

Thursday, 12 September 2024

1
2 (10.00 am)
3 **LADY HALLETT:** Mr Scott.
4 **MR SCOTT:** Good morning, my Lady. May we please call
5 Dr Barry Jones to be sworn.
6 **DR BARRY JONES (sworn)**
7 **Questions from COUNSEL TO THE INQUIRY**
8 **MR SCOTT:** Good morning, Dr Jones.
9 **A.** Good morning.
10 **Q.** Could you give your full name, please?
11 **A.** Dr Barry Jones.
12 **Q.** You have been called today to give evidence as the chair
13 of the Covid-19 Airborne Transmission Alliance. You are
14 also the lead for the British Association for Parenteral
15 and Enteral Nutrition; is that correct?
16 **A.** Correct.
17 **Q.** Would you give a little bit about your personal
18 background and qualifications, please?
19 **A.** Yes, I am a retired consultant physician and
20 gastroenterologist with over 40 years' experience in the
21 NHS and, as you said, I lead for BAPEN. I'm also
22 a member of the British Society of Gastroenterology,
23 which is one of the core groups of the alliance.
24 **Q.** You just call it the alliance there, is that the way
25 that you would refer to it, rather than CATA, which is

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1 heard yesterday.
2 Am I right that you have had a chance to review the
3 report of Professor Beggs --
4 **A.** Indeed I have.
5 **Q.** -- and you listened to the evidence that he gave
6 evidence?
7 **A.** I did.
8 **Q.** In terms of Professor Beggs' evidence in relation to the
9 definition of aerosols, routes of transmission of
10 Covid-19, are there any areas about which you disagree
11 with him?
12 **A.** No.
13 **LADY HALLETT:** What about the terminology? You were
14 a clinician, so which camp are you in for the
15 terminology?
16 **A.** Ah, it's a very good question. No, we absolutely concur
17 with Professor Beggs' expert opinion, particularly on
18 the definition of aerosols and droplets, which we regard
19 as absolutely critical, indeed the elephant in the room
20 which has followed us throughout this pandemic and,
21 without it, his whole pack of cards collapsed, which
22 I believe is the expression he used yesterday. So we
23 understand what he means by "aerosols", it's what we
24 meanly "aerosols", and ballistic droplets are over
25 100 microns, not over 5, and this has absolutely

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1 the way I may normally refer to it?
2 **A.** As you wish.
3 **Q.** If I can just summarise the history and composition of
4 the alliance in the following way: so formed in August
5 2020, it was initially constituted as the Aerosol
6 Generating Procedures Alliance?
7 **A.** Correct.
8 **Q.** Then in September 2021 it renamed to the Covid Airborne
9 Protection Alliance?
10 **A.** Correct.
11 **Q.** At that time, there were a number of professional groups
12 and unions that were part of CAPA, which represented
13 over 100,000 healthcare workers?
14 **A.** That is correct.
15 **Q.** Then at around the time that this Inquiry was announced,
16 the name changed from CAPA to CATA, as it currently is;
17 is that correct?
18 **A.** Yes.
19 **Q.** Presently, the alliance represents over 65,000
20 healthcare professionals from 12 professional bodies?
21 **A.** And many individuals, yes.
22 **Q.** I'm just going to start with a couple of basic
23 principles that are going to go to the core of your
24 evidence today, but what I am keen to avoid doing is
25 duplicating any of the scientific evidence that we've

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1 critical impacts upon the way CATA has proceeded
2 throughout the last four and a half years.
3 **MR SCOTT:** Can I just ask, in terms of the difference
4 between, say, a clinical approach and a physics
5 approach, would you maybe categorise it slightly
6 differently and say that it's not entirely clinicians on
7 one hand but more IPC professionals would draw that
8 distinction?
9 **A.** I think it's a very important distinction, because there
10 are thousands of healthcare workers, doctors, nurses,
11 dieticians, speech and language therapists, chest
12 physios, and so on, who all agree that -- disagree with
13 the IPC guidance and they seem to have a completely
14 different view based on bad science, bad interpretation
15 of the science, which nevertheless is what we had to
16 follow during the pandemic.
17 So it would be quite wrong to say that there's
18 a difference between physicists, engineers and clinical
19 people because most of us actually don't agree with the
20 clinicians in the IPC group.
21 **Q.** Thank you.
22 If I can just come to some of the alliances' core
23 contentions, so that we can understand those and see how
24 they apply to the guidance.
25 So if we could please have up on screen

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1 INQ000273913, it's at page 135.

2 This is the witness statement of you on behalf of
3 the alliance, and if we can just look at paragraph 415,
4 and it's that third line at the end:

5 "One of our strongest criticisms is the fact that
6 government decision-making -- especially in the early
7 stages of the pandemic -- failed to incorporate well
8 known sources of expertise, the practice and evidence
9 led decision-making of those and lived experiences of
10 those affected by the disease."

11 Then if we just go down to paragraph 416, if that
12 could just be highlighted, thank you. It's the second
13 line up from the bottom:

14 "CATA hopes that the Inquiry will investigate why
15 and how, in a country of so much expertise in the area,
16 was the pool of expertise determining the protection of
17 our most crucial nation asset -- healthcare -- so
18 limited."

19 Can you explain what professional expertise you
20 thought was missing and where it was missing from?

21 **A.** The IPC cell is comprised of experts, apparently, in
22 infection prevention and control. The clue is in the
23 title: they are supposed to prevent and control
24 infection and they are supposed to be able to tell us
25 how to do that. But an awful lot of other official

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1 **A.** I couldn't make that more strongly, it was a theme
2 throughout the pandemic that all of us who tried to push
3 back were rebuffed and, as it were, managed so that we
4 weren't a nuisance, and there was an awful lot of
5 expertise directed at the IPC cell and the bodies
6 associated with them, or perhaps superior to them, none
7 of whom seemed to take responsibility for the actions of
8 the IPC cell.

9 **Q.** I'm going to come back to communication bodies and
10 governance later on. I just for the moment want to
11 focus on core contentions. So I'm then going to move to
12 aerosols and the role that aerosols played.

13 Is it right that the alliance's initial focus --
14 that can come down now off the screen, thank you -- when
15 it was formed in August 2020, was that the official list
16 of designated aerosol-generating procedures -- I call
17 them AGPs for short -- fell short because it didn't
18 include all procedures which generate aerosols and,
19 also, the guidance did not address the natural
20 activities such as coughing, sneezing, even breathing,
21 generate significant aerosols which posed a hazard if
22 they weren't provided sufficient protection?

23 **A.** I think that's a very good summary.

24 **Q.** Well, it is yours, Dr Jones.

25 **A.** There we are.

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1 bodies, not just CATA, disagreed with them and made
2 their views known during the pandemic. Right from the
3 very beginning of the pandemic, for example, the
4 Environmental Modelling Group set up by SAGE advised
5 SAGE on 14 April 2020 that the pandemic was likely to be
6 transmitted by the aerosol route, and that the particle
7 size was 100 between aerosols and droplets, not 5, and
8 that was ignored.

9 Public Health England, the parent body apparently,
10 or perhaps, of this cell, pushed back a number of times
11 in December 2020 and 2021 and said they wanted to
12 broaden the use of respiratory protection and invoke the
13 precautionary principle, and they were ignored somehow.

14 **Q.** Can I just ask you, Dr Jones, just in terms of the
15 expertise, so is it right that, actually, you believe
16 that those who were making the IPC guidance wasn't
17 sufficiently multidisciplinary, is that the heart of it?

18 **A.** I think that is absolutely true and Professor Beggs made
19 that point very strongly yesterday and we would
20 absolutely concur with him.

21 **Q.** There's a separate point that, actually, the IPC cell
22 and those within government, as you describe, weren't
23 actually listening to those who may have had the
24 expertise or those who were on the ground; is that
25 a separate point?

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1 **Q.** So is it the essence that the transmission of
2 SARS-CoV-2, or what I will call Covid-19, occurs
3 importantly via the airborne route, via the inhalation
4 of infectious aerosols released, secondary to normal
5 physiological processes and, realistically, that those
6 who were making the IPC guidance didn't take
7 a sufficiently cautious or precautionary approach to the
8 risk of aerosols?

9 **A.** I think it's absolutely true and we don't understand why
10 they did that.

11 **Q.** Are you saying that the reason why a precautionary
12 approach should have been taken to whether Covid-19
13 could be transmitted by aerosols was because, at the
14 start of the pandemic, it simply wasn't clear whether
15 Covid-19 could be spread by the aerosol route?

16 **A.** Two answers there. First of all, I don't agree that it
17 wasn't clear but let's assume that it was unclear to
18 them. That comes under the heading of scientific
19 uncertainty, and the precautionary principle is defined
20 as being -- it should be invoked when there is
21 scientific uncertainty, you fail safe, as it were, and
22 they didn't do that.

23 **Q.** The reason why that mattered is because the wrong PPE,
24 as you said, was being advised, because actually the
25 surgical masks, even fluid-resistant ones, don't prevent

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1 the aerosols from reaching the nose and the mouth and
2 therefore initiating the disease and, therefore,
3 healthcare workers weren't as protected as they could
4 have been?

5 **A.** This is another consequence of the elephant in the room,
6 yes.

7 **LADY HALLETT:** Can I just check the dates, Dr Jones. You
8 say you don't agree it wasn't clear as the aerosol
9 transmission; you said it was 14 April when SPI
10 modelling group advised SAGE it was likely to be. What
11 date roughly would you say when it became clear that it
12 was aerosol transmission?

13 **A.** It was defined as aerosol transmitted from the very
14 moment it came into the country, it was an airborne
15 highly sequential infectious disease, as indeed SARS-1
16 and MERS were, and still are. WHO says that no virus
17 known to man has ever been shown to change its mode of
18 transmission but this one did, under the auspices and
19 direction of the IPC cell.

20 **MR SCOTT:** I will be going through various documentation,
21 Dr Jones, to allow you the opportunity to say when you
22 think that the evidence was there, but then also, as you
23 said earlier on, even if it wasn't initially there to
24 those who were in the IPC cell, when you say that
25 actually the evidence was fairly overwhelming and should

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1 mask because it captures all droplets and therefore the
2 infection doesn't spread; is that essentially the logic?

3 **A.** Yes, that is correct.

4 **Q.** But if, as it turns out, there are aerosols that are
5 over 5 microns, then effectively the protection isn't
6 there, because while you're wearing the fluid-resistant
7 mask aerosols escape around the side of the mask and
8 then can enter around the side of masks of other people
9 who are wearing those? Is that essentially the reason
10 why, if you have this 5-micron border and you call
11 everything above it a droplet, that actually you can
12 then inherently bind yourself to the wrong protection?

13 **A.** Yes, it's why it's not an academic distinction, it's one
14 of extremely important practical distinction, and all
15 pronouncements on droplets by the IPC guidance cell are
16 null and void as a result of Professor Beggs' evidence
17 yesterday and our belief.

18 **Q.** In terms of the precautionary principle, my Lady was
19 saying yesterday she's heard different people address
20 the precautionary principle in a slightly different way.
21 Do you think it necessarily matters whether, when you
22 are looking at creating guidance, you apply the specific
23 precautionary principle or whether you take
24 a precautionary approach to addressing risk?

25 **A.** I think as far as my members are concerned, we wouldn't

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1 have been taken into account, so I will take you to
2 that.

3 I just want to deal firstly with the boundary idea,
4 this 5-micron distinction between --

5 **A.** Yes.

6 **Q.** -- an aerosol and a droplet. That was, let's call it,
7 the orthodox approach within the IPC community prior to
8 the pandemic. Is that the way that you would describe
9 it?

10 **A.** I --

11 **Q.** Whether it's right or wrong, that was the view --

12 **A.** That is correct, and it still is.

13 **Q.** Is the basis of that approach was because 5-microns was
14 the upper size limit of what could penetrate down into
15 the deepest part of the lungs?

16 **A.** I think the limit goes up a bit further than that,
17 according to Professor Beggs.

18 **Q.** Yes.

19 **A.** But it's roughly that area, yes.

20 **Q.** Yes, so therefore does it follow that if you take the
21 view that anything under 5 microns is an aerosol and
22 that anything over 5 microns is a droplet, and that
23 droplets act ballistically, then that effectively sets
24 you down the path that: a droplet behaves ballistically,
25 so you can protect people by wearing a fluid-resistant

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1 draw a distinction between the two, but this
2 precautionary principle is actually enshrined in health
3 and safety regulations, so there is a legal aspect to
4 this as well. But we would take a practical,
5 precautionary approach, a failsafe approach, if you
6 like.

7 **Q.** So when you're creating something like IPC guidance, how
8 should that precautionary principle, precautionary
9 approach be applied? How would you describe it?

10 **A.** Well, if you take the specific example of what happened
11 in mid-March 2020 with the downgrading --

12 **Q.** I don't necessarily want to deal with the specifics now,
13 just in general when somebody is creating guidance?

14 **A.** Then they should always err on the side of safety, and
15 not -- and listen when they're told that they've got it
16 wrong.

17 **Q.** And you were saying that this originates from health and
18 safety legislation, essentially?

19 **A.** The precautionary principle is enshrined in
20 UN documents, WHO documents, SAGE documents and in the
21 health and safety regulations. It's not for
22 interpretation by the chair of the IPC cell, in our
23 opinion, because that's what she did.

24 **Q.** Is there a minimum evidential threshold that you think
25 should apply when the science is uncertain, such as in

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1 the early stages of a pandemic, before any kind of
 2 precautionary principle or precautionary approach
 3 applies?
 4 **A.** I mean, if you take an academic -- if you want an
 5 academic evidential threshold, I guess we could probably
 6 find one, but in practical terms a healthcare worker
 7 can't apply that, at the coalface looking after
 8 a patient. I don't understand how that can be done.
 9 **Q.** So when you are creating guidance, how do you actually
 10 then include that precautionary approach into creating
 11 that guidance? What should you be doing? What should
 12 you be describing? What should you be considering?
 13 **A.** Well, by their own admission, they didn't know as much
 14 as they should have done, and therefore they should have
 15 said: well, what is the safest approach we can take
 16 which will protect the greatest number of healthcare
 17 workers, and by inference, their patients and the public
 18 as a whole?
 19 **Q.** So it's if you consider that there could be a risk then
 20 you should take steps to mitigate that risk?
 21 **A.** Yes. You know, if you think there's asbestos in
 22 a building, you don't think about it, you put on a mask.
 23 **Q.** Is it also right that actually simply because you may
 24 have identified two risks, that if you're protecting
 25 against one it doesn't necessarily mean that you're

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1 any for the droplet route, and indeed there wasn't any
 2 evidence for the droplet route.
 3 **Q.** Well, just dealing at the moment still with these
 4 principles about how you actually create guidance,
 5 talking here about proving evidence certainty, how easy
 6 is it to actually design studies about routes of
 7 transmission for specific infectious diseases?
 8 **A.** Are you asking me here about my opinion on what research
 9 should be done during a pandemic?
 10 **Q.** No, I'm asking you generally: how can you design studies
 11 about infectious diseases? Is it an easy thing to do,
 12 or do you end up with difficulties about trying to
 13 infect people with diseases?
 14 **A.** Right, in that case I'll ask you how far you want me to
 15 go back, because we can go back to Hippocrates. And
 16 I'm not joking, the discussions in medical circles have
 17 gone on for millennia about how diseases are
 18 transmitted, and nearly always when new discoveries have
 19 come along they have been ignored.

20 I can give you the Broad Street pump and cholera,
 21 for example, in 1854, and John Snow's excellent
 22 epidemiological work. It was ignored. It was quite
 23 clear that cholera was transmitted through water, not
 24 through the air.

25 You say experiments; we have to go on evidence that

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1 protecting against the other?

2 **A.** Correct.

3 **Q.** Also, is it right that when you are creating guidance,
 4 particularly when you're dealing with a novel or a new
 5 threat, that it's important that you impose that
 6 precautionary approach at an earlier stage?

7 **A.** I can't think of a more important time to do so.

8 **Q.** And you also say in your statement that you believe that
 9 that should remain in place until such credible
 10 scientific evidence exists which shows beyond reasonable
 11 doubt that the disease is not transmitted, in this case,
 12 via the aerosol route.

13 Why is it that you say it should remain in place
 14 until it is beyond reasonable doubt?

15 **A.** Because the risk remains until you can be sure that that
 16 risk does not pertain, and even the Deputy Chief Medical
 17 Officer, Jonathan Van-Tam, said in January in an email
 18 that it was airborne until proven otherwise.

19 **Q.** So it's that certainty that you are looking for when you
 20 are -- at that point in time dispense with the
 21 precautionary approach?

22 **A.** If you could prove that it was not caused by the
 23 airborne route, that's fine, but actually most of the
 24 effort was directed towards trying to find positive
 25 evidence of the airborne route whilst not looking for

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1 we have, and particularly in the early stages of
 2 a pandemic you haven't got time to do experiments, you
 3 have to look at the evidence you have already and then
 4 to use something which my Lady mentioned yesterday,
 5 which is common sense.

6 **Q.** Yes, but also in terms of the scientific discovery, you
 7 would still be trying to investigate additional sources
 8 of evidence; is that right?

9 **A.** But we already had the evidence when this virus came.
 10 It's the same class of virus as SARS-1 and MERS; they're
 11 both airborne, why should it be any different?

12 **Q.** Again, taking a step away from the specifics, and in
 13 case there is a future pandemic where actually there may
 14 not be that same level of certainty from an existing
 15 virus --

16 **A.** Yes.

17 **Q.** -- how easy is it to generate studies about routes of
 18 transmission of a specific infectious diseases? Is it
 19 a very easy thing to do or is it actually very
 20 difficult?

21 **A.** I think in the case of a respiratory pathogen, which
 22 SARS-CoV-2 is, one has to assume that it is transmitted
 23 by the airborne route, like TB and measles and like
 24 previous coronavirus epidemics. I am not an expert in
 25 designing studies on aerosol -- on infectivity, but I --

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1 so I'm not sure that I can answer your question fully.

2 **Q.** That's okay, I'm going to move on to applying
3 a precautionary approach to the evidence.

4 If I can just take you to document INQ000273913,
5 again. It's your statement --

6 **A.** Yep.

7 **Q.** -- page 30, paragraph 99.

8 You say:

9 "Health and Safety legal principles, critical to the
10 protection of the most vital asset during a pandemic
11 (healthcare professionals) were simply abandoned in
12 favour of Infection Prevention and Control approaches."

13 Please can you explain what you mean by that.

14 **A.** The infection prevention and control specialists who
15 dictated guidance during the pandemic made statements
16 which were not based on evidence. One could even call
17 them dishonest statements. Health and safety
18 incorporates the precautionary principle, to protect
19 workers, and in this case healthcare workers, and
20 although the IPC guidance says that their guidance
21 should be interpreted in the light of health and safety
22 principles, they then ignored them, because they did not
23 take the precautionary principle in the face of
24 scientific uncertainty, which they professed all the
25 time, when in fact there was certainty and they should

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1 transmission?

2 **A.** Well, there clearly were differences. We don't
3 understand why, because, as I've just explained, they
4 weren't based on the science, and yet the government
5 said that it was following the science, but instead it
6 followed bad science, given to them by those who should
7 have known better.

8 **Q.** But are you saying that there may have been differing
9 views on the science, even if you don't necessarily
10 agree with them -- but are you saying that the people
11 making the guidance were not following what they
12 believed was a proper scientific view?

13 **A.** Well, as Professor Noakes said in her Module 2 evidence
14 and Professor Beggs yesterday, there seemed to be
15 a desire on the part of those putting together the
16 guidance to seek very, very hard for high-level evidence
17 to prove that the airborne route was the dominant one,
18 whilst having no evidence whatsoever to justify the
19 droplet one, then or since. And that disparity is
20 completely wrong, it's not scientific, it's a reflection
21 of the culture.

22 **Q.** I just want to be very clear about what criticisms
23 you're raising. So you're criticising the scientific
24 approach rather than the fact that people may have been
25 following a scientific approach?

19

1 have noticed it.

2 **Q.** So in terms of the health and safety principles there,
3 that's for -- the read-across for precautionary
4 principle; is that right?

5 **A.** Yes.

6 **Q.** You said there about a -- you used the word "dishonest".
7 Can you please be very specific about what you mean, or
8 any specific statements that you're saying may be
9 dishonest?

10 **A.** It's not just our IPC cell but the World Health
11 Organisation which initially categorised this virus as
12 airborne, then put out adverts, if you like, Twitter and
13 other media, saying "Covid is not airborne". We had
14 similar statements time and time again in the IPC
15 guidance. We had a letter from Professors Powis, Doyle
16 and MacEwan to all healthcare workers saying "Covid is
17 not airborne, it's droplets, and surgical masks are
18 fine". All this was not based on any evidence
19 whatsoever, and yet they kept telling us in responses to
20 our many letters, "We are following the science, this is
21 the result of the latest scientific review". That is
22 untrue.

23 **Q.** Do you believe that at the start of the pandemic there
24 was any scope for there to be differing opinions on the
25 scientific principles that applied to the routes of

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1 **A.** Yes.

2 **LADY HALLETT:** To what extent would you say or accept or not
3 accept that if the WHO said it's -- I appreciate you say
4 it changed its mind, but is it fair for experts in this
5 country to say, "Well, if this is what the World Health
6 Organisation says, that ought to be based on the science
7 and therefore we ought to follow it"?

8 **A.** Well, the WHO didn't offer any science either, and I see
9 no reason why the excellent scientific community in this
10 country has to automatically follow something so
11 blatantly unscientific no matter where it comes from.

12 **LADY HALLETT:** Thank you.

13 **MR SCOTT:** Thank you, that can now come down off the screen,
14 I'm going to come back to a point that my Lady raised
15 about what point in time -- and I think it's going to be
16 very clear from the evidence that you've already
17 given -- at what point in time do you believe that the
18 precautionary principle or the precautionary approach
19 should have applied to the IPC guidance?

20 **A.** 13 March 2020.

21 **Q.** Why wouldn't it have applied any earlier than that?

22 **A.** Because up until that moment, this infection was
23 classified as airborne, and airborne precautions were
24 being given to healthcare workers to protect themselves
25 at work, and certainly they weren't.

20

1 Q. Can I just explore that a little bit, because you're
2 referring there to HCID status; is that right?
3 A. Not directly, and I shouldn't have to, but I understand
4 your question, so yes.
5 Q. Could you please explain what it is you mean in terms of
6 why, before that date, you believe the precautionary
7 principle didn't need to apply?
8 A. Because as the virus came into the country, it was
9 classified by JCVI as a highly consequential infectious
10 disease, which, as you know, is very strictly defined,
11 and the criteria upon which HCID status is founded were
12 rapidly exceeded as this virus took off and exceeded the
13 capacity of HCID beds and then isolation -- the 500
14 isolation beds in the UK.

15 But, at the same time as it was given HCID status,
16 because it was a respiratory pathogen, it was given
17 airborne status as well. The two are not necessarily
18 inextricably entwined. In other words, you can have
19 a non-HCID which is airborne, you could have an HCID
20 that's not airborne, but it just so happened, at the
21 same time as the downgrading in the HCID, as you call
22 it, status occurred, the type of personal protective
23 equipment, particularly respiratory protective
24 equipment, was also downgraded from what was perceived
25 as safe and the best possible protection for staff to

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1 route, as opposed to the droplet route; is that right?
2 A. Well, if it's an airborne HCID, it's an airborne HCID,
3 and you have to deploy the adequate protection for what
4 is a far more serious and efficient method of
5 transmission than droplets.

6 Q. Yes. Because something has been designated as
7 an airborne HCID, then a standard set of PPE, which
8 includes FFP3 masks, that then applies, doesn't it?
9 A. Yes.

10 Q. That would always have applied for as long as any virus
11 is designated as an airborne HCID?

12 A. Correct.

13 Q. So, for example, SARS is still designated as an HCID?

14 A. Yes.

15 Q. So ...

16 A. Could I just add that the World Health Organisation says
17 that no virus known to man has ever been known to change
18 its route of transmission, so why did this one?

19 Q. Yes, but if there is no droplet HCID, then how does it
20 necessarily follow that, because you have downgraded
21 something from an airborne HCID, that you say that it
22 necessarily follows that they were changing the route of
23 transmission of that virus?

