1 **Tuesday, 17 September 2024**
2 **(10.00 am)**
3 **LADY HALLETT:** Ms Carey.
4 **MS CAREY:** Thank you, my Lady. May I invite Dame Ruth May
5 to be sworn, please.
6 **DAME RUTH MAY (sworn)**
7 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**
8 **LADY HALLETT:** Sorry, send a message, I've got the wrong
9 notebook. If someone could go and get the right one I'd
10 be grateful.
11 **MS CAREY:** Thank you.
12 My Lady, may I make a start on some background
13 matters and we'll remedy the notebook.
14 **LADY HALLETT:** Do please, I can catch up.
15 Dame Ruth, your full name, please?
16 **A.** Ruth Rosemarie May.
17 **Q.** You made a witness statement to the Inquiry dated 17 May
18 this year, INQ000479043, and I hope you have a copy of
19 that in front of you.
20 **A.** I do.
21 **Q.** A little bit of background about you, please. I think
22 it's right that you have been a nurse since student days
23 in 1985.
24 **A.** Yes.
25 **Q.** You were made the Chief Nursing Officer in 2019 --

1 **A.** Yes.
2 **Q.** -- until you retired in July of this year?
3 **A.** Yes.
4 **Q.** Can I ask you, please -- and if it helps you to refer to
5 your statement, please do -- just give us an overview of
6 the role of the Chief Nursing Officer?
7 **A.** I was the former Chief Nursing Officer for England, from
8 January 2019 to end of July. I was the most senior
9 nurse in England. I led my profession and I was the
10 adviser to the government, to DHSC and to the NHS on
11 nursing.
12 **Q.** I think you said there are currently around 386,000
13 nurses and midwives working for the NHS in England?
14 **A.** Yes.
15 **Q.** Is it right that you do not line manage the nurses?
16 **A.** Absolutely.
17 **Q.** I think you said in your statement that you have three
18 categories really towards your work and, if it helps
19 you, paragraph 17, Dame Ruth: you say you are
20 accountable as an Executive lead. Can you give us
21 an example of what you did in that role?
22 **A.** Of course. So I, as a professional leader, I led on
23 some of the national programmes. For example,
24 international nurse recruitment, maternity, nosocomial
25 transmission programmes.

1 **Q.** You also say part of your role is to act as
2 a collaborator. Again, an example of that, please?
3 **A.** I worked with my National Medical Director on the
4 DNACPR. We worked to promote the practice on that.
5 **Q.** That's Sir Stephen Powis?
6 **A.** Yes.
7 **Q.** Thank you. You also have a role as a stakeholder or
8 adviser. Again, an example of that, please?
9 **A.** Of course. So the black, Asian, minority risk
10 assessment, I was an adviser to the CPO -- and my views
11 I'm sure we'll come to.
12 **Q.** I think, whilst you were the Chief Nursing Officer and
13 during our relevant period for Module 3, you were
14 supported by four deputy CNOs, and there were chief
15 nurses in each of the seven regions in the NHS in
16 England?
17 **A.** Yes, there were. There were regional chief nurses who
18 had the responsibility and leadership to support the
19 trust chief nurses, and they worked very much as part of
20 my team CNO.
21 **Q.** Thank you.
22 I'd like to look at your responsibilities during the
23 pandemic itself, and it may be that, during the course
24 of my questions to you, Dame Ruth, I'll ask for
25 documents to be called up on screen. Before I do, and

1 without causing you, I hope, any embarrassment, is it
2 right that you have dyslexia?
3 **A.** Yes, I do.
4 **Q.** If I go too fast or you want to take a moment to read
5 through a document, please will you let us know.
6 **A.** Thank you.
7 **Q.** So to the pandemic, please. You say at your
8 paragraph 27 that you were the senior responsible
9 officer for NHS England's IPC cell. Help us, please,
10 what you did as the senior responsible officer in
11 relation to that cell?
12 **A.** So the IPC -- UK IPC cell, was a consensus group. I was
13 responsible for IPC in England. The group was made up
14 of professionals, public health professionals,
15 microbiologists, IPC nurses, from across each country of
16 the UK.
17 **Q.** We heard yesterday from Dr Ritchie, so we're a little
18 bit familiar with the cell, and indeed we'll be hearing
19 from Laura Imrie, who was also a member of the cell;
20 were you actually on the cell, though?
21 **A.** No, I wasn't. So my oversight came through -- I met
22 with Dr Lisa Ritchie, Professor Mark Wilcox, the
23 National Clinical Director for IPC, and my deputy CNO
24 with responsibility for this, almost on a daily basis
25 during Covid, during the relevant period. Together with

1 being a member of the HOCI working group --
2 **Q.** Pause there, that's the Hospital Onset Commission *(sic)*
3 Infection working group?
4 **A.** Indeed.
5 **Q.** Thank you.
6 **A.** So together with being a member of that, I was being
7 able to see and hear views from across the whole of UK,
8 from public health specialists, microbiologists and from
9 infection control nurses. We relied as well on data,
10 what the data was telling me.
11 I think finally my oversight was partly by
12 membership of the senior clinical group as well.
13 **Q.** I was going to come on to that --
14 **A.** Okay.
15 **Q.** -- if I may. I think that was a group that was made up
16 of who, please?
17 **A.** The senior clinical group was chaired in the early days
18 always by the Chief Medical Officer of England, and then
19 it rotated chair between the UK CMOs. It had Public
20 Health England, senior doctors, Professor Harries, and
21 then she went on to be the chief exec of UKHSA. We had
22 the public health senior medical director, Professor
23 Susan Hopkins. It had the National Medical Director,
24 Sir Stephen Powis, and it had all four UK countries'
25 CNOs and CMOs.

1 **Q.** Right. I think that group is sometimes known as the
2 senior clinicians group or --
3 **A.** It is.
4 **Q.** -- or senior clinical group and is it also known as the
5 senior clinical leads, or is that a different group?
6 **A.** I always knew it as a the senior clinical group --
7 clinicians group.
8 **Q.** So that group of senior clinicians had oversight of the
9 IPC cell?
10 **A.** The oversight -- the IPC cell was a consensus group. It
11 was not a decision-making group. IPC members used to go
12 back to their country and their country then would make
13 the decision. So, for example, in England it would come
14 to me and I would take a paper, often with the National
15 Clinical Director, Professor Mark Wilcox, to our NIRB,
16 our decision-making group. But always, always, after
17 each country had taken it back to their decision-making
18 group, it would go to PHE or UKHSA for the final
19 oversight of the content of any IPC guidance.
20 **Q.** Pause there. So I want to be clear: the IPC cell make
21 a recommendation, it is seen by you and/or Mr Wilcox in
22 relation to England, equivalents, I assume, in Scotland,
23 Wales and Northern Ireland, once it's been seen by those
24 four nations, are you saying that PHE, UKHSA, as it
25 became, still had final say?

1 **A.** Absolutely, yes.
2 **Q.** Right, so there's a number of levels of authority that
3 it's got to go through before it ends up being
4 published?
5 **A.** Absolutely.
6 **Q.** If you and/or Mr Wilcox said you didn't like
7 a recommendation made by the UK IPC cell, what would
8 happen, practically?
9 **A.** So, we would look at it, we would debate it. My role,
10 of course, was around the operational implementation.
11 So I had a view around how cohorting would work, how we
12 would support staff in that. Then, of course, it would
13 go to PHE and to UKHSA for the scientific sign-off of
14 the guidance.
15 **Q.** Right. So if you disagreed with the IPC cell,
16 presumably you would make your views known, would you go
17 back to the IPC cell and say "I don't think this is
18 quite right, it's not going to work on the ground"? How
19 would it actually evolve?
20 **A.** So my role was to question, to challenge, to ask "Have
21 the IPC cell reviewed and considered the latest
22 evidence", and I've done that a number of times during
23 the relevant period. As all UK CNOs did, we all
24 collectively and individually would always challenge and
25 do that but, of course, the scientific advice came from

1 the scientists, so public health doctors. I looked to
2 the public health doctors a lot to give me that
3 scientific advice, as well as the UK IPC cell and,
4 of course, they had public health doctors within --
5 **Q.** Yes.
6 **A.** -- theirs as well as other professionals.
7 **Q.** So if there's some -- don't take this pejoratively --
8 backwards and forwards between you and the UK cell,
9 between the four nations, hopefully agreed position
10 amongst all of you. But are you still saying that, even
11 if you all agreed, Public Health England and UKHSA, as
12 it became, could still say, "We don't think this is the
13 right recommendation to make, we don't think this
14 guidance is correct"?
15 **A.** Absolutely.
16 **Q.** Okay, all right, we may come back to that, Dame Ruth, in
17 a moment.
18 I think one of your other roles in relation to the
19 pandemic was, as an executive director of NHS England,
20 you attended the Covid-19 national incident response
21 board. Help us, please, with what that board did?
22 **A.** It was often referred to as NIRB; it was the
23 decision-making group within NHS England. I was
24 an executive director around there. I took almost 60
25 papers to that group during the relevant period.

1 **Q.** I think you said they met three times a week or more --
2 **A.** Yes.
3 **Q.** -- during that. You obviously engaged with your fellow
4 CNOs in Wales and Scotland and Northern Ireland, and you
5 said that there were 26 meetings just between March and
6 May 2020; you clearly worked with Chief Medical Officer,
7 Sir Chris Whitty; you've told us about the senior
8 clinicians group; you met with the Secretary of State,
9 Mr Hancock and, in due course, presumably Mr Javid?
10 **A.** No, I didn't.
11 **Q.** You didn't meet him, all right, thank you. You worked
12 with PHE on IPC guidance, and one other aspect I'd like
13 to ask you about is your engagement with frontline
14 nurses. If it helps you, Dame Ruth, I'm at paragraph 54
15 in your statement but I think there you said there was
16 initially an informal advisory group which then, in due
17 course, became more formalised. Tell us about that
18 transition.
19 **A.** Thank you. So we were facing some extraordinarily
20 difficult decisions in the very early part of the
21 inquiry, difficult because it was a fast-moving
22 environment, a time when we were seeing the number of
23 cases come in, deaths that we hadn't seen -- like we had
24 seen before.
25 So I wanted to check out the views of potential

1 actions I was taking with some of the most very senior
2 and experienced nurses. So I had a telephone book of
3 probably the most forthright nurses in England at the
4 time, and I chose them because I wanted them to give me
5 their value of their experience, their expertise, but
6 also they weren't going to say "Yes, of course, CNO",
7 they were going to say, "Well, that won't work, that
8 will work, have you thought about ..." and that really
9 helped me make some tough recommendations and decisions .
10 **Q.** You spoke there about your contact with senior nurses.
11 What about those less senior on the front line?
12 **A.** Yes, so I had a shared decision-making council that we
13 set up in May 2020, and they were made up of frontline
14 staff from all over England, of all sorts of backgrounds
15 and settings.
16 We -- they reviewed what we were doing, I used to go
17 to them with questions, I attended a lot of their
18 meetings and, indeed, I'm seeing them tomorrow for my
19 final meeting with them. I also, of course, visited,
20 like I would do pre-pandemic and post-pandemic --
21 **Q.** I want to come on to the visits as a slightly separate
22 topic. So you were having, though, some input through
23 the shared decision-making council from those on the
24 front line and in addition to your contacts with the
25 more vociferous senior nurses that you've told us about.

1 All right.
2 **A.** And with the Chief Nursing Officer, Black Asian Minority
3 Strategic -- their SAG, they were invaluable
4 colleagues --
5 **Q.** I wanted to actually just ask you, please, about your
6 involvement with the -- I think they're called CNO SAG,
7 it's not a particularly attractive name. Just help us,
8 what does that stand for, Dame Ruth?
9 **A.** The Black, Minority Ethnic Chief Nursing Officer
10 Strategic Advisory Group has been running now for
11 22 years. It's made up of people from a black, Asian,
12 minority background, nurses from all levels across the
13 whole of England, and they are the most wonderful group
14 to work with. They are -- they champion, they support
15 each other and they did some great work to support their
16 colleagues and to support our national decision-making
17 during the relevant period.
18 **Q.** I think you say at paragraph 60 in your statement that,
19 thanks to the links through that group, you were
20 involved in raising the issue of disproportionate impact
21 of Covid on the black, Asian and minority ethnic staff,
22 and indeed patients, in April 2020. Can you just,
23 perhaps by reference to paragraph 60, set out, please,
24 some of the issues that came to your attention?
25 **A.** Yes. So they had held a number of teleconferences

1 across all of the seven regions with frontline staff,
2 and it came through that that they said that there were
3 some people, particularly from a Filipino background and
4 particularly women, that some of the masks weren't
5 fitting properly because of the shape of faces were
6 different. I took that and my deputy CNO developed
7 a programme, an improvement programme, to increase the
8 number of types of mask, and indeed there were eight
9 additional FFP3s available then for staff as a result of
10 that programme. That was where listening to frontline
11 staff for me made a change in a national policy.
12 **Q.** Although, with that, the need to fit test another eight
13 different types of FFP3 mask.
14 Can I ask you about this, whilst dealing with this
15 topic: can you help, when did you first become aware
16 that there was an issue of disproportionate infection
17 and indeed death rates amongst black, Asian and minority
18 ethnic healthcare workers?
19 **A.** Yvonne Coghill, the then WRES director, emailed me,
20 I think it was 7 April, I think it's in my statement
21 here somewhere, but she emailed me raising that.
22 I immediately, immediately, talked that through with
23 colleagues in the strategic incident team, and then the
24 next day, I believe, we had a senior clinician meeting
25 and I raised it with my senior clinical colleagues, and

1 that is when the Chief Medical Officer for England
2 commissioned some further work.
3 **Q.** Yes, we're going to be hearing from Sir Chris Whitty
4 next week. May I ask you this, though, there's a lot of
5 people that say they raised issues, they spoke about it
6 with colleagues, they escalate it, to use a phrase that
7 is often used. What practically do you think could be
8 done to help minimise the disproportionate infection and
9 indeed death rate on black and minority ethnic
10 healthcare workers?
11 **A.** So there was a risk assessment process that was
12 established for making sure that workers from a black,
13 Asian, minority background, from all backgrounds, not
14 just nursing midwifery professions. It was led by the
15 CPO directorate and you will know that I raised later,
16 I think it was early June, that I wanted that risk
17 assessment process sped up because I was hearing, from
18 again my colleagues from the Black Asian Minority
19 Strategic Advisory Group that there were still people
20 without a risk assessment and I wanted that sped up.
21 **Q.** We will turn to that a little later in your evidence.
22 Aside from the strategic SAG group that you spoke
23 about, was there any other way that you came to learn
24 about issues and concerns faced by ethnic minority
25 nurses?

1 **A.** The Jabali network, which was a group of male -- men in
2 nursing. It started off just literally before lockdown,
3 9 March 2020, there was nine of them and now there's
4 well over 100. They would give me feedback and, of
5 course, I worked on the front line myself.
6 **Q.** Taking all of those different sources of information,
7 what would you say were the key issues and challenges
8 being faced by black and minority ethnic nurses and
9 midwives?
10 **A.** It was -- it was tough for them, tougher for them than
11 people from my background. If I think back at the
12 Nightingale, there were 30 patients and all but one were
13 from a black, Asian, minority background, and that was
14 replicated in critical care units, and then, if you were
15 staff treating patients that were also looking like you,
16 that was tough for them, very tough. And so that's why
17 we did a lot of work to support the associations -- so
18 this was the Filipino Nurses Association, the British
19 Indian Nurses Association, there were three of them at
20 the start of the pandemic, and I think now there's 36 of
21 them. So we funded a small grant process to support
22 them to do that. But it was tough for black, Asian
23 minority nurses, particularly seeing so many patients
24 from the same background.
25 **Q.** You set out in your statement the work you've done with

1 the Royal College of Nursing, the NMC and like
2 associations. I think you said in your statement that
3 you didn't always necessarily see eye to eye with the
4 Royal College of Nursing. Are you able to give us some
5 examples of where you didn't agree with them and how
6 that impacted either your response to the pandemic or
7 indeed their response to the pandemic?
8 **A.** Thank you. So I had a very good relationship with
9 Dame Donna Kinnair and then Pat Cullen, the chief
10 executives during the relevant period. It was always
11 a robust relationship, as it would be with any
12 college/union. But we always had nurses' and patients'
13 interests at heart. So Dame Donna, particularly around
14 PPE, and I were in conversation where they supported the
15 guidance.
16 But I knew that there were, particularly later into
17 the pandemic, members within the RCN challenging some of
18 the IPC guidance, for example. But at my level, the
19 chief exec level, we had a very robust and challenging
20 but excellent relationship, and I'd say that the same
21 with Pat Cullen.
22 **Q.** In relation to IPC, would that be around the provision
23 or otherwise of FFP3 masks?
24 **A.** Yes, and indeed the beginning it was around gowns and
25 aprons.

1 **Q.** Fine, we're going to come on to look at some of the
2 specific issues with PPE supply.
3 Finally this, you've alluded a number of times
4 already to your work on the front line, and I think in
5 your statement you say you worked during our relevant
6 period on wards on 29 occasions and indeed undertook
7 a number of visits of different wards, including
8 critical care units.
9 Help us, please, on any of those occasions, what was
10 it like?
11 **A.** An utter privilege. Excuse me.
12 **Q.** It's all right.
13 **A.** I'll have a quick drink of water.
14 **Q.** Please do.
15 **LADY HALLETT:** Take your time.
16 **A.** Thank you, my Lady.
17 It was an utter privilege. It really was
18 a privilege to be a nurse.
19 **MS CAREY:** What did you see? Tell us, Dame Ruth. Give us
20 a little insight into what --
21 **A.** Yes, of course.
22 So early on, I did two shifts at the Nightingale.
23 The first time I've already referenced, the second time
24 was literally on the way back from my stepmother's
25 funeral in Wales. I then did another -- I did

1 an evening shift, and I actually nursed a nurse, which
2 was a privilege.
3 I worked -- I visited inclusion nurses, nurses that
4 worked in the homeless, I visited a care home. I had
5 a great privilege in January -- December and January to
6 work in the vaccine programme. That gave me hope.
7 But I also worked in ITU on a Sunday morning, under
8 the radar, under the radar, worked alongside colleagues.
9 There was death. There was death. There was -- there
10 weren't visitors. Nursing ratios were stretched. But
11 it was very powerful, because I was able to go back then
12 to Matt Hancock, to the Secretary of State, and go,
13 "This is what my recommendation is. No, we're not doing
14 that. Yes, we are doing that."
15 So it gave me a real live experience of what it was
16 like to wear full PPE. Dame Donna was with me on the
17 first time in Nightingale, but nurses -- nurses were at
18 the brunt of this.
19 **Q.** What was it like wearing full PPE, from a practical
20 perspective?
21 **A.** I was a theatre nurse by background, so we were used to
22 wearing masks, but not FFP3, of course. I was
23 fit tested at the Nightingale, but I was fit checking
24 every shift I did when I was at Colchester going into --
25 working alongside colleagues at critical care. They

1 gave lots of nurses, including myself, indents into our
2 cheeks, but they were the protection that was needed for
3 critical care units.
4 But it wasn't just the mask, it was the eye
5 protection, the gown, the gloves. It frankly took ages
6 to get everything on and off.
7 **Q.** We might come back to that in a moment.
8 Can I change topic?
9 **A.** Of course.
10 **Q.** I'd like to ask you, please, about pre-pandemic work
11 issues. Dame Ruth, if it helps you, I'm in paragraph 88
12 in your statement.
13 **A.** Yes.
14 **Q.** I think you say this, as at December 2018 there were
15 workforce vacancies in the NHS in England alone of
16 39,686 nursing and midwifery vacancies.
17 Call it 40,000 just for ease.
18 There was some increased funding given, is that
19 right, to provide 5,000 additional places for student
20 nurses?
21 **A.** Can I ask your permission to provide a bit of context
22 before we get to that?
23 **Q.** Of course. Of course you can.
24 **A.** So you're right, there was very nearly 40,000 vacancies.
25 In England, which is different to the other devolved

1 nations, the bursary was removed.
2 **Q.** Is that a student bursary or a ...
3 **A.** So in 2017 or 2015 the then -- George Osborne --
4 Chancellor announced that they would get rid of the
5 student bursary, which is, in effect, the student fees
6 were paid for and a maintenance grant, which meant that
7 there was a significant drop, indeed a 23% drop, in
8 nursing and midwifery applications as a result of that.
9 So instead of nurses being trained, like I was, like
10 many other nurses were, when we received free education
11 and a maintenance grant, nurses and midwives now are
12 students -- well, at that period, were not receiving
13 that. So they ended up in a lot of debt.
14 That meant -- and HEE colleagues have done some
15 analysis of that work --
16 **Q.** Is that Health Education --
17 **A.** Health Education England. They have done some analysis
18 of that work, and it meant that we were 5,000 fewer
19 nurses in March 2020 because of that decision, and
20 700 fewer midwives in March 2020.
21 **Q.** So you have a general deficit in 2018 but come the start
22 of the pandemic a significant number of fewer nurses and
23 midwives?
24 **A.** 5,000.
25 **Q.** 5,000, right.

1 **A.** 5,000 fewer nurses at the beginning of the pandemic
2 because of the bursary decision.
3 **Q.** Can you help us, how does that play out on the ground?
4 If you had 5,000 more, put it another way, how many
5 extra nurses would there be in a hospital?
6 **A.** I reckon it would be about 40, around 40 extra nurses in
7 each hospital. Now, of course hospitals are different
8 sizes. That, I think, would have made a difference.
9 Maybe we needn't have made some of the decisions around
10 critical care ratios. But -- and of course if we had
11 more nurses there would be less burn-out, there would be
12 less psychological impact. Removing the bursary, for
13 me, was a catastrophic decision.
14 **Q.** All right. Let's look at a programme in 2019, I think,
15 launched by the Department of Health and Social Care to
16 deliver 50,000 nurses by 2024 and 2025. Now, basically.
17 Is that new recruits or getting people who were off the
18 register back or international recruits or increasing
19 students? How were they going to make up the
20 50,000 nurses as part of this plan?
21 **A.** So just before that, of course, we had the £5,000
22 maintenance grant that I championed and the government
23 supported. Indeed, Matt Hancock supported that coming
24 in place, which was a support to attract nurses, and
25 that did work, but it wasn't, still, free education.

1 But going on to your point, the DHSC launched the
2 50,000 programme, and it was 50,000 extra. So of course
3 we had to recruit and to retain more than the 50,000 in
4 order to allow for people leaving and retiring.
5 Nurse -- I was responsible for international nurse
6 recruitment, and at the time we had an aim to deliver
7 18,000. Of course we completely exceeded that, and
8 we'll no doubt come to it. And HEE colleagues at the
9 time had a role to increase domestic nursing supply with
10 the aim to get to 19,000 and the CPO nursing retention,
11 so 13,000. So that 50,000 was broken down into
12 international nurse recruitment, domestic supply and
13 retention.
14 Q. All right.
15 Can I ask you this: I think there were projections
16 for between 20 and 30% staff absence in England alone
17 during the pandemic. Does that mean on any given day or
18 week it would be predicted that there would be up to
19 a third almost of nursing staff missing? Or is that too
20 simplistic a way of looking at it?
21 A. So the way I recall it was that the strategic EPRR
22 director, Professor Sir Keith Willett, wrote out to
23 myself and to Steve Powis and said "We're going to be
24 20 to 30% short", it was because that was the formula
25 that was part of the pre-pandemic planning. I think

1 that's where it came from. So increasing workforce
2 supply was a key action for me.
3 Q. Right. I want to -- it may be I've not made myself
4 clear. You're going into the pandemic with a deficit of
5 nurses and midwives. Then there is the impact of the
6 pandemic, so nurses getting sick themselves or
7 isolating, which could cause a 20 to 30% --
8 A. Yeah.
9 Q. -- absence rate. The 50,000, was that meant to cover
10 the pre-pandemic deficit and/or the absences caused by
11 the pandemic itself?
12 A. The pre-pandemic.
13 Q. Right.
14 A. And the 50,000 programme was the step towards the
15 vacancies, it -- my recollection was, in modelling, it
16 should have probably been an 85,000 programme, but it
17 was a 50,000 ambition that the government set.
18 LADY HALLETT: And what happened?
19 A. We delivered 64,000 additional nurses.
20 LADY HALLETT: So I'm not following. You spent some time --
21 as you'll understand there is a limit to how much I can
22 go into austerity measures and party politics and the
23 like.
24 A. Of course.
25 LADY HALLETT: And who decided to introduce fees for

1 education and things. But you did say that you blamed
2 the withdrawal of the bursary for the fact there were
3 fewer nurses, but now you said that the programme
4 recruited 64,000 additional nurses. So I'm not quite
5 following.
6 A. So the -- we went into the pandemic with nearly 40,000
7 vacancies. We would have had an additional 5,000
8 vacancies at the start of the pandemic if the bursary
9 hadn't been removed. The 50,000 ambition came because
10 nurses were going to be -- carry on increasing in need
11 and demand, so the government decided to have a 50,000
12 ambition. I supported that. We actually delivered, by
13 November 2023, with -- using September 2023's data we
14 delivered 64,000 additional nurses. So during -- at the
15 start of the pandemic, September 2019, the programme was
16 launched. We worked hard to increase the number of
17 nurses and even harder throughout the pandemic to make
18 sure that we overdelivered against that.
19 MS CAREY: Thank you.
20 I just briefly asked you about staff absences. Can
21 I just ask you about Long Covid absences in nursing. If
22 it helps you, I'm further on in your statement, at
23 paragraph 219(a), but I think you attended a meeting
24 certainly in December of 2021 looking at the issue in
25 relation to Long Covid absences and the impact it might

1 have on nursing.
2 Can you just summarise what you learnt at that
3 meeting and indeed what was your takeaway in relation to
4 the impact of Long Covid on the nursing profession?
5 A. I believe this was the roundtable chaired by
6 Lord Bethell.
7 Q. It was.
8 A. My medical director colleagues, Nikki Kanani,
9 Cathy Hassell, they presented a paper on Long Covid to
10 the minister with what they were doing on that. I took
11 away from that meeting and others that we needed to
12 support nurses supporting patients with Long Covid, and
13 that's why we developed a framework to do that to
14 support them.
15 Q. In a nutshell, what did the framework achieve or set out
16 to achieve?
17 A. It set out to support nurses because this was -- this
18 was new, it involved multi-professional working and
19 nurses from all sorts of clinical backgrounds. There
20 were -- I received some advice from Dr Elaine Maxwell,
21 who was very helpful in this area, and we got
22 experienced people that were -- through life were
23 experiencing Long Covid, to support that framework
24 development, but by a different one of my deputy CNOs.
25 Q. Can you give us a practical example of the support,

1 perhaps not provided by you, but through the Chief
2 Nursing Officer Directorate, how practically you
3 supported people with Long Covid?
4 A. Well, people with Long Covid, they're often nurses that
5 had Long Covid. Most of the support for that came from
6 the -- how we supported them with their pay, their terms
7 and conditions, how we got them back to work in
8 a part-time capacity, in a very different capacity.
9 I met one of the Long Covid nurses on a Teams call that
10 was describing how she's now doing part-time research
11 and part-time in her old job, so that it supported her
12 back to her full health.
13 Q. We looked there briefly at some of the issues going into
14 the pandemic and some attempts to increase nursing
15 capacity.
16 Can we call onto screen, please, INQ000421158 at
17 page 2.
18 If it helps you, Dame Ruth, it's in tab 2 of the
19 bundle, but it might be easier just to use the screen.
20 This was a letter that you wrote on 6 April from you
21 and indeed the chief nursing officers of all
22 four nations I think outlining the four-ways that it was
23 intended to increase nursing capacity.
24 The first one there is:
25 "Once the government has passed the legislation to

1 enable the NMC [the regulator] to establish a Covid-19
2 temporary register our first focus, we will be inviting
3 those ... who have left the register within the last
4 three years to opt in should they wish to do so."
5 All right, so to get people who have come off the
6 register in the last three years to come back onto the
7 register. Why was the three years chosen?
8 A. Because it was -- it would give us a potential 50,000
9 people. The NMC looked at the data and said that they
10 thought it was -- three years would be the right
11 years -- the right number of years. UK CNOs debated
12 that and agreed, and so it was three years. I think
13 later on we did longer.
14 Q. Thank you, I'm going to come on to that, but I think you
15 said it was anticipated that if you went back
16 three years the NMC thought that it might give you
17 a cohort of around 60,000?
18 A. In the UK --
19 Q. In the UK --
20 A. -- and --
21 Q. 51,000 --
22 A. 51,000 --
23 Q. All right, so that could potentially fill the gap?
24 A. Yes.
25 Q. All right. It was aimed, I think you say, at people

1 under 65 who were perhaps now working in different areas
2 of the healthcare market. You widened that, though, as
3 I understand it, to cover people who'd left the register
4 within the last four to five years. Why was it widened
5 from three to the four to five?
6 A. Because the picture we were facing with Covid and the
7 number of patients coming into hospital was increasing
8 at a further rate, so we needed to take further action.
9 Q. Was it thought that those who had left within
10 three years would effectively be more up-to-date with
11 their skills, if I can put it like that, than those
12 perhaps where four or five years has lapsed?
13 A. Indeed.
14 Q. But notwithstanding that, the need was such that you
15 needed to go back four to five years, all right.
16 Now, whether it was three years off the register or
17 four to five, can you help us with what plans were put
18 in place to ensure that those who were returning were
19 sufficiently skilled and up to date?
20 A. So each of the trusts where people went, nurses went,
21 they did an induction programme, they did some key
22 skills training, but it depends on where they were. So
23 I worked alongside some children's intensive care
24 nurses. Of course they've got very real and very
25 transferable skills. I also worked alongside some

1 people that had been in education and not been on the
2 register but wanted to support. They needed more of
3 those skills. But of course we were in the middle of
4 a global health emergency, we weren't going to be able
5 to provide an induction programme over 12 weeks that you
6 would potentially provide in peacetime. This was
7 unprecedented times.
8 Q. Now, I think expressions of interest from those who were
9 potentially returning do not always equate to staff
10 actually being employed. Can we have a look at that,
11 please.
12 And can I ask that it's put up on screen,
13 INQ000421170.
14 A. Which tab?
15 Q. It is in tab -- I've got the wrong note, but we'll put
16 it on the screen and we'll just work off the screen.
17 Now, this is a very long email setting out the
18 returners. Can we go to page 68, which is the position
19 at the beginning, and as you go through an email
20 inevitably we end up where we need to be.
21 A. Yep. I've got it.
22 Q. Bottom of the page there, this is the position: very
23 early on, just as we're about to go into lockdown, as at
24 11.30 am on Saturday, 21 March, the NMC had received
25 nearly 4,000 applications to join.

