Wednesday, 27 November 2024

(10.00 am)

CLOSING SUBMISSIONS (continued)

MS CAREY: Good morning, I hope you can see and hear us okay.

LADY HALLETT: I can, Ms Carey, thank you. I understand there have been travel difficulties this morning, which I, of course, have avoided. I hope everyone has not had too awful a journey in.

MS CAREY: No, I think we're all in here now and the first closing submissions this morning are coming from Ms Grey King's Counsel.

LADY HALLETT: Thank you very much.

Ms Grey.

Closing statement on behalf of NHS England by MS GREY KC

MS GREY: My Lady, I make these submissions on behalf of NHS England.

We would like to start by thanking this Inquiry, and its chair, for a productive and helpful set of hearings. In particular, we'd like to record our appreciation of the hard work of the Inquiry team, including a thank-you to the Inquiry and Hestia staff for their first-rate behind-the-scene support of witnesses and attendees.

We say thank you for not making this set of

hearings personal. The Inquiry has generally focused on issues rather than individuals.

Our next thank-you is to all those witnesses who came forward to give evidence, sometimes at a high personal cost. It's not been easy, especially when critical and sometimes intemperate comments on social media accompany the public appearances.

Finally, we say thank you, again, to the NHS's staff, who did extraordinary things at a high personal cost during the pandemic. The NHS's overriding goal throughout was always to treat as many patients as possible with the resources that were available. That inevitably led to overstretching those resources, including our staff, causing exhaustion and trauma.

The Inquiry has shone a light on these costs, and we'd ask it to record how magnificently staff, including outsourced workers and private contractors, rose to the challenge and to ensure that this rings out clearly from this module's report.

The Inquiry is charged with producing a factual narrative account of the response in this module of the healthcare sector, and with identifying any lessons learned as a response.

We'd like to make five very high-level points regarding that task, concerning first, the context in

which the NHS operated, an unprecedented global pandemic of a scale not seen for over a century; secondly, structures for dealing with emergencies; then dilemmas, balances and risks; fact-finding about decision-making and, finally, the topic of recommendations.

Things that we're not covering orally include many areas of complexity and debate such as critical care capacity, overwhelm, more specific services such as NHS England. We simply can't do justice to many complex matters in brief oral remarks. We'll do so in writing.

But no one listening now should conclude that because we can't address an issue now, it's being disregarded. To take only one example, we recognise the importance of the inequalities investigated. There's a journey here which requires much further work. As Ms Pritchard said in response to a question from FEMHO about the structural inequalities the pandemic exposed, I agree we need to do more.

Moving to the five themes.

First, it was a global pandemic, a genuine unpreventable catastrophe. At times, the fact that the world was in the midst of a human calamity has seemed remote from these ordered hearings. Burial sites were overrun and mass graves were dug in Iran and Ecuador. Italian hospitals were overrun, Spanish care homes

abandoned. These were the images before decision-makers in the first months of 2020, painting a frightening picture of a disease for which there were no known treatments or vaccines.

Covid has caused around 27 million deaths globally directly or indirectly. It was a tsunami which came at us hard and fast.

NHS England co-ordinated the NHS response to this disaster. We took this task head on and quickly by declaring a level 4 emergency, the highest level of response, giving us the authority to pull all the available levers to increase capacity.

From the start we were trying to provide as much care as possible to patients by stretching the resources we had. Sacrifice was an inevitable consequence and, sadly, suffering was an unavoidable reality, when reacting to a pandemic of this scale.

This applies to staff. You've heard from Ms Pritchard about how more headroom would have allowed a more measured buildup, but realistically we will never build enough headroom to avoid surge measures.

It also applies to patients, patients who experienced the postponement of care or diluted care or curbs on visits. But all of these were fundamentally necessary steps, even if there were issues and lessons

about the exact balance struck.

In a pandemic there are limits on what is preventible. In saying this, we're not denying the duty nor the importance of doing everything possible to protect both patients and staff, and NHS England worked hard to do this and fully accept the importance of learning lessons on how to do things better. And looking back, we recognise that some harms could have been better mitigated with more attention paid to specific interests or issues.

But it's still important not to judge what happened against unattainable ideals.

Turning to structures for dealing with emergencies. The NHS is a complex system and it always will be. In an emergency it needs clear direction. NHS England's EPRR structures were well established by 2020, and moving to level 4 offered clarity about the national response. NHS England believes that we were able to provide effective national co-ordination and support to local NHS organisations working alongside government but operationally focused.

The Inquiry has asked others within the four nations about whether they needed an NHS England, and has heard varying responses. We don't say that one size fits all. We do suggest that within the ecosystem of

the NHS in England, the oversight and co-ordination provided was an asset.

We were able to do things quickly based on the information we'd gathered. The situation was highly stressful and right on the edge at times, but there was effective direction of the matters that lay within NHS England's control.

Again, this is not to say that it was perfect but our witnesses have sought to acknowledge and take ownership of those areas where there's a need for learning. The evidence that Ms Pritchard gave about how, on reflection, NHS should have been explicitly clearer that guidance needed to apply to outsourced staff is one example of many.

But in terms of lessons for the future, was our response delivered through the right structures, the National Incident Response Board, the cell system, regional teams? NHS England completely re-organised itself, creating over 200 Covid cells and workstreams. These hearings have covered the work of perhaps 10% of them.

Generally, our view is that our structures offered clear lines of accountability, rhythm and an informed response. The UK-wide IPC Cell has been the focus of much attention. The Inquiry has heard of a lack of

clarity on decision-making roles in a context in which UKHSA and national IPC leads all had a stake. There was no malintent here. If there were such failings, they derived from the desire to pitch in.

To quote Sir Chris Whitty:

"... I don't think the people involved were exactly clear, although they were all trying to do their bit -- this was not [an abdication or] an abrogation of responsibility ..."

As UKHSA noted yesterday, there's now a written agreement between UKHSA, NHS England and the DHSC setting out their roles and responsibilities in relation to IPC guidance in England.

So what more should be done to plan for such collaboration in advance? What are the peacetime changes to emergency response structures that should be made to address points of weakness, whether within the central EPRR structures, or in relation to engagement with stakeholders? Do any of these translate into recommendations for change at the regional or national level?

Turning to dilemmas, balances, risks and the precautionary principle.

And to more specific elements of our response, witnesses called have demonstrated the dilemmas that

NHS England, with others, faced. The witnesses have equipped the Inquiry in turn to think about the balances struck.

You've heard debates about whether decision-makers applied a precautionary principle, but also that the balance of risk is a more helpful framework.

Sir Chris Whitty described it well when he said in oral evidence:

"... I think people have talked loosely of the 'precautionary principle' ... I consider [it's] only a useful principle where there are no downsides, otherwise you're talking about balance of risk and balance of risk is a different concept."

We specifically urge the Inquiry to adopt the latter framework, when considering lessons learnt. We can't think of policy choices that have no downsides, or additional precautions that do not come at a cost.

But we would welcome the Chair's views on issues such as the balance of risk between the harm to staff from redeployment, staff overstretch and, at times, overwhelm, set against the moral harm of its anticipated alternative, ie the routine or categorical denial of care. To avoid the risk of the latter happening, what options should first be exhausted?

Second, at the risk of oversimplification, how do

you balance the risk of more people becoming infected and dying against providing the best support and access to the individual receiving care? There was poignant testimony on the effects of a lack of physical access to patients, or the absence of support from partners and carers. But we also know of concerns about visits, and that these weren't unreasonable, given that there was likely to be a considerable risk of transmission from visitors at times of high community prevalence, to quote the Inquiry's IPC experts.

Again, how much engagement and consultation is realistic, not in general but at specific points in time when set against the need to move swiftly in a fast moving emergency? Weight should be given to realtime learning. For example, the visiting guidance issued at the time of lockdown on 25 March 2020 was amended by 9 April to enable support for those with mental health issues.

Then, what is the balance to be struck between setting a national standard against the value of local organisations being able to tailor solutions to local circumstances? Local NHS estates vary, for example. Can variations based on local needs genuinely be described as postcode lotteries? And if not, can we get better explaining them to people frustrated by

inconsistencies?

Should the principle of individual clinical decision-making remain paramount in a pandemic? We've heard discussion of decision-making tools to guide triage decisions -- some doctors sought them -- but if deployed, such tools would have removed choice from doctors and provoked understandable resistance given the lack of public engagement.

To avoid this, NHS England worked tirelessly to ensure that there was no need to apply systematic rationing guidance. Does Professor Powis's view that a national stakeholder debate should now occur represent a good way forward?

The fourth point relates to fact finding upon decisions taken, and when reaching conclusions we would ask you to remember that decisions were taken at specific points in time with time-bound knowledge. We encourage you, first, to look at the daily sitreps and data, including the modelling scenarios. As Ms Pritchard pointed out with regards to the Nightingales, this Inquiry would be having a very different kind of conversation if those modelling scenarios had materialised and we would have been unable to treat potentially many, many thousands of patients.

Second, we encourage you to consider the resources

actually available to NHS England or the NHS and against that background to consider what the available counterfactual or alternative was that would have saved lives or served patients better. We've heard much about the adverse impact of decisions but frequently less about available alternatives and their potential impact. There was much work done to make the best of resources in a highly imperfect situation, whether that was on supporting the distribution of limited PPE, or using available PCR tests as best as possible.

We also ask the Inquiry not to forget what wasn't covered in oral hearings. We know that they are only a small part of the Inquiry's work. We value the commitment to study all the written evidence, not least as some of the oral evidence has not accurately reflected the division of responsibilities between, for example, NHS England and the DHSC on topics such as the sourcing and distribution of PPE, for example.

We also suggest that, consistently with the terms of reference, the international context should be further explored to understand what others did differently and any lessons. For example, were the nosocomial rates in UK hospitals worse or better than others abroad?

If now outside of the timeline for M3, the Inquiry

could still recommend that research is commissioned here and on other areas of uncertainty, for example on the reasons why Covid-19 struck those with disabilities so very hard. Sir Chris Whitty noted the case for this.

Finally, on the issue of recommendations.

In thinking about lessons learnt we need to ensure that we are not fighting the last war. We've described the pandemic as unprecedented, and it was, but the next one may be equally unprecedented or fundamentally different. It's important to have key elements of the response capability in place including both a population and a health and social care service which are as resilient as possible, and you've heard much about the need for greater resilience.

But after that, it's likely that any response would depend much upon the ability to be flexible and agile. We have to acknowledge that any response will be imperfect and needs to adapt to uncertainties and choices around matters such as NPIs.

Against that background, we commend to the Inquiry both HSIB's and the House of Lords' work on recommendations. You will have seen the House of Lords' report "Public Inquiries: Enhancing Public Trust", and HSIB's "Recommendations but no actions report".

There is a lot in HSIB's work about the challenges

1 faced by the NHS in responding to many diverse
2 recommendations. Equally, you've heard from
3 Ms Pritchard that the NHS is very much a system in
4 recovery. We would urge the Inquiry to make specific
5 and achievable recommendations which take account of the
6 steps or measures already in hand.
7 My Lady, we hope that these comments have been
8 helpful and we look forward to your findings and
9 recommendations.
10 **LADY HALLETT:** Thank you very much, Ms Grey, and they have
11 indeed been very helpful. I am very grateful to you.
12 **MS GREY:** Thank you.
13 **LADY HALLETT:** Mr Hyam is next, I think.
14 **Closing statement on behalf of group of Welsh Health Bodies**
15 **by MR HYAM KC**
16 **MR HYAM:** Thank you, my Lady. I make these closing
17 submissions on behalf of the group of Welsh Health
18 Bodies. The group comprises the majority of Welsh local
19 health boards and a Welsh NHS trust situated in Wales
20 and, collectively, the boards and the trust were
21 responsible for primary and hospital care for the
22 majority of the population in Wales.
23 Like NHS England, we would like to thank
24 the Inquiry for its productive and conscientious work
25 and those thanks extend, of course, to the Inquiry and

1 all of its various teams.
2 At the conclusion of his oral evidence to the
3 Inquiry, Vaughan Gething, Minister for Health and Social
4 Services in Wales until May 2021, was asked by Counsel
5 to the Inquiry if he had one recommendation for how to
6 improve the healthcare system's response in Wales. He
7 said:
8 "... but I think a lot of it is how you make
9 your sure system is as collaborative and as open as
10 possible so you can listen to the real experience of
11 staff and the challenge is how you manage that ... But
12 it is around culture in the service and I think that
13 really matters. Because you're asking staff to put
14 themselves in harm's way and so how you listen to them
15 and value them I think really does matter."
16 A similar question about lessons learned was asked
17 of the First Minister Baroness Eluned Morgan. She said:
18 "I think the NHS did remarkable work, and
19 I think the staff on the front line did remarkable
20 work and there's a lesson there as well to empower the
21 frontline workers I think, give them responsibility.
22 We gave them responsibility and we empowered them with
23 a lot of money. It's very difficult to do that in
24 times of peace but what they did was just incredible
25 under the circumstances, and they acted really, really

1 quickly. And, you know, if we could bring some of
2 that magic back now it would be wonderful."
3 The group of Welsh health boards endorses those
4 observations. They chime exactly with the sentiments
5 and evidence expressed in writing and orally in
6 the Inquiry from members of the group, and were
7 encapsulated in the oral and written evidence of
8 Professor Philip Kloer from the spotlight hospital in
9 Wales chosen by the Inquiry, Glangwili General Hospital.
10 Professor Kloer, too, was asked a question at the
11 close of his evidence by Counsel to the Inquiry and in
12 his two final suggestions pointed in particular to the
13 staff survey of well-being which was referred to
14 a number of times by the Inquiry's counsel.
15 Two points. On learning lessons he said:
16 "We've been very open about our report on staff
17 well-being, the positives and the negatives, and I think
18 many of the hospitals have undertaken similar work in
19 learning what best supports staff well-being in these
20 situations."
21 Lastly he said:
22 "I'd say that really much earlier awareness of
23 the impact of vulnerable groups, so learning what
24 support we should be applying very early on in
25 a pandemic to any vulnerable group, that would be

1 important."
2 Our overarching submission at the close of the
3 oral evidence is that it was clear in Wales that members
4 of the group were working within considerable
5 constraints, in particular infrastructure and resources,
6 but, in fact, performed remarkably well in those
7 difficult circumstances, and have through initiatives
8 such as the transparent reporting of staff concerns
9 sought to learn the lessons of what worked and what did
10 not work well in the pandemic so as to better improve
11 their services for the future.
12 The general themes which emerged in both the
13 initial written statements by the group, and built on in
14 oral evidence included the clarification that the main
15 source of the guidance and advice given to the boards in
16 Wales emanated from the Welsh Government with whom there
17 was and continues to be a good and close working
18 relationship.
19 The view of, for example, Joanne Whitehead at
20 Betsi Cadwaladr University Health Board was that the
21 consultative and collaborative approach that was taken
22 by the Welsh Government towards the health boards was
23 effective and worked well.
24 That sentiment is echoed in other written
25 statements to the Inquiry, such as that of Tracy Myhill,

CEO at Swansea Bay at the outset of the pandemic. She said:

"My impression as Chief Executive was that [the Swansea Bay University Health Board] was more than able to keep the Welsh Government informed of developments within our organisation and in the community that we served."

That evidence should, of course, be considered against the backdrop of the oral and written evidence given by Sir Frank Atherton, Chief Medical Officer for Wales, the general tenor of whose evidence was that the Welsh Government and local health boards worked well and co-operatively together in response to the very challenging circumstances the pandemic presented.

Similarly, a notable feature of Dr Andrew Goodall's evidence was that it was clear that Public Health Wales was in constant communication with the health boards and was not disabled from functioning from the lack of data provided by them.

The group would also note from his oral evidence that Dr Goodall thought that the response of the NHS staff in Wales was, his words "extraordinary". His view was that it was highly professional, committed, and that things worked best when the Welsh Government worked collaboratively with the local health boards and

frontline staff.

In the middle of all the various structures, it was, he said, important to recognise that the collaborative working that came out of the pandemic was a really good thing. My Lady, the group of Welsh Health Bodies agrees.

The Inquiry received evidence from Professor Philip Kloer who was medical director and deputy chief executive of Hywel Dda University Health Board at Glangwili during the pandemic. In addition to his witness statement, he gave oral evidence, the overall evidence which his evidence created was that the Glangwili Hospital had faced considerable challenges due to its infrastructure and capacity but rose successfully to the complexities caused by the Covid-19 pandemic in a way that was caring, compassionate and conscientious.

To the great credit of Professor Kloer, and his hospital, it was clear that Glangwili Hospital had engaged with staff in an open and transparent way through staff surveys and other internal reviews, and he recognised that the staff have responded to the needs of our population in dealing with a pandemic and have gone above and beyond the call of duty at every opportunity. He said that they have at times compromised their own health and well-being and home and family life to

support our patients and colleagues and have worked to ensure that appropriate 24/7 care has been available to meet patient needs across our three counties.

It was clear from Professor Kloer's evidence that this proactive approach meant that Glangwili Hospital management were able to, and did, identify and understand specific concerns raised by staff and patients, for example with respect to PPE, and two reported matters relating to DNR orders. Professor Kloer gave clear evidence of how the local health board was responsive to such concerns, and while he did not seek to diminish the lived experience of those who identified such issues, it was clear that there had been an entirely proper, balanced and considered response to the concerns that were raised, whether it be vaccine rollout, lateral flow testing or purposeful implementation of centralised IPC guidance to an ageing infrastructure.

In terms of lessons learned and recommendations, the issues which Professor Kloer identified in his witness statement and oral evidence are eminently sensible and based on his direct experience of working as a respiratory physician but also as deputy chief executive during the pandemic. It was clear that he had worked tirelessly throughout this period and

conscientiously sought to meet, and to a large extent, had successfully responded to the challenges that arose.

The group note that many of the recommendations he identifies chime with the matters that other health boards have identified in their written evidence, and include -- and I provide this short list -- that any future recommendations would need to look at the existing infrastructure of hospitals in parallel with future pandemic planning; that all modern hospitals should be designed with pandemics or serious infection outbreaks in mind with existing buildings being upgraded; that pandemic planning needs to develop resilience in staffing, medical equipment and supplies; that there should be sufficient PPE stock or at least local capacity to respond and supply such stock, built into the system; the development of reusable PPE would, he thought, change the landscape; that investment in accurate and up-to-date statistical modelling taking into account the Covid experience would be beneficial to all hospitals; the importance of national co-ordination of the senior clinical voice across Wales to ensure the rapid sharing of experience and learning, drawing on the experience of Covid to have pre-prepared guidance developed from the learned experience of Covid that could be rapidly adapted; to harness the learning from

1 rapid development of vaccines to be applied to future
2 pandemics; to share learning internationally on the best
3 ways of maintaining the well-being of clinical
4 professionals to a high-risk pandemic situation; and
5 finally, the development of surge capacity whether
6 through field hospitals, or otherwise, should be decided
7 nationally and funded centrally.
8 In summary, the Inquiry will already be aware from
9 the statements from Ms Paget in her capacity as
10 chief executive of NHS Wales that a considerable amount
11 of work has already been carried out in Wales in terms
12 of seeking to learn lessons from the Covid-19 pandemic
13 and much of that evidence is set out in annex A to her
14 second statement. This is all part of a firm commitment
15 on behalf of all health bodies in Wales to seek to
16 continue to improve the services they provide for the
17 benefit of patients and in the wider public interest.
18 Ms Paget was asked at the end of her evidence
19 whether the patchwork of reviews which had been carried
20 out had been sufficient. Her response was, and I quote:
21 "... I am confident that it has. I am confident
22 that organisations have learnt individually what we are
23 now going to be doing ... we are now going to be
24 reviewing all of the plans that NHS organisations have
25 updated, following their own learning lessons and

1 reflections. We will review those both individually
2 with organisations and collectively through the NHS
3 Executive, and if there are any further learning or
4 lessons that we need to address then we will do so."
5 My Lady, much learning has already taken place.
6 There is no question that to build resilience to
7 a future pandemic the hospital infrastructure and estate
8 in Wales needs capital funding and upgrading, including
9 improving ventilation systems and the like. Of course
10 one must be realistic as to the resources and capital
11 funding available to the government in Wales for
12 hospital improvements, but the group lives in hope.
13 As, my Lady, you observed to Professor Kloer at
14 the end of his evidence, even institutions that start
15 with Nissen huts can become like Heathrow.
16 Thank you very much.
17 **LADY HALLETT:** Thank you, Mr Hyam, I'm very grateful to you.
18 Right, Mr Stanton, BMA.
19 **Closing statement on behalf of the British Medical**
20 **Association by MR STANTON**
21 **MR STANTON:** Thank you, my Lady.
22 The closing statement of the British Medical
23 Association is as follows. The evidence heard during
24 this module has reinforced the BMA's belief that, while
25 a pandemic or health emergency is always likely to put

1 enormous strain on healthcare systems and the people who
2 work within them, the severity of the impact was not
3 inevitable.
4 What is more, almost five years on from the start
5 of the pandemic, the UK's health systems are in an even
6 worse position to cope with day-to-day care, let alone
7 an emergency.
8 Waiting lists across the UK are around
9 9.4 million. There are severe staff shortages. Bed
10 numbers remain far too low. The UK's maintenance
11 backlog sits at 17.3 billion. Staff mental health and
12 morale is in crisis. And population health and
13 inequalities have worsened.
14 Against this background, the task of your inquiry
15 has never been more urgent and critical, and this
16 statement highlights the key areas of evidence that the
17 BMA asks you to take into account as you develop your
18 report.
19 It is in four main sections. First, the lack of
20 capacity within the UK's healthcare systems.
21 Second, the failure to protect healthcare
22 workers from harm.
23 Third, impacts on staff and patients.
24 Fourth, recommendations.
25 In respect of capacity, the Inquiry's Module 1

1 report found that health and social care services were
2 running close to if not beyond capacity in normal times.
3 This lack of capacity includes insufficient numbers of
4 staff and beds, as well as inadequate physical and
5 digital infrastructure. And during the past ten weeks
6 of hearings, this inescapable reality has been
7 reinforced by almost every witness, including
8 the Inquiry's experts, all four CMOs and CNOs, the heads
9 of all four health services and the political leaders of
10 all four governments.
11 It is vital that when the next emergency occurs,
12 the UK's health systems start from a for more resilient
13 baseline.
14 In respect of staffing, when the pandemic began,
15 the UK had a shortfall of around 40,000 doctors per
16 capita compared to OECD averages. There were nearly
17 40,000 nursing vacancies in England alone, a shortage of
18 around 2,000 midwives and obstetricians, 50% too few
19 anaesthetists, a 10% critical care vacancy rate, and too
20 few GPs to meet patient demand.
21 In the words of a consultant from a BMA survey:
22 "What I needed most during the pandemic were the
23 colleagues I was already missing."
24 And to redress this shortfall will take time and
25 significant investment because, as described by

Professor Summers, you can't just magic up the staff you need.

In addition, ageing estates meant that infection control measures could not always be fully implemented. Witnesses described working in unsuitable spaces with large open bays and inability to distance between beds, a lack of side-room capacity to isolate patients and a lack of ventilation. In the words of Michael McBride, there is no doubt that the "fabric" of NHS estates increased the risk of nosocomial infections.

Over 9,000 deaths are attributable to nosocomial infection in England alone, and we have heard many moving stories of those whose loved ones were admitted to hospital in circumstances unconnected to Covid-19 only to become infected and tragically die.

Regarding the debate about whether the NHS was overwhelmed, the BMA points to the fact that vast swathes of care had to be cancelled and patients who would normally have received treatment did not.

Healthcare workers were physically and emotionally overwhelmed and they still bear the scars today.

To downplay these impacts, intentionally or not, is a mistake. The BMA accepts that the decision to run the NHS in this way is a political one, however the Inquiry proceedings have laid bare its catastrophic

consequences, which are destined to be repeated without fundamental change.

Moving to the failure to protect staff from harm.

Witnesses, including Professor Sir Chris Whitty and Dr Warne, have confirmed that healthcare workers were at higher risk of infection from Covid-19, and ONS data suggests that this increased risk was six times that of the general population.

Despite this increased risk, the Health and Safety Executive abrogated its responsibility to protect staff by failing to challenge the adequacy of the IPC guidance, to act on concerns raised by organisations such as the BMA, and to ensure that employers complied with their health and safety responsibilities.

The HSE's guidance on RIDDOR, the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations, inexplicably sought to discourage the reporting of infections by setting an unnecessarily high threshold for reporting.

In the first two years of the pandemic, medical examiners found 357 cases of healthcare worker deaths from workplace exposure in England alone, compared to just 170 deaths reported through RIDDOR in England, Wales and Scotland combined.

Indeed, BMA analysis of ONS data found that the

number of healthcare workers who died during the pandemic may be almost five times higher than the number reported through RIDDOR.

Accurate, detailed and transparent reporting is vital to understand the spread of infections to ensure workplace safety, to facilitate access to compensation for staff with Long Covid, and to recognise and pay tribute to healthcare workers who died while caring for others.

And in this latter regard, the approach of the NHS during the pandemic is in stark contrast to the way in which other organisations, such as the armed forces, police force and fire service, honour those who die in service.

In relation to PPE, some witnesses have stated that the UK never ran out of PPE and that the problems were with distribution. However, the BMA's position is that if a healthcare worker who needs PPE does not have it readily available and is thereby exposed to risk of serious injury, then this is a PPE shortage, regardless of whether the problem relates to distribution or stock quantity.

The Inquiry has heard shocking evidence about the lengths to which healthcare workers were forced to go to source PPE, including wearing makeshift items out of

bin bags, ski masks, swimming goggles and cagoules, while others purchased equipment from DIY stores.

In an example provided to the BMA by a GP in England:

[As read] "We had no PPE. Our first delivery was a box of 20 masks. This was for a surgery of 22,000 patients and 50-plus staff. We made our own face shields with the use of a 3D printer loaned to us and we made aprons from bin liners."

In respect of respiratory protective equipment such as FFP3, the Inquiry has been provided with a very significant amount of information about airborne transmission, and the BMA will address this issue in detail within its written closing statement.

For present purposes, the BMA simply restates its position in light of the evidence heard during the hearings and briefly responds to the points by those who argue against the wider use of FFP3.

It was known prior to the pandemic that coronaviruses are transmissible through aerosols not merely droplets and that respiratory protective equipment (RPE) provides far greater protection against the airborne virus than a fluid-resistant surgical mask. Indeed, fluid-resistant surgical masks are not even classified as PPE.

The recommended RPE for routine treatment of SARS-CoV-1 in 2013 was FFP3, and decision-makers were aware from the very outset of the pandemic that SARS-CoV-2 could transmit via aerosol.

In response to this risk from a deadly disease, a precautionary approach should have been taken through the recommended use of FFP3 for all staff caring for patients with or suspected to have Covid-19.

Instead, FFP3 was restricted to just intensive care and to aerosol-generating procedures, through a combination of concerns that intensive care might run out of FFP3, fears that staff might refuse to work if the recommended RPE was not available, and an over-reliance on droplet transmission.

Worse, once the evidence in support of aerosol transmission became clear, the IPC Cell stubbornly refused to change their approach, seemingly more worried about not wanting to look like they'd got it wrong and advancing before this Inquiry a series of after-the-event justifications such as comfort and the need for further studies.

The BMA has been astonished by the doubts expressed at the effectiveness of FFP3 respirators. As mentioned, there is clear evidence of their superiority, and witnesses, including inquiry experts, have provided

evidence that those working in intensive care experienced lower levels of infection because of the enhanced protection available to them.

Further, if the efficacy of FFP3 is seriously in doubt, why are they recommended for intensive care and aerosol-generating procedures?

Attempts to justify the failure to recommend FFP3 based on considerations of comfort are equally surprising. PPE can be uncomfortable but this is nothing balanced against the need to protect against a deadly disease transmitted by everyday actions such as coughing, sneezing, talking and breathing.

These arguments are simply a continuation of the stubborn refusal to acknowledge the risks of aerosol transmission, to recognise they'd got it wrong and to take remedial action.

In the words of a doctor in Scotland:

[As read] "The PPE guidance was based not on safety but rather the lack of preparedness. False platitudes of staff safety were peddled out when in fact staff were left at higher risk."

Staff confidence in the IPC guidance is essential for safety, and the widespread loss of confidence is a very serious concern. It is a matter of regret that the opportunity has not been taken to restore confidence

by properly explaining the risks faced by staff and the extent to which supply shortages were a factor. Importantly, Covid-19 is still circulating today and staff still do not have access to adequate RPE.

The IPC guidance in all four nations continues to recommend a fluid-resistant surgical mask for routine care of Covid -- I beg your pardon, Covid patients, and while in Scotland and Wales staff can request RPE if they have concerns, in the BMA's view this is not a sufficient guarantee of protection and is likely to exacerbate existing staff inequalities.

This brings me to the third section, impacts on staff and patients.

ONS data records over 860 Covid-related deaths of healthcare workers across the UK, but given there is no reliable system for recording this information, the true number is likely to be higher.

In addition, many staff continue to be seriously impacted by Long Covid, leaving them unable to work, train and undertake day-to-day activities. Again, exact figures are not known, but the latest ONS data from March 2023 estimates this to be 4.4% of the workforce, which is in the region of 40,000 healthcare workers.

The ongoing consequences of staff physical health

were described by a secondary care doctor in England who told the BMA that:

[As read] "My second Covid infection has left me with damage to my spinal cord. I now walk with crutches and cannot walk more than about 200 metres without them. I also have bladder and bowel problems and have to intermittently catheterise. There is not a day that goes by where I don't have some form of pain."

Sadly, there are many more similar accounts, including the evidence of Nicola Ritchie of the Long Covid Physio group and Dr Nathalie MacDermott of CATA, both of whom developed Long Covid after working without the necessary RPE and are now suffering debilitating consequences which prevents their return to full-time work.

In addition to these serious impacts on physical health, powerful testimony from witnesses such as Professor Fong, highlighted just how traumatic the last few years have been. Professor Fong described a member of staff telling him that "it felt like a terrorist attack since this started and we don't know when the attacks are going to stop".

He also described in one hospital staff who were so overwhelmed that they were putting patients in body bags, lifting them from the bed, putting them on the

1 floor, and putting another patient in their bed straight
2 away because there wasn't time.
3 Staff were far more exposed to death and critical
4 illness than they had ever been before. In the words of
5 a secondary care doctor working in Wales:
6 [As read] "It was horrific. The patients were
7 incredibly sick. There was a general feeling of being
8 helpless. You'd do everything you could and they'd just
9 suddenly die and there was nothing you could do. Having
10 to do end-of-life discussions over the phone, family
11 members being unable to visit, it was bad, very bad."
12 And because they were inadequately protected,
13 staff feared for their lives and readied themselves for
14 the possibility of death. They were terrified about
15 passing infections to family members and went to extreme
16 measures to avoid this, including sleeping in their
17 cars, changing clothes outside and living in temporary
18 accommodation. The sheer scale of the traumas
19 experienced by staff is unprecedented. The Inquiry's
20 intensive care experts reported data from late 2020 that
21 50% of ICU staff met or exceeded the criteria for
22 a mental health disorder.
23 This points to a mental health crisis within the
24 NHS and it is a crisis that is continuing. A survey by
25 NHS Charities Together from earlier this year found that

1 over three in four NHS staff are currently struggling
2 with their mental health. And two in three report that
3 morale is the lowest they have ever experienced.
4 Meanwhile, data from NHS England showed that over
5 a quarter of all staff sickness days in 2023 were due to
6 stress-related illnesses.
7 Staff also suffered moral distress when capacity
8 constraints meant that they were unable to deliver the
9 care that they wished. Lack of capacity meant that
10 staffing ratios had to be stretched to unsafe levels,
11 patients could not be escalated to the next level of
12 care, there were increased numbers of critical care
13 transfers, and there were horrific difficulties
14 accessing ambulances.
15 These concerns about patient care were so severe
16 that doctors raised them with the GMC.
17 Finally on impacts. Infections and exposure were
18 not equally -- were not experienced equally. The Health
19 Service Journal estimates that over 60% of staff who
20 died in the first month were from ethnic minority
21 backgrounds. The gender bias within PPE design meant
22 that female staff often struggled with poorly fitting
23 PPE that left them at risk, while migrant and outsourced
24 workers were disproportionately forced to work without
25 adequate PPE. They were also more likely to be

1 allocated to higher-risk environments and were less able
2 to voice their concerns.
3 Lastly, recommendations. Before proposing
4 a number of specific recommendations, we make two
5 general observations about capacity and safety. It is
6 the BMA's firm belief that any improvements in surge
7 capacity will prove inadequate during a future emergency
8 if health systems start from the same baseline as 2020,
9 and we repeat that capacity is now worse, not better,
10 than five years ago, which is a damning indictment.
11 It is, therefore, vital for the Inquiry to make
12 recommendations that will ensure all healthcare systems
13 have capacity for both day-to-day and emergency
14 situations. As highlighted by Professor Sir Chris
15 Whitty, the resourcing and configuration of the NHS is
16 a choice, and one that can be made differently.
17 Regarding safety, there is an urgent need for
18 improved protections for healthcare staff and patients
19 in all settings. Any repeat of the experiences of
20 Covid-19 is unthinkable, but again, this is exactly what
21 will happen without urgent and fundamental change.
22 Our closing written statement will set out
23 proposed recommendations in more detail, but for now we
24 highlight the following nine areas.
25 First, urgently update the IPC guidance across all

1 four nations to reflect the evidence of aerosol
2 transmission, by recommending FFP3 for the routine care
3 of patients with Covid-19.
4 Second, require a precautionary approach in future
5 emergencies to ensure maximum protection for healthcare
6 staff and patients with IPC guidance that is explicit
7 about the risks and is updated when new evidence becomes
8 available, backed by a stronger more proactive Health
9 and Safety Executive.
10 Third, ensure that pandemic preparations,
11 including plans for rapidly scaling up the use of PPE
12 across a range of settings and a PPE stockpile that is
13 suitable for a diverse range of face and body shapes.
14 Fourth, we must invest to ensure healthcare
15 systems are adequately resourced, including proper
16 modelling of realistic workforce and bed stock needs.
17 Fifth, we need to be able to scale up quickly when
18 the next pandemic hits, which will require streamlined
19 programmes to bring in additional staff more easily and
20 flexibly.
21 Sixth, NHS estates need to be significantly
22 improved, starting with a transparent and
23 independently-audited review of the condition of primary
24 and secondary care estates and infrastructure, with
25 urgent funding for the required improvements identified.

