Tuesday, 10 September 2024

(10.00 am)

LADY HALLETT: Ms Sen Gupta, there you are.

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

MS SEN GUPTA: Good morning, my Lady.

I appear on behalf of the Frontline Migrant Health Workers Group, together with my learned friend Piers Marquis, together with Annabel Tinman and Jessie Smith, we are instructed by Paul Heron, Helen Mowatt and Juliet Galea-Glennie of the Public Interest Law Centre.

As your Ladyship knows, the Frontline Migrant Health Workers Group is comprised of the United Voices of the World, UVW, the Independent Workers Union of Great Britain, IWGB, and Kanlungan, a consortium of Filipino and South East Asian community organisations.

As your Ladyship also knows, our clients' members are outsourced, non-clinical workers, largely from ethnic minority and migrant backgrounds, and clinical nursing and healthcare assistant staff, all of whom were from a migrant background.

We have framed our oral submissions by reference to Boris Johnson's slogan, also mentioned by Ms Carey in opening yesterday, and well known to us all: Stay at

Home, Protect the NHS, Save Lives.

Stay at home. Of course, my Lady, our clients' members could not simply stay at home, they were key workers who were working at the frontline of the UK healthcare system during the pandemic as nurses, healthcare assistants, hospital cleaners, security guards, porters, caterers, couriers and delivery drivers transporting medical samples, and taxi drivers transporting other healthcare workers. Even when these workers became unwell and should have self-isolated, they could not afford to stay at home, whether financially or because of the risk to their jobs or both.

For migrant workers there was the additional risk to their immigration status, which was dependent on their continued employment. Outsourced workers only had recourse to entirely inadequate statutory sick pay of £94.25 per week. Any migrant staff who were directly employed by the NHS but exceeded their entitlement to occupational sick pay, for example in the event of Long Covid, were not entitled to statutory sick pay because it was a condition of their visas that they have no recourse to public funds.

Many frontline health workers who were staying at home because they were self-isolating were pressured to

return to work too quickly rather than stay at home, their vulnerable financial and immigration status often forced them to do so. So stay at home was not practical for our clients' members.

Protect the NHS. Of course a very laudable aim, one in respect of which our clients' members were and remain strongly in favour. As your Ladyship has reported in Module 1, austerity policies had left the NHS with severe staff shortages and infrastructure that was not fit for purpose. The NHS's ability to respond to the pandemic had been constrained by its funding. Many of Kanlungan's members are nurses from the Philippines. They had come to the UK pre-pandemic in order to bolster the workforce of the NHS and thus help protect the NHS, yet their sacrifices were entirely ignored by the government's hostile environment immigration policy.

During the pandemic, the message was that members of the public could help protect the NHS by staying home but what about those outsourced workers who were on the frontline of the UK healthcare system but not employed by the NHS? They were inherently vulnerable, both because of the nature of their occupations and the absence of protection of employment status.

The evidence disclosed suggests they were entirely overlooked. They certainly were not protected. For

example, they weren't provided with PPE. Our clients, UVW, IWGB and Kanlungan sourced their own PPE for their members. They weren't prioritised for vaccination.

Even those members of our clients who were directly employed by the NHS were not adequately protected. The disproportionate impact of Covid-19 on ethnic minority, migrant and precariously employed staff was apparent to government from the early stages of the pandemic, yet there appears to have been little, if any, action taken to protect them.

The disclosure to this Inquiry suggests that there was no consideration of them at all. Further, rather than being protected, migrant workers were disproportionately allocated to higher risk working environments than non-migrant workers. Their vulnerable migrant status meant they felt unable to complain or sometimes were threatened not to do so.

As to knowledge, on 28 April 2020 the British Medical Association attended Downing Street, raising the disproportionate rate of serious illnesses and deaths in ethnic minority practitioners, suggesting that all ethnic minority practitioners be issued with FFP3 masks and pointing out that, because the majority of doctors who had died were migrant, there was a concern that they were being pressured into more frontline work.

Further, on 3 July 2020, the Independent SAGE group submitted a report to government. That report identified the occupations which had increased risk of exposure, infection and death, including the occupations of many of our clients' members. The report raised concerns that some of these occupations had been the last to receive supplies of PPE, that racial inequalities had led to ethnic minority healthcare workers having difficulty acquiring PPE, the higher mortality rates in ethnic minority health workers and that mortality rates in deprived areas were twice that of the least deprived.

The report noted how critical SSP was to ensure self-isolation and shielding the vulnerable. It was too low for working families to live on, and many low zero-hours workers and migrants were not eligible for it. It appears that nothing was done about these significant issues by those in power.

The government's final report on progress to address Covid inequalities, published on 3 December 2021, exactly 17 months after the Independent SAGE report, wrongly suggested that the government had only recently now become aware of the main factors behind the higher risk of Covid-19 infection for ethnic minority groups. The evidence disclosed suggests that was simply not the

case.

Save lives. Our clients' members were working tirelessly to save the lives of patients, yet their own lives were being put at risk by the wholesale failures of the Johnson government during the pandemic. In the first 20 months of the pandemic, up to 22 April 2020, 83% of the ethnic minority health workers who died from Covid-19 were migrant workers, 53% of the total UK healthcare workers who died were migrants. Further, as reported by Professor Cook(?), despite comprising only 3.8% of the nursing workforce, in the first months of the pandemic up to May 2020, Filipino nurses accounted for 22% of NHS nurse staff deaths.

My Lady, these are shocking statistics and, we say, were avoidable.

My Lady, our clients and their members are relying on your Ladyship's report and recommendations to change the future of the healthcare system in the UK, for the benefit of healthcare workers and the public. History must not be allowed to repeat itself. The 40 years of failure of successive governments, so aptly described by Professor Lister, must be reversed.

Your Ladyship's report will assist the new government and indeed future governments to make meaningful changes to the UK healthcare system, first,

by identifying the failures leading up to and made during the pandemic by government; second, by asking why these categories of worker were so comprehensively ignored and exposed during the pandemic; and then, third, identifying changes to ensure that the UK healthcare system is resilient in the face of a future pandemic.

A workforce as important as the frontline migrant health workers should never be left unprotected again.

My Lady, those are our submissions.

LADY HALLETT: Thank you very much, Ms Sen Gupta.

Mr Henderson.

Submissions on behalf of the Academy of Medical Royal Colleges by MR HENDERSON

MR HENDERSON: My Lady, good morning. My name is Alastair Henderson, I was the Chief Executive of the Academy of Medical Royal Colleges throughout the relevant period and I make this opening statement on behalf of the academy and its 23 member organisations.

The academy is the membership body for royal colleges and faculties across the UK. We speak for members on generic issues relating to healthcare quantity, standards and medical education. We do not speak on speciality specific issues, which remain the responsibility of individual medical colleges or

faculties.

I would like to focus on our proposed 11 recommendations, rather than the more generic and retrospective content of our submission. These recommendations have all been agreed by our members and are drawn from their direct experience during the pandemic. Some of the recommendations relate to long-standing and deep-seated problems that were there before the pandemic, others to specific actions taken during the pandemic.

It is worth saying that our experience working at national level was that decisions were mostly based on the best understanding of the issues at the time and were made in good faith. That does not mean they always turned out to be right or that we can't learn from them.

We believe that implementing these recommendations would have a positive impact for the delivery of healthcare across the four nations and help ensure that we are better prepared to meet the challenges of any future pandemic, thus they would be of direct benefit to patients and the public.

The academy's proposals for your considerations are: firstly, capacity. We've heard this before. There has been inadequate workforce capacity across specialities and professions in the NHS for a long time, for a long

time before the pandemic. It is essential that there is sufficient capacity in terms of both workforce and bed numbers in the system to be able to manage future pandemics.

Secondly, in testing. There must be a clear national strategy setting out the purpose, benefits and limitations and delivery of testing.

Third, professional involvement in planning. There should be greater involvement of professional clinical bodies in pandemic planning and running of scenarios.

Fourthly, availability of personal protective equipment. As we've heard a lot about so far. Stocks of PPE must be sufficient and available at the right time and in the right place, with clear agreement and consistent messaging relating to what is appropriate equipment and usage.

Next, returning and additional staff. Clear arrangements for rapidly bringing extra staff back into the NHS or being redeployed need to be drawn up and cover their recruitment, induction and deployment. An NHS reservists scheme may be a solution.

Sixth, care homes. Whilst not our primary area of knowledge, there needs to be a full review of plans for supporting care homes in a pandemic.

Next, mental health consequences. There should be

proactive consideration and planning for the mental health consequences of any pandemic or indeed of disasters.

Next are some more general points in terms of communications. There were many examples of good, local communications and lots of national messaging was clear but there were also too many examples of confused and sometimes contradictory messages at national level.

Nine, political consistency. Beyond healthcare, consistency in the political approach between different administrations is crucial. Different messaging and approaches across the four nations caused difficulties for the public and for healthcare professionals and, at times, it seemed they were differences for difference sake.

Consistency of clinical advice. There also needs to be consistency applied to clinical advice and guidance. Professional bodies have a responsibility for any guidance and advice they produce to follow and align with accepted nationally agreed guidance, or where there is genuine difference of clinical opinion -- which is obviously fine -- this must be evidence based and clearly set out and explained.

Finally, transparency and honesty. Crucially, transparency, honesty and engagement must be at the

heart of any government management of future pandemics. That did not always appear to us to be the case during the pandemic, and any erosion of trust will always have a negative impact and negative consequences.

Finally, slightly separately, we would urge the Inquiry to emphasise the importance of protecting and maintaining clinical education and training for healthcare staff during a pandemic, both for the future of the health service itself, relying on a pipeline of future staff, and for the careers of individual clinicians.

Our written statement and written opening statement provide more detail on these recommendations and we hope the Inquiry will find these useful. We look forward to your Ladyship's recommendations, and we're confident that, if implemented, these will improve the state of healthcare across the system to the benefit of public, patients and health and care staff.

Thank you very much, my Lady.

LADY HALLETT: Thank you, Mr Henderson, very helpful.

Ms Clarke.

Submissions on behalf of the Royal College of Anaesthetists et al by MS CLARKE

LADY HALLETT: You're not on microphone at the moment. Keep pressing buttons.

MS CLARKE: Thank you.

My Lady, I appear on behalf of the Royal College of Anaesthetists, the Faculty of Intensive Care Medicine and the Association of Anaesthetists, along with Samantha Leek King's Counsel.

We would like to start by thanking the Inquiry for its diligent work to date and for offering us the opportunity to provide evidence, but we would also like to say that our thoughts are with all of those impacted by Covid-19, those who died, their loved ones, those who suffer from Long Covid, and everyone whose lives were affected, disrupted or even torn apart by the pandemic.

Our organisations represent over 24,000 clinicians, many of whom worked on the frontline during the pandemic. These include anaesthetists, intensive care doctors, anaesthesia associates, advanced critical care practitioners and critical care pharmacists. Our three organisations all function as representative professional bodies, but the faculty and the royal college also set the curricula and exams for relevant postgraduate medical training.

We hope to provide the Inquiry with valuable evidence about the conditions under which our members delivered care but also to explain how our organisations undertook proactive leadership roles during the

pandemic. This included providing clinical expertise to policymakers, advising the government, educating the public and signposting and interpreting official NHS guidance. We hope that our evidence informs not only the Inquiry's findings generally but, more importantly, any recommendations it makes on how to prepare for a future crisis.

We have also provided a more detailed written opening, but we wish to reiterate some of the most important messages to us here.

First of all, intensive care. One of the key stories we wish to tell is that of intensive care. Intensive care units (ICUs) are where the most critically ill patients are treated and supported in hospital. ICUs are fitted with specialised equipment to closely monitor patients, maintain vital bodily functions and provide treatment for failing organs. During the pandemic almost 50,000 of the very sickest Covid-19 patients were treated in ICUs.

Unfortunately even before the pandemic, ICUs in the UK were perilously under-resourced in terms of funding, staffing, bed capacity, infrastructure and equipment. In order to maintain safe and efficient patient care, the highest recommended fill rate of intensive care beds is 85%. Prior to the pandemic, this level had almost

been reached in Scotland and it had been surpassed in England, Wales and Northern Ireland.

There are different estimates of ICU beds per capita, but they all come to similar conclusions. In 2020 the OECD estimated that England had 10.5 ICU beds per 100,000 population, which was lower than the OECD average of 12. It was also substantially lower than France, the US and Germany with 33.9.

Prior to 2020, lack of ICU capacity was already leading to cancelled operations and reduced quality of care, with potentially negative impacts for patient safety. 40% of units had to close one or more beds on a weekly basis due to lack of staff. To cope with demand, 80% of units reported transferring patients between hospitals.

When the pandemic hit, there was a need to dramatically scale up intensive care capacity, and this was achieved, but only at huge cost to the wellbeing of staff, the education of doctors in training, and to other hospital areas which needed to scale back or, in some cases, stop their activity.

In a survey of intensivists in November 2020, 80% of respondents reported increasing their working hours during the first wave, and 88% reported leave cancellation. There was also redeployment of other

staff such as anaesthetists away from areas like elective surgery to intensive care. In a survey of anaesthetists, 43% reported being redeployed during the first wave.

In order to scale up, intensive care took over other hospital areas such as wards and operating theatres, which highlighted the existing constraints in hospital infrastructure in the UK. It also used supplies from those areas such as ventilators and drugs which led to shortages for other surgery, elective surgery.

Most operations require an anaesthetist in order to take place, but even before the pandemic the UK was approximately 1,400 anaesthetists short. This already constrained the NHS's ability to perform surgery, but redeployments made this much worse. Anaesthetists were also hindered by PPE shortages. In April 2020, almost one in five reported they were unable to access the PPE they needed. In some areas, measures to conserve PPE were used: for example, actions were bundled up so that one person wearing PPE could perform multiple tasks. This led to long periods in PPE and fewer breaks.

Testing for Covid-19 was vital for hospital functioning, however in April 2020 nearly 40% of anaesthetists were unable to access the testing they needed and, furthermore, self-isolation due to limited

testing availability meant that the workforce was sometimes unnecessarily restricted at a time of high demand.

Those reasons and more contributed to why surgical activity dropped by 54% between January 2020 and January 2021. This is equivalent to 9,770 operations being lost per day. In England, waiting lists were already large and growing prior to the pandemic, reaching 4.24 million beforehand, however during the pandemic they grew further and faster, reaching 6.7 million by its end. These are of course not just statistics, real people are behind every story, and huge numbers of people continue to suffer, wait and, in some cases, deteriorate while the hospitals that were there to treat them were focused on pandemic efforts.

Doctors in training. The experience of doctors in training deserves particular mention because doctors in training provide vital clinical service to the NHS while balancing the need to reach important educational milestones. This balance was hindered by the demands of the pandemic working and dramatic changes to the types of cases being addressed. Exams also were disrupted or even cancelled, leading to difficulty with training progression.

Anaesthetists in training were particularly

affected, with 89% reporting that training opportunities had been affected, and 76% said that they had lost out on clinical learning. Intensivists in training suffered from reduced clinical exposure to conditions other than Covid-19, and many took on additional work and unsocial shifts. All of this may have impacted on exam performance, given the anomalously low exam scores in October 2021.

Mental health and wellbeing. It is clear that the stresses of the pandemic impacted on mental health. The percentage of ICU staff reporting probable mental health disorders increased from 51% prior to the 2020-21 winter surge to 64% during it.

The Royal College survey from April 2020 showed that over 40% of respondents suffered mental distress due to the stresses of the pandemic, while over a third felt physically unwell. By July 2020 those reporting mental distress rose to 64%.

Communication with patients and their loved ones during this time was particularly difficult to manage, witness and experience. This also had an impact on the health and wellbeing of staff.

Recommendations. Overall, we believe the lessons of the pandemic need to be learned and channelled into better preparation, however in many respects we are no

better prepared now than we were in 2020. We argue that intensive care capacity should be viewed as a national resource. Improving that capacity would provide much more resilience in the event of a crisis and it requires investment in staff, beds, infrastructure, PPE and equipment.

Staffing deserves particular mention. The situation in intensive care has not improved. For example, the numbers of doctors able to enter intensive care training remains relatively unchanged. In anaesthesia, the situation is now worse than on the eve of the pandemic and the shortfall has grown from 1,400 to 1,900.

Unless action is taken, it seems inevitable that we will repeat the experience of the last pandemic. In any future pandemic understaffed ICUs will need rapid expansion, staff including anaesthetists will need to be redeployed, surgical activity will decrease or stop, patients waiting for operations will suffer and we will be left with another huge backlog on top of the existing one. Staffing needs attention now, especially because of the large and growing bottlenecks in the medical training system.

Last year in England 20,000 doctors in training who had finished foundation training applied for just 8,000 speciality training posts, leaving 12,000 unable to

progress. When the NHS has such huge doctor shortages, this situation is intolerable and action to address it is urgently needed.

Finally, we would like to finish by restating our thanks to all of those involved, re-emphasising the sacrifices and contribution of our members and reiterating that our thoughts and condolences are to all victims, their families and their loved ones.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Clarke.

Mr Stanton.

Submissions on behalf of the British Medical Association by MR STANTON

MR STANTON: The opening statements of the BMA is as follows: the pandemic has had an enormous and in some cases devastating impact on those working in health services, on patients and on the healthcare systems themselves. Behind every statistic is a human story and a deeply personal experience, such as the following account from a doctor working in England, who told the BMA:

"Horrified to find myself caring for friends and colleagues on ITU. I'm tired of being the last person to ever speak to people before I anaesthetise, intubate and ventilate them and for them then to die. Tired of

passing last words between husbands and wives, parents and children. There is no escape from it. I see dead colleagues in the trust news, emails, local and national press. I dream about it intermittently at night. I'm intermittently consumed by the ocean of sadness it has caused."

My Lady, we know that experiences such as these will be at the forefront of your mind during this module, as will the need to consider what more could and should have been done to mitigate these impacts. The BMA believes that, while a pandemic or health emergency is always likely to put enormous strain on healthcare systems and the people who work within them, the extent of the impact was not inevitable.

The impacts on staff and patients were made worse by the fact that healthcare systems entered the pandemic significantly under-resourced and then, once Covid-19 arrived decision-makers failed to protect staff from harm.

The UK entered the pandemic with too few doctors, hospital beds, critical care beds, alongside high staff vacancy rates, growing waiting lists, unfit estates, large maintenance backlogs and substandard IT infrastructure. This exacerbated the severe disruption to healthcare during the pandemic and necessitated

unprecedented large-scale measures to ensure there were enough staff to maintain critical care capacity.

The consequences of entering the pandemic significantly under-resourced and of the severe disruption that followed are still impacting healthcare systems today with millions on waiting lists for treatment.

Regarding the protection of healthcare workers, the nature of their work means they are more likely to be exposed to infectious diseases and, as such, it is vital that adequate protections are put in place. However, at every turn during the pandemic, healthcare workers were not protected from harm. Staggeringly, over four in five respondents to a BMA survey said that they did not feel fully protected during the first wave. The supply of PPE was woefully inadequate and, during the early months of the pandemic, PPE shortages meant that staff had to go without PPE, reuse single-use items, use items that were out of date, with multiple expiry stickers visibly layered on top of each other, or use home-made and donated items.

In addition to these severe shortages, the inadequacies of the IPC guidance meant that any items that staff did have often failed to provide adequate protection from an airborne virus.

Although the understanding of the significance of aerosol transmission evolved during the pandemic, it was well known at the start of the pandemic that there was the potential for aerosol spread. It was also known that respiratory protective equipment, such as FFP3 respirators, provided far greater protection against an airborne virus than a fluid-resistant surgical mask.

Based on these two pieces of knowledge, the IPC guidance should have taken a precautionary approach to protecting the lives of staff and patients, by recommending that all staff working with Covid-19 patients use FFP3 respirators to protect them from infection.

Shockingly, despite the growing weight of evidence of aerosol transmission as the pandemic progressed, the IPC guidance continued to put staff and patients at risk of infection and of spreading that infection by recommending surgical masks for routine care of patients with Covid-19.

Implementing effective infection control measures was made even more challenging due to poor ventilation in some buildings and a lack of space to separate Covid from non-Covid patients.

It is the BMA's view that lives could have been saved if those responsible for producing the IPC

guidance, as well as Britain's national regulator for workplace health and safety, the Health and Safety Executive, had taken a precautionary approach to protecting healthcare workers and patients.

It is vital for this module of the Inquiry to examine the actions of these bodies, including the extent to which considerations of cost and supply were elevated above safety.

The impact of Covid-19 was not experienced equally and it brutally exposed the fault lines of inequality which already existed. Inequalities manifested in a multitude of ways for both staff and patients, including along the lines of disability, ethnicity and gender. This had consequences for infection, mortality, mental health, working lives and so much more.

For staff, there were inequitable experiences relating to feeling protected, having access to adequate and well-fitting PPE, confidence in risk assessments and feeling able to speak out or raise safety concerns.

To give just one example, the Health Service Journal estimates that over 60% of NHS staff who died in the first month of the pandemic were from ethnic minority backgrounds. In the words of a consultant working in England:

"We had no choice but to work in an environment

which we knew to be unsafe. Headlines of health worker deaths and the ethnic risk factors and age made me look at my department and wonder which of us may not be here. Every colleague of mine extended their life insurance. We received the bare minimum protection."

For many staff, the experience of providing care during the pandemic came at a great personal cost to their mental health. Their accounts describe experiences of trauma, grief, exhaustion, burnout, chronic stress, anxiety and fear.

Similarly, Long Covid has severely impacted the lives of staff and patients, leaving them unable to work, train and undertake day-to-day activities. In the words of a resident doctor working in Scotland:

"I caught Covid in March 2020 from a colleague at work. I have been mostly bed bound since. My life as I knew it has ended. These are supposed to be the best years of my life but I'm spending them alone in bed, feeling like I'm dying almost all the time."

The impacts of the pandemic did not simply end when the restrictions lifted. The repercussions continue today with a recent survey by NHS Charities Together finding that over three in four NHS staff are currently struggling with their mental health.

In addition, the failure to adequately invest in the

UK's health services prior to the pandemic meant that staff were unable to provide the level of care they wanted, leading in some cases to moral distress and injury, with devastating consequences for patients, the long-term impacts of which are still being experienced.

The scale of this disruption was unprecedented in the history of the NHS and the BMA argues that it would have been less severe if the UK had entered the pandemic better resourced.

As is made clear in the Inquiry's Module 1 report, the question is not if another pandemic occurs, but when. As with Covid-19, healthcare staff and systems will be at the forefront of any future pandemic response and they need to be in a significantly better position to cope when this occurs.

