Tuesday, 1 October 2024

(10.00 am)

MS HANDS: Good morning, my Lady.

Before Mark Tilley commences his evidence this morning, it may be helpful for me to provide you with an update on the timetable for the hearing today and tomorrow. As you know, Dr Stuart Edwardson was due to give evidence this afternoon. Having carefully considered the helpful evidence that Dr Edwardson has provided in his statement and reflected on the evidence already heard last week about the impact of the pandemic on intensive care units, patients and those working in ICU, the Inquiry has concluded that it is not necessary to hear oral evidence from Dr Edwardson today. A number of witnesses this week will also be giving evidence about critical care in the pandemic.

My Lady, with your consent, the Inquiry will publish on its website Dr Edwardson's statement after the hearing today, and I hope the public will be reassured that you will take his evidence into account when preparing your report and making recommendations.

As a result of Dr Edwardson no longer giving evidence, Professor Kathryn Rowan will commence her evidence this afternoon and will return tomorrow morning. This will then be followed by the evidence of the intensive care experts, who will commence giving evidence slightly earlier than initially scheduled.

LADY HALLETT: Thank you very much and I shall of course take into account the written evidence helpfully provided. People sometimes forget that this isn't just the about oral evidence. The Inquiry is about written and oral evidence together. Thank you very much.

MS HANDS: Thank you. May I please call Mr Mark Tilley.

MR MARK TILLEY (affirmed)

LADY HALLETT: Thank you very much for coming along to help Mr Tilley. If at any stage you feel slightly distressed by what you have to tell us -- I will take a break if you need me to, but sometimes I find that just having a breather and a sip of water can help people when they're distressed, and it's better to get it over with, but I'll be in your hands. You tell me what you need to do.

A. Thank you, my Lady.

Questions from COUNSEL TO THE INQUIRY

MS HANDS: Good morning, Mr Tilley. You should have your witness statement in front of you, and that is INQ000485988.

A. I do.

Q. Mr Tilley, it's right, isn't it, that you are an ambulance technician who has been working in the NHS Ambulance Service for over 20 years?

A. That is correct, yes.

Q. And you have described in your statement how you've responded to all types of calls, from emergency life-threatening incidents to non-emergency transport incidents as well?

A. Yes, that is correct.

Q. And it's also right, isn't it, that you are a GMB representative?

A. I am.

Q. And that's a role that you held before the pandemic?

A. Yes.

Q. And throughout as well?

A. That is correct, yes.

Q. Can you briefly describe your role and responsibilities as a GMB representative during the pandemic.

A. So during the pandemic, we were asked and we were there to look after the health and safety well-being of our members, our colleagues. It was the governance processes behind the scenes for making sure that everything was as safe as possible.

Q. On a daily basis, what did that involve?

A. So there was -- for me, there was multiple meetings. We were having four-hourly meetings on some occasions when it was really at the height. There was the planning of what PPE we had or didn't have. There was the vehicles and what equipment they carried, what was wrong with them.

Q. I'm going to touch on some more examples as we go through this morning. In terms of your role as an ambulance technician, you were, before the pandemic, mostly working in a behind the scenes role; is that right?

A. Yes, that's correct. So I was a GMB rep and I had full-time release to be able to attend meetings, policies, disciplinaries, grievances, sickness absence meetings and planning of what was going on forward.

I undertook a certain amount of road shifts to keep up my clinical skills because ultimately that is what we are there for.

Q. Then, when the pandemic hit, you moved back into a patient-facing role on the front line?

A. Yes, I picked up extra shifts on the front line. I didn't have to, I wasn't made to, but that's where we are a collective. We are a group of people. We are there for our patients. Staff were falling off sick, staff weren't able to attend work because of health problems, therefore others had to backfill, and I was one of the first to volunteer because it was the right thing to do.

Q. You have described how the pandemic had a profound

1 impact on your work. Can you give us a few examples of
2 how that frontline role was different during the
3 pandemic to before?
4 **A.** So before the pandemic we would -- we all know that the
5 winter pressures were hard. We know that there was
6 delays. However, that escalated tenfold with the amount
7 of calls we were going to, what we was expected to
8 undertake prior to getting to the patient. We were
9 having to put our Tyvek suits on if we were going to
10 perform patient -- aerosol-generated tasks, i.e. CPR,
11 when we were bouncing up and down on someone's chest, to
12 protect ourselves and others, and that took extra time
13 in getting to that patient.
14 **Q.** And would you know -- you describe it taking time before
15 you got to the patients, so would you know before you
16 arrived at the incident as to whether you would need to
17 don that level of PPE?
18 **A.** Sometimes we would know because it was a confirmed
19 cardiac arrest. Other times we wouldn't. But what we
20 did know is that basically everyone was having breathing
21 difficulties of some description and sometimes that
22 could be the -- breathing problems are because there's
23 a low respiratory rate, they are not actually moving
24 sufficient air to get the right amount of oxygen into
25 their body.

1 **Q.** And if you didn't know in advance, so you would be
2 donning when you got to the scene, can you just explain
3 to us step by step what that process involves and how
4 long it might take you?
5 **A.** So actually we had to don when we got to scene anyway.
6 We had lots of conversations. Our medical -- no, sorry,
7 our director of nursing and quality and director of
8 operations at the time, I recall having many meetings
9 with them saying: why can't one of the crews on the DCA,
10 on the double-crewed ambulance, be in the back of the
11 ambulance with the suit on already and, therefore, the
12 driver, being in the front, that would be acceptable --
13 we work on an SRV, which is a single response vehicle,
14 we might work on a DCA, a double-crewed ambulance,
15 single crewed because someone has gone sick, so having
16 someone in the back of the ambulance would have actually
17 meant that we were actually able to get to the patient's
18 side quicker, might have only been a minute and a half
19 quicker, because of putting that suit on. Because if
20 you've already got it on, you are ready to go. We
21 didn't have that.
22 That was deemed as inappropriate because -- and
23 for me the excuse that was used was the attendant should
24 be using the MDT screen, which is the computer we've got
25 in the front of the ambulance, to read what was coming

1 through, and the Airwaves radios, they were there to
2 answer that, all of which -- that they could have done
3 either over the back -- in the back of the ambulance,
4 over the Airwaves radio, and the computer we could have
5 turned off part of it. So we could have actually been
6 at the patient's side a minute, a minute and a half
7 quicker in those really most serious cases.
8 **Q.** Coming back to when you do arrive and what that process
9 involves, can you just briefly describe that for us?
10 **A.** What we ended up doing was pulling up at the scene of
11 the address and we would get out the vehicle and we
12 would have to get into the back of the ambulance to put
13 on the Tyvek suits, if that's what we were going to be
14 doing, and that meant taking off our boots because the
15 Tyvek suits most of the time wouldn't go over them,
16 which took extra time.
17 So in the back of the ambulance you would have
18 seen the ambulance rocking where we were taking off our
19 outer jacket, perhaps, if we had it on because it was
20 a cold day, putting on the Tyvek suits, and then
21 collecting the bags that we were going to take into the
22 patient's house. And all of that could have taken
23 a good couple of minutes, three minutes or so, before we
24 got to the patient's side, even if it was outside.
25 There was times where we didn't need to have the

1 Tyvek suits on but we would have to put the aprons on.
2 Aprons are fine if you are in a room, if you are working
3 in a hospital setting. It's like in here today, there's
4 no breeze, but when you're outside, all that's happening
5 is the apron's blowing up into your face, onto your
6 hair. They were poor quality.
7 When we went to some really good thick aprons,
8 they didn't have long ties on so you couldn't tie them
9 up. It just wasn't suitable. And then you've got your
10 arms exposed anyway, which is fine because you can wash
11 them, but if you've got a jacket on because it's cold
12 outside you couldn't then decontaminate that the
13 following day, you couldn't wash it between shifts,
14 because you only had one.
15 **Q.** Two points I want to take from that. The first I think
16 is in relation to the aprons and the suits that you
17 mention. I think you've said in your statement that
18 there were some occasions where there weren't enough
19 aprons or suits and you had to consider alternatives.
20 Could you just explain what alternatives were
21 considered.
22 **A.** So there was -- we had what's called a standard load
23 list which is the equipment that should be on the
24 ambulance.
25 **LADY HALLETT:** Sorry, standard ...?

1 **A.** Standard load list. It's an equipment list basically
2 for the ambulances. And on that there was three
3 extra-large suits, three medium suits, and three large
4 suits, bearing in mind we're probably doing -- unless we
5 were stuck at hospital we were probably doing six jobs a
6 day, and there's two of you, but there's six in total,
7 various size suits.
8 Sorry, can you repeat the question --
9 **MS HANDS:** Yes, of course. You said at times there wasn't
10 always enough and you had to consider alternatives.
11 **A.** Yes, so therefore there wasn't enough for us for the
12 whole shift because there wasn't the availability. The
13 aprons were in short supply, we couldn't get appropriate
14 equipment, appropriate aprons, so we seriously
15 considered using bin bags and literally cutting a hole
16 in them, because that way they wouldn't blow up in front
17 of your face and it was a barrier between your clothes
18 and the patient.
19 Bin bags wouldn't have been the most, sort of,
20 like, sensible but it was obviously hard times.
21 The alternative would have been that the trust
22 provided extra uniform because we could have technically
23 got changed between patients if we needed to, but
24 obviously that would have meant ambulances were not
25 responding every time they'd finished with another

1 patient.
2 **Q.** And then the other point you mentioned is regarding the
3 jacket that you were wearing. Could you describe
4 what -- when you would be required to wear that and what
5 that was like.
6 **A.** So we all know the NHS is 24/7. For the ambulance
7 service it's 24/7, wet/dry, hot/cold, and also the
8 environment you're in, because personally if I'm going
9 into a woods to go and get a patient out and it's a hot
10 day and it's lots of overgrowth -- undergrowth and that
11 sort of side of things, I would be putting my jacket on
12 because it protects my arms, but if it's cold outside,
13 if it's nighttime, you've got your jacket on to keep
14 warm, the only thing we could do is perhaps try and
15 Clinell wipe down the arms of your jacket afterwards,
16 because you didn't have the time to wash your jacket
17 between one shift and another.
18 **Q.** And would that, therefore, be over multiple days?
19 **A.** Multiple days, and with the specification of the
20 vehicles, technically what you should have been doing is
21 hanging your jacket up on a clip that's right behind
22 your head. So if I was the driver it would be there, if
23 I was the attendant it would be there, so it would be
24 hanging down right behind me in what should be a
25 non-clinical environment, because it's the front of the

1 ambulance, but it's got equipment or exposure to bodily
2 fluids on it right behind my head.
3 **Q.** And then coming back to when you were putting on the PPE
4 or the RP when you arrive at the scene, what mask would
5 you be hearing?
6 **A.** So most of the time, and obviously through the different
7 waves and the information that was out there it did
8 change, but most of the time it was the FFP2, just the,
9 sort of, like, very cheap elastic band around the loops,
10 around the ear loops. You would be wearing that in the
11 actual ambulance to the scene.
12 **LADY HALLETT:** Sorry, did you mean FFP2?
13 **A.** Yes, the surgical fluid-repellant mask.
14 **MS HANDS:** I think it's FRSM.
15 **A.** Different terminology, I do apologise.
16 **MS HANDS:** Not at all.
17 **LADY HALLETT:** It's just that the FFP2 is a version
18 apparently that we don't use much in the UK but is used
19 a lot in Europe and is an alternative to the FFP3.
20 **A.** So I will be led by you, my Lady.
21 **LADY HALLETT:** I am learning a lot about masks.
22 **MS HANDS:** Yes, it's a blue one.
23 **A.** Yeah, the blue one, the one that you would see when you
24 went into a hospital or whatever, we would wear them
25 most of the time around our buildings and in the

1 ambulances. So we would have that on for most patients
2 but upgrade if we were performing certain tasks with the
3 patients or if we had a concern or, eventually, we got
4 given the actual hoods which have got respirator
5 masks -- battery-powered packs.
6 **Q.** Can you recall when you received the hoods?
7 **A.** I would have to check that up. It was fairly early on
8 and I recall conversations about the fact that we had
9 got the last batch of them because they were no longer
10 being produced and it was a tie-over situation with what
11 was able to be sourced.
12 **Q.** Okay.
13 Moving on to some of your work in January 2021
14 which you have described in your statement, can you
15 provide some more information about how your work
16 changed during that period and what it was that you were
17 doing?
18 **A.** So obviously we all know there was waves that was
19 hitting different areas at different quantities/amounts
20 and that was changing daily/weekly. Living and working
21 out of the Bognor Regis/Chichester/West Sussex area it
22 was quite quiet in the sense of what was going on
23 nationally.
24 When we were having EU exit, because obviously
25 I worked for the South East Coast Ambulance and Dover's

1 there, there was a lot of concern and work that had been
2 done for the road network because there was concerns it
3 was just going to break down and no-one would be able to
4 move, so there was about 40 of us that had volunteered
5 to go up to -- it was a hotel up in Sittingbourne and
6 work out there for at least three weeks -- it was the
7 plan -- depending on what was actually happening.
8 It was like a different world up there. We had
9 to -- we had ambulances that were brought in for us.
10 Most of them were the most run down because the local
11 areas didn't want them so that's what they provided, but
12 it was an ambulance. We begged, borrowed and stealed.
13 But then that was happening generally anyway.
14 The patients were as poorly as elsewhere but
15 probably for what we'd been experiencing and seeing down
16 in Sussex was a greater requirement of care. Going to
17 the hospital -- I recall one day going to hospital about
18 an hour/hour and a half after my shift had started, so
19 I'd already got to my first patient, and we've ASHICEd
20 the patient to hospital, so they were a poorly patient,
21 we've pre-alerted them. We turn up at Medway Maritime
22 and we park in a queue of ambulances, so I think we were
23 starting at -- we were doing ten-hour shifts on that
24 rota up there at the time, so it was a 6 o'clock start,
25 for example. So we were there by 8 o'clock but when our

1 shift had finished we were still there with the patient
2 in the back of the ambulance. We had run out of oxygen
3 so we'd had to scan the hospital to try to find oxygen.
4 The consultant or doctor had been out to take bloods.
5 Our patient had deteriorated quite heavily. It was
6 a snowy, cold, icy day.
7 We ordered pizza to the registration of the
8 vehicle so that we actually had something to eat that
9 day because otherwise we wouldn't have had anything to
10 eat, trying to source a cup of tea. And I know it's not
11 about us as the clinician, but we couldn't be in the
12 back of the ambulance with the patient because of the
13 exposure because we had to be out -- so slightly outside
14 the back, watching in to them, and the patient, trying
15 to look after their bodily functions, their well-being
16 as well as -- poorly as they were, out there for hours,
17 that was -- that was different.
18 **Q.** And the experiences you've described there around the
19 equipment available to you in the ambulance, was that an
20 issue that you experienced again? Did you have any
21 other experiences of that?
22 **A.** So because what the organisation had done, they'd opened
23 up an ambulance station that had been closed down,
24 obviously everything had been stripped from it so we
25 then had to try and make it literally within a few weeks

1 a proper functioning ambulance station. There wasn't
2 the supplies coming through of masks or hand gel, sort
3 of, like, specialist little bits of equipment that we
4 might use on occasions. We're out and about in the
5 ambulance for the whole 10/12 hours of our shift, you
6 never know what you're going to be sent to next so you
7 need to have all of the equipment there because
8 otherwise you can't do the best for the patient.
9 So we were always trying to find -- and there was
10 blankets -- access to blankets was really tight on
11 occasions because it wasn't getting through the laundry
12 system quick enough.
13 **Q.** I think in your statement you have described some of the
14 problems with ventilation in ambulances which you have
15 just alluded to. Can you explain what those problems
16 were, in particular, in the summer and in the winter
17 months.
18 **A.** Yes. So over the years we had highlighted that the
19 ambulance was our work environment. If it's really hot
20 outside it's hot in ambulance, and the air conditioning
21 doesn't work, it's uncomfortable. We -- certainly
22 I grew up with my mum and dad and they didn't have air
23 conditioning in the car, you opened the window.
24 However, we are in a medical environment and air
25 conditioning can help reduce the temperature in the back

1 of the ambulance. So if we've got a sepsis patient on
2 board, we don't want it to be really hot in there, we
3 want to be able to start chilling it down. We didn't
4 know whether the recirculation -- the systems that were
5 in the vehicles were separate in the front of the
6 ambulance to the rear. So it -- whether the particles,
7 because obviously it was airborne, was just
8 recirculating around.
9 We still don't know as to the different vehicles,
10 because there are so many different types of ambulances
11 and manufacturers, as to whether the air goes from the
12 front to the back, we don't know whether it filters it
13 properly. But what we do know is that some of the
14 vehicles had errors and faults with them where you
15 couldn't put heating on in the front because, like --
16 and I'm not a mechanic, but that the valve isn't -- or
17 the pipe is not connected properly because it's done
18 300,000 or 400,000 miles, it's bounced off or it's not
19 been connected, and, therefore, the heat is not there
20 but without putting the recirculation on, you can't have
21 the heat and, of course, the recirculation is what we
22 didn't necessarily want unless there was a proper
23 particle filter on it.
24 **Q.** And did you receive any guidance locally or nationally
25 about how to manage these issues?

1 **A.** It was -- there was conversations, there was some
2 communication but, if I may touch on the fact of
3 communication, although believed to be quite good, that
4 communication that was sent out, the staff were going
5 into work picking up their ambulance and basically going
6 straight out to patients. There was no time built in
7 for what in hospitals they class as huddles.
8 In the ambulance sector, certainly for our
9 organisation, there's not the time or the built-in
10 facility to do a huddle, so you wouldn't have any
11 important information actually directly told to you,
12 it's only if you picked it up on an email. And with
13 40 or 50 emails coming in, days off and then coming back
14 to them without a sign being put up that you might have
15 seen, you wouldn't have known that communication had
16 come out.
17 There's no -- communication is good but actually
18 it's about the understanding of what it's meant to be
19 saying and that wasn't -- and never verified by anybody.
20 **Q.** And just finishing up on your time down in Kent, in your
21 statement, and you've alluded to it just a moment ago,
22 you have explained that you were staying in a hotel away
23 from home down there. Can you explain the impact that
24 that had during that period of time.
25 **A.** So we travelled over -- some people travelled over New

1 Year's Eve, I travelled over the morning of New Year's
2 Day. So we'd said goodbye to our families, we knew that
3 was going to be for about three weeks. We were told we
4 could go back home on our two days in a row day off, but
5 that obviously puts extra pressure on the fact of you
6 going home to your family and you've been in some of the
7 worst sort of areas dealing with patients.
8 You are in a hotel room. Many of us would have
9 stayed in a Premier or Holiday Inn in our time. That
10 was what you were in. So you couldn't go and socialise
11 because that was stopped at that particular point in
12 time, so you were at work in an ambulance with your
13 crewmate for 10 hours, 12 hours, then you'd go back to
14 the hotel, and that's where you would sit, sleep, and
15 you had nowhere to go. So it was the facilities that
16 was there, the television and a phone. You had just to
17 mull over what you'd been seeing, the queues at the
18 hospital, the poor patients that we were going to.
19 I went over there thinking I was going to help
20 multiple people, I probably did but it didn't feel like
21 it, and afterwards you'd come away thinking: was that
22 real? Did I really do that? Did I spend all that time
23 in the hotel room, all that time sitting outside the
24 hospital, and actually only see a few patients? Poorly,
25 poorly patients.

