

Wednesday, 30 October 2024

1  
2 (10.00 am)  
3 **LADY HALLETT:** Mr Fireman.  
4 **MR FIREMAN:** Good morning, my Lady. Can I please call  
5 Lesley Moore, who will affirm. Hopefully she can hear  
6 us.

**MS LESLEY JEAN MOORE (affirmed)**

**Questions from COUNSEL TO THE INQUIRY**

9 **MR FIREMAN:** Can you provide your full name, please,  
10 Ms Moore.  
11 **A.** Lesley Jean Moore.  
12 **Q.** Ms Moore, you have given a witness statement to the  
13 Inquiry dated 13 June 2024. That's INQ000485656.  
14 I hope you're familiar with this and have a copy  
15 available to you.  
16 Ms Moore, thank you very much for giving evidence  
17 today. You're here to provide evidence of your  
18 experience of shielding and your experience of your son  
19 shielding, who is clinically extremely vulnerable;  
20 that's right, isn't it?  
21 **A.** Indeed.  
22 **Q.** To start, can you please tell the Inquiry a little bit  
23 about your son and his needs.  
24 **A.** I adopted my son when he was three years of age,  
25 however.

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1 stomach, which allows for his movements and enables him  
2 to wear a CPAP mask overnight of the ventilator machine  
3 due to his obstructed breathing overnight.

4 He has very complex, severe learning difficulties  
5 and he is gastrostomy fed, nil by mouth, and this has  
6 been since he was about 12.

7 In 2015 he went down drastically and was likely to  
8 end up with a tracheotomy, but at the time his quality  
9 of life was so poor that that was decided not to be the  
10 answer, so he came home literally in 2015 to die.  
11 However, now he is a very different young man. Although  
12 he still has all his very complex needs he has been much  
13 healthier, apart from the last year where his health has  
14 taken a dip again with chest infections and increased  
15 epilepsy.

16 When he is ill, all of his movements, all of his  
17 vulnerable movements, all of his involuntary movements,  
18 everything increases and he gets into dystonic sort of  
19 spasms which become very, very painful and he's very  
20 difficult to physically manage when he is ill.

21 One of his major issues is his suctioning needs  
22 and he has two types of suctioning needs. One would be  
23 maintenance suction, where you're just taking out little  
24 bits of pieces with a suction machine, any secretions,  
25 or we have what we call "blue light" suctioning, which

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1 **Q.** Sorry, could you just slow down a little.  
2 **LADY HALLETT:** We're having difficulty hearing you. I don't  
3 know if it's something to do with the audio but if you  
4 could start again. I'm really sorry.  
5 **A.** I adopted my son when he was three years of age. I have  
6 known him since he was 18 months of age as I was his  
7 senior portage worker which is a home school teacher for  
8 children with complex and difficulties, special needs.  
9 I had originally had him on respite care at  
10 weekends and then he came home to me when he was three  
11 and a half. He had very complex cerebral palsy, made  
12 more complex by the fact that he has dystonic cerebral  
13 palsy on his left-hand side, which means he has lots of  
14 involuntary movements going on, and he has spastic  
15 cerebral palsy on his right-hand side, which means that  
16 he had very tight movements, which means his body is  
17 pulled all over.  
18 When I first had my son he was screaming a lot and  
19 wasn't sitting in any seating of any sort and was a very  
20 disabled little boy, and it took a number of years for  
21 us to get him to sit in any sort of equipment, and now  
22 he is sitting in a wheelchair, with lots of physical  
23 support. He can't lie on a bed unsupported, he needs  
24 positioning equipment on either side, and overnight he  
25 lies on a specially made sleep system and he lies on his

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1 is where you don't know what the outcome will be, during  
2 the suction you don't know whether he will still be  
3 alive at the end of the suctioning. But he has very  
4 complex needs.

5 **MR FIREMAN:** Thank you for summarising that so eloquently.  
6 In addition, it's right, isn't it, that your son is  
7 non-verbal?

8 **A.** Yes, non-verbal. He takes at least nine months to  
9 a year to understand his movements and his noises. He  
10 can communicate. He can choose from, sort of, objects.  
11 If you were to give him a pair of swimming trunks and  
12 car keys, he would more or less know that he was going  
13 out in the van or he was going -- well, actually he  
14 wouldn't know he was going swimming but he would when  
15 you were by the pool. He has very complex learning  
16 difficulties. And it takes a good nine months to a year  
17 for any member of staff to have any real understanding  
18 of what he's telling him, what he's trying to portray.

19 **Q.** You've just mentioned how long it takes for a member of  
20 staff to understand his movements and his communication  
21 style. In pre-pandemic times what were the specific  
22 care arrangements which were in place?

23 **A.** I have -- or my son had a personal health budget and  
24 there were two members of staff at that time who were  
25 employed who came in and did a number of day shifts,

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1 which would be putting him to bed, getting him up and  
2 working with him during the day, and I think they were  
3 working about two evenings, overnights, a week.

4 **Q.** In your statement I think you make clear that he needs  
5 two care staff with him at all times except for if it's  
6 you who is looking after him?

7 **A.** Yes, when he's at home and it's just me then he -- it's  
8 one to one. Because of the 22 years of having him,  
9 I know if he's smiling in another room just by the sound  
10 of his breathing, whereas if he's at day centre, respite  
11 at home, he's on 2:1 support. And that's mainly for his  
12 suctioning needs and his moving and handling needs.

13 **Q.** Taking you back, Ms Moore, to the start of the pandemic  
14 in March 2020, you make clear in your statement that you  
15 became very concerned about the risk to your son, and  
16 you decided on 11 March 2020 to take him out of school;  
17 is that right?

18 **A.** He was at college at the time. It is. Because of his  
19 very, very complex needs, when my son is poorly he goes  
20 into all this dystonic panic, which very painful, it  
21 increases his suction needs and puts him at great risk.  
22 I was very aware, especially as Covid was coming as  
23 a coughing disease, that my son would be exceedingly  
24 difficult to manage because of this. And on 11 February  
25 I had close contact with another parent of a young man

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1 and the advice was: just follow government advice.  
2 I then said there was no respiratory advice, and she  
3 just said, "Wash hands and wait and see."

4 On 13 March I then rang and asked the ventilation  
5 team at the local hospital what I should do and I got  
6 an email back saying: follow online National Health  
7 Service advice. Again, there was no respiratory advice  
8 specifically for those with respiratory issues.

9 **Q.** Thank you, Ms Moore. If you could just try to keep your  
10 answers a little bit shorter, we may be able to get  
11 through all of the information we need to.

12 So just in terms of the timeline, we were talking  
13 about March 2020, and you spoke about how you decided to  
14 take your son out of college. What did you decide to do  
15 with respect to the care staff who were attending your  
16 house ordinarily to look after him?

17 **A.** Because I knew that they were -- one member of staff had  
18 a young son who was going around family members for  
19 childcare and the other member of staff was still  
20 attending social events and still shopping, I decided  
21 that with -- also discussing it with his disability  
22 social worker, that I would stop the staff members  
23 coming into the house. So I then did my son by myself  
24 for four months.

25 **Q.** Am I right that, given your son's complex needs, you

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1 with special needs and we were starting to contact each  
2 other as news was coming through, because her son also  
3 has respiratory issues, and on 11 February we'd seen  
4 somebody talking about a pandemic coming.

5 By 29 February 2020 we were talking about whether  
6 we should send our sons to college.

7 On 3 March I was really, really stressed about it,  
8 what was going to happen.

9 On 11 March I was sat in the college car park  
10 after just dropping my son off at college and I heard  
11 Michael Rosen, the poet, talking on the radio about how  
12 the elderly were going to be left to get on with it and  
13 that they were like lambs to the slaughter, that they  
14 wouldn't be being looked after, they would just be seen  
15 as of no concern. And as I was sat in the college  
16 car park I was just thinking: this is exactly what's  
17 going to be for my son. His needs pre-pandemic aren't  
18 even taken into account on many occasions, and he's not  
19 valued by many in society, I really felt that he would  
20 not be valued during the pandemic.

21 So on 11 March I made that decision to lock him  
22 down ourselves. And I'd already been out and shopped  
23 and did things that I needed to do to keep him at home  
24 from that point.

25 I did contact the GP surgery and asked for advice

6

1 expected that he would be designated by the government  
2 as clinically extremely vulnerable?

3 **A.** I did.

4 **Q.** Did you in fact receive a letter from the government  
5 indicating --

6 **A.** I did eventually. I registered him myself on the  
7 government clinically vulnerable website page on  
8 23 March and it was only six weeks after I'd locked down  
9 on 23 April that I got a clinically vulnerable letter.

10 **Q.** You then began to shield, I understand it?

11 **A.** I did.

12 **Q.** And can you tell us a little bit about your experience  
13 just you and your son shielding for a number of months  
14 initially until --

15 **A.** Luckily because I come from the profession and have  
16 worked alongside physios and occupational therapists and  
17 speech language therapists that I was able to continue  
18 many of my son's college activities and postural needs  
19 at home.

20 Really it was just surviving, day-to-day  
21 surviving. It's very hard being in a house by yourself  
22 with your son 24 hours a day.

23 **Q.** Just take a moment.

24 What was the impact on you then of that additional  
25 care and responsibility?

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1 **A.** It's the total responsibility that you are responsible  
 2 for your son and your son's needs and the fact that at  
 3 the time I really did not think the government cared  
 4 about my son's needs.

5 **Q.** In June 2020 were you able to re-introduce the personal  
 6 support workers to support you and your son?

7 **A.** I did but very, very slowly and carefully because it was  
 8 better weather, and then they came back and they worked  
 9 in the garden and they were masked up and were trying to  
 10 stay within 2 metres of him but doing singing and  
 11 dancing activities and throwing balls and things, not  
 12 that he can catch a ball but helping him and things, to  
 13 try and keep him as Covid safe as possible so that  
 14 I could have 2 hours to myself at a time.

15 It took quite a long time before they were back in  
 16 doing care. That would probably be a lot longer later  
 17 on that they were actually back in doing personal care.

18 And I used to write Covid guidelines every week  
 19 that I had made for myself to keep him safe which was  
 20 all doors and windows open, they had overalls that they  
 21 put on so that they weren't coming in in their outdoor  
 22 clothes or if I knew they had been anywhere else I had  
 23 asked them to bring a change of clothes so they weren't  
 24 bringing it in with them.

25 **Q.** When you say they were masked up, is it right that you

9

1 account.

2 I had made -- he had a special off-road buggy but  
 3 he can't -- couldn't sit in it very well but I was  
 4 trying very hard to make it very safe for him to sit in  
 5 so that if I did go for a walk and anything happened  
 6 that I could physically put him back but, in the end, he  
 7 had a suctioning episode sat in the buggy in the back  
 8 garden and it became obvious that I wouldn't be able to  
 9 physically manage him so that was put on hold. I didn't  
 10 do it.

11 **Q.** Ordinarily, is it right that you would have had quite  
 12 a lot of interaction with healthcare services prior to  
 13 the pandemic?

14 **A.** I wouldn't say a lot of interaction but then you would  
 15 never have known -- just like now we're having quite  
 16 a lot of interaction with healthcare services, but we  
 17 would now avoid going to healthcare services wherever  
 18 possible because of the nosocomial risk of Covid.

19 **Q.** And during the relevant period is it right that you did  
 20 everything you could to also avoid going to healthcare  
 21 services or hospital?

22 **A.** We wouldn't be going anywhere because the risk was just  
 23 too great. My son cannot mask because of his  
 24 involuntary movements so it's very hard to manage him  
 25 anywhere because he cannot mask.

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1 requested that they wear the FFP3 respiratory masks?

2 **A.** They were provided FFP3 masks but I very quickly, after  
 3 researching the FFP3 masks that we were given, realised  
 4 that they had valves and the valves allowed the staff to  
 5 breath out their air which meant that my son wasn't  
 6 being kept safe. My son was going nowhere, we were  
 7 going nowhere, my son was the one that would have no  
 8 Covid and so he could not possibly give Covid to anybody  
 9 whereas the staff were coming in from elsewhere but were  
 10 given masks, they went off to have them fitted, that had  
 11 valves which meant that the air would be or any Covid  
 12 that they had would travel through the valve to my son.

13 **Q.** During the periods of time where you were shielding, did  
 14 you and your son leave the house at all?

15 **A.** Not for the first 40 days and 40 nights. I have  
 16 a horse, or had a horse at that time, and I had put her  
 17 on full livery because she's 7 miles away and it's  
 18 not -- with my son it's not just the fact that you're  
 19 catching Covid, it's what happens if your car breaks  
 20 down 7 miles away, how on earth do you get him back  
 21 because there aren't sort of adapted taxis that are  
 22 easily available or if you were getting in an adapted  
 23 taxi you were still putting him at Covid risk, so it was  
 24 a lot more than just catching Covid that somebody with  
 25 my son's level of special needs we had to take into

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1 **Q.** You describe in your statement a particular occasion  
 2 where you received correspondence from a hospital  
 3 requesting the return of any spare ventilation machines  
 4 or CPAP machines or feed pumps. Can you describe this  
 5 interaction for us and the impact it had on you?

6 **A.** I cannot remember whether it was a letter or a phone  
 7 call, but we were all asked to return any spare  
 8 ventilating machines or feed pumps.

9 At the time my son had two ventilator machines,  
 10 one that he was using and one as a spare. Because of  
 11 all the things that had been happening in the background  
 12 that we'd heard of that various factories were being  
 13 asked to make ventilating machines, that we weren't  
 14 procuring them from Europe, ventilating machines, that  
 15 I really felt that if I sent the spare ventilating  
 16 machine back and then the one that he was using broke  
 17 down I truly felt that he would not get a ventilating  
 18 machine back because they wouldn't have any spare, so  
 19 I kept hold of them both.

20 It was a major, major concern in all the special  
 21 needs groups that I'm in online about the fact we were  
 22 being asked to return equipment and we all really felt  
 23 or a number of parents and myself felt that if my son  
 24 was to turn up at hospital requiring a ventilating  
 25 machine that if there were three other people and him

12

1 that he probably would not be the person that got the  
 2 ventilating machine.  
 3 **Q.** Can I ask you about --  
 4 **A.** [Unclear: multiple speakers].  
 5 **Q.** Sorry. Can I ask you about another experience that you  
 6 had interacting with the healthcare system, something  
 7 that you describe in your statement as particularly  
 8 harrowing, and this is in relation to receiving a letter  
 9 which suggested that a DNACPR be put in place for your  
 10 son. Is it right you received this letter in around  
 11 July 2020?  
 12 **A.** As far as I can recollect it was around 19 July.  
 13 I believe it was then -- I don't have the letter  
 14 still -- but I believe it was around then because again  
 15 I have close contact with a number of other special  
 16 needs parents and we were discussing our feelings and  
 17 views around this and were absolutely horrified.  
 18 **Q.** Can you remember in general terms, I appreciate you  
 19 don't have the letter in your possession anymore, in  
 20 general terms, can you remember what the letter said?  
 21 **A.** I cannot remember in general terms, all I can remember  
 22 and all I remember discussing was that what we would do  
 23 about the do not resuscitate and we all felt that what  
 24 that letter was saying was that we're not going to take  
 25 care of your young person's medical needs if they needed

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1 physical needs that he usually has at home, like his  
 2 sleep system, a high enough overhead hoist to get him  
 3 onto the sleep system, and all the equipment that we  
 4 have at home to manage his needs.  
 5 **Q.** How did receiving this correspondence impact your  
 6 confidence in the healthcare system?  
 7 **A.** There was no confidence in the healthcare system at that  
 8 time. I had many conversations about the fact that  
 9 I would be keeping him at home because I did not feel  
 10 that he would be treated safely in hospital because of  
 11 his complex needs.  
 12 **Q.** Separately, you discuss in your witness statement a more  
 13 positive experience that you had with the healthcare  
 14 services in relation to your son's wheelchair breaking  
 15 down. Are you able to elaborate a bit on this?  
 16 **A.** They were very quick to come and fix it and they were  
 17 very happy, we have an outdoor balcony that has a lift  
 18 at the back and they were very happy to fix the  
 19 wheelchair on the back, on the outdoor balcony. They  
 20 were masked up and they disinfected it and I was able to  
 21 leave the wheelchair outside for 30 minutes until we  
 22 brought it back in because he was able to be able to be  
 23 lying on his bed and I was able to watch him whilst they  
 24 were repairing the wheelchair.  
 25 **Q.** Overall, how long were you shielding for?

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1 to be.  
 2 **Q.** From what you're saying, is it right that a DNACPR is  
 3 not something you would have wanted to have in place for  
 4 your son?  
 5 **A.** That gets much more complex because if my son had got to  
 6 the level of needing to not be resuscitated I felt he  
 7 would have been so poorly anyway. Our discussion and  
 8 our beliefs were that we wanted our sons and daughters  
 9 to be treated far earlier so they did not get to that  
 10 level of needing do not resuscitate CPR.  
 11 **Q.** Did you ever have any further conversations with the  
 12 healthcare services about the potential for a DNACPR or  
 13 anything around --  
 14 **A.** I can't remember. However, I did definitely get  
 15 a letter on 16 May where I was asked to write down all  
 16 of his needs so that he could go to hospital without me.  
 17 There was no way, knowing how my son is and the fact it  
 18 takes nine months to a year for my son to go anywhere  
 19 without me, that he could have gone into hospital  
 20 without me. He's had two recent admissions to hospital  
 21 this year and on both occasions it has shown that if he  
 22 did not have the one-to-one person that knows him  
 23 really, really well, that his life would be put at  
 24 greater risk by being in hospital, due to the lack of  
 25 equipment to meet his needs. And I'm talking about his

14

1 **A.** Because of his very complex needs he's one-to-one or  
 2 actually two-to-one in a room at college, he didn't  
 3 eventually go back for 18 months. We were fully  
 4 shielding for the first four months, then staff came  
 5 back, then the December in 2020 the staff went off again  
 6 for three months. We were vaccinated in February '21,  
 7 first vaccine', and then he eventually got back to  
 8 college in September 2021. And although it's not  
 9 health, the local authority were trying to take off his  
 10 educational and health and care plan whilst he was away  
 11 from college, they were trying to cease his educational,  
 12 health and care plan which also added increased stress.  
 13 **Q.** Longer term, I appreciate you've described earlier on  
 14 the extent of your son's complex needs and what they  
 15 were like prior to the pandemic. Have you been able to  
 16 identify any significant changes in him as a result of  
 17 shielding or as a result of the time that's passed since  
 18 the beginning of the pandemic?  
 19 **A.** He would have been greatly helped by having physio  
 20 throughout the pandemic and when we were shielding at  
 21 home. I did the best that I could. He managed well but  
 22 he's delighted to be back into his routines, he's very  
 23 keen on seeing his carers and people at his present day  
 24 centre and he thoroughly enjoys going out. There were  
 25 moments in the pandemic or the pandemic when we were

16

1 locking down where he would start to cry uncontrollably  
 2 for no apparent reason and that doesn't happen anymore.  
 3 **Q.** Is it possible to say then that this period had  
 4 an impact on his mental health as well as potentially  
 5 his physical health?  
 6 **A.** It's very hard with my son to say how much it impacted  
 7 him but he was definitely -- he was very excited -- if I  
 8 put his coat on to go outside in the garden and we went  
 9 near the car he would be very, very excited thinking he  
 10 was going out in the car out and about and then would  
 11 get very upset, distressed if we then didn't get in the  
 12 car. He couldn't understand why we weren't going  
 13 anywhere, seeing anybody or doing anything.  
 14 **Q.** From your perspective as a carer for someone with such  
 15 complex needs, what has the long-term effect been on  
 16 you?  
 17 **A.** For me physically I have a very sore hip now, very sore  
 18 wrists, and back issues that I did not have before the  
 19 lockdown and dealing with my son daily. For me the  
 20 mental health came from the fact that I felt very, very  
 21 let down by not having a competent government at the  
 22 time. I felt very unsafe and I did not feel that there  
 23 was anybody really looking out for our needs as  
 24 clinically vulnerable people and I still feel that to  
 25 some extent.

17

1 looking after your son who is lucky to have found you  
 2 and by the sounds of things you're lucky to have found  
 3 him. Thank you very much indeed.

**(The witness withdrew)**

5 **MS CAREY:** My Lady, the next witness is going to be  
 6 Ms Natalie Rogers.

**MS NATALIE ROGERS (affirmed)**

**Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**

9 **MS CAREY:** Ms Rogers, your full name, please.

10 **A.** Natalie Rogers.

11 **Q.** Mrs Rogers, I think you've come to give evidence today  
 12 as a founding trustee of Long Covid Support; is that  
 13 right?

14 **A.** That's correct, yes.

15 **Q.** And Long Covid Support is one of four organisations that  
 16 collectively make up the Long Covid core participant  
 17 group?

18 **A.** That's correct, yes.

19 **Q.** The other organisations in the group are Long Covid  
 20 Kids; is that correct?

21 **A.** Yes.

22 **Q.** Long COVID Physio?

23 **A.** Yes.

24 **Q.** And Long Covid SOS?

25 **A.** That's correct, yes.

19

1 **Q.** As someone who has had the experiences you've described  
 2 are there any particular recommendations which you have  
 3 from your perspective that you'd like to raise with  
 4 the Inquiry?

5 **A.** For me the main thing is that we still are clinically  
 6 vulnerable, my son and I are still shielding to some  
 7 extent. We aren't going anywhere indoors that isn't at  
 8 home or his day centre. I will go in shops but I'm  
 9 masking in shops and also I still feel he's being put at  
 10 great risk by having to go into hospital for treatment  
 11 for things because I really don't think that we're fully  
 12 understanding what clinically vulnerable is and nor are  
 13 we making allowances for clinically vulnerable people.

14 **MR FIREMAN:** My Lady, those are all my questions for  
 15 Ms Moore.

16 Thank you very much, Ms Moore, for attending.

17 I don't know whether you have any questions,  
 18 my Lady.

19 **LADY HALLETT:** No, I have no questions.

20 Ms Moore, thank you very much indeed for your help  
 21 with the Inquiry. I can't imagine what your life is  
 22 like on a normal basis let alone during lockdown on your  
 23 own.

24 **THE WITNESS:** It's been an absolute pleasure.

25 **LADY HALLETT:** Well, you've done an extraordinary job

18

1 **Q.** And I'll just, if I may, at the beginning give a little  
 2 background to those four organisations. Obviously you  
 3 can speak to Long Covid Support but, where you feel  
 4 able, please tell us about the concerns of the group as  
 5 a whole, as we go through your evidence.

6 **A.** I will do.

7 **Q.** I think you have in front of you your statement ending  
 8 370954, and we may call that up on screen if we need to  
 9 look at various parts of it.

10 **A.** Okay.

11 **Q.** The four organisations I think together represent tens  
 12 of thousands of adults and children who have suffered  
 13 life-changing illness or disability following infection  
 14 with Covid; is that correct?

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

16 **Q.** And Long Covid Kids was established in September 2020,  
 17 and supports over 11,000 families, with advocating for  
 18 those families and the children and young people with  
 19 Long Covid?

20 **A.** They do, yes, although there's probably more children  
 21 affected than that.

22 **Q.** Understood. And I think, in fact, Long Covid helps  
 23 those anywhere in the world, not just the UK?

24 **A.** Long Covid Support, you mean?

25 **Q.** Long Covid Kids?

20

1 A. And Long Covid Kids, yes.

2 Q. Long COVID Physio was formed in November 2020 to connect  
3 physiotherapists and allied healthcare professionals who  
4 are living with Long Covid.

5 A. That's correct, yes.

6 Q. And Long COVID Physio has over 25,000 Twitter followers  
7 alone, and the statement sets out the number of times  
8 that the Facebook group and online videos have been  
9 watched. I think there's been more than 1 million  
10 online videos watched by people suffering with  
11 Long Covid and wanting to understand more about  
12 Long COVID Physio?

13 A. Yeah. And if I could just say, the numbers in the  
14 statement referred to, in terms of the membership and  
15 following of all the groups, were correct at the time  
16 but continue to increase.

17 Q. Yes, you are quite right, Mrs Rogers, the statement was  
18 dated 28 November 2023, so 11 months ago now?

19 A. The numbers have increased substantially since then.

20 Q. Understood. Long Covid SOS was established in June 2020  
21 as a volunteer-run patient advocacy and campaign group,  
22 and advocates for recognition, research and  
23 rehabilitation for people affected by Long Covid.

24 A. It does, yes. And those are the kind of core principles  
25 of what the Long Covid groups were advocating for

21

1 number again?

2 INQ000370954\_5. Thank you very much. And if we  
3 could highlight paragraph 1.14. Thank you.

4 I think just at the outset of the statement you  
5 very helpfully set out overarching concerns of the core  
6 participant group and you say this:

7 "From our first-hand experience and the  
8 experience of our members, those who were suffering  
9 from Long Covid struggled for recognition; they  
10 struggled to access appropriate care, diagnosis, and  
11 treatment during the relevant period. Many people  
12 report that their physiological symptoms were routine  
13 disbelieved and disregarded by healthcare  
14 professionals and instead, often attributed to  
15 a psychological cause. In our view, there was  
16 a damaging delay in the UK's healthcare system  
17 recognising and responding to Long Covid."

