

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

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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

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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

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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.

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

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

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

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

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

10 My Lady, those are our submissions.

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

12 Mr Henderson.

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

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

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

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1 case.

2 Save lives. Our clients' members were working
 3 tirelessly to save the lives of patients, yet their own
 4 lives were being put at risk by the wholesale failures
 5 of the Johnson government during the pandemic. In the
 6 first 20 months of the pandemic, up to 22 April 2020,
 7 83% of the ethnic minority health workers who died from
 8 Covid-19 were migrant workers, 53% of the total UK
 9 healthcare workers who died were migrants. Further, as
 10 reported by Professor Cook(?), despite comprising only
 11 3.8% of the nursing workforce, in the first months of
 12 the pandemic up to May 2020, Filipino nurses accounted
 13 for 22% of NHS nurse staff deaths.

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

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

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

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1 faculties.

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

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

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

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

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

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

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

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

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

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

25 Next, mental health consequences. There should be
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1 heart of any government management of future pandemics.
2 That did not always appear to us to be the case during
3 the pandemic, and any erosion of trust will always have
4 a negative impact and negative consequences.

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

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

19 Thank you very much, my Lady.

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

21 Ms Clarke.

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

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

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

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

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

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

24 Finally, transparency and honesty. Crucially,
25 transparency, honesty and engagement must be at the
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1 **MS CLARKE:** Thank you.

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

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

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

22 We hope to provide the Inquiry with valuable
23 evidence about the conditions under which our members
24 delivered care but also to explain how our organisations
25 undertook proactive leadership roles during the
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1 pandemic. This included providing clinical expertise to
2 policymakers, advising the government, educating the
3 public and signposting and interpreting official NHS
4 guidance. We hope that our evidence informs not only
5 the Inquiry's findings generally but, more importantly,
6 any recommendations it makes on how to prepare for
7 a future crisis.

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Those reasons and more contributed to why surgical
5 activity dropped by 54% between January 2020 and
6 January 2021. This is equivalent to 9,770 operations
7 being lost per day. In England, waiting lists were
8 already large and growing prior to the pandemic,
9 reaching 4.24 million beforehand, however during the
10 pandemic they grew further and faster, reaching
11 6.7 million by its end. These are of course not just
12 statistics, real people are behind every story, and huge
13 numbers of people continue to suffer, wait and, in some
14 cases, deteriorate while the hospitals that were there
15 to treat them were focused on pandemic efforts.

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

25 Anaesthetists in training were particularly

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

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

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

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

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

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

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

9 Thank you, my Lady.

10 **LADY HALLETT:** Thank you, Ms Clarke.

11 Mr Stanton.

12 **Submissions on behalf of the British Medical Association by**
13 **MR STANTON**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 "We had no choice but to work in an environment

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

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

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

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

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

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

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

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

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

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

25 In addition, the failure to adequately invest in the

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

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

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

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

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

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

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

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

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

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

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

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

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

14 Thank you, my Lady.

15 **LADY HALLETT:** Thank you very much, Mr Stanton.

16 Ms Domingo.

17 **Submissions on behalf of the Royal Pharmaceutical Society by**
18 **MS DOMINGO**

19 **MS DOMINGO:** Thank you, my Lady.

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

26

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

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

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

25 Community pharmacies only became eligible to order from

28

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

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

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

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

29

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

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

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

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

31

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

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

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

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

30

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

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

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

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

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

32

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

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

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

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

25 It is vital that medicines production facilities are

33

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

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

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

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

35

1 included in considering resilience and preparedness for
2 a future pandemic.

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

9 Thank you, my Lady.

10 **LADY HALLETT:** Thank you very much, Ms Domingo.

11 Mr John-Charles.

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

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

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

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

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

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

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

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

19 A member from Cardiff said:

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

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

3 An Ilford member said:

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

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

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

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

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

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

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

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

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

39

1 support effective co-operation across the health
2 service.

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

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

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

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

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

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

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

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

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

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

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

25 Those are my submissions.

41

1 affected by the pandemic.

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

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

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

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

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

4 Ms Morris.

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

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

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

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

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1 Throughout the pandemic, the Royal College of
2 Nursing engaged with its members through its existing
3 interactive support services, via a call centre and
4 an online platform. Through that, it received more than
5 28,000 contacts from members on issues that they faced
6 during the pandemic. From these contacts, we can see
7 what was experienced contemporaneously and what was
8 reported, including attending work despite not being
9 well enough to perform their duties, being asked to work
10 in unsafe conditions, isolating themselves from their
11 families in order to protect them, spending extended
12 periods, when PPE was available, in PPE that caused
13 damage to them, contributed to their fatigue and stress,
14 feeling depressed, anxious and stressed, experiencing
15 symptoms indicative of PTSD.

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

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

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

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

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

24 Evidence shared with the Inquiry from the college's
25 members highlights the feelings of fear, panic and dread
45

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

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

21 It's the view of the college that a lack of clarity
22 on use of the term "PPE", combined with a culture of
23 assumptions that historical influenza guidance and views
24 on its transmission and impact in the 21st century was
25 inadequate. It placed healthcare workers at
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1 and their sense of vulnerability, as well as the
2 emotional and physical toll of dealing with death, pain
3 and suffering daily at levels they had never experienced
4 before.

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

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

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

25 However, during the pandemic, policymakers in the
46

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

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

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

17 Healthcare professionals described feeling like
18 lambs to the slaughter.

19 The college regularly expressed its concerns in
20 correspondence to the UK Government, devolved
21 administrations and other relevant bodies, including the
22 HSE. However, one-size-fits-all protective equipment
23 was a problem for frontline healthcare workers who were
24 obliged to work with this inadequate material up to
25 12 hours at a time.
48

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

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

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

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1 **Submissions on behalf of the Trades Union Congress by**
2 **MR JACOBS**

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

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

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

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

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1 you can do it.

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

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

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

22 **MS MORRIS:** Thank you, my Lady.

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

24 **MS MORRIS:** Yes.

25 **LADY HALLETT:** Mr Jacobs.

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

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

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

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

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1 the pandemic and subsequently by the growth of waiting
2 lists.

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

7 We have heard this morning about waiting lists
8 approaching 8 million, close to double the figures prior
9 to the pandemic and more than triple the figures in
10 2010. It is patients that face the acute dangers of
11 waiting lists approaching 8 million but it is the
12 workers who sag under the weight of that burden in
13 a system that gives them neither the means nor
14 facilities to address it.

15 As in an account to the TUC of an NHS podiatrist:
16 "Our ulcer caseload has tripled since 2020 because
17 of the lack of routine care. The pressures on other
18 specialties means we are holding onto patients that we
19 shouldn't be. Our role has changed significantly and
20 the stress has continued to get worse but we are told to
21 get back to normal."

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

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

10 A portering supervisor told the TUC:

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

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

55

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

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

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

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

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

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

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

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

11 My Lady, those are our submissions.

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

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

16 (11.22 am)

(A short break)

18 (11.35 am)

19 **LADY HALLETT:** Mr Burton.

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

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

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

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

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

20 My Lady, I briefly remind you and those listening of
21 the disparate impact of Covid-19 on disabled people:
22 three in five Covid deaths experienced by one in five of
23 the population; the hearing and visually impaired were
24 12 times more likely to die of Covid-19; the visually
25 impaired eight times more likely to die of Covid-19; the

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

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

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

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

25 Importantly, in relation to disabled people, these

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 "These changes appear to have been introduced
2 without any reference to an equality assessment at all."
3 Visiting restrictions, my Lady. Initially, no
4 exceptions were made for those with mental health
5 conditions that made them particularly susceptible to
6 distress when isolated from friends or family, or those
7 with physical ailments who needed the support of their
8 carers whilst in hospital. The belated acknowledgement
9 of such basic needs is completely inexplicable.
10 Shielding and the CEV and CV criteria appears again
11 to have been made without apparent regard to the risk
12 factors presented by adults and children with
13 disabilities. The shielding policy was based on
14 perceived clinical risks only. This medicalised model
15 overlooked completely the well-known social and
16 structural barriers to which disabled people were
17 exposed. Indeed, people with learning disabilities and
18 those living with Down's Syndrome were belatedly
19 included in the SPL, but learning disabled adults were
20 not added to the shielding patients list until 19
21 February 2021, despite evidence published in November
22 2020 that they were experiencing a disparate mortality
23 rate. Similarly with those living with Down's Syndrome,
24 they were added in November 2020 but the disparate
25 impact had been made aware to the government by June
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1 huge disparate impact on disabled people but they do
2 serve to create a justifiable suspicion that, despite
3 the rhetoric, because government was not properly and
4 systemically addressing potential disability
5 discrimination, many more disabled people died or were
6 negatively impacted by Covid-19 than ought to have been
7 the case, leaving disabled people feeling expendable, as
8 if their lives were less valued.

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

16 Thank you, my Lady.

17 **LADY HALLETT:** Thank you, Mr Burton.

18 Mr Mitchell.

19 **Submissions on behalf of the Scottish Government by**

20 **MR MITCHELL KC**

21 **MR MITCHELL:** Good morning, my Lady.

22 Now, these are the opening remarks on behalf of the
23 Scottish Government. I appear today along with Mr Way,
24 junior counsel, and we are instructed by
25 Caroline Beattie, and John McPhail of the Scottish
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1 2020. How are these gaps explained?

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

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

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

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

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

24 The final point really is this, my Lady, that these
25 failures do not of themselves necessarily explain the
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1 Government Legal Directorate.

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

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

7 **MR MITCHELL:** Thank you.

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

21 Of course, the Scottish Government is eager to take
22 the opportunity presented by this module to learn from
23 the evidence, to identify what could have been done
24 better and to improve government decision-making. In
25 these opening remarks, we look briefly at the form of
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1 the healthcare system in Scotland, then at the
2 structures within which decisions were taken and,
3 finally, at particular aspects of the response to Covid.

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

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

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

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1 informed by an understanding of the differential impact
2 of the virus on certain parts of the population. For
3 example, the work of the expert reference group for
4 Covid-19 and ethnicity has left a legacy that exists
5 some three to four years after its inception.

6 An understanding of the differential impact can also be
7 seen in the policy and strategy behind the shielding
8 list, known in Scotland from June 2021 as the highest
9 risk list.

