

Monday, 16 September 2024

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2 (10.30 am)  
3 **LADY HALLETT:** Mr Scott.  
4 **MR SCOTT:** Good morning, my Lady. May we call Kevin Rowan,  
5 who can be sworn.  
6 **MR KEVIN ROWAN (affirmed)**  
7 **Questions from COUNSEL TO THE INQUIRY**  
8 **MR SCOTT:** Good morning, Mr Rowan.  
9 **A.** Good morning.  
10 **Q.** Would you please give your full name.  
11 **A.** My full name is Kevin Rowan.  
12 **Q.** And you are the head of organisation and services  
13 department of the Trades Union Congress; is that  
14 correct?  
15 **A.** More or less, I was until about a month ago, I now  
16 I have a new role. But thank you, yeah.  
17 **Q.** In terms of that role, which I think was the role that  
18 you gave when you provided the statement to the Inquiry,  
19 could you provide a very brief summary of what that role  
20 entails, please.  
21 **A.** That role heads a large department in the TUC which  
22 covers a range of policy and campaign areas including  
23 across all public services, health and safety, trade  
24 union renewal, and -- a few other things, but they're  
25 the main kind of core elements.

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1 and it's my impression of his evidence, that RIDDOR was  
2 principally a benefit for employers in their efforts to  
3 manage health and safety in the workplace. While  
4 I think clearly there's -- you know, all employers who  
5 end up in a situation where they have to exercise  
6 a RIDDOR report, there needs to be a learning from that,  
7 a review of their health and safety management  
8 practices, but there's a step before that that  
9 employers, all employers, need to undertake, and that's  
10 a risk assessment. The risk assessment should inform  
11 the health and safety management regime of employers.  
12 RIDDOR is effectively a scenario where that health  
13 and safety management system has failed, where someone's  
14 been injured, made ill or where there's a dangerous  
15 occurrence in the workplace that could have led to  
16 a serious injury. So I think the bit that I thought  
17 was -- I'd have liked to have heard from the Health and  
18 Safety Executive was that RIDDOR reporting should  
19 trigger evidence to the Health and Safety Executive for  
20 them to act in an enforcement and regulatory action,  
21 because it's evidence of an employer failing to manage  
22 health and safety in the workplace.  
23 So RIDDOR is absolutely useful in terms of it's  
24 a test, if you like, of the employer's health and  
25 safety -- the duty, all this health and safety

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1 **Q.** Was it as part of that role that you were  
2 a non-executive director of the HSE from 1 June 2016  
3 until 31 July 2021?  
4 **A.** Well, there's a relation between the engagement with the  
5 Health and Safety Executive, but non-executive board  
6 members are appointed in an individual capacity rather  
7 than on behalf of an organisation, but there's direct  
8 relationship.  
9 **Q.** But it wasn't a **de facto** role?  
10 **A.** No.  
11 **Q.** Mr Rowan, just to contextualise questions I'm going to  
12 be asking you today, so I hope you forgive me if I don't  
13 ask you any questions about the structure of the TUC,  
14 you've set that out in detail in your statement and also  
15 her Ladyship has heard that evidence I think in the  
16 previous four modules. We have also had Ms Gorton's  
17 evidence last week about engagement forums and  
18 partnership arrangements. So I want to focus with you  
19 on health and safety protection.  
20 You heard Mr Brunt's evidence from last Thursday.  
21 Is there any comment that you wish to make in relation  
22 to that evidence?  
23 **A.** I think the one particular issue that struck me with  
24 listening to Mr Brunt's evidence was around his response  
25 to the purpose of RIDDOR reporting. He seemed to imply,

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1 management, but it should also be an alert for the  
2 regulator -- regulatory authority.  
3 **Q.** So it's more --  
4 **LADY HALLETT:** Sorry to interrupt. Can I just challenge one  
5 of your statements, if I may, as a non-expert in this  
6 field, Mr Rowan. You said that if someone becomes ill,  
7 that indicates that there has been a management system  
8 failure. That's not necessarily so, is it? Someone  
9 might become ill and it may not be the employer's fault  
10 at all.  
11 **A.** No, absolutely, my Lady, that's right. But it's  
12 an indication that there could be something wrong with  
13 the management of the health and safety system.  
14 **LADY HALLETT:** So they need to investigate.  
15 **A.** Exactly so.  
16 **MR SCOTT:** So effectively it's a two-stage process, isn't  
17 it, RIDDOR making the report identifies to the employer  
18 that something's gone wrong because the employer feels  
19 that a report has to be made, and then there's a second  
20 stage which alerts the regulator and then it's up to the  
21 regulator to have a much broader systemic view; is that  
22 an encapsulation of it?  
23 **A.** That's how it should happen, yes.  
24 **Q.** Before we deal with the RIDDOR system and going into any  
25 great detail on that, you said that you were

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1 a non-executive director. What is the benefit of having  
 2 independent directors, non-executive directors within  
 3 a regulator such as the HSE?  
 4 **A.** Well, I was an employee representative on the board of  
 5 the Health and Safety Executive, and, you know, the  
 6 value I think that I brought in that role was I --  
 7 a direct connection with, in my case, the kind of trade  
 8 union movement and, if you like, therefore, a direct  
 9 connection with trade unions and a direct connection  
 10 with workplaces and working people, and I could bring to  
 11 the board, if you like, the insight of that -- that  
 12 network of health and safety representatives who voiced  
 13 concerns around health and safety issues at a workplace  
 14 level, and bring that kind of, if you like, perspective  
 15 to the strategic and operational decisions that the  
 16 Health and Safety Executive takes. Similarly, there  
 17 would be employer representatives on the HSE board and  
 18 independent members, sometimes from academia, sometimes  
 19 from other sectors.  
 20 **Q.** Because we've seen from the statement from the Health  
 21 and Safety Executive in Northern Ireland -- sorry, the  
 22 statement about the Health and Safety Executive in  
 23 Northern Ireland that for a number of years there hadn't  
 24 been any non-executive directors in place. Would you  
 25 wish to make a comment on whether that reflects

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1 colleagues in the Scottish TUC or the Irish Congress of  
 2 Trade Unions, but we would certainly speak informally on  
 3 a fairly regular basis, particularly I think in  
 4 scenarios like this where we're all, if you like,  
 5 struggling to kind of respond to, you know, a hugely  
 6 serious issue such as this.  
 7 **Q.** From your perspective, arising out of those discussions,  
 8 as far as they related to healthcare settings, were  
 9 there major differences across England, Wales, Scotland  
 10 and Northern Ireland, or were, effectively, the basic  
 11 concerns the same, even if there may have been nuances  
 12 arising in each individual country?  
 13 **A.** I think the basic concerns were principally the same,  
 14 slightly different approaches in that in  
 15 Northern Ireland in particular I think relationships are  
 16 much closer, so there's, in my view -- and it's not my  
 17 area of expertise, but in my view there's a higher  
 18 degree of collaboration simply because of the nature of  
 19 that part of the world, everybody knows each other  
 20 really well, it's quite a small -- it's quite a small  
 21 community in relative terms.

22 In our experience, in our kind of reflections, if  
 23 you like, looking back, we weren't in a position where  
 24 we had the same level of relationship or engagement with  
 25 government, certainly in the UK, so that was different.

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1 a failing that needs to be remedied?  
 2 **A.** My view, and TUC's view, is that there's real value in  
 3 that tripartite conversation happening at a strategic  
 4 level in organisations like the Health and Safety  
 5 Executive. I think the absence of those representative  
 6 voices to inform, to challenge, to check the strategic  
 7 operations of bodies like that, I think -- the absence  
 8 of that I think is problematic. I think it weakens the  
 9 organisation. And I think you see this in Acas, you see  
 10 this in the Health and Safety Executive, the Low Pay  
 11 Commission, and I think the kind of feedback from all of  
 12 those organisations is that they're more effective when  
 13 they have the opportunity to hear those voices.  
 14 **Q.** Just dealing with the devolved nations as a whole, so  
 15 Wales comes within the auspices of the TUC as a whole,  
 16 Scotland and Northern Ireland don't, they have their own  
 17 separate structures. Again, I'm not going to go over  
 18 the detail of that.

19 Were you having discussions with your opposite  
 20 numbers across Scotland and Northern Ireland in  
 21 particular about the type of issues that they were  
 22 facing in relation to healthcare systems in Scotland and  
 23 Wales?

24 **A.** I mean, I don't think that I could say in all honesty  
 25 that there was a systemic, consistent engagement with

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1 And I think similarly in Scotland, relations between the  
 2 Scottish Parliament and the Scottish TUC were much  
 3 closer, if you like, than I think we had with our  
 4 Westminster government.

5 **Q.** Was that, just to make sure I'm focusing on the right  
 6 issue, just in the healthcare setting or was that across  
 7 all sectors?

8 **A.** For us I think it was across all sectors.

9 **Q.** Okay.

10 I'm going to steal a line from Mr Jacobs last week  
 11 when he said to Mr Brunt that, rather than the niceties  
 12 of RIDDOR, let's focus on what needs to happen in the  
 13 next pandemic. I would like to explore with you in  
 14 healthcare settings in the event of a future pandemic,  
 15 what should happen, what your view is in relation to  
 16 reporting and regulators and the actions of the  
 17 regulators.

18 So do you agree with Mr Brunt that RIDDOR was not  
 19 intended to be used in a pandemic involving thousands of  
 20 instances of infection, it was really designed to  
 21 capture single one-off unexpected events, accidents and  
 22 incidents?

23 **A.** No, I don't agree. I mean, I think -- and if I could be  
 24 allowed a little bit of leeway to respond to this --

25 I think there are three stages that I think have been

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1 exposed as flaws in our health and safety system.  
 2 I think certainly the first point is identification of  
 3 data which would alert both employers and regulators to  
 4 the existence of significant risk.  
 5 The way that report -- RIDDOR was actioned and the  
 6 way that employers were advised around RIDDOR, so the  
 7 argument that they needed medical certificates around  
 8 Covid-19, meant that there wasn't the gathering of  
 9 intelligent data about the presence of risk of Covid-19  
 10 exposure in workplaces. In my view, that is what RIDDOR  
 11 should do, because what RIDDOR does is it gathers data  
 12 about risk beyond the workplace level, because it's  
 13 a report to the Health and Safety Executive. So that's  
 14 the first thing.  
 15 I think that would have informed or should have  
 16 informed that healthcare settings, with the emergence of  
 17 the pandemic, then became a high-risk sector. So the  
 18 intelligence would provide evidence of risk, gathering  
 19 that intelligence in a systemic way would identify  
 20 sectoral risks. That would then inform the Health and  
 21 Safety Executive's enforcement strategy. And HSE's  
 22 enforcement strategy is very effective: where it  
 23 identifies a high-risk sector there's an enforcement and  
 24 inspection regime which results in a significant impact  
 25 in those workplaces. A 40% material breach rate is

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1 explanation -- in your view, did RIDDOR work, in terms  
 2 of reporting incidents within the healthcare setting  
 3 during the pandemic?  
 4 **A.** I don't think RIDDOR worked anywhere near as well as we  
 5 would like it to. As I say --  
 6 **Q.** Is that a structural issue?  
 7 **A.** I think there are a number of factors. One is I don't  
 8 think most employers generally understand the duty that  
 9 they have under RIDDOR. That's one factor. The second  
 10 factor is I think they were given advice that, unless  
 11 there was a medical certificate proving that Covid was  
 12 contracted, they didn't need to produce a RIDDOR report.  
 13 And thirdly, there was the issue of cause and effect.  
 14 We know that there was a lot of contraction of Covid  
 15 in non-workplace settings, and it's not, you know, it's  
 16 not always going to be absolutely clear that Covid was  
 17 contracted in the workplace, but I -- I don't think that  
 18 employers were encouraged or particularly enabled to  
 19 provide evidence of Covid exposure in the workplace.  
 20 So I think there were three failings in the RIDDOR  
 21 system which, you know, if the first thing that you need  
 22 to act is data of risk, there are three different  
 23 factors that prevent that data being produced. So  
 24 straight answer is that, no, RIDDOR didn't work in the  
 25 way that we would want it to.

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1 about standard. That's where an inspector will identify  
 2 a material breach of health and safety law in 40% of  
 3 cases --  
 4 **LADY HALLETT:** Sorry to interrupt, Mr Rowan. I appreciate  
 5 you're in full flow, it's just that you're going very  
 6 quickly. I've got a feeling I might get some complaints  
 7 from the stenographer.  
 8 **A.** Well, my apologies to the stenographers, my Lady.  
 9 **LADY HALLETT:** Sorry, I interrupted you.  
 10 **A.** No, that's all right.  
 11 **LADY HALLETT:** An inspector will identify a material breach  
 12 of health and safety law in 40% of cases.  
 13 **A.** Yeah. So if you have -- the data point starts in  
 14 workplaces where employers identify where health and  
 15 safety regulation in their own management systems has  
 16 broken down. That leads to a RIDDOR report. The RIDDOR  
 17 report is then collected by the Health and Safety  
 18 Executive. That would have identified the health and  
 19 care sector as being a high-risk sector. That should  
 20 have then informed a Health and Safety Executive  
 21 operational and strategic approach, which would have  
 22 resulted in other high-risk sectors' inspectors  
 23 identifying material breaches and issuing enforcement  
 24 actions to correct those breaches.  
 25 **MR SCOTT:** Can I just ask, Mr Rowan -- a very helpful

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1 **LADY HALLETT:** Are you saying that -- what's the timing for  
 2 that comment, Mr Rowan? In the early days, obviously  
 3 there was a great deal of uncertainty, whether or not  
 4 people would get tests. Are you saying it didn't work  
 5 throughout the pandemic or are you saying that it was  
 6 when the uncertainty had gone and people could say  
 7 whether or not they actually had Covid?  
 8 **A.** I don't think it worked during the pandemic, my Lady.  
 9 I think -- and my understanding is that the guidance  
 10 around RIDDOR changed a number of times during the  
 11 pandemic, which wouldn't have helped clarity for  
 12 employers in what they report. But we've seen very  
 13 little evidence of RIDDOR being the mechanism that then  
 14 informed regulatory or enforcement action. So I find it  
 15 hard to identify a scenario where RIDDOR has worked in  
 16 this Inquiry question.  
 17 **MR SCOTT:** Well, then, let me ask you three different  
 18 options, and you may tell me it's none of the three:  
 19 could RIDDOR work in its current format, is option 1;  
 20 option 2 is could RIDDOR work but actually does need  
 21 effectively to be rewritten to deal with the pandemic;  
 22 or, number 3, do you need, in a pandemic time, something  
 23 separate to RIDDOR which does a different job but has  
 24 the same aims?  
 25 **A.** I mean, they're three different questions. I think for

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1 RIDDOR to work well, it needs to be clear, understood  
2 and employers need to respond to the -- their duty under  
3 RIDDOR. For a long time, we have been reporting that  
4 RIDDOR produced significant under-reporting of health  
5 and safety risks generally. So it doesn't work in its  
6 current format.

7 To answer the last question first, if I may, and  
8 I think, to be fair, we were all learning about the  
9 Covid pandemic and how risks were -- how infections  
10 were, you know, being spread. A sensible approach would  
11 be to say: where we're unsure about, you know, kind of  
12 those airborne viruses or how viruses are transmitted,  
13 the most safe approach would be to gather as much data  
14 as possible and to share that data as early as possible.

15 I don't think that was the case with RIDDOR. In  
16 fact, you know, some of the guidelines, particularly  
17 around things like medical proof of Covid, actually  
18 dissuaded employers from gathering and reporting that  
19 evidence. So I think there's certainly -- the  
20 indications would be you need a specific approach to  
21 managing those risks in a pandemic. I think there's  
22 a specific set of circumstances that would apply in  
23 that. So I guess yes is the answer to your third  
24 question: I think it needs specific circumstances for  
25 specific hazards.

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1 regulated system and they are low risk. I mean, to my  
2 understanding, there are huge numbers of incidents of  
3 injury or ill health spread amongst the healthcare  
4 workforce generally.

5 In a pandemic, and I think this was especially  
6 evident when we were hearing about failings around  
7 protective equipment, any logical assessment would  
8 identify that relatively early as a potentially  
9 high-risk environment, and that should have, in my view,  
10 led to a review of the Health and Safety Executive's  
11 regulatory priorities. It's a very effective  
12 organisation in high-risk sectors. What my concern is  
13 that it didn't pivot to treat the healthcare sector as  
14 a high-risk sector.

15 **Q.** Do you think that every infection of a healthcare worker  
16 should have been reported to the HSE?

17 **A.** I think, given what we know about the exposure to risk,  
18 that it was a high-risk setting, that there were huge  
19 problems with personal protective equipment and the  
20 potential risk to individuals, I don't think it's  
21 unreasonable that an employer in that setting should be  
22 required to record and report incidents of Covid -- all  
23 incidents of Covid.

24 **Q.** Is it fair that, simply because there has been a report,  
25 that there doesn't necessarily have to be

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1 **Q.** Because this comes back to your point, doesn't it, in  
2 terms of the breadth of the view of the regulator that  
3 it would have much wider knowledge if it's receiving  
4 RIDDOR reports from across the entire country, or  
5 England and Wales, rather than individual employers who  
6 are making individual reports, who may have  
7 an understanding within their own employment area but  
8 a regulator should be able to identify more than that?

9 **A.** That's absolutely right. If you don't have intelligence  
10 from -- if you don't have data then you can't have  
11 intelligence, and if you don't have intelligence you  
12 can't act, and the systemic process by which you  
13 identify and gather that data and intelligence to then  
14 inform your actions was absent.

15 **Q.** Because I think, again, Mr Jacobs was saying on Thursday  
16 that healthcare settings in a non-pandemic time tend to  
17 be considered low risk because they're well aware of  
18 infection risks and control. Don't they then switch to  
19 high risk when you're in a setting, such as a pandemic,  
20 where you have a novel infection that is spreading in  
21 a way that people aren't entirely certain about?

22 **A.** It seems to me that -- I mean, certainly, it is the case  
23 that, because, of the regulatory nature of the  
24 healthcare sector, there are procedures, there are  
25 processes, people kind of tend to work within a very

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1 an investigation. It can simply be that you're  
2 recording information about the circumstances of that  
3 individual, in this case, infection?

4 **A.** Yeah, I think that's fair. There'll be scenarios where  
5 people work in the healthcare environment, that don't  
6 have direct engagement with patients who have Covid,  
7 will contract the virus. People working, you know, in  
8 kind of ancillary roles often will not come into direct  
9 contact with a patient but it's important that they're  
10 recorded because we also know that people working in  
11 those, if you like, less direct roles were less likely  
12 to be in the front of the queue for personal protective  
13 equipment. So their risk of exposure would have been  
14 different to healthcare workers in the frontline.

15 So it is -- but their lives are equally valuable,  
16 their health and wellbeing is equally valuable, so it is  
17 important that when they do contract, if they do  
18 contract Covid-19, that that is recorded, and it may be  
19 that that would then inform the health and safety  
20 management practice of those employers.

21 **Q.** Because without those reportings, based on your  
22 experience in the role at TUC and as the non-executive  
23 director of HSE, are you actually able to track all the  
24 various different groups, and I mean that, whether it's  
25 protected characteristics, or the equivalent in Northern

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1 Ireland, or otherwise, in terms of their job role,  
 2 unless you know who's been infected in a healthcare  
 3 setting, how do you actually know, effectively, what the  
 4 impact is and where people are getting infections from?  
 5 **A.** That's exactly right. I mean, the first step any  
 6 employer should do, and all employers have a duty to do  
 7 this, is to assess risk. They should, in situations  
 8 where those risks change, so when we have a pandemic  
 9 coming into our society and our economy, they should be  
 10 reviewing those risk assessments. If they're monitoring  
 11 then the health of their workforce, as they should, and  
 12 you may have, you know, a group of, you know, cleaning  
 13 staff who, again, may not have been able to access  
 14 personal protective equipment in the way that frontline  
 15 healthcare workers, if that group of workers, a high  
 16 percentage of them contract Covid, then you would need  
 17 to look at your health and safety management system to  
 18 make sure that those workers are protected.  
 19 So, unless you have that data, you're not going to  
 20 know that you need to change your health and safety  
 21 management practice, and the same is true when you take  
 22 that above the workplace on to a sectoral or wider  
 23 level. If the Health and Safety Executive don't have  
 24 the intelligence that sectors or groups of particular  
 25 workers have a higher prevalence of exposure to the

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1 virus among certain groups of our community and certain  
 2 groups of workers. And again, that would inform  
 3 an intelligent approach to how you regulate and enforce  
 4 amongst those group of workers.

5 We know that ethnicity was a particular concern in  
 6 the experience of Covid-19 -- exposure to Covid-19. We  
 7 also know occupational groups were more or less  
 8 prevalent to contracting the virus depending on their  
 9 roles.  
 10 **Q.** When you say occupational groups, would you also then be  
 11 looking to record where they were actually working at  
 12 the time, in case somebody's been redeployed,  
 13 for example?  
 14 **A.** So the -- we know from our experience that, you know,  
 15 workers who were in more populated occupations or  
 16 populated areas would certainly be more likely to  
 17 contract the virus, so that was a factor, and there  
 18 are -- so there's an occupational, if you like,  
 19 characteristic that would inform any kind of regulatory  
 20 or enforcement regime, and as we've just been  
 21 discussing, we know that the healthcare sector as  
 22 a whole moved from low risk to high risk. So there are  
 23 sectoral factors to consider as well as occupational  
 24 factors as well as personal characteristics.  
 25 **LADY HALLETT:** Can I interrupt, can I just go back to the

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1 virus than others, then the Health and Safety Executive  
 2 has no evidence or intelligence to change its regulatory  
 3 regime.  
 4 **Q.** Could I take the next part in three different sections:  
 5 first it's going to be reporting; then there is going to  
 6 be recording by the regulator; and then investigation by  
 7 the regulator.  
 8 So dealing first with the reporting point: in  
 9 healthcare settings, should there be any limit on what  
 10 is being reported, do you think, in terms of whether  
 11 someone suffered an infection?  
 12 **A.** I don't see a case for not providing as much evidence  
 13 and information as you've got when you're dealing with  
 14 a Covid pandemic that's killed tens of thousands of  
 15 people. I just don't see how that's a reasonable  
 16 approach.  
 17 **Q.** Would that then extend to what should be recorded by the  
 18 regulator about the information that's provided to them?  
 19 **A.** I think the kind of information that should go to  
 20 a regulator -- you know, again, the more you limit it,  
 21 the less intelligent decision-making the regulator is  
 22 able to make. So the more information you have, the  
 23 better decisions you can make.  
 24 **Q.** So factors such as ethnic group should be included?  
 25 **A.** We know that there were a particular prevalence of the

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1 basics, if I'm an employer and I make a RIDDOR report,  
 2 is there a form I fill in or -- and if so, what  
 3 information does that form require of me? Very roughly.  
 4 **A.** Yeah. So there's both a hard copy and an online form  
 5 that employers are required to complete, my Lady, and  
 6 that will detail the nature of the incident, the nature  
 7 of the injury or illness, that's provided, and  
 8 a description of the factors that the employer might  
 9 believe have contributed to it.  
 10 **LADY HALLETT:** So will it depend on whether the employer  
 11 thought that ethnicity was a relevant factor?  
 12 **A.** I'm not sure I can answer that, my Lady, to be honest.  
 13 I'm not an expert in the report --  
 14 **LADY HALLETT:** But ethnicity isn't necessarily a factor that  
 15 has to be reported, so, for example, with the  
 16 pandemic --  
 17 **A.** Correct -- sorry, yeah.  
 18 **LADY HALLETT:** So that wouldn't have been -- even if the  
 19 employers had all been fulfilling the RIDDOR  
 20 regulations, as you say they weren't, that ethnicity  
 21 would not necessarily have come through, it depends on  
 22 the employer?  
 23 **A.** I think that's right, my Lady. I couldn't say with  
 24 certainty, but I think that's right.  
 25 **MR SCOTT:** Do you need to record the same information from

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1 the healthcare system as you would from other sectors,  
 2 for example, in the middle of a pandemic or, as you say,  
 3 that the risk in the healthcare sector is maybe higher  
 4 than it is in other sectors?

5 **A.** I think the reporting is standard across sectors as it  
 6 currently -- currently operates. I think the point that  
 7 we were discussing earlier is relevant in that we know  
 8 that there was a significant increase in risk in the  
 9 healthcare sector, so the kind of things that would have  
 10 been normally recorded in any kind of RIDDOR  
 11 investigation would apply to the healthcare sector. So  
 12 things like provision of PPE, things like work systems,  
 13 things like social distancing, and the existence of risk  
 14 assessments and good management would be the kind of the  
 15 normal things that are recorded and reported.

16 **Q.** But reporting may be standard but does it need to be  
 17 standard, when you're talking about in the context of  
 18 a pandemic, to make sure that you're getting the best  
 19 information?

20 **A.** I mean, I think because I think we were in a particular  
 21 scenario where there was a new set of risks because of  
 22 the existence of the virus, there was a need to record  
 23 more data than RIDDOR would require. So what RIDDOR  
 24 would normally demand is that incidents were -- occurred  
 25 as a direct relation to something that happened in

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1 reporting of instances of Long Covid or do you think it  
 2 was underreported?

3 **A.** I think there's significant under-reporting in all  
 4 aspects, including the impacts of -- long-term impacts  
 5 of Covid.

6 **Q.** Moving then to the regulator has received this  
 7 information, at what point should it look to start to  
 8 investigate or take steps in relation to what  
 9 information it has received?

10 **A.** So I think if the reporting system was working well, it  
 11 would identify occupations or sectors that are more at  
 12 risk of contracting the virus than other sectors. That  
 13 should trigger a systemic response from the regulatory  
 14 authority to pay -- you know, to investigate more, to  
 15 inspect more, in those sectors. So that would be one  
 16 instance.

17 I think where there's clear evidence of occupational  
 18 activity, and that could be inadequate supply of  
 19 personal protective equipment, it could be evidence of  
 20 employers not following the guidelines that were issued  
 21 to try to protect workers, any of those incidents should  
 22 lead to some kind of regulatory activity, some kind of  
 23 enforcement activity.

24 **Q.** Because what's the benefit in the context of a pandemic  
 25 of having enforcement?

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1 an occupational setting.

2 I think for a lot of cases and a lot of circumstance  
 3 it wouldn't necessarily have been obvious that the -- if  
 4 someone got -- you know, contracted Covid that that had  
 5 occurred in the workplace. But it may have done. So  
 6 I think in these particular circumstances, it would be  
 7 more important that employers were reporting incidents  
 8 of Covid across the board rather than where they could  
 9 directly associate the risk of exposure with something  
 10 that had happened in the workplace.

11 **Q.** Would you also be looking to record, although this might  
 12 not be something that was reported at the time when, in  
 13 this case, an infection has been caused, would you be  
 14 looking to record any long-term effects such as  
 15 Long Covid?

16 **A.** I think that's important, as, you know, we were -- and  
 17 to some degree still are -- learning about the  
 18 longer-term impact of Covid, and there's ongoing  
 19 conversations around industrial injuries benefit and  
 20 whether this is a prescribed illness in the workplace.  
 21 So I think gathering the evidence to support that debate  
 22 and that discussion is going to be really important,  
 23 yeah.

24 **Q.** Do you think in the way that RIDDOR was applied to  
 25 Long Covid do you think that there was sufficient

22

1 **A.** Well, the benefit of enforcement is fundamentally to  
 2 correct poor behaviour or poor management systems that  
 3 are there to protect employees. As I've said, the HSE  
 4 is extremely effective, in my view, in informing  
 5 employers about the right way to manage health and  
 6 safety and to act as a check against employers who  
 7 aren't effective at managing health and safety, and  
 8 removing those hazards and making sure that employers do  
 9 manage health and safety well. That's what saves lives.

10 **Q.** How effective, in your view, was the Health and Safety  
 11 Executive at actually carrying out that inspection and  
 12 enforcement process during the pandemic?

13 **A.** Well, what the -- in my view, the Health and Safety  
 14 Executive should have done was understand that the  
 15 health and care sector became a high-risk sector during  
 16 the pandemic and applied its very effective regulatory  
 17 regime in high-risk sectors to the healthcare setting.  
 18 It would have then led to more inspections, more  
 19 engagement with employers and would, undoubtedly, in my  
 20 view, have improved health and safety management in  
 21 those sectors.

22 I think -- and I think you have the numbers, but  
 23 I don't think we saw any increase in engagement between  
 24 the Health and Safety Executive and the healthcare  
 25 sector during the period of the pandemic.

24

1 Q. Again, from your perspective, was that a capacity issue  
2 or not?

3 A. I think certainly there are huge capacity challenges in  
4 the Health and Safety Executive, the number of warranted  
5 inspectors has gone down dramatically in the last 10,  
6 15 years or so, so the ability of the Health and Safety  
7 Executive to be agile and to respond to, if you like,  
8 sudden changes in the health and safety risks across the  
9 economy is limited. But we also know that the Health  
10 and Safety Executive stood down from proactive workplace  
11 inspections in that period. So I think there's  
12 certainly capacity issues across the HSE but I'm not  
13 sure that's the only factor that informed, in my view,  
14 a lack of engagement in the healthcare sector.

15 Q. Is one of those factors funding?

16 A. I think funding is absolutely a factor, I think the  
17 budget of the Health and Safety Executive's been halved  
18 in the last 15, 20 years, so it's huge impact.

19 Q. You are aware in terms of what was said to Ms Gorton  
20 yesterday about the Chair's understanding of funding  
21 positions; are there any other factors that arise in  
22 relation to the Health and Safety Executive in the way  
23 that it was carrying out enforcement?

24 A. I'm not sure that I'm really able to answer that,  
25 I mean, I think the Health and Safety Executive knows

25

1 Q. Does it have sufficient technical skills, or is there  
2 a bit of a grey area between it and, in this example,  
3 the CQC about the areas that it has oversight of?