18 And although this was written back in  
19 November 2023, do they remain the concerns of the  
20 Long Covid core participant group today?

21 A. That remains part of our concern, yes.

22 Q. Right. Now, we have heard from experts about what is  
23 Long Covid so I'm not going to ask you about that,  
24 please, Mrs Rogers, but I'd like to start, really, with  
25 the recognition and diagnosis of Long Covid as

23

1 throughout the pandemic for people affected.

2 Q. And then Long Covid Support began as a peer support  
3 Facebook group in May 2020 and in fact now is  
4 a registered charity, as of May 2021, and Long Covid  
5 Support has 62,500 members globally?

6 A. Again, that was correct at time of writing.

7 Q. As at November 2023.

8 A. Yes.

9 Q. Right.

10 A. Long Covid Kids and Long Covid SOS are also registered  
11 charities.

12 Q. Thank you. And I think you make the point in your  
13 statement that those four organisations are mostly led  
14 by people that have Long Covid or are caring for those  
15 with Long Covid?

16 A. That's true. There are also people involved in the  
17 organisation who are interested in either, you know,  
18 furthering research or clinical care for people with  
19 Long Covid.

20 Q. Can I ask, please, that we call up on screen  
21 INQ000370954\_5, please, and paragraph 1.14.

22 Ms Rogers, if it's easier for you to look on the  
23 screen rather than put your head down into the  
24 statement, all well and good. But I just want at the  
25 outset if I may, through you -- sorry, shall I give the

22

1 a condition.

2 A. Okay.

3 Q. And I think you say in your statement that there was  
4 a significant delay in the UK's healthcare sector  
5 recognising and responding to Long Covid.

6 Can you give us an indication of how long the  
7 delay was and the kind of impact that delay had.

8 A. Okay. So our experience and the experience of our  
9 members and, you know, other people that we hear about  
10 through, you know, social media, et cetera, was very  
11 much that it just wasn't recognised, at all, that there  
12 was any possibility of ongoing symptoms as a result of  
13 Covid-19 infection.

14 So, from the very early days there was this very  
15 pervasive and damaging misconception that, particularly  
16 if you were a non-hospitalised patient, Covid was going  
17 to be a very short, mild, flu-like illness. There was  
18 absolutely no mention of the possibility of there being  
19 any long-term illness at any stage throughout the  
20 pandemic in the daily briefings that people were  
21 watching on the television. So, you know, for us, as  
22 people that did not recover within that expected  
23 two-week time frame, we wanted to raise the alarm that  
24 you weren't necessarily going to recover.

25 There was no recognition of the fact that if you

24

1 were previously fit and healthy or if you were a child  
 2 or a young person there was any chance that you were  
 3 going to develop serious health issues. Which, you  
 4 know, to me, seemed very counterintuitive. There's been  
 5 a long history of post-viral illness. It's not a new  
 6 concept. We've had Spanish flu, we've had SARS, we've  
 7 had MERS. Yet the experience of people seeking  
 8 healthcare, particularly in the early days, was that you  
 9 couldn't possibly have ongoing symptoms as a result of  
 10 a Covid-19 infection. You were met with, you know,  
 11 "Well, it's -- two weeks has passed, it should be  
 12 better", was kind of the response that you got.

13 **Q.** I think you say in your statement that your  
 14 organisations received many reports of patients'  
 15 physiological symptoms being disbelieved and minimised  
 16 by healthcare providers, and I'd like to ask you,  
 17 please, about one of the surveys that was conducted,  
 18 I think by Long Covid SOS.

19 But could we have up on screen page 14 of  
 20 INQ000370954.

21 This was a survey Mrs Rogers conducted in  
 22 September 2020, so about six months in from the start,  
 23 and if we look at paragraph 3.5 we can see there some of  
 24 the difficulties encountered by adult patients when  
 25 contacting their GPs, reporting the symptoms. And it

25

1 health-seeking behaviours.

2 **Q.** If we look further down at some of the responses to the  
 3 survey:

4 "10.7% of respondents reported [having] their GP  
 5 suggested they may be suffering from anxiety due to  
 6 having had Covid-19 or experiencing lockdown."

7 **A.** Yeah, a lot of people did have that suggested to them.  
 8 This is possibly due to the fact that Covid seems to  
 9 have a significant impact on the autonomic nervous  
 10 system, so you kind of completely lost control of your  
 11 blood pressure, heart rate. You know, people had very  
 12 high, racing heart rates when they were presenting to  
 13 healthcare professionals. That was my own experience.  
 14 But it wasn't down to anxiety.

15 **Q.** If I just finally, while looking at the survey, 3.55:

16 "More than two thirds of GP ... did not follow up  
 17 this initial contact by phone or other means."

18 And:

19 "37.0% of respondents reported that their GP did  
 20 not discuss referral to any specialist services."

21 Now, by September they may not have -- we're going  
 22 to hear about the plans that were put in place by  
 23 various governments. In reality, in September 2020  
 24 there wasn't very much, was there, Mrs Rogers, by way of  
 25 referral services at that stage?

27

1 included 33% --

2 "33.3% of respondents stated that their GP was  
 3 willing to accept long-term symptoms were a feature of  
 4 Covid-19 but was unaware of any steps that could be  
 5 taken to alleviate them."

6 **A.** Yes, so it was certainly my experience. I met with  
 7 a number of different GPs in my attempt to access  
 8 healthcare, and I went through quite a few before  
 9 meeting with one that was actually willing to accept  
 10 that the ongoing symptoms that I was experiencing could  
 11 be due to an acute infection with Covid.

12 **Q.** This was a UK-wide survey, I think with 271 respondents  
 13 to it, most of whom were for England but there were  
 14 respondents from Scotland, Wales and Northern Ireland as  
 15 well, and most of the respondents were females --

16 **A.** Yes.

17 **Q.** -- to this survey?

18 **A.** Possibly because females are more likely to respond, in  
 19 terms of wanting to get that information out there to  
 20 share their experience and protect others.

21 **Q.** I think we heard from the experts yesterday that women  
 22 are actually more likely to suffer with the symptoms of  
 23 Long Covid as well, so that may also feed into why more  
 24 women responded to this.

25 **A.** But that, again, could be due to different

26

1 **A.** There wasn't very much in terms of services to refer to  
 2 but there was also a distinct lack of understanding of  
 3 the possibility of ongoing illness. You know, it was,  
 4 as I said before, so widely publicised that,  
 5 particularly for community patients, it would be a short  
 6 illness of two-week duration. You know, many patients  
 7 were met with complete disbelief that they could  
 8 possibly still be suffering the ongoing effects of the  
 9 virus. If they were believed, as you said, there  
 10 weren't any known services to refer in to, there was  
 11 a lack of knowledge and understanding of the symptoms  
 12 that patients were experiencing amongst GPs. So, you  
 13 know, they may have their symptoms acknowledged but then  
 14 there wasn't anything that could be done about them.

15 **Q.** If I understand it correctly, two problems here: those  
 16 that were disbelieved or had their symptoms minimised by  
 17 a GP; but where there is a GP that was a more  
 18 understanding and sympathetic, nowhere for the patient  
 19 to be referred to or help to be -- or support given?  
 20 All right, understood.

21 Can I ask you, from your own experience, did you  
 22 have difficulty with being disbelieved or diagnosed at  
 23 the beginning?

24 **A.** So, I mean, I had difficulty from the outset, from when  
 25 I first became ill. So I was severely acutely unwell at

28

1 home. I tried phoning NHS 111, both the Covid and  
 2 non-Covid lines. It was very difficult getting through  
 3 to either. The whole kind of act of seeking healthcare  
 4 was exhausting at a point that you were sort of  
 5 suffering from crippling fatigue, intense headaches, all  
 6 sorts of, you know, difficulties just being, really.  
 7 Breathing itself was difficult. So having to constantly  
 8 try to get through to seek healthcare during the acute  
 9 phase was a challenge. And when you did get through,  
 10 you may not be believed, because initially there were,  
 11 sort of, three cardinal symptoms: cough, fever, lack  
 12 of -- sorry, loss of sense of smell. If you didn't have  
 13 those cardinal symptoms it was often questioned did you  
 14 have Covid. That was the first thing that happened with  
 15 me.

16 My most intense initial symptom was the inability  
 17 to draw breath, intense crushing chest pain. But I was  
 18 told that for as long as, you know, I could actually  
 19 breath, speak, then I didn't need to be hospitalised and  
 20 I should manage the condition at home. My difficulty  
 21 breathing was so intense that I actually researched  
 22 online myself what I could do to try to manage that, and  
 23 I found a YouTube clip from a doctor that advised lying  
 24 on your front so that you would take the pressure off  
 25 your lungs.

29

1 thing. So I kept phoning up and I did eventually get  
 2 triaged in May.

3 **Q.** 2020?

4 **A.** In May of 2020, having become ill in March of 2020.  
 5 I got triaged in -- it was like a Covid hub, sort of  
 6 outdoor medical tent, if you will.

7 And I hadn't received a test until that point  
 8 because testing wasn't available in the community. So  
 9 I did get a PCR test at that point. But of course by  
 10 this point I think I'd been ill for about 37 days. So  
 11 it unsurprisingly came back negative. So I didn't have  
 12 a positive test result and I also had medical  
 13 professions sort of saying: well, you didn't have the  
 14 typical initial symptoms and you should be better by  
 15 now. And I remember saying, "Look, we are in the middle  
 16 of a pandemic with a novel virus that is impacting  
 17 thousands of people, it's highly likely that that's the  
 18 root cause of the symptoms that I'm experiencing."

19 **Q.** Now, much of what you said will resonance with evidence  
 20 her Ladyship heard yesterday and through other  
 21 witnesses, but is your experience common amongst the  
 22 Long Covid group core participants?

23 **A.** Yeah, so because of that experience, I found myself,  
 24 you know, questioning: do I have Covid? And I just kept  
 25 coming back to the answer: it's got to be. You know,

31

1 And I just kind of, like, lay there, you know,  
 2 sort of listening to my own laboured breathing and  
 3 counting the days, because I'd also read somewhere that  
 4 if I got to day 8 and I was still breathing I was going  
 5 to continue doing so.

6 So, that initial acute phase was really, really  
 7 quite harrowing. But I did survive. And then I kind of  
 8 assumed that I would have that sort of typical linear  
 9 recovery that you expect to get after most illnesses,  
 10 and that didn't really happen. And then I had this sort  
 11 of whole-system crash, really, and then I just had this  
 12 whole raft of debilitating symptoms on top of those that  
 13 I was already experiencing.

14 So I had -- as I said, my heart rate,  
 15 blood pressure sort of went out of control. I had  
 16 vertigo. You know, I couldn't walk. I just felt like  
 17 I was going to fall over. Just getting to my own  
 18 bathroom was a challenge.

19 The only way -- I found it really, really  
 20 difficult, and this was one of the problems when you  
 21 were seeking healthcare, was articulating the symptoms  
 22 that you were having. It was really difficult to  
 23 describe. I felt like I had radiation poisoning. But,  
 24 you know, to go and say that to your GP, they're just  
 25 going to think "What's she talking about?" kind of

30

1 mainly because of the difficulty that I had with  
 2 breathing was so intense and the fevers that I had, it  
 3 was unlike anything else that I had experienced.

4 So I was looking online to try to find any  
 5 information I could.

6 **Q.** That's what I wanted to ask you about, Ms Rogers,  
 7 because I think you say in your statement that although  
 8 you've just told us that you were diagnosed in May 2020,  
 9 it wasn't really until the early summer of 2020 that  
 10 medical and scientific advisers began to recognise the  
 11 long-term effects of Covid. Is that roughly right in  
 12 the chronology of --

13 **A.** That's roughly right, but obviously, you know, the  
 14 people experiencing it, they already had, kind of, all  
 15 of the information about what symptoms they were  
 16 experiencing, so when I went online I stumbled across  
 17 the Facebook group, that has later become the charity,  
 18 Long Covid Support, and that was kind of a sort of  
 19 moment of enlightenment, if you will, because there was  
 20 just story after story of people going through similar  
 21 experiences to mine.

22 **Q.** Can I ask you about that, because you've obviously  
 23 alighted upon a large number of people experiencing the  
 24 same thing as you and I think in your statement you make  
 25 the point that between April and August 2020 there were

32



1 various documents, including those with -- at SAGE level  
 2 beginning to talk about the long-term consequences of  
 3 Covid. But between April and 2020 where there was  
 4 emerging understanding of the consequences, did you ever  
 5 see anything from the Department of Health that was  
 6 warning people or alerting them to the fact that there  
 7 may be long-term consequences of Covid?  
 8 **A.** No. No, I didn't. I have, you know, since become aware  
 9 of the video that was produced.  
 10 **Q.** The video came out I think in October?  
 11 **A.** Right.  
 12 **Q.** So here we are in the summer.  
 13 **A.** Yeah.  
 14 **Q.** It's beginning to be recognised at  
 15 government/organisational level, it's obviously being  
 16 recognised on social media amongst all the people that  
 17 are experiencing these things but do I take it that  
 18 nothing really was coming out warning the public in  
 19 messaging that there was --  
 20 **A.** Nothing. Nothing in the public domain.  
 21 **Q.** You will probably be aware, Mrs Rogers, that we have  
 22 heard evidence that long-term consequences are not new  
 23 but certainly Professor Whitty told us, for example,  
 24 that precisely what those consequences are, are not  
 25 necessarily known at the beginning of a pandemic.

33

1 you about a letter that was sent to the Prime Minister,  
 2 Mr Hancock, Professor Whitty, the chief executive of  
 3 NHS England.  
 4 And could we call up on screen INQ000238582.  
 5 Thank you very much.  
 6 This is July 2020. It's from Long Covid SOS. It  
 7 was signed by over a thousand members of the group and  
 8 we can see there that you're writing to a significant  
 9 number of people in senior positions "on behalf of  
 10 thousands of forgotten victims". Why was it described  
 11 in that way?  
 12 **A.** Well, you just felt like you were invisible because  
 13 there was no public health messaging. When you were  
 14 seeking healthcare you were met with disbelief. So --  
 15 you know, the messaging was that if you weren't  
 16 hospitalised or if you didn't, sadly, lose your life to  
 17 this virus then it was going to be a short two-week  
 18 illness and you were going to be fine.  
 19 So we were suffering, you know -- we were going  
 20 through a horrendous experience. I mean, in fact I'm  
 21 incredibly grateful to the people that wrote this letter  
 22 in July raising the alarm because I myself at this point  
 23 was in bed in a dark room with intense pain, searing  
 24 pain in my head like nothing else I've ever experienced,  
 25 so I wasn't at that point in a position to be able to

35

1 Bearing that in mind, what do you think could have been  
 2 done in terms of public messaging to help alert people  
 3 to the fact there may be the consequences when the  
 4 consequences aren't in fact known at that stage?  
 5 **A.** I think sufficient was known about the fact that there  
 6 were ongoing consequences and that they were potentially  
 7 very debilitating to make people aware of that  
 8 possibility. There were enough -- there was kind of  
 9 a sufficient critical mass of people presenting to  
 10 healthcare, raising the alarm on social media, for it to  
 11 be known that there was potentially going to be  
 12 a significant ongoing problem here if we didn't make  
 13 people aware of the possibility of ongoing symptoms.  
 14 And that at least should have happened.  
 15 **Q.** Can you help, what do you think they should have said?  
 16 **A.** Like I said, the video that was produced that went out  
 17 in October, the messaging on that was actually quite  
 18 good but I didn't see it at the time. Nobody else  
 19 I knew saw it at the time and it's a shame that that  
 20 message didn't get out there.  
 21 **Q.** We'll come to the video in a moment, but I think in your  
 22 statement there was a number of attempts by members of  
 23 the Long Covid core participant group to try to raise  
 24 awareness. I'm not going to go through all of them, you  
 25 set them out in your statement, but I would like to ask

34

1 advocate. And in that respect there were many other  
 2 people like me who were alone, you know, in their room  
 3 trying to make sense of the experience that they were  
 4 having, trying to get validation for the experience that  
 5 they were having, but it was a real challenge to do so  
 6 because the symptoms that you were experiencing at the  
 7 time made it impossible for you to advocate for yourself  
 8 because just the process of breathing was exhausting.  
 9 **Q.** Well, if we just go down in the letter slightly, to the  
 10 paragraph beginning "Throughout this period", having set  
 11 out the statistics about infection rates:  
 12 "Throughout this period the general public have  
 13 been assured by government and public health sources  
 14 that most 'mild' or 'moderate' cases not requiring  
 15 hospital admission, resolve within two weeks.  
 16 However, it is becoming increasingly clear that for  
 17 many this far from the case."  
 18 Then reference there to a study that suggests as  
 19 many as one in ten people with Covid are sick for  
 20 three weeks or more and reports in the press are  
 21 starting to emerge describing a pattern of illness  
 22 experienced by many which is completely at odds with the  
 23 prevailing view about the virus.  
 24 So setting out in terms there --  
 25 **A.** Yes.

36

1 Q. -- that the messaging that it was just mild or moderate  
2 and you'll recover was not according with what a number  
3 of people were feeling and experiencing on the ground.  
4 A. That's correct, and members of the Long Covid groups  
5 were desperately just trying to get that message out  
6 there by whatever channel they could. So in parallel to  
7 raising concerns with government officials,  
8 policymakers, healthcare providers, we were also trying  
9 to get the message out there through social media,  
10 through the media, because you just wanted to do  
11 whatever you could to prevent other people going through  
12 that same experience.  
13 Q. Just finally on the letter, could we go to the final  
14 page, please, page 3.  
15 There were a number of asks made to the recipients  
16 of the letter. Five of them are set out there:  
17 establishment of a working group, commissioning of  
18 research, development of protocols and care pathways to  
19 ensure that the practitioners are empowered to treat  
20 long-term Covid-19 patients, creation of  
21 multi-disciplinary clinics, and the consideration of the  
22 economic implications.  
23 So that was what you asked for in July, and we may  
24 now look at some of the things that did or didn't happen  
25 in that regard.

37

1 first official government guidance published by Public  
2 Health England, as it then was, into the longer-term  
3 effects, and I would just like to ask you about that  
4 please.

5 Can we pull up INQ000272238.

6 It's a shortish document, Mrs Rogers. It  
7 includes, obviously, a list of some of the persistent  
8 health symptoms and it says there is some research  
9 ongoing in terms of the post-hospitalisation Covid  
10 study, but right at the top of the document it says:

11 "Around 10% of mild [Covid] cases who were not  
12 admitted to hospital have reported symptoms lasting  
13 more than 4 weeks. A number of hospitalised cases  
14 reported continuing symptoms for 8 or more weeks  
15 following discharge."

16 Do I understand it correctly that the Long Covid  
17 group have concerns about that highlighted paragraph in  
18 blue there?

19 A. What do you mean by "have concerns"?

20 Q. I think in your statement you said there was  
21 consideration given to the fact the guidance incorrectly  
22 suggested that Long Covid only occurs in individuals who  
23 have been hospitalised with severe Covid --

24 A. All right, yes. Yes.

25 Q. Help me with that. What was the concern?

39

1 Thank you, that letter can come down.

2 And I think you make the point in your statement  
3 that in September 2020 Long Covid SOS met with  
4 Professor Stephen Powis, the medical director of  
5 NHS England, and you say it was the start of regular and  
6 ongoing dialogue about providing better care for people  
7 with Long Covid.

8 So that was clearly quite an important meeting?

9 A. It was a really important meeting. And it seemed to be  
10 the case that up until that point there had been no  
11 attempt to engage with the people that were actually  
12 experiencing Long Covid. So you talked about, you know,  
13 a growth of awareness within government from -- you  
14 know, between April and August, I think you mentioned  
15 before, but there was still no attempt up until this  
16 point, in September 2020, to engage in any way with the  
17 people that were experiencing Long Covid in order to  
18 gain a better understanding of it. And, you know, if  
19 you like, those early patients were the canaries in the  
20 coal mine, they were the people who had the most  
21 information about the condition at that time, they were  
22 the ones living with it.

23 So it was, yes, a turning point, in the sense that  
24 their opinion was finally listened to in some respect.

25 Q. Now, also in September 2020 you say that that was the

38

1 A. So obviously the biggest concern was the fact that there  
2 seemed to be no awareness of the possibility of ongoing  
3 symptoms, that was the biggest initial concern we had.  
4 Then when there did seem to be some acceptance of that  
5 possibility, it was completely focused on hospital  
6 patients. So this, again, overlooks -- you asked before  
7 about people feeling invisible, it completely overlooks,  
8 again, the experience of people that hadn't been  
9 hospitalised. And what we were learning was that you  
10 could have quite severe Long Covid irrespective of the  
11 severity of your acute Covid infection. In fact, you  
12 could have a pretty much asymptomatic acute Covid  
13 infection, go on to develop quite severe Long Covid.  
14 That was one of the issues.

15 Also the other issue was, of course, as we've  
16 previously spoken about, that the threshold for  
17 hospitalisation was so high that you also had patients  
18 in the community that had actually been severely ill  
19 with acute Covid. So that whole cohort of people aren't  
20 considered in that paragraph.

21 Q. Following that guidance, we then come to the video that  
22 was published in October 2020.

23 Can I just look at the press release, please, at  
24 INQ000272221.

25 This press release accompanied the publishing of

40

1 the video. It says:  
 2 "New data suggests Long Covid affects around 10%  
 3 of 18 to 49 years olds who become unwell ..."  
 4 If we go to page 2, there at the top:  
 5 "The Health Secretary urges people to follow the  
 6 guidelines to protect themselves ...  
 7 "A new film ... [features] the stories of  
 8 4 people, one aged just 22, who are living with the  
 9 long-term effects of the virus."  
 10 Now, I know -- I think you said that you didn't  
 11 see the video yourself. Are you aware of how well it  
 12 was viewed across some of the members of the Long Covid  
 13 core participant group? Was it highly publicised?  
 14 **A.** No. Nobody was talking about it at the time. It's  
 15 something that's been discussed, as I said,  
 16 retrospectively, and the messaging in it is quite good,  
 17 but who saw it?  
 18 **Q.** Certainly from your experience and those that you  
 19 represent --  
 20 **A.** And we were people that were actively seeking  
 21 information.  
 22 **Q.** Aside from this video, are you aware if there was any  
 23 other press release or a follow-up video ever?  
 24 **A.** No, this is, to my knowledge, the only one that was  
 25 produced, in terms of videos.

41

1 I can't remember exactly when Your Covid Recovery became  
 2 available. The problem with Your Covid Recovery is it's  
 3 not a resource that was developed specifically for  
 4 Long Covid, it's a post-hospital rehab programme, and  
 5 I think it was just, kind of, sort of, regurgitated and  
 6 rolled out at pace, really. But it certainly wasn't  
 7 specific to or suitable for people with ongoing symptoms  
 8 of Long Covid.  
 9 **Q.** Let me pause you there and help you if I may.  
 10 Can we look at page 36 in Mrs Rogers statement,  
 11 INQ000370954.  
 12 Your Covid Recovery I think was launched  
 13 in July 2020, but it's an online tool as I understand  
 14 it?  
 15 **A.** It is an online tool, yeah. There were two phases to  
 16 it. There's one that patients can just, you know,  
 17 freely access, and there was another one, phase 2, that  
 18 I think GPs had to refer patients into. I think there  
 19 was a distinct lack of knowledge about how to do so.  
 20 I know when I eventually got referred to my local  
 21 Long Covid hub I was working with an allied health  
 22 professional. And this, by now, about spring '21 that  
 23 I had this conversation with him. He was aware that  
 24 phase 2 of Your Covid Recovery as an online tool  
 25 existed. He didn't know how to access it, nor did

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1 **Q.** Do you think there needed to be an ongoing campaign?  
 2 **A.** Yes.  
 3 **Q.** And I think we know then that in December 2020 the NICE  
 4 guide line came out with the first UK clinical  
 5 definition. I'm not going to ask you about it. That  
 6 just rounds off 2020.  
 7 Can I, perhaps before the mid-morning break, just  
 8 ask you a bit about treatment and rehabilitation,  
 9 Mrs Rogers.  
 10 **A.** Yes.  
 11 **Q.** We know that in October 2020, NHS England published  
 12 a 5-point plan for Long Covid, and there was a task  
 13 force and there was something called Your Covid  
 14 Recovery, an online programme. I'd just like to ask you  
 15 a bit about those matters, please.  
 16 Clearly you've told us that initially at least the  
 17 response focused on those people who'd been  
 18 hospitalised?  
 19 **A.** Correct, yes.  
 20 **Q.** And prior to the Long Covid clinics being set up, can  
 21 you help: where were patients referred to before the  
 22 Long Covid clinics came into existence?  
 23 **A.** Well, before the Long Covid clinics came into existence  
 24 there wasn't really very much to refer them into.  
 25 Before and after the clinics came into existence --

42

1 my GP.  
 2 So I don't know to what extent phase 2 was used.  
 3 I do know that people were referred to phase 1 and, as  
 4 I said, it was very much a rehab programme. It wasn't  
 5 suitable for people with Long Covid. It had a lot of  
 6 dangerous advice around goal setting, getting moving.  
 7 **Q.** Can I ask you about that.  
 8 **A.** Yes.  
 9 **Q.** Can you give us an example about what you considered to  
 10 be dangerous advice that was given for those that  
 11 registered on the Your Covid Recovery programme?  
 12 **A.** A lot of people were reporting that if they were  
 13 following this advice of, you know, sort of setting  
 14 yourselves goals, getting back to exercise, they were  
 15 trying to do so and then they were just crashing and  
 16 having a return of incredibly debilitating symptoms,  
 17 which I have since come to personally understand, thanks  
 18 to Long COVID Physio, is something called  
 19 post-exertional malaise or post-exertional symptom  
 20 exacerbation. So I think that was going on for a lot of  
 21 people.  
 22 There were also a lot of people that had, you  
 23 know, undiagnosed ongoing organ damage, so perhaps  
 24 myocarditis of the heart, et cetera. Again, you know,  
 25 you shouldn't be exercising.

