

Monday, 4 November 2024

1  
2 (10.31 am)  
3 **LADY HALLETT:** Mr Fireman.  
4 **MR FIREMAN:** Good morning. May I please call  
5 Patricia Temple, who will be sworn.  
6 **MS PATRICIA ANN TEMPLE (sworn)**  
7 **Questions from COUNSEL TO THE INQUIRY**  
8 **MR FIREMAN:** Could you please give your full name.  
9 **A.** Patricia Ann Temple.  
10 **Q.** Ms Temple, you have given a witness statement dated  
11 14 June 2024, that's INQ000486012.  
12 Ms Temple, you have been a qualified registered  
13 nurse working in various countries since 1972; is that  
14 correct?  
15 **A.** That's correct.  
16 **Q.** Is it correct that from March to November 2020 you  
17 worked as a band 5 nurse in a cardiac care unit of  
18 an NHS trust?  
19 **A.** That's correct.  
20 **Q.** Could you tell the Inquiry, first, what a band 5 nurse  
21 and what your role in the cardiac care unit involved?  
22 **A.** A band 5 nurse is a registered nurse at the first level,  
23 and I worked providing bedside care to patients, both  
24 Covid patients and non-Covid patients, and primarily  
25 those with cardiac problems.

1

1 **Q.** When that took place would those staff who had floated,  
2 to use your word, ever return to -- return relatively  
3 quickly to your ward, the cardiac care unit?  
4 **A.** We would be floated for a shift.  
5 **Q.** And return the next shift?  
6 **A.** Yes, return to your ward the next shift. So it would  
7 only be for a shift.  
8 **Q.** So there was no break time in terms of no time off after  
9 having spent time within a Covid-19 ward to account for  
10 the fact that the nurse had spent time in that ward and  
11 may well have potentially been exposed to Covid-19?  
12 **A.** No.  
13 **Q.** With respect to infection prevention and control, you  
14 say in your statement at paragraph 5 that "policies  
15 seemed to change daily and, at times, did not seem to  
16 adhere to the normally accepted Infection Prevention and  
17 Control Guidelines". What do you mean by this?  
18 **A.** I think that the one particular incident that I said was  
19 we were told on a Friday that we were to wear a mask  
20 starting on Monday, which seemed to me a strange thing  
21 to do.  
22 **Q.** Why?  
23 **A.** Because if we're going to be wearing masks from Monday  
24 surely we should be wearing them now. It seemed to make  
25 no sense at all.

3

1 **Q.** Going back to March 2020, what was your daily working  
2 pattern like?  
3 **A.** I worked full-time night duty at weekends.  
4 **Q.** You mentioned that you cared for both Covid and  
5 non-Covid patients. While working in the cardiac care  
6 unit, were you always aware of whether or not you were  
7 caring for Covid or non-Covid patients?  
8 **A.** Not always. Sometimes patients had not evidenced  
9 symptoms of Covid when they were admitted. Some  
10 patients were admitted as suspect Covid patients and  
11 only proved to be Covid-positive at a later stage once  
12 their test results were back. So at various stages we  
13 were not aware that the patients were Covid-positive  
14 or not.  
15 **Q.** Was there a specific Covid-19-positive ward in your  
16 hospital?  
17 **A.** There was, yes.  
18 **Q.** Were staff from your ward ever called upon to care for  
19 patients in the Covid-19-positive ward?  
20 **A.** Yes, it depended on whether staffing levels in the  
21 Covid-positive ward were actually at appropriate levels  
22 or not, and if not then, if our ward had what they  
23 considered to be sufficient staff they would float, is  
24 the word that we used, to another ward to supplement  
25 staffing levels in that ward.

2

1 **Q.** Did you feel as though the management and those in  
2 charges charge of infection prevention and control  
3 within the hospital were forthcoming with information  
4 about the level of risk that --  
5 **A.** I don't think so, no. Initially I think that we got the  
6 impression that we weren't being told everything.  
7 I have no idea whether that was deliberate or not but it  
8 appeared that we weren't being told about everything  
9 that was going on, particularly as it related to  
10 Covid-positive patients and how many there were and  
11 potential issues with Covid-positive patients.  
12 **Q.** What gave you that impression, that information was  
13 being withheld?  
14 **A.** Just that it was very difficult to extract information  
15 about anything, if you asked questions about how many  
16 Covid-positive patients there were and what was  
17 happening, pandemic-wise in the trust that I worked  
18 with.  
19 **Q.** Did you feel that there was sufficient clarity around  
20 what protective equipment, PPE you should be wearing?  
21 **A.** No, there was confusion, I feel.  
22 **Q.** Was confusion related to the type of PPE that you should  
23 wear?  
24 **A.** Yes, definitely. There was confusion as to whether  
25 surgical masks were adequate as opposed to FFP masks,

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1 and whether -- initially we were told that surgical  
 2 masks were fine for everything except for patients who  
 3 were having aerosol-generating procedures, and in the  
 4 early stages of the pandemic the unit that I was in was  
 5 declared a white unit so that we weren't supposed to be  
 6 admitting Covid-positive patients but as the beds in the  
 7 remainder of the hospital became scarce then we did  
 8 start admitting Covid-positive patients and we were told  
 9 then that only with aerosol-generating procedures were  
 10 we to wear FFP masks for the added protection, but  
 11 otherwise surgical masks were adequate.

12 **Q.** You make clear in your witness statement that you had  
 13 been fit tested for one type of FFP3 mask in 2019. Were  
 14 you able to wear this type of mask in those  
 15 circumstances in which it would have been advised that  
 16 you wear an FFP3?

17 **A.** Yes. Yes, except that during -- I found that out in  
 18 retrospect after I contracted Covid and when  
 19 I investigated a little bit further I found out in  
 20 retrospect that in actual fact the mask for which I had  
 21 been fit tested was actually withdrawn from the trust  
 22 and put back into general stocks in the NHS, I believe  
 23 in July of that year, but that was just -- I have no  
 24 evidence of that, that was just hearsay from someone who  
 25 was actually organising the mask fitting for me, told me

5

1 whom I remember really clearly and in that instance we  
 2 took all our protections we, put FFP masks, we put  
 3 visors and we took full precautions as we were advised  
 4 to do. But it was difficult.

5 **LADY HALLETT:** What was it about the masks, when you weren't  
 6 having a visor and everything else, what was it about  
 7 the masks that meant they weren't giving you sufficient  
 8 protection? Why were they found unsuitable?

9 **A.** There's leakage I believe, so they tested it on the  
 10 computer to see whether it actually -- in previous tests  
 11 what they did was they put the mask on and then they  
 12 injected a smell, you know, some sort of -- so that you  
 13 could smell it and see, and if you could then it meant  
 14 that the mask wasn't effective, but in this instance the  
 15 computer told us that it actually didn't provide  
 16 adequate protection. It gave you percentage protection,  
 17 I believe, some of them gave minimal percentage  
 18 protections, and the last one that they tested on me  
 19 which was I believe called the Stealth mask was the one  
 20 that gave adequate protection.

21 But in actual fact I never tested that again  
 22 because I went -- I was ill shortly thereafter and when  
 23 I came back from my sick leave I actually didn't nurse  
 24 Covid patients again, simply because I felt that it was  
 25 not possible for me to do so.

7

1 that that mask had been removed. We were not advised of  
 2 that.

3 **Q.** So do you actually know whether or not the mask that you  
 4 were wearing, the FFP3 that you were wearing, was one  
 5 you had been fit tested for?

6 **A.** It wasn't. It was initially until those became  
 7 unavailable and then FFP masks that were available  
 8 I used, but later on in the November shortly before  
 9 I acquired Covid I discovered that in actual fact the  
 10 masks for -- the masks that were available in the unit,  
 11 they fit tested me -- they came around with a new  
 12 computerised testing system for fit testing masks and we  
 13 found that all the masks, other than one which I had  
 14 never seen before on the unit, that none of the masks  
 15 were actually suitable for purpose in relation to me.  
 16 So, it became clear to me that obviously I was not  
 17 adequately protected during the time.

18 **Q.** You were wearing an FFP3 mask but not one --

19 **A.** Yes.

20 **Q.** -- which adequately --

21 **A.** Protected you.

22 **Q.** -- fit your face?

23 **A.** Yes. But we did, in terms of aerosol-generating  
 24 procedures, shortly before I became ill I actually was  
 25 caring for a patient on aerosol-generating procedures

6

1 **MR FIREMAN:** To be clear, you found out this detail about  
 2 the accuracy after you had been nursing patients wearing  
 3 FFP3 masks --

4 **A.** Yes.

5 **Q.** -- which turned out not to be sufficiently protective  
 6 for you, is that right?

7 **A.** That's correct.

8 **Q.** Is it right that in your hospital there was an infection  
 9 prevention and control team?

10 **A.** There was.

11 **Q.** Did your working pattern which you mentioned earlier  
 12 working consistently night duties impact your ability to  
 13 engage with that team?

14 **A.** It did. I was fortunate in as much as the education and  
 15 training department came round to those of us on night  
 16 duty during November 2020 and actually provided us with  
 17 mask fitting tests and that's how I established that in  
 18 actual fact the masks that I had been using were not fit  
 19 for purpose.

20 **Q.** What was your experience like of infection prevention  
 21 and control measures in staff areas? Did people tend to  
 22 keep their masks on in staff areas or did they take them  
 23 off, what was the general impression that you got from  
 24 working --

25 **A.** I think we tried to keep them on. It was difficult in

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1 staff areas like when you went for your breaks to  
 2 actually keep your masks on while you ate and drank and  
 3 it was difficult as well to keep masks on if you were at  
 4 the nurses station, for instance. That was the most  
 5 difficult area, I think, to remain infection aware  
 6 because there were so many of us coming and going.

7 **Q.** Was this the case for both the surgical fluid-resistant  
 8 masks and FFP3 masks or particularly the case when you'd  
 9 been wearing an FFP3 mask?

10 **A.** I think we wore the surgical masks routinely and the  
 11 FFP3 masks only when indicated.

12 **Q.** So there wasn't any particular issue in relation to FFP3  
 13 masks having to be taken off; it was in fact the case  
 14 even with the surgical masks people were taking them off  
 15 in staff areas?

16 **A.** Yes.

17 **Q.** Was there anything that you think could have been done  
 18 to improve compliance with infection prevention and  
 19 control, particularly in staff areas?

20 **A.** I think if issues had been explained better, if people  
 21 had actually made themselves available for those of us  
 22 on night duty. I felt that there was general confusion  
 23 surrounding infection control practices and what the  
 24 best things to do were. It was relating as well to how  
 25 many people would be in one area at a time. You know,

9

1 **Q.** Did you encounter staff avoiding testing?

2 **A.** I don't think anyone actually refused to be tested but  
 3 they did try and avoid it as much as -- as was possible  
 4 I think, because of the -- having to go off sick and the  
 5 financial implications thereof.

6 **Q.** One aspect of infection prevention and control which  
 7 the Inquiry has heard a lot about is the visiting  
 8 restrictions that were imposed. From your perspective  
 9 as a nurse, someone who's been nursing for many years,  
 10 what was the impact of having to impose visiting  
 11 restrictions on patients and their families?

12 **A.** That was really sad. I found it really, really sad.  
 13 I remember well one patient that we heard talking to his  
 14 mum on the phone, a learning disabled man who couldn't  
 15 understand why she couldn't come and see him and he was  
 16 dying and you could hear him speaking on the phone to  
 17 his mum and asking her to come and that was devastating  
 18 for all of us because we have an obligation as nurses to  
 19 care for our patients, to empathise with them and to be  
 20 there with them and it was very, very difficult to see  
 21 them suffering without their loved ones there. It was  
 22 difficult for us as well to see them dying alone.

23 **Q.** Did you feel you had the flexibility to adjust the rules  
 24 to individual circumstances?

25 **A.** No.

11

1 there was -- no one explained the sort of science behind  
 2 it, like there could only be three people there or there  
 3 could only be two people there or four people there and  
 4 it didn't seem to be based on anything scientific. So  
 5 it was difficult to adhere to principles that were,  
 6 I suppose, questionable.

7 But I have been nursing for a long period of time  
 8 so I have infection control principles sort of imprinted  
 9 in my brain and some of them really didn't seem to make  
 10 sense and were difficult to adhere to because of that,  
 11 I feel.

12 **Q.** Regardless of what the guidance was, would you have then  
 13 appreciated some more explanation as to how --

14 **A.** Yes, yes.

15 **Q.** -- the guidance had been reached?

16 Did you feel that you had adequate access to  
 17 testing for Covid-19?

18 **A.** I think so, yes. I can't remember that there was any  
 19 problem with that, although people were reluctant to be  
 20 tested because of the implications, if you went off  
 21 sick, particularly, I think, financial implications if  
 22 you went off sick and you didn't have sick leave  
 23 available there was, you know, a reluctance perhaps to  
 24 go off sick so there might have been a reluctance to be  
 25 tested just for that reason.

10

1 **Q.** You note at paragraph 10 of your witness statement that  
 2 staff who did test positive were advised to return to  
 3 work as soon as possible and made to feel guilty if they  
 4 did not. Where did this pressure to return to work come  
 5 from?

6 **A.** I'm not sure whether it actually came from management or  
 7 whether it came from nurses ourselves. You know, we  
 8 ourselves are really obligated to our team members and  
 9 our colleagues and we sometimes I think we probably put  
 10 an inordinate amount of pressure on ourselves to  
 11 actually get back and not let our team down. So I think  
 12 it possibly came from management because of staff  
 13 shortages and we were well aware how short staffing was  
 14 so we were reluctant to let our team down and let our  
 15 patients down.

16 **Q.** You say at paragraph 19 of your witness statement this:

17 "We expected the NHS and management would look  
 18 after us as required. I fear they failed to do so."

19 Can you elaborate a little on your concerns there?

20 **A.** I think there was systemic failures. I think that's the  
 21 big thing is -- I'm very much a quality improvement  
 22 people and in quality improvement you look at the  
 23 systems and I think that if you looked at the system  
 24 that was put in place to deal with Covid there were  
 25 failures and failures and failures. And I think they

12

1 let us down as nurses about many things.  
 2 **Q.** Anything in particular?  
 3 **A.** I think infection prevention and control, particularly.  
 4 I think with myself in terms of Long Covid and looking  
 5 after me when I developed Long Covid, that was really  
 6 difficult. I had to fight really, really hard to get  
 7 any support from management in terms of Long Covid.  
 8 I had to try -- I tried redeployment on a number of  
 9 occasions and that failed. But there could have been  
 10 far more support I feel and far more adjustments made  
 11 and I feel very strongly for the Long Covid nurses that  
 12 are out there now that are having to take ill health  
 13 dismissal. It was less difficult for me I think because  
 14 I had come nearer the end of my career than the  
 15 beginning but there are still -- there are a lot of  
 16 nurses out there that are beginning their careers and  
 17 have had to take dismissal due to ill health and that  
 18 makes me feel that they consider nurses disposable and  
 19 I think that's where they let us down particularly.  
 20 **Q.** Did there ever come a point whilst you were working when  
 21 the vaccine became available?  
 22 **A.** It did, yes.  
 23 **Q.** Did there come a point at your hospital -- it may not  
 24 have -- but did there come a point where it was proposed  
 25 that taking the vaccine was a condition of deployment?

13

1 **A.** Yes.  
 2 **Q.** Do you know when you contracted Covid or how?  
 3 **A.** From that patient that I was talking about that I nursed  
 4 in the 7 to 10 days prior to becoming ill. And  
 5 I remember him well because it became such that we were  
 6 unable to continue to nurse him on the ward that he was  
 7 on and we moved him to the respiratory unit where he  
 8 subsequently died, much to my regret because I knew that  
 9 he, too, would die alone.  
 10 **Q.** After you contracted Covid did you have some time at  
 11 home isolating alone?  
 12 **A.** Until it became such that I had phone calls from  
 13 everybody to tell me that I had to go to hospital but  
 14 I was of the firm belief that we were told that you had  
 15 to isolate at home for 10 days, that whatever you did,  
 16 please not to go to hospital because it would further  
 17 confound the problems that they were having at the  
 18 hospital. So I stayed at home for an exceptionally long  
 19 time. I actually stayed at home for 10 days until I was  
 20 actually ambulated to hospital because I was seriously  
 21 ill.  
 22 **Q.** How long were you admitted to hospital for?  
 23 **A.** 11 days.  
 24 **Q.** Were you then discharged home?  
 25 **A.** Yes.

15

1 **A.** It was, yes, although that didn't affect me particularly  
 2 at that time. My main decision was -- to take the  
 3 vaccine was after I had been put on sick leave due to  
 4 Long Covid, and I lived alone in the UK, my family are  
 5 in Israel and South Africa, and I desperately needed to  
 6 go somewhere to be looked after and the only reason  
 7 I took the vaccine, I think, was so that I could travel.  
 8 And that's an honest opinion.  
 9 **Q.** From the perspective of you and other staff, from your  
 10 perspective and other staff's perspective, the  
 11 opposition of having a policy that required staff to  
 12 take the vaccine in order to be deployed as nurses, did  
 13 that have any impact on staff morale?  
 14 **A.** It didn't, I think, but I think that, if I remember, I  
 15 remember two nurses particularly that they were very  
 16 certain that they were not prepared to have the vaccine  
 17 and as far as I'm aware were still allowed to continue  
 18 to work. I think it possibly became a condition of  
 19 employment but possibly that was by the time I had  
 20 Long Covid and was no longer at work, it might well have  
 21 done. But we were still able to refuse.  
 22 **Q.** You touched on your experiences briefly in relation to  
 23 contracting Covid and developing Long Covid. Am I right  
 24 that you understand or you believe that you contracted  
 25 Covid at work?

14

1 **Q.** And were you able to then return to work?  
 2 **A.** I tried to return to work -- I did try to return to work  
 3 in January 2021 and then had to leave in March of 2021  
 4 simply because I couldn't maintain my oxygen saturation  
 5 levels at an appropriate level to function and to  
 6 breathe, and I also had an inappropriate tachycardia  
 7 that I couldn't manage a full day's work.  
 8 **Q.** What was that period of time working, trying to work as  
 9 a nurse, something you'd done for many, many years but  
 10 simply being unable to do it to the standard that you  
 11 previously had been able to, what was that like?  
 12 **A.** It was six very difficult weeks, because I tried my best  
 13 to manage and not let my team down, as that's very  
 14 important to me that one doesn't let one's colleagues  
 15 down.  
 16 **Q.** When did you recognise that you had in fact developed  
 17 Long Covid?  
 18 **A.** Well, I felt that I had developed something a long time  
 19 before I got the diagnosis because a lot of people  
 20 poo-poo'd the idea of Long Covid, and I believe still  
 21 do, but I knew that there was something wrong with me in  
 22 as much as I couldn't breathe and I had difficulty with  
 23 extremely serious fatigue and was just not able to  
 24 function on a daily basis. To even get around and do my  
 25 shopping was very difficult. I just found difficulty

16

1 with normal, everyday tasks.

2 **Q.** Did you eventually manage to access a Long Covid clinic?

3 **A.** I did but after -- yes, I went to -- yes, there was

4 a Long Covid hub and I managed to get hold of

5 a respiratory physiotherapist who came and visited me at

6 home and they established that I had ongoing symptoms of

7 Covid and that I had respiratory issues and I eventually

8 travelled to South Africa where my daughter was and

9 consulted other physicians there and discovered that

10 I had permanent lung damage from Covid.

11 **Q.** You say in your statement that you feel more should have

12 been done from your employer's perspective to create

13 a supportive environment for nurses while they recover

14 from Covid-19 or, indeed, Long Covid if they've

15 developed it. What do you feel could have been done to

16 support you?

17 **A.** I think people could have kept in touch more. As it

18 were, I lived alone and -- I did have friends obviously

19 that kept in touch with me but in terms of work they

20 didn't keep in touch with me as much as I think they

21 might have. I think there are standards that are set

22 when you're on sick leave but I think it caught them

23 unawares the fact that Long Covid would go on for quite

24 so long, so people found it difficult from a management

25 perspective I think to keep on touching base with you to

17

1 what has happened from this pandemic and why so many

2 people actually -- why so many nurses actually

3 contracted Covid and then Long Covid, so that lessons

4 should be learnt and I hope what this Inquiry does is to

5 learn those lessons and put them into place in the

6 future. But I also would like, in terms of Long Covid

7 nurses, is, they are still willing to nurse and they

8 still could nurse in many, many different capacities, so

9 can we not make reasonable adjustments and allow them to

10 continue in their nursing capacity?

11 I have a lot of nurses that I know who are trying

12 very, very hard to stay in the workplace and are unable

13 to do so and that's something that I think should be

14 seriously looked at and learnt from so -- they are

15 a valuable resource, they are not disposable. Having

16 Covid and Long Covid, you can't be clapped for one

17 minute and declared disposable the next.

18 **MR FIREMAN:** Thank you very much, Ms Temple.

19 My Lady, those are all my questions.

20 **LADY HALLETT:** Ms Temple, thank you very much indeed. I

21 don't have any questions for you. You and I qualified

22 in the same year --

23 **A.** Oh, did we?

24 **LADY HALLETT:** -- 1972, so to see your dedication to your

25 profession after so many years is inspiring, and I'm

19

1 see how you were, and I think there should be a much

2 more robust system of looking after people at home when

3 they have Long Covid.

4 **Q.** You ultimately were required, were you not, to take ill

5 health dismissal?

6 **A.** I was.

7 **Q.** When was that?

8 **A.** September 2023.

9 **Q.** After everything you've experienced have you been able

10 in any form resume nursing?

11 **A.** Not bedside nursing at all but I'm a nurse and always

12 will be a nurse and so I am now working with one-to-one

13 nursing students online to help them with their academic

14 work, and also preparing an online programme for nurses

15 who are compassion fatigued, as I think many of us are,

16 particularly in post pandemic.

17 **Q.** You finish your statement with these words:

18 "Nurses should not be viewed as disposable and

19 every attempt should be made to retain this valuable

20 resource."

21 Are there any recommendations beyond which you've

22 already touched on that you think ought to be borne in

23 mind by the Inquiry to ensure that nurses are better

24 protected in the event of a future pandemic?

25 **A.** I think we have to learn the lessons from this pandemic,

18

1 really sorry that you've had to suffer the impact of

2 Long Covid, it's obviously been a great blow to you to

3 give up nursing in the wards. But you are obviously

4 doing a huge amount of work supporting other nurses

5 online and we're really grateful for what you did during

6 the pandemic and that you continue to do in supporting

7 nurses. Thank you very much for your help.

8 **THE WITNESS:** Thank you very much, my Lady. Thank you.

9 (The witness withdrew)

10 **LADY HALLETT:** Ms Carey.

11 **MS CAREY:** My Lady, the next witness, please, is

12 Mrs Rosemary Gallagher.

13 **MS ROSEMARY GALLAGHER (sworn)**

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

15 **MS CAREY:** Ms Gallagher, your full name, please.

16 **A.** Rosemary Gallagher.

17 **Q.** I think you are known as "Rose" at work, and indeed we

18 look at some emails and we will see you signing off as

19 such.

20 Mrs Gallagher, you're coming to give evidence

21 today as the professional lead for infection prevention

22 and control at the Royal College of Nursing?

23 **A.** That's right.

24 **Q.** I hope you have in front of you your witness statement

25 dated 25 April, INQ000475580.

20

1 A. I do.

2 Q. May we start with a little background, please. Firstly,  
3 to you. Just help us, what does the professional lead  
4 for IPC at the RCN do?