24 A. I don't know why they changed the route of transmission.
25 That's a question we need to answer.

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1 something that clearly wasn't, and no explanation was
2 given.

3 Q. If I could just make sure I'm fully understanding this.
4 So in early January, Covid-19 was designated as an HCID,
5 in the way I've called it.

6 A. Correct.

7 Q. Actually, would you agree that that is probably a good
8 idea -- sorry, that is an effective use of
9 a precautionary approach because we weren't entirely
10 sure about levels of mortality and all the various
11 elements that go into make something an HCID; is that
12 right?

13 A. It was entirely appropriate because SARS-1 and MERS, as
14 I've already said, are categorised as airborne HClDs, to
15 this day.

16 Q. But there are only two categories of HCID: there's
17 airborne and contact, isn't there?

18 A. Correct.

19 Q. So you couldn't, for example, have a droplet HCID?

20 A. Well, probably could, if it was the IPC cell that was in
21 charge, yes.

22 Q. But in terms of the designation, it's either contact or
23 it's airborne, so simply because something is designated
24 as an airborne HCID it doesn't necessarily mean that
25 that is a definition of it transmitting by the aerosol

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1 Q. So you're not saying that it necessarily was changed but
2 the fact that the downgrading changed from airborne and
3 then the droplet protection came in is what you're
4 saying is the reason why you believe that there was
5 a change in the route of transmission?

6 A. Well, they said it's droplet transmitted, and then
7 later -- the first edition of the -- or iteration of the
8 guidance that came out after the downgrading from HCID
9 status, said it's droplet transmitted except for
10 aerosol-generating procedures, and, therefore, only
11 protections which will protect against droplets will be
12 used for all non-AGP situations, which is actually the
13 majority of healthcare provided in a hospital.

14 Q. If I can look, please, at notes of a meeting of NERVTAG
15 on 3 February 2020.

16 This is INQ000119615, and if we can go, please, to
17 page 4, and paragraphs 3.10 and 3.11.

18 So we have there, "JVT" -- that's Jonathan Van-Tam;
19 is that right?

20 A. Mm-hm.

21 Q. "asked is if it is the committee's view [so that is
22 NERVTAG] that for this novel coronavirus, we do not
23 understand the modes of transmission of this virus, and
24 we do not understand the relative contribution of fine
25 particles aka droplet nuclei, large droplets and contact

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1 transmission."
 2 At 3.11:
 3 "Members commented that, yes, NERVTAG do not have
 4 a full understanding of the modes of transmission and
 5 [they] are making assumptions based on other respiratory
 6 pathogens but it is reasonable for us to infer the
 7 nature of transmission of this virus ..."
 8 If that is the assessment of a group such as
 9 NERVTAG, would you expect to see that uncertainty
 10 presented in any guidance that applies?
 11 **A.** Well, first of all, I don't understand the conclusion of
 12 3.11 because, if you actually look at the modes of
 13 transmission similar things, you wouldn't end up hand
 14 washing. So I don't understand that at all.
 15 Sorry, the other question was?
 16 **Q.** That if a group such as NERVTAG --
 17 **A.** Yes.
 18 **Q.** -- are saying that they do not understand the modes of
 19 transmission or fully understand the modes of
 20 transmission because it's put both ways, would you
 21 expect that uncertainty to be identified in any guidance
 22 that follows?
 23 **A.** Yes.
 24 **LADY HALLETT:** Can you remind me of the date of the meeting?
 25 **MR SCOTT:** This is 3 February, so this is still within the
 25

1 you have declassified as an HCID you then have to have
 2 a set of guidance about the IPC and the protection needs
 3 to be put in place; is that right?
 4 **A.** They had already that some weeks beforehand, according
 5 to the evidence. It wasn't decided afterwards.
 6 **Q.** If we can just look, please, at that guidance, and
 7 that's INQ000325350.
 8 So we can see there that this is, at the top,
 9 version 1.0 of the IPC guidance?
 10 **A.** Yes.
 11 **Q.** That's adapted from the pandemic influenza guidance.
 12 **A.** Correct.
 13 **Q.** If we can go to page 7, please, paragraph 2.1, and if we
 14 can take that top paragraph --
 15 **A.** Yes.
 16 **Q.** -- and we can see it set out there, this is under the
 17 heading of "Routes of transmission" and the opening line
 18 is it's:
 19 "... based on the reasonable assumption that the
 20 transmission characteristics of Covid-19 are similar to
 21 those of the 2003 SARS CoV outbreak."
 22 You don't disagree with that line, I presume?
 23 **A.** Absolutely, I agree with that. But not with the rest.
 24 **Q.** Your disagreement there is the transmission is thought
 25 to occur mainly through respiratory droplets?
 27

1 HCID period.
 2 **A.** Yes.
 3 **LADY HALLETT:** Thank you.
 4 **MR SCOTT:** But is it right that, when you are responding to
 5 a virus that has the potential to be a pandemic, which
 6 I think had already been identified by 3 February, that
 7 you may wish to start to plan for what your IPC guidance
 8 may be if you take the view that it's no longer to be
 9 classified as an HCID?
 10 **A.** Well, indeed, you're correct that planning had been
 11 taking place but there was only one plan in town and
 12 that was the pandemic influenza plan, which had been
 13 formulated in the previous decade and which they decided
 14 to implement, come what may, which may have been
 15 convenient because they didn't have enough PPE anyway
 16 for an airborne route, as we've already seen in
 17 Module 1, of course, with regard to preparedness.
 18 **Q.** Because you then say in your statement that the
 19 precautionary principle was removed from IPC guidance in
 20 mid-March 2020 without any such evidence. Is that the
 21 discussion we were just having in relation to the
 22 declassification as HCID?
 23 **A.** They occurred at the same time, which I'm sure was no
 24 coincidence.
 25 **Q.** Well, the IPC guidance came in on 16 March because when
 26

1 **A.** Well, SARS-1 is transmitted by the airborne route, there
 2 are lots of papers to show that and it's still
 3 designated as an airborne HCID, so why would I believe
 4 that it's transmitted by droplets. They never presented
 5 any evidence to that effect whatsoever.
 6 **Q.** If I could just take you to the line in the middle --
 7 **A.** Sorry, if I could just add to that: of course it's
 8 respiratory droplets generated coughing and sneezing.
 9 Here we come back to the elephant in the room and the
 10 size of aerosols versus droplets, as described by
 11 Professor Beggs yesterday. All of the droplets,
 12 so-called, generated by coughing and sneezing that
 13 they're referring to are, in fact, aerosols. So that
 14 statement is incorrect.
 15 **Q.** So that's where you disagree with this --
 16 **A.** Absolutely.
 17 **Q.** Because, at the bottom line, the bottom four lines:
 18 "During AGPs there is an increased risk of aerosol
 19 spread ..."
 20 So you would agree that they recognise the concept
 21 of aerosols?
 22 **A.** Yes.
 23 **Q.** But what you're saying is that, actually, it was applied
 24 in too narrow a set of circumstances and it should have
 25 applied generally?
 28

1 **A.** It's an example of terribly badly applied science.
 2 **Q.** If we can go, please, to page 12. We have at the bottom
 3 there "Routes of transmission", thank you.
 4 **A.** Yes.
 5 **Q.** Again, that bottom paragraph:
 6 "Interrupting transmission of Covid-19 requires both
 7 droplet and contact precautions ..."
 8 Then it's only:
 9 "... if an [AGP] is being undertaken [that] airborne
 10 precautions are required ..."
 11 **A.** Yes, and in the paragraph, you'll notice above, it's
 12 less than 5 microns for aerosols, so again, the elephant
 13 in the room.
 14 **Q.** This is, as you say, the fundamental flaw, that when
 15 applied throughout --
 16 **A.** Yes. It's completely flawed, it's completely wrong.
 17 All of the guidance was based on this false assumption,
 18 which they should have known about, they're supposed to
 19 be experts in infection.
 20 **Q.** So you've made it clear that you believe that
 21 a precautionary approach should have applied from the
 22 outset. You've also, I believe, made it clear that you
 23 thought that the science was sufficiently clear --
 24 **A.** Yes.
 25 **Q.** -- from the outset of the pandemic --

29

1 very clear that the evidence was already there, very,
 2 very early on, only weeks after the downgrading from
 3 HCID status and downgrading from respiratory protection
 4 to droplet protection.
 5 I hope that answers your question.
 6 **Q.** Yes, it does.
 7 If I can take you then to some minutes or some notes
 8 of the meeting of the IPC cell on 22 December, if I can
 9 take you to INQ000398244.
 10 Thank you.
 11 Just because it will become relevant later on, if
 12 I could take, please, your attention just in the
 13 attendance list. At the end of the second line,
 14 Eleri Davies from Public Health Wales and then, on the
 15 fourth line, Colin Brown PHE, so those initials are ED
 16 and CB, just because they will become relevant later on.
 17 If we can go over, please, to page 2, and down at
 18 the bottom we have "LI", which I believe is Laura Imrie,
 19 where this at the time is -- there is a discussion about
 20 whether the new variant, I believe at that time, was
 21 quite prevalent in December 2020, and there is a note
 22 there about "wary of recommending FFP3 masks" and
 23 "should look for the evidence first".
 24 Now, I know you believe that the evidence was
 25 already there, but then we have a note from CB talking

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1 **A.** Yes.
 2 **Q.** -- that aerosols should have been protected against?
 3 **A.** Yes.
 4 **Q.** Do you say that there came a point in 2020 when,
 5 effectively, the scientific base became pretty much
 6 unanswerable that aerosols was a viable route of
 7 transmission or the primary route of transmission?
 8 **A.** Yes, I can give an answer to that. I can answer partly
 9 from Professor Beggs' evidence yesterday. Of course, he
 10 said that by September 2020 there was sufficient
 11 evidence, but I would actually put it earlier than that
 12 because Professor Noakes, who gave evidence to this
 13 Inquiry in Module 2, Professor Andrew Curran from HSE,
 14 joint chairs of the newly formed EMG committee,
 15 a subsidiary of SAGE, within a week had prepared
 16 a document saying the disease was airborne and that
 17 aerosols went up to 100 microns, and they presented that
 18 to SAGE a week later, a week after the formation of that
 19 group on 14 April 2020.
 20 But no one took any notice and there were several
 21 more recommendations from that group and, curiously,
 22 SAGE reverted to the 5-micron in their June report. So
 23 we don't know what was going on there. But I would
 24 argue that left and right hands didn't quite seem to
 25 know what was going on at the time but, to us, it was

30

1 about "difficult ... until the evidence is generated".
 2 If we can just go over the page, please, so you have
 3 the second entry which just says:
 4 "... minimal evidence of patient to staff
 5 transmission ... we should not need to further recommend
 6 FFP3 masks ..."
 7 If we can just avoid chiming in, just for a minute,
 8 please, sorry.
 9 **A.** Sorry, that point, I mean, that was incorrect. There
 10 was very good evidence that healthcare workers were
 11 becoming extremely ill and dying in Italy and in China
 12 and in this country by then.
 13 **Q.** But it's in between the two NRs, kind of the last two,
 14 you have an entry of CB, that's the reason why I pointed
 15 to CB.
 16 **A.** Yes.
 17 **Q.** "Our understanding of aerosol transmission has changed.
 18 A precautionary approach to move to FFP3 masks whilst we
 19 are awaiting evidence should be advised."
 20 So this is a note of a comment from a member of
 21 Public Health England. The IPC cell didn't actually, at
 22 that point in time, change the guidance and make
 23 a precautionary move to FFP3 masks. What was your
 24 understanding of the way that the IPC cell operated?
 25 When I say that, as an outsider at the time, did you

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1 have any idea of how the IPC cell operated or what it
2 was doing or what it was discussing?
3 **A.** That's an important question because we knew what they
4 were -- what was coming out of the IPC cell, but we had
5 no idea where it was coming from, who it was coming
6 from, because they never, ever published any minutes.
7 We managed to obtain some with great difficulty through
8 freedom of information and of course we've seen some
9 disclosed documents, and we don't know -- we didn't know
10 at the time who was on that -- in that cell.

11 We knew that Lisa Ritchie was the initial chair, and
12 later Dr Davies, I think, but subsequently we have
13 learned that the composition of that cell was
14 predominantly from NHS England. I think there were 28
15 people altogether and they -- most of them, there were
16 three representatives from Public Health England and I'm
17 not sure they had voting rights, and the terms of
18 reference, which were eventually -- only drafted in 2020
19 and were eventually agreed in 2021 said that the chair
20 had the final decision when there was disagreement. And
21 we see in the minutes several times that "consensus has
22 been reached" --

23 **Q.** If I could just ask you to pause there because there's a
24 difference between --

25 **A.** She overruled him, ignored that comment, that's the
33

1 going to ask you about how that comment came to be made,
2 but was this what you were talking about where you were
3 saying consensus was noted but actually you don't
4 believe it was there?

5 **A.** It's not the only example, it occurred a year later as
6 well, and when Colin Brown also presented a paper --
7 a proper paper from PHE saying they ought to relax
8 respiratory protection beyond AGPs and the precautionary
9 principles should be invoked, and we don't understand
10 how this cell could actually overrule the parent body,
11 Public Health England, UKHSA, as it's become. It's
12 bizarre, it's tail wagging dog.

13 **Q.** Thank you, that can come down now. I think you have
14 been very clear, Dr Jones, in your evidence about when
15 you believe that the science was there, when you believe
16 there were changes. If I can just take you to -- it's
17 the technical report that was generated by the chief
18 medical officers following the pandemic and it was
19 intended to give advice to future CMOs.

20 **A.** Ah, yes.

21 **Q.** If I can show you, it's INQ000203933. It was published
22 1 December 2022. If I can take you to page 48, and if
23 you just go back a page, then we can show the heading.
24 So this is "What were the important routes of
25 transmission?", section 8 of chapter 1. Then it sets

35

1 point I'm trying to make.

2 **Q.** If I could just scroll down just to actually evidence
3 that point that you're making. So if we scroll down to
4 there's lengthy discussions there but, fourth line up
5 from the bottom, where ED -- I think we just go a little
6 bit further down on my screen, thank you -- ED said --
7 from Public Health Wales, that we were looking at
8 earlier on, second line up from the bottom of the screen
9 at the moment:

10 "There will be pressure from organisations and
11 bodies for more precautionary measures. The confidence
12 of staff in high intensity units is being lost."

13 That's correct that in December 2020 the confidence
14 of staff in high intensity units is being lost?

15 **A.** It's absolutely correct.

16 **Q.** Then the comment is:

17 "If there is a high-risk pathway, we should take
18 precautionary measures."

19 **A.** Correct.

20 **Q.** If we just go over the page, and I think this is the
21 point you were making about consensus, there is that
22 note there:

23 "LR -- We appear to have consensus", and then that
24 is set out.

25 You weren't involved in those meetings, so I'm not
34

1 out some analysis, but if we just go over the page and
2 it's those top two paragraphs, please:

3 "... given the challenges inherent in attempting to
4 determine the relative impacts of different routes of
5 transmission, it was important to retain an open mind as
6 understanding evolved over the course of the pandemic."

7 Again, is that precisely what you believe didn't
8 happen but should have happened?

9 **A.** It most definitely is and, of course, this was written
10 partly by Professor Cath Noakes, who we have already
11 heard evidence that she was ignored.

12 **Q.** Thank you.

13 I want to ask you now about lessons learned and
14 lessons that were arising from masks, protection,
15 elements such as that. Again, that document can come
16 down now, please, thank you.

17 In terms of the masks that you believe should have
18 been advised, so you're talking about FFP3 masks, do you
19 believe that they were the only masks that should have
20 been applied or do you think that there are different
21 approaches that could have been and should have been
22 taken?

23 **A.** Well, if I may be so bold as to correct you, that masks
24 were not the only mitigation for an airborne transmitted
25 pathogen. Ventilation is incredibly important, and that

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1 was ignored and could have been mentioned way back in
2 March 2020, but wasn't until November 2020, by
3 Cabinet Office.

4 Masks -- or respirators, to give them their correct
5 term -- protective ones like FFP3s, maybe FFP2s, and
6 N95s, across the water in North America, those are the
7 ones which provide the greatest protection, but they're,
8 again, not the only form of protection. The
9 power-assisted personal respirator hoods provide a very,
10 very useful alternative, and I'd quite like to explore
11 that later if we may. So there's not just FFP3 masks
12 we're talking about here, and I'm very pleased to see
13 that this Inquiry building has lots of HEPA filters
14 around, as well as mouse poison in the room where I was
15 waiting.

16 **Q.** In terms of the masks, we might deal with them now that
17 you've raised them, Dr Jones. What do you consider, as
18 the representative of somebody -- represented many
19 people who were actually healthcare workers on the
20 ground, to use that phrase, what do you consider were
21 the benefit of using personal hoods, powered hoods, as
22 opposed to just FFP3 masks?

23 **A.** They provide a number of advantages. Although they look
24 quite scary and a bit Star Wars, they provide a clear
25 visor which patients can see through, they can see for

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1 **Q.** Did they require fit testing?

2 **A.** They don't require fit testing either.

3 And if I can just add that Paul Elkington and his
4 colleagues approached not only the president of the
5 Royal College of Physicians, Professor Goddard, who you
6 may hear from later, but Sir Stephen Powis, who was
7 involved in the communications in April 2020, and
8 Professor Elkington offered not only this expertise but
9 the manufacturing capacity of Jaguar Land Rover, which
10 were prepared to manufacture these at pace and scale,
11 and we never heard any more about it.

12 **Q.** In terms of lessons learned, you believe that actually
13 consideration should be given to using these kind of
14 powered respirator hoods?

15 **A.** Well, there is no doubt, from listening to those who
16 have been unfortunate enough to have to wear FFP3 masks
17 for a long period of time, and I've worn one for five or
18 six hours, it's not particularly pleasant, but the side
19 effects quoted -- apart from being uncomfortable, side
20 effects like acne really aren't life-threatening.

21 But there is an alternative and the power respirator
22 hoods I think need exploring. And there are all
23 sorts -- as I've explained, there are all sorts of
24 advantages. And they do get around the enormous problem
25 of 20%, maybe 40% fit test failure, particularly for

39

1 communication purposes -- very important for speech and
2 language therapists -- they protect the eyes, they stop
3 droplets, but above all they stop airborne particles.

4 They are reusable, they don't have to be disposed of
5 after a few minutes of use. And after a couple of years
6 they pay for themselves. And the best example of their
7 use comes from Southampton University Hospitals, and
8 I can expand on that if you like.

9 **Q.** Please do. Yes, please do.

10 **A.** Right. Professor Paul Elkington, who was awarded an MBE
11 for this work by the way, worked with his colleagues in
12 Southampton and with the president of BAPEN -- my
13 president of BAPEN, Trevor Smith, to design, manufacture
14 and distribute what were called PeRSo hoods. They did
15 this at pace and at scale in the early months of the
16 pandemic and they distributed them not only to intensive
17 care staff but all staff in the hospital, whether
18 clinical or support workers, so porters, cleaners and so
19 on. And they heard that -- they had feedback that these
20 were vastly preferable to wearing very horrible FFP3
21 masks for long periods of time, and they were given
22 a mask for the duration of the pandemic. They were in
23 the top 10% of trusts in this country for the low
24 nosocomial infection rates and staff absenteeism due to
25 Covid. They worked.

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1 those from BAME ethnic backgrounds, with beards, turbans
2 and faces that just don't fit. And bearing in mind that
3 over 50% of the NHS workforce is female and FFP3 masks
4 are designed on mannequins based on the male face, it's
5 hardly surprising that there are a lot of fit test
6 failures, but hoods get around that problem, which is
7 a serious logistic problem in fairness.

8 **Q.** This is the final area in relation to IPC aerosol
9 guidance before I move on to something slightly
10 different.

11 There has been a lot of discussion in your statement
12 in relation to designating certain procedures as AGPs.
13 If there had been sufficient aerosol protection, as you
14 contend that there should have been at an early stage
15 because it was sufficiently clear, would there have been
16 any issue in relation to what was an AGP, what wasn't
17 an AGP, or actually would the protection have already
18 been in place whatever happened?

19 **A.** You're absolutely right, and indeed the English manual
20 for IPC now states that when you go into the room of
21 a patient with suspected or confirmed Covid or a similar
22 respiratory pathogen, you should don respiratory
23 protective equipment. So why would you need to put it
24 on for an AGP? AGP list would indeed be redundant, but
25 it was never fit for purpose in the first place.

40

1 **Q.** I just want to deal with the benefit of having that
 2 protection in place. So were any of the AGPs that were
 3 actually on the AGP list potentially life-saving or time
 4 critical procedures?
 5 **A.** Yes.
 6 **Q.** So if there had been general wearing of FFP3s, would
 7 that have had the added benefit that you would have
 8 reduced the time it takes to don the IPC in order to
 9 carry out an AGP?
 10 **A.** I would say that if we're talking about -- are you
 11 talking about CPR now, cardiopulmonary resuscitation?
 12 **Q.** Anything that would be time-critical or potentially --
 13 **A.** Okay, well, if we use that as an example, we had the
 14 absurd situation of paramedics arriving at a dead --
 15 a patient who had died in the street and having to put
 16 on full PPE with gowns and gloves and so on, but
 17 basically what they needed to put on was an FFP3 and
 18 a pair of goggles, and that doesn't take very long, and
 19 shouldn't have delayed administration of the treatments
 20 necessary, chest compression, et cetera. It would have
 21 facilitated a much speedier response, and indeed at one
 22 time they even had to wait for managers to do a risk
 23 assessment, which is absurd.
 24 **Q.** Just moving on to a different topic, and this is about
 25 communication consultation with healthcare workers under

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1 Now, we know that by the autumn of 2020 they did
 2 have enough masks of FFP3 type. CATA and its
 3 predecessors wrote repeatedly to prime ministers,
 4 secretaries of state, first ministers and so on, Public
 5 Health England, NHS England, chief medical officers, to
 6 try to get a change. And we even gave them the option
 7 of saving face with each new variant that came along
 8 which was more transmissible. And each time they came
 9 back and said -- well, the IPC cell said "We've reviewed
 10 the evidence and the virus hasn't changed its mode of
 11 transmission so we don't need to change protection."

12 It hadn't changed its mode of transmission of
 13 course, but as they'd got it wrong in the first place,
 14 that was the problem. That's the elephant in the room
 15 again.

16 **Q.** You said earlier on in your evidence that you felt that
 17 you had been managed out of raising those concerns.

18 **A.** Yes.

19 **Q.** Do you think that that meant that the voices of those on
 20 the ground effectively weren't being heard by the
 21 IPC cell or those creating the guidance?

22 **A.** Well, they weren't. If we just look at CPR, the
 23 Resuscitation Council UK and the Royal College of
 24 Physicians, who should surely be the arbitrators of such
 25 guidance, were completely ignored and the cell continued

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1 the IPC guidance. We were asking earlier on about
 2 whether the IPC guidance should reflect uncertainty in
 3 the evidence. Would healthcare workers actually have
 4 been able to accept and understand that there wasn't
 5 necessarily scientific certainty in the route of
 6 transmission and that they would have just adapted and
 7 dealt with the guidance that they were given?
 8 **A.** Healthcare workers by and large are both intelligent and
 9 caring people, and their purpose is to look after
 10 patients, that's why we become healthcare workers. If
 11 on March 13, 2020 the powers that be that told us it was
 12 only droplet and surgical masks were fine and will
 13 protect you perfectly well against an airborne thing had
 14 actually said "Look, it's tough, there's a world
 15 shortage of PPE", we would have understood. We knew
 16 there was a world shortage, it's not something which we
 17 were ignorant of. We would have understood that. And
 18 if they said, "Well, because it's airborne, we can't
 19 give you the best possible masks, but we can ask you to
 20 open the windows and the rest of the population to take
 21 precautions -- recognising that it's airborne and not
 22 just droplet -- and when we have enough masks, we will
 23 provide them to you, as soon as possible, and we're
 24 working day and night to get them for you", sort of
 25 thing.

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1 to say that CPR is not an AGP, it causes no more trouble
 2 compressing a chest than someone coughing. Well, that's
 3 true too, but they completely missed the point that
 4 coughing generates vast amounts of aerosol.