1 A. Yes.
2 Q. Can we just go to page 67, a day later it's gone up to
3 5,633 applications. I'm going to jump forward
4 a month -- to page 4, if I may, please.
5 A. Yes.
6 Q. It's just coming on screen now. Set out in a slightly
7 different format, with more detail, but here we are, one
8 month on from the nearly 4,000, and now we can see the
9 NMC confirm there is nearly 12,000 nurses and midwives
10 across the UK on its temporary register, and the data
11 has now been broken down into midwife, nurses, into
12 which country, and indeed which age bracket they're in.
13 A. So the NMC set this up very quickly, and we appreciated
14 that by the UK CNOs, and of course we understood that it
15 was UK data to begin with, but as soon as they could
16 they broke it down, as you can see.
17 Q. If we go to page 3, there is an email, I think, from you
18 at the top:
19 "Great to have nearly 12,000 back on the register ..
20 how many of these have done their first shift?"
21 That really brings me on to the point that just
22 because you went back on the register --
23 A. Indeed.
24 Q. -- did not necessarily result in people on the ground.
25 A. Absolutely, and I was corrected by Scott, in my team,

1 quite rightly, because that was the UK figure and the
2 England figure, as he then further goes on, was less.
3 But that was my first time going, "It's all very well
4 having them on the register, temporary register" --
5 Q. But what next?
6 A. But what --
7 Q. So let's look at page 2 of the document, please --
8 A. Yep.
9 Q. -- and there's an email from Scott Binyon --
10 A. Yes.
11 Q. -- setting out, just for England, you've got 9,841
12 opting into the temporary register --
13 A. Yes.
14 Q. -- of whom 8,950 are passed to the regions for
15 deployment.
16 Deployed by regimes to the front line, we go from
17 8,950 to 2,785.
18 Can you help with the decreasing numbers that we see
19 set out in that table? I will leave 111 for a moment
20 but how come is it that there's a lot of people looking
21 to join the register but, when we get to deployed by
22 regions to front line it's 2,785?
23 A. I think this is one of the areas of learning for us.
24 This was an issue that all four countries experienced.
25 There was a lack of capacity within our regional BBS,

1 bring back staff, teams, because they were -- they had
2 a lot of people interested. Now, where it worked well
3 was when critical care nurses had just left two, three
4 years ago, in their local unit and they still had
5 a relationship with them and they rang them up. That's
6 when it worked very well.
7 Interestingly, though, the NMC held -- does hold
8 data on their branch of nursing, whether it's
9 paediatric, mental health, adult, but doesn't hold data
10 on their specialism. So doesn't have a data about -- so
11 these amount of anaesthetic nurses, theatre nurses,
12 critical care nurses, A&E nurses and, if we'd had that,
13 I think we would have been able to concentrate on those
14 first --
15 Q. Yes.
16 A. -- and then maybe we wouldn't have seen the lack of BBS
17 regional capacity like we did.
18 So the bottlenecks, there was pre-employment check
19 bottlenecks, and there was also a difference between
20 what returners, by then, are wanting to do. When we got
21 to wave 2, of course, though, a lot of these people went
22 into the vaccine programme. I'm grateful for everybody
23 that came back to help us and I think what my email does
24 show is there was a lack of data on deployment.
25 Q. Well, you also make the point there -- sorry, Scott

1 makes the point, in the bottom bullet point, that 15 to
2 20% of those opted into the temporary register withdrew
3 from the process prior to deployment, the regions are
4 working through this but there are a number of reasons:
5 changes in circumstances, for example people
6 self-isolating --
7 A. Yep.
8 Q. -- individuals not wanting to work on the frontline and
9 then there was the pre-employment checks and individuals
10 not returning their -- a multitude of reasons as to why
11 initial interest did not always translate to nursing in
12 the wards?
13 A. Yep.
14 Q. All right.
15 Can I just ask you this: is there any merit in
16 always having a temporary register, do you think?
17 A. The NMC does not have the legislative -- I can't say
18 that word, sorry --
19 Q. Legislative.
20 A. -- ability to set up a temporary register, whereas the
21 GMC do.
22 Q. Ah.
23 A. It is part of the legislative reforms that are being
24 considered but, yes, that is something that they do
25 need --

1 Q. So --
2 A. -- certainly, to have.
3 Q. -- in short, if there needs to be a temporary register
4 for whatever reason, there's got to be legislation
5 passed to deal with the NMC aspect of it, whereas the
6 GMC already have a ready-made legislative power to do
7 it?
8 A. Yes.
9 Q. All right, okay.
10 Can I go back, please, to INQ000421158 and look very
11 briefly, if we may, Dame Ruth, at the two other ways of
12 increasing capacity. We've just got to revert back to
13 a different document, or it's in your tab 2, if it helps
14 you. Thank you very much.
15 The second way to increase capacity was:
16 "Encouraging those skilled who are currently on the
17 register, but not working in clinical care, to come into
18 clinical practice ..."
19 Who was this aimed at?
20 A. It was aimed at the many staff who were in
21 organisations, so there were people in governance teams
22 that were a nurse by background that could support, it
23 was aimed at people in our ALBs, in my own directorate,
24 in Health Education England directorate, it was aimed at
25 those people who were still on the register that could

1 provide support.
2 Q. Thank you.
3 The third way was:
4 "Changing the nature of the programme from
5 undergraduate nursing and midwifery students of the last
6 six months of their programme so that they may be
7 delivered in a clinical placement."
8 I think it's a three-year degree for nursing; is
9 that right?
10 A. Yes, it is.
11 Q. So just help us, what was the plan in relation to the
12 students in the last six months of their programme? If
13 it helps you I'm at about paragraph 116 in your
14 statement, Dame Ruth.
15 A. That would be very helpful, thank you. 116.
16 Q. I think you say there the NMC requires 2,300 hours of
17 academic study --
18 A. Yes.
19 Q. -- and 2,300 hours of supervised practice-based learning
20 for those student nurses, is that right, and midwives?
21 A. Yes, so for student -- for students, they needed to be
22 supernumerary, they supervise --
23 Q. What is that?
24 A. They don't -- they're not in the numbers, they are there
25 to learn, they are learners.

1 Of course, we then needed to change the standards,
2 the educational standards, for these learners, for these
3 students, to be able to be working in critical care,
4 therefore without their supernumerary status but we
5 wanted their work to be able to be counted towards their
6 educational studies.
7 So the NMC needed to do that, and they were very,
8 very supportive of us, and they needed to do that across
9 the whole of the four countries. This wasn't something
10 that could just be done for just England, and that's why
11 working with my CNO colleagues was so important.
12 Q. I think you said in your statement that it had been
13 identified that there were 18,700 --
14 A. Yes.
15 Q. -- nursing students in their final six months, so
16 potentially nearly 19,000 nurses that could start
17 helping out. Is that across England or the UK?
18 A. That is across England, but I need to make a correction,
19 because that is nursing and midwifery.
20 Q. Ah, okay, thank you.
21 A. So it was 16,547 for nurses and 2,175 for midwives, and
22 together that made 18,700.
23 Q. Can I ask you this about the student nurses and
24 midwives, though: they're finishing their academic
25 studies, they're doing their practical supervised

1 learning, did you receive any feedback about how young
2 nurses and midwives coped when they were deployed onto
3 the front line? It just seems, if I may put it like
4 this, a baptism of fire. What did you do or how did the
5 CNO try and help cater for that specific cohort of
6 nurses and midwives?
7 A. So this was, again, one of those tough decisions that
8 again I took to my strategic advisory group, this group
9 of very senior, experienced nurses, and none of us
10 wanted to do this, we wanted to continue their
11 education, but we're in such a position that we needed
12 to increase workforce numbers. So we made the decision
13 collectively, we debated it, we wouldn't do first years
14 because they were literally only just out on placement
15 in the January, we wouldn't do third years in the
16 first -- we'd only do them in the very last cohort.
17 Now -- the last part of their training.
18 It was not mandatory to do, though, it was a choice
19 by which people were able to make, and people did make
20 that choice not to go onto the front line, and we
21 respected them to do that.
22 The second years, though, we wanted to continue as
23 much as we could, so they still had one day in their
24 university to keep them linked in. There were risk
25 assessments but this was not an easy decision. But

1 student nurses were amazing support, and their
2 feedback -- the seven-point plan review fed back,
3 there's lots of surveys that the Health Education
4 England colleagues did at the time, fed back, what more
5 support we needed to do, that's one of the things the
6 RCN wanted us to do, which we did do, was to make sure
7 they got sick pay. So there's -- it was difficult but
8 they were amazing.
9 **Q.** I'm not going to ask you about the temporary register at
10 point 4. Can I briefly touch on international
11 recruitment. I think you said in your paragraph 141
12 that the process of recruiting internationally is not
13 new, it's been a long-established process within the NHS
14 but, in reality, given the lockdowns, was it possible to
15 boost the nursing numbers by international recruitment
16 during the pandemic?
17 **A.** Yes, it was.
18 **Q.** How did that happen?
19 **A.** Through a lot of hard work by a lot of directors of
20 nursing and colleagues in the teams. We were recruiting
21 between 5,000 and 6,000 international nurses anyway, and
22 we've welcomed international nurses since the beginning
23 of the NHS, with the Windrush generation, with Filipino
24 and Indian nurses back in the early 2000s, and then this
25 big campaign, recruitment campaign.

1 But, of course, restrictions, like global travel
2 affected everybody, so there were times, particularly at
3 the beginning, that early summer, when nobody was
4 travelling, so even those people that were due to come
5 weren't able to come, they were delayed. Then, of
6 course, there were the closing of the OSCE centres,
7 which was a training -- clinical training centres.
8 **Q.** So that meant that international nurses couldn't go
9 through the requisite training to ensure they had the
10 same standards as applied in the UK, is that right, or
11 in England?
12 **A.** In the UK.
13 **Q.** Thank you.
14 **A.** So they could go through the training but they couldn't
15 go through the assessment and that was -- so in
16 peacetime, what happens now, an international nurse
17 would come over, they're internationally educated,
18 they're trained in their own country. They then have to
19 go through an OSCE assessment of their clinical skills
20 in order for them to go onto the permanent register.
21 With the OSCE centres closed, and they didn't open
22 until July 2020, we would have to use these
23 international nurses in a different way and that's why
24 we came up with the temporary register with them as
25 well.

1 **Q.** Would a number of the international nurses be from
2 a black and ethnic minority background?
3 **A.** Yes.
4 **Q.** Given we know that they were disproportionately
5 impacted, was there any thought given to whether it was
6 the right thing to do to ask black and minority ethnic
7 nurses to come to the UK and potentially face the
8 consequences of a disproportionate impact on them; was
9 any thought given to that?
10 **A.** Yes, of course. So in wave 1 they were here. In
11 wave 2, of course, as we were headed towards the winter
12 of 2020, by that stage all black, Asian, minority nurses
13 had had a risk assessment and some had been removed from
14 clinical frontline care. So yes, of course.
15 **Q.** Can I deal with one other topic, please, perhaps before
16 we take a break, if I may, and it's in relation to
17 redeployment. Can I ask you, please, Dame Ruth, to turn
18 to paragraph 166 in your statement. In particular, I'd
19 like to examine redeployment to critical care and
20 changes to patient and nurse ratios, and you've already
21 referred to that.
22 **A.** Which paragraph, sorry?
23 **Q.** Probably easier actually just to go straight to
24 paragraph 171.
25 **A.** 171. Thank you.

1 **Q.** If we could have on screen, please, INQ000421219_0005 is
2 the page reference, thank you very much.
3 Can you just help us, in non-pandemic times, in
4 critical care, what should be the nursing-to-patient
5 ratio?
6 **A.** Critical care has patients on a ventilator needing high
7 level of intervention and with highly skilled staff. So
8 always, 24 hours a day, there is a trained critical care
9 nurse. Let me just spend half a minute on telling you
10 what that is.
11 **Q.** Yes. How is that different from -- I don't mean
12 an ordinary nurse but you understand there is
13 a distinction.
14 **A.** So I'm a registered nurse, like many, many thousands of
15 other nurses, I have had experience and a qualification
16 post my registration in theatre nursing, which meant
17 I was a trained theatre nurse. It's the same with
18 critical care. These are registered nurses, all with
19 some experience, and many of them many years'
20 experience, but all trained in additional level of skill
21 and expertise, all with an additional qualification. So
22 these are true experts.
23 **Q.** They tend to the sickest patients, if I can put it like
24 that, in theory one to one, in non-pandemic times?
25 **A.** Yes, and, obviously, with medical colleagues, part of

1 a multi-professional team, with the pharmacist, the
2 physio and other colleagues.
3 Q. During the pandemic, however, was there a decision taken
4 to change the patient-to-nursing ratios?
5 A. Yes.
6 Q. Who made that decision, please?
7 A. All four countries made that decision and, for us, the
8 decision formally was made by NIRB.
9 Q. By NIRB, the national incident response board; is that
10 right?
11 A. Yes.
12 Q. Were you part of the decision-making process?
13 A. I led it. So --
14 Q. Can I ask you, then, how is it that you came to take the
15 decision that, in some cases, we may need to go from one
16 critical care nurse to six patients?
17 A. Yes, so Sunday, 23rd -- 22 March was a day that I will
18 never forget. It started off at 9.00 in the morning
19 when we were -- had our meetings and we were -- I was
20 being told that we've got 4,000 critical care beds in
21 England but in 16 days' time we're going to need 7,000.
22 But I had a meeting at 1.30, actually, on the Sunday
23 with the British Association of Critical Care Nurses,
24 Nicki Credland as chair, excellent critical care nurse
25 leader and one of my deputy CNOs, and of course with

1 some other critical care nursing experts, and they'd
2 been doing some great work, this work. They'd been
3 talking to colleagues from across the UK and other
4 colleagues within their profession, that this could be
5 a proposal to take that forward. A team approach, not
6 ideal at all, and I know that -- I know there's been
7 consequences because of it.
8 Q. Let me pause you there. It's not, 1:6 may be slightly
9 misleading because, as you can see there, there are
10 other staff there as well performing rolls. You've got
11 staff A, staff B, but they are not those with critical
12 care training skills, are they?
13 A. No. Staff A are nurses with recent or past critical
14 care experience and staff B are nurses with no critical
15 care experience, and staff C are with healthcare support
16 workers. So it was much more of a team.
17 So I worked as a staff B and I was on a 1:2 ratio at
18 that time, working in my local hospital, and it didn't
19 feel like a 1:2 at all because, when somebody went for
20 a break it wasn't a quick cup of tea and back, it was
21 taking all the PPE off and back on again, so it was
22 a 45-minute experience. So it actually felt like 1:3.
23 That's why in wave 2 we didn't do this. We did this
24 in --
25 Q. Before we come to wave 2, what happened then when the

1 one critical care nurse who is looking after two, three
2 or four patients needs to take a quick comfort break,
3 who was there to fill the gap?
4 A. There was always a 1:4, there was people that would
5 cover for each other, but there were occasions where
6 there was one nurse to six patients, one critical care
7 nurse to six patients. There were other professionals.
8 This is a decision that will stay with me forever.
9 Q. Dame Ruth, do you think that the diluted staff ratios
10 affected the care that those patients received?
11 A. Yes.
12 Q. What about the impact on the critical care nurse
13 themself, an inevitable impact on them, I assume?
14 A. Inevitable, and what we now know, with Kevin Fong's
15 work, for example -- and that's why we launched the
16 Professional Nurse Advocate Programme for Critical Care,
17 but, yeah, this wasn't -- this was not where we wanted
18 to go.
19 Q. Why did you do it, why did you make that decision then?
20 A. In critical care the capacity was doubling, trebling,
21 quadrupling, ten times the capacity in other places. We
22 were seeing reports in Italy where patients weren't able
23 to get into hospital. Yeah.
24 Q. You mentioned, and perhaps we'll pause then after that,
25 if we may, my Lady, you said, "We didn't do it in

1 wave 2". Why not?
2 A. Because 30 July 2020, Professor Kevin Fong's briefing
3 shared with me the impact that it was mainly having on
4 nurses. So we developed the Professional Nurse Advocate
5 Programme, we developed a whole range of practitioner
6 health. But I made the decision then that I'm not
7 doing -- we're not doing this again.
8 But it was a critical care shift that I did in
9 January 2021, a Sunday morning, and I had my regular
10 meeting with the Secretary of State -- Matt Hancock, at
11 the time -- the next day, and of course there's the
12 pressure of getting on with the electives again, and he
13 said to me, you know, "Why can't we do 1:3 ratio all the
14 time", and I said "No, I was there yesterday morning",
15 and I explained to him what it was like.
16 He backed me and we did maximum of 1:2 during the
17 next wave.
18 **MS CAREY:** All right.
19 My Lady, would that be a convenient moment?
20 **LADY HALLETT:** Certainly.
21 I hope you were warned that we take regular breaks.
22 You might welcome one as well. I shall return at 11.20.
23 **MS CAREY:** Thank you very much.
24 **(11.08 am)**
25 **(A short break)**

1 **(11.20 am)**
2 **LADY HALLETT:** Ms Carey.
3 **MS CAREY:** Thank you, my Lady.
4 Dame Ruth, can we turn, please, to a different topic
5 and that of the IPC guidance and it starts in your
6 statement at paragraph 230 onwards. I think you were
7 the national director of IPC for NHS England; is that
8 right?
9 **A.** Yes.
10 **Q.** As you told us, you were the co-chair of the hospital
11 onset Covid working group --
12 **A.** Yes.
13 **Q.** -- and you say in your statement you have national
14 responsibility for NHS England's Covid-19 nosocomial
15 infections programme?
16 **A.** Yes.
17 **Q.** Right. Turning to the guidance itself, at paragraph 232
18 you say that:
19 "NHS England's role in [the guidance] was through
20 membership of [the cell] ..."
21 You brought together the leads and specialists from
22 across the UK:
23 "Initially the ... Cell provided comments on draft
24 guidance, [but], from June 2020 onwards the UK IPC Cell
25 drafted [the] guidance ..."

1 I think, if I've understood your evidence from this
2 morning correctly, you would then see that guidance and
3 have the opportunity to comment on it, agree, disagree,
4 amend, as you saw fit?
5 **A.** Yes, and indeed the draft guidance would go back to each
6 of the countries for their equivalents, their public
7 health and their leaders to consider as well, before it
8 then went to PHE for final approval.
9 **Q.** I think you say in your statement that you don't have
10 specific scientific and technical expertise, and you say
11 "It is not my role to make decisions on issues such as
12 PPE specification and the use and types of disinfectant
13 to use". I just want to be clear what you mean by that.
14 When you say you didn't make decisions on PPE
15 specification, what did you mean there?
16 **A.** I mean that the scientists provided me and across the UK
17 the advice on the scientific elements of the IPC
18 guidance, of which that was it.
19 For my role, my role was much more about providing
20 executive leadership, supporting the conversation,
21 supporting the coming together of UK-wide discussions,
22 as part of UK-wide CNO discussions, supporting, for
23 example, the National Clinical Director, Professor Mark
24 Wilcox, when I was going with him to the senior clinical
25 group, and indeed supporting Dr Eleri Davies, the

1 microbiologist -- the public health doctor in Wales,
2 when she presented the consensus statement in late 2021.
3 **Q.** All right, she, in due course, I think, became the chair
4 of the IPC cell after Dr Ritchie?
5 **A.** She did, the second year.
6 **Q.** I just want to be clear, was it part of your remit to
7 say "I don't agree that it should only be FRSM, I think
8 it should be FFP3"?
9 **A.** I would -- my remit was to challenge, to ensure that the
10 scientists have taken the latest evidence, and the
11 scientists were the public health doctors and the UK IPC
12 cell, which had a range of professionals within it from
13 across the UK.
14 **Q.** So if you thought that a wrong decision had been made
15 about the level of masks, for example, that should be
16 worn --
17 **A.** I would question it --
18 **Q.** Right, and then it would go back to the cell for their
19 view?
20 **A.** -- and indeed questioned Dr Susan Hopkins -- Professor
21 Susan Hopkins, and Jenny. Jenny and I and Susan and
22 I had many a conversation, as did the National Medical
23 Director, Steve Powis, with Susan and Jenny, and Chris
24 Whitty.
25 **Q.** Sorry, I didn't mean to interrupt you.

1 **A.** Sorry, I apologise.
2 **Q.** Were you familiar with the different modes of
3 transmission of this respiratory virus: contact,
4 airborne, droplet?
5 **A.** Yes.
6 **Q.** Are you a scientist by background, familiar with the
7 physics and engineering and droplet sizes?
8 **A.** No, I am absolutely not. I needed to rely on public
9 health specialists and other specialists.
10 **Q.** Can you help us: at; the beginning of the pandemic, what
11 did you understand to be the mode or modes of
12 transmission of Covid?
13 **A.** I understood it, like the World Health Organisation was
14 advising at the time, to be mainly droplet but, of
15 course, with aerosol, particularly then. That's why we
16 had the guidance for AGPs, so that we supported -- it
17 was making sure that -- making sure that we had guidance
18 for aerosol-generating procedures but, at that time, all
19 of the guidance, all the advice, scientific advice, was
20 predominantly droplet.
21 **Q.** Do you accept that, on the back of the scientific
22 advice, consequential decisions were made about what IPC
23 measures should be put in place?
24 **A.** Yes.
25 **Q.** Right. So droplet goes down one or a number of routes

1 for IPC, aerosol and airborne transmission may require
2 different IPC measures; in general, do you agree with
3 that?
4 **A.** In general. IPC measures are a combination of --
5 a combination not just around masks. Masks are very,
6 very, very important but so is distancing between beds,
7 so is eye contact -- eye wear, gowns, gloves, a whole
8 range of measures.
9 **Q.** Did you gain an understanding as the pandemic progressed
10 that aerosol transmission played a larger part in the
11 way that the virus spread?
12 **A.** Yes.
13 **Q.** Can I ask you, please, about December 2020. We heard
14 from Dr Ritchie yesterday -- it's not in your
15 statement --
16 **A.** No.
17 **Q.** -- that Public Health England were telling the IPC cell
18 that they thought that their understanding about aerosol
19 transmission had changed and there was a bigger role
20 that aerosol transmission was playing. Public Health
21 England recommended a move to FFP3 masks on
22 a precautionary basis. Now, that was not the position
23 the IPC cell came to on a consensus basis but Dr Ritchie
24 told us that there was a paper produced and that you and
25 the senior leaders saw the paper.

1 So can I ask you about that, please: do you remember
2 being made aware that Public Health England had come to
3 a changed view about the role that aerosol transmission
4 had played?
5 **A.** I remember that the Public Health England member of the
6 IPC cell had come to a potentially different view. I'm
7 also aware of UK colleagues from public health
8 backgrounds had a different view. There was
9 a consensus. Now, I'm also aware that, because of the
10 differing view, I wanted to make sure we belt and
11 braces, and that first statement was agreed by the most
12 senior medical scientific adviser in PHE/UKHSA, Dr --
13 **Q.** When you say that first statement, what do you mean
14 there, Dame Ruth?
15 **A.** That statement you're talking about then.
16 **Q.** That their understanding had changed?
17 **A.** Yes. The consensus statement, end of 2021, I'm sure
18 we'll come on to later, but ...
19 **Q.** So --
20 **LADY HALLETT:** Could you just complete?
21 **MS CAREY:** Yes, let me deal with it.
22 You became aware then that PHE's understanding had
23 changed?
24 **A.** I --
25 **Q.** You were aware that the consensus cell had come to

1 a slightly different view, it was raised with you,
2 I think you said, you agreed with. Did you agree with
3 the decision of the IPC cell?
4 **A.** I took assurance that there was a debate. I was
5 actually pleased there was a debate. I didn't want
6 groupthink. I wanted to know that people had the
7 confidence to debate the merits of the evidence and the
8 merits of potential action. So in terms of process, for
9 me, that was good. I took assurance that there were
10 other colleagues across the UK from all sorts of
11 professional backgrounds that had a differing view but
12 I also wanted to make sure that PHE's more senior
13 doctors -- I wanted to know their views.
14 **Q.** Right.
15 **A.** And we did have their view.
16 **Q.** Pause there. The question I asked you was: did you
17 agree with the decision of the UK IPC cell?
18 **A.** Yes.
19 **LADY HALLETT:** So even though you said you were concerned
20 about having -- sorry to interrupt --
21 **MS CAREY:** Not at all.
22 **LADY HALLETT:** -- belt and braces?
23 **A.** Yes, because I -- my role has always been to challenge,
24 to ensure that everybody's looking at the evidence --
25 that has got the scientific evidence, scientific

1 background.
2 **LADY HALLETT:** But surely belt and braces, or what I think
3 some have been calling the precautionary principle,
4 would involve going down the path recommended by the
5 Public Health England member who said FFP3 masks,
6 wouldn't that be belt and braces?
7 **A.** I think, at that time, there was nobody other than -- as
8 you said, my Lady, saying the evidence -- there was
9 evidence for FFP3s all of the time. What I also know
10 was I wanted to seek PHE's most senior doctors' view of
11 whether the guidance needed to be changed on FFP3, and
12 we did that, and the view was we didn't need to change
13 it.
14 **LADY HALLETT:** You say that you rightly wanted to avoid
15 groupthink, as you may know it's something I reported on
16 in Module 1. Did you ever consider that there might
17 have been an element of groupthink when it came to the
18 mode of transmission, that the groupthink, including the
19 World Health Organisation, was the mode of transmission
20 was droplet?
21 **A.** I don't think we did because there was the World Health
22 Organisation, there was the UK IPC cell, like -- we know
23 it's got lots of people involved with very technical and
24 scientific expertise -- there was the senior clinical
25 meeting with every UK CMO, CNO, UKHSA chief exec, the

1 senior medical, plus some of the other deputies in
2 there. There were so many people in so many different
3 groups, there was the HOCI working group as well, with
4 another range of people. So there was so many different
5 groups saying that and, even today, as I understand it,
6 World Health Organisation hasn't come out and said it's
7 predominantly aerosol.
8 **MS CAREY:** My Lady, may I just finish this topic in this
9 way:
10 When you came to learn that Public Health England
11 had a changed understanding of the route of
12 transmission, did you speak to anyone in Public Health
13 England about that and what underpinned that change in
14 understanding?
15 **A.** Can I just check for clarity it was that December 20 --
16 **Q.** Yes, 22 and 23 December 2020.
17 **A.** There is email correspondence, I know -- I think
18 I recall it was Mark Wilcox talking to Susan but I also
19 know my National Medical Director spoke to PHE
20 colleagues. I can't recall who, whether that was Susan
21 or Jenny, so I apologise.
22 **Q.** Did you speak to any PHE --
23 **A.** I don't think I did, but I can't recall.
24 **Q.** Fine.
25 What about Sir Chris Whitty, did you speak to him

1 and say, "Well, PHE have got a slightly different view
2 here, Sir Chris, let's discuss the merits or otherwise
3 of it"?
4 **A.** I think we discussed it at senior clinical meeting which
5 Chris was chairing. I'm absolutely sure we did.
6 **Q.** All right.
7 Can we look at some of the specifics in relation to
8 PPE itself. Now, you are not responsible for the supply
9 of PPE, you make that clear in your statement. But
10 I think you say in that statement at paragraph 252, Dame
11 Ruth, that you became aware of supply issues.
12 Can you just help us, how did you become aware of
13 problems with PPE supply?
14 **A.** Oh, numerous ways: from regional chief nurses feeding
15 back; from the UK IPC cell feeding back and, indeed, the
16 first time I game aware was 16 March when the then head
17 of IPC, Linda Dempster, told me and my deputy CNO that
18 there were PPE supply challenges; from the incident, the
19 strategic fusions, when their feedback from the EPRR
20 colleagues; from me going to talk to care home
21 colleagues; from me -- there were PPE -- from the RCN,
22 Dame Donna, yeah.
23 **Q.** A number of different sources there?
24 **A.** Yeah.
25 **Q.** I think you make it clear you were not involved in the

1 decision to declassify Covid as a high-consequence
2 infectious disease. Obviously, you're aware that it was
3 classified and then declassified, and you were not
4 involved in the decision for IPC guidance to recommend
5 FFP3 masks only in intensive care and/or when AGPs are
6 carried out, all right, but you're aware that that's the
7 background and where we end up, essentially, by about
8 6 or 13 March 2020?
9 **A.** Yes.
10 **Q.** Were you concerned that recommending only FRSM to the
11 vast majority of healthcare workers in the guidance in
12 March 2020 did not sufficiently protect those healthcare
13 workers?
14 **A.** I think I was more concerned at the time about supply
15 because that's what was being fed back to me all of the
16 time. So if I think back to -- I think it was 3 April
17 2020, when I had a webinar with my National Medical
18 Director, Sir Stephen Powis, with medical directors,
19 chief nurses, on the webinar. Susan Hopkins very
20 helpfully came to present the tables guidance. It was
21 all about supply, it wasn't about the guidance. So the
22 main concern that was coming in to me was supply.
23 **Q.** Let's look at that supply issue because I think you say
24 that there were concerns about supply through March and
25 April 2020; there were increasing concerns from

1 frontline staff about PPE shortages; concerns were
2 discussed at the senior clinicians group on 9 April; and
3 a pinch point, effectively, coming here around
4 12/13 April. So I would like to focus on that, please,
5 for a moment.
6 Is the position this: that there was a discussion
7 regarding gown use amongst senior clinicians and indeed
8 a number of the people that you've spoken about?
9 Can we have a look on screen, please, at
10 INQ000477782, and it's behind tab 13, Dame Ruth, but it
11 might just be easier to look here. Here we are,
12 12 April, an email to you from Dame Donna Kinnair of the
13 RCN. She's had a discussion with you:
14 "... want to confirm my discussion with you that RCN
15 (and you as our CNO) would not support sending nurses or
16 healthcare assistants to look after patients without the
17 appropriate PPE equipment as determined by the WHO
18 guidance and the recent guidance that we supported that
19 [PHE] issued on 10 April. Whilst we recognise that PPE
20 gowns are in short supply with a possibility of us
21 running out, our stance would be that sending nurses to
22 look after patients without appropriate personal
23 protection is a failure of our duty of care to them as
24 individuals and in breach of health and safety
25 legislation."