5 A. I'm a registered nurse, and I'm a specialist nurse  
6 working in infection prevention and control. My role  
7 essentially is to advise the college and its members on  
8 matters relating to infection prevention and control but  
9 specifically in the context of nursing practice.

10 Q. And presumably, therefore, were rather busy during the  
11 relevant period --

12 A. Yes.

13 Q. -- dealing with the IPC guidance. We're going to come  
14 on and look at some of the guidance and indeed some of  
15 the RCN's concerns --

16 A. Yes.

17 Q. -- about the IPC guidance during the course of your  
18 evidence. May I just ask you, please, though, to give  
19 us an overview of the role of the RCN?

20 A. Yes. So the RCN, the Royal College of Nursing has  
21 a dual function. It was established first as a Royal  
22 College in 1929 and therefore acts as a professional  
23 body for nursing focusing on professional nursing  
24 standards, health policy, and advice and support for its  
25 members.

21

1 evidence and practice and to implement it were actually  
2 involved in its development, and that was a key outcome  
3 from the Ebola incident and review.

4 Our members also work across a variety of health  
5 and care settings, both in the NHS, adult social care  
6 and independent settings, but they're also present in  
7 prisons they work in mental health settings, so it's  
8 really important that there isn't a one-size-fits-all  
9 guidance. Certainly it can be based on principles, but  
10 it has to be implemented the context of where those  
11 nurses are working.

12 So for us to be around the table, whilst I might  
13 not wear my specialist infection prevention and control  
14 hat, I would bring with me that experience of nurses and  
15 look at how it could be implemented in the various  
16 settings.

17 Q. I think you said a moment ago that there was difficulty  
18 certainly with engagement in the early days by which I  
19 mean March/April, that kind of time of 2020.

20 A. Yes.

21 Q. How did it improve, if indeed it did, after the  
22 initial months of the pandemic?

23 A. In the early stages we didn't have specific concerns  
24 around the Covid-19 guidance or the Wuhan guidance, as  
25 it was known at that point, because it was being treated

23

1 It's also a trade union and therefore has the  
2 additional role and ability to support its members in  
3 relation to employment relations, queries or issues.

4 Q. Can we start, then, with one of the major concerns  
5 from -- of the RCN as set out in your statement, which  
6 is that relating to lack of engagement with the RCN and  
7 indeed other stakeholders, particularly, you say, in  
8 reviewing, updating and indeed developing the IPC  
9 guidance.

10 Just help us, please, if you're able: which bodies  
11 did the RCN want to engage with?

12 A. In the early days of the pandemic, the development of  
13 guidance would have been led by Public Health England in  
14 collaboration with the other countries and main  
15 stakeholders, and our experience in previous incidents  
16 had been that royal colleges and nursing was around the  
17 table in terms of considering the impact of that  
18 guidance on those that would implement it.

19 Q. Why do you say on behalf of the RCN that it's so  
20 important for the RCN to be engaged with when IPC  
21 guidance is being developed?

22 A. Well, there are a number of reasons that support our  
23 position. First of all, we had learnt, as I said,  
24 through a number of prior incidents that it was  
25 absolutely critical for people that needed to use the

22

1 as a high consequence infectious disease, and therefore  
2 it followed the high consequence disease management. It  
3 wasn't after SARS-CoV-2 was downgraded from a high  
4 consequence infectious disease that our concerns really  
5 started to actually be raised. Or to come to the  
6 forefront.

7 Q. Was there better engagement in wave 2? Or 3?

8 A. The level of engagement really varied. We tried to be  
9 very proactive in terms of offering our support as  
10 a royal college. This was very much about a one-team  
11 approach to managing the profession -- the pandemic and  
12 ensuring that all healthcare professionals, because our  
13 responsibility as nurses is clearly to our patients.  
14 But we have responsibility for the colleagues that work  
15 alongside us as well, so we wanted to make sure that  
16 that professional voice was there and heard, both to  
17 enable us to be confident that it could be implemented,  
18 but also to support communication and to feed in any  
19 intelligence from the frontline that could shape it.

20 LADY HALLETT: When you say there was a level of engagement  
21 varied, level of engagement with whom?

22 A. The majority of my contact, my personal contact, was  
23 with the leads in NHS England who were leading the NHS  
24 IPC cell. The countries -- because the RCN is a UK-wide  
25 organisation and we have four regions, the four

24

1 countries, they would also have had relationships with  
2 their respective devolved partners and potentially their  
3 IPC leads as well in individual conversations.

4 **MS CAREY:** We've heard evidence from Lisa Ritchie who was at  
5 one stage the chair of the UK IPC cells. Was it people  
6 like her and those that made up the IPC cell that you  
7 were engaging with?

8 **A.** Yes, I would have gone to Lisa directly and although  
9 there was an email address for the UK IPC cell where  
10 a lot of the inquiries went, but I would also contact  
11 Lisa directly as a contemporary and national leader in  
12 IPC.

13 **Q.** Can I ask, what's the impact or the downside, whichever  
14 word you prefer, of a lack of engagement with the nurses  
15 when reviewing and developing IPC guidance?

16 **A.** What became very clear in this incident, which was  
17 different from previous incidents, was that not only in  
18 its scale, but also our members were able to watch on  
19 the television and see what was happening in Europe  
20 before it came to the United Kingdom. So our members  
21 were very aware of seeing other nurses in other  
22 countries wearing respiratory protective equipment  
23 whilst, here, after SARS-CoV-2 was downgraded, they were  
24 offered primarily surgical face masks. So it was  
25 a matter of confusion, and also there was a sense of

25

1 engagement from the get-go, if I can put it like that?

2 **A.** Absolutely. I mean we all understand that in a pandemic  
3 situation which is very fast moving and big, that there  
4 is a requirement to act fast. What I would say is that  
5 there was professional engagement with the swine flu  
6 pandemic in 2009. We all understood we had to turn  
7 documents around very quickly and attend meetings, and  
8 indeed everybody did that, and we achieved  
9 multi-professional collaboration.

10 We simply didn't understand why that engagement  
11 did not happen in this situation, given it was another  
12 pandemic albeit a different organism.

13 **Q.** On this topic I'm asked to ask you this. Do you think  
14 that any future guidance issued by the IPC cell would be  
15 more accurate or better received if there had been not  
16 just engagement with the RCN but perhaps with  
17 independent health providers like the independence  
18 ambulance sector, do you think that would have been of  
19 benefit?

20 **A.** Certainly I mean the College of Paramedics and other  
21 organisations would have been incredibly valuable to  
22 have because the context of risk to them is very  
23 different than it is to a nurse on the ward, and they  
24 would have provided a different perspective. But  
25 I would also just add that what was really needed was

27

1 a lack of confidence around the focus on their  
2 protection and a lack of understanding on why the UK  
3 appeared to be taking a different approach to other  
4 countries dealing with the same science and the same  
5 organism.

6 **Q.** How did that lack of understanding or the confusion that  
7 the nurses felt actually play out on the ground? Are  
8 you able to speak to that at all?

9 **A.** So we had many, many enquiries from nurses across health  
10 and adult social care settings asking us to explain or  
11 to rationalise the difference in levels of PPE. Nurses  
12 are expert in their practice and their patients, and  
13 when they started to raise real concerns, particularly  
14 around specific procedures such as nasogastric tube  
15 insertion or when they're very close-up to patients,  
16 they started to express doubt about the predominance of  
17 the droplet or -- mode of transmission. So they came to  
18 us, they contacted us through RCN direct, they contacted  
19 various people individually, and they wrote to us as  
20 well, raising their concerns.

21 **Q.** I suppose it may be said that in the early days of the  
22 pandemic there simply wasn't time for the level of  
23 engagement that the RCN would have wished for, but  
24 making such allowances as you feel able, do you think,  
25 in the event of a future pandemic, there needs to be

26

1 some form of implementation plan, given that time was  
2 short, and a communication plan, and because we weren't  
3 involved, we weren't able to pursue those asks. And  
4 I think communication was a real issue in terms of the  
5 frontline health workers understanding why they needed  
6 to do what they needed to do.

7 **Q.** And who do you think should be responsible for  
8 an implementation plan and/or a communication plan?

9 **A.** I'm not certain. It should be part of that whole  
10 management of writing guidance. There was an incredible  
11 amount of guidance written both IPC and non-IPC, so  
12 having a governance and risk cell that could support  
13 identify issues around implementation and communication  
14 plans would have been very helpful.

15 **Q.** One other matter you mention in relation to engagement  
16 is you say that the RCN is not a member of the Academy  
17 of Medical Royal Colleges --

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

19 **Q.** -- and therefore was often excluded from key meetings  
20 when, previously, you have been involved in the  
21 meetings. Do you know why the RCN was excluded from  
22 various meetings in the pandemic?

23 **A.** I don't. Certainly we have a good relationship with the  
24 Academy of Royal Colleges, and we have attended meetings  
25 at their request, but during the pandemic it appeared

28

1 that it was only the medical royal colleges around the  
 2 table. It's absolutely critical that nursing as the  
 3 largest part of the professional workforce is there, and  
 4 we are as able to provide insight and intelligence and  
 5 critical thinking to those situations as our medical  
 6 colleagues are as well.

7 **Q.** Now, you've touched on concerns about RPE already.

8 **A.** Yes.

9 **Q.** And I think you say at your paragraph 12 that it was the  
 10 RCN's wish that RPE for healthcare workers, including  
 11 nurses obviously, and for what you call the adoption of  
 12 the precautionary approach rather than just saying there  
 13 was no evidence to justify why IPC not changed. Can you  
 14 expand on that in a nutshell, please, and encapsulate  
 15 the RCN's concerns?

16 **A.** The guidance was predicated on influenza guidance which  
 17 had continued how we had practised at the time, which  
 18 was a predominance of surgical face masks. We knew that  
 19 SARS-CoV-2 was a Coronavirus and that previous  
 20 coronaviruses of high significance such as SARS and  
 21 MERS-CoV were both classified as airborne infections.

22 Now, without getting into the semantics, when you  
 23 talk about something as airborne, healthcare  
 24 professionals are able to visualise what that means and  
 25 are therefore able to easily understand why they need to

29

1 and manage that through existing legislation which  
 2 primarily comes under Health and Safety and COSHH. So  
 3 that was the driving force at that time and COSHH  
 4 remained in place throughout the pandemic and therefore  
 5 was a natural place to go in terms of how to protect  
 6 healthcare workers. The equipment that we had to manage  
 7 that risk was what we had at the time, which was single  
 8 use, predominantly, respiratory protective equipment or  
 9 FFP3s.

10 **Q.** Now, I think in your statement you go on to make  
 11 observations about PPE being reused, out-of-date PPE,  
 12 there are problems that her Ladyship is already familiar  
 13 with in terms of fit testing --

14 **A.** Yes.

15 **Q.** -- and the sheer number of masks that need -- or FFP3  
 16 that needs to be fit tested. So I just wanted to put  
 17 all of those into the round because I would like to ask  
 18 you, please, Mrs Gallagher, about two of the surveys  
 19 that the RCN conducted.

20 **A.** Yes.

21 **Q.** One in April and then another one in May 2020 which  
 22 really bring to the fore the concerns of your members in  
 23 relation to PPE.

24 So can we start with the April 2021, and could we  
 25 have up on screen, please, INQ000114401.

31

1 do what they need to do, ventilation, open windows,  
 2 respiratory protective equipment, whatever.

3 Sorry, I've lost my train of thought.

4 **Q.** I was asking you about the RCN's concerns about the RPE  
 5 or the lack thereof?

6 **A.** Yes. So to have this dominance of surgical face masks  
 7 when we were dealing with what was an airborne high  
 8 consequence infectious disease, other Coronavirus  
 9 infections classified as airborne, the two did not meet  
 10 and we also knew that surgical face masks did not  
 11 protect adequately against airborne particles, aerosols,  
 12 from the Health and Safety Executive themselves.

13 So we were really concerned about the level of  
 14 protection that was being advised. We were equally  
 15 mindful that actually wearing RPE for long periods of  
 16 time is not good to work in those situations, so we  
 17 needed clarity and we needed discussion and debate on  
 18 how best to protect healthcare workers given those  
 19 various tensions.

20 **Q.** Can I ask you then how does the RCN think that that  
 21 tension should be resolved? You want it but you don't  
 22 want to wear it all the time, I understand that, but is  
 23 there a middle ground?

24 **A.** The middle ground, we have to look at the level of risk  
 25 and we are legally bound to look at the level of risk

30

1 The survey was conducted over the Easter bank  
 2 holiday weekend in April 2020, as I understand it?

3 **A.** That's correct.

4 **Q.** And there were 13,605 replies. I ought to have asked  
 5 you, it's my fault, how many members are there of the  
 6 RCN?

7 **A.** At the time we had just under 500,000.

8 **Q.** All right, okay. So it's a large number of responders  
 9 but actually not a huge number of your members?

10 **A.** It's a proportion of our membership.

11 **Q.** All right. But it was a UK-wide survey as we can see  
 12 there. The majority of respondents worked in England,  
 13 11% in Scotland, 4% in Northern Ireland and Wales, 5%  
 14 identified as having a disability, predominantly females  
 15 who replied and we can see the ethnicity breakdown of  
 16 those 13,500-odd that responded.

17 Can, please, we go to page 6 of the survey, and  
 18 set out there really is a number of the concerns of the  
 19 majority of respondents, 11,300 of them, who worked in  
 20 environments with patients with confirmed or possible  
 21 Covid but does not involve undertaking high-risk  
 22 procedures -- do you mean AGPs by that or is that --

23 **A.** Yes, we didn't have major concerns around nurses working  
 24 in, say, intensive care facilities because the  
 25 ventilation tended to be quite good and they were well

32

1 used to using RPE.

2 **Q.** And you can see there what PPE was required to be worn  
3 and then in the section below saying "Access to enough  
4 supplies of PPE" 30% of respondents said there was not  
5 enough eye/face protection for them for the during of  
6 their shift. 28% said they have enough now but are  
7 concerned for the supply for their next shift.

8 One in four said there was not enough  
9 fluid-resistant surgical face masks for the during of  
10 the shift. And, again, a quarter of those were  
11 concerned about the next shift.

12 And 14% said they were lacking surgical masks.  
13 32% said they had enough surgery masks for the duration  
14 of the shift but are concerned, again, about the next  
15 shift.

16 The least shortage was with aprons and gloves.  
17 So over the course of that weekend there's still  
18 a fair proportion of the responders concerned about face  
19 and eye protection, and FRSMs and that was fairly early  
20 on in the pandemic, Easter?

21 **A.** That was April --  
22 **Q.** April 2020.  
23 And if we go to page 14 of the survey, I think  
24 there's -- some more general concerns were outlined.  
25 You see:

33

1 been so much of a problem, but certainly with the  
2 protective goggles and wearing spectacles underneath  
3 there were practical issues and the goggles didn't fit  
4 properly over the spectacles. So for a nurse, for  
5 example, that could have impacted on their ability to  
6 read prescriptions for example, dispensing medications,  
7 and also the fact that the goggles potentially, the  
8 members felt weren't actually protecting them  
9 appropriately.

10 **Q.** Can I ask you this, it doesn't sound like a new problem.  
11 Is there any kind of goggle that does work over glass  
12 wearers?

13 **A.** We don't tend to wear goggles in general practice. If  
14 we need eye protection it tends to be either a visor  
15 that goes over our faces with a mask or an integral  
16 surgical face mask with a visor as part of it.

17 **Q.** And we're familiar, I'm afraid, with the issue of fit  
18 testing for FFP2 and FFP3 masks and indeed those that  
19 had failed the fit test due to having too small a face,  
20 wearing a hijab or a head scarf or having a beard, we've  
21 heard about those, I'm afraid, from a number of other  
22 witnesses, Mrs Gallagher.

23 Can I ask you, what did the RCN do with the  
24 results of the survey?

25 **A.** So the survey was really a snapshot survey to help us

35

1 "Anecdotal evidence from our members revealed that  
2 they were concerned with being pressured by their  
3 employers to care for confirmed or possible COVID-19  
4 patients without suitable PPE."

5 You received calls about that from the members.  
6 The purpose of the survey was to understand how far  
7 nursing professionals had access to materials and  
8 facilities to help address infection control. We asked  
9 about the extent to which nurses were able to raise  
10 concerns, how they did that and whether those concerns  
11 had been addressed.

12 We can see there half of the respondents said that  
13 during Covid pandemic they felt pressure to care for  
14 a patient without adequate protection as outlined in the  
15 current PPE guidance.

16 And one in five of the respondents, almost one in  
17 five, has had issues with PPE due to specific individual  
18 needs such as disabilities, religious and cultural  
19 practices, having facial hair or wearing glasses.

20 The overriding issue related to PPE was for those  
21 wearing spectacles?

22 **A.** Yes.  
23 **Q.** And what was the problem with -- if you're  
24 a glass-wearer?  
25 **A.** So if you were provided with a visor it may not have

34

1 understand the sort of experiences of our members at  
2 that time and in early April 2020 this was at a time  
3 when we were told there weren't any shortages of PPE, so  
4 it allowed to us feed into conversations from  
5 a four-nations perspective to lobby and put pressure on  
6 the governments to ensure that the supply of PPE was  
7 kept going to keep healthcare workers safe.

8 **Q.** I think you said in due course you sent these findings  
9 and indeed the May survey, which we'll come on to, to  
10 Department of Health, the UK Prime Minister, the  
11 equivalents in the devolved nations, NHS England, and  
12 the HSE?

13 **A.** It was widely disseminated, yes.  
14 **Q.** Did you have any response from any of those  
15 organisations to the findings?  
16 **A.** So the four country responses would have gone back to  
17 the respective four country directors. My recollection  
18 is that there was a limited response, an acknowledgement  
19 of the situation but that would be about it.

20 **Q.** Did you find that there was any improvement in the  
21 supply of PPE as the months wore on?  
22 **A.** As the months wore on we didn't really see any  
23 particular issues with aprons or gloves although there  
24 were moments when certainly I remember the issues with  
25 the quality of aprons being an issue. Most of the

36

1 concerns tended to be around masks and eye protection on  
2 an ongoing basis.

3 **Q.** Let's look, please, if we may, at the May 2020 survey  
4 and it's INQ000328873, and could I have on screen page 4  
5 where there's a very helpful summary of the findings.

6 Now, this was conducted over 7-11 May 2020.

7 **A.** Yes.

8 **Q.** This time 5,023 replies and some positive news:

9 "The situation has improved across the board in  
10 terms of access to standard and high-risk items of  
11 PPE ..."

12 When you say high-risk items, what was being  
13 referred to there?

14 **A.** So that would have been respiratory protective equipment  
15 FFP3s.

16 **Q.** Right.

17 **A.** And potentially, but forgive me, I can't quite remember,  
18 but long-sleeve gowns.

19 **Q.** 28% of respondents were very confident their employer  
20 was doing enough to adequately protect them from Covid.  
21 40% moderately confident. You hadn't asked that the  
22 first time around.

23 **A.** No.

24 **Q.** No criticism but just making the position clear:

25 "However, more standard and high-risk PPE are  
37

1 infection control supplies.

2 And this, then, over half of respondents had  
3 raised concerns about PPE and over a quarter of these  
4 were not addressed at all.

5 "However, there had been improvements in the  
6 concerns that had been addressed fully compared to the  
7 previous survey ..."

8 May I ask you about that, please, Mrs Gallagher.  
9 If you are a nurse on the frontline to whom is it that  
10 you should raise concerns initially?

11 **A.** Initially you should go to your manager in the first  
12 place.

13 **Q.** And what's the sort of brief trajectory of an escalation  
14 of concerns from the manager up?

15 **A.** So depending on where you work, it would go to  
16 a manager, then a senior manager, then go up through the  
17 organisation from there in line with the various  
18 governance arrangements. Members did report that they  
19 had a general lack of confidence in concerns being  
20 listened to and acted upon and in fact many members  
21 admitted to not raising concerns based on that.

22 **Q.** That can come down.

23 But one of the things you do say in your statement  
24 is that the first PPE survey revealed that staff from  
25 ethnic minority groups were more likely to report they

39

1 being donated, home-made or self-bought, especially  
2 eye/face protection compared to our previous survey."

3 So still by May of 2020 there are concerns about  
4 the supplies. And what was the position where people  
5 donated or made PPE? Was that an acceptable form of PPE  
6 to be worn?

7 **A.** So if I just explain some of the issues that could have  
8 potentially resulted in that response.

9 **Q.** Yes.

10 **A.** The surveys were open to health and adult social care  
11 settings. So without having the data in front of me  
12 I couldn't say, but certainly we know that a lot of  
13 donations were made to adult social care at the time by  
14 the general public and by family members that were  
15 concerned about their loved ones going to work.

16 Our position was very clear and we added this to  
17 our frequently asked questions on our website that  
18 whilst we really appreciated donated and home-made  
19 items, it was absolutely critical when wearing them in  
20 the workplace that they met the right standards of  
21 protection.

22 **Q.** Over one-third of respondents said they felt pressure to  
23 care for a patient with possible or confirmed Covid.  
24 That had improved since the April survey.

25 Clearly there were some general concerns about  
38

1 did not have access to adequate PPE compared to their  
2 colleagues from British, white British groups. Are you  
3 able to help at all as to why there is this apparent  
4 disparity?

5 **A.** I can't based -- without having the data in front of me.  
6 So for example, I don't know how many of our respondents  
7 were working in adult social care or working in the NHS.  
8 Also we do know that some of our colleagues from black  
9 and ethnic minority groups are very reluctant to  
10 challenge or have a complete lack of confidence in their  
11 concerns being raised and that may well have had  
12 an effect on their ability to ask for PPE, whether or  
13 not that would have been provided.

14 **Q.** I think you set out in your statement and you say:

15 "Staff members from ethnic minority groups  
16 reported feeling less confident in their employer's  
17 ability to protect them from exposure to Covid in  
18 comparison [with] their white British counterparts:  
19 Almost a quarter of ethnic minority staff did not feel  
20 confident at all compared to around 1 in 10 white  
21 British."

22 And you said:

23 "Staff from ethnic minorities reported they were  
24 less likely to have had their concerns addressed in  
25 comparison to their white British counterparts."

40

1 A. Yes.

2 Q. Can I ask you, what did the RCN do, and I'm not  
3 suggesting it's solely your responsibility, but is there  
4 anything the RCN did to try and ameliorate those  
5 concerns or improve the position for ethnic minority  
6 staff to help them feel confident?

7 A. So working through the regions, the organisation, the  
8 Royal College of Nursing has its regional structure and  
9 then work through our branches, our health and safety  
10 and well-being representatives and learning  
11 representatives, so a huge amount of energy went in to  
12 try and reach our black and ethnic minority colleagues  
13 through the various communities and where they worked.

14 We also knew that based on where the majority  
15 where -- or the roles that the majority of our  
16 colleagues had were in sort of band 5, band 6 roles  
17 where they would have had significant patient contact.  
18 So some of this may also have been around the demand  
19 that they need, the demand to use PPE that simply wasn't  
20 being met on the frontline as well. So it's a really  
21 complex issue and it's one that we really want to  
22 understand in order to build in the experiences of our  
23 black and ethnic minority colleagues into future  
24 pandemic planning because it's absolutely critical.

25 Q. You may have answered my question in part there because

41

1 to be adequately decontaminated?

2 A. Yes.

3 Q. Now, I think the RCN, is this right, received reports of  
4 PPE being removed and staff being challenged when they  
5 wore PPE. It's at your paragraph 45 onwards,  
6 Mrs Gallagher, but there's an email that may bring this  
7 to light.

