

Tuesday, 8 October 2024

1
2 (10.00 am)
3 **MS CAREY:** Thank you, my Lady.
4 The first witness this morning is Professor
5 Bamrah. May he please be sworn.
6 **PROFESSOR JASWINDER SINGH BAMRAH (affirmed)**
7 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**
8 **MS CAREY:** So your full name, please.
9 **A.** My full name is Professor Jaswinder Singh Bamrah.
10 **Q.** You are here to give evidence today on behalf of the
11 Federation of Ethnic Minority Healthcare Organisations,
12 or FEMHO for short. I hope you'll forgive me for
13 calling it FEMHO.
14 Can I make sure that you have in front of you,
15 I hope, the two statements that you've prepared for the
16 Inquiry; the first statement dated 22 December 2023,
17 ending 399526, and the second statement dated
18 28 February 2024, ending 427706?
19 **A.** I do.
20 **Q.** Thank you.
21 Can I start, please, with a little bit about you.
22 I think you are a senior consultant psychiatrist working
23 in the NHS, and were you working in that role throughout
24 the pandemic?
25 **A.** I was, yes. I mean, I was working remotely for a while

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1 member organisations they are set out in annex 1.
2 Could you help me, Professor, though, what type of
3 roles does the membership cover?
4 **A.** So we were actually formed at the time of Covid, at the
5 first meeting with the CMO, a number of organisations
6 came together and we at that time understood that
7 there's a major issue in terms of black and ethnic
8 minority representation, as well as the issues that we
9 were having with the morbidity and mortality statistics
10 which were going the wrong way, and at the time we
11 brought all these organisations together. They are
12 largely doctors, nurses, pharmacists, but also people
13 from admin background, managerial background and from
14 social work background.
15 **Q.** I think it also includes cleaners, porters, catering and
16 other support staff.
17 **A.** The support staff.
18 **Q.** So the whole range, really, of healthcare workers that
19 we are concentrating on. And I think you say that
20 a number of FEMHO's members include senior medics and
21 other healthcare professionals who act as pillars of
22 their communities. I would like really to start,
23 please, why is it important to have representation by
24 the ethnic minorities at a higher level and acting as a
25 pillar of the community?

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1 but my mother was 90 at the time, so shielding her as
2 well as, I suppose, myself but most -- but I worked
3 throughout, yes. And I've -- today is the 43rd
4 anniversary of my starting in the NHS. I was a young,
5 enthusiastic, somewhat excited, and very nervous doctor
6 and I'm that today only less young and more nervous.
7 **LADY HALLETT:** But just as excited.
8 **A.** Just as excited.
9 **MS CAREY:** Well, there's an introduction.
10 Professor, with that excitement in mind, though,
11 can we turn to the difficult topic of the
12 disproportionate impact of the pandemic on black, Asian,
13 minority ethnic healthcare workers in particular, and
14 just to help you, and indeed those who are watching, of
15 course, there are clearly a number of structural and
16 wider issues at play but today I would really like your
17 help, please, with the impact that the pandemic had on
18 either creating new inequalities or exacerbating
19 pre-existing inequalities.
20 Just a little bit about FEMHO, though, itself.
21 I think you say in your statement that it is a
22 consortium comprising of 55,000 individual members
23 belonging to over 40 organisations and networks across
24 the entirety of the UK and, my Lady, I won't go through
25 them but if anybody wants to see the individual list of

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1 **A.** I guess all the statistics, including from NHS England,
2 have shown that unless employers -- employees of the NHS
3 have senior managerial positions who look like them, who
4 are black and brown equally represented, they are
5 unlikely to take, understand those instructions, the
6 advice, the policies because they're not formed around
7 them. They're not culturally sensitive.
8 **Q.** We may look at a number of examples of that as we go
9 through evidence this morning but I think you say at the
10 outset in relation to public health communications in
11 many cases they are instinctively distrusted by members
12 of the communities.
13 Why is there such a level of distrust?
14 **A.** I think much of it is in the way that these
15 communications happen. They have happened traditionally
16 top-down rather than policies worked out with the
17 communities and many who've come round around the
18 Windrush generation, around from South Asian countries,
19 they have had that feel that actually we're here as --
20 to provide a service but not to be part of the upper
21 echelons of the society in the NHS and, of course, over
22 time all the statistics have shown that there hasn't
23 been adequate representation even though that
24 acknowledgement has been there that we should be
25 properly represented at all levels of senior management.

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- 1 **Q.** Translating that to the pandemic itself, how did that
2 level of distrust or the lack of representation higher
3 up in the NHS, how did that play out for the BAME
4 healthcare workers on the ground?
- 5 **A.** I guess this is where it was really exposed, wasn't it,
6 that that fabric was already fragile and during the
7 pandemic the issue of all these deaths amongst the
8 black, and ethnic minority people, community, as well as
9 healthcare workers, it really sent shock waves when the
10 first ten doctors died, all of whom were ethnic. It
11 didn't seem as if our voice was being heard although
12 many of us were trying to shout from rooftops to say,
13 look, listen, there's something going on here that
14 shouldn't be happening.
- 15 So that just festered that mistrust even more.
- 16 **Q.** You said there that "many of us were trying to shout
17 from the rooftops". Does that include you, Professor?
- 18 **A.** It does, yes.
- 19 **Q.** Who were you shouting to?
- 20 **A.** To -- well, everybody. The Prime Minister, the
21 Secretary of State for Health, NHS England. Pretty much
22 wrote to everybody you know starting from the end of
23 March, really.
- 24 **Q.** And in relation to NHS England, who would you be
25 directing your shouts towards?

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- 1 "We need to be careful about rushing judgement
2 before we have all of the facts."
- 3 Because there are higher comorbidities from people
4 with people from ethnic minority backgrounds, there are
5 ethnic minority backgrounds that constitute a
6 disproportionately high number of key frontline workers,
7 and those from ethnic minority groups are more likely to
8 be concentrated in poorer areas and live in overcrowded
9 housing and intergenerational houses.
- 10 So there's a number of reasons why there might be
11 this disproportionate impact.
- 12 If we go a little bit further down to the
13 paragraph beginning "In short":
- 14 "... people from ethnic minorities are more likely
15 to have underlying health conditions that make them more
16 vulnerable to the virus, work in roles where they are
17 exposed to it and live in conditions in which it is more
18 likely to spread. As the Mayor of London, Sadiq Khan
19 commented: '... the depth of inequalities is being laid
20 bare in stark fashion'."
- 21 Because I am keen that this doesn't become a
22 statistic-laden examination with you this morning but
23 I just want to set a little bit of context for the
24 evidence you give, and I think you are aware that
25 following these statistics, the Chief Medical Officer

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- 1 **A.** So initially to Sir Simon Stevens and then to Amanda
2 Pritchard but also CMO and Medical Director of
3 NHS England.
- 4 **Q.** Now, you mentioned a moment ago the first ten doctors
5 dying being of ethnic origin. I just want to pick up on
6 that, please.
- 7 Could we have up on screen INQ000215522.
- 8 I just want to ground us in with a few statistics
9 but actually then ask you a bit about not the statistics
10 but the actual people that we are talking about.
- 11 I think you say in your statement, and I'll just
12 preface what we're going to look in a moment, that the
13 NHS is the largest employer of BAME staff, 26% of its
14 employees are BAME. It's about 340,000 people.
- 15 Then, by April 2020, the King's Fund article which
16 we've got up on screen here referenced an analysis done
17 that found that "of [the] 119 NHS staff known to have
18 died in the pandemic, 64 per cent were from an ethnic
19 minority background [whereas in fact] (only 20 per cent
20 of NHS staff ... from an ethnic minority background).
21 This disproportionate toll is shocking."
- 22 So, if we think, that's only six or so weeks into
23 the pandemic, six weeks after lockdown. Could we go to
24 page 2 of that document, please.
- 25 The authors of the article say there:

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- 1 commissioned Public Health England to conduct a review.
2 And if we just look at, please, INQ000106482, just
3 picking up there on some of the inequalities, the Chief
4 Medical Officer told us, for example, that people from a
5 BAME background were more likely to get severe Covid.
6 Those infected were more likely to die, and you can see
7 there, for example, in the paragraph beginning:
- 8 "An analysis of survival among ... COVID-19 cases
9 showed that, after accounting for the effect of sex, age
10 deprivation and region, people of Bangladeshi ethnicity
11 had around twice the risk of death when compared to
12 people of White British ethnicity. People of Chinese,
13 Indian, Pakistani, Other Asian, Caribbean and Other
14 Black ethnicity had between 10 and 50% higher risk of
15 death when compared to White British."
- 16 **LADY HALLETT:** Can you remind me the date of the review.
- 17 **MS CAREY:** Yes, the review came out in June 2020.
- 18 **LADY HALLETT:** Thank you.
- 19 **MS CAREY:** Commissioned around April and published in June.
- 20 Professor, can I ask you, against that background,
21 when the PHE review came out, how was it received by
22 FEMHO and its members?
- 23 **A.** So -- and then before that, the King's Fund which you
24 were referring to had already put up the statistics. So
25 we were -- obviously, we wrote to Public Health England

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

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

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

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

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1 and analysis of data in real time."

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

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

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

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

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1 treat them.

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

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

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

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

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

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

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1 doing this.

2 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Can I ask you about a different aspect of data.

