Tuesday, 26 November 2024

(10.00 am)

MS NIELD: My Lady, are you able to see and hear the hearing room?

LADY HALLETT: I can, thank you, Ms Nield.

MS NIELD: My Lady, I'd like to call, please, Anna-Louise Marsh-Reese.

MS ANNA-LOUISE MARSH-REESE (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Ms Marsh-Reese, can I just say how sorry I am that I can't be there today. I think you know me well enough by now that I would have been there if I could. But I'm obviously very appreciative of you and your fellow bereaved coming along to give evidence again.

THE WITNESS: Thank you, and I hope your Honour mends quickly.

MS NIELD: Can you give your full name, please.

A. It's Anna-Louise Marsh-Reese.

Q. Ms Marsh-Reese, you've provided a witness statement for this module of the Inquiry, dated 10 November 2024. That's INQ000343992. Can I check that you have a copy of that witness statement in front of you?

A. I do.

Q. I think you're familiar with that witness statement?

A. I am.

Q. Thank you. You're a founding member and co-leader of the Covid Bereaved Families for Justice Cymru; is that right?

A. That's correct.

Q. And I think that organisation is the non-political not for profit organisation; is that correct?

A. That's correct.

Q. Could you tell us, please, how the group came to be established.

A. It came to be established -- my father died of hospital-acquired Covid in October 2020, and I immediately tried to get some answers as to how that had happened. I then found other people in the same hospital and the same health board that had experienced similar. And then that grew and found, sort of, many people across Wales that had experienced the same, and -- we were part of a UK group, UK-wide group, but we, you know, quickly realised that because healthcare and social care are devolved to Wales that we needed to focus on the Welsh issue specifically.

Q. And can you tell me how many members the group has currently?

A. We have about 400 members.

Q. And how do members join the group?

A. They can join via Facebook, they can join via Twitter,

they can contact the group directly or go via our legal team.

Q. And could you please explain the purpose and the primary aims of your group.

A. As I said, initially we wanted answers. We just -- which we couldn't get via the formal complaints process. So our initial objective was to call for a Wales-specific inquiry. We felt that would be the right way to scrutinise the very specific problems in Wales. And that's not to say we didn't want to be in the UK inquiry too, we just felt that that would be able to cover the breadth and depth of the very specific issues in Wales.

Q. Thank you.

You've helpfully set out in your witness statement at paragraph 56 the extent of the Covid Bereaved Families for Justice Cymru's engagement with a number of organisations, the Welsh Government primarily but also, to some extent, the UK Government, the Welsh NHS bodies and other interest groups and independent bodies in Wales. But I think it's right to say that the group had a number of meetings with the Welsh Government during the relevant period and subsequently, and those were meetings with the First Minister, the Minister for Health and Social Services, and the Deputy Chief Medical

Officer, Dr Chris Jones; is that correct?

A. That's correct, yes.

Q. For the remainder of your evidence I'd like, if I may, to look at the key areas of concern to your group that fall within the scope of Module 3. So, first of all, primary care and access to primary care in particular I think was a concern for a number of your members, and I think you set this out at paragraphs 16 to 17 of your witness statement. But is it right to say that there was certainly at least a perception for many of your members that general practice was closed or certainly closed for inpatient -- in-person visits; is that correct?

A. Absolutely, yes. More than the perception, many of our members, including my family, could not access their GP. There was never any question that there would be a face-to-face consultation. Video consultations never mentioned.

Q. I think you explain in your witness statement that when your father was discharged from hospital, he'd been admitted to hospital for a non-Covid complaint, I think that's right, but he'd been exposed to Covid-19 when he was on the hospital ward, and after he was discharged and was unwell, your contact was with the out-of-hours GP; is that right?

A. Initially it was with his personal GP, so there was a number of calls with him, and then as his condition deteriorated, we had visits from four out-of-hours doctors, not one of whom suggested Covid even though it was written on his discharge summary that he had been exposed to Covid on his ward.
Q. Did the out-of-hours doctors appear to have access to those discharge notes?
A. We have checked. They did.
Q. And now if we could move on, please, to issues that had been raised by your members in relation to 999, emergency ambulances, and the 111 telephone triage service. I think it's right to say that 111, in fact, wasn't available across all of Wales during the relevant period; is that right?
A. Sadly not. Three of the health boards did not have a 111 service, so this is where the divergence between England and Wales starts. Yeah, I mean -- and it was also chargeable in those three health boards. It wasn't free.
Q. So the health boards that offered 111, it was a chargeable phone number?
A. Yes, it's all very complicated and it's unique to Wales, of course, that the 111 service is run by the Welsh Ambulance Service, but then the triage and sort of

callbacks are done by the respective health boards.
Q. I think one of your members had an experience of trying to call 111 and not being able to get through, but there wasn't actually a recorded message at that time explaining that the 111 service wasn't operating in that area; is that correct?
A. That's correct, yes, and I think one of the main concerns is the confusing, conflicting information that we did get when we called, and part of the problem was that Covid was only deemed -- there was only three symptoms that were attributed to Covid. So if you had any of those other symptoms you were just told it's fine, just, you know, don't worry, when in fact they were clearly Covid symptoms.
Q. So I think the initial three symptoms that were identified on the 111 service were fever or chills, a persistent cough, and shortness of breath. So it's anything out of those three symptoms that wasn't recognised as a potential symptom of Covid; is that correct?
A. That's correct, and I think many older people don't display those three cardinal symptoms and they, you know, it is extreme fatigue, it's headaches, it's nausea, it's diarrhoea, and some others. We're not suggesting that everybody should have, you know, gone to

hospital or needed a test with everything, but the lack of acknowledgement that those were Covid symptoms and, you know -- and it was definitely acknowledged they were by October 2020. It was a real miss.
Q. I think one of your members had had one of those experiences where they were calling the 111 service repeatedly and being told that their loved one was fine, there was no need to go to hospital, it wasn't going to be Covid, and eventually, I think that patient was admitted to hospital, did have Covid and, sadly, died from Covid; is that right?
A. That's correct, yes.
Q. I think there are also some issues that you've raised from your members with emergency ambulances and calling the 999 number and the excessive waiting times in Wales. What steps did your members have to take when they were told they were going to have to wait for hours for an emergency ambulance?
A. I mean, most of us were told, "Don't bother ringing 999, take them yourselves." My sister had to literally bump my dad down the stairs and take him in the car. I mean, the poor man could barely walk.
Q. And was your sister living with your father at that time so she came from another household in order to travel --
A. I mean, we had no choice at that point. He was so

unwell that she had to do that to help him.
Q. You also raise issues in your witness statement in relation to the guidance that was being put out for members of the public, the guidance around the symptoms of Covid and the fact that many of your members found it confusing and unclear; is that right?
A. Yes. I mean, it was unclear for many reasons, you know, we have the whole England/Wales differences. But, you know, we have a Chief Medical Officer in Wales who said there's no need to wear face coverings, you know, we got conflicting and confusing communications about shielding. Pretty much across the board different ways of saying things and, again, the symptoms was a key part of that. The whole, sort of, Protect the NHS, my family would -- my dad was absolutely not going to go to hospital unless he absolutely needed to. It wasn't the right thing to do. Sadly he did have to go and, of course, that was where he got Covid so ...
Q. I think you give the example of your father receiving a shielding letter -- or at least a shielding letter being sent to your father in fact after he had died, in October of 2020, and some of the advice given in that letter including that Covid tests would only work if the patient was symptomatic; is that correct?
A. Yes, and not only -- so it actually says in this

shielding letter that was -- that arrived the day after my father died that was (a) telling him he didn't need to shield, which seemed completely baffling because obviously he was 85 with comorbidities, but not only that you should only take a PCR test if you had symptoms, but only with these three symptoms, and that it was pointless to do one if you didn't have symptoms, which I -- we know in October 2020 that everyone knew that, you know, you could test positive and be asymptomatic.

Q. I think you've also identified that there was an issue with accessibility of the guidance and advice that was being produced by the Welsh Government in that it wasn't easily accessible for people who were deaf or visually impaired or indeed had learning disabilities, and it was the case, was it, that not all Welsh Government broadcasts included a BSL interpreter?

A. Yeah, absolutely.

Q. What about information about local outbreaks? Was there any information put out by hospitals about whether they had an outbreak of Covid at their hospital and whether to stay away? Was that information easily accessible?

A. No, and in fact it was well hidden. It was proactively not broadcast, you know, and I think that's one of the -- obviously the main -- one of our main concerns is

that clusters and outbreaks were not communicated.

You know, I literally had to take screenshots of each health board's Covid pages, and I did them, you know, two years ago, and there was just practically nothing about Covid on there, even how to protect what you do, you know, and it seemed such a simple way of communicating to people, you know, via a website, you know, what you should do and how you should do it. You know, what visiting hours were, what protections were in place at the time. Just absolutely nothing. It was almost like the pages had been forgotten.

Also no letters sent about things. I mean, my father's GP and the out-of-hours doctors didn't seem to be aware that there'd been a cluster outbreak in my father's hospital, which was 21 patients, 13 staff, and yet the ward had been closed for four days after. So it just seemed, in a small place, that that wasn't well-known or communicated -- or at least communicated to local GPs.

Q. If we could look at some of the examples that your members have given about their concerns about the quality of care that was being provided in hospitals in Wales, I think you refer to a "postcode lottery" in terms of inconsistency between different hospitals in terms of the sort of care and the kind of procedures

that were in place. I think you give the example of a patient who had moved hospitals within a single health board in Wales; is that right?

A. That's correct.

Q. Experienced quite different care in those two different hospitals?

A. And I know the Chair is looking at systemic issues, but there are systemic issues that are pertinent just for Wales, but there is also a lack of systemic issues because each health board does things so differently. And that's -- you know, that's -- it just seems crazy that there is not at least a commonality, you know, about processes and policies.

You know, we understand there needs to be some flex for the local, but there should at least be some consistency. And this wasn't just across health boards, this was, you know, across hospitals within health boards and also at ward level: different rules, different policies, different interpretation of those policies.

Q. And so you've given the example of a family of a patient who wasn't allowed to visit their loved one when they were dying but also there wasn't any process or means by which they were offered a video call; is that correct?

A. I don't think anyone was. There was zero patient

liaison. I think that's one of the biggest things as well, for a recommendation, is the lack of a patient voice for the patient themselves and the liaison with the families. That should -- you know, if you can't see your loved one when they're dying, which we do believe you should anyway, but if you can't there has to be -- you know, with all the technology we've got nowadays it's not beyond the wit of man to have an iPad to be able to communicate with them.

But then of course we come back to the lack of digitisation: in many hospitals and wards there was no Wi-Fi. So many, many issues across that communication piece.

Q. I think some of your members had to say goodbye to their loved ones by text message; is that correct?

A. That's right, and they just had to hope that somebody gave them that text message. You know, we have many examples of when their loved one's items are returned there's a mobile phone with, you know, hundreds of missed calls. You know -- and it's not just that kind of communication, it's also the communication with the patient. Many patients were not, sort of, you know, technically disabled, but age is, of course, a disability in itself, but, you know, people weren't given hearing aids or glasses. You know, their world

was already quite small and silent, and yet that only added to it. And I think, you know, we really have to think about, you know, that.

And one of the things I did want to say, that, you know, was -- you know, we've heard a lot about -- and absolutely rightly -- about emergency medicine and, you know, what happened in ICUs, all vital to understand, but most of our loved ones, you know, in our group, were older. They led very silent, quiet deaths. And as Julia Jones from John's Campaign said, it's almost death by indifference. You know, nobody communicated to them, nobody told them what was happening, they didn't have communication with their loved ones. And I really do think we need to ponder on, you know, that element of it. It's those quiet silent deaths that are the real tragedy, I would say.

Q. And you have set out, I think this is at paragraphs 37 and onwards in your witness statement, your members certainly have felt that at times there appeared to be some discriminatory practices within hospitals in terms of access to treatment or escalation of treatment for their loved ones when their loved ones were elderly, and you give the example of having to wait 12 hours before the administering of medication, having to wait for CPAP devices, having to wait for high-flow nasal oxygen.

I think your father had to wait some time after his oxygen levels had dropped before he was offered oxygen; is that correct?

A. Yes, his oxygen levels dropped dramatically and, you know, they knew they weren't going to ventilate him and we understood that but he was -- they couldn't find the high-flow oxygen machine for 40 minutes, and then they told us he was dying. We didn't find out about that until two years after. That was not explained to us at the time. When I asked -- when I did arrive -- fortunately we were allowed to be with him when he died -- I was told -- he became agitated. Well, now we know he was probably agitated because he hadn't had oxygen for 40 minutes but I, you know, as you do, and I was in a panic and very distressed I said, "Please, please can you try again", and the doctor said, "That ship has sailed", and I think this is also something we're really keen, you know, to change, is that words matter, the way the words are written, the way that words are said. Things like that are just, you know, it haunts my sister and I. That -- it's just so casual and -- well, you know.

Q. I think you also give the example of a patient who was refused antibiotics on the basis of their clinical frailty score, that was relayed to you by another

member; is that right?

A. That's correct, yes, and she was also power of attorney as well.

Q. She had power of attorney?

A. Yes, and that wasn't -- that seemed to be ignored.

Q. So she wasn't consulted?

A. Not at all. I don't think any of us were explained what treatment -- you know, once Covid was diagnosed we weren't explained what treatments were being undertaken. It was more a question of we were told what we weren't getting so, "Your loved one will not be ventilated". We would recommend that it's so important to explain the good things that are being done. You know, steroids, you know, dexamethasone, very effective, you know, if I had known my dad was being given that I would have felt, you know, more confident that he was being treated with the right steroid or the right -- yeah, it's just those -- it's not a little thing, obviously, but they're relatively easy things to solve and, you know, one of the things I did canvas my group last night and said, "What is the one thing you want me to say tomorrow", and they said communication is absolutely vital. Clear, honest communication.

Q. And I think there were a number of examples when there wasn't any communication from the hospitals, calls went

unanswered, and loved ones and families were not being given updates either about the progress of their family member, or indeed what kind of treatment they were receiving.

A. Exactly. We understand people are busy. But, you know, when my father was dying of Covid, it wasn't a particularly busy time but, you know, this is where you have to look at other -- this is where the patient voice groups and the patient liaison teams come in, all of which seemed to be -- were not -- were definitely not around when -- you know, during the first and second waves in Wales.

Q. And perhaps also related to that communication issue, you set out a number of your members' concerns around DNACPR notices during the pandemic, and in particular a lack of communication around those decisions. And I think you give the example of one patient who lacked capacity and had, in fact, a lasting power of attorney for one of their family members but they weren't involved in any consultation around the making of a DNACPR notice; is that correct?

A. That's correct. Most of us were not consulted. And most of us didn't find out there even was one placed until we got hold of the hospital notes and that could be some months, even years, later. And then also the

confusion with the DNACPR and the treatment escalation plan. My dad's are contradictory to each other, the treatment escalation plan says he is eligible for CPR; his DNACPR says he's not. Neither of them are filled in completely, and, you know, we were told by the health board that they had tried to contact us, but that we were having our dinner. How they knew this, we've no idea, but they have subsequently apologised that they did not attempt to consult us on that.

But apparently my dad was fine with it. And, again, words matter. It says on my dad's CPR, "We explained to the patient that CPR would be futile". I pray that they did not use the word "futile" to my dad because, I mean, you just wouldn't, would you?

Q. Also perhaps on this subject of communication and insensitive communication, I think it's right that a number of your members voiced concerns about the communication they had from hospitals after their loved ones had died, and returning their loved one's belongings to them. I think you give the example of one family being told to burn their loved one's belongings; is that right?

A. Yes, or they got someone else's. You know, really -- soiled, undergarments, urine-soaked slippers. One lady got her stuff back about -- her husband's stuff back

about a year later with two half-opened packets of biscuits in them. You'd have thought that there would just be some kind of process to check what was being handed over, usually in a bin liner or a plastic bag, and, you know, it's back to that dignity in death. These are people's lives and I think that was largely forgotten. I think the individual was forgotten, you know, in amongst all of the confusion and chaos.

Q. I think you set out in your witness statement that four of your members, at least four of your members, experienced the hospital morgue having lost the bodies of their loved ones temporarily and not being able to locate those bodies.

A. Absolutely, and not even a real apology. It was just like, "Oh, well, they've been moved to hospital X". One of our members had to actually stop her father's body being transported to a supermorgue many, many miles away. Yeah, it's all about communication. It's all about respect. And it's about listening. And I think, you know, we know there's been a number of reviews and investigations, albeit a patchwork, cobbled-together list, but never once have any of the health boards or the Welsh Government consulted those who were actually there and asked us how we think things could be made better, be it communication or infection control or

DNACPR. We've had to do that all of our own volition and lobbied very hard to get those changes.

Q. Can we move on, please, to look at some of the issues that you've raised and your members have raised in relation to concerns around infection prevention and control measures in Welsh hospitals. I think there are a number of concerns that have been raised by your members -- and this is paragraphs 40 to 50 in your witness statement, Mrs Marsh-Reese -- particularly around failures to segregate patients according to their Covid status. I think that was experienced by a number of yours members; is that correct?

A. Yes, there was seemingly a categorisation system of amber, green and red wards, but, you know, we all witnessed non-Covid patients being put on Covid wards, conversely, you know, one of our members had both her mother and father with Covid put on a non-Covid ward, people on corridors. You know, an inconsistent utilisation of those categories. I mean, any of us that were there, you know, experienced it firsthand in both waves 1 -- and seemingly particularly in wave 2, there just seemed no rhyme nor reason to what people were doing. You know, we hear repeatedly "I was following the IPC guidelines". We'd just have to say, well, did someone not -- you know, it's a sign of insanity, isn't

it, to keep doing the same thing and expect different results, but cluster outbreak after cluster outbreak was happening in Wales and yet nobody seemed to go, "Hang on a minute, are those IPC guidelines working then because we -- you know, with the same -- how is it still happening? How are we still having so many infections and deaths?"

Q. I think there were occasions when your members had intervened to try to ask for their loved ones not to be placed on a Covid ward. I think you give the example of a patient who was immunosuppressed and asked for them not to go on the main ward but they were placed on that ward and contracted Covid in those circumstances; is that right?

A. Absolutely. And, you know, even when somebody was with suspected Covid, they kept them on the ward until they tested positive. So that was a scenario in my dad's non-Covid ward was that, you know, patient zero got it, and then everyone else got it, but they weren't testing regularly, they -- you know, they weren't -- there was just no system or structure to, you know -- and, you know, we'd say IPC, the prevention, the P word, you know, you need to prevent it first of all. And that comes back to, you know, building hospitals or starting to build hospitals with the right ventilation.

I mean, Florence Nightingale was saying this 160 years ago. I mean, it's no surprise. We have reports from 2001 from Welsh Government saying, you know, that -- I think one in ten Welsh hospitals were built before 1900. It's not unknown that this stuff needs to happen. So prevention is absolutely key.

We know that ventilation can't be implemented overnight but there could have been HEPA filters put in. They had been -- their efficacy had been tested, you know, I think at the -- Addenbrooke's, Cambridge, in, I'm going to say, July 2020. You know, it's not the only solution but it's -- it cleans the air. You know?

And it's every human -- it's a human right to have fresh, uncontaminated air, isn't it? You know, you wouldn't build a public building without fire prevention, you wouldn't make people eat contaminated food, and yet this concept of having clean, fresh, uncontaminated air just seems to have bypassed everybody. And I'll be honest, it still has.

Q. I think there are also concerns around the way that PPE was being used or worn in Welsh hospitals. I think a number of your members saw healthcare workers with inadequate PPE or sometimes wearing it incorrectly, masks being worn --

A. Chin wearers, yes. That's a thing, yes.

Q. And also I think there were some concerns from your members about the use of agency staff who may have moved between several different hospitals and the potential to spread nosocomial infection in that way; is that right?

A. Yes, and there's a number of things there. Obviously, you know, we know -- I mean, I didn't know at the time, but, you know, the right masks weren't being worn anyway but even surgical masks weren't always being worn or being worn incorrectly. You know, the whole apron thing, we have no idea what -- how an apron was going to protect you from Covid but that seemed to be a thing. And absolutely this is, again, where consistency is required. If you have agency staff maybe working across a number of hospitals, if they don't -- if there's different rules and policies in different hospitals and health boards, it's opening up the risk of human error. I mean, it's not even -- it's not a risk, it's likely to happen, isn't it? Because they just don't know. Oh, in this hospital we do it this way and in another hospital we do it that way. I mean, it's just so simple, isn't it, to have a set of consistent policies that everybody follows?

Q. And you identify, particularly in relation to IPC measures, inconsistencies in the visiting restrictions that applied in different hospitals or across different

local health boards, particularly in relation to visiting around end of life. And what were the views of your members in relation to those visiting restrictions when it appeared that other IPC measures were implemented in quite a lax manner?

A. Well, that's exactly it, isn't it? I mean, if -- there would be no reason for you not to visit your loved one if you had been given an FFP3 mask. There would be no reason. You would not be -- there would be no risk of you passing it to anyone else on your way to visit them. Clearly they'd already got Covid. You would also be protected from them giving you Covid.