The preventable failures that led to harrowing experiences for staff and patients cannot be allowed to happen again. To prevent this, it will be important for recommendations to be made in the following areas:

First, recommendations that will lead to better resourced healthcare systems with sufficient capacity for both day-to-day and emergency situations and which support staff's physical and mental health.

Second, recommendations that lead to better protection of healthcare staff in all settings. This

includes a precautionary approach to staff protection, as well as ensuring that, where unequal impacts exist, these are swiftly identified and mitigated.

Third, recommendations that will address health inequalities and improve population health, which will improve the UK's resilience to a future health emergency and help to reduce the impact on health services.

Ultimately, as highlighted in the Inquiry's Module 1 report, unless lessons are learned and fundamental change is implemented, the effort and cost of the Covid-19 pandemic will have been in vain and, for healthcare staff and patients across all nations of the UK, this has already been monumentally high.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Stanton.

Ms Domingo.

Submissions on behalf of the Royal Pharmaceutical Society by MS DOMINGO

MS DOMINGO: Thank you, my Lady.

This is the opening statement on behalf of the Royal Pharmaceutical Society. Covid-19 highlighted the essential work of pharmacists, pharmaceutical scientists, pharmacy technicians and wider pharmacy teams in supporting the nation's health. Pharmacists faced unparalleled challenges that stretched personal

and professional resilience. A huge surge in demand from patients and an unprecedented and changing working environment.

The Royal Pharmaceutical Society is the professional body for pharmacists and pharmaceutical scientists in Great Britain. Its members work across all care settings, including community pharmacy, hospitals, primary care and the pharmaceutical industry.

The RPS leads and supports the development of the pharmacy profession and its mission is to put pharmacy at the forefront of healthcare. The RPS recognises that there were some successes during the pandemic, including the crucial role of pharmacy teams in maintaining access to essential medicines and supporting the roll-out of Covid-19 vaccinations. But there were also significant failures and challenges that need to be examined, so that vital lessons can be learned and the UK is better placed to respond to future healthcare crises.

This statement highlights five key areas of particular importance to the RPS. The first is safety at work for pharmacists. The RPS asks the Inquiry to consider the failure to protect healthcare workers and pharmacy teams, including through appropriate use of risk assessments and the provision of suitable PPE, and to examine whether IPC guidance and rules on testing,

contact tracing and self-isolation were appropriate for all healthcare settings, including pharmacies.

Pharmacists and wider pharmacy teams played an essential role in combatting Covid-19, often putting themselves at risk so they could continue looking after patients in a time of national crisis. In the early weeks of the pandemic, many members of the public showing symptoms of Covid continued attending community pharmacies and hospitals. Guidance from the International Pharmaceutical Federation said it was reasonable to recommend that pharmacy staff wear a face mask to protect themselves from infection. However, national guidance on PPE failed to reflect the circumstances and environments in which pharmacists and their teams were working. It became clear that the majority of frontline pharmacy teams struggled to source PPE to protect themselves, their patients and their families, and that they were unable to maintain safe social distancing while at work.

Community pharmacy teams were on the frontline of Covid-19, but often felt last in line for support. For example, they were not initially eligible to access a new government PPE portal which enabled GPs and small care homes to register for protective equipment. Community pharmacies only became eligible to order from

the portal on 3 August 2020 when the first wave of the pandemic was over. The RPS England chair commented at the time:

"Pharmacies are one of the last places keeping their doors open to the public without an appointment, and yet seemingly an afterthought when it comes to sourcing PPE for staff. People working on the frontline of Covid-19 should get the same support wherever they may be, including across the whole of primary care."

The Inquiry is well aware of evidence relating to the serious impact of the pandemic on ethnic minority communities and, as Counsel to the Inquiry referred yesterday, an RPS survey from June 2020 showed that more than two-thirds of pharmacists and pre-registration pharmacists from ethnic minority backgrounds working across primary and secondary care did not have access to a Covid-19 risk assessment nearly two months after the NHS said that they should take place.

The second key area is the health and wellbeing of pharmacists. The RPS welcomes the focus within the Module 3 list of issues of the impact of the pandemic on the physical and wellbeing and the mental health and emotional wellbeing of healthcare staff. There is significant concern around the health and wellbeing of pharmacists and their teams.

Before the pandemic, pharmacists had been warning that rising pressures at work were affecting their health and wellbeing. The pandemic placed enormous strain on staff and RPS workforce surveys demonstrate that many pharmacists are now suffering from burnout and from Long Covid.

As the pandemic progressed, pharmacy teams also reported an increase in abuse and hostility from some members of the public. One RPS member in Wales described the "massive impact on mental health, increased pressure of work, medicines shortages and trying to keep your family safe". A community pharmacist in England described how:

"Patients were understandably anxious and fearful of the situation at the time and, unfortunately, as frontline healthcare workers, easily accessible to the public, we received both verbal and physical abuse. In my pharmacy in particular we also faced racial abuse."

The third key issue relates to the work of hospital pharmacists, which is often less visible, yet over the period of the pandemic hospital pharmacists cared for the most critically ill patients with Covid-19, transforming their services and ways of working and supporting the supply of medicines for critical care. Pharmacists also played a key role in rapidly

establishing the Nightingale hospitals, building pharmacy departments in under two weeks to procure, store and supply critical medicines.

Pharmacists in different healthcare settings have described the isolation they and colleagues felt as the pandemic progressed, increased pressures due to staff shortages from illness, self-isolation or annual leave, and the impact of a rapidly changing landscape of advice, policy and protocols. One critical care pharmacist in Wales described how:

"The limited availability of PPE resulted in me being the only member of the pharmacy team allowed to work on the Covid critical care unit, supporting essential medicine supply and helping to minimise infection risk. I faced stigma by peers within the department who did not feel I should be allowed in the department after visiting the Covid wards. I felt isolated at times."

The fourth issue relates to the repeated and systemic difference in treatment between pharmacists who provided NHS contracted services, compared with healthcare workers directly employed by the NHS. The disparity in treatment was seen in the exclusion of pharmacists from visa extensions provided to other healthcare workers in March 2020; in the absence of

specific mention of pharmacists in guidance regarding key workers, which impacted childcare provision at school hubs; and significantly in the initial exclusion of pharmacists from the life assurance scheme covering frontline health and care workers in England.

Despite their crucial role providing care throughout the pandemic, the pharmacy profession, and particularly community pharmacy, was often an afterthought in government planning, guidance and communications. This has had a hugely detrimental impact on morale and wellbeing within the profession.

The RPS remains concerns that the failure to properly recognise the work of pharmacists persists and it welcomed the inclusion of community pharmacy in the Inquiry's list of issues. Covid-19 showed that community pharmacies were an essential provider of primary care in a time of crisis and it is crucial that pharmacy teams are adequately prepared and supported in future.

The RPS encourages the Inquiry in Module 3 to examine and recognise the key role played by pharmacists in hospital settings, in the community and across the health service in the pandemic response.

Finally, resilience. The Inquiry is asked to consider the resilience of frontline workers and

workforce capacity in the event of a future pandemic, the resilience of pharmacy services across all care settings and the resilience of the medicine supply chain and medicines production.

During the pandemic, pharmacy teams went above and beyond to support patient care, but despite their pivotal role community pharmacies are under continued pressure and strain, which is leading to closures and reduced patient access to care.

The pandemic exposed the complexity and fragility of medicine supply chains, leading to shortages of many commonly used medicines as well as those used in critical care. Pharmacists have described the moral distress resulting from times when treatments would be available for specific patients one day and then restricted the next. In the years since the pandemic it has become increasingly common to see medicine shortages. Aseptic pharmacy services, which provide sterile environments for the preparation of injectable medicines, played a crucial role during the pandemic, although a government report has warned that:

"... this response was very much **in extremis** and would be unsustainable in the long term without further investment."

It is vital that medicines production facilities are

included in considering resilience and preparedness for a future pandemic.

The RPS submits that lessons learned must include longer term reforms to better manage demand and build resilience across the health service. Pharmacists and their teams and all healthcare workers must be able to work in a safe environment and be protected, particularly in times of public health emergencies.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Domingo.

Mr John-Charles.

Submissions on behalf of the National Pharmacy Association by MR JOHN-CHARLES

MR JOHN-CHARLES: Thank you, my Lady, and good morning.

The National Pharmacy Association (NPA) is a not-for-profit membership body which represents the vast majority of independent community pharmacies in the UK, from regional chains to single-handed independent pharmacies.

These submissions highlight three principal issues that the NPA asks you to consider during the Module 3 hearings.

The first issue is the central role community pharmacy plays in local communities in maintaining good health and tackling health inequalities across the UK.

Community pharmacists went to great, indeed heroic, lengths to ensure that services were maintained during the pandemic, and really demonstrating the value of the network of community pharmacies across the country.

Community pharmacies are part of primary care, with a unique understanding of the health needs of the populations and the communities they serve. They are disproportionately located in areas of higher deprivation, delivering health services in communities that need them most, and they play a crucial role in reducing health inequalities.

A local pharmacy is one of the few places where patients can walk in off the street and access healthcare advice and treatment without an appointment. While community pharmacy is well known as a dispenser of medicines, its role is actually much broader and includes other NHS and public health services, for example the provision of health advice, the administering of millions of flu vaccines every winter and health checks such as blood pressure. Pharmacies are highly accessible and provide a resource that is always available to respond to emerging health threats at pace.

The core role played by community pharmacy during the pandemic provided crucial support and resilience in

maintaining access to healthcare services, and they became the first port of call for many patients, with NPA members experiencing a substantial increase in the number of patients seeking advice for more serious health conditions.

NPA members also reported a significant increase in the number of prescriptions dispensed from February to March 2020 and phone calls to pharmacies more than tripled during that period. Home deliveries of medications to vulnerable patients more than doubled and many pharmacists experienced long queues outside their doors. Pharmacists and their teams worked tirelessly to maintain service provision and ensure the supply of medicine to their local populations.

Many medicines became difficult to source and expensive as demand outstripped supply and staff spent long hours sourcing medicines. Two quotes from NPA members illustrate the reality of the situation.

A member from Cardiff said:

"I don't know how my staff made it through the period as they were working so hard -- for extended periods, they were up there with the doctors and nurses as the frontline heroes of this crisis. They were working under very difficult conditions, tired to the point of exhaustion, scared about their own chances of

becoming infected -- yet they came in every day because they cared about their patients."

An Ilford member said:

"I've been a community pharmacist for 35 years now but in the last four months I think I have seen the most intense stressful times that I have ever experienced but at the same time I have seen some of the most uplifting stuff that I could ever imagine."

On top of all this, community pharmacy then went on to deliver some 40 million Covid vaccinations.

The increased demand on community pharmacy during the pandemic had a significant impact on pharmacists and their teams, resulting in stress, fatigue and mental health issues for many NPA members.

My Lady, the NPA ask that the contribution of community pharmacy, together with other primary care providers to healthcare, is given careful consideration by the Inquiry during the Module 3 hearings so that proper account can be taken of these positive contributions.

Given the essential nature of their frontline role, the Inquiry is also asked to consider whether there was and is sufficient investment by government in the network and the infrastructure needed to integrate community pharmacy into the broader health system and to

support effective co-operation across the health service.

The second issue is that community pharmacy was often overlooked and under-recognised. Despite the central role played by community pharmacy in delivery of healthcare throughout the pandemic, community pharmacists and their teams were not given comparable treatment to other frontline healthcare workers, which meant that they often did not receive the support that they needed.

The most significant and demoralising example of this different treatment by government was flagged so eloquently by Counsel to the Inquiry, Jacqueline Carey, in her opening statement yesterday and was the initial exclusion of pharmacy workers from the life assurance scheme for frontline workers in England, despite them being part of the NHS primary care, risking their lives to treat patients, and dealing with a huge surge in demand and increasing working hours. The NPA asks the Inquiry to fully examine the circumstances that gave rise to this remarkable omission.

Another example relates to PPE, which was not initially available to community pharmacy throughout the NHS, requiring many pharmacy teams to source and fund their own PPE. Pharmacies were unable to access the NHS

PPE portal to order PPE until August 2020, some months into the pandemic. The supply of PPE was a challenge and pharmacy teams put themselves at risk to help patients stay well, often working in close proximity to others, reusing PPE repeatedly for days or even weeks.

Another reflection from an NPA member in Streatham indicates the challenges faced, they said:

"Very early on we realised that risks staff were carrying was quite significant. When patients came in they would congregate around the till. So we introduced a one-in, one-out policy to maintain social distancing. We also put up signs telling people not to enter if they have symptoms. We had no access to PPE but we were very fortunate that we have dentists as patients who had stock of their own to give us."

There is also the case at the start of the pandemic that many people who worked in community pharmacy were not recognised as key workers, which would allow their children to attend school while they worked, notwithstanding that they were working in a frontline healthcare environment. Nor was Covid-19 testing initially available for community pharmacy staff, and community pharmacy was initially categorised as a retail setting as opposed to a healthcare establishment, which meant that entire teams needed to self-isolate following

a single positive case within the pharmacy. This resulted in fewer available staff and increased pressure on remaining pharmacists and pharmacy teams.

The NPA suggests that the Inquiry examines whether government properly and fairly considered the circumstances of all healthcare workers who contributed to the pandemic response.

Thirdly, and finally, the Inquiry is asked to consider the resilience of the independent community pharmacy sector in responding to a future pandemic. Community pharmacy entered the pandemic facing financial and workforce crisis due to long-term underinvestment in the network. This presented significant challenges for community pharmacy in responding to the pandemic, and increased the difficulties in providing services to patients and maintaining staffing levels. Underinvestment leading to threats to the network is something that persists to this day. However, despite these challenges, community pharmacists showed real resilience and commitment during the pandemic, as the following quote from a community pharmacist in Chesterfield demonstrates. He said this:

"My wife ... and I are co-owners of a single independent pharmacy. We are both pharmacists. When the pandemic hit, it occurred to us that if one of the

team became ill or got Covid, there was the potential for the whole team to go down -- and that would mean closure, leaving patients without medication, putting them in turmoil.

"Our big fear was letting people down. The solution we came up with and kept us running safe was to split the team in half. My wife led one half of the team, while the other half of the team isolated at home. Whichever one of myself or [my wife] was working stayed in a hotel for that week. At the end of the week when I was working, I checked I was symptom-free before going home. Even then, the family would go to a separate room and I would go straight to have a shower and put my clothes in a bag. Only then would I come down to the family. We'd spend a day together, then we'd swap.

"We did that for ten weeks. In 23 years in pharmacy this has been the most challenging time of my career, but it has also been the most rewarding as well. We've not let our patients down, we've come through it."

My Lady, a strong community pharmacy network is an essential element of healthcare services in the UK and the NPA invites the Inquiry to consider the role and resilience of community pharmacy in responding to a future pandemic.

Those are my submissions.

LADY HALLETT: Thank you very much indeed, Mr John-Charles.

Right, we'll do Ms Morris, Mr Jacobs, and then we'll take a break.

Ms Morris.

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

MS MORRIS: My Lady, I represent the Royal College of Nursing. The Royal College of Nursing is the representative voice of nursing across the four nations of the UK. It's a registered trade union and it has over half a million registered nurses, student nurses, midwives, nursing support workers and healthcare associates as its members. They work across NHS hospitals, specialist health facilities, in care and nursing homes, in the community and in the independent healthcare sector.

At the outset the Royal College of Nursing wishes to offer its condolences and heartfelt thoughts to everyone who lost loved ones in the pandemic. It will never forget the sacrifice of healthcare professionals, including those who passed away as a result of the pandemic and those who continue to feel the impacts on their health as a consequence of Covid-19.

The college is committed to continuing to advocate for and support those of its members who were so

affected by the pandemic.

In these submissions, I will first briefly paint a picture of some aspects of nurses' lives during the pandemic, and then focus upon the issues of safe staffing levels, adequate PPE, particularly in the light of the fact that this was a virus transmitted by air, and finally the impact of Long Covid on nurses' lives.

Turning then to how nurses coped with the pandemic. They played a central role in healthcare services and consideration of the impact on them will necessarily be at the heart of this module. They were affected in terms of the work that they had to do day in, day out, the support that was available to them or not available to facilitate that work, and the toll that the work took on their mental and physical health.

Many nurses continued their professional commitment despite particular risks to them as they were pregnant themselves or clinically vulnerable. The impact on nursing staff included suffering from Covid-19 themselves, often on multiple occasions. It's well known that nursing staff carried a heavy burden in the Covid-19 pandemic, and the community responded to this global healthcare crisis in extraordinary ways, coming out of retirement, putting aside their studies and being redeployed to new areas.

Throughout the pandemic, the Royal College of Nursing engaged with its members through its existing interactive support services, via a call centre and an online platform. Through that, it received more than 28,000 contacts from members on issues that they faced during the pandemic. From these contacts, we can see what was experienced contemporaneously and what was reported, including attending work despite not being well enough to perform their duties, being asked to work in unsafe conditions, isolating themselves from their families in order to protect them, spending extended periods, when PPE was available, in PPE that caused damage to them, contributed to their fatigue and stress, feeling depressed, anxious and stressed, experiencing symptoms indicative of PTSD.

Alongside these difficult experiences, nurses were confronted with professional dilemmas, such as whether or not to treat patients without wearing appropriate PPE, how to delegate tasks when there were insufficient staff available, whether to undertake work at a higher level than they were familiar with, and ensuring that they balanced the unpaid overtime that they worked with considerations of patient safety so that their own overwork and exhaustion did not present a risk to others.

Nursing staff from ethnic minority groups suffered poorer outcomes exacerbated by existing structural inequalities and institutional bias.

Nursing students particularly suffered, with difficulties in terms of meeting academic deadlines, undertaking clinical placements, and being excluded from matters such as sick pay and indemnity and life assurance.

Pregnant members and those on maternity leave raised queries about their rights and obligations in relation to attending work in high-risk areas, and those already with children experienced significant childcare difficulties.

Members contacted and continue to contact the college in large numbers with queries about Long Covid. Although the exact figures are not known, the prevalence of Long Covid amongst staff working in healthcare is significantly higher than the wider population. Many nurses who contracted Long Covid via exposure at work have either lost or are now at risk of losing their employment due to their ongoing health issues and the lack of workplace support to enable them to remain in employment.

Evidence shared with the Inquiry from the college's members highlights the feelings of fear, panic and dread

and their sense of vulnerability, as well as the emotional and physical toll of dealing with death, pain and suffering daily at levels they had never experienced before.

Turning then to the issue of safe staffing. Crucially, the size and characteristics of the healthcare nursing workforce across all sectors was inadequate to meet the demand for care and service delivery, and it continues to be so.

For many years, the college had been advocating for the government and devolved administrations to take urgent action to fill vacancies, retain existing staff, and bring new entrants into the nursing workforce. Too few nurses have studied at university and joined the profession, too many have left, and of the colleagues that remain they feel overstretched and undervalued.

The college considers that a workforce crisis was well entrenched in the health and care service before the pandemic struck, and it significantly impacted the ability of the UK to appropriately prepare for the impact the pandemic would have. It shone a spotlight on the critical role undertaken by nurses across the UK, and nurses continue to feel overstretched and undervalued.

However, during the pandemic, policymakers in the

UK Government hid behind a narrative that the pandemic was to blame for the ongoing collapse of the healthcare system, refusing to acknowledge the extent of the workforce shortage until June 2023. This failure in accountability and transparency further damaged an already depleted system and workforce, and the effects of this cannot be remedied quickly enough to ensure patient safety and to meet the expectations of the UK public.

PPE and RPE. Without adequate PPE and RPE and training in its use, nurses and midwifery staff put their own lives, the lives of their families and their patients at risk. These supplies should have been modelled on HSE recommendations and the adoption of a precautionary approach to the protection of healthcare workers. The level and quality of supply should not have been dictated by cost, opinion or confusion over non-UK adopted frameworks such as the hierarchy of controls. The pandemic stock levels were vastly underestimated, as was the extent of global demand.

It's the view of the college that a lack of clarity on use of the term "PPE", combined with a culture of assumptions that historical influenza guidance and views on its transmission and impact in the 21st century was inadequate. It placed healthcare workers at

unacceptable risk when faced with a novel pathogen. Challenges around distribution, the inequality in supply, and other services were among the main issues.

Due to those challenges, there were reports that college members had been required to reuse single-use equipment, use equipment previously marked as out of date, clean used gowns with alcohol wipes, and to use alternative equipment which had been donated and which did not meet adequate standards.

So while public donations were signals of support, they did not replace the legal responsibility of system leaders and governments to ensure that correct PPE was provided. The college received reports of members wearing gowns made out of bin bags, wearing ski masks or swimming goggles because PPE of the required standard was not available.

Healthcare professionals described feeling like lambs to the slaughter.

The college regularly expressed its concerns in correspondence to the UK Government, devolved administrations and other relevant bodies, including the HSE. However, one-size-fits-all protective equipment was a problem for frontline healthcare workers who were obliged to work with this inadequate material up to 12 hours at a time.

There were many brands that did not produce masks which fitted female faces, particularly with the shape and design of those masks being too big and causing many to fail the fit testing process, nor did the masks meet the needs for an adequate fit for members of ethnic minority groups.

Turning then to the question of fit testing. Problems with the lack of trained and available staff to fit test PPE resulted in staff being withdrawn from clinical care at the height of the pandemic to undertake the necessary training. Nursing leaders reported being given up to 17 different types of mask within one trust, which meant that fit testing of all staff was repeatedly required, and some members reported that the equipment needed to undertake the fit testing faced additional procurement and supply issues. Some members reported that equipment to undertake fit testing was not available to them and that demands to fit check not fit test placed nursing and midwifery staff at risk due to issues of masks not providing an adequate facial seal.

LADY HALLETT: I'm sorry, Ms Morris, I'm going to ask to you to -- I've been tough on others, so I'm afraid I'm going to have to ask you to -- I appreciate you have some very important points to make, but I'm sure there are ways

you can do it.

MS MORRIS: My Lady, we do make points in our written submissions concerning both airborne transmission and its significance, and also the response of the IPC, and if I can just briefly deal with that.

There was a serious lack of engagement from the UK IPC cell, and the college's expectation was that stakeholders such as itself would be proactively engaged, especially given the seriousness of the situation in the development of guidance. But as the pandemic progressed, its professional correspondence and offers to support were ignored and offers to meet were turned down. The college expected that, given the fundamental role of the nursing profession, the guidance-making bodies would want to engage with them. Nurses had unique expertise. This lack of engagement prevented the college from putting forward practical and clinical rationale for amendments to guidance.

LADY HALLETT: I'm sorry, I'm going to have to stop you there, Ms Morris. I'm very sorry, it's just not fair on everybody else.

MS MORRIS: Thank you, my Lady.

