Tuesday, 8 October 2024

(10.00 am)

MS CAREY: Thank you, my Lady.

The first witness this morning is Professor Bamrah. May he please be sworn.

PROFESSOR JASWINDER SINGH BAMRAH (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

MS CAREY: So your full name, please.

A. My full name is Professor Jaswinder Singh Bamrah.

Q. You are here to give evidence today on behalf of the Federation of Ethnic Minority Healthcare Organisations, or FEMHO for short. I hope you'll forgive me for calling it FEMHO.

Can I make sure that you have in front of you, I hope, the two statements that you've prepared for the Inquiry; the first statement dated 22 December 2023, ending 399526, and the second statement dated 28 February 2024, ending 427706?

A. I do.

Q. Thank you.

Can I start, please, with a little bit about you. I think you are a senior consultant psychiatrist working in the NHS, and were you working in that role throughout the pandemic?

A. I was, yes. I mean, I was working remotely for a while

but my mother was 90 at the time, so shielding her as well as, I suppose, myself but most -- but I worked throughout, yes. And I've -- today is the 43rd anniversary of my starting in the NHS. I was a young, enthusiastic, somewhat excited, and very nervous doctor and I'm that today only less young and more nervous.

LADY HALLETT: But just as excited.

A. Just as excited.

MS CAREY: Well, there's an introduction.

Professor, with that excitement in mind, though, can we turn to the difficult topic of the disproportionate impact of the pandemic on black, Asian, minority ethnic healthcare workers in particular, and just to help you, and indeed those who are watching, of course, there are clearly a number of structural and wider issues at play but today I would really like your help, please, with the impact that the pandemic had on either creating new inequalities or exacerbating pre-existing inequalities.

Just a little bit about FEMHO, though, itself. I think you say in your statement that it is a consortium comprising of 55,000 individual members belonging to over 40 organisations and networks across the entirety of the UK and, my Lady, I won't go through them but if anybody wants to see the individual list of

member organisations they are set out in annex 1.

Could you help me, Professor, though, what type of roles does the membership cover?

A. So we were actually formed at the time of Covid, at the first meeting with the CMO, a number of organisations came together and we at that time understood that there's a major issue in terms of black and ethnic minority representation, as well as the issues that we were having with the morbidity and mortality statistics which were going the wrong way, and at the time we brought all these organisations together. They are largely doctors, nurses, pharmacists, but also people from admin background, managerial background and from social work background.

Q. I think it also includes cleaners, porters, catering and other support staff.

A. The support staff.

Q. So the whole range, really, of healthcare workers that we are concentrating on. And I think you say that a number of FEMHO's members include senior medics and other healthcare professionals who act as pillars of their communities. I would like really to start, please, why is it important to have representation by the ethnic minorities at a higher level and acting as a pillar of the community?

A. I guess all the statistics, including from NHS England, have shown that unless employers -- employees of the NHS have senior managerial positions who look like them, who are black and brown equally represented, they are unlikely to take, understand those instructions, the advice, the policies because they're not formed around them. They're not culturally sensitive.

Q. We may look at a number of examples of that as we go through evidence this morning but I think you say at the outset in relation to public health communications in many cases they are instinctively distrusted by members of the communities.

Why is there such a level of distrust?

A. I think much of it is in the way that these communications happen. They have happened traditionally top-down rather than policies worked out with the communities and many who've come round around the Windrush generation, around from South Asian countries, they have had that feel that actually we're here as -- to provide a service but not to be part of the upper echelons of the society in the NHS and, of course, over time all the statistics have shown that there hasn't been adequate representation even though that acknowledgement has been there that we should be properly represented at all levels of senior management.

Q. Translating that to the pandemic itself, how did that level of distrust or the lack of representation higher up in the NHS, how did that play out for the BAME healthcare workers on the ground?

A. I guess this is where it was really exposed, wasn't it, that that fabric was already fragile and during the pandemic the issue of all these deaths amongst the black, and ethnic minority people, community, as well as healthcare workers, it really sent shock waves when the first ten doctors died, all of whom were ethnic. It didn't seem as if our voice was being heard although many of us were trying to shout from rooftops to say, look, listen, there's something going on here that shouldn't be happening.

So that just festered that mistrust even more.

Q. You said there that "many of us were trying to shout from the rooftops". Does that include you, Professor?

A. It does, yes.

Q. Who were you shouting to?

A. To -- well, everybody. The Prime Minister, the Secretary of State for Health, NHS England. Pretty much wrote to everybody you know starting from the end of March, really.

Q. And in relation to NHS England, who would you be directing your shouts towards?

A. So initially to Sir Simon Stevens and then to Amanda Pritchard but also CMO and Medical Director of NHS England.

Q. Now, you mentioned a moment ago the first ten doctors dying being of ethnic origin. I just want to pick up on that, please.

Could we have up on screen INQ000215522.

I just want to ground us in with a few statistics but actually then ask you a bit about not the statistics but the actual people that we are talking about.

I think you say in your statement, and I'll just preface what we're going to look in a moment, that the NHS is the largest employer of BAME staff, 26% of its employees are BAME. It's about 340,000 people.

Then, by April 2020, the King's Fund article which we've got up on screen here referenced an analysis done that found that "of [the] 119 NHS staff known to have died in the pandemic, 64 per cent were from an ethnic minority background [whereas in fact] (only 20 per cent of NHS staff ... from an ethnic minority background). This disproportionate toll is shocking."

So, if we think, that's only six or so weeks into the pandemic, six weeks after lockdown. Could we go to page 2 of that document, please.

The authors of the article say there:

"We need to be careful about rushing judgement before we have all of the facts."

Because there are higher comorbidities from people with people from ethnic minority backgrounds, there are ethnic minority backgrounds that constitute a disproportionately high number of key frontline workers, and those from ethnic minority groups are more likely to be concentrated in poorer areas and live in overcrowded housing and intergenerational houses.

So there's a number of reasons why there might be this disproportionate impact.

If we go a little bit further down to the paragraph beginning "In short":

"... people from ethnic minorities are more likely to have underlying health conditions that make them more vulnerable to the virus, work in roles where they are exposed to it and live in conditions in which it is more likely to spread. As the Mayor of London, Sadiq Khan commented: '... the depth of inequalities is being laid bare in stark fashion'."

Because I am keen that this doesn't become a statistic-laden examination with you this morning but I just want to set a little bit of context for the evidence you give, and I think you are aware that following these statistics, the Chief Medical Officer

commissioned Public Health England to conduct a review. And if we just look at, please, INQ000106482, just picking up there on some of the inequalities, the Chief Medical Officer told us, for example, that people from a BAME background were more likely to get severe Covid. Those infected were more likely to die, and you can see there, for example, in the paragraph beginning:

"An analysis of survival among ... COVID-19 cases showed that, after accounting for the effect of sex, age deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British."

LADY HALLETT: Can you remind me the date of the review.

MS CAREY: Yes, the review came out in June 2020.

LADY HALLETT: Thank you.

MS CAREY: Commissioned around April and published in June.

Professor, can I ask you, against that background, when the PHE review came out, how was it received by FEMHO and its members?

A. So -- and then before that, the King's Fund which you were referring to had already put up the statistics. So we were -- obviously, we wrote to Public Health England

at the time, expressing concern, and actually saying there are ways to mitigate the risks, and we'd like to be engaged and involved in discussions around this.

I guess worry and alarm, particularly as many of them were very much on the frontline and wanted to save lives, and so there was major concern around all the communities, you know, in our organisations where all these statistics were being given but, you know, these statistics were important. But what was going to happen in order to mitigate against these disparities and risks, that was the major concern that people had.

Q. That's exactly what I was going to ask you. Given these shocking statistics, can you help with what was done practically on the ground to try and mitigate these impacts? Some examples of things that were practically done?

A. I would say -- I would give a varying response, I don't want to say that -- there's no uniformity, so that was another problem, that there was some who might have acted very -- very responsibly, but the feeling on the ground with frontline workers is they're not listening to us because we're not adequately equipped to look after patients. We are putting our own lives and our family's lives to risk with our work, with the way that we have to go into hospitals and support patients and

treat them.

So while these statistics were there, we didn't feel that enough was being done to actually give us the tools by which we could actually look after patients safely.

Q. And what were those tools? Is that PPE?

A. PPE and, as we now know, pulse oximeters were not really standardised according to skin colour. We also know that respirator was concerned about respirators there was, in terms of social isolation, many who lived in multi-generational households could not actually practise that safely. Some hospitals would put people up in hotels, others didn't. Some would just ask them to go home. The equipment was really -- there was a lot of reprimand around masks.

Q. Pause there because I'm going to deal with masks as a separate topic, if I may, and we'll come back to that. I just want to stay with the levels of infection and mortality that were brought to bear.

I think in your paragraph 13 in your first witness statement, Professor, you made reference to the fact that the first ten doctors to die were from a BAME background, and you said this, that:

"... despite the risks being obvious to many of us, there were delays around ... collecting, collating

and analysis of data in real time."

Can I just ask you about that sentence, in particular. What risks were obvious to you before the PHE, before the King's Fund article? What was obvious to you and FEMHO's members?

A. So the first thing was, why is it that, you know, all the first -- actually then there were 14 people all of whom were ethnic who died, so there was an escalating, an escalation in terms of numbers as well. Why is it that you know black and ethnic people are dying, and why isn't NHS England or the NHS collecting data on ethnicity and race. And, of course, data is key to remedy, and as it happened, you know, data wasn't collected until late.

We also wanted to know why -- is there any reason why these folks are dying, and our thinking at the time was really there needs to be proper risk assessment, and actually, we wrote about this at the end of March even before the lockdown to talk about risk assessments.

Q. I'll come on to risk assessments as well, but in relation to the data, I think you say in your statement that one of your member organisations, the Filipino Nurses Association, began collecting data on Filipino nurses who had died and actually submitted that data to the Chief Nursing Officer because no government body was

doing this.

A. Yes.

Q. Who, in your opinion, should be responsible for collating the data? Is it the Department of Health, NHS England, the respective bodies across the DAAs? Who do you think should be holding the pen and collecting this data?

A. Well, my sense is it's a governmental responsibility and it cuts across all governments. So I think it should rest with them, although obviously there's always delegated responsibility to Public Health England and NHS England. But I think there was that chaos, it seemed to us, that we weren't sure how policies were made, where are they made, we're not involved in these policies, but my sense about it is that this is a real -- in an emergency preparedness situation, this is a government's responsibility to make sure that we are safe and that, you know, they have data around us.

Q. What data would you advocate should be collected? Clearly, number of deaths is important. Number of infections? Roles? What kind of data do you think actually would practically help governments and indeed those running the NHS to work out where the disproportionate impacts are being felt?

A. So, whilst I'm not an epidemiologist, I would say that

basic data is that: demographics around the person. The age, the sex, the ethnicity, the race, the occupation, where they live, because we know now that where they lived, in most deprived areas, are most heavily infected by the virus.

So all of those data, the housing conditions, all of that data is crucially important.

Q. And do you think FEMHO's members, in the first instance, would be happy to provide that data?

A. We would be happy to be involved in providing the data, absolutely.

Q. I ask that because if there is a distrust of government communications and the like, it just struck me that some people might not want to engage with the provision of that data. Is that fear, do you think, unfounded?

A. I think we are a professional organisation so we would be happy. While we don't have the means to collect the data, we would certainly like to be -- be happy to be involved in the decision-making in order to get the right data in the right form, culturally sensitive data there.

Q. I think you make the point in your second statement -- you don't need to turn it up, Professor, but in Wales as well, for example, there was a lack of or poor quality ethnicity data in relation to Wales. We've heard

similar evidence in relation to Northern Ireland as well, in particular, from the Chief Medical Officer from Northern Ireland.

Can I ask you about a different aspect of data. Are you aware of whether there's any reliable data on the impact of Long Covid on the BAME healthcare workers?

A. No, that's another matter of concern to FEMHO that we actually don't have that data and we know that many ethnic people were actually struck by Long Covid and the absence of that data certainly worries us.

I know a number of colleagues who have Long Covid but are actually providing frontline work in the NHS. They are still there, they are still beavering on, soldiering on, but that data is lacking, and that support isn't there either. It's not just about the data. Many of them tell me they are not getting support from organisations that they should.

Q. Has FEMHO in any of its correspondence asked any of the government bodies to collect Long Covid data?

A. Not specifically. We've asked generally around data to be collected, ethnicity data.

Q. Can I ask you, please, about your paragraph 17 in your first witness statement, and you make reference there to FEMHO's members bringing to the public attention and advocating for government intervention once the data in

relation to the disproportionate impact of deaths began to become publicised.

Certainly we've looked briefly at PHE being asked to look at the data. I think you say there Kevin Fenton was appointed to conduct the review.

Can I ask you, please, about any contact or correspondence you had with Kevin Fenton in relation to the PHE review?

A. So we wrote to Professor Fenton at the time, and a declaration, I know Kevin very well. I was with him last week lecturing at a black and ethnic conference. We wrote to him saying that we thought that that was a very important review that he'd carried out and we were very pleased with the recommendations he'd made. Our concern was that the recommendation should be carried out by the government as they were set out by him and we were concerned that that might not happen and I don't think it did, actually.

Q. I think you say in your statement that Professor Fenton invited BIMA, one of your membership organisations, to a roundtable to discuss the impact of Covid-19 on minority ethnic groups and BIMA was asked at the meeting to follow up with representations which they did, but they in turn did not receive any response to the representations that they made.

Professor, can I ask you this: clearly in a pandemic not everyone can answer every piece of correspondence either as well or as promptly as one would like, but where representations from organisations like BIMA aren't answered, does that filter down to those on the front line and does it have any impact on them when they are feeling ignored for whatever reason?

A. Well, that was one of the problems. I suppose, you know, with multi organisations actually writing several letters, the volume, and also we've got a crisis on our hands in 2020-2021, I understand that, but actually it shouldn't take much for the government to respond and take notice of important organisations saying right from the front line shouting, to help them, to say "We're here to help you."

I think it just kind of festered that mistrust and of course it filters down the organisation members because we write to our members to say: this is the response of whoever we wrote to, the government or Mr Matt Hancock or whoever.

Q. Well, in your second statement you give an example at paragraph 8 of some ICNARC data being used to engage with the First Minister and health minister in Wales which prompted better engagement, you say, in Wales and led to the establishment of the First Minister's BAME

Covid-19 Advisory Group. If I understand you correctly, that sort of proactive response or reactive response, I should say, from the Welsh Government, was that of value to Welsh BAME healthcare workers?

A. Yes. I mean, the approaches that -- and then we are witnessing within the UK a different approach by one government where the Welsh Government were very engaging with Professor Singhal, they actually then gave him the responsibility to develop the risk assessment tool for Wales which we then sent to NHS England as well, which actually informed some of the decisions eventually. But there was a lot more engagement in Wales. It was a different tone of conversation that they were having.

Q. Can I ask why -- are you able to opine on why there was a different tone in Wales?

A. I can't say. I think it's been a long-held view amongst not just the black and ethnic minority people but, generally, amongst the NHS employees that, you know, I mean, NHS England sit over there, you know. It's top-down and not bottom-up, and so we saw that at its worst during Covid where they had a completely different approach to Wales and, indeed, Scotland as well.

Q. I was just going to ask you about Scotland because I think in your paragraph 9 in statement 2, clearly in Scotland there was a similar disparity in deaths of

healthcare workers amongst BAME communities.

Can I ask to be called up on screen INQ000409269. Thank you very much.

This is an open letter signed by more than 100 medics in early April 2020 to the Scottish Government to express concerns over PPE once the disparate effect of deaths was made clear.

I just want to ask you about some of the passages in the letter.

If we could just scroll down a little bit to the paragraph starting "Presently", the authors of the letter say:

"Presently what has been provided in primary care (and many areas of secondary care) has been thin plastic aprons which cover very little of the wearer's body, surgical masks which have been shown only to be protective against large droplet spread but not to smaller droplets or anything airborne and flimsy eye cover which does not provide enough protection. Even the [WHO] guidelines state a surgical gown is a minimum. But here in Scotland we should be doing so much better for our dedicated healthcare workers who are risking their well-being daily to help combat this ... fatal virus."

They go on to make reference to aerosol-generating

procedures. They make the point there they are worried about patients coughing and sneezing passing on the virus and:

"There are similar concerns about adequacy of PPE in many areas of secondary care and also by pharmacists who are seeing patients who attend their pharmacies."

I think, is it right, Professor, that as a result of this letter being sent there was -- it was picked up by the media and brought to the attention of Nicola Sturgeon who was the then First Minister and it led to a meeting with Gregor Smith the Scottish CMO to highlight these issues?

A. Yes.

Q. I ask you about Northern Ireland, though. Do you know whether there were --

LADY HALLETT: Just before you move on -- do we know if anything changed as a result of the meeting with --

A. I think there were better dialogue between them and our organisations and in fact they invited again one of our chairs of the organisation there to actually give a report to the Scottish Assembly. So there's been ongoing dialogue and better relations.

LADY HALLETT: Better relations, better dialogue, good, but what really good is to get the equipment that the letter was saying that people needed on the ground. Do we know

whether that happened?

A. I think there was a general problem with equipment but, do you know, my Lady, I wouldn't want to swear on it but I think that there was absolutely -- they heard what we were saying and there was more than an attempt to provide them with better equipment. Certainly better than the flimsy gowns that they were getting. Whether that was widespread or not, I cannot say.

LADY HALLETT: Thank you. Sorry to interrupt.

MS CAREY: No, not at all, thank you.

I was going to ask you whether you knew whether any of FEMHO's membership organisations had written similar letters or tried to raise concerns with the Northern Irish ministers. Can you help with that at all, Professor? Do you know what the position was?

A. No, I don't think anybody wrote to -- but we knew what our colleagues there were feeling.

Q. Thank you. That letter touched on issues of access to and suitability of PPE and I'd like to ask you about that, please.

Professor, we've already heard a lot of evidence about PPE being unavailable or inadequate or fit testing being failed and I think they are consistent concerns of FEMHO's members; is that correct? Could you just help us, please, with how does a member of FEMHO or a BAME

healthcare worker take to task someone and say: this gown isn't good enough, that mask doesn't work, I didn't pass my fit test. How do they practically going about getting a better quality of PPE for themselves?

A. Oh, very hard really.

Q. Why?

A. So in March, people were already raising the question of poor supply of PPE and the inconsistent advice that Trusts were giving them and the inconsistent advice, and these are medical directors, CMOs, saying to us that they were getting inconsistent messages from right up there, and so we know of a lot of instances where medical directors would threaten the doctors and nurses saying if they saw them with a mask in the corridor they would be disciplined or if they asked for a mask they would be disciplined.

So there was a sort of a fear that we will be disciplined and we know that black and ethnic minority doctors and nurses are certainly more likely to be disciplined and to be sacked or erased from the register. So that fear was there, that look, we have to keep quiet under these circumstances. But there was every attempt to raise this issue with employers as well as high up.

Q. Can I ask you about that then, please. When you talk

about doctors and nurses more likely to be disciplined, is that internally by the hospital or the Trust; is that what you mean?

A. I mean by the regulators.

Q. By the regulators, right.

When you heard reports or FEMHO heard reports that there was people being threatened with being disciplined, did you try and take any action with the regulator or with the Trust to try and stop those threats being uttered?

A. We actually wrote to every Trust, I think it would be late in April or May -- I think in late April -- and we wrote, actually -- we wrote to the Department of Health as well about this issue that, look, we're concerned. We also wrote to the General Medical Council, I think it was just before lockdown, to say -- to Charlie Massey to say, look, we're hearing about doctors being told that if they ask for masks they will be disciplined and also our doctors are saying to us that if we are not adequately equipped we cannot work in ICU and in A&E and other frontline areas and would we be protected by the regulator if we don't work.

Q. I'll ask you about that last bit in a moment but can I just stick with the threats to staff if they wore a mask when they seemingly shouldn't.

Is that something that particularly affected BAME healthcare workers or was that more generally, threats? Do you know?

A. So you would be looking at a biased sample from us really. I understood that some were generic but certainly the black and ethnic doctors and nurses and pharmacists felt more threatened by that, and there were individual examples we had of people who had been threatened.

