

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 JUSTICE 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 JUSTICE HALLETT:** Can you remind me the date of the  
17 review.
- 18 **MS CAREY:** Yes, the review came out in June 2020.
- 19 **LADY JUSTICE HALLETT:** Thank you.
- 20 **MS CAREY:** Commissioned around April and published in June.
- 21 Professor, can I ask you, against that background,  
22 when the PHE review came out, how was it received by  
23 FEMHO and its members?
- 24 **A.** So -- and then before that, the King's Fund which you  
25 were referring to had already put up the statistics. So

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1 we were -- obviously, we wrote to Public Health England  
2 at the time, expressing concern, and actually saying  
3 there are ways to mitigate the risks, and we'd like to  
4 be engaged and involved in discussions around this.

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

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

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

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1 us, there were delays around ... collecting, collating  
2 and analysis of data in real time."

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

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

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

21 **Q.** I'll come on to risk assessments as well, but in  
22 relation to the data, I think you say in your statement  
23 that one of your member organisations, the Filipino  
24 Nurses Association, began collecting data on Filipino  
25 nurses who had died and actually submitted that data to

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1 we have to go into hospitals and support patients and  
2 treat them.

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

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

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

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

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

25 "... despite the risks being obvious to many of

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1 the Chief Nursing Officer because no government body was  
2 doing this.

3 **A.** Yes.

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

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

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

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1 **A.** So, whilst I'm not an epidemiologist, I would say that  
2 basic data is that: demographics around the person. The  
3 age, the sex, the ethnicity, the race, the occupation,  
4 where they live, because we know now that where they  
5 lived, in most deprived areas, are most heavily infected  
6 by the virus.

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

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

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

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

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

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

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1 advocating for government intervention once the data in  
2 relation to the disproportionate impact of deaths began  
3 to become publicised.

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

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

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

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

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1 ethnicity data in relation to Wales. We've heard  
2 similar evidence in relation to Northern Ireland as  
3 well, in particular, from the Chief Medical Officer from  
4 Northern Ireland.

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

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

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

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

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

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

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1 representations that they made.

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

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

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

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

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1 led to the establishment of the First Minister's BAME  
 2 Covid-19 Advisory Group. If I understand you correctly,  
 3 that sort of proactive response or reactive response,  
 4 I should say, from the Welsh Government, was that of  
 5 value to Welsh BAME healthcare workers?  
 6 **A.** Yes. I mean, the approaches that -- and then we are  
 7 witnessing within the UK a different approach by one  
 8 government where the Welsh Government were very engaging  
 9 with Professor Singhal, they actually then gave him the  
 10 responsibility to develop the risk assessment tool for  
 11 Wales which we then sent to NHS England as well, which  
 12 actually informed some of the decisions eventually. But  
 13 there was a lot more engagement in Wales. It was a  
 14 different tone of conversation that they were having.  
 15 **Q.** Can I ask why -- are you able to opine on why there was  
 16 a different tone in Wales?  
 17 **A.** I can't say. I think it's been a long-held view amongst  
 18 not just the black and ethnic minority people but,  
 19 generally, amongst the NHS employees that, you know,  
 20 I mean, NHS England sit over there, you know. It's  
 21 top-down and not bottom-up, and so we saw that at its  
 22 worst during Covid where they had a completely different  
 23 approach to Wales and, indeed, Scotland as well.  
 24 **Q.** I was just going to ask you about Scotland because  
 25 I think in your paragraph 9 in statement 2, clearly in  
 17

1 They go on to make reference to aerosol-generating  
 2 procedures. They make the point there they are worried  
 3 about patients coughing and sneezing passing on the  
 4 virus and:  
 5 "There are similar concerns about adequacy of PPE  
 6 in many areas of secondary care and also by pharmacists  
 7 who are seeing patients who attend their pharmacies."  
 8 I think, is it right, Professor, that as a result  
 9 of this letter being sent there was -- it was picked up  
 10 by the media and brought to the attention of Nicola  
 11 Sturgeon who was the then First Minister and it led to a  
 12 meeting with Gregor Smith the Scottish CMO to highlight  
 13 these issues?  
 14 **A.** Yes.  
 15 **Q.** I ask you about Northern Ireland, though. Do you know  
 16 whether there were --  
 17 **LADY JUSTICE HALLETT:** Just before you move on -- do we know  
 18 if anything changed as a result of the meeting with --  
 19 **A.** I think there were better dialogue between them and our  
 20 organisations and in fact they invited again one of our  
 21 chairs of the organisation there to actually give a  
 22 report to the Scottish Assembly. So there's been  
 23 ongoing dialogue and better relations.  
 24 **LADY JUSTICE HALLETT:** Better relations, better dialogue,  
 25 good, but what really good is to get the equipment that  
 19

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

1 the letter was saying that people needed on the ground.  
 2 Do we know whether that happened?  
 3 **A.** I think there was a general problem with equipment but,  
 4 do you know, my Lady, I wouldn't want to swear on it but  
 5 I think that there was absolutely -- they heard what we  
 6 were saying and there was more than an attempt to  
 7 provide them with better equipment. Certainly better  
 8 than the flimsy gowns that they were getting. Whether  
 9 that was widespread or not, I cannot say.  
 10 **LADY JUSTICE HALLETT:** Thank you. Sorry to interrupt.  
 11 **MS CAREY:** No, not at all, thank you.  
 12 I was going to ask you whether you knew whether  
 13 any of FEMHO's membership organisations had written  
 14 similar letters or tried to raise concerns with the  
 15 Northern Irish ministers. Can you help with that at  
 16 all, Professor? Do you know what the position was?  
 17 **A.** No, I don't think anybody wrote to -- but we knew what  
 18 our colleagues there were feeling.  
 19 **Q.** Thank you. That letter touched on issues of access to  
 20 and suitability of PPE and I'd like to ask you about  
 21 that, please.  
 22 Professor, we've already heard a lot of evidence  
 23 about PPE being unavailable or inadequate or fit testing  
 24 being failed and I think they are consistent concerns of  
 25 FEMHO's members; is that correct? Could you just help  
 20

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

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

7 **Q.** Why?

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

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

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1 when they seemingly shouldn't.

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

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

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

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

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1 **Q.** Can I ask you about that then, please. When you talk  
2 about doctors and nurses more likely to be disciplined,  
3 is that internally by the hospital or the Trust; is that  
4 what you mean?

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

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

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

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

24 **Q.** I'll ask you about that last bit in a moment but can I  
25 just stick with the threats to staff if they wore a mask

22

1 arrange her own test in order to see that she had Covid.  
2 From that time on, the Trust completely shut shop on  
3 her.

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

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

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

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

24

1 including sometimes legally.

2 **Q.** I think you give an example in your second statement of,  
3 in Northern Ireland, a frontline social worker speaking  
4 to nursing colleagues it's your paragraph 12, Professor,  
5 those nursing colleagues were Indian, and they had  
6 anxieties they couldn't really communicate to others.  
7 Some had newly arrived in Northern Ireland and didn't  
8 want to be seen to be making a fuss by raising concerns.  
9 Can you think about how any recommendations that  
10 could be made to try and dispel that myth, "It's not a  
11 fuss, it's a legitimate concern"? How can we go about  
12 changing that attitude?

13 **A.** I think it's all -- so I'm a great educator and trainer,  
14 and I think it's all about proper training, cultural  
15 awareness, cultural competence, people understanding  
16 this is the kind of culture that people who are black  
17 and minority ethnic, that's the background they come  
18 from, and if they don't complain but they look unhappy,  
19 what is the reason behind it.  
20 So I think it's, you know, it's understanding that  
21 and being able to say, "Look, we are going to provide  
22 you with the support and not run this department with  
23 fear", which many people seem to do.

24 **Q.** You say as well that those from minority ethnic  
25 backgrounds are less likely to be in trade unions. Why

25

1 **Q.** We've heard that PPE, in particular masks, may not suit  
2 anyone other than the white male without the beard.  
3 That's an oversimplification and it's mine, but you will  
4 understand the general thrust of the question,  
5 Professor. Do you know if there's any work being done  
6 to procure PPE that fits a broader range of healthcare  
7 workers, in particular people with beards, for example?  
8 Do you know if there's anything being done about that?

9 **A.** So one of our members did at the time write to the  
10 Department of Health, and I can share that  
11 correspondence if I haven't already done that through  
12 our legal team. And because these were bearded Sikhs,  
13 Muslims and Jewish people, men, because they did not  
14 pass the fit test with the traditional FFP3 masks, one  
15 of them invented what was called the Tata technique  
16 which he said passed the regulations, but then he was  
17 categorically told by HSE that they cannot agree with  
18 this and that the requirement is to be clean shaven.  
19 Now, and you know we heard about these very sad  
20 instances where Sikhs and Muslim men had to shave their  
21 faces for the first time, which, you know, if you  
22 understand the religion as I'm sure you do, this is just  
23 completely unacceptable but they wanted to provide a  
24 service to their patients and help run the departments  
25 so they did, some of them did become clean-shaven for

27

1 is that the position?

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

7 **Q.** Now, some of these are slightly broader issues than the  
8 impact of the pandemic itself, but can I ask you,  
9 please, about your paragraph 25 in your first witness  
10 statement and some evidence that was given in Module 1  
11 by Sir Christopher Wormald, the Permanent Secretary to  
12 the Department of Health. I think you set out there  
13 that he confirmed the department had stocked lower  
14 levels of PPE suitable for black staff working in  
15 healthcare, and that little planning had been done to  
16 consider the equality of PPE provisions.  
17 When FEMHO's members heard that evidence or  
18 learned of it, what was their reaction to that?

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

26

1 the very first time.  
2 But HSE clearly stated that "This is it, you are  
3 either clean-shaven or" -- and there's no attempt,  
4 really, to produce masks that fit bearded men, as  
5 I know.

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

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

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

15 **A.** Yeah.

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

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

20 **LADY JUSTICE HALLETT:** So where is this coming from?

21 **A.** This is coming from them, the HSE.

22 **LADY JUSTICE HALLETT:** So the HSE, you have something in  
23 writing?

24 **A.** Yes.

25 **LADY JUSTICE HALLETT:** Yes, please.

28

1 A. So:  
 2 "Based on the information provided, HSE cannot  
 3 agree to the use of this method" -- which is the Tata  
 4 method -- "specifically we make the following  
 5 observations. The requirement to be clean-shaven to  
 6 support an effective seal between the wearer's face and  
 7 tight-fitting respirator has been in existence for many  
 8 years and is not a new requirement of the current  
 9 pandemic."  
 10 And so on. It goes on about PPEs as well.  
 11 **MS CAREY:** Professor, can I just ask you, is that a document  
 12 that is exhibited to your witness statement? I know  
 13 there's a number of exhibits and I'm afraid --  
 14 A. I'm not sure, you know.  
 15 Q. If it's not, we will ask you for a copy of it.  
 16 A. Sure.  
 17 Q. All right, thank you very much.  
 18 Now, can I ask you about the BAME healthcare  
 19 workers who failed fit tests and what was done in the  
 20 circumstances where they failed the test. Can you help  
 21 with what provision was made for those who had failed  
 22 the tests?  
 23 A. So there were a lot of Trusts that acted very  
 24 responsibly, and, you know, people were --  
 25 responsibly -- there was a whole problem with PPEs which

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1 Association -- executive member of British Indian Nurses  
 2 Association, and she was very pleased with how this was  
 3 organised. There was a better understanding between  
 4 them and the Welsh Government and the Welsh hierarchy  
 5 including the CNO, and they felt that there was proper  
 6 fit testing, there was proper PPE provided, that there  
 7 were good risk assessments done as well -- it's not in  
 8 that paragraph, but that's what they felt.  
 9 And they were more collaborative, so it worked out  
 10 much better. There was no significant delay in the  
 11 supply or availability of PPE eventually.  
 12 Q. You spoke a moment ago about the problems of PPE for men  
 13 wearing beards, but I think you also in your statement  
 14 speak to the issues where many of the female Muslim  
 15 members of FEMHO couldn't be fit tested to ensure PPE  
 16 fit to the face because they wore a hijab. Do you know  
 17 what steps, if any, were taken to fit test them or to  
 18 check them if they wanted to wear their hijab as well as  
 19 PPE?  
 20 A. So I can't tell you specifically, but I can -- I know  
 21 that -- do you know, I can't be specific about that.  
 22 Q. But there was reports to FEMHO, if I understand you  
 23 correctly, that there was problems with fit testing --  
 24 A. Yes.  
 25 Q. -- female Muslims if they were wearing a hijab?

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1 I know has been rehearsed in this the Inquiry many times  
 2 and I won't go through that.  
 3 So where they absolutely failed, you know, and  
 4 they couldn't wear, such as bearded men, then they were  
 5 shielded from work. But some, including I know that  
 6 there were about 20 or 22 Sikh dentists who then chose  
 7 to get back to work. So there were people who might  
 8 have gone back to work because of the, you know, the  
 9 problems with the resourcing departments.  
 10 Q. So they felt they had to go back to work to help the  
 11 effort?  
 12 A. I think there were -- there were people who had to go  
 13 back, who felt they had -- they needed to get back to  
 14 work.  
 15 Q. Now, you give in your second statement a more positive  
 16 example of the attitude in this case of Wales towards  
 17 PPE. Can I ask you about paragraph 15, please, in your  
 18 second statement.  
 19 I think you give an example there of a nurse  
 20 practitioner and executive lead of the British Indian  
 21 Nurses Association, BINA, in Wales, where that nurse  
 22 practitioner considered that PPE was well organised at  
 23 her hospital. What did that nurse practitioner tell  
 24 FEMHO?  
 25 A. So she's a member of the British Indian Nurses

30

1 A. Yes. But what happened after that, I can't tell you.  
 2 I would be happy to find out.  
 3 Q. And I think you also say that there were some female  
 4 Muslim members in both non-clinical and  
 5 non-patient-facing roles who wished to cover their  
 6 forearms, and were threatened with referral to  
 7 regulators for breaching duties when they expressed  
 8 their views and their religious positions.  
 9 You say this:  
 10 "Changes to multi-faith dress codes policy for PPE  
 11 were sought by some of our members because of these  
 12 problems."  
 13 Do you know, in relation to the changes that you  
 14 sought, whether there was any change in the --  
 15 A. I don't believe that there were changes.  
 16 Q. You made the point in your statement that agency workers  
 17 and locum staff were more likely to be allocated to more  
 18 high-risk patients and areas. Can you give us some  
 19 examples of some of the things that were being reported  
 20 to you for the agency workers and locum staff?  
 21 A. Yes, it was commonplace throughout, actually, where they  
 22 would come in and find out on the day that  
 23 disproportionately they were more likely to turn up  
 24 right at the coalface of Covid, and this was really  
 25 pretty common practice, I would say, across, for agency

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1 doctors and agency nurses.

