1		Wednesday, 9 October 2024	1
2	(10	.00 am)	2
3	LAI	DY HALLETT: Yes, Mr Mills.	3
4	MR	MILLS: My Lady, may I please call the witness M3/WI who	4
5		will affirm.	5
6		MS NORA OHRENSTEIN (Interpreter) (affirmed)	6
7		M3/WI (affirmed)	7
8		Questions from COUNSEL TO THE INQUIRY	8
9		(Interpreted, unless otherwise indicated)	9
10	MR	MILLS: You are providing evidence to the Inquiry this	10
11		morning under the cypher M3/WI; is that right?	11
12	Α.	(In English) Yes.	12
13	Q.	During the pandemic, you worked as a cleaner in	13
14		a hospital?	14
15	A.	(In English) Yes.	15
16	Q.	It is right, isn't it, that you were not directly	16
17		employed by the hospital but you worked for	17
18		an outsourced company?	18
19 20	A.	Yes.	19 20
20 21	Q.	Can you begin by describing to us your normal working	20 21
21	Α.	day before the pandemic? My usual day before the pandemic was working in the	21
22	А.	cardiology floor, three hours a day.	22
23 24	Q.	When the pandemic began, did your working hours	24
24 25	α.	increase?	24
20		1	20
1		family, it was something to be considered.	1
2	Q.	I would like to explore that a little bit.	2
3	Α.	(In English) Okay, no problem.	3
4	Q.	What did you fear would happen if you had said no to	4
5		working longer hours?	5
6	Α.	I feared losing my job, everything was closing down at	6
7		the time.	7
8	Q.	Were you told which wards in the hospital were being	8
9		used for treating patients with Covid-19?	9
10	Α.	We had no information whatsoever.	10
11	Q.	Did that make you feel anxious?	11
12	Α.	Yes, I was very anxious. I didn't even take a lift	12
13		because I had fear.	13
14	Q.	Did you ask your supervisor or anyone within the	14
15		management of the hospital to tell you which wards were	15
16		being used for treating patients with Covid-19?	16
17	Α.	They didn't provide information but I heard rumours,	17
18		just rumours that perhaps they were all on the fourth	18
19		floor.	19
20	Q.	As well as cleaning wards, I think it is right that you	20
21	-	also cleaned individual rooms?	21
22	Α.	Yes.	22
23	Q.	Was the patient ever in the room when you were cleaning	23
24		the individual rooms?	24

25 A. No, the patient was no longer there.

1	Α.	Yes, due to the situation we were going through.
2	Q.	How many hours did you have to start working?
3	Α.	I would start work 6, 7 o'clock in the evening and go
4		until 4, 5 am in the morning, depending.
5	Q.	And that was how many days a week?
6	Α.	Usually for five days a week, but sometimes even
7		weekends.
8	Q.	You said, before the pandemic, you were cleaning one
9		department in the hospital. Were you asked, when the
10		pandemic struck, to clean more areas of the hospital?
11	Α.	Due to the situation, I was obliged to work for more
12		hours during the crisis we were going through.
13	Q.	You refer to the "situation". I think it is right,
14		isn't it, that the hospital was short-staffed at this
15		time?
16	Α.	Yes, short-staffed due to the illness we were suffering.
17	Q.	Is it right that many cleaners also were feeling too
18		scared to go to work?
19	Α.	Yes, we were short of staff all due to the pandemic.
20	Q.	In your statement you say this:
21		"I also didn't really want to work additional
22		hours but I felt pressured by the circumstances and
23 24	Α.	didn't feel able to say no." Yes, because of the general circumstances, but also due
24 25	А.	to my own circumstances, having to pay rent, help my
20		2
1	Q.	And again, were you told whether the patient whose room
2		you were cleaning had Covid-19?
3	Α.	No, we didn't receive any information at all.
4	Q.	Did you receive any training about how to clean
5		differently in accordance with Covid-19 guidelines?
6	Α.	No, we didn't have any information and we just went on
7		cleaning the way we were cleaning before doing things to
8		the best of our ability.
9	Q.	So you weren't, for example, given any new cleaning
10		products?
11	Α.	We started using a product called Bihes(?), and that's
12		the one we used for everything.
13	Q.	Did you receive any guidance about Infection, Prevention
14		and Control?
15	Α.	No. No guidance, no information.
16	Q.	In the absence of guidance about infection prevention
17		and control and about how to clean in a Covid-19
18		compliant way, did you have concerns?
19	Α.	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 workand work.
- 25 **Q.** What about with anyone at the outsourced company? 4

- No, nothing with them. 1 Α.
- 2 Q. In your statement you say this:
- 3 "Despite my concerns, I didn't raise a complaint 4
 - with my employers or with hospital management because
- 5 I was scared there would be negative consequences ..."
- 6 Α. Yes, at that time I couldn't be without a job. We
- 7 needed to support ourselves.
- 8 Q. Do I take it that the negative consequence was that you
- 9 feared you would lose your job?
- 10 Α. Yes
- Q. If you had fallen ill with Covid-19, would you have been 11
- able to survive on the sick pay you were entitled to? 12
- 13 No. We had a very small pay, we didn't have the salary Α. we actually deserved. 14
- Did you in fact manage to avoid catching Covid-19 during 15 Q. 16 the pandemic?
- 17 A. Yes. Thank goodness that was the case. I looked after 18 myself, and together with my colleague, my partner.
- 19 Q. We will come on to some of the ways that you looked
- 20 after yourself. Can I first ask you this, if you had
- 21 fallen ill with Covid-19, would you have felt that you
- 22 had to carry on working because if you don't work you 23 wouldn't be paid your wage?
- 24 A. I would have done so, because I had to survive.
- 25 **Q.** I will come now to the personal protective equipment you 5
- 1 myself that would be picking stuff up for myself and my
- 2 partner, my colleague.
- 3 Q. Did you receive any training about how to wear PPE and 4 how to safely dispose of it?
- 5 A. No, we didn't receive any training, but we knew
- 6 ourselves to use some orange bags that are for
- 7 contaminated articles, and we would use those to dispose 8 of ours.
- 9 Q. Taking all of this together can I ask you this, did you 10 feel safe performing your job?
- A. No, I didn't have any feeling of safety but I had to go 11 12 ahead and do things.
- 13 Q. Did you receive a testing kit at any point during the 14 pandemic?
- Much later, not actually during the pandemic, the 15 Α. pandemic itself, but much later we received some and we 16 17 had to check and report if we were found contaminated.
- How many boxes of testing kits did you personally 18 Q. receive? 19
- 20 A. I believe three perhaps four, not many.
- Can I move finally to ask you about your physical and 21 Q. 22 mental well-being during this time.
- 23 Can you describe to us the impact that working
- 24 during the pandemic had on your mental health?
- 25 Α. I suffer a great impact from all this situation, this

- were provided with. Was there a difference in the PPE
- 2 that outsourced workers like you received, compared to
- 3 what the employed clinical staff at the hospital were
- 4 given?

- 5 A. Yes. We only received a mask, a blue mask, and we had 6 to find, by ourselves, a way to protect ourselves.
- 7 And we were not actually given this mask, we had
- 8 to pick them up ourselves, find them ourselves.
- 9 Q. Find them outside of the hospital?
- 10 Α. They were not given to us, we had to pick them sometimes 11 from reception, sometimes from some consulting room
- where there were some spares. 12
- 13 Q. In addition to the mask, did you acquire any other PPE 14 to give yourself greater protection?
- 15 A. No, they didn't give us anything but myself, together
- 16 with my partner, will pick up things from places where 17 they would be available.
- What kind of --18 Q.
- 19 Α. By hiding ourselves we will pick them up.
- 20 Q. What kind of things? What kind of things?
- 21 Α. Hats, aprons, stronger masks.
- 22 Q. You say "they" wouldn't give us; were you and your 23 colleagues asking for more PPE?
- 24 Α. No, we had nobody to ask. We only had a supervisor who
- 25 would say always, "Later on, later on", so it was mainly
- 1 fear of becoming ill, I had an obligation towards my
- 2 family, the whole thing caused a lot of stress.
- 3 Eventually I lost a lot of weight too due to this 4 stress.
- 5 Q. Were you ever asked about your well-being by either the 6 hospital management or the outsourced company you worked 7 for?
- A. At no time we had any questions from them or any 8 9 inquiries from them.
- Q. Can I ask how that made you feel? 10
- 11 A. I had just the support of my sister, she works in
- 12 Colombia as a nurse and she was the one that supported 13 me.
- 14 Q. Do you think that you and your colleagues have received 15 the recognition you deserve for the work you performed 16 during the pandemic?
- 17 A. Not at all. Not at all.
- 18 Q. Finally this, I think it is right, isn't it, that you
- 19 and your colleagues are now employed directly by the 20 hospital?
- A. At this present time yes. 21
- 22 Q. Can you tell us how, if at all, that has improved your 23 working conditions?
- 24 Α. There has been some improvement in the payment, not as
- 25 much as should be but yes, better than before.

1	MR MILLS: Thank you.	1	MS CARE
2	LADY HALLETT: Can I just ask, was it a private hospital or	2	Mrs L
3	an NHS hospital? Please don't name the hospital but was	3	emer
4	it private or NHS?	4	will up
5	A. As far as I know it is a private hospital.	5	cours
6	LADY HALLETT: Thank you.	6	
7	Those are all the questions we have. Thank you	7	Dr Su
8	very much for your courage in coming forward to help us.	8	affirm
9	It is absolutely essential that we hear from a wide	9	
10	range of people who were working throughout the pandemic	10	pleas
11	in hospitals. So we are very grateful.	11	attem
12	A. Thank you and it has been very hard.	12	
13	LADY HALLETT: I can imagine. Thank you. I have been asked	13	parag
14	to rise while we break for the next witnesses. I shall	14	DR SUNTH
15	return as soon as we are ready.	15	MS CARE
16	(The witness withdrew)	16	distre
7	(10.25 am)	17	princi
8	(A short break)	18	and s
9	(10.31 am)	19	
20	PROFESSOR CHARLOTTE SUMMERS (continued)	20	care p
21	DR GANESH SUNTHARALINGAM (continued)	21	partic
22	Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3	22	pande
23	(continued)	23	DR SUNTH
24	LADY HALLETT: Ms Carey.	24	is tha
25	l am sorry about last week.	25	wishe
1	inevitably time-critical decisions. By the nature of	1	impor
2	these conditions, they can happen quickly, some	2	them
2 3	these conditions, they can happen quickly, some unexpectedly, and wherever possible the patient's wishes	2 3	them way tl
2 3 4	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	2 3 4	them way tl inforn
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2 3 4 5 6 7 8 9	 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 	2 3 4 5 6 7 8 9	them way th inform MS CARE parts is cur
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	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
1	attempt cardiopulmonary resuscitation. All right?
2	And if it helps you, Doctor, we are starting at
3	paragraph 37 at your report.
1	DR SUNTHARALINGAM: Okay.
5	MS CAREY: Some people may find discussing this quite
3	distressing, so can we take our time and set out the
7	principles, the legalities and the realities at a steady
3	and slow pace if we may.
9	I would like to ask you please about why advance
)	care planning is important generally and then why it was
1	particularly important by the time we came to the
2	pandemic. So could we start there.
3	DR SUNTHARALINGAM: I think the broadest way to look at it
1	is that it is a way of ensuring the patient's informed
5	wishes are taken into account when making what are 10
	10
	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
1	there, the diagnosis or relevant information,
2	communication aids, whether they need an interpreter.
3	Would this also be used, for example, if someone had
1	perhaps a support worker or needed someone to help
5	communicate perhaps if they were learning disabled.
3	Would that information all be included in there?
7	DR SUNTHARALINGAM: Yes, I think anyone close to the patient
3	and able to represent firstly help them with the
9	decision-making and also able to represent them.
)	MS CAREY: Then there is a box of:
1	"Details of other relevant planning documents and
2	where to find them."
3	And "Advance Decision to Refuse Treatment" is
1	different, isn't it, as I understand it?

25 **DR SUNTHARALINGAM:** Yes. So that's a legal instrument. Not 12

1	so in Scotland but it would still be taken into account,
2	so the sort of legal framework may differ but they,
3	unlike these other documents which broadly can be
4	considered called treatment escalation plans, the
5	advance decision to refuse treatment is legally
6	binding for the condition it applies for, it is
7	important to say. So it may be for particular
8	circumstances only.
9	MS CAREY: Right, so someone could say, for example, I don't
10	want to have chemotherapy, let's take it outside of
11	a pandemic context. They could make an advance decision
12	to refuse treatment and that would be binding and
13	therefore they would not have chemotherapy; is that
14	correct?
15	DR SUNTHARALINGAM: Yes. So they have legally declared they
16	are not consenting which is different to a statement of
17	values and preferences.
18	MS CAREY: Organ donation may also be discussed. And then
19	there is a section dealing with personal preferences
20	where people explain what is important to them, the
21	quality of life, that they might want to be able to do
22	this but not that. Can you give us some examples of
23	what might be included in that box there?
24	DR SUNTHARALINGAM: So if a discussion, for example, was
25	around instituting mechanical ventilation, something
	13
4	forme in ito
1	form, is it?
2	DR SUNTHARALINGAM: Yes. It includes the same information
2 3	DR SUNTHARALINGAM: Yes. It includes the same information and in a way it is wider and one of the benefits of this
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1	that might lead them to be weaker than they are already,
2	then they might say, actually, if the risk is there
3	is no certain outcomes but if there is a substantial
4	risk that I'm going to be worse off than I am now, even
5	if I survive the intensive care process, as an example,
6	or and I wouldn't wish to be living under those
7	conditions, I would only want aggressive treatment if it
8	left me fully able to do certain activities, then that
9	is to be taken into consideration. It is not
10	an absolute bar but it provides their input into the
11	decision.
12	MS CAREY: Right, and then it goes onto the clinical
13	recommendations, and who fills in that part of the form?
14	DR SUNTHARALINGAM: So really this is about although it
15	is signed by a clinician, the purpose of all these
16	documents is to establish a shared understanding and
17	an expression of values and preferences, so it would be
18	done with the patient, or those close to them, or both,
19	but it is filled in and signed by the clinician.
20	MS CAREY: Then we can see the boxes for signature, and if
21	we look to the just pause there, please, just come
22	down slightly, I just want to look at the box that's
23	ringed in red where CPR attempts are not recommended.
24	So this form can be used for someone to indicate whether
25	they would want CPR but it is not a do not attempt CPR
	14
1	with an acute condition, which case really as close to
2	the front door as possible if they're able to take
3	MS CAREY: So a GP could fill this in with a patient
4	DR SUNTHARALINGAM: Yes.
5	LADY HALLETT: or if you were going through cancer
6	treatment, you might fill it in with someone who is
7	providing that treatment for you?
8	DR SUNTHARALINGAM: Yes.
9	MS CAREY: Clearly slightly different considerations by the
10	time we get to critical care, potentially.
11	DR SUNTHARALINGAM: Yes.
12	MS CAREY: All right. And this form, where does it stay?
13	On whose records?
14	DR SUNTHARALINGAM: I think that is an important point about
15	this. The intention of the ReSPECT form, although
16	similar, is that it is transportable, it stays with the
17	patient. They themselves would have a copy. Where
18	there are electronic systems across regions, it would be
19	part of that, such as an electronic care plan.
20	And that contrasts with so it is an advantage
21	over something like a DNACPR form which is very specific

- 22 to an institution, so you may need different ones for
- 23 the ambulance service than ones for the hospital.
- 24 MS CAREY: We are going to look at a DNACPR form in
- 25 a moment. But do I understand it correctly that if 16

1	I went into hospital and I had a ReSPECT form if they
2	called up my records they should find the ReSPECT form
3	within them?
4	DR SUNTHARALINGAM: It does depend on the information
5	systems, but also you know, in an ideal world you
6	would have a copy with you, and you would be in
7	a position to highlight it and say, look, here is my
8	understanding of things at the moment.
9	MS CAREY: All right. Okay. This is a form in England,
10	Scotland and being rolled out in Northern Ireland. Can
11	we just consider the position in Wales. There is an All
12	Wales DNACPR policy which is different and I will come
13	back to that, but is there any equivalent of ReSPECT or
14	a form like it operating in Wales?
15	DR SUNTHARALINGAM: So the overarching this is
16	Resuscitation Council UK who I know you have as
17	a witness subsequently, they have adopted this as their
18	recommendation for all four nations. I think in terms
19	of the implementation, it is my understanding is that
20	the All Wales DNACPR form is under review as of
21	June 2024.
22	LADY HALLETT: Right.
23	DR SUNTHARALINGAM: And certainly the expert recommendation
24	from the Resuscitation Council is that it should be
25	considered across all the nations.
	17
1	please, about DNACPRs. And some basics, please, if
2	I may, Doctor.
3 4	Is this the position, though, that in fact if you
4 5	have a cardiac arrest outside of hospital the survival
6	rate is relatively low, somewhere around 8%. DR SUNTHARALINGAM: Yes.
7 8	MS CAREY: And if you indeed have a cardiac arrest and your heart stops in hospital, survival rate is higher but it
9	is still only 23%?
9 10	DR SUNTHARALINGAM: Yes.
11	MS CAREY: Now, the DNACPR is this right means that
12	cardiopulmonary resuscitation should not be started for
12	that particular patient, or continued? Can you help me
14	why there might be circumstances where someone has
15	a DNACPR but nonetheless CPR has started and therefore
16	needs to be stopped?
17	DR SUNTHARALINGAM: CPR itself is clearly time-critical,
18	life-saving in those situations where it does work, but
19	only when it is started promptly. So where there is any
20	doubt, the presumption is always to start. Which is why
20	paper DNACPR forms often have red borders, they can be
22	easily identified, in electronic systems they are
23	flagged prominently so that you know in advance or
24	it's easy to spot, but if there's any
25	MS CAREY: Pause there. We will pull one up on the screen
-	19

quir	y 9 October 2024
1	MS CAREY: Why would it help to have a form like ReSPECT
2	working across all four nations?
3	DR SUNTHARALINGAM: In a practical sense, people obviously
4	may travel across borders, and I think it is also about
5	just establishing shared best practice, so even if you
6	were to leave home, so to speak, if it works in one
7	place, it should the principle should apply
8	elsewhere.
9	It is probably worth emphasising this is, as we
10	said, one form among many, and it is a way of capturing
11	what are already existing principles. So it is about
12	best practice rather than new policy.
13	MS CAREY: Whatever the actual format of the form, are they
14	all asking similar questions and have similar
15	considerations set out in them?
16	DR SUNTHARALINGAM: Yes.
17	MS CAREY: Understood. I think, and you say in your
18	statement, you say there is a treatment escalation plan
19	document created by one of the health boards that was
20	adapted after Covid-19 and now carries the All Wales NHS
21	logo, and that applies in hospitals in Wales. Is that
22	correct?
23	DR SUNTHARALINGAM: That's my understanding.
24	MS CAREY: Clearly we have seen, on that ReSPECT form,
25	reference to DNACPRs, and I would like to ask you, 18
	10
1	so that everyone can follow what you are talking about.
2	Could we have INQ000227411, please.
3	I won't go through the detail but we can just look
4	at one so we can see. 227411. Page 23, sorry, it's my
5	fault.
6	There we are. All right. This is an example of a
7	DNACPR form, and we can see there clearly the red
8	border. And where does that go on the patient's notes?
9	DR SUNTHARALINGAM: It can be in any particular place, but
10	it should be easily identifiable. And to return to your
11	previous question, the scenario where CPR may be stopped
12	is where it has been started because a patient is
13	observed to collapse. Appropriately, people may start
14	if they weren't aware of the existence of this form, but
15	once it is found, then it would be an indication to
16	stop, so that's a scenario where that might arise.
17	MS CAREY: So the patient would be treated, but if someone
18	had to go and locate the notes, for whatever reason, and
19	then realise there was a DNACPR, that would be
20	a circumstance in which you would stop, you wouldn't
21	just leave the patient without any treatment
22	DR SUNTHARALINGAM: Yes.
23	MS CAREY: pending location of the form?
24	DR SUNTHARALINGAM: Yes.

