

Monday, 28 October 2024

(10.30 am)

LADY HALLETT: Good morning, everyone. Today is the first day of the second tranche of hearings for Module 3, impact of the pandemic on healthcare. I hope people have been able to get some kind of break in between the hearings, although I know many will have been working hard to prepare for the next few weeks.

We shall begin with the second part of the impact film. It lasts about 14 minutes -- 13 minutes, 35 seconds, to be precise -- and it contains footage of people from across the United Kingdom talking about the impact that the pandemic had on their lives and the lives of their loved ones.

The range of topics covered include Covid, pregnancy and birth, cancer treatment, and lack of or delayed treatment for other conditions, end of life palliative care, bereavement and mental health. Some may therefore find the second part of the film distressing, as many of the films to date have been.

So I suggest that anyone in the hearing room who wishes to leave, should do so now. And those following online may wish to press "pause" on the recording.

When the film is over we shall reconvene and counsel to the Inquiry, Mr Mills, will call the first

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A. Yes.

Q. Can we begin your evidence, please, with your experience of contracting Covid-19. Take us back to the 24 March 2020. When did you realise that something was wrong?

A. It was actually my mother's birthday and I was baking brownies for her and my son commented on the lovely smell in the house, which I couldn't smell, which seemed a bit odd, I couldn't smell anything at all, which was a shock at the time.

I knew that something was wrong but I didn't realise it was linked to Covid, so the first thing I noticed was lack of smell.

Q. Over the next days, and weeks, how did your symptoms develop?

A. Well, from the start there was no smell, which continued, and then I got a sensation, a burning sensation on my tongue, which I'd never had that experience before, and I contacted the doctor, which was difficult because it was lockdown, that had started, and it was all telephone consultations.

So I had to email with my GP, which was very difficult to explain what my symptoms were, particularly the burning on the tongue. They thought maybe an infection. I was given a spray, which didn't help.

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witness of these hearings.

Play the recording, please.

(Video played)

LADY HALLETT: Thank you very much. We shall resume the hearing now.

Mr Mills.

MR MILLS: My Lady, may I please call Dr Sarah Powell.

Interpreters sworn

DR SARAH POWELL (affirmed)

Questions from COUNSEL TO THE INQUIRY

MR MILLS: Your full name, please.

A. Sarah Kathryn Powell.

Q. Dr Powell, you have provided a statement to the Inquiry. The reference is INQ000421866.

You are a highly specialist clinical psychologist working with deaf people?

A. Yes, that is correct.

Q. You have been deaf since birth?

A. Yes.

Q. And your primary language is British Sign Language?

A. Yes.

Q. A little bit about your family. Your husband is also deaf and a BSL user?

A. Yes.

Q. And you have two sons who are hearing?

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I was given antibiotics three times. In the end the doctor decided not to prescribe any more.

So the symptoms I was having, I had pains in my leg, my arms, my joints, and I was completely worn out, and I could not understand what it was. My eyes felt dry. I had headaches. I couldn't name everyday objects. I remember clearly I was trying to remember the word for "slippers", and I could -- what, those things what you wear, house shoes. I couldn't actually remember the word for "slippers". So all of these things were happening to me and I didn't know what was going on and it was awful.

Q. Can I ask, during this time, were you able to have face-to-face meetings with your GP?

A. No. It was either through email, because obviously I don't use a telephone, being deaf, so it was written through e-mail. And I think twice I had to -- face-to-face appointments, but the doctor wore a mask, I wore a mask, interpreters weren't allowed to attend the appointments at the time, because of infection control and only two people were allowed in the room at the time. So I had to write again. The doctor didn't really understand what I was trying to describe. I just felt as if I was being gaslit. It was difficult that he didn't take on board what I was trying to describe.

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- 1 Q. During those appointments, did you ask whether your
2 symptoms were linked to Covid-19?
- 3 A. Yes, I did, yes. It just seemed -- prior to this I was
4 very healthy, I used to run. And suddenly I couldn't do
5 those things. I was so worn out. And at the same time
6 my husband had been hospitalised and he'd been -- it was
7 confirmed that he had Covid-19. So when I asked, doctor
8 said, "No, you haven't got, because you have not tested
9 positive for Covid-19", but all of the cough -- the
10 symptoms I had, such as the sense of smell, were --
11 you know, weren't the ones that people would have put
12 down to Covid-19, such as the high temperature and the
13 cough.
- 14 Q. So at that time, can I ask this, did you think then that
15 you did have Covid-19?
- 16 A. Yes, I did. I did.
- 17 Q. Moving to September 2020, had your condition become
18 worse?
- 19 A. Yes. Yes, indeed. It was much worse. At that time
20 I was not sleeping well at all, I was having vivid
21 dreams, it was impossible to sleep because of the pain
22 that I was feeling. Specifically down my back. And
23 I emailed the doctor about this, I explained that the
24 symptoms were getting worse. They said: possibly you've
25 got a blood clot.

5

- 1 receive that diagnosis?
- 2 A. Yes.
- 3 Q. Can you help the Inquiry understand how that delay had
4 affected your mental health?
- 5 A. Yes, well, I'm actually a clinical psychologist but this
6 was a massive test for me in terms of my mental health
7 because I felt so isolated. There was nobody that
8 I could talk to who had the same symptoms as me. I was
9 trying to Google, as you do, to find out what is going
10 on with me. There was nobody to talk to, and people
11 were looking at me saying, "But Sarah, you look fine."
12 But I wasn't.
- 13 And I use the example of a car. So it is like the
14 car looks fine on the outside. However, the dashboard
15 is telling you there is all kinds of lights coming up
16 saying there are problems. That's how I felt and
17 doctors -- this particular doctor, it was wonderful in
18 the end because I had been back and forth myself to my
19 own GP, which took so much time. I was given medication
20 that didn't work, that wasn't necessary and I was so
21 frustrated over the whole thing.

22 So I eventually joined a group on Facebook for
23 Long Covid, and at last I felt I was in a community that
24 understood my symptoms -- I think that was around about
25 the July time. I was determined to sort it out and

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- 1 So I was sent to hospital to have this checked
2 out. But actually it turned out to be a positive thing
3 because I finally was validated, because the doctor at
4 the hospital himself had Long Covid and, the symptoms
5 I described, he said, "You've got Long Covid". So
6 I felt completely validated, at last, that somebody
7 understood what I was going through.
- 8 Q. Can I ask, how were you able to have that conversation
9 with that particular doctor?
- 10 A. Well, obviously to begin with we had masks on.
11 I explained that I was deaf and relied on lip-reading,
12 so thankfully the doctor removed the mask. And as you
13 can imagine, at the time that was a risky thing to do.
14 So I was able to lip-read the doctor and explain what my
15 symptoms were, rather than having to write down.
- 16 Also the appointment took a lot longer because
17 I was writing things down, lip-reading, so the doctor
18 was patient with me.
- 19 Also on the same day -- I beg your pardon, at the
20 time we weren't allowed to have interpreters in the
21 room, so I had no choice but to manage with the GP --
22 the doctor, I beg your pardon, through lip-reading.
- 23 Q. You said you felt validated?
- 24 A. Yes, I did. Yes, I did.
- 25 Q. It had taken from March until September for you to

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- 1 still my doctor wasn't taking on board the things that
2 I was telling him until I had gone with my lung to the
3 hospital and got the diagnosis there.
- 4 So that doctor had said to me, "You need to check
5 the antibodies through a blood test to see if you have
6 had Covid", and the numbers came back really high. So
7 I was able to show my doctor this and -- I knew I had
8 the Covid, I absolutely knew I did, but anyway, in
9 the March time -- because my husband had tested positive
10 in the March, I knew how bad it could be, but my doctor
11 had never said, you know, "You've got a positive Covid
12 test."
- 13 My life changed so much during that time, and
14 that's the way it was.
- 15 Q. Even after your Long Covid diagnosis, did some medical
16 professionals dismiss your concerns about your health?
- 17 A. Yes. I will never forget one particular person, one
18 doctor said, "Oh, Long Covid isn't even a thing", and
19 I said, "Well, why are blood donors not allowed to
20 give -- why are people with Long Covid not allowed to
21 give blood? Why are they not accepted to give blood?
22 And also why have the Long Covid clinics been set up?"
- 23 And I felt like I was arguing with this medic,
24 an NHS doctor and I was having to convince him that
25 Long Covid was an actual thing.

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1 **Q.** Can I ask you about your experience of Long Covid
2 clinics. Can you describe the treatment you have
3 received at those clinics?
4 **A.** So when I was diagnosed with Long Covid I was put on the
5 waiting list for a Long Covid clinic. One year later,
6 eventually I got to meet and attend those clinics, five
7 different clinics. My eyes -- you know, my eyes were
8 really bad and as a deaf person that's critical because
9 obviously I use my eyes to see everything and to
10 communicate. They were awful from Covid. It was -- but
11 very frustratingly, over the five clinics, they did book
12 interpreters. I arrived at those clinics, ready to go
13 in, but unfortunately they said an interpreter can't be
14 present because the room was only big enough for two
15 people, obviously myself, the doctor, they hadn't
16 considered the interpreter was attending also.

17 So, I've been waiting for this appointment,
18 waiting for this clinic and an interpreter still wasn't
19 able to attend.

20 So they tried to find different rooms. Obviously
21 they were at full capacity at that time, you know, they
22 had so many things going on and they were full, so that
23 meant the interpreter couldn't attend and the
24 appointments were cancelled, which made it more
25 frustrating because obviously I had waited so long,

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1 worse. So certain foods I can't eat, obviously cakes
2 and biscuits. I've had to reduce my carb intake.
3 Caffeine, I can't tolerate caffeine anymore. It makes
4 the pain worse in my body. I just have to drink water
5 constantly. I can't function for one hour without
6 water, I have to -- you know, because I have excessive
7 dry mouth still.

8 I can't remember when the pain actually -- a day
9 without pain actually. I have to have a bath with Epsom
10 salts. Every morning I have to have that, I have to, to
11 help me to be able to function in the day. You know,
12 things you take for granted like cleaning the house
13 I can't do, I have to do one thing so, for example,
14 cleaning the sink. Before I could clean the whole house
15 in one go, now I can barely clean one sink. I really
16 have to plan things in advance and the number one thing
17 that helps me is pacing myself. I have to plan. You
18 know, if anything happens unexpectedly, you know, then
19 I'm going to be -- it's going to ruin my routine and
20 I'll be wiped out. You know, if I'm doing something in
21 the evening -- if I'm doing something in the day I can't
22 go out in the evening also.

23 You know, activities such as going out, you know,
24 on a Saturday or Sunday, I have to book the Monday off
25 if I do Saturday and Sunday. You know, that's my

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1 you know, I thought the interpreter was sorted, but it
2 still wasn't possible.

3 So that wasn't a one-off, this happened
4 repeatedly. And I felt that my treatment was prolonged,
5 that I wasn't getting the treatment that, you know,
6 I thought I'd get from the start because of not being
7 able to have interpreters present.

8 **Q.** One of the things you say in your statement is that
9 medical professionals had told you to exercise more.
10 Can you tell the Inquiry about the impact that
11 exercising had on your symptoms?

12 **A.** I think one of the big reasons I had Long Covid because
13 I carried on exercising. You know, I'm still, you know,
14 pissed off about that at the moment. At that time I was
15 absolutely wiped out. You know, I couldn't function, as
16 I've explained, and the doctor said, "Okay, well, it's
17 better that you exercise some more, just carry on". And
18 as a, you know, psychologist I know the benefits of
19 exercise, absolutely, but that didn't work in this case
20 and I honestly believe that if I hadn't exercised then
21 these symptoms -- I wouldn't have these symptoms today.

22 **Q.** Can you help the Inquiry understand how you have had to
23 change your lifestyle as a result of Long Covid?

24 **A.** Well, I mean, sugar. For one, I've had to cut out sugar
25 because of my burnt tongue sensation. Sugar makes it

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1 holiday that I'm having to take just to recover,
2 you know, it's -- rather than actually going on holiday,
3 going for day trips, I'm booking that extra time for
4 recovery.

5 Walking is painful. I have to plan to make sure
6 these are just short walks. Public transport is
7 incredibly painful, you know, going on the Tube, the
8 stairs are absolutely awful, I'm having to take
9 painkillers to manage that.

10 You know, I have a blue badge now. I never
11 thought that I would need a blue badge now, you know,
12 but I have to. It does help me to reduce the walking to
13 different places, reducing, you know, how many stairs
14 I have to do. But people look at me, even now, and
15 I feel judged, actually saying, "Well, she looks
16 absolutely fine". But, you know, I might be looking
17 like I function okay but inside I'm absolutely not.

18 It would be lovely to do things without having to
19 think about them. I would absolutely love that and to
20 not have to pre-plan. I wish I could.

21 **Q.** Can I move now to your husband's experience. I believe
22 his Covid-19 symptoms started on 23 March 2020, is that
23 right?

24 **A.** Yes.

25 **Q.** Can you tell us about the symptoms he experienced?

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1 A. It makes me smile actually, because his symptoms at that
2 time -- he lost his taste, but we didn't realise at that
3 time, and he blamed my cooking. And he said, "Oh gosh,
4 your cooking tastes awful", and I was thinking: okay,
5 well, maybe -- I've lost my sense of smell so maybe
6 that's affected my cooking. So, okay.

7 The next day still, you know, he was complaining
8 about my cooking, and I thought: okay, do you know what,
9 maybe you need to go to Marks and Spencer and buy
10 ready-made meals. Okay? Still he was saying, "It
11 doesn't taste right". And this went on Monday, Tuesday,
12 Wednesday.

13 By the Thursday, he started to be very tired, very
14 fatigued, and I was thinking something is not right. So
15 I decided to -- for him, he booked Friday off, sorry.
16 So he booked Friday off work. And we are both key
17 workers so we -- you know, we were still working through
18 lockdown, but we decided to -- he decided to book Friday
19 off. So that was -- and he took to his bed. So that
20 was fine. You know, I thought, well -- you know, not
21 really worried, you've gone to bed.

22 By Saturday he was sleeping non-stop. I had to
23 really nudge him to wake him up. I wanted him to have
24 fluids. He's got kidney issues so I thought it is
25 really important that he keep drinking. So I would wake

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1 have a temperature or cough but something felt like it,
2 and I decided to stay in the room with him and I slept
3 on the floor that night. But -- you know, I wanted to
4 be around for him, and I still felt, you know, in my gut
5 something wasn't right.

6 So I rung 111 again and they said they're going to
7 call me back. And I explained, well -- you know, we
8 have a telephone system called Tynetalk which means the
9 hearing person can make the telephone call, they -- and
10 the operator types your message and gives it to me as
11 the deaf person, I will read what you've said and typed
12 and I will type back and we do it through that way. But
13 you need to use a prefix, a number 1, to use this
14 service, and I knew, NHS 111, their computer system
15 would not accept that prefix. So they would not be
16 compatible.

17 So I tried to explain this. I said it wouldn't
18 work, "You won't be able to call me back", but they were
19 adamant. They said, "No, we will call you back", and
20 I said, "Okay, well, I've got my laptop ready", you
21 know, for this Tynetalk. You know, I'm ready and
22 waiting.

23 About 1 o'clock in the morning and the phone was
24 ringing, and I have my phone vibrating in my pocket and
25 they are talking to me. So I ran frantically to wake up

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1 him up to drink fluids. But he kept falling fast back
2 to sleep and I thought, actually, something's not right.

3 And at that time I thought maybe there's an
4 infection, maybe sepsis, you know, because he was not
5 going to the toilet, you know, after these fluids. So
6 I rang 111, through BSL, and of course had to wait
7 a long time. You know, at that time, everyone -- there
8 were a lot of waits. So, you know, they explained to
9 me, you know, advice and they thought: actually we think
10 it is an infection. But they are going to send for
11 an ambulance. And because of Covid at that time we had
12 to wait a long time for an ambulance. I think it was
13 a few hours before the ambulance arrived.

14 So then when the ambulance did arrive, they were
15 in masks, you know, all PPE, gloves, everything, and
16 communication was incredibly difficult, having to write
17 things down. So I had to ask my son to help with
18 communication, because, as I said, my son is hearing,
19 trying to explain the symptoms to the paramedics. So
20 the paramedics said, "Actually it is an infection but we
21 don't think it's sepsis, so it's best you call the
22 doctor on Monday."

23 Okay, so I thought -- but I still thought: okay,
24 something still doesn't feel right, and at that time
25 I thought possibly it could be Covid. I know he didn't

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1 my son. I mean, poor him, I had to ring -- wake him up.
2 And then it cut off, they stopped ringing. So I said,
3 you know, "I'm sorry" to my son and went back to bed.
4 Then again the phone rang and I'm running again to my
5 son's room, waking him up, and again they hung up, so --
6 and it cut off. So it meant no phone calls could get
7 through.

8 About 5 o'clock in the morning my husband,
9 you know, nudged me in a sort of frantic -- he nudged me
10 and said "I can't -- I'm having trouble breathing,
11 I can't breathe."

12 At that time there was no 999 BSL, you know,
13 no 999 service, so you had to do an emergency text
14 to 999 and explain -- I explained that my husband
15 couldn't breathe, he was sweating profusely, I --
16 absolute panic, it was a terrible moment. And about for
17 half an hour, you know, which is a long time in those
18 sort of moments, an ambulance came with a doctor --
19 absolutely awful because, you know, my husband couldn't
20 breathe and it was -- you know, we were having to really
21 struggle with breathing, communication was nowhere,
22 I had to again wake up my son.

23 So I woke up my son -- sorry. Sorry, it's
24 difficult because for the first time I had to use my son
25 for communication. I'm, you know, adamant I don't want

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1 to use my children for my communication needs but, you
2 know, I could not communicate with paramedics or the
3 doctor. You know, we couldn't write things down to
4 explain what was happening. There was no time. This
5 was an absolute emergency. It was, you know, life or
6 death: my husband couldn't breathe. So I had to use my
7 son for communication.

8 And I don't know what it was like for him. I can
9 only imagine. You know, to see his father in this
10 state, the ambulance, the doctor.

11 Anyway -- thank you.

12 Anyway --

13 **Q.** Take a breath, Dr Powell. Take a breath.

14 **A.** His oxygen level was really low and they decided to take
15 him to hospital. So they went to hospital. I stayed
16 home. I had to stay home. And I was consoling my son.
17 You know, it just all happened so quickly.

18 **Q.** During his stay at the hospital, how was your husband
19 able to communicate with staff there?

20 **A.** Well, he didn't. Originally he went along to A&E, he
21 was taken to A&E, and he described it that the staff
22 were in these suits, these hazmat suits. And they were
23 completely covered, their faces, with masks and what
24 have you. And so he explained that he was deaf and used
25 BSL. He wrote that down. And they said: well, you

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1 **Q.** I think on his third or fourth day you received
2 a message from him asking you to translate a note
3 a doctor had written to him. Can you tell us what that
4 note said?

5 **A.** The note said that he was getting worse and wasn't
6 responding to treatment and that he would have to be
7 ventilated, and so the doctor was asking for consent.
8 And my husband -- there was no communication from the
9 hospital, appropriate communication. And I didn't
10 realise it was that bad until I saw the note that my
11 husband asked me to translate.

12 I couldn't translate it into BSL -- because
13 normally if my husband's not understood something,
14 I would do a quick video and sign to him what a written
15 information might say, but because I was so upset by the
16 content of the note, I couldn't describe it in BSL, so
17 I had to do a very plain English translation and said to
18 him, "Speak to the doctor and ask them about your
19 treatment". I just said that, "You're going to need
20 different treatment that may help. They may need to put
21 you to sleep to help you breathe."

22 I wanted to say more than that but I was terrified
23 for him because he was so isolated in hospital, he was
24 so alone with no communication and no support. No
25 interpreter provision.

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1 know, we can't get an interpreter, it's impossible
2 because of the restrictions with the Covid. You're
3 going to have to write with us. He was very poorly at
4 the time.

5 Now, normally deaf people might use a video
6 message to communicate with one another but he wasn't
7 well enough to do that, so it was very brief texts
8 between him and I. So I was at home, not really knowing
9 what was going on in the hospital, and my husband must
10 have been terrified, because he was alone, he didn't
11 have me with him, and everybody had masks on or the haz
12 suits. He was having difficulties breathing, he was
13 using oxygen, and they were monitoring all of his
14 levels.

15 The hospital wrote to him that it may be Covid-19,
16 Coronavirus, and they said they'd have to test him. But
17 I can't imagine that -- he told me about the staff
18 coming with a hazmat suit on and a box with, you know,
19 the skull and crossbone symbol on the box, and that's
20 what my husband saw and he didn't know what was in the
21 box. He knows now but at the time it was all new to him
22 and he wondered: well, what is in this box? What are
23 they planning?

24 Two days later he did test positive for the
25 Coronavirus and was put on a ward for that reason.

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1 **Q.** Was ventilation necessary in the end?

2 **A.** No, thank God. They were preparing to move my husband
3 across. They wanted to do one more test before and his
4 oxygen levels started to go up, so they didn't -- they
5 said: let's just wait and see. And eventually they
6 decided they didn't need to ventilate. Yeah.

7 **Q.** A few days later I think, you received a message from
8 him to say that he could come home?

9 **A.** Yes. Yes. It was strange really because I'd had no
10 contact from the hospital. I'd had to -- and I felt --
11 I wondered if I was hearing, if I wasn't deaf, would
12 there be more contact. Because it seemed that hearing
13 family members were getting information about their
14 loved ones, and they weren't prepared to communicate
15 with me. And all the information that I got about his
16 healthcare and what was happening in the hospital was
17 coming from my husband, not from the hospital staff.

18 Can you imagine that? He was so ill, so poorly,
19 and he had to take control. He'd send me photographs of
20 the drapes and the equipment they were using, his
21 oxygen, with a few words.

22 Anyway, he text me to say he was coming home,
23 which I thought was odd. And they had written him
24 a note, so he took a photograph of the note that the
25 staff had written for him, and they said his symptoms

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1 were stabilising and he was okay to go home to recover.
2 Which of course I was delighted about. But at the same
3 time I thought: is he really ready to come home, because
4 he had been so, so ill? And how are we going to cope at
5 home?

6 Anyway I realised that they were short of beds and
7 they needed to get other people in, but -- I know that
8 now, but at the time I didn't realise that.

9 When I went to pick him up I was sat outside the
10 hospital in my car waiting for him. Now, they were
11 waiting -- the staff were waiting for the corridor to be
12 clear before they could bring my husband out. He was in
13 a wheelchair. And -- so, for me, I thought: he is
14 really -- he's still ill.

15 So I got him into the car and my husband burst out
16 crying. He burst out crying because of the awful
17 experience he'd had in hospital and he was so happy to
18 be with me, to be able to communicate on a one-to-one
19 with me.

20 **Q.** How would you describe your husband's symptoms when you
21 collected him and then over the next few days?

22 **A.** Well, he'd lost weight. He'd lost weight. Because he's
23 a big man. And it was so obvious that he'd lost weight.
24 He was weak and tired. So, so fatigued. We went home
25 and he went straight to bed. I kept checking, "Are you

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1 an infection. He was given antibiotics and came home.

2 So it worked so much better having that
3 communication on a one-to-one and I was so anxious that
4 I didn't want him to go through that experience again
5 that he had had through the hospital and, as I've said,
6 interpreters weren't allowed to be there face to face,
7 hence the online.