2 So where doctors and nurses were shielded,  
3 particularly, then the agency nurses would be put in  
4 disproportionately into those jobs.

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

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

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

21 **A.** Mmm.

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

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1 before lockdown, reports were already coming through,  
2 and because they were not really listening to us, then a  
3 couple of GP trainees, Vis and Joshi, who were with  
4 Bindmans solicitors, decided to take a claim against the  
5 government. So we were signatory, we were interested  
6 party in that claim, and we decided to take the  
7 Health Secretary to court for poor provision or no  
8 provision of PPE.

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

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

23 **Q.** In relation to testing, I think you set out in your  
24 statement at paragraph 37 onwards that you learned from  
25 the members that access to testing at the beginning of

35

1 Could we have up on screen INQ000184474.

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

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

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

24 **A.** Not quickly enough, I'm afraid. So I was signatory to  
25 this letter which I remember very well, and it was just

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1 the pandemic was generally poor. Again, I want to ask,  
2 is that specific to BAME healthcare works or it was poor  
3 generally for everyone working in the healthcare  
4 systems?

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

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

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

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

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1 one hand, we're protecting them more now but therefore  
2 now excluding them from the very roles that they were  
3 trained to provide.

4 How did that play out on the ground, Professor?

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

19 So there wasn't one formula fitted all.

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

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1 risk assessments and many were reporting to us that  
2 they're not getting risk assessed.

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

5 **A.** Yes.

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

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

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

25 **A.** So, I mean, the reason for that was just that Professor

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1 healthcare workers have to Covid?

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

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

18 **A.** So I think in the first instance getting the policy off  
19 the ground was really very difficult in terms of risk  
20 assessments. I think it took off somewhere -- I may be  
21 wrong, but June or July, something like that, probably a  
22 little bit later but there were greater delays in  
23 actually implementing that policy and Trusts, mostly  
24 Trusts, these are mostly Trusts, were implementing it  
25 very variably in the Trust. So some people would get

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1 Singhal who actually led on that was able to impress on  
2 Dr Mark Rutherford, the first secretary, that, look, we  
3 are picking up that there are great vulnerabilities in  
4 the community and we need to know who's exposed to the  
5 virus and who's going to be vulnerable. I understood  
6 that actually there was a real good take up following  
7 that. There was no resistance after that from the Welsh  
8 Government to actually roll out the tool across Wales.

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

15 **A.** Yes.

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

22 **A.** So -- well, in England, typical of us, I suppose, that  
23 there were a few of these tools eventually that were  
24 being bandied around. We actually passed this tool to  
25 NHS England to say the Welsh have already implemented

40

1 this and it seems to be having a good take up and it  
2 seems to have all the stuff that we know about, age and  
3 comorbidities and all that sort of thing, and sex, and  
4 I do understand that by September 2020 the tool that  
5 came out, which I was involved with, with the Chief  
6 Executive of Wigan, I think that that informed  
7 eventually the tool that he devised for NHS England.

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

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

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

23 **A.** Well, I think what we need, really, if you ask me, is --  
24 I mean, I'm a researcher, so I would say that I would be  
25 happy if somebody were to do some research on these

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1 could be the lead clinical director or the lead manager  
2 of that particular department.

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

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

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

14 **A.** *(The witness nodded).*

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

25 **A.** I think that's the nub of the question, isn't it,

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1 assessment tools now. So I think the NHS should  
2 commission what is the most appropriate tool rather than  
3 wait for this to come round again.

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

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

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

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

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

20 **A.** So no they're not being conducted in a cultural way.  
21 That is anecdotal. You know, I know that people felt  
22 that sometimes people didn't really understand the  
23 sensitivities around the various parameters in the risk  
24 assessment tool depending on their culture. So, no.  
25 The people who conducted them were the lead people so it

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1 because I think there was a general feeling that  
2 throughout, even before the pandemic that, you know,  
3 people, our bosses are not actually understanding that  
4 there are particular issues of culture, race and  
5 ethnicity that they need to be aware of. If they were  
6 aware of these things which there had been multiple  
7 attempts, multiple reports to say, look, these are very  
8 important issues to your 1.3 million employees, there  
9 has been just an abject failure to actually understand  
10 the sensitivities around that.

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

18 **A.** Sorry, let me get to --

19 **Q.** Paragraph 53. It's all right.

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

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1 **Q.** Can you expand on that last answer. What were they  
 2 doing to interpret the rules?  
 3 **A.** So it was like, you know, now you can wear -- you don't  
 4 have to wear a mask, now you can wear a flimsy mask and  
 5 there was different grades of mask FFP2s, FFP3s, and  
 6 then there was protective clothing in aerosol-generating  
 7 clinics or operating theatres. There was a whole lot of  
 8 confusion about this for a very long time, unnecessarily  
 9 so, because there was no proper one single guidance that  
 10 should have percolated right from top to all the Trusts  
 11 to say: this is what we think in terms of health and  
 12 safety. We have health and safety regulations but it  
 13 didn't seem to us that they were applying the very rules  
 14 that they were trying to -- try and protect.  
 15 **Q.** Now, we've heard, Professor, that UK IPC cell issued  
 16 UK-wide IPC guidance and it did obviously change as the  
 17 scientific understanding about Covid changed. But just  
 18 help us, from the BAME healthcare workers' perspective  
 19 why was it so difficult to have changing guidance in the  
 20 way that we know had to happen in the pandemic?  
 21 **A.** Principally because it was BAME people who are falling,  
 22 either falling ill or, unfortunately, dying. So there  
 23 was a whole lot of fear in the community, anxiety  
 24 expressed, in the community. I mean, people were saying  
 25 to me: I don't know whether I'm going to say goodbye to  
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1 gleaned from your statement that it was more than just  
 2 terminology. Are you able to help us in other ways in  
 3 which the guidance was inadequate or wasn't culturally  
 4 competent?  
 5 **A.** So, many cultures have differed customs and practices  
 6 and it's not just about the words, it's about  
 7 understanding those practices that, for instance, if you  
 8 don't -- if I woman doesn't look at you eye to eye, if  
 9 you are a man, that that is just the culture. It's the  
 10 way that they are. It's nothing else, you know.  
 11 **Q.** How can we translate those examples, though, into better  
 12 guidance that is less confusing or is more clear? Can  
 13 you think of some practical ways we can try and help to  
 14 overcome those cultural differences?  
 15 **A.** I would go back to training. You know, training of all  
 16 our leaders, make sure that they understand this so that  
 17 it can go down the various paths and, you know,  
 18 tributaries of the NHS. Proper cultural awareness,  
 19 proper cultural competence, and then testing to make  
 20 sure we have updated and people have the knowledge of  
 21 the various cultures we have.  
 22 **Q.** Do you know, was any feedback given to the UK IPC cell  
 23 about cultural incompetence or inadequacies in the way  
 24 the IPC guidance was phrased?  
 25 **A.** I don't know whether we -- I don't remember formally  
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1 my partner today or am I saying good morning to them  
 2 before I go to work. Because there was that tense  
 3 palpable anxiety amongst people: we are going to work,  
 4 we do want to work, we want to save our patients but we  
 5 don't know whether our employers have our own health and  
 6 safety in their mind.  
 7 **Q.** Now, you make the observation in your statement that  
 8 it's important, indeed vital, is your word that  
 9 government guidance is accessible to everyone so that  
 10 individuals can stay informed and you say the government  
 11 guidance was not culturally competent and inadequately  
 12 catered to the needs of the black, Asian, and minority  
 13 ethnic healthcare workers.  
 14 Can you give us an example of culturally  
 15 incompetent or inadequate guidance?  
 16 **A.** So I think Professor Kamlesh Khunti gave an example that  
 17 in many languages "virus" isn't a word and I think that  
 18 it's like that, you know. And depression, which is an  
 19 illness, I'm a psychiatrist so I understand depression,  
 20 depression is not actually a word -- an illness in many  
 21 languages. So there are very many other cultures which  
 22 actually don't understand the English, you know,  
 23 wordology, if you like.  
 24 **Q.** Clearly one can translate the guidance into any number  
 25 of given languages but is that a quick fix? I rather  
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1 writing but I've been in many of these conferences and  
 2 webinars with NHS England where we've brought up this  
 3 issue.  
 4 **Q.** I'd like to just look, please, at some of the steps  
 5 taken by your member organisations to try and engage  
 6 BAME communities with the guidance, and the like, and I  
 7 am at your paragraphs 55 onwards, Professor, but I think  
 8 you make the point there, that there was quite a lot  
 9 work being done by members of the BAME community to try  
 10 and spread the word, stop disinformation, engage with  
 11 the communities. Can you give us some examples of  
 12 things that FEMHO's members did to try and overcome some  
 13 of these difficulties with the guidance?  
 14 **A.** So just simple understanding why people needed to  
 15 sanitise their hands, why social distancing was  
 16 important, why vaccine uptake was important, why there  
 17 were so many black and ethnic doctors and nurses and  
 18 pharmacists who then became vaccinators in order to  
 19 impress on people that these vaccines are quite safe,  
 20 well, as we knew it at the time, we felt that this was  
 21 effective to try and reduce the spread and mitigate  
 22 against the virus.  
 23 So all of those seminars -- there were many  
 24 that -- we've given you a glimpse of some of them but  
 25 there were so many of them.  
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1 **Q.** Yes, I'd like to just look, please, at INQ00099685\_0004,  
2 and if we can just slowly scroll through, there's about  
3 four or five pages of different adverts. Some are  
4 relating to the vaccines but we go through a number of  
5 different webinars, lectures and the like, being hosted  
6 by members of FEMHO to try and communicate with  
7 different BAME communities.

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

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

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

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

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1 to reach"?

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

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

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

20 **A.** Sorry.

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

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

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1 improve matters in the community.

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

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

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

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

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1 morning break.

2 **LADY JUSTICE HALLETT:** Certainly. I hope you were warned  
3 that we take breaks, Professor, and I shall return at  
4 11.30.

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

6 (11.15 am)

(A short break)

7 (11.30 am)

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

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

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

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

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

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

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

25 **A.** Schwartz.

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1 depression, stress, which are written on them for a very  
2 long time.

3 **Q.** We've heard a little of that evidence already from  
4 a number of our witnesses to date, but just thinking  
5 about the BAME healthcare workers themselves, were there  
6 particular anxieties or stresses that were born to bear  
7 by those communities?

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

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

21 **Q.** Can we turn to recommendations that you would urge your  
22 Ladyship to consider to try and ameliorate the impact or  
23 disproportionate impact, or indeed some of it, in BAME  
24 healthcare workers. You touched on data collection  
25 already in your evidence, and I think you make eight

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

2 **A.** So in a Schwartz ward round, somebody who is trained in  
3 that would bring people, the staff together, who have  
4 experienced stress, and it's proven to be very useful  
5 where they can, in a very safe space, be able to talk  
6 about anything they want to talk about, about how the  
7 work and how the stresses of patients might have  
8 impacted, or care might have impacted on them.

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

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

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1 recommendations in your statement including the need for  
2 review and investment where necessary, into culturally  
3 competent and sensitive healthcare equipment.

4 Do you include, in that, PPE?

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

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

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

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1 plan that is -- and we will be able to help. You know,  
2 there are organisations like FEMHO, BAPIO and other  
3 organisations, are very happy to help to make this a  
4 policy.

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

6 **A.** Yes.

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

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

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

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1 and minority ethnic workers are disproportionately  
2 represented in such roles?

3 **A.** Are they represented in agency -- are they represented  
4 as members?

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

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

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

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

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

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

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1 **Q.** Now, I understand all of those matters, but they are  
2 potentially wider than just the impact of the pandemic;  
3 do you have any recommendation that you would urge us to  
4 consider in the event of a future pandemic that could  
5 help FEMHO's members?

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

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

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

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

#### Questions from MR JACOBS

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

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

25 First, is it your understanding that black, Asian,

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1 risk assessed at all.

2 When one looks at those features together, it  
3 paints a pretty grim picture, does it not, Professor, of  
4 the experiences of those healthcare workers who were not  
5 indirectly employed in permanent roles?

6 **A.** It does.

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

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

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1 I guess my answer is there has to be some  
2 concerted effort to bring all of them into some sort of  
3 a trade union, you know, because I don't think currently  
4 it's working as it is. They are really very vulnerable.

5 **Q.** That might be something it's easier for you to raise  
6 than we, Professor.

7 One issue that Sara Gorton has given in evidence  
8 on behalf of the Trades Union Congress is that  
9 agreements for directly employed NHS staff covering full  
10 pay for Covid sickness and self-isolation was difficult  
11 to enforce for staff who were outsourced or working via  
12 banks. Does that, to your knowledge, chime with the  
13 experience of any FEMHO members?