5 Are you aware of whether there's any reliable data on
6 the impact of Long Covid on the BAME healthcare workers?

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

11 I know a number of colleagues who have Long Covid
12 but are actually providing frontline work in the NHS.

13 They are still there, they are still beavering on,
14 soldiering on, but that data is lacking, and that
15 support isn't there either. It's not just about the
16 data. Many of them tell me they are not getting support
17 from organisations that they should.

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

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

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

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

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

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

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

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

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

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

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

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

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1 procedures. They make the point there they are worried
 2 about patients coughing and sneezing passing on the
 3 virus and:
 4 "There are similar concerns about adequacy of PPE
 5 in many areas of secondary care and also by pharmacists
 6 who are seeing patients who attend their pharmacies."
 7 I think, is it right, Professor, that as a result
 8 of this letter being sent there was -- it was picked up
 9 by the media and brought to the attention of Nicola
 10 Sturgeon who was the then First Minister and it led to a
 11 meeting with Gregor Smith the Scottish CMO to highlight
 12 these issues?

13 **A.** Yes.

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

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

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

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

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1 healthcare workers amongst BAME communities.
 2 Can I ask to be called up on screen INQ000409269.
 3 Thank you very much.
 4 This is an open letter signed by more than 100
 5 medics in early April 2020 to the Scottish Government to
 6 express concerns over PPE once the disparate effect of
 7 deaths was made clear.
 8 I just want to ask you about some of the passages
 9 in the letter.
 10 If we could just scroll down a little bit to the
 11 paragraph starting "Presently", the authors of the
 12 letter say:
 13 "Presently what has been provided in primary care
 14 (and many areas of secondary care) has been thin plastic
 15 aprons which cover very little of the wearer's body,
 16 surgical masks which have been shown only to be
 17 protective against large droplet spread but not to
 18 smaller droplets or anything airborne and flimsy eye
 19 cover which does not provide enough protection. Even
 20 the [WHO] guidelines state a surgical gown is a minimum.
 21 But here in Scotland we should be doing so much better
 22 for our dedicated healthcare workers who are risking
 23 their well-being daily to help combat this ... fatal
 24 virus."
 25 They go on to make reference to aerosol-generating

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1 whether that happened?

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

9 **LADY HALLETT:** Thank you. Sorry to interrupt.

10 **MS CAREY:** No, not at all, thank you.
 11 I was going to ask you whether you knew whether
 12 any of FEMHO's membership organisations had written
 13 similar letters or tried to raise concerns with the
 14 Northern Irish ministers. Can you help with that at
 15 all, Professor? Do you know what the position was?

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

18 **Q.** Thank you. That letter touched on issues of access to
 19 and suitability of PPE and I'd like to ask you about
 20 that, please.
 21 Professor, we've already heard a lot of evidence
 22 about PPE being unavailable or inadequate or fit testing
 23 being failed and I think they are consistent concerns of
 24 FEMHO's members; is that correct? Could you just help
 25 us, please, with how does a member of FEMHO or a BAME

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

5 **A.** Oh, very hard really.

6 **Q.** Why?

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

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

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

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

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

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

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

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

4 **A.** I mean by the regulators.

5 **Q.** By the regulators, right.

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

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

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

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

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

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

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

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

24

- 1 **Q.** I think you give an example in your second statement of,
2 in Northern Ireland, a frontline social worker speaking
3 to nursing colleagues it's your paragraph 12, Professor,
4 those nursing colleagues were Indian, and they had
5 anxieties they couldn't really communicate to others.
6 Some had newly arrived in Northern Ireland and didn't
7 want to be seen to be making a fuss by raising concerns.
8 Can you think about how any recommendations that
9 could be made to try and dispel that myth, "It's not a
10 fuss, it's a legitimate concern"? How can we go about
11 changing that attitude?
12 **A.** I think it's all -- so I'm a great educator and trainer,
13 and I think it's all about proper training, cultural
14 awareness, cultural competence, people understanding
15 this is the kind of culture that people who are black
16 and minority ethnic, that's the background they come
17 from, and if they don't complain but they look unhappy,
18 what is the reason behind it.
19 So I think it's, you know, it's understanding that
20 and being able to say, "Look, we are going to provide
21 you with the support and not run this department with
22 fear", which many people seem to do.
23 **Q.** You say as well that those from minority ethnic
24 backgrounds are less likely to be in trade unions. Why
25 is that the position?

25

- 1 anyone other than the white male without the beard.
2 That's an oversimplification and it's mine, but you will
3 understand the general thrust of the question,
4 Professor. Do you know if there's any work being done
5 to procure PPE that fits a broader range of healthcare
6 workers, in particular people with beards, for example?
7 Do you know if there's anything being done about that?
8 **A.** So one of our members did at the time write to the
9 Department of Health, and I can share that
10 correspondence if I haven't already done that through
11 our legal team. And because these were bearded Sikhs,
12 Muslims and Jewish people, men, because they did not
13 pass the fit test with the traditional FFP3 masks, one
14 of them invented what was called the Tata technique
15 which he said passed the regulations, but then he was
16 categorically told by HSE that they cannot agree with
17 this and that the requirement is to be clean shaven.
18 Now, and you know we heard about these very sad
19 instances where Sikhs and Muslim men had to shave their
20 faces for the first time, which, you know, if you
21 understand the religion as I'm sure you do, this is just
22 completely unacceptable but they wanted to provide a
23 service to their patients and help run the departments
24 so they did, some of them did become clean-shaven for
25 the very first time.

27

- 1 **A.** So many of them are locum, so particularly with doctors
2 and agency nurses, many of them are locums, and they
3 don't belong to trade unions, most of them. So they
4 don't have that kind of protection that some of us in
5 substantive positions have.
6 **Q.** Now, some of these are slightly broader issues than the
7 impact of the pandemic itself, but can I ask you,
8 please, about your paragraph 25 in your first witness
9 statement and some evidence that was given in Module 1
10 by Sir Christopher Wormald, the Permanent Secretary to
11 the Department of Health. I think you set out there
12 that he confirmed the department had stocked lower
13 levels of PPE suitable for black staff working in
14 healthcare, and that little planning had been done to
15 consider the equality of PPE provisions.
16 When FEMHO's members heard that evidence or
17 learned of it, what was their reaction to that?
18 **A.** Shocked, really. Perhaps not surprised because that was
19 an admission of what was already prevailing at the time
20 and had been for some time, but absolutely shocked that,
21 you know, there should be an admission of -- well, not
22 that there should be an admission, but that this sort of
23 thing has been allowed to fester in our hospitals and
24 our communities.
25 **Q.** We've heard that PPE, in particular masks, may not suit

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- 1 But HSE clearly stated that "This is it, you are
2 either clean-shaven or" -- and there's no attempt,
3 really, to produce masks that fit bearded men, as
4 I know.
5 **Q.** Do you know if there was any thought given to wearing
6 the powered hoods so you wouldn't need to shave
7 necessarily? Do you know if any FEMHO members were
8 offered that as a potential alternative PPE?
9 **A.** Not as I'm aware, and I've communicated with a lot of
10 these folks, but not as I'm aware.
11 **LADY HALLETT:** Professor, was this instruction they had to
12 be clean-shaven written down anywhere? It's just that
13 it seems to me such an extraordinary thing --
14 **A.** Yeah.
15 **LADY HALLETT:** -- to tell people who, for religious reasons,
16 have beards. So you're confident this isn't apocryphal;
17 do we have any hard evidence?
18 **A.** May I read it out to you, my Lady?
19 **LADY HALLETT:** So where is this coming from?
20 **A.** This is coming from them, the HSE.
21 **LADY HALLETT:** So the HSE, you have something in writing?
22 **A.** Yes.
23 **LADY HALLETT:** Yes, please.
24 **A.** So:

"Based on the information provided, HSE cannot

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

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

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

12 **A.** I'm not sure, you know.

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

14 **A.** Sure.

15 **Q.** All right, thank you very much.

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

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

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

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

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

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

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

22 **A.** Yes.

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

24 **A.** Yes. But what happened after that, I can't tell you.

25 I would be happy to find out.

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

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

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

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

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

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

30

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

7 You say this:

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

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

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

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

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

25 So where doctors and nurses were shielded,

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

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

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

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

19 **A.** Mmm.

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

24 Could we have up on screen INQ000184474.

25 And this is a letter of 27 March to Mr Hancock.

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

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

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

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

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

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

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

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1 generally for everyone working in the healthcare
 2 systems?

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

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

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

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

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1 trained to provide.
 2 How did that play out on the ground, Professor?
 3 **A.** So that conflict, you know, I was referring to that
 4 earlier and, you know, in that conflict of course some
 5 people felt they had a duty to provide, providing they
 6 were not Covid positive, provide a service even if they
 7 were exposed because of their particular
 8 vulnerabilities. I guess people took their position --
 9 in that particular time they took their position as they
 10 thought was best fit, so many of them did shield and
 11 they wrestled with the idea that their departments -- so
 12 there are some departments that are entirely run by
 13 black and ethnic people and those departments would
 14 struggle. So it's more likely that people would feel a
 15 sense of duty to the patients and the Trust and came to
 16 work.

17 So there wasn't one formula fitted all.

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

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

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

3 **A.** Yes.

