Thursday, 10 October 2024

(9.59 am)

LADY HALLETT: Ms Nield.

MS NIELD: My Lady, I call, please, Professor Jonathan Wyllie.

PROFESSOR JONATHAN PETER WYLLIE (sworn)

Questions from COUNSEL TO THE INQUIRY

MS NIELD: Can you give your full name, please.

A. Jonathan Peter Wyllie.

Q. Now, Professor Wyllie, you have provided a signed witness statement. That's INQ000474274. You explain in that witness statement that you have also adopted the witness statement of Professor Lockey, president of the Resuscitation Council UK, that is witness statement INQ000343994, and you will be speaking to that witness statement today?

A. That is correct.

Q. Professor Lockey (*sic*), can I say at the outset that the Inquiry is going to be hearing from five witnesses today and can I ask you, please, at the outset to assist the Inquiry in keeping your answers as concise as possible. Thank you.

You are an executive member of the Resuscitation Council UK, I think that's right?

A. That's correct.

Q. And the immediate past president, so you were the president during the pandemic; is that right?

A. That's correct. I was president from 2018 to 2021.

Q. Thank you. Professor Lockey explains in his witness statement that the Resuscitation Council UK -- and we might call it the RCUK for brevity -- is responsible for issuing resuscitation practice guidelines and standards for the healthcare sector throughout the UK?

A. That's correct.

Q. And I think the process for development of those guidelines is accredited by the National Institute for Health and Care Excellence, NICE, and it follows best practice for guideline development, and those guidelines are implemented across the National Health Service, social care, and in community settings, is that correct?

A. That's correct -- for all four nations.

Q. Thank you. You also explain that the core membership of RCUK comprises specialist clinical and academic experts who are recognised as international leaders in resuscitation, and indeed they play leadership roles with the International Liaison Committee on Resuscitation, ILCOR, and the European Resuscitation Council, the ERC, which scrutinise published scientific evidence on an international scale; is that correct?

A. That's correct.

Q. Professor Wyllie, I'd like to focus three topics today in which RCUK was involved during the pandemic period.

Firstly, the guidance provided by RCUK around PPE protective personal equipment for healthcare workers performing cardiopulmonary resuscitation during the pandemic; secondly, I'd like to look at the role of RCUK in advance care planning across UK and the ReSPECT form that was developed by RCUK, and finally I'd like to move on to issues that arose during the pandemic around DNACPR notices and the making of those notices.

On those latter two issues, we heard yesterday from experts in intensive care and I think you are familiar with the evidence that they provided yesterday; is that correct?

A. I am, yes.

Q. We're not going to be going over the same ground today, but there are some matters in relation to those final two topics that I would like to pick up with you, if I may. Can we begin, please, this morning with cardiopulmonary resuscitation and can we define what that is in a healthcare setting; what does the CPR procedure entail in a hospital?

A. So it is a treatment that can be instituted when a patient has a cardiac arrest and that is not the same as a myocardial infarction, although that can lead to a

cardiac arrest, but it's defined as an absence of breathing or of signs of life, and it is effectively your heart stopping pumping, effectively.

Q. What actions then have to be undertaken by a healthcare worker if they were to perform cardiopulmonary resuscitation? What are the procedures?

A. Initially, basic resuscitation, which focuses on chest compressions and ventilation breaths to support the circulation until more definitive treatment can be brought to bear such as defibrillation to revert the heart to more normal rhythm, or advanced airway manoeuvres in order to more effectively do the breathing for the patient.

Q. And is there any difference between the CPR procedure that's undertaken in a hospital setting, and that provided, for example, by a paramedic either in an ambulance or in someone's home if they've gone to someone's home?

A. So there's very little difference in approach, but obviously there is a difference in timing. In a hospital you are much more likely to be -- to have help immediately available with -- a national 2222 call goes out, an arrest team comes up and there are likely to be healthcare professionals very close by. Obviously, in an out-of-hospital cardiac arrest, mostly

1 you will be in your home. About 70% of cardiac arrests
2 happen in your home, and the rest of the time you're
3 more likely to be out and about with members of the
4 public.
5 Q. Thank you.
6 I think we heard yesterday, I think it's correct
7 that the survival rates of CPR outside hospital is 8%,
8 and the survival rate in hospital, so from the survival
9 rate to hospital discharge, for in-hospital CPR, is 23%?
10 A. That's correct.
11 Q. So, aside from the relatively low survival rate, what
12 about the potential for CPR to cause harm to the
13 patient? I'm thinking now particularly in a hospital
14 setting rather than if somebody's having CPR on a
15 pavement outside.
16 A. So in any setting, I think that what most people think
17 of as CPR, most people think that it is just another
18 treatment, but in actual fact it is quite a violent
19 procedure to compress a chest sufficient for the heart
20 to pump blood around, and therefore there is the
21 immediate risk of harm, and up to 70% of adults who
22 undergo CPR and chest compressions will have rib
23 fractures, or -- large or small. Of course, that is
24 recoverable, but the major issues for a patient are
25 really whether they wanted to be brought back from what

1 is effectively death, and that depends on the quality of
2 life afterwards. So --
3 Q. What about the potential for a patient who has received
4 CPR in a hospital who has been resuscitated to be in
5 a worse medical condition, a worse state than they were
6 before they had the cardiac arrest?
7 A. That is always possible and, therefore, one has to weigh
8 the benefits to your patient against the potential harm.
9 If your heart stops, then there is the potential for
10 damage to organs, and especially the brain, from that
11 moment onwards.
12 Q. So is it the case that somebody could be resuscitated
13 but be, for example, in a persistent vegetative state?
14 A. That is possible.
15 Q. Professor Wyllie, I'd like to come on to some of the
16 issues that came up during the pandemic in relation to
17 the guidance produced by RCUK concerning the appropriate
18 level of PPE for healthcare workers performing CPR, and
19 I think this is set out in some detail in
20 Professor Lockey's witness statement and I'm not going
21 to ask you to give us the chronology of the meetings and
22 contacts between Public Health England and the
23 Resuscitation Council UK, but I think, suffice to say,
24 there was a divergence in the guidance that was given in
25 that Public Health England, the UK IPC guidance, as we

1 have been referring to it, was that they described an
2 absence of clear evidence that chest compressions in
3 CPR -- there was a lack of clear evidence that those
4 chest compressions generated aerosols and therefore full
5 PPE was not a requirement for CPR --
6 A. Indeed.
7 Q. -- and the position of RCUK was somewhat different --
8 you've described it as a precautionary approach -- and
9 advised that full PPE should be worn during CPR.
10 Could you briefly summarise why RCUK gave that
11 different advice?
12 A. So I think there are two or three reasons. One is that
13 we looked at the same evidence but I think that Public
14 Health England regarded a lack of evidence as
15 effectively showing that there was no potential AGP
16 production. We took a lack of evidence as being not
17 enough evidence.
18 We also, from a practical point of view, all of
19 us, and our instructors have done CPR and you can see
20 droplets coming out. So we know what happens. We
21 couldn't prove it because we haven't published that but
22 we know that that happens.
23 Lastly, I think the evidence, because we had all
24 been in contact with our colleagues around the world and
25 especially in Italy, who suggested that full PPE was

1 protective and latterly that came out in the urgent
2 review of deaths in healthcare workers which absolutely
3 showed the pretty much the same proportion of deaths
4 amongst healthcare workers as everybody else in the
5 population.
6 The key thing is it showed that those healthcare
7 workers that were working in the highest risk
8 environment, intensive care, seemed to be
9 underrepresented which definitely suggests that PPE was
10 protective.
11 Q. So those who were working in intensive care had access
12 to full PPE?
13 A. Indeed.
14 And so, lastly, we felt we had to take a
15 precautionary approach because we had to balance the
16 benefit to the patient with the risk to the health of
17 healthcare workers, but also think about that in
18 a cardiac arrest team who comes to a patient with, as
19 you've said, a 23% chance of survival, if they affect
20 five people those people will then not become -- will
21 become unavailable for healthcare for other people until
22 they get over their Covid.
23 And so there were a variety of issues.
24 Q. Thank you.
25 I think it was you, Professor Wyllie, as the

1 president of the Resuscitation Council who engaged in
2 a considerable amount of correspondence, meetings and so
3 on, with Public Health England over that period. That
4 was from, I think, the initial divergence in advice was
5 27 March 2020 right through until 27 May 2022.
6 Your aim throughout that period was to try to
7 bring an alignment, I think, between the positions of
8 Public Health England and RCUK on this subject.
9 **A.** Absolutely.
10 **Q.** Can you explain why it was that RCUK felt it was
11 important to avoid a divergence of advice to healthcare
12 workers?
13 **A.** Because it's confusing, we were getting enquiries from
14 our own members, resuscitation officers, in different
15 Trusts because they were being told one thing by their
16 Trust management, coming down from PHE, and they were
17 getting a slightly different -- only a slightly
18 different message, but it was around PPE, from RCUK.
19 So we reached out and had at the time, and I still
20 feel it was a very useful meeting with Mrs Susan Hopkins
21 to try and bring things together. After that meeting we
22 pointed out they had nobody who was an expert on
23 resuscitation informing their group and she also very
24 helpfully pointed out that we had nobody who was an
25 expert microbiologist or virologist in our group and

1 therefore we asked if we could be put in touch with
2 theirs, and we had a subsequent meeting, I think the day
3 after, with those two people and that was helpful.
4 **Q.** Nevertheless, it's right I think that Public Health
5 England did not change its stance on this PPE guidance.
6 **A.** No.
7 **Q.** This recommendation is made by Professor Lockey in his
8 witness statement:
9 "... in the eventuality of a future pandemic,
10 processes [should be] put in place early whereby
11 government and arm's length bodies are encouraged to
12 engaging with organisations such as RCUK that offer
13 subject matter expertise not immediately available
14 within their own teams."
15 Does it follow from that that you did not consider
16 that the engagement you received from Public Health
17 England was constructive?
18 **A.** So the engagement with the microbiologist and virologist
19 was hugely constructive and helpful to us but it
20 actually confirmed our view because at that we were told
21 they were less worried about aerosol generating
22 particles and much more concerned about droplets. In
23 fact that was proven not to be true in the end. But we
24 knew that droplets were produced by compressions. So --
25 **Q.** Focusing on the level of engagement that you got from

1 Public Health England rather than that specific
2 meeting --
3 **A.** Sorry, I apologise. So --
4 **Q.** In the event of a future pandemic would you like the
5 engagement that takes place with whatever bodies are in
6 charge of IPC guidance to engage in a similar way or
7 would you like a different process or a different type
8 of engagement?
9 **A.** It has to be different. I think there has to be an
10 understanding of what other organisations bring to the
11 table and the communication needs to be two-way not
12 one-way command and control.
13 **Q.** Can I ask you this: was any indication given by Public
14 Health England at any time in the course of your
15 engagement with them that concerns about availability of
16 PPE impacted on their approach to that particular
17 question?
18 **A.** No. But after Mrs Susan Hopkins, we did not really get
19 any acknowledgement of our reaching out.
20 **Q.** Thank you.
21 Can we come on, please, to the subject of --
22 **LADY HALLETT:** Just before you move on, Ms Nield, sorry to
23 interrupt.
24 So in your engagement with Public Health England
25 they are saying there's an absence of evidence. You've

1 explained why that doesn't necessarily mean that there
2 isn't evidence just it hasn't been found yet. If you
3 didn't get an impression it was a resource reason behind
4 the decision not to issue the guidance you were seeking
5 was there any other rational explanation as to why?
6 **A.** Yes, absolutely, and it's important to know that Public
7 Health England, what was put to us was that they did not
8 want any delay in applying CPR to a patient in need.
9 In hospital that delay is very slight because most
10 of us were in some degree of PPE and it was a matter of
11 upgrading that quickly whilst the defibrillator was
12 applied.
13 So that was the reason that was put forward to us
14 at the time.
15 **LADY HALLETT:** Thank you.
16 **MS NIELD:** Just building on that, if I may, I think included
17 in your guidance was that very point, that it would be
18 possible to deliver three shocks with a defibrillator
19 whilst the rest of the team upgraded their PPE; is that
20 correct?
21 **A.** Absolutely, because we knew from data from Wuhan that
22 out of 136 patients with Covid who had a cardiac arrest
23 only one had survived, and that was somebody with a
24 defibrillatable rhythm. So the mortality from cardiac
25 arrest is huge. It's almost, not quite, total, and the

1 one person who survived because the defibrillator was
2 used and that corrected the rhythm.
3 **Q.** So the key intervention --
4 **A.** Was to put the defibrillator on.
5 **Q.** And it wouldn't be necessary to upgrade to full PPE when
6 that was being done?
7 **A.** No, because you can place that and give the shocks, up
8 to three shocks, whilst you're putting PPE on.
9 **Q.** Thank you. If we could move on please to the subject of
10 DNACPRs, do not attempt cardiopulmonary resuscitation,
11 and advance care planning and deal with some of the
12 paperwork, as it were.
13 First of all, the DNACPR notice. The Inquiry
14 heard yesterday from Professor Summers and
15 Dr Suntharalingam on the use of DNACPR notices and also
16 ReSPECT forms from the perspective of intensive care
17 clinicians.
18 They have explained how those are usually
19 encountered in intensive care. Paper forms usually,
20 red-bordered forms, and we saw an DNACPR form yesterday.
21 I think we can get up INQ00227411.
22 This is in fact the All-Wales DNACPR form. So
23 that should be used across any settings in Wales. We
24 heard yesterday that there isn't a single standard form
25 for use in England. I think that's right.

1 **A.** I think that's correct, yes.
2 **Q.** Do you know about the position in relation to Scotland
3 or Northern Ireland, whether there's one form?
4 **A.** I do not know at all about Northern Ireland. I don't
5 know for certain about Scotland but Scotland certainly
6 had a unified approach ahead of England in terms of
7 implementing this, but I don't know the details.
8 **Q.** We can take that down now. Thank you, Lawrence.
9 We heard yesterday how DNACPR notices are
10 encountered in intensive care and also that those
11 discussions were sometimes held with patients or, more
12 commonly, with their loved ones because the patients
13 wouldn't have capacity at that point.
14 Would you usually expect those decisions about
15 DNACPR to have been taken prior to the point that the
16 patient is very unwell, not conscious and going into
17 ICU?
18 **A.** So that is the ideal situation. Of course in the
19 pandemic there was a very fast, quickly-developing
20 problem where people deteriorated surprisingly quickly
21 and so that might not have occurred or might have
22 occurred at speed.
23 **Q.** So, ideally, if these conversations were going to be
24 had, it would be preferable for those discussions to be
25 taking place soon after the patient was admitted to

1 hospital. Would that be correct?
2 **A.** Absolutely, but really a wider discussion would be
3 better if there is time and skill.
4 **Q.** I think you've explained that those DNACPR notices can
5 be made in any setting, and so if they are made outside
6 of a hospital setting, that notice should travel with
7 the patient to the hospital. I think that's correct?
8 **A.** Yes.
9 **Q.** If a DNACPR notice has been made in a community setting
10 or in primary care, is it the view of the
11 Resuscitation Council that that ideally should be part
12 of a wider conversation about advance care planning
13 using the ReSPECT form process or an equivalent?
14 **A.** So the short answer is yes. As you heard yesterday,
15 ReSPECT is a form of just embedding best practice. It
16 isn't to say that people not using ReSPECT were not
17 using best practice because many of them absolutely
18 were. But it would be best part of a wider conversation
19 so that you know the patient's or the family's views on
20 what is important to them. That's not just a decision
21 about CPR or not. It actually helps govern what is the
22 best care for the patient.
23 **Q.** I think we heard yesterday that there can be a risk that
24 a DNACPR decision is seen as a decision not to consider
25 other forms of treatment, not to consider escalation of

1 care. So if a DNACPR notice is just part of a wider
2 advance care plan, does that alleviate some of the
3 concerns or risks in that regard?
4 **A.** So we feel that that's a much more open process, so
5 people know what they're opting in and requiring and
6 wanting, and what they're not, as opposed to a single
7 event being dealt with.
8 **Q.** Can we look, please, at the current ReSPECT form.
9 I think we saw, yesterday, version 2, which was, I think
10 that was in use at the start of the pandemic --
11 **A.** It was.
12 **Q.** -- was that correct, but work was already underway at
13 that point on developing version 3.
14 Can we look at INQ000251666_0001, please.
15 I think this was published in September 2020; is
16 that correct?
17 **A.** So it was. It was ready in February -- and it was aimed
18 to roll out to test it in five Trusts, but actually, of
19 course, that was delayed because it wasn't an
20 appropriate time to do that at the beginning of the
21 pandemic.
22 **Q.** Can we look at some of the key differences, perhaps,
23 between version 2 and version 3, and we see that the
24 first part of that form, number 2, "Shared understanding
25 of my health and current condition", and there are three

1 boxes there, including "I have a legal welfare proxy in
2 place" in the third box, and then number 3, "What
3 matters to me in decisions about my treatment and care
4 in an emergency".
5 So, putting these sections into the first person
6 using "I" and "me", was a change from version 2, is that
7 right?
8 **A.** It was. It was a change brought about by feedback from
9 both patient and relative groups, and also clinicians.
10 **Q.** So why were those changes made, what was hoped to be
11 achieved by that?
12 **A.** Well, two things. This is a form about the person, and
13 it's what's important to them. It also makes that
14 abundantly clear, we hope, to the clinicians that are
15 having those conversations that whilst, obviously, the
16 clinician's expertise is important, everybody has to
17 understand what's important to the patient that is
18 taking part in this.
19 **Q.** Can we see, in "What matters to me in decisions about my
20 treatment and care in an emergency", there's also boxes
21 here, "What I most value", and "What I most fear [or]
22 wish to avoid". I think that was another update --
23 **A.** It was.
24 **Q.** -- to the form to allow patients to express both their
25 ideas of a positive outcome and a negative outcome?

1 **A.** Absolutely, and that is, I think, useful for patients
2 themselves, hugely beneficial for people trying to care
3 for them, and I honestly think would be also very
4 helpful for families to know what their loved one is
5 thinking, and what their worst fear, and the things they
6 most value, because that's not always clear.
7 **Q.** Thank you. Under part 4, "Clinical recommendations for
8 emergency care and treatment", we can see at the top
9 there, there are three boxes: "Prioritise extending
10 life", or "balance extending life with comfort and
11 valued outcomes", or, "Prioritise comfort". And I think
12 that middle box was an addition, a change from
13 version 3; rather than two alternatives there was a
14 third option which was balancing the two; is that
15 correct?
16 **A.** That's absolutely correct.
17 **Q.** Below that -- sorry, just below the boxes, please, still
18 at point 4, there's an open text box for "clinical
19 guidance on specific realistic interventions that may or
20 may not be wanted". You've explained in the witness
21 statement that that is to ensure that there's no
22 conflation between a DNACPR recommendation and not
23 having escalation of treatment. So all the potential
24 treatment options can be identified and explained
25 whether the patient is in favour or not.

1 **A.** Absolutely. ReSPECT came about by professionals and
2 family members and patients realising that there was a
3 conflation, and I've certainly seen that in patients'
4 families, that they assume a DNACPR means no care, which
5 is, as you heard yesterday, not correct at all.
6 **Q.** So we did hear yesterday that there may be sometimes a
7 risk that clinicians might misinterpret a DNACPR,
8 meaning this patient doesn't want to have certainly
9 escalation of care, but that's, I think, a slightly
10 different point that families may misunderstand a DNACPR
11 form also to indicate that.
12 **A.** So I have certainly seen that. I have not witnessed the
13 former.
14 **Q.** Have you been made aware of any issues during the
15 pandemic where clinicians seem to be misinterpreting a
16 DNACPR form? Are you personally aware of anything like
17 that?
18 **A.** So only through reporting in the press as everybody
19 else, because my areas of expertise are in newborn
20 intensive care --
21 **Q.** I think you already -- (overspeaking) -- for this --
22 **A.** -- yes, and paediatrics, so yes.
23 **Q.** Yes.
24 **A.** As a neonatologist, so I wasn't involved in that side of
25 things in my own Trust.

1 **Q.** Thank you.
2 We can take the form down now, thank you.
3 I think that that ReSPECT form has not been
4 adopted everywhere in England -- I think most but not
5 all of the regions of England -- I think currently four
6 out of 14 Scottish Health Boards. It's not used at all
7 in England and Wales.
8 One of your recommendations is that the ReSPECT
9 process be adopted across all four nations of the UK.
10 Do you consider that the absence of a nationally
11 standardised process for advanced care planning creates
12 risks for patient care?
13 **A.** So I think it does, can I just -- because -- it wasn't
14 adopted in Wales, but it has been adopted in five out of
15 seven English health regions, as well as those in
16 Scotland.
17 So I think there is a risk of not having
18 standardised approach. Originally, when we went into
19 ReSPECT, the Resuscitation Council UK has a remit for
20 guidelines teaching in terms of resuscitation. We
21 didn't at that time have the same remit for ReSPECT,
22 although we recognised its, what we thought was its
23 worth, and have supported its development. Now, I think
24 one of the lessons out of the pandemic, I would say, is
25 that we do need a standardised approach. I am not here

1 to sell ReSPECT, but I think that as a country with four
2 nations, we do need a standard approach that would work
3 for patients wherever they are.
4 **Q.** You have said that that was one of the lessons that came
5 out of the pandemic. And you've also explained that the
6 view of the Resuscitation Council UK was that it was
7 appropriate for clinicians to have advance care planning
8 discussions with all patients that were admitted to
9 hospital with Covid-19.
10 What do you think is the importance of having
11 conversations about advance care planning in a pandemic
12 situation?
13 **A.** Well, one of the advantages of ReSPECT is that
14 everything is there on our website for patients or
15 professionals to look at. I think it's about openness
16 and understanding what people wish and want, and that's
17 differ for different people. It's different for
18 depending on backgrounds, your beliefs. Lots of things
19 feed into that. So the idea of having a blanket
20 approach will not work.
21 **Q.** Do you think -- we'll come on to blanket DNACPRs in a
22 moment, but do you think that these considerations are
23 different in a pandemic situation?
24 **A.** So I think there are many different pressures in a
25 pandemic, for certain, because everybody is under stress

1 and, as you heard yesterday, our acute services and
2 adult intensive care had never come under such pressure
3 before, and they had never seen, with or without CPR
4 decisions, they'd never seen the amount of death over
5 such a short period.
6 **Q.** Now, I think during the pandemic, in around March 2020,
7 there was a lot of national media reports about blanket
8 DNACPRs. By that, I mean solely on the basis of
9 disability or age, rather than an individualised
10 approach. Did the Resuscitation Council itself receive
11 any reports of either inappropriate DNACPRs or
12 inappropriate blanket policies about DNACPRs in
13 healthcare settings?
14 **A.** So from two routes. One was that in a non-specific way
15 we got questions from our resuscitation departments,
16 some came through asking for information about that.
17 Certainly in one instance I know of a specific -- one of
18 our members whose Trust implemented a blanket DNACPR.
19 **Q.** Can I ask you a little about that, please, and I don't
20 want the name of the institution of the Trust or indeed
21 the member that brought that to your attention. What
22 was the nature of that blanket policy? Was it on the
23 basis of disability or age?
24 **A.** So age disability and condition, I think, but I did not
25 see the document myself.