14 **A.** So that is my understanding, that, you know, that's how  
15 it was at the time and whether that had been a practice  
16 before that I don't know, but certainly during the  
17 pandemic, the acute part, that's how it was.

18 **Q.** Are these the sorts of macro-level systems and  
19 processes, as you describe in your statement, that  
20 interact with one another to generate and reinforce  
21 inequities among racial and ethnic groups?

22 **A.** Absolutely. Inequity and mistrust.

23 **Q.** And if it follows from that, that these are the sorts of  
24 processes that need to be confronted in preparing and  
25 responding to the next pandemic, how is that to be done

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1 So, for example, to ensure that risk assessments are not  
2 just the preserve of employed staff but also staff who  
3 aren't directly employed?

4 **A.** Absolutely. I mean, I made that point, my Lady, which  
5 is that quite often they were left to their own even,  
6 you know, carrying these bin bags as aprons, and flimsy  
7 masks. How many of these low-paid workers did we expose  
8 to the virus unnecessarily? You know, I think there has  
9 to be some sort of a system of support for them. After  
10 all, we're losing them because they either just go off  
11 the NHS or they become ill and can't work.

12 **MR JACOBS:** Those are my questions. Thank you very much.

13 **LADY JUSTICE HALLETT:** Thank you very much, Mr Jacobs.

14 Ms McDermott.

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

#### 17 Questions from MS McDERMOTT

18 **MS McDERMOTT:** Good morning, Professor.

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

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

25 My first question is about what you started with

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1 practically? What are the practical steps that might be  
2 taken to support the position of those in bank  
3 positions, outsourced workers, and so on?

4 **A.** So my sense about this is really that I think it's  
5 getting -- I mean, I would say that you might say that,  
6 but I think it's about getting all the trade unions  
7 together to see how that protection might be afforded  
8 from government level to these workers. You know,  
9 I think we've had a rule in medicine that every doctor  
10 who joins the GMC register ought to have indemnity even  
11 if they have their own private indemnity, and I think  
12 there's a whole lot of lower-paid staff workers who are  
13 particularly vulnerable because they can't afford that  
14 sort of -- I mean, why is it that they don't have it?  
15 It's because they can't afford it. If they could afford  
16 it, they would. And for low-paid workers it's even  
17 worse. So I think there's a huge army of people there  
18 who really we could do better with, with getting proper  
19 representation for them.

20 **Q.** On some of the recommendations that you describe in your  
21 statement -- so, for example, in relation to risk  
22 assessments and plans for effective Infection,  
23 Prevention and Control -- is it important, in your view,  
24 that these matters need to be tailored in various  
25 respects but including in respect of outsourced staff?

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1 in your evidence and it was a common theme throughout  
2 your evidence about how it didn't seem as though the  
3 black and Asian and minority ethnic voices of the  
4 healthcare workers were being heard and you have given  
5 some striking examples this morning and in both your  
6 statements of evidence of the impact and consequences  
7 brought about by not hearing those voices. So plainly  
8 from your evidence, many within the BAME community were  
9 afraid to speak out.

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

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

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1 So there was a lot of anxiety and stress about  
2 this, you know. There was a lot of fear that they dare  
3 not tell them that the rules are being broken and they  
4 are being impartial in some ways of even racist in some  
5 ways, that word that, you know, is often just in the  
6 background but not used in the NHS.

7 So I think, yes, I think that it was justified.

8 What was your other question?

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

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

19 There are other, what I call micro-aggressions, I  
20 do not know whether you like that term or not, which is,  
21 you know, ignoring somebody, not including them in  
22 communications, not talking to them, not encouraging  
23 them, not planning their PDP or supporting them with  
24 CPD. There are so many different ways that these  
25 mal-communications happen which undermine that person

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1 statement and that's, for the record, paragraph 424, he  
2 cites:

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

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

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

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1 and undermine their morale, who is, after all, a person  
2 who just wants to do their best in their job. I think  
3 everybody wants to do the best in their job unless  
4 proven otherwise.

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

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

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

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

21 Now, in Module 3 the Northern Ireland Chief  
22 Medical Officer, Professor Sir Michael McBride had  
23 spoken about data in relation to age, in relation to  
24 gender and social deprivation and being able to use and  
25 analyse that data but within that same paragraph of his

66

1 well, isn't it? If everybody feels valued then they  
2 will give the best in their job that they can and if  
3 they are just a statistic or even a non-statistic then  
4 how are they going to do their best for the NHS?

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

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

25 **Q.** But is that gap also for -- informed from the

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1 information chasm that we've mentioned?

2 **A.** Yes. I mean, I think it's evident that -- I mean, it

3 works both ways, doesn't it, that there should have been

4 some attempt on them to engage with communities there,

5 which I don't think there was from the government. If

6 there was, I don't know about it, to be truthful,

7 because I would have guessed they would have contacted

8 somebody like myself.

9 **MS McDERMOTT:** Very grateful for your answers and responding

10 to my questions, Professor. Those are my questions.

11 **A.** Thank you.

12 **LADY JUSTICE HALLETT:** Thank you very much, very grateful.

13 That completes the evidence for you, Professor.

14 You have been a very eloquent witness and obviously a

15 very eloquent spokesperson too for a large number of

16 communities, I suspect. Thank you very much for the

17 constructive nature of your evidence, and I too would

18 like to wish you, again, a happy anniversary.

19 **A.** Thank you.

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

21 **A.** Thank you.

22 **(The witness withdrew)**

23 **MS CAREY:** Thank you, my Lady. There may just be a brief

24 pause now while we --

25 **LADY JUSTICE HALLETT:** I will stay here.

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1 **Q.** You have a nice loud voice, please keep it that way;

2 nice and slow as well, please, doctor, so that the

3 stenographer can keep up.

4 I think having left face-to-face clinical work,

5 you completed a master's degree in health services

6 research, and you now work in a non-patient-facing role

7 within the NHS?

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

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

10 **A.** That's correct.

11 **Q.** And can you just help us, please, with a little bit

12 about CVF. I think you say they were formed in

13 August 2020, and what was the reason for the formation

14 of CVF?

15 **A.** Yes, that's right. So CVF was formed in August 2020 at

16 a time when shielding had been paused and children were

17 required to be back in school in September 2020. What

18 that meant was that for people who were living within

19 clinically vulnerable families, they were concerned

20 about the risk of their children returning to school and

21 indeed contracting Covid. This is despite the

22 assurances, at the time, that schools were safe and that

23 children indeed didn't transmit Covid, but Clinically

24 Vulnerable Families was set up by Lara Wong, who was a

25 teacher, and she recognised the risks to parents of

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1 **MS CAREY:** Thank you very much.

2 *(Pause)*

3 **DR CATHERINE FINNIS (sworn)**

4 **LADY JUSTICE HALLETT:** Dr Finnis, I hope we haven't kept you

5 waiting for too long.

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

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

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

9 **A.** Catherine Finnis.

10 **Q.** You made a witness statement on behalf of the Clinically

11 Vulnerable Families core participant group dated

12 31 January 2024, INQ000409574, and I hope you have a

13 copy of that in front of you.

14 **A.** I do, yes.

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

16 A little bit of background to both you and indeed

17 to CVF, as they are known. I think that you trained as

18 a medical doctor some years ago now and practised for

19 five years when you needed to leave face-to-face

20 clinical work due to you being severely immune

21 suppressed; is that correct?

22 **A.** That's correct.

23 **Q.** And is that why, in part, you appear with a face mask

24 today?

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

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1 children returning to school and, indeed, clinically

2 vulnerable and clinically extremely vulnerable teachers

3 who were also required to return to school in

4 September 2020.

5 **Q.** So, pausing there, we understand that the genesis of CVF

6 was because of the concerns about going back to school.

7 Now, you will appreciate, Dr Finnis, that we are

8 concentrating on the impact of the pandemic within the

9 healthcare systems, and so that's not to minimise the

10 impact on children and indeed the teachers who were

11 clinically vulnerable or clinically extremely

12 vulnerable, but can we focus today on healthcare systems

13 impact, if we may.

14 And I think you say this, that there's a combined

15 membership of -- and following of CVF at just under

16 46,000 people, and there are a number of members on

17 Facebook, followers on Twitter and the like, and that

18 CVF's mission is to support, inform and advocate for

19 those in clinically vulnerable households as they face

20 an ongoing threat posed by Covid-19.

21 Can I ask you, please, Doctor, I might concentrate

22 firstly on "clinically extremely vulnerable" and then on

23 "clinically vulnerable", and some different issues may

24 arise, but clearly if I talk about one and there's an

25 issue for the other group, please do say so. And can I,

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1 at the outset, thank you very much for the helpful  
2 quotations that are peppered throughout the statement;  
3 we may look at one or two, but if we don't have  
4 time this morning and during the course of your  
5 evidence, there is a litany of quotations from the  
6 people themselves who were affected.

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

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

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

13 Can I start, please, with clinically extremely  
14 vulnerable people and the shielding list. Indeed, we  
15 have heard about the make-up of the CEV list from  
16 Professor Whitty and others who gave evidence to us  
17 earlier, but it might just be easier to call up on  
18 screen, please, INQ000409574\_0010 just to remind  
19 ourselves, without having to go through it, those that,  
20 as at 1 April, were deemed to be the highest clinical  
21 risk, and a number of different people with medical  
22 vulnerabilities set out there.

23 I think, is it right, that CVF have concerns about  
24 who was on it who should not have been, and conversely  
25 who was not on it who should have been, so can I ask you

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1 people could ask themselves to be added to it. And you  
2 said that led to delays. Are you able to help us, from  
3 CVF's perspective, how long it took, if you were in that  
4 latter category of asking your GP to be added? Days,  
5 weeks, months?

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

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

23 **A.** No.

24 **Q.** All right. Now, what about the timing of the  
25 compilation of the list? I think you say in your

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1 about those two sides of the coin, please.

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

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

22 **Q.** Now, we -- although there are, I think, the different  
23 medical categories, we were also told that if a GP  
24 identified a patient as being clinically extremely  
25 vulnerable, they could be added to the list and, indeed,

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1 statement that obviously we went into lockdown on  
2 23 March, and the letters started to be sent to people,  
3 I think, a couple of days earlier on 21 March. Clearly,  
4 that was some time since reports in early January or  
5 thereabouts of the emergence of the coronavirus in  
6 Wuhan; does CVF have any concerns about the timing of  
7 the compilation of the list?

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

20 We -- you know, it was very late. The shielding  
21 timetable, when people were told to shield, seemed very  
22 late into March, and indeed when you look at the timing  
23 of the first wave, I think CVF would suggest it was too  
24 late, and that in fact some of those clinically  
25 extremely vulnerable people could have been told to

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1 shield earlier and not have become infected.

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

3 was effectively an informal shielding that commenced

4 earlier by some of CVF's members. Are you able to give

5 us an idea of how many of your members started shielding

6 before the letters were actually sent out?

7 **A.** Yes, I don't have a number for you, but certainly when

8 I wrote to our group to do some thematic analysis to

9 understand this, it certainly was a dominant theme that

10 came. So it was a large -- a number of people who were

11 able to do that. However, there is kind of a --

12 discrepancies or inequalities, if you like, about who

13 was able to shield informally. So people of working

14 age, particularly people in frontline roles such as

15 teachers, nurses, doctors, shop workers, bus drivers,

16 taxi drivers were unable to shield informally because

17 they could not work from home. People like myself who

18 had office work, I was able to discuss it with my boss

19 and I was given allowance to work from home, as were

20 some of us in those roles.

21 But certainly it was very late.

22 **Q.** So there are those whose perhaps work allowed it could

23 start informal shielding but without the letter to say

24 you should be staying at home and should not go to work,

25 it made it very difficult for those clinically extremely

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1 "Early in the pandemic, some avoided all contact

2 with people outside of their immediate family because

3 they were anxious about catching the virus. Some did

4 this before there was any official advice, aware of the

5 risks associated with their health conditions."

6 You can see a quotation there:

7 "You didn't know what way it was going to go or

8 how bad it was going to be, especially [in] the early

9 part. Everywhere was closing down, it was very, very

10 scary."

11 Does that echo members of CVF and the concerns

12 that they were enunciating?

13 **A.** Yes, that was absolutely the case. I think, also --

14 I mean, I know it does say here "Early in the pandemic,

15 some avoided all contact with people outside of their

16 immediate family", but of course for many members of our

17 group that continued throughout the emergency part of

18 the pandemic, and for some people it even continues

19 largely today.

20 **Q.** Today.

21 **A.** Yes.

22 **Q.** Understood. Can I ask you about the communications that

23 went out to CVF's members. We know there was a letter

24 sent by GPs, but I'd like to ask you, please, about a

25 text message that I think one of the CVF members -- and

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1 vulnerable people to start any informal or

2 pre-shielding? Is that --

3 **A.** Absolutely, and we've got quite a few teachers,

4 actually, within our group, due to how it was actually

5 set up, and for teachers it was really difficult. They

6 were in school every day with lots of children. They

7 knew that they had one of these conditions on the list,

8 and they were not told to shield. They were not

9 actually given any information what to do. There was no

10 real education. I think at the time we were being told

11 to wash our hands to "Happy Birthday", as I recall, and

12 that was really all the advice. So it was a really

13 stressful time.

14 I guess the group of people for whom we represent

15 that were able to shield informally the most were older

16 people who were retired.