Seventh, ensure that consistent and sustainable occupational and psychological support is available to all staff to improve their health at work. This will require strong direction and leadership from the top.

Eighth, improve Long Covid Support services to ensure they are less variable, take a multidisciplinary approach and that those suffering from Long Covid receive proper support to return to work and proper compensation when this is not possible. Moreover, implement the recommendation from the Industrial Injuries Advisory Council to classify Long Covid as an occupational disease.

Ninth, address the culture of the NHS to ensure working experiences are less variable by background, or protected characteristic and that all feel able to raise concerns.

Finally, the BMA appreciates that the Inquiry's terms of reference require that your recommendations must relate to preparations for future pandemics. However, given that the severity of the impacts of Covid-19 stem from the underprepared and under-resourced health services, the BMA urges the Inquiry to be bold in its recommendations and to address the fundamental issue of capacity head on.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Stanton.

I am being challenged and being encouraged to be bold. I will have to see how far I can go.

Mr John-Charles.

Closing statement on behalf of National Pharmacy Association by MR JOHN-CHARLES

MR JOHN-CHARLES: Thank you, my Lady, and good morning.

This closing statement to Module 3 is on behalf of the National Pharmacy Association, the NPA. My Lady, may I say at the outset that the NPA, which represents the majority of independent community pharmacies in the UK, is most grateful for the continued opportunity to contribute to this module of the Inquiry by this oral statement ahead of their intended closing written statement.

The Inquiry has heard evidence from two witnesses on behalf of the NPA, from Jonathan Rees, pharmacist and a superintendent pharmacist for two independent pharmacies based in the Swansea area, and from Nick Kaye, current chair of the NPA and who was vice chair during the pandemic.

The Inquiry has also published the written witness statement of Sanjeev Panesar, pharmacist and the superintendent pharmacist for a small group of independent pharmacies in the Birmingham area.

These brief submissions, my Lady, are intended to identify the principal issues which the NPA invites the Inquiry to address and the conclusions it should reach in its Module 3 report, in particular the impact of the pandemic on community pharmacies given their key frontline role and the absence of recognition from government.

In this connection, my Lady, this statement addresses four key issues: the role of community pharmacy, including their place in the fabric of communities; the impact on pharmacy staff and their teams; the lack of recognition; and the resilience of community pharmacies in the UK. And we also provide the NPA's suggested recommendations.

Now I begin then with the role of community pharmacy during the pandemic.

Community pharmacy became the first port of call for patients seeking health advice during the pandemic. It has been described by NPA witnesses as the front door of the NHS and a shock absorber for the UK's healthcare systems. Community pharmacy is a crucial part of primary care in the UK.

My Lady, community pharmacies went to great and heroic lengths to ensure services were maintained during the pandemic and demonstrated the value of the network

of community pharmacies across the country.

The Inquiry heard evidence of how community pharmacies stepped up in the crisis in so many different ways, from providing a safe space to support victims of domestic violence to distributing lateral flow tests and maintaining a safe supply of medicines. There was huge and increased demand for their services as other parts of the NHS were required to limit availability.

Community pharmacy was one of the few parts of the health service where patients could obtain expert health advice without an appointment. NPA members reported a significant increase in the number of prescriptions dispensed from February to March 2020, and phone calls to pharmacies more than tripled during this period. Home deliveries of medication to vulnerable patients more than doubled, requiring additional staffing and volunteers. And many pharmacists experienced long queues outside their doors.

The Inquiry has received evidence from the Pharmaceutical Services Negotiating Committee that the average pharmacy carried out 15 informal patient consultations per day -- this is up to November 2020 -- and if pharmacies had not been available this would have led to an additional 65 appointments in each GP practice each week in England.

1 The increase in patient care spanned advice on
2 minor ailments to much more complex and serious
3 conditions requiring onward referral to other parts of
4 the NHS. As Nick Kaye put it in his evidence, this
5 included someone saying that they had been coughing up
6 blood for three weeks.
7 The supply of medicines from community pharmacists
8 to local populations with a challenging and complex.
9 Many medicines became difficult to source and expensive
10 as demand outstripped supply and staff spent long hours
11 sourcing medicines.
12 On top of all of this, my Lady, community pharmacy
13 delivered some 40 million Covid-19 vaccinations.
14 Finally on their role, my Lady, community
15 pharmacies have a unique understanding of the health
16 needs of populations and the communities they serve.
17 They are disproportionately located in areas of higher
18 deprivation, delivering health services to communities
19 that need the most, and they play a crucial role in
20 reducing health inequalities.
21 In his evidence, Nick Kaye explained that
22 approximately 50% of the NPA membership and 50% of the
23 NPA board are from ethnic minority backgrounds, and he
24 described how this level of diversity enabled the board
25 to deliver effective policies, for example in relation

1 to vaccine hesitancy in the community and reducing
2 health inequalities.
3 Next, my Lady, I turn to the impact on pharmacy
4 staff and their teams.
5 The increased demand on community pharmacy during
6 the pandemic had a significant impact on pharmacists and
7 their teams, resulting in stress, fatigue, mental health
8 issues, and financial hardship for many NPA members.
9 The evidence of Sanjeev Panesar provides some indication
10 of the impact of the high workloads.
11 He said:
12 "12. There was no real support from the NHS
13 about how to best deal with the extremely high
14 workloads experienced while simultaneously managing
15 staffing shortages due to self-isolation requirements.
16 "15. For months, myself and some of the team
17 repeatedly came in early before our normal opening
18 time of 8.30 am and stayed after our normal closing of
19 7.00pm, eg starting early from 5am and staying until
20 11pm/midnight was a regular occurrence, and continued
21 throughout the pandemic into early 2022.
22 "16. We had to work such long hours in order to
23 keep on top of workloads ..."
24 The Royal Pharmaceutical Society's Workforce and
25 Well-being Survey from 2022 showed particularly high

1 burnout scores for those working in community pharmacy.
2 Nick Kaye attributed these scores to the uncertainty
3 felt by the community pharmacists and their teams
4 relating to, for example, how they would get the PPE
5 they needed, how to get the medicines they needed, and
6 how they would pay their teams. That became -- "becomes
7 genuinely overwhelming", he said.
8 He described, Nick Kaye described that one of the
9 hardest things as chair of the NPA was listening to
10 members asking "When is it going to get better, Nick?
11 When's this going to change?" and recognising that
12 members did not feel supported or an integral part of
13 the healthcare system.
14 Jonathan Rees highlighted the financial impact on
15 pharmacists in light of the additional costs and
16 expenses that were incurred during the pandemic,
17 describing it as "huge". Nick Kaye told the Inquiry
18 that not only did members feel they were an afterthought
19 from government but they were working from 7 o'clock in
20 the morning until 11 o'clock at night, separated from
21 family members for weeks on end and worrying about
22 whether they could pay their teams and pay their
23 mortgage.
24 My Lady, mention of afterthought leads me to the
25 third issue: that, my Lady, NPA members and their teams

1 were overlooked, under-recognised or excluded.
2 Community pharmacies and their teams were not
3 treated equally with other frontline healthcare workers
4 and they did not receive the support that they needed.
5 The most significant and demoralising example of
6 this different treatment by government was the initial
7 exclusion of pharmacy workers from the life assurance
8 scheme for frontline workers in England.
9 The evidence of Matt Hancock during the Inquiry
10 hearings shed important light on this issue. He made
11 clear that he had instructed that all pharmacy staff
12 should be included within the scheme but the system of
13 government and the NHS failed to implement his clear
14 direction. Mr Hancock said:
15 "The pharmacy contract is managed by
16 NHS England. In order to maximise taxpayer value for
17 money, NHS England is, by tradition, really very tight
18 on pharmacists -- I am a big supporter of community
19 pharmacy -- and there is, therefore, inbuilt into
20 NHS England senior management a lack of enthusiasm for
21 giving more to community pharmacists than they
22 absolutely have to ..."
23 He went on to say:
24 "... my sense was also that the system was not
25 looking after community pharmacists enough."

They evidently were an afterthought as far as the system was concerned.

Another example of the sidelining of community pharmacy was the initial lack of PPE through the NHS, requiring many pharmacy teams to source and fund their own PPE. Pharmacists were unable to access the NHS PPE portal to order PPE until August 2020, some months into the pandemic.

The supply of PPE was a challenge. The pharmacy teams put themselves at risk to help patients stay well, often working in close proximity to others and reusing PPE repeatedly for days or even weeks.

Again, in his evidence to the Inquiry, Mr Hancock confirmed that he had pushed for community pharmacists to have access to the PPE portal and he said that in times of constrained supply community pharmacists, rightly or wrongly, were deemed to be lower in the priority for people. They needed access to the PPE portal.

My Lady, it was also the case at the start of the pandemic that many people who worked in community pharmacy were not recognised as key workers, which would allow their children to attend school while they worked, notwithstanding that they were working in a frontline healthcare environment. Nor was Covid-19 testing

initially available for community pharmacy staff. Community pharmacy was initially categorised as a retail setting as opposed to a healthcare establishment, which meant that entire pharmacy teams needed to self-isolate following a single positive case within a pharmacy. This resulted in fewer available staff and increased pressure on the remaining pharmacists and pharmacy teams.

Having regard to the clear failure to properly recognise community pharmacy as an integral part of NHS primary care, the NPA's participation in this module has provided some solace to NPA members in allowing the voice of community pharmacy to be heard and the significant impact of the pandemic on this sector to be recognised.

The fourth principal issue, my Lady, is lack of resilience and funding issues. Community pharmacy entered the pandemic facing financial and workforce crisis due to long-term under-investment in the network. These issues presented significant challenges for community pharmacy in responding to the pandemic and increased the difficulties in providing services to patients and maintaining staffing levels. My Lady, since the start of the pandemic, approximately 1,000 pharmacies have closed in England. 1,000.

The healthcare system is less resilient to respond to a future pandemic than at the beginning of 2020. Unless urgent action is taken to redress this situation, the vital services that community pharmacy provide which played such an important role in the pandemic response will not be available to the same extent in a future healthcare crisis.

My Lady, turning to the future and recommendations. And with regard to the recommendations, may I draw attention to and build upon Nick Kaye's three simple asks at the end of his evidence to the Inquiry. To better enable pharmacists to fulfil their critical role in a future pandemic, his three key asks were to make sure that we're here, use us, and we are part of primary care.

So three broad asks: make sure that we're here. An accessible pharmacy network adds to the resilience of the health service, reduces health inequalities and must be maintained. If pharmacies continue to close at the current rate, the UK will not be able to respond adequately in the next pandemic.

Use us.

The NPA invites the Inquiry to recommend that the full potential of community pharmacy is recognised and utilised to support other parts of primary care. In any

future pandemic, additional services should be brought to run existing infrastructure wherever possible.

We are part of primary care. That community pharmacy is part of primary care alongside general practice, optical services, and dentistry ought to go without saying. However, as Nick Kaye indicated in his evidence, a cultural shift from government is necessary to fully recognise that community pharmacy and their teams are genuinely part of the NHS family.

Government and the NHS should recast community pharmacy in their minds as a valuable partner in the post-pandemic recovery, not as a cost centre.

My Lady, given the essential nature of their frontline role, the Inquiry is asked to recommend that there is sufficient investment by government in the network and in the infrastructure needed to integrate community pharmacy into the broader health system, and to support effective cooperation across the health service.

My Lady, the final ask concerns recognition of the role of community pharmacy during the pandemic. The NPA ask that the significant contribution of community pharmacy to the pandemic response is reflected in the Module 3 findings in order to redress the lack of recognition they received throughout the pandemic.

That concludes our oral statement, my Lady.

LADY HALLETT: I'm very grateful, Mr John-Charles, thank you very much.

Ms Domingo, could you take us up to the break, please.

Closing statement on behalf of Royal Pharmaceutical Society by MS DOMINGO

MS DOMINGO: Thank you, my Lady.

My Lady, this is the oral statement on behalf of the Royal Pharmaceutical Society.

The Inquiry has heard evidence during this module of the essential work of pharmacists, pharmaceutical scientists, pharmacy technicians and wider pharmacy teams in supporting the nation's help.

Last week, however, we heard from the former Secretary of State for Health and Social Care giving a brutally honest account that the system was not looking after community pharmacists enough. This relegation of a central element of primary care to an afterthought, and a lower priority than other parts of the healthcare system, is a very significant concern that explains much of the unfair treatment of community pharmacy throughout the pandemic, and it is one of four key issues that this statement seeks to highlight.

The other three are: first, the failure to keep

pharmacists and pharmacy teams safe while at work; secondly, the impact of the pandemic on their health and well-being; and, finally, the resilience of the community pharmacy sector more broadly.

But before addressing these issues, the RPS wishes to raise the work of hospital pharmacists, which is often less visible and is a perspective that the Inquiry has not heard in these hearings.

Over the period of the pandemic, hospital or clinical pharmacists provided expert knowledge in the usage and administration of medicines, caring for the most critically ill patients with Covid-19, transforming their services and ways of working, and supporting the supply of medicines for critical care.

The Inquiry's experts in intensive care medicine have told the Inquiry that ICU specialist pharmacists and pharmacy technicians were critical to the pandemic response in sourcing alternative medicines and minimising the impact of the medicine shortage on the provision of clinical care.

The Inquiry has received a statement from Josh Miller, a clinical pharmacist working in the acute sector of a large health board in Scotland, and a board member of the RPS. He has told the Inquiry of the challenges facing hospital pharmacists and the impact on

patient care during the pandemic.

These included responsibility as a pharmacist for up to four respiratory and acute wards and 120 patients per day. Each ward consisted of 30 beds containing four bays of six beds each, and just six single-bedded side rooms for the isolation of infected patients.

Side rooms became quickly overwhelmed as the virus spread to the patients within the bays, and as the wards became closed off, access to patients to discuss their medicines was restricted. Mr Miller described communicating with patients by mobile phone rather than face to face to discuss their medicines, which severely limited the ability to adequately counsel patients.

Mr Miller was fit tested for an FFP3 respirator as he was working on acute wards, and he describes the lack of respirator availability for required healthcare workers to be fit tested with alternative types of masks.

He also described how pharmacy teams within hospitals were often responsible for oxygen supplies, and the real concerns about oxygen shortages to support ventilators. The pharmacy team was on call-out of hours to move and handle oxygen cylinders which was physically demanding and risky work, for which no risk assessment was ever undertaken.

Safety at work for pharmacists is a key concern for the RPS. The RPS witness statements stressed the importance of protecting pharmacists and pharmacy teams, including through appropriate use of risk assessments, ensuring infection prevention and control guidance was suitable for all healthcare settings, including pharmacies, and the provision of adequate and effective PPE to pharmacists and their teams.

The Inquiry has heard evidence, including from NPA chair and RPS fellow Nick Kaye, that pharmacists and wider pharmacy teams went above and beyond the pandemic, often putting themselves at risk so they could continue supporting patient care in a time of national crisis.

In the early weeks of the pandemic, many members of the public presented to their pharmacy even when showing symptoms of Covid-19. As Nick Kaye told the Inquiry, they were trying to seek help and didn't know where else to go. However, by providing face-to-face care to patients, the pharmacy teams were putting themselves at risk of infection.

Pharmacy spaces by their nature are generally small, making it difficult if not impossible for pharmacy teams to maintain safe social distancing while at work. An RPS survey undertaken in April 2020 showed that 94% of respondents said they were unable to

1 maintain 2-metre social distancing from other staff in
2 their workplace, and 40% were unable to maintain social
3 distancing from patients.
4 The Inquiry has heard evidence that the majority
5 of frontline pharmacy teams struggled to source PPE to
6 protect themselves, their patients and their families,
7 resorting to buying their own PPE, including from local
8 DIY centres, or relying on local schools providing
9 masks. This meant that pharmacists and their staff
10 risked spreading the virus or being unable to work
11 because of sickness.
12 Despite being an essential part of primary care,
13 community pharmacy teams were only able to access the
14 government's PPE portal from 3 August 2020, after the
15 first wave of the pandemic. Even then, the Inquiry has
16 heard evidence that initial supplies were quite strained
17 and it wasn't until around November 2020 that pharmacies
18 could increase the amount of PPE they could order.
19 The RPS England chair commented in May 2020:
20 "Pharmacies are one of the last places keeping
21 their doors open to the public without an appointment
22 and yet seemingly an afterthought when it comes to
23 sourcing PPE for staff."
24 This sentiment, that community pharmacy teams were
25 an afterthought, was substantiated by the evidence of

1 the former health secretary that, in times of
2 constrained supply, community pharmacists were deemed to
3 be lower in the priority for people that needed to
4 access PPE. The safety of all healthcare workers
5 attending their work to care for patients during the
6 pandemic should have been a priority for government, but
7 it is apparent that this was not the case.
8 It is the RPS's position that frontline staff
9 should have the same support across the whole of primary
10 care.
11 The pandemic had a significant impact on the
12 health and well-being of pharmacists. The Inquiry has
13 heard compelling evidence about the enormous strain of
14 the pandemic on pharmacy staff and the dedication and
15 determination of pharmacists to keep looking after
16 patients in the face of unprecedented challenges:
17 workload doubling for weeks and months, phone lines
18 constantly in use from patient queries, working overtime
19 every day, increases in the number of prescriptions,
20 increases in the number of deliveries to shielding and
21 vulnerable patients, and hours spent sourcing medicines
22 that were in short supply.
23 This huge surge in demand stretched the personal
24 and professional resilience of pharmacists and their
25 teams.

1 Responding to a call for evidence, one RPS member
2 in Wales described:
3 [As read] "There was a massive impact on mental
4 health, increased pressure of workloads, medicine
5 shortages and trying to keep your family safe."
6 Other stresses came from financial worries, and
7 Nick Kaye told the Inquiry that:
8 "People want to do the right thing, [and] give
9 that care to the communities they serve, but actually
10 being able to pay their bills is another pressure ..."
11 The RPS's workforce survey results show that work
12 burnout scores for the community pharmacy sector have
13 been consistently high since 2020, with 88% of
14 respondents to the 2022 survey reporting they are at
15 high risk of burnout.
16 Pharmacists continue to warn about rising
17 pressures at work and the impact on their mental health
18 and well-being. This continued risk of burnout is
19 evidenced by the responses of more than 6,000
20 pharmacists and pharmacy technicians to the RPS's latest
21 Workforce and Well-being Survey this month, a report
22 that will be published in the spring.
23 The systemic difference in treatment between
24 pharmacists who provided NHS contracted services
25 compared with healthcare workers directly employed by

1 the NHS has also contributed to pharmacy workers feeling
2 demoralised and frustrated. The disparity in treatment
3 was seen in the exclusion of pharmacists from these
4 extensions provided to other healthcare workers
5 in March 2020 in the absence of specific mention of
6 pharmacists in guidance regarding key workers, which
7 impacted childcare provision, as school hubs, and
8 significantly in the initial exclusion of community
9 pharmacists from the life assurance scheme covering
10 frontline health and care workers in England.
11 The Inquiry has heard evidence that inbuilt into
12 the system and into NHS England senior management was
13 a lack of enthusiasm for giving more to community
14 pharmacy than they absolutely had to. This was despite
15 pharmacists' crucial role in providing care throughout
16 the pandemic, which undoubtedly alleviated pressures on
17 other parts of the NHS and which placed pharmacists in
18 heightened risk of coming into contact with
19 Covid-positive patients.
20 Pharmacists and pharmacy teams working across the
21 health service played a key role in the success of the
22 Covid-19 vaccination campaign, with 71% of all Covid
23 vaccinations delivered through general practice and
24 community pharmacy. Given their fundamental role in
25 helping to get the country and the economy back on its

1 feet, the failure to provide community pharmacists with
2 equal levels of support and protection must not be
3 repeated.
4 Covid-19 showed that community pharmacies are
5 an essential provider of primary care and the RPS
6 strongly supports the call to reframe community
7 pharmacy, pharmacists and their teams as a genuine part
8 of the NHS family.
9 Finally, the resilience of pharmacy services is
10 a significant concern. We continue to hear about the
11 pressures facing community pharmacies, and the recent
12 independent investigation of the NHS in England led by
13 Lord Darzi noted concerns about pharmacy closure,
14 reduced patient to access care and the impact on health
15 inequalities.
16 The pandemic also exposed the complexity and
17 fragility of medicine supply chains, leading to
18 shortages of many commonly used medications as well as
19 those used in critical care. The resilience of
20 frontline workers and workforce capacity must be
21 considered in preparation for a future pandemic, with
22 adequate support for pharmacy services across all care
23 settings and steps taken to strengthen the medicine
24 supply chain and medicines production.
25 A new report from the RPS which was published

1 yesterday, 26 November, and developed in discussion with
2 patient groups, health professionals and wider
3 stakeholders, examines the growing impact of medicine
4 shortages in patient care. It calls for a cohesive
5 cross-government and NHS strategy across the UK to
6 improve medicine access, with actions to build supply
7 chain resilience, support UK manufacturing, improve data
8 connectivity, protect access to life-critical medicines
9 and reduce duplication across the NHS.
10 With some national governments looking to develop
11 long-term NHS plans, the RPS submits that the lessons
12 learnt from the pandemic must include longer-term
13 reforms to better manage demand and build resilience
14 across the health service. Pharmacists and their teams
15 will continue to play a key role in our health service
16 and will be essential in the event of a future public
17 health emergency.
18 Thank you, my Lady.
19 **LADY HALLETT:** Thank you very much indeed, Ms Domingo. Very
20 grateful.
21 Very well, I shall break now and return at 11.35.
22 **(11.19 am)**
23 **(A short break)**
24 **(11.35 am)**
25 **MS NIELD:** Good morning, my Lady.

1 **LADY HALLETT:** Sorry, I didn't catch the first bit,
2 Ms Nield.
3 **MS NIELD:** I just said "Good morning, my Lady", I was just
4 checking you were able to hear from the hearing room.
5 **LADY HALLETT:** I can, thank you.
6 I think the next speaker is Ms Campbell, isn't it?
7 Ms Campbell?
8 **Closing statement on behalf of Northern Ireland Covid-19**
9 **Bereaved Families for Justice by MS CAMPBELL KC**
10 **MS CAMPBELL:** Thank you, my Lady.
11 When you think about over the evidence you have
12 heard in this module, I dare to suggest that the
13 evidence of a number of witnesses will stand out.
14 To mention but a few, the evidence of
15 John Sullivan, from whom you first heard, will live long
16 in our memories, his devotion to his daughter on vivid
17 display throughout his evidence. He told us about Susan
18 who needed him and his wife as her voice throughout her
19 life, and never more so than when she was taken into
20 hospital during the pandemic.
21 But the doors were closed on them. His efforts to
22 be recognised on Susan's behalf as her advocate, her
23 care partner, went unmet including and up to that
24 decision not to admit Susan to critical care because, it
25 seems, of her disability.

1 The evidence of Dr Sarah Powell who, amongst her
2 many accomplishments, is a truly excellent communicator,
3 she told us so powerfully about the persistent failure
4 to consider the needs of the disabled, and the combined
5 failure to recognise and to treat Long Covid.
6 For too long, too many with the power to make
7 changes were deaf to her experiences.
8 The articulate and constructive evidence of
9 Julia Jones of John's Campaign, who epitomised so
10 clearly the need to imbue protective measures with
11 compassion and common sense: she gave powerful evidence
12 of the legacy of grief, guilt, anger and mistrust that
13 is left behind when people are left to die alone,
14 because guidance was allowed to trump the most basic
15 human right to dignity and to the comfort of a loved one
16 in death.
17 She urged you, as did so many others, if you can
18 make just one change, change that.
19 The evidence of Professor Beggs, your expert
20 witness and I daresay one of the best expert witnesses
21 from who you have heard throughout your inquiry so far,
22 largely because of his ability to convey complex issues
23 of physics in clear, comprehensive, and evidence-based
24 terms.
25 It was a remarkable feature of his evidence that

1 to all of us who heard it, some for the first time, it
2 made perfect sense.
3 And in our mind's eye we can all clearly see
4 Professor Fong, who bore vivid witness to the sheer
5 horror of what was being experienced by too many
6 patients and too many healthcare staff on too many wards
7 in too many hospitals.
8 My Lady, you have heard all that and much more,
9 a combination of powerful evidence about what went wrong
10 in the healthcare response to the pandemic, interlaced
11 with evidence of heroism of many frontline healthcare
12 staff who kept turning up despite the risks they were
13 exposed to, day in and day out.
14 You have also seen evidence of the indefatigable
15 determination of individuals and groups, not to be
16 silenced; to force learning where there was ignorance,
17 and to force change in the face of denial or inertia.
18 It is, my Lady, a mark of accomplishment of this
19 module that the most powerful evidence that you have
20 heard has been from individuals or groups who were not
21 listened to during the pandemic, and in many cases
22 since.
23 Whether the issue was racism or Long Covid or
24 disability or the clinically vulnerable or pregnancy in
25 childbirth or errors in IPC understanding or guidance or

1 death or bereavement, those impact witnesses all have
2 one thing in common, they were not listened to: they
3 were sidelined, disempowered, silenced and ignored.
4 For many, right up until they took their place in
5 your witness box, not for the want of trying, they could
6 not get their voices heard, they could not get in the
7 room.
8 It seems in fact that some are still not being
9 heard. How could anyone listen to the evidence of
10 Professor Fong and continue to maintain that the NHS was
11 not overwhelmed during the pandemic, when the evidence
12 of the horror of what he and others witnessed in
13 hospital did not even take into account the suffering of
14 hundreds of thousands who could not access medical care
15 because their screening or their treatment was delayed
16 or cancelled, and yet that was the position of
17 Matt Hancock and other health ministers from across the
18 UK, even when challenged by you.
19 By contrast, my Lady, you have listened, and even
20 when unwell you are still determined to listen. And now
21 the burden on you to transfer the combined experiences
22 of the witnesses into meaningful recommendations for the
23 future is significant. I hope it is not too
24 presumptuous to predict that one of your relations will
25 be in relation to communication. But if that

1 communication only comes from the top down, we will have
2 achieved nothing, because the essence of good
3 communication is the ability to listen and to try to
4 understand what it is you are being asked to change and
5 why. And there has been little evidence of listening,
6 even to the evidence from this very hearing room.
7 You observed, at the end of Ms Ferguson's evidence
8 yesterday, that the only way that your recommendations
9 get implemented is if groups like the Northern Ireland
10 Covid Bereaved families keep the pressure up. That is
11 undoubtedly true, but given the strength of the evidence
12 that we have heard, it's undeniably sad. It should not
13 be for the bereaved, or the disabled, or migrant
14 workers, to continue to force change. As you heard
15 yesterday, democracy really is everyone's
16 responsibility, including those who are voted into power
17 to lead a democracy, or who are employed to lead
18 organisations of the state.
19 It has not gone unnoticed by the Bereaved that
20 there has been a distinctly lopsided presence in your
21 hearing room. That, following questions from Counsel to
22 the Inquiry, so many witnesses risked leaving the
23 witness box with a crick in their neck as they turned to
24 answer questions from the non-State core participants
25 who in the main sit to your right.

1 What lessons have been learned, we repeatedly
2 asked? What can be done better, we wanted to know. All
3 the while reduced to the hope that those who can
4 implement the lessons learned or who have the ability to
5 do things better in future, or the power to implement
6 the recommendations that you will make, had at least one
7 ear to the live stream or would cast an eye over the
8 transcript because, my Lady, often they weren't in the
9 room.
10 On behalf of the Department of Health
11 Northern Ireland, we were assured only yesterday that
12 the department had indeed listened carefully to and
13 reflected on all of the evidence that had been heard.
14 That listening, it was then revealed, had led the
15 department to conclude that the evidence was in part
16 wrong, or had been misunderstood or required to be
17 refuted, descending into an unedifying game -- but
18 a familiar game -- of Northern Ireland finger pointing
19 between the Department and the Public Health Agency as
20 to who knew what or should have known what.
21 Mr Dawson, we were told, doesn't understand what
22 data was available, perhaps because he's only been in
23 post since early 2021. It seems, my Lady, that it's the
24 position of the Department of Health that the
25 Chief Executive of the PHA, who has been in post for

1 almost four years, since the middle of the pandemic,
2 doesn't yet understand what data was available to his
3 agency and from where it came. It beggars belief.
4 You were asked by the department to simply accept
5 that the long-standing and enduring concerns about
6 inappropriate use of DNACPR -- I'm so sorry, my Lady.
7 My Lady, would you just give me one moment, please. I'm
8 afraid I've had a technical malfunction.
9 **LADY HALLETT:** You were just completing Mr Dawson and data.
10 **MS CAMPBELL:** Yes, I'm so sorry. This is the danger of not
11 having a printout.
12 You were asked to simply accept that the
13 long-standing and enduring concern about the
14 inappropriate use of DNACPR are entirely misplaced
15 because the department never had a policy that permitted
16 the increase in their use during the pandemic. You
17 should rest assured, it seems, that there is nothing to
18 see here. It was asserted that the military assessment
19 team had got it wrong when, having been invited by the
20 Department of Health to give their assistance and
21 expertise, they raised concerns about a lack of central
22 control. Even, it seems, Mr Scott got it wrong when he
23 tested the former Minister of Health's evidence in
24 relation to the location of the Nightingale hospital.
25 And you, my Lady, need not worry, because the gaps

1 in data, identified by witness after witness, are about
2 to be solved by a ten-year roll-out of a new electronic
3 system that, as yet, is only 60% implemented.
4 My Lady, I had intended to list the areas in which
5 we learned there are gaps in data in Northern Ireland
6 but the list is too long and my time is too short. We
7 will return to it in writing.
8 If the department had really listened, not
9 defensively but with a willingness to learn, the
10 evidence they would have heard included that
11 Catherine Todd was not listened to when, having
12 contracted Covid in summer 2021, she repeatedly
13 contacted primary healthcare, convinced that all was not
14 well with her baby. But she was denied a potentially
15 lifesaving scan because according to her records she was
16 27 weeks and 6 days pregnant and the scan was only
17 available from 28 weeks, the very next day.
18 That there was no sense and a great deal of hurt
19 in the manner in which Ms Todd and her partner TJ had to
20 witness their baby die, and in their treatment after his
21 death. And that such is the state of the healthcare
22 system in Northern Ireland that as a pregnant woman in
23 Northern Ireland in 2024 she did not feel safe.
24 If the department had really listened, it might
25 have acknowledged that families in Northern Ireland have

1 been raising concerns about the improper application of
2 DNACPR notices since the outset of the pandemic and
3 that, as Mr Swann accepted in his evidence, there
4 remains an opportunity respectively to consider and
5 retrospectively to consider and reflect on the true
6 picture of this critically important issue.
7 Instead, the department retreated to its position
8 that there was no policy and nothing to see. It is no
9 answer to the concern of the Bereaved that, as Mr Swann
10 seemed to claim, he took it from his officials or the
11 Chief Nursing Officer that the improper use of DNACPR
12 wasn't happening. Choosing it seems not to listen to
13 the concerns of those who were independently and
14 collectively telling him that they knew different.
15 If the department had really listened it might
16 have offered you assurances that it had heard the
17 harrowing evidence of the impact of visiting
18 restrictions, particularly at the start of life or for
19 dementia patients or those nearing the end of life. It
20 might have reflected on Mr Dawson's evidence of
21 a 9-month process in 2021, discussions in January,
22 a paper in June, a letter in September, to facilitate
23 testing for hospital visitors. It might have
24 acknowledged that that delay was inhumane and
25 unacceptable and is never to be repeated.