Q. Can you give us an example? Don't name the hospital or the trust, please.

A. I can give you an example of somebody who actually -- she was in her late forties, she was a consultant in medicine. She wanted it to be open but I don't want it to be open. She was told by the medical director that if you ask for a mask and if I see you with a mask I will discipline you. She was working on the orthogeriatric ward, this is the orthopaedic ward where you do rehabilitation for patients after a fracture of the femur, repair of the femur, that sort of thing. She actually did catch Covid from a patient. And she was very seriously unwell, she was DNR'd twice actually. They didn't call her back. 18 months she was away from hospital. Nobody bothered to call her. She had to arrange her own test in order to see that she had Covid.

From that time on, the Trust completely shut shop on her.

Q. I hope it follows that she made a recovery?

A. She's made -- she's got Long Covid, but actually she's there, she's right on the front line, and actually she's now a clinical director in medicine somewhere.

Q. Bearing in mind that example and the evidence, I think you said in your statement that challenging authority is not the norm for some members of the black, Asian, and minority ethnic community. How do people from those communities go about, then, asking for better quality PPE -- if that's not how they have been brought up, that's not part of their cultural background? And how do we change it to make them feel enabled to challenge authority where it's appropriate?

A. Yeah, I mean, it's so difficult, isn't it. They do actually feel they really can't -- something will happen to them, like, you know, losing their job. Many of them had come from abroad for the first time just before Covid, so they were scared of doing anything that would mean the loss of a job. And, I guess, you know, they reach out to organisations like FEMHO to say, "Look, can you provide us with support", and we've supported a large number of people over the last four years, including sometimes legally.

Q. I think you give an example in your second statement of, in Northern Ireland, a frontline social worker speaking to nursing colleagues it's your paragraph 12, Professor, those nursing colleagues were Indian, and they had anxieties they couldn't really communicate to others. Some had newly arrived in Northern Ireland and didn't want to be seen to be making a fuss by raising concerns.

Can you think about how any recommendations that could be made to try and dispel that myth, "It's not a fuss, it's a legitimate concern"? How can we go about changing that attitude?

A. I think it's all -- so I'm a great educator and trainer, and I think it's all about proper training, cultural awareness, cultural competence, people understanding this is the kind of culture that people who are black and minority ethnic, that's the background they come from, and if they don't complain but they look unhappy, what is the reason behind it.

So I think it's, you know, it's understanding that and being able to say, "Look, we are going to provide you with the support and not run this department with fear", which many people seem to do.

Q. You say as well that those from minority ethnic backgrounds are less likely to be in trade unions. Why is that the position?

A. So many of them are locum, so particularly with doctors and agency nurses, many of them are locums, and they don't belong to trade unions, most of them. So they don't have that kind of protection that some of us in substantive positions have.

Q. Now, some of these are slightly broader issues than the impact of the pandemic itself, but can I ask you, please, about your paragraph 25 in your first witness statement and some evidence that was given in Module 1 by Sir Christopher Wormald, the Permanent Secretary to the Department of Health. I think you set out there that he confirmed the department had stocked lower levels of PPE suitable for black staff working in healthcare, and that little planning had been done to consider the equality of PPE provisions.

When FEMHO's members heard that evidence or learned of it, what was their reaction to that?

A. Shocked, really. Perhaps not surprised because that was an admission of what was already prevailing at the time and had been for some time, but absolutely shocked that, you know, there should be an admission of -- well, not that there should be an admission, but that this sort of thing has been allowed to fester in our hospitals and our communities.

Q. We've heard that PPE, in particular masks, may not suit

anyone other than the white male without the beard. That's an oversimplification and it's mine, but you will understand the general thrust of the question, Professor. Do you know if there's any work being done to procure PPE that fits a broader range of healthcare workers, in particular people with beards, for example? Do you know if there's anything being done about that?

A. So one of our members did at the time write to the Department of Health, and I can share that correspondence if I haven't already done that through our legal team. And because these were bearded Sikhs, Muslims and Jewish people, men, because they did not pass the fit test with the traditional FFP3 masks, one of them invented what was called the Tata technique which he said passed the regulations, but then he was categorically told by HSE that they cannot agree with this and that the requirement is to be clean shaven.

Now, and you know we heard about these very sad instances where Sikhs and Muslim men had to shave their faces for the first time, which, you know, if you understand the religion as I'm sure you do, this is just completely unacceptable but they wanted to provide a service to their patients and help run the departments so they did, some of them did become clean-shaven for the very first time.

But HSE clearly stated that "This is it, you are either clean-shaven or" -- and there's no attempt, really, to produce masks that fit bearded men, as I know.

Q. Do you know if there was any thought given to wearing the powered hoods so you wouldn't need to shave necessarily? Do you know if any FEMHO members were offered that as a potential alternative PPE?

A. Not as I'm aware, and I've communicated with a lot of these folks, but not as I'm aware.

LADY HALLETT: Professor, was this instruction they had to be clean-shaven written down anywhere? It's just that it seems to me such an extraordinary thing --

A. Yeah.

LADY HALLETT: -- to tell people who, for religious reasons, have beards. So you're confident this isn't apocryphal; do we have any hard evidence?

A. May I read it out to you, my Lady?

LADY HALLETT: So where is this coming from?

A. This is coming from them, the HSE.

LADY HALLETT: So the HSE, you have something in writing?

A. Yes.

LADY HALLETT: Yes, please.

A. So:

"Based on the information provided, HSE cannot

agree to the use of this method" -- which is the Tata method -- "specifically we make the following observations. The requirement to be clean-shaven to support an effective seal between the wearer's face and tight-fitting respirator has been in existence for many years and is not a new requirement of the current pandemic."

And so on. It goes on about PPEs as well.

MS CAREY: Professor, can I just ask you, is that a document that is exhibited to your witness statement? I know there's a number of exhibits and I'm afraid --

A. I'm not sure, you know.

Q. If it's not, we will ask you for a copy of it.

A. Sure.

Q. All right, thank you very much.

Now, can I ask you about the BAME healthcare workers who failed fit tests and what was done in the circumstances where they failed the test. Can you help with what provision was made for those who had failed the tests?

A. So there were a lot of Trusts that acted very responsibly, and, you know, people were -- responsibly -- there was a whole problem with PPEs which I know has been rehearsed in this the Inquiry many times and I won't go through that.

So where they absolutely failed, you know, and they couldn't wear, such as bearded men, then they were shielded from work. But some, including I know that there were about 20 or 22 Sikh dentists who then chose to get back to work. So there were people who might have gone back to work because of the, you know, the problems with the resourcing departments.

Q. So they felt they had to go back to work to help the effort?

A. I think there were -- there were people who had to go back, who felt they had -- they needed to get back to work.

Q. Now, you give in your second statement a more positive example of the attitude in this case of Wales towards PPE. Can I ask you about paragraph 15, please, in your second statement.

I think you give an example there of a nurse practitioner and executive lead of the British Indian Nurses Association, BINA, in Wales, where that nurse practitioner considered that PPE was well organised at her hospital. What did that nurse practitioner tell FEMHO?

A. So she's a member of the British Indian Nurses Association -- executive member of British Indian Nurses Association, and she was very pleased with how this was

organised. There was a better understanding between them and the Welsh Government and the Welsh hierarchy including the CNO, and they felt that there was proper fit testing, there was proper PPE provided, that there were good risk assessments done as well -- it's not in that paragraph, but that's what they felt.

And they were more collaborative, so it worked out much better. There was no significant delay in the supply or availability of PPE eventually.

Q. You spoke a moment ago about the problems of PPE for men wearing beards, but I think you also in your statement speak to the issues where many of the female Muslim members of FEMHO couldn't be fit tested to ensure PPE fit to the face because they wore a hijab. Do you know what steps, if any, were taken to fit test them or to check them if they wanted to wear their hijab as well as PPE?

A. So I can't tell you specifically, but I can -- I know that -- do you know, I can't be specific about that.

Q. But there was reports to FEMHO, if I understand you correctly, that there was problems with fit testing --

A. Yes.

Q. -- female Muslims if they were wearing a hijab?

A. Yes. But what happened after that, I can't tell you. I would be happy to find out.

Q. And I think you also say that there were some female Muslim members in both non-clinical and non-patient-facing roles who wished to cover their forearms, and were threatened with referral to regulators for breaching duties when they expressed their views and their religious positions.

You say this:

"Changes to multi-faith dress codes policy for PPE were sought by some of our members because of these problems."

Do you know, in relation to the changes that you sought, whether there was any change in the --

A. I don't believe that there were changes.

Q. You made the point in your statement that agency workers and locum staff were more likely to be allocated to more high-risk patients and areas. Can you give us some examples of some of the things that were being reported to you for the agency workers and locum staff?

A. Yes, it was commonplace throughout, actually, where they would come in and find out on the day that disproportionately they were more likely to turn up right at the coalface of Covid, and this was really pretty common practice, I would say, across, for agency doctors and agency nurses.

So where doctors and nurses were shielded,

particularly, then the agency nurses would be put in disproportionately into those jobs.

Q. You said, for example, it could take shape in the provision of shifts to treat patients with Covid or being allocated to hot sites or Covid Pathways and the like, and you say there that certainly from the Filipino Nurses Association, they described the agency nurses were being allocated to high-risk patients over non-agency staff and yet had poorer access to PPE, a double whammy, if I may put it colloquially. But does that accord with reports you were hearing, Professor, from your members?

A. Indeed, and also that some of them had to purchase their own PPE. Many of them actually had to purchase their own PPE because the hospitals would not provide them.

Q. I think you say in your statement that some of your member organisations reported that healthcare workers resorted to using bin bags instead of clinical gowns.

A. Mmm.

Q. We looked at some of the correspondence with other nations in relation to PPE but I'd like to ask you about a letter sent to the Health Secretary Matt Hancock in March 2020.

Could we have up on screen INQ000184474. And this is a letter of 27 March to Mr Hancock.

It is from the British Association of Physicians of Indian Origin, BAPIO, as I think they are known. This raises concerns about distribution of PPE and a lack of testing for frontline workers by many NHS trusts. And if we scroll down the page, we can see there an urging to him to "send an urgent instruction to all NHS trusts and CCGs/PCNs" -- primary care networks -- "that PPE should be made available to all those medical nursing staff and other frontline staff who are treating patients presenting to hospital, most certainly patients with any presentation of cough or fever, regardless of the underlying reason why they arrived at the hospital in the first place, and that those doctors, nurses and other staff who are deemed to be at high risk and their family members will be tested without any failures."

I think similar letters were sent to Sir Simon Stevens, the Chief Medical Officer, and I think also Stephen Powis. Do you know, as a result of those letters and letters like this, whether there was any change in the instruction as to what PPE was made available to BAME healthcare workers?

A. Not quickly enough, I'm afraid. So I was signatory to this letter which I remember very well, and it was just before lockdown, reports were already coming through, and because they were not really listening to us, then a

couple of GP trainees, Vis and Joshi, who were with Bindmans solicitors, decided to take a claim against the government. So we were signatory, we were interested party in that claim, and we decided to take the Health Secretary to court for poor provision or no provision of PPE.

Q. Can I ask you, we've obviously looked earlier in the Inquiry at some of the IPC guidance that came out, and it is generic guidance across the entire UK and doesn't suggest or allude to the fact there should be any higher quality PPE for BAME healthcare workers. I want to be clear; do FEMHO say that there should be a distinction drawn in the IPC guidance, or it should just be better PPE for everyone who is high risk or dealing with the patients with or suspected of Covid?

A. Exactly that. We don't expect any exclusivity, but the characteristics of having a beard are not exclusive to Muslim and Sikh people or Jewish people; you know, white men also have beards, so I think we're asking for proper fit testing and more proper equipment.

Q. In relation to testing, I think you set out in your statement at paragraph 37 onwards that you learned from the members that access to testing at the beginning of the pandemic was generally poor. Again, I want to ask, is that specific to BAME healthcare works or it was poor

generally for everyone working in the healthcare systems?

A. It was poor generally but, of course, we were getting reports because of the vulnerability of our folks that they felt very, you know, exposed to the virus.

Q. You make reference to, again, the Filipino nurses had issues accessing testing kits when they needed them, they felt they did not have priority access to testing kits unlike other staff on more stable employment contracts, although you make the point that the Filipino example is, I am afraid, more widely felt across BAME healthcare workers. Is that FEMHO's position?

A. Yes, yes, I think there was generally -- people are afraid to ask as well because, you know, repeatedly. That was another thing. It's a cultural thing. So generally they felt very isolated when it came to these policies.

Q. Can I ask you about the second wave of the pandemic and clearly we've heard that it was worse for staffing levels but you make the point that some of the members of FEMHO were excluded from clinical practice because they now were assessed as being vulnerable. I would like to ask you about perhaps the tension there that, on one hand, we're protecting them more now but therefore now excluding them from the very roles that they were

trained to provide.

How did that play out on the ground, Professor?

A. So that conflict, you know, I was referring to that earlier and, you know, in that conflict of course some people felt they had a duty to provide, providing they were not Covid positive, provide a service even if they were exposed because of their particular vulnerabilities. I guess people took their position -- in that particular time they took their position as they thought was best fit, so many of them did shield and they wrestled with the idea that their departments -- so there are some departments that are entirely run by black and ethnic people and those departments would struggle. So it's more likely that people would feel a sense of duty to the patients and the Trust and came to work.

So there wasn't one formula fitted all.

Q. You go on to say in your statement that there were a number of retired black, Asian, and minority ethnic doctors and nurses that called back or volunteered to return to work. From FEMHO's perspective was any consideration given to those cohort of workers coming back knowing now the vulnerabilities that BAME healthcare workers have to Covid?

A. So we were very concerned. Of course it was their right

to want to come back and serve because some of them obviously had recently retired and they missed providing a service to patients. But we were concerned that many of them were the very people, men mostly, mostly Asian men, and with some comorbidity, asthma or diabetes or whatever, and we were actually concerned that they were properly risk assessed and then only assigned to frontline working if they were not considered to be at risk.

Q. I presume that requires a risk assessment to be undertaken and I'd like to ask you about that, please. You say that there were delays experienced by those that required risk assessments. Can you give us an idea about what kind of length of delay we're talking about in risk assessments being conducted?

A. So I think in the first instance getting the policy off the ground was really very difficult in terms of risk assessments. I think it took off somewhere -- I may be wrong, but June or July, something like that, probably a little bit later but there were greater delays in actually implementing that policy and Trusts, mostly Trusts, these are mostly Trusts, were implementing it very variably in the Trust. So some people would get risk assessments and many were reporting to us that they're not getting risk assessed.

Q. Either didn't get them or when they did, they were far too late?

A. Yes.

Q. Can I pick up on a statistic that you've provided because you said there was a study conducted in June 2020 into risk assessments for black, Asian, and minority ethnic doctors which at that time found that 65% of doctors said they had not yet had a risk assessment. That was a survey done in June 2020, so that gives us an indication of the number of doctors that hadn't yet had a risk assessment.

Now, you say in your second statement that in Wales in April 2020 the Chief Medical Officer of Wales and the Director General were asked to put into place an urgent stratified risk assessment, is how it's described in your statement, and the risk assessment subgroup prepared a simple risk assessment tool which ended up becoming the All Wales Covid-19 Risk Assessment Tool which was launched by the government.

Why, Professor, do you think it was important that there was this risk assessment tool being brought out in Wales and what use was made of the tool?

A. So, I mean, the reason for that was just that Professor Singhal who actually led on that was able to impress on Dr Mark Rutherford, the first secretary, that, look, we

are picking up that there are great vulnerabilities in the community and we need to know who's exposed to the virus and who's going to be vulnerable. I understood that actually there was a real good take up following that. There was no resistance after that from the Welsh Government to actually roll out the tool across Wales.

Q. I think you say in your statement that by 2021 more than 71,000 NHS and social care employees and, indeed, over 74,000 public sector employees had used an online version of the tool plus there were 45,000 people using a paper version of the tool. So a significant take up in Wales.

A. Yes.

Q. I don't know how familiar you are with that tool, Professor, but is that a tool that you would welcome being thought about being rolled out across the other nations? What's the advantage of that tool over the other tools that are available in England, Northern Ireland and Scotland?

A. So -- well, in England, typical of us, I suppose, that there were a few of these tools eventually that were being bandied around. We actually passed this tool to NHS England to say the Welsh have already implemented this and it seems to be having a good take up and it seems to have all the stuff that we know about, age and

comorbidities and all that sort of thing, and sex, and I do understand that by September 2020 the tool that came out, which I was involved with, with the Chief Executive of Wigan, I think that that informed eventually the tool that he devised for NHS England.

Q. You said in that answer there was perhaps too many tools. Is that one from NHS England, plus one from Trusts, plus tools within the hospitals themselves? Can you give us an idea of how many different tools there might be?

A. It seemed like that, you know. It seemed that there were different ways of then trying to risk assess patients, or people rather, and frontline workers.

Q. You say in your statement that the Welsh model can be considered in comparison with the English model where there was more of a focus on a data-intensive approach preparing a risk assessment tool which would be linked to the patient's medical records. Is that -- is there a downside to that? Are you worried about that approach by the English model to risk assessment tools?

A. Well, I think what we need, really, if you ask me, is -- I mean, I'm a researcher, so I would say that I would be happy if somebody were to do some research on these assessment tools now. So I think the NHS should commission what is the most appropriate tool rather than

wait for this to come round again.

Q. And do you know, Professor, are these tools available in multiple languages?

A. No. No they're not -- not as I'm aware.

Q. Does that pose any practical difficulties for the black, Asian, and minority ethnic healthcare workers or is that not so much of an issue as there has to be a base understanding of English in the roles that they're performing?

A. Yes, for the frontline workers all of them would speak English. So I think this would be fine and the people who are applying the tool should be well versed in English.

Q. And in your members' experiences, who is conducting the risk assessment? Is that being done in a culturally appropriate way or do you have any observations to make on that?

A. So no they're not being conducted in a cultural way. That is anecdotal. You know, I know that people felt that sometimes people didn't really understand the sensitivities around the various parameters in the risk assessment tool depending on their culture. So, no. The people who conducted them were the lead people so it could be the lead clinical director or the lead manager of that particular department.

Q. I think you say that in Scotland you've heard from their members there was no push from the Scottish Government to pursue an ethnicity-specific healthcare worker risk assessment tool for primary care staff. Is there a distinction to be drawn between the risk assessment tools for primary care and secondary care?

A. No, I think a risk assessment for a particular illness like Covid would be generic.

Q. But at least from September 2020 the assessments did take into account ethnicity when working out the healthcare worker's risk score?

A. *(The witness nodded)*.

Q. Now, can I just ask you about this because clearly there are underlying inequalities that are well known and well rehearsed. There is clearly variation as to how much concentration a risk assessment places on ethnicity. Why, given everyone knows there's a problem with disproportionate impacts, didn't the risk assessment tools include ethnicity from the outset? Why does it take until September 2020? Do you have any observations as to why there is a delay in ethnicity being picked up in this way?

A. I think that's the nub of the question, isn't it, because I think there was a general feeling that throughout, even before the pandemic that, you know,

people, our bosses are not actually understanding that there are particular issues of culture, race and ethnicity that they need to be aware of. If they were aware of these things which there had been multiple attempts, multiple reports to say, look, these are very important issues to your 1.3 million employees, there has been just an abject failure to actually understand the sensitivities around that.

Q. Can I come on, then, to a larger topic which is the guidance and communication that was issued and I think you say that -- it's your paragraph 53 onwards, Professor -- that the guidance was confusing, lacking in clarity and it caused additional stress. I would just like to be clear, what guidance are you talking about there, Professor?

A. Sorry, let me get to --

Q. Paragraph 53. It's all right.

A. So I mean, this is not just the chair of BINA saying it but we all felt that there was complete inconsistency about what to wear, when to wear, who to wear, and all that sort of thing and that confusion that existed caused some Trusts' senior managers to interpret the rules according to their whim.

Q. Can you expand on that last answer. What were they doing to interpret the rules?

A. So it was like, you know, now you can wear -- you don't have to wear a mask, now you can wear a flimsy mask and there was different grades of mask FFP2s, FFP3s, and then there was protective clothing in aerosol-generating clinics or operating theatres. There was a whole lot of confusion about this for a very long time, unnecessarily so, because there was no proper one single guidance that should have percolated right from top to all the Trusts to say: this is what we think in terms of health and safety. We have health and safety regulations but it didn't seem to us that they were applying the very rules that they were trying to -- try and protect.

Q. Now, we've heard, Professor, that UK IPC cell issued UK-wide IPC guidance and it did obviously change as the scientific understanding about Covid changed. But just help us, from the BAME healthcare workers' perspective why was it so difficult to have changing guidance in the way that we know had to happen in the pandemic?