4 A. No, I think it's probably the other way round, I think  
5 the Health and Safety Executive certainly has the  
6 technical skills and expertise to understand risks in  
7 the workplace, to understand what management controls  
8 are needed in the workplace and to provide the advice  
9 and guidance to those employers to manage those risks.

10 Q. So, in terms of any lessons learned from your  
11 perspective about the way that the Health and Safety  
12 Executive was able to approach its enforcement  
13 functions, are there any recommendations of lessons that  
14 you think should be learned that haven't yet been  
15 learned?

16 A. Across the whole, because I think you have to look at  
17 this at all three stages, I think certainly the ability  
18 to gather sufficient valuable data about how Covid was  
19 impacting on workplaces and causing infection and ill  
20 health was systemic, a huge systemic flaw, in my view,  
21 we didn't find the right way to gather data about where  
22 people were being made ill in the workplace.

Secondly, that didn't then lead to an intelligent  
gathering of that data to inform decision-making that  
then, thirdly, would have encouraged and enabled the

27

1 where it's very effective and how it's very effective,  
2 but I think as -- and I would agree with Rick Brunt's  
3 comments last week, that inspections and enforcements  
4 through enforcement action is one, if you like, arrow in  
5 their quiver. They work with employers to provide good  
6 quality guidance and to develop good practice and lots  
7 of kind of education of duty holders in that regard.

But for me the most effective way to correct  
employers who are not managing health and safety well is  
warranted inspectors. I have been on workplace visits  
with warranted inspectors: they walk through the door,  
employers stand to attention, they listen and they act  
immediately when the warranted inspectors give them  
an instruction to do so. It's a hugely effective tool  
and it wasn't deployed, in my view, as well as it could  
have been during the pandemic.

17 Q. In terms of any future pandemic, does it follow that you  
18 believe that the HSE does have the tools and it's simply  
19 a matter of deployment, rather than there are additional  
20 tools required?

21 A. I think certainly the Health and Safety Executive  
22 manages really well with the resources that it's got  
23 but, if it was to be required to respond in an agile way  
24 to a new and significant health risk, it would struggle  
25 to do that with the resources that it's got, in my view.

26

1 regulatory and enforcement regime to pivot and operate  
2 differently to try and make sure that as few people were  
3 injured as possible.

4 MR SCOTT: My Lady, given the breadth of the answers and the  
5 look forward in terms of the health and safety  
6 perspective, I have no further questions.

7 LADY HALLETT: Thank you very much, Mr Scott.

I think there's one question, is it, Mr Puar?

#### Questions from MR PUAR

10 MR PUAR: I ask questions on behalf of a group of bereaved  
11 families in Wales, and I just have a few questions for  
12 you.

In your written evidence, and your evidence today,  
you contrast the relationship that the TUC had with the  
UK Government and that of the relationship that they had  
with devolved nations, and you make reference to the  
term "machinery" being in place to allow regular  
dialogue between the TUC and the Welsh Government. Can  
you perhaps expand upon that and explain what was that  
machinery in place?

21 A. I can try but, perhaps, my Lady, if we could kind of  
22 follow that up with (inaudible), it's not my area of  
23 expertise but, certainly, my understanding is that we  
24 have a social partnership and social dialogue forum and  
25 arrangement in Wales, where the Welsh TUC has pretty

28

1 close and pretty regular dialogue with the Welsh  
2 Government across the board.

3 **Q.** Can you provide any practical examples on the ground  
4 where this dialogue with the Welsh Government led to  
5 a better health and safety outcome for healthcare  
6 workers in Wales than it did in England?

7 **A.** Apologies, I'm not able to provide that level of detail,  
8 but I'll happily kind of provide some evidence later if  
9 that's helpful.

10 **MR PUAR:** Thank you.  
11 My Lady, those are the questions.

12 **LADY HALLETT:** Thank you very much.  
13 Thank you very much, Mr Rowan, that completes all  
14 the questions we have for you. Thank you very much for  
15 your help.

16 **THE WITNESS:** Thank you, my Lady. Cheers.  
17 **(The witness withdrew)**

18 **LADY HALLETT:** Mr Fireman.

19 **MR FIREMAN:** Thank you, my Lady, may I please call  
20 Ms Rozanne Foyer.

21 **MS ROZANNE FOYER (affirmed)**  
22 **Questions from COUNSEL TO THE INQUIRY**

23 **MR FIREMAN:** Ms Foyer, could you please give your full name?

24 **A.** Yes, my name is Rozanne Foyer.

25 **Q.** Thank you. You have given evidence before to this  
29

1 Scottish Government?

2 **A.** Yes, we have had a long-standing close engagement with  
3 the Scottish Government, I would say that we have a high  
4 level of engagement, it's constructive and it's robust.

5 **Q.** Did that remain the case during the pandemic?

6 **A.** I would say it became even more -- the engagement was  
7 more intense during the pandemic and more regular  
8 because of the nature of what we were dealing with.

9 **Q.** You've set out in your witness statement that you agreed  
10 something called the Coronavirus Fair Work Statement  
11 with the Scottish Government.  
12 If we could just get that on screen, it's  
13 INQ000107242, and if we could go to page 2, please.  
14 What we're looking at there are some principles that  
15 you have agreed with the Scottish Government in terms of  
16 how to approach the workplace and protecting workers  
17 during the pandemic; is that right?

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

19 **Q.** We can see obviously some of those, particularly those  
20 towards the bottom of the page, are particularly  
21 pertinent to healthcare workers, protecting the health  
22 and safety of all workers, particularly those on the  
23 frontline and, of course, ensuring that workers are  
24 provided with clear and comprehensive information on  
25 work related risks on an ongoing basis.

31

1 Inquiry, but you have given a witness statement to  
2 Module 3. That's INQ000411604. Can I just check you've  
3 got that accessible to you?

4 **A.** Yes, I do.

5 **Q.** Thank you.  
6 You are the general secretary of the Scottish Trades  
7 Union Congress; correct?

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

9 **Q.** We just heard from Mr Rowan of the Trades Union  
10 Congress, and I think it's clear, isn't it, that the  
11 Scottish Trades Union Congress operates in a very  
12 similar way to the Trades Union Congress --

13 **A.** Yes, we do.

14 **Q.** -- albeit, of course, its remit is in Scotland?

15 **A.** Yes, we cover over 500,000 members based in Scotland and  
16 have a similar range of affiliates who separately  
17 affiliate to the Scottish TUC.

18 **Q.** Thank you. With respect to the work that the STUC does,  
19 you've explained in your witness statement that it  
20 co-ordinates, of course, work that's done with health  
21 and social care unions among other unions, in terms of  
22 their engagement with the Scottish Government and  
23 ministers and Cabinet Secretaries.  
24 Would you consider that, generally speaking, you  
25 have a good level of access to and liaison with the  
30

1 How effective do you consider agreeing this sort of  
2 statement was in terms of establishing, I suppose,  
3 a sort of contract between the Scottish Government and  
4 workers?

5 **A.** The feedback we received from our member trade unions,  
6 including those in health and social care, was that this  
7 was a very effective document, it was used widely by  
8 reps on the ground to remind employers of the  
9 obligations that Scottish Government expected of them,  
10 and a particular clause in it that was actually very  
11 widely used by reps was the area around making sure that  
12 workers didn't suffer any detriment for following  
13 medical advice during their own sickness or absence. So  
14 that was something that was used widely.

15 **Q.** So is it something that you would consider would be  
16 an appropriate thing to agree, were there to be any  
17 other pandemic in the future, having this sort of  
18 framework in place between the government and --

19 **A.** Yes.

20 **Q.** -- trade unions?

21 **A.** Yes, I would. I mean, it was agreed very early doors,  
22 I believe it was agreed March or April 2020 and, as  
23 I say, it was something that could be referred to by  
24 reps across a range of settings, and empowered them to  
25 demand, you know, certain obligations from their

32



1 employer, if they felt they weren't getting anywhere.

2 **Q.** Thank you, that document can come down.

3 If I can ask you about some of your specific

4 concerns that you had during the pandemic, of course

5 staffing is obviously something that is particularly in

6 your mind at all times, but you had, of course, just --

7 I think like the TUC -- raised concerns prior to the

8 pandemic, hadn't you, about the level of healthcare

9 workers within the workforce and vacancy levels; is that

10 right?

11 **A.** That's right. I believe we produced in our evidence

12 examples of motions that had come to our congress in

13 2017, 2018 and 2019, all of which came from healthcare

14 affiliates who were raising concerns around staffing

15 vacancies, lack of adequate workforce planning and

16 issues around the resourcing of the sector.

17 **Q.** There were, of course, some steps taken to bolster the

18 workforce during the pandemic, weren't there, in terms

19 of bringing back workers who were retired or

20 unregistered? Do you think those steps adequately

21 filled the gaps?

22 **A.** No, I don't. There was much evidence provided by our

23 affiliates that what was already a bad situation at the

24 outset of the pandemic caused by, you know, the

25 austerity measures that had been taking place for up to

33

1 burn-out, or the impact on the mental health and

2 wellbeing of those workers?

3 **A.** Yes. There's a number of our healthcare affiliates that

4 carried out surveys over that period that we've touched

5 on in our evidence, and you can see that coming through,

6 that staff having to work excessive hours, that levels

7 of understaffing are, you know, consistently quoted and

8 that word burn-out, you know, 80, 90% levels of burn-out

9 being quoted in various different staff surveys.

10 **Q.** I think within your witness statement one of the areas

11 you touch on is pharmacists.

12 **A.** Yes.

13 **Q.** But was it the case that this assessment in terms of

14 burn-out and the impact on all healthcare workers was

15 the case across the board, both primary and secondary

16 care, or were there particular areas where it was more

17 acute?

18 **A.** We had evidence came in from Unite, from the

19 Pharmacists' Defence Association, from UNISON, from the

20 royal college of midwifery, a whole range of different

21 areas. So my observation would be that we were really

22 talking that this was quite a general picture, rather

23 than it being one particular area.

24 **Q.** Are you aware of whether there was any national

25 programme in Scotland designed to tackle supporting

35

1 a decade before were really compounded and it became

2 a really, really vicious cycle for our members because

3 we had people who were having to shield and take time

4 off sick through the virus itself, but we increasingly

5 had workers who were succumbing to burn-out, mental

6 health issues, and the more people who were taking time

7 off, the harder it became for our workers who were on

8 the frontline to keep their services going.

9 So we had a really acute set of circumstances for

10 a prolonged period that the workers were having to deal

11 with, and that really made the situation extremely

12 difficult, and we just didn't have the resilience and

13 the capacity from the beginning to really allow us to

14 deal with that. So even though extra resources were put

15 in, the experience of our members on the ground was that

16 the situation was extremely difficult.

17 **Q.** That's specific to healthcare?

18 **A.** That's specific -- you know, we saw that coming through

19 very highly in healthcare, yes.

20 **Q.** You touched on some of the other factors that you

21 mention, including, I think, what you phrased as

22 burn-out.

23 **A.** Yes.

24 **Q.** So would it be the case that you consider there's

25 an inextricable link between levels of staffing and

34

1 healthcare workers in terms of maintaining their mental

2 health and wellbeing during the pandemic, or indeed

3 generally?

4 **A.** I'm not aware of specific programmes within NHS

5 Scotland, however I have seen evidence that -- well,

6 health and social care was merged by the Scottish

7 Government and integrated in 2016, so some of our

8 surveys cover health workers and social care workers.

9 But my understanding is that, certainly in social care,

10 there was evidence that there wasn't support, there was

11 a survey carried out by GMB which is in our evidence

12 bundle that referenced a real lack of support for

13 workers' mental health. My understanding is that there

14 were some provisions with NHS Scotland but I'm not

15 familiar with them, you'd have to ask them about the

16 specifics of that.

17 **Q.** Thank you very much, that's fine.

18 In terms of the wider picture, it's not just, is it,

19 about the staff who were suffering? Of course that's

20 very important, but it's also about the impact that the

21 staff suffering with their own mental health issues may

22 have on patients. Do you -- and I appreciate it's quite

23 a difficult question to assess -- but certainly from

24 a concern perspective, did you have any concerns that,

25 in fact, mental burn-out was having an impact directly

36

1 on the quality of care that was being provided to  
 2 patients?  
 3 **A.** Yes, I think that that's something that came through in  
 4 the reports back that we were receiving. That was part  
 5 of the level of stress and concern that our members  
 6 expressed. They felt that, due to the staffing levels,  
 7 the lack of resources, that they weren't -- you know,  
 8 that added to their burn-out, the feeling that they  
 9 weren't able to give the sort of public service that  
 10 they would want to, to care for people. I think that  
 11 the very nature of the role of care giving and  
 12 healthcare workers, there's a lot of emotional  
 13 investment involved, in fact it's very important, that  
 14 human element is a very important aspect of care, and  
 15 there was real frustrations coming through from staff  
 16 that they weren't giving what -- you know, their feeling  
 17 of a high standard of care because of the sheer lack of  
 18 resources available and the burn-out that they were  
 19 themselves experiencing.  
 20 **Q.** So what's coming through from what you're saying is that  
 21 this is all linked, really. Staffing levels are linked  
 22 to mental health issues; mental health issues are linked  
 23 to the way in which you provide care; and not being able  
 24 to provide good quality care can impact on, again,  
 25 mental health of healthcare workers.

37

1 can see there, under the heading "Black workers and  
 2 fear", we can see first of all that black workers are  
 3 more fearful of infection. This was a report, it should  
 4 be said, done in June 2020?  
 5 **A.** Yes.  
 6 **Q.** So of course then there may be multiple factors  
 7 contributing to this but it would probably be sensible  
 8 to infer that one of the reasons for that fear may have  
 9 been the higher proportion of deaths among black  
 10 healthcare workers; is that right, at this time?  
 11 **A.** Yes, it became clear very early on in the pandemic that  
 12 there was a disproportionate, a really stark  
 13 disproportionate effect on BME workers that was  
 14 emerging, and this report was really trying to get at  
 15 the underlying inequalities that might be contributing  
 16 to that, and it was felt -- I think the report quite  
 17 clearly articulates that that lack of empowerment in  
 18 worker voice, and that if you're fearful in work in  
 19 general or you feel less empowered to raise issues, then  
 20 that could be directly linked to the higher infection  
 21 rates there were. There was more fear about raising  
 22 issues, there was more fear about asking for appropriate  
 23 PPE or refusing to carry out duties or citing health and  
 24 safety protections.

25 **Q.** So do you think that there is potentially a link between

39

1 **A.** Yeah. One of our affiliates, Unite, described their  
 2 members who worked in healthcare as being at breaking  
 3 point, and that was in, I believe, around August 2020,  
 4 and I think that that just illustrates the level of  
 5 anxiety that staff had about the provision.

6 **Q.** Just moving to a linked topic but from a slightly  
 7 different perspective, one of the things that you  
 8 mention in your witness statement is the particular  
 9 impact on workers from ethnic minority backgrounds, and  
 10 you cite a report that was done by UNISON Scotland in  
 11 June 2020, looking at underlying inequalities and  
 12 infection risks, specifically looking at black workers.

13 I don't think this was specific to healthcare, but  
 14 it was looking at specifically the impact on ethnic  
 15 minority workers, particularly black workers, in this  
 16 report; is that right?

17 **A.** Yes, and I think it needs to be seen through the lens  
 18 that there are high levels of BME workers in health and  
 19 social care in Scotland, it's, you know, a higher level,  
 20 so it would have been very -- that report would have  
 21 been reflective of workers in that sector --

22 **Q.** In fact, if we have a look at that, or a section of it,  
 23 in fact, that's INQ000215615.

24 If we just go to page 3, just can see some of the  
 25 summarised points that arise from that report, and we

38

1 fear of some of these other aspects, fear of losing your  
 2 job, more worried about reduced income, a link between  
 3 that and perhaps the areas in which healthcare workers  
 4 were required to work, which may in fact have been  
 5 riskier than other areas, because those workers didn't  
 6 necessarily have the confidence to challenge the fact  
 7 that they may have been placed in particular riskier  
 8 places?

9 **A.** Yes, I think that this is an area we really need to look  
 10 at, because it's not only black and ethnic minority  
 11 workers, but I think that there are definitely  
 12 socioeconomic factors at play when we look at -- and  
 13 this is something that I covered actually in my evidence  
 14 to the Scottish Inquiry on health and social care, so it  
 15 will be available to yourselves. But, you know, that  
 16 dynamic of workers who are in lower grades on poorer pay  
 17 and conditions, workers who are perhaps in more  
 18 precarious work in areas of the care sector who didn't  
 19 feel empowered to demand the appropriate PPE, who might  
 20 not have had as much sight of the appropriate guidance  
 21 or had it explained to them or had training to carry out  
 22 appropriate risk assessments if they were, you know,  
 23 visiting people in home settings, et cetera, we think  
 24 there's definitely a link there that warrants further  
 25 investigation because people feeling empowered to be

40

1 able to raise issues is a massive factor. So if you're,  
2 you know, affected by inequality, you're less likely to  
3 feel that empowerment to be able to protect yourself in  
4 such a grave situation.

5 **Q.** That can come down.

6 I suppose, following on from what you're saying, do  
7 you think that there was a link between the quality and  
8 level of risk assessments that were being done and the  
9 fear that workers were experiencing and then, again,  
10 another link to the types of workers who were  
11 experiencing that fear?

12 **A.** Yes, definitely. We found that many workers who were  
13 being expected to self-risk assess hadn't been given  
14 adequate training to do so when visiting people in home  
15 care settings, and that would have affected a range of  
16 health and social care workers. We also had a range of  
17 agency workers, et cetera, who were not able to  
18 adequately access sick leave, and there were real  
19 concerns, certainly on the social care side of things,  
20 that these workers were, you know, choosing to report  
21 for work, you know, rather than have -- be unable to  
22 feed their families, effectively. And that's a really  
23 unfair decision to ask someone to make. So there were  
24 some serious issues that we had that we raised at the  
25 time with government around these areas.

41

1 statement, and of course we've just heard from Mr Rowan  
2 and he touched on the role of the Health and Safety  
3 Executive in some detail. One of the points you make in  
4 your statement is you say that you weren't informed of  
5 the fact that the HSE was pausing inspections of  
6 healthcare settings during the initial period of the  
7 pandemic. Why would you have expected to have been  
8 informed of that?

9 **A.** Well, I think if we had been informed of it, we would  
10 have been extremely concerned, because we would have,  
11 in -- you know, for us, the healthcare setting at that  
12 point was an extremely high-risk area for our members to  
13 be working in, and we would have expected enhanced  
14 reporting and resources going into looking at some of  
15 the issues happening in those areas, not a withdrawal of  
16 resource, which was the reality.

17 **Q.** I can understand what you're saying about reporting, but  
18 can you clarify what you mean by inspections, because  
19 presumably because of the infection prevention and  
20 control measures, it was not surprising that there may  
21 have been steps taken to reduce more people going into  
22 a healthcare setting at the time, so do you think that,  
23 notwithstanding the infection prevention and control  
24 measures that needed to be complied with, inspections  
25 were so important that in fact it was necessary to

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1 **Q.** I suppose just tying that again back to what we were  
2 looking at before, do you think there is a higher  
3 proportion of -- in fact I think you may have just  
4 touched on it -- a higher proportion of ethnic minority  
5 workers in more precarious roles --

6 **A.** Yes.

7 **Q.** -- therefore that's perhaps an explanation for why they  
8 were more fearful?

9 **A.** Yes, I think if you look at across healthcare and  
10 social care settings, we have high numbers of workers  
11 from BME communities working in these areas and working  
12 in the lower paid jobs in these areas.

13 **Q.** Did the STUC take any action to raise these concerns  
14 during the pandemic about the lack of risk assessments  
15 or appropriate risk assessments for ethnic minority  
16 workers?

17 **A.** Yes, we did. We had a number of meetings with the  
18 Scottish Government through our Covid group, where the  
19 issue of the lack of statistics in relation to BME  
20 workers was raised with government and the need to do  
21 more work on this area, and we had general concerns as  
22 well around the under-reporting and lack of adequate  
23 health and safety reporting in healthcare settings and  
24 other areas.

25 **Q.** This is something you also touch on in your witness

42

1 continue those even during peaks of the pandemic?

2 **A.** Yes, that's exactly what I'm getting at there. We --  
3 I think we would have had the view at the time that the  
4 opposite needed to be happening, we needed to understand  
5 as we were moving forward and learn lessons as we were  
6 moving forward in what was a very difficult situation,  
7 but nonetheless that lesson learning was a very  
8 important aspect of work that was missed.

9 **Q.** Without repeating evidence, you've also spoken about  
10 RIDDOR and the requirements under those regulations.  
11 I suppose if I could just give you the opportunity to  
12 comment on anything further that was said by Mr Rowan in  
13 relation to that, whether you have anything that you'd  
14 like to add or anything you'd like to endorse or  
15 anything from a different perspective?

16 **A.** Yeah, I mean, I would very much endorse Mr Rowan's  
17 comments from the earlier evidence. It's our view that  
18 there was an under-reporting that was problematic. We  
19 actually had a situation where, in 2021, we had  
20 a dispute with the Scottish Government at a later stage  
21 sort of re-lockdown where they did not put  
22 manufacturing, non-essential manufacturing, and  
23 non-essential construction back into lockdown even  
24 though we had a real prevalent strain of the virus  
25 re-emerging, and we took issue with Scottish

44

1 Government's policy on this, and they used Health and  
2 Safety Executive statistics to push back on us and say  
3 to us: well, you know, we don't think there is an issue  
4 with work-based infection in these areas, because the  
5 statistics are not showing it. And we believe that had  
6 there been less under-reporting that, you know, that  
7 wouldn't have been the picture that emerged.

8 So they were pointing to figures that -- you know,  
9 to back up their arguments that perhaps were skewed  
10 because of the under-reporting, and we actually took the  
11 TUC report to Scottish Government on under-reporting of  
12 RIDDOR when we continued the discussion about these  
13 particular sectors, because we felt that there was not  
14 enough resources going in across a range of sectors.

15 So I know that's not directly linked to health and  
16 social care, but I think it's a good example of,  
17 you know, our concerns more generally around the lack of  
18 proper reporting.

19 **Q.** I'm just conscious that you mentioned the discussions  
20 you had with the Scottish Government. Is the issue of  
21 RIDDOR reporting a devolved matter or a reserved matter,  
22 do you know?

23 **A.** It's a reserved matter, but the Scottish Government were  
24 using that UK information to inform their  
25 decision-making, so it's -- it's very much a reserved

45

1 reports from trade unions at an early stage of the  
2 pandemic that there were issues with staff in healthcare  
3 settings getting access to PPE.

4 **A.** Yep.

5 **Q.** Do you recall or are you able to summarise what you  
6 think the main issues were in terms of access, was it  
7 one of supply or was it simply a case of there just not  
8 being access within hospitals to the PPE or, in fact,  
9 just inadequate PPE in terms of the way in which it  
10 fit --

11 **A.** I mean, there was a whole -- there was a whole range of  
12 issues. At the very beginning, there were some really  
13 acute supply issues at the beginning. It became then  
14 a more complex range of issues, so we definitely had  
15 issues with Scottish Ambulance Service at the very  
16 beginning, where there was a really acute lack of  
17 appropriate PPE; we had people across healthcare  
18 settings being asked to reuse, wash and wipe down PPE,  
19 buy their own PPE; there was inconsistent supplies;  
20 there was sometimes PPE in the building but it was  
21 locked away; there were a range of debates about the  
22 type of PPE being fit for purpose, so there was a huge  
23 debate around the FFP3 masks being rationed to only  
24 certainly job roles and procedures, when it was actually  
25 felt that aerosol-generating procedures were happening

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1 matter. And, you know, it is something that we raised,  
2 we did have discussions with the Health and Safety  
3 Executive around a range of -- sometimes problem areas  
4 with the devolved parts were around public health,  
5 you know, public safety in Scotland and public health,  
6 and so we did have devolved workplace guidance that we  
7 felt sometimes the Health and Safety Executive at  
8 UK level weren't really paying much attention to.

9 **Q.** Following on from your earlier comments about having  
10 a good level of access and liaison to the Scottish  
11 Government, of course it's a counterfactual scenario but  
12 if this was in fact a devolved issue, is it something  
13 that you think you would have had a better opportunity  
14 to have challenged the Scottish Government on?

15 **A.** I think that we feel that there was certainly issues  
16 with the fact that health and safety wasn't devolved.  
17 We had a situation where there was public safety  
18 guidance getting issued and perhaps not getting  
19 adequately enforced or taken account of by the Health  
20 and Safety Executive, and that was something we felt was  
21 problematic.

22 **Q.** Could I turn now to a separate topic to ask you about,  
23 that's the provision of PPE for healthcare workers.

24 You say in your witness statement at paragraph 53,  
25 if you want it for reference, that you were aware of

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1 much more widely than the provision of the PPE was being  
2 given out for; and there were also issues with  
3 ill-fitting PPE and symptoms that healthcare workers  
4 were suffering from as a result of that ill-fitting PPE.

5 **Q.** Thank you, that's a very comprehensive summary. But if  
6 I focus on the first point that you made, that was  
7 supply.

8 **A.** Yep.

9 **Q.** If we could please look at Jeane Freeman's statement, of  
10 course she was the Cabinet Secretary for Health and  
11 Sport for a considerable period of this period's of this  
12 module's relevant period.

13 **A.** Yep.

14 **Q.** Her statement and the paragraph I want to take you to is  
15 24, it's INQ000493484. If we start with paragraph 24,  
16 I just read the beginning of it to you, it says:

17 "A unique feature of the distinctive health  
18 infrastructure in Scotland, and one which made  
19 a significant contribution to the pandemic response, is  
20 the existence of National Services Scotland ('NHS NSS').  
21 Amongst other functions, NHS NSS acts as a procurement  
22 arm for the whole of the NHS in Scotland."

23 If we leave that there and then go on to  
24 paragraph 191 of her witness statement, which is at  
25 page, I think, 44, she expands on the benefits of NHS

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1 NSS and she says at 191:

2 "As noted, in terms of PPE, we had the advantage of  
3 a single procurement arm for the whole of NHS Scotland,  
4 namely NHS NSS which has a long-standing relationship  
5 with the providers and manufacturers of PPE. That being  
6 the case, at the very outset of the pandemic and despite  
7 very high global demand and associated pricing, we were  
8 able to increase the volume of PPE on order."

9 Pausing there and having taken that in, I suppose my  
10 question to you is: did you consider or did you feel  
11 that the supposed benefits of NHS NSS as they are  
12 explained within Jeane Freeman's statement, were  
13 translated into a good level of access of PPE for  
14 healthcare workers on the ground?

15 **A.** So I guess at the outset what I would say is that we  
16 didn't have any anything to compare what we were getting  
17 to -- you know, perhaps what was happening across the  
18 rest of the UK, so it's hard to know whether it made  
19 a positive difference or not, from our perspective. But  
20 what I can say to you is we consistently had a range of  
21 issues raised with us which we raised with government,  
22 and I know that these issues were also being raised  
23 directly with NHS Scotland and with, you know, across  
24 the social care sector as well where there were definite  
25 failures to provide appropriate fit for purpose PPE to

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1 **MR FIREMAN:** My Lady, I'm conscious of the time.

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

3 I hope you were warned that we take regular breaks  
4 for the benefit of those trying to transcribe the  
5 proceedings. So I shall return at midday.

6 (11.47 am)

(A short break)

8 (12.00 pm)

9 **LADY HALLETT:** Mr Fireman.

10 **MR FIREMAN:** Thank you.

11 Ms Foyer, before we broke, we were just discussing  
12 Jeane Freeman's evidence, and you were explaining how  
13 the levels of supply of PPE may not always have  
14 translated into access to PPE for healthcare workers on  
15 the ground, so to speak.

16 If we could go back to something that Ms Freeman  
17 says in her evidence, and this is at INQ000493484,  
18 paragraph 200. She describes at paragraph 200 something  
19 called the "PPE helpline", and she says that:

20 "... the Scottish Government set up and managed  
21 a dedicated PPE helpline mailbox for HSC staff to  
22 contact if they did not have access to the PPE that they  
23 needed, or if they had other concerns regarding PPE ..."

24 And that was set up in April 2020.

25 Was this helpline something that you were

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1 the right people on the ground.

2 And I think that's the real value that we brought to  
3 the table because you can have all these procedures in  
4 place and all the procurement and all the systems, and,  
5 from Jeane Freeman's point of view, it might have all  
6 looked tickety-boo but what we were able to inform the  
7 minister of and government of was that that was not the  
8 reality for workers on the ground, in far too many  
9 cases, and, particularly, at the start things did get  
10 better but there were still ongoing and consistent  
11 issues that took place throughout the pandemic for our  
12 workers on the ground.

13 **LADY HALLETT:** You say you informed the minister, so you  
14 informed Ms Freeman at the time of these issues?

15 **A.** Yes, there were early meetings that took place with the  
16 minister, particularly around -- now, it was either with  
17 Ms Freeman or it was with Fiona Hyslop, the Economy  
18 Minister, but they're both cabinet secretaries, but at  
19 very senior level of government, we were raising issues.  
20 There was actually a point at which the Scottish  
21 Ambulance Service was about to walk out, very early on,  
22 on health and safety grounds and we had very high level  
23 emergency meetings to get issues dealt with, because  
24 they just didn't have the access to the PPE they  
25 required.

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1 particularly aware of and, equally, something that you  
2 felt that healthcare workers were properly aware of in  
3 case they needed to contact the helpline?

4 **A.** So I do -- I am aware that there was such a helpline,  
5 but I think you probably have to ask the health unions  
6 in Scotland for more specific examples of how widely  
7 used or helpful they felt the helpline was. It was  
8 certainly something that was publicised and that we were  
9 aware of and promoted, but it was really more done at  
10 the level -- there were direct discussions between  
11 healthcare unions in Scotland and NHS Scotland, through  
12 STAC and industry leadership groups, that took place  
13 that the STUC wasn't party to, and I think there's  
14 probably better people than myself to comment more  
15 deeply on that.

