Wednesday, 9 October 2024

(10.00 am)

LADY HALLETT: Yes, Mr Mills.

MR MILLS: My Lady, may I please call the witness M3/WI who will affirm.

MS NORA OHRENSTEIN (Interpreter) (affirmed)

M3/WI (affirmed)

Questions from COUNSEL TO THE INQUIRY

(Interpreted, unless otherwise indicated)

MR MILLS: You are providing evidence to the Inquiry this morning under the cypher M3/WI; is that right?

A. (In English) Yes.

Q. During the pandemic, you worked as a cleaner in a hospital?

A. (In English) Yes.

Q. It is right, isn't it, that you were not directly employed by the hospital but you worked for an outsourced company?

A. Yes.

Q. Can you begin by describing to us your normal working day before the pandemic?

A. My usual day before the pandemic was working in the cardiology floor, three hours a day.

Q. When the pandemic began, did your working hours increase?

A. Yes, due to the situation we were going through.

Q. How many hours did you have to start working?

A. I would start work 6, 7 o'clock in the evening and go until 4, 5 am in the morning, depending.

Q. And that was how many days a week?

A. Usually for five days a week, but sometimes even weekends.

Q. You said, before the pandemic, you were cleaning one department in the hospital. Were you asked, when the pandemic struck, to clean more areas of the hospital?

A. Due to the situation, I was obliged to work for more hours during the crisis we were going through.

Q. You refer to the "situation". I think it is right, isn't it, that the hospital was short-staffed at this time?

A. Yes, short-staffed due to the illness we were suffering.

Q. Is it right that many cleaners also were feeling too scared to go to work?

A. Yes, we were short of staff all due to the pandemic.

Q. In your statement you say this:

"I also didn't really want to work additional hours but I felt pressured by the circumstances and didn't feel able to say no."

A. Yes, because of the general circumstances, but also due to my own circumstances, having to pay rent, help my

family, it was something to be considered.

Q. I would like to explore that a little bit.

A. (In English) Okay, no problem.

Q. What did you fear would happen if you had said no to working longer hours?

A. I feared losing my job, everything was closing down at the time.

Q. Were you told which wards in the hospital were being used for treating patients with Covid-19?

A. We had no information whatsoever.

Q. Did that make you feel anxious?

A. Yes, I was very anxious. I didn't even take a lift because I had fear.

Q. Did you ask your supervisor or anyone within the management of the hospital to tell you which wards were being used for treating patients with Covid-19?

A. They didn't provide information but I heard rumours, just rumours that perhaps they were all on the fourth floor.

Q. As well as cleaning wards, I think it is right that you also cleaned individual rooms?

A. Yes.

Q. Was the patient ever in the room when you were cleaning the individual rooms?

A. No, the patient was no longer there.

Q. And again, were you told whether the patient whose room you were cleaning had Covid-19?

A. No, we didn't receive any information at all.

Q. Did you receive any training about how to clean differently in accordance with Covid-19 guidelines?

A. No, we didn't have any information and we just went on cleaning the way we were cleaning before doing things to the best of our ability.

Q. So you weren't, for example, given any new cleaning products?

A. We started using a product called Bihes(?), and that's the one we used for everything.

Q. Did you receive any guidance about Infection, Prevention and Control?

A. No. No guidance, no information.

Q. In the absence of guidance about infection prevention and control and about how to clean in a Covid-19 compliant way, did you have concerns?

A. I was very worried, I was -- I had fear of being ill myself, contagious.

Q. Did you raise the concerns you had with anyone at the hospital?

A. We had nobody to speak to. All we had to do was work and work.

Q. What about with anyone at the outsourced company?

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

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

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

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

MR MILLS: Thank you.
LADY HALLETT: Can I just ask, was it a private hospital or an NHS hospital? Please don't name the hospital but was it private or NHS?
A. As far as I know it is a private hospital.
LADY HALLETT: Thank you.
Those are all the questions we have. Thank you very much for your courage in coming forward to help us. It is absolutely essential that we hear from a wide range of people who were working throughout the pandemic in hospitals. So we are very grateful.
A. Thank you and it has been very hard.
LADY HALLETT: I can imagine. Thank you. I have been asked to rise while we break for the next witnesses. I shall return as soon as we are ready.
(The witness withdrew)
(10.25 am)
(A short break)
(10.31 am)
PROFESSOR CHARLOTTE SUMMERS (continued)
DR GANESH SUNTHARALINGAM (continued)
Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3 (continued)
LADY HALLETT: Ms Carey.
I am sorry about last week.

MS CAREY: My Lady, the next witness was in fact due to be Mrs Lesley Moore but due, unfortunately, to a family emergency she is unable to attend today and the Inquiry will update both you and the core participants in due course once we are able to do so.
Can we return then please to Professor Summers and Dr Suntharalingam. You are still under your oaths or affirmations that you made last week.
And I would like to start with you, Doctor, please, on the topic of advance care planning and do not attempt cardiopulmonary resuscitation. All right?
And if it helps you, Doctor, we are starting at paragraph 37 at your report.
DR SUNTHARALINGAM: Okay.
MS CAREY: Some people may find discussing this quite distressing, so can we take our time and set out the principles, the legalities and the realities at a steady and slow pace if we may.
I would like to ask you please about why advance care planning is important generally and then why it was particularly important by the time we came to the pandemic. So could we start there.
DR SUNTHARALINGAM: I think the broadest way to look at it is that it is a way of ensuring the patient's informed wishes are taken into account when making what are

inevitably time-critical decisions. By the nature of these conditions, they can happen quickly, some unexpectedly, and wherever possible the patient's wishes and values, their own thoughts about what will happen to them and what outcomes they would like should be known where possible.
MS CAREY: So outside of the pandemic one might, for example, embark on an advance care plan if they know they have cancer and unfortunately that it is now at a terminal stage?
DR SUNTHARALINGAM: Yes, I think anyone who, for whatever reason, is nearing the end of their life, to their knowledge, or is at risk of death for whatever reason.
MS CAREY: Now, there are various iterations of forms but there's one I would like to ask you about, acknowledging as I do that it is not the only form out there. But can we have a look, please, at the ReSPECT form. Can you just help us please, what is this intended for?
DR SUNTHARALINGAM: So this is a model which, and to make this point, it really encapsulates what is already good practice, so it is not new policy. What it brings is a way of systematically looking at things which are already known to be important, and that includes establishing a shared understanding of the patient's condition, what outcomes they value and fear

importantly, and what medical treatments would benefit them and it is a structured way of looking at that in a way that leads to being able to write down the information for reference when it becomes relevant.
MS CAREY: It has been, I think you say, implemented in parts of England and Scotland since 2016 and I think it is currently being implemented across Northern Ireland. I will deal with Wales separately, but let's just look at the form itself.
Obviously it has got the patient's details in there, the diagnosis or relevant information, communication aids, whether they need an interpreter. Would this also be used, for example, if someone had perhaps a support worker or needed someone to help communicate perhaps if they were learning disabled. Would that information all be included in there?
DR SUNTHARALINGAM: Yes, I think anyone close to the patient and able to represent -- firstly help them with the decision-making and also able to represent them.
MS CAREY: Then there is a box of:
"Details of other relevant planning documents and where to find them."
And "Advance Decision to Refuse Treatment" is different, isn't it, as I understand it?
DR SUNTHARALINGAM: Yes. So that's a legal instrument. Not

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

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

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

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

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

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

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

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

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

form, is it?

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

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

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

MS CAREY: Right.

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

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

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

DR SUNTHARALINGAM: Yes.

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

DR SUNTHARALINGAM: Yes.

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

DR SUNTHARALINGAM: Yes.

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

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

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

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

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

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

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

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

LADY HALLETT: Right.

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

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

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

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

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

DR SUNTHARALINGAM: Yes.

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

DR SUNTHARALINGAM: That's my understanding.

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

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

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

DR SUNTHARALINGAM: Yes.

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

DR SUNTHARALINGAM: Yes.

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

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

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

so that everyone can follow what you are talking about.

Could we have INQ000227411, please.

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

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

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

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

DR SUNTHARALINGAM: Yes.

MS CAREY: -- pending location of the form?

DR SUNTHARALINGAM: Yes.

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

it must be filled in at the front of the patient's healthcare record --

DR SUNTHARALINGAM: Yes.

MS CAREY: -- and we'd hope it would be somewhere visible. All right?

DR SUNTHARALINGAM: It is worth saying that the verbal information about this, although it should be backed up obviously by the document as well, form part of handovers and ward safety briefings and so on so the information is passed on from shift to shift, as it were, or at handover.

MS CAREY: Okay. Now, I think there are different circumstances in which a DNACPR notice may be made.

Is this right, firstly, they can be made in advance where the person has the capacity to say, "I don't want CPR"?

DR SUNTHARALINGAM: Yes.

MS CAREY: All right, and we have looked at an example of that on the ReSPECT form, someone may come to that decision of their own volition?

DR SUNTHARALINGAM: Yes.

MS CAREY: If someone comes to that decision, is that decision respected? It is?

DR SUNTHARALINGAM: Yes.

For them to come to that position, they should

obviously be able to have all the information about their condition, which they have themselves, but to have clinical scenarios explained to them or might be relevant to this if they are acutely ill or things are deteriorating, and despite access to support as well, having written information where feasible. So, again, it all comes to the benefits of having that discussion early.

MS CAREY: Early. All right. Understood. There may also be circumstances, though, where it is a medical treatment decision, made by clinicians such as yourselves, that CPR should not be offered because it is not clinically appropriate, and I want to be clear about that. In the circumstances where a clinician says, "We shouldn't do CPR because it won't work", does the patient or their loved one have to consent to that clinical treatment decision?

DR SUNTHARALINGAM: No, they should be aware of it, and should be able to be involved in it and, if necessary, question it, but they don't specifically consent to it. It is about what treatment may be clinically appropriate and is on offer, so to speak.

