

Wednesday, 9 October 2024

1  
2 (10.00 am)  
3 **LADY JUSTICE HALLETT:** Yes, Mr Mills.  
4 **MR MILLS:** My Lady, may I please call the witness M3/WI who  
5 will affirm.  
6 **MS NORA OHRENSTEIN (Interpreter) (affirmed)**  
7 **M3/WI (affirmed)**  
8 **Questions from COUNSEL TO THE INQUIRY**  
9 *(Interpreted, unless otherwise indicated)*  
10 **MR MILLS:** You are providing evidence to the Inquiry this  
11 morning under the cypher M3/WI; is that right?  
12 **A.** (In English) Yes.  
13 **Q.** During the pandemic, you worked as a cleaner in  
14 a hospital?  
15 **A.** (In English) Yes.  
16 **Q.** It is right, isn't it, that you were not directly  
17 employed by the hospital but you worked for  
18 an outsourced company?  
19 **A.** Yes.  
20 **Q.** Can you begin by describing to us your normal working  
21 day before the pandemic?  
22 **A.** My usual day before the pandemic was working in the  
23 cardiology floor, three hours a day.  
24 **Q.** When the pandemic began, did your working hours  
25 increase?

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1 family, it was something to be considered.  
2 **Q.** I would like to explore that a little bit.  
3 **A.** (In English) Okay, no problem.  
4 **Q.** What did you fear would happen if you had said no to  
5 working longer hours?  
6 **A.** I feared losing my job, everything was closing down at  
7 the time.  
8 **Q.** Were you told which wards in the hospital were being  
9 used for treating patients with Covid-19?  
10 **A.** We had no information whatsoever.  
11 **Q.** Did that make you feel anxious?  
12 **A.** Yes, I was very anxious. I didn't even take a lift  
13 because I had fear.  
14 **Q.** Did you ask your supervisor or anyone within the  
15 management of the hospital to tell you which wards were  
16 being used for treating patients with Covid-19?  
17 **A.** They didn't provide information but I heard rumours,  
18 just rumours that perhaps they were all on the fourth  
19 floor.  
20 **Q.** As well as cleaning wards, I think it is right that you  
21 also cleaned individual rooms?  
22 **A.** Yes.  
23 **Q.** Was the patient ever in the room when you were cleaning  
24 the individual rooms?  
25 **A.** No, the patient was no longer there.

3

1 **A.** Yes, due to the situation we were going through.  
2 **Q.** How many hours did you have to start working?  
3 **A.** I would start work 6, 7 o'clock in the evening and go  
4 until 4, 5 am in the morning, depending.  
5 **Q.** And that was how many days a week?  
6 **A.** Usually for five days a week, but sometimes even  
7 weekends.  
8 **Q.** You said, before the pandemic, you were cleaning one  
9 department in the hospital. Were you asked, when the  
10 pandemic struck, to clean more areas of the hospital?  
11 **A.** Due to the situation, I was obliged to work for more  
12 hours during the crisis we were going through.  
13 **Q.** You refer to the "situation". I think it is right,  
14 isn't it, that the hospital was short-staffed at this  
15 time?  
16 **A.** Yes, short-staffed due to the illness we were suffering.  
17 **Q.** Is it right that many cleaners also were feeling too  
18 scared to go to work?  
19 **A.** Yes, we were short of staff all due to the pandemic.  
20 **Q.** In your statement you say this:  
21 "I also didn't really want to work additional  
22 hours but I felt pressured by the circumstances and  
23 didn't feel able to say no."  
24 **A.** Yes, because of the general circumstances, but also due  
25 to my own circumstances, having to pay rent, help my

2

1 **Q.** And again, were you told whether the patient whose room  
2 you were cleaning had Covid-19?  
3 **A.** No, we didn't receive any information at all.  
4 **Q.** Did you receive any training about how to clean  
5 differently in accordance with Covid-19 guidelines?  
6 **A.** No, we didn't have any information and we just went on  
7 cleaning the way we were cleaning before doing things to  
8 the best of our ability.  
9 **Q.** So you weren't, for example, given any new cleaning  
10 products?  
11 **A.** We started using a product called Bihe(?), and that's  
12 the one we used for everything.  
13 **Q.** Did you receive any guidance about Infection, Prevention  
14 and Control?  
15 **A.** No. No guidance, no information.  
16 **Q.** In the absence of guidance about infection prevention  
17 and control and about how to clean in a Covid-19  
18 compliant way, did you have concerns?  
19 **A.** I was very worried, I was -- I had fear of being ill  
20 myself, contagious.  
21 **Q.** Did you raise the concerns you had with anyone at the  
22 hospital?  
23 **A.** We had nobody to speak to. All we had to do was work  
24 and work.  
25 **Q.** What about with anyone at the outsourced company?

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- 1 A. No, nothing with them.
- 2 Q. In your statement you say this:
- 3 "Despite my concerns, I didn't raise a complaint
- 4 with my employers or with hospital management because
- 5 I was scared there would be negative consequences ..."
- 6 A. Yes, at that time I couldn't be without a job. We
- 7 needed to support ourselves.
- 8 Q. Do I take it that the negative consequence was that you
- 9 feared you would lose your job?
- 10 A. Yes.
- 11 Q. If you had fallen ill with Covid-19, would you have been
- 12 able to survive on the sick pay you were entitled to?
- 13 A. No. We had a very small pay, we didn't have the salary
- 14 we actually deserved.
- 15 Q. Did you in fact manage to avoid catching Covid-19 during
- 16 the pandemic?
- 17 A. Yes. Thank goodness that was the case. I looked after
- 18 myself, and together with my colleague, my partner.
- 19 Q. We will come on to some of the ways that you looked
- 20 after yourself. Can I first ask you this, if you had
- 21 fallen ill with Covid-19, would you have felt that you
- 22 had to carry on working because if you don't work you
- 23 wouldn't be paid your wage?
- 24 A. I would have done so, because I had to survive.
- 25 Q. I will come now to the personal protective equipment you

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- 1 myself that would be picking stuff up for myself and my
- 2 partner, my colleague.
- 3 Q. Did you receive any training about how to wear PPE and
- 4 how to safely dispose of it?
- 5 A. No, we didn't receive any training, but we knew
- 6 ourselves to use some orange bags that are for
- 7 contaminated articles, and we would use those to dispose
- 8 of ours.
- 9 Q. Taking all of this together can I ask you this, did you
- 10 feel safe performing your job?
- 11 A. No, I didn't have any feeling of safety but I had to go
- 12 ahead and do things.
- 13 Q. Did you receive a testing kit at any point during the
- 14 pandemic?
- 15 A. Much later, not actually during the pandemic, the
- 16 pandemic itself, but much later we received some and we
- 17 had to check and report if we were found contaminated.
- 18 Q. How many boxes of testing kits did you personally
- 19 receive?
- 20 A. I believe three perhaps four, not many.
- 21 Q. Can I move finally to ask you about your physical and
- 22 mental well-being during this time.
- 23 Can you describe to us the impact that working
- 24 during the pandemic had on your mental health?
- 25 A. I suffer a great impact from all this situation, this

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- 1 were provided with. Was there a difference in the PPE
- 2 that outsourced workers like you received, compared to
- 3 what the employed clinical staff at the hospital were
- 4 given?
- 5 A. Yes. We only received a mask, a blue mask, and we had
- 6 to find, by ourselves, a way to protect ourselves.
- 7 And we were not actually given this mask, we had
- 8 to pick them up ourselves, find them ourselves.
- 9 Q. Find them outside of the hospital?
- 10 A. They were not given to us, we had to pick them sometimes
- 11 from reception, sometimes from some consulting room
- 12 where there were some spares.
- 13 Q. In addition to the mask, did you acquire any other PPE
- 14 to give yourself greater protection?
- 15 A. No, they didn't give us anything but myself, together
- 16 with my partner, will pick up things from places where
- 17 they would be available.
- 18 Q. What kind of --
- 19 A. By hiding ourselves we will pick them up.
- 20 Q. What kind of things? What kind of things?
- 21 A. Hats, aprons, stronger masks.
- 22 Q. You say "they" wouldn't give us; were you and your
- 23 colleagues asking for more PPE?
- 24 A. No, we had nobody to ask. We only had a supervisor who
- 25 would say always, "Later on, later on", so it was mainly

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- 1 fear of becoming ill, I had an obligation towards my
- 2 family, the whole thing caused a lot of stress.
- 3 Eventually I lost a lot of weight too due to this
- 4 stress.
- 5 Q. Were you ever asked about your well-being by either the
- 6 hospital management or the outsourced company you worked
- 7 for?
- 8 A. At no time we had any questions from them or any
- 9 inquiries from them.
- 10 Q. Can I ask how that made you feel?
- 11 A. I had just the support of my sister, she works in
- 12 Colombia as a nurse and she was the one that supported
- 13 me.
- 14 Q. Do you think that you and your colleagues have received
- 15 the recognition you deserve for the work you performed
- 16 during the pandemic?
- 17 A. Not at all. Not at all.
- 18 Q. Finally this, I think it is right, isn't it, that you
- 19 and your colleagues are now employed directly by the
- 20 hospital?
- 21 A. At this present time yes.
- 22 Q. Can you tell us how, if at all, that has improved your
- 23 working conditions?
- 24 A. There has been some improvement in the payment, not as
- 25 much as should be but yes, better than before.

8

1 **MR MILLS:** Thank you.

2 **LADY JUSTICE HALLETT:** Can I just ask, was it a private  
3 hospital or an NHS hospital? Please don't name the  
4 hospital but was it private or NHS?

5 **A.** As far as I know it is a private hospital.

6 **LADY JUSTICE HALLETT:** Thank you.  
7 Those are all the questions we have. Thank you  
8 very much for your courage in coming forward to help us.  
9 It is absolutely essential that we hear from a wide  
10 range of people who were working throughout the pandemic  
11 in hospitals. So we are very grateful.

12 **A.** Thank you and it has been very hard.

13 **LADY JUSTICE HALLETT:** I can imagine. Thank you. I have  
14 been asked to rise while we break for the next  
15 witnesses. I shall return as soon as we are ready.  
16 **(The witness withdrew)**  
17 **(10.25 am)**  
18 **(A short break)**  
19 **(10.31 am)**  
20 **PROFESSOR CHARLOTTE SUMMERS (continued)**  
21 **DR GANESH SUNTHARALINGAM (continued)**  
22 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**  
23 **(continued)**  
24 **LADY JUSTICE HALLETT:** Ms Carey.  
25 I am sorry about last week.

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1 inevitably time-critical decisions. By the nature of  
2 these conditions, they can happen quickly, some  
3 unexpectedly, and wherever possible the patient's wishes  
4 and values, their own thoughts about what will happen to  
5 them and what outcomes they would like should be known  
6 where possible.

7 **MS CAREY:** So outside of the pandemic one might, for  
8 example, embark on an advance care plan if they know  
9 they have cancer and unfortunately that it is now at  
10 a terminal stage?

11 **DR SUNTHARALINGAM:** Yes, I think anyone who, for whatever  
12 reason, is nearing the end of their life, to their  
13 knowledge, or is at risk of death for whatever reason.

14 **MS CAREY:** Now, there are various iterations of forms but  
15 there's one I would like to ask you about, acknowledging  
16 as I do that it is not the only form out there. But can  
17 we have a look, please, at the ReSPECT form. Can you  
18 just help us please, what is this intended for?

19 **DR SUNTHARALINGAM:** So this is a model which, and to make  
20 this point, it really encapsulates what is already good  
21 practice, so it is not new policy. What it brings is a  
22 way of systematically looking at things which are  
23 already known to be important, and that includes  
24 establishing a shared understanding of the patient's  
25 condition, what outcomes they value and fear

11

1 **MS CAREY:** My Lady, the next witness was in fact due to be  
2 Mrs Lesley Moore but due, unfortunately, to a family  
3 emergency she is unable to attend today and the Inquiry  
4 will update both you and the core participants in due  
5 course once we are able to do so.  
6 Can we return then please to Professor Summers and  
7 Dr Suntharalingam. You are still under your oaths or  
8 affirmations that you made last week.  
9 And I would like to start with you, Doctor,  
10 please, on the topic of advance care planning and do not  
11 attempt cardiopulmonary resuscitation. All right?  
12 And if it helps you, Doctor, we are starting at  
13 paragraph 37 at your report.

14 **DR SUNTHARALINGAM:** Okay.

15 **MS CAREY:** Some people may find discussing this quite  
16 distressing, so can we take our time and set out the  
17 principles, the legalities and the realities at a steady  
18 and slow pace if we may.  
19 I would like to ask you please about why advance  
20 care planning is important generally and then why it was  
21 particularly important by the time we came to the  
22 pandemic. So could we start there.

23 **DR SUNTHARALINGAM:** I think the broadest way to look at it  
24 is that it is a way of ensuring the patient's informed  
25 wishes are taken into account when making what are

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1 importantly, and what medical treatments would benefit  
2 them and it is a structured way of looking at that in a  
3 way that leads to being able to write down the  
4 information for reference when it becomes relevant.

5 **MS CAREY:** It has been, I think you say, implemented in  
6 parts of England and Scotland since 2016 and I think it  
7 is currently being implemented across Northern Ireland.  
8 I will deal with Wales separately, but let's just look  
9 at the form itself.  
10 Obviously it has got the patient's details in  
11 there, the diagnosis or relevant information,  
12 communication aids, whether they need an interpreter.  
13 Would this also be used, for example, if someone had  
14 perhaps a support worker or needed someone to help  
15 communicate perhaps if they were learning disabled.  
16 Would that information all be included in there?

17 **DR SUNTHARALINGAM:** Yes, I think anyone close to the patient  
18 and able to represent -- firstly help them with the  
19 decision-making and also able to represent them.

20 **MS CAREY:** Then there is a box of:  
21 "Details of other relevant planning documents and  
22 where to find them."  
23 And "Advance Decision to Refuse Treatment" is  
24 different, isn't it, as I understand it?

25 **DR SUNTHARALINGAM:** Yes. So that's a legal instrument. Not

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1 so in Scotland but it would still be taken into account,  
2 so the sort of legal framework may differ but they,  
3 unlike these other documents which broadly can be  
4 considered called treatment escalation plans, the  
5 advance decision to refuse treatment is legally  
6 binding -- for the condition it applies for, it is  
7 important to say. So it may be for particular  
8 circumstances only.

9 **MS CAREY:** Right, so someone could say, for example, I don't  
10 want to have chemotherapy, let's take it outside of  
11 a pandemic context. They could make an advance decision  
12 to refuse treatment and that would be binding and  
13 therefore they would not have chemotherapy; is that  
14 correct?

15 **DR SUNTHARALINGAM:** Yes. So they have legally declared they  
16 are not consenting which is different to a statement of  
17 values and preferences.

18 **MS CAREY:** Organ donation may also be discussed. And then  
19 there is a section dealing with personal preferences  
20 where people explain what is important to them, the  
21 quality of life, that they might want to be able to do  
22 this but not that. Can you give us some examples of  
23 what might be included in that box there?

24 **DR SUNTHARALINGAM:** So if a discussion, for example, was  
25 around instituting mechanical ventilation, something

13

1 form, is it?

2 **DR SUNTHARALINGAM:** Yes. It includes the same information  
3 and in a way it is wider and one of the benefits of this  
4 sort of document is it avoids a DNACPR document in  
5 isolation becoming sort of accidentally seen as a proxy  
6 for wider treatment decisions. So by expressly  
7 including all of those and then including the CPR part  
8 as one end of the treatment process it puts it all into  
9 context.

10 **MS CAREY:** As we go on to page 2, we can see there that is  
11 reference to the capacity of the person at the time the  
12 ReSPECT form is being filled in, and then various  
13 options depending on who is involved in it, and the  
14 capacity of the person. ReSPECT forms and those like  
15 this, who are they ordinarily filled in by?

16 **DR SUNTHARALINGAM:** So by clinicians, but in terms of which  
17 clinicians, really those in the best position to do it  
18 at the time.

19 **MS CAREY:** Right.

20 **DR SUNTHARALINGAM:** Which, due to the nature of critical  
21 illness -- and it may obviously involve treatment other  
22 than critical care -- really, as early as possible, when  
23 it becomes relevant. So it may be somebody with  
24 a stable condition that they want to have taken into  
25 account, it may be somebody who has come into hospital

15

1 that might lead them to be weaker than they are already,  
2 then they might say, actually, if the risk is -- there  
3 is no certain outcomes -- but if there is a substantial  
4 risk that I'm going to be worse off than I am now, even  
5 if I survive the intensive care process, as an example,  
6 or -- and I wouldn't wish to be living under those  
7 conditions, I would only want aggressive treatment if it  
8 left me fully able to do certain activities, then that  
9 is to be taken into consideration. It is not  
10 an absolute bar but it provides their input into the  
11 decision.

12 **MS CAREY:** Right, and then it goes onto the clinical  
13 recommendations, and who fills in that part of the form?

14 **DR SUNTHARALINGAM:** So really this is about -- although it  
15 is signed by a clinician, the purpose of all these  
16 documents is to establish a shared understanding and  
17 an expression of values and preferences, so it would be  
18 done with the patient, or those close to them, or both,  
19 but it is filled in and signed by the clinician.

20 **MS CAREY:** Then we can see the boxes for signature, and if  
21 we look to the -- just pause there, please, just come  
22 down slightly, I just want to look at the box that's  
23 ringed in red where CPR attempts are not recommended.  
24 So this form can be used for someone to indicate whether  
25 they would want CPR but it is not a do not attempt CPR

14

1 with an acute condition, which case really as close to  
2 the front door as possible if they're able to take --

3 **MS CAREY:** So a GP could fill this in with a patient --

4 **DR SUNTHARALINGAM:** Yes.

5 **LADY JUSTICE HALLETT:** -- or if you were going through  
6 cancer treatment, you might fill it in with someone who  
7 is providing that treatment for you?

8 **DR SUNTHARALINGAM:** Yes.

9 **MS CAREY:** Clearly slightly different considerations by the  
10 time we get to critical care, potentially.

11 **DR SUNTHARALINGAM:** Yes.

12 **MS CAREY:** All right. And this form, where does it stay?  
13 On whose records?

14 **DR SUNTHARALINGAM:** I think that is an important point about  
15 this. The intention of the ReSPECT form, although  
16 similar, is that it is transportable, it stays with the  
17 patient. They themselves would have a copy. Where  
18 there are electronic systems across regions, it would be  
19 part of that, such as an electronic care plan.

20 And that contrasts with -- so it is an advantage  
21 over something like a DNACPR form which is very specific  
22 to an institution, so you may need different ones for  
23 the ambulance service than ones for the hospital.

24 **MS CAREY:** We are going to look at a DNACPR form in  
25 a moment. But do I understand it correctly that if

16

1 I went into hospital and I had a ReSPECT form if they  
2 called up my records they should find the ReSPECT form  
3 within them?

4 **DR SUNTHARALINGAM:** It does depend on the information  
5 systems, but also -- you know, in an ideal world you  
6 would have a copy with you, and you would be in  
7 a position to highlight it and say, look, here is my  
8 understanding of things at the moment.

9 **MS CAREY:** All right. Okay. This is a form in England,  
10 Scotland and being rolled out in Northern Ireland. Can  
11 we just consider the position in Wales. There is an All  
12 Wales DNACPR policy which is different and I will come  
13 back to that, but is there any equivalent of ReSPECT or  
14 a form like it operating in Wales?

15 **DR SUNTHARALINGAM:** So the overarching -- this is  
16 Resuscitation Council UK who I know you have as  
17 a witness subsequently, they have adopted this as their  
18 recommendation for all four nations. I think in terms  
19 of the implementation, it is my understanding is that  
20 the All Wales DNACPR form is under review as of  
21 June 2024.

22 **LADY JUSTICE HALLETT:** Right.

23 **DR SUNTHARALINGAM:** And certainly the expert recommendation  
24 from the Resuscitation Council is that it should be  
25 considered across all the nations.

17

1 please, about DNACPRs. And some basics, please, if  
2 I may, Doctor.

3 Is this the position, though, that in fact if you  
4 have a cardiac arrest outside of hospital the survival  
5 rate is relatively low, somewhere around 8%.

6 **DR SUNTHARALINGAM:** Yes.

7 **MS CAREY:** And if you indeed have a cardiac arrest and your  
8 heart stops in hospital, survival rate is higher but it  
9 is still only 23%?

10 **DR SUNTHARALINGAM:** Yes.

11 **MS CAREY:** Now, the DNACPR -- is this right -- means that  
12 cardiopulmonary resuscitation should not be started for  
13 that particular patient, or continued? Can you help me  
14 why there might be circumstances where someone has  
15 a DNACPR but nonetheless CPR has started and therefore  
16 needs to be stopped?

17 **DR SUNTHARALINGAM:** CPR itself is clearly time-critical,  
18 life-saving in those situations where it does work, but  
19 only when it is started promptly. So where there is any  
20 doubt, the presumption is always to start. Which is why  
21 paper DNACPR forms often have red borders, they can be  
22 easily identified, in electronic systems they are  
23 flagged prominently so that you know in advance -- or  
24 it's easy to spot, but if there's any --

25 **MS CAREY:** Pause there. We will pull one up on the screen

19

1 **MS CAREY:** Why would it help to have a form like ReSPECT  
2 working across all four nations?

3 **DR SUNTHARALINGAM:** In a practical sense, people obviously  
4 may travel across borders, and I think it is also about  
5 just establishing shared best practice, so even if you  
6 were to leave home, so to speak, if it works in one  
7 place, it should -- the principle should apply  
8 elsewhere.

9 It is probably worth emphasising this is, as we  
10 said, one form among many, and it is a way of capturing  
11 what are already existing principles. So it is about  
12 best practice rather than new policy.

13 **MS CAREY:** Whatever the actual format of the form, are they  
14 all asking similar questions and have similar  
15 considerations set out in them?

16 **DR SUNTHARALINGAM:** Yes.

17 **MS CAREY:** Understood. I think, and you say in your  
18 statement, you say there is a treatment escalation plan  
19 document created by one of the health boards that was  
20 adapted after Covid-19 and now carries the All Wales NHS  
21 logo, and that applies in hospitals in Wales. Is that  
22 correct?

23 **DR SUNTHARALINGAM:** That's my understanding.

24 **MS CAREY:** Clearly we have seen, on that ReSPECT form,  
25 reference to DNACPRs, and I would like to ask you,

18

1 so that everyone can follow what you are talking about.  
2 Could we have INQ000227411, please.

3 I won't go through the detail but we can just look  
4 at one so we can see. 227411. Page 23, sorry, it's my  
5 fault.

6 There we are. All right. This is an example of a  
7 DNACPR form, and we can see there clearly the red  
8 border. And where does that go on the patient's notes?

9 **DR SUNTHARALINGAM:** It can be in any particular place, but  
10 it should be easily identifiable. And to return to your  
11 previous question, the scenario where CPR may be stopped  
12 is where it has been started because a patient is  
13 observed to collapse. Appropriately, people may start  
14 if they weren't aware of the existence of this form, but  
15 once it is found, then it would be an indication to  
16 stop, so that's a scenario where that might arise.

17 **MS CAREY:** So the patient would be treated, but if someone  
18 had to go and locate the notes, for whatever reason, and  
19 then realise there was a DNACPR, that would be  
20 a circumstance in which you would stop, you wouldn't  
21 just leave the patient without any treatment --

22 **DR SUNTHARALINGAM:** Yes.

23 **MS CAREY:** -- pending location of the form?

24 **DR SUNTHARALINGAM:** Yes.