Everybody must have someone with them when they die. They just must. And it would have been, again, a simple solution to have enabled that.

Q. Another aspect of IPC, testing, which you've touched on briefly.

I think your group have a number of concerns, particularly around testing of asymptomatic healthcare workers and the delay in bringing in that policy in Wales and then implementing that policy across all of the health boards.

I think it's right that some health boards had not implemented that policy until March of 2021; is that right?

A. Yes, and Professor Kloer, who gave evidence a couple of weeks ago, said in his health board it was actually July. In England that was brought in in November 2020, as soon as, basically, lateral flow tests were made available, so this enabled healthcare workers to test twice weekly and, clearly, not work if you -- even if you were asymptomatic.

Now, what the reason for that is, we've heard many and varied reasons, from distribution to UK Government comms, didn't quite get that one. But when we met with the then health minister, Eluned Morgan, she told us they needed a strategy, that was why it was delayed: they needed a strategy and it wasn't an easy thing to do to get those tests out. I mean, how it took over six months to get lateral flow tests when hospitals already have an established distribution network is beyond our understanding. We can only imagine -- maybe that was -- it was done on purpose, we don't know.

But just to touch on it, it's not just the healthcare worker testing. Once they realised that they shouldn't be discharging -- not realised, it was absolutely tragic that they were discharging those from hospitals to care homes without testing. But discharging to community hospitals and discharging to people's homes -- you know, when I asked why my dad

wasn't tested before he was discharged, they said that's because it wasn't their policy. I'm like: but he was an old man -- where is the risk assessment? He was 85, immunocompromised. You told him you were sending him home because it was the safest place for him to be -- which is great in the fact they're acknowledging that hospitals aren't safe, so at least that's one win for us.

But, you know, they can't -- you can't just -- you've got to have -- and one of the things -- and I've written down on one of my many postcards in front of me was, this lack of common sense and personal accountability. Whatever the rules were or the IPC guidelines were, or your particular hospital, national or local, if you've got someone that's been, you know, exposed to 20 other patients on a ward, whether it's your policy or not, you should, just because that's what you do, you know, you have to test someone. And, of course, by not testing him that meant he's never been actually categorised as having hospital-acquired Covid because of -- so, you know, there's many, many questions to be asked about that.

Q. I think in addition to concerns about not testing patients before discharge, some of your members also had concerns that their loved ones were not tested on

admission to hospital or not tested until several days had passed; is that right?

A. Yes, there's many, many stories. Not on admittance, not -- eventually. But the other thing that Wales was very late on was the repeat testing of patients, which is absolutely vital because obviously when you do a test that's a kind of -- that's a point in time when you're testing. We know that, you know, the viral load is different at different points. So I think England started to do re-tests of patients, I think from September, and that was every three days. Wales did not do that, and it was every five days, and I'm pretty sure it wasn't until January 2021.

Again, this is why Wales had so many nosocomial infections and deaths because all of those very straightforward things that you could have done to identify someone with Covid weren't done and then, of course, that escalated, and it's just a shame that the -- that there's been -- there's been a sort of investigation into deaths, nosocomial deaths by the Welsh Government but, interestingly, nothing on the cluster outbreaks, which is of course the whole point. It shouldn't be about individual investigations. Lessons learnt has to be on how nosocomial infections start and how they can be prevented and controlled.

Q. I think you've also identified concerns from your members about issues with the use of technology in the healthcare system in Wales, and particular problems with the IT infrastructure, a lack of integration which the Inquiry has heard about between primary and secondary care, and also incompatible IT systems being used by different boards and different GP surgeries, and you identify some of those problems that are particularly clear in relation to DNACPR notices.

Is it your understanding that DNACPR notices in Wales are generally paper copies rather than digital records?

A. They are all paper and one of the things we really want is the digitisation of DNACPR forms.

Apparently they're on a pad and you rip one off when you want to use it. It's not numbered so it can't be traceable, it's not auditable, and that is then just manually attached to a patient's physical folder. So when we asked how many DNACPRs had been, you know, had been placed during the, sort of, key points of the pandemic, we were told, "Not possible to tell you because it would take too long to -- it would be a, sort of, manual paper exercise". I mean, it's astonishing.

Also, you know, there's good digitisation -- you know, there's a stark difference in what NHS England do

and what NHS Wales do. There is that interoperability between primary and secondary healthcare in Wales.

There's also, you know -- and my sister said to please tell you this: every time my dad moved bed within the same hospital she had to tell them the same things about his condition because they didn't know. There was no electronic way -- it wasn't that they picked an iPad up and can see -- you know, it's the same thing with the out-of-hours doctors. It's just this pattern.

And I'd say -- I know Andrew Goodall said that the Welsh Government hit their targets on digital inclusion. Well, I'd say that's because Wales has very little digitisation so it's a very easy target to hit. It's very difficult to exclude people when there isn't any -- isn't much of it.

Q. Finally, you've identified in your witness statement a number of areas that your group have identified as lessons learned and potential recommendations for this Inquiry. I'd like to take you to three particular areas, if I may.

First of all, you've identified the issues that arose because of the state of the Welsh NHS estate, and the challenges that that has created, in particular for the implementation of IPC measures, and you referred earlier to a number of pre-pandemic reports and reviews

that were carried out in relation to that.

So, is that one of the key points of learning that your members would like the Inquiry to consider?

A. Absolutely. And interestingly, Vaughan Gething said to stop tinkering around with hospitals but to build the right ones. So it's great to know that the Welsh Government are listening. But absolutely, we've got a very old NHS estate in Wales. If you don't do something now you're just building up that backlog year after year after year.

If a Covid pandemic hasn't shone a light on what need to be changed, I don't know what will, and I know it will cost money but that has to be cost effective in the long run and, again, if it saves lives, that has to be the right thing.

And it's also not just about patients, it's about those that work there as well, so absolutely.

Q. As well as the physical infrastructure of NHS Wales, you've also identified problems which I think we've already looked at in relation to the IT infrastructure and the way that that can help with the pandemic response in future.

You've also identified issues around palliative care and pandemic palliative care, and the need to build into pandemic plans provision for the rapid training and

upskilling of clinical staff around palliative care and particularly compassionate communication with families and loved ones at the end of life and when patients have died.

Why is it so important to your members that the Inquiry considers the role of palliative and end-of-life care?

A. Because, again, it's someone's life. It's their last -- we have to treat everyone as an individual and our group have lobbied very successfully to get bereavement leads in each of the health boards and we've now got permanent funding, but what we haven't been successful in doing yet is lobbying for mandatory compassionate training for all NHS staff. And this doesn't necessarily have to be just the frontline clinicians but people that deal with complaints or deal with calls.

As I said before, words really matter, and it also helps those that are, you know, delivering the palliative care as well. It is so important to understand how a patient needs to be spoken to, how the loved ones need to be spoken to, how things need to be explained. Again, I say this, it's a human right. It is a human right to have the right treatment when you die. When I think, you know, my dad's death, it haunts us, my mum, my sister and I, it just haunts us because

there was so little compassion and, you know, we were there, we weren't demanding, we weren't rude, but it just looked like they couldn't wait to get rid of us and it's just so important to do that.

And I cannot see -- you know, we're not for one minute suggesting we take frontline nurses off two weeks to do a course. We've suggested modular online courses that, you know, they can do updates on regularly.

And I'm probably being a big cheeky here but one of the things we did just want to mention as a group was a lack of data in Wales. Well, maybe not the lack of data but -- there's a lot of data but maybe it's not interoperable and it's not the right data. But, for us, data itself has no value. It's what you do with the data and the questions you ask of the data. And the data, in our view, is required to tell the truth and if it doesn't tell the truth it's useless, isn't it? And you don't want it to be manipulated for the wrong reasons. So we really want there to be -- I don't know whether the Welsh Government need a chief data officer or health boards lead to, you know, liaise more. But there has to be the right use of data and I feel like I hear about it a lot, "We need good data". That's fairly meaningless. I think what we're trying to say is we need the right data in the right format and for it to

answer the right questions and then to be actionable, and that's the key thing here.

MS NIELD: Thank you very much, Mrs Marsh-Reese, I have no more questions for you.

A. Could I just say one thing? I just wanted to say we've seen a lot of people in the Inquiry that, you know, a, sort of, a lack of accountability and contrition. But what we wanted to say was a massive thank you to groups like CATA, John's Campaign, Clinically Vulnerable Families, the Long Covid groups, who have, outside of their day job, passionately, tenaciously, fought to get the right -- to expose the truth that Covid is airborne and many other things. And I think we need to have to call on our leaders, government and healthcare leaders to stop the gaslighting, stop the scapegoating, own it, take action and stop this happening again.

Thank you very much.

MS NIELD: Thank you, Mrs Marsh-Reese.

LADY HALLETT: Thank you very much indeed, Mrs Marsh-Reese. As ever, extremely helpful and constructive, and I'm really grateful to you.

You talked earlier how the individuals we've lost will be forgotten. Well, as long as there are as people articulate as you are, advocating on their behalf, they'll never been forgotten. So thank you very much

indeed for all your help.
THE WITNESS: And thank you from my mum and sister and my dad, too.
LADY HALLETT: Thank you.
Is it best that we take a break now, Ms Nield, is that right, so that Ms Marsh-Reese can speak to those who represent her and others, and I shall return at 11 o'clock.
MS NIELD: Thank you, my Lady.
(The witness withdrew)
(10.49 am)
(A short break)
(11.00 am)
MR SCOTT: Good morning, my Lady. May we please call Margaret Waterton.
LADY HALLETT: Thank you, Mr Scott.
MS MARGARET WATERTON (affirmed)
Questions from COUNSEL TO THE INQUIRY
LADY HALLETT: I hope you heard what I said earlier. I'm so sorry I can't be with you in person but I shall be paying very close attention obviously to everything you say and I'm really grateful to you for coming along.
A. Thank you, my Lady, totally understand, and we hope that you're fully recovered soon.
MR SCOTT: Good morning, Mrs Waterton.

A. Good morning.
Q. You're a member of Scottish Covid Bereaved?
A. That's correct.
Q. And I think you're particularly keen to give evidence on behalf all of the members of Scottish Covid Bereaved and give the Inquiry a sense of how the majority of the members feel and how they're impacted by the pandemic; is that right?
A. Yes, that's correct.
Q. Just dealing with your own personal experience of Covid bereavement, and it's right that your mother died on 18 June 2020 as a result of a nosocomial infection, and your husband died on 2 January 2021, less than two weeks after his 71st birthday?
A. That's correct.
Q. Would you please describe how it feels to have lost someone to Covid-19 during the pandemic.
A. It's devastating. Any bereavement is devastating in its own right, but the complexities, the restrictions, the situation that we had to experience and endure and our loved ones had to experience and endure make that so much worse. And we -- I -- we all feel the trauma, we feel self-blame, we feel guilt that we could have done more to protect and shield and save their lives, and that we should have done more to do that.

But -- and we are tortured by it every day. I'm haunted by it every day.
Q. Does it feel different being bereaved due to Covid compared to in non-pandemic times then?
A. I've been reflecting long and weary on that. My father died in 1999 and I wasn't there with my father when he died, my mum was. And the inability to be with the people that we love the most while they were taking their final breaths in this life, to offer them comfort, to tell them how much we love them, that was taken away from us. And I feel entirely different about my father's death and the circumstances surrounding that. I have come to terms with all of that. But the circumstances that we were in, being excluded, being kept away -- we have members who were told that they could be with their loved ones when they died but if they did that they wouldn't be able to attend the funeral. So that was a Hobson's choice, that was no choice at all, because those two things were vitally important to us. There were restrictions around the funerals, in terms of numbers, everything was forbidden, and it was all related to: it's all because of Covid. So those things we haven't been able to do, we haven't been able to put people to rest properly, is how we feel. And that's the difference between being bereaved

by Covid and before.
And yesterday I went to the National Covid Memorial Wall and I found the hearts for both my mum and my husband and I put my hands onto those hearts, and feet -- two feet away from me were dozens of tourists taking selfies in the background of the Houses of Parliament, while I'm weeping. And that's the difference, because we understand what it is to have been bereaved by Covid, but for the majority of the world, the rest of the world, Covid is forgotten.
Q. I think the three main areas that Scottish Covid Bereaved wanted to talk about are DNACPRs, nosocomial infection and then visiting restrictions; is that right?
A. That's correct, yeah.
Q. I'll deal with nosocomial infections first. How big an issue was nosocomial infection in Scotland during the pandemic?
A. Well, for our members in Scottish Covid Bereaved it's one of the main issues that we are facing. 1 in 4 of our members lost loved ones to nosocomial infection, so it's a significant area, and we are particularly glad that this module is looking at nosocomial infection, infection prevention and control, in depth.
Nosocomial infection was an issue in Scottish hospitals right across Scotland pre-pandemic, and we

heard evidence from our previous Cabinet Secretary for Health and Social Care, Mr Yousaf, who said in his written evidence that hospitals were safe and sterile environments. Well, during the pandemic they were never safe. They were places of high risk because of the risk of hospital-acquired infection, nosocomial infection. Hospitals have never been sterile environments in their entirety. Yes, of course you can have sterile theatre, for example, but they're not sterile environments, and the pressures of the Scottish hospitals, the contributory factors of nosocomial infection, include the capacity at which the hospital is working.

So Scottish hospitals were working well over 90% pre-pandemic and then exacerbated in the pandemic. Patient movement from ward to ward, commonly known as "boarding", was also a major issue and well established in research as a contributory factor to nosocomial infection.

Asymptomatic transmission was not recognised quickly enough, so patients were in non-Covid wards but were asymptomatic. Testing was insufficient in terms of capacity. The timing of getting the test results back. Some of our hospitals in the highlands of Scotland had to wait a week to get a Covid test result back for a patient by which time of course the infection has

spread.

Availability of PPE, and the nature of that, and we've heard lots of evidence in this particular module about the reluctance of Scottish Government to accept that Covid was transmitted via the airborne route, and focused entirely on droplet. So the provision of PPE was inadequate for all of our healthcare staff who gave their all during the pandemic.

Q. Let me just bring you back to what you were talking about with the Scottish estate. So, those features that you have just been describing that made up the reason why there was nosocomial infection to the level it was in Scotland, how many of those features do you think were unique to Scotland and how many of them were across the United Kingdom?

A. None were unique to Scotland. All were across the United Kingdom. None were unique.

Q. And you mentioned the evidence earlier on of Mr Yousaf. I think you also had some observations about the evidence of Ms Freeman in relation to nosocomial infections.

A. I did. I heard, or we heard in her evidence that she was asked a question by counsel around what she understood the main cause of nosocomial infection was, and her response to that was that it was poor

application of IPC practice. And I think that did a huge disservice to our healthcare workers who gave their all during the pandemic, some gave their lives to the pandemic, and it completely ignored the other contributory factors that I've already mentioned and, of course, staff movement, as we've heard from my colleague previously, bank and agency staff, and so on, also moving from place to place, IPC guidance being -- changed frequently such that staff had no real chance to keep up with it and, as I say, the situation that's been well explored in this module around the availability and the appropriateness of PPE.

Q. I want to look now at DNACPRs then. Your statement sets out that there's a significant concern about communication about DNACPRs in Scotland. What is Scottish Covid Bereaved's number one concern about how DNACPRs operated during the pandemic?

A. That there were times and situations, and our members can attest to that from their lived experience, that not only was the discussion around DNACPR not had with family members, the next of kin, people with power of attorney, and so on, but that DNACPR consent was gained inappropriately.

And if I may use my own mum's situation. When my mum went into hospital for the very first time with

a chest infection she was in hospital for four nights, three days, came home. And in her bundle of belongings I found a DNACPR consent form. And when I asked my mum what that was and did she understand what it was, she at first of all couldn't remember. When I explained to her what it was, she was absolutely horrified at its meaning. And once she'd had time to gather herself she was able to recall -- now, my mother was admitted in a state of delirium, with a very high temperature and therefore, in my view, she did not have capacity to consent to DNACPR. She had signed the form and she remembered doing that but what she said to me was, "I didn't understand what the doctor was telling me, and I felt that she was putting words in my mouth."

Now, I complained to the health board about that and the response indicated that it was a junior doctor who had acted inappropriately and that would be dealt with locally by the medical director.

Q. But just in terms of general communication, as experienced across the whole of Scottish Covid Bereaved, was it a concern about discussions not being had with families, or was it discussions with patients?

A. Both. Some of our members were completely unaware that DNACPR consent had been arrived at until some considerable time after their loved ones had died, and

that might have been by looking through -- you know, finding their medical notes, looking through the notes, or some other means. And without -- almost without exception DNACPR communication was poor.

Again, I had two different experiences of that where it was handled very, very well, compassionate, clear communication, very clear what the rationale was, and in another situation with my husband, I was being asked to determine how far he could walk.

So we're not clear about how these decisions were being arrived at, and there's concern that they were being intertwined with treatment escalation plans and used as a proxy for no escalation of care.

Q. Because your statement sets out there were guidelines in place in Scotland, I think well-established guidelines, is how they're described, about how the process should operate?

A. Yes.

Q. Do you think that during the pandemic there was a lack of clarity in what the guidelines said should happen, in terms of communication about DNACPRs, or that the guidelines were clear but they weren't always being followed?

A. I think there was a plethora of guidance for clinicians around DNACPR treatment escalation and I can only

imagine what it was like in terms of pressure for clinicians during the first and the second waves and the amount of decision-making that they were having to do.

Q. Just to pause you there. You had been a nurse yourself for a number of years; is that right?

A. I had been. I was a registrar with the NMC for 39 years.

Q. So you have an understanding --

A. So ...

Q. And there are other Scottish Covid Bereaved members who are healthcare workers?

A. Yes, we have several healthcare workers so -- as our members. I understand, or we understand, you know, we can imagine the pressures but the number of our members who were not communicated with about the decisions that were having to be made about their loved one's care, ongoing treatment and escalation of care, and DNACPR are the majority.

So there are huge concerns that it's not just about poor communication, but how that guidance was being applied in the moment.

Q. In the event of a future pandemic, what do you think should happen in terms of communication about DNACPR decisions?

A. I think, if I might take a step back, and we've heard

evidence in this module around the ReSPECT form, for example, and that was used in variation across NHS Scotland, it wasn't used consistently. So I think there's something around a recommendation, if I may make so bold, for the -- for my Lady and the Inquiry around, whether it's ReSPECT, or whatever it is, but across the nation that can be used consistently with clear guidance underpinning it that is based around care, compassion and person-centred approach.

Q. I want to move now to visiting restrictions, please.

Do you think that hospital visiting restrictions in Scotland struck the right balance during the pandemic between maintaining infection prevention and control measures and allowing families to visit their loved ones in hospital?

A. I think we understood and we understand the nature of the pandemic and the virus at the outset wasn't entirely known, and of course footfall needed to be reduced. We understand that. But we have heard consistently through the module, particularly from the chief nursing officers of the four nations about visiting restrictions and the guidance around that and that individuals at end of life were to be enabled to have their loved ones with them in their last moments. And that was not consistently applied across a ward, across hospitals, across health

boards. And we were denied the opportunity and so were our loved ones denied that opportunity for us to be with them, to offer them comfort.

And I have been described as lucky because I was with both my mum -- I was able to be with both my mum and my husband when they died. I don't consider myself lucky, I consider that that was my right to be with my mum and my husband when they were dying, to offer them as much comfort and love and reassurance as I could in their final moments, and it was equally their right to have me there and extrapolate that across all of Scottish Covid Bereaved. We all had the right to be there. We all had that right. And it was denied us because the guidance was not consistently applied.

And if we link that in our heads, because that's where we've got to wonder, to DNACPR discussion, escalation of care, we weren't there. We were trying to determine what was happening to our loved ones remotely. We couldn't see them. We couldn't touch them. The deterioration was not obvious to us. And that would have enabled many of us to have understood what was happening to them in a much kinder way.

And we've heard about moral distress, moral injury from BMA and RCN in particular during their evidence, and we understand that, but I understand how much of

that we could have helped reduce, minimise, avoid, if we had been there with those that we loved the most when they were dying.

Q. Do you think there was enough care and compassion being built into how the visiting restrictions were being drafted?

A. Not consistently. I think -- we think -- that it was all about the mechanics of it. And we understand about reducing footfall and we understand the difficulties of members of the public, you know, ranging through hospitals and so on and not adhering to IPC guidance. And many of our members saw that. I witnessed breaches of infection prevention and control practice in staff. Many of us witnessed that, in all aspects.

We understand that. But all of those chief nursing officers said that the guidance was to be applied in an individual way and compassionately, and that's not been our experience of that.

People, members, whose loved ones were on life support and the life support being switched off while they were on the phone, why couldn't they have been there? Why couldn't they have been there?

That looks back into the "You can be in for 15 minutes but then you can't go to a funeral". And that's a Hobson's choice for anyone to have to make.