16 **Q.** Okay, thank you very much. That can come down in that  
17 case.

18 Turning then to a topic which I think you touched on  
19 briefly before in relation to aerosol-generating  
20 procedures, and you said that there were concerns about  
21 that and the distinction drawn between  
22 aerosol-generating procedures and other procedures,  
23 particularly, I think, you're drawing the distinction  
24 between areas in which respirators were recommended and  
25 areas in which they weren't.

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1 You mention a particular concern about a specific  
 2 procedure, chest compressions, not being designated as  
 3 an aerosol-generating procedures. Just to clarify, is  
 4 your concern that it should have been, in terms of what  
 5 you were hearing from healthcare workers, they wanted it  
 6 to be deemed an aerosol-generating procedures and it  
 7 wasn't, or were there concerns that it was in fact  
 8 something that shouldn't have been and there was time  
 9 being taken up putting on unnecessary PPE?  
 10 **A.** No, the concern was very much that they wanted it to be  
 11 classified as an AGC -- sorry --  
 12 **Q.** An aerosol-generating procedure?  
 13 **A.** Yeah, and it wasn't, and that was something that,  
 14 according to the feedback we received, caused a lot of  
 15 resentment and a feeling of, you know, unfair practice  
 16 among the workforce. So it was -- it had a bad effect  
 17 on morale. There were also other areas that the  
 18 chartered society for physiotherapists raised, that they  
 19 felt key practices they carried out were also  
 20 aerosol-generating procedures but weren't recognised  
 21 within the guidance as such.  
 22 **Q.** You mentioned you felt this caused resentment. Are you  
 23 able to explain a bit more about what you felt the  
 24 effect of not designating these procedures as  
 25 aerosol-generating procedures had on healthcare workers

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1 **Q.** Just to pick up on that, is it your view that there  
 2 should have been more discretion for healthcare workers  
 3 to make decisions about what the appropriate PPE was for  
 4 them to wear rather than --  
 5 **A.** Yes.  
 6 **Q.** -- it being mandated by national guidance?  
 7 **A.** Yes, I mean, there's a place for national guidance and  
 8 we probably would have wanted to see an improvement to  
 9 it, but ultimately I think we would have wanted to see  
 10 workers' voices being given a primary consideration in  
 11 that, and if it was felt to be required then it should  
 12 have been provided.  
 13 **Q.** You also mentioned concerns about ill-fitting masks, and  
 14 is that also with respect to respirator masks,  
 15 FFP3 masks in particular?  
 16 **A.** Yes, there were issues raised with our affiliates about  
 17 resultant skin conditions and issues for workers wearing  
 18 ill-fitting FFP3 masks, but also there was a gender  
 19 issue in relation to the default seemed to be that it  
 20 was fitted for a male face and that for many women  
 21 working in healthcare settings this was a problem that  
 22 was identified. So it is something that I'm aware that  
 23 healthcare unions were raising consistently.  
 24 **Q.** This issue about the potentially gendered aspect to it,  
 25 and indeed I think you even describe in your witness

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1 and, indeed, their trust in national guidance?  
 2 **A.** Yeah. Well, it was very detrimental, because we're  
 3 talking about workers who were already scared, stressed,  
 4 felt they were putting themselves and their families at  
 5 risk in going to work every day, and if they felt that  
 6 they were being denied access to appropriate PPE, that  
 7 would only intensify that stress.  
 8 **Q.** Okay. You also describe in your statement the --  
 9 I think it's from the RCM, the Royal College of  
 10 Midwives, saying that they reported that FFP3 masks had  
 11 been or they felt were being rationed.  
 12 Do you see any link between the designation of  
 13 aerosol-generating procedures and that concern that FFP3  
 14 masks were being rationed?  
 15 **A.** Yes. I do, and ultimately I think our preference would  
 16 have been for access to PPE to be worker-led. We're  
 17 talking about well trained, experienced clinicians who  
 18 should have been allowed to determine in what  
 19 circumstances they would require the PPE, and, you know,  
 20 there's a difficulty there when -- you know, if  
 21 a midwife or a physiotherapist or, you know, a nurse  
 22 identifies that they need that when it's been denied to  
 23 them through guidance, that we felt shouldn't have been  
 24 happening, the workers should have had more agency in  
 25 those situations.

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1 statement that there was also an issue in terms of  
 2 ethnic minority --  
 3 **A.** Yes, that's right.  
 4 **Q.** -- healthcare workers as well --  
 5 **LADY HALLETT:** It was -- the white male face was the default  
 6 setting, I think, wasn't it?  
 7 **A.** Yes, indeed, indeed.  
 8 **MR FIREMAN:** Is this something which you were aware of or  
 9 indeed the STUC were aware of prior to the pandemic or  
 10 is this something which in fact came to light as the  
 11 need to use these respirators was increased?  
 12 **A.** So, again, I think that's probably a question for our  
 13 healthcare unions. It certainly wasn't something that  
 14 I was aware of the STUC being aware of prior to the  
 15 pandemic, but I think it's something that during the  
 16 meetings it became clear to me that this had been  
 17 a long-term issue that healthcare unions had been  
 18 raising. I certainly remember a meeting where we had  
 19 officials from healthcare unions and that that was  
 20 a topic of the meeting, and that was the inference  
 21 I took from the discussion at the meeting that this was  
 22 not the first time it had been raised and that it was  
 23 a long-standing issue that had been raised in the past.  
 24 **Q.** Something that had been raised by healthcare workers in  
 25 the past?

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1 A. Yes.

2 Q. But not something which the STUC had actually taken  
3 an initiative and --

4 A. No, I'm not aware of the STUC itself, as the umbrella  
5 body, having raised it with government in the past, but  
6 most of the detailed discussion around issues like that  
7 would not have been a topic for the STUC to raise,  
8 because of the very well established partnership  
9 structures that existed between NHS Scotland and  
10 healthcare unions, so that's an issue that I would have  
11 expected to be raised in those structures in the past.

12 Q. Just finally on PPE, now, you also mentioned, I think,  
13 particular concerns about the ambulance service, and you  
14 talk about, in your witness statement, the concerns you  
15 had about out-of-date PPE being used. Could you just  
16 elaborate a little bit on that.

17 A. Yes. There was a case raised by the GMB Union,  
18 I believe, where there was a whistleblowing case, and  
19 they raised the issue that out-of-date PPE had been in  
20 use and the dates had been covered up, so they made  
21 a formal whistleblowing complaint in that regard. So  
22 I'm aware that that did take place.

23 Q. Just to summarise, you obviously have given a lot of  
24 evidence about a variety of different concerns that the  
25 STUC had, is there anything that we haven't touched on

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1 with catastrophic effects on themselves and their  
2 families.

3 I referred to a report in the Scottish Inquiry from  
4 Professor Phil Taylor, which stated that workers in  
5 health and social care were four times more likely to be  
6 exposed than workers in other industries and our own  
7 affiliate, the HSCA's report Never Again, in 2022,  
8 stated that severe disease, ie --

9 Q. Sorry, can you just slow down slightly --

10 A. Yeah, no problem.

11 Q. -- for the stenographer.

12 A. Yeah, no problem. So the HSCA's report stated that  
13 severe diseases -- and what we're talking about here is  
14 hospitalisation or death from Covid -- was seven times  
15 more prevalent in healthcare workers. So I think that,  
16 given all of that, we really need to ensure, going  
17 forward, that these failings are addressed, we need to  
18 make sure that there's proper PPE guidance and support  
19 put in place for the future, we need to make sure that  
20 there is more effective reporting and enforcement of  
21 health and safety in high-risk areas, and we need to  
22 recognise Covid and Long Covid as occupational diseases  
23 and ensure that those who suffered detriment through the  
24 act of undertaking their work are properly -- you know,  
25 were properly compensated, are properly compensated

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1 but you think, in terms of looking forward and with  
2 a particular focus on healthcare workers, you think  
3 there are particular lessons in that regard that we need  
4 to learn were there to be a future pandemic?

5 A. Yes. I mean, I think that overall, when we're looking  
6 at this, there was definitely serious failures by  
7 government and healthcare employers to be properly  
8 prepared and give the adequate resources and support to  
9 workers on the frontline during the pandemic. That  
10 ranged from, you know, the inadequate staffing levels  
11 that we talked about and the effects that were  
12 compounded on staff as the pandemic progressed; the lack  
13 of PPE, which we've covered quite comprehensively; the  
14 lack of mental health support for workers, as the  
15 effects deepened, and the real trauma and burn-out that  
16 was being experienced; the lack of appropriate resources  
17 for proper safety inspections and learning to take place  
18 as the pandemic progressed.

19 And I think that we need to remember that government  
20 and employers have a duty of care to protect the workers  
21 that work in our healthcare settings in a pandemic or  
22 a serious high-risk situation like that, and we know  
23 that the workers who worked in health and social care  
24 were disproportionately affected and, indeed, infected  
25 during the pandemic, and people paid the ultimate price

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1 going forward and that these protections are in place so  
2 that this can never happen again.

3 **MR FIREMAN:** Thank you very much, and thank you very much  
4 for that comprehensive summary.

5 Those are my questions, I think there are some  
6 others.

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

8 I think it's Ms Mitchell KC. I think you may  
9 remember Ms Mitchell.

#### Questions from MS MITCHELL KC

11 **MS MITCHELL:** Yes, indeed, I'm obliged, my Lady. We have  
12 asked Ms Foyer a few questions before.

13 Ms Foyer, I act on behalf of Aamer Anwar & Company  
14 for the Scottish Covid Bereaved.

15 You spoke in your evidence about well-trained staff  
16 who were able to complain in relation to PPE and  
17 suchlike. I'd like to ask you about the staff who  
18 weren't so well trained and, indeed, weren't trained for  
19 the purposes or the jobs that they were being asked to  
20 do.

21 I don't need to have it up on screen but, at  
22 paragraph 29 of your statement, you raised this issue  
23 and you explained that there were nurses who were asked  
24 to work in intensive care units to deal with critically  
25 ill and dying patients when they'd not been trained or

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1 properly trained to do so.

2 My question is: did your body complain about this  
3 direct to NHS management or the Scottish Government and,  
4 if so, what response did you receive?

5 **A.** Thank you. I believe that was our affiliate, the GMB,  
6 that submitted that report back to us, and my  
7 understanding is that this is something that they had  
8 been actively raising during the pandemic. I think if  
9 you want, you know, more detail on exactly how that was  
10 done, you would need to question them. But my  
11 understanding is that that was an issue that was raised  
12 and, you know, it had really deep effects on those  
13 workers. They have members who suffered PTSD, you know,  
14 as a result of some of the experiences. But it was  
15 common practice during the pandemic that wards -- you  
16 know, certain wards were closed, people were redeployed  
17 because of the acute difficulties with staff going off  
18 sick and staffing shortages. There were lots of areas  
19 where staff were redeployed to areas that they weren't  
20 well trained on and, you know, it's certainly not  
21 an isolated occurrence.

22 **MS MITCHELL:** Thank you.

23 My Lady, I've no more questions.

24 **LADY HALLETT:** Thank you very much, Ms Mitchell.

25 Thank you very much for your help again, Ms Foyer,

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1 team at NHS England as a result of that role?

2 **A.** I do.

3 **Q.** Is it right that by background you are a general  
4 registered nurse?

5 **A.** I am.

6 **Q.** You have a postgraduate diploma in infection control  
7 nursing and also a PhD in a specific infection  
8 prevention and control matter?

9 **A.** I do.

10 **Q.** From 2009, you were a nurse consultant in IPC, infection  
11 prevention and control, in the Antimicrobial and  
12 Healthcare Association Infection group, ARHAI, which was  
13 then part of Health Protection Scotland, HPS; is that  
14 right?

15 **A.** That's correct.

16 **Q.** That Health Protection Scotland, HPS, latterly became  
17 part of Public Health Scotland but not when you were  
18 there?

19 **A.** Not when I was there, no.

20 **Q.** Then you began your new role as Head of IPC at NHS  
21 England in April 2020; is that right?

22 **A.** That's correct.

23 **Q.** During this module's relevant period, that is March 2020  
24 to June 2022, you were a member of various scientific  
25 subgroups including NERVTAG, the UK IPC cell, which

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1 I'm very grateful to you.

2 **THE WITNESS:** Thank you.

3 **(The witness withdrew)**

4 **LADY HALLETT:** Right, Mr Fireman.

5 **MR FIREMAN:** Thank you. My Lady, may I please call Dr Lisa  
6 Ritchie, who will be sworn.

7 **DR LISA RITCHIE (sworn)**

8 **Questions from COUNSEL TO THE INQUIRY**

9 **LADY HALLETT:** I hope we haven't kept you waiting too long,  
10 Dr Ritchie.

11 **MR FIREMAN:** Dr Ritchie, can you please give your full name?

12 **A.** Lisa Ritchie.

13 **Q.** Thank you. Dr Ritchie, you have given a witness  
14 statement to Module 3 dated 23 July 2024. That's  
15 INQ000421939. Can I just check you have that accessible  
16 should you need it?

17 **A.** I do.

18 **Q.** Dr Ritchie, you are the National Deputy Director of  
19 Infection Prevention and Control at NHS England; is that  
20 correct?

21 **A.** That's correct.

22 **Q.** Is that a role that was formerly referred to as Head of  
23 Infection Prevention and Control at NHS England?

24 **A.** That's correct.

25 **Q.** You have responsibility for leading the national IPC

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1 we'll come to in a moment, and the Hospital Onset  
2 Covid-19 Infection Working Group; is that correct?

3 **A.** That's correct.

4 **Q.** As I said, the majority of your evidence is focused  
5 around your role in the UK IPC cell, which you chaired  
6 for a period, I believe, between June 2020 and the end  
7 of March 2021; is that right?

8 **A.** To June 2021.

9 **Q.** To June 2021?

10 **A.** A year.

11 **Q.** Okay, for a year.

12 I'm going to ask you some questions about the IPC  
13 cell but, before I do, my Lady, it's been said before  
14 but it does bear repeating, that this witness was not  
15 the only individual who was on the IPC cell. She acted  
16 as the chair of the cell for a substantial period, which  
17 the Inquiry is examining, and she's, as a result, one of  
18 the most appropriate individuals for the Inquiry's  
19 question but, of course, some of the time she may be  
20 referring to decisions which were made collectively.

21 In fact, Dr Ritchie, if I could ask you to make  
22 clear, where relevant, if you are speaking from a  
23 personal opinion, a personal professional opinion, or  
24 indeed the opinion which was reached from the UK IPC  
25 cell as a whole.

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1 A. Okay.

2 Q. In terms of that cell, it formally started meeting,  
3 I think, in early February 2020; is that right?

4 A. That's correct.

5 Q. Did it evolve from NHS England's own IPC cell, which was  
6 part of its emergency preparedness, resilience and  
7 response unit?

8 A. That's correct.

9 Q. It may have varied but how regularly did the UK IPC cell  
10 meet?

11 A. So when the NHS England IPC cell was stood up, which was  
12 part of a number of cells under the emergency  
13 preparedness and resilience for NHS England, I was not  
14 working in NHS England at that time. So my predecessor,  
15 who was the head of IPC, invited the other UK IPC leads  
16 from Scotland, Northern Ireland and Wales to join the  
17 IPC cell meeting of NHS England, and that evolved into  
18 what became known as the UK IPC cell.

19 Q. Thank you, that's very helpful.

20 You summarised the purpose of the UK IPC cell as  
21 being to provide a UK-wide consensus on issues relating  
22 to infection prevention and control and, of course, that  
23 includes, perhaps most pertinently, the use of PPE?

24 A. So the cell did not advise specifically on PPE, so the  
25 role and purpose of the UK IPC cell and for NHS England

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1 of key national organisations and understanding what the  
2 governance, the decision-making processes and the  
3 primary knowledge resources, evidence bodies and  
4 guidance leads would have been invaluable. So, in  
5 hindsight, it would have been very useful to have  
6 understood or known what that structure was, and maybe  
7 something for the future.

8 Q. We'll come to the structure of the cell in due course  
9 but, before we do so, can I just ask you about the  
10 members of the cell and who was represented on it.  
11 You've listed them out in your witness statement at  
12 paragraph 134, and they are NHS England, Public Health  
13 England -- which then became the UKHSA -- Public Health  
14 Wales, ARHAI Scotland, the Scottish HAI unit, the  
15 Association of Ambulance Chief Executives and the  
16 Department of Health and Social Care.

17 Can I clarify, was membership of the cell then  
18 specific to those organisations, rather than to any  
19 specific individuals?

20 A. Yes.

21 Q. The Inquiry heard from Richard Brunt of the Health and  
22 Safety Executive last week and he talked about having  
23 a direct input to the cell. You didn't mention in your  
24 witness statement them being a member of the cell. Is  
25 it right they weren't actually attending cell meetings

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1 was to come together to agree consistency on infection  
2 prevention and control guidance, so that we had  
3 standardisation across the four nations. So that was  
4 our purpose, to make sure that, when we were drafting  
5 guidance, that that was aligned with WHO and the  
6 scientific evidence that was emerging.

7 Q. You acknowledge, of course, though that PPE falls within  
8 infection prevention and control as a relevant issue?

9 A. It does indeed but it is one part of a very complex  
10 number of IPC measures.

11 Q. Just focusing, if we can, on the actual onset of having  
12 an IPC cell in the first place, are you aware of whether  
13 or not this featured in any specific pandemic planning  
14 documents or, in fact, whether it was something that was  
15 thought up as the emergency was convening? I appreciate  
16 you've spoken about the way in which it developed, but  
17 the actual necessity to convene a cell, was that  
18 something that was always within pandemic planning or  
19 was that just something that was put together as the  
20 emergency was developing?

21 A. I believe it evolved. It did evolve as the emergency  
22 developed. I mean, I think what would have made a real  
23 difference to me, as a new start in NHS England on  
24 1 April, would have been having a clear structure,  
25 outlining the functions, the roles and responsibilities

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1 but they did have direct lines of correspondence to  
2 those who were on the UK IPC cell?

3 A. That's correct. So HSE was not a member of the UK IPC  
4 cell but we did engage with HSE on many issues.

5 Q. You were a member of the cell, both at Health Protection  
6 Scotland, as a representative of Health Protection  
7 Scotland, and then subsequently as a representative of  
8 NHS England; is that right?

9 A. That's correct.

10 Q. One of the things that was mentioned by Dr Barry Jones  
11 of the Covid Airborne Transmission Alliance on Thursday,  
12 when he gave evidence, was he said there were more  
13 members on several occasions attending the cells from  
14 NHS England than any other organisation. Sometimes,  
15 I think he said, there was up to 20. I don't know  
16 whether or not that's accurate but, dealing with the  
17 issue of why there may have been more members from NHS  
18 England attending these cell, is it right that NHS  
19 England bore the secretariat function for the cell and  
20 would, therefore, have sometimes have had more members  
21 attending to take notes, et cetera, or were there other  
22 reasons why they may have had more members attending?

23 A. So because the UK IPC cell had evolved from what was the  
24 NHS England IPC cell, we did continue -- we had the  
25 infrastructure and we had that cell in place, so we

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1 continued to manage the cell in terms of doing --  
 2 organising meetings and doing the minutes and action  
 3 notes from those meetings.  
 4 In terms of membership, from the representative  
 5 organisations, it was down to those other national  
 6 organisations to bring to the meeting who they wished to  
 7 represent their country, public health body, ARHAI  
 8 Scotland, from Public Health Wales, so there was no bar  
 9 from those organisations by the chair or anyone else  
 10 about who from those organisations could attend those  
 11 meetings.  
 12 **Q.** So it goes back to the point that we were speaking about  
 13 earlier that it was the organisations which were  
 14 represented on the cell, rather than specific  
 15 individuals?  
 16 **A.** Correct.  
 17 **Q.** You could have sent many more individuals if you wanted  
 18 or much fewer?  
 19 **A.** Indeed.  
 20 **Q.** Are you able to recall, and I appreciate that to some  
 21 extent you may not know in detail the qualifications of  
 22 absolutely everyone who attending every single cell  
 23 meeting, but are you able to recall whether or not there  
 24 were individuals from non-medical backgrounds or  
 25 non-clinical backgrounds, for example engineers or

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1 **Q.** Professor Beggs told us that he considers that, in  
 2 professional infection prevention and control spheres,  
 3 there has been a bias towards focusing on  
 4 epidemiological evidence over considering what the  
 5 physical science may say and, as a result, a more narrow  
 6 picture has been obtained. So my first question is: do  
 7 you accept that criticism?  
 8 **A.** No. I do think there has been a lot of studies now  
 9 being undertaken by physical scientists and others but  
 10 I think, from an IPC perspective, we would follow the  
 11 epidemiology and the scientific literature in terms of  
 12 the infection prevention and control guidance that we  
 13 would put together. So we would be taking the views of  
 14 our scientific experts, be that from SAGE, UKHSA, Public  
 15 Health England.  
 16 **Q.** So you don't think then, on reflection, that perhaps the  
 17 cell would have benefited from having the expertise of  
 18 a physicist or an engineer or someone from that  
 19 background?  
 20 **A.** There's always room for improvement and, in terms of the  
 21 different backgrounds, maybe that is something for  
 22 future, a lesson learned, that some of these  
 23 organisations, it's how they're plugged in, I suppose,  
 24 it goes back to the structure, doesn't it, and how they  
 25 fit in under the Civil Contingencies Act, for example,

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1 physicists or physical science experts who attended the  
 2 cell?  
 3 **A.** So, predominantly, the membership was clinical and  
 4 probably nursing, I would say, more than medical, and  
 5 I think that was appropriate for the function of the  
 6 cell and the role and purpose of why we had been  
 7 established, given the expertise that we had in  
 8 infection prevention and control. We did not want to  
 9 duplicate the efforts of other meetings, and we were  
 10 aware that there were many meetings happening at the  
 11 same time. For example, there was an engineering  
 12 management group that was a subgroup of SAGE, and we  
 13 would obviously look to the outputs of such groups and  
 14 review what we could translate from the outputs of those  
 15 meetings into the IPC guidance, if it was relevant.  
 16 **Q.** I appreciate that you have said that it was appropriate,  
 17 but the Inquiry heard last week from Professor Beggs who  
 18 comes at things, I think, from a physical science  
 19 perspective and it was his view that, in terms of the  
 20 science associated with transmission of infectious  
 21 diseases, there has been a bias towards epidemiological  
 22 evidence over physical science. I don't know whether or  
 23 not you agree with that at all or if you disagree.  
 24 Perhaps I'll give you an opportunity to comment on that.  
 25 **A.** Can you repeat the question again, sorry?

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1 if they were a responder under that remit or within that  
 2 structure.  
 3 So I'm not saying that -- I think what I am saying  
 4 is that the UK IPC cell evolved over time and the  
 5 membership was specific to the role that we were  
 6 carrying out, that it was infection control leads with  
 7 the expertise in infection control that were pulling  
 8 together the evidence, taking the outputs from SAGE,  
 9 NERVTAG, translating a lot of the science into practical  
 10 guidance for frontline staff. But, you know, if the  
 11 membership is something that we need to review, there's  
 12 always lessons to be learned.  
 13 **Q.** Thank you.  
 14 The one area then I suppose that you would confirm  
 15 you were on top of, from the perspective of the  
 16 representatives of the UK IPC cell, was having direct  
 17 involvement in clinical work; is that right?  
 18 **A.** That's correct.  
 19 **Q.** So there were members who were actually directly  
 20 involved in putting into practice the guidance that was  
 21 being formulated?  
 22 **A.** Yes.  
 23 **Q.** Another issue that has been raised with the Inquiry is  
 24 that of stakeholder engagement. On reflection,  
 25 I appreciate you have been very candid about the

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1 potential benefits of physical science and engineering,  
 2 what about the fact that there were concerns from the  
 3 Royal College of Nursing and the British Medical  
 4 Association about them being engaged? On reflection do  
 5 you think there would be benefit for any future IPC  
 6 cell, if it was convened, to have a representative from  
 7 one of those union organisations attending?

8 **A.** It felt like there was a couple of questions in that.  
 9 I think, first of all, in terms of stakeholder  
 10 engagement, we were working at pace, we had -- I know  
 11 that, as individuals and collectively as an IPC cell, we  
 12 were seeking feedback and making ourselves available to  
 13 people to give that feedback. In terms of the updates  
 14 to the guidance, there were often times, where I would  
 15 make a phone call to RCN or to the Infection Prevention  
 16 Society or the president of other organisations to say  
 17 that we had to get this guidance out quickly but, if  
 18 I sent it over, would they have a look at it and come  
 19 back with any concerns. So we were working at pace so  
 20 it was often difficult to take stakeholder feedback.

21 When there was what we would consider major changes  
 22 to the guidance, so when we'd change the guidance for  
 23 remobilisation, when care pathways were brought in to  
 24 get the NHS back up and running and, equally, when we  
 25 were preparing winter guidance for 2020 to 2021, we did

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1 Nursing, they felt like they were being managed and  
 2 pushed away. I presume that, based on what you've just  
 3 said about stakeholder engagement and the steps you did  
 4 take to consult, you would at least make clear that  
 5 wasn't your intention and, indeed, probably not what you  
 6 consider actually occurred; is that right?

7 **A.** Absolutely and, if that was the perception, it couldn't  
 8 be further from the truth because we did want to get  
 9 feedback from people. But, as I say, when we were  
 10 pulling or drafting guidance and reviewing the evidence  
 11 and updating we were working to very tight timelines.

12 **Q.** All of these points are relevant, of course, because  
 13 what I want to ask you is whether, in fact, you consider  
 14 the membership of the cell, as it was during the  
 15 pandemic, the Covid-19 pandemic, was sufficiently broad  
 16 to ensure that a range of expert opinion was brought to  
 17 the table; do you consider that was the case?

18 **A.** I do.

19 **Q.** One of the points which arises from review of the IPC  
 20 minutes is this concept of cell reaching a consensus.  
 21 Can you explain what the process was by which the cell  
 22 reached a consensus and then made a decision on how to  
 23 proceed?

24 **A.** So it was, as chair -- when I was chair and as a member,  
 25 the decision-making did rely on consensus, it was

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1 more formal consultation. So stakeholders were involved  
 2 in that process because we had a bit more time to get  
 3 the feedback and take their input.

4 I know that my Chief Nursing Officer and other  
 5 colleagues were out and about, you know, and they had  
 6 direct contact with the royal colleges, with very many  
 7 meetings, we put on lots of webinars --

8 **Q.** Can I just pause you there and just ask you about the  
 9 principal basis for my question, which was: what about  
 10 having a representative regularly attending the UK IPC  
 11 cell from the Royal College of Nursing or the BMA?

12 **A.** I think the challenge is the number of different  
 13 representatives from all of those various groups. So  
 14 I think it's important and, again, I think it goes back  
 15 to the structure, about setting that in place, about  
 16 what the consultation looks like, what is the  
 17 communication and engagement strategy and having  
 18 something like that proactively built in, rather than it  
 19 being something reactive. And I accept that, you know,  
 20 it wasn't always easy to take all of the feedback that  
 21 was coming from stakeholders, given the pace at what we  
 22 were working.

23 **Q.** I think that then leads on to the criticism which the  
 24 Inquiry heard last week about the suggestion that, from  
 25 some of the members of the BMA and Royal College of

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1 ensuring that we had broad agreement among the members,  
 2 though not always unanimous, and we provided  
 3 recommendations to national governance bodies, to each  
 4 of the countries, for their final approval. So it was  
 5 making sure that we had open discussion, as I say, that  
 6 we came to a recommendation at the end of that which  
 7 would be broad agreement and those -- if there was any  
 8 doubt or we didn't feel that we had come together and  
 9 reached consensus, then that would have been escalated  
 10 to senior clinical colleagues.

11 **Q.** I sense from what you're saying then that there weren't  
 12 actually formal votes taken during the meeting?

13 **A.** No, there was not.

14 **Q.** So then did it rely, essentially, on whoever was  
 15 chairing the meeting, in many of the instances you,  
 16 getting a broad flavour of what the discussions were and  
 17 then summarising that as the consensus?

18 **A.** Yes.

19 **Q.** If we can then look at one of these documents that's  
 20 relevant, which is the minutes of the IPC cell from  
 21 18 August 2021.

22 This is INQ000398186, and it's the third -- I think  
 23 it's the third page of that document, if it could come  
 24 up on screen, please, if possible.

25 But don't worry if not, I can just summarise what

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1 you say in it. In August you say that you were still  
2 working with a consensus view, however escalation of any  
3 disagreement may need to be included in the next terms  
4 of reference.

5 So this is in August 2021, some time into the  
6 pandemic, and it seems that still at this stage the  
7 terms of reference and the lines of reporting were still  
8 being ironed out; is that a fair summary?

9 **A.** I mean, we did review the terms of reference for the  
10 duration of the cell. I mean, I think it's important to  
11 say here that we could have been disbanded at any time.

12 The cell was given authority by others. We didn't have  
13 a direct route to publication. The guidance could have  
14 been pulled that we put out or the consensus decision  
15 could have been pulled by any of the public health  
16 bodies across the UK. And I'm sure our senior leaders  
17 would have been clear about the decisions that we made,  
18 whether they were right or wrong.

19 **Q.** To be absolutely specific, I know you have mentioned  
20 public health leaders but who would any disagreement or  
21 ambiguity have been escalated to? Who were the  
22 individuals or professionals who would have had  
23 oversight of that?

24 **A.** So the UK senior clinical leads.

25 **Q.** In which departments?

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1 been responsible for the reporting lines, but in  
2 practice, was it the case that recommendations reached  
3 at the UK IPC cell were routinely incorporated into  
4 national guidance?

5 **A.** That's correct.