MS CAREY: Am I right, though, that the law does require the patient, if they have capacity, or their carers/loved ones, to be consulted --

DR SUNTHARALINGAM: Yes.

MS CAREY: -- where a clinician has decided that there should be a DNACPR notice?

DR SUNTHARALINGAM: Yes.

MS CAREY: Right. And is this the position, a patient or loved one cannot demand CPR if it would be clinically inappropriate?

DR SUNTHARALINGAM: That is right. It is a treatment decision and the treatment itself, it is not a switch where you simply decide to save someone's life, it is a treatment process often quite intrusive, and it is like any other treatment: you do it because you think it will work.

LADY HALLETT: Sorry to interrupt. You say it is a legal requirement that a patient should be consulted before the decision is taken. Just looking at the form, I appreciate that there are several boxes which include having discussions with those close to the patient at box 4, for example. But I'm just a bit concerned; box 1 or question 1:

"Has the patient appointed a health or welfare attorney to make decisions on their behalf? If yes, they must be consulted."

Surely that is not highlighting the fact that there is a legal requirement that loved ones of the

patient to be consulted by just taking the health and welfare attorney example. Do you see what I mean?

DR SUNTHARALINGAM: Yes, yes, my Lady.

I think the way -- I think the issue of a chronology is -- my understanding of this is that this shouldn't come as a surprise, if you like to the patient or those close to them after the event, it is not necessarily the same as saying they must be consulted first, so they should be made aware of it, and I agree it should be anyone that is in a position to be a representative of the patient if they themselves can't take part in that discussion.

LADY HALLETT: I just wonder if that form should be clearer?

PROFESSOR SUMMERS: I think the other important thing is this is just one DNACPR form of one particular organisation, I do not think there is one unified --

LADY HALLETT: They won't necessarily be the same.

PROFESSOR SUMMERS: It won't necessarily be the same in every single institution. This is just one example of such a form.

LADY HALLETT: No. I'm just --

MS CAREY: So this one, for example, does not refer to loved ones, families, carers and the like, and people with a power of attorney are in a potentially slightly different category, it doesn't even mention that. But

I don't want anyone to be confused between who has to be consulted.

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

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

DR SUNTHARALINGAM: Yes.

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

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

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

DR SUNTHARALINGAM: It's correct, and it is worth making the point at this stage, which is relevant to other discussion as well, that a patient's capacity can be a stable fixed condition or it can change. So if somebody is confused and delirious on one day, they may not be

the next, and even with the attorney involved, if the patient has capacity on the day, then that takes precedence.

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

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

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

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

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

DR SUNTHARALINGAM: Yes.

MS CAREY: -- something along those lines.

DR SUNTHARALINGAM: Yes.

MS CAREY: Has an appropriate discussion taken place with those close to the patient, the health and welfare

attorney, or a IMCA?

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

DR SUNTHARALINGAM: That is an independent advocate for --

(Unclear: simultaneous speakers)

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

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

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

However, if they then, under the existing treatments, get better, then it may be -- and if that acute condition was part of the reason for the DNACPR, then that may need to be reversed. So it is very much a live document that is always under review.

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

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

LADY HALLETT: Right. And then box 8:

"Copies of the DNACPR decision have been sent to:

[The] patient/carer

GP

Nursing or Care Home."

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

DR SUNTHARALINGAM: I think --

LADY HALLETT: Or is that either/or?

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

LADY HALLETT: And then if we just keep scrolling down slightly:

"All boxes must be completed.

In the event of cardiac or respiratory arrest, no ... (CPR) will be made. All other ... treatment and

care will be provided."

Clearly, I think you have made the point a number of times already in your report that a decision to not perform CPR is not the same as not treating someone in all other respects.

DR SUNTHARALINGAM: Yes.

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

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

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

I suppose talking you through the nuts and bolts of how one does that, you usually would be meeting face to face wherever possible with those family and loved

ones and the place in which I would normally start those conversations is to ask the loved ones what's their understanding about the clinical situation in which we are, so that we can all start from the same place.

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

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

I'm usually very clear that I'm not asking the

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

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

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

PROFESSOR SUMMERS: Absolutely yes.

MS CAREY: And if a second clinician comes along and says, "No, I think it is clinically inappropriate", at that point is the DNACPR notice made?

PROFESSOR SUMMERS: Yes, but I would say that we would make

tremendous effort to try and reach an agreed understanding of the situation. I don't think it is in anybody's interests for there to be wild disagreement. Because this is the family's loved ones, trying to explain why we are where we are is important.

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

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

That differs enormously from the usual clinical practice when the patient's loved ones would often have been at the bed side and seen that deterioration over days and I remember very often people who came into intensive care for Covid had been in hospital for a few days beforehand, so they had deteriorated over some days

and then come to us because of the course of the clinical illness and they would not have seen any of that.

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

PROFESSOR SUMMERS: Yes.

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

PROFESSOR SUMMERS: They were hard because you have never been in the same room as that individual. They have someone who therefore they have not met talking to them about a situation that they have not been able to witness over a period of days, in a very remote and disconnected way, either via telephone or via Zoom and we were having to have these conversations in greater number than you would ordinarily because the number of patients in critical care was greater and the level of severity of the illness and the outcomes were, overall, worse than they would be for the usual ICU population. So you would have done several ward rounds and then maybe making several of these calls in the course of a day to explain to a family the situation their loved one was in. It was not easy for the families or for the

healthcare staff.

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

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

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

PROFESSOR SUMMERS: I do not.

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

DR SUNTHARALINGAM: No.

MS CAREY: We have heard of them, clearly, in a number of respects. Can I ask you this, the Inquiry has also heard there were some examples of families whose patients had been discharged and have subsequently found

out that there is a DNACPR on their record. What is the circumstances -- what is the process then if someone says, "Well, there is one on my record and I'm awake now and I'm alert and I'm better", how does one go about having a DNACPR notice reviewed?

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

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

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

Can I ask you about the CQC findings.

LADY HALLETT: Just before you do that, I have also heard from a large number of bereaved families that not only did they find out about the DNACPR notice on their loved one's records but that they weren't consulted or no discussion took place with them and they knew their loved one was not in a position to have had

a discussion. Are you aware of situations where notices were put on without any discussion with the patient because the patient didn't have capacity and without any discussion with the family member?

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

LADY HALLETT: Is your setting a large teaching hospital?

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

LADY HALLETT: Oh, I see.

DR SUNTHARALINGAM: -- (overspeaking) -- these sort of discussions are really part and parcel and it is not to say they wouldn't be for other people but it may have been a DNACPR decision that was in records from much earlier, may have been made in a very different setting. It is difficult to comment without knowing --

LADY HALLETT: It could have been made in a setting -- in a ward where maybe the staff weren't not used to -- as you are, obviously, sadly, too used to this kind of discussion or process -- but they could have been made in situations where the staff weren't as familiar with the process that needs to be gone through.

DR SUNTHARALINGAM: Potentially, and I think some of the potential benefits of widespread treatment escalation planning such as a ReSPECT form, part of that includes normalising discussions, not only for the public and the patients themselves but also for all staff in all areas, so it becomes part of the process of healthcare for those patients where it is appropriate. So they are at risk of dying.

LADY HALLETT: Sorry to interrupt.

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

Could we call on screen INQ00474255_27.

My Lady will recall there was an interim report and then a final report done by the CQC and it really just picks up on the questions your Ladyship was posing. The CQC found that the healthcare professionals they spoke to:

"... recognised the importance of ensuring the

conversations around advance care planning ... But how well people were involved in conversations about their care and whether or not they wanted to receive [CPR] varied. Some people experienced compassionate, person-centred care where they were fully involved ..."

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

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

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

DR SUNTHARALINGAM: Absolutely yes. I think it is worth just starting with the point that I believe this is the CQC report about what was happening in nursing and care homes and at an earlier stage of the pandemic and things

did improve after, so it partly reflects the sort of multitude of policies and changes early on. But I think your wider point, I absolutely agree.

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

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

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

Now, you two, I'm afraid, have to deal with this more often than a number of other staff. Can I ask you, who practically do you think should be responsible for training those who are not working in critical care or

end of life treatment? Who would be responsible for providing that kind of training? The Trust, the hospital, NHSE, the regulators?

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

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

PROFESSOR SUMMERS: Yes.

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

PROFESSOR SUMMERS: Certainly the matrix for intensive care positions and members of the Royal College of Physicians includes having the skills on keeping up to date with both the legal and the professional best practice.

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

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

Can I just start like this: I think it is obvious from what you have said that clinicians make decisions about who should be admitted to care on a daily basis. I think you told us last time that you would have

a discussion with the ward if the ward thought the patient was deteriorating and you would be involved then in deciding whether it was appropriate for the person to be admitted to ICU.

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

DR SUNTHARALINGAM: I believe so, yes.

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

DR SUNTHARALINGAM: No.

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

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

MS CAREY: And if I understand it, I think on 21 March you and two other colleagues were asked to form a group to consider the clinical prioritisation model to be used in the event that the NHS critical care resources were

saturated, by which I mean there was no bed available.

DR SUNTHARALINGAM: Yes.

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

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

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

DR SUNTHARALINGAM: Essentially, yes.

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

DR SUNTHARALINGAM: No.

MS CAREY: Or, indeed, a neighbouring region that could be sensibly someone transferred to?

DR SUNTHARALINGAM: That is right, and in the context that mutual aid and decompression would already have happened

so essentially talking about -- (overspeaking) -- which would be a very extreme scenario.

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

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

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

Could we call up on screen -- thank you very much -- a summary of how the framework was proposed. I won't necessarily go through all of these but we can

see there it was designed to effectively only operate once CRITCON 4 was declared in one or more regions and where CRITCON 4 is declared, NHS England, in this case, have to be notified so they know the position and all other possible sources of mutual aid between hospitals have been exhausted.