LADY HALLETT: It's just not fair on everybody else.

MS MORRIS: Yes.

LADY HALLETT: Mr Jacobs.

Submissions on behalf of the Trades Union Congress by MR JACOBS

MR JACOBS: My Lady, these are the submissions of the Trades Union Congress. I'm instructed by Thompsons Solicitors and I appear with Ms Ruby Peacock.

My Lady, a few of the submissions on behalf of those who represent healthcare workers have started with or featured direct accounts from workers. We have in common an awareness of the power and importance of the voice and experiences of those working across healthcare. Our own written submission opened with an account of an emergency medical technician in the ambulance service. She says:

"In the beginning, there was a lot of uncertainty, it was terrifying. I cried driving to and from work, mostly in fear of taking Covid home to my parents and child, and the risk of leaving my son without his mum. There was little to no PPE, we were asked to use it sparingly, we were asked to reuse items, we were using out-of-date stock or given two single-use face masks for a 12-hour shift. The sights were harrowing, taking people from their homes, leaving loved ones behind, knowing they would never see them again of. We lost colleagues and friends."

That account, of course, will be familiar to so many

who worked in our nation's health services and indeed it echoes the account of the paramedic in the impact film of yesterday. Healthcare workers on modest pay resolutely continuing on at great personal risk in an embattled health service so that at least some of those who needed it could receive healthcare. We owe them a debt of respect and gratitude but, also, my Lady, of action.

In these submissions, we focus on the impact of the pandemic response on workers, on the causes of that impact and on the lessons to be learned.

On impact, we welcome that the Inquiry, having heard submissions from core participants, has decided to call and hear directly from a number of frontline workers. It is right and important that those voices, representing the many thousands who implemented the decisions made as to the provision of healthcare, should sit alongside the evidence of those who made them.

We have heard from and do not repeat the observations of Ms Carey and others as to the death toll, the high rates of Long Covid and the profound impact on mental health. Of course, the impact of the pandemic has extended far beyond its end. The scarring, drip-by-drip effect of working in a stretched and underfunded service was compounded by the experiences of

the pandemic and subsequently by the growth of waiting lists.

"Four years in and burnt out" was a phrase from the impact film yesterday and it rather encapsulates a damning truth as to what is faced by our healthcare staff.

We have heard this morning about waiting lists approaching 8 million, close to double the figures prior to the pandemic and more than triple the figures in 2010. It is patients that face the acute dangers of waiting lists approaching 8 million but it is the workers who sag under the weight of that burden in a system that gives them neither the means nor facilities to address it.

As in an account to the TUC of an NHS podiatrist:

"Our ulcer caseload has tripled since 2020 because of the lack of routine care. The pressures on other specialties means we are holding onto patients that we shouldn't be. Our role has changed significantly and the stress has continued to get worse but we are told to get back to normal."

As to the causes of that impact, they are myriad. They include significant deficiencies in planning and preparedness and resilience. As in your Module 1 report, my Lady, the NHS was running close to, if not

beyond, capacity in normal times. A root cause of many issues that this module will consider is the staffing of the NHS. Going into the pandemic, there were 106,000 vacancies across the NHS in England alone. As to the effect of that, I can do no better than endorse the powerful observations this morning on behalf of others, particularly the Royal College of Anaesthetists and the Royal College of Nursing.

Another cause is the lack of effective health and safety regulation and enforcement. The HSE is the primary regulator for workplace health and safety but its capacity is frustrated by drastically decreased funding. In the healthcare context specifically, the HSE continued to regard healthcare as an area for lower intervention. Healthcare received little attention in terms of proactive inspection, notwithstanding the glaring deficiencies in workplace safety and the grave risks faced by healthcare workers. The problem was compounded by under-reporting of workplace deaths under the RIDDOR regulations, contributed to by the HSE's own guidance.

In future, it is critical that the HSE should have both the mandate and capacity to respond dynamically to a crisis such as a pandemic and to increase its operations in the healthcare sector. Another cause was

the familiar problem of inadequate PPE and, again, we agree with the observations made by others. It should be kept in mind that adequate PPE is necessary across the whole range of healthcare workers, including in roles that can sometimes be less visible. One NHS worker told the TUC of the experience of intensive care being prioritised but colleagues on other wards did not feel safe, they had little access to PPE and were told they did not need it.

A portering supervisor told the TUC:

"It felt like the porters didn't matter. When we were transporting Covid patients from wards and also to the mortuary, getting in lifts and enclosed spaces, no proper PPE was provided, just plastic aprons and gloves but no proper masks."

The disproportionate impact of the pandemic was exacerbated by the attempt, ultimately abandoned, to bring in a policy of mandatory vaccination. Despite clear warnings at the outset from unions and others, the UK Government proceeded with the plans at great cost to workforce morale and the trust and confidence of black, Asian and minority ethnic healthcare workers. The dubious benefit of the policy, if any existed at all, was readily outweighed by the adverse effects on staffing levels and morale.

Turning finally to lessons to be learned, we have had the welcome indication that the learning of practical lessons will form a focus of the substantive hearing. Within the scope of this short opening, we observe that recommendations are clearly needed in a number of areas, including in respect of resilience and surge capacity, the NHS workforce, infection prevention and control, the general protection of the health and wellbeing of the workforce, including regulation and enforcement, and the consistency and scope of partnership working between the Department of Health, the NHS and its workforce.

One important area for recommendations will be the measures necessary to lessen the disproportionate impact on black, Asian and ethnic minority workers. At a recent collaborative event with the TUC, UNISON and FEMHO, black, Asian and ethnic minority healthcare workers were invited to discuss their experiences of the pandemic and what needed to change.

There were some key messages, my Lady: that the NHS needs to move from simply recording discrimination and disproportionate impacts to removing it; that pre-existing health inequalities should be acknowledged but not used to conceal discrimination in the workplace or be used as a carpet with which to cover the lack of

action; that migrant workers must be valued and protected, rather than treated as dispensable; that there must be effective workplace safety, of adequate and tailored PPE, of meaningful risk assessments, of effective monitoring and regulation; that measures related to worker health and safety must extend in practice to outsourced parts of the workforce which is disproportionately ethnic minority.

Those key areas and no doubt others will serve to lessen the disproportionate impacts in future.

My Lady, those are our submissions.

LADY HALLETT: Thank you very much for your help, Mr Jacobs, very grateful.

Right, we shall take the break now, I shall return at 11.35.

(11.22 am)

(A short break)

(11.35 am)

LADY HALLETT: Mr Burton.

Submissions on behalf of the Disability Charities Consortium by MR BURTON KC

MR BURTON: My Lady, Ms Jones and I appear on behalf of the Disability Charities Consortium instructed by Alex Rook and Anne-Marie Irwin and Rook Irwin Sweeney, both specialist disabled people's rights lawyers.

The DCC includes the Business Disability Forum, Leonard Cheshire, Mencap, Mind, the National Autistic Society, the Royal National Institute of Blind People, Royal National Institute for Deaf People, SCOPE and Sense.

My Lady, as you know, the DCC is not publicly funded in this Inquiry which explains its somewhat restricted approach to participation and, whilst of course it will do all it can to assist, the lack of funding may, to some extent, increase the burden on the excellent CTI team to explore the issues of concern to disabled people.

My Lady, the UK has a proud history of enacting legislation to protect and promote the rights of disabled people, including the Disability Discrimination Act 1995, the ratification of the UN Covenant on the Rights of Disabled People and, of course, the Equality Act 2010.

That includes the duty to make all reasonable adjustments to remove disadvantage relating to disability and to give due regard to the need to eliminate discrimination and advance equality of opportunity for disabled people, amongst others, when exercising public functions.

Importantly, in relation to disabled people, these

duties are anticipatory in nature. In other words, public decision-makers should not wait to be told of disadvantage, they must anticipate and address it in advance and indeed before policy is formulated.

These positive obligations come together to create an obligation to create a level playing field for disabled people. However, unfortunately prior to Covid-19, the UK's standing as a leading exponent of disabled people's rights was already being systemically dismantled by the self-inflicted disaster that was fiscal austerity. Grave and systemic violations the UN found in its special investigation in 2017, reflecting the insufficient incorporation and uneven implementation of the convention across all policy areas.

In the context of healthcare, this was also present, underscored by the lack of preparedness and resilience in the NHS prior to Covid-19 and as is set out so comprehensively by, amongst others, the Bereaved Families for Justice UK.

My Lady, I briefly remind you and those listening of the disparate impact of Covid-19 on disabled people: three in five Covid deaths experienced by one in five of the population; the hearing and visually impaired were 12 times more likely to die of Covid-19; the visually impaired eight times more likely to die of Covid-19; the

hearing impaired four times; and the learning disabled six times more likely to die of Covid-19.

My Lady, one can see immediately from these figures that clinical as opposed to social factors cannot possibly explain these massive disparities in mortality rates. These must also be seen alongside the disparate impact in terms of the Covid-19 restrictions on disabled people.

My Lady, even accounting for its multifaceted nature, it remains striking how little has been achieved in terms of understanding these disparate impacts and why they occur. In the evidence before you in Module 3, the DCC can only alight upon one paragraph of Sapana Agrawal's statement from the Cabinet Office, paragraph 8.57, where she seeks to make some tentative observations about what the causes might have been of this disparate impact.

It is therefore the DCC's position that one vital task for this Inquiry is to ensure that this lack of understanding is remedied. In relation to that, we make three broad points.

The first is that the disparate impact on disabled people is not explained by lack of knowledge. The Department of Health and Social Care and NHS England stress the evolving nature of the knowledge during the

pandemic and how a lack of knowledge explains why some decisions that were made at the time may not have been made with the benefit of hindsight. But the Government was aware of the adverse social impacts for disabled people as early as 14 May 2020 and the disparate impact in terms of mortality rates by 19 June 2020, and yet disability was not listed as a relevant disparity or risk factor in the Public Health England review of disparities published on 4 June or, indeed, the subsequent iterations of that review that took place through the year.

Indeed the disparate impact was not properly considered until much later. The Equality Hub made detailed representations about that impact and its causes and potential remedies in the late autumn and winter of 2020 but, even then, disappointingly, there was a surprising lack of action. The bulk of recommendations were not implemented by government at that time.

I just highlight one example for the benefit of today's hearing. A recommendation to set up a national panel of disabled people was not implemented. No clear explanation for this is provided in the contemporaneous material or, indeed, the statements prepared for the benefit of this module. It's particularly regrettable

because, my Lady, unlike many other bodies, like the royal colleges or the professional bodies and the trade unions, disabled people had no formal mechanism of being consulted or being involved in government decision-making at the time and, indeed, the purpose of the national panel was to improve the interventions by government so as to benefit disabled people and mitigate some of those adverse impacts.

The second submission is that the adverse impact is not explained by hard decisions. Again, the department and NHS England all stress that the exigencies of the situation and the gravity of the threat meant that difficult decisions had to be made. They are at odds to stress that there were seldom right answers or good alternatives to what were hard decisions. It is emphasised that health inequalities existed before and, therefore, inevitably persisted during the pandemic.

My Lady, it is undoubtedly true that to some extent the disparate impacts were made worse by, for example, the state of the NHS and the capacity issues that existed pre-pandemic. But the DCC does not accept that (a) the disproportionate impacts on disabled people were in some way inevitable or (b) merely by being aware of the disproportionate impacts at the time was sufficient to meet the positive obligations. Of course, the duty

to enquire into the impact on disabled people is a vital prerequisite to the fulfilment of the anticipatory and public sector equality duties but that alone can never be enough by itself. Hand wringing, my Lady, is no replacement for positive action.

Indeed, there are hard edged examples of how the difficulties of the situation did not explain or justify the impact on disabled people but one example: why did it require the CEO of RNID to write to the Prime Minister in April 2020 to ask for the most basic of requirements to be met, namely that government communications should be in an accessible format? For example, why was there no BSL interpreter during government announcements, including the lockdown announcement itself?

After that letter, some improvements were indeed made, but multiple errors persisted and, of course, my Lady, you have already heard evidence and submissions about how similar basic errors were made in relation to communications for those who did not speak English as their first language.

The third submission, my Lady is a query: was defective decision-making to blame? The approach to equalities is described variously as being of high or great, even personal, concern to decision-makers,

including former secretaries of state. It was not treated as an add-on or an extra but baked into decision-making, we are told. The practice of engagement and consultation is stressed by, amongst others again, the former secretaries of state.

But does this rhetoric not hide the truth that all too often the needs of disabled people in particular were indeed an afterthought, disadvantage only corrected, if at all, after interventions by, amongst others, DCC members in direct contravention of the legal duties I mentioned?

There are several seriously egregious examples. Government guidance, including the clinical frailty scale, seems to have led to the use of blanket DNR notices and the practice of denying care to certain groups of learning disabled people. Remarkably, in its written submissions, NHS England highlights this issue as an example of flexibility and good practice, a story of success not echoed in the CQC's reports on the same issue.

Mentioned by Ms Carey KC yesterday in her opening, persistent concerns were also raised on behalf of disabled people about the move to remote consultations in primary care. Jackie O'Sullivan from Mencap highlights at paragraph 5 of her statement that:

"These changes appear to have been introduced without any reference to an equality assessment at all."

Visiting restrictions, my Lady. Initially, no exceptions were made for those with mental health conditions that made them particularly susceptible to distress when isolated from friends or family, or those with physical ailments who needed the support of their carers whilst in hospital. The belated acknowledgement of such basic needs is completely inexplicable.

Shielding and the CEV and CV criteria appears again to have been made without apparent regard to the risk factors presented by adults and children with disabilities. The shielding policy was based on perceived clinical risks only. This medicalised model overlooked completely the well-known social and structural barriers to which disabled people were exposed. Indeed, people with learning disabilities and those living with Down's Syndrome were belatedly included in the SPL, but learning disabled adults were not added to the shielding patients list until 19 February 2021, despite evidence published in November 2020 that they were experiencing a disparate mortality rate. Similarly with those living with Down's Syndrome, they were added in November 2020 but the disparate impact had been made aware to the government by June

2020. How are these gaps explained?

Further still, the addition of those people to the SPL list was not properly communicated to those affected. Some people were not told they were on that list until January 2021 and the beginning of the roll-out of the vaccine regime.

My Lady, these hugely difficult decisions were made without proper equality impact assessments or consultation, compounding disadvantage for disabled people in clear breach of the positive duties upon government and other decision-makers. It is notable that the approach to EIAs in particular was not consistent across the devolved nations. For example, the limited EAs done by Scotland in relation to shielding, et cetera, proved the point that breach was not inevitable or unavoidable; it was just negligent.

LADY HALLETT: Mr Burton, I'm afraid I am going to have to ask you to bring things to a close, I'm sorry.

MR BURTON: My Lady, I have just two more points to make, very briefly.

We accepts that these points are identified and, to some extent, acknowledged by NHS England but they are not identified by the politicians themselves.

The final point really is this, my Lady, that these failures do not of themselves necessarily explain the

huge disparate impact on disabled people but they do serve to create a justifiable suspicion that, despite the rhetoric, because government was not properly and systemically addressing potential disability discrimination, many more disabled people died or were negatively impacted by Covid-19 than ought to have been the case, leaving disabled people feeling expendable, as if their lives were less valued.

On any view they were unseen and they must not continue to be unseen by this Inquiry. So they do have one overriding question, my Lady: why was a disabled people so much more likely to die of Covid-19 than a person who was not disabled? The DCC requests respectfully answers, accountability and, above all, action, a repeat avoided at all costs.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Burton.

Mr Mitchell.

Submissions on behalf of the Scottish Government by MR MITCHELL KC

MR MITCHELL: Good morning, my Lady.

Now, these are the opening remarks on behalf of the Scottish Government. I appear today along with Mr Way, junior counsel, and we are instructed by Caroline Beattie, and John McPhail of the Scottish

Government Legal Directorate.

LADY HALLETT: Before you go on, can I just say for the subtitles, it's Mr Mitchell KC.

Sorry, Mr Mitchell, I just suddenly realised that for some reason our records don't have you down properly.

MR MITCHELL: Thank you.

People are at the centre of our healthcare system. At no time in our recent past was this more apparent than during the Covid-19 pandemic. The contribution made by those working in healthcare, in social care, in the NHS and in the voluntary and charity sector was immeasurable and critical to our passage through the pandemic. This was aided by the general public who supported the provision of healthcare. However, the suffering was great. On behalf of the Scottish Government, we convey our deep sympathies and condolences to the many thousands who have lost loved ones, who have suffered and who continue to suffer because of Covid-19.

Of course, the Scottish Government is eager to take the opportunity presented by this module to learn from the evidence, to identify what could have been done better and to improve government decision-making. In these opening remarks, we look briefly at the form of

the healthcare system in Scotland, then at the structures within which decisions were taken and, finally, at particular aspects of the response to Covid.

Looking firstly, then, at the form of the healthcare system in Scotland. In 2004 the NHS trust structure in Scotland was removed by legislation, its replacement was significantly different. It was not designed to create competition between health boards, rather it was designed to be a cohesive system that encourages and promotes collaboration and learning between the boards.

In Scotland, healthcare is fully devolved. Policy is administered through the health and social care directorates of the Scottish Government and delivered through the boards. Prior to the pandemic, chief executives of the boards met regularly with senior civil servants from the directorates and with ministers. This meant that at the start of the pandemic there was a strong working relationship and a familiar way of working already in place. This was useful when it came to dealing with the emergency situation that we all faced.

Looking now at the structures within which healthcare decisions were taken. From the outset of the pandemic, the Scottish Government put in place policies, processes and operational frameworks to support the

response. The four harms framework was introduced early in the first phase of the pandemic. It formed a key part of the context within which strategic healthcare decisions were made.

The framework identified four main categories of harm caused by Covid, namely: one, the direct health impacts of Covid; two, non-Covid health harms; three, societal impacts and; four, economic impacts. One notable feature of the approach to decision-making during the early part of the pandemic was that it prioritised the direct risk of Covid to health. This approach was refined when the framework was introduced. However, managing the risk of direct health impacts of Covid remained a key focus for the Scottish Government when making decisions.

The Scottish Government understood that the harms were interlinked and that no decisions were good or risk free. However, the framework allowed for a freeing, for a weighing and balancing of risks, informed by increasing knowledge and experience of how to respond to the virus.

Looking now at aspects of the response and firstly at the equalities and differential impact of Covid-19, equalities considerations were an important part of decision-making. This is evident in decisions that were

informed by an understanding of the differential impact of the virus on certain parts of the population. For example, the work of the expert reference group for Covid-19 and ethnicity has left a legacy that exists some three to four years after its inception.
An understanding of the differential impact can also be seen in the policy and strategy behind the shielding list, known in Scotland from June 2021 as the highest risk list.

The shielding programme aimed to reduce the risk of infection, severe illness and death. The four UK CMOs, working with other senior clinicians, identified certain health conditions that were likely to present a higher risk of negative outcomes for certain people if they contracted Covid-19. It was the clear and stated policy intent from that point onwards to identify, protect and support people considered to be at highest risk of severe illness or death from Covid.

Shielding advice and guidance was given to those on the list and to the general public. The Scottish Government worked with pharmacies, with regional and local resilience partnerships and with multiple retailers to help people who were self-isolating to get access to food and to medicines that they could not get themselves.

The Scottish Government recognises that shielding was not easy. Mental and physical health was negatively affected. Many individuals tried to follow the guidance to the best of their ability but caring responsibilities and quality of life considerations made this very challenging at times.

There are lessons to be learnt around the support that is necessary to allow people to shield. It also raises questions around what is and what is not feasible in terms of shielding those at the highest risk. However, the principle of protecting those at higher risk remains valid.

Turning to prioritisation of care. Decisions in this area were among the most difficult. There was an acute awareness that patients outside prioritised areas would have to wait for treatment in circumstances where their condition may deteriorate. The key focus was on emergency care, critical care, cancer care, maternity and mental health. The Scottish Government established a clinical prioritisation framework, it set out six key principles that health boards followed when making decisions on elective care waiting lists. Patients were categorised into levels of clinically agreed urgency, based on their particular clinical condition. This allowed health boards to prioritise

those most in need.

Looking now at infection prevention and control within healthcare settings. While the UK Government, and subsequently ARHAI Scotland, held and maintained IPC guidance for Scotland, the Scottish Government nevertheless took a central role. It worked with health boards to ensure that appropriate IPC measures were in place in healthcare settings, it communicated updates and changes in IPC guidance, it worked with the boards to implement IPC measures, such as appropriate use of PPE, extended use of face masks and face coverings, optimal ventilation, enhanced cleaning measures and testing for healthcare workers and patient admissions.

In May 2020 it set up the advisory Covid-19 nosocomial review group to understand better the healthcare-associated Covid-19 epidemiology in emerging evidence.

Coming finally, my Lady, to the impact on doctors, nurses and healthcare staff. The following very sad statistic must be acknowledged, that between 13 April 2020 and 20 July 2022, the Scottish Government was notified of 27 deaths of NHS Scotland staff caused by or suspected to be related to Covid-19.

Responding to the unique challenges presented by the pandemic took a significant toll upon the entire health

and social care workforce in Scotland. Understanding the toll was particularly important in order to ensure wellbeing and to identify opportunities to improve conditions. At the start of the pandemic, the Scottish Government established the workforce senior leadership group, which brought together senior representation from government, health and social care employers, trade unions and representative bodies. It met regularly to discuss and to provide strategic advice and guidance, taking on board realtime feedback from staff representatives. This partnership working led to, for example, the temporary adaptation of terms and conditions of service and, where appropriate, adaptation of policy, all to support NHS staff and services.

Other measures were introduced to ease the burden on the workforce, including financial help and support and assistance for staff wellbeing and mental health.

My Lady, in conclusion, there are other important topics that I could speak about today in detail but time simply does not allow. They include the 2021 NHS recovery plan for Scotland, PPE and the Scottish Government's commitment to tackling Long Covid. These topics and others are covered in our written opening statement, which we would encourage those who are interested to read.

But we finish these opening remarks where they began, with the people who helped to bring Scotland through the pandemic. On behalf of the Scottish Government, we would like to acknowledge the extraordinary contribution made by those working in healthcare, in social care, in the NHS and in the voluntary and charity sector in Scotland during the pandemic. Their professionalism, compassion and resilience in intensely challenging circumstances saved countless lives. The Scottish Government extends its thanks and gratitude to all those who kept healthcare services going during through this period.

My Lady, thank you.

LADY HALLETT: Thank you very much, Mr Mitchell.

Is it Mr Bowie?

Submissions on behalf of Public Health Scotland by MR BOWIE KC

MR BOWIE: Thank you, my Lady.