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

1	it must be filled in at the front of the patient's
2	healthcare record
3	DR SUNTHARALINGAM: Yes.
4	MS CAREY: and we'd hope it would be somewhere visible.
5	All right?
6	DR SUNTHARALINGAM: It is worth saying that the verbal
7	information about this, although it should be backed up
8	obviously by the document as well, form part of
9	handovers and ward safety briefings and so on so the
10	information is passed on from shift to shift, as it
11	were, or at handover.
12	MS CAREY: Okay. Now, I think there are different
13	circumstances in which a DNACPR notice may be made.
14	Is this right, firstly, they can be made in
15	advance where the person has the capacity to say,
16	"I don't want CPR"?
17	DR SUNTHARALINGAM: Yes.
18	MS CAREY: All right, and we have looked at an example of
19	that on the ReSPECT form, someone may come to that
20	decision of their own volition?
21	DR SUNTHARALINGAM: Yes.
22	MS CAREY: If someone comes to that decision, is that
23	decision respected? It is?
24	DR SUNTHARALINGAM: Yes.
25	For them to come to that position, they should 21
	21
1	DR SUNTHARALINGAM: Yes.
2	MS CAREY: where a clinician has decided that there
3	should be a DNACPR notice?
4	DR SUNTHARALINGAM: Yes.
5	MS CAREY: Right. And is this the position, a patient or
6	loved one cannot demand CPR if it would be clinically
7	inappropriate?
8	DR SUNTHARALINGAM: That is right. It is a treatment
9	decision and the treatment itself, it is not a switch
10	where you simply decide to save someone's life, it is
11	a treatment process often quite intrusive, and it is
12	like any other treatment: you do it because you think it
13	will work.
14 15	LADY HALLETT: Sorry to interrupt. You say it is a legal
15	requirement that a patient should be consulted before
16	the decision is taken. Just looking at the form,
17	I appreciate that there are several boxes which include
18 10	having discussions with those close to the patient at
19 20	box 4, for example. But I'm just a bit concerned; box 1
20	or question 1:
21	"Has the patient appointed a health or welfare
22	attorney to make decisions on their behalf? If yes,
23 24	they must be consulted."
24 25	Surely that is not highlighting the fact that
25	there is a legal requirement that loved ones of the
	23

2	2
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inquiry	y 9 October 2024
1	obviously be able to have all the information about
2	their condition, which they have themselves, but to have
3	clinical scenarios explained to them or might be
4	relevant to this if they are acutely ill or things are
5	deteriorating, and despite access to support as well,
6	having written information where feasible. So, again,
7	it all comes to the benefits of having that discussion
8	early.
9	MS CAREY: Early. All right. Understood. There may also
10	be circumstances, though, where it is a medical
11	treatment decision, made by clinicians such as
12	yourselves, that CPR should not be offered because it is
13	not clinically appropriate, and I want to be clear about
14	that. In the circumstances where a clinician says, "We
15	shouldn't do CPR because it won't work", does the
16	patient or their loved one have to consent to that
17	clinical treatment decision?
18	DR SUNTHARALINGAM: No, they should be aware of it, and
19	should be able to be involved in it and, if necessary,
20	question it, but they don't specifically consent to it.
21	It is about what treatment may be clinically appropriate
22	and is on offer, so to speak.
23	MS CAREY: Am I right, though, that the law does require the
24	patient, if they have capacity, or their carers/loved
25	ones, to be consulted
	22
1	patient to be consulted by just taking the health and
2	welfare attorney example. Do you see what I mean?
3	DR SUNTHARALINGAM: Yes, yes, my Lady.
4	I think the way I think the issue of a
5	chronology is my understanding of this is that this
6	shouldn't come as a surprise, if you like to the patient
7	or those close to them after the event, it is not
8	necessarily the same as saying they must be consulted
9	first, so they should be made aware of it, and I agree
10	it should be anyone that is in a position to be
11	a representative of the patient if they themselves can't
12	take part in that discussion.
13	LADY HALLETT: I just wonder if that form should be clearer?
14	PROFESSOR SUMMERS: I think the other important thing is
15	this is just one DNACPR form of one particular

- 16 organisation, I do not think there is one unified --
- 17 LADY HALLETT: They won't necessarily be the same.
- 18 **PROFESSOR SUMMERS:** It won't necessarily be the same in
- every single institution. This is just one example ofsuch a form.
- 20 Such a form.
- 21 LADY HALLETT: No. I'm just --

22 MS CAREY: So this one, for example, does not refer to loved

- 23 ones, families, carers and the like, and people with
- 24 a power of attorney are in a potentially slightly
- 25 different category, it doesn't even mention that. But 24

1	I don't want anyone to be confused between who has to be	1	the next, and even with the attorney involved, if the
2	consulted.	2	patient has capacity on the day, then that takes
3	I was going to look at the form, if I may,	3	precedence.
4	my Lady, and just go through some of the boxes.	4	MS CAREY: But to follow up to her Ladyship's question, in
5	But, does the patient have capacity to make and	5	fact nothing on here about "Has the patient's family,
6	communicate decisions? If they do then they should be	6	loved one, carer been consulted?", and that ought to
7	consulted. Is that the position?	7	happen legally, as I understand it?
8	DR SUNTHARALINGAM: Yes.	8	DR SUNTHARALINGAM: I think so. It is touched on in
9	MS CAREY: Right. If they don't, you have to see whether	9	question 4 in terms of asking the question, but it says
10	there is an advanced decision to refuse treatment, in	10	those close to the patient rather than specifying who
11	which case that would be legally binding, as	11	that should be, so.
12	I understand it. Do they have a health and welfare	12	MS CAREY: Family, loved one, carer, it could be any one of
13	attorney, potentially called different things across the	13	the aforementioned, all right.
14	four nations?	14	Then, the clinician has to fill in why CPR would
15	DR SUNTHARALINGAM: Yes, this is the Welsh document	15	be inappropriate, unsuccessful or not in the patient's
16	MS CAREY: All right. This is the Welsh document, yes, to	16	best interests.
17	make decisions on behalf. But if they do have the	17	Has the discussion taken place with the patient,
18	health and welfare power of attorney in Wales or power	18	"yes" or "no"? If it has not been discussed that ought
19	of attorney in some other countries, then they must be	19	to be recorded in the form. And presumably would say
20	consulted; is that correct?	20	patient is ventilated, patient is unconscious
21	DR SUNTHARALINGAM: It's correct, and it is worth making the	21	DR SUNTHARALINGAM: Yes.
22	point at this stage, which is relevant to other	22	MS CAREY: something along those lines.
23	discussion as well, that a patient's capacity can be a	23	DR SUNTHARALINGAM: Yes.
24	stable fixed condition or it can change. So if somebody	24	MS CAREY: Has an appropriate discussion taken place with
25	is confused and delirious on one day, they may not be	25	those close to the patient, the health and welfare
	25		26
1	attorney, or a IMCA?	4	
1			
	-	1	MS CAREY: Who makes the decision to cancel the DNACPR?
2	I'm afraid I'm not familiar with "IMCA". Can you	2	DR SUNTHARALINGAM: Really the same set of clinicians who
2 3	I'm afraid I'm not familiar with "IMCA". Can you help with that?	2 3	DR SUNTHARALINGAM: Really the same set of clinicians who institute it potentially. So it may have been
2 3 4	I'm afraid I'm not familiar with "IMCA". Can you help with that? DR SUNTHARALINGAM: That is an independent advocate for	2 3 4	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
2 3 4 5	I'm afraid I'm not familiar with "IMCA". Can you help with that? DR SUNTHARALINGAM: That is an independent advocate for <i>(Unclear: simultaneous speakers)</i>	2 3 4 5	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
2 3 4 5 6	I'm afraid I'm not familiar with "IMCA". Can you help with that? DR SUNTHARALINGAM: That is an independent advocate for <i>(Unclear: simultaneous speakers)</i> MS CAREY: Thank you. And then it is filled in, as we can	2 3 4 5 6	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.
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1	care will be provided."	1	ones and the place in which I would normally start those
2	Clearly, I think you have made the point a number	2	conversations is to ask the loved ones what's their
3	of times already in your report that a decision to not	3	understanding about the clinical situation in which we
4	perform CPR is not the same as not treating someone in	4	are, so that we can all start from the same place.
5	all other respects.	5	Sometimes they have just attended the intensive
6	DR SUNTHARALINGAM: Yes.	6	care unit in an emergency, they aren't fully up to speed
7	LADY HALLETT: All right. And then there is various other	7	with how their loved one ended up here and so it is
8	parts of the form that I don't need to trouble you with.	8	important for everyone to clarify their understanding
9	Now, we have looked at this in a rather sterile	9	about the circumstances that have brought us to the
10	and non-pandemic situation. But can I ask you please	10	point we need to have this conversation.
11	about how one fills in this form in critical care	11	And once we have clarified that and it is
12	settings and perhaps, Professor, if I can come to you:	12	I feel that everybody understands what has happened and
13	if someone is brought into critical care and is not	13	why we are all in the room having this conversation,
14	getting better, pre-pandemic, can you give us an example	14	I then ask, have the patient or their loved ones ever
15	of how you would discuss DNACPRs with the patient's	15	discussed what they would want at the end of their life?
16	family?	16	You know, what are their values? What are the things
17	PROFESSOR SUMMERS: As you rightly point out, it is often in	17	that they would say if they were not here, or if they
18	the critical care setting with the patient's loved ones	18	were here and they are not able to contribute? And very
19	rather than with the patient themselves because at that	19	often people haven't ever discussed this as a family and
20	point they have been so compromised that they are unable	20	so we are asking the loved ones, as the people who know
21	to participate in the discussions because they don't	21	the patient best, given that we have rarely met them
22	have capacity.	22	when they are well in a critical care setting, what do
23	I suppose talking you through the nuts and bolts	23	you think they would say if they were able to contribute
24	of how one does that, you usually would be meeting face	24	to this conversation?
25	to face wherever possible with those family and loved	25	I'm usually very clear that I'm not asking the
	29		30
1	family to make a decision, that the burden of that	1	tremendous effort to try and reach an agreed
2	decision is made about what's clinically appropriate by	2	understanding of the situation. I don't think it is in
3	the doctors, and explain very clearly that that's my	3	anybody's interests for there to be wild disagreement.
4	responsibility, I'm not asking them to carry that burden	4	Because this is the family's loved ones, trying to
5	and nor should anyone because you are asking them to	5	explain why we are where we are is important.
6	make a decision about someone whom they love and care	6	MS CAREY: Now, in pandemic times I suspect there was not
7	for very much at a time of great distress.	7	the time there wasn't the bedside conversation or in
8	But it is important that they have the opportunity	8	a side room. How did you practically go about having
9	to input into that decision and then explain, having	9	DNACPR discussions with loved ones perhaps over Zoom c
10	heard what they have said and reflected on what they	10	some other kind of remote meeting? Can you tell us how
11	have said about what they think the patient would think	11	you went about it and how you found it?
12	or any discussion that has ever happened, I explain my	12	PROFESSOR SUMMERS: This was one of the most extraordinar
13	viewpoint on the situation as a clinician, that	13	difficult parts of ICU care in the pandemic. Very often
14	actually, taking everything into consideration, I do or	14	the loved ones of our patients had last seen them when
15	do not feel that resuscitation is appropriate in this	15	they were leaving home to come into hospital and at that
16	particular scenario.	16	point often they were conscious, they were talking, and
17	MS CAREY: Pausing there. If a clinical decision is made by	17	they were in a very different state to they are at the
18	someone like you that there should be a DNACPR, and the	18	point that we are contacting them to have this
19	patient's loved ones disagree, can they ask for a second	19	conversation.
20	opinion?	20	That differs enormously from the usual clinical
21	PROFESSOR SUMMERS: Absolutely yes.	21	practice when the patient's loved ones would often have
22	MS CAREY: And if a second clinician comes along and says,	22	been at the bed side and seen that deterioration over
23	"No, I think it is clinically inappropriate", at that	23	days and I remember very often people who came into
24	point is the DNACPR notice made?	24	intensive care for Covid had been in hospital for a few
25	PROFESSOR SUMMERS: Yes, but I would say that we would make	25	days beforehand, so they had deteriorated over some days
	31	20	32

	, ,
14	I then ask, have the patient or their loved ones ever
15	discussed what they would want at the end of their life?
16	You know, what are their values? What are the things
17	that they would say if they were not here, or if they
18	were here and they are not able to contribute? And very
19	often people haven't ever discussed this as a family and
20	so we are asking the loved ones, as the people who know
21	the patient best, given that we have rarely met them
22	when they are well in a critical care setting, what do
23	you think they would say if they were able to contribute
24	to this conversation?
25	I'm usually very clear that I'm not asking the 30
1	tremendous effort to try and reach an agreed
2	understanding of the situation. I don't think it is in
3	anybody's interests for there to be wild disagreement.
4	Because this is the family's loved ones, trying to
5	explain why we are where we are is important.
6	MS CAREY: Now, in pandemic times I suspect there was not
7	the time there wasn't the bedside conversation or in
8	a side room. How did you practically go about having
9	DNACPR discussions with loved ones perhaps over Zoom or
10	some other kind of remote meeting? Can you tell us how
11	you went about it and how you found it?
12	PROFESSOR SUMMERS: This was one of the most extraordinarily
13	difficult parts of ICU care in the pandemic. Very often
14	the loved ones of our patients had last seen them when
15	they were leaving home to come into hospital and at that
16	point often they were conscious, they were talking, and
17	they were in a very different state to they are at the
18	point that we are contacting them to have this
19	conversation.
20	That differs enormously from the usual clinical
21	practice when the patient's loved ones would often have
22	been at the bed side and seen that deterioration over
23	days and I remember very often people who came into
24	intensive care for Covid had been in hospital for a few

- intensive care for Covid had been in hospital for a few days beforehand, so they had deteriorated over some days 32

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1	and then come to us because of the course of the
2	clinical illness and they would not have seen any of
3	that.
4	MS CAREY: So it may have come as a real shock
5	PROFESSOR SUMMERS: Yes.
6	MS CAREY: when you have to make the call or speak to
7	them on the Zoom, that you haven't even had the
8	conversation, never mind the actual detail of the
9	conversation, and how did those conversations go when
10	you had to speak to the loved ones?
11	PROFESSOR SUMMERS: They were hard because you have never
12	been in the same room as that individual. They have
13	someone who therefore they have not met talking to them
14	about a situation that they have not been able to
15	witness over a period of days, in a very remote and
16	disconnected way, either via telephone or via Zoom and
17	we were having to have these conversations in greater
18	number than you would ordinarily because the number of
19	patients in critical care was greater and the level of
20	severity of the illness and the outcomes were, overall,
21	worse than they would be for the usual ICU population.
22	So you would have done several ward rounds and then
23	maybe making several of these calls in the course of
24	a day to explain to a family the situation their loved
25	one was in. It was not easy for the families or for the 33
4	aut that there is a DNACDD on their record. What is the
1	out that there is a DNACPR on their record. What is the
2	circumstances what is the process then if someone
2 3	circumstances what is the process then if someone says, "Well, there is one on my record and I'm awake now
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2 3 4 5	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?
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healthcare	staff
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2 **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
- 6 people supporting in this role during the pandemic, do
- 7 you know?

8 **PROFESSOR SUMMERS:** Different hospitals and institutions

- 9 organised how they did this differently. Some hospitals
- 10 set up family liaison teams where they had non-critical
- 11 care positions having conversations with families about
- 12 that. We chose not to do that in the hospital in which
- 13 I work and as the critical care consultant and medical
- 14 team we made those phone calls.
- 15 MS CAREY: Can I ask you, Professor, since you are speaking,
- 16 do you personally have any experience or are aware of
- 17 blanket use of DNACPRs in your hospital?
- 18 **PROFESSOR SUMMERS:** I do not.
- 19 MS CAREY: And Dr Suntharalingam, do you have any personal
- 20 experience?
- 21 DR SUNTHARALINGAM: No.
- 22 **MS CAREY:** We have heard of them, clearly, in a number of
- 23 respects. Can I ask you this, the Inquiry has also
- 24 heard there were some examples of families whose
- 25 patients had been discharged and have subsequently found 34
- a discussion. Are you aware of situations where notices
 were put on without any discussion with the patient
- 3 because the patient didn't have capacity and without any
- 4 discussion with the family member?
- 5 DR SUNTHARALINGAM: I think it depends on the context. I
 - think in our clinical setting of critical care, because
- 7 we are very hands on with the patients and the situation
- 8 is changing every day, the sort of discussions the
- 9 professor describes would have been had. There may have
- 10 been some slipped through the net but it wouldn't be the
- 11 normal case. I think some of the examples you have had
- 12 may have been from other settings where there may be
- 13 fewer people looking after larger number of patients.
- 14 So I can't really comment on that but I would think in
- 15 our setting it would be very unusual.
- 16 LADY HALLETT: Is your setting a large teaching hospital?
- 17 DR SUNTHARALINGAM: A clinical setting regardless of site,
- 18 actually, so any intensive care unit --
- 19 LADY HALLETT: Oh, I see.
- 20 DR SUNTHARALINGAM: -- (overspeaking) -- these sort of
- 21 discussions are really part and parcel and it is not to
- 22 say they wouldn't be for other people but it may have
- 23 been a DNACPR decision that was in records from much
- 24 earlier, may have been made in a very different setting.
- 25 It is difficult to comment without knowing --

LOV HALET: It could have been made in a setting in a spour are. choicedy, sed, too used to fish ind of setting in a spour are. choicedy, sed, too used to fish ind of are. choicedy, sed, too used to fish ind of are. choicedy, sed, too used to fish ind of are. choicedy, sed, too used to fish ind of are. choicedy, sed, too used to fish ind of a setting in a spour are. choicedy, sed, too used to fish ind of a setting in a spour are. choicedy, sed, too used to fish ind of a setting in a spour are. choicedy, sed, too used to fish ind of a setting in a spour are. choicedy, sed, too used to fish ind of a setting in a spour are. choicedy, setting ind ind the form of they experison control for they outed have been made in statiations where the staff weren't as familiar value. 0 B SUMTARALINGAM: Foreintment exclusion				
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UK Covid-19 Ir