1 The issue was with gowns, clearly. Do you know why
2 there was an insufficient supply of gowns?
3 **A.** Yes. The pre-pandemic planning stockpiles did not
4 include gowns and that left us extremely short. It was
5 a very stressful time, it was Easter weekend and Donna
6 and I spoke more times than I spoke to my family and she
7 spoke to her family. We were completely aligned that we
8 needed to concentrate on getting more gowns, and not
9 moving to aprons, because that wouldn't protect nurses
10 in the way we felt that they needed to be protected.
11 **Q.** I think the IPC cell in due course, and certainly the
12 guidance, recommended what's called sessional use --
13 **A.** Yes.
14 **Q.** -- and reuse. Can you just help us, what is sessional
15 use, please?
16 **A.** Well, you use it for a session, so you use it for the
17 time you're in caring for a patient. So I, for example,
18 when I used it, and Donna, actually, when we did it in
19 Nightingale and, indeed, in my other shifts, you'd go
20 in, in your head, your mask, your eye contact -- your
21 eye wear, your gown, your gloves, and your gown would be
22 for the session that you were in there. When you cam
23 out --
24 **Q.** How long might this session be?
25 **A.** Three or four hours, or -- yes. It would be different

1 in different places.
2 **Q.** Let me ask you this, then: in non-pandemic times, in
3 three or four hours, how often would you expect a nurse
4 to change their gown?
5 **A.** Erm ... I ... I don't know what an HCID unit would do
6 day-in, day-out in a normal time. I would have to come
7 back to you on that. But I genuinely believe it would
8 be a single use for a single patient.
9 **Q.** Right. So if you've got six patients in a bay, you
10 might change your gown six times, or is that -- I don't
11 want to be overly simplistic about it, Dame Ruth, but is
12 the bottom line that, in non-pandemic times, you would
13 have changed your gowns more than you did when they were
14 recommending sessional use, all right?
15 **A.** As indeed we would have more staff on a 1:1 ratio in
16 a normal time.
17 **Q.** Yes. So here is you and Dame Donna not supporting the
18 proposal for sessional use or reuse?
19 **A.** And I then also talked to my strategic advisory group,
20 my forthright directors of nursing, and they were
21 equally of the same view, as was the UK IPC cell, and my
22 deputy CNO at the time then fed that back. Donna's and
23 my main concern was the safety of our staff and we just
24 felt that this wouldn't be a safe option.
25 **Q.** Well, that was the question: how did the nurses feel

1 about this guidance? Did you get any feedback from the
2 front line about what they thought about sessional use
3 and reuse?
4 **A.** I can't recall about sessional use versus reuse. I can
5 recall how frontline nurses were in fear of not having
6 gowns and going potentially with just aprons, which is
7 why Donna and I were aligned and agreed so much.
8 **LADY HALLETT:** By Easter 2020, this is obviously a major
9 issue for you and your other colleagues; when did you
10 first bring it to the attention of Mr Hancock as
11 Health Secretary?
12 **A.** Of the supply of gowns?
13 **LADY HALLETT:** The supply problems of PPE.
14 **A.** Supply problems. I can't recall an exact date when I --
15 **LADY HALLETT:** Roughly?
16 **A.** I'm sure Mr Hancock was aware at this time that we were
17 struggling with supply. Of course, my colleague Emily,
18 Dr Emily Lawson, was supporting the DH and the DH was
19 leading this, and I'm sure they would have been made
20 aware.
21 I also was on the podium at Number 10 with
22 Mr Hancock, I think it was 3 April, I think, and I think
23 it was 10 April, something like that, so he knew then
24 because we were talking about it. In fact, I talked
25 about it in --

1 **MS CAREY:** My Lady, may I interrupt to help to this extent:
2 we're going to hear from Professor Hopkins and I think
3 it's clear, unless my memory is failing me, that this
4 change to sessional use and reuse was, in fact, agreed
5 by Mr Hancock. So he was aware that there was (a) the
6 concern and (b) the change in the guidance in this
7 regard. We'll perhaps deal with that tomorrow.
8 **LADY HALLETT:** I'm not sure if you're the right witness to
9 ask this question, so just say if you're not. As
10 a layperson, I've never quite understood the concept of
11 use-by dates for PPE if it's made of cloth. I can see
12 how over decades cloth might weather but why does PPE
13 have a use-by date?
14 **A.** As I understand it, the Health and Safety Executive have
15 that as a role -- as a rule for the protection of staff.
16 So I think it may need to be asked of them. I'm sorry,
17 my Lady.
18 **MS CAREY:** No, not at all.
19 Can I just deal briefly, Dame Ruth, please, with
20 a little later on in the pandemic at paragraph 266, if
21 it helps you, the Alpha variant emerged in the end of
22 2020, and I think we then had Omicron later in due
23 course and that did not necessarily result in a change
24 in the IPC guidance. But I think you commissioned the
25 IPC cell to review the IPC guidance in November 2021.

1 What led you to asking the IPC cell to review the
2 guidance at that stage?
3 A. I remember that. It was the UK CNOs were meeting and,
4 actually, we discussed it as a group, and Sue Tranka,
5 the then -- she was my deputy but then she was the CNO
6 of Wales, she emailed on behalf of the UK IPC -- on
7 behalf of the UK chief nursing officers, but yes, we all
8 agreed as a UK --
9 Q. What was it, just that Omicron had emerged by then and
10 that's why you asked for the review to be undertaken?
11 A. Yes. It was, we knew it was more transmissible, that
12 was coming out, so, yes, we wanted to do that.
13 Q. I think --
14 A. It was also in June 2021, from 1 June 2021, it was
15 following a steer from SAGE, you know, SAGE, the most
16 senior scientific advice. They were saying that within
17 the IPC guidance staff could wear respiratory protective
18 equipment such as FFP3 masks following a risk assessment
19 process. So that came on the back of the June as well.
20 Q. I see.
21 A. June 2021.
22 Q. What was the outcome of the November review that you
23 asked the IPC cell to undertake.
24 A. The outcome was a consensus statement that was drafted
25 by the UK IPC cell. Dr Eleri Davies was the chair by

1 then from Wales, so it was a truly multi-UK-wide cell --
2 consensus discussion, and then that went to the senior
3 clinical meeting for a discussion.
4 Q. I think you say in your statement that the consensus
5 that was presented ended up in a document which
6 supported the existing position --
7 A. It did.
8 Q. -- on FFP3 use in the guidance, noting there was
9 provision in the guidance for extended use of RPE,
10 following a local risk assessment but agreed to make
11 this position clearer to staff by stating this at the
12 start of the guidance.
13 So, in short, if a risk assessment suggested that
14 FFP3 should be worn, then that ought to be provided to
15 the staff member; is that right?
16 A. Yes, and that was in place from June 2021.
17 Q. Yes, why is it --
18 A. But this --
19 Q. I'm sorry to interrupt you but can I just ask you this
20 on that point: why is it necessary to move the reference
21 to risk assessments making it clear at the start of the
22 guidance?
23 A. Because feedback was that it wasn't as clear as it
24 needed to be. So the consensus was we needed to make it
25 even clearer to frontline staff that they had the

1 ability to have a -- where a risk assessment indicated
2 it, they should be able to wear an FFP3.
3 Q. Was there any concern being relayed back to you that the
4 risk assessments, although recommended in June 2021,
5 were not, in fact, being undertaken?
6 A. I -- I remember, I recall colleagues being fed back
7 about whether they'd had a risk assessment recently or
8 moved an area, which is why we, one of the reasons why
9 it was moved up, but also one of the reasons why we did
10 webinars with chief nurses and medical directors, to
11 reinforce the messages to them, and I remember doing
12 webinars with chief nurses and medical directors that
13 said, "And we are reinforcing the fact that local risk
14 assessments need to be done and, if, by then, you
15 need -- a member of staff needed to have FFP3s they
16 should have them".
17 Q. I understand that is what should have happened, and if
18 the risk assessment recommended FFP3 it should be
19 provided. What about the staff member or the nurse or
20 midwife who just wants it for their own peace of mind?
21 In those circumstances, would you have expected them to
22 have been provided with an FFP3 mask?
23 A. I know there were units, there were staff that would do
24 that.
25 Q. So that was an option still even if the risk assessment

1 and the guidance didn't necessarily drive you to that
2 conclusion?
3 A. Absolutely.
4 Q. May I turn to a different topic, please, Dame Ruth, and
5 some challenges in particular in relation to maternity
6 care.
7 If it helps you, it's at paragraph 310 in your
8 statement. I think you set out in that paragraph five
9 challenges. I just want to ask you about three of them:
10 there were challenges with staff absence due to illness
11 and self-isolation, there was obviously the concern
12 about the impact of Covid on pregnant women, the
13 implementation of cohorting -- what do you mean by that,
14 what was the challenge there?
15 A. So I remember very well that there were units -- of
16 course we had women that had Covid, women that we
17 weren't sure had Covid, women that we definitely knew
18 hadn't got Covid. So of course estates had directors of
19 nursing, chief midwives -- the labour ward co-ordinators
20 were having to make sure they provided safe care and
21 separated care for women, to protect the women and the
22 staff.
23 Q. I think you are aware that Amanda Pritchard, the now CEO
24 of NHS England, has said in her statement that nursing
25 and midwifery staff, due to their age profiles, were

1 forecast to be the worst affected group for absences; is
2 that right?
3 **A. (Nods).**
4 **Q.** Against that background, can we have a look, please, at
5 a table in your statement at page 69.
6 So it's INQ000 -- thank you very much.
7 This table, I think, sets out some of the impacts of
8 staffing pressures on maternity care.
9 **A.** Yes.
10 **Q.** If we just look at the top box to start with:
11 "Due to the current pressures experienced across
12 urgent and emergency care services, LAS [London
13 Ambulance Service] are no longer in a position to
14 guarantee an ambulance response to women choosing to
15 have a home birth, or birth in one of London's three
16 standalone birth centres."
17 And the risk is set out there in no uncertain terms:
18 "Should there be an obstetric emergency requiring
19 transfer to hospital, there will be no ambulance service
20 to respond."
21 You set out there that midwives are legally obliged
22 to attend the birth and LAS (London Ambulance Service)
23 have been asked to review -- discuss this decision with
24 a view to various options.
25 How did it come to pass that if a woman wanted to

1 give birth at home, not go to potentially a ward where
2 she might get infected with Covid, and/or infect babies,
3 and/or infect the staff, we ended up in a position where
4 she wasn't allowed to have that choice? Do you know
5 what led to decisions like this?
6 **A.** Yes, I do. So, we had over 700 vacancies, 800 vacancies
7 of midwife roles before the pandemic, and you've already
8 heard me say that because of the bursary we could have
9 had those 700 there. But moving on, that each day,
10 regularly, pre-pandemic and post-pandemic, a midwife in
11 charge of a midwifery service at any of our local
12 hospitals would balance operational pressures with staff
13 absences. But these were of a different scale.
14 Midwifery-led care in a home birth situation is
15 often with one and sometimes two midwives, so it's
16 particularly resource-intensive. Now, whilst women
17 quite rightly wanted to have their birth preference
18 supported, in wave 1 in particular, and I know that my
19 chief medical officer and my national clinical director
20 for obstetrics and gynaecology wrote to me on 23 March
21 with this table, and this time, of course, LAS capacity
22 was stretched to the absolute limit because they were
23 transporting patients to hospital with Covid in huge
24 numbers. So it was a difficult situation. And we know
25 that I think it was 57% of birthing units closed during

1 that period, but London closed all of their units.
2 **Q.** Well, can we just close that box, I just want to look at
3 one other different type of concern, the third box down:
4 "Potential withdrawal of epidurals for non-emergency
5 situations [are] being explored ...
6 "The choice of epidural for pain relief during
7 labour may not be available and therefore women's choice
8 of pain relief will be limited."
9 Was there a supply problem with epidural pain
10 relief -- sorry, the use of epidural for pain relief?
11 **A.** Yes. So anaesthetists were a key member of the team
12 supporting patients that were ventilated on critical
13 care, and I believe you heard last week that we didn't,
14 again with workforce planning, we didn't have enough
15 anaesthetists going into the pandemic. There were women
16 that had their epidural delayed.
17 **Q.** It may be not a question for you, but do you know how
18 that was resolved? Did we manage to get more pain
19 relief or was there an alternative option offered? Can
20 you help with any way they tried to manage that?
21 **A.** So the 9 April guidance did advise that anaesthetists
22 need to be freed up for labour care. Equally, I know
23 that anaesthetists worked extraordinarily hard to get to
24 provide that care. And there was -- there was only
25 a small amount of people -- women that didn't get it,

1 but that -- I don't want to trivialise that it was even
2 a small amount of women that didn't get it.
3 **Q.** One of the other challenges that you are aware of in
4 relation to maternity care was women not accessing
5 maternity care at all, and I think you say in your
6 statement that there was an NHS Open for Business
7 campaign launched, pregnant women being one of the main
8 target audiences.
9 Did you become aware of the reason or reasons why
10 women did not want to access maternity services during
11 the relevant period?
12 **A.** Well, there was the stay-at-home message that was
13 around, but of course some people still needed to access
14 the NHS, and that included women of course. We know
15 that there was messages to women, and indeed I gave
16 a message at my second Number 10 conference on 10 April,
17 that: please -- particularly aimed at pregnant women --
18 if you need to contact your midwife, please do. And
19 it's important they did. And then of course this
20 campaign was launched on 25 April.
21 **Q.** Can you think of any way in which the messaging could be
22 done differently to try to encourage people to access
23 necessary health services in the event of a future
24 pandemic?
25 **A.** Of course women were put on the -- pregnant women were

1 put on the vulnerable list, the vulnerable list that was
2 developed, and that probably caused even more concern
3 for them. There were lots of women though that had
4 very, very good care from their midwifery teams and
5 their obstetric teams. I know the Royal College of
6 Obstetricians and Gynaecologists and the Royal College
7 of Midwives really supported professional leaders -- as
8 well as my own team -- in making sure they're cascading
9 the message, which was: pregnant women still need to
10 access. Because of course it was an area of work that
11 couldn't be stepped down.
12 **Q.** No.
13 **A.** It wasn't like elective care. So this needed to
14 continue.
15 **Q.** Do you think the stay-at-home message got the balance
16 wrong?
17 **A.** In hindsight, I wish it was "stay at home but not if
18 you're pregnant or you are" -- in hindsight, yes.
19 **Q.** I think in particular during wave 1 you became aware of
20 evidence that there was a particular reluctance to
21 access maternity services from black, Asian and minority
22 ethnic communities -- I'm at paragraph 339, Dame Ruth --
23 and did that result in, I think, four specific actions
24 being taken to try to encourage women from those
25 communities to come forward?

1 Can we look on screen very briefly at
2 INQ000280429_2, please.
3 Can you see this is taken from, I think, the
4 Maternity Transformation Programme, but can you see in
5 the middle there, England's most senior midwife has
6 recommended the following common sense steps:
7 "1. Increasing support of at-risk pregnant women --
8 e.g. making sure clinicians have a lower threshold to
9 review, admit and consider multidisciplinary escalation
10 in women from a BAME background.
11 "2. Reaching out and reassuring [those] women with
12 tailored communications."
13 There is a recommendation about vitamin D.
14 And:
15 "Ensuring all providers record on maternity
16 information systems the ethnicity of every woman, as
17 well as ... risk factors, such as living in a deprived
18 area ... co-morbidities, BMI [whether they're] aged 35
19 ... or over, to help identify those most at risk of poor
20 outcomes."
21 So that was the recommendations, but do you know
22 whether there was any positive uptake as a result of
23 those recommendations or whether any review was done to
24 see how efficacious or otherwise they were?
25 **A.** So the Chief Midwifery Officer, the then Chief Midwifery

1 Officer, wrote those four areas out. It was about
2 reinforcing the message. So, for example, vitamin D,
3 a supplement, has been there as an advice for a long
4 time, way before the pandemic. I know that there was
5 a CQC survey done that was done -- asked the questions
6 in 2020 and published in 2021, that actually showed that
7 white women felt that they had enough information about
8 their pregnancy, 74% of white women, and 81% of women
9 from a black, Asian, minority background felt that they
10 had enough information. So clearly some of that
11 messaging did get across.
12 And of course local organisations, local trusts,
13 local midwifery teams would be able to tailor some of
14 their communications to their populations. That was
15 really important. It's the tailored communications that
16 was important to ...
17 **Q.** Can I ask you about visiting restrictions in the context
18 of maternity care.
19 I think -- is this the position, and correct me if
20 I'm wrong, was the guidance that partners should be
21 allowed to accompany a woman in labour?
22 **A.** Yes.
23 **Q.** Is that correct?
24 **A.** Yes, it was. So the 16 March guidance said visitors
25 should be limited to one patient -- one per patient or

1 less, unless it's a partner in a birthing situation.
2 **Q.** Yes.
3 **A.** And the same with the 25 March. And that was just after
4 lockdown, the first national lockdown, which is visitors
5 suspended except for birth --
6 **Q.** Yes, so generally speaking no one allowed into the
7 hospital unless one of the exceptions applied, and one
8 of those exceptions was that if you were in labour you
9 should have your partner with you or a partner with you?
10 **A.** Yes.
11 **Q.** All right. Now, did you draw or aware whether there was
12 drawn any distinction about active or non-active labour?
13 **A.** Yes.
14 **Q.** What was the guidance meant to be? Was it meant to draw
15 a distinction or was that something that was created by
16 those who were in charge of trying to manage visitors?
17 **A.** It was the latter. You know, this must have been really
18 difficult for chief midwives and labour ward
19 co-ordinators and the like because they were trying to
20 balance their staff safety and the women and babies'
21 safety. So whilst 97% of women had their partners in
22 labour, half of them only, or half of them, had it due
23 in active labour. Now, there is a definition for active
24 labour, but in practical terms it's when a woman goes
25 from antenatal ward into the labour suite. So that

1 would have been tough for some of those partners, not
2 being -- and for the women -- not being there in the
3 antenatal --
4 **Q.** Yes.
5 **A.** -- as well as then in the labour --
6 **Q.** So although the guidance didn't make reference to
7 whether a woman was in active or non-active labour, it
8 was interpreted by those on the ground, as it were, to
9 be a potential dividing line as to when partners were or
10 weren't allowed?
11 **A.** Yes, I think it's one of those learning points for me
12 for a future pandemic about being more specific earlier.
13 **Q.** Do you think partners should have been allowed in for
14 the entirety of labour?
15 **A.** Yes, I do.
16 **Q.** Were you aware of reports that some women felt obliged
17 to undergo a vaginal examination to prove they were in
18 active labour and therefore get their partner in with
19 them? Did you hear reports of that?
20 **A.** I heard reports of that, and when I talked to
21 Gill Walton, the chief executive of the Royal College of
22 Midwives, some of that could have been true.
23 I find it hard to believe that a midwife would do
24 that, so it could be in translation, I don't know, but
25 in practical terms it's when a woman moves to labour

1 ward.
2 **Q.** Can I just ask you this: when you became aware that
3 there was this distinction being drawn between active
4 and non-active labour, did you or the Chief Midwifery
5 Officer put out any communication to say that's
6 a distinction that shouldn't be being made?
7 **A.** So what I am aware of is that there was some work done
8 by the Royal College of Midwives and the Royal College
9 of Obstetricians over the summer of 2020 which led to
10 the 8 September guidance, which was much more specific,
11 and a regret I have is that wasn't -- that specific
12 detail in the 8 September guidance wasn't in the
13 original guidance.
14 **Q.** I think in your statement you say that by the first week
15 of April 2020 you had had reports coming to you, and
16 indeed to the Chief Midwifery Officer, of not only
17 partners not being able to attend the full range of
18 appointments, scans, partners not being able to stay
19 with their mother and the baby immediately after birth,
20 so a range of difficulties in relation to people
21 accompanying pregnant women. I think you say in your
22 statement that decisions about which scans were able to
23 be attended with, how long the partner could stay after
24 the birth, were decisions for trusts to make; is that
25 right?

1 **A.** Yes.
2 **Q.** Do you think that led potentially to an inconsistency of
3 approach with trust A doing one thing and allowing
4 a partner in, and trust B doing something different and
5 not?
6 **A.** Well, of course their estate is different in different
7 organisations, so what may be safe for staff and for
8 women in one unit may not be the same in others. And
9 some of our estate in maternity units is extraordinary
10 and has great facilities that will allow for this much
11 easier. Some of our NHS estate in maternity services,
12 for example in sonographers, for ultrasound rooms, is
13 very tight, very small, and that created a difficulty,
14 in practical terms, for those leaders and staff.
15 **Q.** If there had been more PPE available early on in the
16 pandemic, which the visitor, the birthing partner, could
17 have worn, do you think that might have affected the
18 stance taken on visiting restrictions?
19 **A.** I don't know, I wasn't involved in the visiting
20 restrictions consideration, that was the clinical cell
21 reporting to the EPRR structure, so I can't tell you
22 whether PPE supply was part of the decision-making.
23 I can tell you, though, that midwives were nervous, as
24 were nurses were nervous, and Royal College of Nursing
25 and Royal College of Midwives, quite rightly, were

1 equally advocating for the support of their staff to be
2 considered.
3 **Q.** If there had been more testing available earlier, to
4 show that the partner was Covid negative, do you think
5 that might have affected the way the visiting guidance
6 was drafted and published?
7 **A.** Oh, without doubt. Without doubt. So it wasn't until
8 the 14 December guidance that -- you know, where those
9 key actions was around -- we had the LFD, we had the
10 lateral flow tests. If we'd had lateral flow tests at
11 the beginning, with us being able to say whether
12 a partner was positive or not, gosh, that would have
13 relieved a lot of anxiety and tension between staff and
14 women and families, and provided better outcomes -- or
15 experience.
16 **Q.** Can I ask you briefly about postnatal support. Do you
17 consider that to be an essential part of maternity care
18 that should be prioritised in the event of a pandemic?
19 **A.** Absolutely. Antenatal care with the scans, postnatal
20 care, I agree completely.
21 **Q.** Did you become aware that health visitors were being
22 redeployed and so were not able to visit new parents?
23 **A.** I was made aware of that, and Alison Morton from the IHV
24 very helpfully made me aware, as well as of course the
25 chief nurse for public health, that -- I didn't have

1 a responsibility for health visitors and school nurses
2 until November 2023, but yes --
3 **Q.** The IHV is the Institute of Health Visiting; is that
4 right?
5 **A.** Yes, it is.
6 **Q.** Can I ask you about face-to-face support for new
7 parents. Clearly some meetings had to be done
8 virtually, but do you think that there should be more
9 prioritisation of face-to-face support for those new
10 mums and dads?
11 **A.** I think it was -- the IHV very helpfully set out
12 concerns about how we should not redeploy staff,
13 redeploy health visitors, away from their core duties.
14 Future pandemic health visitors should stay being
15 health visitors, they should not be redeployed, and then
16 they would have more ability to do the face-to-face
17 contact.
18 **Q.** Can I widen the topic of visiting to more general
19 restrictions on visitors. Clearly you were working on
20 the front line at times. What was the impact on
21 patients, and indeed staff, of not having a visitor when
22 you broke an arm, had an appendix out, whatever the
23 position may be? What was it like for them?
24 **A.** Awful. It was -- particularly with end-of-life care.
25 And whilst the visiting restrictions were done to reduce

1 the footfall, to reduce transmission and to support the
2 balances of staff safety, I can understand if I had
3 a loved one in hospital at that time ... like I did
4 actually.
5 **Q.** Different topic, please.
6 **LADY HALLETT:** Just before you move on, what about those who
7 needed extra support? So, for example, I think we heard
8 about people who are disabled or I think on -- we heard
9 from a gentleman whose daughter was Down's Syndrome.
10 What about people who needed the extra support? It must
11 have been dreadful for them, even worse.
12 **A.** Yes. Although I do believe the guidance was there that
13 people with a learning disability to have somebody to
14 support them would have been there and, in practical
15 terms, the vast majority of times that would have
16 happened.
17 But these were scary times for staff, and for
18 patients, and for carers. If we'd had testing at the
19 time, we could have tested more easily and allowed more
20 people in. Difficult decisions, my Lady.
21 **MS CAREY:** Another difficult area, if I may: DNACPRs, do not
22 attempt cardiopulmonary resuscitation. Did you become
23 aware of any instances of the inappropriate use of
24 DNACPRs?
25 **A.** Would you direct me to my --

1 **Q.** Yes, I think you deal with it at --
2 **A.** I've got it.
3 **Q.** -- paragraph 364, Dame Ruth.
4 **A.** Sorry, I apologise. Yes, I did become aware, early in
5 2020. It was raised with me directly actually at
6 Number 10. I think it was my first Number 10
7 experience, on 3 April.
8 DNACPR is a very sensitive area, a very important
9 area, an area that is part of end-of-life care planning.
10 It should be done sensitively, it should be done with
11 the patient and with family, if possible. I've been
12 part -- as a nurse, in the past, been part of those
13 conversations. But to blanket DNACPRs was wrong.
14 **Q.** Yes. You I think in your statement say that in
15 April 2020 you co-signed a letter, along with
16 NHS England's National Medical Director, to reiterate
17 that blanket DNACPRs should not be used, and I think you
18 say that the issue was raised again with you by the
19 Queen's Nursing Institute in September 2020.
20 I suppose really the question is: if you told
21 everyone in April 2020 to not do it, can you help as to
22 why in September 2020 you're still hearing reports of
23 blanket or inappropriate use of DNACPRs?
24 **A.** So I'm really grateful the QNI raised this directly with
25 me. As I understand it, the survey was done in May and

1 June 2020, so still after the guidance -- the letter had
2 been written.
3 It was raised, I think she said, I think --
4 Crystal -- it was the 16 out of the 163, so it's still
5 there.
6 When I questioned, went back to the QNI, because of
7 the way the survey was done, I wasn't able to find out
8 where -- which of the care homes it was there. But
9 there was a difficulty still in getting the information
10 out.
11 **Q.** So forgetting that, putting the location, I should say,
12 to one side, there still seems to be an issue,
13 notwithstanding the efforts you made in the April 2020
14 letter, and in March 2021, is this right, you were among
15 senior clinicians who signed another letter reiterating
16 the NHS England position that it was unacceptable for
17 people to have a DNACPR on their record just because
18 they had a learning disability, autism or both.
19 What prompted that letter in March 2021?
20 **A.** Because there were still further reports coming through
21 but, between all of these, the National Clinical
22 Director for end-of-life care, working in the medical
23 division, was working and taking all of this into the
24 work on advanced care planning. This is something that
25 should not happen.