The following oral statement is made on behalf of Public Health Scotland or PHS for short.

I would like to make some brief comments under the following three headings: PHS's role generally within the NHS in Scotland, PHS's specific role during the pandemic, and finally PHS's interest in this module of the Inquiry's work.

PHS is Scotland's national public health body. It came into existence in December 2019 and it was created to strengthen national leadership in public health. The rationale was to establish a unified public health organisation with a focus on improving and protecting the health and wellbeing of Scotland's population and, no less importantly, reducing societal health inequalities.

However, PHS is not involved in many of the practical aspects of maintaining public health at a community or local level, which are instead dealt with by public health teams within Scotland's 14 national territorial health boards -- Scotland's 14 territorial health boards. Neither is PHS involved in regulation or inspection, nor is it involved in the development of infection prevention and control (IPC) guidance for healthcare settings, which is a matter for NHS NSS.

Prior to the creation of PHS, the responsibility for protecting the Scottish public from infectious diseases and environmental hazards fell to another organisation, namely Health Protection Scotland (HPS), which was a part of NHS NSS.

When PHS became operational, elements of HPS transferred over to PHS. However, one element remained and still remains a part of NHS NSS, and that element is

ARHAI Scotland, or Antimicrobial Resistance and Healthcare Associated Infection Scotland to give it its full title, and that name will feature significantly in this module.

Unlike the other national NHS boards, PHS is distinct in that it's jointly accountable to and uniquely sponsored by both the Scottish Government and Convention of Scottish Local Authorities (COSLA). This reflects the fact that public health in Scotland is viewed as a shared endeavour of local and national government.

My second heading, PHS's specific role during the pandemic. During the pandemic, PHS had a major role in both leading as well as contributing to Scotland's response across a range of areas. Its scientific knowledge and expertise were relied upon by Scottish Government and the organisation was widely viewed as a key source of data, information and advice. In particular, PHS supported the Scottish Government's modelling of future projections of the pandemic. PHS advised the Scottish Government on the development of its national testing strategy. PHS advised Scottish Government on the development and roll-out of its Test & Protect programme. And finally, PHS shaped the digital infrastructure that supported the response.

My third heading, PHS in this particular module of the Inquiry's work. PHS is particularly interested in how data and guidance played a role in the matters under consideration. On data, its use was particularly important in the response to the pandemic. PHS was the primary source for data and intelligence on the pandemic. Daily figures were produced on the number of tests conducted, the number of confirmed cases, the test positivity rate and mortality figures. PHS monitored and published information on Covid-19 hospital admissions using the Rapid Preliminary Inpatient Data (RAPID) tool. PHS carried out work to identify and report on discharges from NHS hospitals to care homes during the first wave of the pandemic. And the Scottish Intensive Care Society Audit Group, which became a part of PHS in April 2020, monitored and compared activities and outcomes in critical care units.

Successful initiatives included the development of a range of effective data and analytic outputs that included robust estimates of the number of people with Covid in Scotland, hospitalisations and deaths.

The PHS daily dashboard allowed the public, local authorities and Scottish Government to gain immediate access to Covid data in an accessible format.

The EAVE II project. PHS worked with the University

of Edinburgh on a data reporting system called EAVE II which gathered vital intelligence on issues such as the spread of the disease, impact on health and vaccine effectiveness.

Finally, PHS also worked with a number of universities on the REACT-SCOT case control study, which showed that, along with older age and male sex, severe Covid-19 is strongly associated with past medical conditions across all age groups.

On guidance, PHS was responsible for developing, publishing and reviewing a wide range of public health guidance throughout the pandemic. Responsibility for specific guidance on infection prevention and control remained with ARHAI, on whose behalf I will be speaking shortly.

Finally, on public messaging, my Lady, whilst pandemic messaging was led by the Scottish Government, PHS played an important supportive role, working closely with ARHAI Scotland as well as local and national NHS boards to ensure continuity of and congruence of public health messaging in tandem with Scottish Government direction. Public messaging in hospitals and other healthcare settings, however, was the responsibility of the local NHS boards in Scotland.

Finally, before I conclude, most importantly,

my Lady, PHS offers its sincere condolences to all those bereaved as a result of Covid. The organisation understands the enormous suffering of all those who have been affected and are still affected by the far-reaching effects of the pandemic and Covid.

Thank you.

LADY HALLETT: Thank you, Mr Bowie.

Mr Pugh.

Submissions on behalf of the Scottish Territorial Health Boards by MR PUGH KC

MR PUGH: The Scottish Health Boards welcome these hearings into the impact of the pandemic on healthcare systems. They will allow a full explanation of the relevant facts, including the response of the NHS in Scotland.

This brief opening statement will be the first time the Scottish Health Boards have spoken publicly in this Inquiry, and with that in mind we have set out in writing some of the details of who the group comprises.

Put shortly, though, my Lady, it is the 14 territorial health boards that serve the different geographic areas in Scotland, as we heard yesterday morning, together with five of the special health boards that serve the whole of the Scottish population.

My Lady, the ethos behind this group's participation in this Inquiry in this module and later modules is to

assist the Inquiry and in doing so to strive for both learning and improvement, and through that participation and with that ethos the health boards hope to benefit the future healthcare of the Scottish population.

At the outset of these oral remarks, my Lady, the Scottish Health Boards recognise the deep wounds felt by those who have either lost loved ones or who continue to suffer physically and mentally as a result of the Covid-19 pandemic. Our sympathise and condolences are with anyone so affected.

On 17 March, my Lady, as you've already heard in Ms Carey's opening address yesterday, the Cabinet Secretary for Health and Sport said in a speech to the Scottish Parliament, addressing the developing pandemic:

"The scale of the challenge is, as the First Minister has said quite simply, without precedent.

"...

"To respond to Covid-19 requires a swift and radical change in the way our NHS does its work. It is nothing short of the most rapid reconfiguration of our health service in its 71-year history."

From March 2020 the health boards that I represent implemented key changes in practice and policy to create significant additional capacity for Covid-19 patients,

and to manage infection prevention and control within the existing NHS estate. It had to do so whilst continuing emergency, maternity, cancer services and urgent care, all of which have been maintained, alongside many other services, throughout the pandemic.

We've summarised in writing some of the key changes and developments that were undertaken, and in the interests of time I'll not read those out this morning.

However, these key changes and developments, whilst easy to summarise in a paragraph or so, were far from straightforward for those in leadership roles to implement. Furthermore, none of them, nor others too numerous to mention here, would have been possible without the extreme hard work and dedication of the employees of each of the health boards. Exceptional effort and skill were shown not only by those employed in frontline services, IPC and health protection roles, but also those who supported and enabled them, from porters and cleaners through to laboratory staff and administrative personnel.

Healthcare staff and managers found new ways of working and collaborating with colleagues and other agencies to ensure that, overall, the healthcare system has been able to respond to the very significant pressures of Covid-19. The health boards wish to take

this opportunity publicly to thank their employees. The extraordinary lengths to which NHS staff went during the pandemic has of course been rightly recognised by the public throughout the pandemic's course.

Of course, my Lady, recognition of the hard work and dedication of those key workers must also acknowledge the sacrifices that they made. One only need recall stories of frontline staff being unable to return to loved ones at the end of shifts for fear of infecting them to understand the extent of such sacrifice, and that sacrifice was of course shown so powerfully in the opening impact film yesterday morning.

The emotional and physical toll upon those caring for people dying without their family and friends around them was enormous. Healthcare staff were required to work under frequently changing national guidance and to make challenging ethical and clinical decisions under extreme pressure and in unknown circumstances. They were required to do so as colleagues became ill and in some cases tragically died due to the disease.

The media images of those working in high-risk areas dressed fully in PPE caring for such seriously ill patients will live long in the collective memory, and in that regard, my Lady, the early stages of the pandemic in particular saw difficulties in some areas both

determining and obtaining the correct PPE, and that's of course a matter that this Inquiry will look at in detail during the course of this module.

The impact of the pandemic has been felt across the health service. It's affected countless patients' experiences of healthcare. Health boards have not yet recovered from the pandemic and, on current estimates, are unlikely to do so for some time.

The impact on patients caused by delayed diagnosis of certain conditions, combined with the emotional and psychological toll of the pandemic and its knock-on effects on services is unlikely to be understood for some time. And Covid-related conditions, such as Long Covid, fall to be managed alongside the risk that new variants will again require surges in hospital care.

We set out in writing how the health boards anticipate participating in this part of the module, and again I'll not repeat that, but put short, my Lady, the health boards' commitment is to assist the Inquiry in its important work. Participation is important to the health boards and will contribute to their learning and developments, and ultimately it may be for the health boards to implement some of the recommendations that this Inquiry makes in this module. With that -- and they would require to do so having regard to the

resources available to them and are keen to assist the Inquiry in making those recommendations workable.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Pugh, I'm very grateful.

Mr Bowie, you're up again.

Submissions on behalf of NHS National Services Scotland by MR BOWIE KC

MR BOWIE: The following oral statement is made on behalf of NHS National Services Scotland, or NHS NSS for short. I'm going to adopt the same headings as I did with PHS and consider, firstly, NHS NSS's role generally within the NHS in Scotland, secondly, its specific role during the pandemic, and thirdly, its particular interest in this module of the Inquiry's work.

NHS NSS was established to provide national strategic support services and expert advice to Scotland's NHS. Current services provided by NHS NSS are diverse, ranging from ARHAI Scotland, part of the wider directorate NHS Scotland Assure, to Scottish National Blood Transfusion Service and National Procurement and Logistics.

Turning now to my second head, NHS NSS's specific role during the pandemic. Whilst not primarily a public-facing organisation, the services provided by

NHS NSS had a role in the response to the Covid pandemic in Scotland. Specifically its roles included:

- Programme management services, including the commissioning and decommissioning of the Louisa Jordan Hospital, Test & Protect and Covid-19 vaccination programmes;
- Procurement and logistics for personal protective equipment;
- Operational delivery of the UK national and local testing programmes in Scotland, working with partner bodies and organisations to ensure access to appropriate Covid testing for the population;
- Working with other bodies on the production of UK Covid infection prevention and control guidance;
- Development and publication of Scottish Covid infection prevention and control guidance in October 2020;
- Surveillance and monitoring of Covid in Scottish healthcare settings.

NHS NSS played a significant operational role in the response to the pandemic in Scotland across a wide range of diverse functions.

My third heading, NHS NSS's interest in this module of the Inquiry's work. NHS NSS is particularly interested in the scrutiny of the development of IPC

guidance during the pandemic. ARHAI Scotland played an important role in this area and NHS NSS wishes to take the opportunity to clarify a number of points as to the proper role and remit of ARHAI.

ARHAI Scotland has the remit for the development of IPC guidance for Scotland. It's got no responsibility for the development of guidance outwith Scotland.

Prior to the Covid pandemic, Scotland was the only UK nation where the NHS produced and published a National Infection Prevention and Control Manual (NIPCM). The NIPCM is a live document. As such, its evidence base is continuously reviewed through ongoing systematic literature reviews using a defined methodology supported by the Scottish Intercollegiate Guidelines Network (SIGN) in order to develop the guidance recommendations.

The NIPCM Scotland literature reviews critically appraise existing guidelines produced by other international organisations in line with best international practice.

Covid IPC guidance was published at the outset of the pandemic by Public Health England and applied in all four UK nations. The guidance was further developed using a range of intelligence undertaken by multiple organisations including ARHAI. Following the request of

the Chief Nursing Officer in Scotland in October 2020, Scotland moved away from UK IPC guidance and through the NIPCM published a national Covid IPC addendum which formed the Scottish national guidance.

ARHAI had weekly meetings with IPC stakeholders in Scotland where perspectives of health professionals regarding evidence from literature, local epidemiological reports and international organisations' guidance and experience were considered and reflected on. This in part explains why Scotland moved away from the UK IPC guidance.

Now I'd like to make some comments, if I may, about the Covid-19 Nosocomial Review Group in Scotland. In Scotland, the Covid-19 Nosocomial Review Group served as an advisory body that examined the epidemiological, scientific and technical concepts crucial for understanding the evolving Covid situation and its potential impacts on hospitals in Scotland alongside published evidence.

The advisory group applied the advice coming from the WHO, SAGE, the UK-wide IPC guidance cell and other appropriate sources of evidence and information, used it to inform the decision-making process in Scotland. ARHAI provided Scottish epidemiological and clinical data which, as well as supporting the development of

guidance, informed the development of advice to Scottish Government via the nosocomial review group.

One key source of information provided by ARHAI was the Covid cluster monitoring system, which collected varying levels of information on the number of patient and staff cases, hypotheses, investigations and lessons learned, and this was a unique and important tool in Scotland which offered insights into the burden of Covid clusters, the mechanisms of Covid introduction into healthcare settings and the factors promoting its transmission.

These reports enabled ARHAI to provide regular situational updates to stakeholders.

ARHAI also provided epidemiological intelligence to the nosocomial review group via the onset Covid-19 surveillance system -- the hospital-onset Covid surveillance system. That system monitored trends in confirmed hospital-onset Covid cases. As the system collected information for all Covid cases diagnosed in hospital inpatients, the burden of community cases on hospitals could be quantified.

These data informed the development of patient testing strategies and supported the wider understanding of the severity of Covid.

Finally, rapid reviews. ARHAI Scotland undertook

rapid reviews which were primarily focused on the assessment of SARS-CoV-2 virus studies that were published as the pandemic unfolded. Their purpose was to support NHS Scotland IPC and clinical staff, who, without the rapid reviews, would have lacked a reliable source of intelligence to stay updated on emerging evidence. No other organisation in the UK attempted to provide such support for frontline IPC staff.

From March 2020 to April 2022, monthly assessments of IPC measures for the prevention and management of Covid in health and care settings were conducted, weekly meetings were held with Scottish infection control managers, IPC nurses and doctors, and Scottish Government, to share intelligence and support implementation.

The reviews didn't make graded recommendations, instead providing evidence summaries, and this was considered appropriate.

To conclude, my Lady, ARHAI Scotland has invested significantly in national IPC resources and has a well established collaborative network. This ensures and ensured that service providers and supporting organisations are integral in the development and implementation of national IPC guidance.

ARHAI Scotland, we believe, is very well placed to

give an account of the structures, governance and processes that existed regarding the development of IPC guidance during the pandemic in Scotland. The Inquiry will be hearing from Laura Imrie, the clinical lead for ARHAI Scotland, in due course. Her evidence will be important, my Lady, not least given the observations made in the opening statement on behalf of CATA, the content of which my Lady will be familiar with. ARHAI Scotland does not shrink from the important issues that CATA raises.

Finally and importantly, NHS NSS, like PHS, offers its sincere condolences to all those bereaved as a result of Covid. The organisation understands the profound impact that the pandemic has had and continues to have on people and families everywhere.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Bowie.

Mr Kinnier.

Submissions on behalf of the Welsh Government by MR KINNIER KC

MR KINNIER: Prynhawn da, good afternoon, my Lady.

The pandemic had far-reaching effects on healthcare services in Wales and on the people of Wales. Those effects are continuing, not at least on waiting times for treatment. As was movingly demonstrated by

yesterday's film, the Inquiry will hear powerful evidence about people with Covid-19 who were treated in busy and overstretched wards and who were understandably frightened whilst they were in hospital. We will hear from family members who were unable to be with their loved ones as they died, from people who struggled to access NHS care and treatment for conditions other than Covid-19 and from those who continue to suffer from the pandemic's long-term effects.

We will also hear from frontline healthcare workers, who, at great personal cost and risk, continued to provide care and treatment in the most challenging circumstances.

These accounts will lie at the heart of this module. They will cast an unflinching light on what worked and, crucially, what did not work. Their accounts will inform the measures that should be taken in responding to a future pandemic and the Welsh Government is grateful to them for their courage in sharing them with us.

We will also hear from those senior officials and ministers who were responsible for the Welsh Government's response to the pandemic. They will each give a full and frank account of their decisions and the circumstances in which they were made, the reasons for

those decisions and how the Welsh Government's response developed and changed as development of the virus evolved. As in all previous modules, the Welsh Government witnesses will fully co-operate with your work.

May I briefly touch upon a few particular matters. The overall provision of NHS services in Wales is the responsibility of the Welsh Government. NHS services themselves are provided by health boards and NHS trusts. Each health board is responsible for providing services to its local population in its geographical area and NHS trusts, together with two special health authorities in Wales, are responsible for providing certain national services.

Operational decision-making rested with those NHS bodies responsible for day-to-day activities and the allocation of resources to ensure an efficient and effective service in their area.

The Welsh Government is responsible for funding the NHS in Wales, setting the strategic direction and planning requirements to ensure funding is utilised efficiently whilst improving health.

During the course of the pandemic, the Welsh Government revised planning arrangements to allow the NHS in Wales the flexibility to respond as effectively

as it could to the emerging situation.

As the experts concluded, visiting restrictions played an important role in preventing the spread of infections within hospitals. The decision to restrict visiting was not taken lightly. The Welsh Government was acutely aware it would be restricting the access of family and friends to their loved ones at the most difficult of times. It was for that reason that guidance issued by the Chief Nursing Officer made it clear that enabling people to say goodbye to their loved ones at the end of their lives was to be facilitated wherever possible.

That said, the Welsh Government shares the Inquiry's determination to see how the complex balancing of factors relevant to restrictions can be differently or indeed better achieved in the future.

The Welsh Government also recognises that pre-existing health inequalities within Wales were exacerbated during the pandemic, that there were those who struggled to access the care that they needed, and that the use of PPE, visitor restrictions and the increased use of virtual communications caused difficulties for those who are visually or hearing impaired.

To ensure that decisions were informed and in the

best interests of the most vulnerable and the most affected in Wales, the Welsh Government consistently sought to take account of these individuals in its decision-making, including setting up the Black, Asian and Minority Ethnic Covid-19 Advisory Group and the Covid-19 Moral and Ethical Advisory Group to advise ministers. The Inquiry will consider how these groups' contributions informed and improved decision-making during the pandemic.

The Welsh Government accepts the conclusion of Drs Northover and Evans that the preparedness and response capabilities of the UK's healthcare systems failed fully to consider mental health illness and that failure necessarily affected the pandemic response and the provision of child and adolescent mental health services, CAMHS, particularly in the early stages of the pandemic.

The Welsh Government sought to mitigate that omission by a swift response once the pandemic struck. In Wales, CAMHS services were essential services and a range of measures were put in place to support them. Overall services remained open and accessible during the pandemic through adapted service models. The importance of mental health was also reflected in the appointment of a dedicated minister for mental health.

On any view, my Lady, the availability of critical care capacity is a highly complex question. As noted by Professor Summers, the UK as a whole entered the pandemic with a deficiency of critical care capacity. Although bed capacity limits were never breached in Wales, in certain hospitals there were times when capacity was so stretched to CRITCON level 3 was declared and on one occasion they were close to declaring CRITCON 4 because all capacity had been exhausted.

On those occasions, there was still limited capacity in neighbouring health boards and the system of mutual support allowed demand to be satisfied. As far as the government is aware, there were no incidents where a patient who was clinically appropriate to receive critical care was unable to access a critical care bed in the relevant health board area or at least from a neighbouring health board area.

Despite the focus on infection prevention and control in Wales, the Welsh Government accepts that there were too many hospital-acquired infections and it has funded a national programme to investigate and learn from the cases of healthcare acquired Covid-19 infections. The statistical analysis cited by the experts showed that Wales had a significantly higher

percentage of hospital onset cases during the first wave the pandemic, compared to England and Scotland.

Analysis from national surveillance data in Wales identified that, adjusting for confounding factors, there was no increased mortality for hospital acquired cases compared to cases admitted with Covid-19 from the community. It is not known whether the lower level in England reflected differences in hospital admissions or testing over those peak months. Again, that difference will, I'm sure, be investigated in due course.

The provision of appropriate and high quality PPE was undoubtedly one of the most significant challenges in ensuring the safety and wellbeing of the health and social care workforce. The Welsh Government managed and monitored PPE stocks and, although at a national level there was always sufficient in Wales, the evidence from those on the frontline shows that there were still instances where individuals or individual hospitals struggled to obtain sufficient or suitable PPE. Again, that is a matter which we anticipate will be investigated in due course.

Those individuals identified as being clinically vulnerable or extremely vulnerable to severe complications of Covid-19 were asked to endure the most stringent restrictions on their lives in an effort to

keep them safe. The Welsh Government recognises that there were shortcomings in the process by which clinically vulnerable and extremely vulnerable individuals were identified. In particular, no formal equality impact assessment was carried out before the policy was introduced. The policy and its development would also have benefited from greater direct consultation with disabled people, an omission that was later rectified through engagement with Disability Wales from June 2020 onwards.

The Welsh Government's impact of shielding on vulnerable individuals, the integrated impact assessment, noted that the most significant impact of the shielding policy was positive, with the creation of a robust system of governance that provided assurance that access to services and provision continued for those who were identified as extremely vulnerable or shielding.

My Lady, in conclusion, the Welsh Government's overarching objective was to protect the Welsh population and to save lives. To that end, it worked in partnership with stakeholders, frontline workers and the public to support the NHS in Wales to respond to the extreme challenges it faced, to protect it from being overwhelmed, to increase capacity, should the worst-case

scenario materialise, and to minimise transmission of the virus.

The Welsh Government fully supports the need for this Inquiry to identify lessons that can be learned and improvements that could be made to improve its healthcare response in any future pandemic.

My Lady, thank you.

LADY HALLETT: Thank you very much, Mr Kinnier.

Ms Fenelon.

Submissions on behalf of NHS Wales Core Participant Group of Welsh Health Boards (NWSSP - L&RS) by MS FENELON

MS FENELON: My Lady, I appear, led by Jeremy Hyam King's Counsel and instructed by Sarah Watt of Legal & Risk, on behalf of the group of Welsh health bodies, which comprises the majority of Welsh local health boards and Velindre University NHS Trust, collectively responsible for primary and hospital care for the majority of the population in Wales.

The group of Welsh health bodies has, through the various statements its constituent bodies have made, responded to all the Inquiry's requests for information in a timely and detailed manner and has provided the Inquiry with a substantial amount of information in a form which we hope has been focused, digestible and useful for the Inquiry's purpose.

The Inquiry sought by Rule 9 request a large amount of granular detail in respect of a number of specific matters. In response to these requests, each constituent member of the group carried out extensive research and provided the specific data as requested in order that the Inquiry should have as full a picture as possible of the detail on the ground in Wales and of the operational impacts of Covid on the healthcare systems in their respective areas.

As a result of this work, the group now feel that the Inquiry has before it a wealth of evidence which gives a substantial amount of data as to the specific impacts of the pandemic, as well as insights into lessons which might be learned for the future.