8 **Q.** Can you describe the long-term impact that Covid-19 has
9 had on your husband?

10 **A.** We both had different symptoms. His main symptom is
11 fatigue; very fatigued. Loss of taste, still has loss
12 of taste, and has pain, joint pain. His memory is
13 very -- he forgets easily so it's hard for both of us to
14 sort of adapt to that because he has loss of memory and
15 it's difficult to remember things, so I try to be very
16 patient. Obviously, that doesn't always work, but,
17 you know, we try to have different plans and systems in
18 place, having sort of things visual to help remember.

19 He was diagnosed with -- he was diagnosed with
20 a blood clot, an unprovoked blood clot, but we knew it
21 was linked to Covid-19 and recently the -- he had an
22 infection and his body couldn't cope so he had to stay
23 in hospital for a number of days for that infection.
24 His immune system was so low, that's similar to me.

25 You know, he has had terrible, you know, trauma,

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1 okay?", and he said, "Oh, I'm just worn out." He
2 couldn't really walk, he couldn't manage the stairs very
3 well so stayed upstairs in the bedroom, and then he
4 started to get some chest pain. So I was ever so
5 worried about that, contacted 111 again through the BSL
6 system, explained what had happened, got a call back --
7 they said, beg your pardon, "We'll call you back", and
8 I said, "No, that system doesn't work, we are not doing
9 that this time." And they said, "Well, you know, he's
10 been" -- I insisted that he was seen by someone at this
11 point and eventually they said, "Go to the Covid
12 centre."

13 I wasn't allowed to go with him but I didn't want
14 him to have the same experience again with the
15 communication breakdown and so I contacted a team of
16 interpreters that I work with regularly through my
17 employment and managed to find one and said, "Will you
18 be able to work with my husband online whilst he goes to
19 this appointment", which we paid for, from our pockets,
20 because the experience had been so bad and we wanted to
21 avoid that.

22 So we went along to the Covid centre and the
23 interpreter was working with him remotely and it went
24 really well. My husband felt so much better. He was
25 able to describe what was going on. They diagnosed

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1 experience from what has happened. He still can't talk
2 about really what has happened and he struggles and he
3 has that trauma from that experience in hospital still.

4 **Q.** Finally Dr Powell, can I ask you this: what could have
5 been done to improve both of your experiences of the
6 healthcare system during the pandemic?

7 **A.** Four years later, my husband went to hospital actually
8 recently, I stayed for six days and there was still no
9 interpreter. So things haven't changed from then until
10 now. So that's a clear example of that.

11 I wish, you know, there'd be automatically flagged
12 up on the medical system to say: this patient is deaf,
13 they use BSL. You know, there's a system for accessible
14 information standards, but still it's not widely known.
15 I wish it would automatically flag up to show that I'm
16 a deaf BSL user.

17 I wish their computer system would allow the
18 prefix to use -- to make that phone call, you know,
19 because not all deaf people can, you know, whilst they
20 use BSL, they can't use Ttypetalk. It is very primitive,
21 the access at the moment still. They should be able to
22 have -- you know, to be able to access that
23 communication. They should be able to have the
24 interpreter the same day of admission, either face to
25 face or use a remote device. Anything -- you know, that

24

1 they can have that, BSL, and they are able to articulate
2 how they want to -- their chosen language, which is BSL
3 using an interpreter, rather than us having to write,
4 you know, scrappy pieces of notes, you know, English,
5 how do you articulate that, these very complex things
6 that are going on in hospital? So this access
7 absolutely needs to improve.

8 And I feel mine and my husband's symptoms, they've
9 been prolonged because of these barriers in
10 communication and access.

11 But also I wish the doctors would accept more
12 about Long Covid is a thing rather than having to prove
13 myself, showing different things to show that I have
14 Long Covid, to have this explanation, I wish that they
15 got it straight away from the symptoms and, you know,
16 the impact that that has had. I accept that there is
17 still not much known in terms of the treatment for
18 Long Covid, I do understand that, but what I want is
19 that acceptance that Long Covid is a thing and that's
20 really important for me.

21 You know, it was such an awful experience to be
22 dismissed by medical professionals, to experience those
23 barriers, arriving to an appointment, you know, saying
24 the appointment room isn't big enough, not considering
25 the interpreter, you know, come on!

25

(Witness withdrew)

1 **MR MILLS:** My Lady, may I please call Caroline Abrahams.

2 **CAROLINE ABRAHAMS (sworn)**

3 **Questions from COUNSEL TO THE INQUIRY**

4 **MR MILLS:** Your full name, please?

5 **A.** Caroline Susan Abrahams.

6 **Q.** Ms Abrahams, you are the Charity Director of Age UK?

7 **A.** I am.

8 **Q.** You have provided a statement to the Inquiry. The
9 reference for that is INQ000319639.

10 Can you begin by describing in broad terms the
11 work of Age UK?

12 **A.** Age UK is a national charity for older people. We have
13 130 component parts. We have 120 local Age UKs which
14 offer services and support to older people in their
15 local communities.

16 We also have Age Scotland, Age Wales,
17 Age Northern Ireland, and there's a national charity
18 that provides information and advice, and that also
19 lobbies and campaigns on behalf of older people and
20 a sister charity called Age International that supports
21 older people in low- and middle-income countries.

22 **Q.** First topic, please. The heightened risk that Covid-19
23 posed to older people.

24 At paragraph 10 of your statement you identify
25

27

1 You know, I've got an appointment finally for
2 rheumatology but they are saying it is a telephone
3 appointment. Why did they not read the notes to say I'm
4 deaf? So even now they are offering me a telephone
5 appointment. That appointment now has had to be
6 cancelled so I will have to wait some more until they
7 can find me a face-to-face appointment.

8 So it is still ongoing. We are still facing these
9 barriers.

10 **MR MILLS:** Dr Powell, thank you.

11 My Lady, that's all I ask.

12 **LADY HALLETT:** Thank you very much indeed for your help,
13 Dr Powell. I'm very grateful. I just hope that the
14 symptoms that you and your husband are suffering do ease
15 in the foreseeable future, I appreciate how difficult it
16 must have been. I've become very conscious since
17 I started chairing this Inquiry of how acceptance of
18 Long Covid is so important to sufferers like you.

19 I also hope you have forgiven your husband for his
20 monstrous remark about your cooking.

21 **A.** Yes.

22 **LADY HALLETT:** Thank you very much.

23 **A.** Thank you.

24 **LADY HALLETT:** And thank you very much to our excellent
25 interpreters.

26

1 that age is the single biggest risk factor for
2 experiencing severe illness and dying from Covid-19.

3 **A.** Correct.

4 **Q.** In doing so, you refer to a study by the Intensive Care
5 National Audit & Research Centre. I wonder whether you
6 could tell us what that study found.

7 **A.** Yes, certainly. It found what you have just said, which
8 is the older you are, the more likely it is that if you
9 do contract Covid-19 you will suffer serious illness or
10 death, and it goes up very steeply with age.

11 **Q.** I wonder if we could go on screen, please, to
12 INQ000221437.

13 This is an extract from a paper by the Office for
14 National Statistics about Covid-19 deaths which occurred
15 in April 2020. Can you help us, please, Ms Abrahams
16 with what this graph illustrates?

17 **A.** Sure. So if you look at the green on the far left those
18 are the people who have died from Covid-19 aged under
19 65, and then everybody else, all those other colours,
20 are the people over age 65 who died from Covid-19.

21 So you can see just how much bigger your risk is
22 if you were not a working age.

23 **Q.** So those are the figures. Can we consider the reasons
24 behind them. Why is it, please, that age is such a risk
25 factor?

28

1 **A.** I think it is important to realise there is nothing
2 magical about your numerical age. It isn't that you
3 reach a certain number of years and then immediately you
4 are bound to have a certain outcome. It is much more
5 complicated than that. It is partly, and probably
6 mainly due to the fact that as we get older we are more
7 likely to get certain long-term health conditions that
8 undermine our health and our resilience. So if
9 something like -- a virus like Covid-19 comes along we
10 find it harder to fight it off.

11 People are perfectly able to live with those
12 long-term conditions, but they do make you more
13 vulnerable. And in turn, those conditions, whether you
14 have them or not, partly due to luck, partly genetics,
15 but also very importantly, your social and economic
16 status.

17 **Q.** At your paragraph 17 you comment precisely on that. You
18 list four reasons why older people in the least
19 advantaged circumstances faced both a higher risk of
20 exposure and increased barriers to accessing services.
21 I wonder whether you could take the Inquiry through
22 those reasons, please?

23 **A.** Yes. People from lower socioeconomic groups are more
24 likely to have long-term conditions, to acquire them
25 earlier on in life, to have them more severe, and at the

29

1 disparity started to come to your attention during 2020?

2 **A.** I can't honestly remember when that first became
3 apparent. There was a lot of public conversation during
4 the pandemic about the heightened risk to people from
5 minoritised communities. Very rarely was it said that
6 they were almost all older people. So the debates
7 happened separately, which was bizarre because really we
8 were talking about, almost always, older people but from
9 minoritised communities and, of course, not from all
10 minoritised communities as the highlighted section
11 shows.

12 Communities where there was more affluence were
13 more protected so -- but certainly what we know more
14 generally about the lives and experiences of older
15 people across the board would have led us to believe
16 anyway that people from minoritised communities would be
17 impeded by structural racism as we say indeed in our
18 consultation response.

19 **Q.** You said the debates happened separately. In your view,
20 why did that happen?

21 **A.** I think because of ageism actually. And, of course,
22 that was one of the big problems for the people we're
23 talking about here. They not only faced problems of
24 discrimination due to their age but also because of
25 their race and that was mirrored in the public debate.

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1 same time they face problems in accessing healthcare for
2 a variety of reasons, and their overall circumstances
3 living at home may be more difficult. They may not be
4 able to afford to keep their homes warm. They may not
5 be able to afford special diets, or to eat and drink
6 well enough to sustain their health as well as it might
7 be, and their resilience.

8 So, they face a cluster of problems which made
9 them much more likely to be at risk during the pandemic.

10 **Q.** Can we also, next, think about how an older person's
11 race increased their risk.

12 Please can we go to INQ000217401.

13 This is Age UK's consultation response to the
14 Commission on Race and Ethnic Disparities which was
15 published in November 2020.

16 **A.** Yes.

17 **Q.** If we move to page 2, the last paragraph of the
18 introduction, three lines down we read:

19 "The latest ONS data shows that all ethnic
20 minority groups (except the Chinese community) have
21 higher rates of deaths involving Covid-19, with black
22 Caribbean men aged 65+ having the highest rates of
23 deaths at ... almost 2.3x higher than white men [of
24 the same age]."

25 Are you able to say first when evidence of this

30

1 **Q.** Please can we next go to INQ000176650, page 20.

2 This is a page from a study published by Age UK
3 based on surveys conducted in August and September 2020.
4 What do we learn here about the reasons for the higher
5 incidence and severity of Covid-19 in older BAME people?

6 **A.** Yes, one factor definitely is people are more likely
7 from these communities to be living together with
8 younger members of the family, or to be interacting more
9 with younger members of the family, making it more
10 likely that they would acquire the virus in the first
11 place.

12 Might also be dealing -- living in homes that were
13 not decent in the technical sense of not being warm, and
14 also other health risks that these people were very
15 often living with, underlying conditions including
16 obesity, diabetes and heart disease all of which lowered
17 their resilience, made it harder to overcome the virus
18 if they were to acquire it.

19 **Q.** Next can we consider the unequal impact that the
20 digitisation of healthcare services had on older people.

21 Please can we go to INQ000217404.

22 This graph comes from a briefing paper published
23 by Age UK in December 2021 called Living in a Digital
24 World after Covid-19. To orient ourselves, we see the
25 proportion of recent internet users by age since 2011,

32

1 the blue line representing those between 65 to 74; red
2 line, 75 and over.

3 What do we learn here, both about the internet use
4 of these age groups going into the pandemic and during?

5 **A.** Well, the first thing that this graph tells us is that
6 the older you are the less likely you are to be online
7 so there is quite big gap, isn't there, between the 75
8 and over line and the 65 to 74 line?

9 And in both cases the trend is upwards, more older
10 people are going online over time, but there still
11 remain a significant proportion who are not online. And
12 there are other reasons for us to feel, at Age UK, that
13 actually these statistics overstate the digital
14 competence of the older population, because we know it
15 is not just about whether you are online or not, it is
16 whether you have the skills and the confidence to be
17 able to do quite sophisticated things, as were required
18 during the pandemic.

19 In fact, about half of the over 65 population, we
20 think, either isn't online at all or is not able to go
21 online successfully and safely.

22 **Q.** If we move, please, to page 4 of that document and it is
23 the third paragraph, last sentence:

24 "For example, in early 2020 just 53% of people
25 aged 65+ in Great Britain used a smartphone for

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1 didn't have it use it for work for whatever reason, then
2 you can reach 60, 70 now and have had very little
3 contact with it.

4 **MR MILLS:** Relatedly, what challenges did those telephone
5 and video consultations pose for older people during the
6 pandemic?

7 **A.** Absolutely enormous challenges, and frankly continuing
8 challenges today, because what happened was, although
9 there was a trend which -- a policy trend within the NHS
10 of starting to use interactive technology, it got a huge
11 boost in terms of acceleration because of the
12 circumstances of the pandemic.

13 And what this meant was that some older people
14 found that overnight the way of getting hold of your GP,
15 for example, changed from being able to walk to your
16 surgery and have a conversation with someone behind
17 a desk to having to navigate that process online or
18 possibly over the phone, using telephone prompts. And
19 so that was very, very destabilising for some older
20 people.

21 **Q.** At paragraph 26 of your statement, you say this:

22 "People struggled to understand how to reach
23 their GP if not in person, not helped by the fact that
24 most signposting information and advice was available
25 online ..."

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1 private use ..."

2 Does that also tell us something about those
3 internet use figures?

4 **A.** It does, indeed. Having a smartphone or some way of
5 being able to interact digitally is absolutely key. And
6 we also know of quite a few older people who have maybe
7 been given one by a son or daughter for Christmas but it
8 sits in a drawer rather than being actively used.

9 And, you know, I don't want to overstate it, some
10 older people are very competent and avid users of the
11 internet, but very many aren't.

12 **LADY HALLETT:** Can I just ask a question.

13 You said many older people are not able to do
14 things that are considered more sophisticated. I was
15 thinking that there is something that most younger
16 people wouldn't think was sophisticated which is just
17 doing a Zoom call, doing a remote call.

18 **A.** Yes.

19 **LADY HALLETT:** And a number of people I know, who are older,
20 are basically terrified, they've no idea how to do
21 a remote call, and that is something that younger people
22 wouldn't think was sophisticated at all.

23 **A.** Yes, it makes a difference if you've grown up with the
24 technology. And of course, by definition, this age
25 group hasn't and have been later acquirers. And if you

34

1 **A.** Yes.

2 **Q.** "... overlooking the fact that large numbers of older
3 people are not digitally enabled."

4 **A.** Yes, the system forgot about older people not being
5 online. And of course GP practices and their staff in
6 many cases were trying this out for the first time, and
7 frankly didn't always get it right.

8 **Q.** In some cases, are you aware anecdotally of older people
9 being asked to perform tests or checks on themselves
10 during a remote consultation?

11 **A.** Certainly. And then being asked to do things like: take
12 a photo of that wound you are worried about on your leg,
13 and upload it to our website or attach it to an email
14 and send it to us. And that requires a degree of
15 sophistication that is likely to be beyond somebody, for
16 example, who only uses the internet to go on Facebook or
17 to play sudoku, which is not unusual amongst older
18 people.

19 **Q.** At your paragraph 29 you say there was an increase in
20 expectation for patients to do basic checks, such as
21 blood pressure and pulse readings.

22 Did you receive reports that older people lacked
23 confidence in performing those checks?

24 **A.** Yes, because these were things that throughout their
25 lives they had gone to a GP, sat in front of a nurse,

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1 and they'd done it for them, so this was something new
2 and different, which they weren't being particularly
3 well supported to do for themselves.

4 **MR MILLS:** My Lady, I'm about to move on to a new topic.

5 **LADY HALLETT:** Certainly.

6 As you will remember from the last time you helped
7 me, we take a regular break for the sake of the
8 stenographers, so I shall return at 11.55.

9 (11.43 am)

(A short break)

11 (11.57 am)

12 **MR MILLS:** Ms Abrahams, next topic please, suspension of
13 routine care.

14 At paragraph 12 of your statement you say this:

15 "... the older population are far more reliant on
16 routine health ... services."

17 Can you help us understand the impact of the
18 suspension of these services on older people during the
19 pandemic?

20 **A.** So we have already talked about the fact that as people
21 get older they are more likely to have a number of
22 long-term health conditions. In the past these are
23 things that might have killed us but now, thanks to
24 medical advance, we are able to help people to live with
25 them, things like many cancers, diabetes, kidney

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1 shortages during the pandemic, which was another barrier
2 for people being able to get what they needed quickly.

3 **Q.** Please can we go to INQ000217383.

4 What does this graph illustrate about the
5 relationship between age and the number of medications
6 a person is likely to need?

7 **A.** So as we get older, not only are we more likely to have
8 multiple long-term conditions, it follows we are more
9 likely to be given medication of various kinds to deal
10 with those things, and you can see it is a very clear
11 straight upward curve as we get older.

12 **Q.** Does it follow then that the consequences of the
13 barriers to accessing medication would have been more
14 severe the older a person was?

15 **A.** Absolutely, and we have to remember that some of the
16 conditions that people are living with in these older
17 age groups are ones that can kill you if they are not
18 properly controlled.

19 **Q.** Next, please, can we consider the approach of older
20 people to engaging with the healthcare system during the
21 pandemic.

22 Please can we go to INQ000176650, page 10.

23 This comes from the Age UK report we have already
24 looked at. I'd like to consider the quotation in the
25 top left. This comes from a man between 70 and 74:

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1 disease, but people do need to be monitored, their
2 treatment needs to be updated sometimes and so you will
3 often find older people in that situation with one or
4 two appointments every week or so having to go to
5 hospital, or for tests of various kinds or to clinics
6 and during the pandemic, a lot of that stopped, and so
7 people with these health conditions very often found
8 they got worse, there wasn't the ongoing supervision.
9 One of the points of these clinics is to pick up when
10 something is getting worse early on so you can intervene
11 quickly but that opportunity was often lost as well.

12 **Q.** Was one result of that that patients presented later on
13 with a more advanced form of the illness they had been
14 suffering from?

15 **A.** Absolutely. Unfortunately so.

16 **Q.** At your paragraph 40 you explain that access to routine
17 medication was made more difficult for older people.

18 Can you describe to us what the barriers to access were?

19 **A.** Firstly, if people were having problems contacting their
20 GP they couldn't ask for repeat prescriptions or new
21 prescriptions. That was the first barrier.

22 But then even once the request had been accepted
23 some older people were too frightened to go out or to
24 visit a chemist, to pick it up, because of fear of
25 contracting the virus. There were also medication

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1 "Due to the stress and anxiety I have
2 experienced severe headaches and migraine type attacks
3 of flashing light in the eyes."

4 Now this:

5 "Also frightened to go to hospital when offered
6 when I felt extremely anxious on one occasion."

7 In your answer a moment ago you alluded to older
8 people being frightened to go out to a pharmacy. Does
9 what this man says here about going to hospital reflect
10 a fear that was common amongst older people during the
11 pandemic?

12 **A.** Yes, we certainly heard this a lot from older people who
13 were watching the news, listening to the news
14 conferences, and I think often associating hospitals,
15 not as places of healing, in some cases, but of places
16 where people were dying and certainly a fear that the
17 virus would be found there and that they would be at
18 an enhanced risk of contracting it should they attend.

19 But that wasn't the only factor. The other factor
20 putting people off was, I think, some of the messaging
21 which was about protecting the NHS and not going to
22 hospital unless you really needed to, and we know at
23 Age UK that when older people hear messages like that,
24 even when they are not really directed towards them,
25 they often do react in ways that are very responsible,

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1 socially, so they would be less inclined to go.

2 **Q.** And at your 65 you refer to a fear of overburdening the
3 NHS?

4 **A.** Yes, exactly that.

5 **Q.** Do we imagine a pervasive sense of guilt about going to
6 hospital?

7 **A.** In some cases, yes, and of course we have to remember
8 the wider context to that at the time which was lots of
9 conversation in the media and elsewhere about really
10 this being a problem about older people not about the
11 whole population. So I think older people did feel
12 stigmatised by some of that and it would have made them
13 more worried about burdening very important public
14 services.

15 **Q.** Can I ask, in your view, in respect of older people, did
16 public messaging strike a right balance between on the
17 one hand protecting the NHS and on the other making sure
18 older people sought healthcare when they required it?

19 **A.** I think the problem is, as I've just or tried to
20 describe, the blanket message about Protect the NHS,
21 stay away unless you absolutely have to go, wasn't ever
22 really designed to be heard by older people, but that is
23 exactly the group that reacted to it probably most
24 strongly, so that had an unintended consequence of
25 putting older people off when they really should have

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1 should be to ambulances and to the public about who was
2 to be taken to hospital and who wasn't, particularly
3 around, for example, older people living in care homes
4 and whether they would actually ever be given
5 an ambulance to go to hospital or would be expected to
6 stay in the care home and be dealt with and cared for by
7 the staff, which sounds okay, except, unfortunately,
8 care staff are not medically trained and for periods
9 during the pandemic it was very difficult for many care
10 homes to get the clinical support they needed.

11 **MR MILLS:** Please can we have on screen INQ000408832.
12 This is an iteration of the Covid-19 decision
13 support tool to manage access to critical care as
14 developed by the Department of Health and Social Care's
15 Moral and Ethical Advisory Group.

16 At paragraph 56 of your statement you say this:
17 "... in a system with significant pre-existing
18 evidence of age discrimination there were huge and
19 unacceptable risks that [this tool] would be misused to
20 deny acute care to older people ..."

21 Can you set out, please, the four major concerns
22 that Age UK had with this tool?

23 **A.** Yes. First and foremost because this was produced and
24 was being discussed very near the beginning of the
25 pandemic in March 2020, when we still didn't know very

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1 gone to hospital and doctors and nurses wanted them to
2 go to hospital.

3 **Q.** As well as the public messaging and the impact of that,
4 anecdotally were you made aware of instances of older
5 people being discouraged or prevented from accessing
6 healthcare services?

7 **A.** Yes, absolutely, and that was the other side of the
8 coin, that there were a number of policy initiatives and
9 more ad hoc things that we heard about from local areas,
10 where it was made very clear to older people that they
11 should not go to hospital, that an ambulance wouldn't
12 take them and they wouldn't be received into hospital
13 were they to go, regardless actually of the condition
14 with which they were presenting.

15 **Q.** Can we move now to consider older people's access to
16 critical care.

17 **LADY HALLETT:** Before you do that, Mr Mills, sorry to
18 interrupt.

19 The policy initiatives you are talking about
20 there, about ambulances not taking them, they shouldn't
21 go to hospital, can you give me an example of what you
22 mean?

23 **A.** Yes. This is what's referred to, I think, in the
24 statement as non-conveyance where there were discussions
25 with NHS England and others about what the guidance

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1 much about the disease, the data and the evidence about
2 it was still very much emerging.

3 Secondly, because the policy implicitly relied on
4 the idea that you could correctly and easily assess
5 somebody's frailty status and their relevant long-term
6 conditions and we know that is very hard to do at the
7 best of times, let alone during a pandemic when
8 everybody is in a great rush.