1 If the department had really listened it might
2 have responded to the witness statement of
3 Fidelma Mallon, whose husband was admitted to hospital
4 for an operation and acquired Covid in that hospital
5 setting. It would have acknowledged the inconsistency
6 in the fact in a neighbouring trust he would have been
7 treated at home prior to admission for an operation.
8 And it might have offered some assurance as to how
9 inconsistent approaches between trusts were being
10 addressed.
11 If it had really listened, the department might
12 have acknowledged that providing a nurse with an email
13 address to report gaps in PPE is no substitute for
14 a system that manages and controls and provides stocks
15 of appropriate PPE to the frontline from the outset.
16 It might have addressed the plans to reform
17 outdated hospitals with cramped wards, ventilation
18 limited to opening windows, and poor oxygen supply. If
19 it had really listened the department might have
20 acknowledged that people like Martina Ferguson were
21 bringing these issues and more directly to its attention
22 from the outset, and its failure to act and respond in
23 a consistent and compassionate way left people like
24 Ms Ferguson, like Ms Doherty, Katrina Daly or
25 Lauren Mallon, who sit behind me, and many others who

1 watch from home, with a choice of not comforting their
2 loved ones in their final moments or fighting their way
3 onto wards to be with their dying relatives, positions
4 that never the patient nor their loved one nor the nurse
5 on duty should ever have been in.
6 There was not a word of reflection from the
7 department in relation to the evidence of airborne
8 transmission and the scientific divide of a droplet size
9 or aerosols, notwithstanding Mr Swann's evidence that he
10 was aware of the debate from May 2020 and
11 Sir Michael McBride's evidence that he simply accepted
12 and adopted the position of his colleagues in England.
13 Those generating that debate, Professor Beggs and
14 Dr Jones, appeared to be categorised by Sir Chris Whitty
15 in his evidence to you as "outliers". Others will,
16 I know, address this in greater detail. But those who
17 challenge the prevailing approach with solid
18 evidence-based, well-researched and
19 scientifically-recognised input must not be relegated to
20 the margins. They must be listened to.
21 Politicians and their advisers must be willing to
22 adapt, to change course when evidence becomes available,
23 that it is necessary to do so, recognising that the cost
24 of changing course or admitting some errors is never to
25 be traded against the cost of lives lost if you don't.

1 It is important to emphasise that this Inquiry is
2 not about apportioning blame. Self-evidently this was
3 an entirely novel and unprecedented virus. We recognise
4 that people were striving to do their best even if
5 retrospectively it is apparent that things could be done
6 better.
7 But at this point, post pandemic, more than
8 anything there must be evidence of reflection and work
9 towards meaningful change. And yet the absence of
10 reflection of lessons learned in the evidence from
11 Northern Ireland is stark. It was stark in the
12 statement of the Public Health Agency, it was repeated
13 in the statement of Mr Swann, and, my Lady, it appears
14 to persist.
15 And the truth is, my Lady, and I mean no
16 discourtesy whatsoever to you or your team when I say
17 this, that there is a limit to which this module can
18 help us. The issues in the Northern Ireland healthcare
19 system are too large, pervasive and systemic, and the
20 time available and the scope of this module was
21 necessarily limited.
22 Who can forget the statistic accepted by the CMO
23 in his evidence as "roughly accurate", that pre-Covid
24 waiting time figures for a first outpatient appointment
25 to start a pathway to treatment were 2,000 times worse

1 in Northern Ireland than a comparable figure in England.
2 The reality is that the waiting time statistics
3 quoted by Mr Wilcock King's Counsel in his opening to
4 you back in September realistically will only have
5 extended over the 12 weeks since.
6 It's a sobering reality that as we approach the
7 5-year anniversary of the onset of the pandemic, little
8 has changed in Northern Ireland. Has anything changed
9 for the hundreds of thousands trying to access
10 a treatment pathway or for pregnant women? Is the
11 future brighter for Long Covid sufferers? And
12 importantly, if a pandemic hit tomorrow, would the
13 outcome for the bereaved be any different?
14 You know, my Lady, that we hold our deceased
15 relatives in a special place in Northern Ireland. The
16 Northern Irish Covid Bereaved are unwavering in their
17 commitment to ensuring that the posthumous legacy of
18 those we have lost is a brighter future for those who
19 are still here. But they cannot achieve that alone,
20 and, my Lady, not for the want of trying, you cannot
21 achieve that from Paddington. The solution has got to
22 be home-made. So, once again, my Lady, the call goes
23 out to those in leadership in Northern Ireland to commit
24 to working with the bereaved, and with all affected, to
25 ensure lasting change.

1 Thank you.
2 **LADY HALLETT:** Thank you very much indeed, Ms Campbell. As
3 powerful as I expected. Thank you.
4 Mr Jacobs.
5 **Closing statement on behalf of Trades Union Congress by**
6 **MR JACOBS**
7 **MR JACOBS:** Good morning, my Lady. These are the
8 submissions of Trades Union Congress. I am instructed
9 by Thompsons Solicitors and appear with Ms Ruby Peacock.
10 Much of the impact of the pandemic upon healthcare
11 workers has been troubling yet unsurprising. It is well
12 understood that the UK's healthcare services were and
13 are stretched in terms of staffing and resource, that
14 the pandemic struck at a time when staff were already
15 overworked, and that the workforce suffered terrible
16 loss, trauma, burnout, and moral injury.
17 It has, however, been essential to hear workers
18 explain the experience of working through the pandemic.
19 It has brought weight and depth to the written words in
20 witness statements.
21 Understanding and recording that impact is in part
22 to acknowledge it, which is important. It serves to
23 inform both the content of and priority for
24 recommendations. But it also plays a crucial role in
25 making clear the importance of non-pharmaceutical

interventions.

Refraining from the more stringent interventions in the next pandemic would not only risk avoidable loss of life, it would be to abandon the over 2 million workers in the four nations' healthcare services. That is a simple but vital lesson of this module which should be made clear in the Inquiry's report.

These submissions, however, focus predominantly on the question of recommendations.

In these oral submissions we address you on disproportionate impacts and structural racism, the state of the UK's public health care services, dynamic staffing capacity, precarious work, regulatory response and vaccination as a condition of deployment.

Our written submissions will additionally cover infection prevention and control, data on the impacts of Covid-19 upon healthcare workers, risk assessments and social partnership.

First, my Lady, the disproportionate impacts upon black, Asian and minority ethnic healthcare workers.

To our clients, the evidence on this topic has been disheartening. The unequal impact revealed so early in the pandemic, with deaths of black, Asian and minority ethnic workers, was well-known before the module started. The burning questions were: why? And

what needs to be done?

Pre-existing inequalities in society are obviously relevant; however, systemic discrimination within the healthcare service is certainly part of the problem. It exists in plain sight and in the stark figures produced in recent years. NHS England's 2023 Workforce Race Equality Standard reports that representation of black, Asian and minority ethnic staff drops off sharply above pay band 5, and that amongst nurses, midwives and nursing assistants, the largest part of the NHS workforce, BAME staff and staff from other white background have poorer experiences of working for the NHS than their white British colleagues.

This inequality, it says, is most marked for black staff, who feel the least equality of opportunity and are most likely to be victims of discrimination.

Similar statistics arise out of the Workforce Race Equality Standard for Wales, which is reported for the first time this year. The figures chime with the firsthand evidence gathered by the Inquiry of minority ethnic staff feeling unable to raise concerns for fear of being disciplined or erased from the Register, having poorer access to risk assessments, fit tests and PPE, and being disproportionately deployed to frontline, high-risk roles.

Professor Whitty suggested that the pandemic was a wake-up call, as if one were needed, he said, that these problems exist within the health service. But has it been a wake-up call? The answer, we say, is unfortunately, no. It is striking that two consecutive Health Secretaries, Mr Hancock and Sir Sajid, have both in their evidence espoused a policy of colour blindness, the idea that as long as everyone is treated the same, the disproportionate impacts of an action, policy or system do not matter.

The idea that a policy's blindness to disproportionate impact is either a means to addressing it, or even an excuse for its disproportionate impact is a facile approach.

Public authorities are under a duty to take steps to advance equality of opportunity, which may include removing or reducing the disadvantage faced by persons with protected characteristics, or taking steps to meet the specific needs of people with those characteristics.

It appears that at a ministerial level, there was a fundamental misunderstanding of this duty owed to black, Asian and minority ethnic workers in healthcare, and of what practically is required to limit systemic barriers.

We have seen many witnesses anxious to state how

serious the problem is. What has been lacking is not only answers but actually a lack of any real sense that there has been sustained, determined and ongoing effort at removing the barriers.

The Inquiry has quite properly pressed for detail as to the actions which need to be taken, but answers have, on many occasions, been hesitant and devoid of substance.

NHS England has assisted this module with four corporate statements which extend over 1300 pages of evidence. Those 1300 pages say very little about the issue of systemic racism within the health service. For the wake up call to land, the report of this module is a crucial opportunity. Many of the general recommendations developed through this submission are designed to ameliorate disproportionate impacts and we will come on to those shortly, but that is not enough. There is a need for recommendations which fundamentally prompt a shift from a practice of recording systemic racism, to actually removing it.

In our written submissions, they will include as follows: first, a need to remedy the problem of NHS England abrogating too much responsibility to the trusts as the employers; NHS England needs to take a leadership role to promote change and shared learning

across the NHS. It should review current policies and bodies responsible for its race equality work. Consideration should be given to whether an equivalent to the anti-racist action plan in Wales ought to be introduced in England.

Second, there is need for accountability for change on these issues, or lack of it. Trusts should be required to report progress on the NHS England Equality, Diversity and Inclusion Plan, which should be independently evaluated so as to create accountability.

Third, the NHS England Equality, Diversity and Inclusion Plan and the NHS Wales Anti-racist Wales Action Plan should extend to the indirect workforce.

We will develop these further in our written submission alongside other recommendations relating to the NHS Race and Health Observatory, the role of equality, diversity and inclusion leads in trusts, and the publication and effectiveness of equality impact assessments.

We turn to the state and capacity of the UK's public healthcare systems.

At the very heart of the evidence in this module, has been the poor state of the UK's healthcare systems going into the pandemic. That extends to its physical estate, equipment, and crucially its staffing.

In response to questions, Matt Hancock was quite dismissive of the notion that recommendations on healthcare capacity cross rubicon into the political realm, out of reach of a public inquiry. Whatever one thinks of an admonishment from Matt Hancock, maybe he had a point. Sir Sajid was not dissimilar in urging ambition upon the Inquiry. Whether to accept a recommendation is undoubtedly a political decision, but it is the duty of the Inquiry to make recommendations where they are necessary.

The confines upon the Inquiry are not set by its instincts on what becomes too political, but by the Inquiry's terms of reference. My Lady, your terms of reference require you to consider, to quote from them, "initial capacity and the ability to increase capacity and resilience and also to identify the lessons to be learned."

It is the Inquiry's duty to fulfil those terms of reference. The Inquiry is required to examine questions of capacity, and to learn the lessons. In fact, recommendations that steer clear of this issue risk being counter-productive. They would give a false impression that resolving some of the narrower issues can surmount the fundamental problems of capacity and staffing. The reality is they cannot.

In respect of staffing shortages, the emphasis must be upon increasing standing capacity, resilience and flexibility within the substantive workforce. Any mechanisms to supplement that workforce in a pandemic, such as use of volunteers or the military, partnerships with the private sector or a reserve workforce must be very much secondary to a focus upon reducing existing vacancies, ensuring enough staff are presently trained and recruited to meet future need, and retaining existing staff.

Clearly, it is a problem that can only be resolved with long-term action. The National Audit Offices modelling suggest NHS England presently has a workforce shortfall of 150,000 full-time equivalent staff, a vacancy rate of almost 10%.

NHS England itself projects a shortfall of over quarter of a million staff by 2036. NHS England's Long Term Workforce Plan is an important step in the right direction, but the TUC has concerns, to be expanded in our written submissions, that the plan lacks the potency required to really tackle a crisis of this scale.

As of June 2024, estimated vacancies in NHS Wales are at 5,700, a vacancy rate of 5.8%. The Healthier Wales plan is a ground-up strategy which involves health boards identifying the number of staff they project will

be required in three years' time. Centrally, the figures are collated and a recommendation is made to government. This is the benefit of being informed by local need, but a longer term strategy is required, beyond the three-year window and greater vision and investment is urgently needed to overcome present shortages.

Clearly, recommendations also need to address the ageing healthcare estate, including the need for more single occupancy rooms, larger corridors, modern oxygen pipelines, and effective ventilation of buildings and ambulances.

My Lady, we turn to dynamic staffing capacity.

Even with better standing capacity there may well be a role for surge capacity in a pandemic. We invite scepticism as to whether the Nightingale-style model of large temporary field hospitals divorced from existing infrastructure is the best way to achieve that. There has still be no credible explanation as to how the 10,000 additional beds created in England would have been staffed at a time when capacity within existing hospitals had already been stretched to its limit.

Even after all the witnesses and thousands of documents, there was no clear idea as to where trained clinicians were going to come from or how tens of

1 thousands of volunteers would be operationalised.
2 There has been passing reference to training
3 military staff or even airline staff. The reality we
4 suggest is that it was a project driven by politicians
5 who, at least at the time that Nightingales were
6 commissioned, misunderstood that the limiting factor was
7 not one of physical beds but one of staff.
8 Redeployment of staff may be a necessary feature
9 of surge capacity. The lesson is that harms arise for
10 staff and patients where there is widespread and
11 inappropriate redeployment. As one physiotherapist told
12 the TUC:
13 [As read] "The process of redeployment for
14 physiotherapy staff was chaotic and took no account of
15 clinicians' experience or substantive role. Whilst in
16 my redeployed role [she said] no one contacted me to
17 find out how well I was functioning. I had no acute
18 ward experience for many years. I heard reliable
19 accounts of redeployed professionals administering
20 injections when not qualified to do so and other
21 situations where they acted beyond their competence."
22 She says she was asked to do things clinically
23 which were outside of her professional competence and
24 had to refuse.
25 It is important and should feature in

1 recommendations that redeployment, including processes
2 for risk assessment, training and oversight, should
3 feature in pandemic planning.
4 Next, the issue of precarious work in the NHS.
5 During any pandemic, precarious work becomes a threat in
6 terms of transmission and disproportionate impact.
7 Effective infection prevention and control relies on
8 workers who are trained and empowered to follow safe
9 systems of work, who feel confident to sound the alarm
10 when those systems are ineffective and not being
11 followed, and who do not fear being penalised
12 financially or otherwise for isolating when necessary.
13 That, as we understand it, is the basis for
14 Professor Whitty's observation that, in seeking to
15 ameliorate disproportionate impacts, what would have
16 been actually more helpful, he says, is to make the
17 employment of people less precarious during Covid, which
18 solves the problem in a much more sensible and
19 fundamental way.
20 A significant and vulnerable section of the
21 healthcare workforce is not directly employed.
22 Anecdotally it is understood that this group is
23 disproportionately black, Asian and minority ethnic as
24 compared to the directly employed workforce and more
25 likely to be in low pay, both identified as risk factors

1 in respect of Covid-19 and likely to be so again in the
2 next pandemic.
3 Indirectly employed staff, especially agency and
4 outsourced workers, are more likely to have poor or no
5 sick pay provision, they more likely to face pressure,
6 bullying or harassment from employs who face less
7 scrutiny and regulation than NHS trusts and health
8 boards.
9 Presently, the indirectly employed workforce is
10 a blind spot for those responsible for the services
11 these workers deliver. We have heard evidence that
12 NHS England does not hold any data on outsourced staff.
13 Indirectly employed workers are not accounted for in the
14 workforce plans or race equality strategies.
15 Sara Gorton, in her evidence on behalf of the TUC,
16 explained the difficulties this presents during
17 a pandemic in ensuring that terms and conditions
18 negotiated for the indirectly employed workforce are
19 actually afforded to them in practice.
20 Greater visibility and oversight of the indirect
21 workforce must therefore be achieved in advance of
22 a future pandemic, such that measures designed to combat
23 it may take account of and actually reach the full
24 workforce. The TUC and its affiliates consider that
25 outsourcing is a product of short-termism, a solution

1 aimed at reducing costs that results in poor working
2 conditions for which trusts, health boards and
3 centralised management are absolved of responsibility.
4 Interestingly, between 2008 and 2010 in Wales,
5 Scotland and Northern Ireland, cleaning services were
6 brought back in-house, with the key argument being
7 improved infection prevention and control associated
8 with in-house services.
9 In a similar vein, the Equality and Human Rights
10 Commission, in its 2022 report on the treatment of lower
11 paid ethnic minority workers, noted examples of
12 outsourced NHS services being brought back in-house in
13 England. One trust, it noted, was bringing cleaning and
14 catering back in-house to boost workforce equality and
15 support staff from ethnic minority groups.
16 The TUC, for its part, would strongly recommend
17 that a policy of insourcing is pursued in advance of
18 a future pandemic. At the very least, we say, three
19 steps must occur. First, there needs to be greater
20 visibility of the indirectly employed workforce. Trusts
21 and health boards should be obligated to collect from
22 agencies and outsourced workers the same workforce
23 information held about directly employed workers and
24 share it with NHS England and its counterparts in
25 devolved nations.

1 Second, the indirect workforce, once visible, must
2 be included in workforce planning, the Workforce Race
3 Equality Standard and other measures of workforce safety
4 and equality, staff surveys, and of course pandemic
5 planning. Clear plans must be in place to ensure that
6 the indirectly employed workforce receives good quality
7 IPC training, PPE and risk assessments, and promptly
8 receives updated IPC guidance.
9 Third, work needs to be completed to ensure that
10 mechanisms of social partnership reach the indirect
11 workforce and that trusts and health boards can ensure,
12 for example, that if full sick pay for indirectly
13 employed workers is agreed during a pandemic it is
14 actually implemented on the ground.
15 The migrant workforce faces additional layers of
16 precariousness, due in part to conditions of work
17 attached to their visas and their employer's role in
18 their legal status in the UK.
19 It is a part of the workforce less likely to feel
20 able to raise concerns, to demand risk assessments, PPE
21 and IPC training, and is more likely to fall into
22 presenteeism when self-isolation is required. We
23 consider that there are practical steps, to be set out
24 in our written submissions, around visa conditions and
25 sponsorship which would protect migrant workers and the

1 wider workforce from transmission of the virus.
2 Penultimately we turn to regulatory response in
3 the pandemic.
4 The Health and Safety Executive, for entirely
5 proper reasons, focuses its inspection activity on
6 high-risk sectors, which ordinarily means that HSC is
7 not afforded the same level of intervention as, for
8 example, manufacturing. However, in a pandemic, with
9 high levels of hospital admissions and fatalities,
10 a healthcare setting can move from being a relatively
11 safe workplace to a uniquely dangerous one.
12 But HSE inspections in the years of the pandemic
13 remained very low. During the pandemic the HSE
14 conducted over 400,000 spot checks and spot inspections,
15 but only 483 of those were in the healthcare sector,
16 0.1%. Additionally there is the problem of
17 under-reporting under RIDDOR. As a result the HSC did
18 not have the insight into the healthcare sector in order
19 to direct its regime of proactive inspection or identify
20 and remedy systemic problems.
21 We consider that a number of recommendations are
22 required to ensure that the HSC is required and able to
23 pivot at the outset of a pandemic affecting the
24 healthcare sector to provide proactive inspection, that
25 the RIDDOR system functions in a consistent and

1 meaningful way, and that the workforce regulator
2 actually knows when a healthcare worker dies of a virus
3 which they are far more likely to be infected by because
4 of their role.
5 Finally, my Lady, vaccination as a condition of
6 deployment. Significant evidence received in this
7 module has underlined the damaging effect of the pursuit
8 of vaccination as a condition of deployment in the NHS.
9 Proponents of the policy say that the risk-benefit
10 analysis falls in favour of the policy because the
11 issue is one of saving lives. But that misses the
12 point. Increasing vaccination uptake in the healthcare
13 workforce is important but this can be achieved through
14 methods of provision of information and access, support
15 and encouragement. Rates of vaccination observed in the
16 devolved nations' health and social care workforces,
17 where such a policy was not introduced, are evidence of
18 this fact. An approach of encouragement is also
19 consistent with the principle of informed consent which
20 underpins the UK's vaccination strategy.
21 It is clear from the data that in the Covid-19
22 pandemic, black Pakistani and Bangladeshi groups had
23 lower uptake of the vaccine. Studies, including those
24 outlined by Dr Habib Naqvi, found that higher levels of
25 hesitancy amongst some minority ethnic groups can be

1 linked to concerns about the number of minority ethnic
2 people included in clinical trials and fears stemming
3 from historical unethical research.
4 To simply mandate the vaccine to workers is to
5 fail to reckon with the underlying causes and risks
6 exacerbating them.
7 There are powerful arguments of principle against
8 vaccines as a condition of employment at all. Even if
9 those are rejected, the balance of value and cost of
10 such a policy will be influenced by factors such as the
11 characteristics of the particular virus, the efficacy of
12 the vaccine against transmission, and the stage of the
13 pandemic. Any recommendation on this topic must reflect
14 those factors and that nuance.
15 We also suggest that it should await the end of
16 Module 6, given the relevance of the issue to the social
17 care workforce.
18 My Lady, those are our submissions. Earlier this
19 morning you've noted that on a number of occasions
20 you've been challenged to be bold in your
21 recommendations. That reflects, my Lady, that the
22 fundamental problems which resulted in avoidable loss of
23 life in healthcare which we have seen in this module
24 inevitably necessitate bold action. Thank you.
25 **LADY HALLETT:** I'm very grateful, Mr Jacobs, it's as helpful

and constructive as ever. Thank you very much.

Mr Henderson.

Closing statement on behalf of Academy of Medical Royal Colleges by MR HENDERSON

MR HENDERSON: My Lady, you have heard a huge amount of evidence in this module and, like others, I commend all those who have submitted and given evidence, and your Ladyship and the whole Inquiry team for your diligence in absorbing the mass of material that you've had.

In my closing statement on behalf of the Academy of Medical Royal Colleges, which represents the Medical Royal Colleges and faculties across the UK, I want to focus on what we believe the Inquiry should be seeking to achieve, and then what we believe are the key themes the Inquiry needs to address.

The Inquiry must, surely, be more than a record of what happened of who did what and when. It must also be more than just as ascribing responsibility for what was or was not done. It must also seek to avoid inappropriate retrospective judgments. It must, surely, primarily be about learning lessons and should provide practical recommendations for the future to minimise harm in a future pandemic or emergency.

And we know it is highly likely there is going to

be another pandemic in the future. We can also be pretty sure that a pandemic of an unknown disease will cause casualties. People will fall ill and people will probably die because of a disease. There will also be collateral damage: necessary treatments will be cancelled or delayed; people will be unable or unwilling to access appropriate care. This will have its own consequences and its own casualties.

That was the case in this pandemic. It was the case in previous pandemics. It was inevitable, and it will happen again. Eliminating all risk and danger is not possible. However, the great gift of this Inquiry, and what it can bring, is identifying what we can do before and during any future pandemic so that harm and casualties are minimised, and ensuring we are sufficiently prepared to take the right actions so that the suffering felt by so many in Covid-19 is not repeated.

In our original submission in opening and written and oral statements, the academy made a series of 12 recommendations. They were based on the expertise of our member organisations who, in turn, drew on the experiences of their individual doctor members who worked on the front line of health services throughout the pandemic.

We believe and continue to believe that the considered views and experience of medical practitioners are valuable and essential in both the planning and management of pandemics, and in the learning of lessons for the future.

We've not heard anything during these evidence sessions which would lead us to substantially amend those recommendations and we hope the Inquiry will adopt them in its report.

In this statement, however, I'm not going to simply repeat those recommendations; rather, we have sought to pull them together with other lessons we've heard from the evidence into some overarching themes which we believe the Inquiry should address.

The four themes we have identified are: preparedness, responsiveness, learning, and transparency.

I will briefly look at each of those in detail.

Preparedness. Your Ladyship has already reported on the overall state of preparedness at a national level. That preparedness applies equally within the health services. There are things which need to be in place, and current, before any other pandemic starts.

In terms of our recommendations and the evidence that you have heard, this means capacity. As we've

heard, it is essential there is sufficient capacity in both workforce and bed numbers in the system to be able to manage future pandemics.

As has been stated by other people today, that is still not the case.

Testing policy. There must be a clear national strategy setting out the purpose, benefits and indeed limitations and delivery of testing.

Involvement in planning. There has to be full involvement of relevant professional and clinical bodies in pandemic planning, and this includes plans for supporting care homes, and for considering the mental health consequences for public and staff.

IPC strategy. There must be an up-to-date infection prevention and control strategy which can be flexible enough to meet the particular circumstances of a future pandemic. This includes having sufficient stock of PPE and workforce strategies. We must have in place clear plans for the deployment of staff, retaining and bringing in additional capacity.

Second, responsiveness. This relates to the activities which need to happen during a pandemic. Most of these in effect entail effective implementation of the strategies identified in the preparedness phase, and this includes:

- Agile and flexible crisis management, including deployment of resources in response to geographical variation, and efficient delivery of any vaccination or treatment programme.
- Engagement, early and regular and continued engagement, with clinical professional bodies.
- Efficient staff recruitment, deployment and redeployment.
- Staff support in terms of both practical and psychological support.
- The effective distribution and use of PPE.
- And then, rather more broadly, effective communications, clear and consistent public health messaging across four nations. And, importantly, political consistency of wider messaging. Different messaging and approaches across the four nations did cause and would cause difficulties for the public and for healthcare professionals.

Thirdly, learning. We have to ensure shared learning between providers, between research bodies, professional organisations and government.

Next, in terms of clinical advice, we must ensure for the future that any advice professional bodies produce aligns with accepted nationally agreed guidance, or, where there is genuine difference of clinical

opinion, and that may well be the case, that this is evidence-based and clearly set out and explained.

And then, ensuring that we protect clinical education and training. We've not heard about this much but it is vital, both to maintain the future supply of health services and the continuing supply of health professionals, that education and training is not ignored and not lost. It may have to change how it's delivered, some things may have to be on hold, but we cannot ignore education and training.

And finally, transparency. That is for all involved being transparent about the state of affairs, avoiding both rose tinting and doom mongering, both of which I believe we saw during the pandemic.

And then honesty on what can and cannot be achieved. Crucially, transparency, honesty and engagement must be at the heart of any government's management of future pandemics. Any erosion of trust will always have a negative impact and negative consequences.

So in conclusion, my Lady, these are the considered recommendations of those with direct knowledge and understanding of the pandemic, and we will expand on these recommendations in our written submission.

We do not believe we can eliminate risk and harm in a future pandemic, but we do believe, if the Inquiry adopts our recommendations and, crucially, if they are then implemented by government and other relevant bodies, we could significantly reduce the harm for patients, public and staff in any future pandemics.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Henderson. Very grateful to you for your thoughts.

Ms Sen Gupta.

Closing statement on behalf of Frontline Migrant Health Workers Group by MS SEN GUPTA KC

MS SEN GUPTA: Thank you, my Lady.

As your Ladyship knows, the Frontline Migrant Health Workers Group is comprised of three organisations: United Voices of the World (UVW), Independent Workers' Union of Great Britain (IWGB) and Kanlungan. The group sincerely thanks your Ladyship and the Inquiry team for giving their members the opportunity to participate in Module 3, allowing them to give evidence to your Ladyship, to ask questions of other witnesses and to make submissions.

The importance of frontline migrant health workers during the pandemic and the disproportionate impact on them has rightly become a key feature of the evidence

during Module 3.

The group wishes to emphasise that the systemic issues like outsourced employment are applicable across the working class as a whole, regardless of ethnicity.

A persistent and recurring theme in the accounts of outsourced and migrant workers is that they had no voice throughout the pandemic. They could not speak out for fear of the consequences for their employment, and their immigration status. Even when they did speak, no one listened. These accounts are borne out by the evidence in this Inquiry.

In the thousands of pages of documents disclosed by the mass of organisations that make up the healthcare systems, there is barely any reference to them at all. The standout feature of the evidence is that even when they were making the ultimate sacrifice, outsourced and migrant workers were routinely overlooked.

IWGB, UVW and Kanlungan gave their members a voice. This Inquiry has also given them a voice, for which we are grateful.

My Lady, we addressed our opening submissions by reference to the slogan of the Johnson government: "Stay Home, Protect the NHS, Save Lives".

We emphasised how our client's members could not stay at home and how they worked as part of the NHS

healthcare system in order to save lives. We address our oral closing submissions by reference to three periods of time: before the Covid-19 pandemic, during the pandemic, and the future.

Pre-pandemic failures.

Your Ladyship has addressed the pre-pandemic position in Module 1 on preparedness. Lord Darzi has also recently undertaken a review of the NHS. He described how the resilience of the UK had been worn down by the chronic underinvestment and the most austere decade of funding in the NHS that preceded the pandemic. He also described a chronically weakened system, with downgraded capacity and capability, with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems.

At the same time, many of the social determinants of health, such as poor quality housing, low income, insecure employment have moved in the wrong direction over the past 15 years, with the result that the NHS has faced raising demand for healthcare from a society in distress.

The NHS was left underfunded, under-resourced, and understaffed, and the underlying health of the nation has declined significantly.

Underfunding contributed to a rise in outsourced labour, particularly in non-clinical workers. NHS trusts believed that outsourcing would cut some of the costs that they had been forced to cut.

When the pandemic hit in early 2020, around half of the UK's hospital sites had outsourced ancillary services. Outsourced workers were earning poverty wages and working more than one job in different locations but with none of the contractual protections of in-house employees.

Understaffing led to an increased reliance on migrant labour. Clinical and non-clinical staff were recruited from overseas, but the policies and narrative of the "hostile environment" guaranteed their exposure. Their visas were wholly dependent on their continued employment, making them pliable and vulnerable. Their visa conditions excluded them from accessing the public funds that their British colleagues were entitled to.

This low-income insecure employment is precisely what Lord Darzi was referring to. The social determinants of health have moved in the wrong direction in society as a whole, but, critically, they've moved starkly in the wrong direction within the healthcare workforce, the very workforce that exists to protect the rest of us.

During the pandemic the group's members experienced the pandemic as part of a second tier of the healthcare workforce: the lowest paid and in the most insecure employment. The pandemic magnified these issues. Your Ladyship heard compelling evidence from Alex Marshall, president of the IWGB. He told the Inquiry that the pandemic poured petrol on an inferno that was already blazing.

All of the group's members had to work during the pandemic. There was no furlough for the frontline migrant health workers. The nature of their work meant that they were inevitably exposed to infection: the nurses working directly with patients and delivering care; hospital cleaners and porters spending prolonged periods in wards doing physical work; hospital security guards also spending prolonged periods in hospitals, sometimes undertaking additional physical tasks such as portering; medical couriers entering hospitals and returning to a central hub with other couriers, who had also recently entered hospitals, before moving to a different hospital and repeating the process; taxi drivers, contracted to transport healthcare workers and patients to and from hospitals, spending prolonged periods in the confined space of a vehicle.

They were all hospital workers. The two-tier

worker system manifested itself in a number of ways during the pandemic.

Witness 1, a hospital cleaner, gave direct evidence of the experience of many thousands of outsourced migrant workers in relation to PPE. When gowns, aprons, gloves and better masks were provided to in-house staff, she was allowed a single FRSM at the beginning of her shift. She had no one to ask for better protection. She had to take better PPE.

When clinical employed NHS staff received PPE, training late, outsourced workers like W1 often received no training at all.

Risk assessments also often did not happen at all. If they did, they were consistently late, or inadequate.

In W1's case, neither her hospital managers, nor her outsourced employers, ever asked a single question about her welfare. Outsourced non-clinical staff were regularly in the lowest priority categories for testing and vaccination. Migrant and outsourced workers were pressured into working in higher-risk environments. They were unable to say no because of their precarious employment and/or immigration status. The system of sick pay was so inadequate for outsourced workers that they had to choose to go into work and risk lives, or stay at home and face potential destitution.

1 Your Ladyship heard powerful evidence from W1 that
2 had she become symptomatic, she would have had to
3 continue working. These workers knew that they were
4 vulnerable, they knew that they were working with
5 patients who were vulnerable. Their underprotection and
6 overexposure had implications beyond their own welfare.
7 It heightened the risk to those around them. It was
8 a major failing in the whole IPC process. These workers
9 raised warnings on these issues either individually or
10 through organisations like Kanlungan and unions like UVW
11 and IWGB. At no point were any of them listened to.
12 The devastating impact on them was inevitable,
13 from higher infection rates and high incidence and
14 severity of Long Covid to the truly shocking mortality
15 rates, they are worth repeating.
16 Up until 22 April 2020, 63% of the healthcare
17 worker deaths were ethnic minority workers and, of that
18 63%, at least 83% were migrants.
19 36% of those migrant deaths were workers from the
20 Philippines. That was, by far, the highest national
21 mortality rate for migrant health workers. The ONS
22 occupational data from May 2020 flagged these
23 outsourced, gig-economy, low-income occupations in the
24 highest mortality categories: healthcare assistants,
25 care workers, cleaners, security guards, and drivers.