But particularly when we're watching the media, online, scenes from Italy -- you know, were there enough ventilators? Was there enough piped oxygen? Was there enough staff and PPE? All those things where -- we were wondering about and how that impacted on visiting, whether we could actually wear PPE to visit, whether there was enough to supply to that to us as visitors, and how was that decision-making happening, what was impacting on the decision-making.

So it wasn't consistently applied.

And I have to say to you that as a nurse for all those years, whilst I admire everyone in healthcare who was working and giving their all, we lost care and compassion, and we must work hard to get that back.

Q. Were the reasons why there was a different application of visiting restrictions within individual hospital wards across Scotland, were there ever any explanations given as to why they were being applied differently?

A. No. That was very much down to the local discretion of a ward or an ICU or, you know, that clinical area, and so it was up to the individual who would be in charge of the ward at that time, for example. So there was no consistency around it at all.

And that then leads to the fact that we all had a different experience of it, and we should have been

able to be clear and be sure that when our loved ones were dying we would be allowed to be with them. 100%.

Q. Just leaving aside the end of life for a minute, just generally in terms of visiting in hospitals, do you think there would have been a benefit to the Scottish Covid Bereaved members if there had been explanations about why, in certain circumstances, the restrictions needed to be tighter or in certain places they needed to be tighter than in others?

A. Communication is key, and clear communication would have been hugely beneficial. So if, for example, there had been a cluster of Covid cases in a particular ward, an outbreak in a particular ward, then that's explanation enough, about: we need to manage this in a different way and we need to -- it happens. If a ward, for example, or a hospital, has an outbreak of norovirus, that happens. So why couldn't it have happened with Covid, so that we were much clearer about the necessity for the level of restriction that was put in place?

Q. I want to talk now about use of technology as a substitute for visiting. You describe in your statement how technology such as tablets and mobile phones were often used to allow contact when visiting was not permitted. How well did that function in

Scotland?

A. I think, again, that was variable. There was huge reliance on individuals having access to mobile phones, tablets, whatever, and that they would be able to use them. But the Wi-Fi connection in many of Scotland's hospitals is entirely variable and not every ward has good connection, not every room in every ward has good connection. So there was that whole sense of digital exclusion.

And people going into hospital with Covid were very seriously unwell. They would be receiving oxygen through full face masks. So if you wear glasses and you're then forced to wear a full face mask to have high-flow oxygen, you can't see. So you can't see to use a mobile phone, you can't see to use a tablet.

If you're having to be placed in the prone position for periods of time during the day to try to help your oxygen saturations, using technology is not possible for you. And there was just a huge reliance on the individual.

At the same time, we were watching the media telling us that tablets were available everywhere, in wards, in ICUs and staff would use them. When my mother went back into hospital with Covid, a nurse used her own mobile phone to help me have a WhatsApp call with my

mum, and that was the one and only time in a week that I was able to see and speak directly to my mum.

Q. You just used the word "see" there. When technology was being used, how important was it to be able to see the person rather than just being able to talk to them via a phone call?

A. It's vital, because we're reading -- you read all sorts, you see all sorts from each other, and looking at a well-kent, well-loved face was hugely comforting and reassuring, and when I looked at my mum on that call I was reassured because I thought, "Oh, she doesn't look as sick as I thought she might". So there was a level of reassurance and comfort from both sides. And my mum was glad to see and hear me.

I had to speak with my husband over the phone and try to reassure him. He was terrified. People were terrified of what was happening them to in hospital. My mum said, "If I get that Covid, I'll be a goner", and she was right. She knew with her respiratory conditions she would not find very much chance of surviving. And my husband was terrified because I think he knew what was potentially lying in front of him. And when we had both been -- had Covid and been unwell, we were both worried that each was going to die. The outcomes were unknown.

So that seeing individuals is so vitally important, because we can see a smile, we can see a reassuring look, and we're comforted by that.

Q. Can you think of any way that it would be possible for more video calls to have been used during the pandemic or was it simply a reflection of the capacity of healthcare workers to be able to facilitate that?

A. I think it was a reflection of their capacity, the digital ability in the hospitals and that whole sense of digital exclusion.

Q. Did the health boards, whether across a region or for individual hospitals, for example, provide any information about the best way to use technology as a replacement for visiting?

A. No. Not across our membership. Not in any real sense.

Q. Do you think that would have been beneficial?

A. I think there was an -- I think it would have been beneficial, but I think there was an expectation in this day and age that everybody has a mobile phone, can adequately use it, that everybody has access to a tablet, or whatever device of that nature, and is able to use it. And I think there was an assumption that that would all work when in fact, when people are sick those are the last things they're going to be able to use.

Q. I'm just going to move away now from visiting restrictions. Is there anything else you wish to say in relation to visiting restrictions, how they were applied, consistency, use of technology, that you haven't already covered?

A. No, I think we've covered all of it.

Q. I'm just going to ask, then, about Covid hubs, assessment centres, access to GPs. I think Covid hubs and assessment centres were used in Scotland and your statement sets out how they functioned, what they did, and what they were meant to achieve.

Did the Scottish Covid Bereaved find them useful in principle to have these Scottish Covid hubs?

A. I think in principle it was a really good way of enhancing primary care and triaging individuals who either had tested positive for Covid or had Covid symptoms. I think in principle they were -- it was a really good step, and it was there to support -- in Scotland NHS 24 runs the 111 service and it was a really good positive move to enhance that primary contact with healthcare because across the nation, everybody was being told to Stay at Home, Protect the NHS, Save Lives, and there was a -- in our membership there was a real struggle trying to get hold of GPs, particularly to see them face to face, have them do a home visit was almost

impossible, and calling 111 was a very variable and mixed experience for our members, some of whom, because they didn't have the three main symptoms and had other symptoms, were being told that "You don't have Covid and don't be -- come back to us if anything worsens".

I think the issue going forward, if we were to have things around Covid assessment centres and hubs again, is the means by which you access them, by which you're transported there, because in Scotland that was -- it was taxis that were used in the main to transport people from home to the assessment centre and then back again.

It was taxi drivers who were doing that, and they were really brave and courageous, but they weren't allowed to offer any assistance whatsoever, and if you are needing to go to a Covid hub you're pretty unwell. So there needs to be thought given about that transport. And in fact one of our members, her brother was to go to a Covid hub and was so unwell he couldn't manage down -- fully down the length of the garden path and was hanging over the garden fence, when at the same time, the Covid transport, hub transport arrived, and an ambulance, because his condition had deteriorated and his familiarly had called the ambulance and the ambulance crew wouldn't take him and stayed in their vehicle and

he was transported to the Covid hub in the taxi and then ultimately taken to hospital.

Q. So would it be fair to sum it up that in principle these Covid hubs and assessment centres were a good idea and functioned well, but how they actually functioned in practice is a different matter?

A. I think so. I think they are -- they were a good asset but just needed further work and refinement as to how they actually were operationalised.

Q. And you mentioned earlier on about GPs as well. How accessible did Scottish Covid Bereaved members generally find their GP surgeries were?

A. I think, overall, the view, initially certainly, was that GP surgeries, health centres were closed and it was -- then it became very difficult to access a GP face to face. Some of the Near Me stuff in NHS Scotland didn't -- wasn't functioning in every health board. Home visits from a GP. So, again, if I just -- you know, one of -- my mother's first comment, actually, to me was, if I need the doctor, how will I do that? Because she believed from the messaging that she couldn't access a GP at all.

So there's a mixed experience again.

But home visits, very difficult to secure, and seeing a GP face to face, so telephone consult, video

consult. But there are many things a GP and doctor has to lay hands on and can't do over the phone.

Q. But broadly, did remote GP appointments work across Scotland or were there difficulties with how they were set up, how people were able to access them? How did Scottish Covid Bereaved members find them?

A. Again, a mixed experience. One of our members, for example, their family member had several repeat telephone consultations, with repeat medication happening, and when eventually that individual did manage to have a GP appointment and then required to be referred to hospital, and they had an underlying cancer, that hadn't been picked up for some months. So a mixed experience.

Again, I would say that -- again, if I might just use my mum as an example, when she had developed Covid, one of the things we were asked to do was to get her own GP to come and visit her, and it was her family GP who came to see her, and the reassurance that that provided for my mum was significant.

Q. I want to ask you about the experience of Scottish Covid Bereaved where family members were discharged from hospital, not to care homes, but they were discharged home, about how Scottish Covid Bereaved found the experience of discharge and what it was like looking

after their family members?

A. Again, a mixed experience but individuals -- we've heard already about individuals being -- who were unclear whether their family members had been tested, whether they were Covid-positive or not, and indeed we have one member who his wife was discharged after two days with Covid, and she was seriously unwell, and subsequently she died. So, again, that mixed experience of not being clear what the status of somebody was when they were being discharged, not sure whether they had been tested on discharge, to protect family members.

And remember that some of our members were shielding, some of our members were -- you know, had -- were immunocompromised, unwell, frail. And to be -- so there was a situation where you just weren't sure what was going on, and then the impact of that on the wider family, Covid, and the situation I've just articulated.

Q. And then finally in terms of shielding, you just mentioned some of your members had been shielding. What were the experience of Scottish Covid Bereaved in terms of either themselves or their family members of shielding?

A. Shielding was a hugely isolating experience for those of us who were shielding in our group and those of us who had family members that were shielding, and it had

a huge significant impact on emotional well-being as well as physical well-being. But that group were -- probably make up quite a component of our number who developed nosocomial infection, and that group of individuals were hugely protected at home, but they were the most likely to have to seek hospital care and to be hospitalised. And at that point then they're plunged into the hospital environment where there is no testing, huge patient movement, clusters of Covid, outbreaks of Covid, patients with Covid in non-Covid wards, and they become hugely vulnerable to it. And that's actually what happened to my own mum. She was admitted to hospital and there were four patients in what I understood to be a non-Covid ward, a care of frail/elderly ward, and that's where my mother contracted Covid.

Q. You've set out in your statement some lessons learned as the Scottish Covid Bereaved hopes her Ladyship takes on board when considering the evidence. Is there anything on behalf of Scottish Covid Bereaved that you hope her Ladyship bears in mind while she's considering both the oral evidence and the written evidence that she's heard in Module 3?

A. My Lady, we are so grateful to you for your work and we look forward to further robust, clear recommendations,

with clear accountability. And for us that's one of the things that we seek to achieve, is truth, justice and accountability. And accountability isn't about blame, accountability is accepting responsibility for what's yours to own.

And we have heard previously and -- recommendations around hospital estate, ventilation. We've said in our statement around the workforce plan in NHS Scotland, to make sure that is robust, that staff are prepared/enabled to function in a pandemic, and that care and compassion come back and person-centred care come back into that workforce.

Communication.

We've again heard about ventilation, HEPA filtration.

We've got a very old estate. We're not alone but we've got a very old hospital estate in Scotland, and whilst we don't expect that you're going to be able to instruct that new hospitals are built immediately, there has to be something that's done to take away the Nightingale wards that still exist in our hospital estate in Scotland.

Care and compassion.

DNACPR and how that is managed, handled, communicated.

And those for us I think are the main issues.

MR SCOTT: Thank you.

My Lady, I have no further questions.

LADY HALLETT: Thank you very much indeed, Mrs Waterton. You got through a huge amount extremely efficiently and I'm really grateful to you and I promise, as I'm sure you accept, that I'll do my very best to bear all the matters you raise in mind and, if I can, come up with some recommendations. Of course it will then be for others to implement them. So it won't just be a question of what recommendations I can make, it'll be in getting the support of people to get them implemented. That's where things sometimes fall down.

But I promise to do my very best and thank you so much for all that you've -- all the help that you've given to the Inquiry and the support that you've given to us.

THE WITNESS: Thank you, my Lady, and we wish you a speedy recovery and we stand ready to assist you and the Inquiry going forward.

LADY HALLETT: Thank you very much.

We'll take a -- I shall come back at 11.50, so you can talk to your representatives.

(The witness withdrew)

(11.38 am)

(A short break)

(11.50 am)

MS CAREY: My Lady, good morning. I'm taking the next witness, who is Dr Saleyha Ahsan.

LADY HALLETT: Thank you, Ms Carey.

DR SALEYHA AHSAN (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

LADY HALLETT: Dr Ahsan, I'm truly sorry I can't be with you in person but I promise you it doesn't mean I'm not going to pay huge attention to all the help that I know you're going to give, so thank you very much.

THE WITNESS: Thank you.

MS CAREY: Dr Ahsan, your full name, please.

A. It's Dr Saleyha Ahsan.

Q. Dr Ahsan, I'm going to ask you about two witness statements, one that you've prepared for the Inquiry and also one that you're going to speak to from Matt Fowler, who was a co-founder of Covid-19 Bereaved Families for Justice UK. Can I just ask about you firstly.

You lead the healthcare worker group within Covid-19 Bereaved Families for Justice UK and I think you are a doctor by background, in emergency medicine. You have a PhD -- you are a PhD candidate at the University of Cambridge on the subject of delivery of healthcare. You're part of the Royal College of

Emergency Medicine, in their EPRR committee, and you are a former British Army officer commissioned into the Royal Army Medical Corps, and you are going to help us I think in respect of a number of matters that touch on you speaking on behalf of the group, you speaking on behalf of your experience as a doctor, and also, sadly, your experiences of the death of your father and the impact that's had on you and the family.

So, take it nice and slow, please, Dr Ahsan, and can we start, please, with some of the wider observations from Covid Bereaved Families for Justice UK, and I think you say in the statement that there are around 7,000 members, all of whom have lost a loved one to Covid-19, and that the campaign was founded in March 2020 with the purpose of learning lessons throughout the pandemic in order to save lives.

And is this right, that Covid Bereaved Families for Justice UK has campaigned for improved accessibility to bereavement support, policy reviews to prevent avoidable mistakes, and continues to empower its members to hold the government and public bodies to account. And I think was it your group that helped create the National Covid Memorial Wall? Indeed, we just heard the last witness speak about that.

A. That's correct.

Q. Can I start, please, with some of the concerns of the group in relation to NHS 111 and the 999 service, please. And I think you say that a number of the members are critical of the way that 111, firstly, functioned. What were the concerns of Covid Bereaved Families for Justice members?

A. So whilst speaking about this, again, it's not from my perspective as a clinician but representing the group, and also just to say that this is -- unfortunately, we've all been brought together by this unifying factor of having lost a loved one, so we didn't know each other before, we've sadly become a member of this group that no one wanted to be part of.

But through being part of the group, we've got to hear about everyone's stories and experiences and -- gaining an insight into everyone's journey through this horrendous time, and one of the aspects was the encounters with 111 and 999, calling for help from home. And it was quite clear from the accounts of people within the group that access to these services was at times really, really challenged. Not everyone could actually get through on 111, that there were delays, that sometimes the advice wasn't clear, and that trying to get access to urgent care at home sometimes didn't happen. And the order of events of how to get

a clinician to come home, whether it was calling 111 first and then a GP coming or -- which order it came in was sometimes confusing.

Q. I see. So if I understand you correctly, was there a tendency sometimes to ring 111 to try to get a GP but sometimes a GP would say, "I'm not coming out until you've rung 111", a sort of -- stuck between a gatepost and the gate; is that really what you're trying to tell us?

A. I think that's what some of the accounts from some of the members have been. And bearing in mind that this is a UK-wide group so different experiences, it appears, in different areas.

Q. I think --

A. And, again, with the difference between rural and urban, where access to services can be challenged by distance, whether it's a very rural location versus an urban one where things might be more accessible.

Q. I think you say in the statement that some of the members certainly consider that those who died of Covid-19 could and should have had access to treatment earlier but the advice of NHS 111 was to Stay at Home, and that will resonate with her Ladyship because we've heard about a HSIB report into 111 and some of the concerns there.

Was there any concerns raised amongst the members about accessibility for those who were perhaps not so proficient at either ringing 111 or providing care at home, perhaps for those who are either disabled or whose English was not the first language?

A. I think those challenges existed from pre-Covid, to be honest. 111 had reported in the media over the years different sorts of challenges. But we had -- I think generally within the healthcare system we knew it was challenged in different parts of a very complex system, different branches in different systems within an overall complex system were challenged and when we hit Covid, those challenges didn't go away, they were actually increased.

So you had 111 that during busy peak periods, every winter for example, every time there was Christmas, New Year, et cetera, those peak times of other infectious diseases that were rife within the community, we had, and I speak drawing on my background within emergency medicine, these were not new challenges but they were heightened and more severe within Covid. So it was as if there was -- you know, we were already running on nearly empty, that there was nothing left in the tank by the time Covid came. So these kinds of experiences unfortunately happened and I'm not surprised

that they happened and I just feel so -- and having been, you know, just because I'm a healthcare worker didn't mean that I haven't had to use, or for my family, draw on the emergency services for our own care. So when you have the knowledge of what's needed and you can't get that help through the door, it's really distressing. And so my heart really goes out to people who had loved ones in desperate need of someone with medical knowledge arriving to give help and they couldn't access that. The minutes would have dragged like hours and the hours would have dragged like days as they waited for someone to come and there was no one to come.

Q. I think, in short, the concerns about NHS 111, and indeed 999, was: could I get through in the first place, how long did I have to wait if I was going to be answered, and then what was the kind of quality of the advice I was given once I managed to get through.

Does that, sort of, fairly encapsulate the concerns of Covid Bereaved Families' members?

A. I think that has been the overall theme of the concern, yes.

Q. You say in the statement that the picture with regard to access to GPs was mixed. Some GPs would conduct a home visit but some patients asked for a home visit, is this

right, but in fact the GP would not go to see them? So, again, perhaps a slightly inconsistent picture across the UK and across your membership; is that fair?

A. Yeah, I think that is fair. And again, as I said before, different regions in different areas, different stresses and strains. We have, if I may, her name is in the statement, Helen Brewer, who talks about her mother in North Wales, in Deganwy. I was actually a clinical in North Wales, so I can speak with some knowledge of what it was like to deliver primary healthcare in areas that are more rural. It can be challenging.

Q. Tell us about that, then, since you mention -- can I just say whilst we're on that, we are very grateful to Covid Bereaved Families for Justice because the statement is peppered with real examples from your members. I wasn't going to go through them all, Dr Ahsan, but you mentioned Helen Brewer there. But from your perspective what was it like trying to, in Covid times, deliver primary healthcare in a rural setting?

A. So I see this from the perspective of not being a GP but being an emergency medicine doctor, but knowing many GPs, in fact I have two siblings who are GPs, but they work in urban settings, trying to -- I think GPs were stretched. They -- like many other sections of the

health service. And they were looking after vast numbers of people. People were -- again, this is not taking away at all from what Helen Brewer experienced with her poor mother but, from my understanding of it and from what we were witnessing, there was a strain on the services that -- again, no one is going to find that, like, news, that GPs were under pressure, but during that time we had a lot of people within the community that would need some sort of input, didn't really want to come into the hospital in the way that they normally would have done, come into A&E, because they were afraid of what was, you know, lurking behind the front doors in terms of Covid. I had patients who clearly were unwell and should have come in but thought that their condition would get worse if they came to hospital.

In the case of Helen Brewer, her mother became unwell, it turned out to be Covid. They did try to get access to the GP, they called 111 many times and without success. It took a while. You know, the dates -- when you look at the dates, between 16 March and 23 March, that's just a horrendously long time to be so desperately worried and deteriorating and alone actually. And then she says that the GP did finally visit and then she was immediately -- the mother was

immediately sent --

Q. Yes.

A. -- to Glan Clwyd Hospital -- to the nearest hospital, and was found to have Covid.

But it's that -- it's the agony of the wait that will be, you know, really horrendous.

That's an account of one of the members and that's what I want to relay, because that's their experience and their story and that's what they went through. The unpicking of why and what is another matter, but that's what they went through.

Q. Well, I think you say, or Mr Fowler does in his statement certainly, that a number of the members of your group provide accounts of people dying at home as a result of deciding not to seek medical assistance and increased deaths, obviously, through things like delays to cancer treatment, and the like. And her Ladyship has heard a number of pieces of evidence that echo that experience of your members.

Can I ask about those that then got into hospital, and I think particularly there is a concern amongst Covid Bereaved members about hospital-acquired infection.

If it helps you, Dr Ahsan, I think it's at your paragraph 36 in your statement, and there's a number of

accounts set out there about concerns about it. But just help us, are you able to, sort of, give us an overview of the Covid Bereaved's concerns about hospital-acquired infection and what could be done to try and reduce it if it's not possible to minimise it entirely?

A. I think again, and I speak as not an infection control expert. It wasn't my role. But each healthcare provider did, and we do, operate within our sort of realm of infection control, but again, infection control of the whole hospital had designated roles. But -- personnel that were put in charge of doing that.

Yeah, absolutely, hospital-acquired infection from the perspective of the bereaved group members, harrowing stories, accounts of people coming in with one condition, really in need of hospital care because other things didn't stop during Covid, other conditions, other needs for hospital didn't stop.