1 **LADY HALLETT:** Also I've heard on my travels, there are
2 a number of aspects to their use, the blanket use you
3 talked about, people with a disability, without
4 consultation of the patient or their family, but also it
5 wasn't just been used, as I've been told -- I've yet to
6 hear much evidence on it -- it wasn't just used for do
7 not resuscitate, it was used for do not treat. That's
8 totally wrong, isn't it?
9 **A.** It is completely wrong. It's a fundamental principle of
10 the NHS and one that I hold dear as a nurse -- well,
11 former nurse now -- to care for and treat people on
12 an equal basis. So I fundamentally disagree with
13 blanket DNACPR and the same with treatment, my Lady.
14 **MS CAREY:** Can you help as to why you think people merged
15 a DNACPR notice, which is very specific, with escalation
16 of care and end-of-life care decisions? Do you know why
17 they got the two confused or elided them?
18 **A.** Good or best practice, excellence in advanced care
19 planning for end of life does include a conversation
20 about DNACPR. If I was in a situation that I was facing
21 a terminal illness, I'd want to have the conversation,
22 and I'd expect people to have the conversation with me
23 but I wouldn't want it as a blanket decision.
24 **Q.** No.
25 Different topic, if I may, and I have to just deal

1 with a number of discrete issues now, so forgive me if
2 I'm jumping around.
3 Earlier this morning you made reference to risk
4 assessments for black, Asian and minority ethnic
5 workers, and it's at paragraph 192 in your statement.
6 I think you mentioned that you were responsible for
7 increasing the pace of implementation. I just want to
8 go over that so that we're clear what the problem was
9 and what you did to try and solve it.
10 Just help us, please, I think you were aware of the
11 disproportionate impact of Covid on black, Asian and
12 minority ethnic staff, and I think there was concerns,
13 was there, about -- or there was work being done,
14 I should say, around risk assessments for that
15 particular group of people.
16 What work was being done, firstly: was it just risk
17 assessments?
18 **A.** So this was led -- a piece of work led by the chief
19 people officer team but as, of course, a professional
20 and executive, fellow executive, I inputted into it and
21 I had an opinion, because, of course, the BME's
22 strategic advisory group had raised it with me and I was
23 in regular contact with them.
24 The risk assessment was key. The risk assessment is
25 a conversation about a person's risk to working in

1 a frontline Covid environment and, without the risk
2 assessment, action couldn't get taken, which is why
3 I was very keen, probably forthright, in wanting it to
4 be brought forward, so it was achieved sooner because,
5 without the assessment, the action would be delayed.
6 **Q.** So was it, in short, that the plan for implementing the
7 risk assessment was going to be within four weeks and,
8 as a result of your efforts, that came down to two weeks
9 to roll this out; is that where we get to?
10 **A.** Yes. I proposed that it would be two weeks. I cannot
11 recall whether the two weeks was achieved or not.
12 **Q.** Right.
13 **A.** I'm sorry.
14 **Q.** Do you know why it was that a four-week period had
15 originally been suggested?
16 **A.** Because it's a huge task, and I'm not criticising any --
17 my colleagues at all because it's a huge task, it's one
18 that we would be requiring a lot of energy and effort of
19 trust leaders.
20 **Q.** Do I take it, though, that you felt that the four-week
21 period was too long?
22 **A.** Yeah, I wanted it sooner because, without the
23 assessment, the action couldn't take.
24 **Q.** Do you know whether the effects of those risk
25 assessments were monitored and reviewed to make sure

1 that it was happening and it was helping BAME nurses and
2 midwives?
3 **A.** This wasn't just for nurses and midwives, of course.
4 Yes, the CPO team would have been monitoring this, the
5 implementation and the impact. I also know from my own
6 feedback, though, that people were being assessed.
7 **Q.** Different topic. It's my fault, I touched on the issue
8 of Long Covid earlier this morning but I didn't, in
9 fact, ask you when it was you, as CNO, became aware of
10 the effect of Long Covid on healthcare workers. I don't
11 mean a precise date but can you pick a point in the
12 pandemic where it came to your attention?
13 **A.** I'd have to go back to my notes to give you a more
14 accurate picture but I'm very grateful to Dr Elaine
15 Maxwell who brought forward the concerns around Long
16 Covid. I'm so sorry, I can't recall when that was.
17 I don't want to give you a false date.
18 **Q.** No. Just before we conclude, please, Dame Ruth, can
19 I ask you some questions really about the health and
20 wellbeing of the nurses and midwives that you led, and
21 can I ask you, please, to turn to paragraph 182 in your
22 witness statement. I think you speak there, in
23 particular, of surveys conducted on critical care staff
24 and that work was being led by Professor Kevin Fong, and
25 the output of those surveys was shared with you.

1 Could we show on screen, please, INQ000421181, it's
2 behind your tab 10 if you want to look at it, but it
3 might just be easier to use the screen. Was this the
4 note that he provided to you?
5 **A.** Yes, it was. It's a note that was dated the 10th, as
6 I recall, but I received it on 30 July 2020.
7 **Q.** Right. We can see there just the summary for these
8 purposes, it assesses the impact of wellbeing and
9 psychological health on the frontline ICU and
10 anaesthetist workforce, there was pilot survey across
11 five hospitals, more than 700 respondents and this:
12 "There is evidence of significant psychological harm
13 to frontline NHS staff following the first [Covid] surge
14 with high rates of post-traumatic stress amongst
15 frontline professionals."
16 When you received Professor Fong's summary here,
17 what steps if any did you take to try and establish (a)
18 whether it was right, and (b) try and ameliorate the
19 harm that was caused?
20 **A.** So I was raising back in May 2020, before I received
21 Kevin's report, the need for something of a wellbeing
22 service specific for nurses. Obviously, the wellbeing
23 work was very good and developed very quickly and was
24 accessed widely but I was wanting something more for
25 nurses. So I'd started the -- started asking my head of

1 nursing to develop the Professional Nurse Advocate
2 programme. But when I had Kevin's briefing, I met with
3 Kevin virtually but I met with Kevin several times. As
4 more data came out, I met with Kevin.
5 I believed his data, I took his data, and I then --
6 I wanted to make sure that we did everything possible --
7 **Q.** Pause there because I'm going to ask you about the
8 programme in a moment, but is this the position: that at
9 the end of July 2020, I think you attended
10 a psychological harm roundtable and reported to people
11 at that roundtable that four staff nurses had died by
12 suicide, with one further nurse in ICU and a member of
13 staff who had made an attempt to take their life?
14 **A.** Yes.
15 **Q.** Now, against Professor Fong's work, the reports you made
16 at that roundtable, tell us please about the
17 Professional Nurse Advocate programme, what was it meant
18 to do and what did it actually achieve?
19 **A.** So the Professional Nurse Advocate programme was
20 a programme of restorative clinical supervision. It
21 came about by my experience, what I was hearing, and my
22 head of mental health nursing, mental health nurse by
23 background, saying, "We're going to need to provide some
24 more support for, particularly, critical care nurses".
25 So we developed a programme and it was a programme that

1 supported nurses in their workplace.
2 **Q.** Give us an example, what did it actually do?
3 **A.** Have a conversation, check in with people, make sure
4 they were okay, debrief. It was there as a support. It
5 was very successful, the feedback from it was very
6 successful and, of course, then we needed to roll it
7 out, and I think that's what my comments were on that
8 roundtable.
9 It wasn't just for critical care nurses we needed to
10 do this, it was for those that needed to go into
11 critical care and, of course, what we realised was there
12 are lots of nurses elsewhere that wanted this, and so
13 it's been more rolled out, I put in more money into it
14 from my budget, and we developed this -- you know, Kevin
15 was involved with the development of this and saw it in
16 reality but it wasn't the only thing we did, of course.
17 We ended up having practitioner health as well opened up
18 for nurses, which was really important.
19 **Q.** Can I ask about you, please: is it right that, as part
20 of your role as Chief Nursing Officer, you were the
21 victim of abuse meted out to you online?
22 **A.** Yes.
23 **Q.** Can you just give us a couple of examples of kind of
24 things that were said to you, or summarise it in
25 whatever way you can, Dame Ruth.

1 **A.** Yes. The one thing I have learnt throughout the whole
2 of this is the importance of acting with integrity, and
3 sometimes that comes at a cost, and sometimes you have
4 to make decisions or be involved in decisions that mean
5 that in social media, in particular, you are vilified or
6 by some other senior people you are vilified. I wasn't
7 the only one but it was pretty horrible.
8 **Q.** The future, if I may. If you were to try and summarise
9 what worked well for the nursing and midwifery
10 profession, what would you say?
11 **A.** The workforce expansion worked well. The students that
12 came, all 23,000 of them, in wave 1 to support us. The
13 international nurse -- educated nurses that throughout
14 the pandemic joining the temporary register, joining the
15 substantive register, worked well. Delivering the
16 50,000 extra nurses early and overachieving worked well,
17 very well.
18 **Q.** What did not go well, from a nursing and midwife
19 perspective?
20 **A.** A number of areas. So we went into the pandemic with
21 vacancies, nearly 40,000 vacancies, we could have had
22 5,000 less.
23 **Q.** Yes.
24 **A.** The maternity visiting guidance I genuinely believe
25 could have been more specific earlier, and that would

1 have been better for women, better for their partners
2 and better for the staff. And if we'd only had testing
3 in the early days. If I think about the nosocomial
4 transmissions, if only we had testing, because we didn't
5 have testing even for day three testing until
6 20 November. So it wasn't just we didn't have testing
7 to begin with, we didn't have testing for a main part,
8 you know, a big part of the early pandemic.
9 **Q.** If you could make a recommendation or two to her
10 Ladyship to consider, what would be your top picks, if
11 I may put it colloquially?
12 **A.** Ensure we have the workforce supply and everything we
13 can do to either bring back the full educational package
14 or write-off of debt, but the domestic supply of future
15 nurses and midwives in this country is key to a future
16 pandemic.
17 Second, my Lady, it would be that we are able to
18 have testing because not only would visitors have been
19 back earlier, staff would have been safer but patients
20 would have been safer too.
21 **MS CAREY:** My Lady, they are all my questions. There may be
22 a number that you wish to ask.
23 **Questions from THE CHAIR**
24 **LADY HALLETT:** No, there was just one other one I wanted to
25 ask.

1 You've mentioned just then about things that didn't
2 go well, and you talked about visiting guidance with
3 maternity care. Presumably, you would add to that
4 visiting guidance when it came to people who required
5 carers? You remember I asked you about people who had
6 difficulties and relied on a family member for support.
7 If that guidance that you say should have been followed
8 wasn't being followed, presumably you would say that
9 that too is something that ought to be ...
10 **A.** Yes. I said the maternity because that was extremely
11 difficult for lots of women but it included people with
12 a disability of whatever disability too, I agree with
13 you.
14 **LADY HALLETT:** Thank you very much indeed, Dame Ruth.
15 I can't believe that people could be so stupid and
16 wicked as to subject you to the kind of personal abuse
17 that they did. Just ignore them. I'm afraid it looks
18 like it is a fact of life, and it is a dreadful fact of
19 life. So I'm sure we're all genuinely sorry that that
20 happened to you. I know it can't have been easy giving
21 evidence today, reliving not only your own experience
22 but the experience of your colleagues, so thank you very
23 much indeed for your help.
24 **THE WITNESS:** Thank you.
25 **(The witness withdrew)**

1 **LADY HALLETT:** Right, I'm asked to break now for lunch and
2 come back at 1.40.
3 **MS CAREY:** Thank you, my Lady.
4 **(12.40 pm)**
5 **(The short adjournment)**
6 **(1.40 pm)**
7 **LADY HALLETT:** Ms Carey.
8 **MS CAREY:** May Professor Jean White be sworn, please.
9 **PROFESSOR JEAN WHITE (sworn)**
10 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**
11 **LADY HALLETT:** I hope we haven't kept you waiting too long.
12 I appreciate you were probably here this morning.
13 I'm so sorry.
14 **THE WITNESS:** It's okay.
15 **MS CAREY:** Professor, your full name, please.
16 **A.** Jean Christine White.
17 **Q.** You were the Chief Nursing Officer in Wales, I think,
18 from October 2010 to retirement on 6 April 2021?
19 **A.** That's correct.
20 **Q.** Your statement is at INQ000480133. I hope you have it
21 in front of you.
22 **A.** Yes.
23 **Q.** Just to explain, the statement was, in fact, written by
24 you and indeed your successor CNOs. Obviously I'll be
25 asking mainly about your role but it means we will have

1 to cover a number of pages as obviously some of the
2 statement deals with them.
3 Your professional background, please, could you just
4 give us a summary?
5 **A.** So I'm a registered general nurse, a registered nurse
6 teacher, I have postgraduate qualifications up to PhD
7 level.
8 **Q.** When did you become a nurse, if it's not too rude?
9 **A.** I was born and brought up on the Gower Peninsula and
10 I trained at Swansea University -- well, Swansea
11 Hospital, as it was then.
12 **Q.** You know that we have just heard this morning from the
13 Chief Nursing Officer in England during the relevant
14 period. Can you just help us, in relation to the CNO
15 Wales role, is there any substantial difference in
16 functions you had that would differ from those in
17 England?
18 **A.** So the CNO role in Wales is a substantive civil service
19 role, whereas it's an NHS role in England, I think
20 that's the largest difference. So my role was to give
21 advice to Welsh Government ministers and support policy
22 delivery.
23 **Q.** I think you are the head of the nursing and midwifery
24 professions in Wales with about 40,000 practitioners, or
25 thereabouts, as at the relevant time.

1 A. That's correct.
2 Q. I think you are responsible for the performance of nurse
3 directors in each of the health boards and trusts in
4 Wales?
5 A. That's correct.
6 Q. I think you say in your statement, if I may take you to
7 it at paragraph 62 onwards, you said you didn't have
8 a specific role in respect of public health emergencies?
9 A. That's correct.
10 Q. Do you think that the Chief Nursing Officer should be
11 involved in planning for public health emergencies?
12 A. From my experience in this current pandemic, I would say
13 yes, particularly -- not for infection management
14 processes but more around the workforce implications,
15 some of the consequentials really about how nursing and
16 midwifery practice is affected during a pandemic.
17 Q. Have you raised with anyone more senior than you the
18 fact that you think the CNO would have a vital role to
19 play?
20 A. No, I didn't before I retired but I can see in the
21 statement that the current CNO is of a shared view --
22 that's Sue Tranka -- and I would expect her to be part
23 of the post-Covid preparation for the next pandemic.
24 Q. Your particular role during the pandemic, are you able
25 to give us an overview of how that role and your

1 responsibilities changed during the relevant period?
2 A. So some things were built on the pre-pandemic period.
3 So, for example, I had to performance manage and support
4 the executive nurse directors, so I did more of that,
5 and they were sort of key partners in the collective
6 leadership we had to deliver services in Wales. But
7 there were particular new responsibilities that came.
8 For example, I jointly chaired the Nosocomial
9 Transmission Group with the Deputy CMO, which I'm sure
10 you'll come on to in a little while, and there are
11 things to do with changing the way that the nurse
12 education, midwifery education standards were changed by
13 the regulator. So all of the CNOs across the UK were
14 involved in that. So that's an unusual thing for us to
15 do. We didn't normally get that close to changes of the
16 regulator's work.
17 Q. I think you were also a member of the NHS planning and
18 response cell in Wales --
19 A. Yes.
20 Q. -- which was established towards the end of February of
21 2020. In a nutshell, what did the planning and response
22 cell do?
23 A. So this was chaired by the director of planning, so
24 I was a member of it, rather than the leader of it, and
25 that cell brought together folk from the NHS services to

1 work out how we could plan and deliver services during
2 the pandemic, the sorts of things that would affect how
3 the NHS functioned. So we were planning for closures or
4 re-opening. Anything to do with the operational
5 delivery of services in Wales was worked out there and
6 then advised on, if you like.
7 Q. Can I just ask about your role in the pandemic. We
8 heard from Dame Ruth that she was able to take a number
9 of visits and did ward rounds. Did you perform
10 a similar function during the pandemic?
11 A. Unfortunately, I wasn't able to go out and meet people
12 face to face, I have rheumatoid arthritis and,
13 therefore, I have immunosuppressant therapy, which makes
14 me clinically vulnerable, not a shielded person, but it
15 did require me to work remotely and that was enabled,
16 fortunately we had good IT, so I was able to talk to the
17 people I needed to talk to, and was always accessible.
18 But I couldn't physically go and see for myself, which
19 I think is a great shame.
20 I would have liked to have actually talked to people
21 about what it was like to be there and do the role under
22 those extreme circumstances. Obviously, you'd have to
23 be careful with that because you don't want to be one of
24 the agents carrying disease from place to place, so I'm
25 not suggesting I would have done a round-Wales tour, if

1 I'd been able to but I certainly would like to have had
2 more of a chance to talk to people face-to-face, which
3 was a shame, but there you are.
4 Q. How was the frontline impact on nurses and midwives then
5 conveyed to you, given that you couldn't, for the
6 reasons you've set out, go to wards and hospitals?
7 A. So clinical networks pre-dated the pandemic, as well as
8 relationships with the trade union senior officials, so
9 I used the existing frameworks, we have clinical groups
10 on various things, and I had close working
11 relationships, as I said previously, with the executive
12 nurse directors, and I relied on them to tell me what it
13 was like.
14 Occasionally, I would have correspondence between
15 folk that would also tell me what was going on, if they
16 had a particular issue, then I would be able to respond
17 to it, and there were members of nurses -- nursing and
18 midwifery workforce, on the various cells that I sat on,
19 so whether it was the planning cell or the Nosocomial
20 Transmission Group, there were also representatives on
21 it. So I had lots of contact with people, it just
22 wasn't seen for myself and feeling what it was like on
23 the ground.
24 I knew from those conversations that it was very
25 scary and, as a clinically vulnerable person, I have to

1 say that really resonated with me about fear. At the
2 beginning of the pandemic, without a vaccine, the
3 testing was limited, not knowing really what was going
4 to happen to folk, I really felt for everybody affected
5 because I felt it myself and it restricted my life a lot
6 because of it, like a lot of other people.
7 **Q.** Can you give us an overview of what was the state of the
8 nursing and midwifery profession in Wales pre-pandemic
9 in terms of vacancies?
10 **A.** So, obviously, vacancies change almost every day because
11 people leave and they join, and so on. We weren't in
12 the same position as England, we didn't have the volume
13 of vacancies but I'm not suggesting that it was 100%.
14 So there were vacancies in various bits of the health
15 service in Wales, and we had lots of activity to
16 continue to both recruit and retain staff. It's -- the
17 retention often is the issue, rather than the amount of
18 people you're training.
19 So, for example, ours was different from the rest
20 of -- from England for example. We required -- if
21 anybody had a student bursary package -- I think you
22 heard about bursaries earlier. If they received that
23 support from Welsh Government, they were then required
24 to work in NHS Wales for two years on qualifying and, if
25 they chose not to, they had to pay back the money that

1 we had given them. So it was a kind of golden handcuffs
2 approach to keep the staff we had trained.
3 **LADY HALLETT:** You speak, as I do, very quickly.
4 **A.** Oh, I'm sorry.
5 **LADY HALLETT:** Don't worry, it's just to head off any
6 complaints.
7 **A.** I'll slow down.
8 **MS CAREY:** It's my fault, let me slow down as well.
9 Can I call up on screen INQ000480133 at page 58,
10 please. I want to check I've got the right reference
11 for a start, but I want to ask you, Professor, about
12 some of the efforts made to increase capacity within the
13 nursing workforce.
14 We heard this morning there were four main ways that
15 was aimed to achieve that, one of which was, of course,
16 to invite people onto the temporary register, and I just
17 want to look at it from the Welsh position, if I may,
18 and, if that's page 58, I hope it sets out the position
19 as of 21 April 2020.
20 We looked at it this morning in relation to England
21 but we should see, I hope, Wales. Yes, there.
22 Registrants, there were 537. Just pause, please, it's
23 just at the top of our screen there, nurses, as at
24 21 April that joined the register.
25 Can you help with how many of those actually got to

1 work on the front line?
2 **A.** So I don't know accurate numbers but I certainly heard
3 sufficient evidence that quite a number of folk didn't
4 end up practising in the way they wanted to, and that
5 was multifactorial. Some people, when they'd done
6 a risk assessment, realised that they were at higher
7 risk and, therefore, we couldn't deploy them to places
8 that we would have wanted them to do. So a lot of folk
9 would say "Well, I can't travel to that place" or
10 "I don't feel confident to work in that place", so there
11 was a degree of choice amongst the folk that kindly and
12 bravely put themselves forward to come back on the
13 register. We tried our very best to place them. We
14 developed a central system to help with that, that ran
15 during 2020, which supplemented what the local
16 recruitment arrangements were doing but it would be fair
17 to say that not everybody that put themselves forward
18 ended up working for us.
19 **Q.** But the numbers of which you're not clear?
20 **A.** I don't know that number off the top of my head for that
21 particular month in time, sorry.
22 **Q.** Initially, the temporary register was opened up to those
23 who had been practising in the last three years and then
24 expanded to four to five. Were you ever made aware of
25 any concerns about the length of time people had been

1 off the register for, coming back and working and
2 perhaps not having the skill set that they had as at the
3 time they left the register?
4 **A.** Yeah, so anybody that had left the register and was
5 brought back into employment were given an induction
6 programme and were given sort of reminders, if you like,
7 about how infusion technology worked, about moving and
8 handling, those sort of basic things. For the staff
9 that had been away a long time or had been working in
10 roles that were not clinical -- because some academics
11 would come back to practice -- they needed more support
12 and were always supervised by colleagues, if they were
13 not feeling competent; it was part of the safety
14 arrangements.
15 I wasn't told specifically about that age group,
16 that length of time, if you like, being away from the
17 register but all of them needed support, so I wouldn't
18 necessarily pick them out as needing or being a problem,
19 shall we say.
20 **Q.** Okay. Was that support provided though by fellow nurses
21 and midwives?
22 **A.** It was supported by Health Education and Improvement
23 Wales, which is a body we have in Wales, my Lady, who do
24 things on behalf of the government to support the
25 workforce. So that's everything from commissioning

1 education to doing things to develop the workforce and
2 support the workforce.
3 So we asked them to work with the local health
4 boards, who are the employers of the staff in Wales, to
5 make sure that they had the stuff they needed. But most
6 of this was delivered on the ground with respect of who
7 was being brought forward to enable them to get into
8 jobs as an onsite induction programme.
9 **Q.** I suppose really what I was asking was, if you bring
10 them back, they're designed to help relieve the burden
11 but is there not a burden in training them, making sure
12 they're up to speed, as it were, with the skill set?
13 I was trying to work out who that burden fell on.
14 **A.** Well, it would be sort of the health boards, the
15 employer body in the majority, supported by others.
16 I suppose it's a payoff, isn't it? You're going to end
17 up with hundreds more staff but you're going to have to
18 invest a little bit to makes sure that they're safe and
19 competent to work. So it was unavoidable, I'm afraid.
20 **Q.** Can I turn to nurse staffing levels, please?
21 **A.** Yes.
22 **Q.** I think there is an Act in Wales, the Nurse Staffing
23 Levels (Wales) Act 2016, which imposes a number of
24 duties and obligations on the health boards and trusts.
25 If I may, without a legal lecture, are you able to

1 summarise what the Act says and its import?
2 **A.** So the Act brings in a range of duties. The first duty,
3 that across the health system in Wales every
4 organisation must have a duty to see they've got enough
5 nursing staff to sensitively care for patients in all
6 settings.
7 The second duty is to say that in specific service
8 areas, that is adult and medical and adult surgical
9 wards, they must use a defined methodology of working
10 out how many staff they need to sensitively care for the
11 patients in that ward.
12 During my time as CNO we extended the law so it now
13 covers paediatric inpatients, but -- it didn't exist in
14 my time there but it does exist now. The Act goes on
15 then to say how often you need to report, and it has to
16 be reported to Welsh Government every three years.
17 **Q.** So if I understand it correctly, the Act doesn't
18 stipulate it must be one-to-one care in this but it
19 tells the boards that they have to have a process, or
20 a methodology to use your word, to be able to monitor
21 their ratios?
22 **A.** That's right.
23 **Q.** Is that it in a nutshell?
24 **A.** In a nutshell. And this methodology is determined by
25 government, so they can't just make it up themselves.

1 **Q.** Understood.
2 Can I ask you about the ratios in intensive care,
3 please, and the changes that were brought about during
4 the pandemic. If it helps you, Professor, I'm at
5 paragraph 191 in your statement, and it may be we will
6 look at some documents that were shown this morning.
7 But do I take it that in non-pandemic times it should be
8 one critical care nurse per one level 3, ie a patient
9 that's being -- on a ventilator, for example? Is that
10 the general rule?
11 **A.** Yes.
12 **Q.** Ratios were stretched or diluted, were they not, in
13 Wales as well during the pandemic?
14 **A.** Yes.
15 **Q.** Who was responsible for making the decision to change
16 the nurse to patient ratios?
17 **A.** So Wales required its service to double the capacity, so
18 we needed to, if you like, double the capacity of
19 critical care nurses that they were covering -- the
20 patients they were covering. So we have a critical care
21 network that supports all of critical care services
22 across Wales, and it was Welsh Government advice to them
23 to consider the national guidance that had been shared
24 with us about what might be sensible to do, and they
25 then looked to see how that could be delivered within

1 our NHS. So it was a process of a UK collaborative of
2 expert groups coming together to say "This is what we
3 think might work" and that then being given to us as
4 Welsh policy leads to translate into what could happen
5 within our NHS systems in Wales, given that we wanted to
6 increase the number of critical care beds by 100%, so
7 there's, like, 200% of what we used to have.
8 **Q.** So it wasn't your responsibility as CNO. Who -- was it
9 the Health and Social Services Group that made the
10 ultimate decision?
11 **A.** So I gave professional advice into the policy leads and
12 then they worked with the network, so they followed the
13 advice that came from the UK collaborative, if you like,
14 but the critical care network were the ones that had on
15 the ground experience about what would work in practice,
16 and they then challenged back.
17 And the original guidance around dilution was quite
18 extreme, to be honest, it was something like one up to
19 six.
20 **Q.** Yes.
21 **A.** And they were saying "Whoa, that is just -- that's much
22 too far", and the furthest we ever went was one to three
23 and that was only in extraordinary circumstances, so we
24 never went further than that. And that's because the
25 critical care network were giving a push-back, if you

1 like, about what was being suggested by these
2 professional advisory groups.
3 **Q.** I think you said it was one to two or occasionally one
4 to three?
5 **A.** That's right.
6 **Q.** Who was responsible for monitoring the ratios?
7 **A.** Well, the health boards all have responsibility of
8 delivering the services to meet the needs of their
9 patients. The critical care network across Wales, the
10 trauma and critical care network, support them and
11 helped have mutual arrangements. So I'm happy to say we
12 never ran out of critical care bed in Wales. Anybody
13 who needed level 3 care got level 3 care, there was
14 never a moment when there wasn't a bed available. But
15 it may not necessarily be the local bed available, it
16 may be in the next hospital, in the next health board
17 area. And the network helped make the movements around
18 because they knew what vacancies there were. So it was
19 much a collaborative approach across the whole system
20 rather than individual hospitals trying to cope.
21 **Q.** So there may have been the bed available and staff
22 available albeit at a diluted ratio. I wanted to ask
23 you, though, do you think that that dilution impacted
24 the level of care that patients got in Wales?
25 **A.** I would say it added to the stress on the staff, all of

1 the staff, because it wasn't just the nurses obviously,
2 we had more patients, therefore the medical staff and so
3 on were also impacted. Like other parts of the UK, we
4 developed supplementary teams that would support them.
5 So we'd have turning teams, for example, that had --
6 **Q.** To literally turn the patient?
7 **A.** Turn patients for this -- an approach called proning.
8 It was found that those who were very ill, they were --
9 they did well if they were also put face down, and that
10 takes about six people to do that.
11 So we recognised that the critical care nurses would
12 be under tremendous pressure so we tried to bring in
13 things that would support that. But to be honest,
14 I suppose if you're looking after twice the number of
15 patients it's going to be difficult.
16 **Q.** Yes. I follow bringing in someone who can physically
17 help turn the patient or prone them. What about actual
18 support for them, though, dealing with the stresses now
19 dealing with two critical patients or three critical
20 patients day in, day out? Did you, as CNO, do anything
21 to try to help them in a sort of more pastoral context?
22 **A.** So I met with the executive nurse directors from about
23 the middle of March onwards, I think it's from about
24 18 March onwards, twice a week, and throughout the first
25 wave certainly the welfare of staff and the concerns

1 about critical care staff and the pressures they were
2 under were part of our conversation.
3 Obviously the health boards have responsibility for
4 the welfare of the staff as their employer. They have
5 a duty of care. What we did was we supplemented that
6 local support that was being offered by a national offer
7 as well of resources, and that was facilitated by Health
8 Education and Improvement Wales. Remember I said there
9 was a body that helped with the workforce? And so we
10 have had contracts to do with Samaritans -- we extended
11 a programme called Health for Health Professionals,
12 which is an approach that was -- pre-existed pandemic,
13 which was for doctors only but we extended it for all
14 staff, and students, during the pandemic, which is where
15 if you rang up and said "I'm in need, I'm in distress",
16 you would be assessed by a doctor and then a programme
17 would be worked out for you, some of it would be
18 one-to-one guidance and so on. And then we had lots of
19 programmes like SilverCloud, which is online mental
20 health stuff. It wasn't specifically for critical care,
21 there was a doctor --
22 **Q.** Can I pause you there, because I want to just look at
23 one very specific issue in Wales, and I'm sorry to have
24 interrupted you, Professor.
25 **A.** No, it's fine --