8 Could we have a look, please, at INQ000328902.  
9 And could we go to the final page of the document,  
10 page 3.

11 This is an email from Dave Carr at Unite and it is  
12 dated, forgive me, 21 January 2021. And if we could  
13 just go to -- it actually just starts on the bottom of  
14 page 2, I'm so sorry. Thank you very much.

15 The recipient had been "contacted by several  
16 members of staff yesterday, last night and this morning  
17 about PPE provision on a ward.

18 "Staff have been told at morning handover that  
19 they were not allowed to wear FFP3 masks (These masks  
20 have been physically removed from PPE stations in the  
21 areas discussed)

22 "Staff have been told that they will be challenged  
23 if 'caught' wearing them.

24 "[The] ward had their FFP3 stock removed to the  
25 do I was may of the staff working there."

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1 I was going to ask what additional steps could have been  
2 taken to try and address some of those disparities.  
3 Clearly planning?

4 A. Yes.

5 Q. But is there anything else that you can perhaps suggest  
6 that would make a real practical difference here?

7 A. The greater use of collecting data on protective  
8 characteristics is something that we're really keen is  
9 implemented both in terms of data on infections or  
10 deaths but also in day-to-day issues to help us  
11 understand where some of these challenges are and why  
12 they're actually arising.

13 That is counterbalanced slightly by some people  
14 not wanting to disclose their ethnicity and we have to  
15 respect that but it would be really helpful for us to  
16 understand that -- that real lived experience of them in  
17 the workplace.

18 Q. Whilst we're dealing with PPE, I think the RCN, is this  
19 right, advised its members on its dedicated PPE webpage  
20 to not use PPE which was not fit for purpose --

21 A. Correct.

22 Q. -- if it didn't fit correctly; is that correct?

23 A. Yes.

24 Q. Didn't meet the correct standards, had degraded, was  
25 donated as we've just looked at, or was dirty or unable

42

1 I understand -- is it the head of nursing, "HON"?

2 A. I would say that's probably what it refers to.

3 Q. Yes.

4 "... in this area has supported the decision to  
5 remove FFP3 from non-AGP areas."

6 Then it sets out the trust is following the  
7 guidance. The author makes a point:

8 "We are not asking for FFP universally, although  
9 we would be happy with that! We are asking that staff  
10 to have the choice to wear the PPE they feel safe with."

11 A. Yes.

12 Q. "Incidentally medical staff in the same environment as  
13 nurses wearing full FFP3 and long sleeve gowns, this  
14 adds even further [to] distress and alarm to our nurses  
15 discouraged from doing likewise."

16 And so this -- Mr Carr is raising this with the  
17 RCN. Perhaps then if we could scroll up, please, to  
18 follow the thread, there we can see -- you're asked  
19 whether you can support this with the RCN's backing,  
20 they can't find an easy answer on the PPE pages, just  
21 that the RCN has asked for a review of guidance  
22 generally.

23 "... not sure of the evidence base but what I  
24 would say from experience that you can't guarantee the  
25 Covid status of anyone you're dealing with so not having

44

1 FFP3 does seem to be an extreme measure ..."  
 2 And if we go up again, you're copied in.  
 3 **A.** Yes.  
 4 **Q.** And up again, please. We can see your response.  
 5 "... Mark -- thanks this is really timely. [It's]  
 6 very disappointing to hear staff being responded to in  
 7 the way described below. I've copied Jude [another  
 8 colleague at the RCN] in for some advice as I also had a  
 9 conversation today where I discussed with a member  
 10 barriers to a staff requesting FFP3's. The new IPC  
 11 guidance (NHS not [Public Health] ...) does allow for  
 12 employers/Trusts to implement a move to the use of FFP's  
 13 in areas or across the board. If this happens though  
 14 staff must be fit tested ..."  
 15 And if we go up again I think there is an update  
 16 to what was going on at the hospital concerned:  
 17 "... by way of ... update we gather [the]  
 18 hospital removed ... FFP3 as staff were wearing it  
 19 without being fit tested appropriately. They may  
 20 bring it back with fit testing in place. That said  
 21 there is disparity across London with some trusts  
 22 voluntarily providing [a] higher grade PPE because  
 23 they recognise it makes staff feel safer -- all links  
 24 in to the postcode lottery press release that's been  
 25 prepared."

45

1 which was much more transmissible. So staff were highly  
 2 anxious around their status and their protection. They  
 3 knew that FFP3 masks offered a higher degree of  
 4 protection. They clearly identified they needed to use  
 5 them in that area in line with their dynamic risk  
 6 assessment, which sounds complicated but in fact it's  
 7 not if the employer has done their risk assessment  
 8 appropriately, and actually their confidence would have  
 9 been decimated to have those masks removed or fit  
 10 testing not provided.  
 11 **Q.** Can I just ask you about the risk assessments, because  
 12 I think in your statement you say that the RCN  
 13 subsequently worked on developing its own --  
 14 **A.** Yes.  
 15 **Q.** -- Covid-19 risk assessment. Why did the RCN do its  
 16 own?  
 17 **A.** We came to the decision to create a toolkit, so not  
 18 guidance but a toolkit, after we had tried for some time  
 19 to influence the IPC guidance and how it described the  
 20 level of protection that could be used in different  
 21 situations.  
 22 We wrote the guidance with stakeholders rather  
 23 than it just being a nursing document, because this  
 24 clearly was -- should have been available to all, and  
 25 was not available to all. What we wanted to do --

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1 So a number of issues in there.  
 2 **A.** Yes.  
 3 **Q.** It sounds like it was removed, but perhaps not  
 4 necessarily for the reasons people thought, and it was  
 5 being removed because there wasn't proper fit testing  
 6 going on. Is that how you read that chain?  
 7 **A.** So that's certainly a possibility. As I say, this  
 8 incident was reported to us. What we know is that there  
 9 was certainly a lot of misunderstanding around the  
 10 application of the IPC guidance in practice. There was  
 11 huge confusion over the hierarchy of controls. And,  
 12 of course, what a lot of people didn't appreciate was  
 13 that actually the IPC guidance in effect was the minimum  
 14 level of guidance, and that actually organisations were  
 15 quite within their rights to go beyond that in areas in  
 16 line with the employer's overarching risk assessment  
 17 where there were higher risks to staff. So certain  
 18 areas such as Accident & Emergency departments, for  
 19 example, where lots of people would have been coming in  
 20 to the organisation, you wouldn't have known what status  
 21 they had with Covid or whatever. That would be  
 22 different perhaps to an outpatients setting.  
 23 What this email did really was to highlight the  
 24 confusion that was in place, and at this time,  
 25 of course, we had the new variant starting to circulate,

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1 because we had realised by the end of June 2021 that  
 2 there was no way we were going to be successful in  
 3 influencing any changes in the IPC guidance -- so our  
 4 thinking and our decision-making turned to improving  
 5 education and awareness on how to actually implement  
 6 risk assessment, and think about COSHH in the workplace.  
 7 COSHH in particular is something that many nurses  
 8 haven't historically thought about on a day-to-day basis  
 9 and where they would have considered COSHH it would have  
 10 been in specific instances such as working in endoscopy  
 11 with disinfectants or when cleaning up spillages of  
 12 blood and body fluids and using chemicals for those.  
 13 The use of COSHH is applied to a biological  
 14 hazard, so a virus in this situation, is something that  
 15 very, very few people outside of laboratory settings  
 16 would have had to consider. So their knowledge, their  
 17 confidence in this and then to put it into practice with  
 18 a risk assessment was minimal. So that's why we did our  
 19 risk assessment toolkit.  
 20 **Q.** Thank you.  
 21 **LADY HALLETT:** I can't remember if you did explain earlier,  
 22 but for those who don't know, COSHH is the Control of  
 23 Substances --  
 24 **A.** Control of Substances Hazardous to Health. That's  
 25 correct.

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1 **MS CAREY:** May we after the break, please, come on just to  
2 look at some of that IPC guidance and some of the  
3 problems you've just alluded to.

4 **LADY HALLETT:** Very well. I shall return at midday.

5 (11.43 am)

6 (A short break)

7 (12.00 pm)

8 **LADY HALLETT:** Ms Carey.

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

10 Mrs Gallagher, can I ask you, please, about the  
11 IPC guidance you've hinted at some of the RCN's concerns  
12 already, which I hope I may do justice by saying it was  
13 a major concern of the RCN's that the IPC guidance did  
14 not make sufficient or limited reference to HSE  
15 requirements. And I just want to try and understand why  
16 does the RCN say it's so important, for example, to  
17 refer to Health and Safety Executive requirements or  
18 COSHH, as we were just talking about before the break?

19 **A.** Our position was and remains that IPC guidance does not  
20 exist in isolation. So IPC guidance not only has to be  
21 implemented in the context of where a healthcare worker  
22 is working, but it also has to align and reflect the  
23 needs of other legislation or regulations.

24 Given that many healthcare workers were not  
25 familiar in the way that they needed to become familiar

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1 would take place and guidance would inevitably be  
2 adapted over time.

3 So March 2020 would have been the time to really  
4 put additional resources, FAQs, guidance, tips for  
5 whatever it was, in, that then would have guided  
6 employers, managers and healthcare workers through the  
7 rest of the pandemic.

8 **Q.** Would it have been too late to have done it later in the  
9 pandemic or perhaps between wave 1 and wave 2?

10 **A.** Well, providing information is always helpful but that  
11 first iteration, because everything falls from the IPC  
12 guidance, you know, assumptions around demand fall from  
13 the IPC guidance.

14 So, for example, being able to understand the  
15 demand for PPE, taking into account that individual  
16 healthcare workers would at times need to consider the  
17 risk to them and perhaps use an FFP3 mask instead of  
18 a surgical face mask, for example, that could have had  
19 a profound impact on the modelling for PPE supply,  
20 rather than just referring people to the IPC guidance  
21 which felt very flat in a one-size-fits-all.

22 **Q.** May I ask you about one particular piece of guidance.

23 We know that there was in April 2020 the acute shortages  
24 guidance that came out.

25 **A.** Yes.

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1 with COSHH and health and safety legislation we felt  
2 that just having a single reference to refer to health  
3 and safety was not helpful.

4 So our expectation would have been that there  
5 either would have been an appendix or there would have  
6 been signposting, not to a website but to practical or  
7 to guidance in a practical way that healthcare workers  
8 can relate to, to help them relate the IPC guidance to  
9 the implementation of COSHH.

10 **Q.** May I ask you about that, though, because one of the  
11 things we've heard obviously is the guidance changed  
12 a lot throughout the pandemic and the difficulties of  
13 keeping up with the guidance --

14 **A.** Yes.

15 **Q.** -- is something that's been raised. How practically  
16 helpful is it to give yet more information to the  
17 healthcare workers by way of an appendix, perhaps, as  
18 you have just suggested?

19 **A.** I would have liked to have seen that at the beginning.  
20 So when SARS-CoV-2 was downgraded from a high  
21 consequence infectious disease, which would have  
22 happened at some point in the pandemic, we all accept  
23 that's a natural part of the process, that first  
24 iteration of guidance was absolutely critical because it  
25 sets the bar for what would follow given that learning

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1 **Q.** Particularly at that time we've heard there was a real  
2 shortage of gowns at that time, and that guidance in  
3 short advised sessional use of some PPE or reuse of some  
4 PPE, and I think the guidance said that HSE had approved  
5 that where it was safe to do so, where there were acute  
6 shortages.

7 You make the point in your statement,  
8 Mrs Gallagher, that that guidance was developed without  
9 full and formal consultation with the RCN and that the  
10 RCN did not support that guidance.

11 **A.** That's correct.

12 **Q.** And why did the RCN take that position?

13 **A.** The RCN, I mean, this is after the fact but we were  
14 really surprised at the speed at which this guidance was  
15 developed, and also surprised that shortages of PPE  
16 hadn't really been considered and built in at an early  
17 stage, so it would be completely understandable and  
18 expected, given the global supply chain demands, that we  
19 would run short of PPE. It was never going to be  
20 perfect all the time.

21 If this had been -- if this guidance, this concern  
22 had been addressed earlier, with multi-professional  
23 stakeholders including nurses, because it wasn't just us  
24 that were facing risks, our other colleagues were as  
25 well, then that would have given us an opportunity to

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1 think about the types of messages we might need to give  
2 to our members, what sort of questions, you know, to  
3 prepare answers for when they were concerned. But given  
4 that we had had shortages of PPE, as identified in our  
5 survey, and then members were asked to reuse PPE  
6 potentially, it just added to the concern and added to  
7 the confusion and further eroded that confidence around:  
8 am I really protected when I'm going to work to do my  
9 job, which I want to do, to look after my patients but  
10 I am at huge risk from getting an infection.

11 **Q.** It might be said by those that brought it in that they  
12 needed to do it at speed because there was such  
13 a shortage and so they had to do something to try and  
14 bridge the gap.

15 **A.** Yes.

16 **Q.** But when it came out how did it go down with the RCN's  
17 members?

18 **A.** So RCN members were really concerned and our country  
19 directors in particular were really concerned, and in  
20 fact the other nations, so Wales, Northern Ireland and  
21 Scotland chose not to accept the acute shortages  
22 guidance and relied instead on their supply of PPE. So  
23 this was predominantly an England-only issue, for want  
24 of a better word.

25 Although the technical aspects of reusing or

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1 views on how PPE could be reused and what was safe to do  
2 and what wasn't safe to do, but this was around helping  
3 our healthcare workers say confident. I, to this day,  
4 don't understand how considering shortages of PPE wasn't  
5 taken into account at a far earlier stage and then  
6 thinking and engagement around how we might broach this  
7 really difficult subject would have been started to  
8 think -- thought about a lot earlier because to do it in  
9 what was in effect, I think, about 48 hours is  
10 incredibly fast and people are working at pace with  
11 other demands at the same time.

12 So, you know, it was just incredible that,  
13 you know, as the largest part of the workforce and that  
14 nurses were using predominantly the most PPE, we weren't  
15 engaged in that discussion.

16 **LADY HALLETT:** That I understand as a principle, that  
17 obviously as the people who were the most affected you  
18 should have been consulted. I understand that. But my  
19 question really is, what difference would there have  
20 been to the guidance if you had been consulted?

21 **A.** There probably wouldn't have been any difference in  
22 terms of the technical aspects of the guidance, we may  
23 have had some comments around how healthcare workers  
24 could have stored their masks safely, knowing how people  
25 can put things in pockets, you know, what to do, what

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1 decontaminating PPE were considered, and indeed some of  
2 my decontamination colleagues, actually, what didn't  
3 really follow was good communication and explanations  
4 around that and that was the main concern of our  
5 members.

6 **Q.** I think you say in your statement that Dame Donna  
7 Kinnair who was the chief executive of the RCN at the  
8 time wrote to the Secretary of State for Health and  
9 Social Care who was in fact cited on the acute shortages  
10 guidance, as I understand it, and indeed the  
11 chief executive of Public Health England raising  
12 concerns about the lack of consultation with the RCN and  
13 advising both the Secretary of State and the  
14 chief executive that the RCN did not endorse the  
15 guidance?

16 **A.** Yes.

17 **Q.** Do you know whether there was any response from the  
18 Secretary of State and/or the chief executive of PHE?

19 **A.** I don't, I'm sorry.

20 **Q.** So it's not to say there wasn't one but you don't know?

21 **A.** I can't recall, I can't recall one.

22 **LADY HALLETT:** Had the RCN and other interested parties been  
23 consulted, Mrs Gallagher, what difference would it have  
24 made to the guidance as it went out?

25 **A.** So we would not have had -- well, I may have had some

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1 not to do, things like that, and looking at what might  
2 happen in different care settings rather than just in  
3 an NHS hospital, but the technical aspects probably  
4 would not have changed but we would have been able to  
5 support potentially, given the situation, if we had been  
6 able to look at communication and things like that.

7 I do feel, though, that the position of the RCN  
8 would have remained reflective of the position of the  
9 other countries in that we needed to keep the PPE  
10 supplies coming in rather than potentially rely on  
11 reusing PPE as a stop gap or to keep the PPE going.

12 **LADY HALLETT:** I've got one other question that I was going  
13 ask anyway but has arisen. You say the other countries,  
14 Wales, Northern Ireland and Scotland didn't accept the  
15 guidance, so what happened? What happened?

16 **A.** They chose not to implement the shortages guidance. So  
17 they maintained their efforts, as I understand it, on  
18 having the PPE supplies continuing to come through, so  
19 there wasn't a need for them to implement it. And in  
20 fact they didn't advise that that's what healthcare  
21 workers did.

22 **LADY HALLETT:** One more question. But surely in England  
23 they carried on trying to get supplies?

24 **A.** They did. So the acute shortages guidance was written,  
25 I -- forgive me, but I'm not aware that it was ever

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1 really implemented, it was, it was -- they were getting  
2 really, really close to running out of PPE so they had  
3 to have something in place to do that.

4 **MS CAREY:** My Lady may recall that when the Chief Nursing  
5 Officer gave evidence Northern Ireland sent 25,000 gowns  
6 over to England to try and stem the problem, and as  
7 I understand it, the shortages were not so acute in the  
8 other nations that they required the guidance.

9 **A.** There was an issue of mutual aid between the countries  
10 as well as between NHS organisations and somehow they  
11 managed to keep things going.

12 **Q.** Thank you. Mrs Gallagher, it is my fault, I asked you  
13 a bad question but I think in fact in your statement you  
14 do go on to set out that PHE did in fact respond to  
15 Dame Donna's concerns.

16 **A.** Right.

17 **Q.** Dame Donna had asked them for the evidence base on which  
18 the acute shortages guidance was issued and although PHE  
19 indicated that they were worried about the concerns that  
20 the RCN had raised, they did not provide the evidence  
21 base that Dame Donna had requested.

22 Now, can I ask you, though, about some guidance  
23 that did come from the RCN which was that I think given  
24 that there were concerns about availability of PPE, RCN  
25 published guidance to the members about refusal to

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1 through and there are implications for healthcare  
2 workers should they actually find themselves in that  
3 situation. But, given that, what I would say and what  
4 our members were also aware of in some settings was that  
5 a precedent already existed in terms of what healthcare  
6 workers should consider and could do if they found  
7 themselves in danger. So an example would be  
8 a community nurse, for example, going into a patient's  
9 home where weapons were present. If the healthcare  
10 worker felt themselves to be in danger, she could  
11 withdraw, and then there was a process to follow.

12 So this was really an extension of that, and also  
13 the precedent that exists in other professions when  
14 faced with danger.

15 **Q.** Now this came, I think, about on 9 April 2020. Can we  
16 just go to page 2 because at box 6 there's various steps  
17 that the RCN urging the member to consider before  
18 getting to this stage. Box 6 says:

19 "Ultimately, if you have exhausted all other  
20 measures to reduce the risk and you have not been  
21 given appropriate PPE in line with the UK [IPC]  
22 guidance, you are entitled to refuse work. This will  
23 be a last resort and the RCN recognises what  
24 a difficult step this would be for nursing staff."

25 And they advise them to talk to local reps or

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1 treat?

2 **A.** Yes.

3 **Q.** Can we have a look, please, on screen, at INQ000328905.

4 May I, perhaps before we descend to some of the  
5 detail there, why was it necessary for the RCN to  
6 publish a guidance which might be telling the nurses you  
7 don't have to treat people in certain circumstances?

8 **A.** We had been having an increasing number of concerns  
9 raised by members and had actually published guidance on  
10 PPE, am I safe in the wake of the shortages guidance,  
11 and also given the ongoing flux, I suppose, in terms of  
12 supply of PPE.

13 This really came to a head, and in particular  
14 Northern Ireland had a specific concern around the  
15 supply of PPE in discussions with the First Minister in  
16 Northern Ireland. So my recollection is that we brought  
17 this issue back because it was starting to be raised,  
18 and rather than wait for members to potentially refuse  
19 to treat patients, we would issue guidance on what  
20 needed to be considered, given this huge tension around  
21 protecting the patient and protecting the healthcare  
22 worker and what this actually meant in practice.

23 Our professional code takes precedence, so this is  
24 not about somebody just walking into work and suddenly  
25 refusing to treat patients; there is a process to go

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1 indeed phone a telephone number to take advice.

2 **A.** Yes.

3 **Q.** Do you know if any nurses did in fact refuse to treat?

4 **A.** To the best of my knowledge, no nurses did.

5 **Q.** And was there any criticism of perhaps those who were  
6 talking about refusing to treat or thinking about  
7 potentially following and implementing this guidance?

8 **A.** It was an incredibly difficult subject to have  
9 conversations with people about, clearly even when  
10 considering the potential to not provide care to  
11 patients, that is incredibly difficult for nurses to do,  
12 and obviously the other issues were around how their  
13 colleagues may feel in the same areas and things like  
14 that, as well as the implications from a managerial  
15 perspective. But by writing this guidance, it was  
16 available as a resource for people to read and think  
17 through in a structured way, rather than going to the  
18 workplace, and perhaps make a rash decision which is not  
19 what we wanted our members to do.

20 **Q.** In fact, if we just scroll down on the guidance, you can  
21 see there that the implications of a lack of PPE and if  
22 you refused to treat there were potentially legal  
23 consequences of dismissal, action taken by the  
24 regulators --

25 **A.** Yes.

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- 1 Q. -- clinical negligence, inquests or indeed -- it may  
2 well be rare, but potential criminal charges upon it.  
3 A. That's correct. Yes.  
4 Q. So it was setting out fairly and squarely, if I may put  
5 it like that --  
6 A. Yes.  
7 Q. -- that these are difficult steps you have to consider,  
8 but there are also potentially ramifications if you do  
9 in fact refuse to treat?  
10 A. And it was our responsibility to make our members very  
11 clear that whilst you may be in an untenable position  
12 actually there is a process and there are implications  
13 if you go down that line. This is a really important  
14 point for me in terms of learning and future planning  
15 for the pandemic is how we start to consider these  
16 issues for the next incident that occurs, and how we  
17 broach these really difficult conversations and this  
18 tension because if our healthcare workers are getting  
19 infected and are unable to work on one level, obviously  
20 there's the more serious harm that can occur, then how  
21 do we manage the public's expectations and have that  
22 conversation around this really difficult ethical issue.  
23 Q. That document can come down, please. Can I turn to  
24 a slightly different topic and that is of fit testing.  
25 A. Yes.