1 Public Health England's June 2020 report,
2 disparities in risks and outcomes, repeated those
3 findings.
4 Occupations with the highest infection and
5 mortality rates were those with the highest exposure and
6 the lowest pay. Migrants had significantly higher
7 mortality rates. The impact was clearly predictable.
8 Low-paid workers, living in the most deprived areas, in
9 multi-occupancy, low-quality housing, and packed into
10 public transport, were going to be hit hard.
11 When their work is essential and exposed, they
12 were going to be hit harder still. When their work is
13 made precarious by immigration conditions or a lack of
14 contractual protection, they were going to be hit the
15 hardest of all. As Professor Sir Chris Whitty said,
16 "Poverty is a risk factor for infections everywhere."
17 The government response was characterised by
18 silence and inaction. The first layer of silence was
19 the data. The ONS data was considered the gold standard
20 by many of the witnesses, but it did not include the
21 deaths of any workers who arrived in the UK after 2011.
22 Almost a decade's worth of migrant workers were not even
23 counted.
24 Filipinos are the largest national group of
25 workers in the NHS, behind British and Indian workers;

1 no official data was gathered on infection and mortality
2 rates in Filipino workers. No official data was
3 gathered in respect of the migrant mortality rates.
4 Subcontracted staff were not represented in the
5 NHS datasets.
6 The DHSC, "the" department responsible for
7 healthcare workers, did not even include workers like
8 cleaners in its data on healthcare worker mortality.
9 The true picture of migrant mortality would have been
10 significantly higher than that recorded.
11 Despite these data inadequacies, the impact on
12 migrant and outsourced workers was clear enough. But
13 nothing changed. Mr Hancock confirmed that he was
14 aware, from the spring of 2020, that migrant workers
15 were suffering disproportionately high mortality rates.
16 But your Ladyship will recall that his attempts to
17 explain why he took no specific steps in relation to
18 that group were extremely weak.
19 The future. The Race and Health Observatory is
20 focused on tackling ethnic and racial inequalities
21 within the healthcare system, but even their reports
22 have a distinct lack of consideration for the
23 immigration status of the workforce. Lord Darzi,
24 reliant as he was on reports from that observatory,
25 makes no reference to the impacts of immigration status

1 or precarious employment within the healthcare
2 workforce.
3 Across the board, the evidence has shown that
4 these categories of worker were not considered. They
5 were left exposed and unprotected. There was a lack of
6 accountability, a culture of blame shifting, under the
7 health system that is structured in such a way that
8 responsibility is impossible to pin down. That was
9 encapsulated by CTI's very pertinent question to
10 Alex Marshall: if you are an outsourced worker or
11 a migrant worker, who do you complain to?
12 Within the UK health system, even responsibility
13 has been outsourced.
14 Recognition from Dame Jenny Harries and
15 Professor Stephen Powis that risk assessment and IPC
16 measures must be applied consistently and equally across
17 the NHS workforce, whether employed or outsourced, is
18 welcome. But this must translate into concrete change
19 where responsibility for a safe working environment
20 clearly lies with a single entity and subject to
21 regulatory sanction in the event of a breach of health
22 and safety law.
23 The owners or managers of the workplace, where the
24 risk exists, ie, the hospitals, are best placed to
25 assess and mitigate that risk.

The simplest and most effective way of ensuring consistency and equal treatment, leading to a serious reduction in the risk to healthcare workers and the public, is to bring outsourced health workers in-house. It is overwhelmingly clear that if there were another pandemic tomorrow, the low paid, precariously employed, migrant healthcare workers would continue to die at the same, significantly higher, disproportionate rates.

Both Mr Hancock and Sir Sajid rightly acknowledged the importance of the frontline outsourced workers.

The importance of these workers needs to be fairly reflected now so that they are not in the same position during the next pandemic.

To have a two-tier healthcare system, where some workers are more exposed than others because of their employment contracts or immigration status, despite doing the same jobs in the same hospitals, is a fundamental injustice.

As Alex Marshall pointed out, it is also a public health issue. Exposing these workers exposes their communities and their patients.

This is one of the key lessons learned. The primary recommendation sought by the Frontline Migrant Health Workers Group is for an end to this two-tier system of health workers. Professor Sir Chris Whitty

told your Ladyship that part of the preparation for the next pandemic is to reduce the vulnerability of the people we already know are vulnerable. In his words:

"... what would have been actually more helpful is to make the employment of people less precarious ..."

"... reducing economic precariousness is one of my strong recommendations to my successors", he said.

Within the healthcare system, that precarious employment has to end now.

My Lady, we respectfully submit that healthcare workers must be directly employed by the NHS hospital trusts they work in. Migrant healthcare workers must enjoy the same protections as their non-migrant colleagues. We need to ensure that they are not ignored by the NHS and by government in the future.

My Lady, frontline healthcare workers protect us all. We need a healthcare system that also protects them.

Thank you, my Lady.

LADY HALLETT: Very grateful, Ms Sen Gupta, thank you very much.

Mr Thomas, if you'll forgive me, I think we'll break now and come back at 1.50 to hear from you on behalf of FEMHO. Sorry to cut you off in your prime.

MS CAREY: My Lady, I'm sorry to interrupt, but I suspect

Mr Thomas may not be able to be here this afternoon and is rather keen to address you before lunch. I'm so sorry.

LADY HALLETT: I'm sorry, that message hadn't reached me, Mr Thomas. If you're in difficulty this afternoon, of course, carry on now, please.

MS CAREY: Thank you, my Lady.

Closing statement on behalf of Federation of Ethnic Minority Healthcare Organisations by PROFESSOR THOMAS KC

PROFESSOR THOMAS: I am grateful, my Lady.

My Lady, as you know, I represent FEMHO.

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."

Those were the words of Martin Luther King Jr before the Second Convention of the Medical Committee on Human Rights in March 1966.

This Inquiry's legacy begins by confronting an uncomfortable truth: the fact that the pandemic laid bare the pervasive inequities in our healthcare system, inequities that left ethnic minority healthcare workers on the fronts ill-equipped, unsupported, and ultimately betrayed by the institutions that they served and that were there to protect them.

These devastating outcomes are not mere

coincidences or unavoidable tragedies of a global crisis; instead, my Lady, they were the foreseeable results of systemic neglect, historical inequalities left unremedied, and a healthcare system deeply entrenched in structural and institutional racism, a pernicious form of discrimination that we must confront, however uncomfortable that confrontation maybe.

You see, the racism was not only perpetuated by explicit action, but also by omission. It manifested in decisions made, decisions deferred, and decisions never even considered. It resulted in preventible harm, and suffering, lives lost, and communities left without the support they so desperately needed.

The healthcare system's failure to protect ethnic minority healthcare workers was, at its core, a failure of accountability, leadership and a moral imperative to value every life equally.

Yet this Inquiry must do more than just note this reality, it must ask and answer fundamental question: why? Why was this allowed to persist? And why did it take a pandemic to expose it so starkly? After all, there have been numerous reports and recommendations made on many of the underlying issues that have failed to result in positive change.

The answer lies in systemic failings, historical neglect, and an unwillingness to face hard truths until human cost became too great to ignore.

This Inquiry has the potential to be a turning point. It's a chance to confront these failings, to understand why they happened, and to ensure that lessons learned lead to meaningful change and meaningful reform.

My Lady, structural and institutional racism are the elephant in the room. During the pandemic, these were not abstract concepts but lived realities for thousands of black, Asian and minority ethnic healthcare workers. They manifested in policies, practices and systems that disadvantage ethnic minorities, particularly during a crisis. The pandemic exposed deep-rooted deficiencies within the NHS and public health systems that were too ill-equipped and lacked the inclusivity needed to protect all workers equally.

There were data failures. The failure to collect robust ethnicity data was a fundamental flaw, made more egregious by the wealth of evidence that this was a known issue prior to the pandemic.

Inadequate collection of ethnicity data hindered the ability to identify disparities, and delayed targeted interventions with decision-makers preferring to wait for more data rather than take action on what

they were seeing and hearing alone.

Communication gaps. Public health messaging often failed to reach ethnic minority communities due to cultural insensitivity and linguistic barriers. This was a systemic neglect that led to mistrust and ultimately poorer health outcomes.

Vaccine hesitancy among ethnic minority groups, for instance, was compounded by these ineffective communication strategies. Branding ethnic minority groups as hard to reach is particularly unhelpful, however convenient and easy a response it is.

As Professor JS Bamrah put it, it sends the wrong signal because it implies that the problem is with you and not with us.

The lack of ethnic minority representation in decision-making bodies further compounded these issues. Policies were developed without the voices of those most affected, leading to one-size-fits-all approach that ignored or at best misunderstood the unique challenges faced by ethnic minority communities.

My Lady, behind every statistic is a human story, a life impacted, a family grieving, a community left vulnerable. Healthcare workers who lost their lives or endured severe illnesses were not just numbers, they were individuals who deserved protection and respect.

To give proper context to this Inquiry, it is essential to define two key concepts that underpin much of the evidence we have examined: institutional racism and structural racism.

These terms are not interchangeable. Understanding their distinction is critical to understand how systemic inequalities operated during the pandemic.

Let me turn to institutional racism. This refers to the policies, practices and procedures of institutions that intentionally, or unintentionally, produce outcomes that disproportionately disadvantage racial or ethnic groups. It operates within individual organisations such as healthcare trusts, and manifests in inequitable outcomes due to biases embedded in processes and practices.

During the pandemic, institutional racism was evident in deployment practices, access to PPE, exclusion from decision-making, whereas structural racism encompasses the interconnected societal systems and structures that perpetuate racial inequalities. It's reflected in the cumulative effects of inequities across sectors including health, education, housing and employment.

And, during the pandemic, structural racism

operated as a backdrop, amplifying the vulnerabilities of ethnic minority healthcare workers, and we can see that in the socioeconomic disparities: many black, Asian and ethnic minority workers live in areas of high social deprivation, with limited access to healthcare and poorer living conditions. And these factors increased their susceptibility to severe Covid-19 outcomes.

My Lady, why definitions matter: understanding institutional and structural racism is not just an academic exercise; these concepts provide a framework for examining how and why ethnic minority healthcare workers were disproportionately affected. They also offer a roadmap for systemic reform, underscoring the need for accountability. Institutions must confront their role in perpetuating inequities and commit to transformative change. Equity-centred planning, future public health strategies, must actively dismantle structural barriers and embed equity at their core.

Inclusion. Ethnic minority healthcare workers and communities must be central to decision-making processes to ensure that their needs are met.

My Lady, the intersectionality of race, class, and gender further exacerbate their plight. Many ethnic minority workers lived in overcrowded or multi-generational households where the risk of

1 transmitting the virus to vulnerable family members was
2 heightened. For women, often balancing care giving
3 roles with frontline duties, the strain was particularly
4 acute. Economic disadvantage and limited access to
5 resources such as safe housing, or alternative care
6 options, compounded the risks they faced daily.
7 These disproportionate outcomes were not
8 inevitable; they were the predictable result of systemic
9 neglect, of public health strategies largely ignored the
10 socioeconomic and structural determinants of health that
11 amplified vulnerabilities for ethnic minority workers.
12 The tragic loss of life of the first ten doctors should
13 have been a wake-up call. We heard that the first ten
14 doctors were doctors of colour. Instead it highlighted
15 a healthcare system unprepared to protect its most
16 vulnerable workers.
17 Addressing these inequities requires systemic
18 change, not token gestures, to ensure that such
19 devastating disparities are never repeated.
20 My Lady, our written submissions will address
21 these recommendations in detail. At this stage we set
22 out the key themes emerging from Module 3 that need to
23 be addressed.
24 The failures in PPE. This wasn't just
25 a logistical failure. It was a failure in the moral

1 commitment to equity and inclusivity within healthcare.
2 Workers faced a cruel dilemma: choose between
3 personal safety and deeply held religious beliefs.
4 Barry Jones spoke of how powered air purifying
5 respiratory hoods could have been a viable solution, one
6 that did not require fit testing and avoided the
7 exclusionary effects of traditional FFP3 masks; yet
8 these hoods, despite their effectiveness, were not
9 pursued by decision-makers at the highest levels, and
10 were rarely made available.
11 Many ethnic minority healthcare workers who were
12 overrepresented in high-risk roles, such as porters,
13 cleaners, frontline nurses, often reported delay or
14 shortages in accessing accessible PPE. Fiona McQueen
15 testified that the non-clinical roles, including porters
16 and cleaners, were often the last to receive adequate
17 PPE.
18 In the face of such systemic neglect, many others
19 took it upon themselves, my Lady, to repurpose materials
20 for makeshift PPE, driven by a desperate need to protect
21 themselves.
22 PPE stockpiles procured did not account for the
23 diverse facial features, and were largely based on the
24 Sheffield man face, a standard white male face shape
25 that did not reflect the diversity of the healthcare

1 workforce. Such oversights highlight a broader failure
2 to prioritise the safety of vulnerable groups in
3 healthcare planning.
4 Then there was equipment inadequacies. The
5 pandemic also exposed inadequacies in medical equipment,
6 such as -- the pulse oximeters being a stark example:
7 designed and tested without consideration of darker skin
8 tones. Yet these devices frequently provided inaccurate
9 readings for ethnic minority patients.
10 This was a well-known flaw that had existed
11 for years and went unaddressed despite research
12 consistently showing the devices to be less reliable for
13 people with darker skins.
14 The NHS Race and Health Observatory through the
15 testimony of its CEO highlighted how the use of these
16 devices led to delayed treatment for ethnic minority
17 patients, ultimately worsening their health outcomes.
18 And as Sajid Javid himself noted at the time, this may
19 well have as a resulted in deaths.
20 So what does this tell us? It reveals a troubling
21 lack of accountability in design, procurement, and
22 evaluation of medical devices. It shows that the
23 healthcare system failed to challenge or question
24 whether the tools it relied on were suitable for all
25 populations.

1 The reliance on the one-size-fits-all approach in
2 medical equipment and protective gear meant that the
3 healthcare systems tactically endorsed practices that
4 placed ethnic minority lives at greater risk.
5 But, my Lady, this is not just about flawed
6 devices, it's about a flawed system that tolerated
7 inequity in its operation. The failure to address these
8 shortcomings sooner demonstrates the systemic disregard
9 for the unique needs of minority populations,
10 a disregard that should never have been acceptable.
11 Inadequate risk assessments. Risk assessments
12 that could have identified specific needs but were often
13 a tick box exercise.
14 Ruth May mentioned that, despite her push to speed
15 up risk assessments for ethnic minority staff, many were
16 left unprotected in the meantime. There was no national
17 standardisation of these risk assessments and the lack
18 of targeted measures to protect high-risk groups left
19 thousands exposed to the worse effects of the virus.
20 Even where risk management protocols were
21 designed, their implementation was inconsistent across
22 healthcare settings. Some organisations acted swiftly
23 to mitigate risk, conducted thorough assessments in
24 providing accommodation, such as redeployment or
25 enhanced protective measures. However, others failed to

1 adopt such measures uniformly, a failing to achieve
2 effective outcomes leaving gaps in protection for those
3 most in need.
4 This patchwork approach underscored a lack of
5 a centralised accountability and oversight.
6 Let me turn to Long Covid. The pandemic's
7 long-term effects, particularly Long Covid, have
8 disproportionately impacted ethnic minority healthcare
9 workers. These workers not only faced heightened
10 exposures to the virus but now endure lasting health
11 complications at greater rate.
12 Preparedness and future planning. The pandemic
13 revealed glaring gaps in preparedness, particularly
14 equity-focused planning and resource allocation. Ethnic
15 minority healthcare workers were disproportionately
16 affected not because the virus discriminated but because
17 the systems meant to protect them failed to account for
18 pre-existing inequities. The absence of inclusive
19 planning in pandemic responses, such as equitable
20 stockpiling of resources and culturally competent
21 policies, exacerbated these disparities.
22 Accountability. Accountability is pivotal in
23 addressing systemic inequities that plagued the pandemic
24 response. Equally concerning is the lack of robust
25 accountability frameworks to address these disparities.

1 Despite numerous reports highlighting the
2 disproportionate impact of Covid-19 on ethnic minority
3 healthcare workers, there was little evidence of timely
4 or decisive action to mitigate these effects.
5 Data collection and transparency. The
6 inadequacies in ethnic-based data collection during the
7 pandemic severely hampered the ability to develop
8 effective public health responses. A standardised
9 approach to data collection is urgently needed,
10 inclusive tools that accurately capture
11 ethnicity-related metrics must be prioritised.
12 My Lady, let me turn to the impact on mental
13 health. Ethnic minority healthcare workers faced
14 disproportionate mental health challenges during the
15 pandemic, reflecting the compounded effects of systemic
16 inequities on frontline exposures. The heightened risk
17 of infection combined with witnessing disproportionately
18 high mortality rates among colleagues and patients took
19 a significant told on mental well-being.
20 So, my Lady, let me come to my conclusions.
21 FEMHO closes with a stark truth: ethnic minority
22 healthcare workers and communities bore
23 a disproportionate burden during the pandemic, not
24 merely as a consequence of individual failings or
25 oversight but, rather, as a result of deeply entrenched

1 structural and institutional racism within our
2 healthcare system. These factors intertwined to create
3 this impact which was not novel or unexpected but, in
4 contrast, were the inevitable outcomes of known issues.
5 FEMHO workers were not only disproportionately
6 frontlined, they were disproportionately forgotten.
7 So, what can we do? This is not about simply
8 improving processes or updating procurements, it's about
9 a fundamental rethinking of what equity means in
10 healthcare. It's about ensuring that healthcare systems
11 do not treat patients but also care for those who
12 deliver that treatment, whatever their ethnicity or
13 outcome. It's about a commitment to making healthcare
14 not only technically competent but culturally competent.
15 This means investing in research to develop medical
16 equipment that works for all populations.
17 My Lady, as I come to the conclusion, this is not
18 just a story about failures, it's a call to action.
19 FEMHO urges this Inquiry to adopt the forward thinking
20 solutions that have been proposed, embedded in equity,
21 in pandemic preparedness, addressing the disparities
22 through accountable leadership, culturally competent
23 care. These are not just recommendations but these are
24 necessities if we are to build a healthcare system that
25 values life equally.

1 It's not about just finger-pointing; it's about
2 ensuring that we do not repeat the mistakes of the past.
3 The pandemic was a devastating chapter but also offers,
4 my Lady, an unprecedented opportunity to rewrite the
5 narrative of the healthcare in this country.
6 So, as I conclude, as we leave this room, let us
7 not leave lessons behind that we have learned. Let us
8 commit to a future where all healthcare workers are
9 valued for their skills, not discriminated because of
10 the colour of their skin, where no patient is left
11 unseen, where no community is left unheard.
12 Let this Inquiry be a turning point, a moment
13 where we finally say enough: enough of systemic
14 inequities, enough of avoidable harms, enough of lives
15 being lost to racism and neglect.
16 This is our charge, and this is your moment to
17 lead. Let us not waste it.
18 Thank you, my Lady.
19 **LADY HALLETT:** Thank you very much indeed, Mr Thomas. As
20 I expected, another very powerful piece of advocacy.
21 I'm very grateful to you.
22 Right. We shall adjourn now, and I shall return
23 at 2.10.
24 **(1.08 pm)**
25 **(The short adjournment)**

1 **(2.09 pm)**
2 **MS CAREY:** My Lady, good afternoon.
3 **LADY HALLETT:** Good afternoon, Ms Carey.
4 **MS CAREY:** I think the first advocate to address you this
5 afternoon is Mr Wolfe, King's Counsel.
6 **LADY HALLETT:** Thank you very much, Mr Wolfe.
7 **Closing statement on behalf of John's Campaign, Care Rights**
8 **UK and Patients Association by MR WOLFE KC**
9 **MR WOLFE:** My Lady, John's Campaign, The Patients
10 Association and Care Rights UK have closely followed and
11 participated in this module.
12 The issues we highlighted at the start turned out
13 to be key concerns for many witnesses, many core
14 participants and many contributors to the listening
15 exercise. The CTI team notably focussed on the same
16 issues with many witnesses. We thus welcome
17 considerable agreement amongst participants in this
18 module on the issues about which we are concerned.
19 First, agreement on DNACPR as follows. DNACPR
20 notices should never be imposed without individualised
21 assessments or the participation of patients and
22 families. A DNACPR notice does not imply a decision not
23 to treat.
24 The NHS is for all. No group is unworthy of
25 treatment because, for example, of their age,

1 disability, care needs or place of residence.
2 All lives are of equal value and health policies
3 and practices must reflect those things.
4 Secondly, my Lady, agreement on virtual
5 consultations as follows.
6 Virtual consultations facilitated healthcare
7 access for some, but they were not for everyone. They
8 were not for the digitally excluded, not for some older
9 and disabled people, and not for people with particular
10 language needs. That, of course, is an ongoing problem.
11 Third, agreement that the greatly increased
12 reliance on NHS 111 had similar shortcomings against
13 again is an ongoing problem.
14 Fourth, excluding familiar carers and visitors
15 from healthcare settings harmed patients, their loved
16 ones, and healthcare staff.
17 Fifth, agreement that decisions without proper
18 consultation with directly affected people were not good
19 decisions, including decisions on IPC measures.
20 On the basis of those agreements, we point to some
21 key themes coming from this module.
22 The first theme is the core importance that
23 people's loved ones have in their lives. We recall
24 moving evidence from members of the Covid bereaved
25 groups, from impact films and from Every Story Matters.

1 We note the measures voluntarily adopted by members of
2 the Clinically Vulnerable Families group and many others
3 to keep their loved ones safe.
4 It may seem trite to say that we love our loved
5 ones, but Covid and the policies introduced to manage it
6 highlighted the strength of our attachments, the way
7 that they order and shape our lives, and that the way
8 that they impact on our well-being. That realisation
9 must be built upon. It must heighten our concern for
10 those without immediate family, whose suffering may
11 otherwise go unnoticed.
12 My Lady, the second theme we draw is the sheer
13 diversity and variety of people and the uniqueness of
14 personal and medical needs, as seen from the witnesses
15 speaking for older people, for disabled people, for
16 people of colour, expectant and post-partum mothers, and
17 whenever individual voices have been heard.
18 That's closely related, my Lady, to the third
19 theme we've noticed: the unanimity of witnesses saying
20 that high quality healthcare is person-centred. That
21 means a GP focussing on a patient in their community, a
22 specialist nurse assessing a particular course of
23 treatment or a nurse providing effective compassionate
24 care.
25 A patient-centred healthcare system must ensure

1 that a patient's voice is heard; likewise, their chosen
2 representative, like a friend or family member, who is
3 the "expert" in that person.
4 Similarly, even in a pandemic, quality matters.
5 We've heard too many accounts of quality standards,
6 human rights and ethical principles being abandoned or
7 least worse decisions being made. We challenge the
8 wisdom of that approach. And, of course, our healthcare
9 system should serve people, not institutions. The
10 patient's rights must be at the heart of how the system
11 operates, not peripheral to it.
12 We also stress that the NHS staff are vital people
13 within the system who must be protected and supported.
14 And if family carers are understood as equally part of
15 the patient's team, there needs to be no conflict of
16 interest.
17 A final, less well articulated theme, has been the
18 extent to which in the pandemic private individuals
19 stepped up to fill the gaps, to try to compensate for
20 failures in the public healthcare system.
21 We have in mind the nearly 5 million people who
22 newly became additional unpaid familial carers, in
23 effect unacknowledged healthcare workers. When patients
24 were discharged from hospital prematurely, when
25 operations were cancelled, when regular treatments and

1 community support were unavailable. They brought the UK
2 unpaid carer total to perhaps 13.8 million. Yet they
3 were, and remain, overlooked, unsupported and often
4 excluded.
5 Standing back from those things, my Lady, we are
6 concerned how much the pandemic pressure exposed lack of
7 capacity in the healthcare system. So many of the
8 people for whom we speak were denied treatment or had to
9 endure long and damaging postponements, often with poor
10 communication and little apparent recognition of their
11 plight. That was a huge problem. But today we focus on
12 just one element within it, that is the exclusion of
13 people's carers, relatives and friends, both as a denial
14 of person-centredness and as an example of making bad
15 worse.
16 That happened because there was little recognition
17 of the important difference between social visitors and
18 familial carers. The latter always ought to have been
19 treated as indispensable members of the patient's care
20 team.
21 In that regard the Inquiry heard of the terrible
22 impact of excluding carers, relatives and friends, it
23 had on patients and their loved ones, particularly at
24 the key moments of birth and death but also potentially
25 jeopardising the success of the very treatment for which

1 a person had been admitted.
2 For those living with dementia, other cognitive
3 impairments or communication difficulties, exclusion of
4 a carer meant that their safety as well as the quality
5 of their care and treatment was put at risk. Even the
6 legality of treatment interventions became questionable
7 when proper consent was not obtained.
8 Belated modification of blanket exclusion
9 policies, frequent changes in guidance and the
10 psychological effect of initial prohibitions on fearful
11 and overstretched staff meant that carer access was
12 still too often refused even when the guidance improved.
13 Those wards and hospitals which successfully
14 welcomed carers on the other hand showed this was
15 possible and beneficial. Variability within the system
16 added to distress where access was denied.
17 Patients particularly impacted were often those
18 entitled to reasonable adjustments under the
19 Equality Act. We note policies of local discretion, we
20 say unsupported but -- they gave -- unsupported by
21 a clear understanding of patient needs, they proved
22 damagingly inadequate. Then, in breach of the top-down
23 advice, dying patients were often refused the comfort of
24 someone they loved. We can only imagine the suffering
25 and distress this must have caused to dying people. It

1 caused long-term harm to their survivors. It must never
2 happen again.
3 The Inquiry has also heard it was not just
4 patients and their families who suffered as a result of
5 the overly restrictive visiting practices. Many
6 healthcare staff also experienced moral injury and
7 distress as they held iPads to dying patients or felt
8 their ability to provide quality healthcare undermined
9 by the absence of a patient's family. We note that many
10 witnesses agreed that familial carers should have been
11 allowed to support patients in healthcare settings at
12 all times.
13 For example, Stephen Powis agreed there should
14 have been clearer, earlier -- that visitors with
15 dementia -- that patients with dementia and learning
16 disabilities were expressly permitted.
17 Matt Hancock suggested guidance for a future
18 pandemic needs to make this clear. The chief nursing
19 officers of all four nations all agreed.
20 And Amanda Pritchard agreed that families should
21 have been more involved in discharge planning and
22 patient experience teams more involved in helping ensure
23 dialogue with families.
24 My Lady, those things are ongoing issues.
25 We welcome just three points. We make three

1 points going forward arising from those concerns.
2 First, Charlotte McArdle, having attempted a partners in
3 care scheme for Northern Ireland is helping develop
4 a clear inclusive policy for adoption by NHS England.
5 That would be a welcome start but more will be needed.
6 Second, future pandemic planning must ensure
7 patients receiving healthcare in any setting have the
8 clear rights to necessary personal support. Planning
9 can then focus on practical ways to make that happen,
10 even in difficult circumstances.
11 Consideration must also be given to how best to
12 support the individual needs of people who don't have
13 support from family or friends.
14 Third, although there are existing statutory
15 obligations that should have guided how decisions were
16 made, even in emergencies, they fell by the wayside in
17 the pandemic. We mention five of them.
18 The duty to promote the involvement in patients in
19 section 13H of the NHS Act.
20 The NHS's constitution, commitment -- underpinned
21 by a statutory obligation of section 2 of the Health Act
22 to put the patient at the heart of everything the NHS
23 does.
24 The Human Rights Act 1998, which requires
25 individualised assessments to ensure protection of

1 individual rights.
2 Obligations of non-discrimination and obligations
3 to make reasonable adjustments along with the public
4 sector equality duty in the Equality Act.
5 And finally, the duty to consult families to make
6 best interest decisions under the Mental Capacity Act.
7 We learned during the pandemic and from the
8 evidence in this module that at times of fear and
9 overwork, hasty and poorly thought out decisions were
10 made, both at a senior and junior level, without
11 adequate or any regard to these essential legal
12 requirements. We ask the Inquiry to re-emphasise the
13 centrality of law and its supremacy over guidance.
14 We also suggest that training for all healthcare
15 workers should include awareness of these legal
16 principles and how they should apply them in their
17 everyday practice.
18 We then specifically ask the Inquiry to recommend
19 three things.
20 First, the establishment of better complaints and
21 feedback processes for patients and their families.
22 They need a clear point of contact in every institution,
23 large or small, to help with the enforcement of the
24 existing protective obligations, and identify
25 difficulties.

1 Secondly, the establishment of proper systems of
2 consultation with patients, their loved ones and
3 representatives, including representative patient groups
4 and organisations, when steps are being proposed that
5 will have a direct impact on their well-being. Such
6 input should not be just sought, it should be acted
7 upon. Some call it, my Lady, a duty to listen.
8 Third, we ask you to recommend a new legislative
9 right to a care supporter, such as a relative or friend,
10 for all patients who would like this across all health
11 and care settings. That is something specifically
12 supported, as we understand it, by over 90 organisations
13 including Mencap, Age UK and Bliss.
14 Overall, my Lady, if the concerns we describe had
15 been heard and these recommendations in place in the
16 pandemic, lives might have been saved and our society
17 would not have been left with the same damaging legacy
18 of grief, guilt and anger that blights too many lives
19 together today.
20 My Lady, we commend those things to you.
21 Finally, my Lady, before I sit down, can I just
22 thank the Inquiry team and your good self for the way
23 it's all being conducted in this process. Without your
24 good humour and the way it's been conducted, it wouldn't
25 have been the same. And can we extend a special thanks,

1 please, to the staff and other workers at Dorland House
2 for their assistance in every matter.
3 My Lady, I'm grateful.
4 **LADY HALLETT:** Thank you very much, Mr Wolfe, and thank you
5 for the "thank you" to the people at Dorland House, who
6 do their best to make everyone feel as comfortable as
7 possible.
8 Mr Wagner.
9 **Closing statement on behalf of Clinically Vulnerable**
10 **Families by MR WAGNER**
11 **MR WAGNER:** Thank you.
12 Good afternoon, my Lady. I represent Clinically
13 Vulnerable Families. I'm assisted by Daniella Waddoup
14 and Rosa Polaschek, and we are instructed by
15 Kim Harrison and Shane Smith of Slater & Gordon.
16 I must begin where Mr Wolfe ended by also thanking
17 the Inquiry staff and particularly the Inquiry team as
18 well, and it will be remiss of me not to do so.
19 The vast majority of people who died in the
20 pandemic were vulnerable, including many healthcare
21 workers and people who caught Covid-19 in hospitals,
22 which was supposed to be places of safety.
23 The aim of these brief oral submissions is not to
24 focus on what went wrong, but to assist the Inquiry in
25 its important, forward-looking perspective, to use

1 Ms Carey's words in the opening submissions, by focusing
2 on concrete recommendations.
3 Most urgently, we need to make healthcare safe for
4 vulnerable people. It bears repeating: we need to make
5 healthcare save for clinically vulnerable people. And,
6 by making it safe for them, by improving ventilation and
7 putting in place other protective measures, we make it
8 safe for others too.
9 My first section of three is on shielding.
10 It is clear from the impact and Every Story
11 Matters evidence that behind the CEV (clinically
12 extremely vulnerable) label lies a diverse group of
13 people with hugely varied individual circumstances. But
14 the important role of shielding in providing a passport
15 to enable vulnerable people to access essential supports
16 is clear -- for example, the right to work from home.
17 Shielding letters functioned as a fit note. Entitlement
18 to statutory sick pay if unable to work. Food and
19 essential medication deliveries. And, later, priority
20 access to vaccines.
21 These were incredibly important support measures.
22 There were, however, significant problems with the
23 shielding programme.
24 The communications were, at times, frightening and
25 disempowering. Dr Catherine Finnis gave this evidence

about text messages telling clinically extremely vulnerable people to keep a hospital bag by the front door. She said:

"... these were very frightening messages to a group of people who hadn't really been given any information on how to reduce their risk ... Many [CEV people] didn't see themselves as vulnerable ... indeed, I didn't. I was a part of society, community, I have a job, I have a child ... a lot of us were in those situations and then suddenly we were disempowered hugely by really just being told to just 'Stay at Home'."

"We didn't really know what to do. We felt really stuck."

The Chief Medical Officer for Northern Ireland, Professor McBride, recognised the approach that was taken in good faith initially did not fully think through the loss of agency, and the loss of control that many people would experience. The individual rather than the household approach became unrealistic and unworkable. For example, those with children who were returning from schools. This led to distressing consequences. You heard evidence, my Lady, of family members sleeping in a tent in the garden to avoid the risk of infection from their family.

It was no wonder that the limited studies of those

who were living these harsh realities revealed negative mental health impacts.

But those were not unnecessary consequence of shielding. They related to the execution and the design of what was, after all, an experimental programme.

Execution. The systems for identifying those who needed to shield weren't up to the scale of the challenge. You heard a lot of evidence from a number of senior healthcare witnesses about the fact that the databases were not joined up and it took many months to find records and the like. This resulted in delays and people falling through the cracks. Sir Christopher Wormald said that data sharing is a colossal issue in the NHS, but he couldn't give a timescale about when it would be good enough.

Communications. Sir Chris Whitty said you cannot over communicate when someone has been essentially taken out of society. Information is very important. But communications fell short.

As recognised by the Chief Medical Officer for Wales, Frank Atherton, he was sure that many of those who shielded felt comms let them down. We need to learn from that.

Sir Chris Whitty said:

"... Sir Patrick Vallance and I [were] only on TV

[when] we were asked ...

"... I tried to ... signpost ... information, but ... clearly [this was] inadequate and a hopeless way of trying to achieve this aim."

And, communications were not regular enough, and when they did come the advice was incomplete. They didn't focus enough on the practical realities of individuals varying capabilities to comply with the guidance. They didn't focus enough on the scientific rationale for the advice. They underemphasised the importance of non-Covid-19 conditions and making sure that people went to get healthcare treatment. They didn't focus enough on the steps that might have alleviated the short and long-term effects of shielding.

And, perhaps, most importantly, there simply wasn't enough information about the virus itself and practical steps people could take to protect themselves, empowering them, not disempowering them.

Timing. Shielding was paused too soon and too abruptly, particularly in England, reflecting the government's overwhelming drive to return to normality, and reopen the economy to Eat Out to Help Out.

It was known that despite the relatively low rates in August 2020, exponential growth was likely to restart once restrictions were lifted, and of course

in August 2020 there were no vaccines and no mitigations like ventilations and masks, no prophylactics -- meaning that clinically extremely vulnerable remained at risk.

Ending shielding in September 2021. The reliance on the availability of the vaccine and antiviral treatments was undermined by the fact that the vaccines didn't work or didn't work well for many clinically extremely vulnerable people. And, access to antivirals was and is beset with problems. And we reiterate, my Lady, our concern that the antivirals issue may fall through the cracks of Modules 3 and 4, given that it.wasn't focused on at all, in the oral hearings at least, of Module 3.