5 There seemed no way in which healthcare workers
 6 which I was associated with during this pandemic could
 7 actually get to these people and get a sensible
 8 response. They never really ever responded to our
 9 scientific criticisms, they just came back and said
 10 "Read the guidance, it's based on the latest science",
 11 which it wasn't, and that's it. We were managed, we
 12 were pushed away.

13 **Q.** Do you think if there had been some clarification or if
 14 there had been some indication that actually there
 15 wasn't complete certainty in the evidential picture
 16 regarding aerosols, and that that had been transmitted
 17 in the guidance, do you think that that would have
 18 generally helped healthcare workers feel safer?

19 **A.** Well, we would have understood it, and I don't think it
 20 would have resulted in the loss of trust in guidance, in
 21 the demoralisation of the healthcare staff. And it's
 22 put very clearly by Dame Donna Kinnair of the RCN in
 23 a joint letter to the Prime Minister that there was
 24 unequivocal demoralisation and loss of trust in the
 25 guidance.

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1 **Q.** Just a small topic was you raise in your statement about
 2 an inability for there to be local risk assessments to
 3 be carried out. Can you please expand upon what you
 4 mean about how it's not possible to carry out local risk
 5 assessments within an IPC framework?
 6 **A.** Yes, I'd be glad to.
 7 First of all, there was no guidance ever given by
 8 the IPC cell on how to do a risk assessment, certainly
 9 not a local one, and nor from HSE either. We asked them
 10 and they were silent on the subject. So they gave us no
 11 advice on how to do a risk assessment.
 12 If you're going to do a risk assessment, you have to
 13 know what the risk is. The risk was defined as droplet,
 14 for which only surgical masks were used. So if you do
 15 a local risk assessment, you say, "Well, actually
 16 I'm going to be within 1 metre of this patient" -- and
 17 by the way most healthcare occurs within 1 metre of
 18 a patient, because of course no health worker has an arm
 19 longer than 1 metre -- you're in the danger zone there
 20 and you might reasonably say, "That sounds like high
 21 risk, I'd like to use higher grade protection". But the
 22 guidance says no, you can't. And it doesn't just say
 23 no, you can't: if you look at the June 2021, it actually
 24 says FRSMs must be worn for close-range care within
 25 2 metres.

45

1 you just said, you said "you've got to use an FFP3",
 2 I presume you meant to say an FRSM?
 3 **A.** I'm sorry, yes, I beg your pardon, yes.
 4 **MR SCOTT:** Thank you.
 5 My Lady, I was going to move on to a different
 6 topic. I wonder if that might be a suitable time for
 7 a break. I appreciate it's a fraction early, I'm
 8 content to move on and carry on with this next topic, my
 9 Lady, if you prefer.

10 **LADY HALLETT:** I detect a degree of encouragement there,
 11 Mr Scott. Very well, I shall return at 11.20.

12 (11.03 am)

(A short break)

14 (11.20 am)

15 **LADY HALLETT:** Sorry if we're a little late back, there was
 16 some urgent administration we had to attend to.
 17 Mr Scott?

18 **MR SCOTT:** Thank you, Dr Jones.

19 Just a couple of points that I'd just like to
 20 clarify that are arising from your evidence earlier on.
 21 You talked about Lisa Ritchie, and you have been
 22 referring to -- the way you have been phrasing it, it
 23 was her decision-making. It's right, isn't it, that
 24 Lisa Ritchie was, for a period of time, the head of the
 25 IPC cell but this advice in relation to guidance was

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1 So where is the flexibility for local risk
 2 assessment when you've got guidelines like that, which
 3 are going to be read by managers and IPC leads in each
 4 trust?

5 And finally, the proof of the pudding is in when
 6 people actually tried to do local risk assessments. If
 7 I can give you one very good example, at least. We have
 8 in this room Dr Nathalie MacDermott PhD, who tried to do
 9 this. Now, she was one of the most experienced
 10 infectious diseases doctors in this country, with
 11 experience of managing epidemics in Africa and Asia. At
 12 the beginning of the pandemic, she went to her trust,
 13 Leeds, and said "This is an airborne pandemic, I know it
 14 is because I've worked with them, and I want to have
 15 proper protection", and they said "No, you can't have
 16 it, you've got to use an FFP3 mask". She tried
 17 everything she could but she still had to use an FFP3
 18 mask when she was looking after her patients with Covid,
 19 and it wasn't if she got Covid, it was when. And she
 20 did. And she is now in a wheelchair. Terrible
 21 consequences as a result of a failed local risk
 22 assessment.

23 We have another example from one of our members,
 24 Gillian Higgins, who was a --

25 **Q.** If I could just stop you there, there is one thing that

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1 advice coming from the IPC cell; that's right, isn't it?

2 **A.** As I explained earlier, if you put in guidance the word
 3 "must", it ceases to be guidance and is interpreted by
 4 those not always at the coalface, IPC leads and
 5 managers, as being mandatory.

6 **Q.** Yes, but they are the ones --7 **A.** Guidance should be guidance, not tramlines.

8 **Q.** Yes, but the IPC cell was providing advice for the
 9 guidance. They weren't the ones who were deciding
 10 specifically what the wording of that guidance should
 11 be.

12 **A.** Sorry, are you telling me that for a fact or are you
 13 asking me to comment?14 **Q.** I'm asking you to comment on it.

15 **A.** I don't agree. They were supposed to be in an advisory
 16 capacity and their findings, their advice, was published
 17 by PHE, which took no responsibility for them. It
 18 seemed to us that the guidance came directly from the
 19 IPC cell, and it wasn't advisory to another body which
 20 was then implemented. It should have been, it should
 21 have gone up through Public Health England, UKHSA, NHS
 22 England, to SAGE, chaired by Chris Whitty, co-chair, but
 23 it doesn't seem to have happened. It just seems to have
 24 been signed off somewhere along the line by somebody,
 25 we're still not quite sure who. We're not quite sure

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1 who was in charge, if I can put it that way.

2 **Q.** Precisely, it's the lack of certainty about who was
3 taking the decisions, rather than necessarily stating
4 that the IPC cell took the decisions, would you agree
5 with that?

6 **A.** I understand your distinction, yes.

7 **Q.** Also, in terms of Dr Ritchie, Dr Ritchie was the chair
8 for a period, she was part of a cell that took decisions
9 by consensus, so they're not her individual conclusions
10 that she'd reached, these are the conclusions of the
11 cell; would you accept that?

12 **A.** No. I don't agree that it was consensus. I agree --
13 I think that she seemed to have taken an arbitrary view
14 and rejected views of a superior body, Public Health
15 England, as described before the break. I'm not quite
16 sure how that can happen.

17 **Q.** Yes, but you weren't part of the cell, therefore you're
18 not certain precisely how conclusions were reached; is
19 that fair?

20 **A.** Well, none of us can be, except by reading the minutes,
21 which you showed me earlier, and one can only interpret
22 from the minutes that that was the case.

23 **Q.** One other point I want to ask about, the scientific
24 basis and the approach to aerosols. It is not simply
25 the United Kingdom who at the start of the pandemic

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1 about risk assessment?

2 **Q.** Well, I think it appears to be that if hospitals had to
3 risk assess the level of PPE for themselves?

4 **A.** Yes, well, that seems to be an abrogation of the
5 responsibility for those purporting to give guidance.
6 I mean, you can't say you've got to do this and then
7 transfer the responsibility to local people and, as I've
8 already explained, can't do a local risk assessment
9 because the guidance doesn't tell you how to.

10 **Q.** What would you also say to the suggestion that local
11 trusts, hospitals, organisations, boards, HSCTs could
12 choose to locally designate a procedure as an AGP?

13 **A.** They could choose -- sorry, I missed the last bit?

14 **Q.** That they could choose to locally designate a procedure
15 as an AGP; what do you say to that proposition?

16 **A.** I've never heard of that.

17 **Q.** Do you think it was something that would be possible for
18 local bodies to do, given the national guidance?

19 **A.** Not if the guidance says "must", no, and, as I've said
20 already, that's what managers look at. You can't go to
21 your managers and say "Can I have a secure supply of
22 FFP3 for all the people who are looking after these
23 patients doing this procedure", if the guidance says the
24 opposite.

25 **Q.** Because if you have IPC guidance, which is setting out

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1 believed that there was not the primary spread of
2 Covid-19 by aerosol route, is that right? There were
3 other global organisations and other countries who also
4 took that view; is that right?

5 **A.** Correct.

6 **Q.** My Lady, it may be better to deal with those points with
7 other witnesses rather than through Dr Jones.

8 **LADY HALLETT:** Thank you. They included the National Centre
9 of Infectious Diseases in the United States, didn't
10 they?

11 **A.** Indeed. Their views changed a little bit but they came
12 out very early, as far as I understand it, in favour of
13 airborne transmission and proper respiratory protective
14 equipment, and that situation prevails to the current --
15 to the present day.

16 **MR SCOTT:** Just returning then to the idea of local risk
17 assessments, NHS England had asked the question to be
18 asked about whether, if hospitals couldn't decrease the
19 risks based on the hierarchy of controls at any stage
20 during the pandemic, were they not required to risk
21 assess the level of PPE required for their staff, in
22 accordance with their health and safety duties?

23 **A.** Sorry, I'm not sure, the question is exactly?

24 **Q.** Well --

25 **A.** Are you asking me about the hierarchy of controls or

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1 standards, is it incumbent upon professional healthcare
2 workers to follow that guidance?

3 **A.** Professional healthcare workers and their representative
4 bodies took the view that they had a duty of care to
5 their members and imposed guidance and put out their own
6 guidelines, for example the Royal College of Speech and
7 Language Therapy, and my own organisation, BAPEN. But
8 when our members took those to their trusts and those in
9 authority in the trusts, they were often rebuffed, and
10 the guidance which was produced by professional bodies
11 was ignored in favour of the IPC guidance because that
12 seemed to be -- to have the imprimatur of government.

13 **Q.** In terms of the wearing of masks and particularly FFP3
14 masks, do you think that would have had a considerable
15 impact on staff if they had had to wear FFP3 the entire
16 time?

17 **A.** They wouldn't have liked it at all but --

18 **Q.** Do you think --

19 **A.** -- then staff didn't like getting Covid either.

20 **Q.** Which do you think was more important to staff to
21 protect against ...

22 **A.** Well, if it was me, I'd want to wear a mask because
23 I don't like the idea of Covid, and there's at least one
24 person in this room who has had it and will have
25 consequences for the rest of her life and, if you ask

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1 her, she will say, "I would rather prefer to wear
2 a mask".

3 **Q.** Do you think that the fact that there was a possibility
4 that healthcare workers may have caught Covid-19 outside
5 of their professional setting has any relevance
6 whatsoever to whether they should have got less
7 protection from Covid-19 in their professional setting?

8 **A.** That's a good question. Perhaps I could refer to the
9 study from Ferris et al from Cambridge.

10 **Q.** Well, just in terms of referring to the study, I think
11 it's more a matter of principle about whether you do
12 think there is any relevance to what might happen
13 outside, in terms of the level of protection that should
14 be offered to healthcare workers?

15 **LADY HALLETT:** I don't think you need to pursue that,
16 Mr Scott. I don't think there's any relevance.

17 **A.** I was just going to say --

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

19 **A.** -- that community prevalence obviously is reflected in
20 hospital prevalence but we know that healthcare workers
21 were at much greater risk than in the community.

22 **LADY HALLETT:** Exactly.

23 **MR SCOTT:** Then just in terms of any potential
24 recommendations that should be made, I think you were
25 critical of the lack of transparency that there was from

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1 **MS MITCHELL:** It's just arrived on our screen, thank you.
2 This email expresses your continuing concern about
3 the fact that there were delays, and I wonder if I can
4 take you to the bottom of -- or, sorry, halfway down
5 that letter, where it says that your group has been
6 "astonished and dismayed at the slowness" of the AGP
7 panel, pressing need for revised advice, and you've
8 reminded them of the number of people in hospital and
9 also the number of healthcare workers.

10 You have posed a question at the end of that letter,
11 and the question is this, in the context of the fact
12 that you were given assurances that the minutes of
13 meetings would be published, which you've just spoken
14 about, you also say:

15 "Why has it taken so long for any output from this
16 panel when other scientific groups seem to be able to
17 respond to the changing situation so much quicker? This
18 failure to reflect the urgency of the matter may be
19 reflected in greater mortality and morbidity which could
20 have been avoided by a more expeditious response."

21 My question for you in that regard is: did you ever
22 find out what the cause was of the delay for the output
23 from the AGP panel?

24 **A.** This is distinct from the UK IPC cell, just to be clear,
25 and this panel was set up in response to BAPEN, I signed

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1 the IPC cell as a whole and the decisions that they
2 reached. Do you consider that, in the event that there
3 is a body in a future pandemic, like the IPC cell, that
4 the minutes of their discussion should be published?

5 **A.** Yes, I thought that was a standing regulation in
6 government, indeed the King's Speech mentioned a duty of
7 candour, so I would expect that to happen, yes.

8 **MR SCOTT:** My Lady, I have no further questions.

9 **LADY HALLETT:** Thank you very much, Mr Scott.
10 Dr Jones, there are some questions from Ms Mitchell.

11 **Questions from MS MITCHELL KC**

12 **MS MITCHELL:** Dr Jones, I appear on behalf of the Scottish
13 Covid Bereaved, as instructed by Aamer Anwar & Company,
14 and I'd like to ask you a couple of questions.

15 I wonder if we could have before us INQ000300310.
16 This is an email chain, in which you have emailed
17 the AGP panel, and there are a number of emails, but
18 I would just like to deal with the last one of
19 22 December. It's fair to say in this email chain you
20 have been expressing in terms increased frustration at
21 the fact that the output from the panel, in terms of
22 advice or guidance, has not been forthcoming. Your
23 email, the top document, if we can have that up, please,
24 of 22 December 2020 ...

25 **LADY HALLETT:** I've got it up.

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1 the letter to Chris Whitty and to Ruth May, and this was
2 set up at the beginning of May 2020.

3 By September, we'd not heard from them and,
4 eventually, I got a message from one of their officials
5 saying they'd lost our letter, and then we got one later
6 saying that they were just getting to the final stages
7 and they will publish in about a month's time, and I got
8 very exasperated before Christmas and wrote this email.
9 As it happens, the question I posed at the end, about
10 greater mortality and morbidity, which could have been
11 avoided, it turns out that it wouldn't have been avoided
12 because this panel found absolutely no reason to change
13 the list whatsoever, and I can expand on that if you
14 wish.

15 **Q.** Well, no, I think the Chair already may have enough in
16 that regard, and she's nodding her assent to that
17 matter. So there was this delay and still to this day
18 this delay remains, at least in your view unexplained?

19 **A.** I think it's appalling, the rest of us were working at
20 pace to get things done, it took seven months at the
21 height of the pandemic, as the second wave hit. We got
22 the message -- we eventually received this report, not
23 in the first week of January when I was promised it by
24 the chair of this panel on 23 December, say after this
25 email, but in the second week of January, so

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1 seven months, which I think is appalling.

2 **Q.** I wonder if I might briefly then move on to another
3 document and ask you to comment on it.

4 That is INQ000118447.

5 This is a response letter from one which you and
6 other colleagues drafted by the chair, Sarah Newton, of
7 the Health and Safety Executive and this document
8 indicates, if I could guide you down, please, to
9 paragraph 3, it says:

10 "All employers, including those in the NHS, are
11 checked to assess the risks to their workers created by
12 their work activity and to implement appropriate
13 measures to control these risks. In making this
14 assessment, employers are expected to use up to date and
15 relevant guidance."

16 Then later in that letter, just at the bottom of the
17 page, it says:

18 "We will not be undertaking a review of this
19 guidance as this has already been done", and lists the
20 various bodies that that has been done.

21 Can I ask you, did this letter satisfy you that the
22 appropriate enforcement action had been taken by HSE
23 and, if not, why not?

24 **A.** First question: absolutely not. All the correspondence
25 we had from HSE made it clear that as long as trusts,

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1 of speed at which we were moving.

2 My question to you, not necessarily you need to have
3 particular regard to this, but my question to you is: as
4 late as 2021 your organisation considered that Scotland,
5 as well as the rest of the UK, was significantly lacking
6 behind in its approach to PPE infection control.

7 In your opinion, did the UK ever catch up with the
8 rest of the world, either during the pandemic or after?

9 **A.** In part. But here it's very interesting because this
10 virus has generated extraordinary abilities to change
11 its behaviour as it crosses Hadrian's Wall. The English
12 guidance says that when you enter a room -- first of
13 all, it says aerosol transmission is actually rather
14 significant and, when you enter a room with someone with
15 Covid, you should wear respiratory protection, expect
16 that the table of that footnote attached to it says that
17 you must wear an FRSM for routine care and FFP3 for
18 AGPs.

19 In Scotland, it still refers to respiratory
20 particles in the 5-micron definition and they've only
21 got the table there, not the footnote, and it says FRSMs
22 for routine care and FFP3s for AGPs.

23 We understand that the Scottish NIPC, and that's
24 their national manual for IPC, is under review at the
25 moment and we've seen the prelude to that and it's still

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1 hospitals were following, they called it Public Health
2 England guidance, that was fine by them, so if they were
3 using surgical masks and off sick, that was fine. It
4 didn't matter that they were the wrong masks, and we've
5 regarded the response of the Health and Safety Executive
6 as entirely unsatisfactory throughout the whole
7 pandemic. There may be some good reasons for that, but
8 they didn't have to take this view. They could have
9 said "Yes, we do have a regulatory responsibility here
10 and we should discharge it and make sure that others do
11 too". And, as far as we understand it in CATA, the
12 legal aspects of their responsibility and those applying
13 to employers were not suspended by the emergency
14 legislation during Covid, so why were they not
15 continued?

16 **MS MITCHELL:** Dr Jones, I'm obliged.

17 My Lady, I have a third question but I think I'm out
18 of time, so I shall leave it there.

19 **LADY HALLETT:** Ask it, Ms Mitchell.

20 **MS MITCHELL:** Thank you.

21 If I could have INQ000114429 before the screen.

22 This is a document in relation to the lag behind of
23 the UK in its approach to PPE and infection control, and
24 I think, in the course of that particular document
25 further down, there is a quote from you about the lack

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1 predicated on 5 microns. Have we caught up? I do not
2 think so. I don't know why not.

3 **MS MITCHELL:** My Lady, I'm obliged.

4 **LADY HALLETT:** Thank you very much, Ms Mitchell. That
5 completes the questions the Inquiry and the core
6 participants have for you, Dr Jones, thank you very much
7 for your help.

8 **THE WITNESS:** Thank you.

9 **(The witness withdrew)**

10 **LADY HALLETT:** Mr Scott.

11 **MR SCOTT:** My Lady, I don't know whether you wish to rise
12 while we transfer witnesses.

13 **LADY HALLETT:** No.

14 **MR SCOTT:** Then I shall move aside for my learned friend.

15 **LADY HALLETT:** Ms Nield.

16 **(Pause)**

17 **MS NIELD:** I would like to call, please, Mr Brunt.

18 **MR RICHARD BRUNT (affirmed)**

19 **Questions from COUNSEL TO THE INQUIRY**

20 **LADY HALLETT:** Sorry if we've kept you waiting, Mr Brunt.

21 **THE WITNESS:** It's okay, thank you.

22 **MS NIELD:** Could you give your full name, please, Mr Brunt?

23 **A.** Yes, it's Richard Gregory Brunt.

24 **Q.** Mr Brunt, I think you've given a witness statement to
25 this Inquiry, dated 17 November 2023. That's

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1 INQ000347822. You're familiar with that witness
 2 statement. I think you have a copy with you.
 3 **A.** I am, yes.
 4 **Q.** On page 99, that bears your signature and the statement
 5 of truth.
 6 **A.** Yes, it's correct.
 7 **Q.** You can confirm, can you, that the contents of that
 8 statement are true to the best of your knowledge and
 9 belief?
 10 **A.** Yes, it is.
 11 **Q.** Thank you.
 12 Mr Brunt, you're the director of the engagement and
 13 policy division at the Health and Safety Executive; is
 14 that right?
 15 **A.** That's correct, yes.
 16 **Q.** Can you explain, please, what does that role entail?
 17 **A.** I'm a member of HSE's executive committee, the division
 18 I'm responsible for leads on HSE's policy issues,
 19 engagement with others, communication activities, and so
 20 on, across the full range of activities that HSE is
 21 responsible for.
 22 **Q.** In terms of your background with the Health and Safety
 23 Executive, you have also worked as a health and safety
 24 inspector; is that right?
 25 **A.** I have, I have been with the Health and Safety Executive

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1 **Q.** It has a role in enforcing workplace health and safety
 2 law, so that's the 1974 law that we've just referred to,
 3 and associated regulations; is that right?
 4 **A.** That's right, yes, the Health and Safety at Work Act
 5 sets the framework and there are a wide range of
 6 supporting regulations that help enact some of those
 7 provisions.
 8 **Q.** This may seem like a question with an obvious answer
 9 but, in terms of those regulations which it falls to the
 10 Health and Safety Executive to enforce, do the Health
 11 and Safety Executive have a role in making or drafting
 12 those regulations?
 13 **A.** We do. HSE has its own policy function that drafts
 14 regulations. Some of that legislation will have been
 15 generated in the past by European legislation and how we
 16 then implement it into UK law.
 17 The legislation is retained legislation, so it's not
 18 devolved to Scotland and Wales, whereas some of the
 19 other legislations of relevance in healthcare is
 20 a devolved matter. But we are responsible for the
 21 interpretation and application of that legislation.
 22 **Q.** In terms of when regulations are being drafted, would
 23 the Health and Safety Executive have input and advice in
 24 terms of the reach of legislation and regulations?
 25 **A.** Yeah, I mean, with any legislative drafting, we would be

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1 for almost 35 years. I started as an inspector, I've
 2 worked across the range of policy, operational strategy,
 3 and so on, I'm a member of the Institute of Occupational
 4 Safety and Health and a chartered registered safety
 5 practitioner.
 6 **Q.** Thank you.
 7 Can you please set out briefly a summary of the role
 8 and the function of the Health and Safety Executive,
 9 please?
 10 **A.** Okay. The Health and Safety Executive is responsible
 11 for workplace safety across the range of activities in
 12 Britain from major hazards, manufacturing, agriculture,
 13 construction. Our primary focus is on worker safety,
 14 the safety in the workplace of people at work. Some of
 15 the health and safety responsibilities also are there
 16 towards protection of members of the public from
 17 industrial risks and hazards that are generated by the
 18 work of those businesses.
 19 **Q.** I think the Health and Safety Executive is also a UK
 20 Government agency and it's sponsored by the Department
 21 of Work and Pensions; is that right?
 22 **A.** That's correct, yes.
 23 **Q.** The Health and Safety Executive was established,
 24 I think, by the Health and Safety at Work Act 1974?
 25 **A.** That's correct, yes.

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1 responsible for consulting as to the impact of that
 2 legislation, through the usual Parliamentary processes,
 3 with the range of legal advice as to interpretation and
 4 applicability of that legislation. So it is all subject
 5 to the usual processes of the Parliament.
 6 **Q.** Now, in summary, what powers does the Health and Safety
 7 Executive have in enforcing those regulations in the
 8 workplace, if they encountered a breach in a particular
 9 workplace?
 10 **A.** Okay. The short summary, the responsibilities for
 11 enforcing health and safety law comes from section 20 of
 12 the Health and Safety at Work Act, and it gives a full
 13 range of enforcement ability from provision of
 14 information, provision of advice, the -- that can be
 15 both verbal and written advice. We have -- our
 16 inspectors have the power to serve enforcement notices
 17 to require improvements where companies and duty holders
 18 are in breach of legislation. We have the power to
 19 serve prohibition notices for the most serious breaches
 20 and, indeed, we have the power to bring legal
 21 proceedings and prosecution if that's the appropriate
 22 course of action.
 23 **Q.** So in terms of that escalating range of enforcement
 24 actions that are open to the Health and Safety
 25 Executive, you explained the provision of verbal advice

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1 is also regarded by the Health and Safety Executive as
2 enforcement action; is that right?