6 **Q.** The Inquiry has been provided with several of the UK IPC  
7 cell minutes, indeed I think all of them now, I think  
8 that's clear, but the minutes weren't actually  
9 published, and I don't think they ever have been  
10 published. Why is that the case?

11 **A.** The decision not to publish the minutes was never  
12 formally addressed. As I said at the beginning, the  
13 UK cell, IPC cell, evolved from what was the NHS England  
14 cell, and none of those incident cells were publishing  
15 minutes. So our primary focus was on producing timely  
16 evidence-based guidance that aligned to national and  
17 international recommendations.

18 But I think had the conversation come up, I don't  
19 think there would have been any objection to publishing  
20 the minutes, but it wasn't something that we formally  
21 discussed.

22 **Q.** Were there ever any requests from, as far as you can  
23 recall, any union bodies or any other campaigning groups  
24 to publish the UK IPC cell minutes?

25 **A.** During the relevant period, I don't recall.

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1 **A.** In each of the four nations.

2 **Q.** In a related question, would that mean, then, that  
3 Public Health England, for example, who published the  
4 guidance on behalf of England, at least, would they have  
5 had the ability to have come back to you on anything  
6 that was agreed during the IPC cell minutes and, say,  
7 objected to it or required an amendment to be made to  
8 that piece of guidance that was proposed?

9 **A.** As a lead organisation for public health and infection  
10 control in England, they could have come back at any  
11 point and made amendments.

12 **Q.** Would this still apply if Public Health England  
13 themselves, who were obviously members of the IPC cell,  
14 had not in fact agreed with the consensus view that was  
15 reached at the IPC cell meetings?

16 **A.** Yes.

17 **Q.** Can you recall any occasions on which, whether that be  
18 the CMO within each nation, the CNO within each nation,  
19 or public health bodies, actually came back and said  
20 "You need to make a change to this guidance or we're not  
21 going to approve it in its current form"?

22 **A.** So I don't recall specifics, but I do recall  
23 conversations with Public Health England colleagues on  
24 draft guidance content.

25 **Q.** In practice, then -- I appreciate that you may not have

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1 **Q.** Again, trying to take a forward-looking approach, do you  
2 think there would be benefit in publishing these sorts  
3 of minutes to allow for a dialogue of challenge to come  
4 to the surface?

5 **A.** Yes, I mean, I think if publication of such minutes  
6 would be helpful, it might be an area that requires to  
7 be formalised across the four nations of the UK.

8 **Q.** Thank you.

9 If we can now turn to some key principles of  
10 infection prevention and control to try to establish  
11 some of the things that you were looking at as a cell,  
12 and considering. You've set out in your statement and  
13 the Inquiry has heard about standard infection control  
14 measures, and that's measures that I think are taken all  
15 of the time for all healthcare workers regardless of the  
16 threat that is being faced and regardless of the  
17 transmission of any particular virus but to protect  
18 against generally all threats; is that right?

19 **A.** That's correct.

20 **Q.** We then have transmission-based precautions, and this is  
21 relevant to the nature of the disease that you're trying  
22 to protect against, isn't it?

23 **A.** Yep.

24 **Q.** In order to properly protect against a virus, you need  
25 to understand the way in which it's transmitted and

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1 thereafter you need to prepare for and provide for the  
 2 relevant protections that will protect against the way  
 3 in which that virus is transmitted.

4 **A.** Correct.

5 **Q.** We've heard about, and you've set out in your statement,  
 6 the three established routes of transmission for  
 7 a respiratory virus: contact, droplet and aerosol.  
 8 Focusing if we can on droplet and aerosol, because those  
 9 are the two most pertinent here, you would agree,  
 10 I suspect, that there are differences in terms of the  
 11 precautions you need to take when protecting against  
 12 a virus spread via droplets and one which is  
 13 predominantly spread through aerosol transmission?

14 **A.** Yes, and it does support the -- the definition supports  
 15 the IPC measures that would be put in place.

16 **Q.** I'm not sure -- sorry, would you clarify what you just  
 17 said?

18 **A.** So, sorry, could you repeat the question?

19 **Q.** The question is a basic one really, it's just to  
 20 establish that there are differences between the way in  
 21 which you protect against a virus that is spread  
 22 predominantly by droplets and one which is spread  
 23 through aerosols?

24 **A.** That's correct.

25 **Q.** That's why we've heard about the differences between

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1 kit or PPE.

2 **Q.** When dealing, of course, with a virus that's spread  
 3 through droplets?

4 **A.** Correct.

5 **Q.** In terms of the difference between the two modes of  
 6 transmission, aerosol and droplet, the Inquiry heard  
 7 last week about historically this having come down to  
 8 size of the particle. Of course we also heard that  
 9 larger droplets behave ballistically and fall to the  
 10 ground relatively quickly, whereas aerosols float and  
 11 remain in the air for a much longer period of time. Do  
 12 you agree with that summary?

13 **A.** Yes.

14 **Q.** Can we, please, have a look at your paragraph 49 of your  
 15 witness statement.

16 And this can come up on screen, it's paragraph 49,  
 17 page 14.

18 You say this:

19 "It is my view that the distinction between  
 20 a respiratory aerosol and droplet in terms of size  
 21 (micrometres) is an academic consideration that cannot  
 22 be usefully applied in national guidance or by  
 23 healthcare workers in 'real' clinical environments."

24 And you then give your reasons for that, including  
 25 how difficult it is to measure a particle in practice.

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1 fluid-resistant surgical masks and respirators,  
 2 respirators being necessary for aerosol protection and  
 3 surgical masks for droplet protection.

4 You accept, I think, that FRSM, if I can use that  
 5 acronym, don't protect against aerosols, do they?

6 **A.** No.

7 **Q.** We heard last week from Richard Brunt, who explained  
 8 that from the HSE's perspective, FRSMs aren't in fact  
 9 deemed to be PPE because they're not, if I can  
 10 summarise, personally protective; they are, I think,  
 11 source control or a medical device as far as he is  
 12 concerned, they're regulated by the MHRA. You say in  
 13 your witness statement, at paragraph 68 for reference,  
 14 that you do think that FRSMs are considered to be  
 15 a component of PPE. Can you accept that because of the  
 16 issue in terms of them not being approved by the HSE as  
 17 PPE that some may not consider FRSMs to be PPE?

18 **A.** FRSMs have been used in infection prevention and control  
 19 in healthcare settings for a long, long time, and are  
 20 part of established guidelines nationally and  
 21 internationally, the WHO, communicable disease centres  
 22 in America, so as PPE they have been cited as part of  
 23 infection prevention and control precautions for many  
 24 years, in many guidance documents, so it's a well  
 25 established piece of infection prevention and control

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1 **A.** Yeah.

2 **Q.** Can I just try to clarify what you're actually saying  
 3 here. You aren't suggesting, are you, that in fact  
 4 a healthcare worker would need to take a moment to try  
 5 to assess the exact size of a particle that's just been  
 6 emitted, because of course that would be impractical,  
 7 but it is the case, is it not, that it's important that  
 8 those who set the guidance understand the difference  
 9 between the size of particles, because that then informs  
 10 the guidance that you set?

11 **A.** Correct, yeah.

12 **Q.** So when you say academic distinction, it's not fair, is  
 13 it, to call it simply academic, because the  
 14 understanding is directly relevant to the guidance  
 15 that's then used in practice?

16 **A.** I think I was meaning academic in the sense that  
 17 research that is done in laboratory conditions or in  
 18 academic institutions then has to be translated into  
 19 practicable IPC guidance. So understanding a cut-off  
 20 point is helpful, and having a definition, again, which  
 21 has been long established in infection prevention and  
 22 control guidelines, be it contact, droplet or airborne  
 23 transmission, have been the known and established IPC  
 24 transmission measures that have been in the guidance for  
 25 many -- a long time.

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1 Q. So you do accept that there is a use to it; you're  
 2 drawing a distinction between the scenarios in which  
 3 it's useful?  
 4 A. Yes.  
 5 Q. Okay. Professor Beggs gave evidence last week about the  
 6 size of microns that he considers to be aerosols and  
 7 that he considers to be droplets, and the cut-off point  
 8 that he gave was 100 microns: he says anything less than  
 9 100 microns is an aerosol and anything above that is  
 10 a large droplet.  
 11 I suspect you don't necessarily agree with that. Is  
 12 that right?  
 13 A. I respect that that is Professor Beggs' opinion. I am  
 14 not a physical scientist.  
 15 Q. So you aren't in a position to say what your view is on  
 16 the size of particles and the distinction between  
 17 aerosols and droplets?  
 18 A. I think the distinction that I would say is that  
 19 airborne transmission occurs by small droplets, aerosols  
 20 are particles that remain suspended in the air and that  
 21 the airborne transport of those particles may carry  
 22 pathogens long distances, unlike a droplet, which  
 23 involves larger size droplets that requires closer  
 24 contact for transmission to happen.  
 25 Q. It might be helpful if we look at this in practical  
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1 guidance that was issued during the pandemic?  
 2 A. That's correct.  
 3 Q. So it is the case, isn't it, that, for the purposes of  
 4 the guidance that was issued during the pandemic, the  
 5 cut-off point was deemed to be 5 microns, which is  
 6 obviously markedly different to the cut-off point that  
 7 Professor Beggs uses?  
 8 A. Indeed.  
 9 LADY HALLETT: Can I just ask you a question, Dr Ritchie.  
 10 Things that are well established aren't necessarily  
 11 always right. Science moves on, understanding moves on.  
 12 Were you aware of any debate about the size of droplets  
 13 and whether the science had moved on or understanding  
 14 had moved on?  
 15 A. I think as we came through the pandemic, those  
 16 discussions were taking place and scientific individuals  
 17 were putting those cases forward. At the beginning of  
 18 the pandemic that wasn't the case.  
 19 MR FIREMAN: I suppose, thinking about it in practical  
 20 terms, if we go back to those cut-off points, if we look  
 21 at a section -- I can take us, please, to a section of  
 22 Professor Beggs' report.  
 23 This is INQ000474276, page 48, and page 49,  
 24 paragraph 122.  
 25 He summarises here what he considers to be the  
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1 terms and consider how this was then translated into  
 2 healthcare worker infection prevention and control  
 3 guidance.  
 4 If we could go to INQ000251675.  
 5 This is a passage from some of the guidance, this is  
 6 page 13 and 14, it should come up on screen soon. Yes,  
 7 here we go.  
 8 If you look at the bottom part of that, it says  
 9 "Droplet precautions" and it says:  
 10 "Used to prevent and control infection transmission  
 11 over short distances via droplets ..."  
 12 And there it says above 5 microns.  
 13 So just to clarify, this guidance, is this likely to  
 14 have been something that was formulated or agreed upon  
 15 in an IPC cell meeting?  
 16 A. No, this guidance existed well before that.  
 17 Q. Is this guidance which was -- the guidance that was  
 18 adapted from the pandemic influenza guidance?  
 19 A. Even before that. I think back in 1997 HICPAC, which is  
 20 an advisory group to the WHO, came up with these routes  
 21 of transmission, contact, droplet and airborne  
 22 transmission, and they described these droplet sizes.  
 23 Q. Those droplet sizes as they were described all the way  
 24 back then have maintained and made their way into  
 25 infection prevention and control guidance, including the  
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1 issue, as a result of different spheres using different  
 2 cut-off sizes, and he says:  
 3 "One of the unintended consequences of the  
 4 inappropriate [that's his words] 5-micron threshold, was  
 5 that scientists from completely different disciplines  
 6 used completely different terms to describe the same  
 7 objects. So, for example a 23-micron diameter  
 8 respiratory particle might be called a droplet by  
 9 clinicians and microbiologists, whereas the same object  
 10 would be an aerosol particle to an engineer or  
 11 physicist."  
 12 So is that, Dr Ritchie, the nub of the distinction  
 13 between the two disciplines and, indeed, a potential  
 14 cause of concern where you have the established science,  
 15 as it was, in the infection prevention and control  
 16 guidance and, in fact, another reasonable body of  
 17 scientific evidence that says, in fact, you're  
 18 describing these particles in the wrong way and, as  
 19 a result of that, you're devising infection prevention  
 20 and control measures that are incorrect?  
 21 A. I think the challenge for us was to translate a lot of  
 22 this scientific evidence into infection prevention and  
 23 control guidance and I respect, as I say,  
 24 Professor Beggs' view and acknowledging that  
 25 transmission can occur along a spectrum and airborne is  
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1 possible -- I'm talking about airborne generating  
 2 procedures -- that airborne spread is possible,  
 3 particularly in crowded and ventilated settings. But  
 4 the epidemiology and the scientific literature did not  
 5 support that airborne spread as the predominant mode of  
 6 transmission and, indeed, the WHO guidance has not  
 7 stated a change in a predominant mode of transmission  
 8 for SARS-CoV-2.

9 **Q.** But is that using the 5-micron cut-off or the 100-micron  
 10 cut-off?

11 **A.** The WHO have recently looked at and published revised  
 12 terminology for respiratory viruses and that still --  
 13 I don't think -- they've spoken about a continuum now,  
 14 as I've just said, and the cut-off, I think, is part of  
 15 a risk assessment.

16 **Q.** Okay, I'm just struggling to follow because I think,  
 17 ultimately, the question would be: it could have been  
 18 that both you and Professor Beggs agreed entirely on the  
 19 size of the particles that were causing the infection,  
 20 you both look at a 12-micron particle, but he says  
 21 that's aerosol transmission and you say it's droplet  
 22 transmission and, as a result, you say airborne  
 23 transmission is not predominant because we've got  
 24 12-micron particles which are droplets.

25 When you say that airborne transmission has not been  
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1 that it's the predominant mode of transmission.

2 **LADY HALLETT:** Thank you, I had misunderstood.

3 **A.** Apologies.

4 **LADY HALLETT:** Thank you. No, it's my fault,  
 5 I misunderstood.

6 **MR FIREMAN:** I suppose this leads on to a point you make in  
 7 your witness statement, which is that you say that the  
 8 established modes of transmission as defined before the  
 9 pandemic, ie with specific infectious particle cut-off  
 10 sizes, is, in fact, not as delineated as first thought  
 11 prior to the pandemic.

12 I suppose, first of all: what do you mean by that?

13 **A.** So I again accept that airborne spread is possible and  
 14 I think what we learned through the pandemic was that,  
 15 rather than these distinct cut-offs, that there was more  
 16 of a spectrum of airborne spread was possible.

17 So having distinct cut-offs probably now is not  
 18 a helpful thing to have, and I think there's been many  
 19 reports of nosocomial infection, like hospital  
 20 infections, where other routes of transmission can't be  
 21 ruled out.

22 **Q.** That can come down, that document.

23 I suppose there are two questions which arise from  
 24 that. The first is: if that is the case and that's the  
 25 view you've come to now, when did you come to that view?  
 91

1 recognised as being predominant, do you know on what  
 2 basis you're saying that with respect to particle sizes,  
 3 or are you not able to say that?

4 **A.** I'm probably not able to say that in terms of particle  
 5 sizes but, in terms of the epidemiology and the  
 6 scientific literature, and the outputs from those  
 7 scientific groups that we were taking advice from.

8 **Q.** I suppose, trying to follow this up, then, just to tie  
 9 things up, those scientific groups that you were taking  
 10 advice from, saying that airborne transmission was not  
 11 a significant threat, were they doing so on the basis of  
 12 a 5-micron cut-off; do you know that?

13 **A.** I don't know that.

14 **LADY HALLETT:** Sorry, can I just make sure I've understood.  
 15 I thought you said, just a moment or two ago, that the  
 16 World Health Organisation has not even now said that  
 17 aerosol transmission is the most dominant route; is that  
 18 what you said?

19 **A.** Yes.

20 **LADY HALLETT:** I thought they had.

21 **A.** They haven't changed their guidance --

22 **MR FIREMAN:** My Lady, I'm not sure if they said "most  
 23 dominant" or if they've just acknowledged it as a route.  
 24 Do you know the answer to that, Dr Ritchie?

25 **A.** They've acknowledged it as a route but they've not said  
 90

1 **A.** Could you repeat the question, sorry?

2 **Q.** I think you said that you accept that there are multiple  
 3 routes of transmission, airborne was possible, there's  
 4 a spectrum of different ways in which a virus can  
 5 transmit, if I'm summarising what you said, I think.

6 **A.** Yeah.

7 **Q.** So I suppose what I'm asking you is when did you reach  
 8 the conclusion that that was, in fact, the appropriate  
 9 way to assess the risk?

10 **A.** I think when the cut-off measures of the particle sizes  
 11 were not seemed or deemed to be helpful within clinical  
 12 guidelines and that the awareness of airborne  
 13 transmission became more apparent --

14 **Q.** Can I push you to try and identify a timeframe?

15 **A.** I don't recall.

16 **Q.** Was it during this module's relevant period of March  
 17 2020 to June 2022 or after it?

18 **A.** Probably more towards the end and after.

19 **Q.** Just to tie this area up before we break, does your  
 20 understanding that things are perhaps more nuanced than  
 21 was previously considered to be the case, and that in  
 22 fact there's a spectrum, does that not reinforce the  
 23 need to protect against a variety of different modes of  
 24 transmission and perhaps be more precautionary and  
 25 protect against all of them at once, rather than just be  
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1 specific and say "This is the way in which it was  
2 transmitted"?

3 **A.** Indeed.

4 **MR FIREMAN:** Thank you.  
5 My Lady, I don't know if that's an appropriate time.

6 **LADY HALLETT:** Yes, certainly. I shall return at -- I hope  
7 you were warned that we would be taking a lunch break.  
8 Thank you, I shall return at 2 o'clock.

9 (1.00 pm)

10 (The short adjournment)

11 (2.00 pm)

12 **LADY HALLETT:** Mr Fireman.

13 **MR FIREMAN:** Thank you.

14 Dr Ritchie, I want to, before I actually begin,  
15 I just need to make one point of clarification. Prior  
16 to starting -- earlier on I referred to a document  
17 INQ000 -- well, in fact, I'm going to give you the  
18 correct reference for the document I should have  
19 referred to. I can't remember the wrong one because  
20 I don't know which one I did refer to incorrectly, but  
21 I can tell you --

22 **LADY HALLETT:** You're getting confused here, Mr Fireman.

23 **MR FIREMAN:** I got confused. The correct one is  
24 INQ000398180, and if just for formalities we could have  
25 that on the screen for a second or two and then take it  
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1 an HCID, the categorisation of airborne encompasses both  
2 respiratory droplets or droplets, let's use droplets for  
3 the sake of clarity, and aerosols?

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

5 **Q.** Do modes of transmission, other than in the way you've  
6 just described in terms of distinguishing between  
7 whether something is an airborne or a contact HCID, have  
8 any bearing on the fact that something is designated as  
9 an HCID?

10 **A.** So the mode of transmission of an HCID classification  
11 does not differentiate between transmission modes.

12 **Q.** Put another way, then, just trying to clarify this, are  
13 the implications from an infection prevention and  
14 control perspective, in terms of the requirement to wear  
15 respiratory protective equipment and I think using  
16 negative pressure rooms, the same if you're dealing with  
17 a contact HCID and an airborne HCID?

18 **A.** That's correct.

19 **Q.** So in January and until March 2020, because of the fact  
20 that Covid was designated as an HCID, it was  
21 a requirement for all healthcare workers to wear  
22 respiratory protective equipment and also to be dealt  
23 with in negative pressure rooms; is that correct?

24 **A.** That's correct.

25 **Q.** The decision was then taken to declassify Covid as  
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1 down and it will be corrected for the purposes of  
2 recording it. Thank you.

3 Turning then back to your evidence, Dr Ritchie,  
4 I want to deal with the issue of the role of  
5 high-consequence infectious diseases, HCID, and the  
6 classification as an HCID, and how that plays a part in  
7 infection prevention and control, if it does at all, and  
8 how it in fact did play a part during the early part of  
9 the pandemic.

10 So, starting point, it's right, and I think you  
11 acknowledge, in January 2020 Covid-19 was designated as  
12 an HCID, if I can use that acronym?

13 **A.** That's correct.

14 **Q.** Generally, is it right that HCIDs are divided into two  
15 categories, contact and airborne?

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

17 **Q.** What is the difference between a contact and an airborne  
18 HCID?

19 **A.** So the difference is how they are transmitted. So  
20 a contact HCID spreads primarily through direct contact  
21 with an infected person, their bodily fluids, tissues or  
22 contaminated materials. An airborne HCID spreads via  
23 respiratory droplets and aerosols and may also involve  
24 contact routes.

25 **Q.** So the key point there is that in the context of  
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1 an HCID and, following that, is it right that the  
2 stringent requirements about how to deal with the virus,  
3 because of the fact it was designated in such a way,  
4 fell away and there was no need to at that point  
5 necessarily to deal with what actually happened, but  
6 once it was not categorised as an HCID those  
7 requirements were not -- you didn't need to abide by  
8 those requirements necessarily?

9 **A.** That's right. So when something is classified or  
10 a pathogen is classified as a high-consequence  
11 infectious disease, be it contact or be it airborne,  
12 there is one PPE kit ensemble, as we refer to it, that  
13 includes a respiratory -- sorry, which includes an FFP3  
14 respirator, RPE, so it does not matter how that HCID is  
15 classified, the PPE ensemble or kit is exactly the same  
16 for both contact and airborne.

17 **Q.** So it may well have been, and it may be that your  
18 evidence is that this is the case, that whilst Covid was  
19 designated as an airborne HCID, it was not thought  
20 necessarily that it was airborne but it may have been  
21 thought that it was spread by droplets, and as a result,  
22 because it was an HCID, it was designated as an airborne  
23 HCID and requirements to wear respirators applied?

24 **A.** Correct.

25 **Q.** On reflection, I think you recognised that this is  
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1 an area where there is quite a great deal of scope for  
 2 confusion, isn't there?  
 3 **A.** Indeed.  
 4 **Q.** There are a number of terms that are used in different  
 5 contexts which, from a layperson's perspective, seem  
 6 very similar. I can mention some of them. Is it right  
 7 that in this context, of course, airborne means both  
 8 droplet and aerosol, but in other circumstances airborne  
 9 is essentially synonymous with aerosol?  
 10 **A.** Correct.  
 11 **Q.** It's also right that there is a term used to describe  
 12 an aerosol that's often used I think scientifically but  
 13 also in clinical circles as droplet nuclei?  
 14 **A.** That's --  
 15 **Q.** That refers to an aerosol, doesn't it?  
 16 **A.** It does.  
 17 **Q.** Not a droplet?  
 18 **A.** No.  
 19 **Q.** You recognise quite clearly then that there is, without  
 20 even going to the detail, immediately a challenge in  
 21 understanding what's being spoken about, given the way  
 22 in which these terms are referred to?  
 23 **A.** Yes.  
 24 **Q.** And is it right that NHS England has looked to undertake  
 25 some work to try to assist with clarifying these things,

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1 **A.** I do think it is important to have some -- if the WHO  
 2 have made those inroads, and I know that the work they  
 3 have recently done in the publication and the  
 4 terminology that they've looked at has included some  
 5 professionals from the UK, so it is a global document  
 6 that they have looked at and come up with terms, and  
 7 I do think it's important going forward that  
 8 international and national guidelines are aligned, and  
 9 we did aim to do that throughout the duration of the  
 10 pandemic.  
 11 **Q.** At the outset of the pandemic, once Covid was no longer  
 12 designated as a high-consequence infectious disease  
 13 (HCID), is it right that the starting point for  
 14 understanding likely modes of transmission of the virus  
 15 SARS-CoV-2 was what was known about SARS-CoV-1? In  
 16 other words, what was known about Covid was informed by  
 17 what was known about SARS; is that right?  
 18 **A.** That would be correct.  
 19 **Q.** In 2013, do you recall that you co-authored a paper  
 20 alongside some other medical experts including  
 21 Sir Jonathan Van-Tam, who was the Deputy CMO for part of  
 22 this relevant period, and that paper was aimed at giving  
 23 guidance to healthcare workers on how to protect against  
 24 various different viruses?

Can I call that document up, please. It's

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1 and do you think that it is important that definitions  
 2 of these terms can be clarified in a way that it is  
 3 clear, without any ambiguity, what each of them refer  
 4 to?  
 5 **A.** Yeah. I think there's definitely scope to be clear on  
 6 definitions and what they mean. It's really important  
 7 that we make things clear to our frontline healthcare  
 8 workers so they know exactly what to do and that we are  
 9 speaking a common language which when we talk about  
 10 different terms that people understand exactly what  
 11 we're talking about.  
 12 The work that NHS England is looking at currently is  
 13 almost going back to the history in a way of how did we  
 14 end up with those three contact -- those three  
 15 definitions of contact, droplet and airborne, and just  
 16 bringing that information forwards and understanding the  
 17 terminology. We have had a publication more recently  
 18 from the WHO, who have looked at terminology and again  
 19 have given some different terms to describe contact,  
 20 what effectively would have been droplet and airborne,  
 21 both short and long range.  
 22 **Q.** So is that something that you think the WHO are doing  
 23 and that should then be adopted worldwide, or is it  
 24 something which you think we within the UK can define  
 25 ourselves and ensure that is consistent nationally?

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1 INQ000130561, and I want to go to page 5 in particular,  
 2 please.

3 So this is an article -- as I said, you were one of  
 4 several authors too. We can see that this is a table  
 5 which has various different viruses. In the middle  
 6 there is "Main route of transmission" and then further  
 7 along we have "Respiratory personal protective equipment  
 8 for healthcare workers" and "[FFP required". We can  
 9 see first of all, with tuberculosis, it's described as  
 10 "Aerosol" under "Main route of transmission". And then  
 11 we have "FFP3 required" and then it has a tick there and  
 12 some language underneath that -- some text underneath  
 13 that, sorry.

14 If we look at SARS coronavirus, that's SARS, it  
 15 describes main route of transmission for SARS as  
 16 "Droplet/aerosol", and in terms of "Respiratory personal  
 17 protective equipment", it says "(recommended to be worn  
 18 until patient is no longer considered infectious)" with  
 19 a tick next to it.

20 Given that SARS was the starting point in terms of  
 21 informing the way in which Covid was to be protected  
 22 against, and SARS was described as "Droplet/aerosol",  
 23 and indeed recommended that an FFP3 be required when  
 24 caring for SARS, can you explain why that didn't apply  
 25 when providing guidance as to how to deal with Covid,

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1 despite the fact they were so similar?  
 2 **A.** So the SARS-CoV-1 which would have been the SARS  
 3 outbreak in 2003 -- and I think you're correct in saying  
 4 that the principle of this paper was to help guide  
 5 personal protective equipment and particularly  
 6 respiratory and facial protection, what it didn't do was  
 7 specifically look at individual pathogens, but  
 8 SARS-CoV-1 that -- in the 2003 outbreak was  
 9 predominantly found to be spread by droplet contact with  
 10 the potential that it could be airborne, but it was  
 11 never confirmed that that was the predominant route of  
 12 transmission for SARS-CoV-1.

13 **LADY HALLETT:** Sorry, I don't think that's answered  
 14 Mr Fireman's question.

15 **A.** Sorry.

16 **LADY HALLETT:** Well, if SARS-1 was meant to be guiding you,  
 17 why didn't it?

18 **A.** Because this paper wasn't specifically targeted towards  
 19 SARS-CoV-2, so this was a paper that was written  
 20 ten years ago, and SARS Coronavirus 1, I think they did  
 21 guide us in terms of droplet contact with the potential  
 22 to be airborne transmitted, so it did guide us in that  
 23 way.

24 **MR FIREMAN:** The guidance said on its face that it -- in  
 25 fact within the context of the guidance it specifically

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1 **A.** Yes.

2 **Q.** So was that what guided you? Or not you. When I'm  
 3 saying "you" here, I don't mean you personally, I should  
 4 be clear. Was that what you think guided the guidance,  
 5 or guided those who were making the guidance, the fact  
 6 that Covid wasn't going to kill as many people,  
 7 proportionately, of those who were infected as SARS?

8 **A.** Sorry, could you --

9 **Q.** Was the fact that a higher proportion of people who  
 10 catch SARS die part of the reason that you recommended  
 11 that airborne precautions be taken against SARS than  
 12 with respect to Covid?

13 **A.** So part of the declassification -- so more information  
 14 was coming out with regards to how SARS-CoV-2 was being  
 15 transmitted and, with that information, we were using  
 16 that from NERVTAG, from SAGE, the bodies who were  
 17 looking at the science, to inform or translate that  
 18 science in what would be infection prevention and  
 19 control guidance.

20 **Q.** Sorry, just because I think this is important, I'm  
 21 trying to understand from what you're saying whether or  
 22 not, in fact, you did look at SARS to inform the way in  
 23 which you dealt with Covid but, in fact, you thought  
 24 SARS was predominantly droplet based and that was why  
 25 that influenced the way in which the guidance was

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1 addresses the fact that it was based on the reasonable  
 2 assumption that SARS-CoV-2 would behave in a similar way  
 3 to SARS-CoV-1.

4 You say in your -- perhaps it's easier to go to your  
 5 witness statement, because at paragraph 110 there's  
 6 a footnote to your witness statement which deals with  
 7 this, and you say:

8 "The evidence that SARS-CoV-1 could transmit by  
 9 aerosol was weak, circumstantial and very limited in  
 10 volume ... So it was certainly possible and worth noting  
 11 as a possibility due to the high consequence nature of  
 12 SARS-CoV-1, but there wasn't evidence (certainly not  
 13 with any certainty) to say that the airborne route was  
 14 common/dominant."

15 So that's obviously a different explanation, isn't  
 16 it, to -- if we just look at this document, which does  
 17 seem to describe the main route of transmission as being  
 18 at least partially aerosol?

19 **A.** Correct.

20 **Q.** But it seems that you're drawing a distinction in your  
 21 statement between the two viruses, not based on routes  
 22 of transmission but based on the case fatality rate, or  
 23 the extent to which a higher proportion of patients die  
 24 when they catch SARS, as opposed to when they catch  
 25 Covid?