1 Yeah, I'm sorry.
2 **Q.** Was there any support provided to you at the time or
3 after that period of time?
4 **A.** So in the Ambulance Service we use a thing called TRiM,
5 I can't remember what that acronym's for, I do
6 apologise. That's 72 hours or so after an event, so
7 it's fine if you've been to an individual incident that
8 may have triggered some feelings, some concerns but
9 this, obviously, was over a long length of time.
10 Me, because of my union role, I knew where I could
11 go to talk to people but I'm not aware of any
12 communication from the trust to the 40 people in this
13 situation that went up there, let alone the rest of the
14 staff as to: do you want to talk after the event?
15 I don't think that's ever been sent out.
16 **Q.** Continuing then on the topic of infection prevention
17 control on the ambulance vehicle itself and access to
18 PPE, in your statement at paragraph 11 you have
19 summarised a number of issues that you experienced
20 during the pandemic with those. I wonder if you could
21 perhaps just describe some of the other issues that you
22 had.
23 **A.** So yeah, under the topic of IPC, technically we should
24 have got a, if you like, made-ready ambulance. A lot of
25 the time they had been hot-loaded, so it's just bags

1 being replaced with the equipment, obviously fluids or
2 spillages would have been wiped up and maybe a quick mop
3 over.
4 When we got a patient to a hospital, because
5 service level agreements have changed over the years,
6 there's no mop and bucket at the hospital for us to wipe
7 out the floor of the ambulance. We would have wiped
8 down with Clinell wipes the stretchers and that side of
9 things. But the masks, when you took over the
10 ambulance, were generally -- the ones in the front of
11 the ambulance was in the fridge. We've got cold boxes
12 in the front of our ambulances. So if you're storing
13 something like that in a fridge, actually how good is it
14 actually going to be? Because of course it's going to
15 be damp. So is it going to work? Is it suitable?
16 The dates on the gloves, on the masks, were all
17 expired. We had concerns as to how they'd been stored
18 because we know the government had, obviously, contracts
19 with different individuals to store them in warehouses
20 and we know that some of those were damp and leaky -- at
21 least that's what I'd been told.
22 So the aprons not being suitable, the gloves being
23 out of date, and a lot of times, because we were getting
24 some really cheap nasty gloves, you were putting your
25 hands straight through them. To start with, they ripped

1 and tore quite easy. The masks were being stored in the
2 fridge. If it was the more solid surgical -- more --
3 fluid -- FFP --
4 **LADY HALLETT:** FFP3.
5 **A.** Yes -- masks, they were stored in Chinese containers.
6 We literally got some Chinese containers, or the
7 organisation did, and that's where they stored them.
8 Now, if you go for small-size or a medium-size
9 Chinese, and you put something that's going to go over
10 your face, it's not going to fit in there, so it's
11 squashed down, and then we put that into a bag and we
12 again squashed it again to get in. So, actually, have
13 we stored it correctly? And that's what we were being
14 expected to use and trust our lives with. And obviously
15 then going home to our loved ones knowing that 24 hours
16 or 36 hours later we might have symptoms because the
17 equipment, the PPE, hadn't been stored properly and
18 wasn't in date.
19 **MS HANDS:** Yes, thank you.
20 Had you had any fit testing of those masks?
21 **A.** So previously, no. This all had to be worked up very
22 quickly. Fit testing was done. There was a process
23 that was taught to someone, that was taught to someone
24 else, that was taught to someone else and they would
25 sort of, like, try to fit test you. You had to guess

1 whether there was a sweet smell or a bitter smell, that
2 was done to see whether you'd passed or failed it.
3 I actually failed it with -- I have lost a little bit of
4 weight -- but I failed it so I couldn't be fit tested on
5 the masks that we had, bearing in mind there was three
6 or four different styles of masks and you had to be
7 individually tested on each one. And until we started
8 sourcing the hoods there was no way of actually being
9 properly protected.
10 **Q.** So during that period where you had failed the fit test
11 and before the hoods were introduced, what were you
12 wearing?
13 **A.** Before that -- well, before Covid, nothing, and since
14 the start of Covid we were at times wearing the masks.
15 Information changed. We weren't wearing then in crew
16 rooms or EOCs. We weren't obviously -- that wasn't the
17 recommendations at the time, and in the ambulance, you
18 were there, you knew that you were at work, you felt
19 fine, why would you have it on until, obviously,
20 knowledge changed and information was shared to wear the
21 masks in the ambulances.
22 **Q.** Did you receive any training or advice about how to
23 communicate with patients, for example, when you were
24 wearing the PPE, and did that cause any problems?
25 **A.** Not that I can recall. Because of the condition of my

1 mother-in-law -- I normally get told I speak too loud
2 when I'm talking to her, but she obviously watches our
3 lips moving and she can talk to us in her way, and that
4 taught me over the years that -- just to slow down and
5 take my time.
6 With wearing a mask, dementia patients,
7 hard-of-hearing patients and others, can't get that
8 mouth movement from you. So when the hoods became
9 available, I actually went over to wearing my hoods for
10 virtually all the patients. Which scared some people
11 because they were thinking I was bringing into hospital
12 really, really poorly patients when it was a painful
13 ankle or whatever they might have fractured, but I -- of
14 course I had my hood on. But the patients could see my
15 face. They could see expression. I wasn't taught that.
16 That was life experience that I'd done that because
17 of -- and even today, I still don't think there's been
18 any learning from any of this or that topic because
19 there are occasions when we should still be wearing face
20 masks today.
21 **Q.** Moving on to some of the non-clinical areas that you
22 would have been in during the pandemic, so in terms of
23 ambulance staff rooms and offices, were there any issues
24 with social distancing or IPC measures in those
25 environments?

1 **A.** So it was very varied. We'd highlighted about space
2 over the time but obviously it's all about budgets.
3 The desk that I'm at at the moment would have been
4 in some locations a large desk for us. So if you take
5 this as being a large desk for us to have a meal at,
6 there was a white line drawn down the centre of it. One
7 would be at one end, one would be at the other end, that
8 is where we would be expecting to have a romantic meal
9 and eat our dinner. There was no social distancing in
10 some areas because it wasn't physically able to be done.
11 It depends on how far you want to take safety. If
12 we turned up somewhere and the knives and forks and
13 plates were still dirty from the last people that used
14 them, we've obviously got to wash them up, but in bigger
15 areas where -- let's use an EOC as an example --
16 **Q.** Sorry, just to stop you there. An EOC, do you mind --
17 **A.** Emergency operation centre, so the control room.
18 They've got dishwashers, but they went over to using
19 disposable plates and cups, but -- when we were on the
20 response post, where the table was this size, we would
21 have reusable stuff, which was nice for the environment,
22 sort of, side of things, but it's about where do you
23 level that risk factor.
24 In rooms, yeah, functions like human resourcing,
25 organisational development, finance, they just

1 squirreled themselves away at home very quickly and went
2 over to using Teams for everything, so that freed up
3 a bit of space, but we couldn't -- we had to go through
4 a process, and I'm sure other organisations within the
5 ambulance sector elsewhere would have done, to spread
6 out the desks that people were at to take the 999 calls,
7 because they were a desk similar to this with two or
8 three screens on it and there literally just banks of
9 them. Because it's a call centre. It's gone over to
10 the call centre environment mentality of how much can we
11 squeeze into this space to get best value for money, so
12 everyone on top of themselves.
13 **Q.** Did you experience or hear of any experiences that
14 drivers in non-emergency patient transport vehicles had
15 with IPC guidance?
16 **A.** So in many areas, obviously, like, the patient transport
17 services have been subcontracted out, in some areas they
18 are still in the NHS. The majority of those vehicles
19 would be van conversions with no bulkhead, so it's like
20 the cab and the rear of the vehicle are all in one. So
21 not the issue of, to a certain extent, about the
22 circulation we had in the double-crewed ambulances, it's
23 just literally -- because then you have got one person
24 that's driving, goes and picks up a few walking wounded
25 people that are pre-planned into hospital.

1 It was -- sorry, what was the question?
2 **Q.** Were you aware of any issues with IPC measures in those
3 vehicles?
4 **A.** Yeah, so it was -- because it was exposed. The driver
5 was in there, technically, with all their patients
6 getting on and off, and it was just that one person, so
7 there was no separation. As to the equipment, the IPC
8 side of masks would have been similar in the NHS setting
9 I'm sure.
10 We had some patient transport vehicles which,
11 because of trying to segregate, the service purchased
12 bulkheads that was then put into the vehicles over
13 a period of time but all too late in the day.
14 **Q.** And in terms of the information that was available to
15 you during the pandemic, were you assisted at all by
16 your GMB role and was the information accessible to you
17 throughout?
18 **A.** So I was lucky/unlucky, depending on which way you look
19 at it. I was aware of what was going on, obviously,
20 behind the scenes. The plans about using ice rinks to
21 store bodies, the fact of what the figures were, where
22 the concerns were coming from, the lack of equipment.
23 I had the ability to challenge for myself or for my
24 colleagues the fact that we were doing things that was
25 probably just fundamentally wrong by expecting them just

1 to follow and not ask questions.
2 **Q.** And it is a difficult question but can you describe for
3 us, or is there anything else you want to add, as to the
4 long-term impact that the experience of the pandemic has
5 had on you working on the front line and those around
6 you?
7 **A.** So my family was -- my family was -- I could have stayed
8 at home and worked from home to look after my members,
9 to look after the patients from there, because obviously
10 some people need to be working from a non-patient side
11 of things to have all of the cogs working in the engine,
12 so to speak.
13 I exposed them to elements of risk that I could
14 have avoided, and that's something that I live with, but
15 I would be going home from work and having to strip off
16 in the hallway so that I didn't go in in my uniform, to
17 try and protect them. That plays on my mind. Turning
18 up at people's houses where someone was unfortunately
19 dead inside the front window or just on the pathway up
20 to their property, and I've got out the vehicle and
21 I would have normally gone over, started bouncing up and
22 down on their chest, but we went and got our masks and
23 suits on and all of that. That plays on my mind all the
24 time.
25 Yeah.

1 Would I do it again? Yes. I'd be jumping out
2 there straight away to go and start supporting my
3 colleagues on the front line and responding to patients
4 if we were to get another wave of something. Do I hope
5 that people would question more? Yes.
6 I bottle things away. I'm quite -- I'm told quite
7 a lot of times I'm cold. I'm not. I just deal with it
8 in the way that I deal with it. Yeah, sort of --
9 I think I've answered part of your question but not all
10 of it, so do you want to rephrase?
11 **Q.** It was if there is anything else you wanted to add about
12 the impact on you and those around you, but if that's
13 everything, that's fine.
14 **A.** For me, I can't change history, no matter what you talk
15 about, it's history. We can't change it. It is what it
16 is. But what we can do is we can learn from it, we can
17 adjust it, we can make sure it doesn't repeat again or
18 that we've at least looked at everything at made an
19 informed decision but all we're seeing at the moment is
20 things have reverted back to what it was beforehand,
21 tight spaces for working, still having out-of-date
22 equipment, consumables on stations and getting into the
23 system, vehicles that are not fit for purpose.
24 We're lucky, I suppose, in a way, down south. We
25 got quite a lot of Make Ready Centres but the concept of

1 the Make Ready Centre was to be all-encompassing, which
2 would mean, like, laundering the uniform rather than
3 taking it home and using your own washing machine to
4 wash the bodily fluids and then obviously your family's
5 undergarments going in it following wash. All those
6 sort of bits are what I just hope that we learn from and
7 it's -- understanding there's budgets but actually it's:
8 what does the public want? What does the patient need?
9 What does the staff member that's attending the scene
10 need to actually do their job properly?
11 **MS HANDS:** Thank you, Mr Tilley.
12 I don't have any further questions, my Lady.
13 **LADY HALLETT:** I don't think there are any other questions.
14 **MS HANDS:** No.
15 **LADY HALLETT:** Thank you very much for your help, Mr Tilley.
16 I'm very grateful and I understand how difficult it must
17 have been for you and your colleagues.
18 **A.** Thank you, my Lady.
19 **LADY HALLETT:** Thank you very much.
20 **(The witness withdrew)**
21 **MS HANDS:** My Lady, I think we will move straight to the
22 next witness.
23 My Lady, may I call Mr Marsh.
24
25

1 **MR ANTHONY MARSH (sworn)**
2 **LADY HALLETT:** Mr Marsh, I think you are our first witness
3 in full uniform.
4 **A.** Thank you, my Lady. Good morning.
5 **Questions from COUNSEL TO THE INQUIRY**
6 **MS HANDS:** Good morning, Mr Marsh. You should have your
7 witness statement in front of you, and that is
8 INQ000479041.
9 Mr Marsh, you are here today in your capacity as
10 former chair of the Ambulance Association of Chief
11 Executives, a role you held from 2014 to July 2020; is
12 that right?
13 **A.** That's correct.
14 **Q.** And also as the current national strategic adviser for
15 ambulance services at NHS England, a position you've
16 held since 2018?
17 **A.** That's also correct.
18 **Q.** And you are also the current chief executive of West
19 Midlands Ambulance Service?
20 **A.** Yes, that's correct.
21 **Q.** I want to start with the centralisation of ambulance
22 services in England at the start of the pandemic, and
23 it's correct, isn't it, that ambulance services in
24 England were led under a single command and control
25 structure that was supported by the National Ambulance

1 Coordination Centre, or the NACC, from around
2 25 March 2020?
3 **A.** That's correct.
4 **Q.** And in your statement you've set out the role of the
5 NACC, but can you briefly summarise that for us please.
6 **A.** In the initial stages of the pandemic, the National
7 Ambulance Coordination Centre was essentially collecting
8 intelligence, situational awareness, from ambulance
9 services across England to establish the pressures that
10 were being exerted from the pandemic, so collecting
11 information, updating the live NACC Dashboard, and also
12 collecting information from ambulance services that were
13 then fed into national directors at NHS England.
14 **Q.** And from around September 2020, when the national
15 emergency level was lowered, it's right that the NACC
16 responsibilities changed, didn't they? Could you just
17 briefly say how they changed.
18 **A.** That's correct. There were two aspects of the
19 responsibilities of the National Ambulance Coordination
20 Centre, and indeed my role, that were moved from the
21 national co-ordination to the regions, which were
22 requests for military assistance to civil communities,
23 so military support, and secondly, mutual aid as well
24 was moved to the regions.
25 **Q.** Do you want to briefly describe your role in that.

1 **A.** My role in NACC was to support the preparations for
2 ambulance services in response to the pandemic, to
3 provide advice to ambulance services and what I thought
4 they should be doing to prepare, and then deal with the
5 various waves of the pandemic, to oversee and make
6 recommendations on the escalation of Protocol 36, the
7 flu -- the pandemic protocol within the triage systems.
8 The deployment of the mutual aid of the St John
9 Ambulance national contingency as well fell with my
10 responsibilities, and also working with British Telecom
11 when we put in place the two filter arrangements, one
12 for dealing with information calls and, secondly, for
13 dealing with 999 duplicate calls as well.
14 **Q.** We're going to come on to discuss some of those this
15 morning.
16 Did the emergency level increase again after
17 September 2020 and, if so, was the decision to change
18 the responsibilities of NACC reviewed again?
19 **A.** The level did change, so you're right that the national
20 emergency within the NHS was de-escalated to a 3, was
21 increased again to a 4. The levels of responsibility,
22 i.e. the MACA request and the mutual aid, remained with
23 the regions at that time. They didn't revert back to
24 national co-ordination.
25 **LADY HALLETT:** How many levels are there?

1 **A.** Four, my Lady.
2 **LADY HALLETT:** So 4 is the worst?
3 **A.** Yes, my Lady.
4 **MS HANDS:** And it's correct that you didn't have any
5 involvement as the strategic adviser, this is, with your
6 equivalents in Wales, Scotland or Northern Ireland, did
7 you?
8 **A.** That's correct.
9 **Q.** And you've also said in your statement that you didn't
10 have any relationship in that role with the College of
11 Paramedics, the chief medical officers or public health
12 bodies?
13 **A.** That's also correct.
14 **Q.** Touching then on your role in the AACE, the ambulance
15 association, that's a membership organisation for
16 ambulance trusts across the UK, isn't it?
17 **A.** Correct.
18 **Q.** And all ten English ambulance services and the Welsh
19 ambulance service are full members; is that right?
20 **A.** Yes.
21 **Q.** And Scotland, Northern Ireland and the Isle of Wight are
22 associate members?
23 **A.** Correct.
24 **Q.** Could you just very briefly explain what the distinction
25 is in practice.

1 **A.** There's really only one distinction, and that is that
2 full members, i.e. the ten English ambulance services
3 and the Welsh ambulance service are able to vote and the
4 associate members are not. But in terms of voting, the
5 only time I can ever recall us voting is to elect the
6 chair of the association, once every three years.
7 **Q.** Again, as chair of AACE, you didn't work directly with
8 any equivalents in the devolved nations, did you?
9 **A.** That's correct.
10 **Q.** Or in that role as chair with the College of Paramedics?
11 **A.** That's correct.
12 **Q.** And the AACE was represented on the UK IPC cell but not
13 by yourself, is that right?
14 **A.** That's also correct.
15 **Q.** We'll come on to discuss that more in due course.
16 Turning now, to the topic of capacity in the
17 ambulance service, you refer in your statement to
18 REAP levels, R-E-A-P. Can you briefly explain the four
19 levels and what the agreed national triggers were for
20 those levels?
21 **A.** So essentially an ambulance service operating business
22 as usual, where activity is stable, staff attendance is
23 stable, then that ambulance service would be operating
24 at level 1.
25 As pressures emerge, which could be in response to

1 increased emergency activity or inclement weather or
2 staffing, those escalation levels will increase up to
3 the highest level of the fourth -- the fourth level.
4 And at each level, not only is there a series of
5 triggers that determine the escalation of each of those
6 levels, there's also a set of actions that should be
7 considered by each individual ambulance service to
8 determine their response to mitigate those pressures
9 that are being presented.
10 **Q.** And were there changes to the trigger levels during the
11 pandemic?
12 **A.** There weren't changes to the trigger levels. The
13 trigger levels are already established within the policy
14 and within the procedure.
15 **Q.** And it's correct that you advised on when the timing of
16 escalation and de-escalation of REAP levels and
17 therefore the impact on the triage systems during the
18 pandemic, didn't you?
19 **A.** Not quite, if I've understood the question correctly.
20 If I may?
21 **Q.** Yes.
22 **A.** So, the levels of REAP is a matter for individual
23 ambulance services. They determine the level that they
24 believe is appropriate depending upon the prevailing
25 circumstances and the actions that they are able to

1 take. Where I was recommending escalation is in
2 relation to the Protocol 36 of the 999 call-handling
3 triage system.
4 **Q.** Which we'll come to. Thank you for clarifying.
5 So at the end of March 2020 in England, it's
6 correct that six out of ten ambulance trusts were at
7 REAP level 3 and three trusts were at level 4, which was
8 extreme pressure, weren't they?
9 **A.** That's correct.
10 **Q.** That level 4 of extreme pressure also includes the
11 potential for service failure; is that right?
12 **A.** Potentially.
13 **Q.** Then moving forward into July 2021, is it right that all
14 English ambulance services were at REAP level 4?
15 **A.** That's correct.
16 **Q.** And that continued into the end of 2021, around
17 November?
18 **A.** Yes.
19 **Q.** It's correct that you advised on increasing capacity in
20 your role as adviser to NHS England and as the chair of
21 the NHS England 999 ambulance cell; is that right?
22 **A.** Correct.
23 **Q.** And you've described some of the objectives of that NHSE
24 cell, and the topic's discussed in your statement, which
25 included triage systems, protocol levels and to review

1 data; is that right?
2 **A.** Correct.
3 **Q.** You've said in your statement that around 26 March you
4 advised that 999 call handlers capacity should be
5 increased?
6 **A.** Yes.
7 **Q.** And that trusts should look to using students to help
8 with that capacity.
9 **A.** Yes, but just to clarify, if I may, please? Earlier on,
10 as pressures were building in response to the pandemic,
11 I'd already advised ambulance services they should be
12 acting now to increase capacity both in the control room
13 and in ambulance crews. So that was happening
14 throughout February and into March.
15 In relation to the point the deployment of
16 university students, my initial advice was that,
17 commensurate with their training, given they're in three
18 years, so year 1, year 2, year 3 students, those
19 students should be mobilised and deployed where possible
20 to help support and increase ambulance crews, not
21 necessarily in the control room, but that clearly is
22 a consideration that could be made on an individual
23 basis.
24 **Q.** I think you said in your statement that not all trusts
25 followed that advice, and we also heard from Ms Nicholls

1 of the College of Paramedics last week that perhaps
2 students could have been used more effectively in
3 increasing capacity.
4 So what's your view as to what the barriers were
5 to increasing capacity and how perhaps that could be
6 improved going forward?
7 **A.** So certainly the mobilisation of university students on
8 to the front line has never been put in place
9 previously. My view was that we were confronted with a
10 national emergency and what I had seen happening in
11 parts of Europe and some states in America, where
12 emergency services were under enormous pressure, I was
13 absolutely trying to ensure that the ambulance service
14 across England did everything we could as early as
15 possible to increase the number of ambulance crews. And
16 so therefore deploying those students was something that
17 I saw as a really valuable resource, given it was
18 a career that they had chosen to pursue, which is why
19 they had gone to university, and that potentially,
20 particularly the year 3s, had already spent nearly
21 three years at university, a significant proportion of
22 that time as part their clinical placements with the
23 ambulance crews, and therefore to me it just seemed
24 a very obvious way of mobilising those onto the front
25 line to support our existing staff by splitting crews

1 and therefore potentially being able to increase quite
2 significantly the number of ambulance crews available.
3 But I think because it was something we'd never
4 done before, there was some apprehension or concern
5 about actually implementing that advice, and I think
6 that was really the reason why some ambulance services
7 were more hesitant than others. But my view was really
8 clear: this was a national emergency and we needed to
9 act now to save as many lives as possible.
10 **Q.** And in terms of staff that weren't students and
11 increasing the capacity in call handling centres there,
12 what were the barriers there?
13 **A.** So ambulance services recruiting sufficient staff,
14 I just feel that some ambulance services really gripped
15 it and thought "We absolutely need to recruit more
16 staff, advertise, go through the selection process,
17 recruit and train", and other ambulance services, in my
18 opinion, should have been more robust in the timescales
19 that they applied in terms of being able to recruit all
20 of those staff as quickly as we needed to.
21 **Q.** In either role for the AACE or as adviser, did you
22 support those trusts in implementing those measures?
23 **A.** Absolutely. I kept giving advice to increase the
24 capacity in the control rooms. The arrangements for
25 recruiting 999 call handlers were in place. All