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

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

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

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

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

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

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

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

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

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1 those most in need.
 2 Looking now at infection prevention and control
 3 within healthcare settings. While the UK Government,
 4 and subsequently ARHA Scotland, held and maintained IPC
 5 guidance for Scotland, the Scottish Government
 6 nevertheless took a central role. It worked with health
 7 boards to ensure that appropriate IPC measures were in
 8 place in healthcare settings, it communicated updates
 9 and changes in IPC guidance, it worked with the boards
 10 to implement IPC measures, such as appropriate use of
 11 PPE, extended use of face masks and face coverings,
 12 optimal ventilation, enhanced cleaning measures and
 13 testing for healthcare workers and patient admissions.

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

18 Coming finally, my Lady, to the impact on doctors,
 19 nurses and healthcare staff. The following very sad
 20 statistic must be acknowledged, that between 13 April
 21 2020 and 20 July 2022, the Scottish Government was
 22 notified of 27 deaths of NHS Scotland staff caused by or
 23 suspected to be related to Covid-19.

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

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

13 My Lady, thank you.

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

15 Is it Mr Bowie?

16 **Submissions on behalf of Public Health Scotland by**
 17 **MR BOWIE KC**

18 **MR BOWIE:** Thank you, my Lady.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Finally, before I conclude, most importantly,

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

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

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

25 The EAVE II project. PHS worked with the University

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

6 Thank you.

7 **LADY HALLETT:** Thank you, Mr Bowie.

8 Mr Pugh.

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

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

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

19 Put shortly, though, my Lady, it is the
20 14 territorial health boards that serve the different
21 geographic areas in Scotland, as we heard yesterday
22 morning, together with five of the special health boards
23 that serve the whole of the Scottish population.

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

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

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

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

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

18 "...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 resources available to them and are keen to assist
2 the Inquiry in making those recommendations workable.
3 Thank you, my Lady.

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

6 Mr Bowie, you're up again.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Finally, rapid reviews. ARHAI Scotland undertook
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1 give an account of the structures, governance and
2 processes that existed regarding the development of IPC
3 guidance during the pandemic in Scotland. The Inquiry
4 will be hearing from Laura Imrie, the clinical lead for
5 ARHAI Scotland, in due course. Her evidence will be
6 important, my Lady, not least given the observations
7 made in the opening statement on behalf of CATA, the
8 content of which my Lady will be familiar with.
9 ARHAI Scotland does not shrink from the important issues
10 that CATA raises.

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

16 Thank you, my Lady.

17 **LADY HALLETT:** Thank you, Mr Bowie.

18 Mr Kinnier.

19 **Submissions on behalf of the Welsh Government by MR KINNIER**

20 **KC**

21 **MR KINNIER:** Prynawn da, good afternoon, my Lady.

22 The pandemic had far-reaching effects on healthcare
23 services in Wales and on the people of Wales. Those
24 effects are continuing, not at least on waiting times
25 for treatment. As was movingly demonstrated by
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1 rapid reviews which were primarily focused on the
2 assessment of SARS-CoV-2 virus studies that were
3 published as the pandemic unfolded. Their purpose was
4 to support NHS Scotland IPC and clinical staff, who,
5 without the rapid reviews, would have lacked a reliable
6 source of intelligence to stay updated on emerging
7 evidence. No other organisation in the UK attempted to
8 provide such support for frontline IPC staff.

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

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

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

25 ARHAI Scotland, we believe, is very well placed to
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1 yesterday's film, the Inquiry will hear powerful
2 evidence about people with Covid-19 who were treated in
3 busy and overstretched wards and who were understandably
4 frightened whilst they were in hospital. We will hear
5 from family members who were unable to be with their
6 loved ones as they died, from people who struggled to
7 access NHS care and treatment for conditions other than
8 Covid-19 and from those who continue to suffer from the
9 pandemic's long-term effects.

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

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

21 We will also hear from those senior officials and
22 ministers who were responsible for the Welsh
23 Government's response to the pandemic. They will each
24 give a full and frank account of their decisions and the
25 circumstances in which they were made, the reasons for
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1 those decisions and how the Welsh Government's response
2 developed and changed as development of the virus
3 evolved. As in all previous modules, the Welsh
4 Government witnesses will fully co-operate with your
5 work.

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

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

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

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

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

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

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

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1 as it could to the emerging situation.

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

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

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

25 To ensure that decisions were informed and in the

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

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

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

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

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

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

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

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1 scenario materialise, and to minimise transmission of
2 the virus.

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

7 My Lady, thank you.

8 **LADY HALLETT:** Thank you very much, Mr Kinnier.

9 Ms Fenelon.

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

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

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

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

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

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

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

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

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

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1 reached the position where an ICU bed, if required,
2 could not be found for a patient.
3 He highlights an issue echoed in other statements
4 from the group of Welsh health bodies, that the frequent
5 changing of guidance, particularly during the pandemic
6 onset, caused obvious practical problems but also staff
7 confusion and anxiety. In similar vein to concerns
8 identified by Velindre NHS Trust, he points to the fact
9 that Public Health England guidance was usually
10 announced on a Thursday but Public Health Wales on the
11 following afternoon. This led to difficulties in
12 initial implementation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Pandemic planning needs to develop resilience in

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

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

12 Thank you, my Lady.

13 **LADY HALLETT:** Thank you very much indeed.

14 Ms Grey.

15 **Submissions on behalf of NHS England by MS GREY KC**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 remains an acknowledged need for further research on the
2 virus.

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

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

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

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

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

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

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

23 At times this included supporting the development of
24 guidance that was not NHS England's responsibility.

25 Other groups, such as the royal colleges, did the same,
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1 highlighting and exacerbating entrenched inequalities
2 nationwide, including in the NHS workforce, where there
3 are about 200 nationalities employed. People from
4 black, Asian and minority ethnic backgrounds make up
5 over 20% of the NHS workforce and we know that they
6 suffered disproportionately in the pandemic. We've set
7 out in our corporate witness statement what was done in
8 response, such as the creation of the NHS Race
9 Observatory in May 2020 but we know that there is much
10 more to do.

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

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

18 That message resonates in the context of the
19 pandemic too. We acknowledge that one area of looking
20 after is ensuring that all staff, especially the most
21 vulnerable, feel able to speak out about their
22 experiences and contribute to learning. We are deeply
23 sorry that there are NHS witnesses to this Inquiry whose
24 genuine fear of victimisation, as a result of giving
25 evidence, has required them to give evidence
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1 and this was truly appreciated. Such co-operation not
2 only helped the pandemic response to be agile but was
3 also a check against groupthink.

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

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

24 I turn briefly to inequalities and the culture of
25 the NHS. The pandemic is widely recognised as
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1 anonymously. NHS Freedom to Speak Up campaign aims to
2 create work spaces where people feel safe to speak with
3 confidence and in confidence but we know that there is
4 much more to be achieved to make workforces safe for
5 everyone.

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

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

25 Thank you, my Lady.
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1 **LADY HALLETT:** Thank you, Ms Grey, very grateful.
 2 Mr Jory.
 3 **Submissions on behalf of the Independent Ambulance**
 4 **Association by MR JORY KC**
 5 **MR JORY:** My Lady, I make brief representations on behalf of
 6 the Independent Ambulance Association.
 7 I, together with Ms Jessica Tate, am instructed by
 8 Linda Barker of Duncan Lewis Solicitors. The IAA is
 9 a not-for-profit trade association and the pre-eminent
 10 voice for independent ambulance providers across the UK.
 11 The IAA has over 50 member organisations who
 12 collectively employ thousands of individuals. They
 13 provide a range of critical services supplementing the
 14 NHS in the UK, and these include non-emergency patient
 15 transport, 999, frontline responses, high dependency
 16 patient transfers and mental health patient
 17 transportation.
 18 Approximately half of all NHS funded non-emergency
 19 patient transport is provided by independent ambulance
 20 providers.
 21 During the pandemic, the independent ambulance
 22 providers pivoted their services to assist in the
 23 transport of Covid patients to and from hospital, and to
 24 care for Covid patients, often at considerable risk to
 25 themselves and their families. The contribution of IAA

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1 NHS or local authority managed portals, but there were
 2 problems in accessing these portals, which in turn
 3 created delay, uncertainty and disruption to services.
 4 Unregulated ambulance providers. There were
 5 significant problems regarding unregulated ambulance
 6 providers carrying out what should have been regulated
 7 activities. IAA members are required to adhere to
 8 strict Care Quality Commission guidance. These
 9 unregulated providers are not subject to the same rigour
 10 of CQC inspection or indeed accountability. They cannot
 11 provide the same level of professionalism and service,
 12 and this in turn puts patients and workers at risk.
 13 Some of the non-regulated providers were
 14 opportunistically advertising for staff in response to
 15 the Covid crisis, having circumvented the normal
 16 approvals process by being subcontracted by
 17 CQC-regulated providers.
 18 Mental health patients. The wellbeing of mental
 19 health patients is of particular concern. The
 20 availability of mental health beds during Covid was
 21 limited, and this continues to be an issue. The lack of
 22 beds locally results in patients being taken by IAA
 23 members on long journeys at short notice in order to
 24 receive appropriate care. The knock-on effect of this
 25 is a subsequent practical challenge for family and loved

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1 members undoubtedly mitigated the impact of Covid on the
 2 UK's health systems. The headline topics we wish to
 3 address at this stage include the following:
 4 Key worker recognition. As you've heard from many
 5 other CP groups here, the failure to grant immediate
 6 key worker status to our members had an immediate and
 7 practical impact on the ability of our members to
 8 provide an effective service alongside the NHS to
 9 support the Covid response.
 10 Next, the shortage of oxygen and other medical
 11 gases. During the pandemic, oxygen and oxygen cylinders
 12 were in extremely high demand in the UK and indeed
 13 globally. The main domestic oxygen supplier was unable
 14 to meet the unprecedented demand for oxygen, and it was
 15 evident there was insufficient medical gas production
 16 capacity in the UK.
 17 Independent ambulance organisations were unable to
 18 replenish stocks for existing cylinders, resulting in
 19 vehicles not being operational. There remains
 20 an ongoing reliance on -- and therefore vulnerability
 21 to -- offshore manufacturing of medical gas cylinders,
 22 particularly oxygen, with a lengthy lead time for new
 23 cylinders. Further, during the pandemic, normal open
 24 market supply chains were effectively usurped by the
 25 government in favour of managed provision through the