17 **Q.** Yes. Well, can I ask you about that, because can we

18 have a look on screen, please, at INQ000474233\_0190, and

19 I think, Dr Finnis, you have read the "Shielding"

20 chapter of the Every Story Matters record, and indeed on

21 the first page of the shielding section, there is

22 reference there to a number of clinically vulnerable and

23 clinically extremely vulnerable telling ESM about how

24 frightened they were at the start of the pandemic, and

25 we can see there in the second sentence down:

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1 could we have a look on screen at INQ000408799, and

2 I think this is provided by one of your members as a

3 text that they received, I think, before they got the

4 letter; is that correct?

5 **A.** Yes, I believe that is the case, and actually quite a

6 lot of us did receive digital communications either by

7 text and/or email before we received the letters. In

8 fact, personally, I think I received my letter maybe two

9 weeks later, but I received a text very quickly.

10 **Q.** Then look at the text, I think it was sent on 24 March

11 received at 9.46 from the "NHS Coronavirus Service":

12 "Do you know how you will get your medicines while

13 you are staying in your home? You can order repeat

14 prescriptions online ..."

15 It gives the website address.

16 "Please ask your family, friends or neighbours to

17 pick up your prescriptions from a pharmacy. Just remind

18 them to leave the items outside your door.

19 "The NHS is still here for you - you will still

20 get the care you need, but the way you receive it might

21 change. More will happen over the phone and internet."

22 Do you know how CVF members reacted if they got

23 the text before they had the shielding letter and how it

24 impacted them to receive a text like this?

25 **A.** There were lots of different texts being received.

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

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

25 So a lot of us were very perplexed by these texts.

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1 themselves in harm's way to help those people.  
2 **Q.** Dr Finnis, can I just stay with that text for one  
3 moment. Do you on behalf of your members think there  
4 should be no texts at all in these circumstances or is  
5 it there's an issue with the timing with which they came  
6 at and then, indeed, an issue with the content and the  
7 way it was delivered? I just want to be clear about  
8 what your sort of position is and how we might do  
9 something differently in the future?

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

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

21 The other thing I just want to say about these  
22 texts we received, I received tens of texts, tens of  
23 letters, loads of emails. It was really frightening and  
24 constantly to be told that you're at high risk of dying  
25 should you step outside your house for a period that

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

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

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1 amounted to, you know, from March 2020 to summer 2021,  
2 is really difficult for people to cope with.

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

4 **A.** Sorry.

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

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

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

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

22 I mean, so we have members throughout group who  
23 were told or given information about -- to shield over  
24 the, you know, the whole period, over the whole 18-month  
25 period of shielding. Initially there was all sorts of

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1 problems. There were people for whom they certainly  
2 didn't get their letter straight away. It was a bit of  
3 a problem, as I recall, in terms of using it as a  
4 passport to being able to work from home if you didn't  
5 have the written letter. It felt as though the written  
6 letter was still the formal communication rather than a  
7 text message.

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

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

16 **A.** Yes.

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

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

23 **A.** It would empower people. So people would be able to,  
24 with advice and guidance, try and prevent their risk,  
25 their real risk and also understand what the risk really

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1 we've been doing, is really filling that gap from  
2 August 2020, trying to inform people about what masks  
3 can be worn, whether it's droplet or airborne, to be  
4 honest. You know, what other things you can do to  
5 reduce your spread -- ventilation, you know, being  
6 outside. Things like that.

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

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

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

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

21 **A.** Yes.

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

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

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

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

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1 what circumstances?

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

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

15 **A.** Yes.

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

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

24 **Q.** One of the other offers of support, if that be the right  
25 phrase, was there was a suggestion that there would

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1 be -- in January 2021, those in residential or nursing  
2 homes would be offered a free supply of vitamin D  
3 through the post if they were clinically extremely  
4 vulnerable. Was that ever expanded to those that  
5 weren't living or residing in the care sector?

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

14 **Q.** Were you offered any PPE at all?

15 **A.** No.

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

18 **A.** Yes. So we were able to access lateral flow tests.  
19 Initially we were able to order online as many boxes as  
20 we needed but then there's been a reducing access. So  
21 then it was only the clinically extremely vulnerable or,  
22 actually, it was the person who could access antivirals,  
23 which is a different list. It became really  
24 complicated. That was one of the other issues. But if  
25 you could access antivirals then you -- which wasn't

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1 that you could work from home or, indeed, if you could  
2 not work from home that you were then offered Statutory  
3 Sick Pay which meant that you could at least afford to  
4 shield.

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

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

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

24 "... shows that [CEV] people experienced a higher  
25 rate of deaths compared to the general population over

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1 necessarily the shielded list but a lot them but  
2 involved some clinically vulnerable, for example, then  
3 you could order your box of lateral flow tests that  
4 would come for you and now we cannot order them at all.  
5 I have to go into, we all do, have to go into a pharmacy  
6 to get them which is not easy.

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

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

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

18 **A.** I think given how worried people were with the  
19 information coming from, first, China and then Italy and  
20 understanding that people with underlying conditions  
21 were at much higher risk of severe disease and sadly  
22 death, I think that shielding was something for us to at  
23 least hold on to. It felt that perhaps we were being  
24 offered something by society. I think that it was  
25 really important that whole passporting aspect of it,

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1 the pandemic. At the peak of the first wave on  
2 2 April 2020 the rate of deaths amongst the clinically  
3 vulnerable population was over two and a half times that  
4 in the general population (1 in 2,500 ... compared to 1  
5 in 7,000 ...) Furthermore, by the end of August ... the  
6 clinically extremely vulnerable population accounted for  
7 19% of all deaths while only making up 4% of the total  
8 population ..."

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

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

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

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

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1 as safe as could be, anyway at that time, I think that  
2 it was -- it was of benefit but I'm not sure that's true  
3 for a future pandemic. I would hope that there would  
4 be, obviously hopefully from this Inquiry that, you  
5 know, suggestions for better planning and things could  
6 be arranged in a better way and more empowering way for  
7 people who are at greater risk rather than just leaving  
8 this only option of locking them away.

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

14 It's INQ000409574\_25 and on to page 26, which just  
15 sets out and encapsulates the concerns about the  
16 guidance and it's that -- there you are, paragraph 57:

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

24 And then you set out there a number of different  
25 aspects to the guidance. It failed to ensure complete

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1 the CEV individual; do you think there needs to be a  
2 better balance struck in the guidance that is offered to  
3 the non-shielded person in the household?

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

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

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

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1 household protection focussing on the CEV individual but  
2 often neglecting the risk posed by non-shielded house  
3 members.

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

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

23 **Q.** I suppose, to play devil's advocate, there might be  
24 other members of the household, though, that don't want  
25 to take those steps, no matter how protective it is of

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1 could it have been more thoughtful?

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

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

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

25 **A.** So we had a weekly mental health post on our Facebook

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1 page, where people could add a differed coloured heart,  
2 and then depending on the colour of the heart, meant the  
3 sort of support that we then went in and offered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 **A.** Yeah, so certainly during the -- you know, during the  
23 main part of the emergency part of the pandemic, I think  
24 because more people were wearing masks, it was more  
25 accepted, but there has been a real kind of sea change,

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1 gov.uk, and you look for Covid-19 guidance today for  
2 people who are severely immune suppressed or higher  
3 risk, it tells us several things, if I may.

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

6 **A.** Yes.

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

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

12 **A.** Yes.

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

14 **A.** Yes.

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

17 **A.** Yes, because it was the drop in the face masks from  
18 hospitals.

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

20 **A.** Yes.

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

22 **A.** Yes. I mean, our pages now, even today, are full of  
23 people having trouble accessing hospitals. They are  
24 unsafe for people who are clinically vulnerable, and one  
25 of the problems why they're unsafe is because of the

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1 problems of face masks -- staff aren't wearing them, but  
2 neither are patients.

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

6 **LADY JUSTICE HALLETT:** And more slowly, please.

7 **MS CAREY:** I'm doing it now. I'm so sorry, my Lady.

8 It's my fault, Dr Finnis. INQ000409574\_0055.

9 Just one of the quotations that you have provided the  
10 Inquiry with. Quote 47 there, from a CVF member:

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

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

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1 a busy crowded environment, multiple people coughing the  
2 last time I went into A&E, I cannot follow the guidance.

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

6 **A.** Yes.

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

9 **A.** So, I mean, I suppose, you know, ideally we would say  
10 that, you know, almost all healthcare is high risk given  
11 the people who attend healthcare. However, high risk  
12 could be, for example, and perhaps other people need to  
13 determine this rather than me but I might suggest it  
14 would be A&E, general medical wards, haematology wards,  
15 cancer wards, but also places where those people go.

16 So, if I may, I did hear Professor Hopkins, last week or  
17 the week before, tell us that she still would advise  
18 some of those precautions in those high-risk wards. But  
19 as someone who is high risk, I have to go to blood  
20 tests, A&E, clinic appointments. I don't just stay in  
21 those areas. I walk the whole hospital.

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

25 Could we look on screen at INQ000409574\_58,

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1 wanted to tell us about.

2 **A.** Yes. So that's the, as I say, the gov.uk, and it's  
3 replicated within the NHS guidance as well. It says  
4 four key things. Firstly, it advises us not to be  
5 around people who have Covid-19 nor people who have  
6 respiratory infections. It tells us to try and do -- to  
7 get the people visiting us to do a lateral flow test  
8 before they visit us. It tells us to ask people who  
9 visit us to consider wearing a mask of face covering --  
10 that does actually say face mask or face covering -- or  
11 us to use a face mask or face covering, and it also  
12 tells us to consider ventilation.

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

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

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

21 **A.** No, there is now no testing. There's no formal testing,  
22 so you can be put next to somebody who is  
23 Covid-positive. Of course, clinically extremely  
24 vulnerable or high users of healthcare, that's our  
25 greatest problem. When we walk into A&E, we're in

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1 please.

2 It's your paragraph 145, Dr Finnis. You set out  
3 there some of the measures that the CV people would  
4 contend for: allowing people to wear their own, either  
5 FFP3 or FFP2; enabling people at higher risk to easily  
6 request staff to wear masks before their appointments.

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

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

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

16 **A.** Mm-hmm.

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

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1 is acceptable on a clinical basis.  
 2 Now, a number of practical measures set out there.  
 3 Are any of those happening routinely as far as CVF  
 4 members are concerned?  
 5 **A.** No. I mean, generally not. So nothing happens  
 6 automatically at all despite that guidance in the NHS  
 7 and in the government -- the Gov.UK. So, I mean,  
 8 practically all really of people that were within  
 9 clinically vulnerable families have significant  
 10 underlying conditions, so we frequent healthcare, myself  
 11 included, often, so we have tested all these things. We  
 12 do wear FFP3 and FFP2 and it's very variable but, as  
 13 I said, many people do get a very bad reception, not  
 14 personally actually, but certainly many people have  
 15 really suffered what you would term or we have termed  
 16 "CVF mask abuse".  
 17 We have no way at the moment to ask staff to wear  
 18 masks and in fact even if we do, we often find that it's  
 19 not then done. So, for example, we've had clinically  
 20 vulnerable people who have gone in for an operation who  
 21 would normally wear a mask who are worried that after  
 22 they are anaesthetised, for example, in the recovery  
 23 room they are worried they will be exposed to Covid and  
 24 they've asked whether they can -- that people wear  
 25 masks. Either there's a battle at that point, to be  
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1 old estate in the NHS, so there's really no kind of  
 2 modern mechanical ventilation. Often the windows are  
 3 kind of painted shut, there's certainly very few and far  
 4 between HEPA filtration machines, although we have seen  
 5 them in some hospitals -- a few.  
 6 I don't think any of us or very few of us -- any  
 7 of us, in fact, have really managed to ask to get staff  
 8 successfully to wear an FFP2 mask. Ditto on LFT. They  
 9 will sometimes offer us first or early appointment in  
 10 the day but, again, it's on us, you see, it's on us,  
 11 this personal responsibility that's so hard to negotiate  
 12 in that kind of relationship with the healthcare system.  
 13 **MS CAREY:** I want to pause you there because you have given  
 14 a number of things I would like to pick up on.  
 15 I wonder, my Lady, if that might be a convenient  
 16 moment for lunch and I can bring back some of those  
 17 answers in the afternoon session.  
 18 **LADY JUSTICE HALLETT:** Are you all right to come back after  
 19 lunch? I am sure you were warned, Dr Finnis. Thank you  
 20 very much indeed.  
 21 I know the team and I have other commitments at  
 22 lunchtime, so I will return at 2.00.  
 23 **MS CAREY:** Thank you, my Lady.  
 24 **(12.48 pm)**  
 25 **(Luncheon Adjournment)**  
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1 honest, because it's not guidance, you know, they follow  
 2 IPC, you know. Or somebody says they can and then when  
 3 they arrive it's not anyway. So it's kind of two points  
 4 where that fails.  
 5 Allowing high-risk people to wait in a different  
 6 setting. So there are examples of that, particularly in  
 7 things like -- dentists tend to be quite good at that  
 8 but in hospital it's very difficult to do. It doesn't  
 9 appear to be able to be done.  
 10 There's also another thing that could possibly  
 11 happen which is high-risk patients wait in a different  
 12 area. So like a mask area. The only time I've ever  
 13 seen that was probably about a year and a half ago where  
 14 there was actually a mask waiting room for Covid-19  
 15 vaccination. So I have seen that once.  
 16 So, I mean, that's another consideration.  
 17 There's no CO2 readings available. Some of us  
 18 carry our own CO2 meters but obviously we can just  
 19 measure it, there's nothing we can do.  
 20 Just to say, though, I was in a big London  
 21 hospital pharmacy a while ago and it was pretty packed  
 22 and I had to get this medication and the CO2 reading was  
 23 well over 3,000, and the kind of safe level is between  
 24 800 and 1,000. So that shows you the problems.  
 25 Obviously, the waiting rooms can be -- it's very  
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1 **(2.00 pm)**  
 2 **MS CAREY:** Dr Finnis, may I just pick up on one thing you  
 3 told us about before the lunch break, which was you made  
 4 reference to mask abuse, and I'd like just to have a  
 5 look at one of the quotations that you've included in  
 6 your statement.  
 7 Could we call up on screen INQ000409574\_0023, and  
 8 quote 13 there from one of your members that says they  
 9 were:  
 10 "... taking [their] child to an appointment at  
 11 Great Ormond Street ... parked the car and was  
 12 approached by a man and a woman who were shouting at me.  
 13 They were really 'in my face' and swearing. The man  
 14 threatened to 'punch me up' and then that 'he hoped our  
 15 car would be all right' whilst we left ... to go to our  
 16 appointment. We were all wearing masks. The woman told  
 17 us there was no need as we were all outside."  
 18 Maria, aged 39, under felt such threat that she  
 19 called 999.  
 20 I just wanted to get a sense from you, if I may,  
 21 Dr Finnis, how widespread a problem was this, and is it  
 22 still now a problem, now here we are in October 2024?  
 23 **A.** Yes. So I guess during the emergency time in the  
 24 pandemic it was less of an issue because obviously there  
 25 were mask mandates and more people were therefore  
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1 wearing masks. Certainly, as that time's gone on and  
2 certainly after, first of all, Freedom Day in 2021,  
3 which was the general removal or reduction of masks in  
4 society, and then 2022, June 2022 where England removed  
5 masks from healthcare, after those two dates, wearing a  
6 mask has become increasingly concerning and worrying.