1 ambulance services have those in place and that's
2 business as usual.
3 But my advice was that we needed to substantially
4 increase the number of 999 call handlers, because I was
5 concerned that if the pressure was such that there was
6 significant increase in 999 calls for ambulance
7 services, that would place pressure on BT, that answered
8 the calls initially, to determine whether you need
9 police, fire or ambulance and then connect the caller to
10 the relevant emergency control room, that there could be
11 members of the public that actually needed maybe fire or
12 police that wouldn't be able to get through because BT
13 would be so busy dealing with ambulance calls and not
14 being able to connect them as quickly as necessary to
15 the relevant ambulance controls. And I was doing
16 everything I could to prevent the ambulance service --
17 and, as part of our national critical infrastructure,
18 from being overwhelmed.
19 **Q.** And you provided a checklist, I think, didn't you, for
20 trusts to fill out for their surge preparation. Were
21 they monitored for compliance?
22 **A.** That wasn't the purpose of the checklist. The checklist
23 was to identify the areas where I felt ambulance
24 services could focus their energy where I believe this
25 would give them the greatest benefit and the greatest

1 impact to increase staff in the control rooms and
2 ambulance crews, and then I followed up with specific
3 advice to each individual ambulance service based on the
4 information within their return.
5 **Q.** And moving away from people to vehicles and fleet
6 availability, in a survey on escalation of care that the
7 Inquiry commissioned, 45% of paramedics and 55% of GPs
8 said that a barrier to escalating care was access to an
9 ambulance, and part of your role was about maximising
10 fleet availability, so were you aware of these issues
11 and was any support provided to increase the
12 availability of the fleet?
13 **A.** Yes, it was. So there was a number of things. Firstly,
14 again, I offered advice to say that we needed to
15 increase the size of the fleet, which, given ambulances
16 are very specialist vehicles, that's not always easy to
17 do, but I gave some specific advice about how that could
18 be facilitated, and indeed how we can reduce the
19 downtime of the fleet to maximise the operational
20 availability of the fleet that we did have.
21 And that advice was ongoing as well, particularly
22 for a couple of ambulance services who did get into
23 difficulty at various points during the waves of the
24 pandemic.
25 **Q.** And in terms of the use of non-emergency patient

1 transport vehicles, particularly early on in the
2 pandemic, where their work and their journeys were
3 significantly reduced, was there any work done to try to
4 utilise, effectively, their services and their vehicles
5 and to co-ordinate that work?
6 **A.** Absolutely. A couple of points on that.
7 Firstly, those PTS staff that volunteered to
8 undertake additional training, we asked them to step
9 forward, complete that additional training, and we used
10 those staff on the lower acuity emergency calls in some
11 urgent cases as well.
12 And then for the PTS staff that were remaining
13 that weren't required necessarily to do their normal PTS
14 business-as-usual work, I asked that those crews pay
15 particular attention to discharges, hospital -- patients
16 from hospital, so that we could really speed up the flow
17 through the hospitals to avoid delays in the
18 emergency department and delays of unloading ambulances
19 outside of the emergency department.
20 **Q.** Can you recall when that advice was given and when that
21 work started?
22 **A.** That was March 2020.
23 **Q.** You have referred in your statement to the issues with
24 staff absence in the ambulance service during the
25 pandemic and you've said how some 999 call handling

1 centres were impacted by staff absence up to 30% and,
2 indeed, NHS data shows that absence peaked actually
3 later on, in January 2020, at around 9%.
4 **LADY HALLETT:** 2020 --
5 **MS HANDS:** 2021. I beg your pardon.
6 What action was taken at a national level to
7 support trusts not only to try to reduce the amount of
8 staff sickness, but also to meet the demand when those
9 staff sickness absence levels were high?
10 **A.** A couple of points. Firstly, national advice was issued
11 to ambulance services to protect the workforce that we
12 already had; so providing advice and the installation of
13 plastic screens around the call handlers to protect them
14 from the potential spread of any virus from colleagues
15 sat in close proximity to those staff, but also regular
16 wipe-downs of their desks, using hand gel before and
17 after they entered the control room, before and after
18 they entered the building, and all of the IPC
19 arrangements that were set out for clinical areas were
20 also applied in large part to non-clinical areas, which
21 included the control.
22 So protecting the existing workforce was the first
23 priority.
24 I've already mentioned recruiting additional staff
25 to deal with that capacity, but we also then put in

1 place two filters with British Telecom, who monitored
2 the 999 calls: one for information calls, patients who
3 actually didn't need an emergency ambulance but just
4 wanted information in how to handle the Covid symptoms
5 for themselves; and then, secondly, later on, where
6 there were delays for ambulances responding, patients
7 would often ring back, not -- on the 999 system, seeking
8 an estimated time of arrival for the ambulance.
9 **MS HANDS:** Mr Marsh, I'm just going to stop you there
10 because we are going to come on to those two call
11 filters in more detail. But, in terms of the staff
12 absence in the call centres, it's right that there
13 wasn't any national guidance for those non-clinical
14 areas, so the AACE, in fact, produced working safely
15 guidance, didn't they, that was updated throughout the
16 pandemic for use in those areas?
17 **A.** That's correct, but there was initial business-as-usual
18 arrangements for good IPC measures across all of our
19 working areas, which included the control rooms, but
20 more specific advice in response to the pandemic and
21 rising absence levels was introduced later on by AACE,
22 you are quite right.
23 **Q.** Were you made aware of issues with implementing that
24 advice on the ground; so whether it could actually be
25 implemented?

1 **A.** Not in the control rooms from memory, no.
2 **Q.** What about other staff areas, staff rooms, break-out
3 areas, those kind of areas?
4 **A.** Once the guidance had been issued, I'm confident no-one
5 ever drew to my attention that the guidance or the
6 advice was not being followed, but I recognise there was
7 a gap between business-as-usual good hygiene amongst our
8 work areas and the more specific guidance that was
9 issued for non-clinical areas in due course, and that
10 was obviously why that additional guidance was issued.
11 **LADY HALLETT:** I think what Ms Hands is trying to get at is,
12 for the previous witness, Mr Tilley -- I don't know if
13 you had a chance to listen to his evidence?
14 **A.** Most of it I did, my Lady.
15 **LADY HALLETT:** The suggestion was that there were some
16 trusts certainly where the guidance that you were
17 giving, for good reason, wasn't being implemented. It
18 didn't come to your attention?
19 **A.** Not to my attention. I am really sorry if that was the
20 case, because the guidance was there for all of us to
21 follow, to protect all of us.
22 **MS HANDS:** You have accepted, Mr Marsh, in your statement
23 there were times during the pandemic that demand did
24 outstrip capacity in 999 call handling centres. Was
25 enough done to prevent this happening early in the

1 pandemic, early enough in the pandemic?
2 **A.** I don't believe it was.
3 **MS HANDS:** My Lady, before I move on to my next topic,
4 I wonder if that might be a convenient time to have a
5 break.
6 **LADY HALLETT:** Certainly.
7 I'm sorry about this, Mr Marsh, but we take
8 regular breaks for the sake of everybody. I shall
9 return at 11.25.
10 **(11.09 am)**
11 **(A short break)**
12 **(11.25 am)**
13 **MS HANDS:** Mr Marsh, we're going to move on to a new topic
14 of call handling and triage systems.
15 First of all, I wanted to just establish what the
16 systems are that are used in England. So we have two
17 systems for emergency call handling -- in fact they are
18 used across the UK -- and that's NHS Pathways and AMPDS.
19 I'm going to talk about the changes to the triage
20 Pathways that were introduced into 999 and 111 in
21 response to the pandemic.
22 It's right that you chaired the Emergency Call
23 Prioritisation Advisory Group advising NHS England on
24 ambulance call prioritisation, triage systems and
25 clinical coding; is that right?

1 **A.** Correct.
2 **Q.** If we can have on the screen, please, INQ000479041, this
3 is taken from your statement and this sets out the
4 initial changes that were made in mid-March 2020 to
5 ambulance disposition codes within 999 and a new
6 prioritisation pathway for Covid-19 callers contacting
7 999 with breathing difficulties.
8 Could you briefly explain what this change meant
9 in practice if I called 999 with Covid symptoms, firstly
10 with breathing difficulties and then, secondly, without,
11 at this time?
12 **A.** When patients ring 999, once we've established whether
13 the patient's breathing or not, we ask the caller, which
14 may or may not be the patient, what the chief complaint
15 that they're suffering with is. And if they were
16 suffering with difficulty breathing or any particular
17 problem with their breathing, then normally that patient
18 would be taken through the difficulty breathing
19 algorithm. But once the pandemic protocols were
20 implemented, those patients would be taken through the
21 pandemic protocol to establish or not whether those
22 patients can be safely and appropriately dealt with
23 without an ambulance being sent or whether they need an
24 ambulance to be sent and, therefore, the speed of which
25 and the category that would be applied to that

1 particular patient.
2 **Q.** When you say the pandemic protocol, are you talking
3 about Protocol 36?
4 **A.** Yes, I am.
5 **Q.** That wasn't introduced until 3 April 2020. So looking
6 at the changes that were made on 12 March 2020, in front
7 of you, what was this pathway and how was this
8 different?
9 **A.** These were two new disposition codes that were
10 introduced to be able to identify, given the questions
11 that were being asked of patients and the definitions of
12 potential Covid at this point, if those patients
13 potentially had Covid then there was an opportunity, an
14 option, for the call handlers to assign one of those two
15 codes to that particular patient.
16 **Q.** What level of scrutiny did these changes undergo at this
17 time?
18 **A.** It was the clinical coding group, which is made up of
19 doctors, medical directors from ambulance services, and
20 the clinical director within NHS England.
21 **Q.** Between the introduction of this pathway in March, and
22 Protocol 36, which we'll come on to, in April, was there
23 any review of those disposition codes or any changes to
24 them?
25 **A.** Not in that intervening period.

1 Q. So these pathways remained in place with the disposition
2 codes you have just described until Protocol 36 was
3 introduced?
4 A. That's correct.
5 Q. Moving on then to Protocol 36, my understanding --
6 please correct me if I'm wrong -- is that the intention
7 of Protocol 36 was to ensure that call handling services
8 were not so overwhelmed with calls about Covid-19 that
9 they were prevented from triaging and responding to
10 other incidents and to focus on those most in need?
11 A. Yes, it's designed that the ambulances aren't
12 overwhelmed rather than the actual call handlers in the
13 control rooms themselves.
14 Q. And it's right that Protocol 36 was first proposed on
15 23 March 2020 and implemented on 3 April 2020 in all
16 ambulance trusts; is that right?
17 A. In England, correct.
18 Q. In England. We know demand was increasing before that
19 and you've said in your statement that obtaining
20 approval for pandemic triage code set changes or
21 escalation levels often proved challenging due to the
22 time it would take to get sign-off from NHS England and
23 therefore decisions were not always implemented quickly
24 enough.
25 Is this an example of when it wasn't implemented

1 quickly enough?
2 A. No.
3 Q. The current AACE chair has provided a statement to this
4 Inquiry and he has referred to trusts requesting
5 permission to shorten call handling triage before
6 Protocol 36 was introduced, and in fact you wrote to
7 ambulance trusts in England on 7 April -- so a few days
8 after Protocol 36 was introduced -- with agreed
9 principles to allow trusts to make changes to their call
10 handling process, and AACE developed a set of codes that
11 they could use alongside it.
12 Why were these principles and this set of codes
13 produced at this time when Protocol 36 had been
14 introduced?
15 A. There's two separate issues here. We've talked about
16 Protocol 36 and the escalation. This particular
17 reference is in relation to a shortened training course
18 for new 999 call handlers.
19 The usual duration of training for new call
20 handlers is about five weeks, plus several weeks, maybe
21 up to two months, where new staff, having completed
22 their training, then work in the control room alongside
23 existing experienced members of staff to gain their
24 competence and to build their confidence before they
25 take 999 calls on their own.

1 It had been drawn to my attention that a couple of
2 ambulance services were looking to provide a shortened
3 initial training course for new recruits, much less than
4 the usual five weeks.
5 Q. It's right, isn't it, that in fact they were looking to
6 reduce it to one day from the five weeks?
7 A. So I believed -- in at least one service.
8 Q. And what action did you take in response to that?
9 A. As you referred, I -- as soon as it was drawn to my
10 attention I sent an email to all ambulance service chief
11 executives in England saying that I didn't support such
12 a proposition. Clearly it is a matter for individual
13 ambulance services and their chief executives as to what
14 training they provide but I made my position very clear
15 that I didn't think it was sensible, the training of
16 five weeks is there for a reason, and that if ambulance
17 services still believed it was the right thing to do,
18 they needed to ensure that the training that they were
19 going to provide, the shortened course, still met the
20 requirements of the licence and the requirements of the
21 regulator for that particular provider of the triage
22 system.
23 And then, second, it was followed up with
24 a letter, which you just referred to, which again
25 reaffirmed my position but also did include some

1 principles that if an ambulance service still believed
2 it was the right thing or it was necessary for them to
3 do, that they should at least apply and adhere to those
4 principles that were set out by AACE.
5 Q. Were any changes to the length of training monitored at
6 a national level?
7 A. No, it was a matter for individual ambulance services.
8 Q. Were you aware of any guidance or advice that was in
9 place to support, for example, new call handlers around
10 decision-making on the type of assessments that they
11 were offering to callers? For example, whether they
12 were passed on to a clinical call handler for an
13 assessment or remote assessment?
14 A. Are you referring to the new call handlers?
15 Q. Well, both.
16 A. Well, those arrangements exist business as usual. Call
17 handlers are able to either transfer 999 callers or,
18 indeed, once they've closed the case, then place that
19 case on the queue for paramedics and nurses to call
20 those patients back where that's necessary, and control
21 rooms generally have at least one paramedic that's
22 available to provide, in real time, clinical advice
23 whilst that call is in progress as well. That's
24 business as usual.
25 Q. Were you aware of instances where there wasn't the

1 capacity to provide that clinical supervision to call
2 handlers?
3 **A.** There would have been occasions where that option's not
4 always available in all control rooms from time to time.
5 **Q.** And in terms of Protocol 36, returning back to that,
6 trusts that use NHS Pathways as a system had to use
7 paper workarounds with scripts; is that right?
8 **A.** In the early stages that is correct.
9 **Q.** So it's right, isn't it, that they would be updated
10 almost daily, sometimes multiple times a day, as the
11 situation was developing in the early stages of the
12 pandemic?
13 **A.** Correct.
14 **Q.** And that would provide that the script, the questions
15 that the call handler should be asking the caller?
16 **A.** On the potential Covid algorithm, that is correct.
17 **Q.** And was there any concern or are you aware of there
18 being any inconsistencies in that advice being followed,
19 given that it was on a paper basis?
20 **A.** No. From time to time, previous to the pandemic, paper
21 workarounds are introduced if something urgent comes up
22 before the system can be updated. But, as you quite
23 rightly say, this was happening much more frequently
24 given the change in information in relation to the
25 initial wave of the pandemic.

1 **Q.** I think in an investigation that was carried out by the
2 Healthcare Safety Investigation Branch into 111 services
3 in fact found that there was up to 35 different changes
4 to the algorithm within 2020 whereas there would
5 normally be seven to eight per year. Does that sound
6 about right?
7 **A.** Yes. Yes, it does.
8 **Q.** So those would be in NHS Pathways on paper?
9 **A.** Certainly the initial workarounds would be but then they
10 would be built into the system within a few weeks.
11 **Q.** Moving on to the escalation and de-escalation of
12 pandemic protocols and 999 call handling, you have set
13 out in your statement that a tiered approach was taken
14 to national changes depending on the escalation level
15 but that it applied -- that level applied across
16 England; is that right?
17 **A.** That's correct.
18 **Q.** If we could have up, please, INQ004790471.
19 And the top of the page, this is a table that's in
20 your statement. Now, we can see here the different
21 levels from 0 to 3. These are, just for clarity,
22 different to the REAP levels that we discussed this
23 morning, aren't they?
24 **A.** Yes, they are.
25 **Q.** And these were specific to Covid-19; is that right?

1 **A.** That's correct.
2 **Q.** And it's correct that you had responsibility for
3 deciding on the level at the time?
4 **A.** And making recommendations to NHS England for
5 ratification, that's correct.
6 **Q.** It's right that during the peak waves of Covid-19,
7 Protocol 36 was implemented at level 1, is that right,
8 so when it was introduced in April, it was at level 1?
9 **A.** Correct.
10 **Q.** But level 1 wasn't exceeded at all throughout the
11 pandemic, was it?
12 **A.** Correct.
13 **Q.** And in fact we went back to level 0 quite a few times,
14 didn't we?
15 **A.** That's also correct.
16 **Q.** Why did we not go above level 1, in your view?
17 **A.** To move to level 2, and ultimately to level 3, would
18 provide more codes for clinical assessment and
19 potentially not initially sending ambulances. What
20 I was trying to assess was the balance of risk across
21 England as a whole to ensure that that balance was
22 proportionate to those services which were under
23 pressure, and that clearly needed level 1, maybe an
24 element of level 2, and the rest of the country that may
25 not have been under the same amount of pressure, and

1 trying to keep a consistent approach so that those
2 ambulance services that had availability to send
3 ambulances still continued to do so.
4 In some ways these Protocol 36 levels formalise
5 the internal surge levels within ambulance services, and
6 so I was clear that we needed to make sure that we
7 didn't expose more risk by trying to address the
8 particular challenges that might have existed in one or
9 two ambulance services at any particular point in time.
10 **Q.** So, in practice, one ambulance service could be under
11 severe pressure but because, as a whole, the ambulance
12 service in your view and recommendation was under
13 moderate pressure, the whole of the ambulance services
14 in England would be at level 2?
15 **LADY HALLETT:** 1.
16 **A.** 1.
17 **MS HANDS:** 1. I beg your pardon, 1.
18 **A.** That's correct.
19 **Q.** Thank you.
20 If we could, please, have up INQ000472375, and
21 these are minutes of the ambulance expert group of the
22 National Directors of Operations from 4 November 2020.
23 Now, I accept that you weren't present at this
24 meeting but if we could look at the bottom of this
25 document, please, where it's highlighted, and the

1 escalation levels that we've just been looking at were
2 discussed at this meeting and we can see here that it
3 says that the position was summarised as EMAS and
4 NWAS -- now they are two different ambulance services,
5 aren't they?
6 **A.** Correct.
7 **Q.** -- were withdrawing their request to escalate following
8 clarification. However, NASMeD -- and that's the
9 National Ambulance Service Medical Executive Directors'
10 Group, isn't it?
11 **A.** Medical directors, yes.
12 **Q.** -- had not withdrawn their request:
13 "In essence the process is not working as
14 envisaged."
15 And somebody confirmed that YAS -- and that's
16 another ambulance service, is that right?
17 **A.** Correct.
18 **Q.** -- had withdrawn their request and no further requests
19 to escalate were received.
20 What this is essentially showing is that three
21 ambulance services had requested an escalation to
22 a higher level but their requests had been withdrawn; is
23 that right?
24 **A.** Correct.
25 **Q.** But, despite that, NASMeD were of the view that there

1 should still be consideration of an escalation to a
2 higher level.
3 In the second part of that box there is
4 a suggestion that the previous barrier to regional
5 escalation had been resolved and:
6 "[It] might open a possibility to [NHS England]
7 reviewing the process to introduce regional discussions
8 on escalation rather than the national approach
9 currently in place."
10 Why was there no review at this point of
11 whether -- or was there a review at this point, as to
12 whether a regional approach to escalation would be
13 beneficial?
14 **A.** There was a review and I did consider the benefits and
15 the disbenefits of moving from a national position to
16 allowing some regional flexibility but, on balance,
17 I still held the view, and so did other senior
18 colleagues, that England remaining at one level
19 consistently was still the right thing to do on balance.
20 **Q.** It's right, isn't it, that in Wales they had adopted a
21 more flexible approach where they could adapt based on
22 the regional pressures at the time?
23 **A.** Yes, given that Wales is, you know, a devolved nation.
24 **Q.** Moving further through this document to page 3, please,
25 and -- yes, thank you -- the major incident update in

1 the North West Ambulance Service, here a major incident
2 was declared and the stack of holding calls was reduced
3 from 520 to nearer 250, and it caused in the Greater
4 Manchester area extensive delays, lost hours at ED.
5 Then there was reference to a suspension of meal breaks
6 and a request for a report. "SoS" -- is that the
7 Secretary of State?
8 **A.** I believe so.
9 **Q.** Thank you.
10 Is this one of the consequences on a regional
11 level of that decision not to allow for a regional
12 approach to the levels?
13 **A.** No, not at all.
14 **Q.** Can you explain why?
15 **A.** Of course. Individual ambulance services already have
16 their specific surge plans, and whilst REAP is in place
17 for a longer period of time, which we've discussed
18 already, the individual surge plans are on-the-day,
19 in-the-moment plans that deal with rising surge as
20 increases in demand occur during the day or maybe
21 handover delays deteriorate during the day or maybe
22 inclement weather causes disruption for the ambulance
23 service response.
24 So the individual ambulance service, so North West
25 in this case, would still have had their specific surge

1 plans that they would have applied in managing the
2 demand and the pressures that they experienced on that
3 day. Moving to level 2, or even level 3, across the
4 whole of England wouldn't have helped the North West on
5 this particular day.
6 **Q.** You provided the Inquiry with a statement as chief
7 executive of the West Midlands Ambulance Service and
8 you've referred in that statement to there being cells
9 and regular meetings in response to Covid which allowed
10 the trust to make informed, effective decisions about
11 how to operationally respond which were dynamic and were
12 reactive to the changes in national guidance, resourcing
13 and resource availability.
14 Would you agree, therefore, that that localised
15 decision-making can allow for more dynamic and effective
16 decisions and responses based on the situation on the
17 ground, as happened in your trust?
18 **A.** Yes.
19 **Q.** If we could have on the screen, please, INQ000410621,
20 please.
21 This is a summary of a legal opinion you received
22 in relation to changes to triage processes for Covid-19
23 on 2 April 2020. So this is the day before Protocol 36
24 was implemented in England.
25 The question comments that it's not clear from the

1 documentation as to how the needs of vulnerable groups
2 have been taken into account.
3 And then in the response below it confirms that
4 there has not been a formal impact assessment of the
5 impact on vulnerable groups of the changes to triage
6 before implementation but it was going to remain under
7 review.
8 Was a review conducted at any point during the
9 pandemic?
10 **A.** Not a formal review outside of the existing arrangements
11 that are in place for the algorithms for all patients.
12 **Q.** But Protocol 36 was introduced specifically for
13 Covid-19; is that right?
14 **A.** It is, but the basis upon which the algorithms work are
15 based on the clinical presentations of patients and,
16 therefore, the code and the category that follows from
17 that.
18 **Q.** Were you aware of Protocol 36 having an impact on
19 vulnerable groups during the triage process?
20 **A.** Not any more than would have normally been the case.
21 **Q.** I want to turn now to the practical impact of
22 Protocol 36 and a real-life example so that we can put
23 it into some context. That can be seen in a report
24 produced by the emergency call prioritisation group that
25 you chaired, 23 March 2020.