1 **Q.** But can I ask, please, that you look behind tab 9.
2 We call up on screen INQ000412539, and actually
3 start at the back of that document, on page 0005.
4 Because clearly there was pressures at the beginning
5 of the pandemic, but I want to ask you about an email
6 chain that is from January 2021. And to put it in
7 context Andrew Goodall, who I think was the chief
8 executive at the time of the Health and Social Services
9 Group?
10 **A.** Yes, that's right.
11 **Q.** He sent round to a number of people a newspaper article
12 talking about the dilution in England, which then
13 prompted a discussion about the position in Wales. Just
14 for the context.
15 If we go to page 3, having skimmed through the
16 article, I think he was asking you what was going on in
17 Wales, and you say at the bottom:
18 "Is there anything I should be saying back to Andrew
19 re: dilution of staff in our units. Can you give me
20 a summary position."
21 Then up to the email above, so here we are,
22 12 January 2021, and you are addressed:
23 "Sorry for the delay in replying on Monday
24 for example, 11 of the 13 ICU units were on a 'stretched
25 nursing ratios 1:2 for level 3 patients'. Redeployed

1 staff have been moved to critical care to help out these
2 units. However, given the whole hospital strain and
3 vast number of patients in critical care, redeployment
4 hasn't actually been 100% enough for all critical care
5 patients/units in Wales. Uncertainty around the impact
6 of this on the quality of care and ultimately to the
7 outcomes ...
8 "I raised staffing ratios in the critical care
9 network meeting they were off the opinion particularly
10 as in many units there are not redeployed staff to
11 support stretched 1 [to] 2 ... care ... we should only
12 further stretch this by exception ..."
13 **A.** Yes.
14 **Q.** So by January 2021, is it fair to say that "stretch"
15 might be an understatement --
16 **A.** Yes.
17 **Q.** -- for the 11 of the 13 ICU units across the nation?
18 **A.** Yes, it was very tough. During the second wave, to
19 a degree, I suppose it was worse than the first wave
20 because a lot of staff were needed, because we were
21 starting to re-open other bits of the hospitals, so
22 there weren't the availability of staff to redeploy.
23 I think the network was very sensible in saying, look,
24 we can't have sort of 1:3, that would be too dangerous
25 because there aren't the supplementary staff to support

1 them.
2 So that's what this was all about because, at that
3 time, we were having other guidance to say, "Yeah, yeah,
4 you might still be able to do 1:3 but no further than
5 that". I think that's what the UK guidance was kind of
6 suggesting, and the network, as I said, with our
7 sounding board about what was actually happening on the
8 ground was saying that that wouldn't be safe to do that,
9 and so we listened to that.
10 **Q.** A slightly different topic but still on ratios, I think
11 in your statement at paragraph 257, there was a concern
12 raised with you about ratios of registered nurses to
13 patients in the field hospitals in Wales. Can you help,
14 what were the ratios in the field hospitals and what was
15 the concern?
16 **A.** So it wasn't necessarily that I was worried about the
17 number of nurses, it was more how the make-up of the
18 teams were being constructed. So field hospitals in
19 Wales were not intensive care provision, they were
20 actually step-down provision. So we wanted to increase
21 the flow of patients out of hospital. So these were
22 people that were taking some time to recover before
23 returning home or needed to have some more support
24 before returning to a care home, for example.
25 So I discussed with the nurse directors, and this is

1 what this document starts to talk about here, is how are
2 we going to do this, what kinds of teams should we have,
3 and the nurse directors were of an opinion, actually, we
4 should have occupational health nurses, mental health
5 nurses, physiotherapists, rather than it all be nurses,
6 registered nurses and nursing staff, we needed to have
7 a more multidisciplinary team. And so the nurse
8 directors themselves shared their practice and, as the
9 field hospitals started to come live, if you like, in
10 sort of a phased approach across Wales, they learnt from
11 earlier experience to work out what would be best.
12 **Q.** Different topic, please --
13 **A.** Okay.
14 **Q.** -- looking at the Nosocomial Transmission Group.
15 **A.** Okay.
16 **Q.** It starts in your statement at paragraph 316 but it was
17 established, I think, on 19 May 2020, you jointly
18 chaired it with the Deputy Chief Medical Officer in
19 Wales. What was the purpose of the group, please?
20 **A.** So it had a number of functions. We were there as
21 an advisory and oversight group to look at the evidence
22 based guidance that the system needed about giving
23 advice on everything from, you know, how far apart
24 hospital beds should be to handling how the deceased
25 person's body should be managed. It was there to look

1 at the education and skill set around IPC, and trying to
2 support how the system was responding to
3 hospital-acquired infection, which is what nosocomial
4 transmission is about.
5 Later on, after a few months, we took on
6 a particular role in oversight of outbreaks because we
7 were finding that the health boards, some of them were
8 struggling to get on top of outbreaks of the infection
9 and so what we wanted to do is promote best practice and
10 keep a closer eye on the system to help them deal with
11 that, so we took on more of a role to do with outbreaks
12 later on.
13 **Q.** I think in your statement you give a number of examples
14 of operational matters that the group became involved in
15 but I would like to ask you about one, please.
16 **A.** Sure.
17 **Q.** If you look in your statement at page 121, it's in
18 relation to the wearing of face masks in non-clinical
19 settings, and can we just -- we haven't heard very much
20 about non-clinical settings yet, but what are they in a
21 nutshell?
22 **A.** So, if you like, it's the backroom arrangements, so that
23 would be your folk in offices, perhaps dealing with
24 ordering kit, it could be, well, anything where you're
25 not actually looking after a patient, I suppose, would

1 be the simplest way of doing it.
2 Q. Okay. I think the position is that there was UK and IPC
3 guidance issued in due course by England, I think it may
4 have been Scotland as well --
5 A. That's right.
6 Q. -- that said that face masks or face coverings should be
7 worn in both clinical and non-clinical areas, and when
8 that came out in England and Scotland, Wales decided not
9 to make face masks mandatory in non-clinical settings;
10 have I got that right?
11 A. That's right.
12 Q. Why did Wales take the decision not to make face masks
13 mandatory?
14 A. So I was not the policy lead on this, I did take sort of
15 the steer from the CMO, who had given advice to
16 government on this issue. So we had found that the
17 evidence around face coverings and face masks, in a sort
18 of a community setting, rather than a clinical -- I'm
19 not talking about the kind of delivery of care
20 settings -- was less robust than it was for clinical
21 settings and, particularly, concern had been expressed
22 in the summer time about how people in the public were
23 actually using face masks.
24 It increased things like touching your face and
25 not -- it caused people to perhaps not follow some of

1 the other guidance, it took more risky behaviours, and
2 so on and so forth, there is a long list that I have
3 listed out in my statement.
4 So the CMO was of the view that the evidence wasn't
5 strong enough to require that, so we had taken the
6 policy position in Wales that we will do it where the
7 evidence took us, which is in clinical areas.
8 Now, I think in his evidence he's gone on to say how
9 that then --
10 Q. Well, we'll hear from Mr Atherton in due course but can
11 I just ask you this: do you think though that, by not
12 making face masks mandatory in those areas, there was
13 a lack of protection for those workers who were in the
14 non-clinical areas?
15 A. I think hindsight's important here because, at the time,
16 we felt that if you kept distance and had good
17 ventilation, and had other sort of environmental factors
18 in play, the risk was probably low. That's what the
19 evidence was telling us at the time.
20 Q. Pausing you there, Professor, is a non-clinical area
21 likely to be well ventilated in most of the Welsh
22 hospital estate?
23 A. Some of it probably not so much, I couldn't hand on
24 heart say everybody was able to open a window, and so on
25 and so forth. Some of our estate is very old in Wales.

1 Q. Do you not think that the benefit of mask-wearing
2 outweighed the asserted downsides of people touching
3 their mouths or touching the mask?
4 A. At the time we didn't feel that they did. I think, as
5 time went on -- and I'm looking in hindsight now, not
6 from what I felt at that moment -- understanding about
7 how the disease was spread would probably give different
8 advice now, if we were to go back in time. But, at that
9 moment in time, the evidence wasn't very strong about
10 wearing face coverings, unless you were in a high-risk
11 area, which is direct patient care in closed confined
12 areas. In well ventilated areas with other good IPC
13 practices, the risk was less.
14 Q. In due course though did Wales make face mask wearing
15 mandatory in non-clinical areas?
16 A. They did.
17 Q. Was it about three months or so after --
18 A. Yeah, so it was the autumn, I can't remember exactly the
19 date.
20 Q. Why did it change its stance, come the autumn?
21 A. I think partly it was leading to confusion with the
22 public because there were different messaging across the
23 four parts of the UK, and our intelligence was growing
24 about what was needed to prevent infection. I think
25 that was it. But, as I say, I wasn't the policy lead

1 for this, I was in more of a supportive role and the
2 Chief Medical Officer was, if you like, the lead adviser
3 on this. I don't have personal expertise in infection
4 prevention and control measures, I'm not a scientist by
5 background. So I needed to follow the advice I was
6 being given rather than saying "No, I think I'll go UDI
7 here and make my own device."
8 Q. I think in due course, certainly there have been some
9 studies to suggest that infection rates went down when
10 there was universal mask wearing. Although it won't be
11 a decision taken by you in due course, do you think that
12 had there been universal mask wearing throughout the
13 hospital estate, that would have helped prevent
14 infections of patients and, indeed, healthcare workers?
15 A. I'm sure it would have helped but also the other
16 practices were very important. Face mask wearing on its
17 own would not stop the spread of disease, if people were
18 not hand washing, were not keeping distance and doing
19 all the other things that we were advising. So I would
20 say it's part of a package. It's not a panacea of
21 stopping all infections but it certainly has a part to
22 play.
23 Q. One of the other things that the Nosocomial Transmission
24 Group did was set up what's called a sort of lessons
25 learnt group. Was it the early learning platform?

1 **A.** Yes, we called it Corsil(?), which sounds like some sort
2 of chemical you would use, but it was the Covid -- early
3 learning is what it was, it was a platform.
4 **Q.** What was the kind of things that were being reported via
5 the early learning platform?
6 **A.** So this was set-up so that anybody in any of the health
7 boards across Wales and the trusts as well could say,
8 "Look, I've done this thing, whatever it was, large or
9 small, and it either worked or didn't work and perhaps
10 you shouldn't do it". So it could be anything from
11 cohorting patients who have the disease when you've got
12 lots of open plan areas, to anything, it could have been
13 anything at all and, throughout the pandemic, that was
14 available to people to do that.
15 **Q.** Do you think it was a useful reporting platform?
16 **A.** I think it was helpful. It had a one particular
17 limitation in that it was on a separate IT system to --
18 we have lots of different IT systems, my Lady, across
19 the service.
20 **LADY HALLETT:** I've got that T-shirt from this Inquiry!
21 **A.** So you know exactly what I mean.
22 So it meant that, rather than it automatically
23 sucking things and easily transferring information, you
24 had to go out of your system, into another system and
25 then report it I think it put off a few people. So

1 I think it was useful, I certainly would have it again
2 but probably on a system that is a little bit more
3 joined up.
4 **MS CAREY:** I just want to understand the genesis of
5 a document that I'm going to ask to be called up on
6 screen, which is INQ000473936 and we can go to 0001.
7 I want to understand how this document was reported.
8 It's a Covid outbreak reporting, is this linked in any
9 way to the early learning --
10 **A.** No.
11 **Q.** That was my error, then, thank you. Can we nonetheless
12 look at this document, though, please?
13 **A.** Yeah, yeah.
14 **Q.** This is an example, is it not, of weekly reports that
15 were submitted showing outbreaks and changes and the
16 location of the outbreaks within Wales; is that right?
17 **A.** That's right.
18 **Q.** Here's one for 11 December 2020. Who is collating this
19 information?
20 **A.** So a little bit of context, if that would be all right.
21 **Q.** Yes, please.
22 **A.** So outbreak management was previously managed by Public
23 Health Wales, pre-pandemic, but we were finding that the
24 data had a delay in it. So you would have a report of
25 the outbreak that was last month. Well, when you're

1 managing outbreaks you needed it to know every day.
2 So where the Nosocomial Transmission Group developed
3 a form that was required to be filled in by the
4 operational manager in each hospital on a daily basis
5 and sent in to the Public Health Wales and Welsh
6 Government mailbox, and so this report is the data that
7 was submitted by each of the health boards about what
8 was happening, so that's the number of patients involved
9 in any outbreak, the number of staff affected, and any
10 patients that had died within 28 days of the outbreak.
11 So it's showing us a direct impact on the patients of
12 those outbreaks.
13 So we needed to know exactly where they were
14 happening, how quickly they were coming under control,
15 and what the health boards were -- actions they were
16 taking, so they were also telling us what they were
17 doing.
18 **Q.** Pause there, let's look at one example. Can we turn to
19 page 5 in this document, please, and I think
20 a submission, by the Hywel Dda health board.
21 **A.** Yeah.
22 **Q.** If we see what that health board submitted that day,
23 I presume all of those there are different hospitals --
24 **A.** Yes.
25 **Q.** -- with the names of them, and you can see, across the

1 four sites, there were two wards closed in Glangwili;
2 the position there in Prince Phillip Hospital, they've
3 had to transfer patients?
4 **A.** Yes.
5 **Q.** We have a ward closed in Withybush and a slightly
6 different position in the community hospital.
7 Was this being done on a daily basis?
8 **A.** So the data was being reported to us on a daily basis,
9 and we had sort of a weekly position, if you like, to
10 see what was going on. But it was useful for both us,
11 as the government, and Public Health Wales to look at
12 what's happening across the whole system, but it was
13 also useful to the managers in the hospital because they
14 have -- the data was shared back to them, if you like,
15 they could see what was happening.
16 It also meant that if, say, Hywel Dda was struggling
17 in Prince Phillip Hospital, yet another hospital was
18 doing very well and very quickly getting under control
19 we were able to say to them "You need to talk to that
20 manager to see what they're doing that you're not doing
21 to learn from this".
22 So this was a really transparent way for us to see
23 what was going on and a really good way to help the
24 system learn because people were obviously catching the
25 disease in hospital when they were already ill and there

1 because of another reason.
2 **Q.** I wanted to ask about that actually, because I think
3 it's right that there was guidance issued that said that
4 there should be testing for all patients admitted into
5 hospitals in Wales issued on 3 June 2020?
6 **A.** That's right.
7 **Q.** I'm in paragraph 324, if it helps you, Professor.
8 **A.** Yep.
9 **Q.** So the guidance came in on 3 June for testing of all
10 patients but was brought in in Wales on 15 July. Can
11 I ask you, why was there a gap between the guidance
12 being issued at the beginning of June and it not coming
13 in until six weeks later?
14 **A.** I can -- I think we gave them a run-in time to actually
15 get the systems in place in order to do that
16 consistently. Now, obviously, once the guidance is out
17 there, there will be early adopters but some folk will
18 take a little bit longer to get systems in place. So
19 often we would give them a couple of weeks' time lag to
20 get to a position where everybody was doing it. It's
21 a big system.
22 **Q.** We heard this morning from Dame Ruth that she thought
23 that the roll-out of testing would have a big impact on
24 the healthcare system's response and, indeed, in
25 particular on nurses and midwives and visiting

1 restrictions, for example.
2 **A.** Yes.
3 **Q.** Do you agree with her as to the importance of testing in
4 the event of a pandemic?
5 **A.** Absolutely. If you want to try to enable the system to
6 keep delivering other care, you need to separate out
7 those folk who have got an infectious disease from those
8 folk who don't, so that you're able to have, I hate to
9 say, sort of a clean system, but those not affected.
10 I don't know what language I should use here which
11 doesn't sound inappropriate, but you understand what I'm
12 trying to say.
13 **Q.** Yes.
14 **A.** If you want to run an orthopaedic service, you want to
15 know those folk that have got and who hasn't got it
16 because the last thing you want to do is bring somebody
17 into the system that's then going to contaminate the
18 system that they've gone into. So testing was very
19 important, which is why it's a requirement.
20 **Q.** Am I right in thinking that testing of healthcare
21 workers in Wales was not fully rolled out until March
22 2021; is that right?
23 **A.** I believe so, I can't remember exactly the dates.
24 **Q.** Do you think it should have been rolled out sooner for
25 healthcare workers?

1 **A.** I think that the issue was more around asymptomatic
2 testing and symptomatic testing. So we did have testing
3 availability and staff could test if they had any
4 symptoms, so there was a lot of issue about when they
5 should return, because obviously it's -- shorten the
6 number of staff you had if they were off sick for a long
7 period of time, so you needed to know when they were fit
8 and safe to return to work. I think the issue is more
9 around asymptomatic testing because at the early days we
10 didn't know that the disease could be spread by those
11 who weren't showing any symptoms and therefore you
12 didn't know that they had it in order to spread it.
13 Testing was not my policy area so I may not be the best
14 person to fully explain all of this --
15 **LADY HALLETT:** But on that point, sorry to interrupt.
16 **A.** Not at all.
17 **LADY HALLETT:** I think I heard that asymptomatic
18 transmission was recognised by the summer of 2020,
19 certainly by the autumn, so it still leaves quite a long
20 gap until Wales introduced testing for all healthcare
21 workers, symptomatic and asymptomatic?
22 **A.** Yes, I think that's about right.
23 **Q.** Is it a capacity issue?
24 **A.** As I say, I'm not really the best person to ask about
25 this, because I wasn't involved at all in anything to do

1 with the testing, I'm sorry.
2 **Q.** All right, don't worry, we'll seek to answer it through
3 someone else.
4 **A.** Okay.
5 **Q.** IPC guidance, please. Can we be clear at the outset,
6 what is your role in relation to the approval or
7 otherwise of IPC guidance?
8 **A.** So the IPC guidance, we had an agreement to work
9 collaboratively across the UK and there was a UK IPC
10 cell. Public Health Wales contained our experts and so
11 we sent our representatives of experts to the UK cell.
12 Once the cell had made advice, it then was brought back
13 to Wales and was presented to the Nosocomial
14 Transmission Group, because that seemed a sensible place
15 for it to go, but it did feature in other conversation,
16 but it was mostly at that. And then --
17 **Q.** So you saw it as part of your role on the NTG?
18 **A.** That's right.
19 **Q.** I'm sorry to interrupt you, but did you then comment on
20 the guidance?
21 **A.** So the NTG looked at the guidance and looked to see
22 whether or not there were things in it that didn't fit
23 or might be challenging for us or -- a sense check
24 I suppose it would be.
25 The people who were sent from Public Health Wales

1 also sat on the NTG, so we were able to sort of say to
2 them: does this sound about right? Were you able to say
3 the Welsh position in the development? So it wasn't
4 like there was great separation out, we were all one and
5 the same, if you like.
6 So the UK guidance was given to us as a best
7 practice guidance. The NTG then received it to work out
8 what was best for the system. But I understand the UK
9 cell were drawing scientific evidence from things like
10 SAGE and NERVTAG, which we weren't involved with at all.
11 **Q.** Right. So in your statement, where you say the CNO
12 played no role in providing advice or guidance as to the
13 types of PPE or RPE that nursing or midwifery staff
14 should use in the workplace, that is correct in terms of
15 your CNO role but you had a role reviewing it as part of
16 your role chairing the NTG; is that a fair way of
17 summarising it?
18 **A.** Yes.
19 **Q.** Can you recall now any examples of you in your NTG
20 capacity saying to the cell "We don't agree with that
21 recommendation" or "That bit of guidance we'd like to
22 re-word or amend"?
23 **A.** No, I do recall us talking about face coverings in
24 non-clinical areas, which we referred to earlier, but on
25 the whole, because we'd had experts from Wales help

1 design it, it mostly fitted our system, so there was
2 very little "Oh no, we don't agree with that" kind of
3 conversation.
4 **Q.** I think you were made aware, though, in your CNO role,
5 of issues in relation to FFP3 masks. If it helps you,
6 Professor, it's at paragraph 309 in your statement.
7 You say that there was:
8 "Issues regarding the fit and suitability of PPE ...
9 raised with [you] during ... meetings of the Nurse
10 Directors."
11 You give an example there that on 3 April concerns
12 were raised around FFP3 masks used in critical care that
13 were not fully waterproof and staff were resorting to
14 double masking. I assume that means wearing two FRSMs,
15 does it?
16 **A.** Mm-hm.
17 **Q.** How were those concerns -- so they were coming to you
18 from those directors, what, presumably from the front
19 line to the nurse director and director to you?
20 **A.** That's right. So we had a PPE cell which pulled
21 together folk from procurement, who knew about the
22 supply chains and what we had in stock, along with folk
23 from service, which is about distribution and so on.
24 **Q.** Right.
25 **A.** So my role here was really to make sure any issues

1 I came aware of were reported to the cell for them to
2 take action on. And that's what I did. Whenever there
3 was an issue raised about any PPE, whatever it was, or
4 shortages or difficulties in accessing it, I made sure
5 it was reported.
6 We had a lot of stock, often the issue was around
7 distribution, so people on the frontline were not
8 necessarily receiving what they wanted. We didn't run
9 out of stock, it's just not necessarily -- we had
10 everything but not necessarily in the right place.
11 **Q.** Of course. Let me ask you about that specific example
12 there, though. There was a concern about the masks in
13 critical care not being fully waterproof. What did you
14 actually do when a concern like that -- who did you
15 tell? How was it resolved?
16 **A.** So I think in the text here I mention I talked to
17 David Goulding, who was our health emergency planning
18 officer, because he was part of the cell, but in other
19 examples I would have gone to Dr Chris Jones, who was
20 the deputy chief CMO, who was chairing that cell. If it
21 was -- depending on what it was that was the issue,
22 I would report it to a lead policy officer in that cell.
23 If I felt it was a distribution thing that might be
24 inside a hospital -- because I think I gave an example
25 further on in my statement about that -- I would make

1 sure I also told the nurse director, "I've heard from
2 your staff there's an issue, I think you should look to
3 see if that ward or that team are actually getting
4 access to the things that they actually need."
5 So sometimes it would be back down the chain rather
6 than into policy, so I was more of a conduit of
7 information than a fixer of the problem.
8 **Q.** I think you set out in your statement a number of other
9 problems, for example straps perishing?
10 **A.** Yes.
11 **Q.** You also dealt with an example on 19 May where you,
12 in -- one of the nurse directors noted that up to 50% of
13 FFP3 masks were failing fit testing. I just wanted to
14 be clear about that, do you mean that the fit, it didn't
15 work 50% of the time?
16 **A.** Yes. A lot of it was not suitable for the staff there
17 so they couldn't fit them tightly to the face, because
18 you've got to have a good seal. So I would say, if we
19 come on to recommendations, we need to think about
20 having masks that fit different shapes of face.
21 Different ethnic groups have different shapes of face.
22 If you have a beard, it's very difficult to have a good
23 fit. So there's lots of things around fit that probably
24 need to be looked at in the type of stock we have.
25 **Q.** Were you made aware of any specific issues regarding PPE

1 fit for ethnic minority nursing staff in Wales?
2 A. That's what I was referring to there, some of that was
3 to do that with. If you have a different shaped face,
4 it is a little difficult -- more difficult --
5 Q. Now, you mentioned to my Lady that in due course there
6 might need to be a recommendation about broadening the
7 types of mask that might fit different type faces, but
8 if you're made aware of a problem with PPE fit for
9 ethnic minority staff in Wales, what steps did you take
10 to try to address that, given you can't just rustle up
11 a new mask overnight?
12 A. No, again, I fed it into the PPE cell because they are
13 the ones that were working with our NHS shared services.
14 What we have in Wales is an arrangement where all the
15 health boards fund one body to do things like
16 procurement for them. It's a way of saving money and
17 being more efficient. So if it became -- they became
18 aware that they needed to have different kinds of
19 equipment, that would be the place where the procurement
20 would be dealt with. So that was the route back. And
21 they sat on the PPE cell.
22 Q. I'll turn to visiting restrictions.
23 A. Okay.
24 Q. We have heard that visiting was restricted unless there
25 were a number of specific exceptions that applied,

1 for example end of life or a woman in labour. Can I ask
2 you this: did you have any role in developing the
3 restriction on visiting guidance?
4 A. Yes. It was my -- I was the lead adviser on that.
5 Q. In developing that guidance or determining that you
6 shouldn't visit unless you're in one of the exceptions,
7 did you consult with any people like disabled groups or
8 any of the groups that might be impacted by that
9 decision before coming to your ultimate view?
10 A. So there were five versions of guidance. So if I take
11 us at the very, very beginning, when the complete
12 lockdown came. The nurse directors asked me to set out
13 a policy position for Wales because they felt they
14 needed to have one voice for Wales and the Welsh
15 Government was able to do that for them, and I agreed
16 with them what it is that they thought was suitable for
17 the NHS. And so the very first iteration which was in
18 the beginning of -- middle of March -- 20 March, I think
19 it was -- was very restrictive.
20 Over the iterations that followed that, it became
21 far more nuanced and far more permissive as we heard
22 more voices saying about the impact, and certainly
23 issues around folk that may have dementia or other
24 cognitive learning, about the importance of people who
25 might need an interpreter. So there were lots of folk

1 that might need to accompany a patient in any part of
2 their hospital journey would need to be involved.
3 So yes, we listened, but in the very first I was
4 responding from a request from the nurse directors in
5 Wales to say "Please, Jean, will you just give us
6 a statement about what we should do to lock down".
7 There was a tremendous amount of fear at that time
8 caused by it and visiting, they were fearful for the
9 staff, for bringing it in. I have to say visiting and
10 the role I played in visiting is the thing that has
11 stayed with me the most out of all my experiences during
12 this, because I was acutely aware that stopping loved
13 ones being together, stopping a father seeing the first
14 blip of life in an antenatal scan, you don't get that
15 back again and, to this day, it's the thing that
16 I reflect on the most, I think, and with the heaviest of
17 hearts, that I did it at the time and was able to
18 hopefully listen and respond as more and more voices
19 came to us about changing it.
20 But always it was a balance between what the staff
21 felt they could manage with in the environments in which
22 they were working, given the lack of vaccination, in the
23 first three versions of the guidance, that's --
24 you know, we didn't have vaccines until December, so all
25 of 2020 this was done in a time where the staff were

1 very fearful.
2 Did we get the balance right? I'm not sure we
3 did --
4 Q. Well, I was going to ask you that: is it a necessary
5 evil or was the balance not struck; what do you think?
6 A. Well, as time went by, we got much better at giving
7 guidance around taking a risk based approach and, as we
8 started having lateral flow tests and point of care
9 testing, so we knew a lot more about who was carrying
10 disease, and having a vaccine that protected a lot more
11 people, some of those risk-based approaches became
12 easier to do. But in the first period of between March
13 and December, when the vaccine came in, staff anxieties
14 were through the roof about this.
15 Now, I always wrote into the guidance that we needed
16 to be as enabling as possible, particularly at end of
17 life. The last thing I ever wanted was somebody to pass
18 away without their loved ones having contact, and that
19 was even from the get go, when we'd locked everything
20 down, I always said that that was something you should
21 enable.
22 We got more and more permissive, if you like, in the
23 guidance, but it was only ever guidance, it wasn't
24 a "you must under" -- you know, it wasn't legislation,
25 it was guidance to service and they were allowed to

1 depart from it.
2 **Q.** Although there comes with that an inconsistency,
3 depending on which board, which hospital, maybe even
4 which ward?
5 **A.** Indeed, indeed.
6 **Q.** All right. Can I ask you about, I think, a change that
7 was made in Wales, where there was a relaxation in July
8 2020, whereas, providing the visitor did not have Covid
9 and the visit was agreed in advance, then the visitor
10 could come on to the ward but PPE may need to be worn,
11 and there may still need to be social distancing.
12 I appreciate that was an attempt to allow more people to
13 visit, but --
14 **A.** Yeah.
15 **Q.** -- do you think that was an onerous ask to make of the
16 staff who had to manage the visitors, make sure they
17 were Covid negative, provide them with PPE, make sure
18 they were socially distancing, agree this all across a
19 ward; what do you think about those considerations?
20 **A.** It's a fair point. However, I go back to saying there
21 was still a tremendous amount of anxiety about this
22 because we didn't have a routine testing of visitors
23 sort of -- and I should say a word about the lateral
24 flow test. It isn't a 100% accurate, there are lots of
25 false positives, false negatives, so it wasn't like it

1 was a sure-fast way. If you did a swab that says you're
2 clear, you might still be carrying the infection and,
3 when we didn't have the vaccines, which was the case in
4 the summer, staff were keen that, if folk were coming
5 in, they wanted to be as safe as possible for everybody,
6 the last thing you would want to do is either give it to
7 the staff or to another patient or another relative
8 visiting, so they did have to manage their environments
9 to keep it safe for everybody.
10 **Q.** Thinking about maternity services in particular, was it
11 right that in Wales women in labour should be permitted
12 a birthing partner from their household from 25 March
13 2020; was that the general rule?
14 **A.** Well, it was for them to have a birthing partner, yes,
15 when they're in active labour, and it stayed like that
16 in the next three -- further two iterations -- there
17 were the three iterations -- that was the case.
18 **Q.** So we heard from Dame Ruth this morning that, certainly,
19 the guidance in England didn't make a distinction
20 between active and non-active labour. In Wales, was it
21 only allowed in once in active labour?
22 **A.** That's right.
23 **Q.** Right.
24 **A.** The reason being, it's to do with the geography because
25 if you're starting off early in labour you might be in

1 a ward with many other people. When you're in active
2 labour, you're taken into a room on your own. So it's
3 much easier to manage. So it was a practical physical
4 thing at that -- that kind of helped with that.
5 **Q.** Were you aware of examples of women being examined
6 vaginally to prove they were in active labour and
7 therefore have the support of their partner?
8 **A.** That wasn't told to me, and it sounds extraordinarily
9 distressing if that was the case. Normally, there would
10 be examinations, as normal, part of it to --
11 **LADY HALLETT:** To check where you are.
12 **A.** Exactly. So I'm not sure if anybody would do it just to
13 have their partner in. If they're in active labour,
14 they ought to have support, and we increased the type of
15 people who can come with them. So if somebody needed
16 extra support because of whatever issue, they may have
17 a mental; health problem or a language problem, we also
18 said that they may have an essential worker, as well as
19 a birth partner, that came later on, because we listened
20 to what people were saying to us.
21 **MS CAREY:** Just standing back and thinking about the
22 visiting restrictions, would you make the same decision
23 next time?
24 **A.** Well, fortunately, I don't have to do this again because
25 I'm retired. Should I be --

1 **Q.** Were you in that position, would you make the same
2 decision again?
3 **A.** Were I in that position, I think I would like us to be
4 more permissive earlier on and find ways to do it, and
5 I would say, in particular areas, neonatal services,
6 I've reflected on this quite a lot, I think both parents
7 should have always been allowed to be with their child.
8 I certainly was affected by the Bliss report that
9 described what the impact on was having not the two
10 parents seen as a unit, if you like rather, than one
11 parent in there and the other parent not there.
12 Neonatal care is very fraught and often the child
13 may not survive. So it is a very difficult area, and
14 I think, on reflection, I would have said they always
15 should be as a pair.
16 And other areas, I think we should have been much
17 more careful around giving support, so if somebody's got
18 dementia, it's a very difficult situation and having
19 someone they have some recognition of, so there's lots
20 of folk that I think we should have made more exceptions
21 of earlier on. So yeah, I would have -- wouldn't have
22 done exactly the same thing all over again. But, you
23 know, hopefully next time there will be a vaccination
24 sooner so that we could be more confident in doing that
25 anyway.