3 **A.** Effectively, if an inspector finds a business to be
4 lacking in some respect, the level of action they take
5 is proportionate to the level of breach they've found,
6 and we have ways of working through that. So if
7 somebody is just slightly below the level expected, we
8 may decide verbal advice is sufficient. If it's
9 a little more serious, we would move up to written
10 advice or written action.

11 I think it's relevant when we take -- when we commit
12 something to writing, the way HSE is funded, that
13 triggers what we call fee for intervention, so a duty
14 holder has to pay to cover HSE's costs for having taken
15 that action. Then as that moves up, enforcement notices
16 and, as I say, ultimately, in serious cases, prosecution
17 are all possible. That is the full range of
18 enforcement, if an inspector decides they need
19 a business to take corrective action.

20 **Q.** Thank you.

21 Now, as to the Health and Safety Executive's
22 approach to enforcement, you've set out in your witness
23 statement that the Health and Safety Executive have
24 designed or developed an enforcement management model to
25 assist inspectors. Could you very briefly please

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1 would come to this point and say "I think I need to take
2 the following action". We then allow the -- the
3 guidance allows the inspector to take the discretionary
4 local factors as to the conditions they've found
5 on site, previous advice, the attitude of the company,
6 et cetera, to either escalate that or increase that
7 level of enforcement or, indeed, decrease it if they
8 think that's appropriate.

9 **Q.** Thank you very much. Now, we'll come on to talk about
10 the enforcement management model in relation to Covid-19
11 in healthcare settings in due course, but you mentioned
12 there that the enforcement management model looks at the
13 level of risk and the level of harm, and there's
14 a categorisation process of different degrees of harm in
15 terms of the consequences of the breach; is that right?

16 **A.** There is. We categorise from serious harm --

17 **Q.** I think there was also significant.

18 **A.** Significant, thank you, I was just trying to get them in
19 the right order: serious, significant, minor and
20 negligible.

21 **Q.** Thank you.

22 **A.** So there's different levels and we would compare that
23 against sort of known standards.

24 **Q.** As I say, we will come back to that in due course but
25 that's very helpful.

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1 explain what that enforcement model is?

2 **A.** Absolutely. As you pointed out, the Health and Safety
3 at Work Act and those powers came into existence some
4 50 years ago, and throughout that, the inspectors'
5 application of their powers, as an individual appointed
6 as an inspector is at the discretion of that inspector
7 and what they've found.

8 So, historically, HSE, to make sure we are
9 consistent, proportionate, transparent as a regulator,
10 as indeed regulators are required to be, developed
11 a process that captured the thought process an inspector
12 goes through, and we refer to that as our enforcement
13 management model. So it is a tool that replicates
14 a thought process that inspectors go through and still
15 gives them the discretion to make a final decision about
16 enforcement.

17 So, very briefly, an inspector visits a premises,
18 they observe the conditions there, they compare them
19 with the expected standards and how far apart the
20 observed conditions are from the standards on site and,
21 if there is a gap, they then assess how big the risk is
22 of that gap, how likely harm is, how serious the harm
23 could be, and all of those factors then play into what
24 we'd refer to as an initial enforcement expectation.

25 So that's the point where we'd say most inspectors

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1 You also set out that, under the Health and Safety
2 at Work Act there's a general duty for every employer to
3 ensure, so far as is reasonably practicable, the health,
4 safety and welfare at work of all its employees and that
5 general duty extends to those employers working within
6 the healthcare setting to look after the health, safety
7 and welfare of its healthcare staff.

8 Now, in healthcare settings, not all those workers
9 who are going to be working in that setting are directly
10 employed, they're not all employees, some might be
11 agency workers, some might be contractors. In terms of
12 protection of the health and safety of those workers who
13 are not employees, does the Health and Safety Executive
14 have a different approach to those, or do the duties
15 also extend to them?

16 **A.** No, those duties extend. The framework of the Health
17 and Safety at Work Act is goal setting, it requires
18 those people that create the risk to manage the risk and
19 it recognises within the section, section 2 refers to
20 employees, section 3 refers to others who may be
21 affected, and we take that as those that are working
22 under an undertaking, be it a business, be it a health
23 trust, a duty holder, that duty extends to protect all
24 of those that are affected by that work activity.

25 **Q.** I think section 3 also is considered to extend to risk

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1 to patients who would be in a healthcare setting, but
 2 you go on and explain that there is a memorandum of
 3 understanding between the healthcare regulators and the
 4 Health and Safety Executive in terms of how their
 5 respective responsibilities are delineated in that
 6 regard; is that correct?

7 **A.** That's correct. As I said, the -- some of the
 8 healthcare matters are devolved to the nations of the
 9 UK, whereas health and safety legislation is retained.
 10 Because of that, there are slight differences between
 11 England, Scotland and Wales, and I should clarify that
 12 HSE works in GB and there is an HSE Northern Ireland
 13 that takes care of Northern Ireland, so we have the
 14 arrangements between those healthcare enforcement
 15 bodies. Their primary focus is generally on patient
 16 safety in terms of clinical decisions, treatment,
 17 et cetera. Some of the health and safety of patients is
 18 also devolved to those other bodies, such as the CQC in
 19 England and the equivalents in Scotland.

20 **Q.** So that would be the non-clinical risks, such as
 21 slipping, scalding?

22 **A.** Absolutely, the non-clinical. The clinical risks would
 23 rest with those agencies.

24 **Q.** So the focus of the Health and Safety Executive of
 25 course is on workplace health and safety, and you've

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1 in your witness statement that COSHH applies to both
 2 incidental exposure to and deliberate work with
 3 biological agents; is that correct?

4 **A.** That's correct, yes.

5 **Q.** You go on to say that that would not apply to the
 6 situation where one employee catches a respiratory
 7 infection from another employee; is that right?

8 **A.** That's correct.

9 **Q.** Can you explain how the COSHH regulations applied to
 10 Covid-19 infections in a healthcare setting during the
 11 pandemic?

12 **A.** I can, but I think, just to set the context, it would be
 13 useful to explain that COSHH, like a lot of other
 14 legislation, requires a risk assessment process and the
 15 hierarchy of control, and that hierarchy starts with
 16 eliminating a hazard. If you can't eliminate it, you
 17 substitute; if you can't, you use physical controls, you
 18 use administrative controls; and, ultimately, if you
 19 can't do all of that, you may rely on personal
 20 protective equipment. And that does have to be applied
 21 as a hierarchy and it does have to be applied on the
 22 basis of a risk assessment.

23 So in a healthcare setting, in relation to Covid, in
 24 some of those non-clinical areas where you are thinking
 25 that there may be, you know, patient -- people that

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1 explained that, in relation to healthcare settings
 2 during the Covid-19 pandemic, that remained your focus.

3 You did not have a role as the enforcement body for
 4 the coronavirus regulations in the workplace or in
 5 healthcare settings; is that right?

6 **A.** That's correct, the coronavirus regulations were made in
 7 recognition that the Health and Safety at Work Act
 8 itself is work focused and not focused on the more
 9 general public health issues of a pandemic. So the
 10 coronavirus regulations were made to address some of
 11 those difficulties, where we would not be able to apply
 12 the Health and Safety at Work Act.

13 **Q.** You explain that the enforcing role was with the police
 14 and local authorities in relation to the Coronavirus
 15 Act; is that right?

16 **A.** That's correct, yes.

17 **Q.** If I can move on to those regulations that were
 18 enforceable in healthcare settings during the pandemic
 19 by the Health and Safety Executive, we're going to look
 20 at the Control of Substances Hazardous to Health
 21 regulations, which I'm going to call COSHH, and the
 22 Reporting of Injuries, Diseases and Dangerous
 23 Occurrences Regulations 2013, which I'm going to call
 24 RIDDOR.

25 If we can deal firstly with COSHH, you've explained

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1 could coincidentally come near patients with Covid, such
 2 as cleaners, you would be looking at the elimination,
 3 the distancing, physical separation, and so on.

4 As you start working through that, you recognise
 5 that some of that hierarchy cannot be applied and still
 6 enable a healthcare worker to give the right level of
 7 care to the patient, and carry out any procedures and
 8 care they may need to give. So, in those, you get
 9 closer and closer to relying on personal protective
 10 equipment. All of that does have to be based on a risk
 11 assessment that is applicable to that undertaking but
 12 some of the standards expected could be extrapolated
 13 from elsewhere.

14 **Q.** Right. We'll come on to that in a moment.

15 Does COSHH specify precisely what level and types of
 16 PPE should be provided to workers or does that depend on
 17 a risk assessment?

18 **A.** That depends on a risk assessment. COSHH is applicable
 19 to a full range of work activities right across all
 20 industries and, because of that, as I said, it sets the
 21 goals and the process by which you must get there and
 22 leaves the decision-making to those that have the most
 23 knowledge of the risk and the ability to control it.

24 **Q.** You said a moment ago that it may be possible for
 25 employers to extrapolate what's the appropriate

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1 protection from other sources. I don't think we need to
2 get this up on screen but, from health and safety
3 guidance that was drafted to guide decision-making by
4 Health and Safety Executive regulatory staff, it says:

5 "If an employer is following the relevant public
6 health guidance for their sector, they will generally be
7 taking reasonably practicable precautions to control
8 workplace risks."

9 Now, in relation to the UK-wide IPC guidance,
10 I think you refer to it sometimes in your witness
11 statement as the "four nations PHE guidance", that's the
12 same thing?

13 **A.** That's correct, it's the same thing, yes.

14 **Q.** So if an employer in a healthcare setting during the
15 pandemic ensured that the UK IPC guidance was being
16 implemented and the PPE specified in that guidance for
17 that activity was being provided for workers, would the
18 Health and Safety Executive consider that that employer
19 had taken appropriate measures to protect workers from
20 risks of Covid?

21 **A.** The simple answer is yes, and I think to explain that
22 and put it in context, you've used the phrase quite
23 rightly "reasonable practicability", which is the
24 bedrock of the Health and Safety at Work Act. That is
25 a balance between the level of risk and the amount of

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1 I think the other thing is that that IPC guidance
2 will set a sort of -- the benchmark, the minimum
3 standard to be achieved. Should someone wish to go
4 above that there would be nothing to stop their
5 assessment saying that's what they could do.

6 **Q.** Thank you. But, certainly, if a healthcare employer
7 didn't go beyond that minimum standard or minimum level
8 of protection specified in the IPC guidance, the Health
9 and Safety Executive wouldn't consider that to be --

10 **A.** We accepted that as the appropriate level of compliance.

11 **Q.** Can we have a look, please, at the PPE ensemble table
12 under the IPC guidance.

13 This is INQ000269663.

14 Have you got that on your screen?

15 **A.** I have, yes.

16 **Q.** I think you explain in your witness statement that in
17 March 2020 the Health and Safety Executive were invited
18 to comment on these PPE ensemble tables in relation to
19 the UK IPC guidance. This had been formulated by the UK
20 IPC cell. Other than being asked to comment upon this
21 table, did the Health and Safety Executive have any role
22 within the UK IPC cell? Were they members of that cell?
23 Were they involved in formulating guidance?

24 **A.** We would have provided advice in the same way as we've
25 commented on this through our regulatory and scientific

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1 effort to manage and control that risk. That's where
2 a judgement comes in.

3 If I then refer it to the enforcement management
4 model that we've talked about, we would look for
5 benchmark standards as that measure of reasonable
6 practicability. So, effectively, the IPC guidance and
7 the parts of that that relate to protecting the
8 healthcare worker would be seen as a defined standard
9 that demonstrates that that level is being achieved.

10 **Q.** Did the Health and Safety Executive consider that there
11 was a lack of clarity for employers concerning their
12 duties under COSHH and how they might apply the IPC
13 guidance?

14 **A.** I think we've looked at that through our work and how we
15 have supported and helped healthcare trusts throughout
16 the pandemic. As I said, some of the approach we used,
17 enforcing and ensuring compliance with duty holders, is
18 around providing adequate information, et cetera. So,
19 effectively, our advice and support to trusts, through
20 the various routes we'd have used, would have indicated
21 that using that guidance is the right thing to do, and
22 giving them that latitude to look at their local risk
23 assessments required by that, that the employer could
24 carry out, to actually decide whether or not that fully
25 fitted their situation.

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1 advice through the Department of Health, through Public
2 Health England at the time, and sort of acting as
3 an adviser in our sort of role as a Category 2 responder
4 for UK emergencies.

5 **Q.** If we can have a look briefly at some of the PPE that's
6 set out here as recommended, we can see that in the
7 third row:

8 "Working in an inpatient area (not a higher risk
9 acute care area) with suspected or confirmed cases and
10 frequent direct patient contact/within 1 [metre]."

11 What are recommended there are single use disposable
12 gloves, single use plastic apron, sessional use
13 fluid-resistant -- it says "(Type IIR) surgical mask"
14 and sessional use eye protection.

15 Then if we can have a look at the top row, please:

16 "Performing an aerosol-generating procedure in any
17 setting."

18 What's then recommended is single use disposable
19 gloves, single use disposable fluid-resistant gown,
20 filtering face piece respirator, single use, and single
21 use eye protection.

22 Did the Health and Safety Executive have any role in
23 specifying or have a position on airborne exposure to
24 Covid-19 in relation to non-aerosol-generating
25 procedures?

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- 1 **A.** I believe at that time the scientific advice -- and our
2 chief scientific adviser will have been, you know, part
3 of the national bodies sharing such information, that at
4 the time this was drafted it was considered that
5 airborne aerosol transmission wasn't a factor, other
6 than those aerosol-generating procedures. So we will
7 have challenged the science behind this and made sure
8 that we were satisfied as a regulator that that was the
9 best available information at the time.
- 10 **Q.** If we can look at the different types of PPE, we see
11 that filtering face piece respirator is specified for
12 aerosol-generating procedures. I think you have
13 explained in your witness statement that the filtering
14 face piece respirators for use in healthcare settings in
15 the UK are FFP3 and FFP2; is that right?
- 16 **A.** That's right.
- 17 **Q.** And that FFP2 have been found to be equivalent to the US
18 specification N95?
- 19 **A.** That's correct.
- 20 **Q.** And you've explained in your witness statement that
21 whilst FFP3 was the usual recommended control measure,
22 if global supplies of FFP3 masks were low, FFP2 could be
23 used as an alternative?
- 24 **A.** That's correct. And effectively the number at the end
25 of an FFP equates to a level of protection, and

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- 1 and I say limited in terms of they're not the same as
2 an FFP.
- 3 If I put it in context, HSE regulates the provision
4 of PPE. PPE is designed to protect the individual and
5 nobody else. It's personal. The fluid-resistant mask
6 is classed as a medical device, not as PPE. It's
7 regulated by the MHRA, that's the Medicines and
8 Healthcare products Regulatory Agency, and we obviously
9 liaise very closely with them around those. So although
10 it may offer some protection, it's not what we would
11 consider PPE. You may look at it in terms of being
12 other parts of a precaution.
- 13 **Q.** When the Health and Safety Executive commented on this
14 ensemble table, PPE ensemble table, did the Health and
15 Safety Executive raise any comments about the adequacy
16 of specifying fluid-resistant surgical masks in
17 non-aerosol-generating procedures?
- 18 **A.** I think from our point of view, I don't know
19 categorically whether or not we did offer any comments
20 on that, but we would be looking at that -- we would be
21 looking at the aerosol-generating procedures as things
22 that are likely to affect the worker, which is where we
23 would have had a focus, rather than necessarily on the
24 outside of that environment, and that would be the MHRA.
- 25 **Q.** Did you raise any issues with -- this is set out as

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1 effectively how much of a contaminant you could be
2 exposed to and it would protect you from and for how
3 long. So FFP2 3 gives a higher standard.

4 As I recall, when changes in the sort of World
5 Health Organisation position changed as to how big
6 a risk this was, there was a move to say FFP2 was
7 sufficient for the level of risk and how communicable
8 the disease was.

9 **Q.** Thank you.

10 If we could look now, please, at fluid-resistant
11 surgical masks, I'm going to call these FRSMs. They are
12 not considered by the Health and Safety Executive to be
13 PPE, are they? You say in your witness statement
14 they're used as source control:

15 "... this means they are intended to limit the
16 transmission of infective agents from staff (the wearer)
17 to patients (non-wearer) during surgical procedures and
18 in other medical settings ... The aim of universal
19 masking in hospital settings using surgical masks was to
20 reduce the emission of virus particles by everyone
21 wearing a surgical mask."

22 Does that mean that the Health and Safety Executive
23 consider that fluid-resistant masks offer no protection
24 to the wearers?

25 **A.** They offer a limited amount of protection for droplets,

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1 a recommended PPE table, but fluid-resistant surgical
2 masks are not considered by HSE to be PPE. Was that
3 point raised in the drafts on the guidance?

4 **A.** As far as I'm aware, yes, it would, and certainly I know
5 the conversations that I had with PHE and DHSC
6 throughout the pandemic, we were always going back to
7 that, that fluid-resistant masks are not PPE.

8 **Q.** Thank you.

9 While we're on the subject of PPE -- and we can take
10 that table down, thank you, Lawrence -- I'd like to deal
11 briefly, if I can, with some issues that arose during
12 the pandemic in relation to marking on PPE products.

13 There were broadly three areas of concern, and we
14 can go through each one, but: firstly, PPE that was not
15 CE marked as compliant with conformity with European
16 safety regulations; secondly, PPE that had been re-lifed
17 by placing a new expiry date over the original expiry
18 date stamp; thirdly, PPE that was marked "not for
19 medical use" but was used in healthcare settings.

20 Is it right to summarise it in this way: in respect
21 of all three of those labelling issues, before that --
22 any such PPE was made available for use in the
23 healthcare sector, that PPE had to have been assessed by
24 the Health and Safety Executive and found to be
25 compliant with the relevant elements of the essential

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- 1 health and safety requirements of the regulations?
- 2 **A.** That is, and I'd also stress that it could only be
3 supplied for the healthcare sector, because HSE had a --
4 were able to give that derogation under EU legislation,
5 we were a member of the EU at the time, and that would
6 not allow that equipment to be used anywhere outside the
7 healthcare setting.
- 8 **Q.** Was the Health and Safety Executive aware or was it made
9 aware during the pandemic that those three types of RPE
10 or those three labelling issues were causing concern for
11 healthcare workers in healthcare settings as to causing
12 some confusion about whether those were appropriate
13 items for them to use?
- 14 **A.** Yes, we were aware of that. We worked very closely with
15 DHSC and others through the supply chain, gave advice as
16 to the information that would also need to be included
17 in those. As I said, the whole basis of being able to
18 provide that for healthcare is a derogation that was
19 from EU legislation that said "for healthcare only",
20 therefore the enforcing authority can, subject to them
21 being satisfied with the performance of that equipment,
22 allow it to be supplied in these circumstances.
- 23 **Q.** So was it envisaged by the Health and Safety Executive
24 that would be for employers to explain that those safety
25 steps had been taken?

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- 1 whether they can smell or taste that substance that's
2 being released. Is that right?
- 3 **A.** That's correct. I mean, very broadly there's two ways:
4 one, you either put a measuring device inside the mask
5 and see what is being drawn into the air quantitative
6 measurement, otherwise it's asking someone "Is this
7 fitting? Can you smell or taste" -- whatever he's being
8 exposed to.
- 9 **Q.** With the quantitative measurement there's a machine that
10 has to do that?
- 11 **A.** There is, yes.
- 12 **Q.** With either type of fit testing, the fit tester has to
13 be trained to carry out a fit test, so that requires
14 training a person?
- 15 **A.** Yeah, you need a person with the right skills,
16 experience, et cetera, trained, yes.
- 17 **Q.** And evidently, as everyone's face shape is a different
18 shape and size, it's going to be unlikely for a single
19 model of FFP to fit every face type, so it's necessary
20 to have a range of models; is that right?
- 21 **A.** Exactly. Any employer, anyone that's relying on PPE
22 should have a number of different models. You then test
23 to see which one is giving the right level of
24 protection.
- 25 **Q.** Now, you have been made aware, I think, of a study which

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- 1 **A.** It would be ultimately for the employer to explain. The
2 expectation is it's cascaded through that supply chain,
3 which was being run closely by DHSC and others, saying
4 make sure adequate information was being provided with
5 that PPE to be able to explain those -- those
6 circumstances.
- 7 **Q.** Thank you.
- 8 If we can move on, please, to fit testing of
9 respiratory protective equipment. You explain that in
10 relation to FFP2 and FFP3, those are respirators which
11 rely on having a good seal, a good fit and a good seal
12 with the skin of the wearer; is that right?
- 13 **A.** Absolutely. In order to give the right level of
14 protection, they've got to fit very firmly against the
15 face, because if there's any gaps, as you inhale the air
16 takes the line of least resistance, and it can be as
17 significant as a gentleman that hasn't shaved for
18 24 hours, the mask worked yesterday, it might not work
19 today.
- 20 **Q.** And you explain that there are two basic types of
21 fit testing, qualitative and quantitative. Am I right
22 to summarise it in this way: qualitative fit testing
23 relies on the subjective assessment of the wearer,
24 they're asked to apply the mask and then a strong smell
25 or a bitter taste is released and it's a question of

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- 1 has been provided, it's been provided to the Inquiry by
2 the Federation of Ethnic Minority Healthcare
3 Organisations, and that's been provided to you, and that
4 study found that the failure rates of fit testing were
5 significantly higher in staff from black and ethnic
6 minority ethnic backgrounds.
- 7 Was Health and Safety Executive aware that
8 fit testing was more often failed by black and minority
9 ethnic staff?
- 10 **A.** I think some of that information was available. The key
11 point to us is that somebody has to be able to pass
12 a fit test before you're relying on that protective
13 equipment, and hence the -- it underlines the importance
14 of having that range of models.
- 15 Effectively, the standards that PPE is designed to,
16 certainly that -- these CE marked, is based on European
17 standards and the face shape of those ethnic groups.
- 18 **Q.** Did Health and Safety Executive take any steps in
19 relation to those difficulties with not every model
20 fitting every face? Did Health and Safety Executive
21 issue any guidance or any advice for employers about the
22 need to have a diverse range of --
- 23 **A.** Yes, our guidance has always said that, and that would
24 have been the guidance we relied on. As I said, it is
25 the individual nature of PPE.

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1 **Q.** Now, you set out that there were a number of issues with
 2 fit testing during the pandemic: a lack of testing
 3 machines, sometimes a lack of the testing fluids that
 4 were needed for qualitative testing, and also issues in
 5 relation to staffing resources to carry out the
 6 fit tests. And you explain that towards the end of
 7 March 2020, the chief executive for a group of
 8 NHS trusts contacted the Health and Safety Executive to
 9 ask whether it would be possible to remove the
 10 requirement to fit test RPE and do a fit check instead.
 11 Can you help us with the response of the Health and
 12 Safety Executive to that request?

13 **A.** If I summarise it, it was: you must do a fit test, a fit
 14 check is not a substitute.

15 **Q.** What is a fit check?

16 **A.** A fit check is sort of like the daily check by the
 17 person using the PPE to assure themselves that they have
 18 fitted it correctly as it was at the fit test. A very
 19 simple way of describing it is having had a -- chosen
 20 a model that gives you the right level of protection,
 21 has passed the fit test, when you then put it on you put
 22 your hands over the filter to sort of try to slow the
 23 air going down through it, take a sharp intake of breath
 24 and see if it collapses. In very simple terms, it is
 25 just making sure it is on as it's supposed to be.

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1 something of that nature.

2 **Q.** Were those specified? We didn't see those specified in
 3 the ensemble table that we saw. Were those specified in
 4 IPC guidance, those alternatives to FFP2?

5 **A.** I can't off the top of my head recall if they were
 6 specified in IPC guidance, but certainly within sort of
 7 health and safety standards and guidance on PPE they
 8 would have been there as an alternative.

9 **Q.** Thank you.

10 Can we move on, please, to Reporting of Injuries,
 11 Diseases and Dangerous Occurrences Regulations, which
 12 you will be relieved to know I'm just going to call
 13 RIDDOR.

14 **A.** Thank you.

15 **Q.** You set out the outline and purpose of RIDDOR in your
 16 witness statement, and you explain that these
 17 regulations:

18 "... provide the national reporting framework for
 19 responsible persons (usually [means] employers [in
 20 healthcare settings] ...) to report certain cases of
 21 injury, diseases and specified dangerous occurrences to
 22 the relevant enforcing authority ..."

