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

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

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

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

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

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

My Lady, I will just quote two at the outset. A hospital porter said this:

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

A hospital cleaner said this to Every Story Matters:

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

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

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

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

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

Secondary care includes planned or elective care

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

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

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

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

These will all be aspects of the evidence heard in

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

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

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

the suitability and reliability of PPE that was supplied.

And my Lady may hear of some innovative ways that staff and management filled those gaps.

In total, over 16,500 documents have been disclosed. It amounts to over 225,000 pages of evidence. That work has resulted in a huge body of evidence. Many of the statements run to hundreds of pages, from which you will be able to draw your conclusions and, importantly, make recommendations to help the healthcare system's response in the future. I know that you will be assisted by the 36 core participants and their questions and submissions.

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

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

At the outset, it should be noted that when the

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

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

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

As health is a devolved matter, there are four distinct health systems within the UK, and whilst it may be an oversimplification, and the names and terminology may vary between the nations, it may be helpful to think of the structure in each nation in this way: the government minister sets the strategy, the respective government department devises the policy to deliver that strategy, and then each nation has its own body, bodies, organisations to put that policy into practice.

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

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

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

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

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

During the pandemic, the secretaries of state were

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Under that was silver command, or the bodies such as Public Health Agency in Northern Ireland, known as PHA, whose responsibilities include health protection. During the pandemic this entailed Public Health Agency providing sit rep data -- situation reports -- to the department, they maintained surveillance systems of Covid-19 cases and they looked at outbreaks, and they adapted guidance on the management of cases, to name just a few of their responsibilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There are 14 geographical health boards and seven

non-geographical special boards that are all supported by NHS National Services Scotland, or NSS, and indeed by Healthcare Improvement Scotland.

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

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

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

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

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

Healthcare Associated Infection service, or ARHAI for short. ARHAI provides national expertise for infection prevention and control. ARHAI's IPC guidance was published in what is called the *National Infection Prevention and Control Manual*, NIPCM, and that manual was first published in Scotland in 2012 and it's important because it now forms what I may call the backbone of much of the IPC guidance used across the UK today.

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

My Lady, may I just say one thing about that cell. That cell brought together IPC leads of the NHS and the public health bodies from all four nations. Each national representative on the cell was responsible for taking the cell's recommendation back to its respective country for approval, usually either by the Chief Nursing Officer or the Chief Medical Officer. It was not technically a decision-making body. However, you

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

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

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

The term NHS Wales is commonly used to refer collectively to the local health boards and indeed the

special health authorities but, unlike in NHS England, there is no central legal entity of this name.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

evidence.

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

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

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

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

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

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

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

treated "as an afterthought" during the pandemic.

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

Might that be a convenient moment for a break?

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

I shall return at 11.40.

MS CAREY: Thank you, my Lady.

(11.28 am)

(A short break)

(11.40 am)

LADY HALLETT: Ms Carey.

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

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

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

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

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

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

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

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

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

As to transmission, in very basic terms, in order

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

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

Thank you.

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

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

respiratory tract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And can I call up page 10, please.

There is the hierarchy of controls, the most

effective at the top, down to the least effective.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

an HCID or not.

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

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

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

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

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

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

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

a known or suspected infection.

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

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

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

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

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

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

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

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

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

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

During the course of the evidence, my Lady will

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

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

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

You can be asymptomatically infectious and not

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

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

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

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

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

examined during this module.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GPs to meet the level of demand.

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

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

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

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

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

Story Matters:

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

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

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

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

The reduced access to GPs led to a surge in demand

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

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

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

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

As originally planned, the scheme would only extend to pharmacists in exceptional circumstances. However, the government soon changed its mind and included pharmacists in the scheme and it is worth noting, for example, that a similar scheme in Wales included pharmacists from the outset.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

During the pandemic, there was great concern amongst

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You said this, my Lady:

"This combination of factors had a directly negative

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

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

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

MS CAREY: Certainly.

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

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

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

Can I ask your Ladyship to look at the second column

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the luncheon break now. I shall return at 1.50.

(12.50 pm)

(The short adjournment)

(1.50 pm)

LADY HALLETT: Ms Carey.

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

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

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

Due to the nature of the treatment, in some

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

as the pandemic progressed.