DR SUNTHARALINGAM: That is right.

MS CAREY: So it really is in extremis?

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

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

DR SUNTHARALINGAM: Absolutely.

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

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

DR SUNTHARALINGAM: It was the discussion we had earlier really about having -- although it's useful to think in terms of notional surge capacity, those are, sort of, fairly abstract numbers and if units are becoming

realistically saturated under the conditions at the time, that's what's going to start influencing clinical decision-making, albeit subconsciously, and in practical terms through simple lack of available beds. So that is the realistic frontline conditions in the view of those working there that needs to feed into this level of realistic decision-making. And percentages of notional total surge capacity may not help with that.

MS CAREY: Then 110.4:

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

What was that trying to convey?

DR SUNTHARALINGAM: It was really the point we made earlier that this is reflecting -- this is not about triaging people in the sense of saying they will never get an intensive care bed unless that is the clinically appropriate scenario in any case, but under pandemic conditions it is not about ruling people in or out, it is saying for the next available bed who should take precedence over somebody else on the grounds of survivability using these principles.

MS CAREY: Right. In a scenario where you have two patients

and both are eligible and it is appropriate to escalate them to ICU, you would use the tool to say that person should be number 1 to get that bed and then if one becomes available, the next person gets it. Is that how it was meant to work?

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

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

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

MS CAREY: So you were not asked, nor did you in fact, I think, consider the possibility of having to take someone off a ventilator, for example, to make room for others; that is not what the tool was designed for?

DR SUNTHARALINGAM: No.

MS CAREY: Understood, all right.

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

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

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

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

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

MS CAREY: Can I pause you there. Do I take it from that

that prior to the pandemic there was no in extremis saturation tool available?

DR SUNTHARALINGAM: No.

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

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

MS CAREY: Is there any, do you know, will or desire among the medical profession to have a tool such as this in case we find ourselves again in a situation where we are overflowing in ICU beds?

DR SUNTHARALINGAM: I would say yes. Obviously, having been

involved in that particular point of view, but I think genuinely looking at wider discussions there was a need for it and, to be clear, it is not about a tool that you pick up and start using on your own, it is knowing that there is something -- there is a plan in the background that may be activated and I think that in itself provides reassurance for people.

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

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

DR SUNTHARALINGAM: That is correct. On 28 March when the work for the quintet of CMOs and National Medical Director was stood down on the grounds that, at that stage, it looked as if the first wave was as seceding

and the tool wouldn't be needed, there was a discussion around publishing it so it could be developed openly and with as much professional and public input as possible by a professional society.

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

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

DR SUNTHARALINGAM: Sure.

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

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

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

DR SUNTHARALINGAM: That is correct.

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

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

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

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

But in that context, in terms of applicability, the document has statements of moral and ethical principles which are applicable to any crisis, and potentially outside a crisis. It has a statement about

shared escalation, mutual aid, the CRITCON framework, which are also -- should apply to any crisis.

And then the tool at the end is specific to Covid, and would need to be re-assessed, re-designed as indeed it would have done during the pandemic itself if it were in use, because it was based on available data at 28 March, or would in any case have been adapted.

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

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

DR SUNTHARALINGAM: Yes.

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

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

MS CAREY: Yes, let's go back to that then, because that is a more general application.

DR SUNTHARALINGAM: Yes. To some extent this is a further version of the discussion about CRITCON that we had

previously. But I think the bits to highlight here are that usual decision-making applies when we are at CRITCON 0 to 3, with the sort of blue arrows saying that.

MS CAREY: Yes.

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

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

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

MS CAREY: Right. Can I just then finish on this topic. There is this prototype that could be adapted in the event of future need. I think you make the point in your statement that there is a potential benefit to discussing this in non-pandemic times --

DR SUNTHARALINGAM: Yes.

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

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

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

MS CAREY: I wonder if we could leave that topic there.

My Lady, I'm moving to a new topic. It is a little early, but I can start the new topic or we

might perhaps take our mid-morning break?

LADY HALLETT: No, that's absolutely fine.

I shall return at 11.45 am.

MS CAREY: Thank you, my Lady.

(11.25 am)

(A short break)

(11.46 am)

LADY HALLETT: Thank you.

MS CAREY: Thank you, my Lady.

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

I wonder if we could call up on screen figure 11 at INQ000474255_0060.

With your help, Professor, I would like you just to explain -- we are not going through all the regions but all four nations are represented on this figure, which is the regional increases in occupied ICU beds above baseline, provided by The Intensive Care Society, and it is really to get a sense of how different it was

in 2021 than how it was in 2020, or, in some cases, it is the data from 2019.

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

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

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

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

PROFESSOR SUMMERS: Yes.

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

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

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

PROFESSOR SUMMERS: Intensive care is a multidisciplinary package of care for patients. All of these people and others besides, like the ICNARC data clerks that we heard about from Professor Rowan when she was speaking, administrative staff, support staff, are all required.

And you can see some of these ratios are absolutely extraordinary.

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

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

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

PROFESSOR SUMMERS: In most cases, yes.

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

You make the point there that the data doesn't tell us entirely accurately the people that were receiving critical care outside of ICU. I think you say in your report there was also a fall in admissions, for example, those people that had suffered a heart attack and stroke. There was a significant drop in the number of those people attending ICU.

Could we have on the screen, please, figure 12a,

which is a very neat depiction -- there we are -- of the fall in the number of admissions to intensive care.

This is data that comes from ICNARC, my Lady.

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

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

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

PROFESSOR SUMMERS: So, I guess, to allude to the myocardial infarction graph that we were shown, I think there is data that very eloquently speak to the fact that not only were they not appearing in intensive care units with myocardial infarction, people were not appearing in hospital. And that actually, as a result of changes in behaviour, and in people's trying to, I guess, do the

best that they could, and people were probably dying at home rather than being admitted to hospital and having the care from hospital and, as a consequence of that, intensive care units that they might have done otherwise for their myocardial infarctions, and you can see that the decrease in admissions to ICU happened both in the peak of spring 2020 but also again in January/February 2021. So both of those coincide.

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

All right, now on to older people --

PROFESSOR SUMMERS: Yes.

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

PROFESSOR SUMMERS: There are several lines of evidence that suggest that at peaks of the ICU strain, that people who were admitted to intensive care, despite there being no national change in policy, may actually not have been

the same as those at times of less strain. And I think that Professor Rowan spoke to some of this, but to reiterate, one example of the data supporting that proposal comes from ICNARC that looked at admissions to ICU during the first wave, and they found that people who were admitted during that wave were younger and less severely ill when compared to those who admitted pre and post-period. So that was my paragraph 161.

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

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

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

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

PROFESSOR SUMMERS: There is a second line of evidence that comes from a different organisation that suggests that this may have been the case. So ISARIC, by their clinical characterisation group, tracked the clinical longitudinal paths of just over 142,000 people who were admitted from across the four nations of the United Kingdom with Covid to hospital between March and

December 2020, so again covering the sort of wave one period rather than wave two.

MS CAREY: Yes.

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

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

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

MS CAREY: Understood. Now why that might be may be difficult to ascertain, but can I ask you this: was there any policy or diktat that said: don't admit older people or anything of that nature?

PROFESSOR SUMMERS: I'm aware of absolutely no circumstances

in which a policy was issued about age as a cut-off in the United Kingdom.

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

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

MS CAREY: Understood. I think, though, Professor, you are aware of the research that was conducted by the Inquiry and have seen the findings of the survey. Can we have up on screen INQ000499523_0017.

This is a slide depicting what happened during the first wave and people contributing to the survey, and there were nearly 1700 healthcare professionals who were spoken to UK-wide. If one looks at the critical care nurse and the critical care doctor, they were asked during the first wave how they were able to escalate by role the frequency of their inappropriate to escalate,

and the critical care nurses said that there was 20% of them that had to make a decision about that on a daily basis, 19% for critical care doctors, and we can see the varying statistics there.

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

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

The survey asked about the reasons for difficulty escalating, and if we could highlight the two columns that deal with "Critical care nurse" and "Critical care doctor", one can see that "Lack of available beds for high dependency care such as high flow oxygen or CPAP", look at the figures there for critical care nurses and critical care doctors, that clearly was a reason they felt unable to escalate.

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

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

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

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

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

MS CAREY: No. If one just looks, please, at page 22, Professor, there is a quotation given there from a critical care doctor in Wales. And they were giving their experience of escalating care, they said:

"We knew it wouldn't help because we had come to

see what kind of people died of this disease despite escalated care. So we decided not to admit to critical care whereas had they had a different illness, they probably would have been more likely to benefit so we would have escalated. We didn't have enough space to 'give people a go' who had a very remote chance of getting better. If we had had more capacity, we might have been in a position to try."

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

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

Can you help with how acting in conflict with your roles and your values affected the staff on the ground, Professor?

PROFESSOR SUMMERS: I can. I think we heard very powerfully

the other day from Professor Fong, he organised and led the peer support programme of visits. I should declare that I also participated in leading and attending some of those visits, and some of the evidence that he shared is evidence that I was privileged but also unfortunate to have to hear from staff members, from various regions of the United Kingdom. I am only too painfully aware of the conflict and the moral injury that occurred to, particularly, critical care nurses, but healthcare staff of all kinds during the pandemic.

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

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

PROFESSOR SUMMERS: Yes.

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

PROFESSOR SUMMERS: So there was work undertaken, again actually led by Professor Fong in an academic capacity to undertake a series of surveys at different points, looking at how staff were doing in terms of their well-being and actually 56 hospitals in England

participated with round about 6,000 respondents across the time points. And it happened before the winter 2020/21 peak and during and after the winter 2020/21 peak.

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

And what were those disorders, please?