The Inquiry has also identified a spotlight hospital in Wales, Glangwili hospital. Professor Philip Kloer, Interim Chief Executive of the Hywel Dda University Health Board has provided a detailed statement giving a full account of how Glangwili hospital responded to the pandemic. He highlights how staffing capacity, already a problem before the pandemic, was compounded by Covid related sickness, but a recruitment drive commenced in March 2020 resulted in the creation of around 1,100 new staff. He explains how bed capacity was increased and, in fact, Glangwili hospital never

reached the position where an ICU bed, if required, could not be found for a patient.

He highlights an issue echoed in other statements from the group of Welsh health bodies, that the frequent changing of guidance, particularly during the pandemic onset, caused obvious practical problems but also staff confusion and anxiety. In similar vein to concerns identified by Velindre NHS Trust, he points to the fact that Public Health England guidance was usually announced on a Thursday but Public Health Wales on the following afternoon. This led to difficulties in initial implementation.

As to hospital infrastructure, he identifies what is a fairly common theme in the evidence from Wales and elsewhere, that the buildings themselves gave rise to practical problems implementing infection prevention and control guidance, in particular poor ventilation.

In similar vein to the reports of other university health boards, he reports that sourcing of PPE was not the problem that might have been anticipated. The health board procurement teams were able to procure equipment appropriately and, although there was considerable anxiety in relation to PPE stock and supplies of face masks at one point reached critical levels at Glangwili hospital, supply was not an issue

and neither were there significant delays in obtaining equipment once ordered.

This is not to say that there were not some practical difficulties but, overall, although there was considerable anxiety at the start of the pandemic, the hospital was able to work around any issues over PPE supply.

As to visiting restrictions and the difficult balance that had to be struck, the overall view was that the hospital did its best and probably struck the right balance through specific arrangements supported with all necessary PPE.

The group of Welsh health bodies know that many of the recommendations Professor Kloer identifies chime with matters that other health boards have also identified and, while still very much provisional submissions, the group would endorse the following suggestions:

Any future recommendations would need to look at the existing infrastructure of hospitals in parallel with future pandemic planning and all modern hospitals should be designed with pandemics and serious infection outbreaks in mind, with existing buildings being upgraded.

Pandemic planning needs to develop resilience in

staffing, medical equipment and supplies and, to that end, there should be sufficient PPE stock or local capacity to respond and supply such stock built into the system. The development of reuse-useable PPE would change the landscape.

The creation of a reserve workforce, both skilled and volunteer, would assist with staffing resilience.

The importance of national co-ordination of the senior clinical voice across Wales, to ensure rapid sharing of experience and learning, cannot be underestimated.

Drawing on the experience of Covid, have pre-prepared guidance developed that could be swiftly adapted, disseminated and implemented.

Harness the learning from the rapid development of vaccines to be applied to future pandemics.

Share the learning internationally on the best ways of maintaining the wellbeing of clinical professionals in a high risk pandemic situation.

Finally, the development of surge capacity, whether through field hospitals or otherwise, should be decided nationally and funded centrally.

In conclusion, the Inquiry will already be aware from the two statements from Ms Judith Paget in her capacity as the Chief Executive of NHS Wales that

a considerable amount of work has already been carried out in Wales in terms of seeking to learn lessons from the Covid-19 pandemic. This is all part of a firm commitment on behalf of all health bodies in Wales to seek to continue to improve the services they provide for the benefit of patients and in the wider public interest.

Like the Welsh Government, the group of Welsh health bodies will be watching the Inquiry's progress closely to learn further lessons in order to continue this improvement.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed.

Ms Grey.

Submissions on behalf of NHS England by MS GREY KC

MS GREY: Thank you. My Lady, I rise on behalf of NHS England.

NHS England co-ordinates the provision of healthcare services in England and had the responsibility of leading the emergency response of the NHS to the pandemic within England.

At the outset, NHS England wishes to acknowledge the death, pain and suffering and burnout experienced by so many in this country and worldwide because of the global pandemic. We know that despite the concerted efforts

made to mitigate the pandemic's effects, many suffered greatly. CTI has outlined the numbers of deaths involving Covid in this country and, over the last day, we've heard justifiably hard hitting reminders of suffering, including in relation to the continuing effects of the pandemic, from participants representing patients and the public, expectant mothers and babies, for example, and staff such as migrant workers.

We expect that the further impact evidence will be just as harrowing and we are committed to listening and learning, but focusing on the impact of the pandemic first on healthcare staff, no patient care would have been possible without the sustained and dedicated efforts of NHS staff and contractors across the hospital, primary care and community sectors, who worked under extraordinary pressures for very lengthy periods.

For NHS staff, the pandemic has almost certainly been the most challenging and painful period of their working lives, with many courageous personal sacrifices made. NHS England wishes again to recognise the extraordinary effects that NHS staff and wider personnel went to in the pandemic and its continued impact.

Their dedication has been remembered in a variety of ways, including by the award of the George Cross by the late Queen.

Now, every piece of evidence to this Inquiry challenges us to learn lessons from what happened. NHS England sees this Inquiry's exploration of events as critical to not just preparation for future pandemics but also to improving patient care now. We share the Inquiry's desire to learn from past mistakes but also to learn we hope from achievements and what was done as well.

It now seems difficult to speak of successes when the dominant theme over the last two days has been one of the costs of the pandemic or of suffering. We were and are not deaf to the negative impacts of policies adopted, whether demands on healthcare workers or on patients facing delayed or disrupted care. Nor do we say, particularly with the advantage of reflection and hindsight, that we always got the balance right. But there are things to learn from in relation to what we would repeat.

We cannot, my Lady, in this opening address all aspects of NHS care and the many issues to be examined have been outlined systematically by CTI yesterday, but we would like to make a few thematic points.

First, when hearing evidence of what was done during the relevant period from January 2020 onwards, we ask the Inquiry to bear in mind the resources that were

available to the NHS and the external constraints: resources such as the ageing NHS estate; constraints on matters such as testing capacity. Many, including CTI, have addressed the issue of NHS resilience in its capacity and, important though those issues are, we will not repeat our submissions about them now.

But sometimes what was accomplished has to be measured against what was known and what was available. Of course, this doesn't mean that the issue of emergency planning and preparation should be overlooked. However, plans can only get you so far when hit with unprecedented demand.

Secondly, we ask the Inquiry to recognise the serious purpose for which all measures were adopted: ultimately to preserve life. This is not a tale of carelessness or improper motives, nor one of accepting a disproportionate impact on different people, but one in which difficult choices have weighed very heavily on staff whose overriding concern and priority was always to save lives.

Third, we ask the Inquiry to have in mind at all times the fog of war, the context on the day at the time, in which decisions were made by organisations such as NHS England, and the many uncertainties including about the virus and its properties. Even now there

remains an acknowledged need for further research on the virus.

Fourth, we ask the Inquiry to assess the alternatives or, to put it another way, the counterfactuals: evidence of the harm caused by a measure that was adopted has to be balanced by an equally serious assessment of the anticipated harms of alternatives, to understand the choices made.

We referred in our written opening to a few example of dilemmas faced and many more will be explored. Yesterday, we heard strong and deeply felt accounts of harm from choices made affecting pregnant women, babies and the rights of birthing partners, yet the Inquiry will also need to understand the experiences of and the need to protect midwives, other staff and patients in considering how the balance is best struck in future.

Finally, we ask the Inquiry to look at the process or systems that were involved in striking these balances, to focus on systems rather than personalities. Many witnesses giving evidence are often speaking, not simply of their own judgements, but of the consensus reached by a group, cell or committee, and we submit that this should be recognised in questioning.

Our experience of decision-making in the pandemic was that it was highly collaborative with extensive

stakeholder consultation and involvement. Against that background, we're eager to know what systems would enable better decision-making in future crises.

I would just like to say a few words on NHS England's perspective on decision-making and its evidence. We've just mentioned collaborative decision-making, and we set out in our written opening how, as a national body and a leader of the NHS, we work with a wide range of organisations and stakeholders and have to respect their remits. We've heard that this may lead to concerns about a lack of clarity on who is accountable or failure to take responsibility. This Inquiry is, of course, one form of accountability and we know that it will consider and delineate responsibilities carefully. We welcome this. However, the NHS is large and decisions frequently require both input and then action from a number of bodies.

Overall, our experience was that this was a source of strength. It enabled the all hands on deck approach, the loaning of staff to share expertise and the formation of joint groups, such as the UK IPC cell, a four nations group.

At times this included supporting the development of guidance that was not NHS England's responsibility. Other groups, such as the royal colleges, did the same,

and this was truly appreciated. Such co-operation not only helped the pandemic response to be agile but was also a check against groupthink.

In written evidence we provided NHS England's perspective on policy guidance and systems as well as high level data or statistics. This NHS England perspective will often be summative or an overview but may not always reflect the variety of local experiences witnessed in other parts of the NHS.

For example, in relation to critical care, the Inquiry will hear both of periods of intense local pressures on bed availability in one region or hospital and evidence of the overall system response to maintain capacity, increasing ICU beds, the opening of specialist beds outside of the ICU and many other measures. In seeking to hold in mind both of these perspectives, we are not seeking to advance a false or an overoptimistic narrative but to reflect the complexity of the NHS response over the protracted length of the pandemic. When we talk about the national system's response, we're not denying the experience of individuals and we absolutely acknowledge the heightened pressure that clinicians were asked to manage.

I turn briefly to inequalities and the culture of the NHS. The pandemic is widely recognised as

highlighting and exacerbating entrenched inequalities nationwide, including in the NHS workforce, where there are about 200 nationalities employed. People from black, Asian and minority ethnic backgrounds make up over 20% of the NHS workforce and we know that they suffered disproportionately in the pandemic. We've set out in our corporate witness statement what was done in response, such as the creation of the NHS Race Observatory in May 2020 but we know that there is much more to do.

In particular, NHS England wishes to acknowledge the issues raised by the Frontline Migrant Health Workers Group submission. This summer, the CEO of NHS England said unequivocally to those within the NHS who were afraid in the wake of the summer riots:

"You are welcome, you are a valued member of our community and that community should look after you."

That message resonates in the context of the pandemic too. We acknowledge that one area of looking after is ensuring that all staff, especially the most vulnerable, feel able to speak out about their experiences and contribute to learning. We are deeply sorry that there are NHS witnesses to this Inquiry whose genuine fear of victimisation, as a result of giving evidence, has required them to give evidence

anonymously. NHS Freedom to Speak Up campaign aims to create work spaces where people feel safe to speak with confidence and in confidence but we know that there is much more to be achieved to make workforces safe for everyone.

My Lady, in conclusion, we have set out in evidence how, although there were no perfect options and often no good ones, the NHS did its best to deliver a shared and co-ordinated response to share learning rapidly, to maintain treatment and to avoid harm. NHS England was able to provide a national co-ordination integration with local NHS providers in a way that was never done before, working alongside government but operationally focused and independent of the wider demands of being a department of state.

The Inquiry's relevant period ends in June 2022. Over two years later, the NHS continues to face multiple challenges in recovering from the effects of the pandemic. The impact on its staff has been profound and the legacy of increased waiting times endure. We had hoped to see in this module an examination of issues which will further help recovery and identify and embed lessons to assist in the management of any future crisis.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Grey, very grateful.

Mr Jory.

Submissions on behalf of the Independent Ambulance Association by MR JORY KC

MR JORY: My Lady, I make brief representations on behalf of the Independent Ambulance Association.

I, together with Ms Jessica Tate, am instructed by Linda Barker of Duncan Lewis Solicitors. The IAA is a not-for-profit trade association and the pre-eminent voice for independent ambulance providers across the UK.

The IAA has over 50 member organisations who collectively employ thousands of individuals. They provide a range of critical services supplementing the NHS in the UK, and these include non-emergency patient transport, 999, frontline responses, high dependency patient transfers and mental health patient transportation.

Approximately half of all NHS funded non-emergency patient transport is provided by independent ambulance providers.

During the pandemic, the independent ambulance providers pivoted their services to assist in the transport of Covid patients to and from hospital, and to care for Covid patients, often at considerable risk to themselves and their families. The contribution of IAA

members undoubtedly mitigated the impact of Covid on the UK's health systems. The headline topics we wish to address at this stage include the following:

Key worker recognition. As you've heard from many other CP groups here, the failure to grant immediate key worker status to our members had an immediate and practical impact on the ability of our members to provide an effective service alongside the NHS to support the Covid response.

Next, the shortage of oxygen and other medical gases. During the pandemic, oxygen and oxygen cylinders were in extremely high demand in the UK and indeed globally. The main domestic oxygen supplier was unable to meet the unprecedented demand for oxygen, and it was evident there was insufficient medical gas production capacity in the UK.

Independent ambulance organisations were unable to replenish stocks for existing cylinders, resulting in vehicles not being operational. There remains an ongoing reliance on -- and therefore vulnerability to -- offshore manufacturing of medical gas cylinders, particularly oxygen, with a lengthy lead time for new cylinders. Further, during the pandemic, normal open market supply chains were effectively usurped by the government in favour of managed provision through the

NHS or local authority managed portals, but there were problems in accessing these portals, which in turn created delay, uncertainty and disruption to services.

Unregulated ambulance providers. There were significant problems regarding unregulated ambulance providers carrying out what should have been regulated activities. IAA members are required to adhere to strict Care Quality Commission guidance. These unregulated providers are not subject to the same rigour of CQC inspection or indeed accountability. They cannot provide the same level of professionalism and service, and this in turn puts patients and workers at risk.

Some of the non-regulated providers were opportunistically advertising for staff in response to the Covid crisis, having circumvented the normal approvals process by being subcontracted by CQC-regulated providers.

Mental health patients. The wellbeing of mental health patients is of particular concern. The availability of mental health beds during Covid was limited, and this continues to be an issue. The lack of beds locally results in patients being taken by IAA members on long journeys at short notice in order to receive appropriate care. The knock-on effect of this is a subsequent practical challenge for family and loved

ones to visit and provide support.

Financial stability. In the first two weeks of the Covid pandemic, NHS-funded non-emergency patient transport journeys reduced from 100% to less than 40%. As independent operators, relied heavily upon by the NHS, IAA members found their financial viability suddenly and significantly undermined.

As with all the matters mentioned, we will make practical proposals for recommendations from this Inquiry to avoid such a problem in the future.

Communication. One consistent concern highlighted by our members was the lack of a clear line of communication as the scale and impact of the pandemic developed. Non-emergency patient transport does not have a permanent national team providing oversight and leading the work. In our view, the establishment of a small but permanent national team with powers of oversight and delegation would bring consistency in approach to commissioning of services, whilst also providing innovation, equality of access, and ensuring value for money.

Finally, a more strategic role for ambulance service NHS trusts. We invite the Inquiry to consider a more strategic role for ambulance service NHS trusts in co-ordinating and deploying the available assets of

independent ambulance providers.

For example, during the pandemic, the London Ambulance Service NHS Trust, who do not themselves provide non-emergency patient transport, co-ordinated with NHS hospitals on the patient movements required in the London area, and directed independent ambulance providers accordingly. This regional system of commissioning and co-ordination was more responsive and efficient than the pre-existing centralised system.

My Lady, we look forward to assisting this Inquiry in identifying issues and providing practical suggestions for solutions based on our members' experience.

LADY HALLETT: Thank you very much, Mr Jory.

Right, I think that completes the submissions on behalf of the core participants. We shall break now and we shall begin hearing evidence this afternoon at 1.55.

(12.57 pm)

(The short adjournment)

(1.55 pm)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you. May I call, please, Mr Sullivan, who can be sworn.

MR JOHN SULLIVAN (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

LADY HALLETT: Mr Sullivan, thank you so much for coming to help. I appreciate that it's not going to be easy for you but we're really grateful to you.

THE WITNESS: Okay, thank you.

MS CAREY: Mr Sullivan, just start, please, with your full name.

A. It's John James Sullivan.

Q. I'm going to ask you some questions, please, about your family and, in particular, your daughter Susan.

A. Yeah.

Q. I think you have made a statement to help us and, if you need to look at it, it should be in the bundle in front of you.

A. Yeah.

Q. Susan, I think, was born on 17 November 1963.

A. Correct.

Q. She was born with Down's Syndrome.

A. Yes.

Q. She died, as we're about to hear, on 28 March 2020.

A. Correct.

Q. She was 56 at the time.

A. Correct.

Q. Right. Just help us, please, just summarise a little bit about Susan -- who I think you called Susie; is that right?

A. Susie, yes.

Q. Just tell us a little bit about Susie and some of the things she did during her life.

A. Yes, well, Susie was born, as you said, with Down's Syndrome and we were told she wouldn't walk, she wouldn't talk, and every time we took her to a doctor, with something positive there was a negative, so I came home one day and my wife was crying, she'd been to the GP. I said, "Right, forget the doctors, we're going to do this our way", and we crawled round the floor with her, we smacked her bum if necessary, we tapped her bum, we encouraged her to crawl, we encouraged her to walk and then she just blossomed.

Her talking wasn't good but then she became the dancing queen, I mean, she just -- she swum in the Special Olympics, she won gold, she won silver, she won bronze. She was just a remarkable, lively, empathetic person, she was just a special human being.

Q. I think you said -- did she live at home with you and your wife, Ida?

A. All the time, yeah, all her life.

Q. But she attended some day centres during the week?

A. That's right, yeah, she went to day centres five days a week.

Q. She was on holiday with you?

A. Always on holiday, yeah, yeah.

Q. Between you and your wife, and I think Susie's brother, Clifford, you looked after her?

A. Yeah, we did. Yeah, we did, and her brother Andrew, before he went off to Australia -- to live in Australia.

Q. In terms of her health, is this right, that in 2018 she was fitted with a pacemaker --

A. Yeah.

Q. -- but other than that, no major problems?

A. No, no. She was fit as a fiddle. I mean, you don't win gold, silver and bronze medals for swimming if you're not fit.

Q. No.

Can I come to the start of the pandemic and I think, is this right, that around the beginning of March you and your wife and Susie started isolating to try and keep Covid away from her; is that right?

A. Yeah. We couldn't understand why the government basically didn't appear to be doing anything and they didn't appear to be doing anything, you know, there was no borders shut down, there was no -- you know, they were doing nothing. I mean, even the Prime Minister was telling people to shake other people's hands. I mean, it was kind of a lunacy. We were in this worry and we decided, well, we'll close down, and what we did then is

everything that came in the house -- we were confined to the house in the back garden and our son Clifford took control, and everything that came in was sprayed with disinfectant cans. We did everything humanly possible to protect ourselves and Susan from -- our neighbours did all shopping and Clifford did all the shopping, you know what I mean?

Q. But in spite of all of those efforts, is this right, Susie began showing Covid symptoms around 21 March, did she?

A. That's right, she -- basically Susie suffered with Graves' disease and she had a habit of rubbing her eyes, and we think that's possibly where she picked it up before we'd locked down and it had taken hold afterwards.

Q. I think you said in your statement that, having had a few days of you trying to look after her at home, she began to perk up around the morning of 26 March?

A. Yes, I mean, I was with Susie, we did puzzles, we did -- I mean, because I'm riddled with cancer anyway and my idea was, like, you know, I'm going to die anyway so what the hell, I'm going to look after her and be with her. So we planted bulbs in pots in the back garden, we did puzzles, we watched her favourite movies, Grease, about 400 times, and we did all these kind of things.

But she was kind of up and down, if you understand, she was a bit lethargic at times but other times she was great, she was fine, she was quite normal.

Q. I think, though, notwithstanding the ups and downs, by the morning of 27 March she began to complain of a tummy ache; is that right?

A. Yeah, yeah.

Q. Was it then in the early hours of 27 March that I think you asked your son to call an ambulance?

A. Yeah, we did.

Q. Do you remember what time that was, Mr Sullivan?

A. Well, I'd been up with Susie the night before by her bed and then they woke me about 4.00 --

Q. In the morning?

A. -- and said -- yeah, in the morning, at 4.00 am, and said, "Susie's complaining about tummy ache", and I went into the bedroom -- into Susan's bedroom, and my wife then was in a bit of a flap because she'd just read a story on her iPad about a lady dying with Covid and they said that was a ...

Q. A symptom?

A. A symptom of Covid and so, therefore, I left it for about 45, 50 minutes, and I said to Clifford -- because she was in really, really, really bad pain with her tummy, I said, "I think we'd better phone an ambulance",

and we phoned an ambulance about 4.45, 4.50, something like that.

Q. Now, we know from Susie's records that she went into the hospital about midday, so from ringing the ambulance just before 5.00 am and the ambulance turning up is a good few hours; is that right, Mr Sullivan?

A. Oh, yeah. I mean, not only that, I mean, the ambulance was diverted --

Q. That's what I wanted to ask you about. So in that time when you rang the ambulance and Susie ending up being taken to hospital, how many times did you or the family try to get the ambulance out to see her quicker?

A. Well, Clifford was on the phone. I think he spoke to them three times. I mean, when they hadn't come the first time, then they told us that they'd had to divert the ambulance and, of course, you know, when these things happen, you know -- and in retrospect you start to think "Was it diverted because she was Down's Syndrome?" You start thinking these things, like, you know what I mean, because she was poorly, she was obviously poorly and why did they divert her ambulance? So just it never made sense.

Q. Can you remember now roughly what time the ambulance did arrive?

A. Well, Ida had phoned the pharmacists -- the local

pharmacists to get some advice about the belly pain, and he said "Don't wait any longer for the ambulance", he said, "Just get her in a car and get her to the hospital". So we got her out of bed and got her dressed, and we'd just got her down the stairs and into the kitchen and I was putting her shoes on and the ambulance arrived. So it was probably something around about six hours, six hours after -- six and a half hours, maybe.

Q. Yes, so in that time three calls from the family to chase up the ambulance and a call from Ida to the pharmacist to try and seek some advice?

A. Yeah.

Q. Then eventually, just as you're getting ready to leave, the ambulance arrived?

A. The ambulance arrived, yeah.

Q. Can you remember now whether the ambulance crew were wearing any protective equipment, masks, goggles and the like?

A. The only thing I can remember, I'm pretty sure, because I was in a bit of a state at the time, let's be honest, I remember -- I'm pretty sure I remember them having masks on and gloves. But I don't think they had anything else on. I mean, to be honest with you, they were in the house two minutes because Susan was sitting

in the chair, they came in, they -- I think they took her temperature or put something on her finger, I can't remember, and they stuck an oxygen mistake mask on her, which surprised me because she never complained about any breathing issues. They stuck the oxygen mask on her and she was gone, you know, so it was that quick.