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- 1 age 50, with a certain face shape and of course we all  
2 don't fit that shape. So what we need, I'm not aware of  
3 any specific work that is going on in a structured way  
4 around looking at this, but certainly from our  
5 perspective in terms of recommendations and learning, we  
6 need personal protective equipment, respiratory  
7 protective equipment that will enable to us do our job  
8 safely. At the moment we have only what is provided,  
9 which is predominantly single use FFP3, that apart from  
10 the fact that it doesn't fit everyone and there are huge  
11 practical problems with fit testing, it's not  
12 sustainable and the wastage is huge.  
13 So reusable respiratory protective equipment, our  
14 members are suggesting is the way forward should we need  
15 it. We need innovation at pace to find and test designs  
16 that are not only acceptable to nurses but are  
17 acceptable to our patients and can enable lip-reading  
18 and some of the practical care provision. And also,  
19 that we involve the public because they will be the  
20 recipients of healthcare workers wearing these masks.  
21 So it's a huge piece of work but one I think that  
22 the UK would really benefit from in terms of preparing  
23 us in the future, whatever that design looks like.  
24 Q. And I presume, from what you've said, that that answer  
25 would apply equally to some of the problems we've heard

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- 1 Q. I think in your statement you make the observation  
2 obviously that we are aware there needs to be a fit test  
3 for FFP3. There were reports, is this right, of up to  
4 sometimes 17 different types of mask within one trust?  
5 A. That's correct, yes.  
6 Q. Each of which has to be fit tested?  
7 A. Yes.  
8 Q. And you say in your statement that some brands of FFP3  
9 do not appropriately fit female faces?  
10 A. That's correct.  
11 Q. And that's been raised with the British Safety Industry  
12 Federation. Can you help now, is there any working with  
13 done to try and broaden the numbers of types of FFP3 to  
14 fit female faces, those wearing beards, all the other  
15 different problems that we've heard of?  
16 A. So there is an issue, in that the use of respiratory  
17 protective equipment in healthcare is -- historically  
18 it's not been something that's been widespread, it's  
19 something that we've used when nursing particular  
20 patients with, for example, TB, or other infections, but  
21 generally it's not widely used. And we lost  
22 an opportunity after the swine flu pandemic to actually  
23 build that into our planning.  
24 The FFP3 masks that we have are built on something  
25 called the Sheffield man face so a white man, about

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- 1 with ethnic minority healthcare workers not having --  
2 A. Absolutely.  
3 Q. -- sufficient supplies of PPE that fit them.  
4 A. And we would clearly need to take their views and their  
5 input into the design and everything alongside both for  
6 ethnicity to meet ethnicity needs but also religious  
7 needs, as you've said.  
8 Q. I think you're aware that we have heard from  
9 Professor Dinah Gould in relation to the independent  
10 review --  
11 A. Yes.  
12 Q. -- that the RCN commissioned her to undertake so I don't  
13 need to ask you about that, Mrs Gallagher, and also  
14 we've heard from the Resuscitation Council --  
15 A. Right.  
16 Q. -- in relation to AGPs and what was or wasn't deemed to  
17 be an AGP, and so I don't need to ask you that, but I  
18 just say that so that if anyone who is following wants  
19 to look when the statement is published, there are  
20 various sections in your statement dealing with that.  
21 A. Yes.  
22 Q. Can I just ask you this. In your statement you set out  
23 over 25 or so pages a chronology of the RCN's concerns  
24 that were raised with government, with the IPC cell and  
25 with other bodies, other stakeholders, and I'm not going

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1 to go through all of it but there are some topics  
2 I'd like to ask you about, please.  
3 Clearly you say -- have told us already that  
4 certainly in the beginning of the pandemic there was  
5 concerns raised across all four nations about the lack  
6 of PPE in March 2020, going into April 2020. And  
7 I think, is this right, that Dame Donna wrote to the  
8 Prime Minister on 23 March raising concerns? There was  
9 a similar letter sent to the First Minister of  
10 Scotland --

11 **A.** Yes.

12 **Q.** -- and indeed one to the Welsh minister.

13 Indeed, in relation to the Welsh minister there  
14 was concerns about PPE being of poor quality, so not  
15 just the lack of it but the quality of it once it was  
16 available.

17 Perhaps we could just put up on screen the letter  
18 to Vaughan Gething. It's at INQ000417538.

19 It's from the Royal College of Nursing's branch in  
20 Wales. 27 March. We've just gone into lockdown. The  
21 author, Helen Whyley, who is the director of RCN  
22 Wales --

23 **A.** That's correct.

24 **Q.** -- wrote to the minister and said that there was  
25 concerns. Firstly:

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1 guidance changed and implemented locally by the Monday,  
2 and the communication around why the guidance was  
3 changing, so the rationale for that -- to aid the  
4 communication and reassure people's anxiety, they felt  
5 was lacking. So that was a major concern there that --  
6 of course the guidance will change. Our members,  
7 I feel, would have been reassured if they felt we were  
8 around the table. Now, that may have resulted in  
9 criticism for us if they didn't agree with what the  
10 guidance said, but there was -- by that time their  
11 confidence was, as the letter says, really being --  
12 becoming eroded.

13 **Q.** Can I just ask you about something you said there. You  
14 mentioned the guidance coming out on a Friday afternoon  
15 and we heard from a witness from the RCN just before you  
16 gave evidence who said, "It seemed ridiculous that  
17 I needed to wear a mask on Monday and I was given  
18 a weekend of not wearing a mask and therefore being at  
19 risk."

20 **A.** Yes.

21 **Q.** How practically possible would it have been for  
22 a guidance to come out on a Friday afternoon saying:  
23 from now masks have got to be worn?

24 Is that realistic for the trusts and all of the  
25 other settings to be able to bring in mask wearing

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1 "The guidance is not clear and is causing  
2 confusion.

3 "The changes in approaches has made staff confused  
4 and not trusting of the ... guidance."

5 As I think you've already alluded to in your  
6 evidence.

7 "What has been extremely challenging is the  
8 constant change in advice/guidelines, particularly in  
9 relation to PPE. When we are sending out updated advice  
10 this is causing anxiety with people, as whilst we are  
11 being totally transparent, people's confidence in the  
12 system is being eroded."

13 May I just ask you about that because there is  
14 a tension. The guidance needs to be updated --

15 **A.** Absolutely, yeah.

16 **Q.** -- as and when there are, perhaps, acute shortages as  
17 we've just been discussing, or change in the routes of  
18 transmission in due course. How do you balance the need  
19 to keep people updated without overburdening them with  
20 ever-changing guidelines?

21 **A.** What I found in my experience is that nurses understand  
22 that the guidance will need to change over time. Their  
23 real concern in phase 1 of the pandemic was that the  
24 guidance changes always came out on a Friday afternoon  
25 and there was a massive scramble to try and get the

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1 forthwith?

2 **A.** It was incredibly difficult. So some of that may have  
3 been something around making sure the supplies were in  
4 place, I don't know. What I do know is that infection  
5 prevention and control specialist nurses found  
6 themselves really stuck in the middle of trying to  
7 implement the guidance that was coming down from the UK  
8 infection prevention and control guidance and then  
9 implementing it in practice to meet the needs of the  
10 board and senior managers so they could say they were  
11 complying with the guidance whilst dealing with  
12 healthcare workers on the ground who were asking them  
13 many, many questions about why that was, and asking for  
14 explanations and those infection prevention and control  
15 nurses often didn't have the answers.

16 So there was a huge amount of pressure within the  
17 system at all levels to implement the guidance quickly  
18 and at pace.

19 **Q.** I think just to finish off with this letter. Can we go  
20 to the second page, please and the section beginning:

21 "PPE is of poor quality and unsuitable.

22 "... very poorly produced, is one size, so for  
23 example the visors fall off and does not instill  
24 confidence.

25 "Staff fit test one mask and then get issued

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1 with a different type of mask so have to fit test  
 2 everyone again -- no one has capacity to keep doing  
 3 [that].  
 4 "We fit test with one mask and then get issued  
 5 with a different type ...  
 6 "FFP3 ... only to be used in certain  
 7 procedures. [There are] only 30 masks given for  
 8 a team of 30 ... [so] we have to wear basic fluid  
 9 repellent masks.  
 10 "Basically our PPE is Apron, short gloves, fluid  
 11 repellent theatre masks and [what are described as]  
 12 Christmas cracker glasses."  
 13 So fairly clearly telling the Welsh minister --  
 14 **A.** I think this was a draft letter. There's a "draft"  
 15 water print through so you will have to forgive me,  
 16 I don't know if this letter actually went but what it's  
 17 doing is really describing the reality on the ground of  
 18 the challenges that were being faced in relation to PPE  
 19 provision and many of the issues that are mentioned here  
 20 are actually reflective of what happened in the other  
 21 countries as well.  
 22 **Q.** The statement doesn't say it's draft but perhaps you can  
 23 clarify if we need to. Certainly Mr Gething --  
 24 **A.** Sorry, I saw the watermark on the previous page.  
 25 **Q.** No, not at all. If it is a draft we'll deal with that

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1 "We reiterated our concerns that while the recent  
 2 publication of guidance for domestic settings implied  
 3 airborne transmission, IPC guidance and policy did not  
 4 seem to align with this in a clinical setting."  
 5 Which had caused confusion and questions to be  
 6 asked about the risk in healthcare settings?  
 7 **A.** Yes.  
 8 **Q.** Can you just summarise, please, why it was that the RCN  
 9 wanted the IPC guidance to make clear whether there was  
 10 airborne transmission or implied airborne transmission?  
 11 Why was it so important for your members?  
 12 **A.** Our members, nurses, healthcare support workers, cadet  
 13 nurses, students, are members of the public that happen  
 14 to be nursing professionals. So when they saw the  
 15 Cabinet Office video talking about the need to open  
 16 windows, have good ventilation because Covid was  
 17 airborne, that led them to reflect on that in their own  
 18 domestic settings or perhaps if they were going to  
 19 patients' own homes, and then to consider the stark  
 20 difference in hospital settings, where actually we have  
 21 no particular ventilation unless you're in specific  
 22 areas like operating theatres, bone marrow transplant  
 23 ITUs for example, so nurses knew that there was no  
 24 ventilation in hospitals, our ability to open windows  
 25 generally is extremely restricted so these are stuffy,

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1 by way of correction, but the statement says that was  
 2 the letter that was sent and he responded a couple  
 3 of weeks later --  
 4 **A.** Oh, all right, thank you.  
 5 **Q.** -- noting the Welsh Government were working hard to have  
 6 extra supplies of PPE.  
 7 You say that the Prime Minister didn't respond to  
 8 Dame Donna's letter.  
 9 The Scottish minister did respond to -- it went to  
 10 Scotland.  
 11 And in relation to Northern Ireland, letters were  
 12 sent to the First Minister and Deputy First Minister, I  
 13 think, is this correct, about a lack of PPE? There was  
 14 a holding response that the department was not in  
 15 a position to respond due to volume of work --  
 16 **A.** That's correct.  
 17 **Q.** -- but the letter had been sent to what was described as  
 18 the lead policy official?  
 19 **A.** Yes.  
 20 **Q.** Thank you, that document can be taken off the screen.  
 21 And may I ask you, please, about one aspect of the  
 22 chronology that you mention in your statement. It is at  
 23 paragraph 176, Mrs Gallagher. We are in November 2020  
 24 and the RCN wrote that month to NHS England asking for  
 25 clarification about the IPC guidance.

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1 hot environments so when they looked at the video and  
 2 reflected on what that meant where they worked, they  
 3 noted the difference there.  
 4 So if Covid-19 was in fact airborne, which was the  
 5 challenge that they put to us, then that meant that it  
 6 had implications for the infection prevention and  
 7 control guidance on one hand, but also what was the NHS  
 8 estate going to do to make it safe by improving the  
 9 ventilation or looking at other technologies that could  
 10 support it to let Covid out, which was what the public  
 11 were being advised to do.  
 12 **Q.** I think those concerns remained extant in January of  
 13 2021 when Dame Donna wrote to, I think the chair of  
 14 Public Health England cautioning them against group  
 15 think.  
 16 **A.** Yes.  
 17 **Q.** And indeed continued until, I think, May 2021, when the  
 18 RCN issued a press release.

19 And can I have up on screen, please, INQ000114429.  
 20 The concern in the press release was a global  
 21 recognition that Covid is airborne shows the UK is  
 22 lagging behind, and there is reference in there to the  
 23 alliance members, which includes the RCN, AGP Alliance,  
 24 the Fresh Air NHS writing to the Prime Minister to  
 25 express their concerns.

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1 "They say the response they received from  
 2 Number 10 failed to recognise the growing evidence that  
 3 the virus could be spread in tiny particles known as  
 4 aerosols."  
 5 And there was reference to SAGE, the WHO, and I  
 6 think the CDC in the States beginning to recognise  
 7 airborne transmission, yet UK guidance only recommends  
 8 the use of higher grade FFP3 respiratory masks for  
 9 a limited range of procedures.  
 10 Why did the RCN take such steps as to make a press  
 11 release like this, which is fairly critical, I think  
 12 it's fair to say?  
 13 **A.** It is. I mean, the concerns were -- because we had seen  
 14 at least two new variants by that time, each one  
 15 increasing in transmissibility, and a healthcare worker  
 16 or nursing workforce that was really starting to become  
 17 affected by Long Covid and also the rates of  
 18 healthcare-acquired Covid-19 along with our patients.  
 19 So we had been really trying to influence behind  
 20 the scenes since November/December 2020 to have the IPC  
 21 guidance changed and really it was a case of  
 22 a last-ditch attempt to try and get the issue discussed  
 23 in the open and to try and influence change but we  
 24 weren't able to do that, despite the fact that, as you  
 25 said, the UK guidance was contrary to other guidance

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1 workforce and how it was really struggling to do the  
 2 right thing at that time.  
 3 So what our members subsequently told us was that  
 4 they felt blamed for increasing rates of  
 5 healthcare-acquired infection of Covid-19 but in fact  
 6 they were decimated as a workforce and didn't have the  
 7 time or capacity to do the right thing.  
 8 **Q.** Did the RCN take any steps itself to try and reinforce  
 9 the need for compliance?  
 10 **A.** We were invited to review -- to go to a meeting and to  
 11 review a survey that was planned to go out in  
 12 early January. We reviewed the survey, but actually the  
 13 questioning, the way that the questions were posed we  
 14 felt wasn't helpful to members, and in fact it could  
 15 result in healthcare workers being blamed even more for  
 16 increasing rates of healthcare associated infections.  
 17 **Q.** May I change topic, please, Mrs Gallagher, and ask you  
 18 about the reporting of data relating to the deaths of  
 19 healthcare workers and nurses in particular.  
 20 If it helps you, I'm at around paragraph 130  
 21 onwards in your report. But in short, we've already  
 22 heard there are difficulties with ascertaining a precise  
 23 number of deaths of healthcare workers. Why did the RCN  
 24 say it's so important that this data should be  
 25 collected?

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1 including within Europe by ECDC.  
 2 **Q.** Thank you, that document can be taken down.  
 3 May I ask you about one thing you do say in your  
 4 statement was that at times, certainly at the end  
 5 of December 2020, there were obviously enormous  
 6 pressures on IPC staff and there was concern that there  
 7 was some non-adherence to IPC guidance?  
 8 **A.** Yes.  
 9 **Q.** How did that get reported back to the RCN, the  
 10 non-adherence?  
 11 **A.** We didn't actually hear much about the non-adherence to  
 12 IPC measures until we received the communications from  
 13 NHS England. What we did know was that there were many  
 14 nurses and other healthcare workers off sick. We knew  
 15 that staff were by now extremely tired and all the  
 16 existing literature, not about Covid but about the state  
 17 of the workforce points to how missed episodes of care  
 18 or mistakes or errors can be made if you are  
 19 short-staffed or are looking after too many patients.  
 20 So when we received that information from  
 21 NHS England I wasn't surprised that there was concerns  
 22 being raised around a lack of adherence to infection  
 23 prevention and control guidelines, which are clearly the  
 24 gold standard that you would expect, but actually what  
 25 hadn't been taken into account was the state of the

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1 **A.** Despite the fact that you're in a pandemic which is  
 2 clearly a chaotic and very busy situation, data is  
 3 absolutely critical to give you an indication over time  
 4 on what the situation is, but also to be able to adapt  
 5 and change practices if needed. So the data that was  
 6 provided on healthcare worker infections, although it  
 7 was reported as initial data a bit more frequently than  
 8 it was published, it was extremely lagging, so it was  
 9 published monthly but reported quarterly.  
 10 So that meant that if organisations were trying to  
 11 adapt and put in place interventions, so for example  
 12 some organisations moved their healthcare workers to  
 13 wearing FFP3s for all suspected or known patients with  
 14 Covid-19. Then actually understanding the impact of  
 15 that on healthcare worker infections, that data is  
 16 absolutely critical.  
 17 And, likewise, to support learning after the  
 18 event, we need good data so we can build that into  
 19 future planning and our future understanding of what  
 20 worked well and what didn't work well.  
 21 **Q.** I think you say in your statement that you think data  
 22 ought to be collected as well from non-NHS  
 23 organisations. Who did you have in mind?  
 24 **A.** So our membership, includes as I said before, nurses  
 25 working in independent healthcare settings and adult

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1 social care, so I would include all the data from those  
 2 settings as well.

3 **Q.** And can I ask you, Mrs Gallagher, who do you think  
 4 should be the body or the organisation to actually  
 5 collate this data?

6 **A.** That's a really important question, and the honest  
 7 answer is I don't know given the current organisations  
 8 we have and their roles and remits. I would not  
 9 suggest -- and this is my personal view -- that it is  
 10 not the role of UKHSA -- because we are not talking  
 11 about surveillance data per se -- they may disagree --  
 12 I don't believe it's the role of the Health and Safety  
 13 Executive. Our suggestion would be that we need to  
 14 consider how we can collect data from a UK perspective  
 15 and a standardised way as a minimum data set. Perhaps  
 16 it needs an independent organisation, but something  
 17 where we can all feed in digitally, in realtime, and  
 18 then look to clarify the data afterwards.

19 **Q.** And presumably make it comparable across all four  
 20 nations --

21 **A.** Yes.

22 **Q.** -- so we are comparing like with like?

23 **A.** Yes, we understood that the data was collected and  
 24 reported in slightly different ways across the four  
 25 nations, and that wasn't always helpful in trying to get

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1 **A.** We may need to look at how we write guidance in  
 2 a slightly different way, but I absolutely believe that  
 3 these non-IP specialists are critical in terms of  
 4 shaping guidance. Their input would I imagine be  
 5 different in different ways but certainly my -- from my  
 6 experience in clinical practice I heavily relied on my  
 7 authorised engineers for decontamination, my health and  
 8 safety leads, parties in other areas, estates and  
 9 facilities to help me make sure that the infection  
 10 control policies that we were writing were set in the  
 11 right context and able to be implemented. And the same  
 12 would apply but on a national basis, so it may not be  
 13 a small group that write the guidance, but that doesn't  
 14 mean that everyone has to be around the table at one  
 15 time. There are different ways of working.

16 And the most important thing for me, as I've said  
 17 before, is that infection control guidance has to be  
 18 implemented in context. So one-size-fits-all doesn't  
 19 necessarily work. So whilst you may not have an aerosol  
 20 scientist working in a prison, for example, they would  
 21 be able to take the principles and look at what that  
 22 meant in different care settings with professionals.

23 **Q.** One other recommendation that you would urge  
 24 her Ladyship to consider is funding for the urgent  
 25 development of reusable RPE --

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1 a sense of what was going on from a UK perspective. So,  
 2 yes, a standardised minimum set across the UK that  
 3 everybody feeds into, but then everyone can use that  
 4 data to suit their needs.

5 **Q.** That brings me to recommendations, please, and I'd like  
 6 to ask you about a number of them that you've set out in  
 7 your statement. Clearly, data for those healthcare  
 8 workers that died is one of them. I think you advocate  
 9 for nursing input into the IPC guidance, including early  
 10 on in a pandemic?

11 **A.** Yes.

12 **Q.** And we've looked at that. Can I ask you about this,  
 13 though. You recommend that there is input from non-IPC  
 14 specialists --

15 **A.** Yes.

16 **Q.** -- when producing future IPC guidance, including health  
 17 experts, occupational hygienists, aerosol scientists,  
 18 occupational health and wider professional stakeholders  
 19 such as paramedics, speech and language therapists.  
 20 A number of people there that you would advocate for  
 21 being involved in the guidance. Can I ask you this  
 22 though, might that be actually a danger of too many  
 23 people being involved in it so that you don't turn it  
 24 around as quickly as one needs to do particularly at the  
 25 beginning of a pandemic?

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1 **A.** Yes.

2 **Q.** -- is acceptable to staff and patients?

3 **A.** Yes.

4 **Q.** Help us, why you urge that recommendation, and when you  
 5 say is acceptable to staff and patients, what do you  
 6 mean by that?

7 **A.** So we have to be prepared for future pandemics. There  
 8 will be a future pandemic and it may well be one that is  
 9 another respiratory virus, whatever that is. It may not  
 10 be, it could be something else, but in terms of  
 11 protecting us from infection where we are inhaling the  
 12 pathogen, we need protective equipment. So our  
 13 experience from this pandemic is that constantly fit  
 14 testing, and looking for different multiple types or  
 15 trying to draw on global supplies of FFP3s, wastes a  
 16 huge amount of energy and resources.

17 We need to train our healthcare workers to become  
 18 more accustomed to the wearing of respiratory protective  
 19 equipment in the future so we need to find a solution  
 20 that is comfortable, that both in terms of being able to  
 21 breathe, but also heat, because our workforce is  
 22 predominantly female and there are particular issues for  
 23 the female workforce. We need to be visible. As I said  
 24 before, we need to be able to lip-read or patients to  
 25 lip-read for us, and to have our own equipment that we

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1 take responsibility for, rather than put the shared pool  
2 of equipment -- which our members were very clear that  
3 they did not want -- is something that we need to look  
4 at in the future, but the design needs to involve many  
5 stakeholders, our patients, and the public. And it is  
6 an area where I think it would make a huge difference in  
7 the future.

8 **Q.** Final question from me, please. We often hear lots  
9 about what didn't work well during the pandemic. Are  
10 there any aspects of the healthcare systems response  
11 that you think did work well that we should adopt in the  
12 event of a future pandemic?

13 **A.** I was really impressed at how the nursing workforce,  
14 both those that were employed at the time but those that  
15 came back from retirement, actually responded to the  
16 pandemic, and also the public's response in terms of  
17 supporting us with that. So that worked extremely well,  
18 but in order to maintain it, that workforce needs to be  
19 confident. So we need to address the learning, rapidly,  
20 to support that.

21 There was a real sense of camaraderie, and from my  
22 personal perspective I'm incredibly grateful to all  
23 those that supported me through intelligence and  
24 guidance, and answered my endless questions and the  
25 check-ins that came with assuring me that what we

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1 rather than in the workplace.

2 The HSE has disclosed to this Inquiry the numbers  
3 of RIDDOR reports received by the HSE from NHS employers  
4 between two dates, and that's 16 May 2021 and  
5 19 February 2022. The data they've disclosed shows that  
6 between those two dates, out of the 98 NHS employers  
7 listed, 51 made three or fewer RIDDOR reports in total  
8 for infections and fatalities.

9 And just for reference for others, that is at  
10 INQ000269831 at table 1.

11 So just reflecting on that evidence, and given  
12 what you've set out about the threshold for making  
13 a RIDDOR report, and the guidance that went with that,  
14 does it surprise you that RIDDOR reporting was so low in  
15 so many trusts?

16 **A.** It does, and the fact that we have this huge variation  
17 in reporting given that the whole of the UK was impacted  
18 by Covid-19 to me means that, well our expectation would  
19 have been that the Health and Safety Executive would  
20 look at why there was this variation, and was it down to  
21 people not understanding the change in requirements from  
22 RIDDOR reporting, or was it in fact down to some other  
23 form of bias that was present in the system? So, yes.

24 **Q.** And just reflecting on the fact that the guidance came  
25 with a warning that it was most likely contracted

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1 advised as the RCN, or what the RCN needed to consider,  
2 was both appropriate and relevant and the right thing to  
3 do. So I'm very grateful to them.

4 **MS CAREY:** My Lady, those are all the questions I ask.

5 There are some questions from core participants.

6 **LADY HALLETT:** There are.