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

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

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

concern at the lack of support and advice they received.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Instructed to help in this task are experts in those

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

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

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

He states that during the pandemic there were more

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

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

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

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

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

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

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

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

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

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

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

The final non-Covid condition is the Inquiry considers it is important to consider the impact of the pandemic on inpatient mental health services for children and young people. The deterioration in the mental health of children and young people during the pandemic was stark. A statement from the chair of the Royal College of Psychiatrists Faculty of Child and Adolescent Psychiatry makes clear that the rates of probably mental health disorders rose during the relevant period. There is particular concern for children and young people with eating disorders and demand for those services increased substantially, as did the number of children and young people presenting

with severe eating disorders.

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

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

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

place were the reality for those seeking and providing maternity care.

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

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

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

"It was heartbreaking to lose my baby, the only child I conceived in a three-year ongoing infertility journey, confused, masked, distraught and without my partner to hold my hand and grieve with me."

Another lady said this:

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

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

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

There appears to have been inconsistency about the

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

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

The Scottish Government launched "NHS is Open". In England there were campaigns such as "Help Us Help You" and "Open for Business". In Northern Ireland there was

a GP mythbuster published which sought to reinforce that GPs were still open, and in Wales there were similar messages put by the Welsh Government and through local partners and authorities to highlight the NHS was there for people who needed urgent care.

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

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

of those working in healthcare systems have attested in their statements to the gratitude to the staff who worked tirelessly to look after us all, often at the detriment of their own physical and mental health.

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

Although the public health emergency phase of the pandemic has ended, the myriad effects of the pandemic are still keenly felt by those providing healthcare and those receiving healthcare in the UK today. They are felt by those who are suffering from Long Covid, whose

treatment was delayed, the many thousands of healthcare workers left feeling completely and utterly exhausted and burnt out by the work they undertook and the efforts they went to to look after us, and by those who deeply miss and mourn the friends, family and colleagues that died. That, my Lady, is why, in my submission, Module 3's findings and recommendations are of such significance to each and every one of us who has the benefit of access to healthcare which is available to all based on clinical need and not on an individual's ability to pay.

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

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

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

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

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

MS WEERERATNE: Thank you, my Lady.

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

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

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

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

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

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

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

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

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

though only a small handful are being called to give oral evidence to have their accounts tested through questioning. This leaves the rest to be taken as read. How then can our criticisms of Welsh pandemic healthcare be properly explored with all Welsh witnesses?

A quick illustration is that the Inquiry has directed us to ask our questions about, for example, the TUC to a relevant Welsh witness but Adam Morgan who has provided a Rule 9 witness statement from the TUC in Wales is not being called, so we have to turn elsewhere. We will of course be pursuing Welsh evidence with all witnesses as appropriate but it is an indirect process of challenge or inquiry that defies reliable aim or answers.

The Welsh government testimony will come from on high: Frank Atherton, Vaughan Gething, Baroness Eluned Morgan and similar. The group do not consider that a high level gloss on what was happening in Wales will adequately discharge the commitment to enquire into Welsh processes.

The shield of hindsight must not be wielded once more by Welsh Government witnesses and there are issues of credibility to surmount. The Inquiry has already encountered this with the deletion of Welsh Government WhatsApp communications and now iMessages which remain

under investigation. The Welsh Government has also been slow to provide its evidence in this module necessitating the use of section 21 notices by the Inquiry.

In relation to expert evidence, as far as we can tell none, bar one -- Professor Edwards of Cardiff Hospital on primary care -- is able within their professional expertise to opine on what happened in Wales. It's not considered proportionate continually to ask experts: what about Wales? Yet that is usually the first question on this group's lips.

We consider it imperative that the Inquiry is alert to probe the experience in Wales with all witnesses. Any gap in expert evidence, in particular, will, we fear, make it difficult for the Inquiry to draw conclusions and make recommendations on untested Welsh evidence, save to the extent that it does not appear on paper to comply with experiences in other devolved nations and especially England, to which the preponderance of expert evidence applies. There is danger, we say, that conclusions will be skewed towards England and risk not being applicable to the different systems in Wales for the future.

On issues, our written submission is a distillation of some of our main areas of concern and this has not

been an easy task because every issue is a key issue for one or other member of the group.

Across Wales and across all four nations, ordinary folks needlessly lost their lives. Their stories are a central part of this Inquiry. The accounts you will hear from this group chime across Wales with systematic failures of healthcare at their heart through waves 1 and 2. Some of the stories frankly beggar belief. They bring into graphic relief the passive, disjointed and technocratic responses from the Welsh Government, leaving hospitals and staff floundering in the face of an unfolding disaster.