1 **Q.** As far as you're aware, it was a written policy?
2 **A.** No, I don't know that. I don't know.
3 **Q.** I see. Having been made aware of that, what steps did
4 you take or the Resuscitation Council take?
5 **A.** So we put out what we felt was a very clear statement
6 that blanket DNACPR was not an appropriate way forward
7 and should not be implemented. That was on our website,
8 and that -- our stance on that has never changed.
9 It was also -- it also went out to resuscitation
10 departments with whom we were in contact, not as a
11 document, but as a -- they were notified that there was
12 an update on our website to look at.
13 **Q.** In terms of that particular Trust, was there any
14 engagement with that trust or with NHS authorities in
15 relation to that particular issue?
16 **A.** No.
17 **Q.** Did you have any mechanism as the Resuscitation Council
18 to deal with that?
19 **A.** No, we didn't and if I'm brutally honest I would say
20 that our bandwidth was probably taken up by trying to
21 sort out the issue with guidelines and get on the same
22 page with Public Health England.
23 **Q.** Do you think that there should be a mechanism by which,
24 if it transpires that there are these sort of
25 inappropriate blanket policies going on at Trust level,

1 how would that be dealt with by the appropriate NHS
2 bodies? Is there a mechanism in place? Should there be
3 if there isn't?
4 **A.** So I know that within trusts if you've an issue there
5 are mechanisms to raise it within your own Trust. But
6 I think in this situation, especially in a pandemic
7 situation, there should be almost a central clearing
8 house for: I have an issue, this is going on, does this
9 need looking at? That could be devolved or it could go
10 to the different people within the NHS in different
11 countries.
12 **Q.** So that would be, to break it down nation by nation,
13 NHS England level in England, and within the devolved
14 administrations at government level within the bodies
15 responsible for the NHS?
16 **A.** Somebody with responsibility for sorting out an issue
17 which may or may not be the case because some of this is
18 hearsay. But such a route would have been useful even
19 to us with the guidelines to say: we have a problem
20 here, it is not helping, can somebody please help us
21 sort this out.
22 **Q.** Thank you.
23 In relation to inappropriately made DNACPR notices
24 then during the pandemic, the Inquiry has heard about
25 various concerns. Do you think there should be a

1 systematic review of DNACPR notices that were made
2 during the pandemic?
3 **A.** So I don't have -- I honestly don't have enough
4 information to comment on that. It's -- I believe
5 strongly that we need a better system for engaging with
6 patients and their families in terms of what they wish.
7 We didn't get any -- quite rightly, we didn't get any
8 patient-identifiable issues coming through to us because
9 we were not the correct body to be dealing with that.
10 **Q.** If a systematic review of DNACPR notices was proposed,
11 do you know what that would look like, how that would
12 take place? For example, are these notices usually
13 purely on paper or are they usually part of an
14 electronic patient record? How is easy is it to check?
15 **A.** So that it is still a problem, I can only speak for
16 England, but we are still in various levels of
17 digitisation and electronic patient record and depending
18 upon where you are, it may be on paper, it may be
19 digital, it might be both, or there might be a different
20 system.
21 So I think it would be quite difficult to look at
22 all of that across the whole of the UK but there are
23 people better able to answer that question for certain
24 than myself.
25 **Q.** In addition to concerns that DNACPR notices were being

1 made on an inappropriate basis, the Inquiry has also
2 heard about poor communication or sometimes a lack
3 entirely of communication with patients or their loved
4 ones to explain that a DNACPR decision has been taken
5 and the reasons for it and the effects of that.
6 What is your view as to how to ensure that
7 clinicians are having these difficult conversations in
8 the right way? Is it a training issue?
9 **A.** So I think that that has to -- there is -- I think
10 that's on a number of levels. Yes, I think there's a
11 training issue. Look at me: I trained a long time ago
12 and I'm senior and yet I should be one of the people
13 that's having these discussions, but that doesn't mean
14 to say I'm good at it.
15 The other thing is that families have not been
16 prepared for that kind of discussion and too many will
17 see it as a negative thing when in actual fact it could
18 be a wholly positive thing about understanding what
19 somebody wants at several stages of their lives.
20 So I think, personally, that there is more
21 training needed. There's time, that people will say,
22 all of the doctors and nurses and healthcare
23 professionals will say, so we need time for that but,
24 actually, I think you'll find that patients value that
25 hugely if you've got time to talk about something like

1 that and I personally feel that we need a public health
2 information drive to get people to think about this as
3 families and as individuals what is important to you.
4 Just having that conversation does not mean you are on a
5 one-way train to anywhere but it does give you more
6 power to decide how you want to live your life.
7 **Q.** If we can come back to this point about training,
8 I think we heard yesterday Professor Summers'
9 understanding was that medical students do receive
10 training on communicating difficult decisions as part of
11 the medical curriculum and that certainly it forms part
12 of the continuing professional education for intensive
13 care specialists?
14 **A.** Yes.
15 **Q.** And I think also for members of the Royal College of
16 Physicians.
17 **A.** Yes.
18 **Q.** Are you aware whether there is training specifically
19 around advance care planning, DNACPR and having those
20 conversations either as part of initial training or
21 continuing professional education for other specialisms?
22 **A.** So unfortunately the answer would be both yes, I am
23 aware, and no, it isn't a national generalised thing.
24 So you will, again, find areas of excellent practice
25 where that kind of training goes on, both in a mentored

1 way but also with actors and simulation so that people
2 get a feel for this.
3 What we're talking about with the ReSPECT form
4 isn't just a decision, it's a much wider thing and,
5 therefore, one needs time and some slightly different
6 skills in order to make that useful for the patient and
7 for the family.
8 **Q.** Do you also agree with Professor Summers that this sort
9 of training should be embedded in medical training?
10 **A.** I absolutely think it should. And not just medical
11 training, because I honestly believe that it should be
12 part of nursing training. It's actually going to be
13 best for the patient to have the person who is most
14 appropriate for that patient and with the best will in
15 the world, sometimes we're a bit scary, doctors.
16 **Q.** Thank you.
17 We also heard yesterday how difficult it was to
18 have those kind of conversations with family members
19 when those conversations couldn't take place
20 face-to-face during the pandemic. So it was over a
21 video call or a telephone call. Were you aware of any
22 training that took place during the pandemic to assist
23 clinicians or nurses in having those kind of
24 conversations through remote means?
25 **A.** So not in a wider context. We certainly did training

1 within our neonatal unit to use online discussions with
2 parents and also updates for ward rounds because of some
3 of the issues with parents not always being present on
4 ward rounds with our intensive care babies.
5 So, again, I'm sure that some training went on but
6 this was not a generalised thing.
7 **Q.** Is that the kind of thing that should be perhaps
8 embedded into pandemic planning and preparedness for the
9 healthcare system about how to give the sort of advice
10 or have those sort of conversations when it's not
11 face-to-face?
12 **A.** So I think that it is one of the lessons to learn in
13 a different setting. I know that there was huge
14 national learning in terms of safeguarding in that they
15 had meetings and shared what was happening and good
16 practice spread, and I'm not aware of that happening in
17 terms of this area of care which might have been useful
18 and is something that could have been done online.
19 **Q.** Thank you.
20 We've already touched on some of your
21 recommendations, Professor Wyllie, but I would like to
22 ask about the recommendations that are made at paragraph
23 89(d) and (e) of Professor Lockey's witness statement.
24 It's this: Firstly:
25 "that everyone has access to conversations with

1 their clinician to explore future options for treatment
2 and care in an emergency when they may not be able to
3 voice their own preferences. These conversations
4 should, wherever possible, happen before they are
5 needed, be communicated to those important to the
6 person, and documented in a format that's readily
7 accessible and understood by emergency care providers."
8 Then:
9 "The normalising of such conversations in society
10 as a whole, both between person and clinical team, but
11 also within the family setting to reduce the need for
12 difficult and challenging decisions to be made when a
13 person becomes so unwell that they cannot voice their
14 preferences."
15 I'd like to ask you how do we do that? How do we
16 go about normalising these conversations in our society?
17 What needs to happen and particularly what needs to
18 happen from the healthcare sector?
19 **A.** So, well, I think from a healthcare sector point of view
20 we need to accept that this is a vital part of care.
21 Within my own field, I will tell trainees that, you
22 know, we strive to do the best, we strive for success
23 but the take home message is when someone dies you'd
24 better get it right because everybody who survives will
25 remember you forever. It's ingrained, as I think we've

1 seen, in stone.
2 So I think that we need to accept, just as you
3 heard people yesterday and the many good clinicians do,
4 that this is a vital area of practice that we should get
5 right. I think that the other thing that we need to do
6 is that we need to make those conversations part of life
7 and that needs, I think especially in Britain, a change
8 of a number of cultures, especially what was thought of
9 as British culture, and that's why I mention I think
10 this would be an excellent long-term public health
11 campaign to say it's okay to talk about these things and
12 your perspective is going to be very different to
13 somebody who's 23 and collapses on a football field as
14 opposed to somebody of my age or older, but also
15 depending upon your culture, your gender, lots of things
16 go into that, and it's just important that people have
17 those conversations and feel free to have those
18 conversations because I think that if we get the message
19 right it will be an uplifting, freeing thing, not a
20 frightening, terrifying thing which is how it's come
21 about through the pandemic.
22 **MS NIELD:** Thank you very much, Professor Wyllie.
23 I have no more questions.
24 **LADY HALLETT:** Can I just follow up on that, Professor.
25 Supposing everybody changed their habits in the way that

1 you suggest, it might be a bit tricky in this country
2 given our traditional attitude to death, but what's
3 concerning me are the IT systems. So I accept your
4 advice, I go to my GP and I have this discussion and my
5 family then know what my wishes are and then I collapse
6 I'm taken to hospital. What are the chances of the
7 clinician in the hospital being able to get hold of my
8 GP records?
9 **A.** So you're absolutely correct. I think it's one of the
10 massive failures of care in this country and I'm old
11 enough to remember 20 billion went on NHS IT systems.
12 I have no idea where that went because I haven't seen
13 any of it.
14 We just have to get better and more sensible.
15 There's also a need for responsibility because it is not
16 and beyond the bounds of any of us to think that lots of
17 people will now have alert bracelets when they have a
18 condition that needs to be known to everybody. There
19 are other ways of doing things as well as having a big
20 centralised IT system. I think that we do need to think
21 about this and I'm not the -- I definitely am not the IT
22 expert to sort it out but it does need to be sorted and
23 I think it needs to be given thought for the whole of
24 the UK.
25 **LADY HALLETT:** Thank you very much.

1 Mr Weatherby.
2 **MR WEATHERBY:** The points I had have been covered, thank
3 you.
4 **LADY HALLETT:** Thank you very much, Mr Weatherby.
5 I think those are the only questions for you.
6 Professor Wyllie, what happened in your unit during the
7 pandemic?
8 **A.** In the neonatal unit?
9 **LADY HALLETT:** Yes.
10 **A.** From what point of view?
11 **LADY HALLETT:** Well, just you've heard some of the stories
12 I heard. Any particular lessons that --
13 **A.** So we too had -- we had to have visiting by rota because
14 we didn't have isolation rooms, our babies were safely
15 isolated but the parents were very understanding that
16 the space that we had meant they couldn't all come at
17 once. We instituted a system whereby at the end of ward
18 rounds I would do a summary and that was posted for
19 them.
20 But there was -- there were difficult
21 conversations to be had both about babies and especially
22 about some mothers and their babies. Some -- and this
23 comes again to planning, we had to discuss with some
24 mothers who were going to go to theatre for section that
25 they wouldn't be waking up and early in the pandemic

1 there was a 50% chance they would never see their baby.
2 **LADY HALLETT:** I'm almost sorry I asked.
3 **A.** It's real and they -- you know, I've just got --
4 everything was fine several times, everything was fine.
5 I think the other thing that we found that we
6 benefited in my own Trust in that we had army doctors
7 and nurses who had dealt with severe infections and
8 setting up hospitals in Africa for Ebola and they were
9 awesome.
10 **LADY HALLETT:** I'm extremely grateful, Professor Wyllie.
11 Thank you for, obviously, everything you did on the
12 frontline during the pandemic and continue to do, by the
13 sounds of it, and thank you for your help in coming to
14 give evidence.
15 **A.** Thank you so much.
16 **(The witness withdrew)**
17 **MS NIELD:** My Lady, I think the next witness is to be taken
18 by Mr Scott.
19 **MR SCOTT:** My Lady, may we please call Alex Marshall.
20 **LADY HALLETT:** Thank you.
21 **MR ALEX MARSHALL (affirmed)**
22 **Questions from COUNSEL TO THE INQUIRY**
23 **MR SCOTT:** Good morning, Mr Marshall.
24 **A.** Good morning.
25 **Q.** You are giving evidence today on behalf of the Frontline

1 Migrant Health Workers' Group, and you yourself are
2 president of the trade union the Independent Workers'
3 Union of Great Britain; is that correct?
4 **A.** That's correct.
5 **Q.** And during the pandemic you yourself were working as a
6 courier within the Health Service?
7 **A.** Yes, that's right.
8 **Q.** And just to provide a bit of understanding about
9 Frontline Migrant Healthcare Workers' Group, or FMHWG as
10 I will refer to them that's a collective grouping made
11 up of three broad organisations; is that correct?
12 **A.** That's correct.
13 **Q.** So you have two trade unions, United Voices of the World
14 and the Independent Workers Union of Great Britain and,
15 then you have another group called Kanlungan who are a
16 consortium of several Filipino and Southeast and Eastern
17 Asian grassroots community organisations, and I think
18 you are, to be fair, more familiar with the work of the
19 UVW and IWGB more so than Kanlungan, is that right?
20 **A.** Yes, that's right.
21 **Q.** If there are areas where you feel it's a bit too
22 detailed in terms of Kanlungan, please do feel free to
23 say.
24 **A.** Yes. So, yeah, I think it's good to point out here that
25 I am speaking on behalf of the three organisations, two

1 of which I'm very comfortable to speak on behalf of.
2 The other, I had the privilege of being nominated to
3 speak on behalf of, which I'm very proud to do today.
4 However, their experiences are something that I have had
5 to spend time with them to try and understand, and
6 I hope to convey that as well as possible today. But
7 yes, so -- that's my area where I'm slightly weaker,
8 perhaps.
9 **Q.** Not a problem at all. In terms of actually, it's not
10 just the people who you represent, you are also speaking
11 on behalf of those people who are in the same position
12 as those people you represent. I think we had the
13 evidence of Professor Bamrah who talked about workers
14 who weren't in the union, or weren't aware of a union --
15 **A.** Yes.
16 **Q.** -- to actually speak on behalf of their voices as well
17 as; is that right?
18 **A.** Yes. I mean, the work that Kanlungan, the IWGB and UBW
19 do is we represent precarious workers, many of whom
20 struggle to pay the bills, let alone pay for union
21 membership or anything like that, but the work we do is
22 a microcosm of, you know, what needs to happen across
23 the whole of the UK, and we represent the struggles of
24 tens of thousands, hundreds of thousands of workers,
25 yes.

1 **Q.** Those type of roles that you represent, or BNR nurses,
2 couriers, cleaners, porters, security officers, private
3 hire drivers, a lot of that sector of the healthcare
4 workers; is that right?
5 **A.** Yes. So we represent a huge part of healthcare workers,
6 a lot of whom are deemed as less important than, you
7 know, the primary function of, you know, doctors,
8 nurses, but a lot of the outsourced workers, and you
9 mentioned there about the private hire drivers who,
10 during the course of the pandemic, were sort of brought
11 into essentially the care sector, when their employer
12 decided, perhaps, as a bit of a PR stunt, to offer
13 nurses and vulnerable patients free rides in taxis.
14 This was despite the fact they had insufficient PPE, a
15 lot of them were clinically vulnerable, a lot of them
16 didn't have the choice to necessarily work, but these
17 guys were basically reappropriated into the care sector.
18 **Q.** Let me just take a step back, because what I want to ask
19 you about was kind of the broad views of a large number
20 of people who you represent, because yesterday the
21 Inquiry heard oral evidence from a witness given the
22 name MC3/W1. Presumably, the evidence of that witness
23 is representative of cleaners across the UK working in
24 both private and NHS hospitals; is that right?
25 **A.** That's right.

1 **Q.** But actually, probably the evidence of W1 and the
2 evidence of W2 contained in W2's statement that is to be
3 published, I mean, that's representative of the
4 experiences of outsourced workers, migrant workers
5 working in all types of roles across health systems all
6 across the UK?
7 **A.** Yes.
8 **Q.** Is that a fair description?
9 **A.** Yes. So, I mean you will have heard some evidence from
10 individuals, but that is representative of, as I said,
11 you know, tens of thousands of people across the UK, and
12 throughout the course of the pandemic, the three
13 different organisations were presented with various
14 situations of their members, and we responded in the
15 best way possible. And as deeply harrowing and
16 troubling it was to hear of these experiences, it was
17 equally as troubling to know that these weren't unique,
18 these weren't one-offs, that these were situations that
19 thousands of people were struggling with, where their
20 voices weren't being heard where they were just asking
21 for basic protections so they could do their job, so
22 they could continue to earn, but also so they could
23 protect people and not spread the virus.
24 **Q.** There's a lot of information that you just gave in that
25 answer. Just a couple of words I just want to focus on.

1 You said that their voices weren't being heard.
2 Did outsourced workers, migrant workers, did they feel
3 listened to during the pandemic?
4 **A.** No. I mean, this was a common theme for everyone we
5 represent, and I know way far beyond is that -- these
6 were people who, from one day to the next, you know,
7 they went home on a day, they watched the TV, they heard
8 announcements of lockdown, they'd seen this coming
9 months before, you know, January they had started to see
10 specimens, they had started to see a rise in issues of
11 Covid, and they'd seen it coming in. But one day to the
12 next, there would be huge announcements where people
13 were told to stay home and they turned up the next day
14 at work, and basically nothing had changed for them.
15 And A lot of these workers were making basic
16 demands. These weren't, you know, these were
17 specialists in the spread of viruses or anything like
18 that; these were frontline workers who had been doing a
19 job and knew they were going to be particularly
20 vulnerable, and they were asking for things to be
21 implemented that would protect them, that would protect
22 their families.
23 Also, we knew that we were going into places where
24 there were incredibly vulnerable people. We're talking
25 about cancer wards, we're talking about antenatal wards,

1 we're talking about old people's homes, and we were just
2 asking for things to be put in place to ensure that we
3 weren't spreading the virus more than you know it was
4 already clearly spreading like wildfire.
5 **Q.** That takes me back to one of the other points, the words
6 you used. You talked about protected people. It's not
7 just about protecting yourselves, but it's also
8 protecting patients and others; is that right?
9 **A.** Yes, I mean, there's a huge responsibility on these
10 workers. We knew that every single day you're coming
11 into contact with people who are unwell, who are sick,
12 who are vulnerable, and you know we were carrying
13 specimens of Covid to and from these places. We were
14 going into crowded lifts. We were going in and out of
15 wards. And we knew that we could be superspreaders if
16 we weren't given sufficient protections in order to try
17 and mitigate against that.
18 And going back to what you asked earlier, despite
19 the fact that so many of our members are individually
20 raising this with management, raising this through their
21 unions, campaigning, were being told no, time and time
22 and time again, and relying on, you know, government
23 orders which seemed that they had been composed to keep
24 people safe who were staying at home, not vulnerable
25 people who were heading straight into pick up the exact

1 thing that people were being told to stay home and stay
2 safe from.
3 **Q.** Let's try and boil it down. Did you, did outsourced
4 workers, did they feel protected during the pandemic by
5 the people they worked for?
6 **A.** No. I think we felt protected by our colleagues, we
7 felt protected by our unions and organisations that were
8 there, but there was no point throughout the pandemic,
9 through the whole duration of it, not just the relevant
10 period, where we felt that our employers or the state,
11 the government, were actually going the extra mile to
12 think of how they can protect us and keep us safe.
13 There was clear demoralisation. It was a case of
14 "when" people were going to contract it, not "if", and
15 also like how bad it would be, and people planning
16 around, "You know, if I get it hopefully, it's not that
17 bad, hopefully, you know, I don't spread it within my
18 family, hopefully I can get back to work in time, maybe
19 I can even work through it".
20 These were the thoughts that many of the people we
21 represent and beyond were having, because there was no
22 point where we felt people were listening to us, or they
23 were going the extra mile to ensure that the people
24 heading into these incredibly dangerous situations were
25 being looked after.