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1 ones to visit and provide support.
 2 Financial stability. In the first two weeks of the
 3 Covid pandemic, NHS-funded non-emergency patient
 4 transport journeys reduced from 100% to less than 40%.
 5 As independent operators, relied heavily upon by the
 6 NHS, IAA members found their financial viability
 7 suddenly and significantly undermined.
 8 As with all the matters mentioned, we will make
 9 practical proposals for recommendations from this
 10 Inquiry to avoid such a problem in the future.
 11 Communication. One consistent concern highlighted
 12 by our members was the lack of a clear line of
 13 communication as the scale and impact of the pandemic
 14 developed. Non-emergency patient transport does not
 15 have a permanent national team providing oversight and
 16 leading the work. In our view, the establishment of
 17 a small but permanent national team with powers of
 18 oversight and delegation would bring consistency in
 19 approach to commissioning of services, whilst also
 20 providing innovation, equality of access, and ensuring
 21 value for money.
 22 Finally, a more strategic role for ambulance service
 23 NHS trusts. We invite the Inquiry to consider a more
 24 strategic role for ambulance service NHS trusts in
 25 co-ordinating and deploying the available assets of

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

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

14 **LADY HALLETT:** Thank you very much, Mr Jory.
 15 Right, I think that completes the submissions on
 16 behalf of the core participants. We shall break now and
 17 we shall begin hearing evidence this afternoon at 1.55.

18 (12.57 pm)

(The short adjournment)

20 (1.55 pm)

21 **LADY HALLETT:** Ms Carey.

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

MR JOHN SULLIVAN (sworn)

25 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**

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1 **A.** Susie, yes.
 2 **Q.** Just tell us a little bit about Susie and some of the
 3 things she did during her life.
 4 **A.** Yes, well, Susie was born, as you said, with Down's
 5 Syndrome and we were told she wouldn't walk, she
 6 wouldn't talk, and every time we took her to a doctor,
 7 with something positive there was a negative, so I came
 8 home one day and my wife was crying, she'd been to the
 9 GP. I said, "Right, forget the doctors, we're going to
 10 do this our way", and we crawled round the floor with
 11 her, we smacked her bum if necessary, we tapped her bum,
 12 we encouraged her to crawl, we encouraged her to walk
 13 and then she just blossomed.

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

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

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

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

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

25 **Q.** She was on holiday with you?

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

4 **THE WITNESS:** Okay, thank you.

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

7 **A.** It's John James Sullivan.

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

10 **A.** Yeah.

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

14 **A.** Yeah.

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

16 **A.** Correct.

17 **Q.** She was born with Down's Syndrome.

18 **A.** Yes.

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

20 **A.** Correct.

21 **Q.** She was 56 at the time.

22 **A.** Correct.

23 **Q.** Right. Just help us, please, just summarise a little

24 bit about Susan -- who I think you called Susie; is that
 25 right?

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1 **A.** Always on holiday, yeah, yeah.

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

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

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

8 **A.** Yeah.

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

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

13 **Q.** No.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 **A.** Yeah, yeah.

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

10 **A.** Yeah, we did.

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

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

14 **Q.** In the morning?

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

21 **Q.** A symptom?

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

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

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

13 **A.** Yeah.

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

16 **A.** The ambulance arrived, yeah.

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

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

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

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

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

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

12 **A.** Yeah.

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

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

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

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

11 **A.** Yes.

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

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

17 **Q.** Do you mean do not resuscitate?

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

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

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

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

6 **A.** Yeah.

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

10 **A.** Always, yes.

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

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

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

19 **A.** Absolutely, yes.

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

22 **A.** Absolutely.

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

25 **A.** Yeah, they made a reasonable adjustment and allowed

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

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

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

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

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

17 **A.** Yeah, that's right, yeah.

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

20 **A.** Correct, yeah.

21 **Q.** What did Ida take with her to wear?

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

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

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1 **A.** No, it was all kind of up in the air and they basically
 2 said to call the ward later, you know, call the ward
 3 later. I mean, the thing about it is that the A&E guy
 4 had called Ida to the door before she left -- called Ida
 5 to the door before she left and said "Oh, we're very
 6 happy with Susan" and blah, blah, blah and call the ward
 7 later basically. I mean, how the hell they were happy
 8 with Susan is another question, I don't know.
 9 **Q.** But the impression that Ida was given was that Susan was
 10 stable, it was okay, and --
 11 **A.** Yeah.
 12 **Q.** -- "Ida, you can go home"?
 13 **A.** I mean, the reality is the doctor -- Susan had one
 14 chance of life, that was ITU, end of, that one chance
 15 and, at the end of the day, this doctor knew that he was
 16 sending her into a ward into a bed to die, end of. So
 17 for him to turn round and say "We're very happy with
 18 Susan" was, you know, was pretty cruel, was pretty
 19 cruel.
 20 **Q.** Pause there, Mr Sullivan, because I want to show you
 21 a document that might help explain the answer that
 22 you've just given. Can you turn, please, behind tab 2
 23 in your bundle.
 24 And could we call up, please, INQ000483292 --
 25 **A.** Yeah.

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1 **A.** Yeah.
 2 **Q.** All right.
 3 Now, can we go down the page again, please, to the
 4 addendum at 15.36. Pause there, thank you. Could you
 5 highlight that, please. This is added to the notes
 6 a little bit later that afternoon and it says:
 7 "ITU declined in view of Down's Syndrome and cardiac
 8 comorbidities."
 9 Then it sets out various statistics and saturation
 10 levels and she is she can move to the ward.
 11 **A.** Yes. At the end of the day, that, that is what
 12 started -- that one line in that medical note is what
 13 started my quest for the truth because I'm not a medical
 14 person but I brought Susan up with my wife and my
 15 family, Down's Syndrome shouldn't be a reason for
 16 declining ITU, and a pacemaker, which is the comorbidity
 17 they're talking about and which was subsequently proved
 18 in the investigation -- but that is what triggered my --
 19 I couldn't believe that she could be declined ITU
 20 because she was Down's Syndrome.
 21 **Q.** Yes. Now, that brings me exactly on to what the review
 22 found some years later. So let's look at that now.
 23 **A.** Yes.
 24 **Q.** Can we call up, please, behind your tab 4, INQ000483295,
 25 and page 8, please.

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1 **Q.** -- and page 2, please. Right, can you see that
 2 all right, Mr Sullivan?
 3 **A.** Yes.
 4 **Q.** Pull your chair in by all means. I want to just look at
 5 some of the things on this document. This is Susan's
 6 medical records and the top part of the page deals with
 7 the position as Susan came in to the hospital.
 8 **A.** Yeah.
 9 **Q.** You can see she's 56, she had a fever, it records there
 10 that she has Down's Syndrome, she had a pacemaker
 11 in situ but no other cardiac comorbidities?
 12 **A.** No.
 13 **Q.** Independently mobile, despite being non-verbal. If you
 14 just go down the page, can you see where it says
 15 "Plan" --
 16 **A.** Yeah.
 17 **Q.** -- and number 6?
 18 **A.** Yeah.
 19 **Q.** At that stage there, this was the plan for Susan's care
 20 at the beginning --
 21 **A.** That's what we were told.
 22 **Q.** -- that she would be reviewed for ITU if her condition
 23 was not improving?
 24 **A.** Exactly.
 25 **Q.** Right, so that's sometime around midday-ish on the 27th?

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1 **(Pause)**
 2 My Lady, in due course we will hear that there was
 3 a review conducted by the hospital but I would like to
 4 deal with this now.
 5 Can we look, please, at the top two or three
 6 paragraphs because it picks up on what Mr Sullivan has
 7 just been saying and the review there at 3.36 that
 8 afternoon recording that Susan had been declined ITU
 9 admission due to cardiac comorbidities and Down's
 10 Syndrome.
 11 When this was investigated by the hospital, they
 12 said this:
 13 "The investigating team have been unable to find any
 14 documented evidence of an ITU review taking place and
 15 can conclude that the patient was not reviewed
 16 face-to-face by ITU staff. A contemporaneous record of
 17 conversations held between the admitting ITU consultants
 18 on [the 27th] and any reasons for declining ITU
 19 admission does not show that the patient was discussed
 20 for consensus opinion for ITU suitability, as was the
 21 recognised process at the time. This led the review
 22 team to conclude that either the patient was not
 23 discussed at a consultant level or that the discussion
 24 was not recorded."
 25 So it appears she was not seen by ITU staff and the

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

4 Mr Sullivan, looking at the next paragraph:
5 "The reviewing team considered the degree to which
6 the patient's cardiac comorbidities would be a reason
7 for not admitting [Susan] to ITU and agreed that the
8 presence of moderate to severe mitral and aortic
9 regurgitation and a cardiac pacemaker would not be
10 exclusion factors for ITU on their own but ... could
11 certainly adversely affect patient outcomes ..."

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

14 A. Yeah.

15 Q. Equally, reference to Down's Syndrome as a reason for
16 not admitting to ITU was also reviewed and again agreed
17 this was not a reason for declining Susan ITU admission.

18 So the two reasons at 15.36 for saying she shouldn't go
19 into ITU, the review said were not proper reasons --

20 A. Yeah.

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

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

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

7 Q. So Clifford's liaising --

8 A. He was doing the liaising, yes.

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

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

21 And the vexing thing is that, had that reasonable
22 adjustment that was made in the A&E and when she was
23 dying, had that been made in that 20-year (sic) period,
24 you know, family by the bedside to help her keep her
25 oxygen mask on that they said she was benefiting from,
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1 down bogus reasons, I mean, you know, even a non-medical
2 like me looked at it, it jumped out -- off the page and
3 said "This can't be right", so, you know, somebody's put
4 that down. And the question is: is that -- is the
5 person that wrote that on her medical notes the only
6 person in the last four years of this battle I've had
7 with the hospital, is the only person that's ever told
8 the truth in the whole thing, because it's been decline,
9 decline, cover-up, obfuscate. But I've asked 1,000
10 times, if Down's Syndrome and a pacemaker were not
11 justifications for declining ITU, why is it on her
12 medical notes, and nobody wants to tell me.