4 **Q.** Can I pick up on a statistic that you've provided
 5 because you said there was a study conducted in
 6 June 2020 into risk assessments for black, Asian, and
 7 minority ethnic doctors which at that time found that
 8 65% of doctors said they had not yet had a risk
 9 assessment. That was a survey done in June 2020, so
 10 that gives us an indication of the number of doctors
 11 that hadn't yet had a risk assessment.

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

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

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

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

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

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

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

7 **Q.** I think you say in your statement that by 2021 more than
 8 71,000 NHS and social care employees and, indeed, over
 9 74,000 public sector employees had used an online
 10 version of the tool plus there were 45,000 people using
 11 a paper version of the tool. So a significant take up
 12 in Wales.

13 **A.** Yes.

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

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

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1 comorbidities and all that sort of thing, and sex, and
 2 I do understand that by September 2020 the tool that
 3 came out, which I was involved with, with the Chief
 4 Executive of Wigan, I think that that informed
 5 eventually the tool that he devised for NHS England.
 6 **Q.** You said in that answer there was perhaps too many
 7 tools. Is that one from NHS England, plus one from
 8 Trusts, plus tools within the hospitals themselves? Can
 9 you give us an idea of how many different tools there
 10 might be?
 11 **A.** It seemed like that, you know. It seemed that there
 12 were different ways of then trying to risk assess
 13 patients, or people rather, and frontline workers.
 14 **Q.** You say in your statement that the Welsh model can be
 15 considered in comparison with the English model where
 16 there was more of a focus on a data-intensive approach
 17 preparing a risk assessment tool which would be linked
 18 to the patient's medical records. Is that -- is there a
 19 downside to that? Are you worried about that approach
 20 by the English model to risk assessment tools?
 21 **A.** Well, I think what we need, really, if you ask me, is --
 22 I mean, I'm a researcher, so I would say that I would be
 23 happy if somebody were to do some research on these
 24 assessment tools now. So I think the NHS should
 25 commission what is the most appropriate tool rather than

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1 **Q.** I think you say that in Scotland you've heard from their
 2 members there was no push from the Scottish Government
 3 to pursue an ethnicity-specific healthcare worker risk
 4 assessment tool for primary care staff. Is there a
 5 distinction to be drawn between the risk assessment
 6 tools for primary care and secondary care?
 7 **A.** No, I think a risk assessment for a particular illness
 8 like Covid would be generic.
 9 **Q.** But at least from September 2020 the assessments did
 10 take into account ethnicity when working out the
 11 healthcare worker's risk score?
 12 **A.** *(The witness nodded).*
 13 **Q.** Now, can I just ask you about this because clearly there
 14 are underlying inequalities that are well known and well
 15 rehearsed. There is clearly variation as to how much
 16 concentration a risk assessment places on ethnicity.
 17 Why, given everyone knows there's a problem with
 18 disproportionate impacts, didn't the risk assessment
 19 tools include ethnicity from the outset? Why does it
 20 take until September 2020? Do you have any observations
 21 as to why there is a delay in ethnicity being picked up
 22 in this way?
 23 **A.** I think that's the nub of the question, isn't it,
 24 because I think there was a general feeling that
 25 throughout, even before the pandemic that, you know,

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1 wait for this to come round again.
 2 **Q.** And do you know, Professor, are these tools available in
 3 multiple languages?
 4 **A.** No. No they're not -- not as I'm aware.
 5 **Q.** Does that pose any practical difficulties for the black,
 6 Asian, and minority ethnic healthcare workers or is that
 7 not so much of an issue as there has to be a base
 8 understanding of English in the roles that they're
 9 performing?
 10 **A.** Yes, for the frontline workers all of them would speak
 11 English. So I think this would be fine and the people
 12 who are applying the tool should be well versed in
 13 English.
 14 **Q.** And in your members' experiences, who is conducting the
 15 risk assessment? Is that being done in a culturally
 16 appropriate way or do you have any observations to make
 17 on that?
 18 **A.** So no they're not being conducted in a cultural way.
 19 That is anecdotal. You know, I know that people felt
 20 that sometimes people didn't really understand the
 21 sensitivities around the various parameters in the risk
 22 assessment tool depending on their culture. So, no.
 23 The people who conducted them were the lead people so it
 24 could be the lead clinical director or the lead manager
 25 of that particular department.

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1 people, our bosses are not actually understanding that
 2 there are particular issues of culture, race and
 3 ethnicity that they need to be aware of. If they were
 4 aware of these things which there had been multiple
 5 attempts, multiple reports to say, look, these are very
 6 important issues to your 1.3 million employees, there
 7 has been just an abject failure to actually understand
 8 the sensitivities around that.
 9 **Q.** Can I come on, then, to a larger topic which is the
 10 guidance and communication that was issued and I think
 11 you say that -- it's your paragraph 53 onwards,
 12 Professor -- that the guidance was confusing, lacking in
 13 clarity and it caused additional stress. I would just
 14 like to be clear, what guidance are you talking about
 15 there, Professor?
 16 **A.** Sorry, let me get to --
 17 **Q.** Paragraph 53. It's all right.
 18 **A.** So I mean, this is not just the chair of BINA saying it
 19 but we all felt that there was complete inconsistency
 20 about what to wear, when to wear, who to wear, and all
 21 that sort of thing and that confusion that existed
 22 caused some Trusts' senior managers to interpret the
 23 rules according to their whim.
 24 **Q.** Can you expand on that last answer. What were they
 25 doing to interpret the rules?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 issue.

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

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

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

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

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

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

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

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

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

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

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

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

18 **A.** Sorry.

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

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

25 **LADY HALLETT:** Certainly. I hope you were warned that we
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1 this is part of your job, so there should be an
2 acknowledgement in people's job that this is really what
3 your duties are and make it part of your core NHS duties
4 that you're an educator, a trainer, and this is what
5 you're doing as part of that. And then, with that,
6 would come the admin support that you need because these
7 are very senior people in the NHS who are then setting
8 up their own seminars, setting up -- flyers, right from
9 flyers, up until delivery of these programmes, and then
10 getting feedback.

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

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

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

25 **A.** I would say abolish the term altogether, "hard to
50

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

2 **MS CAREY:** Thank you, my Lady.

3 **(11.15 am)**

4 **(A short break)**

5 **(11.30 am)**

6 **MS CAREY:** Thank you, my Lady.

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

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

15 **A.** How long have we got? I think this is one of the
16 neglected areas, to be truthful, because -- I mean, much
17 as there was a lot of stress in the acute system, can
18 you imagine our mental health workers going to A&E, and
19 A&E saying, "Well, actually it's the responsibility of
20 your Trust to provide you with PPE and all the
21 equipment, so you can't come in to see our patients
22 because you need to be properly equipped by them", and
23 the Trusts, knowing that they were keeping PPE for their
24 staff, there was kind of a breakdown about what the NHS
25 is, which is that we're one organisation.
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1 So that was the stress of the work. And then
 2 patients on mental health wards having Covid but
 3 obviously not being able to access the right medical
 4 support which they needed, and, of course, we understand
 5 medicine with our doctors, but actually we're not
 6 physicians or treating those patients. A lot of stress,
 7 moral injury, to a lot of workers during that time, not
 8 being able to give patients the kind of support and that
 9 was generic, not being able to give patients the right
 10 amount of treatment at the right time caused a lot of
 11 pain all around but, of course, our members who
 12 articulated this to us felt really that that has not
 13 been addressed even until today. Mental health, as
 14 ever, came right, you know, on the back of the envelope
 15 right at the front.

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

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

22 **A.** Schwartz.

23 **Q.** Help us with that please, Professor.

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

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

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

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

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

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

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

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

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

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1 Do you include, in that, PPE?

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

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

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

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1 policy.

2 **Q.** So, better engagement with organisations such as yours?

3 **A.** Yes.

4 **Q.** We've looked at effective risk assessments which would
5 factor in race and ethnicity. I won't ask you about
6 that. But if you could just stand back, Professor, and
7 perhaps think about one central recommendation that you
8 would like your Ladyship to consider, do you have one
9 burning recommendation out of all of them?

10 **A.** I guess that would be that apart from those things is
11 really, I think we need good training and leadership
12 where they, at the top, understand the nuances of all
13 these cultures. I think there are over 200
14 nationalities in the NHS from -- were my last statistics
15 on that, and do they have an understanding of this so
16 that they can understand the way that black and ethnic
17 people work.

18 I think there should be safer practices, safe and
19 flexible working, there should be better protection for
20 people who -- you know, legal and institutional
21 protection for people who are discriminated against or
22 bullied or, you know, harassed, if you like.

23 **Q.** Now, I understand all of those matters, but they are
24 potentially wider than just the impact of the pandemic;
25 do you have any recommendation that you would urge us to

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1 as members?

2 **Q.** Are they disproportionately overrepresented in --

3 **A.** In disciplinary procedures, yes.

4 **Q.** No, just in terms of numbers of healthcare workers in
5 those roles. So, for example, some professions in roles
6 that are more outsourced like cleaners and porters and
7 what have you, do we see instances in which ethnic
8 minorities are disproportionately overrepresented?

9 **A.** I haven't got an answer to that. I'm really sorry.

10 **Q.** That's fine. I think we can move on to the next topic
11 and look at some of what you do describe about the
12 particular position of agency workers.

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

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

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1 consider in the event of a future pandemic that could
2 help FEMHO's members?