9 Thirdly, because we were worried about the ability
10 of the NHS to implement this policy fairly and
11 consistently.

12 And lastly, because we thought that if knowledge
13 of this tool was to be shared or to escape to the
14 public, that it would cause enormous panic amongst our
15 older population, and undermine trust in the NHS at
16 exactly the time when we needed to sustain it. And this
17 was the single most difficult thing that we dealt with
18 as Age UK during the pandemic and the thing that gave us
19 the greatest concern because, just to be clear, what
20 this shows is that somebody who is aged 80 and who is in
21 good health would automatically not get help from
22 intensive care, should they need it.

23 And the problem is that age impacts us very
24 differently and so of course there might be an older
25 person who's 80 who was very unwell who was reaching the

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1 end of their life. But equally, we could have someone
2 who's just run the marathon. And this blanket policy at
3 a time of enormous public disquiet, great turmoil within
4 the NHS could far too easily have resulted in people
5 being denied care simply on the basis of their age, and
6 we considered this to be totally unacceptable, to the
7 extent that when I had the opportunity to talk to
8 somebody from the committee about it, I said that unless
9 they stopped it we would leak it to the media and we
10 would kill it because that's how strongly I personally
11 felt about this.

12 **Q.** What was the outcome of the interaction you had with the
13 group?

14 **A.** In the event, fortunately, thankfully, conditions within
15 our hospitals improved just in time to mean that there
16 was never a need formally to put anything like this into
17 practice, although unfortunately we do know that
18 something like this was used in some local areas at
19 times, which was very sad.

20 I suspect the fact that I said what I said may
21 have made a small difference, but I think really,
22 ultimately, thankfully, the position in our hospitals
23 improved, and that was the key factor.

24 **Q.** Thank you, that can come down.

25 Next please, Long Covid. At paragraph 79 of your
45

1 **A.** So I will pick out three. The first and probably the
2 most important, that there needs to be a much stronger
3 rights-based framework embedded in how our health system
4 works to challenge and root out the very obvious age
5 discrimination that exists and that became very apparent
6 during the pandemic, with that decision support tool
7 being the most flagrant example but not the only
8 example.

9 Secondly, getting it right in the community and
10 with primary care, with GPs, with community services.
11 Making those strong enough to be able to still provide
12 good care even under the most stressful conditions is
13 very, very important.

14 And finally, because unfortunately tackling the
15 ageism within the NHS will be a marathon not a sprint,
16 the importance of the NHS and government working more
17 constructively with the VCSE and with social care during
18 an emergency like this, because had that happened we
19 would have been able -- we saw some of this coming and
20 we could have alerted politicians and policymakers in
21 time for them to change some of their decisions in a way
22 that I think ultimately would have saved lives.

23 **MR MILLS:** Ms Abrahams, thank you.

24 My Lady, that is all I ask.

25 **LADY HALLETT:** I think we have some questions for you
47

1 statement you raise the concern that Long Covid symptoms
2 in older people are at risk of being written off as
3 age-related. Are you able to provide some examples of
4 the types of symptom that are at risk of being written
5 off?

6 **A.** Yes. I think a very obvious one is delirium which is
7 often anyway mistaken in hospitals for dementia, and it
8 is a reaction to stress and uncertainty and different
9 sorts of living conditions, which older people quite
10 often can display when they are taken into hospital,
11 because it is new and foreign and they are not very
12 well. And it seemed all too easy, and from what we have
13 heard from older people, for those who may have
14 Long Covid simply to be old, "Oh, it's just your age".
15 And there isn't enough research at the moment
16 specifically looking at how Long Covid impacts different
17 age groups, particularly older people, who do, as I say,
18 respond differently sometimes to illness.

19 **Q.** Finally, can we turn to the lessons of the pandemic.
20 Your statement concludes with this observation:

21 "The pandemic has highlighted and exacerbated
22 pre-existing discrimination towards older people."

23 What are the key recommendations you would like
24 this Inquiry to consider to ensure that this does not
25 happen again in a future pandemic?
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1 Ms Abrahams. I think we start with Ms Mitchell, who is
2 that way.

3 **Questions from MS MITCHELL KC**

4 **MS MITCHELL:** Obligated, my Lady.

5 Ms Abrahams, I appear as instructed by Aamer Anwar
6 & Company on behalf of the Scottish Covid Bereaved.
7 Hearing what you have said about advice you just
8 tendered there, I'm going to ask you the same to see if
9 there are some recommendations that might assist.

10 It's the experience of the Scottish Covid Bereaved
11 that older family members were asked to sign DNACPRs,
12 and even when they didn't sign it they were worried that
13 this would impact upon the medical treatment they would
14 receive. First of all, was that something noticed by
15 you in any feedback that you got?

16 **A.** Yes, it certainly was, I'm afraid.

17 **Q.** And secondly, given that is so, in what way can the
18 trust be rebuilt between healthcare, government and
19 people of age to give older people the confidence to ask
20 for their healthcare needs to be met when the next
21 pandemic comes?

22 **A.** Yes, well, again, that is going to take time and hard
23 work. And there is nothing wrong with advanced care
24 planning but it needs to be advance. It can't be done
25 in a rush, in an emergency. And if that happens we
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1 can't expect the outcomes to be good.
 2 So I think the answer is to take advance care
 3 planning more seriously right across our society and not
 4 just see it as something to be used in extremis.
 5 **Q.** Do you think that would have the effect of allowing
 6 people a confidence in their own autonomy over their
 7 health or the right to demand healthcare when it's
 8 required?
 9 **A.** Yes, as long as it is done properly and well and,
 10 ideally, well in advance of any of us ever needing to
 11 face these decisions in reality. People of my age
 12 should be doing this now.
 13 **Q.** My next question is also in relation perhaps to some
 14 assistance you might be able to give. Some of those
 15 that I represent in Scottish Covid Bereaved have
 16 experience of family members, particularly older family
 17 members, having been isolated and unfortunately
 18 thereafter becoming ill with Covid and dying.
 19 You in your statement talk about the isolation for
 20 older people sometimes and the issue of loneliness.
 21 How important do you think it is for consideration
 22 to be given to tackling or at least not exacerbating
 23 loneliness when promulgating policies during a pandemic?
 24 **A.** I think it is tremendously important, and it was the
 25 need for older people in particular, especially if they

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1 Our questions are due in today for our healthcare
 2 minister so that may be a timely opportunity for us to
 3 pose that question.
 4 I'm obliged, my Lady.
 5 **LADY HALLETT:** Thank you, Ms Mitchell.
 6 Just pursuing that, one of the reasons, obviously,
 7 people feel isolated was they're in their own homes,
 8 they don't have family nearby and any family that can
 9 visit, they are stuck outside. Trying to look after
 10 people like that depended a lot on local communities and
 11 people who were prepared to go and collect the
 12 medication, deliver supplies. Are you confident that
 13 enough work is going on involving the voluntary and
 14 community sector in making sure that if anything like
 15 that does happen again that there are people who can
 16 step in to try and relieve some of the loneliness and
 17 isolation?
 18 **A.** I think you are absolutely right. We certainly saw
 19 during the pandemic that people stepped up. There were
 20 amazing examples of formal organisations but informal
 21 groups, too, getting together to support older people,
 22 in particular, who really benefited from it. But that's
 23 all gone, and unfortunately not only is the same impetus
 24 not there now, we are also seeing voluntary
 25 organisations in local areas closing because they can't

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1 were living alone, or if they were in a care home
 2 of course, in a residential setting or a hospital, to
 3 have people they know and love and trust around them
 4 wasn't properly understood, but we can certainly see it
 5 now because I think many older people emerged from the
 6 pandemic with significant mental health problems,
 7 created by the isolation that they experienced at that
 8 time.
 9 **Q.** And I think we saw in the document that my learned
 10 friend brought up earlier, about the feelings of anxiety
 11 that many older people are feeling. Again, the same
 12 question that I asked before in relation to the other
 13 matter: given that there is that anxiety, is there
 14 anything that could be put in place to try and ensure
 15 that people can gain confidence that their healthcare
 16 will be met in the next pandemic?
 17 **A.** It is a big ask, isn't it, but I am reassured that these
 18 messages about taking older people's health needs
 19 seriously are being listened to, at least in England.
 20 I cannot say whether it is the same in Scotland but
 21 policy developments underway now from our new government
 22 should help us get to a place where older people's needs
 23 are better met at home and in the community, but it is
 24 going to take time.
 25 **MS MITCHELL:** I'm obliged.

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1 afford to keep running. So taking support, taking
 2 infrastructure seriously in the community and building
 3 it up would definitely put us in a better place should
 4 we face another pandemic.
 5 **LADY HALLETT:** Thank you.
 6 Mr Weatherby, I think you are next.
 7 **Questions from MR WEATHERBY KC**
 8 **MR WEATHERBY:** Good afternoon, Ms Abrahams. I ask questions
 9 on behalf of Covid Bereaved Families for Justice UK.
 10 Just one very short topic but it is an important
 11 topic and you have touched upon it already.
 12 In your statement -- for the record
 13 paragraph 62-63 -- you refer to evidence that Age UK
 14 had, I think early in the pandemic, but ongoing,
 15 evidence relating to the blanket use of DNACPRs and
 16 denial of care policies relating to age.
 17 And earlier in your statement you had referred to
 18 the fact that Age UK was a major charity, had a major
 19 qualitative and quantitative research programme and
 20 collected insights from literally hundreds of thousands
 21 of older people. So when you refer to evidence in your
 22 statement, it is widespread evidence; is that fair?
 23 **A.** Yes, and I think as with so much during the pandemic, it
 24 was patchy.
 25 **Q.** Yes.

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- 1 A. So there were some areas --
- 2 Q. I see.
- 3 A. -- and some places where we know that these practices
- 4 happened. They were relatively isolated.
- 5 Q. Yes.
- 6 A. But within a very broad, national context.
- 7 Q. Yes.
- 8 A. There wasn't a simple pattern.
- 9 Q. No. And that caused you, I think, to pressure
- 10 NHS England, initially, to take steps, and they did take
- 11 steps to indicate to stakeholders that policies such as
- 12 these were unacceptable; is that right?
- 13 A. Absolutely.
- 14 Q. Yes. However, you do go on then to say that in fact you
- 15 then had evidence of the practices continuing, and you
- 16 subsequently issued a series of public statements
- 17 between March and November 2020 relating to these issues
- 18 to highlight them; is that right?
- 19 A. Correct.
- 20 Q. The statements were co-signed by your partners and other
- 21 partners from Wales, Scotland and Northern Ireland.
- 22 Does that reflect the fact that the concerns were
- 23 widespread not just within England but in fact across
- 24 the UK?
- 25 A. Absolutely.

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- 1 this morning. And also barriers around English as not
- 2 a first language.
- 3 Would those things have been improved, access to
- 4 information, if family carers had had more involvement
- 5 in the delivery of healthcare?
- 6 A. Yes.
- 7 Q. And how might that be changed in the future?
- 8 A. Well, I think there was a long debate, a very intense
- 9 debate, throughout the pandemic, about the extent to
- 10 which family carers were equal partners in the care of
- 11 their older relatives, together with the NHS and social
- 12 care. I think many people assumed at the start they
- 13 were equal partners but some of the events that
- 14 happened, the policies that came into place, caused that
- 15 to be questioned.
- 16 So, taking forward those principles, I think they
- 17 will probably be discussed in a future module obviously,
- 18 in particular of this Inquiry, would make a difference.
- 19 But of course we also have to remember that a lot of
- 20 older people don't have family carers and are completely
- 21 on their own, have nobody to advocate for them, and in
- 22 the end it is those older people who we at Age UK
- 23 worried about the most through the pandemic, and they
- 24 probably had the worst outcomes of all.
- 25 Q. Thank you.

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- 1 Q. Finally, this. In respect of those statements, that
- 2 series of statements over those months, to what extent,
- 3 so far as you are able to say from the evidence that you
- 4 are able to collect, to what extent did those statements
- 5 have an effect?
- 6 A. Very hard to say, I'm afraid, but I think the fact that
- 7 the organisations and individuals, who included
- 8 appointed commissioners for older people in
- 9 Northern Ireland and Wales, came together to express
- 10 such strong concern --
- 11 Q. Yes.
- 12 A. -- I think was heard, where it needed to be heard.
- 13 Q. Thank you very much. That is all I ask.
- 14 LADY HALLETT: Thank you very much, Mr Weatherby.
- 15 Mr Wolfe.

Questions from MR WOLFE KC

- 17 MR WOLFE: Morning, Ms Abrahams.
- 18 I ask questions on behalf of the Patients
- 19 Association, Care Rights UK and John's Campaign. I just
- 20 have three brief topics, if I may, arising from your
- 21 evidence.
- 22 The first one relates to barriers to older people
- 23 accessing information during the pandemic. You mention
- 24 in paragraph 17 and 27 of your witness statement
- 25 barriers around technology. You have talked about that

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- 1 Second topic, if I may. Access to healthcare for
- 2 people with dementia. In paragraph 38 of your witness
- 3 statement you explain that dementia patients experienced
- 4 a rapid deterioration in cognitive functions. Some were
- 5 left alone without visitors and with no understanding
- 6 what was going on around them with no family access.
- 7 Do you think sufficient consideration was given to
- 8 the needs of people with dementia during the pandemic
- 9 whilst in hospital?
- 10 A. No.
- 11 Q. And might that have been affected again by the
- 12 involvement of family members and family carers?
- 13 A. Yes.
- 14 Q. Again, how might that change in the future?
- 15 A. I hope that new laws and regulations will come into
- 16 place to make it clear that if somebody with dementia is
- 17 in hospital or is in a care home that their family
- 18 carers, under certain conditions, should always have the
- 19 right to be with them. That would have made an enormous
- 20 difference to the well-being, and the survival I think,
- 21 of some older people during the pandemic.
- 22 Q. Third topic, if I may. Your organisation gave evidence
- 23 to the Joint Committee on Human Rights. One of the
- 24 topics it talked about was the need for individualised
- 25 assessments and an individualised approach.

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1 Again, how do you think that played out in
2 a pandemic? Was there a sufficiently individualised
3 approach?
4 **A.** Absolutely not. All the things I have talked about
5 today, our biggest concerns for older people during the
6 pandemic, were when blanket policies were imposed, or
7 when sweeping assumptions were made about older people
8 all being the same. And older people are not all the
9 same. And we need to improve the sophistication of our
10 analysis of how our systems work to take that fully into
11 account.
12 **Q.** Finally, if I may, one aspect of those individualised
13 assessments: reasonable adjustments under the
14 Equality Act. Again, any observations on how reasonable
15 adjustments, including possibly, again, involvement of
16 family carers as a reasonable adjustment, took place
17 during the pandemic?
18 **A.** Well, as far as we're aware, they didn't, or not very
19 much. And more generally, the fact that age is
20 a protected characteristics under the Equality Act is
21 often overlooked.
22 Disability is talked about much more often, and
23 that is nothing wrong with that of course, but enormous
24 numbers of our professionals and people who interact
25 with older people are totally unaware that the

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1 the director of strategy and influence.
2 **Q.** I apologise.
3 **A.** That's okay.
4 **Q.** But thank you for that correction.
5 Can you, though, please tell us a little bit about
6 Mencap, its role generally and its role during the
7 pandemic.
8 **A.** Yes, of course. So we are a learning disability
9 charity. We support around 4,000 people in social care
10 settings. We have a further 2,000 that we support
11 through employment programmes and various other
12 community activities. We have a network of over 300
13 independent organisations and through them we have
14 contact with 40,000 people with a learning disability.
15 We also run an information and advice service and
16 deal with 12,000 calls to our helpline every year and
17 around 40,000 visits to our website every month, and we
18 campaign, particularly on health, on employment, and
19 getting people out of assessment and treatment units.
20 **Q.** Is it right that Mencap's remit is in England, Wales and
21 Northern Ireland but not in Scotland?
22 **A.** That's right. That's correct.
23 **Q.** I want to ask you today about some of the concerns that
24 Mencap had predominantly during the relevant period of
25 Module 3. If we can start, please, with the

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1 Equality Act applies to older people too.
2 **Q.** I get the impression that almost you would say the
3 Equality Act was suspended during the pandemic; would
4 that be a fair assessment?
5 **A.** That assumes it was ever applied properly to older
6 people in the first place, which our view is it isn't.
7 **MR WOLFE:** Thank you, Ms Abrahams. Thank you, Chair.
8 **LADY HALLETT:** Thank you very much, Mr Wolfe.
9 I think that completes the questions we have for
10 you, Ms Abrahams. I think I may have said it when you
11 first helped me in Module 2, I think it was, I'm really
12 grateful to you for your help. You are an excellent
13 communicator and a superb witness and everything you
14 have done so far -- and I'm sorry it is "so far",
15 because I fear I may be calling on your help again in
16 a future module -- has been extremely helpful. Thank
17 you very much indeed.
18 **THE WITNESS:** Thank you.
19 **(Witness withdrew)**
20 **MR FIREMAN:** May I please call Jackie O'Sullivan.
21 **MS JACKIE O'SULLIVAN (sworn)**
22 **Questions from COUNSEL TO THE INQUIRY**
23 **MR FIREMAN:** Ms O'Sullivan, you are the chief executive of
24 the Royal Mencap Society; is that correct?
25 **A.** No, I was the acting chief executive but I'm actually

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1 disproportionate number of deaths amongst people with
2 learning disabilities. Your witness statement sets out
3 that pre-pandemic --
4 **A.** Yes.
5 **Q.** -- NHS England's 2019 Learning Disability Mortality
6 Review demonstrated that women with a learning
7 disability died 27 years earlier than the general
8 population and men 22 years earlier than those in the
9 general population.
10 Do you recognise those figures, first of all?
11 **A.** Yes, absolutely. And we knew, going into the pandemic,
12 that it was likely that these health inequalities would
13 be exacerbated and I'm afraid that was the case.
14 **Q.** The Inquiry heard a couple of weeks ago --
15 **A.** Yes.
16 **Q.** -- from Mr Matthew Stringer on behalf of the Disability
17 Charities Consortium, and he gave evidence that during
18 the pandemic people with a learning disability were six
19 times more likely to die than those without learning
20 disabilities and that this was 30 times more likely for
21 adults between 18 and 34.
22 **A.** Yes.
23 **Q.** Again, are you familiar with those figures?
24 **A.** Yes, I am and that is backed up as well. So we had some
25 data from CQC in June 2020 which showed 134% increase in

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1 the number of deaths of people with a learning
2 disability and the age group that was particularly
3 affected was 55-64, so people were dying at a younger
4 age. Obviously then we had the PHE data, which you
5 referred to just now. And then the Office for National
6 Statistics that showed that disabled people were -- 60%
7 of the deaths due to Covid were from disabled people.

8 So we suspected that people would be severely
9 impacted and then we heard about this anecdotally. The
10 way we were set up because we have so much direct
11 contact with people in our day-to-day lives, we were
12 picking up on early signs. We were getting calls to the
13 helpline. A lot of the organisation was focused on
14 supporting the people we have direct responsibility for
15 through this.

16 But my role particularly was thinking, how are we
17 going to show up for the wider 1.5 million people with
18 a learning disability in the UK and what do we need
19 to do?

20 So we were picking up on news reports, on
21 government announcements, on people calling the
22 helpline, on things that we were hearing through our
23 services and through our network partners, and just
24 trying to do our best to support people through the
25 pandemic, because we knew that people were likely to die

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1 If we could take a look at the critical care
2 guideline which NICE produces, INQ000474301.

3 The Inquiry has looked at it before but I just
4 want to give you the opportunity to explain, from
5 Mencap's perspective --

6 **A.** Yes.

7 **Q.** -- what your concerns were.

8 If we could go to the next page of this guidance
9 please -- yes -- there we can see the criteria that was
10 being proposed as to how to assess adults upon admission
11 to hospital.

12 Can you just explain in your own words what the
13 concerns were from Mencap's perspective?

14 **A.** Well, this makes it clear that the Clinical Frailty
15 Scale should be applied to all adults irrespective of
16 age, and that comorbidities -- and doctors would
17 consider a learning disability often to be
18 a comorbidity -- or an underlying health condition
19 should also be affected.

20 If you look at the Rockwood scale, which is
21 attached to the Clinical Frailty Scale, that shows very
22 clearly that if you need extra support with your
23 household affairs, your shopping, your bills, maybe
24 taking medication, then you were unlikely to get
25 a ventilator and unlikely to be treated for Covid in

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1 in greater numbers and then the evidence started to
2 unfold and, sure enough, that was the case.

3 **Q.** You mentioned your suspicion that that may have been the
4 case early on during the pandemic. What do you consider
5 to be the main reasons -- both that you had that
6 suspicion and indeed that in fact it became a reality,
7 what do you consider to be the main reasons for the
8 disproportionate number of deaths amongst people with
9 learning disabilities?

10 **A.** So in some ways they weren't thought about, they weren't
11 considered, and we see that in general that people
12 sometimes are after thoughts, that reasonable
13 adjustments aren't made for people and that some of it
14 relates to attitude as well.

15 So of those deaths, we know that before the
16 pandemic 1,200 deaths were avoidable and there were
17 a higher proportion of those that were taking place in
18 healthcare settings and related to healthcare than there
19 were for the general population, which suggests that
20 people weren't getting the treatment that they should
21 have and, as a result, were dying.

22 **Q.** One of the most significant concerns that you raise
23 within your witness statement relates to critical care
24 guidance and whether that had a bearing on the outcomes
25 of people with learning disabilities.

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1 hospital.

2 So we saw this came out, this NICE guidance came
3 out on 20th.

4 **Q.** 20 March?

5 **A.** Yes, 20 March. We picked up on it on 22 March because
6 the Rockwood scale was published in the
7 Sunday Telegraph. And we were immediately alarmed by it
8 because essentially it meant that most people with
9 a learning disability, even people with mild and
10 moderate needs would be ineligible for treatment.

11 So we were very concerned. We got hold of NICE.
12 I had multiple emails and also a meeting with
13 Paul Chrisp at NICE about this. He said during the
14 course of that that they were still firming up how they
15 could get in place equality impact assessments due to
16 the speed of turning the guidance around and it was
17 clear to us that people with a learning disability had
18 not been considered as part of this.

19 **Q.** And part of the reason for that, I understand, and
20 the Inquiry has heard that the Clinical Frailty Scale is
21 not validated on people under the age of 65 or with
22 long-term stable disabilities; that's right, isn't it?

23 **A.** Yes, that's right, that's the case.

24 **Q.** And you mentioned -- that can come down, thank you --
25 that you were immediately in correspondence with

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1 Dr Paul Chrisp, I think that's the director of the
2 centre of NICE guidelines, who the Inquiry will hear
3 from later on in the week. And is it right that you
4 advised him immediately of the concerns --

5 **A.** Yes.
6 **Q.** -- that Mencap had about the content of that guideline?
7 **A.** Yes, I did. Yes, I did. And then we had email
8 exchanges and a meeting as well because we eventually
9 agreed the changes which obviously were still put in
10 place, although I must note the even the amended
11 guidance has the same date of the 20th on -- but the
12 final email from Paul was on 31 March and that said that
13 he had made the changes and it was due to go live.