25 **MS CAREY:** I understood. And in fact this form says on it,  
20

1 it must be filled in at the front of the patient's  
 2 healthcare record --  
 3 **DR SUNTHARALINGAM:** Yes.  
 4 **MS CAREY:** -- and we'd hope it would be somewhere visible.  
 5 All right?  
 6 **DR SUNTHARALINGAM:** It is worth saying that the verbal  
 7 information about this, although it should be backed up  
 8 obviously by the document as well, form part of  
 9 handovers and ward safety briefings and so on so the  
 10 information is passed on from shift to shift, as it  
 11 were, or at handover.  
 12 **MS CAREY:** Okay. Now, I think there are different  
 13 circumstances in which a DNACPR notice may be made.  
 14 Is this right, firstly, they can be made in  
 15 advance where the person has the capacity to say,  
 16 "I don't want CPR"?  
 17 **DR SUNTHARALINGAM:** Yes.  
 18 **MS CAREY:** All right, and we have looked at an example of  
 19 that on the ReSPECT form, someone may come to that  
 20 decision of their own volition?  
 21 **DR SUNTHARALINGAM:** Yes.  
 22 **MS CAREY:** If someone comes to that decision, is that  
 23 decision respected? It is?  
 24 **DR SUNTHARALINGAM:** Yes.  
 25 For them to come to that position, they should  
 21

1 **DR SUNTHARALINGAM:** Yes.  
 2 **MS CAREY:** -- where a clinician has decided that there  
 3 should be a DNACPR notice?  
 4 **DR SUNTHARALINGAM:** Yes.  
 5 **MS CAREY:** Right. And is this the position, a patient or  
 6 loved one cannot demand CPR if it would be clinically  
 7 inappropriate?  
 8 **DR SUNTHARALINGAM:** That is right. It is a treatment  
 9 decision and the treatment itself, it is not a switch  
 10 where you simply decide to save someone's life, it is  
 11 a treatment process often quite intrusive, and it is  
 12 like any other treatment: you do it because you think it  
 13 will work.  
 14 **LADY JUSTICE HALLETT:** Sorry to interrupt. You say it is  
 15 a legal requirement that a patient should be consulted  
 16 before the decision is taken. Just looking at the form,  
 17 I appreciate that there are several boxes which include  
 18 having discussions with those close to the patient at  
 19 box 4, for example. But I'm just a bit concerned; box 1  
 20 or question 1:  
 21 "Has the patient appointed a health or welfare  
 22 attorney to make decisions on their behalf? If yes,  
 23 they must be consulted."  
 24 Surely that is not highlighting the fact that  
 25 there is a legal requirement that loved ones of the  
 23

1 obviously be able to have all the information about  
 2 their condition, which they have themselves, but to have  
 3 clinical scenarios explained to them or might be  
 4 relevant to this if they are acutely ill or things are  
 5 deteriorating, and despite access to support as well,  
 6 having written information where feasible. So, again,  
 7 it all comes to the benefits of having that discussion  
 8 early.  
 9 **MS CAREY:** Early. All right. Understood. There may also  
 10 be circumstances, though, where it is a medical  
 11 treatment decision, made by clinicians such as  
 12 yourselves, that CPR should not be offered because it is  
 13 not clinically appropriate, and I want to be clear about  
 14 that. In the circumstances where a clinician says, "We  
 15 shouldn't do CPR because it won't work", does the  
 16 patient or their loved one have to consent to that  
 17 clinical treatment decision?  
 18 **DR SUNTHARALINGAM:** No, they should be aware of it, and  
 19 should be able to be involved in it and, if necessary,  
 20 question it, but they don't specifically consent to it.  
 21 It is about what treatment may be clinically appropriate  
 22 and is on offer, so to speak.  
 23 **MS CAREY:** Am I right, though, that the law does require the  
 24 patient, if they have capacity, or their carers/loved  
 25 ones, to be consulted --  
 22

1 patient to be consulted by just taking the health and  
 2 welfare attorney example. Do you see what I mean?  
 3 **DR SUNTHARALINGAM:** Yes, yes, my Lady.  
 4 I think the way -- I think the issue of a  
 5 chronology is -- my understanding of this is that this  
 6 shouldn't come as a surprise, if you like to the patient  
 7 or those close to them after the event, it is not  
 8 necessarily the same as saying they must be consulted  
 9 first, so they should be made aware of it, and I agree  
 10 it should be anyone that is in a position to be  
 11 a representative of the patient if they themselves can't  
 12 take part in that discussion.  
 13 **LADY JUSTICE HALLETT:** I just wonder if that form should be  
 14 clearer?  
 15 **PROFESSOR SUMMERS:** I think the other important thing is  
 16 this is just one DNACPR form of one particular  
 17 organisation, I do not think there is one unified --  
 18 **LADY JUSTICE HALLETT:** They won't necessarily be the same.  
 19 **PROFESSOR SUMMERS:** It won't necessarily be the same in  
 20 every single institution. This is just one example of  
 21 such a form.  
 22 **LADY JUSTICE HALLETT:** No. I'm just --  
 23 **MS CAREY:** So this one, for example, does not refer to loved  
 24 ones, families, carers and the like, and people with  
 25 a power of attorney are in a potentially slightly  
 24

1 different category, it doesn't even mention that. But  
2 I don't want anyone to be confused between who has to be  
3 consulted.

4 I was going to look at the form, if I may,  
5 my Lady, and just go through some of the boxes.

6 But, does the patient have capacity to make and  
7 communicate decisions? If they do then they should be  
8 consulted. Is that the position?

9 **DR SUNTHARALINGAM:** Yes.

10 **MS CAREY:** Right. If they don't, you have to see whether  
11 there is an advanced decision to refuse treatment, in  
12 which case that would be legally binding, as  
13 I understand it. Do they have a health and welfare  
14 attorney, potentially called different things across the  
15 four nations?

16 **DR SUNTHARALINGAM:** Yes, this is the Welsh document --

17 **MS CAREY:** All right. This is the Welsh document, yes, to  
18 make decisions on behalf. But if they do have the  
19 health and welfare power of attorney in Wales or power  
20 of attorney in some other countries, then they must be  
21 consulted; is that correct?

22 **DR SUNTHARALINGAM:** It's correct, and it is worth making the  
23 point at this stage, which is relevant to other  
24 discussion as well, that a patient's capacity can be a  
25 stable fixed condition or it can change. So if somebody

25

1 those close to the patient, the health and welfare  
2 attorney, or a IMCA?

3 I'm afraid I'm not familiar with "IMCA". Can you  
4 help with that?

5 **DR SUNTHARALINGAM:** That is an independent advocate for --  
6 *(Unclear: simultaneous speakers)*

7 **MS CAREY:** Thank you. And then it is filled in, as we can  
8 see, by the healthcare professional, and they have to  
9 give various of their details.

10 Cancellation of decision, can I ask you about  
11 that. In what circumstances would a DNACPR be  
12 cancelled?

13 **DR SUNTHARALINGAM:** So the factors leading into that  
14 discussion are partly around the underlying condition of  
15 the patient, but also about their acute condition. And  
16 it may be their severity at that stage is such that it  
17 is felt that they wouldn't benefit further from CPR if,  
18 for example, they are already receiving maximum life  
19 support on intensive care. If their heart stops at the  
20 end of that, it may be felt that that's not going to  
21 benefit.

22 However, if they then, under the existing  
23 treatments, get better, then it may be -- and if that  
24 acute condition was part of the reason for the DNACPR,  
25 then that may need to be reversed. So it is very much

27

1 is confused and delirious on one day, they may not be  
2 the next, and even with the attorney involved, if the  
3 patient has capacity on the day, then that takes  
4 precedence.

5 **MS CAREY:** But to follow up to her Ladyship's question, in  
6 fact nothing on here about "Has the patient's family,  
7 loved one, carer been consulted?", and that ought to  
8 happen legally, as I understand it?

9 **DR SUNTHARALINGAM:** I think so. It is touched on in  
10 question 4 in terms of asking the question, but it says  
11 those close to the patient rather than specifying who  
12 that should be, so.

13 **MS CAREY:** Family, loved one, carer, it could be any one of  
14 the aforementioned, all right.

15 Then, the clinician has to fill in why CPR would  
16 be inappropriate, unsuccessful or not in the patient's  
17 best interests.

18 Has the discussion taken place with the patient,  
19 "yes" or "no"? If it has not been discussed that ought  
20 to be recorded in the form. And presumably would say  
21 patient is ventilated, patient is unconscious --

22 **DR SUNTHARALINGAM:** Yes.

23 **MS CAREY:** -- something along those lines.

24 **DR SUNTHARALINGAM:** Yes.

25 **MS CAREY:** Has an appropriate discussion taken place with  
26

1 a live document that is always under review.

2 **MS CAREY:** Who makes the decision to cancel the DNACPR?

3 **DR SUNTHARALINGAM:** Really the same set of clinicians who  
4 institute it -- potentially. So it may have been  
5 a DNACPR that was set up on a ward, they come to  
6 intensive care, things change. So, really the clinician  
7 looking after the patient at that time.

8 **LADY JUSTICE HALLETT:** Right. And then box 8:

9 "Copies of the DNACPR decision have been sent to:  
10 [The] patient/carers  
11 GP  
12 Nursing or Care Home."

13 In a hospital setting, is there someone  
14 responsible for sending the DNACPR to the patient or  
15 their carer and the GP?

16 **DR SUNTHARALINGAM:** I think --

17 **LADY JUSTICE HALLETT:** Or is that either/or?

18 **DR SUNTHARALINGAM:** Yes, it's either/or, and I think it  
19 comes under sort of discharge management and sharing  
20 information when the patient leaves the -- leaves the  
21 institution.

22 **LADY JUSTICE HALLETT:** And then if we just keep scrolling  
23 down slightly:

24 "All boxes must be completed.

25 In the event of cardiac or respiratory arrest, no  
28

1 ... (CPR) will be made. All other ... treatment and  
2 care will be provided."  
3 Clearly, I think you have made the point a number  
4 of times already in your report that a decision to not  
5 perform CPR is not the same as not treating someone in  
6 all other respects.

7 **DR SUNTHARALINGAM:** Yes.

8 **LADY JUSTICE HALLETT:** All right. And then there is various  
9 other parts of the form that I don't need to trouble you  
10 with.

11 Now, we have looked at this in a rather sterile  
12 and non-pandemic situation. But can I ask you please  
13 about how one fills in this form in critical care  
14 settings and perhaps, Professor, if I can come to you:  
15 if someone is brought into critical care and is not  
16 getting better, pre-pandemic, can you give us an example  
17 of how you would discuss DNACPRs with the patient's  
18 family?

19 **PROFESSOR SUMMERS:** As you rightly point out, it is often in  
20 the critical care setting with the patient's loved ones  
21 rather than with the patient themselves because at that  
22 point they have been so compromised that they are unable  
23 to participate in the discussions because they don't  
24 have capacity.

25 I suppose talking you through the nuts and bolts  
29

1 to this conversation?

2 I'm usually very clear that I'm not asking the  
3 family to make a decision, that the burden of that  
4 decision is made about what's clinically appropriate by  
5 the doctors, and explain very clearly that that's my  
6 responsibility, I'm not asking them to carry that burden  
7 and nor should anyone because you are asking them to  
8 make a decision about someone whom they love and care  
9 for very much at a time of great distress.

10 But it is important that they have the opportunity  
11 to input into that decision and then explain, having  
12 heard what they have said and reflected on what they  
13 have said about what they think the patient would think  
14 or any discussion that has ever happened, I explain my  
15 viewpoint on the situation as a clinician, that  
16 actually, taking everything into consideration, I do or  
17 do not feel that resuscitation is appropriate in this  
18 particular scenario.

19 **MS CAREY:** Pausing there. If a clinical decision is made by  
20 someone like you that there should be a DNACPR, and the  
21 patient's loved ones disagree, can they ask for a second  
22 opinion?

23 **PROFESSOR SUMMERS:** Absolutely yes.

24 **MS CAREY:** And if a second clinician comes along and says,  
25 "No, I think it is clinically inappropriate", at that  
31

1 of how one does that, you usually would be meeting face  
2 to face wherever possible with those family and loved  
3 ones and the place in which I would normally start those  
4 conversations is to ask the loved ones what's their  
5 understanding about the clinical situation in which we  
6 are, so that we can all start from the same place.

7 Sometimes they have just attended the intensive  
8 care unit in an emergency, they aren't fully up to speed  
9 with how their loved one ended up here and so it is  
10 important for everyone to clarify their understanding  
11 about the circumstances that have brought us to the  
12 point we need to have this conversation.

13 And once we have clarified that and it is --  
14 I feel that everybody understands what has happened and  
15 why we are all in the room having this conversation,  
16 I then ask, have the patient or their loved ones ever  
17 discussed what they would want at the end of their life?  
18 You know, what are their values? What are the things  
19 that they would say if they were not here, or if they  
20 were here and they are not able to contribute? And very  
21 often people haven't ever discussed this as a family and  
22 so we are asking the loved ones, as the people who know  
23 the patient best, given that we have rarely met them  
24 when they are well in a critical care setting, what do  
25 you think they would say if they were able to contribute  
30

1 point is the DNACPR notice made?

2 **PROFESSOR SUMMERS:** Yes, but I would say that we would make  
3 tremendous effort to try and reach an agreed  
4 understanding of the situation. I don't think it is in  
5 anybody's interests for there to be wild disagreement.  
6 Because this is the family's loved ones, trying to  
7 explain why we are where we are is important.

8 **MS CAREY:** Now, in pandemic times I suspect there was not  
9 the time -- there wasn't the bedside conversation or in  
10 a side room. How did you practically go about having  
11 DNACPR discussions with loved ones perhaps over Zoom or  
12 some other kind of remote meeting? Can you tell us how  
13 you went about it and how you found it?

14 **PROFESSOR SUMMERS:** This was one of the most extraordinarily  
15 difficult parts of ICU care in the pandemic. Very often  
16 the loved ones of our patients had last seen them when  
17 they were leaving home to come into hospital and at that  
18 point often they were conscious, they were talking, and  
19 they were in a very different state to they are at the  
20 point that we are contacting them to have this  
21 conversation.

22 That differs enormously from the usual clinical  
23 practice when the patient's loved ones would often have  
24 been at the bed side and seen that deterioration over  
25 days and I remember very often people who came into  
32



1 intensive care for Covid had been in hospital for a few  
2 days beforehand, so they had deteriorated over some days  
3 and then come to us because of the course of the  
4 clinical illness and they would not have seen any of  
5 that.

6 **MS CAREY:** So it may have come as a real shock --

7 **PROFESSOR SUMMERS:** Yes.

8 **MS CAREY:** -- when you have to make the call or speak to  
9 them on the Zoom, that you haven't even had the  
10 conversation, never mind the actual detail of the  
11 conversation, and how did those conversations go when  
12 you had to speak to the loved ones?

13 **PROFESSOR SUMMERS:** They were hard because you have never  
14 been in the same room as that individual. They have  
15 someone who therefore they have not met talking to them  
16 about a situation that they have not been able to  
17 witness over a period of days, in a very remote and  
18 disconnected way, either via telephone or via Zoom and  
19 we were having to have these conversations in greater  
20 number than you would ordinarily because the number of  
21 patients in critical care was greater and the level of  
22 severity of the illness and the outcomes were, overall,  
23 worse than they would be for the usual ICU population.  
24 So you would have done several ward rounds and then  
25 maybe making several of these calls in the course of

33

1 heard there were some examples of families whose  
2 patients had been discharged and have subsequently found  
3 out that there is a DNACPR on their record. What is the  
4 circumstances -- what is the process then if someone  
5 says, "Well, there is one on my record and I'm awake now  
6 and I'm alert and I'm better", how does one go about  
7 having a DNACPR notice reviewed?

8 I don't know if, Professor, or Doctor, whichever  
9 of you feels best able to speak to this.

10 **DR SUNTHARALINGAM:** I think it means going through the  
11 institution where it was generated so likely in an acute  
12 hospital and through the services of that hospital. So  
13 there are outpatient liaison services or an email to the  
14 chief executive, whatever is required to get in touch  
15 with the hospital through existing routes, and they can  
16 then take it from there.

17 **MS CAREY:** Right, so if it was made in a hospital, they  
18 ought to contact the hospital; if it was made by a GP,  
19 go back to the GP and any other settings and every other  
20 setting in between.

21 Can I ask you about the CQC findings.

22 **LADY JUSTICE HALLETT:** Just before you do that, I have also  
23 heard from a large number of bereaved families that not  
24 only did they find out about the DNACPR notice on their  
25 loved one's records but that they weren't consulted or

35

1 a day to explain to a family the situation their loved  
2 one was in. It was not easy for the families or for the  
3 healthcare staff.

4 **MS CAREY:** No, well, I was going to ask you, who was  
5 actually -- obviously you may have made some calls  
6 yourself, but was there a set person who had to made the  
7 call, was it always the clinician, was there other  
8 people supporting in this role during the pandemic, do  
9 you know?

10 **PROFESSOR SUMMERS:** Different hospitals and institutions  
11 organised how they did this differently. Some hospitals  
12 set up family liaison teams where they had non-critical  
13 care positions having conversations with families about  
14 that. We chose not to do that in the hospital in which  
15 I work and as the critical care consultant and medical  
16 team we made those phone calls.

17 **MS CAREY:** Can I ask you, Professor, since you are speaking,  
18 do you personally have any experience or are aware of  
19 blanket use of DNACPRs in your hospital?

20 **PROFESSOR SUMMERS:** I do not.

21 **MS CAREY:** And Dr Suntharalingam, do you have any personal  
22 experience?

23 **DR SUNTHARALINGAM:** No.

24 **MS CAREY:** We have heard of them, clearly, in a number of  
25 respects. Can I ask you this, the Inquiry has also

34

1 no discussion took place with them and they knew their  
2 loved one was not in a position to have had  
3 a discussion. Are you aware of situations where notices  
4 were put on without any discussion with the patient  
5 because the patient didn't have capacity and without any  
6 discussion with the family member?

7 **DR SUNTHARALINGAM:** I think it depends on the context. I  
8 think in our clinical setting of critical care, because  
9 we are very hands on with the patients and the situation  
10 is changing every day, the sort of discussions the  
11 professor describes would have been had. There may have  
12 been some slipped through the net but it wouldn't be the  
13 normal case. I think some of the examples you have had  
14 may have been from other settings where there may be  
15 fewer people looking after larger number of patients.  
16 So I can't really comment on that but I would think in  
17 our setting it would be very unusual.

18 **LADY JUSTICE HALLETT:** Is your setting a large teaching  
19 hospital?

20 **DR SUNTHARALINGAM:** A clinical setting regardless of site,  
21 actually, so any intensive care unit --

22 **LADY JUSTICE HALLETT:** Oh, I see.

23 **DR SUNTHARALINGAM:** -- (overspeaking) -- these sort of  
24 discussions are really part and parcel and it is not to  
25 say they wouldn't be for other people but it may have

36

1 been a DNACPR decision that was in records from much  
2 earlier, may have been made in a very different setting.  
3 It is difficult to comment without knowing --

4 **LADY JUSTICE HALLETT:** It could have been made in  
5 a setting -- in a ward where maybe the staff weren't not  
6 used to -- as you are, obviously, sadly, too used to  
7 this kind of discussion or process -- but they could  
8 have been made in situations where the staff weren't as  
9 familiar with the process that needs to be gone through.  
10 **DR SUNTHARALINGAM:** Potentially, and I think some of the  
11 potential benefits of widespread treatment escalation  
12 planning such as a ReSPECT form, part of that includes  
13 normalising discussions, not only for the public and the  
14 patients themselves but also for all staff in all areas,  
15 so it becomes part of the process of healthcare for  
16 those patients where it is appropriate. So they are at  
17 risk of dying.

18 **LADY JUSTICE HALLETT:** Sorry to interrupt.

19 **MS CAREY:** No, not at all because actually it alights on  
20 exactly what I was going to ask about with the CQC  
21 findings.

22 Could we call on screen INQ00474255\_27.

23 My Lady will recall there was an interim report  
24 and then a final report done by the CQC and it really  
25 just picks up on the questions your Ladyship was posing.

37

1 just starting with the point that I believe this is the  
2 CQC report about what was happening in nursing and care  
3 homes and at an earlier stage of the pandemic and things  
4 did improve after, so it partly reflects the sort of  
5 multitude of policies and changes early on. But I think  
6 your wider point, I absolutely agree.

7 And it is worth saying, this is a positive  
8 discussion, as well. It is about how people want their  
9 last days of life to be and whether CPR is something  
10 they want as the means of their death, which  
11 unfortunately is often the case, or whether they would  
12 rather die at home without intervention. So obviously  
13 those answers will vary a lot depending on the patient's  
14 medical condition itself, their values and wishes, so it  
15 is really a positive discussion around -- and it is  
16 a society-wide discussion around death really.

17 I agree the more open and prevalent that is and  
18 people not feeling embarrassed to talk about it with  
19 their family members, the more likely it will be that  
20 these sorts of situations don't arise in a crisis.

21 **MS CAREY:** The CQC report goes on to refer to a lack of  
22 training and support for staff and how confident they  
23 were in holding these conversations has impacted on the  
24 quality of people's experience.

25 Now, you two, I'm afraid, have to deal with this

39

1 The CQC found that the healthcare professionals they  
2 spoke to:

3 "... recognised the importance of ensuring the  
4 conversations around advance care planning ... But how  
5 well people were involved in conversations about their  
6 care and whether or not they wanted to receive [CPR]  
7 varied. Some people experienced compassionate,  
8 person-centred care where they were fully involved ..."

9 And then there were others where it did not happen  
10 and they found it hugely distressing. In these cases,  
11 they say:

12 "Conversations took place at short notice and  
13 people did not fully understand what was happening or  
14 what a DNACPR was. Having the time and information to  
15 talk about what care and support people want and need to  
16 have a dignified and peaceful death is essential."

17 Can I ask you both this, do you agree with the  
18 CQC's conclusion there about trying to talk about this  
19 when we are not in a pandemic situation with stretched  
20 ratios, where people have seen someone leave in  
21 an ambulance and then see them potentially on  
22 a ventilator, is this really all about talking about  
23 death and how we would like to die in advance of the  
24 urgent critical situation we ended up in the pandemic?

25 **DR SUNTHARALINGAM:** Absolutely yes. I think it is worth

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1 more often than a number of other staff. Can I ask you,  
2 who practically do you think should be responsible for  
3 training those who are not working in critical care or  
4 end of life treatment? Who would be responsible for  
5 providing that kind of training? The Trust, the  
6 hospital, NHSE, the regulators?

7 **PROFESSOR SUMMERS:** So communication training and having  
8 conversations such as this actually is a core part of  
9 the medical training curriculum for medical students as  
10 set out by, I think, the General Medical Council. So  
11 actually it is a training thread that should go through,  
12 certainly for doctors, and I would argue other  
13 healthcare professionals too, throughout their training.  
14 We are required in the nature of our work to have all  
15 kinds of difficult conversations with people around  
16 death and other personal issues and I don't think saying  
17 it was just the responsibility of Trusts is broad  
18 enough. I think that actually it should be embedded as  
19 a core part of professional education.

20 **MS CAREY:** I was going to say, do you have to do continuing  
21 professional education?

22 **PROFESSOR SUMMERS:** Yes.

23 **MS CAREY:** Is it part currently of any continuing  
24 professional education programme that you are aware of?

25 **PROFESSOR SUMMERS:** Certainly the matrix for intensive care  
40

1 positions and members of the Royal College of Physicians  
2 includes having the skills on keeping up to date with  
3 both the legal and the professional best practice.

4 **DR SUNTHARALINGAM:** It is worth adding the point that  
5 I think those who generated the ReSPECT form would say  
6 that as part of the implementation of that, so we are  
7 talking about four nations' implementation that funded  
8 training by institutions, organisations supporting the  
9 Trusts and Health Boards and employers is a key part of  
10 it as well, and there is a wider point behind that,  
11 which is whether it is about DNACPR, or around treatment  
12 escalation planning, having clinician time to actually  
13 have these conversations, clearly in a pandemic certain  
14 things apply but in normal life it's making sure the  
15 time is there to have those conversations as well as the  
16 training.