1 **Q.** Do you think that a large number of your workers felt
2 that they had any other option but to go to work?
3 **A.** No, I think -- you know, even myself, I had various
4 times where, if the burden had been shifted from myself
5 as an individual I would have stayed home, that I felt
6 like it could have been some symptoms that were coming
7 through but I didn't feel like I had the choice, and
8 I think so many workers due to, you know, just not
9 having the money, not having the -- good enough sick
10 pay, not enough security in place, they just did not
11 have the choice, and they were having to either choose
12 to go into work and risk their lives or stay at home,
13 potentially face destitution, and that is not a choice
14 that any individual should be making, and that's a
15 choice that should have been taken care of by the
16 employers and the government who actually had the
17 resources to make that decision for them.
18 **Q.** There are two comments in, I'm going to say your
19 statement, it's a statement on behalf of FMHWG that you
20 have adopted. The first one is at paragraph 36 where it
21 says:
22 "The failure to heed the warnings of frontline
23 migrant health workers put patients, the public, and
24 those same workers at greater risk."
25 Could you expand upon what's meant by that?

1 **A.** Well, as I said, I mean, a lot of these workers saw the
2 signs coming months before any official implementation
3 of any, like, mitigation to keep people safe was put in
4 place and the voices were being raised, the alarms were
5 being raised and the way the panic was handled was like
6 it started when that first lockdown started. But it
7 didn't. You know, people were handling swabs with their
8 bare hands, and they were they saw this all coming. Can
9 you repeat a part of the question?
10 **Q.** Sure. I can put the statement up on screen if you like
11 to see, if it would help to see what you actually said.
12 **A.** Oh, yes, it was about -- yes, if we had been listened
13 to.
14 **Q.** So that one is:
15 "Failure to heed the warnings of frontline migrant
16 health workers put patients, the public and those same
17 workers at greater risk."
18 **A.** Yes, I mean -- yes, I totally agree. Obviously, this is
19 my statement, but --
20 **Q.** Well, it's a statement you have adopted, so not your
21 words.
22 **A.** But no, no, it's -- we were crying out for this. We
23 were talking about being superspreaders, we were asking
24 for the implementation of basic things that would keep
25 more people safe. These were completely ignored and is

1 believe as a result of it this led to more deaths, this
2 led to more hospitalities *(sic)*, this -- it was a
3 failure to listen to the very people who were experts in
4 the situation and how to mitigate against it.
5 **Q.** Because you say that it seems like it felt that the
6 pandemic started when lockdown happened. You're talking
7 about these warnings. When were these warnings coming
8 in roughly? Was it January, February, early March?
9 **A.** Well, I know that my colleagues, when I was working as a
10 medical courier, we were starting to see swabs with
11 yellow labels that said "Covid" from, like, January. We
12 were starting to see it come in then. We were asking
13 and saying this isn't safe. I remember some of my
14 colleagues, they went and picked up a swab of Covid that
15 the zip bag had been left open and this was a guy who
16 had a young child at home, he had a young family and he
17 came back and he approached me and said, "This isn't
18 right, I'm going to go home, I'm going to kill my family
19 and no-one seems to care." They want us to walk off the
20 job and we were pushing our company to say, you know,
21 "What's going on?" And the response was, you know,
22 we'll wait for advice, it's wait and see.
23 Where I was working was a private medical firm.
24 This is a place that makes huge amounts of profits from
25 being experts in medical diagnostics. This is a place

1 that you would think would have not only the PPE that's
2 used for the lab staff and these protections but would
3 have the kind of understanding of situations to get a
4 little bit ahead of the game. However, due to the fact
5 that we were outsourced workers, we were gig economy
6 workers, there just seemed to be no thought for this
7 section of the workforce as to how we can keep these
8 guys safe, and any of our complaints were made to feel
9 like we were just being annoying, like we were just
10 asking for too much, like they just wanted to silence
11 us. And we saw this coming and we were raising the
12 alarm.
13 But, you know, these are situations that so many
14 of these workers are putting up with day to day. There
15 are power dynamics at play whether you're on an unstable
16 visa or if you're an outsourced working or you are
17 working in the gig economy that we're crying out like,
18 look, all of these organisations are dealing with these
19 issues on a daily basis. The pandemic was pouring
20 petrol on a blazing inferno that's already going on for
21 a lot of our members.
22 So we're constantly raising the alarm. We
23 definitely -- our voices got louder during the pandemic
24 but, as I said, we made some basic demands as to things
25 that could be done to keep not only us safe but also to

1 keep the members of the public, the vulnerable patients
2 we were coming into contact, and systematically we were
3 told: no, no, no.
4 That's why this way of employing people, the way
5 of treating people, the power dynamics, the structural
6 racism, the structural inequalities, that are, you know,
7 very much on display is a public health issue.
8 **Q.** Let's -- who do you complain to? If you are an
9 outsourced worker or a migrant worker for example,
10 because I think you say that these issues arise for both
11 of those kind of groups, those very broad groups; is
12 that right?
13 **A.** Yes, definitely.
14 **Q.** If you are working for a company which is then
15 contracting you to a private hospital, an NHS hospital,
16 who do you complain to, who do you talk to?
17 **A.** So I think it's really important to understand that as
18 an outsourced worker there are these power dynamics at
19 play and a precarity at play from being a migrant worker
20 as well, from being on a precarious visa, or English not
21 being your first language, or the fact you have
22 dependents back at home that you are having to support,
23 that really make you very scared to speak out on an
24 individual basis. Also the nature of outsourcing and
25 the visa system has decimated the ability to

1 collectivise and build unions, it's very hard doing what
2 we are doing, the three organisations to build this
3 collective voice --
4 **LADY HALLETT:** I'm sorry to -- I am sorry to interrupt.
5 It's just that I do have limited powers, Mr Marshall, as
6 I'm sure you appreciate. I can't change society and
7 I just think maybe we are straying beyond what I can and
8 can't find or recommend.
9 **MR SCOTT:** If I can bring you back to the question which is
10 about who you complain to within that healthcare system.
11 **A.** Yes, I just wanted to make that point because you can
12 complain to a manager but it's very difficult to come
13 forward and make that complaint. You go to your union,
14 you collectivise, and then that collective voice makes
15 it more of a kind of prominent, like, complaint but this
16 is how you complain. If you're an outsourced worker you
17 are told to go and complain to the outsourcing company,
18 you know, you don't even complain to the manager who
19 actually oversees the work you are doing in the
20 workplace. So then this gets completely disconnected
21 and by the time the complaint is heard, it's just not
22 even responded to or something's been lost in
23 communication and they don't do anything about it.
24 **Q.** So in terms of, then, access to things like PPE, again,
25 somebody in that same situation who provides the PPE?

1 Is it the hospital? Is it the Trust or is it the
2 company?
3 **A.** So I think in a lot of the situations it was coming
4 through the hospitals. However, the kind of in-house
5 workers were prioritised so they would get primary
6 access to the PPE and then the outsourced workers would
7 then get limited access and what we also saw --
8 **Q.** Can I just ask why?
9 **A.** Why?
10 **Q.** Yes. Why do you think that was?
11 **A.** Why was it prioritised?
12 **Q.** Yes.
13 **A.** Because they clearly thought these workers were more
14 important, that they were more so their responsibility
15 than the people who were clearly also integral to the
16 business.
17 **Q.** Even if people had been redeployed into what would be
18 perceived to be higher risk settings?
19 **A.** Yes, well, that's exactly what happened. We've seen the
20 situation of cleaners, we've seen the situation of
21 couriers, and nurses who were given secondary access to
22 PPE despite the fact that they were not only going into
23 incredibly dangerous places but also were then going
24 into loads of different rooms, loads of different
25 hospitals, so had the potential to be superspreaders.

1 **Q.** One of the aspects in the statement is talking about:
2 "In April 2020 Kanlungan organised a meeting with
3 NHS managers ..."
4 It's paragraph 57. I don't know if it's something
5 you are entirely familiar with. This was about NHS
6 managers verbally acknowledging the disproportionate
7 impact on Filipino staff members with regard to the
8 overrepresentation of nurses in infection and also
9 assignment to high-risk wards.
10 So it was apparent, I know you said it was
11 apparent prior to March, but it was apparent in April
12 about what the impact was on migrant workers, minority
13 ethnic workers, outsourced workers, and that was being
14 raised. Did it ever feel to those workers like anything
15 actually changed?
16 **A.** No, I don't believe it did and for a lot of these
17 workers, again, because of their visa status and, you
18 know, that fear of speaking out because of the precarity
19 of the nature in which they're in this country and their
20 employment they felt that they were pushed into really
21 dangerous situations where they weren't able to push
22 back, where people in more stable working conditions
23 were actually able to say "no" and that definitely led
24 to this disproportionate number of people dying.
25 **Q.** There is one question that we have been asked to ask.

1 It's in relation to the precarity of the workers. From
2 your members' experience did the imposition of no
3 recourse to public funds conditions on healthcare
4 workers' immigration status exacerbate the impact of
5 Long Covid?
6 **A.** Well, I mean, people were forced back into work before
7 they were able to take the appropriate rest because they
8 were unable to access any support that was needed.
9 Like, people were having to work through when they
10 probably had symptoms which were worsening. So I think,
11 you know, access to or having no access to it certainly
12 meant that, you know, it was definitely a contributing
13 factor to this.
14 **Q.** Was there a feeling amongst outsourced workers or
15 migrant works that the availability of PPE within a
16 hospital, whether private of NHS hospital, was that
17 driving supply to workers who were actually working in
18 that hospital or was it just actually about allocation
19 of roles?
20 **A.** So what do you mean?
21 **Q.** Was it supply that the hospitals actually had available
22 to them that was then driving about how it was handed
23 out or was it more a guidance and a principle point?
24 **A.** I think there was an issue of supply. I think that was
25 widely known. But when they did come by supply it

1 didn't seem like there was any, you know, forward
2 thinking as to keep getting it in, but it also felt
3 like, you know, the in-house staff were given a better
4 quality of PPE, they were given an abundance of it and
5 many of our workers were given sort of disposable masks
6 that they were told to reuse. They were given gloves
7 that they were wearing throughout the day when they are
8 meant to be disposable gloves.
9 We were given very little instruction as to how to
10 safely use PPE. Even though it was inadequate PPE, we
11 were also given insufficient instruction. So as I said,
12 people were wearing gloves all day long to keep their
13 hands clean of germs. However, they were then touching
14 things, picking up specimens, just using them as -- so
15 there was definitely limited supplies given to people.
16 We had cases where people were given a little 10 ml
17 bottle, or whatever, a really small bottle of hand
18 sanitiser, and told to kind of make sure it lasts. How
19 are you meant to make sure its lasts when you are going
20 in and out of wards where you are meant to be hand
21 sanitising every single time you touch something?
22 Disposable masks, where you go in, you try and get
23 more, and you were told you were being greedy by asking
24 for more. If you questioned the masks that were being
25 used and said, "Shouldn't we be using these?", you were

1 told to be happy that you've got anything. And that was
2 the kind of discourse that was given to many of our
3 members who dared to ask or dared to question.
4 What we also saw was people who did question what
5 they were given were sometimes faced with punitive
6 measures, that they were called trouble makers, they
7 were told they were scaring people, they were told that
8 they shouldn't be speaking out and they were moved into
9 places to keep them out of the way or sent into more
10 dangerous situations. So we actually saw, you know,
11 punitive measures being exercised when people dared to
12 question the kind of inadequate protections that they
13 were given.
14 **Q.** And again, everything that you have just been covering
15 there, that's being felt by lots of different workers in
16 lots of different roles cross the entirety of the
17 country, is that right?
18 **A.** Well, that's the whole of the UK and beyond, I'm sure,
19 but this is a dynamic that was playing out. As I said
20 at the beginning, this was not a unique experience to
21 certain individuals, this was a dynamic that was playing
22 out for outsourced precarious migrant workers all over
23 the UK.
24 **MR SCOTT:** My Lady, I am about to move on to an another
25 topic. Is that a convenient moment to have our morning

1 break?
2 **LADY HALLETT:** Yes, certainly. Half past.
3 **(11.13 am)**
4 **(A short break)**
5 **(11.29 am)**
6 **LADY HALLETT:** I hope you were warned that we take the
7 breaks that we take, Mr Marshall.
8 **MR SCOTT:** Mr Marshall, two very discrete topics before
9 I ask you about recommendations and lessons learned.
10 As far as you're aware, were there any risk
11 assessments done, or any kind of formal redeployment
12 processes when workers were redeployed into differed
13 working areas?
14 **A.** Yes. There were.
15 **Q.** And how effective were those risk assessments and
16 processes?
17 **A.** Oh, just in terms -- sorry, I --
18 **Q.** Sorry, it was about the risk assessments done rather
19 than when they would be deployed.
20 **A.** Yes. Yes, I think risk assessments were largely like
21 insufficient, and I think a lot of the times workers, as
22 you said before, in terms of raising complaints, we had
23 people who were reporting workplaces to the HSE and very
24 often they weren't responded to. When risk assessments
25 did take place in various workplaces where we have

1 members, they were done quite late. You know, months
2 into the pandemic, risk assessments were made that
3 should have been done in those months leading up to the
4 first lockdown. Risk assessments don't take long; you
5 can put basic things in place while you continue to
6 assess the situation, but a lot of the time these risk
7 assessments were made when we were very much in the
8 pandemic, when people were getting infected, when people
9 were dying.
10 **Q.** Did it feel like anything changed afterwards, even if
11 what had been done is different to --
12 **A.** Yeah --
13 **Q.** -- to whether there was an output from it?
14 **A.** Yes, I think, you know, changes were made, but as I said
15 before, a lot of these changes seemed to be the bare
16 minimum, as opposed to going the extra mile for these
17 workers. So, you know, social distancing was put in
18 place, there were certain systems that were put in
19 place, but a lot of it seemed too little too late, but
20 also just too little in general, that wasn't actually
21 there to protect the workers but was just more to show
22 that employers were doing what was, you know, asked of
23 them, rather than what they should be doing.
24 **Q.** Moving now to lessons learned and recommendations, you
25 had heard her Ladyship earlier on in terms of the limits

1 of what she is able to do.
2 In terms of lessons learned and recommendations,
3 what would you say are the main lessons learned from the
4 perspective of outsourced workers and migrant workers?
5 **A.** Yes, so I mean outsourcing within the health sector
6 should be ended. Heading towards another pandemic, if
7 one does happen, or any other crisis like this, it was
8 laid bare on how this inequality within the workplace
9 becomes a public issue and actually contributes to a
10 crisis rather than helps with efficiencies or savings or
11 anything like that. So we need an end to outsourcing,
12 and for everyone to have parity, everyone should have
13 access to the same rights, so they able to take the
14 appropriate steps.
15 **Q.** But in terms of making sure your voices can be heard?
16 **A.** In terms voices being heard.
17 **Q.** Do you have any recommendations that you would like her
18 Ladyship to consider to make sure there's a better --
19 (overspeaking) -- outsourced?
20 **A.** Yeah, so I think that also, yeah, in the build up,
21 I think it's great that we're able to have our voices
22 heard now. Obviously, this is retrospective, but
23 I think workers' voices need to be at the centre of --
24 you know, we need to be listening to the workers who are
25 on the frontline, who are crying out for things to be

1 implemented and I think that always needs to be that
2 centre of making any changes. So as we reflect on what
3 happened, we need to go deeper and to talk to workers
4 and ensure that the things they are crying out for, you
5 know, enough money to be able to take time off work, the
6 inequality they are facing on a daily basis, this needs
7 to be considered and acted on, not just left to be
8 something that people are still being subjected to
9 today.
10 **MR SCOTT:** Thank you, Mr Marshall.
11 My Lady, I have no further questions.
12 **LADY HALLETT:** No, I think there's some questions.
13 Mr Weatherby.
14 **Questions from MR WEATHERBY KC**
15 **MR WEATHERBY:** Thank you very much.
16 Mr Marshall, I have just a few questions on behalf
17 of the Covid Bereaved Families for Justice UK, and they
18 are all about the effect of the hostile environment
19 policy on migrant workers, and they are based around
20 some evidence. So a study and a report which I think
21 you've had the opportunity of looking at in the last day
22 or two, certainly.
23 It's the Kanlungan consortium and RAPAR report.
24 Obviously, you told us about Kanlungan. Now, RAPAR is a
25 well known refugee and asylum research organisation

1 based in Manchester, I think. They conducted a study of
2 Filipino workers in the context of Covid-19 between May
3 and June 2020, and we have the report. I don't think
4 we'll need to refer to it, but I'm going to
5 give reference just for the record, which is
6 INQ000235265, and for anybody who wants to look at it,
7 it's really page 4 I'm going to concentrate on.
8 The report looked at the impact of the hostile
9 environment policies on migrant workers in the context
10 of Covid-19. Hostile environment was a government
11 policy from at least 2012, and that was directed at
12 undocumented migrants in the UK, yes? So the first
13 question I want to ask is that the evidence about in
14 this study was based around a group of Filipino workers,
15 and of course there are many Filipino workers within the
16 healthcare sector, but is it your experience, and from
17 your knowledge of your union members and the people you
18 work with, that this study is reflective of the
19 experience of people with precarious immigration status
20 as a whole within the healthcare sector?
21 A. Yes, certainly.
22 Q. So the study itself -- and I'm going to deal with it in
23 very broad outline because I don't want to take too much
24 time up here -- but in what ways did the hostile
25 environment policies lead to workers being faced with a

1 choice in terms of, for example, risking getting the
2 virus or becoming destitute, being not in employment?
3 In what ways did the hostile environment policies lead
4 to that dilemma?
5 A. So the hostile environment policies feeds into the
6 people that I'm representing here today, both people on
7 the precarious visas coming from the Philippines who
8 have their work tied to their visas, and if they do push
9 back, they can find themselves fired and they have only
10 two months to then try and find different work. So the
11 risks of pushing. Back.
12 Also, outsourced work, the gig economy, is heavily
13 reliant on migrants who are, like, filtered into this.
14 But the hostile environment contributes -- sorry, can
15 you just repeat the end of the question there?
16 Q. Yes, I was just asking how these policies impacted on
17 workers with precarious immigration status, but the
18 words the report used on page 4 is that they were forced
19 into "informal exploitative employment" and "no work no
20 pay".
21 A. Yeah.
22 Q. So is one of the effects of those policies that migrant
23 workers with precarious status were required to work
24 when otherwise they might have --
25 A. Yes, definitely. Almost every worker, I'm speaking on

1 behalf of predominantly migrant workers who are
2 subjected to these policies, are -- they don't have the
3 security that a lot of in-house workers do, a lot of
4 employees do, and as a result of this they were forced
5 to continually make these choices individually whether
6 they stay home and stay safe and recover from whatever
7 illness they have, or they go to work and get paid. And
8 this was something that individuals were having to make
9 on a daily basis where they literally did not have --
10 you know, I put two choices there, but they are not
11 really choices, are they? Every time someone is going
12 to go to work and continue to earn over staying home
13 and -- their existence is so hand to mouth a lot of
14 people cannot quite comprehend that literally missing a
15 day's work you're making up for it weeks, months after
16 that happening.
17 Q. And that applied to outsourced workers generally but
18 particularly where people have precarious immigration
19 status and they would be scared that they would lose,
20 their employment as well?
21 A. Yes. You miss a day's work, your manager is chasing
22 you, a lot of the time they don't trust you, and this
23 can lead to you losing your job, and when you've got
24 people who are reliant on you back in the country that
25 you might have left, that your visa is reliant on it,

1 it's not a choice, you have to just continue to --
2 Q. And I think the report went on to say that additional to
3 those points that migrants with precarious status were
4 pushed into overcrowded housing and they had a fear and
5 isolation which prevented them accessing support and led
6 to mental health problems; is that right?
7 A. Yes, I mean, people were -- they had limited choices,
8 they were forced into situations, be that housing, be
9 that more dangerous situations at work, because they
10 just did not feel they could push back and have their
11 voices heard.
12 Q. That's the employment side and the precarious nature of
13 that, but in terms of migrant workers accessing
14 healthcare themselves, how did these policies impact
15 that access?
16 A. I think what's really important to understand is also --
17 the hostile environment is so deeply entrenched in the
18 society that we live in that you even have situations
19 with people who can access these resources who are so
20 scared to access them because they think they are
21 unwelcome, they think they are going to be deported,
22 they think -- that they are just choosing not to because
23 they don't feel welcome, because they fear
24 repercussions.
25 So that's how deeply entrenched it is, let alone

1 for people who might well be undocumented, who might
2 have no recourse to public funds, they just are so
3 terrified that --
4 Q. Yes, and I think those are the two points that the
5 report highlighted, aren't they, that there was a fear
6 of being reported to immigration authorities, on the one
7 hand, and there were also prohibitive charges for
8 treatment on the other?
9 A. Yes.
10 Q. Thank you very much.
11 A. But also, as a result, we had organisations like
12 Kanlungan who were having to set up, like, these safe
13 spaces where people could access vaccination, where
14 people could access support. The IWGB and UBW also had
15 to set up similar spaces which people could access PPE
16 because people saw them as a safe space where they felt
17 welcome, whereas across the rest of society they are, on
18 the one hand, made to feel unwelcome. However, they had
19 been applauded every evening for the service they were
20 providing the population to counter a pandemic that was
21 spreading and killing so many people.
22 **MR WEATHERBY:** Thank you, Mr Marshall.
23 **LADY HALLETT:** Thank you, Mr Weatherby.
24 Mr Marshall, that completes the questions we have
25 for you. You are a superb advocate for your cause. You

1 spoke very eloquently about the horrid problems that
2 people you represent suffered. So thank you very much.
3 A. Thanks very much.
4 **(The witness withdrew)**
5 **MR MILLS:** My Lady, may I call Mr Matthew Stringer who can
6 be sworn.
7 **MR MATTHEW STRINGER (sworn)**
8 **LADY HALLETT:** I hope we haven't kept you waiting too long.
9 A. You are early in fact.
10 **Questions from COUNSEL TO THE INQUIRY**
11 **MR MILLS:** Your full name, please.
12 A. Matthew Stringer.
13 Q. Mr Stringer, you are the chief executive officer of the
14 Royal National Institute of Blind People. Is that a
15 role you have held since May 2019?
16 A. That's right, yes.
17 Q. You have provided a statement to the Inquiry
18 representing the collective experience of the members of
19 the Disability Charities Consortium -- that's the DCC?
20 A. Yes.
21 Q. And for reference, that statement is INQ000235594.
22 Introduce us, please, Mr Stringer to the DCC.
23 Which charities is it made up of and what are its aims?
24 A. It's made up of nine charities, so it is RNIB, the RNID,
25 the Royal National Institute for Deaf People, Sense,