1	DR SUNTHARALINGAM: It is worth adding the point that
2	I think those who generated the ReSPECT form would say
3	that as part of the implementation of that, so we are
4	talking about four nations' implementation that funded
5	training by institutions, organisations supporting the
6	Trusts and Health Boards and employers is a key part of
7	it as well, and there is a wider point behind that,
8	which is whether it is about DNACPR, or around treatment
9	escalation planning, having clinician time to actually
10	have these conversations, clearly in a pandemic certain
11	things apply but in normal life it's making sure the
12	time is there to have those conversations as well as the
13	training.
14	MS CAREY: Thank you. Can I move to a different topic with
15	you, Doctor, and it is the work that you undertook in
16	March 2020 in relation to a clinical prioritisation tool
17	that you were asked to consider working on some
18	guidelines for by I think the Chief Medical Officer. We
19	heard from Professor Whitty two weeks ago now and I said
20	then we were hearing from the person involved or one of
21	the three involved.
22	Can I just start like this: I think it is obvious
23	from what you have said that clinicians make decisions
24	about who should be admitted to care on a daily basis.
25	I think you told us last time that you would have
	41
1	saturated, by which I mean there was no bed available.
2	DR SUNTHARALINGAM: Yes.
3	MS CAREY: And we have heard about the NHS being in CRITCON
4	4. Is it this that the tool was designed to address?
5	DR SUNTHARALINGAM: Yes. In fact the wider framework that
6	was very much part of this work, so bearing in mind this
7	was very early on in the pandemic, and at that point
8	numbers were rising, and in fact the framework very
9	explicitly tied CRITCON and mutual aid to the potential
10	trigger for a tool. So it wasn't the tool in isolation,
11	it was pairing those two things so there was
12	an operational context to what might then be needed.
13	MS CAREY: I just wanted can I perhaps put it more
14	simply. Was this designed in the event that there was
15	no bed anywhere and you had two people vying for one
16	bed?
17	DR SUNTHARALINGAM: Essentially, yes.
18	MS CAREY: Now, that is a very heartless way, I appreciate,
19	of describing it but that's what we are talking about
20	here and no other bed in a neighbouring hospital?
21	DR SUNTHARALINGAM: No.
22	MS CAREY: Or, indeed, a neighbouring region that could be
23	sensibly someone transferred to?
24	DR SUNTHARALINGAM: That is right, and in the context that
25	mutual aid and decompression would already have happened
	43

nquiry	9 October 2024
1	a discussion with the ward if the ward thought the
2	patient was deteriorating and you would be involved then
3	in deciding whether it was appropriate for the person to
4	be admitted to ICU.
5	Yesterday I think you are aware we heard about
6	a NICE guideline to assess patients when they are
7	admitted to hospital to consider whether they might need
8	critical care. Is that correct?
9	DR SUNTHARALINGAM: I believe so, yes.
10	MS CAREY: That's not the same thing that the tool that you
11	were working on that Professor Whitty
12	DR SUNTHARALINGAM: No.
13	MS CAREY: And as I understand it you were asked to draw up
14	guidance in the event that critical care was saturated?
15	DR SUNTHARALINGAM: That is right. In fact the lead for it
16	was Professor Whitty and he was kind enough to comment
17	on it two weeks ago, as you say, saying that it was
18	difficult but he felt the outcome at the time was useful
19	and sensible. It was for the four nations, so it was
20	the quintet of four CMOs and the National Medical
21	Director.
22	MS CAREY: And if I understand it, I think on 21 March you
23	and two other colleagues were asked to form a group to
24	consider the clinical prioritisation model to be used in
25	the event that the NHS critical care resources were 42
1	an accorticily talking about (overspeaking) which
2	so essentially talking about (overspeaking) which would be a very extreme scenario.
3	MS CAREY: We looked at all the transfers and the rising
4	numbers and indeed we looked at the circular diagram of
5	the example of Northwick Park and the number of other
6	hospitals that they transferred patients to. But
7	assuming in that example that there was no other bed
8	available and CRITCON 4 had been declared, this was when
9	the tool was envisaged to operate; is that correct?
10	DR SUNTHARALINGAM: That is correct. And two things to
11	emphasise. Firstly, CRITCON 4 is a national situation
12	not just in that hospital. We have talked about
13	scenarios where CRITCON might be triggered as
14	an alerting tool but where CRITCON 4 is agreed by those
15	in authority to be a national state, and then the other
16	point to make is this is all time sensitive. It is
17	really about queuing for the next available bed and that
18	might change when a bed comes up. So it is not about
19	barring people from being admitted, it is saying who we
20	would admit into the beds available right now.
21	MS CAREY: Perhaps if we look at how the tool was envisaged
22	to work by reference to your paragraph 110, Doctor.
23	Could we call up on screen thank you very
24	much a summary of how the framework was proposed.
25	I won't necessarily go through all of these but we can
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1	see there it was designed to effectively only operate
2	once CRITCON 4 was declared in one or more regions and
3	where CRITCON 4 is declared, NHS England, in this case,
4	have to be notified so they know the position and all
5	other possible sources of mutual aid between hospitals
6	have been exhausted.
7	DR SUNTHARALINGAM: That is right.
8	MS CAREY: So it really is in extremis?
9	DR SUNTHARALINGAM: That is right. And although CRITCON was
10	sort of convenient vocabulary for this, obviously for
11	the other three nations it is around that same
12	information being escalated in other ways about capacity
13	and saturation.
14	MS CAREY: It makes the point there at 110.2 that there
15	should be no triage until every accessible ICU is full.
16	DR SUNTHARALINGAM: Absolutely.
17	MS CAREY: "This assessment should be based on accurate
18	collection and communication of realistic frontline ICU
19	conditions using CRITCON or equivalent rather than
20	abstract bed counts against a theoretical bed base."
21	What were you getting at there, if I may ask?
22	DR SUNTHARALINGAM: It was the discussion we had earlier
23	really about having although it's useful to think in
24	terms of notional surge capacity, those are, sort of,
25	fairly abstract numbers and if units are becoming
	45
1	and both are eligible and it is appropriate to escalate
1 2	and both are eligible and it is appropriate to escalate them to ICU, you would use the tool to say that person
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2	them to ICU, you would use the tool to say that person
2 3	them to ICU, you would use the tool to say that person should be number 1 to get that bed and then if one
2 3 4	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
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1	realistically saturated under the conditions at the
2	time, that's what's going to start influencing clinical
3	decision-making, albeit subconsciously, and in practical
4	terms through simple lack of available beds. So that is
5	the realistic frontline conditions in the view of those
6	working there that needs to feed into this level of
7	realistic decision-making. And percentages of notional
8	total surge capacity may not help with that.
9	MS CAREY: Then 110.4:
10	"If critical care resources become exhausted
11	nationally, any declared clinical prioritisation would
12	operate on a ranking basis in the event of needing to
13	prioritise one patient over another when competing for
14	the same resource (in effect, 'the last ICU bed')."
15	What was that trying to convey?
16	DR SUNTHARALINGAM: It was really the point we made earlier
17	that this is reflecting this is not about triaging
18	people in the sense of saying they will never get
19	an intensive care bed unless that is the clinically
20	appropriate scenario in any case, but under pandemic
21	conditions it is not about ruling people in or out, it
22	is saying for the next available bed who should take
23	precedence over somebody else on the grounds of
24	survivability using these principles.
25	MS CAREY: Right. In a scenario where you have two patients
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	46
1	MS CAREY: Understood, all right.
1 2	
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2	MS CAREY: Understood, all right. So, effectively, it was a ranking system for who
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	that prior to the pandemic there was no in extremis	1	involved in that particular point of view, but I think
2	saturation tool available?	2	genuinely looking at wider discussions there was a need
3	DR SUNTHARALINGAM: No.	3	for it and, to be clear, it is not about a tool that you
4	Thirdly, I would say there is reassurance in two	4	pick up and start using on your own, it is knowing that
5	forms, one is for clinicians to know that even if you	5	there is something there is a plan in the background
6	are saying this is usual conditions, we are not	6	that may be activated and I think that in itself
7	saturated yet, for clinicians to know that there is some	7	provides reassurance for people.
8	sort of plan for what happens next means, firstly it	8	MS CAREY: I think just to finish this topic, albeit only
9	means that they don't feel that sense of moral doubt and	9	the only seven days when the framework was being
10	injury, potentially worrying they will find themselves	10	considered by your group, I think you say that the group
11	in that situation on their own in the middle of the	11	consulted with the critical care professional community,
12	night at their site. They know there is a plan.	12	age and disability groups, and with the Department of
13	Secondly, for the public and for patients it gives	13	Health and Social Care's moral and ethical advisory
14	them the safety that people aren't going to find	14	group, and there were various changes made to the
15	themselves in a position of being triaged	15	putative framework during that period as a result of
16	inappropriately. If there is a national plan and people	16	those meetings.
17	know when it's switched on and when it's switched off,	17	Just finally on this topic then, did your work as
18	that only the CMOs can activate it, it protects the	18	part of that group effectively form a starting point for
19	public by avoiding the risk that we're not talking	19	a document that is now in existence, which is the
20	about something, it sort of happens unseen.	20	clinical guidance published by the Intensive Care
21	MS CAREY: Is there any, do you know, will or desire among	21	Society.
22	the medical profession to have a tool such as this in	22	DR SUNTHARALINGAM: That is correct. On 28 March when the
23	case we find ourselves again in a situation where we are	23	work for the quintet of CMOs and National Medical
24	overflowing in ICU beds?	24	Director was stood down on the grounds that, at that
25	DR SUNTHARALINGAM: I would say yes. Obviously, having been 49	25	stage, it looked as if the first wave was as seceding 50
1	and the tool wouldn't be needed, there was a discussion	1	DR SUNTHARALINGAM: That is correct.
1 2	and the tool wouldn't be needed, there was a discussion around publishing it so it could be developed openly and	1 2	DR SUNTHARALINGAM: That is correct. MS CAREY: We can see there that it is endorsed by Royal
2	around publishing it so it could be developed openly and	2	MS CAREY: We can see there that it is endorsed by Royal
2 3	around publishing it so it could be developed openly and with as much professional and public input as possible	2 3	MS CAREY: We can see there that it is endorsed by Royal College of Physicians, the Scottish Intensive Care
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51

es which are applicable to any crisis, and potentially outside a crisis. It has a statement about 52

(13) Pages 49 - 52

1	shared escalation, mutual aid, the CRITCON framework,	1	
2	which are also should apply to any crisis.	2	
3	And then the tool at the end is specific to Covid,	3	
4	and would need to be re-assessed, re-designed as indeed	4	
5	it would have done during the pandemic itself if it were	5	MS
6	in use, because it was based on available data at	6	DR
7	28 March, or would in any case have been adapted.	7	
8	For a different disease there would be different	8	
9	criteria, different things to look at.	9	
10	MS CAREY: So barring the, I think it is appendix 2, if we	10	MS
11	just look at it at page 12 of the document, there is the	11	
12	decision to support aid in relation to Covid. But	12	
13	essentially, if one looked at pages 1 to 11, they would	13	
14	be applicable whatever the virus, whatever the disease,	14	
15	whatever the extremis circumstances underpinning it.	15	DR
16	DR SUNTHARALINGAM: Yes.	16	
17	MS CAREY: You could basically use pages 1 to 11, and add on	17	
18	an appendix, to be specific, to whatever circumstance	18	
19 20	that was appropriate?	19	
20 21	DR SUNTHARALINGAM: I think so, I don't know, would it be	20 21	MS
21	useful to look at page 11 briefly?	21	
22	MS CAREY: Yes, let's go back to that then, because that is a more general application.	22	
23 24	DR SUNTHARALINGAM: Yes. To some extent this is a further	23 24	
24	version of the discussion about CRITCON that we had	24	DR
	53		
1	MS CAREY: and you said it could be done with publicly	1	
2	accountable oversight. Who did you envisage might	2	LAD
3 4	provide that oversight?	3	
4	DR SUNTHARALINGAM: So, in a sense I'm very open to sort of	4	
		4	MS
5	expert opinion as to how this could be implemented, but	5	MS (11.:
5 6	expert opinion as to how this could be implemented, but some form of public commission or stakeholder meeting,	5 6	(11.
5 6 7	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	5 6 7	(11.) (11.)
5 6 7 8	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	5 6 7 8	(11. (11. LAC
5 6 7 8 9	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,	5 6 7 8 9	(11.) (11.)
5 6 7 8 9 10	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	5 6 7 8 9 10	(11. (11. LAC
5 6 7 8 9 10 11	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.	5 6 7 8 9 10 11	(11. (11. LAC
5 6 7 8 9 10 11 12	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	5 6 7 8 9 10 11	(11. (11. LAC
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5 6 7 8 9 10 11 12 13 13	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	5 6 7 8 9 10 11 12 13 13	(11.) (11.) LAC
5 6 7 8 9 10 11 12 13 14 15	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	5 6 7 8 9 10 11 12 13 14 15	(11.) (11.) LAC
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5 6 7 8 9 10 11 12 13 14 15 16 17 18	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	5 6 7 8 9 10 11 12 13 14 15 16 17 18	(11.) (11.) LAC
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5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	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.	5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	(11.) (11.) LAC

- 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.
- CAREY: Yes.

;	DR SUNTHARALINGAM:	And then CRITCON 4, and in fact that
·	DITOUTINATALITUA	

- 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.
- 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?
- 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.
- 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 --
 - SUNTHARALINGAM: Yes. 54

1	might perhaps take our mid-morning break?
2	LADY HALLETT: No, that's absolutely fine.
3	l shall return at 11.45 am.
4	MS CAREY: Thank you, my Lady.
5	(11.25 am)
6	(A short break)
7	(11.46 am)
8	LADY HALLETT: Thank you.
9	MS CAREY: Thank you, my Lady.
10	Professor Summers, can I turn to you, please, and
11	just look briefly at ICU capacity in 2021. Because we
12	concentrated a lot on the early stages of the pandemic,
13	and I think you make the point in your report that, in
14	fact, by early 2021 there was a far larger surge in
15	critically ill patients than there had been earlier on
16	in the pandemic. If it helps you, I'm at page 60 in
17	your report.
18	I wonder if we could call up on screen figure 11
19	at INQ000474255_0060.
20	With your help, Professor, I would like you just
21	to explain we are not going through all the regions
22	but all four nations are represented on this figure,
23	which is the regional increases in occupied ICU beds
24	above baseline, provided by The Intensive Care Society,
25	and it is really to get a sense of how different it was 56

1	in 2021 than how it was in 2020, or, in some cases, it	1
2	is the data from 2019.	2
3	Perhaps if we take Scotland as the first example,	3
4	can you speak to this? And is this showing us that in	4
5	2019 in Scotland they had 203 occupied beds in ICU? And	5
6	by 2021 that jumped considerably to 303?	6
7	PROFESSOR SUMMERS: Exactly. So this is an attempt to	7
8	quantify the degree of the surge in ICU capacity that	8
9	was required in January 2021 by using exact data at this	9
10	time from NHS England and estimates that they could	10
11	acquire, I think, from Scotland and Northern Ireland.	11
12	Subsequently, actually, it looks like their best	12
13	estimates for Scotland were almost exactly correct when	13
14	the real data had become available from SICSAG.	14
15	I think the important message from the entire UK	15
16	picture is that the equivalent of about 141 extra	16
17	intensive care units were required in January 2021 above	17
18	the capacity that was available in January 2020, and	18
19	that's assuming an average size of 15 or 16 beds in	19
20	intensive care.	20
21 22	MS CAREY: I think at the bottom of the screen it says it	21 22
22	was based on one ICU being a 16-bed unit PROFESSOR SUMMERS: Yes.	22
23 24	MS CAREY: and so by 2021 we needed 141 extra ICUs across	23 24
24 25	the UK.	24 25
20	57	20
1	And you can see some of these ratios are absolutely	1
1 2	And you can see some of these ratios are absolutely extraordinary	1
2	extraordinary.	2
	extraordinary. MS CAREY: And ordinarily, would these be all the people	
2 3	extraordinary.	2 3
2 3 4	extraordinary. MS CAREY: And ordinarily, would these be all the people that would be around the bedside of the patient in ICU?	2 3 4
2 3 4 5	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	2 3 4 5
2 3 4 5 6	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.	2 3 4 5 6
2 3 4 5 6 7	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	2 3 4 5 6 7
2 3 4 5 6 7 8	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?	2 3 4 5 6 7 8
2 3 4 5 6 7 8 9	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.	2 3 4 5 6 7 8 9
2 3 4 5 6 7 8 9 10	 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 	2 3 4 5 6 7 8 9 10
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2 3 4 5 6 7 8 9 10 11 12	 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 	2 3 4 5 6 7 8 9 10 11 12
2 3 4 5 6 7 8 9 10 11 12 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13
2 3 4 5 6 7 8 9 10 11 12 13 13	 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 	2 3 4 5 6 7 8 9 10 11 12 13 13
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uiry	y 9 October 2024
1	PROFESSOR SUMMERS: Yes. And we did not create that
2	physical capacity of 141 extra ICUs with any more staff,
3	to reiterate that point again; we did it with exactly
4	the same number of staff as we had in January 2020 in
5	terms of specialist critical care staff. We stretched
6	what we had to make that extra capacity.
7	MS CAREY: Understood. I think in fact there is
8	an accompanying document on page 61 which exemplifies
9	this, and can we have the table at the top there, that,
0	ordinarily in well, not ordinarily in January 2020,
1	so just pre-pandemic, one member of staff cares for
2	it was a consultant, they can care for 12 patients, and
3	you can see the jump there from into 2021, they were
4	caring for 16 or as many as 33 patients. We're familiar
5	with the changes to the nursing ratios, but when you
6	look at some of the other people involved in providing
7	care, pharmacists, there is a jump again.
8	Physiotherapists. Speech and language. Members of
9	staff, occupational therapists. Huge increases in the
20	number of patients they had to care for in January 2021.
21	PROFESSOR SUMMERS: Intensive care is a multidisciplinary
22	package of care for patients. All of these people and
23	others besides, like the ICNARC data clerks that we
24	heard about from Professor Rowan when she was speaking,
25	administrative staff, support staff, are all required.
	58
1	which is a very neat depiction there we are of the
2	fall in the number of admissions to intensive care.
3	This is data that comes from ICNARC, my Lady.
4	One can see that ordinarily, fluctuations just
5	above or below 300 people on average coming into
6	intensive care with a heart attack per month.
7	And then when we look at the yellow line which
8	indicates the pandemic, if one looks just after January
9	2020, a huge drop in the number of people being
0	admitted, so what is that, under 150 or thereabouts, and
1	it slowly rises but still doesn't reach the same rough
2	grey area that had been the case in the three years from
3	2016 to 2019.
4	So people weren't presenting to ICU in the way
5	that they had. Can you help me with this, I think you
6	make the point in your report that there were fewer
7	older people being admitted to ICU during the pandemic,
8	and can you help with why that was?
9	PROFESSOR SUMMERS: So, I guess, to allude to the myocardial
20	infarction graph that we were shown, I think there is
21	data that very eloquently speak to the fact that not
22	only were they not appearing in intensive care units
23	with myocardial infarction, people were not appearing in

- with myocardial infarction, people were not appearing in 3
- hospital. And that actually, as a result of changes in
 - behaviour, and in people's trying to, I guess, do the 60

1	best that they could, and people were probably dying at	1
2	home rather than being admitted to hospital and having	2
3	the care from hospital and, as a consequence of that,	3
4	intensive care units that they might have done otherwise	4
5	for their myocardial infarctions, and you can see that	5
6	the decrease in admissions to ICU happened both in the	6
7	peak of spring 2020 but also again in	7
8	January/February 2021. So both of those coincide.	8
9	MS CAREY: Whilst you are dealing with this, and perhaps	9
10	looking at older people, of course, my Lady has the	10
11	report from Professor Gale, dealing with not only falls	11
12	in ICU admissions but falls generally into the	12
13	healthcare system in relation to people with ischaemic	13
14	heart disease. So it is really tallying a number of	14
15	different ways of showing that people weren't coming	15
16	into the healthcare system for heart attacks and the	16
17	like.	17
18	All right, now on to older people	18
19	PROFESSOR SUMMERS: Yes.	19
20	MS CAREY: admissions to ICU. What did you set out in	20
21	your report, please, Professor?	21
22	PROFESSOR SUMMERS: There are several lines of evidence that	22
23	suggest that at peaks of the ICU strain, that people who	23
24	were admitted to intensive care, despite there being no	24
25	national change in policy, may actually not have been	25
	61	
1	December 2020, so again covering the sort of wave one	1
2	period rather than wave two.	2
2 3	period rather than wave two. MS CAREY: Yes.	
2 3 4	period rather than wave two. MS CAREY: Yes. PROFESSOR SUMMERS: And they found that the likelihood of	2 3 4
2 3	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	2 3
2 3 4	period rather than wave two. MS CAREY: Yes. PROFESSOR SUMMERS: And they found that the likelihood of	2 3 4
2 3 4 5	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	2 3 4 5
2 3 4 5 6	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	2 3 4 5 6
2 3 4 5 6 7	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	2 3 4 5 6 7
2 3 4 5 6 7 8 9 10	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	2 3 4 5 6 7 8
2 3 4 5 6 7 8 9	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	2 3 4 5 6 7 8 9
2 3 4 5 6 7 8 9 10	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	2 3 4 5 6 7 8 9 10
2 3 4 5 6 7 8 9 10	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	2 3 4 5 6 7 8 9 10 11
2 3 4 5 6 7 8 9 10 11 12	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.	2 3 4 5 6 7 8 9 10 11 12
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	 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 periodsand people more generally to get into ICU 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
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ir	y 9 October 2024
	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.
i	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?
	$\label{eq:professor} \textbf{PROFESSOR SUMMERS:} \text{There is a second line of evidence that}$
	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 62
	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, 64

