

Tuesday, 1 October 2024

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(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

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1 Ambulance Service for over 20 years?
2 **A.** That is correct, yes.
3 **Q.** And you have described in your statement how you've
4 responded to all types of calls, from emergency
5 life-threatening incidents to non-emergency transport
6 incidents as well?
7 **A.** Yes, that is correct.
8 **Q.** And it's also right, isn't it, that you are a GMB
9 representative?
10 **A.** I am.
11 **Q.** And that's a role that you held before the pandemic?
12 **A.** Yes.
13 **Q.** And throughout as well?
14 **A.** That is correct, yes.
15 **Q.** Can you briefly describe your role and responsibilities
16 as a GMB representative during the pandemic.
17 **A.** So during the pandemic, we were asked and we were there
18 to look after the health and safety well-being of our
19 members, our colleagues. It was the governance
20 processes behind the scenes for making sure that
21 everything was as safe as possible.
22 **Q.** On a daily basis, what did that involve?
23 **A.** So there was -- for me, there was multiple meetings. We
24 were having four-hourly meetings on some occasions when
25 it was really at the height. There was the planning of

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1 the intensive care experts, who will commence giving
2 evidence slightly earlier than initially scheduled.
3 **LADY JUSTICE HALLETT:** Thank you very much and I shall of
4 course take into account the written evidence helpfully
5 provided. People sometimes forget that this isn't just
6 the about oral evidence. The Inquiry is about written
7 and oral evidence together. Thank you very much.
8 **MS HANDS:** Thank you. May I please call Mr Mark Tilley.
9 **MR MARK TILLEY (affirmed)**
10 **LADY JUSTICE HALLETT:** Thank you very much for coming along
11 to help Mr Tilley. If at any stage you feel slightly
12 distressed by what you have to tell us -- I will take a
13 break if you need me to, but sometimes I find that just
14 having a breather and a sip of water can help people
15 when they're distressed, and it's better to get it over
16 with, but I'll be in your hands. You tell me what you
17 need to do.
18 **A.** Thank you, my Lady.
19 **Questions from COUNSEL TO THE INQUIRY**
20 **MS HANDS:** Good morning, Mr Tilley. You should have your
21 witness statement in front of you, and that is
22 INQ000485988.
23 **A.** I do.
24 **Q.** Mr Tilley, it's right, isn't it, that you are an
25 ambulance technician who has been working in the NHS

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1 what PPE we had or didn't have. There was the vehicles
2 and what equipment they carried, what was wrong with
3 them.
4 **Q.** I'm going to touch on some more examples as we go
5 through this morning. In terms of your role as an
6 ambulance technician, you were, before the pandemic,
7 mostly working in a behind the scenes role; is that
8 right?
9 **A.** Yes, that's correct. So I was a GMB rep and I had
10 full-time release to be able to attend meetings,
11 policies, disciplinarys, grievances, sickness absence
12 meetings and planning of what was going on forward.
13 I undertook a certain amount of road shifts to
14 keep up my clinical skills because ultimately that is
15 what we are there for.
16 **Q.** Then, when the pandemic hit, you moved back into a
17 patient-facing role on the front line?
18 **A.** Yes, I picked up extra shifts on the front line. I
19 didn't have to, I wasn't made to, but that's where we
20 are a collective. We are a group of people. We are
21 there for our patients. Staff were falling off sick,
22 staff weren't able to attend work because of health
23 problems, therefore others had to backfill, and I was
24 one of the first to volunteer because it was the right
25 thing to do.

4

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

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- 1 in the front of the ambulance, to read what was coming
2 through, and the Airwaves radios, they were there to
3 answer that, all of which -- that they could have done
4 either over the back -- in the back of the ambulance,
5 over the Airwaves radio, and the computer we could have
6 turned off part of it. So we could have actually been
7 at the patient's side a minute, a minute and a half
8 quicker in those really most serious cases.
- 9 **Q.** Coming back to when you do arrive and what that process
10 involves, can you just briefly describe that for us?
- 11 **A.** What we ended up doing was pulling up at the scene of
12 the address and we would get out the vehicle and we
13 would have to get into the back of the ambulance to put
14 on the Tyvek suits, if that's what we were going to be
15 doing, and that meant taking off our boots because the
16 Tyvek suits most of the time wouldn't go over them,
17 which took extra time.

18 So in the back of the ambulance you would have
19 seen the ambulance rocking where we were taking off our
20 outer jacket, perhaps, if we had it on because it was
21 a cold day, putting on the Tyvek suits, and then
22 collecting the bags that we were going to take into the
23 patient's house. And all of that could have taken
24 a good couple of minutes, three minutes or so, before we
25 got to the patient's side, even if it was outside.

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

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

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1 **LADY JUSTICE HALLETT:** Sorry, standard ...?
 2 **A.** Standard load list. It's an equipment list basically
 3 for the ambulances. And on that there was three
 4 extra-large suits, three medium suits, and three large
 5 suits, bearing in mind we're probably doing -- unless we
 6 were stuck at hospital we were probably doing six jobs a
 7 day, and there's two of you, but there's six in total,
 8 various size suits.

9 Sorry, can you repeat the question --

10 **MS HANDS:** Yes, of course. You said at times there wasn't
 11 always enough and you had to consider alternatives.

12 **A.** Yes, so therefore there wasn't enough for us for the
 13 whole shift because there wasn't the availability. The
 14 aprons were in short supply, we couldn't get appropriate
 15 equipment, appropriate aprons, so we seriously
 16 considered using bin bags and literally cutting a hole
 17 in them, because that way they wouldn't blow up in front
 18 of your face and it was a barrier between your clothes
 19 and the patient.

20 Bin bags wouldn't have been the most, sort of,
 21 like, sensible but it was obviously hard times.

22 The alternative would have been that the trust
 23 provided extra uniform because we could have technically
 24 got changed between patients if we needed to, but
 25 obviously that would have meant ambulances were not

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1 non-clinical environment, because it's the front of the
 2 ambulance, but it's got equipment or exposure to bodily
 3 fluids on it right behind my head.

4 **Q.** And then coming back to when you were putting on the PPE
 5 or the RP when you arrive at the scene, what mask would
 6 you be hearing?

7 **A.** So most of the time, and obviously through the different
 8 waves and the information that was out there it did
 9 change, but most of the time it was the FFP2, just the,
 10 sort of, like, very cheap elastic band around the loops,
 11 around the ear loops. You would be wearing that in the
 12 actual ambulance to the scene.

13 **LADY JUSTICE HALLETT:** Sorry, did you mean FFP2?

14 **A.** Yes, the surgical fluid-repellant mask.

15 **MS HANDS:** I think it's FRSM.

16 **A.** Different terminology, I do apologise.

17 **MS HANDS:** Not at all.

18 **LADY JUSTICE HALLETT:** It's just that the FFP2 is a version
 19 apparently that we don't use much in the UK but is used
 20 a lot in Europe and is an alternative to the FFP3.

21 **A.** So I will be led by you, my Lady.

22 **LADY JUSTICE HALLETT:** I am learning a lot about masks.

23 **MS HANDS:** Yes, it's a blue one.

24 **A.** Yeah, the blue one, the one that you would see when you
 25 went into a hospital or whatever, we would wear them

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1 responding every time they'd finished with another
 2 patient.

3 **Q.** And then the other point you mentioned is regarding the
 4 jacket that you were wearing. Could you describe
 5 what -- when you would be required to wear that and what
 6 that was like.

7 **A.** So we all know the NHS is 24/7. For the ambulance
 8 service it's 24/7, wet/dry, hot/cold, and also the
 9 environment you're in, because personally if I'm going
 10 into a woods to go and get a patient out and it's a hot
 11 day and it's lots of overgrowth -- undergrowth and that
 12 sort of side of things, I would be putting my jacket on
 13 because it protects my arms, but if it's cold outside,
 14 if it's nighttime, you've got your jacket on to keep
 15 warm, the only thing we could do is perhaps try and
 16 Clinell wipe down the arms of your jacket afterwards,
 17 because you didn't have the time to wash your jacket
 18 between one shift and another.

19 **Q.** And would that, therefore, be over multiple days?

20 **A.** Multiple days, and with the specification of the
 21 vehicles, technically what you should have been doing is
 22 hanging your jacket up on a clip that's right behind
 23 your head. So if I was the driver it would be there, if
 24 I was the attendant it would be there, so it would be
 25 hanging down right behind me in what should be a

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1 most of the time around our buildings and in the
 2 ambulances. So we would have that on for most patients
 3 but upgrade if we were performing certain tasks with the
 4 patients or if we had a concern or, eventually, we got
 5 given the actual hoods which have got respirator
 6 masks -- battery-powered packs.

7 **Q.** Can you recall when you received the hoods?

8 **A.** I would have to check that up. It was fairly early on
 9 and I recall conversations about the fact that we had
 10 got the last batch of them because they were no longer
 11 being produced and it was a tie-over situation with what
 12 was able to be sourced.

13 **Q.** Okay.

14 Moving on to some of your work in January 2021
 15 which you have described in your statement, can you
 16 provide some more information about how your work
 17 changed during that period and what it was that you were
 18 doing?

19 **A.** So obviously we all know there was waves that was
 20 hitting different areas at different quantities/amounts
 21 and that was changing daily/weekly. Living and working
 22 out of the Bognor Regis/Chichester/West Sussex area it
 23 was quite quiet in the sense of what was going on
 24 nationally.

25 When we were having EU exit, because obviously

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1 I worked for the South East Coast Ambulance and Dover's
2 there, there was a lot of concern and work that had been
3 done for the road network because there was concerns it
4 was just going to break down and no-one would be able to
5 move, so there was about 40 of us that had volunteered
6 to go up to -- it was a hotel up in Sittingbourne and
7 work out there for at least three weeks -- it was the
8 plan -- depending on what was actually happening.

9 It was like a different world up there. We had
10 to -- we had ambulances that were brought in for us.
11 Most of them were the most run down because the local
12 areas didn't want them so that's what they provided, but
13 it was an ambulance. We begged, borrowed and stole.
14 But then that was happening generally anyway.

15 The patients were as poorly as elsewhere but
16 probably for what we'd been experiencing and seeing down
17 in Sussex was a greater requirement of care. Going to
18 the hospital -- I recall one day going to hospital about
19 an hour/hour and a half after my shift had started, so
20 I'd already got to my first patient, and we've ASHICed
21 the patient to hospital, so they were a poorly patient,
22 we've pre-alerted them. We turn up at Medway Maritime
23 and we park in a queue of ambulances, so I think we were
24 starting at -- we were doing ten-hour shifts on that
25 rota up there at the time, so it was a 6 o'clock start,

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1 then had to try and make it literally within a few weeks
2 a proper functioning ambulance station. There wasn't
3 the supplies coming through of masks or hand gel, sort
4 of, like, specialist little bits of equipment that we
5 might use on occasions. We're out and about in the
6 ambulance for the whole 10/12 hours of our shift, you
7 never know what you're going to be sent to next so you
8 need to have all of the equipment there because
9 otherwise you can't do the best for the patient.

10 So we were always trying to find -- and there was
11 blankets -- access to blankets was really tight on
12 occasions because it wasn't getting through the laundry
13 system quick enough.

14 **Q.** I think in your statement you have described some of the
15 problems with ventilation in ambulances which you have
16 just alluded to. Can you explain what those problems
17 were, in particular, in the summer and in the winter
18 months.

19 **A.** Yes. So over the years we had highlighted that the
20 ambulance was our work environment. If it's really hot
21 outside it's hot in ambulance, and the air conditioning
22 doesn't work, it's uncomfortable. We -- certainly
23 I grew up with my mum and dad and they didn't have air
24 conditioning in the car, you opened the window.

25 However, we are in a medical environment and air

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1 for example. So we were there by 8 o'clock but when our
2 shift had finished we were still there with the patient
3 in the back of the ambulance. We had run out of oxygen
4 so we'd had to scan the hospital to try to find oxygen.
5 The consultant or doctor had been out to take bloods.
6 Our patient had deteriorated quite heavily. It was
7 a snowy, cold, icy day.

8 We ordered pizza to the registration of the
9 vehicle so that we actually had something to eat that
10 day because otherwise we wouldn't have had anything to
11 eat, trying to source a cup of tea. And I know it's not
12 about us as the clinician, but we couldn't be in the
13 back of the ambulance with the patient because of the
14 exposure because we had to be out -- so slightly outside
15 the back, watching in to them, and the patient, trying
16 to look after their bodily functions, their well-being
17 as well as -- poorly as they were, out there for hours,
18 that was -- that was different.

19 **Q.** And the experiences you've described there around the
20 equipment available to you in the ambulance, was that an
21 issue that you experienced again? Did you have any
22 other experiences of that?

23 **A.** So because what the organisation had done, they'd opened
24 up an ambulance station that had been closed down,
25 obviously everything had been stripped from it so we

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1 conditioning can help reduce the temperature in the back
2 of the ambulance. So if we've got a sepsis patient on
3 board, we don't want it to be really hot in there, we
4 want to be able to start chilling it down. We didn't
5 know whether the recirculation -- the systems that were
6 in the vehicles were separate in the front of the
7 ambulance to the rear. So it -- whether the particles,
8 because obviously it was airborne, was just
9 recirculating around.

10 We still don't know as to the different vehicles,
11 because there are so many different types of ambulances
12 and manufacturers, as to whether the air goes from the
13 front to the back, we don't know whether it filters it
14 properly. But what we do know is that some of the
15 vehicles had errors and faults with them where you
16 couldn't put heating on in the front because, like --
17 and I'm not a mechanic, but that the valve isn't -- or
18 the pipe is not connected properly because it's done
19 300,000 or 400,000 miles, it's bounced off or it's not
20 been connected, and, therefore, the heat is not there
21 but without putting the recirculation on, you can't have
22 the heat and, of course, the recirculation is what we
23 didn't necessarily want unless there was a proper
24 particle filter on it.

25 **Q.** And did you receive any guidance locally or nationally

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1 about how to manage these issues?
 2 **A.** It was -- there was conversations, there was some
 3 communication but, if I may touch on the fact of
 4 communication, although believed to be quite good, that
 5 communication that was sent out, the staff were going
 6 into work picking up their ambulance and basically going
 7 straight out to patients. There was no time built in
 8 for what in hospitals they class as huddles.

9 In the ambulance sector, certainly for our
 10 organisation, there's not the time or the built-in
 11 facility to do a huddle, so you wouldn't have any
 12 important information actually directly told to you,
 13 it's only if you picked it up on an email. And with
 14 40 or 50 emails coming in, days off and then coming back
 15 to them without a sign being put up that you might have
 16 seen, you wouldn't have known that communication had
 17 come out.

18 There's no -- communication is good but actually
 19 it's about the understanding of what it's meant to be
 20 saying and that wasn't -- and never verified by anybody.