1 Scope, the National Autistic Society, Leonard Cheshire,
2 Mencap, Mind, and the Business Disability Forum, and
3 we've come together as a group for about 15 years,
4 meaningfully, to provide a sort of group that supports
5 the 16 million disabled people in the UK and that group
6 with the weight we bring collectively, engages with
7 ministers, influences national strategy on disability
8 and, clearly, you know, has engaged across the Health
9 Service and other related bodies over 15 years.
10 Q. Can we start with some basics. First, definitions.
11 Under the Equality Act do we define disability in this
12 way: a person has a disability if they have a physical
13 or mental impairment which has a substantial and
14 long-term adverse effect on their ability to carry out
15 normal day-to-day activities?
16 A. Yes, that's right.
17 Q. Building on that, how do we define when a person has
18 complex disabilities?
19 A. I mean, complex disabilities would be a number of
20 disabilities coming together. I mean, clearly we
21 represent people who have a particular disability, so my
22 own charity supports people who are blind and visually,
23 that's about 2 million people in the UK. Clearly some
24 of those people have other disabilities, they might be
25 learning disabilities, people who are deaf as well as

1 blind, and so you get the point that there are layers of
2 disability that can build up that make someone's life
3 more complex than just having one singular disability.
4 Q. Next, please, the key figures. You have told us there
5 are around 16 million disabled people in the UK.
6 Approximately that is one in how many of us?
7 A. It's about 20% of the population, if you take we're
8 about 70 million, 16 million is about one in five of the
9 population.
10 Q. Now, of that 16 million, is it right that 1.6 million
11 have complex disabilities according to the definition
12 you've just shared?
13 A. Yes, I think so. I mean, if you just break down some of
14 the statistics in terms of the number of people that we
15 support, how that breaks down, there's 1.6 million with
16 complex disabilities. We think there's 1.5 million with
17 a learning disability. As I said, there's 2 million
18 people who have some sort of visual impairment. There's
19 12 million who have some sort of hearing loss, actually.
20 700,000 people have autism. So that 16 million, you can
21 see, breaks down plus a number of different disability
22 characteristics and there's obviously some overlap when
23 we go back to the point about complexity.
24 Q. Now, with those figures in mind, can we move to another
25 set of figures in respect of mortality amongst disabled

1 people during the pandemic. At your paragraph 14 you
2 refer to data published by the Office for National
3 Statistics which examined deaths from Covid-19 between
4 January and November 2020.
5 Help us, Mr Stringer, with what that data
6 revealed.
7 A. Well, I think it's pretty shameful data, really, that
8 talked to the fact that of the 50,000 deaths between
9 January and November of 2020, 30,000 of the 50,000 were
10 disabled people. So that is 60% of the total when, as
11 we've just been speaking about, disabled people
12 represent 20% of the UK population. So a very, very
13 high disproportionate impact on disabled people through
14 the time we're talking about, January to November 2020.
15 Q. You go on at your paragraph 15 to refer to further data
16 published by the ONS in November 2022 in respect of
17 working age people with hearing and visual impairments.
18 What did that tell us, please?
19 A. Well, it told us that working age people with a hearing
20 and visual impairment were 12 times more likely to die
21 than those that didn't have hearing and visual
22 impairment. So, again, a very disproportionate number
23 compared to what you would expect.
24 Q. Then finally this. At paragraph 17, you refer to data
25 published by the Learning Disability Mortality Review.

1 What do we learn from that?
2 A. Well, again, a disproportionate outcome. So people who
3 have a learning disability were six times more likely to
4 die and that rose to 30 times more likely for adults
5 between 18 and 34.
6 Q. Now, when we are considering these figures should we or
7 should we not be thinking about other factors that might
8 have contributed to these mortality rates, for example,
9 that disabled people are on average older, that they
10 experience higher levels of comorbidities,
11 socio-economic deprivation, and the barriers they face
12 in accessing care?
13 A. Yes, potentially but I think one of the things we feel
14 as the DCC group is we haven't done enough analysis of
15 these headline numbers to really understand what is
16 driving this disproportionate outcome. There have been
17 some further studies done but even now we're sitting
18 here not really getting under the skin of why there were
19 60% of people that died in that first year of Covid were
20 disabled versus the 20% proportion that they represent
21 in the population. All the things you mentioned clearly
22 would play a part but it's an easy thing to say, well,
23 that's the reason why we can accept that
24 disproportionality.
25 We don't think that's right. That's an easy thing

1 to assume but we think that's too easy to assume and we
2 will be advocating for further analysis to be done so we
3 can really get under the skin of that data and then do
4 something about the lessons that come from it and that
5 is an incomplete picture at the moment.
6 Q. Do you see this as being reflective of wider, more
7 fundamental issues with the collection of data about
8 disabled people more generally?
9 A. Well, I think, you know, clearly people have been
10 computing data through Covid and really trying to get to
11 understand it. I think through the first year this
12 information wasn't really known. It really became --
13 first mortality data came out in June 2020 and then we
14 got some further data in February 2021, so almost a year
15 into Covid before I think we really started to see, you
16 know, this direction of travel that we've been talking
17 about over the last few minutes.
18 I think, you know, as I say, since then there's
19 been further things done. There's been, you know,
20 information sought on the government's national autism
21 strategy for example, which I think again has some flaws
22 in it. I think the fundamental point remains that there
23 is work to be done to really understand that data at
24 a more detailed granular level to really understand some
25 of the intersectionality issues that you have hinted at

1 in your questions you know to really give us much more
2 insight into what really happen and then do something
3 about it.
4 Q. We haven't been able to refer this morning to mortality
5 data for autistic people. Is that because we don't have
6 reliable data?
7 A. Well, again, I think the headline number of deaths that
8 I've talked about being able to break that down in a way
9 that really understands what caused it is a gap in our
10 knowledge. There's been a government national autism
11 strategy from 2021, it's ongoing, the National Autistic
12 Society would say to us that actually the way the
13 government is collecting that data and did collect it
14 through the pandemic was collecting it on people who
15 were in regulated CQC registered services, which clearly
16 is one piece of data which is valid but is not the
17 complete picture which needed to include people of
18 autism who were living at home and in other locations.
19 So, again, it makes my point that the data
20 collection we've had has not necessarily been as full as
21 it should have been whether it's on autism or the
22 general picture.
23 Q. Yes, and in fact in your statement you say there is no
24 means of recording autism on death certificates and it
25 is not regularly recorded in hospital data?

1 A. Yes, that's right, yes.
2 Q. Turning next, please, to the DCC's concerns about the
3 care received by disabled people during the pandemic.
4 A. Yes.
5 Q. And I'll start with this, please: reasonable adjustments
6 in healthcare settings for those with disabilities.
7 Is it right that one of the DCC's primary concerns
8 is that the restrictions in respect of hospital visiting
9 had a disproportionate impact on disabled people because
10 they needed someone in hospital with them?
11 A. Yes, I think that's right. I think there's two key
12 points maybe to draw out your question.
13 The first one is the guidance that came out
14 initially in April 2020 and then subsequently was
15 updated was quite high level. It was quite blunt. It
16 didn't have disabled people's input into shaping it in
17 a much more nuanced way.
18 Q. I wonder, Mr Stringer, if we might look at the guidance
19 so you can make sure answer whole.
20 Can we please go to INQ000000132.
21 This is 8 April guidance. We have a list of the
22 only exceptional circumstances where one visitor, an
23 immediate family member or carer, will be permitted to
24 visit are below. At the final bullet we read:
25 "You are supporting someone with a mental health

1 issue such as dementia, a learning disability or autism,
2 where not being present would cause the patient to be
3 distressed."
4 A. Yes. So as I was just saying before, I think these four
5 bullet points, and you have drawn the attention to the
6 last one, are quite high level. Clearly that last
7 bullet point doesn't cover everybody who might have a
8 disability, it doesn't talk about people who have Down's
9 syndrome, it doesn't talk about people who are deaf,
10 people who are blind. So it's quite a blunt instrument
11 which leaves as much open to interpretation by the
12 people who are trying to apply this as it does help
13 them.
14 So this was not, you know, a very valuable
15 document or helpful document, in a sense. I can
16 understand what they were trying to do. It was trying
17 to be positive in showing that people needed to be
18 accompanied. It obviously, you know, was alert to that
19 need. What it didn't do was go into enough detail, you
20 know, to both support people with different disabilities
21 but also to give the Health Service the appropriate sort
22 of advice and input so they could do the right thing in
23 supporting patients.
24 Q. Are you able to give us an example of the further
25 detailed support that you would have liked to have seen

1 in this guidance?
2 A. I can maybe just give some examples of some of the
3 beneficiaries that we've seen across the DCC group.
4 So, you know, there was a blind lady who was of
5 full mental faculty who was going through a medical
6 procedure which was nothing to do with Covid. She was
7 denied her partner being there with her and her partner,
8 husband, had to take out a sort of power of attorney to
9 accompany his wife to that health visit or that health
10 process, you know, because the hospital wouldn't allow
11 him to accompany her which we would have said should
12 have been allowed by this sort of advice.
13 There's a number of examples we have across the
14 different charities whereby people were not accompanied
15 in a way we would have advocated and probably the
16 guidance should have allowed through 2020.
17 Q. Yes.
18 Can we go now to INQ000330865.
19 This is the 5 June 2020 guidance which replaced
20 the 8 April guidance. It's right, isn't it, that the
21 paragraph we have just read together, that final bullet
22 point, doesn't appear in the June guidance?
23 A. No, it doesn't.
24 Q. What we do have is this, on page 2, please, penultimate
25 bullet point:

1 "Other people who are in attendance to support the
2 needs of the patient, for example a familiar
3 carer/supporter/personal assistant, should not be
4 counted as an additional visitor. Patients may be
5 accompanied where appropriate and necessary to assist
6 with the patient's communication and/or to meet the
7 patient's health or social care needs."
8 Mr Stringer, how does the language used here
9 compare to that used in the April 2020 version?
10 A. Well, I mean, clearly it is fuller and I think has taken
11 probably reference back to April that that was probably
12 quite, quite quick and quite high level. So there was
13 more thought and detail in here.
14 I still think we would say this updated version
15 two months on was not created with enough input from
16 disabled people who were able to provide that nuance and
17 that insight that I mentioned earlier to make it a much
18 more sort of thoughtful and relevant document.
19 I think one of the problems is that guidance, you
20 know, certainly early in Covid, was issued at quite a
21 high level, quite a blanket level, clearly it had to be
22 done quite quickly, we understand that, but A, it
23 didn't, as I say, address some of the nuance and the
24 difference that was required and also for those people
25 trying to apply it, left it quite uncertain, quite what

1 you had to do in certain situations when different types
2 of disabled patients might have presented themselves.
3 So this would be a move on after two months but we
4 don't think it did the full job that was required.
5 **LADY HALLETT:** Can I just ask in relation to that, you just
6 mentioned a point I was thinking about: the recipient of
7 this guidance.
8 **A.** Yes.
9 **LADY HALLETT:** The more you try to broaden it to include the
10 people you ought to be including, the harder it gets for
11 the recipient of the guidance to interpret it, doesn't
12 it? Isn't that one of the problems with making it ...
13 **A.** Yes, it does. When you take that argument to its final
14 conclusion, you then say, well, we don't support
15 disabled people and the difference that they present.
16 It's too difficult. And we will believe that's not an
17 acceptable position. We think that the Health Service
18 should be able to support people of different
19 disabilities.
20 **MR MILLS:** Were you or your organisation made aware of
21 patients facing difficulties in bringing a supporter or
22 a carer into hospital after the June 2020 guidance was
23 issued?
24 **A.** Yes, as I said, I think the example I gave was after
25 June with the lady who was going through an experience

1 and had to get her husband to take a power of attorney
2 so he could attend. We have another example of a lady
3 going through, who was pregnant -- one of our employees,
4 actually -- who was blind who was going through
5 pregnancy, and again had to do that in isolation without
6 the support of partner and family. So, yes, I mean,
7 there are examples of that.
8 **Q.** Next please, remote care. A reference to one or two
9 examples. Can you help us with the ways in which a
10 phone or a video consultation is not going to be
11 suitable for someone with a disability?
12 **A.** I mean, I think you know health processes moved to being
13 remote from -- well, some moved to being remote from
14 being face-to-face. I mean, it is a double-edged sword.
15 There were some people who were able to use technology,
16 would have welcomed the ability to do it remotely
17 because they didn't have to travel, they wouldn't then
18 get exposed to Covid, so we're not saying that every
19 remote procedure was a problem, that would be the wrong
20 thing to assert.
21 However, clearly, for people who are -- you know,
22 people with autism who are used to a familiar process,
23 they are used to familiar individuals, they are used to
24 a familiar setting, for that to be moved to something
25 which was sort of two-dimensional, impersonal, was

1 clearly a challenge. And so you can see how, for many
2 people who are used to a physical and got comfort from a
3 physical interaction to be moved to something which is
4 remote, would be challenging.
5 **Q.** With one eye on the future, could remote care be made
6 fully inclusive such that no individuals with the
7 disabilities we have discussed would be unable to access
8 it?
9 **A.** I think it needs to be a mixed position. As I said,
10 I think, you know, we can't deny the march of
11 technology, you know, for reasons of efficiency and
12 appropriateness, you know, certain remote processes we
13 think are a good thing actually, and, as I say, patients
14 welcomed them.
15 I think the thing is to be able to provide the
16 appropriate process for the individual and be able to
17 have that for the individual, and see the individual as
18 an individual who can choose between having a physical,
19 you know, sort of personal experience or being happy to
20 rely on something that's more remote where technology is
21 used.
22 And I think, you know, it's that ability to be
23 able to offer that sort of bespoke service, that bespoke
24 relevant service to each individual patient, I think, is
25 a critical answer to your question as opposed to seeing

1 it as a binary thing as between remote versus physical
2 only.
3 **Q.** Yes, so it may be that there will always need to be a
4 place for face-to-face consultation?
5 **A.** Yes, I think -- you know, as I say, a number of people,
6 people with autism, people who are deaf, who were
7 taking, you know, appropriate comfort and benefit from
8 visual clues which you get much more when you are
9 face-to-face with someone, you know, there are many
10 people who would, for those reasons, want to have a
11 physical interaction, and would see an in-person or
12 remote interaction as being very much of second best and
13 potentially quite worrying and quite challenging.
14 So, yes, I mean, I think we absolutely need to
15 make sure that physical approach is still part of our
16 Health Service provision, yes.
17 **Q.** The move to remote care came alongside a reduction in
18 routine medical appointments?
19 **A.** Yes.
20 **Q.** Can you help us, please, how were disabled people
21 particularly affected by this?
22 **A.** Well, I think, you know, there was the -- you know,
23 I think, first of all, disabled people, you know, found
24 it much more difficult to navigate society in Covid, you
25 know, if you are blind and you are going out in society,

1 you can't be guided because of social distancing rules,
2 you are worried about social distancing, you don't
3 necessarily have the technology to rely on to move to a
4 remote process. You know, people were very anxious
5 about going out, and provision, you know, was
6 restricted. So we've seen, across all our
7 beneficiaries, you know a massive fall-off in the number
8 of people who were actively taking on -- or undergoing
9 their routine health appointments, partly because they
10 didn't feel confident to go out and do it, and partly
11 because the Health Service was not able offer those.
12 If I maybe just put some stats to that just to
13 make the point.
14 From an eye health perspective, we saw a 23%
15 reduction in eye tests from 2020 to 2019, there was a
16 28% drop off in referrals to ophthalmology, there was an
17 up to 40% reduction in ophthalmology outpatients, and
18 there was 235,000 necessary eye surgeries were missed or
19 delayed in 2020. So you can see that people did not
20 feel confident to go at and engage with a health
21 appointment, and actually the provision of that was
22 reduced as well.
23 The RNID, you know, surveyed 384 respondents since
24 September 2020, and people who were deaf or had some
25 sort hearing loss, 60% were put off seeking medical

1 advice, and ONS put a report out in September 2020,
2 talking to 47% of people with hearing impairment had
3 access to healthcare impacted.
4 So I think it was a sort of a bit of a pincer
5 movement here, really, that the provision of non-Covid
6 health declined, reduced, and people's confidence to go
7 and engage with it also reduced.
8 **LADY HALLETT:** Could you slow down a little.
9 **A.** Yes. No problem.
10 **MR MILLS:** Can I move next, please, to the concerns about
11 the use of DNACPR notices. Is it fair to set out, in
12 headline terms, the DCC's concerns as being threefold?
13 First, that DNACPR notices were being issued in
14 a blanket fashion to fit and healthy disabled people of
15 working age; second, often without consultation with
16 either the patient or, if the patient lacked capacity,
17 their family; and, third, that there were instances of
18 DNACPR notices being confused with do not treat notices.
19 **A.** I mean, the answer is yes to all those three questions,
20 let me try and embellish. I think, first of all -- and
21 Mencap have spoken very well to this in their "My Health
22 My Life" report from December 2020 -- I think there was
23 some confused guidance, so NICE issued guidance on
24 20 March, and then there was a two-week period where
25 there was a lot of input into that because we felt that

1 guidance sort of encouraged or opened the door to that
2 slightly more blanket approach. And that was sort of
3 rowed back on 3 April, so about two weeks later. But we
4 felt that, you know, the sort of cat was out of the bag,
5 in essence, or the horse had bolted over those two weeks
6 with that guidance sort of permeating into the Health
7 Service, and people then you know taking that
8 encouragement to maybe use DNACPR notices in a slightly
9 more, sort of, to use your word, blanket fashion. And
10 we've seen evidence of that from, you know, our
11 membership, in essence.
12 There was evidence from Mencap of a GP applying
13 blanket notices to the people then under the care of
14 that Mencap institution, and we've seen individuals go
15 through hospital when their family and carers were not
16 aware that a DNACPR had been applied to that individual.
17 So, you know, we can see that everything you've
18 said in your question, you know, was evident through
19 that period and, as I say, not necessarily helped by the
20 guidance that went out on the 20th which, whilst it was
21 rescinded on 3 April, still left two weeks whereby some
22 unfortunate guidance did permeate the Health Service.
23 **Q.** Let's have a look at the letter of 3 April. Please can
24 we have on screen INQ000216427. Thank you.
25 First paragraph:

1 "We are writing to ensure that there is clarity in
2 relation to the use of the Clinical Frailty Scale ...
3 and the use of ... (DNACPR) with younger patients, those
4 with a stable long term physical need, learning
5 disability or autism."
6 Pausing there, Mr Stringer only to signpost that
7 the use of the Clinical Frailty Scale will be addressed
8 in detail with other witnesses in due course.
9 Turning to page 2, please, we have in the final
10 paragraph:
11 "It is imperative that decisions regarding
12 appropriateness of admission to hospital and for
13 assessment and treatment for people with learning
14 disabilities and/or autism are made on an individual
15 basis and in consultation with their family and/or paid
16 carers, taking into account the person's usual physical
17 health, the severity of any co-existing conditions and
18 their frailty at the time of examination. Treatment
19 decisions should not be made on the basis of the
20 presence of learning disability and/or autism alone."
21 I think you'd said -- you'd used the phrase the
22 cat was already out of the bag. Can you help us: in
23 your view, why did this letter not adequately address
24 the concerns that were surrounding the use of DNACPR
25 notices at that time?