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Lack	1	and the critical care nurses said that there was 20% of	1
ventilation,	2	them that had to make a decision about that on a daily	2
Lack	3	basis, 19% for critical care doctors, and we can see the	3
equipment.	4	varying statistics there.	4
of access to	5	But when one looks at the last two columns, "At	5
it no higher	6	least weekly", 34% of those critical care nurses had	6
to be made	7	an inability to escalate and, indeed, critical care	7
people may	8	doctors, 35% at least weekly. And then if we look at	8
Doe	9	the "Ever" again, 49% of critical care nurses had	9
your experi	10	an inability to escalate, and critical care doctors 48%.	10
that there a	11	So fairly grim statistics, if I may put it like	11
care nurses	12	that, as to the people that contributed to this survey,	12
they could	13	suggesting that there was various reasons why the nurses	13
on page 19	14	and the doctors felt there was an inability to	14
PROFESSOR SI	15	escalate and some of those reasons, I think, were	15
think was s	16	given. If one looks at page 19.	16
other day, f	17	The survey asked about the reasons for difficulty	17
evidence th	18	escalating, and if we could highlight the two columns	18
year, I unde	19	that deal with "Critical care nurse" and "Critical care	19
were in 202	20	doctor", one can see that "Lack of available beds for	20
MS CAREY: N	21 22	high dependency care such as high flow oxygen or CPAP",	21 22
Professor, a critical ca	22	look at the figures there for critical care nurses and critical care doctors, that clearly was a reason they	22
their experi	23 24	felt unable to escalate.	23 24
"We	25	Lack of care or staff, 62 and 61% respectively.	25
		65	
the other d	1	see what kind of people died of this disease despite	1
the peer su	2	escalated care. So we decided not to admit to critical	2
that I also p	3	care whereas had they had a different illness, they	3
of those vis	4	probably would have been more likely to benefit so we	4
is evidence	5	would have escalated. We didn't have enough space to	5
to have to l	6	'give people a go' who had a very remote chance of	6
of the Unite	7	getting better. If we had had more capacity, we might	7
the conflict	8	have been in a position to try."	8
particularly	9	I suspect not an easy thing for that doctor to	9
of all kinds	10	have said, but can I ask you, please, about page 33 of	10
lt wa	11	the survey. This is entitled "Acting in conflict with	11
many of us	12	values by role". But critical care nurses were	12
MS CAREY: It	13	particularly likely to have to act in a way which	13
that were d	14	conflicted with their values when at work during the	14 15
the stresse	15 16	pandemic, likely linked to the higher proportion feeling that there were insufficient staff. And if we look	15 16
ability to do	10		17
about that PROFESSOR SI	17	there, daily, critical care nurses were reporting that they were acting in conflict with values by role.	18
MS CAREY: 11	10	And indeed the critical care doctors, if one looks	19
in your repo	20	down the page slightly, 26% of those were saying they	20
PROFESSOR SI	20	had that on a daily basis.	20
actually led	21	Can you help with how acting in conflict with your	21
to undertak	22	roles and your values affected the staff on the ground,	23
looking at h	20	Professor?	24
well-being	25	PROFESSOR SUMMERS: I can. I think we heard very powerfully	25

1	Lack of available beds for invasive mechanical
2	ventilation, 85 and 80%.
3	Lack of available beds for acute wards. Lack of
4	equipment. And I don't need to ask you about the lack
5	of access to ambulance. But clearly indicative I put
6	it no higher than that of difficult decisions having
7	to be made, and a number of varying resource reasons why
8	people may not have been escalated.
9	Does that not necessarily accord entirely with
10	your experience, but does it come as a surprise to you
11	that there are quite significant numbers of critical
12	care nurses and doctors answering this survey saying
13	they could not escalate for the reasons that are set out
14	on page 19?
15	PROFESSOR SUMMERS: No, I think like Professor Whitty, who I
16	think was shown similar evidence when he testified the
17	other day, this accords with the totality of the
18	evidence that's available. It is a snapshot done this
19	year, I understand, of how people felt their experiences
20 21	were in 2020, and I'm not in any way surprised. MS CAREY: No. If one just looks, please, at page 22,
21 22	Professor, there is a quotation given there from
22	a critical care doctor in Wales. And they were giving
23 24	their experience of escalating care, they said:
25	"We knew it wouldn't help because we had come to
20	66
1	the other day from Professor Fond, he organised and led
1 2	the other day from Professor Fong, he organised and led
2	the peer support programme of visits. I should declare
2 3	the peer support programme of visits. I should declare that I also participated in leading and attending some
2 3 4 5	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
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2 the time points. And it happened before the winter 2 both the demands of a greater number of critically ill 3 2020/21 peak and during and after the winter 2020/21 3 patients, atongate the demands of trying to resume 6 MS CAREY. So just pousing there. It hink, as a result of 5 trying to support the full delivery of elective 6 at least one part of the surveys over different periods 6 are required to undertake the delivery of elective 7 of time, in November to December 2020, more than 50% of 7 sargial care. 8 staff met or exceeded the threshold criteria for at 6 6 the attres for a all coals the numeusally are in operating 10 And what were those discorders, please? 10 theattres for ad ho calings their periods 11 PROFESSOR SUMMERS: So post-traumatic distress symptoms and 11 werren tubing their operating 11 markes of meral h-attraumatic distress symptoms and other 13 administrators, and intensive care, there are data about 12 back three symptoms were increased in previdence, as 11 the athree symptoms were increased on previdence, as 13 saccond reliable symptoms were increased in previdence, as 12 LADY HALLETT: Hore three are data about				
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4 peak. 4 elective surgical care and many of the people who were 5 MS CAREY: So just pausing there. I think, as a result of 5 triving to support the ICU surge are the same people who were 7 of and, in November to December 2200, more than 50% of as aff more an exceeded the threshold criterits for at 9 least one of the surveyed mental health disorders. 9 10 And what were boos disorders, justed and the threshold criterits for at duals the threshold criterits for at duals the threshold criterits for at duals the threshold criterits for at and the distress. 10 11 werent doing their day jib. Corruse they were 12 distressed. As were nurses. healthcast support workers. 12 questions around problematic abcold misuse and other 13 administrators, and not just in intensive care. If his this data 13 administrators. 14 that for the survey were and the surge were the support workers. 14 that serve intron particip. 12 administrators, and not just in intensive care. If his about the survey targe are the sector. 15 is around intensive care. 13 administrators, and not just in intensive care. 16 beather survey out and the particularly in intensive care. 14 that fit dat not. 17 p				
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1	"In general, there were adequate numerical
2	quantities of PPE in ICUs as these were often
3	prioritised over other parts of the health and social
4	care system."
5	But I want to understand, were there any shortages
6	of PPE within individual ICUs that you are aware of?
7	DR SUNTHARALINGAM: So I use the word "numerically" there
8	because there certainly were factors that were very
9	the opposite of reassuring. So different models
10	arriving every day. Although hospitals carried out fit
11	testing the supplies changed. I'm not aware of specific
12	shortages as a systematic factor. And the comment about
13	ICUs compared to others is partly based on some research
14	work that others have done of surveying people. So
15	there was some advantage. However, it certainly felt at
16	any given moment that things might be short, that things
17	were changing all the time, particularly early in the
18	pandemic, and obviously people had anxieties about their
19	own health and about taking disease home to families.
20	So it felt under pressure. It felt dangerous. It
21	felt like shortages. Numerically, intensive care was
22	arguably better than some other areas. Also due to
23	decisions that FFP3 was used universally and that wasn't
24	the case elsewhere in the hospital. And arguably should
25	be.
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1	DR SUNTHARALINGAM: Yes. For example, recommendations
2	about and to be fair to the organisation in the UK,
3	obviously it was also affected by perceptions from
4	elsewhere. So if you are seeing healthcare workers in
5	other countries wearing full body Hazmat suits then it
6	raised questions about what should be the right course
7	of action here.
8	MS CAREY: Understood. I would like to ask you about
9	aerosol-generating procedures. We have heard quite
10	a bit of evidence about that already including that some
11	of them may not in fact generate as many aerosols as
12	hitherto believed and also evidence that AGPs aside,
13	talking, coughing, singing, shouting, inevitably
14	generates aerosols.
15	I just would like your views, please, on the AGP
16	list. I think you have set them out in your
17	paragraph 210. Help us with that, please.
18	DR SUNTHARALINGAM: So this was something where there was,
19	again, debate about, including in elements such as
20	resuscitation, which you may hear about from another
21	witness. Also some professions and specialities, as we
22	have heard from Professor Summers, it is a very
23	multidisciplinary profession and particularly speech and
24	language therapists felt that some of the interventions
25	they do weren't adequately recognised.

1	MS CAREY: I won't take up that thread with you, if I may,
2	Doctor, but can I ask you about this. You say in your
3	report that there was clearly, obviously, the
4	physical and emotional challenges of working with the
5	significant, more quantities of PPE being worn. You
6	make reference to uncertainty and changing guidelines,
7	anxiety over supplies and fit testing generally
8	contributing to the psychological impact of the
9	pandemic.
10	Can I just ask you, which guidelines were you
11	referring to in that part of your report?
12	DR SUNTHARALINGAM: There was initially guidance coming from
13	the various bodies at the time which did actually change
14	identity during the pandemic. So I think Public Health
15	England moving into the other organisations. So there
16	was reorganisation going on as well. And it was really
17	around the best way of coping and diminishing risk early
18	on.
19	So, appropriately, things were kept under review
20	and disseminated as they changed but at the frontline
21	I think it felt difficult to keep abreast of all of it
22	and on the background of people's concerns that they
23	were getting what they needed.
24	MS CAREY: Even within the ICU setting where, as you say,
25	you had FFP3?
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1	However, I think there is a wider issue which is
2	the "P" in AGP. I'm not really qualified to talk about
3	the aerosol and droplet side of it, but I think the
4	focus on procedures, rather than risk, is a problem
5	because it means when there is no procedure going on,
6	but you are in front of the infected patient, that risk
7	is sort of diminished in the guidance whereas actually
8	taking the risk into account rather than what particular
9	procedure they are having at the time is a better way of
10	doing it, and particularly in an intensive care setting
11	where there is a procedure going on all the time
12	somewhere and the patients are all together, again, a
13	focus on procedure is not necessarily the right thing.
14	So guidance based on environment and risk profile
15	would make more intuitive sense and be easier to handle.
16	And as you say, there are many things that are not
17	interventions that put you at risk if a patient coughs,
18	for example.
19	MS CAREY: Finally, please, this. I would like to ask in a
20	minute about recommendations but can I just draw
21	together some of the things that you have been telling
22	us during the course of your evidence.
23	There was clearly a significant impact on those
24	working in ICU. Was any support in place to help the
25	critical care nurse, those that were redeployed? Was 76

1	there any support in place during any of the waves of
2	the pandemic.
3	Perhaps, Professor, if I turn to you first?
4	PROFESSOR SUMMERS: Definitely healthcare system providers
5	in a variety of ways attempted to provide support by
6	making sure that counselling or other mental health
7	services were made available.
8	I think what's also important to remember is that
9	providing support is fine. However, you are not also
10	able to remove the source of the ongoing injury if you
11	have another wave coming and more patients coming in and
12	you are trying to restore elective surgical services
13	because there are a backlog of people who are also
14	experiencing harm from not having their surgery. People
15	cannot and do not want to stop working and continuing
16	being exposed to the ongoing moral injury of not being
17	able to provide care as they would want to.
18	So it is a complex situation and just providing
19	a mental health service doesn't necessarily remove the
20	strain.
21 22	Q. Shutting the door after the horse has bolted may be
22	a very inelegant way of putting it. But you have to tackle the underlying problem. That's what I really
23 24	wanted to ask you about.
24 25	You have set out in your report a number of
25	77
1	earlier decompression of the hot sites rather than
2 3	letting them get to 1:6 and then seeing what happened
3 4	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.
4 5	PROFESSOR SUMMERS: There is a reason we have 1:1 nursing of
6	intensive care outside of pandemics.
7	DR SUNTHARALINGAM: Absolutely, yes.
8	MS CAREY: I won't ask you about all of the other
9	recommendations you set out save for one of them,
10	Doctor. I think you wanted to speak to the
11	recommendation where you say to address the issue of
12	future public health emergency, you recommend
13	a citizen's assembly or other formal government
14	consultation with an appropriate range of stakeholders.
15	Why do you advocate for a citizen's assembly, and
16	what is it you envisage they might do and assist with?
17	DR SUNTHARALINGAM: Thank you. It was largely just because
18	I was a bit vague to answer your question before. So in
19	terms of a practical aspect of how this could be, sort
20	of, addressed. But, really, the wider topic is of
21	making sure that everyone who has an interest is
22	involved. We can work on developing moral and ethical
23	principles for an agreed, fair and just framework for
24	allocating healthcare if demand exceeds supply, so in
25	a crisis.
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1	lessons learned and recommendations and I wanted to ask,
2	we have heard a lot about the stretching of ratios
3	within the critical care setting. Do you know if there
4	is any research ongoing to understand the minimum safe
5	staffing requirements that we could stretch to if we
6	needed to in the event of a future pandemic?
7	PROFESSOR SUMMERS: Actually, since before the pandemic
8	there has been a piece of research going on called
9	SEISMIC, that has been looking to generate an evidence
10	base around staffing ratios, particularly nurse staffing
11	ratios in intensive care units. I don't think at the
12	time the work was conceived it was thought about in
13	terms of pandemic and stretch but I understand that the
14	authors and the people who are working on that are also
15	including that strain in their work but the results of
16	that work are not yet available, but it is important
17	work that I think will provide an evidence for how we
18	provide care and ratios.
19	DR SUNTHARALINGAM: I think just less academically but from
20	practical experience, I think something learnt during
21	the pandemic was, just to put a figure on it, very
22	unscientifically, but the 1:6 ratios originally proposed
23	caused excessive strain even in this context.
24	So moving to a 1:4 during the course of the
25	pandemic before wave 2, which in a practical sense meant
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	-
1	But also it's an opportunity to have an honest
2 3	conversation about the role of, if you like, extreme
3 4	healthcare, aggressive healthcare, towards the end of
4 5	someone's life, both on a societal basis about how we might do things differently during a crisis and when
6	things are overwhelmed but also for people to have
0 7	
-	discussions with their families about what they
8 9	themselves would want under normal conditions but also in a future crisis and to take that time while we are
9 10	able to have those conversations in an open way and
11	doing it in a structured format through a citizen's
12	assembly.
13	Thank you for that.
14	Is it okay if we can pick out two of the others?
15	MS CAREY: I was going to ask you each actually for a it
16	is not about single recommendations but if there were
17	one you wanted to impress upon her Ladyship, what would
18	it be?
19	Perhaps you, Professor, first or I don't mind
20	who goes first.
21	PROFESSOR SUMMERS: I'm happy to go first. I think the
22	thing that I would like to emphasise is that intensive
23	care is, as we have entitled the report, the last line
24	of defence. We are required when everything else has
25	failed, when prevention hasn't worked, when improving
	80

1	and tackling health inequalities, all of those other	1	completely agree with my colleague.
2	things, have not prevented disaster arriving at our door	2	The point I would like to raise, though, is about
3	and intensive care is a supportive care package. It did	3	the capacity side of it, we have talked about it many
4	not change the trajectory of the pandemic. What changed	4	times, but we would propose as an objective measure, in
5	the trajectory of the pandemic is therapies and vaccines	5	the next two years, a systematic UK-wide review of
6	and our research being embedded into the care system.	6	baseline ICU capacity. And the justification for that
7	If we do not ensure that that is a continued line of	7	in this pandemic discussion is if we start lower then we
8	defence, it doesn't matter how much resource we put into	8	have to stretch more and that does more damage. So it
9	healthcare systems, in the absence of being able to	9	is about getting it right, not only in absolute quantum
10	change the trajectory of any kind of emergency we will	10	but also where it is, matching it to local populations,
11	potentially exhaust all capacity.	11	healthcare needs, planning ahead for changing patterns
12	So we have to embed into our response to	12	and disease and other processes, and we propose that be
13	emergencies, pandemic and otherwise, means to change the	13	done by an independent body and not by, for example,
14	trajectory of them and that means having robust supply	14	NHS England or the other NHS bodies, not because they
15	lines, having the ability to understand novel emerging	15	can't be trusted but because it puts them in a difficult
16	threats, to develop vaccinations and treatments, and to	16	position, they are the providers, and have to look at
17	do that rapidly and at scale.	17	the funding. This is about identifying the need in
18	MS CAREY: Ideally we wouldn't need you.	18	an independent way.
19	PROFESSOR SUMMERS: Exactly.	19	So a body such as The Nuffield Foundation or The
20	DR SUNTHARALINGAM: Exactly.	20	King's Fund or a university, to look at it independently
21	MS CAREY: And Doctor?	20	with expert input from the critical care bodies but also
22	DR SUNTHARALINGAM: Thank you.	22	all of those involved in acute care as well as
23	Firstly, I would very much agree with that, that	23	epidemiology experts.
24	intensive care is to provide life support while the	20	So really a baseline look from the ground up at
25	disease gets better, so we need to address that, I	25	what critical care in the UK should look like, and then
	81		82
4		4	Trades Usian Commerce and it takes up Destes what we
1	what can be afforded and provided becomes a separate	1	Trades Union Congress, and it takes up, Doctor, what you
2	discussion and I think this is a piece of work that	2	were describing a moment ago in terms of the
3	hasn't been done but the pandemic should be a trigger	3	recommendation for a UK-wide review of baseline capacit
4	for doing it.	4	and an objective assessment of whether it is adequate
5	MS CAREY: Thank you very much.	5	and matched to local health needs.
6	My Lady, they are all the questions that I had.	6	The need for a review is noted, but do you both
7	LADY HALLETT: It may be you can't answer, this	7	have a view as to what baseline capacity should
8	Professor/Doctor, I have been asked to ask you about the	8	reasonably be, so as to have a reasonable level of
9	making of DNACPRs in a wider hospital setting. Is that	9	resilience in a pandemic?
10	a question for you or perhaps for later experts?	10	PROFESSOR SUMMERS: I guess I might to pick that up,
11	PROFESSOR SUMMERS: I do not clinically practise outside of	11	reminding everybody that there are OECD figures for the
12	the intensive care unit.	12	number of intensive care beds per 100,000 population is
13	LADY HALLETT: Doctor?	13	one way of looking at the problem, but that doesn't take
14	DR SUNTHARALINGAM: Sorry, the question was about a wider	14	into account individual health inequalities and health
15	LADY HALLETT: Yes, it is about people who are clinically	15	need and burden of particular areas of geography. So
16	vulnerable receiving calls at home about having notices	16	the situation in how healthcare systems are delivered in
17	put on their records.	17	one country compared to another, and the health
18	DR SUNTHARALINGAM: Again, I think that's outside our remit.	18	inequalities in those, don't make that a straightforward
19	LADY HALLETT: Thank you.	19	calculation, so I would hesitate to give a precise
20	The next person to ask questions is Mr Jacobs.	20	number. It is more than we have because I do not
21	Please don't worry about turning your back to me as long	21	think I think we have demonstrated we do not have the
22	as your reply goes into the microphone, thank you.	22	capacity that we should do for routine care, let alone
	Questions from MR JACOBS	23	in pandemics, but I think it needs to be properly
23			
23 24	MR JACOBS: Yes. Thank you.	24	conducted piece of work, and no one has done it.
	MR JACOBS: Yes. Thank you. Just one question, actually, on behalf of the	24 25	conducted piece of work, and no one has done it. DR SUNTHARALINGAM: And I think just to add to the previou