21 **Q.** And just finishing up on your time down in Kent, in your
 22 statement, and you've alluded to it just a moment ago,
 23 you have explained that you were staying in a hotel away
 24 from home down there. Can you explain the impact that
 25 that had during that period of time.

17

1 poorly patients.

2 Yeah, I'm sorry.

3 **Q.** Was there any support provided to you at the time or
 4 after that period of time?

5 **A.** So in the Ambulance Service we use a thing called TRiM,
 6 I can't remember what that acronym's for, I do
 7 apologise. That's 72 hours or so after an event, so
 8 it's fine if you've been to an individual incident that
 9 may have triggered some feelings, some concerns but
 10 this, obviously, was over a long length of time.

11 Me, because of my union role, I knew where I could
 12 go to talk to people but I'm not aware of any
 13 communication from the trust to the 40 people in this
 14 situation that went up there, let alone the rest of the
 15 staff as to: do you want to talk after the event?

16 I don't think that's ever been sent out.

17 **Q.** Continuing then on the topic of infection prevention
 18 control on the ambulance vehicle itself and access to
 19 PPE, in your statement at paragraph 11 you have
 20 summarised a number of issues that you experienced
 21 during the pandemic with those. I wonder if you could
 22 perhaps just describe some of the other issues that you
 23 had.

24 **A.** So yeah, under the topic of IPC, technically we should
 25 have got a, if you like, made-ready ambulance. A lot of

19

1 **A.** So we travelled over -- some people travelled over New
 2 Year's Eve, I travelled over the morning of New Year's
 3 Day. So we'd said goodbye to our families, we knew that
 4 was going to be for about three weeks. We were told we
 5 could go back home on our two days in a row day off, but
 6 that obviously puts extra pressure on the fact of you
 7 going home to your family and you've been in some of the
 8 worst sort of areas dealing with patients.

9 You are in a hotel room. Many of us would have
 10 stayed in a Premier or Holiday Inn in our time. That
 11 was what you were in. So you couldn't go and socialise
 12 because that was stopped at that particular point in
 13 time, so you were at work in an ambulance with your
 14 crewmate for 10 hours, 12 hours, then you'd go back to
 15 the hotel, and that's where you would sit, sleep, and
 16 you had nowhere to go. So it was the facilities that
 17 was there, the television and a phone. You had just to
 18 mull over what you'd been seeing, the queues at the
 19 hospital, the poor patients that we were going to.

20 I went over there thinking I was going to help
 21 multiple people, I probably did but it didn't feel like
 22 it, and afterwards you'd come away thinking: was that
 23 real? Did I really do that? Did I spend all that time
 24 in the hotel room, all that time sitting outside the
 25 hospital, and actually only see a few patients? Poorly,

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1 the time they had been hot-loaded, so it's just bags
 2 being replaced with the equipment, obviously fluids or
 3 spillages would have been wiped up and maybe a quick mop
 4 over.

5 When we got a patient to a hospital, because
 6 service level agreements have changed over the years,
 7 there's no mop and bucket at the hospital for us to wipe
 8 out the floor of the ambulance. We would have wiped
 9 down with Clinell wipes the stretchers and that side of
 10 things. But the masks, when you took over the
 11 ambulance, were generally -- the ones in the front of
 12 the ambulance was in the fridge. We've got cold boxes
 13 in the front of our ambulances. So if you're storing
 14 something like that in a fridge, actually how good is it
 15 actually going to be? Because of course it's going to
 16 be damp. So is it going to work? Is it suitable?

17 The dates on the gloves, on the masks, were all
 18 expired. We had concerns as to how they'd been stored
 19 because we know the government had, obviously, contracts
 20 with different individuals to store them in warehouses
 21 and we know that some of those were damp and leaky -- at
 22 least that's what I'd been told.

23 So the aprons not being suitable, the gloves being
 24 out of date, and a lot of times, because we were getting
 25 some really cheap nasty gloves, you were putting your

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1 hands straight through them. To start with, they ripped
2 and tore quite easy. The masks were being stored in the
3 fridge. If it was the more solid surgical -- more --
4 fluid -- FFP --

5 **LADY JUSTICE HALLETT:** FFP3.

6 **A.** Yes -- masks, they were stored in Chinese containers.

7 We literally got some Chinese containers, or the
8 organisation did, and that's where they stored them.

9 Now, if you go for small-size or a medium-size
10 Chinese, and you put something that's going to go over
11 your face, it's not going to fit in there, so it's
12 squashed down, and then we put that into a bag and we
13 again squashed it again to get in. So, actually, have
14 we stored it correctly? And that's what we were being
15 expected to use and trust our lives with. And obviously
16 then going home to our loved ones knowing that 24 hours
17 or 36 hours later we might have symptoms because the
18 equipment, the PPE, hadn't been stored properly and
19 wasn't in date.

20 **MS HANDS:** Yes, thank you.

21 Had you had any fit testing of those masks?

22 **A.** So previously, no. This all had to be worked up very
23 quickly. Fit testing was done. There was a process
24 that was taught to someone, that was taught to someone
25 else, that was taught to someone else and they would

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1 **A.** Not that I can recall. Because of the condition of my
2 mother-in-law -- I normally get told I speak too loud
3 when I'm talking to her, but she obviously watches our
4 lips moving and she can talk to us in her way, and that
5 taught me over the years that -- just to slow down and
6 take my time.

7 With wearing a mask, dementia patients,
8 hard-of-hearing patients and others, can't get that
9 mouth movement from you. So when the hoods became
10 available, I actually went over to wearing my hoods for
11 virtually all the patients. Which scared some people
12 because they were thinking I was bringing into hospital
13 really, really poorly patients when it was a painful
14 ankle or whatever they might have fractured, but I -- of
15 course I had my hood on. But the patients could see my
16 face. They could see expression. I wasn't taught that.
17 That was life experience that I'd done that because
18 of -- and even today, I still don't think there's been
19 any learning from any of this or that topic because
20 there are occasions when we should still be wearing face
21 masks today.

22 **Q.** Moving on to some of the non-clinical areas that you
23 would have been in during the pandemic, so in terms of
24 ambulance staff rooms and offices, were there any issues
25 with social distancing or IPC measures in those

23

1 sort of, like, try to fit test you. You had to guess
2 whether there was a sweet smell or a bitter smell, that
3 was done to see whether you'd passed or failed it.
4 I actually failed it with -- I have lost a little bit of
5 weight -- but I failed it so I couldn't be fit tested on
6 the masks that we had, bearing in mind there was three
7 or four different styles of masks and you had to be
8 individually tested on each one. And until we started
9 sourcing the hoods there was no way of actually being
10 properly protected.

11 **Q.** So during that period where you had failed the fit test
12 and before the hoods were introduced, what were you
13 wearing?

14 **A.** Before that -- well, before Covid, nothing, and since
15 the start of Covid we were at times wearing the masks.
16 Information changed. We weren't wearing then in crew
17 rooms or EOCs. We weren't obviously -- that wasn't the
18 recommendations at the time, and in the ambulance, you
19 were there, you knew that you were at work, you felt
20 fine, why would you have it on until, obviously,
21 knowledge changed and information was shared to wear the
22 masks in the ambulances.

23 **Q.** Did you receive any training or advice about how to
24 communicate with patients, for example, when you were
25 wearing the PPE, and did that cause any problems?

22

1 environments?

2 **A.** So it was very varied. We'd highlighted about space
3 over the time but obviously it's all about budgets.

4 The desk that I'm at at the moment would have been
5 in some locations a large desk for us. So if you take
6 this as being a large desk for us to have a meal at,
7 there was a white line drawn down the centre of it. One
8 would be at one end, one would be at the other end, that
9 is where we would be expecting to have a romantic meal
10 and eat our dinner. There was no social distancing in
11 some areas because it wasn't physically able to be done.

12 It depends on how far you want to take safety. If
13 we turned up somewhere and the knives and forks and
14 plates were still dirty from the last people that used
15 them, we've obviously got to wash them up, but in bigger
16 areas where -- let's use an EOC as an example --

17 **Q.** Sorry, just to stop you there. An EOC, do you mind --

18 **A.** Emergency operation centre, so the control room.
19 They've got dishwashers, but they went over to using
20 disposable plates and cups, but -- when we were on the
21 response post, where the table was this size, we would
22 have reusable stuff, which was nice for the environment,
23 sort of, side of things, but it's about where do you
24 level that risk factor.

25 In rooms, yeah, functions like human resourcing,

24

1 organisational development, finance, they just
 2 squirreled themselves away at home very quickly and went
 3 over to using Teams for everything, so that freed up
 4 a bit of space, but we couldn't -- we had to go through
 5 a process, and I'm sure other organisations within the
 6 ambulance sector elsewhere would have done, to spread
 7 out the desks that people were at to take the 999 calls,
 8 because they were a desk similar to this with two or
 9 three screens on it and there literally just banks of
 10 them. Because it's a call centre. It's gone over to
 11 the call centre environment mentality of how much can we
 12 squeeze into this space to get best value for money, so
 13 everyone on top of themselves.

14 **Q.** Did you experience or hear of any experiences that
 15 drivers in non-emergency patient transport vehicles had
 16 with IPC guidance?
 17 **A.** So in many areas, obviously, like, the patient transport
 18 services have been subcontracted out, in some areas they
 19 are still in the NHS. The majority of those vehicles
 20 would be van conversions with no bulkhead, so it's like
 21 the cab and the rear of the vehicle are all in one. So
 22 not the issue of, to a certain extent, about the
 23 circulation we had in the double-crewed ambulances, it's
 24 just literally -- because then you have got one person
 25 that's driving, goes and picks up a few walking wounded

25

1 probably just fundamentally wrong by expecting them just
 2 to follow and not ask questions.
 3 **Q.** And it is a difficult question but can you describe for
 4 us, or is there anything else you want to add, as to the
 5 long-term impact that the experience of the pandemic has
 6 had on you working on the front line and those around
 7 you?
 8 **A.** So my family was -- my family was -- I could have stayed
 9 at home and worked from home to look after my members,
 10 to look after the patients from there, because obviously
 11 some people need to be working from a non-patient side
 12 of things to have all of the cogs working in the engine,
 13 so to speak.

14 I exposed them to elements of risk that I could
 15 have avoided, and that's something that I live with, but
 16 I would be going home from work and having to strip off
 17 in the hallway so that I didn't go in in my uniform, to
 18 try and protect them. That plays on my mind. Turning
 19 up at people's houses where someone was unfortunately
 20 dead inside the front window or just on the pathway up
 21 to their property, and I've got out the vehicle and
 22 I would have normally gone over, started bouncing up and
 23 down on their chest, but we went and got our masks and
 24 suits on and all of that. That plays on my mind all the
 25 time.

27

1 people that are pre-planned into hospital.

2 It was -- sorry, what was the question?

3 **Q.** Were you aware of any issues with IPC measures in those
 4 vehicles?

5 **A.** Yeah, so it was -- because it was exposed. The driver
 6 was in there, technically, with all their patients
 7 getting on and off, and it was just that one person, so
 8 there was no separation. As to the equipment, the IPC
 9 side of masks would have been similar in the NHS setting
 10 I'm sure.

11 We had some patient transport vehicles which,
 12 because of trying to segregate, the service purchased
 13 bulkheads that was then put into the vehicles over
 14 a period of time but all too late in the day.

15 **Q.** And in terms of the information that was available to
 16 you during the pandemic, were you assisted at all by
 17 your GMB role and was the information accessible to you
 18 throughout?

19 **A.** So I was lucky/unlucky, depending on which way you look
 20 at it. I was aware of what was going on, obviously,
 21 behind the scenes. The plans about using ice rinks to
 22 store bodies, the fact of what the figures were, where
 23 the concerns were coming from, the lack of equipment.
 24 I had the ability to challenge for myself or for my
 25 colleagues the fact that we were doing things that was

26

1 Yeah.

2 Would I do it again? Yes. I'd be jumping out
 3 there straight away to go and start supporting my
 4 colleagues on the front line and responding to patients
 5 if we were to get another wave of something. Do I hope
 6 that people would question more? Yes.

7 I bottle things away. I'm quite -- I'm told quite
 8 a lot of times I'm cold. I'm not. I just deal with it
 9 in the way that I deal with it. Yeah, sort of --
 10 I think I've answered part of your question but not all
 11 of it, so do you want to rephrase?

12 **Q.** It was if there is anything else you wanted to add about
 13 the impact on you and those around you, but if that's
 14 everything, that's fine.

15 **A.** For me, I can't change history, no matter what you talk
 16 about, it's history. We can't change it. It is what it
 17 is. But what we can do is we can learn from it, we can
 18 adjust it, we can make sure it doesn't repeat again or
 19 that we've at least looked at everything at made an
 20 informed decision but all we're seeing at the moment is
 21 things have reverted back to what it was beforehand,
 22 tight spaces for working, still having out-of-date
 23 equipment, consumables on stations and getting into the
 24 system, vehicles that are not fit for purpose.

25 We're lucky, I suppose, in a way, down south. We

28

1 got quite a lot of Make Ready Centres but the concept of
 2 the Make Ready Centre was to be all-encompassing, which
 3 would mean, like, laundering the uniform rather than
 4 taking it home and using your own washing machine to
 5 wash the bodily fluids and then obviously your family's
 6 undergarments going in it following wash. All those
 7 sort of bits are what I just hope that we learn from and
 8 it's -- understanding there's budgets but actually it's:
 9 what does the public want? What does the patient need?
 10 What does the staff member that's attending the scene
 11 need to actually do their job properly?

12 **MS HANDS:** Thank you, Mr Tilley.

13 I don't have any further questions, my Lady.

14 **LADY JUSTICE HALLETT:** I don't think there are any other
 15 questions.

16 **MS HANDS:** No.

17 **LADY JUSTICE HALLETT:** Thank you very much for your help,
 18 Mr Tilley. I'm very grateful and I understand how
 19 difficult it must have been for you and your colleagues.

20 **A.** Thank you, my Lady.

21 **LADY JUSTICE HALLETT:** Thank you very much.

22 **(The witness withdrew)**

23 **MS HANDS:** My Lady, I think we will move straight to the
 24 next witness.

25 My Lady, may I call Mr Marsh.

29

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.

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1 **MR ANTHONY MARSH (sworn)**

2 **LADY JUSTICE HALLETT:** Mr Marsh, I think you are our first
 3 witness 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

30

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 JUSTICE HALLETT:** How many levels are there?

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1 A. Four, my Lady.
 2 **LADY JUSTICE 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.

33

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

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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

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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

36

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

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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

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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

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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

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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
 41

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 JUSTICE 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
 43

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
 42

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?
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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 JUSTICE HALLETT:** I think what Ms Hands is trying to
12 get at is, for the previous witness, Mr Tilley --
13 I don't know if you had a chance to listen to his
14 evidence?