1 Q. Can I ask you, please, about DNACPRs. Were you made
2 aware of any concerns that they were being issued
3 inappropriately or there was blanket use of them in
4 Wales?
5 A. So I had heard from various groups about concerns about
6 having a blanket do not resuscitate -- cardiopulmonary
7 resuscitation. They came from the disability advisory
8 group that advised into government. But I also was
9 aware from Healthcare Inspectorate Wales, which is our
10 inspectorate body, that they had come across one GP
11 practice that had sent out a letter suggesting to their
12 patients that perhaps you should all consider -- not all
13 patients but, you know, certain groups of patients --
14 should consider signing this, which is completely
15 inappropriate.
16 Every bit of guidance we've ever issued before the
17 pandemic, during the pandemic, makes it very clear that
18 these conversations should be individual, should be
19 based on agreement with the patient and their loved ones
20 and about what's best for them in their care pathway.
21 Under no circumstances, and I think Ruth may have
22 said this this morning -- under no circumstances is
23 a blanket approach ever, ever appropriate.
24 Q. Can I ask you about an example, if that be the right
25 word, behind your tab 15 and at INQ000300091_0009,

1 please, which is a note of the executive director's
2 daily calls on 3 April. It's probably going to come up
3 on screen in a moment. There we are. I just want to
4 ask you about the PPE box.
5 A. Right.
6 Q. I know you're not in this meeting, but there was:
7 "[a discussion] held on PPE and specifically on
8 ventilators. The Deputy Minister has held discussions
9 with Ty Hafan ..."
10 Is that a hospice service?
11 A. It's sheltered accommodation.
12 Q. Sheltered accommodation, right. I'm so sorry if I
13 pronounced it incorrectly.
14 A. That's okay.
15 Q. "... as their service users had received a letter from
16 their GPs which said that if they caught the virus and
17 were seriously ill they wouldn't be resuscitated."
18 Oh, you are in this, forgive me. You and your
19 colleagues were working on the ethical framework?
20 A. Yes, there was a moral and ethical framework that
21 Dr Heather Payne and I and others worked on and issued
22 which sort of -- it was to help people make the right
23 kinds of clinical decisions in extraordinary
24 circumstances, and it was certainly highlighted in that,
25 but there were also subsequent letters that the CMO and

1 I wrote out reminding people about not doing blanket do
2 not resuscitate order --
3 Q. Did you ever see the letter from this example?
4 A. I didn't -- not that example but, as I say, I heard from
5 different sources, that wasn't the only example I was
6 told about. It came from a number of routes.
7 Q. May I ask you about Long Covid --
8 A. Yes.
9 Q. -- please.
10 Was any data collected on the number of nurses and
11 midwives that reported symptoms of Long Covid?
12 A. No, it wasn't. As far as I can see, the health boards
13 would have kept their own records about staff sickness,
14 but there was no central reporting back to Welsh
15 Government, then or -- I don't think even now that we
16 know exactly how many staff have got Long Covid
17 symptoms, and certainly not in the time I was the CNO.
18 Q. Well, I was going to ask you, did it come to your
19 attention during your tenure?
20 A. No. I was aware that some people were taking a longer
21 time to recover from it, so Long Covid became a thing
22 during my tenure, because Welsh Government started work
23 on setting up a framework of how to support patients and
24 members of the population, and that would include staff
25 members who developed the symptoms of Long Covid.

1 Q. Final two topics from me, please. I'd just like your
2 assistance, please, Professor, on the impact on the
3 nursing and midwifery profession in Wales, and it starts
4 at your paragraph 287 if it helps you.
5 You've told us about some of the support that was
6 provided and practical help for nurses and midwives.
7 Can you, though, give us, if it's possible, an overview
8 of the impact on the profession in Wales?
9 A. I think it was an extraordinarily difficult time for
10 anybody in frontline services -- and for the people who
11 were managing the services, because obviously I was
12 seeing the senior leaders, they were having to make
13 extraordinarily difficult decisions as well. I think
14 it's had a long-term effect on the health and wellbeing
15 of many people. We've seen people leave the service as
16 a consequence of their experience. And because of that
17 we've had to continue offering a wide range of national
18 support that has been described in my statement and my
19 two successors, and I've touched on them before.
20 Health Education Improvement Wales has this very
21 large reservoir of resources that are there for people.
22 The sort of Health for Health Professionals programme is
23 still there. There's now a programme called Adferiad,
24 which is a Welsh Government-funded service for staff
25 with Long Covid. It has taken a much more of a holistic

1 approach rather than a disease approach. This is about
2 helping people's mental health, mental wellbeing,
3 getting physically active again. So it's a much more
4 rehabilitative model than a medical model.
5 But to be honest, the legacy of Covid is going to be
6 quite long and I have -- obviously I'm retired now, but
7 I see the stories about people leaving the workforce,
8 and certainly reports like the Royal College of Nursing
9 reports --
10 **Q.** I was just going to ask you about that, if I may, and if
11 it helps you let me just summarise it. But I think you
12 received a query from Vaughan Gething about a report of
13 an RCN nursing survey in November 2020 which highlighted
14 that 34% of staff, nurses in particular, felt
15 undervalued by the Welsh Government. This was the
16 highest figure of any government in the UK. And 74% of
17 staff believed they'd seen an increase in the stress
18 levels.
19 I don't doubt that the Welsh Government didn't want
20 to undervalue their nursing --
21 **A.** No.
22 **Q.** -- and midwifery profession, but the stress levels, how
23 were they addressed?
24 **A.** So obviously receiving a report like that is very
25 concerning. I was worried about the staff then and

1 I understand the longevity of the condition, how it's
2 affected people's health and wellbeing after the surge
3 of pandemic, is now still an issue for a lot of people.
4 And I had a conversation with a lot of my colleagues
5 within Welsh Government about what more could we do,
6 what more can we respond to, and, as I said to you
7 before, we already had a series of programmes of work
8 under way to do with the mental health and wellbeing
9 issue, and there was a Welsh health circular, which is
10 an instruction to the health service issued by
11 Andrew Goodall, reminding all the health boards and
12 trusts about their employer responsibilities, about
13 providing wellbeing services. So there was a push-back
14 from us, it wasn't just Welsh Government that needed to
15 do this, all the employers needed to do something about
16 it.
17 I think I was also aware that the report was part of
18 a call to address pay and conditions, so that --
19 an element of this, I had to talk to my workforce
20 colleagues who were involved in pay negotiations. So
21 this isn't something that Wales does in isolation, it is
22 part of a UK pay thing, and both the UK RCN report and
23 the Welsh RCN report also make a claim about "we need to
24 be recognising, and staff will feel more recognised if
25 they have more pay". So I'm not trying to diminish what

1 they were saying, because the stress was really real and
2 the effect on their health and wellbeing is pronounced,
3 I couldn't do anything about the pay though, I'm afraid.
4 **Q.** I think you are aware, though, of the disproportionate
5 impact of Covid on the black, Asian and minority ethnic
6 healthcare workforce. Is this right, there was a --
7 I think you asked that nurses took into account where
8 they were deployed, to try to, presumably --
9 **A.** Yes.
10 **Q.** -- mitigate that disproportionate impact?
11 **A.** Yes.
12 **Q.** Can you help us, please, with the all Wales Covid-19
13 risk assessment tool and how that helped that
14 disproportionate impact if at all?
15 **A.** Okay, so early on in the pandemic, the First Minister
16 asked for a series of work to be done to look at the
17 impact on the black, Asian and minority ethnic
18 population in Wales, and one of the groups that was
19 established was to look at developing a risk assessment
20 tool -- for all staff, not just people who are black,
21 Asian and minority ethnic, and it took the learning that
22 we had to that point about who was more at risk, so
23 people who are older, people who have diabetes or and so
24 on and so forth. So it wasn't just what ethnic group
25 you were from.

1 The tool was developed and issued in May of 2020,
2 I think, 20 May sticks in my head, and it was sent out
3 both in paper form and then electronically, and all
4 staff within the system were invited to complete it and
5 then go to their manager to say "I've assessed myself
6 either as low risk or medium risk or high risk". It's
7 like a traffic light system, so you could work out where
8 you are. And if you are in a high-risk group, it's
9 a reasonable suggestion you should be deployed somewhere
10 not in frontline.
11 I should point out that the people who were excluded
12 from that were people like myself, who were clinically
13 vulnerable or shielding, because we expected them not to
14 be in frontline -- in fact not to be in work a lot of
15 the time, the shielded people were at home. So it was
16 designed for everybody else, if you like.
17 That changed when the shielded people came back, so
18 there is a second iteration of it. So I did ask to find
19 out so how many people from black, Asian and minority
20 ethnic background staff-wise had completed it, and you
21 will see in the pack there, I think, that the -- all of
22 the directors of workforce in each of the health boards
23 and trusts came back to say: yes, everybody has
24 completed this. Even when the IT systems didn't quite
25 capture it automatically -- it's another element of the

1 IT systems -- they were still able to do it paper-wise,
2 to track down -- so everybody was able to do it. And
3 most were in a low-risk group not in a high-risk group.
4 **Q.** All right.
5 Finally this, please, you've obviously endorsed
6 recommendations in relation to testing and the roll-out,
7 but if you were to provide my Lady with another
8 alternative, perhaps Wales-based, recommendation, what
9 would you say would be the most important thing from
10 your perspective that could help the nursing and
11 midwifery profession in Wales?
12 **A.** I think my reflections from the time would be around
13 infection prevention and control expertise, both in
14 terms of every staff knowing more about it but also
15 having expert leadership. We really struggled during
16 Covid to actually have people who had the right
17 knowledge and had the senior leadership in this area.
18 So I would say we need to invest in that
19 pre-registration existing workforce and I would say
20 there should be a senior leader in each health
21 organisation with expertise, rather than somebody who is
22 a leader who covers infection, if you see the difference
23 there.
24 So that would be my first -- am I allowed a second?
25 **MS CAREY:** My Lady, they're all the questions that I have.

1 Is there anything that your Ladyship would like to ask?
2 **LADY HALLETT:** No.
3 Professor White, there are some questions for you
4 that I think might take something like 20 minutes. Are
5 you okay to come back after the break?
6 **THE WITNESS:** Of course.
7 **LADY HALLETT:** Thank you very much. In which case, we will
8 break now and I shall return at 3.10.
9 **MS CAREY:** Thank you, my Lady.
10 **(2.56 pm)**
11 **(A short break)**
12 **(3.10 pm)**
13 **LADY HALLETT:** Mr Weatherby, are you asking the questions,
14 or is Ms Munroe? I thought you were the one sitting
15 there and when I saw Mr Weatherby arrive, and it says
16 Mr Weatherby on my list, I got confused. Ms Munroe.
17 **Questions from MS MUNROE KC**
18 **MS MUNROE:** Good afternoon, Professor, my name is
19 Allison Munroe. I ask questions on behalf of Covid
20 Bereaved Families for Justice UK. I'm instructed by
21 Nicola Brook of Broudie Jackson Canter, solicitor, who
22 assists me today, along with counsel Oliver Lewis.
23 Just a few matters, please, three discrete topics
24 and a couple of questions on each, my Lady, some of
25 which have been sufficiently addressed by Ms Carey

1 King's Counsel, so I won't trouble you with those.
2 First topic, relationships with Wales and the CNOs
3 in Wales and the other CNOs in the three other nations
4 of the UK. Now, I'm mindful, Professor White, of the
5 evidence you gave this afternoon that the role of the
6 CNO in Wales is a substantive civil service one, as
7 opposed to somebody like Dame Ruth May, who has an NHS
8 role.
9 With that in mind, could you assist us, as
10 succinctly as possible here, please, with what
11 communications did the Welsh CNO have with the other
12 CNOs across the other nations of the UK. I know it's
13 a rather broad and what I have in mind is sort of the
14 nature and effectiveness or otherwise of those
15 communications, please?
16 **A.** So each part of the UK has a Chief Nursing Officer who
17 gives advice to government. They have slightly
18 different roles but, essentially, that's what we do.
19 Before the pandemic, we would meet on a quarterly basis,
20 either in person or virtually, to help drive the
21 professional agenda forward, because nurses and midwives
22 are regulated to work anywhere in the UK, we needed to
23 have a shared understanding of what that would mean. We
24 can't have health policies completely different because
25 it would make it difficult for nurses to work across the

1 whole system.
2 During the pandemic, we just increased the amount of
3 contact we had, partly to give peer support but mostly
4 so that we could learn from one another the approaches
5 being taken in our health systems, so that good practice
6 could be shared or systems to find solutions.
7 So I'll give an example, the hospital visiting
8 guidance, we talked about that, so we all were taking
9 a similar approach, so there was less difference
10 geographically.
11 **Q.** Thank you.
12 On 30 March 2020, nursing directors raised concerns
13 regarding delays in the publication of Public Health
14 England's guidance on dealing with deaths. Why was that
15 delay in England relevant to what was going on in Wales,
16 and decision-making in Wales?
17 **A.** So quite a bit of guidance around infection prevention
18 and control was being developed at a UK level, so rather
19 than each country going their own way, we tended to
20 share good practice, particularly in infection
21 prevention and control, and we had decided to take the
22 Public Health England guidance and apply it to Wales, in
23 this particular instance.
24 **Q.** So was the reality, as you saw it, that Public Health
25 England was making the major decisions and Wales were

1 following suit or was it more collaborative than that?
2 A. I think it was more collaborative than that. There can
3 be a lot of wasted energy if everybody had to go from
4 first principles and develop guidance. It's much better
5 to share information and then apply it to systems if we
6 all agreed that that original piece of work was sound.
7 So, yes, it was more of a collaborative and building
8 into application to our own systems, rather than develop
9 from scratch.
10 Q. Lastly, on this first topic, about temporary
11 registration of third year student nurses, we heard
12 a little bit about that this morning from Dame Ruth May.
13 On 17 April 2020, in a nursing directors' meeting,
14 concerns were expressed that temporary registration of
15 third year students may hinder their progress and delay
16 full registration.
17 A. Yes.
18 Q. Now, a decision was taken in Wales not to adopt the
19 NMC's emergency standards which was placing third year
20 students in rostered aid employment.
21 A. That's not correct, we did place third year students in
22 their last six-month of their role into paid employment.
23 They weren't on a temporary register, that was the bit.
24 Q. Right.
25 A. They were still students and the hours they did in

1 practice counted towards their degree. Sorry, if the
2 note was not clear enough. So they were paid as
3 a band 4 healthcare support worker for that six months
4 and they had a six-month contract dated from 27 April
5 2020.
6 Q. So, in that respect, Wales was not adopting a different
7 position from the NMC's --
8 A. That's correct.
9 Q. -- and IPC standard. I'm grateful for that
10 clarification, thank you.
11 Second topic, then, communications within Wales. My
12 first question has actually been addressed, it was about
13 the absence of a CNO role in pre-pandemic planning.
14 That's been sufficiently addressed by you already.
15 But my second question is this, Professor White: do
16 you think there was a gap in the communication between
17 health boards in Wales and the CNO, bearing in mind the
18 absence of the CNO role in the pre-pandemic and
19 emergency health planning?
20 A. I had a very close relationship with the executive nurse
21 directors. Wales is not a very large place, so we met
22 regularly before the pandemic and I met with them twice
23 weekly during, particularly, the first wave and then it
24 reverted to a less frequent contact, and then increased
25 again as the second wave came along. So I wouldn't say

1 that I had a poor relationship, it was a very good
2 relationship, actually. Did you have a specific area
3 that you felt that it was difficult?
4 Q. No, it wasn't so much about the quality of the
5 relationship, whether it's poor, but whether there were
6 any gaps in terms of the communications?
7 A. I didn't feel so at the time, no.
8 Q. I'm grateful, thank you.
9 The last topic, then, the CNO's ability to act on
10 concerns. Now, the word "concerns" is something that is
11 repeated throughout your very lengthy and very helpful
12 witness statement. You've already told us in detail
13 about the visiting guidance and you were the lead in
14 relation to that, so that takes care of my first
15 question there.
16 So my second question in terms of concerns is this,
17 Professor White: at a meeting on 10 April 2020, concerns
18 were raised about the deployment of returning staff over
19 the age of 60 years of age into Covid-19 areas, and this
20 was particularly so, this concern was raised, because of
21 the very well publicised, at the time, numbers of older
22 staff in Italy that were being affected.
23 A. Yes.
24 Q. What actions did you personally, or collectively with
25 others, take in terms of addressing those concerns?

1 A. So that was back in April, so --
2 Q. Yes.
3 A. -- it was raised at a meeting with the other nurse
4 directors. This was from -- the Cardiff and Wales
5 University Health Board Nurse Director raised it. So
6 that practice was shared with others at that moment, but
7 it was fed into the development of the Wales risk
8 assessment tool that we developed for all healthcare
9 workers. So age on its own is not necessarily
10 exclusive, it's the things that go with age, you often
11 have a chronic condition, like I have, when you're
12 older. So age was one of the factors that was described
13 in the risk assessment tool that all workers were
14 encouraged to do to work out how susceptible they might
15 be, and that included other chronic conditions or from
16 a black, Asian and minority ethnic background, and, in
17 fact, men were more susceptible than women, for example.
18 But that on its own wouldn't be necessarily a thing to
19 move you to somewhere else. Does that answer your
20 question?
21 MS MUNROE: It does, thank you very much, Professor White.
22 Thank you, my Lady, those are my questions.
23 LADY HALLETT: Thank you, Ms Munroe, very grateful.
24 Now you have questions from Ms Weeretatne KC. Have
25 you got a direct line of sight?

1 **THE WITNESS:** Yes, I have, thank you very much.
2 **MS WEERERATNE:** Thank you, my Lady, an excellent line of
3 sight, there's just a pillar between you and I, which
4 I'm sure I can navigate.
5 **LADY HALLETT:** I'm afraid we always knew that would be
6 a problem, sorry.
7 **Questions from MS WEERERATNE KC**
8 **MS WEERERATNE:** Thank you very much.
9 I'm asking questions on behalf of the Covid Bereaved
10 Families for Justice Cymru, many of whose members were
11 bereaved through the loss of loved ones to nosocomial
12 infection.
13 You may already know that this group is critical of
14 the Welsh Government's response to the pandemic and,
15 amongst other things, has said that it was slow and
16 disjoined.
17 I do have some questions for you remaining and they
18 will involve a little bit of context setting, so if you
19 would just bear with me on that.
20 First, I wanted to ask you about timings of
21 responses by three of the Welsh Government bodies that
22 responded, and the context of the questions is that of
23 urgency.
24 So on 30 January 2020 the WHO declared a global
25 public health emergency. On 4 February 2020, SAGE

1 confirmed the first case of human-to-human transmission
2 had occurred outside of China. On 28 February 2020,
3 Covid-19 struck for the first time in Wales.
4 So first question on that is from paragraph 68 of
5 your witness statement, and you don't need to look at
6 this, you say it was only on 16 March 2020 that the
7 executive team meetings of the Health and Social
8 Services Group to discuss issues affecting planning and
9 delivery of health and social care in Wales stepped up
10 frequency of its meetings from monthly to weekly. So
11 bear with me. Then, secondly, at paragraph 69, you also
12 say that on the same date, 16 March, monthly Welsh
13 nursing directors' meetings increased to twice weekly
14 meetings to share information on service issues that may
15 require Welsh Government response.
16 So the first question is: do you accept that
17 increasing frequency of these meetings in key groups on
18 16 March was too slow a response to an already urgent
19 situation?
20 **A.** Some groups were meeting sooner than that, so I think it
21 would be fair to say that the planning and response cell
22 actually started meeting in February to start working
23 out how the system could change. So it was -- certainly
24 certain meetings were starting to step up its frequency
25 during March. Possibly it was later than that could

1 have been done, but I'm not sure what more we could have
2 done earlier until we had some of the plans in place,
3 which other groups were already working on.
4 **Q.** So I was going to ask you that. Of course I was talking
5 about key groups in relation to the executive team, HSSG
6 group, and the nursing group, which you would accept are
7 key groups, wouldn't you?
8 **A.** Yes, yes. And the executive director team meeting was
9 weekly, so I would meet with other colleagues and the
10 director general on a weekly basis, usually a Thursday
11 morning, and that was supplemented by daily contact as
12 soon as the pandemic really started to get its claws
13 into us.
14 **Q.** All right. So if I was to offer an explanation for the
15 delay on 16 March would you have anything additional to
16 add?
17 **A.** I don't think so. As the work escalated, so our need to
18 meet more frequently escalated alongside it. I'm not
19 quite sure whether meeting more frequently before that
20 of some of these groups would have been necessarily
21 helpful. Hindsight's a wonderful thing, you know.
22 Possibly, I don't know.
23 **Q.** I'll ask you another question on that point. The Welsh
24 Government's Nosocomial Transmission Group was
25 established on 19 May --

1 **A.** That's right.
2 **Q.** -- 2020. Its role, you've already been asked about, was
3 to provide advice, guidance and leadership on actions
4 needed to minimise nosocomial infections. So you were
5 the joint chair of that group --
6 **A.** That's right.
7 **Q.** -- along with Chris Jones. Again referring to the state
8 of knowledge in January and February regarding the virus
9 as it emerged, and that nosocomial infection had been
10 identified by SAGE in March 2020 as being a pressing
11 issue, do you accept that 19 May 2020 was too slow
12 a response to establish a Welsh nosocomial group?
13 **A.** Yes, well, Public Health Wales were working on the
14 infection prevention and control issue. The IPC cell
15 I think had met in January of that year. So we were
16 relying a lot on the expertise and support of Public
17 Health Wales. It was decided that additional support
18 would be needed at a government level. Possibly we
19 could have started it a few weeks earlier, I accept
20 that, but certainly it became a focus of our attention
21 and we met very, very regularly throughout my time as
22 CNO --
23 **Q.** Yes.
24 **A.** -- and produced a lot of guidance as a result.
25 **Q.** But do you accept there was about a six-week delay

1 between the SAGE announcement and your group being set
2 up?
3 A. As I say, that was because we had other mechanisms that
4 were already in play, so this was an additional thing we
5 added later on. I wouldn't call it a delay
6 particularly. It was as the issues started to emerge we
7 realised we needed more support and a place where we
8 could work on broader guidance rather than the immediate
9 infection prevention and control measures that Public
10 Health Wales already was dealing with.
11 Q. But as we know it became a pressing issue, nosocomial
12 infection, and you were asked about outbreak
13 surveillance monitoring, which you said in evidence came
14 later on. Now, it's correct, isn't it, that "later on"
15 means, November 2020, so that's yet another six months
16 after the setting up of the Nosocomial Transmission
17 Group; that's correct, isn't it?
18 A. So what I said in my statement was that we had
19 a pre-pandemic arrangement that Public Health Wales
20 dealt with all outbreaks, but the way that their data
21 was presented to us as a Welsh Government was there's
22 some time lag, so we didn't know every day what was
23 happening across the system, so we had to develop a way
24 of gathering real-time data. So I would say yes, there
25 was a delay in having real-time data, not that we

1 weren't actually managing outbreaks in a particular way.
2 It just wasn't timely enough. So that would be fair to
3 say that, yes.
4 Q. Yes, because the daily reporting didn't start till
5 November 2020, and that's the evidence you referred
6 to --
7 A. That's right.
8 Q. -- earlier.
9 So in relation to what I'm going to call slow
10 responses at this critical time in Wales, it would be
11 correct to say, wouldn't it, that valuable planning and
12 response time and data was inevitably lost?
13 A. Well, certain systems had to be established, and I would
14 say that that was slow to happen. Some of our systems,
15 IT systems, I think, my Lady, I've already mentioned
16 that some of them didn't talk very well to each other,
17 so it's quite hard at a government level when you don't
18 have access to real-time data. So that certainly took
19 a while.
20 We did have a planning cell that was working with
21 the service about how to change what we were providing,
22 so that was done in a reasonable time. I wouldn't say
23 it was early, but it was reasonable. So it's a mixed
24 answer, I would say to you. Some of it was possibly
25 slower than we would have ideally liked because we had

1 to establish systems.
2 Q. Thank you.
3 I'm just going to move on to another topic now,
4 because I only have ten minutes to ask you questions.
5 A. I'm so sorry.
6 Q. So within your statement you do explain that on
7 3 April 2020 a conflict was brought to your attention by
8 directors of nursing between the Public Health England
9 PPE guidance and the UK Resuscitation Council guidance
10 in respect of whether CPR and chest compressions
11 constituted AGP and whether, in hospital settings at
12 least, full protective equipment should be worn,
13 including FFP3 respirators. Do you know what
14 I'm referring to?
15 A. Yes, I do.
16 Q. So on 10 April, you were told that practitioners in
17 Wales did not want to use the Public Health England
18 guidance. Can you confirm that on 21 April you received
19 an email from one nursing director of a local health
20 board alerting you to the fact that some health boards
21 were insisting on accepting the Resuscitation Council
22 position over that of Public Health England?
23 A. Yes, this remained quite a contentious issue within the
24 service for a number of months, it wasn't just that one
25 instance. We talked about it multiple times as

1 executive nurse directors and, in the end, the CMO and
2 I actually put out what we hoped was helpful guidance to
3 find a way through, while the scientific experts looked
4 at the issue. I'm not in an expert in this area, so
5 this became a problem for some months and, eventually,
6 an aerosol-generating procedures specialist group was
7 established at the request of the --
8 Q. Yes, I'm going to interrupt you, if you don't mind,
9 there was a specific line of questioning that I wanted
10 to follow.
11 A. Okay, go ahead.
12 Q. But I want to be fair, on 14 April you did issue
13 a letter, which is in your statement at paragraph 208.
14 I believe you've set that out there. But I just wanted
15 to ask you this: so you did receive that there was
16 an insistence on the part of some local health boards to
17 use the RCUK guidance and you forwarded that, didn't
18 you, to Frank Atherton, then the CMO of Wales and also
19 to Chris Jones --
20 A. Yes.
21 Q. -- the Deputy CMO, and you stated:
22 "As I said before, I wonder if we should have made
23 a decision to just accept the Resus Council position as
24 best practice for Wales, given the level of distrust now
25 apparent within the PHE PPE guidance."

1 Bear with me. The response you received from
2 Chris Jones was that it was not for the Welsh Government
3 to mediate the stand-off between the RCUK and PHE, that
4 the Welsh Government supports the PHE guidance and that
5 it was for organisations to consider what advice they
6 wished to adopt, and Frank Atherton said that there
7 should be no further action.
8 So my question is this: do you agree that further
9 action should have been taken to provide clear
10 leadership in respect of the PPE guidance to be used in
11 Welsh hospitals during CPR?
12 **A.** So Frank and I did actually send a letter, I think it
13 was about a week after that, which tried to mediate
14 a way forward while the issue was being sorted out. So
15 this needed to have further scientific view on it. The
16 whole issue about whether chest compressions causes
17 aerosol particles to a degree that would actually cause
18 a risk to staff, so we tried to be helpful, but it
19 wasn't really Frank or I's place to try to sort out the
20 scientific argument that was going on.
21 **Q.** Yes, so do you accept though that the argument, if you
22 like, was causing confusion on the ground --
23 **A.** It did.
24 **Q.** -- and that patients and staff were at risk as a result?
25 **A.** Probably.