1 A. Well, I think there was a simple point that, you know,
2 advice having been promulgated two weeks before, it was
3 very difficult to sort of get the genie back in the
4 bottle two weeks later, whatever that advice had been.
5 So that had obviously permeated through the Health
6 Service, and it was very difficult to think you could
7 completely rescind that advice and replace it. I think
8 that's a simple point.
9 I think, again, these are complex things, DNACPRs,
10 and I think there is a complexity to this which I think
11 is the underlying problem here where, you know,
12 everything that's subsequent sort of reviews showed, you
13 know, were evident here. I think you have problems
14 with, you know, Health Service under complete strain in
15 2020, having to think, as I said earlier, about
16 individual people as individuals with a disability that
17 needed to be thought about on an individual basis, with
18 enough time to consider all the underlying issues
19 pertaining to that individual with enough training,
20 enough time on the Health Service workers to be able to
21 provide that service, and enough sort of leadership and
22 management to make this a priority.
23 I think all those things, you know, were difficult
24 through a time of incredible strain in the Health
25 Service. So, you know, I think the advice in March, you

1 know, rather sort of allowed people to take slightly
2 more of a blanket approach, and even though this advice
3 two weeks later was trying to sort of rescind that, and
4 be a bit more thoughtful, as this paragraph shows, to
5 encourage people to be more thoughtful in their
6 approach, I still think it was asking a lot of the
7 system at the time to be able to do that.
8 Q. Almost a year later in March 2021, the Care Quality
9 Commission published a review of DNACPR decisions based
10 on work conducted between November 2020 and
11 January 2021. Please can we have on screen INQ00016428.
12 At page 2, please, starting on the penultimate
13 paragraph, we read:
14 "People's experiences of DNACPR decisions [were]
15 varied. We heard that some people felt they had been
16 involved in the decision-making process, as part of a
17 holistic conversation about their care. However, others
18 felt that conversations around whether they would want
19 to receive CPR came out of the blue and that they were
20 not given the time or information to fully understand
21 what was happening or even what a DNACPR was. In some
22 cases, people were not always aware that a DNACPR
23 decision was in place. This could be hugely distressing
24 for people and their families and/or carers."
25 Just moving to the next paragraph before I ask you

1 about this:
2 "It is concerning that some people across a range
3 of equality groups, including older people, people with
4 dementia and people with a learning disability, told us
5 that they were not supported to the extent they needed
6 to be in advance care planning conversations, or given
7 the information they needed in an accessible way."
8 Given the dialogue that had taken place between,
9 as you say, the National Autistic Society which led to
10 the April 2020 letter coming out, how concerned are you
11 by the conclusions of this report in March 2021?
12 A. Yes, I think it shows, you know, almost a year after the
13 correspondence from March and April 2020, that there
14 were still challenges in the system, there were still
15 challenges, I think, in terms of people, you know,
16 working in the frontline of the Health Service having
17 enough training, having enough awareness of disabled
18 people to be able to apply a correct approach. I think
19 struggles with time, there were still issues of having
20 access to families and carers to get that rounded view
21 about an individual and there was, we would surmise,
22 still some challenges in terms of the consistent
23 application of the policy and process from the centre,
24 even after the updated letters of April 2020.
25 Q. In your view, should there be a systematic review of the

1 DNACPR notices that were issued during the pandemic?
2 A. I think as part of the point I made earlier about
3 understanding the data better than we do now, I think
4 that would be a useful thing for us to investigate.
5 There is a concern, even now, that we still think
6 there's a lingering problem with DNACPR still being
7 attached to people's records even in a sort of non --
8 you know, in a world where we're not the -- in the sort
9 of intense period of the pandemic. So I think some work
10 to understand that, yes, would be a good thing but
11 I think it also needs to look at what is happening now
12 as much as what is happening three or four years ago.
13 Q. Thinking about what's happening now and also looking to
14 the future what changes would the DCC like to see in the
15 way that DNACPR decisions are made?
16 A. Well, I think the report that we're now looking at from
17 March 2021 has got some actually very good conclusion's
18 actually, so we think -- we can see that properly
19 implemented, you know, both in terms of the
20 understanding of the individual, you know, if some
21 rounded decision can be taken with the right input from
22 family, carers, and any other, you know, bodies
23 involved, to make sure all the information and all the
24 concerns are properly addressed, and the appropriate
25 training for people in the Health Service working in

1 this space, you know, to make sure they're aware of
2 their responsibilities, but also to understand, as
3 I say, that they need to take into consideration all
4 those factors I've mentioned.
5 So I mean we think the findings were actually
6 pretty good. It's a question of getting those properly
7 still fully implemented we would still advocate for.
8 **Q.** Next please, shielding. At your paragraph 58, you
9 observe that many disabled people were not identified as
10 being clinically extremely vulnerable. Can you help us
11 with the effect that this had on those people?
12 **A.** Well, I think it obviously made people more open to
13 harm, more open to problems, because they weren't
14 assessed as being clinically vulnerable or clinically
15 extremely vulnerable. I think we would feel that there
16 was quite a sort of clinical lens applied to this
17 consideration at the time, and what wasn't, you know,
18 maybe brought into play early enough was a more rounded
19 view of individuals to look at things that went purely
20 beyond the clinical and looked a bit more at
21 socio-economic, looked at the domestic circumstances and
22 was able to create a fuller picture of an individual to
23 work out, you know, whether or not they should be
24 thought of as clinically vulnerable or clinically
25 extremely vulnerable, and as we saw people with Down's

1 syndrome were added to that list in autumn 2020 because
2 through the first few months of Covid, there had been an
3 assessment of what I have just said, that there was a
4 more rounded view to be taken about people with Down's
5 syndrome, the data showed they had greater
6 vulnerability, and they were added to the list.
7 There were still challenges then on how that was
8 applied to those individuals with Down's syndrome but
9 the point being that I think people realised, maybe six
10 months into Covid, that actually a more rounded view
11 needed to be taken, in consideration of who would be
12 clinically vulnerable or clinically extremely
13 vulnerable.
14 **Q.** How could that rounded view have been taken into account
15 from the very outset?
16 **A.** Well, you know, as I said, I think in a few of my
17 answers today, I think, you know, there was a clinical
18 lens applied to Covid. People -- disabled people,
19 I think, were seen as a sort of collective. There
20 wasn't enough understanding of the nuance we've seen
21 different types of disability and different potential
22 requirements. In my initial answer about the 16 million
23 disabled people in the UK, I broke down, you know, some
24 of the core groups within that, and then gave a sense
25 that there are people with very different requirements

1 and very different conditions and different aspects.
2 So, you know, I think there should have been more
3 thought, even at that quite high level, of disability,
4 to some of the challenges that those people would
5 experience societally in getting through Covid, and that
6 extra consideration added to the slightly more limited
7 clinical consideration.
8 **Q.** More thought and perhaps early engagement with
9 organisations like the one you represent?
10 **A.** Yes, that sounds a little self-serving if I say yes to
11 that, but I think, you know, more insight and more
12 information that comes from the beneficiaries comes from
13 the lived experience is critical. And I think, you
14 know, whilst we did have good engagement at different
15 times on different topics, I think, you know, our sense
16 would be that we were always slightly playing catch up
17 on whichever aspect of Covid we were engaged with, and
18 the problem was that the preparation hadn't been done
19 with that engagement sort of upfront so that we were
20 better prepared. And I think it was evident in your
21 question on people who were clinically vulnerable or
22 clinically extremely vulnerable.
23 **Q.** For those that did receive a shielding letter, were
24 those letters always sent in a format they could read?
25 **A.** No, not always. I mean, we're going to come on to the

1 broader points about communication. I think one of the
2 challenges that we had from the very start was making
3 sure communication to disabled people was in the
4 accessible format that they could absorb, and clearly it
5 wasn't. So whether that was a shielding letter or any
6 other form of communication, it was a very patchy
7 process, and a very patchy, you know, sort of -- it
8 didn't work very well for disabled people, the
9 communication processes, because accessible
10 communication was not a thread that ran through our
11 response to Covid.
12 **Q.** Yes. Just thinking for a moment about someone who
13 receives a shielding letter that they are not able to
14 read: what is the practical impact on that person? That
15 they wouldn't know that they had to shield?
16 **A.** Yes, that's right. I mean, if you can just use the
17 example of someone who is visually impaired, first of
18 all, the letter lies on your door, first of all, how do
19 you know what the letter is? How can you tell from the
20 envelope what's in it? You can't actually read it if
21 it's not in an accessible format and you rely on someone
22 else, a neighbour or another family member; often that
23 might be difficult if you're living on your own, you
24 might be able to do that late in the day but, as I say,
25 the fundamental problem first is you might not even know

1 that letter's arrived in the first place and, therefore,
2 if you don't know or you are late in being able to
3 access the information clearly, it puts yourself at risk
4 if you are being asked to shield, for example.
5 **Q.** Moving on to communication issues more broadly then, how
6 would you characterise the accessibility of public
7 health information about Covid-19 for disabled people?
8 **A.** We think it was a real challenge through all of Covid,
9 honestly. We think it started in a difficult way, and
10 whilst there was some improvements, it didn't get to a
11 point whereby, you know, systematically information was
12 accessible for disabled people in the UK, if I could
13 just maybe give some examples.
14 So we've talked about critical letters around
15 shielding that should have been available for people in
16 their preferred format, whether that's large font,
17 whether that's Braille, and we never really achieved
18 that through Covid. There was some representation with
19 the Cabinet Office and the Department of Health and
20 Social Security, and there were times we were able to,
21 for example, put the RNIB in there as a helpline so they
22 knew they could contact us, and we could do that, but
23 frankly, putting the RNIB into a letter that is in an
24 inaccessible format is far from a satisfactory answer.
25 Then you have other challenges. So for people who

1 are deaf, the RNID were very keen to try and get, you
2 know, British Sign Language interpreters involved in all
3 government and other important communications, and from
4 a UK Government perspective, that never happened in
5 a systematic way. When BBC News and sort of BBC1 came
6 together, it was achieved, but often the 5 o'clock daily
7 press conference was conducted without any sign language
8 interpretation. And it can be done; it was done in
9 Wales, it was done in Scotland by the First Ministers
10 who did have sign language interpreters routinely there
11 is, for their daily press conferences in the devolved
12 nations.
13 **Q.** So despite engagement by disability charities with the
14 government, the problems persisted throughout the
15 pandemic?
16 **A.** Yes. As I say, we started I think with quite a low
17 base. There was engagement. Again, we were engaging in
18 March I think individually with people like the Cabinet
19 Office. I certainly did that from an RNIB perspective.
20 We came together in April and the letter we send to the
21 Prime Minister and response from the minister for
22 disabled people, Justin Tomlinson, in May talked about
23 setting up a sort of comms group which happened but if
24 you look across all the different media of communication
25 through the pandemic, so there were the daily press

1 conferences, we talked about letters, there were
2 government apps, there was social media activity, it was
3 patchy about how those sort of evolved and were fully
4 accessible over time, made some good progress on things
5 like government websites where they were fully
6 accessible, but things like some of the social media
7 activity, government press conferences, you know, letter
8 communication, never really got to a point whereby it
9 was fully accessible in a sort of foolproof way. That
10 just didn't happen.
11 **Q.** In your view were these issues reflective of
12 long-standing pervasive problems around the
13 accessibility of public information for disabled people?
14 **A.** Yes. I mean, if you go back, I mean, one of the things
15 that we would really recommend would be the
16 implementation of the Accessible Information Standards
17 which has been mandated from 2016, which basically says
18 that, you know, information around health -- people's
19 engagement with the Health Service should be done in an
20 accessible format for that individual.
21 That is ready to go. It's an oven-ready thing.
22 We have been campaigning on it even recently because
23 it's not in place and if that had been in place before
24 the pandemic it would have made life so much easier for
25 disabled people to have the confidence that they were

1 going to get their communication in an accessible
2 format.
3 **Q.** Mr Stringer, your statement concludes with this
4 observation:
5 "The DCC is concerned that disabled people were
6 treated as an afterthought during the pandemic."
7 To ensure this does not happen again, what lessons
8 or recommendations do you wish this afternoon to share
9 with the Inquiry?
10 **A.** Yes, I think, I would say, three things. I think a
11 point, a thread through all my answers has been the need
12 to see disabled people as individuals and not as a
13 collective and not as some second-class collective and
14 I think too often through Covid, whether we were talking
15 about communications, whether we were talking about
16 application of DNACPRs, whether we've been talking
17 about, sort of, access to health and guidance to the NHS
18 on how to support disabled people through, sort of,
19 routine health, sort of, visits, you know, all too often
20 we can see that there was a sort of blanket approach,
21 there was an unthinking approach and we were playing
22 catch-up throughout that.
23 So I think, you know, we need to think about
24 disabled people as individuals and be able to put in
25 place solutions which much more support them as

1 individuals. There was a real gap that we saw
2 exacerbated in Covid.
3 The second point is a point I would like to make
4 about data. I think one of the challenges we have is
5 data flows, which is a real panacea to try and fix, but
6 I think one of the problems we saw was that we didn't
7 know where to go to for data, we didn't know which was
8 the primary data. So if we're looking at, you know,
9 understanding who should be, for example, you know,
10 classed as clinically vulnerable, or clinically
11 extremely vulnerable, you know, we had GPs with
12 information, we had local authorities with information
13 on registers, you know, we had the DWP with information
14 from a welfare perspective. I think one of the problems
15 was we did not have single version of the truth or a
16 primary source of data to use that we could have then
17 everybody rode in behind and used that data as something
18 that then drove, you know, a common policy and a policy
19 we all understood, you know, what we were doing with it.
20 And I think whilst those data pools aren't perfect
21 I think we were using different sources of data which
22 was inconsistent and incomplete through Covid.
23 The final think I would say is what I just said a
24 few minutes ago. We could implement the Accessible
25 Information Standard. That exists. That is not

1 something that has to be created and would go a long way
2 to providing disabled people with communication in
3 a format they could understand and I think what -- I
4 think it's trying to get across, as I think we saw from
5 beneficiaries, was a real sense of despair and feeling
6 very forlorn and abandoned through this process because
7 you weren't getting the communication in a format you
8 could access and therefore you weren't getting critical
9 information on time to do something with and I think,
10 you know, that was a real problem for disabled people
11 through Covid and it then exacerbated other issues
12 because then you didn't access things, and you didn't do
13 things on time.
14 So we could implement the Accessible Information
15 Standard which has been ready to go since 2016 that
16 would be a real boon for disabled people in the UK.
17 **Q.** A proposal that you offer in your statement is to
18 introduce a mechanism within the policy making process
19 for new policies to be sense checked with disabled
20 people or, indeed, the organisations representing them.
21 Can you give us a sense of how you envisage a process
22 like that operating?
23 **A.** I think the Disability Charity Consortium, you know, are
24 the -- it's the biggest group, it's the best group, it
25 brings the insight we can bring from those millions of

1 people that we support and I think, you know, the DCC
2 engaging appropriately with national institutions,
3 government, Health Service, all of which we do to a
4 degree. You know, we have regular ministerial meetings,
5 we meant Stephen Timms recently.
6 If we go back through the previous administration,
7 regular meetings on national disability strategy with
8 previous Conservative ministers.
9 So the channels are there. I think it is putting
10 in place a more considered process about what those
11 channels are doing and to make sure that we're
12 addressing some of the critical things in time, not
13 using those channels as we did in Covid to sort of play
14 catch-up on events where we were already too late,
15 actually, to address some of these problems that had
16 already started through Covid.
17 So I think the DCC group is very a valid reference
18 point, and those contacts are there. It's just a
19 question of codifying and using those on the right
20 things, I think.
21 **MR MILLS:** Mr Stringer, thank you.
22 My Lady, that's all I ask.
23 **LADY HALLETT:** Mr Weatherby.
24 **Questions from MR WEATHERBY KC**
25 **MR WEATHERBY:** Mr Stringer, I ask questions on behalf of

1 Covid Bereaved Families for Justice UK, just a few
2 questions from me, and back to the access and treatment
3 of those with learning disabilities within the
4 healthcare sector with some questions about the
5 importance of specialist nursing.
6 I want to concentrate around a report of one of
7 your member organisations, Mencap, which I think you
8 have had an opportunity to look at. So in terms of
9 providing the Inquiry some evidence here, can I take you
10 straight to that. Perhaps we could have it up on the
11 screen and if we could start with the front page of it,
12 it's INQ000176404.
13 Whilst it is being brought up, this is a Mencap
14 report which I think you referred to earlier --
15 **A.** Yes.
16 **Q.** -- and it's entitled "Barriers to healthcare for people
17 with a learning disability during the pandemic".
18 If we could jump to page 21, please, again this is
19 the page, the heading, for the relevant section that
20 I want to take you to, "Care for people with a learning
21 disability in hospital". Then the next page, please,
22 and the top part of that page.
23 So what the report is looking at is reasonable
24 adjustments are vital to accessing healthcare for people
25 with a disability. These can be relatively simple

1 things, as you have already adverted to, such as waiting
2 in a quiet area or being accompanied by a supporter on
3 an overnight stay, or quite complex adjustments
4 requiring whole teams to work together and do something
5 very differently. And sometimes these adjustments need
6 specialist input.
7 So there's quite a big picture here. Then it goes
8 on to talk about the legal requirements and the fact
9 that they weren't affected by the Coronavirus Act and
10 then this, third paragraph:
11 "It is known that a lack of adjustments to care
12 even in 'normal' times can have fatal consequences for
13 people with a learning disability."
14 So as a starting point that grounds us, doesn't
15 it, in the absolute imperative for proper access and
16 services to be provided for those with learning
17 disabilities in the healthcare sectors; is that a fair
18 way of putting it?
19 **A.** That's fair, yes.
20 **Q.** Yes. Then, at the bottom of that page, please, the last
21 two paragraphs, this is where Mencap has surveyed
22 healthcare professionals and nurses in particular. I'll
23 just read those two paragraphs:
24 "Many nurses surveyed by Mencap were critical of
25 the care that is being given to people with a learning

1 disability during the COVID-19 pandemic, with one
2 participant remarking, 'Unfortunately the support I have
3 witnessed in hospitals falls very short of even basic
4 nursing care.'.
5 Only 1 in 5 [learning disability] nurses surveyed
6 said they had always seen reasonable adjustments made
7 for people with a learning disability."
8 Those are stark survey findings, aren't they?
9 **A.** I mean, yes, they are, and I think Mencap have done a
10 very thorough job with this report. It's from
11 December 2020, so it takes, I think, some very real and
12 very raw feedback from the people surveyed, and as you
13 have just highlighted in this extract from the nurses
14 who were providing that care --
15 **Q.** Yes.
16 **A.** -- so I think it's a very relevant, raw, genuine
17 perspective, yes.
18 **Q.** Raw, genuine, and very much from the people who would be
19 most knowing about it.
20 **A.** Yes.
21 **Q.** Of course it's correct, isn't it, that learning
22 disability nurses, specialist nurses, play an absolutely
23 vital role in ensuring that access and reasonable
24 adjustments are put in place in a hospital setting for
25 people with learning disabilities?

1 **A.** Yes, that is right.
2 **Q.** If we could then go to the bottom of the next page,
3 please, the final paragraph on page 23:
4 "Covid-19 has created extra risk that people may
5 need to attend hospital unaccompanied, and infection
6 control measures may have made it more likely that items
7 such as hospital passports and other important
8 communication aids are lost. This will have created
9 extra barriers to people's support needs even being
10 flagged to hospital staff in the first place."
11 Sorry, I stumbled over those words, but that
12 really starkly again sets out the entry point of the
13 problems for learning disabled patients during the
14 pandemic, doesn't it?
15 **A.** Yes, I think Mencap I think in the report and separately
16 have got some very compelling evidence from individuals
17 and beneficiaries who went through a process whereby
18 they were on their own, unaccompanied, as this paragraph
19 says, but didn't have those items with them, hospital
20 passports and that sense of the individual, you know,
21 which was sort of lost and then moving through the
22 process on their own and therefore decisions were taken
23 about their care which ultimately did involve, for some
24 individuals, DNACPR decisions which were done very much
25 in a two-dimensional way without that rounded view being

1 taken.
2 **Q.** So the problem started from the outset?
3 **A.** Yes.
4 **Q.** The lack of recognition of identifying needs?
5 **A.** Yes.
6 **Q.** And then after that the provision of specialist nurses,
7 of course the capacity issues in the healthcare setting
8 and the pandemic itself put enormous strain on staffing
9 and that meant that many learning disability nurses were
10 redeployed, sometimes leaving no specialist service at
11 all for learning disabled patients; is that right?
12 **A.** Yes, that's right. I think it comes out in the report
13 that there are examples. I think we've seen, you know,
14 pressures on the Health Service clearly probably coping
15 with sickness themselves having to move resources
16 around, you know, and make some very tough real-time
17 decisions, totally sympathetic to the challenge.
18 Clearly one of the implications was that people were
19 moved away from, you know, an area of specialty into
20 something else and those people who relied on that area
21 of speciality were then left, you know, slightly
22 abandoned because that care was no longer there.
23 **Q.** Yes. I will come back to slightly abandoned in a
24 moment, if I may, but the last passage of this report,
25 the next page, please, just the top paragraph of it,

1 this is the last reference, page 24:
2 "Many healthcare staff have been also redeployed
3 throughout the NHS and may be working in unfamiliar
4 environments, stressed and exhausted -- making it harder
5 for them to make adjustments to the care they're pricing
6 under such pressures. Among those redeployed were
7 a number of learning disability nurses, meaning that in
8 some trusts, there may have been a lack of specialist
9 support for patients needing adjustments to their care."
10 Then some statistics:
11 "Around 11% of acute learning disability nurses we
12 surveyed said they or a team member had been redeployed;
13 for community based learning disability nurses it was
14 34%. One first commented, 'I was redeployed for four
15 weeks to [another] ward. During this period there was
16 no specialist learning disability service provided
17 across the Trust'."
18 And that's evidence of the seriousness of the
19 redeployment issues, isn't it?
20 **A.** Yes, that's right. As I've just said earlier, we saw
21 people not having access to the sort of learning
22 disability service because redeployment decisions had
23 been taken, yes.
24 **Q.** Looping back to where we started, with the recognition
25 that even in normal times that the lack of provision for

1 people with learning disabilities could be fatal, would
2 you agree that there is a link between the redeployment
3 and the lack of services and what we've looked at in
4 terms of the mortality statistics in terms of people
5 with learning disabilities?
6 **A.** Yes, potentially. I mean, as I said earlier, I think we
7 need to do some more earlier analysis on the mortality
8 stats to really understand what was going on. There
9 might well be to your question a link with the support
10 that disappeared from specialist nurses because they
11 were redeployed. Yes, I mean, I think that's a fair
12 link but, as I say, I think we need to do some more
13 analysis of the data to really be able to prove that
14 empirically.
15 **Q.** Yes and, of course, the Inquiry has heard some direct
16 evidence about this.
17 Finally this: in future pandemic planning,
18 learning disability specialist care should be seen as an
19 integral part of the delivery of essential services,
20 shouldn't it? That was a key missing part here.
21 **A.** Yes, it should be but, again, I just refer back to my
22 earlier answers. I think there's a general gap in
23 thinking about disabled people in the round and in
24 a full way, and clearly consideration as to the learning
25 disability service provided within the Health Service is

1 part of that consideration. So decisions can be taken
2 understanding where that bit slots into the overall
3 improved, you know, analysis of what is required to
4 support disabled people through another pandemic, yes.
5 **Q.** That's very helpful. Thank you very much indeed.
6 **A.** Thank you.
7 **LADY HALLETT:** Thank you, Mr Weatherby.
8 That concludes the questions we have for you,
9 Mr Stringer. Thank you so much indeed for your help and
10 obviously all the work that you and your other
11 organisations do to help people who so desperately need
12 the support you can provide. Thank you very much
13 indeed.
14 **A.** Thank you.
15 **(The witness withdrew)**
16 **LADY HALLETT:** I shall return at 1.40.
17 **(12.40 pm)**
18 **(Luncheon Adjournment)**
19 **(1.40 pm)**
20 **LADY HALLETT:** Yes, Ms Nield.
21 **MS NIELD:** Thank you, my Lady.
22 Could I call Professor Naqvi who will affirm.
23 **PROFESSOR HABIB NAQVI (affirmed)**
24 **Questions from COUNSEL TO THE INQUIRY**
25 **MS NIELD:** Can you give your full name, please.