A common theme in these stories is that Covid was acquired in hospital, sometimes a week or more after admission for non-Covid-related reasons, for a minor leg operation, a kidney infection or serious heart condition and suspected sepsis, or after a negative Covid test.

That the source of the infection lay within the hospital is clear in many stories. One member's loved one was moved from ward to ward, an infection control technique criticised by the Welsh government's nosocomial investigation recently published. He caught Covid and died in ICU. There are many such stories. Vulnerable people at high risk through existing health conditions were at more risk in hospital than when

shielding in the community.

One member's loved one with an autoimmune disorder was placed on a main ward after a negative test on admission. Members recall seeing nurses wearing inadequate PPE or failing to renew PPE as they moved from one part of a hospital to another, and nurses walking around with face masks on their chins. A member recalls being asked to wear full PPE when visiting relatives, yet nurses wore none.

Elderly and frail people were refused or had treatment delayed or were coerced into accepting do not resuscitate notices. One member was told her mother was being refused oxygen therapy based on her frailty score. There are scores of stories of failed contact with GPs out of hours or on 999 services. There was no dignity in death. One health board authorised staff to move around hospitals taking photos of those who were suffering and dying and also after death. This group says it is clear that the evidence in this module will show that hospital-acquired or nosocomial infection was not inevitable, it was a result of a basic misunderstanding of IPC.

During the first wave the First Minister and health minister in Wales said that there was no value in regular testing of healthcare workers without symptoms,

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

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

health systems for the future.

That completes our opening statement.

LADY HALLETT: Thank you very much, Ms Weereratne, very grateful.

I think Ms Mitchell.

Submissions on behalf of Scottish Covid Bereaved by MS MITCHELL KC

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

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

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

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

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

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

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

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

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

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

In the course of this hearing, the bereaved hope

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

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

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

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

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

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

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

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

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

These are the submissions of the Scottish Covid Bereaved.

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

Mr Wilcock, I think you're next.

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

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

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

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

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

be.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Take Samuel Patterson, who was admitted to hospital in Belfast on 25 March 2020. He was 75, frail and totally dependent on care from others. When his family contacted the GP about repeated recent episodes of falling, they were told that the GP was not attending homes and that he was probably suffering from a UTI or mini-stroke. When an ambulance came to collect Sam, they were told that the local hospital would not accept

him, simply because he had a temperature and so he was diverted to the recently re-designated Covid unit at the Mater Hospital.

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

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

The family were told that Samuel would be sedated to make him more comfortable, only to discover later that day that he had died with only a nurse present, leaving

them to contemplate horrendous questions such as why was Samuel placed on a Covid ward in the first place and had the hospital unilaterally imposed what the family describe as a DNR, perhaps because of Samuel's age or disability.

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

Finally, Sir Michael has told this Inquiry that it is incumbent on all that we use the opportunity of this Inquiry to learn those lessons of what happened, hear

the experience of those most directly affected, and to ensure we are as prepared as we can be for the next, because there will be a next, pandemic.

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

My Lady, thank you very much.

LADY HALLETT: Thank you, Mr Wilcock.

Mr Weatherby.

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

MR WEATHERBY: My Lady, Dr Saleyha Ahsan is a member of the Royal College of Emergency Medicine EPRR committee (emergency preparedness, response and resilience). She is an emergency medicine doctor and an academic researcher at the University of Cambridge. In February 2020, Dr Ahsan undertook a PHE-related medical

role at Heathrow Airport dealing with travellers who arrived with Covid-type symptoms, but her primary role was in critical care in a hospital in North Wales, where she subsequently managed patients with Covid on ITU and HDU wards.

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

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

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

In the course of her evidence, Dr Ahsan will tell

you that her sister had a senior clinical position at the hospital where her father was, and that it was "overwhelmed by Covid". She will also tell you that the ITU consultant responsible for her father candidly explained that he could not be admitted to critical care or HDU because there were no available beds, and indeed that was the picture for much younger patients too. This was a capacity and not a clinical decision, a point that chimes with comments made by Ms Carey earlier.

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

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

We have no doubt that you will want to honour the

hundreds of thousands of healthcare workers who valiantly and selflessly put themselves on the line to care for all those ill and dying, and we do too, not least because we represent healthcare workers themselves bereaved and bereaved families of many healthcare workers who died, but their efforts, their sacrifice must not become a cloak for the austerity and underfunding and lack of planning which put them in such an untenable position. The families do not want to clap for healthcare workers, they want their services properly funded and they want proper staffing levels and bed capacity before it's too late for the next time.