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

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

PROFESSOR SUMMERS: So I think it found that later on, at peak, those symptoms were increased in prevalence, as you would expect. I mean, no one can be surprised by this. You have a healthcare system and healthcare staff that were under tremendous stress in wave 1 or in spring 2020. The pressure never fully came off during the

whole of 2020 and then going into 2021's peak, there was both the demands of a greater number of critically ill patients, alongside the demands of trying to resume elective surgical care and many of the people who were trying to support the ICU surge are the same people who are required to undertake the delivery of elective surgical care.

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

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

PROFESSOR SUMMERS: I did not.

LADY HALLETT: He was talking about something else initially but he was asked about giving evidence here and one of the things he said was that the kind of impact that you have just described on staff is continuing today and so if anybody is trying to make sure the NHS works in a way

that we would all hope, that we have to remember the impact on staff is still having an effect.

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

LADY HALLETT: Doctor, you are nodding.

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

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

"We coped but only just."

PROFESSOR SUMMERS: Yes.

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

PROFESSOR SUMMERS: I think what is often forgotten is that the catastrophic failure of the healthcare system would not be a switch that was just thrown in an instant where we went from everything being okay to everything not being okay the next second. It is in the dilution of

a million and one tiny little things, particularly in intensive care. We are a speciality of attention to detail. Every single tiny little bit of attention to detail is what makes the difference and cumulatively provide better outcomes for patients. When we stretch those and we are unable to pay the attention to all of those details in the way that we would want to and that we know we are capable of, we are failing our patients really, or at least that is how it feels to us. We are not providing the care that we would want to if -- and that we would want for our own families.

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

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

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

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

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

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

So it felt under pressure. It felt dangerous. It felt like shortages. Numerically, intensive care was arguably better than some other areas. Also due to decisions that FFP3 was used universally and that wasn't the case elsewhere in the hospital. And arguably should be.

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

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

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

So, appropriately, things were kept under review and disseminated as they changed but at the frontline I think it felt difficult to keep abreast of all of it and on the background of people's concerns that they were getting what they needed.

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

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

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

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

DR SUNTHARALINGAM: So this was something where there was, again, debate about, including in elements such as resuscitation, which you may hear about from another witness. Also some professions and specialities, as we have heard from Professor Summers, it is a very multidisciplinary profession and particularly speech and language therapists felt that some of the interventions they do weren't adequately recognised.

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

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

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

MS CAREY: Finally, please, this. I would like to ask in a minute about recommendations but can I just draw together some of the things that you have been telling us during the course of your evidence.

There was clearly a significant impact on those working in ICU. Was any support in place to help the critical care nurse, those that were redeployed? Was

there any support in place during any of the waves of the pandemic.

Perhaps, Professor, if I turn to you first?

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

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

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

Q. Shutting the door after the horse has bolted may be a very inelegant way of putting it. But you have to tackle the underlying problem. That's what I really wanted to ask you about.

You have set out in your report a number of

lessons learned and recommendations and I wanted to ask, we have heard a lot about the stretching of ratios within the critical care setting. Do you know if there is any research ongoing to understand the minimum safe staffing requirements that we could stretch to if we needed to in the event of a future pandemic?

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

DR SUNTHARALINGAM: I think just less academically but from practical experience, I think something learnt during the pandemic was, just to put a figure on it, very unscientifically, but the 1:6 ratios originally proposed caused excessive strain even in this context.

So moving to a 1:4 during the course of the pandemic before wave 2, which in a practical sense meant

earlier decompression of the hot sites rather than letting them get to 1:6 and then seeing what happened next I think was a crucial step. So whatever the number is, it's more likely to be 4 than 6, in a surge pattern.

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

DR SUNTHARALINGAM: Absolutely, yes.

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

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

DR SUNTHARALINGAM: Thank you. It was largely just because I was a bit vague to answer your question before. So in terms of a practical aspect of how this could be, sort of, addressed. But, really, the wider topic is of making sure that everyone who has an interest is involved. We can work on developing moral and ethical principles for an agreed, fair and just framework for allocating healthcare if demand exceeds supply, so in a crisis.

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

Thank you for that.

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

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

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

PROFESSOR SUMMERS: I'm happy to go first. I think the thing that I would like to emphasise is that intensive care is, as we have entitled the report, the last line of defence. We are required when everything else has failed, when prevention hasn't worked, when improving

and tackling health inequalities, all of those other things, have not prevented disaster arriving at our door and intensive care is a supportive care package. It did not change the trajectory of the pandemic. What changed the trajectory of the pandemic is therapies and vaccines and our research being embedded into the care system. If we do not ensure that that is a continued line of defence, it doesn't matter how much resource we put into healthcare systems, in the absence of being able to change the trajectory of any kind of emergency we will potentially exhaust all capacity.

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

MS CAREY: Ideally we wouldn't need you.

PROFESSOR SUMMERS: Exactly.

DR SUNTHARALINGAM: Exactly.

MS CAREY: And Doctor?

DR SUNTHARALINGAM: Thank you.

Firstly, I would very much agree with that, that intensive care is to provide life support while the disease gets better, so we need to address that, I

completely agree with my colleague.

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

So a body such as The Nuffield Foundation or The King's Fund or a university, to look at it independently with expert input from the critical care bodies but also all of those involved in acute care as well as epidemiology experts.

So really a baseline look from the ground up at what critical care in the UK should look like, and then

what can be afforded and provided becomes a separate discussion and I think this is a piece of work that hasn't been done but the pandemic should be a trigger for doing it.

MS CAREY: Thank you very much.

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

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

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

LADY HALLETT: Doctor?

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

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

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

LADY HALLETT: Thank you.

The next person to ask questions is Mr Jacobs. Please don't worry about turning your back to me as long as your reply goes into the microphone, thank you.

Questions from MR JACOBS

MR JACOBS: Yes. Thank you.

Just one question, actually, on behalf of the

Trades Union Congress, and it takes up, Doctor, what you were describing a moment ago in terms of the recommendation for a UK-wide review of baseline capacity and an objective assessment of whether it is adequate and matched to local health needs.

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

PROFESSOR SUMMERS: I guess I might to pick that up, reminding everybody that there are OECD figures for the number of intensive care beds per 100,000 population is one way of looking at the problem, but that doesn't take into account individual health inequalities and health need and burden of particular areas of geography. So the situation in how healthcare systems are delivered in one country compared to another, and the health inequalities in those, don't make that a straightforward calculation, so I would hesitate to give a precise number. It is more than we have because I do not think -- I think we have demonstrated we do not have the capacity that we should do for routine care, let alone in pandemics, but I think it needs to be properly conducted piece of work, and no one has done it.

DR SUNTHARALINGAM: And I think just to add to the previous

point about where it is as much as how much it is. As somebody who works in London, I might be arguing against myself, but it is -- is everything in the right places and properly distributed around the regions and nations?

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

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

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

MR JACOBS: Thank you very much.

LADY HALLETT: Thank you, Mr Jacobs.

Who is next?

Mr Odogwu.

Questions from MR ODOGWU

MR ODOGWU: My Lady.

Good afternoon. I represent the Federation of Ethnic Minority Healthcare Organisations which advocates for healthcare workers from ethnic minority backgrounds who were disproportionately impacted by the pandemic.

My question is probably best addressed to Professor Summers, but I'm happy for Dr Suntharalingam to answer if better placed.

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

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

PROFESSOR SUMMERS: So I recognise very much the evidence that you reference has been heard by the Inquiry. I could not find systemic data that outlined that problem for any of the nations. That doesn't mean that

it doesn't exist. What it means is there was no publicly available data that I could find. I'm not denying that that was the case, just that I could not find a data source to be able to reference.

Q. The data gap. Okay.

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

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

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

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

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

workers?

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

MR ODOGWU: Thank you very much, my Lady.

LADY HALLETT: Thank you very much.

Next, I think it is Ms Mitchell who is directly ahead of you.

Questions from MS MITCHELL KC

MS MITCHELL: (inaudible).

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

MS MITCHELL: The microphone appears on.

LADY HALLETT: Yes, you're on now.

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

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

Firstly, it is in relation to the confusion surrounding some of these notices. I don't need to take you to it, but at paragraph 40 of your report you state that:

"A DNACPR notice is not meant as a proxy for broader treatment decisions. However, in the absence of

[a] clearly documented discussion and decisions about other forms of treatment, there is a potential for inappropriate over-interpretation of DNACPR[s] as a generalised treatment limitation option."

Now, I presume that that potential for over-interpretation is in respect of medical professionals, not of families and patients? Is that correct?

DR SUNTHARALINGAM: Potentially, although arguably it could be both; if that's the only discussion around treatment limitation that happens, then people may go away thinking that's been the wider discussion, and -- I say it can also lead to misinterpretation in the healthcare community. So going back to treatment escalation planning such as the ReSPECT form which is being implemented in parts of Scotland, part of the argument before having that broader discussion is to be very clear about which is the CPR decision and which is around other treatments, and having the opportunity for people to say, "I would like for myself or for my loved one active treatment, but I hear that CPR might not be the right thing for them. We can draw a line there, but other treatments should be actively pursued", which is actually a very standard set of circumstances, and it avoids the risk of the DNACPR itself being

over-interpreted to cover other aspects of healthcare.

Q. And indeed, one might make sense of that in terms of the recommendations that you have made in that regard.

What I would like to ask on behalf of the Scottish Covid Bereaved about those potential over-interpretations or, as you describe later, potential misrepresentation, is: what were the possible implications for patients of those things that you describe?

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

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

Q. Can I ask you, moving on from that, you spoke about the questions, in fact my Lady posed a question to you about how the bereaved found out that there were DNACPRs sometimes from their loved ones who were still with us or sometimes sadly no longer with us.