15 A. Most of it I did, my Lady.

16 **LADY JUSTICE HALLETT:** The suggestion was that there were
17 some trusts certainly where the guidance that you were
18 giving, for good reason, wasn't being implemented. It
19 didn't come to your attention?

20 A. Not to my attention. I am really sorry if that was the
21 case, because the guidance was there for all of us to
22 follow, to protect all of us.

23 **MS HANDS:** You have accepted, Mr Marsh, in your statement
24 there were times during the pandemic that demand did
25 outstrip capacity in 999 call handling centres. Was

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1 clinical coding; is that right?

2 A. Correct.

3 Q. If we can have on the screen, please, INQ000479041, this
4 is taken from your statement and this sets out the
5 initial changes that were made in mid-March 2020 to
6 ambulance disposition codes within 999 and a new
7 prioritisation pathway for Covid-19 callers contacting
8 999 with breathing difficulties.

9 Could you briefly explain what this change meant
10 in practice if I called 999 with Covid symptoms, firstly
11 with breathing difficulties and then, secondly, without,
12 at this time?

13 A. When patients ring 999, once we've established whether
14 the patient's breathing or not, we ask the caller, which
15 may or may not be the patient, what the chief complaint
16 that they're suffering with is. And if they were
17 suffering with difficulty breathing or any particular
18 problem with their breathing, then normally that patient
19 would be taken through the difficulty breathing
20 algorithm. But once the pandemic protocols were
21 implemented, those patients would be taken through the
22 pandemic protocol to establish or not whether those
23 patients can be safely and appropriately dealt with
24 without an ambulance being sent or whether they need an
25 ambulance to be sent and, therefore, the speed of which

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1 enough done to prevent this happening early in the
2 pandemic, early enough in the pandemic?

3 A. I don't believe it was.

4 **MS HANDS:** My Lady, before I move on to my next topic,
5 I wonder if that might be a convenient time to have a
6 break.

7 **LADY JUSTICE HALLETT:** Certainly.

8 I'm sorry about this, Mr Marsh, but we take
9 regular breaks for the sake of everybody. I shall
10 return at 11.25.

11 **(11.09 am)**

12 **(A short break)**

13 **(11.25 am)**

14 **MS HANDS:** Mr Marsh, we're going to move on to a new topic
15 of call handling and triage systems.

16 First of all, I wanted to just establish what the
17 systems are that are used in England. So we have two
18 systems for emergency call handling -- in fact they are
19 used across the UK -- and that's NHS Pathways and AMPDS.
20 I'm going to talk about the changes to the triage
21 Pathways that were introduced into 999 and 111 in
22 response to the pandemic.

23 It's right that you chaired the Emergency Call
24 Prioritisation Advisory Group advising NHS England on
25 ambulance call prioritisation, triage systems and

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1 and the category that would be applied to that
2 particular patient.

3 Q. When you say the pandemic protocol, are you talking
4 about Protocol 36?

5 A. Yes, I am.

6 Q. That wasn't introduced until 3 April 2020. So looking
7 at the changes that were made on 12 March 2020, in front
8 of you, what was this pathway and how was this
9 different?

10 A. These were two new disposition codes that were
11 introduced to be able to identify, given the questions
12 that were being asked of patients and the definitions of
13 potential Covid at this point, if those patients
14 potentially had Covid then there was an opportunity, an
15 option, for the call handlers to assign one of those two
16 codes to that particular patient.

17 Q. What level of scrutiny did these changes undergo at this
18 time?

19 A. It was the clinical coding group, which is made up of
20 doctors, medical directors from ambulance services, and
21 the clinical director within NHS England.

22 Q. Between the introduction of this pathway in March, and
23 Protocol 36, which we'll come on to, in April, was there
24 any review of those disposition codes or any changes to
25 them?

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

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1 take 999 calls on their own.
 2 It had been drawn to my attention that a couple of
 3 ambulance services were looking to provide a shortened
 4 initial training course for new recruits, much less than
 5 the usual five weeks.
 6 **Q.** It's right, isn't it, that in fact they were looking to
 7 reduce it to one day from the five weeks?
 8 **A.** So I believed -- in at least one service.
 9 **Q.** And what action did you take in response to that?
 10 **A.** As you referred, I -- as soon as it was drawn to my
 11 attention I sent an email to all ambulance service chief
 12 executives in England saying that I didn't support such
 13 a proposition. Clearly it is a matter for individual
 14 ambulance services and their chief executives as to what
 15 training they provide but I made my position very clear
 16 that I didn't think it was sensible, the training of
 17 five weeks is there for a reason, and that if ambulance
 18 services still believed it was the right thing to do,
 19 they needed to ensure that the training that they were
 20 going to provide, the shortened course, still met the
 21 requirements of the licence and the requirements of the
 22 regulator for that particular provider of the triage
 23 system.
 24 And then, second, it was followed up with
 25 a letter, which you just referred to, which again

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1 Is this an example of when it wasn't implemented
 2 quickly enough?
 3 **A.** No.
 4 **Q.** The current AACE chair has provided a statement to this
 5 Inquiry and he has referred to trusts requesting
 6 permission to shorten call handling triage before
 7 Protocol 36 was introduced, and in fact you wrote to
 8 ambulance trusts in England on 7 April -- so a few days
 9 after Protocol 36 was introduced -- with agreed
 10 principles to allow trusts to make changes to their call
 11 handling process, and AACE developed a set of codes that
 12 they could use alongside it.

13 Why were these principles and this set of codes
 14 produced at this time when Protocol 36 had been
 15 introduced?

16 **A.** There's two separate issues here. We've talked about
 17 Protocol 36 and the escalation. This particular
 18 reference is in relation to a shortened training course
 19 for new 999 call handlers.

20 The usual duration of training for new call
 21 handlers is about five weeks, plus several weeks, maybe
 22 up to two months, where new staff, having completed
 23 their training, then work in the control room alongside
 24 existing experienced members of staff to gain their
 25 competence and to build their confidence before they

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1 reaffirmed my position but also did include some
 2 principles that if an ambulance service still believed
 3 it was the right thing or it was necessary for them to
 4 do, that they should at least apply and adhere to those
 5 principles that were set out by AACE.
 6 **Q.** Were any changes to the length of training monitored at
 7 a national level?
 8 **A.** No, it was a matter for individual ambulance services.
 9 **Q.** Were you aware of any guidance or advice that was in
 10 place to support, for example, new call handlers around
 11 decision-making on the type of assessments that they
 12 were offering to callers? For example, whether they
 13 were passed on to a clinical call handler for an
 14 assessment or remote assessment?
 15 **A.** Are you referring to the new call handlers?
 16 **Q.** Well, both.
 17 **A.** Well, those arrangements exist business as usual. Call
 18 handlers are able to either transfer 999 callers or,
 19 indeed, once they've closed the case, then place that
 20 case on the queue for paramedics and nurses to call
 21 those patients back where that's necessary, and control
 22 rooms generally have at least one paramedic that's
 23 available to provide, in real time, clinical advice
 24 whilst that call is in progress as well. That's
 25 business as usual.

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

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

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

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

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1 document, please, where it's highlighted, and the
2 escalation levels that we've just been looking at were
3 discussed at this meeting and we can see here that it
4 says that the position was summarised as EMAS and
5 NWS -- now they are two different ambulance services,
6 aren't they?

7 **A.** Correct.

8 **Q.** -- were withdrawing their request to escalate following
9 clarification. However, NASMeD -- and that's the
10 National Ambulance Service Medical Executive Directors'
11 Group, isn't it?

12 **A.** Medical directors, yes.

13 **Q.** -- had not withdrawn their request:

14 "In essence the process is not working as
15 envisaged."

16 And somebody confirmed that YAS -- and that's
17 another ambulance service, is that right?

18 **A.** Correct.

19 **Q.** -- had withdrawn their request and no further requests
20 to escalate were received.

21 What this is essentially showing is that three
22 ambulance services had requested an escalation to
23 a higher level but their requests had been withdrawn; is
24 that right?

25 **A.** Correct.

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1 and -- yes, thank you -- the major incident update in
2 the North West Ambulance Service, here a major incident
3 was declared and the stack of holding calls was reduced
4 from 520 to nearer 250, and it caused in the Greater
5 Manchester area extensive delays, lost hours at ED.
6 Then there was reference to a suspension of meal breaks
7 and a request for a report. "SoS" -- is that the
8 Secretary of State?

9 **A.** I believe so.

10 **Q.** Thank you.

11 Is this one of the consequences on a regional
12 level of that decision not to allow for a regional
13 approach to the levels?

14 **A.** No, not at all.

15 **Q.** Can you explain why?

16 **A.** Of course. Individual ambulance services already have
17 their specific surge plans, and whilst REAP is in place
18 for a longer period of time, which we've discussed
19 already, the individual surge plans are on-the-day,
20 in-the-moment plans that deal with rising surge as
21 increases in demand occur during the day or maybe
22 handover delays deteriorate during the day or maybe
23 inclement weather causes disruption for the ambulance
24 service response.

25 So the individual ambulance service, so North West

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1 **Q.** But, despite that, NASMeD were of the view that there
2 should still be consideration of an escalation to a
3 higher level.

4 In the second part of that box there is
5 a suggestion that the previous barrier to regional
6 escalation had been resolved and:

7 "[It] might open a possibility to [NHS England]
8 reviewing the process to introduce regional discussions
9 on escalation rather than the national approach
10 currently in place."

11 Why was there no review at this point of
12 whether -- or was there a review at this point, as to
13 whether a regional approach to escalation would be
14 beneficial?

15 **A.** There was a review and I did consider the benefits and
16 the disbenefits of moving from a national position to
17 allowing some regional flexibility but, on balance,
18 I still held the view, and so did other senior
19 colleagues, that England remaining at one level
20 consistently was still the right thing to do on balance.

21 **Q.** It's right, isn't it, that in Wales they had adopted a
22 more flexible approach where they could adapt based on
23 the regional pressures at the time?

24 **A.** Yes, given that Wales is, you know, a devolved nation.

25 **Q.** Moving further through this document to page 3, please,

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1 in this case, would still have had their specific surge
2 plans that they would have applied in managing the
3 demand and the pressures that they experienced on that
4 day. Moving to level 2, or even level 3, across the
5 whole of England wouldn't have helped the North West on
6 this particular day.

7 **Q.** You provided the Inquiry with a statement as chief
8 executive of the West Midlands Ambulance Service and
9 you've referred in that statement to there being cells
10 and regular meetings in response to Covid which allowed
11 the trust to make informed, effective decisions about
12 how to operationally respond which were dynamic and were
13 reactive to the changes in national guidance, resourcing
14 and resource availability.

15 Would you agree, therefore, that that localised
16 decision-making can allow for more dynamic and effective
17 decisions and responses based on the situation on the
18 ground, as happened in your trust?

19 **A.** Yes.

20 **Q.** If we could have on the screen, please, INQ000410621,
21 please.

22 This is a summary of a legal opinion you received
23 in relation to changes to triage processes for Covid-19
24 on 2 April 2020. So this is the day before Protocol 36
25 was implemented in England.

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1 The question comments that it's not clear from the
2 documentation as to how the needs of vulnerable groups
3 have been taken into account.

4 And then in the response below it confirms that
5 there has not been a formal impact assessment of the
6 impact on vulnerable groups of the changes to triage
7 before implementation but it was going to remain under
8 review.

9 Was a review conducted at any point during the
10 pandemic?

11 **A.** Not a formal review outside of the existing arrangements
12 that are in place for the algorithms for all patients.

13 **Q.** But Protocol 36 was introduced specifically for
14 Covid-19; is that right?

15 **A.** It is, but the basis upon which the algorithms work are
16 based on the clinical presentations of patients and,
17 therefore, the code and the category that follows from
18 that.

19 **Q.** Were you aware of Protocol 36 having an impact on
20 vulnerable groups during the triage process?

21 **A.** Not any more than would have normally been the case.

22 **Q.** I want to turn now to the practical impact of
23 Protocol 36 and a real-life example so that we can put
24 it into some context. That can be seen in a report
25 produced by the emergency call prioritisation group that

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1 the ambulance arriving at the scene than a category 1
2 response; is that right?

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

4 **Q.** And that's the same in both of those examples; is that
5 right?

6 **A.** Well, in the first example the patient would have been
7 potentially assigned category 5.

8 **Q.** And that would be -- a category 5 response, under the
9 pandemic protocol, would be to have stay-at-home
10 management advice?

11 **A.** Category 5 is for a clinical assessment ringback.

12 **Q.** Thank you.

13 Did that change apply to the triaging of callers
14 who did not report Covid-19 symptoms?

15 **A.** There were some codes that were not on the Protocol 36
16 or the pandemic algorithm that were allocated a lower
17 category response priority in levels 2 and in levels 3
18 if they had been implemented.

19 **Q.** And it's right, isn't it, that in August 2020 the
20 emergency call prioritisation group conducted a review
21 of Protocol 36 specifically in regard to ineffective
22 breathing and recommended that a category 1 response
23 should be received as opposed to category 2; is that
24 right?

25 **A.** That's true. That was new code for ineffective

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1 you chaired, 23 March 2020.

2 So it's INQ000281180. Thank you.

3 It's the box in the middle here. Essentially what
4 we have here is an example of what would happen under
5 Protocol 36. So in order to demonstrate the comparable
6 triage outcomes in the two systems, the clinical
7 scenarios describe the change in management for a
8 patient with low acuity symptoms and a patient requiring
9 an emergency response.

10 So, dealing first with the low acuity:

11 "A 30-year old who has chest pain and Coronavirus
12 symptoms ... will be assessed based on these symptoms
13 and managed in a similar way. As the triage levels
14 escalate patients who are assigned a category 5 response
15 priority at triage level 1 will be signposted to home
16 management by call handlers at triage level 3 ..."

17 And that disposition would be the same in both the
18 systems we have discussed under the pandemic protocols.

19 And then in terms of the more serious emergency
20 response:

21 "A patient who has severe breathing difficulty
22 (Classified as fighting for breath/ineffective
23 breathing ...) will be allocated a category 2 response
24 across each of the escalating triage levels."

25 A triage 2 response would be slower in terms of
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1 breathing that was applied to the pandemic protocol at
2 category 2 and when we conducted that review in August
3 we decided that that code should receive a category 1
4 response.

5 **Q.** Were there any instances that had led to that decision
6 being made in August?

7 **A.** It was just a review of those codes and the application
8 of those codes and as part of that review it was
9 determined that that code would be better suited to a
10 category 1 response and so therefore it was changed.

11 **Q.** Thank you.

12 I want to look now at the meeting minutes from the
13 National Ambulance Service Medical Directors' Group
14 meeting on 23 April 2020.

15 And this is INQ000410581.

16 Here there was a discussion around the escalation
17 levels of Protocol 36, or card 36, as it is referred to
18 here. There was a reference that it "should be lowered
19 to 0", but that it wasn't present -- "it wasn't possible
20 at present but they thought it should be considered if
21 trusts were operating at good performance levels."