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

As you heard this morning, the Inquiry's own primary care experts will give evidence that there was little if any pandemic planning in GP services and health services at all. There was a funding crisis, too few primary

care doctors and healthcare staff, and a consequent retention problem.

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

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

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

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

According to the HSIB, there was a general problem with no questions being asked and no regard paid to pre-existing conditions by 111 algorithms. And

distressing though these individual accounts are, the Inquiry will want to look to whether they are just isolated examples or whether they're more general problems.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR WEATHERBY: I'll leave it there.

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

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

LADY HALLETT: Carry on.

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

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

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

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

Those are our submissions.

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

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

Submissions on behalf of Long Covid Groups by MS HANNETT KC

MS HANNETT: Thank you, my Lady.

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

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

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

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

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

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

person with Long Covid is supported with access tot he care that they need, they note that, as implicitly acknowledged, this does not reflect the current position.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

(3.13 pm)

(A short break)

(3.25 pm)

LADY HALLETT: All right, yes, Mr Wolfe.

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

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

LADY HALLETT: Are you on the microphone?

MR WOLFE: Thank you, apologies. I lead a team, my Lady, which speaks on behalf of John's Campaign, Care Rights

UK and the Patients Association.

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

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

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

They were not always protected from harm. They were placed at a significant disadvantage compared to the

rest of the population. In far too many cases, their existing conditions actually worsened, sometimes to the point of hastening their deaths.

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

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

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

"When in A&E Chris was still saying he wanted to

die. We asked if one of us could stay with him to be his voice but this was dismissed due to Covid. He said he didn't trust himself to be left alone yet, despite requesting admission to a psychiatric hospital, he was discharged with no follow-up care and with no communication with his family. He died by suicide in February 2021."

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

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

"I fear that the sudden and dramatic separation from us caused him distress and despair, potentially resulted in him giving up hope of recovering."

She spoke of her own distress and added:

"I feel that my father should have had a right to our loving presence and care during the last weeks of his life. If I had been given permission to wear PPE and care for him on the isolation ward, the risk to me would have been minimal and it would have been greatly outweighed by the benefit to my father and to all of us."

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

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

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

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

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

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

and were given the least support.

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

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

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

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

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

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

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

Can we then give some thoughts on what we say needs

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

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

providing her complex and specialist care alongside the professionals.

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

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

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

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

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

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

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Wolfe.

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

MR WAGNER: No longer hiding.

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

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

Shane Smith of Slater & Gordon.

I begin with the PBPOs.

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

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

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

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

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

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

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

First, restrictions on access to services for

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

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

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

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

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

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

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

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

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

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

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

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

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

for the pregnant women or birthing people.

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

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

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

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

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

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

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

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

There were extraordinary and upsetting experiences

for many parents and there seems to have been a failure to consider the wider health consequences of imposing blanket rules, such as mask wearing for new parents in the name of general public health and at the expense of skin-to-skin contact.

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

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

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

I start with this point, Chair: some 18 months ago, on 28 February last year, you held the first preliminary hearing in this module. As you know, we were not in this hearing room but in a cavernous function suite in a hotel. After each advocate spoke, from the same lectern, and before the next one could begin, a gloved employee painstakingly wiped the lectern down. When

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

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

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

A number of questions arise: who knew? When did they know? When should they have known? Those are classic questions for lawyers. But finding out who knew what and where and who should have known when and when will not bring back a single life of the over 200,000 who have died, the vast majority of them clinically

vulnerable, including many healthcare workers and people who caught Covid-19 in hospitals, which were supposed to be places of safety.

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

For many of the pandemic the clinically vulnerable and clinically extremely vulnerable were told: if you follow some simple rules you'll be protected, you will be shielded. But as the evidence in this module will show, there was a paradox. The people who were given the strictest precautionary advice at home were the same people who were most likely to have to spend time at GP practices and in hospitals, and there they were exposed to a serious risk of contracting Covid-19. The clinically vulnerable were told to take personal responsibility, wash their hands and keep their

distance. But by focusing on personal responsibility, public authorities may at the same time have been washing their hands of their own responsibility.

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

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

Against that background, I'll briefly summarise some

key points we make in our written submissions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

Ms Murnaghan, I think you're going next.

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

MS MURNAGHAN: Good afternoon, my Lady.

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

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

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

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

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

In reaching the least wrong decisions, the

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

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

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

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

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

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

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

The same approach of minimising restrictions of

non-pharmaceutical interventions was mirrored in a more formal way in the Health Protection (Coronavirus, Restrictions) regulations of 2020. Regulation 2(2) of those regulations required the department to review the need for restrictions at least once every 21 days.