So people, for example in the case of Andrew Ireland and his wife Susannah who needed -- she needed to come in because of acute pancreatitis and becoming quite unwell, needed to come in, and, you know, that is a condition that can make people very, very sick, can -- they can need intensive care for this care. She had that treatment but unfortunately acquired

Covid-19 during that time, which, again, just horrendous. And from a perspective of what it was like working in hospitals where -- I mean, that was a constant worry. I mean, that wasn't something that was taken lightly. That was a constant, constant worry, of patients acquiring infection when they'd come for a different reason.

And often, you know, at that time really only the very sickest were coming in, or who needed to be in hospital, and then to actually -- you know, they were already on a back foot with their health anyway, and then to have the risk of Covid.

Q. Can I just pick up on something you just said there, because obviously PPE is one of the ways that we can prevent infection. And I think it was June 2020 that face masks were made mandatory for staff and face coverings were made mandatory for patients and visitors, providing the patient could tolerate it. Do your members have any views about whether that was brought in too soon, too late, struck the right balance? Can you help with that, Doctor?

A. I think generally within the group I think the overall consensus was that many of the steps were too late. Too late, too slow, lots of confused messaging coming centrally. I refer to some of the comments, press

conferences, for example, interviews that were done by the Prime Minister at the time with the Deputy Chief Medical Officer, Jenny Harries, having a whole discussion about whether we should be wearing face masks or not. Which, as a healthcare provider, and amongst other healthcare providers, we felt that was really confusing the message of what people should be doing and shouldn't be doing when really, if we looked at other countries who had brought -- who had a tradition of face mask wearing, for example, or where steps were taken earlier with less confusion and less dithering, if I may say, that their outcomes were better.

So I think come -- by the time June had happened, the horse had already bolted. And not only had it bolted because of infection spread but also the mindset of people. So rather than it becoming something that people thought was the right thing to do, protective of themselves and others, there was an onslaught of debate and discussion that carried on long after it was made mandatory. You still had people who were reluctant to put on face masks and we had -- and I know this from the fact that I work in television as well and I was asked quite frequently to come on and have debates about whether it was -- whether we should be wearing masks or not, whether we should be having lockdowns, often

within a -- the other perspective would be from someone who had no real health background but just was a -- you know, a broadcaster who had spent a lot of time on Google reading evidence incorrectly.

So I feel by June it was too late. I feel as a group we also have that consensus.

Q. Right. And I think there was also concerns raised by a number of the members of the group about the lack of consistency in the way that some NHS staff use their PPE, not across the board, clearly, and we might look at some examples of that from your own experience in a moment.

Can I just ask you about shielding, because I think a number of the members of the CBFFJ UK group were shielders. And certainly they were concerned about information that was provided to them, the quality of it, and indeed that they may themselves have to go into hospital and therefore run higher risks of catching Covid.

Is there any consensus among the group about how best to relay information to those who are shielding or any practical things that you've been asked to relay to us about how it could be improved?

A. Improved in terms of how to shield?

Q. In terms of the communication that was given to

shielders.

A. I think, again from the perspective of my own father, I remember him and one of my siblings, who also had to shield, for health reasons, that a text message came through to say -- but it was -- and again, I'm trying to remember the dates and the timings but I just remember it feeling quite late and definitely for the second wave, I -- in the second wave I had decided -- I was working in intensive care in North Wales but I -- and I was also making documentary for Channel 4 about Covid and what was coming, the second wave, and we knew that it was going to be bad, hence I managed to get a commission to make the film. I didn't need a crystal ball to say -- know how bad it was going to be, but I had made the decision around about, sort of, towards the end of November, December time to go home and impose a lockdown on my father even before national guidance because I could see the direction of travel of this.

Unfortunately, I was a week too late and he caught Covid, and it was during the Partygate season. So I think the messaging on shielding came too late for many, especially during the second wave and I think that's unforgivable. We had been through the first wave. If we were going to be generous at all we could say, okay, this was the first time. But the second wave

is the disaster and had some of the worst figures out of both, I think, periods, both waves.

But I think, again -- text messaging, that's an effective way but -- and I think now people would know what that means but in the beginning it was challenging.

But also I think it also caused anxiety, a lot of anxiety about shielding which I think has, and this is also part of what the Bereaved Families group are calling for, better support for mental health and well-being after the event, because I think there's a lot of anxiety of what people can and cannot do now even, when they can go out, when they can't go out, who they can be with. Again -- but that side of it has now suddenly all gone away as if it doesn't exist, but it very much still does exist and we're still getting quite sick people coming to emergency departments with Covid or other respiratory, sort of, viral illnesses. So the whole area of shielding, I think -- as a group, we think could have been done better and I think it's suddenly now all gone away without any further advice.

Q. Much of what you said there will -- echoes what we heard from the Clinically Vulnerable Families witnesses and their evidence they gave us.

Can I turn to your father because he picks up on

a number of issues that I'd like to ask you about. Just before we go, is this right, at the beginning of the pandemic you were working in North Wales, is that right, and during the first wave you worked for Public Health England doing shifts at Heathrow, certainly monitoring those that were coming into the UK at the time when we still could travel?

And then certainly you say in your statement that in February 2020 you were on a shift in North Wales and asked to respond to a call from passengers on a train coming to North Wales from Scotland and the passengers had been around someone with confirmed Covid. At that point in time, there were no recorded Covid infections in the North Wales area and you wanted to seek some guidance on what to advise the passengers and where they should go and what they should do. And what happened when you tried to find out what you should advise the passengers?

A. Yeah, in those early days I think, just to give some context, there was a lot of confusion, if I can say, about what we should be doing as a profession in terms of guidance, strategies, et cetera. Things hadn't filtered through centrally. We were waiting, I remember, and colleagues just waiting for that moment where we were all going to be called to some big meeting

somehow and have this, you know, briefing of, you know, this is what we're facing, this is what we're going to do. That never really came. And, again, not to put any blame whatsoever on my clinical leaders, I've now subsequently learnt that they were also waiting for that big moment, that big central briefing: okay, this is it, guys, this is what we're going to be doing. That didn't come for them.

And what I've learnt subsequently, as well, and I have permission to say this from meetings I have been having with other people in relation to future response and resilience, is that leaders, clinical leaders were phoning other colleagues in other hospitals to say: we know this is coming, we're watching the news, we're seeing what's happening in China, we can see it coming across Europe, what are you doing to get ready?

So that was the environment that we were operating in.

Q. So slightly informal, if you like, when actually what you really wanted was some direction from leadership; is that really where --

A. Absolutely, and I was drawing on my own background in the military. I mean, that's -- whenever we were deployed anywhere there was a big, you know, a big movement of preparation and deployment and preparedness

but we didn't have any of that in this situation. And I think that was a bit of a shock for many of us.

We had healthcare workers not even sure if they should take their leave, you know, things like that, in February time, or travel abroad on holiday, should we go, should we not, don't know what to do, no one is telling us what to do. So that was the level of confusion that was going on at the time, sort of January, February time.

And then, again, I do want to talk a little bit about Heathrow. I was really shocked, if I may --

Q. I do, but I'd like to try and just stick within the confines of the healthcare system --

A. Fine, fine.

Q. -- but, of course, clearly some of those people went into quarantine, and the like.

A. Absolutely, absolutely. So within -- so we saw it from the perspective -- what happened at Heathrow and what happened on that day when I got that phone call kind of made me realise that actually the entire system is not ready.

Q. Right.

A. So whether it's within my hospital in a small trust in North Wales, or working within a wider healthcare system in London in one of the busiest airports in the UK, but

for a big entity like Public Health England, you know, which was, you know, designed to keep people safe. So in terms of the, very briefly, the Heathrow airport scenario, I was really shocked how the week before I'd been there and the response was as I would expect it to be. If the crew from the aircraft calls to say, "We've got someone, these are the symptoms, okay, what do we do?", the action would be: keep the person on the plane, we will meet you at the plane, come up the steps in our PPE and we'll take a history, take a name, decide on what the next action is but hold the person there, we'll take their details, we'll log and track and trace, if you like, tracking of that.

The following week I went in, nothing had changed. The number -- in terms of the wider situation, the numbers were still going up within the country, the stats of people getting sick every day, we were hearing that it was getting higher. When I came in to the shift that week with higher numbers, the advice was: we're not going out to meet any more planes, we're not even taking their names, this is all you have to do, you've just got to take the phone call from the flight and then you've just got to tell the person to get home. And my question was, well, do we need to know where they live? Do we need to know who they are? No, we don't need to

know what their names are, we don't need to know where they live, we don't even need to get them home. Just you tell them to get home by whatever means. And I asked, "Do you mean even by public transport, on a bus or on the tube?" "Yeah, that's fine, just tell them to get home."

And that was February. So -- and then at the same time in North Wales when I was on shift --

Q. Can I just stop you there, Dr Ahsan, and just pause for a moment and it may be my fault for not making you slow down just so we can keep up.

A. Sorry.

Q. It's all right. But really, essentially, what you are saying to us there is there was a shift within the week in your experience at Heathrow, which really goes back to preparedness, which is something that her Ladyship has already heard about and obviously looked at in depth in Module 1. And so I just would want to, sort of, actually bring us back to what was going on, perhaps not at Heathrow but in that smaller setting that you were coming on to telling us about --

A. Sure.

Q. -- and certainly then coming on to deal with your experiences when your father went in to hospital.

Can I just finish the passengers on the train

account, please. When you sought advice as to what to tell them and where they should go, what advice were you given?

A. Okay, so when I phoned up -- I remember getting the call. We were in doctors' and nurses' sort of room where we make all decisions and have the board with all the patients, et cetera, and I remember speaking to my colleague saying, okay, what do we do about this, and I was -- the consultants had gone home for the evening and I was the in-charge registrar in the evening and I spoke to the nurse in charge and we pulled out a folder, the folder said: call this number. I called that number and I think what we had were a few pages at that point of what to do "if".

And I found that there was -- I can't remember if there was actually someone to call.

Q. Let me help you. Let me say, you tried to call Public Health Wales, it was a Friday, late at night, and in fact they'd gone home. You left a message and you were told you would get a call back the following week. Of course, the point being that the passengers by that time were already in Wales --

A. Exactly.

Q. -- and absent the advice they were looking for.

A. So what I can't remember is if it was an automated phone

call or whether there was a human being on that Friday night, and I think it was an automated message. But I just remember that I was able to relay that I needed to pass on a message that someone is coming from -- I think it might have been an out-of-hours individual person who basically relayed that "You need to call back next week".

Q. So another example there of preparedness or the lack thereof potentially. All right.

Can I jump forward in time to December 2020. And I think it's the case that on 17 December your dad, who I think was 81, a retired teacher, had asthma and a number of other symptoms but was generally well, had to go into A&E, and -- on 17 December, it's suspected that he caught Covid-19 in the hospital. And he was discharged I think -- is that right?

A. He went in for just a standard --

Q. Procedure?

A. Yeah, something that I had done with him many times before. It was just about a catheter that was blocked. Quite routine. And we believe -- and this was during that period of time where I had wanted to get home to lock down but I was on shift and I was working, but it was during that period -- we feel that he caught Covid during that period of time.

Q. I think you said he tested -- he was tested upon arrival but the result was lost and when they re-tested him a couple of days later he received a positive test result and then was placed, nonetheless, on a normal ward initially. Was that whilst the lost test result --
A. Yeah.
Q. Right. Understood.
A. So yeah, during that period of time he'd gone in for a normal, rather routine thing, catheter change. He wasn't -- he didn't normally have a catheter, something had happened during that period of time that he needed it, and he went in very, very quickly with one of my siblings, came back home. But a few days later started to have signs and symptoms that made us worried and he -- we were -- again, we knew there would be waits, et cetera, for him to be seen. Again, this was all second-hand relayed to me, because I was on shift in North Wales, and it was a case of two of my siblings, both of them medical, just making the decision to take him into A&E and it was a frightening journey because he was having difficulty in breathing. And they got him to A&E, a swab was taken at that point but lost. A chest x-ray was done. It was quite typical of the Covid picture.
Q. Right.

A. And my siblings were there, yeah.
Q. And I think, did -- were you able, then, in due course to take some compassionate leave from your job and come down to join him in the hospital?
A. I think -- yeah.
Q. I just want to ask you about that because you say he was moved to a Covid-19 ward. He needed one-to-one care which you provided and you stayed in his room for 24 hours a day for six days in full PPE. So clearly visiting was allowed. Can you tell us, what PPE were you wearing whilst you were with your father at his bedside?
A. So it was almost the same PPE as I'd been wearing in ITU in my hospital bar the big -- excuse me, I've forgotten the name of the big respirator that we wear, but I wore in the hospital with my father in the room, it was a full gown, gloves, a fluid-resistant mask, not an FFP --
Q. One of the blue ones?
A. Yeah, but fluid-resistant, so three-ply, and a visor.
Q. And was that PPE that was provided to you?
A. Yes.
Q. So you wore that throughout the time at your dad's. Did you observe what the nurses and doctors were wearing? Were they wearing similar levels of PPE?

A. Yes.
Q. And can you help at all with --
A. I can't recall if it was an FFP3 or a surgical -- I think it was a surgical mask. FFP3s, I think were for when there was nebulised -- aerosol-generating procedures.
Q. We've heard about those, all right.

And I think you say, though, that whilst your dad was in the Covid-19 ward he was not taken to a high dependency unit although you were told that would have been the right place for him. Were you told why it wasn't possible to admit your dad an HDU?

A. So -- and this was happening -- again, it was really challenging because I just really -- during that time I really sort of wished I didn't know the details, that I didn't know what was happening. I just really, like, wished for ignorance because I knew that I was -- I knew what we were doing in our hospital where pressures -- we were busy and actually everything coincided at the same time. I got compassionate leave to come home for my father whilst things were getting busy in my own hospital. So it was -- it wasn't just an increase in cases in London, it was also simultaneously increasing in North Wales, as well, and I felt, bizarrely, you know, my normal reaction was feeling guilty leaving my

colleagues, but my colleagues were incredible and gave me that time to be with my father. And so I went -- I was with him and I knew that just even the week before, or even the weeks after when I went back to work, that there were patients who were similar to my father, if we had capacity, you know, even at that age and other comorbidities they would be -- they would get -- if it was deemed correct for their care, for their care package, and in the patient's best interest, then, and there was capacity, then that's where they would be going which is how we would normally function, where you have those important conversations with family members and the patient about ceilings of care.

What we had on this occasion, and what I experienced with my father during that time in this particular hospital, which was under enormous pressure, and this is a hospital that I have worked in in the past within the emergency department.

Q. Just tell us, what did the consultant tell you about why your dad could or couldn't go into HDU?
A. So we waited all day. I remember it being a really, again, that's why I feel so much family members on the issue of time where, you know, time takes on a different meaning when you're just terrified for your loved one, and there's -- things are not moving in the way that

they should be. And within healthcare time is really critical, as we all know, I don't need to tell people that. But I remember those couple of days where everyone was just exhausted and working without breaks. Working without -- I couldn't recognise this hospital that I had known and worked in for years before. Bearing in mind my sister was also a GP in that hospital running urgent care downstairs. None of us could recognise this place that we'd all grown up in clinically as doctors and worked in. It had just transformed and the consultant that day, eventually she came to see me, she looked exhausted, really exhausted, and her registrar had come earlier in the day and I could see the list of things that they had to do. It was huge. It went on for pages and pages and they hadn't -- the registrar had definitely not had a break. I could tell. This was about 5 or 6 in the evening.

Essentially, we just had a really sort of frank discussion with the consultant and she said, "Look, you know and I know that this isn't how it would normally be. I have got 40-year-old male patients that I am trying to desperately find an ITU bed for across the region, you know, that's what I'm dealing with." And at that point I knew that this is it for my dad.

Q. Was she basically saying to you that in normal times he

might have been a candidate for HDU but because of the pressures they were under region-wide, he was not going to be admitted into high dependency?

A. Yeah, he was not going to get that level -- escalation of care. He'd reached the ceiling of ward-based care. The next step would have been one-to-one care. Yeah.

Q. Can I ask you about care, because clearly you were at his bedside for a number of days and the hospital had a policy that if the patient had had a carer at home, they would allow the carer to remain in hospital, and I think your dad had had some care at home.

Are you able to tell us, Dr Ahsan, what you think his care would have been like or how it would have been impacted if you had not been present?

A. Yeah, that's frightening. It's really frightening.

Q. Why do you describe it in that way?

A. There were so many -- he was in a side room. And we had to advocate hard for him to get into the Covid ward. I remember those few days of just frantic phone calls. Again, you just got the sense of the system being so overwhelmed. People were exhausted, running on empty, just overwhelmed by the numbers.

And he -- my father, before he went into the Covid ward, had been in a normal ward. Yeah, he was in a normal ward but I think, to be honest, many other

patients in this normal ward had respiratory symptoms as well. And we had to sort of advocate for him to go to -- you know, for them to repeat the test and to prove that he had Covid. But also look at the patient symptomatically: it looks like Covid, it must be Covid. And to move him onto the Covid ward. Because then that kind of opened up another passage of care, including CPAP and -- which is the big mask that I think everyone is aware of, and the medications.

And I think -- I'm so sorry, could you just repeat that question.

Q. Not at all. You described it as being truly frightening to have contemplated what care your father would have got had you not been there. Is really what you are saying to us is because they're so overrun had you not been there his care would have inevitably been less?

A. I think it would have been -- again, I think this is one of -- we're now going into one of the areas where I have had a huge number of flashbacks, because I remember --

Q. Take your time.

A. All right. And it's one of the things -- one of the contributing factors as to why I haven't yet gone back to work. But I just remember feeling so completely helpless. And, you know, from the perspective of someone the week before looking after other people's

parents and -- fathers and mothers, and now really relying on others to look after mine, and just being super frightened, I just remember feeling like my legs were going to give way at some point and feeling so scared I felt sick. But like seeing that my dad would sometimes slide down the bed and the moment -- Covid is so positional and the minute a patient moved, anything could just set them off and they'd be fighting for breath, like fighting for breath in a way that you see horrendous, you know, on television people suffocating for other reasons, you know, dramatised, you know, in films. Well, this was suddenly very real. And seeing a grown man thrashing on the bed to breathe was really harrowing.

And bearing in mind that I'd actually been in ITU and so we had intubated patients that were calm, you know, that weren't in that -- they might have been like that for a short while before we took over and relieved those kind of symptoms, but with my father, because there was a ceiling of care made that he wasn't going to be for intubation -- and we'd had those discussions and I think I agreed with those discussions, we'd had those discussions earlier --

Q. I'm going to ask you about that if I may.

A. Yeah. So for him the ceiling of care was CPAP and

ongoing treatment, but during that period of time he would slide down the bed, sometimes he would thrash, he would be really, really frightened and he'd cry out. It was -- I've -- you know, I've never seen my father like that. And sometimes the piping from the CPAP would get dislodged and, you know, again, that was his source of oxygen. But if I hadn't been in the room, I don't know how the overworked nurses in that space would have been able to keep an eye on every single side room.

Q. Yes.

A. So I just kept thinking, "Thank God I'm here, what about the others?" And I hope that by being there it took some of the pressure off the nurses for the other patients, but again I remember being in that side room and seeing the porters taking yet another trolley of another person out just across -- you know, behind us.

Obviously the nurses -- we have a routine normally that when a patient dies the curtains are drawn. Every effort is made so that other patients don't see this. But there were too many.

Q. Can I perhaps bring you to the end of your father's life, and you just touched on it there were some discussions had. Was any DNACPR discussion had with you or your siblings in relation to your dad? What was the communication like when those discussions were being had

with you and your family?

A. I think we were, again, minded that that was the -- that was an important area for us and for my father. He at some point got so bad that he just said, "I want to die", and to hear that -- and he just said, "I want to die". And at this point his mouth was full of blood from -- I don't know whether it was the pressure of the CPAP -- he'd been on CPAP for a good few days and he had not eaten and he had lost a lot of weight, his stomach was rumbling from hunger but he was too scared to take the mask off because every time we took the mask off to try to feed him he would desaturate, become really frightened. I remember taking -- I took him a favourite drink of his -- I took a -- it's a drink, a yoghurt drink, and I thought he might like that, and I can remember his face lighting up when he saw that drink and then when I went "Shall I pour it?" and then he thought and he said no, because he didn't want to take his mask off.

Q. All right. Just pause there for a moment, all right, Doctor.

Obviously you had to have painful discussions with doctors and indeed your family about what may happen to him. And do I take it from everything that Matt Fowler has said in his statement that from the Covid Bereaved

Families' perspective, it's the communication around the DNACPRs that is the real concern. The way you communicate with a patient, the way you communicate with the family, how it's recorded. We've heard a lot of evidence about potential failings in that regard, areas of good practice in that regard. So I won't need to trouble you with that, all right.

A. But I have to say that I think we were fortunate. We were fortunate that we did have those conversations. Again, with DNACPR -- and I really feel for the families, because the end of a life happens once, and it has to be done properly. Because the impact of when it's not done properly can last a lifetime for others. It's so important.