Q. Is this right, was it your wife that went in the ambulance with Susie?

A. Yeah, my wife went in the ambulance with her, yeah.

Q. I think then you can tell us about what you understand happened to Susie once she got to A&E?

A. Yeah.

Q. Obviously, Ida's helped tell you about what happened there. In the emergency department, do you know now, was Ida allowed to go in and be with Susan while she was being assessed and decisions were being made --

A. No, not initially. Not initially, she was -- she was sent into a room to wait and so, therefore, any discussion regarding Susan's health or wellbeing was -- the conversation only took place with the medics and Susan and, you know, if you have a conversation with Susan about Abba, Cliff Richards, Meat Loaf, you know what I mean, Grease, you're in with a chance. You start talking about her medical -- you know, she wouldn't have had a clue.

So, you know, I never understood -- 50 years we -- over 50 years we've sat in a hospital or a doctor, and a doctor's realised within seconds that Susan needs -- you know, isn't able to discuss, so therefore --

Q. Well, that's what I wanted to ask you.

A. Yeah.

Q. So in the past when Susan's needed treatment or help with something, has it been you and Ida that sort of helped Susan understand what was going on --

A. Always, yes.

Q. -- and helped the doctor understand what Susan needs?

A. My wife used to keep a detailed, literally detailed, record of everything, like, and they would ask us -- not exclude Susie, bring her into the conversation, but anything of any importance, the answers to the question would come from either Ida or myself.

Q. So you helped, really, the communication between the professional and Susan and --

A. Absolutely, yes.

Q. I understand, all right. So Susan initially was on her own with the doctors?

A. Absolutely.

Q. But did there come a point when Ida was allowed to go in and be with Susan?

A. Yeah, they made a reasonable adjustment and allowed

Susan in to the -- Ida in to see Susan but it was only for a short period. Ida said she loved Susie, Susie said "I love you" and, basically, that was it. But there was no -- no conversation about Susan's health, how has she been, you know, how long has she had the tummy ache, and so on and so forth. So there was no discussion of that nature.

Q. Now, I think you said in your statement that there was a discussion between Ida and the doctor once Ida had left Susan.

A. Yes.

Q. Can I ask you about that, please? Can you tell us now what it was the doctor asked Ida?

A. Yeah, the doctor, the doctor -- and this was in quite early stages, the doctor asked Ida if she had anything in place for DNR, and --

Q. Do you mean do not resuscitate?

A. Yeah, and Ida didn't quite grasp what he was saying, and Ida challenged the doctor and said "Would you explain that for me", and he said -- he explained what he meant and she said "No, Susan's never been seriously ill", you know what I mean, "We have no reason to have a plan of that nature. So therefore -- therefore, in the event it becomes necessary, we would want her resuscitated".

Q. If I've understood you correctly, if a doctor had tried

to speak to Susan about a do not resuscitate order, do you think Susan would have been able to grasp what the doctor was saying?

A. She wouldn't have had a scooby. She would have had no idea what they were talking about. I mean, Susie would say "upstairs" when she meant "downstairs" and "downstairs" when she meant up. So you know what I mean, asking her questions of that nature, she wouldn't have had a clue.

Q. It really needed you and Ida or Clifford to be there to help?

A. Well, it needed that for 50-odd years. This was the first time in 50-odd years they deemed it unnecessary.

Q. I think after that discussion, it wasn't long after that that Ida left the hospital and came back home; is that right?

A. Yeah, that's right, yeah.

Q. Can I just ask you this: is it right that when Ida went to the hospital with Susan, Ida wore her own PPE?

A. Correct, yeah.

Q. What did Ida take with her to wear?

A. Ida took, she wore a mask and she wore -- she wore gloves.

Q. Do you know what the plan was for, once Ida had left, you to be updated about how Susan's condition was?

A. No, it was all kind of up in the air and they basically said to call the ward later, you know, call the ward later. I mean, the thing about it is that the A&E guy had called Ida to the door before she left -- called Ida to the door before she left and said "Oh, we're very happy with Susan" and blah, blah, blah and call the ward later basically. I mean, how the hell they were happy with Susan is another question, I don't know.

Q. But the impression that Ida was given was that Susan was stable, it was okay, and --

A. Yeah.

Q. -- "Ida, you can go home"?

A. I mean, the reality is the doctor -- Susan had one chance of life, that was ITU, end of, that one chance and, at the end of the day, this doctor knew that he was sending her into a ward into a bed to die, end of. So for him to turn round and say "We're very happy with Susan" was, you know, was pretty cruel, was pretty cruel.

Q. Pause there, Mr Sullivan, because I want to show you a document that might help explain the answer that you've just given. Can you turn, please, behind tab 2 in your bundle.

And could we call up, please, INQ000483292 --

A. Yeah.

Q. -- and page 2, please. Right, can you see that all right, Mr Sullivan?

A. Yes.

Q. Pull your chair in by all means. I want to just look at some of the things on this document. This is Susan's medical records and the top part of the page deals with the position as Susan came in to the hospital.

A. Yeah.

Q. You can see she's 56, she had a fever, it records there that she has Down's Syndrome, she had a pacemaker in situ but no other cardiac comorbidities?

A. No.

Q. Independently mobile, despite being non-verbal. If you just go down the page, can you see where it says "Plan" --

A. Yeah.

Q. -- and number 6?

A. Yeah.

Q. At that stage there, this was the plan for Susan's care at the beginning --

A. That's what we were told.

Q. -- that she would be reviewed for ITU if her condition was not improving?

A. Exactly.

Q. Right, so that's sometime around midday-ish on the 27th?

A. Yeah.

Q. All right.

Now, can we go down the page again, please, to the addendum at 15.36. Pause there, thank you. Could you highlight that, please. This is added to the notes a little bit later that afternoon and it says:

"ITU declined in view of Down's Syndrome and cardiac comorbidities."

Then it sets out various statistics and saturation levels and she is she can move to the ward.

A. Yes. At the end of the day, that, that is what started -- that one line in that medical note is what started my quest for the truth because I'm not a medical person but I brought Susan up with my wife and my family, Down's Syndrome shouldn't be a reason for declining ITU, and a pacemaker, which is the comorbidity they're talking about and which was subsequently proved in the investigation -- but that is what triggered my -- I couldn't believe that she could be declined ITU because she was Down's Syndrome.

Q. Yes. Now, that brings me exactly on to what the review found some years later. So let's look at that now.

A. Yes.

Q. Can we call up, please, behind your tab 4, INQ000483295, and page 8, please.

(Pause)

My Lady, in due course we will hear that there was a review conducted by the hospital but I would like to deal with this now.

Can we look, please, at the top two or three paragraphs because it picks up on what Mr Sullivan has just been saying and the review there at 3.36 that afternoon recording that Susan had been declined ITU admission due to cardiac comorbidities and Down's Syndrome.

When this was investigated by the hospital, they said this:

"The investigating team have been unable to find any documented evidence of an ITU review taking place and can conclude that the patient was not reviewed face-to-face by ITU staff. A contemporaneous record of conversations held between the admitting ITU consultants on [the 27th] and any reasons for declining ITU admission does not show that the patient was discussed for consensus opinion for ITU suitability, as was the recognised process at the time. This led the review team to conclude that either the patient was not discussed at a consultant level or that the discussion was not recorded."

So it appears she was not seen by ITU staff and the

lack of records mean either there was a failure to record a consultation or, in fact, there was no discussion at all.

Mr Sullivan, looking at the next paragraph:

"The reviewing team considered the degree to which the patient's cardiac comorbidities would be a reason for not admitting [Susan] to ITU and agreed that the presence of moderate to severe mitral and aortic regurgitation and a cardiac pacemaker would not be exclusion factors for ITU on their own but ... could certainly adversely affect patient outcomes ..."

So the pacemaker was not a reason for her not to go to ITU; is that right, Mr Sullivan?

A. Yeah.

Q. Equally, reference to Down's Syndrome as a reason for not admitting to ITU was also reviewed and again agreed this was not a reason for declining Susan ITU admission. So the two reasons at 15.36 for saying she shouldn't go into ITU, the review said were not proper reasons --

A. Yeah.

Q. -- for not allowing her into the ITU?

A. That's it, that's exactly what I'm saying. I mean, you know, the thing about it is that the reasons they gave her to decline her -- let's be honest, declining her ITU was declining her a chance of life and, to put

down bogus reasons, I mean, you know, even a non-medic like me looked at it, it jumped out -- off the page and said "This can't be right", so, you know, somebody's put that down. And the question is: is that -- is the person that wrote that on her medical notes the only person in the last four years of this battle I've had with the hospital, is the only person that's ever told the truth in the whole thing, because it's been decline, decline, cover-up, obfuscate. But I've asked 1,000 times, if Down's Syndrome and a pacemaker were not justifications for declining ITU, why is it on her medical notes, and nobody wants to tell me.

Q. Can I just finish dealing with that page, because the review went on to set out what was going on in that hospital's intensive care unit that day, and you can see there that on 27 March they had 27 level 3 patients, the baseline capacity was 23 beds, so they already had more patients than they normally would have, and it goes on to say that they were expanding a neighbouring ward, albeit it's not clear if they were expanding it on that day and, even within a few days, that also had reached its maximum surge capacity.

So Susan was not admitted to ITU and then, to pick up the story of what happened to her, was Clifford the one liaising with the hospital to find out how she was

doing?

A. Yeah -- I mean, yeah, because Ida, her mother, was in a diabolical state, I was in a diabolical state, trying to look after Ida, trying to deal with the reality of what had happened, and the only one that was keeping a level head was Clifford, so he was --

Q. So Clifford's liaising --

A. He was doing the liaising, yes.

Q. -- and then the next morning, on the 28th, was the family told that Susan wasn't tolerating her oxygen mask and kept taking it off?

A. Yeah, a nurse phoned, really lovely nurse and she phoned and she was pleading with us to plead with Susan to keep her mask on because she said she's benefiting from the -- which is backed up by the medical notes -- benefiting from keeping the oxygen mask on, and then Clifford tried talking to Susie first and then Ida spoke to Susie, and by the time I got -- she was so distressed, she was -- I didn't get a chance to speak to her again.

And the vexing thing is that, had that reasonable adjustment that was made in the A&E and when she was dying, had that been made in that 20-year *(sic)* period, you know, family by the bedside to help her keep her oxygen mask on that they said she was benefiting from,

the outcome could have been different.

Q. So that's exactly what I wanted to ask you, Mr Sullivan. Once Susan went on to the ward, were any of the family allowed to go and visit her --

A. No.

Q. -- to comfort her, encourage her to keep her mask on?

A. No.

Q. No. Do you think, knowing Susan, that, if you had been, or one of you had been, allowed at the bedside, that would have helped Susan understand what was going on?

A. Oh, absolutely, she would -- she would have kept the mask on. I mean, she would have kept the mask on and -- you know, you've got to understand, she was frightened, she's frightened, everybody in the place is running around with a mask on their face, she's been forced to put a mask on her face and she hated anything on her face and if we'd have been there just to comfort her, give her that little bit of support, because that's all Susie ever needed was that little bit of support, you know, the outcome could have been -- could have been very different, you know what I mean.

It doesn't make sense that reasonable adjustment was made in the casualty, reasonable adjustment was made for Clifford minutes before she died, and yet in that 20-hour period where reasonable adjustment could have

been a huge benefit, and it was just denied, it just denied.

Q. Let me ask you about that, because if we go, please, to page 10 of the document that may still be on the screen, there is reference in the review to whether sufficient reasonable adjustments were made in light of Susan's learning disabilities.

Can you see there in the middle of the page, Mr Sullivan, reference to:

"The patient was not referred to the acute liaison nurse ..."

It's the second paragraph.

A. Yeah.

Q. "... resultantly there is no evidence to suggest the Trust's Learning Disability Team were involved in the patient's care despite the service being available throughout the pandemic. This may in part have been due to the relatively short time [Susan] was in [the hospital] ([less than] 28 hours) and that this service is not available at weekends."

But while Susan was in the hospital, obviously family weren't allowed in?

A. Yeah.

Q. Do you know if any liaison learning disability team went to speak to Susan?

A. No.

Q. Tried to help with the communication?

A. No.

Q. Anything like that?

A. Nobody. Nobody. She was left to her own devices.

Q. Do you think speaking to someone from the Learning Disability Team would have helped Susan?

A. Oh, absolutely, you know what I mean? I mean, you know, at the end of the day the thing is when you're dealing with somebody with learning difficulties it's, it's either -- it's something you learn over years or you have an inborn empathy for. And, you know, I'm sure they would have made a difference.

Q. I think you've already mentioned that just before Susan died, Clifford was allowed to go and be with her?

A. Yeah.

Q. And he was with her when she passed away at about --

A. She died in his arms.

Q. The cause of death on her death certificate was Covid-19; is that right?

A. Yeah.

Q. And Down's Syndrome?

A. Yeah.

Q. And I think in due course, although there was a delay to the funeral, is it right that hundreds of people turned

up or were online?

A. Yeah. Well, yeah. We delayed the funeral. We couldn't even go to her cremation because my illness, my cancer, had taken over and I was having serious treatment, and I couldn't go and my wife was in no state, and she -- we couldn't even go to her cremation, but then once the time changed and our son and my grandson was allowed to come from Australia, we had a memorial for her, and over 240 people turned up at the memorial and then there were people watching it in Canada, in America, in Spain, in -- you know, I mean, everywhere. You know, Susan didn't matter to maybe them doctors, but she mattered to all those hundreds of people that took the day off to attend her memorial, do you know what I mean, so it was -- she was just, you know, one of life's special people, like, you know what I mean, she really was.

Q. A couple of final things from me. I think in due course you -- and we can take that page down, please -- you made a complaint in due course to the hospital -- and we've just been looking at some of the review documents --

A. Yeah.

Q. -- was that prompted by an article you did for The Guardian?

A. Yeah, actually what happened is that, for personal

reasons, I didn't trust the hospital's complaints department. That's why I've got a syringe driver bag on me now, keeping me alive. So I didn't trust that system. I needed people with disabled families, disabled loved ones, to know that, you know, you -- we're not getting a good deal here, we're not getting a good deal here. And Bereaved Families for Justice put me on to Shanti Das at The Guardian, and I thought: that's great, because that gets the message across.

Q. Pause there then, and we'll look briefly at the article. It's behind your tab 3, and can I put onscreen -- thank you very much.

This is a copy of the article. We see you there, and is that Ida?

A. That's Ida, yeah.

Q. And there's a photo of Susan.

A. Yeah.

Q. I think this essentially was you setting out Susan's story, as you have done today. Is that right?

A. Yeah.

Q. And you putting in the public domain what was written on Susan's records?

A. Yeah.

Q. And you trying to seek answers on her behalf?

A. Yeah.
Q. And then did the hospital start the investigation?
A. Yeah, just out the blue I got a letter. It must have -- somebody must have read it and I got a letter advising me that they were going to undertake a serious incident investigation. Which they did. Which they did.
Q. Thank you.
And we can take that down because we've been looking at the some of the investigation documents as you have been giving evidence.
Can I ask you this, please, Mr Sullivan: obviously there are concerns about what happened to Susan, but can I just ask you generally about your views about the NHS?
A. I'm here because of the NHS. I've great time for the NHS, for the doctors and for the nurses. I'm not going to say I've got great time for the management, you know what I mean, but I have for the doctors and nurses. They're fabulous people, they're fantastic people. And I'm not here to knock any doctor or any nurse. You know, they do a brilliant job and I've got nothing but pride for them. I mean, they looked after my wife who's really been seriously ill as well. I don't want anybody to think that I'm here to knock the doctors and the nurses, but if they want me to think I'm here to knock the management, then ...

Q. I understand.
A. ... go for it.
Q. It's probably obvious to all of us, but can you sum up to us the impact of losing Susan in the way that you did on you and Ida and Clifford and her other brother?
A. The impact on me, on my wife was devastating. I mean, you know, I mean, you know, it's a -- first of all me, within a month -- Susie passed on 28 October, and on May 9 I was in the Royal Free Hospital having nuclear medicine treatment that lasted ten months. So the impact on my health was massive.
Q. Yes.
A. I mean, I've -- you know, enormous. And it might be an old wives' tale, but my wife had breast cancer 28 years ago and with all the upset and all the shock and everything -- you know, some people say that shock can bring it something back, and it came back, and she's had to have a double mastectomy and -- you know what I mean? So we've gone through hell and back. And the thing about it is you die, a part of you dies when your child dies. And dealing with the death of a child is one thing, but dealing with the death of a child because nobody gave her a chance of life is a completely -- is the hardest thing to deal with, you know what I mean. If she'd have just died of Covid, then we've got to say,

"Well, you know, that's just the luck of the draw", isn't it? But I said in that Guardian article, before the serious investigation -- I knew Susie, I nurtured her, I loved her, I've spent all my time with her, and I knew that she just needed a little bit of moral support, but I said in that Guardian article they gave her a bed to die in. And when I read all of this, serious incident investigation and the treatment that -- at the casualty, where they didn't want to talk to mum, didn't want to talk to dad, all of a sudden we're talking about DNAR before we're talking about -- one minute they're going to consider -- you know what I mean? When I read all that, it just sadly makes me write: what they did, they gave her a bed to die in, and they gave her a bed to die in because she had Down's Syndrome, end of.
Q. I think you concluded your statement by saying this:
"Providing this statement to the Covid Inquiry has allowed me to give Susan and her disabled peers a voice: that has been my motivation."
A. That's -- I don't -- I don't want -- I don't want any parent that have invested their whole life in protecting and raising a child with Down's Syndrome from an infant to an adult, I don't want them to go through what we've gone through. They've got to learn that people with

a disability have got as much value as anybody else in this life, and to just cast them away as though they're of no importance and -- is wrong. And when the next pandemic comes, I just hope to God me sitting here just for this, while -- and me struggling with the NHS lie machine for the last three years, that's had a massive impact on my health, I just hope that when the next pandemic comes along disabled people are treated with a bit more respect and a little bit more consideration. And that's why I'm here. I wouldn't be here otherwise.
And the most important thing, for the first time today, in an official capacity, disabled people are being given a voice, which they have been denied.
MS CAREY: My Lady, that is all I wanted to ask.
LADY HALLETT: Mr Sullivan, I've got no questions for you, just a couple of comments. You're right, Susie does matter, and disabled people matter and you've done a huge amount to ensure that people understand that.
THE WITNESS: Thank you.
LADY HALLETT: She was obviously a very special person and you at least had 56 years with her.
THE WITNESS: Yeah.
LADY HALLETT: All I can say is that it sounds as if you had 56 years because of the love and devotion that you and your family showed her. So thank you so much for what

you've done to get people to understand that disabled people matter, and Susie mattered.

THE WITNESS: Thank you very much.

(The witness withdrew)

MS CAREY: Thank you, my Lady.

LADY HALLETT: Very well, I shall break now and return in five minutes.

(2.37 pm)

(A short break)

(2.42 pm)

MS NIELD: My Lady, may I please call Paul Jones, who can be sworn.

MR PAUL JONES (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Mr Jones, thank you very much. Please take a seat. Thank you very much for coming along to assist the Inquiry. I can imagine --

THE WITNESS: Thank you, my Lady.

LADY HALLETT: -- how difficult it is for you. If at any stage you need a break, please say.

THE WITNESS: Okay, thank you very much. Thank you.

MS NIELD: Can I start by asking you please to give your full name.

A. Yes, my name is Paul Jones.

Q. I'm going to ask you, please, throughout your evidence

to try to keep your voice up -- you've got a nice clear voice -- so that we can hear you but also so that your evidence can be recorded. If I ask you a question that you don't understand or that isn't clear, then please say so and ask me to rephrase it or repeat it.

A. Okay, thank you.

Q. Mr Jones, you have provided a witness statement to the Inquiry which is dated 20 June 2024, that's at INQ000486000, and your signature is on page 8 of that witness statement. Are the contents of that statement true to the best of your knowledge and belief?

A. Yes, they are.

Q. Thank you.

Now, Mr Jones, you're here to tell us about the circumstances in which you and your wife tragically lost your daughter, Lauren, to Covid-19 on 30 December 2020; is that right?

A. That's correct, yes.

Q. I think Lauren was just 25 years old?

A. Yes, that's correct.

Q. Could you please tell us a little something about Lauren?

A. Yeah. As you say, Lauren was 25 years old. She was myself and my wife Karen's only child. She lived with us in the Rhondda, she worked with Karen at St Andrews

doctors surgery in Tonypandy, where she was an administration assistant and a bit of an IT guru as well. So she was also doing an Open University degree, initially in IT and then towards the end of her degree in social work.

She had a heart of gold, she was our princess, she loved music, loved film. She went to many concerts over the years, particularly at the Principality Stadium. Yeah, she just loved life and, yeah, she was our princess.

Q. I think she had a taste for travelling and, at one point, had wanted to be cabin crew; is that right?

A. That's correct, yes. She -- her goal was initially to join one of the main airlines as cabin crew. She loved travelling. We used to take her on holidays, I think she went on holidays from the age of two with us, and yeah, she just absolutely loved travelling. She loved flying, so she was her initial sort of goal, was to be cabin crew with one of the airlines. Unfortunately, because of an injury to her foot, she wasn't able to follow that sort of line of work, unfortunately, but, like I say, she found a line of work that she enjoyed anyway.

Q. I think because of that problem with Lauren's foot, she used crutches to relieve some of the pressure on her

foot; is that right?

A. That's correct, yeah, just to relieve the pressure on her right foot, yeah.

Q. I think it was diagnosed as chronic regional pain syndrome?

A. Yes, that's correct.

Q. Other than that pain syndrome with her foot, did Lauren have any other underlying health problems?

A. No, she had no other underlying health problems, no.

Q. I think, in addition to working with your wife at the GP surgery, she also did some agent work selling cosmetic products in the homes around your local area; is that right?

A. That's correct, yeah. She was a representative for Avon and Body Shop, she used to go round to the local community, friends, family, taking orders and she'd enjoy sort of putting the orders together and delivering them sort of -- yeah, delivering them round the houses and I'd take them to work with me for sort of colleagues of mine in work and, yeah, she just -- like I say, in the community, she just highly thought of because of that. Yeah, she just -- she was a workaholic, I suppose, to an extent, yeah.

Q. Thank you.

Now, you've explained that your wife worked with

Lauren at the same GP surgery. I think your wife, Karen, was a surgery practice manager; is that right?
A. That's right, yeah, yeah.
Q. During the pandemic, I think both Karen and Lauren were required to go into the GP surgery to work?
A. That's correct, yeah, yeah, they were, yeah.
Q. I think Lauren was there three days a week?
A. Yes, correct, yeah.
Q. Your wife worked in an office by herself during the pandemic?
A. Yes, primarily, yes, yeah.
Q. She was supplied with PPE in her work role; is that right?
A. Yes, they were, yeah, yeah.
Q. At the time when Lauren was also working in the GP surgery during the pandemic, were there many other staff members working there?
A. I think they had quite a few sort of members of staff working there. I don't know the exact amount but, yeah, most of them worked through the pandemic, yeah.
Q. Now, in terms of your work, I think you work for the South Wales Police; is that right?
A. That's correct, yeah, yeah.
Q. You're a response sergeant with that force?
A. I am, yes.