1 So it's INQ000281180. Thank you.
2 It's the box in the middle here. Essentially what
3 we have here is an example of what would happen under
4 Protocol 36. So in order to demonstrate the comparable
5 triage outcomes in the two systems, the clinical
6 scenarios describe the change in management for a
7 patient with low acuity symptoms and a patient requiring
8 an emergency response.
9 So, dealing first with the low acuity:
10 "A 30-year old who has chest pain and Coronavirus
11 symptoms ... will be assessed based on these symptoms
12 and managed in a similar way. As the triage levels
13 escalate patients who are assigned a category 5 response
14 priority at triage level 1 will be signposted to home
15 management by call handlers at triage level 3 ..."
16 And that disposition would be the same in both the
17 systems we have discussed under the pandemic protocols.
18 And then in terms of the more serious emergency
19 response:
20 "A patient who has severe breathing difficulty
21 (Classified as fighting for breath/ineffective
22 breathing ...) will be allocated a category 2 response
23 across each of the escalating triage levels."
24 A triage 2 response would be slower in terms of
25 the ambulance arriving at the scene than a category 1

1 response; is that right?
2 **A.** That's correct.
3 **Q.** And that's the same in both of those examples; is that
4 right?
5 **A.** Well, in the first example the patient would have been
6 potentially assigned category 5.
7 **Q.** And that would be -- a category 5 response, under the
8 pandemic protocol, would be to have stay-at-home
9 management advice?
10 **A.** Category 5 is for a clinical assessment ringback.
11 **Q.** Thank you.
12 Did that change apply to the triaging of callers
13 who did not report Covid-19 symptoms?
14 **A.** There were some codes that were not on the Protocol 36
15 or the pandemic algorithm that were allocated a lower
16 category response priority in levels 2 and in levels 3
17 if they had been implemented.
18 **Q.** And it's right, isn't it, that in August 2020 the
19 emergency call prioritisation group conducted a review
20 of Protocol 36 specifically in regard to ineffective
21 breathing and recommended that a category 1 response
22 should be received as opposed to category 2; is that
23 right?
24 **A.** That's true. That was new code for ineffective
25 breathing that was applied to the pandemic protocol at

1 category 2 and when we conducted that review in August
2 we decided that that code should receive a category 1
3 response.
4 **Q.** Were there any instances that had led to that decision
5 being made in August?
6 **A.** It was just a review of those codes and the application
7 of those codes and as part of that review it was
8 determined that that code would be better suited to a
9 category 1 response and so therefore it was changed.
10 **Q.** Thank you.
11 I want to look now at the meeting minutes from the
12 National Ambulance Service Medical Directors' Group
13 meeting on 23 April 2020.
14 And this is INQ000410581.
15 Here there was a discussion around the escalation
16 levels of Protocol 36, or card 36, as it is referred to
17 here. There was a reference that it "should be lowered
18 to 0", but that it wasn't present -- "it wasn't possible
19 at present but they thought it should be considered if
20 trusts were operating at good performance levels."
21 If we could go down, please -- thank you -- just
22 a little bit more, to "Several Trusts".
23 It was discussed at the meeting that:
24 "Several Trusts [had] reported increases of
25 patients found deceased when crews arrived, more serious

1 illnesses in patients, patients waiting longer before
2 calling 999, and ... patients were reluctant to go to
3 hospital, and needed to be convinced sometimes that the
4 diagnosis related to other conditions and not COVID-19."
5 And the North West Ambulance Service wanted to
6 know how long you might need to stay on card 36.
7 I accept you weren't at that meeting but were you
8 aware of issues as such as those described here and did
9 they continue throughout the pandemic?
10 A. So I was aware of the issues that are highlighted here
11 but I think there are two separate points being made
12 here.
13 Firstly, on level 1 of the pandemic protocol,
14 actually medical directors were reporting that many
15 patients were getting a more appropriate safe response
16 rather than automatically just sending an emergency
17 ambulance, and that was one of the considerations that
18 led us to believe that remaining on level 1 was the
19 right thing to do.
20 In relation to the other point in this highlighted
21 section, I do believe it's -- it was the case that some
22 patients were delaying calling for help and, as a sad,
23 terrible consequence of that, by the time the ambulance
24 call was made and the ambulance arrived, those patients
25 hadn't made it and, as we've gone on to see in this

1 section, that even when the ambulance had arrived, some
2 patients were also reluctant to be conveyed to hospital
3 as well.
4 Q. You referred earlier on to the delays that there could
5 be to the changing of triage codes. Was one of those
6 examples a change to the script included the loss of
7 taste and smell in May 2020?
8 A. Not that I remember, no. I don't think there was a
9 delay.
10 Q. In the healthcare safety investigation branch report
11 into 111 services they found that there was in fact a
12 delay of four days in which the script was not updated.
13 So anybody calling in that period would not have been
14 told it was a symptom. So you weren't aware of that?
15 A. No, not at the time.
16 Q. Is that the kind of example of where the processes that
17 were required to change the scripts impacted on the
18 callers?
19 A. I don't believe so because whilst that's an important
20 factor in recognising whether the patient may or may not
21 be suffering Covid, it wouldn't have influenced in any
22 way the code that was allocated to the patient once they
23 had been taken through the algorithm.
24 Q. Moving on then to the demands on 999, there was a
25 significant increase in 999 call answering time in

1 England in March and April 2020, with an average
2 49 seconds compared to an average of 10 seconds before
3 the pandemic.
4 One of NACC's role was to monitor performance and
5 report data. How did you respond to escalate those
6 issues and what did you do in response -- what response
7 did you receive to those issues?
8 A. So we were monitoring 999 call answering on a very
9 regular basis throughout the day, every day, and
10 receiving reports from British Telecom as to the number
11 of over two-minute delays on a daily basis on each
12 ambulance service, and I asked the colleagues within
13 AACE to develop some arrangements whereby they could
14 provide support, advice and mutual aid to those
15 ambulance services that were under pressure by
16 strengthening the buddy arrangements, which we already
17 had in place, and to see what further steps we could
18 take to provide mutual aid to those 999 ambulance
19 services that were under pressure, and at the same time
20 to ensure that the technical links were in place that
21 once a 999 call had been answered in an ambulance
22 service in which the incident hadn't occurred they could
23 transfer the details of that case to the host ambulance
24 service to enable them to respond.
25 Q. And when was that introduced?

1 A. It was finally completed by October 2020 but most of
2 those ambulance services already had the ability to
3 transfer those cases, with the exception of London, and
4 that was the one that took the most time to complete.
5 Q. In your statement you've discussed the issue of "no send
6 scripts", and essentially they are used during times of
7 significant pressure, for example asking the call
8 handler to make their own way to hospital as part of
9 individual trust surge plans. So there's no national
10 agreed script; is that right?
11 A. That's correct.
12 Q. You've said that they were discussed at the emergency
13 call prioritisation group to standardise the scripts and
14 set out the changes that were agreed nationally. Were
15 those changes monitored for implementation to ensure
16 that there was consistency across the trusts for the
17 scripts that were used?
18 A. Absolutely. That was the whole purpose of the pandemic
19 protocol and moving through those levels. But "no send"
20 was a generic term that was used, it didn't
21 automatically mean that all of those patients that
22 resulted in the end disposition from that algorithm
23 didn't get an ambulance. Some may have been advised to
24 make their own way to hospital but the majority of those
25 patients actually were then sent for further clinical

1 assessment before a decision was made whether they
2 actually needed an ambulance or not. And some of them
3 did and an ambulance was subsequently sent.
4 **Q.** Moving on, then, to NHS 111 during the pandemic, it's
5 correct, isn't it, that the instruction from the
6 Secretary of State was that NHS 111 should remain a
7 single point of contact for all enquiries for Covid-19?
8 **A.** Correct.
9 **Q.** And were you a member of the NHS England 111 Covid-19
10 cell?
11 **A.** No.
12 **Q.** Would it have been helpful if you had been a member of
13 that cell to ensure consistency across 999 and
14 111 services?
15 **A.** I don't believe so.
16 **Q.** We know that there was a dramatic increase in calls to
17 111 in March 2020 with over 3 million calls in that
18 month and over half of those were not answered.
19 If we could, please, look at INQ000348589.
20 This is a briefing note that was prepared for --
21 by Public Health England for a cabinet meeting on the
22 following day on 26 March, and the author states at the
23 top there that capacity -- sorry:
24 "Whilst PHE has maintained high level of
25 performance, this has been a difficult time for

1 NHS 111."
2 And we can see the performance of NHS 111 below.
3 They say that:
4 "The capacity at NHS 111 has responded to around
5 40,000 calls with slightly more at weekends since the
6 beginning of the incident. This is despite calls
7 offered being regularly over 100,000 per day. If
8 anything, their ability to answer calls has dropped
9 since mid-March."
10 In fact if we look specifically at 23 March, it is
11 quite small, at the bottom of the graph. You can see
12 there that the NHS 111 calls answered in 60 seconds is
13 10% and the target was around 95% at that time.
14 Then if we move down the page to page 3, please.
15 At the first paragraph there had been a request
16 from NHS England and NHS 111 to PHE for additional
17 1,000 call handlers, which was achieved within 24 hours'
18 notice, in order to support capacity of NHS 111 Covid
19 response separate from the PHE capacity.
20 Then if we just go to the final page 4, please,
21 and at the bottom and paragraph 3.1, one of the issues
22 that Public Health England draws attention to is that
23 capacity issues at the end of March 2020 in NHS 111
24 remain. There would be no attempt to augment the core
25 capacity and recruitment that the beginning of the

1 incident would now be providing additional core NHS 111
2 staff but that had not happened.
3 To your knowledge why did NHS England not recruit
4 call handlers before 26 March?
5 **A.** I honestly don't know. I wasn't involved in
6 decision-making with NHS England in relation to 111, I'm
7 afraid.
8 **Q.** Are you able to help us with the call filters that were
9 introduced to NHS 111 in March 2020 in order to manage
10 demand?
11 **A.** I'll try if this is a specific question, of course.
12 **Q.** Okay.
13 If we could, please, have up INQ000320204.
14 And this is the Healthcare Safety Investigation
15 Branch report that I've referred to into the changes to
16 111 triage.
17 These changes suggest that they were requested at
18 the -- at the request of the NHS England central
19 ambulance team and it was only to be used by providers
20 when advised by NHS England, and this is a further
21 pathway update at the end of March with a Covid-19
22 level 4 switch enabling an ambulance category 3 and
23 category 4 dispositions reached by core NHS 111 health
24 advisers using the Covid-19 algorithm to instead be
25 directed to a clinician, with a "Speak to a clinician

1 from our service immediately".
2 So is it right that in this -- when this switch
3 would be turned on, those that were calling that would
4 ordinarily have received a category 3 or category 4
5 ambulance response would now be actually called back by
6 a clinician in the first instance?
7 **A.** Yes, to determine their clinical needs, that's correct.
8 **Q.** And is it correct that you were part of that NHS England
9 central ambulance team?
10 **A.** Yes, that's true, yes.
11 **Q.** So were you involved in advising when this should be
12 switched on or off?
13 **A.** Yes.
14 **Q.** If we move to the next page, please, and 4.2.8, and then
15 we can see here that there were further updates to the
16 pathway we've just been looking at around pregnancy,
17 vulnerability and the symptoms, and depending upon those
18 would depend on the disposition that they reached?
19 **A.** That's correct.
20 **Q.** Thank you.
21 If we move down to 4.2.10, sorry, this is another
22 update the following day. So this is 31 March. Here
23 the summary of the update was that:
24 "Those who [were] not breathless and identified as
25 extremely vulnerable by the NHS will be triaged for

1 persistent cough and fever."
2 And:
3 "Those over 65 years of age will now receive
4 a full breathlessness triage and will reach an
5 appropriate disposition."
6 Are you aware as to the clinical input and quality
7 assurance that those updates underwent?
8 A. No.
9 Q. And it's correct that the call handlers that would be
10 dealing with these issues were not clinically qualified
11 or trained, were they?
12 A. That's correct.
13 Q. And a substantial amount of them, as we've just looked
14 at from that note, would be new call handlers that had
15 just been drafted in that would be dealing with these
16 calls?
17 A. Some of them would have been, yes, yes.
18 Q. And do you know how long their training period and
19 supervision was?
20 A. I believe it's the same if not very similar, circa five
21 weeks plus a good number of weeks in the call centres
22 gaining their experience and competence.
23 Q. During the pandemic, are you aware as to whether that
24 period of training was reduced?
25 A. Not formally but whether an individual provider or an

1 individual ambulance service reduced it, then that may
2 well have been the case. But I certainly wasn't made
3 aware of any shortening of the experience time in the
4 control rooms.
5 Q. Do you accept that the result of these changes overall
6 was that more people were advised to manage their
7 symptoms at home to reduce the demand on 111 services?
8 A. That would have been the case where it was believed to
9 have been safe and appropriate, yes.
10 Q. Thank you.
11 That document can come down. If we could, please,
12 have up INQ000069487.
13 This is an email between the Deputy CMO, the CMO
14 and Department of Health and Social Care on 30 May 2020,
15 where they refer to NHS 111 wanting to remove Covid
16 symptoms, and it reports that NERVTAG were "very
17 uncomfortable" and that we would "lose an important
18 early warning system for a resurgence", and a note from
19 111 had been requested.
20 Were you aware or involved in discussions about
21 NHS 111 no longer coding Covid-19 cases and the impact
22 that could have?
23 A. Not at all.
24 Q. Do you know who would have been involved in that
25 decision?

1 A. I'm assuming it would be the NHS 111 Pathways team but
2 I couldn't be sure.
3 Q. Thank you. That can come down.
4 We've discussed a little bit about the alternative
5 and additional helplines and assessment services that
6 were set up during the pandemic and, indeed, there were
7 a number of them. Those being set up by NHS England
8 were the Covid-19 Response Service and the Covid-19
9 Clinical Assessment Service, and then there was also the
10 Public Health England helpline; is that right?
11 A. That's my understanding.
12 Q. And were you involved in setting those up, monitoring or
13 deciding on when they would be switched on or off?
14 A. None of those at all.
15 Q. NHS England was responsible for monitoring the Covid-19
16 Response Service. You didn't play any part in that?
17 A. That's correct. I played no part in it.
18 Q. Moving on then to the NHS 111 First service which you
19 referred to, this was a booking system for NHS 111
20 online -- sorry, NHS 111 and NHS online -- 111 online,
21 for emergency departments that was available to trusts
22 by March 2021 to encourage access and to reduce
23 pressures on A&E and NHS 111. Were you involved in the
24 implementation of that?
25 A. No, but I was aware of it.

1 Q. In terms of future triage systems, you recommended that
2 there should be a single NHS 999 call prioritisation
3 triage system, and in fact the AACE made a similar
4 finding following a review in July 2020. Are you aware
5 as to whether anything was done in response to such
6 findings at that time or since to implement that?
7 A. No. This has been an ongoing debate amongst ambulance
8 services for many years actually, and I do strongly
9 believe that having one prioritisation system for 999
10 ambulance calls is the right thing to do.
11 Q. Moving on to the topic of call filtering, please, it's
12 right that you approved the switching on of a BT call
13 filter on 27 March 2020 to refer patients calling 999
14 who required Covid advice to NHS 111 online if it wasn't
15 life-threatening or they were not over *(sic)* 5 or above
16 70 years old; is that right?
17 A. Under 5 and over 70, that's correct.
18 Q. Yes. And on 15 April 2020 there was an update to that
19 to change the 5 years old to 16 years old. Were you
20 involved in that decision?
21 A. Yes.
22 Q. Can you explain why that change was made?
23 A. That was advice that was given to us by some of the
24 ambulance service medical directors and the NHS England
25 clinical director.

1 Q. And it's right that those call filters were switched on
2 and off throughout the pandemic; is that right?
3 A. Correct.
4 Q. And the second filter that you switched -- that you
5 advised on is one that you referred to around duplicate
6 callers asking for an ETA as to when their ambulance
7 would arrive if they had already requested it and they
8 hadn't deteriorated.
9 In the expert report from Professor Snooks, she
10 referred to research during the pandemic identifying
11 that NHS 111 telephone triage may have underestimated
12 the importance of those repeated callers as predictors
13 of adverse outcomes.
14 Is that something that you recognise and is that
15 something that was considered before the call filter was
16 switched on?
17 A. Not at that point. That was knowledge that wasn't known
18 to us at that time. But we did very clearly set out in
19 the algorithm which was issued to BT for their use that
20 if the patient had deteriorated or the condition had
21 changed then the call was to be connected to the
22 ambulance control room. It was only those patients that
23 felt comfortable that the condition hadn't deteriorated
24 or changed in any way, that they were simply only asking
25 for an ETA, it was those calls that were not connected

1 to the ambulance control rooms.
2 Q. Are you aware of any training that those call handlers
3 were given on that distinction?
4 A. I'm not aware of any training but the algorithm was very
5 straightforward. It was a series of yes/no questions
6 and answers. And of course if there was any doubt then
7 we said to BT: please connect the caller to the control
8 room.
9 Q. Moving on to conveyance to hospital and decision support
10 tools, it's right, isn't it, that NHS England developed
11 clinical guidance for paramedics to aid decision-making
12 on conveyance to hospital for adult patients in
13 April 2020?
14 A. That's correct.
15 Q. And in fact that guidance was issued on 10 April 2020
16 but it was issued by mistake, essentially, because there
17 had been identification of potential impact on patient
18 safety with the inclusion of the clinical frailty scale?
19 A. Correct.
20 Q. Later that month it was reissued without the clinical
21 frailty scale; is that right?
22 A. That's my understanding, yes.
23 Q. So there were 12 days when it was in use. Do you know
24 if patient safety was monitored during that time?
25 A. To be honest, I have not found any evidence that

1 ambulance services applied that guidance. It was posted
2 on the website, as I understand it, but I actually don't
3 think it was implemented in any ambulance service.
4 Q. And it's right that there was no national guidance
5 issued on conveyance after that until much later in the
6 pandemic; is that right?
7 A. Until much later, when the toolkit algorithms were
8 published.
9 Q. And as a result of that were you aware that ambulance
10 trusts were developing their own tools?
11 A. Yes, but, again, some ambulance services will have had
12 or potentially will have had some kind of conveyance
13 advice or tools within their individual trusts, but
14 overwhelmingly the guidance for ambulance paramedics on
15 conveyance of patients exists within the Joint Royal
16 Colleges Ambulance Liaison Committee guidelines.
17 Q. Were you aware of requests from those on the front line
18 who were making those decisions for a national tool to
19 support that decision-making?
20 A. Not specifically, no.
21 Q. Could we have up, please, INQ000499523 and if we could
22 go to page 34.
23 This is the survey that the Inquiry commissioned
24 into escalation of care decision-making, and if we look
25 at the fourth quotation down, this is a quotation from

1 a paramedic. He said that:
2 "One example of frontline staff being left to make
3 very difficult decisions on managing critically unwell
4 patients was not being able to ventilate a patient,
5 unless we were in level 3 PPE ..."
6 Sorry, it actually should be the top one. Sorry,
7 that's my fault, the first one, the "Harm from inability
8 to escalate care":
9 "It was very difficult and upsetting to leave some
10 sick patients at home due to tightening of criteria for
11 conveyance to A&E. Some of these patients would have
12 deteriorated and died. I understand why it had to
13 happen, but it went against my paramedic values."
14 Do you agree that a national tool early in the
15 pandemic would have assisted those on the front line
16 that were making these kind of decisions?
17 A. Possibly.
18 Q. And it was January 2021 when a decision support tool was
19 issued but use of it in the ambulance service in England
20 was discretionary; is that right?
21 A. Correct.
22 Q. What led to the tool being developed at that time?
23 A. Well, I wasn't involvement in the development of the
24 tool but my understanding is that it was an attempt to
25 standardise advice over and above that which already

1 exists within the Joint Royal Colleges' guidelines so
2 that paramedics had a clearer algorithm to follow for
3 patients, based on a series of observations, to help
4 them decide which patients needed to be conveyed to
5 hospital and which of those patients could safely be
6 left at home.
7 **Q.** And did you receive any feedback as to the benefits of
8 that advice after it had been issued?
9 **A.** No.
10 **Q.** Were you made aware of any guidance or reasonable
11 adjustments that were made to allow for patients with
12 additional needs to be accompanied in an ambulance
13 during conveyance to hospital?
14 **A.** The guidelines that were issued were for patients that
15 had no requirement for someone to accompany them, that
16 they should be conveyed alone, but for those patients
17 that were vulnerable or children, et cetera, then should
18 have an appropriate responsible adult conveyed with that
19 patient.
20 **Q.** And were you made aware of any issues with that guidance
21 being followed?
22 **A.** Not other than it was enormously distressing for
23 patients and their relatives.
24 **Q.** I want to move on now to infection prevention and
25 control. It's right, isn't it, that national guidance

1 is invariably based on hospital settings and not always
2 suitable for the ambulance setting and that was the case
3 pre-pandemic?
4 **A.** That's correct.
5 **Q.** So when it came to the pandemic, it had to be updated
6 multiple times, which you said took some time to
7 arrange; is that right?
8 **A.** Sometimes, yes.
9 **Q.** And part of AACE's role was to review that guidance and
10 to make recommendations to NHS England; is that right?
11 **A.** Yes.
12 **Q.** And I think you've said in your statement that they were
13 always accepted?
14 **A.** Yes.
15 **Q.** If we could look, please, at INQ000226616.
16 This is feedback from a survey of the workforce at
17 the West Midlands Ambulance Service, your trust,
18 following wave 2.
19 And if we could look at box 2, some of the
20 feedback received from those in your trust was that:
21 "The trust [had] taken the approach that one PPE
22 solution fits all."
23 And they were saying that:
24 "This isn't always the case ... [and it's not
25 always] possible ... staff have to balance risk benefits

1 and often fly intubated patients whilst in level 2 PPE.
2 We have asked for a specialist solution but been told
3 the same WMAS party line. I think going forward there
4 has to be acceptance that specialist teams may require
5 specialist PPE."
6 Is that "one solution fits all" approach something
7 that you were aware of during the pandemic?
8 **A.** Certainly my service we were very clear that before the
9 pandemic we had already procured the respiratory hoods,
10 because we recognised the enormous challenges of fit
11 testing, et cetera, with FFP3 masks, and so we moved to
12 the respiratory hoods. And of course during the
13 pandemic I was very clear that we were going to do
14 everything necessary to protect our staff, and therefore
15 to protect the emergency service.
16 And actually, in the early stages of the pandemic,
17 potential Covid patients and certainly patients for
18 which an AGP was being undertaken that would have
19 required level 3 shouldn't have been conveyed in the
20 aircraft anyway because at that point we weren't able to
21 adequately decontaminate the aircraft having conveyed
22 such a patient. So those patients would have been
23 conveyed by land, as they would if the aircraft's not
24 flying and indeed at night when the aircraft didn't fly.
25 **Q.** Thank you.