1 **A.** Professor Habib Naqvi.
2 **Q.** Professor Naqvi, you have given a witness statement to
3 the Inquiry dated 13 October 2023. That's INQ000315604.
4 I think you are familiar with that statement and you
5 have a copy in the front of you; is that right?
6 **A.** That's correct.
7 **Q.** Professor Naqvi, you are the chief executive officer of
8 the Race and Health Observatory; is that correct?
9 **A.** That's correct.
10 **Q.** And you have been so since its inception in April 2021?
11 **A.** That's correct.
12 **Q.** I think previously you worked for NHS England where you
13 directed the development and implementation of national
14 programmes including the Equality Delivery System and
15 the NHS Workforce Race and Equality Standard, and prior
16 to working for NHS England, I think you worked at
17 Department of Health and Social Care where you led on
18 national equality and diversity policy; is that right?
19 **A.** That's correct.
20 **Q.** The Race and Health Observatory I think was established
21 during the Covid pandemic in April 2021 but that wasn't
22 the reason for its creation. What are the purpose and
23 aims of the Observatory, please.
24 **A.** The Observatory's purpose and aims are to identify and
25 tackle ethnic and racial inequalities in health by

1 focussing on some of the deep-seated issues within the
2 healthcare system but also within the social
3 determinants of health as well.
4 **Q.** I think whilst the Observatory works closely with and
5 receives funding from NHS England, it is an independent
6 body; is that right?
7 **A.** Absolutely. It is an independent organisation that can
8 hold up a mirror to the rest of the healthcare system
9 and act as an excuse remover.
10 **Q.** You explain in your witness statement that the work of
11 the Race and Health Observatory is not only focused on
12 patient experiences and outcomes in healthcare but also
13 racism and inequalities experienced by those working in
14 the NHS system. Is that in England or across the UK?
15 **A.** That's predominantly in England, yes.
16 **Q.** And I think the core work of the Race and Health
17 Observatory is its research work and I think that's
18 twofold, both in relation to conducting or funding
19 original research but also a synthesis or review of the
20 existing research and studies; is that right?
21 **A.** That's correct.
22 **Q.** We're going to look today, if we may, at the research
23 work that the Observatory has undertaken in connection
24 to Covid-19 and racial inequalities.
25 Could we begin, please, with the rapid evidence

1 review that was undertaken in March of 2021 in relation
2 to pulse oximetry and racial bias. I think you set out
3 this in your witness statement.
4 Can you help us, first of all, with what is a
5 rapid review?
6 **A.** A rapid review is bringing together the existing
7 evidence base around a particular area. It doesn't
8 specify that a robust examination of the quality of that
9 work is undertaken but it brings together the evidence
10 base that exists at that particular point in time.
11 **Q.** So it's a way of reviewing and bringing together what
12 exists in the research literature at that point in time?
13 **A.** That is correct.
14 **Q.** If we can site this in the context of what was going on
15 during the pandemic at that time, I think it's right
16 that the COVID Oximetry @home programme had been rolled
17 out by NHS England in around November of 2020 and in
18 December of 2020 there was an article published in the
19 British Medical Journal about pulse oximetry and the
20 potential for inaccurate readings in patients with
21 darker skins which itself referenced, I think, an
22 American journal article.
23 Was that the trigger for the rapid review that
24 took place?
25 **A.** Those were the prime triggers in addition to some

1 anecdotal insights that we were getting from some medics
2 around potential inaccuracies in this device.
3 **Q.** I think the rapid review identified a number of
4 international studies going back as far as 1990 which
5 identified the potential for inaccurate or variable
6 readings from pulse oximeters used by non-white
7 patients; is that correct?
8 **A.** That's correct.
9 **Q.** I think it's also right to say that the rapid review
10 identified that there were some studies that found that
11 the degree of pigmentation did not affect accuracy in
12 the studies that they had undertaken, and at page 3,
13 I think, of that rapid evidence review it suggested a
14 possible explanation for inaccuracies related to how
15 those devices had been calibrated or tested. It was
16 suggested that it may have been that the devices had
17 only been tested on white people; is that correct?
18 **A.** That's correct. There's a fundamental point here,
19 though, with regards to representation or lack of
20 representation in clinical trials that then leads on to
21 the development or design of devices, medical devices,
22 including pulse oximetry. Where there is a lack of
23 representation we often get products or devices that may
24 not be suitable for the diverse population that we're
25 here to serve.

1 **Q.** I think it's right to say that the studies that were
2 referenced had largely been undertaken in America or
3 internationally and so this wasn't a review of the
4 devices that were being used in England at that time but
5 I think the report concluded that more research was
6 needed and it would be necessary to review the devices
7 that were being used in the UK.
8 Do you know if the recommendations made in that
9 rapid evidence review were taken forward by the relevant
10 bodies?
11 **A.** Yes, there were very clear recommendations in that
12 review and the ones that were taken forward included
13 further research that was carried out -- a substantial
14 bid was put out by the NIHR with regards to particularly
15 evidence from the UK and an update of the existing
16 guidance around pulse oximeters and their usage on the
17 NHS Choice's website.
18 **Q.** It was also suggested that the MRHA should undertake an
19 urgent review of the pulse oximetry products used in the
20 UK. Do you know whether the MRHA did conduct that
21 review?
22 **A.** I believe an assessment was carried out in addition to
23 the government announcing an independent review into
24 equity with regards to all medical devices generally, as
25 well.

1 Q. Thank you. I think after the Race and Health
2 Observatory had published that rapid review in March
3 2021, the Observatory met with NHS England's health
4 inequalities improvement team to discuss that report.
5 You've been provided with the witness statement of
6 Stephen Powis of NHS England who states that there were
7 some concerns at that point within NHS England that the
8 Race and Health Observatory report might potentially
9 discourage some patients from ethnic minority
10 backgrounds from participating in the COVID Oximetry
11 @home programme and that this could further disadvantage
12 those patients by limiting the tools available to
13 clinicians in monitoring their progress or any
14 deterioration if they had Covid-19.
15 Is that something that was discussed between
16 NHS England and the Race and Health Observatory at that
17 time?
18 A. Yes, it was discussed and at great length. I guess
19 there were also concerns within the Observatory that
20 these devices could put people at risk and the fact that
21 the colour of your skin should not determine your
22 chances of survival, and so where there were issues or
23 doubts around a medical device we thought it was
24 absolutely critical that we highlight those particularly
25 during a pandemic that was affecting the level of oxygen

1 in people's bodies.
2 Q. Mr Powis, in his witness statement -- Professor Powis,
3 I should say, states that subsequent to the publishing
4 of the report, there were ongoing collaborative
5 discussions between the Race and Health Observatory, the
6 MRHA and NHS England. Can I ask you this: were the Race
7 and Health Observatory satisfied with the engagement
8 with NHS England on this issue?
9 A. Yes.
10 Q. Thank you.
11 It's also suggested by Professor Powis that in
12 hindsight it might have been more advantageous for the
13 Race and Health Observatory report to have been shared
14 with NHS England prior to publication so that
15 NHS England could have worked with the Observatory on
16 sensitive and constructive messaging including how to
17 maximise potential benefits as well as minimising the
18 risks.
19 Can you help us, Professor Naqvi, with your views
20 on that bearing in mind also the timing of this review
21 which I appreciate was before the Race and Health
22 Observatory had officially come into being?
23 A. Absolutely. This report was published in March 2021.
24 The Observatory was officially launched in April 2021 so
25 we were doing, as the title suggests, a rapid evidence

1 review which in fact took six weeks for us to pull
2 together. In hindsight, it may have taken longer to
3 arrange a meeting with NHS England to discuss the report
4 but the importance here was to get the information out
5 and to highlight potential inaccuracies in the devices.
6 This wasn't about looking at the reputation of any
7 individual or any individual organisation but about
8 saving, potentially saving lives.
9 Q. In terms of, now that the Race and Health Observatory is
10 well established, if something similar was going to be
11 done in relation to a review of evidence on a topic
12 where NHS England, for example, are currently running a
13 programme, how would that engagement, in terms of
14 engagement prior to publication, how would that take
15 place under your existing processes?
16 A. Sure. So that piece of work around oximetry was carried
17 out during the period where the Observatory was setting
18 up its policies and its processes. The Observatory now
19 has well-established processes by which it engages, you
20 know, in a proactive way with the policy leads in
21 various organisations that are relevant to the subject
22 matter being looked at within any particular report.
23 Q. So, now, that engagement would take place even prior to
24 publication?
25 A. Absolutely.

1 Q. Thank you. Can we move on, please, to look at the next
2 piece of work that the Race and Health Observatory
3 undertook during the pandemic period. That was, again,
4 another rapid review that you set out at paragraph 9c of
5 your witness statement, if that assists you,
6 Professor Naqvi.
7 I think in February 2022, a piece of work which
8 reviewed a number of studies and surveys focused on
9 inequalities in healthcare settings and particularly for
10 healthcare workers during the pandemic. You've
11 summarised the findings of that rapid evidence review in
12 your witness statement. Essentially it identified
13 racial inequalities in a number of aspects: higher rates
14 of Covid-19 infection rates amongst ethnic healthcare
15 workers compared to white healthcare workers, less
16 access to PPE for ethnic minority healthcare workers and
17 less access to properly fitting RPE; higher risk work
18 roles allocated to healthcare workers in terms of frisk
19 of composure to Covid-19 infection; and, worse mental
20 health and well-being, particularly in relation to
21 symptoms of post-traumatic stress disorder found amongst
22 ethnic minority healthcare workers as opposed to white
23 healthcare workers.
24 Can I ask you this. In your view, were these
25 racial inequalities that were identified in the studies

1 synthesised in this rapid review a manifestation of
2 structural or institutional racism in the NHS?
3 A. Well, it would be a combination of structural
4 inequalities, the inequalities and structural racism
5 that we see within society, how that plays out, for
6 example, within the education system or the legal
7 system, or within healthcare, as well as the
8 interpersonal racism that we see on an everyday basis,
9 the trauma, the bullying and harassment, what we call
10 micro and macro aggressions, and how those two interact
11 in terms of institutional racism, how that plays out
12 within policies and processes within organisations,
13 including, of course, our healthcare system.
14 Q. Can you help us with this: what's the difference, if
15 there is one, between institutional racism and
16 structural racism, because you mentioned both of those
17 things in your answer?
18 A. So structural racism is about the, I guess, the
19 structures of society, how they are organised to impact
20 upon individuals or groups of individuals, and that may
21 well be in relation to access to services, and -- or
22 outcomes with regards to, for example, the education
23 system, and institutional racism is more in relation to
24 the everyday policies and processes that are looked at
25 and used on an everyday basis in the NHS, for example.

1 That may well be in relation to recruitment processes or
2 disciplinary processes, et cetera.
3 Q. Thank you. Staying with that rapid review report for
4 now, I think at page 87 of that report there were
5 a number of recommendations made, and I'd like to ask
6 about one in particular, which was in relation to
7 including more information in the national data set such
8 as the NHS Workforce Race and Equality Standard.
9 The recommendation was that all NHS staff in all
10 sectors, including casually employed staff, and those
11 working in subcontracted services, should be represented
12 in those datasets to present a comprehensive and
13 accurate picture of workplace inequalities.
14 Was that recommendation implemented, do you know?
15 A. I believe it was, and in fact I think for the first time
16 this year, NHS England published the Workforce Race and
17 Equality Standard for agency staff working in the NHS.
18 Q. Thank you.
19 Can we move on, please, to the Nuffield elective
20 care report. This was a joint report undertaken by the
21 Observatory together with Nuffield Health in
22 November 2022, and you set this out at page 7 of your
23 witness statement if that assists, Professor, at
24 paragraph 9e.
25 I think this was a study based on statistical

1 analysis of data from the hospital episode statistics,
2 admitted patient care data, and it covered three years
3 from March 2019 to February 2022; is that right?
4 A. That's correct.
5 Q. I think that research looked at the data and statistics
6 to explore variation in treatment rates for routine and
7 hospital care, both before and during the pandemic, and
8 looking at the changes in elective activity overall.
9 And it identified seven particular groups of common
10 hospital procedures, and five main ethnic groups of
11 patients to see whether there was a variation according
12 to ethnicity; is that right?
13 A. That's correct.
14 Q. You summarise that very helpfully in your witness
15 statement. I think it's fair to say that there was
16 considerable variation, both between the ethnic groups
17 and in relation to the different procedures that were
18 considered, but there was a clear picture, I think, that
19 emerged in relation to the Asian ethnic group; is that
20 right?
21 A. That's correct.
22 Q. Can you summarise what that trend or picture was?
23 A. I think the first thing to say is that there were
24 pre-existing inequalities in elective care that kind
25 pre-dated the pandemic, and that's one of the reasons

1 why we need to focus on tackling ethnic inequalities in
2 health on a continuous basis, and not just when we're in
3 an emergency situation as we were during Covid-19.
4 But there's known epidemiology with regards to --
5 and particularly the South Asian group having higher
6 healthcare needs, and cardiac procedures is one example
7 of that which we highlight very clearly within that
8 report. But there were other issues around the
9 healthcare system moving towards remote consultations
10 and digital care, and --
11 Q. Before we move on to the causes of those disparities or
12 the variation between the Asian ethnic group and the
13 white ethnic group, I think the trend that was
14 identified was that across all the different procedures
15 that were looked at, the Asian ethnic group suffered a
16 greater deficit in elective activity compared to any of
17 the other ethnic groups and particularly in relation to
18 the white ethnic group; is that correct?
19 A. That's correct.
20 Q. I think the report noted that if the proportional fall
21 in activity during the pandemic was the same for the
22 Asian group as that fall was for the white group, they
23 would have expected to see just over 17,000 more
24 elective procedures for the Asian group, is that
25 correct?

1 A. That's correct, I believe, yes.
2 Q. I think the report also found that those larger falls in
3 activity for the Asian group occurred irrespective of
4 regional differences in the impact of Covid-19, so
5 infection rates in different geographical areas, and the
6 conclusion was that the falls for that Asian group must
7 have been largely related to changes in demand from that
8 patient group.
9 A. That's correct.
10 Q. And I think the authors then suggested some potential
11 explanations for that. Could you assist us with that,
12 please.
13 A. I think I mentioned the pre-existing backlog and known
14 epidemiology particularly amongst South Asian groups,
15 but the digital exclusion point was highlighted in the
16 report, and potential language barrier with regards to
17 that. Private healthcare access was another point we
18 know, that 41% of Asian households lived in the 10% most
19 deprived areas, and therefore access to private
20 healthcare may not have been an option for those
21 patients.
22 But looking at deprivation only tells you where an
23 inequality exists, but not why it exists, and therefore,
24 focussing on issues around the trust and confidence that
25 communities and patients had with the NHS, and with the

1 healthcare system, is an important point to keep in mind
2 with regards to some of the potential reasons for why
3 there may have been a decrease in elective procedures
4 for that particular group.
5 Q. I think the report also highlighted that it was possible
6 that there may have been concerns about increased
7 exposure to Covid-19 for the Asian group leading to
8 greater concern about coronavirus risk, and so choosing
9 not to go ahead with elective procedures was a possible
10 explanation; is that right?
11 A. That's correct.
12 Q. I think that report also highlighted some limitations in
13 the statistical analysis that could be carried out
14 because of the quality of ethnicity coding in hospital
15 datasets, and I think you have identified that there are
16 three principal issues or problems with ethnicity
17 coding. Could you help us with those please, Professor?
18 A. Poor ethnicity data recording in the NHS is
19 long-standing challenge. The healthcare system has, and
20 in fact the patchy data meant than the NHS was perhaps
21 flying blind in its attempts to meet its moral and legal
22 obligations. There are issues around the collection of
23 data, ensuring that patients and the community know
24 exactly why data is being collected in the first place,
25 to build that level of trust and confidence. Secondly

1 around the quality of the data itself. So ascribing
2 people to broad labels isn't helpful, particularly as we
3 can see in the -- with regards to Covid-19 and the
4 pandemic, it was having a differential impact upon
5 differential groupings --
6 Q. So the ethnicity coding is currently too broad, there's
7 a lack of granularity?
8 A. Absolutely.
9 Q. So, for example, is there currently an ethnicity coding
10 for Filipino ethnicity?
11 A. The codings that are generally used relate back to the
12 census categories, and very often are not the most
13 current census categories. So there wouldn't be in that
14 instance, no.
15 Q. I think there are five broad ethnicity groupings, is
16 that correct?
17 A. I think there's more than five at the moment in terms of
18 the census.
19 Q. Thank you. Following on from that, one of the
20 recommended actions from the Nuffield report was an
21 urgent need to improve ethnicity coding to enable these
22 kind of analyses, and it was identified that the
23 healthcare quality improvement partnership should take a
24 lead on implementation of that recommendation. Do you
25 know whether that has been done?

1 A. I wouldn't know the answer to that, but what I do know
2 is that there is a national drive, including within the
3 Race and Health Observatory, to focus on improving
4 ethnicity data recording going forward.
5 Q. I'd like to ask now about the ongoing work of the
6 Observatory related to Covid-19. I understand that the
7 Race and Health Observatory have funded an ongoing
8 longitudinal cohort study into the impact of Long Covid
9 on black, Asian, and minority ethnic healthcare workers.
10 That's called the REACH-OUT study; is that correct?
11 A. That's correct.
12 Q. I think no findings have been released yet; when is the
13 final report expected?
14 A. Early 2025 will be kind of the publication time frame
15 for the final study.
16 Q. And also, as part of your ongoing work, I think the
17 Observatory have initiated a piece of work exploring the
18 role of trust in interactions in primary care, and you
19 set out that helpfully at paragraph 9f of your report.
20 What's the nature of that work? Is it a study or a
21 survey, or?
22 A. It's a survey that was first distributed in
23 January 2022, and responses were collected in
24 April 2022. It's a survey of the public with regards to
25 their views around accessing primary care and the levels

1 of trust and confidence that they have with primary
2 care.
3 Q. So is analysis undergoing at moment in relation to that?
4 A. The analysis has taken place. We're just finalising the
5 report which we hope can be published in the coming
6 months.
7 Q. Thank you. You have set out in your witness statement
8 at paragraphs 10 to 18 some observations on the context
9 of the unequal impacts of the pandemic, and that context
10 being the pre-existing inequalities caused by structural
11 racism.
12 I would like to ask you, if I may, about the
13 example you give in paragraphs 13 and 14 of the
14 different ways of analysing data, for example, the ONS
15 data on mortality rates by ethnic group.
16 You explain that when the Office of National
17 Statistics published those statistics on Covid mortality
18 rates, the data was present with the rates adjusted for
19 location, measures of disadvantage, occupation, living
20 arrangements, and pre-existing health conditions. And
21 the conclusion of the ONS was that this accounted for a
22 large proportion -- not all, but a large proportion of
23 the excess Covid-19 mortality risk in most ethnic
24 minority groups.
25 Can you help us, please, with the view of the Race

1 and Health Observatory on this statistical analysis and
2 is the adjusting of the mortality rates, and what's the
3 impact of carrying out that adjustment?
4 A. Sure. I think there's a fundamental point around this,
5 which is that those reasons highlight the causes of the
6 inequalities but not the causes of the causes of the
7 inequalities. What I mean by that is that at that time
8 we were informed of the reasons, as you have
9 highlighted, being multigenerational households,
10 comorbidities, ethnic minority people more likely to
11 work on the frontline, including within the NHS. But
12 what we weren't informed of was why that's the case, why
13 is it that ethnic minority staff are more likely to find
14 themselves on the frontline and less likely to find
15 themselves in managerial positions or being able to
16 progress within their field to that level?
17 Why is it that they are more likely to live in
18 multigenerational households and less likely to live in
19 open space, green-space environments?
20 So focussing on some of the deep-seated issues
21 around, for example, the ethnicity pay gap that occurs
22 within society across institutions and organisations is
23 absolutely critical. So if we are to focus on
24 surface-level solutions to these deep-seated issues we
25 will be having these conversations again in five years

1 to ten years' time and not be on the front foot in terms
2 of tackling these pandemics and these challenges in the
3 future.
4 Going back to your point around the ONS, I think
5 it is important to note that those are experimental
6 data, perhaps not as robust as data that's gone through
7 a rigorous process, but also you can cut and analyse
8 data in any way to tell any particular story. It's
9 about having your moral compass pointing in the right
10 direction so that you can really kind of focus on the
11 issues at hand.
12 Q. What you have said in your witness statement at
13 paragraph 14 is that -- talking about the way that the
14 ONS data had been adjusted for those additional factors,
15 that:
16 "These statistical analyses, while useful, had the
17 effect of moving the conversation on disparity away from
18 conversations about the impacts of structural racism.
19 It meant the government's policy interventions at the
20 time focussed on the effects of structural racism (such
21 as occupation and living conditions) without ever
22 engaging with the causes of these inequalities,
23 including racism itself."
24 A. Absolutely. I mean, racism has an impact on the effects
25 that we then see play out in terms of, for example in

1 relation to the healthcare system, access and experience
2 and outcomes, but racism also plays an impact on the
3 social determinants of health as well, and that's
4 housing, and that's education, et cetera. So we must
5 focus on the causes of the causes if we are to have
6 permanent solutions to these challenges.
7 Q. Moving on, if we may, to the lessons learned which you
8 have identified in your witness statement, you identify
9 as a key lesson the need to view inequalities or
10 disparities evident in the pandemic in the context of
11 structural racism.
12 Do you have any recommendations for addressing
13 structural racism within healthcare settings
14 particularly to improve outcomes for ethnic minority
15 healthcare workers?
16 A. Well, we heard so vividly during the pandemic from
17 leaders, from government, from the NHS, pledges and
18 commitments and promises to tackle ethnic and racial
19 inequalities. Now, these were pre-existing inequalities
20 for patients, communities and the NHS workforce. But
21 justice cannot be a fairweather commitment. We must
22 focus on this issue on a continuous basis and that means
23 focussing on building and rebuilding levels of trust
24 with our staff, our NHS staff, with communities and with
25 patients, and trust is about truth told consistently