1 **Q.** Yes.
2 **A.** I mean, all I can say is we tried to find a way with
3 advice to mitigate the risk but, certainly, having the
4 confusion added to a distrust of guidance that was
5 coming out, and that was not helpful to anybody.
6 **Q.** So that was my final point on this, in relation to the
7 distrust of guidance, and my question is this: did this
8 attitude of distrust by the local health boards spill
9 over into other aspects of PPE guidance and damage the
10 confidence in Public Health England's guidance and
11 compliance by hospital staff in Wales?
12 **A.** Possibly, but it was not reported to me as an issue as
13 clearly as this. This was, I would say, the standout
14 conflict between advice that was given to staff. It may
15 very well have made people question what other guidance
16 was out there, but it -- and it needed to be clarified
17 to help. So I can't give you another example, I'm
18 sorry.
19 **MS WEERERATNE:** All right.
20 **LADY HALLETT:** Thank you.
21 **MS WEERERATNE:** Thank you very much, those are my questions.
22 **LADY HALLETT:** Thank you very much.
23 Thank you very much indeed, Professor White, I'm
24 really grateful for your help. I don't know if it's
25 pleasant meeting your former colleagues in this

1 situation when you've all got to relive such a dreadful
2 time but, anyway, thank you for coming along today.
3 **THE WITNESS:** Thank you very much, my Lady.
4 **MS CAREY:** Thank you very much.
5 **(The witness withdrew)**
6 **LADY HALLETT:** Ms Carey.
7 **MS CAREY:** May we now hear, my Lady, from Ms Fiona McQueen,
8 who is just coming in.
9 **MS FIONA McQUEEN (sworn)**
10 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**
11 **LADY HALLETT:** You have been waiting a long time, I'm very
12 sorry.
13 **THE WITNESS:** Not a problem, my Lady.
14 **MS CAREY:** Ms McQueen, your full name, please.
15 **A.** Fiona Catherine McQueen.
16 **Q.** I think you were initially the interim Chief Nursing
17 Officer in November 2014, became the Chief Nursing
18 Officer then until February 2021?
19 **A.** That's correct.
20 **Q.** Can you just help us, please, with your own professional
21 background, just summarise that if you --
22 **A.** So I essentially am a generalist nurse leader, I became
23 an executive nurse director in 1993. So the bulk of my
24 clinical practice has been in nurse management or
25 executive nurse director roles. So generalist

1 leadership across a number of areas.
2 **Q.** I think the Chief Nursing Officer has its own
3 directorate which sits within the DG HSC, or
4 Director-General Health and Social Care, in Scotland?
5 **A.** That's correct.
6 **Q.** Your roles and responsibilities are set out in your
7 statement but they include providing policy and
8 professional advice to ministers and leading on
9 professional and policy aspects of healthcare associated
10 IPC and antimicrobial resistance measures?
11 **A.** Yes.
12 **Q.** A mouthful, but is that it in a nutshell?
13 **A.** That's it.
14 **Q.** All right.
15 You provided advice to a number of groups, I think,
16 during your tenure as CNO Scotland, including the Health
17 and Social Care Management Board. I know that was
18 briefly reconstituted to be called, I think, the Health
19 and Social Care Planning and Assurance Group before
20 going back to the board; is that right?
21 **A.** That's right.
22 **Q.** Just tell us, what was the board's remit?
23 **A.** Essentially, within Scotland, the NHS is run by NHS
24 boards from a legislative perspective, and the Director
25 General is also known as the Chief Executive of the NHS

1 in Scotland and the accountable officer financially, and
2 the Director General has a team of directors, including
3 the Chief Nursing Officer, and we would oversee policy
4 on health and provide advice to ministers, but also look
5 at enabling that policy to develop into strategy for
6 delivery of the NHS.
7 **Q.** I think one of the other advisory groups that you either
8 attended or was associated with the CNO and the
9 directorate was the Covid-19 Nosocomial Review Group, or
10 CNRG, as it was known. Was that something that you set
11 up alongside the CMO in Scotland?
12 **A.** Yes, in Scotland, I think we have a very effective
13 national group. Now, over March to April 2020, at
14 Health Protection Scotland -- we had the creation of
15 Public Health Scotland and Health Protection Scotland,
16 which was NHS ARHAI, the derivative of that. So
17 sometimes HPS and NHS ARHAI are used interchangeably.
18 So we had a good system in Scotland for oversight of
19 nosocomial infection, antimicrobial resistance and that
20 was there. Obviously, during the pandemic there were
21 other bodies nationally across the UK that were set up
22 but I wanted, you know, after a few weeks, I realised
23 there was a gap and I had wanted to have a more expert
24 group who could look at what was happening in SAGE, look
25 at what was happening internationally, and provide

1 advice to myself and Gregor Smith, the CMO, and we could
2 then onward to ministers or into the service. Just
3 wanted something that was more locally applied to
4 Scotland, more responsive to our questions and our
5 direction, and able to formalise what was happening
6 within Scotland.
7 **Q.** I think you said in your statement that that group first
8 met on 7 May 2020 and, as I understand it, are you
9 actually a member of the group or do they report to you?
10 **A.** They reported to me.
11 **Q.** Right, and the CMO as well?
12 **A.** Yes.
13 **Q.** All right.
14 Were you involved in any advice giving to ministers
15 between January and March 2020, so the pre-pandemic
16 phase --
17 **A.** With regards to IPC or in general?
18 **Q.** In general.
19 **A.** No, a lot of that was done by the CMO, the
20 Cabinet Secretary for Health, and the resilience unit
21 did a lot of that work. But we were beginning to ramp
22 up in terms of looking at the student nurse -- our
23 senior student nurses moving into employment. Similarly
24 with the ITU guidance. So I wasn't involved in the
25 national -- advice that would be happening nationally

1 across Scotland. It was more bespoke with regards to
2 the nursing midwifery workforce.
3 **Q.** All right, thank you very much.
4 Can we look at the CNRG in a bit more detail,
5 please.
6 If I understand it correctly, it was there -- set up
7 to try to understand nosocomial infections and identify
8 any other IPC measures that might be needed to try to
9 combat those infections; is that right?
10 **A.** Yes. I think it's important to clarify. Nosocomial
11 infection exists, unfortunately. It exists right across
12 the world and it's a well known phenomenon
13 internationally. Also when there is circulating
14 infection in the community, then the people who are in
15 the community bring that into institutions. It's easy
16 to see in the winter vomiting bug, when we see the
17 norovirus coming into hospitals or care homes over the
18 winter, which is why visiting can be suspended for
19 particular wards or departments. So I think the
20 understanding of nosocomial infection is quite clear,
21 but what we wanted to have was additional advice from
22 a group on -- in particular, because we would not
23 normally -- in normal times you don't have the infection
24 being brought into the organisation, so needing to have
25 advice about how it was travelling through the

1 organisations, what was happening with staff, and giving
2 advice particular to Covid-19. And we very quickly
3 published cluster information and minutes of the CNRG as
4 soon as we could.
5 **Q.** Yes, I think you said you published the minutes, but did
6 you publish the recommendations that the CNRG made?
7 **A.** So they would be summarised in the minute.
8 **Q.** Right, okay, thank you.
9 You say in your statement that the CNRG's advice was
10 provided to you and the Chief Medical Officer and
11 thereafter you and ARHAI considered the advice and used
12 it to inform policy development. Can you give us
13 an example of what, practically, you did as a result of
14 CNRG's advice?
15 **A.** So a bit of context as well.
16 **Q.** Of course.
17 **A.** Within my directorate, I had policy civil servants as
18 well as clinicians who worked in what we would call the
19 HAI team. The chair of CNRG was also the nurse director
20 of NSS, so was associated with ARHAI, and there were
21 members of NHS ARHAI on CNRG, so to say it then went to
22 ARHAI is correct, but there was a lot of commonality
23 amongst that.
24 Things like whether or not to test staff in
25 high-risk areas, whether or not to look at testing -- so

1 one of the early pieces of advice it gave us was where
2 you have an unusual or even one member of staff testing
3 positive for Covid or a patient testing positive for
4 Covid in a ward, an elective ward, which was not a Covid
5 ward, they recommended testing patients and staff.
6 Q. You mentioned testing, and I was going to ask you,
7 please, about paragraph 28 in your statement, where
8 I think you say that there was advice from the group to
9 the directorate in May, late May 2020, for "additional
10 targeted [healthcare worker] testing to protect highly
11 vulnerable patients in hospital at risk of poor outcomes
12 from acquiring Covid-19".
13 Who were the highly vulnerable group that were being
14 spoken of there?
15 A. So this is against the backcloth of testing capacity not
16 being what we would want it to have been. So oncology
17 patients, so inpatient oncology patients, including
18 those who were having chemotherapy -- if chemotherapy
19 had started back by then, I know we suspended it for
20 a short time -- care of the elderly, so our frail
21 elderly wards, and also our long-term -- our wards where
22 we had long-term mental health patients for longer than
23 three months. So we thought -- or the advice from CNRG
24 was this was a group who were particularly vulnerable
25 and therefore we would look at testing staff on a weekly

1 basis.
2 Q. What about those with dementia, were they as part of
3 this group or not --
4 A. So that would be -- I do beg your pardon, Ms Carey, that
5 would be part of the older people's wards.
6 Q. Right, understood. Thank you very much.
7 Can I ask us, please, to have a look at
8 INQ000250382.
9 Ms McQueen, it's behind your tab 3 but it might just
10 be easier to look at it on the screen. This is a note
11 from you to the Cabinet Secretary in June of 2020, on
12 the 3rd, in relation to healthcare worker testing in
13 hospitals, and you can see it's:
14 "To propose an approach for healthcare worker
15 testing for COVID-19, further to the advice of the
16 [CNRG] ..."
17 And I think we can see the background to this is
18 "Asymptomatic transmission and testing", and at that
19 stage in Scotland only healthcare workers who were
20 symptomatic were tested and the proposal was to test
21 more to try to identify those who may be asymptomatic;
22 is that it in summary?
23 A. That's correct, yes.
24 Q. I think you say there, I might just need your help with
25 this, at paragraph 4:

1 "Latest analysis finds that approximately half of
2 the cases in all of the reported NHS Scotland cluster
3 outbreaks in non-COVID wards are healthcare workers ..."
4 Can you help us with a "cluster outbreak"; how is
5 that term used in Scotland?
6 A. So the term "cluster" and the term "outbreak" are both
7 used epidemiologically within public health and within
8 infection prevention and control. An outbreak would be
9 two or more cases where there's a common source, and
10 a cluster would be two or more cases, not necessarily
11 needing that common source. So it's at a higher --
12 an outbreak as a subset of a cluster.
13 Q. Thank you very much.
14 So, here:
15 "... at present, almost 70% of cases in the active
16 clusters are healthcare workers."
17 Then the six active incidents involved 26 patients,
18 59 members of staff, the 118 closed incidents. What is
19 the "closed incidents" a reference to?
20 A. It's where the cluster or outbreak has been deemed to
21 have stopped, so no more new infections, and not being
22 actively managed.
23 Q. So it had historically been the position in Scotland
24 that there were 118 closed incidents involving the
25 888 patients, 213 deaths?

1 A. Yes, at that time.
2 Q. At that time. And 862 staff cases.
3 I think if we just go to page 2 in that document, at
4 paragraph 7 -- at the top of the page, thank you --
5 there was some work done on mathematical modelling
6 which:
7 "... estimates that the weekly screening of
8 [healthcare workers] could reduce onward transmission
9 from [healthcare workers] by a further 16-23% on top of
10 self-isolation ..."
11 Although that was an assumption, essentially, here,
12 were you asking the minister to bring in testing for the
13 asymptomatic healthcare worker?
14 A. No, I think -- so I think we weren't asking that as
15 a blanket way, I think the recommendations are in under
16 paragraph 11.
17 Q. Yes.
18 A. I think what we were saying is where there's
19 an unexpected cluster or outbreak we would want to look
20 at that, and where the infection prevention and control
21 teams believed they needed to do that, that they would
22 do that as well.
23 Q. So you were wanting to do target testing where there
24 were these unexpected clusters or outbreaks. Is there
25 any reason why it wasn't wider and just

1 an implementation of asymptomatic testing across the
2 board?
3 A. So I'm not sure if it's -- if it was close. So we would
4 brief the minister post-CNRG or post something new
5 happening, and I think the Imperial College presented
6 a paper that talked about the value of asymptomatic
7 testing. Now, CNRG looked at that and their view was it
8 was a theoretical or abstract piece but, in the real
9 world, good infection prevention and control measures
10 would actually be more effective because it would reduce
11 nosocomial infection by 80%, and their advice at that
12 time was not to test -- blanket test asymptomatic
13 workers.
14 My sense is, if we had had the testing capacity we
15 would have been there --
16 Q. That's what I was going to ask you: so if I understand
17 your evidence correctly, there was an evidence-based
18 decision taken not to roll it out more widely, was that
19 the driver of the decision or was it the lack of testing
20 capacity?
21 A. I think if it had been only a lack of testing capacity,
22 then the briefing that I would have had from CNRG and my
23 team, that I would have given to the minister and
24 I would have talked to Gregor Smith about was we don't
25 have enough testing to do this. Is it a priority and

1 how can we possibly do that. So I think it was
2 an on-balance, actually, it may not be productive and
3 good IPC measures are important with the testing where
4 there are even just one unexpected case.
5 Now, that didn't last, because we then moved --
6 I don't think that lasted because this was before the
7 end of June, when we were starting to do the vulnerable
8 patients, I think, but -- so I don't think it was
9 predominantly because there was a lack of testing
10 capacity but there's no doubt at the early days of the
11 pandemic lack of testing capacity was a problem.
12 Q. I don't know if you heard any of Dame Ruth May or your
13 Welsh counterpart's evidence, but they have both spoken
14 to her Ladyship already about the role of testing. Did
15 you hear any of that evidence whilst you were waiting?
16 A. I did hear on and off both Ruth and Jean, but I don't
17 remember testing because I was travelling across London
18 at times.
19 Q. They both, in short, for an increased amount of testing
20 to help with visiting restrictions and the need for it,
21 or otherwise, prevention of nosocomial infections; do
22 you have any dissent or assent to their --
23 A. Complete assent. You know, increased testing would have
24 been enormously beneficial, I think right across
25 society, but since we're here to talk about health,

1 within our health system.
2 Q. A different aspect of CNRG's work, please, in relation
3 to face mask guidance and, Ms McQueen, it's at your
4 paragraph 35 and I may need to put up on screen the
5 table that you've set out in your statement, could we
6 have, please, INQ000474225_0013. I think really you've
7 set out a timeline there of the changes to the face mask
8 guidance that was brought in in various stages in 2020.
9 June 2020, there is introduction of interim guidance
10 on the wider use of face masks, decision to introduce
11 the face masks in adult hospitals and care homes for the
12 elderly, and the reason for the change is set out there:
13 to help reduce nosocomial transmission in hospitals and
14 care homes.
15 I presume we're talking about FRSM masks?
16 A. Yes.
17 Q. That guidance in June 2020, did that include people
18 working in non-clinical roles?
19 A. No, I think that was -- the non-clinical roles was in
20 September 2020.
21 Q. Yes.
22 A. It does seem curious now that it didn't, but no, it
23 didn't.
24 Q. Do you think now you would make a distinction between
25 those in clinical roles and those in non-clinical roles

1 for something as simple as an FRSM?
2 A. Absolute -- for something as simple as an FRSM, and
3 knowing now -- and it is always difficult to move us
4 from where we are today to where we were then, and
5 knowing now what we know about ventilation, about, you
6 know, air throughput and about transmission, I think it
7 would have been better if we had had that as early as
8 possible.
9 Q. September 2020, as you rightly pointed out, updated face
10 mask guidance to cover now primary and wider social
11 care, primary care including GP practices, dentists,
12 opticians, pharmacies and the wider community care are
13 set out there.
14 Can you help as to why GPs and pharmacists weren't
15 included in the roll-out in June 2020?
16 A. So they would have been wearing it in patient facing,
17 when they were seeing patients, but not when they were
18 perhaps in the staff room or, you know, if the
19 pharmacists were in dispensing areas. So it would be
20 the non-patient facing roles then as well.
21 Q. At the bottom of the screen, we can just see there June
22 2021, a year on from the initial introduction of the
23 interim guidance, now we've got wider FRSMs by clinical
24 and non-clinical staff. So is it right that a year
25 elapsed before the recommendation was for non-clinical

1 staff to wear FRSMs?
2 A. So by that time, I had (unclear) office, at the end of
3 February 2021 --
4 Q. Yes.
5 A. -- so I apologise, Ms Carey, I would have thought from
6 memory that we introduced FRSMs for non-clinical staff
7 earlier than that but I could --
8 Q. You think it happened in your tenure?
9 A. I thought it did but I may be wrong. So when we talk
10 about clinical staff, if you were part of the trades
11 workforce and that would have included them, going into
12 wards and departments, in the June 2020.
13 Q. It's my fault, I'm not familiar with the trades
14 workforce. What do you mean by that?
15 A. Well, plumbers, electricians, engineers.
16 Q. Right, sorry, okay.
17 If I understand you correctly, though, for the
18 porters, the cleaners, people in that non-clinical role
19 within the hospitals, though, when do you think they
20 were advised to wear FRSMs?
21 A. So I think -- I think in the September -- so I think in
22 June 2020 we would have been looking at the introduction
23 for all staff. So we weren't just seeing clinicians, so
24 anyone who was in a ward or department, which would be
25 the trades workforce or cleaning staff or catering

1 staff, as well as doctors and nurses, would have worn
2 that, but in the workshop, the trades workforce may not
3 have, in June 2020, but they ought to have in September
4 2020.
5 Q. Okay. Dealing with guidance but in a different sphere,
6 can I ask you about the IPC guidance, please. We can
7 take that down, thank you.
8 I think, is this right, that Scotland followed the
9 UK-wide IPC guidance but, in October 2020, Scotland
10 published its own Covid-19 specific guidance; is that
11 correct?
12 A. In terms of IPC or --
13 Q. Yes.
14 A. So it would have been a Scottish version of it.
15 Q. That's what I was going to ask you: did it replace the
16 UK-wide or did it supplement the UK-wide IPC guidance?
17 A. So I struggled with the UK IPC guidance because -- and
18 the feedback we got from staff was it was confusing
19 going onto the -- to have a look online because the
20 National Infection Prevention and Control Manual that we
21 had had in Scotland for some time was an online manual,
22 and staff were used to going online to check what the
23 most up-to-date guidance was, and then they were sent
24 through to Public Health England, and at times that may
25 or may not have had everything that was relevant to

1 Scotland. So I was always keen that we had very clear
2 and explicit communication for people working within the
3 Scottish health service and social care.
4 Q. So although the UK IPC guidance was designed to try and
5 standardise the position across the UK, in fact did it
6 serve to confuse in Scotland; is that really where you
7 get to?
8 A. Yes.
9 Q. Okay. You do say in your witness statement that there
10 were 15 times that guidance was issued on a Friday. Was
11 that IPC guidance or guidance across other areas?
12 A. I think the IPC guidance was particularly problematic
13 and particularly -- because, realistically, NHS and the
14 civil service were working seven days a week, so in
15 a way, whether or not it was issued on a Friday, was
16 kind of immaterial, but smaller -- in social care, we
17 had much smaller organisations who had less resource,
18 who struggled with information coming out on a Friday.
19 So I think there were other issues, other than IPC
20 guidance, that would be issued on a Friday as well,
21 other workforce issues.
22 Q. Did you become aware of concerns though about it being
23 received, in theory, late in the week albeit --
24 A. Definitely and it wasn't ideal but the question was do
25 we hold it until -- because we weren't going to issue it

1 on Saturday or Sunday, do we hold it until Monday or do
2 we issue it and give people time to get it in place. We
3 didn't criticise people for not having immediate
4 implementation because some of these things would take
5 a number of days to take over and implement.
6 Q. Can you think of any way to try and, if there is
7 a concern about it coming out on a Friday and saying
8 it's got to be in place by Monday, is there anything
9 practically that you think could or should be done to
10 try and soften the blow, if I can put it like that?
11 A. I think resourcing is an issue so, in reality, coming
12 out on a Friday I would be, I may be wrong but I'd be
13 surprised if we said this is for implementation by
14 Monday or, you know, there will be firm words taken.
15 I think we would have said "As soon as you can, could
16 you implement this, please", and we would often give
17 a bit of time for things to be implemented, depending on
18 what it was, if it went to an NHS board, our biggest NHS
19 board has over 20,000 staff, so that's never going to
20 reach the front line in anything other than a matter of
21 days.
22 Q. Generally in relation to the IPC guidance, we've heard
23 that there was the UK IPC cell, with representatives
24 from Public Health Scotland on it, and all the other
25 public health agencies, and a number of other bodies.

1 What role, if any, did you have in approving, amending,
2 disagreeing with any guidance that the IPC cell wished
3 to have published?
4 A. I'm a generalist in terms of my leadership skills, I'm
5 not an infection prevention and control expert. I had
6 policy but, in particular, clinicians working in my team
7 and I relied completely on NHS ARHAI, so if they came
8 and said "This is the guidance that we believe we should
9 be implementing", I may have asked questions, and I may
10 have queried parts of it so that I could have a better
11 understanding of how that guidance was formulated before
12 I then advised ministers, because I was not going to
13 have NHS ARHAI saying "Fiona, I think we should do
14 this", and then me say to the minister, "I don't think
15 we should". So I was relying on the clinical experts in
16 NHS ARHAI and also my policy team to advise me.
17 Q. Can you ever recall an occasion where you disagreed with
18 the guidance that was coming from the UK IPC cell and
19 pushed back, I think to use the popular phrase?
20 A. So in the early days, when I was unaware of the IPC
21 cell, I think it was late March because it was the
22 2 April guidance that was being worked towards. My team
23 alerted me to the IPC cell developing guidance and, in
24 Scotland, we have a heavy -- not just tradition, our
25 working practice is to work in partnership with the

1 trade unions and the professional organisations. So
2 almost anything that we develop, we develop in
3 partnership and it's in partnership rather than develop
4 it and then consult. And the Royal College of Nursing
5 were concerned because they had not been involved in the
6 development of this guidance and they had concerns about
7 access to fluid-resistant surgical masks for some staff.
8 Now, at that time, and again it seems very strange
9 to think back to when we would ask clinicians to go
10 into -- and it was particularly into homes, into
11 patients' homes and not wear an FRSM, but that was the
12 guidance at the time: if your client or patient wasn't
13 displaying symptoms of Covid and didn't have Covid, you
14 didn't need a face mask.
15 That -- so my team had signalled to me there was
16 real concern here because there was a UK body or a UK
17 group trying to develop guidance and it wasn't
18 listening. So I became involved then and, after that,
19 we -- there were four tables in that guidance and
20 table 4 -- so there was table 1, 2 and 3, which outlined
21 what happened when you either suspected someone had
22 Covid or someone had Covid.
23 Table 4 was where there was high levels of
24 circulating virus in the community and the member of
25 staff believed they would be better and safer to wear

1 a mask, and that's where we insisted on moving to have
2 a wider level of guidance.
3 I think there was also another time when there was
4 a safety alert, a CAS alert that NHS England had issued,
5 that appeared on the UK website, and I advised my staff
6 that that could not happen. We needed to have either
7 completely UK or we'd just go back to the four
8 countries.
9 So there were times -- and, similarly, with a letter
10 I wrote in May about AGP or not of CPR and whether or
11 not staff could wear FFP3 masks on that. I had
12 a discussion with Gregor Smith, the CMO, and we issued
13 a letter to say if staff want to wear that then they
14 may.
15 Q. Yes, I think you set some of that out at paragraph 55 in
16 your statement. I won't take you to it but, in short,
17 was the position in Scotland that, if staff wanted to
18 wear FFP3 during CPR, then they could, even though that
19 wasn't necessarily the recommendation that was coming
20 from NERVTAG and perhaps the UK-wide guidance?
21 A. And before doing that I talked -- because I was hearing
22 concerns, I talked to the IPC team because I didn't want
23 to be seen to be trumping them and I wasn't saying this
24 was IPC advice, but cardiopulmonary resuscitation is
25 such an emotional response, as well as a physical

1 response, to try and save your patient's life and I just
2 didn't think it was worth arguing about whether it was
3 FRSM or FFP3, I thought it was better to give people as
4 much support as we possibly could.
5 Q. May I change topic slightly, please, and just ask you
6 about the temporary register. We know that certainly by
7 April 2020 the figures of those returning to the
8 temporary register were broken down nation by nation.
9 Could we just put up on screen INQ000421170_0004,
10 please, and we've looked at this now with your
11 counterparts and I just wanted to look at the Scottish
12 position. So by 21 April, there were 1,272 nurses
13 and/or midwives going back on to the register in
14 relation to Scotland and the question really for you is
15 how many of those were actually deployed to the
16 frontline, do you know?
17 A. So I don't know but I think anecdotally not that many,
18 because remembering we -- a live registration we
19 revalidate every three years, so somebody could have,
20 they could almost be five or six years out of practice
21 when they came on to the temporary register, and I've
22 already heard evidence from my two CNO colleagues about
23 choice, so people may not have wanted to go to the front
24 line and we certainly used people on the temporary
25 register or on the other -- we also had returners --

1 within the vaccination centres.
2 But I think there was something about need and
3 demand, so whether or not NHS boards actually needed the
4 additional staff and in many cases they didn't, and then
5 whether the additional staff wanted to do frontline work
6 or whether there was work that they could do. So -- and
7 also I think there's learning that on-boarding process,
8 although Scottish Government paid for their PVG checks
9 and tried to facilitate it, the on-boarding took longer
10 than was helpful.
11 **Q.** So, happily, you say the board didn't need the staff
12 returning to the register but the bottom line is that
13 you don't know how many were in fact deployed to front
14 line. Do you think that kind of data would be helpful
15 or not in the case of Scotland?
16 **A.** I think it would be helpful, I think we have to have
17 a balance between, depending on how good your electronic
18 systems are, if you had good electronic systems at the
19 press of a button you could find out, you know, 300 went
20 to the front line, but it would have been adding more
21 bureaucracy and more paperwork to already hard-pressed
22 clinicians and managers. So I think in the future it
23 would be helpful to know but I didn't feel bereft
24 because I didn't know.
25 **Q.** I think you said in your statement at paragraph 108,

1 I'll just read it to you, you say:
2 "I was not aware of issues and concerns regarding
3 the lack of relevant training, the suitability of roles
4 to which staff were redeployed and/or support for
5 redeployed nursing staff and midwives."
6 So no concerns were raised to you about those either
7 coming back on to the register or being moved from one
8 department to another?
9 **A.** No, I'm not saying they weren't there and concerns would
10 be raised to me in a variety of ways, particularly
11 through the nurse directors, who I met with on a regular
12 basis, who would signal things but also anecdotally
13 things could come up, but I wasn't aware, no.
14 **Q.** Did you ever have discussions with someone like the
15 TUC -- or the Scottish TUC, I should say -- about
16 concerns about those who were being redeployed?
17 **A.** So I wouldn't have but every, probably, twice a week, so
18 the health workforce, so there's a director of health
19 workforce who would take the lead on workforce issues
20 and she would convene meetings probably twice a week and
21 one of my deputy chief nursing officers, Diane Murray,
22 would be at that, and that would be where, whether it
23 was the Royal College of Nursing, UNISON, Unite, that
24 would be brought up there.
25 **Q.** Can I ask you about a different concern that may have

1 been raised with you in relation to the fit of PPE and
2 around face fitting, and particularly in relation to
3 ethnic minorities and the like. Were concerns raised in
4 that regard with you?
5 **A.** So concerns were raised, so even pre-dating the
6 pandemic, there was always a niggle about face fitting,
7 and everyone should be face -- you know, should have
8 face fitting, it was something that was sometimes tricky
9 because people didn't see the immediate need to have
10 an FFP3, so, actually, going to be face fitted was not
11 necessarily high on their priorities. So, even before
12 the pandemic, I was aware of the fact that face fitting
13 was not universally carried out and there were times
14 when the size of the mask, the type of the mask didn't
15 fit.
16 That clearly was highlighted during the pandemic,
17 and so both for -- I say the shortage, the lack of
18 supply meant we were having to source internationally,
19 so there were a number of different masks which would
20 need to be face fitted for different people. So it was
21 a huge exercise, but yes, I think facial hair, black,
22 Asian and minority ethnic colleagues and a lot of women
23 as well would have trouble with that.
24 **Q.** In relation to black, Asian and minority ethnic nurses
25 and midwives, were there any other major concerns, or

1 what were the major challenges facing them, I should
2 say, as far as you were made aware?
3 **A.** I think the real worry of -- what was the impact the
4 pandemic was having on the black, Asian and minority
5 ethnic community in terms of -- and there was a lot of
6 uncertainty at first, this was a new virus, we weren't
7 quite sure what was happening, and was there a greater
8 death rate or not, and in the early days of the pandemic
9 it was difficult to be definitive about it. So I think
10 there were aspects of morbidity and mortality, who was
11 going to be affected more by the virus, as well as then
12 physically in work not having the right protective
13 equipment. So there was a suite of measures which
14 I think is why there was a response in May -- Scottish
15 Government -- but my sense is we probably all did this
16 roughly the same time --
17 **Q.** May 2020?
18 **A.** Yes, risk assessment. So where we issued an instruction
19 to the NHS in Scotland that every member of staff from
20 black and minority ethnic communities should have
21 a conversation with their manager which should be
22 a supportive conversation and, within that, have a risk
23 assessment where they could talk to them about, you
24 know, did they have any other predisposing conditions,
25 how did they feel about being -- you know, whether they