A. Principally because it was BAME people who are falling, either falling ill or, unfortunately, dying. So there was a whole lot of fear in the community, anxiety expressed, in the community. I mean, people were saying to me: I don't know whether I'm going to say goodbye to my partner today or am I saying good morning to them before I go to work. Because there was that tense

palpable anxiety amongst people: we are going to work, we do want to work, we want to save our patients but we don't know whether our employers have our own health and safety in their mind.

Q. Now, you make the observation in your statement that it's important, indeed vital, is your word that government guidance is accessible to everyone so that individuals can stay informed and you say the government guidance was not culturally competent and inadequately catered to the needs of the black, Asian, and minority ethnic healthcare workers.

Can you give us an example of culturally incompetent or inadequate guidance?

A. So I think Professor Kamlesh Khunti gave an example that in many languages "virus" isn't a word and I think that it's like that, you know. And depression, which is an illness, I'm a psychiatrist so I understand depression, depression is not actually a word -- an illness in many languages. So there are very many other cultures which actually don't understand the English, you know, wordology, if you like.

Q. Clearly one can translate the guidance into any number of given languages but is that a quick fix? I rather gleaned from your statement that it was more than just terminology. Are you able to help us in other ways in

which the guidance was inadequate or wasn't culturally competent?

A. So, many cultures have differed customs and practices and it's not just about the words, it's about understanding those practices that, for instance, if you don't -- if I woman doesn't look at you eye to eye, if you are a man, that that is just the culture. It's the way that they are. It's nothing else, you know.

Q. How can we translate those examples, though, into better guidance that is less confusing or is more clear? Can you think of some practical ways we can try and help to overcome those cultural differences?

A. I would go back to training. You know, training of all our leaders, make sure that they understand this so that it can go down the various paths and, you know, tributaries of the NHS. Proper cultural awareness, proper cultural competence, and then testing to make sure we have updated and people have the knowledge of the various cultures we have.

Q. Do you know, was any feedback given to the UK IPC cell about cultural incompetence or inadequacies in the way the IPC guidance was phrased?

A. I don't know whether we -- I don't remember formally writing but I've been in many of these conferences and webinars with NHS England where we've brought up this

issue.

Q. I'd like to just look, please, at some of the steps taken by your member organisations to try and engage BAME communities with the guidance, and the like, and I am at your paragraphs 55 onwards, Professor, but I think you make the point there, that there was quite a lot work being done by members of the BAME community to try and spread the word, stop disinformation, engage with the communities. Can you give us some examples of things that FEMHO's members did to try and overcome some of these difficulties with the guidance?

A. So just simple understanding why people needed to sanitise their hands, why social distancing was important, why vaccine uptake was important, why there were so many black and ethnic doctors and nurses and pharmacists who then became vaccinators in order to impress on people that these vaccines are quite safe, well, as we knew it at the time, we felt that this was effective to try and reduce the spread and mitigate against the virus.

So all of those seminars -- there were many that -- we've given you a glimpse of some of them but there were so many of them.

Q. Yes, I'd like to just look, please, at INQ00099685_0004, and if we can just slowly scroll through, there's about

four or five pages of different adverts. Some are relating to the vaccines but we go through a number of different webinars, lectures and the like, being hosted by members of FEMHO to try and communicate with different BAME communities.

Can you help us, was this co-ordinated by anyone or was this work being done off these organisations own back if I can put it like that?

A. Yes. Done very much off their own -- they are all valid organisations and they have structures so, yes, between them, they did a lot of great work.

Q. You make the point in your statement that this voluntary effort was pursued on top of already the high workloads that these people were undertaking. You say "with little to no formal support from the system", and I wanted to ask you about that, please; what support would you envisage or would be welcomed by people who are organising webinars at the like?

A. These were very much weekend, evenings, you know, taken up after work and -- I mean, I think -- there wasn't even an acknowledgement, you know, that all of this, not that -- we're not looking for a pat on the back from anybody because this is for the community and this is to improve matters in the community.

I suppose, you know, I think there should be --

this is part of your job, so there should be an acknowledgement in people's job that this is really what your duties are and make it part of your core NHS duties that you're an educator, a trainer, and this is what you're doing as part of that. And then, with that, would come the admin support that you need because these are very senior people in the NHS who are then setting up their own seminars, setting up -- flyers, right from flyers, up until delivery of these programmes, and then getting feedback.

It's quite a lot of effort, to be truthful. Some kind of admin support would have been very handy.

MS CAREY: My Lady, might I just ask one or two final questions perhaps before we take our break.

And it's about this, Professor. You say in your statement that communities were often referred to both in policy and the press as "hard to reach", implying that black, Asian and minority ethnic communities were the problem rather than the ineffectiveness of public communications. I'd just like to ask you, do you have any suggestions for either a different phrase or a different way that people can try and communicate with communities that have hitherto been described as "hard to reach"?

A. I would say abolish the term altogether, "hard to

reach", because, you know, I mean, this happens in psychiatry all the time. You know, there are hard-to-reach patients because they have schizophrenia. I see that very often, and actually it's such a sad phrase, isn't it? It is us, how we try and -- the hardness is with us, not with -- and it sends the wrong signal because it implies that "The problem is with you and not with us", and so I would say, you know, that term really needs to be abolished altogether.

So, put out the title as it is, you know, we are doing this for this reason, you know, vaccine uptake or more information about Covid or something. Put the title up rather than putting out that we're doing this because you are so hard to reach.

LADY HALLETT: I think the Inquiry may be guilty of using that expression, Professor -- no, I accept any criticism.

A. Sorry.

LADY HALLETT: No, I am perfectly prepared to accept a criticism if it's justified, and by the sounds of it, it may well be.

MS CAREY: My Lady, can we pause there. There's a few more topics I need to conclude with the professor after our morning break.

LADY HALLETT: Certainly. I hope you were warned that we

take breaks, Professor, and I shall return at 11.30.

MS CAREY: Thank you, my Lady.

(11.15 am)

(A short break)

(11.30 am)

MS CAREY: Thank you, my Lady.

Professor, may I ask you, please, about the impact of the pandemic on the mental health of FEMHO's members, and it's at paragraph 63 in your first statement if you need to refer to it.

Clearly, we've heard about the impact of the pandemic on the mental health of healthcare workers generally, but can you help us with some particular examples of how it affected FEMHO's members?

A. How long have we got? I think this is one of the neglected areas, to be truthful, because -- I mean, much as there was a lot of stress in the acute system, can you imagine our mental health workers going to A&E, and A&E saying, "Well, actually it's the responsibility of your Trust to provide you with PPE and all the equipment, so you can't come in to see our patients because you need to be properly equipped by them", and the Trusts, knowing that they were keeping PPE for their staff, there was kind of a breakdown about what the NHS is, which is that we're one organisation.

So that was the stress of the work. And then patients on mental health wards having Covid but obviously not being able to access the right medical support which they needed, and, of course, we understand medicine with our doctors, but actually we're not physicians or treating those patients. A lot of stress, moral injury, to a lot of workers during that time, not being able to give patients the kind of support and that was generic, not being able to give patients the right amount of treatment at the right time caused a lot of pain all around but, of course, our members who articulated this to us felt really that that has not been addressed even until today. Mental health, as ever, came right, you know, on the back of the envelope right at the front.

So, you know, I would have liked to have seen that to be addressed for people to be able to articulate their fears or the stresses that they had. You know there are simple things like Schwartz ward rounds that can be do that.

Q. I've missed that last phrase; what kind of ward round?

A. Schwartz.

Q. Help us with that please, Professor.

A. So in a Schwartz ward round, somebody who is trained in that would bring people, the staff together, who have

experienced stress, and it's proven to be very useful where they can, in a very safe space, be able to talk about anything they want to talk about, about how the work and how the stresses of patients might have impacted, or care might have impacted on them.

Q. One might say, in normal times, we have time for that kind of decompression and for the staff, but how practical do you think the Schwartz ward round would be at the height of the pandemic when there are overflowing beds and more patients queuing to get into the hospitals? I'm just trying to see how practical that would be in the eye of the storm, if I can put it like that.

A. In the eye of the storm, not practical, you're right, but I think that -- but some kind of peer support is necessary, and I think a lot of people felt very lonely as they were working in A&E or intensive care units. You know, they felt -- although there were teams around them, but actually because of, putting crudely, the death and destruction we were seeing in Covid, it was really quite, for them, mentally, it was a very difficult time, and a lot of them have scars of depression, stress, which are written on them for a very long time.

Q. We've heard a little of that evidence already from

a number of our witnesses to date, but just thinking about the BAME healthcare workers themselves, were there particular anxieties or stresses that were born to bear by those communities?

A. So because they live in multi-generational households, many of them, there was obviously that, that, you know, because there was close communities that, you know, they were bringing Covid sometimes to their family, their parents; so there was the stress of that. Many of them are migrant workers who have come here, so they have parents who live abroad in Africa or India, or Pakistan, Sri Lanka, Bangladesh mostly, and they had difficulty, how do we support them, so they had that issue to deal with, the stringent rules here where parents could not come and join them on the adult dependent rules.

So I think a whole lot of cultural issues came up with them when it came to Covid.

Q. Can we turn to recommendations that you would urge your Ladyship to consider to try and ameliorate the impact or disproportionate impact, or indeed some of it, in BAME healthcare workers. You touched on data collection already in your evidence, and I think you make eight recommendations in your statement including the need for review and investment where necessary, into culturally competent and sensitive healthcare equipment.

Do you include, in that, PPE?

A. Yes, so I include in that PPE as well as pulse oximeters, as we know now, are not really designed for dark-skinned people.

Q. Yes. You would also urge what you term as a specific and actionable plan to redress the gap in racial equality in senior management roles. And can I ask you, Professor, as laudable as that is, how practically do you think we should go about achieving that?

A. It's very practical, and the work and race health equality standards which NHS England has actually constructed around the workforce actually tells us how to do it. You know, that's the irony of it, is that the data is there, you know, it's not acceptable that in managerial, only 15% are ethnic and very senior management position only 11% are ethnic. You know, over nearly 50% of doctors are black and ethnic, and over 20% of all NHS workers are black and ethnic. So that statistics is crying out for change. That change, actually, we know how to get there because, you know, there are already -- it's what's behind the statistics, isn't it? That's what you are asking me, and there is a plan that is -- and we will be able to help. You know, there are organisations like FEMHO, BAPIO and other organisations, are very happy to help to make this a

policy.
Q. So, better engagement with organisations such as yours?
A. Yes.
Q. We've looked at effective risk assessments which would factor in race and ethnicity. I won't ask you about that. But if you could just stand back, Professor, and perhaps think about one central recommendation that you would like your Ladyship to consider, do you have one burning recommendation out of all of them?
A. I guess that would be that apart from those things is really, I think we need good training and leadership where they, at the top, understand the nuances of all these cultures. I think there are over 200 nationalities in the NHS from -- were my last statistics on that, and do they have an understanding of this so that they can understand the way that black and ethnic people work.

I think there should be safer practices, safe and flexible working, there should be better protection for people who -- you know, legal and institutional protection for people who are discriminated against or bullied or, you know, harassed, if you like.
Q. Now, I understand all of those matters, but they are potentially wider than just the impact of the pandemic; do you have any recommendation that you would urge us to

consider in the event of a future pandemic that could help FEMHO's members?
A. Get us into the room early. I would say that because I think that if we're involved right at the outset, you know, this "us and them" mentality is where -- why things were so disjointed, I would say. Get us into the room. It's about -- it's about defining policies around people, not people around policies.
MS CAREY: My Lady, those are the questions I have. I think there are some questions.
LADY HALLETT: It's Mr Jacobs to start.

Mr Jacobs is behind you, Professor, but don't worry, he is used to people turning their back on him.

Questions from MR JACOBS

MR JACOBS: Professor, do speak into the microphone when you give your answer, thank you.

Professor, just a few questions on behalf of the Trades Union Congress. My questions are going to focus on the position of agency, locum, bank, and outsource staff in healthcare, so really those other than indirectly employed in permanent roles.

First, is it your understanding that black, Asian, and minority ethnic workers are disproportionately represented in such roles?
A. Are they represented in agency -- are they represented

as members?
Q. Are they disproportionately overrepresented in --
A. In disciplinary procedures, yes.
Q. No, just in terms of numbers of healthcare workers in those roles. So, for example, some professions in roles that are more outsourced like cleaners and porters and what have you, do we see instances in which ethnic minorities are disproportionately overrepresented?
A. I haven't got an answer to that. I'm really sorry.
Q. That's fine. I think we can move on to the next topic and look at some of what you do describe about the particular position of agency workers.

In your statement and, in some respects, your evidence today, you have described agency workers and locum staff being more likely to be allocated to higher-risk roles, agency nurses being excluded from access to PPE, agency nurses and bank nurses having greater difficulty accessing testing kits, outsourced workers in the NHS often not being given a risk assessment -- your second statement, for example, describes an account from a Northern Ireland healthcare worker who says they don't know if agency staff were risk assessed at all.

When one looks at those features together, it paints a pretty grim picture, does it not, Professor, of

the experiences of those healthcare workers who were not indirectly employed in permanent roles?
A. It does.
Q. How would you describe the particular experiences faced by those in more precarious employment roles in the pandemic in terms of, for example, the ability to raise concerns about PPE, about the infection and prevention control they see around them and what have you?
A. So, as you know, bank, agency, and locum staff, this is a growing number in the National Health Service and my fear is -- I mean, I'm a trade unionist myself, I have been a director of the BMA, so I understand this myself that, look, these folks don't have the kind of protection that substantive people have in employment and that is a big worry, and because they are a growing number, I feel that they are hugely disadvantaged. That is why they have ended up in jobs that they know are frontline and that they are going to be at risk but they can't say "no", and if they said "no" they would not get another job somewhere else. They don't have the kind of protection -- despite our good employment laws, they don't have the kind of protection.

I guess my answer is there has to be some concerted effort to bring all of them into some sort of a trade union, you know, because I don't think currently

it's working as it is. They are really very vulnerable.
Q. That might be something it's easier for you to raise than we, Professor.

One issue that Sara Gorton has given in evidence on behalf of the Trades Union Congress is that agreements for directly employed NHS staff covering full pay for Covid sickness and self-isolation was difficult to enforce for staff who were outsourced or working via banks. Does that, to your knowledge, chime with the experience of any FEMHO members?
A. So that is my understanding, that, you know, that's how it was at the time and whether that had been a practice before that I don't know, but certainly during the pandemic, the acute part, that's how it was.
Q. Are these the sorts of macro-level systems and processes, as you describe in your statement, that interact with one another to generate and reinforce inequities among racial and ethnic groups?
A. Absolutely. Inequity and mistrust.
Q. And if it follows from that, that these are the sorts of processes that need to be confronted in preparing and responding to the next pandemic, how is that to be done practically? What are the practical steps that might be taken to support the position of those in bank positions, outsourced workers, and so on?

A. So my sense about this is really that I think it's getting -- I mean, I would say that you might say that, but I think it's about getting all the trade unions together to see how that protection might be afforded from government level to these workers. You know, I think we've had a rule in medicine that every doctor who joins the GMC register ought to have indemnity even if they have their own private indemnity, and I think there's a whole lot of lower-paid staff workers who are particularly vulnerable because they can't afford that sort of -- I mean, why is it that they don't have it? It's because they can't afford it. If they could afford it, they would. And for low-paid workers it's even worse. So I think there's a huge army of people there who really we could do better with, with getting proper representation for them.
Q. On some of the recommendations that you describe in your statement -- so, for example, in relation to risk assessments and plans for effective Infection, Prevention and Control -- is it important, in your view, that these matters need to be tailored in various respects but including in respect of outsourced staff? So, for example, to ensure that risk assessments are not just the preserve of employed staff but also staff who aren't directly employed?

A. Absolutely. I mean, I made that point, my Lady, which is that quite often they were left to their own even, you know, carrying these bin bags as aprons, and flimsy masks. How many of these low-paid workers did we expose to the virus unnecessarily? You know, I think there has to be some sort of a system of support for them. After all, we're losing them because they either just go off the NHS or they become ill and can't work.
MR JACOBS: Those are my questions. Thank you very much.
LADY HALLETT: Thank you very much, Mr Jacobs.

Ms McDermott.

That way, Professor. Ms McDermott is within your eye line.

Questions from MS McDERMOTT

MS McDERMOTT: Good morning, Professor.

Professor Bamrah, today I will be asking questions on behalf of the UK Covid Bereaved Families for Justice and the Northern Ireland Covid Bereaved Families for Justice.

And, firstly, congratulations on your 43 years in the NHS. It's a remarkable feat.

My first question is about what you started with in your evidence and it was a common theme throughout your evidence about how it didn't seem as though the black and Asian and minority ethnic voices of the

healthcare workers were being heard and you have given some striking examples this morning and in both your statements of evidence of the impact and consequences brought about by not hearing those voices. So plainly from your evidence, many within the BAME community were afraid to speak out.

My question is this: specifically at paragraph 42 of your first statement you recount how many healthcare workers express fear of speaking out about unfair redeployment due to concerns over negative repercussions. I don't know if you want to have an opportunity to reflect on that paragraph but my question is this: in your view, was this fear justified and what specific consequences do you think those particular employees risked by speaking out?
A. Yes, and sorry, but they were justified -- I'm sure you understand that -- because that was the practicality on the shop floor that many of them were very, very fearful of actually going against -- it's also a cultural thing, that if you're a senior person or you're older than the person, that you don't challenge them as well. That's also kind of a cultural thing.

So there was a lot of anxiety and stress about this, you know. There was a lot of fear that they dare not tell them that the rules are being broken and they

are being impartial in some ways of even racist in some ways, that word that, you know, is often just in the background but not used in the NHS.

So I think, yes, I think that it was justified. What was your other question?

Q. The second question is about the consequences and what were the specific consequences do you think those particular employees feared should they have spoken out?

A. So the worst consequence, isn't it, that they would lose their job, and as I was referring to, certainly when you look at the statistics in terms of the disciplinary action taken against doctors and nurses you will find that they are disproportionately from the black and ethnic minority community. So that's the ultimate consequence.

There are other, what I call micro-aggressions, I do not know whether you like that term or not, which is, you know, ignoring somebody, not including them in communications, not talking to them, not encouraging them, not planning their PDP or supporting them with CPD. There are so many different ways that these mal-communications happen which undermine that person and undermine their morale, who is, after all, a person who just wants to do their best in their job. I think everybody wants to do the best in their job unless

proven otherwise.

Q. I'm grateful for that fulsome answer.

Can I take you then -- you mentioned statistics and I'm going to bring you to a Northern Ireland focus because I know Ms Carey KC's questions have been navigated this morning so as not to be statistic laden, but statistics on the number of BAME care workers in Northern Ireland are very difficult to unearth.

If you just bear with me one moment while I explain this.

An example of that is that the data from the 2021 census for Northern Ireland indicated that almost 12,000 of the 60,000 workers within the healthcare sector were not born in Northern Ireland and, more specifically, Belfast Trust had around 47.1% of graduate nurses employed between April '21 and March '23 were from abroad, but the census does not reveal their ethnicity.

Now, in Module 3 the Northern Ireland Chief Medical Officer, Professor Sir Michael McBride had spoken about data in relation to age, in relation to gender and social deprivation and being able to use and analyse that data but within that same paragraph of his statement and that's, for the record, paragraph 424, he cites:

"Analysis regarding ethnic minorities was not

available due to the poor coding of ethnicity in healthcare records and it was not possible to look at trends in those from different ethnic backgrounds nor to analyse differential impacts of the pandemic according to ethnicity in our general population."

My question is about the chasm of information, and reflecting on your evidence today and reflecting on the point that you've made about the need for the NHS to commission a risk assessment tool, do you agree, perhaps more generally and more urgently, that the gap in data for Northern Ireland should be urgently addressed?

A. The answer is absolutely yes. I mean, I'm concerned that, you know, it's okay to give these statistics, Sir Michael, but actually then say what your next step is going to be to address this huge -- unless you have the data. You know, as I said, I'm a researcher, unless you have the data, unless you know what's happening you can't actually address it and I can't see -- I mean, you have given some data there and it might be that -- these are kind of crude data but they tell you a story that actually we need to look at all of these people who are coming there. It's about retention and recruitment as well, isn't it? If everybody feels valued then they will give the best in their job that they can and if they are just a statistic or even a non-statistic then

how are they going to do their best for the NHS?