1 over time and when there's a breakdown in any part of
2 that algorithm there's a breakdown in trust and there's
3 a breakdown in levels of confidence that patients and
4 communities and staff have.
5 So building and rebuilding that level of trust is
6 absolutely important and that's about telling the truth
7 about past failings, telling the truth about the reality
8 of the causes of the causes of the inequalities, is
9 about consistency of action to tackle those causes of
10 the causes, and it is about time and engagement that
11 requires time, but engagement that is sustained and
12 meaningful over time and not piecemeal as has been the
13 case, I guess, in the past.
14 That's why having organisations that can hold up a
15 mirror to the rest of the system, such the Race and
16 Health Observatory, to highlight issues as that exist is
17 absolutely critical as we move forward.
18 Of course, you know, the NHS wasn't built to
19 reflect inequality; it was built to remedy inequality
20 and that should be our aim and focus as we move forward.
21 **Q.** Can I circle back, please, to the point you made about
22 trust or lack of trust both from ethnic minority
23 healthcare workers and also the wider, in the
24 communities, ethnic minority communities. You have
25 highlighted in your witness statement a number of issues

1 which emerged which made it quite clear during the
2 pandemic that there was this lack of trust between those
3 communities and public organisations, public bodies, and
4 the healthcare system as well.
5 You used the example of vaccine hesitancy and some
6 of the concerns around that.
7 Does that sort of -- that level of mistrust,
8 particularly in relation to the healthcare system appear
9 to have increased during the pandemic, in your view, and
10 if it has, what are the reasons for that?
11 **A.** Absolutely. I believe it did increase to a level which
12 was reflected in the uptake rates of the vaccine,
13 particularly amongst ethnic minority communities.
14 I remember having my first vaccine within the Malcolm X
15 Centre in the heart of St Pauls in Bristol,
16 predominantly a multi-ethnic community, and it was the
17 community leader stood at the gate of that community
18 centre inviting people in. It was a trusted personal in
19 a trusted place. It's about creating environments where
20 people feel safe, people feel as though they have a
21 level of engagement and trust with not just people but
22 places and therefore having vaccination hubs within
23 community centres, within places of worship was
24 absolutely critical, and utilising community leaders,
25 community pharmacists, faith leaders, to pass on the

1 message. The message is important but so is the
2 messenger and having diversity in both was critical to
3 build levels of trust during the pandemic.
4 **Q.** Thank you for that example.
5 Have you observed, Professor Naqvi, any successful
6 initiatives or policies within healthcare settings that
7 have made progress in reducing structural racism or the
8 impacts of structural racism?
9 **A.** On patients or ...
10 **Q.** Either patients or healthcare workers?
11 **A.** Well, there's a number of initiatives that have stemmed
12 out since the core period of the pandemic and those
13 include engagement with communities and the
14 understanding that actually that engagement needs to be
15 sustained and it needs to be meaningful as opposed to
16 being focussed on any particular project. So engagement
17 with communities.
18 But there's a lot more that needs to be done:
19 investment in local public health, investment in local
20 communities and building that level of trust, investment
21 in making sure that we have the adequate environments in
22 our workplaces within the NHS or our ethnic minority
23 staff with regards to their experiences within the
24 workplace, reducing the bullying and harassment that we
25 see and the gaps that we see between black, minority

1 ethnic, and white staff, increasing the progress that we
2 need with regards to opportunities for progression
3 within the workplace.
4 We need to focus on the long-standing ethnicity
5 pay gap review particularly so within the NHS as well.
6 **Q.** Those measures or recommendations obviously apply
7 outside of a pandemic situation but I would like to ask
8 whether you have any recommendations looking forward and
9 to the potential for a future pandemic whether you have
10 any recommendations for the response of the healthcare
11 system or planning for the response of the healthcare
12 system in the event of a future pandemic, to avoid that
13 pandemic exacerbating the pre-existing inequalities that
14 may well still exist at that future point?
15 **A.** I think the answer is probably in your question. These
16 are pre-existing inequalities that require a concerted
17 and focused approach. Our approach to addressing these
18 inequalities must be continuous and must be deliberate
19 and not reactive or temporary, having a long-term focus
20 on tackling racial and ethnic inequalities in health and
21 healthcare is something that the government and the NHS
22 should invest in and should focus on so that we're not
23 on the back foot when it comes to any future pandemic,
24 that we can tackle these issues and learn the lessons
25 from previous situations and emergency situations rather

1 than planning whilst we're in the eye of the storm.
2 **MS NIELD:** Thank you. I have no more questions for you and
3 I think --
4 **LADY HALLETT:** I think it is Mr Thomas.
5 Mr Thomas sits behind you, Professor, but -- by
6 all means look at Professor Thomas while he is asking
7 the question, but if you could make sure your replies go
8 into the microphone, I would be very grateful.
9 **Questions from PROFESSOR THOMAS KC**
10 **PROFESSOR THOMAS:** Good afternoon, Professor. Just a few
11 questions I have. I should say I represent the
12 Federation of Ethnic Minority Healthcare Organisations
13 and I ask questions on their behalf.
14 I've only got a handful of questions. My first is
15 this: in paragraph 14 you discuss the ONS report which
16 adjusted mortality data based on location, socio and
17 economic factors, occupation and pre-existing health
18 conditions. Here's my first question. Do you believe
19 these adjustments accurately reflect the lived
20 experiences and heightened risks faced by ethnic
21 minority groups during the pandemic or might certain
22 aspects of their experience have been understated?
23 **A.** Well, those statistics provide a limited picture in the
24 sense, as I've highlighted earlier, they present a
25 picture of potential reasons and causes but not the

1 causes of the causes, not the underlying issues that
2 then relate out in terms of the statistics that we see.
3 And the other point is, of course, you know, they
4 cannot in any way reflect the lived experience of
5 individuals. Behind every statistic is, of course, an
6 individual and an individual's experiences with regards
7 to that cannot come out in a figure or in any one
8 statistic alone.
9 **Q.** Secondly, in your opinion, how might future reports be
10 improved to ensure that the full impact on ethnic
11 minority groups is accurately reflected?
12 **A.** Well, a number of things here. One is for any change to
13 happen, an organisation or individual must acknowledge
14 that there is an issue to change. Without actually
15 acknowledging that racism exists we will not be able to
16 move from the base.
17 Secondly, qualitative data is great, is fine, it
18 gives us information but turning that information, that
19 data, into insight and that insight into action is
20 something that we must, and organisations must focus on
21 going forward, and that will include, yes, focussing on
22 quantitative data and statistics, but also looking at
23 the qualitative lived experience of individuals and
24 communities and the NHS workforce.
25 **Q.** Thank you.

1 Thirdly, do you think that the adjustments made in
2 the ONS report may have masked or minimised the true
3 extent of the disparities in infection risk amongst
4 ethnic minority healthcare workers?
5 **A.** Yes.
6 **Q.** And, if so, and you said yes, what aspects of the
7 workforce's experience might have been overlooked and
8 what data points or considerations could have been
9 included in the report to provide a clearer picture of
10 infection risks for ethnic minority healthcare workers?
11 **A.** Well, there are a number of factors that were clear
12 through what we were hearing and what we were observing
13 at that time including access to PPE or the lack of
14 access to PPE, particularly for ethnic minority members
15 of staff, with regards to protective equipment and the
16 fit, with regards to risk assessments, with regards to a
17 kind of a range of challenges and issues and, I guess,
18 dilemmas for the healthcare system that were not fully
19 played out in some of those reports.
20 **Q.** Let me come to my last question.
21 In multivariable analysis factors such as living
22 in large households, frequent exposure to Covid-19
23 patients, working in emergency or in-patient ward
24 settings, and serving as healthcare assistants are
25 disproportionately present amongst black, Asian, and

1 minority ethnic healthcare workers.
2 Given this, firstly do you think that these
3 factors should be prioritised over others when
4 addressing health inequalities and risk factors in the
5 healthcare workforce and, secondly, how can these
6 occupational and social risk factors be better addressed
7 in a future pandemic response to protect ethnic minority
8 healthcare workers?
9 **A.** I think the answer to both parts is probably related or
10 the same, and it goes back to my earlier point around
11 focussing on the causes of the causes of inequalities.
12 So looking at why is it the case that ethnic minority
13 staff are more likely to find themselves on the
14 frontline, to be earning less, to be on the wrong end of
15 an ethnicity pay gap, why is it that they are therefore
16 living in multigenerational households or in areas or
17 spaces that do not have the quality of air, for example,
18 that was highlighted in one of the reports, that other
19 groups, other ethnic groups have.
20 So looking, focussing in the here and the now with
21 regards to some of those causes of the causes will hold
22 the government and the NHS on a firm footing when it
23 comes to any future pandemic.
24 **PROFESSOR THOMAS:** Thank you.
25 Thank you, my Lady.

1 **LADY HALLETT:** Thank you, Mr Thomas.
2 Mr Marquis? Oh, you are there.
3 **Questions from MR MARQUIS**
4 **MR MARQUIS:** I ask questions on behalf of the Frontline
5 Migrant Health Workers Group. I have some questions on
6 the ONS data that you have just been referring to and
7 that you have very helpfully agreed may have
8 underrepresented the impact on ethnic minorities.
9 Professor, first of all, can you confirm that that
10 dataset on which those statistics were based is linked
11 to the census from 2011?
12 **A.** I believe so.
13 **Q.** For the record, if you need confirmation of that, I'm
14 not sure we need to bring it up, but it's INQ000302499
15 on page 1, which stresses that, if I can read it in:
16 "This data deals with estimates of differences in
17 Covid-19 mortality risk by ethnic group for deaths
18 occurring up to 31 March 2021 using linked data from the
19 2011 census."
20 So it follows, Professor, doesn't it, that these
21 ONS results do not include the deaths of any migrant who
22 arrived after the 2011 census date?
23 **A.** Well, I assume they would be captured in some category,
24 whether that's "other ethnic group" I cannot be certain
25 about that, but there are limitations with regards to

1 the census categories as well as, of course, limitations
2 to the data themselves in the sense that they were kind
3 of experimental data that represented.
4 **Q.** Professor, I'm going to have to stop you for a moment
5 because your assumptions can, of course, be a little
6 dangerous -- I appreciate that's comment, but -- if this
7 data is based on census from 2011 follows, doesn't it,
8 that it cannot include people who were not on that
9 census, i.e. those people that arrived after the 2011
10 census? It must follow.
11 **A.** Yes, I guess so.
12 **Q.** Well, again for the record -- we don't need to call this
13 up, but should there need to be confirmation of this,
14 INQ00089742_0021, which is one of Her Majesty's
15 Government's quarterly reports on progress to address
16 Covid-19 health inequalities. That document
17 specifically states that any death of someone who
18 arrived in England and Wales after the census would not
19 be included in the ONS analysis.
20 So, having heard that, now you're aware of that,
21 would you agree with my initial question that migrants
22 who arrived after March 2011 would not be counted in
23 that analysis?
24 **A.** Yes.
25 **Q.** Thank you. Professor, we've also asked you to review a

1 article from the Health Service Journal. For the
2 record, again, that's INQ000352887. First, this is an
3 early pandemic article from April 2020 dealing with the
4 ethnic minority mortality rates in healthcare workers by
5 Professor Cook and Dr Lennane. Have you had the
6 opportunity of reading that before giving evidence
7 today?
8 **A.** Yes.
9 **Q.** Thank you. All of my questions really are on page 6.
10 There are three key features of this research that I'm
11 going to ask you to confirm from the research of course.
12 Mortality rates up until 22 April 2020, 63 of the
13 healthcare worker deaths were ethnic minority workers,
14 is that right, on the basis of this data?
15 **A.** That's correct.
16 **Q.** Of that 63%, 83% at least were migrants. The figure
17 there, if you're got it in front of you, is actually 53
18 of the 64 deaths.
19 **A.** Yes.
20 **Q.** But, of course, the status of the remaining 11 deaths
21 was uncertain. So it's at least 83% were migrant, would
22 you agree with that?
23 **A.** Yes.
24 **Q.** If you can turn over on to page 7, we can see from the
25 break down of national mortality rates that 36% of those

1 migrant deaths were workers from the Philippines?
2 **A.** Yes.
3 **Q.** And that is, by far, the highest national mortality rate
4 for migrant health workers in that set of data?
5 **A.** That's correct.
6 **Q.** So, bearing in mind we have ONS data that lacks migrant
7 mortality post-2011 --
8 **A.** Yes.
9 **Q.** -- and we have early data that suggests very strongly,
10 certainly in health workers, that migrants were bearing
11 the brunt of the mortality, would you agree that ethnic
12 minority mortality rates could have been significantly
13 higher than those rates suggested by the ONS analysis?
14 **A.** That's correct, yes.
15 **Q.** Thank you very much.
16 Three quick questions now. As far as you know, is
17 there any official data in respect of migrant mortality
18 rates?
19 **A.** Not that I know of, no.
20 **Q.** Would you agree that that is a data gap that needs to be
21 filled?
22 **A.** Yes, absolutely.
23 **Q.** Thank you very much.
24 **A.** For a number of reasons, if I may add.
25 **Q.** Yes, please.

1 **A.** With the influx of nurses particularly in the NHS,
2 coming from beyond Europe in particular, it's critical
3 that we -- sorry, it's critical that the NHS makes sure
4 that the environments for those migrant staff are
5 supportive, and that those individuals are engaged at
6 all levels within the NHS.
7 **Q.** Thank you, Professor. Final question. You've already
8 told us when counsel to the Inquiry was asking you
9 questions that there's no inclusion of a Filipino
10 category in equality monitoring in the current ONS.
11 Would you agree that that exclusion also has to be
12 remedied?
13 **A.** It would be as beneficial to have as many categories as
14 we can, so that we can see trends and patterns in
15 disease over time.
16 **MR MARQUIS:** Thank you, Professor, and thank you, my Lady.
17 **LADY HALLETT:** Thank you, Mr Marquis.
18 Professor, thank you very much indeed for your
19 help. You have managed to make what for some people
20 might be a dry subject obviously very informative and
21 interesting. Thank you very much.
22 **A.** Thank you.
23 **(The witness withdrew)**
24 **LADY HALLETT:** Right. I think it is Ms Hands next?
25 **MS HANDS:** Yes. My Lady, if I may call Mr Jonathan Rees.

1 **MR JONATHAN REES (sworn)**
2 **Questions from COUNSEL TO THE INQUIRY**
3 **MS HANDS:** Hello, good afternoon, Mr Rees. You should have
4 your witness statement in front of you, and our
5 reference for that is INQ000492290.
6 Mr Rees, it's correct that you are a pharmacist;
7 is that right?
8 **A.** That's correct.
9 **Q.** And also a superintendent pharmacist for two independent
10 family pharmacies?
11 **A.** That's correct.
12 **Q.** During the pandemic you also held the role of country
13 manager for Wales for the National Pharmacy Association
14 or NPA?
15 **A.** Correct.
16 **Q.** You've described that role in your statement as
17 representing the views of Welsh pharmacies to
18 stakeholders on a UK level and ensuring NPA guidance
19 remains appropriate for Welsh members. Is that an
20 accurate summary of that role?
21 **A.** Yes.
22 **Q.** Can you provide us with some examples as to how you
23 gathered the views of Welsh pharmacies to fulfil that
24 role?
25 **A.** Several methods, really. Obviously, during the pandemic

1 it was more difficult but usually we would either have
2 face-to-face meetings in the pharmacies, or by phone
3 calls, emails and whichever technology we would care to
4 use, really.
5 **Q.** And so during the pandemic did you mostly rely on that
6 remote technology to --
7 **A.** Almost 100%.
8 **Q.** Sorry?
9 **A.** Yes, almost 100%.
10 **Q.** I'm grateful. You have said in your statement that you
11 heard, obviously, concerns and issues from pharmacists
12 through that role. Can you provide some examples of the
13 concerns or issues that you heard?
14 **A.** So the main issues would be revolving around staffing
15 and skill mix to ensure, when staff were unavailable due
16 to infection or having to isolate, how to appropriately
17 either acquire locum staff, or how they can manage with
18 the staff they have remaining, and also following
19 guidelines in terms of things that are changing week to
20 week or month to month, in terms of what is
21 appropriate in how you run your business. And then else
22 guidance how they may apply for certain grants that were
23 available at the time, or certainly maximise the
24 contract that was available within pharmacy to ensure
25 they maximise the business potential.

1 **Q.** Would you provide them with that information straight
2 away, or would you take that back to the meeting, gather
3 the meeting and then report it back to them?
4 **A.** It really did depend on the query. Many of them were
5 repetitive, so I had the information to hand and we
6 could just issue it, but it was something more nuanced,
7 then I may have to defer to some colleagues who would be
8 sort of more learned in that area.
9 **Q.** How frequent were the meetings during the pandemic?
10 **A.** With?
11 **Q.** The NPA stakeholder meetings that you referred to.
12 **A.** Daily, yes. So, certainly, earlier on, we had a daily
13 meeting before working hours, or very early in the
14 working hours to establish if anything had changed
15 overnight or the following day, which I could then
16 disseminate appropriately. But in terms of meetings
17 with other stakeholders, it would be the frequency
18 determined by them, but they were regular.
19 **Q.** When you raised issues or concerns at those stakeholder
20 meetings, did you feel that your contributions were
21 listened to, and did they lead to any changes?
22 **A.** Certainly largely the vast majority of people were
23 reporting the same issues. It was balancing workload,
24 the pressures involved, the staffing pressures. So
25 myself or my CCA colleagues, we would all be reporting

1 largely the same information back into whatever
2 stakeholder we were reporting to at the time.
3 Q. When you say they all were saying the same, can we take
4 it from that it was across the UK, not just in Wales?
5 A. I would say -- I was only really exposed, in terms of
6 the meetings I had, within Wales, but my NPA colleagues
7 were -- there were other regional managers across
8 England we would all report in to, but largely the
9 issues were pretty much the same.
10 Q. Thank you. And did you feel that that role provided you
11 with additional insight and resources during the
12 pandemic that you might not otherwise have had access
13 to, had you not had that role?
14 A. Absolutely. Learning off of other people is a key part
15 of developing, and having the ability to see good ideas
16 of how people are running their business certainly
17 helped me in private enterprise.
18 Q. I want to now move on to your role within your own
19 pharmacy, if I may.
20 A. Sure.
21 Q. You have -- dealing first with the staff in your
22 pharmacy, could you just set out for us what the make-up
23 of staff was, the matrix, before the pandemic, and then
24 at the start?
25 A. Sure. So before the pandemic it would be myself and my

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1 father as the pharmacist with a split week, pretty much,
2 and then we have two checking technicians, and then
3 around eight other members of staff, plus a delivery
4 driver.
5 At the start of the pandemic my father had to
6 isolate, which meant my wife came back from maternity,
7 who is also a pharmacist, so she took over his portion
8 of the week while I worked for the NPA, and two other
9 members of staff had to -- to isolate.
10 So then we took a decision with our workload, our
11 team, to try and split into basically two teams within
12 our pharmacy, with one coming in, out of hours to try
13 and complete the bulk of the dispensing work, leaving
14 the team who works during the day to deal with patient
15 phone calls, patient queries, and the patients that come
16 through the door. So that was quite an efficient way of
17 working.
18 Q. Did you bring that in quite early on in the pandemic,
19 that way of working, or did that develop --
20 A. Within the first two weeks or so.
21 Q. Is that a practice that you shared with others at those
22 NPA meetings?
23 A. Yes, but it's quite difficult to replicate. We were
24 fortunate in, kind of, the pharmacists we had within the
25 family and also the number of staff that we had who were

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1 available to work overtime who lived very locally and
2 were happy to do it. So although we shared the
3 information, it wasn't easily replicated.
4 Q. I think you have said in your statement that it was very
5 frequent that you would be working overtime for long
6 periods of time up to many hours a day?
7 A. Pretty much every day.
8 Q. Is it correct that you also brought on two pharmacy
9 students to supplement your staff?
10 A. Yes. So they are the students who would have been
11 working through (sic) us through holiday periods. They
12 were advised by their universities to not work during
13 the pandemic, to keep to their studies, but as all of
14 their work was done remotely they were happy to come in
15 and work alongside us and then the following year we
16 took on an additional student as well.
17 Q. Was that through the apprentice scheme that you refer to
18 in your statement?
19 A. No, that was a different member of staff again.
20 Q. Okay, so you also brought on an apprentice through the
21 government scheme, is that right?
22 A. Through the Kickstart scheme, yes.
23 Q. And was that early on in the pandemic?
24 A. I believe that came in in 2021, I think.
25 Q. You've have explained in your statement how the Welsh

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1 Government allowed pharmacies to close for up to two
2 hours a day to process and dispense the increased volume
3 of prescriptions and you have described that as
4 invaluable.
5 A. Yes.
6 Q. In terms of what you would do during that period of time
7 could you just give us some insight as to what you would
8 do?
9 A. Sure. So it basically allowed undisturbed dispensing.
10 So there would be somebody labelling prescriptions
11 followed by somebody collecting those labels, attaching
12 them to the relevant boxes, dispensing, and then finally
13 to checking and bagging that prescription without
14 patients coming through the door or the phone calls,
15 that could be as a production line and done as
16 efficiently as possible without interruption. It just
17 meant the volume you can dispense like that is
18 astronomical compared to having your doors open and
19 trying to deal with patients.
20 It also allowed us time to clean and reset the
21 pharmacy, order the stock that we need, because our
22 phone lines were constantly in use from patient queries,
23 meaning phoning out to wholesalers was difficult.
24 Q. And it may be obvious but to those of us that perhaps
25 aren't as familiar with the backroom of a pharmacy, how

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1 did that workload differ to before the pandemic?
2 A. So it was at least double for several weeks and then not
3 far off that then for several months afterwards, and not
4 only double in terms of the number of prescriptions
5 through the door but also the number or medications on
6 those prescriptions plus the dose frequency of them, or
7 the dosing interval, so instead of supplying one month
8 of medications we were being asked to supply three
9 months of medication which then obviously meant that we
10 needed to order triple the medication from our
11 wholesaler which takes longer to go put away, to
12 organise, storage becomes an issue. So we're geared up
13 for the volume -- in an ideal world your pharmacy
14 remains at a pretty constant level so trying to double
15 or triple everything in a matter of days is very
16 difficult to organise.
17 Q. Do you think it was widely understood by members of the
18 public why pharmacies had to close for that period of
19 time during the day during the pandemic which obviously
20 was different to before?
21 A. I believe so. Certainly where I'm based the public were
22 very accommodating to us, understood fully what we were
23 trying to achieve and that we were clearly working very
24 hard to supply their medications. I'm aware of certain
25 instances across Wales where that wasn't the case or if

1 the patients didn't have the ability to return at a time
2 where the pharmacy was then re-opened, that could be
3 difficult, but in terms of personal experience our
4 patients were wonderful with us.
5 Q. I think it is right, as you said, the National Pharmacy
6 Association in their statement to the Inquiry have
7 referred to an increase in inappropriate behaviour from
8 some members of the public due to frustration around
9 waiting times increasing and supply of medications to
10 the extent that some pharmacies had to recruit
11 volunteers to act as security or introduce body cameras
12 to protect their members of staff.
13 So although you didn't experience that in your
14 community, were you aware of that happening in other
15 areas?
16 A. Yes, they did tend to be in more urban areas but
17 certainly even in localities close to where I'm based
18 that was happening largely because some people were in
19 queues for two to three hours and then they would get to
20 the front of the queue and the stock wouldn't be there.
21 It inevitably led to frustration.
22 But that's where, in our case, trying to do that
23 dispensing overnight, we tried to mitigate that as much
24 as possible but, as I say, it is not always viable for
25 everyone else to do likewise.