44

1 We just didn't know enough about the sort of  
2 biological mechanisms of Long Covid for people to be  
3 taking this approach, and they were doing so because,  
4 you know, people wanted to get better.

5 **Q.** Yes.

6 **A.** So they were following whatever advice was out there in  
7 the hopes of getting better and it was making some  
8 people seriously unwell.

9 So we did approach Your Covid Recovery, as did  
10 Long Covid SOS, to make them aware of the fact that we  
11 didn't feel that the programme was suitable for people  
12 with Long Covid.

13 Another issue with it was that it just had large  
14 volumes of information that you needed to read in order  
15 to, kind of, support your own recovery, and that didn't  
16 account for the neurocognitive issues, level of fatigue  
17 that people were experiencing.

18 **Q.** I think you said there that you raised some of the  
19 concerns with Your Covid Recovery. Was there any  
20 positive outcome once you'd told them of your concerns?

21 **A.** Not for a long time. It took a long time and a lot of  
22 advocacy for any changes whatsoever to be made.  
23 You know, another of our concerns was the imagery on it  
24 was very much targeted about, you know, getting back to  
25 exercise kind of thing, and these were people that were

45

1 Long Covid service was set up as -- in an existing  
2 respiratory service because Covid was initially believed  
3 to be, you know, solely a respiratory disease, and they  
4 were kind of dealing with my care from a rehabilitation  
5 perspective but I was also having to go through the GP  
6 surgery for all other investigations that were required,  
7 which involved multiple disciplines, and I was having to  
8 kind of co-ordinate and administrate my care through,  
9 you know, many different healthcare providers. Which  
10 was utterly exhausting. And also letters got lost,  
11 I didn't receive the results of tests. You know, there  
12 was a point at which I completely sort of fell between  
13 respiratory care and cardiology in terms of the  
14 diagnosis of what was going on for me. So from that  
15 perspective it is really important that somebody has  
16 oversight and there is centralised co-ordinated care of  
17 patients.

18 Some services do that well. Others don't. Some  
19 services are purely a therapeutic-led service, a bit  
20 like mine was. So, where that's the case, they can't  
21 diagnose, treat, refer onwards to other disciplines, so  
22 you, kind of, are sort of in the service but it isn't  
23 fully able to oversee your care needs.

24 So it is important, you know, that we have that  
25 team that can address everything.

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1 just too debilitated, too disabled, at that point, to  
2 even consider to being able to do that.

3 So any changes that were taken on board were  
4 incredibly slow. I'm aware that the site has now been  
5 taken down, but people are still being directed to it by  
6 many hospital trusts, so ...

7 **Q.** Is there any replacement that you're aware of now  
8 that --

9 **A.** No.

10 **Q.** One final issue before the break. We heard yesterday  
11 from Professors Brightling and Evans about the variation  
12 in the services that are available across the UK for  
13 those who are suffering Long Covid. Certainly we heard  
14 of what are colloquially known as one-stop shops that  
15 are available --

16 **A.** Yes.

17 **Q.** -- and I just wondered, are you able to give us the  
18 Long Covid group core participant's view on whether they  
19 are a good way of trying to deal with the very many  
20 symptoms that Long Covid sufferers experience?

21 **A.** I believe so. Yeah, you do need a multi-disciplinary  
22 team approach that involves both clinical care and  
23 rehabilitation care. It needs to be led by a doctor.  
24 You need to have a single person co-ordinating the care  
25 of the patient because, as was my experience, my

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1 **Q.** I think you say in the statement that certainly  
2 Long Covid SOS were of the view that the one-stop shop  
3 is what they would consider the benchmark for Long Covid  
4 care. I was wondering, does that also stand true for  
5 the other three organisations that make up the  
6 Long Covid core participant group?

7 **A.** Yeah, that's what everybody would advocate would be the  
8 best service, both for the patient but also in terms of  
9 efficiency of healthcare, because if you're having to  
10 utilise all of these different services it's not very  
11 economical in terms of healthcare provision.

12 **MS CAREY:** My Lady, would that be a convenient moment?

13 **LADY HALLETT:** Of course.

14 I hope you were warned that we take breaks,  
15 Ms Rogers. I shall return at 11.30.

16 (11.14 am)

(A short break)

17 (11.30 am)

18 **LADY HALLETT:** Ms Carey.

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

20 Mrs Rogers, I'd like to ask you some questions  
21 about Long Covid in children.

22 **A.** Yes.

23 **Q.** And I think you say in your statement that as  
24 at March 2023, ONS estimated that 52,000 children and  
25

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1 young people aged between 2 and 16 had suffered  
2 Long Covid for over 12 months.

3 And it may be that those figures need to be  
4 adjusted now in 2024 but it's a significant number --

5 **A.** I think they've doubled.

6 **Q.** They've doubled. So over 100,000 children now?

7 **A.** Mm.

8 **Q.** Thank you.

9 And I think there is concern amongst your core  
10 participant group that from the outset of the pandemic  
11 there was a failure really to regard the risk of  
12 infection in children and indeed then in terms of the  
13 long-term consequences that Covid had on children. And  
14 in part that led to the setting up of Long Covid Kids;  
15 is that correct?

16 **A.** That's correct, yes. So I mean, all of the issues that  
17 were faced by adults were also faced by children and  
18 young people and their families and that was further  
19 hampered by the narrative that children didn't get  
20 unwell from Covid which was very pervasive from the  
21 beginning of the pandemic.

22 **Q.** Her Ladyship will recall, I think, in one of the earlier  
23 modules there was the impact video with a family talking  
24 about the impact of Long Covid on one of their children  
25 and there's other evidence we have as well.

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1 awareness and support from GPs about post-viral  
2 conditions. Complete lack of awareness about the  
3 incidence of Long Covid in children and indeed in turn  
4 the absence of treatment pathways. All had been told or  
5 made to feel they were neurotic or over-concerned  
6 parents.

7 So a different form of minimisation but  
8 minimisation nonetheless of what the adults were being  
9 told when they were telling GPs about their symptoms?

10 **A.** Yes, so again there's been this history of attributing  
11 unexplained illness to psychological causes. Adults  
12 were certainly experiencing that when they were seeking  
13 healthcare, but, you know, that was kind of almost  
14 ramped up to another level with families in the way that  
15 parents were being kind of almost blamed for making up  
16 that their children had these symptoms and said before  
17 about, you know, my own experience and how difficult it  
18 was to communicate and articulate the symptoms that  
19 I was experiencing and that's even more difficult for  
20 children because they don't have the same communication  
21 tools as adults to articulate their experience.

22 It's a complex multi-systemic illness, you really  
23 don't know what's happening to your body, and that's  
24 very, very difficult for children to articulate, and  
25 often they don't articulate with words, they articulate

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1 Long Covid Kids, is this correct, in  
2 September 2020 produced a film called "Our Unhappily  
3 Ever After" which was put on YouTube and shared on  
4 social media and, essentially, after sharing that film  
5 was it at that stage that a number of families contacted  
6 Long Covid Kids and kept doing so as the film got shared  
7 and shared and reshared?

8 **A.** Yes, because again the families were meeting with  
9 disbelief. There seemed to be a complete lack of  
10 professional curiosity about what was going on with  
11 children, and a failure to respond to the emerging  
12 evidence that was continually being put to healthcare  
13 professionals by, you know, children, their parents,  
14 their grandparents so like with the case with adults,  
15 Long Covid Kids kind of sort of stepped into that space  
16 to try and communicate what was going on for these  
17 families in order to try and prevent that happening to  
18 other children.

19 **Q.** Well, can I -- let's look at how some of the families  
20 were affected and put on screen your paragraph 5.3.  
21 INQ000370954\_45, please.

22 There's a reference we can see there at 5.3 to the  
23 sharing of the film. Clearly each family's experience  
24 was distressing, similar and yet unique. In terms of  
25 Long Covid in children, all had experienced a lack of

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1 through their behaviours. That doesn't mean that the  
2 cause is psychological, that there's an underlying  
3 physiological illness but it's not yet understood and  
4 really what we needed was people just to say: we don't  
5 yet fully understand it.

6 **Q.** Can I ask you about some of the factors that you set out  
7 in your statement that negatively impacted children with  
8 Long Covid accessing healthcare.

9 Could we put up paragraph 5.5, at page 46, of  
10 Mrs Rogers' statement.

11 And can we see at the top of that page there you  
12 set out helpfully a number of factors, including there  
13 was no information published by the government, the  
14 Royal College of Paediatrics and Child Health and by  
15 healthcare providers on the risk of Covid-19 to  
16 children.

17 And then this:

18 "There was no paediatric clinical definition of  
19 Long Covid until February 2023 ..."

20 So the adult definition certainly from NICE came  
21 out in December 2020.

22 **A.** 2020, yeah.

23 **Q.** Two and a bit years on for the clinical definition of  
24 paediatric Long Covid to come out.

25 **A.** And I know that in that intervening period that is

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1 something that Long Covid Kids were campaigning very  
 2 hard to have established because, you know, illness in  
 3 children often presents slightly differently to illness  
 4 in adults and there just didn't seem to be any urgency  
 5 to investigate what was going on for these children and  
 6 families and establish a paediatric clinical definition  
 7 that would enable people to then go on to access care  
 8 because of course without a clinical definition for  
 9 an illness there's no established care pathways and it  
 10 makes it much more difficult to seek help.

11 **Q.** I think you make the point that that delay prolonged  
 12 Long Covid Kids members accessing help, being believed  
 13 and, of course, being diagnosed.

14 **A.** Yeah.

15 **Q.** "... lack of data collection and reporting on hospital  
 16 admissions, deaths and Long Covid in children."  
 17 Why do you think it's important that we have that  
 18 data available?

19 **A.** Well, if you don't measure what's going on you can't  
 20 plan to deal with it. It's hidden and that was the  
 21 experience of these families, their experience was  
 22 hidden and that's meant that, you know, there's been no  
 23 warning system to prevent other children being affected.  
 24 There's been no considered need to mitigate better, to  
 25 prevent children being infected. There's been no

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1 Can I also, through you if I may, urge those  
 2 watching to read the section of your statement dealing  
 3 with Long Covid and healthcare. We're going to take up  
 4 that thread with other witnesses that are coming in the  
 5 next few weeks, Mrs Rogers, but what I'd like to turn to  
 6 with you now, please, is really the effect of Long Covid  
 7 on sufferers' and their families' mental health,  
 8 well-being, and the enduring physical symptoms.

9 I think you set some of that out at starting at  
 10 your section 7 in your report.

11 Could you just help me with this. What was the  
 12 impact really on you and your members of having to  
 13 advocate all the time to say to professionals, "I'm not  
 14 getting better, I need more support, it isn't a heart  
 15 problem, it isn't a lung problem"? How did that affect  
 16 you and the members of those that you represent?

17 **A.** Okay, so it's exhausting having to continually fight  
 18 that hard for recognition. We're talking about people  
 19 who are sick, really unwell, in the middle of  
 20 a pandemic. These people want to know what's wrong and  
 21 they want to get better. That's all they're asking for.  
 22 You shouldn't have to fight that hard to get help.  
 23 Having to fight that hard, you know, being  
 24 repeatedly gas lit and disbelieved while you are  
 25 suffering from a really debilitating illness that has

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1 urgency to research the illness in children or to  
 2 provide care pathways because it's not been measured.

3 **Q.** And then finally you say:  
 4 "At best, [there was] an adult framework being  
 5 applied to paediatric problems. There needs to be  
 6 child-specific data and child centred approach. It is  
 7 important that children suffering are heard and that  
 8 there is a voice for all children and young people ..."  
 9 Do you know if there is now any child framework  
 10 being applied to children with Long Covid?

11 **A.** There have been I think 15 children and young people  
 12 Long Covid clinics established. Again, the sort of care  
 13 pathway that's put in place for them is not always  
 14 adequate. There's still a lot of attributing the  
 15 symptoms that children are experiencing to behaviour  
 16 rather than physiological illness because there hasn't  
 17 been sufficient research, sufficient focus on  
 18 establishing an adequate framework on which to diagnose  
 19 and treat the disease.

20 **Q.** I won't go through it now but the statement sets out  
 21 a number of the steps Long Covid Kids took to try and  
 22 advocate on behalf of children with Long Covid and if  
 23 anyone wishes to look at those, they are set out in  
 24 a number of pages from 51 onwards in Mrs Rogers'  
 25 statement.

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1 genuine physiological symptoms is going to have knock-on  
 2 psychological impacts, because, you know, it affects  
 3 every aspect of your life to be that unwell. It affects  
 4 your ability to work. Your ability to socialise. Your  
 5 interactions with your family. Your financial  
 6 stability.

7 So, you know, there is going to be straining on  
 8 your mental health but on top of that you're also having  
 9 to work really, really hard to try and be recognised and  
 10 get any form of adequate healthcare.

11 **Q.** I think you say in your statement that for those that  
 12 had to give up work or certainly reduce their hours,  
 13 obviously there's a financial consequence including  
 14 people using up their savings, taking out private loans,  
 15 using debt services and there was a Long Covid Support,  
 16 I think, survey that said that one in 16 of the  
 17 respondents were using food banks?

18 **A.** That's correct, so I don't think that there's anybody  
 19 that has been affected by Long Covid that hasn't,  
 20 you know, had at least some degree of financial harm.  
 21 There's financial implications to this thing at every  
 22 step. Loss of income. Sick pay or lack of it,  
 23 depending on your profession, that has a knock-on effect  
 24 on your pension, so we're talking about lifelong  
 25 financial implications. There's the cost of private

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1 healthcare because people are desperate to find answers  
2 to help them get better. People are spending their  
3 savings trying to do so, if they're not spending their  
4 savings trying to put a roof over their head, as you  
5 say. There are people that should be able to work that  
6 were able to work prior to the pandemic, that were able  
7 to engage fully in society that now aren't because  
8 they're so considerably disabled.

9 **Q.** I think you said one in seven respondents to the survey  
10 that Long Covid Support did had lost their job because  
11 of reasons connected to Long Covid?

12 **A.** Yeah.

13 **Q.** Can I ask you about risk of reinfection and how your  
14 members feel about that. Clearly we're not in the  
15 emergency phase of the pandemic anymore, but it's still  
16 with us. How have your members felt and what have they  
17 said about the risks of reinfection and how they're  
18 treated now given that risk to them?

19 **A.** Okay, so since we sort of opened up in the summer of  
20 2022, freedom day, as it was, that was a really  
21 difficult day for people with Long Covid because we know  
22 firsthand that the virus can utterly destroy your life  
23 as you know it and yet the talk was very much about just  
24 exposing people to it continuously. People are being  
25 infected with Covid several times a year, still.

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1 removed from them, it's not an option.

2 **Q.** Can I ask you a little bit about research because one of  
3 the recommendations that you make in your statement is  
4 for a more focused and better-funded approach to  
5 research. Now, I think we heard that the initial  
6 research was into those people that had been  
7 hospitalised, then there was cause for research into  
8 those people who had not been hospitalised but can you  
9 help us, please, Mrs Rogers as to why it is that those  
10 you speak on behalf of today are still calling for more  
11 focus and a better-funded approach to research?

12 **A.** So a lot of those research studies that you refer to  
13 were kind of more on the epidemiology and  
14 characterisation of Long Covid. We need to be  
15 prioritising biomedical research into Long Covid so that  
16 we can establish accurate diagnostic tests. We don't  
17 have that at present. There's no tests that have been  
18 developed that are specific to this condition, although  
19 a lot of research has been done that has identified  
20 potential biomarkers that could lead to tests for it and  
21 then we need to look at developing treatments so that  
22 needs to be a priority for research.

23 There needs to be separate studies into the  
24 paediatric population and comparing the burden of  
25 Long Covid in children with other childhood illnesses.

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1 There's been quite a lot of research about the  
2 fact that every time you're exposed to the virus that  
3 increases your risk of developing Long Covid. If you  
4 already have Long Covid it opens you up to a worsening  
5 of your existing symptoms. So naturally it's perfectly  
6 rational to want to avoid getting it again. So that has  
7 made life quite difficult for people with Long Covid  
8 because they are effectively clinically vulnerable to  
9 this virus and, you know, they're often having to seek  
10 healthcare and there's currently no mask requirements in  
11 healthcare, there's not adequate ventilation or air  
12 filtration, so they are repeatedly exposing themselves  
13 to a risk that they know can do devastating harm.

14 **Q.** I think you also say that people with Long Covid are not  
15 regarded as a priority group for vaccinations?

16 **A.** That's correct. And, again, you know, we don't  
17 understand why that hasn't been considered because we  
18 are clearly clinically at risk in terms of the health  
19 consequences of this virus. That's an established fact.  
20 So why are we not being prioritised to avoid getting it  
21 again?

22 Seeing as, you know, the whole underpinning  
23 ideology of opening up is that we now have this vaccine  
24 that protects those that are at risk and people with  
25 Long Covid are at risk, yet that protection has been

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1 I think it is, you know, one of the most significant  
2 childhood illnesses presently. So we need to better  
3 understand the pathophysiology of what's going on with  
4 this illness, how to treat it, and we need to invest in  
5 that quickly because people continue to be affected by  
6 it all the time.

7 **Q.** You set out at the end of your statement helpfully  
8 a number of recommendations that you would argue for.  
9 There are, I think, 11 in total. I'm not going to go  
10 through all of them with you, Mrs Rogers. We just  
11 looked at the recommendation in relation to research but  
12 you say at recommendation 2 that:

13 "Healthcare systems can only respond adequately to  
14 longer-term sequelae when they are actively monitoring  
15 and counting it. The UK should ensure that  
16 decision-makers prioritise the early collection of  
17 syndromic surveillance data of longer-term sequelae."

18 Why is it that you argue so strongly for that  
19 recommendation?

20 **A.** Well, if we aren't measuring, as I said previously, we  
21 are not measuring what's going on, we can't adequately  
22 plan for it. We are at the moment potentially facing  
23 going backwards in terms of Long Covid provision, both  
24 in terms of existing research studies winding-up.  
25 There's been no further investment since November 2021.

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1 There's significant concern about what is happening with  
2 Long Covid clinics because the funding for them is only  
3 announced on an annual basis. We don't know whether  
4 there's going to be funding for them or whether they're  
5 going to be merged into existing services beyond 2024.

6 Again, if we don't know the number of people that  
7 are needing support through healthcare we can't  
8 adequately plan for it. And, you know, we need to be  
9 aware, 30% of people with Long Covid have been infected  
10 in the last year. We often talk about this in the past  
11 tense but it's an ongoing problem and we need to measure  
12 the problem in order that we can adequately mitigate  
13 against future people being infected and also adequately  
14 support and treat those who have ongoing health issues.

15 And I think, you know, Long Covid is a really  
16 difficult thing to understand unless you are affected by  
17 it or you know somebody that's affected by it. It's in  
18 many ways an invisible illness societally and sadly  
19 there are people in here that will end up with  
20 Long Covid, and until they do so you really can't  
21 understand the full ramifications that it's going to  
22 have on your life.

23 **Q.** Just a final topic and I just want to pick up on what  
24 you said there about the invisible illness, and we  
25 understand the context you use it in, but can I just ask

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1 not, you know, having that cultural capital to advocate  
2 for themselves in order to access healthcare. And  
3 you know, it's a worry that because it's viewed as being  
4 an illness that largely impacts white women, that that's  
5 kind of feeding into the sort of misogynistic view there  
6 is of this illness that means that patients are having  
7 their symptoms attributed to psychological causes.

8 There's a lot that we still need to understand and  
9 there's a lot of people that we're still not reaching.

10 **Q.** I think, in addition to research suggesting women  
11 experience Long Covid more, you make the point in your  
12 statement that data from Long Covid services suggest the  
13 majority of people who access the clinics are white.  
14 Yet, as we know, Covid-19 more severely and  
15 disproportionately affected those from minority ethnic  
16 communities. So potentially under-reporting or people  
17 from those communities not, for whatever reason,  
18 accessing those Long Covid services?

19 **A.** And we saw the example yesterday of the barriers that  
20 were faced by the lady that was trying to communicate  
21 using British Sign Language throughout the pandemic.  
22 So, you know, those barriers are also going to be faced  
23 by people for whom English is their second language, but  
24 for both language and cultural reasons.

25 **MS CAREY:** Mrs Rogers, thank you very much. They are all

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1 you about your group's experience of inequality-related  
2 issues with Long Covid because I think you say in your  
3 statement that your organisation has observed through  
4 your membership that people from under-served groups and  
5 areas of deprivation suffer structural barriers to  
6 accessing patient support organisations for Long Covid  
7 sufferers.

8 You've already told us about the problems that  
9 you've had, but do I understand from that that if you're  
10 coming from a black, Asian or minority ethnic background  
11 it's even harder to try and seek out the support that  
12 you yourself found difficult enough in the first place  
13 to obtain?

14 **A.** Yes, so I regard myself as somebody that has quite kind  
15 of high health capital in terms of my ability to access  
16 healthcare. If it's been this hard for me I can't even  
17 begin to imagine how difficult it would be for people  
18 that already face structural barriers to healthcare,  
19 you know, by virtue of where they live geographically,  
20 deprivation, from a minority group etc. We think that  
21 there's an over representation of women with the illness  
22 but that's potentially because there are many groups of  
23 people that healthcare or support groups like ours are  
24 not able to reach because of the healthcare-seeking  
25 behaviours of those groups, because of stigma. Just

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1 the questions that I had for you.

2 My Lady, is there anything you would like to ask?

3 **LADY HALLETT:** No, thank you very much for your help,  
4 Mrs Rogers. I do hope the work of this Inquiry will  
5 help gain Long Covid the recognition that obviously it  
6 deserves. We're doing our best to ensure that it does.

7 **A.** I very much appreciate your support.

8 **LADY HALLETT:** Whether we can make a difference in other  
9 respects will wait to be seen but at least we can get  
10 you some recognition, I hope.

11 **A.** Thank you.

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

13 **MS CAREY:** Thank you very much, my Lady. Can I hand over to  
14 Mr Mills to take the next witness.

(The witness withdrew)

16 **MR MILLS:** My Lady, may I please call Dr Paul Chrisp who  
17 will affirm.

**DR PAUL CHRISP (affirmed)**

**Questions from COUNSEL TO THE INQUIRY**

20 **MR MILLS:** Your full name, please.

21 **A.** Paul Chrisp.

22 **Q.** Dr Chrisp you have provided a statement to the Inquiry.  
23 For reference that is INQ000438429. You are now  
24 retired. Before that, you were the head of publishing  
25 and products at NICE. That's the National Institute for

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1 Health and Care Excellence, and during the pandemic you  
2 were the director of the Centre for Guidelines at NICE,  
3 is that right?

4 **A.** That's correct.

5 **Q.** In broad terms, please, what are the roles and  
6 responsibilities of NICE, the organisation?

7 **A.** So, NICE is an independent arm's length body of The  
8 Department of Health and Social Care. It produces  
9 robust, independent evidence-based guidance and advice.

10 The aim of NICE's recommendations are to help  
11 practitioners and commissioners get the best care to  
12 people fast while ensuring value to the taxpayer.

13 The Centre for Guidelines develops and maintains  
14 up-to-date evidence-based guidance to prevent ill  
15 health, promote good health, and improve the quality of  
16 care and services.

17 **Q.** And as for the status of the guidelines NICE produces,  
18 can you help us with this. Must they be followed by  
19 healthcare professionals, or is there an expectation  
20 that they will be?

21 **A.** There's an expectation. So guidelines are intended to  
22 support professionals and the judgment of healthcare  
23 professionals as they discuss and consider options with  
24 patients. And this is clearly expressed at the  
25 beginning of every guideline. So it's not mandatory to

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1 **Q.** We will come in a moment to the standard process for  
2 producing guidelines. But just help us at the outset  
3 with this. Had NICE ever before had to produce  
4 guidelines at such pace?