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

23 So Susan was not admitted to ITU and then, to pick
24 up the story of what happened to her, was Clifford the
25 one liaising with the hospital to find out how she was
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1 the outcome could have been different.

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

5 A. No.

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

7 A. No.

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

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

22 It doesn't make sense that reasonable adjustment was
23 made in the casualty, reasonable adjustment was made for
24 Clifford minutes before she died, and yet in that
25 20-hour period where reasonable adjustment could have
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1 been a huge benefit, and it was just denied, it just
 2 denied.
 3 **Q.** Let me ask you about that, because if we go, please, to
 4 page 10 of the document that may still be on the screen,
 5 there is reference in the review to whether sufficient
 6 reasonable adjustments were made in light of Susan's
 7 learning disabilities.
 8 Can you see there in the middle of the page,
 9 Mr Sullivan, reference to:
 10 "The patient was not referred to the acute liaison
 11 nurse ..."
 12 It's the second paragraph.
 13 **A.** Yeah.
 14 **Q.** "... resultantly there is no evidence to suggest the
 15 Trust's Learning Disability Team were involved in the
 16 patient's care despite the service being available
 17 throughout the pandemic. This may in part have been due
 18 to the relatively short time [Susan] was in [the
 19 hospital] ([less than] 28 hours) and that this service
 20 is not available at weekends."
 21 But while Susan was in the hospital, obviously
 22 family weren't allowed in?
 23 **A.** Yeah.
 24 **Q.** Do you know if any liaison learning disability team went
 25 to speak to Susan?

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1 up or were online?
 2 **A.** Yeah. Well, yeah. We delayed the funeral. We couldn't
 3 even go to her cremation because my illness, my cancer,
 4 had taken over and I was having serious treatment, and
 5 I couldn't go and my wife was in no state, and she -- we
 6 couldn't even go to her cremation, but then once the
 7 time changed and our son and my grandson was allowed to
 8 come from Australia, we had a memorial for her, and over
 9 240 people turned up at the memorial and then there were
 10 people watching it in Canada, in America, in Spain,
 11 in -- you know, I mean, everywhere. You know, Susan
 12 didn't matter to maybe them doctors, but she mattered to
 13 all those hundreds of people that took the day off to
 14 attend her memorial, do you know what I mean, so it
 15 was -- she was just, you know, one of life's special
 16 people, like, you know what I mean, she really was.
 17 **Q.** A couple of final things from me. I think in due course
 18 you -- and we can take that page down, please -- you
 19 made a complaint in due course to the hospital -- and
 20 we've just been looking at some of the review
 21 documents --
 22 **A.** Yeah.
 23 **Q.** -- was that prompted by an article you did for
 24 The Guardian?
 25 **A.** Yeah, actually what happened is that, for personal

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1 **A.** No.
 2 **Q.** Tried to help with the communication?
 3 **A.** No.
 4 **Q.** Anything like that?
 5 **A.** Nobody. Nobody. She was left to her own devices.
 6 **Q.** Do you think speaking to someone from the Learning
 7 Disability Team would have helped Susan?
 8 **A.** Oh, absolutely, you know what I mean? I mean, you know,
 9 at the end of the day the thing is when you're dealing
 10 with somebody with learning difficulties it's, it's
 11 either -- it's something you learn over years or you
 12 have an inborn empathy for. And, you know, I'm sure
 13 they would have made a difference.
 14 **Q.** I think you've already mentioned that just before Susan
 15 died, Clifford was allowed to go and be with her?
 16 **A.** Yeah.
 17 **Q.** And he was with her when she passed away at about --
 18 **A.** She died in his arms.
 19 **Q.** The cause of death on her death certificate was
 20 Covid-19; is that right?
 21 **A.** Yeah.
 22 **Q.** And Down's Syndrome?
 23 **A.** Yeah.
 24 **Q.** And I think in due course, although there was a delay to
 25 the funeral, is it right that hundreds of people turned

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1 reasons, I didn't trust the hospital's complaints
 2 department. That's why I've got a syringe driver bag on
 3 me now, keeping me alive. So I didn't trust that
 4 system. I needed people with disabled families,
 5 disabled loved ones, to know that, you know, you --
 6 we're not getting a good deal here, we're not getting a
 7 good deal here. And Bereaved Families for Justice put
 8 me on to Shanti Das at The Guardian, and
 9 I thought: that's great, because that gets the message
 10 across.
 11 **Q.** Pause there then, and we'll look briefly at the article.
 12 It's behind your tab 3, and can I put onscreen -- thank
 13 you very much.
 14 This is a copy of the article. We see you there,
 15 and is that Ida?
 16 **A.** That's Ida, yeah.
 17 **Q.** And there's a photo of Susan.
 18 **A.** Yeah.
 19 **Q.** I think this essentially was you setting out Susan's
 20 story, as you have done today. Is that right?
 21 **A.** Yeah.
 22 **Q.** And you putting in the public domain what was written on
 23 Susan's records?
 24 **A.** Yeah.
 25 **Q.** And you trying to seek answers on her behalf?

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1 A. Yeah.

2 Q. And then did the hospital start the investigation?

3 A. Yeah, just out the blue I got a letter. It must have --

4 somebody must have read it and I got a letter advising

5 me that they were going to undertake a serious incident

6 investigation. Which they did. Which they did.

7 Q. Thank you.

8 And we can take that down because we've been looking

9 at the some of the investigation documents as you have

10 been giving evidence.

11 Can I ask you this, please, Mr Sullivan: obviously

12 there are concerns about what happened to Susan, but can

13 I just ask you generally about your views about the NHS?

14 A. I'm here because of the NHS. I've great time for the

15 NHS, for the doctors and for the nurses. I'm not going

16 to say I've got great time for the management, you know

17 what I mean, but I have for the doctors and nurses.

18 They're fabulous people, they're fantastic people. And

19 I'm not here to knock any doctor or any nurse.

20 You know, they do a brilliant job and I've got nothing

21 but pride for them. I mean, they looked after my wife

22 who's really been seriously ill as well. I don't want

23 anybody to think that I'm here to knock the doctors and

24 the nurses, but if they want me to think I'm here to

25 knock the management, then ...

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1 "Well, you know, that's just the luck of the draw",

2 isn't it? But I said in that Guardian article, before

3 the serious investigation -- I knew Susie, I nurtured

4 her, I loved her, I've spent all my time with her, and

5 I knew that she just needed a little bit of moral

6 support, but I said in that Guardian article they gave

7 her a bed to die in. And when I read all of this,

8 serious incident investigation and the treatment that --

9 at the casualty, where they didn't want to talk to mum,

10 didn't want to talk to dad, all of a sudden we're

11 talking about DNAR before we're talking about -- one

12 minute they're going to consider -- you know what

13 I mean? When I read all that, it just sadly makes me

14 write: what they did, they gave her a bed to die in, and

15 they gave her a bed to die in because she had

16 Down's Syndrome, end of.

17 Q. I think you concluded your statement by saying this:

18 "Providing this statement to the Covid Inquiry has

19 allowed me to give Susan and her disabled peers

20 a voice: that has been my motivation."

21 A. That's -- I don't -- I don't want -- I don't want any

22 parent that have invested their whole life in protecting

23 and raising a child with Down's Syndrome from an infant

24 to an adult, I don't want them to go through what we've

25 gone through. They've got to learn that people with

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1 Q. I understand.

2 A. ... go for it.

3 Q. It's probably obvious to all of us, but can you sum up

4 to us the impact of losing Susan in the way that you did

5 on you and Ida and Clifford and her other brother?

6 A. The impact on me, on my wife was devastating. I mean,

7 you know, I mean, you know, it's a -- first of all me,

8 within a month -- Susie passed on 28 October, and on

9 May 9 I was in the Royal Free Hospital having nuclear

10 medicine treatment that lasted ten months. So the

11 impact on my health was massive.

12 Q. Yes.

13 A. I mean, I've -- you know, enormous. And it might be

14 an old wives' tale, but my wife had breast cancer

15 28 years ago and with all the upset and all the shock

16 and everything -- you know, some people say that shock

17 can bring it something back, and it came back, and she's

18 had to have a double mastectomy and -- you know what

19 I mean? So we've gone through hell and back. And the

20 thing about it is you die, a part of you dies when your

21 child dies. And dealing with the death of a child is

22 one thing, but dealing with the death of a child because

23 nobody gave her a chance of life is a completely -- is

24 the hardest thing to deal with, you know what I mean.

25 If she'd have just died of Covid, then we've got to say,

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1 a disability have got as much value as anybody else in

2 this life, and to just cast them away as though they're

3 of no importance and -- is wrong. And when the next

4 pandemic comes, I just hope to God me sitting here just

5 for this, while -- and me struggling with the NHS lie

6 machine for the last three years, that's had a massive

7 impact on my health, I just hope that when the next

8 pandemic comes along disabled people are treated with

9 a bit more respect and a little bit more consideration.

10 And that's why I'm here. I wouldn't be here otherwise.

11 And the most important thing, for the first time

12 today, in an official capacity, disabled people are

13 being given a voice, which they have been denied.

14 MS CAREY: My Lady, that is all I wanted to ask.

15 LADY HALLETT: Mr Sullivan, I've got no questions for you,

16 just a couple of comments. You're right, Susie does

17 matter, and disabled people matter and you've done

18 a huge amount to ensure that people understand that.

19 THE WITNESS: Thank you.

20 LADY HALLETT: She was obviously a very special person and

21 you at least had 56 years with her.