23 Which in the case of healthcare settings is the
 24 Health and Safety Executive.

25 "The purpose of [those regulations] is to inform

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1 **Q.** Thank you.

2 What would the Health and Safety Executive view be
 3 of any proposals to, in a future pandemic, amend the
 4 regulations so that there could be a derogation from
 5 that requirement to fit test if resources were scarce,
 6 if there was a lack of fit testing, staff or equipment?

7 **A.** It would be the same response as this pandemic: you have
 8 to fit test. The adage that we were living by is
 9 personal protective equipment has to protect, and
 10 anything that undermines that you're not satisfying your
 11 legal duty.

12 **Q.** Now, if either a member of staff failed the fit test for
 13 the models of RPE that were available, or there were
 14 some other reasons, religious head coverings or glasses
 15 or beards that meant they couldn't get a good fit, were
 16 there alternatives that offered a similar level of
 17 protection?

18 **A.** There are. I mean, FFP (filtering face piece), the mask
 19 as we commonly refer to them, they're not always
 20 popular, they're not comfortable, et cetera. There are
 21 other respiratory protective devices that involve
 22 filtering air and pumping it through a mask or a hood.
 23 We call them positive powered respirators, so they blow
 24 air in and create a sort of cushion of air around your
 25 face. They will tend to be, as I say, a hood type or

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1 [HSE] in a timely fashion that an incident or event has
 2 occurred and [it allows] an appropriate regulatory
 3 response to be made."

4 It is "not a source of definitive statistics as to
 5 reportable workplace incidents", but it does enable the
 6 "broader monitoring and analysis of trends over time and
 7 prioritisation and targeting of risks in particular ...
 8 sectors".

9 Is that a fair summary?

10 **A.** That is -- that's how we would use that data. It either
 11 enables us to make an immediate response where something
 12 very significant has happened and we believe there may
 13 be unmanaged or uncontrolled risk. But also that
 14 sort of overview of particular industries, that helps us
 15 with targeting of our resource.

16 **Q.** You also set out that making a report under RIDDOR is
 17 not an acceptance of blame or that a breach has
 18 occurred?

19 **A.** Absolutely, it's just a statement that an event has
 20 taken place.

21 **Q.** You have stated that RIDDOR was not intended to be used
 22 in a pandemic involving thousands of instances of
 23 infection, it was really designed to capture single
 24 one-off unexpected events, accidents and incidents; is
 25 that right?

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1 **A.** I think that's a very fair way of viewing it. That's
2 the intention of those regulations as to what is
3 happening in a workplace, not what is happening globally
4 or, you know, across the country.

5 **Q.** In terms of reporting Covid-19 under RIDDOR, I think the
6 Health and Safety Executive published guidance --
7 I think the first guidance was on 2 April 2020, and that
8 set out that the responsible person, so the employer,
9 was required to make a RIDDOR report if there was
10 reasonable evidence that a worker diagnosed with
11 Covid-19 had been exposed while at work?

12 **A.** That's correct. I mean, I think that it's useful to
13 have the context that the injuries part of RIDDOR has
14 very specified injuries, you know, it lists what those
15 are. The diseases part of RIDDOR has specified
16 diseases, it lists what those are. Either of those
17 apply to Covid. The dangerous occurrences is the
18 exposure to a biological agent, so it's very broad, but
19 that's why it needs that reasonable evidence that it's
20 linked to work to actually fall under that duty to
21 report it.

22 **LADY HALLETT:** How would that apply to healthcare work?
23 Wouldn't it apply to all of them? Because yes, they may
24 catch Covid on the bus or in a cab to work, but chances
25 are the exposure was at work. How does it -- does it

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1 this number of nurses have all got Covid", and they
2 couldn't tell you whether they got it in the corridor
3 when they were passing a colleague or whether they got
4 it when they were dealing with the patient?

5 **A.** Or on the bus or at home.

6 **LADY HALLETT:** Yes.

7 **A.** And that's why it requires an employer to actually be
8 looking at what's going on. It's a difficult judgement.
9 It's legislation that wasn't intended for this type of
10 situation, and we had to work out: what do we do that
11 gives us a reasonable view of what's happening in
12 workplaces, and indeed what we may need to do in
13 response to it. It's not intended to track the total
14 number of cases that are happening. It's not intended
15 necessarily for that liability, and, you know, if it's
16 helpful we could talk about, you know, the purpose of
17 investigation and selecting them for investigation.

18 **MS NIELD:** I think, following on from her Ladyship's point,
19 can I ask you, Mr Brunt, you say it became quite clear
20 to the Health and Safety Executive early in the pandemic
21 that there was both overreporting, or what you
22 determined to be overreporting and under-reporting of
23 Covid-19 under RIDDOR, and you explain that, when the
24 guidance was first published, the Health and Safety
25 Executive received a large volume of queries from

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1 not mean that every case of a healthcare worker getting
2 Covid would have to be reported?

3 **A.** We're looking at the -- we were taking the view it's the
4 work activity, so if you're exposed to a colleague at
5 work that, you know, you meet them coincidentally in the
6 corridor, et cetera, that's not the work activity, so we
7 were looking specifically at those people that could be
8 exposed to patients known to have Covid, carrying out
9 procedures where they are sort of directly interacting
10 with them. And it requires a judgement by the employer:
11 the duty, the legal responsibility is with them to
12 decide how likely it was that it was caused by that work
13 related exposure, the working with patients. And it's
14 not necessary -- and we also need to think about this in
15 terms of RIDDOR applying across all businesses and we're
16 trying to be transparent and consistent. And it's the
17 same whereas just because I was in the same workplace as
18 somebody that had Covid doesn't necessarily mean I did
19 catch it from them. So it's a judgement as to: how did
20 my work bring them into contact with that disease?

21 **LADY HALLETT:** I go back to the point I make: every
22 healthcare worker in the frontline had hugely increased
23 exposure, so if they got Covid the chances were it was
24 work-related; so wouldn't you, under this guidance, have
25 been inundated by trusts saying "This number of doctors,

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1 employers, picking up on just the point that my Lady
2 made, clarification as to what constitutes reasonable
3 evidence that the worker was exposed to Covid-19 at
4 work; is that right?

5 **A.** That's right, and we did several iterations of that
6 guidance in a relatively short space of time for exactly
7 that reason. The feedback we were getting, as my Lady
8 said, was people were struggling to understand how to
9 apply it, when to apply it.

10 **Q.** Can I ask this, after several reiterations -- or
11 iterations of that guidance, I'm sorry -- were you still
12 getting a large number of queries or did the guidance --

13 **A.** I think --

14 **Q.** -- have the desired effect?

15 **A.** It had some effect, and we still needed to write to
16 individual trusts, collectively, to explain what we
17 expected of them and to help them improve the overall
18 figures, and this has always been a feature of RIDDOR.
19 There are some areas you get under-reporting, some areas
20 you get over reporting. It is not unique to this
21 situation.

22 **Q.** Can I ask, from the Health and Safety Executive, what
23 are the consequences of under-reporting under RIDDOR?
24 What would the practical impacts of that be?

25 **A.** If we were looking at an individual business, then you

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1 don't have a picture of what's happening there. In the
2 circumstances with Covid and reporting, we were still
3 able to extrapolate enough of that to be able to
4 understand how people were applying precautions in the
5 workplace and to be able to take a sort of holistic
6 approach to helping those healthcare settings in terms
7 of how they comply, how they improve their procedures
8 and, indeed, some of our inspection activity in
9 hospitals and healthcare trusts was geared up exactly
10 for that, to be able to assess what was going on,
11 identify where the best practice were and where the
12 shortcomings were and, again, go to the whole industry
13 and be able to share that information to enable
14 improvement.

15 **Q.** You have been provided with the witness statements of
16 four of the core participants in this module, the Trades
17 Union Congress, the Royal College of Nursing, the
18 British Medical Association and the Covid-19 Airborne
19 Transmission Alliance, and all those core participants
20 have taken the view that the Health and Safety Executive
21 set the bar too high for reporting occupational Covid-19
22 in healthcare settings under RIDDOR. What's the health
23 and safety view on that?

24 **A.** We think that that bar was the correct one, we kept that
25 under review, it was peer reviewed over a period of time

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1 in the right way and being able to improve that.
2 **LADY HALLETT:** Given the numbers we're dealing with, so it's
3 going to be very unlikely that you're going to be able
4 to investigate individual cases, wouldn't one solution
5 have been to say, "Right, all National Health trusts,
6 hospitals, whatever, have to report every member of
7 staff or contracted worker who gets Covid", and then
8 you, as the Health and Safety Executive, can analyse
9 whether there appears to be a systemic problem, in other
10 words is that hospital properly carrying out infection
11 prevention and control measures, are they providing the
12 right PPE?

13 Isn't that the only way you can cope with
14 an analysis of the workplace safety in a pandemic, when
15 you've got so many hundreds and thousands of healthcare
16 workers and contractors who are falling ill with Covid?
17 I mean, you've got to move from the individual case to
18 the systemic case?

19 **A.** To the systemic case. There's many ways that we can
20 regulate and what we did during the pandemic, as well as
21 looking at whether we investigated particular incidents
22 or patterns, we carried on with the inspection activity
23 in hospitals where we were looking specifically at Covid
24 controls, or we did inspections and also looked at Covid
25 controls.

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1 by senior regulatory colleagues as to was that giving us
2 the appropriate information. From having looked at the
3 statements that you've mentioned, I think you have to
4 consider the angle of what the expectation is. If it is
5 an expectation that everything gets investigated and
6 there's some incredible retribution for what happened,
7 that isn't the purpose of necessarily selecting the
8 incidents and investigating them.

9 So when we investigate an incident, it's either to
10 improve our knowledge on an emerging situation or,
11 indeed, you know, part of that is to consider whether or
12 not there is corrective action or punitive action. When
13 we looked at the incidents that have been reported and
14 our selection of those that were reported, there was
15 a proportion selected for investigation, there was many
16 we looked at that we decided we could not see the causal
17 work link and did not investigate. Some of those we
18 have a threshold of incident selection criteria that's
19 long established and publishes as to what we will
20 investigate and won't. A lot of those Covid cases will
21 have fallen beneath that bar. And then, of those we did
22 select, we go on to decide (a) is the new learning that
23 we feed back into the system where we've identified new
24 problems or is this down to individual businesses,
25 individual settings, not actually applying the guidance

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1 As a regulator, you don't have to visit every
2 business to regulate them, you need to learn enough to
3 be able to tell those businesses what to do, and that
4 doesn't matter whether it's healthcare or anything else.
5 So a proportionate and transparent approach to it and,
6 indeed, that's what we did. Our inspection activities
7 that continued on hospitals, we extrapolated information
8 from that to be able to help those healthcare settings
9 across the piece be able to identify where the
10 challenges were, the sort of things that we would find.
11 So there is a level as to at what point will you stop
12 learning anything new and be able to say that we
13 understand enough to tell them what is expected.

14 **MS NIELD:** So does it follow from that, Mr Brunt, that what
15 you're saying is RIDDOR isn't used to track general
16 compliance with health and safety rules in a workplace,
17 it has a different purpose, and the way you tried to
18 track compliance in a workplace or across a sector is
19 through your inspection activity?

20 **A.** There's a whole range and I could spend far too long
21 talking about it but, in terms of targeting activity,
22 RIDDOR is part of a dataset. We also pick up data from
23 what concerns we may get reported to us. There are
24 labour force surveys that look more generically at
25 what's happening across businesses. So that is how we

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1 function as a health and safety regulator.
 2 In these particular circumstances, as I say, we
 3 understood, we knew what we were getting was going to be
 4 varied trust by trust but, collectively, putting that
 5 together with intervention data, et cetera, gave us
 6 an approach to be able to play our part in the workplace
 7 regulation that was part of a bigger UK-wide management
 8 of a pandemic.

9 **Q.** Can we move on, please, to deal with inspections and
 10 spot checks in healthcare settings during the pandemic.

11 I think you explain in your witness statement that
 12 the Health and Safety Executive continued to undertake
 13 inspections in healthcare settings, there wasn't
 14 a formal suspension of inspections, but operational
 15 decisions were taken to initially cut back on
 16 inspections as the sector was under strain. You explain
 17 that, as part of your inspection activity, between
 18 December 2020 and January 2021, there were inspections
 19 focused on Covid-19 arrangements at 17 acute hospitals,
 20 that's 13 trusts in England, two health boards in
 21 Scotland and two in Wales.

22 In terms of the outcomes of those inspections,
 23 I think it's right to say that the Health and Safety
 24 Executive identified that there was quite a wide range
 25 of compliance, both with the health and safety rules,

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1 effectively, the spot check gave a three-stage triage
 2 process, so the initial check/contact could be by phone,
 3 it could be by a non-warranted person visiting. That
 4 enables you to assess whether or not you believe someone
 5 is compliant. If there were concerns that moved up to
 6 a second stage, if that still didn't give a satisfactory
 7 answer, that moved over to a regulatory inspector,
 8 a warrant holder, who could take enforcement action if
 9 necessary.

10 **Q.** In terms of the process of the spot check, I think the
 11 first stage was a questionnaire that was completed by
 12 the duty holder; is that right?

13 **A.** That's right.

14 **Q.** Then the second stage could be a visit or it could be
 15 carried out by telephone?

16 **A.** That's right.

17 **Q.** So those features of the spot check put quite a strong
 18 reliance and a trust in the answers of the duty holder
 19 being accurate and honest; would you agree?

20 **A.** Well, inasmuch as we then go and validate whether or not
 21 we're getting the right answers and whether what we're
 22 being told is what's happening. So we had a good
 23 validation process behind that that involved sample
 24 inspections and follow-up, and I think we were finding,
 25 as I recall, 96% compliance with what we'd been told

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1 both in terms of comparing the hospitals with one
 2 another but even within hospitals, and you noted
 3 particularly that there were lower levels of compliance
 4 frequently found in non-clinical areas, even where those
 5 were adjacent to clinical areas; is that correct?

6 **A.** That's correct, that's a good summary.

7 **Q.** If I can ask now please about Covid-19 spot checks,
 8 I think these were just introduced during the pandemic
 9 to try to check how businesses generally, not just
 10 healthcare settings, were implementing the Covid secure
 11 guidance about keeping workplaces Covid secure. But
 12 healthcare settings were amongst the workplaces that
 13 were subject to spot checks; is that right?

14 **A.** That's correct.

15 **Q.** If we can briefly summarise in numbers, the spot check
 16 programme, 483 spot checks and spot inspections were
 17 conducted in healthcare settings and, from those 483, 18
 18 duty holders were issued with written advice. Do you
 19 consider that that's quite a low enforcement rate?

20 **A.** I think that's proportionate to what we were finding, as
 21 I say, the enforcement rate depends on the facts of what
 22 you find when you carry out an inspection. But the spot
 23 checks, to clarify that, not all of those are
 24 necessarily inspections by regulatory inspectors, that
 25 carry warrants. There was a process there by which,

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1 over the telephone, so we validated that we could be
 2 confident what we were being told was right.

3 I mean, if we look at spot checks across the piece,
 4 the country is facing something it's never faced before.
 5 On the whole, everybody is saying, "Tell us what you
 6 need us to do and we'll do it", and that was the
 7 guidance that was going out across businesses that was
 8 produced for the safer workplaces, that is as applicable
 9 to healthcare settings as everywhere else. So,
 10 generally, a spot check call puts people on notice that
 11 you're looking and those that want to comply will do
 12 everything they can to comply and it helps with really
 13 gauging their understanding of what they're putting in
 14 place.

15 **Q.** Thank you. You mentioned earlier that, as well as
 16 inspections, there is a process by which the Health and
 17 Safety Executive are able to receive and monitor
 18 concerns that have been brought to the attention of the
 19 Executive by workers or indeed members of the public.
 20 I think you explain that those concerns can be reported
 21 to the Health and Safety Executive via the website or
 22 via telephone.

23 In spring of 2020, I think the Health and Safety
 24 Executive were aware that there was a greatly increased
 25 level of concerns coming from healthcare settings, and

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1 particularly regarding the availability of PPE and the
 2 inadequacy of face fit testing for FFP3 face masks; is
 3 that correct?
 4 **A.** That's correct.
 5 **Q.** You have set out some of the data around health and
 6 safety concerns logged by the Health and Safety
 7 Executive, in relation to Covid-19 in healthcare
 8 settings, this is from 1 March 2020 to 30 June 2022, so
 9 that's the relevant period, or roughly the relevant
 10 period of this module. There were 1,587 such concerns
 11 logged; 192 of those were categorised under the red,
 12 amber, green system as red concerns. Would a red
 13 concern trigger an inspection of a setting?
 14 **A.** That's right, effectively we'd again, a triage system to
 15 decide the credibility, validity, the seriousness of
 16 what we were being told and how to intervene with that.
 17 So the red concerns those that we see as most
 18 serious, which trigger a visit. Those of a -- you know,
 19 that we would consider to be amber would trigger
 20 a contact but not necessarily in person: telephone, for
 21 example.
 22 **Q.** In terms of how these concerns could be reported to the
 23 Health and Safety Executive, was it possible for workers
 24 to report a concern anonymously?
 25 **A.** Yes, that's always been a feature of our concerns

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1 part of that management model, there's a categorisation
 2 of the risk of harm and, in terms of Covid-19, that the
 3 health effect was categorised as "significant" rather
 4 than "serious". It may help you if I remind you from
 5 your witness statement how the Health and Safety
 6 Executive defines "serious harm", and that is:
 7 "Harm that has an effect which is permanent,
 8 progressive or irreversible, permanently disabling,
 9 a lifelong restriction of work capability or a major
 10 reduction in the quality of life."
 11 "Significant harm", which is one rung below, is:
 12 "... non-permanent or reversible, non-progressive
 13 and any disability is temporary."
 14 Is that right?
 15 **A.** That's correct. It's looking at what is the likely
 16 outcome of the exposure to the risk and the harm that
 17 eventualises from that risk.
 18 **Q.** I, think in terms of that classification, although it
 19 caused some controversy at the time, the Health and
 20 Safety Executive peer reviewed that classification and
 21 it was confirmed; is that correct?
 22 **A.** Absolutely, and when we are looking at that sort of
 23 level, it is what is the most credible, what is the most
 24 likely outcome of that risk to the working population.
 25 So we're taking into account, in the circumstances of

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1 process, that people can contact us, raise their
 2 concerns about their workplace and, as far as we can
 3 give that anonymity, particularly if they're doing it
 4 online.
 5 **Q.** In terms of those workers who may have precarious
 6 employment situations, and particularly those who aren't
 7 union members or who are maybe not employees, did the
 8 Health and Safety Executive take any steps to ensure
 9 that the system for reporting concerns was accessible to
 10 all healthcare workers including those that I've
 11 mentioned?
 12 **A.** Yes, the telephone and the web facilities were available
 13 for anyone to use.
 14 **Q.** Was there any sort of outreach work done by the Health
 15 and Safety Executive to bring to people's attention that
 16 there was this process for reporting?
 17 **A.** I can't honestly answer that one, I don't know the
 18 answer.
 19 **Q.** Right.
 20 **A.** It's something in my statement I may have forgotten.
 21 **Q.** If we could turn now to look at the health and safety
 22 approach to enforcement action during the Covid-19
 23 pandemic, and the way that the Health and Safety
 24 Executive applied the enforcement management model,
 25 which you mentioned earlier. You've explained that, as

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1 Covid, the scientific advice, the medical advice,
 2 et cetera, of what is most likely for somebody that
 3 contracts Covid in terms of the long-term outcome.
 4 **Q.** That's in terms of the working population as a whole, so
 5 the effects aren't stratified, for example if it was
 6 a 65-year old worker who might be more likely to suffer?
 7 **A.** It's the working population on average, yes.
 8 **Q.** So that probably answers the next question but one of
 9 the points that was made was in relation to Long Covid
 10 having potentially long-term disabling effects, and
 11 whether knowledge and understanding about Long Covid
 12 developing in some people who had contracted Covid,
 13 whether that would affect the classification of Covid-19
 14 as "significant" rather than "serious"?
 15 **A.** Right, and as with everything else during the pandemic,
 16 as evidence came out, we did keep that under review and,
 17 again, when we reviewed that, and including our
 18 scientific and medical advice that peer review said
 19 that's still the right classification when we're
 20 comparing that with all the other risks that HSE is
 21 responsible for regulating.
 22 **Q.** There's a final point on that topic. You've said that
 23 the decision to classify the health effect of Covid-19
 24 as "significant" did not impact on the level of
 25 enforcement action that an inspector could take in

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1 respect of a Covid-related matter or breach; is that
2 correct?
3 **A.** That's correct. As I explained earlier with the
4 enforcement management model, it sets an initial
5 starting point for an inspector to consider what
6 enforcement action is relevant, and you have to consider
7 that enforcement action is in relation to the severity
8 of the breach of legislation and not what the actual
9 outcome may have been, because, you know, if I was to
10 try and put this in very simple terms, anyone can slip
11 over and receive a really minor injury on a perfectly
12 level floor. Equally, you can fall over and bang your
13 head and suffer a really major injury. The severity of
14 the incidents, the causal effects is the same and that's
15 where we would be pitching what the enforcement outcomes
16 are, and that's not necessarily the same as the physical
17 outcomes of the consequences.

18 **MS NIELD:** Mr Brunt, thank you very much.

19 I wonder, my Lady, if that's a convenient --

20 **LADY HALLETT:** Yes, certainly.

21 I hope you were warned that we would be breaking for
22 lunch.

23 **THE WITNESS:** I was indeed, thank you.

24 **LADY HALLETT:** Thank you. I shall return at 1.45.

25 (12.48 pm)

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1 could report an exposure that didn't lead to any
2 infection at all, so it's the acts -- the event that is
3 the reportable.

4 **Q.** Thank you very much.

5 I'm also asked to clarify a point in relation to the
6 evidence that you gave this morning. You were asked
7 whether the Health and Safety Executive had a role --
8 sorry, had a position on airborne exposure to Covid-19
9 in relation to non-aerosol-generating procedures, and
10 this was your answer, I'm taking this from the [draft]
11 transcript:

12 "I believe at the time the scientific advice and our
13 chief scientific adviser will have been part of the
14 national bodies sharing such information, that at the
15 time this was drafted it was considered that airborne
16 aerosol transmission wasn't a factor, other than those
17 aerosol-generating procedures."

18 This is the part that you were asked about, you went
19 on to say:

20 "So we will have challenged the science behind this
21 and made sure that we were satisfied as a regulator that
22 that was the best available information at the time."

23 Are you aware whether the Health and Safety
24 Executive did, in fact, challenge the science behind it
25 and make sure that you were satisfied as a regulator

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(The short adjournment)

2 (1.45 pm)

3 **LADY HALLETT:** Ms Nield.

4 **MS NIELD:** Thank you, my Lady.

5 Mr Brunt, I'm asked to clarify a couple of matters
6 with you. First of all, if we can return to the RIDDOR
7 regime, and the guidance during the pandemic in relation
8 to reporting incidents of Covid-19 infection in
9 healthcare settings.

10 You have set out in your witness statement that
11 the condition known as Long Covid is not reportable
12 under RIDDOR, as any occupational exposure to
13 a biological agent that causes Covid-19 occurs at the
14 time of initial infection. As Long Covid occurs later,
15 it is not reportable.

16 Would it be correct to say that it is the infection
17 with Covid-19 due to occupational exposure that's
18 reportable, rather than any long-term consequences?

19 **A.** Exactly, the reportability is the exposure to the
20 infectious agent, not the consequence of the exposure.

21 **Q.** So whether someone develops Long Covid subsequently
22 doesn't make any difference to how reportable the
23 initial infection was?

24 **A.** Absolutely, you could theoretically be reporting
25 an exposure -- if you had a release in a laboratory, you

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1 that that was the best information; what steps did you
2 take?

3 **A.** That would have been the role with our chief scientific
4 adviser developing that understanding and where we were.
5 So it was that advisory and discussion role across
6 government so that we could understand where we were,
7 and our chief scientific adviser, who was also a member
8 of SAGE, would have attended there.

9 **LADY HALLETT:** So the HSE has its own chief scientific
10 adviser?