Families were excluded for very good reason

obviously on occasion from being with their loved ones when they were in hospital. Was the exclusion of loved ones from visiting a possible way that inadvertently DNACPR discussions were lost for families at that time?

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

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

DR SUNTHARALINGAM: I don't -- as far as I'm aware, no. In that the principles are the same. The legal position, I think, is roughly similar in that although the legal position of advanced decisions to refuse treatment and

so on is different, the DNACPR is an advisory notice, and the principles that it should be discussed with a patient where possible, that people should be informed, that it guides treatment options, I think, are the same across the nations.

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

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

If the DNACPR reflects fixed factors, such as their stable condition or where they are in their life in terms of getting towards the end of their life, in terms of a natural death, then that may not be necessary for review on any particular timetable.

If there is any sort of formal system for that, that's different between the countries I'm not aware of

it, I'm afraid.

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

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

So I think it should be reviewed where clinically appropriate, and where patients feel that they wish it to be reviewed too. Setting a hard and fast time point of reviewing it every so many days might not necessarily facilitate the kind of patient discussions that we would all hope for.

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

MS MITCHELL: I'm obliged my, Lady.

LADY HALLETT: Thank you Ms Mitchell, very grateful. Ms Woodward.

Questions from MS WOODWARD

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

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

And you set out that this was:

"... (conscious or unconscious alterations in decision-making by individual clinicians rather than due to policies or guidelines being issued) ..."

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

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

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

PROFESSOR SUMMERS: I think that is one interpretation of the situation. I guess what I would like to be able to give you a definitive answer is absolute concrete data to say that that was the case. I have, in writing this particular section and it was me who drafted this particular section, set out the data that I could find to support that there may have been a change in the people who were admitted to intensive care units whilst acknowledging, as you rightly highlight, that not everybody who was critically ill was admitted to a intensive care unit, and often critically ill treatment was carried out in places that would not normally do so.

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

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

So I would make the wider point that it is the role of national bodies to step into that breach and

support not only their members but the wider patients and public in order to provide variation and provide consistency among the four nations, but also to make sure the staff don't have that moral injury of feeling themselves in that position without external support of people that are meant to be representing and protecting them.

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

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

DR SUNTHARALINGAM: I would echo that among the three nations including Wales, because although they weren't specifically using CRITCON as a tool due to different

sizes and layers and the complexity, but I think that information about local strain was being passed up and down the chain in a similar way, so I think had that -- hospitals reached that state, it would have been transmitted in a way that then triggered the activation of further measures, and that wasn't the case.

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

PROFESSOR SUMMERS: So, to be really clear, there is a very big difference between prioritising whether critical care is appropriate for an individual patient, and we know from data before the pandemic that people sometimes, when their intensive care restrained vary in a soft or ill-defined way, the way in which they make those decisions -- I think the data from Wales, the doctor said in the survey about patients who they think might not make -- have benefit from critical care, but there is a small chance they might on some days would get admitted, but at times of strain would not, that is a very different thing from triage by absence of resource.

Q. Do you think that there was any scope for further

guidance to perhaps bridge that gap where critical care was reaching saturation but we weren't quite at CRITCON 4 or the equivalent for the devolved nations?

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

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

Q. Thank you.

Given the evidence that we heard earlier from you, Professor Summers, about older people being less likely to be admitted into ICU during the surges despite no

policy that you were aware of regarding this, is it likely that the elderly were disproportionately disadvantaged by unconscious or conscious alterations in decision making made on an informal basis?

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

Q. My next question is about continuous positive airway pressure, or CPAP, as it is more commonly referred to.

If we could bring up INQ000480136.

This is a witness statement prepared on behalf of the Cardiff and Vale University Health Board and if we could look at the bullet point right at the bottom of the page. This is setting out the various steps that were taken at the local level by the Health Board to

increase ICU capacity. And it says:

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

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

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

At the very bottom of that paragraph it states that:

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

But:

"There was a notable difference between Wales and England in this regard as many more patients in England had CPAP on ICU."

I wanted to ask you on the basis of this, what the drawbacks and risks are to patient safety of not

receiving CPAP on the ICU and instead receiving it on a ward.

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

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

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

LADY HALLETT: Thank you very much.

Ms Munroe.

Questions from MS MUNROE KC

MS MUNROE: Good afternoon. My name is Allison Munroe, I represent Covid-19 Bereaved Families for Justice UK. I have a few questions. Some of them have been touched upon to a lesser or larger extent during the course of

your evidence.

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

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

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

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

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

Then you add:

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

Doctor, in terms of what we can glean or what we can take from those observations, does that mean that although national guidance and policies had not officially changed or altered there were instances of some local hospitals and ICUs operating a system of

perhaps what -- if I can call it resource-led clinical prioritisation? I don't know if this chimes in this triage in the absence of a resource.

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

PROFESSOR SUMMERS: Thank you.

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

Q. And so on that specific point of resource-led clinical prioritisation, do we simply not have the data, robust data to come to any conclusions?

PROFESSOR SUMMERS: Other than the data that I presented about the changes during the peak of the demographic

characteristics of the people who were admitted, I couldn't find any data and I did look quite hard, but that doesn't mean that it didn't happen, and it doesn't mean it did happen, it just means I could not find data.

Q. Thank you. Staying on the issue of data, ICNARC data, you again touched upon this in your evidence just after the break, and I want to highlight two parts of your report, and I think again you mentioned paragraph 161 on page 64. But the next paragraph, at 162, you note that the ICNARC publication data raised the possibility -- and you put it no higher than a possibility -- that:

"... efforts were directed at saving patients with the greatest chance of survival (those who were younger and previously fitter but with the most severe illness) during the peak of the first wave."

Then you talk about, again, same page, paragraph 164, this group, the 142,000 longitudinal clinical path, where they found:

"... ward mortality was highest when older patients were least likely to be admitted into ICU, suggesting these patients may potentially have benefited from ICU admission."

Just a couple of questions arising from that please. Firstly, is it fair to conclude then that the corollary of that data, and those observations, was that

patients who became very ill with Covid-19 in this period, who required intensive care but were not admitted to ICU, for example, due to old age or pre-existing health conditions and disabilities, effectively had their chances of survival reduced?

PROFESSOR SUMMERS: I think what I was trying to say was that at times of strain, the data and the authors of both these separate publications said that in people who were thought to be less likely to survive, so people who were older and had a greater burden of healthcare, co-morbidity, they were less likely to be admitted into an intensive care unit, and that their mortality was thereby increased.

Now, whether that mortality is increased as a function of the fact that they were thought initially to not be as likely to survive as a younger, less comorbid person, I'm unable to tell. I can tell you that their mortality was increased, and that they were less likely to come to an intensive care unit. Whether those two things are causally related, I can't tell from you the available data.

Q. All right. Secondly, at paragraph 163, you further consider the analysis of the data. And you use a phrase -- it is by the authors of the report, not yours -- rationing of care.

My question is this, Professor: do you accept or believe that the informal "rationing of care", due to a lack of ICU capacity, likely caused or contributed to deaths during this period?

PROFESSOR SUMMERS: I think what I would say is that I have uncertainty. I do not think I can tell you either way. I don't have anything to support it. I cannot rule it out and I cannot rule it in.

Q. All right.

PROFESSOR SUMMERS: If you ask me for an overall impression, I think it would be a very unwise person who tells you that in every circumstance in every hospital across the country, that something happened as it was supposed to happen.

Q. Thank you very much. Then, thirdly, on this related topic and this may be a question for you, Doctor, you spoke earlier about transparency and the need for transparency when you were discussing the clinical tool for the four nations to consider clinical prioritisation levels.

Now, this question is maybe a difficult one because it sort of traverses perhaps moral, ethical and perhaps even political considerations, but do you consider that patients and their families could or should have been told that there were instances -- if

there were instances -- where decisions not to admit them to ICU were based on resources rather than whether or not admission was clinically indicated? Is that something they should have been told or indeed could have been told?

DR SUNTHARALINGAM: I think the question takes the premise that it happened, which we don't know --

Q. Yes.

DR SUNTHARALINGAM: -- and in fact, just to reference your last question, I noticed the quote that you gave came from London, and actually there was a lot of transfer activity and hospital that became overwhelmed would be transferring out. In London, the hospitals are closer -- I happened to work there, the hospitals are fairly close together, the transfer systems were there prior to Covid, to a large extent, so I think it is less likely, if anything, that somebody would simply turn someone away for lack of beds when there is another hospital not far away. But that's just a comment on that particular paragraph, as it were.

I think, to answer your -- the present question, as a matter of principle, I would say yes, they should be told. It is difficult to answer whether they were told because I'm not aware of those particular scenarios happening.

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

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

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

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

Do you believe that as a result of the NICE algorithm and guidance, there was a risk that clinicians would perhaps over estimate clinical frailty scores associated to factors such as age, pre-existing health conditions when considering whether patients were

eligible for ICU admission, ventilation, and other hospital care at a time when there was a severe constraints on resources and capacity?

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

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

Inevitably, in putting things into that sort of framework, things get simplified, and for example, the need for being bed-bound or need for carers and so on becomes part of the assessment. And one of the dangers of it is that somebody who, for example, might need carers for another reason such as learning disability, but that doesn't reflect biological weakness, so to

speak, in their bodily tissues, may become labelled with that. So a clarification was made by the authors of the NICE guidance which was not ours, that firstly this shouldn't be used under 65 where it is not validated. The tool is validated in those older, and that care should be taken to consider other factors.

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

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

So I think I would answer the question that way, which is that the discussion around frailty is complex. Including it in a decision-making tool, in a situation of the healthcare system being overwhelmed is a topic for discussion, and the more discussion and development we have of it, the better. But there wasn't a situation where it would have been used in its current form as we

didn't reach that operational trigger.