7 Ms Peacock.

8 Behind you, Mrs Gallagher, but if you could make  
9 sure your answers go into the microphone, please. Thank  
10 you.

#### 11 Questions from MS PEACOCK

12 **MS PEACOCK:** Good afternoon. I ask questions on behalf of  
13 the Trades Union Congress. My questions relate to the  
14 reporting of Covid-19 infections in healthcare workers  
15 to the Health and Safety Executive, which of course  
16 you've touched upon already.

17 You explain in your witness statement, I'm just  
18 going to return to it, at paragraph 133 that revised  
19 RIDDOR guidance produced by the HSE on 17 April 2020 had  
20 the effect of requiring definitive evidence that  
21 Covid-19 was contracted as a result of exposure in the  
22 workplace, and you set out the threshold and go on to  
23 say this revised guidance stipulated that it was most  
24 likely, even in a healthcare setting, that a case of  
25 Covid-19 would have been contracted in the community

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1 outside of the workplace setting, is it fair to say that  
2 there are elements of the guidance that are in a sense  
3 dissuading employers from making a report?

4 **A.** Yes, the conditions as I recall that were required for  
5 RIDDOR reporting were felt to be very limiting in health  
6 and care settings, and the reality would be that in fact  
7 very few patients would, for example, rip the face mask  
8 off the face of the healthcare worker. It also meant  
9 that if it was acquired at work, there could potentially  
10 be questions and insinuations around whether staff and  
11 managers were complying with the PPE guidance through  
12 the IPC guidance.

13 So it was a very difficult situation, and  
14 certainly in terms -- it wasn't felt to be helpful for  
15 our members in terms of collating data in the first  
16 place.

17 **Q.** And do you have a view as to what the threshold or the  
18 guidance around making a RIDDOR report to HSE should  
19 have been or as to how the guidance should have been  
20 different?

21 **A.** I can't comment on that specifically, it's not my area  
22 of expertise, but what I can say is, for future  
23 incidents, the recommendation I would make is that we  
24 need to think very carefully about whether or not RIDDOR  
25 reporting is actually helpful in those situations, or

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1 whether we need other forms of data to support us and  
2 the role of the health and safety executive which they  
3 would of course continue to have. What would be better  
4 in a different situation?

5 **Q.** So we need to really re-think the system and consider  
6 whether more wholesale reporting of infections is  
7 required?

8 **A.** Yes.

9 **MS PEACOCK:** I'm grateful, those are my questions.

10 **LADY HALLETT:** Thank you, Ms Peacock.

11 Mr Thomas.

12 Mr Thomas is also behind you.

13 **Questions from PROFESSOR THOMAS KC**

14 **PROFESSOR THOMAS:** I'm representing the FEMHO, the  
15 Federation of Ethnic Minority Healthcare Organisations.

16 In your witness statement at paragraph 128, you  
17 address concerns raised by ethnic minority members of  
18 the RCN regarding inappropriate treatment during the  
19 pandemic, and you note that the draft reduction  
20 framework was viewed as lacking cultural sensitivity and  
21 did not include comprehensive equality impact  
22 assessments. Yeah?

23 So here's my question. When the RCN launched its  
24 own toolkit in December 2021, how did it address these  
25 identified shortcomings?

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1 assessment. So that equality and diversity assessment  
2 was done as part of the process prior to publication of  
3 the toolkit. And that assessment takes into account  
4 existing evidence, how we worked with our stakeholders  
5 around that and how we implemented learning from  
6 previous incidents.

7 So I hope that goes some way to answering your  
8 question.

9 **Q.** Let me move on to my next question. The RCN conducted  
10 extensive surveys as early as April/May 2020. Could you  
11 explain why, despite this early data collection, the  
12 toolkit was not launched until December 2021?

13 **A.** The risk assessment toolkit really came about  
14 specifically after we had exhausted all other efforts to  
15 try and have the infection prevention and control  
16 guidance amended. So it was after June 2021 that we  
17 took the decision to put our energy into supporting  
18 people specifically around the risk assessment process.

19 This was predominantly because in many  
20 communications and conversations we were constantly  
21 referred to the hierarchy of controls within the  
22 infection prevention and control guidance which forms  
23 part of that risk assessment process. So -- and the  
24 reason we didn't implement the toolkit earlier was  
25 because our attention was focused on trying to influence

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1 **A.** Are you referring to the risk assessment toolkit?

2 **Q.** Yes.

3 **A.** When we developed this toolkit, as I said before, it was  
4 very much focused on COSHH but we were very mindful of  
5 how to support our black and ethnic minority members in  
6 terms of supporting their awareness raising but also how  
7 they could raise concerns in the workplace.

8 Have I gone off-track?

9 **Q.** No, no, I'm listening to you.

10 **A.** We focused it very much on the process that was there,  
11 but put a lot of effort into communication through our  
12 branches, through our representatives in helping to  
13 raise awareness across our membership. So the toolkit  
14 was applicable to all members but recognising that some  
15 members felt very challenged in terms of raising  
16 concerns, as we've identified in our PPE survey.

17 **Q.** Okay, well, just touching and following on from that.

18 Were specific measures implemented to ensure that the  
19 toolkit was culturally sensitive and could be adapted to  
20 meet the diverse needs of healthcare workers from varied  
21 backgrounds?

22 **A.** In the process of developing and publishing the toolkit  
23 we have an internal quality assurance process and that  
24 quality assurance process has a number of criteria, and  
25 one of those is to undertake an equality and diversity

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1 the guidance rather than specifically risk assessment.

2 **Q.** You would agree that timing was crucial, right?

3 **A.** I would.

4 **Q.** Let me move on to my last question. Were there specific  
5 challenges or constraints that contributed to this delay  
6 and in retrospect what steps might be taken to ensure  
7 that similar resources are made available more swiftly  
8 in a future health crisis?

9 **A.** If I can answer the second bit first. So our learning  
10 from this and recommendations we would make is that we  
11 need to educate and raise awareness amongst the whole of  
12 our workforce on what risk assessment means in practice  
13 and in particular what it means in the context of  
14 biological harms as opposed to, perhaps, chemicals that  
15 we might use in practice. So we have -- we need to look  
16 at what's needed and how we do that and perhaps who  
17 should be leading in implementing that.

18 Could you repeat the first part of your question,  
19 sorry?

20 **Q.** The first part of the question is ...

21 **LADY HALLETT:** Were there specific challenges or constraints  
22 -- have you found it, Mr Thomas?

23 **PROFESSOR THOMAS:** Yes, I have.

24 Were there specific challenges or constraints that  
25 contributed to the delay?

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1 A. Not specifically. We were trying to focus, because  
 2 everything fell from the IPC guidance, so that became  
 3 our main focus to try and amend and get adapted. It did  
 4 include some reference to expanding health and safety  
 5 content within the guidance, but that took utmost of our  
 6 concentration in the early stages of the pandemic and it  
 7 wasn't, as I said, until we felt we had exhausted that  
 8 we felt that we needed to produce something different.  
 9 We looked at a number of options and the toolkit was  
 10 something that was the final sort of decision that we  
 11 came to around that.

12 **PROFESSOR THOMAS:** Thank you.

13 Thank you, my Lady. Those are my questions.

14 **LADY HALLETT:** Thank you, Mr Thomas. Are you okay to return  
 15 this afternoon; you were warned?

16 **THE WITNESS:** I am.

17 **LADY HALLETT:** I shall return at 2 o'clock this afternoon.

18 (12.59 pm)

19 (The short adjournment)

20 (2.00 pm)

21 Questions from MS MITCHELL KC

22 **LADY HALLETT:** I think it's Ms Mitchell next, isn't it?

23 **MS MITCHELL:** I appear as instructed by Aamer Anwar &  
 24 Company on behalf of the Scottish Covid Bereaved, and my  
 25 learned friend, when she was asking you questions, asked

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1 A. Sorry.

2 Q. -- of moving staff around; did that happen, is that what  
 3 happened?

4 A. No, I have no knowledge of that, but knowing how nursing  
 5 teams work in different situations where there are  
 6 particular issues, maybe there'd been an issue with  
 7 a particular patient or a nurse might not be immune to  
 8 chicken pox, for example, if there was a patient with  
 9 chicken pox in the side room and things like that, it  
 10 doesn't come out as a refusal to treat, but we might  
 11 reallocate in the first instance. So I am  
 12 hypothesising. I don't know the --

13 Q. You explained to us something perhaps very  
 14 understandable that refusing to treat and -- refusing is  
 15 an incredibly difficult to talk about and a really  
 16 difficult ethical issue. Is it possible, in those  
 17 circumstances, that these issues, the way you're  
 18 describing them, were sometimes fudged? What I'm  
 19 looking to see is, do we really not know the real  
 20 position in relation to whether or not there was or  
 21 wasn't refusal to treat?

22 A. I can only report on what I know or don't know, and  
 23 I don't know of any instances where refusal to treat was  
 24 implemented. That's not to say that theoretically that  
 25 may have happened, but it's nothing I'm aware of. It

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1 about refusal to treat and I would just like to ask you  
 2 a few follow-up questions on that.

3 You gave evidence that you didn't know of any  
 4 examples of refusal to treat if a person had not been  
 5 given appropriate PPE to do so. Might it be that the  
 6 fact that you didn't know of any examples is because of  
 7 what you also referred to earlier in your evidence as  
 8 not raising concerns due to a general lack of confidence  
 9 that they would be dealt with properly?

10 A. You mean as a barrier to not pursuing the refusal to  
 11 treat guidance?

12 Q. Indeed.

13 A. In all honesty, I'm not sure. What I think may well  
 14 have happened in practice, in settings where a number of  
 15 patients were being looked after by a team is perhaps  
 16 discussions took place around allocation of team  
 17 members. So where specific risks were identified and  
 18 members were hesitant or afraid for whatever reason,  
 19 vulnerable family members at home being pregnant  
 20 themselves, that they may have reallocated some of those  
 21 resources. So it wouldn't be a refusal to treat in  
 22 its -- in those words, but we would move the staff  
 23 around not to put staff under pressure.

24 Q. And can I just check, you started that as a hypothetical  
 25 and then you ended it as an actuality --

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1 may be something around the language. As nurses we may  
 2 not talk about refusal to treat in that terms, but  
 3 that's the language that -- the technical language  
 4 that's been used in the guidance that the RCN has  
 5 issued. So that's why we really need those  
 6 conversations to unpick, have clear language, and talk  
 7 about this issue, because it's such a huge ethical  
 8 issue for everyone involved.

9 Q. And following up from that, had there been refusal to  
 10 treatment, would you know about it, ie, would it have  
 11 been recorded and would you have been informed?

12 A. The only potential way that I can see that I would find  
 13 out about it would potentially be if it came through RCN  
 14 direct call line. The key message of the guidance was:  
 15 talk to us. So I would hope that members would have  
 16 contacted us somehow through the various routes to  
 17 enable us to have that conversation about the situation,  
 18 about the risks and about the implications for them, for  
 19 us to then signpost them on perhaps where they might go  
 20 next.

21 Q. Finally, you said that the guidance was produced as a  
 22 resource, and you said so that members didn't make rash  
 23 decisions; what did you mean by that? Did you mean  
 24 a rash decision in relation to refusal to treat, or  
 25 a rash decision in relation to continue to treat without

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1 the appropriate PPE?

2 **A.** I was thinking of the former, but we do any that a lot  
3 of nurses continued to work and put themselves at risk,  
4 knowing they were at risk. And there is very much  
5 a culture within nursing where the -- which we all  
6 accept, which is that the patient comes first, and there  
7 is an inevitable -- how did a nurse describe it to  
8 me? -- occupational hazard acquired with getting  
9 an infection as a result of caring for people, whether  
10 it's Covid-19 or something else.

11 And we need to change that culture, but we need to  
12 do it in a way that suits everybody's needs.

13 **Q.** And is that because whilst there's the need to treat  
14 people, there's also the danger of treating someone when  
15 you're not properly protected means that you're exposing  
16 them to further risk?

17 **A.** There is that, but also there's a wider issue around our  
18 finite workforce numbers as well. So there is this  
19 inherent tension between how do we approach a situation  
20 where staff are clearly at risk of acquiring infection  
21 and then being off sick which further depletes  
22 an under-resourced workforce, how do we work through  
23 these huge ethical issues, and that has to be part of  
24 our future pandemic planning.

25 **MS MITCHELL:** My Lady, those are my questions.

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1 impact that the delay on implementing regular test  
2 woing have had on patient or staff safety?

3 **A.** Not directly, and I don't recall any specific actions  
4 coming to me in particular. We were talking at the time  
5 around testing from a UK perspective and some of the  
6 general issues around that and how to manage staff that  
7 were found to be infected but asymptomatic and isolation  
8 etc, but in relation to Wales specifically, I don't  
9 recall anything.

10 **Q.** I'm going to move on to my next question then, which is,  
11 there is a letter from September 2020, where the Chief  
12 Nursing Officer for Wales, who is Professor Jean Wright,  
13 and the Deputy Chief Medical Officer in Wales,  
14 Dr Chris Jones, wrote to all health boards in Wales, and  
15 I am just going to very briefly quote from what they  
16 say:

17 "We are writing to reiterate the essential  
18 requirement for routine SARS-CoV-2 testing in  
19 unplanned emergency and urgent admissions to our  
20 hospitals.

21 "We are concerned to discover that following an  
22 investigation into a recent outbreak that not all  
23 emergency admissions to one of our hospitals is being  
24 tested. We have become increasing aware of the  
25 significant amount of Covid-19 transmission in

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1 **LADY HALLETT:** Thank you very much, Ms Mitchell. Very  
2 grateful.

3 Next, I think it's Ms Shepherd -- behind the  
4 pillar, I don't know if you've got a direct line of  
5 sight.

6 **A.** I have, thank you, my Lady.

7 **Questions from MS SHEPHERD**

8 **MS SHEPHERD:** Good afternoon, Ms Gallagher. I appear on  
9 behalf of Covid-19 Bereaved Families for Justice Cymru.  
10 I have two topics to ask you about. The first is  
11 testing.

12 Now, for context, the Welsh Government did not  
13 introduce routine testing of healthcare staff until  
14 December 2020 although full roll-out was supposed to  
15 commence from January 2021. In fact, it did not occur  
16 until much later in 2021, and in some cases as late  
17 as July 2021.

18 So, questions arising from that. Were any  
19 concerns raised by RCN's membership regarding the  
20 absence of regular testing for healthcare workers during  
21 that implementation period?

22 **A.** I can't recall specifically at this moment, I would need  
23 to refer to our RCN direct inquiry to get that  
24 information for you.

25 **Q.** Thank you. The second question is, are you aware of any

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1 patients who are asymptomatic or presymptomatic."

2 They go on to say that routine testing of  
3 admissions is critical.

4 Was the RCN aware of any operational difficulties  
5 in implementing testing in September 2020?

6 **A.** I can't recall any specific issues around implementing  
7 testing at that phase. A lot of the discussions, as  
8 I recall, centred around how we would manage staff and  
9 staffing if staff were found to be positive, but I don't  
10 recall anything specific, sorry.

11 **Q.** Final topic and final question. At paragraph 87 of your  
12 witness statement you say that:

13 "At a time when strong evidence of the  
14 transmission dynamics of SARS-CoV-2 may not have  
15 satisfied those developing and approving IPC guidance,  
16 the RCN expected a more precautionary approach to be  
17 adopted rather than the position of no evidence to  
18 justify no change to IPC guidance."

19 Are there any particular measures that you say  
20 should have been adopted on a precautionary or a common  
21 sense basis?

22 **A.** A lot of our activities, you will have heard, focused on  
23 preventing the risk of essentially inhaling the virus  
24 and staff becoming infected, therefore we're generally  
25 naturally drawn to wearing respiratory protective

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1 equipment, but our focus actually was also around  
 2 improving ventilation in health and care facilities  
 3 although the mask discussions got most of the attention.  
 4 So we did feel that there was a scarcity of information  
 5 within the IPC guidance on ventilation that would then  
 6 have enabled staff to perhaps think more -- in more  
 7 detail around the hierarchy of controls and then come to  
 8 decisions around what PPE was required.

9 **Q.** One follow-up. When you talk of hierarchy of controls,  
 10 you're really saying that before we even get to RPE, we  
 11 should be thinking about what we can do to reduce the  
 12 amount of virus in the air first?

13 **A.** That's how the hierarchy of controls is supposed to  
 14 guide people to think about how you can reduce risks,  
 15 but the hierarchy of controls isn't a linear process.  
 16 You can consider and implement more than one control at  
 17 once, so it's not something that you have to move  
 18 through from level to level, and in fact knowing that  
 19 the ventilation in many areas was insufficient would  
 20 help guide practitioners to that decision around RPE.  
 21 I have an analogy if that would help, but I don't  
 22 know if there's time.

23 **MS SHEPHERD:** I'm in my Lady's hands.

24 **LADY HALLETT:** Very well.

25 **A.** The analogy a colleague described to me which I found  
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1 questions relate to the topic of IPC guidance, please.  
 2 You've helpfully told us, and it's at  
 3 paragraph 210 of your witness statement for those  
 4 following, about a widely-attended PPE IPC guidance  
 5 stakeholder engagement meeting that took place on  
 6 3 June 2021 and we know that you attended that on  
 7 behalf, of course, of the RCN and also present was the  
 8 chair of the IPC cell, Eleri Davies, the Chief Nursing  
 9 Officer for England, Ruth May, the National Clinical  
 10 Director of Infection Prevention and Control, Mark  
 11 Wilcox, as well as Dr Barry Jones, the chair of CATA,  
 12 amongst numerous others.

13 **A.** Yes.

14 **Q.** And at this meeting serious concerns were raised by and  
 15 on behalf of healthcare workers on the frontline  
 16 regarding the IPC guidance not reflecting the scientific  
 17 evidence that Covid-19 was an airborne virus.  
 18 Now, my first question is this. What did you,  
 19 please, on behalf of nursing healthcare workers hope  
 20 would be achieved following this large stakeholder  
 21 meeting on 3 June 2021, please?

22 **A.** What we hoped for was agreement between all parties  
 23 around how we could clarify the language of airborne  
 24 transmission of Covid-19 that would then allow for  
 25 greater protection of healthcare workers given where we  
 99

1 very helpful because around the confusion around the  
 2 hierarchy of controls is how you protect people inside  
 3 a castle from an invading army. So when you have  
 4 a castle or a fort and an invading army, you have  
 5 a number of controls in place to prevent that army  
 6 reaching you on the inside. So you might have a moat,  
 7 you have a drawbridge, you have a number of other  
 8 controls.

9 You don't wait until the army has swum the moat,  
 10 got through the drawbridge, climbed the wall, and got  
 11 into the inner courtyard before you issue them with  
 12 a bow and arrow. You give them a bow and arrow that's  
 13 available first while you try and use the other controls  
 14 that you have in place. So that's what I mean by not  
 15 being a linear process, but lots of people got very  
 16 confused about the hierarchy of controls and felt they  
 17 couldn't move to PPE. And that's why the hierarchy of  
 18 controls were viewed as being too restrictive.

19 **MS SHEPHERD:** Thank you, Ms Gallagher.  
 20 Thank you, my Lady.

21 **LADY HALLETT:** Thank you, Ms Shepherd.  
 22 Ms Alexis. Behind you.

23 **Questions from MS ALEXIS**

24 **MS ALEXIS:** Ms Gallagher, I ask questions on behalf of the  
 25 COVID-19 Airborne Transmission Alliance, CATA, and my  
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1 were at that point in the pandemic. It wasn't about  
 2 having every healthcare worker in an FFP3 mask all the  
 3 time because clearly that's impractical, as well as  
 4 being very uncomfortable, so it was about making it  
 5 easier for healthcare workers to do the right thing to  
 6 protect themselves in those particular circumstances and  
 7 up until that point the feedback from our members was  
 8 that actually the guidance didn't allow them to do that.

9 **Q.** What, if anything, changed in relation to the IPC  
 10 guidance as a result of this meeting, please?

11 **A.** So in effect there was no change. We hoped, because the  
 12 meeting was a very professional one, to be able to  
 13 continue the dialogue to move things forward. There  
 14 were a number of people there and we used examples  
 15 around reusable respiratory protective equipment, some  
 16 was a new design, some were powered respirators, as  
 17 examples of what was also possible. But actually we, in  
 18 effect, didn't get out of the meeting what we hoped we  
 19 would achieve.

20 **Q.** And you've said there in effect there was no change.  
 21 Why do you think this was?

22 **A.** In all honesty I'm unclear. I think by that time for  
 23 whatever reason the guidance was so wedded to being  
 24 predicated on droplets that it just didn't change.

25 **MS ALEXIS:** Thank you, my Lady, those are my questions.  
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1 **LADY HALLETT:** Thank you, very much Ms Alexis, very  
2 grateful.  
3 Next I think is Ms Munroe who is in clear sight.

4 **Questions from MS MUNROE KC**

5 **MS MUNROE:** Good afternoon, Mrs Gallagher. My name is  
6 Allison Munroe and I ask questions on behalf of Covid-19  
7 Bereaved Families for Justice UK.

8 Two topics. BAME nurses, and within that umbrella  
9 a question of migrant nurses and IPC guidance and  
10 messaging, both of which you've been asked about in some  
11 detail during the course of your evidence this afternoon  
12 and this morning. So just a few specific, I hope, and  
13 focused questions in relation to that.

14 Firstly, on 1 July 2020 the Royal College of  
15 Nursing published submissions reflecting on issues  
16 contributing to unequal impact based upon the experience  
17 of your own members.

18 My Lady, for reference that's INQ000328840.

19 And in that submission you reported a lack of  
20 confidence amongst BAME nurses in raising concerns  
21 regarding adequate Covid-19 protection. Something like  
22 68% said that the main reason being that they did not  
23 believe any action would be taken and almost a third,  
24 29%, were fearful of speaking out.

25 Now, specifically looking at migrant nurses, one  
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1 how their concerns would be taken seriously.  
2 **Q.** Thank you. In your evidence this morning in relation to  
3 BAME nurses and the lack of confidence in raising  
4 concerns, you reiterated that the RCN needs to  
5 understand why and it would be really helpful you said  
6 for the RCN to understand the related lived experiences  
7 of your BAME colleagues in the workplace.

8 Now, going back to these submissions from  
9 July 2020, the RCN also in those submissions gave  
10 examples of a contributing factor that in some places  
11 organisational cultures may inhibit BAME staff from  
12 raising concerns for fear of reprisals and that  
13 management structures favoured white British staff which  
14 further caused BAME staff to feel disengaged and  
15 unheard.

16 Are these examples part of a systemic structural  
17 racism that existed and exist within health and care  
18 provisions that the RCN urged should be tackled in the  
19 same submission document?

20 **A.** I'm not sure if I can answer the question around  
21 structural challenges in place. We do know that there  
22 are inequalities in relation to how black and ethnic  
23 minority nurses are able to move and progress within  
24 nursing and that there is a predominance of them to be  
25 present in the adult social care sector but also within  
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1 of the issues identified by the RCN as contributing to  
2 this unequal impact was the precarious position of  
3 migrant nurses especially in light of the hostile  
4 environment.

5 Could you briefly, Mrs Gallagher, tell us why the  
6 RCN believed that that had an impact, a negative impact  
7 in terms of protection of migrant nurses?

8 **A.** Nurses recruited from overseas you're referring to  
9 specifically there?

10 **Q.** Yes.