5 **A.** No.

6 **Q.** In these early stages, March 2020, did NHS England also  
7 assist NICE by producing its own clinical guidance?

8 **A.** Yes, NHS England and others produced some other guidance  
9 aimed at the NHS.

10 **Q.** Was that an unusual thing for NHS England to do?

11 **A.** So NICE occupies the guideline space with many others.  
12 Royal College, for example, produce guidance for certain  
13 specialisms. So it's not particularly unusual.

14 **Q.** Did there come a point when NHS England stopped  
15 providing clinical guidance and left the development of  
16 such guidance, as it were, to NICE?

17 **A.** So, yes, the focus moved to NICE producing guidance. We  
18 were -- worked very closely with NHS England to produce  
19 what we call waves of guidance, so every week we'd get  
20 the next three or four topics, over the course of the  
21 first three months of the pandemic.

22 **Q.** Staying at the mid-point of March 2020, as we are, can  
23 I ask you this. Were prioritisation criteria agreed for  
24 the work the Centre for Guidelines would perform?

25 **A.** Yes, we -- as an organisation we prioritised our work on

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1 apply the recommendations. The guideline does not  
2 override the responsibility to make decisions that are  
3 appropriate to the circumstances of an individual or  
4 their families and carers.

5 **Q.** A little bit about your professional background, please.  
6 I think it's right that you qualified as a pharmacist in  
7 1984 and practised for about a year. What has the focus  
8 of your career been?

9 **A.** So I had a -- prior to joining NICE in 2009, I had  
10 a career in medical publishing and the thread really  
11 through my career has been on evidence-based information  
12 to inform clinical decisions and therapeutics.

13 **Q.** Moving to those early stages of the pandemic, then.  
14 When did NICE receive its first commission to develop  
15 what became known as rapid guidelines from NHS England?

16 **A.** So the first commission was on 11 March 2020 and we were  
17 asked to produce guidelines on aspects of managing  
18 Covid-19. We had three topics in that first wave.

19 **Q.** What were those three topics?

20 **A.** They were the management of patients in critical care,  
21 the management of patients in the dialysis unit and the  
22 management of patients undergoing chemotherapy.

23 **Q.** And when were those guidelines published?

24 **A.** So we started work on them on 17 March and they were  
25 published on 20 March.

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1 the Covid response, guidelines to support the Covid  
2 response, and on what we call therapeutically important  
3 topics, so, for example, on evaluating medicines for  
4 cancer treatment.

5 **Q.** At your paragraph 15 you say the purpose at the time of  
6 the prioritisation criteria was to avoid distracting the  
7 NHS when it was facing unprecedented pressure, releasing  
8 frontline healthcare staff who might otherwise have been  
9 engaged in guideline committees and as consultees of  
10 draft guidelines.

11 As well as the prioritisation, can we think about  
12 the core principles that NICE had for developing  
13 guidelines? Did those core principles remain the same  
14 for the rapid guidelines, and can you tell us, please,  
15 what they were?

16 **A.** Yes, the principles for producing guidance remained the  
17 same, and those principles are to base our  
18 recommendations on the best available evidence, where it  
19 exists, about what works and what it may cost.  
20 Guidelines are developed by independent experts,  
21 committees. We work with lay members, so we retained  
22 that in a form, and I can come on to that later. We  
23 retained the principle of consultation. All guidelines  
24 that NICE produces are signed off by an executive which  
25 is a delegated authority of the NICE board. And once

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1 published, all NICE guidelines are maintained and kept  
2 up to date as new evidence and the knowledge base  
3 changes.

4 **Q.** Let's look now at the standard process.

5 Please can we go to INQ000438429.

6 This is a flow chart you produce in your  
7 statement, Dr Chrisp. It is, is it not, a summary of  
8 NICE's standard guideline development process?

9 **A.** Yes.

10 **Q.** I wonder if you could take us through each stage in  
11 headline terms and, as you do, give us a sense of the  
12 timings that each of these stages would take.

13 **A.** So, starting at the top, topics are usually referred to  
14 NICE by NHS England or the Department of Health and  
15 Social Care. We then scope the topic, and that's  
16 important to understand what the guideline will include  
17 and importantly what it will not include. And that can  
18 take two to three months and it also includes a two to  
19 four-week consultation period, so we consult on the  
20 scope of a guideline.

21 We will amend the scope and then we start the  
22 development. The development stage can take anything  
23 from 6 to 18 months, depending on the size of the topic.  
24 As you can appreciate, some topics can be quite small,  
25 and therefore with a smaller evidence base, and we can

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1 it right that a standard topic would have a 142-week  
2 process; accelerated, 86 weeks; short, 44 weeks?

3 **A.** Yes.

4 **Q.** You were taking us through this flow chart. It does not  
5 appear that we see an equality impact assessment in  
6 writing within the chart. Before I ask you to explain  
7 where that fits in in the process, can you explain what  
8 an equality impact assessment is.

9 **A.** Yes. So in an equality impact assessment captures and  
10 considers any health inequality considerations for the  
11 guideline. So the aim is to reduce health inequalities  
12 and consider where it may be appropriate to make  
13 different recommendations for different groups of people  
14 if required.

15 We look at four dimensions of health inequality:  
16 we look at socioeconomic status and deprivation; we look  
17 at protected characteristics; we look at specific health  
18 groups, for example people who may be experiencing  
19 homelessness; and we look at any geographical impacts.

20 So, an equality impact assessment really looks at  
21 whether any emerging recommendations offer the  
22 opportunity to reduce health inequality, or to advance  
23 health equality.

24 **Q.** Can I take it from that then that the assessment process  
25 is a critical part of guideline development?

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1 move more rapidly. Others have a fairly extensive  
2 evidence base and can take a lot of committee meetings  
3 to work through the evidence, analyse the evidence and  
4 for our committees to reach their recommendations.

5 The next step consultation would normally take  
6 four to six weeks. This is where we ask for the views  
7 of stakeholders on the draft recommendations that have  
8 been made. The guideline, the draft guideline, is then  
9 revised in line with consultee comments, and that can  
10 take, again, anything between two to three months.  
11 There's then a quality assurance stage of a month or so.  
12 The guideline is then signed off and published.

13 And then the final stage of updating. We have  
14 regular checks to see if evidence has changed, if the  
15 knowledge base has changed, and there are four outcomes  
16 of a review. One would be no update needed. Another  
17 would be what we call a refresh, so there might be new  
18 evidence published which simply reaffirms or reinforces  
19 what's already recommended.

20 Thirdly, an update. So that may be in full,  
21 a full guideline, or a partial update, where we just  
22 look at a section of a guideline.

23 And the final outcome of a review is a withdrawal  
24 of the guidance and a standing down of the evidence.

25 **Q.** Just to give those timings their total figures then, is

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1 **A.** It is.

2 **Q.** Where then in this flow chart does an equality impact  
3 assessment come in?

4 **A.** At two places. An equality impact assessment is  
5 considered during scoping and also during development of  
6 recommendations. So it's specifically we ask our  
7 committees as they're formulating their recommendations  
8 to consider the aspects of health inequality and health  
9 equality that I've mentioned.

10 **Q.** As you took us through this process you described the  
11 role of stakeholders. There is, I think, a standing  
12 stakeholder list; is that right?

13 **A.** Correct.

14 **Q.** Can you help us with the sorts of organisations that we  
15 would imagine are on the standing stakeholder list?

16 **A.** Yes. So the standing stakeholder list includes national  
17 organisations that would have an interest in  
18 recommendations from NICE.

19 So, for example, I think there's 80 or thereabouts  
20 organisations on that standing list. They would range  
21 from the Care Quality Commission, NHS England, the  
22 Office for Health [Inequality] and Disparities, the  
23 MHRA, those sorts of organisations, and groups such as  
24 the Richmond group of charities.

25 **Q.** Just so I follow, are there any disability charities or

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1 organisations on the list?

2 **A.** On that standing list, I don't believe so.

3 **Q.** Has consideration been given as to whether there ought

4 to be?

5 **A.** Yes. We do reach out to disability charities and engage

6 with them on specific topics.

7 **(Alarm interruption)**

8 **MR MILLS:** My Lady, I'm not sure I know what that one means.

9 **LADY HALLETT:** No, nor I.

10 **UNKNOWN SPEAKER:** (Inaudible).

11 **LADY HALLETT:** Oh, I see. As long as everything is okay.

12 **MR MILLS:** Dr Chrisp, I apologise.

13 You were just saying you reach out to disability

14 charities and engage with them on specific topics?

15 **A.** That's correct. So we know from engaging with patient

16 and voluntary community sector organisations that they

17 would prefer to be contacted on topics which are

18 considered directly relevant for their members rather

19 than being overwhelmed with lots of guidelines. At any

20 one time NICE is working on 20 or so topics and it's

21 a judgment to ensure that we have the right stakeholders

22 involved but not overwhelming people.

23 **Q.** Can we move now to consider the changes that NICE made

24 to produce the rapid guidelines then. In what key ways

25 was this standard process amended so that NICE could

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1 experts would generally be drawn from?

2 **A.** So they were drawn from the specific specialism that we

3 were looking at. So, for example, when we were looking

4 at dialysis we worked with people with an expertise in

5 that particular topic.

6 **Q.** Did the Centre for Guidelines maintain equality impact

7 assessments as part of its process during the

8 formulation of the rapid guidelines?

9 **A.** So for the first phase we did, however they weren't in

10 the format or level of detail that we would normally

11 produce for a standard guideline.

12 **Q.** Are you able to give us an insight into the difference

13 between an equality impact assessment as part of the

14 standard process, and the ones you were able to perform

15 during the first phase of the rapid guidelines?

16 **A.** I think the main difference would be the speed, the

17 thoroughness. So we had less time to conduct

18 an equality impact assessment for those first topics

19 compared with a standard process. So we tried to cover

20 those aspects I mentioned in terms of opportunities

21 where we saw them to reduce health inequality and

22 promote health equality, but because we were moving at

23 speed, the process was not as thorough.

24 **Q.** With that context, let us consider a particular rapid

25 guideline together, please. That is guideline NG159,

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1 produce rapid guidelines within the time it was given?

2 **A.** So we tried to stick to the core principles which

3 I've previously outlined, but we had to compress the

4 development stage, initially looking at five to ten days

5 to produce guidance. So some of the development time

6 was done in parallel, the consultation processes were

7 shortened and targeted, and the guidelines were rapidly

8 updated as we became aware of new evidence and the

9 knowledge base changed, in light of findings for what

10 was a new disease, a new condition.

11 **Q.** How did NICE ensure, within this truncated process, that

12 expert input could still be secured?

13 **A.** So we worked with experts on specific topics. So we

14 worked with targeted experts, usually groups of between

15 seven to ten individuals, for each guideline, to develop

16 the draft recommendations. And then going out to

17 consultation, again that was a targeted consultation,

18 aimed at organisations who we thought would have

19 an interest.

20 **Q.** Is it possible, and it may not be so, to say how many

21 experts would typically be involved in formulating

22 the -- a rapid guideline?

23 **A.** Yes, so between seven to ten would be normal for that

24 early phase of development.

25 **Q.** And is it possible to say from which disciplines those

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1 critical care in adults.

2 Please can we have on screen INQ000474301.

3 This is -- although it says March 2020 at the top,

4 this is the original version of the guideline as

5 published on 20 March 2020.

6 Before we move into the detail of it, can you help

7 us with this, please. What was this guideline designed

8 to achieve?

9 **A.** It was intended to support clinicians and support

10 patients who were admitted to hospital and the

11 management of movement to critical care.

12 **Q.** The request for this guideline came to NICE on

13 11 March 2020?

14 **A.** I think it was 13 March.

15 **Q.** The 13th. I apologise.

16 Did NICE draft this guideline from, as it were,

17 a blank page, or was there something on the stocks

18 already that NICE was able to adapt in order to produce

19 it?

20 **A.** So we took the view, the principles that we worked with

21 were to produce short succinct documents with minimal

22 narrative and to link to existing frameworks where they

23 existed. So we drew upon the expertise from the experts

24 we worked with and from their knowledge of the admission

25 of patients into critical care.

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1 **Q.** If we move to page 2 we read at paragraph 1.1:  
 2 "On admission to hospital assess all adults for  
 3 frailty, irrespective of age and COVID-19 status.  
 4 Consider comorbidities and underlying health  
 5 conditions.  
 6 "Use the Clinical Frailty Scale for frailty  
 7 assessment ..."  
 8 And it goes on to say where that is available.  
 9 The Inquiry heard evidence from Dr Daniele Bryden,  
 10 the dean of the Faculty of Intensive Care Medicine, she  
 11 said that the faculty provided advice to NICE about this  
 12 guidance; is that correct?  
 13 **A.** Yes.  
 14 **Q.** In her evidence she agreed that the Clinical Frailty  
 15 Scale is not appropriate for use on people under 65 or  
 16 those with stable disabilities. Do you agree with that?  
 17 **A.** Yes.  
 18 **Q.** Do you agree that this version of the guideline did not  
 19 make that clear?  
 20 **A.** Yes.  
 21 **Q.** Can we next, please, go to INQ000228378.  
 22 We'll look now at correspondence you had with both  
 23 Mencap, that's Mrs Jackie O'Sullivan, who the Inquiry  
 24 heard from on Monday, and from Tim Nicholls, of the  
 25 National Autistic Society, in the days that followed the

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1 bottom of the page from you on the 25th, your email  
 2 begins by explaining the consequence of applying the  
 3 Clinical Frailty Scale to people with autism was not  
 4 intended and we go on to read the amended paragraph 1.1:  
 5 "On admission to hospital, assess all adults for  
 6 frailty, irrespective of COVID-19 status.  
 7 "Use the Clinical Frailty Scale ... for frailty  
 8 assessment, available from the NHS Specialised  
 9 Clinical Frailty Network as part of a holistic  
 10 assessment of frailty."  
 11 Now this:  
 12 "Be aware of the limitations of using the CFS  
 13 tool as the sole assessment of frailty. The CFS  
 14 should not be used in younger people, people with  
 15 stable long-term disabilities, learning disabilities,  
 16 autism or cerebral palsy. An individualised  
 17 assessment is recommended in all cases where the CFS  
 18 is not appropriate."  
 19 Are you able to give us an insight, please, into  
 20 how this amended language was produced within NICE in  
 21 the 48 hours between you receiving the concern from  
 22 Mr Nicholls and sharing it with him on the 25th?  
 23 **A.** Yes, so we're grateful that this was pointed out to us.  
 24 We're grateful for that to Mr Nicholls and to Mencap for  
 25 pointing this out to us and we worked to clarify the

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1 publication of the original guideline on 20 March.  
 2 Here, halfway down the page, we have an email that you  
 3 received from Mr Nicholls on 23 March. In his second  
 4 paragraph, third sentence he expressed concern that:  
 5 "The list of criteria outlined in the Clinical  
 6 Frailty Scale, include criteria such as help keeping  
 7 finances in order, meal preparation and help with  
 8 dressing. We are concerned that these criteria  
 9 outline difficulties that many autistic people face --  
 10 but that does not make them frail. On the current  
 11 wording of the guideline, though, this assessment  
 12 would be carried out. This could lead to doctors  
 13 making decisions about otherwise healthy autistic  
 14 people that would put them at serious risk."  
 15 When you read this email, did you agree with the  
 16 concern that Mr Nicholls was expressing?  
 17 **A.** Yes.  
 18 **Q.** We'll come in a moment to the contact you had with  
 19 Mrs O'Sullivan from Mencap about this issue. For now  
 20 can I ask this. At this time, 23 March 2020, do you  
 21 recall whether other disability charities or  
 22 organisations had made contact with you or someone else  
 23 at NICE expressing similar concerns?  
 24 **A.** I think it was predominantly Mr Nicholls and Mencap.  
 25 **Q.** If we move to page 1. The email starting towards the

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1 wording and when the Clinical Frailty Scale should and  
 2 should not be used and hoped that this new wording would  
 3 make that clear. So it was really a dialogue working  
 4 with the National Autistic Society and with Mencap to  
 5 produce a form of wording that was clear.  
 6 **Q.** Let us look then, please, at the dialogue with Mencap.  
 7 We begin on page 10. We see here bottom email that on  
 8 23 March again, so the same day that you are in contact  
 9 with Mr Nicholls, you receive an email from  
 10 Jackie O'Sullivan of Mencap. She expresses this  
 11 concern:  
 12 "The key concern is that people with a learning  
 13 disability who need support with daily living would be  
 14 scored down to a level 5, 6 or 7, meaning that adverse  
 15 decisions about treatment might be made."  
 16 This concern is, in broadly similar terms to that  
 17 which the National Autistic Society had raised with you.  
 18 If we move then to the bottom of page 13, into 14, you  
 19 email Mrs O'Sullivan on 24 March, the following day and  
 20 you say this:  
 21 "As you can appreciate, because of the speed we  
 22 were asked to produce these guidelines, they weren't  
 23 subject to some of our usual steps. We are firming up  
 24 how we get an Equalities impact assessment into all  
 25 future topics."

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1 You described earlier the amended version of the  
2 equalities impact assessment that took place in respect  
3 of rapid guidelines. Just so the Inquiry is clear, had  
4 such an assessment been carried out before 20 March in  
5 respect of this guideline?

6 **A.** There was a guideline -- there was an equality impact  
7 assessment on this guideline but it wasn't as thorough  
8 because of the speed we were working at.

9 **Q.** In respect of this particular guideline are you able to  
10 assist the Inquiry with what that assessment considered?

11 **A.** Yes. I think it looked at age and it looked at --  
12 I think that was the main consideration of the equality  
13 impact assessment at that time.

14 **Q.** Ought it to have also looked at the impact on those with  
15 stable long-term disabilities, learning disabilities or  
16 autism?

17 **A.** Yes.

18 **Q.** Are you troubled, were you troubled, that it did not?

19 **A.** Yes.

20 **Q.** Can I ask whether any disability charities or  
21 organisations had been approached for input during the  
22 formulation of this guideline before 20 March?

23 **A.** They were not.

24 **Q.** Should they have been?

25 **A.** Yes.

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1 emails already that the CFS should not be used in  
2 respect of certain individuals.

3 And then that an individualised assessment is  
4 recommended in all cases where the CFS is not  
5 appropriate.

6 In your view did these revisions remedy the  
7 concerns that had been raised with you by the NAS and  
8 Mencap?

9 **A.** I think they did.

10 **Q.** Could the need to have revised the guideline on 25th or  
11 by 25th March and again by 31st March have been avoided  
12 if stakeholders such as Mencap and the NAS had been  
13 engaged prior to 20 March?

14 **A.** Yes.

15 **Q.** In her evidence to the Inquiry on Monday, Mrs O'Sullivan  
16 said that despite the revision to the guidance, Mencap  
17 remained worried that the genie was out of the bottle.  
18 Were you ever made aware of concerns that despite the  
19 revision the damage, as it were, had been done and that  
20 NICE had lost the trust of those with stable long-term  
21 disabilities, learning disabilities or autism?

22 **A.** No, I was not.

23 **Q.** If we keep up, please, only the revised guideline  
24 INQ000315780, this section is called "Admission to  
25 critical care", and I'd like to look at what this page

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1 **Q.** Let us look then, please, at the revised guidance.

2 Please can we go to INQ000315780.

3 If we move first to page 14, this page sets out  
4 the various updates within the iterations of this  
5 guideline. Do we see, looking down at the 25 March 2020  
6 that there was an amendment to paragraph 1.1, that's the  
7 paragraph we've been discussing, to clarify that the  
8 Clinical Frailty Scale should be used as part of  
9 a holistic assessment but should not be used for younger  
10 people, people with stable long-term disabilities,  
11 learning disabilities or autism?

12 And then there was a further recommendation by --  
13 further amendment, I apologise, by 31 March to  
14 paragraph 1.1?

15 **A.** Correct.

16 **Q.** If we move to page 6 we have the revised 1.1. Keeping  
17 that up, please, can we have the original guidance  
18 side-by-side. That's back to INQ000474301, page 2, so  
19 we have the original on the left, the revised on the  
20 right. If we compare the two, in the revised we have  
21 the warning at the end of the first bullet point:

22 "Be aware of the limitations of using the CFS as  
23 the sole assessment of frailty."

24 In the second bullet point we have the language,  
25 very similar language to that which we have seen in your

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1 says about DNACPR decisions. At 2.4 we read this:

2 "Sensitively discuss a possible '[DNACPR]'  
3 decision with all adults with capacity and [perform]  
4 an assessment suggestive of increased frailty ..."

5 This is an instruction to clinicians, is it not?

6 **A.** It's a recommendation.

7 **Q.** Yes. In your view, did the inclusion of a paragraph  
8 about DNACPR decisions in this guidance within a section  
9 about admission to critical care risk conflating these  
10 two issues?

11 **A.** The intention was to be clear that DNACPRs should be  
12 individualised and sensitively discussed with people,  
13 their families and their carers in the normal ethical  
14 course of decision-making.

15 **Q.** Were you ever made aware of reports that patients with  
16 DNACPR notices were not being admitted to critical care  
17 to receive treatment?

18 **A.** No.

19 **Q.** Please can we go to PHT000000112.

20 Dr Chrisp, this is an extract of Dr Bryden's  
21 evidence to the Inquiry on the subject of  
22 a prioritisation tool in the event that critical care  
23 capacity was reached. If we begin at the bottom of  
24 page 152 she said this:

25 "If I can go back to the NICE guidance, when we

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1 were advising NICE, we had actually identified with  
2 NICE that we felt at that point that we wanted  
3 something to go into the guidance to say where to look  
4 for guidance if the system became overwhelmed but that  
5 piece of advice that we gave was never produced into  
6 the final document."

7 Can I ask this. Are you able to recall whether  
8 the Faculty of Intensive Care Medicine advised that the  
9 critical care rapid guideline should offer clinicians  
10 assistance about what to do in the event that critical  
11 care capacity was reached?

12 **A.** I don't recall that but I do know that prioritisation of  
13 treatment in a capacity constrained system was excluded  
14 from the scope.

15 **Q.** Can you help the Inquiry understand how that exclusion  
16 was decided?

17 **A.** I think that was in the consultation and amendment of  
18 the scope as it was developed rapidly in that five-day  
19 working period when we developed the guideline.

20 **Q.** Can you help with any of the reasons why the decision  
21 was made to exclude it from the scope?

22 **A.** I am not sure about that. I can only think that service  
23 provision is not normally within the remit of NICE  
24 guidelines.

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

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1 consultation process.

2 **Q.** I see. Is it right that in March 2021 this rapid  
3 guideline and indeed all the other rapid guidelines NICE  
4 produced through 2020 to March 2021 were consolidated  
5 into what NICE called the "living guideline",  
6 "... managing COVID-19"?

7 **A.** Yes, that's correct.

8 **Q.** I'd like to ask you a question or two about whether NICE  
9 considered including within that managing Covid-19  
10 guideline a scoring system which the inquiry has heard  
11 some evidence about called ISARIC4C.

12 I do so with the caveat that this is not something  
13 you have personally assessed in your capacity, as you  
14 were then, the director of the Centre for Guidelines,  
15 but that you have made the relevant enquiries within  
16 NICE so that you are able to assist the Inquiry with the  
17 consideration that was given to that scoring system; is  
18 that right?

19 **A.** Yes.

20 **Q.** If we could, please, start by going to INQ000474255.

21 Thank you.

22 This comes from the expert report the Inquiry has  
23 received on intensive care. We read at the start of  
24 this paragraph:

25 "Although ISARIC-4C is the best available numeric

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1 I wonder whether that might be lunch.

2 **LADY HALLETT:** Certainly. I hope you were warned -- well,  
3 you probably gather we might have a lunch break, so  
4 you'll have to come back this afternoon at 1.40, please.

5 **(12.40 pm)**

6 **(The short adjournment)**

7 **(1.40 pm)**

8 **LADY HALLETT:** Mr Mills.

9 **MR MILLS:** My Lady.

10 Dr Chrisp, before we move on from the critical  
11 care rapid guideline we were discussing before lunch,  
12 can I ask this, are there any final points that you  
13 would like to share with the Inquiry that you haven't  
14 already had the chance to?

15 **A.** Yes, thank you for the opportunity. It goes back to  
16 involvement in the targeted consultation on NG159. You  
17 asked the question did we involve the groups involved  
18 with people with learning disabilities and autism, and  
19 we didn't. However, we did engage with the clinical  
20 lead for critical care and with The Richmond Group of  
21 Charities, who represent organisations for people with  
22 long-term conditions and complex needs. So it covers,  
23 for example, Mind, the Alzheimer's Society,  
24 Parkinson's UK. And the issue surrounding the Clinical  
25 Frailty Scale was not raised with us during the

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1 predictive score for Covid-19 outcomes, it is not in  
2 general clinical use as, despite the impressive rapidity  
3 of development, it was not published and available for  
4 use by the time of the first wave peak."