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

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

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

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

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

I think, from your answers both to my Lady and to

Ms Carey KC, that you would agree that the poor mental health of healthcare workers during the pandemic is likely or could have been likely to negatively impact upon the quality of care and safety of patients?

PROFESSOR SUMMERS: Unquestionably.

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

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

PROFESSOR SUMMERS: I think that is a really difficult and complicated question that's not easy to answer. How much would be enough to offset what everybody has been through? I'm not sure that for people whose loved ones who were in hospital, for those of us that were in hospital or in primary care settings or in social care settings, there would ever be enough support to make what we all went through better.

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

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

DR SUNTHARALINGAM: I would completely agree with that, and I would like to raise anyway -- without taking away anything from that -- so one positive learning, I think, an improvement has been there is greater emphasis now across the healthcare sector about well-being, but also in concrete terms more ICUs now have clinical psychologists, funded and deployed, and they look after

either the same people or different teams look after the staff or patients. This is part of standard critical care in other countries such as France, and I think this has been an important positive development.

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

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

MS MUNROE: Thank you both very much.

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

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

Thank you for your help in preparing the written report, and, of course, the help you have given in the course of your evidence. It has been extremely helpful. And thank you for your patience, having had your evidence disrupted last week. So thank you again.

2.10 pm.

(The witnesses withdrew)

(1.06 pm)

(Luncheon adjournment)

(2.10 pm)

LADY HALLETT: Mr Fireman.

MR FIREMAN: May I please call Dr Mathieu.

DR STEPHEN MATHIEU (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: I hope you haven't been waiting for too long.

A. No, not at all. Thank you.

MR FIREMAN: Could you please give your full name.

A. Stephen Mathieu.

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

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

A. That is correct.

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

A. That is correct.

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

A. Correct.

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

A. Thank you.

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

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

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

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

A. It is UK-wide. And thank you, that was the purpose of the supplementary appendix. We do our very best to support and to provide a voice for all nations but clearly we do that in very close collaboration with other partner organisations, including the Welsh Intensive Care Society, Northern Ireland and Scottish Intensive Care Society.

Q. Just for clarity, what is the role of those individual societies given that The Intensive Care Society has

a UK-wide reach?

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

Q. Dr Mathieu, we have heard earlier this morning from Professor Summers and Dr Suntharalingam who are obviously in the intensive care sphere. There may well be some of the issues that we will talk about today that they have covered but so that you are aware, we will cover some of those topics perhaps a little bit more briefly. But those are the topics that I was going to ask you about and so just to give you a heads up that in terms of those topics they include capacity, to some degree, ICU capacity, ethical issues, the mental health and wellbeing of staff working in intensive care, and I will ask you a little bit more specifically about some of the work that The Intensive Care Society did during the pandemic.

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

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

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

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

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

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

A. Yes. So the NECCC, the National Emergency Critical Care Committee, was set up at pace and set up specifically for us to understand and support our plans, our understanding, our engagement, our interactions with all the other professional teams, the other disciplines.

So it was set up by Professor Hugh Montgomery and

Dr Ganesh Suntharalingam, who is one of the expert witnesses, and it was done very quickly and it was, I suppose, unique in the sense that it was done intentionally to try and -- for us to understand as much as we could quickly about the SARS-2 virus Covid-19, but also to understand learning from other organisations and other countries, particularly Italy, at that point in time that had just had quite a significant impact from Covid.

It was a very different type of committee in that it was very much bottom up. It was nonhierarchical, it was very much an open invite to those that were able who felt they could offer some support/guidance. So we opened it up to all of our council members and the Operational Delivery Networks leads throughout the country. We opened it up to other societies, so actually, what we also did, which I think was the benefit and the power of it, was opening it up to emergency medicine, acute medicine, British Thoracic Society, the Renal Association. So suddenly we had a lot more granular detail about what their experiences were and how we could support each other.

Q. Just for clarity, was this a series of virtual meetings that were taking place?

A. Yes. So it was set up, as I say, at pace with -- in the

end there were about 30 virtual meetings, there were no face-to-face meetings, they were all done virtually, and there were also knowledge-sharing webinars. So actually, by doing that, we were able to extend our reach to around 100 organisations.

Q. Did those organisations include government agencies or government departments?

A. So they included the presidents of the societies of Wales, Northern Ireland and Scotland critical care and they included some of the medical directors of NHSE. But they also included lots of other important people through military, we had all sorts of invites that actually were helpful to get their understanding, the likes of Google, Microsoft, lots of different ideas to try and generate as much information as we could about data, how we could share it, how we could use it, really as a bit of a hive of understanding and knowledge dissemination.

Q. Just for the Inquiry's understanding, was the Committee more concentrated on information sharing and supporting members or was it involved actually in shaping any policy in relation to intensive care?

A. I think the intent was to do both and, if I may, I will perhaps give some examples. So the context to some of this in terms of feeding information through was that

The Intensive Care Society set up a national leads WhatsApp group very quickly. That was the sort of trying to get an understanding of what people were feeling at a unit-by-unit level, bringing those experiences and information into NECCC to see whether there was -- that sort of information was something that others were experiencing and then trying to address what the problem was and help with some solutions.

So in terms of the guidance, the statements, the policy side of things, one example is we knew that, for instance, that there was a risk around if there would be enough dialysis machines. I think in the end we were able to provide enough options for renal replacement therapy but at the time we weren't sure, so what we were able to do is work very quickly and agilely with other organisations -- I think probably removing some of the bureaucracy that can be associated with committees and associations and how you want to navigate some of this guidance documents by getting straight to the experts and getting the guidance out very quickly.

I guess that was one example.

The treatment decision support guidance framework that has been discussed, that was also discussed at NECCC meetings.

Q. If I could just pause you there for a second. I suppose

you are giving examples of where there were discussions that ultimately then led to the production of relevant guidance albeit not necessarily direct cause and effect; is that correct?

A. Yes.

Q. There were discussions about the relevant issues with professionals within the sphere and some of these points were then taken on and produced in a more formal way; is that right?

A. Yes. I think the intent was always for somebody with the expert knowledge and access to the right people would be the person who would take responsibility for those actions and research is obviously a big part of that, as well as trying to make sure we were asking the right questions and using our directors of research through The Intensive Care Society to help us with that.

Q. Within your witness statement you have set out a number of recommendations for her Ladyship to consider in the context of recommendations around intensive care. One of them is about the Society having a voice -- this is, for your reference, recommendation Q at the second-last paragraph of your witness statement, and you refer to the Society having a voice at the relevant fora informing national policy and decision-making for acute and intensive care, both in peace time and during

national emergencies.

Do I take it from that that you didn't feel that the Society did have the voice that it should have had during the relevant period?

A. We are a charity, we are not a Royal College or obviously part of the Academy of Royal Colleges so therefore I suppose our accessibility directly to higher level, sort of, ministers, is different to the experiences that those organisations will have.

I think we have an important place in those discussions and we do have those discussions but they are often a little bit more difficult to navigate and I think the strength of our place and I think it was demonstrated through NECCC, was that we are genuinely a very multi-professional organisation. We are not doctors, we are not nurses, we are not physiotherapists, we are not pharmacists, we are not the other HPs that are important, the psychologists we talked about. We represent all of them, and that's where I think we have the benefit of being able to provide that different way of thinking and therefore our ability, I think, to extend into those professions and to get their views is an important one.

Q. Do you think there's anything in the fact that you are a charity rather than perhaps a body that might

otherwise be seen to be more part of, to use a colloquial term, the establishment or something to that effect, the fact that you have charitable status and you are not embedded within the institutions, does that have any relevance here?

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

Q. Can I turn to another topic which is something which we did cover to a great degree earlier on this morning, which is that of intensive care capacity. If I can just ask you a few questions about this area. One of these is in relation to the way in which you measure intensive care capacity, and we heard about the fact that it can be measured and was indeed measured in different ways.

You say in your witness statement that on 3rd January 2021 -- this is at paragraph 129 -- that the Society issued a document advising all hospitals to use the percentage change from baseline as a reporting

figure. Do you recall why it was the Society felt it was necessary to issue that statement?

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

The problem happened is that everyone at the early phase of the pandemic was asked to see where there were opportunities to expand their intensive care bed spaces, and we did that, and I think we did that very well. But what then -- the risk that then happened is that those beds that were not intensive care beds, they were pop-up ICUs with different staffing ratios, with access that was different to some of the equipment that we have discussed already, meant that as a result of that, it looked like there was more available ICU bed capacity than there was.

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

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

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

A. So I think why it is important is that we know that when we are at or near capacity, and certainly if we are over capacity, that will have an impact, the impact being the ability to admit patients in a more timely fashion. The ability for staff to stretch to meet those demands because they are already stretched. It also has an impact on decision-making around mutual aid transfers, for an example.

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

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

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

A. Yes, and that was very much the reason that we issued our statement and made it public in the hope that that would be captured, and it did. I think it did influence change. We saw some of the data being better accorded. I have seen, first-hand, within my own region, the way we capture data now is much more advanced and accurate

compared to where it used to be.
Q. One of the measures that was used to try to increase capacity was the introduction of Nightingale hospitals. You touch on that very briefly within your statement but I want to just ask you do you consider that the role of Nightingale hospitals and the use of them was an appropriate way to try to increase intensive care capacity?
A. I think the intent was right in that the data very early on in the pandemic, as we were looking at various scenarios, which obviously at that point we didn't have the vaccine, we were still trying to understand a multi-system pathogen that affects all organs, we were trying to better understand what our therapeutic options were.