There was also a lack of transitional and long-term support after shielding ended. Despite the recognition of Dame Jenny Harries, Sir Sajid Javid and others, that pausing and ending shielding had to be handled sensitively, for many it was like falling off a cliff. There was a marked lack of transitional support to bridge the gap between the passporting protections and the Enhanced Protection Programme, and then from the Enhanced Protection Programme to nothing.

The effect was that the CEV were thrust into a world where the public were being given false confidence that the virus no longer posed a significant

1 threat, but not given the protections they needed to
2 guard against that ongoing threat.
3 What about the clinically vulnerable as opposed to
4 the clinically extremely vulnerable? The wider
5 clinically vulnerable group suffered disproportionately
6 from the viruses, but fell between the cracks of the
7 pandemic policies. They were not shielded, they weren't
8 actively contacted or informed about their higher level
9 of risk. Many didn't find out about that higher level
10 of risk until they were invited for vaccination in 2021.
11 There were no employment protections, no help getting
12 drugs from pharmacies, no statutory sick pay.
13 We accept, of course, there had to be a cut-off,
14 but, as Professor Snooks described it, it was an almost
15 arbitrary one. More careful thought was required about
16 how to better protect this group on a spectrum rather
17 than an arbitrary cut-off.
18 What happens next time?
19 We say that Professor Snooks goes too far to rule
20 out any form of shielding ever again. Her evidence
21 about effectiveness is an outlier in this Inquiry and is
22 not well supported, for example, contradicted by the
23 CMO's technical report, Sir Chris Whitty,
24 Sir Frank Atherton, Dame Jenny Harries, Matt Hancock and
25 others. We submit that the core focus in any future

1 pandemic should be that it is the duty of government to
2 protect those who are vulnerable. There should be
3 a shift to personal responsibility and individual risk
4 assessment.
5 More broadly, only government can make structural
6 changes so that the vulnerable are protected from
7 a virus and are identified more efficiently.
8 The government and the NHS needs to grapple with
9 the data issues, accept that these are complex and will
10 require resources to fix. We need to lay the groundwork
11 now so that a QCovid-type algorithm that identifies
12 people that are most at risk can be rolled out faster.
13 It is not good enough that it would take months,
14 as Dame Jenny Harries said, to get it back up working
15 again.
16 But anyway, such a tool needs to be the beginning
17 of a personalised, clinical decision-making process, not
18 the end.
19 We need to put in place a mechanism to support
20 people to support themselves, and we need to engage
21 clinically vulnerable people so we can better understand
22 what they need.
23 We need to facilitate more prompt and effective
24 access to antiviral treatments, and that's an issue that
25 remains today.

1 And, finally, to educate the public: that the
2 virus continues to circulate, that some people remain at
3 heightened risk and they will need to protect
4 themselves. We need to end mask abuse, and this can
5 only happen with the help of public education.
6 My next topic is making healthcare safe for the
7 clinically vulnerable.
8 "... you're more likely to catch Covid in
9 a hospital than in almost any other setting."
10 That was the words of the former Health Secretary
11 Matt Hancock to this Inquiry. What an admission, and
12 what a dire reflection on our healthcare system. He
13 also accepted it was not safe, clinically, to go for
14 some cancer treatment during the pandemic, because
15 cancer treatment sometimes involves reducing the immune
16 system.
17 Hospital-acquired infection has been the elephant
18 in the room throughout the Module 3 hearings. If you
19 cannot keep clinically vulnerable people safe in
20 healthcare settings, then it rendered policies like
21 shielding almost ineffective, because those people are
22 kept out of the frying pan of community transmission,
23 but then thrown into the fire of healthcare settings
24 where Covid is rife.
25 The important question for you, my Lady, is

1 whether nosocomial hospital-acquired infection is
2 inevitable, as Mr Hancock seemed to suggest, somewhat
3 blithely, or something that can be reduced.
4 We say the answer is the latter. There seems to
5 be a fatalistic acceptance of hospital-acquired
6 infections. This doesn't have to be the case.
7 High rates in healthcare also created knock-on
8 effects, as you've heard a lot of evidence about, that
9 people didn't want to go to hospital and didn't want to
10 go to their GP. And that wasn't because they were
11 frightened or because they were nervous or anxious; it's
12 because they legitimately felt unsafe.
13 It's striking that it's essentially impossible for
14 those at high risk to comply with the good government's
15 own guidance even today, when seeking to access
16 healthcare, because the environment itself is not safe.
17 An increased remote access is an answer, but it's
18 not "the" answer for obvious reasons.
19 Matt Hancock's assessment that there is a cultural
20 problem within the NHS, that it simply does not do
21 enough to tackle nosocomial infection is, again,
22 a serious consideration and a serious admission. It
23 needs to change.
24 I'll now move on to how Covid is transmitted. For
25 too long, officials have tried to prop up the house of

1 cards on incorrect assumptions about modes of
2 transmission. The Inquiry has heard plenty of evidence
3 about explanations, groupthink, entrenchment,
4 confirmation bias, deference to the IPC Cell. But
5 whatever the reason, the reality is that this led to
6 a failure to adopt a sufficiently precautionary
7 approach.
8 I don't propose to dwell on the reasons; instead,
9 now that the house of cards has come tumbling down, in
10 fact has been blown down, and the significant role
11 played by airborne transmission is beyond doubt, CVF
12 urges focus on the next steps.
13 Adequate ventilation has been something of
14 an afterthought by IPC professionals, as Professor Beggs
15 said. Now, everyone seems to agree on its importance,
16 from Beggs, to Hopkins, to Ritchie, and many in between,
17 including the Inquiry's own expert Dr Shin, who picked
18 this as his headline recommendation. He said:
19 "It would be really important to review and
20 improve the NHS estate, particularly in ventilation
21 and isolation capacity. The reason why this is
22 important is because, in facing any epidemic or future
23 pandemic, if the legacy inadequacies of our NHS estate
24 across the country, which in some places is very old,
25 if that is not improved, we will face the next

1 emergency with the same difficulties that we
2 encountered this Covid pandemic."
3 Sir Chris Whitty:
4 "... we should [take] indoor ventilation ...
5 a lot more seriously and ... more vigorously than we
6 [did] previously ..."
7 No one has seriously challenged Professor Beggs'
8 robust conclusion that the HTM guidelines are not fit
9 for purpose and in urgent need of reform.
10 And no one disputes that modernising the NHS
11 estate, and so improving mechanical ventilation makes
12 a remarkable difference to the rates of nosocomial
13 infection for Covid-19 and other pathogens.
14 My Lady, we hope that you don't shy away from
15 making a strong recommendation on this despite the cost.
16 The cost of doing nothing will be much higher,
17 especially when -- when, and not if -- there is another
18 pandemic with a pathogen which spreads through the air.
19 In the meantime, HEPA filters are low-hanging
20 fruit, as one expert said. No one has disagreed they
21 need to be more widely deployed now, and that urgent
22 research is required on how they can be deployed more
23 effectively.
24 Personal protective equipment. The FRSM versus
25 the FFP2, and FFP3 issue has become polarised,

1 potentially even a distraction. CVF urges the Inquiry
2 to accept the commonsense evidence of its own
3 independent experts. Professor Beggs:
4 "... wearing masks [is] better than not wearing
5 masks ... respirators [are] better than surgical masks."
6 It's not too hard, is it?
7 Reports of the IPC experts:
8 [As read] "FFP3s are designed to protect the user
9 against 99% of respiratory particles -- when properly
10 fit tested. FFP2s, 95%."
11 We cannot wait for randomised control trials which
12 probably will never come. And it's also internally
13 inconsistent to do so, given that FFP3s are already
14 recommended for high consequence infectious diseases and
15 aerosol-generating procedures.
16 Of course they are not a silver bullet -- the
17 language of Lisa Ritchie and Susan Hopkins -- but
18 ventilation and masks are an important part of the
19 package of controls, and we prefer "package" to
20 "hierarchy".
21 Another analogy which my clients have given me is
22 the Swiss cheese model where there are slices of Swiss
23 cheese with different holes in them, that if you put
24 them all together, the holes are covered. I didn't
25 bring a packet of Swiss cheese to demonstrate, my Lady

1 you'll be happy to hear.
2 CVF urges the Inquiry to recommend the following
3 inexpensive, practical, and high impact measures.
4 Better information around the masks.
5 Instructions to hospital staff that it's not
6 appropriate to tell clinically vulnerable patients to
7 take off their masks.
8 Policies to make it possible in practice for
9 clinically vulnerable patients to request that
10 healthcare workers in direct contact with them wear
11 a mask, or test.
12 More routine asymptomatic testing in general.
13 Wider use of CO2 monitors.
14 Implementation and further expansion of Dr Warne's
15 suggestions about staggered appointments, greater social
16 distancing in waiting rooms, guiding patients directly
17 into clinic rooms.
18 It is, frankly, absurd that these policies are not
19 being implemented now, not just for clinically
20 vulnerable patients, but for everyone. Who wants to
21 catch a virus in a GP surgery or a hospital?
22 In the longer term, continued research into
23 removing barriers to effective use of RPE in practice.
24 Why can't we make the masks more comfortable? Why can't
25 we make it so that they are easier to communicate in?

It's surely not beyond the scientific community to find the solution.

Finally, restoring trust and confidence that the lives of clinically vulnerable are treated as worthy of protection.

There are two issues here. The first one is: "do not attempt" CPR orders or agreements. Those issues have been well described to you, my Lady, and you'll be well familiar with them. As you know, CVF are calling for the Inquiry to recommend, one, a full review of all DNACPRs put in place from the start of the pandemic to date.

Two, a review of the notes of all clinically -- formerly shielded people from early 2020 to date.

And, three, psychological support for those affected.

And then finally, decision support tools.

CVF remains deeply concerned about the use of such tools, but if they are to be developed, they have to be part of an overall clinical assessment.

And one final point on the Equality Act: Covid is not going away. There are still hundreds of people, mostly clinically vulnerable, around 200, dying each week.

Many CV people do not come under the definition of

"disability" in the Equality Act and would therefore not be protected under the law. But they still suffer serious detriments in society, at work, in healthcare, because of their clinical vulnerability, and that is why we are asking the Inquiry to consider recommending changes to the Equality Act, and indeed to the Inquiry's own equality and human rights statement, as important first steps in ensuring that the clinically vulnerable people do not continue to be overlooked.

Those are my submissions, thank you very much.

LADY HALLETT: Thank you very much, Mr Wagner. I can't guarantee your Swiss cheese analogy will make it into the report, but all your other submissions I will bear very much in mind. Thank you.

Mr Simblet next, please.

Closing statement on behalf of Covid-19 Airborne Transmission Alliance by MR SIMBLET KC

MR SIMBLET: Good afternoon, my Lady. These are the submissions on behalf of the Covid-19 Airborne Transmission Alliance, or CATA.

It can be convincingly and appropriately be submitted, my Lady, that CATA's core themes are right -- it's clear that the airborne risk was always extant. It's clear the precautionary principle was not engaged, and we say the decision not to pursue the precautionary

principle was corrupted by pragmatic concerns.

So we say your point of focus should thus be on why those in charge got things so wrong, and seemed so determined to deny or justify those failings.

Those failings are compounded by the denial of the obvious of those in leadership positions in healthcare, both during the pandemic and in your inquiry, and are serious public health failings which we say must be addressed by the Inquiry in its recommendations.

So, my Lady, Covid-19 being airborne.

Covid-19 is transmitted by the airborne route, and measures to combat and protect against its spread sheeted and continue to need to be in place to address that danger. We say you should reinforce your Module 1 conclusion and find as a fact that there is and always has been sufficient airborne transmission of Covid-19 to require effective protective measures and that it is wrong, and always was wrong, to think otherwise.

Further, my Lady, there was abundant early evidence of airborne transmission, including what was known about TB and SARS-CoV-1 and other data prior to Covid-19's arrival in the UK.

Dr Barry Jones, in his written and oral evidence, explained how and why that should have been the position. His witness evidence on this issue carefully

explaining the history, mechanics and epidemiological evidence was not challenged or controverted in any meaningful way.

Professor Beggs knew that. Professor Catherine Noakes, from whom you heard in Module 2, knew that. And doctors and nurses operating on the front line -- or one example among many, Professor McKay -- quickly saw that based on what they were seeing with their own eyes.

So the contention that this was unexpected to public authorities should be rejected. On the contrary, they should have known that. This country is world leading in terms of its scientific in infection prevention and control expertise.

Those in charge had and have access to high quality scientific advice, and although many state witnesses have tried to obfuscate the position, the scientific position was clear enough from the very start of the pandemic, that the airborne transmission was at least a possibility, if not the probable cause. The stark absence of any attempt at analysis equivalent to that of Dr Jones, or of Professor Beggs, in any of the disclosure and witness evidence from the state bodies, we say, is telling.

We began this final hearing with the observation

1 that the airborne nature of Covid had now become
2 orthodoxy. These last ten weeks show how clear that is,
3 and indeed we invite you to go further. We say the
4 absence of proper challenge and evidence to justify the
5 state's position means that you can make a finding that
6 the outright denial of the airborne transmission route
7 was never justifiable.
8 As has become increasingly obvious during this
9 Inquiry, the state bodies' narrative has moved from
10 denial of airborne, to possibility of airborne, to, yes,
11 some airborne but not predominantly. But in real life,
12 working in close contact healthcare, predominance is
13 completely irrelevant. General ventilation will not
14 protect patients or healthcare workers. If Covid is
15 airborne to any extent, patients and healthcare workers
16 need and needed protection, as is required also by the
17 law.
18 But, my Lady, even if there had been scientific
19 uncertainty, as is still claimed by bodies such as the
20 UKHSA, then health and safety legislation and the
21 precautionary principle applies. So on the
22 precautionary principle, we say, even more problematic
23 than the denial of airborne transmission, was the
24 failure to apply the precautionary principle.
25 The claimed uncertainty about modes of

1 transmission and scientific knowledge at the time does
2 not begin to explain why measures were not taken to
3 address the obvious possibility of airborne
4 transmission. Professor Noakes' evidence to Module 2
5 accurately describes:
6 "... although the evidence at the outset was weak,
7 in truth it was weak for all transmission routes.
8 I think there was just a tendency to assume the other
9 transmission routes, and then require evidence for
10 airborne transmission."
11 So, that being the position, why did key
12 decision-makers close their own eyes to the evidence and
13 to the science?
14 We say this is not about the balance of risk, as
15 Ms Grey characterised it this morning. The failure to
16 pursue the precautionary approach was not a scientific
17 failure but a political one. We say there were concerns
18 about the availability of FFP3 masks, and the signal
19 that that would send to the public about an airborne
20 pandemic that we weren't prepared for. Those
21 considerations predominated over technical scientific
22 advice in the development of IPC guidance and in short,
23 the process of standard setting was either corrupted by
24 those concerns, as CATA would say, or, taken into
25 account, as Matt Hancock did say. Indeed, Mr Hancock

1 was very clear that he thought that development of IPC
2 guidance was and should have been influenced by these
3 considerations.
4 So in that vein, my Lady, you may well think that
5 Laura Imrie's acknowledgment that the UK IPC Cell took
6 supply into account was more compelling than her later
7 attempted retreat from that concession. Her evidence,
8 and that of Mr Hancock, is in keeping with the
9 contemporaneous minutes from the UK IPC Cell which
10 expressly referred to and considered supply issues in
11 relation to FFP3 masks.
12 Yet, my Lady, supply is only one part of the
13 failure. You need to consider the even still
14 unexplained decision to redesignate Covid as
15 droplet-transmitted instead of airborne. We invite you
16 to find that science was following the politics. The
17 government tried to make its Covid-19 response fit the
18 pandemic it had been prepared for, not the pandemic
19 actually presenting.
20 So dissent became a direct challenge to the
21 reputations of those who had taken those decisions, and
22 caused them to take even more entrenched positions.
23 And, of course, my Lady, another course was possible,
24 the government could have said to the public and
25 healthcare workers that we are not as prepared for

1 a virus of this nature as we would want to be, and we
2 will need to make temporary accommodations with good
3 enough protections while we look for the right ones. It
4 could have been candid. But that -- it would need the
5 cooperation, support and innovation of healthcare
6 workers and the public to get through those challenges.
7 That would have demonstrated leadership, honesty and
8 integrity, which CATA says sadly was absent.
9 And this is why, my Lady, there needed to be CATA.
10 CATA in its previous incarnations came about only
11 because the response to this flawed approach was
12 necessary, to try and shift people in entrenched
13 positions to see the problems that they had caused,
14 alerted by experienced clinicians and those working in
15 healthcare settings, who were seeing in realtime the
16 consequences of those policy failures.
17 The concerns that CATA had about the official
18 guidance being published and promoted should not have
19 been dismissed as some sort of crankish or disruptive
20 position. CATA was wrongly, continually, ignored. What
21 we have heard in this Inquiry shows they should have
22 been listened to. The Inquiry has heard abundant
23 evidence from people on the ground who considered that
24 the IPC guidance was unclear, and, contrary to their own
25 clinical information, including clear evidence about how

people were getting Covid in ways that could not be explained by droplet or fomite transmission.

Essentially, the failure to listen to stakeholders like CATA at the time when a different course could have been taken is one of the most serious failures of this pandemic. The response by Ms Imrie that she would want to hear from anyone but CATA was at least refreshingly honest, but the failure to reflect and learn gives rise to very serious concerns about responses to the next pandemic.

On now to make some further observations on some of the evidence you've heard.

Given the profound importance of the IPC guidance, CATA had hoped that state witnesses would have come to this Inquiry and answered questions candidly. Regrettably, no individual, group organisation, or group took responsibility for the decisions around IPC, RPE or airborne transmission. We say this is because they understand how badly things have gone wrong.

Indeed, you may think that had the IPC arrangements been a resounding success, those same witnesses would have been clamouring to take the credit. Instead, nobody says "It was me"; every witness seeks to deflect responsibility on to any other number of other groups, organisations or individuals, which we say is of

itself a structural failure.

We now know that the UK IPC Cell was de facto the central government body evaluating and determining issues of transmission, appropriate RPE and healthcare worker infection prevention and controls. Although it received inputs from other organisations such as SAGE and the EMG or NERVTAG, it discussed and determined its response to those inputs.

So, the fact the entire edifice appears to be the work of four individuals working for ARHAI carrying out rapid reviews with no clear methodology is a real concern, particularly when that work became the institutional position for one of the four constituent public health agencies.

You may think that when that work was being discussed in the UK IPC Cell meetings, there was an unacceptably restrictive base of expertise. Vital additional expertise from disciplines like engineering or physics were excluded. Key sectors such as the ambulance sector were inadequately represented. This had real world consequences, as explained by Tracy Nicholls, or John's evidence in the first impact video, one of the most effecting pieces of evidence in the Inquiry. Even within the cell, a few handful of people became the true decision-takers; what they called

"consensus" was really just what some key people, including Lisa Ritchie, and the ARHAI personnel, thought should happen. Sustained and consistent dissent from December 2020 onwards from Public Health England and belatedly the UKHSA, concerning airborne transmission and the wider use of FFP3 masks, was brushed aside.

This consensus view is also fundamentally dangerous. Essentially, consensus is a popularity test for an agreement rather than seeking the right answer based on facts. Those problems were compounded by there being insufficient safeguards in relation to what was produced by the UK IPC Cell. Public health bodies did not re-review the guidance before publishing it. The witnesses from Public Health Wales and Public Health Agency in Northern Ireland said that in their oral evidence. The CNOs and CMOs did not review the guidance despite having oversight responsibility.

Those involved in the IPC Cell have demonstrated, even in their evidence at this Inquiry, they would rather maintain wrong thinking than admit those failures. Lisa Ritchie's extraordinary answer that she still, today, considers Covid-19 as primarily transmitted by droplet and contact methods, and Laura Imrie not wanting input from experts who -- such

as CATA, but preferring to take scientific advice from a small panel, including a former and recently qualified dentist, we say are examples of those problems continuing.

Yesterday's submissions from Mr Rawat for UKHSA will be addressed in writing, but, one, the contention that PHE had to contact on evidence that previous viruses were spread by contact and respiratory routes ignores the fact that the decision on 17 March 2020 only recognised droplet and excluded airborne.

Secondly, the contended lack of high-quality evidence on the advantages of FFP3 masks over FRSMs ignores the impossibility of controlled trials of masks.

So the absence of such evidence cannot sensibly override the obvious: masks that prevent aerosols travelling person-to-person are infinitely better than those that are not.

And, thirdly, what is being relied on is in relation to negative effects of FFP3. Why should healthcare workers not be able to make a judgment for themselves and balance the discomfort of an FFP3 mask against the harm of a virus causing death or serious disability?

They've not been listening and, I'm afraid, will not learn.

1 In this topic also, the production and dogmatic
2 insistence on the AGP list, you may conclude, was either
3 about rationing or, worse, seeking to provide false
4 reassurance to healthcare workers.
5 Ultimately, this AGP list and the debate around it
6 was pointless because the rationale was flawed. The
7 fact that the list itself became the subject of
8 arguments distracted from the futility of the list
9 itself.
10 Obviously, many ill people will generate aerosols
11 from a cough. A symptom of Covid is coughing.
12 Professor Banfield agreed, a cough is a cough, whether
13 naturally produced or stimulated by a procedure. The
14 cough and the aerosols generated by do not change. RPE
15 was obviously required well beyond intensive care.
16 It was similarly unhelpful, in fact, ridiculous
17 for there to be evidence from the IPC Cell witnesses
18 that healthcare workers could carry out their own risk
19 assessments. As Dr Barry Jones said in his evidence,
20 local risk assessments are impossible, especially since
21 most healthcare occurs within 1 metre of patients, and
22 the guidance mandated FRSMs within 2 metres.
23 Ultimately, these risk assessments are impossible
24 to carry out when they were being misled as to the
25 routes of Covid-19's transmission.

1 Also, staff were prevented from responding to risk
2 in front of them. You have statements from CATA
3 members, Dr Nathalie MacDermott and Dr Gillian Higgins,
4 Nathalie MacDermott is an international expert in
5 infectious diseases but when she and separately Gillian
6 Higgins tried to procure their own suitable respiratory
7 protective equipment, they were rebuffed.
8 You may think, my Lady, that this reinforced
9 illustrates your concerns about the UK IPC guidance
10 being treated as carved in stone.
11 Similarly, when Dr Higgins tried to solve those
12 problems by establishing a non-profit to produce RPE
13 supply, she was also rebuffed from doing so.
14 So my Lady, also I want to reinforce some of the
15 other points on the evidence, including the consequences
16 of healthcare workers being -- losing trust through
17 being treated as difficult or people that could be
18 simply fed inaccurate guidance.
19 Trust in IPC measures and its importance was
20 reinforced by your expert Professor Dinah Gould,
21 "winning hearts and minds". This trust has been
22 catastrophically lost during the pandemic, and it
23 requires serious action to win it back now.
24 In making your recommendations, my Lady, you will
25 need to consider why there was such obdurate

1 determination by the government and NHS institutions
2 dogmatically to adhere to this flawed thinking in the
3 face of informed voices producing evidence to the
4 contrary.
5 So we say that healthcare workers can no longer
6 have confidence in the current IPC leadership. The
7 evidence that you've heard from the IPC witnesses is
8 unhelpful and, going forward, healthcare workers are not
9 going to be able to have their trust restored in that.
10 The NHS and other public health bodies have
11 a leadership issue. It speaks to wider cultural issues
12 with healthcare which have already been laid bare by
13 other investigations. The contribution to this Inquiry
14 of those in leadership positions has the potential for
15 far-reaching consequences on the confidence of the
16 healthcare worker professions and also the ability of
17 the system to respond to major healthcare crises in the
18 future.
19 Deflection and covering up will not do. The
20 worry, my Lady, is that in future pandemics that loss of
21 trust causes issues with whether healthcare workers are
22 going to be wanting to refuse to treat people if they
23 know that their own lives are not protected in that way.
24 Obviously leadership and decision-making involve
25 a series of high-risk serious decisions made under

1 pressure, sometimes with incomplete information. Some
2 judgment calls will turn out to be erroneous in
3 hindsight. That's what all frontline paramedics, nurses
4 and doctors understand. But the hallmark of someone
5 taking decisions for the right reasons, motivated by the
6 right principles, is the ability to acknowledge
7 existence of a mistake, to explain themselves and
8 then -- to those that they lead, and then have the
9 humility to learn from that mistake.
10 Unfortunately this could not be further from the
11 reality of what happened. The Inquiry has heard from
12 those involved in decision-making around airborne
13 transmission and appropriate RPE. Denial, obfuscation
14 and evasion has unfortunately been the hallmark of that
15 evidence. And your recommendations will need to address
16 measures to restore trust.
17 CATA's written submissions will contain suggested
18 recommendations that are pragmatic and forward-looking
19 suggestions for our healthcare system so that patients
20 and staff can be better protected in the future.
21 CATA is pleased to have participated in this
22 module and looks forward to your recommendations,
23 my Lady. Thank you very much.
24 **LADY HALLETT:** Thank you very much, Mr Simblet.
25 Mr Wagner, I think you are back up.

1 **MR WAGNER:** I am.
2 **LADY HALLETT:** If you could take (unclear) break, perhaps.
3 **MR WAGNER:** Sure. A break now or after --
4 **LADY HALLETT:** No, no, could you take us to the break.
5 **MR WAGNER:** Oh, take us to the break. Absolutely.
6 I thought you needed some time to prepare for my
7 submissions!
8 **Closing statement on behalf of 13 Pregnancy, Baby and Parent**
9 **Organisations by MR WAGNER**
10 **MR WAGNER:** I act for 13 Pregnancy, Baby and Parent
11 Organisations, the PBPOs for short, and I am again
12 assisted by Daniella Waddoup and Rosa Polaschek, and
13 instructed by Kim Harrison and Shane Smith of Slater &
14 Gordon.
15 I began my oral opening submissions by saying that
16 the healthcare response to Covid-19 failed to properly
17 value the care of women, pregnant people and newborn
18 babies.
19 After nine weeks of evidence, that submission has
20 sadly been shown to be correct. There were real
21 failures to provide adequate healthcare, and those
22 failures had real long-term consequences, such as
23 long-term trauma perinatal depression, rates almost
24 doubled during Covid.
25 There were two suicides of women who were not seen

1 face to face due to Covid-19 restrictions. And during
2 the pandemic, Covid was the leading cause of maternal
3 death in the UK according to embrace.
4 As Ms Todd, the mother of baby Ziggy who passed
5 away during the pandemic, told the inquiry about her
6 experience:
7 "It's obviously something that has completed
8 impacted the rest of our lives, and I think we have just
9 been left to deal with it ourselves. We're kind of away
10 from the hospital now and that's all ... that matters to
11 them, we're out of the door, and we're the ones left
12 with this for the rest of our lives ..."
13 Overall, the evidence to the Inquiry has shown
14 that the correct balance was not struck between
15 necessary, proportionate restrictions and the need to
16 ensure the continuity of pregnancy-related care,
17 including early pregnancy and neonatal care and
18 bereavement support, which cannot be stopped or halted
19 no matter the circumstances.
20 I have three topics and my first is visiting
21 restrictions.
22 Across the UK it was acknowledged too late that
23 partners and supporters for a birthing woman, and at all
24 stages of the pregnancy journey, are not visitors but
25 partners in care. Not visitors but partners in care.

1 NHS England did not do this until
2 14 December 2020, almost a year into the pandemic.
3 Professor Sir Stephen Powis accepted NHS England could
4 have been clearer earlier in defining birthing partners
5 as partners in care rather than visitors.
6 Judith Paget likewise accepted that this
7 recognition came too late.
8 Antenatal scans in early pregnancy care.
9 These antenatal scans can be scene of bad news
10 being delivered, for example an ectopic pregnancy or
11 a miscarriage. Partners were very often not permitted
12 to attend. It should have been a priority to allow the
13 support of a loved one. As one impact witness to the
14 Inquiry said:
15 "I think that the long-term impact that my
16 experience of having an ectopic pregnancy during the
17 pandemic has made me lose faith ... in the NHS and has
18 really knocked my confidence in them. I really needed
19 my husband with me when I was waiting for that surgery,
20 and I really needed a little bit of compassion from the
21 nursing staff ... I was very much alone.
22 Impact on birthing experience.
23 Jenny Ward, the PBPOs' representative, explained
24 to the Inquiry the role of a birth partner in advocating
25 for a woman during birth and assisting healthcare staff

1 in flagging, for example, when a woman is deteriorating.
2 This mirrors the findings of the then -- the Health
3 Services Safety Investigations Body report about the
4 important role of birthing support for women who do not
5 speak English.
6 And the findings of the Welsh Government
7 commission reported on the impact of Covid-19 on
8 disabled people in Wales, which identified the
9 difficulties disabled women had in conveying their
10 genuine needs to be accompanied by partners or advocates
11 during care.
12 The PBPOs have provided evidence of women waiting
13 to be sufficiently dilated to be allowed a partner in
14 the room, and feeling obliged to submit to medically
15 unnecessary checks in order to hurry that process up.
16 This simply wasn't good enough.
17 Neonatal care. The Inquiry has heard powerful
18 evidence from Tamsin Mullen of the practical unreality
19 of the visiting restrictions that were place for
20 neonatal care, of being made to sit in the waiting room
21 while your partner visits one of your babies, of being
22 refused a room to sit and express milk in, of hearing
23 bad news alone, and the impacts on the wider family of
24 doing so.
25 The visiting restrictions which were put in place

1 were overly strict and lacked common sense. There was
2 no justification for preventing parents who lived in the
3 same household from being together in the hospital. PPE
4 was often not offered or enforced on wards to allow
5 better visiting access. Rules were enforced too
6 strictly, for example refusing to allow Ms Mullen and
7 her partner to visit their twin neonatal babies together
8 even once the babies were in a private room away from
9 all the other babies.
10 Rules were seemingly arbitrary, such as enforcing
11 a divide between women in active labour and those who
12 were insufficiently progressed. And this resulted in
13 some partners missing the birth of their child
14 completely. Other women were simply left alone
15 for hours.
16 The visiting restrictions did not reflect robust
17 science. Lisa Ritchie, Professor Fu-Meng Khaw,
18 Aidan Dawson, Dr Shin and Dr Warne all said essentially
19 the same thing, that visiting restrictions were not
20 assessed by the IPC Cell, or subjected to
21 rigorous analysis from an infection prevention and
22 control perspective. Although the IPC experts
23 considered that visiting restrictions were necessary at
24 the outset, they appeared to have misunderstood the
25 extent to which exceptions were built into that

1 guidance.
2 The PBPOs gave evidence that it was not accurate
3 to say that such exceptions were built in for early
4 pregnancy, neonates, newborn babies and for many of
5 those in labour. In many cases exceptions did not exist
6 until well into 2022.
7 The IPC experts did recognise that there was
8 a difference where the carer is somebody who is already
9 living with a patient, because they already have the
10 same exposure and risks already. Dr Shin said that he
11 thought it was reasonable for a carer to be let into the
12 hospital in those circumstances.
13 Vaughan Gething said if a couple live together and
14 one partner in that couple goes in for a scan, there's
15 a fair argument about whether actually you're reducing
16 the risk significantly, whether it's a scan or whether
17 it's the ability to go into a neonatal ward if babies
18 are particularly ill. And that was the same conclusion
19 that many women and pregnant people reached themselves,
20 applying their own common sense.
21 The postcode lottery.
22 There were real downsides to having a different
23 local regime for both the patients and their families
24 and staff. It created a real anxiety for women entering
25 a hospital that they didn't know what restrictions they

1 would face, even compared to the hospital that was down
2 the road. The clear impression from the Royal College
3 of Midwives' evidence was that staff were fearful and
4 anxious and found the absence of PPE concerning. And we
5 do not criticise them for that. Of course staff were
6 under huge pressure and the PBPOs believe they were
7 doing their absolute best. But we say there is a real
8 risk that this may have influenced decisions on visiting
9 rules and led to stricter rules than were actually
10 necessary.
11 Many healthcare leaders also took the view that
12 later specific guidance on allowing more care-giving
13 support in maternity related care had solved initial
14 problems without acknowledging there continued to be
15 a postcode lottery. To the PBPOs' knowledge, there was
16 no systematic monitoring of local systems to ensure that
17 they were consistent and properly reflected local
18 infection rates or that all alternatives had been tried
19 such as PPE and testing. It was, frankly, a mess.
20 There were unacceptable delays across the UK but
21 especially in England and Wales in updating and
22 promoting visiting guidance during 2020. Wales,
23 Scotland and Northern Ireland did not issue national
24 guidance until early to mid July 2020, months after the
25 pandemic began.