Q. I think moving on from that but within the same rubric, the information and what you do with that data and how it informs policies right up to the top, and we've heard some evidence today regarding the engagement between FEMHO and devolved nation governments, but specifically at paragraphs 5 to 8 of your second statement you talk about the increased awareness and concerns in Wales and Scotland regarding Covid infection rates and the disproportionately high mortality rates for BAME healthcare workers. To this end, you even manage to set out some of your responses from the First Minister levels from Scotland and Wales, and it will be for the Inquiry to consider the adequacy of those responses, but are you aware of the Northern Ireland Government response in relation to the high BAME mortality rates?

A. I'm not, actually, unfortunately, you know, and I think it's probably a gap in my system that I should have been addressing. We did address the issue of the workers there, but in terms of our engagement with the First Minister there, there was a gap.

Q. But is that gap also for -- informed from the information chasm that we've mentioned?

A. Yes. I mean, I think it's evident that -- I mean, it works both ways, doesn't it, that there should have been

some attempt on them to engage with communities there, which I don't think there was from the government. If there was, I don't know about it, to be truthful, because I would have guessed they would have contacted somebody like myself.

MS McDERMOTT: Very grateful for your answers and responding to my questions, Professor. Those are my questions.

A. Thank you.

LADY HALLETT: Thank you very much, very grateful.

That completes the evidence for you, Professor. You have been a very eloquent witness and obviously a very eloquent spokesperson too for a large number of communities, I suspect. Thank you very much for the constructive nature of your evidence, and I too would like to wish you, again, a happy anniversary.

A. Thank you.

LADY HALLETT: Stay in the NHS as long as you can.

A. Thank you.

(The witness withdrew)

MS CAREY: Thank you, my Lady. There may just be a brief pause now while we --

LADY HALLETT: I will stay here.

MS CAREY: Thank you very much.

(Pause)

DR CATHERINE FINNIS (sworn)

LADY HALLETT: Dr Finnis, I hope we haven't kept you waiting for too long.

A. No, not at all.

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

MS CAREY: Dr Finnis, your full name, please.

A. Catherine Finnis.

Q. You made a witness statement on behalf of the Clinically Vulnerable Families core participant group dated 31 January 2024, INQ000409574, and I hope you have a copy of that in front of you.

A. I do, yes.

Q. All right, thank you.

A little bit of background to both you and indeed to CVF, as they are known. I think that you trained as a medical doctor some years ago now and practised for five years when you needed to leave face-to-face clinical work due to you being severely immune suppressed; is that correct?

A. That's correct.

Q. And is that why, in part, you appear with a face mask today?

A. Yes, that's correct.

Q. You have a nice loud voice, please keep it that way; nice and slow as well, please, doctor, so that the

stenographer can keep up.

I think having left face-to-face clinical work, you completed a master's degree in health services research, and you now work in a non-patient-facing role within the NHS?

A. That's correct.

Q. And you are the volunteer deputy leader of CVF?

A. That's correct.

Q. And can you just help us, please, with a little bit about CVF. I think you say they were formed in August 2020, and what was the reason for the formation of CVF?

A. Yes, that's right. So CVF was formed in August 2020 at a time when shielding had been paused and children were required to be back in school in September 2020. What that meant was that for people who were living within clinically vulnerable families, they were concerned about the risk of their children returning to school and indeed contracting Covid. This is despite the assurances, at the time, that schools were safe and that children indeed didn't transmit Covid, but Clinically Vulnerable Families was set up by Lara Wong, who was a teacher, and she recognised the risks to parents of children returning to school and, indeed, clinically vulnerable and clinically extremely vulnerable teachers

who were also required to return to school in September 2020.

Q. So, pausing there, we understand that the genesis of CVF was because of the concerns about going back to school.

Now, you will appreciate, Dr Finnis, that we are concentrating on the impact of the pandemic within the healthcare systems, and so that's not to minimise the impact on children and indeed the teachers who were clinically vulnerable or clinically extremely vulnerable, but can we focus today on healthcare systems impact, if we may.

And I think you say this, that there's a combined membership of -- and following of CVF at just under 46,000 people, and there are a number of members on Facebook, followers on Twitter and the like, and that CVF's mission is to support, inform and advocate for those in clinically vulnerable households as they face an ongoing threat posed by Covid-19.

Can I ask you, please, Doctor, I might concentrate firstly on "clinically extremely vulnerable" and then on "clinically vulnerable", and some different issues may arise, but clearly if I talk about one and there's an issue for the other group, please do say so. And can I, at the outset, thank you very much for the helpful quotations that are peppered throughout the statement;

we may look at one or two, but if we don't have time this morning and during the course of your evidence, there is a litany of quotations from the people themselves who were affected.

I think it's right, as a result of your medical problems, were you on the shielded patients list?

A. Yes, that's correct.

Q. Okay. So if you have your own experience to bring to bear as well as speaking on behalf of CVF, please do say so.

Can I start, please, with clinically extremely vulnerable people and the shielding list. Indeed, we have heard about the make-up of the CEV list from Professor Whitty and others who gave evidence to us earlier, but it might just be easier to call up on screen, please, INQ000409574_0010 just to remind ourselves, without having to go through it, those that, as at 1 April, were deemed to be the highest clinical risk, and a number of different people with medical vulnerabilities set out there.

I think, is it right, that CVF have concerns about who was on it who should not have been, and conversely who was not on it who should have been, so can I ask you about those two sides of the coin, please.

A. Yes, that's absolutely right. So as we understand it,

there was an algorithm initially that -- who identify people who should be put on the shielding list, but there were people, because algorithms are never perfect and there's a data quality issue that I think you have heard about within the NHS anyway, some people weren't identified by the algorithm. They were then left thinking, "Well, you know, I don't appear to have been told that I'm being shielded", and that then led them to contact their general practitioner to ask whether they indeed could be added on.

However, that did bring about delays to shielding and, as we'll go on to talk about, probably the benefits of shielding was that you actually had a passport, through that shielding letter, to enable you to work from home. So people who were delayed not being able to do that and who, for example, had frontline jobs as you have just heard the previous witness say, were required to still go into frontline jobs until they had those letters.

Q. Now, we -- although there are, I think, the different medical categories, we were also told that if a GP identified a patient as being clinically extremely vulnerable, they could be added to the list and, indeed, people could ask themselves to be added to it. And you said that led to delays. Are you able to help us, from

CVF's perspective, how long it took, if you were in that latter category of asking your GP to be added? Days, weeks, months?

A. Yes, it could take weeks. And that was because the GPs themselves, you know, everything had changed at that time, so it was quite hard, actually, to sometimes contact your GP. You know, everything was remote, people didn't know really who to contact. You know, everyone was very worried, scared at that time. They knew that they had a vulnerability. The list was publicly available, and they thought they should be on it, and so it was a very worrying time for them. They knew they should be on the list, they didn't have a shielding letter, they weren't able to work from home at that time, so their life was potentially at risk, and, indeed, being put on the shielding list could then take weeks.

Q. From CVF's perspective, is there a category or type of condition on here that you think should not be on the shielding list?

A. No.

Q. All right. Now, what about the timing of the compilation of the list? I think you say in your statement that obviously we went into lockdown on 23 March, and the letters started to be sent to people,

I think, a couple of days earlier on 21 March. Clearly, that was some time since reports in early January or thereabouts of the emergence of the coronavirus in Wuhan; does CVF have any concerns about the timing of the compilation of the list?

A. Yes, very much so. So obviously we are aware, or those of us that were aware, of which many people that had underlying conditions were watching closely the pandemic, because we soon realised that people, sadly, who were dying, had underlying conditions, and so, you know, we had worked out, really, that we were at higher risk, and we were obviously watching, initially, the WHO and the problems in China, and then later, of course, the terrible problems in Italy, and indeed that was being beamed into our front rooms on television, and then, people with these underlying conditions and even telling us what they were, even at that point.

We -- you know, it was very late. The shielding timetable, when people were told to shield, seemed very late into March, and indeed when you look at the timing of the first wave, I think CVF would suggest it was too late, and that in fact some of those clinically extremely vulnerable people could have been told to shield earlier and not have become infected.

Q. I think you say in your statement that actually there

was effectively an informal shielding that commenced earlier by some of CVF's members. Are you able to give us an idea of how many of your members started shielding before the letters were actually sent out?

A. Yes, I don't have a number for you, but certainly when I wrote to our group to do some thematic analysis to understand this, it certainly was a dominant theme that came. So it was a large -- a number of people who were able to do that. However, there is kind of a -- discrepancies or inequalities, if you like, about who was able to shield informally. So people of working age, particularly people in frontline roles such as teachers, nurses, doctors, shop workers, bus drivers, taxi drivers were unable to shield informally because they could not work from home. People like myself who had office work, I was able to discuss it with my boss and I was given allowance to work from home, as were some of us in those roles.

But certainly it was very late.

Q. So there are those whose perhaps work allowed it could start informal shielding but without the letter to say you should be staying at home and should not go to work, it made it very difficult for those clinically extremely vulnerable people to start any informal or pre-shielding? Is that --

A. Absolutely, and we've got quite a few teachers, actually, within our group, due to how it was actually set up, and for teachers it was really difficult. They were in school every day with lots of children. They knew that they had one of these conditions on the list, and they were not told to shield. They were not actually given any information what to do. There was no real education. I think at the time we were being told to wash our hands to "Happy Birthday", as I recall, and that was really all the advice. So it was a really stressful time.

I guess the group of people for whom we represent that were able to shield informally the most were older people who were retired.

Q. Yes. Well, can I ask you about that, because can we have a look on screen, please, at INQ000474233_0190, and I think, Dr Finnis, you have read the "Shielding" chapter of the Every Story Matters record, and indeed on the first page of the shielding section, there is reference there to a number of clinically vulnerable and clinically extremely vulnerable telling ESM about how frightened they were at the start of the pandemic, and we can see there in the second sentence down:

"Early in the pandemic, some avoided all contact with people outside of their immediate family because

they were anxious about catching the virus. Some did this before there was any official advice, aware of the risks associated with their health conditions."

You can see a quotation there:

"You didn't know what way it was going to go or how bad it was going to be, especially [in] the early part. Everywhere was closing down, it was very, very scary."

Does that echo members of CVF and the concerns that they were enunciating?

A. Yes, that was absolutely the case. I think, also -- I mean, I know it does say here "Early in the pandemic, some avoided all contact with people outside of their immediate family", but of course for many members of our group that continued throughout the emergency part of the pandemic, and for some people it even continues largely today.

Q. Today.

A. Yes.

Q. Understood. Can I ask you about the communications that went out to CVF's members. We know there was a letter sent by GPs, but I'd like to ask you, please, about a text message that I think one of the CVF members -- and could we have a look on screen at INQ000408799, and I think this is provided by one of your members as a

text that they received, I think, before they got the letter; is that correct?

A. Yes, I believe that is the case, and actually quite a lot of us did receive digital communications either by text and/or email before we received the letters. In fact, personally, I think I received my letter maybe two weeks later, but I received a text very quickly.

Q. Then look at the text, I think it was sent on 24 March received at 9.46 from the "NHS Coronavirus Service":

"Do you know how you will get your medicines while you are staying in your home? You can order repeat prescriptions online ..."

It gives the website address.

"Please ask your family, friends or neighbours to pick up your prescriptions from a pharmacy. Just remind them to leave the items outside your door.

"The NHS is still here for you - you will still get the care you need, but the way you receive it might change. More will happen over the phone and internet."

Do you know how CVF members reacted if they got the text before they had the shielding letter and how it impacted them to receive a text like this?

A. There were lots of different texts being received. There was one that said you can open your window but do not go outside of your home. Put a medical bag ready to

be taken to hospital by the front door. I mean, these were very frightening messages to a group of people who hadn't really been given any information on how to reduce their risk, for example. We were simply told to 'Stay at Home'. Many people within Clinically Vulnerable Families didn't see themselves as vulnerable, as indeed I didn't. I was a part, or am a part of the society, community, I have a job, I have a child. You know, a lot of us were in those situations and then suddenly we were disempowered hugely by really being told to just 'Stay at Home'.

This particular text was really, you know, worrying because, again, highly disempowering, asking your family, friends or neighbours to pick up your prescriptions from a pharmacy but they're not necessarily people who are used to asking people to do things for them. They were often stalwarts of the community who were doing things for other older people. Many of us have older parents for example. We wouldn't want to put them in harm's way and indeed we weren't necessarily part of those, kind of, maybe, I would say, older-age community groups to support us.

So a lot of us were very perplexed by these texts. We didn't really know what to do. We felt really stuck. Many people, we didn't know how to get our prescriptions

and these texts, they make it seem quite sort of easy, you know, you can order repeat prescriptions online on the NHS app. Lots of people didn't have the NHS app at that point. Lots of us weren't plugged into remote pharmacy deliveries at that time because obviously before we could go to the pharmacy and collect our medications on the way home from work, for example.

But suddenly we're being told we can't do all of these normal things and we must now ask other people, and that was really problematic for our group. I just want to talk about the clinically vulnerable if I can here, because I think it's really important because although they were never formally shielded, they were obviously told they were at higher risk and they too often needed medication, for example diabetics, asthmatics, needed really life-saving, important medication. They also were sort of advised to obviously ask family and friends, et cetera, but there was a real problem that developed with the clinically vulnerable, as I understand it from members in our group, who said that well -- "Oh, you are only clinically vulnerable, you are not clinically extremely vulnerable, you are not shielded." And people started to not want to put themselves in harm's way to help those people.

Q. Dr Finnis, can I just stay with that text for one

moment. Do you on behalf of your members think there should be no texts at all in these circumstances or is it there's an issue with the timing with which they came out and then, indeed, an issue with the content and the way it was delivered? I just want to be clear about what your sort of position is and how we might do something differently in the future?

A. I think it was a good idea to use all communication, to be honest. We would say that the timing was too late. It was already lockdown, wasn't it, by now so we should have received these before that.

I think the information is difficult. I think, you know, they do need to give people information. I guess it's all just about planning, for me. You know, why had they not set some of this stuff up already? Why did we not know that we could order prescriptions from the pharmacy, for example in February or late February or early March? Why leave it until we got to lockdown?

The other thing I just want to say about these texts we received, I received tens of texts, tens of letters, loads of emails. It was really frightening and constantly to be told that you're at high risk of dying should you step outside your house for a period that amounted to, you know, from March 2020 to summer 2021, is really difficult for people to cope with.

LADY HALLETT: Could you speak a little more slowly.

A. Sorry.

MS CAREY: It's probably my fault, Doctor. Just listening to that answer there, it strikes me that the balance between providing the right amount of information at the right time is what's the issue here. No-one's going to complain about being told what to do, if you're being asked to shield, but to be bombarded with it is perhaps not helpful either. I understand.

Can I ask you this, though, in particular there are core participants here on behalf of the Welsh bereaved group who make reference to a processing error in the Welsh Government's communications in April 2020 which resulted in 13,000 shielding letters being sent to the wrong address and arriving two weeks late.

Did CVF's members experience this and, if so, what was the impact on them of receiving the letters so late?

A. So just to clarify, these were people who should have been shielded, so just late letters.

I mean, so we have members throughout group who were told or given information about -- to shield over the, you know, the whole period, over the whole 18-month period of shielding. Initially there was all sorts of problems. There were people for whom they certainly didn't get their letter straight away. It was a bit of

a problem, as I recall, in terms of using it as a passport to be able to work from home if you didn't have the written letter. It felt as though the written letter was still the formal communication rather than a text message.

Q. We've touched on there some of the measures that were designed to assist those who were on the shielded patients list, including entitlement to Statutory Sick Pay which would have helped in those examples where people could no longer go to work.

I think you also say that in the information that was sent out there was early emphasis on hand washing, is that correct?

A. Yes.

Q. And there was no information on the airborne or droplet spread of Covid-19.

Now, put aside the controversies about the amount of transmission and how it was transmitted, why would it have made a difference if there had been information about the route of transmission?

A. It would empower people. So people would be able to, with advice and guidance, try and prevent their risk, their real risk and also understand what the risk really was because without really being told or just wash your hands, I mean, Covid obviously is an invisible risk, but

not telling people the route of transmission, just telling people to 'Stay at Home', it was -- being made a prisoner in your own home without any real understanding why and how you might -- why can we not go outside our house, and shielded people lived in different places. Some people lived in the middle of the countryside. So why could they not go for a walk outside their house or, indeed, their garden we were initially told not to go into our gardens.

Q. Can I ask you this: you may have heard some of the evidence that suggests there was uncertainty about the route of transmission. Do you think it would have helped CVF people if the communications had said: we don't know yet what the route of transmission is. Would that have been important to CVF's members?

A. Yes, absolutely. I think any information that you can give people -- you know, although we were scared and frightened, we were -- you know, there's many capable people in society, as we know, and many capable people who have underlying conditions and they would be really ready to understand that information, to empower themselves to be able to reduce their own risk and indeed that's what CVF has tried to do. That's what we've been doing, is really filling that gap from August 2020, trying to inform people about what masks

can be worn, whether it's droplet or airborne, to be honest. You know, what other things you can do to reduce your spread -- ventilation, you know, being outside. Things like that.

Q. We'll come on to ventilation I think as a separate topic.

Can I ask you about masking, though. I think you said in your statement that in the information that was given to shielded people there was no advice on masking. Do you mean it didn't mention masks at all?

A. No, I don't believe that certainly in the shielding letters, texts or emails I received that anything was ever said about face masks. There may have been something said about face covering a bit later on but certainly not in that initial wave. I don't believe there was anything at all about face masks or face coverings.

Q. Do you think there should have been?

A. Yes.

Q. Did CVF provide any advice or support when its members started to query -- I appreciate it was slightly later into the pandemic once CVF was set up, but were you receiving queries about what type of mask to wear in what circumstances?

A. Absolutely, yes, and we are still receiving those

queries to today. So one of our missions, if you like, is to really try and educate people and offer that, sort of, gap that remains, even now, in education between the type of masks -- I know you've been through -- which ones to wear when and, indeed, which ones to wear when accessing different kinds of medical treatment. So, for example, one that I'm wearing at the moment that has metal over it, you can't wear in an MRI machine, but there are masks available that you can wear and so we let our members know which is the best mask for them.

Q. And you -- is it by choice that you've chosen to wear the mask that you are?

A. Yes.

Q. Is there any reason why you didn't choose to wear the blue FRSM masks?

A. I'm wearing an FFP3, so I know that this is -- a much higher filtering capability, in excess of 99%. Although I am severely immunosuppressed I do actually -- and I do still live a limited life like a lot of us do -- despite that I do actually do most things wearing an FFP3 and I'm yet to catch Covid.

Q. One of the other offers of support, if that be the right phrase, was there was a suggestion that there would be -- in January 2021, those in residential or nursing homes would be offered a free supply of vitamin D

through the post if they were clinically extremely vulnerable. Was that ever expanded to those that weren't living or residing in the care sector?

A. Yes. So I believe it was offered to everybody who was on the shielding list. I certainly was offered a supply of vitamin D. I think what perplexed me at the time and still now is why at that point that -- I received my stash of vitamin D through the post, why not just give an FFP2 or 3 mask in the post? Why not use that opportunity to send those more protective masks to those very vulnerable people at that time?

Q. Were you offered any PPE at all?

A. No.

Q. What about lateral flow tests and the like, were you offered those when they became available?

A. Yes. So we were able to access lateral flow tests. Initially we were able to order online as many boxes as we needed but then there's been a reducing access. So then it was only the clinically extremely vulnerable or, actually, it was the person who could access antivirals, which is a different list. It became really complicated. That was one of the other issues. But if you could access antivirals then you -- which wasn't necessarily the shielded list but a lot them but involved some clinically vulnerable, for example, then

you could order your box of lateral flow tests that would come for you and now we cannot order them at all. I have to go into, we all do, have to go into a pharmacy to get them which is not easy.

There's no real process and it's risky.

Q. Can I ask you about some of the impacts of shielding on the clinically extremely vulnerable. You say, Doctor, at your paragraph 44 that shielding, despite all its challenges -- and we'll look at some of the challenges in a moment -- it was often a reassurance and a practical help to clinically extremely vulnerable.

Help us, please, with how it reassured people and perhaps some more positive aspects to the shielding programme before we look at perhaps some of the negative aspects.