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1 produced for Covid, but the difference with SARS is that  
 2 it's deadlier, essentially?

3 **A.** Yes.

4 **Q.** Is that the distinction that was being drawn by those  
 5 who were producing the guidance, do you think?

6 **A.** Yes.

7 **Q.** Thank you.

8 That can come down, that document.

9 The Inquiry has also heard criticisms, I think in  
 10 Module 2, from Professor Catherine Noakes, who was,  
 11 I think, on the Environmental Modelling Group, and she  
 12 said, to summarise, essentially, that she considered  
 13 that there may have been a belief or a consideration  
 14 that we needed a higher threshold of evidence to be  
 15 confident that airborne transmission was occurring,  
 16 whereas, with respect to droplets and contact, it was  
 17 sufficient to make assumptions based on what was  
 18 reasonably known previously.

19 Do you think that's a fair criticism?

20 **A.** Sorry, could you --

21 **Q.** Put another way, was a higher threshold of evidence  
 22 required for airborne transmission, as opposed to  
 23 droplet and contact transmission?

24 **A.** So the infection -- the UK IPC cell was basing the  
 25 guidance on the evidence that we were being given from

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1 outputs from NERVTAG, SAGE and aligned to what was in  
2 WHO guidance. So the early IPC guidance was based on  
3 the available evidence on transmission routes which  
4 aligned with the WHO recommendations.

5 **LADY HALLETT:** The question was: were you looking for more  
6 evidence?

7 **A.** I don't think it was looking for more evidence. We were  
8 translating the science that we were being given. So,  
9 had our science evidence groups, such as NERVTAG and  
10 SAGE, said that that evidence was available in the  
11 literature, then we would -- or that was the mode of  
12 transmission, it was airborne, then that is what we  
13 would have put into the IPC guidance.

14 **MR FIREMAN:** Just following up on that, I thought that the  
15 reason that you looked, or the guidance looked, at what  
16 happened with SARS to inform how to protect against  
17 Covid was because there wasn't evidence of the way in  
18 which Covid specifically transmitted and so, in order to  
19 do that, you look at SARS to inform and make reasonable  
20 assumptions.

21 Is that right, first of all?

22 **A.** Yes.

23 **Q.** If that's right, you didn't have evidence about the mode  
24 of transmission with respect to Covid either, did you?  
25 You didn't know whether it was droplet or contact, you

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1 the second paragraph under "Comparison with WHO  
2 guidelines", just about four lines up from the bottom,  
3 it says this:

4 "Covid-19 is not airborne, it is droplet carried."

5 So this was on 28 March 2020, sent by the medical  
6 director of NHS England at that time. Of course, do you  
7 think that it was helpful to be this definitive about  
8 the way in which the mode of transmission was for  
9 Covid-19, this early on in the pandemic?

10 **A.** That -- if that was what was known as the science at  
11 that time and was the information being given by the  
12 CMO.

13 **Q.** I think this reflects, in fact, a tweet or is similar to  
14 a tweet that the World Health Organisation similarly put  
15 out saying more or less the same thing, but let's take  
16 it back to your perspective. You were obviously  
17 involved heavily with the IPC cell, you chaired it for  
18 some time. Did statements such as this, that were so  
19 definitive, make your job harder in terms of changing  
20 the approach as the IPC cell because to do so would mean  
21 going against statements that had been this definitive  
22 early on?

23 **A.** We were working to keep the guidance updated with the  
24 information that we were being given, so --

25 **Q.** If you could answer the question: did this make it

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1 just knew that it was likely it may have behaved in the  
2 way that SARS did?

3 **A.** Correct.

4 **Q.** So, given that you didn't know that, the obvious  
5 question is to say: why wasn't it presumed that we don't  
6 know about the way in which this virus transmits at all  
7 and we're going to protect against all three established  
8 modes of transmission?

9 **A.** Well, we were taking our lead from the expert science  
10 groups to translate that, as I've said before, into the  
11 infection prevention and control guidance.

12 **Q.** So was it essentially a risk assessment that you  
13 considered, based on the evidence it's likely that it's  
14 droplet based?

15 **A.** Correct.

16 **Q.** Can we go, please, to a document now, which is  
17 INQ000130506, and I think it's the third page. We can  
18 start with the first page, just to orientate ourselves.  
19 So this is a letter from Professor Stephen Powis,  
20 I believe, on 28 March 2020, and it was sent to all of  
21 these various groups. We can see here all chief  
22 executives of all NHS trusts and foundation trusts and  
23 to lots of those interested parties in the NHS,  
24 including the royal colleges, the BMA and the RCN.

25 If we can go to page 3, please, if we can look at

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1 harder for you to go against what had previously been  
2 said and decide in fact that there was airborne  
3 transmission?

4 **A.** There is a possibility that it could have been airborne  
5 transmitted.

6 **Q.** No, no, the question is: did statements such as this  
7 influence you on the IPC cell and make it more difficult  
8 for you to say, "Actually, this is an airborne virus,  
9 notwithstanding what's been said previously"?

10 **A.** No.

11 **Q.** Thank you.

12 Can we go now to a different document, so this is  
13 a passage from Professor Beggs' report, INQ000474276,  
14 and this is paragraph 139.

15 If we can just increase the size, here we go, here  
16 is the bold section. We've looked at this before in the  
17 Inquiry but, just to orientate yourself, this is  
18 basically Professor Beggs' view, where he sets out that  
19 he considers by September 2020 there was enough moderate  
20 certainty evidence to strongly suggest that SARS-CoV-2  
21 could be transmitted via the airborne route, and to  
22 justify precautionary measures being taken by health  
23 authorities to prevent this route of transmission in  
24 hospitals and elsewhere.

25 Do you think that that is right? Was it the case

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1 that, by September 2020, you felt there was sufficient  
 2 evidence, or is that unfairly early in terms of the  
 3 history of events?  
 4 **A.** So the weight of evidence that we were being advised  
 5 with, I mean, the guidance was approved by Public Health  
 6 England, UKHSA and the recommendations that were in the  
 7 UK IPC guidance was consistent and aligned with the  
 8 World Health Organisation.  
 9 **LADY HALLETT:** Sorry, I think Mr Fireman's point is getting  
 10 to the timing. Do you agree there was enough, what the  
 11 professor called, moderate certainty evidence, I think  
 12 he means moderately certain evidence that SARS-CoV-2 was  
 13 aerosol transmitted by September 2020?  
 14 **A.** It could be aerosol transmitted if there was  
 15 aerosol-generating procedures being performed.  
 16 **MR FIREMAN:** Right, that's a different point but thank you.  
 17 So, other than outside of aerosol-generating procedures,  
 18 you didn't think in September 2020 that was the case?  
 19 **A.** And potentially, if people were in poorly ventilated and  
 20 overcrowded situations, then again that had been raised  
 21 as a possibility that it could be airborne spread.  
 22 **Q.** Bear with me one second.  
 23 With respect to poorly ventilated areas, is it not  
 24 the case that ventilation is only a relevant precaution  
 25 if you are guarding against an airborne transmitted  
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1 transmission and you appreciated that. From the IPC  
 2 cell's perspective was there ever a point where you  
 3 collectively reached the view that it was a significant  
 4 threat and needed to be guarded against with, for  
 5 example, routine respirators being used?  
 6 **A.** No.  
 7 **Q.** Did the level of things like nosocomial outbreaks impact  
 8 your assessment of whether or not airborne transmission  
 9 was a significant threat?  
 10 **A.** Yes, they did.  
 11 **Q.** Why then, when there were some instances -- I think,  
 12 particularly in the first wave and sometimes in the  
 13 second wave, there were instances of nosocomial  
 14 outbreaks -- why did that not cause you to reconsider  
 15 and think about the threat of airborne transmission?  
 16 **A.** So we did investigate or we enquired about the different  
 17 nosocomial outbreaks of infection that had happened.  
 18 What we tended to see was that, when community  
 19 prevalence went up, so when there was more Covid in the  
 20 community, then the hospital admissions increased.  
 21 In terms of those outbreaks, infection control is --  
 22 there seemed to be -- the FFP3 respirators became almost  
 23 like the silver bullet, if I could use that term, and  
 24 there are many other precautionary measures that do need  
 25 to be put in place. So I think some of the publications  
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1 disease? There is no point in opening the windows in  
 2 terms of trying to protect against a contact disease or  
 3 a droplet disease, is there?  
 4 **A.** Potentially, yes, skin scales, you know, things like  
 5 that to get into the air potentially.  
 6 **Q.** So you consider that ventilation is helpful both for all  
 7 modes of transmission?  
 8 **A.** Yeah, specific air conditioning units and specialised  
 9 ventilation are necessary for airborne or preventing  
 10 airborne transmission.  
 11 **Q.** So you agree predominantly it's an airborne measure but  
 12 it's also beneficial in your view --  
 13 **A.** Yes.  
 14 **Q.** -- for other measures?  
 15 Just dealing then, first of all -- we'll come back  
 16 to that -- with the timeline, because here we're talking  
 17 about September 2020, are you aware that there are other  
 18 organisations involved in the Inquiry, such as the BMA,  
 19 the British Medical Association, who do support the view  
 20 that Professor Beggs espouses about the IPC cell being  
 21 too slow to acknowledge airborne transmission?  
 22 Just trying to get down to timing, I know you said  
 23 earlier that you, latterly, towards the end of the  
 24 relevant period, you started to acknowledge that  
 25 actually there was a genuine threat of airborne  
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1 that came out, and there was a rapid influx of Covid-19  
 2 related scientific information, much of that was  
 3 disseminated through pre-prints or press releases and it  
 4 posed difficult in sustaining a well considered  
 5 scientific narrative, and information was often taken  
 6 out of context.  
 7 **Q.** Sorry, so just to try to understand what you're saying,  
 8 are you saying that it wasn't possible to sort of  
 9 disentangle the causes of nosocomial outbreaks --  
 10 **A.** Correct.  
 11 **Q.** -- in order to say it was caused by --  
 12 **A.** Correct.  
 13 **Q.** -- route of transmission as opposed to all of the other  
 14 factors which may have been contributing?  
 15 **A.** Because infection prevention and control is  
 16 multi-interventional, so it's multifaceted, so it means  
 17 many things need to be put in place, and it's very  
 18 difficult to extract one thing to say that was the thing  
 19 that made a difference or caused this outbreak.  
 20 **Q.** I just want to explore this point about ventilation  
 21 slightly further, seeing as you mentioned it before.  
 22 Can we go, please, to INQ000203993.  
 23 This is a paper from September 2020 which SAGE  
 24 produced, and it says:  
 25 "Role of Ventilation in Controlling SARS-CoV-2  
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1 Transmission."

2 In this executive summary, just to deal with this  
3 point, it says:

4 "Ventilation is an important factor in mitigating  
5 against the risk of far-field ... aerosol transmission,  
6 but has no impact on other transmission routes (high  
7 confidence)."

8 So that's SAGE's view, that's the view of the EMG.  
9 That's inconsistent with what you've just said, isn't  
10 it, about ventilation being a good measure generally to  
11 take in infection prevention and control?

12 **A.** In the context, so this is set in the context of  
13 SARS-CoV-2. I think what I was saying earlier was other  
14 pathogens have the potential and ventilation is  
15 important.

16 **Q.** But you would accept then, would you, that with respect  
17 to SARS-CoV-2 or Covid, ventilation is only a useful  
18 precaution measure if in fact you are accepting as  
19 a prima facie standpoint that in fact there is airborne  
20 transmission outside of aerosol-generating procedures?

21 **A.** Okay.

22 **Q.** I'm asking you the question: is that not -- I'm not  
23 telling you that, it's your evidence, but what is your  
24 position on that?

25 **(Pause)**

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1 was a significant risk of far-field aerosol  
2 transmission, what did you think the benefit of  
3 ventilation was? If you didn't think that the virus was  
4 airborne, why were you recommending that people --

5 **A.** But we weren't just recommending ventilation, there was  
6 multiple measures.

7 **Q.** Sure, but just focusing on ventilation.

8 **A.** If there was aerosol-generating procedures being  
9 undertaken in those areas, then it was important to have  
10 good ventilation. There are -- infection control sits  
11 within a complex framework of many other regulatory  
12 documents, including health building notes and health  
13 technical memorandum, so ventilation is an important  
14 part of healthcare buildings.

15 **Q.** So any recommendations that you made about ventilation  
16 weren't necessarily indications that you thought that  
17 there was aerosol transmission, they were just general  
18 tips as to how to deal with the virus and all viruses?

19 **A.** Yeah.

20 **Q.** Okay, thank you.

21 That can come down.

22 Can I just ask you, then, just to conclude this area  
23 of questioning, about what you say in your witness  
24 statement, which is that your view is that aerosol  
25 transmission is -- you say this at page 31:

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1 **A.** So I think that what that's saying is that the aerosol  
2 transmission depends on the interaction of multiple  
3 factors.

4 **Q.** It does, yes, but the starting point is that in terms of  
5 recommending ventilation as a measure of protecting  
6 against the virus, it's only worth ventilating -- and  
7 this is something that Professor Beggs said last week,  
8 he said that people generally think ventilation is  
9 a good thing, but they don't necessarily acknowledge  
10 that it's -- the virus may be airborne. But they think  
11 ventilation is a good thing. But this paper seems to be  
12 saying that ventilation as an IPC measure is only worth  
13 taking if in fact you're protecting against  
14 an aerosol-borne disease -- or an aerosol -- against  
15 aerosol transmission.

16 So I'm just trying to understand why you think  
17 ventilation was good if you didn't think there was  
18 aerosol transmission as of earlier on in 2020 and into  
19 2021?

20 **A.** Sorry, I don't think I'm disagreeing, I think  
21 I'm agreeing, saying that ventilation is an important  
22 factor to mitigate against that far-field aerosol  
23 transmission.

24 **Q.** I understand that you're saying that, but what  
25 I'm trying to understand is, if you didn't think there

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1 "My view ... that aerosol transmission is  
2 significant compared to other routes is that this is not  
3 sufficiently strong to recommend that FFP3 respirators  
4 are routinely used in locations other than high-risk  
5 clinical areas where AGPs take place."

6 **A.** That's correct.

7 **Q.** Does that remain your view today?

8 **A.** Yes.

9 **Q.** What would have been sufficiently strong evidence to  
10 justify, certainly during the pandemic, routinely using  
11 FFP3 respirators for healthcare workers?

12 **A.** So that would have been the scientific evidence that  
13 would have come from the expert bodies who were  
14 providing that information during the pandemic, and from  
15 international organisations such as the World Health  
16 Organisation.

17 **Q.** So a conclusive statement that Covid-19 was airborne?

18 **A.** Yes.

19 **Q.** Would it ever be practical, ever, at all -- a slightly  
20 different point, but would it ever have been practical  
21 to advise that FFP3 respirators would be used on  
22 patients, or is that simply impractical given the need  
23 to fit test?

24 **A.** It's not recommended to put FFP3 respirators on patients  
25 because they -- they're not -- they're protective when

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1 wearing but they can exhale, if they have a valve,  
2 actually leak the pathogen you're trying to protect  
3 against. So you would never -- the recommendation is,  
4 and as I understand it, put an FFP3 respirator on  
5 a patient.

6 **Q.** That includes a very vulnerable patient, for example?

7 **A.** Yes.

8 **Q.** We were speaking earlier about the March 2020 guidance  
9 and what informed it. The guidance itself was also  
10 adapted, I think it says on its head, from the pandemic  
11 influenza guidance; is that right?

12 **A.** That's correct.

13 **Q.** You've described in your statement that while you were  
14 at Health Protection Scotland you led a working group  
15 commissioned by the Department of Health and Social Care  
16 to review pandemic influenza control guidance; is that  
17 right?

18 **A.** That's correct.

19 **Q.** Does it follow that of course Covid-19 was a different  
20 virus to pandemic influenza or influenza generally, but  
21 the principles that were derived from that review on how  
22 to deal with a pandemic and the pandemic influenza virus  
23 also applied to the way in which you would approach  
24 Covid-19, given that that guidance then was adapted for  
25 the Covid-19 guidance?

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1 use of PPE but you weren't informed by the actual level  
2 of supply of PPE?

3 **A.** That's correct.

4 **Q.** Can we look, please, at INQ000489907, page 31,  
5 paragraph 6.33. This is a passage from Dame Jenny  
6 Harries', who was the Deputy Chief Medical Officer,  
7 witness statement, and she is discussing the selection  
8 of aerosol-generating procedures in March 2020.

9 She says, four lines up:

10 "The list of AGPs included chest compressions."

11 Don't worry about that:

12 "There were, at that time, extremely constrained  
13 supplies of respirators, and so they were prioritised  
14 for staff performing the highest risk activities.  
15 Alongside this, there was a recommendation that FFP2s  
16 also be sourced."

17 Okay. So she seems to be saying here that the  
18 constrained supplies of respirators directly impacted on  
19 the designation of aerosol-generating procedures, which  
20 would suggest that supply did influence IPC advice. So  
21 she seems to be saying that she has a slightly different  
22 view to what you say the UK IPC cell's view was; is that  
23 correct?

24 **A.** So the recommendation in the guidance at that time was  
25 not to do with supply but the recommendation was to wear

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1 **A.** Yes.

2 **Q.** You say in your statement at paragraph 89 that one of  
3 the conclusions of the review was that, during  
4 a pandemic, supplies of RPE and PPE may become scarce,  
5 making it essential to avoid unnecessary or  
6 inappropriate use.

7 This is a principle that it appears to apply to all  
8 pandemics; is that right?

9 **A.** Correct.

10 **Q.** You go on to say in your witness statement that the  
11 supply of PPE did not influence the IPC advice provided  
12 by the UK IPC cell?

13 **A.** That is correct.

14 **Q.** Can I try to understand the two points you're making  
15 there: are you drawing a distinction between being  
16 guided generally by a principle that it's important to  
17 avoid inappropriate and unnecessary use of PPE and RPE,  
18 with the fact that you weren't monitoring the numbers of  
19 supplies of PPE to inform the guidance that you gave?

20 **A.** Sorry, could you --

21 **Q.** You say as a general principle it's important to avoid  
22 unnecessary or inappropriate use of PPE but you then say  
23 that the supply of PPE didn't influence the advice you  
24 gave. Are you saying that you were informed by the  
25 general principle that you need to avoid inappropriate

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1 a respirator if aerosol-generating procedures were being  
2 performed and, of course, they would be the highest-risk  
3 activities, in terms of airborne transmission. That was  
4 a decision that was endorsed by NERVTAG and ACDP, as  
5 stated there, and the Health and Safety Executive.

6 **Q.** But she seems to be saying here that what happened,  
7 because there were constrained supplies, it was  
8 necessary to prioritise the highest possible risk areas  
9 as being aerosol-generating procedures. The logical  
10 inference from that is that, if you had more supplies,  
11 you may not have needed to do that?

12 **A.** That --

13 **Q.** Is that right?

14 **A.** That was not the case.

15 **Q.** So you disagree with her?

16 **A.** I think it's a different context. I'm not disagreeing.  
17 I think what she's saying there, that if we had got to  
18 a point -- and I recognise that -- that supplies were  
19 limited, then they might have had to prioritise and what  
20 she, Dame Jenny is saying in that regard is that staff  
21 performing the highest risk should have those supplies  
22 made available to them. I don't recall us ever being in  
23 that position and the -- and that was not what was  
24 recommended in the IPC guidance.

25 **Q.** Thank you. Of course, we do know that the way in which

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1 the guidance -- that can come down -- was approached was  
2 that the highest risk aerosol areas, if I can put it  
3 that way, were aerosol-generating procedures and where  
4 you were dealing with those, or in AGP hotspots, you  
5 needed to wear respirators?

6 **A.** Correct.

7 **Q.** So this, I think, reflects the understanding, does it  
8 not, that AGPs were thought at that time -- and they may  
9 well be thought by you to continue to be the case -- to  
10 generate a higher number of aerosols than activities  
11 such as breathing or talking or coughing or sneezing; is  
12 that right?

13 **A.** Correct.

14 **Q.** The Inquiry has received evidence from organisations  
15 such as the Royal College of Anaesthetists, the Faculty  
16 of Intensive Care Medicine and the Association of  
17 Anaesthetists, and I just want to take you to a passage  
18 from their witness statement that they've set out, it's  
19 INQ000389244, paragraph 291 to 292. They talk about  
20 here that frontline healthcare workers in general were  
21 at higher risk of infection, but:

22 "... anaesthetists and intensivists seemed  
23 relatively less affected, both in terms of infection and  
24 Covid-19 related mortality."

25 They then cite a study from April 2020 -- and  
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1 they are performing, how ill the patients are, the  
2 severity of the pathogen, in terms of the approach that  
3 they take. So we were giving guidance in terms of what  
4 infection prevention and control measures to put in  
5 place.

6 **Q.** I understand what you're saying there but, if those  
7 working in ICU and HCU and performing aerosol-generating  
8 procedures were actually being protected to a greater  
9 extent -- in terms of infection rates, there were less  
10 infection rates among those than those who were working  
11 on wards, for example, with Covid-19 patients -- would  
12 that not indicate that maybe the protective factor of  
13 the PPE that they were using was part of the  
14 contributing factor to them being better protected?

15 **A.** I go back to the previous discussion response. Trying  
16 to extrapolate out that that was a defining factor that  
17 they were wearing an FFP3 respirator is quite difficult,  
18 it's --

19 **Q.** Thank you, that's clear, can we take that down, please.  
20 A linked issue is really the distinction that is drawn  
21 between aerosol-generating procedures and other  
22 procedures. We've heard the evidence of Professor  
23 Beggs, who doesn't think there is a huge distinction to  
24 be drawn between them, and I think the British Medical  
25 Association in their witness statement called it a false  
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1 I appreciate that's very early on and perhaps not the  
2 most comprehensive in terms of how lengthy it is --  
3 where they talk about 119 deaths of healthcare workers  
4 and no deaths found among anaesthetists and  
5 intensivists. Then in the reasons being explored they  
6 talk about the use of higher performing PPE.

7 So I suppose the question is this: if it was the  
8 case that those using higher performing PPE were dying  
9 at lower rates and were infected at lower rates, did  
10 that not indicate that, in fact, it was necessary to  
11 spread the use of higher performing RPE and PPE more  
12 widely among other areas?

13 **A.** No.

14 **Q.** Why?

15 **A.** Because the risks are not the same in different areas,  
16 the risks were clearly different in those AGP hotspot  
17 areas and intensive care units but providing routine  
18 care did not -- may not provide the same risk. But  
19 I think risk assessment is the approach that we also put  
20 within the guidance for healthcare organisations who are  
21 well versed in performing risk assessments on  
22 a day-to-day basis. Covid-19 is not the only pathogen  
23 that we deal with in our healthcare settings, we are  
24 dealing with infections all of the time, and clinicians  
25 will make risk assessments depending on the tasks that  
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1 dichotomy. So do you accept that there is or began to  
2 be, at least, some way into the pandemic, a reasonable  
3 body of scientific evidence which said, in fact, there  
4 isn't a distinction between the activities that do and  
5 don't produce aerosols in terms of aerosol-generating  
6 procedures. You accept that as a reasonable body of --

7 **A.** Yes.

8 **Q.** I suppose then, of, course, the obvious question is:  
9 would it then have been appropriate, if that was the  
10 case and you accepted that to be the case at the time,  
11 to have more widely recommended the use of respirators?

12 **A.** Sorry, I don't follow.

13 **Q.** If, in fact, you accepted there is a reasonable body of  
14 scientific evidence that says aerosols are generated in  
15 a number of different circumstances, not just  
16 aerosol-generating procedures; if that's an accepted  
17 scientific view, does it follow that respirators should  
18 be more widely used?

19 **A.** No.

20 **Q.** Why not?

21 **A.** Because I think respiratory droplets or respiratory  
22 particles that come out of your mouth, they do vary, so,  
23 you know, and we go back to that, the droplets, you  
24 know -- so there are multiple different sizes. I think  
25 what we recognise is that there is now probably  
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1 a continuum of those droplet sizes and not the  
 2 demarcations that we had before. So, again, it doesn't  
 3 follow that FFP3 respirators should be worn for routine  
 4 activity when there are other measures that can be put  
 5 and source control, so patients wearing an FRSM, the  
 6 staff are wearing an FRSM, and other infection  
 7 prevention and control measures are put in place.  
 8 I don't -- the FFP3 wearing is not the silver bullet to  
 9 prevent an infection.

10 **Q.** I understand what you're saying about other measures  
 11 but, of course, you acknowledged earlier on in your  
 12 evidence that using an FRSM won't protect against the  
 13 inhalation of aerosols and so, if aerosols are generated  
 14 in lots of other areas, using that won't protect you in  
 15 the way that a respirator will, so why not use  
 16 a respirator in those circumstances, if there is aerosol  
 17 risk of transmission?

18 **A.** We're trying to control all of the factors, it's not  
 19 just down to the PPE, so the kind of environmental  
 20 factors and other, and when, you know, viral load is  
 21 important as well and there's likely more viral load in  
 22 a heavy droplet that comes out of someone's mouth, that  
 23 will fall quite quickly, rather than fine aerosols that  
 24 will remain suspended through the air, and FFP3s are not  
 25 a comfortable piece of kit to wear and, in certain

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1 initial identification of aerosol-generating procedures  
 2 for the Covid-19 guidance?

3 **A.** The initial AGP or aerosol-generating procedure list was  
 4 published, as I recall, in the first UK IPC guidance  
 5 document by Public Health England and that AGP list was  
 6 based on the aerosol-generating procedure list that was  
 7 in the national manual for Scotland.

8 **Q.** I think that's correct. I think can we have a look  
 9 at -- I think that guidance was 13 March or something  
 10 around then --

11 **A.** Around.

12 **Q.** -- that was issued. Can we look at an email chain,  
 13 INQ000381163. This is an email chain which you're  
 14 involved in, in early March 2020. If we start, you can  
 15 see right at the bottom there, there's an email from  
 16 Susan Hopkins of Public Health England, Dr Susan  
 17 Hopkins -- Professor Hopkins I believe it is. If we go  
 18 down to the next page on page 6, we can see what she  
 19 said. Sorry, apologies, yes, here we go, it says here:  
 20 "The list I submitted to Keith [I think this is  
 21 Keith Willett of NHS England]", is as follows, and we  
 22 can see a list of them, non-invasive ventilation,  
 23 et cetera.

24 The one I want to ask you about is there is  
 25 cardiopulmonary resuscitation, CPR, included on her list

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1 circumstances, you know, we had frontline nurses telling  
 2 us that they found it difficult to breathe.

3 So I think it's important that we look to those  
 4 other hierarchy of control measures that the Health and  
 5 Safety Executive are set out about, you know, how we --  
 6 processes that we put in place, the environment, the  
 7 ventilation, notwithstanding that PPE is important, but  
 8 it's not the silver bullet.

9 **Q.** If, however, we are going to distinguish between the  
 10 procedures which do generate aerosols and those which  
 11 don't, and I know what you say about respirators not  
 12 being the only way of protecting against aerosols but,  
 13 if we are going to say that some procedures are  
 14 aerosol-generating procedures and, therefore, recommend  
 15 a higher level of respiratory protection in those areas,  
 16 do you agree that it's important that those procedures  
 17 that are designated as AGPs are correctly so identified?

18 **A.** Yes.

19 **Q.** There are two disadvantages, aren't there, both in terms  
 20 of wrongly categorising a procedure, which is, in fact,  
 21 not aerosol generating and failing to designate one  
 22 which is, in fact, aerosol generating?

23 **A.** Sure.

24 **Q.** Do you recall being involved separately perhaps to your  
 25 role in the IPC cell, or in fact in addition to, in the

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1 and then, if we go back to the email chain and we can  
 2 see that you then provided a list above. This was  
 3 a subsequent email from you later that evening, where  
 4 you list out a series of procedures that were in the,  
 5 I think, NIPCM in Scotland?

6 **A.** Correct.

7 **Q.** The National Infection Prevention and Control Manual.  
 8 We can see here, omitted from this list is CPR; is that  
 9 right?

10 **A.** That's correct.

11 **Q.** We can see then that Dr Hopkins subsequently says thank  
 12 you and you use that list, and that's the list that then  
 13 makes its way into the guidance, isn't it?

14 **A.** Yes.

15 **Q.** So can I just understand, do you know if this  
 16 conversation where Dr Hopkins proposed one list of  
 17 procedures and you then proposed another, as was  
 18 reflected within the NIPCM in Scotland, was in fact the  
 19 genesis of the list of aerosol-generating procedures  
 20 that ended up on the guidance?

21 **A.** Yes.

22 **Q.** If we can then also go to another document, which is  
 23 INQ000381182.

24 This is an email of 25 March 2020, and there are  
 25 a number of individuals, senior clinicians and -- in

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1 senior roles in NHS, I think in Public Health England at  
2 least.

3 Then if we go to page 3 of this document, we can see  
4 it says "Dear All" and there's a read-out of a meeting  
5 "this morning". Then if you just go to the bullet point  
6 that is just second from the bottom, this is  
7 25 March 2020, here it says:  
8 "Chest compressions also represent an aerosol  
9 generating procedure."  
10 So what I want to clarify, first of all, with you,  
11 is that chest compressions and CPR didn't end up in the  
12 guidance, we know that, but as of 25 March 2020, and  
13 indeed of Dr Hopkins' initial list, there were senior  
14 clinicians who did think that CPR or chest compressions  
15 were procedures that should be designated as AGPs. Do  
16 you agree with that statement?

17 **A.** Yes.

18 **Q.** Ultimately, you're right, the situation was reviewed by  
19 NERVTAG, and they said essentially that whilst chest  
20 compressions could produce aerosols, that was just in  
21 the same way as breathing or coughing; is that right?

22 **A.** Correct.

23 **Q.** So they considered it wasn't appropriate to designate it  
24 as an AGP?

25 **A.** Correct.