11 **A.** To come to the UK to work as a nurse from overseas  
12 within the pandemic would have been an enormous strain  
13 for our nurses, particularly those from black and ethnic  
14 minority groups that had come from overseas. So in  
15 addition to having to adapt to the culture within the UK  
16 and how our hospitals and our healthcare system works,  
17 they would have been faced with many new and different  
18 ways of working that would have been, you know, very  
19 challenging to them. We know that our overseas  
20 recruited nurses were suffering potentially financially  
21 from not being able to access public funds, and we knew  
22 that Covid-19 was exposing some inherent inequalities  
23 within certain nursing groups. So all of these would  
24 have combined really to undermine their -- or not give  
25 them confidence around how they would be listened to and  
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1 band 5 and band 6 roles. So not being able -- not  
2 seeing and working with senior leaders from black and  
3 ethnic minority backgrounds could be something that our  
4 nurses feel is compounding their lack of concern or  
5 confidence in terms of raising concerns.

6 Have I answered your question?

7 **Q.** To an extent, yes, thank you. Related topic. Do you  
8 agree that there was an issue in terms of disparity in  
9 support faced by agency nurses?

10 **A.** I don't feel I can answer that. I think agency nurses  
11 as a whole have really quite a difficult role.  
12 I've worked as one myself. Some prefer it, some it's  
13 because it's the only way they can work around family  
14 and home commitments. So I would say that although the  
15 reliance has reduced somewhat and the use of nursing  
16 banks has increased with organisations that should offer  
17 more support for all staff including those from black  
18 and ethnic minorities, I think we would have to really  
19 go back and talk to those nurses and understand if we  
20 are to really be able to answer that question around the  
21 disparities.

22 **Q.** Based on what you've just said you may not be able to  
23 answer the next question, which is whether or not you  
24 agreed that that impact particularly on Filipino and  
25 BAME nurse because they make up quite a large proportion  
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1 of agency nurses.

2 **A.** Filipino nurses certainly are a large proportion of our  
3 overseas recruited nurses and they have very close  
4 connections with other Filipino nurses and relatives  
5 that are here in the UK so they will often, you know,  
6 socialise and stay within the groups that they feel  
7 confident in.

8 So, again, I think the learning is that we really  
9 need to understand their lived experience but also we  
10 need to be much better in terms of when we collect data  
11 on those protected characteristics so we can also use  
12 the data as well as the lived experience to bring  
13 everything to understand things better.

14 **Q.** Thank you. Then finally in the time left, just briefly  
15 on IPC guidance and communication you dealt quite  
16 extensively with that this morning. My question is in  
17 relation to a specific email chain, again for reference,  
18 INQ000417625, between yourself and Dr Lisa Ritchie  
19 regarding the review of IPC guidance and selection of  
20 respiratory protections. It's an email chain dated  
21 23 November 2020. You stated in that email that UK IPC  
22 guidance and policy:  
23 "... does not currently support any mention of  
24 airborne transmission. However, we seem to have  
25 conflicting language and advice."

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1 Sivakumaran.

2 **LADY HALLETT:** Oh, I'm so sorry. Forgive me.

3 **Questions from MS SIVAKUMARAN**

4 **MS SIVAKUMARAN:** Sorry, my Lady.

5 I will be asking questions on behalf of the Long  
6 Covid groups. We have a number of questions relating to  
7 matters raised by Patricia Cullen, the general secretary  
8 and chief executive of the RCN in her statement to this  
9 Inquiry, so please do say if any of these matters are  
10 outside of your knowledge.

11 **A.** Thank you.

12 **Q.** The first topic touches on data collection which you  
13 have addressed briefly this morning. At paragraph 139  
14 of your statement you note that there was no central  
15 data collection system in place to collate the number of  
16 healthcare workers who had or may have acquired Covid-19  
17 in the workplace. Now, Patricia Cullen has also said in  
18 her statement at paragraph 173 that in relation to  
19 Long Covid, the exact number of healthcare workers who  
20 are affected by or who have been affected is unknown, as  
21 no national data collection took place, nor is it taking  
22 place today.

23 This lack of data was further exacerbated by the  
24 pausing of the self-reported Long Covid information in  
25 March 2023 by the Office for National Statistics. So my

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1 My question is this. From the answers you have  
2 given this morning it's clear that nothing or very  
3 little was done to address that confusion arising from  
4 conflicting language and advice. You set out your  
5 concerns and they remained extant until January 2021.  
6 The question is this: could and should more have been  
7 done to address the confusion in respect of the  
8 conflicting messaging around airborne transmission?

9 **A.** So, yes is the short answer. It should have been done.  
10 The language was confusing for staff that would have  
11 been using the guidance and what members and nurses said  
12 to me that were not working in the speciality of IPC  
13 because we're very familiar with the language and we can  
14 interpret and unpick most of it but actually to those on  
15 the frontline, they need clear unambiguous language and  
16 guidance that enables them to do the right thing at the  
17 right moment in time. So it felt, in their words, as if  
18 the guidance had been written for IPC specialists but  
19 not necessarily for clinicians implementing it at the  
20 frontline. Thank you very much indeed.

21 Thank you, my Lady.

22 **LADY HALLETT:** Thank you, Ms Munroe.  
23 Ms Sangeetha. You look surprised; you weren't  
24 expecting to be called?

25 **MS SIVAKUMARAN:** It's a different name, Ma'am. It's

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1 question is: is there a significant gap in data  
2 collection on healthcare workers suffering from  
3 Long Covid?

4 **A.** Based on my limited knowledge of Long Covid, I would say  
5 yes, which is why we need better data collection. This  
6 is an area where we're learning fast, so that makes it  
7 even more important to have data collection so we can go  
8 back and understand things in more detail.

9 **Q.** Thank you. And turning now to support for nurses with  
10 Long Covid, Patricia Cullen says that the RCN received  
11 a large number of calls from members about Long Covid.  
12 I think she numbers that at 50 calls from November 2021  
13 to December 2021 and 500 calls in 2022. She states that  
14 although keen to get back to work, many RCN members  
15 found workplace support was lacking and reasonable  
16 adjustments difficult to secure. And many faced reduced  
17 pay and some have lost their jobs. We've also heard  
18 from Patricia Temple today about the difficulties nurses  
19 with Long Covid face in returning to work.

20 Could you outline RCN's recommendations for  
21 improving support for healthcare workers with  
22 Long Covid?

23 **A.** I'm not able to go into a lot of detail, but the RCN is  
24 certainly calling very clearly for it to be recognised  
25 as an occupational disease that will allow nurses who

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1 acquire, in this case, Covid-19 in the workplace to  
 2 receive the financial and physical support that they  
 3 need in the long-term.

4 **Q.** Thank you, and I think Patricia Cullen has also referred  
 5 to recommendations from the report of the all-party  
 6 parliamentary group which, in addition to recognition of  
 7 Long Covid as an occupational disease, recommend  
 8 production of guidelines for employers and private and  
 9 public sectors for managing the impact of Long Covid  
 10 amongst the workforce, and collecting accurate and  
 11 comprehensive data which I think you have already  
 12 mentioned on Long Covid, and the launch of  
 13 a compensation scheme. So those would all be  
 14 recommendations that you would endorse?

15 **A.** Yes, they would.

16 **Q.** Finally, I want to return to your evidence about IPC  
 17 guidance. You've explained today RCN's concerns about  
 18 the inadequacy of IPC guidance in place for healthcare  
 19 workers. To what extent was the risk of the long-term  
 20 consequences of Covid-19 factored into decision-making  
 21 about the necessary IPC measures for Covid-19?

22 **A.** To the best of my knowledge on the long -- I don't  
 23 recall the long-term consequences being part of the  
 24 conversations around developing the guidance. Once we  
 25 started to realise that Long Covid was becoming an issue

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1 Control Manual, although I would have to say that that's  
 2 not the purpose of the National Infection Control Manual  
 3 as a to-do guide, if that makes sense.

4 **Q.** It does. I think my, and I believe possibly your last  
 5 question: are there sufficient public health  
 6 communications warning about the risk of Long Covid in  
 7 healthcare settings?

8 **A.** I don't hear conversations around Long Covid in the  
 9 context of healthcare acquired infections, whether that  
 10 is in terms of the impact on patients or on staff. It's  
 11 something that we should certainly look at and look to  
 12 embed within our education of our healthcare workers,  
 13 both in terms of patients and staff, as I said, knowing  
 14 what we know now, some four years on from the beginning  
 15 of the pandemic, but there's still a lot more work that  
 16 we need to do on Long Covid.

17 **MS SIVAKUMARAN:** Thank you. Those are my questions.

18 **LADY HALLETT:** Thank you very much, and apologies again for  
 19 the confusion of your name. I'm so sorry. But I was  
 20 misled. I will blame it on someone else.

21 Right, I think that concludes the questions.

22 Thank you very much for your help, Mrs Gallagher.

23 **A.** Thank you, my Lady.

24 **LADY HALLETT:** You've helped me before and I don't know if  
 25 I'm going to have to ask you to help me again, but we'll

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1 and it was one of the impacts of this pandemic, then  
 2 really it became very clear that the only way to reduce  
 3 the risk of acquiring Long Covid -- and I can only talk  
 4 about healthcare workers whilst they're at work, because  
 5 clearly exposure in their private lives isn't something  
 6 that we can manage or control in any circumstances, but  
 7 whilst healthcare workers are at work we should be doing  
 8 everything, because not only did these healthcare  
 9 workers get sick with Covid-19 -- most of the time, not  
 10 all the time but most of the time -- but then there is  
 11 then the additional risk of them going on to acquire  
 12 Long Covid.

13 So the only way to stop Long Covid is to not get  
 14 Covid-19 essentially is what I'm saying. Yes.

15 **Q.** So then moving forward to the present day, do you think  
 16 there is now sufficient consideration of the risk of  
 17 Long Covid in assessment of necessary IPC measures to  
 18 prevent transmission of Covid-19 in healthcare settings?

19 **A.** We're now in the position where the IPC guidance has  
 20 moved to the National Infection Control Manual, so we're  
 21 not using pandemic guidance currently.

22 I don't recall, I would have to check, but I don't  
 23 recall having seen any reference to Long Covid in  
 24 pandemic IPC guidance and I don't recall any reference  
 25 to Long Covid in the National Infection Prevention and

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1 maintain a careful analysis of whether we really do have  
 2 to impose on you, but thank you for all you've done.

3 **THE WITNESS:** Thank you very much.

4 **(The witness withdrew)**

5 **MR MILLS:** My Lady, may I please call Nick Kaye who can be  
 6 sworn.

7 **MR NICHOLAS ROBERT KAYE (sworn)**

8 **Questions from COUNSEL TO THE INQUIRY**

9 **LADY HALLETT:** Mr Kaye, I hope you haven't been waiting too  
 10 long.

11 **THE WITNESS:** Not at all, my Lady. Thank you for the  
 12 privilege to address the Inquiry.

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

14 **A.** My full name is Nicholas Robert Kaye.

15 **Q.** Mr Kaye, you have provided a statement to the Inquiry.  
 16 The reference for that is INQ000340104.

17 Since April 2023 you have been the chair of the  
 18 National Pharmacy Association, that's the NPA?

19 **A.** That's correct.

20 **Q.** Can you begin your evidence by telling us, please, who  
 21 the NPA represents and the work it performs on their  
 22 behalf?

23 **A.** Yes, so the National Pharmacy Association is  
 24 a representative organisation of pharmacy owners that's  
 25 just over 100 years old, we celebrated our 100th

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1 anniversary in 2021 whilst I was vice chair. We  
2 represent -- there are 7,000 community pharmacies and  
3 most of our members are smaller family-owned businesses.

4 One of my -- the phrases one of my colleagues uses  
5 which I do like to use is that we're almost a family of  
6 families, and that the National Pharmacy Association  
7 board is then elected from those members.

8 **Q.** Is it right that over 50% of the NPA's membership are  
9 from an ethnic minority background and that that  
10 percentage is reflected in the membership of the NPA's  
11 board?

12 **A.** Yes, Mr Mills, it is, and at the time of the statement  
13 I think it was 7 out of 14 and that, although we've had  
14 elections, is reflective as well.

15 I should also say the NPA acts as a head office,  
16 if you will. Being a small business you can all feel  
17 very isolated and actually specifically and pertinent to  
18 this Inquiry that isolation could be something that our  
19 members specifically relied on both for insurance  
20 advice, guidance, policy decision-making, from the  
21 National Pharmacy Association.

22 **Q.** During the pandemic you have mentioned you were the vice  
23 chair of the NPA?

24 **A.** I was.

25 **Q.** You were also I think working at a pharmacy in Cornwall;

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1 **Q.** -- as a, your words, "first port of call for patients  
2 struggling to access other parts of the health service".  
3 Can you help us, why did pharmacies assume this role?

4 **A.** So I think -- I'm exceptionally proud of all community  
5 pharmacies for the way in which they stood up within  
6 this time frame as being accessible, yes with waits, yes  
7 with those other things that we had to put into place  
8 maybe we'll talk about later but, you know, being  
9 an accessible healthcare professional where someone  
10 could still walk in and see you was a unique part,  
11 I think, of community pharmacy at that time.

12 And I think both people were -- we have to go  
13 back, people were scared, people were frightened, we  
14 didn't have all the answers but we certainly were  
15 dealing with lots more inquiries both from the standard  
16 things you'd expect within medicine supply but also  
17 maybe more technical general healthcare questions being  
18 fired at us from all angles.

19 **Q.** I wonder if we could go on screen, please, to  
20 INQ000319520.

21 This is written evidence that the Pharmaceutical  
22 Services Negotiating Committee submitted to the House of  
23 Commons Health and Social Care Committee  
24 in November 2020. At paragraph 6 we read that -- and  
25 I'm paraphrasing here -- PSNC asked 9,441 pharmacies to

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1 is that correct?

2 **A.** Yes, it is. I was working in a pharmacy in Cornwall in  
3 Penryn delivering frontline services. Yes, I was doing  
4 that role.

5 **Q.** Our first topic together this afternoon will be the key  
6 changes to the work of pharmacies during the pandemic  
7 but, please, Mr Kaye, before we turn to it can we  
8 briefly consider the condition of community pharmacy  
9 prior to the pandemic?

10 **A.** Yes, thank you. So community pharmacy, I think, across  
11 all four nations was under particular strain, I think,  
12 in England reflected by reduction in funding. Also a  
13 workforce under huge demand, I see that specifically in  
14 my sort of rural area in Cornwall, but that's reflected  
15 in other rural areas such as Cumbria, Northern Ireland  
16 and Wales. And that it would be right to say that  
17 pharmacists as a profession had the ability to maybe  
18 work in other sectors, so the community pharmacy  
19 workforce was strained and the funding envelope was also  
20 challenged pre pandemic. So a system that was  
21 functioning but certainly strained.

22 **Q.** At paragraph 39 of your statement you make the  
23 observation that during the pandemic pharmacies took on  
24 a bigger role --

25 **A.** Yes.

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1 pick a day in June or July 2020 and record how many  
2 informal patient consultations they had. And the  
3 results indicated that the average pharmacy carried out  
4 15 informal patient consultations a day.

5 To give that figure some context at paragraph 7,  
6 the report indicates that if the pharmacies hadn't been  
7 there, this would have led to an additional 65  
8 appointments in each GP practice each week in England.

9 Do these figures give us a sense of the scale of  
10 the role that pharmacies assumed?

11 **A.** Yes, I think this does give a scale of what was taking  
12 place and I think also the recognition at that time  
13 standard work was also -- what we call standard work,  
14 traditional work in the community pharmacy was also at  
15 a heightened level and, again, on reflection those were,  
16 you know, queries that could have been relatively basic  
17 or, in my own experience, those that were relatively  
18 complex, you know, from somebody telling me that they'd  
19 a cough, that they were coughing up blood for  
20 three weeks, could they -- what would be the advice?

21 So that shock absorber, I think, of healthcare  
22 advice I think is really proportionate. And, again,  
23 you know, 65 appointments, when you're a community  
24 pharmacist and some of the people we represent, you are  
25 not only lead clinician, duty clinician, manager,

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1 business owner, counsellor, all those other things, it's  
2 an extremely important part of what we do but I do think  
3 I would like to say that, you know, I don't think we  
4 resent that work, the clue is in the title, the  
5 community pharmacy is part of its community and that's  
6 what we thought we were -- what we do, try and support  
7 and help.

8 But an unprecedented increase in demand, Mr Mills.  
9 **Q.** At your paragraph 65 you touch on another of the major  
10 roles that community pharmacies picked up. That is  
11 from April 2020, pharmacies began delivering medicines  
12 to the shielded population. How did it come to be that  
13 pharmacies were tasked with this particular role?  
14 **A.** So I think pharmacy was the right place for it to be  
15 tasked given that we're the experts on medicines, we're  
16 the last part of that supply chain. I think the  
17 medicine supply chain came under a huge amount of  
18 pressure at this time. I think there was something  
19 about, as well, the way in which people were able to  
20 step up and manage that, you know, from an NPA point of  
21 view we were helping giving guidance about, you know,  
22 who should be delivering medicines, how they should be  
23 delivering medicines, the use of volunteers, you know,  
24 that keeping going whilst maintaining supply to the most  
25 vulnerable people that we were serving was something

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1 running because they were both pharmacists, and didn't  
2 see each other for that amount of time, so that they  
3 could run teams in parallel. People going into work at  
4 6 o'clock, leaving at 11 o'clock because, as I've said  
5 already, the clue is in the title, we are there to serve  
6 the communities within which we're based. The use of  
7 volunteers, the use of other members of the team were  
8 really important.

9 But it really was that overall effort of  
10 understanding our patients, the people that we serve to  
11 try and make sure that they had medicines and advice.

12 **Q.** Next, please, the contribution to the vaccine rollout.

13 **A.** Yes.

14 **Q.** The Inquiry has heard evidence from  
15 Dr Michael Mulholland of the Royal College of General  
16 Practitioners.

17 **A.** Yes.

18 **Q.** His statement, if we can have it on screen, please, is  
19 INQ000339027. And I'm reading the last sentence of  
20 paragraph 65:

21 "According to the National Audit Office's report  
22 into the rollout of the Covid-19 vaccination programme  
23 in London, by the end of October 2021, GP practices  
24 working in [primary care network] groups and community  
25 pharmacies had delivered 71% of all doses of the

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1 that we thought was absolutely critical and crucial and  
2 yeah, I think was welcomed at the time.

3 The other thing as well is it also protected those  
4 people from coming into environments like a community  
5 pharmacy which I guess the government perceived as being  
6 something which was a dangerous place to be, which is  
7 interesting as we move forward.

8 **Q.** How many deliveries took place in the first month this  
9 was introduced, approximately?

10 **A.** I think in England, I think it was just over 490,000.

11 **Q.** And similar schemes operated in Scotland, Wales and  
12 Northern Ireland?

13 **A.** Indeed.

14 **Q.** Given the -- you used the word "strain" when we were  
15 talking about the position of community pharmacy prior  
16 to the pandemic.

17 **A.** Yes.

18 **Q.** Given that strain, how did community pharmacies meet the  
19 demand of this task?

20 **A.** So community pharmacies and community pharmacists and  
21 their entire teams worked harder, longer than they  
22 probably ever had, putting things that were  
23 unprecedented in place, I think. From a witness there's  
24 a recollection of a husband and wife couple who actually  
25 spent 10 weeks working apart to keep their businesses

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1 Covid-19 vaccine administered in England."

2 Are those statistics reflective of the  
3 contribution community pharmacies, together with GP  
4 practices, made to the vaccination effort throughout the  
5 UK?

6 **A.** So I would recognise those as being significant as  
7 primary care working together to deliver that. I think  
8 it's really an interesting point as well that they're  
9 not large new infrastructure centres, they are the use  
10 of the infrastructure that existed at that time,  
11 being -- whether that's slightly changed within primary  
12 care networks or community pharmacies delivering things  
13 in a different way, but I think, as well, given the  
14 strain that we've already described, that implementation  
15 phase of the vaccination by both parts of that primary  
16 care sector is really important to be noted from a  
17 practical delivery point of view.

18 **Q.** Can I ask you precisely about that. Are you able to  
19 give the Inquiry a sense of the impact that the  
20 administration of providing the vaccine had on the  
21 workload of these small community pharmacies?

22 **A.** Yeah, so it did increase those significantly, both from  
23 the regulatory process of having to be approved by  
24 NHS England, in England and other parts of the UK. It  
25 wasn't classed as a business-as-usual-type activity

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1 Covid in the same way that maybe flu vaccination would  
2 be, it had other things to go through, so there was not  
3 only time had to be taken to be involved in the  
4 programme but then also the way in which that was  
5 administered also added additional workload and strain.

6 Some very small community pharmacies in rural  
7 locations I know tried to change the way in which they  
8 worked, designate a certain afternoon or work in  
9 a different way, to try and meet that demand whilst also  
10 trying to protect themselves at that time because,  
11 again, if you're a single-handed operation you need to  
12 balance that risk of business continuity with the giving  
13 of the vaccine.

14 **Q.** In a future pandemic, would you recommend the removal of  
15 this administrative barrier for community pharmacies  
16 providing such a critical role?

17 **A.** I'd recommend it from now, because it still exists.

18 **Q.** Can we next consider the challenges pharmacies faced in  
19 adopting --

20 **LADY HALLETT:** Sorry to interrupt, just before you go on, so  
21 I understand.

22 **A.** Yes.

23 **LADY HALLETT:** Could you give me more of an idea of what  
24 administrative barrier it was?

25 **A.** Yes, so there were a couple of things, my Lady. There  
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1 care networks and community pharmacy had go through, for  
2 want of a better description, accreditation process,  
3 my Lady.

4 **LADY HALLETT:** Thank you.

5 **MR MILLS:** Can we first think about PPE together.

6 **A.** Yes.

7 **Q.** At your paragraph 73, you say that PPE was not initially  
8 available to community pharmacy teams through the NHS.

9 **A.** That's correct.

10 **Q.** Is this because community pharmacy was considered to be  
11 a private sector provider?

12 **A.** Of course, when 90% of the income of most of our members  
13 comes from the NHS, it seems logical to call it  
14 a private provider, Mr Mills.

15 **Q.** I appreciate that is the NPA view and indeed your view  
16 of that categorisation.

17 **A.** Yes.

18 **Q.** Are you able to help us, insofar as you are aware of  
19 them, the reasons for that categorisation?

20 **A.** I assume it's because -- and it's an assumption that,  
21 you know, some part of community pharmacy is involved in  
22 a retail element, whether selling medicines for  
23 over-the-counter sale, or whatever it may be.

24 **Q.** I see. Without NHS support --

25 **A.** Yes.  
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1 was one around the way in which the designated supply of  
2 vaccine was held centrally, so there were things where  
3 people had to be designated as certain centres, whether  
4 that was primary care networks or community pharmacies,  
5 so -- there then also had to be a commitment to do  
6 a certain number per week, so there was something about  
7 the ability to deliver at the time was considered such  
8 a precious resource, so I think as things have moved  
9 forward, I think that may be not so important now, and  
10 actually business as usual would be much more  
11 appropriate, but people were then having to try and  
12 create space to deal with that, and I know that the  
13 National Pharmacy Association certainly help people.  
14 I know of one pharmacy in a very rural location in  
15 Cornwall where there was no other access for quite  
16 a long time, but to help that person both through the  
17 administrative burden and then work out what his work  
18 plan would look like were something that we needed to  
19 act as a head office for delivering.

20 Now, those numbers weren't massive, but they were  
21 hugely important to that community that was there, and  
22 quite an elderly and vulnerable community as well,  
23 my Lady.