1 Worse, NHS England didn't publish any guidance
2 until December 2020. In all those cases there was still
3 a large emphasis on local risk assessments. There's no
4 good explanation about why this took so long. And we
5 say, my Lady, that you should take seriously the
6 suggestion from some witnesses that services mainly
7 involving care for women were deprioritised, because
8 they mainly involved care for women.
9 In terms of guidance on neonatal care and both
10 parents having unrestricted access there were serious
11 delays. There was no reporting and therefore no
12 monitoring in England at all on visiting restrictions in
13 neonatal care until June 2021. And it took until
14 May 2022 in Wales for visiting guidance to be updated to
15 allow unrestricted access to newborn babies for both
16 parents and no explanation has been given for that
17 delay.
18 Once testing was available there was limited
19 efforts to focus testing -- to focus testing resources
20 on maternity services. It just wasn't enough and it was
21 often delayed.
22 The PBPOs welcome the recognition from some senior
23 witnesses that visiting rules did not strike the right
24 balance. Chief Nursing Officer Ruth May said maternity
25 visiting guidance could have been more specific earlier

1 about extending access for birthing women to their
2 partners throughout the entirety of labour. She said
3 this would have been better for women, for partners and
4 for staff.
5 Chief Nursing Officer Jean White said:
6 "[She] certainly was affected by the Bliss report
7 that described ... the impact [of not having] ...
8 parents seen as a unit ..."
9 In neonatal care.
10 "... and I think, on reflection, I would have said
11 they should always have been a pair."
12 Baroness Morgan agreed and said if she had her
13 time again she would definitely have introduced guidance
14 for birthing partners being recognised as partners in
15 care earlier.
16 Sir Stephen Powis said much the same. He said it
17 was a lesson for next time.
18 There was a notable contrast in the evidence of
19 Matt Hancock who, despite being aware of concerns about
20 visiting since at least June 2020, insisted the
21 restrictions were appropriate, though you may consider,
22 your Ladyship, that this reflected Mr Hancock's overall
23 reluctance to accept that anything should have been done
24 differently.
25 Vaughan Gething said:

1 "In hindsight ... [more might have been done] to
2 enable visits."
3 Jeane Freeman, of NHS Scotland, thought the issue
4 with operational delivery of the national guidance was
5 too strict, particularly as the virus was better
6 understood later.
7 PPE and RPE. The PBPOs, along with other
8 healthcare organisations, have consistently expressed
9 concerns about blanket approaches to PPE and
10 mask wearing in maternity settings, for example neonatal
11 wards.
12 Skin-to-skin care between parents and new babies
13 is an evidence-based intervention that supports physical
14 well-being of the neonates as well as the emotional
15 health of the parents. The Inquiry has heard evidence
16 of a lack of joined-up thinking across the four nations
17 on these issues.
18 My second main topic is women and pregnant
19 people's healthcare. The Inquiry has heard evidence
20 that stark central government directives to "Stay at
21 Home" had the unfortunate consequence of discouraging
22 pregnant people who needed healthcare from going to get
23 that healthcare. As Jenny Ward noted, some conditions
24 in pregnancy can only be picked up at face-to-face
25 consultations. Some women delayed access to care

1 because of fears of going to hospital and those who were
2 in digital poverty or who had pre-existing inequalities
3 were shut out of remote access.
4 Dame Ruth May accepted that in hindsight the
5 message should have been: Stay at Home but not if you're
6 pregnant. We agree.
7 Evidence suggests that there was a particular
8 reluctance to access maternity services for black, Asian
9 and minority ethnic communities. And this was another
10 serious problem that needs to be considered in your
11 report, my Lady.
12 Overall there was belated recognition of maternity
13 care being essential. This should have been locked in
14 from the start and, again, I ask, was it not so because
15 it was care that mainly involved women?
16 The initial redeployment of staff in maternity
17 from hands-on health visitors to anaesthetists
18 aggravated pre-existing staff shortages which have been
19 well evidenced in this module.
20 Later, maternity staff were ring-fenced but there
21 were still inconsistencies and some face-to-face work
22 like health visiting and bereavement support were
23 stopped altogether. Data shows there was a significant
24 drop in provision of different birth settings:
25 water births, home births and other options were hugely

1 restricted, as well as midwife-led units. These
2 services should not be considered optional. Cutting
3 them had serious consequences.
4 Dr Morris of the RCOG identified instances where
5 blanket changes to service provision to maximise
6 capacity to manage Covid-19 patients were not based on
7 evidence and did not recognise the importance of
8 antenatal appointments as part of an essential service.
9 Studies on stillbirth, which increased during the
10 pandemic -- that's the stillbirths not the studies --
11 suggested that these could be linked to reluctance to
12 attend hospital settings, for example there is evidence
13 that women were missing antenatal care altogether. In
14 fact, a study from May to July 2020 found 70% of units
15 reporting a reduction in antenatal appointments and 89%
16 reported using remote consultation methods which aren't
17 as good though they are part of the picture.
18 Health visitors who attend families' homes have
19 a crucial safeguarding role for young babies who are at
20 their most vulnerable, as Jenny Ward explained to you.
21 Bereavement support, which should be considered to
22 be essential care, was often curtailed or stopped
23 altogether with specialist bereavement midwives moved to
24 provide other forms of care. And studies show that
25 childbirth experiences can result in PTSD and are

1 affected by matters arising during the pandemic such as
2 negative -- such as a reduction in staff, mother
3 contact, feelings of loss of control over the situation
4 and lack of partner support.
5 My final topic, redressing the place of women and
6 pregnant people in healthcare.
7 Pregnancy-related healthcare needs to be promoted,
8 not relegated as it was during the pandemic. Not only
9 is this important for women and pregnant people but also
10 for their partners, fathers, and families, who suffered
11 from being excluded from crucial moments and, of course,
12 for babies. What does this mean?
13 One, properly protecting and resourcing early
14 pregnancy, maternity and neonatal services so that high
15 standards of care can be maintained, including care for
16 those experiencing pregnancy loss or pregnancy sickness.
17 Two, ensuring that women, pregnant people and
18 partners are not left isolated and alone, both in
19 hospitals and in the community, and are allowed access
20 to support networks and in-person healthcare when
21 necessary.
22 Three, ensuring that babies can have both parents
23 with them in hospital at all times and that they
24 continue to be monitored and protected in the crucial
25 stages of their development, including through

1 face-to-face contact where needed.
2 Four, ensuring all clinicians across the hospital
3 are aware of evidence-based guidance on the care of
4 pregnant women and people and have the time and
5 resources to engage with that guidance.
6 Five, ensuring better, clearer communications
7 between the government, NHS and local trusts and
8 pregnant women and people, and this must include
9 proactive plans from the outset to reach out to minority
10 groups.
11 Finally, sixth, the PBPOs call for greater
12 recognition of the role of charities like themselves.
13 Each of their organisations strived during the pandemic
14 to assist women, pregnant people, those experiencing
15 bereavement, families and new parents. They wished to
16 be of assistance to the NHS, including the many
17 hardworking NHS staff and clinicians. In many cases
18 they were not consulted with or assisted to provide
19 support, despite the detrimental impacts of Covid-19 on
20 charities' incomes and the identifiable impact on women,
21 pregnant people, and new families.
22 Ultimately, nothing is inevitable in a pandemic
23 and it's always easy, or at least it's possible, to come
24 along to an inquiry like this and say, "Well, it was
25 a very difficult balance and we did the best we could

1 and if we did it again, we'd probably do the same
2 thing". However, here, there were clear harms, there
3 were clear improvements that could have been made and
4 a clear difference could have been made for women,
5 pregnant people and their families.
6 Thank you, those are my submissions.
7 **LADY HALLETT:** Thank you very much indeed, Mr Wagner. Very
8 helpful and constructive, thank you.
9 I shall take the break now and return at 3.35 for
10 the last session.
11 **(3.20 pm)**
12 **(A short break)**
13 **(3.35 pm)**
14 **MS CAREY:** My Lady, good afternoon. The final session is
15 started by Ms Hannett King's Counsel submissions.
16 **LADY HALLETT:** Thank you, Ms Carey.
17 Yes, Ms Hannett.
18 **Closing statement on behalf of Long Covid Groups by**
19 **MS HANNETT KC**
20 **MS HANNETT:** My Lady, the Long Covid Groups in Module 3 are
21 Long Covid Kids, Long Covid Physio, Long Covid SOS and
22 Long Covid Support. They are patient advocacy groups
23 who were formed in 2020, to address a gap in the
24 response by government and the national health services
25 to Covid-19.

1 The Long Covid Groups became providers of public
2 health information on the long-term effects of the
3 virus, producers of evidence-based research on the
4 protracted symptoms of Covid-19, and advocates for an
5 effective clinical response to Long Covid at healthcare
6 roundtables.
7 The Long Covid Groups played, and continue to
8 play, a unique and necessary role in the identification
9 of and response to Long Covid.
10 At the outset, the Long Covid Groups wish to
11 acknowledge the loss suffered by all of the bereaved
12 families and to express their solidarity and support for
13 all surviving victims of Covid-19 represented in this
14 room by the Clinically Vulnerable Families, John's
15 Campaign, Frontline Migrant Health Workers, FEMHO, TUC,
16 CATA, the Disability Charities Consortium, the BMA, and
17 RCN, amongst others.
18 In these closing comments the Long Covid Groups
19 ask the Inquiry to learn from their experience and make
20 recommendations to support the around 2 million adults
21 and children who continue now to suffer the harm of
22 Long Covid, as well as recommendations to prevent the
23 same harms arising in a future, as yet unknown,
24 pandemic.
25 These recommendations are urgent and the Inquiry

should therefore consider making interim recommendations.

More than once witnesses to the Inquiry have suggested that the pandemic is historic. This is both incorrect and dangerous. The current unmitigated spread of Covid-19 is causing ongoing harm to our public health. Natalie Rogers warned there will be people in this Inquiry hearing room who will contract Long Covid. All adults and children are potentially vulnerable to Long Covid, in Professor Evans' words, "everybody is at risk".

The healthcare setting remains a place of particular risk. The Inquiry has heard much evidence confirming the airborne nature of transmission of SARS-CoV-2 and of the ongoing inadequacy of PPE supply. This has, inevitably, resulted in workplace-acquired Long Covid.

Healthcare workers are not returning to their previous jobs. Some are unable to work at all. Several are working less or in different roles because of Long Covid. Inadequate protection of SARS-CoV-2 in healthcare settings puts everyone at risk of infection and the harm of Long Covid.

Ensuring IPC measures recognise and protect against the airborne nature of the transmission are

matters that have real life consequences for all healthcare workers and patients today.

The Long Covid Groups will provide detailed written closing submissions that identify the findings of fact and the consequential recommendations that we ask the Inquiry to make. Today, I propose to address seven broad themes arising from the evidence that the Inquiry has heard which demand the making of recommendations, namely:

First, the failure by the healthcare systems to recognise and respond to foreseeable long-term sequelae.

Second, the absence of public messaging on Long Covid.

Third, the inadequacy of Long Covid care provision for adults.

Fourth, the inadequate response of healthcare to Long Covid in children and young people.

Fifth, the particular adverse impact that Long Covid has on healthcare workers.

Sixth, Long Covid's impact on inequalities in society.

And seven, the ongoing indiscriminate risk of Long Covid.

We signpost the recommendations we invite the Inquiry to make in the course of each them.

So turning first to the healthcare systems' approach to foreseeable long-term sequelae.

Long Covid was foreseeable, yet none of the healthcare systems across the four nations prepared for it. The CMOs from all four nations confirmed to the Inquiry that they recognised the possibility of long-term sequelae early on in the pandemic but did nothing but wait. It fell to patient advocates to raise the alarm that people may not recover from Covid infection.

None of the four nations introduced systems of surveillance to track the prevalence and severity of long-term symptoms of Covid-19 at the outset of the pandemic. The Long Covid Groups filled the initial gap with patient surveys in 2020 and persuaded the ONS to adapt the Covid-19 infection survey to gather data on Long Covid, but since that survey ended there has been no data collection on the prevalence of Long Covid. UKHSA have said they do not regard the current collection of prevalence data as their responsibility and neither, it appears, do the public health bodies of the four nations. It has therefore fallen through the cracks.

The Long Covid Groups therefore invite the Inquiry to endorse witnesses' unanimous call for the resumption

of surveillance of the prevalence of Long Covid. They also invite the Inquiry to recommend that pandemic planning addresses the risks of and makes provision for surveillance in care planning for long-term sequelae. Further, future pandemic responses should incorporate patient advocates into the healthcare response from the outset.

Turning second to the absence of public messaging on Long Covid. The evidence has revealed two distinct but related issues. Poor clinical understanding of Long Covid and a lack of public health messaging on its risks. As to the first, the delay in formally recognising Long Covid has meant that there is still disbelief of Long Covid in the medical profession. Professor Evans has unequivocally rejected any scepticism of Long Covid as being deeply unscientific whilst acknowledging that disbelief is still pervasive.

Natalie Rogers describes from the early days that there was pervasive and damaging misconception that Covid was going to be a very short, mild flu-like illness. This meant that, for her, the very act of seeking healthcare was exhausting. When you were seeking healthcare you were met with disbelief.

The Inquiry has heard distressing evidence from multiple sources of patients and parents having to fight

1 to be believed. Seriously unwell patients were forced
2 to fight for recognition of their symptoms and access to
3 the necessary healthcare. The Long Covid Groups
4 therefore ask the Inquiry to recommend immediate
5 improvements to the clinical education and training to
6 enable accurate, timely diagnosis of Long Covid and
7 prompt referrals into Long Covid services.
8 It's against this context of enduring disbelief
9 that the Long Covid Groups invite the chair to approach
10 with caution the evidence of witnesses who have said
11 that more understanding is required before there can be
12 public health messaging on Long Covid.
13 Professor Sir Chris Whitty has told the Inquiry
14 that different messaging on the indiscriminate risk of
15 Long Covid would not have led to different behaviours
16 cautioning that what you don't want to do is overload
17 large numbers of messages that don't lead to
18 a particular change.
19 Professor Hopkins has similarly justified PHE's,
20 and now UKHSA's failure to provide any mental health
21 communications on Long Covid by suggesting they had
22 insufficient information to devise a useful message.
23 The Inquiry is invited to consider whether these
24 positions withstand rational scrutiny.
25 The ongoing absence of clear public messaging on

1 the indiscriminate risk of Long Covid means that the
2 public cannot make informed decisions about health risk.
3 This also has carried important implications for other
4 branches of the public health response to Covid-19.
5 Professors Whitty and Hopkins both gave evidence that
6 they were aware vaccination was an important factor for
7 reducing the severity and impact of Long Covid, yet
8 government messaging did not promote vaccine update on
9 this basis.
10 Sir Sajid Javid stated that informing the public
11 about Long Covid would confuse the message on the
12 efficacy of vaccination. When pressed he was, however,
13 unable to explain why.
14 The Inquiry should urgently recommend that each
15 nation launch a public health messaging campaign on the
16 indiscriminate risk of Long Covid. Such messaging
17 should include information on the benefits of
18 vaccination for reducing severity and impact of
19 Long Covid.
20 Turning, third, to the inadequacy of the current
21 Long Covid healthcare for adults.
22 There is no cure for Long Covid, only management
23 of the symptoms of what is a relapsing unremitting
24 disease. Whilst commending the UK's initial approach to
25 research into Long Covid, the experts to the Inquiry

1 stated that research for Long Covid is very much
2 a marathon and the UK has won the first 400 metres, but
3 has now paused.
4 The Inquiry is invited to recommend there is
5 a more focused and better funded approach to research
6 into Long Covid.
7 This should include research into paediatric
8 Long Covid as a priority, as well as research into the
9 pharmacological and non-pharmacological treatments for
10 adults and children alike. The Long Covid experience of
11 care is neither singular nor equitable. The
12 December 2020 guidelines for long-term effects of
13 Covid-19 recommended access to multidisciplinary
14 services for clinical and rehabilitation services, or
15 "one-stop" clinics, a recommendation endorsed by
16 the Inquiry's Long Covid experts.
17 Some nations, instead of creating specialist
18 services, have embedded services within primary care.
19 Even where Long Covid clinics exist, they vary widely in
20 terms of services offered, and the level of supervision
21 by specialist clinicians, the latter accepted by Sir
22 Stephen Powis as being concerning. Patients' access to
23 the specialist care they needed was delayed by a lack of
24 urgency in the provision of funding and care for
25 Long Covid and, regrettably, several of the services

1 that even now are in place are at risk of closure.
2 The Long Covid experts have told us that if you
3 start to undermine the clinics, then the whole
4 discipline of being able to look after people with
5 Long Covid starts to become undermined, and then that
6 clearly has consequences in terms of training and future
7 research.
8 The Inquiry is, therefore, invited to recommend
9 that all four nations ensure equitable access to
10 dedicated multidisciplinary Long Covid clinics.
11 Dedicated funding for Long Covid should be ring-fenced
12 beyond 2025.
13 Further, in respect of a future as yet unknown
14 pandemic, the planning should include a strategy for
15 creating scalable, specialised services for the
16 assessment and care of the long-term sequelae of a novel
17 virus.
18 UKHSA and the CMO have confirmed that vaccines
19 mitigate the incidence and severity of Long Covid,
20 however UKHSA demonstrated a marked disinterest in
21 addressing the need to prevent Long Covid in their work.
22 For example, their Covid-19 vaccine surveillance reports
23 are silent on the impact of vaccines on Long Covid,
24 despite assurances by Dame Jenny Harries that these
25 impacts are being monitored.

1 The Inquiry is therefore asked to recommend that
2 the JCVI review the evidence on the impact of vaccines
3 on Long Covid, with a view to ensuring both that
4 Long Covid patients be treated as a priority cohort for
5 vaccinations and that booster vaccinations be made more
6 widely available to prevent new cases of Long Covid.
7 We turn, fourth, to children and young people.
8 Long Covid is a new childhood disease, whose prevalence
9 is equivalent to childhood diabetes. As at March 2024,
10 there were over 55,000 children and young people with
11 Covid in England and Scotland alone suffering from
12 symptoms that persisted for at least 12 weeks. Its
13 impact on children can be life-changing.
14 Long Covid devastates childhoods, disrupts
15 education and impedes children's development. It has
16 created a cohort of newly disabled children. For
17 example, one teenager told Every Story Matters that:
18 [As read] "It's a big identity crisis. My mum and
19 I were fit, active people. I was meant to be beginning
20 pro ballet at a career. To go from that to being in bed
21 all the time is massive. At a young age, difficult, as
22 you're finding out who you are. I'm 18, it's
23 an identity I don't want."
24 The Inquiry has heard evidence that the healthcare
25 system was particularly reluctant to recognise that

1 Covid-19 would have any impact on Covid and young
2 people. Children and their parents were and still are
3 met with disbelief. It should not be left to my
4 clients, who are parents of children with Long Covid, to
5 point out the risk to children and young people.
6 Sammie McFarland, on behalf of Long Covid Kids,
7 told the inquiry:
8 [As read] "In the UK throughout 2020 there was no
9 information published by the government stating that
10 children and young people could have any, let alone have
11 debilitating, symptoms from Covid-19 and Long Covid.
12 Early public health statements suggested the contrary,
13 that Covid-19 posed only a minimal risk to children. In
14 Long Covid Kids' experience, this meant that when our
15 families sought assistance for children suffering from
16 harmful symptoms, they were routinely dismissed, and
17 unable to access healthcare."
18 Not only was there no public messaging on the risk
19 of Long Covid to children and young people, but even
20 before conclusive studies had been conducted, in summer
21 of 2020 the Office of the Chief Medical Officer put out
22 a statement minimising the risk of Covid causing serious
23 illness to children and young people.
24 In her evidence to this Inquiry, Dame Jenny
25 Harries was unable to explain why the OCMO had not

1 published a subsequent statement informing that
2 Long Covid posed a real danger to children and young
3 people. This has left parents misinformed. They were
4 left unaware that children attending schools without
5 Covid-safe measures could put their children at risk of
6 developing a disabling long-term illness.
7 This Inquiry must grapple with the truth, that
8 some children suffer long-term harm from Covid-19. This
9 should not be minimised, either in this module or in the
10 forthcoming Module 8.
11 Paediatric Long Covid services were slow to be
12 created and several of the sparse paediatric services
13 that are now in place in England are closing. This is
14 despite the last ONS figures, from spring 2024, showing
15 that the number of children and young people with
16 Long Covid are increasing.
17 Children under 16 in Northern Ireland and Wales
18 still do not have access to specialist paediatric
19 services, whilst in Scotland they've had to wait until
20 2024 for the publication of just one care pathway in
21 just one health board area.
22 While former First Minister Humza Yousaf fully
23 accepted that the Scottish Government just did not move
24 at a quick enough pace, this provides little solace for
25 children in 13 of the 14 health boards in Scotland who

1 remain today still without access to a clinical care
2 pathway, a fact notably omitted in the closing
3 submissions of the Scottish Government yesterday.
4 The Inquiry is asked to ensure that the disease
5 burden on children and young people should be recognised
6 without comparison to adults. Children and young people
7 who suffer illness must be heard and listened to. As
8 such, recommendations should ensure that all children
9 and young people with Long Covid have access to
10 dedicated, specialist Long Covid paediatric services.
11 Clinicians, patients and parents should be informed
12 about Long Covid in children and young people through
13 public health campaigns and clinical educational
14 material.
15 I turn fifth, my Lady, to the impact of Long Covid
16 on healthcare workers.
17 Healthcare workers sacrificed their health, their
18 careers and their livelihoods on the front line.
19 The Inquiry is urged to consider healthcare staff in the
20 broader sense: clinical and non-clinical staff, those
21 working for the NHS, as well as those privately
22 employed, fixed-term and agency staff, porters, cleaners
23 and administrative staff all comprise the workforce that
24 sacrificed their own long-term health for the health of
25 the country.

1 The evidence before the Inquiry has demonstrated
2 that airborne transmission of Covid-19, the inadequacies
3 of the PPE provided, the limitations of the IPC measures
4 and the high rate of Covid-19 and Long Covid are all
5 inextricably linked. By way of example, Nicola Ritchie
6 contracted Covid-19 in the workplace and developed
7 Long Covid.
8 She told the Inquiry:
9 [As read] "I feel the PPE we were given was
10 inadequate to be seeing patients that had Covid."
11 She said:
12 [As read] "I felt that we should have been wearing
13 more appropriate PPE, regardless of who we were seeing.
14 At the time, Covid was so unknown it was a scary time to
15 be working."
16 As to routes of transmission and PPE, the
17 Long Covid Groups invite the Chair to accept the expert
18 evidence of Professor Beggs, who stated that by the end
19 of September 2020, at the latest, there was enough
20 evidence to strongly suggest that SARS-CoV-2 can be
21 transmitted via the airborne route.
22 Health minister after health minister has
23 confirmed to the Inquiry that they were aware that FFP3
24 masks provided greater protection than FRSMs.
25 Mr Hancock even described it as obvious. Yet the UK's

1 IPC guidance still doesn't reflect the need for
2 FFP3 masks to combat the airborne nature of the
3 SARS-CoV-2's transmission.
4 Further, Mr Hancock gave evidence that levels of
5 stock of PPE dictated the level of protection the IPC
6 guidance recommended. Decision-makers should have taken
7 a precautionary approach, informed healthcare workers of
8 the very real risk they faced, and provided suitable
9 PPE. Protection should only ever been dictated by level
10 of risk, not levels of supply.
11 Ventilation measures also remain inadequate in
12 healthcare settings and risk assessments are still not
13 routinely undertaken. The Inquiry must condemn the lack
14 of protection and subsequent support provided to
15 healthcare workers.
16 The Long Covid Groups therefore call upon
17 the Inquiry to recognise the significance of airborne
18 transmission of Covid-19, to make recommendations for
19 the consequential review of the IPC guidance on the need
20 for respirators in healthcare settings, and the
21 HTM guidelines on improved ventilation and the
22 introduction of air cleaning devices in public
23 buildings.
24 Over the last ten weeks the Inquiry has heard oral
25 evidence from multiple healthcare workers on the impact

1 that Long Covid has had on their lives, and yet the true
2 effect of Long Covid on healthcare workers remains
3 unmonitored.
4 Additionally, in the context of a pandemic, RIDDOR
5 was unfit for purpose and failed to provide workplace
6 protection and accountability. You've heard from the
7 BMA and the TUC this morning, and we endorse those
8 submissions.
9 Healthcare workers who develop Long Covid require
10 occupational support. There is an urgent need to
11 provide injury benefit for healthcare workers who are no
12 longer able to work, and ensure economic and
13 occupational support is available to assist them in
14 returning to work.
15 The Long Covid Groups therefore ask the Inquiry to
16 recommend that data on the incidence and impact of
17 Long Covid amongst healthcare workers is collected,
18 economic support is provided to healthcare workers
19 unable to work and to assist them in returning to work,
20 that Long Covid is designated as an occupational
21 disease, and that a new reporting system is developed
22 for use in pandemics to replace the use of RIDDOR.
23 I turn, sixth, to the burden of Long Covid not
24 being felt equally across the population.
25 Long Covid has created new health inequalities.

1 It has created a cohort of newly disabled people who are
2 unable to work, study or live life as they knew it
3 before infection. Long Covid has also exacerbated
4 existing healthcare inequalities. You've heard from
5 FEMHO this morning about the disproportionate on BME
6 healthcare workers. We endorse their submissions.
7 Evidence from Frontline Migrant Healthworkers
8 highlighted additional barriers that migrants face in
9 receiving a diagnosis and accessing care. Despite
10 suffering from the debilitating symptoms of Long Covid,
11 many migrant healthcare workers felt forced to return to
12 work out of the additional fear of losing their
13 immigration status in the United Kingdom.
14 The Inquiry is, therefore, asked to recommend that
15 the differential impact of Long Covid is monitored and
16 studied and, further, to recommend that Long Covid
17 healthcare addresses and overcomes new and pre-existing
18 healthcare and health inequalities.
19 Finally, the ongoing impact of Covid-19.
20 Covid-19 continues to circulate in an uncontrolled
21 way through healthcare settings. Covid-safe measures
22 are not in place.
23 Professor Banfield warned:
24 "... we are currently in a society that is running
25 as if Covid-19 doesn't exist anymore and yet clearly

1 Covid infections are still a source of hospital
2 admissions. Because we now no longer wear masks in
3 hospitals we have got a situation in which the carers
4 are walking around as if Covid doesn't exist ..."
5 The Long Covid Groups ask the Inquiry to recommend
6 that Covid-safe adaption measures are re-introduced in
7 healthcare settings: the implementation of adequate
8 ventilation measures, HEPA filtration systems, mask
9 mandates and Covid testing in all healthcare settings
10 are the low-hanging fruit of IPC measures that would
11 protect those working and those seeking care.
12 To conclude, the Long Covid Groups hope that their
13 experience of suffering in isolation without care, of
14 being disbelieved and rendered invisible by the
15 healthcare system is not in vain. Covid causes to cause
16 harm and Long Covid is a current public health priority.
17 The Chair said yesterday that the reason the Inquiry is
18 here is to make change for the good, so that people do
19 not have to suffer in the way that many of the witnesses
20 to this Inquiry and the Long Covid Groups' members have
21 done.
22 The Long Covid Groups look to the Inquiry to
23 ensure that recommendations fully address what went
24 wrong and remedy now what can be put right.
25 Thank you, my Lady.

1 **LADY HALLETT:** Thank you very much, Ms Hannett.
2 Mr Pezzani.
3 **Closing statement on behalf of Mind by MR PEZZANI**
4 **MR PEZZANI:** Thank you, my Lady.
5 My Lady, these closing remarks are made on behalf
6 of Mind. Mind is grateful to be included as a core
7 participant and on the subject of inpatient mental
8 health services for children and young people, which
9 I will abbreviate to CAHMS. Mind suggests that
10 the Inquiry's task in relation to that subject is
11 perhaps a bit easier than for some other subjects of
12 Module 3 because there is consistency across both the
13 witness evidence and those witnesses' recommendations.
14 These closing remarks will try to identify those
15 consistencies but, first, I make three foundational
16 points.
17 Point 1. In specific relation to inpatients, it's
18 vital to understand the reasons that a child or young
19 person will be admitted as an inpatient. Dr Northover
20 gave examples: very severe mental illness, perhaps
21 a psychotic illness or serious self-harm, an illness
22 that can't be treated in the community because of the
23 degree of risk, because of the intensity of the support
24 that is needed. Inpatient admission is a last resort
25 and is associated with significant risk to the child

1 from mental disorder. Please remember that when we come
2 to the figures about what has been called the treatment
3 gap, ie the ability of the inpatient sector to admit
4 children that need to be admitted to hospital.
5 Foundational point 2. This module concerns
6 healthcare systems. The inpatient sector represents
7 only one part of a system for the provision of mental
8 health care to children and young people. To examine it
9 in isolation is to mistake the tip of the iceberg for
10 the whole thing. That's why multiple witnesses
11 emphasised the importance of outpatient treatment and
12 other community resources including social care. They
13 represent a typical referral route into a hospital. If
14 they're applied promptly they can head off the need for
15 admission to hospital, but if they're missing then
16 there's a greater likelihood that the problem will
17 worsen and eventually require inpatient treatment, hence
18 Dr Northover's evidence that "we should continue to look
19 at how we can provide the care that's needed in the
20 community and get to a position where we need less and
21 less inpatient beds."
22 Foundational point 3 is that statistics and broad
23 statements are, of course, useful but as Professor Fong
24 memorably said, there is understandable value that we
25 attribute to stuff that you can count but not everything

1 that counts can be counted, hence this Inquiry's impact
2 statements which introduce a perspective that's missed
3 by sets of data. Not statistical graph could
4 communicate Ms Pashley's anguish at being given total
5 responsibility for her acutely suicidal daughter
6 in March 2020, only to discover later the same day that
7 her daughter had gone to a bridge with the intention of
8 ending her life.
9 That alarming story was the direct result of the
10 pandemic and should inform the need for clear planning
11 and guidance for CAHMS about the balancing of risks from
12 infection against the risks arising from mental
13 disorder.
14 To the evidential themes, of which there are
15 seven. The first theme is that the pandemic undoubtedly
16 had a mental health impact, stemming from the
17 psychological effect of the pandemic and from systemic
18 reactions to it. Dr Lockhart, for the Royal College of
19 Psychiatrists Faculty of Child and Adolescent
20 Psychiatry, recorded that, following each lockdown:
21 "... we have heard from our members that children
22 and young people who then presented to services were
23 more unwell than had ever been seen before, and in
24 a greater volume. It is not simply that presentations
25 and contacts with services increased, but rather, the

1 nature and severity of mental [illness] among those
2 presenting had worsened markedly."
3 But with the onset of the pandemic CAHMS inpatient
4 discharges increased sharply. In March to May 2020, bed
5 occupancy fell below 40%. IPC measures affected CAHMS
6 patients in multiple ways. School closures meant that
7 a common first source of support and alert was lost.
8 Inpatient capacity was reduced. Patients waited longer
9 for assessment and treatment. Community provision was
10 reduced resulting in symptoms getting worse. More
11 patients were placed in hospitals distant to their home
12 area and family, or on adult psychiatric wards. There
13 was thus a coincidence between an increase in the need
14 for CAHMS inpatient services and a decrease in the
15 availability of those services. By March 2022,
16 according to Dr Lockhart, almost a third of all people
17 in contact with mental health services across England
18 were children and young people.
19 The second theme is that the mental health impact
20 on children and young people was foreseeable.
21 Drs Northover and Evans in 2024 reported that the
22 Covid-19 pandemic exposed young people to known risk
23 factors for mental illness, such as disrupted schooling,
24 social isolation, health anxiety, and economic
25 instability.

1 But none of this is new. Daniel Defoe's
2 *"A Journal of the Plague Year*" described the effects of
3 the Great Plague of London in 1665 and recorded what
4 would now be called the mental health impact of
5 a pandemic. He wrote:
6 "[As read] It is scarce credible what dreadful
7 cases happened in particular families every day, some
8 dying of mere grief as a passion, some of mere fright
9 and surprise without any infection at all. Others
10 frighted into idiotism and foolish distractions. Some
11 into despair and lunacy, others into melancholy
12 madness."
13 The language is archaic but the message from both
14 history and contemporary clinical expertise is clear.
15 The third theme is that notwithstanding this
16 foreseeable impact, CAHMS did not feature in the
17 planning for pandemic preparedness. Part of that
18 inexplicable failure was the guidance about the
19 pandemic's unique challenges to inpatient mental health
20 services came either late or was absent. This had
21 palpable effects on individual lives, for example
22 Ms Pashley pleading with a hospital to admit her acutely
23 suicidal daughter and being turned away because of the
24 hospital's interpretation of IPC measures. Or the
25 eating disorder inpatient who was isolated on a ward, on

1 her own, behind a locked door, who suddenly found
2 herself without any monitoring of her nutrition.
3 Remember that eating disorders are as dangerous as some
4 cancers. If the mental health sector had been in the
5 room during planning and when guidance was being issued,
6 then these perils could and should have been taken into
7 account.
8 Instead, we have this from the witness statement
9 of Lade Smith, President of the Royal College of
10 Psychiatrists:
11 [As read] "It is unclear whether mental health
12 settings were simply forgotten, considered less of
13 a priority, or considered not to need any guidance
14 compared with other settings. All of these scenarios
15 are entirely unsatisfactory and undermine the
16 principle of parity of esteem between mental and
17 physical health."
18 The fourth broad theme is capacity and capability
19 are as important as planning. There are references in
20 the evidence to a treatment gap in CAHMS inpatient
21 services. Treatment chasm might be a more apt term.
22 According to NHS providers in a May 2021 survey,
23 two-thirds of CAHMS services who were surveyed could not
24 meet outpatient and inpatient demand and 85% couldn't
25 meet demand for eating disorder treatments.