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1 a caveat that the interpretation and the application of  
2 that AGP list was ultimately to be determined at a local  
3 level where specific risks and exposures were better  
4 understood.

5 So I think the first time we ever had an agreed --  
6 well, not an agreed, but we had an aerosol-generating  
7 procedure -- or a list of aerosol-generating procedures  
8 was that that was published in 2016 in the Scottish  
9 infection control manual, and they teased out those  
10 parts of the procedure that could be aerosol generating,  
11 so I suppose they dissected CPR whereas the WHO and  
12 others just put cardiopulmonary resuscitation down as  
13 one procedure.

14 **Q.** And that would include chest compressions, would it?

15 **A.** Yes.

16 **Q.** Okay, that can come down.

17 Just to summarise, this issue, as I said, caused  
18 some controversy. There was a statement put out by,  
19 I believe, the Resuscitation Council, and they  
20 essentially said that their guidance, contrary to  
21 national guidance, was that you should wear a respirator  
22 and respiratory protective equipment when doing chest  
23 compressions and CPR in its entirety.

24 Can you recognise that the conflicting guidance  
25 between the bodies and the national guidance was an area

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1 **Q.** That can come down, thank you.

2 I just want to just tie this up with one more  
3 document, if that's okay, and go to a document of --  
4 INQ000189351.

5 This is a review that was done by Health Protection  
6 Scotland of the comparison between different countries  
7 and different guidance providers and the way in which  
8 they approached things.

9 If we look at page 13, please.

10 This is the guidance that was given by the European  
11 Centre for Disease Prevention and Control. I think it  
12 says last accessed there, 4 May 2020.

13 Under guidance on AGPs, at the bottom, they do  
14 include cardiopulmonary resuscitation in an AGP in their  
15 guidance.

16 So I just want to understand, this is an area that  
17 caused quite a lot of controversy, wasn't it?

18 **A.** Yes.

19 **Q.** Given that there were a number of clinicians and indeed  
20 the European guidance classifying CPR as an AGP, was it  
21 perhaps not precautionary enough to have not included  
22 CPR as an AGP within the UK guidance?

23 **A.** So that was a decision made by NERVTAG, as you correctly  
24 say, and Public Health England, as I recall, then  
25 published the outcome of the NERVTAG review with

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1 that was unhelpful and perhaps damaged trust in guidance  
2 from healthcare workers?

3 **A.** Yes. But, as I say, I think Public Health England, as  
4 I recall, then put out a published -- you know,  
5 a statement on the back of it then giving local  
6 determination, and I do recall that UK Resuscitation  
7 Council did reply saying that that was a helpful thing  
8 for Public Health England to have done.

9 **Q.** Can I ask you about the way in which the cell approached  
10 evidence generally, and emerging evidence about Covid-19  
11 being transmitted through various different means --  
12 modes, sorry.

13 What was the role of the ARHAI rapid review process  
14 that you relied on, at least partially, during the IPC  
15 cell discussions?

16 **A.** So Scotland had a National Infection Prevention and  
17 Control Manual, and that manual was underpinned by  
18 evidence, reviews on standard infection control  
19 precautions and the basics of transmission-based  
20 precautions, so they had a well established scientific  
21 evidence base for the manual in Scotland. So that  
22 provided a really good foundation for what was then the  
23 pandemic flu guidance for 2019 and was the document that  
24 we adopted.

25 Because Scotland had that infrastructure, it was

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1 helpful to the cell because we did not have that  
 2 structure in England. Initially when I first came into  
 3 post in April 2020 that structure wasn't in place, and  
 4 Wales were using -- they had adopted Scotland's manual,  
 5 and Northern Ireland had something slightly different.  
 6 So Scotland were in a good position to support us with  
 7 some rapid reviews.

8 It wasn't the only place that we were taking  
 9 evidence from. So, as I say, they had the mechanism and  
 10 the structure in place to do that. We were also looking  
 11 at the outputs, as I say, coming from SAGE, NERVTAG and  
 12 the other scientific groups and using that to support  
 13 and translate that evidence into infection prevention  
 14 and control practice, and always making sure that we  
 15 were aligned with WHO guidelines.

16 **Q.** So did relying on this rapid review process reflect  
 17 a process that you would use both pre-pandemic and  
 18 during the pandemic of it being one of a number of  
 19 different ways in which you were assessing evidence?

20 **A.** Correct.

21 **Q.** Do you recall a specific meeting of the UK IPC cell  
 22 which took place on 22 December 2020, and a discussion  
 23 at that meeting about potentially extending the use of  
 24 FFP3 masks that wasn't ultimately proceeded with?  
 25 I think that's right, isn't it?

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1 down, it says:  
 2 "If we increase the use of FFP3 masks we need to  
 3 consider stock availability ..."

4 We touched on supply earlier but is this a comment  
 5 more about examining, if we do extend the use of FFP3s,  
 6 we need to just make sure that that's not going to have  
 7 an impact on putting trusts under additional pressure,  
 8 rather than saying we don't have the stocks?

9 **A.** Yeah, so that wouldn't have been a decision that we  
 10 had -- would have made but, if we had come to  
 11 a consensus agreement that there had been a change in  
 12 the mode of transmission and we were going to move to  
 13 FFP3 masks, then that's something that we would have  
 14 required to escalate across all the UK nations to senior  
 15 clinical leaders, if that was the position to say that  
 16 we think there's a change here this is going to impact  
 17 on use.

18 **Q.** Thank you. Then two comments down, CB there, I think  
 19 that's Colin Brown of Public Health England, he says:  
 20 "Our understanding of aerosol transmission has  
 21 changed. A precautionary approach to move to FFP3 masks  
 22 whilst we are awaiting evidence should be advised."  
 23 So this is, it seems, one of the first points,  
 24 I think, in the IPC cell meetings where someone is  
 25 saying in fact we need to take a precautionary approach

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1 Can we just as a starting point in fact go to  
 2 INQ000398244. I want to actually go to page 3 of this,  
 3 if that's okay.

4 If we can look at some of the discussions that were  
 5 had at this meeting -- as I said, this was a meeting  
 6 where you were discussing the potential to extend FFP3s,  
 7 and you start the conversation on this page and you're  
 8 saying:  
 9 "If patient and staff face mask wearing and other  
 10 IPC measures e.g. decontamination of  
 11 environment/equipment are not being reliably implemented  
 12 as they should be, it does not seem appropriate, in the  
 13 absence of evidence regarding any change in mode of  
 14 transmission, that a change to PPE should be  
 15 recommended ..."

16 So that goes back, I think, to something that you're  
 17 saying today about how it's difficult to disentangle the  
 18 causes of increased transmission --

19 **A.** Correct.

20 **Q.** -- and that you need specific evidence that, in fact,  
 21 the reason for that cause is the increased aerosol  
 22 transmission before recommending FFP3s be more widely  
 23 used?

24 **A.** Or a change in the mode of transmission.

25 **Q.** Then a fourth line down it says -- or fourth comment

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1 and extend the use of FFP3s. Can you explain, were you  
 2 able to reach any sort of agreement on this during this  
 3 meeting, can you recall?

4 **A.** I do recall that we did come to a consensus or  
 5 an agreement, after which we pulled together a position  
 6 statement setting out what our recommendations were, and  
 7 that --

8 **Q.** I apologise, I think there's two meetings, there is the  
 9 22nd and there is the 23rd.

10 **A.** Yes.

11 **Q.** If we carry on to the next page we might be able to see  
 12 what happens in this particular meeting. You say here  
 13 that there's then a comment about fit testing by LI,  
 14 I think that's Laura Imrie, and then I think you say:  
 15 "We appear to have consensus."  
 16 You've listed what you have a consensus on. But you  
 17 don't appear to say you have a consensus, or at least  
 18 it's not within the bullet points on the question of  
 19 whether you need to change the level of PPE/RPE?

20 **A.** That's correct.

21 **Q.** So was this the point, a point at which the UK IPC cell  
 22 wasn't able to specifically agree how to proceed with  
 23 this issue, and I think you then met again the next day;  
 24 is that right?

25 **A.** So there was a consensus, and based on the information

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1 and the discussion that we had, as I recall, was that  
 2 the new variant that we were discussing and whether that  
 3 was going to have an impact on control measures was or  
 4 seemed, to be more transmissible, but what hadn't  
 5 changed was the mode of transmission. So what that  
 6 meant for the cell, in a way, was to be clear that all  
 7 those other precautionary measures were being put in  
 8 place to make sure that infection wasn't being  
 9 transmitted. So again not just down to the FFP3  
 10 respirator, but were organisations checking that those  
 11 precautionary measures that they had in place were  
 12 reliably being applied and monitored actually have been  
 13 followed.

14 **Q.** What you didn't agree with then, at this stage, if I can  
 15 summarise, is that a precautionary approach to move to  
 16 FFP3 masks, whilst awaiting further evidence, should be  
 17 advised; you didn't agree that that was the way to go at  
 18 this stage, did you?

19 **A.** That was a consensus across the UK IPC cell and that was  
 20 what we put into a position statement that we then took  
 21 or it was discussed. I then discussed it with my CNO,  
 22 and that paper was discussed at the UK senior leads  
 23 meeting. So it would have been them that would have  
 24 made a final decision on whether any change should have  
 25 been made.

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1 "LR confirmed today's meeting will be a further  
 2 discussion to reach consensus regarding the IPC/PPE  
 3 guidance following the meeting yesterday to discuss  
 4 [the] new variant", because you were discussing it in  
 5 light of the new variant and the potential  
 6 transmissibility of that variant, I believe; is that  
 7 right?

8 **A.** Yeah, that's correct.

9 **Q.** You then summarise that you think the consensus from  
 10 yesterday was that you don't need to change the  
 11 recommendations. Again, I suppose this goes back to  
 12 what you were saying earlier about the way in which you  
 13 got that assessment of there being a consensus, that was  
 14 your assessment of the way in which the discussions had  
 15 gone; is that right?

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

17 **Q.** We then see, I think, just further discussion of this  
 18 issue to try and reach a formal view from the IPC cell;  
 19 is that right?

20 **A.** That's correct, and I think what that minute draws out  
 21 is that every nation and the leads, the representative  
 22 leads from those nations all were given the opportunity  
 23 to put their position forward. So everybody got the  
 24 opportunity to put their discussion in and we came to  
 25 a general agreement at the end of that.

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1 **Q.** But, of course, you say consensus but that's consensus  
 2 not including Public Health England who had proposed  
 3 a precautionary approach of extending FFP3 masks; is  
 4 that right?

5 **A.** General agreement but, of course, there was the checks  
 6 and balance in place that, when it went it the UK senior  
 7 clinical leads to discuss, they could have decided that  
 8 that was not the right approach and that we should take  
 9 a precautionary approach, in which case we would have  
 10 changed the IPC guidance to reflect that.

11 **Q.** Well, when you say "clinical leads", do you mean after  
 12 this discussion, this was escalated to any particular  
 13 individual?

14 **A.** Yeah. So there was a UK senior clinical leads group,  
 15 which was CMOs and CNOs, and other national clinical  
 16 directors from across the UK and UKHSA Public Health  
 17 England were a member of that group.

18 **Q.** Then I think do you remember if this happened, the  
 19 escalation, after this meeting or after the next  
 20 meeting? Because I want to go to the next meeting that  
 21 happened the next day, and that's INQ000398242. Here's  
 22 page 2 of this.

23 So we've just seen what you were summarising before.  
 24 You said that you considered there was a consensus. You  
 25 start this meeting saying, this is three lines down:

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1 **Q.** So if we look at the bottom of the page there, it says  
 2 Northern Ireland were invited to present their position,  
 3 and it says:  
 4 "In the absence of robust evidence to support the  
 5 move, CM felt that colleagues might think that they have  
 6 not been appropriately protected with what has been  
 7 previously recommended."  
 8 Two points there: again, does this not come back to  
 9 the issue of requiring robust evidence to justify  
 10 a change in a way that perhaps wasn't the case earlier  
 11 on in the pandemic for other modes of transmission?

12 **A.** I can't speculate as to --

13 **Q.** What was meant by --

14 What about the fact that colleagues might have  
 15 thought that they might not be protected with what had  
 16 previously been recommended. Do you think that  
 17 influenced the way -- was the fear that colleagues might  
 18 have thought they weren't protected influential in terms  
 19 of any decision-making you made.

20 **A.** Absolutely not, and I come back to there was checks and  
 21 balances in place and that if our UK senior clinical  
 22 leaders had thought or Public Health England, UKHSA had  
 23 thought that the guidance that was drafted out in the  
 24 document was incorrect, then I'm sure that they would  
 25 have made us aware of that.

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1 Q. If we can just continue through some of these comments,  
2 we can see there's more discussion, PHE are invited to  
3 present their position and they then continue to say  
4 they're recommending FFP3s in all medium/high-risk  
5 pathways, irrespective of AGP. So they're continuing to  
6 make that statement.

7 To summarise, in essence, the cell doesn't agree  
8 with that decision and the consensus you then take is  
9 that everyone else, I think, except, predominantly PHE,  
10 considers that that shouldn't be the case; is that  
11 right?

12 A. So there was general agreement, there was a paper  
13 produced, which was discussed at the UK IPC senior leads  
14 group, and the decision was made there.

15 Q. The way in which this was resolved though was that the  
16 IPC cell didn't endorse the PHE position, did it?

17 A. I don't think it was about endorsement. We had  
18 a discussion, and the consensus agreement; the broad  
19 agreement was that we didn't need to -- the mode of  
20 transmission had not changed and, therefore, we weren't  
21 going to recommend the use of FFP3 respirators more  
22 broadly than what was already stated in the guidance.  
23 But what we did do was strengthen some of the  
24 information round about risk assessments and pointing to  
25 the other precautionary measures to make sure that they

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1 controls. If an unacceptable risk of transmission  
2 remains following this risk assessment", et cetera,  
3 et cetera for now.

4 Can we just deal with hierarchy of controls. You've  
5 mentioned it before. What is the importance of the  
6 hierarchy of controls?

7 A. I think the key thing with the hierarchy of controls is  
8 that we try -- or the aim is to maximally mitigate risk  
9 for as many people as possible without it getting down  
10 to an individual level where it comes down to personal  
11 protective equipment. So it's dealing with the  
12 engineering controls, process --

13 Q. It may help -- you've put a diagram in your witness  
14 statement, if I put it up it might help you.

15 A. Thank you.

16 Q. It's at paragraph 60 of your witness statement. You can  
17 then talk us through, I think, how that assists. Yes,  
18 there we go.

19 A. Yeah. So the whole point is system wide to try to  
20 "eliminate or reduce exposure to risks", as stated  
21 there. Elimination with a respiratory virus, not always  
22 possible, but measures were put in place, for example  
23 telemedicine, which could be, you know, administrative  
24 controls as well, so that people weren't actually coming  
25 into healthcare environments, and engineering controls

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1 were being robustly implemented.

2 Q. Ultimately, did Public Health England, despite their  
3 position in this cell meeting, where they are there  
4 pushing for just to put it in colloquial terms a move  
5 for FFP3 masks to be used more widely did they  
6 ultimately still publish the guidance that was proposed  
7 as a result of the consensus?

8 A. That's correct.

9 Q. So they didn't decide to take a different view and  
10 perhaps overrule the IPC cell but your view is they  
11 could have done if they had wanted to?

12 A. Correct.

13 Q. You mentioned just before the role of risk assessments  
14 and you spoke about that and you say that they had  
15 an important role in terms of properly applying  
16 infection prevention and control measures within  
17 healthcare settings.

18 I want to just quickly look at the guidance that  
19 directly refers to risk assessments.

20 This is INQ000271659 and the fifth page.

21 At the bottom there it says -- this is June 2021, to  
22 be absolutely clear -- it says:

23 "To ensure maximum workplace risk mitigation,  
24 organisations should undertake local risk assessments  
25 based on the measures as prioritised in the hierarchy of

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1 we've talked about such as ventilation.

2 So by putting different things in place and  
3 different administrative controls, the way that people  
4 work, and trying to maximally mitigate the risk for all  
5 healthcare workers and patients in that environment is  
6 far more conducive to health and safety and the  
7 wellbeing of everyone than you having to use PPE. But  
8 I do recognise that -- what we said about residual risk,  
9 individual risk assessments are important --

10 Q. Utilising this framework?

11 A. Use -- yeah.

12 Q. Of course I think you do also recognise that some of  
13 these steps, elimination perhaps even substitution --

14 A. Yeah.

15 Q. -- is simply not possibly, especially if you are  
16 providing close quarters care as a healthcare worker.  
17 In those circumstances it is going to be necessary to  
18 use protective equipment, isn't it, personal  
19 protective --

20 A. Yes.

21 Q. If we go back to the guidance that we were looking at  
22 before, it's a similar point that we touched on earlier  
23 but I just want to understand it in this context, one of  
24 the things that was suggested, again in doing a risk  
25 assessment, it says:

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1 "If an unacceptable risk of transmission remains  
2 following the risk assessment, it may be necessary to  
3 consider the extended use of RPE for patient care in  
4 specific situations. The risk assessment should include  
5 an evaluation of the ventilation in the area ..."

6 We spoke earlier about ventilation being a measure  
7 that was relevant to airborne transmission but certainly  
8 in at least a paper from SAGE they considered it was  
9 only that mode of transmission that it was relevant for,  
10 so was this guidance an acknowledgement of the growing  
11 risk of airborne transmission, because it's directly  
12 pointing to ventilation as a measure that might need to  
13 be taken?

14 **A.** So local -- sorry, do you mean in terms of the hierarchy  
15 of controls?

16 **Q.** In terms of directing a risk assessment that looks at  
17 ventilation, was that because there was, by this stage,  
18 in June 2021, an acceptance that there was an increased  
19 risk of the virus existing in the air?

20 **A.** I would say not specifically. I think the hierarchy of  
21 controls and risk assessments are something that should  
22 be inherent in healthcare organisations. No healthcare  
23 facility is free of risk and therefore risk assessment  
24 and local risk assessments are vital to adapt infection  
25 prevention and control measures to specific environments

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1 is essentially making them make the decision about the  
2 level of risk rather than guiding them as to how to  
3 protect against the virus?

4 **A.** I don't think it's directing them to do it on their own.  
5 I think there is guidance there to do it. Risk  
6 assessment is something that is, you know, ingrained  
7 within healthcare systems, it's set out in the Health  
8 and Social Care Act for infection prevention -- the code  
9 for infection prevention control risk assessment is  
10 fundamental within all of that and in the day-to-day  
11 business and work of organisations.

12 What we did do, recognising that it seemed to be  
13 a challenge, was we developed tools for various  
14 different settings, be it acute care settings, GP  
15 practices, dental practices, to support organisations or  
16 employers to undertake a risk assessment in accordance  
17 with the hierarchy of controls.

18 We also had teams within or personnel, colleagues  
19 within the national IPC team who were part of a support  
20 mechanism who would go out and help organisations where  
21 they were struggling or where they had outbreaks of  
22 infection to help them undertake some of the risk  
23 assessment and put mitigating measures in place.

24 **Q.** Thank you. Just in terms of these risk assessments,  
25 they appear to be -- this is a general recommendation

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1 and specific healthcare settings, so you're looking to  
2 identify what are the unique infection risks in this  
3 area and then ensure compliance with the recommendations  
4 and guidance and that those are being reliably applied.

5 **Q.** In terms of directing the need for risk assessments, was  
6 this something that was directed at organisations,  
7 employers or individual healthcare workers?

8 **A.** At different levels -- I mean, for employers, the Health  
9 and Social Care Act for healthcare premises includes  
10 within that risk assessments. I mean, our clinicians do  
11 risk assessments probably every day when they are seeing  
12 their patients and managing their patients. I think  
13 risk assessment of the environment will include many  
14 people. It's an employer's responsibility to ensure  
15 health and safety in the workplace. So the risk  
16 assessments would be carried out by a multidisciplinary  
17 team of individuals including ventilation engineers and  
18 ensuring that that approach was taken.

19 **Q.** The Inquiry's heard some evidence and has received some  
20 evidence that there are challenges in terms of actually  
21 conducting risk assessments and that sometimes guidance  
22 that requires an additional step to be taken in terms of  
23 then doing a risk assessment can be difficult for  
24 healthcare workers to actually implement. Do you accept  
25 that directing an organisation to do a risk assessment

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1 and one of the things the Inquiry has heard about is the  
2 disproportionate infection rates among some healthcare  
3 workers, including those from ethnic minorities. This  
4 wasn't a particular risk assessment that was specific to  
5 them or those particular workers or any particular  
6 workers, was it; it was a general risk assessment?

7 **A.** A general risk assessment.

8 **Q.** The IPC cell didn't, did it, delve into providing  
9 specific advice about how to account for specific  
10 inequalities or anything like that, that wasn't the  
11 remit of the IPC cell, was it?

12 **A.** No, but we did, with the guidance, what we did do was  
13 a complete Equality Diversity Impact Assessment,  
14 an EHIA -- they call it Health Impact Assessment -- for  
15 the guidance initially and then we would review that  
16 when we were updating the guidance documents.

17 **MR FIREMAN:** Thank you, I think that might be an appropriate  
18 time.

19 **LADY HALLETT:** Certainly, I shall return at 3.30.

20 (3.15 pm)

(A short break)

22 (3.30 pm)

23 **LADY HALLETT:** Mr Fireman.

24 **MR FIREMAN:** Thank you.

25 Dr Ritchie, can I just clarify something on the

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1 basis of evidence you gave earlier on. You said in your  
 2 evidence, when you were talking about the need to  
 3 control environmental factors as well as others, and you  
 4 talked about viral load is also important, and you said  
 5 that it's likely more viral load is in a heavy droplet  
 6 that comes out of someone's mouth that will fall quite  
 7 quickly rather than fine aerosols that remain suspended  
 8 in the air. Can I clarify, that's your view, is it,  
 9 that it's more likely that there will be more viral load  
 10 in a heavy droplet than there will be in an aerosol?  
 11 **A.** Correct.  
 12 **Q.** Are you aware that Professor Beggs told the Inquiry that  
 13 he considers the majority of exhaled viruses are in fact  
 14 found in fine aerosols?  
 15 **A.** I respect that opinion and I am not an aerobiologist or  
 16 scientist.  
 17 **Q.** It's an area where you disagree, though, is it?  
 18 **A.** Yes.  
 19 **Q.** On what basis did you come to the view that a heavy  
 20 droplet contained a higher level of infectious particles  
 21 than an aerosol, given you're not a physical scientist  
 22 expert?  
 23 **A.** My understanding would be that in a larger droplet and  
 24 in a heavy droplet there is likely to be more viral  
 25 particles, whereas in a finer droplet it's going to dry

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1 **A.** I'm not sure that I can answer that.  
 2 **Q.** Okay.  
 3 Can I ask you about the changes to guidance,  
 4 healthcare guidance, and the language that was used  
 5 within healthcare guidance, and just taking an example,  
 6 but it's cited within Professor Hopkins' statement, if  
 7 we can go to that.  
 8 It's INQ000410867, and it's paragraph 353.  
 9 So here she's describing a change that was made to  
 10 the IPC guidance where it said:  
 11 "... where a risk assessment indicates it, RPE  
 12 should be available to all relevant staff. The risk  
 13 assessment should include evaluation of the ventilation  
 14 in the area, operational capacity, and prevalence of  
 15 infection/new SARS-CoV-2 variants of concern in the  
 16 local area. Staff should be provided with training on  
 17 correct [route]."  
 18 Then it goes on to describe other additional edits  
 19 that were made, including:  
 20 "... removing the word 'wholly' in relation to  
 21 transmission and use of RPE as follows ..."  
 22 And if we look at the next paragraph, please, if we  
 23 could find that -- yes. If we could just -- the top  
 24 bit, "A respirator". It says:  
 25 "A respirator with an assigned protection factor

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1 out quite quickly, so the viability of that causing any  
 2 kind of infection subsequently is less so. But I think  
 3 going back to the other environmental factors, those  
 4 droplets and aerosols that, you know, do finally settle  
 5 on surfaces, it's important that cleaning of equipment  
 6 and the environment is just as important as other  
 7 measures.  
 8 **Q.** If you are wrong about your assessment of which  
 9 particles contain a greater amount of viral load in  
 10 them, and in fact it's the case that aerosols contain  
 11 the highest number of viral load, or the highest level  
 12 of viral load, would that influence the guidance that  
 13 you would give in terms of use of respirators, if in  
 14 fact they are in aerosols to a higher -- infectious  
 15 particles are in aerosols to a higher degree, would that  
 16 influence the guidance as to when to use FFP  
 17 respirators?  
 18 **A.** I'm understanding then -- it's almost confusing two  
 19 separate things. So the guidance currently for droplet  
 20 protection is FRSMs.  
 21 **Q.** Yes, if in fact -- this is probably my fault, I didn't  
 22 phrase that brilliantly, but in fact it's the case  
 23 that there is a higher viral load in aerosols than in  
 24 droplets, would you recommend that FFP3 respirators be  
 25 used more widely, if you're wrong about your belief?

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1 (APF) 20, that is, an FFP3 respirator (or equivalent),  
 2 must be worn by staff when: caring for patients with  
 3 a suspected or confirmed infection spread ..."  
 4 And then what was "wholly" removed:  
 5 "... by the airborne route ..."  
 6 So it previously says, does it not, that you should  
 7 use a respirator where you're caring for a patient with  
 8 a suspended infection that is from a virus spread wholly  
 9 by the airborne route; is that right?  
 10 **A.** Yes.  
 11 **Q.** So with respect to Covid-19, it wasn't the case at any  
 12 point, I don't think, that it was said that it was  
 13 wholly spread by the airborne route, and so it wouldn't  
 14 be the case, interpreting this guidance, that you're  
 15 supposed to use a respirator?  
 16 **A.** Correct.  
 17 **Q.** But by removing the word "wholly", Professor Hopkins  
 18 explains that this caused confusion because then it just  
 19 said "spread by the airborne route" and it could be  
 20 interpreted that Covid was spread by the airborne route  
 21 and so you should use a respirator when caring for  
 22 Covid-19 patients; is that right?  
 23 **A.** That's correct.  
 24 **Q.** Simple question: was it confusing to use language such  
 25 as "wholly" and then to remove it entirely?

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1 **A.** I accept that it probably was confusing. Again, that  
2 was wording, "wholly", being a predominant mode that we  
3 had used in earlier guidance. We had feedback from  
4 frontline staff, other stakeholders saying that that  
5 word wasn't helpful, so in response to that we removed  
6 it, and then that caused more confusion.

7 So, yes, I accept that terminology/language, is  
8 something -- having a standardised and consistent  
9 language base will be important going forward,  
10 absolutely.

11 **Q.** I think in fact what happened was the word  
12 "predominantly" was in fact added in to replace the fact  
13 that there was no word, but "predominantly" -- I mean,  
14 how did you expect a healthcare worker to know whether  
15 or not Covid-19 was spread predominantly by the airborne  
16 route? Is it for them -- if the guidance doesn't  
17 expressly say that it is, how are they to know whether  
18 or not it is?

19 **A.** Well, I don't think the guide -- the guidance didn't  
20 express that it was predominantly spread by the airborne  
21 route, so it did cover other contact measures, so the  
22 guidance wasn't just about the airborne route, the  
23 guidance covered contact, droplet and airborne. So  
24 invariably those transmission routes do not happen in  
25 isolation. And we talked earlier just about the

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1 UK IPC guidance.

2 **Q.** Okay. Can you then -- just generally speaking, talking  
3 about the fact that in guidance and healthcare-wide  
4 guidance generally, the phrases such as "wholly spread  
5 by the airborne route", "predominantly spread by the  
6 airborne route" and no phrases at all about how it was  
7 spread were used -- understand how that of course caused  
8 issues in terms of interpretation with respect to  
9 Covid-19?

10 **A.** Sure.

11 **Q.** Do you have any thoughts about how to avoid that sort of  
12 thing in the future?

13 **A.** I think that it's agreeing the terminology and the  
14 definitions and being as clear and give clarity as much  
15 as we possibly can going forward in guidance documents.  
16 As I said, earlier, WHO have made a start on that by  
17 their published document on airborne transmission risk  
18 where they describe new terminology. I don't believe  
19 that that has been signed up to by the UK as yet, but  
20 I do think it's important that the national and  
21 international guidance is aligned with the language that  
22 we use, because it's important that, you know,  
23 healthcare workers understand what they need to do to  
24 keep themselves and their patients safe.

25 **Q.** Would one way through this be to have clarity in terms

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1 environmental impact, that if you've got droplet spread  
2 or airborne spread you invariably will have contact  
3 spread as well, if you don't keep the environment clean.  
4 So it's a very complex number of procedures, so the  
5 standard infection control procedures and the  
6 transmission-based precautions.

7 **Q.** What happens is that there's the -- the chain of events,  
8 as I understand it, is it goes from -- in fact it might  
9 help if we look at INQ000502072, which is a document  
10 that's been produced by the Inquiry's trio of experts,  
11 Shin, Gould, Warne, who summarise changes to the  
12 guidance.

13 If we just look at what happens afterwards, if we go  
14 down and look at 15 March 2020, it says that what  
15 happened was it was then changed to saying  
16 "predominantly by the airborne route".

17 So if I can just summarise this, what happened is it  
18 started off from January 2020 saying "wholly spread by  
19 the airborne route", it then changed to be removed and  
20 there was no word at all there, it just said "spread by  
21 the airborne route", and it then said "predominantly  
22 spread by the airborne route". Is that right in terms  
23 of the chronology?

24 **A.** So just to clarify, so the highlighted 15 March document  
25 is a UKHSA guidance document. I don't think that's the

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1 of the guidance making clear exactly how it is  
2 considered that a virus is spread so that when  
3 interpreting whether or not something is or isn't spread  
4 by the airborne route we know what the guidance says  
5 about how the virus is spread?

6 **A.** Yes.