1 Did you seek to raise those concerns at a national
2 level in those roles that you held, around the guidance
3 on PPE and the solutions?
4 **A.** Well, more generally, I was aware that staff were,
5 concerned about the levels of PPE that they were being
6 advised to wear and I absolutely raised their concerns
7 with senior colleagues within NHS England, yes.
8 **Q.** We'll come on to that in a bit more detail.
9 Throughout the pandemic the hierarchy of controls
10 was promoted by public health bodies and AACE. We heard
11 from the College of Paramedics last week that they
12 didn't think it was suitable for the sector and indeed
13 they raised those concerns throughout the pandemic.
14 Do you agree that it was not appropriate for the
15 sector and did you take any action to escalate those
16 concerns?
17 **A.** Well, I actually think that applying the hierarchy of
18 control is the right thing to do. The principle set out
19 in the hierarchy, for example eliminating the risk where
20 that's possible, we increased hear and treat rate
21 through the Protocol 36 level 1 we've already discussed,
22 by ventilating the area as best you can, by regular
23 wiping down of surfaces, et cetera, I think is the right
24 thing to do.
25 But I absolutely recognise the enormous anxiety

1 that frontline staff were experiencing in dealing with
2 the pandemic.
3 Q. The UK IPC cell agreed on 6 March 2020 that PPE for
4 ambulance guidance would be, "downgraded" and it was
5 David Cunningham, on behalf of the AACE, that attended
6 on behalf of the sector. During a later meeting in that
7 month it was confirmed that ambulance trusts were not
8 consulted on ambulance PPE guidance. At that time you
9 were chair of the AACE. So how regularly did you
10 correspond with Mr Cunningham and discuss the
11 information coming out of the cell with him?
12 A. Not at all. That was dealt with by the expert groups of
13 the IP&C with NHS England, the IPC cell and Public
14 Health England. It falls outside of my experience and
15 expertise. So there would have been no value in me
16 regularly meeting with the experts.
17 Q. But you received correspondence from, for example,
18 Unison and the GMB union and the College of Paramedics
19 about the issues that they were having with the
20 recommended level of PPE and RPE on the front line. Did
21 you seek to raise those or bring those to
22 Mr Cunningham's attention in order for them to be raised
23 at the UK IPC cell?
24 A. Yes, he was aware of the concerns. I raised I did with
25 colleague that were in AACE, and of course the

1 colleagues that were part of the ambulance policy,
2 advisory and assurance group that was established as
3 well.
4 Q. And what was the response?
5 A. That we should continue to follow the guidance from the
6 experts of Public Health England and the NHS England IPC
7 cell.
8 Q. If I could bring you forward a bit more in time now to
9 the end of 2020/the start of 2021, where we start to see
10 an increase in the handover delays.
11 So if we could look, please, at a graph in your
12 statement. It's INQ0004190041.
13 And the national handover delays are set out there
14 at the top. It's correct that the target is 15 minutes,
15 isn't it?
16 A. Correct.
17 Q. And we can see here that the delays are increasing in
18 December 2020 and January 2021 and coming up to -- well,
19 certainly over 30,000 --
20 A. Yes.
21 Q. -- hours lost in those two months. And then from
22 April 2021 onwards we can see a significant
23 deterioration in the hours lost, can't we?
24 A. Correct.
25 Q. Put very simply, that meant that patients and crew were

1 spending longer in the back of an ambulance cab than
2 they would have been had there not been the delays; is
3 that right?
4 A. Absolutely right.
5 Q. I think it's right to say that sometimes up to 12 hours
6 in December 2021, and the longest delay in that month
7 was, in fact, 20 hours?
8 A. Correct.
9 Q. The Inquiry heard from the College of Paramedics last
10 week that as delays increased at the end of 2020 they
11 were advocating for a change in the IPC guidance for
12 staff to have flexibility to conduct a dynamic risk
13 assessment on their PPE levels.
14 Did you share those concerns at that time as well,
15 that paramedics essentially should be given that
16 flexibility?
17 A. They already had it. Even from the very start of the
18 publication of the guidance for ambulance staff they
19 already had the ability, having undertaken what we call
20 the dynamic risk assessment, it was simple -- a case of
21 assessing the risk that you believed you were being
22 confronted with, and if the level of PPE -- the minimum
23 level of PPE, whether it was level 2 or indeed level 3,
24 if you didn't think that risk that you were being
25 confronted with was being sufficiently mitigated, our

1 staff had the ability to upgrade some or all of their
2 PPE in order that they felt safe. And that was no
3 different when we got into these dreadful handover
4 delays in the winter.
5 LADY HALLETT: Sorry to interrupt, does that depend on,
6 whether they could upgrade, whether the equipment was on
7 the ambulance?
8 A. I absolutely accept that that is also down to
9 availability. But the point I was making was they
10 already did have the ability to upgrade where that
11 equipment was available and it should have been made
12 available.
13 MS HANDS: It's right, though, isn't it, that there was no
14 guidance on how to actually conduct that dynamic risk
15 assessment until 2022?
16 A. There may not have been specific written guidance, but
17 our staff are well trained, professional colleagues
18 right across the country, that, by their own
19 admission -- and I fully understand that -- were feeling
20 enormously vulnerable, and they felt that the PPE that
21 they were being advised to wear was inadequate, so by
22 definition, if they had established that they believed
23 the PPE was inadequate, they had already undertaken the
24 dynamic risk assessment, even it was just
25 subconsciously, and therefore they could have and were

1 able to, subject to the equipment being available --
2 been able to upgrade any item or all of the items of
3 PPE.
4 **Q.** Ms Nicholls from the College of Paramedics told the
5 Inquiry that it was impossible to carry out a risk
6 assessment about Covid because you didn't know what you
7 were going to and staff would often be working on a
8 closed basis with no windows and she wasn't aware of any
9 training for Covid risk assessments specifically.
10 Do you think that would have been helpful to have
11 training or guidance earlier than 2022?
12 **A.** I think it would have been very helpful if we had used
13 language, narrative, that was much more straightforward
14 for our crews. Using terminology like a "dynamic risk
15 assessment" and "hierarchy of control" when actually we
16 were saying "If you don't feel safe, upgrade your
17 PPE" -- would have been much more straightforward.
18 I entirely accept that.
19 **LADY HALLETT:** It doesn't seem to be an NHS thing, speaking
20 in plain English.
21 **A.** No, it's a challenge, and we need to get better at that,
22 my Lady.
23 **MS HANDS:** The outcome of the College of Paramedics raising
24 those concerns and the UK IPC cell considering them was
25 that there was no change to the national PPE guidance or

1 any changes for the ambulance setting at that time; is
2 that right?
3 **A.** That's my understanding, that's correct.
4 **Q.** And there were a set of suggestions made as to how the
5 risks could be mitigated.
6 So if we could have on the screen, please,
7 INQ000412354 -- thank you -- and just down to the bullet
8 points.
9 If I can just summarise these, essentially they
10 advise that: patients should wear a surgical mask at all
11 times where possible; minimise people accompanying the
12 patient; avoid sitting face-to-face; maintain
13 ventilation systems; rotate clinicians regularly; and
14 decontaminate more frequently.
15 Those suggestions appeared a bit later on in
16 statements by the AACE. Ms Nicholls told us about how
17 she was disappointed by this response.
18 Mr Marsh, were these suggestions practical in the
19 ambulance setting, for example the back of a cab, in the
20 middle of winter during these handover delays?
21 **A.** Well, so I think a couple of things. Firstly,
22 I absolutely recognise the stress and the anxiety our
23 staff were under. I share that absolutely. But I also
24 think that taking a sensible approach as best we could,
25 within the circumstances ambulance crews work, of as

1 best you can ventilating the ambulance, the patient
2 wearing a mask where that wouldn't undermine their
3 clinical treatment and wiping down are good measures.
4 Most of those -- with the exception of the patients
5 wearing a face mask, most of those measures would have
6 been taken as business as usual anyway.
7 And I accept, you know, in the winter you wouldn't
8 want to leave both of the back doors wide open for all
9 of the time, but you could leave a door slightly ajar.
10 Because we are into a balance of risk, trying to
11 mitigate the risk of any potential transmission but also
12 protecting the patient as well.
13 **Q.** Another matter that was discussed on the same topic of
14 the back of ambulance cabs is that of ventilation. In
15 fact it was discussed that UK IPC cell in June 2021,
16 where it was recorded that Public Health England had
17 raised concerns about poor ambulance ventilation, but it
18 wasn't taken any further as events and moved on and the
19 scenario was no longer relevant.
20 Was the lack of ventilation and extraction in
21 ambulance vehicles and the unique environment of the
22 back of an ambulance cab given enough attention and
23 guidance during the pandemic?
24 **A.** I believe it was. That's not to say that we could have
25 communicated to our staff in a much more straightforward

1 way. But, as I understand it, advice was given to crews
2 to set the ventilation system to extract in the back of
3 the vehicle, that the changes per hour -- the minimum
4 standard in the changes per hour in the back of an
5 ambulance is 20 per hour. In hospital rooms, it's about
6 12 and in the specification of the ambulances in my
7 service it's 20 times per hour.
8 And of course there was also the option, where
9 appropriate, to leave one of the doors ajar as well to
10 be able to provide fresh air ventilation into the
11 ambulance as well.
12 **Q.** The delays that we were looking at continued, as we saw
13 in that graph, and in an AACE report they concluded that
14 12,000 patients by the end of 2021 could have
15 experienced severe harm, including patients with Covid
16 who needed continuous oxygen therapy.
17 Was enough done at a national level to prevent
18 these delays increasing and what more could have been
19 done?
20 **A.** Well, I raised my deep concerns in relation to ambulance
21 crews being unable to hand over their patients promptly.
22 Almost on a daily basis. There were various meetings
23 and national meetings on the pressures across ambulance
24 services every day and everyone was aware -- we've
25 mentioned earlier the National Ambulance Coordination

1 Centre live dashboard that included long delays, there
2 were daily reports setting out the numbers of lost hours
3 in each ambulance service, the longest delays at each of
4 the most challenged hospitals across the country. So we
5 were all aware, everybody was aware of the enormous
6 pressures. And despite everyone's best efforts,
7 unfortunately, those delays in handing over patients
8 continued.
9 **Q.** Moving on to non-emergency patient transport services,
10 were you aware of concerns around the issues with social
11 distancing when conveying multiple patients to hospital
12 in those vehicles?
13 **A.** Yes, and that's why national guidance was issued, yes.
14 **Q.** It wasn't issued until September 2020, though, was it?
15 **A.** I think it was issued -- there was clarification and
16 changes in September but the initial guidance was
17 published much sooner, I think March 2020.
18 **Q.** And were you aware and did you help with resolving
19 issues around access to the national PPE supply for
20 those providing non-emergency patient transport services
21 that were not part of the NHS?
22 **A.** I wasn't aware there were challenges, only much more
23 recently, that some non-NHS PTS providers experienced
24 difficulty. Which is a great shame because, frankly,
25 had I have been made aware at the time I would have

1 definitely intervened and resolved the challenges that
2 they were experiencing.
3 **Q.** Dealing briefly with aerosol-generating procedures, and
4 I really do want to deal with this briefly, but its
5 right, isn't it, that there were contrary positions
6 adopt by the different bodies, including Public Health
7 England and AACE and the Resuscitation Council UK and
8 College of Paramedics, as to whether or not CPR and
9 intubation were an AGP. Were you aware of those
10 contrary positions at the time?
11 **A.** Yes, I think -- if I may, I think it was more about
12 whether cardiac massage constituted an AGP rather than
13 any of the other procedures. But yes, I was aware that
14 there were conflicting opinions.
15 **Q.** And what role did you play in trying to assist perhaps
16 those that came to you with concerns and anxieties
17 around those different positions?
18 **A.** Two things. Firstly, to ensure that the experts were
19 aware of the concerns that were being raised by
20 ambulance staff and by paramedics, so that everyone was
21 very clear. And then, secondly, that my view was that
22 we should still continue to follow the advice of the
23 experts. They had access to all of the experience, the
24 expertise, the scientific data, and it -- therefore we
25 should follow their -- we should follow their advice.

1 **Q.** If we could, please, have up INQ000499523, please.
2 And, again, this is a quotation from the survey
3 that was commissioned by the Inquiry into escalation of
4 care, and this is the quotation I took you to earlier.
5 So:
6 "[The] example of frontline staff being left to
7 make very difficult conditions on managing critically
8 unwell patients was not being able to ventilate
9 a patient, unless we were in level 3 PPE ... Ambulance
10 staff were therefore forced to not intervene when they
11 had the skills and equipment to hand and watch people
12 die ... Arguably this was implemented to protect
13 ambulance staff from contracting COVID, but still an
14 ethically challenging time."
15 Were you aware of those concerns at the time?
16 **A.** Yes, I was.
17 **Q.** Did you do anything to try and escalate or deal with
18 those matters?
19 **A.** Well, as I mentioned, I raised the concerns of frontline
20 staff with senior colleagues. But I think the point
21 that's being made here is that the moral injury, the
22 moral harm that was being caused to frontline staff
23 because they knew -- we all know -- that time is of the
24 essence for those patients that are critically ill, that
25 we need to move forward as quickly as we can -- I think

1 the point, if I'm understanding you correctly, that is
2 being made here that staff felt that whilst they were
3 donning that level 3 PPE we were losing time to be able
4 to help that patient.
5 **Q.** And did you consider whether there might be anything
6 that could help reducing that time to don that level of
7 PPE? For example, whilst they were travelling to the
8 scene?
9 **A.** I honestly don't believe that would have been safe for
10 the crew to have done so.
11 **Q.** You've touched briefly on shortages of PPE in the
12 non-emergency ambulance vehicles. What action did you
13 take to ensure that the ambulance sector was prioritised
14 for access to and resupply of PPE and RPE?
15 **A.** I made it very clear with national colleagues that,
16 given the unique circumstances that ambulance crews work
17 in, i.e. no access to running water so it was much more
18 difficult for ambulance crews to be able to wash their
19 hands and their equipment, that appropriate PPE should
20 be prioritised to the ambulance sector. But also the
21 types of PPE as well, so, for example, the aprons.
22 **Q.** And what was the response to those requests you
23 received?
24 **A.** They were accepted. The situation was understood. The
25 request was accepted. So, for example, the slightly

1 thicker aprons were attempted to be prioritised to the
2 ambulance service, but actually that ambition to ensure
3 that those thicker aprons were sent to ambulance
4 services didn't always happen on the ground, and
5 I suspect that may just have been down to logistics, the
6 huge logistical operation that was having to be put in
7 place to get that PPE -- the right PPE to the right NHS
8 sector.
9 **Q.** And you have referred earlier in your evidence to the
10 use of the powered respiratory hoods in your trust. Did
11 you take any action on a more national level to
12 encourage the use or availability of that type of RPE in
13 other trusts?
14 **A.** Certainly the use, not the availability. That was
15 clearly outside of my control unfortunately.
16 But every ambulance service was aware that at
17 least two services had already procured the respiratory
18 hoods before the pandemic, in fact earlier in 2019, and
19 other ambulance services during the pandemic, when they
20 absolutely as well recognised the challenges of fit
21 testing and the different types of FFP3 masks that were
22 being delivered and therefore having to repeat the
23 fit testing, et cetera, several other ambulance services
24 attempted to move over on to respiratory hoods as well.
25 **Q.** Were you aware of fit testing issues?