22 THE WITNESS: Yeah.

23 LADY HALLETT: All I can say is that it sounds as if you had

24 56 years because of the love and devotion that you and

25 your family showed her. So thank you so much for what

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1 you've done to get people to understand that disabled
 2 people matter, and Susie mattered.
 3 **THE WITNESS:** Thank you very much.
 4 (The witness withdrew)
 5 **MS CAREY:** Thank you, my Lady.
 6 **LADY HALLETT:** Very well, I shall break now and return in
 7 five minutes.
 8 (2.37 pm)
 9 (A short break)
 10 (2.42 pm)
 11 **MS NIELD:** My Lady, may I please call Paul Jones, who can be
 12 sworn.
 13 **MR PAUL JONES (affirmed)**
 14 **Questions from COUNSEL TO THE INQUIRY**
 15 **LADY HALLETT:** Mr Jones, thank you very much. Please take
 16 a seat. Thank you very much for coming along to assist
 17 the Inquiry. I can imagine --
 18 **THE WITNESS:** Thank you, my Lady.
 19 **LADY HALLETT:** -- how difficult it is for you. If at any
 20 stage you need a break, please say.
 21 **THE WITNESS:** Okay, thank you very much. Thank you.
 22 **MS NIELD:** Can I start by asking you please to give your
 23 full name.
 24 **A.** Yes, my name is Paul Jones.
 25 **Q.** I'm going to ask you, please, throughout your evidence

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1 doctors surgery in Tonypany, where she was
 2 an administration assistant and a bit of an IT guru as
 3 well. So she was also doing an Open University degree,
 4 initially in IT and then towards the end of her degree
 5 in social work.
 6 She had a heart of gold, she was our princess, she
 7 loved music, loved film. She went to many concerts over
 8 the years, particularly at the Principality Stadium.
 9 Yeah, she just loved life and, yeah, she was our
 10 princess.
 11 **Q.** I think she had a taste for travelling and, at one
 12 point, had wanted to be cabin crew; is that right?
 13 **A.** That's correct, yes. She -- her goal was initially to
 14 join one of the main airlines as cabin crew. She loved
 15 travelling. We used to take her on holidays, I think
 16 she went on holidays from the age of two with us, and
 17 yeah, she just absolutely loved travelling. She loved
 18 flying, so she was her initial sort of goal, was to be
 19 cabin crew with one of the airlines. Unfortunately,
 20 because of an injury to her foot, she wasn't able to
 21 follow that sort of line of work, unfortunately, but,
 22 like I say, she found a line of work that she enjoyed
 23 anyway.
 24 **Q.** I think because of that problem with Lauren's foot, she
 25 used crutches to relieve some of the pressure on her

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1 to try to keep your voice up -- you've got a nice clear
 2 voice -- so that we can hear you but also so that your
 3 evidence can be recorded. If I ask you a question that
 4 you don't understand or that isn't clear, then please
 5 say so and ask me to rephrase it or repeat it.
 6 **A.** Okay, thank you.
 7 **Q.** Mr Jones, you have provided a witness statement to the
 8 Inquiry which is dated 20 June 2024, that's at
 9 INQ000486000, and your signature is on page 8 of that
 10 witness statement. Are the contents of that statement
 11 true to the best of your knowledge and belief?
 12 **A.** Yes, they are.
 13 **Q.** Thank you.
 14 Now, Mr Jones, you're here to tell us about the
 15 circumstances in which you and your wife tragically lost
 16 your daughter, Lauren, to Covid-19 on 30 December 2020;
 17 is that right?
 18 **A.** That's correct, yes.
 19 **Q.** I think Lauren was just 25 years old?
 20 **A.** Yes, that's correct.
 21 **Q.** Could you please tell us a little something about
 22 Lauren?
 23 **A.** Yeah. As you say, Lauren was 25 years old. She was
 24 myself and my wife Karen's only child. She lived with
 25 us in the Rhondda, she worked with Karen at St Andrews

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1 foot; is that right?
 2 **A.** That's correct, yeah, just to relieve the pressure on
 3 her right foot, yeah.
 4 **Q.** I think it was diagnosed as chronic regional pain
 5 syndrome?
 6 **A.** Yes, that's correct.
 7 **Q.** Other than that pain syndrome with her foot, did Lauren
 8 have any other underlying health problems?
 9 **A.** No, she had no other underlying health problems, no.
 10 **Q.** I think, in addition to working with your wife at the GP
 11 surgery, she also did some agent work selling cosmetic
 12 products in the homes around your local area; is that
 13 right?
 14 **A.** That's correct, yeah. She was a representative for Avon
 15 and Body Shop, she used to go round to the local
 16 community, friends, family, taking orders and she'd
 17 enjoy sort of putting the orders together and delivering
 18 them sort of -- yeah, delivering them round the houses
 19 and I'd take them to work with me for sort of colleagues
 20 of mine in work and, yeah, she just -- like I say, in
 21 the community, she just highly thought of because of
 22 that. Yeah, she just -- she was a workaholic, I
 23 suppose, to an extent, yeah.
 24 **Q.** Thank you.
 25 Now, you've explained that your wife worked with

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1 Lauren at the same GP surgery. I think your wife,
 2 Karen, was a surgery practice manager; is that right?
 3 **A.** That's right, yeah, yeah.
 4 **Q.** During the pandemic, I think both Karen and Lauren were
 5 required to go into the GP surgery to work?
 6 **A.** That's correct, yeah, yeah, they were, yeah.
 7 **Q.** I think Lauren was there three days a week?
 8 **A.** Yes, correct, yeah.
 9 **Q.** Your wife worked in an office by herself during the
 10 pandemic?
 11 **A.** Yes, primarily, yes, yeah.
 12 **Q.** She was supplied with PPE in her work role; is that
 13 right?
 14 **A.** Yes, they were, yeah, yeah.
 15 **Q.** At the time when Lauren was also working in the GP
 16 surgery during the pandemic, were there many other staff
 17 members working there?
 18 **A.** I think they had quite a few sort of members of staff
 19 working there. I don't know the exact amount but, yeah,
 20 most of them worked through the pandemic, yeah.
 21 **Q.** Now, in terms of your work, I think you work for the
 22 South Wales Police; is that right?
 23 **A.** That's correct, yeah, yeah.
 24 **Q.** You're a response sergeant with that force?
 25 **A.** I am, yes.

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

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

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1 **Q.** I think about a week after that briefing had been held,
 2 you found out that a number of police officers who had
 3 attended the briefing had become ill with Covid-19
 4 symptoms?
 5 **A.** Yes, that's right, yeah, yeah.
 6 **Q.** A number of those were from the same team; is that
 7 correct?
 8 **A.** From the same -- from the same sort of station and
 9 primarily off the team I was on, yeah.
 10 **Q.** I think you began to experience some symptoms of Covid
 11 around 9 December; is that right?
 12 **A.** Yes. It would have been around about the sort of middle
 13 of the week, the following week, about 9 December, yeah.
 14 **Q.** What were your first symptoms?
 15 **A.** Initially, just sort of cold symptoms, which I thought
 16 nothing of. They weren't your normal sort of three
 17 sort of Covid symptoms, which they were -- they'd said
 18 about throughout the pandemic, but -- so I thought
 19 nothing of it at the time.
 20 **Q.** Did there come a point when your sense of taste began to
 21 change?
 22 **A.** It did, it would have been probably, probably 10 or
 23 11 December, my sort of taste sort of was different.
 24 I had a drink at home and it didn't seem to -- it tasted
 25 a bit stale.

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1 Q. I think by 13 December 2020 when you woke up for work,
 2 you were feeling unwell by that point?
 3 A. I didn't feel as I should have. But, again, didn't
 4 really have sort of what I would -- what they were
 5 describing as the three sort of symptoms of Covid at the
 6 time.
 7 Q. I think the next day you had to pick your wife up from
 8 work because she had a very high temperature at that
 9 point?
 10 A. That's correct, yeah, yeah. She phoned me to say she
 11 had a high temperature at work and could I pick her up
 12 because we'd have to try and arrange a sort of Covid
 13 test.
 14 Q. Did you manage to arrange a Covid test?
 15 A. We did for the following day, yes.
 16 Q. Who was tested then that day?
 17 A. Myself, Karen and Lauren were tested that day.
 18 Q. I think your results came back three days later on the
 19 17th?
 20 A. That is correct, yeah, yeah.
 21 Q. What were the results at that point?
 22 A. So myself and Karen came back as Covid positive, and
 23 Lauren was negative at the time.
 24 Q. Then over the next few days, how were you feeling?
 25 A. Initially I didn't feel too bad but then over the space

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

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1 of probably the next two or three days my sort of health
 2 rapidly deteriorated, yeah, felt really terrible.
 3 Q. I think Lauren and Karen, because of their role as
 4 frontline workers, were actually due to be given their
 5 first vaccinations in that week that they fell ill; is
 6 that right?
 7 A. That's correct, yeah, yeah.
 8 Q. But they couldn't go and get their vaccinations because
 9 they had to isolate?
 10 A. That's right, yeah, yeah.
 11 Q. So by 20 December, I think you were feeling very unwell
 12 indeed?
 13 A. I was, yes. The early hours of the morning of
 14 20 December, I was really struggling. I was sat on the
 15 edge of my bed early hours of the morning and
 16 I remember -- I remember Lauren waking up, coming in to
 17 see me and saying that she was going to phone 111
 18 because she didn't like the sort of way I sort of looked
 19 and from an illness point of view, so, yeah, Lauren was
 20 looking after me from day one really.
 21 Q. And did Lauren manage to get through to 111?
 22 A. She phoned 111, I believe she spoke to them, she
 23 explained my symptoms to them and they said they would
 24 phone back in a sort of short period of time, I think
 25 within the next four hours.

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1 A. Yes, I was given an intravenous drip with some glucose
 2 and antibiotics, and eventually my blood oxygen levels,
 3 my sats, were high enough for them to -- deemed for me
 4 to be released. And they sent me home -- with some
 5 antibiotics at the time, yes.
 6 Q. How long had you been in hospital then approximately?
 7 A. I think I was probably in for about six to eight hours,
 8 I think.
 9 Q. Thank you. So once you were discharged, Lauren picked
 10 you up --
 11 A. Yeah, she came and she drove back down and picked me up
 12 then, yes, yeah.
 13 Q. If I can come on to two days later, that's 22 December.
 14 A. Yes.
 15 Q. I think at that point your wife Karen was feeling --
 16 A. She was, yes, yeah, she was feeling really ill herself
 17 then. Yeah, she had really bad palpitations and again
 18 phoned for an ambulance at the time.
 19 Q. Before she called an ambulance, did she try to contact
 20 111?
 21 A. I can't remember whether she tried to contact 111.
 22 I think we -- from what I can remember, I think we tried
 23 to phone an ambulance I think, potentially.
 24 Q. Was an ambulance able to come?
 25 A. No, it wasn't, no, no.