A. I think given how worried people were with the information coming from, first, China and then Italy and understanding that people with underlying conditions were at much higher risk of severe disease and sadly death, I think that shielding was something for us to at least hold on to. It felt that perhaps we were being offered something by society. I think that it was really important that whole passporting aspect of it, that you could work from home or, indeed, if you could not work from home that you were then offered Statutory

Sick Pay which meant that you could at least afford to shield.

So from that perspective, I think it was helpful. There was other things such as food parcels, we were sent food parcels early on, just in the first wave. There was also something about supermarket shopping. So we were given free slots, essentially, to enable -- that took a while to kick in, to be honest. There was a first few hairy weeks, where, if we weren't prepared, and maybe that was one of the problems, was that because we weren't really forewarned all of a sudden we were perhaps stuck at home without any food in the larder and we were in lockdown, you know.

Q. It comes back to preparedness, and so many answers often do, if I may offer that comment.

Can I ask you, though, about some of the more negative impacts of shielding. I think in particular it might be helpful to look on the screen at INQ000408810 and some research that was conducted by The Health Foundation. If we just look at the second paragraph there. The analysis conducted by The Health Foundation:

"... shows that [CEV] people experienced a higher rate of deaths compared to the general population over the pandemic. At the peak of the first wave on 2 April 2020 the rate of deaths amongst the clinically

vulnerable population was over two and a half times that in the general population (1 in 2,500 ... compared to 1 in 7,000 ...) Furthermore, by the end of August ... the clinically extremely vulnerable population accounted for 19% of all deaths while only making up 4% of the total population ..."

So clearly there is statistically a higher risk of death for those who were deemed to be CEV.

I think there was also a decrease in CEV people attending planned admissions and emergency admissions and that is set out in the third paragraph there and clearly there may be all sorts of other emotional, psychological, mental ill health side effects to those who were asked to shield.

As a shielder yourself, may I ask, do you think the upsides outweigh the downsides or vice versa?

A. Yes, I think they do and I think they did. I think that the problem was -- it's difficult, isn't it? In talking about the past I think that's true because we were left with nothing else at that point, it was kind of dire straits, as you have heard, and that actually to get the information out really quickly to people who, as shown here were at very much higher risk of death, to get them as safe as could be, anyway at that time, I think that it was -- it was of benefit but I'm not sure that's true

for a future pandemic. I would hope that there would be, obviously hopefully from this Inquiry that, you know, suggestions for better planning and things could be arranged in a better way and more empowering way for people who are at greater risk rather than just leaving this only option of locking them away.

Q. You say in your statement that the negative effects of shielding were at least in part because of the poor quality of the guidance rather than necessarily the need to shield itself, and I wonder if I might be easier to look on screen, please, at your paragraph 57.

It's INQ000409574_25 and on to page 26, which just sets out and encapsulates the concerns about the guidance and it's that -- there you are, paragraph 57:

"Our view is that the negative effects were at least in part because of the poor quality of the guidance rather than necessarily the need to shield. The content of the guidance was sometimes scary and constantly changed. The advice was often unachievable and certainly was insufficiently reassuring ... Additionally ..."

And then you set out there a number of different aspects to the guidance. It failed to ensure complete household protection focussing on the CEV individual but often neglecting the risk posed by non-shielded house

members.

Just thinking about that aspect of the guidance, Dr Finnis, what do you think the guidance should say next time if we have to have a shielding programme?

A. I believe that you should shield the household, everybody that lives within the house, because one of the problems with the shielding guideline is it told us to stay two metres away from everybody within our household at all times, including our children, and this was really challenging. Of course, though, if we didn't then those other people potentially was a threat to life. So we were left in a very difficult situation within our own houses and in fact we have members who -- I mean, it drove people to extreme situations. So, for example, you know, a caravan -- staying outside on their own in a caravan in their front garden, moving into their shed in the back garden or into the loft, and we also had people who lived their life completely upside down. So their family were up in the day and then they did their cooking and eating in the night.

Q. I suppose, to play devil's advocate, there might be other members of the household, though, that don't want to take those steps, no matter how protective it is of the CEV individual; do you think there needs to be a better balance struck in the guidance that is offered to

the non-shielded person in the household?

A. I think it's essentially guidance. So I think that -- the whole point, really, is that the whole family should have the protection to work from home, or to get SSP, or the child to be home-educated, you know, remote-educated rather than put that -- that risk, because it's not only that those people -- I mean, generally speaking, in families people want to protect their mum or dad or brother or sister, and in fact it was psychologically extremely difficult for people to still go out and do their jobs knowing that they may well return home with a virus that could kill their loved one.

So, in fact, the pressure on those families during that time was immense. So I think it is guidance, but I think that you should at least have that as a protection that everybody can use those passporting to protect the shielded person, if it's right for them.

Q. Can I ask you about just a couple more of the sub-paragraphs in your paragraph 57. You say that the guidance contributed to significant mental health challenges due to isolation, an impact that could have been mitigated with more thoughtful guidance. Can you help us, practically, if you are able to, in what way could it have been more thoughtful?

A. It was very -- like we have already said, it was very

focussed. I mean I personally found it very triggering, to want to use the modern parlance, you know, constantly, every day, every week, every month, for months and months on end, I was told, if I go outside my house I might die. You know, having some kind of support, or some kind of, you know, even just basic how to relax kind of tips, or some kind of maybe online -- you know, how to relax, or some more information about -- it was just so stressful, you know, how to reduce the impact of that.

Also -- and some community hubs did this but certainly I don't remember the shielding guidance, but just letting people know what was available online for them to join. So, for example, book clubs were set up, or there was even a choir that you could do remotely from your home, and so just telling people of those things rather than just leaving it up to the person to go searching.

Q. Did CVF, once it was established, provide advice or provide any kind of information to its members as to how they could access something to try and at least relieve some of the burden --

A. So we had a weekly mental health post on our Facebook page, where people could add a differed coloured heart, and then depending on the colour of the heart, meant the

sort of support that we then went in and offered.

We also have CVF coffee evenings, and those are regular, even today, where people who are still very vulnerable and high risk today can at least have some social life.

Q. That can be taken off the screen.

Can I ask you, please, though, about CVF members' experience when they had to return to healthcare settings, and I think in particular we've already heard some evidence about use of masks in hospital and, indeed, CVF members attending hospital wearing masks and being asked to remove them.

So can you help us, Dr Finnis, with how CVF have found it when they have had to go to appointments in hospitals, GPs and the like?

A. Yes. So it's changed throughout the pandemic. So initially, obviously it was mainly remote, and generally speaking, our membership actually seems to like remote -- generally -- although we also recognise it's not right for everyone, and there should be a choice. And that, of course, it shouldn't be a choice of remote because healthcare isn't safe; that's what we would say, that it should be a real choice.

Other things that happened was that some of our members went to hospitals and were wearing a mask like

I'm wearing today, a good quality mask, well-fitted, and they were asked to remove it and put on the blue FRSM mask that we knew, and clinically vulnerable family members knew, was not as protective. That was very stressful, very worrying for them.

I actually experienced it myself, and I spent quite a long time outside the -- just with the reception staff, kind of advocating for myself that I needed to wear this mask, but it felt that I was better educated than the healthcare staff at that point, and ultimately there was no real fix to it. I was asked to remove it.

Q. I was going to -- who won, I suppose, is an inelegant way of putting it. Do you think -- how did the staff react, though, when they saw you coming in and wearing a mask and saying, "Look, I need to wear it because I have these underlying health conditions?"

A. Yeah, I mean --

Q. Did they seem to know what -- how they were supposed to deal with it?

A. Yeah, so certainly during the -- you know, during the main part of the emergency part of the pandemic, I think because more people were wearing masks, it was more accepted, but there has been a real kind of sea change, I would say, really, from when face masks were removed from hospitals in summer of 2022 in England, and in fact

we'd done some polls in CVF, which shows the problem. So just before the masks were removed, we did a poll in 2022, and it was with hundreds of people who were clinically vulnerable, and they were asked whether they had delayed or cancelled any appointments, and we were told that I think it was about just above 50% had done that.

Move on to November, though, of that year in 2022, and we asked the question again, the same question, to the same group, and they -- over 90% now were telling us that they were delaying or cancelling appointments or operations in hospital.

We repeated it again, actually, in November 2023 -- we need to repeat it again this year -- and again, it's over 90% delayed or cancelled appointments and operations.

Now, this is because people are now really worried. There are no mitigations in hospitals and, moreover, people who go in wearing a mask, and we've had many, many reports now of people being sort of gaslit why they need to wear one, belittled, made fun of, harassed, dismissed. You know, that's despite the, if I may, the government guidance, still -- so if you go on gov.uk, and you look for Covid-19 guidance today for people who are severely immune suppressed or higher

risk, it tells us several things, if I may.

Q. Can I just pause because you have given a lot of information there that I want to pick up on.

A. Yes.

Q. Don't worry, doctor, we will cover it but I just wanted to ask you this.

In your poll in June 2022, if I understand it correctly, 54% of the contributors to the survey said they delayed or cancelled healthcare appointments?

A. Yes.

Q. It jumps in October of that year, if I understand it --

A. Yes.

Q. -- to 91%? Now, do you know why there was the jump between June and October?

A. Yes, because it was the dropping of face masks from hospitals.

Q. Right. And have your members told you that --

A. Yes.

Q. -- or is that what you surmise from the timings?

A. Yes. I mean, our pages now, even today, are full of people having trouble accessing hospitals. They are unsafe for people who are clinically vulnerable, and one of the problems why they're unsafe is because of the problems of face masks -- staff aren't wearing them, but neither are patients.

Q. Pause there, please, Doctor, because there's a quote in your statement that I'd like to just put up on screen. It's INQ --

LADY HALLETT: And more slowly, please.

MS CAREY: I'm doing it now. I'm so sorry, my Lady. It's my fault, Dr Finnis. INQ000409574_0055. Just one of the quotations that you have provided the Inquiry with. Quote 47 there, from a CVF member:

"I feel healthcare is no longer safe, now that masking has been removed, I find every visit stressful I spend a week before and after feeling very anxious and worried. I can't cancel appointments, I need my treatments, I still need facial surgery for my skin cancer, but I have delayed having a minor surgery to have my port removed. It seemed safer in 2020 because everyone [was] masked, there were more virtual appointments available, and the hospitals were much quieter."

I just wanted to bring to life something that one of your members had said to support the findings of the CVF survey. I think, though, you were going on to say, doctor, and it's my fault I interrupted you, that there was several things in the current guidance that you wanted to tell us about.

A. Yes. So that's the, as I say, the gov.uk, and it's

replicated within the NHS guidance as well. It says four key things. Firstly, it advises us not to be around people who have Covid-19 nor people who have respiratory infections. It tells us to try and do -- to get the people visiting us to do a lateral flow test before they visit us. It tells us to ask people who visit us to consider wearing a mask or face covering -- that does actually say face mask or face covering -- or us to use a face mask or face covering, and it also tells us to consider ventilation.

It also tells us not to go into busy crowded areas, and to reduce attending those.

I just want to really kind of talk about the juxtaposition of that guidance with healthcare. How can people who are advised to follow that guidance now safely access healthcare today?

Q. Yes. Do you get any information as to who is or isn't Covid-positive?

A. No, there is now no testing. There's no formal testing, so you can be put next to somebody who is Covid-positive. Of course, clinically vulnerable or high users of healthcare, that's our greatest problem. When we walk into A&E, we're in a busy crowded environment, multiple people coughing the last time I went into A&E, I cannot follow the guidance.

Q. Is that in part why CVF advocates in the statement, as they do, for the return of face masks in all high-risk healthcare settings for both patients and staff?

A. Yes.

Q. Can I ask you, Dr Finnis, what is meant by the phrase "high-risk healthcare settings"?

A. So, I mean, I suppose, you know, ideally we would say that, you know, almost all healthcare is high risk given the people who attend healthcare. However, high risk could be, for example, and perhaps other people need to determine this rather than me but I might suggest it would be A&E, general medical wards, haematology wards, cancer wards, but also places where those people go. So, if I may, I did hear Professor Hopkins, last week or the week before, tell us that she still would advise some of those precautions in those high-risk wards. But as someone who is high risk, I have to go to blood tests, A&E, clinic appointments. I don't just stay in those areas. I walk the whole hospital.

Q. Yes. The statement that you have provided actually goes on to outline some interim measures that CVF would advocate for.

Could we look on screen at INQ000409574_58, please.

It's your paragraph 145, Dr Finnis. You set out

there some of the measures that the CV people would contend for: allowing people to wear their own, either FFP3 or FFP2; enabling people at higher risk to easily request staff to wear masks before their appointments.

Can I ask, has there been any examples among CVF members where they've asked a staff member to wear a mask and the staff member has refused?

A. Yes, many, every day. It's a problem we face every day and some of CVF's activities are around advocating for people.

Q. Allowing higher-risk patients to wait in a different setting, so maybe in their car or in another room until they are called in for their appointment.

A. Mm-hmm.

Q. Monitoring carbon dioxide; improving the waiting rooms and there you make reference to mechanical or natural ventilation or added HEPA filtration; improving the consultation rooms; staff working in a setting with clinically vulnerable patients to wear FFP2 or, if symptomatic, or not symptomatic and at the request of a patient they do a lateral flow test; offering people the first or early appointment in the day; and offering a digital option to those who prefer it, and for whom it is acceptable on a clinical basis.

Now, a number of practical measures set out there.

Are any of those happening routinely as far as CVF members are concerned?

A. No. I mean, generally not. So nothing happens automatically at all despite that guidance in the NHS and in the government -- the Gov.UK. So, I mean, practically all really of people that were within clinically vulnerable families have significant underlying conditions, so we frequent healthcare, myself included, often, so we have tested all these things. We do wear FFP3 and FFP2 and it's very variable but, as I said, many people do get a very bad reception, not personally actually, but certainly many people have really suffered what you would term or we have termed in CVF as "mask abuse".

We have no way at the moment to ask staff to wear masks and in fact even if we do, we often find that it's not then done. So, for example, we've had clinically vulnerable people who have gone in for an operation who would normally wear a mask who are worried that after they are anaesthetised, for example, in the recovery room they are worried they will be exposed to Covid and they've asked whether they can -- that people wear masks. Either there's a battle at that point, to be honest, because it's not guidance, you know, they follow IPC, you know. Or somebody says they can and then when

they arrive it's not anyway. So it's kind of two points where that fails.

Allowing high-risk people to wait in a different setting. So there are examples of that, particularly in things like -- dentists tend to be quite good at that but in hospital it's very difficult to do. It doesn't appear to be able to be done.

There's also another thing that could possibly happen which is high-risk patients wait in a different area. So like a mask area. The only time I've ever seen that was probably about a year and a half ago where there was actually a mask waiting room for Covid-19 vaccination. So I have seen that once.

So, I mean, that's another consideration.

There's no CO2 readings available. Some of us carry our own CO2 meters but obviously we can just measure it, there's nothing we can do.

Just to say, though, I was in a big London hospital pharmacy a while ago and it was pretty packed and I had to get this medication and the CO2 reading was well over 3,000, and the kind of safe level is between 800 and 1,000. So that shows you the problems.

Obviously, the waiting rooms can be -- it's very old estate in the NHS, so there's really no kind of modern mechanical ventilation. Often the windows are

kind of painted shut, there's certainly very few and far between HEPA filtration machines, although we have seen them in some hospitals -- a few.

I don't think any of us or very few of us -- any of us, in fact, have really managed to ask to get staff successfully to wear an FFP2 mask. Ditto on LFT. They will sometimes offer us first or early appointment in the day but, again, it's on us, you see, it's on us, this personal responsibility that's so hard to negotiate in that kind of relationship with the healthcare system.

MS CAREY: I want to pause you there because you have given a number of things I would like to pick up on.

I wonder, my Lady, if that might be a convenient moment for lunch and I can bring back some of those answers in the afternoon session.

LADY HALLETT: Are you all right to come back after lunch? I am sure you were warned, Dr Finnis. Thank you very much indeed.

I know the team and I have other commitments at lunchtime, so I will return at 2.00.

MS CAREY: Thank you, my Lady.

(12.48 pm)

(Luncheon Adjournment)

(2.00 pm)

MS CAREY: Dr Finnis, may I just pick up on one thing you

told us about before the lunch break, which was you made reference to mask abuse, and I'd like just to have a look at one of the quotations that you've included in your statement.

Could we call up on screen INQ000409574_0023, and quote 13 there from one of your members that says they were:

"... taking [their] child to an appointment at Great Ormond Street ... parked the car and was approached by a man and a woman who were shouting at me. They were really 'in my face' and swearing. The man threatened to 'punch me up' and then that 'he hoped our car would be all right' whilst we left ... to go to our appointment. We were all wearing masks. The woman told us there was no need as we were all outside."

Maria, aged 39, under felt such threat that she called 999.

I just wanted to get a sense from you, if I may, Dr Finnis, how widespread a problem was this, and is it still now a problem, now here we are in October 2024?

A. Yes. So I guess during the emergency time in the pandemic it was less of an issue because obviously there were mask mandates and more people were therefore wearing masks. Certainly, as that time's gone on and certainly after, first of all, Freedom Day in 2021,

which was the general removal or reduction of masks in society, and then 2022, June 2022 where England removed masks from healthcare, after those two dates, wearing a mask has become increasingly concerning and worrying.

You know, again -- so I do wear a mask everywhere, and I never know what kind of reaction I'm going to get. Certainly I've been coughed on, spat on, that kind of thing, just out and about in shops or on public transport. Certainly other CVF members report people forcibly taking their mask or pinging their mask, and we've had people call us, you know, sheep, kind of a whole load of different things.

I think that probably almost all of us have experienced now some kind of unpleasantness simply surrounding wearing a mask.

Q. There's no accounting for some members of society who think that's the right way to behave, but I just wondered in part whether you think there is something wrong with the messaging in that, because although the emergency phase of the pandemic is over, clearly indeed there's a variant, as we understand it, circulating now, whether the messaging has gone slightly awry in not ensuring that CV and CEV people are still at risk and therefore there may be good reason why they are wearing masks.

What do you have to say about that?

A. Yes, absolutely. I mean, we do feel like we've just kind of fallen off the edge of the cliff, really.

I mean, really as far as back as you know shielding ended, I mean, none of us, don't forget, were ever told to what kind of mask to wear. There's never been any education or information or examples given to us or posted or anything like that. Those of us that do wear masks now almost certainly do have clinical vulnerability.

One of the things that really worries me, and in fact it happened this morning when I was coming up on the train, I noticed two individuals wearing masks. Both of them, though, were not wearing them correctly. One was wearing what you would term a fabric face covering, and one was wearing an FRSM. And both of them were wearing under their noses, and it really affects me now, because I really feel that people that are now wearing masks are probably clinically vulnerable. I'm almost feeling like I should have a stash of FFP2s with me that I start to give out to people, because CVF's mission is still mainly online, but there is no public health messaging, information on the television or radio, there's no healthcare professionals that are informing people with clinical vulnerability and high

risk to Covid that they are still at risk, even.

And unless you really understand the science or you are part of, for example clinically vulnerable families or you have been warned by your physician then, generally speaking, it's been minimised in all quarters of life, even in healthcare.

Q. You mentioned a moment ago shielding stopping and I'd like to ask you about that, please, in two respects.

There was the decision to pause shielding, and then of course the decision to close the programme in its entirety.

Can I just start with the decision to pause shielding in August 2020, and is this right, that CVF was of the strong view that stopping shielding in August 2020 was too early?

A. Yes, absolutely.

Q. Why are CVF and its members of that view?

A. Yes, absolutely. So people who were, you know of much higher risk and we've seen the increased death rates of these people were suddenly in August 2020 -- it was literally like the withdrawal of suddenly all this support. So suddenly there was no access to supermarket slots, there was no access to help with going to the pharmacy. None of us were vaccinated at that time, and it coincided with Eat Out to Help Out. There was no

public advice for people who were still high risk at that time, that they were still higher risk.

Nothing had changed in those people that meant that they were now lower risk. Although there was less current, at that time, in that part of August in the community, of course we know the story that happened, which is that the cases rose again throughout that period, and shielding was not brought back in, I believe, properly until I think some tiers -- because we went into tiers, and I think sometimes if you were in tier 4 you were expected to shield, I think for me that was kind of December, but I think formal shielding happened again in January 2021.

So for a huge period of time, clinically extremely vulnerable and shielded people were really left to their own devices without any help and support at all, either advice or practical support.

Q. Can I pause you there because that might be a slightly different issue. The question I asked was whether you were of the view that it finished too early. The support provided whenever it finished is a slightly different question, but why is it that you say on behalf of CVF members that it was too soon to stop shielding in August 2020?