24 **LADY HALLETT:** And who imposed the burdens? Was it the NHS?

25 **A.** So, yeah, it was part of NHS, the delivery, both primary  
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1 **Q.** -- in the provision of PPE, how did pharmacies source  
2 PPE?

3 **A.** So there was a myriad of ways and I think in our  
4 evidence there was a note where a dentist actually  
5 helped a pharmacy out with some that they had. I know  
6 that in previous witness statements given that one of my  
7 colleagues has suggested that they had some made by  
8 a local school. I personally -- we tried to source them  
9 from a DIY centre. There was all sorts of things that  
10 were going on in place to try and work out ways to try  
11 and keep ourselves safe. And I think what's really  
12 important as well is, back then, we didn't know what we  
13 were dealing with, you know, I'm now a dad of five; at  
14 the time I was a dad of four and I was having messages  
15 from my close friends, my best man at my wedding going,  
16 "Do you really want to go to work?" You know, "Are you  
17 really sure you want to do this? Is this really worth  
18 it?" And I'm sure that conversation was going on up and  
19 down the country, especially in those members with those  
20 single-handed businesses where they truly feel a sense  
21 of their community.

22 So we were doing, I think, Mr Mills, whatever we  
23 could to try and keep ourselves safe whilst deliver that  
24 care.

25 **Q.** Please can we go to INQ000319522.  
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1 This is the guidance for ordering PPE via the PPE  
 2 portal.  
 3 **A.** Yes.  
 4 **Q.** Before we have a look at its contents, can I ask you in  
 5 brief terms to explain how this portal functioned?  
 6 **A.** Yeah, so the way in which it would function, as  
 7 I recollect, is you would both have to register it to  
 8 make sure that you were eligible for its use, and then  
 9 you would be able to, once that was verified, you'd then  
 10 be able to order a set amount weekly, given where the  
 11 setting that you were. And as we moved through that  
 12 pandemic, the amount that you could order was changed.  
 13 So I note that I think from November 2020, there  
 14 was a slight increase in the amount we could order and  
 15 that felt more comfortable. But up until that point it  
 16 felt quite strained and quite uncomfortable --  
 17 **Q.** If we look at page 9, please. This is a record of the  
 18 various updates --  
 19 **A.** Yes.  
 20 **Q.** -- to the guidance. Underneath 3 August, we read:  
 21 "Added pharmacies and larger social care  
 22 providers to the categories of provider that are  
 23 invited to order from the portal."  
 24 **A.** Yes.  
 25 **Q.** Were you immediately able to order from the portal from  
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1 areas where that may have been a problem. Can I just,  
 2 on PPE, finish --  
 3 **A.** Yes, of course.  
 4 **Q.** -- with this, please. Looking to the future --  
 5 **A.** Yes.  
 6 **Q.** -- would you recommend that community pharmacies have  
 7 access to PPE on the same terms and at the same time as  
 8 other healthcare providers?  
 9 **A.** Yeah, I think that would be absolutely critical, given  
 10 the nature of the work, and I think really importantly  
 11 sometimes some of the language used was around  
 12 pharmacists, but I -- really important for me to state  
 13 that community pharmacies are much more than pharmacists  
 14 although we have pharmacy technicians, medicine counter  
 15 assistants, there are a huge team involved with that.  
 16 So I think recognition of the whole team, not just the  
 17 pharmacist. Quite often, when you walk in to a  
 18 community pharmacy, it's not the pharmacist on the  
 19 initial counter that would meet you and greet you, and  
 20 it would be really important to me that those counter  
 21 assistants, dispenser counter assistants, pharmacy  
 22 technicians, pharmacy dispensers, that wider team is  
 23 recognised in any future -- any future involvement with  
 24 that, Mr Mills.  
 25 **Q.** You have alluded to the issues around social distancing.  
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1 3 August, or did things take some time?  
 2 **A.** So I think the -- as my recollection, and this would be  
 3 my personal recollection, would be that yes, it was you  
 4 were able to register and then be validated to order,  
 5 but orders tended to be sporadic in the first instance.  
 6 **Q.** I take it then that PPE issues were not entirely  
 7 resolved then by admission to the portal?  
 8 **A.** Eased but definitely not resolved.  
 9 **Q.** Are you able to help us with some of the issues that  
 10 continued?  
 11 **A.** Yeah, so there was lots of decisions made about where  
 12 you wear it, how you wear it, you know, following those  
 13 guidances but I think as well, we might come on to  
 14 later, community pharmacies tend to be quite small  
 15 environments, so actually maintaining things like  
 16 2-metre rules were quite difficult. So community  
 17 pharmacy, I think, was somewhere where -- which was  
 18 actually a high user of PPE for various reasons, and  
 19 I think that was then reflected later with people like  
 20 the National Pharmacy Association feeding that back.  
 21 But initially, I'm not sure, given that we were decided  
 22 originally to be retail, that that actually was -- our  
 23 public patient-facing role, I don't think was fully  
 24 acknowledged at that point.  
 25 **Q.** And we'll come on in due course to look at some other  
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1 **A.** Yes.  
 2 **Q.** Please can we go to INQ000319559.  
 3 These are the results of a survey conducted by the  
 4 Royal Pharmaceutical Society, the RPS, in April 2020.  
 5 **A.** Yes.  
 6 **Q.** We read in the second paragraph that:  
 7 "... 94% of respondents said they were unable to  
 8 maintain 2 [metre] social distancing from other  
 9 staff ..."  
 10 **A.** Yes.  
 11 **Q.** "... 40% ... said they were unable to maintain social  
 12 distancing from [their] patients."  
 13 **A.** Yes.  
 14 **Q.** Generally speaking, did the small size of pharmacies  
 15 present an incredibly difficult structural hurdle to  
 16 overcome in achieving social distancing?  
 17 **A.** So I think people that would work in community  
 18 pharmacies would recognise, you know, you would need  
 19 things to be easily accessible, the speed with which you  
 20 can move around a dispensary actually makes it more  
 21 efficient if it's more compact and you're not working  
 22 large distance, purely from time and motion. There is a  
 23 standing joke: it doesn't matter where you stand in a  
 24 pharmacy, you'll always bump into someone in  
 25 a dispensary because of the busyness and the way in  
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1 which things are going around. Plus the increase in  
 2 workload; I think one piece of evidence had a record  
 3 30 -- 93 million items dispensed, I think, in March  
 4 or April 2020 --  
 5 **LADY HALLETT:** Slow down.  
 6 **A.** Sorry. I get overexcited, my Lady. My apologies. Not  
 7 enough coffee or too much, I'm not sure.  
 8 **LADY HALLETT:** "So many items ..." several million. I think  
 9 we missed however many million.  
 10 **A.** 93 million.  
 11 **LADY HALLETT:** 93 million items dispensed March  
 12 through April.  
 13 **A.** Yes. Thank you, my Lady. Apologies.  
 14 And I think that that's just the practicalities of  
 15 the way in which community pharmacies are designed.  
 16 I think, as well, from the maintaining distance  
 17 from patients, I think quite often, you know, a Perspex  
 18 screen over a counter that is no bigger than what I'm  
 19 sitting in front of now, when somebody -- when you're  
 20 wearing a mask and someone is leaning around the side to  
 21 go "Hello, can you help me with", would just give real  
 22 life practicality of how that would be difficult to  
 23 maintain the 2 metres.  
 24 **MR MILLS:** So, then, within the confines you have  
 25 described --

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1 **Q.** Broadly speaking, please, what was the purpose of these  
 2 risk assessments?  
 3 **A.** The purpose of the risk assessments was to see whether  
 4 or not community pharmacy teams were running as safely  
 5 as they possibly could. The NPA issued risk assessments  
 6 to complete based on both -- or the risk factors that  
 7 were being promoted at that time, so ethnic minority,  
 8 pregnancy, long-term condition, all the things that you  
 9 would expect in a risk assessment -- to try and make  
 10 sure that both pharmacy owners, pharmacy team members,  
 11 were both aware of the risks that they may be putting  
 12 themselves against, and then any mitigating factors they  
 13 could do to try and avoid those.  
 14 **Q.** If we now consider the extent to which the end of July  
 15 target was achieved --  
 16 **A.** Yes.  
 17 **Q.** -- please, can we go to INQ000319552. These are the  
 18 results from a survey conducted by the RPS and the UK  
 19 Black Pharmacist Association as of 25 June 2020, so  
 20 a month or so away from the end of July deadline. In  
 21 the first paragraph, second line, we read:  
 22 "... more than two-thirds of ... (BAME)  
 23 pharmacists and pre-registration pharmacists across  
 24 primary and secondary care have still not had access  
 25 to potentially lifesaving COVID-19 risk assessments."

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1 **A.** Yes.  
 2 **Q.** -- what measures did community pharmacies take to try  
 3 and achieve those social distancing measures?  
 4 **A.** So there was, within the person and patient flow, there  
 5 were lots of examples of where people were limiting the  
 6 number of people within a pharmacy at a time, queuing  
 7 systems outside of pharmacies which again was  
 8 problematic for people maybe waiting when it was cold,  
 9 but they were things that we had to do in practical  
 10 terms.  
 11 And within the dispensaries, I think what you saw  
 12 is you almost saw a budding up and a team approach,  
 13 because the 2 metres was going to be non-achievable. So  
 14 how do you actually accept that wearing the best PPE you  
 15 can obtain, but also making sure that business  
 16 continued, was a practical way of trying to keep things  
 17 going as opposed to not being able to maintain the  
 18 2 metres?  
 19 **Q.** Next, please, risk assessments.  
 20 **A.** Yes.  
 21 **Q.** At your paragraph 84 you explain that in June 2020,  
 22 NHS England and NHS improvement asked pharmacies to  
 23 complete risk assessments for their staff by the end  
 24 of July 2020?  
 25 **A.** Yes.

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1 To complete the picture, can we go to  
 2 INQ000319555. This is a second survey by the RPS and  
 3 the UK BPA published on 11 August, so after the  
 4 deadline. The third paragraph reads:  
 5 "The new survey shows that nearly a quarter of  
 6 all pharmacists are still waiting for this to happen."  
 7 "This" being the risk assessment. Appreciating  
 8 that these surveys were of those working in all types of  
 9 pharmacy across primary and secondary care, can  
 10 I nevertheless ask you this: was the NPA aware of issues  
 11 that were preventing risk assessments from being carried  
 12 out in community pharmacies particularly in respect of  
 13 their BAME colleagues?  
 14 **A.** So I think what I would say is that the NPA tried to  
 15 support its members from an organisational point of view  
 16 by both producing those risk assessments for people use,  
 17 and trying to help with guidance of how people to fill  
 18 them in and the things to make, the recommendations of  
 19 what those risk assessments meant.  
 20 On reflection of were we aware that members  
 21 weren't doing those, I don't think we were, but my  
 22 personal reflection would be that people were probably  
 23 overwhelmed, if I'm being honest, with all the other  
 24 things that were needing to be done. I don't think  
 25 that's an excuse, I just think that's a realistic

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1 reflection.

2 **Q.** Can we now consider the instances where in your  
3 statement you have described that support provided to  
4 other healthcare professionals was slower to reach  
5 pharmacists.

6 **A.** Yes.

7 **Q.** First, the life assurance scheme. Can you help us,  
8 please, what did that scheme offer?

9 **A.** So in that scheme offered a compensation I think of  
10 £60,000 for those people that had been passed away with  
11 Covid-19. And I think there was an expectation that  
12 community pharmacists and their team would be part of  
13 that.

14 **Q.** Can you help us with when that scheme was announced?

15 **A.** So I believe it was announced on 27 April.

16 **Q.** Please can we go to INQ000271969. This is a letter sent  
17 by the NPA to the then Health Secretary on 29 April.

18 **A.** Yes.

19 **Q.** We read here, second sentence:  
20 "Unfortunately, community pharmacy has not been  
21 explicitly included in your Department's  
22 communications about this scheme."  
23 Just to complete the picture here, can we go to  
24 INQ000319544. This came the following day, 30 April, we  
25 see it just underneath the Tweet. Mr Hancock said:

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1 Also, I would note as well that this says  
2 community pharmacists, and as I've already stated  
3 community pharmacy is not community pharmacists. I did  
4 note that there was a letter reply from Mr Hancock which  
5 also included pharmacy technicians and counter  
6 assistants, but again I think having then within that  
7 reply and that Tweet as teams as opposed to the  
8 individual professional, I think, would have boosted the  
9 morale of those people delivering that care.

10 **Q.** Next, please, key worker status. Were pharmacists  
11 originally included in the list of key workers?

12 **A.** No, as a dad of five, why would I be?

13 **Q.** Can you help us: when were pharmacists included? How  
14 long did it take?

15 **A.** I would have to have some recollection on that, I'm  
16 afraid, but I think it was 2, 3 months after the  
17 original announcement. We, the NPA, wrote a letter  
18 suggesting to schools that we, pharmacists were key  
19 workers, and people that worked in pharmacy teams.

20 **Q.** Can you help the Inquiry understand the practical and  
21 indeed the psychological impact of not immediately  
22 designating pharmacists as key workers?

23 **A.** So I think it reflects to my previous point, Mr Mills,  
24 on the fact that again it felt a little bit like  
25 an afterthought, you know, the evidence already stated

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1 "I'm glad to be able to confirm that community  
2 pharmacists are included in our death in service  
3 benefits. Because they are employed in a different  
4 way, it is arranged in a different way, but  
5 pharmacists are a vital part of our NHS family. They  
6 are of course covered."

7 Can I ask first, please, do you recall now whether  
8 you were made aware of this Tweet?

9 **A.** So I was made aware of that Tweet in my role as  
10 vice-chair of the National Pharmacy Association, given  
11 the letter we'd written the day before.

12 **Q.** Did this resolve, from the NPA's perspective, the  
13 concerns that it had outlined the previous day, namely  
14 that community pharmacy had not been explicitly included  
15 in the communications hitherto about the scheme?

16 **A.** I think there's maybe a couple of things I'd like to say  
17 on this.

18 I think it's right to say that that was a fairly  
19 quick turnaround and reaction and that has to be  
20 acknowledged, however, the fact that we weren't included  
21 to start with does make it feel like an afterthought,  
22 which, given some of the things that I've described and  
23 the effort the teams were going into, I think is  
24 demotivating and demoralising for those people giving  
25 that care.

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1 even from vaccination programme, 71% of Covid vaccines  
2 being delivered, yet community pharmacists and their  
3 team not being felt as if they were key workers. There  
4 was appointments and increase in healthcare advice which  
5 you've already described whilst maintaining medicine  
6 supply, but, again, not being classed as key workers is  
7 both demoralising and frustrating.

8 Yes, they were organised, and yes, it was sorted  
9 out, but again it feels more like an afterthought,  
10 Mr Mills.

11 **Q.** Would it be the NPA's recommendation that in a future  
12 pandemic, pharmacists should be designated as a key  
13 worker if indeed that term is used again from the  
14 outset?

15 **A.** I would and I would probably extend it further, I think  
16 to pharmacists and their teams. As I keep saying, you  
17 know, a community pharmacy is much more than the  
18 pharmacist but the team members as well I think are  
19 really important.

20 **Q.** Next, testing?

21 **A.** Thanks.

22 **Q.** When testing became available for healthcare  
23 professionals, was it made available to those working in  
24 pharmacies at the same time?

25 **A.** No.

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1 Q. Are you able to help us with when testing did become  
2 available for pharmacies?  
3 A. Again, I would have to check my recollection but I think  
4 that was again a couple of months after initial rollout  
5 and I believe that was because we were classed as being  
6 part of a private sector, as opposed to being part of  
7 the NHS family. Again, given what we've already  
8 mentioned that feels disingenuous.  
9 Q. If I can assist with the timing --  
10 A. Thank you.  
11 Q. -- you say at paragraph 78 of your statement that  
12 testing eventually became available and confirmed for  
13 English pharmacists in November 2020. You have alluded  
14 to categorisation, I think it's right that when testing  
15 did become available, community pharmacies were  
16 categorised as retail settings --  
17 A. Yes.  
18 Q. -- as opposed to healthcare establishments?  
19 A. Yes.  
20 Q. Was effect did that have on the self-isolation  
21 requirements that community pharmacies had to observe in  
22 the event of someone within their team testing positive  
23 for Covid-19?  
24 A. Yes, so this is where a lot of the practical  
25 implementation issue could occur because you would have

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1 that we could allow those people to work and be insured  
2 to maintain supplies -- to maintain services within  
3 communities, as a practical way to make sure people kept  
4 getting their care delivered.  
5 Q. In your view did the categorisation of community  
6 pharmacies as retail settings, and we have heard in  
7 respect of PPE the categorisation as a private sector  
8 provider, reflect an under-appreciation of their role in  
9 providing critical healthcare?  
10 A. I would have to say yes. I would also note that those  
11 things were changed but it felt like an afterthought  
12 when people were giving their all to deliver care in  
13 an unprecedented time.  
14 Q. Can you help us with when the retail setting  
15 categorisation was changed?  
16 A. I think that was the month after -- December.  
17 Q. Finally this, perhaps before we take our afternoon  
18 break, my Lady. In respect of testing for community  
19 pharmacies, are there any recommendations you would like  
20 the Inquiry to consider in the event of a future  
21 pandemic?  
22 A. So I think it would be to consider us as being  
23 healthcare professionals and part of the healthcare  
24 family and for those testing recommendations to be  
25 uniform across all those healthcare settings, GP

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1 to then have everyone isolating as opposed to the  
2 individual and those people in contact with. And again  
3 within small teams that has a really difficult  
4 operational effect. We know of pharmacies where in  
5 rural locations they may have had to close because of  
6 this type of classification which ultimately resulted in  
7 a reduction of care for those peoples in that community.  
8 So, again, as I said potentially slightly  
9 tongue-in-cheek earlier, Mr Mills, with 90% of most of  
10 our members' income coming from the NHS, you know, it  
11 seems perfectly reasonable to not class as a healthcare  
12 setting.

13 Q. Did the NPA offer any practical solutions to enable  
14 pharmacies to keep providing their services in the event  
15 of a positive test?

16 A. Yeah, so there were some practical things that we tried  
17 to do both from a guidance and keeping up-to-date point  
18 of view when classification and reclassification  
19 happened but we also worked with another organisation  
20 called the Company Chemists Association which represents  
21 larger organisations, people would probably be familiar  
22 with Boots, for example, and Superdrug as high street  
23 chains, allowing individual team members to be able to  
24 swap across different organisations and as part of the  
25 NPA we have a wholly-owned insurance company which meant

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1 practices, hospitals, pharmacies, I think that would be  
2 an appropriate and reasonable recognition of the work  
3 that was done by the teams.

4 MR MILLS: My Lady, would that be a convenient moment?

5 LADY HALLETT: Certainly. I shall return at 3.25.  
6 (3.11 pm)

(A short break)

7  
8 (3.25 pm)

9 LADY HALLETT: Mr Mills.

10 MR MILLS: My Lady.

11 Mr Kaye, funding. What financial support, please,  
12 did community pharmacies receive to enable them to  
13 safely perform all of the roles we have discussed this  
14 afternoon?

15 A. So I think it was different across different nations,  
16 Mr Mills, but I think for England, if I reflect to start  
17 with, there was an advance given of 300 million. So  
18 it's important to recognise that as what it is, that's  
19 an advance which needs to be paid back.

20 So community pharmacy for medicine supply gets  
21 paid in quite an odd way, in that the work you do today  
22 gets paid in three months' time. If you suddenly got  
23 an increase in prescription volume or medicine supply,  
24 your medicine supplier, your pharmaceutical wholesaler  
25 will want payment in 30 days. So if you've then got

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1 a cashflow issue between purchasing the medicine and  
2 that money being received, that can be a problem.

3 So there was an advance given for that but then  
4 that needed to be recouped.

5 In Northern Ireland, something similar; Scotland  
6 had, I think, funding of 5.5 million, given to them.

7 So different nations dealt with it in different  
8 ways, but primarily it was by advance and then claiming  
9 of potentially Covid expenses afterwards.

10 **Q.** So we have the advance loan.

11 **A.** Yes.

12 **Q.** That needed to be repaid by the community pharmacies?

13 **A.** Indeed.

14 **Q.** We then also have reimbursement?

15 **A.** Yes.

16 **Q.** For -- is that for Covid-19 related costs --

17 **A.** Yes.

18 **Q.** -- expenses. At paragraph 120 of your statement you  
19 record that the considerable extra costs incurred by  
20 pharmacies to keep services going throughout the  
21 pandemic were not fully reimbursed until 2022.

22 **A.** That's right.

23 **Q.** So in addition to having to pay back the advanced loans,  
24 not full reimbursement for the expenses until 2022?

25 **A.** Yes.

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1 **Q.** Can we perhaps consider the consequences of the concerns  
2 you have put on the well-being of those working in  
3 community pharmacies by going to INQ000319535, please.  
4 And if we can focus on the table. Thank you.

5 This comes from the RPS's workforce and well-being  
6 survey 2022. We see along the top row the burnout  
7 scores through the Inquiry's relevant period at 89, 89,  
8 88. Of particular note the figures for those working in  
9 community pharmacy are higher than those in other  
10 sectors --

11 **A.** Yes.

12 **Q.** -- as are the figures for women compared to men?

13 **A.** Yes.

14 **Q.** Can you help the Inquiry understand, please, some of the  
15 reasons behind these very high burnout figures?

16 **A.** It's hard to look at, isn't it? It really is, for me,  
17 you know, community pharmacy and being a pharmacist has  
18 been a fantastic profession. I get so much from it but  
19 that is a really stark reminder and reflection of what  
20 is going on out there, and I think my reflection on that  
21 burnout would be some of the things we've already talked  
22 about in not only uncertainty, uncertainty in how you're  
23 going to get the PPE you need, how you're going to get  
24 the medicines you need, how you're going to pay your  
25 team, that that becomes overwhelming, you know, and --

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1 **Q.** Can you help the Inquiry understand the sort of  
2 financial pressure that that delay put on community  
3 pharmacies?

4 **A.** So I think it's right to put into that context  
5 potentially some of the additional mental stress that  
6 has on somebody who is sometimes single-handed, as  
7 I've described the NPA as being those people's, our  
8 members' virtual head office. So not only are you in  
9 a situation potentially where, for some of the reasons  
10 already described, you're feeling a bit of  
11 an afterthought from some members of government, you're  
12 then actually worried, well, I'm going to work from  
13 7 o'clock in the morning until 11 o'clock at night,  
14 examples of my -- separated from family members for  
15 10 weeks but then can I actually pay my team, can  
16 I actually pay my mortgage?

17 And those in my NPA role are some of the most  
18 difficult conversations I have. People want to do the  
19 right thing, they want to give that care to the  
20 communities they serve but actually being able to pay  
21 their bills is another pressure and thought process that  
22 just invades the parts of their downtime if they've got  
23 any.

24 And I don't think that that should be  
25 under-recognised.

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1 genuinely overwhelming.

2 It's probably one of the hardest things as being  
3 the chair of the NPA I have to listen to is people who  
4 are, "When's it going to get better, Nick? When's this  
5 going to change?" And that within the Inquiry is  
6 something that should be really recognised as people not  
7 feeling, I think, supported and part of that integral  
8 healthcare team.

9 I think, as well, you know, it would be right to  
10 say that, again, a female colleague of mine who was not  
11 on the NPA board anymore but just said that she felt not  
12 only overwhelmed with all the things I have described  
13 that I was having to deal with but also that additional  
14 caring responsibility which we have to be realistic  
15 falls on the women in our society more often than not  
16 and I think that that additional burden is unbelievably  
17 difficult to fathom.