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

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1 same evening?
 2 **A.** They were certainly discharged home, yes. I think they
 3 arrived home about 10 o'clock, I think.
 4 **Q.** So these are the events of 22 December, so we're coming
 5 into the Christmas period.
 6 **A.** That's correct, yeah.
 7 **Q.** And over that period, I think you and your wife started
 8 to feel a little bit better?
 9 **A.** As the week went on, because of the sort of medication,
 10 certainly I was on, yeah, I -- I'd started to obviously
 11 feel a little bit sort of better as the week went on,
 12 yeah.
 13 **Q.** But Lauren's symptoms were getting worse at that point?
 14 **A.** They seemed to get a little bit worse but not to the
 15 extent that we thought there was sort of any particular
 16 problem, because of her -- because of her age, really.
 17 **Q.** And you were able to spend Christmas Day and Boxing Day
 18 watching films together?
 19 **A.** Yeah, that's correct, yeah, we did. We loved watching
 20 films together and, yeah, we did throughout
 21 Christmas Day, Boxing Day, and then things started to
 22 change.
 23 **Q.** So then if I can ask about that. The following day,
 24 27 December, after Boxing Day, I think in the early
 25 hours of the 27th Lauren began to feel quite unwell and

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

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

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

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1 help her and that -- if I wanted to discuss that matter.
 2 I said I was -- you know, I'd discuss with them there
 3 and then on the Sunday evening, on the 27th, but they
 4 said, "No, there's no rush to speak about it tonight,
 5 we'll speak to you about it tomorrow", on Monday the
 6 28th. Unfortunately, that conversation never took
 7 place.
 8 **Q.** That conversation didn't take place?
 9 **A.** I was never told anything about any trial medication the
 10 following day.
 11 **Q.** I think there came a point where you had a conversation
 12 with the hospital about transferring Lauren to the
 13 intensive care unit.
 14 **A.** That was on the Monday night. That would have been
 15 28 December. We were told that she was transferred to
 16 intensive care. We were told that she wasn't doing too
 17 well that and she would be needed to be put on
 18 a ventilator that night, on the Monday night.
 19 **Q.** So the concern at that point was she was not doing so
 20 well on the CPAP --
 21 **A.** That's correct, yes --
 22 **Q.** -- and needed to be ventilated?
 23 **A.** -- and needed to be ventilated, yes, that's correct.
 24 **Q.** It was likely that it would be that evening that that --
 25 **A.** Yeah, they told me that it would be sort of happening

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

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

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

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

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

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

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1 down the hospital now". So yeah, that's when we got in
 2 the car and drove down to the hospital.
 3 **Q.** So the hospital where Lauren was being treated didn't
 4 seem to be aware that that --
 5 **A.** No.
 6 **Q.** -- decision about her treatment had been taken already?
 7 **A.** That's correct, yeah, not all members of staff there.
 8 There was certainly some miscommunication somewhere,
 9 yeah.
 10 **Q.** I think you were able to speak to the consultant who had
 11 been looking after Lauren?
 12 **A.** Very briefly when we got there, the consultant came in
 13 to speak to us in a room, took us into a sort of side
 14 room, and said that they'd done everything they could
 15 for Lauren and that she wouldn't survive the night,
 16 unfortunately. Like I say, I -- personally, I didn't
 17 think they'd done everything they could because I think
 18 the ECMO treatment should have been made available to
 19 her.
 20 **Q.** Can you tell us how was that news about Lauren's
 21 condition conveyed to you, what was the tone of the
 22 consultant?
 23 **A.** It was almost as if it was the normal thing for
 24 a 25-year old to lose their life to Covid.
 25 **Q.** I think you were told by the consultant that Lauren

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1 **A.** Yeah, we were. We were able to stay with her, I --
 2 I think -- we weren't sort of given a timescale as such,
 3 but we were able to stay with her. But then, like
 4 I say, we chose -- you know, they'd have to take all the
 5 sort of ventilator out and take the lines out, so we
 6 didn't want to see that being done.
 7 **Q.** I think once you were leaving the hospital, you and your
 8 wife, you were given Karen's (*sic*) belongings in
 9 a plastic bag; is that right?
 10 **A.** Yeah, yeah, Lauren's belongings, yeah. Yeah, two
 11 plastic bags we were given, sealed plastic bags.
 12 **Q.** I think you were told you couldn't open those bags for
 13 ten days?
 14 **A.** And we were told we couldn't open them -- "Don't open
 15 them for ten days."
 16 **Q.** When you did open them, you discovered some missing
 17 items and some damage to her clothes; is that right?
 18 **A.** Well, the shoes she was wearing when I took her to the
 19 hospital on the Sunday, they were missing, and
 20 subsequently I made efforts to -- with the hospital to
 21 find them afterwards, because they were
 22 sentimental value to us. But they never found them,
 23 so ... and then when eventually we did open the plastic
 24 bags, they'd put a T-shirt that Lauren was obviously
 25 wearing at the time, I'm guessing when they would have

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1 having been on 100% oxygen had done some damage to her
 2 lungs; is that right?
 3 **A.** That's right, yeah. They said that she'd been on high
 4 pressure oxygen to try and get her sats up, her blood
 5 oxygen levels, and they said that they had to put her on
 6 100% oxygen to try and do that, and that would have
 7 caused sort of significant damage to her lungs
 8 potentially.
 9 **Q.** What were you told about, then, her prognosis, her
 10 options for treatment?
 11 **A.** There were none, there weren't any other options for
 12 treatment unfortunately. We sat down by the side of
 13 Lauren, and they told us we'd have to decide when to
 14 switch her life support off.
 15 **Q.** I think having made that decision, you were able to go
 16 and see Lauren then at that point?
 17 **A.** Yeah, we were already sitting next to her at that time,
 18 yeah, we went to see her, and she was pretty much in
 19 a room -- or in a room with other patients almost next
 20 to the room where the consultant told us.
 21 **Q.** Then I think, having switched off the ventilator, Lauren
 22 sadly passed away at 4.04 that morning.
 23 **A.** That's correct.
 24 **Q.** I think you and your wife were able to stay with her for
 25 just 30 minutes.

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1 had to ventilate her, and the T-shirt had obviously been
 2 either ripped or cut up the middle for them to do
 3 whatever they had to do at the time.
 4 **Q.** How did that make you feel? Had you been notified that
 5 those things had happened to Lauren's clothing?
 6 **A.** No, no, not at any time had we been told that sort of
 7 anything like that had happened. Like I say, we were
 8 just -- we were obviously told she had to be ventilated,
 9 but it was obviously clear that something had gone
 10 sort of very wrong at some point.
 11 I'm guessing they maybe had to do an emergency
 12 ventilation, but that's only a guess, I've never --
 13 I haven't been told that officially, but from the state
 14 of her T-shirt, I'm guessing that would have been the
 15 case, yeah.
 16 **Q.** I think you made a request to access Lauren's medical
 17 notes and you obtained those?
 18 **A.** That's correct, yeah, I've got them and I've read
 19 through them quite -- quite a lot, and had meetings with
 20 the doctors as well, because I just wasn't happy with
 21 what had happened.
 22 **Q.** I think it transpired from those medical notes that when
 23 you had asked why Lauren wasn't going to be ventilated
 24 on 27 December you were told that her oxygen saturation
 25 levels were better than they'd originally thought, so

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1 she didn't need to be ventilated?

2 **A.** That's right, yeah. And I think the -- from what I can
3 remember, they also told me that it was Lauren's
4 decision not to be ventilated, which again I kind of
5 found strange because if it was the best option for her
6 then maybe they should have involved myself and Karen in
7 a discussion with Lauren and maybe we could have spoken
8 to Lauren and sort of maybe suggested that she went on
9 the ventilator to help her. But they said that it was
10 Lauren's decision as well not to be ventilated. They
11 also, as I say, told me that throughout the night her
12 oxygen levels were better than expected, so that was
13 another reason they didn't ventilate her. I don't know
14 what to believe, to be honest.

15 **Q.** I think that the notes from the hospital indicated that
16 in fact when they ventilated Lauren on 29 December her
17 oxygen saturation levels were at 10% at that point?

18 **A.** That's correct, yeah, they'd dropped obviously to
19 a life-threatening level unfortunately.

20 **Q.** I think a nurse told you in fact that they nearly lost
21 Lauren at that point?

22 **A.** That's correct, they told us that when we were actually
23 sitting by her bedside before we'd sort of made the
24 decision to switch her ventilator off, it was almost
25 a passing comment, in the fact that they said "We almost

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1 communication, decisions made that were -- that
2 certainly we weren't consulted with, decisions that
3 probably should have involved maybe a conversation with
4 Lauren as well. Maybe even the chance to speak to
5 Lauren at some time would have been -- or text message
6 to her would have been helpful, but we had absolutely no
7 communication whatsoever. Really poor. And it was
8 a terrible experience.

9 **Q.** Can you sum up, Mr Jones, how the loss of Lauren has
10 impacted your and your wife's lives?

11 **A.** It's left a huge hole in our lives, lives of our family.
12 Lauren was a gift to us. We'd lost a child back about
13 a year and a half before we had Lauren, through
14 something totally different, during pregnancy, so
15 Lauren -- because we had to go through genetic testing,
16 Lauren was our gift, and so it's left a massive hole in
17 our lives and something we'll never fill again. To see
18 that sort of empty seat in our house every day is
19 a constant reminder of how the sort of pandemic has
20 affected us.

21 **MS NIELD:** Thank you very much, Mr Jones. I appreciate that
22 that won't have been easy but I have no more questions
23 for you.

24 **LADY HALLETT:** Mr Jones, thank you so much. As a parent,
25 I can't imagine the grief that you and your wife are

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1 lost Lauren when we ventilated her at 4.30", which
2 really took us aback because that wasn't mentioned at
3 any time either during the phone call at 4.45 or the
4 phone call at 8 o'clock.

5 **Q.** You say in your witness statement that you believe that
6 Lauren was left to struggle and suffer on CPAP?

7 **A.** Yes, yeah, I think she was. By what I've been told, she
8 was struggling to breathe. And from reading her notes,
9 she was struggling to breathe before she was ventilated.

10 **Q.** Is it right that you subsequently found out that someone
11 known to you who was much older than Lauren who had also
12 been on ward 3 was ventilated the night that Lauren was
13 initially --

14 **A.** Yeah, that's correct, I found that out, yeah, from
15 another -- from -- it was a sort of friend of ours had
16 been in hospital I think a number of weeks and was
17 ventilated the same night as Lauren probably should have
18 been.