A. Because nobody had been vaccinated --

Q. Right.
A. -- people were still the same high risk. Their condition hadn't changed. The virus hadn't changed.
Q. All right. Was there any consultation, as far as you are aware, or other CVF members, before the decision in August 2020 to stop shielding?
A. No, I'm not aware.
Q. And coming back to the support issue with whether it's stopped in 2020 and restarted, ultimately I think it came to an end by July 2021. What consultation, if any, had there been before the shielding finished ultimately?
A. So there was no consultation with me as a clinically extremely vulnerable person that I knew of, and none that I know of within Clinically Vulnerable Families either.
Q. And, again, support: was there any support in place for when the shielding programme finally closed?
A. No, none whatsoever.
Q. And how did that impact the CVF members?
A. Well, all the issues that we've been talking about, such as difficulty with accessing healthcare, mask abuse, this personal responsibility, trying to rationalise the GOV.UK advice, which is really all that remains with how we live our lives now, feels really impossible.
It all comes down to this "personal

responsibility", which is what we've been told about, that we feel in CVF that it's really impossible to be personally responsible for some of these things because as I said, in busy A&Es, et cetera, it's very hard to, even wearing a good mask like I am, you're still at some risk without, for example, ventilation or testing. And indeed many, many people who are not part of clinically vulnerable families don't understand how to wear a mask, which mask, and how.
Clinically Vulnerable Families, we have -- I've done myself various videos trying to show people how to wear masks correctly and get the best fit, but it's really hard to get that information out there to everybody who I see on the streets, such as this morning.
Q. You've mentioned the clinically vulnerable, and I would like to just ask you a little about that. Clearly we are aware that there was a different definition and you've mentioned the absence of measures to protect the clinically vulnerable as opposed to the clinically extremely vulnerable, but I think it's right that CVF provide a degree of support to clinically vulnerable households, and if it helps you, Dr Finnis, I'm at paragraph 89 in your report, but could you just help us with some of the measures that CVF have taken to support

clinically vulnerable households?
A. Yes, that's right. So just to be absolutely clear, though about our definition. So Clinically Vulnerable Families represent clinically vulnerable households. Within clinically vulnerable households there are clinically extremely vulnerable, or shielded people, and clinically vulnerable. So "clinically vulnerable", if you like, is a bigger --
Q. Yes.
A. -- group and then "clinically extremely vulnerable" and "shielding" is sort of a smaller circle within that group.
So "clinically vulnerable" then encompasses everybody with higher risk.
So, as it says in the statement there, in 2020, so Lara was able to draw on her expertise in microbiology pathology and science to create a series of practical mitigations for children and school staff in schools, because -- I appreciate that's not what we're talking about here, but that was real issue for our members at that time.
There's also an easily accessible pinned post which remains today within Clinically Vulnerable Families that everybody can access, and we have thousands of members who can access this, which is

updated to reflect the evolving scientific understanding.
Q. Right.
A. So what we're trying to do is to give people proper, decent, scientific information that we have translated for them, so that they are able to be empowered to reduce the risk themselves and understand what their risk is, but also how to reduce it, what mitigations they need to take, and what is riskier than something else, for example.
It's really hard to kind of be expected, as a clinically vulnerable person, to judge your own risk --
Q. Yes.
A. -- the route to transmission and how to mitigate against it.
Q. Can I ask you about one of the matters that you raise there. You say that:
"Additionally CVF was able to negotiate group discounts on essential products such as mask and air filtration units."
Has there been any efforts to try and ask one of the departments or NHS England or anyone like that to help the clinically vulnerable negotiate discounts, given how much PPE they are likely to go through in comparison with someone who is not clinically

vulnerable?
A. No, I don't believe we have actually asked the NHS but we have written to the NHS about lots of things, as you might imagine, about healthcare and, to be honest, nothing has been extremely forthcoming about anything to do with clinically vulnerable people's safety within healthcare.

So I would suggest that it wouldn't perhaps be very successful.

In fact, we've just had to, right from the start of the pandemic, certainly from my own experience, right back to 2020, I've been having to, you know, work out which mask is the best mask for me, access them, buy them online, ditto air filtration units. I mean, we've got lots of information now so we're able to advise people which mask might be better for them depending on whether they are male or female, what kind of, as I said earlier activity they want to do and, of course, air filtration units, we are in touch with one of the major providers of air filtration units. We're able to advise people of some charts that engineers have done which shows us the size of HEPA filter that you need for the space that you want to clean the air.
Q. Yes, I think you make the point in your statement that HEPA units for the home can be anywhere from £80 to £700

depending on the model and the size and the space that it's got to filtrate.

Clearly that's going to be a significant cost for most people, particularly at the upper end of that scale. Is there any financial support in place for filters such as those?
A. No. So the only support that we've managed is, Lara has managed to negotiate a small, but we're very grateful for, you know, air filtration units from this particular company. But, no, generally speaking, there are a lot of financial burdens actually on clinically -- extremely and clinically vulnerable people, especially nowadays. Masks can be very expensive. I'm still paying between £35 and £50 for a box of 10 of these.
Q. Is that per month or --
A. Yes, it depends how quickly I wear them but I have a child in school and I work, so I need probably one every working day at least and then if I go shopping. So yes, I need two boxes a month.

Then I personally also have HEPAs in every room of my house because, as I say, I have a child in school and it's not only having the HEPAs themselves but obviously you do need to change the filter when that's right. It's totally worth it cost-wise for me. It's a completely good idea, but you do have to factor that in.

Many, many of our group now have got air filters. I think it's one of the commonest things that people have managed to put in place at home, particularly in those clinically vulnerable households where, for example, people may still be informally shielding and -- but their household members are going out to work in places like frontline jobs, like hospitals or schools, and to have that HEPA filter in their front room is really helpful.
Q. So there's no misunderstanding about it, we know that CVF support the use of HEPA filtration in a number of different respects but obviously most importantly in the healthcare system.
A. Yes.
Q. And, indeed, I think you make the point in your statement that there is NHS England guidance now on the use of cleaning air with HEPA?
A. Yes.
Q. And you strongly support the roll-out of that guidance.
A. Yes.
Q. Just one other consequential cost that may get lost in this. I think you make the point in your statement that many CVF members now feel they have no choice but to access healthcare through private hospitals because they consider the NHS is unsafe due to the risk of

hospital-acquired infection. Can you just help us. Have you got any sense of how many members are having to resort to private healthcare rather than going through the NHS?
A. Again, so when I did a thematic analysis of the group it was certainly one of the dominant things that came about, was certainly the financial burdens, and certainly private healthcare is certainly something -- I mean, it depends if people can afford it or not, but I think, generally speaking, if people can afford it even if it's at the very ends of their affordability, for example, I think -- I don't know where it is -- but within my statement there's a quote from somebody who I think took out their pension funds to --
Q. Pause there, Dr Finnis, because there's two quotes on that page.

Can I go to INQ000409574_66. It may not be the pension quote but I have seen that one as well, but there's a quote here at 57 from a CVF member. Thank you:

"I took early retirement, so my private health insurance stopped. I decided to pay myself, which this year was over £6,000, which is a very heavy financial burden. In 2021 I and to have a new heart valve and pacemaker and I simply would not risk an NHS hospital."

They say:

"The special measures the hospital took were brilliant."

They:

"... have had hand surgery recently too ... limited contact, private room and personalised treatment, ie they wear masks on request ..."

I presume they mean staff there.

"... no crowded waiting rooms, makes it worth it to me. Of course, private health does not cover chronic conditions and NHS hospitals and waiting rooms continue to frighten me, so I minimise attendance."

And you are right, there are other examples you give in your statement about the financial burden it places on people.

Can I just ask you two final matters, please. You set out in your statement anecdotal evidence that CVF has gathered in relation to the use of DNACPRs and concerns about blanket use and otherwise of those. That's at your paragraph 112 onwards, Dr Finnis.

I think there is concern, is this right, amongst the CVF membership that there may have been DNACPR orders placed on those that are clinically extremely vulnerable or clinically vulnerable as well -- I wasn't clear which.

propose to help identify this group or these groups of people in the event of a future pandemic?

A. I think we would support QCovid. I think that any developed algorithm which is specific to the illness brought about as quickly as possible. I think in the meantime, though, you make your best guess, if you like, from, as they said, from the science that's coming out of the other countries to decide.

I think the important thing, though, is that it's about not only who you protect but how you choose to protect those people. So, for example, rather than going sort of straight into shielding, you do give people that proper information about potential modes of transmission, how to reduce the transmission, you know, whether masks work or not, or whatever it might be for that particular infection, and to actually give people that passporting to enable them to work from home, to support the family, so that they too can work or be at home too if needed.

I think it's about empowering people that's important.

MS CAREY: Dr Finnis, that's all the questions that I have. I know there are some other questions from core participants.

LADY HALLETT: Mr Weatherby?

A. I mean, we don't know. I think that's the important thing to say. But from the people who do know because obviously we don't know how big the problem is, but we do know that a fair number of people who were shielded, so clinically extremely vulnerable, were either approached during that emergency part of the pandemic in a way that they wouldn't have expected to have been done just, you know, the day before that started, to ask whether they want to be resuscitated.

Indeed, there's quite a few examples of, you know, relatively young people in their 30s, 40s and 50s who have been either asked that question or have found it on their discharge letters when they come out of hospital, it having not been discussed with them at all and it being a real shock.

Q. Another topic, please.

During the course of your evidence we've looked at a number of recommendations that you would urge her Ladyship and the Inquiry to consider, but one of the matters you raise in your statement is you say that there needs to be better identification of vulnerable people based on early scientific evidence and there needs to be good communication to people at high risk with information on how to reduce their risks.

I just wondered whether CVF has any measures to

Questions from MR WEATHERBY KC

MR WEATHERBY: Good afternoon, Dr Finnis.

I'm going to ask you a few questions on behalf of Covid-19 Bereaved Families for Justice UK. I think that's an organisation you know because they've done joint work with you and your organisation.

Just a few questions picking up some of the points that you have already touched upon.

Can I start with the issue of DNACPR orders. In your statement, you express the deep concern, I think the term you use is "very concerned", the deep concern of CVF about what you describe as the discriminatory and inappropriate use of such orders.

For the record it's paragraphs 122 to 3.

Now, we know that in the report of the Inquiry experts they say the following, that a DNACPR notice is not meant as a proxy for broader treatment decisions. However, in the absence of clearly documented discussion and decisions about other forms of treatment, there's a potential for inappropriate overinterpretation of DNACPR as a generalised treatment limitation option.

That's at paragraph 40 of their report.

They go on and they say and again I quote paragraph 49 of their report:

"When DNACPR is the only documentation of any form

of treatment limitation it also may open the way for potential misinterpretation of DNACPR as a general indication of poor outcomes or a decision to restrict other treatment options which is not its intended purpose."

Now -- sorry to read out two long passages to you but you refer in your statement to mission creep. So, first of all, do you agree with the observations that I have just read out to you from the experts?

A. Yes.

Q. Do they in fact resonate with the views that you have expressed?

A. Yes, definitely, and I think clinically vulnerable people, some have experienced that but also would be very worried about that still being left on people's records --

Q. Yes.

A. -- and that would mean that they wouldn't be able to access some other treatment other than resuscitation.

Q. In terms of mission creep, are you saying that there's a concern about a tendency for such orders to lead to the exclusion of clinically vulnerable people from other life-saving treatment?

A. Yes.

Q. Thank you.

In terms of the decision to end or to pause shielding, and you have been asked about the initial pause in August 2020, and in fact in paragraph 62 of your statement you refer to this as being like falling of a cliff and you've told us about one of the concerns was that this was pre-vaccines. Apart from the fact that you and CVF believe that this was far too early, is another concern that it should, whenever the appropriate time was, that shielding should have been reduced by stage, it should have been a staged reduction rather than a blanket reduction; is that right?

A. Yes.

Q. Part of that would have involved a more nuanced risk assessment approach accompanied by ongoing support?

A. Yes, absolutely. I think one of the difficult things was when we fell off the cliff, as you say, there was no information about how to manage your own risk, identify your own risk even, and there was no offer of any psychological support either.

Q. Right. I was going to -- my next question is about support and you've already told us that there wasn't any. But in terms of transitional support, first of all, in your view, should it have been vital that there was support once there was a step down from shielding?

A. Yes, absolutely. People have been knocked and, you

know, really traumatised by these constant text messages, letters and emails that they are going to die if they step outside their house. It never happened before. It was extreme. And they just literally left us and I think, you know, to have had an offer of transitional support with other parts of support, such as psychological support, would really have helped.

Q. So psychological support, proper information, perhaps ongoing food parcels that kind of thing?

A. Yes, certainly supermarket delivery slots, I think by that point and, obviously, you know, collecting things such as pharmacy prescriptions.

Q. And maybe financial support too?

A. Financial support, yes.

Q. Now, you have talked about the necessity for the provision of information to clinically vulnerable and clinically extremely vulnerable people in these circumstances but should the pausing or ending of shielding programmes have been accompanied by a wider public information campaign to educate all of us, employers, schools, other organisations, of the ongoing risks to people who were clinically vulnerable and would that have been something that should have been put in place?

A. Yes, please. I think we would, you know, that's what

clinically vulnerable families would say. I think that's been one of our problems is that we've been really left to fend for our own rights but also advocate for the risks that we still face in all of those places, such as schools and healthcare, even despite the GOV.UK, which tells us to take all these precautions, we simply cannot, without any understanding on behalf of the employers or the organisations.

Q. Thank you.

The only other question I had has been covered certainly in part which is about the healthcare position, the lack of provision in healthcare for clinically vulnerable and clinically extremely vulnerable people both at the outset and ongoing. As a medical doctor and a spokesperson for CVF, isn't this something that is really very obvious? Isn't this something that should have been planned for and should be still obvious that if there's a whole section of the population who are particularly vulnerable, then measures need to be put in place?

A. Yes, absolutely. I mean, CVF -- yeah, absolutely. It just seems like we've been completely left to our own devices, only personal responsibility, as I say. There is still no obvious measures, as you say, that should be Infection, Prevention and Control in hospitals.

Q. Yes.
A. Or any part of healthcare actually, GPs, et cetera too.
Q. GPs perhaps very importantly.
A. Yes.
MR WEATHERBY: Doctor, thank you very much.
LADY HALLETT: Thank you, Mr Weatherby.
Thank you very much indeed, Dr Finnis. I'm so sorry to hear about what's been called mask abuse. It sounds such a trivial term but I can imagine just how distressing it must be for people like you and your colleagues to receive such abuse. I'm afraid the toxicity of some people never ceases to surprise me, but anyway. Thank you very much indeed for all your help, I'm very grateful to you.
Just one question: how do you manage to avoid Covid when you have got school -- child or children?
A. So my child, we actually managed to get HEPA filters into all the classrooms, and the school are really good at telling us whether there's a Covid case. So it just proves it can be done.
LADY HALLETT: I was going to say I find my grandchildren are the biggest vectors of any disease that's going round. Anyway, thank you very much for all your help.
A. Thank you.
MS CAREY: Thank you, my Lady. The next witness is going to

be taken by Mr Fireman and there will just be a pause while we allow Dr Finnis to depart.
(The witness withdrew)
MR FIREMAN: May I please call Dr Bryden.
DR DANIELE CLARE BRYDEN (affirmed)
LADY HALLETT: Dr Bryden, I hope you haven't been waiting too long.
A. Thank you.
Questions from COUNSEL TO THE INQUIRY
MR FIREMAN: Your full name, please.
A. Daniele Clare Bryden.
Q. You have, I hope, a witness statement in front of you?
A. Yes.
Q. That should be INQ000389244. That is dated 18 December 2023?
A. Yes.
Q. Dr Bryden, you are the Dean of the Faculty of Intensive Care Medicine, is that correct?
A. Yes.
Q. And you have attended today as a witness on behalf of three organisations: the Faculty of Intensive Care Medicine, the Royal College of Anaesthetists and the Association of Anaesthetists?
A. Yes, that's correct.
Q. Are you able to provide us with a bit of background

about each of those organisations.
A. Yes. So the Faculty of Intensive Care Medicine is the UK professional and statutory body for the medical specialty of intensive care medicine -- the intensivists, the advanced critical care practitioners, and the critical care pharmacists -- and has around 4 and a half thousand members across the UK.
The Royal College of Anaesthetists is the UK professional and statutory body for the medical specialty of anaesthesia, and has a combined membership of more than 24,000 fellows and members.
The Association of Anaesthetists is a professional organisation made up of over 10,000 anaesthetists in the UK, Republic of Ireland, and internationally.
Q. Thank you very much.
Dr Bryden, I'm going to ask you about the following today: first of all, I'm going to ask you a bit about your organisation's involvement with senior decision-makers; I'm then going to ask you a bit about Infection, Prevention and Control measures; and I'm then going to ask you a bit about critical care capacity, then redeployment, and then a bit about the impacted of suspending elective care. Is that all clear?
A. Yes.
Q. Can we turn, please, to the first of those topics. Is

it correct that your organisation's work collectively and individually involved with regular meetings with NHS England and the Chief Medical Officers?
A. Yes, that's correct.
Q. And you describe various topics within your witness statement that you discussed with them. One of those is the need for clarity around PPE requirements. Can you recall what those specific concerns that you raised in terms of availability of PPE were, with the NHS England medical director?
A. I am aware that our organisations at the time had three broad levels of concern. Early on in the pandemic it was around the provision of advice and the timeliness of the advice as to the correct PPE to wear, because we were aware that many of our members and fellows were looking to us for distillation of advice, and we were struggling to be clear as to what that advice was.
We then also had concerns around the consistency of the advice in terms of the timescales and, again, what PPE individuals should wear, and then finally there were concerns, as later on in the first wave, around the availability of PPE and the appropriate PPE.
Q. Can you recall when you -- what sort of time-frames you raised these particular concerns?
A. There were, at the time in the first wave of the

pandemic, there were regular meetings with both the Chief Medical Officer and the National Medical Director's office. Those meetings went up to twice weekly in frequency. I do not have a specific date for you, but I can get that information for you if you -- require it.

Q. Do you know, broadly, what response you received to each of the concerns you raised before?

A. I know early on in March, sort of in the first week of March, it was very much around highlighting the need for the clarity of information, and we were made aware of the fact that the correct information was expected, but we were not in receipt of information as to when we could expect it.

Q. The Inquiry's obviously heard, and this is the next topic, really, which is linked, which is Infection, Prevention and Control measures, and the Inquiry has heard a lot of evidence about the availability of PPE as we were just talking about. You raise in, your witness statement, a particular concern that you were getting from members, and given the nature of the role that your members do, you talk about availability and so on. I was going to ask you, is that about availability of respirators, or is that about gowns or any particular PPE that was not available to healthcare workers?

A. So the first wave did not impact equally on all areas of the country, and we were getting reports from different groups of individuals around the availability of suitable PPE in terms of gowns and visors that were both clean and appropriate for donning and doffing, that is taking on and taking off in a safe manner.

And then there were also concerns around the FFP3 masks, and being able to have the appropriate FFP3 masks to be fit tested to our members and fellows.

So there was a heterogenous response to the fit testing. Some individuals were fit tested, some individuals were not fit tested, and there was different PPE availability at different times. So individuals were reporting the fact that they might have been fit tested for a mask one week that was not then available to them the next week or a short period after, and it became a situation that people were identifying concerns around using PPE that they had been appropriately fit tested for, and also some people having a concern around appropriate PPE that was clean and safe to use.

Q. So --

LADY HALLETT: Forgive my interrupting, these concerns relate just to England, or did they relate to Scotland, Northern Ireland and Wales? Or any of the three?

A. Because the pandemic effectively came through the

south-east initially, most of those reports in the early phases were around what was happening in the south-east, but obviously in other parts of the country, people were aware of what was being reported in the south-east and had concerns, therefore, that we were needing to conserve PPE and manage it in a responsible fashion. So that then influenced thinking around availability of PPE and how it should be used.

MR FIREMAN: Did you also have concerns about the effects of using PPE?

A. I'm sorry, I'm not --

Q. In terms of the effect that that had on healthcare workers and some of the side effects of using PPE?

A. I was not aware of any concerns at the time around the effects of using PPE. People wanted to make sure that they had PPE that enabled them to do their job, but I think as the pandemic, particularly that first wave developed, the problems of wearing PPE for long periods of time became more apparent, and the impact that that was having on people doing their actual activities became clearer.