7 **MR FIREMAN:** Thank you.

8 Those are all my questions, my Lady.

9 **Questions from THE CHAIR**

10 **LADY HALLETT:** Just before we turn to the core participants.

11 Going back to the routes of transmission,  
12 Dr Ritchie, you've been asked a little about this, but  
13 where there is uncertainty, would you agree that the  
14 precautionary principle should be applied?

15 **A.** I do agree that the precautionary principle should be  
16 applied. That is a number of measures, in its broadest  
17 term, so again I don't think it's just one thing. So  
18 the silver bullet of the FFP3 is the answer and the  
19 precautionary measure to SARS-CoV-2, I think there are  
20 multiple other interventions from an infection  
21 prevention and control perspective that need to be put  
22 in place, because none of these transmission routes  
23 function in isolation or act in isolation.

24 **LADY HALLETT:** I understand that. It's just that, if you  
25 have uncertainty and there's a possibility and you don't

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1 know yet that the pathogen could be airborne, aerosol --  
2 sorry, aerosol -- we say aerosol because of the  
3 confusing nature of the HCID classification.

4 So you have a possibility it could be aerosol.  
5 Amongst the package of measures, if you're going to  
6 exercise a precautionary principle, wouldn't it be best  
7 to advise the highest level of face mask protection that  
8 is reasonable, in other words the FFP3? Wouldn't it be  
9 best to advise the highest reasonable measure of face  
10 mask?

11 **A.** But not every situation is the same, so in those higher  
12 risk areas then where people are exposed to aerosol or  
13 aerosols, so you need aerosol precautions, then  
14 absolutely, but in other given routine care, when the  
15 predominant mode was understood to be droplet and it  
16 could be aerosol, if aerosol-generating procedures were  
17 performed, then FFP3 respirators might not be required.

18 And I think this goes back to risk assessment, it's  
19 putting in place things that are risk based and  
20 proportionate to keep healthcare workers safe and  
21 patients safe, but FFP3 respirators are not comfortable  
22 to wear, and if you -- in setting that position with  
23 FFP3 respirators, it's then saying, well, when do you  
24 step down from that? And we're now living with Covid-19  
25 as well.

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1 "Actually, there's science there or there's evidence  
2 there or we are telling you as experts, IPC cell, that  
3 you are wrong", we would have moved to a different  
4 position.

5 **LADY HALLETT:** In December 2020 when you had that meeting to  
6 which Mr Fireman took you, you had advice from the  
7 Public Health England representatives on the cell that  
8 the -- I'm going to call them "F3 respirators" should be  
9 used, and that advice was not accepted, the consensus  
10 that the cell reached was not to go with that  
11 recommendation. I mean, Public Health England has some  
12 highly qualified scientists who work for it, doesn't it,  
13 or it did have some highly qualified scientists; on what  
14 basis did the cell not accept that advice from Public  
15 Health England?

16 **A.** So we had a discussion across all four nations. If  
17 Public Health England had felt strongly that we, again,  
18 were wrong with the broad consensus that we had come out  
19 with, and that the position statement that we put  
20 together with recommendations of not to move to FFP3  
21 respirators for all, they could, as the lead  
22 organisation for infectious diseases in England, have  
23 trumped our decision and said "We're moving", and that  
24 consensus statement and position statement that the cell  
25 put to the UK senior leads group has Public Health

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1 So I think there are many, there are multiple  
2 factors that need to be considered rather than just  
3 moving to that position, in the absence of that evidence  
4 that it is airborne to put everyone in an FFP3  
5 respirator, or all our healthcare workers.

6 **LADY HALLETT:** But the premise of my question was there is  
7 uncertainty, so the uncertainty means we don't yet know  
8 the source of transmission, and what I don't really  
9 understand is that the IPC cell seems to have become  
10 wedded to the idea that it was droplet and hadn't really  
11 thought about whether they should be exercising the  
12 precautionary principle on the basis it might be  
13 aerosol.

14 **A.** But I don't -- the IPC cell, with respect, I don't think  
15 was wedded to the idea. So initially when it was high  
16 consequence it was declassified, so we were using known  
17 established frameworks. If we had been advised by the  
18 scientific advisers from SAGE, from NERVTAG, that there  
19 was a potential of airborne and that actually we needed  
20 to move, then we would have moved to that position. So  
21 our responsibility and our role and function in the IPC  
22 cell was to translate the scientific evidence and  
23 advice, the outputs from all of those scientific groups  
24 into practical IPC guidelines. If our senior clinical  
25 leaders had not agreed with that position and said

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1 England, UKHSA representation on that group.

2 That document went there, it was discussed and it  
3 was approved. Had they not approved it and come back  
4 and said "Actually you guys are wrong", we would have  
5 changed our guidance. So we weren't there building the  
6 science, we were taking the outputs and the science and  
7 translating that into what would be, as much as  
8 possible, and I accept the terminology, but into  
9 practical guidance for frontline healthcare workers to  
10 put into action.

11 **LADY HALLETT:** On that point, can I go back to something  
12 again Mr Fireman asked you about, which is membership of  
13 the cell. Given you were trying to interpret what was  
14 at times quite complex science and some top notch  
15 experts on SAGE, and the like, and NERVTAG advising you,  
16 do you think now, looking back, that it would have been  
17 better if you had had different experts on the cell?

18 **A.** Potentially now, in hindsight, there is always room for  
19 improvement and I think that goes back to what  
20 I initially said about, had I come in and there had been  
21 a structure, it would have been helpful to know where  
22 everyone was placed in their roles and functions.

23 I think, given the role that we were performing at  
24 that time, we were senior infection prevention and  
25 control clinicians and our role was to translate that

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1 evidence into IPC practical guidance. I think we were  
2 qualified to do that, and we had our senior clinicians  
3 who would have advised us, had that not been right, to  
4 change that guidance. But, yes, in future, I think it  
5 would be really helpful to have more of a structured:  
6 what should the membership look like, where does the  
7 evidence come from. So yeah, lesson learned, thank you.

8 **LADY HALLETT:** Thank you.

9 Finally from me, as you may know, there's one issue  
10 that's particularly concerning to a number of families,  
11 bereaved, pregnant women, and the like, about visiting  
12 restrictions to hospitals. They obviously caused really  
13 serious concern and, given that visiting restrictions  
14 were imposed in the name of infection prevention and  
15 control, did the cell get involved with visiting  
16 restrictions?

17 **A.** No.

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

19 **A.** We would have been asked -- and I wasn't personally  
20 asked, but colleagues in the national IPC team would  
21 have been asked to comment possibly on those visiting  
22 guideline restriction document, but it wasn't a document  
23 that came from the IPC cell.

24 **LADY HALLETT:** Is there a reason for that, given, as I say,  
25 they were imposed in the name of infection control?

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1 You can see a chart on this page, which is headed "[PPE]  
2 suspected/confirmed Covid-19 patient/individual". Then  
3 in the top left-hand corner, you can see:

4 "PPE required by type of transmission/exposure."

5 Then if you look in the bottom row, bottom left,  
6 there is a reference to airborne PPE, and then there's  
7 a sentence at the end:

8 "If an unacceptable risk of transmission remains  
9 following rigorous application of the hierarchy of  
10 control."

11 The RCN is concerned that it wasn't appropriate to  
12 apply the hierarchy of control in this type of  
13 healthcare setting, given the importance of having to  
14 provide care which meets individual patient need. In  
15 the light of that, our question is whether use of this  
16 language, of the hierarchy of control, created a risk  
17 that decisions about granting access to PPE would be  
18 made wrongly and, in particular, would allow the  
19 rationing of PPE?

20 **A.** So that would not have been the intent of guidance. The  
21 hierarchy of controls and risk assessment, as I said  
22 earlier, is something that organisations would be  
23 performing and, as part of the infrastructure of  
24 infection prevention and control, and by saying, you  
25 know, an unacceptable risk remains, goes back to that

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1 **A.** Many things are imposed in the name of IPC and, you  
2 know, it's trying to balance protecting healthcare  
3 workers and staff from infection and being proportional,  
4 in that respect. Not always an easy balance to make  
5 and, hence, the risk assessments are so important in  
6 situations like that because local organisations have  
7 unique situations and can make decisions based on, you  
8 know, what they see and what they think will be right  
9 for their organisation.

10 **LADY HALLETT:** Particular patients may have particular  
11 needs, like a disabled patient --

12 **A.** Sure, absolutely.

13 **LADY HALLETT:** -- and they need a support --

14 **A.** Agreed.

15 **LADY HALLETT:** -- person.

16 Right, Ms Morris, I think you have a couple of  
17 questions for the Royal College of Nursing?

#### 18 **Questions from MS MORRIS KC**

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

20 Good afternoon, Doctor.

21 Could we have up, please, document INQ000271659 and,  
22 within that document, page 36. This document represents  
23 IPC recommendations produced by Public Health England.  
24 We don't need to look at it but the preceding page makes  
25 it clear that this table relates to healthcare settings.

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1 individual organisation identifying unique risks for  
2 their staff in that situation and making a decision  
3 based on that risk assessment, and an individual risk  
4 assessment as well, if there were particular healthcare  
5 workers who felt that they were going to be at risk,  
6 then having those appropriate occupational health  
7 assessments.

8 **Q.** But do you accept that sticking with, say, trust level  
9 risk assessment, that language left it open to a trust  
10 to say, I don't know, "We've got all the windows open,  
11 we've taken all these other steps, therefore we're not  
12 going to provide you with PPE"?

13 **A.** I don't think I can answer that question. I mean,  
14 I think organisations are, they should -- you know,  
15 doing risk assessments all of the time, and the  
16 hierarchy of controls is something that the Health and  
17 Safety Executive -- you know, the Health and Safety at  
18 Work Act, it's not a new document. So, yeah, I don't --  
19 you know, trusts were able to make those individual risk  
20 assessments and I would like to think that they made  
21 them appropriately and did not withhold PPE from  
22 individuals who were risk assessed to need to higher  
23 level of PPE.

24 **Q.** So turning to my second question, we heard from the  
25 Scottish TUC this morning the view that nurses should

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1 have been able to make their own decisions as to whether  
2 and what PPE was required by them in a particular  
3 setting, and that PPE should have been provided to them  
4 on that basis. Do you agree or disagree with that  
5 proposition?

6 **A.** I think it's challenging when selecting items of PPE on  
7 an individual basis is down to personal preference,  
8 because I think healthcare workers need to understand  
9 the reasons for wearing that PPE and knowing when to  
10 wear it, for how long, all of those reasons. So I think  
11 those clinicians should be involved in the discussions  
12 around risk assessments and, you know, that  
13 an organisation or a department come to an agreement  
14 about what their risk assessment is and what the level  
15 of PPE is going to be, but not down at an individual  
16 personal level, because that could land us in places  
17 where I choose not to wear it, and put myself at risk,  
18 and then someone else chooses to wear it.

19 So I think the personal preference route is quite  
20 difficult and it's not easy to navigate, but I do agree  
21 that within certain -- within settings or units then  
22 clinicians should be involved in the discussions with  
23 regards to what PPE and understand the risks that are in  
24 that area.

25 **MS MORRIS:** Thank you very much.

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1 a different country. That said, the national infection  
2 control manual for Scotland was something that was added  
3 as an ambition into the 2019 five-year UK antimicrobial  
4 resistance national action plan that England would adopt  
5 the manual, and we have indeed done so.

6 **Q.** That's helpful. It isn't in fact an answer to the  
7 question. But would you agree with the summary of the  
8 experts that I anticipate will give this on Thursday,  
9 the IPC experts, that because there was no national  
10 manual, that the IPC guidance in England pre-pandemic  
11 was in fact fragmented, it came -- the IPC guidance that  
12 people were following or looked to follow came from  
13 professional societies with an expertise in infection or  
14 professional bodies or PHE, there was a fragmented  
15 picture?

16 **A.** I can't comment on that, I wasn't working in NHS England  
17 at the time.

18 **Q.** Okay, but you arrived in April, what did you find? You  
19 didn't find a national manual, so the guidance that was  
20 there you would be sighted on, you would look at, it was  
21 fragmented; is that right?

22 **A.** So at the time that I arrived we were working on UK  
23 guidance for SARS-CoV-2, Covid-19, so I suppose I wasn't  
24 looking at the wider IPC guidance for other specific  
25 pathogens that was available, and I -- to currently

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1 **LADY HALLETT:** Thank you, Ms Morris.

2 Mr Weatherby.

3 **Questions from MR WEATHERBY KC**

4 **MR WEATHERBY:** Thank you.

5 Dr Ritchie, I've got a very short number of  
6 questions. I'm asking on behalf of Covid Bereaved  
7 Families for Justice UK, which includes families  
8 bereaved from nosocomial infection and also healthcare  
9 workers.

10 You've touched twice, I think, on my first point,  
11 which is that when you arrived at NHS England in  
12 April 2020, you found that there was no national IPC  
13 manual and there was no national England IPC team; is  
14 that right?

15 **A.** That's correct.

16 **Q.** Obviously it wasn't your fault that there was neither of  
17 those, but did you learn, in the course of the handover  
18 or the arrival, why that -- or those gaps had been?

19 **A.** I'm not aware what the rationale for that was.

20 **Q.** Yes. But obviously you had come from Scotland where you  
21 had had a similar role in relation to the manual, and  
22 you had a national manual there. Did you not ask your  
23 colleagues as to why the structures simply weren't  
24 there?

25 **A.** I was working in a different NHS organisation in

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1 and -- then and now, Public Health England are the  
2 advisory body on specific pathogen guidance.

3 **Q.** Okay. But the work of the cell and your subsequent work  
4 on Covid from when you arrived sat on top of the  
5 existing IPC guidance that was available, didn't it? It  
6 was complementary to the general IPC guidance --

7 **A.** Yes.

8 **Q.** -- that was there.

9 Are you able to say what impact the lack of  
10 a national manual, what I've referred to,  
11 a fragmentation of IPC guidance, what effect that had on  
12 your work in terms of Covid?

13 **A.** I think that's why we used the foundation of the  
14 Scottish manual in terms of standard infection control  
15 precautions and the basics round transmission-based  
16 precautions and used that as a foundation to base the  
17 SARS-CoV-2 Covid-19 guidance on going forward, and then  
18 as we developed that guidance, as that guidance evolved  
19 throughout the pandemic, we were taking the appropriate  
20 scientific advice.

21 **Q.** So Scotland had effectively had the lead on it, so, in  
22 the absence of joined-up national guidance in England,  
23 you looked to the work that you had done in Scotland; is  
24 that a fair summary?

25 **A.** To give us an initial foundation.

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- 1 **Q.** Now, very quickly the second area, would you agree that  
2 traditional views about IPC were firmly ingrained and  
3 hard to change?
- 4 **A.** I disagree. I think there was established modes of  
5 transmission that were set out/defined in international  
6 and national guide -- pre-pandemic guidance across many  
7 countries, the WHO. I don't think we were wedded to  
8 that. Had the science and our expert colleagues,  
9 science colleagues, told us that there was a change then  
10 we would have followed.
- 11 **Q.** All right, I've lifted that as a quote from the expert  
12 report, so we can go back and ask them when they give  
13 their evidence on Thursday.
- 14 When Professor Noakes, who was referred to earlier,  
15 a bioengineering professor, has given evidence, both in  
16 Module 2 and in her witness statement, she referred to  
17 a simplistic distinction in healthcare between droplet  
18 and airborne, aerosol, respiratory virus transmission,  
19 and gave the view that it was persistent because it had  
20 been taught for years and ran through IPC guidance.
- 21 Would you agree with that, that there was this  
22 hardwired view which just kept being taught and that's  
23 one of the reasons that it persisted?
- 24 **A.** I don't think it's a hardwired view. I think infection  
25 prevention and control is very much down the pecking

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- 1 **LADY HALLETT:** Thank you, Mr Weatherby.  
2 I think it's now Mr Odogwu. I'm so sorry,  
3 Ms Banton. Well, I was told it was Mr Thomas, so there  
4 we go.
- 5 **Questions from MS BANTON**
- 6 **MS BANTON:** I apologise, my Lady, there has been some  
7 movement this afternoon. Thank you.
- 8 Dr Ritchie, I represent FEMHO, which is the  
9 Federation of Ethnic Minority Healthcare Organisations.  
10 We advocate for healthcare workers from ethnic minority  
11 backgrounds who were disproportionately impacted by the  
12 pandemic, and those concerns include surrounding  
13 personal protective equipment and fit.
- 14 If I may ask a question regarding your statement,  
15 you mentioned the recommendation of fluid-resistant  
16 surgical masks -- this is in footnote 3, paragraph 16 of  
17 your statement -- for GPs triaging suspected Covid-19  
18 cases, despite evidence showing a higher risk of  
19 infection when compared to FFP3 masks, especially for  
20 those who failed fit tests, including ethnic minority  
21 staff.
- 22 So, given this evidence, why did you believe that  
23 recommending FRSMs provided providing sufficient  
24 protection at the time, particularly for those facing  
25 fit testing challenges, such as we've heard of before?

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- 1 order in terms of research and good research, and  
2 I respect Professor Noakes' position. I accept the  
3 science is far from settled, we need studies with  
4 improved quality to further understand short and  
5 long-term airborne transmission. But I -- we were not  
6 wedded to those. They were a foundation that existed in  
7 all of the international and national guidance, and  
8 had -- and, if evidence demonstrates that that is  
9 incorrect, then the guidance will shift.
- 10 **Q.** Okay.
- 11 Finally this, then: would it follow, would you  
12 agree, that there was a reluctance to acknowledge  
13 airborne transmission because there was an emphasis on  
14 looking for the evidence of aerosol transmission, rather  
15 than the possibility that it would persist, it would  
16 exist?
- 17 **A.** I don't -- if the evidence had demonstrated and --  
18 I mean, I go back to the role of the UK IPC cell, we  
19 weren't driving the science, our role throughout the  
20 pandemic was to take the outputs from the science groups  
21 and the evidence that they had discussed, and their  
22 recommendations and translate that into the IPC guidance  
23 document.
- 24 **MR WEATHERBY:** Thank you very much.
- 25 **THE WITNESS:** Thank you.

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- 1 **A.** So on the primary care and the FRSM, the date round  
2 about that guidance, as I recall from my statement, that  
3 Covid-19 at that point in time was classified as  
4 a high-consequence infectious disease and, given that,  
5 in primary care settings, FFP3 fit testing was not  
6 widely established, then the advice that we were giving  
7 in that situation at that particular time was obviously  
8 for people who suspected themselves was not to turn up  
9 at a GP practice but, if they did, for the GP to  
10 basically identify through assessment that there could  
11 be a potential that this individual may have SARS-CoV-2,  
12 to isolate them and not undertake any intervention, and  
13 then to inform their local infectious diseases service  
14 to take advice on what to do next.
- 15 As the pandemic progressed and evolved, GP services  
16 took on quite a different approach where, you know, they  
17 were triaging on the phone and, you know, individuals  
18 not turning up, so we were looking at more  
19 administrative controls in the primary care setting  
20 rather than the PPE.
- 21 **Q.** Right, thank you.
- 22 **LADY HALLETT:** I'll just interrupt there, forgive me,  
23 Ms Banton. I thought you said that as long as it was  
24 classified as a high-consequence infectious disease, all  
25 healthcare workers had to wear respiratory protection

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1 equipment.

2 **A.** That's correct.

3 **LADY HALLETT:** But wouldn't that be more than the

4 fluid-resistant masks that Ms Banton was talking about?

5 **A.** At the time, when it was classified as

6 a high-consequence infectious disease, we didn't have

7 many cases or if any cases in the UK, and because we

8 knew that FFP3 respirators was not something fit,

9 because they have to be fit tested, there will not be

10 many GP practices and clinicians in primary care that

11 are fit tested for a FFP3 respirator. So the guidance

12 was to put in place measures that would protect the

13 individual patient but protect the healthcare worker at

14 the same time. So we were not anticipating that those

15 primary care practitioners would come into contact with

16 a high-consequence infectious disease at that time, but

17 if they did and they presented, then it was identify,

18 isolate and inform.

19 **LADY HALLETT:** Right.

20 Sorry to cut across you.

21 **MS BANTON:** I'm very grateful, my Lady.

22 If I may, just a question that arises from an

23 earlier answer which also is relating to my question,

24 just to clarify that something was raised in questioning

25 before the afternoon break on the topic of risk

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1 Health and Safety Executive's hierarchy of controls, and

2 the health equality impact assessment on the guidance

3 did highlight within that the PPE, particularly the FFP3

4 fit testing for BAME groups and colleagues, so that was

5 highlighted in that document. And as I say, I know that

6 a deputy CNO colleague did take forward some work, which

7 I wasn't involved in, to do with fit testing for ethnic

8 minority groups.

9 **MS BANTON:** Thank you.

10 Thank you, my Lady.

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

12 Mr Simblet.

13 **Questions from MR SIMBLET KC**

14 **MR SIMBLET:** Thank you, my Lady.

15 Dr Ritchie, I'm asking questions on behalf of the

16 Covid Airborne Transmission Alliance in connection with,

17 well, first, some issues in relation to IPC guidance and

18 its applicability.

19 Now, can I have your witness statement on screen,

20 please.

21 It's INQ000421939, and internal page 12.

22 While that's being located, Dr Ritchie, your witness

23 statement for this module, and I think it's your only

24 witness statement, is dated 23 July 2024, so barely

25 seven weeks or so before we began and well after

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1 assessments.

2 You told us that the IPC cell developed various

3 tools to support organisations and that teams would help

4 those struggling with outbreaks to undertake risk

5 assessments and to put in place mitigating measures.

6 Counsel to the Inquiry asked whether there was any

7 particular risk assessment specific to ethnic minority

8 healthcare workers, and your response was that it was

9 only a general risk assessment.

10 However, there was a clear and stark disparity

11 evident in the disproportionate infection rates for

12 ethnic minority healthcare workers which was public at

13 the time. We've heard reference to unequal access to

14 PPE, working conditions, et cetera.

15 So can you explain why a specific risk assessment

16 tool was not worked on or, indeed, support from IPC

17 teams directed at addressing such specific issues?

18 **A.** So in terms of the FF -- the facial protection,

19 respiratory protection, I do note that a colleague, one

20 of the deputy chief nursing officers, did undertake

21 a piece of work with BAME representatives, which was on

22 making sure that there was a proper risk assessment on

23 how to end up with good FFP3 protection when it was

24 necessary. When I was talking about risk assessments,

25 it was more in relation to the environment and the

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1 disclosure of the infection -- of the expert statements

2 and so on in relation to transmission science.

3 So could I have paragraph 40 put on the screen,

4 please, and zoomed in. It's at the bottom of the page.

5 What you have told us there is that:

6 "Effective IPC guidance must be broadly applicable.

7 IPC strategies are not specific to any one pathogen and

8 generally apply to all routes of transmission."

9 With that in mind, Dr Ritchie, a pathogen is any

10 micro-organism that can cause disease, and some

11 pathogens, this is obvious I would have expected, are

12 more serious and harmful to human health than others,

13 and they are called serious pathogens. Is that right?

14 **A.** Correct.

15 **Q.** And those include TB, MERS, SARS-1, and even some more

16 common ones such as measles. Is that right?

17 **A.** Correct.

18 **Q.** With TB, healthcare workers will wear respiratory

19 protective equipment when dealing with cases; is that

20 right?

21 **A.** That's recommended.

22 **Q.** Yes, and local risk assessments are not required for TB?

23 **A.** They are recommended.

24 **Q.** Right. Why is Covid-19 any different from TB?

25 **A.** Covid-19 is different from TB because the predominant

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1 mode of spread for TB is airborne; for Covid-19 the  
 2 predominant mode of spread is droplet and contact.  
 3 **Q.** Is that still your position in this Inquiry today, after  
 4 all the evidence we've heard: that the primary mode of  
 5 transmission for Covid-19 is droplet and contact?  
 6 **A.** That is my position.  
 7 **Q.** So what you've said at paragraph 40 needs to be looked  
 8 at in this context as well, doesn't it, that when it  
 9 comes to respiratory protection for healthcare workers,  
 10 you think that those who are guarding against Covid-19  
 11 require less than is required for TB?  
 12 **A.** It's not just -- what I've tried to explain in the last  
 13 couple of hours is not just the respiratory protective  
 14 equipment, it's making sure that the environment and the  
 15 hierarchy of controls is applied and risk assessment is  
 16 applied as well. Paragraph 40, saying about effective  
 17 IPC guidance must be broadly applicable, is because  
 18 pathogens generally don't just transmit by one route,  
 19 they generally transmit by many routes and, when it says  
 20 "IPC strategies are not specific to any one pathogen",  
 21 that's the approach. IPC is multifaceted, there is no  
 22 one single thing like hand washing that's going to make  
 23 a difference for a pathogen; it's multiple interventions  
 24 that are reliably applied all of the time and the  
 25 monitoring of that is happening all of the time to

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1 assessment, to protect themselves, the healthcare  
 2 worker, it's almost impossible, isn't it?  
 3 **A.** I'm not quite sure I follow your question.  
 4 **Q.** The disease against which they are guarding is one that  
 5 cannot be seen or smelt or heard, or whatever, so for  
 6 them to suddenly sit down and start deciding what they  
 7 ought to do to guard against it, as opposed to being  
 8 assisted and instructed in what to do by specialist  
 9 infection prevention and control guidance, is  
 10 effectively impossible, isn't it?  
 11 **A.** But that could then be said for many pathogens, like  
 12 MRSA, or C. diff. You do an assessment of the patient,  
 13 you look for signs and symptoms, you may take some  
 14 tests, and on the basis of your clinical assessment,  
 15 which our healthcare workers are doing every single day,  
 16 they are seeing patients with suspected and known  
 17 infections in many of the healthcare settings, so they  
 18 are making that individual risk assessment depending on  
 19 also the procedure that they're going to undertake. So  
 20 the patient may not even have an infection, but they  
 21 might be going to undertake a procedure where there  
 22 might be some spraying or splashing of blood,  
 23 for example, and in that situation they would clinically  
 24 risk assess and wear the appropriate PPE.

25 **LADY HALLETT:** Mr Simblet, (a) I don't see where this is

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1 ensure that those things are in place.

2 **Q.** Right.

3 Now, one of the things that you've mentioned at  
 4 various points in your evidence is risk assessments and  
 5 you've spoken of local risk assessments and healthcare  
 6 workers' own risk assessments. Do you accept that with  
 7 a disease such as Covid-19, where you can't see it, or  
 8 hear it, or smell it, or anything like that, that it's  
 9 essentially impossible for a individual healthcare  
 10 worker to undertake their own individual risk  
 11 assessment?

12 **A.** But that individual may -- there is an assessment done  
 13 on the individual and the individual may have signs and  
 14 symptoms, they may be tested, so you would have some  
 15 idea of someone being suspected or known to have that  
 16 pathogen. And the high risk assessment is not and  
 17 should not be new to healthcare systems. In the Health  
 18 and Social Care Act, the code of practice for infection  
 19 prevention and control mentions risk assessment many,  
 20 many times, and it is something that should be put in  
 21 place across every healthcare facility to make sure that  
 22 people are looking at ventilating systems and assessing  
 23 the environment and making the environment as safe as  
 24 possible for patients and staff and visitors.

25 **Q.** No, but in terms of doing their own individual risk

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1 going and (b) I don't see it on the list of questions  
 2 I authorised.

3 **MR SIMBLET:** Right, well, in that case, could I move to  
 4 something else. My Lady, we have asked, as you know,  
 5 over the weekend -- there was some material which was  
 6 highly relevant to the IPC guidance which was disclosed  
 7 very recently. We have been working very hard over the  
 8 weekend to try and assist in formulating questions. It  
 9 may be that we have to ask for this witness to come  
 10 back, but we've submitted questions this afternoon and  
 11 had the email back that we're awaiting your  
 12 determination, but it's now 4.15, so would you like me  
 13 to ask them or would you like me to pursue this in  
 14 a different way?

15 **LADY HALLETT:** I'm sorry, I haven't got the foggiest what  
 16 you're saying, Mr Simblet. I will only allow for  
 17 a witness to be recalled if I think it's absolutely and  
 18 strictly necessary. I've given permission for you to  
 19 ask certain questions, you may ask them, but just be  
 20 warned that if you don't ask them you may not get the  
 21 opportunity because I may not agree that the witness  
 22 needs to be recalled.

23 **MR SIMBLET:** Thank you.

24 Then I shall -- can I move on to a different issue,  
 25 please. It's in relation to the suggestion that --

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1 well, it's in relation to what you thought the guidance  
2 should lead to and the confidence that you wanted people  
3 to have in it.

4 Could we have on the screen, please, INQ000398144.

5 These are an extract from some of the minutes of the  
6 IPC cell for 9 September 2020.

7 **LADY HALLETT:** Have you warned our wonderful document  
8 manager of the document you want up on screen?

9 **MR FIREMAN:** Yes, I wonder if the question could be  
10 summarised with reference to the relevant passage.

11 **LADY HALLETT:** If you could summarise what's in the  
12 document.

13 **MR SIMBLET:** Okay, if that's easier.

14 And my Lady, I'm sorry to be doing this on my feet.

15 This is not any fault of me or those instructing me or  
16 my clients. This is material that could and should, we  
17 would say, have been disclosed --

18 **LADY HALLETT:** All right, Mr Simblet, I'm not going down  
19 that path now. So could you carry on with the  
20 questions. You're running out of time.

21 **MR SIMBLET:** Thank you.

22 It's in those minutes and it's for the people  
23 following at box 3, bullet point 3, it was said that,  
24 well, somebody in the meeting said:

25 "If you wanted to change the guidance itself it  
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1 permission to ask a question on.

2 **LADY HALLETT:** What's the question, Mr Simblet, and I'll  
3 reconsider? Apparently I have declined permission.

4 **MR SIMBLET:** Oh. Well, if you did so, my Lady, it was  
5 something that hadn't happened when we got to the break.