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	1	point about where it is as much as how much it is. As	1	
	2	somebody who works in London, I might be arguing against	2	
	3	myself, but it is is everything in the right places	3	
	4	and properly distributed around the regions and nations?	4	
	5	Q. Are you able to give us a sense of how much the dial	5	
	6	needs to shift, in broad terms?	6	
	7	DR SUNTHARALINGAM: I think to compare just among the OECD	7	
	8	figures, so I think we entered into the pandemic with	8	
	9	about half the number of the median figure, so we were	9	
	10	clearly way behind, and the level of stretch seemed to	10	
	11	be a lot higher than us.	11	
	12	PROFESSOR SUMMERS: To give some context to that, the OECD	12	
	13	average in 2021 was 16.9 per 100,000 population, and we	13	
	14	went in, in the UK, considerably lower than that. Italy	14	
	15 16	has 11.6 at that point, Sweden had 4.9, and Germany had 29.3. So there is wide variation which I think feeds	15 16	
	17		10	
	18	into how healthcare systems are delivered and individual nations, but we were definitely substantially below the	17	
	19	average of the OECD nations.	18 19	
	20	MR JACOBS: Thank you very much.	20	
	21	LADY HALLETT: Thank you, Mr Jacobs.	20	
	22	Who is next?	22	F
	23	Mr Odogwu.	23	
2	24	Questions from MR ODOGWU	24	
2	25	MR ODOGWU: My Lady.	25	
		85		
	1	it doesn't exist. What it means is there was no	1	
	2	publicly available data that I could find. I'm not	2	F
	3	denying that that was the case, just that I could not	3	
	4	find a data source to be able to reference.	4	
	5	Q. The data gap. Okay.	5	
	6	Well, given that, well-documented, higher rates of	6	
	7	infection and mortality among ethnic minority healthcare	7	N
	8	workers, were you able to assess whether there were any	8	L
	9	adequate risk assessments or safeguards or policies that	9	
	10	were put in place in ICU for ethnic minority healthcare	10	
	11	workers?	11	
	12	PROFESSOR SUMMERS: So the occupational risk assessments	12	N
	13	that were done within the NHS were the same for critical	13	F
	14 15	care staff as they were for all other NHS staff. So there wasn't a separate critical care risk assessment	14 15	N L
	16	undertaken.	15 16	N
	17	Q. So there was nothing tailored specifically to ethnic	10	n
	18	minority healthcare workers?	18	
	19	PROFESSOR SUMMERS: Or to intensive care workers is what I'm	10	
	20	saying. It was the standard NHS occupational risk	20	
	21	assessment, rather than it being tailored to one	20	
	22	particular group.	22	
	23	Q. Given the vulnerabilities of ethnic minority healthcare	23	
	24	workers in particular, do you consider that there were	24	
2	25	adequate measures within the ICU setting for those	25	
		87		

	y 5 October 2024
	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
1	came at significant costs to both staff and patients.
2	My question relates to potential racial
3	disparities in the redeployment of healthcare workers
1	during the pandemic. There has been some evidence in
5	this Inquiry of ethnic minority workers reporting that
5	they were given higher risk tasks and being redeployed
7	to Covid wards more often than their white colleagues.
3	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
1	critical care settings?
2	PROFESSOR SUMMERS: So I recognise very much the evidence
3	that you reference has been heard by the Inquiry.
1	I could not find systemic data that outlined that
5	problem for any of the nations. That doesn't mean that
	86
	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.
1	Questions from MS MITCHELL KC
2	MS MITCHELL: (inaudible).
3	PROFESSOR SUMMERS: I'm terribly sorry, I can't hear you
1	MS MITCHELL: The microphone appears on.
5	LADY HALLETT: Yes, you're on now.
6	MS MITCHELL: I'm on now, thank you.
7	I appear as instructed by Aamer Anwar & Co
3	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
1	surrounding some of these notices. I don't need to take
2	you to it, but at paragraph 40 of your report you state
3	that:
1	"A DNACPR notice is not meant as a proxy for

broader treatment decisions. However, in the absence of

1	[a] clearly documented discussion and decisions about	1	over
2	other forms of treatment, there is a potential for	2	Q. And
3	inappropriate over-interpretation of DNACPR[s] as	3	reco
4	a generalised treatment limitation option."	4	
5	Now, I presume that that potential for	5	Covi
6	over-interpretation is in respect of medical	6	over
7	professionals, not of families and patients? Is that	7	pote
8	correct?	8	impl
9	DR SUNTHARALINGAM: Potentially, although arguably it could	9	desc
10	be both; if that's the only discussion around treatment	10	DR SUNT
11	limitation that happens, then people may go away	11	som
12	thinking that's been the wider discussion, and I say	12	is th
13	it can also lead to misinterpretation in the healthcare	13	wou
14	community. So going back to treatment escalation	14	
15	planning such as the ReSPECT form which is being	15	resu
16	implemented in parts of Scotland, part of the argument	16	beca
17	before having that broader discussion is to be very	17	activ
18	clear about which is the CPR decision and which is	18	quite
19	around other treatments, and having the opportunity for	19	mea
20	people to say, "I would like for myself or for my loved	20	Q. Can
21	one active treatment, but I hear that CPR might not be	21	ques
22	the right thing for them. We can draw a line there, but	22	how
23	other treatments should be actively pursued", which is	23	som
24	actually a very standard set of circumstances, and it	24	or so
25	avoids the risk of the DNACPR itself being 89	25	
1	obviously on occasion from being with their loved ones	1	SO 0
2	when they were in hospital. Was the exclusion of loved	2	and
3	ones from visiting a possible way that inadvertently	3	a pa
4	DNACPR discussions were lost for families at that time?	4	infor
5	DR SUNTHARALINGAM: I think in a so to start a bit with	5	the s
6	the part of the hospital where I'm most familiar with	6	Q. And
7	and am really qualified to comment on, which is in	7	DNA
8	intensive care, the sort of processes that	8	unde
9	Professor Summers described would have been how it was	9	DR SUNT
10	done. If the families weren't there, which was clearly	10	l kno
11	the case most of the time, they would have had the	11	or a
12	discussion or the explanation by telephone. Elsewhere	12	whic
13	in the hospital we can't sort of necessarily comment,	13	cond
14 15	but if your question is, does the necessary visiting	14 15	there
16	restriction raise a risk of things happening without those phone calls being made, then again theoretically	16	exar
17	I would say that it would be a risk.	10	parti revie
18	Q. Can I ask you then briefly about the issue of reviewing	18	parti
19	of DNACPRs. Is the situation, as you understand it, in	10	paru
20	respect of the review of making a DNACPR, different in	20	their
20	Scotland?	20	in te
22	DR SUNTHARALINGAM: I don't as far as I'm aware, no. In	21	term
23	that the principles are the same. The legal position,	22	for r
24	I think, is roughly similar in that although the legal	24	
25	position of advanced decisions to refuse treatment and	25	that'
	91		

1		over-interpreted to cover other aspects of healthcare.
2	Q.	And indeed, one might make sense of that in terms of the
3		recommendations that you have made in that regard.
4		What I would like to ask on behalf of the Scottish
5		Covid Bereaved about those potential
6		over-interpretations or, as you describe later,
7		potential misrepresentation, is: what were the possible
8		implications for patients of those things that you
9		describe?
10	DR	SUNTHARALINGAM: This is theoretical, but if it led to
11		somebody thinking that somebody has a DNACPR order and
12		is therefore not for active treatment of any sort, that
13		would be incorrect.
14		And, to take sort of a fictional example, if it
15		resulted in them not getting antibiotics for sepsis
16		because they are somehow felt to be not for further
17		active treatment of any sort, that would obviously be
18		quite a serious misunderstanding of what the DNACPR
19		meant. But this is a fictional example.
20	Q.	
21	α.	questions, in fact my Lady posed a question to you about
22		how the bereaved found out that there were DNACPRs
23		sometimes from their loved ones who were still with us
24		or sometimes sadly no longer with us.
25		Families were excluded for very good reason
		90
1		so on is different, the DNACPR is an advisory notice,
2		
3		and the principles that it should be discussed with
0		and the principles that it should be discussed with a patient where possible, that people should be
4		
		a patient where possible, that people should be
4	Q.	a patient where possible, that people should be informed, that it guides treatment options, I think, are
4 5	Q.	a patient where possible, that people should be informed, that it guides treatment options, I think, are the same across the nations.
4 5 6	Q.	a patient where possible, that people should be informed, that it guides treatment options, I think, are the same across the nations. And particularly in respect of the issue of review of
4 5 6 7		a patient where possible, that people should be informed, that it guides treatment options, I think, are the same across the nations. And particularly in respect of the issue of review of DNACPRs, is there a difference in Scotland as you
4 5 6 7 8		a patient where possible, that people should be informed, that it guides treatment options, I think, are the same across the nations. And particularly in respect of the issue of review of DNACPRs, is there a difference in Scotland as you understand it?
4 5 6 7 8 9		a patient where possible, that people should be informed, that it guides treatment options, I think, are the same across the nations. And particularly in respect of the issue of review of DNACPRs, is there a difference in Scotland as you understand it? SUNTHARALINGAM: Not as I understand it. And as far as
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4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22		a patient where possible, that people should be informed, that it guides treatment options, I think, are the same across the nations. And particularly in respect of the issue of review of DNACPRs, is there a difference in Scotland as you understand it? 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

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1		it, I'm afraid.
2	Q.	I wonder if there is or there may be such a review. It
3		doesn't seem entirely clear, I would have to say, but
4		there is certainly a suggestion in the guidelines in
5		Scotland that there may be an opportunity for timed
6		reviews. If this is something that the Chair may be
7		interested in, might you be able to look into that and
8		give us your expert response on that?
9	PR	OFESSOR SUMMERS: I guess I would put it, as
10		Dr Suntharalingam has just said, there are circumstances
11		in which a timed review would be appropriate if the
12		status was likely to change, but I can think of other
13		circumstances in which a patient would have had
14		an informed discussion with their healthcare team, for
15		example, in the setting of widely disseminating
16		malignancy, and they were towards the end of their life,
17		that it may not be appropriate to have a recurrent
18		discussion with that patient because that status is
19		unlikely to change.
20		So I think it should be reviewed where clinically
21		appropriate, and where patients feel that they wish it
22		to be reviewed too. Setting a hard and fast time point
23		of reviewing it every so many days might not necessarily
24		facilitate the kind of patient discussions that we would
25		all hope for.
		93
1		And that meant that those who might usually be
2		admitted to ICU were not.
3		And we have also discussed in your evidence today
4		that critical care was often being delivered outside of
5		the ICU setting, and that that means, as you also set
6		out in your report that the data likely underestimates

	And that meant that those who might usually be
2	admitted to ICU were not.
3	And we have also discussed in your evidence today
4	that critical care was often being delivered outside of
5	the ICU setting, and that that means, as you also set
6	out in your report, that the data likely underestimates
7	the overall number of critically ill patients.
8	My question arising from that is, is it likely
9	that the informal variations in ICU admissions, combined
10	with the data underestimating the overall number of
11	critically-ill patients, created an incorrect perception
12	that critical care was not saturated?
13	PROFESSOR SUMMERS: I think that is one interpretation of
14	the situation. I guess what I would like to be able to
15	give you a definitive answer is absolute concrete data
16	to say that that was the case. I have, in writing this
17	particular section and it was me who drafted this
18	particular section, set out the data that I could find
19	to support that there may have been a change in the
20	people who were admitted to intensive care units whilst
21	acknowledging, as you rightly highlight, that not
22	everybody who was critically ill was admitted to
23	a intensive care unit, and often critically ill
24	treatment was carried out in places that would not
25	normally do so.
	95

1	DR SUNTHARALINGAM: I agree. It may also have unpredictable
2	effect. If there is a timed review every week, for the
3	sake of argument, and the patient improves within two
4	days, it may actually delay a discussion that might
5	otherwise happen. I mean, it shouldn't do, but there
6	are ups and downs, all these things, in healthcare.
7	MS MITCHELL: I'm obliged my, Lady.
8	LADY HALLETT: Thank you Ms Mitchell, very grateful.
9	Ms Woodward.
10	Questions from MS WOODWARD
11	MS WOODWARD: I ask questions on behalf of Covid-19 Bereaved
12	Families for Justice Cymru, and we have heard evidence
13	today about the drafting of a national prioritisation
14	framework, and notwithstanding the fact that this was
15	never formally implemented, at paragraph 156 of your
16	report you state that:
17	"Unfortunately, it is likely that in practice, ICU
18	capacity was overwhelmed in some individual locations at
19	certain times and that the criteria for ICU admission
20	changed via local informal processes when capacity was
21	stretched"
22	And you set out that this was:
23	" (conscious or unconscious alterations in
24	decision-making by individual clinicians rather than due
25	to policies or guidelines being issued)" 94
1	So I think we have an incomplete picture but

1	So I think we have an incomplete picture but
2	I certainly cannot tell you that it was not saturated,
3	and I guess the other thing that I would highlight is
4	that and I have quoted it I think, Helen MacNamara,
5	the Deputy Cabinet Secretary, suggests that she had a
6	conversation, was present for a conversation, where it
7	was suggested that ventilator capacity may have been
8	exceeded in January 2021, that was not something i was
9	aware of until reading her evidence to Module 2, and it
10	is concerning.
11	DR SUNTHARALINGAM: Just on the leaving aside data, but
12	sort of anecdotally, as it were, I noted that the IFF
13	survey, it was actually a doctor from Wales, as it
14	happened, who stated that they were perhaps not
15	admitting people at lower threshold as they might have
16	done because it was perceived that the disease process
17	for Covid was different, and that is really an example
18	of where there is an arguable need for guidance, so that
19	individual clinicians are not put in that position, and
20	either they know to wait until there is a stage of
21	triage, or they have some guidance, whether
22	professionally or nationally, to encourage that
23	decision-making.
24	So I would make the wider point that it is the
25	role of national bodies to step into that breach and 96

1		support not only their members but the wider patients
2		and public in order to provide variation and provide
3		consistency among the four nations, but also to make
4		sure the staff don't have that moral injury of feeling
5		themselves in that position without external support of
6		people that are meant to be representing and protecting
7		them.
8	Q.	Do you think that perhaps that incorrect perception may
9		have led those in charge to believe that a formal
10		prioritisation framework was not needed when, in fact,
11		perhaps, either a framework or more formal guidance was
12		in fact needed from those in charge?
13	PR	OFESSOR SUMMERS: So I do not think and we looked at
14		the data when we were here a week ago the proportion
15		of critical care units that declared CRITCON 4 and
16		I think NHS England have shared their data on that, was
17		incredibly small. So I think actually the units, when
18		asked to assess their strain, almost all, and whilst
19		under huge strain, did not declare that they had reached
20		the point where they thought that that was
21		an appropriate thing and that we needed to proceed to
22		national triage.
23	DR	SUNTHARALINGAM: I would echo that among the three
24		nations including Wales, because although they weren't
25		specifically using CRITCON as a tool due to different 97
		57
1		guidance to perhaps bridge that gap where critical care
2		was reaching saturation but we weren't quite at CRITCON
3		4 or the equivalent for the devolved nations?
4	PR	OFESSOR SUMMERS: I think there was very clear guidance
5		that usual decision-making should proceed and that
6		decisions should be made in the best interest of
7		individual patients, absolutely, until the point it was
8		declared people were at CRITCON 4 and there was national
9		guidance for anything to change. I think that was
10		repeatedly and appropriately shared by all nations at
11		multiple time points during the pandemic.
12	DR	SUNTHARALINGAM: I think there was a greater awareness of
13		the guidance that did exist and there was something in
14		the background that could be activated and engagement by
15		all the relevant parties, which in this case was
16		endorsed by the Welsh Intensive Care Society and
17		Critical Care Network Wales. But, I think, broader
18		awareness of that is probably the answer to your
19		question that there is a plan and it could be brought
20		out, but in the meantime usual decision-making applies,
21	_	as Professor Summer has said.
22	Q.	Thank you.
23		Given the evidence that we heard earlier from you,
24 25		Professor Summers, about older people being less likely to be admitted into ICU during the surges despite no

1		sizes and layers and the complexity, but I think that
2		information about local strain was being passed up and
3		down the chain in a similar way, so I think had that
4		hospitals reached that state, it would have been
5		transmitted in a way that then triggered the activation
6		of further measures, and that wasn't the case.
7	Q.	But given what you said in your report about local
8		informal processes likely changing, is it likely that
9		prioritisation decisions were made, and were in fact
10		incurring but just in the absence of formal guidance as
11		to how those decisions should be approached?
12	PR	OFESSOR SUMMERS: So, to be really clear, there is a very
13		big difference between prioritising whether critical
14		care is appropriate for an individual patient, and we
15		know from data before the pandemic that people
16		sometimes, when their intensive care restrained vary in
17		a soft or ill-defined way, the way in which they make
18		those decisions I think the data from Wales, the
19		doctor said in the survey about patients who they think
20		might not make have benefit from critical care, but
21		there is a small chance they might on some days would
22		get admitted, but at times of strain would not, that is
23		a very different thing from triage by absence of
24		resource.
25	Q.	Do you think that there was any scope for further
		98
1		
		policy that you were aware of regarding this, is it
2		policy that you were aware of regarding this, is it likely that the elderly were disproportionately
2 3		
		likely that the elderly were disproportionately
3	PR	likely that the elderly were disproportionately disadvantaged by unconscious or conscious alterations in
3 4	PR	likely that the elderly were disproportionately disadvantaged by unconscious or conscious alterations in decision making made on an informal basis?
3 4 5	PR	likely that the elderly were disproportionately disadvantaged by unconscious or conscious alterations in decision making made on an informal basis? OFESSOR SUMMERS: So I think to clarify exactly what
3 4 5 6	PR	likely that the elderly were disproportionately disadvantaged by unconscious or conscious alterations in decision making made on an informal basis? OFESSOR SUMMERS: So I think to clarify exactly what I said both verbally and in the report, I said elderly
3 4 5 6 7	PR	likely that the elderly were disproportionately disadvantaged by unconscious or conscious alterations in decision making made on an informal basis? OFESSOR 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,
3 4 5 6 7 8	PR	likely that the elderly were disproportionately disadvantaged by unconscious or conscious alterations in decision making made on an informal basis? OFESSOR 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
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3 4 5 6 7 8 9 10 11	PR	likely that the elderly were disproportionately disadvantaged by unconscious or conscious alterations in decision making made on an informal basis? OFESSOR 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
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- If we could bring up INQ000480136.
- 21 This is a witness statement prepared on behalf of
- 22 the Cardiff and Vale University Health Board and if we
- 23 could look at the bullet point right at the bottom of
- 24 the page. This is setting out the various steps that
- 25 were taken at the local level by the Health Board to 100

1	in an and 1011 and aite And it and a	4
	increase ICU capacity. And it says:	1
2 3	"Patients who, under normal circumstances, would	2 3
3 4	have gone to critical care for CPAP, [non-invasive ventilation] or High Flow Nasal Oxygen were admitted to	4
4 5	the escalated Respiratory Support Unit on the	4 5
6	respiratory ward instead."	6
7	At the top of the next page, on the third line	7
8	down, it says:	8
9	"It was agreed that should a patient not improve	9
10	after 3 days on ward level with CPAP/high level nasal	10
11	oxygen then we would refer for possible transfer to	11
12	ICU."	12
13	At the very bottom of that paragraph it states	13
14	that:	14
15	"The published data (from across all of Wales)	15
16	showed that there was no significant difference in	16
17	mortality for patients receiving CPAP managed on the	17
18	respiratory wards and/or on ICU when corrected for age	18
19	and comorbidity."	19
20	But:	20
21	"There was a notable difference between Wales and	21
22	England in this regard as many more patients in England	22
23	had CPAP on ICU."	23
24	I wanted to ask you on the basis of this, what the	24
25	drawbacks and risks are to patient safety of not	25
	101	
1	your evidence.	1
2		
~	My Lady, I will try and rationalise and summarise	2
3	My Lady, I will try and rationalise and summarise my questions accordingly.	2 3
3	my questions accordingly.	3
3 4	my questions accordingly. The first one is in relation to escalation to ICU.	3 4
3 4 5	my questions accordingly. The first one is in relation to escalation to ICU. Dr Suntharalingam, I look towards you but, of course,	3 4 5
3 4 5 6	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.	3 4 5 6
3 4 5 6 7	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	3 4 5 6 7
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3 4 5 6 7 8 9	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.	3 4 5 6 7 8 9
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3 4 5 6 7 8 9 10 11	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	3 4 5 7 8 9 10 11
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3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	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	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

nquiry	9 October 2024
1	receiving CPAP on the ICU and instead receiving it on
2	a ward.
3	PROFESSOR SUMMERS: So ordinarily acutely unwell and
4	hypoxemic, so lacking in oxygen, patients would receive
5	CPAP inside a critical care setting. We do that because
6	it provides an increased level of ability to monitor the
7	patient, both their oxygen levels, experienced care
8	providers and also a higher nursing ratio and
9	physiotherapy ratio than you might perhaps have on
10	a regular ward.
11 12	So that would be our default gold standard way of
12	delivering care. Unfortunately that was not possible during the pandemic at scale and not just in Wales,
14	there is data suggesting that in many hospitals up to
15	50% of people received their CPAP outside an intensive
16	care unit.
17	It is the critically ill people who are not inside
18	critical care units who I have repeatedly referred to.
19	LADY HALLETT: Thank you very much.
20	Ms Munroe.
21	Questions from MS MUNROE KC
22	MS MUNROE: Good afternoon. My name is Allison Munroe,
23	I represent Covid-19 Bereaved Families for Justice UK.
24	I have a few questions. Some of them have been touched
25	upon to a lesser or larger extent during the course of 102
1	perhaps what if I can call it resource-led clinical
2	prioritisation? I don't know if this chimes in this
3	triage in the absence of a resource.
4	DR SUNTHARALINGAM: I will defer to Professor Summers, in a
5	sense that was sort of a bridging paragraph looking at
6	what the guidelines and the policy was and then leading
7	into what might be more data led, so I will pass on to
8	my colleague.
9 10	PROFESSOR SUMMERS: Thank you.
10 11	So in drafting this paragraph what I was trying perhaps ineloquently to communicate is that, whilst no
12	policy was and guidance that decision-making should
13	change was ever issued, I wasn't certain that that
14	hadn't happened. Hence my use of "conscious" and
15	"unconscious" because I cannot speculate about the
16	individual decision-making that happened in every case
17	by every clinician across all four nations of the
18	country. And I was trying to communicate uncertainty as
19	opposed to me having evidence that particular things
20	happened.
21	Q. And so on that specific point of resource-led clinical
22	prioritisation, do we simply not have the data, robust
23	data to come to any conclusions?
24 25	PROFESSOR SUMMERS: Other than the data that I presented
25	about the changes during the peak of the demographic