Q. If we could go to your witness statement, and this is at paragraph 180, it might help to get this on the screen, there are two -- some quotes here, a series of quotes that I understand are taken from the Association of

Anaesthetists as part of their series. If we just look at the second and third ones, we can see here:

"When we first started treating patients we were only allowed surgical face masks. The evidence from Italy at that time was to beware the patient who had tested negative. I am sure that there were members of staff who became infected due to not being allowed the appropriate level of PPE. We did have enough PPE most of the time although FFP3 masks were rationed to a degree ..."

It carries on. Then the next one underneath that says:

"I remember the sound of my own breath in my ears, amplified by the respirator. I remember [swearing] under plastic PPE" --

LADY HALLETT: "Sweating".

MR FIREMAN: "Sweating", sorry, thank you. Important clarification there.

"... sweating under plastic PPE and viewing the world through a smeared visor. I remember struggling to recognise colleagues under their PPE or understand what was being said. It made everything harder."

What I wanted to ask you about was those two quotes; are they essentially the two sides of the concerns around PPE, on the one hand the concern about

not being able to use it, and on the other hand the concern about the effects of having to use it?

A. Certainly the second quote I very strongly recognise personally, and also in terms of people's experiences of working for long periods of time in PPE and the difficulties that imposed.

I think in the first quote there was a lack of understanding, initially, on wearing PPE outside of the areas where it was known that there were aerosol-generating procedures, so I think there was an understanding from the get-go that intensive care units were going to be areas that had aerosol-generating procedures and people needed full levels of PPE. But there was perhaps less clear understanding about other areas of the hospital and what PPE was required.

Q. That's, in a related topic, something that you touch on in your witness statement in terms of the difference between aerosol-generating procedures and other areas, and some of the points you make in fact include that there are some down sides of designating areas as aerosol-generating areas or aerosol-generating procedures. Is that something that was of concern to you and your organisations?

A. I think we, at the time, were very concerned, particularly with the evidence that was coming from

China and India, that both individuals working as anaesthetists in a theatre complex, and intensivists working in an intensive care unit, were going to be working in areas where there was a high risk of aerosol-generating procedures. So there was an understanding from all our members that they were going to be at particular risk, and therefore there was concern around having appropriate PPE.

Q. You also cite in your witness statement a study from early in the pandemic. It's at paragraph 291 if you want to refer to it, but essentially it's a study of 119 healthcare workers who died, and in it you note that there were no intensivist and anaesthetist deaths. And there are a number of reasons that you've provided for that, which include higher-performing PPE amongst other reasons, including the stage at which patients in intensive care are treated in terms of the development of the virus.

Do you recall that study?

A. I'm afraid I'm not able to access --

Q. If we can put it on the screen, it's at paragraph 291 of Dr Bryden's witness statement. You should hopefully see there that there is this cited study.

A. Yes.

Q. Then there is a series of reasons as to why it may have

been the case that intensivists and anaesthetists died at lower rates or, indeed, not at all in this study?

A. Yes.

Q. This was something which was asked about from the Infection, Prevention and Control perspective with Dr Ritchie of NHS England, but from your perspective, can I ask you whether or not you felt that healthcare workers working in intensive care felt that they were better protected by using respirators?

A. My recollection at the time was it was not a question of feeling better protected, it was around having the necessary equipment to do the role and the job that was required of you and we knew working in an intensive care unit was an area where there was going to be a lot of aerosol. So, effectively, it was around making sure staff were appropriately protected with the equipment they needed. It wasn't about necessarily a comparison against other areas, it was about having the right equipment for the job you were doing.

Q. So when that -- what you quote in your witness statement where you say "higher-performing PPE", just to be absolutely clear, do you mean respirators there?

A. Intensive care staff were wearing FFP3 masks, visors in the first phase of the pandemic, gowns and gloves. Individuals who could not find an FFP3 mask that would

fit them appropriately were very often provided with a respirator-type system.

Q. Sorry, and including, within respirators, a respirator mask?

A. Yes.

Q. My apologies. That can come down.

Turning then to a different topic, the next topic, capacity -- and when I say "capacity" here I mean critical care capacity -- and you describe in your witness statement that in early 2020, some clinicians were concerned that services would be overwhelmed, as was the case in terms of the scenes that were seen in north Italy, and that there was a desire for additional triage guidance. So you were aware of that?

A. Yes.

Q. You then describe -- this is at paragraph 49 of your witness statement -- that the Faculty of Intensive Care Medicine were involved in drafting a guideline which they co-authored with NICE, which I think is NG159, and we'll get that up on screen in a moment, but can you explain, first of all, what the purpose of creating a new guideline was at the outset of the pandemic?

A. Yes. So the Faculty of Intensive Care Medicine was one of the organisations that was co-opted to the NHS England Critical Care Clinical Reference Group, and the

clinical reference group discussed areas of support that were going to be needed for hospitals as the pandemic was approaching, or as patient numbers were perceived to be increasing.

The concept really was around, after discussion in the Clinical Reference Group, having some form of document that would support clinicians in making usual clinical decisions in extraordinary circumstances, so the perception was that the NHS England Clinical Reference Group would work with NICE to produce a document that would support the clinicians and from that initial, if you like, scoping exercise, a document was produced which became the NICE guidance NG159.

Q. You make clear in your statement at paragraph 55 that this guidance wasn't ethical or legal guidance on how to triage patients in the event of saturation of critical care capacity. So in those circumstances, why did a new guidance -- why was a new guideline, as opposed to the ordinary principles of determining whether someone is appropriate for critical care, applying? Why was a new guideline necessary?

A. So if it's okay to put some context into this. So approaching that first wave of the pandemic, the thinking very much was we would have our normal critical care patient workload and we would have an additional

Covid patient population of an unknown size and critical care teams often provide support to ward teams and patients in terms of providing support and advice and helping them to help patients make a decision about if they deteriorated if they would want to come to critical care.

Our understanding was that with this increased workload and the need to bring more intensive care staff back into the building, if you like, the intensive care service to support patient care, we were going to be less able to provide that historical degree of support.

So the focus very much was around giving ward teams the ability to be supported to have important conversations with patients that were coming into hospital at the earliest stage possible and to allow them to contemplate what they would want for their own treatment. So the idea was very much around giving patients an understanding of what was involved and an ability to express their views whilst they were still able to do so.

Q. So if I understand what you are saying correctly, is it then a case of having a discussion that would ordinarily take place later on in the pathway earlier on?

A. Yes, it was about having an earlier discussion and giving individuals who perhaps wouldn't routinely have

these discussions a degree of ability and a toolkit of resources to enable them to have those discussions.

Q. If we could look at the first iteration of that guidance -- this is INQ000474301, page 2.

This is the iteration that was published first on 20 March 2020. I want to look at that first section. So it says "admission to hospital", "On admission to hospital", so just pausing after that first comma, is that "on admission to hospital" the distinction between what was involved previously and what is now the starting point of this guidance?

A. Yes. NICE had identified with the Clinical Reference Group its plans for producing information to support clinical teams and we were advising them on this document in terms of an additional piece of information to help.

Q. What would happen in a scenario where someone was admitted to hospital and it was deemed that they were not appropriate for escalation to critical care?

A. I'm sorry, in normal circumstances or ...

Q. Well, in normal circumstances, I understood from what you were saying that generally at the point of referral to critical care, that's when you would decide whether or not someone was appropriate for escalation to critical care. What about in circumstances where the

guidance is telling us that you need to make a decision about whether someone's appropriate for critical care at the point at which they're admitted to hospital? Does that change in any way the patient experience?

A. So I think it's important to go back to the fact that this is actually not making a decision in isolation. It's about involving patients and ideally their families in normal circumstances in the decision-making process about what they want for their care and their treatment and whether or not they want escalation of care.

So it's very much focussed on making sure that patients who, particularly when the capacitous have the ability to identify what they want for their treatment, and often in intensive care a situation can sadly arise where an individual may deteriorate very rapidly and that conversation has not been explored with them and those views aren't known.

But this was about saying when a person comes to hospital it's really important to involve them in the plans for their care and the discussions around what they want for their treatment at the earliest possible phase because we were not aware of how their condition was going to then subsequently be managed over the --

Q. The Inquiry -- sorry to cut across you, but the Inquiry has heard a lot of evidence about the difficulties of

having conversations with patients and with their families within the context of the pandemic. Was it possible, do you think, to have these conversations at an early stage?

A. We as the Faculty of Intensive Care Medicine have been trying to support individuals and families to contemplate what an intensive care admission means for a long time before the pandemic. So we had produced documents to enable individuals to consider that and other hospital services to consider that.

For us, the perspective was very much on not missing the opportunity to have this conversation with somebody because it was an important conversation.

So it was about making sure that that attempt was made and to try and have that conversation rather than to leave it to the point where it was going to be impossible to have that conversation.

Q. Can I ask you about the second part of this sentence. It says "On admission to hospital" -- we've looked at that:

"... assess all adults for frailty, irrespective of age and Covid-19 status."

Then it goes on to recommend using the clinical frailty scale for frailty assessment.

Is it right that the clinical frailty scale is not

appropriate to use on people who have long-term stable disabilities or are under 65?

A. Yes, that's correct. It has not been developed for use in those groups.

Q. This guideline didn't make that clear, did it?

A. No.

Q. Why was this omission allowed to come into the published guidance?

A. I do not know. As I said, we provided advice to NICE in the drafting of it. I do not recollect ever having a conversation in which we were specifically asked about particular groups of individuals. But obviously, you know, we would be clear about where the frailty scale had been validated and who it was intended to apply to.

Q. Sorry, just to clarify, I thought that the Faculty of Intensive Care Medicine co-wrote this guideline. Is that not correct?

A. We provided advice with the chair of the Clinical Reference Group to NICE. NICE wrote the guideline and we provided advice to them and input to them around the writing of the guideline but the final decision around the format of the guideline was NICE's decision.

Q. The Inquiry understands there was then some correspondence with various groups, including I think MENCAP on behalf of learning disability -- people with

learning disabilities, apologies, and the guideline was then amended.

If we could then have a look at that amended guideline. This is -- and we might be able to put it on the screen as a comparison here. It's INQ000315780. So -- here we go.

This is the amended version. So we can see here there is a series of further caveats now in terms of how to use the clinical frailty scale, in particular the second bullet point:

"[It] should not be used in younger people, people with stable long-term disabilities (for example, cerebral palsy), learning disabilities or autism. An individualised assessment is recommended in all cases where the CFS is not appropriate."

My question really is a similar one. It's right, isn't it, that the first iteration should have included all of these caveats?

A. Yes.

Q. Thank you. That can come down.

A. If I could also add to that?

Q. Please do.

A. I think it's also important to make the point that people should be helped to have the conversations that are required and are given the support that they need to

have those conversations and that's something that we always have tried to do within intensive care medicine. So it was not a change in our practice that we would have not looked to try and provide support to individuals to help them make a decision. That was not intended to change.

Q. You made clear earlier that this guidance, it's not guidance designed to be used in the event of a saturation of critical care resources. I've been asked to ask you by one of the core participants whether you think that directing healthcare professionals to the clinical frailty scale without caveats in the beginning could have encouraged rationing of care on this basis and indeed the use of DNACPRs because people were scoring poorly on the clinical frailty scale?

A. Our intention and our advice was very much around helping as many people as possible to be given the information they needed to make a decision about their care and treatment, and bearing in mind we were looking at a large number of people who could potentially require intensive care treatment at a time in the pandemic when there was no other treatment that impacted on the course of Covid or the outcome from Covid, all intensive care treatments at that time were supportive and didn't impact on what the disease did to the

individual, and all of those supported treatments had an associated morbidity and harm in themselves. It was really important to make sure that as many people understood what an intensive care admission involved as possible to allow them to be clear about whether or not they wanted to have that and contemplate that.

Q. Do you see any connection between critical care capacity and decisions about escalation of critical care and the use of do not attempt cardiopulmonary resuscitation orders or notices being used?

A. Could you --

Q. Could you see any link between capacity pressures and the increased use of DNACPRs?

A. So what we have always known historically in intensive care is that when we have less resource available our ability to take patients who need monitoring is impacted but it doesn't actually impact on the decisions that individuals make about whether an individual should come to intensive care and as our organisations were clear throughout the pandemic, we emphasise the importance of using normal ethical decision-making principles which does involve involving patients.

So we know when resource is impacted the ability to take people to monitor them is reduced but the actual behaviour in terms of the conversations and the ability

to offer treatment should not be impacted and we made that very clear to our members throughout.

Q. So presumably that includes the use of -- provision of CPR, for example, if appropriate?

A. Well, we would have discussions around CPR in intensive care with individuals but usually discussions around CPR on the wards are often conducted and led by ward teams.

Q. Can I ask you about the concept of a prioritisation of critical care tool in the event that critical care capacity is reached.

You acknowledge at paragraph 58 of your statement that the lack of a national prioritisation tool -- in other words, a nationally- or government-endorsed tool to tell clinicians how to assess patients in the event that they had to make decisions about triage because of resources -- the lack of that tool left some working in intensive care feeling vulnerable and exposed. Is that right?

A. Yes. Our members were clear that they were not -- were concerned about what happened if resources were significantly impacted and they could no longer do what they normally did which is use their normal ethical and decision-making processes and what the position was going to be under that circumstance.

So there was a concern that that situation might

arise, most predominantly in the early phase of the first wave of the pandemic when people didn't have the experience that they subsequently had.

Q. The Intensive Care Society created or, indeed, published after some amendments, its own tool which may have been based on the national prioritisation tool which didn't actually make its way into formal guidance. Is it right that your organisations didn't endorse any prioritisation tool in the event of critical care capacity being reached?

A. We did not endorse any prioritisation tool. As I said, we were clear to our members that we wanted them to continue using their normal decision-making processes and we were also very clear and consistent in our position that if a tool was going to be developed it needed to be developed by an organisation like NHS England or NICE and actually have wide buy-in from multiple stakeholders and that was a position we maintain.

Q. Sorry, can I ask you -- why, why does it need to have endorsement from NHS England or NICE? Why couldn't an organisation within the intensive care sphere have published their own guidance?

A. I think the fundamental intention of guidance is to help individuals but we were very clear that there were

a number of issues around a single organisation producing guidance, not the least of which is the importance of guidance being able to respond to the change in the knowledge base, in the information, being able to monitor and change that guidance appropriately, to have the appropriate consultation and understanding of all endorsing organisations and to also have a wider involvement of the public and an understanding that this was in place.

We also took a view that as the pandemic went on and treatments changed and our understanding of the disease process changed, our understanding of the need for triage guidance again altered and we felt that it wasn't appropriate at later points to have that kind of guidance because we had different ways of managing the system when it was under pressure.

Q. Sorry, could you clarify what is it about it being endorsed by a government agency or from the Department of Health that you felt was particularly important as opposed to just the general difficulties, which there may well have been in producing this guidance in any event?

A. If I can go back to the NICE guidance, when we were advising NICE, we had actually identified with NICE that we felt at that point that we wanted something to go

into the guidance to say where to look for guidance if the system became overwhelmed but that piece of advice that we gave was never produced into the final document.

But our view very much was it needed to be a four-nation-type approach in order to be fair. There were issues around equity, concerns around the fact that we didn't want one part of the UK to be triaging patients and, if you like, not admitting people to intensive care while other patients had the ability to do that.

Q. Can I ask you about that particular point because it's something which you note in your statement about the potential variability of ICU capacity amongst -- within England and also across the UK but would it not be the case that a tool or a prioritisation guidance would only come into place once all options had been explored such as mutual aid, critical care transfers? So would it not be something that would be in place to only be used if in fact capacity was reached in all senses and you couldn't transfer patients somewhere else, for example?

A. Well, our view very much was that there needed to be a clear instruction to embark on that kind of activity and that that really needed to come from a central organisation and that it did need to have a wide endorsement so that people were understanding why this

activity was taking place and that's why we took the view that it needed to be a central organisation that took ownership and leadership of this. We were consistent in that view throughout.

Q. The Inquiry has obtained a series of spotlight witness statements from various hospitals across the United Kingdom, some of which I hope you've seen and some of these hospitals produced their own prioritisation guidance to guide their own staff as to what to do in circumstances where critical care capacity was reached.

Have you any views on the fact that there were potentially different tools being produced by different organisations and are there any risks in that occurring?

A. I think it's difficult to comment on any particular validity of the tools that you've asked us to look at.

Q. Just generally --

A. Generally, I think our view very much is that that kind of activity developed probably because there was an absence of nationally-agreed guidance and that people with the best intentions were trying to develop a tool in case it was needed. But I haven't any particular knowledge -- we haven't any particular knowledge of why certain tools were developed. Our view, very much, was that there needed to be a consistency and there needed

to be a common shared understanding of what was going to be done and who was going to be responsible for that.

Q. So can I ask you this then: is it the case that what you're saying is that you -- it's not that you don't support the production of a clinical care -- critical care prioritisation tool, it's that you think that any such tool should be endorsed by national bodies. Is that right? Or did you not support during the pandemic the production of any such tool?

A. So, going back to that first wave and that first phase, that's when the fear amongst clinicians was greatest because of what people had observed particularly in Italy two or three weeks before. So that was the point, if you like, of heightened anxiety. But inevitably, as that experience developed in the first wave, people's clinical experience improved and their confidence improved, and obviously by the time we got to the second wave we had different ways of managing patients with Covid. We had much more effective use of mutual aid in terms of transferring patients. It went from a situation very early on, of a fear that such a tool might be required, to an understanding that the baseline had changed, and it was not required at that point.

There was an understanding that it might be required at a future point, but we had other options,

clinical options available.

Q. Can I ask you, from a different angle, do you think then, practically and in reality, that everyone who needed intensive care during the relevant period received it?

A. I'm not able to comment on that because I don't have the data and I don't know about that, but I can say from our organisation's perspective, we were consistent throughout the pandemic that we said to people, "Our members and fellows use the normal clinical and ethical decision-making processes, and continue to do what you normally do".

Q. Did you receive reports from your members or from members of all of the organisations you represent to the effect that they were having to take any decisions about who to prioritise based on resources?

A. As far as I am aware, the concern particularly in that first phase of the pandemic was around whether or not there was a tool that was being supported by a central organisation, and whether or not that tool should be used. So I am personally aware having been contacted via WhatsApp from a clinical lead in another area, who sent me a copy of an early copy of a tool and the question was, are we meant to be using this or not, that there was confusion to a certain extent about whether or

not there was a central tool being provided.
MR FIREMAN: Thank you.
My Lady, I'm going to turn to another topic so it might be an appropriate time to have a ten-minute break?
LADY HALLETT: Certainly.
I hope you were warned about our breaks, Doctor. I shall return at 3.25.
(3.09 pm)
(A short break)
(3.25 pm)
MR FIREMAN: Thank you, my Lady.
Dr Bryden, I want to turn to a different topic now which we foreshadowed earlier which is redeployment. Can I ask you about it both from the perspective of anaesthetists and also intensivists, because I understand your organisations represent both of those professions.
With respect to anaesthetists, were the majority or a high proportion of them redeployed to intensive care units?
A. It's important to consider the various phases of the pandemic and the involvement of our anaesthetic colleagues in supporting intensive care units. All anaesthetists do some intensive care medicine training and certain hospitals at times of particular pressure

and at certain points of the pandemic will have had support from anaesthetists to provide additional input into the critical care unit.
We don't have a specific number of people who were redeployed at any one particular time but there are a number of surveys that were conducted, particularly those by the Faculty of Intensive Care Medicine and the Royal College of Anaesthetists, which gives, if you like, overall figures at certain time points as to how many people identified as being redeployed.
Q. So just, generally speaking, during the peaks of the pandemic, were anaesthetists going to intensive care units in higher proportions than they would normally have been?
A. Yes, absolutely. Normally we would say that of the intensivists who have anaesthetic training about 50% of intensivists have some anaesthetic training, all of those would have been brought back into the intensive care full time and then, in addition, additional anaesthetists will have been brought in to support local services as and when required.
Q. In terms of the experiences of those anaesthetists who were redeployed, do you know and are you able to summarise whether or not the experience was positive or negative or a mixed experience?