14 But we were also concerned because this had been
15 communicated out quite widely and we were worried that
16 the genie was out of the bottle, really, and that it had
17 been in the media and how was this then going to be
18 communicated to healthcare professionals who were
19 probably working under the assumption that it was
20 policy.
21 And we saw this -- we saw this during the course
22 of that week, so on 24th March some of our services
23 alerted us to the fact that they were receiving letters
24 dated 24 March that essentially said: if anyone in your
25 service gets Covid, they are unlikely to be treated and

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1 share on the date of publication.

2 So we would have done everything we possibly could
3 to help NICE get this right. But we weren't asked.

4 **Q.** Turning to another of your concerns, that of DNACPRs.
5 There are three issues I'd like to go through with
6 you. Broadly they are: inappropriate use of DNACPRs,
7 lack of communication around DNACPR notices, and the
8 possibility that DNACPR notices were being confused with
9 Do Not Treat orders.

10 **A.** Yes.
11 **Q.** Am I right that Mencap was made aware early on in the
12 pandemic around particular issues with GP surgeries
13 sending letters to individuals and, indeed, groups of
14 individuals with learning disabilities indicating that
15 they may want to consider having a DNACPR on the
16 patient's file?
17 **A.** Yes, we were, yes. Some of our support workers flagged
18 it. It turned out that there were two letters that we
19 supplied but those weren't the only ones where people
20 were reporting all over the country getting copies of
21 letters, similar letters, and some of the care
22 providers, as well, that we are in contact with also
23 reported this as well.

24 We also picked up on instances of individual
25 DNACPRs being applied without proper consultation.

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1 therefore please don't bring them to hospital.

2 **Q.** Thank you. And we will look at some of the
3 correspondence you refer to later on.

4 But just going back to the engagement you had with
5 Dr Paul Chrisp. You mentioned that after having had
6 some correspondence with you there was -- there were
7 amendments made to the guideline.

8 **A.** Yes.

9 **Q.** Her Ladyship has seen the amendments previously, so
10 I don't propose that we go to them but they essentially
11 added a number of caveats, didn't they, to the use of
12 the Clinical Frailty Scale?

13 **A.** Yes, yes.

14 **Q.** Is it right to assume, then, that prior to the
15 publication of the initial guideline you were not
16 contacted by NICE or anyone else involved in the
17 publication of that document?

18 **A.** No. And if they had contacted us, we would have helped
19 them and we would have pointed that out. At the same
20 time, I was involved in a working group on the Care Act
21 easements. We turned that around in a week. There were
22 a group of charities like myself and representatives and
23 we were literally, you know, commenting on things
24 overnight, it didn't slow up the process, we even
25 produced an Easy Read guide for officials to be able to

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1 So I will give you two examples of this.

2 One was the parents of a teenage person with
3 a learning disability who got a letter asking them if
4 they'd agree to a DNACPR for that individual.

5 And the other one was a conversation that happened
6 and fortunately one of our support workers listened in
7 on the call, and it went along the lines of: I'm just
8 calling from the doctors to see if it is okay to put
9 a DNACPR on your file and when the person said, "What's
10 that?", the doctor said, "Well, you know, it is nothing
11 to worry about but if something bad happened to you they
12 wouldn't give you the kiss of life", to which the person
13 replied, "Well, I wouldn't want that because I might
14 catch Covid", and that was the end of the conversation.

15 And if the support worker hadn't been in the room
16 at the time that DNACPR would still be on that person's
17 file.

18 **Q.** It follows, then, based on what you are saying that that
19 particular concern is a concern about not necessarily --
20 it may well be that there was a concern about the
21 appropriateness or otherwise of a DNACPR but that's
22 about the communication of the decision, isn't it?

23 **A.** Well, I think it is both really, isn't it? Why would
24 you expect in your 40s to have a conversation like that
25 with your GP? And if you think about the fact that this

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- 1 is somebody in authority having this conversation, it is
2 completely out of context. I think it is inappropriate
3 for the conversation to be had in the first place let
4 alone for it to unfold in the way that it did.
- 5 **Q.** When you say it is inappropriate, that's on the basis,
6 is it, that this individual did not have any other
7 particular concerns, comorbidities, simply they had
8 a learning disability?
- 9 **A.** Yes, yes, they had a learning disability and they were
10 living in a care setting. So I think there was quite
11 a lot of confusion around that as well. That people
12 with a learning disability live in supported living
13 settings which are everyday homes. They live everyday
14 gloriously ordinary lives in everyday homes with,
15 you know, two, three, four people living in the same
16 setting and these -- these letters were sent as if it
17 was a large care home full of very frail people and they
18 are not, they are people living everyday lives, working,
19 going out, having -- you know, very healthy people, full
20 of independence and possibility.
- 21 **Q.** Can we have a look, please, at one of the letters that
22 you have appended to your witness statement. This is
23 INQ000505520.

24 And this is a letter that's has gone to a number
25 of people, I think a home, or a setting on 24 March 2020

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- 1 **Q.** Is it right that you had some concerns that the
2 production of these letters had, whether directly or
3 not, been influenced by the publication of that
4 guidance?
- 5 **A.** I do. And I think around that time we had the message
6 to Protect the NHS and I think that led to the Clinical
7 Frailty Scale. This was all about relieving pressure on
8 hospitals, and if you were a GP and you looked at that
9 Clinical Frailty Scale and, actually, these letters have
10 text to that effect, that actually there is no point
11 this person going to hospital because they are not going
12 to get any treatment so we may as well apply a Do Not
13 Resuscitate notice and then we will give them palliative
14 care at home. And I think that was the thought process.
- 15 So I think we ran very quickly from "we are going
16 to protect the NHS" to NICE issuing the guidelines and
17 those being communicated out, to -- and everybody was
18 working at speed and under a huge amount of pressure,
19 but then GPs thinking actually it's in people's best
20 interests to send these letters and to apply the DNACPRs
21 and if they didn't send the letters they were increasing
22 the number of DNACPRs that existed and we also had cases
23 where old DNACPRs were brought into play and people
24 refused conveyance to hospital on the basis that when
25 they had a broken ankle ten years beforehand a DNACPR

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- 1 and if we could go to the second page, under the title
2 "Cardiopulmonary Resuscitation - CPR", just looking at
3 the second paragraph there it says:

4 "The chances of success in CPR for a patient
5 with advanced disease or frailty are virtually zero.
6 CPR is therefore not appropriate for the vast majority
7 of these people and should only be attempted if it is
8 considered that it may be successful. For these
9 reasons, many people decide in advance not to have
10 CPR, and choose to be allowed to have a natural and
11 peaceful death."

12 That paragraph may seem relatively anodyne but why
13 was that particularly concerning for you?

- 14 **A.** Because this letter was sent to a household of people
15 who were not frail and were not at the end of their
16 lives and I think this is the issue here, that there was
17 a blanket assumption that anyone that got care and
18 anyone who had a learning disability had a comorbidity
19 or was frail and therefore advance care planning should
20 be applied.
- 21 **Q.** Going back to something you said earlier. This letter
22 was sent on 24 March 2020.
- 23 **A.** Yes.
- 24 **Q.** The guidance from NICE was published on 20 March 2020.
- 25 **A.** Yes.

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- 1 had been put in place.
- 2 And so you can also see how these were then
3 confused with treatment.
- 4 So, you know, whilst actually, you know,
5 intervention, intubation, CPR in its true sense may be
6 something that people might not want to avoid, it
7 doesn't mean that they are signing away their rights to
8 any treatment at all and that's, in practice, what was
9 happening, that people were not getting treatment, they
10 were not getting conveyance to hospital.
- 11 **Q.** A point of clarification, Ms O'Sullivan. The Inquiry
12 heard from Mr Stringer on behalf of the Disability
13 Charities Consortium a couple of weeks ago and he said
14 there was evidence from Mencap of a GP applying blanket
15 notices to people then under the care of a Mencap
16 institution -- those were his words. Is that the sort
17 of thing that we just saw in that letter, is that what
18 he is referring to?
- 19 **A.** Yes, that's the sort of thing. And there were obviously
20 other letters and also phone calls as well.
- 21 Can I just -- just, again, as a point of
22 clarification, we don't have any institutions. We
23 campaigned heavily to get rid of institutions,
24 successfully, and these -- these are social care
25 services. Everyday homes. It is -- the word

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1 "institution" conveys an idea of, you know, an isolated
 2 hospital, and that's absolutely not the case.
 3 **Q.** The point you are making, really, is that these
 4 individuals are living ordinary lives, albeit supported
 5 by carers?
 6 **A.** Absolutely. Absolutely, yes. Typically it will be
 7 a normal house, everyday house. There will be a team of
 8 carers that may go in and out during the day. Some
 9 people only get a few hours a week. Some people might
 10 have 24/7 care. Some people might have someone sleep on
 11 site just in case there's a problem in the night. But
 12 it very much is -- it is ordinary people in ordinary
 13 homes.
 14 **Q.** Finally on this topic, can we please go to
 15 Ms O'Sullivan's statement paragraph 16.
 16 I'm not sure if I read this out before, but it's
 17 INQ000479878.
 18 And we're looking here at paragraph 16 and at
 19 an example that you have given of something else
 20 happening in relation to communication around DNACPRs.
 21 I'm just reading from the second sentence where it
 22 says:
 23 "In one such case, the person we supported was
 24 admitted into ... hospital on 31st March 2020 due to
 25 sepsis diagnosed by the GP. He was in hospital for
 73

1 likely to get treatment for Covid. And level 5 was
 2 someone who needs a bit of additional help with their
 3 shopping, their household finances, their medication.
 4 That's the majority of people with a learning
 5 disability.
 6 **Q.** Focusing though on the communication around these
 7 decisions, who would you have expected to have been
 8 contacted to discuss the decision to provide a DNACPR to
 9 this individual?
 10 **A.** Well, firstly, if the individual lacks capacity then it
 11 would be their families and if the family wasn't around
 12 then it would be carers. So we would have expected
 13 conversations with -- and it may be that the hospital
 14 would have attempted to have a conversation with the
 15 individual and the team might have facilitated and
 16 helped that in terms of communication.
 17 But what was happening was even where there
 18 were -- there was one case where a family member was
 19 asked. She said she needed to go away and consult her
 20 mother and her sister about it. Before she even had
 21 a couple of hours to do so, the sister was denied
 22 a routine scan in hospital that then resulted in her
 23 death a few days later. And when the family asked for
 24 an investigation, it was shown that there was a do not
 25 attempt resuscitation notice on the patient's file that
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1 5 days, and was successfully treated. On arrival back
 2 to his home, which was a supported living service,
 3 staff discovered a DNACPR form at the bottom of his
 4 bag. There was no reason stated for its issue. The
 5 person had no pre-existing health conditions and was
 6 in good health prior to his admission for sepsis. The
 7 team who supported him were not contacted with regards
 8 to the DNACPR decision, and the person would not have
 9 had capacity to make the decision, if an attempt to
 10 discuss it with him was made."
 11 So how did you then come to be aware of this
 12 particular incident?
 13 **A.** Well, this would have come through our teams and we had
 14 multiple cases like this. We also got examples through
 15 our helpline and families contacting us asking for
 16 support and advice.
 17 So in March 2020 we had a bereaved family saying
 18 that their loved one had not received any treatment
 19 whilst in hospital and that a DNACPR had been applied
 20 without their knowledge, and had been done so according
 21 to their functional status because they were dependent
 22 on care. So this to me suggests a real link with the
 23 Clinical Frailty Scale, which clearly said -- the
 24 Rockwood scale and the article in the Sunday Telegraph,
 25 clearly said if you are level 5 or above you are not
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1 they had not agreed to, but the records suggested that
 2 the sister had. And that was quite common as well.
 3 So families were left with the grief of losing
 4 somebody but also an insinuation that they had actually
 5 agreed to something that they felt very strongly they
 6 hadn't.
 7 **Q.** That can come down.
 8 Are you aware that NHS England did put out
 9 a bulletin, a primary care bulletin, on 8 April 2020
 10 reiterating the key principles around DNACPRs, that it
 11 needs to be an individual assessment and preferences
 12 must be taken into account and that blanket DNACPRs are
 13 not appropriate?
 14 **A.** Yes. And we pushed for that and we also pushed for the
 15 letter that went from Claire Murdoch to PCTs on 3 April
 16 as well, so I must say when we raised things people were
 17 responsive and tried to put them right, but I do think
 18 the genie was out of the bottle.
 19 **Q.** Turning to a different topic: the impact of infection
 20 protection and control measures on those with learning
 21 disabilities.
 22 Can you explain your concerns in particular about
 23 the restrictions on visiting and how they impacted those
 24 with Mencap support.
 25 **A.** Absolutely. So family members and carers are absolutely
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1 vital for people with a learning disability and it was
2 treated a little as if it was a nice-to-have in some
3 instances and people were denied access. But it is
4 absolutely important.

5 People can help with communication. We see a lot
6 of diagnostic overshadowing, people not displaying pain
7 in the same way that perhaps you might expect from
8 a member of the general public. And also family members
9 have a lot of information about the way that their loved
10 one behaves in stressful situations. So actually
11 visiting wasn't just something that would provide
12 reassurance for the family member and the individual,
13 but it was absolutely vital if the care was to be
14 successful.

15 And we know that anyway. We have campaigned for
16 a long time on reasonable adjustments and the right for
17 families and carers to be listened to.

18 So what we saw were people going into hospital in
19 distress. The distress was exacerbated because they
20 were alone. There was no one to help interpret what
21 their needs were. In some instances they weren't
22 allowed to take hospital passports because paper wasn't
23 allowed in.

24 **Q.** Just pausing there to explain what the hospital passport
25 is.

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1 patient wasn't speaking to them. To which they replied,
2 "It is because she is non-verbal". And the hospital for
3 four days had no idea that the patient couldn't
4 communicate with them verbally. And she then was
5 discharged two days later and she was covered in bruises
6 and traumatised and we had no idea what had happened.
7 The team think that they also didn't realise -- she
8 wasn't able to take her wheelchair with her in the
9 ambulance, and the team think that they didn't realise
10 that she was immobile as well and probably got her to
11 try to walk.

12 **Q.** And is this an issue that arose from this individual not
13 having a passport or is it an issue that she wasn't
14 allowed to bring it in?

15 **A.** She wasn't allowed to bring it in. So she had one but
16 wasn't allowed to take it. And the team weren't allowed
17 to accompany her and they weren't allowed to visit her
18 and there was very poor communication between the
19 hospital and the team.

20 **Q.** Are you aware that the guidance did change, I think it
21 was in October of 2020, to allow visitors to accompany
22 those with learning disabilities?

23 **A.** Yes, yes. So on 25 March we were told no visitors. On
24 9 April, some exemptions were made, but it wasn't clear
25 or clear enough, and then in May it was re-issued and it

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1 **A.** A hospital passport is a document that would set out
2 your needs if you were admitted to hospital. And we
3 encourage everyone with a learning disability to create
4 one. It will set out your communication preferences, it
5 will set out medications, dietary requirements, things
6 like that. But also it will say if you don't exhibit
7 pain in the same way a healthcare professional might
8 expect you to, and it will give clinicians -- the idea
9 is that it will help clinicians assess you.

10 So I will give you an example of what happened
11 here. In March 2020 we had an individual of
12 49 years old with Down's syndrome who had never been
13 alone in their life, ever. The family were barred from
14 visiting. They didn't have a hospital passport. The
15 person died and then the family were called and informed
16 that they passed away.

17 Another one, in one of our settings, it was
18 a person with a chest infection that was resistant to
19 antibiotics. She was taken into hospital, put on
20 a Covid ward but repeatedly tested negative for Covid,
21 and eventually she was given the antibiotics and started
22 to recover.

23 The team called the hospital every day. They
24 weren't successful in speaking to people. On the fourth
25 day they were and the hospital team asked why the

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1 was much clearer. But even then it wasn't always
2 accepted by hospitals and nursing staff.

3 **Q.** You also raise a concern in your witness statement on
4 a very similar note about the wording of ambulance
5 guidance in relation to conveyance to hospital.

6 If we could, please, show on screen INQ000498063.

7 And I'm looking here at the heading 10.2 "Using
8 the most appropriate conveying resource", and the second
9 bullet point up from the bottom where it says:

10 "non-essential persons (such as observers,
11 family members) are not to travel within the patient
12 compartment with a suspected or confirmed case, unless
13 the patient is a child who requires conveyance."

14 Just going to pause there. There is obviously
15 an exception there for a child. Does it follow that you
16 would have expected there to also have been an exception
17 for, for example, a person with a learning disability?

18 **A.** Yes, absolutely. It would be a reasonable adjustment
19 that should have been made and should have been
20 respected despite the circumstances of the pandemic.

21 **Q.** And is the issue with this particular guidance that the
22 phrasing "non-essential" is really open to significant
23 interpretation as to whether or not a carer is or is not
24 or a family member is or is not essential to that
25 individual?

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1 A. Yes, yes. And I believe that's how it ended up being
2 poorly applied, even after the guidance had been
3 clarified, that it was the -- what constitutes
4 an essential person.

5 Q. If that can come down.
6 Is it right you campaigned to have this guidance
7 changed?

8 A. Yes, yes we did.

9 Q. And did it change?

10 A. Yes, it did. It did. But we still got -- we still had
11 issues where people were using the old guidance and
12 interpreting this wrongly.

13 Q. And given the number of issues which Mencap has raised
14 in terms of the way in which guidance was produced and
15 the wording of that guidance, is there any thought, from
16 your perspective, about the involvement that Mencap has
17 or individual organisations such as Mencap has in the
18 production of guidance going forward?

19 A. Well, this is the thing that really -- you know, if
20 anyone had asked, if anyone had shown us this guidance
21 we would have happily looked at it and we would have
22 happily advised on it, and I think we could have avoided
23 a lot of these issues had that happened.

24 So, we know -- in slower time, we would expect to
25 actually co-produce things with people with a learning

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1 So, yes, absolutely it was an issue.

2 **MR FIREMAN:** My Lady, I'm going to turn to a slightly
3 different topic. That might be an appropriate time.

4 **LADY HALLETT:** Yes, of course. I hope you were warned that
5 we break at this stage for lunch?

6 A. Yes.

7 **LADY HALLETT:** Are you okay to come back this afternoon?

8 A. Yes, absolutely.

9 **LADY HALLETT:** I shall return at 2.05.

10 (1.02 pm)

11 (The short adjournment)

12 (2.05 pm)

13 **LADY HALLETT:** Mr Fireman.

14 **MR FIREMAN:** Thank you.
15 Ms O'Sullivan, a slightly different topic to what
16 we were talking about prior to the break, that of
17 learning disability nurses and the role they play in
18 supporting people with learning disabilities within
19 a healthcare setting.
20 Could you just give us a sort of explanation as to
21 how vital the role that learning disabilities nurses
22 play is?

23 A. It's absolutely vital. So they support by giving expert
24 advice. They have a deep knowledge of people with
25 a learning disability, they can help with communication

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1 disability and really get -- but in the absence of --
2 and at speed, we do have colleagues with a learning
3 disability who will gladly look at guidance, turn around
4 Easy Reads. We have lots of policy experts who can help
5 and support.

6 So even in the times when everything was so
7 pressured, and we were operating at speed, we could have
8 helped with a lot of these things.

9 Q. Did you also have concerns about the use of PPE and its
10 impact on those with learning disabilities in healthcare
11 settings?

12 A. Yes. I mean obviously PPE reduces people's ability to
13 take verbal -- visual clues from the way people are
14 presenting and talking, and especially compounded with
15 if you can't -- if you're in hospital it is
16 a frightening experience at the best of times. You do
17 not necessarily understand what is happening to you,
18 what is going on. And then if you are approached by
19 strangers wearing masks, you can't pick up on visual
20 clues in terms of smiling and things like that. So it
21 absolutely did. And it is important to note that PPE
22 was also used in social care settings for a very long
23 time after it was no longer required in healthcare
24 settings. And again, that was problematic for people in
25 terms of communication.

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1 issues, they can help with treatments. And what we saw
2 during the pandemic was that many of them were
3 redeployed into ICUs and other areas. And that stripped
4 hospitals of that expertise and that knowledge.

5 I will give you an example just to illustrate how
6 important this is.

7 We had somebody who had Covid who was admitted to
8 hospital and she was unable to tolerate a face mask, so
9 she was unable to be given oxygen, an oxygen mask. And
10 as you can imagine, she was non-verbal, she had
11 strangers wearing face masks who were trying to putting
12 something on her face and it was very, very scary and
13 she just wouldn't allow it. And the hospital tried and
14 in the end they contacted the family and said that they
15 were going to discharge her with palliative care because
16 there was nothing they could do for her.

17 Actually, we managed to get on -- the family
18 contacted us immediately and we managed to get on to
19 a learning disability nurse from another hospital who
20 was able to give some advice.

21 What she said was actually this is very common,
22 that what could be used in its place was a simple oxygen
23 hood or an oxygen tent. And an oxygen tent looks
24 a little like one of those things that people put over
25 child buggies when it rains, so it is a very simple

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1 piece of plastic, basically, that goes over somebody.
2 And that's in fact what happened. We managed to get
3 this person saved.

4 The following day she went home, she was
5 discharged, she was having a cup of tea in her garden
6 with her family. She is still alive today, still
7 parties and still is a lovely woman, and she would not
8 have survived had it not been for the intervention of
9 a learning disability nurse from another trust.

10 So that's a -- just to give you a flavour of the
11 example of how important that knowledge and
12 understanding is.

13 **Q.** Is it right that a number of learning disability nurses
14 were redeployed to various different parts of the
15 healthcare system during the relevant period?

16 **A.** Yes, it is. Yes.

17 **Q.** Did you have particular concerns about the decision to
18 redeploy these nurses?

19 **A.** Yes, absolutely. And we made those known. And I think
20 it is fair to say that the nurses themselves had that
21 concern. Some of the survey work that we did during
22 that period of time that fed into a report we published
23 at the end of 2020 said that only one in five had any
24 confidence that reasonable adjustments were being made
25 in their hospital during that time. And we were really

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1 What were your particular concerns about the use
2 of remote services for people with learning
3 disabilities?

4 **A.** Well, they are harder to access. So, not everyone with
5 a learning disability is IT literate, not everyone is
6 able to use the technology. And then there is the
7 issue of diagnostic overshadowing and GPs not being able
8 to pick up on the signals that are coming from patients
9 if they are seeing them in real life. And that's
10 especially the case of people with a learning
11 disability. So you've got an additional barrier --
12 communication is sometimes more difficult and then you
13 have the additional barrier of the technology and the
14 remote nature of the conversation.

15 And I think it probably led to a lot of people not
16 getting in touch. There was general anxiety and fear,
17 particularly around health and doctors, and I think
18 there were probably lots of people that should have
19 consulted their GPs during that time and who didn't,
20 partly because they felt they shouldn't, partly
21 because -- and I know that was an issue for the general
22 public as well, but actually for people with a learning
23 disability because they actually couldn't.

24 **Q.** One of the significant changes that was brought in was
25 increased use of the 111 service?

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1 concerned about the loss of expertise, the loss of
2 someone to advocate as well, for patients.

3 **Q.** Do you think then there is a link between the fact that
4 learning disability nurses were redeployed and perhaps
5 a lower level of care being provided to patients with
6 learning disabilities?

7 **A.** Yes, absolutely. Absolutely. Because they were the
8 ones that could actually put in place simple reasonable
9 adjustments that could make a huge -- as in the case
10 with this woman -- that could make the difference
11 between life and death.