And again very, very quickly I know the impact of it going wrong, because it happened to my mother in 2019, horrendous death without adequate -- and this was pre-Covid, without anyone really being sympathetic or giving us the time for end of life. And at that point we were really desperate for her to have proper end-of-life care and it didn't happen and we were really terrified, and my father was terrified -- well, he had witnessed it and we were terrified of him going through that same route.

But on this occasion we were very fortunate that

the conversations were had and they were had in a supportive way. And when he said -- when my father had said, "I want to die", we were able to then move forward with the appropriate medication to help him to be more comfortable and to stop having those horrendous symptoms.

Q. Two very contrasting experiences there.

A. Mm. And what I -- really, really am sad and upset for the other members of the group, that they didn't have that opportunity, and I fully feel their pain because we experienced what they experienced with our mother.

Q. And your dad sadly passed away on 28 December, is that right, of 2020, so just before the New Year?

A. Yes.

Q. Can I ask a bit about your experience.

You've told us about the PPE that you wore as a visitor when you were caring for your dad. What about when you were actually working in Wales, what PPE were you provided with then?

A. So when I was working in the emergency department it was -- I remember it varied. It changed. I remember right at the beginning of the first wave there was a period of time where -- when guidance was coming out of how we need to respond. Eventually guidance was coming, centrally. When I say "centrally", I suppose

what -- I'm thinking about, you know, the Department of Health, NHS England, et cetera. Eventually it would arrive to us all the way in North Wales and then we would be given guidance on what we had to wear. And it started -- I remember one particular week it was -- full PPE was the guidance if we come into contact with suspected Covid, and we were fit tested for this, which is, you know, tested with the FFP3. And so we started the week thinking that that's what we're going to be wearing. During that same week, I believe it was about March time, it was downgraded almost on a daily basis, three or four times that same week, to eventually, at the end of the week, it was literally just a normal surgical mask and then an apron and gloves.

And when we -- you know, you've got an informed, scientifically-minded workforce that are asking: why? Is there new evidence? Has something emerged?

And we would be pointed back to the guidelines, and they would say: well, the guidelines say ... And then when you referred to the guidelines -- and I was making another -- dispatches at the time, so we were looking at this evidence. There was no new evidence. They were still relying on the same scientific evidence but just the guidelines had changed.

And then --

Q. I just want to clarify. When you were talking about the same week in March time, I assume we're talking about March 2020?

A. Yes, March 2020, to the point -- and I remember it so well. I remember that period. And I've now subsequently learned that that wasn't just unique to us in our hospital, that was happening everywhere. And I remember it and, if I may, I remember colleagues being really alarmed that -- one person even posted on a Facebook group that we'll be in flip flops and speedos by the end of the week. You know, that's how bad it was. And people being generally concerned. But then with no real explanation.

But then, in different -- again, it was where you were in a different section of the hospital. So if you were within the decontamination space of ED, which is where the really sick Covid patients who would need aerosol procedures or intubation would go, we would then wear full PPE. So it was FFP3 masks, visors, gowns, et cetera.

Q. In your statement you made reference to, whilst working, you saw and wore out-of-date PPE, including masks, during the second wave. And you say this:

"[The] face masks broke whilst wearing them."

Is that a reference to FFP3 -- it is, I can see you nodding.

A. Yeah. I have photographs of them -- they're all on this phone -- where you can see -- which I'm more than happy to provide you, because I took photographs of them and I filmed them because I was, as I mentioned, also filming at the time. But you could quite clearly see stickers that said a date in the future and then when you looked underneath that sticker there was another sticker that was an out-of-date sticker, by at least two or three layers of different dates.

Q. Were you ever told what tests had been conducted on the masks to make sure that they were safe?

A. No.

Q. And I think you said it was the elastic breaking?

A. Yeah.

Q. And indeed you experienced that yourself?

A. Yes, I experienced that. I remember speaking to another nurse who that had happened to as well within the decontamination space. And when you're in that space, it's -- there's a process to get in and out. It's not a normal room. There's an inner door and there's the donning and doffing space, and then the outside bit. So when it -- and you would be in that room because there would be, you know, a patient was either going to be

intubated or -- there'd be lots of viral load in that room. And when, you know, the masks -- the straps -- I don't know if people have worn the FFP3 masks, they're quite thin, but, you know, these ones were, sort of, out of date by at least ten years, and they did snap. And it snapped on my face during a procedure. I just remember going, sort of, like this, trying to, you know --

Q. Put your head on your shoulder to try to hold the mask on?

A. Yes.

Q. I follow you.

A. And I don't know what the nurse did, how she managed, I think she -- because it happened to her on a separate occasion, but I just -- and again, I didn't want to alarm anyone, we just -- you just kind of extract yourself as quietly and quickly as possible and sort yourself out.

Q. Can I ask you about some experiences that you had with Covid. I think you contracted Covid yourself. And you said you've subsequently developed symptoms that are being examined for Long Covid. Have you actually had a diagnosis now of Long Covid or --

A. So I have a diagnosis of lupus. I began to feel unwell in -- so I just thought it was burnout. I thought it

was bereavement grief, I thought it was all of that. But I went to the GP and, you know, I thought it must be the time of life and she said, no, let's just do some bloods and the blood test came back as abnormal, that had been normal in earlier years, and then that just unlocked the door to other tests and it turned out that I had developed lupus. And I've seen a few professors and, you know, I'm looked after quite well. There is -- I've been told a number of times it's quite unusual for someone your age to suddenly just develop lupus.

Q. Had you had the lupus symptoms before you had had Covid?

A. No. So there's obviously a trigger. The way that it was, you know, described was that somehow the lupus has been unlocked. You might have had a dormant, sort of, tendency to have it but something has come and unlocked -- what has happened? Well, I've had Covid. And evidence within literature does suggest that there have been cases of lupus being developed as a consequence of Covid. But unfortunately I'm not sure if it's come up already but, you know, in terms of Long Covid and research into this area, there's not much funding and funding is being shut down and also funding for the care of people with things like this in this spectrum of area, is being quietly ended. So, for example, in North East London Foundation Trust they did

have four Covid clinics. I think they've shut three down and there's only one.

Q. Can I ask you something, if you can, about a number of things that you've alluded to. In your statement you've set out that the number of TV and radio documentaries that you have been involved in, in relation to Covid, and I'd just like, sort of, an overview of what talking to other patients and staff has given you, as if your own personal experiences weren't enough.

Can I just ask you this, Dr Ahsan. In making the documentaries and the programmes, how many clinicians and patients have you spoken to, roughly?

A. I think in excess of 50 along a course of a year's worth of filmmaking, writing, print and radio documentaries. Really, a large number of people.

Q. Can I ask you about the patients, firstly.

A. Yes.

Q. What were their main concerns or things they were raising with you about the impact that Covid had had on them and their experience of the healthcare system?

A. You had people who -- again, I just remember quite clearly people who had other conditions who needed high-level care, critical care, but with other conditions and the fear that they had of catching Covid, of delays of coming in. I remember speaking to one lady

who had fractured her hip, that's something that we normally would see almost immediately as soon as a patient is scooped off the floor and brought in. This lady had stayed at home for four weeks with a broken neck of femur, you know, neck of femur fracture. I've never heard of anything like that before.

We had patients who were terrified of coming in. My brother, for example, an immunocompromised patient, but himself a doctor had caught Covid whilst working. And if I may quickly say, he was working within the first wave. Again, horrendously poor PPE, and he was actually working in the same hospital where my father had died later that year. He didn't have PPE. He was being sent to work in cubicles with patients with, as he described it: there's some really strange patients coming in right now with weird respiratory symptoms, and this was the wave 1, and he caught it. I was able to look after him during the first wave because I myself was terrified of him going in.

Q. Dr Ahsan, can I ask you, your brother's concerns about PPE, was that things you were hearing from the staff that you were working with on the documentaries and TV programmes?

A. Yeah, I think there was a real -- there was fear about PPE, about the lack of PPE, about not being told the

truth about why we're not having -- you know, insufficient levels of PPE. And why, again, a scientifically-minded informed population are being told things that just don't add up. And now we know the reasons: that there wasn't enough; it wasn't the fact that it was safe.

And I think -- again, with healthcare workers and what they were telling me, there was -- I think it was -- a lot of them -- well, let's talk about the patients -- concern about coming into hospitals, concern about what impact this was having on existing conditions. I interviewed a woman with cancer, in the early stages of cancer diagnosis, and the absolute terror and fear that her and her family were going through on how they were going to navigate this during -- she got her diagnosis around about the first wave, so that was quite an impactful interview. And just alerted, you know, reminders of the fact that there's a whole -- you know, the rest of healthcare is not going to stop because of this.

Q. If I can bring you back to the staff. I think you say in your statement you have four months of footage that details concerns, poor supplies, out-of-date PPE which you yourself have experienced, and staff stress, which again you've very ably, if I may say, brought to life

today having, watched what happened with your dad.
Can I just finally ask you this, please, Doctor.
I think you say that as a result of everything that you've been through, you've suffered depression, anxiety and burnout from about March 2021?
A. Hmm.
Q. And you had to take, I think, a break from your PhD and it's impacted your ability to return to clinical practice. Have you been able to resume clinical practice? What's the update there?
A. I haven't yet but I must. And it's about -- it's about being able to go back into an environment where there will be patients who are short of breath and being able to deal with that. I know that this has had a really detrimental impact on my career progression and my ambitions of what I want to achieve within emergency medicine, but I'm very fortunate that I have really generous and empathetic colleagues who have -- but I think it's because we all know what we've each been through.
I just want to sort of -- and again, during that time I was filming I cannot not mention the healthcare workers that didn't make it. Our colleagues. You know, that's -- up to 52, that's a doctor a year that didn't make it, that died from Covid. And there were

a significant number of healthcare workers who were from the black and Asian minority community, extra vulnerable. What might be helpful to know early on -- well, not that early on, but I think it was around about June/July time, that we were all being screened. We got phone calls from our hospital if we were from a black and Asian minority community, identified that we would be at higher risk and we had a telephone call for screening. So that, at that point, meant that someone somewhere has recognised that we are extra vulnerable.
But during the course of the media work that I was doing, I spoke to a surgeon -- the family of a surgeon, Mr Abdul Mabud Chowdhury, who was a surgeon, a urology surgeon, in the Homerton, I mean, we're talking about urology, we're talking about surgery, so just confining high-level PPE to certain professions wasn't correct. He had posted on Facebook an open letter to the Prime Minister asking for adequate PPE. He, sadly, caught Covid and died and his -- I had the privilege of speaking to his son and arranging for him to tell his story on Channel 4 News. Really painful.
We have the story of Dr Yusuf Patel who was an East End GP, much loved by his community. Again, we talked about GPs earlier, but again, healthcare workers were -- he was in his early 60s -- very vulnerable, as

well, you know, and trying their best to the end, and sort of dying in the line of service.
And we had people from all ages. You know, I think the youngest was, that I've read about is a 44-year-old, Dr Sedghi, Abdorreza Sedghi, who was a GP trainee, we had surgeons, we had anaesthetists, we had so many healthcare workers and, you know, frontline staff succumbing to their illnesses, and I spoke to, in the course of my work, trying to tell their stories, I spoke to many of these people and I think the data was one thing, but the real-life stories and the accounts of what people experienced and saw and witnessed is really crucial. It's so, so crucial.
And that's one of the reasons why I tried to make, you know, content, tried to do two jobs at the same time because something didn't feel right. That we were being told these numbers that were going the wrong way on an almost daily basis, wrong way, ie going up, but we were still having alternative narratives coming out, right from, you know, the Prime Minister himself, from the Secretary of State for Health at that time, from other people associated with that department, that were downplaying or giving alternative narratives to what we were actually physically witnessing.
And if I may talk about just one very quick

example. Like, as I say, things didn't make sense with what we were seeing on the ground, with what our patients were telling us and what they were witnessing and experiencing.
I tried to understand how there could be such a disconnect. Okay for the first wave, but definitely for the second wave, what was going on? And I -- and this was a year later, I had an opportunity to speak to a civil servant. It was at a social gathering so I wasn't prepared. I didn't realise that she would be there. It was a social gathering. And obviously the subject of Covid came up, as it often does, and people wanted to ask about what I'd done during it, and I told them it, and it turns out that this individual was a former adviser to Matt Hancock. And she, at that point, stated that everyone was on -- well, she was on the front line, her front line was just as hard, and so it was very combative and defensive and that her experience was just as challenging and as hard as a frontline healthcare worker dealing with patients who couldn't breath and were thrashing on the bed. And that gave me an insight into the absolute disconnect between -- the people that were actually making the decisions were not connected with the people that were actually delivering the care. And there was a massive

gulf.

I would still like to have --

Q. Can I pause you there, because as you were giving that answer, her Ladyship was nodding when you said the data is one thing but it's not everything, and we've heard a number of pieces of evidence to that effect. And so can I just ask you this finally, please. I suspect the lesson learned is to try to bridge that gap between what was going on on the front line and what the decision-makers were being told or the data was telling them. Is there any way, Dr Ahsan, that you think that that gap could be bridged and that practically we could do different in the event of a future pandemic?

A. I think there are a couple of things. I think understanding that data are not -- each -- each specific number is a human life, and a human life that has gone on a journey, and when you're thinking about the data that relates to Covid, that's a death that has not been an easy death. The illness is not an easy death illness and, at that point in time, where the system was under so much pressure, that it would not have been an easy journey, it would have been a frightening journey for all involved.

I think resources and -- I have to bring it back to funding.

Q. Yes.

A. But, you know, the Health Foundation states, you know, even with an extra 38 billion per year, by the end of next Parliament -- so that's 38 billion a year -- will allow the NHS in England to meet growing demands. And where we are, you will know the graphs better than me and you'll have pored over them, but right now, in terms of the EU14, we are so low down on that scale. We are No. 10 out of the 14. And there is no -- when you talk about the pressures that we face, and I know that there was extra funding ploughed into the NHS during Covid, but then you're asking for ready-made things to be able to be bought off the shelf. Well, you can't just buy a ready-made highly experienced consultant or a nurse to suddenly buy them off-the-shelf. These are not sort of pre-packed things that you can just suddenly build overnight. This takes money, time and investment, and resources as well, that take many years to build up. Training, for example, takes years to build up.

So it does boil down -- without any shadow of a doubt, and through the NHS that I started in and to the NHS that began to emerge from 2010 onwards, it was very different.

MS CAREY: And I'm going to stop you there if I may, Dr Ahsan. That's all the questions I have for you,

thank you very much.

My Lady, is there anything that you would wish to ask Dr Ahsan?

LADY HALLETT: No, thank you very much indeed, Dr Ahsan. I'm extremely grateful to you, obviously for the work you did on the front line, the work you've done trying to bring to the attention of the public -- it shouldn't really need it but I'm afraid people are beginning to forget the -- all that you're trying to do to bring matters of concern to the public attention.

And I do hope that you haven't suffered too much distress from helping us today. I appreciate that some of the things you have been talking about may have been triggering. I know you're a doctor but don't forget to look after yourself and get support if you need it. And I'm really grateful to you for the help you have given us.

THE WITNESS: Thank you.

MS CAREY: Thank you, my Lady.

LADY HALLETT: Thank you.

(The witness withdrew)

LADY HALLETT: Very well, I shall return at 2.05.

(1.06 pm)

(The short adjournment)

(2.05 pm)

MS CAREY: My Lady, good afternoon. The final witness is Mrs Martina Ferguson.

LADY HALLETT: Thank you, Ms Carey.

MS MARTINA FERGUSON (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

LADY HALLETT: Ms Ferguson, as you probably heard, I can't be with you today in person and I'm genuinely sorry, as I said to your predecessor bereaved witnesses. I can't be with you in person but I promise you that doesn't mean that your evidence isn't extremely important to me and to the Inquiry. And if I'm not with you in person, I'm with you in spirit.

THE WITNESS: Thank you, my Lady, and I hope you are feeling much better soon.

LADY HALLETT: Thank you.

MS CAREY: Mrs Ferguson, you are one of the group leads of the Northern Ireland Covid Bereaved Families for Justice, NICBFFJ, if I might just call you the Northern Irish Bereaved, if I may. And the Northern Irish Bereaved group is a branch of the UK-wide Covid Bereaved Families for Justice group; is that correct?

A. That is correct, Ms Carey.

Q. And I think you started in around December 2021, although prior to that, a number of the group's members were involved in trying to discuss matters with people

in the state, public representatives, and were involved in other support and, indeed, memorial groups. So no one should think it just emerged until the end of 2021, there'd been work going on for some time before that; is that correct?

A. That is correct, yeah.

Q. You say in your statement, which we will publish, and is INQ000360941, that the Northern Irish Bereaved group was formed as both a support group and an action group. Could you give us an example of the kind of support the group has provided?

A. Yeah. So I suppose I should say during the pandemic, probably not at the beginning of the pandemic, it would have been after my mum's first period of hospitalisation, I had felt very strongly that we needed a public inquiry into what was happening, so I had connections with other groups, and it would have been summer/autumn 2021, we had joined the UK Covid Bereaved Families for Justice group that Jo and Matt had set up. So Brenda, my co-lead and I, had connected. We had discussed setting up a Northern Ireland branch, and thankfully we've had the privilege of working with very highly experienced legal teams and campaigning with like-minded bereaved families.

The aims of the group, when we set up the Northern

Ireland branch, was really to have, like, a supportive place for, you know, bereaved families to kind of connect for those that wanted to connect. It was to place a focus on devolved matters, and also, you know, to support one another as a bereaved person.

There's lots of questions bereaved families had around, you know, finances because maybe the bread winner in their family had, you know, passed away. They had maybe legal questions. And just general questions around, you know, grief and support, so we were able to, you know, signpost those families.

Q. Now, you say in the statement you're also not just on the support side of things but an action group, and I think that included that engagement from the start of the pandemic -- so back into March 2020, engagement with senior officials from the Department of Health, its arm's length bodies, Public Health Agency, the Regulation and Quality Improvement Agency, the RQIA, the Patient and Client Council, senior management representatives the health and social care trusts in Northern Ireland, Commissioner for Older People, Human Rights Commissioner and, indeed, the former UK Prime Minister, Boris Johnson.

So a great deal of work being done by the members of the group to engage with all of those different types

of bodies and their different remits.

And was that engagement letters, demonstrations: Just give us an insight into what was done.

A. Yeah, the engagement with state entities, whilst that has continued, when we got together, you know, as a group -- can I just put that into perspective? During the first week of the pandemic, between 23 March and 31 March, I was completely at my wits' end, you know, when I wasn't allowed into my mummy's care home. And that first week I had contacted, you know, the Department of Health, the private office of the former health minister, Robin Swann, the social -- the Southern Trust directors and assistant directors for older people in primary care. I actually got speaking directly to the Human Rights Commissioner at the time, Les Allamby. We had a discussion around, you know, human rights and how the state could interfere, you know, in -- when there's a public health crisis.

I had contacted RQIA, four of the MLA officers, the DUP, the SDLP and Sinn Fein.

I also had contacted the UUP, but that wasn't within the first week of the pandemic.

Q. Can I ask you this. About what topic or topics were you contacting all these different types of people and organisations?

A. So my email, for example to Boris Johnson, what made me think he was going to respond, I don't know, but I was a really desperate daughter.

Q. Was this about getting in to see your mum in the care home?

A. It was actually asking -- I was very conscious -- you know, my mummy had dementia, she couldn't speak for herself, and I wanted to know, you know, could there be exceptional circumstances for those that, you know, had dementia or Alzheimer's. I was also asking about testing. And in normal circumstances when there is an outbreak of vomiting and diarrhoea, admissions would normally be stopped in a care home. So I was asking for admissions to be stopped, you know, to help stop the spread, you know, of the virus.

So there was a number of issues but they were the main issues that I'd highlighted all of these state entities within the first week of the pandemic. And then as our group grew we continued to engage with state entities, with public health as well, and the First Minister and deputy First Minister and all of the political leaders.

Q. Now, I think you know, Mrs Ferguson, that the focus of this module is on the healthcare systems, and your mum went into hospital and we're going to turn to that. But

clearly her Ladyship has got another module dealing with the impact on the care homes, so can we focus perhaps on what happened to your mum, who went into hospital, I think, firstly, from her nursing home, in July of 2020, and I think during that month, is it right that your mum had two admissions? She went in firstly on 5 July until 8 July, so a 3-day spell, and then she went in later again that month?

A. Yeah.

Q. Can I just ask you about the month generally. Were you able to visit your mum in the hospital in July 2020?

A. Yes, so in -- it was Sunday, 5 July. If I remember, it was the day before -- so this is 2020 -- it was the day before the rest of the restrictions -- they were kind of relaxed, I think, that Monday, 6 July. So my mummy went in that Sunday, the 5th, and she went in with seizure activity, and was normal because that had happened the year before and I think the year before that as well.

But can I -- I know we have a separate module and it's -- care homes will be dealt with later, but can I just explain and put a little bit of context around how vulnerable my mummy was and all of the bereaved families who have lost, you know, a loved one.