Q. I think you've explained that, during the pandemic, most of your working time was actually spent at the police station?
A. Yes, my role at the time included sort of -- mainly sort of included working out of an office where I did quite a lot of sort of admin work for the staff I was managing, yeah.
Q. There were some Covid rules or social distancing rules that were implemented --
A. Yes.
Q. -- at the police station in normal times?
A. That's correct, yes, there were, yeah, there were restrictions on the number of people in -- able to sort of go in a room at the same time, in different rooms right throughout the station really.
Q. I think there were also one-way systems instituted in the corridors, and so on, to control the flow of people and --
A. That's correct, yeah, there were, yeah. There were arrows on the floor to sort of guide people around and make sure people sort of stayed on the same side of the corridor, yeah.
Q. Now, I think that, notwithstanding the fact that generally there were social distancing measures operating in the police station, there came an occasion

on 2 December when you were working an overtime shift to assist with some firearm warrants being executed, and there was a briefing at that point with a large number of people in a conference room; is that correct?
A. That's correct, yes, yeah. There were a large number of people in the station itself, in the parade room, as we call it, so way more than we'd sort of had in the parade room throughout the sort of pandemic.
Q. How many people would have normally been in the parade room at that time?
A. I think we were limited to 13 throughout the pandemic and I would guess there were about 20, maybe 25 in there this particular day.
Q. I think then there was a briefing that took place in the conference room; is that correct?
A. That's correct, yeah, yeah.
Q. How many people would normally have been in the conference room?
A. It was restricted to six, right throughout the pandemic and, again, there was probably about 20 of us there.
Q. Was it possible to maintain social distancing with that number of people in --
A. Not at all, no, we were standing shoulder to shoulder.
Q. Did you have concerns at that point?
A. I did, yes, yeah.

Q. I think about a week after that briefing had been held, you found out that a number of police officers who had attended the briefing had become ill with Covid-19 symptoms?
A. Yes, that's right, yeah, yeah.
Q. A number of those were from the same team; is that correct?
A. From the same -- from the same sort of station and primarily off the team I was on, yeah.
Q. I think you began to experience some symptoms of Covid around 9 December; is that right?
A. Yes. It would have been around about the sort of middle of the week, the following week, about 9 December, yeah.
Q. What were your first symptoms?
A. Initially, just sort of cold symptoms, which I thought nothing of. They weren't your normal sort of three sort of Covid symptoms, which they were -- they'd said about throughout the pandemic, but -- so I thought nothing of it at the time.
Q. Did there come a point when your sense of taste began to change?
A. It did, it would have been probably, probably 10 or 11 December, my sort of taste sort of was different. I had a drink at home and it didn't seem to -- it tasted a bit stale.

Q. I think by 13 December 2020 when you woke up for work, you were feeling unwell by that point?
A. I didn't feel as I should have. But, again, didn't really have sort of what I would -- what they were describing as the three sort of symptoms of Covid at the time.
Q. I think the next day you had to pick your wife up from work because she had a very high temperature at that point?
A. That's correct, yeah, yeah. She phoned me to say she had a high temperature at work and could I pick her up because we'd have to try and arrange a sort of Covid test.
Q. Did you manage to arrange a Covid test?
A. We did for the following day, yes.
Q. Who was tested then that day?
A. Myself, Karen and Lauren were tested that day.
Q. I think your results came back three days later on the 17th?
A. That is correct, yeah, yeah.
Q. What were the results at that point?
A. So myself and Karen came back as Covid positive, and Lauren was negative at the time.
Q. Then over the next few days, how were you feeling?
A. Initially I didn't feel too bad but then over the space

of probably the next two or three days my sort of health rapidly deteriorated, yeah, felt really terrible.
Q. I think Lauren and Karen, because of their role as frontline workers, were actually due to be given their first vaccinations in that week that they fell ill; is that right?
A. That's correct, yeah, yeah.
Q. But they couldn't go and get their vaccinations because they had to isolate?
A. That's right, yeah, yeah.
Q. So by 20 December, I think you were feeling very unwell indeed?
A. I was, yes. The early hours of the morning of 20 December, I was really struggling. I was sat on the edge of my bed early hours of the morning and I remember -- I remember Lauren waking up, coming in to see me and saying that she was going to phone 111 because she didn't like the sort of way I sort of looked and from an illness point of view, so, yeah, Lauren was looking after me from day one really.
Q. And did Lauren manage to get through to 111?
A. She phoned 111, I believe she spoke to them, she explained my symptoms to them and they said they would phone back in a sort of short period of time, I think within the next four hours.

Q. Did that happen?
A. Unfortunately, no, they never phoned back, I never got a call back.
Q. So, at that point, I think Lauren decided that she was going to take you to the Accident & Emergency Department?
A. So it was a number of hours later, it was probably -- so that would have been -- so early hours of the morning, we sort of -- it would have been that she phoned 111 and it would have been sort of the afternoon of that day that eventually she said "I'm going to take you to the hospital, Dad."
Q. So I think she booked you into A&E, was she able to come in with you?
A. No, she didn't, I didn't want her to put herself at risk and come in with me, so she first stayed -- she stayed in the car while I went to be examined, and then I told her that she could go home and if she didn't mind coming back down and picking me up if and when I was released.
Q. So I think you were admitted and assessed, and you were given some treatment, which included a x-ray of your lung; is that right?
A. That's correct, yes, yeah.
Q. You were also given some antibiotics and some glucose intravenously?

A. Yes, I was given an intravenous drip with some glucose and antibiotics, and eventually my blood oxygen levels, my sats, were high enough for them to -- deemed for me to be released. And they sent me home with some antibiotics at the time, yes.
Q. How long had you been in hospital then approximately?
A. I think I was probably in for about six to eight hours, I think.
Q. Thank you. So once you were discharged, Lauren picked you up --
A. Yeah, she came and she drove back down and picked me up then, yes, yeah.
Q. If I can come on to two days later, that's 22 December.
A. Yes.
Q. I think at that point your wife Karen was feeling --
A. She was, yes, yeah, she was feeling really ill herself then. Yeah, she had really bad palpitations and again phoned for an ambulance at the time.
Q. Before she called an ambulance, did she try to contact 111?
A. I can't remember whether she tried to contact 111. I think we -- from what I can remember, I think we tried to phone an ambulance I think, potentially.
Q. Was an ambulance able to come?
A. No, it wasn't, no, no.

LADY HALLETT: Before you go on, Mr Jones, in your statement -- this isn't a memory test -- you said that you tried -- or she rang 111 and, after explaining her symptoms, was told to take an aspirin. Does that --
A. Ah, yes, yes, I remember the aspirin. I remember the aspirin. And yes, Karen did take an aspirin at the time, yes, so -- following on from those sort of orders by the 111.
LADY HALLETT: Can you remember what symptoms she described that led to the 111 operator saying "Take an aspirin"?
A. Karen thought she was having symptoms of a heart attack because she had chest pain as well.
MS NIELD: And she was told to take an aspirin?
A. Yes.
Q. So by the point where you have phoned for an ambulance, you're told there's none available, and what happened then for Karen?
A. So Karen was sitting on the floor in the house because she was too uncomfortable to sit sort of anywhere else, and again, because we couldn't get an ambulance, eventually Lauren decided to tell her to go down the hospital. So Lauren drove her down the hospital on the Tuesday evening then, which would have been the 22nd.
Q. How was Lauren at this point?
A. At that time, Lauren didn't have that many sort of

symptoms of Covid as such. She was well enough to drive herself. I wasn't well enough to drive Karen at the time. So I think Lauren had, I think, a little bit of breathlessness, but again didn't put it down to Covid, because she didn't have any of the three main symptoms.
Q. I think Lauren had been given a Covid test the previous day but hadn't got a result back at that point, is that right?
A. That's correct, yes, yeah. That's correct, yes, yeah.
Q. So I think at the hospital, both Lauren and Karen were then assessed by medical staff?
A. Yes, they were, because Lauren had -- because she'd told them that she'd had a Covid test the previous day, they checked Lauren out as well, yeah.
Q. And I think she had an x-ray for her chest at that point?
A. She did, yes.
Q. And that was clear then?
A. That was clear at the time, yes, yeah.
Q. Was Karen prescribed some tablets for her symptoms at that point?
A. I can't remember at the moment, I'm sorry.
Q. I think in your witness statement your recollection was that Karen had been prescribed some tablets for sickness and then both Karen and Lauren were discharged home that

same evening?
A. They were certainly discharged home, yes. I think they arrived home about 10 o'clock, I think.
Q. So these are the events of 22 December, so we're coming into the Christmas period.
A. That's correct, yeah.
Q. And over that period, I think you and your wife started to feel a little bit better?
A. As the week went on, because of the sort of medication, certainly I was on, yeah, I -- I'd started to obviously feel a little bit sort of better as the week went on, yeah.
Q. But Lauren's symptoms were getting worse at that point?
A. They seemed to get a little bit worse but not to the extent that we thought there was sort of any particular problem, because of her -- because of her age, really.
Q. And you were able to spend Christmas Day and Boxing Day watching films together?
A. Yeah, that's correct, yeah, we did. We loved watching films together and, yeah, we did throughout Christmas Day, Boxing Day, and then things started to change.
Q. So then if I can ask about that. The following day, 27 December, after Boxing Day, I think in the early hours of the 27th Lauren began to feel quite unwell and

was coughing; is that right?
A. She did, yeah. She was coughing a little bit sort of the early hours of the 27th but she managed to go back to sleep. We all got up as normal sort of on the -- what would have been Sunday the 27th. Lauren, from what I can remember, took her time sort of getting ready and came downstairs and watched TV with us. And then sort of out of the blue she said "Dad, I think you -- do you mind taking me to hospital to get checked out?" Didn't really say sort of what symptoms she had, but I said "Yes, no problem, I'll take you now."
Q. So you drove Lauren to the hospital?
A. So I drove Lauren to the hospital then myself, yeah.
Q. When you got to the hospital, were you able to go in with her or did you have to wait outside?
A. I booked her in myself while she's waited in the car, but I wasn't able to go in with her, she went in herself and I waited in the car outside in the car park.
Q. I think Lauren was able or you were able to get into contact with Lauren after a little wait in the car park?
A. I managed to send her a text message after a while. I did try phoning her first of all but I couldn't get hold of her. Then she eventually answered a text message and then I -- after that, I did manage to get through in a short phone call asking her if she wanted

me to stay outside in the car or whether she wanted me to go home and then come back down sort of later to pick her up, which I thought I'd be doing as she did for me.
Q. Did she tell you anything about how she was being treated at that point?
A. She didn't say a lot. I think she said she was on an oxygen mask. Other than that, no, she didn't say a lot about how she was being treated at the time.
Q. So you understood she was having some oxygen?
A. Yes.
Q. And I think she asked you to go home and wait and come and pick her up later?
A. That's correct, yes.
Q. Later on that evening, did you find out that she'd been admitted on to the Covid ward at the hospital?
A. Yes, we had a phone call later on that evening to say that Lauren wasn't very well, and that she'd be admitted to the Covid ward, which was, I think, ward 3 at the time.
Q. Was that call from Lauren or the doctors --
A. No, that was from one of the doctors, I believe, in A&E.
Q. So you didn't speak to Lauren that evening?
A. No, I didn't, no, I wasn't able to speak to her at all that evening.
Q. But I think Lauren was able to message you the next day;

is that right?
A. The following day, yes, yeah.
Q. What was the gist of Lauren's message, what was she telling you at that point?
A. I asked her how she was doing, and she said "I'm doing okay, Dad, I was on a CPAP mask initially", but then they took her off it for a short time or for a few hours but then they had to wake her up to put it back on because her oxygen levels were dropping again, I believe.
Q. Thank you.
What impression did you get at that point in terms of how poorly Lauren seemed to be?
A. At that time, I didn't think she -- I knew she wasn't well, and I knew her sort of sats were quite low but not for one minute did I think there would be any sort of problem, I thought she was in the best place in hospital, having the best treatment, and that she would, and that she'd be home soon.
Q. I think that evening you got a call from the hospital about Lauren's treatment and about her progress.
A. It was initially on the Sunday night, I think, when she went to the Covid ward. I had a conversation with one of the doctors who said that there was potentially some trial medication that they could possibly give her to

help her and that -- if I wanted to discuss that matter. I said I was -- you know, I'd discuss with them there and then on the Sunday evening, on the 27th, but they said, "No, there's no rush to speak about it tonight, we'll speak to you about it tomorrow", on Monday the 28th. Unfortunately, that conversation never took place.
Q. That conversation didn't take place?
A. I was never told anything about any trial medication the following day.
Q. I think there came a point where you had a conversation with the hospital about transferring Lauren to the intensive care unit.
A. That was on the Monday night. That would have been 28 December. We were told that she was transferred to intensive care. We were told that she wasn't doing too well that and she would be needed to be put on a ventilator that night, on the Monday night.
Q. So the concern at that point was she was not doing so well on the CPAP --
A. That's correct, yes --
Q. -- and needed to be ventilated?
A. -- and needed to be ventilated, yes, that's correct.
Q. It was likely that it would be that evening that that --
A. Yeah, they told me that it would be sort of happening

that evening or late that night, because they said there won't be a problem, because I asked if I should phone for a update within a few hours, and they said, "No, there's no need, she'll be okay, she'll be well looked after, give us a ring in the morning and we'll update you on her progress tomorrow".
Q. So did you have an opportunity to speak to Lauren at that point?
A. No, we were never offered an opportunity to speak to her.
Q. So I think the next morning, this would be 29 December, about 9.00 in the morning, you phoned the hospital, and you were told at that point that Lauren was still on CPAP; is that right?
A. That's correct, yeah, we were told that she was still on CPAP, which came as a quite a shock to us, really, because they were sort of convinced -- you know, they were convinced, saying that they would have to put her on a ventilator.
Q. Did they give any reason at that point as to why she hadn't been put on a ventilator?
A. They didn't -- no, they didn't give any indication, they just said that they hadn't needed to put her on a ventilator.
Q. What did you take from that?

A. I took it that she was -- she'd turned a corner and she was starting to make a recovery.
Q. Then I think you phoned again to the hospital at around midday that day and you were told that Lauren was stable but still unwell?
A. Yes. I was told that she -- I think I phoned maybe on about midday, 1.00, I think, and I was told she was sort of critical but stable, which again surprised me because of the fact that they didn't sort of ventilate her the night before, really.
Q. Then I think the next contact was a call from the hospital at around 4.45 that evening?
A. That's right, yeah, yeah, and I remember the time exactly pretty much, saying that they'd had to ventilate Lauren, I think, probably at about 4.30, which came as a real shock to us because we'd had no sort of communication as to how she'd gone downhill so quickly that they needed to ventilate her at that particular time. It was just -- yeah, it came as a bit of a shock to us really.
Q. Then I think that same evening, a few hours later, around 8.00, you got another call from the hospital with an update on Lauren's condition?
A. That's right, yeah. So the hospital phoned again to say that the ventilator didn't seem to be working too well

for Lauren in her condition, so they -- they would be giving Lauren what we call ECMO treatment. I was told that an ECMO team would be travelling down from London because that's where the only bed was at that time, the only ECMO bed. I was told that they'd be travelling down, they'd be putting her on the ECMO machine at Royal Glamorgan Hospital, and then she'd be transported to London where she'd be on the sort of full ECMO treatment in London then.
Q. Did they explain to you at that point what ECMO was? I think it's extracorporeal membrane oxygenation.
A. They very briefly told us but I had to pretty much look it up on Google, really, as to the extent of what it was.
Q. So having been told that Lauren was going to be transferred to London for ECMO, I think you received a call from the ECMO consultant in London about 11.00 at night?
A. That's correct, yeah, yeah, because we'd even told sort of members of our family -- we'd even told our family that she was sort of going for ECMO treatment and said we were told literally by the nurse on the sort of intensive care that -- I even asked sort of how long they thought she'd be on ECMO for and they said probably three to seven days maybe, and it was a tremendous

treatment that would help her recover from Covid --
Q. But I think --
A. -- but then we had, like I say, the phone call.
Q. What was explained in that telephone call?
A. It was the ECMO consultant in London that phoned me. They basically said that there were no beds available in the ECMO centre in London, the only bed available was in Leicester at the time. However, they had four ECMO consultants in each of the centres around the UK and, apparently, they'd had a discussion, which during that discussion they decided that Lauren wouldn't be a candidate for ECMO, for some reason.
Q. Did they give you an explanation, did they give you a reason?
A. At the time, not much of an explanation but it was all a blur really because, like I say, myself and Karen were still recovering from Covid ourselves and everything happened so quickly. It was difficult to take in the information they were telling us, really.
Q. I think in your witness statement you say that the consultant explained that because Lauren was overweight there might be a difficulty in placing a line into her --
A. Initially -- initially they -- eventually, they asked me if Lauren had any problems with disability. I said that

she's only on crutches, she's got complex regional pain syndrome but she's on crutches and she gets about without too much difficulty. But then, yeah, they mentioned then that, because of Lauren's weight, they probably wouldn't be able to get a line into her groin. I didn't think that was -- I didn't think that was the case, mind, I've got to be honest.
Q. I think at that point the consultant informed you that Lauren was unlikely to survive the night; is that right?
A. Yeah, that's correct, yeah, yeah. Yeah.
Q. You were told to --
A. I'll never forget those words. I'll never forget those words, yeah, and so we just, myself and Karen -- I just pretty much ended the call and we went down to Royal Glam and we were going to go in to see her whatever happened.
Q. So I think you spoke to the ICU nurse, that may have been a telephone call before you went down --
A. We did, yes. They told us, when we said we were on our way down to see Lauren, because she wasn't going on ECMO, they said, yeah, they said "There's an ECMO team already on their way". I said, "There can't be, I've just had a conversation with the consultant to say that she's not a candidate, so they can't be on their way", I said. So I said, "We'll come down and speak to you

down the hospital now". So yeah, that's when we got in the car and drove down to the hospital.

Q. So the hospital where Lauren was being treated didn't seem to be aware that that --

A. No.

Q. -- decision about her treatment had been taken already?

A. That's correct, yeah, not all members of staff there. There was certainly some miscommunication somewhere, yeah.

Q. I think you were able to speak to the consultant who had been looking after Lauren?

A. Very briefly when we got there, the consultant came in to speak to us in a room, took us into a sort of side room, and said that they'd done everything they could for Lauren and that she wouldn't survive the night, unfortunately. Like I say, I -- personally, I didn't think they'd done everything they could because I think the ECMO treatment should have been made available to her.

Q. Can you tell us how was that news about Lauren's condition conveyed to you, what was the tone of the consultant?

A. It was almost as if it was the normal thing for a 25-year old to lose their life to Covid.

Q. I think you were told by the consultant that Lauren

having been on 100% oxygen had done some damage to her lungs; is that right?

A. That's right, yeah. They said that she'd been on high pressure oxygen to try and get her sats up, her blood oxygen levels, and they said that they had to put her on 100% oxygen to try and do that, and that would have caused sort of significant damage to her lungs potentially.

Q. What were you told about, then, her prognosis, her options for treatment?

A. There were none, there weren't any other options for treatment unfortunately. We sat down by the side of Lauren, and they told us we'd have to decide when to switch her life support off.

Q. I think having made that decision, you were able to go and see Lauren then at that point?

A. Yeah, we were already sitting next to her at that time, yeah, we went to see her, and she was pretty much in a room -- or in a room with other patients almost next to the room where the consultant told us.

Q. Then I think, having switched off the ventilator, Lauren sadly passed away at 4.04 that morning.

A. That's correct.

Q. I think you and your wife were able to stay with her for just 30 minutes.

A. Yeah, we were. We were able to stay with her, I -- I think -- we weren't sort of given a timescale as such, but we were able to stay with her. But then, like I say, we chose -- you know, they'd have to take all the sort of ventilator out and take the lines out, so we didn't want to see that being done.

Q. I think once you were leaving the hospital, you and your wife, you were given Karen's *(sic)* belongings in a plastic bag; is that right?

A. Yeah, yeah, Lauren's belongings, yeah. Yeah, two plastic bags we were given, sealed plastic bags.

Q. I think you were told you couldn't open those bags for ten days?

A. And we were told we couldn't open them -- "Don't open them for ten days."

Q. When you did open them, you discovered some missing items and some damage to her clothes; is that right?

A. Well, the shoes she was wearing when I took her to the hospital on the Sunday, they were missing, and subsequently I made efforts to -- with the hospital to find them afterwards, because they were sentimental value to us. But they never found them, so ... and then when eventually we did open the plastic bags, they'd put a T-shirt that Lauren was obviously wearing at the time, I'm guessing when they would have

had to ventilate her, and the T-shirt had obviously been either ripped or cut up the middle for them to do whatever they had to do at the time.

Q. How did that make you feel? Had you been notified that those things had happened to Lauren's clothing?

A. No, no, not at any time had we been told that sort of anything like that had happened. Like I say, we were just -- we were obviously told she had to be ventilated, but it was obviously clear that something had gone sort of very wrong at some point.

I'm guessing they maybe had to do an emergency ventilation, but that's only a guess, I've never -- I haven't been told that officially, but from the state of her T-shirt, I'm guessing that would have been the case, yeah.

Q. I think you made a request to access Lauren's medical notes and you obtained those?

A. That's correct, yeah, I've got them and I've read through them quite -- quite a lot, and had meetings with the doctors as well, because I just wasn't happy with what had happened.