1 Q. I think you've said in your statement that that was also
2 impacted by the reduction of in-person contact across
3 primary care in general, so GPs for example?
4 A. Yes. Inevitably it meant, to use a phrase coined by the
5 NPA, we did have to become quite literally the front
6 door of the NHS. We were triaging patients that we
7 wouldn't really otherwise see in a pharmacy environment,
8 and we had no real control of those patients coming into
9 us, whether they had Covid or not. It was impossible
10 for us to ascertain that. But it just meant we were
11 trying to direct those patients as best as we could to
12 the most appropriate care provider at the time.
13 Q. Was there guidance produced for pharmacists in order to
14 help them with those changes in practice and care
15 pathways?
16 A. Not particularly because the variability of what you may
17 see, the vast majority would be those we would refer
18 back into our primary care colleagues for them to deal
19 with either remotely or in person, if it was that
20 serious. But it's essentially just an extrapolation of
21 the job we would do normally, just times, multiplied
22 several times.
23 Q. I want to ask you briefly about some feedback that the
24 National Pharmacy Association received from discussions
25 with its members during March and April 2020.

1 So if we could have on screen INQ000340104.
2 So this is following extensive discussions and
3 feedback and the NPA believes that the number of
4 prescriptions dispensed went up 25 to 35% from February
5 to March 2020, home deliveries more than doubled with
6 some pharmacies reporting an increase of 300%. Phone
7 calls to pharmacies more than tripled. Many pharmacies
8 were experiencing long queues. All the pharmacies
9 reported a big increase in working hours often requiring
10 the hiring of locum staff to meet workload.
11 Some of those echo the experience that you had in
12 your pharmacy. Were you aware of the others experiences
13 that are expressed here also happening in Wales and
14 across the UK, if that same up in your NPA role?
15 A. Yes, I would imagine almost every pharmacy would have
16 the same story as this.
17 Q. And did this level of demand continue throughout the
18 pandemic?
19 A. Largely. Obviously, the initial flurry was noticeably
20 different but certainly up until kind of the autumn
21 period it remained very busy and then winter pressures
22 kicked in shortly after which also, sort of, increased
23 workload and then we were into obviously vaccination
24 season also, which was then difficult to manage on top.
25 Q. Which actually brings me to my next question which is

1 whether you were involved in the vaccine roll-out?
2 **A.** Yes, we were one of the first within Swansea to offer
3 Covid vaccinations.
4 **Q.** Did you receive any support from the government or
5 public health bodies for that additional workload?
6 **A.** So the Health Board were very good at organising the
7 patients, giving us the flow, the -- kind of the
8 timetable for all the patients and they were organising
9 all of the appointments and they were very good at that,
10 to be fair. But that was kind of the limit of the input
11 from them.
12 **Q.** What measures did you implement locally to meet that
13 additional workload?
14 **A.** So we had four vaccinators trained on site for
15 ourselves. We, at that point, were able to incorporate
16 the two teams into the same day but we would have one,
17 sort of, set of vaccinators and team organising those
18 who were arriving for vaccines and then the remainder of
19 the team with the normal pharmacy functions.
20 So we tried to separate the business into two
21 within the same premises so that the vaccinations didn't
22 interfere with those coming in for prescriptions.
23 **Q.** Moving on to the topic of the supply of medicines and
24 delivery of medication, you have described in your
25 statement how before the pandemic you would be

1 undertaking medicine deliveries approximately every two
2 and a half days a week and that during the pandemic that
3 increased to six days; is that right?
4 **A.** Yes. Yes, it was almost always -- well, it was always
5 five days a week and then six most weeks.
6 **Q.** And is it also correct that that service, that home
7 delivery service is not funded, so your business had to
8 absorb the cost of that?
9 **A.** That's correct.
10 **Q.** How did you manage to meet that demand?
11 **A.** With difficulty, in all honesty.
12 So one of the benefits of being a pretty small
13 business is our agility and ability to respond so as
14 soon as we realised the demand was there, within two
15 days we'd employed a new delivery driver, we were up and
16 running five days a week and then at pinch points up to
17 six, and then also on the weekends my wife and I would
18 be delivering ourselves to try and meet demand.
19 **Q.** And it's right, isn't it, that pharmacies were also
20 asked to deliver medications to the shielded population?
21 **A.** Correct.
22 **Q.** And the NPA told the Inquiry they worked with the Welsh
23 Government to enable software to support that delivery
24 of medications. Did you benefit from that?
25 **A.** We didn't use it personally but many within Wales did

1 use that, particularly for new patients it allows GPS
2 tracking of where the medication is going. It was
3 largely rolled out for those using a volunteer system to
4 deliver medication so that they would know where to drop
5 the medication, they could take a photo of where it was
6 delivered and as we weren't using signatures at the
7 time, it allowed a timestamp delivery of where that
8 medication was left.
9 **Q.** So did you benefit or use -- or make use of any other
10 support that was available to you, financial or
11 otherwise, to provide that additional service?
12 **A.** Not in terms of delivery, no.
13 **Q.** It's correct that there were shortages of medications
14 early in the pandemic which you have described as being
15 partly due to a panic amongst patients?
16 **A.** Yes.
17 **Q.** How did you in your pharmacy mitigate against those
18 stock shortages and can you provide some examples of the
19 type of medications that were in short supply?
20 **A.** So the vast majority at that point were inhalers and
21 asthmatics or COPD patients seeking to attain additional
22 inhalers, and also paracetamol became an issue as well
23 for quite a spell.
24 So in terms of mitigation what we would attempt to
25 do, as many prescriptions at that time were changed from

1 28-day prescribing interval to 56 or 84, so we would
2 firstly try to ensure that everybody received one and
3 then work our way from there, if we had sufficient, to
4 give them the balance.
5 Many patients -- not many -- but we did have
6 incidences where we would issue medication to people and
7 they would then turn round and say, well, I have already
8 got two or three but I thought I better get an extra
9 one, and that became a frustration but there was no way
10 to control that. You were just relying on patients
11 being fair to their -- society basically.
12 **Q.** The NPA also conducted a survey at the end of 2020 in
13 November in regard to the medicine shortages and at that
14 time it was reported that 50% of respondents were
15 spending between one and five hours sorting medicines
16 and 40% were spending up to ten hours, in some cases
17 over ten hours. Is that an experience that you had or
18 you were aware of others having?
19 **A.** Yes, certainly some weeks were worse than others. We
20 spent the majority of the first six weeks, as the
21 pandemic hit, trying to open new accounts with new
22 wholesalers to try and gain a wider access to the market
23 as possible. So that took several hours to arrange.
24 That's something that's not always available to a lot of
25 pharmacies, particularly rural areas, they wouldn't be

1 able to gain a new supplier, and also you have to meet
2 minimum spend thresholds which, if you are quite a small
3 supplier you wouldn't be able to do so, and trying to
4 then manage your stock with limited supply is difficult,
5 but we certainly spent many, many hours trying to find
6 stock and then find it at a reasonable price also.
7 **Q.** I think you have also described how it was very
8 time-consuming speaking to not only patients and trying
9 to explain to them the situation, but also to GPs as
10 well about alterations to prescriptions. So that was in
11 addition to the workload; is that right?
12 **A.** That's correct.
13 **Q.** The NPA have referred to the use of government-issued
14 serious shortage protocols authorising pharmacists to
15 supply alternative medicines if one was unavailable that
16 had been prescribed. Were they used in Wales as well,
17 to your knowledge.
18 **A.** At that time they were the exact same, yes.
19 **Q.** And did you use them?
20 **A.** It would be an automatic process if that medication
21 became an SSP then it would automatically be relevant
22 and generally those that fall into that category are
23 used in pretty much every pharmacy.
24 **Q.** Were they helpful in managing?
25 **A.** To a certain extent. So it allowed you then to know an

1 increased price for which you could purchase the product
2 for, and give you some -- there was a tolerance then
3 built into what you could pay. Whereas, otherwise, you
4 would be dispensing that at a loss, which basically
5 means that the business is funding the supplier of that
6 medication to the patient, not the Health Service.
7 **Q.** I want to move on to the topic of Infection, Prevention
8 Control and PPE. You've said that there were multiple
9 times when guidelines were unclear, or Welsh guidelines
10 differed from the UK. Can you provide some examples of
11 when that occurred?
12 **A.** I was trying to think of some exact ones earlier and
13 they have become hazy as time has gone on. A lot of the
14 ones which stick in my mind are the distances people are
15 allowed to travel. Certainly, as we moved through the
16 pandemic, there was variation in how far you were
17 allowed to leave from your location. So we cover an
18 area which would go sort of nearly ten miles sort of
19 west and then likewise east, so those patients may not
20 then feel confident that they are close enough to travel
21 to us, or leaving their immediate area.
22 And, also, there were some discrepancies, I
23 believe in the social distancing requirements at various
24 points as well. But for further examples, I would have
25 to research a bit more.

1 **Q.** That's okay, thank you. Was that discussed during the
2 NPA stakeholder meetings that you attended?
3 **A.** Yes, yes. So that would mean we would try to tailor the
4 communications we would send across the four nations, we
5 would try to tailor them appropriately for the nations,
6 or to phrase them so that they may catch-all.
7 **Q.** Were there any problems interpreting, for example,
8 physical distancing, or the spaces between --
9 **A.** That was our biggest issue in terms of -- I don't know
10 pharmacy spaces you've been into but they're generally
11 quite small environments, so when you are trying to fit,
12 perhaps, six people into areas that are quite small,
13 maintaining that social distance is then an issue. And
14 it's unreasonable to then be able to work in that
15 environment, with those distances, so trying to cut the
16 number of stuff there in the day is also difficult
17 because you can't then manage the same workload. So
18 finding that balance was an issue.
19 **Q.** How did you try and achieve that balance?
20 **A.** By splitting the teams in two.
21 **Q.** Okay.
22 **A.** Yes.
23 **Q.** So were there any changes in the actual physical
24 pharmacy pathway, so the way that you went in or
25 anything like that?

1 **A.** Yeah, so we taped areas off so each section would be
2 where somebody would -- so if they were working at a
3 computer station to label, then they would be within a
4 certain taped area. If they were then dispensing for
5 deliveries, they would be in one area, or dispensing for
6 collections in another area, to try and segregate you
7 into a zone. It wasn't perfect because not everything
8 within a pharmacy exists in that zone, but as best we
9 could.
10 **Q.** I think the Welsh Government made available funding of
11 £300 on 1 May 2020 to implement perspex screens.
12 **A.** Yes.
13 **Q.** Did you use that funding or had you implemented them
14 before that?
15 **A.** Yes, it was an automatic payment that everybody
16 received, so before then we were already trying to
17 segregate as best we could, and certain companies, did
18 offer the perspex screens. They were generally more
19 expensive than £300, but it was appreciated, the effort.
20 **Q.** Did community pharmacies in Wales have access to
21 Covid-19 testing for staff?
22 **A.** Yes. It wasn't immediate, I don't believe that we were
23 on the priority list, but it was fairly shortly after
24 that we were included in that.
25 **Q.** Can you recall when?

1 A. Not off the top of my head, unfortunately, but there was
2 a period where, if you did test, anyone in the pharmacy
3 did test positive, that the entire team would need to
4 isolate. But as we became part of the priority list,
5 that meant that only that person unless the others
6 tested positive.
7 Q. Yes, I think the NPA have explained that in their
8 statement that the categorisation of community
9 pharmacies initially as a retail setting --
10 A. Yes.
11 Q. -- meant -- so not healthcare?
12 A. Yes.
13 Q. -- meant that an entire pharmacy team had to
14 self-isolate following one positive test in the
15 pharmacy, and close contacts --
16 A. Yes.
17 Q. -- had to be isolated as well. And so did that impact
18 on your work force?
19 A. Luckily no, but I am aware of about three instances that
20 I was covering in Wales where the pharmacies had to
21 close for a period as a result of that.
22 Q. Was that discussed during the NPA meetings that you
23 attended?
24 A. Yes.
25 Q. Can you recall when the change was implemented, it's not

1 a problem if not.
2 A. I can't. Sorry.
3 Q. And you've said in your statement that during the first
4 month of the pandemic, you had to source your own PPE as
5 there was no access to the national supply; is that
6 right?
7 A. That's correct.
8 Q. Could you perhaps just explain to us how you went about
9 obtaining PPE during the early stages of the pandemic?
10 A. So the best offer we received at the time was from
11 our -- one of the local comprehensive schools, where the
12 design and technology teacher created their own plastic
13 face masks, which they then issued to pharmacies locally
14 and, you know, we applaud the effort. It was marvellous
15 that someone put the effort in, but being what they
16 were, they weren't really conducive to wear for eight
17 hours in a day, or particularly fit for purpose
18 obviously moving forward, but they were the best that we
19 had at the time.
20 Q. I think you have described in your statement the
21 inability of obtaining antiseptic hand gel during the
22 early months as well and resorting to creating your own
23 product; is that right?
24 A. Yes, it was the only real option at the time. So WHO
25 released their manufacturing of how to create your own

1 hand gel, so we, my wife and I, we created our own for
2 use for pharmacy staff and patients as they came in.
3 Q. Did that continue throughout the pandemic?
4 A. No, we did that for about two months, and then I had a
5 discussion with a local brewery who were interested in
6 doing likewise. So I discussed with them how to proceed
7 with that, and then we became their first wholesale
8 customer, and they've done very well, as a result. They
9 now sell it in Harrods and places like that, so ...
10 Q. And when did have access to the national supply of PPE,
11 was that supply consistent and suitable for your staff?
12 A. So by the end of May into June, the Health Board had
13 taken over the supply of PPE where they would send a box
14 a week of what you would need, and at that time, that
15 was sufficient. You could request extra of certain
16 particulars if you needed to. And from that point on,
17 it was fairly well controlled.
18 Q. I want to ask you some questions now about financial
19 support from the Welsh Government. Did you experience
20 or hear from NPA members about the financial impact on
21 pharmacies, in particular, in the additional costs and
22 expenses that were incurred during the pandemic?
23 A. Hugely. That was a large part of most conversations.
24 So in terms of how pharmacy works, any work that we do,
25 say, in this month, you're not paid until three months

1 later, but your wholesaler bill is due 30 days later
2 than today. So there's that gap between when we have to
3 repay the wholesaler to when we actually get paid.
4 In a general month, that's fine because you're
5 constantly being paid for what you have previously done,
6 but if your workload were to double or triple in
7 a certain month, you would need to be able to find that
8 money within 30 days rather than wait for when you are
9 reimbursed for the work that you've done.
10 So that became a real issue for people into April,
11 start of May, before they got reimbursed then in June
12 for what they had done.
13 Q. The Welsh Government in particular announced support for
14 small Wales-based businesses. Did that provide any
15 relief during that period?
16 A. So there was an easily accessible £25,000 grant, which
17 was very welcome at the time, because it was something
18 that you could get hold of fairly quickly within a
19 matter of two to three weeks, and it had no real strings
20 attached to it, which was excellent.
21 Then there was also the Covid advance payment from
22 Welsh Government, which gave you an average of your last
23 three months' NHS payments to be paid into your next
24 monthly account, which I think came in the, I want to
25 say the May payment of that year.

1 **Q.** 2020?
2 **A.** Yes.
3 **Q.** Thank you. The Inquiry understands that pharmacists did
4 not initially have access to the government life
5 assurance scheme which was introduced for frontline
6 staff. Was that the case in Wales as well?
7 **A.** Yes, that was the same.
8 **Q.** And they were eventually included. Did you play any
9 role in advocating for their inclusion?
10 **A.** No, so my NPA colleagues managed that, on a UK-wide --
11 well, England and Wales basis. I wasn't required on
12 that. I fed in views from Wales, but broadly speaking,
13 a lot of members, I don't think, had noted it at that
14 time.
15 **Q.** So I was going to ask you, but -- what was the impact on
16 either your staff or members, but is it that there
17 wasn't particularly an impact that you were aware of at
18 the time?
19 **A.** Yeah, not noticeably. There was relief when they were
20 incorporated, because that became publicised, but it
21 wasn't publicised initially that pharmacists weren't
22 included, so unless they looked for the information,
23 they wouldn't have known.
24 **Q.** I see.
25 Then the same was the case in terms of key worker

1 status. Pharmacists weren't granted that. What impact
2 did that have on your staff or on NPA members that you
3 were aware of?
4 **A.** So it meant delays or difficulty in basic items like
5 food shopping, things like that became an issue. And
6 just allowing extra time to be able to do that, and for
7 certain members of staff childcare was also a key
8 component to allow your child to go into school, or into
9 a childcare facility whilst you worked. It was
10 prohibitive to some of them working. Luckily, in terms
11 of my personal staff, if -- one of the two would have
12 been home to look after the staff at that time -- to
13 look after the child at that time. Apologies.
14 **Q.** You've described at the end of your statement the
15 importance of pharmacies during a pandemic, and how you
16 had hundreds of new patients that you served during that
17 period. Can you summarise that importance for us?
18 **A.** Yes, with difficulty. I think the value of pharmacy
19 prior to Covid, I don't think it was completely
20 understood or realised by the population at large how we
21 have the ability to walk in to see a healthcare
22 professional, to obtain advice from trained staff, and
23 receive the medication that you need promptly. So
24 having the focus on what pharmacy can offer has been
25 very good for the sector on a public facing level. But

1 I think, as you can see from how we are dealt with
2 nationally, that perhaps -- the workload that's involved
3 is not realised in terms of revenue or profits because
4 since Covid, even though our workload has increased
5 astronomically, you are still seeing four pharmacies a
6 week closing, which is reflective of the revenue that
7 you drive for the work that you do actually undertake.
8 **Q.** Finally this, Mr Rees: can you describe for us the
9 personal impact on you and your staff and any views of
10 NPA members as well the impact that has had on you?
11 **A.** From a personal point of view, sort of led me to a love
12 of pharmacy that I didn't quite realise I had before,
13 and I found great satisfaction in my job which wasn't
14 quite there before. Not that I disliked my job, but
15 being able to serve the volume of people, to be able to
16 help the new patients and be a reliable source of
17 information for patients was quite, I don't know how to
18 phrase it, but it's something I'm quite proud of from
19 our time there.
20 The staff, likewise, the way we came together as a
21 team, it's -- we showed a resilience and an agility as a
22 business to react to what is an unprecedented situation.
23 Likewise, across the network. The whole pharmacy
24 network really did stand up to what was thrown at it.
25 My concern is that moving forward, I'm not sure

1 that same resilience will be there, purely from closures
2 and fragility of the network. If it were to happen
3 again, I'm not sure the pharmacy network would stand up
4 quite as well as it did the first time.
5 **MS HANDS:** Thank you.
6 My Lady, I don't have any further questions.
7 **LADY HALLETT:** And I don't think there are any --
8 **MS HANDS:** There aren't.
9 **LADY HALLETT:** No.
10 Thank you very much indeed. I'm really grateful
11 to you. I for one certainly appreciate the work of
12 pharmacies -- apart from the fact my brother was a
13 pharmacist, so I probably ought to declare an
14 interest -- but you worked enormously hard to look after
15 your local communities, so thank you very much indeed
16 for everything that you did, for your colleagues around
17 the UK did. And if I may say so, the area of Swansea
18 seems to be very well served by you.
19 **A.** Great. Thank you.
20 **LADY HALLETT:** Did the family -- you said your wife was on
21 maternity leave. Then you ended up taking her back to
22 work?
23 **A.** Yes. So she came back from maternity early to cover the
24 earlier part of the week while I worked for the NPA. In
25 many ways -- so it meant that I was working from home

1 for the NPA but also in charge of our three children,
2 all of which were under 4.
3 **LADY HALLETT:** Ah.
4 **A.** So in some ways being in work was easier. It was a busy
5 time.
6 **LADY HALLETT:** I know that feeling as well. Thank you very
7 much indeed for your all help. I'm really grateful.
8 **A.** Thank you.
9 **(The witness withdrew)**
10 **LADY HALLETT:** That completes the evidence for this week.
11 **MS HANDS:** It does, my Lady.
12 **LADY HALLETT:** That completes part 1.
13 **MS HANDS:** It does.
14 **LADY HALLETT:** So congratulations to everybody for getting
15 all the witnesses through and I shall sit again in
16 relation to this module on 28 October at 10.30.
17 **MS HANDS:** Grateful. Thank you.
18 **(3.10 pm)**
19 **(Hearing adjourned until Monday, 28 October 2024)**
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