1 **A.** Yes, that was one of the main reasons we moved to
2 respiratory hoods in 2019.
3 **Q.** And on a national level, not just on your trust, were
4 you aware of that during the pandemic?
5 **A.** Yes.
6 **Q.** And were you aware -- you have talked about those hoods
7 becoming available -- well, advising that they should be
8 looked and considered but not necessarily available. So
9 were you aware of there being issues with alternative
10 PPE being made available if fit tests were failed?
11 **A.** There was no national -- so far as I'm aware, there was
12 no national alternative to FFP3s. Respiratory hoods, to
13 the best of my knowledge, weren't being made available
14 through the NHS push stock.
15 **Q.** I think in fact it's one of your recommendations, that
16 that should be considered; is that right?
17 **A.** Absolutely, my Lady, yes.
18 **Q.** Dealing with the issue of Covid-19 testing for ambulance
19 workers, can you explain what your involvement in that
20 was, please.
21 **A.** Yes. As soon as testing was being made available,
22 I made it very clear, nationally, that I believed that
23 ambulance staff, critical ambulance staff, should be
24 including early testing. By "critical" I meant
25 frontline crews, paramedics, but also the control room

1 staff as well. I truly believe those staff needed to be
2 included in the early roll-out of testing. And that
3 advice was accepted as well.
4 **Q.** You've said in your statement, on the topic of risk
5 assessments for staff, that you were aware that some
6 ethnic minority staff felt that risk assessments had
7 tokenistic and failed to lead to sustained change or
8 action.
9 Did you take any action in response to such
10 concerns or did you have those concerns at the time and,
11 if so, did you make any response to them?
12 **A.** I wasn't aware of specific concerns absolutely at the
13 time, which was around May 2020, but certainly I was
14 doing everything I could in my own trust to make sure
15 that we firstly protected our vulnerable staff,
16 particularly our BME staff, and equally importantly that
17 they understood that we were doing everything we could
18 to protect them as well.
19 **Q.** Do you think there should have been a national risk
20 assessment tool for the ambulance sector specifically?
21 **A.** I think a standard risk assessment would have been
22 helpful. Each individual ambulance service developed
23 their own risk assessment but I think a standard
24 national risk assessment would have been helpful, yes.
25 **Q.** And were you aware in your national roles of issues

1 implementing or following risk assessments in other
2 trusts?
3 **A.** No.
4 **Q.** You've said in your statement that your belief is that
5 IPC guidance was sufficiently clear for the ambulance
6 sector setting and there were clear definitions for what
7 procedures constituted an AGP. Based on the evidence
8 you've heard, do you accept that there were those on the
9 ground implementing that guidance who did not agree with
10 that assessment of it?
11 **A.** I think, if you don't mind me saying, if the question is
12 do I believe the guidance was clear, I do believe the
13 guidance was clear. If the question is slightly
14 nuanced, insofar that did everyone agree with the
15 guidance, I think that's slightly different. And
16 I think there were other things at play as well.
17 **Q.** Would you accept that others may have formed the
18 contrary view that it was clear?
19 **A.** Yes.
20 **MS HANDS:** My Lady, I have just a couple more topics but
21 I wondered if that might be a convenient place to break.
22 **LADY HALLETT:** How long do you think your couple of topics
23 will take?
24 **MS HANDS:** No longer than 15 to 20 minutes, my Lady.
25 **LADY HALLETT:** Oh, another 15 minutes. Are you all right to

1 come back this afternoon, Mr Marsh?
2 **A.** Yes, my Lady.
3 **LADY HALLETT:** Very well. I shall return at 1.45.
4 **(12.47 pm)**
5 **(Luncheon Adjournment)**
6 **(1.45 pm)**
7 **LADY HALLETT:** Ms Hands.
8 **MS HANDS:** My Lady, good afternoon.
9 Mr Marsh, I have just two short topics left to
10 cover with you, and the first is in relation to
11 Long Covid.
12 I acknowledge that you say in your statement that
13 you didn't in fact provide any advice or information on
14 Long Covid during the pandemic, and you've referred to
15 guidance produced in England for the sector in
16 July 2020.
17 The Inquiry has heard evidence from -- has
18 received evidence from the Welsh Ambulance Services, who
19 developed an action card called "Guidance for Employers"
20 to inform them on how to manage Long Covid
21 sickness/absence as an employer from March 2021. Do you
22 think anything more could have been done on a national
23 level in England to support sufferers from Long Covid in
24 the ambulance sector?
25 **A.** Guidance was issued by NHS Confederation for all NHS

1 organisations, which I know the ambulance sector
2 followed, and the principles of the way in which we
3 cared for staff suffering Long Covid was built upon that
4 which we already provide for staff suffering other
5 conditions as well.
6 **Q.** Can you provide a couple of examples of those
7 principles, please.
8 **A.** Yes. So certainly staff that may be unable to undertake
9 a full range of shift duty, so there may be staff that
10 just can't work nights anymore and, therefore, we can
11 provide flexibility around their shifts, but also
12 suitable alternative employment. So there may be a
13 particular individual that undertakes a role that is of
14 a physical nature, maybe a paramedic on the front line,
15 and therefore we could offer them alternative employment
16 working in the control room, so it's less activity, less
17 strenuous, maybe with less shift work, shorter working
18 days. Whatever was required to best accommodate their
19 needs in order to keep them in the workplace and keep
20 them gainfully employed.
21 **Q.** Moving on then to the topic of mental health and
22 well-being support for the ambulance sector, the Inquiry
23 has received an expert report from Professor Snooks
24 which touches upon the absence rates in the sector,
25 which we've already discussed but also the stress,

1 anxiety and depression which was the single biggest
2 reason for sickness absence among ambulance staff both
3 before and during the pandemic.
4 So given that data before the pandemic, should
5 mental health support have been included in pandemic
6 planning for the ambulance sector?
7 **A.** Yes, I believe it should have been, and certainly we
8 will continue to build upon the arrangements which were
9 in place before the pandemic and during the pandemic
10 into plans going forward, and I know that all ambulance
11 services have really strengthened their work in relation
12 to health and well-being support for all of our staff,
13 our volunteers and our students.
14 **Q.** And it's right that the College of Paramedics issued
15 guidance in April 2020 to support managers with
16 supporting their employees with mental health and
17 well-being. There wasn't any national guidance or
18 advice on managing mental health and well-being at that
19 time, was there?
20 **A.** Not specifically in relation to the pandemic, no.
21 **Q.** And it's also right, isn't it, that in August 2021 the
22 chief executives of trusts in England came together to
23 request immediate additional support for employee mental
24 health support until -- and that was issued until the
25 end of 2020; is that right?

1 **A.** Yes.
2 **Q.** One of the outcomes of the pandemic has been a
3 substantial increase in the turnover of ambulance staff
4 and those that are leaving the profession.
5 In your view, was enough done at a national and at
6 a local level early enough to support the mental health
7 and well-being of ambulance staff during the pandemic?
8 **A.** Well, the first thing I would say is that attrition
9 levels vary quite considerably between ambulance
10 services and I think that is one of the factors as
11 a result of the support that individual ambulance
12 services provide. But I do absolutely recognise there
13 is a lot more that we should be doing both nationally
14 and locally to support our staff, for them to be able to
15 give of their best looking after all of our patients
16 every day, and in particular recognition of the enormous
17 pressure that we were all under in response to and
18 during the pandemic. And I think our staff deserve it.
19 You know, I am enormously proud of all of our
20 staff, our volunteers, our students, staff that retired
21 that returned to work to deal with the pandemic. I am
22 enormously proud of all of those individuals that
23 stepped forward, often in harm's way, and gave their all
24 to keep as many patients safe and to save as many lives
25 as possible.

1 So by offering greater health and well-being
2 support in part is also a recognition of everything all
3 of our staff did on the front line and in our control
4 rooms and working alongside our union staff
5 representatives as well is so, so important going
6 forward.
7 **Q.** And you've summarised in your statement what your main
8 objectives were as a national adviser for the ambulance
9 sector, and they were to protect staff, to maintain a
10 safe 999 service, increase capacity in ambulance
11 emergency operation centres and crews, reduce handover
12 delays, and mitigate the possibility of services being
13 overwhelmed.
14 Upon reflection, do you believe those objectives
15 were achieved during the pandemic?
16 **A.** In the main, yes.
17 **Q.** Mr Marsh, do you have any other lessons or
18 recommendations for the future that have not already
19 been covered in your evidence today?
20 **A.** Only those that I've set out in my witness statement, my
21 Lady.
22 **MS HANDS:** Thank you.
23 My Lady, I don't have any further questions.
24 **LADY HALLETT:** I have been asked to ask you a follow-up
25 question, Mr Marsh. The question is this: if you took

1 the view that the national IPC guidance was adequate
2 requiring FRSMs with a dynamic risk assessment, if you
3 were satisfied with the guidance in your role as chair
4 of the AACE, why did you make respirator hoods mandatory
5 across the entirety of the West Midlands Ambulance
6 Service?
7 **A.** Thank you, my Lady.
8 The hoods that we made available to all of my
9 staff in the West Midlands in 2019 were for specific
10 airborne transmission viruses and other high consequence
11 infectious diseases. They weren't for all patients. So
12 that would have applied, then, when we got into the
13 pandemic: the use of those hoods would have applied to
14 those staff undertaking AGPs and as part of the dynamic
15 risk assessment or just, plain speaking, a member of
16 staff that felt vulnerable to upgrade to wearing the
17 hood for all other patients. It wasn't that the hood
18 was made mandatory for all patients, only those for AGPs
19 and for those crews that thought the patient justified
20 the situation, justified them wearing the respiratory
21 hoods.
22 **LADY HALLETT:** I think the point being made is that if the
23 national guidance is saying that those of your staff
24 who, with those strict conditions, would be wearing
25 hoods in the West Midlands, why is it that you were

1 prepared to accept the IPC guidance nationally so that
2 the ambulance service in, say, the South East would be
3 wearing fluid-resistant surgical masks? I think that's
4 question, and Mr Simblet is nodding.
5 **A.** If the patient was having an AGP performed upon them
6 then they would not have been in a type 2 mask. The
7 crews would have been wearing FFP3, if they didn't have
8 a respiratory hood. Whereas in the West Midlands we
9 didn't have FFP3s, they had been withdrawn. So for AGPs
10 it was the hood, and for all other patients, unless
11 following a dynamic risk assessment justified the
12 wearing of a hood, then the staff would have been
13 wearing surgical masks in the West Midlands as they
14 would everywhere across the country.
15 **LADY HALLETT:** I think I have taken it as far as I can,
16 Mr Simblet, thank you.
17 Those are all the questions we have, Mr Marsh.
18 Thank you very much for your help and I'm sorry we had
19 to bring you back over the lunch adjournment. Very
20 grateful to you.
21 **A.** Thank you, my Lady.
22 **(The witness withdrew)**
23 **LADY HALLETT:** Mr Mills.
24 **MR MILLS:** My Lady, may I please call Ms Tilna Tilakkumar.
25

1 **DR TILNA TILAKKUMAR (affirmed)**
2 **LADY HALLETT:** I hope we haven't kept you waiting too long,
3 Doctor.
4 **Questions from COUNSEL TO THE INQUIRY**
5 **MR MILLS:** Your full name, please.
6 **A.** It's Dr Tilna Subanthi Tilakkumar.
7 **Q.** Dr Tilakkumar, you have provided a statement to the
8 Inquiry. For the transcript, the reference is
9 INQ000492278.
10 You completed your training as a GP in
11 December 2022?
12 **A.** Yes, that's right.
13 **Q.** Prior to that, and I'm summarising, you attended medical
14 school from 2009 to 2015. That was at Barts and The
15 London School of Medicine?
16 **A.** *(The witness nodded)*.
17 **Q.** Before starting your GP training in August 2019?
18 **A.** Yes.
19 **Q.** In February 2020 you started a six-month rotation with a
20 community adult mental health team; is that right?
21 **A.** Yes.
22 **Q.** Could you just describe for us the pattern of your
23 working day there before the pandemic.
24 **A.** So this was a community adult mental health team. I was
25 a junior member of that medical team. There was myself,

1 another two psychiatry trainees and a consultant, as
2 well as mental health nurses, therapy staff and social
3 workers.
4 We had a patch, a locality that we would look
5 after. My day-to-day work was clinic, so outpatient
6 clinics of patients with chronic mental health
7 conditions. We would, on occasion, do scheduled home
8 visits for patients who were too unwell to attend
9 clinics, but it was all face-to-face appointments, and
10 then I also did on-calls to look after the inpatient
11 mental health patients.
12 **Q.** On 25 March 2020, you were at home on annual leave and
13 you received a phone call from a consultant within your
14 home trust. Tell us about that call, please.
15 **A.** Yes, it was a very brief call. We were already in
16 lockdown at that point, so my annual leave was spent at
17 home, and I was told that there was a Covid -- suspected
18 Covid outbreak on one of their inpatient wards and that
19 they needed more medical assistance, and so I was chosen
20 as the GP registrar to go there and assist.
21 **Q.** For those of us who aren't familiar, can you just
22 introduce us to the type of inpatient ward that you were
23 redeployed to?
24 **A.** So this was a fairly unique ward. It was what we call a
25 continuing care ward. So it was for patients who had

1 complex mental health needs that would require inpatient
2 hospital care for life, and not suitable for a nursing
3 or residential home in the community.
4 **Q.** When you were told that this was happening, how did it
5 make you feel?
6 **A.** I wasn't surprised. We were already being informed that
7 redeployments were going to be happening. They were
8 happening in the acute trust close by, so I was aware
9 from colleagues that this was happening, and we were in
10 the midst of the first wave, so I didn't really have any
11 questions. I did just go along the next day, not
12 knowing what was happening.
13 **Q.** So you joined the next day, 26 March, and you worked
14 there until 29 April.
15 **A.** Yes.
16 **Q.** On the day that you joined, did you receive a risk
17 assessment about working in a ward that had Covid?
18 **A.** No.
19 **Q.** Did you ever receive a risk assessment at any point you
20 were on that ward?
21 **A.** No.
22 **Q.** Did you ask for one?
23 **A.** No.
24 **Q.** Why not?
25 **A.** I didn't realise it was a thing until it was offered to

1 me later.
2 **Q.** When you say it was offered to you later?
3 **A.** On a different placement at a different trust.
4 **Q.** You have told us that Covid was on the ward. Were both
5 patients and staff affected at that point?
6 **A.** Yes. So the ward, which was a home to long-term
7 residents, suffered their outbreak because a small group
8 of patients from another ward was transferred into this
9 unit, because there was a Covid outbreak on that ward.
10 So it seemed like they were trying to mitigate risk and
11 move patients away from that ward but obviously one of
12 them already had caught it and spread it into this ward.
13 Initially it was one patient on arrival who had
14 a fever and by the end of the next week, when I arrived
15 on the Thursday, there was 11 patients who had symptoms
16 of Covid. Friday, it was 12, and by the following
17 Monday it was 15, and staff numbers had dropped day by
18 day as well. So we had a very skeletal team.
19 **Q.** Are you able to help us with how far below being fully
20 staffed the ward was when you joined?
21 **A.** So I was told ordinarily this would be a ward that was
22 staffed by two nurses, two mental health nurses. There
23 would be a ward manager as well, who was a senior nurse
24 but would not be doing any clinical work, and there
25 would be maybe four or five support staff as well as

1 occupational therapists, psychologists, who would come
2 in and out to do activities.
3 When I arrived there was still a senior -- the
4 ward manager and maybe one nurse and then just a handful
5 of support staff. And we did rely on community staff to
6 come in voluntarily day to day but they were very
7 patchy. We didn't know who was coming when and how long
8 they would be there for. It could be an hour, it could
9 be a whole day.
10 **Q.** Can you describe to us the work you did during your
11 first few days on the ward?
12 **A.** So when I joined part of the medical team -- the medical
13 team, I didn't explain, sorry, is two consultants who
14 would come once a week to review their patients. Then
15 there would be two ward doctors who would also come once
16 a week to mop up anything in between. It was long-term
17 residents so they didn't really require that much
18 medical input.
19 So on the first day that I arrived there was one
20 ward doctor. They were already showing signs of being
21 unwell when I met them. And so Friday they called in
22 sick, they didn't turn up, so I was the only doctor
23 there. The consultants also were off sick or on leave.
24 So I was trying to move -- the ward functioned more like
25 a care home into a medical ward, so I was trying to

1 firstly isolate patients who were showing signs of
2 Covid. It had large communal spaces. I thought about
3 isolating them into their bedrooms, perhaps cohorting
4 patients, because we didn't have enough staff to monitor
5 them one to one each so we were trying to see if we
6 could cohort them. That wasn't a possibility because
7 they had bedrooms. These were not hospital rooms that
8 they could move between very easily.
9 I set up, sort of, spreadsheets of patient lists,
10 patient names, vital signs, charts of what we call
11 national early warning system, so you can score their
12 vital signs and see who's scoring high and who needs
13 further medical assistance. We had one observation
14 machine to go round 26 patients, which we required to be
15 wiped down between each use so it took a long time.
16 This wasn't something that they would be doing
17 ordinarily on the ward, so I had to sort of signpost
18 them to what -- or show them what ranges were normal,
19 what was abnormal, what needed to be flagged to me as
20 a doctor, or the nurse.
21 Yes, it was really just trying to organise chaos.
22 **Q.** At this point had you been provided with any information
23 or guidance about how to treat a patient with Covid-19?
24 **A.** No. Nothing from the trust. It was all sort of word of
25 mouth from my colleagues in the main hospital. It was

1 largely supportive. There was nothing else we could do
2 in our healthcare setting anyway.
3 **Q.** In terms of how the patients responded to some of the
4 measures that were implemented within the ward, you
5 divided them I think into two groups. Can you describe
6 to us the two types of response that you perceived from
7 patients?
8 **A.** Yes. So these were patients with chronic mental health
9 issues. So a large majority of them were how I could
10 describe as subdued, would be compliant with
11 instructions to stay in their rooms, hypoactive, quiet,
12 and then there was a group who was more restless, more
13 agitated, and that includes the six acutely mentally
14 unwell patients who came from that other ward who needed
15 psychiatric input. One of them in particular was very
16 agitated and definitely couldn't be kept in their room,
17 would often be walking around, coming very close to you,
18 breaking that 3-metre rule, would never wear a face
19 mask, could spit as well. Yes.
20 **Q.** For those sorts of patients, what level of staff
21 supervision was required?
22 **A.** We didn't try to restrain this patient. For his mental
23 health he probably needed one-to-one observation just to
24 make sure he didn't come to harm himself, when he was
25 particularly agitated perhaps two-to-one.

1 **Q.** Moving to a different topic, you say in your statement
2 that almost immediately upon joining the ward you began
3 to have phone conversations with family members of
4 patients who were identified as potentially not
5 surviving severe illness with Covid-19 as a result of
6 their comorbidities. Are you able to describe in
7 general terms the nature of those conversations?
8 **A.** On the whole they went well. In my experience they all
9 went fine. These were long-term residents so the
10 families of these residents knew the staff, you know,
11 were happy with their care and trusted the staff and so
12 there was good communication and rapport with them
13 already.
14 They knew what was going on nationally, they knew
15 what was going on on the ward in terms of the outbreak
16 that we had here, and more and more patients were
17 becoming unwell every day and staff were going off sick,
18 so they were very understanding.
19 My conversation with them was more anticipatory.
20 So did they already have ideas, did they already have
21 wishes that they knew their loved one had about whether
22 they would want to be admitted to hospital should they
23 become unwell, would they want resuscitation, if not --
24 if their wish -- some of them would have had wishes to
25 die in their own home, which was this ward. Some of

1 them made requests for specific music to play if they
2 should be unwell and pass away on the ward.
3 So, yes, it was -- I know it was difficult for the
4 staff to have these conversations because I think there
5 was nothing that they would have been planning for any
6 time soon. These weren't particularly elderly patients.
7 **Q.** Did you personally feel equipped to both have the
8 conversations and cope with having had them?
9 **A.** Because of my experience before GP training I'd done
10 quite a few years in geriatrics already so I did feel
11 comfortable having these conversations but it's always
12 difficult when it's a patient you don't know, relatives
13 you don't know, and doing them over the phone and not
14 face-to-face is very difficult.
15 **Q.** Can I ask you about PPE and IPC guidance. When you
16 arrived on the ward, what were the standard PPE
17 requirements that you were expected to wear?
18 **A.** I do not know if it was a guideline or guidance but what
19 was happening on the ward was that everyone was wearing
20 full PPE. So that was a surgical mask, gloves, apron,
21 shoe covers, at all times everywhere on the ward, and
22 then at some point, in the middle of the next week, we
23 were downgraded to only having to wear that when we were
24 in contact with the Covid patients.
25 **Q.** I'll ask you about the downgrade in a moment but first

1 can I ask you this: that was the requirement, what ought
2 to have been worn. Was the PPE always available?
3 **A.** Initially it was. When I first started towards the end
4 of March, yes, we had PPE that was accessible, yes.
5 **Q.** It sounds like you're about to say but it then wasn't?
6 **A.** Yes. When it was downgraded to only being used with
7 Covid patients then it became very hard to actually find
8 where they were and replenish stock.
9 **Q.** Were there instances of staff having to source their own
10 PPE?
11 **A.** Yes. So we -- so a lot of us used our own scrubs.
12 I borrowed some scrubs from the neighbouring trust, an
13 acute trust. We bought visors and goggles off the
14 internet. That was something that we asked for. That
15 wasn't included in the original PPE that we had, but we
16 needed that specifically for our cohort of patients who
17 could come very close to you, spit. So we did end up
18 buying those ourselves because they never came from the
19 trust.
20 **Q.** Were you reimbursed?
21 **A.** No.
22 **Q.** You have referred to the downgrade. Can I ask you this,
23 how were the changes in that guidance communicated? How
24 were you told that the PPE you had been wearing was in
25 effect no longer required?

1 **A.** Verbally. So we would get visits from managers to the
2 ward on a daily basis, different managers, different
3 roles that we didn't always understand but, yes, we
4 would be communicated verbally or it would be through
5 maybe a Teams call to our ward manager and our ward
6 manager to us on the ground.
7 **LADY HALLETT:** I am terribly sorry, I am going to have to
8 rise.
9 **(2.13 pm)**
10 **(A short break)**.
11 **(2.19 pm)**
12 **LADY HALLETT:** Sorry about that, everyone. I suppose if you
13 are going to feel sick you might as well do it with a GP
14 in the witness box. Everyone stay away from me is all
15 I can say. I'll think I'll be all right. If I make
16 another rush for it, you will all know what is
17 happening.
18 **MR MILLS:** Thank you, my Lady.
19 Dr Tilakkumar, you were just explaining the
20 communication of the downgrade in PPE requirements. Can
21 I ask you this: having become accustomed to wearing
22 a certain level of PPE and that level being downgraded,
23 how did you and the other members of staff on the ward
24 feel about your safety?
25 **A.** As far as we were concerned nothing had changed in our

1 clinical environment. We were still dealing with at
2 least 15, probably more, patients with Covid at that
3 point. None of them were successfully being -- not all
4 of them were being successfully isolated at that point.
5 So there was no guarantee that we could contain Covid to
6 bedrooms, so the entire ward was a Covid ward as far as
7 we were concerned and PPE needed to be worn at all
8 times, and I know some staff members did continue to
9 wear PPE at all times.
10 And there was an incident where a visiting manager
11 did come and see a healthcare assistant wearing
12 a plastic apron and she pulled it off her. And the
13 healthcare assistant was black and the manager was not.
14 **Q.** Because the healthcare assistant was wearing that apron
15 somewhere where the guidance said you do not need to?
16 **A.** Yes.
17 **Q.** Can you tell us about your experience of being fit
18 tested for FFP3 masks.
19 **A.** So this was something that I was asking for and was
20 being rolled out at the trust anyway. On Friday,
21 3 April we had fit testing on the ward. I called in my
22 colleagues who worked in other places on the site to
23 come to the ward and have fit testing and then realised
24 they were using FFP2 masks, so I told them to stop. And
25 we did later have FFP3 masks tested at various points

1 over the next few weeks.
2 I failed on two of the masks and I passed on
3 a third. That was by the end of April.
4 **LADY HALLETT:** Can I just check. Are you using FFP2 in the
5 same sense as the previous witness? The blue masks that
6 we all got used to seeing or do you mean the actual
7 specialist FFP2 which is one step down from the FFP3?
8 **A.** Yes.
9 **LADY HALLETT:** Thank you.
10 **MR MILLS:** Did you ever have a day where you wore an FFP3
11 that had been fit tested correctly to you?
12 **A.** No. We were told they really only needed to be used
13 during aerosol-generating procedures, so that was only
14 CPR, so I didn't have to wear it in any case in the end.
15 **Q.** Before you had your successful fit test, you've just
16 touched on it in respect of CPR, it is right, isn't it,
17 that you had a serious concern about who might be able
18 to perform CPR on the ward?
19 **A.** Yes. I mean, all our staff are trained in CPR so we
20 could all initiate it, but as the doctor, especially on
21 call, you would obviously be looked to to be the one who
22 would lead the basic life support until paramedics
23 arrive.
24 **Q.** Did testing become available whilst you were working on
25 the ward?