In my mummy's situation, I just want you to think for a moment. Let's imagine that your arms were in

a fixed flexion. You know, you've got dementia, so -- advanced dementia. You can't speak. If you sneezed and your nose was dripping, with your arms in a fixed flexion you wouldn't be able to clean your nose. If your head was itchy, you wouldn't be able to scratch your head. And that was my mummy.

Q. So when she went into the hospital, were people, the nurses, the healthcare professionals, were they able to provide that most basic care, the wiping of her nose, the scratching of an itch? Tell us what it was like at, sort of, that level for you and your mum.

A. Yeah, when she went in she was triaged, you know, at A&E. She didn't look very well that day. And, you know, the doctors checked her. They were going to discharge her, you know, a couple of days later, which was the Wednesday, 8 July.

I remember having a conversation with the doctor and I said, "Look, you know, my mummy's had this seizure activity before, it happened last year if you want to check her notes, and she was discharged back into the care home too soon, you know, and I'd really appreciate if you could keep her under observation just for another 24 hours."

And the doctor's response was, you know, "Your mummy's medically fit to be discharged. She's going

back to the care home."

Q. And they discharged her, in your view, at least a day early?

A. Yeah, it was too early. I knew that and -- you know, we often talk about specialists and experts amongst doctors and clinicians, you know, and healthcare professionals are the specialist. I think, you know, it's families that are really the expert because they know their loved one well.

So I knew she was being discharged soon, but anyhow we went with the flow, my mummy went back into the care home, and then I got a phone call the next day, you know, on, I think it was, Thursday, 9 July, to say that my mummy had mild tremoring again and seizure activity, so she had to go back in. So we had to go through the whole process around, you know, A&E and being triaged again, and then they decided to keep my mum in and she was in for approximately -- you know, from 5 July really, apart from that 24-hour discharge, to 22 July.

Q. Pause there, Mrs Ferguson, because you obviously went with her the first time and again the second time. When you were visiting her, were you required to wear any PPE?

A. Yes.

Q. And what did you wear?

A. My mum was up on one of the normal wards and I was wearing -- I remember because I was involved heavily in her -- you know, help, assisting with feeding. You know, there didn't -- I remember I was allowed to come into the hospital for about three four times during the day, and I know that that has been a major issue for some of the bereaved families in our group. You know, there's been a lot of inconsistency, you know, where they've been told in one trust that you are only allowed in for an hour a day and another trust they get in a couple of times during the day. But my mummy was in -- I was assisting with her feeding. She was on a particular diet.

Q. Yes.

A. You know, level 4, I think it was, on her diet, and a level 3 on her fluids. So I was wearing a paper apron and gloves. I was doubling up on the gloves but then I was told I didn't need to wear the gloves in July 2020. And I was wearing a paper face mask.

So back then, you know, that July, I knew that we could manage with Covid. I know not everybody wants to hear that but we had some of the critical tools then, you know, the PPE. My mummy went in. She had seizure activity, she was discharged. She was tested twice

before she was discharged back into the care home after those two weeks and she was negative.

Q. Can I ask you this. Given your mum's dementia, how was it communicating with her if you were wearing the mask? And indeed, how were the staff able to communicate with her through masks?

A. So my mummy would have recognised my voice, you know, and just things that we would have said to each other -- sorry, she wouldn't have responded apart from, like, maybe a "yes" or a "no" but wouldn't have understood the instruction, but just laughing with her she would have recognised me, she would have recognised my voice, and I knew that straight away.

Q. Were there any difficulties with the staff communicating with her or were you really the one looking after her, helping her to feed, drink --

A. I felt like I was looking after her, yeah, because I had asked the staff at the time, you know, could we get some food charts displayed, because I wanted to take a note of what my mum was eating, because I had went into the hospital one day and asked, you know, what did my mum have for lunch -- this was one of the days that I wasn't there at lunch time -- and a member of staff wasn't sure what she had, so I had asked for food charts to be implemented straight away so we knew, you know, what

fluids and what my mum was eating as well.

Q. And is it right that your mum had to take her medication in liquid form not in tablet form?

A. So a couple of years prior to the pandemic my mummy, just because of the dementia and the advanced dementia, she wasn't able to chew, you know, like, a tablet, so she was on liquid medication, probably about 3, 4 years prior to the pandemic. Yeah, I mean --

Q. All right --

A. -- during that ...

Q. No, no, don't let me interrupt. Say what you want to say about July because I want to come on to December then, and that's really why I asked you about the level of care you were providing for your mum.

If you hadn't been there in July, do you think there was sufficient staff in and around the hospital to provide the most basic care for your mother?

A. Yeah, I mean, I didn't -- never really experienced a shortage of staff. I found the staffing levels, you know, in July 2020 and in December 2020 similar to prior to the pandemic. So I didn't really notice, you know, a decline in staffing levels.

Q. Can I come on to December 2020, because I think you received a phone call from one of the nurses at your mum's care home on 23 December, so just before Christmas

that year, who advised that your mum had to go to hospital due to a high heart rate and they were going to phone for an ambulance for your mum.

A. Yes.

Q. And is it right then that you went to A&E and that's where you met up with your mother at the hospital?

A. Yes. If you're going to fast forward to December 2020 or January 2021, you know I lost the two most important women --

Q. Well, I was just going to say --

A. -- in my life.

Q. You say in your statement the news that your mum was going into hospital in fact came the day after you buried your mother-in-law?

A. Yeah.

Q. So just clearly a lot going on in your life in the run-up to Christmas that year.

A. So, in -- it was Saturday 19 December we lost my mother-in-law.

Q. And then four days later you get the call to say your mum is now going into hospital. All right.

A. So my mother-in-law was diagnosed during the pandemic with a brain tumour and lung cancer. We had buried her on 22 December. And then the next day I received that phone call from the care home to say that my mummy had

high heart rate, she needed to go to hospital. You know, there was a couple of different conversations going on that morning because the GP was contacted as well. I contacted the GP. And I asked -- I was just concerned about my mummy going back into hospital.

Q. What were you concerned -- what was it that particularly concerned you about her going back in?

A. I think it was the September 2020 -- yeah, it was after the first period of hospitalisation -- and this is in the public domain as well, but there was a number of patients in the haematology ward in Craigavon Area Hospital and the former health minister Robin Swann had called a serious adverse incident. So these were patients that had went into hospital, it was non-Covid-related, there was very poor infection prevention and control measures in place, and that is now -- you know, came out of this Inquiry around Craigavon Area Hospital, and I was just really worried that my mummy was going into hospital and it wasn't -- you know, we think that hospitals are a safe place to be in, that you're going to be -- you know, get well, and I didn't feel that.

So I can't remember if the GP rang me that morning or I rang the GP and I said, "Look, is there any chance -- you know, because my mummy's got high heart

rate, is there any chance -- and again she had that prior to the pandemic -- would -- could the acute care team come to the care home and deal with my mummy?"

And to be fair, the GP that morning, you know, she phoned me back very quickly and said, "Martina, there is no capacity, you know, with the acute care team", and I said, "Right, okay, so my mum is going to hospital."

Q. But your primary concern for her not going was because you didn't want her to catch Covid at the hospital; is that right?

A. Yes, and I was just afraid for her.

So my mummy went to -- the ambulance was rang that morning and my mummy -- I think it came quite quickly. And again I'm just thinking of other families, you know, in our group who rang for ambulances and they didn't come. And my heart goes out to them.

Q. Pause there for a moment.

You met your mum at A&E and I think after she was triaged she had a Covid test and the doctor came to tell you, is this right, that your mum had actually tested positive for Covid. Had anyone told you prior to the doctor confirming the positive test that your mum was suspected of having Covid? They wanted to do some investigations to see if she had Covid? Had anything been mentioned even about her possibly having Covid?

A. No, the nurse on the phone from the care home had rang to say it was high heart rate. Nobody mentioned Covid. When my mummy -- I met my mummy in A&E. She'd been triaged quite quickly as well. She had also been tested and her swab, you know, went to the lab quite quickly. It was only later that night -- so my mummy was becoming unwell, you know, she had a high temperature, and later on that night the doctor approached me and said, you know, your mummy has tested positive. And I was really shocked, you know. And I know that maybe -- it was the second wave and I should have expected something like that, but when you're told that your mummy's going in with high heart rate and Covid wasn't mentioned, I didn't really think about it too much.

Q. Let me ask you this. Before you knew she was Covid positive, were you wearing any masks or PPE before you knew that she was -- she had Covid?

A. Yes, when I met my mummy in A&E she was wearing a paper mask and I was wearing a paper mask but, I mean, you know, we took them off, I gave her a kiss and a hug because I hadn't, you know, been in her company, you know, to touch her, you know, to provide that kind of tactile and sensory therapy that dementia residents need when they are non-verbal. So I probably wouldn't have done that if I had of been told that my mummy was

going with suspected Covid. That is only something that I realised a couple of months after my mummy passed away whenever I requested my mother's hospital records and I contacted, through an MLA, the Northern Ireland Ambulance Service, I requested my mummy's 999 patient call record and some of it was redacted but it clearly stated on that 999 call that my mummy was going in with suspected Covid.

Q. But no one had told you that?

A. No one had told me that.

Q. Now, once your mum had tested positive, I think she was transferred to the Covid ward on Christmas Eve, but can I ask you about a conversation that a doctor had with you about a DNACPR or a DNR, call it whichever is easier for you, Mrs Ferguson, what did the doctors say to you when they spoke to you about a possible DNR for your mother?

A. So that actually happened that evening in A&E, so when I was in A&E when the doctor came over and explained that my mummy was positive for Covid. He started to discuss with me a DNR and whilst I understand that clinicians, you know, it's their decision, and they can also decide not to perform CPR, me being me, I said, "Look, Doctor, I need to speak with the rest of my family." And I just got the distinct impression that,

you know, a DNR was being placed on my mummy.

At the time I thought, well, I need to give consent to this and I wasn't sure of the entire process.

Q. Right.

A. But when the doctor walked away and I sat and I thought about it, I went back over to the doctor, there was probably about 5 to 10 doctors in A&E, and there was a lot of staff about, again very similar levels prior to the pandemic. But I went back over to the doctor and I said, "Look, just because you are placing -- or if you're going to place a DNR on my mummy, that doesn't mean to me, and it shouldn't mean that my mummy will not be receiving treatment and I want to make sure that my mummy receives the same treatment that somebody else would get despite her age."

Q. I think --

A. I -- whenever I was -- I had lived in the States with two doctors, one was a heart surgeon and one was a doctor, I had phoned them that evening and I said, "Look, I need some medical advice. If you have got Covid, how is this being treated in the States? What kind of treatment should my mummy be receiving, you know, setting her age aside?" And their response was, "Look, in the States they're using steroids and, you know, oxygen if that's required," so I kind of knew

in A&E, right, this is the treatment that my mummy should be getting.

So when I left for maybe five, ten, fifteen minutes I came back in and my mummy was really distressed, so she was -- so they were giving my mummy oxygen and I think initially she had, like, 10 litres of oxygen and she just deteriorated, you know, really quickly in that space of time. But the oxygen obviously was helping her. And I went back over to the doctor and I said, "Look, my mummy needs to be on steroids. I know you're the specialist but, you know, remember what I said earlier, I want my mummy treated."

So they were putting my mummy on steroids and then the following morning they had explained to me that night, "Look, your mum has to go to the Covid ward", and I said, "Okay". So I went home just for a couple of hours to get some sleep.

Q. Let me pause you there because I want to come on to what happened to your mum on the Covid ward. But I think, although you had the discussion with the doctor about the DNR, no doubt discussed it amongst your siblings, in your statement you say that there are a number of concerns of members of the Northern Irish Covid Bereaved group about what you call institutional pessimism, resignation, indeed fatalism, on the part of care

professionals and often families being unaware that DNACPR decisions had been made, who had made them, or why they had been made. Are you able to give us, Mrs Ferguson, a sort of sense of the scale of the concern amongst the Covid Bereaved members of all these problems with DNACPR notices?

A. I know this has been highlighted so many time but, yeah, this has been a major issue for, you know, Bereaved Families in our Northern Ireland group. One lady in our group had lost her husband, there was no discussion at all with that family. Another young woman, who is here today, and her mother, they lost their brother, uncle. He had Down's syndrome. And, you know, one minute they were told that, you know, he was fine, he was recovering well, you know, and then the next five minutes they got a phone call to say, "You need to be at the hospital here" and unfortunately they weren't at the hospital to be with their loved one.

Q. One of our witnesses this morning said, I think, to quote "communication is key". And do I take it that you would wholeheartedly agree with that?

A. You know, absolutely. This was a horrendous time for families during the pandemic, and grief is bad enough, you know, during normal times but, you know, when you are locked out of the hospital or a care setting and you

can't be with that person, you know, it's really, really important that communication is, you know -- that it flows. One particular lady who had lost her husband, and her husband was in Craigavon Area Hospital, the same hospital that my mummy was in, you know, she had overheard staff saying, you know, that we're far too busy, you know, to update your family.

Her husband had heard the nurse in charge say that, you know, "You've been fond of the drink during your time", and I mean, to hear something like that, notwithstanding the fact that that patient had been a lifelong pioneer, so he had never drank. So it was that -- it was the tone. It was the tenor, you know. It was really, really upsetting for families to hear things like that. And to be also hearing "We don't have time to update families".

Q. I interposed that because it just seemed to fit in with some of the things that the Northern Irish Covid Bereaved members are concerned about and, clearly, communication not just in respect of DNACPRs, but all of these areas is important.

Can I come back to your mother on the Covid ward between, I think it was Christmas Eve and her death on 4 January, and I think in your statement, Mrs Ferguson, you wanted to cover some of the treatment that she

received or didn't receive as the case may be. Can I just ask you this. This time round now, in December into January, you told us that you were wearing a mask in A&E. Once she moved to the Covid ward were you wearing any PPE when you were visiting her on the Covid ward?

A. So when my mummy left A&E and she was transferred up to the Covid ward, you know, I grabbed her bag and I assumed that I was going with her. I was met with the nurse in charge on the ward, and I hope no other families feel distressed about this because I know that not a lot of families get into the Covid ward. So the nurse said to me, her response to me was, "Where do you think you're going?" And I said, "I am accompanying my mummy." And she said, "No, you're not, there are no families allowed into this ward." And I said, "Says who?" And I know that probably didn't sound right but you've got to bear in mind that I had been locked out of my mummy's care home for nine months.

So she explained to me, "We have a policy" and I said, "Well, I read your policy and I read that last night and it is three months out of date". And it was a policy that was on their website, and only because I had engaged with the Department of Health I knew that they should be receiving communication from the

Department of Health and that should filter down to all of the trusts in Northern Ireland.

And I said, "Look, I am my mummy's care partner, I'm not sure if you're familiar with the guidance but you should be, and at that time" -- I mean, we can talk about the care partner guidance another day, but at that time that was endorsed, you know, and it was released by the Department of Health and the Executive and that was September 2020, and that is something that I had been instrumental on in terms of campaigning for. And I assumed that that care partner stayed with that person. So it wouldn't have mattered whether they were in a care home or they went into hospital.

So when I was saying to the nurse that day, "Look, I'm my mummy's care partner, you should be familiar with that guidance", she said she wasn't. And I said, "Look, I want to come in here to help and my mummy needs me. None of the staff know my mummy, they don't know her likes and her dislikes." And she took a note, actually, on the corridor of my mummy's likes and dislikes, and I said, "Look, we need to compromise, I need to be with my mum", and she said, "Right" -- I wasn't getting anywhere with her and I don't like to name drop but I did say to her, "I have contacted the chief executive", and at the time it was Shane Devlin,

and that was early December, and I said, "Look, can I suggest that you get him on the phone or you get him to this ward now, because I'm not going home unless I know that I am getting into this ward to be with my mum."

She literally walked around the corner and she came back two minutes later and said, "Right, one hour." And I said to her, "Well, What's that for?" And she said, "To feed your mummy", and I said, "Well, my mummy feeds seven times a day", but at that stage, Ms Carey, I thought I'm not going to push this because I want in there.

Q. Yes, you wanted -- I understand.

A. So the Covid ward, it was full PPE.

Q. Mask, gloves, apron?

A. It was like hazmat, kind of, outfit, yeah. And I said to her, "Look, I am a quick learner, I'm willing to learn how to don and duff", I kind of knew how to do that and she explained to me, so I did get in to the Covid ward.

Q. Now, in your statement you set out that during your mum's time on the Covid ward you had a number of concerns about some of the care that she was receiving. It included the wrong levels of food and consistency to enable your mum to be able to take the food without

choking; soiled clothes not being changed regularly; they left tablets at your mum's bedside even though, as you told us, she required liquid medication; and you say the staff lacked training and understanding of dementia patients, despite that trust and other trusts across Northern Ireland having implemented, prior to Covid, the Butterfly Scheme for dementia patients.

Can I just ask you about that. Are you able just to summarise, what was the Butterfly Scheme aimed to ensure?

A. It was really for highlighting whether a patient had dementia or not. So that scheme was rolled out in the Southern Health and Social Care Trust. I think it was a couple of years prior to the pandemic because I remember when my mummy was hospitalised prior to the pandemic she was on a ward that had -- it was a massive wall display of the dementia-friendly scheme, and instead of, you know, writing up on your hospital bedside that this person has got dementia, then a butterfly would have been drawn and that should have explained to staff, you know, that this particular person or patient has dementia.

Q. So when you were looking after your mum over that December into January, was there a butterfly up on the wall or did anyone even seem to acknowledge or be aware

of the existence of the Butterfly Scheme?

A. No, I mean, prior to the pandemic when my mummy was in hospital, you know, when my husband and I went to visit her we would have drew the butterfly ourselves. I remember one time that I had wrote "my mother is a dementia patient" and when I came back in to visit her it was removed. But nobody replaced it with the actual picture of a butterfly.

So it just didn't seem to filter down to the staff even though they were promoting. They had it in place prior to the pandemic. And it seemed a really excellent scheme if it had have been used properly.

Q. You've told us about the PPE you were wearing. What were the staff wearing over that period of time that your mum was in hospital? Were they in full PPE as well?

A. Full hazmat suits, yes, on the Covid ward.

Q. Now, I think you say notwithstanding that that there are examples amongst the members of Northern Irish Covid Bereaved about PPE that wasn't always being worn appropriately. I think one of the members gives an account of masks being worn under the chin and the like. Did you get any sense of how much compliance or how little compliance there was with PPE being worn by staff, from either your experience or the experience of

the members?
A. Yeah, I mean, again, this has come from a lot of the families, you know, in our group where, you know, yeah, masks, were worn, you know, beneath chins, beneath noses, they maybe weren't wearing PPE at all. You know, I certainly experienced that looking through a window for nine months in my mummy's care home.

In the hospital I probably didn't notice it as much, you know, on the Covid ward, the staff, you know, they were in their hazmat suit, they continued. They were quite strict in that there was no food or drink allowed on the Covid ward for staff. So I didn't witness anything, you know, when I was there.
Q. I think your mum was on the ward for about two weeks and passed away in January, on 4th January 2021. Were you allowed or any of your siblings allowed to be with her at the end of her life?
A. Yeah, I mean, I had been on the Covid ward for, you know, approximately two weeks. I remember the staff had come in, you know, to check on my mum, the early hours of the morning of 4 January 2021. And they left and then my mummy had been moved a couple of times on the Covid ward. I think it was about three times. And she was in a room, you know, a side room. It was just her and I. I had used the toilet, I came back out, and

I remember washing my hands and I looked over at her and I thought, I'm not so sure if there's any signs of, you know, life. So ...
Q. Take a moment. Take a moment.
A. So ...
Q. You were with your mum then?
A. I went over, just said some things to her.
Q. All right. Can I ask you this. Clearly you were with your mum in her last moments with us. What about other members of the Covid Bereaved? Were they able to be with their loved ones or was there a very mixed picture across the --
A. There was a very -- yeah, a very mixed picture amongst the group. Some people, you know, got to be with their loved one, some people didn't.
Q. And --
A. Um --
Q. I'm so sorry, I didn't mean to interrupt you, but I just was wondering, were they allowed in, sort of, perhaps in wave 2 and not in -- is there a sort of a sense of --
A. It was just a mixture in both.
Q. Okay.
A. You know, a lot of the families had to say goodbye through an iPad or a telephone. You know, it -- some of it just didn't make sense. I remember, you know, one

story where a -- daughters had their mother and father in the same hospital and, you know, why they were not allowed to come together, you know, and they died, like, days apart from one another, it just made no sense.

But that morning, you know, when my mummy passed away, I remember I just knew, you know, it was the end. I had phoned the funeral parlour because all sorts of questions, you know, were going through your head, you know: who is going to wash my mummy? Who is going to embalm her body? You know, and staff were explaining that, you know, your mummy will be wrapped in a -- I think they said shroud and I said, "You mean a bed sheet and put into a body bag?"
Q. Mm.
A. And I thought, "This can't be happening."

So the funeral home, you know, they were very professional. You know, they explained, "Martina, we're following the guidelines. We can't do anything like that."

And, you know, I remember one of the nurses on the Covid ward, she was absolutely brilliant, you know. She -- she said to me, "Martina, calm down, this isn't the time to think about things like this. We will do whatever you want."