22 If we could go down, please -- thank you -- just
23 a little bit more, to "Several Trusts".

24 It was discussed at the meeting that:

25 "Several Trusts [had] reported increases of

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1 patients found deceased when crews arrived, more serious
2 illnesses in patients, patients waiting longer before
3 calling 999, and ... patients were reluctant to go to
4 hospital, and needed to be convinced sometimes that the
5 diagnosis related to other conditions and not COVID-19."

6 And the North West Ambulance Service wanted to
7 know how long you might need to stay on card 36.

8 I accept you weren't at that meeting but were you
9 aware of issues as such as those described here and did
10 they continue throughout the pandemic?

11 **A.** So I was aware of the issues that are highlighted here
12 but I think there are two separate points being made
13 here.

14 Firstly, on level 1 of the pandemic protocol,
15 actually medical directors were reporting that many
16 patients were getting a more appropriate safe response
17 rather than automatically just sending an emergency
18 ambulance, and that was one of the considerations that
19 led us to believe that remaining on level 1 was the
20 right thing to do.

21 In relation to the other point in this highlighted
22 section, I do believe it's -- it was the case that some
23 patients were delaying calling for help and, as a sad,
24 terrible consequence of that, by the time the ambulance
25 call was made and the ambulance arrived, those patients

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1 significant increase in 999 call answering time in
2 England in March and April 2020, with an average
3 49 seconds compared to an average of 10 seconds before
4 the pandemic.

5 One of NACC's role was to monitor performance and
6 report data. How did you respond to escalate those
7 issues and what did you do in response -- what response
8 did you receive to those issues?

9 **A.** So we were monitoring 999 call answering on a very
10 regular basis throughout the day, every day, and
11 receiving reports from British Telecom as to the number
12 of over two-minute delays on a daily basis on each
13 ambulance service, and I asked the colleagues within
14 AACE to develop some arrangements whereby they could
15 provide support, advice and mutual aid to those
16 ambulance services that were under pressure by
17 strengthening the buddy arrangements, which we already
18 had in place, and to see what further steps we could
19 take to provide mutual aid to those 999 ambulance
20 services that were under pressure, and at the same time
21 to ensure that the technical links were in place that
22 once a 999 call had been answered in an ambulance
23 service in which the incident hadn't occurred they could
24 transfer the details of that case to the host ambulance
25 service to enable them to respond.

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1 hadn't made it and, as we've gone on to see in this
2 section, that even when the ambulance had arrived, some
3 patients were also reluctant to be conveyed to hospital
4 as well.

5 **Q.** You referred earlier on to the delays that there could
6 be to the changing of triage codes. Was one of those
7 examples a change to the script included the loss of
8 taste and smell in May 2020?

9 **A.** Not that I remember, no. I don't think there was a
10 delay.

11 **Q.** In the healthcare safety investigation branch report
12 into 111 services they found that there was in fact a
13 delay of four days in which the script was not updated.
14 So anybody calling in that period would not have been
15 told it was a symptom. So you weren't aware of that?

16 **A.** No, not at the time.

17 **Q.** Is that the kind of example of where the processes that
18 were required to change the scripts impacted on the
19 callers?

20 **A.** I don't believe so because whilst that's an important
21 factor in recognising whether the patient may or may not
22 be suffering Covid, it wouldn't have influenced in any
23 way the code that was allocated to the patient once they
24 had been taken through the algorithm.

25 **Q.** Moving on then to the demands on 999, there was a

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1 **Q.** And when was that introduced?

2 **A.** It was finally completed by October 2020 but most of
3 those ambulance services already had the ability to
4 transfer those cases, with the exception of London, and
5 that was the one that took the most time to complete.

6 **Q.** In your statement you've discussed the issue of "no send
7 scripts", and essentially they are used during times of
8 significant pressure, for example asking the call
9 handler to make their own way to hospital as part of
10 individual trust surge plans. So there's no national
11 agreed script; is that right?

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

13 **Q.** You've said that they were discussed at the emergency
14 call prioritisation group to standardise the scripts and
15 set out the changes that were agreed nationally. Were
16 those changes monitored for implementation to ensure
17 that there was consistency across the trusts for the
18 scripts that were used?

19 **A.** Absolutely. That was the whole purpose of the pandemic
20 protocol and moving through those levels. But "no send"
21 was a generic term that was used, it didn't
22 automatically mean that all of those patients that
23 resulted in the end disposition from that algorithm
24 didn't get an ambulance. Some may have been advised to
25 make their own way to hospital but the majority of those

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1 patients actually were then sent for further clinical
 2 assessment before a decision was made whether they
 3 actually needed an ambulance or not. And some of them
 4 did and an ambulance was subsequently sent.

5 **Q.** Moving on, then, to NHS 111 during the pandemic, it's
 6 correct, isn't it, that the instruction from the
 7 Secretary of State was that NHS 111 should remain a
 8 single point of contact for all enquiries for Covid-19?

9 **A.** Correct.

10 **Q.** And were you a member of the NHS England 111 Covid-19
 11 cell?

12 **A.** No.

13 **Q.** Would it have been helpful if you had been a member of
 14 that cell to ensure consistency across 999 and
 15 111 services?

16 **A.** I don't believe so.

17 **Q.** We know that there was a dramatic increase in calls to
 18 111 in March 2020 with over 3 million calls in that
 19 month and over half of those were not answered.
 20 If we could, please, look at INQ000348589.
 21 This is a briefing note that was prepared for --
 22 by Public Health England for a cabinet meeting on the
 23 following day on 26 March, and the author states at the
 24 top there that capacity -- sorry:
 25 "Whilst PHE has maintained high level of
 69

1 capacity and recruitment that the beginning of the
 2 incident would now be providing additional core NHS 111
 3 staff but that had not happened.

4 To your knowledge why did NHS England not recruit
 5 call handlers before 26 March?

6 **A.** I honestly don't know. I wasn't involved in
 7 decision-making with NHS England in relation to 111, I'm
 8 afraid.

9 **Q.** Are you able to help us with the call filters that were
 10 introduced to NHS 111 in March 2020 in order to manage
 11 demand?

12 **A.** I'll try if this is a specific question, of course.

13 **Q.** Okay.
 14 If we could, please, have up INQ000320204.
 15 And this is the Healthcare Safety Investigation
 16 Branch report that I've referred to into the changes to
 17 111 triage.
 18 These changes suggest that they were requested at
 19 the -- at the request of the NHS England central
 20 ambulance team and it was only to be used by providers
 21 when advised by NHS England, and this is a further
 22 pathway update at the end of March with a Covid-19
 23 level 4 switch enabling an ambulance category 3 and
 24 category 4 dispositions reached by core NHS 111 health
 25 advisers using the Covid-19 algorithm to instead be
 71

1 performance, this has been a difficult time for
 2 NHS 111."

3 And we can see the performance of NHS 111 below.
 4 They say that:
 5 "The capacity at NHS 111 has responded to around
 6 40,000 calls with slightly more at weekends since the
 7 beginning of the incident. This is despite calls
 8 offered being regularly over 100,000 per day. If
 9 anything, their ability to answer calls has dropped
 10 since mid-March."
 11 In fact if we look specifically at 23 March, it is
 12 quite small, at the bottom of the graph. You can see
 13 there that the NHS 111 calls answered in 60 seconds is
 14 10% and the target was around 95% at that time.
 15 Then if we move down the page to page 3, please.
 16 At the first paragraph there had been a request
 17 from NHS England and NHS 111 to PHE for additional
 18 1,000 call handlers, which was achieved within 24 hours'
 19 notice, in order to support capacity of NHS 111 Covid
 20 response separate from the PHE capacity.
 21 Then if we just go to the final page 4, please,
 22 and at the bottom and paragraph 3.1, one of the issues
 23 that Public Health England draws attention to is that
 24 capacity issues at the end of March 2020 in NHS 111
 25 remain. There would be no attempt to augment the core
 70

1 directed to a clinician, with a "Speak to a clinician
 2 from our service immediately".

3 So is it right that in this -- when this switch
 4 would be turned on, those that were calling that would
 5 ordinarily have received a category 3 or category 4
 6 ambulance response would now be actually called back by
 7 a clinician in the first instance?

8 **A.** Yes, to determine their clinical needs, that's correct.

9 **Q.** And is it correct that you were part of that NHS England
 10 central ambulance team?

11 **A.** Yes, that's true, yes.

12 **Q.** So were you involved in advising when this should be
 13 switched on or off?

14 **A.** Yes.

15 **Q.** If we move to the next page, please, and 4.2.8, and then
 16 we can see here that there were further updates to the
 17 pathway we've just been looking at around pregnancy,
 18 vulnerability and the symptoms, and depending upon those
 19 would depend on the disposition that they reached?

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

21 **Q.** Thank you.
 22 If we move down to 4.2.10, sorry, this is another
 23 update the following day. So this is 31 March. Here
 24 the summary of the update was that:
 25 "Those who [were] not breathless and identified as
 72

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

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

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

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

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1 clinical director.

2 **Q.** And it's right that those call filters were switched on
3 and off throughout the pandemic; is that right?

4 **A.** Correct.

5 **Q.** And the second filter that you switched -- that you
6 advised on is one that you referred to around duplicate
7 callers asking for an ETA as to when their ambulance
8 would arrive if they had already requested it and they
9 hadn't deteriorated.

10 In the expert report from Professor Snooks, she
11 referred to research during the pandemic identifying
12 that NHS 111 telephone triage may have underestimated
13 the importance of those repeated callers as predictors
14 of adverse outcomes.

15 Is that something that you recognise and is that
16 something that was considered before the call filter was
17 switched on?

18 **A.** Not at that point. That was knowledge that wasn't known
19 to us at that time. But we did very clearly set out in
20 the algorithm which was issued to BT for their use that
21 if the patient had deteriorated or the condition had
22 changed then the call was to be connected to the
23 ambulance control room. It was only those patients that
24 felt comfortable that the condition hadn't deteriorated
25 or changed in any way, that they were simply only asking

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1 **A.** To be honest, I have not found any evidence that
2 ambulance services applied that guidance. It was posted
3 on the website, as I understand it, but I actually don't
4 think it was implemented in any ambulance service.

5 **Q.** And it's right that there was no national guidance
6 issued on conveyance after that until much later in the
7 pandemic; is that right?

8 **A.** Until much later, when the toolkit algorithms were
9 published.

10 **Q.** And as a result of that were you aware that ambulance
11 trusts were developing their own tools?

12 **A.** Yes, but, again, some ambulance services will have had
13 or potentially will have had some kind of conveyance
14 advice or tools within their individual trusts, but
15 overwhelmingly the guidance for ambulance paramedics on
16 conveyance of patients exists within the Joint Royal
17 Colleges Ambulance Liaison Committee guidelines.

18 **Q.** Were you aware of requests from those on the front line
19 who were making those decisions for a national tool to
20 support that decision-making?

21 **A.** Not specifically, no.

22 **Q.** Could we have up, please, INQ000499523 and if we could
23 go to page 34.

24 This is the survey that the Inquiry commissioned
25 into escalation of care decision-making, and if we look

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1 for an ETA, it was those calls that were not connected
2 to the ambulance control rooms.

3 **Q.** Are you aware of any training that those call handlers
4 were given on that distinction?

5 **A.** I'm not aware of any training but the algorithm was very
6 straightforward. It was a series of yes/no questions
7 and answers. And of course if there was any doubt then
8 we said to BT: please connect the caller to the control
9 room.

10 **Q.** Moving on to conveyance to hospital and decision support
11 tools, it's right, isn't it, that NHS England developed
12 clinical guidance for paramedics to aid decision-making
13 on conveyance to hospital for adult patients in
14 April 2020?

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

16 **Q.** And in fact that guidance was issued on 10 April 2020
17 but it was issued by mistake, essentially, because there
18 had been identification of potential impact on patient
19 safety with the inclusion of the clinical frailty scale?

20 **A.** Correct.

21 **Q.** Later that month it was reissued without the clinical
22 frailty scale; is that right?

23 **A.** That's my understanding, yes.

24 **Q.** So there were 12 days when it was in use. Do you know
25 if patient safety was monitored during that time?

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1 at the fourth quotation down, this is a quotation from
2 a paramedic. He said that:

3 "One example of frontline staff being left to make
4 very difficult decisions on managing critically unwell
5 patients was not being able to ventilate a patient,
6 unless we were in level 3 PPE ..."

7 Sorry, it actually should be the top one. Sorry,
8 that's my fault, the first one, the "Harm from inability
9 to escalate care":

10 "It was very difficult and upsetting to leave some
11 sick patients at home due to tightening of criteria for
12 conveyance to A&E. Some of these patients would have
13 deteriorated and died. I understand why it had to
14 happen, but it went against my paramedic values."

15 Do you agree that a national tool early in the
16 pandemic would have assisted those on the front line
17 that were making these kind of decisions?

18 **A.** Possibly.

19 **Q.** And it was January 2021 when a decision support tool was
20 issued but use of it in the ambulance service in England
21 was discretionary; is that right?

22 **A.** Correct.

23 **Q.** What led to the tool being developed at that time?

24 **A.** Well, I wasn't involvement in the development of the
25 tool but my understanding is that it was an attempt to

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1 standardise advice over and above that which already
 2 exists within the Joint Royal Colleges' guidelines so
 3 that paramedics had a clearer algorithm to follow for
 4 patients, based on a series of observations, to help
 5 them decide which patients needed to be conveyed to
 6 hospital and which of those patients could safely be
 7 left at home.

8 **Q.** And did you receive any feedback as to the benefits of
 9 that advice after it had been issued?

10 **A.** No.

11 **Q.** Were you made aware of any guidance or reasonable
 12 adjustments that were made to allow for patients with
 13 additional needs to be accompanied in an ambulance
 14 during conveyance to hospital?

15 **A.** The guidelines that were issued were for patients that
 16 had no requirement for someone to accompany them, that
 17 they should be conveyed alone, but for those patients
 18 that were vulnerable or children, et cetera, then should
 19 have an appropriate responsible adult conveyed with that
 20 patient.

21 **Q.** And were you made aware of any issues with that guidance
 22 being followed?

23 **A.** Not other than it was enormously distressing for
 24 patients and their relatives.

25 **Q.** I want to move on now to infection prevention and
 81

1 always] possible ... staff have to balance risk benefits
 2 and often fly intubated patients whilst in level 2 PPE.
 3 We have asked for a specialist solution but been told
 4 the same WMAS party line. I think going forward there
 5 has to be acceptance that specialist teams may require
 6 specialist PPE."