17 **MS CAREY:** Thank you. Can I move to a different topic with  
18 you, Doctor, and it is the work that you undertook in  
19 March 2020 in relation to a clinical prioritisation tool  
20 that you were asked to consider working on some  
21 guidelines for by I think the Chief Medical Officer. We  
22 heard from Professor Whitty two weeks ago now and I said  
23 then we were hearing from the person involved or one of  
24 the three involved.

25 Can I just start like this: I think it is obvious

41

1 and two other colleagues were asked to form a group to  
2 consider the clinical prioritisation model to be used in  
3 the event that the NHS critical care resources were  
4 saturated, by which I mean there was no bed available.

5 **DR SUNTHARALINGAM:** Yes.

6 **MS CAREY:** And we have heard about the NHS being in CRITCON  
7 4. Is it this that the tool was designed to address?

8 **DR SUNTHARALINGAM:** Yes. In fact the wider framework that  
9 was very much part of this work, so bearing in mind this  
10 was very early on in the pandemic, and at that point  
11 numbers were rising, and in fact the framework very  
12 explicitly tied CRITCON and mutual aid to the potential  
13 trigger for a tool. So it wasn't the tool in isolation,  
14 it was pairing those two things so there was  
15 an operational context to what might then be needed.

16 **MS CAREY:** I just wanted -- can I perhaps put it more  
17 simply. Was this designed in the event that there was  
18 no bed anywhere and you had two people vying for one  
19 bed?

20 **DR SUNTHARALINGAM:** Essentially, yes.

21 **MS CAREY:** Now, that is a very heartless way, I appreciate,  
22 of describing it but that's what we are talking about  
23 here and no other bed in a neighbouring hospital?

24 **DR SUNTHARALINGAM:** No.

25 **MS CAREY:** Or, indeed, a neighbouring region that could be

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1 from what you have said that clinicians make decisions  
2 about who should be admitted to care on a daily basis.  
3 I think you told us last time that you would have  
4 a discussion with the ward if the ward thought the  
5 patient was deteriorating and you would be involved then  
6 in deciding whether it was appropriate for the person to  
7 be admitted to ICU.

8 Yesterday I think you are aware we heard about  
9 a NICE guideline to assess patients when they are  
10 admitted to hospital to consider whether they might need  
11 critical care. Is that correct?

12 **DR SUNTHARALINGAM:** I believe so, yes.

13 **MS CAREY:** That's not the same thing that the tool that you  
14 were working on that Professor Whitty --

15 **DR SUNTHARALINGAM:** No.

16 **MS CAREY:** And as I understand it you were asked to draw up  
17 guidance in the event that critical care was saturated?

18 **DR SUNTHARALINGAM:** That is right. In fact the lead for it  
19 was Professor Whitty and he was kind enough to comment  
20 on it two weeks ago, as you say, saying that it was  
21 difficult but he felt the outcome at the time was useful  
22 and sensible. It was for the four nations, so it was  
23 the quintet of four CMOs and the National Medical  
24 Director.

25 **MS CAREY:** And if I understand it, I think on 21 March you

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1 sensibly someone transferred to?

2 **DR SUNTHARALINGAM:** That is right, and in the context that  
3 mutual aid and decompression would already have happened  
4 so essentially talking about -- (overspeaking) -- which  
5 would be a very extreme scenario.

6 **MS CAREY:** We looked at all the transfers and the rising  
7 numbers and indeed we looked at the circular diagram of  
8 the example of Northwick Park and the number of other  
9 hospitals that they transferred patients to. But  
10 assuming in that example that there was no other bed  
11 available and CRITCON 4 had been declared, this was when  
12 the tool was envisaged to operate; is that correct?

13 **DR SUNTHARALINGAM:** That is correct. And two things to  
14 emphasise. Firstly, CRITCON 4 is a national situation  
15 not just in that hospital. We have talked about  
16 scenarios where CRITCON might be triggered as  
17 an alerting tool but where CRITCON 4 is agreed by those  
18 in authority to be a national state, and then the other  
19 point to make is this is all time sensitive. It is  
20 really about queuing for the next available bed and that  
21 might change when a bed comes up. So it is not about  
22 barring people from being admitted, it is saying who we  
23 would admit into the beds available right now.

24 **MS CAREY:** Perhaps if we look at how the tool was envisaged  
25 to work by reference to your paragraph 110, Doctor.

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1           Could we call up on screen -- thank you very  
2 much -- a summary of how the framework was proposed.  
3 I won't necessarily go through all of these but we can  
4 see there it was designed to effectively only operate  
5 once CRITCON 4 was declared in one or more regions and  
6 where CRITCON 4 is declared, NHS England, in this case,  
7 have to be notified so they know the position and all  
8 other possible sources of mutual aid between hospitals  
9 have been exhausted.

10 **DR SUNTHARALINGAM:** That is right.

11 **MS CAREY:** So it really is in extremis?

12 **DR SUNTHARALINGAM:** That is right. And although CRITCON was  
13 sort of convenient vocabulary for this, obviously for  
14 the other three nations it is around that same  
15 information being escalated in other ways about capacity  
16 and saturation.

17 **MS CAREY:** It makes the point there at 110.2 that there  
18 should be no triage until every accessible ICU is full.

19 **DR SUNTHARALINGAM:** Absolutely.

20 **MS CAREY:** "This assessment should be based on accurate  
21 collection and communication of realistic frontline ICU  
22 conditions using CRITCON or equivalent ... rather than  
23 abstract bed counts against a theoretical bed base."

24           What were you getting at there, if I may ask?

25 **DR SUNTHARALINGAM:** It was the discussion we had earlier  
45

1           precedence over somebody else on the grounds of  
2 survivability using these principles.

3 **MS CAREY:** Right. In a scenario where you have two patients  
4 and both are eligible and it is appropriate to escalate  
5 them to ICU, you would use the tool to say that person  
6 should be number 1 to get that bed and then if one  
7 becomes available, the next person gets it. Is that how  
8 it was meant to work?

9 **DR SUNTHARALINGAM:** Yes. The tool in its final form was  
10 about "expected to survive" or "likely to survive"  
11 versus "may" or "may not survive", versus "unlikely" or  
12 "not expected to survive". So it was really just  
13 a verbal description rather than a numerical score and  
14 using that you would use it as a ranking system in the  
15 scenario that you found yourself.

16 **MS CAREY:** Was it ever envisaged the tool would say that  
17 someone should be taken out of ICU? Was that part of  
18 the framework you were considering?

19 **DR SUNTHARALINGAM:** No. Under the label of reverse triage,  
20 it is a concept and people did raise whether we should  
21 but in the context of this, no, it wasn't. I think, in  
22 this case, it was too difficult to put into a structured  
23 form that would make sense to people at the time.

24 **MS CAREY:** So you were not asked, nor did you in fact,  
25 I think, consider the possibility of having to take  
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1           really about having -- although it's useful to think in  
2 terms of notional surge capacity, those are, sort of,  
3 fairly abstract numbers and if units are becoming  
4 realistically saturated under the conditions at the  
5 time, that's what's going to start influencing clinical  
6 decision-making, albeit subconsciously, and in practical  
7 terms through simple lack of available beds. So that is  
8 the realistic frontline conditions in the view of those  
9 working there that needs to feed into this level of  
10 realistic decision-making. And percentages of notional  
11 total surge capacity may not help with that.

12 **MS CAREY:** Then 110.4:

13           "If critical care resources become exhausted  
14 nationally, any declared clinical prioritisation would  
15 operate on a ranking basis in the event of needing to  
16 prioritise one patient over another when competing for  
17 the same resource (in effect, 'the last ICU bed')."

18           What was that trying to convey?

19 **DR SUNTHARALINGAM:** It was really the point we made earlier  
20 that this is reflecting -- this is not about triaging  
21 people in the sense of saying they will never get  
22 an intensive care bed unless that is the clinically  
23 appropriate scenario in any case, but under pandemic  
24 conditions it is not about ruling people in or out, it  
25 is saying for the next available bed who should take  
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1           someone off a ventilator, for example, to make room for  
2 others; that is not what the tool was designed for?

3 **DR SUNTHARALINGAM:** No.

4 **MS CAREY:** Understood, all right.

5           So, effectively, it was a ranking system for who  
6 should get the next bed available whilst there were  
7 these extreme conditions?

8 **DR SUNTHARALINGAM:** That is right. I think in terms --  
9 although it is quite appropriate to talk about beds it  
10 is really about starting a treatment process in  
11 a limited setting in CRITCON 4 and in extremis.

12 **MS CAREY:** Can I ask you, why is it important to have a tool  
13 at all?

14 **DR SUNTHARALINGAM:** I think the benefits are, firstly,  
15 transparency. Both within the profession and also to  
16 the public and particularly those who might be  
17 disadvantaged in general. So even if people may not  
18 agree with it or like it, the fact that they can see it  
19 I think is important and that replaces any risk of  
20 subconscious bias or unseen decision-making. So,  
21 firstly, there is one of transparency.

22           Secondly, there is one of efficacy, which is that  
23 by publishing something and having a plan it may be  
24 adapted and modified and improved and disputed if  
25 necessary, but you have to work with what is available  
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1 and it means that what we do have is the best we could  
2 manage at the time.

3 **MS CAREY:** Can I pause you there. Do I take it from that  
4 that prior to the pandemic there was no in extremis  
5 saturation tool available?

6 **DR SUNTHARALINGAM:** No.

7 Thirdly, I would say there is reassurance in two  
8 forms, one is for clinicians to know that even if you  
9 are saying this is usual conditions, we are not  
10 saturated yet, for clinicians to know that there is some  
11 sort of plan for what happens next means, firstly -- it  
12 means that they don't feel that sense of moral doubt and  
13 injury, potentially worrying they will find themselves  
14 in that situation on their own in the middle of the  
15 night at their site. They know there is a plan.

16 Secondly, for the public and for patients it gives  
17 them the safety that people aren't going to find  
18 themselves in a position of being triaged  
19 inappropriately. If there is a national plan and people  
20 know when it's switched on and when it's switched off,  
21 that only the CMOs can activate it, it protects the  
22 public by avoiding -- the risk that we're not talking  
23 about something, it sort of happens unseen.

24 **MS CAREY:** Is there any, do you know, will or desire among  
25 the medical profession to have a tool such as this in

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1 work for the quintet of CMOs and National Medical  
2 Director was stood down on the grounds that, at that  
3 stage, it looked as if the first wave was as seceding  
4 and the tool wouldn't be needed, there was a discussion  
5 around publishing it so it could be developed openly and  
6 with as much professional and public input as possible  
7 by a professional society.

8 The Intensive Care Society took that on, in  
9 consultation with as many other groups as possible.  
10 What was originally published, firstly as a guideline  
11 from the Intensive Care Society, endorsed by the Royal  
12 College of Physicians and --

13 **MS CAREY:** Pause there, because we'll have a look at it.

14 **DR SUNTHARALINGAM:** Sure.

15 **MS CAREY:** Can I have on screen, please, INQ000395282. Just  
16 before, you were about to tell us who it was endorsed  
17 by, this was obviously not the framework that you worked  
18 on in that week in March 2020, but it is effectively  
19 using your work, this guidance was then developed based  
20 on it; is that correct?

21 **DR SUNTHARALINGAM:** That is correct, and in the context of  
22 if a national guidance at NHS level were to be required,  
23 then this provides a starting point to pick up and start  
24 from this rather than from a blank page. So it would be  
25 sort of relevant and looping back again if necessary, so

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1 case we find ourselves again in a situation where we are  
2 overflowing in ICU beds?

3 **DR SUNTHARALINGAM:** I would say yes. Obviously, having been  
4 involved in that particular point of view, but I think  
5 genuinely looking at wider discussions there was a need  
6 for it and, to be clear, it is not about a tool that you  
7 pick up and start using on your own, it is knowing that  
8 there is something -- there is a plan in the background  
9 that may be activated and I think that in itself  
10 provides reassurance for people.

11 **MS CAREY:** I think just to finish this topic, albeit only  
12 the -- only seven days when the framework was being  
13 considered by your group, I think you say that the group  
14 consulted with the critical care professional community,  
15 age and disability groups, and with the Department of  
16 Health and Social Care's moral and ethical advisory  
17 group, and there were various changes made to the  
18 putative framework during that period as a result of  
19 those meetings.

20 Just finally on this topic then, did your work as  
21 part of that group effectively form a starting point for  
22 a document that is now in existence, which is the  
23 clinical guidance published by the Intensive Care  
24 Society.

25 **DR SUNTHARALINGAM:** That is correct. On 28 March when the  
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1 to speak.

2 **MS CAREY:** I think this guidance came out on 28th May 2020;  
3 is that correct?

4 **DR SUNTHARALINGAM:** That is correct.

5 **MS CAREY:** We can see there that it is endorsed by Royal  
6 College of Physicians, the Scottish Intensive Care  
7 Society, the Welsh Intensive Care Society, All Wales  
8 Trauma Critical network, the national Critical Care  
9 Networks of England and Northern Ireland.

10 So a UK-wide document. It is entitled "Assessing  
11 whether Covid-19 patients will benefit from critical  
12 care ... an objective approach ..."

13 But is it solely for use during a respiratory  
14 pandemic that involves Covid-19?

15 **DR SUNTHARALINGAM:** No, I would say, and then there are  
16 three elements to this, and I think also to reassure  
17 anyone listening, the guidance has the same elements as  
18 the original framework, which is including the shared  
19 escalation, the mutual aid, the fact that any decision  
20 tool would apply in CRITCON 4, so if somebody has to  
21 pick those up and use this today, they would say, well,  
22 we're in CRITCON 2 or 3, therefore the usual  
23 decision-making applies, nobody is going -- should be  
24 going to the back page and using the tool on its own.

25 But in that context, in terms of applicability,

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1 the document has statements of moral and ethical  
2 principles which are applicable to any crisis, and  
3 potentially outside a crisis. It has a statement about  
4 shared escalation, mutual aid, the CRITCON framework,  
5 which are also -- should apply to any crisis.  
6 And then the tool at the end is specific to Covid,  
7 and would need to be re-assessed, re-designed as indeed  
8 it would have done during the pandemic itself if it were  
9 in use, because it was based on available data at  
10 28 March, or would in any case have been adapted.

11 For a different disease there would be different  
12 criteria, different things to look at.

13 **MS CAREY:** So barring the, I think it is appendix 2, if we  
14 just look at it at page 12 of the document, there is the  
15 decision to support aid in relation to Covid. But  
16 essentially, if one looked at pages 1 to 11, they would  
17 be applicable whatever the virus, whatever the disease,  
18 whatever the extremis circumstances underpinning it.

19 **DR SUNTHARALINGAM:** Yes.

20 **MS CAREY:** You could basically use pages 1 to 11, and add on  
21 an appendix, to be specific, to whatever circumstance  
22 that was appropriate?

23 **DR SUNTHARALINGAM:** I think so, I don't know, would it be  
24 useful to look at page 11 briefly?

25 **MS CAREY:** Yes, let's go back to that then, because that is  
53

1 your statement that there is a potential benefit to  
2 discussing this in non-pandemic times --

3 **DR SUNTHARALINGAM:** Yes.

4 **MS CAREY:** -- and you said it could be done with publicly  
5 accountable oversight. Who did you envisage might  
6 provide that oversight?

7 **DR SUNTHARALINGAM:** So, in a sense I'm very open to sort of  
8 expert opinion as to how this could be implemented, but  
9 some form of public commission or stakeholder meeting,  
10 with a very wide buy-in from interested members of the  
11 public, particularly those representing disability and  
12 other disadvantaged -- potentially disadvantaged groups,  
13 and to make sure that all sections of society are  
14 involved.

15 There is some academic work which suggests that  
16 actually the public may be sort of ahead of the  
17 profession in things that they might want to have  
18 considered. This is purely from a research paper in  
19 Oxford, but they found ideas coming up were around  
20 prioritising people with young children, or even  
21 healthcare workers, and they wanted to talk about things  
22 like taking people off ventilators. I'm not advocating  
23 for that, but it is interesting that the discussion  
24 beyond the profession can be wider than the discussion  
25 that we ourselves have.

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1 a more general application.

2 **DR SUNTHARALINGAM:** Yes. To some extent this is a further  
3 version of the discussion about CRITCON that we had  
4 previously. But I think the bits to highlight here are  
5 that usual decision-making applies when we are at  
6 CRITCON 0 to 3, with the sort of blue arrows saying  
7 that.

8 **MS CAREY:** Yes.

9 **DR SUNTHARALINGAM:** And then CRITCON 4, and in fact that  
10 table we just looked at at the back, the decision aid,  
11 only applies at a stage of sort of universal CRITCON 4  
12 as declared by -- at, sort of, government level.

13 **MS CAREY:** If I follow you correctly, Doctor, if we go down  
14 to the 4 triage risk, all in red there, we are at  
15 CRITCON 4, it is only then that you would turn over to  
16 appendix 2 and follow the tool for whatever disease or  
17 virus or situation was necessary?

18 **DR SUNTHARALINGAM:** Absolutely. And the logic of having it  
19 there is so they can talk about it openly. It really is  
20 in order to avoid having to use it, so everyone is at  
21 least aware of what we would be facing if we got to that  
22 position.

23 **MS CAREY:** Right. Can I just then finish on this topic.  
24 There is this prototype that could be adapted in the  
25 event of future need. I think you make the point in  
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1 **MS CAREY:** I wonder if we could leave that topic there.

2 My Lady, I'm moving to a new topic. It is  
3 a little early, but I can start the new topic or we  
4 might perhaps take our mid-morning break?

5 **LADY JUSTICE HALLETT:** No, that's absolutely fine.  
6 I shall return at 11.45 am.

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

8 (11.25 am)

9 (A short break)

10 (11.46 am)

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

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

13 Professor Summers, can I turn to you, please, and  
14 just look briefly at ICU capacity in 2021. Because we  
15 concentrated a lot on the early stages of the pandemic,  
16 and I think you make the point in your report that, in  
17 fact, by early 2021 there was a far larger surge in  
18 critically ill patients than there had been earlier on  
19 in the pandemic. If it helps you, I'm at page 60 in  
20 your report.

21 I wonder if we could call up on screen figure 11  
22 at INQ000474255\_0060.

23 With your help, Professor, I would like you just  
24 to explain -- we are not going through all the regions  
25 but all four nations are represented on this figure,  
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1 which is the regional increases in occupied ICU beds  
2 above baseline, provided by The Intensive Care Society,  
3 and it is really to get a sense of how different it was  
4 in 2021 than how it was in 2020, or, in some cases, it  
5 is the data from 2019.

6 Perhaps if we take Scotland as the first example,  
7 can you speak to this? And is this showing us that in  
8 2019 in Scotland they had 203 occupied beds in ICU? And  
9 by 2021 that jumped considerably to 303?

10 **PROFESSOR SUMMERS:** Exactly. So this is an attempt to  
11 quantify the degree of the surge in ICU capacity that  
12 was required in January 2021 by using exact data at this  
13 time from NHS England and estimates that they could  
14 acquire, I think, from Scotland and Northern Ireland.  
15 Subsequently, actually, it looks like their best  
16 estimates for Scotland were almost exactly correct when  
17 the real data had become available from SICSAG.

18 I think the important message from the entire UK  
19 picture is that the equivalent of about 141 extra  
20 intensive care units were required in January 2021 above  
21 the capacity that was available in January 2020, and  
22 that's assuming an average size of 15 or 16 beds in  
23 intensive care.

24 **MS CAREY:** I think at the bottom of the screen it says it  
25 was based on one ICU being a 16-bed unit --

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1 others besides, like the ICNARC data clerks that we  
2 heard about from Professor Rowan when she was speaking,  
3 administrative staff, support staff, are all required.  
4 And you can see some of these ratios are absolutely  
5 extraordinary.

6 **MS CAREY:** And ordinarily, would these be all the people  
7 that would be around the bedside of the patient in ICU?

8 **PROFESSOR SUMMERS:** So they are all part of the intensive  
9 care multidisciplinary team.

10 **MS CAREY:** Would they therefore be wearing a higher level of  
11 PPE because they were in an intensive care setting?

12 **PROFESSOR SUMMERS:** In most cases, yes.

13 **MS CAREY:** Now, we have looked at increases in intensive  
14 care, and I think when you gave evidence last week, we  
15 had already made the point that the data was not  
16 necessarily entirely representative because there was  
17 a lot of people receiving critical care outside of  
18 an ICU and therefore weren't captured by the data, but  
19 can I ask you about any alterations to the kinds of  
20 people that came into ICU. I'm at your paragraph 158.

21 You make the point there that the data doesn't  
22 tell us entirely accurately the people that were  
23 receiving critical care outside of ICU. I think you say  
24 in your report there was also a fall in admissions, for  
25 example, those people that had suffered a heart attack

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1 **PROFESSOR SUMMERS:** Yes.

2 **MS CAREY:** -- and so by 2021 we needed 141 extra ICUs across  
3 the UK.

4 **PROFESSOR SUMMERS:** Yes. And we did not create that  
5 physical capacity of 141 extra ICUs with any more staff,  
6 to reiterate that point again; we did it with exactly  
7 the same number of staff as we had in January 2020 in  
8 terms of specialist critical care staff. We stretched  
9 what we had to make that extra capacity.

10 **MS CAREY:** Understood. I think in fact there is  
11 an accompanying document on page 61 which exemplifies  
12 this, and can we have the table at the top there, that,  
13 ordinarily in -- well, not ordinarily in January 2020,  
14 so just pre-pandemic, one member of staff cares for --  
15 it was a consultant, they can care for 12 patients, and  
16 you can see the jump there from -- into 2021, they were  
17 caring for 16 or as many as 33 patients. We're familiar  
18 with the changes to the nursing ratios, but when you  
19 look at some of the other people involved in providing  
20 care, pharmacists, there is a jump again.

21 Physiotherapists. Speech and language. Members of  
22 staff, occupational therapists. Huge increases in the  
23 number of patients they had to care for in January 2021.

24 **PROFESSOR SUMMERS:** Intensive care is a multidisciplinary  
25 package of care for patients. All of these people and

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1 and stroke. There was a significant drop in the number  
2 of those people attending ICU.

3 Could we have on the screen, please, figure 12a,  
4 which is a very neat depiction -- there we are -- of the  
5 fall in the number of admissions to intensive care.

6 This is data that comes from ICNARC, my Lady.

7 One can see that ordinarily, fluctuations just  
8 above or below 300 people on average coming into  
9 intensive care with a heart attack per month.

10 And then when we look at the yellow line which  
11 indicates the pandemic, if one looks just after January  
12 2020, a huge drop in the number of people being  
13 admitted, so what is that, under 150 or thereabouts, and  
14 it slowly rises but still doesn't reach the same rough  
15 grey area that had been the case in the three years from  
16 2016 to 2019.

17 So people weren't presenting to ICU in the way  
18 that they had. Can you help me with this, I think you  
19 make the point in your report that there were fewer  
20 older people being admitted to ICU during the pandemic,  
21 and can you help with why that was?

22 **PROFESSOR SUMMERS:** So, I guess, to allude to the myocardial  
23 infarction graph that we were shown, I think there is  
24 data that very eloquently speak to the fact that not  
25 only were they not appearing in intensive care units

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1 with myocardial infarction, people were not appearing in  
2 hospital. And that actually, as a result of changes in  
3 behaviour, and in people's trying to, I guess, do the  
4 best that they could, and people were probably dying at  
5 home rather than being admitted to hospital and having  
6 the care from hospital and, as a consequence of that,  
7 intensive care units that they might have done otherwise  
8 for their myocardial infarctions, and you can see that  
9 the decrease in admissions to ICU happened both in the  
10 peak of spring 2020 but also again in  
11 January/February 2021. So both of those coincide.

12 **MS CAREY:** Whilst you are dealing with this, and perhaps  
13 looking at older people, of course, my Lady has the  
14 report from Professor Gale, dealing with not only falls  
15 in ICU admissions but falls generally into the  
16 healthcare system in relation to people with ischaemic  
17 heart disease. So it is really tallying a number of  
18 different ways of showing that people weren't coming  
19 into the healthcare system for heart attacks and the  
20 like.