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

So I can understand the rationale for looking at it and exploring it. I think the reality as we all then understood is that intensive care is so reliant on a team, a multi-professional team, that need to be in the same place; we need the access to the diagnostics, the other important specialists provide us with their input, and I think with all the best intent, the

Nightingale hospitals were not going to be able to do that reliably for intensive care. It might work in some places, for instance, in London, in terms of decompressing, but the reality is I don't think it will have worked in the way that it was intended to, and in some ways probably was an unintended distraction in terms of us trying to consolidate and manage the workforce that we had within our own hospitals.
LADY HALLETT: Taking up that point, Doctor, given that the staff you had was stretched beyond capacity --
A. Yes.
LADY HALLETT: -- some might argue, and you could only open a Nightingale hospital if you had the staff, the intent may have been good, but the intent was physical beds. How was anybody ever going to staff a Nightingale hospital, given the pressures on all of you working already, full stretch?
A. Yes, I think you have probably eloquently described it in a better way than I have. I think it is exactly that, which is that -- space is one thing, equipment is one thing, but the staff is fixed, and intensive care staff, many of the other speciality staffs, they can't -- we can't just generate them quickly. They take years and years of training, and those staff were not available. So all of these things that we talk about in

terms of stretching the staffing models are all reliant on the existing staff working more, harder, more shifts, all of those things, with the impact that created. So moving them to another hospital not only meant it was the same staff doing that, but actually made you less resilient within your own organisations.
MR FIREMAN: I don't know whether you are able to answer this, but do you think that maybe there is a role for a temporary hospital in circumstances where you need to increase capacity, but that's not necessarily in the context of intensive care?
A. Yes. I think that's probably -- well, I think the first thing is that now, in the situation we are in at the moment, it is something we have to explore, which is what would we do and what would we use it for if we were to ask that same question again, and I think the answer is right, that it wouldn't be used for intensive care. The question is, could it be used for other lower acuity level care, provided it has the right staff mix there available to look after those patients, or as a form of rehabilitation, post-acute illness?

But I think we do need to understand whether -- what the benefits would be in the future, and the impact particularly around the staffing models.
Q. The Society produced a report in January 2021 called

"Recovery and restitution of critical care". I want to have a look at a passage that was in that report. It is INQ000395297, and it is the third page. If we could just look at this text here that has been enlarged. If we look about four sentences down, there is a sentence that starts:

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

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

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

We looked briefly at this earlier today, but if we just come away from this text and look at the box below, you have then mapped these onto the recommended guidelines for the provision of intensive care services. These guidelines, just to be clear, we have heard a lot about staffing ratios, nurses, trained ICU nurses, 1:1 being the ideal ratio, and is it 1:8 for consultants or 1:12?
A. I think it is 1:8 to 12.
Q. 1:8 to 12. Okay, that's helpful. You have set out here all of the additional staff that would be needed to

ensure that ratios weren't stretched at the point that we were in, in January 2021. Have I understood that correctly?

A. That is correct, yes.

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

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

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

cover that.

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

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

There are other repercussions of stretching the work of the staffing ratios, which is the only way that we can try and improve the number of practitioners, improve the quality of care, is to redeploy staff from other areas, with the collateral damage of those

decisions being that will impact on the services that they would usually provide for, and we have seen that through the delays in planned surgery, and that truly is one of the collateral damages of the Covid pandemic.

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

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

In terms of what it meant, it meant that the existing critical care staff took on a very supervisory role, as well as supporting direct patient care, which creates its own pressures and it creates its own psychological impact on them, as well as obviously those

that have come into a new environment, with lots of skills, but different skills to do their very best as well.

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

A. I think so, and I think it is an important recommendation because the reality is that we can't plan to staff intensive care for a pandemic every single day, but what we can do is we can make incremental steps that get us closer to what we need to, when that happens again, and anything we can do to reduce that gap, in terms of numbers and knowledge base, are key. So, you will have heard yesterday about enhanced care beds, level 1 beds, which are effectively somewhere between a ward base level of care and a level 2 care bed, and critical care, and I think that probably gives us some opportunities to do some rotational programmes that enable people to get exposure to critical care.

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

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

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

I think as part of that there has to be psychological support as well. It is something I can expand on if helpful but there has been work that The Intensive Care Society has done to I think probably dovetail quite well with what Professor Fong discussed in terms of psychological support.

Q. Dr Suntharalingam was talking earlier this morning about the prioritisation guidance that he was working on and he explained that The Intensive Care Society ultimately

published and updated a version of the draft that he had worked on initially. I don't need to take you to the guidance but one of the comments he made was about the reassurance that guidance such as this, albeit hopefully never used, may provide for staff. Is that a view that you and the Society would endorse?

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

Q. I understand that the document that was published by The Intensive Care Society which we looked at briefly earlier was obviously developed and issued in the context of the Covid-19 emergency. Would you support the development of a tool that could be adapted to different emergencies produced perhaps not in the midst of an emergency but now or -- now we are not in the

emergency phase of the pandemic?

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

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

You describe particular challenges that were caused by oxygen supply during the pandemic and you describe particularly the impact of supply pipes having automatic cut offs.

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

A. So I think what we have always thought is that oxygen would be an endless supply in a hospital, that there

would be no limitation of oxygen supply and I think there was a really important lesson in this pandemic, which I don't think we necessarily realised or learnt back in 2009 with the H1N1 pandemic, which is the way a hospital is designed means that there is -- can be a plentiful supply of oxygen but it is deliberately designed in a way that it is used for the purpose that it is intended to be used for. So if you have a critical care unit, the diameters of those pipes, the flow, the pressure of those pipes is manufactured differently to other areas of the hospitals where you might not need as high volume of oxygen, which is why the theatre recovery areas and the theatre environments were the ones that were generally used much more frequently than other areas for surge capacity in intensive care because they are also designed to have an oxygen-rich provision.

What we have learned from that is that I think we spent a lot of time trying to understand the schematics of a hospital, the flow, the pressure differences, which actually, if we understood them correctly beforehand would have enabled us to have really decided very quickly early on which were the best places to look after patients.

So it wasn't necessarily a case of we couldn't

provide the oxygen in the hospital, it was trying to find the right location to look after patients that were needing different levels of oxygen.

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

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

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

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

A. So, I think there are some really quite simple measures

in here which is to understand and to ensure that every hospital understands the schematics of their environment, and that's something that can be done, to work alongside our colleagues in clinical engineering, to work alongside our oxygen committee, which is often led by a clinical pharmacist, and to basically do a review of all of those things in a hospital. To understand what the schematics are, first and foremost, and then design what you might do differently, if at all. It might be that we made all the correct decisions but actually what we would do differently faced with another pandemic that required patients to need more oxygen than they would during our baseline level of acuity.

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

A. So a pulse oximeter is a very readily available piece of equipment, effectively a peg that usually goes on the finger or an ear and patients will also use them at home to monitor their oxygens for certain chronic conditions.

So it is readily available and we use it as a marker to understand what the oxygen levels might be in the bloodstream but doing it in a noninvasive way

which allows us then to titrate oxygen accordingly.

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

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

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

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

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

A. I think, as you say, this has been known for quite some years and there are still ongoing studies looking at exactly this problem. I think we felt it was important because of our reliance on pulse oximetry that we were really cascading it for awareness. But also -- well, I was going to say indirectly but actually I mean directly, to actually put some pressure on industry to actually make equipment that is useful and is calibrated for all of our populations and I know some of the manufacturers are doing a lot of work in this area but this is a really important basic-level piece of equipment that we use all of the time and therefore it is absolutely essential that it can be used for all of

the patients that we look after.

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

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

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

A. Thank you. So, I think probably the key recommendation or the key recommendations, if I may, are around workforce. I think there is two elements of that. One is around looking at opportunities to bridge the gaps in our existing workforce. We know that we came into the pandemic with not enough staff to look after the sickest patients that we care for in hospital. So there's that element to it.

I think the bit that is probably the more urgent

and pressing matter is retention of staff. The pandemic has really harmed people. We talked about well-being and psychological support and moral distress. The number of staff that have left because of what is basically embedded scars because of the pandemic, trying to do their very best, is something that we have to learn from and we have to support them, and whatever psychological support we can provide and learning opportunities is key.

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

MR FIREMAN: Thank you very much.

Those are my questions.

Questions from THE CHAIR

LADY HALLETT: Can I go back to the pulse oximeters, Dr Mathieu, please. It seems extraordinary that over 30 years ago, people could have recognised that those who had a darker coloured skin might have their lives put at risk because these pieces of equipment weren't measuring the oxygen in their blood. Whose fault is it that nothing has happened? Is it the manufacturers? Is it regulations? Is it those who buy the manufacturer's products? Where is it going wrong because it is

seriously wrong, isn't it?

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

What I would say is that a lot of the -- I understand the manufacturers looked at different algorithms to try and resolve it to some success, but not complete success, so what I would say if I may, just for assurance for patients who we would be caring for in a hospital environment, is that is one element of physiology that we look at. There are many others which would tell us -- give us some idea of whether the oxygen levels were lower than were being seen or recorded, including wakefulness, cognition, other elements of organ or body dysfunction.

We also have access to doing more invasive blood tests, but of course we don't want to do those if we can

avoid doing them because whilst they will give us more reliable data, actually we don't want to do unnecessary blood tests on people, if we can avoid it.

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

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

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

Right. Mr Jacobs.

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

Thank you very much.

LADY HALLETT: Thank you very much.

Mr Weatherby.

Questions from MR WEATHERBY

MR WEATHERBY: I'm going to ask you a few questions, Doctor, on behalf of the Covid Bereaved Families for Justice UK. I want to pick up just a couple of points on staffing

and capacity which I know you have been asked a lot about, we have heard a lot of evidence about. I want to preface them by making clear that I'm not criticising the massive efforts that were made by yourself and staff in intensive care units to fill the gaps. Not least because some of the families that I represent are the families of healthcare workers that actually died.

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

A. Yes.

Q. And at paragraph 128 of your statement you say that:

"... ICUs were very quickly at or over capacity ..."