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

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

18 **Q.** There's no accounting for some members of society who  
19 think that's the right way to behave, but I just  
20 wondered in part whether you think there is something  
21 wrong with the messaging in that, because although the  
22 emergency phase of the pandemic is over, clearly indeed  
23 there's a variant, as we understand it, circulating now,  
24 whether the messaging has gone slightly awry in not  
25 ensuring that CV and CEV people are still at risk and

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1 radio, there's no healthcare professionals that are  
2 informing people with clinical vulnerability and high  
3 risk to Covid that they are still at risk, even.

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

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

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

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

18 **A.** Yes, absolutely.

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

20 **A.** Yes, absolutely. So people who were, you know of much  
21 higher risk and we've seen the increased death rates of  
22 these people were suddenly in August 2020 -- it was  
23 literally like the withdrawal of suddenly all this  
24 support. So suddenly there was no access to supermarket  
25 slots, there was no access to help with going to the

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1 therefore there may be good reason why they are wearing  
2 masks.

3 What do you have to say about that?

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

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

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

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1 pharmacy. None of us were vaccinated at that time, and  
2 it coincided with Eat Out to Help Out. There was no  
3 public advice for people who were still high risk at  
4 that time, that they were still higher risk.

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

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

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

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1 August 2020?  
 2 **A.** Because nobody had been vaccinated --  
 3 **Q.** Right.  
 4 **A.** -- people were still the same high risk. Their  
 5 condition hadn't changed. The virus hadn't changed.  
 6 **Q.** All right. Was there any consultation, as far as you  
 7 are aware, or other CVF members, before the decision in  
 8 August 2020 to stop shielding?  
 9 **A.** No, I'm not aware.  
 10 **Q.** And coming back to the support issue with whether it's  
 11 stopped in 2020 and restarted, ultimately I think it  
 12 came to an end by July 2021. What consultation, if any,  
 13 had there been before the shielding finished ultimately?  
 14 **A.** So there was no consultation with me as a clinically  
 15 extremely vulnerable person that I knew of, and none  
 16 that I know of within Clinically Vulnerable Families  
 17 either.  
 18 **Q.** And, again, support: was there any support in place for  
 19 when the shielding programme finally closed?  
 20 **A.** No, none whatsoever.  
 21 **Q.** And how did that impact the CVF members?  
 22 **A.** Well, all the issues that we've been talking about, such  
 23 as difficulty with accessing healthcare, mask abuse,  
 24 this personal responsibility, trying to rationalise the  
 25 GOV.UK advice, which is really all that remains with how

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1 paragraph 89 in your report, but could you just help us  
 2 with some of the measures that CVF have taken to support  
 3 clinically vulnerable households?  
 4 **A.** Yes, that's right. So just to be absolute clear, though  
 5 about our definition. So Clinically Vulnerable Families  
 6 represent clinically vulnerable households. Within  
 7 clinically vulnerable households there are clinically  
 8 extremely vulnerable, or shielded people, and clinically  
 9 vulnerable. So "clinically vulnerable", if you like, is  
 10 a bigger --  
 11 **Q.** Yes.  
 12 **A.** -- group and then "clinically extremely vulnerable" and  
 13 "shielding" is sort of a smaller circle within that  
 14 group.  
 15 So "clinically vulnerable" then encompasses  
 16 everybody with higher risk.  
 17 So, as it says in the statement there, in 2020, so  
 18 Lara was able to draw on her expertise in microbiology  
 19 pathology and science to create a series of practical  
 20 mitigations for children and school staff in schools,  
 21 because -- I appreciate that's not what we're talking  
 22 about here, but that was real issue for our members at  
 23 that time.  
 24 There's also an easily accessible pinned post  
 25 which remains today within Clinically Vulnerable

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1 we live our lives now, feels really impossible.  
 2 It all comes down to this "personal  
 3 responsibility", which is what we've been told about,  
 4 that we feel in CVF that it's really impossible to be  
 5 personally responsible for some of these things because  
 6 as I said, in busy A&Es, et cetera, it's very hard to,  
 7 even wearing a good mask like I am, you're still at some  
 8 risk without, for example, ventilation or testing. And  
 9 indeed many, many people who are not part of clinically  
 10 vulnerable families don't understand how to wear a mask,  
 11 which mask, and how.  
 12 Clinically Vulnerable Families, we have -- I've  
 13 done myself various videos trying to show people how to  
 14 wear masks correctly and get the best fit, but it's  
 15 really hard to get that information out there to  
 16 everybody who I see on the streets, such as this  
 17 morning.  
 18 **Q.** You've mentioned the clinically vulnerable, and I would  
 19 like to just ask you a little about that. Clearly we  
 20 are aware that there was a different definition and  
 21 you've mentioned the absence of measures to protect the  
 22 clinically vulnerable as opposed to the clinically  
 23 extremely vulnerable, but I think it's right that CVF  
 24 provide a degree of support to clinically vulnerable  
 25 households, and if it helps you, Dr Finnis, I'm at

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1 Families that everybody can access, and we have  
 2 thousands of members who can access this, which is  
 3 updated to reflect the evolving scientific  
 4 understanding.  
 5 **Q.** Right.  
 6 **A.** So what we're trying to do is to give people proper,  
 7 decent, scientific information that we have translated  
 8 for them, so that they are able to be empowered to  
 9 reduce the risk themselves and understand what their  
 10 risk is, but also how to reduce it, what mitigations  
 11 they need to take, and what is riskier than something  
 12 else, for example.  
 13 It's really hard to kind of be expected, as a  
 14 clinically vulnerable person, to judge your own risk --  
 15 **Q.** Yes.  
 16 **A.** -- the route to transmission and how to mitigate against  
 17 it.  
 18 **Q.** Can I ask you about one of the matters that you raise  
 19 there. You say that:  
 20 "Additionally CVF was able to negotiate group  
 21 discounts on essential products such as mask and air  
 22 filtration units."  
 23 Has there been any efforts to try and ask one of  
 24 the departments or NHS England or anyone like that to  
 25 help the clinically vulnerable negotiate discounts,

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1 given how much PPE they are likely to go through in  
2 comparison with someone who is not clinically  
3 vulnerable?

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

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

12 In fact, we've just had to, right from the start  
13 of the pandemic, certainly from my own experience, right  
14 back to 2020, I've been having to, you know, work out  
15 which mask is the best mask for me, access them, buy  
16 them online, ditto air filtration units. I mean, we've  
17 got lots of information now so we're able to advise  
18 people which mask might be better for them depending on  
19 whether they are male or female, what kind of, as I said  
20 earlier activity they want to do and, of course, air  
21 filtration units, we are in touch with one of the major  
22 providers of air filtration units. We're able to advise  
23 people of some charts that engineers have done which  
24 shows us the size of HEPA filter that you need for the  
25 space that you want to clean the air.

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1 It's totally worth it cost-wise for me. It's a  
2 completely good idea, but you do have to factor that in.

3 Many, many of our group now have got air filters.  
4 I think it's one of the commonest things that people  
5 have managed to put in place at home, particularly in  
6 those clinically vulnerable households where, for  
7 example, people may still be informally shielding and --  
8 but their household members are going out to work in  
9 places like frontline jobs, like hospitals or schools,  
10 and to have that HEPA filter in their front room is  
11 really helpful.

12 **Q.** So there's no misunderstanding about it, we know that  
13 CVF support the use of HEPA filtration in a number of  
14 different respects but obviously most importantly in the  
15 healthcare system.

16 **A.** Yes.

17 **Q.** And, indeed, I think you make the point in your  
18 statement that there is NHS England guidance now on the  
19 use of cleaning air with HEPA?

20 **A.** Yes.

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

22 **A.** Yes.

23 **Q.** Just one other consequential cost that may get lost in  
24 this. I think you make the point in your statement that  
25 many CVF members now feel they have no choice but to

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1 **Q.** Yes, I think you make the point in your statement that  
2 HEPA units for the home can be anywhere from £80 to £700  
3 depending on the model and the size and the space that  
4 it's got to filtrate.

5 Clearly that's going to be a significant cost for  
6 most people, particularly at the upper end of that  
7 scale. Is there any financial support in place for  
8 filters such as those?

9 **A.** No. So the only support that we've managed is, Lara has  
10 managed to negotiate a small, but we're very grateful  
11 for, you know, air filtration units from this particular  
12 company. But, no, generally speaking, there are a lot  
13 of financial burdens actually on clinically -- extremely  
14 and clinically vulnerable people, especially nowadays.  
15 Masks can be very expensive. I'm still paying between  
16 £35 and £50 for a box of 10 of these.

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

18 **A.** Yes, it depends how quickly I wear them but I have a  
19 child in school and I work, so I need probably one every  
20 working day at least and then if I go shopping. So yes,  
21 I need two boxes a month.

22 Then I personally also have HEPAs in every room of  
23 my house because, as I say, I have a child in school and  
24 it's not only having the HEPAs themselves but obviously  
25 you do need to change the filter when that's right.

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1 access healthcare through private hospitals because they  
2 consider the NHS is unsafe due to the risk of  
3 hospital-acquired infection. Can you just help us.  
4 Have you got any sense of how many members are having to  
5 resort to private healthcare rather than going through  
6 the NHS?

7 **A.** Again, so when I did a thematic analysis of the group it  
8 was certainly one of the dominant things that came  
9 about, was certainly the financial burdens, and  
10 certainly private healthcare is certainly something --  
11 I mean, it depends if people can afford it or not, but  
12 I think, generally speaking, if people can afford it  
13 even if it's at the very end of their affordability, for  
14 example, I think -- I don't know where it is -- but  
15 within my statement there's a quote from somebody who I  
16 think took out their pension funds to --

17 **Q.** Pause there, Dr Finnis, because there's two quotes on  
18 that page.

19 Can I go to INQ000409574\_66. It may not be the  
20 pension quote but I have seen that one as well, but  
21 there's a quote here at 57 from a CVF member. Thank  
22 you:

23 "I took early retirement, so my private health  
24 insurance stopped. I decided to pay myself, which this  
25 year was over £6,000, which is a very heavy financial

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1 burden. In 2021 I and to have a new heart valve and  
2 pacemaker and I simply would not risk an NHS hospital."

3 They say:

4 "The special measures the hospital took were  
5 brilliant."

6 They:

7 "... have had hand surgery recently too ...

8 limited contact, private room and personalised

9 treatment, ie they wear masks on request ..."

10 I presume they mean staff there.

11 "... no crowded waiting rooms, makes it worth it

12 to me. Of course, private health does not cover chronic

13 conditions and NHS hospitals and waiting rooms continue

14 to frighten me, so I minimise attendance."

15 And you are right, there are other examples you

16 give in your statement about the financial burden it

17 places on people.

18 Can I just ask you two final matters, please. You

19 set out in your statement anecdotal evidence that CVF

20 has gathered in relation to the use of DNACPRs and

21 concerns about blanket use and otherwise of those.

22 That's at your paragraph 112 onwards, Dr Finnis.

23 I think there is concern, is this right, amongst

24 the CVF membership that there may have been DNACPR

25 orders placed on those that are clinically extremely

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1 with information on how to reduce their risks.

2 I just wondered whether CVF has any measures to

3 propose to help identify this group or these groups of

4 people in the event of a future pandemic?

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

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

22 I think it's about empowering people that's

23 important.

24 **MS CAREY:** Dr Finnis, that's all the questions that I have.

25 I know there are some other questions from core

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1 vulnerable or clinically vulnerable as well -- I wasn't

2 clear which.

3 **A.** I mean, we don't know. I think that's the important

4 thing to say. But from the people who do know because

5 obviously we don't know how big the problem is, but we

6 do know that a fair number of people who were shielded,

7 so clinically extremely vulnerable, were either

8 approached during that emergency part of the pandemic in

9 a way that they wouldn't have expected to have been done

10 just, you know, the day before that started, to ask

11 whether they want to be resuscitated.

12 Indeed, there's quite a few examples of, you know,

13 relatively young people in their 30s, 40s and 50s who

14 have been either asked that question or have found it on

15 their discharge letters when they come out of hospital,

16 it having not been discussed with them at all and it

17 being a real shock.

18 **Q.** Another topic, please.