7 Is that "one solution fits all" approach something
 8 that you were aware of during the pandemic?

9 **A.** Certainly my service we were very clear that before the
 10 pandemic we had already procured the respiratory hoods,
 11 because we recognised the enormous challenges of fit
 12 testing, et cetera, with FFP3 masks, and so we moved to
 13 the respiratory hoods. And of course during the
 14 pandemic I was very clear that we were going to do
 15 everything necessary to protect our staff, and therefore
 16 to protect the emergency service.

17 And actually, in the early stages of the pandemic,
 18 potential Covid patients and certainly patients for
 19 which an AGP was being undertaken that would have
 20 required level 3 shouldn't have been conveyed in the
 21 aircraft anyway because at that point we weren't able to
 22 adequately decontaminate the aircraft having conveyed
 23 such a patient. So those patients would have been
 24 conveyed by land, as they would if the aircraft's not
 25 flying and indeed at night when the aircraft didn't fly.
 83

1 control. It's right, isn't it, that national guidance
 2 is invariably based on hospital settings and not always
 3 suitable for the ambulance setting and that was the case
 4 pre-pandemic?

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

6 **Q.** So when it came to the pandemic, it had to be updated
 7 multiple times, which you said took some time to
 8 arrange; is that right?

9 **A.** Sometimes, yes.

10 **Q.** And part of AACE's role was to review that guidance and
 11 to make recommendations to NHS England; is that right?

12 **A.** Yes.

13 **Q.** And I think you've said in your statement that they were
 14 always accepted?

15 **A.** Yes.

16 **Q.** If we could look, please, at INQ000226616.
 17 This is feedback from a survey of the workforce at
 18 the West Midlands Ambulance Service, your trust,
 19 following wave 2.
 20 And if we could look at box 2, some of the
 21 feedback received from those in your trust was that:
 22 "The trust [had] taken the approach that one PPE
 23 solution fits all."
 24 And they were saying that:
 25 "This isn't always the case ... [and it's not
 82

1 **Q.** Thank you.
 2 Did you seek to raise those concerns at a national
 3 level in those roles that you held, around the guidance
 4 on PPE and the solutions?

5 **A.** Well, more generally, I was aware that staff were,
 6 concerned about the levels of PPE that they were being
 7 advised to wear and I absolutely raised their concerns
 8 with senior colleagues within NHS England, yes.

9 **Q.** We'll come on to that in a bit more detail.
 10 Throughout the pandemic the hierarchy of controls
 11 was promoted by public health bodies and AACE. We heard
 12 from the College of Paramedics last week that they
 13 didn't think it was suitable for the sector and indeed
 14 they raised those concerns throughout the pandemic.
 15 Do you agree that it was not appropriate for the
 16 sector and did you take any action to escalate those
 17 concerns?

18 **A.** Well, I actually think that applying the hierarchy of
 19 control is the right thing to do. The principle set out
 20 in the hierarchy, for example eliminating the risk where
 21 that's possible, we increased hear and treat rate
 22 through the Protocol 36 level 1 we've already discussed,
 23 by ventilating the area as best you can, by regular
 24 wiping down of surfaces, et cetera, I think is the right
 25 thing to do.
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1 But I absolutely recognise the enormous anxiety
2 that frontline staff were experiencing in dealing with
3 the pandemic.

4 **Q.** The UK IPC cell agreed on 6 March 2020 that PPE for
5 ambulance guidance would be, "downgraded" and it was
6 David Cunningham, on behalf of the AACE, that attended
7 on behalf of the sector. During a later meeting in that
8 month it was confirmed that ambulance trusts were not
9 consulted on ambulance PPE guidance. At that time you
10 were chair of the AACE. So how regularly did you
11 correspond with Mr Cunningham and discuss the
12 information coming out of the cell with him?

13 **A.** Not at all. That was dealt with by the expert groups of
14 the IP&C with NHS England, the IPC cell and Public
15 Health England. It falls outside of my experience and
16 expertise. So there would have been no value in me
17 regularly meeting with the experts.

18 **Q.** But you received correspondence from, for example,
19 Unison and the GMB union and the College of Paramedics
20 about the issues that they were having with the
21 recommended level of PPE and RPE on the front line. Did
22 you seek to raise those or bring those to
23 Mr Cunningham's attention in order for them to be raised
24 at the UK IPC cell?

25 **A.** Yes, he was aware of the concerns. I raised I did with

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1 **Q.** Put very simply, that meant that patients and crew were
2 spending longer in the back of an ambulance cab than
3 they would have been had there not been the delays; is
4 that right?

5 **A.** Absolutely right.

6 **Q.** I think it's right to say that sometimes up to 12 hours
7 in December 2021, and the longest delay in that month
8 was, in fact, 20 hours?

9 **A.** Correct.

10 **Q.** The Inquiry heard from the College of Paramedics last
11 week that as delays increased at the end of 2020 they
12 were advocating for a change in the IPC guidance for
13 staff to have flexibility to conduct a dynamic risk
14 assessment on their PPE levels.

15 Did you share those concerns at that time as well,
16 that paramedics essentially should be given that
17 flexibility?

18 **A.** They already had it. Even from the very start of the
19 publication of the guidance for ambulance staff they
20 already had the ability, having undertaken what we call
21 the dynamic risk assessment, it was simple -- a case of
22 assessing the risk that you believed you were being
23 confronted with, and if the level of PPE -- the minimum
24 level of PPE, whether it was level 2 or indeed level 3,
25 if you didn't think that risk that you were being

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1 colleague that were in AACE, and of course the
2 colleagues that were part of the ambulance policy,
3 advisory and assurance group that was established as
4 well.

5 **Q.** And what was the response?

6 **A.** That we should continue to follow the guidance from the
7 experts of Public Health England and the NHS England IPC
8 cell.

9 **Q.** If I could bring you forward a bit more in time now to
10 the end of 2020/the start of 2021, where we start to see
11 an increase in the handover delays.

12 So if we could look, please, at a graph in your
13 statement. It's INQ0004190041.

14 And the national handover delays are set out there
15 at the top. It's correct that the target is 15 minutes,
16 isn't it?

17 **A.** Correct.

18 **Q.** And we can see here that the delays are increasing in
19 December 2020 and January 2021 and coming up to -- well,
20 certainly over 30,000 --

21 **A.** Yes.

22 **Q.** -- hours lost in those two months. And then from
23 April 2021 onwards we can see a significant
24 deterioration in the hours lost, can't we?

25 **A.** Correct.

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1 confronted with was being sufficiently mitigated, our
2 staff had the ability to upgrade some or all of their
3 PPE in order that they felt safe. And that was no
4 different when we got into these dreadful handover
5 delays in the winter.

6 **LADY JUSTICE HALLETT:** Sorry to interrupt, does that depend
7 on, whether they could upgrade, whether the equipment
8 was on the ambulance?

9 **A.** I absolutely accept that that is also down to
10 availability. But the point I was making was they
11 already did have the ability to upgrade where that
12 equipment was available and it should have been made
13 available.

14 **MS HANDS:** It's right, though, isn't it, that there was no
15 guidance on how to actually conduct that dynamic risk
16 assessment until 2022?

17 **A.** There may not have been specific written guidance, but
18 our staff are well trained, professional colleagues
19 right across the country, that, by their own
20 admission -- and I fully understand that -- were feeling
21 enormously vulnerable, and they felt that the PPE that
22 they were being advised to wear was inadequate, so by
23 definition, if they had established that they believed
24 the PPE was inadequate, they had already undertaken the
25 dynamic risk assessment, even it was just

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1 subconsciously, and therefore they could have and were
2 able to, subject to the equipment being available --
3 been able to upgrade any item or all of the items of
4 PPE.

5 **Q.** Ms Nicholls from the College of Paramedics told the
6 Inquiry that it was impossible to carry out a risk
7 assessment about Covid because you didn't know what you
8 were going to and staff would often be working on a
9 closed basis with no windows and she wasn't aware of any
10 training for Covid risk assessments specifically.

11 Do you think that would have been helpful to have
12 training or guidance earlier than 2022?

13 **A.** I think it would have been very helpful if we had used
14 language, narrative, that was much more straightforward
15 for our crews. Using terminology like a "dynamic risk
16 assessment" and "hierarchy of control" when actually we
17 were saying "If you don't feel safe, upgrade your
18 PPE" -- would have been much more straightforward.
19 I entirely accept that.

20 **LADY JUSTICE HALLETT:** It doesn't seem to be an NHS thing,
21 speaking in plain English.

22 **A.** No, it's a challenge, and we need to get better at that,
23 my Lady.

24 **MS HANDS:** The outcome of the College of Paramedics raising
25 those concerns and the UK IPC cell considering them was

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1 within the circumstances ambulance crews work, of as
2 best you can ventilating the ambulance, the patient
3 wearing a mask where that wouldn't undermine their
4 clinical treatment and wiping down are good measures.
5 Most of those -- with the exception of the patients
6 wearing a face mask, most of those measures would have
7 been taken as business as usual anyway.

8 And I accept, you know, in the winter you wouldn't
9 want to leave both of the back doors wide open for all
10 of the time, but you could leave a door slightly ajar.
11 Because we are into a balance of risk, trying to
12 mitigate the risk of any potential transmission but also
13 protecting the patient as well.

14 **Q.** Another matter that was discussed on the same topic of
15 the back of ambulance cabs is that of ventilation. In
16 fact it was discussed that UK IPC cell in June 2021,
17 where it was recorded that Public Health England had
18 raised concerns about poor ambulance ventilation, but it
19 wasn't taken any further as events and moved on and the
20 scenario was no longer relevant.

21 Was the lack of ventilation and extraction in
22 ambulance vehicles and the unique environment of the
23 back of an ambulance cab given enough attention and
24 guidance during the pandemic?

25 **A.** I believe it was. That's not to say that we could have

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1 that there was no change to the national PPE guidance or
2 any changes for the ambulance setting at that time; is
3 that right?

4 **A.** That's my understanding, that's correct.

5 **Q.** And there were a set of suggestions made as to how the
6 risks could be mitigated.

7 So if we could have on the screen, please,
8 INQ000412354 -- thank you -- and just down to the bullet
9 points.

10 If I can just summarise these, essentially they
11 advise that: patients should wear a surgical mask at all
12 times where possible; minimise people accompanying the
13 patient; avoid sitting face-to-face; maintain
14 ventilation systems; rotate clinicians regularly; and
15 decontaminate more frequently.

16 Those suggestions appeared a bit later on in
17 statements by the AACE. Ms Nicholls told us about how
18 she was disappointed by this response.

19 Mr Marsh, were these suggestions practical in the
20 ambulance setting, for example the back of a cab, in the
21 middle of winter during these handover delays?

22 **A.** Well, so I think a couple of things. Firstly,
23 I absolutely recognise the stress and the anxiety our
24 staff were under. I share that absolutely. But I also
25 think that taking a sensible approach as best we could,

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1 communicated to our staff in a much more straightforward
2 way. But, as I understand it, advice was given to crews
3 to set the ventilation system to extract in the back of
4 the vehicle, that the changes per hour -- the minimum
5 standard in the changes per hour in the back of an
6 ambulance is 20 per hour. In hospital rooms, it's about
7 12 and in the specification of the ambulances in my
8 service it's 20 times per hour.

9 And of course there was also the option, where
10 appropriate, to leave one of the doors ajar as well to
11 be able to provide fresh air ventilation into the
12 ambulance as well.

13 **Q.** The delays that we were looking at continued, as we saw
14 in that graph, and in an AACE report they concluded that
15 12,000 patients by the end of 2021 could have
16 experienced severe harm, including patients with Covid
17 who needed continuous oxygen therapy.

18 Was enough done at a national level to prevent
19 these delays increasing and what more could have been
20 done?

21 **A.** Well, I raised my deep concerns in relation to ambulance
22 crews being unable to hand over their patients promptly.
23 Almost on a daily basis. There were various meetings
24 and national meetings on the pressures across ambulance
25 services every day and everyone was aware -- we've

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1 mentioned earlier the National Ambulance Coordination
 2 Centre live dashboard that included long delays, there
 3 were daily reports setting out the numbers of lost hours
 4 in each ambulance service, the longest delays at each of
 5 the most challenged hospitals across the country. So we
 6 were all aware, everybody was aware of the enormous
 7 pressures. And despite everyone's best efforts,
 8 unfortunately, those delays in handing over patients
 9 continued.

10 **Q.** Moving on to non-emergency patient transport services,
 11 were you aware of concerns around the issues with social
 12 distancing when conveying multiple patients to hospital
 13 in those vehicles?

14 **A.** Yes, and that's why national guidance was issued, yes.

15 **Q.** It wasn't issued until September 2020, though, was it?

16 **A.** I think it was issued -- there was clarification and
 17 changes in September but the initial guidance was
 18 published much sooner, I think March 2020.

19 **Q.** And were you aware and did you help with resolving
 20 issues around access to the national PPE supply for
 21 those providing non-emergency patient transport services
 22 that were not part of the NHS?

23 **A.** I wasn't aware there were challenges, only much more
 24 recently, that some non-NHS PTS providers experienced
 25 difficulty. Which is a great shame because, frankly,

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1 should follow their -- we should follow their advice.

2 **Q.** If we could, please, have up INQ000499523, please.

3 And, again, this is a quotation from the survey
 4 that was commissioned by the Inquiry into escalation of
 5 care, and this is the quotation I took you to earlier.
 6 So:

7 "[The] example of frontline staff being left to
 8 make very difficult conditions on managing critically
 9 unwell patients was not being able to ventilate
 10 a patient, unless we were in level 3 PPE ... Ambulance
 11 staff were therefore forced to not intervene when they
 12 had the skills and equipment to hand and watch people
 13 die ... Arguably this was implemented to protect
 14 ambulance staff from contracting COVID, but still an
 15 ethically challenging time."

16 Were you aware of those concerns at the time?

17 **A.** Yes, I was.

18 **Q.** Did you do anything to try and escalate or deal with
 19 those matters?

20 **A.** Well, as I mentioned, I raised the concerns of frontline
 21 staff with senior colleagues. But I think the point
 22 that's being made here is that the moral injury, the
 23 moral harm that was being caused to frontline staff
 24 because they knew -- we all know -- that time is of the
 25 essence for those patients that are critically ill, that

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1 had I have been made aware at the time I would have
 2 definitely intervened and resolved the challenges that
 3 they were experiencing.

4 **Q.** Dealing briefly with aerosol-generating procedures, and
 5 I really do want to deal with this briefly, but its
 6 right, isn't it, that there were contrary positions
 7 adopted by the different bodies, including Public Health
 8 England and AACE and the Resuscitation Council UK and
 9 College of Paramedics, as to whether or not CPR and
 10 intubation were an AGP. Were you aware of those
 11 contrary positions at the time?

12 **A.** Yes, I think -- if I may, I think it was more about
 13 whether cardiac massage constituted an AGP rather than
 14 any of the other procedures. But yes, I was aware that
 15 there were conflicting opinions.