1 Others have conveyed the same message both before
2 and during the pandemic. They include Mind, repeatedly
3 for years, the senior courts, again repeatedly
4 for years, and last Friday, the Secretary of State for
5 Health and Social Care from July 2018 to June 2021. The
6 relevance to this Inquiry of a long-standing lack of
7 capacity is that when there's a predictable surge in
8 demand caused by a pandemic a system that lacks capacity
9 is liable to become overwhelmed. When asked about this,
10 Matt Hancock said:
11 "So this is a clear and significant problem in the
12 NHS. It remains so today irrespective of Covid. So
13 I would say that these services were not overwhelmed by
14 Covid, they were already under very significant pressure
15 before the pandemic."
16 In one way that's disarmingly frank. It could be
17 interpreted as a concession that CAHMS were overwhelmed
18 even before the pandemic began, but it's also
19 wrong-headed. The evidence overwhelmingly indicates
20 that child mental health worsened during the pandemic
21 and as a result of the pandemic so that demand increased
22 and the treatment chasm widened.
23 I ask you to go back and watch Dr Northover's
24 answer to this question from Ms Nield:
25 **"Question:** And in terms of inpatient CAHMS

provision across UK, was there sufficient capacity to meet demand before the pandemic?"

The transcript records the doctor's answer as a simple "No", but on video you can see and hear a rather resigned laugh at the question.

Of course there was insufficient capacity and of course the insufficiency was exposed and exacerbated by the pandemic.

The fifth theme is this. This lack of capacity which originated before the pandemic, and worsened during it, had concrete effect on CAHMS inpatients: increased waiting times, delayed discharges, delayed admissions, placement out of areas, so that family contact was difficult or impossible, placement on general paediatric wards or on adult psychiatric wards. In this latter regard it's a matter of concern that the CEO of NHS England, when asked about placement of children on adult psychiatric wards said, "I'm not aware of cases where children have been placed in adult mental health settings."

There's clear and readily available evidence that such admissions occurred and in fact increased during the pandemic from both Dr Northover and Sarah Hughes of Mind. Their evidence was based on robust CQC data which recorded the main reason for the admission of a child to

an adult ward as being that "there was no alternative mental health inpatient or outreach service available."

The admission of a child to an adult ward is taken so seriously by Parliament that it attracts express statutory procedural duties in section 131(a) of the Mental Health Act 1983, as well as the duty to notify the CQC, and in relation to the effect on the child patient, Dr Northover called the admission to an adult ward "a double whammy of challenge" because the young person would be in an inappropriate environment where they would have to self-isolate and then once an appropriate bed became available they would then have to move and would then have to self-isolate again. That's the systemic effect.

For an example of the personal impact on a mentally unwell child, Sarah Hughes' statement records the understandable fear and concerns for the child's safety that it causes.

The sixth theme is that all of these impacts increase the risk of harm to child patients. A lack of capacity to meet a surge in demand means that mental health conditions are not addressed in the early stages and so the condition worsens, and so longer and more intensive treatment, including inpatient treatment is needed. This is particularly worrying in the case of

CAHMS because those first two decades of life are so profoundly influential. It is manifestly to the benefit of society as a whole to ensure that their mental health -- children's mental health problems are addressed early rather than left to fester.

Children are typically admitted where there is a high risk to them and where treatment cannot be provided in the community. It's so important to remember that the consequence of untreated mental illness can be sudden and catastrophic to the child and to their family, and to the surprise of nobody the mental health impact on children came down hardest on the most disadvantaged.

Drs Northover and Evans identified a significant rise in the number of admissions from the most deprived areas of the country during the pandemic. They say the pandemic most significantly affected people from deprived areas and worsened health inequalities within CAHMS.

Dr Lockhart says:

"The impacts of early life exposure to childhood adversity on mental health have been compounded by the pandemic ... which has contributed to unemployment, poverty, and stress among many families who were already disadvantaged, thereby further increasing

socioeconomic inequalities."

Children from a racialised background were hit particularly hard.

Dr Frank Atherton accepted there was a ladder of inequalities with different steps. He said:

[As read] "If you're from an ethnic minority group and you are poor, then your risk of damage to both physical and mental well-being is much, much greater. There are layers of inequality which affect people's mental health. I recognise that absolutely."

The seventh and final theme is that not all measures devised during the pandemic to address these impacts were successful. In particular, remote contact between children and young people and CAHMS is not a panacea. Several sources of evidence that address the value of remote contact also identified that remote appointments do not work for everybody in every situation, and went on to say that there are particular issues in relation to their use with children and young people. There is a danger here that a hurriedly developed contingency comes to viewed as an answer to the capacity problem that has beset CAHMS for years. It is, at best, an incomplete answer and not an alternative to the provision of face-to-face mental health treatment. There is no substitute for adequate

1 capacity.
2 I move on briefly to the recommendations.
3 There are six broad recommendations that were
4 repeatedly endorsed by a range of witnesses. They're
5 consistent with the recommendations by Mind's CEO
6 Sarah Hughes in her witness statement.
7 The first is for investment in capacity across the
8 board in CAHMS to meet current rising demand and to
9 ensure surge capability in the event of a future
10 pandemic.
11 The second is for forward planning and early
12 CAHMS-specific guidance.
13 The third is for a move away, where possible, from
14 inpatient admission and towards community treatment
15 which, where it is possible, will reduce the burden on
16 the inpatient sector.
17 The fourth is a recognition that isolation of
18 a child or a young person on an inpatient ward hinders
19 their therapeutic progress which is the purpose of their
20 admission.
21 The fifth is for specific consideration to be
22 given to the balance to be struck between (a) the risks
23 arising from exposure to a pandemic and (b) the risks to
24 inpatients arising from their mental disorder.
25 It's clear from Ms Pashley's evidence that that

1 balance was not always achieved. The consequence are
2 potentially catastrophic and yet, according to
3 Dr Northover's oral evidence, there was no guidance on
4 that vital issue.
5 Sixth, and this one merits just a little more
6 detail. Dr Northover was as clear as Sarah Hughes that
7 national governments must act to reduce health
8 inequalities before there is a further pandemic. That
9 should include measures to mitigate digital exclusion,
10 and promote early support hubs in the community to
11 address the understandable lack of trust in racialised
12 communities in a health sector that has a long history
13 of discriminatory treatment, particularly of black
14 patients.
15 Mind welcomes the current government's acceptance
16 that early support hubs are necessary but emphasises
17 that if these hubs are to fulfil a hitherto unmet need,
18 particularly for children and young people from social
19 deprived communities, then their focus must be on mental
20 health support and not simply crime prevention.
21 To conclude, there's now clear evidence that the
22 Covid pandemic had a profound effect on the mental
23 health of the generations that represent this nation's
24 future and that this nation was simply unable to help
25 many of them.

1 It matters profoundly because mental disorders are
2 seldom fleeting, particularly where they're not treated
3 promptly. Delay treatment of a mental disorder and the
4 best you can expect is that it will get worse and last
5 longer. The worst, particularly in the case of eating
6 disorders, is that it will end a young life.
7 My Lady, those are Mind's closing remarks.
8 **LADY HALLETT:** Thank you very much indeed, Mr Pezzani.
9 Mr Burton, I think you get the last slot of
10 the day. Sorry you come at the very end of today.
11 **Closing statement on behalf of Disability Charities**
12 **Consortium by MR BURTON KC**
13 **MR BURTON:** My Lady, the Disability Charities Consortium is
14 grateful to you for the opportunity to be a core
15 participant in Module 3 and also extends its thanks to
16 CTI and STI and, indeed, the staff here at the hearing
17 centre who have shown relentless hospitality and
18 efficient assistance, not always easy to a room full of
19 stressed-out lawyers.
20 These closing oral submissions are focused on the
21 lessons DCC considers needs to be learnt and
22 recommendations for the future.
23 I'm very grateful to junior counsel Ms Jones and
24 the client Mr Philippa for their expert assistance with
25 their preparation.

1 We address four topics, my Lady. The first is
2 accessible communications.
3 One might speculate with some confidence that were
4 you to ask the average person in the street to identify
5 the most obvious reasonable adjustments, they might say
6 that communications with the public ought to be in
7 a format that we can all understand. And yet, the
8 evidence shows that there was a persistent problem with
9 inaccessible communications from lockdown announcements
10 all the way through to shielding letters.
11 Matt Stringer, CEO of RNIB highlighted the massive
12 exclusionary impact of this failure. It took highest
13 level interventions by him and other charity bosses to
14 draw the government's attention to it.
15 Professor Powis confirmed that:
16 "Compliance with the [Accessible Information
17 Standard] was generally managed on a sporadic basis, and
18 in particular when specific concerns were raised in
19 respect of particular NHS material."
20 He explained that once confronted with legal
21 action by a visually impaired individual who met the CEV
22 criteria but only became aware of the shielding letters
23 some time after they were sent out, the DHSC did amend
24 communications by, I quote again "offering more
25 flexibility".

1 However, even when steps were taken they were not
2 adequate. As Mr Stringer of RNIB said, putting the
3 RNIB's contact details on a letter that is in
4 an inaccessible format hardly amounts to a satisfactory
5 solution.
6 My Lady, there are times where this Inquiry must,
7 of course, respect the impact the exigencies of the
8 situation had on government operations, but the DCC
9 invites you to underscore that there can be no
10 conceivable excuse for the persistent failures regarding
11 accessible communications, and demand that we do better
12 next time.
13 The specific recommendation is that the Accessible
14 Information Standard should be fully implemented in
15 England with equivalence in the devolved nations and,
16 importantly, its compliance audited across all public
17 services that it applies to.
18 My Lady, moving on to topic 2: the risks inherent
19 in not consulting with disabled people. In relation to
20 several important issues, a failure to take modest
21 practical steps to consult disabled people led to DHSC
22 and NHS output being revised only after the event, often
23 with serious adverse consequences for disabled people.
24 The first example is messaging. Save the NHS
25 predictably helped form the impression in vulnerable

1 people that they were expected to sacrifice themselves
2 to Protect the NHS from being overwhelmed. Attempts to
3 correct this impression ran straight into another
4 problem when former Secretary of State Matt Hancock said
5 on 22 April 2020 that people with non-coronavirus
6 symptoms must still contact their GP, he stipulated that
7 they should do so either online or by phone. This
8 second example, the policy of moving GPs to remote
9 consultations without explicit exceptions created
10 further barriers for some disabled people.
11 For example, RNID research in September 2020 found
12 nearly 60% of some 400 respondees were put off seeking
13 medical advice after the introduction of remote
14 appointments during Covid.
15 Similarly, my Lady, visiting restrictions. Across
16 the nations, rules were promulgated only to be modified
17 to take account of people with disabilities weeks or
18 even months later. The lag effect of this was that the
19 original restrictive rules cast a shadow over
20 decision-making once it was devolved back to the local
21 level. True it is that the rules were relaxed as
22 testing and other measures increased safety but
23 Professor Whitty effectively conceded that it had been
24 a mistake not to make an exception for people living
25 with learning disabilities, and autism, and Alzheimer's,

1 at the outset of the pandemic.
2 The DCC would same the say applies for carers
3 helping those with physical disabilities. As
4 Jackie O'Sullivan put it, to have a carer present was
5 not a nice-to-have, it was essential to the disabled
6 person's capacity to navigate the healthcare system
7 safely and effectively.
8 The last example of poor consultation. On
9 20 March 2020, NICE published rapid Covid-19 guidelines
10 on critical care in adults which advised that all
11 adults, not just those over 65, should be assessed for
12 frailty using the clinical frailty scale. As the
13 Inquiry experts explained, importantly the nature of the
14 indicators used may have overestimated the risk of
15 a poor outcome in people with stable conditions, such as
16 cerebral palsy or learning disability. A higher
17 clinical frailty score may reflect their stable
18 disability and not, as intended, their overall ability
19 to receive treatment.
20 CQC confirmed in its interim report that the use
21 of the CFS was interpreted by some as meaning that
22 disabled people who are not frail but needed assistance
23 would be denied access to critical care. It was only
24 after the persistent intervention of Mencap and the
25 National Autistic Society that NICE revised the guidance

1 to make it clear that the CFS should not be used for
2 younger people or those with learning or stable
3 long-term disabilities.
4 However, while the changes were widely
5 communicated, Mencap concluded in its report "My Health,
6 My Life" that the original NICE guidance had ongoing
7 damaging consequences as in GPs had sent letters to care
8 settings implying that people with learning disabilities
9 would not be treated if they went to a hospital and
10 advanced decisions, including using DNACPR orders,
11 should be made.
12 As Jackie O'Sullivan put it, the genie was out of
13 the bottle and it was very hard to put it back in.
14 The frustration for Mencap is palpable from the
15 emails between Mrs O'Sullivan and Paul Chrisp at NICE.
16 He claimed the speed of the work had meant an
17 inequalities impact assessment could not be done, but
18 Jackie O'Sullivan confirmed to you, my Lady, that she
19 would have been happy to look at it, the CFS, that is,
20 and would have spotted the problems immediately. After
21 all, during the same week she had turn around other
22 Covid-19-related government work in a week, on one
23 occasion even overnight.
24 What the evidence therefore shows is that even at
25 the height of the pandemic Mencap and others proved they

1 could constructively engage with the drafting of
2 guidance and suggest improvements for people with
3 disabilities. Therefore, even if formal full blown EIAs
4 and in-depth consultation with all stakeholders was not
5 always practicable, or as Humza Yousaf said, potentially
6 of limited use, the DCC does not accept that other forms
7 of more limited engagement would not have been possible
8 even if only, as Mr Stringer suggested, to get a sense
9 check. The evidence also shows this might have made
10 a real difference in realtime on the ground.
11 Moving towards recommendations under this second
12 topic, my Lady. As Mr Stringer also said, pre-pandemic
13 equality considerations had long been neglected and were
14 not embedded in decision-making. This meant
15 decision-makers were operating from a standing start.
16 There was somewhat of an uneven picture in this regard.
17 The Welsh Government was able to engage with established
18 groups like the Disability Equality Forum and Mr Yousaf
19 gave similar evidence about prior engagements with
20 people with lived experience of disability.
21 It is, however, a matter of very serious regret to
22 the DCC that despite the recommendation by the
23 equalities hub in the Cabinet Office that it would
24 improve interventions ahead of the anticipated second
25 wave, the Westminster government chose not to set up

1 a disabled persons panel.
2 Therefore, our three relations on consultation.
3 First, establish a standing body that can provide
4 timely context-specific reflections on policy,
5 particularly where full consultation or EIAs are not
6 objectively expedient. Whether it's called a disabled
7 person's panel or something else, the important thing is
8 this: no more standing starts.
9 Number two. Engage with DPOs and those with lived
10 experience and obtain qualitative alongside quantitative
11 data to help improve interventions. Mr Yousaf's
12 evidence was compelling in that regard.
13 Number three. Consider making co-design the
14 default principle not the exception. Co-production
15 processes will not only improve policy outcomes but also
16 build stronger, more trusting relationships between the
17 government and disabled communities. Nothing for us,
18 without us, my Lady.
19 Moving on to topic three. Clinical training and
20 guidance regarding escalation of care and national
21 policy regarding rationing in the event of NHS
22 saturation. Both are important but very different, and
23 should never be conflated or confused. The risk to
24 disabled people is too grave otherwise.
25 My Lady, it is clear that there was misuse of

1 DNACPRs that affected disabled people adversely. This
2 was not surprising. We know it happened before the
3 pandemic. We also know that disablism, conscious or
4 otherwise, was and remains a real phenomenon in society.
5 But on this there appears to have been a profound
6 state of national cognitive dissonance. Every witness
7 was unanimous that blanket policies are outrageous, but
8 yet LeDeR research showed that 78% of deaths of learning
9 disabled people in the first wave were in relation to
10 cases where DNACPR attached to the individual concerned.
11 In addition to this, as the CQC so powerfully
12 described in their report, DNACPRs are often seen as
13 a proxy for do not treat notices and confusion reigns
14 about how and for how long a DNACPR should be applied.
15 Recommendations, my Lady.
16 First, full implementation of the CQC's
17 recommendations. Equivalent work in Scotland and Wales
18 to establish and learn from the facts in relation to
19 DNACPRs.
20 Creation of a single methodology for recording
21 a DNACPR decision-making process, the ReSPECT document
22 or something similar.
23 Finally, training for clinical staff and a public
24 awareness campaign around the misconceptions around
25 disability and quality of life.

1 Now, my Lady, the very different other thing under
2 this topic, the rationing tool to be deployed in the
3 event of CRITCON 4. In March 2020 the CMOs commissioned
4 work on such a tool. The Inquiry experts explain it as
5 follows:
6 If critical care resources become exhausted
7 nationally, any declared clinical prioritisation would
8 operate on a ranking basis in the event of needing to
9 prioritise one patient over another when competing for
10 the same resource, in effect the last ITU bed.
11 This is a hugely emotive topic, laden with
12 controversy. Some witnesses have understood the
13 theoretical imperative for such a tool or policy even if
14 they don't like it. Others spoke vehemently against it.
15 Chris Whitty and Professor Powis and the experts
16 commissioned by the Inquiry agreed there is a place for
17 a debate and arguably such a tool. Mr Hancock gave
18 different evidence but, with respect, was not entirely
19 clear he understood the issue being put to him and may,
20 indeed, have been guilty of eliding the two concepts
21 himself.
22 You may feel that, as everyone is operating on the
23 working assumption there will be another pandemic and
24 NHS saturation may become a very real threat, the nettle
25 is better grasped now in the relative calm of

1 non-pandemic times.
2 Should that be the course you adopt, my Lady, DCC
3 say there must be four things in place.
4 First of all, a widely-drawn, deliberative process
5 that engages conscientiously with all relevant
6 stakeholders, free of political influence if possible,
7 a genuine public debate.
8 Two, total clarity about when it can and cannot be
9 used. The working group was tasked to only look at the
10 question of what to do and how to rank, not exclude,
11 patients when and if the ICU beds ran out in the context
12 of a national declaration of a state of emergency. It
13 did not look at the possibility of turning patients away
14 while beds were still available to keep space for others
15 deemed more deserving, nor at the question of taking
16 someone off a ventilator to make room for others. That
17 question was deemed too complex to be addressed in the
18 heat of the moment. But it's not difficult to see how
19 easily these two scenarios or criteria might become
20 confused or conflated. Indeed, there is evidence before
21 you that suggests that consideration surrounding this
22 piece of work, the tool, may have leached into the rapid
23 clinical guidance published by NICE at the end of March.
24 Indeed, it was not hard to notice that Mr Hancock and
25 other witnesses appeared to find the distinctions

1 difficult to grasp.
2 Three, there must be total commitment to ensuring
3 people living with disabilities are not disadvantaged
4 inadvertently or otherwise, and that any potentially
5 demeaning or discriminatory content is left out.
6 Four, unrelenting vigilance in ensuring that the
7 tool is never misused or mishandled. Sadly,
8 well-meaning rules are not always followed, often with
9 tragic consequences for disabled people.
10 The fourth topic, my Lady, mortality rates, what
11 we know and, more importantly, what we don't know.
12 The DCC started its submissions here and it's
13 appropriate to finish here.
14 All the evidence shows that, even when controlled
15 for age, socioeconomic status, comorbidities, health and
16 vaccine status, et cetera, there were still very
17 significant disparities in mortality for disabled people
18 when compared with the general population.
19 The government was aware of this from
20 late June 2020, but it did not feature in the Public
21 Health England reports. Indeed, it only became central
22 to government thoughts very late in 2020, after the
23 Equality Hub was set up, and even then most of its
24 recommendations, including around access to healthcare,
25 communications and consultation, were not followed.

1 And sadly, as we all know, the rate of disparities
2 and mortality in the first wave were then replicated in
3 the second wave. You might think there is a lesson
4 right there, my Lady.
5 The harsh reality is that despite the positive
6 legal obligations to protect disabled people from
7 particular disadvantage, precious little was done.
8 Shielding was entirely focused on clinical
9 vulnerability, whilst those living with Down's syndrome
10 were added to shielded persons list. A policy
11 predicated only on medical conditions, rather than
12 a wider social model of vulnerability or disability,
13 always risked overlooking entire categories of disabled
14 people, leaving them without a mechanism to ameliorate
15 risk effectively and quickly.
16 But, my Lady, beyond that statement of principle,
17 the DCC is hard pressed to advocate what should have
18 been done, or might be done in a future pandemic,
19 because even now, some four year later, we do not know
20 what caused the disparities.
21 Sir Christopher Wormald and Ms Pritchard accepted
22 as much in their evidence. Matt Hancock's evidence, on
23 the other hand, caused very significant alarm. The DCC
24 is not aware of any evidence to support his contention
25 that Covid-19 was intrinsically more aggressive against

1 people living with difficulties. Did he really think
2 that the virus, or does he really think that the virus
3 knows if somebody has a learning disability, or knows if
4 they have a hearing or visual impairment?
5 If Mr Hancock really was of this view it's not
6 surprising that under his leadership little was done to
7 address disparities. Relatedly the DCC endorses the
8 comments made by Mr Jacobs this afternoon when he
9 criticised the colour blind approach at the
10 Secretary of State level as being facile. The complaint
11 applies equally well to disabled people.
12 My Lady, Professor Whitty and Christopher Wormald
13 accepted further research must be done to establish the
14 causes, and DCC was very pleased to hear this morning
15 Ms Grey suggest the same on behalf of NHS England. We
16 hope that you will make that recommendation. The data
17 and lessons learnt from the disparities must be
18 published and acted upon.
19 On data, my Lady, you don't need to hear much more
20 from us. It's clear that action is underway to improve
21 data across the board. But please do be wary of the
22 "poor data" excuse. Much of the complaints about what
23 couldn't be done are reliant on the idea that disabled
24 people couldn't have been identified and located.
25 However, steps were not taken with GPs and local

1 authorities and others to try and overcome that problem.
2 They ought to have been. We only add that qualitative
3 research should also be added to the data reforms, and
4 that there are existing resources, like the learning
5 disability register, that could be better used.
6 My Lady, I turn to conclusions for my last minute.
7 The DCC commends you and your team for carrying
8 out this Inquiry with such impressive speed and
9 attention to detail.
10 On urgency, DCC policy leads have expressed a hope
11 that the learnings be implemented imminently in
12 forthcoming policy opportunities, such as the upcoming
13 NHS ten-year plan.
14 Whenever it comes, a report highlighting the
15 lessons learned, that offers meaningful and bold
16 recommendations, will go some way to ameliorating the
17 collective trauma of disabled people, and limit the
18 scope for the same or other mistakes to be made in the
19 future, hopefully leading us to better overall outcomes
20 for disabled people.
21 Ultimately, however, we say that the overarching
22 lesson is cultural and systemic. Disabled people
23 continue to get the rough end of the stick time and time
24 again.
25 My Lady a systemic problem requires a systemic

1 solution.
2 I'm sure we'd all have some sympathy, my Lady, if
3 you felt somewhat burdened by an obligation to craft a
4 set of recommendations capable of curing all systemic
5 inequalities in society. But if we can help with one
6 proposed recommendation that might go some way to
7 address structural inequalities, at least as they affect
8 disabled people, it is this.
9 The international community has settled upon the
10 UN Convention on the Rights of Persons with Disabilities
11 as an overarching effective set of rights. We urge you
12 to give serious thought to making a recommendation to
13 Government to ensure that the rights of disabled people,
14 as set out in the UNCRPD, are better respected,
15 protected and fulfilled, and that this should be
16 enforceable through systems of direct accountability.
17 My Lady, an embedded rights based approach would
18 at least elevate disabled people to the status of
19 individual rights holders, an important upgrade on their
20 current position as de facto second class citizens.
21 Thank you, my Lady.
22 **LADY HALLETT:** Extremely helpful, Mr Burton, thank you very
23 much indeed. Obviously I shall consider all the
24 submissions I have heard today, and indeed tomorrow,
25 very carefully.

1 Tomorrow I think is 10 o'clock, please.
2 **MS CAREY:** Yes, it is, my Lady. Thank you very much.
3 **LADY HALLETT:** Thank you.
4 **(4.30 pm)**
5 **(The hearing adjourned until 10.00 am**
6 **on Thursday, 28 November 2024)**
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 **INDEX**
2 **PAGE**

3 CLOSING SUBMISSIONS 1
4 (continued)
5 Closing statement on behalf 1
6 of NHS England by MS GREY KC
7 Closing statement on behalf 13
8 of group of Welsh Health Bodies by MR HYAM KC
9 Closing statement on behalf 22
10 of the British Medical Association by
11 MR STANTON
12 Closing statement on behalf 38
13 of National Pharmacy Association by
14 MR JOHN-CHARLES
15 Closing statement on behalf 49
16 of Royal Pharmaceutical Society by MS DOMINGO
17 Closing statement on behalf of 59
18 Northern Ireland Covid-19 Bereaved Families
19 for Justice by MS CAMPBELL KC
20 Closing statement on behalf 72
21 of Trades Union Congress by MR JACOBS
22 Closing statement on behalf 89
23 of Academy of Medical Royal Colleges by
24 MR HENDERSON

25

1 Closing statement on behalf 95
2 of Frontline Migrant Health Workers Group by
3 MS SEN GUPTA KC
4 Closing statement on behalf 107
5 of Federation of Ethnic Minority Healthcare
6 Organisations by PROFESSOR THOMAS KC
7 Closing statement on behalf of 121
8 John's Campaign, Care Rights UK and Patients
9 Association by MR WOLFE KC
10 Closing statement on behalf 131
11 of Clinically Vulnerable Families by MR WAGNER
12 Closing statement on behalf 146
13 of Covid-19 Airborne Transmission Alliance by
14 MR SIMBLET KC
15 Closing statement on behalf 161
16 of 13 Pregnancy, Baby and Parent Organisations
17 by MR WAGNER
18 Closing statement on behalf 175
19 of Long Covid Groups by MS HANNETT KC
20 Closing statement on behalf 194
21 of Mind by MR PEZZANI
22 Closing statement on behalf 207
23 of Disability Charities Consortium by
24 MR BURTON KC
25

LADY HALLETT: [30] 1/6 1/13 13/10 13/13 22/17 38/1 49/2 58/19 59/1 59/5 65/9 72/2 88/25 95/8 106/20 107/4 120/19 121/3 121/6 131/4 146/11 160/24 161/2 161/4 175/7 175/16 194/1 207/8 222/22 223/3
MR BURTON: [1] 207/13
MR HENDERSON: [1] 89/5
MR HYAM: [1] 13/16
MR JACOBS: [1] 72/7
MR JOHN-CHARLES: [1] 38/7
MR PEZZANI: [1] 194/4
MR SIMBLET: [1] 146/18
MR STANTON: [1] 22/21
MR WAGNER: [5] 131/11 161/1 161/3 161/5 161/10
MR WOLFE: [1] 121/9
MS CAMPBELL: [2] 59/10 65/10
MS CAREY: [8] 1/4 1/10 106/25 107/7 121/2 121/4 175/14 223/2
MS DOMINGO: [1] 49/8
MS GREY: [2] 1/16 13/12
MS HANNETT: [1] 175/20
MS NIELD: [2] 58/25 59/3
MS SEN GUPTA: [1] 95/13
PROFESSOR THOMAS: [1] 107/10

'

'precautionary [1] 8/10
'Stay [1] 133/11

0

0.1 [1] 86/16

1

1,000 [2] 46/24 46/25
1.08 pm [1] 120/24
1.50 [1] 106/23
10 [3] 6/20 24/19 79/15
10 o'clock [1] 223/1
10,000 [1] 80/20
10.00 [2] 1/2 223/5
11 o'clock [1] 43/20
11.19 [1] 58/22
11.35 [2] 58/21 58/24
111 [1] 122/12
11pm/midnight [1] 42/20
12 [2] 42/12 90/20
12 weeks [2] 71/5 185/12
120 [1] 51/3
13 [4] 161/8 161/10 187/25 225/16
13.8 million [1] 125/2
1300 pages [2] 76/10 76/11
131 [1] 202/5
13H [1] 128/19
14 December 2020 [1] 163/2
14 health [1] 187/25
15 [2] 40/21 42/16
15 years [1] 97/20
150,000 [1] 79/14
16 [2] 42/22 187/17
1665 [1] 198/3
17 March 2020 [1] 156/9
17.3 billion [1] 23/11
170 deaths [1] 26/23
18 [1] 185/22
19 [64] 12/3 18/15 21/12 25/14 26/6 29/8 31/3 35/20 36/3 37/21 41/13 45/25 50/12 52/16 56/22 57/4 59/8 73/17 83/1 87/21 90/17 97/3 112/7 118/2 131/21 135/11 142/13 146/16 146/19 147/10 147/11 147/16 151/17 155/23 161/16 162/1 164/7 172/6 174/19 175/25 176/4 176/13 177/6 179/13 179/16 182/4 183/13 184/22 186/1 186/11 186/13 187/8 189/2 189/4 189/6 190/18 192/19 192/20 192/25 197/22 211/9 219/25 224/18 225/13
19's [2] 147/22 157/25
1966 [1] 107/17
1983 [1] 202/6
1998 [1] 128/24

2

2 metres [1] 157/22
2 million [2] 73/4 176/20
2's [1] 190/3
2,000 [1] 70/25
2,000 midwives [1] 24/18
2-metre [1] 53/1
2.09 pm [1] 121/1
2.10 [1] 120/23
20 March 2020 [1] 211/9
20 masks [1] 28/6
200 [1] 145/23
200 Covid [1] 6/19
200 metres [1] 32/5
2008 [1] 84/4
2010 [1] 84/4
2011 [1] 102/21
2013 [1] 29/2
2018 [1] 200/5
2020 [46] 4/2 5/17 9/16 33/20 35/8 40/13 40/22 45/7 47/2 52/24 53/14 53/17 53/19 55/13 56/5 69/10 98/5 101/16 101/22 102/1 103/14 135/24 136/1 145/14 155/4 156/9 163/2 167/22 167/24 168/2 169/20 172/14 175/23 179/15 183/12 186/8 186/21 189/19 196/6 197/4 210/5 210/11 211/9 216/3 218/20 218/22
2021 [9] 14/4 64/23 66/12 67/21 136/4 137/10 168/13 199/22 200/5
2022 [7] 42/21 42/25 55/14 84/10 166/6 168/14 197/15
2023 [3] 31/22 34/5 74/6
2024 [8] 1/1 66/23 79/22 185/9 187/14 187/20 197/21 223/6
2025 [1] 184/12
2036 [1] 79/17
22 April 2020 [2] 101/16 210/5
22,000 [1] 28/6
24/7 [1] 19/2
25 March 2020 [1] 9/16
26 November [1] 58/1
27 million [1] 4/5
27 November 2024 [1] 1/1
27 weeks [1] 66/16
28 November 2024 [1] 223/6
28 weeks [1] 66/17

3

3 August 2020 [1] 53/14
3.20 pm [1] 175/11
3.35 [1] 175/9
3.35 pm [1] 175/13
30 [1] 51/4
357 cases [1] 26/21
36 [1] 101/19
3D [1] 28/8

4

4.30 pm [1] 223/4
4.4 [1] 31/22
40 [2] 53/2 197/5
40 million [1] 41/13
40,000 [2] 24/15 31/23
40,000 nursing [1] 24/17
400 [1] 210/12
400 metres [1] 183/2
400,000 [1] 86/14
483 [1] 86/15

5

5 million [1] 124/21
5,700 [1] 79/23
5-year [1] 71/7
5.8 [1] 79/23
50 [4] 24/18 33/21 41/22 41/22
50-plus [1] 28/7
55,000 [1] 185/10
5am [1] 42/19

6

6 days [1] 66/16
6,000 [1] 55/19
60 [3] 34/19 66/3 210/12
63 [2] 101/16 101/18
65 [2] 40/24 211/11

7

7 o'clock [1] 43/19
7.00pm [1] 42/19
70 [1] 172/14
71 [1] 56/22
78 [1] 215/8

8

8.30 [1] 42/18
83 [1] 101/18
85 [1] 199/24
860 [1] 31/14
88 [1] 55/13
89 [1] 172/15

9

9 April [1] 9/17
9,000 [1] 25/11
9.4 million [1] 23/9
90 [1] 130/12
94 [1] 52/25
95 [1] 143/10
99 [1] 143/9

A

abandon [1] 73/4
abandoned [2] 4/1 124/6
abbreviate [1] 194/9
abdication [1] 7/8
ability [14] 12/16 51/13 60/22 63/3 64/4 78/15 109/23 118/7 127/8 159/16 160/6 166/17 195/3 211/18
able [21] 5/19 6/3 9/21 17/5 19/6 35/1 36/17 37/15 47/20 53/13 55/10 59/4 85/20 86/22 92/2 107/1 156/20 159/9 184/4 191/12 213/17
about [106] 3/4 3/17 4/19 5/1 5/17 5/23 6/11 8/2 8/4 8/12 9/6 11/4 11/6 12/6 12/13 12/25 14/16 15/16 25/16 27/23 28/12 29/18 32/5 33/14 34/15 35/5 36/7 42/13 43/21 51/21 54/13 55/16 57/10 57/13 59/11 59/17 60/3 61/9 65/5 65/13 65/21 66/1 67/1 70/2 76/11 84/23 88/1 89/22 94/4 94/12 100/17 116/5 116/6 119/7 119/8 119/10 119/13 119/18 120/1 120/1 121/18 133/1 134/9 134/14 135/16 137/3 137/8 137/9 137/15 137/21 140/8 141/1 141/3 144/15 145/18 147/21 149/25 150/14 150/18 150/19 152/10 152/17 152/25 153/9 157/3 158/9 162/5 164/3 166/15 168/4 169/1 169/19 170/9 182/2 182/11 188/12 192/5 195/2 196/11 198/18 200/9 201/17 213/19 215/14 217/8 220/22
above [3] 18/23 52/11 74/8
abroad [1] 11/24