1 A. Testing for staff was available if you were symptomatic.
2 That was across the trust which covered multiple sites,
3 and there were only 35 tests available a day. Tests for
4 patients did come in at some point and that was being
5 done on a weekly basis when it did start.
6 Q. Did you ever receive a test?
7 A. No, I didn't show any signs, so I never had an antigen
8 test but I did have the blood test for PCR antibody done
9 in May. That was being done by my other trust that
10 I was employed by and I tested positive for antibodies,
11 which did suggest that I had been exposed and had a
12 reaction to Covid.
13 Q. During your time on the ward, I think it's right, isn't
14 it, that you requested that you and your partner be
15 moved into hotel accommodation. Can you tell us about
16 what prompted that request?
17 A. Both -- so I was working on a Covid ward and my husband
18 was working in A&E at the time, at a different trust.
19 We were both living with my parents at the time, who
20 were both in their late 60s. Initially it didn't occur
21 to me that we would need to probably shield from them or
22 they would have to shield from us but, as time went on,
23 and I realised how serious Covid was and how prevalent
24 it was on our ward and how I couldn't really keep myself
25 safe from catching it, nor my husband, we asked for

1 accommodation to shield my parents.
2 Q. Was it provided?
3 A. Yes.
4 Q. How long did it take?
5 A. Maybe a week.
6 Q. We heard some evidence this morning from a paramedic who
7 was living in a hotel. Can you tell us about the impact
8 that living in a hotel had on you and your husband.
9 A. It was a very basic hotel but definitely not meant for
10 long-term living. There was no -- I mean, we had food
11 provided to us by the trust, so we had three meals a day
12 provided from the canteen, so we were provided for.
13 But, yes, apart from a kettle we didn't have anything
14 else in our room and laundry was difficult.
15 Q. The concerns that you have told the Inquiry about this
16 afternoon were things that you raised eventually with
17 the trust; is that right? What, if any, response did
18 you receive from management after you raised those
19 concerns?
20 A. So I raised concerns throughout the time that I was on
21 the ward from the very first, so I joined on the
22 Thursday and over that first weekend I drafted a very
23 long email and I sent it out to everyone that I could cc
24 in, everyone I could think of in the trust, and this
25 chain continued for over the five weeks I was on that

1 ward.
2 I did get more medical help, so I got two other
3 doctors redeployed to join me on that ward by the next
4 week but, other than that, my requests for another
5 observation machine didn't come, my requests for more
6 PPE was patchy, for other staff members was, as I said,
7 voluntary -- on a voluntary basis, so there was nothing
8 consistent. Other bits of equipment that we asked for,
9 a syringe driver for palliative care medication was
10 difficult to come by and in the end the communication
11 was getting a bit more difficult by email and then in
12 the end I was asked -- I was referred to speak to our
13 Freedom To Speak Up champion at the trust and this was
14 towards the end of April.
15 Q. Are you able to tell us about the conversation you had
16 with the Freedom To Speak Up champion?
17 A. Yes, it was -- it felt very open and very friendly. We
18 spoke for quite a while, maybe half-an-hour to an hour,
19 and I laid out all -- a summary of all the things that
20 I'd been asking for that the ward still needed,
21 equipment, more staff, better well-being facilities for
22 the staff. At that point I still hadn't been fit
23 tested, so my fit test was organised the next day, but
24 then I was also just moved back to my original placement
25 by the next day as well. The other two doctors were

1 not.
2 Q. When you returned to your previous -- this is the
3 community role, isn't it -- on 29 April, in what ways
4 had that role changed since you left it in February?
5 A. So it was mostly all -- well, it was mostly remote
6 working. Everything was being done by phone, so all our
7 appointments were by phone or video. My consultant was
8 shielding so I never actually saw him again in the
9 flesh, so all my supervision was done remotely. There
10 had to be one doctor on the team available on site so
11 we -- me and the other two doctors had a rota --
12 rotation to go into the office, otherwise we worked from
13 home with laptops.
14 Q. Did you feel as if you could provide the care you wanted
15 to patients remotely?
16 A. I don't think our number of appointments went down but
17 telephone and even video consultations does form a
18 barrier with patients who have -- already have mental
19 health difficulties. So in that way I'm not sure how
20 effective the consultations were.
21 Q. Was it possible at that time to arrange face-to-face
22 appointments with certain patients?
23 A. Not straight away. I think the clinics were still
24 closed. We could do home visits still with PPE provided
25 to us. We could go out and see patients if we needed

1 to.
2 **Q.** You then, I think, in August 2020 began a rotation in
3 obstetrics and gynaecology; is that right?
4 **A.** Yes.
5 **Q.** Whilst you were there, did you perceive the impact of
6 visiting restrictions on patients receiving maternity
7 care?
8 **A.** Yes. We -- so pregnant people were not allowed to bring
9 in anyone else to the antenatal appointments, so they
10 would attend alone. There was no visitors allowed on
11 the antenatal ward and only one birthing partner allowed
12 in the birthing suites, which were obviously private
13 suites, and then again when they went back to a
14 postnatal ward no partners were allowed -- no visitors
15 were allowed which was, yes, hugely impactful for new
16 parents.
17 **Q.** In March 2021 you rotated to general practice for the
18 first time in your training; is that right?
19 **A.** Mm-hm.
20 **Q.** Can you tell us about the IPC measures that were in
21 place at the surgery where you were.
22 **A.** Yes. We had -- we were doing everything remotely at
23 that point, March 2021. It was all video and telephone
24 calls. If we had to bring anyone in it was -- every
25 practice would be different on this but our practice, we

1 had one room that was available to bring in patients if
2 you needed to see them and you would wear full PPE,
3 which was apron, gloves, and a surgical mask, the blue
4 mask. We did have a visor as well.
5 **Q.** The patients that were attending the surgery in
6 March 2021, were you able to perceive whether there had
7 been a real downturn in their physical health?
8 **A.** Because I'd never done general practice before the Covid
9 pandemic I wouldn't know how to compare the population
10 before and after, but everyone who was asking for an
11 appointment needed an appointment, yes.
12 **Q.** Did there come a point during 2021 when you were offered
13 psychological support?
14 **A.** Yes. This was through my GP training programme. We
15 were offered -- we still had once-a-week a half-day
16 teaching session as a group and during one of those
17 sessions in 2021 we were offered sort of a break-out
18 group for those who -- it was optional if you wanted any
19 kind of debrief about the Covid pandemic. We were
20 offered a psychologist there, so it was a bit of a group
21 session. But during that session the psychologist
22 suggested that I probably should seek further
23 counselling because it might be possible that I had PTSD
24 from my time working on the Covid ward.
25 **Q.** Did you seek that further counselling?

1 **A.** I did. I asked -- I went through occupational health
2 and had a consultation and I was told that I probably
3 didn't have PTSD but I could self-refer to the trust's
4 counselling service, which I didn't do at the time.
5 **Q.** Is the impact of working during the pandemic on your
6 mental health something you still feel today?
7 **A.** Yes. I didn't -- I didn't have any problems with my
8 mental health before the pandemic. I also didn't have
9 any problems working -- with my mental health before
10 I started working in general practice. So I don't know
11 if it's the combination of working in general practice
12 in a post-pandemic world which has resulted in me having
13 now two episodes of depression, mostly from working in
14 isolation, feeling burnt out, feeling that lack of
15 satisfaction in my work that I don't feel I can really
16 help patients when they come asking for help in the NHS
17 these days.
18 **MR MILLS:** Dr Tilakkumar, thank you.
19 My Lady, that's all I ask.
20 **LADY HALLETT:** Thank you very much indeed. I'm really sorry
21 to hear about the depression. I hope the physician has
22 tried her best to heal herself but I appreciate it's not
23 something you can heal yourself and I do hope that you
24 do recover from it in the fullness of time.
25 **A.** Thank you.

1 **LADY HALLETT:** Thank you very much for what you did and
2 thank you for helping the Inquiry.
3 **A.** Thank you.
4 **(The witness withdrew)**.
5 *(Pause)*
6 **PROFESSOR KATHRYN ROWAN (affirmed)**
7 **LADY HALLETT:** Professor Rowan, I think you may have had to
8 make some rearrangements to come here this afternoon.
9 I am really grateful to you. We try to get everything
10 organised well in advance but sometimes changes are made
11 so thank you for your help.
12 **A.** My Lady.
13 **Questions from COUNSEL TO THE INQUIRY**
14 **MR FIREMAN:** Your full name, please, Professor Rowan.
15 **A.** My full name is Kathryn Rowan.
16 **Q.** Thank you. You have given a witness statement to
17 Module 3 dated 23 May 2024. That's INQ000480139. Can I
18 check that you are familiar with it and you have a copy
19 available to you?
20 **A.** I do.
21 **Q.** Professor Rowan, you are the founder of the Intensive
22 Care National Audit and Research Centre known by the
23 acronym ICNARC; that's correct, isn't it?
24 **A.** It is.
25 **Q.** You were a director of ICNARC from its inception in 1994

1 until September 2023 and you remain a scientific adviser
2 today?
3 **A.** I do.
4 **Q.** You are also an honorary professor at the London School
5 of Hygiene and Tropical Medicine?
6 **A.** I am.
7 **Q.** And you are a programme director at the National
8 Institute for Health and Care Research?
9 **A.** I am.
10 **Q.** Professor Rowan, today I would like to cover, first of
11 all, a bit about ICNARC. I then want to ask you about
12 some of the work that you have done for the Inquiry, and
13 we're then going to ask about some of the specific
14 analysis within those reports, particularly in relation
15 to patient admissions, critical care transfers, then
16 some of the pressure that was on intensive care units
17 and some of the specific characteristics of patients in
18 intensive care units.
19 So, hopefully, that's all clear for you.
20 **A.** It is, thank you.
21 **Q.** You set out in your witness statement that ICNARC is an
22 independent, scientific, not-for-profit organisation
23 which works to facilitate improvements in structure,
24 process, outcomes, and experiences of critical care and
25 it does so through clinical audit and research

1 programmes; is that right?
2 **A.** That's correct.
3 **Q.** You also describe something called the Case Mix
4 Programme. Can you tell us briefly what that is and how
5 it works.
6 **A.** Sure. So the Case Mix Programme is a national clinical
7 audit of adult intensive care or adult critical care and
8 essentially the purpose of it is to monitor care and the
9 outcomes of care across different critical care units.
10 So the way it works is that we have specified a
11 dataset to be collected by units, so a mix of electronic
12 data capture and data collection by hand, and those data
13 are sent to us on a monthly or quarterly basis. They
14 are run through a large number of validation checks to
15 get the data as accurate as possible and then we provide
16 quarterly quality reports which contain various
17 indicators around the delivery and outcomes of care to
18 compare units with each other but to actually sort of
19 benchmark across the units with a view to allowing units
20 to sort of look at their practice and also to institute
21 sort of local quality improvement programmes.
22 We also use the data, the pooled data in the
23 database, to as transparently as possible to try to help
24 patients, clinical staff, managers, policymakers to
25 understand critical care and sort of inform best

1 management, best sort of operation of critical care.
2 **Q.** You've touched on it just now, but just to be clear, who
3 do your reports actually go to?
4 **A.** So the reports go back to the critical care units that
5 submit the data but within those reports, they can see
6 and identify their own data or their own outcomes or
7 their own indicators and then they can compare them with
8 all other critical care units but also critical care
9 units that are deemed to be similar to them in operating
10 characteristics.
11 **Q.** What about national decision-makers, for example
12 NHS England or the Department of Health and Social Care,
13 do your reports go routinely to those organisations?
14 **A.** So the quarterly quality reports don't. We operate a
15 policy whereby once a year we publicly report a sort of
16 global state of intensive care in the UK, critical care
17 in the UK, but we also have a very close working
18 relationship with NHS England and the NHS sort of
19 organisations in the devolved nations and also the
20 Department of Health and Social Care. So it can often
21 be on a sort of an *ad hoc* basis that they may request
22 reports and we will undertake those analyses for them.
23 **Q.** One point which is worth clarifying is I understand the
24 Case Mix Programme applies in England, Wales and
25 Northern Ireland but not in Scotland; is that correct?

1 **A.** Yes, I think that's possibly by dint of history. The
2 Scottish Intensive Care Society Audit Group with Public
3 Health Scotland run the Scottish audit, which I think
4 set up the year before us, and it's just sort of by dint
5 of that history that we have a scope or reach for
6 England, Wales and Northern Ireland.
7 **Q.** But you and the Scottish Intensive Care Society Audit
8 Group, SICSAG, do almost identical things; is that
9 correct?
10 **A.** We do almost identical things, absolutely, but certainly
11 one of the lessons from the pandemic was we don't
12 collect exactly the same data, and I'm pleased to say
13 that one of my new co-directors today is actually up at
14 SICSAG discussing, perhaps, one of the lessons from the
15 pandemic which might be trying to make sure that we
16 collect compatible data going forward.
17 **Q.** Focusing, if we can, just on for the moment your data --
18 **A.** Yes.
19 **Q.** -- is it right that all NHS general critical care units
20 in England, Wales and Northern Ireland providing level 3
21 care, I think level 3 care is typically care that
22 involves one-to-one critical care nursing, usually with
23 mechanical invasive ventilation; is that right?
24 **A.** That is correct.
25 **Q.** All of those critical care units, you get all of the

1 relevant information within the case --
2 A. We have 100% coverage of those.
3 Q. A very comprehensive picture with respect to those
4 particular critical care units?
5 A. Yes, indeed, yes.
6 Q. Did you specifically create Covid-19-related data
7 collection sets during the pandemic?
8 A. We did not and the reason we did not was really from the
9 lessons that we learnt a decade earlier with the H1N1,
10 sort of, epidemic where we did try to identify a sort of
11 bespoke additional data collection and, of course, at
12 that point the system's not ready to adopt new data sort
13 of systems, new data structures, and the lesson we
14 learnt was to do the best we could with the data that we
15 currently collected rather than to try and burden an
16 already burdened system.
17 Q. With additional --
18 A. With additional data collection.
19 Q. You did, though, collect data on patients with critical
20 care -- sorry, patients with Covid-19 who were admitted
21 to critical care?
22 A. So, again, one of the learnings from H1N1 was that we
23 created within the new dataset following that sort of
24 some temporary fields which could identify, should
25 another epidemic or pandemic come along, we would be

1 able to kind of tag those patients, and we opened those
2 fields up -- which I'm sure is not the technical term,
3 I'm not a data or technology person -- at the beginning
4 of the Covid-19 pandemic to make sure that we would be
5 able to identify suspected and confirmed Covid-19.
6 Q. You also, I think, as a result of that work were able to
7 send, in addition to the reports we spoke about before,
8 daily emails, I understand, to Professor Stephen Powis
9 and Sir Simon Stevens at NHS England updating them with
10 respect to the numbers of patients with Covid-19
11 admitted to critical care units; is that correct?
12 A. It is correct. The way that we did that was because
13 we're aware of the burden of data collection we asked
14 the units -- and I really should shout out for the
15 amazing network of audit clerks within the critical care
16 units across England, Wales and Northern Ireland who
17 managed to keep up these data collections throughout the
18 pandemic.
19 So what we did was sort of stagger the data
20 submission so they could tell us about numbers daily and
21 then they could sort of fill in the first day's data,
22 and then the full stay data at later stages, so it meant
23 we could just keep on top of the numbers that were being
24 admitted to critical care on a daily basis.
25 Q. For how long did you continue sending those daily

1 reports to NHS England?
2 A. Daily throughout the whole pandemic. So clearly as --
3 Q. That's fine, in terms of --
4 A. As waves dropped it might have been less frequent.
5 Q. That's fine. Just to get a sense of the period in which
6 you were doing that.
7 Did you spend any specific reports similar to this
8 or identical to any of the officials within the devolved
9 nations?
10 A. No.
11 Q. Do you recall ever receiving requests from any officials
12 within Northern Ireland or Wales for similar reports?
13 A. Not for daily reporting but we did produce reports as
14 requested for both Wales and Northern Ireland just as
15 and when they requested them.
16 Q. Thank you.
17 To turn now to what the data itself is showing us,
18 ICNARC has very helpfully produced two bespoke reports
19 for the Inquiry. One of those reports was produced
20 solely by ICNARC, a lengthier report, and then a
21 combined report that was compiled alongside SICSAG, who
22 we were just speaking about. I understand you are
23 familiar with both of those reports?
24 A. I am familiar with both the reports.
25 Q. Just for clarity, with respect to the joint report, you

1 weren't involved in any of the data collection from
2 ICNARC's perspective with respect to Scotland but that
3 data has now been compared and the relevant checks have
4 taken place to ensure it's compatible with the data you
5 collected for England, Wales and Northern Ireland; is
6 that correct?
7 A. The two analytical teams worked closely together to
8 ensure that there was consistency and standardisation
9 before that report was produced.
10 Q. As a result you are able to speak to the joint report?
11 A. I am happy to speak for the two reports or the combined
12 report.
13 Q. Thank you. Just -- again, just a precursor to us
14 starting to look at this data, we're going to go to a
15 lot of graphs so I'm just going to headline that.
16 What the graphs will show us, generally speaking,
17 is a period two years or so prior to the pandemic and
18 then our relevant period for the purposes of this
19 module, which is March 2020 to June 2022, and that, as
20 I understand it, was done in order to give us
21 a reasonable comparison period; is that correct?
22 A. So I think the Inquiry, in discussion with us, agreed on
23 the periods, but, absolutely, it was about a sort of a
24 stable period of what sort of usual critical care looked
25 like beforehand and then, moving into the period, the

1 relevant period determined by the Inquiry team.
2 **Q.** If we can now go to the first graph that I'd like to
3 take us to. That's INQ -- oh, it's already on screen.
4 I will say it anyway: INQ000474239.
5 What we should see here, I hope, is a graph in
6 relation to mean daily patients admitted to critical
7 care. Are you able to explain what this graph shows us?
8 **A.** Yes, absolutely. Let me take you through it. There
9 will be lots like this so maybe I will just take
10 a period sort of -- so along the bottom, along the
11 horizontal are in weeks, so each line represents a week
12 and the data are daily but average daily for the given
13 week, and you can see the period up until the sort of
14 dotted horizontal line around the middle, which is what
15 you might call the pre-pandemic period, it's identified
16 there, and then what we would call the relevant period
17 to the right of that line, which is the period for the
18 Inquiry and obviously the period of the Covid-19
19 pandemic.
20 On the vertical axis, you can see it says "Mean
21 daily patients admitted to critical care,
22 United Kingdom", and this is from the, I think joint
23 report.
24 **Q.** This is from the joint report.
25 **A.** What you can see is usual critical care is about

1 approaching 600 mean daily patients admitted to critical
2 care, and then to the right of the line in the relevant
3 period you can see there's a quite substantial drop in
4 the mean daily patients admitted to critical care.
5 This feels slightly counter-intuitive because we
6 think about the kind of -- so this is daily admissions,
7 and so what you can see is that because critical care --
8 sorry, Covid-19 patients in critical care were staying,
9 at the beginning, about 17 days in critical care, it
10 reduced down to about 14 as it, sort of, stabilised and,
11 sort of, treatment became a little more understood, and
12 that compares with all other patients, which is a mix of
13 planned patients, elective patients, and unplanned
14 patients.
15 Unplanned patients normally stay about seven days
16 and elective and planned patients about four days. So
17 you basically have a lower admission because the beds
18 are full with these very long-staying patients. And, as
19 you can see, after each wave you can see the kind of
20 slight recovery in terms of the numbers of all other
21 patients, and that's sort of the opening up of elective
22 and planned work again, and then when the next pandemic
23 wave hits, that elective and planned work drops off
24 again.
25 **Q.** So focusing just on daily patients admitted to critical