21 All right, now on to older people --

22 **PROFESSOR SUMMERS:** Yes.

23 **MS CAREY:** -- admissions to ICU. What did you set out in  
24 your report, please, Professor?

25 **PROFESSOR SUMMERS:** There are several lines of evidence that  
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1 longitudinal paths of just over 142,000 people who were  
2 admitted from across the four nations of the United  
3 Kingdom with Covid to hospital between March and  
4 December 2020, so again covering the sort of wave one  
5 period rather than wave two.

6 **MS CAREY:** Yes.

7 **PROFESSOR SUMMERS:** And they found that the likelihood of  
8 a patient being in ICU, three or seven days after  
9 admission, varied by month and such that actually you  
10 were more likely in periods between surges to get  
11 admitted to intensive care than you were at periods of  
12 surge. So, actually, the people who were getting  
13 admitted were more likely to be younger during the  
14 peaks, which accords with the ICNARC suggestion from  
15 their looking at the peak of 2020.

16 **MS CAREY:** Can I see if I can summarise this accurately and  
17 correct me if I have got it wrong: older people less  
18 likely to go into ICU during pre and post-peak  
19 periods --and people more generally to get into ICU  
20 between the surges?

21 **PROFESSOR SUMMERS:** So, older people less likely to be  
22 admitted and people with higher degrees of dependency  
23 were less likely to be admitted during the surges.

24 **MS CAREY:** Understood. Now why that might be may be  
25 difficult to ascertain, but can I ask you this: was  
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1 suggest that at peaks of the ICU strain, that people who  
2 were admitted to intensive care, despite there being no  
3 national change in policy, may actually not have been  
4 the same as those at times of less strain. And I think  
5 that Professor Rowan spoke to some of this, but to  
6 reiterate, one example of the data supporting that  
7 proposal comes from ICNARC that looked at admissions to  
8 ICU during the first wave, and they found that people  
9 who were admitted during that wave were younger and less  
10 severely ill when compared to those who admitted pre and  
11 post-period. So that was my paragraph 161.

12 Their paper suggests that the proportion of  
13 patients aged greater than 75 years, or had any prior  
14 dependency, was lower during the peak period in 2020.

15 **MS CAREY:** That's not what one would have expected  
16 ordinarily?

17 **PROFESSOR SUMMERS:** I wouldn't have expected to see any  
18 change.

19 **MS CAREY:** Yes, and you say the older and sicker patients  
20 would not have disappeared during that time, but fewer  
21 will have been admitted to ICU?

22 **PROFESSOR SUMMERS:** There is a second line of evidence that  
23 comes from a different organisation that suggests that  
24 this may have been the case. So ISARIC, by their  
25 clinical characterisation group, tracked the clinical  
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1 there any policy or diktat that said: don't admit older  
2 people or anything of that nature?

3 **PROFESSOR SUMMERS:** I'm aware of absolutely no circumstances  
4 in which a policy was issued about age as a cut-off in  
5 the United Kingdom.

6 I should also point out that also, the type of  
7 care of critically ill people that was happening, and  
8 where that was happening, as you point out, not all  
9 critically ill people were in intensive care units, and  
10 the strain on the intensive care units will have  
11 affected -- at some times you may have had your CPAP in  
12 an intensive care unit, at times of great strain where  
13 everybody in intensive care was receiving invasive  
14 mechanical ventilation, you may have had that on a ward.

15 So, being inside the walls of an intensive care  
16 unit doesn't necessarily mean you did or did not receive  
17 critical care.

18 **MS CAREY:** Understood. I think, though, Professor, you are  
19 aware of the research that was conducted by the Inquiry  
20 and have seen the findings of the survey. Can we have  
21 up on screen INQ000499523\_0017.

22 This is a slide depicting what happened during the  
23 first wave and people contributing to the survey, and  
24 there were nearly 1700 healthcare professionals who were  
25 spoken to UK-wide. If one looks at the critical care  
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1 nurse and the critical care doctor, they were asked  
2 during the first wave how they were able to escalate by  
3 role the frequency of their inappropriate to escalate,  
4 and the critical care nurses said that there was 20% of  
5 them that had to make a decision about that on a daily  
6 basis, 19% for critical care doctors, and we can see the  
7 varying statistics there.

8 But when one looks at the last two columns, "At  
9 least weekly", 34% of those critical care nurses had  
10 an inability to escalate and, indeed, critical care  
11 doctors, 35% at least weekly. And then if we look at  
12 the "Ever" -- again, 49% of critical care nurses had  
13 an inability to escalate, and critical care doctors 48%.

14 So fairly grim statistics, if I may put it like  
15 that, as to the people that contributed to this survey,  
16 suggesting that there was various reasons why the nurses  
17 and the doctors felt there was an inability to  
18 escalate -- and some of those reasons, I think, were  
19 given. If one looks at page 19.

20 The survey asked about the reasons for difficulty  
21 escalating, and if we could highlight the two columns  
22 that deal with "Critical care nurse" and "Critical care  
23 doctor", one can see that "Lack of available beds for  
24 high dependency care such as high flow oxygen or CPAP",  
25 look at the figures there for critical care nurses and

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1 a critical care doctor in Wales. And they were giving  
2 their experience of escalating care, they said:

3 "We knew it wouldn't help because we had come to  
4 see what kind of people died of this disease despite  
5 escalated care. So we decided not to admit to critical  
6 care whereas had they had a different illness, they  
7 probably would have been more likely to benefit so we  
8 would have escalated. We didn't have enough space to  
9 'give people a go' who had a very remote chance of  
10 getting better. If we had had more capacity, we might  
11 have been in a position to try."

12 I suspect not an easy thing for that doctor to  
13 have said, but can I ask you, please, about page 33 of  
14 the survey. This is entitled "Acting in conflict with  
15 values by role". But critical care nurses were  
16 particularly likely to have to act in a way which  
17 conflicted with their values when at work during the  
18 pandemic, likely linked to the higher proportion feeling  
19 that there were insufficient staff. And if we look  
20 there, daily, critical care nurses were reporting that  
21 they were acting in conflict with values by role.

22 And indeed the critical care doctors, if one looks  
23 down the page slightly, 26% of those were saying they  
24 had that on a daily basis.

25 Can you help with how acting in conflict with your

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1 critical care doctors, that clearly was a reason they  
2 felt unable to escalate.

3 Lack of care or staff, 62 and 61% respectively.

4 Lack of available beds for invasive mechanical  
5 ventilation, 85 and 80%.

6 Lack of available beds for acute wards. Lack of  
7 equipment. And I don't need to ask you about the lack  
8 of access to ambulance. But clearly indicative -- I put  
9 it no higher than that -- of difficult decisions having  
10 to be made, and a number of varying resource reasons why  
11 people may not have been escalated.

12 Does that not necessarily accord entirely with  
13 your experience, but does it come as a surprise to you  
14 that there are quite significant numbers of critical  
15 care nurses and doctors answering this survey saying  
16 they could not escalate for the reasons that are set out  
17 on page 19?

18 **PROFESSOR SUMMERS:** No, I think like Professor Whitty, who I  
19 think was shown similar evidence when he testified the  
20 other day, this accords with the totality of the  
21 evidence that's available. It is a snapshot done this  
22 year, I understand, of how people felt their experiences  
23 were in 2020, and I'm not in any way surprised.

24 **MS CAREY:** No. If one just looks, please, at page 22,  
25 Professor, there is a quotation given there from

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1 roles and your values affected the staff on the ground,  
2 Professor?

3 **PROFESSOR SUMMERS:** I can. I think we heard very powerfully  
4 the other day from Professor Fong, he organised and led  
5 the peer support programme of visits. I should declare  
6 that I also participated in leading and attending some  
7 of those visits, and some of the evidence that he shared  
8 is evidence that I was privileged but also unfortunate  
9 to have to hear from staff members, from various regions  
10 of the United Kingdom. I am only too painfully aware of  
11 the conflict and the moral injury that occurred to,  
12 particularly, critical care nurses, but healthcare staff  
13 of all kinds during the pandemic.

14 It was and continues to be an ongoing issue for  
15 many of us.

16 **MS CAREY:** I think in your report you set out some studies  
17 that were done into staff well-being and indeed whether  
18 the stresses they were under in fact impaired their  
19 ability to do their job, and I would like to ask you  
20 about that please.

21 **PROFESSOR SUMMERS:** Yes.

22 **MS CAREY:** I think there was, if it helps you, 135 onwards  
23 in your report --

24 **PROFESSOR SUMMERS:** So there was work undertaken, again  
25 actually led by Professor Fong in an academic capacity

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1 to undertake a series of surveys at different points,  
2 looking at how staff were doing in terms of their  
3 well-being and actually 56 hospitals in England  
4 participated with round about 6,000 respondents across  
5 the time points. And it happened before the winter  
6 2020/21 peak and during and after the winter 2020/21  
7 peak.

8 **MS CAREY:** So just pausing there. I think, as a result of  
9 at least one part of the surveys over different periods  
10 of time, in November to December 2020, more than 50% of  
11 staff met or exceeded the threshold criteria for at  
12 least one of the surveyed mental health disorders.

13 And what were those disorders, please?

14 **PROFESSOR SUMMERS:** So post-traumatic distress symptoms and  
15 functional impairment predominantly, but also there were  
16 questions around problematic alcohol misuse and other  
17 markers of mental health and functional impairment.

18 **MS CAREY:** That's in the run up to the pressures we have  
19 seen in January 2021. I think the survey went on to  
20 look at January to February 2021. Can you help, what  
21 did the survey find in relation to that particularly  
22 stressful period in ICU?

23 **PROFESSOR SUMMERS:** So I think it found that later on, at  
24 peak, those symptoms were increased in prevalence, as  
25 you would expect. I mean, no one can be surprised by  
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1 and one of the things he said was that the kind of  
2 impact that you have just described on staff is  
3 continuing today and so if anybody is trying to make  
4 sure the NHS works in a way that we would all hope, that  
5 we have to remember the impact on staff is still having  
6 an effect.

7 **PROFESSOR SUMMERS:** I think I would say that I don't know  
8 a healthcare worker and certainly not an intensive care  
9 clinician who does not carry the scars of the last five  
10 years, and you may have to forgive me a moment. All of  
11 us have carried it forwards. You cannot see what we  
12 have seen, hear what we have heard, and do what we have  
13 had to do and be untouched by it. You cannot and be  
14 human and we are very much human.

15 **LADY JUSTICE HALLETT:** Doctor, you are nodding.

16 **DR SUNTHARALINGAM:** Yes, I absolutely agree with all of  
17 that.

18 **MS CAREY:** Professor, that brings me onto something I wanted  
19 to ask you about which was a phrase in your report which  
20 is as follows:

21 "We coped but only just."

22 **PROFESSOR SUMMERS:** Yes.

23 **MS CAREY:** Can you just try, please, to help her Ladyship  
24 and us understand why it is your phrase it in that way?

25 **PROFESSOR SUMMERS:** I think what is often forgotten is that  
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1 this. You have a healthcare system and healthcare staff  
2 that were under tremendous stress in wave 1 or in spring  
3 2020. The pressure never fully came off during the  
4 whole of 2020 and then going into 2021's peak, there was  
5 both the demands of a greater number of critically ill  
6 patients, alongside the demands of trying to resume  
7 elective surgical care and many of the people who were  
8 trying to support the ICU surge are the same people who  
9 are required to undertake the delivery of elective  
10 surgical care.

11 Anaesthetists often unusually are in operating  
12 theatres. In 2021, we were using their operating  
13 theatres for ad hoc intensive care units and they  
14 weren't doing their day job. Of course they were  
15 distressed. As were nurses, healthcare support workers,  
16 administrators, and not just in intensive care, I think  
17 that's the other point to make here. Whilst this data  
18 is around intensive care, there are data about  
19 healthcare workers in hospitals all of whom have similar  
20 patterns of impairment.

21 **LADY JUSTICE HALLETT:** I don't know if you heard  
22 Professor Fong on the radio this morning.

23 **PROFESSOR SUMMERS:** I did not.

24 **LADY JUSTICE HALLETT:** He was talking about something else  
25 initially but he was asked about giving evidence here  
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1 the catastrophic failure of the healthcare system would  
2 not be a switch that was just thrown in an instant where  
3 we went from everything being okay to everything not  
4 being okay the next second. It is in the dilution of  
5 a million and one tiny little things, particularly in  
6 intensive care. We are a speciality of attention to  
7 detail. Every single tiny little bit of attention to  
8 detail is what makes the difference and cumulatively  
9 provide better outcomes for patients. When we stretch  
10 those and we are unable to pay the attention to all of  
11 those details in the way that we would want to and that  
12 we know we are capable of, we are failing our patients  
13 really, or at least that is how it feels to us. We are  
14 not providing the care that we would want to if -- and  
15 that we would want for our own families.

16 And whether you describe that as coping or not, is  
17 a very moot point. Coped as in the outcomes were as  
18 good as we could make it and we didn't get to the point  
19 where we had to say that there was national triage, but  
20 we would never want to be where we were. Large numbers  
21 of intensive care units declared CRITCON 3. That wasn't  
22 okay.

23 **MS CAREY:** Final couple of discreet topics if I may.

24 If I may turn to you, Doctor. I would like your  
25 help, please, about PPE in intensive care units. And we  
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1 are familiar with the problems with lack of PPE that  
2 suits a diverse range of faces, size, ethnicities and  
3 the like. I would like to ask you please about your  
4 paragraph 199 where you say:

5 "In general, there were adequate numerical  
6 quantities of PPE in ICUs as these were often  
7 prioritised over other parts of the health and social  
8 care system."

9 But I want to understand, were there any shortages  
10 of PPE within individual ICUs that you are aware of?

11 **DR SUNTHARALINGAM:** So I use the word "numerically" there  
12 because there certainly were factors that were very --  
13 the opposite of reassuring. So different models  
14 arriving every day. Although hospitals carried out fit  
15 testing the supplies changed. I'm not aware of specific  
16 shortages as a systematic factor. And the comment about  
17 ICUs compared to others is partly based on some research  
18 work that others have done of surveying people. So  
19 there was some advantage. However, it certainly felt at  
20 any given moment that things might be short, that things  
21 were changing all the time, particularly early in the  
22 pandemic, and obviously people had anxieties about their  
23 own health and about taking disease home to families.

24 So it felt under pressure. It felt dangerous. It  
25 felt like shortages. Numerically, intensive care was

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1 and on the background of people's concerns that they  
2 were getting what they needed.

3 **MS CAREY:** Even within the ICU setting where, as you say,  
4 you had FFP3?

5 **DR SUNTHARALINGAM:** Yes. For example, recommendations  
6 about -- and to be fair to the organisation in the UK,  
7 obviously it was also affected by perceptions from  
8 elsewhere. So if you are seeing healthcare workers in  
9 other countries wearing full body Hazmat suits then it  
10 raised questions about what should be the right course  
11 of action here.

12 **MS CAREY:** Understood. I would like to ask you about  
13 aerosol-generating procedures. We have heard quite  
14 a bit of evidence about that already including that some  
15 of them may not in fact generate as many aerosols as  
16 hitherto believed and also evidence that AGPs aside,  
17 talking, coughing, singing, shouting, inevitably  
18 generates aerosols.

19 I just would like your views, please, on the AGP  
20 list. I think you have set them out in your  
21 paragraph 210. Help us with that, please.

22 **DR SUNTHARALINGAM:** So this was something where there was,  
23 again, debate about, including in elements such as  
24 resuscitation, which you may hear about from another  
25 witness. Also some professions and specialities, as we

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1 arguably better than some other areas. Also due to  
2 decisions that FFP3 was used universally and that wasn't  
3 the case elsewhere in the hospital. And arguably should  
4 be.

5 **MS CAREY:** I won't take up that thread with you, if I may,  
6 Doctor, but can I ask you about this. You say in your  
7 report that there was -- clearly, obviously, the  
8 physical and emotional challenges of working with the  
9 significant, more quantities of PPE being worn. You  
10 make reference to uncertainty and changing guidelines,  
11 anxiety over supplies and fit testing generally  
12 contributing to the psychological impact of the  
13 pandemic.

14 Can I just ask you, which guidelines were you  
15 referring to in that part of your report?

16 **DR SUNTHARALINGAM:** There was initially guidance coming from  
17 the various bodies at the time which did actually change  
18 identity during the pandemic. So I think Public Health  
19 England moving into the other organisations. So there  
20 was reorganisation going on as well. And it was really  
21 around the best way of coping and diminishing risk early  
22 on.

23 So, appropriately, things were kept under review  
24 and disseminated as they changed but at the frontline  
25 I think it felt difficult to keep abreast of all of it

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1 have heard from Professor Summers, it is a very  
2 multidisciplinary profession and particularly speech and  
3 language therapists felt that some of the interventions  
4 they do weren't adequately recognised.

5 However, I think there is a wider issue which is  
6 the "P" in AGP. I'm not really qualified to talk about  
7 the aerosol and droplet side of it, but I think the  
8 focus on procedures, rather than risk, is a problem  
9 because it means when there is no procedure going on,  
10 but you are in front of the infected patient, that risk  
11 is sort of diminished in the guidance whereas actually  
12 taking the risk into account rather than what particular  
13 procedure they are having at the time is a better way of  
14 doing it, and particularly in an intensive care setting  
15 where there is a procedure going on all the time  
16 somewhere and the patients are all together, again, a  
17 focus on procedure is not necessarily the right thing.

18 So guidance based on environment and risk profile  
19 would make more intuitive sense and be easier to handle.

20 And as you say, there are many things that are not  
21 interventions that put you at risk if a patient coughs,  
22 for example.

23 **MS CAREY:** Finally, please, this. I would like to ask in a  
24 minute about recommendations but can I just draw  
25 together some of the things that you have been telling

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1 us during the course of your evidence.

2 There was clearly a significant impact on those  
3 working in ICU. Was any support in place to help the  
4 critical care nurse, those that were redeployed? Was  
5 there any support in place during any of the waves of  
6 the pandemic.

7 Perhaps, Professor, if I turn to you first?

8 **PROFESSOR SUMMERS:** Definitely healthcare system providers  
9 in a variety of ways attempted to provide support by  
10 making sure that counselling or other mental health  
11 services were made available.

12 I think what's also important to remember is that  
13 providing support is fine. However, you are not also  
14 able to remove the source of the ongoing injury if you  
15 have another wave coming and more patients coming in and  
16 you are trying to restore elective surgical services  
17 because there are a backlog of people who are also  
18 experiencing harm from not having their surgery. People  
19 cannot and do not want to stop working and continuing  
20 being exposed to the ongoing moral injury of not being  
21 able to provide care as they would want to.

22 So it is a complex situation and just providing  
23 a mental health service doesn't necessarily remove the  
24 strain.

25 **Q.** Shutting the door after the horse has bolted may be

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1 unscientifically, but the 1:6 ratios originally proposed  
2 caused excessive strain even in this context.

3 So moving to a 1:4 during the course of the  
4 pandemic before wave 2, which in a practical sense meant  
5 earlier decompression of the hot sites rather than  
6 letting them get to 1:6 and then seeing what happened  
7 next I think was a crucial step. So whatever the number  
8 is, it's more likely to be 4 than 6, in a surge pattern.

9 **PROFESSOR SUMMERS:** There is a reason we have 1:1 nursing of  
10 intensive care outside of pandemics.

11 **DR SUNTHARALINGAM:** Absolutely, yes.

12 **MS CAREY:** I won't ask you about all of the other  
13 recommendations you set out save for one of them,  
14 Doctor. I think you wanted to speak to the  
15 recommendation where you say to address the issue of  
16 future public health emergency, you recommend  
17 a citizen's assembly or other formal government  
18 consultation with an appropriate range of stakeholders.

19 Why do you advocate for a citizen's assembly, and  
20 what is it you envisage they might do and assist with?

21 **DR SUNTHARALINGAM:** Thank you. It was largely just because  
22 I was a bit vague to answer your question before. So in  
23 terms of a practical aspect of how this could be, sort  
24 of, addressed. But, really, the wider topic is of  
25 making sure that everyone who has an interest is

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1 a very inelegant way of putting it. But you have to  
2 tackle the underlying problem. That's what I really  
3 wanted to ask you about.

4 You have set out in your report a number of  
5 lessons learned and recommendations and I wanted to ask,  
6 we have heard a lot about the stretching of ratios  
7 within the critical care setting. Do you know if there  
8 is any research ongoing to understand the minimum safe  
9 staffing requirements that we could stretch to if we  
10 needed to in the event of a future pandemic?

11 **PROFESSOR SUMMERS:** Actually, since before the pandemic  
12 there has been a piece of research going on called  
13 SEISMIC, that has been looking to generate an evidence  
14 base around staffing ratios, particularly nurse staffing  
15 ratios in intensive care units. I don't think at the  
16 time the work was conceived it was thought about in  
17 terms of pandemic and stretch but I understand that the  
18 authors and the people who are working on that are also  
19 including that strain in their work but the results of  
20 that work are not yet available, but it is important  
21 work that I think will provide an evidence for how we  
22 provide care and ratios.

23 **DR SUNTHARALINGAM:** I think just less academically but from  
24 practical experience, I think something learnt during  
25 the pandemic was, just to put a figure on it, very

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1 involved. We can work on developing moral and ethical  
2 principles for an agreed, fair and just framework for  
3 allocating healthcare if demand exceeds supply, so in  
4 a crisis.

5 But also it's an opportunity to have an honest  
6 conversation about the role of, if you like, extreme  
7 healthcare, aggressive healthcare, towards the end of  
8 someone's life, both on a societal basis about how we  
9 might do things differently during a crisis and when  
10 things are overwhelmed but also for people to have  
11 discussions with their families about what they  
12 themselves would want under normal conditions but also  
13 in a future crisis and to take that time while we are  
14 able to have those conversations in an open way and  
15 doing it in a structured format through a citizen's  
16 assembly.

17 Thank you for that.

18 Is it okay if we can pick out two of the others?

19 **MS CAREY:** I was going to ask you each actually for a -- it  
20 is not about single recommendations but if there were  
21 one you wanted to impress upon her Ladyship, what would  
22 it be?

23 Perhaps you, Professor, first -- or I don't mind  
24 who goes first.

25 **PROFESSOR SUMMERS:** I'm happy to go first. I think the

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1 thing that I would like to emphasise is that intensive  
2 care is, as we have entitled the report, the last line  
3 of defence. We are required when everything else has  
4 failed, when prevention hasn't worked, when improving  
5 and tackling health inequalities, all of those other  
6 things, have not prevented disaster arriving at our door  
7 and intensive care is a supportive care package. It did  
8 not change the trajectory of the pandemic. What changed  
9 the trajectory of the pandemic is therapies and vaccines  
10 and our research being embedded into the care system.  
11 If we do not ensure that that is a continued line of  
12 defence, it doesn't matter how much resource we put into  
13 healthcare systems, in the absence of being able to  
14 change the trajectory of any kind of emergency we will  
15 potentially exhaust all capacity.

16 So we have to embed into our response to  
17 emergencies, pandemic and otherwise, means to change the  
18 trajectory of them and that means having robust supply  
19 lines, having the ability to understand novel emerging  
20 threats, to develop vaccinations and treatments, and to  
21 do that rapidly and at scale.

22 **MS CAREY:** Ideally we wouldn't need you.

23 **PROFESSOR SUMMERS:** Exactly.

24 **DR SUNTHARALINGAM:** Exactly.

25 **MS CAREY:** And Doctor?

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1 all of those involved in acute care as well as  
2 epidemiology experts.

3 So really a baseline look from the ground up at  
4 what critical care in the UK should look like, and then  
5 what can be afforded and provided becomes a separate  
6 discussion and I think this is a piece of work that  
7 hasn't been done but the pandemic should be a trigger  
8 for doing it.