11 **A.** We do, Professor Andrew Curran.

12 **MS NIELD:** So far as you're aware, did the HSE's chief
13 scientific adviser challenge that, what was perhaps the
14 orthodoxy at the time?

15 **A.** I wouldn't be aware of any conversations he's had
16 specifically, I know that he was part of that forum and
17 that was his role, and the conversations that I've had
18 with him would lead me to believe he's been part of
19 those discussions and had an opinion. I do remember
20 talking to him during the course of the pandemic and the
21 point at which he said to me, "I have been persuaded and
22 seen new evidence, I now believe there's an aerosol
23 route", so his original opinion and his challenge would
24 have been that he saw this as a droplet.

25 **Q.** Thank you.

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1 If we can move on, please, to lessons learned by the
 2 Health and Safety Executive in relation to the Covid
 3 pandemic. I think the Health and Safety Executive
 4 undertook a report reviewing the effect of Covid-19 in
 5 the workplace, and that was published in January 2021
 6 and based on Health and Safety Executive data between
 7 April and September 2020. Arising out of that, or
 8 indeed any of the other reflective work that the Health
 9 and Safety Executive have undertaken, how would you
 10 summarise what lessons have been learnt by the HSE that
 11 can be applied to workplace health and safety in
 12 healthcare settings in future pandemics?

13 **A.** I think one of the key things was being able to respond
 14 quickly to emerging evidence, being able to keep alive
 15 and keep reviewing the information that's coming out.
 16 I think there was a very clear need identified for clear
 17 communication, and that links to some of the things
 18 we've talked about this morning, of, you know, messaging
 19 on PPE, et cetera. So it's being able to make sure
 20 everybody understands what's happening and how things
 21 are developing.

22 **Q.** Do you consider that, in a future health pandemic, the
 23 Health and Safety Executive would be likely to take
 24 a different approach to health and safety in healthcare
 25 settings, and particularly things like the RIDDOR

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1 first document, which hopefully will be brought up on
 2 your screen, is INQ000097909. This is a joint letter of
 3 the BMA and the Royal College of Nursing from
 4 21 January 2021. At the first paragraph there, you will
 5 see, second sentence, it states:

6 "We write to you with concerns about the ongoing
 7 threat posed to health and care staff following the
 8 identification of the SARS-CoV-2 variant ... and your
 9 regulator's role in preventing work related ill health,
 10 death or injury."

11 The next paragraph:

12 "Our very serious concerns relate to the risk of
 13 aerosol/airborne infection; RCN and BMA members working
 14 in all settings are raising concerns that they are not
 15 adequately protected. Our members are concerned that
 16 fluid repellent surgical face masks and face coverings,
 17 as currently advised in most general healthcare
 18 settings, do not protect against smaller more
 19 ineffective aerosols."

20 Then right down at the bottom of the page, Mr Brunt:

21 "... we are calling for the Health and Safety
 22 Executive ... to take a precautionary approach and to
 23 use your role as a regulator to ensure employers and
 24 those developing national guidance meet and understand
 25 their responsibilities."

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1 reporting regime?

2 **A.** I think each one of these would have to be judged on its
 3 merits. We don't see many pandemics in anybody's
 4 lifetime. As an organisation we have to have that
 5 organisational memory of what we've done, and so on.
 6 But those decisions were based around the evidence and
 7 the science as we saw it in this case, and the approach
 8 would be the same, but whether or not the decisions
 9 were, would depend on that evidence.

10 **MS NIELD:** Thank you very much. I've no more questions for
 11 you, Mr Brunt.

12 My Lady, I understand there are some questions.

13 **LADY HALLETT:** There are others, so you can't escape just
 14 yet.

15 Mr Stanton, I think you're going first.

16 **Questions from MR STANTON**

17 **MR STANTON:** Thank you, my Lady.

18 Good afternoon, Mr Brunt. Firstly, I apologise for
 19 this slightly awkward positioning, please don't feel any
 20 need to turn to face me but do so if you wish.

21 **LADY HALLETT:** We have to get everything you say recorded.

22 **THE WITNESS:** Absolutely, I'm making sure I can hear.

23 **LADY HALLETT:** Okay, so hear and then turn to me, thank you.

24 **MR STANTON:** Mr Brunt, I would like to show you an exchange
 25 of correspondence between the BMA and the HSE. The

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1 Then over the page, at the first paragraph, there is
 2 a request for you to review the IPC guidance and to make
 3 an assessment of the use of appropriate PPE across
 4 settings.

5 Your chief executive responded on 29 January.

6 This is within document INQ000417574, at the second
 7 page, please.

8 Right at the top, it is stated in response:

9 "Before publication of the revised guidance, on
 10 21 January, a clinical and scientific review was carried
 11 out and, as the guidance states 'no changes to the
 12 recommendations, including PPE, have been made in
 13 response to the new variant strains at this stage,
 14 however this position will remain under constant
 15 review'."

16 Then next paragraph:

17 "Whilst HSE will not be undertaking a review, as
 18 this has already been done by those responsible for the
 19 guidance, we will continue working closely with DHSC and
 20 other government departments", et cetera.

21 I don't think we need to go any further.

22 Mr Brunt, just pausing there, this exchange of
 23 correspondence took place at the very height of the
 24 pandemic in January 2021 when hospitals and healthcare
 25 workers were overwhelmed with Covid patients. The

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1 correspondence is also on behalf of some three-quarters
2 of a million healthcare workers whom RCN and BMA
3 represent, and it took place at a time when there was
4 widespread acknowledgement of the risk of aerosol
5 transmission.

6 So in these circumstances, I'd like to ask you:
7 given the HSE's long-standing position, from well before
8 the pandemic, that surgical masks are not RPE and do not
9 provide adequate protection against airborne
10 transmission, can you explain why the HSE refused to
11 engage with the BMA and the RCN on this important issue?

12 **A.** I think we gave a full response based on the questions
13 we'd been asked. As I've explained in my evidence this
14 morning that position of HSE working with other
15 government departments in support of the national
16 response to Covid, constantly keeping things under
17 review, as we stated in this response, that recognition
18 that those things have to -- we have to iterate the
19 guidance, et cetera, this was the response based on the
20 position at that time and our understanding.

21 We fully recognised the significant pressures that
22 the health services were working under and we were part
23 of that overall response of the IPC, the Department of
24 Health, et cetera, in trying to take that forward. So
25 to be able to pick up that when we're already dealing

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1 tried to make representations of a similar nature. The
2 BMA certainly feels that they were being managed and
3 pushed away by your response.

4 Is the reason for that because there wasn't any
5 scientific basis to your response?

6 **A.** I think that our response was based on that position at
7 that time. And as I've said before, we're taking
8 account of the advice we're getting from our chief
9 scientists, from other scientific advisers working in
10 that cross-government position, recognising that the
11 lead on this was others and we are part of that.

12 **Q.** Thank you, Mr Brunt.

13 Can I take you to another document, please.

14 This is INQ000269711, at page 11.

15 This document is helpfully exhibited by you to your
16 statement, and commendably it is a lessons learned
17 document that the HSE commissioned and asked a workplace
18 health expert committee to undertake.

19 It reported in May 2022. And at page 11, which
20 I see you have before you, right at the bottom, under
21 the heading "Airborne Spread", it states -- or it finds:

22 "Aerosol transmission was underestimated
23 significantly at the outset and for some months
24 thereafter. Controls were therefore less effective than
25 they could have been, notably in settings like health

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1 with it at that national level was a key part of our
2 response to this.

3 **LADY HALLETT:** I think the point that Mr Stanton is making
4 is that by January 2021, there's widespread
5 acknowledgement -- including, by the sounds of it, by
6 your own chief scientific adviser -- that this was
7 an airborne virus and that you've always accepted that
8 certain kind of masks weren't suitable. So why doesn't
9 something change? This looks a bit like a fobbing off.
10 **A.** I think this -- as I say, we were looking to the Public
11 Health England and DHSC as the leads on the pandemic,
12 how we're working with them, making sure that guidance
13 is suitable based on what we knew at the time. I know
14 I said that Andrew Curran's position changed, I couldn't
15 put a date on that off the top of my head, I don't know,
16 and I would be very confident that when we've drafted
17 this response, we will have taken that into account.

18 **LADY HALLETT:** Sorry I interrupted, Mr Stanton.

19 **MR STANTON:** No, thank you, Chair.

20 Mr Brunt, leaving aside the slight irony in
21 responding by saying the guidance will be kept under
22 constant review and then refusing to review it, I don't
23 know if you heard the evidence of Dr Barry Jones of CATA
24 this morning, who expressed the view that at every turn
25 his organisation was managed and pushed away when they

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1 and social care."

2 It goes on to indicate a particular lesson learned,
3 that is:

4 "All plausible routes of transmission for a novel
5 biological agent should be considered and an initial
6 precautionary approach to risk management should be
7 adopted."

8 Then just if I could take you to another page,
9 a final page from this document, page 17, you'll
10 hopefully see four bullet points at the top of the page.
11 Again, further lessons learned in this area:

12 "Use of simple PPE was afforded undue prominence
13 early on in the pandemic and that has had lasting
14 consequences on perceptions of its importance as
15 a control measure."

16 Next point:

17 "In contrast the use of more effective respiratory
18 protective equipment was downplayed in the early stages
19 of the pandemic and that may have been contributed to
20 higher infection rates."

21 The third point:

22 "Understanding of the different types of respirators
23 and the differences between these and face coverings
24 remains sub-optimal."

25 And the final point:

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1 "Early and consistent messaging about the real value
2 of PPE and face coverings should be a priority in any
3 future pandemic involving a respiratory disease."
4 Mr Brunt, I'd like to ask you whether the HSE
5 accepts that these identified concerns, coupled with the
6 refusal to engage with the RCN and the BMA on these very
7 same issues, identifies failures on the part of the HSE
8 to discharge your statutory responsibilities?
9 **A.** I think when we -- it's very good that we are looking at
10 that process of review and learning. This is, as we've
11 said, published in 2022, a retrospective. It is also
12 looking broadly across the whole of the situation and
13 all industries, and some of those nuances about PPE.
14 I think it's really important that we recognise and we
15 learn from those, and we take those into account.
16 It does come back to, from a health and safety at
17 work point of view as well, not putting all the emphasis
18 on PPE, and that's the hierarchy of control that has
19 always been there. So it's really important that we do
20 learn these lessons and take those forward.
21 **Q.** Thank you, Mr Brunt.
22 Just moving to a slightly different area, this is my
23 final question, can I ask: what role did the limited
24 supply of RPE play in the way the HSE sought to
25 discharge its responsibilities?

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1 **MR STANTON:** Thank you very much, Mr Brunt.
2 Thank you, my Lady.
3 **LADY HALLETT:** Thank you, Mr Stanton.
4 I think next it is Mr Jacobs.
5 **Questions from MR JACOBS**
6 **MR JACOBS:** Thank you.
7 Mr Brunt, these are questions on behalf of the
8 Trades Union Congress. Good afternoon.
9 Firstly, inspections. Very roughly, what is the
10 number of inspections of workplaces across all sectors
11 in an ordinary year?
12 **A.** Currently that would be around about 14,000 inspections
13 a year.
14 **Q.** The healthcare sector generally is considered to be
15 lower risk, well controlled risk and an area for lower
16 inspections, isn't it?
17 **A.** It is. We prioritise work based on -- our inspection
18 work based on the risk profile of the industries that we
19 regulate, and also where we have specific intelligence
20 of businesses that aren't performing or managing risk as
21 we would expect. So healthcare settings are considered
22 to be in many of those high-risk areas they're better
23 performing.
24 **Q.** No issue is taken with that, Mr Brunt, generally. We
25 can see that, can't we, because in the year prior to the

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1 **A.** I think the only role that played is it did emphasise
2 the importance of what we were doing to make sure PPE
3 was available, the situation we -- or the set-up we had
4 for making sure we could do the regulatory easements for
5 adequate and suitable PPE that met the right standards
6 but wasn't CE marked, the efforts we put into making
7 sure that that could be distributed, the support we gave
8 to that supply chain. So I think we did as much as we
9 were able to within that regulatory framework to
10 facilitate the supply of PPE.
11 **Q.** If I could just briefly clarify, Mr Brunt. The reason
12 for asking that question is because the BMA and other
13 organisations are slightly scratching their heads
14 because they don't see any scientific basis for the IPC
15 guidance which remained in place for so long, and
16 I'm asking whether, instead of a scientific underlying
17 basis, actually was the IPC guidance drafted in the way
18 it was because of concerns about the supply of equipment
19 such as FFP3?
20 **A.** I'm not aware of those final decisions at the IPC.
21 Certainly HSE's input was that if PPE is required, it is
22 required, we shouldn't be getting away from that.
23 That's the requirement and it should protect. It is
24 also part of an overall control or risk control
25 mechanism and has to be considered in that totality.

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1 pandemic, of those 14,000-odd inspections, 95 were in
2 healthcare settings, that's paragraph 87 of your
3 statement.
4 **A.** That's correct.
5 **Q.** When the pandemic hit, the number of inspections of
6 healthcare settings was 81. That's paragraph 92 of your
7 statement. How can it be in circumstances that
8 healthcare workers are facing a new and significant
9 risk -- even before it hits our shores there's reports
10 of healthcare workers dying in China and Italy. Those
11 healthcare workers know, indeed the public knows, that
12 they are fighting it with serious problems with PPE and
13 the like, there's early reports of healthcare workers in
14 the UK dying, how can it be that, in those
15 circumstances, the number of inspections doesn't go up
16 and, in fact, goes down?
17 **A.** I think inspection isn't the only form of regulation.
18 In that year, when the pandemic broke out, like every
19 other work activity, we had to take stock of whether or
20 not we were key workers and when to intervene and not
21 intervene. We also have to consider the role of
22 inspectors visiting places that there is high numbers of
23 Covid patients, as whether or not we would become part
24 of that vector.

But the key thing is to be able to regulate

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1 an industry, as I explained this morning, is as much
2 about providing information, advice and working through
3 others, as it is about inspecting. So to use the levels
4 of inspections we did helps us understand that's going
5 on. We don't have to inspect every premises to be able
6 to provide advice to all of them.

7 **Q.** Not every premises, Mr Brunt, but the numbers were
8 extraordinarily low, weren't they? In fact, the HSE
9 stepped back from its role in the healthcare sector of
10 monitoring, of looking at what was going on in
11 healthcare premises. That was just wrong, wasn't it?

12 **A.** You're talking about a number of inspections, as if
13 that's the only means of providing information, so to
14 say that the number of inspections reflect whether or
15 not we stepped up or stepped back doesn't reflect the
16 input, the liaison we were having with the Department of
17 Health, the health services and how that regulatory
18 effect is going through others.

19 **Q.** If we look at some of those alternatives, Mr Brunt, one
20 was spot checks and spot inspections. There were over
21 400,000 in your statement, that's paragraph 207, but 483
22 of those were in healthcare settings, 0.1%. So it
23 wasn't the case, was it, that spot checks and spot
24 inspections were really focused in any meaningful way on
25 healthcare; do you agree with that?

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1 compliance in the non-clinical areas when there was good
2 levels of compliance in clinical areas, so we found
3 varied performance, as we do indeed across lots of areas
4 that we regulate and, again, the proportionality is
5 taking that learning and that knowledge and sharing it
6 with those that need to use it so that they can improve.

7 **Q.** On those themes you describe, Mr Brunt, of the
8 importance of leadership being present, non-clinical
9 areas having lower compliance, it matches with accounts
10 that the Inquiry has heard. But in your statement you
11 describe December and January 2020 and 2021, 17 acute
12 hospitals visited, and 12 of them received advice or
13 written advice. Is that not the sort of valuable and
14 important inspection that needs to be increased in the
15 next pandemic, if we focus on learning lessons?

16 **A.** I think, as I said earlier, the response has to be in
17 the context of what we're facing, so you can't give
18 a blanket response as to something that may happen in
19 the future. It is certainly the learning that has to be
20 taken into account.

21 **Q.** Mr Brunt, in the very short time I have left I'm going
22 to ask about RIDDOR, okay? Rather than asking you about
23 the wording of the guidance, what "reasonable evidence"
24 does and does not mean, can I ask you this: in terms of
25 an outcome, should a health and safety regulator want to

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1 **A.** They were focused on Covid-19 across the whole of the GB
2 regulatory regime, as indeed they should have been.

3 **Q.** Yes, but, in terms of focus on healthcare, we've heard
4 lots of evidence about high death rates, high rates of
5 Long Covid, PTSD and the like, in circumstances in which
6 there are real profound problems in safety measures.
7 Was there a fundamental difficulty, Mr Brunt, of the
8 Health and Safety Executive, when we look at it
9 realistically, just being absent?

10 **A.** I don't think so at all. I think we were playing a very
11 significant role through those various channels and we
12 were playing a role in a government national response to
13 a pandemic. We don't target specific sectors when
14 a pandemic is happening right across all of them.

15 **Q.** Would it be fair to say, Mr Brunt, that when the Health
16 and Safety Executive did inspect, on the few occasions
17 it did, it found actually quite significant problems
18 with health and safety practices in hospitals?

19 **A.** I think we found a spectrum and, indeed, it's reflected
20 in my statement and some of the exhibits, that, when we
21 inspected, we found differing levels of performance, we
22 found things that we would see where good leadership was
23 generally reflected in good standards, where leadership
24 wasn't being shown in the same ways and, indeed, was
25 mentioned this morning, we could find lower levels of

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1 know if a healthcare worker, who has been in contact
2 with Covid-positive patients, has died; should they want
3 to have a report to that effect?

4 **A.** We have to look in terms of, as a regulator, we are
5 regulating work activities, so to understand what's
6 happening and to be able to investigate those
7 circumstances is important. It still comes down to our
8 role in regulating the workplace and work activity. So,
9 yes, we do need to understand if that work has led to
10 a death, we need to understand that, and to be able to
11 take the appropriate action.

12 **Q.** But --

13 **A.** It is still a judgement of that business as to the
14 effect of deciding whether that work activity was
15 contributory and there was reasonable evidence of that.

16 **Q.** Mr Brunt, you've repeatedly referred to that exercise of
17 judgement and in exhibits to your statement there's
18 stats of some hospitals in the entirety of the pandemic
19 making one RIDDOR report as part of that judgement.
20 Should that judgement, should the guidance as to that
21 judgement not be changed so that RIDDOR reports are
22 made?

23 **A.** The duty on RIDDOR, and if we're looking at the guidance
24 generically --

25 **Q.** Sorry, Mr Brunt, I'm going to interrupt. Let's focus on

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1 the next pandemic. So rather than the niceties of
 2 RIDDOR, let's focus on what needs to happen in the next
 3 pandemic. Should it be the case that, where
 4 a healthcare worker dies of Covid, the health and safety
 5 regulator should be told about it?

6 **A.** If that was caused by their work, yes, but just because
 7 a healthcare worker dies of Covid, as indeed if anyone
 8 else dies of Covid, I'm afraid to link that -- or
 9 a RIDDOR report still has to be linked to that work
 10 activity.

11 **MR JACOBS:** My Lady, I'm probably pushing your patience, can
 12 I ask just one --

13 **LADY HALLETT:** I'm in a very generous mood today!

14 **MR JACOBS:** Clearly that judgement is, with the nature of
 15 a pandemic, going to be sometimes difficult. But is it
 16 a problem that it rests exclusively with the hospital in
 17 the case of a hospital, rather than the information
 18 being provided to the regulator, so that the regulator
 19 can see the picture, rather than have a scenario where,
 20 in a whole pandemic, they get one RIDDOR report from
 21 a hospital?

22 **A.** The duty under RIDDOR lies with the responsible person,
 23 that is clearly defined. So it imposes that duty so
 24 that they do apply their legal obligations of being able
 25 to understand what's happening in their position. So

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1 found -- you note that the chief executive of the
 2 NHS Trust asked the Health and Safety Exec to remove the
 3 requirement for fit testing and replace it with
 4 a fit check as fit testing was putting strain on
 5 resources.

6 Then further -- between paragraphs 303 -- you
 7 explain that the HSE could not provide a derogation from
 8 this requirement, as it would have led to inadequate
 9 protection for staff and undermined the regulatory
 10 requirements.

11 You further clarify that at paragraphs 304 to 306,
 12 where you say that the responsibility for addressing
 13 these supply chain issues rested with the employer, and
 14 that a fit check should never be used as a substitute
 15 for a proper fit test.

16 So, coming to the question. In the light of the
 17 significant challenges faced by ethnic minority
 18 healthcare workers, many of whom had higher failure
 19 rates in that fit test due to facial features and
 20 characteristics, cultural factors such as facial hair,
 21 and inadequate PPE provisions during the pandemic,
 22 question: to the extent that healthcare workers from
 23 ethnic minorities were subject to fit checking rather
 24 than fit testing, would you agree that this was
 25 an example of cutting corners that put those workers at

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1 for them, it is abrogating that duty as much just to
 2 report everything and not think about it, as it is to
 3 actually consider what's happening in their workplace
 4 and coming to an opinion.

5 **MR JACOBS:** I think that's probably as far as I can take it.
 6 Thank you, very much, my Lady.

7 **LADY HALLETT:** Mr Jacobs wasn't being rude. They all have
 8 limited time and that's why he was --

9 **THE WITNESS:** I understand, my Lady. Thank you.

10 **LADY HALLETT:** Right, Mr Thomas, I think you're next.

11 Questions from PROFESSOR THOMAS KC

12 **PROFESSOR THOMAS:** Good afternoon, Mr Brunt. Again, don't
 13 feel the need to look in this direction.

14 **A.** Thank you.

15 **Q.** I'm representing FEMHO, the Federation of Ethnic
 16 Minority Healthcare Organisations. As you may know,
 17 FEMHO has been deeply concerned by the challenges faced
 18 by black, Asian and minority ethnic healthcare workers
 19 particularly during the pandemic, where issues around
 20 the adequacy and appropriateness of PPE and respiratory
 21 protective equipment were of paramount importance.

22 So let me just give you a little bit of context to
 23 the question that I've got for you. It's this: in your
 24 witness statement at paragraph 301, that's on page 66,
 25 so that's INQ000347822 -- that's where the document's

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1 increased risk?

2 **A.** I think as we've said there, you're absolutely right, if
 3 we're going to use PPE, respiratory protection of that
 4 type, it does have to be fit tested to know it is
 5 offering that protection, and if that was not happening
 6 those employers were not meeting their duty.

7 **Q.** So this is my final point, so just help me with this:
 8 we've heard so many stories about these issues and these
 9 problems, why didn't the HSE do anything to address this
 10 issue to make sure that healthcare employers were
 11 complying with this requirement?

12 **A.** The action we took was to make sure we were drawing this
 13 through the attention -- through that supply chain,
 14 through the DHSC and the National Health -- the health
 15 trusts to make sure they understood their duty and
 16 clearly, in the responses we gave them, that you cannot
 17 use RPE if it's not been fit tested.

18 And you've mentioned specifically people with facial
 19 hair for religious reasons, and I know we were in
 20 correspondence with various organisations on that and
 21 the use of alternative forms of respiratory protective
 22 equipment when you cannot use an FFP type.

23 **Q.** So, in a nutshell, you say the HSE was doing enough?

24 **A.** I think we were doing what we needed to through those
 25 chains to make sure that those people understood what

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1 their duty was.

2 **PROFESSOR THOMAS:** My Lady, thank you.

3 **LADY HALLETT:** Thank you, Mr Thomas.

4 Mr Simblet.

5 I'm afraid everybody is coming from behind you.

6 **Questions from MR SIMBLET KC**

7 **THE WITNESS:** I'm being ambushed.

8 **MR SIMBLET:** Good afternoon, Mr Brunt. I'm asking questions

9 on behalf of the Covid Airborne Transmission Alliance.

10 I think you had correspondence with various members of
11 them during the pandemic. I'm not going to ask you
12 about the correspondence, I'm asking questions on their
13 behalf.

14 The first, I suppose it's an obvious point, but the
15 Health and Safety Executive would know that many
16 activities carried out by healthcare workers involved
17 being close up to patients and sometimes other
18 colleagues, close quarters working; would you agree that
19 would be known about and obvious?

20 **A.** I'd agree, that is very obvious.