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

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

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

to learn from this Inquiry's work.

Thank you.

LADY HALLETT: Thank you very much.

Mr Pezzani. Have I pronounced it correctly?

MR PEZZANI: My Lady, yes.

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

Submissions on behalf of Mind by MR PEZZANI

MR PEZZANI: My Lady, I make submissions on behalf of Mind, the leading mental health charity in England and Wales. The focus of this module is on, in relation to mental health, children and young person inpatients, but Mind reminds the Inquiry that the pandemic had a profound impact on all people struggling with their mental health. One study found that people with serious or severely mental illness were almost five times more likely to die during the pandemic than people without severe mental illness.

On 13 November 2020 the then Chief Executive of Mind issued an urgent communique, warning that the nation was in the grip of a mental health emergency. Mind identified the personal trauma this was causing individuals but also the added strain on the NHS. Mind urged the government to learn from what went wrong in the first wave of Covid-19 and make sure that people could get prompt access to the help they needed in order

to protect both their mental health and the NHS.

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

The pandemic resulted in an increase in mental health problems for children and young people leading to increased demand for services to meet that need. Children and young people are at a higher risk of anxiety and depression caused by lockdown. Notably,

cases of severe eating disorder in children and young people increased significantly during and beyond the pandemic with potentially grave consequences: eating disorders have the highest mortality rate of any mental illness.

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

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

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

financial distress and grief.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Those are the opening submissions of Mind.

LADY HALLETT: Thank you very much for your help.

Mr Simblet?

Submissions on behalf of COVID-19 Airborne Transmission Alliance by MR SIMBLET KC

MR SIMBLET: Good afternoon, my Lady.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Then she continues with a number of specific examples.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, my Lady, those are my submissions.

LADY HALLETT: Thank you very much, Mr Simblet.

Mr Thomas, last but definitely not least.

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

PROFESSOR THOMAS: I hope fatigue has not set in.

LADY HALLETT: Not at all.

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

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

PROFESSOR THOMAS: Yes.

On behalf of FEMHO, Federation of Ethnic Minority Healthcare Organisations, we say we don't have to accept it. We just don't. Why? It reminds me of that James Baldwin quote:

"Not everything that is faced can be changed but nothing can be changed until it is faced."

This is a pivotal moment for your Ladyship's Inquiry, and we will be hearing from a diverse and poignant array of voices, from the heart-wrenching testimonies of those who are bereaved to the invaluable perspectives shared by others devastatingly impacted by the pandemic.

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

I'm not going to go into the background in any great detail. Your counsel, Ms Carey KC, really set out the framework, I say respectfully, in a great way this morning. But the pandemic has laid bare the deep seated inequalities within our healthcare system. Professors James Nazroo and Laia Bécares confirmed the ethnic inequalities in health in the UK:

"... are long-standing and persistent and have been

researched and documented for several decades."

On this basis, we consider it indisputable that the disparate impact arising from the pandemic of this nature was foreseeable. It did not have to be, however, inevitable, as impactful as it was here.

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

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

My Lady, key questions for this Inquiry remain to be answered. Why? Why were so many lives impacted and lost, and how many of those deaths were avoidable?

You see, systemic racism in healthcare is a deeply entrenched issue and the pandemic exposed it with unprecedented clarity. Do you remember when former Health Secretary Matt Hancock openly admitted when being questioned by myself that he was aware of and agreed with the assertions that there was systemic racism prevalent within the NHS prior to the pandemic? Yet no effective action appears to have been taken by him or others to address that issue.

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

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

healthcare workers during the pandemic?

Why? Why no new measures coming from the NHS's top brass indicating a recognition and decided steps to address the problems that ethnic minority healthcare workers faced?

Why? Why no new policy or regulatory updates to indicate that the agencies will play a crucial role in the planning in the future pandemic?

Why? Why no critical mass forming in the public consciousness around the direct relationship between racial health inequality and the disproportionate adverse health outcomes?

A few more bullet points and then I'll sit down and finish.

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

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

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

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

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

Root causes. Leadership. Diversity leadership was notably lacking.

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

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

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

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

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

So let me come to my conclusion.

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

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

Thank you.

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

Right, well, I've had a great deal of food for thought today, and on that note we'll draw matters to a close for today. I shall return for Ms Sen Gupta, wherever she is -- I think she's back there somewhere -- tomorrow at 10.

(4.35 pm)

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

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