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

10 My Lady, they are all the questions that I had.

11 **LADY JUSTICE HALLETT:** It may be you can't answer, this  
12 Professor/Doctor, I have been asked to ask you about the  
13 making of DNACPRs in a wider hospital setting. Is that  
14 a question for you or perhaps for later experts?

15 **PROFESSOR SUMMERS:** I do not clinically practise outside of  
16 the intensive care unit.

17 **LADY JUSTICE HALLETT:** Doctor?

18 **DR SUNTHARALINGAM:** Sorry, the question was about a wider --

19 **LADY JUSTICE HALLETT:** Yes, it is about people who are  
20 clinically vulnerable receiving calls at home about  
21 having notices put on their records.

22 **DR SUNTHARALINGAM:** Again, I think that's outside our remit.

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

24 The next person to ask questions is Mr Jacobs.

25 Please don't worry about turning your back to me as long

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1 **DR SUNTHARALINGAM:** Thank you.

2 Firstly, I would very much agree with that, that  
3 intensive care is to provide life support while the  
4 disease gets better, so we need to address that, I  
5 completely agree with my colleague.

6 The point I would like to raise, though, is about  
7 the capacity side of it, we have talked about it many  
8 times, but we would propose as an objective measure, in  
9 the next two years, a systematic UK-wide review of  
10 baseline ICU capacity. And the justification for that  
11 in this pandemic discussion is if we start lower then we  
12 have to stretch more and that does more damage. So it  
13 is about getting it right, not only in absolute quantum  
14 but also where it is, matching it to local populations,  
15 healthcare needs, planning ahead for changing patterns  
16 and disease and other processes, and we propose that be  
17 done by an independent body and not by, for example,  
18 NHS England or the other NHS bodies, not because they  
19 can't be trusted but because it puts them in a difficult  
20 position, they are the providers, and have to look at  
21 the funding. This is about identifying the need in  
22 an independent way.

23 So a body such as The Nuffield Foundation or The  
24 King's Fund or a university, to look at it independently  
25 with expert input from the critical care bodies but also

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1 as your reply goes into the microphone, thank you.

#### 2 **Questions from MR JACOBS**

3 **MR JACOBS:** Yes. Thank you.

4 Just one question, actually, on behalf of the  
5 Trades Union Congress, and it takes up, Doctor, what you  
6 were describing a moment ago in terms of the  
7 recommendation for a UK-wide review of baseline capacity  
8 and an objective assessment of whether it is adequate  
9 and matched to local health needs.

10 The need for a review is noted, but do you both  
11 have a view as to what baseline capacity should  
12 reasonably be, so as to have a reasonable level of  
13 resilience in a pandemic?

14 **PROFESSOR SUMMERS:** I guess I might to pick that up,  
15 reminding everybody that there are OECD figures for the  
16 number of intensive care beds per 100,000 population is  
17 one way of looking at the problem, but that doesn't take  
18 into account individual health inequalities and health  
19 need and burden of particular areas of geography. So  
20 the situation in how healthcare systems are delivered in  
21 one country compared to another, and the health  
22 inequalities in those, don't make that a straightforward  
23 calculation, so I would hesitate to give a precise  
24 number. It is more than we have because I do not  
25 think -- I think we have demonstrated we do not have the

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1 capacity that we should do for routine care, let alone  
 2 in pandemics, but I think it needs to be properly  
 3 conducted piece of work, and no one has done it.

4 **DR SUNTHARALINGAM:** And I think just to add to the previous  
 5 point about where it is as much as how much it is. As  
 6 somebody who works in London, I might be arguing against  
 7 myself, but it is -- is everything in the right places  
 8 and properly distributed around the regions and nations?

9 **Q.** Are you able to give us a sense of how much the dial  
 10 needs to shift, in broad terms?

11 **DR SUNTHARALINGAM:** I think to compare just among the OECD  
 12 figures, so I think we entered into the pandemic with  
 13 about half the number of the median figure, so we were  
 14 clearly way behind, and the level of stretch seemed to  
 15 be a lot higher than us.

16 **PROFESSOR SUMMERS:** To give some context to that, the OECD  
 17 average in 2021 was 16.9 per 100,000 population, and we  
 18 went in, in the UK, considerably lower than that. Italy  
 19 has 11.6 at that point, Sweden had 4.9, and Germany had  
 20 29.3. So there is wide variation which I think feeds  
 21 into how healthcare systems are delivered and individual  
 22 nations, but we were definitely substantially below the  
 23 average of the OECD nations.

24 **MR JACOBS:** Thank you very much.

25 **LADY JUSTICE HALLETT:** Thank you, Mr Jacobs.

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1 **PROFESSOR SUMMERS:** So I recognise very much the evidence  
 2 that you reference has been heard by the Inquiry.  
 3 I could not find systemic data that outlined that  
 4 problem for any of the nations. That doesn't mean that  
 5 it doesn't exist. What it means is there was no  
 6 publicly available data that I could find. I'm not  
 7 denying that that was the case, just that I could not  
 8 find a data source to be able to reference.

9 **Q.** The data gap. Okay.

10 Well, given that, well-documented, higher rates of  
 11 infection and mortality among ethnic minority healthcare  
 12 workers, were you able to assess whether there were any  
 13 adequate risk assessments or safeguards or policies that  
 14 were put in place in ICU for ethnic minority healthcare  
 15 workers?

16 **PROFESSOR SUMMERS:** So the occupational risk assessments  
 17 that were done within the NHS were the same for critical  
 18 care staff as they were for all other NHS staff. So  
 19 there wasn't a separate critical care risk assessment  
 20 undertaken.

21 **Q.** So there was nothing tailored specifically to ethnic  
 22 minority healthcare workers?

23 **PROFESSOR SUMMERS:** Or to intensive care workers is what I'm  
 24 saying. It was the standard NHS occupational risk  
 25 assessment, rather than it being tailored to one

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1 Who is next?  
 2 Mr Odogwu.

3 **Questions from MR ODOGWU**

4 **MR ODOGWU:** My Lady.  
 5 Good afternoon. I represent the Federation of  
 6 Ethnic Minority Healthcare Organisations which advocates  
 7 for healthcare workers from ethnic minority backgrounds  
 8 who were disproportionately impacted by the pandemic.  
 9 My question is probably best addressed to  
 10 Professor Summers, but I'm happy for Dr Suntharalingam  
 11 to answer if better placed.

12 The report acknowledges at paragraph 32 that staff  
 13 ratios were diluted, and that non-critical care staff  
 14 were redeployed to assist ICU during the pandemic which  
 15 came at significant costs to both staff and patients.

16 My question relates to potential racial  
 17 disparities in the redeployment of healthcare workers  
 18 during the pandemic. There has been some evidence in  
 19 this Inquiry of ethnic minority workers reporting that  
 20 they were given higher risk tasks and being redeployed  
 21 to Covid wards more often than their white colleagues.  
 22 Did you, as part of your assessment and report, assess  
 23 whether ethnic minority healthcare workers were over  
 24 represented and more likely to be placed within ICU or  
 25 critical care settings?

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1 particular group.

2 **Q.** Given the vulnerabilities of ethnic minority healthcare  
 3 workers in particular, do you consider that there were  
 4 adequate measures within the ICU setting for those  
 5 workers?

6 **PROFESSOR SUMMERS:** I think when -- as Dr Suntharalingam has  
 7 emphasised, the availability of PPE and protective  
 8 measures in intensive care settings was arguably better  
 9 available than in other parts of the hospital, so  
 10 I think that that is a complex question.

11 **MR ODOGWU:** Thank you very much, my Lady.

12 **LADY JUSTICE HALLETT:** Thank you very much.  
 13 Next, I think it is Ms Mitchell who is directly  
 14 ahead of you.

15 **Questions from MS MITCHELL KC**

16 **MS MITCHELL:** (inaudible).

17 **PROFESSOR SUMMERS:** I'm terribly sorry, I can't hear you --

18 **MS MITCHELL:** The microphone appears on.

19 **LADY JUSTICE HALLETT:** Yes, you're on now.

20 **MS MITCHELL:** I'm on now, thank you.

21 I appear as instructed by Aamer Anwar & Co  
 22 on behalf of the Scottish Covid Bereaved, and I have got  
 23 some questions to ask you about DNACPR.

24 Firstly, it is in relation to the confusion  
 25 surrounding some of these notices. I don't need to take

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1 you to it, but at paragraph 40 of your report you state  
2 that:  
3 "A DNACPR notice is not meant as a proxy for  
4 broader treatment decisions. However, in the absence of  
5 [a] clearly documented discussion and decisions about  
6 other forms of treatment, there is a potential for  
7 inappropriate over-interpretation of DNACPR[s] as  
8 a generalised treatment limitation option."  
9 Now, I presume that that potential for  
10 over-interpretation is in respect of medical  
11 professionals, not of families and patients? Is that  
12 correct?  
13 **DR SUNTHARALINGAM:** Potentially, although arguably it could  
14 be both; if that's the only discussion around treatment  
15 limitation that happens, then people may go away  
16 thinking that's been the wider discussion, and -- I say  
17 it can also lead to misinterpretation in the healthcare  
18 community. So going back to treatment escalation  
19 planning such as the ReSPECT form which is being  
20 implemented in parts of Scotland, part of the argument  
21 before having that broader discussion is to be very  
22 clear about which is the CPR decision and which is  
23 around other treatments, and having the opportunity for  
24 people to say, "I would like for myself or for my loved  
25 one active treatment, but I hear that CPR might not be

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1 how the bereaved found out that there were DNACPRs  
2 sometimes from their loved ones who were still with us  
3 or sometimes sadly no longer with us.

4 Families were excluded for very good reason  
5 obviously on occasion from being with their loved ones  
6 when they were in hospital. Was the exclusion of loved  
7 ones from visiting a possible way that inadvertently  
8 DNACPR discussions were lost for families at that time?

9 **DR SUNTHARALINGAM:** I think in a -- so to start a bit with  
10 the part of the hospital where I'm most familiar with  
11 and am really qualified to comment on, which is in  
12 intensive care, the sort of processes that  
13 Professor Summers described would have been how it was  
14 done. If the families weren't there, which was clearly  
15 the case most of the time, they would have had the  
16 discussion or the explanation by telephone. Elsewhere  
17 in the hospital we can't sort of necessarily comment,  
18 but if your question is, does the necessary visiting  
19 restriction raise a risk of things happening without  
20 those phone calls being made, then again theoretically  
21 I would say that it would be a risk.

22 **Q.** Can I ask you then briefly about the issue of reviewing  
23 of DNACPRs. Is the situation, as you understand it, in  
24 respect of the review of making a DNACPR, different in  
25 Scotland?

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1 the right thing for them. We can draw a line there, but  
2 other treatments should be actively pursued", which is  
3 actually a very standard set of circumstances, and it  
4 avoids the risk of the DNACPR itself being  
5 over-interpreted to cover other aspects of healthcare.  
6 **Q.** And indeed, one might make sense of that in terms of the  
7 recommendations that you have made in that regard.  
8 What I would like to ask on behalf of the Scottish  
9 Covid Bereaved about those potential  
10 over-interpretations or, as you describe later,  
11 potential misrepresentation, is: what were the possible  
12 implications for patients of those things that you  
13 describe?

14 **DR SUNTHARALINGAM:** This is theoretical, but if it led to  
15 somebody thinking that somebody has a DNACPR order and  
16 is therefore not for active treatment of any sort, that  
17 would be incorrect.

18 And, to take sort of a fictional example, if it  
19 resulted in them not getting antibiotics for sepsis  
20 because they are somehow felt to be not for further  
21 active treatment of any sort, that would obviously be  
22 quite a serious misunderstanding of what the DNACPR  
23 meant. But this is a fictional example.

24 **Q.** Can I ask you, moving on from that, you spoke about the  
25 questions, in fact my Lady posed a question to you about

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1 **DR SUNTHARALINGAM:** I don't -- as far as I'm aware, no. In  
2 that the principles are the same. The legal position,  
3 I think, is roughly similar in that although the legal  
4 position of advanced decisions to refuse treatment and  
5 so on is different, the DNACPR is an advisory notice,  
6 and the principles that it should be discussed with  
7 a patient where possible, that people should be  
8 informed, that it guides treatment options, I think, are  
9 the same across the nations.

10 **Q.** And particularly in respect of the issue of review of  
11 DNACPRs, is there a difference in Scotland as you  
12 understand it?

13 **DR SUNTHARALINGAM:** Not as I understand it. And as far as  
14 I know, no nation has a sort of scheduled review process  
15 or anything formalised, but the principles are the same  
16 which is that, if there are elements of the patient's  
17 condition that are acute, and those may change, and  
18 therefore if the patient's condition changes, for  
19 example they improve, then any DNACPR that's in place  
20 partly for that reason, due to severity, should be  
21 reviewed on clinical grounds rather than on any  
22 particular calendar or timescale.

23 If the DNACPR reflects fixed factors, such as  
24 their stable condition or where they are in their life  
25 in terms of getting towards the end of their life, in

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1 terms of a natural death, then that may not be necessary  
2 for review on any particular timetable.

3 If there is any sort of formal system for that,  
4 that's different between the countries I'm not aware of  
5 it, I'm afraid.

6 **Q.** I wonder if there is or there may be such a review. It  
7 doesn't seem entirely clear, I would have to say, but  
8 there is certainly a suggestion in the guidelines in  
9 Scotland that there may be an opportunity for timed  
10 reviews. If this is something that the Chair may be  
11 interested in, might you be able to look into that and  
12 give us your expert response on that?

13 **PROFESSOR SUMMERS:** I guess I would put it, as  
14 Dr Suntharalingam has just said, there are circumstances  
15 in which a timed review would be appropriate if the  
16 status was likely to change, but I can think of other  
17 circumstances in which a patient would have had  
18 an informed discussion with their healthcare team, for  
19 example, in the setting of widely disseminating  
20 malignancy, and they were towards the end of their life,  
21 that it may not be appropriate to have a recurrent  
22 discussion with that patient because that status is  
23 unlikely to change.

24 So I think it should be reviewed where clinically  
25 appropriate, and where patients feel that they wish it

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1 And you set out that this was:  
2 "... (conscious or unconscious alterations in  
3 decision-making by individual clinicians rather than due  
4 to policies or guidelines being issued) ..."

5 And that meant that those who might usually be  
6 admitted to ICU were not.

7 And we have also discussed in your evidence today  
8 that critical care was often being delivered outside of  
9 the ICU setting, and that that means, as you also set  
10 out in your report, that the data likely underestimates  
11 the overall number of critically ill patients.

12 My question arising from that is, is it likely  
13 that the informal variations in ICU admissions, combined  
14 with the data underestimating the overall number of  
15 critically-ill patients, created an incorrect perception  
16 that critical care was not saturated?

17 **PROFESSOR SUMMERS:** I think that is one interpretation of  
18 the situation. I guess what I would like to be able to  
19 give you a definitive answer is absolute concrete data  
20 to say that that was the case. I have, in writing this  
21 particular section and it was me who drafted this  
22 particular section, set out the data that I could find  
23 to support that there may have been a change in the  
24 people who were admitted to intensive care units whilst  
25 acknowledging, as you rightly highlight, that not

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1 to be reviewed too. Setting a hard and fast time point  
2 of reviewing it every so many days might not necessarily  
3 facilitate the kind of patient discussions that we would  
4 all hope for.

5 **DR SUNTHARALINGAM:** I agree. It may also have unpredictable  
6 effect. If there is a timed review every week, for the  
7 sake of argument, and the patient improves within two  
8 days, it may actually delay a discussion that might  
9 otherwise happen. I mean, it shouldn't do, but there  
10 are ups and downs, all these things, in healthcare.

11 **MS MITCHELL:** I'm obliged my, Lady.

12 **LADY JUSTICE HALLETT:** Thank you Ms Mitchell, very grateful.  
13 Ms Woodward.

#### Questions from MS WOODWARD

14 **MS WOODWARD:** I ask questions on behalf of Covid-19 Bereaved  
15 Families for Justice Cymru, and we have heard evidence  
16 today about the drafting of a national prioritisation  
17 framework, and notwithstanding the fact that this was  
18 never formally implemented, at paragraph 156 of your  
19 report you state that:

21 "Unfortunately, it is likely that in practice, ICU  
22 capacity was overwhelmed in some individual locations at  
23 certain times and that the criteria for ICU admission  
24 changed via local informal processes when capacity was  
25 stretched ..."

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1 everybody who was critically ill was admitted to  
2 a intensive care unit, and often critically ill  
3 treatment was carried out in places that would not  
4 normally do so.

5 So I think we have an incomplete picture but  
6 I certainly cannot tell you that it was not saturated,  
7 and I guess the other thing that I would highlight is  
8 that -- and I have quoted it I think, Helen MacNamara,  
9 the Deputy Cabinet Secretary, suggests that she had a  
10 conversation, was present for a conversation, where it  
11 was suggested that ventilator capacity may have been  
12 exceeded in January 2021, that was not something I was  
13 aware of until reading her evidence to Module 2, and it  
14 is concerning.

15 **DR SUNTHARALINGAM:** Just on the -- leaving aside data, but  
16 sort of anecdotally, as it were, I noted that the IFF  
17 survey, it was actually a doctor from Wales, as it  
18 happened, who stated that they were perhaps not  
19 admitting people at lower threshold as they might have  
20 done because it was perceived that the disease process  
21 for Covid was different, and that is really an example  
22 of where there is an arguable need for guidance, so that  
23 individual clinicians are not put in that position, and  
24 either they know to wait until there is a stage of  
25 triage, or they have some guidance, whether

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1 professionally or nationally, to encourage that  
2 decision-making.

3 So I would make the wider point that it is the  
4 role of national bodies to step into that breach and  
5 support not only their members but the wider patients  
6 and public in order to provide variation and provide  
7 consistency among the four nations, but also to make  
8 sure the staff don't have that moral injury of feeling  
9 themselves in that position without external support of  
10 people that are meant to be representing and protecting  
11 them.

12 **Q.** Do you think that perhaps that incorrect perception may  
13 have led those in charge to believe that a formal  
14 prioritisation framework was not needed when, in fact,  
15 perhaps, either a framework or more formal guidance was  
16 in fact needed from those in charge?

17 **PROFESSOR SUMMERS:** So I do not think -- and we looked at  
18 the data when we were here a week ago -- the proportion  
19 of critical care units that declared CRITCON 4 and  
20 I think NHS England have shared their data on that, was  
21 incredibly small. So I think actually the units, when  
22 asked to assess their strain, almost all, and whilst  
23 under huge strain, did not declare that they had reached  
24 the point where they thought that that was  
25 an appropriate thing and that we needed to proceed to

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1 get admitted, but at times of strain would not, that is  
2 a very different thing from triage by absence of  
3 resource.

4 **Q.** Do you think that there was any scope for further  
5 guidance to perhaps bridge that gap where critical care  
6 was reaching saturation but we weren't quite at CRITCON  
7 4 or the equivalent for the devolved nations?

8 **PROFESSOR SUMMERS:** I think there was very clear guidance  
9 that usual decision-making should proceed and that  
10 decisions should be made in the best interest of  
11 individual patients, absolutely, until the point it was  
12 declared people were at CRITCON 4 and there was national  
13 guidance for anything to change. I think that was  
14 repeatedly and appropriately shared by all nations at  
15 multiple time points during the pandemic.

16 **DR SUNTHARALINGAM:** I think there was a greater awareness of  
17 the guidance that did exist and there was something in  
18 the background that could be activated and engagement by  
19 all the relevant parties, which in this case was  
20 endorsed by the Welsh Intensive Care Society and  
21 Critical Care Network Wales. But, I think, broader  
22 awareness of that is probably the answer to your  
23 question that there is a plan and it could be brought  
24 out, but in the meantime usual decision-making applies,  
25 as Professor Summer has said.

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1 national triage.

2 **DR SUNTHARALINGAM:** I would echo that among the three  
3 nations including Wales, because although they weren't  
4 specifically using CRITCON as a tool due to different  
5 sizes and layers and the complexity, but I think that  
6 information about local strain was being passed up and  
7 down the chain in a similar way, so I think had that --  
8 hospitals reached that state, it would have been  
9 transmitted in a way that then triggered the activation  
10 of further measures, and that wasn't the case.

11 **Q.** But given what you said in your report about local  
12 informal processes likely changing, is it likely that  
13 prioritisation decisions were made, and were in fact  
14 incurring but just in the absence of formal guidance as  
15 to how those decisions should be approached?

16 **PROFESSOR SUMMERS:** So, to be really clear, there is a very  
17 big difference between prioritising whether critical  
18 care is appropriate for an individual patient, and we  
19 know from data before the pandemic that people  
20 sometimes, when their intensive care restrained vary in  
21 a soft or ill-defined way, the way in which they make  
22 those decisions -- I think the data from Wales, the  
23 doctor said in the survey about patients who they think  
24 might not make -- have benefit from critical care, but  
25 there is a small chance they might on some days would

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1 **Q.** Thank you.

2 Given the evidence that we heard earlier from you,  
3 Professor Summers, about older people being less likely  
4 to be admitted into ICU during the surges despite no  
5 policy that you were aware of regarding this, is it  
6 likely that the elderly were disproportionately  
7 disadvantaged by unconscious or conscious alterations in  
8 decision making made on an informal basis?

9 **PROFESSOR SUMMERS:** So I think to clarify exactly what  
10 I said both verbally and in the report, I said elderly  
11 people and those with greater burdens of comorbidities,  
12 so it was not just purely an age phenomenon, excluding  
13 anybody from anything on a purely age basis -- I'm  
14 surrounded by lawyers so I'm aware of this -- is legally  
15 dubious is I think where I will go. But actually, it is  
16 ethically inappropriate too. What matters is the  
17 individual patient and their circumstance and their  
18 comorbidities and their health status and their values  
19 and wishes. So I'm not aware of anywhere where there  
20 was an expressed policy, formal or informal where age  
21 was used as a cut-off.

22 **Q.** My next question is about continuous positive airway  
23 pressure, or CPAP, as it is more commonly referred to.  
24 If we could bring up INQ000480136.

25 This is a witness statement prepared on behalf of

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1 the Cardiff and Vale University Health Board and if we  
2 could look at the bullet point right at the bottom of  
3 the page. This is setting out the various steps that  
4 were taken at the local level by the Health Board to  
5 increase ICU capacity. And it says:

6 "Patients who, under normal circumstances, would  
7 have gone to critical care for CPAP, [non-invasive  
8 ventilation] or High Flow Nasal Oxygen were admitted to  
9 the escalated Respiratory Support Unit on the  
10 respiratory ward instead."

11 At the top of the next page, on the third line  
12 down, it says:

13 "It was agreed that should a patient not improve  
14 after 3 days on ward level with CPAP/high level nasal  
15 oxygen then we would refer for possible transfer to  
16 ICU."

17 At the very bottom of that paragraph it states  
18 that:

19 "The published data (from across all of Wales)  
20 showed that there was no significant difference in  
21 mortality for patients receiving CPAP managed on the  
22 respiratory wards and/or on ICU when corrected for age  
23 and comorbidity."

24 But:

25 "There was a notable difference between Wales and  
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1 **MS MUNROE:** Good afternoon. My name is Allison Munroe,  
2 I represent Covid-19 Bereaved Families for Justice UK.  
3 I have a few questions. Some of them have been touched  
4 upon to a lesser or larger extent during the course of  
5 your evidence.

6 My Lady, I will try and rationalise and summarise  
7 my questions accordingly.

8 The first one is in relation to escalation to ICU.  
9 Dr Suntharalingam, I look towards you but, of course,  
10 Professor Summers feel free to jump in and vice versa.

11 In the same paragraph you have just been referred  
12 to actually, paragraph 156 at your page 61, but  
13 a different question arising.