19 **Q.** And that person made a full recovery?

20 **A.** Eventually they did -- they have, yes, yeah, yeah.

21 **Q.** Mr Jones, it's perhaps evident from what you've told us
22 this afternoon, but how would you describe your
23 experience with the health service around Lauren's
24 critical illness with Covid-19?

25 **A.** Our experience was just shocking, really poor

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1 suffering. But I hope that you've understood just how
2 grateful we are for you to come along and explain what's
3 happened to you because one of the reasons it's so
4 important, it's not merely the impact on the bereaved,
5 which obviously is exceedingly important, but it's also
6 there are still some who think that the Covid pandemic
7 only affected those who are older or those who had other
8 conditions, and what your evidence does, your awful
9 tragic experience helps us remind us it was not just
10 those who were older or had other conditions.

11 **THE WITNESS:** That's right, yeah.

12 **LADY HALLETT:** So thank you for coming and let's hope you
13 can find a way to come to terms with that huge hole.

14 **THE WITNESS:** Thank you for the opportunity of me being able
15 to tell Lauren's story and I hope it helps the Inquiry.
16 Thank you, my Lady. Thank you very much.

17 **LADY HALLETT:** Thank you. I shall take a break until 3.40.

18 **(The witness withdrew)**

19 **(3.31 pm)**

20 **(A short break)**

21 **(3.40 pm)**

22 **LADY HALLETT:** Ms Nield.

23 **MS NIELD:** My Lady, may I please call Carole Steele, who can
24 be sworn.

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1 **MS CAROLE STEELE (sworn)**
 2 **(Evidence via videolink)**
 3 **Questions from COUNSEL TO THE INQUIRY**
 4 **LADY HALLETT:** Ms Steele, I'm sorry if you have been kept
 5 waiting, I hope you haven't, but thank you so much for
 6 coming along to help us.
 7 **THE WITNESS:** Thank you.
 8 **MS NIELD:** Could you please state your full name?
 9 **A.** It's Carole Evans Steele.
 10 **Q.** Could I ask you please to keep your voice up so that we
 11 can hear you but also so that your evidence can be
 12 recorded, and if I ask you a question that you don't
 13 understand, then please say so and ask me to repeat it
 14 or rephrase it, and I'll try to do so.
 15 **A.** Okay.
 16 **Q.** Mrs Steele, you have kindly provided a witness statement
 17 to the Inquiry, which is dated 9 July 2024, and it has
 18 the reference number INQ000492925.
 19 Your signature is on page 12 of that witness
 20 statement. Mrs Steele, can you confirm that the
 21 contents of that statement are true to the best of your
 22 knowledge and belief?
 23 **A.** Yes, I can.
 24 **Q.** Thank you very much. You're here today to tell us what
 25 happened in relation to the tragic death of your son,

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1 **Q.** I think Andrew lived with his girlfriend in an apartment
 2 in the same town as you; is that correct?
 3 **A.** That's correct, yes, just a few minutes in the car and
 4 maybe a 15-minute walk from our house.
 5 **Q.** During the pandemic, was Andrew working at home or was
 6 he going into the office?
 7 **A.** He was furloughed and he was working at home. The very
 8 odd occasion he would go in to retrieve the documents
 9 that he needed for work but mostly he worked from home.
 10 **Q.** What about his girlfriend, I think she had a job as
 11 an office assistant?
 12 **A.** She -- at that time she worked, she worked from home,
 13 the business that she worked for had provided laptops
 14 for home working, so they shared -- Andrew and his
 15 girlfriend shared an office in their apartment. Things
 16 did change and the management of the business that she
 17 worked for started to just increase demand for working
 18 on site instead of working at home, so a rota was set
 19 up.
 20 **Q.** I think that was around the autumn of 2020; is that
 21 right, when his girlfriend was being asked to go into
 22 the office more often?
 23 **A.** She was, and it concerned -- it concerned Andrew and it
 24 concerned -- it concerned us because that just wasn't
 25 happening in other workplaces and it concerned us even

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1 Andrew Steele, who died from Covid on 2 January 2021; is
 2 that right?
 3 **A.** Yes, that's right.
 4 **Q.** I think Andrew was just 28 years of age?
 5 **A.** He was, he was 28.
 6 **Q.** He was a fit and healthy young man, he didn't have any
 7 underlying health conditions or illnesses; is that
 8 right?
 9 **A.** He had no illnesses, the only thing he did have was
 10 hay fever.
 11 **Q.** I think in fact he was a very talented artist and had
 12 studied at Strathclyde University and then at Edinburgh
 13 Napier University, and was working as an architectural
 14 technician; is that correct?
 15 **A.** That's right. He also -- his main hobby was painting,
 16 he was a very talented artist.
 17 **Q.** Thank you. I think he was also a former Tae Kwon Do
 18 black belt Scottish champion; is that right?
 19 **A.** He was, yes.
 20 **Q.** Whilst he was at home during the pandemic, he had set up
 21 a small home gym in his home office and was keeping fit
 22 throughout the pandemic; is that right?
 23 **A.** Yes, as much as he could, as I think there was times
 24 that we were only allowed out once a day for a walk. So
 25 it was as much as he could.

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1 more when we realised that the office she was working
 2 in, there was no, no adequate social distancing or
 3 ventilation.
 4 **Q.** In fact, I think around the middle of December there was
 5 an outbreak of Covid-19 at Andrew's girlfriend's place
 6 of work?
 7 **A.** There was, yes, and very quickly she -- she was asked to
 8 isolate, get a test and isolate, which she did, as her
 9 manager had tested positive for Covid.
 10 **Q.** I think, in fact, Andrew's girlfriend began to
 11 experience some symptoms of Covid-19 and went for a test
 12 herself?
 13 **A.** She did. She did go for a test, and followed by Andrew,
 14 and they were both positive.
 15 **Q.** I think Andrew's girlfriend's test result came back on
 16 21 December, and Andrew's positive result came back on
 17 the 23rd; is that right?
 18 **A.** Yes, we were hoping -- at that time in Scotland we were
 19 hoping that we could see each other outside on Christmas
 20 Day but we couldn't.
 21 **Q.** I think also -- I'm sorry, Mrs Steele, please carry on.
 22 **A.** Just because they both tested positive, that arrangement
 23 couldn't go ahead.
 24 **Q.** So they had to isolate at home?
 25 **A.** Yes.

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

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- 1 and get through things, through his symptoms.
2 **Q.** Is it right that at that time you were aware that the
3 local hospital was at full capacity?
4 **A.** Yes, I remember from social media that our local
5 hospital was at capacity, yes.
6 **Q.** So the following day, which was New Year's Day, I think,
7 after Andrew had placed that call to NHS 24, I think you
8 had some contact with him by telephone and by Messenger;
9 is that right?
10 **A.** Yes, we kept in touch. He felt slightly better the next
11 day and I remember -- I remember hearing other patients
12 that this could be a trend that on your ninth, tenth day
13 you could feel a bit better and then, after that, there
14 was a slump. But we didn't know that at that time,
15 I just know that now.
16 But, yes, we made contact and I just wanted to check
17 if they needed anything, if they wanted dinner. We made
18 sure that they had food, that they had fresh things and
19 some meals, and he was keen, he felt well enough and
20 keen to have his dinner. So we arranged to drop off New
21 Year's Day dinner, which they would pick up -- you know,
22 we didn't actually meet with them but we would drop it
23 off and they would pick it up.
24 **Q.** So you left it on the doorstep, as it were?
25 **A.** Yes.

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

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

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1 where you were living.
 2 **A.** We did, we went round, and we went straight into the
 3 apartment. We just didn't think that there was a danger
 4 of infection, it was just -- just something that we just
 5 did on automatic pilot, we just went straight in, and we
 6 found Andrew on the living room floor and his girlfriend
 7 was performing CPR.

8 **Q.** And I think at the time that you arrived, Andrew -- you
 9 were able to see his lips were blue, and his eyes were
 10 half open, and Andrew's girlfriend asked you to check
 11 for a pulse, and you couldn't feel any pulse at that
 12 point; is that right?

13 **A.** Yes, I couldn't feel anything. I could hear the
 14 ambulance service person on the phone giving his
 15 girlfriend instructions. I was in the living room on
 16 the floor with Andrew and his girlfriend, and my husband
 17 and my daughter were in the hallway.

18 **Q.** I think you were then holding Andrew's hand while his
 19 girlfriend performed CPR?

20 **A.** Yes.

21 **Q.** Paramedics then arrived within a relatively short time?

22 **A.** Yes.

23 **Q.** And --

24 **A.** I don't have the exact time, but it seemed fairly quick.
 25 I believe that two ambulance crews arrived and the

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1 explained that Andrew just had hay fever, and you went
 2 to look in the kitchen bin to see if there was any signs
 3 of any medication that he had taken; is that correct?

4 **A.** That's correct, but I couldn't see -- I couldn't see
 5 anything. But I wasn't really sure what they were
 6 looking for, but there was nothing.

7 **Q.** The doctor at that point I think explained to you that
 8 the paramedics hadn't been able to get his heart
 9 restarted and Andrew was going to be taken to the local
 10 hospital. And I think there were some difficulties in
 11 getting Andrew out of the apartment because it was three
 12 floors up, with -- so there was some difficulty in
 13 getting him down the stairs and out into the ambulance.

14 **A.** Yes. There were -- I think there were four staff
 15 carrying the -- I've forgotten the name of it, they were
 16 carrying him, and he kept slipping off and they would
 17 have to stop and try and put him back on again. My
 18 husband -- I couldn't look at it but my husband -- my
 19 husband was there and he tried to help.

20 **Q.** I think once Andrew was placed into the ambulance, he
 21 was taken straightaway to the local hospital and you
 22 followed in your car?

23 **A.** We did.

24 **Q.** And that journey didn't take very long, about
 25 15 minutes; is that right?

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1 doctor that was on call, and I'm sure there was five
 2 medical professionals in the apartment.

3 **Q.** So there seemed to be four paramedics and a doctor of
 4 some description who you thought, I think, might have
 5 been a critical care anaesthetist; is that right?