5 That may well explain why it could not have been  
6 considered for inclusion in the early iterations of the  
7 rapid guideline critical care in adults. It is right to  
8 set the scene, is it not, that ISARIC4C was not included  
9 in any further iterations of the critical care rapid  
10 guideline, nor was it included in the living guidance  
11 managing Covid-19?

12 **A.** That's right.

13 **Q.** Can you help the Inquiry then in this way. Whether NICE  
14 considered incorporating ISARIC4C into either of those  
15 pieces of guidance, or indeed any other, and ultimately  
16 why the decision was made not to?

17 **A.** Yes. So we did look at it. It was identified through  
18 our continuous surveillance of the knowledge base as  
19 more knowledge and experience and expertise was  
20 developed as the pandemic continued.

21 So we became aware of a number of scoring tools  
22 that were being developed, so in October 2020 we  
23 conducted a systemic review on risk prediction tools or  
24 models for admission to hospital or critical care to  
25 understand the broader evidence base. We found a large

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1 number of studies covering a variety of tools and  
2 models, and the conclusion at that time -- so this was  
3 conducted in October and December 2020. The conclusion  
4 at the time was there were a variety of early warning  
5 scores being developed, and it wasn't possible to, at  
6 that time, determine that one was better than another  
7 and therefore should be recommended.

8 So, that's one aspect of it that's particularly  
9 relevant to that particular tool.

10 And also in December 2020, in step with the way  
11 that clinical care was developing, our focus moved away  
12 from individual rapid guidelines, as you've indicated,  
13 that looked at, for example, admission, moving more  
14 toward this consolidated guideline which had more of  
15 a focus on management in therapeutics as we developed  
16 more knowledge about what management techniques and  
17 processes and interventions worked.

18 So there were two answers to the question:

19 Yes, we looked at it. It was one of many. There  
20 wasn't enough evidence to recommend it.

21 Secondly, it was this shift away from tools and  
22 models for admission to more of a focus on management in  
23 therapeutics.

24 **Q.** Can I take it then the second part of your answer  
25 perhaps explains why further consideration wasn't given

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1 As we progressed through those first guidelines,  
2 we learnt that there were some areas that we could  
3 actually move back towards a more normal process. So  
4 could it work, could it do that better in the future?

5 Yes, we could, and those new ways of working, those  
6 methods and processes we published in July 2020.

7 And in particular I want to go back to the  
8 evidence -- sorry, the equality impact assessment that  
9 we spoke about earlier. We would take a different  
10 approach to a future scenario. We have a greater  
11 awareness of the need to involve a wider stakeholder  
12 group as we would do normally on a guideline, so that  
13 interim process and methods guide for producing  
14 guidelines in response to a pandemic, the equality  
15 impact assessment element of that has not been  
16 condensed. It's the same as it would be in a regular  
17 standard guideline.

18 So that's one learning.

19 And then the second one is a deeper, more thorough  
20 systematic approach the organisation took in 2022 where  
21 the executive team looked at an organisational lessons  
22 learned, so not just guidelines but what else can we  
23 learn.

24 So the more flexible agile methods and processes  
25 and the prioritisation based on what would have the

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1 to it in 2021?

2 **A.** Again, I think if we were -- and it is a living  
3 guideline, if more evidence and knowledge with that  
4 particular tool was developing, the team would look at  
5 that. And when we talked earlier about updating and  
6 reviewing guidelines, if there was enough evidence to  
7 suggest a change in a recommendation, so, for example,  
8 to recommend ISARIC or indeed any other scoring tool, we  
9 would consider that and consider whether it warranted  
10 a partial update or a refreshing of the recommendations.

11 **Q.** Can we turn finally then, Dr Chrisp, to lessons and  
12 recommendations. Can I start with this. In the event  
13 of a future pandemic, is NICE in a better position to  
14 create rapid guidelines and if so, how?

15 **A.** I believe it is. Again, two aspects to that. One was  
16 in July 2020, after we'd produced 21 guidelines in  
17 three months, very rapidly. We -- during that time we  
18 were continually looking at what worked well and what we  
19 could do better, and we summarised that in an interim  
20 process and methods guide in July 2020, which, if you  
21 like, codified a future approach.

22 So if you recall when we spoke earlier, the first  
23 three guidelines were produced in five working days. So  
24 NICE had taken that decision to move quickly and  
25 condense and company many of its normal processes.

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1 greatest impact on user needs are now built into the way  
2 we work, the way the organisation works. And that  
3 further strengthening and signposting of efforts to  
4 address health inequalities has been taken to heart.

5 **Q.** Those are key lessons that NICE has learnt and acted  
6 upon. Perhaps looking forward, are there any further  
7 recommendations that you would like the Inquiry to  
8 consider?

9 **A.** I think the main one would be to -- when I reflect back  
10 to March 2020, NICE had a position in the health system  
11 as producing guidelines and everybody understood what  
12 that meant and what a guideline was and it would take 12  
13 to 24 months. When we were asked to rapidly pivot and  
14 produce guidelines within often five working days to  
15 fourteen working days I think we could have been more  
16 prepared, had we been more involved in the emergency  
17 response infrastructure, if you will.

18 And again, one of the lessons learned that we've  
19 put into practice is that our chief medical officer is  
20 now part of the national emergency preparedness,  
21 resilience and response clinical reference group, which  
22 is good, and it's acting more as a system, I think, as  
23 early as possible and I think the product would have  
24 been better and the advice and guidance we gave would  
25 have been better.

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1 **MR MILLS:** Dr Chrisp, thank you.  
 2 My Lady, that's all I ask.  
 3 **LADY HALLETT:** Thank you very much.  
 4 Mr Puar.  
 5 He's behind the pillar. Don't know if you can see  
 6 him.

7 **Questions from MR PUAR**

8 **MR PUAR:** Good afternoon, Dr Chrisp.  
 9 **A.** Good afternoon.  
 10 **Q.** I asked questions on behalf for Covid-19 Bereaved  
 11 Families for Justice Cymru who are a group of bereaved  
 12 families in Wales and the members of the group are  
 13 particularly concerned about the inconsistent  
 14 application of DNACPR policies.  
 15 So my first question is in relation to the  
 16 guidelines that we've already looked at, the NG159  
 17 guidelines.  
 18 Upon reflection, do you accept or would you like  
 19 to comment as to whether the guidelines themselves gave  
 20 clinicians too wide a discretion to make DNACPR  
 21 decisions without taking into account the wishes and  
 22 feelings of the patient and/or their family and/or  
 23 failed to refer the reader to local policies that were  
 24 place?  
 25 **A.** So the intent of the guideline was to support normal  
 93

1 doesn't normally produce guidance on professional  
 2 standards or conduct.  
 3 But I think any topic should be looked at through  
 4 that prioritisation lens and that's how NICE would make  
 5 that decision, should it be referred to the  
 6 organisation.  
 7 **MR PUAR:** Thank you, Dr Chrisp, those were the questions  
 8 I had.

9 **LADY HALLETT:** Thank you, Mr Puar.  
 10 Mr Weatherby.

11 **Questions from MR WEATHERBY KC**

12 **MR WEATHERBY:** Just one very discrete and short topic from  
 13 me on behalf of Covid-19 Bereaved Families for Justice  
 14 UK, Dr Chrisp.  
 15 In April 2020 NICE issued guidance with respect to  
 16 target oxygen saturation levels with respect to the  
 17 range for the most acutely ill patients and it reduced  
 18 the target saturation level from 94 to 98% which was the  
 19 standard pre pandemic. First of all, down to 92-96% and  
 20 then down to 90-94% and that was because of a shortage  
 21 of oxygen, wasn't it?  
 22 **A.** So that particular piece of guidance that you're  
 23 referring to was an NHS England piece of guidance that  
 24 was published on the NICE website so it wasn't a NICE  
 25 piece of guidance.  
 95

1 ethical decision-making and that shouldn't have changed  
 2 due to Covid-19. We expected clinicians still to  
 3 exercise their clinical judgment and in consultation  
 4 with patients, their carers, and families. So  
 5 I think -- you asked the question too much discretion.  
 6 I would say that discretion is part of reaching  
 7 a DNACPR. It should be individualised, it should be  
 8 person-centred.  
 9 **Q.** Thank you. And do you think that NICE could or should  
 10 develop a DNACPR quality standards guideline with  
 11 significant contribution of patient care involvement so  
 12 that a uniform standard can be adopted in the UK, and  
 13 effectively end -- and so that end-of-life care is less  
 14 a postcode lottery and, if so, what challenges would  
 15 that task pose?  
 16 **A.** So as I mentioned earlier, topics are referred to NICE  
 17 through NHS England and the Department of Health and  
 18 Social Care and they are then assessed by  
 19 a prioritisation panel within NICE and which guidelines  
 20 are taken forward depends on a number of factors,  
 21 including whether the guidance is within NICE's remit,  
 22 whether there's a gap in a portfolio or significant  
 23 unwarranted variation. I think the answer to your  
 24 question would primarily fall within: does it fall  
 25 within NICE's remit? And to that I would say NICE  
 94

1 **Q.** Okay. You refer to it in your table 4 at page 59 to 60.  
 2 But my question, is it right? If you don't know  
 3 obviously say you don't know but --  
 4 **A.** I don't know, I'm sorry.  
 5 **Q.** You don't know, I won't ask you any more then. Except  
 6 for, do you know that the guidance then went back up to  
 7 the pre-pandemic level or not?  
 8 **A.** I'm sorry, I don't know.  
 9 **MR WEATHERBY:** Thank you very much.  
 10 **LADY HALLETT:** Thank you, Mr Weatherby.  
 11 Ms Hannett -- over that way.

12 **Questions from MS HANNETT KC**

13 **MS HANNETT:** Dr Chrisp, I ask questions on behalf of the  
 14 Long Covid groups.  
 15 Can I ask you, first, please, about the  
 16 development of the guidelines on the management  
 17 long-term symptoms of Covid-19, the Long Covid guidance.  
 18 Do you agree that there was time lost in starting to  
 19 prepare guidelines between July 2020, when SIGN first  
 20 proposed the idea to NICE, and October 2020 when NICE  
 21 agreed to work with SIGN and RCGP on the guidelines,  
 22 since treating clinicians were dependent on the  
 23 guidelines to inform their response to Covid-19?  
 24 **A.** So to produce a guideline we wait for a referral from  
 25 NHS England or The Department of Health and Social Care  
 96



1 and the referral came in on 30 September. So if we'd  
 2 have received it earlier we would have started earlier.

3 **Q.** Thank you. And I was going to ask you about Long Covid  
 4 in children and young people. And there were no  
 5 guidelines issued for Long Covid in children  
 6 in December 2020 when the NICE guidelines were first  
 7 published and it wasn't until November 2021 that the  
 8 NICE guidelines were reviewed with evidence on children  
 9 and young people. Again, do you agree that there ought  
 10 to have been some information on care and support for  
 11 children and young people earlier than November 2021?

12 **A.** So I think the scope -- I know the scope included  
 13 children and young people in the update that you refer  
 14 to in November 2021, and had there been information in  
 15 the first version I think we would have included it as  
 16 well. I'm sorry, I can't recall if children and young  
 17 people were included in the scope of the first guideline  
 18 we've produced in December 2020.

19 **Q.** Is it right, then, that you weren't then asked to review  
 20 it until November? There was no -- why were they not  
 21 then included in the revisions whether -- if it was  
 22 included in the scope originally, why were they then not  
 23 included in the revisions between December 2020 and  
 24 November 2021?

25 **A.** So we conducted a review in November 2021 that, was the  
 97

1 knowledge base increases there is always a point where  
 2 there might be a trigger to update the recommendations  
 3 we make.

4 So as I said, the guideline has research  
 5 recommendations because we were unable to make them  
 6 in November 2021, around the clinical effectiveness of  
 7 exercise and whether exercise rehabilitation assists in  
 8 improving symptoms. So there may be evidence and  
 9 knowledge on that which may be able to trigger an update  
 10 but, again, I'm not familiar with that, I'm not close to  
 11 the subject but if there was, that could be taken into  
 12 account in an update of the guideline.

13 **Q.** And can you just on that, on the -- a follow-up question  
 14 on that, can you explain why there hasn't been any  
 15 substantive update to the guidelines  
 16 since November 2021? You've just described there's been  
 17 quite a lot of knowledge and expertise that's developed  
 18 since then and yet there's been no revision since  
 19 November 2021. Can you help the Inquiry with why  
 20 that is?

21 **A.** Yes, I'll try. NICE has a portfolio of, I think, about  
 22 350 guidelines, all of which need to be kept up to date,  
 23 as well as new topics coming in and the decisions to  
 24 produce new guidance or update whole guidelines or  
 25 sections of guidelines is taken through this  
 99

1 first opportunity we had to do a complete review of the  
 2 guideline, and that included symptoms, referral, and  
 3 management, because there'd been a lot of new experience  
 4 and evidence from people suffering from these awful  
 5 debilitating symptoms.

6 **Q.** And were you not asked to do a review before then?

7 **A.** No.

8 **Q.** Can I just ask you then about post-exertional malaise?

9 **LADY HALLETT:** Just before you do, Ms Hannett, could you  
 10 make sure, Dr Chrisp, that your answers go into the  
 11 microphone, I'm sorry.

12 **A.** Sorry.

13 **LADY HALLETT:** That's all right. It is easily done to look  
 14 towards the questioner.

15 **MS HANNETT:** I am sorry, Dr Chrisp, I'm not ideally located  
 16 to ask you questions.

17 Would you agree with Professor Brightling and  
 18 Professor Evans who gave evidence yesterday that  
 19 clinicians would now be assisted with clear advice on  
 20 post-exertional symptom exacerbation in the guidelines  
 21 on treating long-term symptoms of Covid-19?

22 **A.** I think there's a research recommendation in the  
 23 guideline for what's the clinical effectiveness of  
 24 exercise interventions, so the Long Covid guideline is  
 25 under continual surveillance and as evidence and the  
 98

1 prioritisation panel that makes a decision on where we  
 2 should be placing our resources as to which guideline to  
 3 update on what sort of timeline. So it is one guideline  
 4 amongst many that NICE needs to consider where it  
 5 prioritises its efforts to update depending on need, the  
 6 variation in care, impact on people and impact on the  
 7 quality of the care they're receiving.

8 **Q.** Can I just ask you, though, what about the living  
 9 guidelines though, Dr Chrisp, that are meant to be  
 10 consistently updated and why hasn't that process been  
 11 applied to the Long Covid guidelines?

12 **A.** So, again, it's a case of whether or not the team has  
 13 found the evidence to trigger an update and I'm  
 14 surmising that they feel that they haven't.

15 **Q.** But you don't know?

16 **A.** I don't know. I've been out of the organisation for  
 17 several months now.

18 **MS HANNETT:** Thank you, my Lady.  
 19 Thank you, Dr Chrisp.

20 **LADY HALLETT:** Thank you, Ms Hannett.  
 21 I think that concludes all the questions for you,  
 22 Dr Chrisp. Let me just check.

23 **MR MILLS:** That's right, my Lady.

24 **LADY HALLETT:** It does. Thank you very much for coming out  
 25 of retirement to help and I'm very grateful for your  
 100

1 assistance and for your frankness where you thought  
2 something may have gone wrong, and for being open with  
3 the Inquiry. Thank you.

4 **THE WITNESS:** Thank you.

5 (The witness withdrew)

6 **LADY HALLETT:** Ms Carey.

7 **MS CAREY:** My Lady, the next witness is  
8 Professor Helen Snooks.

9 **PROFESSOR HELEN SNOOKS (affirmed)**

10 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**

11 **LADY HALLETT:** I see you're still suffering.

12 **A.** Yes.

13 **LADY HALLETT:** I hope your recovery is continuing.

14 **A.** Yes, thank you.

15 **MS CAREY:** Your full name, please.

16 **A.** Helen Ann Snooks.

17 **Q.** I think you have a copy of your expert report in front  
18 of you, ending 474285, but I suspect it might be easier  
19 to put on screen any passages that we need to look at to  
20 save you rifling through it.

21 **A.** Thank you.

22 **Q.** A little bit about you. You are a professor of health  
23 services research, with over 30 years' experience in the  
24 fields of emergency and unscheduled care, and  
25 particularly experience in emergency pre-hospital care.

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1 and I think you set out in your report that calls to 999  
2 are categorised by their urgency. And am I right in  
3 thinking that in England and Northern Ireland there are  
4 categories 1 to 4 and in Scotland and Wales they are  
5 colour coded but essentially four colour schemes, all of  
6 them in common have the most life threatening and  
7 serious as their first category, if I can put it like  
8 that, and all of them have at the bottom end perhaps the  
9 less urgent category, those who have tripped over or  
10 have got vomiting, matters like that.

11 I'm not going to go through the precise niceties  
12 of each of the different categorisations but one can  
13 understand the need to categorise the calls depending on  
14 how urgent the call is?

15 **A.** Yes, in order to provide a speedy response to the most  
16 urgent calls and to provide a less -- a slower response,  
17 not such a speedy response, to those that don't require  
18 it.

19 **Q.** Yes. And I think the category of the call then  
20 determines the response time target and each of those  
21 vary by nation and each of those vary by category?

22 **A.** Yes.

23 **Q.** All right. Now that is all set out in the report, if  
24 people want to descend to the detail. We may touch on  
25 one or two response times as we go through your

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1 You are primarily a methodologist and, is this  
2 right, you're not a clinician?

3 **A.** That's right.

4 **Q.** You haven't worked for an ambulance service?

5 **A.** I have worked for an ambulance service. So I have  
6 worked between universities and the ambulance service,  
7 and in the 1990s I was based at the London Ambulance  
8 Service, and employed by the London Ambulance Service as  
9 clinical audit and research manager from 1995 to 1999.

10 **Q.** Thank you very much for clarifying that. You are  
11 a researcher though and you have been the editor for the  
12 National Institute for Health and Care Research for over  
13 ten years and have recently taken on the role of senior  
14 editor for the National Institute for Health and Care  
15 Research?

16 **A.** Yes.

17 **Q.** You were instructed by the Inquiry to look at two  
18 different matters: emergency pre-hospital care and the  
19 efficacy or otherwise of the shielding programme. And  
20 I'd like to concentrate on the former for this reason,  
21 Professor, since you were unable to join us a few weeks  
22 ago we've heard a lot of evidence about shielding so I'm  
23 hoping I can take that a little more quickly than  
24 otherwise I would have done. All right?

25 Can we start then, please, with pre-hospital care,  
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1 evidence.

2 Can I ask you, please, though about clinical  
3 decision support software and the systems that are used  
4 across the UK ambulance services.

5 **A.** Just.

6 **LADY HALLETT:** Sorry, just before you go on, I'm terribly  
7 sorry, I meant to ask a question.

8 In relation to categorisations, so you get  
9 categorised as 1, obviously you are top priority. If  
10 you get categorised as 2, and I confess here I'm  
11 speaking from personal experience, does it make any  
12 difference to your categorisation even if you wait  
13 for hours because more category 1 calls have come in?

14 **A.** No, it doesn't make any difference. If you called back  
15 your categorisation could change because your symptoms  
16 may have worsened, so you could actually be put into  
17 a higher category. But the -- no, it doesn't change  
18 from what you've said, you're in that category until the  
19 ambulance is available to come to you. And as Ms Carey  
20 said, there are response time targets associated with  
21 each category. But they're not always met.

22 **LADY HALLETT:** I was going to say, that's what made me ask  
23 the question about whether if your time target hadn't  
24 been met did it make any difference to your  
25 categorisation. But not unless your symptoms worsened.

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1 Thank you.  
 2 Sorry to interrupt.  
 3 **MS CAREY:** Not at all.  
 4 The different pathways that are used by the  
 5 ambulance services, there are two. One is known as the  
 6 Advanced Medical Priority Dispatch System (AMPDS) and  
 7 the other one is NHS Pathways. But can you just give us  
 8 an overview of what those pathways are designed to  
 9 achieve.  
 10 **A.** So these are the -- they're the computerised software  
 11 used by the call takers, so the people that answer the  
 12 999 calls, to assign those priority categories. And  
 13 they go through a set of questions which -- they are  
 14 slightly different, so AMPDS is more structured than  
 15 NHS Pathways, but they are aiming to do the same thing:  
 16 to find a way -- well, to put people into the  
 17 appropriate category for their need.  
 18 **Q.** So, for example, you might be asked straight away: is  
 19 the patient breathing? A pretty clear indication of how  
 20 severe or otherwise. And then the pathways will depend  
 21 on which one is being used and the questions that are  
 22 asked to elicit the right response?  
 23 **A.** Yes. Yes.  
 24 **Q.** All right. Understood. I think, pre-pandemic, was  
 25 there any evidence being conducted of how accurate or  
 105

1 accessing emergency care in business as usual, so  
 2 pre-pandemic, times, and I won't go through the various  
 3 steps but, in short, obviously if you ring 999 you go  
 4 through to an emergency operation centre, then the call  
 5 handler takes you through the questions to determine how  
 6 urgent the response is, and then the call gets processed  
 7 to a dispatcher; is that correct?  
 8 **A.** Yes. Each ambulance service also has a clinical desk so  
 9 if further advice is required, the call taker, the call  
 10 handler, who is non-clinical, can pass it over to -- for  
 11 clinical advice. This existed even pre-pandemic. And  
 12 then, yes, it gets sent on it a dispatcher to  
 13 operationalise the response from the ambulance or  
 14 whatever.  
 15 **Q.** And then the ambulance gets dispatched and attends the  
 16 scene or the home or wherever it may be. Ordinarily, is  
 17 this the position, an ambulance will have two crew  
 18 members, usually one paramedic, who is educated to  
 19 degree level, and, indeed, one emergency medical  
 20 technician, who has done a slightly shorter period of  
 21 training?  
 22 **A.** Yes, that's the ideal. It doesn't always happen that  
 23 way. Sometimes you might get two EMTs, the more basic  
 24 level crew, together, and sometimes you might get two  
 25 paramedics, but ideally there's one paramedic and one  
 107

1 otherwise those two pathways were?  
 2 **A.** There has been some research published over the last,  
 3 I would say, 20 or 30 years, but there wasn't an awful  
 4 lot of recent evidence. And it wasn't -- I wouldn't say  
 5 it was definitive, but -- and a lot of ambulance  
 6 services have been carrying out their own audits and  
 7 quality improvement exercises because they have not all  
 8 selected the same system, so there has been quite a lot  
 9 of work going on to understand.  
 10 And there's a completely different financial cost.  
 11 So the AMPDS is a commercial -- a company that's paid  
 12 for, we've a contract for that, whereas NHS Pathways has  
 13 been derived from within the NHS, in the UK.  
 14 **Q.** Do you know whether there was any evidence conducted  
 15 into those pathways as to whether the algorithms might  
 16 have produced unequal results for patients?  
 17 **A.** I'm not aware of that.  
 18 **Q.** So one can't say: well, AMPDS is better at diagnosing  
 19 this and you get a better response time with that  
 20 pathway as opposed to NHS Pathways?  
 21 **A.** No. And that -- I don't think ambulance services would  
 22 have been choosing both if that was the case. So  
 23 they've been really choosing both based on other  
 24 decisions, other factors.  
 25 **Q.** Now, your report sets out at paragraph 9 the process to  
 106

1 EMT.  
 2 **Q.** Right.  
 3 **A.** But I would just say that not every call will receive  
 4 the dispatch of an ambulance. Some calls will end  
 5 with -- the 999 call -- with other advice, self-care  
 6 advice.  
 7 **Q.** See a GP?  
 8 **A.** A "no send", yes.  
 9 **Q.** Understood. And then the ambulance crew attends, the  
 10 decision is made with the patient about whether to  
 11 convey the patient to hospital, and then, depending on  
 12 how urgent it is, various notifications go through to  
 13 the hospital?  
 14 **A.** Yes.  
 15 **Q.** Can I ask you about the metrics, or the performance  
 16 metrics as they're called, for ambulance response times  
 17 and your paragraph 10.  
 18 Perhaps if we could call up on screen, please,  
 19 INQ000474285\_8 and 9.  
 20 I think people will see now why we haven't  
 21 descended to the detail of all of the different  
 22 categories. But I want to pick the most serious  
 23 category for each of the nations so we can understand  
 24 where we were pre-pandemic.  
 25 In England, is this right, since 2018, if the call  
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1 to 999 is categorised as 1, being life threatening, so  
 2 someone has had a cardiac arrest or respiratory arrest,  
 3 target response time is 7 minutes. Is that 7 minutes  
 4 till the ambulance arriving at the patient?  
 5 **A.** Yes, from the call to arriving at the patient. And  
 6 that's on average.  
 7 **Q.** Right. And 90% of the calls must be responded to within  
 8 15 minutes?  
 9 **A.** Yes.  
 10 **Q.** That gives us an indication of how truly life  
 11 threatening category 1 calls are.  
 12 **A.** Yes.  
 13 **Q.** And I think in Northern Ireland, if we just go down to  
 14 paragraph 12, please, similar category 1 in  
 15 Northern Ireland, response time there is 8 minutes?  
 16 **A.** Yes.  
 17 **Q.** In Scotland, their most serious category I think is  
 18 purple; is that correct?  
 19 **A.** I believe so.  
 20 **Q.** And if we look at page 9, there's some bullet points on  
 21 page 9 -- thank you very much -- in Scotland, the purple  
 22 category are based on the median times. 6 minutes  
 23 there, and 90% of the calls have to be responded to in  
 24 15 minutes.  
 25 **A.** 95% it says.