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1	characteristics of the people who we	re admitted,	1
2	I couldn't find any data and I did look		2
3	that doesn't mean that it didn't happe		3
4	mean it did happen, it just means I c		4
5	Q. Thank you. Staying on the issue of the	data, ICNARC data,	5
6	you again touched upon this in your	evidence just after 6	6
7	the break, and I want to highlight two	o parts of your	7
8	report, and I think again you mentior	ned paragraph 161 on 8	8
9	page 64. But the next paragraph, at	162, you note that	9
10	the ICNARC publication data raised	the possibility 1	0
11	and you put it no higher than a possi	ibility that: 1	1
12	" efforts were directed at say	ving patients with 1	2
13	the greatest chance of survival (thos	se who were younger 1	3
14	and previously fitter but with the mos	st severe illness) 1	4
15	during the peak of the first wave."	1	5
16	Then you talk about, again, sa	ame page, 1	6
17	paragraph 164, this group, the 142,0	00 longitudinal 1	7
18	clinical path, where they found:	1	8
19	" ward mortality was highest	t when older 1	9
20			20
21	suggesting these patients may poter	ntially have benefited 2	21
22	from ICU admission."	2	22
23	Just a couple of questions ari	•	23
24	please. Firstly, is it fair to conclude t	then that the 2	24
25	3	ervations, was that 2	25
	105		
1	My question is this, Professor	r do vou accept or	1
2	believe that the informal "rationing o	5 1	2
3	a lack of ICU capacity, likely caused		3
4	deaths during this period?		4
5	PROFESSOR SUMMERS: I think what I	would say is that I have	5
6	uncertainty. I do not think I can tell y	-	6
7	I don't have anything to support it. I		7
8	out and I cannot rule it in.		8
9	Q. All right.	ç	9
10	PROFESSOR SUMMERS: If you ask me	for an overall impression, 1	0
11	I think it would be a very unwise pers	son who tells you 1	1
12	that in every circumstance in every h	nospital across the 1	2
13	country, that something happened a	s it was supposed to 1	3
14	happen.	1	4
15	Q. Thank you very much. Then, thirdly	, on this related 1	5
16	topic and this may be a question for	you, Doctor, you 1	6
17	spoke earlier about transparency an	d the need for 1	7
18	transparency when you were discuss	sing the clinical tool 1	8
19	for the four nations to consider clinic	al prioritisation 1	9
		in priorition in the second seco	
20	levels.	•	20
		2	20 21
20	Now, this question is maybe a	a difficult one 2	
20 21	Now, this question is maybe a because it sort of traverses perhaps	a difficult one 2 moral, ethical and 2	21
20 21 22	Now, this question is maybe a because it sort of traverses perhaps perhaps even political consideration	2 a difficult one 2 moral, ethical and 2 s, but do you 2	21 22
20 21 22 23	Now, this question is maybe a because it sort of traverses perhaps perhaps even political consideration consider that patients and their famil	2a difficult one2moral, ethical and2s, but do you2lies could or2	21 22 23

quiry	9 October 2024
1	patients who became very ill with Covid-19 in this
2	period, who required intensive care but were not
3	admitted to ICU, for example, due to old age or
4	pre-existing health conditions and disabilities,
5	effectively had their chances of survival reduced?
6	PROFESSOR SUMMERS: I think what I was trying to say was
7	that at times of strain, the data and the authors of
8	both these separate publications said that in people who
9	were thought to be less likely to survive, so people who
10	were older and had a greater burden of healthcare,
11	co-morbidity, they were less likely to be admitted into
12	an intensive care unit, and that their mortality was
13	thereby increased.
14	Now, whether that mortality is increased as
15	a function of the fact that they were thought initially
16	to not be as likely to survive as a younger, less
17	comorbid person, I'm unable to tell. I can tell you
18	that their mortality was increased, and that they were
19	less likely to come to an intensive care unit. Whether
20	those two things are causally related, I can't tell from
21	you the available data.
22	Q. All right. Secondly, at paragraph 163, you further
23	consider the analysis of the data. And you use
24	a phrase it is by the authors of the report, not
25	yours rationing of care. 106
	100
1	there were instances where decisions not to admit
2	them to ICU were based on resources rather than whether
3	or not admission was clinically indicated? Is that
4	something they should have been told or indeed could
5	have been told?
6	DR SUNTHARALINGAM: I think the question takes the premise
7	that it happened, which we don't know
8	Q. Yes.
9	DR SUNTHARALINGAM: and in fact, just to reference your
10	last question, I noticed the quote that you gave came
11	from London, and actually there was a lot of transfer
12	activity and hospital that became overwhelmed would be
13	transferring out. In London, the hospitals are closer
14	I happened to work there, the hospitals are fairly
15	close together, the transfer systems were there prior to
16	Covid, to a large extent, so I think it is less likely,
17	if anything, that somebody would simply turn someone
18	away for lack of beds when there is another hospital not
19	far away. But that's just a comment on that particular
20	paragraph, as it were

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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

paragraph, as it were.

happening.

(27) Pages 105 - 108

1		I think, if there were some future crisis, whether	1	eligible for ICU admission, ventilation, and other
2		it is disease or anything else, some major incident,	2	hospital care at a time when there was a severe
3		and decisions were made on that basis using whatever	3	constraints on resources and capacity?
4		framework or tool was in use at the time, then, as	4 [DR SUNTHARALINGAM: So that guidance was separate to our
5		a matter of principle, yes, people should be told that	5	piece of work. I think my understanding is that it was
6		"This is the reason. We would admit you to ICU	6	brought out in a form which talked about the frailty
7		normally, we are unable to now for these and these	7	score without qualification, and was then rapidly
8		factors, this is how we made the decision", and there	8	withdrawn and replaced with a version that made some
9		should be transparency.	9	points about not misinterpreting frailty in the context
10		As I say, I can't comment on whether that's	10	of stable disability.
11		happened this time. We don't believe it did. And so	11	And just to sort of gloss that a little bit, the
12		that's as far as I can answer that I think.	12	frailty score, which is a clinically validated tool used
13	Q.	Thank you. Frailty scoring and DNACPR. We have dealt	13	in the care of the elderly community as a marker of
14		quite a lot with DNACPR, so perhaps looking more at the	14	biological frailty, in other words, people's bodily
15		frailty scoring aspect here.	15	tissues slowly deteriorate to the point where their
16		You refer to the NICE in your report at pages 45	16	ability recover from illness is impaired, and there are
17		and 46, paragraph 108 the NICE algorithm of	17	proxy measures for that, which include their state of
18		22 March 2020, which was part of a broader written	18	mobility and general health.
19		agreement that emphasised the limitations of using	19	Inevitably, in putting things into that sort of
20		Clinical Frailty Scale.	20	framework, things get simplified, and for example, the
21		Do you believe that as a result of the NICE	21	need for being bed-bound or need for carers and so on
22		algorithm and guidance, there was a risk that clinicians	22	becomes part of the assessment. And one of the dangers
23		would perhaps over estimate clinical frailty scores	23	of it is that somebody who, for example, might need
24		associated to factors such as age, pre-existing health	24	carers for another reason such as learning disability,
25		conditions when considering whether patients were	25	but that doesn't reflect biological weakness, so to
		109		110
1		speak, in their bodily tissues, may become labelled with	1	didn't reach that operational trigger.
2		that. So a clarification was made by the authors of the	2	The NICE guidance, I can't really comment on, but
3		NICE guidance which was not ours, that firstly this	3	I do note a version was withdrawn and replaced with one
4		shouldn't be used under 65 where it is not validated.	4	which made some explanatory notes to clarify the use of
5		The tool is validated in those older, and that care	5	frailty scoring.
6		should be taken to consider other factors.	6	The document which we then later worked on was
7		Now, in the terms of the guidance and your	7	a separate one which went into a little bit more detail,
8		question, the later work that was done very clearly	8	and that's something as well I can leave it there.
9		paired those discussions with capacity and escalation,	9	In consultation with as part of that piece of
10		mutual age, and CRITCON or other measures of units being	10	work, discussion with, I believe, Age UK and other
11		overwhelmed, so in any formal sense, people should not	11	bodies, they commented on the fact that graphics were
12		be using the tool because they had not been authorised	12	what they felt to be simplifying and potentially
13		to do so because the nation was not in a state of	13	demeaning, so the graphical element of the frailty score
14		CRITCON 4.	14	was taken out in the version that we then used. But
15		And part of the argument for making it public and	15	there's obviously a lot more to it than just that.
16		open and transparent is that people are aware that's the		Q. Thank you. My final question has for the most part been
17		framework and the sort of guard rails to stop it being	17	answered, but if I can just ask you, perhaps,
18		used prematurely.	18	Professor Summers, a point of clarification more than
19		So I think I would answer the question that way,	19	anything else.
20		which is that the discussion around frailty is complex.	20	In your paragraph 55 of the report you talk about,
21		Including it in a decision-making tool, in a situation	20	obviously, the poor mental health of ICU staff and the
22		of the healthcare system being overwhelmed is a topic	22	phenomenon of presenteeism, working while sick, where
23		for discussion, and the more discussion and development	23	staff continue to work even though their functioning is
24		we have of it, the better. But there wasn't a situation	24	impaired.
25		where it would have been used in its current form as we 111	25	I think, from your answers both to my Lady and to 112

(28) Pages 109 - 112

1	Ms Carey KC, that you would agree that the poor mental
2	health of healthcare workers during the pandemic is
3	likely or could have been likely to negatively impact
4	upon the quality of care and safety of patients?
5	PROFESSOR SUMMERS: Unquestionably.
6	Q. You said in answers right at the end of your examination
7	by Ms Carey KC that "No one can be surprised by this,
8	the pressure never came off in 2020, and then going into
9	2021 peaks, there were greater demands as well as trying
10	to resume elective surgery care. We all carry the scars
11	of the last five years."
12	My question is simply this on behalf of those
13	I represent: has enough, do you think, been done to help
14	healthcare workers heal from those scars, and prevent
15	the moral distress leading to moral injury that
16	Dr Suntharalingam described last week, and the poor
17	mental health impacting negatively upon patients?
18	PROFESSOR SUMMERS: I think that is a really difficult and
19	complicated question that's not easy to answer. How
20	much would be enough to offset what everybody has been
21	through? I'm not sure that for people whose loved ones
22	who were in hospital, for those of us that were in
23	hospital or in primary care settings or in social care
24	settings, there would ever be enough support to make
25	what we all went through better.
	113
1	either the same people or different teams look after the
2	staff or patients. This is part of standard critical
3	care in other countries such as France, and I think this
4	has been an important positive development.
5	I wouldn't want, in any way, to say that is enough
6	for a part of it, but it is a group of staff, just to
7	mention, really, the work they do, and the importance of
8	having them resourced and funded. But that's only one
9	small part and I completely agree with Professor
10	Summers's wider message.
11	PROFESSOR SUMMERS: And it is not just intensive care staff
12	that carry these scars.
13	MS MUNROE: Thank you both very much.
14	We've gone over into lunch, I do apologise.
15	LADY HALLETT: Don't worry, not your fault. That completes
16	all the questions we have for you, thank you both for
17	all your clinical work, obviously, and I can only
18	imagine the scars you talked about.
19	Thank you for your help in preparing the written
20	report, and, of course, the help you have given in the
21	course of your evidence. It has been extremely helpful.
22	And thank you for your patience, having had your
23	evidence disrupted last week. So thank you again.
24	2.10 pm.
25	(The witnesses withdrew) 115
	ΠU

inquiry	5 OCIODEI 2024
1	Is there enough support to enable people to
2	continue to do their roles in a way that makes the
3	healthcare safe? I think the commitment and the amazing
4	efforts by healthcare workers, and social care
5	workers I think that should be recognised too to
6	continue to deliver care for those that need it, has
7	been extraordinary. Many of them are continuing to do
8	so, carrying the scars that I talked about. They won't
9	ever be the same. There is no going back to how we were
10	before; that is not possible, we can't unsee things, but
11	there is a huge, huge burden of care that is still
12	needed. There are enormous elective waiting lists and
13	care lists that need to be addressed because they were
14	delayed during the pandemic, and we went into the
15	pandemic with some fairly sizeable waiting lists too.
16	So, there is no chance to pause and reflect and
17	stop and repair; people are doing the very best they
18	can.
19	DR SUNTHARALINGAM: I would completely agree with that, and
20	l would like to raise anyway without taking away
21	anything from that so one positive learning, I think,
22	an improvement has been there is greater emphasis now
23	across the healthcare sector about well-being, but also
24	in concrete terms more ICUs now have clinical
25	psychologists, funded and deployed, and they look after
	114
1	(1.06 pm)
2	(Luncheon adjournment)
3	(2.10 pm)
4	LADY HALLETT: Mr Fireman.
5	MR FIREMAN: May I please call Dr Mathieu.
6	DR STEPHEN MATHIEU (affirmed)
7	Questions from COUNSEL TO THE INQUIRY
8	LADY HALLETT: I hope you haven't been waiting for too long.
9	A. No, not at all. Thank you.
10	MR FIREMAN: Could you please give your full name.
11	A. Stephen Mathieu.
12	Q. Dr Mathieu, you have given two witness statements to the
13	Inquiry. They are dated 26th March 2024 and
14	20 August 2024 and for the record they are INQ000472300
15	and INQ000474302.
16	Dr Mathieu, you are the president of The Intensive
17	Care Society; is that correct?
18	A. That is correct.
10	• And you have been in that regition gives December 20222

- 19 **Q.** And you have been in that position since December 2022?
- 20 A. That is correct.
- 21 Q. You are also a consultant in critical care at Portsmouth
- 22 Hospital University Trust; is that right?
- 23 A. Correct.
- 24 Q. What is the role of The Intensive Care Society?
- 25 A. Thank you.

(29) Pages 113 - 116

1		So The Intensive Care Society is a charity. It	1
2		was founded in 1970. It is the largest	2
3		multi-professional intensive care society, certainly in	3
4		the UK and across Europe, and its main purpose is	4
5		effectively to be the voice and support for patients,	5
6		relatives and do that through our team. So our	6
7		multi-professional staff.	7
8		So we do that through education, policy standards,	8
9		guidelines, encouraging research, education.	9
10		The Society itself has 23 council members and it	10
11		has 10 professional advisory groups which means that	11
12		amongst the team we have probably got to near 100 people	12
13		that are active clinicians, multi-professionals, that	13
14	_	work throughout our country.	14
15		You say across the UK, is the society UK-wide or it is	15
16		England-specific?	16
17	Α.	It is UK-wide. And thank you, that was the purpose of	17
18		the supplementary appendix. We do our very best to	18
19		support and to provide a voice for all nations but	19
20		clearly we do that in very close collaboration with	20
21		other partner organisations, including the Welsh	21
22		Intensive Care Society, Northern Ireland and Scottish	22
23		Intensive Care Society.	23
24		Just for clarity, what is the role of those individual	24
25		societies given that The Intensive Care Society has 117	25
1		Just for clarity, you confirmed earlier your	1
2		professional role as well as your role as president of	2
3		the Society. Were you also working in intensive care	3
4		during the relevant period?	4
5	Α.	I was. So I have a clinical and a management role in my	5
6		organisation throughout the pandemic period. I would	6
7		have effectively worked full-time on critical care.	7
8	Q.	Were you also heavily involved with the Society although	8
9		you weren't president, were you heavily involved with	9
10		many of the ongoing activities of the Society during the	10
11		pandemic and during the relevant period of the pandemic?	11
12	Α.	Sorry to interrupt. Yes, I have been a member of the	12
13		Society for eight years now.	13
14	Q.	You describe in your witness statement some of the	14
15		activities of the Society during the relevant period	15
16		which included the establishment of the National	16
17		Emergency Critical Care Committee. Can you explain	17
18		I think you use the acronym the NECCC can you explain	18
19		the work that was done by that committee?	19
20	Α.	Yes. So the NECCC, the National Emergency Critical Care	20
21		Committee, was set up at pace and set up specifically	21
22		for us to understand and support our plans, our	22
23		understanding, our engagement, our interactions with all	23
24		the other professional teams, the other disciplines.	24
25		So it was set up by Professor Hugh Montgomery and	25
		110	

1		a UK-wide reach?
2	Α.	I think they have a very important role but and, as
3		I say, we do collaborate with them. The intent is very
4		much for us to do that together, but I think it is
5		important that we reflect that we are not only trying to
6		do what we need to do for patients, relatives and our
7		teams just in England alone but as you allude to there
8		are other organisations that are important and we work
9		closely with them.
10	Q.	Dr Mathieu, we have heard earlier this morning from
11		Professor Summers and Dr Suntharalingam who are
12		obviously in the intensive care sphere. There may well
13		be some of the issues that we will talk about today that
14		they have covered but so that you are aware, we will
15		cover some of those topics perhaps a little bit more
16		briefly. But those are the topics that I was going to
17		ask you about and so just to give you a heads up that in
18		terms of those topics they include capacity, to some
19		degree, ICU capacity, ethical issues, the mental health
20		and wellbeing of staff working in intensive care, and
21		I will ask you a little bit more specifically about some
22		of the work that The Intensive Care Society did during
23		the pandemic.
24		If I could start with the last of those given
25		that's your specific role.
		118

1		Dr Ganesh Suntharalingam, who is one of the expert
2		witnesses, and it was done very quickly and it was,
3		I suppose, unique in the sense that it was done
4		intentionally to try and for us to understand as much
5		as we could quickly about the SARS-2 virus Covid-19, but
6		also to understand learning from other organisations and
7		other countries, particularly Italy, at that point in
8		time that had just had quite a significant impact from
9		Covid.
10		It was a very different type of committee in that
11		it was very much bottom up. It was nonhierarchical, it
12		was very much an open invite to those that were able who
13		felt they could offer some support/guidance. So we
14		opened it up to all of our council members and the
15		Operational Delivery Networks leads throughout the
16		country. We opened it up to other societies, so
17		actually, what we also did, which I think was the
18		benefit and the power of it, was opening it up to
19		emergency medicine, acute medicine, British Thoracic
20		Society, the Renal Association. So suddenly we had
21		a lot more granular detail about what their experiences
22		were and how we could support each other.
23	Q.	Just for clarity, was this a series of virtual meetings
24		that were taking place?