12 And I must say that post pandemic the numbers of
13 learning disability nurses has been dropping since then
14 as well. And that is of major concern to us because
15 they play a vital role.

16 **Q.** Do you consider that were there to be a future pandemic
17 the specialist care provision of learning disability
18 nurses should be protected and redeployment of those
19 nurses be avoided?

20 **A.** Absolutely, absolutely. And I also think that we need
21 to increase the numbers as well, so that every hospital
22 has access to a learning disability nurse.

23 **Q.** Turning to an area that is linked to the changes that
24 were made during the relevant period. The increased use
25 of remote services.

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1 **A.** Yes.

2 **Q.** Did Mencap have, again particular issues that they took
3 with the way in which that service was being run?

4 **A.** Yes, yes we did. So, again, it's more difficult for
5 people to use. It's also more difficult for people to
6 articulate their symptoms in a way that is then
7 interpreted by nurses remotely and on the phone, and we
8 did have lots of cases as well of where family members
9 had done this on behalf of patients, and actually the
10 111 people wouldn't listen to the fact that they had
11 a learning disability and wouldn't make reasonable
12 adjustments.

13 So well into the pandemic we had situations
14 where -- you know, I remember one case a family
15 contacted us on a Saturday night and they were trying to
16 get antiviral drugs and the person on the end of the
17 line wouldn't -- you know, they had a daughter with
18 Down's syndrome, the person on the other end of the line
19 couldn't make that happen, but they were told to go and
20 collect them, which would have meant leaving the
21 daughter on her own and they couldn't do that because of
22 her learning disability. So there were lots of areas
23 where there was less understanding of the situations
24 people were in, and the things that the people with the
25 learning disability needed, by staff there.

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1 Q. Do you know whether or not the algorithm which was used
2 by these 111 services accounted for or asked questions
3 about whether an individual had a learning disability?

4 A. I don't, I'm afraid.

5 Q. Finally, then, bearing in mind, of course, what we have
6 already spoken about, and as we have gone along you have
7 made several points that are potential recommendations
8 for her Ladyship to consider, are there any other points
9 that you would like to draw out for the Inquiry to
10 consider?

11 A. Yes, absolutely. So I think there are three things that
12 we could do that would make a massive difference in the
13 future.

14 The first is around the learning disability
15 register. There are only a third of adults with
16 a learning disability on that register. If we got
17 everybody on it we could then use it to collect data to
18 make reasonable adjustments to passport, things like
19 vaccines, and to really analyse what was going on and
20 the impact on people with a learning disability.

21 So that would be my first recommendation.

22 The second one is around clarity and
23 communications, particularly around the clinical frailty
24 scales, ceilings of care, do not treat, do not
25 resuscitate notices where there is and still is quite

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1 the quality of somebody's life who perhaps has
2 a learning disability, perhaps is non-verbal, perhaps is
3 a wheelchair user, perhaps doesn't have a job, and
4 I think those values cloud some of the decisions that
5 have been made, and really we need to really focus on
6 everybody with a learning disability has the right to
7 a happy and healthy life, just like you and I do, we
8 should all have the same rights.

9 And also that people with a learning disability do
10 make really positive contributions to society and to
11 everyday lives. People live really good lives.
12 Somebody non-verbal could come in this room and light it
13 up and have everyone laughing, and I don't think that is
14 recognised and really understood. So something around
15 the attitudes and values that particularly healthcare
16 professionals place on people's lives would be good.

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

18 My Lady, that's all I ask.

19 **LADY HALLETT:** Thank you, Mr Fireman.

20 Mr Weatherby.

21 **Questions from MR WEATHERBY KC**

22 **MR WEATHERBY:** Ms O'Sullivan, I'm going to ask you just
23 a few questions on behalf of the Covid Bereaved Families
24 for Justice UK. There are just three short topics.

25 I will start, if I may, just picking up a point

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1 a lot of confusion, the BMJ article that we submitted
2 shows that there is still confusion on those areas, even
3 after the pandemic. And also that article shows that
4 resources are becoming factors in people's
5 decision-making.

6 So some clarity in communication so that everyone
7 is really clear.

8 And the other area is around understanding and
9 attitudes towards people with a learning disability. So
10 I think there is general lack of understanding around
11 what a learning disability is in some spaces. We saw
12 that during vaccination where people were told that they
13 couldn't have a vaccine because they didn't have
14 cerebral palsy and cerebral palsy was the only learning
15 disability. So there is some general lack of
16 understanding around that. But a lot of it is actually
17 around the attitudes of people towards people with
18 a learning disability.

19 So with the DNACPRs, the interpretation of them
20 and the decision not to treat people is taken by
21 clinicians based on value judgments according to their
22 abilities and qualities of life. And if you think about
23 it, doctors are university educated, they have really
24 good jobs, they have a really clear contribution to
25 society and they are then making a value judgment about

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1 about DNACPRs, and you have given a fair amount of
2 evidence about that already.

3 You are familiar with the NHS Learning Disability
4 Mortality Review?

5 A. Yes.

6 Q. And we asked for the 2019 one to be added to the
7 documents so I think you may have had a chance to look
8 at that. I can put it on the screen but I don't think
9 I'll have to. It is just one discrete point.

10 Now, these are -- just to remind us, these are
11 annual reports, NHS reports and they are designed to
12 review cases and learn lessons and improve the quality
13 of care for people with learning disabilities; that's
14 right, isn't it?

15 A. Yes, it is, yes.

16 Q. The only point I want to pull out of that is that, and
17 I will give you the reference just for the record. It's
18 INQ000474362, and it's page 26.

19 So this is the 2019 Learning Disability Mortality
20 Review and it's annex 3 which is a table of findings and
21 consequent remedial action. Just this, and this is
22 a quote:

23 "19 reviews reported that the term learning
24 disabilities or Down's syndrome was given as the
25 rationale for a DNACPR order."

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- 1 **A.** Yes.
- 2 **Q.** And that's quite a shocking finding, isn't it?
- 3 **A.** It is. It really is.
- 4 **Q.** And just to complete the picture, the action was to send
5 a letter out to NHS Trust chief executives and others.
- 6 So bearing in mind that was a May 2019 document
7 would you agree that the placing of entirely
8 inappropriate DNACPRs on those bases in relation to
9 people with learning disabilities or Down's syndrome has
10 been a somewhat persistent issue prior to the pandemic
11 and a known issue?
- 12 **A.** Yes, it is. It was known before and it still is
13 afterwards and we also see learning disability being
14 listed as a cause of death on death certificates as
15 well.
- 16 **Q.** Yes, indeed, which again is inappropriate?
- 17 **A.** Yes, it is to say if somebody put "woman" on my death
18 certificate.
- 19 **Q.** Yes, indeed.
- 20 This is an issue, bearing in mind this is the 2019
21 review and it is an important review document, this is
22 an issue that decision-makers should have had well in
23 mind at the beginning of the pandemic when they were
24 looking at pandemic-specific guidance as well?
- 25 **A.** Yes. Yes.

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- 1 **Q.** Was that a surprise and a concern that that hadn't been
2 done before that point?
- 3 **A.** It was certainly a concern that it hadn't been done
4 before, given that there had been several bits of data
5 that had come through that suggested that people with
6 a learning disability, not specifically people with
7 Down's syndrome but people with a learning disability
8 were at higher risk, and I would have expected some
9 further study to have gone on really to assess whether
10 it was the type of learning disability that someone had
11 or other factors.
- 12 **Q.** Yes.
- 13 **A.** So, yes, it was. And it made it all the more shocking
14 as well, given that welter of evidence that when
15 vaccines came around we had to campaign to get people
16 onto the priority list for a vaccine, it wasn't
17 automatic.
- 18 **Q.** Yes. And people with learning disabilities, but
19 specifically people with Down's --
- 20 **A.** Specifically people with -- I think people with
21 Down's syndrome were included by that point because they
22 were on the clinically extremely vulnerable list.
- 23 **Q.** When the -- when people with Down's were added to the
24 CEV list, is it correct that Mencap was consulted by the
25 DHSC, Department of Health and Social Care, in planning

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- 1 **Q.** So when we are looking at guidance, for example the
2 guidance that you have discussed before, the NICE
3 guidance from 20 March, is it a particular
4 disappointment that this issue wasn't highlighted then
5 so that it wouldn't happen again?
- 6 **A.** Yes, it really is, and I think what you have highlighted
7 also shows that there are some people in NHS England, in
8 the Department of Health who knew this and understood it
9 and probably were advocating for it as strongly as
10 I was --
- 11 **Q.** Yes.
- 12 **A.** -- but they weren't being listened to either.
- 13 **Q.** Yes, and I think the point you made earlier was that,
14 having been in the initial Covid guidance it then -- it
15 was too late to put the genie back in the bottle?
- 16 **A.** Yes, and it fed existing perceptions and attitudes.
- 17 **Q.** So there was certainly the potential for it to carry on
18 later into the pandemic?
- 19 **A.** Yes.
- 20 **Q.** Second topic, and briefly, the inclusion of people with
21 Down syndrome on the clinically extremely vulnerable
22 list. It is correct, I think, in late autumn of 2020 it
23 was announced that people with Down's syndrome had been
24 added to the clinically extremely vulnerable list.
- 25 **A.** Yes.

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- 1 out the communications rollout about it?
- 2 **A.** Yes, it was. Yes, and we were given advance warning
3 that it was going to happen.
- 4 **Q.** Yes. And it was initially intended to be through GPs by
5 the use of easy to read leaflets and letters?
- 6 **A.** Yes.
- 7 **Q.** However, did it later become known to Mencap that the
8 communication plan hadn't been implemented effectively
9 and many GPs were in fact unaware of the responsibility
10 that had been placed on them, or were struggling to find
11 the materials?
- 12 **A.** Yes, I believe so.
- 13 **Q.** And as a result of that a different strategy had to be
14 put in place with individuals being directed to contact
15 their GPs?
- 16 **A.** Yes, yes.
- 17 **Q.** And was Mencap involved in all that process to make it
18 happen?
- 19 **A.** Yes, we were. I mean, this was our role almost
20 throughout the pandemic was trying to communicate with
21 our communities and empower them to ask for their rights
22 as well as working with government to try and get the
23 cascade working the other way around, yes.
- 24 **Q.** So it was good that Mencap was being involved but in
25 fact really you were filling in the gaps --

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1 A. Yes.

2 Q. -- that really ought not to have been there.

3 And did the overall result in this failure of the

4 rollout of the communication and the problems with it,

5 did that in fact then delay some people receiving

6 shielding letters, for example, until January 2021 at

7 least?

8 A. For sure, yes, some of the letters were delayed and

9 I think some of the other consequence of it is that

10 people were actually taking matters into their own

11 hands. So we knew there were lots of people who perhaps

12 didn't need to but who were shielding because they

13 didn't know what to think and they just wanted to keep

14 their loved one safe. So it was placing intense

15 pressure on families who might have other children who

16 were in and out of school. There were tales of parents

17 having to live in two bits of the house and not speaking

18 to each other while one looked after the child with the

19 learning disability and one looked after the other kids.

20 Q. Yes.

21 Final topic, and again it's a brief one, and it is

22 the impact of rapidly changing guidance on people with

23 autism.

24 The Inquiry has a statement from Dr Lade Smith of

25 the Royal College of Psychiatrists and she reports

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1 A. -- and I can see absolutely how that can make people

2 very upset indeed.

3 Q. And is it right then that insufficient consideration was

4 given to for example people with autism in terms of the

5 frequency of changes and the specific measures --

6 A. Yes.

7 Q. -- that should have been applied and weren't to assist

8 them?

9 A. So in the frequency but also the specific measures. So

10 it took a while for people to be allowed to not have to

11 use a face mask. It took a while for some of the rules

12 to be changed so that people could go and exercise with

13 a support worker because either the previous rule said,

14 you know, you had to be alone. So it took a while for

15 things to be acted upon, which actually a bit of

16 consultation would have made all the difference and

17 perhaps reduced the number of changes.

18 **MR WEATHERBY:** Indeed.

19 Thank you very much. Those are my questions.

20 **LADY HALLETT:** Thank you very much Mr Weatherby.

21 Mr Wolfe.

22 **Questions from MR WOLFE KC**

23 **MR WOLFE:** Good afternoon, Ms O'Sullivan, I ask questions on

24 behalf of the Patients Association, Care Rights UK and

25 John's Campaign. I just have two brief topics, if

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1 hearing from an autistic patient representative that

2 frequent government rule changes were confusing and

3 upsetting for people living with autism and the patient

4 representative felt that communication of the rules

5 allowed for different interpretations and that was

6 difficult for people to pass and understand that

7 guidance personally and that knock-on effect was on

8 public safety --

9 A. Yes.

10 Q. -- for people. Is that something that Mencap was aware

11 of or became aware of?

12 A. Yes. I mean, just the rules changing constantly but

13 also the way they were communicated out. So we would

14 read something in the newspaper at the weekend, then

15 maybe mid-week it would be part of one of the press

16 conferences, then the guidance would come out a few days

17 later. It was all very bitty and confusing and that

18 really made people anxious.

19 And I think, you know, if you are told that you

20 are vulnerable, and if you are told that there are

21 various rules in place in order to keep vulnerable

22 people safe, and then you see people in society breaking

23 those rules, that's basically telling you that those

24 people don't value you and your life --

25 Q. Yes.

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1 I may.

2 The first relates to escalation pathways for

3 people with a learning disability. You say in

4 paragraph 51 of your witness statement that:

5 "There should be a clear and effective escalation

6 pathway for access to care issues for people with

7 a learning disability in times of emergency."

8 What would that involve?

9 A. So actually this is how the relation around the learning

10 disability register could be really helpful, that

11 actually if it is known that a patient has a learning

12 disability the pathway could involve, say, consultation

13 with a learning disability nurse, it could involve

14 ensuring that communication preferences that -- were

15 met, it could involve extra stringency around the use of

16 things like DNACPRs. So there are various measures that

17 could be put in place. Specifically if it is known that

18 a patient has a learning disability, that doctors are

19 aware that they might need to communicate differently,

20 they might need to take account of the fact that they

21 might be aware of diagnostic overshadowing or particular

22 issues, and that they might need expert support from

23 a learning disability nurse.

24 Q. And they might also need to involve family care?

25 A. Absolutely, yes. Absolutely. The role of families is

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1 absolutely vital, and we saw that absolutely through the
2 pandemic where families weren't listened to.

3 And we have seen that dating back quite a long
4 way. I mean, this is -- the origins of the Oliver
5 McGowan Mandatory Training stem exactly from a family
6 not being listened to and that their son tragically
7 dying.

8 **Q.** You have taken me naturally into my second topic, which
9 is the involvement of family carers being listened to in
10 the pandemic, and you have explained how your view was
11 that they were not sufficiently listened to.

12 How did that impact on the process of informed
13 consent for treatment for people with learning
14 disabilities?

15 **A.** Well, it meant that there was no one there to advocate
16 for the patient, that in some instances we know do not
17 attempt resuscitation notices were applied without
18 family consent or with very limited family consultation.
19 So, you know, an example I think I might have used
20 earlier where, you know, one family member was asked
21 about it in relation to her sister, she said she needed
22 to go and consult other family members, notably her
23 mother, and by the time she came back the patient had
24 been refused treatment and then died subsequently as
25 a result of that and there was an indication that she

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1 people with learning disabilities?

2 **A.** Well, absolutely -- and in fact, that specific example,
3 it was the sister of the person concerned that came to
4 us, because she would not give up on her sister. She
5 was not willing to leave her in a situation where she
6 was just going to get palliative care and die. And she
7 came to us and we managed quite swiftly to reach out,
8 through our networks of learning disability nurses, get
9 her some expert advice, which she then took back to the
10 hospital and advocated really strongly for the
11 treatment. And it was entirely successful. And rapidly
12 successful. So that's a really good example of how
13 family intervention can really make a difference.

14 **MR WOLFE:** Thank you, my Lady.

15 **LADY HALLETT:** Thank you very much, Mr Wolfe.

16 I think that completes all the questions that we
17 have of you. Thank you very much, indeed, for your
18 help. I'm sorry we had to ask you to come back this
19 afternoon but it has been very interesting and very
20 helpful, thank you.

(Witness withdrew)

22 **MR SCOTT:** My Lady, may we call Professor Philip Banfield.

23 **PROFESSOR PHILIP BANFIELD (affirmed)**

24 **Questions from COUNSEL TO THE INQUIRY**

25 **LADY HALLETT:** Thank you for coming back to help,

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1 had given consent when she is really clear that she
2 hadn't.

3 So this was happening a lot where families were
4 either not consulted or where they were their views were
5 being ignored.

6 **Q.** Thank you. So one of the particular concerns that my
7 clients have is about the way family members who were
8 involved in healthcare, including in communications, as
9 you describe, were often treated as mere visitors and
10 subject to conventional visiting policies rather than
11 being treated as part of the healthcare team. Do you
12 have an observation on that?

13 **A.** Yes, absolutely. And I think that's -- that led to them
14 being denied access to hospitals and visiting
15 arrangements, which, as I described earlier, it is not
16 a nice-to-have, this is -- it's really vital for someone
17 with a learning disability to have someone there who
18 knows them really well.

19 **Q.** Final thought, you gave a very helpful example, indeed
20 you have given a couple, how learning disability nurses
21 were instrumental in providing support. You gave the
22 example of a person who was resistant to an oxygen mask
23 and the learning disability nurse assisted with that.
24 Do you by any chance have any examples similar that you
25 can illustrate the role of family carers in supporting

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1 Professor Banfield.

2 **MR SCOTT:** Good afternoon, Professor.

3 If I just briefly set out your background. So you
4 are the chair of the BMA's UK council and have been
5 since July 2022; is that correct?

6 **A.** That's correct.

7 **Q.** And you are a consultant obstetrician and gynaecologist
8 based in North Wales and honorary professor in the
9 Cardiff University's School of Medicine. Before being
10 appointed as chair of council, you spent several years
11 as a representative of BMA Cymru Wales and have sat on
12 the UK council since 2012?

13 **A.** I have indeed, yes.

14 **Q.** We've heard a significant amount of evidence and the
15 BMA's written evidence sets out a lot of the impact upon
16 doctors, patients and healthcare workers.

17 Could you briefly just give us an idea of the
18 human impact that the pandemic had on doctors?

19 **A.** Well, doctors went into the pandemic already with
20 significant pressures in work, large instances of
21 burn-out and quite a high attrition rate of the
22 profession, number of people leaving the profession.
23 What the pandemic did, initially, strangely enough, was
24 to increase morale, as people felt that they were
25 needing to pull together in this national crisis. But

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1 very rapidly, and across the course of the pandemic, we
 2 saw a worsening of both physical and mental health of
 3 the medical profession.

4 **Q.** How did that manifest itself, how were people on the
 5 ground impacted?

6 **A.** Well, we saw physically that because doctors were
 7 exposed to Covid so readily and so much more than the
 8 general public that there was a sixfold increase in the
 9 chance of a healthcare worker getting Covid. So they
 10 were off. Sadly we know of at least 50 doctors who died
 11 from the pandemic and we know of many hundreds who have
 12 still got Long Covid. Those physical disabilities have
 13 affected the mental health -- especially at the point at
 14 which the services on the frontline did feel overwhelmed
 15 and people were frightened of what was about to come and
 16 then frightened about being put in situations that they
 17 were unfamiliar with, untrained for, and might put them
 18 at risk.

19 **Q.** Was that the same for doctors across the entirety of the
 20 United Kingdom?

21 **A.** Yes, it was.

22 **Q.** Was that the same for doctors of all different
 23 specialities and seniority?

24 **A.** Well, there were different pressures on different age
 25 groups, so the older consultants, as it became apparent

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1 any health service that has to change the way it
 2 practices. So obviously in maternity we suddenly were
 3 in a very strange situation of pregnant women's partners
 4 not being allowed in for scans or at the point at which
 5 they were receiving bad news. But of course if you stop
 6 elective care and you are not then able to provide care
 7 to patients that have been under you for some time, if
 8 you are stopped from operating, then the stress and
 9 distress that that causes is huge. And of course that
 10 then has a knock-on effect to our colleagues in general
 11 practice because they effectively then took over the
 12 care of people on waiting lists that secondary care had
 13 effectively stopped working on.

14 **Q.** Was the medical profession as a whole overwhelmed, both
 15 personally and professionally?

16 **A.** The medical profession is used to working under
 17 pressure. The feedback that we have had is that many
 18 people did feel overwhelmed, the sickness rates went up,
 19 and that sense of burn-out lasts to this day. And we
 20 have seen, certainly, a large number of people leave the
 21 service early because of the effects of that.

22 **Q.** In the event of a future pandemic, how would you prevent
 23 that happening again?

24 **A.** That's a difficult one because it doesn't feel as if
 25 much has changed at this point in time. But valuing the

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1 that Covid disproportionately affected those in older
 2 age groups, were a huge issue. It didn't affect doctors
 3 equally. We saw our black, African and minority ethnic
 4 colleagues affected. And then we saw the resident
 5 doctors, the doctors in training and local employed
 6 doctors, were more likely to be redeployed, having a lot
 7 of stresses because they were suddenly being put at
 8 short notice into strange environments.

9 **Q.** We will come back and look at that a little bit later
 10 on.

11 Dr Kevin Fong gave evidence to the Inquiry in the
 12 first period of hearings and he talked about the detail
 13 and the dedication and the ability to provide everything
 14 that could be provided to provide the best care for
 15 a patient who is critically unwell in intensive care.
 16 And he said:

17 "If your definition of overwhelmed is your ability
 18 to provide that, then at many times and in many places
 19 the units were overwhelmed."

20 Now, Dr Fong was talking there about intensive
 21 care.

22 Would you say that other parts of the NHS and HSE
 23 across the United Kingdom were overwhelmed during the
 24 pandemic?

25 **A.** I think that happened everywhere. And, by definition,

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1 staff and enabling them to get on with the job that they
 2 are there to do would be helpful.

3 We went into the pandemic with no capacity to
 4 expand, and at the same time, now, we are being expected
 5 to address the large backlog. And it would seem
 6 sensible to invest quite heavily in expanding that
 7 capacity now that could then be utilised for a future
 8 pandemic.

9 **Q.** Is it just capacity or is it flexibility of staff,
 10 systems and that capacity?

11 **A.** Well, I mean, it is all of those things. It is being
 12 able to match demand to capacity overall. There are
 13 mechanisms in place to discuss with the workforce how to
 14 work and how to optimise treating the largest number of
 15 patients in the most effective time.

16 **Q.** You mentioned GPs earlier on. Going to slightly take
 17 you through almost, like, a patient journey. So, in
 18 terms of GP appointments, does the BMA recognise that
 19 the public felt frustration that it was difficult to get
 20 an appointment with their GP during the pandemic?

21 **A.** We recognise it because that what was reported.
 22 Of course very early on in the pandemic there was
 23 a specific instruction from the NHS to GPs to switch to
 24 remote working, which GPs did remarkably efficiently and
 25 in very short timescale.

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1 The GPs' surgeries were not geared to separate
 2 patients out. The duty of care on GP partners, as
 3 an employer, meant that one had to protect their staff
 4 as well, and because there are often smaller numbers of
 5 GPs you only had to have one, two or three GPs either
 6 ill or isolating and the entire service would collapse.

7 **Q.** Let me slightly unpick this. So if there was
 8 a difficulty in getting access to GPs appointments --
 9 firstly, do you think that there was difficulty for
 10 people to be able to access their GP?