19 During the course of your evidence we've looked at

20 a number of recommendations that you would urge her

21 Ladyship and the Inquiry to consider, but one of the

22 matters you raise in your statement is you say that

23 there needs to be better identification of vulnerable

24 people based on early scientific evidence and there

25 needs to be good communication to people at high risk

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1 participants.

2 **LADY JUSTICE HALLETT:** Mr Weatherby?

3 **Questions from MR WEATHERBY KC**

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

5 I'm going to ask you a few questions on behalf of

6 Covid-19 Bereaved Families for Justice UK. I think

7 that's an organisation you know because they've done

8 joint work with you and your organisation.

9 Just a few questions picking up some of the points

10 that you have already touched upon.

11 Can I start with the issue of DNACPR orders. In

12 your statement, you express the deep concern, I think

13 the term you use is "very concerned", the deep concern

14 of CVF about what you describe as the discriminatory and

15 inappropriate use of such orders.

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

17 Now, we know that in the report of the Inquiry

18 experts they say the following, that a DNACPR notice is

19 not meant as a proxy for broader treatment decisions.

20 However, in the absence of clearly documented discussion

21 and decisions about other forms of treatment, there's a

22 potential for inappropriate overinterpretation of DNACPR

23 as a generalised treatment limitation option.

24 That's at paragraph 40 of their report.

25 They go on and they say and again I quote

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1 paragraph 49 of their report:

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

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

12 **A.** Yes.

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

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

19 **Q.** Yes.

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

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

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1 was support once there was a step down from shielding?

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

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

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

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

16 **A.** Financial support, yes.

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

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1 **A.** Yes.

2 **Q.** Thank you.

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

14 **A.** Yes.

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

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

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

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1 place?

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

11 **Q.** Thank you.

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

23 **A.** Yes, absolutely. I mean, CVF -- yeah, absolutely. It  
24 just seems like we've been completely left to our own  
25 devices, only personal responsibility, as I say. There

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1 is still no obvious measures, as you say, that should be  
2 Infection, Prevention and Control in hospitals.

3 **Q.** Yes.

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

5 **Q.** GPs perhaps very importantly.

6 **A.** Yes.

7 **MR WEATHERBY:** Doctor, thank you very much.

8 **LADY JUSTICE HALLETT:** Thank you, Mr Weatherby.

9 Thank you very much indeed, Dr Finnis. I'm so  
10 sorry to hear about what's been called mask abuse. It  
11 sounds such a trivial term but I can imagine just how  
12 distressing it must be for people like you and your  
13 colleagues to receive such abuse. I'm afraid the  
14 toxicity of some people never ceases to surprise me, but  
15 anyway. Thank you very much indeed for all your help,  
16 I'm very grateful to you.

17 Just one question: how do you manage to avoid  
18 Covid when you have got school -- child or children?

19 **A.** So my child, we actually managed to get HEPA filters  
20 into all the classrooms, and the school are really good  
21 at telling us whether there's a Covid case. So it just  
22 proves it can be done.

23 **LADY JUSTICE HALLETT:** I was going to say I find my  
24 grandchildren are the biggest vectors of any disease  
25 that's going round. Anyway, thank you very much for all  
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1 Association of Anaesthetists?

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

3 **Q.** Are you able to provide us with a bit of background  
4 about each of those organisations.

5 **A.** Yes. So the Faculty of Intensive Care Medicine is the  
6 UK professional and statutory body for the medical  
7 specialty of intensive care medicine -- the  
8 intensivists, the advanced critical care practitioners,  
9 and the critical care pharmacists -- and has around 4  
10 and a half thousand members across the UK.

11 The Royal College of Anaesthetists is the UK  
12 professional and statutory body for the medical  
13 specialty of anaesthesia, and has a combined membership  
14 of more than 24,000 fellows and members.

15 The Association of Anaesthetists is a professional  
16 organisation made up of over 10,000 anaesthetists in the  
17 UK, Republic of Ireland, and internationally.

18 **Q.** Thank you very much.

19 Dr Bryden, I'm going to ask you about the  
20 following today: first of all, I'm going to ask you a  
21 bit about your organisation's involvement with senior  
22 decision-makers; I'm then going to ask you a bit about  
23 Infection, Prevention and Control measures; and I'm then  
24 going to ask you a bit about critical care capacity,  
25 then redeployment, and then a bit about the impacted of  
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1 your help.

2 **A.** Thank you.

3 **MS CAREY:** Thank you, my Lady. The next witness is going to  
4 be taken by Mr Fireman and there will just be a pause  
5 while we allow Dr Finnis to depart.

6 **(The witness withdrew)**

7 **MR FIREMAN:** May I please call Dr Bryden.

8 **DR DANIELE CLARE BRYDEN (affirmed)**

9 **LADY JUSTICE HALLETT:** Dr Bryden, I hope you haven't been  
10 waiting too long.

11 **A.** Thank you.

12 **Questions from COUNSEL TO THE INQUIRY**

13 **MR FIREMAN:** Your full name, please.

14 **A.** Daniele Clare Bryden.

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

16 **A.** Yes.

17 **Q.** That should be INQ000389244. That is dated  
18 18 December 2023?

19 **A.** Yes.

20 **Q.** Dr Bryden, you are the Dean of the Faculty of Intensive  
21 Care Medicine, is that correct?

22 **A.** Yes.

23 **Q.** And you have attended today as a witness on behalf of  
24 three organisations: the Faculty of Intensive Care  
25 Medicine, the Royal College of Anaesthetists and the  
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1 suspending elective care. Is that all clear?

2 **A.** Yes.

3 **Q.** Can we turn, please, to the first of those topics. Is  
4 it correct that your organisation's work collectively  
5 and individually involved with regular meetings with  
6 NHS England and the Chief Medical Officers?

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

8 **Q.** And you describe various topics within your witness  
9 statement that you discussed with them. One of those is  
10 the need for clarity around PPE requirements. Can you  
11 recall what those specific concerns that you raised in  
12 terms of availability of PPE were, with the NHS England  
13 medical director?

14 **A.** I am aware that our organisations at the time had three  
15 broad levels of concern. Early on in the pandemic it  
16 was around the provision of advice and the timeliness of  
17 the advice as to the correct PPE to wear, because we  
18 were aware that many of our members and fellows were  
19 looking to us for distillation of advice, and we were  
20 struggling to be clear as to what that advice was.

21 We then also had concerns around the consistency  
22 of the advice in terms of the timescales and, again,  
23 what PPE individuals should wear, and then finally there  
24 were concerns, as later on in the first wave, around the  
25 availability of PPE and the appropriate PPE.  
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1 Q. Can you recall when you -- what sort of time-frames you  
 2 raised these particular concerns?  
 3 A. There were, at the time in the first wave of the  
 4 pandemic, there were regular meetings with both the  
 5 Chief Medical Officer and the National Medical  
 6 Director's office. Those meetings went up to twice  
 7 weekly in frequency. I do not have a specific date for  
 8 you, but I can get that information for you if you --  
 9 require it.  
 10 Q. Do you know, broadly, what response you received to each  
 11 of the concerns you raised before?  
 12 A. I know early on in March, sort of in the first week of  
 13 March, it was very much around highlighting the need for  
 14 the clarity of information, and we were made aware of  
 15 the fact that the correct information was expected, but  
 16 we were not in receipt of information as to when we  
 17 could expect it.  
 18 Q. The Inquiry's obviously heard, and this is the next  
 19 topic, really, which is linked, which is Infection,  
 20 Prevention and Control measures, and the Inquiry has  
 21 heard a lot of evidence about the availability of PPE as  
 22 we were just talking about. You raise in, your witness  
 23 statement, a particular concern that you were getting  
 24 from members, and given the nature of the role that your  
 25 members do, you talk about availability and so on.

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1 concerns relate just to England, or did they relate to  
 2 Scotland, Northern Ireland and Wales? Or any of the  
 3 three?  
 4 A. Because the pandemic effectively came through the  
 5 south-east initially, most of those reports in the early  
 6 phases were around what was happening in the south-east,  
 7 but obviously in other parts of the country, people were  
 8 aware of what was being reported in the south-east and  
 9 had concerns, therefore, that we were needing to  
 10 conserve PPE and manage it in a responsible fashion. So  
 11 that then influenced thinking around availability of PPE  
 12 and how it should be used.

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

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

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

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

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1 I was going to ask you, is that about availability of  
 2 respirators, or is that about gowns or any particular  
 3 PPE that was not available to healthcare workers?

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

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

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

24 Q. So --

25 **LADY JUSTICE HALLETT:** Forgive my interrupting, these  
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1 Q. If we could go to your witness statement, and this is at  
 2 paragraph 180, it might help to get this on the screen,  
 3 there are two -- some quotes here, a series of quotes  
 4 that I understand are taken from the Association of  
 5 Anaesthetists as part of their series. If we just look  
 6 at the second and third ones, we can see here:

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

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

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

20 **LADY JUSTICE HALLETT:** "Sweating".

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

23 "... sweating under plastic PPE and viewing the  
 24 world through a smeared visor. I remember struggling to  
 25 recognise colleagues under their PPE or understand what

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1 was being said. It made everything harder."  
 2 What I wanted to ask you about was those two  
 3 quotes; are they essentially the two sides of the  
 4 concerns around PPE, on the one hand the concern about  
 5 not being able to use it, and on the other hand the  
 6 concern about the effects of having to use it?  
 7 **A.** Certainly the second quote I very strongly recognise  
 8 personally, and also in terms of people's experiences of  
 9 working for long periods of time in PPE and the  
 10 difficulties that imposed.  
 11 I think in the first quote there was a lack of  
 12 understanding, initially, on wearing PPE outside of the  
 13 areas where it was known that there were  
 14 aerosol-generating procedures, so I think there was an  
 15 understanding from the get-go that intensive care units  
 16 were going to be areas that had aerosol-generating  
 17 procedures and people needed full levels of PPE. But  
 18 there was perhaps less clear understanding about other  
 19 areas of the hospital and what PPE was required.  
 20 **Q.** That's, in a related topic, something that you touch on  
 21 in your witness statement in terms of the difference  
 22 between aerosol-generating procedures and other areas,  
 23 and some of the points you make in fact include that  
 24 there are some down sides of designating areas as  
 25 aerosol-generating areas or aerosol-generating

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1 Dr Bryden's witness statement. You should hopefully see  
 2 there that there is this cited study.  
 3 **A.** Yes.  
 4 **Q.** Then there is a series of reasons as to why it may have  
 5 been the case that intensivists and anaesthetists died  
 6 at lower rates or, indeed, not at all in this study?  
 7 **A.** Yes.  
 8 **Q.** This was something which was asked about from the  
 9 Infection, Prevention and Control perspective with  
 10 Dr Ritchie of NHS England, but from your perspective,  
 11 can I ask you whether or not you felt that healthcare  
 12 workers working in intensive care felt that they were  
 13 better protected by using respirators?  
 14 **A.** My recollection at the time was it was not a question of  
 15 feeling better protected, it was around having the  
 16 necessary equipment to do the role and the job that was  
 17 required of you and we knew working in an intensive care  
 18 unit was an area where there was going to be a lot of  
 19 aerosol. So, effectively, it was around making sure  
 20 staff were appropriately protected with the equipment  
 21 they needed. It wasn't about necessarily a comparison  
 22 against other areas, it was about having the right  
 23 equipment for the job you were doing.  
 24 **Q.** So when that -- what you quote in your witness statement  
 25 where you say "higher-performing PPE", just to be

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1 procedures. Is that something that was of concern to  
 2 you and your organisations?  
 3 **A.** I think we, at the time, were very concerned,  
 4 particularly with the evidence that was coming from  
 5 China and India, that both individuals working as  
 6 anaesthetists in a theatre complex, and intensivists  
 7 working in an intensive care unit, were going to be  
 8 working in areas where there was a high risk of  
 9 aerosol-generating procedures. So there was an  
 10 understanding from all our members that they were going  
 11 to be at particular risk, and therefore there was  
 12 concern around having appropriate PPE.  
 13 **Q.** You also cite in your witness statement a study from  
 14 early in the pandemic. It's at paragraph 291 if you  
 15 want to refer to it, but essentially it's a study of 119  
 16 healthcare workers who died, and in it you note that  
 17 there were no intensivist and anaesthetist deaths. And  
 18 there are a number of reasons that you've provided for  
 19 that, which include higher-performing PPE amongst other  
 20 reasons, including the stage at which patients in  
 21 intensive care are treated in terms of the development  
 22 of the virus.  
 23 Do you recall that study?  
 24 **A.** I'm afraid I'm not able to access --  
 25 **Q.** If we can put it on the screen, it's at paragraph 291 of

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1 absolutely clear, do you mean respirators there?  
 2 **A.** Intensive care staff were wearing FFP3 masks, visors in  
 3 the first phase of the pandemic, gowns and gloves.  
 4 Individuals who could not find an FFP3 mask that would  
 5 fit them appropriately were very often provided with a  
 6 respirator-type system.  
 7 **Q.** Sorry, and including, within respirators, a respirator  
 8 mask?  
 9 **A.** Yes.  
 10 **Q.** My apologies. That can come down.  
 11 Turning then to a different topic, the next topic,  
 12 capacity -- and when I say "capacity" here I mean  
 13 critical care capacity -- and you describe in your  
 14 witness statement that in early 2020, some clinicians  
 15 were concerned that services would be overwhelmed, as  
 16 was the case in terms of the scenes that were seen in  
 17 north Italy, and that there was a desire for additional  
 18 triage guidance. So you were aware of that?  
 19 **A.** Yes.  
 20 **Q.** You then describe -- this is at paragraph 49 of your  
 21 witness statement -- that the Faculty of Intensive Care  
 22 Medicine were involved in drafting a guideline which  
 23 they co-authored with NICE, which I think is NG159, and  
 24 we'll get that up on screen in a moment, but can you  
 25 explain, first of all, what the purpose of creating a

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1 new guideline was at the outset of the pandemic?  
 2 **A.** Yes. So the Faculty of Intensive Care Medicine was one  
 3 of the organisations that was co-opted to the NHS  
 4 England Critical Care Clinical Reference Group, and the  
 5 clinical reference group discussed areas of support that  
 6 were going to be needed for hospitals as the pandemic  
 7 was approaching, or as patient numbers were perceived to  
 8 be increasing.