16 **Q.** And what role did you play in trying to assist perhaps
 17 those that came to you with concerns and anxieties
 18 around those different positions?

19 **A.** Two things. Firstly, to ensure that the experts were
 20 aware of the concerns that were being raised by
 21 ambulance staff and by paramedics, so that everyone was
 22 very clear. And then, secondly, that my view was that
 23 we should still continue to follow the advice of the
 24 experts. They had access to all of the experience, the
 25 expertise, the scientific data, and it -- therefore we

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1 we need to move forward as quickly as we can -- I think
 2 the point, if I'm understanding you correctly, that is
 3 being made here that staff felt that whilst they were
 4 donning that level 3 PPE we were losing time to be able
 5 to help that patient.

6 **Q.** And did you consider whether there might be anything
 7 that could help reducing that time to don that level of
 8 PPE? For example, whilst they were travelling to the
 9 scene?

10 **A.** I honestly don't believe that would have been safe for
 11 the crew to have done so.

12 **Q.** You've touched briefly on shortages of PPE in the
 13 non-emergency ambulance vehicles. What action did you
 14 take to ensure that the ambulance sector was prioritised
 15 for access to and resupply of PPE and RPE?

16 **A.** I made it very clear with national colleagues that,
 17 given the unique circumstances that ambulance crews work
 18 in, i.e. no access to running water so it was much more
 19 difficult for ambulance crews to be able to wash their
 20 hands and their equipment, that appropriate PPE should
 21 be prioritised to the ambulance sector. But also the
 22 types of PPE as well, so, for example, the aprons.

23 **Q.** And what was the response to those requests you
 24 received?

25 **A.** They were accepted. The situation was understood. The

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1 request was accepted. So, for example, the slightly
2 thicker aprons were attempted to be prioritised to the
3 ambulance service, but actually that ambition to ensure
4 that those thicker aprons were sent to ambulance
5 services didn't always happen on the ground, and
6 I suspect that may just have been down to logistics, the
7 huge logistical operation that was having to be put in
8 place to get that PPE -- the right PPE to the right NHS
9 sector.

10 **Q.** And you have referred earlier in your evidence to the
11 use of the powered respiratory hoods in your trust. Did
12 you take any action on a more national level to
13 encourage the use or availability of that type of RPE in
14 other trusts?

15 **A.** Certainly the use, not the availability. That was
16 clearly outside of my control unfortunately.

17 But every ambulance service was aware that at
18 least two services had already procured the respiratory
19 hoods before the pandemic, in fact earlier in 2019, and
20 other ambulance services during the pandemic, when they
21 absolutely as well recognised the challenges of fit
22 testing and the different types of FFP3 masks that were
23 being delivered and therefore having to repeat the
24 fit testing, et cetera, several other ambulance services
25 attempted to move over on to respiratory hoods as well.

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1 frontline crews, paramedics, but also the control room
2 staff as well. I truly believe those staff needed to be
3 included in the early roll-out of testing. And that
4 advice was accepted as well.

5 **Q.** You've said in your statement, on the topic of risk
6 assessments for staff, that you were aware that some
7 ethnic minority staff felt that risk assessments had
8 tokenistic and failed to lead to sustained change or
9 action.

10 Did you take any action in response to such
11 concerns or did you have those concerns at the time and,
12 if so, did you make any response to them?

13 **A.** I wasn't aware of specific concerns absolutely at the
14 time, which was around May 2020, but certainly I was
15 doing everything I could in my own trust to make sure
16 that we firstly protected our vulnerable staff,
17 particularly our BME staff, and equally importantly that
18 they understood that we were doing everything we could
19 to protect them as well.

20 **Q.** Do you think there should have been a national risk
21 assessment tool for the ambulance sector specifically?

22 **A.** I think a standard risk assessment would have been
23 helpful. Each individual ambulance service developed
24 their own risk assessment but I think a standard
25 national risk assessment would have been helpful, yes.

99

1 **Q.** Were you aware of fit testing issues?

2 **A.** Yes, that was one of the main reasons we moved to
3 respiratory hoods in 2019.

4 **Q.** And on a national level, not just on your trust, were
5 you aware of that during the pandemic?

6 **A.** Yes.

7 **Q.** And were you aware -- you have talked about those hoods
8 becoming available -- well, advising that they should be
9 looked and considered but not necessarily available. So
10 were you aware of there being issues with alternative
11 PPE being made available if fit tests were failed?

12 **A.** There was no national -- so far as I'm aware, there was
13 no national alternative to FFP3s. Respiratory hoods, to
14 the best of my knowledge, weren't being made available
15 through the NHS push stock.

16 **Q.** I think in fact it's one of your recommendations, that
17 that should be considered; is that right?

18 **A.** Absolutely, my Lady, yes.

19 **Q.** Dealing with the issue of Covid-19 testing for ambulance
20 workers, can you explain what your involvement in that
21 was, please.

22 **A.** Yes. As soon as testing was being made available,
23 I made it very clear, nationally, that I believed that
24 ambulance staff, critical ambulance staff, should be
25 including early testing. By "critical" I meant

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1 **Q.** And were you aware in your national roles of issues
2 implementing or following risk assessments in other
3 trusts?

4 **A.** No.

5 **Q.** You've said in your statement that your belief is that
6 IPC guidance was sufficiently clear for the ambulance
7 sector setting and there were clear definitions for what
8 procedures constituted an AGP. Based on the evidence
9 you've heard, do you accept that there were those on the
10 ground implementing that guidance who did not agree with
11 that assessment of it?

12 **A.** I think, if you don't mind me saying, if the question is
13 do I believe the guidance was clear, I do believe the
14 guidance was clear. If the question is slightly
15 nuanced, insofar that did everyone agree with the
16 guidance, I think that's slightly different. And
17 I think there were other things at play as well.

18 **Q.** Would you accept that others may have formed the
19 contrary view that it was clear?

20 **A.** Yes.

21 **MS HANDS:** My Lady, I have just a couple more topics but
22 I wondered if that might be a convenient place to break.

23 **LADY JUSTICE HALLETT:** How long do you think your couple of
24 topics will take?

25 **MS HANDS:** No longer than 15 to 20 minutes, my Lady.

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1 **LADY JUSTICE HALLETT:** Oh, another 15 minutes. Are you all
2 right to come back this afternoon, Mr Marsh?

3 **A.** Yes, my Lady.

4 **LADY JUSTICE HALLETT:** Very well. I shall return at 1.45.

5 (12.47 pm)

6 (Luncheon Adjournment)

7 (1.45 pm)

8 **LADY JUSTICE HALLETT:** Ms Hands.

9 **MS HANDS:** My Lady, good afternoon.

10 Mr Marsh, I have just two short topics left to
11 cover with you, and the first is in relation to
12 Long Covid.

13 I acknowledge that you say in your statement that
14 you didn't in fact provide any advice or information on
15 Long Covid during the pandemic, and you've referred to
16 guidance produced in England for the sector in
17 July 2020.

18 The Inquiry has heard evidence from -- has
19 received evidence from the Welsh Ambulance Services, who
20 developed an action card called "Guidance for Employers"
21 to inform them on how to manage Long Covid
22 sickness/absence as an employer from March 2021. Do you
23 think anything more could have been done on a national
24 level in England to support sufferers from Long Covid in
25 the ambulance sector?

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1 which we've already discussed but also the stress,
2 anxiety and depression which was the single biggest
3 reason for sickness absence among ambulance staff both
4 before and during the pandemic.

5 So given that data before the pandemic, should
6 mental health support have been included in pandemic
7 planning for the ambulance sector?

8 **A.** Yes, I believe it should have been, and certainly we
9 will continue to build upon the arrangements which were
10 in place before the pandemic and during the pandemic
11 into plans going forward, and I know that all ambulance
12 services have really strengthened their work in relation
13 to health and well-being support for all of our staff,
14 our volunteers and our students.

15 **Q.** And it's right that the College of Paramedics issued
16 guidance in April 2020 to support managers with
17 supporting their employees with mental health and
18 well-being. There wasn't any national guidance or
19 advice on managing mental health and well-being at that
20 time, was there?

21 **A.** Not specifically in relation to the pandemic, no.

22 **Q.** And it's also right, isn't it, that in August 2021 the
23 chief executives of trusts in England came together to
24 request immediate additional support for employee mental
25 health support until -- and that was issued until the

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1 **A.** Guidance was issued by NHS Confederation for all NHS
2 organisations, which I know the ambulance sector
3 followed, and the principles of the way in which we
4 cared for staff suffering Long Covid was built upon that
5 which we already provide for staff suffering other
6 conditions as well.

7 **Q.** Can you provide a couple of examples of those
8 principles, please.

9 **A.** Yes. So certainly staff that may be unable to undertake
10 a full range of shift duty, so there may be staff that
11 just can't work nights anymore and, therefore, we can
12 provide flexibility around their shifts, but also
13 suitable alternative employment. So there may be a
14 particular individual that undertakes a role that is of
15 a physical nature, maybe a paramedic on the front line,
16 and therefore we could offer them alternative employment
17 working in the control room, so it's less activity, less
18 strenuous, maybe with less shift work, shorter working
19 days. Whatever was required to best accommodate their
20 needs in order to keep them in the workplace and keep
21 them gainfully employed.

22 **Q.** Moving on then to the topic of mental health and
23 well-being support for the ambulance sector, the Inquiry
24 has received an expert report from Professor Snooks
25 which touches upon the absence rates in the sector,

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1 end of 2020; is that right?

2 **A.** Yes.

3 **Q.** One of the outcomes of the pandemic has been a
4 substantial increase in the turnover of ambulance staff
5 and those that are leaving the profession.

6 In your view, was enough done at a national and at
7 a local level early enough to support the mental health
8 and well-being of ambulance staff during the pandemic?

9 **A.** Well, the first thing I would say is that attrition
10 levels vary quite considerably between ambulance
11 services and I think that is one of the factors as
12 a result of the support that individual ambulance
13 services provide. But I do absolutely recognise there
14 is a lot more that we should be doing both nationally
15 and locally to support our staff, for them to be able to
16 give of their best looking after all of our patients
17 every day, and in particular recognition of the enormous
18 pressure that we were all under in response to and
19 during the pandemic. And I think our staff deserve it.

20 You know, I am enormously proud of all of our
21 staff, our volunteers, our students, staff that retired
22 that returned to work to deal with the pandemic. I am
23 enormously proud of all of those individuals that
24 stepped forward, often in harm's way, and gave their all
25 to keep as many patients safe and to save as many lives

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1 as possible.

2 So by offering greater health and well-being
3 support in part is also a recognition of everything all
4 of our staff did on the front line and in our control
5 rooms and working alongside our union staff
6 representatives as well is so, so important going
7 forward.

8 **Q.** And you've summarised in your statement what your main
9 objectives were as a national adviser for the ambulance
10 sector, and they were to protect staff, to maintain a
11 safe 999 service, increase capacity in ambulance
12 emergency operation centres and crews, reduce handover
13 delays, and mitigate the possibility of services being
14 overwhelmed.

15 Upon reflection, do you believe those objectives
16 were achieved during the pandemic?

17 **A.** In the main, yes.

18 **Q.** Mr Marsh, do you have any other lessons or
19 recommendations for the future that have not already
20 been covered in your evidence today?

21 **A.** Only those that I've set out in my witness statement, my
22 Lady.

23 **MS HANDS:** Thank you.

24 My Lady, I don't have any further questions.

25 **LADY JUSTICE HALLETT:** I have been asked to ask you
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1 wearing hoods in the West Midlands, why is it that you
2 were prepared to accept the IPC guidance nationally so
3 that the ambulance service in, say, the South East would
4 be wearing fluid-resistant surgical masks? I think
5 that's question, and Mr Simblet is nodding.

6 **A.** If the patient was having an AGP performed upon them
7 then they would not have been in a type 2 mask. The
8 crews would have been wearing FFP3, if they didn't have
9 a respiratory hood. Whereas in the West Midlands we
10 didn't have FFP3s, they had been withdrawn. So for AGPs
11 it was the hood, and for all other patients, unless
12 following a dynamic risk assessment justified the
13 wearing of a hood, then the staff would have been
14 wearing surgical masks in the West Midlands as they
15 would everywhere across the country.

16 **LADY JUSTICE HALLETT:** I think I have taken it as far as
17 I can, Mr Simblet, thank you.

18 Those are all the questions we have, Mr Marsh.
19 Thank you very much for your help and I'm sorry we had
20 to bring you back over the lunch adjournment. Very
21 grateful to you.

22 **A.** Thank you, my Lady.

23 **(The witness withdrew)**

24 **LADY JUSTICE HALLETT:** Mr Mills.

25 **MR MILLS:** My Lady, may I please call Ms Tilna Tilakkumar.
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1 a follow-up question, Mr Marsh. The question is this:
2 if you took the view that the national IPC guidance was
3 adequate requiring FRSMs with a dynamic risk assessment,
4 if you were satisfied with the guidance in your role as
5 chair of the AACE, why did you make respirator hoods
6 mandatory across the entirety of the West Midlands
7 Ambulance Service?

8 **A.** Thank you, my Lady.

9 The hoods that we made available to all of my
10 staff in the West Midlands in 2019 were for specific
11 airborne transmission viruses and other high consequence
12 infectious diseases. They weren't for all patients. So
13 that would have applied, then, when we got into the
14 pandemic: the use of those hoods would have applied to
15 those staff undertaking AGPs and as part of the dynamic
16 risk assessment or just, plain speaking, a member of
17 staff that felt vulnerable to upgrade to wearing the
18 hood for all other patients. It wasn't that the hood
19 was made mandatory for all patients, only those for AGPs
20 and for those crews that thought the patient justified
21 the situation, justified them wearing the respiratory
22 hoods.

23 **LADY JUSTICE HALLETT:** I think the point being made is that
24 if the national guidance is saying that those of your
25 staff who, with those strict conditions, would be
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1 **DR TILNA TILAKKUMAR (affirmed)**

2 **LADY JUSTICE HALLETT:** I hope we haven't kept you waiting
3 too long, 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,
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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

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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

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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

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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

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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

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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

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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.

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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

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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?

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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

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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 JUSTICE HALLETT:** I am terribly sorry, I am going to
 8 have to rise.

9 (2.13 pm)

(A short break).

11 (2.19 pm)

12 **LADY JUSTICE HALLETT:** Sorry about that, everyone.
 13 I suppose if you are going to feel sick you might as
 14 well do it with a GP in the witness box. Everyone stay
 15 away from me is all I can say. I'll think I'll be all
 16 right. If I make another rush for it, you will all know
 17 what is 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

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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 JUSTICE HALLETT:** Can I just check. Are you using FFP2
 5 in the same sense as the previous witness? The blue
 6 masks that we all got used to seeing or do you mean the
 7 actual specialist FFP2 which is one step down from the
 8 FFP3?