3 **A.** Get us into the room early. I would say that because
4 I think that if we're involved right at the outset, you
5 know, this "us and them" mentality is where -- why
6 things were so disjointed, I would say. Get us into the
7 room. It's about -- it's about defining policies around
8 people, not people around policies.

9 **MS CAREY:** My Lady, those are the questions I have. I think
10 there are some questions.

11 **LADY HALLETT:** It's Mr Jacobs to start.

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

14 **Questions from MR JACOBS**

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

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

22 First, is it your understanding that black, Asian,
23 and minority ethnic workers are disproportionately
24 represented in such roles?

25 **A.** Are they represented in agency -- are they represented

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1 the experiences of those healthcare workers who were not
2 indirectly employed in permanent roles?

3 **A.** It does.

4 **Q.** How would you describe the particular experiences faced
5 by those in more precarious employment roles in the
6 pandemic in terms of, for example, the ability to raise
7 concerns about PPE, about the infection and prevention
8 control they see around them and what have you?

9 **A.** So, as you know, bank, agency, and locum staff, this is
10 a growing number in the National Health Service and my
11 fear is -- I mean, I'm a trade unionist myself, I have
12 been a director of the BMA, so I understand this myself
13 that, look, these folks don't have the kind of
14 protection that substantive people have in employment
15 and that is a big worry, and because they are a growing
16 number, I feel that they are hugely disadvantaged. That
17 is why they have ended up in jobs that they know are
18 frontline and that they are going to be at risk but they
19 can't say "no", and if they said "no" they would not get
20 another job somewhere else. They don't have the kind of
21 protection -- despite our good employment laws, they
22 don't have the kind of protection.

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

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1 it's working as it is. They are really very vulnerable.
 2 **Q.** That might be something it's easier for you to raise
 3 than we, Professor.
 4 One issue that Sara Gorton has given in evidence
 5 on behalf of the Trades Union Congress is that
 6 agreements for directly employed NHS staff covering full
 7 pay for Covid sickness and self-isolation was difficult
 8 to enforce for staff who were outsourced or working via
 9 banks. Does that, to your knowledge, chime with the
 10 experience of any FEMHO members?
 11 **A.** So that is my understanding, that, you know, that's how
 12 it was at the time and whether that had been a practice
 13 before that I don't know, but certainly during the
 14 pandemic, the acute part, that's how it was.
 15 **Q.** Are these the sorts of macro-level systems and
 16 processes, as you describe in your statement, that
 17 interact with one another to generate and reinforce
 18 inequities among racial and ethnic groups?
 19 **A.** Absolutely. Inequity and mistrust.
 20 **Q.** And if it follows from that, that these are the sorts of
 21 processes that need to be confronted in preparing and
 22 responding to the next pandemic, how is that to be done
 23 practically? What are the practical steps that might be
 24 taken to support the position of those in bank
 25 positions, outsourced workers, and so on?

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1 **A.** Absolutely. I mean, I made that point, my Lady, which
 2 is that quite often they were left to their own even,
 3 you know, carrying these bin bags as aprons, and flimsy
 4 masks. How many of these low-paid workers did we expose
 5 to the virus unnecessarily? You know, I think there has
 6 to be some sort of a system of support for them. After
 7 all, we're losing them because they either just go off
 8 the NHS or they become ill and can't work.
 9 **MR JACOBS:** Those are my questions. Thank you very much.
 10 **LADY HALLETT:** Thank you very much, Mr Jacobs.
 11 Ms McDermott.
 12 That way, Professor. Ms McDermott is within your
 13 eye line.

Questions from MS McDERMOTT

15 **MS McDERMOTT:** Good morning, Professor.
 16 Professor Bamrah, today I will be asking questions
 17 on behalf of the UK Covid Bereaved Families for Justice
 18 and the Northern Ireland Covid Bereaved Families for
 19 Justice.
 20 And, firstly, congratulations on your 43 years in
 21 the NHS. It's a remarkable feat.
 22 My first question is about what you started with
 23 in your evidence and it was a common theme throughout
 24 your evidence about how it didn't seem as though the
 25 black and Asian and minority ethnic voices of the

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

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

7 My question is this: specifically at paragraph 42
 8 of your first statement you recount how many healthcare
 9 workers express fear of speaking out about unfair
 10 redeployment due to concerns over negative
 11 repercussions. I don't know if you want to have an
 12 opportunity to reflect on that paragraph but my question
 13 is this: in your view, was this fear justified and what
 14 specific consequences do you think those particular
 15 employees risked by speaking out?

16 **A.** Yes, and sorry, but they were justified -- I'm sure you
 17 understand that -- because that was the practicality on
 18 the shop floor that many of them were very, very fearful
 19 of actually going against -- it's also a cultural thing,
 20 that if you're a senior person or you're older than the
 21 person, that you don't challenge them as well. That's
 22 also kind of a cultural thing.

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

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

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

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

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

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

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

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

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

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1 proven otherwise.

2 **Q.** I'm grateful for that fulsome answer.

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

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

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

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

25 "Analysis regarding ethnic minorities was not

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

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

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

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

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

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

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

8 **A.** Thank you.

9 **LADY HALLETT:** Thank you very much, very grateful.
 10 That completes the evidence for you, Professor.
 11 You have been a very eloquent witness and obviously a
 12 very eloquent spokesperson too for a large number of
 13 communities, I suspect. Thank you very much for the
 14 constructive nature of your evidence, and I too would
 15 like to wish you, again, a happy anniversary.

16 **A.** Thank you.

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

18 **A.** Thank you.

19 **(The witness withdrew)**

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

22 **LADY HALLETT:** I will stay here.

23 **MS CAREY:** Thank you very much.
 24 *(Pause)*
 25

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1 stenographer can keep up.
 2 I think having left face-to-face clinical work,
 3 you completed a master's degree in health services
 4 research, and you now work in a non-patient-facing role
 5 within the NHS?

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

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

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

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

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

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1 **DR CATHERINE FINNIS (sworn)**

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

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

5 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**

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

7 **A.** Catherine Finnis.

8 **Q.** You made a witness statement on behalf of the Clinically
 9 Vulnerable Families core participant group dated
 10 31 January 2024, INQ000409574, and I hope you have a
 11 copy of that in front of you.

12 **A.** I do, yes.

13 **Q.** All right, thank you.
 14 A little bit of background to both you and indeed
 15 to CVF, as they are known. I think that you trained as
 16 a medical doctor some years ago now and practised for
 17 five years when you needed to leave face-to-face
 18 clinical work due to you being severely immune
 19 suppressed; is that correct?

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

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

23 **A.** Yes, that's correct.

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

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

3 **Q.** So, pausing there, we understand that the genesis of CVF
 4 was because of the concerns about going back to school.
 5 Now, you will appreciate, Dr Finnis, that we are
 6 concentrating on the impact of the pandemic within the
 7 healthcare systems, and so that's not to minimise the
 8 impact on children and indeed the teachers who were
 9 clinically vulnerable or clinically extremely
 10 vulnerable, but can we focus today on healthcare systems
 11 impact, if we may.

12 And I think you say this, that there's a combined
 13 membership of -- and following of CVF at just under
 14 46,000 people, and there are a number of members on
 15 Facebook, followers on Twitter and the like, and that
 16 CVF's mission is to support, inform and advocate for
 17 those in clinically vulnerable households as they face
 18 an ongoing threat posed by Covid-19.

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

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

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

7 **A.** Yes, that's correct.

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

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

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

25 **A.** Yes, that's absolutely right. So as we understand it,
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1 CVF's perspective, how long it took, if you were in that
 2 latter category of asking your GP to be added? Days,
 3 weeks, months?

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

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

21 **A.** No.

22 **Q.** All right. Now, what about the timing of the
 23 compilation of the list? I think you say in your
 24 statement that obviously we went into lockdown on
 25 23 March, and the letters started to be sent to people,
 75

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

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

20 **Q.** Now, we -- although there are, I think, the different
 21 medical categories, we were also told that if a GP
 22 identified a patient as being clinically extremely
 23 vulnerable, they could be added to the list and, indeed,
 24 people could ask themselves to be added to it. And you
 25 said that led to delays. Are you able to help us, from
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1 I think, a couple of days earlier on 21 March. Clearly,
 2 that was some time since reports in early January or
 3 thereabouts of the emergence of the coronavirus in
 4 Wuhan; does CVF have any concerns about the timing of
 5 the compilation of the list?

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

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

25 **Q.** I think you say in your statement that actually there
 76

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

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

19 But certainly it was very late.

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

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

4 You can see a quotation there:

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

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

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

18 **Q.** Today.

19 **A.** Yes.

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

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

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

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

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

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

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

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

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

13 It gives the website address.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 **LADY HALLETT:** Could you speak a little more slowly.

2 **A.** Sorry.

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

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

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

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

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

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

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

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

14 **A.** Yes.

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

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

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

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

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

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

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

18 **Q.** Do you think there should have been?

19 **A.** Yes.

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

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

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

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

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

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

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

13 **A.** Yes.