18 **Q.** Please can we go next to INQ000271989.

19 This is an open letter that the NPA, together with  
20 the CCA, who you have mentioned already, published  
21 in April 2020. The letter asked the public to help  
22 pharmacists by doing seven things. We see them in these  
23 bullet points.

24 Can I perhaps invite you to take us through each  
25 of these points, and also think about whether this

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1 letter had the desired effect, sent as it was  
2 in April 2020, against the context of those burnout  
3 figures that we have just looked at running from 2020 to  
4 2022?

5 **A.** Thank you. I mean, my reflection I think on these asks  
6 of the public and I would say most people were  
7 incredibly understanding especially as the pandemic  
8 started and some of the things that people were being  
9 asked to do. I think the first point when people had  
10 an infection, a cough and fever, I know I've had people  
11 present to me who did have those symptoms but that's  
12 because they were trying to seek help and didn't know  
13 where else to go, maybe a lack of knowledge, a lack of  
14 understanding, and we would have to deal with those  
15 people in a really sensitive way to make sure that they  
16 got the care they needed but also that our teams were  
17 protected.

18 And I think that accessibility of community  
19 pharmacy came through with that but it was hard to deal  
20 with when you actually had people presenting with those  
21 symptoms which we did.

22 And again, family and those people that are, you  
23 know, symptom-free to collect those medicines. I think  
24 some of that was supported by the medicines delivery  
25 service that you've already mentioned, but for those

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1 needs some extra thought, as soon as you tell somebody  
2 something is going to go short it's a self-fulfilling  
3 prophecy, isn't it? This may be short, therefore  
4 I'll order four more to make sure I'm okay.

5 Instructions. People were pretty good at that,  
6 I think. More often than not they did listen to us.

7 And again, we did have incidences, I had  
8 incidences where people got, you know, we had to sort of  
9 treat them in a slightly different way and maybe be  
10 a bit more forceful because I had to then explain to the  
11 team that these were people that were scared, that were  
12 frightened just like us and, actually, you know, the way  
13 in which we needed to deal with the people had to  
14 reflect some care but some of the incidences we had  
15 weren't great.

16 And keeping up to date with everything that's  
17 online, well, you know, that was the challenge I think  
18 for everyone within the pandemic trying to keep up to  
19 date with everything, but we were just trying to get our  
20 way through that to keep people safe.

21 **Q.** Finally, then, lessons and recommendations.

22 **A.** Yes.

23 **Q.** In your statement and indeed in your evidence this  
24 afternoon, you have described pharmacies as the shock  
25 absorber --

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1 people that did feel as if they were needing a family  
2 member or friend to pick it up, then there were some of  
3 the questions -- as we've already seen about Test and  
4 Trace as those guidance changed, "Is it okay? I saw  
5 them last week" -- how does that deal with?

6 The other one as well is buying the medicines and  
7 supplies you only need right now. That's really hard.  
8 We heard things on media, on social media, in  
9 supermarkets there were no toilet rolls in, pharmacies  
10 there was no Calpol, you know, again as a dad of many  
11 children, as I've already described, there is a human  
12 being reaction to want to look after your family and  
13 that was quite hard and that caused some of the most  
14 challenging conversations about saying: you can only  
15 have one bottle of this or one bottle of that.

16 I think that sort of slight confrontational type  
17 experience led some pharmacy team members to have to  
18 wear body cameras and things which I'd never seen or  
19 heard of in my time but still continues unfortunately.

20 Repeat medications, as well. Especially those  
21 things around inhalers people. You know, people who  
22 needed inhalers, they were specifically -- you know,  
23 they were particularly worried about the continuation of  
24 supply. And having done lots of work on medicine  
25 supply, because I think it's a fascinating area that

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1 **A.** Yes.

2 **Q.** -- for the healthcare system. Can I ask you to share  
3 any recommendations which you have not already had the  
4 chance to do so today that you would like the Inquiry to  
5 consider to better enable pharmacies to fulfil their  
6 critical role in a future pandemic?

7 **A.** Yeah, thank you, and thank you for the opportunity.

8 I think the shock absorber isn't mine, it is  
9 a phrase one of my colleagues used first, and it's  
10 absolutely perfect to describe, I think, some of the  
11 things that community pharmacy did at the time.

12 There's lots of recommendations in the report, but  
13 I think if I had to pick three that I would really want  
14 the Inquiry to focus on, I think a sustainable and  
15 resilient community pharmacy network. As I sit here  
16 today, seven pharmacies a week are closing across the  
17 four nations, and that is tragic for any future  
18 response. So a resilient network that exists, I think,  
19 is going to be key.

20 Infrastructure. It's hard to make infrastructure,  
21 whether that be large Nightingale hospitals, large  
22 vaccination centres, but reflecting on the evidence from  
23 your general practitioner colleague of 71% of vaccines  
24 being delivered across existing infrastructure, I think  
25 if that community pharmacy network is resilient and

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1 exists, then get ready to use it, and to my Lady's  
2 comment earlier about who -- you know, about how that  
3 NHS bureaucracy could be maybe reduced, understanding  
4 those safety things that need to be in place, I think,  
5 would be really important.

6 And then really reframe community pharmacy,  
7 pharmacists and their teams, as a genuine part of the  
8 NHS family and a key delivery in healthcare, which we  
9 absolutely are. As I've stated before, 90% of the  
10 income of most of our members come from delivering NHS  
11 services. And they would be my three key asks: make  
12 sure that we're here, use us, and we are part of primary  
13 care.

14 **MR MILLS:** Mr Kaye, thank you.

15 My Lady, that's all I have.

16 **LADY HALLETT:** Thank you.

17 A few questions from Ms Campbell who is directly  
18 in my sight, I might add.

19 **Questions from MS CAMPBELL**

20 **MS CAMPBELL:** Thank you, my Lady.

21 Mr Kaye, my name is Brenda Campbell and I ask  
22 questions on behalf of the Northern Ireland Covid-19  
23 Bereaved Families for Justice.

24 **A.** Thank you.

25 **Q.** Three topics, all of which in fact have been touched on  
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1 was a key part of what was really important to us, but  
2 we also have an individual board member for Scotland,  
3 Wales and Northern Ireland so, actually, cross-country  
4 sharing of information, I think put the NPA in a really  
5 interesting place, to be able to share intel,  
6 information across all four nations.

7 So "yes" is the short answer to your question, but  
8 I think the board's diversity both in where people are  
9 elected from, and also the diversity of the group of  
10 people that we are, I think, makes us a board that was  
11 able to step up in this place.

12 **Q.** But can you give us any specific examples of that in  
13 terms of issues that may have arisen that your board was  
14 better placed to deal with?

15 **A.** So one that jumps to mind immediately would be things  
16 around actually vaccine hesitancy. So we had people in  
17 the community that were from an ethnic minority who were  
18 going, actually, this is really, you know, there's some  
19 vaccine hesitancy, there's some education pieces, and  
20 actually that frontline -- because people on our board  
21 were actually delivering care, you've got to remember  
22 that our board is made up of people that run their own  
23 business and delivering care, we had a lot of frontline  
24 intel that was coming up. So, you know, family members  
25 that were maybe shielding in a different way, or like  
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1 in your evidence already, but if I might take you back,  
2 please, to the opening stages of your evidence in which  
3 you mentioned that the NPA board reflects the  
4 membership --

5 **A.** Yes.

6 **Q.** -- of the NPA itself, and as much as over 50% of the  
7 NPA's membership comes from ethnic minority  
8 backgrounds --

9 **A.** Yes.

10 **Q.** -- and over 50% of your board also comes from black,  
11 Asian or minority ethnic backgrounds --

12 **A.** Yes.

13 **Q.** And I gather, from the way in which you answered the  
14 question initially, that is a source of pride for the  
15 NPA?

16 **A.** Yes, absolutely.

17 **Q.** Did or does the NPA consider that the diversity of your  
18 board in fact strengthened effective communication in  
19 the course of the pandemic between the membership and  
20 the leadership?

21 **A.** Yeah, I would say it did, and I think it's really  
22 important to understand that the NPA board elected from  
23 the members of the NPA, so to add to your question, not  
24 only the ethnic minority dimension, which was real, we  
25 had people who knew family members that were dying, that  
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1 I say, vaccine hesitancy, that type of thing was  
2 directly from the frontline straight into the board, and  
3 then straight out into policy recommendation.

4 And I think as well, things like risk assessments  
5 we talked about earlier, our risk assessment was out  
6 in June, which was relatively quick, I think, as far as  
7 that was concerned -- because that's what our membership  
8 demanded.

9 **Q.** Thank you. Second topic, and it's -- the topic is  
10 entitled medicine shortages, but it's perhaps more  
11 focusing on the stress that that put on community  
12 pharmacists and their teams.

13 In your statement, you highlight the considerable  
14 amount of time that pharmacists and their teams had to  
15 spend sourcing medicines particularly when they were out  
16 of stock, and in fact the statistics are concerning.  
17 I think your November 2020 survey indicated that 50% of  
18 respondents were spending up to 5 hours per week, 40%  
19 between 5 and 10 hours per week --

20 **A.** Yes.

21 **Q.** -- and some over 10 hours per week. Every week.

22 **A.** Every week.

23 **Q.** Which in real terms is well over a day in normal working  
24 conditions, trying to source medicine on behalf of your  
25 patients and customers.

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1 How did that impact the workload of those who  
2 remained in the store at the frontline to deal with your  
3 customers?

4 **A.** So it's a really -- really grateful for the question  
5 because that medicine supply function is a key part of  
6 what community pharmacy does, and actually the taking  
7 that time away from frontline delivery of care is really  
8 problematic, because community pharmacy is a team, it's  
9 not always the pharmacist that is having to deal with  
10 that, but it's definitely taking time away from other  
11 members, like you say, who are supporting someone else  
12 or if, you know, somebody needs to be shielded, that  
13 does have an impact, then, on the ability to do other  
14 functions within the pharmacy, such as dispense  
15 medications and do the day-to-day.

16 So it definitely does have an impact. Or, if you  
17 decide that you're going to replace that time, and you  
18 need more time and more staff, that then has a financial  
19 impact which, we've already touched on, was particularly  
20 challenging with the advances and things that were given  
21 at that time.

22 **Q.** Your statement reflects some examples of pharmacists who  
23 really went above and beyond in order to access  
24 patients' medicines.

25 **A.** Yes.

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1 the top of my head, I think there were 20 serious  
2 shortage protocols issued over the time frame, 14 of  
3 which were for HRT which then caused lots and lots of  
4 additional questions and things. So different groups.

5 I wouldn't say it was an overall lack of  
6 confidence but when something was highlighted certain  
7 groups then caused extra pressure.

8 **Q.** I know in your statement, and I'll leave it for present  
9 purposes, you have some suggestions of how that might be  
10 addressed in the future.

11 But if I might turn to my final topic and that is  
12 funding and, again, you have touched on it just very  
13 recently indeed. In Northern Ireland when you mentioned  
14 that there was some special advance funding available  
15 the figure in fact in Northern Ireland was some  
16 35 million.

17 **A.** Yes.

18 **Q.** Now, that was to a sector that had been recognised was  
19 in need of much needed resilience and support. The  
20 35 million special advance Covid funding was made  
21 available up until March 2021, so still very much in the  
22 grips of the pandemic --

23 **A.** Yes.

24 **Q.** -- and then it began to be withdrawn.

25 **A.** It did. And paid back.

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1 **Q.** But what about from the other end in terms of patient  
2 and customer confidence? How did it impact their  
3 confidence in the community pharmacy system?

4 **A.** So I think what it did was, as I mentioned earlier,  
5 I think as soon as something becomes publicised in the  
6 media or social media about something become short in  
7 supply, I think that's then a self-fulfilling  
8 proficiency, everybody then wants to grab something.  
9 I think, as well, what the government did was put in  
10 place the serious shortage protocol so what that allowed  
11 people to do is to -- and pharmacists and their teams to  
12 be able to go: actually, this medicine is out of stock,  
13 I don't have to send you back to another part of primary  
14 care to get that prescription changed, I can change this  
15 for you now. Or: your prescription is for three  
16 inhalers. Actually, so everybody gets one, I'm only  
17 going to give you one.

18 Those were some challenging conversations with  
19 people but they were things that were important to do to  
20 maintain that supply.

21 I think overall confidence -- this is a personal  
22 experience, overall confidence in supply chain remained  
23 high but there were then specific areas that went out of  
24 stock that were highlighted that then people had lots of  
25 questions and those drove a lot of demand. I think, off

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1 **Q.** And paid back. And really that's the question. What is  
2 the impact on a sector that needs much needed support  
3 and resilience to give 35 million for that specific  
4 period of time, I think it's June 2020 until May 2021,  
5 and then say: right, it's time to start giving it back?

6 **A.** It's not only -- it's soul destroying and it actually  
7 impacts both, you know, the resilience of the network,  
8 the ability to invest, the ability, as you said, to  
9 actually somebody is taking 10 hours to source  
10 medicines, can I replace them.

11 Also, at the time, there was some uncertainty,  
12 I believe about how much of it would be reclaimed, how  
13 quickly that would be reclaimed, how -- you know, what  
14 that would take -- I think in Northern Ireland it was  
15 actually taken back over 24 months, I think.

16 **Q.** Yes.

17 **A.** But that wasn't known at the time, so that additional  
18 living of uncertainty I think is really, really  
19 problematic.

20 And, again, I would say your colleagues in  
21 Northern Ireland now with both vaccine programmes now  
22 that have come out, vaccines in care homes that have  
23 come primarily now through community pharmacies, I think  
24 shows to the testament of the network within  
25 Northern Ireland and how it did respond, but it was

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1 really, really challenging at that time.  
 2 **MS CAMPBELL:** Thank you very much.  
 3 Thank you, my Lady.  
 4 **LADY HALLETT:** Thank you, Ms Campbell. Very grateful.  
 5 I think that completes the questions that we have  
 6 for you, Mr Kaye. I see from your statement both  
 7 grandfathers, father, uncle, aunt, brother, all  
 8 pharmacists.  
 9 **A.** Yes, there was no hope for me.  
 10 **LADY HALLETT:** What happens if none of your five children  
 11 become --  
 12 **A.** Well, the first one has decided to be a paramedic, so  
 13 you never know, there's still some chance.  
 14 Thank you, my Lady.  
 15 **LADY HALLETT:** Well, it's interesting because as you may  
 16 know, the previous pharmacist witness also was a family  
 17 business where he was working.  
 18 Anyway, thank you so much for your help in this  
 19 Inquiry and also obviously for the superb work that you  
 20 and your colleagues did during the pandemic. We are  
 21 really grateful.  
 22 **THE WITNESS:** My Lady, thank you.  
 23 **LADY HALLETT:** And I'm sorry you didn't get the recognition  
 24 at the time that you should have done.  
 25 **THE WITNESS:** Thank you. I appreciate that.

1 (The witness withdrew)  
 2 **LADY HALLETT:** Right.  
 3 10 o'clock tomorrow, Tuesday, 5 November.  
 4 (3.47 pm)  
 5 (The hearing adjourned until 10.00 am on  
 6 Tuesday, 5 November 2024)  
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98/24 100/25	<b>14 June 2024 [1]</b>	<b>21 January 2021 [1]</b>	<b>6 o'clock [1]</b> 119/4	43/17 47/11 48/6 48/8
<b>MS CAMPBELL: [2]</b>	1/11	43/12	<b>60,000 [1]</b> 133/10	49/10 49/18 50/10
149/20 157/2	<b>15 [1]</b> 116/4	<b>210 [1]</b> 99/3	<b>65 [4]</b> 116/7 116/23	51/22 53/1 54/12 55/8
<b>MS CAREY: [7]</b>	<b>16 May 2021 [1]</b> 83/4	<b>23 March [1]</b> 65/8	117/9 119/20	55/9 57/19 57/22
20/11 20/15 25/4 49/1	<b>17 [1]</b> 62/4	<b>23 November 2020</b>	<b>68 [1]</b> 101/22	57/24 57/25 58/24
49/9 57/4 82/4	<b>17 April 2020 [1]</b>	<b>[1]</b> 105/21		59/15 60/6 60/6 60/9
<b>MS MITCHELL: [2]</b>	82/19	<b>24 months [1]</b>	<b>7</b>	62/25 64/13 65/2 65/5
89/23 93/25	<b>173 [1]</b> 107/18	156/15	<b>7 o'clock [1]</b> 142/13	65/14 66/13 67/13
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101/5	<b>19 [39]</b> 3/9 3/11	<b>25 April [1]</b> 20/25	<b>7-11 May 2020 [1]</b>	70/25 71/6 71/15 74/3
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		<b>3.25 [1]</b> 140/5	<b>90 [3]</b> 123/12 138/9	146/23 149/2 149/2
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<p><b>W</b></p> <p><b>worked... [5]</b> 104/12 118/21 121/8 135/19 138/19</p> <p><b>worker [10]</b> 49/21 58/22 59/10 73/15 76/6 76/15 84/8 100/2 135/10 136/13</p> <p><b>workers [48]</b> 28/5 29/10 30/18 31/6 36/7 49/24 50/7 50/17 51/6 51/16 55/3 55/23 56/21 59/2 59/6 61/18 63/20 64/1 68/12 71/12 74/14 75/15 75/19 75/23 76/12 78/8 80/17 82/14 86/20 94/20 99/15 99/19 99/25 100/5 107/16 107/19 108/2 108/21 109/19 110/4 110/7 110/9 111/12 135/11 135/19 135/22 136/3 136/6</p> <p><b>workforce [17]</b> 29/3 55/13 73/16 74/17 75/1 75/6 80/21 80/23 81/13 81/18 88/12 93/18 93/22 109/10 114/13 114/19 143/5</p> <p><b>working [39]</b> 1/13 2/1 2/5 8/11 8/12 8/24 13/20 16/8 18/12 21/6 23/11 32/23 40/7 40/7 41/7 43/25 48/10 49/22 55/10 62/12 70/5 76/25 79/15 79/20 102/18 104/2 106/12 113/25 114/2 118/25 119/24 120/7 128/21 132/8 136/23 143/2 143/8 152/23 157/17</p> <p><b>workload [4]</b> 120/21 121/5 129/2 153/1</p> <p><b>workplace [13]</b> 19/12 38/20 42/17 48/6 60/18 82/22 83/1 84/1 86/7 103/7 107/17 108/15 109/1</p> <p><b>works [1]</b> 102/16</p> <p><b>worn [3]</b> 33/2 38/6 67/23</p> <p><b>worried [3]</b> 57/19 142/12 146/23</p> <p><b>worth [1]</b> 124/17</p> <p><b>would [188]</b></p> <p><b>wouldn't [4]</b> 46/20 55/21 90/21 155/5</p> <p><b>Wright [1]</b> 95/12</p> <p><b>write [2]</b> 79/1 79/13</p> <p><b>writing [5]</b> 28/10 60/15 72/24 79/10</p>	<p>95/17</p> <p><b>written [5]</b> 28/11 56/24 106/18 115/21 134/11</p> <p><b>wrong [1]</b> 16/21</p> <p><b>wrote [9]</b> 26/19 47/22 54/8 65/7 65/24 70/24 72/13 95/14 135/17</p> <p><b>Wuhan [1]</b> 23/24</p> <hr/> <p><b>Y</b></p> <p><b>yeah [11]</b> 66/15 85/22 118/2 120/22 122/25 125/6 126/11 127/9 138/16 148/7 150/21</p> <p><b>year [2]</b> 5/23 19/22</p> <p><b>years [5]</b> 11/9 16/9 19/25 111/14 112/25</p> <p><b>yes [140]</b> 2/17 2/20 3/6 4/24 5/17 5/17 6/19 6/23 8/4 9/16 10/14 10/14 10/18 13/22 14/1 15/1 15/25 17/3 17/3 21/12 21/16 21/20 23/20 25/8 29/8 30/6 31/14 31/20 32/23 34/22 36/13 37/7 38/9 41/1 42/4 42/23 43/2 44/3 44/11 45/3 46/2 47/14 50/14 51/25 53/15 54/16 58/2 60/2 60/25 61/3 61/6 61/25 62/5 62/7 64/11 64/21 65/11 67/20 70/19 71/7 72/16 74/8 77/21 77/23 78/2 78/11 78/15 80/1 80/3 83/23 84/4 85/8 86/2 88/23 99/13 102/10 104/7 106/9 108/5 109/15 110/14 112/23 113/12 114/2 114/3 114/10 114/25 115/6 115/6 116/11 118/17 119/13 119/17 121/22 121/25 123/6 123/17 123/25 125/3 125/19 125/24 126/3 127/3 127/5 128/1 128/5 128/10 128/13 129/13 130/1 130/20 130/25 131/16 133/6 133/18 136/8 136/8 137/17 137/19 137/24 139/10 141/11 141/15 141/17 141/25 143/11 143/13 147/22 148/1 150/5 150/9 150/12 150/16 151/7 152/20 153/25 155/17 155/23 156/16 157/9</p> <p><b>yesterday [1]</b> 43/16</p> <p><b>yet [3]</b> 50/16 73/7</p>	<p>136/2</p> <p><b>you [525]</b></p> <p><b>you know [20]</b> 9/25 10/23 51/12 53/2 55/12 55/13 92/10 102/18 105/5 116/16 116/23 123/21 124/13 129/17 143/25 147/8 151/18 153/12 156/7 156/13</p> <p><b>you want [2]</b> 30/21 124/17</p> <p><b>you'd [4]</b> 9/8 16/9 115/16 125/9</p> <p><b>you'll [1]</b> 128/24</p> <p><b>you're [25]</b> 17/22 20/20 22/10 34/23 44/18 44/25 45/2 64/8 71/21 76/1 91/17 93/15 93/15 97/10 102/8 116/23 121/11 128/21 129/19 142/10 142/11 143/22 143/23 143/24 153/17</p> <p><b>you've [24]</b> 18/9 18/21 20/1 29/7 49/3 49/11 63/24 64/7 66/5 78/6 82/16 83/12 94/4 99/2 100/20 101/10 104/22 109/17 111/24 112/2 136/5 140/25 145/25 151/21</p> <p><b>your [118]</b> 1/8 1/21 2/1 2/15 2/18 3/2 3/3 3/6 3/14 5/12 6/22 8/8 8/11 8/12 8/20 9/1 9/2 11/8 12/1 12/16 12/19 13/23 14/9 14/22 17/11 17/12 18/17 19/24 19/24 20/7 20/15 20/24 21/17 22/5 29/9 31/10 31/22 32/9 39/11 39/23 40/14 41/3 43/5 45/4 47/12 52/7 54/6 57/13 62/1 62/8 64/20 64/22 66/5 70/22 71/11 74/3 75/21 76/21 78/7 82/9 82/17 85/16 87/7 88/18 90/7 96/11 99/3 101/11 101/17 103/2 103/7 104/6 106/4 107/10 107/14 109/16 111/4 111/19 111/22 112/13 112/20 114/22 115/1 117/9 123/7 123/15 130/21 133/2 133/21 137/11 139/5 140/24 140/24 141/18 143/24 146/12 147/23 147/23 148/23 150/1 150/2 150/10 150/17 150/23 151/7 151/13 152/13 152/17 152/24</p>	<p>153/2 153/22 154/15 155/8 156/20 157/6 157/10 157/18 157/20</p> <p><b>your November 2020 [1]</b> 152/17</p> <p><b>yourself [1]</b> 105/18</p>	
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