14 That is the paragraph where you note that in  
15 practice ICU capacity was overwhelmed in some locations  
16 at certain times, which chimes in with the evidence from  
17 Professor Fong of last week. You go on to say:

18 "The criteria for ICU admissions changed via local  
19 informal processes (conscious or unconscious)  
20 alterations in decision-making by individual clinicians  
21 rather than due to policy or guidelines being issued."

22 Then you add:

23 "This is a contentious topic for which robust data  
24 is challenging to assemble."

25 Doctor, in terms of what we can glean or what we  
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1 England in this regard as many more patients in England  
2 had CPAP on ICU."

3 I wanted to ask you on the basis of this, what the  
4 drawbacks and risks are to patient safety of not  
5 receiving CPAP on the ICU and instead receiving it on  
6 a ward.

7 **PROFESSOR SUMMERS:** So ordinarily acutely unwell and  
8 hypoxemic, so lacking in oxygen, patients would receive  
9 CPAP inside a critical care setting. We do that because  
10 it provides an increased level of ability to monitor the  
11 patient, both their oxygen levels, experienced care  
12 providers and also a higher nursing ratio and  
13 physiotherapy ratio than you might perhaps have on  
14 a regular ward.

15 So that would be our default gold standard way of  
16 delivering care. Unfortunately that was not possible  
17 during the pandemic at scale and not just in Wales,  
18 there is data suggesting that in many hospitals up to  
19 50% of people received their CPAP outside an intensive  
20 care unit.

21 It is the critically ill people who are not inside  
22 critical care units who I have repeatedly referred to.

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

24 Ms Munroe.

25 **Questions from MS MUNROE KC**  
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1 can take from those observations, does that mean that  
2 although national guidance and policies had not  
3 officially changed or altered there were instances of  
4 some local hospitals and ICUs operating a system of  
5 perhaps what -- if I can call it resource-led clinical  
6 prioritisation? I don't know if this chimes in this  
7 triage in the absence of a resource.

8 **DR SUNTHARALINGAM:** I will defer to Professor Summers, in a  
9 sense that was sort of a bridging paragraph looking at  
10 what the guidelines and the policy was and then leading  
11 into what might be more data led, so I will pass on to  
12 my colleague.

13 **PROFESSOR SUMMERS:** Thank you.

14 So in drafting this paragraph what I was trying  
15 perhaps ineloquently to communicate is that, whilst no  
16 policy was -- and guidance that decision-making should  
17 change was ever issued, I wasn't certain that that  
18 hadn't happened. Hence my use of "conscious" and  
19 "unconscious" because I cannot speculate about the  
20 individual decision-making that happened in every case  
21 by every clinician across all four nations of the  
22 country. And I was trying to communicate uncertainty as  
23 opposed to me having evidence that particular things  
24 happened.

25 **Q.** And so on that specific point of resource-led clinical  
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1 prioritisation, do we simply not have the data, robust  
 2 data to come to any conclusions?  
 3 **PROFESSOR SUMMERS:** Other than the data that I presented  
 4 about the changes during the peak of the demographic  
 5 characteristics of the people who were admitted,  
 6 I couldn't find any data and I did look quite hard, but  
 7 that doesn't mean that it didn't happen, and it doesn't  
 8 mean it did happen, it just means I could not find data.  
 9 **Q.** Thank you. Staying on the issue of data, ICNARC data,  
 10 you again touched upon this in your evidence just after  
 11 the break, and I want to highlight two parts of your  
 12 report, and I think again you mentioned paragraph 161 on  
 13 page 64. But the next paragraph, at 162, you note that  
 14 the ICNARC publication data raised the possibility --  
 15 and you put it no higher than a possibility -- that:  
 16 "... efforts were directed at saving patients with  
 17 the greatest chance of survival (those who were younger  
 18 and previously fitter but with the most severe illness)  
 19 during the peak of the first wave."  
 20 Then you talk about, again, same page,  
 21 paragraph 164, this group, the 142,000 longitudinal  
 22 clinical path, where they found:  
 23 "... ward mortality was highest when older  
 24 patients were least likely to be admitted into ICU,  
 25 suggesting these patients may potentially have benefited  
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1 **Q.** All right. Secondly, at paragraph 163, you further  
 2 consider the analysis of the data. And you use  
 3 a phrase -- it is by the authors of the report, not  
 4 yours -- rationing of care.  
 5 My question is this, Professor: do you accept or  
 6 believe that the informal "rationing of care", due to  
 7 a lack of ICU capacity, likely caused or contributed to  
 8 deaths during this period?  
 9 **PROFESSOR SUMMERS:** I think what I would say is that I have  
 10 uncertainty. I do not think I can tell you either way.  
 11 I don't have anything to support it. I cannot rule it  
 12 out and I cannot rule it in.  
 13 **Q.** All right.  
 14 **PROFESSOR SUMMERS:** If you ask me for an overall impression,  
 15 I think it would be a very unwise person who tells you  
 16 that in every circumstance in every hospital across the  
 17 country, that something happened as it was supposed to  
 18 happen.  
 19 **Q.** Thank you very much. Then, thirdly, on this related  
 20 topic and this may be a question for you, Doctor, you  
 21 spoke earlier about transparency and the need for  
 22 transparency when you were discussing the clinical tool  
 23 for the four nations to consider clinical prioritisation  
 24 levels.  
 25 Now, this question is maybe a difficult one  
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1 from ICU admission."  
 2 Just a couple of questions arising from that  
 3 please. Firstly, is it fair to conclude then that the  
 4 corollary of that data, and those observations, was that  
 5 patients who became very ill with Covid-19 in this  
 6 period, who required intensive care but were not  
 7 admitted to ICU, for example, due to old age or  
 8 pre-existing health conditions and disabilities,  
 9 effectively had their chances of survival reduced?  
 10 **PROFESSOR SUMMERS:** I think what I was trying to say was  
 11 that at times of strain, the data and the authors of  
 12 both these separate publications said that in people who  
 13 were thought to be less likely to survive, so people who  
 14 were older and had a greater burden of healthcare,  
 15 co-morbidity, they were less likely to be admitted into  
 16 an intensive care unit, and that their mortality was  
 17 thereby increased.  
 18 Now, whether that mortality is increased as  
 19 a function of the fact that they were thought initially  
 20 to not be as likely to survive as a younger, less  
 21 comorbid person, I'm unable to tell. I can tell you  
 22 that their mortality was increased, and that they were  
 23 less likely to come to an intensive care unit. Whether  
 24 those two things are causally related, I can't tell from  
 25 you the available data.  
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1 because it sort of traverses perhaps moral, ethical and  
 2 perhaps even political considerations, but do you  
 3 consider that patients and their families could or  
 4 should have been told that there were instances -- if  
 5 there were instances -- where decisions not to admit  
 6 them to ICU were based on resources rather than whether  
 7 or not admission was clinically indicated? Is that  
 8 something they should have been told or indeed could  
 9 have been told?  
 10 **DR SUNTHARALINGAM:** I think the question takes the premise  
 11 that it happened, which we don't know --  
 12 **Q.** Yes.  
 13 **DR SUNTHARALINGAM:** -- and in fact, just to reference your  
 14 last question, I noticed the quote that you gave came  
 15 from London, and actually there was a lot of transfer  
 16 activity and hospital that became overwhelmed would be  
 17 transferring out. In London, the hospitals are closer  
 18 -- I happened to work there, the hospitals are fairly  
 19 close together, the transfer systems were there prior to  
 20 Covid, to a large extent, so I think it is less likely,  
 21 if anything, that somebody would simply turn someone  
 22 away for lack of beds when there is another hospital not  
 23 far away. But that's just a comment on that particular  
 24 paragraph, as it were.  
 25 I think, to answer your -- the present question,  
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1 as a matter of principle, I would say yes, they should  
2 be told. It is difficult to answer whether they were  
3 told because I'm not aware of those particular scenarios  
4 happening.

5 I think, if there were some future crisis, whether  
6 it is disease or anything else, some major incident,  
7 and decisions were made on that basis using whatever  
8 framework or tool was in use at the time, then, as  
9 a matter of principle, yes, people should be told that  
10 "This is the reason. We would admit you to ICU  
11 normally, we are unable to now for these and these  
12 factors, this is how we made the decision", and there  
13 should be transparency.

14 As I say, I can't comment on whether that's  
15 happened this time. We don't believe it did. And so  
16 that's as far as I can answer that I think.

17 **Q.** Thank you. Frailty scoring and DNACPR. We have dealt  
18 quite a lot with DNACPR, so perhaps looking more at the  
19 frailty scoring aspect here.

20 You refer to the NICE in your report at pages 45  
21 and 46, paragraph 108 -- the NICE algorithm of  
22 22 March 2020, which was part of a broader written  
23 agreement that emphasised the limitations of using  
24 Clinical Frailty Scale.

25 Do you believe that as a result of the NICE  
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1 becomes part of the assessment. And one of the dangers  
2 of it is that somebody who, for example, might need  
3 carers for another reason such as learning disability,  
4 but that doesn't reflect biological weakness, so to  
5 speak, in their bodily tissues, may become labelled with  
6 that. So a clarification was made by the authors of the  
7 NICE guidance which was not ours, that firstly this  
8 shouldn't be used under 65 where it is not validated.  
9 The tool is validated in those older, and that care  
10 should be taken to consider other factors.

11 Now, in the terms of the guidance and your  
12 question, the later work that was done very clearly  
13 paired those discussions with capacity and escalation,  
14 mutual age, and CRITCON or other measures of units being  
15 overwhelmed, so in any formal sense, people should not  
16 be using the tool because they had not been authorised  
17 to do so because the nation was not in a state of  
18 CRITCON 4.

19 And part of the argument for making it public and  
20 open and transparent is that people are aware that's the  
21 framework and the sort of guard rails to stop it being  
22 used prematurely.

23 So I think I would answer the question that way,  
24 which is that the discussion around frailty is complex.  
25 Including it in a decision-making tool, in a situation  
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1 algorithm and guidance, there was a risk that clinicians  
2 would perhaps over estimate clinical frailty scores  
3 associated to factors such as age, pre-existing health  
4 conditions when considering whether patients were  
5 eligible for ICU admission, ventilation, and other  
6 hospital care at a time when there was a severe  
7 constraints on resources and capacity?

8 **DR SUNTHARALINGAM:** So that guidance was separate to our  
9 piece of work. I think my understanding is that it was  
10 brought out in a form which talked about the frailty  
11 score without qualification, and was then rapidly  
12 withdrawn and replaced with a version that made some  
13 points about not misinterpreting frailty in the context  
14 of stable disability.

15 And just to sort of gloss that a little bit, the  
16 frailty score, which is a clinically validated tool used  
17 in the care of the elderly community as a marker of  
18 biological frailty, in other words, people's bodily  
19 tissues slowly deteriorate to the point where their  
20 ability recover from illness is impaired, and there are  
21 proxy measures for that, which include their state of  
22 mobility and general health.

23 Inevitably, in putting things into that sort of  
24 framework, things get simplified, and for example, the  
25 need for being bed-bound or need for carers and so on  
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1 of the healthcare system being overwhelmed is a topic  
2 for discussion, and the more discussion and development  
3 we have of it, the better. But there wasn't a situation  
4 where it would have been used in its current form as we  
5 didn't reach that operational trigger.

6 The NICE guidance, I can't really comment on, but  
7 I do note a version was withdrawn and replaced with one  
8 which made some explanatory notes to clarify the use of  
9 frailty scoring.

10 The document which we then later worked on was  
11 a separate one which went into a little bit more detail,  
12 and that's something as well -- I can leave it there.

13 In consultation with -- as part of that piece of  
14 work, discussion with, I believe, Age UK and other  
15 bodies, they commented on the fact that graphics were  
16 what they felt to be simplifying and potentially  
17 demeaning, so the graphical element of the frailty score  
18 was taken out in the version that we then used. But  
19 there's obviously a lot more to it than just that.

20 **Q.** Thank you. My final question has for the most part been  
21 answered, but if I can just ask you, perhaps,  
22 Professor Summers, a point of clarification more than  
23 anything else.

24 In your paragraph 55 of the report you talk about,  
25 obviously, the poor mental health of ICU staff and the  
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1 phenomenon of presenteeism, working while sick, where  
2 staff continue to work even though their functioning is  
3 impaired.

4 I think, from your answers both to my Lady and to  
5 Ms Carey KC, that you would agree that the poor mental  
6 health of healthcare workers during the pandemic is  
7 likely or could have been likely to negatively impact  
8 upon the quality of care and safety of patients?

9 **PROFESSOR SUMMERS:** Unquestionably.

10 **Q.** You said in answers right at the end of your examination  
11 by Ms Carey KC that "No one can be surprised by this,  
12 the pressure never came off in 2020, and then going into  
13 2021 peaks, there were greater demands as well as trying  
14 to resume elective surgery care. We all carry the scars  
15 of the last five years."

16 My question is simply this on behalf of those  
17 I represent: has enough, do you think, been done to help  
18 healthcare workers heal from those scars, and prevent  
19 the moral distress leading to moral injury that  
20 Dr Suntharalingam described last week, and the poor  
21 mental health impacting negatively upon patients?

22 **PROFESSOR SUMMERS:** I think that is a really difficult and  
23 complicated question that's not easy to answer. How  
24 much would be enough to offset what everybody has been  
25 through? I'm not sure that for people whose loved ones

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1 an improvement has been there is greater emphasis now  
2 across the healthcare sector about well-being, but also  
3 in concrete terms more ICUs now have clinical  
4 psychologists, funded and deployed, and they look after  
5 either the same people or different teams look after the  
6 staff or patients. This is part of standard critical  
7 care in other countries such as France, and I think this  
8 has been an important positive development.

9 I wouldn't want, in any way, to say that is enough  
10 for a part of it, but it is a group of staff, just to  
11 mention, really, the work they do, and the importance of  
12 having them resourced and funded. But that's only one  
13 small part and I completely agree with Professor  
14 Summers's wider message.

15 **PROFESSOR SUMMERS:** And it is not just intensive care staff  
16 that carry these scars.

17 **MS MUNROE:** Thank you both very much.

18 We've gone over into lunch, I do apologise.

19 **LADY JUSTICE HALLETT:** Don't worry, not your fault. That  
20 completes all the questions we have for you, thank you  
21 both for all your clinical work, obviously, and I can  
22 only imagine the scars you talked about.

23 Thank you for your help in preparing the written  
24 report, and, of course, the help you have given in the  
25 course of your evidence. It has been extremely helpful.

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1 who were in hospital, for those of us that were in  
2 hospital or in primary care settings or in social care  
3 settings, there would ever be enough support to make  
4 what we all went through better.

5 Is there enough support to enable people to  
6 continue to do their roles in a way that makes the  
7 healthcare safe? I think the commitment and the amazing  
8 efforts by healthcare workers, and social care  
9 workers -- I think that should be recognised too -- to  
10 continue to deliver care for those that need it, has  
11 been extraordinary. Many of them are continuing to do  
12 so, carrying the scars that I talked about. They won't  
13 ever be the same. There is no going back to how we were  
14 before; that is not possible, we can't unsee things, but  
15 there is a huge, huge burden of care that is still  
16 needed. There are enormous elective waiting lists and  
17 care lists that need to be addressed because they were  
18 delayed during the pandemic, and we went into the  
19 pandemic with some fairly sizeable waiting lists too.

20 So, there is no chance to pause and reflect and  
21 stop and repair; people are doing the very best they  
22 can.

23 **DR SUNTHARALINGAM:** I would completely agree with that, and  
24 I would like to raise anyway -- without taking away  
25 anything from that -- so one positive learning, I think,

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1 And thank you for your patience, having had your  
2 evidence disrupted last week. So thank you again.  
3 2.10 pm.

4 **(The witnesses withdrew)**

5 **(1.06 pm)**

6 **(Luncheon adjournment)**

7 **(2.10 pm)**

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

9 **MR FIREMAN:** May I please call Dr Mathieu.

10 **DR STEPHEN MATHIEU (affirmed)**

11 **Questions from COUNSEL TO THE INQUIRY**

12 **LADY JUSTICE HALLETT:** I hope you haven't been waiting for  
13 too long.

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

15 **MR FIREMAN:** Could you please give your full name.

16 **A.** Stephen Mathieu.

17 **Q.** Dr Mathieu, you have given two witness statements to the  
18 Inquiry. They are dated 26th March 2024 and  
19 20 August 2024 and for the record they are INQ000472300  
20 and INQ000474302.

21 Dr Mathieu, you are the president of The Intensive  
22 Care Society; is that correct?

23 **A.** That is correct.

24 **Q.** And you have been in that position since December 2022?

25 **A.** That is correct.

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1 Q. You are also a consultant in critical care at Portsmouth  
2 Hospital University Trust; is that right?

3 A. Correct.

4 Q. What is the role of The Intensive Care Society?

5 A. Thank you.

6 So The Intensive Care Society is a charity. It  
7 was founded in 1970. It is the largest  
8 multi-professional intensive care society, certainly in  
9 the UK and across Europe, and its main purpose is  
10 effectively to be the voice and support for patients,  
11 relatives and do that through our team. So our  
12 multi-professional staff.

13 So we do that through education, policy standards,  
14 guidelines, encouraging research, education.

15 The Society itself has 23 council members and it  
16 has 10 professional advisory groups which means that  
17 amongst the team we have probably got to near 100 people  
18 that are active clinicians, multi-professionals, that  
19 work throughout our country.

20 Q. You say across the UK, is the society UK-wide or it is  
21 England-specific?

22 A. It is UK-wide. And thank you, that was the purpose of  
23 the supplementary appendix. We do our very best to  
24 support and to provide a voice for all nations but  
25 clearly we do that in very close collaboration with

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1 I will ask you a little bit more specifically about some  
2 of the work that The Intensive Care Society did during  
3 the pandemic.

4 If I could start with the last of those given  
5 that's your specific role.

6 Just for clarity, you confirmed earlier your  
7 professional role as well as your role as president of  
8 the Society. Were you also working in intensive care  
9 during the relevant period?

10 A. I was. So I have a clinical and a management role in my  
11 organisation throughout the pandemic period. I would  
12 have effectively worked full-time on critical care.

13 Q. Were you also heavily involved with the Society although  
14 you weren't president, were you heavily involved with  
15 many of the ongoing activities of the Society during the  
16 pandemic and during the relevant period of the pandemic?

17 A. Sorry to interrupt. Yes, I have been a member of the  
18 Society for eight years now.

19 Q. You describe in your witness statement some of the  
20 activities of the Society during the relevant period  
21 which included the establishment of the National  
22 Emergency Critical Care Committee. Can you explain --  
23 I think you use the acronym the NECCC -- can you explain  
24 the work that was done by that committee?

25 A. Yes. So the NECCC, the National Emergency Critical Care

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1 other partner organisations, including the Welsh  
2 Intensive Care Society, Northern Ireland and Scottish  
3 Intensive Care Society.

4 Q. Just for clarity, what is the role of those individual  
5 societies given that The Intensive Care Society has  
6 a UK-wide reach?

7 A. I think they have a very important role but -- and, as  
8 I say, we do collaborate with them. The intent is very  
9 much for us to do that together, but I think it is  
10 important that we reflect that we are not only trying to  
11 do what we need to do for patients, relatives and our  
12 teams just in England alone but as you allude to there  
13 are other organisations that are important and we work  
14 closely with them.

15 Q. Dr Mathieu, we have heard earlier this morning from  
16 Professor Summers and Dr Suntharalingam who are  
17 obviously in the intensive care sphere. There may well  
18 be some of the issues that we will talk about today that  
19 they have covered but so that you are aware, we will  
20 cover some of those topics perhaps a little bit more  
21 briefly. But those are the topics that I was going to  
22 ask you about and so just to give you a heads up that in  
23 terms of those topics they include capacity, to some  
24 degree, ICU capacity, ethical issues, the mental health  
25 and wellbeing of staff working in intensive care, and

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1 Committee, was set up at pace and set up specifically  
2 for us to understand and support our plans, our  
3 understanding, our engagement, our interactions with all  
4 the other professional teams, the other disciplines.

5 So it was set up by Professor Hugh Montgomery and  
6 Dr Ganesh Suntharalingam, who is one of the expert  
7 witnesses, and it was done very quickly and it was,  
8 I suppose, unique in the sense that it was done  
9 intentionally to try and -- for us to understand as much  
10 as we could quickly about the SARS-2 virus Covid-19, but  
11 also to understand learning from other organisations and  
12 other countries, particularly Italy, at that point in  
13 time that had just had quite a significant impact from  
14 Covid.

15 It was a very different type of committee in that  
16 it was very much bottom up. It was nonhierarchical, it  
17 was very much an open invite to those that were able who  
18 felt they could offer some support/guidance. So we  
19 opened it up to all of our council members and the  
20 Operational Delivery Networks leads throughout the  
21 country. We opened it up to other societies, so  
22 actually, what we also did, which I think was the  
23 benefit and the power of it, was opening it up to  
24 emergency medicine, acute medicine, British Thoracic  
25 Society, the Renal Association. So suddenly we had

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1 a lot more granular detail about what their experiences  
 2 were and how we could support each other.  
 3 **Q.** Just for clarity, was this a series of virtual meetings  
 4 that were taking place?  
 5 **A.** Yes. So it was set up, as I say, at pace with -- in the  
 6 end there were about 30 virtual meetings, there were no  
 7 face-to-face meetings, they were all done virtually, and  
 8 there were also knowledge-sharing webinars. So  
 9 actually, by doing that, we were able to extend our  
 10 reach to around 100 organisations.  
 11 **Q.** Did those organisations include government agencies or  
 12 government departments?  
 13 **A.** So they included the presidents of the societies of  
 14 Wales, Northern Ireland and Scotland critical care and  
 15 they included some of the medical directors of NHSE.  
 16 But they also included lots of other important people  
 17 through military, we had all sorts of invites that  
 18 actually were helpful to get their understanding, the  
 19 likes of Google, Microsoft, lots of different ideas to  
 20 try and generate as much information as we could about  
 21 data, how we could share it, how we could use it, really  
 22 as a bit of a hive of understanding and knowledge  
 23 dissemination.  
 24 **Q.** Just for the Inquiry's understanding, was the Committee  
 25 more concentrated on information sharing and supporting

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1 I guess that was one example.  
 2 The treatment decision support guidance framework  
 3 that has been discussed, that was also discussed at  
 4 NECCC meetings.  
 5 **Q.** If I could just pause you there for a second. I suppose  
 6 you are giving examples of where there were discussions  
 7 that ultimately then led to the production of relevant  
 8 guidance albeit not necessarily direct cause and effect;  
 9 is that correct?  
 10 **A.** Yes.  
 11 **Q.** There were discussions about the relevant issues with  
 12 professionals within the sphere and some of these points  
 13 were then taken on and produced in a more formal way; is  
 14 that right?  
 15 **A.** Yes. I think the intent was always for somebody with  
 16 the expert knowledge and access to the right people  
 17 would be the person who would take responsibility for  
 18 those actions and research is obviously a big part of  
 19 that, as well as trying to make sure we were asking the  
 20 right questions and using our directors of research  
 21 through The Intensive Care Society to help us with that.  
 22 **Q.** Within your witness statement you have set out a number  
 23 of recommendations for her Ladyship to consider in the  
 24 context of recommendations around intensive care. One  
 25 of them is about the Society having a voice -- this is,

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1 members or was it involved actually in shaping any  
 2 policy in relation to intensive care?  
 3 **A.** I think the intent was to do both and, if I may, I will  
 4 perhaps give some examples. So the context to some of  
 5 this in terms of feeding information through was that  
 6 The Intensive Care Society set up a national leads  
 7 WhatsApp group very quickly. That was the sort of  
 8 trying to get an understanding of what people were  
 9 feeling at a unit-by-unit level, bringing those  
 10 experiences and information into NECCC to see whether  
 11 there was -- that sort of information was something that  
 12 others were experiencing and then trying to address what  
 13 the problem was and help with some solutions.  
 14 So in terms of the guidance, the statements, the  
 15 policy side of things, one example is we knew that, for  
 16 instance, that there was a risk around if there would be  
 17 enough dialysis machines. I think in the end we were  
 18 able to provide enough options for renal replacement  
 19 therapy but at the time we weren't sure, so what we were  
 20 able to do is work very quickly and agilely with other  
 21 organisations -- I think probably removing some of the  
 22 bureaucracy that can be associated with committees and  
 23 associations and how you want to navigate some of this  
 24 guidance documents by getting straight to the experts  
 25 and getting the guidance out very quickly.