9 **A.** Yes.

10 **LADY JUSTICE HALLETT:** Thank you.

11 **MR MILLS:** Did you ever have a day where you wore an FFP3
 12 that had been fit tested correctly to you?

13 **A.** No. We were told they really only needed to be used
 14 during aerosol-generating procedures, so that was only
 15 CPR, so I didn't have to wear it in any case in the end.

16 **Q.** Before you had your successful fit test, you've just
 17 touched on it in respect of CPR, it is right, isn't it,
 18 that you had a serious concern about who might be able
 19 to perform CPR on the ward?

20 **A.** Yes. I mean, all our staff are trained in CPR so we
 21 could all initiate it, but as the doctor, especially on
 22 call, you would obviously be looked to to be the one who
 23 would lead the basic life support until paramedics
 24 arrive.

25 **Q.** Did testing become available whilst you were working on

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1 the ward?

2 **A.** Testing for staff was available if you were symptomatic.

3 That was across the trust which covered multiple sites,

4 and there were only 35 tests available a day. Tests for

5 patients did come in at some point and that was being

6 done on a weekly basis when it did start.

7 **Q.** Did you ever receive a test?

8 **A.** No, I didn't show any signs, so I never had an antigen

9 test but I did have the blood test for PCR antibody done

10 in May. That was being done by my other trust that

11 I was employed by and I tested positive for antibodies,

12 which did suggest that I had been exposed and had a

13 reaction to Covid.

14 **Q.** During your time on the ward, I think it's right, isn't

15 it, that you requested that you and your partner be

16 moved into hotel accommodation. Can you tell us about

17 what prompted that request?

18 **A.** Both -- so I was working on a Covid ward and my husband

19 was working in A&E at the time, at a different trust.

20 We were both living with my parents at the time, who

21 were both in their late 60s. Initially it didn't occur

22 to me that we would need to probably shield from them or

23 they would have to shield from us but, as time went on,

24 and I realised how serious Covid was and how prevalent

25 it was on our ward and how I couldn't really keep myself

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1 chain continued for over the five weeks I was on that

2 ward.

3 I did get more medical help, so I got two other

4 doctors redeployed to join me on that ward by the next

5 week but, other than that, my requests for another

6 observation machine didn't come, my requests for more

7 PPE was patchy, for other staff members was, as I said,

8 voluntary -- on a voluntary basis, so there was nothing

9 consistent. Other bits of equipment that we asked for,

10 a syringe driver for palliative care medication was

11 difficult to come by and in the end the communication

12 was getting a bit more difficult by email and then in

13 the end I was asked -- I was referred to speak to our

14 Freedom To Speak Up champion at the trust and this was

15 towards the end of April.

16 **Q.** Are you able to tell us about the conversation you had

17 with the Freedom To Speak Up champion?

18 **A.** Yes, it was -- it felt very open and very friendly. We

19 spoke for quite a while, maybe half-an-hour to an hour,

20 and I laid out all -- a summary of all the things that

21 I'd been asking for that the ward still needed,

22 equipment, more staff, better well-being facilities for

23 the staff. At that point I still hadn't been fit

24 tested, so my fit test was organised the next day, but

25 then I was also just moved back to my original placement

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1 safe from catching it, nor my husband, we asked for

2 accommodation to shield my parents.

3 **Q.** Was it provided?

4 **A.** Yes.

5 **Q.** How long did it take?

6 **A.** Maybe a week.

7 **Q.** We heard some evidence this morning from a paramedic who

8 was living in a hotel. Can you tell us about the impact

9 that living in a hotel had on you and your husband.

10 **A.** It was a very basic hotel but definitely not meant for

11 long-term living. There was no -- I mean, we had food

12 provided to us by the trust, so we had three meals a day

13 provided from the canteen, so we were provided for.

14 But, yes, apart from a kettle we didn't have anything

15 else in our room and laundry was difficult.

16 **Q.** The concerns that you have told the Inquiry about this

17 afternoon were things that you raised eventually with

18 the trust; is that right? What, if any, response did

19 you receive from management after you raised those

20 concerns?

21 **A.** So I raised concerns throughout the time that I was on

22 the ward from the very first, so I joined on the

23 Thursday and over that first weekend I drafted a very

24 long email and I sent it out to everyone that I could cc

25 in, everyone I could think of in the trust, and this

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1 by the next day as well. The other two doctors were

2 not.

3 **Q.** When you returned to your previous -- this is the

4 community role, isn't it -- on 29 April, in what ways

5 had that role changed since you left it in February?

6 **A.** So it was mostly all -- well, it was mostly remote

7 working. Everything was being done by phone, so all our

8 appointments were by phone or video. My consultant was

9 shielding so I never actually saw him again in the

10 flesh, so all my supervision was done remotely. There

11 had to be one doctor on the team available on site so

12 we -- me and the other two doctors had a rota --

13 rotation to go into the office, otherwise we worked from

14 home with laptops.

15 **Q.** Did you feel as if you could provide the care you wanted

16 to patients remotely?

17 **A.** I don't think our number of appointments went down but

18 telephone and even video consultations does form a

19 barrier with patients who have -- already have mental

20 health difficulties. So in that way I'm not sure how

21 effective the consultations were.

22 **Q.** Was it possible at that time to arrange face-to-face

23 appointments with certain patients?

24 **A.** Not straight away. I think the clinics were still

25 closed. We could do home visits still with PPE provided

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

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

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

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

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1 A. It is.
 2 Q. You were a director of ICNARC from its inception in 1994
 3 until September 2023 and you remain a scientific adviser
 4 today?
 5 A. I do.
 6 Q. You are also an honorary professor at the London School
 7 of Hygiene and Tropical Medicine?
 8 A. I am.
 9 Q. And you are a programme director at the National
 10 Institute for Health and Care Research?
 11 A. I am.
 12 Q. Professor Rowan, today I would like to cover, first of
 13 all, a bit about ICNARC. I then want to ask you about
 14 some of the work that you have done for the Inquiry, and
 15 we're then going to ask about some of the specific
 16 analysis within those reports, particularly in relation
 17 to patient admissions, critical care transfers, then
 18 some of the pressure that was on intensive care units
 19 and some of the specific characteristics of patients in
 20 intensive care units.
 21 So, hopefully, that's all clear for you.
 22 A. It is, thank you.
 23 Q. You set out in your witness statement that ICNARC is an
 24 independent, scientific, not-for-profit organisation
 25 which works to facilitate improvements in structure,

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

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

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

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1 A. That is correct.

2 Q. All of those critical care units, you get all of the
3 relevant information within the case --

4 A. We have 100% coverage of those.

5 Q. A very comprehensive picture with respect to those
6 particular critical care units?

7 A. Yes, indeed, yes.

8 Q. Did you specifically create Covid-19-related data
9 collection sets during the pandemic?

10 A. We did not and the reason we did not was really from the
11 lessons that we learnt a decade earlier with the H1N1,
12 sort of, epidemic where we did try to identify a sort of
13 bespoke additional data collection and, of course, at
14 that point the system's not ready to adopt new data sort
15 of systems, new data structures, and the lesson we
16 learnt was to do the best we could with the data that we
17 currently collected rather than to try and burden an
18 already burdened system.

19 Q. With additional --

20 A. With additional data collection.

21 Q. You did, though, collect data on patients with critical
22 care -- sorry, patients with Covid-19 who were admitted
23 to critical care?

24 A. So, again, one of the learnings from H1N1 was that we
25 created within the new dataset following that sort of

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1 admitted to critical care on a daily basis.

2 Q. For how long did you continue sending those daily
3 reports to NHS England?

4 A. Daily throughout the whole pandemic. So clearly as --

5 Q. That's fine, in terms of --

6 A. As waves dropped it might have been less frequent.

7 Q. That's fine. Just to get a sense of the period in which
8 you were doing that.

9 Did you spend any specific reports similar to this
10 or identical to any of the officials within the devolved
11 nations?

12 A. No.

13 Q. Do you recall ever receiving requests from any officials
14 within Northern Ireland or Wales for similar reports?

15 A. Not for daily reporting but we did produce reports as
16 requested for both Wales and Northern Ireland just as
17 and when they requested them.

18 Q. Thank you.

19 To turn now to what the data itself is showing us,
20 ICNARC has very helpfully produced two bespoke reports
21 for the Inquiry. One of those reports was produced
22 solely by ICNARC, a lengthier report, and then a
23 combined report that was compiled alongside SICSAG, who
24 we were just speaking about. I understand you are
25 familiar with both of those reports?

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1 some temporary fields which could identify, should
2 another epidemic or pandemic come along, we would be
3 able to kind of tag those patients, and we opened those
4 fields up -- which I'm sure is not the technical term,
5 I'm not a data or technology person -- at the beginning
6 of the Covid-19 pandemic to make sure that we would be
7 able to identify suspected and confirmed Covid-19.

8 Q. You also, I think, as a result of that work were able to
9 send, in addition to the reports we spoke about before,
10 daily emails, I understand, to Professor Stephen Powis
11 and Sir Simon Stevens at NHS England updating them with
12 respect to the numbers of patients with Covid-19
13 admitted to critical care units; is that correct?

14 A. It is correct. The way that we did that was because
15 we're aware of the burden of data collection we asked
16 the units -- and I really should shout out for the
17 amazing network of audit clerks within the critical care
18 units across England, Wales and Northern Ireland who
19 managed to keep up these data collections throughout the
20 pandemic.

21 So what we did was sort of stagger the data
22 submission so they could tell us about numbers daily and
23 then they could sort of fill in the first day's data,
24 and then the full stay data at later stages, so it meant
25 we could just keep on top of the numbers that were being

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1 A. I am familiar with both the reports.

2 Q. Just for clarity, with respect to the joint report, you
3 weren't involved in any of the data collection from
4 ICNARC's perspective with respect to Scotland but that
5 data has now been compared and the relevant checks have
6 taken place to ensure it's compatible with the data you
7 collected for England, Wales and Northern Ireland; is
8 that correct?

9 A. The two analytical teams worked closely together to
10 ensure that there was consistency and standardisation
11 before that report was produced.

12 Q. As a result you are able to speak to the joint report?

13 A. I am happy to speak for the two reports or the combined
14 report.

15 Q. Thank you. Just -- again, just a precursor to us
16 starting to look at this data, we're going to go to a
17 lot of graphs so I'm just going to headline that.

18 What the graphs will show us, generally speaking,
19 is a period two years or so prior to the pandemic and
20 then our relevant period for the purposes of this
21 module, which is March 2020 to June 2022, and that, as
22 I understand it, was done in order to give us
23 a reasonable comparison period; is that correct?

24 A. So I think the Inquiry, in discussion with us, agreed on
25 the periods, but, absolutely, it was about a sort of a

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

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

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

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

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1 people weren't out about having traumatic injuries.
2 As I say, there was a reduction in sort of stopped
3 elective surgery and other sort of more planned
4 procedures. So the pool is changing.

5 And then there was hesitancy and this is just,
6 I believe, in terms of, you know, seeking access to
7 hospital, you know, there was a sort of a stay at home,
8 help the NHS, or -- and that may have changed
9 healthcare-seeking behaviour.

10 **Q.** So a variety factors, some of which we can't see from
11 the data alone?

12 **A.** Not from intensive care data *per se*.

13 **Q.** That can come down for the moment.

14 We don't need to go to it but you have also
15 included in your report messages about all of the
16 individual nations of the UK and how they were affected.
17 The headline message, I think, is that there were
18 similar patterns in terms of mean daily admissions?

19 **A.** Patterns were incredibly similar across all four
20 nations.

21 **Q.** We do now need to go to another graph, though, which is
22 INQ000474239, page 9, and this is figure 3.

23 What we're going to look at now is the daily
24 number of patients actually in critical care as opposed
25 to the number of patients who were admitted.

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1 policy and roll-out was it did reduce the numbers
2 getting really sick with Covid-19 and, therefore, the
3 demand on critical care did reduce in those later waves.

4 **Q.** Tying together what you told us before and you touched
5 on it briefly, are we correct to draw from these two
6 graphs that in fact the pressure on intensive care units
7 was not caused by a significant increase in the number
8 of admissions and individual patients coming into ICU on
9 a daily basis but, as you said, patients spending a lot
10 longer in ICU and, during peaks --

11 **A.** It was the --

12 *(Unclear: simultaneous speakers)*

13 **Q.** -- many of them doing that?

14 **A.** It was the numbers in critical care. So the reduced
15 admission rate is because the -- sort of, no free bed to
16 put them in. And, again, you've heard that a bed is not
17 a bed, a bed is a skilled nursing colleague and other
18 allied health professionals, and there simply -- you
19 heard how stretched they were. And you can see how much
20 they have increased their capacity. There was a lot of
21 sort of stretching to try to deliver care to as many
22 people as possible.

23 **Q.** Even with the caveats that you provided before about not
24 covering all surge areas, you can see significant
25 increases during the peak, can't you?

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1 So if we could get that up, please.

2 Yes, so we should see here what I was just talking
3 about. Can you now explain -- I think you touched on it
4 a little bit before --

5 **A.** So we can remember from the last graph that pre-pandemic
6 there were 600 patients admitted, mean daily patients
7 admitted, and this now translates to, in the
8 pre-pandemic, in more normal times, about
9 3,000 admissions in intensive care on any, sort of,
10 given day or averaged over days into the week.

11 And I think this probably now feels a little more
12 familiar, if that makes sense. So as we move -- I'm not
13 going to explain the axes again, in that the graphs are
14 so similar, but do ask me if you want me to.

15 So what you can see here is again that line moving
16 into the relevant period, and that initial drop-off is
17 actually probably the stopping of elective work, and
18 then you see the peaks of the waves of -- in orange --
19 of the patients admitted for Covid-19 and you can see it
20 is more than half the case load in critical care in both
21 the first and the second wave.

22 The third wave, as you sort of got to Delta and
23 Omicron, the other thing to just bear in mind around
24 February '21 vaccination starts to kick in and, you
25 know, one of the thankful things about the vaccination

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1 **A.** Massive, yes, and the numbers are not accurately known
2 for the numbers who were critically ill and managed in
3 surge areas that we didn't cover.

4 **Q.** Can I ask you -- that can come down for the moment.

5 Can I ask you, Professor Rowan, about something
6 you say in your witness statement at paragraph 7.3 and
7 I'll just read it out. You say this:

8 "Overall, approximately 24% fewer patients were
9 admitted to critical care for reasons other than
10 COVID-19 across England, Wales and Northern Ireland than
11 would have been expected based on pre-pandemic rates of
12 admission."

13 You then go on to say it is impossible to
14 determine exactly the causes for that.

15 Sorry, I will bear with you. It is paragraph 7.3.

16 **A.** Yes.

17 **Q.** Did you hear what I read out?

18 **A.** I'm sorry?

19 **Q.** Did you hear what I read out?