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1 **A.** NHS 24 is the service, and it's operated by -- I'm not  
 2 sure but it's not the ambulance service. Whereas 111  
 3 services are often, not always but often, operated by  
 4 ambulance services in England, Wales and  
 5 Northern Ireland.  
 6 **Q.** All right. But if I understand it correctly, certainly  
 7 by the time we were in the pandemic, all four nations  
 8 were operating not only 999 but a 111 type service?  
 9 **A.** Yes.  
 10 **Q.** All right.  
 11 And 111, is that a service that also relies on  
 12 algorithms to talk through the level of care and the  
 13 kind of advice that might be needed to be given to the  
 14 patient?  
 15 **A.** Yes, absolutely.  
 16 **Q.** And in 111, again, is the call handler not clinically  
 17 qualified but, where necessary, the caller can get  
 18 a call back, a nurse or a paramedic?  
 19 **A.** My understanding is that varies between service. And  
 20 I know in the past they've -- I'm not familiar with the  
 21 current situation. In the past there have certainly  
 22 been some services which have provided that call taking  
 23 facility with a clinical -- a clinically trained call  
 24 handler. So it has varied by service.  
 25 **Q.** But generally speaking, two different ways now people

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1 **Q.** Yes, 95%, thank you, not 90.  
 2 And finally, in Wales, red calls they're called in  
 3 Wales, set response standard:  
 4 "65% of ... [the] calls are expected to have  
 5 an emergency response ... within 8 minutes."  
 6 So I think it's 6 to 8 minutes roughly, depending  
 7 where you are in the UK --  
 8 **A.** Yes.  
 9 **Q.** -- for an urgent call?  
 10 **A.** Yes.  
 11 **Q.** All right. Now, I've set that as a base so we can see  
 12 then what happened potentially during the pandemic.  
 13 That's clearly if you're calling 999. Can I ask you  
 14 about 111, please. And are you able to help us, what is  
 15 the purpose of 111 services?  
 16 **A.** The purpose of 111 is to provide healthcare advice and  
 17 information to anybody, for free, by telephone. They  
 18 also provide online services.  
 19 **Q.** Is it for non-urgent calls, urgent calls, everything?  
 20 **A.** Everything and anything, yeah.  
 21 **Q.** All right. And I think there is 111 in England and  
 22 Wales, and during the pandemic it was rolled out in  
 23 Northern Ireland; is that correct?  
 24 **A.** I believe so, yes.  
 25 **Q.** And in Scotland it is operated by someone called NHS 24?

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1 can ring if it's really urgent or ring 111 if there may  
 2 be some doubt in their mind about how urgent. But  
 3 I think you make this point: if you ring 111 and it's  
 4 urgent you can be transferred to 999.  
 5 **A.** Yes.  
 6 **Q.** Understood.  
 7 **A.** Sometimes they're in the same room, literally.  
 8 **Q.** You make the observation that you have less direct  
 9 expertise and knowledge of preparedness but, based on  
 10 your research, the preparedness for 999 and 111 service  
 11 prior to the pandemic had predominantly been placed  
 12 around major incidents as opposed to a nation-wide  
 13 pandemic; is that right?  
 14 **A.** That's my understanding but I haven't done direct  
 15 research of my own in that area.  
 16 **Q.** Now I'd like to ask you, please, about what is called  
 17 "Protocol 36".  
 18 And can you help us in layman's terms, if I may  
 19 put it like that, what was Protocol 36?  
 20 **A.** So Protocol 36 was a specific protocol that was added in  
 21 or brought into use within the pandemic to assess calls  
 22 of patients with or patients with suspected Covid  
 23 infection. So it was noted very early on in the  
 24 pandemic that the generic priority, assisted priority  
 25 dispatch system, AMPDS, did not have a specific protocol

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1 for dealing with the pandemic situation. And there was  
2 that protocol available but it wasn't in regular use.  
3 So it was brought in and introduced in, I believe,  
4 early April of 2020. That was to services that used  
5 AMPDS. And NHS -- services that used NHS Pathways, the  
6 other priority dispatch system, developed their own  
7 tailored protocol for responding to suspected Covid-19  
8 calls.

9 **Q.** So this was to really try to help the ambulance services  
10 work out who did or may have Covid-19?

11 **A.** It was in order to assess their need for the response to  
12 that. So it was a specific way of asking questions to  
13 callers with suspected -- with symptoms that might be  
14 Covid-19, to assess those specific symptoms in need --  
15 in terms of their need for an emergency response. Which  
16 it was felt that the generic system wasn't able to do,  
17 was under -- not taking enough account of specific  
18 symptoms that were coming up in Covid-19.

19 **Q.** Can I perhaps put it another way. If someone is ringing  
20 up saying they have a cough, they have a fever, they've  
21 lost their sense of smell or sense of taste, it might be  
22 difficult for the ambulance service to work out how  
23 serious or otherwise the symptoms were. Was Protocol 36  
24 designed to try to work out: this person might have  
25 Covid and might need to go to hospital?

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1 patients is absolutely key to the provision of care to  
2 patients in an emergency. And it might be easy to  
3 think, well, why not just send the highest response to  
4 everybody, but that carries its own risks. So it's very  
5 important to not over-respond to people because that  
6 puts the whole system under pressure, as well as if the  
7 patient, for instance, has Covid-19 but does not need  
8 emergency transportation to hospital then it's exposing  
9 more people to the risk of transmission and the  
10 ambulance crew as well.

11 So I just wanted to preface that because I think  
12 people might think, well, why not just send the top  
13 response to everybody. But that's risky in its own way.

14 So it's very important to not over-respond or  
15 under-respond and to try to sort out which patients are  
16 needing this highest level of response. That inevitably  
17 means that whilst trying to not over-respond, sometimes  
18 the services will under-respond.

19 The research shows that those using card --  
20 Protocol 36, those instances of under-response, when the  
21 patient wasn't given enough priority were relatively  
22 rare. They did happen but they were relatively rare.  
23 But this was kind of at the cost of over-response to  
24 quite a lot of patients.

25 **Q.** We might look at some of the detail, but that just gives

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1 **A.** Yes, it was precisely to understand, in the context of  
2 Covid-19, when the need for the emergency response --  
3 what priority should that patient be given in a specific  
4 circumstance.

5 **Q.** And I think you say in your report that, in fact, this  
6 protocol had been around since -- was developed in the  
7 time of swine flu and was brought back in then -- into  
8 play during the Covid pandemic.

9 **A.** It's sometimes called "card 36". If you see that,  
10 it's ...

11 **Q.** Can I just ask you the sort of bald question. Given  
12 that that was its aim, was to work out if you had Covid,  
13 and if so if you needed an emergency response, in  
14 general terms are you able to say whether Protocol 36  
15 actually achieved its aim?

16 **A.** So I don't think it was to work out if the patient had  
17 Covid-19, it was to understand, if they thought they  
18 might have Covid-19, what was the response required.  
19 How well it performed that function does come up in  
20 other parts of the report through research that was  
21 carried out.

22 **Q.** Are you able to give us an overview before perhaps we  
23 descend to some of the detail?

24 **A.** Yes. So, overall, I think I just need to say that  
25 triage or sorting patients out and the priority of

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1 a sort of overview of what it was aimed to do and the  
2 pros and cons, if I may put it colloquially, of what the  
3 service is trying to achieve.

4 **A.** Yes.

5 **Q.** Can I ask you, before we look at that, about some trends  
6 in 111 and 999 use during the pandemic. And I think you  
7 and a number of your colleagues conducted a survey of  
8 all the UK ambulance services and received data from  
9 12 of the 13 ambulance services?

10 **A.** Yes.

11 **Q.** And what was the aim of the survey that you were  
12 conducting which I think you did from February to  
13 June 2020?

14 **A.** We wanted to gain a snapshot picture of what was the  
15 volume of demand, what was the pressure on ambulance  
16 services overall and also in terms of Covid-related  
17 calls, and what was the effect on their response times,  
18 and also we asked all the services about what changes  
19 had they implemented during that period.

20 So it was partly about providing us with  
21 statistics, which weren't routinely available, and it  
22 was partly about asking them, well, what happened in the  
23 control room and how did you change practice during that  
24 period?

25 **Q.** 12 of the 13 ambulance services across the UK responded.

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1 It was Northern Ireland that did not reply as  
 2 I understand it. So you just don't know whether they  
 3 had the data and didn't give it to you or they just  
 4 didn't have a chance to get around to replying to you.  
 5 **A.** Yes.  
 6 **Q.** But can we have a look at the call volumes, I think you  
 7 say that the highest proportions of suspected Covid-19  
 8 calls were all recorded in the weeks of 23 or 30 March.  
 9 We went into lockdown on the 23rd. And then we get the  
 10 calls here on screen identified as suspected Covid-19 by  
 11 the ambulance services and it's -- you haven't named  
 12 them but we can see there are 12 and they are given in  
 13 different colours and lines.  
 14 But if we look at, along the bottom, at around the  
 15 23 March, 30 March, 6 April, and we track up -- and it  
 16 may be that our evidence handler can add an arrow, but  
 17 you can see, going up the page, a huge spike, certainly  
 18 for ambulance service 3 -- thank you -- on receiving,  
 19 where we were, a relatively low number of calls  
 20 in February up to nearly 20,000 calls in 23rd and  
 21 30 March?  
 22 **A.** Yes. I mean, I think it's obvious from here that the  
 23 peaks of demand in terms of Covid-related calls did not  
 24 hit each ambulance service at the same time. So whilst  
 25 there is that overall generalised spike there, and

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1 report that from February 2020 the public were  
 2 encouraged to ring 111 as their first point of contact  
 3 and so I just want to bear that in mind when we look at  
 4 what happened with the calls in relation to that, but  
 5 I think you say there were huge increases in 111 demand.  
 6 In England, and if we could have up on screen  
 7 page 17 and figure 4, this is the number of calls to 111  
 8 that were either abandoned, answered within 60 seconds  
 9 or answered in over 60 seconds, and it's in the millions  
 10 down the left-hand side of the graph. So we can see as  
 11 we start very early on, 2014, roughly relatively stable  
 12 numbers and then if we go to the huge spike there  
 13 in March/April 2020 there was, I think, 1.5 million  
 14 calls in January 2020 and it spikes to just over  
 15 2.5 million calls going to 111 in March 2020. And is  
 16 this right, over 1.1 million of those calls were  
 17 abandoned?  
 18 **A.** Yes.  
 19 **Q.** And only 30% were answered in 60 seconds?  
 20 **A.** Yeah.  
 21 **Q.** So having told the public to ring 111 as their first  
 22 point of contact --  
 23 **A.** Yeah.  
 24 **Q.** -- 1.1 million out of over 2.5 million were abandoned at  
 25 some stage during the call.

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1 I think ambulance service 3 is here in London, but there  
 2 were other services where the peak hit a bit later, and  
 3 there were some services which were not affected by that  
 4 massive peak in the same way. So it was very different  
 5 between services and over time. Reflecting the  
 6 transmission and spread of the pandemic across the  
 7 country at that time.  
 8 **Q.** Acknowledging all of those comments, though, clearly  
 9 a huge jump, if one takes ambulance service 3 there, and  
 10 do you know whether there were sufficient call handlers  
 11 to be able to deal with spikes like that? Has there  
 12 been any research done to understand whether we were  
 13 ready for it, if I can put it that way?  
 14 **A.** At that point I'd say no, not for a huge change like  
 15 that. I mean, that was like New Year's Eve every day  
 16 and so the London Ambulance Service put into place the  
 17 New Year's Eve protocol of when to send, when to not  
 18 send, and to calling back to tell people there was not  
 19 an ambulance service available. But that was more  
 20 extreme than anywhere else. There were definitely  
 21 shortages of call handlers at a point, yes.  
 22 **Q.** And this is calls to 999?  
 23 **A.** This is 999 calls and it's just the Covid-19, suspected  
 24 Covid-19 calls.  
 25 **Q.** Looking at 111, I think you make the point in your

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1 I think you say there was a similar pattern in  
 2 Wales to that demonstrated in England, and although not  
 3 quite the same data in Scotland -- could we call up on  
 4 screen INQ000474258\_33 -- NHS 24 did provide some data.  
 5 It's not quite in the same format but if we see there  
 6 these are the calls offered, calls answered and the  
 7 average time to answer. Beginning of March 2020, 8,157  
 8 calls, 6,249 of which were answered. Average time in  
 9 about 10 seconds.  
 10 And if we go down to 23 March, up to 12,000 calls,  
 11 only 3,324 of which were answered, and it's gone from  
 12 being answered in 10 seconds to an average answer time  
 13 of 1 hour, 11 minutes and 34 seconds.  
 14 So significant pressures on 111?  
 15 **A.** Yes.  
 16 **Q.** I think, can I just deal with Northern Ireland. Did you  
 17 have the data for 111 in Northern Ireland?  
 18 **A.** I don't think we did. Is it not in the report?  
 19 **Q.** No, it's not.  
 20 **A.** No, we weren't able to retrieve that.  
 21 Could I just say that we were only -- for this  
 22 report only accessing data that was already in the  
 23 public domain. So we weren't doing any sort of request,  
 24 new request for data. So if we couldn't find it we  
 25 haven't reported it.

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1 **Q.** Can I stick with 999 and 111 calls, having looked at the  
2 various peaks of them, and just try to understand the  
3 impact that the peaks were having on the quality and the  
4 safety of 999 and 111 calls during the pandemic. And  
5 perhaps we'll deal with that as a section and then come  
6 back to some other matters.

7 If it helps you, can we call up on screen page 22  
8 of INQ000474285.

9 And I'd like your help, Professor, with this  
10 section of your report. You've explained why triage is  
11 important and I think you set out here that there was  
12 a study. It was originally designed after the flu  
13 pandemic but was hibernated and so therefore woken up  
14 during March 2020.

15 Help us with what the PRIEST study was set out to  
16 analyse, please?

17 **A.** So the PRIEST study was looking at both calls to 999 and  
18 the 111 services that were categorised as potentially or  
19 suspect Covid-19 and was able to link those calls to  
20 outcomes to find out what was the accuracy of  
21 prioritisation really in terms of dispatch of  
22 an ambulance or conveyance to hospital for the 999, and  
23 for 111 the advice that was given, whether it was  
24 self-care advice or whether it was advice to seek  
25 further care to understand the accuracy of those  
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1 died or needed major organ support?

2 **A.** Yeah, this is the definition used in this paper -- well,  
3 there's two papers, one for 999 and one for 111 but they  
4 used the same definition.

5 **Q.** And so where it says "The risk of adverse outcome was 3%  
6 in adults calling NHS 111", what does that actually mean  
7 in lay terms?

8 **A.** So it means 3% of people that called 111 and were  
9 categorised as having suspected Covid-19, ended up at  
10 30 days having died or needed major organ support.

11 **Q.** If I follow you then, 11% of the adults that rang 999  
12 either died or needed major organ support and 17.6% of  
13 those who were taken to hospital by ambulance either  
14 died or needed major organ support.

15 **A.** Yes.

16 **Q.** They're just the bare facts, if I can put it like that,  
17 but what does it actually tell us about how 111 and 999  
18 was operating and how safe or otherwise it was?

19 **A.** Well, very broadly, there's an indication that there's  
20 some kind of appropriate triage going on there, that --  
21 and although there were adverse outcomes for people that  
22 had called 111, they were at a lower rate than people  
23 that had called 999 and then with -- in terms of the  
24 999 response, that that was a lower -- it was a higher  
25 rate again of people that were taken to ambulance --  
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1 categorisations, whether they were working well.

2 **Q.** I think it's just analysing data from one ambulance  
3 service; is that correct?

4 **A.** Yes, it's from the Yorkshire Ambulance Service and it's  
5 for a fairly restricted period of time between April  
6 and June 2020.

7 **Q.** Even with that caveat to one side, one can see there  
8 they're still analysing quite a lot of data from 40,261  
9 adults who contacted that ambulance service alone in  
10 that period of time, 111. There was over twelve and  
11 a half thousand that rang 999. And over seven and  
12 a half thousand adults that went by an emergency  
13 ambulance.

14 **A.** And these have all been categorised as suspected  
15 Covid-19 cases. This is not the whole workload of these  
16 services.

17 **Q.** No, this is just focusing on suspected Covid-19. So if  
18 you rang up because you had had a heart attack you're  
19 not going to be included in this data?

20 **A.** Yeah.

21 **Q.** Right, understood, thank you.

22 Now, can I ask you about your paragraph 61 which  
23 looks at NHS 111. Help us there:

24 "The risk of an adverse outcome ..."

25 Where you refer to that you mean where the patient  
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1 taken to hospital by ambulance had these adverse  
2 outcomes.

3 So in very broad terms that is reassuring.

4 **Q.** Looking perhaps at the detail of paragraph 62 which  
5 focuses on 111, is it most patients who contacted 111  
6 were given either recommendations for self-care or seek  
7 a non-urgent assessment and the adverse outcomes were --  
8 when I say "only", I don't mean it like that, but were  
9 1.3% of people who rang 111 died or needed major organ  
10 support?

11 **A.** Sorry, 1.3% of people that were recommended self-care or  
12 to seek non-urgent assessment.

13 **Q.** Thank you. Right.

14 **A.** So 60% of patients that contacted 111 were recommended  
15 self-care or a non-urgent assessment. In other words,  
16 not referred to the ambulance service or told to go to  
17 the emergency department.

18 And of that 60%, 1.3% had an adverse outcome,  
19 meaning death or organ support at 30 days.

20 **Q.** Right.

21 Are you able to help us with whether that is  
22 a tolerably acceptable percentage of an adverse outcome  
23 or not?

24 **A.** I think it's a judgment call. It is a small proportion  
25 but it's a significant proportion and an important  
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1 proportion. Whether that is inevitable is another  
2 question. Could triage have been better? Maybe but  
3 maybe not. This is not a question that I can answer  
4 directly. This would be -- you might get a different  
5 answer from a different person because it's a judgment  
6 call. And it's also: what is achievable in this  
7 circumstance?

8 So this is not really about whether -- the speed  
9 of response of the ambulance service or whether -- this  
10 is about the decision made using the algorithm, the  
11 computer decision support, as to whether the person,  
12 what did that person need? And of those that were told  
13 they could look after themselves, and usually it says  
14 "call back if symptoms worsen", but of those that were  
15 given that advice then a small proportion did  
16 unfortunately have a very poor outcome.

17 **Q.** And it will be for others to judge whether that's a good  
18 outcome, a bad outcome, one that we accept or one we  
19 think is totally unacceptable. All right.

20 So that's if you rang 111, were recommended  
21 self-care or not to seek urgent assessment, there was  
22 a 1.3% risk of an adverse outcome.

23 If we go to paragraph 63 I think this looks at  
24 those that contacted 999 and you say there most patients  
25 in this study that contacted 999 received an emergency  
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1 attended by an ambulance were taken to hospital. Of  
2 those that were not taken they had a 7.9% risk of an  
3 adverse outcome. So higher again for those that didn't  
4 go to hospital.

5 Again, does that strike you as being out of what  
6 you would have otherwise expected for those patients  
7 that rang 999 but decided for whatever reason not to go  
8 to hospital?

9 **A.** Yes, that's actually a bit more concerning, I would say,  
10 because they've had a face-to-face response from  
11 probably a paramedic and then the decision has been  
12 taken not to take them to hospital and they are at  
13 higher risk of an adverse outcome. So one would have  
14 hoped that would be lower, I think.

15 **Q.** Are you able to opine as to what the reasons might be  
16 for why people were not taken to hospital, given that we  
17 know they had an ambulance response?

18 **A.** So earlier on you did say it's a joint decision and to  
19 some extent it's a joint decision, but I think patients  
20 usually will go with the advice of the ambulance crew  
21 and -- but they could refuse. So the patient could have  
22 refused, the ambulance crew may have advised them that  
23 they didn't need to go to hospital or that there are  
24 a lot of patients queuing outside hospitals in  
25 ambulances as well at this time. So I can't really  
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1 response. 84% it was. Patients contacting 999 who did  
2 not receive an emergency response, so 16% didn't receive  
3 an emergency response, had a 3.5% risk of an adverse  
4 outcome.

5 And, again, I presume the same answer whether  
6 that's a good outcome, bad outcome?

7 **A.** Yeah, I just want to explain that receiving an emergency  
8 response means essentially being sent an ambulance or  
9 some kind of face-to-face -- it could be a motorbike,  
10 but a face-to-face response for assessment face to face.

11 And yes, there's a slightly higher risk here of an  
12 adverse outcome for those that actually did not receive  
13 an emergency response and that might have been for many  
14 reasons they did not receive an emergency response. And  
15 it may have been in this case a lack of a response to  
16 send.

17 **Q.** Right.

18 **A.** But it -- but that also may indicate that people that  
19 called 999 were maybe sicker than people that were  
20 calling 111, which is what you would expect.

21 **Q.** I was going to say, does it seem out of kilter with the  
22 figures of adverse outcome that we looked at for 111  
23 services?

24 **A.** No, it feels, again, what you would expect.

25 **Q.** And then paragraph 64, most patients, 65% who were  
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1 comment on which of those was happening. But it's --  
2 you would like to see a lower rate than -- of that.

3 But it also could be that people deteriorated  
4 later. So at the point that decision -- because this is  
5 a 30-day outcome. So at the point that they were seen  
6 by the ambulance crew maybe they didn't need to go to  
7 hospital. Maybe a week later they needed to. So it's  
8 easy to jump to conclusions, I think, but actually it's  
9 very complex.

10 **Q.** There's a number of reasons why it may be that on that  
11 given day they weren't taken to hospital?

12 **A.** Yes.

13 And they may not have needed to. I think that's  
14 important because people's symptoms were varying and  
15 people did deteriorate very quickly during the pandemic,  
16 so it might have been entirely appropriate on the day.

17 **Q.** Can I ask you about your paragraph 67 which is about  
18 some research undertaken during the pandemic which  
19 identified that:

20 "... 111 triage may have overestimated the  
21 importance of chronic lung disease as predictors of  
22 adverse outcomes and underestimated the importance of  
23 diabetes and repeated calls to the service as predictors  
24 of adverse outcome."

25 A little bit of a mouthful there.

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1 Can you help us, Professor, with what was the  
2 concern you were trying to bring to our attention here  
3 in this paragraph?

4 **A.** So this is the same study, the PRIEST study, and this  
5 is 111 calls. And in addition to looking at how well  
6 did the call outcome, whether it's self-care advice,  
7 referral to 999 or whatever, how well did that match  
8 with then what happened to the patient, they looked at  
9 that and they looked at well, what factors were involved  
10 in that and what factors influenced the outcomes. So --  
11 and they found that the -- that in decision-making that  
12 some factors were given too much priority and other  
13 factors were under-considered.

14 So, for instance, diabetes and more than one call  
15 to the service were found to be actually associated with  
16 poorer outcomes, which they had not known before. So  
17 this information can help with improving the algorithms  
18 and the decision support tools for the future. But that  
19 was -- that's what they found in the PRIEST study and  
20 the 111 calls.

21 **Q.** Do you know having -- the study having reported its  
22 findings, were any changes made to the algorithms to  
23 correct either the underestimate or overestimate?

24 **A.** I don't know but I can't imagine that the timeliness  
25 would have worked for that but I'm not sure.

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1 of policy decision or a clinical policy decision for the  
2 service as to the trade-off really between sending to --  
3 when a patient didn't need that level of response,  
4 and/or not doing that but occasionally missing someone  
5 that does. Just to say that, to remind everybody really  
6 that this is done on the basis of information given over  
7 the phone by non-clinical people, members of the public  
8 calling with information about maybe they're in a very  
9 highly stressed situation and it's not an easy job to  
10 assign that priority.

11 But where the acceptable levels are is not  
12 something I can comment on really.

13 **Q.** You do make the point in paragraph 69 though that  
14 results are not presented by ethnicity which is seldom  
15 coded in the ambulance call centre and often missing on  
16 the scene. Can you help with why there's no coding  
17 either at the call centre or indeed on the scene for  
18 ethnicity?

19 **A.** So we're actually doing a study about this right now.  
20 So this is why we know this in more detail. But I think  
21 to present ethnicity, to get ethnicity data the question  
22 has to be asked. And in the context of a 999 call one  
23 could imagine that that's not the priority to ask --  
24 they're looking -- the call takers are looking for the  
25 priority of the call, and the name and address: where do

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1 **Q.** Whilst we've got this page up on screen, I think at your  
2 paragraph 69 you make reference to false positives and  
3 false negatives certainly lower down the page. Just  
4 help us with what you mean by that, please.