11 **A.** There is no evidence at all that GPs stopped seeing
 12 patients face to face. And in fact, actually, you know,
 13 the nearest percentage of face-to-face contacts was 52%.
 14 So -- and that was in England. So all the way through
 15 the pandemic more than half of the appointments were
 16 maintained as being face to face.

17 What GPs did was that they undertook total triage,
 18 where they talked to patients first to ascertain whether
 19 it was a problem that could be sorted out remotely, or
 20 whether they needed to be seen face to face. And they
 21 tended to concentrate on people with mental health, the
 22 elderly and those with long-term conditions.

23 **Q.** Did primary care generally have the capacity, the
 24 physical infrastructure, the capability, to deal with
 25 the number of remote consultations that ended up taking

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1 ways in which people with varying disabilities are
 2 continually disadvantaged.

3 **Q.** Can you think of any specific recommendations in this
 4 area that the Chair may wish to consider?

5 **A.** The most obvious is about having suitable PPE. It took
 6 quite a long time for example --

7 **Q.** Sorry, just in terms of the remote consultations.

8 **A.** So in terms of the remote consultations, it is being
 9 able to ask or communicate with patients to ask what is
 10 their optimal way of dealing with their interaction with
 11 the GP.

12 **Q.** Do you think that there was a loss of patient confidence
 13 in GPs because people felt they weren't able to get
 14 appointments?

15 **A.** Well, I think a lot of the loss of confidence was driven
 16 by the Department of Health and NHS England appearing to
 17 blame GPs for the lack of contact, and I think that got
 18 picked up in the media. I would not blame GPs for
 19 a lack of ability to contact. We know that general
 20 practice is under-resourced for the work that it has
 21 been asked to do.

22 **Q.** What do you think could be done to improve that
 23 situation?

24 **A.** Well, I mean, significant investment in
 25 GP infrastructure and GP estates would help enormously.

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1 place?

2 **A.** Well, there was a significant investment in IT and that
 3 is one of the successes of the pandemic, was a rapid
 4 expansion of the number of laptops and the remote
 5 working facilities.

6 **Q.** Is it right then that it was only after that expansion
 7 that there was that sufficient capability but initially
 8 there wasn't?

9 **A.** Yes. So it wasn't initially capacity.

10 **Q.** And so at what point in time? Because I think you set
 11 out in your statement that over 50% of primary care
 12 respondents were limited by hardware, infrastructure,
 13 software, mobile devices, speed. Were all of those
 14 issues solved or is there more work to be done in order
 15 to make sure there is sufficient remote capabilities?

16 **A.** No, that work is still ongoing, but it is progressing
 17 more rapidly in general practice than it is in secondary
 18 care.

19 **Q.** And do you think that there was sufficient preparation,
 20 planning or consideration given to those, like Dr Powell
 21 we heard from this morning, who was -- communicates
 22 primarily through BSL. Do you think there was
 23 consideration given to inequalities that might be caused
 24 by remote consultations?

25 **A.** No, I think that the pandemic has exposed all sorts of

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1 **Q.** Would that provide social distancing, what -- broader
 2 rooms -- how would that assist?

3 **A.** It will help in any future pandemic by making sure that
 4 you can be proactive with your patients in assessing
 5 what their needs would be at any particular time if you
 6 needed to change the way that care was given.

7 **Q.** Okay.

8 Finally, if we can look now at shielding. What
 9 was the difficulties that GPs faced in contacting those
 10 who were advised to shield?

11 **A.** Well, originally they were being told that they would
 12 receive the lists of clinically extremely vulnerable
 13 patients. They came off several national datasets and
 14 they had to cross-reference them with their own patient
 15 records and they were finding that there were a lot of
 16 errors in those datasets. They then had lists from
 17 secondary care and subsequently lists of patients who
 18 self identified as clinically extremely vulnerable. So
 19 there was a lot of cross-checking that was needed and
 20 quite a short period of time in which to do that.

21 **Q.** Do you think it was appropriate for GPs to be
 22 responsible for contacting those who had to shield?

23 **A.** Do I think it was --

24 **Q.** Well, was it the best way of doing it? Let's phrase it
 25 a different way.

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- 1 **A.** The GPs know the patients best, that's why general
2 practice is so successful, they are the most likely to
3 know whether the condition is still ongoing or not, but
4 if you are going to ask GPs to do that, you need to give
5 them the resources to do it.
- 6 **Q.** And I presume by that answer it meant they didn't have
7 the resources to do that, is that --
- 8 **A.** No -- well, no, but they actually -- they get on with
9 the job and they delivered.
- 10 **Q.** And was there clear communication of the criteria for
11 who should shield and if not, how should that have been
12 dealt with differently?
- 13 **A.** Well, there weren't clear instructions and in fact the
14 criteria changed several times across the pandemic which
15 added to the confusion.
- 16 **Q.** Can you offer any recommendations, this is a question we
17 have been asked to ask, any recommendations to improve
18 the ability of healthcare -- doctors, nurses, GPs, to
19 safeguard clinically vulnerable and clinically extremely
20 vulnerable people in the event of another pandemic?
- 21 **A.** It is being able to contact people quickly and
22 accurately but it is having central advice as to what
23 help and support would be available to them.
- 24 **Q.** And that central advice should come from government
25 rather than from their own GPs?

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- 1 to be predominantly droplet spread -- I'm not sure that
2 I agree with that, I think there is evidence to the
3 contrary -- but because it is droplet spread that
4 therefore an FFP3 mask is not needed.
- 5 Now, I would argue that a precautionary approach
6 is advisable, and if I was an employer my duty is to
7 protect my employees. So if there is any chance that
8 the infection can be caught by aerosol spread I have a
9 duty of care to protect against that.
- 10 **Q.** It is more we have heard people giving evidence who have
11 said if you explain the reasons why certain decisions
12 have been taken, that doctors, healthcare workers would
13 have been able to get on and cope with it -- we heard
14 that in the initial impact video. I'm asking whether
15 there was any explanation to the BMA or to doctors as to
16 why the guidance was as it was rather than what you felt
17 it should have been?
- 18 **A.** No, there was no explanation given. We all felt, and
19 I think that was widespread across the profession, that
20 the advice was given to match the availability of PPE
21 rather than based on evidence.
- 22 **Q.** What do you think about any suggestion that doctors
23 wouldn't want to wear FFP3s because of any discomfort
24 that may cause in the middle of a pandemic?
- 25 **A.** Well, none of us enjoy wearing protective equipment. If

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- 1 **A.** Yes.
- 2 **Q.** I want to ask now about infection prevention control.
3 The Inquiry has heard a lot of evidence about the
4 protection offered by FFP3s compared to FRSMs. On the
5 whole -- obviously, you can't speak for every doctor, on
6 the whole did doctors think that FFP3s provided them
7 with more protection against a pathogen such as Covid-19
8 compared to FRSMs?
- 9 **A.** I can say that overwhelmingly the majority of people
10 feel let down, felt let down at the time and still feel
11 let down by the observation that fluid-resistant
12 surgical masks are not protective against airborne
13 infections.
- 14 **Q.** So doctors were asking for FFP3 masks, is that --
- 15 **A.** Well, they were asking for appropriate respiratory
16 protection because the surgical masks are not
17 respiratory protection.
- 18 **Q.** Was there ever any explanation as to why -- coming from
19 the IPC cell or anybody else who provided the guidance,
20 as to why the guidance was being written as it was, as
21 to why the view had been taken that FFP3s were only
22 required for AGPs?
- 23 **A.** I mean, ultimately you are going to have to ask them but
24 it was put to us that their view, and there are some --
25 still some predominant views that because Covid is felt

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- 1 you've got to put an extra gown on, if you have an apron
2 on, it is enormously uncomfortable but we do it because
3 it protects us and therefore protects our patients
4 because we know that you could catch Covid from
5 healthcare workers and, you know, there was nosocomial
6 spread within hospitals so it is not just about
7 yourself, it is about everyone else as well.
- 8 So there are different versions of FFP3 masks
9 available. They come from very simple to very complex
10 and ultimately you can have an air filtering hood as
11 well so, you know, it is up to you and your employer to
12 find the PPE that allows you to do your job across those
13 shifts.
- 14 **Q.** Moving now to a concern that had been raised about FFP3s
15 and expiration dates. I believe there were concerns
16 that have been raised by doctors and other healthcare
17 workers that they were being asked to wear FFP3s that
18 had come in boxes where the expiration date had expired
19 and then there were stickers that had been placed over
20 the top of them. That's a concern that you recognise;
21 is that fair?
- 22 **A.** Yes.
- 23 **Q.** There has been evidence that suggests that FFP3s were
24 quality-controlled even if they had been expired and if
25 they passed that quality control they were then put back

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1 into circulation for use. Was anything like that ever
 2 explained to the medical profession, that actually this
 3 was making use of the -- what they thought was
 4 sufficiently good-quality PPE that was available at that
 5 time?
 6 **A.** No, those suggestions were not held with the BMA. It
 7 felt as if it was being used as an excuse for not having
 8 PPE available. Now, we had gone into the pandemic as
 9 a profession thinking that we might be overwhelmed and
 10 that we might not have sufficient equipment or beds, so
 11 it was within our own minds as to, well, how could we
 12 take single-use PPE and perhaps have to reuse it later,
 13 you know, you build for those contingencies.
 14 Now, we know subsequently that some of the expired
 15 stock was quality tested and was still fit for purpose,
 16 and therefore it is not unreasonable to use that in
 17 those circumstances.
 18 **Q.** Do you think if there'd been better communication or
 19 dialogue from those who were writing the IPC guidance or
 20 those who were providing that PPE with doctors and
 21 healthcare workers, do you think the doctors would have
 22 felt more protected than they actually did?
 23 **A.** Yes. It would have been much more helpful to have
 24 discussed it with the BMA so we could have explained it
 25 to our members. It would have also been, because we

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1 just ask you for a practical example about what you feel
 2 should have been done better by the HSE?
 3 **A.** We feel that they should have inspected and enforced
 4 more in the workplace.
 5 **Q.** What recommendations would you wish to make, just
 6 briefly outline them, please, in relation to what more
 7 should be done in order to make doctors feel safer with
 8 the PPE that they are using in the event of a pandemic?
 9 **A.** Well, the immediate one would be to recognise that
 10 infections like Covid-19 are possibly
 11 aerosol-transmitted and therefore that appropriate
 12 respiratory protection should be available to them
 13 because we still have Covid in our hospitals, we still
 14 have clinically extremely vulnerable patients who are
 15 frightened about engaging with the health service
 16 because we don't routinely wear masks around hospitals
 17 anymore so we are not protecting them.
 18 But the medical profession as a whole still feels
 19 that its worries about infection control and respiratory
 20 protection, ventilation in the hospital estates, is
 21 still unheeded and therefore we are unready for the next
 22 pandemic.
 23 **Q.** Did the BMA take any steps to try and ensure that any
 24 ethnic minority healthcare worker specifically who
 25 I think as the evidence shows, had a greatly likelihood

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1 like data and evidence, if they had actually shown us
 2 the data and evidence of that testing. But this was at
 3 a time in which people were feeling that there was
 4 a lack of aprons, gowns, visors, you know, GPs were
 5 buying their FFP3 masks from DIY stores and Amazon, and
 6 so there was a kind of element of feeling that we were
 7 so underprepared, you know, what else was being bent as
 8 a rule?
 9 **Q.** You set out in your statement that doctors didn't feel
 10 protected by the Health and Safety Executive. What more
 11 should HSE have done in the opinion of the BMA?
 12 **A.** Well, there were two important things arising from
 13 health and safety law. The first was a duty to assess
 14 the hazard and then to mitigate against that hazard and
 15 we feel that the Health and Safety Executive didn't
 16 really do either adequately. So, for example, they --
 17 there was quite a long lag between getting risk
 18 assessments for patients and then getting the right kind
 19 of respiratory protection for staff and if you have
 20 a situation in which the Health and Safety Executive is
 21 aware that there are deficiencies in the advice about
 22 fluid-resistant surgical masks, for example, because it
 23 was their research in 2008 that showed that aerosols can
 24 get behind these masks.
 25 **Q.** Sorry, to cut across you, Professor Banfield, if I could

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1 of being redeployed than other ethnic groups, that they
 2 had equitable access to PPE?
 3 **A.** Yes, we flagged it on many occasions with both
 4 government and the NHS in all four nations. The
 5 difficulty for people of black, Asian and minority
 6 ethnic origin is that are much more reticent, we know,
 7 in raising concerns, they were much more readily
 8 deployed, they were less likely to protest about having
 9 inadequate protections because we know that systemically
 10 there are issues with systemic racism in the NHS.
 11 **Q.** I'm going to move on to a different topic.
 12 In terms of the provision of guidance or
 13 prioritisation protocols, you set out in your statement
 14 that there was no government guidance or prioritisation
 15 protocols that were issued about criteria or policies
 16 about which patients were being admitted into intensive
 17 care in the event that demand outstripped already
 18 limited resources or services were overwhelmed.
 19 Fundamentally, do you believe that's a question
 20 for politicians to provide or clinicians to provide that
 21 kind of guidance in the event that it was required?
 22 **A.** Well, it is a bit of both, isn't it, it is where it
 23 overlaps because if you are going into a pandemic under
 24 resourced and under prepared, the state of the NHS at
 25 that point has arisen because of government policies

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1 then if you are going to -- if you are going to at that
2 point -- sorry, I've lost my train of thought.

3 **LADY HALLETT:** I think the question was were protocols for
4 politicians and clinicians and I think you suggested
5 both. But I'm going to challenge you that really the
6 protocols -- I take your point about funding being for
7 politicians and making decisions about where the money
8 went in that kind of prioritisation, but not the
9 protocols.

10 **A.** So we were not -- the point and the issue that we had
11 was not necessarily with the frontline decision-making
12 on a day-to-day basis which doctors take every day.
13 You know, we have to decide we have got four people all
14 needing major surgery but there is one intensive care
15 bed.

16 **MR SCOTT:** Can I just ask for my own clarity, is this in
17 a non-pandemic time or in a pandemic time?

18 **A.** In a non-pandemic time.

19 **Q.** Right.

20 **A.** When you get to a stage where you are then getting
21 a large number of people who may need a limited amount
22 of services then you need a framework of what are the
23 ethical and moral considerations and that's what we were
24 asking for because, to a certain extent, that has
25 a societal discussion to it as well.

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1 So I'm going to challenge you, if I may, do we
2 want politicians involved in clinical decisions?

3 **A.** I'm going to say that it is political how we have ended
4 up with the number of staff and the number of beds --

5 **LADY HALLETT:** That I follow. I think that's a separate
6 argument.

7 **A.** And therefore the point at which there is choice about
8 what you still do and what you don't do. So for
9 example, it is a political decision or it was
10 a political decision to stop cancer screening or some
11 cancer screening during the pandemic in order to create
12 extra capacity. So there are circumstances in which you
13 need all of this joined up, because really what you are
14 talking about is a situation in which rationing has to
15 take place, and we saw that quite considerably during
16 the pandemic. And that is not a clinical decision
17 alone. That is, you know, as I say, a wider societal
18 political decision as to what is funded or not funded
19 and what is continued and not continued.

20 **LADY HALLETT:** Thank you.

21 **MR SCOTT:** Because your statement then goes on to continue
22 in terms of what practically happened in the pandemic,
23 that:

24 "A lack of guidance in circumstances of extreme
25 uncertainty created anxiety amongst doctors and other

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1 **Q.** Yes, although I think the chair's question is: is that
2 a matter for government to provide you or is that
3 a matter for clinicians to provide for themselves?

4 **A.** Well, it is getting consistency. That's the -- and
5 therefore having some form of national lead or
6 national -- and, of course, MEAG did at one point
7 commission a report to look at what the ethical
8 framework of being -- in the event of services being
9 overrun, how do you then decide to get the most care for
10 the most people, and what then happens, if you have got
11 people who are being treated but are not getting better,
12 what are the ethical considerations in saying, well,
13 that patient is not getting better, we must deescalate
14 or stop care.

15 **LADY HALLETT:** I'm still going to challenge you, if I may,
16 on an ethical consideration, a clinical decision.
17 I don't see that that should come anywhere near
18 a politician. No disrespect to politicians but it seems
19 to me that they are for doctors. I don't know if you
20 heard the evidence of Jeremy Hunt when he was health
21 secretary and he was involved in, I can't remember which
22 exercise -- was it Nimbus, I can't remember, and he said
23 he had been asked to take what he decided was a clinical
24 decision about who should be discharged from hospital,
25 treated, and he said, "No, it is not for a politician."

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1 healthcare professionals."

2 And then:

3 "As a result of the UK Government's decision not
4 to issue guidance or any protocols for prioritising
5 care, the BMA issued its own guidance for the profession
6 ... as did a number of other organisations."

7 So why was it that the BMA filled that gap?

8 **A.** Because if you are in that situation as a group of
9 clinicians or a single doctor, having to make such
10 profound decisions about what does and doesn't get done,
11 who do you admit to hospital, who do you give the bed
12 that's available to? And we saw, for example, a large
13 number of people who normally would have been admitted
14 to hospital with respiratory symptoms not admitted to
15 hospital because there were not the beds for them so
16 they were kept at home and managed at home and,
17 you know, having that sense that there are other people
18 outlining and understanding that there are moral and
19 ethical dilemmas and sharing those and getting
20 consistency. So we issued guidance, a number of other
21 colleges offered guidance as well. It would have been
22 better if there was one set because it would have been
23 something that everyone then could have said: we have
24 made the decisions as fairly and ethically as we can, we
25 have tried to treat everyone with respect and equally.

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1 Q. How is a doctor who is faced with that situation meant
2 to apply multiple versions of guidance from different
3 organisations?

4 A. Well, that's why I would argue that it would have been
5 more helpful for there to be a single guidance on this.

6 Q. And did, to your knowledge, your members feel better
7 because there was that guidance had been put in place
8 once the BMA had published it?

9 A. Yes, they did, they felt better protected. I was on UK
10 council at the time that we were discussing how
11 necessary this was and when you are facing a situation
12 where you know people are going to die because you can't
13 help them or you can't help them as best you can, or you
14 are going to give care that is not up to your normal
15 standard, you need to feel that there are other people
16 with you as you take these decisions.

17 Q. Can I just take you, please, to INQ00011773.
18 This is the "COVID-19 - ethical issues.
19 A guidance note", dated March 2020. I think this is the
20 guidance we have been talking about; is that correct?

21 A. Yes, it is.

22 Q. And if we just go to page 5, please. Thank you very
23 much. It's that bottom paragraph.
24 There is the example that's given there about
25 clinicians reviewing and documenting the appropriateness
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1 that and we were advocating much more for advanced care
2 discussions. So, for example, you know, my mother was
3 elderly at the point at which the pandemic started and
4 we had the conversation very early in the pandemic, and
5 we have been encouraging families to have those
6 conversations with their loved ones more and more,
7 because it then avoids the confusion and it avoids the
8 surprise.

9 Q. I just want to touch very briefly on one topic in terms
10 of the deaths of healthcare workers. What is your view
11 on the fact that not all departments and other public
12 bodies across the United Kingdom recorded specific data
13 about the death of healthcare workers? Do you think
14 that there should have been recording of the deaths of
15 all healthcare workers?

16 A. Well, I do, because we've ended up this end of the
17 pandemic with really no idea how many healthcare workers
18 have died from the pandemic, as far as I know. It's
19 been very difficult to ascertain. And even throughout
20 the pandemic we were getting data from individual
21 doctors, people were finding out who had died from press
22 releases rather than being any central data.

23 Q. Did it make you feel valued as doctors, the fact that
24 this wasn't being recorded?

25 A. Doctors felt very undervalued during the pandemic and in
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1 of cardiopulmonary resuscitation for all patients.
2 I think it is fair to say that you are not
3 suggesting that this guidance, the threshold for
4 implementing this guidance, was ever reached, are you?

5 A. No, this is guidance for if the service is completely
6 overwhelmed. I mean, of course, we do have discussions
7 with patients all of the time in hospital about what
8 they wish for the future of their care and we do discuss
9 with them what happens if there is deterioration in
10 their condition. That has been part of routine
11 practice. We had -- there was guidance in 2001 and 2016
12 on this.

13 Q. Do you think, though, that if you published guidance of
14 this type, which is talking about CPR, that there is
15 a risk that doctors in the middle of a pandemic may see
16 this guidance and may potentially apply it in situations
17 where it wasn't intended to be implied?

18 A. I would hope that that is not the case. And the reason
19 I would hope that that was not the case is because these
20 are conversations that the profession had already
21 started to have prior to the pandemic.
22 You know, we went -- way before the pandemic, the
23 issue of doctors or other clinical staff unilaterally
24 deciding who should have a DNACPR were a matter of
25 public debate and we had started to work our way through
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1 fact many times in our calls for evidence we have had
2 comments back about how doctors felt as if they were
3 kind of disposable commodities.

4 Q. Do you think there would have been a beneficial impact
5 about having an understanding of the types of doctors,
6 the areas they were working in, gender, BAME groupings,
7 if there had been this record about healthcare workers
8 and doctors who had died?

9 A. Well, we would have picked it up much quicker and it
10 would have been much more valid as an argument then for
11 taking precautions and more precautions earlier. If we
12 had known, for example, that healthcare workers --
13 I mean, if you have a look at the first 100 or so
14 healthcare worker deaths as were reported in the Health
15 Services Journal, what was striking was there were no
16 deaths recorded from anaesthetists or intensive care,
17 but there were from the wards. And of course people
18 on -- using -- anaesthetists and intensive care had FFP3
19 respiratory protection.
20 And what we were witnessing was that -- you know,
21 I, as, you know, a clinical school teacher, our medical
22 students wanted to help straight away. As soon as the
23 pandemic, they said: what can we do to help? They went
24 out onto the wards with fluid-resistant surgical masks
25 and they all caught Covid. Straight off.
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1 Now, if that had been tracked and if the deaths
2 had been tracked earlier, we would have known. Less
3 doctors, less healthcare workers would have caught
4 Covid, fewer would have died, and, you know, fewer
5 people would have caught Covid within the hospital and
6 care setting.

7 **Q.** Just two more questions if I may. The first is, do you
8 think there was adequate support for doctors' and
9 healthcare workers' mental and physical needs while they
10 were working during the pandemic?

11 **A.** No. I mean, we went into the pandemic with very poor
12 occupational health services, very under-resourced
13 mental health services. What we did see in the early
14 stages, as other services were closed down, many of the
15 psychological services were redirected to providing
16 support for health and well-being. We saw in the BMA
17 across 2019 to 2021 a 343% increase in people contacting
18 our well-being services.

19 **Q.** Where was that, was that across the UK?

20 **A.** That's across the UK, yes.

21 **Q.** And then finally, what more do you think should be done
22 to protect doctors and healthcare workers in the event
23 of a future pandemic?

24 **A.** Well, the immediate ones are to take a precautionary
25 approach because, you know, if there is any -- any --

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Questions from MR WEATHERBY KC

1 **MR WEATHERBY:** Thank you.

2 Professor, as I think you know I'm going to ask
3 you some questions on behalf of the Covid Bereaved
4 Families for Justice UK group. I think all of the
5 points that I'm going to ask you about are quite short
6 and they've been touched upon so that hopefully will
7 allow to us go a bit swifter than otherwise.