6 What I wanted to ask is that in the minutes there  
7 are various suggestions of people raising concerns that  
8 it's "as caused by the minority", ie a minority of  
9 healthcare workers, and what I wanted to ask you about  
10 is: what did you understand to be the minority and what  
11 was the concern about listening to them?

12 **LADY HALLETT:** I think you've asked the question now, so  
13 you've got permission.

14 Dr Ritchie?

15 **A.** I don't recall the minute. If it's something that I can  
16 help with outwith this session, and provide a written  
17 response, I'd be happy to do that.

18 **MR SIMBLET:** Thank you.

19 There's one more question I would like to ask,  
20 please, and it's this: there are some references in the  
21 minutes, including going back as early as March and  
22 February 2020, to concerns that, if the guidance on  
23 changes to PPE is changed, that that could affect PPE  
24 supplies. To what extent were you worried that the  
25 guidance needed to reflect what materials you actually  
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1 would need a very careful narrative as it would be easy  
2 to give the impression that we got it wrong the first  
3 time when it's something we collectively signed off on  
4 and submitted to our chief nursing officers."

5 Now, that was said in a meeting on 9 September. You  
6 weren't there, but the minutes came out subsequently.

7 Would you say that sometimes the IPC cell was more  
8 bothered about maintaining face than actually  
9 transparently and accurately providing the best and most  
10 reliable information?

11 **A.** Absolutely not. As a UK IPC cell, it was not about  
12 saving face. We were doing our level best to make sure  
13 that the guidance that was put out was going to protect  
14 our healthcare workers and protect patients.

15 Had that guidance been incorrect and had we been  
16 advised by any of our senior clinicians that the  
17 guidance was incorrect, it would have been changed. We  
18 were not a rogue cell.

19 **Q.** Can I go on to a different topic, please, and, again,  
20 this is INQ000398221, and page 6 of that. These are  
21 minutes from 27 January 2021 and, taking the approach  
22 I've just been asked to do, I'll summarise this.

23 **MR FIREMAN:** Sorry, I'm not sure if these minutes have  
24 actually been authorised in terms of the particular  
25 question that the core participant has been given  
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1 had, what supplies you actually had?

2 **A.** So the supply, the purchase, all of the issues round  
3 about PPE was not within the remit of the UK IPC cell.  
4 We were aware, given the global demand, that that might  
5 be something that could happen, that there would be  
6 a limit or run out of PPE. The guidance was not based  
7 on any supply issues to do with PPE.

8 **MR SIMBLET:** Well, I've got the answer to that. Thank you.

9 **LADY HALLETT:** Thank you, Mr Simblet.

10 **Further questions from THE CHAIR**

11 **LADY HALLETT:** One last question, Dr Ritchie, and I promise  
12 you it is the last question. It's been a long day for  
13 you, I know. Basically, it's a question that's come  
14 from the BMA.

15 You've placed quite a lot of reliance, many people  
16 would understand why, some may question why, on the  
17 World Health Organisation. Dare I say it, none of us  
18 are infallible and the question comes based on  
19 a statement made by, forgive my pronunciation if I get  
20 it wrong, Dr Soumya Swaminathan, the World Health  
21 Organisation's chief scientist, who stated on her  
22 retirement in November 2022 that her biggest regret was  
23 not acknowledging earlier in the pandemic that  
24 SARS-CoV-2 could be spread by aerosols.

25 I suppose it's really a comment rather than  
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1 a question, but given that, haven't you, as somebody  
 2 exercising an expert capacity, got to be careful about  
 3 the reliance you place on any one body or one expert,  
 4 because they may not always be right?  
 5 **A.** Absolutely, I don't disagree with that, and I think  
 6 a body of evidence is much better than a single view.  
 7 I think, you know, we've got a long way to go on the  
 8 research, and I think those clinical medical groups that  
 9 made a difference was the behavioural scientists and our  
 10 clinical medical people.  
 11 The research currently, and this might be something  
 12 for the way forward, I think a lot of the research  
 13 grants go to a lot of the "omics", like genomics and  
 14 research in that space. It's not easy to do infection  
 15 prevention and control research, so it feels like we  
 16 need to have something pre-made, ready to go, to test  
 17 all of these interventions, because it's really  
 18 difficult to tease out: well, was it because we put the  
 19 patient in a single room, was it because they were  
 20 wearing FFP, the healthcare worker was wearing an FFP3  
 21 respirator? So I think bringing the operational arm,  
 22 like us nurses, IPC nurses, with the scientific arm and  
 23 really bringing that much closer together in research  
 24 would be a major step forward.  
 25 Thank you.

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1 **LADY HALLETT:** Thank you very much indeed. As I say, I do  
 2 realise it's been a long day for you, thank you very  
 3 much indeed for all your help.  
 4 We will finish there and I shall start again at  
 5 10 o'clock tomorrow morning.

(The witness withdrew)

7 (4.27 pm)

(The hearing adjourned until 10 am on Tuesday, 17 September 2024)

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| <b>H</b> | 25/4 25/6 25/8 25/9<br>25/17 25/22 25/25<br>26/9 26/21 26/24 27/5<br>27/11 27/20 28/5 29/5<br>30/20 31/21 32/6 34/6<br>35/1 36/2 36/6 36/8<br>36/13 36/21 37/22<br>37/22 37/25 38/18<br>39/23 40/14 41/16<br>42/23 43/2 45/1 45/15<br>46/2 46/4 46/5 46/7<br>46/16 46/19 48/10<br>48/17 50/22 52/5<br>58/14 58/23 59/5<br>59/21 63/13 63/16<br>63/17 67/12 67/13<br>67/16 67/21 68/5 68/6<br>69/7 69/8 71/15 77/15<br>77/20 78/3 78/9 78/12<br>78/19 78/23 90/16<br>107/14 108/22 109/5<br>109/8 115/12 115/12<br>116/15 117/14 117/15<br>120/5 126/4 127/5<br>127/16 129/1 130/5<br>130/24 132/3 132/8<br>135/19 138/2 138/16<br>140/22 142/2 144/6<br>146/8 146/15 147/7<br>148/14 159/7 159/11<br>159/15 159/17 159/25<br>162/23 164/6 164/16<br>164/17 168/1 175/1<br>175/2 176/12 178/17<br>184/17 184/20 | 151/4 151/5 153/14<br>155/3 155/23 157/20<br>158/5 160/9 162/2<br>162/25 163/13 164/4<br>165/8 166/8 169/17<br>171/9 171/10 172/25<br>173/13 174/8 174/12<br>176/18 177/9 178/5<br>178/9 178/17 178/21<br>179/1 179/15 179/17<br>182/14 183/9 185/20<br><b>healthcare-wide [1]</b><br>155/3<br><b>hear [2]</b> 6/13 178/8<br><b>heard [23]</b> 2/15 2/20<br>3/17 30/9 43/1 67/21<br>70/17 74/24 80/13<br>81/5 81/25 82/7 83/6<br>83/8 104/9 123/22<br>146/19 148/1 164/24<br>171/25 174/13 177/4<br>179/5<br><b>hearing [3]</b> 15/6 53/5<br>186/8<br><b>heavily [1]</b> 107/17<br><b>heavy [5]</b> 125/22<br>149/5 149/10 149/19<br>149/24<br><b>help [11]</b> 29/15 61/25<br>101/4 143/13 143/14<br>147/20 147/22 154/9<br>174/3 183/16 186/3<br><b>helped [1]</b> 12/11<br><b>helpful [17]</b> 10/25<br>29/9 52/7 65/19 80/6<br>84/20 85/25 91/18<br>92/11 107/7 110/6<br>132/7 133/1 153/5<br>160/21 161/5 167/6<br><b>helpline [6]</b> 51/19<br>51/21 51/25 52/3 52/4<br>52/7<br><b>hence [1]</b> 162/5<br><b>her [9]</b> 2/15 48/14<br>48/24 51/17 120/15<br>127/25 169/16 184/21<br>184/22<br><b>her Ladyship [1]</b><br>2/15<br><b>here [22]</b> 59/13 77/11<br>81/9 84/3 86/7 87/25<br>93/22 103/3 106/21<br>108/15 108/15 110/16<br>119/17 120/6 121/20<br>127/19 127/19 128/8<br>129/7 135/16 136/12<br>151/9<br><b>Here's [1]</b> 138/21<br><b>HICPAC [1]</b> 86/19<br><b>hierarchy [15]</b> 126/4<br>142/25 143/4 143/6<br>143/7 145/14 145/20<br>147/17 163/9 163/12<br>163/16 163/21 164/16 | 175/1 177/15<br><b>high [35]</b> 9/17 9/23<br>10/19 10/22 14/19<br>15/9 15/12 15/14<br>15/18 17/15 19/22<br>24/15 24/17 31/3<br>37/17 38/18 42/10<br>43/12 49/7 50/22<br>58/22 59/21 94/5<br>96/10 99/12 102/11<br>113/6 116/4 141/4<br>158/15 172/4 172/24<br>173/6 173/16 178/16<br><b>high-consequence [1]</b> 94/5<br><b>high-risk [8]</b> 10/22<br>15/9 15/12 24/17<br>43/12 58/22 59/21<br>116/4<br><b>higher [25]</b> 7/17<br>17/25 21/3 38/19 39/9<br>39/20 42/2 42/4<br>102/23 103/9 104/14<br>104/21 121/10 121/21<br>122/6 122/8 122/11<br>126/15 149/20 150/14<br>150/15 150/23 157/11<br>164/22 171/18<br><b>highest [9]</b> 119/14<br>120/2 120/8 120/21<br>121/2 150/11 150/11<br>157/7 157/9<br><b>highest-risk [1]</b><br>120/2<br><b>highlight [1]</b> 175/3<br><b>highlighted [2]</b><br>154/24 175/5<br><b>highly [4]</b> 34/19<br>159/12 159/13 180/6<br><b>hindsight [2]</b> 67/5<br>160/18<br><b>his [4]</b> 2/24 3/1 70/19<br>88/4<br><b>historically [1]</b> 83/7<br><b>history [2]</b> 98/13<br>109/3<br><b>holders [1]</b> 26/7<br><b>home [2]</b> 40/23 41/14<br><b>honest [1]</b> 20/12<br><b>honesty [1]</b> 6/24<br><b>hope [4]</b> 2/12 51/3<br>62/9 93/6<br><b>Hopkins [6]</b> 127/16<br>127/17 127/17 128/11<br>128/16 152/17<br><b>Hopkins' [2]</b> 129/13<br>151/6<br><b>hospital [3]</b> 64/1<br>91/19 111/20<br><b>hospitalisation [1]</b><br>59/14<br><b>hospitals [3]</b> 47/8<br>108/24 161/12<br><b>hotspot [1]</b> 122/16 | <b>hotspots [1]</b> 121/4<br><b>hours [2]</b> 35/6<br>177/13<br><b>how [50]</b> 4/23 13/9<br>13/9 13/12 17/3 18/15<br>19/3 24/10 26/1 27/18<br>31/16 32/1 51/12 52/6<br>61/9 65/9 71/23 71/24<br>75/22 83/25 86/1 94/6<br>94/8 94/19 96/2 96/14<br>98/13 99/23 100/25<br>103/14 105/16 115/18<br>117/21 122/2 123/1<br>126/5 134/17 136/22<br>143/17 147/2 148/9<br>153/14 153/17 155/6<br>155/7 155/11 156/1<br>156/5 165/10 174/23<br><b>however [4]</b> 36/5<br>77/2 126/9 174/10<br><b>HPS [2]</b> 63/13 63/16<br><b>HSC [1]</b> 51/21<br><b>HSCA's [1]</b> 59/7<br><b>HSE [12]</b> 2/2 5/3 5/17<br>15/16 16/23 24/3<br>25/12 26/18 43/5 68/3<br>68/4 82/16<br><b>HSE's [2]</b> 9/21 82/8<br><b>huge [7]</b> 15/2 15/18<br>25/3 25/18 27/20<br>47/22 123/23<br><b>hugely [2]</b> 7/5 26/14<br><b>human [2]</b> 37/14<br>176/12<br><b>Hyslop [1]</b> 50/17 |
|          |  |  | <b>I</b>   |   |
|          |  |  | <b>I accept [5]</b> 74/19<br>153/1 153/7 160/8<br>170/2<br><b>I act [1]</b> 60/13<br><b>I actually [1]</b> 93/14<br><b>I again [1]</b> 91/13<br><b>I am [5]</b> 52/4 63/5<br>72/3 85/13 149/15<br><b>I anticipate [1]</b> 167/8<br><b>I apologise [2]</b> 136/8<br>171/6<br><b>I appreciate [8]</b> 10/4<br>36/22 66/15 69/20<br>70/16 72/25 78/25<br>122/1<br><b>I arrived [1]</b> 167/22<br><b>I ask [3]</b> 28/10 132/9<br>151/3<br><b>I authorised [1]</b><br>180/2<br><b>I believe [10]</b> 32/22<br>33/11 38/3 57/18 61/5<br>64/6 66/21 106/20<br>127/17 131/19<br><b>I brought [1]</b> 5/6<br><b>I call [1]</b> 99/25<br><b>I can [18]</b> 20/12  |   |

|                               |                               |                               |                               |                               |
|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <b>I</b>                      | 62/9 93/6                     | 90/8 91/6 91/12 91/23         | 114/21                        | identifying [2] 10/23         |
| <b>I can... [17]</b> 28/21    | <b>I initially [1]</b> 160/20 | 122/7 124/8 131/11            | <b>I'm asking [3]</b> 113/22  | 164/1                         |
| 33/3 43/17 49/20              | <b>I interrupt [1]</b> 19/25  | 139/11 167/23 184/25          | 166/6 175/15                  | <b>ie [3]</b> 59/8 91/9 183/8 |
| 76/25 82/4 82/9 87/21         | <b>I interrupted [1]</b> 10/9 | <b>I suspect [2]</b> 81/10    | <b>I'm aware [2]</b> 55/22    | <b>if [204]</b>               |
| 93/21 94/12 97/6              | <b>I just [22]</b> 4/4 10/25  | 85/11                         | 57/22                         | <b>ill [12]</b> 3/14 4/6 4/9  |
| 121/2 137/14 151/1            | 18/15 19/25 28/11             | <b>I take [1]</b> 18/4        | <b>I'm conscious [1]</b>      | 15/3 27/19 27/22 48/3         |
| 154/17 164/13 183/15          | 30/2 48/16 62/15 67/9         | <b>I then [1]</b> 137/21      | 51/1                          | 48/4 55/13 55/18              |
| <b>I can't [3]</b> 93/19      | 74/8 84/2 87/9 90/14          | <b>I think [218]</b>          | <b>I'm disagreeing [1]</b>    | 60/25 123/1                   |
| 140/12 167/16                 | 93/15 112/20 115/22           | <b>I thought [5]</b> 3/16     | 114/20                        | <b>ill-fitting [4]</b> 48/3   |
| <b>I certainly [1]</b> 56/18  | 121/17 128/15 130/2           | 90/15 90/20 105/14            | <b>I'm focusing [1]</b> 8/5   | 48/4 55/13 55/18              |
| <b>I choose [1]</b> 165/17    | 130/16 144/23 148/25          | 172/23                        | <b>I'm getting [1]</b> 44/2   | <b>illness [2]</b> 20/7 22/20 |
| <b>I clarify [2]</b> 67/17    | <b>I know [9]</b> 45/15       | <b>I took [1]</b> 56/21       | <b>I'm going [5]</b> 2/11     | <b>illustrates [1]</b> 38/4   |
| 149/8                         | 49/22 73/10 74/4              | <b>I try [1]</b> 118/14       | 8/10 64/12 93/17              | <b>immediately [2]</b>        |
| <b>I come [2]</b> 140/20      | 77/19 99/2 110/22             | <b>I turn [1]</b> 46/22       | 159/8                         | 26/13 97/20                   |
| 160/20                        | 126/11 175/5                  | <b>I understand [5]</b>       | <b>I'm just [3]</b> 45/19     | <b>impact [21]</b> 9/24 17/4  |
| <b>I could [6]</b> 5/10 6/24  | <b>I make [1]</b> 20/1        | 114/24 123/6 125/10           | 89/16 114/16                  | 22/18 25/18 35/1              |
| 8/23 44/11 64/21              | <b>I may [5]</b> 4/5 13/7     | 154/8 156/24                  | <b>I'm not [17]</b> 6/17      | 35/14 36/20 36/25             |
| 111/23                        | 171/14 173/22 180/21          | <b>I want [11]</b> 2/18       | 20/12 20/13 25/12             | 37/24 38/9 38/14              |
| <b>I couldn't [1]</b> 20/23   | <b>I mean [23]</b> 6/24 8/23  | 48/14 75/13 93/14             | 25/24 29/7 36/4 36/14         | 111/7 113/6 135/7             |
| <b>I covered [1]</b> 40/13    | 12/25 15/1 16/24 17/5         | 94/4 100/1 127/24             | 57/4 72/3 81/16 90/22         | 135/16 137/3 148/13           |
| <b>I didn't [1]</b> 150/21    | 21/20 25/25 32/21             | 129/10 134/2 138/20           | 113/22 120/16 166/19          | 148/14 154/1 168/9            |
| <b>I disagree [1]</b> 169/4   | 44/16 47/11 55/7 58/5         | 142/18                        | 179/3 182/23                  | 175/2                         |
| <b>I do [20]</b> 30/4 52/4    | 66/22 77/10 80/5              | <b>I wanted [2]</b> 183/6     | <b>I'm obliged [1]</b> 60/11  | <b>impacted [2]</b> 119/18    |
| 54/15 62/17 63/2 63/9         | 109/5 146/8 146/10            | 183/9                         | <b>I'm probably [1]</b> 90/4  | 171/11                        |
| 64/13 71/8 75/18              | 153/13 159/11 164/13          | <b>I was [10]</b> 1/15 5/4    | <b>I'm really [1]</b> 25/24   | <b>impacting [1]</b> 27/19    |
| 78/22 99/1 99/7 132/6         | 170/18                        | 56/14 63/19 65/13             | <b>I'm sorry [2]</b> 180/15   | <b>impacts [2]</b> 23/4 23/4  |
| 136/4 144/8 155/20            | <b>I might [1]</b> 10/6       | 75/24 84/16 113/13            | 181/14                        | <b>implement [1]</b>          |
| 156/15 165/20 174/19          | <b>I misunderstood [1]</b>    | 166/25 174/24                 | <b>I'm summarising [1]</b>    | 146/24                        |
| 186/1                         | 91/5                          | <b>I wasn't [4]</b> 161/19    | 92/5                          | <b>implemented [2]</b>        |
| <b>I don't [52]</b> 2/12 6/24 | <b>I move [1]</b> 180/24      | 167/16 167/23 175/7           | <b>I'm sure [2]</b> 77/16     | 134/11 142/1                  |
| 8/23 11/4 11/7 11/17          | <b>I now [1]</b> 1/15         | <b>I will [1]</b> 180/16      | 140/24                        | <b>implications [1]</b>       |
| 12/8 13/15 15/20              | <b>I please [2]</b> 29/19     | <b>I wonder [1]</b> 181/9     | <b>I'm trying [1]</b> 114/25  | 95/13                         |
| 18/12 24/23 33/22             | 62/5                          | <b>I would [15]</b> 8/13      | <b>I'm understanding [1]</b>  | <b>imply [1]</b> 2/25         |
| 38/13 60/21 68/15             | <b>I presume [1]</b> 75/2     | 26/2 31/3 31/6 32/21          | 150/18                        | <b>importance [2]</b> 143/5   |
| 70/22 78/22 79/9              | <b>I promise [1]</b> 184/11   | 44/16 49/15 57/10             | <b>I'm very [2]</b> 62/1      | 163/13                        |
| 79/18 79/25 89/13             | <b>I push [1]</b> 92/14       | 70/4 73/14 85/18              | 173/21                        | <b>important [38]</b> 16/9    |
| 90/13 92/15 93/5              | <b>I put [1]</b> 143/14       | 145/20 164/20 176/11          | <b>I've [13]</b> 10/6 24/3    | 16/17 22/7 22/16              |
| 93/20 101/13 103/3            | <b>I recall [5]</b> 127/4     | 183/19                        | 61/23 89/14 90/14             | 22/22 36/20 37/13             |
| 105/7 114/20 120/22           | 130/24 132/4 137/1            | <b>I'd [3]</b> 3/17 60/17     | 106/10 166/5 168/10           | 37/14 43/25 44/8              |
| 124/12 125/8 141/17           | 172/2                         | 183/17                        | 169/11 177/12 180/18          | 74/14 77/10 84/7 98/1         |
| 147/4 152/12 153/19           | <b>I recognise [1]</b>        | <b>I'll [5]</b> 29/8 70/24    | 182/22 184/8                  | 98/6 99/1 99/7 103/20         |
| 154/25 155/18 156/17          | 120/18                        | 172/22 182/22 183/2           | <b>I've got [1]</b> 166/5     | 113/4 113/15 114/21           |
| 158/8 158/14 158/14           | <b>I referred [2]</b> 59/3    | <b>I'll give [1]</b> 70/24    | <b>I've lifted [1]</b> 169/11 | 115/9 115/13 118/16           |
| 164/10 164/13 164/18          | 93/16                         | <b>I'll just [1]</b> 172/22   | <b>I've no [1]</b> 61/23      | 118/21 125/21 126/3           |
| 169/7 169/24 170/17           | <b>I represent [1]</b> 171/8  | <b>I'll summarise [1]</b>     | <b>I've referred [1]</b>      | 126/7 126/16 142/15           |
| 179/25 180/1 183/15           | 182/22                        | 182/22                        | 168/10                        | 144/9 149/4 150/5             |
| 185/5                         | <b>I respect [4]</b> 85/13    | <b>I'm [55]</b> 2/11 6/17 8/5 | <b>I've said [2]</b> 24/3     | 150/6 153/9 155/20            |
| <b>I fill [1]</b> 20/2        | 88/23 149/15 170/2            | 8/10 20/1 20/12 20/13         | 106/10                        | 155/22 162/5                  |
| <b>I find [1]</b> 12/14       | <b>I said [4]</b> 64/4 100/3  | 25/12 25/24 25/24             | <b>I've understood [1]</b>    | <b>imposed [3]</b> 161/14     |
| <b>I first [1]</b> 133/2      | 134/5 163/21                  | 29/7 36/4 36/14 44/2          | 90/14                         | 161/25 162/1                  |
| <b>I focus [1]</b> 48/6       | <b>I say [9]</b> 32/23 75/9   | 45/19 51/1 55/22 57/4         | <b>ICU [1]</b> 123/7          | <b>impossible [3]</b> 178/9   |
| <b>I follow [1]</b> 179/3     | 76/5 132/3 133/9              | 57/22 60/11 62/1              | <b>idea [3]</b> 158/10        | 179/2 179/10                  |
| <b>I get [1]</b> 184/19       | 133/11 161/24 175/5           | 64/12 72/3 77/16              | 158/15 178/15                 | <b>impractical [2]</b> 84/6   |
| <b>I go [4]</b> 123/15        | 184/17                        | 81/16 89/1 89/16 90/4         | <b>identification [2]</b> 9/2 | 116/22                        |
| 160/11 170/18 182/19          | <b>I sense [1]</b> 76/11      | 90/22 92/5 92/7 93/17         | 127/1                         | <b>impression [2]</b> 3/1     |
| <b>I guess [2]</b> 13/23      | <b>I sent [1]</b> 73/18       | 103/2 103/20 113/22           | <b>identified [3]</b> 10/18   | 182/2                         |
| 49/15                         | <b>I shall [6]</b> 51/5 93/6  | 113/22 114/16 114/20          | 55/22 126/17                  | <b>improved [2]</b> 24/20     |
| <b>I had [1]</b> 91/2         | 186/4                         | 114/21 114/25 120/16          | <b>identifies [3]</b> 4/17    | 170/4                         |
| <b>I have [7]</b> 1/16 26/10  | <b>I should [1]</b> 103/3     | 140/24 150/18 151/1           | 9/23 54/22                    | <b>improvement [3]</b>        |
| 28/6 36/5 175/19              | <b>I submitted [1]</b>        | 159/8 166/6 166/19            | <b>identify [13]</b> 9/19     | 55/8 71/20 160/19             |
| 176/3 183/3                   | 127/20                        | 171/2 173/21 175/15           | 10/1 10/11 10/14              | <b>Imrie [1]</b> 136/14       |
| <b>I haven't [1]</b> 180/15   | <b>I suppose [18]</b> 32/2    | 179/3 180/15 181/14           | 12/15 14/8 14/13 15/8         | <b>inadequate [3]</b> 23/18   |
| <b>I hope [4]</b> 2/12 51/3   | 41/6 42/1 44/11 49/9          | 181/18 182/23                 | 23/11 92/14 146/2             | 47/9 58/10                    |
|                               | 71/23 72/14 87/19             | <b>I'm agreeing [1]</b>       | 172/10 173/17                 | <b>inappropriate [5]</b>      |

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|--|---|--|--|--|
| <b>W</b><br><b>wrong... [7]</b> 150/8<br>150/25 159/3 159/18<br>160/4 182/2 184/20<br><b>wrongly [2]</b> 126/20<br>163/18  | 43/11 45/3 45/6 45/8<br>45/17 46/1 46/5 49/17<br>49/23 53/15 54/19<br>54/20 58/10 59/24<br>61/9 61/12 61/13<br>61/20 72/10 74/5<br>74/19 125/20 126/1<br>126/5 132/4 147/6<br>150/4 155/22 164/14<br>164/17 165/12 172/16<br>172/17 185/7<br><b>you'd [3]</b> 36/15 44/13<br>44/14<br><b>you're [46]</b> 10/5 10/5<br>14/19 16/1 17/19<br>18/13 21/17 21/18<br>37/20 39/18 41/1 41/2<br>41/6 43/17 52/23<br>76/11 80/21 84/2 85/1<br>88/17 88/19 90/2<br>93/22 95/16 101/3<br>102/20 103/21 112/7<br>114/13 114/24 117/2<br>118/14 123/6 125/10<br>127/13 129/18 134/7<br>134/16 146/1 149/21<br>150/25 152/7 152/14<br>157/5 180/16 181/20<br><b>you've [27]</b> 2/14<br>18/13 30/2 30/19 31/9<br>44/9 66/16 67/11 75/2<br>80/12 81/5 91/25 95/5<br>113/9 117/13 136/16<br>143/4 143/13 154/1<br>156/12 166/10 177/7<br>178/3 178/5 183/12<br>183/13 184/15<br><b>your [101]</b> 1/10 2/14<br>4/5 6/19 7/7 8/15 11/1<br>13/23 14/1 14/14<br>16/21 17/17 17/20<br>24/10 25/1 27/10<br>28/13 28/13 29/15<br>29/23 30/19 31/9 33/3<br>33/6 35/10 38/8 40/1<br>42/25 43/4 46/9 46/24<br>53/4 54/8 55/1 55/25<br>57/14 60/15 60/22<br>61/2 61/25 62/11<br>63/20 64/4 64/5 67/11<br>67/23 75/5 80/12 81/5<br>82/13 83/14 83/14<br>83/24 85/15 91/7<br>92/19 94/3 96/17<br>102/4 102/4 102/6<br>102/20 107/16 107/19<br>110/12 111/8 113/23<br>113/23 115/23 115/24<br>116/7 117/13 118/2<br>118/10 124/22 125/11<br>126/24 139/14 142/10<br>143/13 143/16 149/1<br>149/8 150/8 150/25<br>166/16 166/22 168/3 | 168/12 171/14 171/17<br>174/8 175/19 175/22<br>175/23 177/3 178/4<br>179/3 179/14 180/11<br>186/3<br><b>yourself [2]</b> 41/3<br>108/17<br><b>yourselves [1]</b> 40/15 |  |  |
| <b>Y</b><br><b>yeah [26]</b> 1/16 10/13<br>16/4 20/4 20/17 22/23<br>38/1 44/16 53/13 54/2<br>59/10 59/12 84/1<br>84/11 92/6 98/5 110/8<br>115/19 135/9 138/14<br>139/8 143/19 144/11<br>144/14 161/7 164/18<br><b>year [3]</b> 64/10 64/11<br>167/3<br><b>years [6]</b> 5/23 25/6<br>25/18 82/24 101/20<br>169/20<br><b>Yep [4]</b> 47/4 48/8<br>48/13 80/23<br><b>yes [83]</b> 4/23 13/23<br>29/24 30/4 30/13<br>30/15 31/2 31/18<br>32/19 32/21 34/19<br>34/23 35/3 35/12 37/3<br>38/17 39/5 39/11 40/9<br>41/12 42/6 42/9 42/17<br>44/2 50/15 51/2 54/15<br>55/5 55/7 55/16 56/3<br>56/7 57/1 57/17 58/5<br>60/11 67/20 72/22<br>76/18 78/16 80/5<br>81/14 83/13 85/4 86/6<br>90/19 93/6 97/23<br>103/1 104/3 104/6<br>105/22 110/4 110/13<br>111/10 114/4 116/8<br>116/18 117/7 118/1<br>124/7 126/18 127/19<br>128/14 128/21 129/17<br>130/18 131/15 132/3<br>136/10 143/17 144/20<br>149/18 150/21 151/23<br>152/10 153/7 156/6<br>161/4 166/20 168/7<br>176/22 181/9<br><b>yesterday [3]</b> 25/20<br>139/3 139/10<br><b>yet [4]</b> 27/14 155/19<br>157/1 158/7<br><b>you [721]</b><br><b>you know [61]</b> 3/4<br>5/5 11/15 11/21 13/10<br>13/11 13/16 16/7<br>17/12 17/12 18/20<br>19/14 22/4 22/16<br>23/14 32/25 33/24<br>34/18 35/7 35/8 37/16<br>38/19 40/15 40/22<br>41/2 41/20 41/21 | <b>Z</b><br><b>zoomed [1]</b> 176/4   |  |  |  |