6 **A.** I think we were told that afterwards, that he was
 7 an on-call anaesthetist, uh huh.

8 **Q.** Then I think after the paramedics had arrived, you were
 9 asked to leave the room while they worked on Andrew, and
 10 so you were outside the living room door but the door
 11 was open and you were able to see the paramedics working
 12 on him for quite a period of time, about 20 minutes; is
 13 that correct?

14 **A.** I think it was 20 minutes, I think at the end of the
 15 20 minutes the doctor came and spoke with us and I think
 16 he told us it had been 20 minutes.

17 **Q.** Thank you. The paramedics, do you recall, were they
 18 wearing PPE, did they have personal protective equipment
 19 and safety gear?

20 **A.** They did, they had full masks and suits. I remember
 21 seeing a few of them and they were perspiring a lot. It
 22 must have been very uncomfortable.

23 **Q.** When the doctor spoke to you after they had been working
 24 on Andrew, I think you were asked whether Andrew had any
 25 allergies or if he had taken any medication, and you

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1 **A.** That's right.

2 **Q.** Then what happened when you arrived at the hospital?

3 **A.** When we arrived at A&E, we had to tell them who we were
 4 and they eventually took us into a room and asked us to
 5 wait. Andrew's girlfriend was in that room with us.
 6 Her family had arrived at the hospital, so they were
 7 taken to a different room because they were from
 8 a different household. At that time I still thought
 9 they would be able to resuscitate him. I just -- I just
 10 didn't realise that Covid could be fatal for younger
 11 people.

12 **Q.** When you were in the family room where you had been
 13 asked to wait, did there come a point where a doctor and
 14 a nurse came in to talk to you?

15 **A.** Yes. I don't know how long it was, but a female doctor
 16 and a senior male nurse came in and they told us that
 17 Andrew had passed away.

18 **Q.** Did they tell you what had caused Andrew's death?

19 **A.** They told us that he'd had a blood clot, blood clot,
 20 a pulmonary embolism, and that it had been caused by
 21 Covid, and the damage that it had done was irreversible.
 22 And I just couldn't understand how that was possible, he
 23 was young. I remember the advice at the time was that
 24 we were to look out for the elderly and the vulnerable,
 25 those that are most at risk, and I couldn't understand

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1 why someone at 28 years old, this could happen to.

2 **Q.** I think you spoke to the doctor and asked her about
3 that, and the doctor told you that she had seen quite
4 a lot of people developing blood clots from Covid; is
5 that correct?

6 **A.** She did, and she also said that they had been seeing it
7 in younger patients too, which I was really shocked
8 about, because we -- we were not aware of that, and as
9 far as I know nobody else was aware of that. It didn't
10 seem to be in the public domain that younger people
11 could be at risk.

12 **Q.** Were you able on that occasion to talk to the doctor and
13 ask questions about what had happened?

14 **A.** We did. We did. We sat for a while in that room and
15 asked questions. But I think we probably ran out of
16 questions, we were just in shock. We were just in
17 shock. And I think it was the next day that I had more
18 questions and I had phoned back, phoned back the
19 hospital, to ask more questions.

20 **Q.** We'll come on to that in a moment, Mrs Steele. I think
21 you had some questions about if -- whether Andrew had
22 been able to get to the hospital, been taken to the
23 hospital earlier, whether that could have made
24 a difference in terms of the kinds of treatment that
25 could have been tried for him?

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1 Andrew's dad and I went and saw him.

2 **Q.** You told us that he was lying on a trolley in A&E and
3 you stood by the trolley, there were no seats or
4 anywhere to sit down, and Andrew had black blotches on
5 his skin and his lips were dark, and you didn't know if
6 you were allowed to touch him; is that right?

7 **A.** Yes. Yeah, I didn't, I didn't know what to do.
8 I didn't know how long -- how long we were allowed to
9 stay, how long we should stay, it was all just very
10 surreal. Our youngest daughter that came with us to the
11 hospital, she chose not to go and see him.

12 **Q.** You were given a folder with some information about how
13 to register a death and make funeral arrangements, and
14 so on. Were you offered any counselling services or
15 bereavement counselling?

16 **A.** No.

17 **Q.** You weren't signposted to anything like that at the
18 hospital?

19 **A.** Not that I remember. We were given a small A5 folder
20 and it had lots of information in it about registering
21 a death, and I'd never seen anything like that before.
22 No, the only thing -- the doctor gave me her number at
23 the hospital, which I noted down in case I had any
24 questions or anything for -- you know, after we went
25 home, she did give me her number.

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1 **A.** She did, she -- the doctor explained that the blood
2 clot, his death would have been instant. She said that
3 there were treatments for blood clots but it wasn't
4 straightforward, they can have complications and, even
5 if he had got there earlier, it might not have been
6 successful.

7 **Q.** How would you describe the communication that you had
8 with the doctor at that point, when you were still at
9 the hospital, and the manner of the doctor when you were
10 talking to her and she was answering your questions?

11 **A.** I found the female doctor and the male nurse -- I found
12 them quite helpful, quite compassionate. I think, you
13 know, they did very well. It was -- we were obviously
14 in shock, so it must have been very difficult to ... to
15 communicate with us but I thought they were very
16 compassionate.

17 **Q.** Were you given an opportunity to see Andrew that
18 evening?

19 **A.** They did ask us. This was all very surreal. I just
20 expected them to be able to resuscitate him, I wasn't
21 expecting to see him lying on a trolley. But we were
22 asked if we were wanted to, as this would probably be
23 the last time we would see him because of restrictions
24 that were in force then. So Andrew's girlfriend went
25 and saw him first, and then she came back and then

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1 **Q.** I think you were also asked that evening whether you
2 wanted to have a postmortem examination of Andrew?

3 **A.** Yeah.

4 **Q.** You decided not to; is that right?

5 **A.** Yes. Again, we were just in shock, just wasn't
6 expecting that question but it just -- I just remember
7 feeling just horrified at that thought. The doctor,
8 I think she could sense -- sense that and she did say
9 that she would put her reputation on it being a blood
10 clot due to Covid-19, meaning that there perhaps wasn't
11 a need. So, taking all that into consideration, we
12 decided not to go ahead with a postmortem.

13 **Q.** Mrs Steele, I think you then left the hospital, this was
14 the early hours of 2 January, and you then had to
15 telephone the family members to let them know what had
16 happened to Andrew?

17 **A.** We did. We realised that in the time from us going to
18 Andrew's apartment to being at the hospital, that
19 Andrew's older brother and his other younger sister
20 weren't aware. We just hadn't thought to contact them.
21 I think, personally, I just thought he would survive.
22 So we had, we had to go home and think about phoning
23 them, waking them up, phoning them, and that took
24 a while to get hold of his older brother and his other
25 younger sister.

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1 **Q.** It was you who made those phone calls; is that right?
 2 **A.** My husband just couldn't speak, so I did it and it was
 3 just the hardest thing I've ever had to do. I just knew
 4 that it would cause them pain.
 5 **Q.** Mrs Steele, would you like to take a break?
 6 **A.** Yes, please.
 7 **LADY HALLETT:** I'd only say this, Mrs Steele, of course have
 8 a break if you want, it's just I've dealt with a lot of
 9 distressed witnesses over the years and sometimes people
 10 find it -- just to get it out of the way, as opposed to
 11 having a break but it's entirely a matter for you. Do
 12 you want to just have a glass of water and then, as
 13 I say, if you wish to have a break you must do so.
 14 Just sometimes people would rather get it done and
 15 we haven't got that much more for you anyway. I mean,
 16 I have your written statement and I can read that, so
 17 just take it shortly, Ms Steele.
 18 So please just say, though, Mrs Steele, I don't want
 19 you to feel I'm putting you under any pressure.
 20 **THE WITNESS:** Thank you. No, I'm fine. I'm fine.
 21 **MS NIELD:** Thank you. Thank you, my Lady.
 22 So having made those telephone calls to your family,
 23 to your children and also your mother, I think, you
 24 contacted the doctor who had given you her mobile phone
 25 number the next day and spoke about the questions that

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1 that point your mental health began to deteriorate and
 2 you connected that to the trauma and the traumatic
 3 circumstances in which you lost Andrew, and at that
 4 point you had to take another six months' absence leave;
 5 is that correct?
 6 **A.** I did, yes. I was prescribed medication for anxiety,
 7 but it was caused, as you said, by the harassment at
 8 work, the conditions that I was asked to work in.
 9 **Q.** And I think after transferring to a different office
 10 with that employer, after a few months you left that
 11 employment entirely and took up a new job elsewhere.
 12 How are you now, Mrs Steele?
 13 **A.** I work with lovely compassionate people, so that is
 14 a help. I work part-time, I don't work full-time any
 15 more. I do have ongoing anxiety problems, but not near
 16 as bad as I used to. I tend to avoid social things,
 17 sort of gatherings, things like that. My confidence has
 18 been knocked, but I think mostly because of the problems
 19 I had in my old work, my old employment. I think this
 20 experience has damaged relationships, and I think this
 21 type of bereavement, people ... you just don't
 22 understand it until you've been through it. So I have
 23 some friends that are very, very good, but people must
 24 find it very difficult.
 25 **Q.** I think you have had four rounds of counselling to date?

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

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

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1 giving evidence but you have been so brave and
 2 I'm really grateful to you. I hope you haven't found it
 3 too distressing. I suspect once we stop you will
 4 possibly break down but that's probably a good thing,
 5 let all the emotion out.
 6 I know how difficult it is for people who have
 7 suffered the kind of tragedy you have to give evidence,
 8 but it's so important that not only I hear but that the
 9 world hears your kind of story and, though we can try
 10 and make recommendations to try and ensure that things
 11 are better in the future, no parent should have to lose
 12 a child. So I know how difficult it was, and thank you.
 13 **THE WITNESS:** Thank you. Thank you.
 14 **LADY HALLETT:** Thank you very much.
 15 **(The witness withdrew)**
 16 **LADY HALLETT:** Right, I think probably it's time to take
 17 a break. I think there's a limit to how much we can all
 18 take in half a day. 10.00 tomorrow.
 19 **(4.20 pm)**
 20 **(The hearing adjourned until 10.00 am**
 21 **on Wednesday, 11 September 2024)**
 22
 23
 24
 25

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