25 **A.** Yes. So it was set up, as I say, at pace with -- in the 120

1		end there were about 30 virtual meetings, there were no
2		face-to-face meetings, they were all done virtually, and
3		there were also knowledge-sharing webinars. So
4		actually, by doing that, we were able to extend our
5		reach to around 100 organisations.
6	Q.	Did those organisations include government agencies or
7		government departments?
8	Α.	So they included the presidents of the societies of
9		Wales, Northern Ireland and Scotland critical care and
10		they included some of the medical directors of NHSE.
11		But they also included lots of other important people
12		through military, we had all sorts of invites that
13		actually were helpful to get their understanding, the
14		likes of Google, Microsoft, lots of different ideas to
15		try and generate as much information as we could about
16		data, how we could share it, how we could use it, really
17		as a bit of a hive of understanding and knowledge
18		dissemination.
19	Q.	
20		more concentrated on information sharing and supporting
21		members or was it involved actually in shaping any
22		policy in relation to intensive care?
23	Α.	I think the intent was to do both and, if I may, I will
24		perhaps give some examples. So the context to some of
25		this in terms of feeding information through was that 121
1		you are giving examples of where there were discussions
2		that ultimately then led to the production of relevant
3		guidance albeit not necessarily direct cause and effect;
4		is that correct?
5	A.	Yes.
6	Q.	There were discussions about the relevant issues with
7		professionals within the sphere and some of these points
8		were then taken on and produced in a more formal way; is
9		that right?
10	Α.	Yes. I think the intent was always for somebody with
11		-
		the expert knowledge and access to the right people
12		the expert knowledge and access to the right people would be the person who would take responsibility for
12 13		
		would be the person who would take responsibility for
13		would be the person who would take responsibility for those actions and research is obviously a big part of
13 14		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
13 14 15	Q.	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
13 14 15 16	Q.	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.
13 14 15 16 17	Q.	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. Within your witness statement you have set out a number
13 14 15 16 17 18	Q.	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. Within your witness statement you have set out a number of recommendations for her Ladyship to consider in the
13 14 15 16 17 18 19	Q.	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. 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
13 14 15 16 17 18 19 20	Q.	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. 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,
13 14 15 16 17 18 19 20 21	Q.	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. 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
 13 14 15 16 17 18 19 20 21 22 23 24 	Q.	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. 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
13 14 15 16 17 18 19 20 21 22 23	Q.	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. 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

1		The Intensive Care Society set up a national leads
2		WhatsApp group very quickly. That was the sort of
3		trying to get an understanding of what people were
4		feeling at a unit-by-unit level, bringing those
5		experiences and information into NECCC to see whether
6		there was that sort of information was something that
7		others were experiencing and then trying to address what
8		the problem was and help with some solutions.
9		So in terms of the guidance, the statements, the
10		policy side of things, one example is we knew that, for
11		instance, that there was a risk around if there would be
12		enough dialysis machines. I think in the end we were
13		able to provide enough options for renal replacement
14		therapy but at the time we weren't sure, so what we were
15		able to do is work very quickly and agilely with other
16		organisations I think probably removing some of the
17		bureaucracy that can be associated with committees and
18		associations and how you want to navigate some of this
19		guidance documents by getting straight to the experts
20		and getting the guidance out very quickly.
21		I guess that was one example.
22		The treatment decision support guidance framework
23		that has been discussed, that was also discussed at
24		NECCC meetings.
25	Q.	If I could just pause you there for a second. I suppose
		122
1		national emergencies.
2		Do I take it from that that you didn't feel that
3		the Society did have the voice that it should have had
4		during the relevant period?
5	Α.	We are a charity, we are not a Royal College or
6		obviously part of the Academy of Royal Colleges so
7		therefore I suppose our accessibility directly to higher
'		and only to highlight

- 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

8 9

- discussions and we do have those discussions but they 11
- 12 are often a little bit more difficult to navigate and I think the strength of our place and I think it was 13
- 14 demonstrated through NECCC, was that we are genuinely
- 15 a very multi-professional organisation. We are not
- 16 doctors, we are not nurses, we are not physiotherapists,
- 17 we are not pharmacists, we are not the other HPs that
- 18 are important, the psychologists we talked about. We
- 19 represent all of them, and that's where I think we have 20
- the benefit of being able to provide that different way 21 of thinking and therefore our ability, I think, to
- 22 extend into those professions and to get their views is 23 an important one.
- 24 **Q.** Do you think there's anything in the fact that you are
- 25 a charity rather than perhaps a body that might 124

1		otherwise be seen to be more part of, to use
2		a colloquial term, the establishment or something to
3		that effect, the fact that you have charitable status
4		and you are not embedded within the institutions, does
5		that have any relevance here?
6	Α.	I don't necessarily think so and I would want to point
7		out I think the other organisations have an important
8		role to play and we are strategic partners with many of
9		those organisations. I guess the ask, which is the
10		recommendation, is that it would be helpful and I think
11		we would genuinely be able to provide a positive and
12		supportive influence particularly around learning and
13		genuine multi-professional representation; we would have
14		a helpful place.
15	Q.	Can I turn to another topic which is something which we
16		did cover to a great degree earlier on this morning,
17		which is that of intensive care capacity. If I can just
18		ask you a few questions about this area. One of these
19		is in relation to the way in which you measure intensive
20		care capacity, and we heard about the fact that it can
21		be measured and was indeed measured in different ways.
22		You say in your witness statement that on
23		3rd January 2021 this is at paragraph 129 that the
24		Society issued a document advising all hospitals to use
25		the percentage change from baseline as a reporting
		125

1		So if I use that same example, if we create
2		another 20 beds in another part of the hospital and
3		perhaps use a theatre recovery as the example, if ten of
4		those beds are full, you don't then have 75% occupancy,
5		you have got 100 plus 50 or 150%, however you want to
6		describe it, but it just meant that what it looked like
7		was that there were many empty beds available across the
8		UK, which there absolutely were not.
9		So it's about descriptions, it is about
10		definitions, it wasn't in any way, I don't think
11		intended to cause confusion, but that was the result of
12		it, and it is recorded differently I think in Scotland,
13		Wales and Northern Ireland as opposed to how it was very
14		early on in the pandemic in England.
15	Q.	Why is it so important on a practical level to
16		understand the real terms capacity across ICUs, across
17		the country?
18	Α.	So I think why it is important is that we know that when
19		we are at or near capacity, and certainly if we are over
20		capacity, that will have an impact, the impact being the
21		ability to admit patients in a more timely fashion. The
22		ability for staff to stretch to meet those demands
23		because they are already stretched. It also has
24		an impact on decision-making around mutual aid
25		transfers, for an example.
		127

1		figure. Do you recall why it was the Society felt it
2		was necessary to issue that statement?
3	Α.	I do, thank you. So, there was a variation in the way
4		that data was being recorded, and that was leading to
5		confusion, not intended, but it was leading to
6		confusion, and the data that was therefore being
7		declared and discussed at a sort of media level, public
8		level was sometimes inaccurate. Not intentionally, but
9		that was the result of it. So if I could give
10		an example, if we had a 20-bedded intensive care unit,
11		we have a physical capacity of 20 beds. If all of those
12		beds are filled with unwell patients, we have
13		an occupancy versus our baseline capacity of
14		100 per cent.
15		The problem happened is that everyone at the early
16		phase of the pandemic was asked to see where there were
17		opportunities to expand their intensive care bed spaces,
18		and we did that, and I think we did that very well. But
19		what then the risk that then happened is that those
20		beds that were not intensive care beds, they were pop-up
21		ICUs with different staffing ratios, with access that
22		was different to some of the equipment that we have
23		discussed already, meant that as a result of that, it
24		looked like there was more available ICU bed capacity
25		than there was.
		100

1		So that is one element of a wider group of tools
-		So that is one element of a wider group of tools
2		I guess we use to describe pressure on intensive care
3		unit occupancy capacity. CRITCON, which we have talked
4		about already and then if I may, the other bit that
5		none of this describes is all of the activity that was
6		happening outside of what would be an expanded intensive
7		care or critical care footprint. So none of this data
8		captured all of the work that was being done and all the
9		patients that were only cared for on respiratory high
10		care support units in acute medical wards.
11		And that's why I think the definitions are so key
12		here, that we really do capture the amount of work and
13		effort, the amount of people because there is a risk
14		we are talking about beds and capacity people that we
15		are desperately trying to do our best for.
16	Q.	Can I take it from what you have said, then, that you
17		would support there being a nationally agreed definition
18		of capacity to be used both in non-pandemic and in
19		pandemic times?
20	Α.	Yes, and that was very much the reason that we issued
21		our statement and made it public in the hope that that
22		would be captured, and it did. I think it did influence
23		change. We saw some of the data being better accorded.
24		I have seen, first-hand, within my own region, the way
25		we capture data now is much more advanced and accurate 128

4			4	
1 2	Q.	compared to where it used to be. One of the measures that was used to try to increase	1	
2	Q.	capacity was the introduction of Nightingale hospitals.	2	
4		You touch on that very briefly within your statement but	4	
5		I want to just ask you do you consider that the role of	5	
6		Nightingale hospitals and the use of them was	6	
7		an appropriate way to try to increase intensive care	7	
8		capacity?	8	
9	Α.	I think the intent was right in that the data very early	9	L
10	7.0	on in the pandemic, as we were looking at various	10	
11		scenarios, which obviously at that point we didn't have	11	Α
12		the vaccine, we were still trying to understand	12	L
13		a multi-system pathogen that affects all organs, we were	13	
14		trying to better understand what our therapeutic options	14	
15		were.	15	
16		All of the scenarios were showing that we just	16	
17		would not have enough physical capacity, never mind	17	
18		about staffing or equipment.	18	A
19		So I can understand the rationale for looking at	19	
20		it and exploring it. I think the reality as we all then	20	
21		understood is that intensive care is so reliant on	21	
22		a team, a multi-professional team, that need to be in	22	
23		the same place; we need the access to the diagnostics,	23	
24		the other important specialists provide us with their	24	
25		input, and I think with all the best intent, the	25	
		129		
1		terms of stretching the staffing models are all reliant	1	
2		on the existing staff working more, harder, more shifts,	2	
3		all of those things, with the impact that created. So	3	
4		moving them to another hospital not only meant it was	4	
5		the same staff doing that, but actually made you less	5	
6		resilient within your own organisations.	6	
7	MR	FIREMAN: I don't know whether you are able to answer	7	
8		this, but do you think that maybe there is a role for	8	
9		a temporary hospital in circumstances where you need to	9	
10		increase capacity, but that's not necessarily in the	10	
11		context of intensive care?	11	
12	Α.	Yes. I think that's probably well, I think the first	12	
13		thing is that now, in the situation we are in at the	13	
14		moment, it is something we have to explore, which is	14	
15		what would we do and what would we use it for if we were	15	
16		to ask that same question again, and I think the answer	16	
17		is right, that it wouldn't be used for intensive care.	17	
18		The question is, could it be used for other lower acuity	18	
19		level care, provided it has the right staff mix there	19	
20		available to look after those patients, or as a form of	20	
21		rehabilitation, post-acute illness?	21	
22		But I think we do need to understand whether	22	
23		what the benefits would be in the future, and the impact	23	Α
24		particularly around the staffing models.	24	Q
25	Q.	The Society produced a report in January 2021 called	25	
		131		

1		Nightingale hospitals were not going to be able to do
2		that reliably for intensive care. It might work in some
3		places, for instance, in London, in terms of
4		decompressing, but the reality is I don't think it will
5		have worked in the way that it was intended to, and in
6		some ways probably was an unintended distraction in
7		terms of us trying to consolidate and manage the
8		workforce that we had within our own hospitals.
9	LAI	DY HALLETT: Taking up that point, Doctor, given that the
10		staff you had was stretched beyond capacity
11	Α.	Yes.
12	LAI	DY HALLETT: some might argue, and you could only open
13		a Nightingale hospital if you had the staff, the intent
14		may have been good, but the intent was physical beds.
15		How was anybody ever going to staff a Nightingale
16		hospital, given the pressures on all of you working
17		already, full stretch?
18	Α.	Yes, I think you have probably eloquently described it
19		in a better way than I have. I think it is exactly
20		that, which is that space is one thing, equipment is
21		one thing, but the staff is fixed, and intensive care
22		staff, many of the other speciality staffs, they can't
23		we can't just generate them quickly. They take years
24		and years of training, and those staff were not
25		available. So all of these things that we talk about in
		130
1		"Recovery and restitution of critical care". I want to
2		have a look at a passage that was in that report. It is
3		INQ000395297, and it is the third page. If we could
4		just look at this text here that has been enlarged. If
5		we look about four sentences down, there is a sentence
6 7		that starts:
7		"Bed occupancy was thus greater: on
8 9		24th January 2021, 5446 English ICU beds were occupied,
		compared to 3423 in January 2020."
10 11		Then it describes the difference there and it goes on at the bottom the final sentence which says that:
12		"UK-wide in January 2021, 2,251 intensive care
13		beds were occupied above baseline capacity, equivalent
14		to 141 new 16-bedded ICUs."
14		We looked briefly at this earlier today, but if we
16		just come away from this text and look at the box below,
17		you have then mapped these onto the recommended
18		guidelines for the provision of intensive care services.
19		These guidelines, just to be clear, we have heard a lot
20		about staffing ratios, nurses, trained ICU nurses, 1:1
20		being the ideal ratio, and is it 1:8 for consultants or
21		
23	Α.	I think it is 1:8 to 12.
24	Q.	1:8 to 12. Okay, that's helpful. You have set out here
25		all of the additional staff that would be needed to
-		132

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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

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

1		ensure that ratios weren't stretched at the point that	1		cover that.
2		we were in, in January 2021. Have I understood that	2	Q.	Given that this is the amount of staff that would be
3		correctly?	3		needed at a peak of the pandemic, do you accept that
4	Α.	That is correct, yes.	4		during peaks of pandemics, if we had a pandemic that
5	Q.	We can see there is a huge amount of additional staff	5		stretched ICU capacity to the same degree or in fact
6		that would be needed, including up to almost	6		greater than was the case in January 2021, do you acc
7		2-and-a-half thousand critical care nurses in order to	7		that it is necessary to allow staffing ratios to be
8		maintain ratios. You would accept, would you not, that	8		stretched in that scenario?
9		in January 2021, which is we have seen data to	9	Α.	
10		suggest that was the peak of the pandemic, and the	10		could provide in terms of stretching the staffing ratios
11		highest point in terms of occupancy of ICU can I just	11		because the staff that are needed, were needed, are
12		clarify, you aren't suggesting that all of these	12		simply not there. So one of the lessons around that is
13		additional staff need to be recruited to account for	13		how we can be better prepared for the future. The
14		that scenario, are you?	14		corollary of that is that we do stretch the staffing
15	Α.	So, in order for us to be able to deliver the pandemic	15		ratios. We know that that's not the recommendations.
16		level of care in terms of the GPIC standards of the	16		The recommendations are based on what is the right
17		ratios that we recommend, those additional staff would	17		staffing ratios to keep patients safe. So we know there
18		be required, and it is worth just pointing out that	18		is an impact from us doing that, both in terms of the
19		that's for every 12 hour shift. It is double those	19		patient quality care that we can deliver, but also the
20		numbers for a 24 hour period.	20		impact on the staff themselves.
21		Just to give a sense of what that is. For one	21		There are other repercussions of stretching the
22		critical care nurse for us to have one critical care	22		work of the staffing ratios, which is the only way that
23		nurse looking after a level 3 patient on intensive care,	23		we can try and improve the number of practitioners,
24		24 hours a day, 7 days a week, you would need about five	24		improve the quality of care, is to redeploy staff from
25		to six whole-time equivalent critical care nurses to 133	25		other areas, with the collateral damage of those 134
1		decisions being that will impact on the services that	1		that have come into a new environment, with lots of
2		they would usually provide for, and we have seen that	2		skills, but different skills to do their very best as
3		through the delays in planned surgery, and that truly is	3		well.
4		one of the collateral damages of the Covid pandemic.	4	Q.	Looking forward, were we to need to redeploy staff to
5	Q.	Can I ask you about that, following up on what you said	5		intensive care in another scenario, would you support
6		about the need to redeploy staff from other areas. From	6		a programme, perhaps, of staff who routinely don't wor
7		the intensive care perspective, professionals working	7		in intensive care, receiving training on intensive care
8		routinely in intensive care, what was the impact of	8		skills or in fact perhaps working a shift in intensive
9		having to work with staff that weren't ordinarily	9		care every so often? That may not be practical, but do
10		trained in intensive care?	10		any or either of those two options offer suitable
11	Α.	So my experience of it was that everyone wanted to do	11		ways of improving the workforce should we need to rely
12		the absolute best they could do. That feeling was just	12		on redeployment?
13		palpable throughout my organisation and all of the other	13	Α.	I think so, and I think it is an important
14		units that I have sort of discussed with through	14		recommendation because the reality is that we can't pla
15		colleagues, and everyone wanted to help, so that was the	15		to staff intensive care for a pandemic every single day,
16		first thing to say, is whilst some colleagues were not	16		but what we can do is we can make incremental steps
17		necessarily wanting to or felt comfortable within their	17		get us closer to what we need to, when that happens
18		skill mixes to support intensive care, they absolutely	18		again, and anything we can do to reduce that gap, in
19		stepped up and did more than we could possibly ever ask	19		terms of numbers and knowledge base, are key. So, y
20		of then, and we will be very grateful forever for that.	20		will have heard yesterday about enhanced care beds,
21		In terms of what it meant, it meant that the	21		level 1 beds, which are effectively somewhere between
22		existing critical care staff took on a very supervisory	22		a ward base level of care and a level 2 care bed, and
23		role, as well as supporting direct patient care, which	23		critical care, and I think that probably gives us some
24		creates its own pressures and it creates its own	24		opportunities to do some rotational programmes that
25		psychological impact on them, as well as obviously those 135	25		enable people to get exposure to critical care. 136

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published and updated a version of the draft that he had worked on initially. I don't need to take you to the

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

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

us to have more society discussion around these things

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

Q. I understand that the document that was published by The

context of the Covid-19 emergency. Would you support

different emergencies produced perhaps not in the midst

Intensive Care Society which we looked at briefly

earlier was obviously developed and issued in the

the development of a tool that could be adapted to

of an emergency but now or -- now we are not in the 138

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

were the ones that were generally used much more

frequently than other areas for surge capacity in

an oxygen-rich provision.

after patients.

might not need as high volume of oxygen, which is why

the theatre recovery areas and the theatre environments

intensive care because they are also designed to have

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

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

What we have learned from that is that I think we

support visits that we have discussed.

you and the Society would endorse?

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

1		I would say I don't think that in itself is	1
2		enough, there is still a gap to be bridged in terms of	2
3		intensive care capacity.	3
4	Q.	Does it follow that based on the difficulties for staff	4
5		who don't ordinarily work in intensive care in perhaps	5
6		it perhaps being a little bit traumatic for them in	6
7		terms of not being used to seeing very, very severely	7
8		ill patients and often patients dying, does it follow	8
9		that any training should include support around the	9
10		impact of seeing those patients?	10
11	Α.	Yes. Thank you. So it does and I think one of the	11
12		benefits we saw from Kevin Fong's testimony was around	12
13		peer review support and I think that was a very powerful	13
14		way of understanding what was happening at	14
15		a unit-by-unit level and hearing what the staff were	15
16		saying and what the relatives were saying.	16
17		I think as part of that there has to be	17
18		psychological support as well. It is something I can	18
19		expand on if helpful but there has been work that The	19
20		Intensive Care Society has done to I think probably	20
21		dovetail guite well with what Professor Fong discussed	21
22		in terms of psychological support.	22
23	Q.	Dr Suntharalingam was talking earlier this morning about	23
24		the prioritisation guidance that he was working on and	24
25		he explained that The Intensive Care Society ultimately	25
1		emergency phase of the pandemic?	1
2	Α.	I would, yes. We made a decision that whilst that	2
3		decision support framework was not needed, that actually	3
4 5		it was a really important guideline that needed to be in	4
5		the public domain which is why we have published in our	5
6		journal, which is peer reviewed, an academic journal,	6
7		because actually one of the lessons we have to learn	7
8		from this is that the discussions we need to have around	8
9		being genuinely overwhelmed where we have got national	9
10		decompensation and inadequate resources, that we have	10
11		all of the right tools, all of the right discussions, we	11
12		have engaged with all of the right people, and that is	12
13		society, around what is the right thing to do in those	13
14		situations and hope that we never will need them but	14
15	~	that's not a reason not to have the discussion.	15
16	Q.	Can I ask you about a different topic that you have	16
17		discussed in your witness statement and that is oxygen.	17
18		You describe particular challenges that were	18
19		caused by oxygen supply during the pandemic and you	19
20		describe particularly the impact of supply pipes having	20
21		automatic cut offs.	21
22		Are you able to give us a sense of how widespread	22
23	•	this issue was?	23
24	Α.	So I think what we have always thought is that oxygen	24
25		would be an endless supply in a hospital, that there	25