Q. I think it transpired from those medical notes that when you had asked why Lauren wasn't going to be ventilated on 27 December you were told that her oxygen saturation levels were better than they'd originally thought, so

she didn't need to be ventilated?
A. That's right, yeah. And I think the -- from what I can remember, they also told me that it was Lauren's decision not to be ventilated, which again I kind of found strange because if it was the best option for her then maybe they should have involved myself and Karen in a discussion with Lauren and maybe we could have spoken to Lauren and sort of maybe suggested that she went on the ventilator to help her. But they said that it was Lauren's decision as well not to be ventilated. They also, as I say, told me that throughout the night her oxygen levels were better than expected, so that was another reason they didn't ventilate her. I don't know what to believe, to be honest.
Q. I think that the notes from the hospital indicated that in fact when they ventilated Lauren on 29 December her oxygen saturation levels were at 10% at that point?
A. That's correct, yeah, they'd dropped obviously to a life-threatening level unfortunately.
Q. I think a nurse told you in fact that they nearly lost Lauren at that point?
A. That's correct, they told us that when we were actually sitting by her bedside before we'd sort of made the decision to switch her ventilator off, it was almost a passing comment, in the fact that they said "We almost

lost Lauren when we ventilated her at 4.30", which really took us aback because that wasn't mentioned at any time either during the phone call at 4.45 or the phone call at 8 o'clock.
Q. You say in your witness statement that you believe that Lauren was left to struggle and suffer on CPAP?
A. Yes, yeah, I think she was. By what I've been told, she was struggling to breathe. And from reading her notes, she was struggling to breathe before she was ventilated.
Q. Is it right that you subsequently found out that someone known to you who was much older than Lauren who had also been on ward 3 was ventilated the night that Lauren was initially --
A. Yeah, that's correct, I found that out, yeah, from another -- from -- it was a sort of friend of ours had been in hospital I think a number of weeks and was ventilated the same night as Lauren probably should have been.
Q. And that person made a full recovery?
A. Eventually they did -- they have, yes, yeah, yeah.
Q. Mr Jones, it's perhaps evident from what you've told us this afternoon, but how would you describe your experience with the health service around Lauren's critical illness with Covid-19?
A. Our experience was just shocking, really poor

communication, decisions made that were -- that certainly we weren't consulted with, decisions that probably should have involved maybe a conversation with Lauren as well. Maybe even the chance to speak to Lauren at some time would have been -- or text message to her would have been helpful, but we had absolutely no communication whatsoever. Really poor. And it was a terrible experience.
Q. Can you sum up, Mr Jones, how the loss of Lauren has impacted your and your wife's lives?
A. It's left a huge hole in our lives, lives of our family. Lauren was a gift to us. We'd lost a child back about a year and a half before we had Lauren, through something totally different, during pregnancy, so Lauren -- because we had to go through genetic testing, Lauren was our gift, and so it's left a massive hole in our lives and something we'll never fill again. To see that sort of empty seat in our house every day is a constant reminder of how the sort of pandemic has affected us.
MS NIELD: Thank you very much, Mr Jones. I appreciate that that won't have been easy but I have no more questions for you.
LADY HALLETT: Mr Jones, thank you so much. As a parent, I can't imagine the grief that you and your wife are

suffering. But I hope that you've understood just how grateful we are for you to come along and explain what's happened to you because one of the reasons it's so important, it's not merely the impact on the bereaved, which obviously is exceedingly important, but it's also there are still some who think that the Covid pandemic only affected those who are older or those who had other conditions, and what your evidence does, your awful tragic experience helps us remind us it was not just those who were older or had other conditions.
THE WITNESS: That's right, yeah.
LADY HALLETT: So thank you for coming and let's hope you can find a way to come to terms with that huge hole.
THE WITNESS: Thank you for the opportunity of me being able to tell Lauren's story and I hope it helps the Inquiry. Thank you, my Lady. Thank you very much.
LADY HALLETT: Thank you. I shall take a break until 3.40.
(The witness withdrew)
(3.31 pm)
(A short break)
(3.40 pm)
LADY HALLETT: Ms Nield.
MS NIELD: My Lady, may I please call Carole Steele, who can be sworn.

MS CAROLE STEELE (sworn)
(Evidence via videolink)
Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Ms Steele, I'm sorry if you have been kept waiting, I hope you haven't, but thank you so much for coming along to help us.

THE WITNESS: Thank you.

MS NIELD: Could you please state your full name?

A. It's Carole Evans Steele.

Q. Could I ask you please to keep your voice up so that we can hear you but also so that your evidence can be recorded, and if I ask you a question that you don't understand, then please say so and ask me to repeat it or rephrase it, and I'll try to do so.

A. Okay.

Q. Mrs Steele, you have kindly provided a witness statement to the Inquiry, which is dated 9 July 2024, and it has the reference number INQ000492925.

Your signature is on page 12 of that witness statement. Mrs Steele, can you confirm that the contents of that statement are true to the best of your knowledge and belief?

A. Yes, I can.

Q. Thank you very much. You're here today to tell us what happened in relation to the tragic death of your son,

Andrew Steele, who died from Covid on 2 January 2021; is that right?

A. Yes, that's right.

Q. I think Andrew was just 28 years of age?

A. He was, he was 28.

Q. He was a fit and healthy young man, he didn't have any underlying health conditions or illnesses; is that right?

A. He had no illnesses, the only thing he did have was hay fever.

Q. I think in fact he was a very talented artist and had studied at Strathclyde University and then at Edinburgh Napier University, and was working as an architectural technician; is that correct?

A. That's right. He also -- his main hobby was painting, he was a very talented artist.

Q. Thank you. I think he was also a former Tae Kwon Do black belt Scottish champion; is that right?

A. He was, yes.

Q. Whilst he was at home during the pandemic, he had set up a small home gym in his home office and was keeping fit throughout the pandemic; is that right?

A. Yes, as much as he could, as I think there was times that we were only allowed out once a day for a walk. So it was as much as he could.

Q. I think Andrew lived with his girlfriend in an apartment in the same town as you; is that correct?

A. That's correct, yes, just a few minutes in the car and maybe a 15-minute walk from our house.

Q. During the pandemic, was Andrew working at home or was he going into the office?

A. He was furloughed and he was working at home. The very odd occasion he would go in to retrieve the documents that he needed for work but mostly he worked from home.

Q. What about his girlfriend, I think she had a job as an office assistant?

A. She -- at that time she worked, she worked from home, the business that she worked for had provided laptops for home working, so they shared -- Andrew and his girlfriend shared an office in their apartment. Things did change and the management of the business that she worked for started to just increase demand for working on site instead of working at home, so a rota was set up.

Q. I think that was around the autumn of 2020; is that right, when his girlfriend was being asked to go into the office more often?

A. She was, and it concerned -- it concerned Andrew and it concerned -- it concerned us because that just wasn't happening in other workplaces and it concerned us even

more when we realised that the office she was working in, there was no, no adequate social distancing or ventilation.

Q. In fact, I think around the middle of December there was an outbreak of Covid-19 at Andrew's girlfriend's place of work?

A. There was, yes, and very quickly she -- she was asked to isolate, get a test and isolate, which she did, as her manager had tested positive for Covid.

Q. I think, in fact, Andrew's girlfriend began to experience some symptoms of Covid-19 and went for a test herself?

A. She did. She did go for a test, and followed by Andrew, and they were both positive.

Q. I think Andrew's girlfriend's test result came back on 21 December, and Andrew's positive result came back on the 23rd; is that right?

A. Yes, we were hoping -- at that time in Scotland we were hoping that we could see each other outside on Christmas Day but we couldn't.

Q. I think also -- I'm sorry, Mrs Steele, please carry on.

A. Just because they both tested positive, that arrangement couldn't go ahead.

Q. So they had to isolate at home?

A. Yes.

Q. I think, at that time, Andrew's girlfriend's sister was also staying with them at the apartment and she had also tested positive and had to isolate with them?
A. That's right, so they all isolated in the apartment, yes.
Q. The rules at that point were to isolate at home for ten days from the onset of symptoms, until your symptoms had alleviated?
A. That's correct.
Q. During that isolation period of ten days, I think Andrew's girlfriend and her sister quite quickly began to recover from their infection but Andrew didn't make such rapid progress?
A. No, he seemed -- I remember that he had one symptom and it would move on to the next. At that time there was quite a long list of different symptoms, and he would get rid of one and get the next one. He -- I remember he felt that he had a temperature, loss of taste and smell, and then his taste would come back, he was extremely tired, he had a cough, and he just progressed through all of the symptoms.
Q. Is it right that the advice at that time from the government was to stay at home, isolate and phone NHS 24 on the ninth or tenth day if there was no improvement in symptoms?

A. That's -- that's what I remember. The type of work that I did at that time, I knew all the rules very, very clearly, so I remember that's the way it was at that time.
Q. I think by the ninth or tenth day of Andrew's isolation, he didn't seem to be making an improvement at that point?
A. No. No, he didn't. It was just staying the same or getting a bit worse.
Q. So I think you advised Andrew or his girlfriend to call NHS 24?
A. I did, yes. I just thought that was the best thing to do, to get advice, and they did that. They did make that call, although I wasn't present for the call, but they did do that.
Q. What advice were they given?
A. Andrew had to speak to the call handler himself, I think that's -- they wouldn't speak to his girlfriend, they had to speak to him. I think it was a 15-minute call, I do have the report, and he had to describe his symptoms, which he did. He had a cough, his girlfriend felt that his breathing was heavier, fluctuating temperature, tiredness and he was very thirsty, and he was told to wait another day because it was only his ninth day, and the adviser also said that he was to try

and get through things, through his symptoms.
Q. Is it right that at that time you were aware that the local hospital was at full capacity?
A. Yes, I remember from social media that our local hospital was at capacity, yes.
Q. So the following day, which was New Year's Day, I think, after Andrew had placed that call to NHS 24, I think you had some contact with him by telephone and by Messenger; is that right?
A. Yes, we kept in touch. He felt slightly better the next day and I remember -- I remember hearing other patients that this could be a trend that on your ninth, tenth day you could feel a bit better and then, after that, there was a slump. But we didn't know that at that time, I just know that now.

But, yes, we made contact and I just wanted to check if they needed anything, if they wanted dinner. We made sure that they had food, that they had fresh things and some meals, and he was keen, he felt well enough and keen to have his dinner. So we arranged to drop off New Year's Day dinner, which they would pick up -- you know, we didn't actually meet with them but we would drop it off and they would pick it up.
Q. So you left it on the doorstep, as it were?
A. Yes.

Q. That was early in the evening of New Year's Day; is that right?
A. Yes.
Q. I think later that evening there was a call between yourself and Andrew's girlfriend when she said she was worried about Andrew's condition?
A. Yes, she just -- she just felt that he was different. There was just a change in him. And I remember it was the colour of his lips, and he just seemed to -- he was starting to be -- feel confused or appear confused, and I -- we had a call, phone call together, myself and Andrew's girlfriend, and it was during that call that he became unresponsive, and I could hear the panic in her voice.
Q. And what did you tell her to do then?
A. I told her to phone an ambulance, 999, straightaway, which she did.
Q. I think the ambulance call handler gave Andrew's girlfriend instructions over the phone on how to perform CPR, cardiopulmonary resuscitation, on Andrew, and she was attempting to do that; is that right?
A. Yes, she did.
Q. I think then you, your husband and your daughter went straight round to Andrew's apartment and went inside to help. That's just a short drive away, I think, from

where you were living.
A. We did, we went round, and we went straight into the apartment. We just didn't think that there was a danger of infection, it was just -- just something that we just did on automatic pilot, we just went straight in, and we found Andrew on the living room floor and his girlfriend was performing CPR.
Q. And I think at the time that you arrived, Andrew -- you were able to see his lips were blue, and his eyes were half open, and Andrew's girlfriend asked you to check for a pulse, and you couldn't feel any pulse at that point; is that right?
A. Yes, I couldn't feel anything. I could hear the ambulance service person on the phone giving his girlfriend instructions. I was in the living room on the floor with Andrew and his girlfriend, and my husband and my daughter were in the hallway.
Q. I think you were then holding Andrew's hand while his girlfriend performed CPR?
A. Yes.
Q. Paramedics then arrived within a relatively short time?
A. Yes.
Q. And --
A. I don't have the exact time, but it seemed fairly quick. I believe that two ambulance crews arrived and the

doctor that was on call, and I'm sure there was five medical professionals in the apartment.
Q. So there seemed to be four paramedics and a doctor of some description who you thought, I think, might have been a critical care anaesthetist; is that right?
A. I think we were told that afterwards, that he was an on-call anaesthetist, uh huh.
Q. Then I think after the paramedics had arrived, you were asked to leave the room while they worked on Andrew, and so you were outside the living room door but the door was open and you were able to see the paramedics working on him for quite a period of time, about 20 minutes; is that correct?
A. I think it was 20 minutes, I think at the end of the 20 minutes the doctor came and spoke with us and I think he told us it had been 20 minutes.
Q. Thank you. The paramedics, do you recall, were they wearing PPE, did they have personal protective equipment and safety gear?
A. They did, they had full masks and suits. I remember seeing a few of them and they were perspiring a lot. It must have been very uncomfortable.
Q. When the doctor spoke to you after they had been working on Andrew, I think you were asked whether Andrew had any allergies or if he had taken any medication, and you

explained that Andrew just had hay fever, and you went to look in the kitchen bin to see if there was any signs of any medication that he had taken; is that correct?
A. That's correct, but I couldn't see -- I couldn't see anything. But I wasn't really sure what they were looking for, but there was nothing.
Q. The doctor at that point I think explained to you that the paramedics hadn't been able to get his heart restarted and Andrew was going to be taken to the local hospital. And I think there were some difficulties in getting Andrew out of the apartment because it was three floors up, with -- so there was some difficulty in getting him down the stairs and out into the ambulance.
A. Yes. There were -- I think there were four staff carrying the -- I've forgotten the name of it, they were carrying him, and he kept slipping off and they would have to stop and try and put him back on again. My husband -- I couldn't look at it but my husband -- my husband was there and he tried to help.
Q. I think once Andrew was placed into the ambulance, he was taken straightaway to the local hospital and you followed in your car?
A. We did.
Q. And that journey didn't take very long, about 15 minutes; is that right?

A. That's right.
Q. Then what happened when you arrived at the hospital?
A. When we arrived at A&E, we had to tell them who we were and they eventually took us into a room and asked us to wait. Andrew's girlfriend was in that room with us. Her family had arrived at the hospital, so they were taken to a different room because they were from a different household. At that time I still thought they would be able to resuscitate him. I just -- I just didn't realise that Covid could be fatal for younger people.
Q. When you were in the family room where you had been asked to wait, did there come a point where a doctor and a nurse came in to talk to you?
A. Yes. I don't know how long it was, but a female doctor and a senior male nurse came in and they told us that Andrew had passed away.
Q. Did they tell you what had caused Andrew's death?
A. They told us that he'd had a blood clot, blood clot, a pulmonary embolism, and that it had been caused by Covid, and the damage that it had done was irreversible. And I just couldn't understand how that was possible, he was young. I remember the advice at the time was that we were to look out for the elderly and the vulnerable, those that are most at risk, and I couldn't understand

why someone at 28 years old, this could happen to.
Q. I think you spoke to the doctor and asked her about that, and the doctor told you that she had seen quite a lot of people developing blood clots from Covid; is that correct?
A. She did, and she also said that they had been seeing it in younger patients too, which I was really shocked about, because we -- we were not aware of that, and as far as I know nobody else was aware of that. It didn't seem to be in the public domain that younger people could be at risk.
Q. Were you able on that occasion to talk to the doctor and ask questions about what had happened?
A. We did. We did. We sat for a while in that room and asked questions. But I think we probably ran out of questions, we were just in shock. We were just in shock. And I think it was the next day that I had more questions and I had phoned back, phoned back the hospital, to ask more questions.
Q. We'll come on to that in a moment, Mrs Steele. I think you had some questions about if -- whether Andrew had been able to get to the hospital, been taken to the hospital earlier, whether that could have made a difference in terms of the kinds of treatment that could have been tried for him?

A. She did, she -- the doctor explained that the blood clot, his death would have been instant. She said that there were treatments for blood clots but it wasn't straightforward, they can have complications and, even if he had got there earlier, it might not have been successful.
Q. How would you describe the communication that you had with the doctor at that point, when you were still at the hospital, and the manner of the doctor when you were talking to her and she was answering your questions?
A. I found the female doctor and the male nurse -- I found them quite helpful, quite compassionate. I think, you know, they did very well. It was -- we were obviously in shock, so it must have been very difficult to ... to communicate with us but I thought they were very compassionate.
Q. Were you given an opportunity to see Andrew that evening?
A. They did ask us. This was all very surreal. I just expected them to be able to resuscitate him, I wasn't expecting to see him lying on a trolley. But we were asked if we were wanted to, as this would probably be the last time we would see him because of restrictions that were in force then. So Andrew's girlfriend went and saw him first, and then she came back and then

Andrew's dad and I went and saw him.
Q. You told us that he was lying on a trolley in A&E and you stood by the trolley, there were no seats or anywhere to sit down, and Andrew had black blotches on his skin and his lips were dark, and you didn't know if you were allowed to touch him; is that right?
A. Yes. Yeah, I didn't, I didn't know what to do. I didn't know how long -- how long we were allowed to stay, how long we should stay, it was all just very surreal. Our youngest daughter that came with us to the hospital, she chose not to go and see him.
Q. You were given a folder with some information about how to register a death and make funeral arrangements, and so on. Were you offered any counselling services or bereavement counselling?
A. No.
Q. You weren't signposted to anything like that at the hospital?
A. Not that I remember. We were given a small A5 folder and it had lots of information in it about registering a death, and I'd never seen anything like that before. No, the only thing -- the doctor gave me her number at the hospital, which I noted down in case I had any questions or anything for -- you know, after we went home, she did give me her number.

Q. I think you were also asked that evening whether you wanted to have a postmortem examination of Andrew?
A. Yeah.
Q. You decided not to; is that right?
A. Yes. Again, we were just in shock, just wasn't expecting that question but it just -- I just remember feeling just horrified at that thought. The doctor, I think she could sense -- sense that and she did say that she would put her reputation on it being a blood clot due to Covid-19, meaning that there perhaps wasn't a need. So, taking all that into consideration, we decided not to go ahead with a postmortem.
Q. Mrs Steele, I think you then left the hospital, this was the early hours of 2 January, and you then had to telephone the family members to let them know what had happened to Andrew?
A. We did. We realised that in the time from us going to Andrew's apartment to being at the hospital, that Andrew's older brother and his other younger sister weren't aware. We just hadn't thought to contact them. I think, personally, I just thought he would survive. So we had, we had to go home and think about phoning them, waking them up, phoning them, and that took a while to get hold of his older brother and his other younger sister.

Q. It was you who made those phone calls; is that right?
A. My husband just couldn't speak, so I did it and it was just the hardest thing I've ever had to do. I just knew that it would cause them pain.
Q. Mrs Steele, would you like to take a break?
A. Yes, please.
LADY HALLETT: I'd only say this, Mrs Steele, of course have a break if you want, it's just I've dealt with a lot of distressed witnesses over the years and sometimes people find it -- just to get it out of the way, as opposed to having a break but it's entirely a matter for you. Do you want to just have a glass of water and then, as I say, if you wish to have a break you must do so.

Just sometimes people would rather get it done and we haven't got that much more for you anyway. I mean, I have your written statement and I can read that, so just take it shortly, Ms Steele.

So please just say, though, Mrs Steele, I don't want you to feel I'm putting you under any pressure.
THE WITNESS: Thank you. No, I'm fine. I'm fine.
MS NIELD: Thank you. Thank you, my Lady.

So having made those telephone calls to your family, to your children and also your mother, I think, you contacted the doctor who had given you her mobile phone number the next day and spoke about the questions that

you had, and you were told then that you were going to have to isolate because you had been very close to Andrew when you were at his apartment; is that right?
A. Yes. We were told that we must isolate ourselves, my husband and our younger daughter -- youngest daughter. So we had no symptoms, so there was no road for getting a test unless you had symptoms at that time, so we had to wait. We had to wait and see if we developed symptoms.
Q. So I think Andrew's funeral was arranged through online meetings and telephone calls?
A. It was, and we just had to wait to see if it could go ahead on the day that it was arranged, because if we developed symptoms then we wouldn't have been able to go.
Q. Mrs Steele, I would like to ask you some questions about the impact that this has had on you and on your family. First of all, for you, I think, you were off work for six months after Andrew's passing on bereavement leave; is that right?
A. That's right, six months, until I felt that I was sleeping better and managing better, then I felt I could try to go back to work.
Q. I think when you did go back to work, there were issues with your employer not following the Covid rules and at

that point your mental health began to deteriorate and you connected that to the trauma and the traumatic circumstances in which you lost Andrew, and at that point you had to take another six months' absence leave; is that correct?
A. I did, yes. I was prescribed medication for anxiety, but it was caused, as you said, by the harassment at work, the conditions that I was asked to work in.
Q. And I think after transferring to a different office with that employer, after a few months you left that employment entirely and took up a new job elsewhere.

How are you now, Mrs Steele?
A. I work with lovely compassionate people, so that is a help. I work part-time, I don't work full-time any more. I do have ongoing anxiety problems, but not near as bad as I used to. I tend to avoid social things, sort of gatherings, things like that. My confidence has been knocked, but I think mostly because of the problems I had in my old work, my old employment. I think this experience has damaged relationships, and I think this type of bereavement, people ... you just don't understand it until you've been through it. So I have some friends that are very, very good, but people must find it very difficult.
Q. I think you have had four rounds of counselling to date?

A. Yes, I have had four.
Q. And you still experience some recurring flashbacks from the events around Andrew's death?
A. I do, certain flashbacks, mostly from seeing Andrew after he passed away.
Q. And how has your husband been affected by this bereavement?
A. He is -- he works from home, he also had six months' bereavement leave. He has a lot of guilt and anger, and he does blame himself for not being able to protect Andrew. He doesn't sleep well, and he does suffer from low self-esteem and flashbacks.
Q. Mrs Steele, I think you've said that everyone in the family has been very greatly affected by Andrew's death, including his siblings and your mother, and I think your children have also had to take bereavement leave from work, and in the case of your eldest daughter has been diagnosed with depression since his death?
A. She was. She's -- she is better now, but she -- I was very, very worried about her for a while.
MS NIELD: Thank you very much, Mrs Steele. I realise this won't have been easy at all. I've no more questions for you.
LADY HALLETT: Thank you, Ms Nield.

Mrs Steele, I know you were very nervous about

giving evidence but you have been so brave and I'm really grateful to you. I hope you haven't found it too distressing. I suspect once we stop you will possibly break down but that's probably a good thing, let all the emotion out.

I know how difficult it is for people who have suffered the kind of tragedy you have to give evidence, but it's so important that not only I hear but that the world hears your kind of story and, though we can try and make recommendations to try and ensure that things are better in the future, no parent should have to lose a child. So I know how difficult it was, and thank you.

THE WITNESS: Thank you. Thank you.

LADY HALLETT: Thank you very much.

(The witness withdrew)

LADY HALLETT: Right, I think probably it's time to take a break. I think there's a limit to how much we can all take in half a day. 10.00 tomorrow.

(4.20 pm)

(The hearing adjourned until 10.00 am on Wednesday, 11 September 2024)

INDEX