21 **Q.** Thank you. It's in that context that I want to ask
22 a couple of questions about what the HSE knew about
23 transmission and risk.

24 Could we have on the screen, please, INQ000269803,
25 and then the second page of that. I've asked for

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1 the different circumstances is understood.

2 **Q.** So within 1 metre, ie the sort of area in which
3 healthcare workers work.

4 Now, in that context, I want to ask you something
5 about what you understood about fluid-resistant surgical
6 masks, and I think this morning in your oral evidence
7 you made clear that these are medical devices, you
8 wouldn't call them PPE --

9 **A.** Mm-hm.

10 **Q.** -- and it is your understanding, and was your
11 understanding at the time, that such fluid-resistant
12 surgical masks would not provide, in themselves,
13 adequate protection in close-quarters working; do you
14 agree with that?

15 **A.** They're not adequate protection for aerosols, they're
16 there for droplet protection, source protection. The
17 fluid-resistance is in case there's bodily fluids
18 expelled towards the person that's wearing them.

19 **Q.** Thank you. Can I have a piece of your witness statement
20 displayed, please, INQ000347822, page 85, and it's
21 paragraph 402. I think that's coming on screen now.
22 I hope it will be shown. Yes, so this is what you've
23 put in your witness statement. You've explained what
24 you just elaborated on there, and it's particularly the
25 last sentence I want to ask you about, because you put:

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1 paragraph 7 to be highlighted. This is an HSE document
2 in which it is summarised what the risk factors for
3 Covid-19 are.

4 We can see from that that (1) Covid-19 was known by
5 the HSE to be an airborne disease; do you agree?

6 **A.** We refer to aerosol as droplets and we refer to
7 aerosol-generating procedures, so there's a correlation
8 there.

9 **LADY HALLETT:** Sorry, the date of this document, Mr Simblet?

10 **MR SIMBLET:** I can't find the date.

11 **LADY HALLETT:** Oh, I see. Right.

12 **MR SIMBLET:** It's one of the things -- I was wondering if
13 the witness knows the date, actually.

14 **A.** I can't --

15 **Q.** I know you've been blindsided by it. All right.

16 The second point: infectious persons expel various
17 containing aerosols, and that the concentration of these
18 aerosols and risk is greatest within 1 metre. So would
19 you agree with those propositions and those appear to
20 have been known to the HSE?

21 **A.** The information there, I think, is reflecting that
22 totality of what was in the IPC guidance, so if there is
23 an aerosol that is generated, that is one route. We
24 talk about touching a surface that's contaminated, and
25 so on. So that range of transmission possibilities in

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1 "However, there is a common misperception that they
2 will provide protection against aerosols."

3 My question is this: since you know that surgical
4 masks do not provide adequate protection and that there
5 is a common misperception, amongst others, that they do
6 provide protection, why didn't the HSE provide
7 instructions that healthcare workers required
8 respirators?

9 **A.** I think that's reflected in the IPC guidance, that where
10 we believe there is aerosol-generating procedures they
11 used FFP3 and, outside of those areas, that's where they
12 were using fluid-resistant surgical masks.

13 **Q.** Related to that question, do you recall a meeting in
14 2022 where various people asked the HSE to give a clear
15 and unequivocal message about people wearing FFP
16 respirators, and some follow-up correspondence to that?
17 Do you remember that being specifically requested?

18 **A.** In answer to your question do I recall the meeting,
19 I don't.

20 **Q.** Well, do you recall being asked by, I think it was the
21 RCN and others for the HSE to send a clear message about
22 that, and there being some discussions about that?

23 **A.** I'll be honest, I don't recall the fine detail of if
24 there was correspondence and so I'd need to refresh my
25 memory.

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1 Q. In the time available, I don't think we've got time to
 2 go through that. So I will move --

3 LADY HALLETT: It's not going to come out of your time,
 4 Mr Simblet, I'll be generous with you too.
 5 Can I just follow up a point being made by
 6 Mr Simblet. It's a point Mr Simblet was making about
 7 the IPC or you made in your answer. If you know, as the
 8 HSE, that it is airborne, and if you know that surgical
 9 masks aren't sufficient, you surely can't, in accordance
 10 with your statutory duties, say, "Well, we'll just
 11 follow whatever the IPC cell says", could you? I mean,
 12 shouldn't you then say, "Well, we've got a statutory
 13 duty to protect", as Mr Stanton said, "750,000
 14 healthcare workers", shouldn't you step in?

15 A. I think that's what we were doing at that time, in that
 16 the knowledge and evidence at the time, at the start of
 17 the pandemic, about routes of transmission was reflected
 18 in the IPC guidance. Had we thought that that was
 19 falling short of what we thought was going to be the
 20 exposure routes, we would have advised accordingly and
 21 stepped in.

22 MR SIMBLET: But you were part of the -- I mean, there was
 23 an HSE representative as part of the IPC cell, wasn't
 24 there?

25 A. Yes, we had input into that and we were there looking at
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1 invisible, it's silent, you can't detect it by any
 2 normal non-laboratory means, so would you agree, as
 3 a health and safety expert, that there's no realistic
 4 way that an individual healthcare worker could carry out
 5 their own individual risk assessment as to what
 6 equipment they would require when doing their job?

7 A. I'd agree entirely but it's not their responsibility to
 8 carry out a risk assessment, it's their employer's
 9 responsibility. We didn't expect individual healthcare
 10 workers to be carrying out individual assessments.

11 MR SIMBLET: Thank you very much.
 12 My Lady, those are the questions I ask.

13 LADY HALLETT: Thank you, Mr Simblet.
 14 I think that completes the core participant
 15 questions.

16 MS NIELD: I think so.

17 LADY HALLETT: Nobody is protesting.
 18 Right, thank you very much, Mr Brunt, I'm very
 19 grateful for your help.

20 THE WITNESS: Thank you very much.
 21 (The witness withdrew)

22 LADY HALLETT: Now, Mr Scott.

23 MR SCOTT: Thank you, my Lady. May we please call
 24 Sara Gorton.
 25

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1 the reasonable practicability of the precautions and
 2 being able to use those to satisfy the legal obligations
 3 under the Health and Safety at Work Act.

4 Q. So to that extent, and picking up on the question my
 5 Lady just asked, the HSE was part of the IPC cell and in
 6 a position to pass on to the IPC cell those views as to
 7 what was required and what was insufficient, and in
 8 a position to say, actually, there's a statutory duty to
 9 enforce this?

10 A. We were inputting into that cell as to what was
 11 required, yes.

12 Q. The document, my Lady, I'm assisted, it's April 2020,
 13 the document to which I referred earlier, so right at
 14 the start of the pandemic.

15 A. Could you repeat the question on that?

16 Q. Well, I think I've asked my question. Sorry,
 17 Mr Brunt --

18 LADY HALLETT: It was the one about the document summarising
 19 risk factors and that you knew by April 2020 it was
 20 an airborne disease.

21 MR SIMBLET: Yes, you knew it was airborne, infectious
 22 persons expel virus-containing aerosols and the
 23 concentration of the virus is greatest, therefore,
 24 within 1 metre.
 25 My final question is this: Covid doesn't smell, it's
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1 MS SARA GORTON (affirmed)
 2 Questions from COUNSEL TO THE INQUIRY

3 LADY HALLETT: I hope we haven't kept you waiting,
 4 Ms Gorton.

5 MR SCOTT: Ms Gorton, would you please give your full name.

6 A. I'm Sara Gorton.

7 Q. And would you please give your current role.

8 A. So my job title is national secretary and I work for the
 9 trade union, UNISON.

10 Q. I think as part of your role are you co-chair of the NHS
 11 Staff Council?

12 A. So during the relevant period I was UNISON's head of
 13 health and co-chair of the NHS Staff Council and the NHS
 14 Social Partnership Forum.

15 Q. Thank you. I'm going to come back to those points.
 16 I want to start effectively just before the
 17 beginning of the pandemic. You've set out in your
 18 statement a large number of concerns that the TUC have
 19 in relation to, I think you call it, the "funding
 20 crisis" in the NHS.
 21 If I can just read you what's part of the executive
 22 summary of the Module 1 report of the UK
 23 Covid-19 Inquiry.
 24 It states:
 25 "In 2020, the UK lacked resilience. Going into the
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1 pandemic, there had been a slowdown in health
2 improvement, and health inequalities had widened. High
3 pre-existing levels of heart disease, diabetes,
4 respiratory illness and obesity, and general levels of
5 ill-health and health inequalities, meant that the UK
6 was more vulnerable. Public services, particularly
7 health and social care, were running close to, if not
8 beyond, capacity in normal times."

9 You wouldn't disagree with any of that, I presume?

10 **A.** Not at all, no.

11 **Q.** I want to focus your questions in relation to not so
12 much staffing levels or the reason for staffing levels,
13 but on your understanding of the impact of the pandemic
14 on staff and the resilience that they were able to have
15 as a result.

16 Were you aware of any pre-pandemic plans for how NHS
17 staff would be used or deployed to respond in the event
18 of a pandemic?

19 **A.** So I think there are two or three broad points to
20 mention here. So I think the first is that trade unions
21 and myself weren't deeply involved in the planning. You
22 have the statement that we refer to in the witness
23 statement, that the staff council put together, and this
24 was --

25 **Q.** I'll come to that in a minute. This is I think around
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1 partnership with their employers in the NHS
2 organisations.

3 It's a UK-wide body, but within Scotland, Cymru,
4 Wales, and Northern Ireland there are also separate
5 bodies that look at the particular issue for those
6 jurisdictions.

7 **Q.** But it is -- I know there is a different meaning in
8 terms of partnership and a more formal kind of
9 partnership arrangement, but the staff council is a kind
10 of partnership between unions, employers and department
11 officials; is that correct?

12 **A.** That's correct. It's separate to the Social Partnership
13 Forum.

14 **Q.** Yes, yes.

15 If we can please go to INQ000339374.

16 I think this is the staff council statement that you
17 were just referring to. Are you able to just remind me,
18 I think you said the date, roughly when this statement
19 was actually made?

20 **A.** January 2020, I think.

21 **Q.** Because we can see at the third paragraph:

22 "At the time of writing, cases and suspected cases
23 of Covid-19 are being managed in specialist units."

24 I presume that's a reference to within an HCID
25 setting at that point in time, so we can kind of

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1 February time, maybe, the staff council statement; is
2 that right?

3 **A.** Produced at the end of January 2020.

4 **Q.** But prior to that you weren't aware of any kind of
5 formal plans or anything along those lines?

6 **A.** We weren't involved in those discussions, no.

7 **Q.** You've just referred to the staff council. Could you
8 please describe what the NHS Staff Council is and who is
9 involved in it.

10 **A.** So the NHS Staff Council is the collective bargaining
11 body. So it's set up to bring trade unions and
12 employers together with the Department of Health
13 officials to maintain the contract of employment, the
14 set of pay terms and conditions that are common to staff
15 who are currently described as Agenda for Change staff,
16 so these are all the non-medical staff in the NHS.

17 It also has a range of subgroups, such as the Health
18 and Wellbeing Subgroup, where we interact with external
19 bodies and look at issues like the health and wellbeing
20 of the workforce of the NHS.

21 So it's an opportunity to maintain that contract, to
22 bring people together to try and service it, and to
23 produce advice and guidance that goes out into the
24 employing organisation, where it can be picked up and
25 implemented by trade union representatives working in

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1 identify the time as January from that; is that fair?

2 **A.** That's fair, yes.

3 **Q.** I just want to understand a little about how this
4 statement came to be made. Could you explain the
5 process that led up to this?

6 **A.** So this was the result of work mainly through that
7 health and wellbeing partnership group of the staff
8 council, and that is a body of -- that's made up of
9 a mixture of trade union representatives. A lot of
10 those people are people with a good grounding in health
11 and safety, well linked in to trade union health and
12 safety representative structures, working with employers
13 to produce guidance, and, as you can see at the end of
14 the statement, they've made reference to quite a lot of
15 the evidence that was available at the time and being
16 produced by the health protection bodies across the UK.

17 **Q.** What was the intended purpose of this statement?

18 **A.** So the purpose of the statement, I think it's fairly
19 clear in the -- in setting this out at the start, that
20 what we're trying to do here is urge local partnerships,
21 by which I mean employers and trade unions working
22 together within employing organisations, to not only use
23 this but to consult the latest advice and to work
24 together to put in place the measures that are described
25 in the guidance statement.

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1 **Q.** If we can just go down and have a look at some of those
 2 measures, please. Thank you. I don't -- there are ...
 3 there are 12 on the pages that I have, and there are
 4 some further on. I'm not proposing to take you through
 5 all of them, but they cover issues such as communicating
 6 risk about transmission, identifying and mitigating
 7 risks arising from Covid-19, ensuring adequate PPE,
 8 making sure there's sufficient fit testing, training for
 9 PPE, maintaining non-Covid services, allowing staff or
 10 making sure staff are able to raise concerns in a way
 11 that doesn't impose any detriment, managing risks to
 12 vulnerable staff, e.g. those with suppressed immune
 13 systems, maintaining care for staff members.

14 When you read back this statement, what do you think
 15 when you actually look about whether you identified
 16 essential principles for how a healthcare system should
 17 have responded to a pandemic?

18 **A.** I think most of the issues that we dealt with throughout
 19 the rest of the pandemic, from this point onwards, were
 20 rooted here. So all of the key principles to adhere to
 21 were set out. I think the question is to what extent
 22 those principles were able to be put in place is --
 23 you know, that's -- was -- and how these were
 24 interpreted and implemented at a localised level was the
 25 major difficulty.

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1 **Q.** On reflection, do you think there were any principles
 2 that you missed?

3 **A.** I think all of the principles are in here. I think
 4 looking at that second bullet point, there obviously
 5 needed to be a lot more guidance about identifying who
 6 might be more vulnerable and anticipating that. So
 7 thinking --

8 **Q.** That's the delivery of this principle, is that what
 9 you're saying?

10 **A.** Exactly.

11 **Q.** You've got the principle right, how much then delivered
 12 is a different matter?

13 **A.** That's right, and all the guidance that might need to
 14 sit behind it.

15 **Q.** So in terms of identifying the key principles of
 16 a pandemic response and particularly in the early stages
 17 of Covid-19, this had been foreseen by a group involving
 18 the unions, NHS employers and Department of Health
 19 officials in January 2020?

20 **A.** I think so, yes.

21 **Q.** I'll move on now to some of the other points about how
 22 they were necessarily implemented but, firstly, what was
 23 the resilience level, do you think, of, not the system,
 24 but of the NHS staff themselves, whether medical,
 25 non-medical, the whole panoply of the members of the

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1 You can see here they focussed on making sure that
 2 people who are looking after Covid patients, who are
 3 working with PPE have access to lots of rest, the link
 4 between fatigue and burn-out, and you know from your own
 5 experience of the pandemic that that situation was
 6 not -- you know, didn't come to pass in the way that
 7 people were expected to work.

8 When you look at some of the evidence that we've
 9 provided in the witness statement, there were signs
 10 prior to the pandemic that people were already burnt
 11 out. We as trade unions had been raising the impact of
 12 the --

13 **Q.** Sorry to cut across you, Ms Gorton, I will be coming to
 14 those points. I want to focus on -- I think you were
 15 calling them the key principles here --

16 **A.** Yes.

17 **Q.** -- because one point before I forget is you were talking
 18 about all the key principles were set out. Do you think
 19 in terms of an early stage or, dare one say it, a kind
 20 of plan, in the loosest possible sense, of how to
 21 respond to a pandemic, is essentially set out in very
 22 broad form but set out in this statement?

23 **A.** I think the principles are here. Putting them in place
 24 is obviously -- requires further work at local level,
 25 but the principles, yes, I would agree.

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1 NHS. How were they able to withstand a pandemic in
 2 January 2020?

3 **A.** So this was what I was picking up in response to your
 4 earlier question, that there were signs going into the
 5 pandemic for the few years in the run-up that the
 6 workforce had been largely overlooked and neglected in
 7 favour of a government and policymakers who seemed to be
 8 obsessed with structure, system architecture, rather
 9 than addressing the needs of the workforce. In this --

10 **Q.** Sorry, I phrased the question very badly. It's their
 11 own individual capacity. For example, the TUC report
 12 from 2020 entitled "The NHS workforce crisis, a decade
 13 in the making" is talking about in 2019 high levels of
 14 work-related stress and then it talks about work-related
 15 stress. You have the UNISON Safe Staffing forum in 2020
 16 talking about whether NHS staff have sufficient skill
 17 mixes on their team.

18 In terms of that personal capacity, rather than the
 19 system's, in terms of that personal capacity, do you
 20 think, how was the NHS workforce at that point?

21 **A.** Well, that survey that you just referred to, if you look
 22 at that, it paints a picture of people who describe
 23 themselves at breaking point. So it talks about the
 24 impact that people described just in that one snapshot
 25 survey of not having -- not having enough staff, not

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1 having access to the breaks they need in order to work
 2 the shifts, it talks about the pressures that they feel
 3 under to accept more work in order to cover the gaps,
 4 and it talks about the personal impact that they felt at
 5 the time from feeling that they weren't able, they
 6 didn't have what they needed in order to deliver the
 7 services they wanted to the standards they wanted to
 8 deliver them to patients, and it describes people
 9 feeling very vulnerable, talking about turning up for
 10 work dreading their shifts, not being able to be
 11 hydrated properly during their working hours, and
 12 feeling constantly under pressure while they were there,
 13 and that's not -- that's not a description of
 14 a resilient workforce ahead of a major crisis.

15 Ahead of a major crisis, you want people to feel
 16 well motivated and well rested and able to deal with it,
 17 and the signs were there in that report, and other
 18 evidence, that this was not the condition of the NHS
 19 workforce.

20 **Q.** I just want to bookend that with what you set out in
 21 your statement about March 2022, about staff wanting to
 22 leave the NHS, was the pressure that they felt at not
 23 being able to deliver the appropriate quality and
 24 standard of care, that staff were traumatised by the
 25 ability to deliver care at the level and quality that

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1 trade unions contributed to over that time, a lot of
 2 work was done to set up what was called health and
 3 wellbeing portals, to provide access to the sort of
 4 emergency mental health triage, hotlines and on the spot
 5 occupational health type interventions, and you can see
 6 some of those described in the statement.

7 But what's really clear is that the -- what health
 8 workers needed was an opportunity for rest and
 9 recuperation and, with the levels of staffing in the NHS
 10 as they were ahead of the pandemic and compounded by the
 11 pandemic, that was really difficult to achieve. So
 12 although there were measures put in place, it's clear
 13 that they -- you know, it was going to be a really
 14 uphill struggle to try and provide support in enough
 15 measure and, to an extent, a lot of the impact will take
 16 a long time to work through.

17 **Q.** In terms of working through, you do say that the impact
 18 of the pandemic on recruitment and retention in
 19 healthcare may not become entirely clear for some time.
 20 Even now, is it starting to become clear?

21 **A.** So, recruitment and retention in the NHS was, I mean,
 22 it's a very complex web and it's difficult to pick apart
 23 exactly what part the pandemic had in this. But you can
 24 see from the evidence that we've provided that, by 2021,
 25 one in five health workers were telling us that they

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1 they're required to.

2 Again, leaving aside considerations of funding, is
 3 there anything that can be done to prevent staff leaving
 4 because of those concerns?

5 **A.** So working conditions are everything. You can see in
 6 the statement the themes that workers were raising
 7 through their unions about not enough access to rest
 8 breaks, about not enough access to the rest and
 9 recuperation they needed, and trade unions knew -- as
 10 early as May 2020, we were raising issues at a central
 11 level to call for support packages to be put in place to
 12 allow the rest and recovery from dealing with that first
 13 phase. As it turned out, that was a hiatus rather than
 14 an end, as we might have imagined at that point, but the
 15 signs were there that the workforce were already
 16 suffering and, by the period that you refer to, by 2022,
 17 it was really evident that that support hadn't been
 18 provided in sufficient measure to make people feel
 19 resilient enough and to make them motivated to want to
 20 stay in their jobs.

21 **Q.** You say that you have been raising issues from May 2020,
 22 and then you talked about the hiatus, was anything done
 23 during that hiatus to help the healthcare workers who
 24 had been through that initial wave?

25 **A.** So in the statement you'll see the pieces of work that

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1 were seriously or very seriously considering leaving
 2 their job in the NHS. So it had a profound impact on
 3 those workers and in the ability of the NHS to recruit
 4 staff.

5 That came on top of several factors leading up to
 6 the pandemic which had made it more difficult to retain
 7 staff of the NHS. Lots of those are referred to in the
 8 statement, so I won't go into them in detail, unless you
 9 wish me to at this stage, but it's very clear that the
 10 effects of having low staffing going into the pandemic
 11 had contributed to the way people felt approaching the
 12 pandemic, that that worsened during the pandemic and, as
 13 a consequence, it was more difficult for the NHS to
 14 recruit and retain staff.

15 Staff morale seems to be levelling out to some
 16 extent, if you look at the latest staff -- NHS staff
 17 survey for England at least, confidence does seem to be
 18 restored in some areas but it's -- the pandemic had
 19 a very marked impact on health workers, for all the
 20 reasons I'm sure you will be talking about to me and
 21 other witnesses.

22 **Q.** In terms of the steps that were taken during the
 23 pandemic to increase numbers of healthcare workers, we
 24 had the kind of reserve scheme that was brought in,
 25 there was the student registration scheme, issues like

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1 that across all different types of healthcare workers.
 2 From your staffing perspective, what were the merits or
 3 the benefits of those schemes, and are there any issues
 4 that the Chair should look at in terms of any
 5 improvements that could be made to those schemes moving
 6 forward?

7 **A.** So, I personally, and to my knowledge, the trade union
 8 structures weren't engaged proactively on the decisions
 9 to set these schemes up. The point at which I came into
 10 contact with them, the core decisions about whether
 11 those approaches should be taken had already been made.
 12 So we engage --

13 **Q.** Sorry, presumably you didn't think it was a bad thing to
 14 put those in place?

15 **A.** Well, it's not that they were a bad -- any of those
 16 suggestions were bad, it's that there are practical and
 17 feasibility issues that I think would have been -- we
 18 could have pointed out if those had been discussed with
 19 us in advance.

20 So, for example, on the Nightingale hospitals,
 21 you know, it was very, very impressive that these
 22 buildings were acquired and converted so quickly, but
 23 I think in the statement we refer to a King's Fund
 24 report that kind of points out some of the practical and
 25 feasible difficulties in using them for the purpose that

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1 conversations through trade union structures and
 2 I personally had conversations about those -- about how
 3 those people could be used. I think you've got evidence
 4 in the witness statement about suggestions that trade
 5 unions put forward about how the -- those volunteers
 6 could be used to supplement the testing --

7 **Q.** Yes.

8 **A.** -- process. So there were some practical suggestions
 9 that we were putting forward at that time. But, as
 10 I say, we weren't proactively engaged in the discussions
 11 about them at the time those ideas were being developed.

12 **Q.** Okay. So in terms of those who were deemed vulnerable
 13 or who were working from home, do you think that
 14 sufficient use was made of the skills and capabilities
 15 of people who were vulnerable or working from home?
 16 For example, could more use have been put into NHS 111
 17 or triaging or using those skills remotely in any way,
 18 shape or form?

19 **A.** I think the only comments I can offer on that topic are
 20 about the impact that suddenly converting to having to
 21 run services from home had on the people that I talked
 22 to, the health workers I was working with. So most of
 23 these were people who do jobs where their job
 24 satisfaction, their whole role is in providing
 25 face-to-face services, the bond they feel with their

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1 they were -- for which they were set up, such as the
 2 difficulty transporting people between hospital sites
 3 and the Nightingales and, for our part, I think the
 4 trade unions would have been asking questions about how
 5 the staffing arrangements might have been set up and
 6 working. So, as a -- you know, was there the capacity
 7 to deliver them anyway, given what we knew about
 8 staffing in the NHS? What would the arrangements have
 9 been between different providers? Some of those issues
 10 we were able to work through. Those happened at a much
 11 more localised level, but they could have been
 12 anticipated in advance. So it's those sort of issues
 13 where the principles seem right but, actually, the
 14 ability of those schemes to really deliver was hampered
 15 by a range of factors.