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1		provide the oxygen in the hospital, it was trying to	1		in here which is to understand and to ensure that every
2		find the right location to look after patients that were	2		hospital understands the schematics of their
3		needing different levels of oxygen.	3		environment, and that's something that can be done, to
4	Q.	Is it an issue with the nature of the hospital estate	4		work alongside our colleagues in clinical engineering,
5		rather than the supply?	5		to work alongside our oxygen committee, which is often
6	Α.	Yes, so I think initially there was a concern that we	6		led by a clinical pharmacist, and to basically do
7		would not have enough oxygen supply delivered through	7		a review of all of those things in a hospital. To
8		BOC. That wasn't an issue. There was enough oxygen.	8		understand what the schematics are, first and foremost,
9		It was purely the estates and some of the hospitals, the	9		and then design what you might do differently, if at
10		designs clearly are very, very old which means that they	10		all. It might be that we made all the correct decisions
11		were designed for different purposes or different	11		but actually what we would do differently faced with
12		reasons at those time points.	12		another pandemic that required patients to need more
13		So it was about identifying where the right places	13		oxygen than they would during our baseline level of
14		were to look after the patients, being really cognisant	14		acuity.
15		of the fact that where we wanted to look after the	15	Q.	On a related note is it right that one of the ways in
16		patients might not necessarily be the best location in	16		which patient oxygen concerns are managed is
17		terms of oxygen provision and we would have to adapt	17		including within intensive care, is with the use of
18		that and also for cohorting patients and working out	18		pulse oximeters?
19		what the right balance was in terms of the cohorting of	19	Α.	So a pulse oximeter is a very readily available piece of
20		patients, the proximity to an intensive care environment	20		equipment, effectively a peg that usually goes on the
21		and what would be the best care of course for the	21		finger or an ear and patients will also use them at home
22		patient.	22		to monitor their oxygens for certain chronic conditions.
23	Q.	Beyond building new hospitals, what are the best ways to	23		So it is readily available and we use it as
24		ensure that these issues don't arise again?	24		a marker to understand what the oxygen levels might be
25	Α.	So, I think there are some really quite simple measures	25		in the bloodstream but doing it in a noninvasive way
		141			142
1		which allows us then to titrate oxygen accordingly.	1		the patients that we look after.
2	Q.	On 22 June 2021, the Society issued a statement entitled	2	Q.	So is it about manufacturing and testing products prior
3		"Pulse Oximetry and Ethnicity the time to act is	3		to them coming into force that don't risk inaccurately
4		now".	4		assessing a person's oxygen saturation levels?
5		We can have a look at it. It is INQ000395299.	5	Α.	I think so. I think it is part of the review process
6		If we have a look at the problem, it says here:	6		before any product is licensed that every opportunity
7		"Thirty years ago, it was recognised that SpO2	7		has been taken to ensure that it is calibrated and
8		measurements were less accurate when pulse oximeters	8		validated in a way that is meaningful to the patients
9		were used in patients with darker skin pigmentation	9		that we are caring for.
10		and research in the 2000s confirmed this."	10	Q.	Dr Mathieu, you have been very helpful and you have
11		If this is right why did the Society need to issue	11		explained a number of points within the questions that
12		a statement in 2021 to this effect?	12		I have asked you, so those are the questions that I have
13	Α.	I think, as you say, this has been known for quite some	13		to ask you. I'm going to just ask you now whether you
		years and there are still ongoing studies looking at	14		have any particular recommendations that you would like
14		exactly this problem. I think we felt it was important	15		to point out at this stage that we haven't already
14 15		because of our relience on pulse eximatry that we were			spoken about?
		because of our reliance on pulse oximetry that we were	16		
15		really cascading it for awareness. But also well,	16 17	Α.	Thank you. So, I think probably the key recommendation
15 16				Α.	Thank you. So, I think probably the key recommendation or the key recommendations, if I may, are around
15 16 17		really cascading it for awareness. But also well,	17	Α.	
15 16 17 18		really cascading it for awareness. But also well, I was going to say indirectly but actually I mean	17 18	Α.	or the key recommendations, if I may, are around
15 16 17 18 19		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	17 18 19	Α.	or the key recommendations, if I may, are around workforce. I think there is two elements of that. One
15 16 17 18 19 20		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	17 18 19 20	Α.	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
15 16 17 18 19 20 21		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	17 18 19 20 21	Α.	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
15 16 17 18 19 20 21 22		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	17 18 19 20 21 22	Α.	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
15 16 17 18 19 20 21 22 23		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	17 18 19 20 21 22 23	Α.	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
15 16 17 18 19 20 21 22 23 24		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	17 18 19 20 21 22 23 24	Α.	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.

1	and pressing matter is retention of staff. The pandemic	
2	has really harmed people. We talked about well-being	
3	and psychological support and moral distress. The	
4	number of staff that have left because of what is	
5	basically embedded scars because of the pandemic, trying	
6	to do their very best, is something that we have to	
7	learn from and we have to support them, and whatever	
8	psychological support we can provide and learning	
9	opportunities is key.	
10	I think the oxygen schematics one we have talked	1
11	about is what I have described is a relatively quick	1
12	win, in that we can plan better for the future with no	1
13 14	additional resource by doing that.	
14	MR FIREMAN: Thank you very much.	
16	Those are my questions. Questions from THE CHAIR	1
17	LADY HALLETT: Can I go back to the pulse oximeters,	-
18	Dr Mathieu, please. It seems extraordinary that over	-
19	30 years ago, people could have recognised that those	
20	who had a darker coloured skin might have their lives	2
21	put at risk because these pieces of equipment weren't	2
22	measuring the oxygen in their blood. Whose fault is it	2
23	that nothing has happened? Is it the manufacturers? Is	2
24	it regulations? Is it those who buy the manufacturer's	2
25	products? Where is it going wrong because it is	2
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1	avoid doing them because whilst they will give us more	
2	reliable data, actually we don't want to do unnecessary	
3	blood tests on people, if we can avoid it.	
4	LADY HALLETT: Presumably intensive care specialists would	
5	be trained and know of the problems with pulse oximeters	
6	if you have darker, or black or brown skin?	
7	A. Yes. It is well understood, but part of the reason we	
8 9	wanted to put that statement out was just as another	
9 10	reminder, really. LADY HALLETT: The NHS must have huge buying power. You	
11	might have thought anyway. You are not	1
12	a manufacturer so maybe I need to pursue it with someone	-
13	else, but I do find it extraordinary we haven't solved	
14	that problem.	
15	Right. Mr Jacobs.	1
16	MR JACOBS: My Lady, in fact the question I was going to ask	1
17	has been amply covered, so I shan't cover the same	1
18	ground.	1
19	Thank you very much.	1
20	LADY HALLETT: Thank you very much.	2
21	Mr Weatherby.	2
22	Questions from MR WEATHERBY	2
23	MR WEATHERBY: I'm going to ask you a few questions, Doctor,	2
24	on behalf of the Covid Bereaved Families for Justice UK.	2
25	I want to pick up just a couple of points on staffing	2
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and et cetera. One of the things that the consensus	23		agreed by a number of other groups including the faculty
	24		
	25		and et cetera. One of the things that the consensus

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1		said made clear was that probably the biggest	1		so much they could add.
2		contributing factor to the delivery of care in intensive	2	Α.	That's correct. The way that many intensive care units
3		care is staffing.	3		would have done their very best to manage that would
4		Now, that might seem a very obvious statement to	4		have been to bring those staff that were I suppose most
5		make, but you felt the necessity of reinforcing that.	5		familiar with intensive care, whether they had had
6		Am I right that the Society reinforced that point	6		previous background in intensive care training and had
7		because it is the quality of staffing or the level of	7		gone off to do other specialist work including community
8		training of staffing, rather than quality, that is a key	8		nursing as well, research obviously, the impact of
9		part of the staffing issues?	9		that is that meant some of the research work that needed
10	Α.	You are absolutely correct.	10		to be done might get delayed. So, obviously, we would
11	Q.	Yes.	11		try and redeploy the staff that were most capable and
12	Α.	So there is the staffing in terms of the numbers of	12		able and willing to
13		trained staff	13	Q.	You would be as smart as possible in the way that you
14	Q.	Yes.	14		redeployed?
15	Α.	there is also the experience of those trained staff.	15	Α.	Correct.
16		It takes many years to train as a specialist in critical	16	Q.	The consensus statement went on and expressly stated
17		care. It takes even more years for them to become those	17		that although things had to be done that way, the
18		really, really experienced, high-level performing staff	18		staffing ratios that had been recommended in peacetime
19		that we are all accustomed to working with. That is	19		should remain as they are until or unless there was
20		the risk of recruitment problems at this stage.	20		further evidence about them. That is right, isn't it?
21	Q.	Yes. So in March 2021, here you are, reinforcing the	21		So
22		point that although you have managed to draft in many	22	Α.	Yeah.
23		other staff who did their absolute level best, a key	23	Q.	what the consensus statement said was that GPICS
24		problem was that even where you had the numbers, they	24		addition to recommendations now that's the Guidelines
25		weren't the sufficiently trained staff. So there's only	25		to the Provision of Intensive Care Services that the
		149			150
1		faculty and yourselves put out, just for the record	1		"It is widely acknowledged that the intensive care
2		INQ000361989 so during the pandemic, although you had	2		workforce is costly. However, previous attempts to
3		to have this work-round as best as you possibly could,	3		re-configure this workforce in order to reduce staffing
4		you were underlining that that shouldn't become the new	4		budgets have resulted in negative patient outcomes."
5		norm, and that the recommendations that had been made	5		That's pre-pandemic. So, during the pandemic, the
6		before the pandemic should remain in place. That is	6		Society puts out this consensus statement indicating
7		right, isn't it?	7		that so far as is possible we have to keep to the
8	Α.	That's absolutely correct. The point being that those	8		recommended levels, otherwise patient outcomes will be
9	7.0	standards are the best evidence that we have for our	9		negatively impacted. That is right?
10		safe staffing model at present, and we have to or had to	10	Α.	So that's correct
11		stretch that staffing ratio to enable us to care for the	11	Q.	Yes.
12		number of patients that we needed to look after. What	12	<u>А</u> .	and the only way of managing to keep to those
13		we couldn't do and shouldn't do is reset those standards	13		staffing levels was for the existing staff to do more,
14		as business as usual.	10		and that's exactly what they did do.
15	Q.	Yes, and the worry was that if those standards slipped	15	Q.	Because you simply didn't have the sufficiency of staff,
16	ч.	without evidence to the contrary, but unless they were	16	ч.	then that would inevitably have led to a negative
17		kept, then the problem was that they would be a negative	10		impact?
18		impact on patient outcomes. That is right, isn't it?	18	Α.	Correct. I'm in agreement, the staffing levels are
19	Α.	Yes, I think that's absolutely right. The staffing	10	Λ.	there for a purpose, which is that we know that those
20	Π.	levels, the staffing ratios are embedded within the	20		are the safest staffing levels that we require to look
21		Guidelines to the Provision of Intensive Care Services	20		after acutely unwell patients (overspeaking)
22		for that exact reasons, which is safe staffing models.	21	Q.	Yes, and in fact there is ICNARC data showing there were
22	Q.	We don't need to go to the GPICS guidance from 2019 but	22	ά.	higher acute hospital mortality rates where there was
23 24	ά.	I do just want to read out one sentence from it if I can	23 24		a higher capacity strain on ICUs?
24 25		find it, which is at page 32 of it. It is this:	24 25	Α.	That is correct.
20		151	20	д.	152

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professionals:

level of care."

leaning down.

criteria?

MR WEATHERBY: I'm so sorry.

On the left-hand side we have "Instructions from

"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

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

It's 28% of critical care nurses and 17% of

rather indicates that there were instructions on blanket

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

A. So that's exactly what this data suggests, and I have

That is a huge proportion, yes? Then, on the

employers". This is the survey of healthcare

1	Q.	Quickly moving on, changing the subject to older people.	1
2		The Society's clinical guidance about critical care and	2
3		Covid again I will give the reference, we don't need	3
4		to put it up INQ000395282 and it is at page 5 that	4
5		clinical guidance that the ICS put out makes clear, and	5
6		l quote:	6
7		"Each patient will continue to be considered as	7
8		an individual comprehensive individualised	8
9		assessments will be used and that short of reaching	9
10		a CRITCON 4"	10
11		We discussed earlier today that had other	11
12		approaches should not be used for individualised	12
13		decision-making. Is that a fair summary of the guidance	13
14		that was put out?	14
15	Α.	It is, yes. I mean, it is absolutely clear, as you say,	15
16		that the guidance is only to be used in the context of	16
17		national de-compensation at CRITCON level 4, with some	17
18		decision support frameworks and ethical guidance that	18
19		surrounds that, yes.	19
20	Q.	I think you have seen the research that was done for the	20
21		Inquiry, the IFF research on escalation of care. I do	21
22		want to show you this bit. We looked at it briefly with	22
23		the experts this morning, but there is one more page	23
24		I just want to put to you for your comment. I think it	24
25		is available. It is INQ000499523, and it is page 24. 153	25
		155	
1	-	a clinical decision.	1
2	Q.	All right. I shan't ask you anything more about that	2
2 3	Q.	All right. I shan't ask you anything more about that data then, but obviously it is there.	2 3
2 3 4	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	2 3 4
2 3 4 5	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	2 3 4 5
2 3 4 5 6	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	2 3 4 5 6
2 3 4 5 6 7	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	2 3 4 5 6 7
2 3 4 5 6 7 8	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	2 3 4 5 6 7 8
2 3 4 5 6 7 8 9		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?	2 3 4 5 6 7 8 9
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2 3 4 5 6 7 8 9 10 11 12 13		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? 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	2 3 4 5 6 7 8 9 10 11 12 13
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2 3 4 5 6 7 8 9 10 11 12 13 14 15	A.	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? 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	2 3 4 5 6 7 8 9 10 11 12 13 14 15
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16		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? 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 Can I just stop you there, just on that point, sorry to	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	A.	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? 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 Can I just stop you there, just on that point, sorry to interrupt you, but we are here talking about data from	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A. 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? 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 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.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	A.	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? 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 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. Oh, apologies.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19
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	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 154
	individualised clinical guidance?
Α.	I'm not I'm sorry, I can't comment on that.
Q.	Fair enough.
Α.	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.
LAD	Y 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

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1		that guidance was very related to CRITCON status.
2		My question is given that CRITCON was not formally
3		adopted in Wales how was it intended that the guidance
4		would be used in Wales?
5	Α.	So I think thank you. I think CRITCON is, as you
6		rightly point out, is not universally used in Wales or
7		indeed Scotland and Northern Ireland. It very much is
8		used within England. I think the size, the
9		organisational structures of Scotland, Wales and
10		Northern Ireland are different and different in a way
11		that the connectivity to higher levels of
12		decision-making at sort of CMO level is probably more
13		direct than it is in England, and that's not meant to
14		be that is a comment rather than a point of view.
15		They are just different types of structures. So what
16		I do know is that there are the way that pressure is
17		discussed and concerns raised will still be to the
18		Parliamentarians, the main decision makers, but not
19		necessarily using CRITCON as that way of describing it.
20		I think CRITCON would be a really helpful tool to
20		be used across all devolved nations because actually
21		what it would do is give us just one simple language
23		that we could then use to enable us when we are at
23 24		a point of national if we were at a point of national
24 25		decompensation to use that scoring that description
20		157
1		difficulties in talking about capacity because of the
1		difficulties in talking about capacity because of the
2		way the data was collected. Were there any other
2 3		way the data was collected. Were there any other barriers or deficiencies in respect of effective data
2 3 4		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
2 3 4 5	Δ	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?
2 3 4 5 6	А.	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? Not that I'm aware of. I think probably, if I may, just
2 3 4 5 6 7	A.	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? Not that I'm aware of. I think probably, if I may, just to try and describe a positive around data capture is
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2 3 4 5 6 7 8 9 10	A.	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? 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
2 3 4 5 6 7 8 9 10 11	A.	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? 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
2 3 4 5 6 7 8 9 10 11 12	A.	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? 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.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	A.	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? 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
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	A.	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? 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.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A.	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? 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A.	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? 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A.	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? 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
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Α.	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? 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

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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? Α. 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 158 My next question is about staff wellbeing which you have addressed at paragraph 94 of your witness

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

14 needed to just try and conform to whatever the guideline 15 would tell us to do but I think equally I think there were concerns expressed about staff testing, when it 16 17 should be done. I think one of the problems we had certainly at points of the pandemic was the fact that 18 lateral flow tests for example would remain positive for 19 a very long period of time even though we knew that from 20 21 a viremic point of view in terms of risk, it probably 22 was much shorter than that and the challenge then became 23 what do you do with that information when you have got 24 staff that are incredibly stretched and staff that want 25 to work, are available to work but might have a positive 160

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1	test.	1
2	I think that's probably a different way to	2
3	describe your point, and I'm sorry for doing it that	3
4	way, but I guess like everyone we were looking at the	4
5	guidelines and being consistent with how we approached	5
6	it.	6
7	Q. And were there any concerns specifically raised about	7
8	absence of routine testing for patients, which is	8 9
9 10	perhaps a slightly different issue to what you have just said about staff?	9 10
11	A. Yes, but probably modified by the use of PPE for	10
12	aerosol-generating procedures.	12
13	MS WOODWARD: Thank you very much. Those are my questions.	13
14	Thank you.	14
15	LADY HALLETT: Thank you Ms Woodward, very grateful.	15
16	That completes the questioning for you,	16
17	Dr Mathieu. Thank you very much for all your work you	17
18	do on the frontline, and obviously for your work in	18
19	preparing your written statement, which I will consider	19
20	as well as your oral evidence, so don't worry if you	20
21	haven't covered something. Thank you very much for	21
22	coming today.	22
23	A. Thank you.	23
24	(The witness withdrew)	24
25	LADY HALLETT: I think that completes the evidence we can	25
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1	Critical Care Network and so speaks to the impact from	1
2	his perspective in Wales.	2
3	Sarah Jones, who is a member of the 13 PBPOs,	3
4	suffered an ectopic pregnancy during the pandemic, and	4
5	she speaks powerfully of the impact of that on her.	5
6	There is the statement from M3/W2, who was a nurse	6
7	originally from the Philippines, who worked in the NHS,	7
8	who gave a statement on behalf of FMHWG.	8
9	There is a statement from Sanjeev Panesar, who is	9
10	a pharmacist based in Birmingham and a member of the	10
11	National Pharmacy Association that we would like you to	11
12	publish.	12
13	There is a statement from M3/W3, who is an ethnic	13
14	minority healthcare worker who assessed patients with	14
15	suspected mental health difficulties that presented	15
16	themselves at A&E that we would ask you to publish.	16
17	Two statements from witnesses from Qatar, Gillian	17
18	Higgins and Nathalie McDermott who speak to IPC	18
19 20	measures, but in addition, Ms Higgins was redeployed to A&E during January 2021, and she attests to that.	19 20
20 21	Indeed Nathalie McDermott, along with the other	20 21
21	matters that she set out, worked on a Covid ward during	21
23	the pandemic. She speaks to that.	22
24	Clare Cole from the John's Campaign speaks about	23
25	the circumstances of her father's death.	25
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uiry	9 October 2024
-	
	hear today. I do hope that the witness' emergency
-	resolves itself successfully.
5	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
5	is the statements of some additional impact evidence
)	that we would like to invite your Ladyship to publish.
0	There are 13 statements in all at this stage to be
1	published, and may I just indicate, without giving the
2	INQs, just the witnesses' names and the brief outline of
3	the topics they cover.
4	There is a statement from Mrs Carla Jones-Charles,
5	who is a member of Trades Union Congress. She is
6	a director of midwifery at the Walsall Healthcare NHS
7	Trust and speaks to the impact on midwives, picking up
8	on some of the evidence you heard this week.
9	The statement of Dr David Bailey, who is a member
0	of the BMA. He is a GP in Wales and so attests to the
1 2	impact of the pandemic from his perspective.
2	Dr Jack Parry-Jones, who is a member of the Royal
3 ⊿	College of Anaesthetists, the Faculty of Intensive Medicine and the Association of Anaesthetists. He is in
4 5	fact the lead clinician for the South East Wales
5	162
	And Rachel Ashton, also from the John's Campaign,
2	was a nurse working during the pandemic, but she sadly
}	cared for her brother who had mental health difficulties
ŀ	and during the pandemic died by suicide in
5	February 2021.
6	And there are two statements from Josh Miller and
•	Priyanka Patel, both of whom are members of the Royal
3	Pharmaceutical Society. Mr Miller was based in Scotland
)	and gives evidence from his perspective there. Ms Patel
0	was a student at the start of the pandemic, and so
1	brings to bear some slightly different evidence about
2	how the pandemic affected her, her studies and her
3	training thereafter. May
4	LADY HALLETT: Thank you. Not only may they be published
5	but I wish to emphasise, yet again, that I will ensure
6	that they are all read extremely carefully and the
7	contents considered. The oral part of these hearings is
8	just one part. The written material is as important and
9	I am just sorry that we haven't got the time to call
0	everybody to give oral evidence. We just don't. Thank
1	you very much. Very well, 10 o'clock tomorrow please.
2	(3.26 pm)
3	(The hearing adjourned until 10.00 am

- 23 (The hearing adjourned until 10.00 am
- 24 on Thursday, 10 October 2024)

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