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

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

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1 then a case of having a discussion that would ordinarily  
 2 take place later on in the pathway earlier on?

3 **A.** Yes, it was about having an earlier discussion and  
 4 giving individuals who perhaps wouldn't routinely have  
 5 these discussions a degree of ability and a toolkit of  
 6 resources to enable them to have those discussions.

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

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

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

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

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

25 **Q.** Well, in normal circumstances, I understood from what

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1 **A.** So if it's okay to put some context into this. So  
 2 approaching that first wave of the pandemic, the  
 3 thinking very much was we would have our normal critical  
 4 care patient workload and we would have an additional  
 5 Covid patient population of an unknown size and critical  
 6 care teams often provide support to ward teams and  
 7 patients in terms of providing support and advice and  
 8 helping them to help patients make a decision about if  
 9 they deteriorated if they would want to come to critical  
 10 care.

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

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

25 **Q.** So if I understand what you are saying correctly, is it

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1 you were saying that generally at the point of referral  
 2 to critical care, that's when you would decide whether  
 3 or not someone was appropriate for escalation to  
 4 critical care. What about in circumstances where the  
 5 guidance is telling us that you need to make a decision  
 6 about whether someone's appropriate for critical care at  
 7 the point at which they're admitted to hospital? Does  
 8 that change in any way the patient experience?

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

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

22 But this was about saying when a person comes to  
 23 hospital it's really important to involve them in the  
 24 plans for their care and the discussions around what  
 25 they want for their treatment at the earliest possible

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1 phase because we were not aware of how their condition  
 2 was going to then subsequently be managed over the --  
 3 **Q.** The Inquiry -- sorry to cut across you, but the Inquiry  
 4 has heard a lot of evidence about the difficulties of  
 5 having conversations with patients and with their  
 6 families within the context of the pandemic. Was it  
 7 possible, do you think, to have these conversations at  
 8 an early stage?  
 9 **A.** We as the Faculty of Intensive Care Medicine have been  
 10 trying to support individuals and families to  
 11 contemplate what an intensive care admission means for a  
 12 long time before the pandemic. So we had produced  
 13 documents to enable individuals to consider that and  
 14 other hospital services to consider that.  
 15 For us, the perspective was very much on not  
 16 missing the opportunity to have this conversation with  
 17 somebody because it was an important conversation.  
 18 So it was about making sure that that attempt was  
 19 made and to try and have that conversation rather than  
 20 to leave it to the point where it was going to be  
 21 impossible to have that conversation.  
 22 **Q.** Can I ask you about the second part of this sentence.  
 23 It says "On admission to hospital" -- we've looked at  
 24 that:  
 25 "... assess all adults for frailty, irrespective  
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1 the format of the guideline was NICE's decision.  
 2 **Q.** The Inquiry understands there was then some  
 3 correspondence with various groups, including I think  
 4 MENCAP on behalf of learning disability -- people with  
 5 learning disabilities, apologies, and the guideline was  
 6 then amended.  
 7 If we could then have a look at that amended  
 8 guideline. This is -- and we might be able to put it on  
 9 the screen as a comparison here. It's INQ000315780.  
 10 So -- here we go.  
 11 This is the amended version. So we can see here  
 12 there is a series of further caveats now in terms of how  
 13 to use the clinical frailty scale, in particular the  
 14 second bullet point:  
 15 "[It] should not be used in younger people, people  
 16 with stable long-term disabilities (for example,  
 17 cerebral palsy), learning disabilities or autism. An  
 18 individualised assessment is recommended in all cases  
 19 where the CFS is not appropriate."  
 20 My question really is a similar one. It's right,  
 21 isn't it, that the first iteration should have included  
 22 all of these caveats?  
 23 **A.** Yes.  
 24 **Q.** Thank you. That can come down.  
 25 **A.** If I could also add to that?  
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1 of age and Covid-19 status."  
 2 Then it goes on to recommend using the clinical  
 3 frailty scale for frailty assessment.  
 4 Is it right that the clinical frailty scale is not  
 5 appropriate to use on people who have long-term stable  
 6 disabilities or are under 65?  
 7 **A.** Yes, that's correct. It has not been developed for use  
 8 in those groups.  
 9 **Q.** This guideline didn't make that clear, did it?  
 10 **A.** No.  
 11 **Q.** Why was this omission allowed to come into the published  
 12 guidance?  
 13 **A.** I do not know. As I said, we provided advice to NICE in  
 14 the drafting of it. I do not recollect ever having a  
 15 conversation in which we were specifically asked about  
 16 particular groups of individuals. But obviously, you  
 17 know, we would be clear about where the frailty scale  
 18 had been validated and who it was intended to apply to.  
 19 **Q.** Sorry, just to clarify, I thought that the Faculty of  
 20 Intensive Care Medicine co-wrote this guideline. Is  
 21 that not correct?  
 22 **A.** We provided advice with the chair of the Clinical  
 23 Reference Group to NICE. NICE wrote the guideline and  
 24 we provided advice to them and input to them around the  
 25 writing of the guideline but the final decision around  
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1 **Q.** Please do.  
 2 **A.** I think it's also important to make the point that  
 3 people should be helped to have the conversations that  
 4 are required and are given the support that they need to  
 5 have those conversations and that's something that we  
 6 always have tried to do within intensive care medicine.  
 7 So it was not a change in our practice that we would  
 8 have not looked to try and provide support to  
 9 individuals to help them make a decision. That was not  
 10 intended to change.  
 11 **Q.** You made clear earlier that this guidance, it's not  
 12 guidance designed to be used in the event of a  
 13 saturation of critical care resources. I've been asked  
 14 to ask you by one of the core participants whether you  
 15 think that directing healthcare professionals to the  
 16 clinical frailty scale without caveats in the beginning  
 17 could have encouraged rationing of care on this basis  
 18 and indeed the use of DNACPRs because people were  
 19 scoring poorly on the clinical frailty scale?  
 20 **A.** Our intention and our advice was very much around  
 21 helping as many people as possible to be given the  
 22 information they needed to make a decision about their  
 23 care and treatment, and bearing in mind we were looking  
 24 at a large number of people who could potentially  
 25 require intensive care treatment at a time in the  
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1 pandemic when there was no other treatment that impacted  
2 on the course of Covid or the outcome from Covid, all  
3 intensive care treatments at that time were supportive  
4 and didn't impact on what the disease did to the  
5 individual, and all of those supported treatments had an  
6 associated morbidity and harm in themselves. It was  
7 really important to make sure that as many people  
8 understood what an intensive care admission involved as  
9 possible to allow them to be clear about whether or not  
10 they wanted to have that and contemplate that.

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

15 **A.** Could you --

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

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

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1 they normally did which is use their normal ethical and  
2 decision-making processes and what the position was  
3 going to be under that circumstance.

4 So there was a concern that that situation might  
5 arise, most predominantly in the early phase of the  
6 first wave of the pandemic when people didn't have the  
7 experience that they subsequently had.

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

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

24 **Q.** Sorry, can I ask you -- why, why does it need to have  
25 endorsement from NHS England or NICE? Why couldn't an

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1 does involve involving patients.

2 So we know when resource is impacted the ability  
3 to take people to monitor them is reduced but the actual  
4 behaviour in terms of the conversations and the ability  
5 to offer treatment should not be impacted and we made  
6 that very clear to our members throughout.

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

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

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

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

23 **A.** Yes. Our members were clear that they were not -- were  
24 concerned about what happened if resources were  
25 significantly impacted and they could no longer do what

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1 organisation within the intensive care sphere have  
2 published their own guidance?

3 **A.** I think the fundamental intention of guidance is to help  
4 individuals but we were very clear that there were  
5 a number of issues around a single organisation  
6 producing guidance, not the least of which is the  
7 importance of guidance being able to respond to the  
8 change in the knowledge base, in the information, being  
9 able to monitor and change that guidance appropriately,  
10 to have the appropriate consultation and understanding  
11 of all endorsing organisations and to also have a wider  
12 involvement of the public and an understanding that this  
13 was in place.

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

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

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1 event?  
 2 **A.** If I can go back to the NICE guidance, when we were  
 3 advising NICE, we had actually identified with NICE that  
 4 we felt at that point that we wanted something to go  
 5 into the guidance to say where to look for guidance if  
 6 the system became overwhelmed but that piece of advice  
 7 that we gave was never produced into the final document.

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

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

25 **A.** Well, our view very much was that there needed to be a  
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1 in case it was needed. But I haven't any particular  
 2 knowledge -- we haven't any particular knowledge of why  
 3 certain tools were developed. Our view, very much, was  
 4 that there needed to be a consistency and there needed  
 5 to be a common shared understanding of what was going to  
 6 be done and who was going to be responsible for that.

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

14 **A.** So, going back to that first wave and that first phase,  
 15 that's when the fear amongst clinicians was greatest  
 16 because of what people had observed particularly in  
 17 Italy two or three weeks before. So that was the point,  
 18 if you like, of heightened anxiety. But inevitably, as  
 19 that experience developed in the first wave, people's  
 20 clinical experience improved and their confidence  
 21 improved, and obviously by the time we got to the second  
 22 wave we had different ways of managing patients with  
 23 Covid. We had much more effective use of mutual aid in  
 24 terms of transferring patients. It went from a  
 25 situation very early on, of a fear that such a tool  
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1 clear instruction to embark on that kind of activity and  
 2 that that really needed to come from a central  
 3 organisation and that it did need to have a wide  
 4 endorsement so that people were understanding why this  
 5 activity was taking place and that's why we took the  
 6 view that it needed to be a central organisation that  
 7 took ownership and leadership of this. We were  
 8 consistent in that view throughout.

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

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

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

21 **Q.** Just generally --

22 **A.** Generally, I think our view very much is that that kind  
 23 of activity developed probably because there was an  
 24 absence of nationally-agreed guidance and that people  
 25 with the best intentions were trying to develop a tool  
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1 might be required, to an understanding that the baseline  
 2 had changed, and it was not required at that point.

3 There was an understanding that it might be  
 4 required at a future point, but we had other options,  
 5 clinical options available.

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

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

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

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

6 **MR FIREMAN:** Thank you.

7 My Lady, I'm going to turn to another topic so it  
8 might be an appropriate time to have a ten-minute break?

9 **LADY JUSTICE HALLETT:** Certainly.

10 I hope you were warned about our breaks, Doctor.

11 I shall return at 3.25.

12 (3.09 pm)

(A short break)

14 (3.25 pm)

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

16 Dr Bryden, I want to turn to a different topic now  
17 which we foreshadowed earlier which is redeployment.  
18 Can I ask you about it both from the perspective of  
19 anaesthetists and also intensivists, because  
20 I understand your organisations represent both of those  
21 professions.

22 With respect to anaesthetists, were the majority  
23 or a high proportion of them redeployed to intensive  
24 care units?

25 **A.** It's important to consider the various phases of the

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

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

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

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

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

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1 pandemic and the involvement of our anaesthetic  
2 colleagues in supporting intensive care units. All  
3 anaesthetists do some intensive care medicine training  
4 and certain hospitals at times of particular pressure  
5 and at certain points of the pandemic will have had  
6 support from anaesthetists to provide additional input  
7 into the critical care unit.

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

15 **Q.** So just, generally speaking, during the peaks of the  
16 pandemic, were anaesthetists going to intensive care  
17 units in higher proportions than they would normally  
18 have been?

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

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1 anything we could be doing in non-pandemic times to  
2 enable the transition to intensive care to be easier?

3 **A.** Yes, and if again I can provide a degree of context. So  
4 prior to pandemic the Faculty of Intensive Care Medicine  
5 had done some work on the development of an enhanced  
6 care service. This was around supporting patients on  
7 elective care pathways who didn't need a full intensive  
8 care admission but needed more treatment in care than  
9 could be supported on the ward, and that service could  
10 be managed by our anaesthetic colleagues and, again, our  
11 anaesthetic colleagues were very supportive of the  
12 concept of trying to provide more for patients on the  
13 perioperative care pathway because a lot of them do work  
14 in perioperative medicine.

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

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

25 **A.** Absolutely. We have been clear from the publication of

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1 the initial enhanced care report in, I think it was  
2 May 2020, and then the subsequent report that we wrote  
3 with the Centre for Perioperative Care around how you  
4 provide enhanced care services for perioperative  
5 surgical patients that the benefit of this is great for  
6 the patient because it provides them a secure pathway  
7 for elective surgery but it's also beneficial for staff,  
8 both medical and nursing, and allied health  
9 professionals because it keeps a degree of skills up  
10 that were perhaps not as recent at the start of the  
11 pandemic.

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

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

24 I think from a nursing perspective, and this is a  
25 completely different perspective, the pressure on

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1 **Q.** In some ways one can see, obviously, how the additional  
2 support was helpful but having to supervise untrained  
3 staff in addition to looking after patients at stretched  
4 ratios, did that carry an additional burden for some of  
5 those intensive care nurses?

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

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

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

21 **Q.** Is it not right that within the context of surgery an  
22 anaesthetist has a very considerable role. Particularly  
23 in the context of suspending elective surgery, would  
24 that not have resulted in a number of anaesthetists who  
25 would ordinarily have been working in elective care

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1 nursing staff of working with individuals who don't have  
2 those skills is very different and the concerns around  
3 supervising individuals who haven't got basic intensive  
4 care nursing skills was a considerable burden for our  
5 nursing colleague. I'm aware of that.