5 **A.** So a false positive is when somebody is allocated  
6 a higher response when they didn't need it. So they  
7 were thought to be in an immediate and life-threatening  
8 situation when they weren't. We call that a false  
9 positive. And whilst that is going to put pressure on  
10 the whole system and you don't want to over-respond to  
11 calls, it's not putting an individual in danger.

12 But the false negative is putting an individual in  
13 danger because it's when a patient who should have had  
14 a high priority is given a low priority and so it's  
15 a false negative and that is -- it happens more rarely,  
16 it doesn't happen as often as the false positives but it  
17 does happen and that's a situation which is dangerous or  
18 lacking safety for the patient.

19 **Q.** I think you're saying there, though, that in fact no  
20 triage tool always gets it perfectly right all of the  
21 time. You say there will always be false positives and  
22 false negatives but you reduce them to what is called  
23 an acceptably low level where the test is worth it  
24 despite the occasional errors?

25 **A.** Yes, and that is actually a decision -- that is a sort

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1 we need to send the ambulance? And other questions are  
2 not generally asked.

3 So whether it should be is another matter but that  
4 is the current situation and I think it's  
5 understandable, but on scene when patients are attended  
6 by ambulance crews there's much more information filled  
7 out and there's an opportunity then, unless the patient  
8 is in a critical situation or unconscious, there's  
9 generally the opportunity to ask for ethnicity. But we  
10 have found that ethnicity data is very, very often  
11 missing.

12 And where -- for instance, we're doing a study now  
13 where an ambulance service told us that we have  
14 ethnicity on 80%, 84% or something of our patients. But  
15 when we came to look at it they were the white British  
16 patients that were marked down with ethnicity. And the  
17 missing ethnicity, there were very, very few other  
18 ethnic groups coded so we assume other ethnic groups are  
19 going into the non-coded -- we can only assume that it's  
20 a reluctance on the part of the ambulance crew to ask  
21 those questions in the emergency situation.

22 **Q.** Do you think it would be helpful, let's take the call  
23 centre out of it because I take your point about it may  
24 be urgent and different priorities, but do you think it  
25 would be helpful if in future there were at least on the

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1 scene ethnicity data recorded?  
 2 **A.** Yes.  
 3 **Q.** And can I then just bring this to -- this section to  
 4 a conclusion and I think you say at your paragraph 78  
 5 that clearly 999 and 111 services were overwhelmed at  
 6 times with great degree of variation depending on which  
 7 service it was. Are you able to help, though, with  
 8 whether 111 effectively reduced the pressure on the  
 9 ambulance services and the emergency departments as was  
 10 the aim by telling people to call 111?  
 11 **A.** I actually think it's impossible to tell that because  
 12 when NHS Direct and then 111 were first introduced that  
 13 was the aim of the services, and it actually seemed to  
 14 generate new demand, and so the extent to which people  
 15 who called 111 would otherwise have called 999 we just  
 16 don't know.

17 **MS CAREY:** My Lady, would that be a convenient moment?

18 **LADY HALLETT:** Yes, certainly. I shall return at 3.10.

19 (2.53 pm)

20 (A short break)

21 (3.10 pm)

22 **LADY HALLETT:** Ms Carey.

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

24 Professor Snooks, can I ask you, please, about two  
 25 other services that were set up in the pandemic to  
 133

1 service, was only started in April, which is why there's  
 2 a zero in that column.

3 It might be easier, Professor, to look on the  
 4 screen if that helps you.

5 **A.** Yes. No, I was looking at the purple still.

6 **Q.** Ah, thank you, feel free to jump in if there's anything  
 7 that you want to add, but we can see for those people  
 8 that ended up being diverted to the CRS in March 2020,  
 9 quite a large number there, 851,000 calls offered,  
 10 answered, 779 of those, abandoned, 38,000, so the  
 11 abandonment rate was 4.5% and, as we can see, CCAS  
 12 wasn't up and running then. There's quite a large  
 13 volume of calls through CRS in March, April and May of  
 14 2020. And I think, did it -- did CRS operate at  
 15 different times which is why we have got periods where  
 16 there's no data?

17 **A.** As I said, I'm sorry, I'm less familiar with this  
 18 service.

19 **Q.** I think it just gives us an overview, really, though, of  
 20 the number of people trying to ring and find out more  
 21 advice and seek assistance in relation to Covid calls.  
 22 And if we just look down the CCAS calls, they were,  
 23 I think, a remote clinical review of patients that then  
 24 directed them on to the most appropriate care and you  
 25 can see there, 62,000 people ringing that in May of 2020  
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1 support NHS 111. We've looked at, obviously, the real  
 2 spike in the number of people calling them and the  
 3 impact that had but I think it's right that you set out  
 4 in your report that there was something called the Covid  
 5 Response Service that was set up, and then another  
 6 service called the Covid-19 Clinical Assessment Service.

7 Can you help me with both of those, what were they  
 8 trying to do and did they achieve it?

9 **A.** So I'm less familiar with these services. I know that  
 10 they varied across the UK so there were different local  
 11 responses and these services set up but in terms of how  
 12 they all fitted together this is not my area of  
 13 expertise.

14 **Q.** Fine. I think you did include in your report, though,  
 15 some of the call volumes that went to both the Covid  
 16 Response Service and indeed the Clinical Assessment  
 17 Service. And correct me if I'm wrong, is this people  
 18 that are ringing 111 and then are diverted again to one  
 19 or other of these two services; is that the aim?

20 **A.** Yes, I also believe 999 were diverted to these services.  
 21 I'm not sure if I'm right on that.

22 **Q.** Okay. I think -- can we look on screen at  
 23 INQ000474285\_21.

24 CRS, the Covid Response Service was set up in  
 25 March 2020, and the CCAS, the clinical assessment  
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1 and then diminishing numbers and varying in numbers  
 2 depending on where we were in the peaks and the waves of  
 3 the pandemic.

4 In your report you make the observation that those  
 5 people working in the emergency operations centres  
 6 providing the immediate response to 999, they were  
 7 trained but not clinically qualified; is that correct?

8 **A.** Yes.

9 **Q.** Ambulance services increased the number of clinical  
 10 advisers to support the increase in the volume and they  
 11 diverted clinically qualified staff from other roles to  
 12 help in that response?

13 **A.** Yes.

14 **Q.** And you say in the Welsh Ambulance Service many clinical  
 15 advisers switched to working from home leading to  
 16 reported increased levels of autonomy but some concerns  
 17 about clinical supervision and support. Are you able to  
 18 expand on that at all, Professor?

19 **A.** Which paragraph?

20 **Q.** Paragraph 53, your page 20. If it helps you, we are  
 21 going to put it up on the screen.

22 **A.** So this is taken from this paper by Brady and Harry.  
 23 I don't think I can further comment on that.

24 **Q.** So you wouldn't be able to help with what clinical  
 25 supervision was provided to the workers at home or  
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1 anything of that nature?  
 2 **A.** No, or how it differed from what they would get if they  
 3 were in the call centre.  
 4 **Q.** That was the other question I was going to ask.  
 5 **A.** Sorry.  
 6 **Q.** I fear you won't be able to help. All right.  
 7 Perhaps a topic you will be able to help us with,  
 8 Professor, is the trends in ambulance responses and  
 9 handovers. And it starts at your paragraph 79. And  
 10 clearly, you say, response times were variable at the  
 11 start of the pandemic. People will be familiar with  
 12 delays to ambulance response times even outside of  
 13 pandemic times but you say, for example, it might be  
 14 easiest to look at figure 6 on page 26.  
 15 So Category 2 calls in England, not the most  
 16 urgent but the next one down, it would include people  
 17 having a stroke and with chest pains. This is the mean  
 18 ambulance response times in England and we can see there  
 19 in January '19 the position and the dotted line running  
 20 across the bottom there I think is the line at  
 21 18 minutes which is the target response time for  
 22 a Category 2 --  
 23 **A.** In England.  
 24 **Q.** -- in England. So you should get an ambulance with you  
 25 in 18 minutes. 90% of calls to be responded to within  
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1 which is the time from when the 999 call is made till  
 2 when that vehicle is free again, really increased  
 3 dramatically and we saw ambulances queuing outside  
 4 hospitals more than we'd seen before, which is then  
 5 impacting further on the availability of ambulances to  
 6 respond to the next calls.  
 7 So this is a complex picture of demand and coping  
 8 with that demand by the services. So it's -- and it is  
 9 demand but it's more than that and the availability of  
 10 staff as well, because of the high sickness levels. So  
 11 all these things are coming together to mean that at  
 12 times ambulance services, I would say, were overwhelmed  
 13 by their demand.  
 14 **Q.** In fact, we can see there a shift from London being the  
 15 spike at the beginning of March 2020, and if we go to  
 16 the spike in March of 2022, it's now the south-west of  
 17 England that's got the worst response time and, indeed,  
 18 it remained in the south-west of England by the time we  
 19 got to the end of 2022?  
 20 **A.** Well, you can see there in that spike, the London  
 21 Ambulance Service -- the spike for the London Ambulance  
 22 Service is higher than it was in the first year.  
 23 **Q.** Yes.  
 24 **A.** So yes, it was generalised but it didn't affect everyone  
 25 at the same time.  
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1 40 minutes. And then if we track across we can see that  
 2 in March 2020 in London, which is the black line,  
 3 response times jumped to over an hour.  
 4 **A.** Yeah.  
 5 **Q.** Go on again, a dip in the summer, a rise again then in  
 6 autumn and winter into 2021 and then, Professor, we get  
 7 a significant increase as we go through 2021 into 2022  
 8 and albeit outside of our relevant period, a spike of  
 9 over 2 hours 30 minutes response time by the time we get  
 10 to November/December of January 2022.  
 11 **A.** Yeah.  
 12 **Q.** Now, I'll come to the end but we can see there a rise  
 13 throughout the pandemic albeit perhaps less severe  
 14 waves -- can you help with why it was rising throughout  
 15 2021 and 2022?  
 16 **A.** So -- it's complex. So it's important to remember these  
 17 are not the Category 1 calls which are immediately  
 18 life-threatening calls which are prioritised really at  
 19 the expense of Category 2 and other calls.  
 20 So it's very related to demand. So at peak times  
 21 of call demand then we're seeing these higher response  
 22 times. They're very variable, so they're not affecting  
 23 everywhere at the same time but it's complex because  
 24 with the increased volume and also the increased  
 25 complexity of calls with Covid-19, the job cycle time,  
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1 **Q.** It's nonetheless, though, a long wait from the  
 2 18 minutes that should have happened at the beginning of  
 3 the pandemic to waiting over 2 hours plus for  
 4 a Category 2 response?  
 5 **A.** Very much so.  
 6 **Q.** Let's look at Wales briefly.  
 7 Can I have up on screen figure 7.  
 8 These are Amber calls which, again, is not  
 9 immediately life threatening, as I understand it; is  
 10 that correct?  
 11 **A.** Yes. I think it's equivalent to Category 2 for England.  
 12 **Q.** Are you aware that Amber was subdivided into Amber 1,  
 13 life threatening, and Amber 2, serious but not  
 14 immediately life threatening? Were you aware of that?  
 15 **A.** Yes.  
 16 **Q.** And in Wales here are the health board's response times  
 17 and we can see in 2020 they start to rise significantly  
 18 as we go through the pandemic and again a significant  
 19 spike as you go through again towards the end of '22 and  
 20 into the beginning of 2023.  
 21 **A.** Yes.  
 22 **Q.** I think there's no set response time; is that correct?  
 23 **A.** That's right.  
 24 **Q.** There's no baseline of 18 minutes or the equivalent in  
 25 Wales?  
 140

1 **A.** Not for the -- yes, they only have the 8-minute response  
2 time for the immediately life-threatening one.  
3 **Q.** Life threatening, thank you. But again, nonetheless  
4 significant waits by the time you get into 2021 and  
5 2022, if you are in the Amber category, including up to  
6 nearly 4 hours by the time you go through 2021 and 2022.  
7 And not an equivalent set of data for Scotland but --  
8 just give me one moment. Data for Scotland I think  
9 shows again that there was a significant rise in the  
10 average turnaround time from 30 minutes pre-pandemic to  
11 nearly an hour at the end of June 2022. So not in the  
12 same category as England and Wales there but a rise  
13 nonetheless.

14 Are you able to help at all as to why there was  
15 a rise but not such a steep rise in Scotland?

16 **A.** Can you point me to where you saw the turnaround time?

17 **Q.** Yes. It is in paragraphs 82 and 83 in your report. And  
18 I think it was in data provided by Scotland that showed  
19 the turnaround time?

20 **A.** I can't see the Scottish data there but I just wanted to  
21 say that turnaround time is not the same as the job  
22 cycle time that I referred to earlier. Turnaround time  
23 is the time specifically at hospital to offload the  
24 patient, pass on -- clinical handover and then the  
25 ambulance being free, for which there are national

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1 I won't ask you about it.

2 Can I change topic completely, please, and deal  
3 with parts of your report in relation to shielding and  
4 I'd like to, please, start at the end, as it were, and  
5 before I do so, is it right, Professor, that you in fact  
6 were on the shielding patient list yourself?

7 **A.** Yes, that's right.

8 **Q.** May I ask you at the outset, and I don't mean this  
9 impolitely, has your personal experience of being on the  
10 shielded patient list affected anything that you've  
11 included in your expert report?

12 **A.** I think being on the shielded patient list myself only  
13 made me really keen to gather some evidence about the  
14 effectiveness of shielding. So I was very committed to  
15 being able to carry out some research and evaluation in  
16 this area, but not in terms of the interpretation and  
17 the results provided.

18 **Q.** Thank you very much. All right. Can I put up on  
19 screen, please, page 52 of your statement which is where  
20 you deal with your summary.

21 Now, you make the point that shielding was  
22 implemented and evaluated in the context of almost  
23 simultaneous introduction of general lockdown and  
24 therefore we have to keep that in mind when we look at  
25 some of your conclusions. And you say this at

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1 standards of 15 minutes and the turnaround time you are  
2 talking about now is that handover and handover delay  
3 which is what is referred to in paragraphs 82 and 38.

4 **Q.** Fine. So we don't always have the equivalent data in  
5 terms of the length of time you wait for an ambulance.  
6 In Scotland, though, we do have the length of time at  
7 hospital, is that the --

8 **A.** I don't think so. Because 82 and 83 are not about  
9 Scotland.

10 **Q.** Right, have a look on the screen because we have called  
11 it up onto the screen now in front of you, and we have  
12 got the turnaround times for Scotland where we can see  
13 it rises quite significantly as we go through 2019,  
14 2020, and throughout then our relevant period.

15 **A.** As it did across the UK, I believe.

16 **Q.** All right.

17 **A.** But yes, the individual datasets and definitions are not  
18 exactly the same so it's quite confusing to try to pull  
19 this data together in a consistent manner.

20 **Q.** Thank you. That's all I wanted to ask in relation to  
21 that aspect.

22 Professor, if it helps you, although you've set  
23 out in your report some of the impacts that the pandemic  
24 had on the ambulance service workforce, we've actually  
25 heard some evidence from other witnesses about that so

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1 paragraph 147:

2 "There is no evidence of overall reductions in  
3 Covid-19 infection associated with shielding, except  
4 in a subgroup of rheumatoid arthritis. There is  
5 evidence that hospital acquired infection was higher  
6 in the shielded group. As the mechanism for  
7 protecting [clinically extremely vulnerable] people  
8 from serious harm or death during the pandemic is to  
9 avoid infection, these results cast doubt on the  
10 effectiveness of the shielding policy."

11 And in coming to that conclusion you make the  
12 point:

13 "There is little high-quality evidence on the  
14 impact of shielding on mortality but those researchers  
15 that have investigated this have not found consistent or  
16 sustained effects."

17 And then you set out various other things.

18 Now, I just want to ask you, given that you accept  
19 there is little high quality evidence on the impact of  
20 shielding on mortality, and given that we've got to  
21 bring into it a caveat we're in lockdown generally  
22 across the entire population and I think you make the  
23 point there is no clear control group to say, well, if  
24 you hadn't shielded this is what would've happened, why  
25 is it that you come to the view that the shielding

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1 policy was perhaps not as effective as it might  
2 otherwise have been?  
3 **A.** Because shielding -- so the shielding was introduced  
4 against the background of generalised lockdown. And  
5 that's just context. That's not a caveat really, that's  
6 just context. Shielding was not evaluated as  
7 a standalone policy because it was introduced almost at  
8 the same time as lockdown. So that's -- and nobody  
9 could look at shielding outside of lockdown. That was  
10 the background.

11 Because shielding was introduced as a public  
12 health policy across the UK, at one time, there was no  
13 possibility of carrying out any kind of randomised trial  
14 or experimental research to see whether it was effective  
15 or not. There was no evidence of effectiveness that it  
16 was based on. It was introduced only in the UK and in  
17 Republic of Ireland, nowhere else in the world.

18 So, in that context, we've looked at the best  
19 quality evidence that was produced, through several  
20 high-quality research studies, but they were not  
21 randomised control trials, which were impossible.

22 So my view then is that you make the best of the  
23 evidence that you have, and several of these studies  
24 constructed the best control group or comparator group  
25 possible by, for instance, constructing a similarly

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1 of hospital-acquired infection amongst people in the  
2 shielding group to their comparators, which I think --  
3 this is the interpretation that we've come to, that  
4 that's the reason it couldn't work.

5 Whilst people might have been shielding from their  
6 neighbours, their friends, their families and so on,  
7 they were having such a high contact with hospital staff  
8 and healthcare practitioners that, whilst  
9 healthcare-associated infection was not under control,  
10 shielding didn't seem to be able to -- was not -- was  
11 not able to be effective.

12 **Q.** So does your conclusion come to this, that whilst  
13 hospital-acquired infection rates were high then  
14 shielding itself could not have been effective as  
15 a policy?

16 **A.** Yes. Yes, as a public policy. Not on an individual  
17 level. I want to make this really clear, because I know  
18 this is really a sensitive subject, that this is not  
19 saying that individuals should not have isolated at all.

20 This is saying: as a public health policy, should  
21 this have been -- was there evidence? Should this have  
22 been produced? Should it be introduced in a future  
23 pandemic? And my conclusion from this, all this  
24 research, is that whilst hospital-acquired infection is  
25 so high then shielding, as it was introduced last time,

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1 vulnerable group. They couldn't be exactly matched  
2 because the shielding policy included entire clinical  
3 codes. So you couldn't have matches for those clinical  
4 codes. And so every study that has used some kind of  
5 propensity matching, which is sort of trying to identify  
6 other people that were equally vulnerable, none of those  
7 studies, including one that I led, was able to do that  
8 perfectly.

9 Nevertheless, the comparisons between people  
10 shielding, the best comparator group available, and then  
11 the general population, several studies have come to the  
12 same conclusions. There may have been isolated  
13 short-term regional improvements in one aspect or  
14 another but, overall, no consistent evidence of  
15 an impact on infection rates or Covid-related mortality,  
16 which is what shielding was trying to achieve.

17 **Q.** May I understand this though, would you not expect  
18 a higher rate of mortality in people because they're  
19 CEV? It's their underlying comorbidities make them more  
20 at risk so it's not surprising, is it, therefore, that  
21 more of them died?

22 **A.** Well, I -- so when -- most studies have found a higher  
23 mortality rate, which I would expect, but a higher  
24 Covid-19-related mortality rate one would have hoped not  
25 to see. And in particular there is a much higher rate

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1 simply couldn't be effective.

2 **Q.** What about those shielders who didn't need to attend  
3 hospital? Presumably there's no evidence about what the  
4 effect the policy had on people who weren't going into  
5 hospital for appointments and scans and the like?

6 **A.** But I think there were very few people in the shielding  
7 group that were not having contact with healthcare  
8 professionals. And the hospitalisation rates were much  
9 higher amongst shielded people than the other groups.  
10 But there may have been pockets of people. We did look  
11 in subgroups. We didn't find any evidence within those  
12 subgroups -- clinical subgroups -- of reduced infections  
13 and reduced Covid-related mortality. We were looking  
14 but we didn't find it.

15 And if ours was the only study done that's one  
16 thing, but ours was not an outlier. Each of the studies  
17 we looked at, the large-scale studies, were coming up  
18 with the same conclusions.

19 **Q.** Of course, if the people who shielded did not suffer  
20 hospital-acquired infection, is there anything to  
21 suggest that shielding policy wasn't effective for those  
22 people?

23 **A.** This would require a further look at the data. Which  
24 could be done, hasn't been -- as soon as you start  
25 separating out groups it becomes very complicated,

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1 because then you're looking at: well, who is our  
2 comparator group? And is that -- so in the other  
3 vulnerable people group, who were comparators, do we  
4 then take out the people there that were -- went into  
5 hospital.

6 As soon as you start doing that subdivision the  
7 comparisons become less and less credible, and valid.  
8 So we can look at that more but that hasn't been  
9 published to date.

10 **Q.** I'm asked to ask a number of questions of you on this  
11 topic, and I suppose one of the matters I think you are  
12 aware of is we asked Professor Whitty about your views  
13 and he made the observation that you'd set out the  
14 various studies in the way that you have in your report,  
15 but essentially said he wouldn't go as far as you in  
16 interpreting them in this way. He said that he is not  
17 excluding the possibility that you're right but that  
18 certainly wasn't the intention. And certainly he says  
19 there's -- effectively, an absence of evidence one way  
20 or the other doesn't mean that the shielding policy did  
21 not work.

22 Can I ask for your views on that, please,  
23 Professor.

24 **A.** I think this comes down to whether, in a situation where  
25 you cannot carry out a randomised control trial, which

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1 **A.** Yes.

2 **Q.** I ask you though because actually when it comes to your  
3 ultimate conclusions in your report, you said:

4 "We cannot recommend that shielding is introduced  
5 in a future pandemic as the best current evidence does  
6 not show that it was effective in terms of reduced  
7 infections or Covid-19 related mortality."

8 And you say that:

9 "In a future pandemic we recommend attention needs  
10 to be paid to healthcare transmission as a priority  
11 because shielding cannot work while infection rates from  
12 hospital and other healthcare contacts are high."

13 I'm going ask you, do you think that's overstating  
14 it and it may be that it might not work whilst infection  
15 rates are high, because clearly there are plenty of  
16 people who didn't go into hospital who were shielding?

17 **A.** I don't believe it's overstating. I've considered this  
18 and reflected and considered, because I've been  
19 challenged several times during the course of putting  
20 this report together on this, and have come back to the  
21 same conclusion from our research and from the research  
22 that others have carried out in this area.

23 That's the conclusion and the recommendation.

24 And that's also taking into account that -- the  
25 cost to the public purse and alternatives that have not

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1 is generally seen as the gold standard of evidence, in  
2 that situation any other study is going to be -- have  
3 its caveats and its limitations. And -- but I don't  
4 think -- it's a sort of do you throw the baby out with  
5 the bath water. We still have to try to gather the  
6 evidence that we can and interpret it to the best of our  
7 ability. So these are very large scale studies.

8 The study I led was the whole population of Wales,  
9 a 130,000 shielding people and 130,000 comparators, so  
10 these are not small studies. These are over  
11 considerable time as well.

12 And so my response with that would be we are  
13 taking the best studies we can with the best evidence we  
14 can and making the most of that.

15 For instance, the Medical Research Council funded  
16 our study, was £1 million to do that study. I wouldn't  
17 like to sit here and say, oh, we didn't find anything  
18 out. We found what we found, which was no evidence of  
19 an improvement in Covid-related infections. And higher  
20 Covid-related mortality. And much higher  
21 hospital-acquired infection. So I feel duty bound to  
22 report that and make the best of that evidence that  
23 I can. But I understand that others will criticise  
24 that.

25 **Q.** Or have a different view?

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1 been able to be done, and also the restrictive nature of  
2 shielding and the adverse effects on people's  
3 psychological well-being. So it's not like there's no  
4 costs to shielding. There are both financial and costs  
5 in terms of harms to patients through the shielding --  
6 and protective effects. Both. And it's trying to get  
7 a balance of that out.

8 But whilst -- the whole point was to reduce  
9 infection rates. And if it couldn't achieve that,  
10 whether it be through the overall infection or the  
11 hospital-acquired infection, then it doesn't feel to me  
12 that we could recommend it in a future pandemic. That  
13 the priority should be on reducing hospital-acquired  
14 infections.

15 And it is absolutely not to say that individuals  
16 should not or should not have self-isolated. This is  
17 not what we're saying here. We're saying: as a public  
18 health policy, did this work?

19 **Q.** Hence why you say you've come to the conclusion that you  
20 have.

21 Can I ask you about perhaps a more positive aspect  
22 of the shielding programme. I think you said that if  
23 you are on the shielding programme you're more likely to  
24 be vaccinated?

25 **A.** Yes.

