden of illness and
 2 death led to elevated levels of anxiety, depression and
 3 burnout. The scrapped plan to mandate vaccination as
 4 a condition of deployment added to a climate of fear and
 5 distrust.

6 Furthermore, my Lady, the emotional strain on
 7 healthcare workers who had to support patients'
 8 families, often unable to visit due to the
 9 restriction -- we just heard about that -- compounded
 10 their mental health challenges. The intersection of
 11 racism, economic hardship and social isolation during
 12 the pandemic had significant impacts on the mental
 13 health of black, Asian and minority ethnic communities,
 14 exacerbating physical healthcare problems and
 15 exponentially increasing their vulnerability to
 16 Covid-19.

17 Root causes. Leadership. Diversity leadership was
 18 notably lacking.

19 So, my Lady, as I come to the end of my opening, let
 20 me just say this: recommendations and the call to
 21 action. As we proceed with Module 3, it's essential to
 22 address the systemic issues that have and may emerge as
 23 critical areas of concern. Perhaps we need to
 24 strengthen the public sector equality duty. We would
 25 urge a robust commitment to compliance with that duty.

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1 healthcare workers during the pandemic?
 2 Why? Why no new measures coming from the NHS's top
 3 brass indicating a recognition and decided steps to
 4 address the problems that ethnic minority healthcare
 5 workers faced?
 6 Why? Why no new policy or regulatory updates to
 7 indicate that the agencies will play a crucial role in
 8 the planning in the future pandemic?
 9 Why? Why no critical mass forming in the public
 10 consciousness around the direct relationship between
 11 racial health inequality and the disproportionate
 12 adverse health outcomes?
 13 A few more bullet points and then I'll sit down and
 14 finish.

15 As foreshadowed by your counsel this morning, why
 16 the failure in PPE provision? Why the lack of risk
 17 assessments? Why the failure in the provision of
 18 equipment? We heard about the oximeter.

19 Let us not forget or ignore the psychosocial and
 20 mental health impacts. You see, the emotional and
 21 mental toll on black, Asian and minority ethnic health
 22 and social care workers and their communities during the
 23 pandemic cannot be overstated.

24 One of my clients, Professor JS Bamrah's testimony
 25 will illuminate how stress of increased exposure,

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1 In other words it wasn't complied with, it simply needs
 2 to be complied with.

3 The duty of candour on public health bodies. You
 4 see, the Department of Health is just not learning the
 5 cultural lessons.

6 Thirdly, as I said, promoting diversity in
 7 leadership and decision-making.

8 Enhancing cultural competency in community
 9 engagement and looking at medical devices and equipment.

10 So let me come to my conclusion.

11 So in conclusion, this Inquiry has a crucial
 12 opportunity to address these systemic issues with
 13 seriousness and resolve. By thoroughly investigating
 14 the impact of institutional and structural racism and
 15 inequality and implementing the suggested
 16 recommendations that I've outlined, we can work towards
 17 creating a more equitable and more effective healthcare
 18 system.

19 It was Eleanor Roosevelt who said "It's better to
 20 light a candle than to curse darkness". Well, my Lady,
 21 the time for cursing the darkness of the Covid years has
 22 passed. We urge you to be that light, a beacon of hope
 23 and change, so shine brightly for all of those affected
 24 and lead the way towards justice, equity and greater
 25 equality.

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1 Thank you.
 2 **LADY HALLETT:** Thank you very much indeed, Mr Thomas.
 3 Right, well, I've had a great deal of food for
 4 thought today, and on that note we'll draw matters to
 5 a close for today. I shall return for Ms Sen Gupta,
 6 wherever she is -- I think she's back there somewhere --
 7 tomorrow at 10.

8 (4.35 pm)

9 (The hearing adjourned until 10 am
 10 on Tuesday, 10 September 2024)

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