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1 for your reference, recommendation Q at the second-last  
 2 paragraph of your witness statement, and you refer to  
 3 the Society having a voice at the relevant fora  
 4 informing national policy and decision-making for acute  
 5 and intensive care, both in peace time and during  
 6 national emergencies.  
 7 Do I take it from that that you didn't feel that  
 8 the Society did have the voice that it should have had  
 9 during the relevant period?  
 10 **A.** We are a charity, we are not a Royal College or  
 11 obviously part of the Academy of Royal Colleges so  
 12 therefore I suppose our accessibility directly to higher  
 13 level, sort of, ministers, is different to the  
 14 experiences that those organisations will have.  
 15 I think we have an important place in those  
 16 discussions and we do have those discussions but they  
 17 are often a little bit more difficult to navigate and  
 18 I think the strength of our place and I think it was  
 19 demonstrated through NECCC, was that we are genuinely  
 20 a very multi-professional organisation. We are not  
 21 doctors, we are not nurses, we are not physiotherapists,  
 22 we are not pharmacists, we are not the other HPs that  
 23 are important, the psychologists we talked about. We  
 24 represent all of them, and that's where I think we have  
 25 the benefit of being able to provide that different way

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1 of thinking and therefore our ability, I think, to  
2 extend into those professions and to get their views is  
3 an important one.

4 **Q.** Do you think there's anything in the fact that you are  
5 a charity rather than perhaps a body that might  
6 otherwise be seen to be more part of, to use  
7 a colloquial term, the establishment or something to  
8 that effect, the fact that you have charitable status  
9 and you are not embedded within the institutions, does  
10 that have any relevance here?

11 **A.** I don't necessarily think so and I would want to point  
12 out I think the other organisations have an important  
13 role to play and we are strategic partners with many of  
14 those organisations. I guess the ask, which is the  
15 recommendation, is that it would be helpful and I think  
16 we would genuinely be able to provide a positive and  
17 supportive influence particularly around learning and  
18 genuine multi-professional representation; we would have  
19 a helpful place.

20 **Q.** Can I turn to another topic which is something which we  
21 did cover to a great degree earlier on this morning,  
22 which is that of intensive care capacity. If I can just  
23 ask you a few questions about this area. One of these  
24 is in relation to the way in which you measure intensive  
25 care capacity, and we heard about the fact that it can

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1 ICUs with different staffing ratios, with access that  
2 was different to some of the equipment that we have  
3 discussed already, meant that as a result of that, it  
4 looked like there was more available ICU bed capacity  
5 than there was.

6 So if I use that same example, if we create  
7 another 20 beds in another part of the hospital and  
8 perhaps use a theatre recovery as the example, if ten of  
9 those beds are full, you don't then have 75% occupancy,  
10 you have got 100 plus 50 or 150%, however you want to  
11 describe it, but it just meant that what it looked like  
12 was that there were many empty beds available across the  
13 UK, which there absolutely were not.

14 So it's about descriptions, it is about  
15 definitions, it wasn't in any way, I don't think  
16 intended to cause confusion, but that was the result of  
17 it, and it is recorded differently I think in Scotland,  
18 Wales and Northern Ireland as opposed to how it was very  
19 early on in the pandemic in England.

20 **Q.** Why is it so important on a practical level to  
21 understand the real terms capacity across ICUs, across  
22 the country?

23 **A.** So I think why it is important is that we know that when  
24 we are at or near capacity, and certainly if we are over  
25 capacity, that will have an impact, the impact being the

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1 be measured and was indeed measured in different ways.

2 You say in your witness statement that on  
3 3rd January 2021 -- this is at paragraph 129 -- that the  
4 Society issued a document advising all hospitals to use  
5 the percentage change from baseline as a reporting  
6 figure. Do you recall why it was the Society felt it  
7 was necessary to issue that statement?

8 **A.** I do, thank you. So, there was a variation in the way  
9 that data was being recorded, and that was leading to  
10 confusion, not intended, but it was leading to  
11 confusion, and the data that was therefore being  
12 declared and discussed at a sort of media level, public  
13 level was sometimes inaccurate. Not intentionally, but  
14 that was the result of it. So if I could give  
15 an example, if we had a 20-bedded intensive care unit,  
16 we have a physical capacity of 20 beds. If all of those  
17 beds are filled with unwell patients, we have  
18 an occupancy versus our baseline capacity of  
19 100 per cent.

20 The problem happened is that everyone at the early  
21 phase of the pandemic was asked to see where there were  
22 opportunities to expand their intensive care bed spaces,  
23 and we did that, and I think we did that very well. But  
24 what then -- the risk that then happened is that those  
25 beds that were not intensive care beds, they were pop-up

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1 ability to admit patients in a more timely fashion. The  
2 ability for staff to stretch to meet those demands  
3 because they are already stretched. It also has  
4 an impact on decision-making around mutual aid  
5 transfers, for an example.

6 So that is one element of a wider group of tools  
7 I guess we use to describe pressure on intensive care  
8 unit occupancy capacity. CRITCON, which we have talked  
9 about already -- and then if I may, the other bit that  
10 none of this describes is all of the activity that was  
11 happening outside of what would be an expanded intensive  
12 care or critical care footprint. So none of this data  
13 captured all of the work that was being done and all the  
14 patients that were only cared for on respiratory high  
15 care support units in acute medical wards.

16 And that's why I think the definitions are so key  
17 here, that we really do capture the amount of work and  
18 effort, the amount of people -- because there is a risk  
19 we are talking about beds and capacity -- people that we  
20 are desperately trying to do our best for.

21 **Q.** Can I take it from what you have said, then, that you  
22 would support there being a nationally agreed definition  
23 of capacity to be used both in non-pandemic and in  
24 pandemic times?

25 **A.** Yes, and that was very much the reason that we issued

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1 our statement and made it public in the hope that that  
2 would be captured, and it did. I think it did influence  
3 change. We saw some of the data being better accorded.  
4 I have seen, first-hand, within my own region, the way  
5 we capture data now is much more advanced and accurate  
6 compared to where it used to be.

7 **Q.** One of the measures that was used to try to increase  
8 capacity was the introduction of Nightingale hospitals.  
9 You touch on that very briefly within your statement but  
10 I want to just ask you do you consider that the role of  
11 Nightingale hospitals and the use of them was  
12 an appropriate way to try to increase intensive care  
13 capacity?

14 **A.** I think the intent was right in that the data very early  
15 on in the pandemic, as we were looking at various  
16 scenarios, which obviously at that point we didn't have  
17 the vaccine, we were still trying to understand  
18 a multi-system pathogen that affects all organs, we were  
19 trying to better understand what our therapeutic options  
20 were.

21 All of the scenarios were showing that we just  
22 would not have enough physical capacity, never mind  
23 about staffing or equipment.

24 So I can understand the rationale for looking at  
25 it and exploring it. I think the reality as we all then

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1 one thing, but the staff is fixed, and intensive care  
2 staff, many of the other speciality staffs, they can't  
3 -- we can't just generate them quickly. They take years  
4 and years of training, and those staff were not  
5 available. So all of these things that we talk about in  
6 terms of stretching the staffing models are all reliant  
7 on the existing staff working more, harder, more shifts,  
8 all of those things, with the impact that created. So  
9 moving them to another hospital not only meant it was  
10 the same staff doing that, but actually made you less  
11 resilient within your own organisations.

12 **MR FIREMAN:** I don't know whether you are able to answer  
13 this, but do you think that maybe there is a role for  
14 a temporary hospital in circumstances where you need to  
15 increase capacity, but that's not necessarily in the  
16 context of intensive care?

17 **A.** Yes. I think that's probably -- well, I think the first  
18 thing is that now, in the situation we are in at the  
19 moment, it is something we have to explore, which is  
20 what would we do and what would we use it for if we were  
21 to ask that same question again, and I think the answer  
22 is right, that it wouldn't be used for intensive care.  
23 The question is, could it be used for other lower acuity  
24 level care, provided it has the right staff mix there  
25 available to look after those patients, or as a form of

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1 understood is that intensive care is so reliant on  
2 a team, a multi-professional team, that need to be in  
3 the same place; we need the access to the diagnostics,  
4 the other important specialists provide us with their  
5 input, and I think with all the best intent, the  
6 Nightingale hospitals were not going to be able to do  
7 that reliably for intensive care. It might work in some  
8 places, for instance, in London, in terms of  
9 decompressing, but the reality is I don't think it will  
10 have worked in the way that it was intended to, and in  
11 some ways probably was an unintended distraction in  
12 terms of us trying to consolidate and manage the  
13 workforce that we had within our own hospitals.

14 **LADY JUSTICE HALLETT:** Taking up that point, Doctor, given  
15 that the staff you had was stretched beyond capacity --

16 **A.** Yes.

17 **LADY JUSTICE HALLETT:** -- some might argue, and you could  
18 only open a Nightingale hospital if you had the staff,  
19 the intent may have been good, but the intent was  
20 physical beds. How was anybody ever going to staff  
21 a Nightingale hospital, given the pressures on all of  
22 you working already, full stretch?

23 **A.** Yes, I think you have probably eloquently described it  
24 in a better way than I have. I think it is exactly  
25 that, which is that -- space is one thing, equipment is

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1 rehabilitation, post-acute illness?

2 But I think we do need to understand whether --  
3 what the benefits would be in the future, and the impact  
4 particularly around the staffing models.

5 **Q.** The Society produced a report in January 2021 called  
6 "Recovery and restitution of critical care". I want to  
7 have a look at a passage that was in that report. It is  
8 INQ000395297, and it is the third page. If we could  
9 just look at this text here that has been enlarged. If  
10 we look about four sentences down, there is a sentence  
11 that starts:

12 "Bed occupancy was thus greater: on  
13 24th January 2021, 5446 English ICU beds were occupied,  
14 compared to 3423 in January 2020."

15 Then it describes the difference there and it goes  
16 on at the bottom the final sentence which says that:

17 "UK-wide in January 2021, 2,251 intensive care  
18 beds were occupied above baseline capacity, equivalent  
19 to 141 new 16-bedded ICUs."

20 We looked briefly at this earlier today, but if we  
21 just come away from this text and look at the box below,  
22 you have then mapped these onto the recommended  
23 guidelines for the provision of intensive care services.  
24 These guidelines, just to be clear, we have heard a lot  
25 about staffing ratios, nurses, trained ICU nurses, 1:1

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1 being the ideal ratio, and is it 1:8 for consultants or  
2 1:12?

3 **A.** I think it is 1:8 to 12.

4 **Q.** 1:8 to 12. Okay, that's helpful. You have set out here  
5 all of the additional staff that would be needed to  
6 ensure that ratios weren't stretched at the point that  
7 we were in, in January 2021. Have I understood that  
8 correctly?

9 **A.** That is correct, yes.

10 **Q.** We can see there is a huge amount of additional staff  
11 that would be needed, including up to almost  
12 2-and-a-half thousand critical care nurses in order to  
13 maintain ratios. You would accept, would you not, that  
14 in January 2021, which is -- we have seen data to  
15 suggest that was the peak of the pandemic, and the  
16 highest point in terms of occupancy of ICU -- can I just  
17 clarify, you aren't suggesting that all of these  
18 additional staff need to be recruited to account for  
19 that scenario, are you?

20 **A.** So, in order for us to be able to deliver the pandemic  
21 level of care in terms of the GPIC standards of -- the  
22 ratios that we recommend, those additional staff would  
23 be required, and it is worth just pointing out that  
24 that's for every 12 hour shift. It is double those  
25 numbers for a 24 hour period.

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1 There are other repercussions of stretching the  
2 work of the staffing ratios, which is the only way that  
3 we can try and improve the number of practitioners,  
4 improve the quality of care, is to redeploy staff from  
5 other areas, with the collateral damage of those  
6 decisions being that will impact on the services that  
7 they would usually provide for, and we have seen that  
8 through the delays in planned surgery, and that truly is  
9 one of the collateral damages of the Covid pandemic.

10 **Q.** Can I ask you about that, following up on what you said  
11 about the need to redeploy staff from other areas. From  
12 the intensive care perspective, professionals working  
13 routinely in intensive care, what was the impact of  
14 having to work with staff that weren't ordinarily  
15 trained in intensive care?

16 **A.** So my experience of it was that everyone wanted to do  
17 the absolute best they could do. That feeling was just  
18 palpable throughout my organisation and all of the other  
19 units that I have sort of discussed with through  
20 colleagues, and everyone wanted to help, so that was the  
21 first thing to say, is whilst some colleagues were not  
22 necessarily wanting to or felt comfortable within their  
23 skill mixes to support intensive care, they absolutely  
24 stepped up and did more than we could possibly ever ask  
25 of them, and we will be very grateful forever for that.

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1 Just to give a sense of what that is. For one  
2 critical care nurse -- for us to have one critical care  
3 nurse looking after a level 3 patient on intensive care,  
4 24 hours a day, 7 days a week, you would need about five  
5 to six whole-time equivalent critical care nurses to  
6 cover that.

7 **Q.** Given that this is the amount of staff that would be  
8 needed at a peak of the pandemic, do you accept that  
9 during peaks of pandemics, if we had a pandemic that  
10 stretched ICU capacity to the same degree or in fact  
11 greater than was the case in January 2021, do you accept  
12 that it is necessary to allow staffing ratios to be  
13 stretched in that scenario?

14 **A.** I think we have to accept that that's the best that we  
15 could provide in terms of stretching the staffing ratios  
16 because the staff that are needed, were needed, are  
17 simply not there. So one of the lessons around that is  
18 how we can be better prepared for the future. The  
19 corollary of that is that we do stretch the staffing  
20 ratios. We know that that's not the recommendations.  
21 The recommendations are based on what is the right  
22 staffing ratios to keep patients safe. So we know there  
23 is an impact from us doing that, both in terms of the  
24 patient quality care that we can deliver, but also the  
25 impact on the staff themselves.

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1 In terms of what it meant, it meant that the  
2 existing critical care staff took on a very supervisory  
3 role, as well as supporting direct patient care, which  
4 creates its own pressures and it creates its own  
5 psychological impact on them, as well as obviously those  
6 that have come into a new environment, with lots of  
7 skills, but different skills to do their very best as  
8 well.

9 **Q.** Looking forward, were we to need to redeploy staff to  
10 intensive care in another scenario, would you support  
11 a programme, perhaps, of staff who routinely don't work  
12 in intensive care, receiving training on intensive care  
13 skills or in fact perhaps working a shift in intensive  
14 care every so often? That may not be practical, but do  
15 any or -- either of those two options offer suitable  
16 ways of improving the workforce should we need to rely  
17 on redeployment?

18 **A.** I think so, and I think it is an important  
19 recommendation because the reality is that we can't plan  
20 to staff intensive care for a pandemic every single day,  
21 but what we can do is we can make incremental steps that  
22 get us closer to what we need to, when that happens  
23 again, and anything we can do to reduce that gap, in  
24 terms of numbers and knowledge base, are key. So, you  
25 will have heard yesterday about enhanced care beds,

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1 level 1 beds, which are effectively somewhere between  
2 a ward base level of care and a level 2 care bed, and  
3 critical care, and I think that probably gives us some  
4 opportunities to do some rotational programmes that  
5 enable people to get exposure to critical care.

6 I would say I don't think that in itself is  
7 enough, there is still a gap to be bridged in terms of  
8 intensive care capacity.

9 **Q.** Does it follow that based on the difficulties for staff  
10 who don't ordinarily work in intensive care in perhaps  
11 it perhaps being a little bit traumatic for them in  
12 terms of not being used to seeing very, very severely  
13 ill patients and often patients dying, does it follow  
14 that any training should include support around the  
15 impact of seeing those patients?

16 **A.** Yes. Thank you. So it does and I think one of the  
17 benefits we saw from Kevin Fong's testimony was around  
18 peer review support and I think that was a very powerful  
19 way of understanding what was happening at  
20 a unit-by-unit level and hearing what the staff were  
21 saying and what the relatives were saying.

22 I think as part of that there has to be  
23 psychological support as well. It is something I can  
24 expand on if helpful but there has been work that The  
25 Intensive Care Society has done to I think probably

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1 earlier was obviously developed and issued in the  
2 context of the Covid-19 emergency. Would you support  
3 the development of a tool that could be adapted to  
4 different emergencies produced perhaps not in the midst  
5 of an emergency but now or -- now we are not in the  
6 emergency phase of the pandemic?

7 **A.** I would, yes. We made a decision that whilst that  
8 decision support framework was not needed, that actually  
9 it was a really important guideline that needed to be in  
10 the public domain which is why we have published in our  
11 journal, which is peer reviewed, an academic journal,  
12 because actually one of the lessons we have to learn  
13 from this is that the discussions we need to have around  
14 being genuinely overwhelmed where we have got national  
15 decompensation and inadequate resources, that we have  
16 all of the right tools, all of the right discussions, we  
17 have engaged with all of the right people, and that is  
18 society, around what is the right thing to do in those  
19 situations and hope that we never will need them but  
20 that's not a reason not to have the discussion.

21 **Q.** Can I ask you about a different topic that you have  
22 discussed in your witness statement and that is oxygen.

23 You describe particular challenges that were  
24 caused by oxygen supply during the pandemic and you  
25 describe particularly the impact of supply pipes having

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1 dovetail quite well with what Professor Fong discussed  
2 in terms of psychological support.

3 **Q.** Dr Suntharalingam was talking earlier this morning about  
4 the prioritisation guidance that he was working on and  
5 he explained that The Intensive Care Society ultimately  
6 published and updated a version of the draft that he had  
7 worked on initially. I don't need to take you to the  
8 guidance but one of the comments he made was about the  
9 reassurance that guidance such as this, albeit hopefully  
10 never used, may provide for staff. Is that a view that  
11 you and the Society would endorse?

12 **A.** Yes, we do. I think the decision support framework and  
13 ensuring that it was very much related dependent on  
14 CRITCON status and the use of mutual aid transfers is  
15 really important and it is important for a platform for  
16 us to have more society discussion around these things  
17 but it is also really important for the staff to know  
18 that what they are doing is the best that they can  
19 provide and that they know that if they are under  
20 immense pressure there is a mechanism to enable them to  
21 be supported and that's through CRITCON status, decision  
22 support frameworks, and also the sort of trigger peer  
23 support visits that we have discussed.

24 **Q.** I understand that the document that was published by The  
25 Intensive Care Society which we looked at briefly

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1 automatic cut offs.

2 Are you able to give us a sense of how widespread  
3 this issue was?

4 **A.** So I think what we have always thought is that oxygen  
5 would be an endless supply in a hospital, that there  
6 would be no limitation of oxygen supply and I think  
7 there was a really important lesson in this pandemic,  
8 which I don't think we necessarily realised or learnt  
9 back in 2009 with the H1N1 pandemic, which is the way  
10 a hospital is designed means that there is -- can be  
11 a plentiful supply of oxygen but it is deliberately  
12 designed in a way that it is used for the purpose that  
13 it is intended to be used for. So if you have  
14 a critical care unit, the diameters of those pipes, the  
15 flow, the pressure of those pipes is manufactured  
16 differently to other areas of the hospitals where you  
17 might not need as high volume of oxygen, which is why  
18 the theatre recovery areas and the theatre environments  
19 were the ones that were generally used much more  
20 frequently than other areas for surge capacity in  
21 intensive care because they are also designed to have  
22 an oxygen-rich provision.

23 What we have learned from that is that I think we  
24 spent a lot of time trying to understand the schematics  
25 of a hospital, the flow, the pressure differences, which

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1 actually, if we understood them correctly beforehand  
2 would have enabled us to have really decided very  
3 quickly early on which were the best places to look  
4 after patients.

5 So it wasn't necessarily a case of we couldn't  
6 provide the oxygen in the hospital, it was trying to  
7 find the right location to look after patients that were  
8 needing different levels of oxygen.

9 **Q.** Is it an issue with the nature of the hospital estate  
10 rather than the supply?

11 **A.** Yes, so I think initially there was a concern that we  
12 would not have enough oxygen supply delivered through  
13 BOC. That wasn't an issue. There was enough oxygen.  
14 It was purely the estates and some of the hospitals, the  
15 designs clearly are very, very old which means that they  
16 were designed for different purposes or different  
17 reasons at those time points.

18 So it was about identifying where the right places  
19 were to look after the patients, being really cognisant  
20 of the fact that where we wanted to look after the  
21 patients might not necessarily be the best location in  
22 terms of oxygen provision and we would have to adapt  
23 that and also for cohorting patients and working out  
24 what the right balance was in terms of the cohorting of  
25 patients, the proximity to an intensive care environment

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1 finger or an ear and patients will also use them at home  
2 to monitor their oxygens for certain chronic conditions.

3 So it is readily available and we use it as  
4 a marker to understand what the oxygen levels might be  
5 in the bloodstream but doing it in a noninvasive way  
6 which allows us then to titrate oxygen accordingly.

7 **Q.** On 22 June 2021, the Society issued a statement entitled  
8 "Pulse Oximetry and Ethnicity -- the time to act is  
9 now".

10 We can have a look at it. It is INQ000395299.

11 If we have a look at the problem, it says here:

12 "Thirty years ago, it was recognised that SpO2  
13 measurements were less accurate when pulse oximeters  
14 were used in patients with darker skin pigmentation ...  
15 and research in the 2000s confirmed this."

16 If this is right why did the Society need to issue  
17 a statement in 2021 to this effect?

18 **A.** I think, as you say, this has been known for quite some  
19 years and there are still ongoing studies looking at  
20 exactly this problem. I think we felt it was important  
21 because of our reliance on pulse oximetry that we were  
22 really cascading it for awareness. But also -- well,  
23 I was going to say indirectly but actually I mean  
24 directly, to actually put some pressure on industry to  
25 actually make equipment that is useful and is calibrated

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1 and what would be the best care of course for the  
2 patient.

3 **Q.** Beyond building new hospitals, what are the best ways to  
4 ensure that these issues don't arise again?

5 **A.** So, I think there are some really quite simple measures  
6 in here which is to understand and to ensure that every  
7 hospital understands the schematics of their  
8 environment, and that's something that can be done, to  
9 work alongside our colleagues in clinical engineering,  
10 to work alongside our oxygen committee, which is often  
11 led by a clinical pharmacist, and to basically do  
12 a review of all of those things in a hospital. To  
13 understand what the schematics are, first and foremost,  
14 and then design what you might do differently, if at  
15 all. It might be that we made all the correct decisions  
16 but actually what we would do differently faced with  
17 another pandemic that required patients to need more  
18 oxygen than they would during our baseline level of  
19 acuity.

20 **Q.** On a related note is it right that one of the ways in  
21 which patient oxygen concerns are managed is --  
22 including within intensive care, is with the use of  
23 pulse oximeters?

24 **A.** So a pulse oximeter is a very readily available piece of  
25 equipment, effectively a peg that usually goes on the

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1 for all of our populations and I know some of the  
2 manufacturers are doing a lot of work in this area but  
3 this is a really important basic-level piece of  
4 equipment that we use all of the time and therefore it  
5 is absolutely essential that it can be used for all of  
6 the patients that we look after.

7 **Q.** So is it about manufacturing and testing products prior  
8 to them coming into force that don't risk inaccurately  
9 assessing a person's oxygen saturation levels?

10 **A.** I think so. I think it is part of the review process  
11 before any product is licensed that every opportunity  
12 has been taken to ensure that it is calibrated and  
13 validated in a way that is meaningful to the patients  
14 that we are caring for.