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

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

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

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1 through the post if they were clinically extremely
 2 vulnerable. Was that ever expanded to those that
 3 weren't living or residing in the care sector?
 4 **A.** Yes. So I believe it was offered to everybody who was
 5 on the shielding list. I certainly was offered a supply
 6 of vitamin D. I think what perplexed me at the time and
 7 still now is why at that point that -- I received my
 8 stash of vitamin D through the post, why not just give
 9 an FFP2 or 3 mask in the post? Why not use that
 10 opportunity to send those more protective masks to those
 11 very vulnerable people at that time?
 12 **Q.** Were you offered any PPE at all?
 13 **A.** No.
 14 **Q.** What about lateral flow tests and the like, were you
 15 offered those when they became available?
 16 **A.** Yes. So we were able to access lateral flow tests.
 17 Initially we were able to order online as many boxes as
 18 we needed but then there's been a reducing access. So
 19 then it was only the clinically extremely vulnerable or,
 20 actually, it was the person who could access antivirals,
 21 which is a different list. It became really
 22 complicated. That was one of the other issues. But if
 23 you could access antivirals then you -- which wasn't
 24 necessarily the shielded list but a lot them but
 25 involved some clinically vulnerable, for example, then

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1 Sick Pay which meant that you could at least afford to
 2 shield.
 3 So from that perspective, I think it was helpful.
 4 There was other things such as food parcels, we were
 5 sent food parcels early on, just in the first wave.
 6 There was also something about supermarket shopping. So
 7 we were given free slots, essentially, to enable -- that
 8 took a while to kick in, to be honest. There was a
 9 first few hairy weeks, where, if we weren't prepared,
 10 and maybe that was one of the problems, was that because
 11 we weren't really forewarned all of a sudden we were
 12 perhaps stuck at home without any food in the larder and
 13 we were in lockdown, you know.
 14 **Q.** It comes back to preparedness, and so many answers often
 15 do, if I may offer that comment.

16 Can I ask you, though, about some of the more
 17 negative impacts of shielding. I think in particular it
 18 might be helpful to look on the screen at INQ000408810
 19 and some research that was conducted by The Health
 20 Foundation. If we just look at the second paragraph
 21 there. The analysis conducted by The Health Foundation:
 22 "... shows that [CEV] people experienced a higher
 23 rate of deaths compared to the general population over
 24 the pandemic. At the peak of the first wave on
 25 2 April 2020 the rate of deaths amongst the clinically

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

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

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

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

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

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1 vulnerable population was over two and a half times that
 2 in the general population (1 in 2,500 ... compared to 1
 3 in 7,000 ...) Furthermore, by the end of August ... the
 4 clinically extremely vulnerable population accounted for
 5 19% of all deaths while only making up 4% of the total
 6 population ..."

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 members.

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

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

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

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

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

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

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

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1 sort of support that we then went in and offered.

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

6 **Q.** That can be taken off the screen.

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

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

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

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

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1 we'd done some polls in CVF, which shows the problem.
2 So just before the masks were removed, we did a poll in
3 2022, and it was with hundreds of people who were
4 clinically vulnerable, and they were asked whether they
5 had delayed or cancelled any appointments, and we were
6 told that I think it was about just above 50% had done
7 that.

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

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

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

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

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

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

17 **A.** Yeah, I mean --

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

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

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

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

4 **A.** Yes.

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

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

10 **A.** Yes.

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

12 **A.** Yes.

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

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

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

18 **A.** Yes.

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

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

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

4 LADY HALLETT: And more slowly, please.

5 MS CAREY: I'm doing it now. I'm so sorry, my Lady.
6 It's my fault, Dr Finnis. INQ000409574_0055.
7 Just one of the quotations that you have provided the
8 Inquiry with. Quote 47 there, from a CVF member:
9 "I feel healthcare is no longer safe, now that
10 masking has been removed, I find every visit stressful I
11 spend a week before and after feeling very anxious and
12 worried. I can't cancel appointments, I need my
13 treatments, I still need facial surgery for my skin
14 cancer, but I have delayed having a minor surgery to
15 have my port removed. It seemed safer in 2020 because
16 everyone [was] masked, there were more virtual
17 appointments available, and the hospitals were much
18 quieter."

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

25 A. Yes. So that's the, as I say, the gov.uk, and it's
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1 Q. Is that in part why CVF advocates in the statement, as
2 they do, for the return of face masks in all high-risk
3 healthcare settings for both patients and staff?

4 A. Yes.

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

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

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

23 Could we look on screen at INQ000409574_58,
24 please.

25 It's your paragraph 145, Dr Finnis. You set out
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1 replicated within the NHS guidance as well. It says
2 four key things. Firstly, it advises us not to be
3 around people who have Covid-19 nor people who have
4 respiratory infections. It tells us to try and do -- to
5 get the people visiting us to do a lateral flow test
6 before they visit us. It tells us to ask people who
7 visit us to consider wearing a mask or face covering --
8 that does actually say face mask or face covering -- or
9 us to use a face mask or face covering, and it also
10 tells us to consider ventilation.

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

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

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

19 A. No, there is now no testing. There's no formal testing,
20 so you can be put next to somebody who is
21 Covid-positive. Of course, clinically vulnerable or
22 high users of healthcare, that's our greatest problem.
23 When we walk into A&E, we're in a busy crowded
24 environment, multiple people coughing the last time
25 I went into A&E, I cannot follow the guidance.
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1 there some of the measures that the CV people would
2 contend for: allowing people to wear their own, either
3 FFP3 or FFP2; enabling people at higher risk to easily
4 request staff to wear masks before their appointments.

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

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

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

14 A. Mm-hmm.

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

25 Now, a number of practical measures set out there.
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1 Are any of those happening routinely as far as CVF
 2 members are concerned?
 3 **A.** No. I mean, generally not. So nothing happens
 4 automatically at all despite that guidance in the NHS
 5 and in the government -- the Gov.UK. So, I mean,
 6 practically all really of people that were within
 7 clinically vulnerable families have significant
 8 underlying conditions, so we frequent healthcare, myself
 9 included, often, so we have tested all these things. We
 10 do wear FFP3 and FFP2 and it's very variable but, as
 11 I said, many people do get a very bad reception, not
 12 personally actually, but certainly many people have
 13 really suffered what you would term or we have termed in
 14 CVF as "mask abuse".
 15 We have no way at the moment to ask staff to wear
 16 masks and in fact even if we do, we often find that it's
 17 not then done. So, for example, we've had clinically
 18 vulnerable people who have gone in for an operation who
 19 would normally wear a mask who are worried that after
 20 they are anaesthetised, for example, in the recovery
 21 room they are worried they will be exposed to Covid and
 22 they've asked whether they can -- that people wear
 23 masks. Either there's a battle at that point, to be
 24 honest, because it's not guidance, you know, they follow
 25 IPC, you know. Or somebody says they can and then when
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1 kind of painted shut, there's certainly very few and far
 2 between HEPA filtration machines, although we have seen
 3 them in some hospitals -- a few.

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

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

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

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

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

21 **MS CAREY:** Thank you, my Lady.

22 (12.48 pm)

(Luncheon Adjournment)

24 (2.00 pm)

25 **MS CAREY:** Dr Finnis, may I just pick up on one thing you
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1 they arrive it's not anyway. So it's kind of two points
 2 where that fails.

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

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

14 So, I mean, that's another consideration.

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

18 Just to say, though, I was in a big London
 19 hospital pharmacy a while ago and it was pretty packed
 20 and I had to get this medication and the CO2 reading was
 21 well over 3,000, and the kind of safe level is between
 22 800 and 1,000. So that shows you the problems.

23 Obviously, the waiting rooms can be -- it's very
 24 old estate in the NHS, so there's really no kind of
 25 modern mechanical ventilation. Often the windows are
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1 told us about before the lunch break, which was you made
 2 reference to mask abuse, and I'd like just to have a
 3 look at one of the quotations that you've included in
 4 your statement.

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

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

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

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

21 **A.** Yes. So I guess during the emergency time in the
 22 pandemic it was less of an issue because obviously there
 23 were mask mandates and more people were therefore
 24 wearing masks. Certainly, as that time's gone on and
 25 certainly after, first of all, Freedom Day in 2021,
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1 which was the general removal or reduction of masks in
2 society, and then 2022, June 2022 where England removed
3 masks from healthcare, after those two dates, wearing a
4 mask has become increasingly concerning and worrying.

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

13 I think that probably almost all of us have
14 experienced now some kind of unpleasantness simply
15 surrounding wearing a mask.
16 **Q.** There's no accounting for some members of society who
17 think that's the right way to behave, but I just
18 wondered in part whether you think there is something
19 wrong with the messaging in that, because although the
20 emergency phase of the pandemic is over, clearly indeed
21 there's a variant, as we understand it, circulating now,
22 whether the messaging has gone slightly awry in not
23 ensuring that CV and CEV people are still at risk and
24 therefore there may be good reason why they are wearing
25 masks.

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

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

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

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

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

16 **A.** Yes, absolutely.

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

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

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1 What do you have to say about that?

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

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

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

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

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

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

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

25 **A.** Because nobody had been vaccinated --

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1 Q. Right.

2 A. -- people were still the same high risk. Their
3 condition hadn't changed. The virus hadn't changed.

4 Q. All right. Was there any consultation, as far as you
5 are aware, or other CVF members, before the decision in
6 August 2020 to stop shielding?

7 A. No, I'm not aware.

8 Q. And coming back to the support issue with whether it's
9 stopped in 2020 and restarted, ultimately I think it
10 came to an end by July 2021. What consultation, if any,
11 had there been before the shielding finished ultimately?