16 **Q.** I'm going to put you on the spot a fraction. You say
 17 they could have been foreseen. Had you foreseen those
 18 difficulties just in and around the time that they were
 19 being established? And if so, did you communicate those
 20 difficulties?

21 **A.** I do remember having lots of conversations about the
 22 reserves scheme, and in particular what the people that
 23 were signing up -- there were lots of very well meaning
 24 people who wanted to help out, so the limits about what
 25 those people could do, I think I do recall that we had

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1 patients is really deep and is part of their work, and
 2 in the scramble to turn their services into Covid-safe
 3 services, a lot of that was lost, and that had
 4 a profound impact on the job satisfaction for those
 5 people. They felt it had a profound impact on the
 6 services that they were able to provide.

7 And if you think yourself about the way that we
 8 suddenly had to adapt and find new ways of reaching
 9 people through our computer screens and our phones,
 10 that's very different from the services that had
 11 previously been provided by staff working in therapy
 12 services. If you imagine being an occupational or
 13 a physiotherapist, suddenly having to deliver
 14 interventions through a computer screen, that had
 15 a very -- a very big impact. So I think that's the
 16 extent of the response I can give you on those issues.

17 **Q.** Well, in terms of people who are -- obviously the ideal
 18 is that people would not be moved out of their
 19 patient-facing roles. In the event of a future
 20 pandemic, say that was unavoidable for a myriad of
 21 reasons, is it going to be beneficial for those
 22 workers -- and for the NHS or HSE -- to make use of
 23 those workers, and is it also going to be beneficial for
 24 them that use is made of them if they have to be at
 25 home, rather than not being able to assist in any way?

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1 **A.** Completely. And I think in the statement we do refer to
2 evidence that we heard from people who were available
3 for work but not called upon, and those people felt --
4 you know, felt disenfranchised and forgotten. So
5 I think for future learning it's very important to
6 consider how the planning can take those people into
7 account.

8 You know, I think there are probably lessons about
9 fragmentation that may need to be looked at. Certainly
10 the fact that the test and trace effort was being run
11 separate to the health service probably meant those
12 people couldn't be integrated into that effort in the
13 same way. I'm sure you'll have other expertise on those
14 matters.

15 **MR SCOTT:** My Lady, I think that may be a convenient moment
16 for the afternoon break?

17 **LADY HALLETT:** Certainly. I shall return at 3.10.

18 I hope you were warned, Ms Gorton, that we take
19 breaks.

20 (2.59 pm)

(A short break)

22 (3.10 pm)

23 **LADY HALLETT:** Mr Scott.

24 **MR SCOTT:** Thank you, my Lady.

25 Ms Gorton, you were talking earlier on about the
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1 engagement group, which met from 30 March, and weekly
2 initially, until July, when it started to meet
3 fortnightly, which provided detailed conversation upon
4 topics like guidance policy positions. Is that
5 a summary of the engagement group?

6 **A.** Yes, so at the start of the -- the start of the
7 lockdown, we adapted the Social Partnership Forum
8 structures and those loosely fell in three different
9 groupings. So we created a new group, the Covid
10 Engagement Group that, as you say, met weekly, and we
11 had a standing agenda and you've got a sample in the --
12 in my statement of some of the issues that were
13 regularly discussed through that meeting, topics like
14 PPE, testing, vaccines, as that was added to the -- that
15 was added to the suite of measures, as we went on.

16 So that was the Covid Engagement Group. We also
17 used social partnership structures to subsume some of
18 the work of the staff council which I talked about
19 earlier. So we had been able to influence, through
20 trade union routes, a set of temporary terms and
21 conditions that were put in place to support the safe
22 working and to prevent financial detriment on the health
23 workforce, for people who were -- had to work during the
24 pandemic or were in, you know, a variety of different
25 categories, like self-isolating, shielding, et cetera.
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1 partnership -- sorry, you referred earlier on to the
2 partnership. I would like to move to that now.

3 The NHS Social Partnership Forum, can you describe
4 what that is, please?

5 **A.** The Social Partnership Forum body is an England-wide
6 structure that brings together trade unions with
7 employers and policymakers through a central body called
8 the Social Partnership Forum. We have our terms set out
9 in a formal partnership agreement that all parties
10 signed up to, and we discuss workforce policy matters
11 through a series of formal meetings with a wider group
12 meeting that is held, normally quarterly, chaired at
13 ministerial level.

14 **Q.** Okay, so I think the way that you say it in your
15 statement is that it ensures ministers, civil servants
16 and system leaders are made aware of the real-time
17 concerns of healthcare staff?

18 **A.** That's true.

19 **Q.** Were there equivalents in Scotland, Wales or Northern
20 Ireland?

21 **A.** Yes, they're all structured slightly differently but
22 there are bodies across the whole UK that bring trade
23 unions and policymakers together.

24 **Q.** There was a separate group, the Covid-19 SPF --
25 I'll just shorten it to SPF, if you don't mind --
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1 So we also had a standing terms and conditions group
2 that met -- I think at certain points they were meeting
3 several times a week in order to take forward the
4 technical work, and then we were able to convene one-off
5 workshops or meetings on specific topics, and in the
6 statement I give a few examples of the kind of topics we
7 discussed.

8 **Q.** So really it gave you a very good close access to
9 a number of central decision-makers about the healthcare
10 system, dealing with important topics and policy points;
11 is that it, in a nutshell?

12 **A.** It did bring us into contact with people. I think two
13 points that I think are probably important to make: one
14 is that obviously the range of topics that we were
15 discussing and the busyness of the people we were
16 discussing them with, obviously we did our best, on the
17 trade union side, to marshal our resources properly and
18 to use that time as efficiently as we could. So we
19 would have pre-meetings, for example, before every
20 meeting, knowing who was coming, so that we didn't
21 duplicate questions, that we asked things as efficiently
22 as possible, and didn't waste the time of people who
23 were managing big parts of the pandemic response.

24 But the other point I would make is that the really
25 critical work, to keep workers safe and interpret all
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1 the central guidance, happened within -- at organisation
 2 level, so this was the work that trade union
 3 representatives in every workplace did with their
 4 employers, in order to take what we were doing at
 5 national level, take that guidance and convert it into
 6 measures to keep people safe, to interpret all of the --
 7 all of the information that was coming out and, most
 8 importantly, to feed back up to us issues where guidance
 9 was being received, you know, and wasn't clear, or where
 10 there were issues where there was confusion or clashes,
 11 perceived clashes, between different pieces of advice.

12 **Q.** Just to follow on though with that thread, was there
 13 a difficulty in doing that because there had effectively
 14 been a loss of the middle layer of engagement?

15 **A.** So the structural reforms that had taken place in the
 16 NHS over the preceding decade had stripped out the
 17 sort of middle layer in the NHS, so the layer that was
 18 previously there in England and filled by the strategic
 19 health authorities. And those were a route often for
 20 trade unions to have intervention and engagement with
 21 employers and with officials over workforce policy
 22 matters and practical measures.

23 So that layer wasn't there, so that had denuded
 24 systems and structures to an extent, but the same
 25 pressures that I talked about that were on health

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1 Then:

2 "What response can they make to the disproportionate
 3 impact due to Covid?"

4 So this is a presentation from people from NHSE; is
 5 that correct?

6 **A.** That's true, yes.

7 **Q.** So it's been recognised, even in June 2020, that this
 8 was an issue, about protecting, engaging and supporting
 9 staff, those were the key questions.

10 Then if we can just go over the page, please, and if
 11 we can just, please, go to the fourth paragraph, if that
 12 could be highlighted. So this is the note of the
 13 meeting:

14 "Aware of the trust and psychological issues that
 15 have arisen amongst BAME colleagues due to support and
 16 PPE and other issues. These colleagues do not trust us.
 17 They are looking to their communities for support and we
 18 need to go there to assist. It is not a one size fits
 19 all approach. Some of the engagement has led to
 20 cultural awareness of some of the policies and
 21 procedures impacts on some colleagues ..."

22 That seems quite an open and honest assessment, that
 23 NHSE had lost the trust of a number of healthcare
 24 workers. Was that the impression that you were taking
 25 from those meetings at that time, in June 2020?

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1 workers, you know, trade union representatives are
 2 health workers themselves in the NHS, so the trade union
 3 structures had also been reporting through the staff
 4 council for a few years before the pandemic that people
 5 were saying to us that they were finding it more and
 6 more difficult to get access to time to participate in
 7 those structures. So there were signs of strain on
 8 capacity from the trade union side as well, and it was
 9 more difficult, particularly for people in clinical
 10 roles and from team leader roles, to participate in
 11 partnership working at trust level.

12 **Q.** Ms Gorton, you have an excellent habit of foreshadowing
 13 all of my questions, so I'm just going to ask you about
 14 some of the conversations that were taking place.

15 If I could please have up on screen, and I hope
 16 I have the right number here, INQ000119027. Thank you.

17 So this is the SPF wider group, this is the group as
 18 opposed to the forum; is that right? So the slightly
 19 more detailed analysis.

20 **A.** So the wider group is wider because it involves more
 21 people.

22 **Q.** Right. Thank you.

23 And this is 3 June 2020. If we can go down, please,
 24 to page 3, and it's that bottom header:

25 "BAME Strategy/Action Plan ..."

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1 **A.** I recall this conversation very well, and it was
 2 an honest response to the issues that were coming
 3 through in the data and the issues that we were
 4 referring as trade unions as well. So I think your
 5 categorisation was correct, yes.

6 **Q.** What was done after June 2020 to rebuild that trust?
 7 Maybe you're not the correct person to answer this
 8 question, but from your perception.

9 **A.** So I was going to say, you know, I'm not the person
 10 whose trust was breached, and, you know, you will be
 11 able to follow up with others. But the --

12 **Q.** Well, can I ask it a slightly different way. From your
 13 perspective, from your role with the staffing, was
 14 enough done to rebuild the trust?

15 **A.** I was at an event that the TUC held last week where we
 16 had the opportunity to talk to staff who had been
 17 through the pandemic, staff from black backgrounds, and
 18 the feeling in the room was clearly that not enough had
 19 been done, either before the pandemic or since.

20 I think what you're seeing on this set of notes is
 21 that there is a recognition of the need to look at these
 22 issues. I think you will need to take further evidence
 23 from people better suited than me to tell you how
 24 successful that has been, but I think I refer in the --
 25 elsewhere in the witness statement to a set of evidence

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1 that was given to the EHRC and to other bodies during
2 the pandemic about the particular impact on black staff.
3 And, you know, the issues that are set out here are
4 specific to looking at some of the practical effects of
5 the pandemic, but they don't reach into some of the
6 concerns about structural racism that had been raised
7 prior to the pandemic and still persist beyond it.

8 **MR SCOTT:** Okay.

9 Ms Gorton, given your very helpful statement and
10 evidence today, my questions are covered.

11 My Lady, I've no further questions.

12 **LADY HALLETT:** Thank you very much, Mr Scott.

13 I think there are some core participant questions.

14 Who is going first? Ah, Ms Hannett. There you are.

15 **Questions from MS HANNETT KC**

16 **LADY HALLETT:** The questions are likely to come from either
17 behind you or to the right, could you make sure that you
18 do speak into the microphone because that's where we get
19 your evidence recorded. Thank you.

20 **MS HANNETT:** Ms Gorton, I appear on behalf of the Long Covid
21 groups and I want to ask you a couple of questions
22 arising out of a letter sent by healthcare unions to the
23 Prime Minister, Boris Johnson, on 18 February 2021.

24 Please could we have INQ000114832 on the screen.

25 Ms Gorton, for your ease of reference, I think that's

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1 guidance should remain the same."

2 Questions following on from that document: why did
3 the TUC not have confidence in the review of the IPC
4 guidance?

5 **A.** So I think the issues around PPE and around the IPC
6 guidance that I refer to in the statement flag up,
7 firstly, the impact -- the practical impact of having
8 a set of guidance that's constantly updated. The trade
9 unions worked really, really hard. We knew right from
10 the start of the pandemic that if we had all worked
11 separately and all re-interpreted the guidance and put
12 those out through our separate networks, that would be
13 17 different sets of contrary guidance.

14 So we worked really hard to work together, not only
15 producing advice as joint unions but actually making
16 sure that, wherever we could, we were a reputable source
17 of information and referring people back to the original
18 source documents, so the official IPC guidance and, in
19 particular, the PPE specifications that were laid out in
20 those, and worked with employers to supplement those
21 through frequently asked questions to respond to issues
22 of detail. And we produced those, and they were checked
23 by the IPC specialists.

24 Now, obviously, there were areas where the trade
25 unions had been reflecting either confusion amongst the

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1 also at tab 15 of your bundle. Thank you. You see the
2 date is at the top, 18 February 2021, addressed to the
3 Prime Minister and the health ministers of each of the
4 four nations.

5 The title you will see is "Protecting healthcare
6 workers" and, at the bottom of the first page, the last
7 paragraph:

8 "Health and care workers are at three to four times
9 greater risk of developing and dying from Covid-19 than
10 the general public."

11 Over the top of page 2:

12 "... now no scientific doubt that Covid-19 spreads
13 via the airborne route."

14 The third paragraph:

15 "The current UK Infection Prevention and Control ...
16 guidance ... does not accurately depict the airborne
17 risks ..."

18 The letter then sets out five potential courses of
19 action to be taken. Then the paragraph immediately
20 after those five points, towards the bottom of page 2:

21 "We have addressed this letter to you because your
22 agencies and departments have not yet sufficiently
23 responded to our concerns. While we are aware that
24 a review of the IPC guidance has been carried out, we
25 cannot agree with its apparent conclusions that the

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1 workforce with the status or the content, or where there
2 were gaps. So early on in the pandemic, the -- there
3 was no reference to the situation that needed to be
4 adopted in either community settings or ambulance
5 settings, and we were hearing from workers in both of
6 those settings that they were being expected to go in
7 and out of homes where potentially they were being
8 exposed to people who were Covid positive and, if you
9 remember, at that time, there was no testing, so they
10 had no way of telling, people had no way of telling,
11 other than having symptoms, whether they were Covid
12 positive or not.

13 So it's gaps like that that we were able to flag.

14 But this particular issue of the airborne nature was
15 a gap that lots of professional bodies had been raising.
16 I think it's important to note that the trade union
17 structures themselves are industrial relations
18 structures, so we don't have a role in setting or
19 challenging scientific evidence. But I do remember this
20 being a very hot topic, and what we did through trade
21 union routes is that we were able to identify to
22 policymakers where this was a gap and to bring people
23 together with policymakers to try and address it.

24 And my recollection is that, on this particular
25 issue, we had a specific workshop convened through the

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1 Social Partnership Forum to bring together some of the
2 professional bodies that were raising these issues
3 around ventilation, around the airborne transmission
4 route, together with the experts from Public Health
5 England and other bodies to discuss the guidance.

6 So our role was to flag the gaps, to identify where
7 there was confusion, but it was very important to the
8 trade unions that we were seen as a reputable source of
9 information and that we were there to flag up where the
10 guidance had gaps and needed to be supplemented with
11 other advice, and this issue was one of those -- was one
12 of those gaps that was very, very clearly identified.

13 **Q.** Ms Gorton, that's helpful, thank you. Can I just check
14 that the points at bullet point 1 to 5 of that letter
15 reflect the position of your union in February 2021?

16 **A.** So I think if you look at the signatories of the letter,
17 that grouping is a group of professional bodies who have
18 got specialisms in respiratory issues and in ventilation
19 specialisms. That's not my own union's position, but we
20 raised suppose issues through Social Partnership Forum
21 structures.

22 **MS HANNETT:** I'm grateful, Ms Gorton.

23 **LADY HALLETT:** Thank you, Ms Hannett.

24 Mr Wilcock?

25 **Questions from MR WILCOCK KC**

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1 campaign, for example.

2 I referred earlier to the stripping out of that
3 middle layer of the contact structures, and I think
4 that -- that means that, without that middle layer,
5 either issues are more frequently raised, fast-tracked
6 either through to NHS England through employer
7 structures or through to people like me and my
8 colleagues in sort of UK trade union structures, or,
9 what's most likely, not raised at all.

10 So I think you do miss out on those, and I think the
11 lack of involvement in the planning, particularly -- you
12 know, I was thinking on the way in about previous
13 experience in the run-up to the -- I can't remember the
14 terminology, I think it was H1N1, the bird flu campaign,
15 and I think we had quite a lot more involvement in the
16 planning stages prior to that than I recall in Covid.

17 So those are the three areas that I would just flag.
18 Partnership working is only as good as the people
19 that -- and the trust that you can generate in doing it,
20 and it is dependent on those relationships that are
21 cultivated. What we did at national level, you know,
22 was set out opportunities for proper partnership working
23 at local level, but that feedback loop was rarely
24 closed.

25 **Q.** If I can stop you there, only because I'm obviously

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1 **MR WILCOCK:** Thank you, Ms Gorton. I represent the Northern
2 Ireland Covid Bereaved Families campaign and I think
3 it's right that your union, UNISON, has 50,000 members
4 in Northern Ireland, so you have some familiarity with
5 the situation there.

6 In your evidence this afternoon and in your
7 statement, you spoke of the positives of the social
8 partnership system which, as I understand, is primarily
9 an English NHS system, but there are equivalents in the
10 devolved nations. You mentioned those positives,
11 including the fact that they enabled unions to ensure
12 that ministers, civil servants and the system leaders
13 were made aware of the real-time concerns of healthcare
14 workers.

15 Are you able to give us any examples of how the
16 system could have worked better in England, first of
17 all?

18 **A.** So I think my reflection on partnership as a principle
19 is that it works best when people listen and then take
20 action, and I think the statement identifies some areas
21 where unions might have been saying things but they
22 weren't necessarily acted on, and there were some clear
23 policies like vaccination, as a condition of deployment,
24 where unions had been advising a particular course of
25 action would be detrimental to a good vaccination

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1 representing families from Northern Ireland, and you
2 said a lot of it depends on the trust that exists, and
3 we know that the healthcare system and the political
4 system in Northern Ireland is different. Are you able
5 to make the same sort of comments but this time specific
6 to the situation in Northern Ireland?

7 **A.** So I was chair of the English partnership structure, so
8 I wouldn't want to speak for colleagues in Northern
9 Ireland. I know there's some reference in the statement
10 to Northern Ireland but very happy to address specific
11 questions in writing afterwards through those
12 colleagues.

13 **MR WILCOCK:** We might take up on that. Thank you very much.

14 **LADY HALLETT:** I'm more than happy you should, Mr Wilcock,
15 if you decide you want to.

16 **MR WILCOCK:** Thank you.

17 **LADY HALLETT:** Ms Sen Gupta, I think you are -- where are
18 you? There you are!

19 **Questions from MS SEN GUPTA KC**

20 **LADY HALLETT:** Can you see, if you look --

21 **MS SEN GUPTA:** I can see Ms Gorton. My Lady, I'm sorry that
22 I'm not directly --

23 **LADY HALLETT:** Don't worry, I'll survive.

24 **MS SEN GUPTA:** Ms Gorton, I represent the Frontline Migrant
25 Health Workers Group, and we have been given permission

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1 to ask you a few questions which relate specifically to
2 the position of Filipino healthcare workers.

3 First, I'll provide some brief context for the
4 questions. Filipinos are the third largest national
5 group in the NHS, after British and Indian, but official
6 data gathering does not include Filipino as an ethnic
7 group for monitoring. The significant and
8 disproportionate impact of Covid-19 on the Filipino
9 community has been referred to by community
10 organisations such as Kanlungan.

11 In the first months of the pandemic, up to May 2020,
12 Filipinos accounted for only 3.8% of the nursing
13 workforce but 22% of Covid-19 deaths among nurses.

14 At paragraph 135 of your statement, you refer to the
15 government's awareness of the potential disproportionate
16 impact of Covid-19 on black, Asian and minority ethnic
17 workers from a relatively early stage of the pandemic,
18 and you also there refer to recognition of an urgent
19 need to act to mitigate this impact from at least 6 May
20 2020.

21 Given your experience in advocating for NHS health
22 staff, are you aware of any actions that were taken by
23 NHS management during the relevant period for this
24 module, which is 1 March 2020 to 28 June 2022, to
25 monitor and/or address the disproportionate impact of

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1 were given, or we were --

2 **Q.** Let me take this opportunity just to focus on the
3 question that I was asking, which was about monitoring
4 and addressing the disproportionate impact
5 specifically --

6 **A.** This is what I was coming to, because we were given --
7 we were asked to participate in the production of the
8 tool, the risk assessment tool, and we received some
9 information about compliance with the risk assessment
10 tool. So I think at one point that I refer to in the
11 statement we were assured that 95% of trusts had
12 completed their risk assessment processes. But what we
13 asked for was information coming back to us about what
14 was happening as a consequence of that, so what had
15 changed for those people as a consequence of having
16 those risk assessments. And that's the type of
17 information that we didn't get back.

18 So yes, there was work done, but I'm not aware of --
19 and we didn't get -- responses to questions about what
20 had happened as a follow-up.

21 The other aspect of work that was -- that I'm aware
22 did take place and into which trade unions had some
23 input was the matter I referred to earlier about setting
24 up of the health and wellbeing portals and the
25 helplines, and I know that there were conversations

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1 Covid-19 on Filipino nurses?

2 **A.** So I think the two aspects I would refer to, and I think
3 are covered in the statement, are that from that upon
4 onwards, so from May/June of 2020, there was
5 a re-engagement with that principle that's set out in
6 that early staff council statement of the need for risk
7 assessments, and -- so I am aware, we were asked to
8 contribute to a -- to the provision of very specific
9 risk assessment tools that were put together
10 specifically to address issues of disparity, and there's
11 evidence in the statement of the work of the -- through
12 the Social Partnership Forum to provide input into that.

13 So the principle of risk assessment was that
14 people's individual circumstances should be taken into
15 account, so not just a tick box that was done looking at
16 somebody's work environment, but actually taking their
17 wider experience into account.

18 So things like taking into account how people
19 travelled to work, their living circumstances, their
20 family circumstances, et cetera, as well as looking at
21 other factors like other -- whether people had other
22 health conditions, as well as the environments that they
23 were working in.

24 So risk assessments was one area where we know that
25 piece of work was stepped up and the figures that we

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1 about providing culturally specific elements of that, of
2 that helpline services. So those are the two areas of
3 provision that I'm aware that NHSE put in place.

4 **Q.** Thank you, Ms Gorton.

5 Is the disproportionate impact of Covid-19 on
6 Filipino nurses an issue that was specifically raised by
7 the TUC or UNISON with NHS management during that
8 relevant period?

9 **A.** I do remember us talking about the disproportionate
10 impact on black staff in general, and I remember
11 specifically in relation to the issue of the helpline
12 discussions about impact on Filipino nurses, and other
13 Filipino workers. But beyond that, I can't -- I can't
14 recall specifics.

15 **Q.** Ms Gorton, Filipino nurses wouldn't come under
16 the categorisation of black staff, I'm asking you
17 specifically about --

18 **A.** Sorry, I should explain, I'm using black in the way that
19 UNISON defines black, so within the broader definition
20 of black and minority ethnic staff.

21 **Q.** Looking to the future, Ms Gorton, do you agree that the
22 inclusion of Filipino as a separate category of ethnic
23 group in equality monitoring would assist in preventing
24 and addressing such issues in the future?

25 **A.** I can't offer a view from my own organisation, but

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1 personally it would certainly give visibility, yes.
 2 **MS SEN GUPTA:** Thank you very much.
 3 Thank you, my Lady.
 4 **LADY HALLETT:** Thank you, Ms Sen Gupta.
 5 That completes the questioning for you, Ms Gorton.
 6 I'm extremely grateful for your help, and I have got
 7 your written statement and I promise you, people always
 8 think the Inquiry is only about the oral evidence. It's
 9 not, it's about the oral evidence and the written
 10 material, so I can assure you, don't think on the bus on
 11 the way home, "Oh my goodness, I wish I'd said that",
 12 because I will take it all into account.

13 Thank you very much.
 14 **(The witness withdrew)**
 15 **LADY HALLETT:** Right, I shall return for a 10.30 start on
 16 Monday, 16 September.

17 **(3.42 pm)**
 18 **(The hearing adjourned until 10.30 am**
 19 **on Monday, 16 September 2024)**

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