A. I think it would be fair to say that we would not have been able to deliver what we did without the involvement of our anaesthetic colleagues but that came at a burden, a considerable burden, to them. Some reported in our surveys that they found the experience helpful and useful, particularly around maintaining skills, closer working with intensive care colleagues; others found it very difficult and very stressful working in an intensive care unit after a period of time.
So I don't think it would be possible to say there was a uniform experience. It was very personal.
Q. Of course. That makes sense.
But focussing -- one can understand why it may be potentially harrowing for some people to be involved with intensive care in circumstances where they hadn't previously been, but focussing on some of the positive aspects of redeployment and you talked about the skills that were learnt, is there anything that we can learn about the fact that those staff learnt new skills by being in intensive care about how we could best prepare for the potential need to redeploy staff again, is there anything we could be doing in non-pandemic times to enable the transition to intensive care to be easier?
A. Yes, and if again I can provide a degree of context. So prior to pandemic the Faculty of Intensive Care Medicine

had done some work on the development of an enhanced care service. This was around supporting patients on elective care pathways who didn't need a full intensive care admission but needed more treatment in care than could be supported on the ward, and that service could be managed by our anaesthetic colleagues and, again, our anaesthetic colleagues were very supportive of the concept of trying to provide more for patients on the perioperative care pathway because a lot of them do work in perioperative medicine.
These kind of reservist skills, as we identified and called them, were a way of saying people could be involved in aspects of care for patients that were more than they might ordinarily have done before the pandemic, would allow them to have some degree of confidence. So if they were required to go back and work in the intensive care environment they would at least have some familiarity with what had been happening in terms of basic intensive care management.
Q. That's something which you think should be maintained?
A. Absolutely. We have been clear from the publication of the initial enhanced care report in, I think it was May 2020, and then the subsequent report that we wrote with the Centre for Perioperative Care around how you provide enhanced care services for perioperative

surgical patients that the benefit of this is great for the patient because it provides them a secure pathway for elective surgery but it's also beneficial for staff, both medical and nursing, and allied health professionals because it keeps a degree of skills up that were perhaps not as recent at the start of the pandemic.

Q. What about from the perspective of the intensivists having to work with staff who were not ordinarily trained in intensive care? What was the experience like from their perspective?

A. So we had a survey from the Faculty of Intensive Care Medicine towards the end of 2020 of our fellows and members around the experiences and many of those responses included positive comments about the benefits of working with anaesthetic colleagues, getting a perspective that allowed a greater mutual understanding of our roles which inevitably would have a positive impact on patient care.

I think from a nursing perspective, and this is a completely different perspective, the pressure on nursing staff of working with individuals who don't have those skills is very different and the concerns around supervising individuals who haven't got basic intensive care nursing skills was a considerable burden for our

nursing colleague. I'm aware of that.

Q. The Inquiry's heard a lot about intensive care ratios being stretched and nursing ratios and the fact that they should normally be 1:1 and at times they were, I think, sometimes as high as 1:6. Is that something you are aware of?

A. Yes.

Q. Is that -- when talking about those ratios of 1:6, does that include staff who may not have been trained in intensive care or is that only with respect to trained intensive care nurses?

A. So my understanding of those relaxation of the ratios was one trained intensive care nurse to one patient. The 1:4 ratio or the 1:6 ratio was around one trained intensive care nurse looking after six patients with support of additional staff who were not trained in intensive care medicine. So it was not understood to be one nurse alone looking after six patients; it was one trained nurse supervising a number of other individuals who had a variable degree of skills in delivering care for the patients.

Q. In some ways one can see, obviously, how the additional support was helpful but having to supervise untrained staff in addition to looking after patients at stretched ratios, did that carry an additional burden for some of

those intensive care nurses?

A. I'm aware that it did carry a considerable psychological burden for a number of intensive care nurses. Intensive care nurses are highly trained individuals who have a high degree of responsibility, who work very closely with medical staff in very close-knit teams and when that normal working practice is disrupted, you have a number of patients who are very unwell, then that does add to the burden and obviously the concern around being able to do your job to the level that you expect to do your job.

Q. Turning then to a new topic, the decision to suspend elective care -- elective surgery, I should say. This is a decision which I would imagine had quite a significant impact on anaesthetists; is that right?

A. Can I ask you to clarify.

Q. Is it not right that within the context of surgery an anaesthetist has a very considerable role. Particularly in the context of suspending elective surgery, would that not have resulted in a number of anaesthetists who would ordinarily have been working in elective care moved out of that area?

A. Yes. So there were two reasons why elective care was impacted, one of which is that some of the anaesthetists, both those in training and at consultant

and SAS doctor level, were required to come and work in intensive care units at various times. There was also an impact in the removal of some of those trainees from service, so some of the consultants that would have been doing elective surgery were then required to cover services out-of-hours and provide a more consultant-led delivery of service than might ordinarily have been the case. So there were just fewer anaesthetists around to do the elective work. And then the final impact was around being able to develop Covid-secure pathways for patients that were needing to have procedures.

So all of those, if you like, conditions impacted on the ability to provide elective operating.

Q. Yes. You talk about this in your statement. You talk about the clinical realities, some of which you've just touched on, including the availability of anaesthetists and also availability of theatre space because some areas of hospitals have been re-purposed, Infection, Prevention and Control measures, some of which you were just touching on in terms of pathways.

Is it the case, then, that practically even had the decision not to pause elective surgery been taken, it would have been very difficult to have continued with elective surgery in any event?

A. What we know from our surveys and experience at the time

is it was very variable and it very much depended on local arrangements and local facilities. So where you had an intensive care service that was well resourced that you were able to provide a Covid-secure pathway, perhaps your estate was amenable to being able to provide a Covid-secure pathway for patients, that made doing some elective surgery much easier and perhaps the larger hospitals had the ability to do that because they had more flexibility than some of the smaller hospitals had.

So it was very location dependent and perhaps also time dependent because it was not a consistent pattern throughout the period of the pandemic.

Q. Did your organisation support the decision to suspend elective surgery in March 2020 which was taken in various different guises across all four nations?

A. I think there was an understanding that at that period it was going to be necessary in order to ensure that we had sufficient individuals who were able to respond to that first wave of the pandemic because we didn't know at that point how severe it was going to be, but our organisations were also involved in producing guidance to help local Trusts and services identify how they could safely reintroduce elective operating at the earliest point. So we were also very keen to support

our members and our services to make sure that patients were brought back in for surgery as soon as we could safely do so.

Q. The Inquiry has instructed experts, Professor Andrew Metcalfe and Ms Chloe Scott to examine the impact all the pandemic upon those requiring hip replacements. I would like to bring up a passage from their report. It's INQ000474262, paragraph 48. And it says here:

"Given both the anticipated impact of the pandemic on the healthcare service, and the uncertain risks for patients undergoing surgery, the decision to suspend elective surgery in March 2020 and in many Trusts in December 2020 or January 2021 was unavoidable in the circumstances. However, the delays in many hospitals and regions in restarting elective surgery, and the variation around the country, reflected a variability in both resource and decision-making that had a major negative impact on the lives of hundreds of thousands of people across the country, and continues to do so."

Do you agree with that broad statement?

A. Yes, and if I can add some additional context. So we went into the pandemic with about 50% too few anaesthetists. We knew we also had too few intensivists as well and that that had an impact on our ability to provide support to elective operating.

We also had early research evidence that suggested that patients shouldn't have surgery within seven weeks of having Covid so that impacted on decision-making and planning around when an individual came in for surgery and we also know that at times of pressure like that early first wave and then over the winter of 2020-2021, again there was not the space or the individuals who were able to re-escalate elective surgery back to where it was. So we started with a low level of resource both human and, to a certain extent, estate and then when we were under pressure we were limited in how we could respond.

Q. The issue then is what you and the experts instructed by the Inquiry have summarised there, really, one of restarting elective care rather than the initial logic behind the initial decision. The Inquiry has heard the phrase "postcode lottery" used occasionally. Is that a phrase that fairly encapsulates the fact that there was significant geographical variability in terms of the ability to provide patients with elective surgery?

A. So if I could go back to the provision of intensive care beds and facilities, we know that across all four nations of the UK that baseline was not equal and we have health inequality. So going back to pre-pandemic, Wales and Northern Ireland had intensive care bed

occupancy that was over 95%. Even within that 10 per 100,000 figure quoted for England, there were certain parts of England, namely London, that had more intensive care beds than other parts of the country. If the pandemic was then impacting not equally on all areas of the country at the same time, you will then have a situation where certain services will be in a better position to restart than others.

Q. So there's an obvious link, then, between critical care capacity and the ability to perform elective care?

A. If we had sufficient critical care capacity, we would not have required as much support from our anaesthetic colleagues as we did, and if we had the ability to develop some of these Covid-secure pathways like enhanced care, so that we could have additional alternatives, we would have been able to perhaps respond differently.

Q. And also perhaps not needed -- wouldn't have needed to suspend elective care as well, because you wouldn't have needed to redeploy those anaesthetists? Does that follow or not?

A. I think it's difficult to be certain about that because we know that particularly over the winter of December 2020/January 2021, there was extreme pressure on the NHS in general, and again the complexities of

keeping patients without Covid coming for elective surgery safe and protected from areas of the hospital where there were large numbers of patients with Covid that ability wasn't there.

MR FIREMAN: Thank you very much, Dr Bryden.

My Lady, that's all I ask.

LADY HALLETT: Thank you very much, Mr Fireman.

Ms McDermott.

Questions from MS McDERMOTT

MS McDERMOTT: Dr Bryden, today I will be asking questions on behalf of the Covid -- UK Covid Bereaved Families for Justice and the Northern Ireland Covid Bereaved Families for Justice. Mr Fireman has taken you through the fringes of the question I would like to ask you in terms of capacity, and separately working with intensivists and the ratios around that. But the topic I want to focus on is the capacity in terms of staffing levels, and, set out within your witness statement at paragraph 96, you state that during the pandemic due to the need to considerably increase the number of critical care beds, there were not enough trained critical care staff to call upon to meet the expected staffing standards.

Now, the Faculty of Intensive Care Medicine carried out a survey during November 2020, and in

response to the question "Do you think any increase in ICU footprint has been adequately staffed?", 82% of the respondents said no.

In your experience and that of your members, was this indicative of a problem during the pandemic that physical capacity in ICUs was not matched by adequate staff members?

A. So, again, before the pandemic, the faculty had conducted a series of workforce engagements around the UK, and we had also data that were very clearly indicating that we did not have adequate capacity in critical care, and that there were certain areas of the UK that were more severely impacted than others.

The other important message that we made very, very clear right from the beginning was capacity was not just around the physical space and the provision of a bed of a piece of equipment; it was around the human resource, if you like, the ability to care for and treat an individual. And, again, we had identified the fact that we didn't have sufficient numbers of critical care staff who had been adequately trained at the start of the pandemic.

So, during the pandemic when there were increased numbers of patients presenting, we had that situation of even more pressure, and therefore needing additional

support, in order to be able to do what was asked of us.

Q. That's somewhat of a separate topic in terms of you've mentioned in your evidence about Wales and Northern Ireland having bed space of already ICUs over 95%, that's different to then actually having the staff, isn't that correct?

A. Yes, because it will depend on whether or not -- there may be a physical bed space, but if there's not the contracted funding to provide the staff to look after the bed, then it's not an operational bed; it doesn't exist in terms of a bed that you can safely admit a patient into.

Q. Thank you. Considering your statement in the round from the perspective of those which I represent from Northern Ireland, your statement contains very limited reference to data emanating from Northern Ireland. Now, I don't expect you to know this offhand, but on 11 October 2022, the Royal College of Anaesthetists Northern Ireland held a board meeting, and at that meeting it was certainly anticipated that the Northern Ireland Royal College of Anaesthetists would contribute to this Inquiry. There was then a debate as to whether it would partner with the Academy of Medical Royal Colleges or whether it would stand alone as an organisation with a reluctance to the latter because of

cost implications.

I'm just wondering, do you know if the Royal College of Anaesthetists Northern Ireland did make an application to stand alone as a body?

A. So if I can provide a point of clarification, the Royal College of Anaesthetists is based in London but is a four nation body, so it has boards, and one of those boards is in Northern Ireland. So its Northern Ireland board impacts and advises the Royal College of Anaesthetists as a whole in its entirety. So on that basis, it's not an independent organisation but it is part of the Royal College of Anaesthetists and does advise and gives information.

Q. Thank you for that clarification. I'm just wondering, mindful of what it said in the minutes, it had suggested it would go in potentially as a standalone body, and I'm wondering, do you know whether or not the Northern Ireland branch of the Royal College of Anaesthetists had applied to go in as a standalone body?

A. I don't, but I can find that out for you.

Q. If the Northern Ireland college -- the Royal College of Anaesthetists Northern Ireland branch had worked with you, did they liaise with you in providing your statement or information to this Inquiry?

A. So the information that is in my statement is from all

three organisations, and my understanding is that the Royal College of Anaesthetists has drawn its information from its wider college membership and information that it held at the time.

Q. So then, looking at your statement specifically, do you accept that there's very little or very limited reference to data in Northern Ireland?

A. I would accept that, yes.

Q. I'm grateful. In a similar vein, your statement makes no mention of any meetings or engagement between the Northern Ireland branch of your body, with either the Chief Medical Officer for Northern Ireland or the medical directors for the Health and Social Care Trust of Northern Ireland during the pandemic. Are you aware that any such engagement ever took place?

A. Again, I'm not directly aware of that but I can find out for you.

Q. Okay. And if you are to provide that information to the Inquiry, perhaps you could follow that up with what the reasons were, if the answer is in the negative, if they didn't engage with the CMO and the medical directors?

A. Yes.

MS McDERMOTT: Those are my questions, I'm very grateful, my Lady.

LADY HALLETT: Thank you, Ms McDermott.

Ms Cat Jones.

Questions from MS JONES

MS JONES: Dr Bryden, I ask questions on behalf of the Covid Bereaved Families for Justice Cymru Group, or Wales, and I'd like to ask you first of all about communication with Wales and Welsh bodies.

Other than the Royal College of Anaesthetists Welsh board having representation on the Academy of Medical Royal Colleges Wales, which met with the CMO every two or three weeks as you outlined for us at the beginning of your evidence, was there any other engagement between the Royal College of Anaesthetists, the Faculty of Intensive Care Medicine and/or the Association of Anaesthetists, with either Welsh Government or with Public Health Wales that you are aware of?

A. So prior to the pandemic, the Faculty of Intensive Care Medicine conducted a workforce engagement event in Wales and also met with the health minister at the time, who then became the First Minister. So we had engaged, prior to the pandemic, during the pandemic, one of the board members of the Faculty of Intensive Care Medicine was also a member of the Academy of Medical Royal Colleges in Wales and was also, as I understand it, engaging with the Chief Medical Officer for Wales.

Q. And within that engagement, are you aware what issues, if any, were raised?

A. I would not be aware of specific issues in relation to Wales, but again I can find that out for you. But my understanding is that a lot of the issues in relation to Wales were very similar to the issues in relation to the rest of the UK in addition to, as I've already highlighted, the very poor provision of intensive care beds in Wales that was known about prior to the pandemic -- so the lack of resource, and the impact that that was having on Wales.

Q. Thank you, Doctor. That brings me on to my next topic.

In paragraph 105 of your witness statement, you set out for the Inquiry and I'll read it for you, Doctor:

"The highest level recommended for intensive care bed-fill rate for safe and efficient patient care is 85%. However, ICUs were running above this pre-Covid-19, making the UK woefully underprepared to cope with the large additional demand for intensive care."

Then you go on in paragraph 106 to set out some survey data from the FICM taken in 2018, which showed the bed-fill rate in Wales was estimated to be at least 95% in 2018.

Therefore, my question is this: in addition to being woefully unprepared, what would the impact of that bed-fill rate have been in Wales be at the time the pandemic hit?

A. So we have a situation where you have inadequate numbers of staff who are able to respond, and you also don't have the facility, the estate in order to take increased numbers of patients, and it does impact in terms of the ability to manage patients within the footprint of an intensive care service.

So we know that when there's a high bed occupancy it does impact on how we deliver care to patients.

MS JONES: Thank you, Doctor.

My Lady, those are my questions.

LADY HALLETT: Thank you, Ms Jones.

Ms Peacock.

Ms Peacock is behind you but -- by all means look at Ms Peacock when she asks the question but if you could make sure you get your answer into the microphone, I would be really grateful.

A. Okay.

Questions from MS PEACOCK

MS PEACOCK: Good afternoon. I ask questions on behalf of the Trades Union Congress. My questions focus on the Nightingale hospitals which were constructed during the

pandemic.

In your witness statement you explain that the Faculty of Intensive Care Medicine was consulted on that project to construct Nightingale hospitals. That's at paragraph 39 of your statement. You speak of initial meetings which focused on potential locations for the Nightingale hospitals and later meetings which focused on guidelines, patient safety and training.

At what stage in the pandemic did these meetings take place? Are you able to identify a broad time period?

A. So my understanding is that that was effectively around the first wave of the pandemic and some of the conversations were particularly around providing training materials and very rapid upskilling for staff that would be working in the Nightingale hospitals. We were supplied with information from some of the local London hospitals around the information that or the materials that they were using for the -- or proposing to use that the London Nightingales and we were then advising and trying to identify how they could be made more generic for the Nightingales, in addition liaising with Health Education England at that time around how we could recognise the skills of staff that may be working in those units both in terms of pre-existing skills and

then recognising any skills that were required subsequently to enable staff to effectively passport to say that they had worked in an area and could transfer to working in another area because they had the appropriate skill set.

Q. You go on in your statement at paragraph 40 to explain that the FICM pointed out that workforce would be a major issue as experienced clinicians would be required to staff the new hospitals which would denude existing NHS hospitals and potentially make the project unviable.

Just to put that into some context, the Nightingale hospitals were large with maximum bed capacities in the hundreds and thousands and you set out in your witness statement, and in your evidence today, that pre-pandemic staffing levels were very overstretched.

Where existing IC units were already struggling to maintain appropriate staffing levels, should it not have been clear at the outset to the teams establishing very large temporary hospitals that staffing provision would be a significant barrier?

A. So I think we were clear from the very beginning that we had insufficient critical care staff to, if you like, as a baseline going into the pandemic and throughout we were very, very clear that provision of an intensive

care bed was not just around the bed and the equipment, it was the human resource. So it was around having the individuals who could care for patients that were in those beds and that was a consistent view that we took both in terms of public information and messaging and also in terms of private messaging in terms of meetings that we were having around saying that it was around identifying a resource that was more than a physical one.

Q. Were you given any response to your -- you said it was from a very early stage, your initial advice that staffing would potentially render the Nightingale project unviable; was any response provided to you?

A. So, again, just to clarify I am not aware of any specific advice that we gave that said the Nightingale project was unviable. Our view was very much around making clear what the criteria would need to be in order to staff such a facility safely and being very clear about where the staff would come from. So we were not making comments around the viability or otherwise, it was being very clear what was needed in order to operate those facilities.

Q. But your evidence in your statement, if I'm correct, is that the staffing levels available at that time would potentially render the project unviable. That's at

paragraph 40.

A. Yes. So our view very much was around we could not staff the Nightingale hospitals and continue to run existing critical care units because the staff were needed at the existing critical care units. So the only way that we could consider would be moving staff to the Nightingale hospitals wholesale. Our understanding or my understanding is that the Nightingales that operated as an intensive care unit were effectively the London Nightingale, and the others did not. And, again, feedback from colleagues was around the fact that they didn't have spare staff to go and work in the Nightingales. So that was often a rate limiting step in terms of providing support to the Nightingales.

Q. Do you think at its heart, and this is my final question, the establishment of the Nightingales in such large numbers with the staffing issues you've identified reflected a misunderstanding that an intensive care bed is much more than just a piece of equipment that can be dropped into a new temporary hospital but it requires an eco-system of highly trained staff around it?

A. So, again, I think we have been consistent from before the pandemic and across the four nations of the UK and throughout the pandemic that the critical care service that existed prior to the pandemic was already under

pressure and we were consistent throughout the pandemic that it was the human resource that was going to be the rate limiting step and that is why we needed the support of colleagues from the rest of the hospital and the impact that that had in patient care in the rest of the hospital because those staff members were not available to provide the care and treatment that they needed.

MS PEACOCK: Thank you, I have used up my time so I will leave that there. I am grateful, my Lady.

LADY HALLETT: Thank you, Ms Peacock.

Those are all the questions we have for you, Dr Bryden. Thank you very much indeed for your help. I am very grateful. I shall return at 10.00 tomorrow.

(The witness withdrew)

(3.59 pm)

(The hearing adjourned until 10.00 am on Wednesday, 9~October 2024)

I N D E X