12 A. So there was no consultation with me as a clinically
13 extremely vulnerable person that I knew of, and none
14 that I know of within Clinically Vulnerable Families
15 either.

16 Q. And, again, support: was there any support in place for
17 when the shielding programme finally closed?

18 A. No, none whatsoever.

19 Q. And how did that impact the CVF members?

20 A. Well, all the issues that we've been talking about, such
21 as difficulty with accessing healthcare, mask abuse,
22 this personal responsibility, trying to rationalise the
23 GOV.UK advice, which is really all that remains with how
24 we live our lives now, feels really impossible.
25 It all comes down to this "personal

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1 clinically vulnerable households?

2 A. Yes, that's right. So just to be absolutely clear,
3 though about our definition. So Clinically Vulnerable
4 Families represent clinically vulnerable households.
5 Within clinically vulnerable households there are
6 clinically extremely vulnerable, or shielded people, and
7 clinically vulnerable. So "clinically vulnerable", if
8 you like, is a bigger --

9 Q. Yes.

10 A. -- group and then "clinically extremely vulnerable" and
11 "shielding" is sort of a smaller circle within that
12 group.
13 So "clinically vulnerable" then encompasses
14 everybody with higher risk.
15 So, as it says in the statement there, in 2020, so
16 Lara was able to draw on her expertise in microbiology
17 pathology and science to create a series of practical
18 mitigations for children and school staff in schools,
19 because -- I appreciate that's not what we're talking
20 about here, but that was real issue for our members at
21 that time.
22 There's also an easily accessible pinned post
23 which remains today within Clinically Vulnerable
24 Families that everybody can access, and we have
25 thousands of members who can access this, which is

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1 responsibility", which is what we've been told about,
2 that we feel in CVF that it's really impossible to be
3 personally responsible for some of these things because
4 as I said, in busy A&Es, et cetera, it's very hard to,
5 even wearing a good mask like I am, you're still at some
6 risk without, for example, ventilation or testing. And
7 indeed many, many people who are not part of clinically
8 vulnerable families don't understand how to wear a mask,
9 which mask, and how.

10 Clinically Vulnerable Families, we have -- I've
11 done myself various videos trying to show people how to
12 wear masks correctly and get the best fit, but it's
13 really hard to get that information out there to
14 everybody who I see on the streets, such as this
15 morning.

16 Q. You've mentioned the clinically vulnerable, and I would
17 like to just ask you a little about that. Clearly we
18 are aware that there was a different definition and
19 you've mentioned the absence of measures to protect the
20 clinically vulnerable as opposed to the clinically
21 extremely vulnerable, but I think it's right that CVF
22 provide a degree of support to clinically vulnerable
23 households, and if it helps you, Dr Finnis, I'm at
24 paragraph 89 in your report, but could you just help us
25 with some of the measures that CVF have taken to support

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1 updated to reflect the evolving scientific
2 understanding.

3 Q. Right.

4 A. So what we're trying to do is to give people proper,
5 decent, scientific information that we have translated
6 for them, so that they are able to be empowered to
7 reduce the risk themselves and understand what their
8 risk is, but also how to reduce it, what mitigations
9 they need to take, and what is riskier than something
10 else, for example.
11 It's really hard to kind of be expected, as a
12 clinically vulnerable person, to judge your own risk --

13 Q. Yes.

14 A. -- the route to transmission and how to mitigate against
15 it.

16 Q. Can I ask you about one of the matters that you raise
17 there. You say that:
18 "Additionally CVF was able to negotiate group
19 discounts on essential products such as mask and air
20 filtration units."
21 Has there been any efforts to try and ask one of
22 the departments or NHS England or anyone like that to
23 help the clinically vulnerable negotiate discounts,
24 given how much PPE they are likely to go through in
25 comparison with someone who is not clinically

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1 vulnerable?

2 **A.** No, I don't believe we have actually asked the NHS but

3 we have written to the NHS about lots of things, as you

4 might imagine, about healthcare and, to be honest,

5 nothing has been extremely forthcoming about anything to

6 do with clinically vulnerable people's safety within

7 healthcare.

8 So I would suggest that it wouldn't perhaps be

9 very successful.

10 In fact, we've just had to, right from the start

11 of the pandemic, certainly from my own experience, right

12 back to 2020, I've been having to, you know, work out

13 which mask is the best mask for me, access them, buy

14 them online, ditto air filtration units. I mean, we've

15 got lots of information now so we're able to advise

16 people which mask might be better for them depending on

17 whether they are male or female, what kind of, as I said

18 earlier activity they want to do and, of course, air

19 filtration units, we are in touch with one of the major

20 providers of air filtration units. We're able to advise

21 people of some charts that engineers have done which

22 shows us the size of HEPA filter that you need for the

23 space that you want to clean the air.

24 **Q.** Yes, I think you make the point in your statement that

25 HEPA units for the home can be anywhere from £80 to £700

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1 Many, many of our group now have got air filters.

2 I think it's one of the commonest things that people

3 have managed to put in place at home, particularly in

4 those clinically vulnerable households where, for

5 example, people may still be informally shielding and --

6 but their household members are going out to work in

7 places like frontline jobs, like hospitals or schools,

8 and to have that HEPA filter in their front room is

9 really helpful.

10 **Q.** So there's no misunderstanding about it, we know that

11 CVF support the use of HEPA filtration in a number of

12 different respects but obviously most importantly in the

13 healthcare system.

14 **A.** Yes.

15 **Q.** And, indeed, I think you make the point in your

16 statement that there is NHS England guidance now on the

17 use of cleaning air with HEPA?

18 **A.** Yes.

19 **Q.** And you strongly support the roll-out of that guidance.

20 **A.** Yes.

21 **Q.** Just one other consequential cost that may get lost in

22 this. I think you make the point in your statement that

23 many CVF members now feel they have no choice but to

24 access healthcare through private hospitals because they

25 consider the NHS is unsafe due to the risk of

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1 depending on the model and the size and the space that

2 it's got to filtrate.

3 Clearly that's going to be a significant cost for

4 most people, particularly at the upper end of that

5 scale. Is there any financial support in place for

6 filters such as those?

7 **A.** No. So the only support that we've managed is, Lara has

8 managed to negotiate a small, but we're very grateful

9 for, you know, air filtration units from this particular

10 company. But, no, generally speaking, there are a lot

11 of financial burdens actually on clinically -- extremely

12 and clinically vulnerable people, especially nowadays.

13 Masks can be very expensive. I'm still paying between

14 £35 and £50 for a box of 10 of these.

15 **Q.** Is that per month or --

16 **A.** Yes, it depends how quickly I wear them but I have a

17 child in school and I work, so I need probably one every

18 working day at least and then if I go shopping. So yes,

19 I need two boxes a month.

20 Then I personally also have HEPAs in every room of

21 my house because, as I say, I have a child in school and

22 it's not only having the HEPAs themselves but obviously

23 you do need to change the filter when that's right.

24 It's totally worth it cost-wise for me. It's a

25 completely good idea, but you do have to factor that in.

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1 hospital-acquired infection. Can you just help us.

2 Have you got any sense of how many members are having to

3 resort to private healthcare rather than going through

4 the NHS?

5 **A.** Again, so when I did a thematic analysis of the group it

6 was certainly one of the dominant things that came

7 about, was certainly the financial burdens, and

8 certainly private healthcare is certainly something --

9 I mean, it depends if people can afford it or not, but

10 I think, generally speaking, if people can afford it

11 even if it's at the very ends of their affordability,

12 for example, I think -- I don't know where it is -- but

13 within my statement there's a quote from somebody who I

14 think took out their pension funds to --

15 **Q.** Pause there, Dr Finnis, because there's two quotes on

16 that page.

17 Can I go to INQ000409574_66. It may not be the

18 pension quote but I have seen that one as well, but

19 there's a quote here at 57 from a CVF member. Thank

20 you:

21 "I took early retirement, so my private health

22 insurance stopped. I decided to pay myself, which this

23 year was over £6,000, which is a very heavy financial

24 burden. In 2021 I had to have a new heart valve and

25 pacemaker and I simply would not risk an NHS hospital."

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1 They say:
 2 "The special measures the hospital took were
 3 brilliant."
 4 They:
 5 "... have had hand surgery recently too ...
 6 limited contact, private room and personalised
 7 treatment, ie they wear masks on request ..."
 8 I presume they mean staff there.
 9 "... no crowded waiting rooms, makes it worth it
 10 to me. Of course, private health does not cover chronic
 11 conditions and NHS hospitals and waiting rooms continue
 12 to frighten me, so I minimise attendance."
 13 And you are right, there are other examples you
 14 give in your statement about the financial burden it
 15 places on people.
 16 Can I just ask you two final matters, please. You
 17 set out in your statement anecdotal evidence that CVF
 18 has gathered in relation to the use of DNACPRs and
 19 concerns about blanket use and otherwise of those.
 20 That's at your paragraph 112 onwards, Dr Finnis.
 21 I think there is concern, is this right, amongst
 22 the CVF membership that there may have been DNACPR
 23 orders placed on those that are clinically extremely
 24 vulnerable or clinically vulnerable as well -- I wasn't
 25 clear which.