20 **A.** Could you just repeat that for me. I am sorry, I got
21 a bit distracted about finding the page.

22 **Q.** That's okay. You said:

23 "Overall, approximately 24% fewer patients were
24 admitted to critical care for reasons other than
25 COVID-19 across England, Wales and Northern Ireland than

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1 would have been expected based on pre-pandemic rates of
2 admission."

3 So we've obviously just looked at admissions, both
4 in terms of the number of patients coming into ICU and
5 the number of patients actually in ICU.

6 Given what you say about there being approximately
7 24% fewer patients for non-Covid reasons, are we correct
8 to assume that there are potentially number of patients
9 with non-Covid conditions who we would normally have
10 expected to come to ICU who simply didn't for one reason
11 or another?

12 **A.** So I -- without the information, without the data on, if
13 you like, the pool of patients in hospital -- so what we
14 do know, very early on in the pandemic we did a report
15 that was part of my witness statement around what kind
16 of gains could there be made in capacity in critical
17 care by the cancellation of elective and planned work,
18 and that amounted, I think, from my memory, to about
19 sort of 20/22% of bed days that would not be occupied,
20 and therefore some of this will be the cancellation of
21 elective, sort of, and planned work.

22 But I think it wouldn't account for all of it.
23 I think if we look across the whole pandemic period
24 there was probably about, if you cover all the waves,
25 probably about 9 to 12 months of stopped or cancelled

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1 January 2022 here, it looks as if in Northern Ireland
2 there is a significant increase, is that right, in
3 January 2022, so almost double what it was even at the
4 beginning on average?

5 **A.** So you can see that there are gaps in the orange line
6 because we don't report for small numbers, so for those
7 sort of months where there were fewer than ten
8 admissions, and the numbers are smaller in
9 Northern Ireland and also less were going into intensive
10 care in those later waves.

11 But there's no two ways about it that when you do
12 an average -- obviously you're doing an average, but
13 it's very skewed by longer-staying patients, and that
14 will have a bigger impact on a smaller number of
15 patients in the sum, if that makes sense.

16 **Q.** Sorry. So is the explanation for this that there were
17 a few -- as it sort of says in the headline, there were
18 a few patients who were spending significant --

19 **A.** Yes, who will have dragged the average up.

20 That doesn't mean that those patients did not have
21 those considerable long stays but it means that it may
22 have dragged the figure higher than what would be the,
23 sort of, what we might call more normal stay for those
24 patients. Does that make sense?

25 **Q.** I think it does but it makes it very clear that there

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1 elective work because obviously it recovered between the
2 waves.

3 So that would have been some of it but probably
4 not all of it.

5 **Q.** That's very clear, thank you.

6 Touching on -- well, you touched on earlier the
7 fact that there was a considerable difference in terms
8 of the average length of stay of a patient with Covid-19
9 and a patient for all other reasons. I think you said
10 something like 17 days in the beginning for a Covid-19
11 patient.

12 We heard yesterday from Dr McConnell, who is the
13 former medical director at the Western Health and Social
14 Care Trust in Northern Ireland, and she spoke about some
15 very lengthy stays in ICU in Northern Ireland,
16 particularly in her trust, in, I think, the Omicron
17 period. I'm not sure entirely. But we have
18 a particular graph which ICNARC has produced in relation
19 to length of stays in Northern Ireland.

20 So if we could just go to that, please. It's
21 INQ000480138, and we're looking at figure 96, please.

22 So if we're just looking at this graph, it looks
23 as if -- you mentioned before something to the effect of
24 17 days in the beginning, and then a reduction in the
25 length of stay of Covid-19 patients, but if we look at

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1 were some patients having --

2 **A.** Absolutely.

3 **Q.** -- extraordinarily long stays in ICU, particularly in
4 Northern Ireland, in January 2022, which may be quite
5 surprising.

6 **A.** So the other thing to just bear in mind is when we get
7 to Omicron, the population is more vaccinated, let's
8 say, more highly vaccinated, than in those earlier
9 waves. So the patients now getting into intensive care
10 come with much greater other sort of advanced chronic
11 conditions. So these are people who, despite
12 vaccination, Covid is a significant hit and requires
13 their admission to critical care; so sort of a much more
14 complex and a much different patient to earlier
15 pre-vaccination where it was a disease that in its own
16 in isolation would bring you into critical care.

17 **Q.** I appreciate that you necessarily have to caveat things
18 in terms of only being able to infer what the data says,
19 but would that also coincide perhaps with the fact that
20 those patients may have been shielding previously?

21 **A.** That I don't know.

22 **Q.** Okay. That can come down.

23 I want to ask you about critical care transfers.

24 **A.** Yes.

25 **Q.** So this is INQ000474239 --

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1 **LADY JUSTICE HALLETT:** Before we move on --

2 **MR FIREMAN:** Sorry, would you like to take a break?

3 **LADY JUSTICE HALLETT:** I was just thinking that might be --

4 **MR FIREMAN:** -- a convenient time, yes --

5 **LADY JUSTICE HALLETT:** -- if you are going to a different

6 subject.

7 **MR FIREMAN:** No, no, definitely.

8 **LADY JUSTICE HALLETT:** We take regular breaks,

9 Professor Rowan. So I shall return at 3.25, all being

10 well.

11 **(3.09 pm)**

12 **(A short break)**

13 **(3.24 pm)**

14 **LADY JUSTICE HALLETT:** Mr Fireman.

15 **MR FIREMAN:** Thank you, my Lady.

16 As mentioned, we're going to move to critical care

17 transfers and look at INQ000474239.

18 We're looking at figure 9 here. A similar sort of

19 graph to the ones we were looking at before. Can I hand

20 over to you to explain a bit about what we can see here?

21 **A.** Sure, absolutely.

22 So, again, you've got that pre-pandemic and then

23 the relevant period and then you've got the mean daily

24 transfers between critical care units.

25 **Q.** Sorry, can I just pause you in fact to just explain what

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1 **Q.** Sorry, just to clarify, repatriation is going back to

2 somewhere that is closer to perhaps where you live --

3 *(Unclear: simultaneous speakers)*

4 **A.** So if you have been moved from your original critical

5 care unit, it is a return to the critical care unit.

6 And as I say, that move may have been for more

7 specialist care or it may have been because of capacity

8 issues and therefore for just comparable care in a unit

9 with space.

10 **Q.** Sorry, just to be absolutely clear, I think because

11 we're getting a bit confused in terms of the words,

12 I think -- am I right to think that it's the other

13 reasons that might be for comparable care --

14 **A.** So those are in the orange, yes.

15 **Q.** And the repatriation --

16 **A.** Yes.

17 **Q.** -- is for care that would be closer to your home, for

18 example?

19 **A.** Yes, absolutely.

20 So what you can see here is there's about 20 mean

21 daily transfers between critical care units in the

22 pre-pandemic period. And then during the first two

23 waves you can see this threefold and fourfold increase

24 in the number of inter-hospital transfers during the

25 first and second wave and, because of the

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1 critical care transfer is?

2 **A.** I'm sorry, yes, absolutely, forgive me.

3 So these are the transfer of patients between

4 critical care units in different hospitals, so they

5 don't include, sort of, movements within the same

6 hospital, which was about managing care, you know, under

7 stress and whatever, but this is where patients have to

8 be put in a transport vehicle with a team and taken to

9 another critical care unit.

10 **Q.** Thank you.

11 We can go back to what the graph shows us.

12 **A.** Okay. So I think, as others have indicated, that the

13 provision of critical care beds in the UK relative to

14 similar OECD countries is low. So we have, you know,

15 capacity issues and therefore there are transfers

16 between critical care units.

17 At the bottom there, the repatriation, that's very

18 often where perhaps you'll move to another critical care

19 unit further away, sometimes for good reasons, for more

20 specialist care, sometimes for not so good reasons,

21 which is being moved because there's no room and for

22 capacity issues or comparable care. But repatriation is

23 coming back to a critical care unit sort of near where

24 you live, so some of those can be thought for good

25 reasons --

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1 differences between the Case Mix Programme and the

2 SICSAG data, we weren't able to sort of --

3 **Q.** Break down further.

4 **A.** -- break down the other reasons further.

5 As I say, patients were being transferred for ECMO

6 and very specialist services that are centralised, but

7 a number of these were, as we heard from Kevin Fong,

8 around helping units manage, particular units manage an

9 overburden of patients and moving them to units that --

10 **Q.** May have had capacity.

11 **A.** -- had space.

12 **Q.** As you touched on, you couldn't, for data comparison

13 reasons, get this data in terms of the breakdown of

14 those other reasons for the whole of there UK but you

15 can for those in the Case Mix Programme --

16 **A.** Indeed.

17 **Q.** -- in England, Wales and Northern Ireland. So I would

18 like to look at those so we can see some of the

19 breakdowns for the reasons for critical care transfers.

20 **A.** Indeed.

21 **Q.** This is in your own report, figure 13, it's

22 INQ000480138.

23 **A.** So, again, you can see consistency between these

24 because -- the dominance of England, Wales and Northern

25 Ireland, the Scottish data only bring a few more

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1 numbers, but you can see that pre-pandemic there's about
2 20 mean daily transfers.

3 And, again, now what we've split here is you're
4 worried about the orange ones, that's just being
5 transferred for comparable care. More specialised care
6 is because for certain techniques that are not needed
7 all the time it's quite right to centralise those, so
8 something like ECMO, where skills are actually enhanced
9 in delivering that care and patients would be
10 transferred for more specialist care, that's in the sort
11 of bluey-grey, and then, again, you can see the
12 repatriation.

13 I guess the alarming bit for me is you can see
14 that the big uptick in the inter-hospital transfers
15 between critical care units is predominantly in that
16 sort of comparable care. And while, you know,
17 a transfer, when it's necessary, can be done safely, it
18 does come with a risk to move a critically ill patient,
19 and it comes with a burden of resources that, as we
20 know, were probably needed back in the original
21 transferring unit.

22 And there were sort of specialised transfer
23 services, sort of, established during the pandemic to
24 try to meet some of this demand, but again, you can just
25 see these huge increases.

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1 particularly over the winter season of flu and other
2 pressures, sees situations where demand outstrips
3 supply. Demand being -- let me just make sure I've got
4 this right -- the number of patients who you want to
5 provide critical care for, and supply being the
6 available beds to deliver that care.

7 So we wanted to look at that, and we did look at
8 it some years back, and we showed that -- we created
9 a sort of concept of the number of patients in the unit
10 as you are admitted sort of tells you how busy the unit
11 was as you were admitted. So for every patient in every
12 unit you can get the -- sort of a concept of were they
13 admitted on a typical day or were they admitted on a day
14 that was lower than typical in terms of number of other
15 patients in unit or higher than typical, sort of, type
16 thing.

17 So the notion being that your first day in
18 intensive care is very important in terms of setting up
19 your care, and I'm talking now pre-pandemic, equally so
20 post -- during the pandemic, but pre-pandemic, and what
21 we showed, with careful analysis and adjusting for the
22 confounding factors of the types of patients and that
23 kind of thing, was that patients who were admitted in
24 periods of higher capacity strain were less likely to
25 survive.

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1 **Q.** So just to tie up what you were saying, are we right to
2 conclude, generally speaking, that transfers for either
3 of the two blue reasons, repatriation or more
4 specialised care, may be clinically appropriate, whereas
5 transfers for the orange comparable care reason would
6 indicate that was driven by capacity concerns rather
7 than clinical need?

8 **A.** Yes, and ideally you would like to see none of those
9 pre-pandemic and certainly not be forced into the
10 situation we found ourselves in during the relevant
11 period of the pandemic.

12 **Q.** We should recognise that there are some transfers for
13 comparable care pre-pandemic, though, aren't there?

14 **A.** Indeed, but you can see the large increases in the
15 relevant period of the pandemic.

16 **Q.** That can come down now, thank you.

17 I want to ask you about, within the context of
18 pressure that's been put on critical care units having
19 looked at admissions, both number of patient admissions
20 on a daily basis and also patients in critical care and
21 critical care transfers, you talk about a concept in
22 your witness statement at paragraph 6.1 which you have
23 termed "ICU capacity strain". Are you able to explain
24 what that term is and where it comes from?

25 **A.** Okay. So even during normal times critical care,

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1 **Q.** That was work that you started pre-pandemic?

2 **A.** That we did pre-pandemic.

3 **Q.** Am I right you then did some further work to adapt that
4 model for the pandemic?

5 **A.** So then we found ourselves in the situation where during
6 the pandemic we hadn't seen such strain on intensive
7 care units. So not unlike the comparisons here, we took
8 a period for each intensive care unit to understand
9 their typical, you know, sort of, numbers of admissions
10 daily and then we took the period of the pandemic and we
11 identified each patient as being admitted, again, at the
12 normal or typical, sort of, number of patients in the
13 unit, lower than that, higher than that, but then we
14 created this, sort of, pandemic high and pandemic
15 extreme.

16 Pandemic high was you were admitted at a period
17 that was 10 to 50% higher; pandemic extreme was the unit
18 was greater than 50% fuller than normal.

19 In that situation, again, we carried out a very
20 careful analysis, adjusting for the types of patients,
21 and what we showed was -- and I just will read this to
22 get it absolutely correct.

23 **Q.** Yes. I wonder, Professor Rowan, if we have on screen,
24 perhaps, your paragraph 6.4, it might help.

25 **A.** Yes, that would help, thank you.

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

1 **MR FIREMAN:** Yes, I'm sorry.
 2 **LADY JUSTICE HALLETT:** I'm terribly sorry, Professor Rowan.
 3 I'll see everybody at 10.00 tomorrow.
 4 **(3.37 pm)**
 5 **(Adjourned until 10.00 am the following day)**

1 patients, you know, and I felt -- you know, we've all
 2 heard what our clinical teams were under in terms of
 3 that but then the kind of more balancing in the second
 4 wave and subsequently, whereas to be a non-Covid patient
 5 in that first wave or in that second wave, which were
 6 the two waves that we studied, there was a notion in
 7 which, once again, with careful adjustment, that that
 8 strain did impact on survival.
 9 **Q.** So to take the headline message if we can from that,
 10 certainly in the second wave, the peak within
 11 January 2021 onwards --
 12 **A.** Which is that very high one.
 13 **Q.** -- it was the highest peak of the pandemic, for both
 14 Covid and non-Covid patients, if you were admitted to
 15 ICU during that period, you had a greater likelihood of
 16 dying than if you were admitted during any other period;
 17 is that correct?
 18 **A.** So if you were admitted on a day where the strain was
 19 higher, yes, but that's likely during the wave,
 20 absolutely. And that's sort of done doing the most
 21 careful adjustment that we can for other patient
 22 characteristics. It's the best statistical methods that
 23 we have to study this phenomenon.
 24 **LADY JUSTICE HALLETT:** I'm afraid we're going to have to
 25 call it a day.

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