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1 Q. And was that not a positive benefit?  
 2 A. Yes.  
 3 Q. Particularly to those -- later, once vaccines were  
 4 available and being rolled out?  
 5 A. Absolutely. It wasn't the purpose of shielding but it  
 6 provided a really good vehicle for rolling out  
 7 vaccinations to the most vulnerable people first. And  
 8 we did find both a higher proportion of people  
 9 vaccinated than our matched group, and much higher than  
 10 the general population, and also they got vaccinated  
 11 earlier.  
 12 Q. Professor, would you give me one moment. I just want to  
 13 check that I have covered all of the questions I need to  
 14 ask you in relation to the shielding programme.  
 15 (Pause)  
 16 Only this, and I suspect I know the answer, but  
 17 I'm asked to ask whether it's more accurate and nuanced  
 18 to say that the effectiveness of shielding would have  
 19 been better enhanced by better controlling rates of  
 20 nosocomial infection rather than saying we shouldn't  
 21 have the programme in the future at all; what do you say  
 22 that to that?  
 23 A. Well, we don't know the answer to that.  
 24 MS CAREY: My Lady, they are all the questions that I have.  
 25 There are a number of core participant questions though

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1 risk profiles?  
 2 A. Sorry, I don't think I'm understanding the question.  
 3 I mean, one -- I don't think we can ever account for all  
 4 confounding factors but the comorbidities would have  
 5 been indicative of the risk category they were put into,  
 6 so, in a way, it was -- they were considered, I believe.  
 7 Am I answering -- I'm not sure if I'm answering your  
 8 question.  
 9 Q. Well, I'll take your answer so that I can move on to my  
 10 next question.  
 11 A. Thank you.  
 12 Q. And I'll move on to the Liverpool study, which was the  
 13 one by Filipe, Barnett and others.  
 14 That was a study, wasn't it, where there was  
 15 an attempt to match a comparator group; is that right?  
 16 A. Ooh. I believe so.  
 17 Q. Because I think from our reading of your report and the  
 18 study, it compared a shielded and non-shielded group,  
 19 matched, for example, for age, sex, diagnosis with  
 20 a long-term condition. So there was an effort to find  
 21 a comparator group, wasn't there?  
 22 A. In the Liverpool study?  
 23 Q. Yes.  
 24 A. Yes.  
 25 Q. The authors of that study found and I quote:

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1 for the Professor.  
 2 LADY HALLETT: I think we begin with Mr Rawat.  
 3 MS CAREY: Yes.  
 4 LADY HALLETT: Over that way, Professor.  
 5 Questions from MR RAWAT  
 6 MR RAWAT: Good afternoon, Professor Snooks. My name is  
 7 Bilal Rawat and I am here on behalf of the  
 8 United Kingdom Health Security Agency, or UKSA as it has  
 9 been described during the course of the inquiry.  
 10 I have a number of questions for you which relate  
 11 to some of the studies on shielding that you've cited in  
 12 your report for this Inquiry. My time, as you may find  
 13 out, as I may find out, is limited, so I'd be grateful,  
 14 if you can, if you can keep your answers relatively  
 15 short.  
 16 My first question relates to the 2021 paper  
 17 by Jani and others, which is the Glasgow study I think.  
 18 Can you confirm that that study considered three  
 19 different groups with three different levels of risk for  
 20 catching Covid and for dying if they did catch it?  
 21 A. Yes.  
 22 Q. And would you agree, therefore, that the Jani study did  
 23 not account for all confounding factors, an obvious one  
 24 being the levels of comorbidity, because the three  
 25 groups in the study had, by definition, three different

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1 "Shielding was associated with a 34% reduction  
 2 in the risk of dying ... compared with  
 3 a propensity-matched non-shielded group."  
 4 Would you agree that this was a reasonable  
 5 conclusion for these experts to reach based on the data  
 6 available to them?  
 7 A. So, my reading of that study was that there was at one  
 8 point in time a reduced risk of mortality but then over  
 9 a longer period that reduced risk of mortality  
 10 disappeared.  
 11 It's quite confusing to understand their results,  
 12 I do -- I agree. But that's what I understand from that  
 13 study, that it was a short-lived -- and it was also in  
 14 just that one area, in one region -- but it was  
 15 a short-lived reduction in mortality. But then over the  
 16 longer period it disappeared.  
 17 Q. Thank you. If I move on, and I'm going back to a point  
 18 that was canvassed with you by counsel to the Inquiry,  
 19 and my question is this. Given that those shielding (a)  
 20 could attend hospital appointments, (b) were likely to  
 21 have to attend hospital more frequently than those who  
 22 were not shielding, and (c) were, by virtue of  
 23 pre-existing factors, more at risk of acquiring  
 24 an infection when attending hospital, would you agree  
 25 that the incidence of hospital-acquired infection in the

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1 shielding group is not a viable measure of the efficacy  
2 of a programme that was intended to reduce the exposure  
3 of the most vulnerable to community transmission?

4 **A.** I think that's fairly nuanced. I think actually the  
5 point -- the point is that shielding was intended -- my  
6 understanding, that shielding was intended to reduce  
7 Covid infections overall in the clinically extremely  
8 vulnerable. And where they got it is -- it doesn't feel  
9 like it's really the point.

10 But you would hope that -- I would have hoped that  
11 hospital-acquired infection would be -- I mean, it's  
12 dreadfully sad -- it's all sad but it's dreadfully sad  
13 when the infection is picked up in hospital.

14 So you're asking me whether it's an unfair  
15 comparison because they had to go to hospital; is that  
16 right?

17 **Q.** Well, my question is directed to the use of the  
18 incidence of hospital-acquired infection as a measure of  
19 a programme that was intended to reduce community  
20 transmission.

21 **A.** Okay. I guess that's a fair point.

22 We were looking at that point. This was not our  
23 primary outcome. Our primary outcome was infection and  
24 Covid-related mortality. The hospital-acquired  
25 infection was an attempt to understand the mechanism.

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1 was a level above general lockdown, so general lockdown  
2 was, of course, restrictive to people, but shielding was  
3 on another level. So to be asked or instructed, however  
4 you saw those initial letters, to take one's meals  
5 separately from one's family for the next 12 weeks, to  
6 not be in the room with family members during that next  
7 12 weeks, it was -- it was a step up -- much higher than  
8 general lockdown.

9 So I think -- well, as a researcher, and as  
10 a health services researcher, it's absolutely my -- it's  
11 my obligation to try to understand how well that worked  
12 and is that something that should be done again.

13 **MR RAWAT:** Professor Snooks, thank you for that.

14 My Lady, those are our questions.

15 **LADY HALLETT:** Thank you very much indeed.

16 Ms Mitchell. That way.

#### 17 Questions from MS MITCHELL KC

18 **MS MITCHELL:** Professor Snooks, I appear as instructed by  
19 Aamer Anwar & Company on behalf of the Scottish Covid  
20 Bereaved, and I'd like to ask you some questions on  
21 a matter which hasn't been touched on in any great  
22 detail so far. And I hope you're able to assist me. If  
23 it's not within your area of expertise, please just  
24 obviously let us know.

25 The Inquiry has heard a lot about the

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1 **Q.** Thank you for that.

2 Can I move on to my last question for you. It's  
3 this. And it picks up on a point that was put to you  
4 about Professor Whitty's views on your report.

5 Would you agree that it is near impossible to  
6 conduct a meaningful analysis of the shielding  
7 programme, not only because of the limitations in  
8 relation to a comparator group, but also because it's  
9 difficult to disentangle shielding policy during this  
10 pandemic from wider societal measures such as social  
11 distancing and lockdown?

12 **A.** Sure, it makes it more challenging, but we did -- our  
13 study and other studies did not -- I said this at the  
14 beginning -- did not evaluate shielding. It was not  
15 a standalone initiative.

16 In the study that we looked at in Wales, we did  
17 send out questionnaires to people in the shielded group  
18 and in the also vulnerable matched control group, and  
19 there was a distinct difference in terms of behaviours.  
20 So people in the shielded group both originally and  
21 one year later were still isolating a lot more than  
22 people -- were reporting that they were self-isolating  
23 a lot more than the people in the matched control group.

24 So it -- and for people who were affected by  
25 shielding, I think they will understand that shielding

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1 precautionary principle, and perhaps it's something that  
2 seems easy to say, and quite a few people disagree what  
3 it is, but going on the basis that using the  
4 precautionary principle is, in layman's terms, better  
5 safe than sorry, would, in your opinion, the  
6 availability of powered respirator hoods have helped  
7 reduce infection rates in paramedics?

8 **A.** So, I'm very sorry, but it is outside my area of  
9 expertise. I'm not able to answer.

10 **Q.** I did preface my question as I wondered, having  
11 reflected, whether or not that was in your area.

12 And I have no further questions, my Lady.

13 **A.** I'm sorry I couldn't answer that.

14 **MS MITCHELL:** No problem.

15 **LADY HALLETT:** Thank you very much, Ms Mitchell.

16 Mr Puar.

#### 17 Questions from MR PUAR

18 **MR PUAR:** Professor Snooks, good afternoon. I ask questions  
19 on behalf of Covid-19 Bereaved Families for Justice  
20 Cymru who are a group of bereaved families based in  
21 Wales.

22 Can I ask you a question about 999 and 999 in  
23 Wales. In the statement to this Inquiry from  
24 Jason Killens, who's the chief executive of the Welsh  
25 Ambulance Service NHS Trust, he describes a system that

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1 existed before the roll out of the intelligent routing  
2 platform in November 2022 where those that made calls to  
3 999 who were based on the Welsh borders, particularly  
4 when they made that call on their mobile phones, were  
5 often responded to by providers in England and then  
6 would have to be retransferred to callers within the  
7 Welsh Ambulance Service NHS trust.

8 First of all, were you familiar or are you  
9 familiar with that system?

10 **A.** I'm familiar with it broadly but not in great detail.

11 **Q.** All right. Well, I'll just ask you some follow-up  
12 questions on that and see if you can assist us with it.

13 Did that system add at all delays in responding to  
14 999 calls by having to transfer to England and then back  
15 to Wales?

16 **A.** I would have thought it would have improved the response  
17 because they were transferred, I understand, when calls  
18 were not being able to be picked up quickly within the  
19 one service. I may be misunderstanding.

20 **Q.** Okay. And can you explain, in practical terms, how call  
21 handlers were trained when they were based on the  
22 borders?

23 **A.** I'm sorry, no, I'm not able to answer that.

24 **Q.** Fine. The next topic I want to ask you about is  
25 111 calls within Wales. And you state at paragraph 43  
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1 day or the 999 service or the emergency department.  
2 Those would be the sources of advice available but they  
3 were all compromised at the same time.

4 **MR PUAR:** Yes, thank you.

5 The remainder of my questions have already been  
6 answered in the course of your evidence, so I'm  
7 grateful.

8 **LADY HALLETT:** Just before you sit down, Mr Puar.

9 Can I just pursue a matter that Mr Puar was asking  
10 you about. I am afraid I didn't appreciate this until  
11 Mr Puar's questions.

12 If you're on the Welsh border and you basically  
13 need a response from the Welsh Ambulance Service, but  
14 you're using a mobile phone so your area can't be  
15 tracked -- which I think is the point of using the  
16 mobile phone, Mr Puar; is that right?

17 **MR PUAR:** Yes, as I understood it, it was that the call  
18 centre pylons, whatever, pick it up.

19 **LADY HALLETT:** Okay, yes. So basically it's picking up  
20 somebody who is on the English/Welsh border but can't  
21 actually pick up that they live in Cardiff, or wherever,  
22 I'm just thinking about the -- so supposing it's  
23 rerouted to an English call handler, their first  
24 questions aren't going to be "Where do you live?", are  
25 they?  
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1 of your report that Welsh Government data demonstrated  
2 a similar pattern to that of England in terms, at least  
3 as I understand it, the volume of calls that took place  
4 at the start of the pandemic but does it follow as well  
5 from your paragraph 43 that performance in Wales also  
6 reflected the performance in England?

7 **A.** I believe so but I don't have the specifics of that.

8 **Q.** Okay. In that case, can I ask you, also again in  
9 practical terms, when calls weren't answered on 111, did  
10 it go through an automated system at all or did it just  
11 simply continue to ring, or you don't know?

12 **A.** I don't know but I would -- I don't know. This is the  
13 answer to that. And the term "abandoned" is a bit like  
14 abandoned by the caller or abandoned by the service and  
15 I think it means it wasn't answered. The term  
16 "abandoned" is slightly not helpful there, I think.

17 **Q.** My last question is just in relation to calls not being  
18 answered on the 111 system, what was the expected  
19 alternative for families who couldn't access the  
20 service, what was the advice or what were they supposed  
21 to do in that situation?

22 **A.** Well, I don't think it was expected that 111 wouldn't  
23 answer their calls but then they would be falling back  
24 on the other providers of unscheduled care, be it their  
25 out-of-hours GP, or in hours, depending on the time of  
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1 **A.** Are we 999 -- 999?

2 **LADY HALLETT:** 999.

3 **A.** The first questions are: is the patient conscious,  
4 breathing?

5 **LADY HALLETT:** Exactly.

6 **A.** Yes.

7 **LADY HALLETT:** So it must cause a delay, mustn't it, if the  
8 call handler has to go through all the process of what's  
9 your categorisation triage process before they even get  
10 to the address and the postcode?

11 **A.** I don't think necessarily because that call  
12 prioritisation could be passed back to the Welsh  
13 Ambulance Service, they wouldn't have to go through it  
14 again. But I'm sorry, I misunderstood at the time  
15 because there are also systems for when services are at  
16 over capacity and they can't answer their calls for  
17 neighbouring services to be handling those calls and  
18 that's what I thought you were referring to at the  
19 beginning. So this is a different issue.

20 I don't think, in principle, that should lead to  
21 a large delay, but at a time when services were so  
22 stretched I can't answer if it actually did, in  
23 practice.

24 **LADY HALLETT:** Did I get the wrong principle, Mr Puar?

25 **MR PUAR:** No. Can I ask one further question arising from  
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1 that, then?

2 So, there's a delay initially when calling 999 to  
3 get through to an operator.

4 **A.** Very short.

5 **Q.** So the operator in England, then, is ringing on the same  
6 system or can they transfer directly to a --

7 **A.** Yes, I don't know about the telephony arrangements they  
8 have in place but -- so when you call 999 first you get  
9 through to the generic responder asking: fire, police  
10 ambulance? When you get through to the ambulance  
11 service those pick up those -- those answering the phone  
12 delays are very short and I believe remained very short  
13 during this period. And so then the call prioritisation  
14 would happen and then it would get transferred back. In  
15 principle, there shouldn't be a big delay involved in  
16 that unless the receiving service was very stretched  
17 with its -- with answering and dispatching, which they  
18 were at this time, but in principle I couldn't see that  
19 that in itself should be causing a delay.

20 **Q.** All right.

21 **A.** But I don't have the data to back that up.

22 **MR PUAR:** Thank you.

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

24 Mr Wagner.

25 Mr Wagner is over there. Can you see him?

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1 an end, was lifted, in March 2021, other protective  
2 measures such as mask mandates and social distancing  
3 requirements were lifted around the same time and at  
4 that stage vaccines and antivirals were still not widely  
5 available and in fact they hadn't -- vaccines hadn't  
6 been given out to even all of the clinically extremely  
7 vulnerable. Do you agree that the combination of those  
8 factors would have caused very significant stress and  
9 anxiety to the people who had been told up to that point  
10 they should shield?

11 **A.** Yeah, I think that was a very difficult time. But we  
12 did find very, very high rates of vaccination amongst  
13 shielded people at that time but still that wouldn't  
14 have -- that would have maybe gone to some level to  
15 mitigate that but, yes, I think that was a very anxious  
16 time. And we did find that the effects of the -- well,  
17 the association between being in the shielded group and  
18 strictly isolating was still going -- was still much  
19 higher in that group than other vulnerable people, even  
20 a year, 15 months after the start of the pandemic  
21 in March 2020. So 15 months, 18 months later there was  
22 still a very high level of self-isolation,  
23 self-isolating behaviours going on and some fear of  
24 going outside.

25 **Q.** I want to ask you about the effects of the shielding

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### Questions from MR WAGNER

1 **MR WAGNER:** Good afternoon, Professor Snooks. I want to ask  
2 you first about what I've come to think of as the frying  
3 pan and the fire issue.

4 **A.** Sorry, could you just let me know who you are speaking  
5 on behalf of.

6 **Q.** I'm sorry, I'm speaking on behalf of the Clinically  
7 Vulnerable Families.

8 **A.** Thank you.

9 **Q.** So for many clinically extremely vulnerable people, on  
10 the one hand they were being told they needed to stay at  
11 home because they were at high risk from Covid, that  
12 community transmission point, and on the other, they  
13 knew or at least suspected that if they went to  
14 a healthcare setting for an appointment they could be at  
15 high risk of contracting Covid because of lack of  
16 adequate protection and mitigations in those settings.

17 Do you agree that that led to extremely difficult  
18 choices for those clinically extremely vulnerable  
19 people, perhaps including yourself, about deciding  
20 whether to attend healthcare appointments or not?

21 **A.** Absolutely, yes.

22 **Q.** I want to ask you, secondly, about the end of shielding  
23 which you haven't talked about in the oral evidence but  
24 you refer to in your report. So when shielding came to

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1 programme, and trying to distinguish it slightly from  
2 the sort of, if I put it like this, a brute focus on  
3 mortality as the outcome. And just on a couple of  
4 positive effects and just see whether you agree or not.  
5 Firstly, shielding, it functioned as a passport which  
6 gave access to various forms of support, so entitlement  
7 to deliveries, at home with food parcels, priority  
8 access to supermarkets, home deliveries of prescription  
9 medication and, very importantly, Statutory Sick Pay for  
10 those not eligible for furlough. Do you agree that just  
11 in terms of helping people on an individual basis  
12 protect themselves in the community, do you agree that  
13 was a positive aspect of the scheme?

14 **A.** Yes, absolutely, and I also think that in considering  
15 the future, although shielding as it was implemented  
16 during this pandemic may not be appropriate and was --  
17 we didn't find it to be effective in terms of, as you  
18 say, the brute outcomes but I do believe that there  
19 should be some consideration given to how people who are  
20 maybe eligible or need or wish to self-isolate, how they  
21 can do that because taking away shielding would be  
22 taking away all those benefits as well and I'm very  
23 aware of that.

24 **Q.** And secondly, the ability to communicate and for members  
25 of the public to readily understand, so for example

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1 an employer, that those shielding had an urgent and  
2 legitimate need to reduce their risks, quite different  
3 to the other population, the general public, do you  
4 agree that educational aspect, communication aspect was  
5 a positive effect?

6 **A.** I think it was but I also think that there were people  
7 that were not categorised as require -- as clinically  
8 extremely vulnerable who then kind of missed out on that  
9 and some of those people felt that should have been in  
10 the shielding group. So it was in some ways almost  
11 an arbitrary cut-off between shielding and -- well,  
12 clinically extremely vulnerable and clinically  
13 vulnerable.

14 **Q.** Well, that just brings me neatly onto the final question  
15 I have for you which is about who got in and who didn't.  
16 So, obviously clinically vulnerable people, and  
17 when I speak about clinically vulnerable I'm excluding  
18 clinically extremely vulnerable just for now.

19 **A.** Yes.

20 **Q.** So the people who wouldn't have been told to shield, but  
21 they were still at higher risk of dying from Covid,  
22 weren't they, by definition, and having bad effects from  
23 Covid; is that fair?

24 **A.** I think so, yes.

25 **Q.** Would you agree that more learning is required for  
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1 report, where your key points were that the services of  
2 111 and 999 were at times overwhelmed and you then go on  
3 to say that existing inequalities may have been  
4 exacerbated by those factors. Firstly, in terms of  
5 ethnicity you then indicate, as you indicated to  
6 Ms Carey before, that there's a lack of data?

7 **A.** Yes, there's a lack of coding.

8 **Q.** Yes. Now, you've already helpfully given evidence about  
9 the difficulties of collecting data in an emergency  
10 situation, but without collecting data then, of course,  
11 first of all, we don't know?

12 **A.** Yes.

13 **Q.** And secondly, we can't put it right if we don't know?

14 **A.** Yes, exactly.

15 **Q.** So something has to be done?

16 **A.** Yes, yes, so we're currently doing a study exactly on  
17 this in injuries and this is where we found that there  
18 is no data in ambulance control about the ethnic, I was  
19 going to say case mix, but the ethnic profile of the 999  
20 callers but they can be linked. So if you can link  
21 those callers to other datasets then ethnicity is  
22 available.

23 **Q.** Yes.

24 **A.** So this can be done but it isn't routinely done at the  
25 moment.

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1 a future pandemic to think through how better to protect  
2 those individuals who were given none of the protections  
3 that clinically extremely vulnerable people were and  
4 perhaps there could be more of a spectrum?

5 **A.** Yes, I think that could be considered, definitely, yes.

6 And as Ms Carey had said earlier, perhaps look in more  
7 detail of -- a secondary analysis of some of the data of  
8 some of the studies that have already come out, to find  
9 these pockets if those pockets exist of people that  
10 actually benefited from shielding for instance or  
11 didn't, to help contribute to that formulation of policy  
12 for the future.

13 **MR WAGNER:** Thank you. Those are my questions.

14 **LADY HALLETT:** Thank you very much, Mr Wagner.

15 Mr Weatherby.

16 **Questions from MR WEATHERBY KC**

17 **MR WEATHERBY:** Thank you.

18 Professor Snooks, just one topic from me and I ask  
19 questions on behalf of the Covid-19 Bereaved Families  
20 for Justice UK group and it's simply the extent to which  
21 people with different characteristics, the needs of  
22 people with different characteristics, whether they were  
23 sufficiently and adequately catered for by the 111 and  
24 999 services.

25 So you were earlier taken to paragraph 78 of your  
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1 **Q.** No. So, again, that's a call for optimism there that  
2 work is -- it is in fact being addressed?

3 **A.** To some extent but it needs more, yes, it does need more  
4 attention --

5 **Q.** Indeed.

6 **A.** -- because that work is, it's been partially done ad hoc  
7 here and there but not been done systematically.

8 **Q.** Sure. Just to take this point a little further  
9 paragraph 73 you refer to the Healthcare Safety  
10 Investigations Branch 2022 report on the 111 service and  
11 part of that you note that they raised questions rather  
12 than conclusions about the efficacy of the service,  
13 about a number of matters but including language  
14 difficulties. So that would include the potential  
15 problems of people whose first language wasn't English.  
16 And again, this is an area where there's a lack of data,  
17 is that right?

18 **A.** Absolutely. Again, I don't think there's any data on  
19 this at all. So this would have to be the subject in  
20 the first place of actually funded research,  
21 commissioned research to look at this.

22 **Q.** Yes, so that should happen.

23 **A.** We cannot get that from routine information.

24 **Q.** And from family members that we represent, we know that  
25 on occasion questions were asked of them about them or

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1 their loved ones which assumed that they were white.  
 2 **A.** Right.  
 3 **Q.** For example, had lips turned blue or skin colour turned  
 4 blue? Again, this may indicate a wrong assumption being  
 5 put forward by call handlers or the algorithms, and  
 6 would you agree that there needs to be work done to  
 7 identify those problems and to rectify them if they  
 8 are --  
 9 **A.** Absolutely, yes, I would definitely support that.  
 10 **Q.** Okay, same point but moving away from ethnicity.  
 11 At paragraph 73 you highlight the fact that the  
 12 algorithms didn't take sufficient account of  
 13 comorbidities and can you help us with that, but I think  
 14 that what you're driving at there is that because there  
 15 was insufficient account of -- taken of comorbidities  
 16 then it was less efficient at people being signposted to  
 17 what they needed or emergency treatment being provided?  
 18 **A.** Yes, we're quoting from this study by Rick Body,  
 19 I believe, and so this is their conclusion. I'm quoting  
 20 them but I would support it.  
 21 **Q.** You would support that. Again, this is a deficit which  
 22 needs to be looked at --  
 23 **A.** Yes.  
 24 **Q.** -- and addressed?  
 25 **A.** Yes.

1 **Q.** Can I take that one stage further. Would you agree that  
 2 not just the algorithms but perhaps call handler  
 3 training needs to be improved in terms of taking account  
 4 of people with comorbidities or perhaps people who have  
 5 neurodiversity?  
 6 **A.** Yes.  
 7 **MR WEATHERBY:** Thank you very much, Professor.  
 8 **LADY HALLETT:** Thank you, Mr Weatherby.  
 9 Professor, that concludes, I think, all the  
 10 questions that we have for you. Thank you for your  
 11 help, and I hope that the recovery continues apace.  
 12 **THE WITNESS:** Thank you very much.  
 13 **LADY HALLETT:** I hope you haven't been too uncomfortable.  
 14 **THE WITNESS:** No. Thank you.  
 15 **LADY HALLETT:** Very well, 10 o'clock tomorrow, please.  
 16 **(Witness withdrew)**  
 17 **(4.05 pm)**  
 18 **(The hearing adjourned until 10.00 am**  
 19 **on Thursday, 31 October 2024)**  
 20  
 21  
 22  
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