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

11 **A.** Yes.

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

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

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1 moved out of that area?

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

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

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

25 Is it the case, then, that practically even had

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1 the decision not to pause elective surgery been taken,  
2 it would have been very difficult to have continued with  
3 elective surgery in any event?

4 **A.** What we know from our surveys and experience at the time  
5 is it was very variable and it very much depended on  
6 local arrangements and local facilities. So where you  
7 had an intensive care service that was well resourced  
8 that you were able to provide a Covid-secure pathway,  
9 perhaps your estate was amenable to being able to  
10 provide a Covid-secure pathway for patients, that made  
11 doing some elective surgery much easier and perhaps the  
12 larger hospitals had the ability to do that because they  
13 had more flexibility than some of the smaller hospitals  
14 had.

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

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

21 **A.** I think there was an understanding that at that period  
22 it was going to be necessary in order to ensure that we  
23 had sufficient individuals who were able to respond to  
24 that first wave of the pandemic because we didn't know  
25 at that point how severe it was going to be, but our

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1 went into the pandemic with about 50% too few  
2 anaesthetists. We knew we also had too few intensivists  
3 as well and that that had an impact on our ability to  
4 provide support to elective operating.

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

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

25 **A.** So if I could go back to the provision of intensive care

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1 organisations were also involved in producing guidance  
2 to help local Trusts and services identify how they  
3 could safely reintroduce elective operating at the  
4 earliest point. So we were also very keen to support  
5 our members and our services to make sure that patients  
6 were brought back in for surgery as soon as we could  
7 safely do so.

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

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

24 Do you agree with that broad statement?

25 **A.** Yes, and if I can add some additional context. So we

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1 beds and facilities, we know that across all four  
2 nations of the UK that baseline was not equal and we  
3 have health inequality. So going back to pre-pandemic,  
4 Wales and Northern Ireland had intensive care bed  
5 occupancy that was over 95%. Even within that 10 per  
6 100,000 figure quoted for England, there were certain  
7 parts of England, namely London, that had more intensive  
8 care beds than other parts of the country. If the  
9 pandemic was then impacting not equally on all areas of  
10 the country at the same time, you will then have a  
11 situation where certain services will be in a better  
12 position to restart than others.

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

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

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

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1 **A.** I think it's difficult to be certain about that because  
 2 we know that particularly over the winter of  
 3 December 2020/January 2021, there was extreme pressure  
 4 on the NHS in general, and again the complexities of  
 5 keeping patients without Covid coming for elective  
 6 surgery safe and protected from areas of the hospital  
 7 where there were large numbers of patients with Covid  
 8 that ability wasn't there.

9 **MR FIREMAN:** Thank you very much, Dr Bryden.  
 10 My Lady, that's all I ask.

11 **LADY JUSTICE HALLETT:** Thank you very much, Mr Fireman.  
 12 Ms McDermott.

13 Questions from MS McDERMOTT

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

2 So, during the pandemic when there were increased  
 3 numbers of patients presenting, we had that situation of  
 4 even more pressure, and therefore needing additional  
 5 support, in order to be able to do what was asked of us.

6 **Q.** That's somewhat of a separate topic in terms of you've  
 7 mentioned in your evidence about Wales and  
 8 Northern Ireland having bed space of already ICUs over  
 9 95%, that's different to then actually having the staff,  
 10 isn't that correct?

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

17 **Q.** Thank you. Considering your statement in the round from  
 18 the perspective of those which I represent from  
 19 Northern Ireland, your statement contains very limited  
 20 reference to data emanating from Northern Ireland. Now,  
 21 I don't expect you to know this offhand, but on  
 22 11 October 2022, the Royal College of Anaesthetists  
 23 Northern Ireland held a board meeting, and at that  
 24 meeting it was certainly anticipated that the Northern  
 25 Ireland Royal College of Anaesthetists would contribute  
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1 staff to call upon to meet the expected staffing  
 2 standards.

3 Now, the Faculty of Intensive Care Medicine  
 4 carried out a survey during November 2020, and in  
 5 response to the question "Do you think any increase in  
 6 ICU footprint has been adequately staffed?", 82% of the  
 7 respondents said no.

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

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

18 The other important message that we made very,  
 19 very clear right from the beginning was capacity was not  
 20 just around the physical space and the provision of a  
 21 bed of a piece of equipment; it was around the human  
 22 resource, if you like, the ability to care for and treat  
 23 an individual. And, again, we had identified the fact  
 24 that we didn't have sufficient numbers of critical care  
 25 staff who had been adequately trained at the start of  
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1 to this Inquiry. There was then a debate as to whether  
 2 it would partner with the Academy of Medical Royal  
 3 Colleges or whether it would stand alone as an  
 4 organisation with a reluctance to the latter because of  
 5 cost implications.

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

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

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

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

25 **Q.** If the Northern Ireland college -- the Royal College of  
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1 Anaesthetists Northern Ireland branch had worked with  
 2 you, did they liaise with you in providing your  
 3 statement or information to this Inquiry?  
 4 **A.** So the information that is in my statement is from all  
 5 three organisations, and my understanding is that the  
 6 Royal College of Anaesthetists has drawn its information  
 7 from its wider college membership and information that  
 8 it held at the time.  
 9 **Q.** So then, looking at your statement specifically, do you  
 10 accept that there's very little or very limited  
 11 reference to data in Northern Ireland?  
 12 **A.** I would accept that, yes.  
 13 **Q.** I'm grateful. In a similar vein, your statement makes  
 14 no mention of any meetings or engagement between the  
 15 Northern Ireland branch of your body, with either the  
 16 Chief Medical Officer for Northern Ireland or the  
 17 medical directors for the Health and Social Care Trust  
 18 of Northern Ireland during the pandemic. Are you aware  
 19 that any such engagement ever took place?  
 20 **A.** Again, I'm not directly aware of that but I can find out  
 21 for you.  
 22 **Q.** Okay. And if you are to provide that information to the  
 23 Inquiry, perhaps you could follow that up with what the  
 24 reasons were, if the answer is in the negative, if they  
 25 didn't engage with the CMO and the medical directors?

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1 board members of the Faculty of Intensive Care Medicine  
 2 was also a member of the Academy of Medical Royal  
 3 Colleges in Wales and was also, as I understand it,  
 4 engaging with the Chief Medical Officer for Wales.  
 5 **Q.** And within that engagement, are you aware what issues,  
 6 if any, were raised?  
 7 **A.** I would not be aware of specific issues in relation to  
 8 Wales, but again I can find that out for you. But my  
 9 understanding is that a lot of the issues in relation to  
 10 Wales were very similar to the issues in relation to the  
 11 rest of the UK in addition to, as I've already  
 12 highlighted, the very poor provision of intensive care  
 13 beds in Wales that was known about prior to the  
 14 pandemic -- so the lack of resource, and the impact that  
 15 that was having on Wales.  
 16 **Q.** Thank you, Doctor. That brings me on to my next topic.  
 17 In paragraph 105 of your witness statement, you  
 18 set out for the Inquiry and I'll read it for you,  
 19 Doctor:  
 20 "The highest level recommended for intensive care  
 21 bed-fill rate for safe and efficient patient care is  
 22 85%. However, ICUs were running above this  
 23 pre-Covid-19, making the UK woefully underprepared to  
 24 cope with the large additional demand for intensive  
 25 care."

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1 **A.** Yes.  
 2 **MS McDERMOTT:** Those are my questions, I'm very grateful, my  
 3 Lady.  
 4 **LADY JUSTICE HALLETT:** Thank you, Ms McDermott.  
 5 Ms Cat Jones.  
 6 **Questions from MS JONES**  
 7 **MS JONES:** Dr Bryden, I ask questions on behalf of the Covid  
 8 Bereaved Families for Justice Cymru Group, or Wales, and  
 9 I'd like to ask you first of all about communication  
 10 with Wales and Welsh bodies.  
 11 Other than the Royal College of Anaesthetists  
 12 Welsh board having representation on the Academy of  
 13 Medical Royal Colleges Wales, which met with the CMO  
 14 every two or three weeks as you outlined for us at the  
 15 beginning of your evidence, was there any other  
 16 engagement between the Royal College of Anaesthetists,  
 17 the Faculty of Intensive Care Medicine and/or the  
 18 Association of Anaesthetists, with either Welsh  
 19 Government or with Public Health Wales that you are  
 20 aware of?  
 21 **A.** So prior to the pandemic, the Faculty of Intensive Care  
 22 Medicine conducted a workforce engagement event in Wales  
 23 and also met with the health minister at the time, who  
 24 then became the First Minister. So we had engaged,  
 25 prior to the pandemic, during the pandemic, one of the

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1 Then you go on in paragraph 106 to set out some  
 2 survey data from the FICM taken in 2018, which showed  
 3 the bed-fill rate in Wales was estimated to be at least  
 4 95% in 2018.

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

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

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

17 **MS JONES:** Thank you, Doctor.

18 My Lady, those are my questions.

19 **LADY JUSTICE HALLETT:** Thank you, Ms Jones.

20 Ms Peacock.

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

25 **A.** Okay.

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1 **Questions from MS PEACOCK**

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

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

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

16 **A.** So my understanding is that that was effectively around  
17 the first wave of the pandemic and some of the  
18 conversations were particularly around providing  
19 training materials and very rapid upskilling for staff  
20 that would be working in the Nightingale hospitals. We  
21 were supplied with information from some of the local  
22 London hospitals around the information that or the  
23 materials that they were using for the -- or proposing  
24 to use that the London Nightingales and we were then  
25 advising and trying to identify how they could be made

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1 **A.** So I think we were clear from the very beginning that we  
2 had insufficient critical care staff to, if you like, as  
3 a baseline going into the pandemic and throughout we  
4 were very, very clear that provision of an intensive  
5 care bed was not just around the bed and the equipment,  
6 it was the human resource. So it was around having the  
7 individuals who could care for patients that were in  
8 those beds and that was a consistent view that we took  
9 both in terms of public information and messaging and  
10 also in terms of private messaging in terms of meetings  
11 that we were having around saying that it was around  
12 identifying a resource that was more than a physical  
13 one.

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

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

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1 more generic for the Nightingales, in addition liaising  
2 with Health Education England at that time around how we  
3 could recognise the skills of staff that may be working  
4 in those units both in terms of pre-existing skills and  
5 then recognising any skills that were required  
6 subsequently to enable staff to effectively passport to  
7 say that they had worked in an area and could transfer  
8 to working in another area because they had the  
9 appropriate skill set.

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

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

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

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1 those facilities.

2 **Q.** But your evidence in your statement, if I'm correct, is  
3 that the staffing levels available at that time would  
4 potentially render the project unviable. That's at  
5 paragraph 40.

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

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

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1 **A.** So, again, I think we have been consistent from before  
 2 the pandemic and across the four nations of the UK and  
 3 throughout the pandemic that the critical care service  
 4 that existed prior to the pandemic was already under  
 5 pressure and we were consistent throughout the pandemic  
 6 that it was the human resource that was going to be the  
 7 rate limiting step and that is why we needed the support  
 8 of colleagues from the rest of the hospital and the  
 9 impact that that had in patient care in the rest of the  
 10 hospital because those staff members were not available  
 11 to provide the care and treatment that they needed.  
 12 **MS PEACOCK:** Thank you, I have used up my time so I will  
 13 leave that there. I am grateful, my Lady.  
 14 **LADY JUSTICE HALLETT:** Thank you, Ms Peacock.  
 15 Those are all the questions we have for you,  
 16 Dr Bryden. Thank you very much indeed for your help.  
 17 I am very grateful. I shall return at 10.00 tomorrow.  
 18 **(The witness withdrew)**  
 19 **(3.59 pm)**  
 20 (The hearing adjourned until 10.00 am  
 21 on Wednesday, 9~October 2024)  
 22  
 23  
 24  
 25

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<p><b>Y</b></p> <p><b>yeah [5]</b> 24/17 28/15 98/19 98/22 128/23</p> <p><b>year [5]</b> 99/10 99/16 100/13 106/13 120/25</p> <p><b>years [5]</b> 24/25 29/8 63/23 70/18 70/19</p> <p><b>yes [113]</b> 1/25 2/3 5/18 8/18 12/3 17/6 19/14 28/24 28/25 31/24 32/1 32/21 36/15 36/15 39/5 40/15 42/12 49/1 49/11 49/12 56/5 56/8 57/6 59/6 64/19 65/7 67/15 69/2 70/14 70/25 71/15 73/9 74/2 75/6 76/8 77/7 78/17 79/13 79/21 80/5 85/16 86/18 87/21 88/2 88/15 89/6 89/18 92/19 97/18 100/6 100/12 100/14 100/17 100/20 100/22 102/2 102/19 103/6 103/22 104/10 108/23 110/4 111/18 111/20 115/4 115/11 116/15 118/1 118/18 118/20 119/16 119/20 119/22 125/12 125/15 125/19 126/1 126/14 126/17 127/2 127/12 127/16 128/2 128/23 129/3 129/6 130/16 130/19 130/22 131/2 131/5 132/2 132/7 139/3 139/7 140/9 140/19 141/2 143/3 143/16 146/7 147/23 150/23 158/19 160/3 162/11 164/2 164/18 166/25 171/11 173/12 174/1 180/6</p> <p><b>yet [5]</b> 33/11 39/10 39/13 86/16 88/23</p> <p><b>you [767]</b></p> <p><b>you'll [1]</b> 1/12</p> <p><b>you're [10]</b> 28/17 50/6 50/7 54/17 64/23 64/23 83/24 84/9 114/7 155/8</p> <p><b>you've [17]</b> 1/15 39/6</p>				