Do you know? Whereas had another member of staff

who -- would have came along and said, "No, that will not be happening."

So you had a real inconsistency. And this has been a big problem, you know, for our group, and we have found across all the hospitals in Northern Ireland where you have a nurse in charge of a ward. And whilst I get that and that is required, but the discretion is left to them. And you see when discretion is left to people, that can just create chaos. Because I've seen that in the care homes when discretion was left to care home managers. You got so much inconsistency across the board, it was unbelievable.

So that morning when my mummy passed away, I said to the nurse, you know, "What's happening now?"

And she explained the porter will be coming up, they'll be putting my mummy in a bed -- you know, in body bag, and I said, "Look, if nobody is going to help me, I am washing my mummy's body, my mummy is not leaving here in a sheet, my mummy is going in her suit."

So I had brought the clothes with me. And a nurse very kindly came in and she helped me, you know, wash my mummy's body. And we dressed my mummy. And whilst I feel very privileged to have done something like that and feel really lucky and I know families didn't get a chance, but I was one of six children, so ...

Q. All right.
A. The rest of our family had to say goodbye through FaceTime, you know, and it was horrendous.
Q. Ms Ferguson, that is no doubt why you urge her Ladyship at the end of your statement to say visiting must be enabled as a default position. And I don't need to ask you anything about that. It speaks for itself.
A. The funeral, you know, it was very heavily restricted. There was -- we contacted the church chapel, whatever you want to call it. We were told that, you know, there would be no service for my mummy. That wasn't allowed. We were allowed only, I think it was, 15, and the cemetery gates would be locked, nobody else was allowed in. But whenever -- it was a very short service by the graveside, you know, it was a couple of prayers, and then the gates would be allowed to be open, you know, and they would have allowed social distancing.

None of it made sense. You know, we were outside. You know, we had learned a little bit more about the virus at that time.
Q. Can I just, I suppose, ask you this finally. You've actually covered, through the prism of what happened with you and your mum, a number of the concerns of the bereaved members of the Northern Irish Covid Bereaved group. Is there anything else, Mrs Ferguson, you would

like to say to her Ladyship or any other recommendation that you'd like to urge the Inquiry to consider?
A. Yeah, I mean, what we're looking -- is we want a legislative change. I know it's came out from Module 1. You know, I'm grateful that, my Lady, you put a report together, and we have contacted the First Minister and deputy First Minister. We've contacted them a couple of times. You know, I would hope that, you know, our group will be allowed to meet with them and that they will make change happen. But I was campaigning, you know, before my mummy died, after my mummy died, for the care partner guidance. You will have heard during this Inquiry that that was ruled out in care homes in September 2020. It was extended in hospitals in February 2022. I want that on a legislative footing. You know, it has to be.

You know, because when you have a member of the Department of Health in an email says -- that says to me, you know, "Guidance is guidance", that's not good enough. That is not good enough. We need to see a legislative change, we need to make sure that nobody dies alone ever again, because it's so important that their family is with them. Because at the end of the day family is the most important people to those in their dying hours and days.

MS CAREY: Mrs Ferguson, you are our final witness for Module 3. Can I thank you.

And can I turn to her Ladyship to see if there's any questions you'd like to ask Mrs Ferguson?
LADY HALLETT: No, I have no questions, Mrs Ferguson. Thank you so much for all the help, because it's not just today but you obviously helped the Inquiry before and I'm really grateful to you.

And you mentioned just now about the first report and the recommendations. The only way, as I said, I think to Mrs Waterton this morning, that my recommendations will get implemented is if groups like yours keep the pressure up. So thank you for all you're trying to do to get any recommendations implemented and change implemented because that's why we're here doing this Inquiry, we're trying to make some change for the good so that people don't have to suffer as you did.

And I hope that by helping the Inquiry we're not increasing your suffering because obviously your grief is still very raw and I understand that. One of the very first things I learned when I went around the UK was just how bereavement during the pandemic is very different from other bereavement and that's why it seems to last so long and seems to be so traumatic. So I do hope we haven't played any part in making it worse but

we are extremely helpful for all the help you have given.
THE WITNESS: Thank you, my Lady. And I am really, you know, privileged to be here today. Whilst it was very nerve racking, you know, but I think that everyone needs to reflect on what has happened, specifically the Department of Health, because I don't think that they have reflected and I think that that has came to light, you know, when we heard the evidence from the former health minister, who I did meet in person early in the pandemic in May 2020 and in May 2021. I don't think a lot of change has happened since then. You know, we want to work closer with the Inquiry team. We want better outcomes for everybody, d'you know?

And sometimes people ask me, you know: why do you bother? Why do you do this? Because I have realised over the last couple of years that, you know, democracy is everybody's responsibility.
LADY HALLETT: It is, Mrs Ferguson, spot on. We all have a duty and public service is part of that duty, so thank you very much indeed.
A. Thank you, my Lady.

(The witness withdrew)
MS CAREY: My Lady, may I invite a short break this afternoon before we turn to the next phase of the

Inquiry's hearing.

LADY HALLETT: Certainly. Shall I break for ten minutes to allow Mrs Ferguson to speak to those who are representing her.

There won't be any more breaks today, and I shall obviously begin closing submissions.

I'm really grateful to everybody that has led us to the stage where we have completed the evidence this afternoon, as we'd planned to do. So, thank you all very much indeed.

MS CAREY: Thank you, my Lady.

LADY HALLETT: See everybody at, shall I say, 3.05.

(2.53 pm)

(A short break)

(3.05 pm)

CLOSING SUBMISSIONS

MS CAREY: Before we turn to closing submissions, can I just deal with one matter. Can I invite you, please, to publish 69 statements.

I'm going to show on screen, rather than read out descriptions and INQs of all 69, but we would invite you, please, to publish these statements which include statements from the royal colleges, a number of government departments, the spotlight hospitals, a number of charities, including those involved with the

modules non-Covid conditions, the regulators, and some other NHS bodies.

As ever, the fact that other statements obtained by Module 3 are not being published at this stage, does not diminish their importance. Of course, all the evidence obtained by the module will be taken into account by you and, indeed, the Inquiry may publish further statements in due course.

And in a moment the document handler will have scrolled through all 69 of the statements that we invite you to publish this afternoon.

Once that's done can I invite, please, Mr Rawat King's Counsel to address you on behalf of the UK Health and Security Agency.

LADY HALLETT: Certainly. And I, too, wish to emphasise that obviously people pay attention to the oral hearings but there's a great deal of very important material in the written evidence and I shall take it all into account.

Something that should have occurred to me before and you're doing it now, Ms Carey, you're on your feet addressing what I assume is an empty chair.

MS CAREY: Yes.

LADY HALLETT: I just wondered whether people would rather make their closing submissions sitting down. I'm sorry

I hadn't thought about it before but it must be a bit strange.

MS CAREY: I don't know if people sit down whether the camera will pick them up, but I suspect the advocates will feel comfortable standing, it being our natural habitat.

LADY HALLETT: Well, I leave it to anybody's preference.

MS CAREY: Thank you very much, my Lady.

LADY HALLETT: Mr Rawat, please.

Closing statement on behalf of UK Health and Security Agency by MR RAWAT

MR RAWAT: Good afternoon, my Lady. As you can see, I've opted to stand.

I appear today on behalf of the United Kingdom Health and Security Agency, or UKHSA, as it has been called during this module.

UKHSA is an executive agency of the Department for Health and Social Care and today I appear with Ms Verrall-Withers.

I'll say a little something about UKHSA's role. That role is to protect the public from infectious diseases, as well as external hazards, including biological, nuclear, and environmental threats.

UKHSA brings together expertise from several predecessor organisations, including Public Health

England or PHE.

UKHSA's capabilities lie in, for example, health protection science and data analytics and surveillance and it responds to future health security hazards by collaborating with the NHS, among others.

My Lady, with an eye to the future I want today to touch on three issues which have been explored during the Module 3 hearings, the first being infection prevention and control guidance. Or, as we've all called it, IPC guidance.

One issue that may arise in relation to IPC guidance is how it evolved over the course of the pandemic and it's useful to make some observations about the developing understanding of the virus. First, as with any other novel virus, PHE's initial understanding had to be based on available research on other genetically similar viruses. That showed that such viruses were transmitted via touch, contact with contaminated surfaces or materials, and respiratory. This evidence base, in turn, informed consideration of likely routes of transmission.

Second, defining particle sizes in relation to the transmission of Covid-19 is not a helpful metric as the transmission of infectious airborne particles depends on many environmental factors. Recognising that, better

informs the choice of the most effective measures of mitigation for all respiratory infections and those measures include ventilation and the physical separation of patients.

Third, many infections are transmitted through the respiratory route where airborne components may play a role. However, emerging evidence is critical to determining the public health response.

Fourth, while over the course of the pandemic the national and international understanding of the contribution of airborne transmission evolved, the precise delineation of particle sizes and the extent to which evidence supported the dominant transmission route through the different phases of the pandemic remains unclear.

And finally, PHE recognised the possibility of asymptomatic transmission as early as 28 January 2020. However, at that time, while the clinical evidence did not rule out the existence of asymptomatic transmission, expert opinion and scientific consensus concluded that it was less likely to be the major driver of transmission and there remained insufficient data to assess the scale of it until April 2020.

Turning now to the IPC cell. PHE, and subsequently UKHSA, were not responsible specifically

for IPC in healthcare settings. PHE's role within the IPC cell was to provide technical advice and to support others in their operational delivery of guidance produced by the IPC cell. That guidance was published. It was directed to all four nations and it reflected a consensus view.

The IPC cell demonstrates the importance of having mechanisms for working collaboratively and ways of working evolved during the pandemic and there is now a written agreement between UKHSA, NHS England , and DHSC setting out their roles and responsibilities in relation to IPC guidance in England.

There is an important distinction, however, between UKHSA's role in providing technical advice and contributing to what is national guidance and the work of those responsible for implementing such guidance. That responsibility would fall to healthcare providers in the four nations, and we say that there are good reasons for this.

First, the NHS is the employer of many of those to whom the guidance was directed.

Second, the NHS estate is varied. So what risk assessments are undertaken and how national guidance is to be implemented is a matter best determined at the local level.

And third, that local implementation can draw on the IPC expertise that exists within the NHS.

It's pertinent also to mention the position of PPE in IPC guidance. Your Ladyship has heard about the hierarchy of controls and, while these form a packet of measures, PPE is the last measure to be considered. It's still important, of course, to have evidence as to the effectiveness of a particular form of PPE, and we can use FFP3 masks as an example. As the Inquiry's own expert Dr Ben Warne explained, there is a lack of high-quality evidence as to the efficacy of such masks, as compared to fluid-resistant surgical masks, and the question of when FFP3 masks should be used therefore demonstrates two factors of wider relevance to the development of guidance.

The first is the need to balance benefits against harms.

Using an FFP3 mask can make communication with patients more difficult. Prolonged use of such a mask can lead to pressure sores and the risk of infection.

The second factor is that there may be a difference between a person's perception as to the effectiveness of a piece of equipment and the evidence of that effectiveness. You'll remember, my Lady, the evidence of Professor Dinah Gould, who spoke of

hand washing being seen as more effective than the use of an alcohol rub even though the latter was recommended in IPC guidance.

There is, therefore, a need for more research in the field of IPC. Now -- including clinical trials to strengthen the evidence base for specific interventions.

My Lady, can I move on to a second matter, which is the shielding programme.

This was a protective programme recommended by SAGE which aimed to reduce mortality in, and offer practical support to, those individuals who were predictably most at risk from Covid-19. It was a novel programme, only made possible by the structure of the National Health Service in the United Kingdom. The programme was always voluntary and this was made clear in guidance and in public health messaging.

You'll be familiar with the terms "clinically vulnerable" and "clinically extremely vulnerable". The clinical basis for the CV and CEV lists was a condition-led process which was reviewed throughout the pandemic, with additional groups being added as it progressed.

The development of QCovid, a risk prediction tool, allowed for the adding of patients using a data-driven approach.

The shielding programme itself was an exercise in balancing benefit and risk. It was recognised at the time that while shielding conceptually was likely to reduce the risk of severe disease in the most vulnerable, it brought with it risks, such as an impact on mental health.

You have heard evidence about the operation of the programme, about its effect on individuals, and from Professor Snooks about its effectiveness.

A fundamental problem with trying to evaluate the shielding programme, however, was the lack of a control group and the studies cited by Professor Snooks reflect that crucial difficulty. They also reflect the inability to disentangle the impact of shielding from that of wider non-pharmaceutical interventions.

Given the lack of a robust evidence base to show that shielding did not work, our submission is that Professor Snooks' central conclusion in relation to the future use of this strategy is one that lacks the necessary rigour.

The better question is whether if in a future pandemic there is a policy decision to adopt shielding, then how could such a programme be delivered in a better way to reduce the risks that come with it. And there is a wider lesson, we say, to be learned from the shielding

programme, because it highlighted the importance of data.

Identifying individuals as clinical extremely vulnerable was a difficult task about because it required drawing in data from multiple sources and such an exercise can cause delay.

That allows me to move on to the third point that I wished to make submissions on today, and that is the future use of data.

Data preparedness is vital in responding to future health threats, including pandemics. As Professor Harris observed, much of UKHSA's work involves interpreting data. And to give an example relevant to this module, while UKHSA cannot and does not advise NHS England on operational matters, its analysis of data allows it to give advice and contribute to actions taken to improving health responses both for patients and for healthcare workers. And reference has been made during the course of these hearings, for example, to PHE's analysis of disparities in the risks and outcomes of Covid-19 and to the impact of the virus on BAME groups. Your Ladyship is also aware of the ongoing SIREN studies which are examining the impact of Covid-19 on a cohort of healthcare workers.

A key lesson from the pandemic, therefore, is that

data sharing could be improved, particularly by more clearly defining roles and responsibilities and accountability to underpin a culture of data sharing and to establish the platforms that are needed to make improvements in the future.

UKHSA has a published data strategy and as a body with a surveillance role, it wants the best data. However, the agency relies on other organisations across the healthcare sector for the provision of timely and robust data. Improving how the system collects and uses data is not for UKHSA alone. The agency is, however, committed to working with the relevant bodies to improve and implement data utilisation within healthcare.

My Lady, can I finally draw these threads together by setting out some headline points which are, we hope, focused on the future and which we will develop in our written closing submission.

The first is, and this is as your Ladyship will be aware, that the IPC cell operated on a multidisciplinary basis. And looking forward that approach is one that could be broadened to ensure that the production of guidance is informed by as wide a range of views as possible. And those views come, for example, from hospital engineers or even from those who have to operationalise and use national guidance at a local

level.

Second, we should not ignore the importance of ventilation as an IPC measure. Improving ventilation in the NHS estate, whether temporary or permanent, would bring benefits.

Third, and returning to the need for more research in IPC, the effectiveness of FFP3 masks does need to be investigated. And if as a result, their use were to be more -- were to be recommended on a more routine or a wider basis, then there would be a need for a permanent cadre of staff trained to fit such masks.

Fourth, and you'll be aware, my Lady, that during the pandemic when the shielding programme was up and running, the clinical aspects of it were overseen by Professor Harries, when she was the Deputy Chief Medical Officer, and then she returned to that co-ordinating role when she subsequently became chief executive of UKHSA. But, again, looking forward, we say that the clinical aspect of any future shielding programme should be led by a senior responsible officer operating at departmental level. That is not a role for UKHSA, given its remit, but ideally it does -- it would be a role for DHSC given its position within the healthcare system. And that co-ordinating role could then take forward the bringing together of key clinicians, including from

UKHSA, NHS England, and the devolved administrations, to create a group that would then have links to relevant policy teams across government and be supported by a dedicated digital team to better be able to identify clinically vulnerable individuals.

My Lady, the final point we make is, again, returning to the question of data.

Being able to obtain data from multiple sources quickly means that you can more accurately assess individual risk rather than putting people into very broad categories. It therefore makes for more focused interventions.

Advances in technology means that tools which are even more sophisticated than QCovid was can be developed for future pandemics. However, before we can use technology to get a head start on the next pandemic, there is a need for a conversation on how to improve data sharing, and what regulatory frameworks are necessary. Given the legal and ethical issues that arise, and that there are competing interests, this will not be an easy conversation, but it is one that needs to begin now.

My Lady, those are the submissions on behalf of UKHSA.

LADY HALLETT: Thank you very much indeed, Mr Rawat, I'm

very grateful.

Ms Murnaghan. I thought I saw you behind Mr Rawat.

MS MURNAGHAN: Yes, my Lady.

Closing statement on behalf of Department of Health Northern Ireland by MS MURNAGHAN KC

MS MURNAGHAN: Thank you very much. This is a closing statement which I wish to make on behalf of the Department of Health of Northern Ireland, which I'll refer to as "the department".

The department wishes to emphasise that it has carefully listened to and reflected on all of the evidence adduced and the issues that have emerged over the course of these hearing sessions. In these submissions, the department would like to expand on and address some issues which pertain to its work.

And the first thing, my Lady, that I'd like to touch on is the issue of the DNACPR and, as recently as this afternoon, of course, my Lady, many witnesses, including those from Northern Ireland have been asked about the use of DNACPR or do not attempt cardiopulmonary resuscitation notices.

The department, my Lady, is very conscious of individual bereaved families' concerns around the particular circumstances in which such notices were

used, and in particular the communication in respect of same. Nevertheless, it is hoped that it should be clear that in Northern Ireland blanket decisions or policies based solely on age, disability or a clinician's view of quality of life did not occur. Not only was there never a policy for the blanket use of DNACPR notices in Northern Ireland, but there was also no increase in the use of such notices during the pandemic.

Indeed in 2022, our former health minister, Mr Swann, launched a policy which provides a framework for advanced care planning for adults in Northern Ireland. The advanced care planning policy aims to support people in having greater choice and control over decisions about their future.

Central to this is ensuring that individuals have regular opportunities to express their feelings, wishes, beliefs, and values, in relation to advanced care planning. Those aspirations will then be reflected in the care, support, and/or treatment that they will receive. This policy will mean that difficult decisions around DNACPRs will be avoided in future.

The department considers that individuals should be encouraged and indeed empowered to have conversations about what matters to them as they approach the end of life.

Now, my Lady, another issue that we'd like to mention is the potential confusion arising out of some of the PHE evidence, and the department is concerned that there is the potential for some confusion following evidence that was given by Mr Aidan Dawson, given that he only took up his role as the CEO of the Northern Ireland PHA from 1 January 2021. This confusion may have arisen from evidence in relation to professional and technical matters which may, in the department's view, be outwith Mr Dawson's personal and professional experience and knowledge, given the relevant time frame within which they took place.

The first such issue was the reference that Mr Dawson made to the difficulties of accessing primary care tracking data in respect of the number of Covid-19 cases. The department considers that Mr Dawson's evidence on this matter does not fully explain the situation.

Following the establishment of Covid-19 centres in March and April 2020, which had been developed in partnership with GPs and the five HSC trusts, GPs submitted data to newly developed data collection processes which were created and managed by the then HSCB directors of Integrated Care. While the process was manual and labour intensive, GPs did participate in

the process willingly and proactively, both in the establishment of the Covid-19 centres and in the provision of the data required.

Reports that were based on the data collected were presented by the then director of Integrated Care at the HSC silver meetings.

The second issue, my Lady, is in relation to the agreement that Mr Dawson had with Counsel to the Inquiry's suggestion that the PHA in Northern Ireland had failed to identify the importance of widespread testing of healthcare workers and patients in various settings. While Mr Dawson may legitimately consider that the PHA failed to recognise the importance of testing, this does not accord with the opinion or experience of the department with respect to the operational implementation of testing by the PHA.

Neither was this the experience of the expert advice provided to the department by the Expert Advisory Group on Testing, which was chaired by the PHA.

The department did not fail to recognise the importance of widespread testing. This, of course, should not be conflated with the fact that, in the early stages of the pandemic, there was a lack of testing capacity, which was accompanied with the need to prioritise the limited number of tests available.

The department considers that this is an important distinction to draw.

My Lady, I'd also like to make some comments around data collection in Northern Ireland, and much has been said about the quality of data collection in Northern Ireland in relation to disabilities, ethnic minorities, those suffering with Long Covid, and other vulnerable groups.

Criticisms have also been made about data collection in respect of healthcare workers and Covid.

While the ethnic composition of the population of Northern Ireland is materially different to the rest of the UK, it is accepted that Northern Ireland's performance in this area was lacking during the pandemic. However, the department wishes to dispel the impression that just because such data was not adequately monitored does not mean that the impact on those groups did not matter.

The department would highlight the significant practical and operational steps that it took, as well as steps taken by the PHA, across the totality of the pandemic response with respect to ethnic minorities. These steps included communication and engagement with the ethnic minority groups in relation to testing, isolation and vaccination.

Since 2015 the department has been planning the introduction of an electronic record system that digitises health and social care records known as encompass. A phased rollout of encompass began in November 2023 and at present it is in place in three out of five of the health trusts. The two remaining trusts are scheduled to implement encompass in 2025.