15 **Q.** Dr Mathieu, you have been very helpful and you have  
16 explained a number of points within the questions that  
17 I have asked you, so those are the questions that I have  
18 to ask you. I'm going to just ask you now whether you  
19 have any particular recommendations that you would like  
20 to point out at this stage that we haven't already  
21 spoken about?

22 **A.** Thank you. So, I think probably the key recommendation  
23 or the key recommendations, if I may, are around  
24 workforce. I think there is two elements of that. One  
25 is around looking at opportunities to bridge the gaps in

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1 our existing workforce. We know that we came into the  
2 pandemic with not enough staff to look after the sickest  
3 patients that we care for in hospital. So there's that  
4 element to it.

5 I think the bit that is probably the more urgent  
6 and pressing matter is retention of staff. The pandemic  
7 has really harmed people. We talked about well-being  
8 and psychological support and moral distress. The  
9 number of staff that have left because of what is  
10 basically embedded scars because of the pandemic, trying  
11 to do their very best, is something that we have to  
12 learn from and we have to support them, and whatever  
13 psychological support we can provide and learning  
14 opportunities is key.

15 I think the oxygen schematics one we have talked  
16 about is what I have described is a relatively quick  
17 win, in that we can plan better for the future with no  
18 additional resource by doing that.

19 **MR FIREMAN:** Thank you very much.

20 Those are my questions.

21 **Questions from THE CHAIR**

22 **LADY JUSTICE HALLETT:** Can I go back to the pulse oximeters,  
23 Dr Mathieu, please. It seems extraordinary that over  
24 30 years ago, people could have recognised that those  
25 who had a darker coloured skin might have their lives  
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1 levels were lower than were being seen or recorded,  
2 including wakefulness, cognition, other elements of  
3 organ or body dysfunction.

4 We also have access to doing more invasive blood  
5 tests, but of course we don't want to do those if we can  
6 avoid doing them because whilst they will give us more  
7 reliable data, actually we don't want to do unnecessary  
8 blood tests on people, if we can avoid it.

9 **LADY JUSTICE HALLETT:** Presumably intensive care specialists  
10 would be trained and know of the problems with pulse  
11 oximeters if you have darker, or black or brown skin?

12 **A.** Yes. It is well understood, but part of the reason we  
13 wanted to put that statement out was just as another  
14 reminder, really.

15 **LADY JUSTICE HALLETT:** The NHS must have huge buying power.  
16 You might have thought -- anyway. You are not  
17 a manufacturer so maybe I need to pursue it with someone  
18 else, but I do find it extraordinary we haven't solved  
19 that problem.

20 Right. Mr Jacobs.

21 **MR JACOBS:** My Lady, in fact the question I was going to ask  
22 has been amply covered, so I shan't cover the same  
23 ground.

24 Thank you very much.

25 **LADY JUSTICE HALLETT:** Thank you very much.  
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1 put at risk because these pieces of equipment weren't  
2 measuring the oxygen in their blood. Whose fault is it  
3 that nothing has happened? Is it the manufacturers? Is  
4 it regulations? Is it those who buy the manufacturer's  
5 products? Where is it going wrong because it is  
6 seriously wrong, isn't it?

7 **A.** I think I'm making an assumption that this is  
8 resolvable. I find it frustrating that we have  
9 a product that is so important that isn't -- doesn't  
10 provide the same reliability of data of evidence that we  
11 need for all of our population. I think the question of  
12 the manufacturers and those that validate those pieces  
13 of equipment and allow them to go onto the public market  
14 is really, is this the very best we can do? And if the  
15 answer is no, then we should not be validating it and  
16 allowing it to be used, and pushing industry to find  
17 solutions.

18 What I would say is that a lot of the --  
19 I understand the manufacturers looked at different  
20 algorithms to try and resolve it to some success, but  
21 not complete success, so what I would say if I may, just  
22 for assurance for patients who we would be caring for in  
23 a hospital environment, is that is one element of  
24 physiology that we look at. There are many others which  
25 would tell us -- give us some idea of whether the oxygen  
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1 Mr Weatherby.

2 **Questions from MR WEATHERBY**

3 **MR WEATHERBY:** I'm going to ask you a few questions, Doctor,  
4 on behalf of the Covid Bereaved Families for Justice UK.  
5 I want to pick up just a couple of points on staffing  
6 and capacity which I know you have been asked a lot  
7 about, we have heard a lot of evidence about. I want to  
8 preface them by making clear that I'm not criticising  
9 the massive efforts that were made by yourself and staff  
10 in intensive care units to fill the gaps. Not least  
11 because some of the families that I represent are the  
12 families of healthcare workers that actually died.

13 But the starting point, as I think you said only  
14 a moment ago, is that you have started the pandemic, you  
15 came into it, we -- came into the pandemic where,  
16 already, business as usual, ICU staffing was under  
17 strain, it was understaffed, yes?

18 **A.** Yes.

19 **Q.** And at paragraph 128 of your statement you say that:  
20 "... ICUs were very quickly at or over capacity  
21 ..."

22 So those are the two sort of starting points, if  
23 you like.

24 It is right, isn't it, that during the course of  
25 the pandemic in March 2021, the Society produced  
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1 a consensus statement entitled "Levels of adult critical  
2 care", which was a consensus statement because it was  
3 agreed by a number of other groups including the faculty  
4 the RCM, the British Association of Critical Care Nurses  
5 and et cetera. One of the things that the consensus  
6 said made clear was that probably the biggest  
7 contributing factor to the delivery of care in intensive  
8 care is staffing.

9 Now, that might seem a very obvious statement to  
10 make, but you felt the necessity of reinforcing that.  
11 Am I right that the Society reinforced that point  
12 because it is the quality of staffing or the level of  
13 training of staffing, rather than quality, that is a key  
14 part of the staffing issues?

15 **A.** You are absolutely correct.

16 **Q.** Yes.

17 **A.** So there is the staffing in terms of the numbers of  
18 trained staff --

19 **Q.** Yes.

20 **A.** -- there is also the experience of those trained staff.

21 It takes many years to train as a specialist in critical  
22 care. It takes even more years for them to become those  
23 really, really experienced, high-level performing staff  
24 that we are all accustomed to working with. That is  
25 the risk of recruitment problems at this stage.

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1 So --

2 **A.** Yeah.

3 **Q.** -- what the consensus statement said was that GPICS  
4 addition to recommendations -- now that's the Guidelines  
5 to the Provision of Intensive Care Services that the  
6 faculty and yourselves put out, just for the record  
7 INQ000361989 -- so during the pandemic, although you had  
8 to have this work-round as best as you possibly could,  
9 you were underlining that that shouldn't become the new  
10 norm, and that the recommendations that had been made  
11 before the pandemic should remain in place. That is  
12 right, isn't it?

13 **A.** That's absolutely correct. The point being that those  
14 standards are the best evidence that we have for our  
15 safe staffing model at present, and we have to or had to  
16 stretch that staffing ratio to enable us to care for the  
17 number of patients that we needed to look after. What  
18 we couldn't do and shouldn't do is reset those standards  
19 as business as usual.

20 **Q.** Yes, and the worry was that if those standards slipped  
21 without evidence to the contrary, but unless they were  
22 kept, then the problem was that they would be a negative  
23 impact on patient outcomes. That is right, isn't it?

24 **A.** Yes, I think that's absolutely right. The staffing  
25 levels, the staffing ratios are embedded within the

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1 **Q.** Yes. So in March 2021, here you are, reinforcing the  
2 point that although you have managed to draft in many  
3 other staff who did their absolute level best, a key  
4 problem was that even where you had the numbers, they  
5 weren't the sufficiently trained staff. So there's only  
6 so much they could add.

7 **A.** That's correct. The way that many intensive care units  
8 would have done their very best to manage that would  
9 have been to bring those staff that were I suppose most  
10 familiar with intensive care, whether they had had  
11 previous background in intensive care training and had  
12 gone off to do other specialist work including community  
13 nursing as well, research -- obviously, the impact of  
14 that is that meant some of the research work that needed  
15 to be done might get delayed. So, obviously, we would  
16 try and redeploy the staff that were most capable and  
17 able and willing to --

18 **Q.** You would be as smart as possible in the way that you  
19 redeployed?

20 **A.** Correct.

21 **Q.** The consensus statement went on and expressly stated  
22 that although things had to be done that way, the  
23 staffing ratios that had been recommended in peacetime  
24 should remain as they are until or unless there was  
25 further evidence about them. That is right, isn't it?

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1 Guidelines to the Provision of Intensive Care Services  
2 for that exact reasons, which is safe staffing models.

3 **Q.** We don't need to go to the GPICS guidance from 2019 but  
4 I do just want to read out one sentence from it if I can  
5 find it, which is at page 32 of it. It is this:

6 "It is widely acknowledged that the intensive care  
7 workforce is costly. However, previous attempts to  
8 re-configure this workforce in order to reduce staffing  
9 budgets have resulted in negative patient outcomes."

10 That's pre-pandemic. So, during the pandemic, the  
11 Society puts out this consensus statement indicating  
12 that so far as is possible we have to keep to the  
13 recommended levels, otherwise patient outcomes will be  
14 negatively impacted. That is right?

15 **A.** So that's correct --

16 **Q.** Yes.

17 **A.** -- and the only way of managing to keep to those  
18 staffing levels was for the existing staff to do more,  
19 and that's exactly what they did do.

20 **Q.** Because you simply didn't have the sufficiency of staff,  
21 then that would inevitably have led to a negative  
22 impact?

23 **A.** Correct. I'm in agreement, the staffing levels are  
24 there for a purpose, which is that we know that those  
25 are the safest staffing levels that we require to look

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1 after acutely unwell patients -- (overspeaking) --  
 2 **Q.** Yes, and in fact there is ICNARC data showing there were  
 3 higher acute hospital mortality rates where there was  
 4 a higher capacity strain on ICUs?  
 5 **A.** That is correct.  
 6 **Q.** Quickly moving on, changing the subject to older people.  
 7 The Society's clinical guidance about critical care and  
 8 Covid -- again I will give the reference, we don't need  
 9 to put it up -- INQ000395282 and it is at page 5 -- that  
 10 clinical guidance that the ICS put out makes clear, and  
 11 I quote:  
 12 "Each patient will continue to be considered as  
 13 an individual ... comprehensive individualised  
 14 assessments will be used and that short of reaching  
 15 a CRITCON 4 ..."  
 16 We discussed earlier today that had other  
 17 approaches should not be used for individualised  
 18 decision-making. Is that a fair summary of the guidance  
 19 that was put out?  
 20 **A.** It is, yes. I mean, it is absolutely clear, as you say,  
 21 that the guidance is only to be used in the context of  
 22 national de-compensation at CRITCON level 4, with some  
 23 decision support frameworks and ethical guidance that  
 24 surrounds that, yes.  
 25 **Q.** I think you have seen the research that was done for the

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1 **A.** So that's exactly what this data suggests, and I have  
 2 reviewed the survey. I genuinely cannot understand  
 3 those responses because I am not aware of any employer  
 4 within an intensive care environment being given  
 5 instructions on who should be escalated. That is  
 6 a clinical decision.  
 7 **Q.** All right. I shan't ask you anything more about that  
 8 data then, but obviously it is there.  
 9 Just one more point on this. We heard earlier  
 10 today of research which shows that admissions to ICUs in  
 11 March and early April of 2020, the average age of  
 12 admissions went down and again there is a lack of  
 13 evidence as to why that was as I understood the evidence  
 14 earlier. Are you able to comment on that?  
 15 **A.** So I listened to Professor Rowan's response to that and  
 16 I think I would probably come to the same conclusion  
 17 which is I don't know why the data is different.  
 18 I think there are probably a number of reasons which  
 19 include vaccination, therapeutic strategies available  
 20 being different during the second wave. There was --  
 21 **Q.** Can I just stop you there, just on that point, sorry to  
 22 interrupt you, but we are here talking about data from  
 23 late March, early April 2020.  
 24 **A.** Oh, apologies.  
 25 I'm afraid I can't give you an answer to that

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1 Inquiry, the IFF research on escalation of care. I do  
 2 want to show you this bit. We looked at it briefly with  
 3 the experts this morning, but there is one more page  
 4 I just want to put to you for your comment. I think it  
 5 is available. It is INQ000499523, and it is page 24.  
 6 On the left-hand side we have "Instructions from  
 7 employers". This is the survey of healthcare  
 8 professionals:  
 9 "During each wave of the pandemic, 1 in 3 HCPs  
 10 said they received instructions from their employer on  
 11 which groups should not be he is circulated to the next  
 12 level of care."  
 13 That is a huge proportion, yes? Then, on the  
 14 right-hand side, just the bits that you will be most  
 15 concerned about, is that within that figure, 28% of  
 16 critical care nurses and 17% of critical care doctors --  
 17 **LADY JUSTICE HALLETT:** Microphone, Mr Weatherby, because you  
 18 are leaning down.  
 19 **MR WEATHERBY:** I'm so sorry.  
 20 It's 28% of critical care nurses and 17% of  
 21 critical care doctors were included in those figures.  
 22 Would you agree that doesn't really fit with the  
 23 guidance in terms of individualised assessments? It  
 24 rather indicates that there were instructions on blanket  
 25 criteria?

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1 question.  
 2 **Q.** I shan't pursue that further. But it is disturbing,  
 3 isn't it, that there are these reports and there is this  
 4 data which does paint a picture of the admissions not  
 5 being in accordance with the clinical guidance,  
 6 individualised clinical guidance?  
 7 **A.** I'm not -- I'm sorry, I can't comment on that.  
 8 **Q.** Fair enough.  
 9 **A.** I do not think the guideline or the guidance is  
 10 different to what is current practice for intensive  
 11 care, which is very much around those staffing ratio,  
 12 they should be protected unless we are in a position  
 13 where we have local pressure to regional to national  
 14 pressure or with the option to try and decompress  
 15 through to using our workforce differently, internally,  
 16 I don't mean redeploying staff but moving people away  
 17 from other important ICU roles to ensure that we protect  
 18 the clinical, direct clinical care but also with that  
 19 mutual aid transfer option.  
 20 **MR WEATHERBY:** I shan't pursue it any further, thank you  
 21 very much.  
 22 **LADY JUSTICE HALLETT:** Thank you Mr Weatherby.  
 23 Ms Woodward.  
 24 **Questions from MS WOODWARD**  
 25 **MS WOODWARD:** Thank you, Doctor. I ask questions on behalf

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1 of Covid-19 Bereaved Families for Justice Cymru and my  
 2 first question is about the draft guidance published  
 3 from the Intensive Care Society for use as a decision  
 4 support tool, which we have heard quite a lot about now,  
 5 and you said during your evidence earlier today that  
 6 that guidance was very related to CRITCON status.  
 7 My question is given that CRITCON was not formally  
 8 adopted in Wales how was it intended that the guidance  
 9 would be used in Wales?  
 10 **A.** So I think -- thank you. I think CRITCON is, as you  
 11 rightly point out, is not universally used in Wales or  
 12 indeed Scotland and Northern Ireland. It very much is  
 13 used within England. I think the size, the  
 14 organisational structures of Scotland, Wales and  
 15 Northern Ireland are different and different in a way  
 16 that the connectivity to higher levels of  
 17 decision-making at sort of CMO level is probably more  
 18 direct than it is in England, and that's not meant to  
 19 be -- that is a comment rather than a point of view.  
 20 They are just different types of structures. So what  
 21 I do know is that there are -- the way that pressure is  
 22 discussed and concerns raised will still be to the  
 23 Parliamentarians, the main decision makers, but not  
 24 necessarily using CRITCON as that way of describing it.  
 25 I think CRITCON would be a really helpful tool to  
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1 come up with a common terminology that means that  
 2 actually when we do review the data, to try and get much  
 3 more of a UK understanding of where we are, that  
 4 actually we are using the same descriptions.  
 5 **Q.** As you said, Doctor, there you spoke earlier about the  
 6 difficulties in talking about capacity because of the  
 7 way the data was collected. Were there any other  
 8 barriers or deficiencies in respect of effective data  
 9 collection, analysis or sharing between the four nations  
 10 that you were aware of outside of the capacity issue?  
 11 **A.** Not that I'm aware of. I think probably, if I may, just  
 12 to try and describe a positive around data capture is  
 13 obviously we -- the data needs to be anonymised and that  
 14 is obviously important and whatever we do around data  
 15 collection we need to be clear that we are not -- that  
 16 we are sticking to the standards that we would expect of  
 17 that data capture.  
 18 But the reality of it is that what we did and  
 19 I think did really well across all nations was knowledge  
 20 share, understand, use data, work out what it was  
 21 telling us, direct the research activity that we needed  
 22 to be directed towards and try to use that common  
 23 language as best we could to describe the best treatment  
 24 strategies that we could.  
 25 So I think the data is there and the data is  
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1 be used across all devolved nations because actually  
 2 what it would do is give us just one simple language  
 3 that we could then use to enable us when we are at  
 4 a point of national -- if we were at a point of national  
 5 decompensation to use that scoring -- that description  
 6 of pressure and the action associated which may include  
 7 transfers outside of regional boundaries to be used.  
 8 **Q.** Thank you. My next question is about data collection  
 9 and access and you address this at paragraph 75 of your  
 10 witness statement.  
 11 You state that the absence of centrally held data  
 12 for Covid-19 patients made it difficult to obtain,  
 13 compare and analyse data being recorded and you  
 14 highlight in that paragraph the differences between  
 15 England and Scotland in the way they hold data.  
 16 What was the position regarding data collection in  
 17 Wales, to your knowledge?  
 18 **A.** So, I'm afraid I don't have a detailed answer to that  
 19 but what I can say is that the way -- so Wales will  
 20 capture data in a similar way to the other nations.  
 21 I think where we are perhaps different across nations  
 22 and including within regions in England is the  
 23 descriptions, the definitions that we use and that's the  
 24 point very much I was making around occupancy and  
 25 capacity and surge capacity and we do need to try and  
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1 enriched by having as many nations involved in sharing  
 2 that information. I guess what would be helpful for the  
 3 future is to be able to access it through a single  
 4 portal.  
 5 **Q.** Thank you, Doctor.  
 6 My next question is about staff wellbeing which  
 7 you have addressed at paragraph 94 of your witness  
 8 statement where you look at the impact of the pandemic  
 9 on the society's members, patients and their families.  
 10 In there you identify the many challenges faced by staff  
 11 including lack of beds, lack of experience and trained  
 12 intensive care staff, a lack of PPE and concerns about  
 13 staffing protecting themselves and their own families at  
 14 home.  
 15 My question is whether staff, from your knowledge,  
 16 were also concerned about the absence of routine patient  
 17 and staff testing?  
 18 **A.** I think like everyone the view was very much that we  
 19 needed to just try and conform to whatever the guideline  
 20 would tell us to do but I think equally I think there  
 21 were concerns expressed about staff testing, when it  
 22 should be done. I think one of the problems we had  
 23 certainly at points of the pandemic was the fact that  
 24 lateral flow tests for example would remain positive for  
 25 a very long period of time even though we knew that from  
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1 a viremic point of view in terms of risk, it probably  
2 was much shorter than that and the challenge then became  
3 what do you do with that information when you have got  
4 staff that are incredibly stretched and staff that want  
5 to work, are available to work but might have a positive  
6 test.

7 I think that's probably a different way to  
8 describe your point, and I'm sorry for doing it that  
9 way, but I guess like everyone we were looking at the  
10 guidelines and being consistent with how we approached  
11 it.

12 **Q.** And were there any concerns specifically raised about  
13 absence of routine testing for patients, which is  
14 perhaps a slightly different issue to what you have just  
15 said about staff?

16 **A.** Yes, but probably modified by the use of PPE for  
17 aerosol-generating procedures.

18 **MS WOODWARD:** Thank you very much. Those are my questions.  
19 Thank you.

20 **LADY JUSTICE HALLETT:** Thank you Ms Woodward, very grateful.

21 That completes the questioning for you,  
22 Dr Mathieu. Thank you very much for all your work you  
23 do on the frontline, and obviously for your work in  
24 preparing your written statement, which I will consider  
25 as well as your oral evidence, so don't worry if you

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1 impact of the pandemic from his perspective.

2 Dr Jack Parry-Jones, who is a member of the Royal  
3 College of Anaesthetists, the Faculty of Intensive  
4 Medicine and the Association of Anaesthetists. He is in  
5 fact the lead clinician for the South East Wales  
6 Critical Care Network and so speaks to the impact from  
7 his perspective in Wales.

8 Sarah Jones, who is a member of the 13 PBPOs,  
9 suffered an ectopic pregnancy during the pandemic, and  
10 she speaks powerfully of the impact of that on her.

11 There is the statement from M3/W2, who was a nurse  
12 originally from the Philippines, who worked in the NHS,  
13 who gave a statement on behalf of FMHWG.

14 There is a statement from Sanjeev Panesar, who is  
15 a pharmacist based in Birmingham and a member of the  
16 National Pharmacy Association that we would like you to  
17 publish.

18 There is a statement from M3/W3, who is an ethnic  
19 minority healthcare worker who assessed patients with  
20 suspected mental health difficulties that presented  
21 themselves at A&E that we would ask you to publish.

22 Two statements from witnesses from Qatar, Gillian  
23 Higgins and Nathalie McDermott who speak to IPC  
24 measures, but in addition, Ms Higgins was redeployed to  
25 A&E during January 2021, and she attests to that.

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1 haven't covered something. Thank you very much for  
2 coming today.

3 **A.** Thank you.

4 **(The witness withdrew)**

5 **LADY JUSTICE HALLETT:** I think that completes the evidence  
6 we can hear today. I do hope that the witness'  
7 emergency resolves itself successfully.

8 **MS CAREY:** So do we, and we will update your Ladyship as  
9 soon as we are able.

10 My Lady, all being well, we have a very busy  
11 timetable for tomorrow. So there is one matter I would  
12 like to, with your permission, deal with today, and it  
13 is the statements of some additional impact evidence  
14 that we would like to invite your Ladyship to publish.

15 There are 13 statements in all at this stage to be  
16 published, and may I just indicate, without giving the  
17 INQs, just the witnesses' names and the brief outline of  
18 the topics they cover.

19 There is a statement from Mrs Carla Jones-Charles,  
20 who is a member of Trades Union Congress. She is  
21 a director of midwifery at the Walsall Healthcare NHS  
22 Trust and speaks to the impact on midwives, picking up  
23 on some of the evidence you heard this week.

24 The statement of Dr David Bailey, who is a member  
25 of the BMA. He is a GP in Wales and so attests to the

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1 Indeed Nathalie McDermott, along with the other  
2 matters that she set out, worked on a Covid ward during  
3 the pandemic. She speaks to that.

4 Clare Cole from the John's Campaign speaks about  
5 the circumstances of her father's death.

6 And Rachel Ashton, also from the John's Campaign,  
7 was a nurse working during the pandemic, but she sadly  
8 cared for her brother who had mental health difficulties  
9 and during the pandemic died by suicide in  
10 February 2021.

11 And there are two statements from Josh Miller and  
12 Priyanka Patel, both of whom are members of the Royal  
13 Pharmaceutical Society. Mr Miller was based in Scotland  
14 and gives evidence from his perspective there. Ms Patel  
15 was a student at the start of the pandemic, and so  
16 brings to bear some slightly different evidence about  
17 how the pandemic affected her, her studies and her  
18 training thereafter. May --

19 **LADY JUSTICE HALLETT:** Thank you. Not only may they be  
20 published but I wish to emphasise, yet again, that  
21 I will ensure that they are all read extremely carefully  
22 and the contents considered. The oral part of these  
23 hearings is just one part. The written material is as  
24 important and I am just sorry that we haven't got the  
25 time to call everybody to give oral evidence. We just

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1 don't. Thank you very much. Very well, 10 o'clock  
 2 tomorrow please.  
 3 (3.26 pm)  
 4 (The hearing adjourned until 10.00 am  
 5 on Thursday, 10 October 2024)  
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