1 were on the front line or not, and where did they want
2 to be redeployed, did they have the right level of PPE
3 or not.
4 **Q.** In your witness statement you set out the chronology of
5 changes to various bits of guidance and, essentially, by
6 April 2022, there was, I think, a letter issued setting
7 out responsibility for ensuring staff were given access
8 to FFP3 masks based on their personal preference, and
9 not in response to a risk assessment or IPC guidance,
10 but if they wanted it to make them feel safer at work,
11 by April 2022 that was a stance that was being supported
12 by the government.
13 What do you think about that having been brought in
14 earlier and should it have been?
15 **A.** So that, of course, was after my time as CNO.
16 **Q.** I know.
17 **A.** I think the whole precautionary principle piece is one
18 that is important to explore, and the IPC world, we're
19 very keen to be particular, and I think it's important
20 to say and describe what PPE is appropriate for keeping
21 people safe. So I think you do need a standard and you
22 do need to have that rigorously implemented.
23 If people start wearing different types of PPE,
24 whether it's higher or lower protection, there are
25 a number of factors, it can wane public confidence, it

1 can cause difficulties, but I see now -- it's in the
2 National Infection Prevention and Control Manual -- when
3 I was refreshing to come here, I see that, last month,
4 under transmission-based precautions there is work going
5 on which is looking at the definition of aerosol droplet
6 and contact. And the problem I think we had was it was
7 very linear and it was either FRSM or FFP3; people were,
8 in a way, defending their corners, rather than trying to
9 find the best possible solution, and because of that,
10 I think we've been blinkered.
11 Now, there may or may not be unintended consequences
12 of wearing FFP3. For instance, there's an increased
13 level of carbon dioxide within the wearer's blood. We
14 don't know -- now, if you're working in -- you know,
15 a high-consequence infectious disease -- so such as
16 intensive care, where there were aerosol-generating
17 procedures, then these staff were wearing FFP3 for
18 12 hours.
19 **Q.** Yes.
20 **A.** So I think it's something we would want to be exploring
21 anyway, and I think, you know, given where Gregor and
22 I were in May of 2020, saying "If you're carrying out
23 CPR and you want to wear an FFP3 then wear it", I think
24 I would have wanted to have at least the dialogue.
25 So one of the difficulties of being outwith the

1 healthcare system now is I miss having colleagues to
2 talk these things through with. And the unintended
3 consequences of having that -- more on the health and
4 wellbeing of the workforce who's wearing it, because if
5 the employer is saying "You may wear FFP3", then we need
6 to be aware of the risks that that would entail for the
7 member of staff.
8 So that's a long answer to say, on balance, I think
9 an earlier discussion would have been helpful.
10 **Q.** Well, it will resonate with evidence we've heard, that
11 her Ladyship has been hearing now for the last few days.
12 Can I deal with some topics very briefly,
13 I'm afraid. I mean no disrespect to you for the lack of
14 time that we've been able to afford you today.
15 **A.** None taken.
16 **Q.** Inspections.
17 **A.** Yes.
18 **Q.** They I think were stopped initially in Scotland and you
19 asked them to be reinstated, I think it was, on
20 30 May 2020. You reinstated what's called a combined
21 safety and cleanliness inspection and an older people
22 acute hospital inspection. Why were you asking for them
23 to be reinstated and what were you expecting them to try
24 to ensure didn't happen?
25 **A.** So part of the CNRG work influenced me to think through:

1 how can we keep our vulnerable people as safe as
2 possible? And therefore we stopped the inspections, so
3 that we weren't intruding into difficult times
4 delivering care, we wanted to redeploy clinicians who
5 were involved in inspections, and we stopped them in
6 March. So I was concerned about nosocomial infection,
7 our inspections I think signal and flag up some very
8 helpful areas for improvement, and therefore the
9 programme of work that I agreed to was looking at
10 settings where our more vulnerable patients would be, so
11 community hospital, older people's hospitals, and the
12 inspections that we had there certainly highlighted
13 areas where practice could improve and reduce nosocomial
14 infection.
15 **Q.** Different topic, DNACPRs. In your time as Chief Nursing
16 Officer, did you become aware of any instances of
17 inappropriate use of DNACPRs or blanket use of DNACPRs?
18 **A.** So there was anecdotal evidence of GPs writing to --
19 you know, going into care homes and saying, "Well, we'll
20 have a DNACPR". Now, anticipatory care planning is
21 important, probably for all of us in this room never
22 mind older people as they get near the end of their
23 life, so it is something that should be done, but done
24 sensitively and done in partnership with that person and
25 in partnership with the families.

1 So a letter I think went out from the CMO in March,
2 and that I think caused distress, but all it said was:
3 make sure your ACPs were in place. It didn't say
4 anything else. And out of that we developed what is in
5 my statement, care home professional advisory group,
6 where we set up a group that was co-chaired by my DCNO
7 and one of the senior medical staff in the CMO's
8 directorate. In that we had patients representatives,
9 we had social work, social care, we had the chief
10 executive of a social care organisation there, so that
11 we could develop comprehensive guidance for social care.
12 So I'm aware anecdotally. Under no circumstances
13 should it ever have happened and I think we put
14 mechanisms in place in Scotland to prevent that from
15 happening.
16 **Q.** I think during your time in post you said you were not
17 aware of any work specifically undertaken to support
18 nursing and midwifery staff with Long Covid. That's
19 clearly an impact on nurses and midwives. Can you
20 summarise from your perspective the impact of the
21 pandemic on the nursing and midwifery profession in
22 Scotland?
23 **A.** So going into the pandemic we had been strengthening the
24 nursing workforce we had been increasing the nursing
25 workforce, we had been increasing undergraduate nurse

1 places, we had been investing in GP nursing workforce,
2 over 200 additional school nurses. So going into the
3 pandemic. And we also had developed legislation which
4 would -- was set in a statutory footing the number of
5 nurses in a ward or department. Along with a wellbeing
6 requirement for employers to make sure that they were
7 measuring and supporting wellbeing of the workforce.
8 The pandemic was relentless and it's affected
9 probably every single person in society but I think that
10 the nursing workforce -- and I'm incredibly grateful to
11 them all who stepped forwards -- has had a real impact.
12 Some have been exhausted. Others have been rejuvenated
13 and found new areas that they want to work in, but
14 I think having the right number of nurses -- we did have
15 a wellbeing hub, so we put -- invested in the May of
16 2020 having wide support mechanisms for nurses, in fact
17 we also -- for all staff -- National Education for
18 Scotland also have -- now are recovering from the
19 pandemic, so they have a wellbeing section on their
20 website which is to support health and wellbeing of
21 nurses.
22 My daughter was one of the student nurses who was
23 deployed to the front line, so I was well aware of the
24 impact that that had on the whole workforce, so I had
25 briefings every day of what was happening and the

1 devastation it had caused, the death that they saw that
2 they should never have seen, and the work that people
3 have done, and I think as a society we need to be
4 incredibly grateful.
5 But I'm confident and hopeful that the nursing
6 workforce will move on and be stronger as a consequence
7 of this.
8 **Q.** Well, with that sense of hope, can I ask you finally
9 this, please:
10 Aside from joining the call for better testing and
11 greater testing capacity in the event of a future
12 pandemic, do you have any other recommendation you would
13 make to her Ladyship that would really, practically, you
14 think help the response and help nursing and midwives in
15 Scotland?
16 **A.** I think capacity, with surge capacity, is going to be
17 really important, because I think we were caught on the
18 hop in terms of we needed to cancel -- and you would
19 cancel -- with a new virus circulating you're going to
20 cancel elective work until you see how the virus
21 behaves, but I think making sure you have enough
22 capacity in the workforce. The nursing workforce is
23 iller and have more chronic conditions than the
24 population in general, so I think looking at the health
25 of the whole workforce but also having physical space

1 and physical capacity so that you have surge capacity
2 and you can move patient -- you don't need to move
3 patients for space, that actually you have, you know,
4 a sufficiency of space to care for patients.
5 And just one other I think small thing. We had
6 return -- retire and return gave us more capacity for
7 nurses when we had that within the pandemic, but at that
8 age the normal pension age was 60 and nurses could
9 retire at 55 without actuarial reduction. The next
10 pandemic the normal pension age is going to be at
11 least 65, so we will not be able to, I don't think, rely
12 on nurses returning the way we did this time, and
13 I think that's where a lot of our additional workforce
14 came from, rather than the temporary register.
15 **MS CAREY:** Understood.
16 My Lady, those are all the questions I have. I know
17 there are some questions from core participants. Is
18 there anything your Ladyship wishes to ask?
19 **LADY HALLETT:** No, thank you very much.
20 Ms Mitchell. That way, and I do give permission for
21 you to swop the question, Ms Mitchell, in case there's
22 any confusion.
23 **Questions from MS MITCHELL KC**
24 **MS MITCHELL:** I'm obliged, my Lady, that's helpful.
25 I appear as instructed by Aamer Anwar & Company on

1 behalf of the Scottish Covid Bereaved and there are just
2 a short number of questions that I would like to ask you
3 about.
4 My learned friend, Counsel to the Inquiry, has
5 already taken you to paragraph 35 about the face mask
6 timeline, and we saw from that that in June 2020 there
7 was a wider use of face masks. You have also commented
8 in your evidence about noticing after a few weeks that
9 there was gaps in the expertise that you might need,
10 including what was happening internationally, and I want
11 to ask you quite a simple question really about
12 face masks in healthcare.
13 When we were watching the experience of healthcare
14 workers abroad and the unrolling of Covid, we saw in
15 those healthcare settings in China and in South Korea,
16 where they had dealt with SARS and MERS, we saw in those
17 healthcare settings the use of face masks from the
18 start, and I suppose my question is: given that we
19 didn't know what was the method of transmission that was
20 most likely, ought a protective or preventative approach
21 have been used and a decision been taken we should use
22 masks immediately until we know the method of
23 transmission? Could we have learnt from watching your
24 colleagues abroad and implementing that as
25 a precautionary principle?

1 A. Ms Mitchell, I've already, I think, said to Ms Carey
2 I think one of the difficulties of being out of the
3 health workforce is I don't have colleagues with whom
4 I can have a meaningful discussion who could perhaps
5 caution me or -- about some of my thoughts. But the
6 whole precautionary principle of going in at a higher
7 level of protection would make sense to me, having
8 looked back on what we had.
9 I think the view was it was droplet transmission, so
10 I think we very quickly came to a view. I think
11 throughout the pandemic we've looked -- so I think --
12 Q. Sorry, if I may stop you, we understand the progression
13 that was made, it was really whether or not it would
14 have been a good idea at a very early stage to have some
15 ability to look internationally, to speak to colleagues
16 across the various different countries where they had
17 already experienced respiratory problems, and to have
18 that expertise right from the very start and implement
19 it?
20 A. So, Ms Mitchell, I do think so. I think our NHS ARHAI
21 and the IPC cell would say they have looked
22 internationally, but I do think that some of the
23 countries who have experienced pandemics in a different
24 way from us have the wisdom that we should perhaps be
25 learning from.

1 Q. I'm obliged.
2 Moving on, can I ask you, you explained what your
3 area of expertise is and then when you took guidance
4 from others. Did you understand, having received
5 guidance or advice, that transmission routes, droplets
6 or aerosols, rarely function in isolation, ie where you
7 have one you will have to a degree another, and if so,
8 if you understood that to be the case, did you report or
9 advise the need for a multi-intervention approach, and
10 if so to whom?
11 A. So the advice I was given was it was droplet, and
12 I don't think for me the -- the aerosol piece would be
13 coming from where aerosol-generating procedures were
14 carried out rather than routine day-to-day areas where
15 they were not carried out. So it was not in my
16 conscious level that the mixed mode, which -- I think
17 I talked about then the NIPCM and the work that's going
18 on just now, which I would welcome, to make it clearer
19 what's happening.
20 So at no time was I of the view that there was
21 aerosol contamination whereby staff needed to have FFP3
22 protection and not -- I took no action.
23 Q. So could I just be clear about that, are you saying that
24 essentially what you were thinking was this is a droplet
25 route and therefore you weren't really considering the

1 issue of aerosols unless it related to the carrying out
2 of something that would produce aerosols per se?
3 A. That was the advice I received.
4 Q. Moving on to another question which my Lady has granted
5 authority for, earlier on in your evidence you were
6 talking about PPE and you said that -- when talking
7 about PPE, you indicated that you were having a shortage
8 and then you corrected yourself and said the "lack of
9 supply", and I want to ask you a little bit about that,
10 in particular your comment at paragraph 135 of your
11 statement -- I don't need that brought up -- but it
12 said:
13 "Neither I nor my directorate were aware of any
14 shortages in PPE or RPE for nursing and midwifery staff
15 but were aware anecdotally of issues in supplies not
16 being easily available to staff in some instances."
17 Now, I just sort of want to break that down, because
18 from the evidence that we have heard from various
19 bodies, and indeed I think a comment my Lady made to
20 Jeane Freeman when she gave her evidence earlier on
21 about shortage in supply, it might come as a surprise
22 that people hear you say that neither you nor your
23 directorate were aware of any shortages.
24 Are we really talking about the difference in
25 emphasis and language? If there were issues of supplies

1 not being easily available, presumably the people on the
2 ground floor would see that as a shortage?
3 **A.** So I probably haven't been clear enough and the language
4 choice of my statement I think could have been better.
5 My understanding is if I put -- if I maybe talk --
6 I don't know if I'm allowed, my Lady, to talk about
7 social care separately, because --
8 **LADY HALLETT:** I would rather you didn't, if you don't mind.
9 **A.** Okay, that's fine, if we talk about the health system.
10 My understanding that every single person who needed
11 an apron, a mask, a pair of gloves, a gown, got one.
12 And there was a heroic effort from managers moving
13 supply from ward to ward, sometimes from hospital to
14 hospital, so that my understanding is that everyone had
15 the PPE that they needed, but it was complex and
16 challenging. And when I remember speaking to one of the
17 nurse directors about: is there enough? He said: there
18 is, but there's a palpable sense of relief when a new
19 supply comes into the hospital.
20 **MS MITCHELL:** I think you've mentioned that in your
21 statement. Did you speak to people who were using PPE
22 on the nursing floor and ask them if they had enough
23 PPE?
24 **A.** So I didn't, we relied on our twice-weekly meetings with
25 the Health Workforce Directorate and the trade unions

1 and the royal colleges to brief us on what was happening
2 with PPE, and I think there's no doubt in the early days
3 that the supply was not as good as it should have been,
4 and it did cause anxiety, and -- because in my mind not
5 just clinicians, anyone who needs it should be able to
6 put their hand out, get a face mask or a gown and put it
7 on and not have to worry about next time they go back to
8 that will there be one there.
9 So there is early on in the pandemic we could -- we
10 would have been much better to have a better supply of
11 PPE. There was one -- so when you're asking me if
12 I knew -- we had a system in Scotland, there was
13 a single point of contact and there was a Scottish
14 Government email and one of my colleagues emailed me to
15 say: Fiona, I have this email, I wouldn't normally
16 bother you with it, we'll deal with it, but because of
17 what it said I wanted you to know. And someone had said
18 emailed to say: I live near Fiona McQueen, I'm not
19 getting enough PPE and if you don't sort it I'm going to
20 go and knock her door.
21 So they wanted me to know that, and I then -- they
22 said but they will sort it. I then spoke to the nurse
23 director and she said that they had more than enough
24 PPE. So I don't want to say nobody ever alerted me to
25 it or nobody -- everyone said there was plenty, because

1 that wasn't always the case, but I was aware of
2 anecdotal evidence, but it's my understanding that
3 everyone who needed it got it, and once we were a few
4 months in there was a plentiful supply.
5 **MS MITCHELL:** My Lady, I would of course like to ask more
6 questions, but that noise was my colleague setting the
7 timer for me to tell me that my time was up!
8 **LADY HALLETT:** I did wonder if somebody was giving you
9 a warning.
10 **MS MITCHELL:** Albeit that I think there are many more
11 questions that I would like to ask.
12 **LADY HALLETT:** I think Mr Weatherby also may have some
13 questions on this.
14 **MS MITCHELL:** I'm obliged.
15 **LADY HALLETT:** Thank you, Ms Mitchell.
16 Mr Weatherby.
17 **Questions from MR WEATHERBY KC**
18 **MR WEATHERBY:** Thank you.
19 Can I just pick up, then, where Ms Mitchell left
20 off. I ask questions on behalf of the Covid Bereaved
21 Families for Justice UK group. Again, picking up on
22 PPE, we heard evidence yesterday from the Scottish TUC
23 of really acute shortages of PPE in the early stages.
24 Now, you were represented on what was called the
25 workforce senior leadership group, weren't you?

1 **A.** Yes.
2 **Q.** That's a group which brought together senior leadership
3 from the NHS Scotland, the trade unions, professional
4 bodies and health and social care partners. Were you
5 aware through that group, who, presumably, one of its
6 roles was this kind of liaison, were you aware in the
7 early stages through that group of concerns about really
8 acute shortages of PPE?
9 **A.** Yes, I was.
10 **Q.** Yes.
11 **A.** But as I've outlined to Ms Mitchell, it's my -- so yes,
12 I understand --
13 **Q.** Right.
14 **A.** -- there was a shortage but everyone -- my understanding
15 is that everyone who needed it got PPE.
16 **Q.** Were you aware of shortages in hospitals, for example,
17 the Glasgow Royal Infirmary, where the Inquiry has
18 evidence that it was running low of FFP3 masks in March
19 2020; were you aware of hospitals running short of masks
20 and PPE at that stage?
21 **A.** Yes. So my understanding is, so before the pandemic
22 came, that anyone who needed PPE and a supply of PPE did
23 not have to think twice about going to the supply
24 cupboard and taking it and using it, but once we
25 increased the amount of PPE people had to wear --

1 **Q.** Yes.
2 **A.** -- then stocks diminished and, at one time, for gowns,
3 I think there was less than a full day's supply within
4 Scotland.
5 **MR WEATHERBY:** That's where I was going to head next.
6 My Lady, there's a crossed wire I think about my
7 next question?
8 **LADY HALLETT:** Oh just put it up on screen, Mr Weatherby.
9 It's the end of the day.
10 **MR WEATHERBY:** Thank you, I will be as quick as I can.
11 INQ000108737, and it's page 12, please.
12 I think, just while it's being put up, this
13 illustrates the point that I think you were just about
14 to make. Can we highlight the graph, please, at the
15 top. Now, this is a report from Audit Scotland,
16 a government report, and it sets out various pieces of
17 PPE, and it's between April 2020 and May 2021 and the
18 levels, and just from a brief glance at that, it appears
19 that, to start at April, the levels of PPE were almost
20 out, putting it briefly; would you agree with that?
21 **A.** Yes.
22 **Q.** Yes, and were you aware of that at the time?
23 **A.** Yes.
24 **Q.** Okay. Just very briefly indeed, what actions did you
25 personally take to resolve those issues, if any?

1 **A.** So PPE was not -- in terms of the supply of it, was the
2 responsibility of national shared services and --
3 **Q.** Right.
4 **A.** -- but, however, that did not mean to say I did not have
5 anything to do with it. So my DCNO was on these
6 workforce meetings and she would feed back to me, we
7 would be assured by our colleagues, policy colleagues
8 who were overseeing it, that they were doing as much as
9 they possibly could to do that --
10 **Q.** Right, so, effectively, you escalated it and you were
11 reassured?
12 **A.** I think I would go further than reassure, I think I was
13 assured, though evidence was given in terms of -- and,
14 of course by this time, there was an international
15 demand, so --
16 **Q.** Yes.
17 **A.** -- our suppliers were struggling to supply us, we needed
18 to get PPE from different areas across the world, and
19 that in itself was tricky. So, although we thought we
20 maybe have a two-day supply and we know we're going to
21 get four weeks' supply coming into Prestwick Airport
22 from China, until it was actually into us and through
23 Customs we didn't know.
24 **Q.** Right. Just again, in one sentence, if you can, is
25 there a lesson here, moving forward, for the next

1 emergency of this nature which will occur?
2 **A.** For sure, I think that whole -- the management of PPE,
3 so the rotation of stock, how much do you have, looking
4 at best and worst-case scenarios, then I think there's
5 absolutely no doubt that that is one of the key areas
6 that needs to be addressed.
7 **Q.** Yes, thank you.
8 **A.** Subject to funding.
9 **Q.** Okay. I've got a second topic but I think you've
10 probably dealt with most of it, so I'll be very brief
11 indeed.
12 You say in your statement that the Scottish
13 Government's specific role was limited to the general
14 promotion of NHS Scotland as a potential employment
15 opportunity for temporary registrants. My question was
16 going to be why you said that. Is it right that you say
17 that it was limited because of your earlier evidence
18 that, in fact, you didn't think the temporary
19 registrants were in fact necessary?
20 **A.** So if I may take slightly more than one sentence to
21 answer you.
22 **Q.** Sure.
23 **A.** I think at the beginning of the pandemic we didn't know,
24 in fact, I thought we would have been much more
25 overwhelmed than we were. We were looking at pictures

1 of Italy and patients lying on ED floors, nurses, you
2 know, becoming incredibly ill at work. So we didn't
3 know what we were going to get, and we didn't know
4 whether or not, so we needed to open all avenues --
5 **Q.** Yes.
6 **A.** -- so that we would have that supply.
7 I think there are ways we could better utilise
8 temporary registrants, I think if we had a better
9 system. Now, one of the things we did put in place from
10 about May was we had a calculator of workload right
11 across health and social care, so that we knew what the
12 demand was and we knew whether or not there was a demand
13 for workforce.
14 **Q.** Yes, okay.
15 **A.** I think we probably could have done more to help the
16 temporary registrants into perhaps social care or some
17 other place that was struggling.
18 **Q.** My last point, you refer later to further preparatory
19 work that might have been done, does that relate to the
20 point you were just making, in terms of how you could
21 arrange it so that temporary registrants could be
22 brought on, on-boarded and used appropriately?
23 **A.** I think most definitely, as well as looking at surge
24 capacity and how we can keep practitioners who are not
25 working contemporaneous in their practice.

1 **Q.** That's perhaps something that should be looked at going
2 forward?
3 **A.** Definitely.
4 **MR WEATHERBY:** Thank you very much.
5 Thank you, my Lady.
6 **LADY HALLETT:** Thank you, Mr Weatherby, very grateful.
7 Mr Wagner.
8 **Questions from MR WAGNER**
9 **MR WAGNER:** Yes, I'm all the way over here, hello.
10 My name is Adam Wagner and I ask questions on behalf
11 of 13 pregnancy, baby and parenting organisations.
12 I've got two topics to ask you about. The first is
13 about guidance in neonatal care. In November 2020 the
14 Scottish Government added a line to the neonatal care
15 guidance, which said this:
16 "Parents should be offered opportunities to remove
17 face masks where it's safe to do so to encourage bonding
18 and support skin-to-skin and kangaroo care."
19 Just to pick up on those final two words, is it
20 right to say kangaroo care is a method of holding your
21 baby to your bare chest allowing for skin-to-skin
22 contact?
23 **A.** Skin to skin, so the baby would be bare and you would be
24 bare.
25 **Q.** Were you involved in the changing of that guidance?

1 **A.** So I had another Deputy Chief Nursing Officer, who was
2 the Chief Midwifery Officer and she would have developed
3 that guidance, along with the Director of Children and
4 Families Directorate.
5 **Q.** Do you have any knowledge of why the Scottish Government
6 decided to modify the guidance in that way and add in
7 that extra reference to skin-to-skin care?
8 **A.** No, I don't, but my view is skin-to-skin care is
9 an evidence-based intervention that supports physical
10 wellbeing of a neonate as well as the emotional health
11 of the parent.
12 **Q.** So that would be why that exception was made to the mask
13 wearing, that they could take their mask off, because
14 skin-to-skin care is so important.
15 **A.** It's so important and, by that time, we would have seen
16 how the virus was operating, we would have been able to
17 take on balance proportionate risks that we were not
18 prepared to take earlier on in the pandemic.
19 **Q.** So on-balance proportionate risks relating to the mask
20 wearing versus the benefits of skin-to-skin care.
21 The second area I wanted to ask you about is the
22 wider restrictions that were placed on maternity
23 services, and I appreciate you said that there was --
24 that you had a deputy who was responsible for that care,
25 but may I ask you just a couple of questions about that

1 overall point because you do refer to it in your
2 statement.
3 So just by way of context, there has been a number
4 of reports since the very early stages of the pandemic
5 relating to the impact of IPC, infection prevention and
6 control, restrictions on maternity services.
7 Are you aware that, according to a 2022 report,
8 perinatal depression -- that's depression around
9 maternity and birth -- and anxiety almost doubled during
10 Covid-19?
11 **A.** Yes.
12 **Q.** You are. Are you aware of the statistic that's in the
13 same report that the rates of depression and anxiety
14 amongst women who gave birth during Covid-19 were as
15 high as 61%?
16 **A.** So I wouldn't have been able to give you the statistic,
17 but I knew it was high.
18 **Q.** Yes. Then, secondly, are you aware of the -- there was
19 an MBRRACE rapid report published in August 2020,
20 relating to maternity services.
21 **A.** No, but I may know the topic, if you remind me.
22 **Q.** One of the findings that the report made, so it looked
23 at March to May 2020, and it was published in August
24 2020, and it found that four women who were pregnant or
25 had recently given birth had died by suicide during that

1 three-month period, and the authors found that changes
2 to the service provision as a direct consequence of the
3 pandemic meant that women were not able to access
4 appropriate mental health care, and it found that the
5 receipt of the specialist care they needed may have
6 prevented their deaths.
7 Have you heard about that, those kind of issues
8 arising?
9 **A.** I've heard about those kind of issues not necessarily
10 associated with maternity but with wider societal
11 issues, yes, tragically.
12 **Q.** Then, thirdly, there was a study in October 2021 that
13 concluded the re-establishment of face-to-face parenting
14 support groups appeared to be imperative to postnatal
15 emotional wellbeing and recommended the prioritisation
16 of essential face-to-face healthcare visitation in the
17 immediate postnatal period?
18 Now, you may not be aware of the report but would
19 you agree with the sort of sentiment of that?
20 **A.** Yes.
21 **Q.** So in that context, I just want to ask you about your
22 statement at paragraph 208, and I don't need to have it
23 up on the screen, but you say there:
24 "Whilst we recognise the impact the virus had on the
25 more vulnerable in society, I wonder if we could have

1 done more during the pandemic to support such groups
2 ..."
3 You say:
4 "With hindsight a number of measures may have been
5 beneficial, changing restrictions to support new mothers
6 to receive additional in-person support from family and
7 friends ..."
8 So with hindsight, can you give a bit of detail
9 about what kinds of changes you would have made for new
10 mothers?
11 **A.** So without -- I'm going to repeat that I have been out
12 of healthcare for over three years and, therefore,
13 I don't have the benefit of the wisdom of having
14 colleagues, but it's my understanding that a new mother
15 could not have visitors. So I think being able to have
16 your mum or your sister or a close friend, or someone
17 else coming in to help and support you, would have been
18 beneficial.
19 So I think looking -- and that, if we look at
20 visiting in maternity hospitals, the real challenge
21 there is, if somebody is looking for additional support,
22 then the balance is people who come in may have been
23 bringing Covid and then there would have been nosocomial
24 infection right across the unit. So the balance there
25 is someone's benefit could be harming someone else.

1 Once pregnant women are home with their babies or,
2 you know, in the lead-up to birth, when they're in their
3 own house then they can make their own decisions and
4 take their own risks about the balance of having
5 emotional support for their wellbeing versus the risk of
6 Covid, and of course they could then talk to whoever was
7 providing them with that support and know that their
8 behaviour was keeping them safe without Covid.
9 So I think there are ways that we could have learned
10 for how we could bubble bigger groups together to
11 provide emotional support or provided, with social
12 distancing, classes or supports. Because I know that --
13 you know, in the postnatal period, if it had been --
14 although you don't have to have a toddler to go to
15 toddlers groups, you can have a brand new baby,
16 you know, there are many informal ways that people in
17 society have support and new mothers have there as well.
18 So I think, you know, working with women to find out
19 what was most distressing for them, and I think we know,
20 but working to see what we could do I think would be
21 important, so that we know for the next pandemic, and it
22 needs to be rehearsed and looked over, at ways we can
23 mitigate and prevent some of the tragedies that have
24 happened as a consequence of this pandemic.
25 **LADY HALLETT:** I'm afraid you're going to have to leave it

1 there, Mr Wagner, I'm sorry.
2 **MR WAGNER:** Yes.
3 **LADY HALLETT:** I think I've stretched the stenographer's
4 patience to the limit today.
5 Thank you very much indeed, Ms McQueen. I'm really
6 grateful to you. I hope your daughter didn't get put
7 off nursing, did she?
8 **THE WITNESS:** No, she is thriving, thank you.
9 **LADY HALLETT:** Wonderful. Well, I'm sure it's a proud
10 family tradition now. So thank you very much for your
11 help, I'm really grateful, thank you.
12 **THE WITNESS:** Thank you, my Lady.
13 **(The witness withdrew)**
14 **LADY HALLETT:** 10 o'clock tomorrow.
15 **(4.46 pm)**
16 **(The hearing adjourned until 10 am**
17 **on Wednesday, 18 September 2024)**
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