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1 propose to help identify this group or these groups of
 2 people in the event of a future pandemic?
 3 **A.** I think we would support QCovid. I think that any
 4 developed algorithm which is specific to the illness
 5 brought about as quickly as possible. I think in the
 6 meantime, though, you make your best guess, if you like,
 7 from, as they said, from the science that's coming out
 8 of the other countries to decide.
 9 I think the important thing, though, is that it's
 10 about not only who you protect but how you choose to
 11 protect those people. So, for example, rather than
 12 going sort of straight into shielding, you do give
 13 people that proper information about potential modes of
 14 transmission, how to reduce the transmission, you know,
 15 whether masks work or not, or whatever it might be for
 16 that particular infection, and to actually give people
 17 that passporting to enable them to work from home, to
 18 support the family, so that they too can work or be at
 19 home too if needed.
 20 I think it's about empowering people that's
 21 important.

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

25 **LADY HALLETT:** Mr Weatherby?

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

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

16 **Q.** Another topic, please.

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

25 I just wondered whether CVF has any measures to

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Questions from MR WEATHERBY KC

1 **MR WEATHERBY:** Good afternoon, Dr Finnis.

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

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

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

13 For the record it's paragraphs 122 to 3.

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

21 That's at paragraph 40 of their report.

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

24 "When DNACPR is the only documentation of any form

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

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

10 **A.** Yes.

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

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

17 **Q.** Yes.

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

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

24 **A.** Yes.

25 **Q.** Thank you.

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

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

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

13 **Q.** And maybe financial support too?

14 **A.** Financial support, yes.

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

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

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

12 **A.** Yes.

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

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

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

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

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

9 **Q.** Thank you.

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

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

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1 Q. Yes.

2 A. Or any part of healthcare actually, GPs, et cetera too.

3 Q. GPs perhaps very importantly.

4 A. Yes.

5 MR WEATHERBY: Doctor, thank you very much.

6 LADY HALLETT: Thank you, Mr Weatherby.

7 Thank you very much indeed, Dr Finniss. I'm so

8 sorry to hear about what's been called mask abuse. It

9 sounds such a trivial term but I can imagine just how

10 distressing it must be for people like you and your

11 colleagues to receive such abuse. I'm afraid the

12 toxicity of some people never ceases to surprise me, but

13 anyway. Thank you very much indeed for all your help,

14 I'm very grateful to you.

15 Just one question: how do you manage to avoid

16 Covid when you have got school -- child or children?

17 A. So my child, we actually managed to get HEPA filters

18 into all the classrooms, and the school are really good

19 at telling us whether there's a Covid case. So it just

20 proves it can be done.

21 LADY HALLETT: I was going to say I find my grandchildren

22 are the biggest vectors of any disease that's going

23 round. Anyway, thank you very much for all your help.

24 A. Thank you.

25 MS CAREY: Thank you, my Lady. The next witness is going to

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1 about each of those organisations.

2 A. Yes. So the Faculty of Intensive Care Medicine is the

3 UK professional and statutory body for the medical

4 specialty of intensive care medicine -- the

5 intensivists, the advanced critical care practitioners,

6 and the critical care pharmacists -- and has around 4

7 and a half thousand members across the UK.

8 The Royal College of Anaesthetists is the UK

9 professional and statutory body for the medical

10 specialty of anaesthesia, and has a combined membership

11 of more than 24,000 fellows and members.

12 The Association of Anaesthetists is a professional

13 organisation made up of over 10,000 anaesthetists in the

14 UK, Republic of Ireland, and internationally.

15 Q. Thank you very much.

16 Dr Bryden, I'm going to ask you about the

17 following today: first of all, I'm going to ask you a

18 bit about your organisation's involvement with senior

19 decision-makers; I'm then going to ask you a bit about

20 Infection, Prevention and Control measures; and I'm then

21 going to ask you a bit about critical care capacity,

22 then redeployment, and then a bit about the impacted of

23 suspending elective care. Is that all clear?

24 A. Yes.

25 Q. Can we turn, please, to the first of those topics. Is

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1 be taken by Mr Fireman and there will just be a pause

2 while we allow Dr Finniss to depart.

3 (The witness withdrew)

4 MR FIREMAN: May I please call Dr Bryden.

5 DR DANIELE CLARE BRYDEN (affirmed)

6 LADY HALLETT: Dr Bryden, I hope you haven't been waiting

7 too long.

8 A. Thank you.

9 Questions from COUNSEL TO THE INQUIRY

10 MR FIREMAN: Your full name, please.

11 A. Daniele Clare Bryden.

12 Q. You have, I hope, a witness statement in front of you?

13 A. Yes.

14 Q. That should be INQ000389244. That is dated

15 18 December 2023?

16 A. Yes.

17 Q. Dr Bryden, you are the Dean of the Faculty of Intensive

18 Care Medicine, is that correct?

19 A. Yes.

20 Q. And you have attended today as a witness on behalf of

21 three organisations: the Faculty of Intensive Care

22 Medicine, the Royal College of Anaesthetists and the

23 Association of Anaesthetists?

24 A. Yes, that's correct.

25 Q. Are you able to provide us with a bit of background

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1 it correct that your organisation's work collectively

2 and individually involved with regular meetings with

3 NHS England and the Chief Medical Officers?

4 A. Yes, that's correct.

5 Q. And you describe various topics within your witness

6 statement that you discussed with them. One of those is

7 the need for clarity around PPE requirements. Can you

8 recall what those specific concerns that you raised in

9 terms of availability of PPE were, with the NHS England

10 medical director?

11 A. I am aware that our organisations at the time had three

12 broad levels of concern. Early on in the pandemic it

13 was around the provision of advice and the timeliness of

14 the advice as to the correct PPE to wear, because we

15 were aware that many of our members and fellows were

16 looking to us for distillation of advice, and we were

17 struggling to be clear as to what that advice was.

18 We then also had concerns around the consistency

19 of the advice in terms of the timescales and, again,

20 what PPE individuals should wear, and then finally there

21 were concerns, as later on in the first wave, around the

22 availability of PPE and the appropriate PPE.

23 Q. Can you recall when you -- what sort of time-frames you

24 raised these particular concerns?

25 A. There were, at the time in the first wave of the

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

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

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

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

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

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

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

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

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

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

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

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

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

21 **Q.** So --

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

25 **A.** Because the pandemic effectively came through the

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

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

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

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

16 **LADY HALLETT:** "Sweating".

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

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

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

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1 not being able to use it, and on the other hand the
2 concern about the effects of having to use it?
3 **A.** Certainly the second quote I very strongly recognise
4 personally, and also in terms of people's experiences of
5 working for long periods of time in PPE and the
6 difficulties that imposed.

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

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

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

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

3 **A.** Yes.

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

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

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

23 **A.** Intensive care staff were wearing FFP3 masks, visors in
24 the first phase of the pandemic, gowns and gloves.

25 Individuals who could not find an FFP3 mask that would

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

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

19 Do you recall that study?

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

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

24 **A.** Yes.

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

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

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

5 **A.** Yes.

6 **Q.** My apologies. That can come down.

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

15 **A.** Yes.

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

23 **A.** Yes. So the Faculty of Intensive Care Medicine was one
24 of the organisations that was co-opted to the NHS

25 England Critical Care Clinical Reference Group, and the

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

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

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

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

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

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

5 This is the iteration that was published first on
6 20 March 2020. I want to look at that first section.
7 So it says "admission to hospital", "On admission to
8 hospital", so just pausing after that first comma, is
9 that "on admission to hospital" the distinction between
10 what was involved previously and what is now the
11 starting point of this guidance?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 having conversations with patients and with their
 2 families within the context of the pandemic. Was it
 3 possible, do you think, to have these conversations at
 4 an early stage?
 5 **A.** We as the Faculty of Intensive Care Medicine have been
 6 trying to support individuals and families to
 7 contemplate what an intensive care admission means for a
 8 long time before the pandemic. So we had produced
 9 documents to enable individuals to consider that and
 10 other hospital services to consider that.

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

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

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

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

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

25 Is it right that the clinical frailty scale is not
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1 learning disabilities, apologies, and the guideline was
 2 then amended.

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

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

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

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

19 **A.** Yes.

20 **Q.** Thank you. That can come down.

21 **A.** If I could also add to that?

22 **Q.** Please do.

23 **A.** I think it's also important to make the point that
 24 people should be helped to have the conversations that
 25 are required and are given the support that they need to
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1 appropriate to use on people who have long-term stable
 2 disabilities or are under 65?

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

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

6 **A.** No.

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

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

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

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

23 **Q.** The Inquiry understands there was then some
 24 correspondence with various groups, including I think
 25 MENCAP on behalf of learning disability -- people with
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1 have those conversations and that's something that we
 2 always have tried to do within intensive care medicine.
 3 So it was not a change in our practice that we would
 4 have not looked to try and provide support to
 5 individuals to help them make a decision. That was not
 6 intended to change.

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

16 **A.** Our intention and our advice was very much around
 17 helping as many people as possible to be given the
 18 information they needed to make a decision about their
 19 care and treatment, and bearing in mind we were looking
 20 at a large number of people who could potentially
 21 require intensive care treatment at a time in the
 22 pandemic when there was no other treatment that impacted
 23 on the course of Covid or the outcome from Covid, all
 24 intensive care treatments at that time were supportive
 25 and didn't impact on what the disease did to the
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1 individual, and all of those supported treatments had an
2 associated morbidity and harm in themselves. It was
3 really important to make sure that as many people
4 understood what an intensive care admission involved as
5 possible to allow them to be clear about whether or not
6 they wanted to have that and contemplate that.