8 Can I start with the point that my Lady was
9 particularly concerned about with the idea of the
10 central guidance about triage or decision-making for
11 resource allocation and it won't surprise you to know
12 that the family members that we represent are very
13 concerned about this area, many of them believe that
14 their loved ones were -- interventions were not taken,
15 care that would have otherwise been given wasn't
16 provided due to rationing. So it is a point that's very
17 dear to their hearts.

18 Your statement identifies how towards the middle
19 and end of March the government was in fact looking at
20 issuing guidance on this subject and then decided that
21 they felt that the resources would not be exhausted,
22 that's your paragraph 127.

23 And you go on to mention that identifying the lack
24 of certainty was an important issue and to emphasise
25

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1 doubt about how someone can catch an infection, then the
2 duty of care is with the employer, and doctors still do
3 not feel protected in that workplace. We still have
4 inadequate ventilation, for example. We are still
5 unable to separate out patients.

6 And -- you know, that was very distressing for
7 doctors to be told: you have to put a patient with Covid
8 in a room with patients without Covid. This was
9 a really difficult space for doctors to be in. And that
10 ability to plan proactively and ahead to do that spacing
11 out. What is going to stop if we don't have that
12 capacity at the time?

13 But if we stopped doctors leaving, if we stop that
14 exodus of doctors, then at least you are retaining your
15 part of your workforce that is there for the future.

16 **MR SCOTT:** My Lady, those are all the questions I have.

17 **LADY HALLETT:** There are quite a few questions from core
18 participants for you, Professor Banfield, so, if you'll
19 forgive me, we will take a break now and then come back
20 at 3.30, but I promise you we will finish you this
21 evening or this afternoon. Thank you.

22 (3.15 pm)

(A short break)

24 (3.30 pm)

25 **LADY HALLETT:** Mr Weatherby.

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1 that the BMA was aware that there were at times
2 rationing of important resources such as oxygen.

3 So, is that really where the need for central
4 guidance was, that there are issues of resourcing, there
5 is issues of resource management, and there is also
6 issues of clinical decisions, and all of those need to
7 be considered together in terms of when there is
8 a possibility of the system or part of it being
9 overwhelmed, and is that why there is a need for some
10 centralised guidance?

11 **A.** There is need for centralised guidance because there
12 needs to be a recognition at what point care is being
13 rationed.

14 **Q.** Yes.15 **A.** Care was rationed.16 **Q.** Yes.

17 **A.** We stopped elective procedures, we stopped screening for
18 certain cancers, so although the term "the service was
19 not overwhelmed" has been used, in fact that was only
20 because we rationed and left out other things.

21 The ethical decisions that we are faced on the
22 frontline, actually we are used to making every day
23 because we sometimes get more than one patient needing
24 care at the same time and what you do is you try to make
25 the fairest and best judgment and you try not to

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1 prejudice your decision but make it on the clinical facts
 2 in front of you.
 3 There is a stage though in between that where you
 4 have a large number of people and therefore having some
 5 form of framework as to who is going to make those
 6 decisions and how is, you know, incredibly useful.
 7 **Q.** So on the individual level, the clinician is plainly the
 8 person who should be making the decisions about the
 9 priority of treatment or whether treatment is
 10 appropriate. But the clinician doesn't necessarily know
 11 the amount of resources available or what's coming down
 12 the track in terms of resources, so there needs to be
 13 an overarching departmental guidance about this as well.
 14 **A.** Yes, and you need to know where your next bit of
 15 resources is coming from.
 16 **Q.** Yes. Okay, that's all I ask on that.
 17 So can I just return to FFP3s briefly. Between
 18 paragraphs 266 and on from that, you talk about the fact
 19 that the PPE guidance was downgraded in March 2020 and
 20 that's when the requirement for FFP3 masks for
 21 healthcare workers was removed and you have indicated
 22 earlier that many doctors thought that was matching what
 23 was available rather than the actual requirement for
 24 protection for doctors.
 25 And is that what the BMA thought at the time?

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1 fact that FRSMs were not sufficient for aerosol,
 2 potentially aerosol viruses?
 3 **A.** Well, I think the evidence as a BMA that aerosol
 4 transmission was a significant part of the problem,
 5 probably developed in the latter half of 2020 and 2021.
 6 The point at which it became unequivocal to us that this
 7 was a significant mode of transmission, we went both to
 8 government and then to our members as well, to raise
 9 publicly that we thought this was an issue.
 10 **Q.** Yes. That's very helpful.
 11 Now, on the same theme, I don't know whether you
 12 followed it but Professor Susan Hopkins recently gave
 13 evidence to this Inquiry that there was weak evidence
 14 that FFP3 masks offered greater protection than surgical
 15 masks in practical healthcare settings, as opposed to
 16 a laboratory environment. Is that a statement that you
 17 would agree with?
 18 **A.** No, I wouldn't.
 19 **Q.** And why is that?
 20 **A.** Well, it was interesting because at one point
 21 Addenbrooke's decided to implement wholesale use of FFP3
 22 masks instead fluid-resistant surgical masks and found
 23 the infection rate plummeted. So that was practical use
 24 of FFP3 masks.
 25 **Q.** Yes, so you would say there is evidence that FFP3 masks

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1 **A.** The BMA was involved in discussing the evidence. There
 2 were a lot of internal discussions about the science --
 3 **Q.** Yes.
 4 **A.** -- at that time, and probably the biggest discussion
 5 that we had was that if the science was uncertain --
 6 **Q.** Yes.
 7 **A.** -- that as a protective measure you should take
 8 a precautionary approach.
 9 **Q.** Absolutely.
 10 **A.** So we had a large number of our members in the workplace
 11 make decisions about that they would continue to use
 12 FFP3 masks even in situations with non-aerosol --
 13 **Q.** Right. That's where I was headed. So did the BMA give
 14 guidance at that stage to say that even though the
 15 requirement had been removed, that doctors should still
 16 wear FFP3 masks?
 17 **A.** It did not give official guidance. It was trying to
 18 align itself as much as it could with the government and
 19 the IPC guidance. What we did was we tried to push back
 20 to the CMOs --
 21 **Q.** Yes.
 22 **A.** -- and government to have the IPC guidance changed.
 23 **Q.** Yes, but to your members were you indicating that there
 24 ought to be a precautionary approach? I mean, why
 25 didn't the BMA give guidance to its members about the

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1 are more effective in clinical practice?
 2 **A.** Yes, I -- I mean, FFP3 masks are a form of respiratory
 3 protection. Surgical masks are not.
 4 **Q.** Yes. If there is a disparity between the laboratory
 5 evidence and the real-life setting, well, first of all,
 6 it wouldn't be surprising if there was a difference
 7 between those two, would it?
 8 **A.** Well, no, and nor would it be surprising if some of that
 9 difference didn't appear to be founded because the use
 10 of FFP3 masks is heavily dependent on you having them
 11 correctly fit tested.
 12 **Q.** Yes.
 13 **A.** So if you wear an FFP3 mask wrongly then it does limit
 14 your protection.
 15 **Q.** Yes, and also perhaps in common rooms and corridors and
 16 things like that?
 17 **A.** That's true in terms of passing between healthcare
 18 workers, but predominantly most of the transmission is
 19 on wards working in areas of large numbers of
 20 Covid-positive patients.
 21 **Q.** Yes, sure. If there is a disparity between the
 22 laboratory evidence and what happens in real life, is
 23 the answer to abandon FFP3 and just use FRSM or
 24 a consideration of how to use FFP3s as efficiently as
 25 possible in real life?

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1 A. Well, I would go for the latter and I still recommend
2 the latter.

3 Q. Moving on. The HSE, you have given evidence a little
4 earlier about this but I just want to clarify exactly
5 the position what you are saying about the role of the
6 HSE. Again, your paragraph 287, just for the record,
7 you say that in November 2021 the BMA, together with
8 other groups, raised concerns with the HSE, calling for
9 a review of IPC guidance, greater scrutiny of NHS
10 practices relating to the supply of RPE (respiratory
11 protective equipment) and asked the HSE to give specific
12 additional guidance to complement or correct, as
13 appropriate, IPC measures in effect at that time, but
14 the HSE declined to do that, saying that the guidance
15 from the department and UKHSA and the devolved
16 administrations was what they regarded as "competent
17 bodies". Is that right in your view? Was it right that
18 HSE should simply defer to the department and the other
19 bodies I've just referred to?

20 A. It felt to us and it felt to doctors on the frontline
21 that this was a bit of cop out of responsibility,
22 because it created a circular argument. The HSE was
23 responsible for insuring that hazards are identified and
24 that risks are mitigated, and then to use what we would
25 say was flawed logic from other party doesn't get rid of

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1 running out of time. Ethnic minorities. In your
2 statement paragraph 67 you refer to the rapid review in
3 May 2020 into the disproportionate impact of Covid on
4 ethnic minorities and the concerns about that from
5 the BMA. The Inquiry has heard quite a bit of evidence
6 in an earlier module, as you know, about that, but can
7 I just cut to the chase here. What were the
8 recommendations that you, the BMA, considered that ought
9 to have been included in that report that weren't?

10 A. Well, what was very important was to make sure that the
11 risk assessments for ethnic minority doctors were
12 undertaken, but not just that but the recommendations of
13 those risk assessments were implemented, because they
14 often were not and doctors from ethnic minorities were
15 more likely to be redeployed or put in areas of high
16 risk, really because they were not in a position to feel
17 empowered.

18 Q. Yes. That brings me on to my next point, at
19 paragraph 318 in your statement. The BMA's survey found
20 that twice as many ethnic minority doctors as white
21 doctors felt pressure to work in high-risk settings
22 without adequate PPE, and you described the NHS as
23 having a significant degree of institutional racism.
24 Can you expand on that and what you mean by that?

25 A. We know that doctors from ethnic minorities are less

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1 your responsibility as the regulator.

2 Q. Yes, you refer, and I quote, to an "abrogation of their
3 responsibility as the workplace health and safety
4 regulator", and is that largely driven by a factor you
5 referred to earlier, which is the 2008 report that you
6 knew that the HSE had knowledge of, in terms of aerosols
7 and the fact that they knew that aerosols wouldn't be
8 stopped by FRSMs?

9 A. So, I mean, that's -- that is part of why the profession
10 has a sense that it was -- that it was being sold out,
11 because this wasn't common knowledge to us at the start
12 of the pandemic and it has become apparent since then
13 that people who should have been in a position to
14 protect directors and healthcare workers knew that there
15 was a possibility that optimal protection was not being
16 employed.

17 Q. Yes.

18 A. And that then translated into a real life experience,
19 which was, you know, if you were using appropriate PPE
20 and RPE you were relatively protected.

21 Q. Yes.

22 A. If you were not using that, you caught Covid, you got
23 Long Covid, and some of you died.

24 Q. Yes.

25 Final topic I will deal with briefly as I know I'm

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1 likely to progress in their careers. They are less
2 likely to be successful in job appointments. We know
3 that they are more likely to be subject to bullying and
4 harassment. That is endemic within our NHS. It is well
5 recognised and it is one of the things that we are
6 desperately trying to correct. But the pandemic really
7 exposed it like, you know, no other situation.

8 Q. So, going forward, that institutional racism really
9 needs to be combated, and that would mean that in
10 a similar situation in the future there would be less
11 pressure, a disproportionate pressure, on ethnic
12 minority doctors and healthcare workers if that was
13 tackled?

14 A. Yes, I mean, that's true, but of course there are other
15 groups as well, like female doctors and those with
16 disabilities, that also encounter discrimination in the
17 workplace.

18 MS WEATHERBY: I think I'm out of time, my Lady.

19 LADY HALLETT: Thank you very much, I'm very grateful.
20 Mr Wolfe.

21 Questions from MR WOLFE KC

22 MR WOLFE: Good afternoon, Professor Banfield.
23 At paragraphs 241 to 243 of your statement -- you
24 don't need to turn them up -- you talk about the
25 long-term impact of Long Covid on doctors and in

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1 paragraph 243 you talk about the way in which family
 2 members are providing support and to some extent
 3 healthcare support for their doctor family members.
 4 Presumably you would also agree that family
 5 members can provide valuable support including
 6 healthcare input for patients generally, it's not just
 7 doctors who can receive that and benefit from that
 8 support, it's patients generally?
 9 **A.** Oh, a huge number amount of care in this country is
 10 given by families and relatives.
 11 **Q.** And particular examples of that during the pandemic, how
 12 were doctors able to be confident that family members
 13 returning home, where they did, would continue to
 14 receive the necessary support and treatment if they
 15 hadn't had the family member involved in the hospital
 16 stage of the treatment?
 17 **A.** I'm not following -- I'm not sure I follow your
 18 question.
 19 **Q.** Let me put it the other way round. If you had had
 20 a situation where a person was in hospital being treated
 21 and the doctors in ordinary times would have expected
 22 the family members to be present and providing support
 23 but in the pandemic they weren't for whatever reason,
 24 how could those same doctors be confident during the
 25 pandemic that whatever support was needed at home would

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1 an important role, indeed are consultees, should be
 2 consultees in that process, shouldn't they?
 3 **A.** We would encourage all, you know, anyone having that
 4 discussion to discuss it with their families.
 5 **Q.** Yes. So in the context of the pandemic where family
 6 members were not present in the hospitals there would
 7 have been a potential gap in all of those areas,
 8 wouldn't there?
 9 **A.** It depends whether the patient themselves had capacity
 10 to consent or not.
 11 **Q.** Yes.
 12 **A.** I mean, a number of patients who are severely ill do not
 13 want their relatives -- to have their care discussed
 14 with relatives because they are trying to protect their
 15 relatives.
 16 **Q.** But in the instances where somebody had a communication
 17 need, a language need, whatever it may be, whether it
 18 was a DNACPR-type situation or a consent situation, the
 19 absence of their family member was a potential
 20 impediment, wasn't it?
 21 **A.** It is a potential impediment if you cannot speak the
 22 language and the NHS tries to engage people in their own
 23 languages, so we engage with various language lines or
 24 interpreters to assist with that.
 25 **Q.** You are not saying that that all was hunky-dory, worked

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1 then continue, or was there a gap there?
 2 **A.** I think there most certainly was a gap. I mean, I think
 3 that a large number of patients during the pandemic were
 4 abandoned once they were out in the community.
 5 **Q.** And then similarly in relation to doctors securing
 6 consent, making sure they had consent for treatment.
 7 Again, presumably family members could have a very
 8 significant role in supporting the consent-giving
 9 process particularly of people with communication
 10 difficulties, language issues and so on?
 11 **A.** Yes, it is only the patient that can give consent.
 12 There are mechanisms to -- well-defined mechanisms for
 13 gaining consent in people that can't give consent and
 14 then of course we have a duty of care where there is
 15 a lack of capacity to act in the patient's best
 16 interests.
 17 **Q.** But in those cases where the patient has consented they
 18 may have other reasons why they struggle to communicate.
 19 They may have a communication difficulty, they may have
 20 a language issue, they may have all sorts of things, and
 21 in that case family members can provide communication
 22 support, can't they?
 23 **A.** Yes, but we obviously try and make it as independent as
 24 we can.
 25 **Q.** Similarly, DNACPR, again, family members can have

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1 fine in the pandemic during a period when family members
 2 were not routinely around, are you?
 3 **A.** No. So much didn't work in the pandemic but, as I say,
 4 in terms of capacity to consent and consent, it is only
 5 the patient that can give that consent.
 6 **Q.** My focus is on the impact that not having the family
 7 members around had on the process. I think we are
 8 agreeing that it had a detrimental impact.
 9 **A.** I'm not agreeing that it did, I'm not disagreeing that
 10 it might have, and that is because if a patient is happy
 11 to have a discussion about consent then they are happy
 12 to have that and actually it isn't in that case anything
 13 to do with the relative, it is the patient's decision.
 14 **LADY HALLETT:** Mr Wolfe, if it helps, I take your point.
 15 **MR WOLFE:** I'm grateful, my Lady.
 16 Let's not argue about the extent of the
 17 impediment, there was an issue -- I think we're
 18 agreeing, let's not fall out about the extent of it --
 19 of patients' communication and so on and the support
 20 that came around that being impacted by lack of family
 21 members. I want to understand why we think that
 22 happened during the pandemic. Do you have any sense of
 23 why that came about, why were patient family members not
 24 able to be sufficiently involved?
 25 **A.** Well, in the hospital environment a decision was taken

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1 to minimise (a) the exposure of the general public to
2 Covid by putting restrictions on visiting, and (b) to
3 concentrate on trying to treat as many patients with
4 very limited resources. That led to situations that
5 were far from ideal. So I think to explore I hope where
6 you want to be with this, you would normally have
7 conversations that are difficult conversations with
8 patients with relatives present unless the patient
9 themselves says, "No, I do not want the patient --
10 a relative here, I want to discuss this just with you",
11 which the patient has the prerogative to do.

12 **LADY HALLETT:** I think we have to leave it there, Mr Wolfe,
13 I'm really sorry. We have a lot more to get through
14 this evening, I'm sorry.

15 **MR WOLFE:** My Lady.

16 **LADY HALLETT:** Ms Peacock.

17 **Questions from MS PEACOCK**

18 **MS PEACOCK:** Good afternoon, Professor. I ask questions on
19 behalf of the Trades Union Congress. If you could just
20 ensure, although I'm behind you, that your answers go
21 into the microphones. They just need to be picked up.

22 My questions relate to the reporting of Covid-19
23 infections in healthcare workers to the Health and
24 Safety Executive.

25 You refer in your statement to the fact that many
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1 you know, you have your hard hat in case a brick is
2 going to come, not because you expect it is going to
3 come. But if you find that even if you've got your hard
4 hat on and it is not saving you, sooner or later you
5 need someone to say: actually there is a problem here,
6 isn't there? And that wasn't a sense that we got during
7 the pandemic.

8 **Q.** So, in essence, the regulator doesn't have the necessary
9 broad insights about what is or may be happening in the
10 sector to accurately direct its investigations; is that
11 fair?

12 **A.** Yes. I mean, and it's -- you know, whereas it, you
13 know, passes quite detailed comment about asbestosis,
14 for example, I would have expected it to do the same in
15 the health environment.

16 **Q.** You have referred to the threshold there slightly but,
17 in your view, was underreporting a problem of the
18 threshold set by the HSE or was it a problem of the
19 threshold not being properly applied by employers? Or
20 perhaps both, of course.

21 **A.** Well, of course, we as the BMA wrote to both, so we
22 reminded employers of their duties to report and to HSE
23 for their duty to investigate. Neither of those
24 appeared to happen and we had a large number of
25 members -- we did a survey of over 600 people with
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1 employers failed to report Covid-19 infections of staff
2 by RIDDOR, despite it being a legal requirement for
3 employers to report instances of workplace-acquired
4 Covid-19 infections. And that's at paragraph 289.

5 My question is, why is it a problem if
6 occupationally-acquired Covid-19 infections in
7 healthcare workers are not leading to RIDDOR reports?
8 Why is underreporting a concern for the BMA?

9 **A.** Well, I mean, the biggest and most obvious consequence
10 to that is an enormous number of healthcare workers who
11 really can only have caught Covid -- and are now
12 disabled and unable to work or earn a living, are having
13 to undertake individual litigation to get their
14 work-acquired Covid recognised. And it is difficult for
15 us because, you know, the RIDDOR reporting is supposed
16 to be based on if there was a reasonable chance, and
17 that -- that -- the goalposts seem to move during the
18 pandemic to a balance of probabilities, and then, "Well,
19 you don't need to report it if someone was using the
20 IPC relevant PPE at the time". Well, of course, if the
21 IPC guidance is incorrect, as we would say, then,
22 you know, you are not getting the right number of things
23 reported.

24 I mean, it's a bit like, I don't know, someone
25 going onto a building site with a hard hat on and,
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1 Long Covid and a large proportion of them said that they
2 had asked for their Covid to be reported under the
3 RIDDOR's reporting mechanism and it had been declined.

4 **Q.** Thank you.

5 The HSE produced an interim report in January 2021
6 titled "The impact of Covid-19 in the workplace", and
7 the report stated, in relation to the duty to report
8 occupational exposure under RIDDOR:

9 [as read] "There may have been criticisms of the
10 HSE in how this has been interpreted, alleging that
11 an exclusive rather than an inclusive approach will
12 significantly underestimate the true toll of
13 Covid-19-related effects, thereby missing opportunities
14 to learn lessons."

15 And this really is the focus of my question. It
16 goes on to say there is an implied view that -- in the
17 criticisms that HSE would be able to follow up every
18 such report.

19 In your witness statement, however, you explain
20 that reporting is crucial to understanding infections at
21 the health service level, how infection spreads within
22 healthcare settings and how to better protect staff and
23 patients. That's at paragraph 290.

24 Can you help on this point? Is the expectation
25 that the HSE will follow up individually on each RIDDOR
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1 report, or do you criticise the threshold adopted by the
2 HSE during the pandemic for a different reason?
3 **A.** I'm going to answer this as someone on the frontline,
4 and that is that I would expect the system to protect
5 me. And therefore if there wasn't and should have been
6 an opportunity to highlight that harm was coming sooner,
7 then we would have recognised that more needed to be
8 done and we could quite possibly have saved many of the
9 lives that were lost.

10 **Q.** This is my final area of questioning.

11 In oral evidence, Mr Brunt said of RIDDOR:

12 "It's not intended to track the total number of
13 cases that are happening."

14 However, the Chair suggested to Mr Brunt -- and,
15 my Lady, I'm afraid I'm paraphrasing -- that, given the
16 large number of cases and the obvious difficulties in
17 investigating all individual cases, a solution could
18 have been to say that all NHS trusts and boards have to
19 report every Covid-19 infection in a healthcare worker
20 so that the HSE can analyse whether there appears to be
21 a systemic problem.

22 Focusing on the next pandemic and thinking
23 creatively, if you will, so ignoring the legal
24 requirements as they currently stand, would it in fact
25 make sense for the HSE to have access, whether by RIDDOR

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1 a Covid-19 infection in a healthcare worker?
2 **A.** In terms of -- because we are in a situation where we
3 have no idea what has happened, that is not
4 an unreasonable suggestion for Covid-19 until we are in
5 a position to clarify exactly what has happened and what
6 it means for the future.

7 **MS PEACOCK:** I'm grateful.

8 Those are my questions, my Lady.

9 **LADY HALLETT:** Thank you very much, Ms Peacock. Very
10 helpful.

11 Ms Woodward.

12 There we are. Around the pillar, Professor.

13 **Questions from MS WOODWARD**

14 **MS WOODWARD:** Thank you, Professor. I ask questions on
15 behalf of Covid Bereaved Families for Justice Cymru and
16 there is a few topics I'd like to ask you about this
17 afternoon but the first of those is on IPC guidance, and
18 in response to a question raised by the UK Covid
19 Bereaved Families a few moments ago you said that one of
20 the things the BMA were trying to do was to push back to
21 have IPC guidance changed and that you went to
22 government to raise this.

23 We know that BMA Cymru made several communication s
24 to the Welsh Government asking them to strengthen IPC
25 guidance on masks, and to increase protection for

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1 or perhaps another process, to data on all infections
2 and deaths taking place amongst healthcare workers, so
3 that it would be possible for them to identify hot spots
4 or outbreaks and to investigate accordingly?