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

It is right, isn't it, that during the course of the pandemic in March 2021, the Society produced a consensus statement entitled "Levels of adult critical care", which was a consensus statement because it was agreed by a number of other groups including the faculty the RCM, the British Association of Critical Care Nurses and et cetera. One of the things that the consensus

said made clear was that probably the biggest contributing factor to the delivery of care in intensive care is staffing.

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

A. You are absolutely correct.

Q. Yes.

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

Q. Yes.

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

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

so much they could add.

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

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

A. Correct.

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

A. Yeah.

Q. -- what the consensus statement said was that GPICS addition to recommendations -- now that's the Guidelines to the Provision of Intensive Care Services that the

faculty and yourselves put out, just for the record INQ000361989 -- so during the pandemic, although you had to have this work-round as best as you possibly could, you were underlining that that shouldn't become the new norm, and that the recommendations that had been made before the pandemic should remain in place. That is right, isn't it?

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

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

A. Yes, I think that's absolutely right. The staffing levels, the staffing ratios are embedded within the Guidelines to the Provision of Intensive Care Services for that exact reasons, which is safe staffing models.

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

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

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

A. So that's correct --

Q. Yes.

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

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

A. Correct. I'm in agreement, the staffing levels are there for a purpose, which is that we know that those are the safest staffing levels that we require to look after acutely unwell patients -- (overspeaking) --

Q. Yes, and in fact there is ICNARC data showing there were higher acute hospital mortality rates where there was a higher capacity strain on ICUs?

A. That is correct.

Q. Quickly moving on, changing the subject to older people. The Society's clinical guidance about critical care and Covid -- again I will give the reference, we don't need to put it up -- INQ000395282 and it is at page 5 -- that clinical guidance that the ICS put out makes clear, and I quote:

"Each patient will continue to be considered as an individual ... comprehensive individualised assessments will be used and that short of reaching a CRITCON 4 ..."

We discussed earlier today that had other approaches should not be used for individualised decision-making. Is that a fair summary of the guidance that was put out?

A. It is, yes. I mean, it is absolutely clear, as you say, that the guidance is only to be used in the context of national de-compensation at CRITCON level 4, with some decision support frameworks and ethical guidance that surrounds that, yes.

Q. I think you have seen the research that was done for the Inquiry, the IFF research on escalation of care. I do want to show you this bit. We looked at it briefly with the experts this morning, but there is one more page I just want to put to you for your comment. I think it is available. It is INQ000499523, and it is page 24.

On the left-hand side we have "Instructions from employers". This is the survey of healthcare professionals:

"During each wave of the pandemic, 1 in 3 HCPs said they received instructions from their employer on which groups should not be he is circulated to the next level of care."

That is a huge proportion, yes? Then, on the right-hand side, just the bits that you will be most concerned about, is that within that figure, 28% of critical care nurses and 17% of critical care doctors --

LADY HALLETT: Microphone, Mr Weatherby, because you are leaning down.

MR WEATHERBY: I'm so sorry.

It's 28% of critical care nurses and 17% of critical care doctors were included in those figures. Would you agree that doesn't really fit with the guidance in terms of individualised assessments? It rather indicates that there were instructions on blanket criteria?

A. So that's exactly what this data suggests, and I have reviewed the survey. I genuinely cannot understand those responses because I am not aware of any employer within an intensive care environment being given instructions on who should be escalated. That is

a clinical decision.

Q. All right. I shan't ask you anything more about that data then, but obviously it is there.

Just one more point on this. We heard earlier today of research which shows that admissions to ICUs in March and early April of 2020, the average age of admissions went down and again there is a lack of evidence as to why that was as I understood the evidence earlier. Are you able to comment on that?

A. So I listened to Professor Rowan's response to that and I think I would probably come to the same conclusion which is I don't know why the data is different. I think there are probably a number of reasons which include vaccination, therapeutic strategies available being different during the second wave. There was --

Q. Can I just stop you there, just on that point, sorry to interrupt you, but we are here talking about data from late March, early April 2020.

A. Oh, apologies.

I'm afraid I can't give you an answer to that question.

Q. I shan't pursue that further. But it is disturbing, isn't it, that there are these reports and there is this data which does paint a picture of the admissions not being in accordance with the clinical guidance,

individualised clinical guidance?

A. I'm not -- I'm sorry, I can't comment on that.

Q. Fair enough.

A. I do not think the guideline or the guidance is different to what is current practice for intensive care, which is very much around those staffing ratio, they should be protected unless we are in a position where we have local pressure to regional to national pressure or with the option to try and decompress through to using our workforce differently, internally, I don't mean redeploying staff but moving people away from other important ICU roles to ensure that we protect the clinical, direct clinical care but also with that mutual aid transfer option.

MR WEATHERBY: I shan't pursue it any further, thank you very much.

LADY HALLETT: Thank you Mr Weatherby.

Ms Woodward.

Questions from MS WOODWARD

MS WOODWARD: Thank you, Doctor. I ask questions on behalf of Covid-19 Bereaved Families for Justice Cymru and my first question is about the draft guidance published from the Intensive Care Society for use as a decision support tool, which we have heard quite a lot about now, and you said during your evidence earlier today that

that guidance was very related to CRITCON status.

My question is given that CRITCON was not formally adopted in Wales how was it intended that the guidance would be used in Wales?

A. So I think -- thank you. I think CRITCON is, as you rightly point out, is not universally used in Wales or indeed Scotland and Northern Ireland. It very much is used within England. I think the size, the organisational structures of Scotland, Wales and Northern Ireland are different and different in a way that the connectivity to higher levels of decision-making at sort of CMO level is probably more direct than it is in England, and that's not meant to be -- that is a comment rather than a point of view. They are just different types of structures. So what I do know is that there are -- the way that pressure is discussed and concerns raised will still be to the Parliamentarians, the main decision makers, but not necessarily using CRITCON as that way of describing it.

I think CRITCON would be a really helpful tool to be used across all devolved nations because actually what it would do is give us just one simple language that we could then use to enable us when we are at a point of national -- if we were at a point of national decompensation to use that scoring -- that description

of pressure and the action associated which may include transfers outside of regional boundaries to be used.

Q. Thank you. My next question is about data collection and access and you address this at paragraph 75 of your witness statement.

You state that the absence of centrally held data for Covid-19 patients made it difficult to obtain, compare and analyse data being recorded and you highlight in that paragraph the differences between England and Scotland in the way they hold data.

What was the position regarding data collection in Wales, to your knowledge?

A. So, I'm afraid I don't have a detailed answer to that but what I can say is that the way -- so Wales will capture data in a similar way to the other nations. I think where we are perhaps different across nations and including within regions in England is the descriptions, the definitions that we use and that's the point very much I was making around occupancy and capacity and surge capacity and we do need to try and come up with a common terminology that means that actually when we do review the data, to try and get much more of a UK understanding of where we are, that actually we are using the same descriptions.

Q. As you said, Doctor, there you spoke earlier about the

difficulties in talking about capacity because of the way the data was collected. Were there any other barriers or deficiencies in respect of effective data collection, analysis or sharing between the four nations that you were aware of outside of the capacity issue?

A. Not that I'm aware of. I think probably, if I may, just to try and describe a positive around data capture is obviously we -- the data needs to be anonymised and that is obviously important and whatever we do around data collection we need to be clear that we are not -- that we are sticking to the standards that we would expect of that data capture.

But the reality of it is that what we did and I think did really well across all nations was knowledge share, understand, use data, work out what it was telling us, direct the research activity that we needed to be directed towards and try to use that common language as best we could to describe the best treatment strategies that we could.

So I think the data is there and the data is enriched by having as many nations involved in sharing that information. I guess what would be helpful for the future is to be able to access it through a single portal.

Q. Thank you, Doctor.

My next question is about staff wellbeing which you have addressed at paragraph 94 of your witness statement where you look at the impact of the pandemic on the society's members, patients and their families. In there you identify the many challenges faced by staff including lack of beds, lack of experience and trained intensive care staff, a lack of PPE and concerns about staffing protecting themselves and their own families at home.

My question is whether staff, from your knowledge, were also concerned about the absence of routine patient and staff testing?

A. I think like everyone the view was very much that we needed to just try and conform to whatever the guideline would tell us to do but I think equally I think there were concerns expressed about staff testing, when it should be done. I think one of the problems we had certainly at points of the pandemic was the fact that lateral flow tests for example would remain positive for a very long period of time even though we knew that from a viremic point of view in terms of risk, it probably was much shorter than that and the challenge then became what do you do with that information when you have got staff that are incredibly stretched and staff that want to work, are available to work but might have a positive

test.

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

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

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

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

LADY HALLETT: Thank you Ms Woodward, very grateful.

That completes the questioning for you, Dr Mathieu. Thank you very much for all your work you do on the frontline, and obviously for your work in preparing your written statement, which I will consider as well as your oral evidence, so don't worry if you haven't covered something. Thank you very much for coming today.

A. Thank you.

(The witness withdrew)

LADY HALLETT: I think that completes the evidence we can

hear today. I do hope that the witness' emergency resolves itself successfully.

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

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

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

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

The statement of Dr David Bailey, who is a member of the BMA. He is a GP in Wales and so attests to the impact of the pandemic from his perspective.

Dr Jack Parry-Jones, who is a member of the Royal College of Anaesthetists, the Faculty of Intensive Medicine and the Association of Anaesthetists. He is in fact the lead clinician for the South East Wales

Critical Care Network and so speaks to the impact from his perspective in Wales.

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you. Not only may they be published but I wish to emphasise, yet again, that I will ensure that they are all read extremely carefully and the contents considered. The oral part of these hearings is just one part. The written material is as important and I am just sorry that we haven't got the time to call everybody to give oral evidence. We just don't. Thank you very much. Very well, 10 o'clock tomorrow please.

(3.26 pm)

(The hearing adjourned until 10.00 am

on Thursday, 10 October 2024)

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