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

11 **A.** Could you --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So there was a concern that that situation might
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1 a number of issues around a single organisation
2 producing guidance, not the least of which is the
3 importance of guidance being able to respond to the
4 change in the knowledge base, in the information, being
5 able to monitor and change that guidance appropriately,
6 to have the appropriate consultation and understanding
7 of all endorsing organisations and to also have a wider
8 involvement of the public and an understanding that this
9 was in place.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 **Q.** Just generally --

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

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1 clinical options available.

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

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

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

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

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1 not there was a central tool being provided.
 2 **MR FIREMAN:** Thank you.
 3 My Lady, I'm going to turn to another topic so it
 4 might be an appropriate time to have a ten-minute break?
 5 **LADY HALLETT:** Certainly.
 6 I hope you were warned about our breaks, Doctor.
 7 I shall return at 3.25.

8 (3.09 pm)

9 (A short break)

10 (3.25 pm)

11 **MR FIREMAN:** Thank you, my Lady.
 12 Dr Bryden, I want to turn to a different topic now
 13 which we foreshadowed earlier which is redeployment.
 14 Can I ask you about it both from the perspective of
 15 anaesthetists and also intensivists, because
 16 I understand your organisations represent both of those
 17 professions.

18 With respect to anaesthetists, were the majority
 19 or a high proportion of them redeployed to intensive
 20 care units?

21 **A.** It's important to consider the various phases of the
 22 pandemic and the involvement of our anaesthetic
 23 colleagues in supporting intensive care units. All
 24 anaesthetists do some intensive care medicine training
 25 and certain hospitals at times of particular pressure

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1 **A.** I think it would be fair to say that we would not have
 2 been able to deliver what we did without the involvement
 3 of our anaesthetic colleagues but that came at a burden,
 4 a considerable burden, to them. Some reported in our
 5 surveys that they found the experience helpful and
 6 useful, particularly around maintaining skills, closer
 7 working with intensive care colleagues; others found it
 8 very difficult and very stressful working in an
 9 intensive care unit after a period of time.

10 So I don't think it would be possible to say there
 11 was a uniform experience. It was very personal.

12 **Q.** Of course. That makes sense.

13 But focussing -- one can understand why it may be
 14 potentially harrowing for some people to be involved
 15 with intensive care in circumstances where they hadn't
 16 previously been, but focussing on some of the positive
 17 aspects of redeployment and you talked about the skills
 18 that were learnt, is there anything that we can learn
 19 about the fact that those staff learnt new skills by
 20 being in intensive care about how we could best prepare
 21 for the potential need to redeploy staff again, is there
 22 anything we could be doing in non-pandemic times to
 23 enable the transition to intensive care to be easier?

24 **A.** Yes, and if again I can provide a degree of context. So
 25 prior to pandemic the Faculty of Intensive Care Medicine

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1 and at certain points of the pandemic will have had
 2 support from anaesthetists to provide additional input
 3 into the critical care unit.

4 We don't have a specific number of people who were
 5 redeployed at any one particular time but there are
 6 a number of surveys that were conducted, particularly
 7 those by the Faculty of Intensive Care Medicine and the
 8 Royal College of Anaesthetists, which gives, if you
 9 like, overall figures at certain time points as to how
 10 many people identified as being redeployed.

11 **Q.** So just, generally speaking, during the peaks of the
 12 pandemic, were anaesthetists going to intensive care
 13 units in higher proportions than they would normally
 14 have been?

15 **A.** Yes, absolutely. Normally we would say that of the
 16 intensivists who have anaesthetic training about 50% of
 17 intensivists have some anaesthetic training, all of
 18 those would have been brought back into the intensive
 19 care full time and then, in addition, additional
 20 anaesthetists will have been brought in to support local
 21 services as and when required.

22 **Q.** In terms of the experiences of those anaesthetists who
 23 were redeployed, do you know and are you able to
 24 summarise whether or not the experience was positive or
 25 negative or a mixed experience?

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1 had done some work on the development of an enhanced
 2 care service. This was around supporting patients on
 3 elective care pathways who didn't need a full intensive
 4 care admission but needed more treatment in care than
 5 could be supported on the ward, and that service could
 6 be managed by our anaesthetic colleagues and, again, our
 7 anaesthetic colleagues were very supportive of the
 8 concept of trying to provide more for patients on the
 9 perioperative care pathway because a lot of them do work
 10 in perioperative medicine.

11 These kind of reservist skills, as we identified
 12 and called them, were a way of saying people could be
 13 involved in aspects of care for patients that were more
 14 than they might ordinarily have done before the
 15 pandemic, would allow them to have some degree of
 16 confidence. So if they were required to go back and
 17 work in the intensive care environment they would at
 18 least have some familiarity with what had been happening
 19 in terms of basic intensive care management.

20 **Q.** That's something which you think should be maintained?

21 **A.** Absolutely. We have been clear from the publication of
 22 the initial enhanced care report in, I think it was
 23 May 2020, and then the subsequent report that we wrote
 24 with the Centre for Perioperative Care around how you
 25 provide enhanced care services for perioperative

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

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

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

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

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1 those intensive care nurses?

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

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

16 **A.** Can I ask you to clarify.

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

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

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1 nursing colleague. I'm aware of that.

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

7 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **Q.** The Inquiry has instructed experts, Professor
 5 Andrew Metcalfe and Ms Chloe Scott to examine the impact
 6 all the pandemic upon those requiring hip replacements.

7 I would like to bring up a passage from their report.
 8 It's INQ000474262, paragraph 48. And it says here:

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

20 Do you agree with that broad statement?

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

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1 occupancy that was over 95%. Even within that 10 per
 2 100,000 figure quoted for England, there were certain
 3 parts of England, namely London, that had more intensive
 4 care beds than other parts of the country. If the
 5 pandemic was then impacting not equally on all areas of
 6 the country at the same time, you will then have a
 7 situation where certain services will be in a better
 8 position to restart than others.

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

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

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

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

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

5 **MR FIREMAN:** Thank you very much, Dr Bryden.

6 My Lady, that's all I ask.

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

8 Ms McDermott.

9 Questions from MS McDERMOTT

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

24 Now, the Faculty of Intensive Care Medicine
25 carried out a survey during November 2020, and in
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1 support, in order to be able to do what was asked of us.

2 **Q.** That's somewhat of a separate topic in terms of you've
3 mentioned in your evidence about Wales and
4 Northern Ireland having bed space of already ICUs over
5 95%, that's different to then actually having the staff,
6 isn't that correct?

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

13 **Q.** Thank you. Considering your statement in the round from
14 the perspective of those which I represent from
15 Northern Ireland, your statement contains very limited
16 reference to data emanating from Northern Ireland. Now,
17 I don't expect you to know this offhand, but on
18 11 October 2022, the Royal College of Anaesthetists
19 Northern Ireland held a board meeting, and at that
20 meeting it was certainly anticipated that the Northern
21 Ireland Royal College of Anaesthetists would contribute
22 to this Inquiry. There was then a debate as to whether
23 it would partner with the Academy of Medical Royal
24 Colleges or whether it would stand alone as an
25 organisation with a reluctance to the latter because of
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1 response to the question "Do you think any increase in
2 ICU footprint has been adequately staffed?", 82% of the
3 respondents said no.

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

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

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

23 So, during the pandemic when there were increased
24 numbers of patients presenting, we had that situation of
25 even more pressure, and therefore needing additional
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1 cost implications.

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

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

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

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

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

25 **A.** So the information that is in my statement is from all
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1 three organisations, and my understanding is that the
 2 Royal College of Anaesthetists has drawn its information
 3 from its wider college membership and information that
 4 it held at the time.

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

8 **A.** I would accept that, yes.

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

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

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

22 **A.** Yes.

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

25 **LADY HALLETT:** Thank you, Ms McDermott.

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

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

12 **Q.** Thank you, Doctor. That brings me on to my next topic.
 13 In paragraph 105 of your witness statement, you
 14 set out for the Inquiry and I'll read it for you,
 15 Doctor:

16 "The highest level recommended for intensive care
 17 bed-fill rate for safe and efficient patient care is
 18 85%. However, ICUs were running above this
 19 pre-Covid-19, making the UK woefully underprepared to
 20 cope with the large additional demand for intensive
 21 care."

22 Then you go on in paragraph 106 to set out some
 23 survey data from the FICM taken in 2018, which showed
 24 the bed-fill rate in Wales was estimated to be at least
 25 95% in 2018.

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1 Ms Cat Jones.

2 **Questions from MS JONES**

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

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

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

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

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

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

13 **MS JONES:** Thank you, Doctor.
 14 My Lady, those are my questions.

15 **LADY HALLETT:** Thank you, Ms Jones.
 16 Ms Peacock.

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

21 **A.** Okay.

22 **Questions from MS PEACOCK**

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

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1 pandemic.

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

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

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

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

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

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

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

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

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

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

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

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

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1 paragraph 40.

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

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

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

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

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

10 **LADY HALLETT:** Thank you, Ms Peacock.

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

14 **(The witness withdrew)**

15 **(3.59 pm)**

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

1 I N D E X

2

3 PROFESSOR JASWINDER SINGH BAMRAH 1
 (affirmed)

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