5 **A.** It doesn't actually matter who does it, but someone
6 needs to do it. Someone need to know whether harm is
7 happening to the workforce. So, you know, whether it is
8 HSE or whether it is Public Health England or
9 government, but someone has to do it. And that absence,
10 sadly, has led to harm and it gives us no confidence
11 that that has been rectified for either now or the
12 future.

13 You know, if you had a circumstance, for example,
14 in which Covid-19 was a recognised industrial disease,
15 then you wouldn't be in the situation of now not knowing
16 exactly what has happened to these workers -- who went
17 into this and gave up their lives to serve other people.

18 **Q.** And I guess the essence of my question really is, there
19 is been a lot of discussion about the threshold for the
20 report and what it should be and how difficult it can be
21 for employers to interpret it and decide which instances
22 to report. My question really, in this context of
23 a widespread pandemic that's highly infectious, would it
24 be helpful for the removal of that potentially complex
25 threshold and to simply report on every instance of

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1 healthcare workers.

2 My question is: does the BMA consider that the
3 Welsh Government acted sufficiently robustly to form its
4 own view on the adequacy of IPC guidance in order to
5 provide clear leadership to health organisations in
6 Wales?

7 **A.** Ultimately I think you are going to have to ask them
8 that question as to, you know, because they had a need
9 or, as it was put to us, to be in consensus with the
10 other nations because a lot of the PPE was being sourced
11 communally.

12 I can answer the discussions that we had at
13 clinician level because I had weekly meetings with
14 consultants across the whole of Wales and we had quite
15 a lot of discussion about the pushback that was coming
16 against IPC guidance and we effectively came to
17 an agreement that we would advise in Wales our doctors
18 to use FFP3 masks if they felt that was appropriate to
19 their situation, and especially with Covid-19-positive
20 patients.

21 **Q.** Thank you, that's helpful.

22 My next question is on a different topic and
23 that's in relation to testing, both of patients and of
24 healthcare staff. And in your witness statement you
25 discuss the importance of protecting staff and patients

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1 through regular testing and that was something that the
2 BMA called strongly for. And again we know that BMA
3 Cymru wrote to the Welsh Government as early as
4 July 2020 calling for a robust testing system for
5 patients and the regular testing of asymptomatic staff.

6 My question arising is: do you consider that there
7 was sufficient engagement between the Welsh Government
8 and relevant stakeholders such as the BMA or BMA Cymru
9 on the issues of testing?

10 **A.** Was there adequate engagement? Yes, there was. There
11 was quite a lot of toing and froing. Did it happen
12 quickly enough? No, it didn't but it didn't happen
13 quickly enough around the UK. Once we got into
14 a situation where it was possible to test with lateral
15 flow tests for example it made much more sense. The
16 difficulty was the point at which it was recognised that
17 transmission could be by, you know, asymptomatic spread
18 because at that point you didn't really know who had and
19 who hadn't got Covid and who was able to pass it on.

20 **Q.** Just so I can clarify, when you say that it didn't
21 happen quickly enough, do you mean the engagement with
22 the BMA or the testing programme in Wales or perhaps
23 both?

24 **A.** Mainly the testing programme. It didn't become
25 available quickly enough for us to either test staff in

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1 were simply not the beds.

2 My question arising from that, especially given
3 the evidence we have heard this morning from Age UK
4 about difficulties across the nations in relation to the
5 care for older persons, is: would you agree that it is
6 likely that the elderly were disproportionately
7 advantaged by those alterations in decision-making
8 during the pandemic?

9 **A.** I'm not sure that I have enough data to say that it was
10 specific to any particular group of patients. The
11 discussion that GPs have with patients every day, even
12 outside of Covid, is the state of the health service and
13 quite often -- I'm married to a GP and she has
14 conversations with elderly patients about going into
15 hospital and long waits on trolleys in corridors and
16 they quite often say to her, do you know what, I would
17 rather not go into hospital I would rather, you know,
18 spend my last days at home.

19 Do I think that the criteria necessarily changed?
20 No. But I do think that what happened was that people
21 who would have gone into hospital for care were managed
22 and nursed at home who in times when there are perhaps
23 beds available they would have been admitted for that
24 care.

25 **Q.** And do you think those problems also persisted once

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1 a meaningful way or patients.

2 **Q.** And what do you think the impact of those delays on both
3 patient and staff testing was on both patient and staff
4 safety, particularly in the context of nosocomial
5 infections?

6 **A.** Well, there is no doubt in our minds that that increased
7 the rate of infection and therefore the harm that arose
8 as a result of that.

9 **Q.** And is the BMA aware of whether there were any
10 operational difficulties in implementing the
11 Welsh Government's testing guidance and what those
12 issues were?

13 **A.** Well, I mean, they had the same issue over the
14 availability of testing and scaling up testing as the
15 rest of the four nations.

16 **Q.** But nothing specific over and above that that you were
17 aware of in Wales?

18 **A.** No.

19 **Q.** My next topic is on escalation of care and what you have
20 spoken about today in your evidence as care rationing
21 which I suppose is the flip side of that. And earlier
22 today you said that during the pandemic there were
23 a large number of people with respiratory symptoms, for
24 example, who would have been admitted to hospital in
25 other circumstances who were not admitted because there

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1 people were in hospital, so for example with admissions
2 into critical care, were patients not being admitted to
3 critical care from the wards whereas in other
4 circumstances they might have been?

5 **A.** I think it goes back to what we were talking about
6 individual decisions about who is going to benefit from
7 care. I mean, if you have a look at cardiopulmonary
8 resuscitation the number of people who survive CPR is
9 relatively small and you can predict who may or may not
10 do well from that, so having those discussions with
11 people is something that we do on a regular basis.
12 I've got no direct evidence of that kind of rationing.
13 I do not believe that we got to the stage of having two
14 patients for one intensive care bed with the same kind
15 of possible outcome and then having someone who was
16 older being selected as not having care. I think it was
17 always done on who was most likely to benefit in the
18 quickest and most effective manner.

19 **Q.** My next topic is regards to advanced care planning and
20 DNACPRs. My first question is, has the Welsh Government
21 ever consulted, to your knowledge, with BMA Cymru on
22 issues of DNACPRs or advance care planning either prior
23 to, during or since the pandemic?

24 **A.** There have been ongoing discussions, as we were talking
25 about earlier, about the need to have advanced care

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1 decision-making discussions because it is really
 2 important for people to maintain their dignity and to
 3 have those discussions while they are well so that they
 4 don't need to come as a surprise when they become ill.
 5 So there has been, you know, before the pandemic, a push
 6 to start those discussions between families and their
 7 loved ones.

8 So I would say that the way it works in Wales, the
 9 NHS Wales, the Chief Medical Officer, so Welsh
 10 Government, and the service would be used to the idea
 11 that in general this is a discussion that we want to
 12 have round Wales.

13 **Q.** And you will be aware, I'm sure, of the introduction of
 14 the ReSPECT process in England and that there are no
 15 such plans to roll out the ReSPECT process in Wales.
 16 Are there any, in your opinion, downsides of the
 17 proposed Welsh approach, which is the all-Wales national
 18 DNACPR policy and treatment escalation plan, as compared
 19 to the ReSPECT process in England?

20 **A.** Well, I think that a lot of GPs in Wales know their
 21 patients very well and are having those conversations
 22 already, regardless of what process may or may not be in
 23 place.

24 **Q.** And perhaps a very similar question but in a slightly
 25 different form. Do the BMA, or BMA Cymru in particular,
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1 to a certain extent that continues to today. The GPs
 2 have always seen clinically extremely vulnerable
 3 patients face to face and are geared still to do that.

4 **Q.** Second, Professor, was patient safety put at risk by
 5 that confusion? And if so, can you expand on how.

6 **A.** Well, those who are clinically extremely vulnerable and
 7 with long-term conditions have higher rates of morbidity
 8 and mortality anyway and therefore they have or
 9 certainly they did stay away from engaging with services
 10 and have continued to do so, is the evidence. And the
 11 effect of that is that they are not optimising their
 12 treatment, and many of them are suffering in silence at
 13 home.

14 **Q.** Thank you. And thirdly, Professor, the shielding
 15 programme came to an official end on 15 September 2021,
 16 but you have said in your statement that questions and
 17 anxieties remain to this day amongst the formerly
 18 shielding, and I think you have touched on this in your
 19 last answer, but can you explain the nature of those
 20 questions and anxiety that remain from the BMA's
 21 observations?

22 **A.** Yes, I mean, we are currently in a society that is
 23 running as if Covid-19 doesn't exist anymore and yet
 24 clearly Covid infections are still a source of hospital
 25 admissions. Because we now no longer wear masks in
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1 consider that perhaps still there would be any benefit
 2 in Wales adopting a nationally standardised process so
 3 it was in line with the other nations in the UK in the
 4 form of ReSPECT?

5 **A.** My Lady, I don't know enough about that to comment.

6 **MS WOODWARD:** Thank you very much, Professor.

7 **LADY HALLETT:** Thank you Ms Woodward. Very grateful.
 8 Ms Polaschek.

9 Over that way.

10 **Questions from MS POLASCHEK**

11 **MS POLASCHEK:** Good afternoon, Professor. I ask questions
 12 on behalf of Clinically Vulnerable Families and we have
 13 just three, hopefully brief, clarifying questions around
 14 shielding, all of which refer back to specific
 15 paragraphs in your witness statement.

16 First of all, you describe at paragraph 447 of
 17 your statement that when shielding advice was relaxed in
 18 the summer of 2020 the BMA considered that the poor
 19 communication of that advice had caused confusion and
 20 you give an example about a lack of clarity over whether
 21 shielding people should visit GP surgeries for routine
 22 medical treatment or not. What was the effect of that
 23 confusion on patients?

24 **A.** Well, I mean, the effect at the time was to create doubt
 25 in their minds where safety existed and didn't exist and
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1 hospitals we have got a situation in which the carers
 2 are walking around as if Covid doesn't exist and the
 3 clinically extremely vulnerable for whom Covid could
 4 still be an issue either from a mortality or from
 5 a Long Covid issue are wondering what's going on, and
 6 they are feeling very anxious and there is, you know,
 7 evidence that they are not engaging with either society
 8 or with medical services. And that is something that we
 9 have to address.

10 **MS POLASCHEK:** Thank you, Professor.

11 My Lady, those are my questions.

12 **LADY HALLETT:** Thank you very much.

13 Mr Simblet.

14 **Questions from MR SIMBLET KC**

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

16 Professor, some of my questions have been asked.
 17 I'm asking questions on behalf of the Covid-19 Airborne
 18 Transmission Alliance.

19 Now, you have mentioned various examples of
 20 medical -- medical students getting Covid on the wards
 21 and people working in intensive care not getting Covid.
 22 What sort of equipment are you talking about in your
 23 recommendation in your statement that there should be
 24 more routine use of RPE in healthcare settings?

25 **A.** Yes, can I just be clear that it's not absolute because
 160

1 there are people --

2 **Q.** Yes, of course.

3 **A.** -- who subsequently did catch Covid in those

4 environments. There are various forms of respiratory

5 protection from the FFP3 masks to, you know, much bigger

6 masks that are incredibly uncomfortable to wear and that

7 fit almost like a fireman's visor and then there are

8 almost self-ventilating hoods as well, and so it is

9 getting the right equipment that provides your safety as

10 judged by fit testing because you are objectively then

11 measuring whether that is appropriate for you.

12 **Q.** And is there anything more precise that you can say on

13 what sort of equipment or is it that you would want to

14 leave your answer in the territory of what is

15 appropriate?

16 **A.** Yes, what's appropriate and what fits and suits you for

17 the job at hand.

18 **Q.** Was it the BMA's position that all healthcare workers

19 should have been provided with respiratory protective

20 equipment during the pandemic?

21 **A.** Yes.

22 **Q.** Thank you. Now, as you know, and it is described in

23 your statement and so on, a list was drawn up of

24 aerosol-generating procedures, or AGPs, that had

25 an impact on how protective equipment was deployed. Did

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1 you should provide the appropriate respiratory equipment

2 for anyone caring for them.

3 **Q.** Thank you. I'm going to move to something else. It is

4 something you have been asked about already but I've got

5 a couple of different questions to ask about in relation

6 to the Reporting of Injuries, Diseases and Dangerous

7 Occurrences Regulations, or RIDDOR. You have described

8 in some detail the problems for doctors when there is

9 an underreporting or a misreporting, or however you want

10 to use it in relation to the application of RIDDOR, but

11 what do you see as being the public health value of

12 accurately recording the incidents of infection of

13 healthcare workers from the perspective of patients?

14 **A.** Any recording or tracking of nosocomial infections is

15 highly relevant to anyone within the healthcare setting,

16 as a patient. I mean, it just beggars belief that we

17 report MRSA infections when you have a cluster of three

18 or four and yet here we had clusters of hundreds of

19 Covid infections and we are not taking those into

20 account and it was relevant to patients then. It

21 certainly should be relevant to patients now and it will

22 be relevant to any future pandemic.

23 **Q.** Why do you think RIDDOR reporting appeared to have been

24 suspended or downgraded in the way that you have

25 described during the pandemic?

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1 you consider that the list of aerosol-generating

2 procedures was too restrictive?

3 **A.** Yes, we did, and we wrote with the RCN and the

4 Resuscitation Council to have CPR added to that list of

5 aerosol-generating procedures. The whole idea of AGPs

6 preceded the pandemic and, clearly, when one is talking

7 about aerosols, there are significant aerosols generated

8 by other normal activities, like coughing or singing.

9 **Q.** I was about to say, it is right, isn't it, that a cough

10 is a cough?

11 **A.** Well, that's right. And even if you have got

12 a predominantly explosive droplet output, there are

13 aerosols generated at the same time.

14 **Q.** Did you consider that the AGP list was too restrictive

15 because there were concerns about managing the supply

16 of, in particular, FFP3 masks?

17 **A.** No, I don't think that that was part of our thinking at

18 that time.

19 **Q.** What about subsequently?

20 **A.** No, I think that once we got into understanding more

21 about the previous evidence and then the emerging

22 evidence of airborne transmission, our concerns went

23 away from AGPs to everything.

24 **Q.** Everything, yes?

25 **A.** Everything. If you have got someone who has Covid then

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1 **A.** Well, no, I have absolutely no idea. As a frontline

2 clinician I find it unbelievable.

3 **Q.** And both as a frontline clinician and as

4 an authoritative figure from the BMA, did the BMA take

5 any steps to fill in the gap in recording and what could

6 you and did you do, if anything?

7 **A.** Well, I mean, it was very difficult. In our tracker

8 surveys that we did, we were getting a lot of data back

9 about the harm that was happening in terms of Long Covid

10 and we have tried to push on that front ever since.

11 **MR SIMBLET:** Thank you.

12 Those are the questions I wanted -- I'm just going

13 to swap with Mr Thomas.

14 **LADY HALLETT:** The last questioner is Mr Leslie Thomas KC,

15 who is in a similar position, Professor. Oh, he's going

16 to move. Well done.

17 **Questions from PROFESSOR THOMAS KC**

18 **PROFESSOR THOMAS:** Good afternoon, Professor Banfield, let

19 me introduce myself. I'm representing FEMHO, the

20 Federation of Ethnic Minority Healthcare [workers]

21 Organisations.

22 My first question is this, I want to look at data

23 sufficiency and the early action on the mortality

24 disparities. Okay?

25 At paragraph 214 of your statement you discussed

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1 the disparity and high mortality rates amongst black and
2 Asian groups. We know that by 9 April 2020 Dr Nagpaul
3 of the UK council called on the NHS England to
4 investigate the disproportionate impact of Covid-19 on
5 black and Asian minority healthcare workers.

6 Question: at that time, do you believe there was
7 sufficient data or evidence for public health bodies to
8 take action on the heightened mortality risks faced by
9 ethnic minority healthcare workers?

- 10 **A.** I don't think at that time the quality of the data was
11 known. It was sufficient for us to say: you need to
12 know more. I mean, our actual data collection about,
13 you know, ethnic origin is poor overall, so I think it
14 was essential at that point to push. And, you know,
15 Chaand Nagpaul, as chair of UK council, pushed
16 repeatedly even to get the review and then to get the
17 reports -- and then still is pushing for the action that
18 needs to take place, because it has not taken place.
- 19 **Q.** Let me follow on from that and ask you this. So, given
20 what you just said about the state of the data and the
21 need to know more, in your view what would have been the
22 most appropriate action for public health bodies to take
23 based on the available evidence?
- 24 **A.** Well, I think at that point, in a sense, to the theme
25 throughout, it would have been eminently preferable to

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1 ourselves.

- 2 **Q.** So, again, that leads me on to this question. What
3 action, if any, did the BMA take to address these
4 disparities in the mortality rates?
- 5 **A.** Well, in terms of our advice to our own members and --
6 we started to look very proactively at pushing for risk
7 assessments that took other factors, such as ethnicity,
8 into account, and we in the end created risk assessment
9 tools both within England, that Professor David Strain
10 had started to organise, and in Wales separately, that
11 had ethnicity as one of the risk factors that had to be
12 mitigated.
- 13 **Q.** Let me move on. At paragraph 318 of your statement you
14 address the ongoing issue of institutional racism within
15 the NHS and you talked very powerfully about that this
16 morning -- sorry, earlier on this afternoon.
- 17 Could you expand, please, on how this
18 institutional racism manifested itself before and during
19 the pandemic, particularly in relation to the
20 experiences of ethnic minority BMA members?
- 21 **A.** Before the pandemic we already knew that there was,
22 you know, a disparity in opportunity, what was happening
23 to you in the workplace, disproportionate referral to
24 the GMC, you were less likely to have been -- correctly
25 had an induction at work, and therefore you were always

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1 have taken a precautionary approach. And at that point
2 to have made sure that we were absolute in our support
3 and making sure that people from ethnic minority
4 backgrounds were protected and facilitated in making
5 sure they were getting their risk assessments and that
6 those -- whatever the risk assessment was was being
7 enacted, and that they were not being pressurised to
8 work in unsafe environments.

9 **Q.** Let me move on.

10 Before Dr Nagpaul's letter, FEMHO is aware of
11 other organisations, such as the British Association of
12 Physicians of Indian Origin, for example, that had
13 raised concerns about mortality disparities amongst
14 ethnic minority healthcare workers.

15 Question: were there indications of these concerns
16 prior to April 2020, and how did the BMA respond to
17 them?

- 18 **A.** Well, I mean, Chaand Nagpaul is a member of BAPIO and,
19 you know, BMA works closely with BAPIO, so the point at
20 which -- you know, it was obvious very, very early on,
21 the first ten deaths of doctors were all black or --
- 22 **Q.** People of colour?
- 23 **A.** -- South Asian. Yeah. And at that point it is the why.
24 And what do we do, what do we not know? So that was
25 escalated. At the same time we started looking for data

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1 on the back foot about being able to practice in a safe
2 environment.

3 **Q.** Mm.

4 **A.** And we went into the pandemic, you know, in that state.
5 The BMA was already aware of that and has been busily
6 trying to support doctors in the workplace, which is why
7 we worked with the diaspora organisations like BAPIO and
8 MANSAG.

9 **Q.** I want to be forward thinking and look at this not just
10 from a negative point of view, so my next question
11 is: what actions or reforms do you believe are necessary
12 to address these long-standing issues of institutional
13 racism within the NHS?

14 **A.** I think we've got to accept it and acknowledge it and
15 then actively do something about it, rather than
16 passively. So, you know, at the moment we don't have
17 very good data. We need to create the space in which
18 people can speak up and feel safe about doing that.
19 We've got to create allyships where we, you know,
20 observe the micro aggressions and the cultural
21 insensitivities, and being able to speak up and speak
22 out and feel safe about doing that. All right? That's
23 about our attitude and our culture.

24 **Q.** The BMA's concern with Public Health England's review on
25 Covid impact, you mention at paragraph 67 of the BMA

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1 serious concerns regarding Public Health England's
 2 May 2020 review on the disproportionate impact of Covid
 3 on ethnic minority groups. Could you elaborate on the
 4 specific issues that the BMA identified with the content
 5 of this report? What were some specifics?
 6 **A.** So the first report came out and appeared to be missing
 7 the recommendations and then we had some feedback saying
 8 that 60-odd pages had been removed from the report and
 9 that sparked off an exchange between the BMA and Public
 10 Health England over what was happening and also the
 11 minister for inequalities.
 12 **Q.** Yes.
 13 **A.** A few weeks later a part 2 appeared with recommendations
 14 in it. Those recommendations still have not been rolled
 15 out.
 16 **Q.** You pre-empted my next question which is: what
 17 recommendations, if any, did the BMA make to improve the
 18 report and to what extent were those recommendations
 19 adopted?
 20 **A.** So, you know, I can't say -- the explanation that was
 21 given to us was that there was always intention for it
 22 to be a two-part report. I cannot comment on whether
 23 that is factually correct or not. But that bit about
 24 making sure that people who are from an ethnic
 25 background are in a safe space and listened to and that

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1 **Q.** Well, we were all clapping for them, weren't we?
 2 **A.** Yes.
 3 **Q.** Let me come to the very last question. Reflecting on
 4 paragraphs 500 and 501 of your statement where you
 5 provide recommendations for a future healthcare crisis,
 6 based on the impact of the pandemic what are the BMA's
 7 key lessons for better protecting ethnic minority
 8 doctors in any future emergencies?
 9 **A.** Well, I mean, we have to make sure that we engage in
 10 a culturally appropriate manner, that we understand that
 11 there are cultural differences, so for example in the
 12 way that PPE is applied. What is appropriate? So there
 13 are all sorts of things that -- being able to listen,
 14 really listen.
 15 **Q.** Greater cultural sensitivity?
 16 **A.** Absolutely.
 17 **PROFESSOR THOMAS:** Madam, those are my questions. Thank
 18 you.
 19 **LADY HALLETT:** Thank you very much, Mr Thomas.
 20 Professor, thank you very much indeed for the work
 21 obviously that you did on the frontline but for all your
 22 help with the Inquiry. I'm not sure if this is your
 23 last time helping me. I suspect it may not be but we
 24 will have to see, but thank you for all your help to
 25 date.

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1 we are proactive in making sure that they feel safe and
 2 are safe and are treated in an equal manner. All of
 3 those recommendations have not really had concrete: yes,
 4 but what has actually happened now.
 5 **Q.** Two more questions and then I'm finished. My
 6 penultimate question is this. At paragraph 436 of your
 7 statement you discuss shielding of high-risk
 8 populations. Were ethnic minority healthcare workers
 9 adequately informed and supported regarding shielding
 10 protocols considering the higher risk of severe Covid
 11 outcomes?
 12 **A.** That's an interesting question because I'm not sure that
 13 anyone who was shielding was adequately informed about
 14 what it actually meant. In terms of people from ethnic
 15 minorities as healthcare workers, we knew that they were
 16 more vulnerable, we knew that they were under more
 17 pressure to work, less likely to say, "Do you know what,
 18 I am vulnerable, I shouldn't be working in this
 19 environment", and that's for many reasons not least
 20 because there were fear amongst a number of
 21 international medical graduates for their visa status.
 22 **Q.** Sure.
 23 **A.** So, you know, they ended up with all sorts of reasons
 24 doing the wrong thing but actually the right thing
 25 because they put their lives on the line for us.

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1 **THE WITNESS:** Thank you.
 2 **LADY HALLETT:** And it is 10 o'clock tomorrow. Thank you.
 3 **(4.36 pm)**

**(The hearing adjourned until 10.00 am
 on Tuesday, 29 October 2024)**

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