1 care and obviously the emphasis being on patients
2 admitted --
3 **A.** Yes.
4 **Q.** -- each day --
5 **A.** Yes.
6 **Q.** -- we can see that there was a drop, as you've touched
7 on. You touch on the lack of elective care potentially
8 impacting on daily admissions. Are there any other
9 reasons that may have impacted on --
10 **A.** So just capacity. So there was a decision to, you know,
11 help the Health Service by sort of stopping and people
12 would be aware of operations being cancelled and other
13 sort of planned care perhaps not happening with the same
14 frequency.
15 The other thing that this graph doesn't show is
16 that there were critically ill patients being managed
17 outside the intensive care units. So these are patients
18 admitted to critical care. These are not patients who
19 are critically ill and there would have been a larger
20 number of patients sort of outside the critical care
21 units who were critically ill and being managed, and you
22 heard -- I watched -- Professor Kevin Fong's testimony
23 and you heard about the challenge of that management of
24 patients.
25 **Q.** Just to pick up on that, those patients who may be in

1 what may sometimes be termed "surge areas"?
2 **A.** Yes.
3 **Q.** Or areas in which they are receiving high intensity care
4 albeit it is in a general ward or in a non-ICU
5 environment, those patients wouldn't necessarily be
6 picked up by this graph; is that correct?
7 **A.** So we had some coverage of surge units but it was really
8 down to the local hospitals and their ability to extend
9 their data collection to those areas.
10 But as I understand it, there was a lot of
11 delivery of what you call non-invasive respiratory
12 support outside critical care units and a need for
13 invasive respiratory support was obviously a key or
14 other, sort of, complex organ support.
15 **Q.** What about patients potentially staying at home and
16 simply not attending ICUs?
17 **A.** So in terms of sort of the pool, yes, there's a whole
18 journey you need to think of. So you need to think
19 about the people at home on their own who maybe had
20 unwitnessed heart attacks, who in normal circumstances
21 might be witnessed and make their way to hospital and,
22 hopefully, their way to intensive care. There was some
23 notion that trauma cases reduced during lockdown because
24 people weren't out about having traumatic injuries.
25 As I say, there was a reduction in sort of stopped

1 elective surgery and other sort of more planned
2 procedures. So the pool is changing.
3 And then there was hesitancy and this is just,
4 I believe, in terms of, you know, seeking access to
5 hospital, you know, there was a sort of a stay at home,
6 help the NHS, or -- and that may have changed
7 healthcare-seeking behaviour.
8 **Q.** So a variety factors, some of which we can't see from
9 the data alone?
10 **A.** Not from intensive care data *per se*.
11 **Q.** That can come down for the moment.
12 We don't need to go to it but you have also
13 included in your report messages about all of the
14 individual nations of the UK and how they were affected.
15 The headline message, I think, is that there were
16 similar patterns in terms of mean daily admissions?
17 **A.** Patterns were incredibly similar across all four
18 nations.
19 **Q.** We do now need to go to another graph, though, which is
20 INQ000474239, page 9, and this is figure 3.
21 What we're going to look at now is the daily
22 number of patients actually in critical care as opposed
23 to the number of patients who were admitted.
24 So if we could get that up, please.
25 Yes, so we should see here what I was just talking

1 about. Can you now explain -- I think you touched on it
2 a little bit before --
3 **A.** So we can remember from the last graph that pre-pandemic
4 there were 600 patients admitted, mean daily patients
5 admitted, and this now translates to, in the
6 pre-pandemic, in more normal times, about
7 3,000 admissions in intensive care on any, sort of,
8 given day or averaged over days into the week.
9 And I think this probably now feels a little more
10 familiar, if that makes sense. So as we move -- I'm not
11 going to explain the axes again, in that the graphs are
12 so similar, but do ask me if you want me to.
13 So what you can see here is again that line moving
14 into the relevant period, and that initial drop-off is
15 actually probably the stopping of elective work, and
16 then you see the peaks of the waves of -- in orange --
17 of the patients admitted for Covid-19 and you can see it
18 is more than half the case load in critical care in both
19 the first and the second wave.
20 The third wave, as you sort of got to Delta and
21 Omicron, the other thing to just bear in mind around
22 February '21 vaccination starts to kick in and, you
23 know, one of the thankful things about the vaccination
24 policy and roll-out was it did reduce the numbers
25 getting really sick with Covid-19 and, therefore, the

1 demand on critical care did reduce in those later waves.
2 **Q.** Tying together what you told us before and you touched
3 on it briefly, are we correct to draw from these two
4 graphs that in fact the pressure on intensive care units
5 was not caused by a significant increase in the number
6 of admissions and individual patients coming into ICU on
7 a daily basis but, as you said, patients spending a lot
8 longer in ICU and, during peaks --
9 **A.** It was the --
10 *(Unclear: simultaneous speakers)*
11 **Q.** -- many of them doing that?
12 **A.** It was the numbers in critical care. So the reduced
13 admission rate is because the -- sort of, no free bed to
14 put them in. And, again, you've heard that a bed is not
15 a bed, a bed is a skilled nursing colleague and other
16 allied health professionals, and there simply -- you
17 heard how stretched they were. And you can see how much
18 they have increased their capacity. There was a lot of
19 sort of stretching to try to deliver care to as many
20 people as possible.
21 **Q.** Even with the caveats that you provided before about not
22 covering all surge areas, you can see significant
23 increases during the peak, can't you?
24 **A.** Massive, yes, and the numbers are not accurately known
25 for the numbers who were critically ill and managed in

1 surge areas that we didn't cover.
2 **Q.** Can I ask you -- that can come down for the moment.
3 Can I ask you, Professor Rowan, about something
4 you say in your witness statement at paragraph 7.3 and
5 I'll just read it out. You say this:
6 "Overall, approximately 24% fewer patients were
7 admitted to critical care for reasons other than
8 COVID-19 across England, Wales and Northern Ireland than
9 would have been expected based on pre-pandemic rates of
10 admission."
11 You then go on to say it is impossible to
12 determine exactly the causes for that.
13 Sorry, I will bear with you. It is paragraph 7.3.
14 **A.** Yes.
15 **Q.** Did you hear what I read out?
16 **A.** I'm sorry?
17 **Q.** Did you hear what I read out?
18 **A.** Could you just repeat that for me. I am sorry, I got
19 a bit distracted about finding the page.
20 **Q.** That's okay. You said:
21 "Overall, approximately 24% fewer patients were
22 admitted to critical care for reasons other than
23 COVID-19 across England, Wales and Northern Ireland than
24 would have been expected based on pre-pandemic rates of
25 admission."

1 So we've obviously just looked at admissions, both
2 in terms of the number of patients coming into ICU and
3 the number of patients actually in ICU.
4 Given what you say about there being approximately
5 24% fewer patients for non-Covid reasons, are we correct
6 to assume that there are potentially number of patients
7 with non-Covid conditions who we would normally have
8 expected to come to ICU who simply didn't for one reason
9 or another?
10 **A.** So I -- without the information, without the data on, if
11 you like, the pool of patients in hospital -- so what we
12 do know, very early on in the pandemic we did a report
13 that was part of my witness statement around what kind
14 of gains could there be made in capacity in critical
15 care by the cancellation of elective and planned work,
16 and that amounted, I think, from my memory, to about
17 sort of 20/22% of bed days that would not be occupied,
18 and therefore some of this will be the cancellation of
19 elective, sort of, and planned work.
20 But I think it wouldn't account for all of it.
21 I think if we look across the whole pandemic period
22 there was probably about, if you cover all the waves,
23 probably about 9 to 12 months of stopped or cancelled
24 elective work because obviously it recovered between the
25 waves.

1 So that would have been some of it but probably
2 not all of it.
3 **Q.** That's very clear, thank you.
4 Touching on -- well, you touched on earlier the
5 fact that there was a considerable difference in terms
6 of the average length of stay of a patient with Covid-19
7 and a patient for all other reasons. I think you said
8 something like 17 days in the beginning for a Covid-19
9 patient.
10 We heard yesterday from Dr McConnell, who is the
11 former medical director at the Western Health and Social
12 Care Trust in Northern Ireland, and she spoke about some
13 very lengthy stays in ICU in Northern Ireland,
14 particularly in her trust, in, I think, the Omicron
15 period. I'm not sure entirely. But we have
16 a particular graph which ICNARC has produced in relation
17 to length of stays in Northern Ireland.
18 So if we could just go to that, please. It's
19 INQ000480138, and we're looking at figure 96, please.
20 So if we're just looking at this graph, it looks
21 as if -- you mentioned before something to the effect of
22 17 days in the beginning, and then a reduction in the
23 length of stay of Covid-19 patients, but if we look at
24 January 2022 here, it looks as if in Northern Ireland
25 there is a significant increase, is that right, in

1 January 2022, so almost double what it was even at the
2 beginning on average?
3 **A.** So you can see that there are gaps in the orange line
4 because we don't report for small numbers, so for those
5 sort of months where there were fewer than ten
6 admissions, and the numbers are smaller in
7 Northern Ireland and also less were going into intensive
8 care in those later waves.
9 But there's no two ways about it that when you do
10 an average -- obviously you're doing an average, but
11 it's very skewed by longer-staying patients, and that
12 will have a bigger impact on a smaller number of
13 patients in the sum, if that makes sense.
14 **Q.** Sorry. So is the explanation for this that there were
15 a few -- as it sort of says in the headline, there were
16 a few patients who were spending significant --
17 **A.** Yes, who will have dragged the average up.
18 That doesn't mean that those patients did not have
19 those considerable long stays but it means that it may
20 have dragged the figure higher than what would be the,
21 sort of, what we might call more normal stay for those
22 patients. Does that make sense?
23 **Q.** I think it does but it makes it very clear that there
24 were some patients having --
25 **A.** Absolutely.

1 **Q.** -- extraordinarily long stays in ICU, particularly in
2 Northern Ireland, in January 2022, which may be quite
3 surprising.
4 **A.** So the other thing to just bear in mind is when we get
5 to Omicron, the population is more vaccinated, let's
6 say, more highly vaccinated, than in those earlier
7 waves. So the patients now getting into intensive care
8 come with much greater other sort of advanced chronic
9 conditions. So these are people who, despite
10 vaccination, Covid is a significant hit and requires
11 their admission to critical care; so sort of a much more
12 complex and a much different patient to earlier
13 pre-vaccination where it was a disease that in its own
14 in isolation would bring you into critical care.
15 **Q.** I appreciate that you necessarily have to caveat things
16 in terms of only being able to infer what the data says,
17 but would that also coincide perhaps with the fact that
18 those patients may have been shielding previously?
19 **A.** That I don't know.
20 **Q.** Okay. That can come down.
21 I want to ask you about critical care transfers.
22 **A.** Yes.
23 **Q.** So this is INQ000474239 --
24 **LADY HALLETT:** Before we move on --
25 **MR FIREMAN:** Sorry, would you like to take a break?

1 **LADY HALLETT:** I was just thinking that might be --
2 **MR FIREMAN:** -- a convenient time, yes --
3 **LADY HALLETT:** -- if you are going to a different subject.
4 **MR FIREMAN:** No, no, definitely.
5 **LADY HALLETT:** We take regular breaks, Professor Rowan. So
6 I shall return at 3.25, all being well.
7 **(3.09 pm)**
8 **(A short break)**
9 **(3.24 pm)**
10 **LADY HALLETT:** Mr Fireman.
11 **MR FIREMAN:** Thank you, my Lady.
12 As mentioned, we're going to move to critical care
13 transfers and look at INQ000474239.
14 We're looking at figure 9 here. A similar sort of
15 graph to the ones we were looking at before. Can I hand
16 over to you to explain a bit about what we can see here?
17 **A.** Sure, absolutely.
18 So, again, you've got that pre-pandemic and then
19 the relevant period and then you've got the mean daily
20 transfers between critical care units.
21 **Q.** Sorry, can I just pause you in fact to just explain what
22 critical care transfer is?
23 **A.** I'm sorry, yes, absolutely, forgive me.
24 So these are the transfer of patients between
25 critical care units in different hospitals, so they

1 don't include, sort of, movements within the same
2 hospital, which was about managing care, you know, under
3 stress and whatever, but this is where patients have to
4 be put in a transport vehicle with a team and taken to
5 another critical care unit.
6 **Q.** Thank you.
7 We can go back to what the graph shows us.
8 **A.** Okay. So I think, as others have indicated, that the
9 provision of critical care beds in the UK relative to
10 similar OECD countries is low. So we have, you know,
11 capacity issues and therefore there are transfers
12 between critical care units.
13 At the bottom there, the repatriation, that's very
14 often where perhaps you'll move to another critical care
15 unit further away, sometimes for good reasons, for more
16 specialist care, sometimes for not so good reasons,
17 which is being moved because there's no room and for
18 capacity issues or comparable care. But repatriation is
19 coming back to a critical care unit sort of near where
20 you live, so some of those can be thought for good
21 reasons --
22 **Q.** Sorry, just to clarify, repatriation is going back to
23 somewhere that is closer to perhaps where you live --
24 *(Unclear: simultaneous speakers)*
25 **A.** So if you have been moved from your original critical

1 care unit, it is a return to the critical care unit.
2 And as I say, that move may have been for more
3 specialist care or it may have been because of capacity
4 issues and therefore for just comparable care in a unit
5 with space.
6 **Q.** Sorry, just to be absolutely clear, I think because
7 we're getting a bit confused in terms of the words,
8 I think -- am I right to think that it's the other
9 reasons that might be for comparable care --
10 **A.** So those are in the orange, yes.
11 **Q.** And the repatriation --
12 **A.** Yes.
13 **Q.** -- is for care that would be closer to your home, for
14 example?
15 **A.** Yes, absolutely.
16 So what you can see here is there's about 20 mean
17 daily transfers between critical care units in the
18 pre-pandemic period. And then during the first two
19 waves you can see this threefold and fourfold increase
20 in the number of inter-hospital transfers during the
21 first and second wave and, because of the
22 differences between the Case Mix Programme and the
23 SICSAG data, we weren't able to sort of --
24 **Q.** Break down further.
25 **A.** -- break down the other reasons further.

1 As I say, patients were being transferred for ECMO
2 and very specialist services that are centralised, but
3 a number of these were, as we heard from Kevin Fong,
4 around helping units manage, particular units manage an
5 overburden of patients and moving them to units that --
6 **Q.** May have had capacity.
7 **A.** -- had space.
8 **Q.** As you touched on, you couldn't, for data comparison
9 reasons, get this data in terms of the breakdown of
10 those other reasons for the whole of there UK but you
11 can for those in the Case Mix Programme --
12 **A.** Indeed.
13 **Q.** -- in England, Wales and Northern Ireland. So I would
14 like to look at those so we can see some of the
15 breakdowns for the reasons for critical care transfers.
16 **A.** Indeed.
17 **Q.** This is in your own report, figure 13, it's
18 INQ000480138.
19 **A.** So, again, you can see consistency between these
20 because -- the dominance of England, Wales and Northern
21 Ireland, the Scottish data only bring a few more
22 numbers, but you can see that pre-pandemic there's about
23 20 mean daily transfers.
24 And, again, now what we've split here is you're
25 worried about the orange ones, that's just being

1 transferred for comparable care. More specialised care
2 is because for certain techniques that are not needed
3 all the time it's quite right to centralise those, so
4 something like ECMO, where skills are actually enhanced
5 in delivering that care and patients would be
6 transferred for more specialist care, that's in the sort
7 of bluey-grey, and then, again, you can see the
8 repatriation.
9 I guess the alarming bit for me is you can see
10 that the big uptick in the inter-hospital transfers
11 between critical care units is predominantly in that
12 sort of comparable care. And while, you know,
13 a transfer, when it's necessary, can be done safely, it
14 does come with a risk to move a critically ill patient,
15 and it comes with a burden of resources that, as we
16 know, were probably needed back in the original
17 transferring unit.
18 And there were sort of specialised transfer
19 services, sort of, established during the pandemic to
20 try to meet some of this demand, but again, you can just
21 see these huge increases.
22 Q. So just to tie up what you were saying, are we right to
23 conclude, generally speaking, that transfers for either
24 of the two blue reasons, repatriation or more
25 specialised care, may be clinically appropriate, whereas

1 transfers for the orange comparable care reason would
2 indicate that was driven by capacity concerns rather
3 than clinical need?
4 A. Yes, and ideally you would like to see none of those
5 pre-pandemic and certainly not be forced into the
6 situation we found ourselves in during the relevant
7 period of the pandemic.
8 Q. We should recognise that there are some transfers for
9 comparable care pre-pandemic, though, aren't there?
10 A. Indeed, but you can see the large increases in the
11 relevant period of the pandemic.
12 Q. That can come down now, thank you.
13 I want to ask you about, within the context of
14 pressure that's been put on critical care units having
15 looked at admissions, both number of patient admissions
16 on a daily basis and also patients in critical care and
17 critical care transfers, you talk about a concept in
18 your witness statement at paragraph 6.1 which you have
19 termed "ICU capacity strain". Are you able to explain
20 what that term is and where it comes from?
21 A. Okay. So even during normal times critical care,
22 particularly over the winter season of flu and other
23 pressures, sees situations where demand outstrips
24 supply. Demand being -- let me just make sure I've got
25 this right -- the number of patients who you want to

1 provide critical care for, and supply being the
2 available beds to deliver that care.
3 So we wanted to look at that, and we did look at
4 it some years back, and we showed that -- we created
5 a sort of concept of the number of patients in the unit
6 as you are admitted sort of tells you how busy the unit
7 was as you were admitted. So for every patient in every
8 unit you can get the -- sort of a concept of were they
9 admitted on a typical day or were they admitted on a day
10 that was lower than typical in terms of number of other
11 patients in unit or higher than typical, sort of, type
12 thing.
13 So the notion being that your first day in
14 intensive care is very important in terms of setting up
15 your care, and I'm talking now pre-pandemic, equally so
16 post -- during the pandemic, but pre-pandemic, and what
17 we showed, with careful analysis and adjusting for the
18 confounding factors of the types of patients and that
19 kind of thing, was that patients who were admitted in
20 periods of higher capacity strain were less likely to
21 survive.
22 Q. That was work that you started pre-pandemic?
23 A. That we did pre-pandemic.
24 Q. Am I right you then did some further work to adapt that
25 model for the pandemic?

1 A. So then we found ourselves in the situation where during
2 the pandemic we hadn't seen such strain on intensive
3 care units. So not unlike the comparisons here, we took
4 a period for each intensive care unit to understand
5 their typical, you know, sort of, numbers of admissions
6 daily and then we took the period of the pandemic and we
7 identified each patient as being admitted, again, at the
8 normal or typical, sort of, number of patients in the
9 unit, lower than that, higher than that, but then we
10 created this, sort of, pandemic high and pandemic
11 extreme.
12 Pandemic high was you were admitted at a period
13 that was 10 to 50% higher; pandemic extreme was the unit
14 was greater than 50% fuller than normal.
15 In that situation, again, we carried out a very
16 careful analysis, adjusting for the types of patients,
17 and what we showed was -- and I just will read this to
18 get it absolutely correct.
19 Q. Yes. I wonder, Professor Rowan, if we have on screen,
20 perhaps, your paragraph 6.4, it might help.
21 A. Yes, that would help, thank you.
22 Thank you.
23 So the bit I will read from is:
24 "For COVID-19 patients admitted during periods of
25 'pandemic high' [that's where the unit is sort of

1 anything greater than 10% but less than 50% fuller than
2 typically] or 'pandemic extreme' [greater than]
3 ICU capacity strain during the first wave, we found no
4 difference in hospital mortality ..."
5 For Covid-19 patients.
6 In the second wave, we found a 17% increase in the
7 likelihood of dying for pandemic extreme -- sorry,
8 pandemic high, and pandemic extreme was about 15%. They
9 are quite similar figures.
10 For non-Covid patients -- so alongside the Covid
11 patients at this time there are patients being admitted
12 not for Covid reasons -- there was a 16% increase for
13 pandemic high and a 30% increase for pandemic extreme
14 for -- this is a 16% increase in not surviving to leave
15 hospital alive or a 30% higher overall odds of acute
16 hospital mortality when compared with typical capacity
17 strain.
18 So what this sort of suggests to me was the reason
19 maybe that we didn't see it for Covid patients during
20 the first wave was all the attention that was being
21 placed on, you know, the delivery of care to Covid
22 patients, you know, and I felt -- you know, we've all
23 heard what our clinical teams were under in terms of
24 that but then the kind of more balancing in the second
25 wave and subsequently, whereas to be a non-Covid patient

1 in that first wave or in that second wave, which were
2 the two waves that we studied, there was a notion in
3 which, once again, with careful adjustment, that that
4 strain did impact on survival.
5 **Q.** So to take the headline message if we can from that,
6 certainly in the second wave, the peak within
7 January 2021 onwards --
8 **A.** Which is that very high one.
9 **Q.** -- it was the highest peak of the pandemic, for both
10 Covid and non-Covid patients, if you were admitted to
11 ICU during that period, you had a greater likelihood of
12 dying than if you were admitted during any other period;
13 is that correct?
14 **A.** So if you were admitted on a day where the strain was
15 higher, yes, but that's likely during the wave,
16 absolutely. And that's sort of done doing the most
17 careful adjustment that we can for other patient
18 characteristics. It's the best statistical methods that
19 we have to study this phenomenon.
20 **LADY HALLETT:** I'm afraid we're going to have to call it a
21 day.
22 **MR FIREMAN:** Yes, I'm sorry.
23 **LADY HALLETT:** I'm terribly sorry, Professor Rowan.
24 I'll see everybody at 10.00 tomorrow.
25 **(3.37 pm)**

1 **(Adjourned until 10.00 am the following day)**
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