We acknowledge that encompass is not a panacea but it does address deficiencies in information gathering in respect of ethnic minorities in Northern Ireland. The changes that encompass implements will address the department's inability in 2020 to consider ethnicity in its Coronavirus health inequalities reports, when information on ethnicity was not uniformly collated across the system.

My Lady, I'd like to say something now about health inequalities, and tackling health inequalities is a priority of the Minister of Health, Minister Nesbitt, and he has announced an initiative called Live Better. Live Better is designed to bring targeted health support to communities which need it most. This initiative will focus initially on health and social care services, and will look at better alignment of and access to existing resources and services.

Live Better is focused on the outcomes, summarised

as Starting Well, Living Well and Ageing Well. For example, my Lady, Starting Well will focus on improving issues such as regional areas of low immunisation take-up amongst children. Living Well will tackle health inequalities such as preventing disparity in diabetes in lower socioeconomic groups. The Ageing Well component will focus on the benefits and importance of physical activity to help the community live longer and stronger.

Recognising that health inequalities is an issue which requires action across all parts of government, Live Better has been referenced in the draft programme for government, published by the Executive Office in September 2024.

There is also a new framework for planning health and social care services in Northern Ireland: the Integrated Care System. This system is focused on collaboration, outcomes, and person-centred care. It will place greater focus on prevention, early intervention, and community health and well-being whilst ensuring that resources available are maximised.

My Lady, I'd also like to say something now about the military assessment team and its recommendations. In his oral evidence, Mr Swann was asked about the military assessment team's recommendations in respect of

the central control. The department refutes suggestions that there was no central control prior to the military assessment recommendation.

Fundamental to the nature and function of health and social care in Northern Ireland is the application of the principle of subsidiarity. In other words, matters will be dealt with at the most appropriate local level possible, given that those local levels will have the most operational knowledge and the highest level of expertise.

In the case of the central control of the management of critical care, this meant that the Critical Care Network for Northern Ireland was best placed to fulfil this role, and did so expertly during the first surge. However, as the milliary assessment team identified, the role required greater co-ordination given the scale of the pandemic in anticipation of future waves.

Accordingly, a critical care hub was created in early January 2021 to strategically manage critical care admissions and transfers on a regional basis.

My Lady, I'd also like to remark on the question of surge planning, which was addressed in evidence, and the apparent lack of a specific critical care surge plan until 16 April 2020. The department wishes to emphasise

that it is important to note that Northern Ireland has had a critical care escalation plan in place since 2011. This was modelled on a response to pandemic influenza. At the direction of the department in early February and March 2020, significant work was undertaken by the HSCB, the PHA, and the trusts, to adapt the existing escalation plan to the known risks and likely impact of Covid-19, and this plan was published on 19 March 2020.

A summary plan was underpinned by detailed operational plans in each individual trust, and was further revised and updated on 1 April 2020, based on revised Covid-19 modelling and was in place in the low surge period of the first wave.

The basis of these plans was for an escalation of trust, that is to say local hospital level, prior to regional escalation. Even at the highest level of the pandemic such local escalation was not completely exhausted.

Finally, my Lady, I'd like to make some remarks about the Nightingale hospital. The department would like to refute any perception that planning for a Nightingale hospital in Northern Ireland was too slow. The department rejects the suggestion that the Belfast City Hospital was the incorrect location. Whilst at one stage it is correct that the Eikon centre had emerged as

a preferred site, this was before a full viability assessment had been carried out. The department remains of the view that a Nightingale hospital would never have been appropriate as a detached standalone facility in a location such as that of the Eikon centre. Having a Nightingale hospital in such a detached location would have had a significant adverse impact on every other hospital caring for critically-ill patients and providing emergency surgical services. This is because staff from those other hospitals would have had to have been redeployed to that detached location.

As the region had, and indeed continues to have, a finite number of experienced staff to provide critical care support, the approach taken in locating the hospital in Belfast City Hospital was assessed as being more efficient, and lower risk than removing staff from individual trusts to staff a detached Nightingale hospital.

Such an approach, also allowed for continued critical care at hospitals around the region for those patients who were non-Covid.

Finally, my Lady in conclusion, I'd like to remark that this module has been focused on healthcare systems and it should be emphasised that no healthcare system can even exist without its staff.

Over the course of this hearing, many tributes have been paid to health and social care workers for their contribution and commitment during the pandemic. These tributes bare repeating and the department believes that this is an appropriate point at which to, again, express its sincere thanks to those staff for their unerring and unselfish commitment.

Thank you very much, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Murnaghan, I'm very grateful.

Ms McNeill on behalf of the Welsh Government.

Closing statement on behalf of Welsh Government by MS McNEILL

MS McNEILL: Thank you, my Lady.

In opening, the Welsh Government acknowledged that the evidence of the bereaved of frontline NHS workers and the Inquiry's experts would cast an unflinching and critical light on decisions taken in Wales and, crucially, identify those that did not work.

Our written closing statement will address the significant issues which have emerged or crystallised during these hearings, including NHS capacity and critical care capacity in particular, the availability and distribution of PPE, field hospitals, nosocomial transmissions, and the services available to treat

Long Covid.

Today, my Lady, I will concentrate on the important and complex question of recommendations.

In considering potential recommendations, the Welsh Government's views have been formed by two principal factors.

First, any recommendation should clearly and effectively address a clear deficiency or problem arising from the evidence.

Secondly, although there is no ideal number and the Inquiry will make such recommendations as are considered necessary to cure any significant deficiency, this may be a situation where the Inquiry is better assisted by an approach of less is more.

To that end the Welsh Government would put three potential recommendations before the Inquiry for its consideration.

First, establishing a reserve NHS workforce list that could be swiftly deployed in a public health emergency.

Second, establishing arrangements to be overseen by the NHS Executive in Wales for collating, reviewing and implementing NHS healthcare-related recommendations in order to ensure effective and consistent implementation.

Thirdly, establishing arrangements to ensure greater consistency in the implementation of Welsh Government policy by NHS bodies in Wales.

Returning to the first, my Lady. An NHS reserve workforce would consist of recently retired NHS employees and possibly former military medical personnel who could be called upon, if required, for a fixed term following their retirement. Although the detail of pay, conditions of service, and professional obligations pre-eminently continuing professional development would need to be carefully considered, in principle there is much to commend a mechanism which allows the NHS to increase its personnel swiftly, significantly and at short notice.

As to the second recommendation, there is a systemic and chronic issue about how best to ensure that recommendations and learning from public and other inquires are effectively implemented so that the identified problem is cured. That concern has been recently echoed by statements in the Thirlwall Inquiry that the many recommendations made by various healthcare investigations over the past decade have not been implemented effectively or at all.

This Welsh Government's second proposed recommendation is designed to address that problem in

Wales by ensuring that the Welsh NHS Executive collects and considers all relevant recommendations to make sure that they are effectively implemented. The substance of the arrangements for doing so will be informed by this Inquiry's findings about the effectiveness of implementation.

The aim of the Welsh Government's third recommendation is to address unnecessary inconsistency between relevant health organisations in their application of Welsh Government policies, with a view to achieving more effective and efficient application.

One point that has emerged from the evidence is the incidence of avoidable inconsistencies in local health boards' applications of Welsh Government policies on, for example, visiting restrictions, where those inconsistencies are not explained or justified by local requirements.

This proposal is aimed at ensuring greater consistency while not interfering with or limiting the local health boards' discretion to tailor clinical provision to local needs.

My Lady, I should finish this closing statement with the assurance that the Welsh Government has carefully and humbly listened to the evidence that has been adduced offer the past three months. That was

reflected in the evidence of ministers and of senior officials.

The Welsh Government's written closing statement will deal with the one stance of Module 3 evidence but, as it is recognised in opening, the Welsh Government accepts that not every measure was as effective as was hoped and there will be criticism of some decisions and policies.

In that light, the Welsh Government will continue to give every assistance to the Inquiry as it continues its necessary and valuable work.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms McNeill, very grateful.

Mr Mitchell for the Scottish Government.

Closing statement on behalf of the Scottish Government by GEOFFREY MITCHELL KC

MR MITCHELL: Good afternoon, my Lady.

This is the oral closing statement on behalf of the Scottish Government. I appear today along with junior counsel, Ms Julie McKinlay. I am instructed by Caroline Beattie and John McPhail for the Scottish Government Legal Directorate.

Across the United Kingdom the human cost of the pandemic was enormous. Everyone paid a price. The

impact on people, families, communities and the workforce was devastating. Across Scotland, in hospital settings alone, 9,573 people, workers included, lost their lives.

Frankly, we cannot be reminded enough about such statistics. They cannot be forgotten. The Scottish Government expresses its sincere condolences to those who have lost loved ones and those who have suffered and who continue to suffer. We've heard some emotive and upsetting evidence today in that regard.

It also expresses its sincere gratitude for the many sacrifices that people made, often for the benefit of others, and the Herculean efforts of the health and social care workforce, particularly when looking after our most vulnerable.

The Scottish Government has made such statements before and it will continue to make them because in truth there is no limit to the number of times that they can and should be made.

The Scottish Government talks a lot about the core values that underpin the health and social care system in Scotland. Those values, such as care, compassion dignity and respect, are evident in those who perform the day-to-day job of keeping the system going. The pandemic response was a prime example of those core

values in action.

The quality of care provided, the myriad of ways in which people took on new roles and worked across boundaries, and the distress felt by many at what they witnessed in our hospitals and care homes are all testament to those values.

Importantly, the values are on display across the whole of the health and social care system because the response to the pandemic was a whole-system response.

There was collaboration across the whole system for the benefit of people and their families, and Scottish Government worked to ensure that the workforce was supported. Thus, terms and conditions were adapted, a bonus was paid and a life assurance scheme was created.

We submit that the evidence has clearly shown that during the pandemic in Scotland there was public health capability. That is, there was a strategy, there were plans and there was guidance.

We submit that the evidence shows that the response was comprehensive and effective. Certainly at times the system was severely tested and stretched but, as Ms Freeman said, it was not overwhelmed, acknowledging, of course, that others may define that term differently.

Several important decisions were made which, taken together, resulted in an increase in capacity in expectation of the reasonable worst-case scenario. And at in time was the provision of healthcare in Scotland rationed.

It is worth reminding listeners of the guiding light that steered decision-makers through the pandemic in Scotland, namely the four harms approach. This allowed for reasonable and proportionate decision-making in the context where no option was risk free. It allowed for a nuanced approach which recognised risk across the board, and sought to mitigate those risks with a range of measures. It also allowed for an approach that evolved over time in response to specific developments and advancements in our knowledge of the behaviour of the virus.

In our opening statement we highlighted the absence of an NHS trust structure in Scotland. As we believe my Lady recognises, while a local approach have the effect of regional variation, in a country of the size of Scotland it can lead to more effective delivery of the services that matter most in a particular area.

The evidence showed that there was and is a strong collaborative working relationship between the Scottish Government and the health boards. As Caroline Lamb

explained in evidence, it produces a shared understanding of the priority of ministers and consequent alignment of policy, planning and delivery. And, as Ms Freeman noted in evidence, it is important that the highest spending public service and the largest employer is directly accountable to the Cabinet Secretary for Health.

Turning now to specific aspects of the response in Scotland, and looking firstly at capacity issues.

A number of key decisions were taken that increased capacity, allowed staff to be redeployed, and prevented the NHS from being overwhelmed.

Crucially, on 17 March of 2020, Ms Freeman put the NHS in Scotland on an emergency footing. Strategic and operational leadership was required in order to determine which areas should be focused on. Elective and non-urgent healthcare was cancelled. Cancer screening programmes were paused. Covid-19 community pathways for primary care were introduced. Retired health staff, final year medical students and nursing students were brought into the workforce.

The NHS Louisa Jordan, commissioned on 30 March 2020 and officially opened a month later, on 30 April 2020, provided backup to the permanent acute estate if needed.

Sir Gregor Smith and Ms Freeman told the Inquiry that at no stage was the further expansion of capacity, that is the quadrupling of the baseline, exceeded. The CMO was unaware of any resource-based escalation of care decisions being taken. Miss Freeman said there were no discussions at all about the rationing of healthcare. She was concerned that increase in capacity would have consequences for the quality of care. Yet, as she said, everyone worked to make it as good as it can be.

The evidence of Ms Freeman and Ms Lamb showed the Scottish Government closely monitored bed and staff capacity, not simply by means of spreadsheets, but through multiple telephone conversations and meetings throughout the course of a day, with everyone from health board CEOs to the Chief Nursing Officer.

In summary, we submit that the evidence showed a government that had a good grasp of the figures, knew when problems arose and strove to prevent the NHS from being overwhelmed.

Turning now to health and healthcare inequalities. Tackling health inequalities has long been a key mission for successive governments in Scotland. Measures to create immediate capacity in March 2020 were taken, with the protection of the vulnerable in mind. So, for example, the decision to pause non-urgent elective care

was one with which, even in hindsight, all the expert evidence has agreed.

But it had obvious negative effects. The decision balanced different risks and considerations to arrive at a proportionate outcome, albeit one which did not eliminate all of those risks.

Acknowledging the point made by Ms Freeman that it is not only through formal equality impact assessments that a government minister comes to understand equalities, formal assessments did become a regular part of Scottish Government decision-making.

However, as Mr Yousaf candidly recognised, had Cabinet heard directly from disabled people's organisations, it may have helped to inform decision-making, particularly in removing NPIs.

Ministers did engage with ethnic minority stakeholder groups such as BEMIS and, as Professor Bamrah said, with FEMHO. However, as Mr Yousaf acknowledged, the data available on the experience and impact of the pandemic on ethnic minority groups was, in his words, sub-optimal.

To that end, the Inquiry has heard evidence on the steps taken to improve data collection in this regard, including the establishment of anti -- of the anti-racism observatory. This will help to ensure that,

in the future, Scotland has better access to the data concerning ethnic minorities.

Turning to shielding. The Inquiry has heard contrasting evidence about the shielding programme, the Scottish Government is under no illusions about how difficult shielding was for many people. It acknowledges the indirect harms, particularly in terms of isolation, loneliness and mental health. No witness unequivocally suggested that with the benefit of hindsight they would re-run the shielding programme exactly as it had been. The Scottish Government recognised this early in the pandemic and commissioned rapid evaluation of the programme. There are, inevitably, costs and benefits that would have to be weighed in the event of a future pandemic.

The Scottish Government agrees with Sir Chris Whitty that some form of government-backed support framework would be required.

Certainly, the principle of supporting the vulnerable to help keep them safe is one that the Scottish Government does endorse and would endorse in a future pandemic. It may involve a variation on a model whereby people are provided with information and tools to allow them to make personalised, informed decisions, as spoken to in evidence by Sir Gregor Smith.

This would be similar, in fact, to the one that the Scottish Government moved to in May of 2020.

Looking now at infection prevention and control. The Inquiry has heard that by the end of September 2020 there was sufficient evidence to suggest strongly that Covid-19 could be transmitted via the airborne route. The Scottish Government did not close its eyes to the possibility of airborne transmission. From the beginning of the pandemic, the CMO for Scotland kept an open mind and was alive to the prospect.

It was clear, even at that early stage, that aerosol transmission contributed to the spread, albeit thought to be less significant than other routes. The unequivocal statement from the WHO on 28 March that Covid-19 was not airborne was considered by Sir Gregor Smith to be unhelpful.

As the evidence and the understanding of the virus developed, so too did the advice of the CMO and the guidance from the Scottish Government. The issue was discussed at a Cabinet meeting on 8 July 2020, with it being noted that airborne transmission would alter the measures required to protect against infection.

On 4 August 2020, a ministerial submission specifically acknowledged aerosol as a possible route of transmission. It is therefore simply not the case, as

has been suggested, that the Scottish Government has not acknowledged this possibility. In light of the emerging evidence, there was greater emphasis on good ventilation and meeting outdoors to reduce the risk.

All that said, there continues to be scientific disagreement on the contribution made by aerosol spread. WHO's current position is that maintaining a strict dichotomy between droplet and aerosol transmission with reference to particle size is unhelpful, rather that the descriptor "through the air" should be used in a general way to characterise an infectious disease where the main mode of transmission involves the pathogen travelling or being suspended in the air.

Ms Laura Imrie told the Inquiry that following a systematic literature review, ARHAI support this position.

Looking now to PPE. The Scottish Government recognises that the droplet against aerosol debate was not academic or inconsequential. It led to widespread anxiety amongst healthcare workers who felt they were not being provided with appropriate PPE. Many advocated for more extensive use of FFP3 masks. The Inquiry heard from Dr Ben Warne that although such masks would have provided greater protection, the extent to which their widespread use by healthcare workers would have reduced

nosocomial infections amongst that group is unclear.

However, the Scottish Government saw the real difficulties this issue was causing for some healthcare workers who felt that they were not being provided with sufficient protection.

As spoken to in evidence by Ms Lamb, there were several occasions, the first as early as May of 2020, when the Scottish Government recognised the personal preference of healthcare workers to wear an FFP3 mask and issued guidance accordingly.

The Scottish Government recognises that notwithstanding every effort made by NSS Scotland to procure sufficient PPE, parts of the healthcare system had, as Ms Freeman put it, concerns about getting their hands on PPE that she knew we had. At the beginning of the pandemic there were clearly issues for workers on the ground, as highlighted the BMA and spoken to in evidence by Rozanne Foyer of the STUC, and Professor Colin MacKay from Greater Glasgow Health Board. There were particularly acute difficulties for the Scottish Ambulance Service. The Scottish Government reacted quickly to these issues.

Ministers met with union representatives and subsequently set up a helpline so that healthcare workers could report problems directly. This enabled

issues to be raised, heard and quickly acted upon.

The Scottish Government also recognised the difficulties with face fit testing, particularly for women and ethnic minorities. Concerns were listened to, taken seriously, and concerted efforts were made to improve the PPE provided. Where available, adjustable products were bought to reduce the risk of fit test failures. In June of 2020 the Scottish Government established an expert reference group on Covid-19 and ethnicity to understand better the challenges faced.

As Ms Lamb told the Inquiry, in May and July of 2020 guidance was produced that required health boards as employers to ensure that risk assessments were performed for individual health workers who may be particularly vulnerable, including black, Asian and ethnic minority staff.

In October 2020, the Scottish Government published a PPE action plan which recognised the challenges faced by such individuals and detailed the ongoing work to resolve this issue.

By March of 2021, NHS National Services Scotland were providing at least eight different models of FFP3 masks to ensure that the majority of healthcare workers could be provided with a mask that fitted.

My Lady, turning finally to Long Covid.

Of course, every pandemic is different and different viruses produce different long-term sequelae, but as Sir Gregor Smith frankly acknowledged, Scotland was not prepared to deal with either the volume or type of long-term sequelae that Covid-19 produced. Recognising that Long Covid comprises a number of different syndromes and that it is consequently not straightforward either to diagnose or to treat, fairly significant steps have been taken in Scotland to redress the balance. A Long Covid Support fund of £10 million was established, from which resource has been allocated to health boards to use as they deem appropriate for their populations to deliver the best models of care. All 14 territorial health boards in Scotland now have rehabilitation and clinical pathways for Long Covid patient referrals.

My Lady, in conclusion, a key learning point from this and from other modules is that too rigid a plan for future pandemics is of limited value. All pandemics are different. By contrast investment in Scotland's health and social care system is of value, as too is strength and depth of relationship, trust that permits honest conversations, and decision-making that is unrestricted by organisational boundaries.

Counterintuitively, the pandemic had some positive

effects on the health and social care system in Scotland. It has placed us in a stronger position to respond in the future. For example, the detailed planning that went into the rollout of the vaccine programme, Test and Protect, and the National Treatment Centres has helped to change forever the nature of public sector service planning and design in Scotland.

Again, the reality of responding to a global pandemic at pace, with implications for every aspect of society, has led to improvements in how people are redeployed at speed and how capacity can be supplemented in creative ways.

Further, there is the success of the NHS 24 programme. It has led to a 10% reduction in people presenting at Accident & Emergency. Also the Integrated Clinical Hub, now used by the Scottish Ambulance Service, provides enhanced remote triage to patients who present with urgent care needs, and ambulance crews with access to clinical advice and support whilst on scene. The effect has been to reduce by 50% the number of ambulance call-outs that result in conveyance to A&E.

But, my Lady, we end where we began, with the human cost of the pandemic.

The Scottish Government once again passes its sincere condolences and sympathies to those who have

lost loved ones and to those who have suffered and continue to suffer. And it once again acknowledges the efforts and sacrifices of our health and social care workforce during the pandemic.

My Lady, those are our oral submissions. Thank you.

LADY HALLETT: Thank you very much indeed, Mr Mitchell, I'm very grateful.

It's been a long day emotionally if not time wise, so I think we'll close there, and I understand the next speaker isn't here today anyway.

So I will resume at 10 o'clock tomorrow morning.

MS CAREY: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Carey.

(4.00 pm)

(The hearing adjourned until 10.00 am on Wednesday, 27 November 2024)

INDEX