A

abrogated [1] 26/10
abrogating [1] 76/23
abrogation [1] 7/8
abruptly [1] 135/20
absence [13] 9/5 39/6 56/5 70/9 117/18 127/9 148/21 149/4 156/14 167/4 178/12 180/8 181/25
absent [2] 152/8 198/20
absolute [1] 167/7
absolutely [4] 44/22 56/14 161/5 204/10
absolved [1] 84/3
absorber [1] 39/20
absorbing [1] 89/9
abstract [1] 109/10
absurd [1] 144/18
abundant [2] 147/19 152/22
abuse [1] 139/4
academic [1] 112/10
academy [4] 89/3 89/11 90/20 224/23
accept [10] 5/6 65/4 65/12 78/7 137/13 138/9 143/2 169/23 189/17 213/6
acceptable [1] 116/10
acceptance [2] 140/5 206/15
accepted [13] 67/3 69/11 70/22 93/24 139/13 163/3 163/6 171/4 183/21 187/23 204/4 219/21 220/13
accepts [1] 25/23
access [49] 9/2 9/4 27/6 31/4 45/6 45/15 45/18 51/9 53/13 54/4 57/14 58/6 58/8 62/14 71/9 74/23 87/14 90/7 111/18 112/5 113/4 122/7 126/11 126/16 132/15 132/20 136/8 138/24 140/15 140/17 148/15 165/5 168/10 168/15 169/1 170/25 171/3 171/8 173/19 181/2 183/13 183/22 184/9 186/17 187/18 188/1 188/9 211/23 218/24
accessible [6] 47/17 114/14 208/2 208/16 209/11 209/13
accessing [4] 34/14 98/17 114/14 192/9
accommodation [2] 33/18 116/24
accommodations [1] 152/2
accompanied [1] 164/10
accompany [1] 2/7
accomplishment [1] 61/18
accomplishments [1] 60/2
according [5] 66/15 162/3 197/16 199/22 206/2
account [14] 2/21 13/5 20/19 23/17 49/17 62/13 81/14 83/23 114/22 117/17 150/25 151/6 199/7 210/17
accountability [13] 6/23 77/6 77/10 104/6 108/17 112/14 115/21 117/5 117/22 117/22 117/25 191/6 222/16
accountable [1] 119/22
accounted [1] 83/13
accounts [5] 32/9 81/19 96/5 96/10 124/5
accurate [5] 20/18 27/4 70/23 166/2 181/6
accurately [3] 11/15 118/10 150/5
achievable [1] 13/5
achieve [6] 71/19 71/21 80/18 89/15 117/1 135/4
achieved [5] 63/2 83/21 87/13 94/16 206/1
acknowledge [6] 6/9 12/17 30/14 72/22 160/6 176/11
acknowledged [7] 66/25 67/24 68/5 68/12 68/20 105/9 162/22
acknowledging [2] 167/14 180/17
acknowledgment [1] 151/5
acquired [5] 68/4 139/17 140/1 140/5 177/16
across [39] 19/3 20/21 23/8 31/15 35/25 36/12 40/1 48/18 54/9 56/20 57/22 58/5 58/9 58/14 62/17 77/1 89/13 93/14 93/16 96/3 104/3 104/16 111/23 116/21 130/10 141/24 162/22 167/20 170/16 174/2 179/4 191/24 194/12 197/17 201/1 205/7 209/16 210/15 220/21
act [15] 26/12 68/22 126/19 128/19 128/21 128/24 129/4 129/6 145/21 146/1 146/6 161/10 180/21 202/6 206/7
acted [5] 14/25 81/21 116/22 130/6 220/18
action [14] 30/16 47/3 75/9 77/4 77/13 79/12 88/24 108/10 109/25 118/4 119/18 158/23 208/21 220/20
actions [5] 12/24 30/11 58/6 76/6 90/16
active [2] 165/11 185/19
actively [2] 112/17 137/8
activities [2] 31/20 92/22
activity [1] 86/5
actually [13] 11/1 55/9 76/2 76/20 82/16 83/19 83/23 85/14 87/2 106/4 151/19 166/15 167/9
acute [5] 50/22 51/3 51/15 81/17 113/4
acutely [2] 196/5 198/22
adapt [3] 12/18 69/22 179/16
adapted [1] 20/25
adaption [1] 193/6
add [1] 221/2
added [3] 126/16 219/10 221/3
addition [5] 18/10 25/3 31/18 32/16 215/11
additional [14] 8/17 36/19 40/16 40/24 43/15 48/1 80/20 85/15 92/20 99/17 124/22 154/18 192/8 192/12
additionally [3] 73/15 86/16 191/4
address [31] 3/12 7/17 22/4 28/13 37/13 37/23 39/3 68/13 69/16 73/10 80/8 89/16 91/14 97/1 107/2 113/20 116/7 117/25 121/4 147/13 150/3 160/15 175/23 178/6 193/23 204/12 204/15 206/11 208/1 220/7 222/7
addressed [10] 68/10 68/16 96/21 97/6 113/23 147/9 156/6 202/22 203/5 217/17
addresses [3] 39/9 180/3 192/17
addressing [6] 50/5 75/12 113/17 117/23 119/21 184/21
adds [1] 47/17
adequacy [1] 26/11
adequate [11] 31/4 34/25 52/7 57/22 114/16 129/11 141/13 161/21 193/7 204/25 209/2
adequately [3] 36/15 47/21 51/13
adhere [1] 159/2
adjourn [1] 120/22
adjourned [1] 223/5
adjournment [1] 120/25
adjustments [3] 126/18 129/3 208/5
administering [1] 81/19
administration [1] 50/11
administrative [1] 188/23
admission [10] 68/7 139/11 140/22 194/24 195/15 201/25 202/3 202/8 205/14 205/20
admissions [5] 86/9 193/2 201/13 201/22 203/15
admit [4] 59/24 155/21 195/3 198/22
admitted [6] 25/13 68/3 126/1 194/19 195/4 203/6
admitting [1] 69/24
admonishment [1] 78/5
Adolescent [1] 196/19
adopt [6] 8/14 91/8 117/1 119/19 141/6 217/2
adopted [2] 69/12 123/1
adoption [1] 128/4
adopts [1] 95/3
adult [7] 197/12 201/15 201/18 201/19 202/1 202/3 202/8
adults [8] 176/20 177/9 178/15 182/21 183/10 188/6 211/10 211/11
advance [4] 7/15 75/16 83/21 84/17
advanced [1] 212/10
advancing [1] 29/19
advantages [1] 156/12
adverse [3] 11/5 178/18 209/23
adversely [1] 215/1
adversity [1] 203/22
advice [13] 16/15 39/18 40/11 41/1 93/22 93/23 126/23 135/6 135/10 148/16 150/22 156/1 210/13
advised [1] 211/10
advisers [1] 69/21
Advisory [1] 37/11
advocacy [2] 120/20 175/22
advocate [3] 59/22 121/4 219/17
advocates [4] 164/10 176/4 179/8 180/6
advocating [1] 163/24
aerosol [7] 29/4 29/10 29/15 30/6 30/14 36/1 143/15
aerosol-generating [3] 29/10 30/6 143/15
aerosols [5] 28/20 69/9 156/15 157/10 157/14
affairs [1] 94/12
affect [2] 204/9 222/7
affected [11] 71/24 110/18 112/12 117/16 122/18 145/16 169/6 173/1 197/5 203/17 215/1
affecting [1] 86/23
affiliates [1] 83/24
afforded [2] 83/19 86/7
afraid [2] 65/8 156/24
after [26] 12/15 29/20 32/12 42/18 44/25 49/18 53/14 54/15 66/1 66/20 80/23 102/21 108/22 134/5 136/15 161/3 161/19 167/24 184/4 189/22 208/23 209/22 210/13 211/24 212/20 218/22
after health [1] 189/22
afternoon [9] 107/1 107/5 121/2 121/3 121/5 131/12 146/18 175/14 220/8
afterthought [7] 43/18 43/24 45/1

A

afterthought... [4] 49/20 53/22 53/25 141/14
again [22] 2/8 6/8 9/11 31/20 35/20 45/13 71/22 83/1 90/11 122/13 127/2 137/20 138/15 140/21 161/11 169/13 171/14 175/1 200/3 202/13 208/24 221/24
against [26] 5/12 8/21 9/2 9/13 9/20 11/1 12/20 17/9 23/14 28/18 28/22 30/10 30/10 69/25 88/7 88/12 122/12 137/2 143/9 147/12 156/22 177/25 181/8 196/12 216/14 219/25
age [4] 121/25 130/13 185/21 218/15
Age UK [1] 130/13
ageing [3] 19/18 25/3 80/9
agencies [2] 84/22 154/14
agency [7] 64/19 65/3 70/12 83/3 133/17 155/16 188/22
aggravated [1] 171/18
aggressive [1] 219/25
agile [2] 12/17 93/1
ago [1] 35/10
AGP [2] 157/2 157/5
agree [3] 3/18 141/15 171/6
agreed [9] 85/13 93/24 127/10 127/13 127/19 127/20 157/12 169/12 216/16
agreement [7] 7/11 121/17 121/19 122/4 122/11 122/17 155/10
agreements [2] 122/20 145/7
agrees [1] 18/6
ahead [2] 38/14 213/24
Aidan [1] 165/18
Aidan Dawson [1] 165/18
ailments [1] 41/2
aim [2] 131/23 135/4
aimed [1] 84/1
air [3] 114/4 142/18 190/22
airborne [34] 28/12 28/23 69/7 141/11 146/16 146/19 146/23 147/10 147/11 147/16 147/20 148/19 149/1 149/6 149/10 149/10 149/11 149/15 149/23 150/3 150/10 150/19 151/15 153/18 155/5 156/10 160/12 177/14 177/25 189/2 189/21 190/2 190/17 225/13
airline [1] 81/3
alarm [3] 82/9 179/9 219/23
alarming [1] 196/9
alert [1] 197/7
alerted [1] 152/14
Alex [3] 99/6 104/10 105/19
Alex Marshall [2] 99/6 105/19
Alex Marshall: if [1] 104/10
algorithm [1] 138/11
aligns [1] 93/24
alike [1] 183/10
all [116] 1/10 2/3 4/11 4/24 5/25 7/2 7/7 11/14 14/1 18/2 20/9 20/20 21/14 21/15 21/24 24/8 24/9 24/10 29/7 31/5 34/5 35/12 35/19 35/25 37/3 37/15 41/12 44/11 52/6 54/4 56/22 57/22 61/1 61/3 61/8 62/1 64/2 64/13 66/13 71/24 80/23 88/8 89/6 90/11 94/11 96/14 99/9 99/25 100/12 100/13 102/15 106/17 107/12 108/22 109/17 110/18 115/24 116/1 119/16 120/8 121/24 122/2 127/12 127/19 127/19 129/14 130/10 130/10 130/23 134/5 136/12 143/24 145/10 145/13 146/13 150/7 160/3 162/10 162/23 165/9 165/18 167/18 168/2 168/12 173/23 174/2 176/11 176/13 177/9 177/19 178/1 179/5 184/9 185/21 188/8 188/23 189/4 193/9 197/16 198/9 199/14 202/19 204/11 208/7 208/10 209/16 211/10 212/21 213/4 217/4 217/5 218/14 219/1 222/2 222/4 222/23
alleviated [2] 56/16 135/14
Alliance [3] 146/17 146/20 225/13
allocated [1] 35/1
allocation [1] 117/14
allow [5] 45/23 163/12 165/4 165/6 168/15
allowed [7] 4/19 60/14 100/7 108/21 127/11 164/13 173/19
allowing [3] 46/12 95/20 167/12
almost [12] 23/4 24/7 27/2 65/1 79/15 102/22 137/14 139/9 139/21 161/23 163/2 197/16
alone [13] 23/6 24/17 25/12 26/22 60/13 71/19 110/1 163/21 164/23 165/14 173/18 185/11 186/10
along [3] 129/3 170/7 174/24
alongside [4] 5/20 48/4 77/15 214/10
already [17] 13/6 21/8 21/11 22/5 24/23 72/14 80/22 91/19 99/8 106/3 143/13 159/12 166/8 166/9 166/10 200/14 203/25
also [73] 4/22 8/5 9/6 11/11 11/19 17/20 19/23 32/6 32/23 34/7 34/25 38/22 39/13 44/24 45/20 51/19 56/1 57/16 61/14 72/24 78/16 80/8 87/18 88/15 89/18 89/20 90/1 90/4 96/19 97/8 97/12 99/16 99/20 100/13 105/19 106/17 108/10 112/12 115/5 119/11 120/3 124/12 125/24 127/3 127/6 128/11 129/14 131/16 136/14 139/13 140/7 143/12 149/16 155/8 157/1 158/1 158/13 158/14 159/16 167/11 173/9 180/2 182/3 190/11 192/3 200/18 204/16 207/15 213/9 213/12 214/15 215/3 221/3
alternative [7] 8/22 11/3 50/18 51/17 113/5 202/1 204/23
alternatives [2] 11/6 167/18
although [6] 7/7 128/14 148/16 150/6 154/5 165/22
altogether [3] 171/23 172/13 172/23
always [16] 2/11 5/14 22/25 25/4 94/19 125/18 146/23 147/15 147/18 169/11 174/23 206/1 207/18 213/5 218/8 219/13
Alzheimer's [1] 210/25
am [14] 1/2 13/11 21/21 21/21 38/2 42/18 44/18 58/22 58/24 72/8 107/10 161/1 161/11 223/5
Amanda [1] 127/20
Amanda Pritchard [1] 127/20
ambition [1] 78/7
ambulance [1] 154/20
ambulances [2] 34/14 80/12
ameliorate [3] 76/16 82/15 219/14
ameliorating [1] 221/16
amend [2] 91/7 208/23
amended [1] 9/16
among [5] 110/7 118/18 148/7 197/1 203/24
amongst [6] 60/1 74/9 87/25 121/17 176/17 191/17
amount [4] 21/10 28/12 53/18 89/5
amounts [1] 209/4
amplified [1] 113/11
amplifying [1] 112/1
anaesthetists [2] 24/19 171/17
analogy [2] 143/21 146/12
analysis [4] 26/25 87/10 148/21 165/21
ancillary [1] 98/6
Andrew [1] 17/15
Anecdotally [1] 82/22
anger [2] 60/12 130/18
anguish [1] 196/4
annex [1] 21/13
annex A [1] 21/13
anniversary [1] 71/7
announcements [1] 208/9
another [13] 33/1 45/3 55/10 90/1 105/5 120/20 142/17 143/21 151/23 171/9 210/3 216/9 216/23
answer [14] 63/24 67/9 75/4 108/20 109/1 140/4 140/17 140/18 155/10 155/22 200/24 201/3 204/21 204/23
answered [1] 153/15
answers [2] 76/2 76/6
antenatal [5] 163/8 163/9 172/8 172/13 172/15
anti [2] 77/4 77/12
anti-racist [2] 77/4 77/12
anticipated [2] 8/21 213/24
antiviral [2] 136/5 138/24
antivirals [2] 136/8 136/10
anxiety [2] 166/24 197/24
anxious [3] 75/25 140/11 167/4
any [50] 2/22 7/19 11/22 12/15 12/17 15/25 20/6 22/3 35/6 35/19 47/25 71/13 76/2 79/3 82/5 83/12 88/13 90/14 91/23 93/3 93/23 94/17 94/18 95/6 96/14 101/11 102/21 128/7 129/11 133/5 137/20 137/25 139/9 141/22 148/2 148/21 148/22 149/15 153/24 168/1 180/15 181/20 186/1 186/10 198/9 199/2 199/13 216/7 218/4 219/24
anymore [1] 192/25
anyone [2] 62/9 153/7
anything [4] 70/8 71/8 91/6 169/23
anyway [1] 138/16
apparent [3] 54/7 70/5 125/10
appear [1] 72/9
appearances [1] 2/7
appeared [3] 69/14 165/24 217/25
appears [5] 70/13 75/20 154/9 179/21 215/5
applicable [1] 96/3
application [1] 67/1
applied [5] 8/5 21/1 104/16 195/14 215/14
applies [7] 4/18 4/22 91/21 149/21 209/17 211/2 220/11
apply [4] 6/13 10/10

A

apply... [2] 129/16 149/24
applying [2] 15/24 166/20
appointment [3] 40/11 53/21 70/24
appointments [6] 40/24 144/15 172/8 172/15 204/17 210/14
apportioning [1] 70/2
appreciates [1] 37/17
appreciation [1] 1/21
approach [28] 16/21 19/5 27/10 29/6 29/17 36/4 37/7 69/17 71/6 75/14 87/18 110/18 116/1 117/4 118/9 124/8 133/15 133/19 141/7 150/16 152/11 179/2 181/9 182/24 183/5 190/7 220/9 222/17
approaches [3] 68/9 93/16 170/9
appropriate [11] 19/2 52/4 68/15 90/7 144/6 154/4 160/13 169/21 189/13 202/12 218/13
appropriately [1] 146/21
approximately [2] 41/22 46/24
April [4] 9/17 52/24 101/16 210/5
aprons [2] 28/9 100/6
apt [1] 199/21
arbitrary [3] 137/15 137/17 165/10
archaic [1] 198/13
are [221] 1/11 5/2 7/15 8/11 11/12 12/7 12/12 19/21 21/22 21/23 22/3 23/5 23/8 23/9 25/11 26/1 28/20 28/24 30/5 30/8 30/13 31/21 32/9 32/13 32/22 34/1 36/15 37/6 37/14 39/1 41/17 41/23 47/15 48/3 48/9 49/25 52/21 53/20 55/14 57/4 60/13 62/8 62/20 63/4 63/16 63/17 65/14 66/1 66/5 70/19 71/16 71/19 72/7 72/13 74/2 74/16 75/15 76/15 78/10 78/11 79/8 79/23 80/2 82/8 82/10 83/4 83/13 83/18 84/3 85/23 86/21 87/3 87/17 88/7 88/9 88/18 89/15 90/15 90/15 91/3 91/15 91/22 94/21 95/3 96/3 96/10 96/20 101/15 102/24 104/10 104/24 105/12 105/15 106/3 106/14 107/25 109/8 111/5 112/21 113/19 119/23 119/23 119/24 120/8 121/18 122/2 124/12 124/14 125/5 127/24 128/14 130/4 131/14 138/2 138/6 138/7 138/9 138/12 139/21 142/8 142/19 143/5 143/8 143/13 143/16 143/18 143/22 143/24 144/18 144/25 145/4 145/6 145/9 145/19 145/22 146/5 146/10 146/18 146/22 147/5 147/7 151/25 156/3 156/16 156/17 157/20 157/23 159/8 159/21 159/23 160/18 160/25 162/24 166/18 172/17 172/19 172/25 173/18 173/19 174/3 175/6 175/20 175/22 176/25 177/9 177/18 177/19 177/20 177/25 184/1 184/1 184/23 184/25 185/22 186/2 186/4 187/13 187/13 187/16 189/4 190/12 191/11 192/1 192/22 192/24 193/1 193/4 193/6 193/10 194/5 195/23 196/14 199/3 199/15 199/19 199/19 202/22 203/1 203/4 203/6 204/7 204/9 204/18 205/3 206/1 206/16 206/17 207/1 207/7 207/20 209/6 211/22 214/5 214/22 215/7 215/12 218/3 218/8 220/23 221/4 222/14
are generally [1] 52/21
area [4] 38/19 38/25 187/21 197/12
areas [12] 3/7 6/10 12/2 23/16 35/24 41/17 66/4 102/8 112/4 201/13 203/16 203/18
aren't [1] 172/16
arguably [1] 216/17
argue [1] 28/18
argument [2] 84/6 166/15
arguments [3] 30/13 88/7 157/8
ARHAI [2] 154/10 155/2
arise [2] 74/17 81/9
arising [7] 128/1 173/1 176/23 178/7 196/12 205/23 205/24
armed [1] 27/12
arose [1] 20/2
around [21] 4/5 12/19 14/12 23/8 24/15 24/18 53/17 85/24 98/5 101/7 144/4 145/23 153/17 157/5 160/12 176/20 193/4 212/21 215/24 215/24 218/24
around November 2020 [1] 53/17
arrangements [1] 153/21
arrival [1] 147/22
arrived [1] 102/21
articulate [1] 60/8
articulated [1] 124/17
as [297]
ascribing [1] 89/19
Asian [8] 73/20 73/23 74/8 75/22 82/23 109/11 112/3 171/8
aside [1] 155/7
ask [19] 2/16 10/16 11/11 48/20 48/22 95/21 100/8 108/20 129/12 129/18 130/8 171/14 176/19 178/6 181/4 191/15 193/5 200/23 208/4
asked [18] 5/22 14/4 14/16 15/10 21/18 48/14 63/4 64/2 65/4 65/12 81/22 100/16 135/1 185/1 188/4 192/14 200/9 201/17
asking [3] 14/13 43/10 146/5
asks [4] 23/17 47/11 47/14 47/16
asserted [1] 65/18
assess [1] 104/25
assessed [2] 165/20 211/11
assessing [1] 123/22
assessment [10] 51/24 65/18 82/2 104/15 138/4 140/19 145/20 184/16 197/9 212/17
assessments [19] 52/4 73/17 74/23 77/19 85/7 85/20 100/13 116/11 116/11 116/15 116/17 116/23 121/21 128/25 157/19 157/20 157/23 168/3 190/12
asset [1] 6/2
assets [1] 97/15
assist [4] 131/24 174/14 191/13 191/19
assistance [7] 65/20 131/2 174/16 186/15 207/18 207/24 211/22
assistants [2] 74/10 101/24
assisted [4] 76/9 131/13 161/12 174/18
assisting [1] 163/25
associated [2] 84/7 194/25
Association [9] 22/20 22/23 38/5 38/9 121/8 121/10 224/10 224/13 225/9
assume [1] 150/8
assumption [1] 216/23
assumptions [1] 141/1
assurance [3] 44/7 56/9 68/8
assurances [2] 67/16 184/24
assured [2] 64/11 65/17
astonished [1] 29/22
asymptomatic [1] 144/12
at [158] 2/4 2/9 3/21 4/6 6/5 7/20 8/17 8/20 8/25 9/9 9/12 9/15 10/16 10/18 14/2 15/10 16/2 16/19 17/1 17/1 18/10 18/23 18/24 20/7 20/14 21/18 22/13 23/11 26/6 29/23 30/21 34/23 37/3 38/10 43/20 45/10 45/20 47/2 47/11 47/19 50/1 52/1 52/12 52/20 52/24 55/14 55/17 58/21 63/7 64/6 67/18 68/7 70/7 72/14 75/20 76/4 77/22 79/23 80/21 81/5 81/5 84/1 84/18 86/23 88/8 91/18 91/20 94/17 96/14 96/25 97/17 100/7 100/12 100/13 100/25 101/11 101/18 105/7 106/23 108/16 110/19 112/18 113/21 114/9 115/18 116/4 117/11 120/23 121/12 124/10 125/23 126/5 127/11 128/22 129/8 129/10 131/1 131/5 132/24 133/11 136/3 136/12 136/12 138/12 139/2 140/14 146/3 148/19 148/21 150/1 150/6 153/4 153/7 155/20 162/23 165/23 168/12 169/20 170/20 170/24 171/5 172/19 173/23 174/23 175/9 176/5 176/10 177/10 177/19 177/22 179/13 184/1 185/9 185/12 185/20 185/21 187/5 187/24 189/14 189/19 195/19 196/4 198/9 201/5 204/23 207/10 207/16 211/1 212/15 212/19 212/24 217/9 217/13 217/15 217/23 220/9 222/7 222/18
at all [7] 88/8 96/14 100/12 100/13 136/12 168/12 198/9
at March 2024 [1] 185/9
Atherton [4] 17/10 134/21 137/24 204/4
attached [2] 85/17 215/10
attachments [1] 123/6
attack [1] 32/21
attacks [1] 32/22
attempt [2] 145/7 148/21
attempted [2] 128/2 151/7
attempts [3] 30/7 103/16 210/2
attend [4] 45/23 163/12 172/12 172/18
attendees [1] 1/24
attending [2] 54/5 187/4
attention [6] 5/9 6/25 47/10 68/21 208/14 221/9
attracts [1] 202/4
attributable [1] 25/11
attribute [1] 195/25
attributed [1] 43/2
Audit [1] 79/12
audited [2] 36/23 209/16
August [4] 45/7 53/14 135/24 136/1
austere [1] 97/10
authorities [3] 75/15 148/11 221/1
authority [1] 4/11
autism [1] 210/25
Autistic [1] 211/25
availability [5] 40/8

A

availability... [4] 51/16 136/5 150/18 197/15
available [30] 2/12 4/12 11/1 11/2 11/6 11/10 19/2 22/11 27/19 29/13 30/3 36/8 37/2 40/23 46/1 46/6 47/6 64/22 65/2 66/17 69/22 70/20 114/10 168/18 185/6 191/13 201/21 202/2 202/12 217/14
average [2] 40/21 208/4
averages [1] 24/16
avoid [6] 4/21 8/23 10/9 33/16 89/20 133/23
avoidable [3] 73/3 88/22 120/14
avoided [2] 1/8 114/6
avoiding [1] 94/13
await [1] 88/15
aware [12] 21/8 29/3 69/10 103/14 169/19 174/3 182/6 189/23 201/18 208/22 218/19 219/24
awareness [3] 15/22 129/15 215/24
away [9] 33/2 142/14 145/22 162/5 162/9 165/8 198/23 205/13 217/13
awful [1] 1/9

B

babies [12] 161/18 164/21 165/7 165/8 165/9 166/4 166/17 168/15 170/12 172/19 173/12 173/22
baby [6] 66/14 66/20 161/8 161/10 162/4 225/16
back [15] 5/8 15/2 56/25 71/4 84/6 84/12 84/14 106/23 125/5 138/14 158/23 160/25 200/23 210/20 212/13
backdrop [2] 17/9 112/1
backed [1] 36/8
background [6] 11/2 12/20 23/14 37/14 74/12 204/2
backgrounds [2] 34/21 41/23
backlog [1] 23/11
bad [5] 33/11 33/11 125/14 163/9 164/23
badly [1] 153/19
bag [1] 133/2
bags [2] 28/1 32/25
balance [15] 5/1 8/6 8/12 8/13 8/19 9/1 9/19 88/9 150/14 156/21 162/14 168/24 174/25 205/22 206/1
balanced [2] 19/14 30/10
balances [3] 3/4 7/22 8/2
balancing [2] 113/2 196/11
ballet [1] 185/20
BAME [1] 74/11
Bamrah [1] 110/12
band [1] 74/9
Banfield [2] 157/12 192/23
Bangladeshi [1] 87/22
bare [3] 25/25 107/20 159/12
barely [1] 96/14
Baroness [2] 14/17 169/12
Baroness Morgan [1] 169/12
barriers [7] 75/24 76/4 110/4 112/18 144/23 192/8 210/10
Barry [3] 114/4 147/23 157/19
Barry Jones [1] 157/19
base [1] 154/17
based [20] 6/3 9/23 19/22 30/8 30/18 38/19 60/23 69/18 90/21 94/2 114/23 118/6 148/8 155/11 170/13 172/6 174/3 176/3 201/24 222/17
baseline [2] 24/13 35/8
basic [1] 60/14
basis [5] 82/13 122/20 182/9 208/17 216/8
Bay [2] 17/1 17/4
bays [3] 25/6 51/5 51/8
be [278]
bear [2] 25/21 146/13
bears [1] 132/4
became [18] 29/16 39/17 41/9 43/6 51/7 51/9 109/3 124/22 126/6 133/19 151/20 154/12 154/25 157/7 176/1 202/12 208/22 218/21
because [54] 3/12 14/13 24/25 30/2 33/2 33/12 53/11 59/24 60/14 60/22 62/15 63/2 64/8 64/22 65/15 65/25 66/15 87/3 87/10 90/4 100/21 105/15 107/13 110/13 117/16 117/16 120/9 121/25 125/16 139/14 139/21 140/10 140/11 140/12 140/16 141/22 146/4 152/11 153/18 157/6 166/9 168/7 171/1 171/14 177/20 193/2 194/12 194/22 194/23 198/23 202/9 203/1 207/1 219/19
become [12] 22/15 25/15 95/25 101/2 142/25 149/1 149/8 184/5 200/9 216/6 216/24 217/19
becomes [5] 36/7 43/6 69/22 78/12 82/5
becoming [1] 9/1
bed [10] 23/9 32/25 33/1 36/16 92/2 97/13 185/20 197/4 202/12 216/10
bedded [1] 51/5
beds [10] 24/4 25/6 51/4 51/5 80/20 81/7 97/14 195/21 217/11 217/14
been [131] 1/7 2/5 5/9 6/12 6/24 10/23 13/7 13/11 15/16 19/2 19/14 21/11 21/19 21/20 23/15 24/6 28/11 29/6 29/22 30/25 32/19 33/4 39/19 40/23 41/5 54/6 55/13 61/20 63/5 63/20 64/1 64/13 64/16 64/22 64/25 65/19 67/1 68/6 69/5 72/11 72/17 73/22 75/4 76/1 76/3 76/7 77/23 80/21 80/22 81/2 82/16 88/20 92/4 97/9 98/4 103/9 104/13 106/4 108/23 113/13 114/5 116/10 119/20 123/17 124/17 125/18 126/1 127/10 127/14 127/21 130/15 130/16 130/17 130/24 130/25 133/5 134/17 139/17 141/10 141/13 145/8 147/16 147/24 149/18 151/2 151/18 152/4 152/19 152/22 153/5 153/21 153/22 156/24 158/21 159/12 160/14 161/20 162/9 163/4 163/12 167/18 168/16 168/25 169/3 169/11 169/23 170/1 171/5 171/13 171/18 175/3 175/4 179/17 186/20 189/12 190/9 195/2 196/23 199/4 199/6 201/19 203/22 210/23 212/19 213/7 213/13 215/5 216/20 219/18 220/24 221/2
before [28] 4/1 29/19 33/4 35/3 42/17 50/5 73/24 90/14 91/23 97/3 99/20 107/2 107/16 130/21 155/14 181/11 186/20 189/1 192/3 196/23 200/1 200/15 200/18 201/2 201/10 206/8 215/2 217/20
beg [1] 31/7
began [5] 24/14 148/25 161/15 167/25 200/18
beggars [1] 65/3
Beggs [8] 60/19 69/13 141/14 141/16 143/3 148/4 148/22 189/18
Beggs' [1] 142/7
begin [3] 39/15 131/16 150/2
beginning [4] 47/2 100/8 138/16 185/19
begins [1] 107/18
behalf [49] 1/15 1/16 13/14 13/17 21/15 22/19 38/5 38/8 38/17 49/6 49/9 59/8 59/22 64/10 72/5 83/15 89/3 89/11 95/11 106/24 107/8 121/7 131/9 146/16 146/19 161/8 175/18 186/6 194/3 194/5 207/11 220/15 224/5 224/7 224/9 224/12 224/15 224/17 224/20 224/22 225/1 225/4 225/7 225/10 225/12 225/15 225/18 225/20 225/22
behaviours [1] 181/15
behind [8] 1/23 60/13 68/25 102/25 110/21 120/7 132/11 199/1
being [81] 3/12 9/21 15/13 15/17 15/19 18/25 20/11 21/3 33/7 33/11 38/2 38/2 42/25 50/3 53/10 53/12 54/12 55/10 55/18 55/21 61/5 62/8 63/4 68/9 74/22 74/24 78/22 80/3 82/10 82/11 84/6 84/12 86/10 94/12 115/6 118/19 120/15 123/8 124/6 124/7 130/4 130/5 130/23 133/11 136/24 144/19 147/10 150/11 152/18 154/15 155/12 156/18 157/24 158/10 158/16 158/17 163/10 164/20 164/21 165/3 169/14 169/19 170/14 171/13 173/11 180/16 183/22 184/4 184/25 185/20 191/24 193/14 196/4 198/23 199/5 202/1 204/8 209/22 210/2 216/19 220/10
belated [2] 126/8 171/12
belatedly [1] 155/5
belief [3] 22/24 35/6 65/3
beliefs [1] 114/3
believe [9] 89/14 89/15 91/1 91/1 91/14 94/14 95/1 95/2 167/6
believed [2] 98/3 181/1
believes [1] 5/18
below [1] 197/5
beneficial [2] 20/19 126/15
benefit [5] 21/17 80/3 87/9 191/11 203/2
benefits [2] 92/7 182/17
bereaved [11] 59/9 63/10 63/13 63/19 67/9 71/13 71/16 71/24 122/24 176/11 224/18
bereavement [6] 62/1 162/18 171/22 172/21 172/23 174/15
beset [2] 136/9 204/22
best [19] 9/2 11/7 11/10 15/19 17/24 21/2 42/13 60/20 70/4 80/18 104/24 110/19 128/11 129/6 131/6 167/7 174/25 204/23 207/4
betrayed [1] 107/23
Betsi [1] 16/20
Betsi Cadwaladr [1] 16/20
better [35] 5/7 5/9 9/25 11/4 11/23 16/10 35/9 43/10 47/12

B

better... [26] 58/13 64/2 64/5 70/6 80/14 100/6 100/9 100/9 129/20 137/16 138/21 143/4 143/5 144/4 156/16 160/20 165/5 169/3 170/5 174/6 183/5 209/11 216/25 221/5 221/19 222/14
between [26] 7/11 8/19 9/19 11/16 25/6 55/23 64/19 68/9 84/4 93/20 93/20 114/2 125/17 136/20 137/6 141/16 162/14 165/11 170/12 174/7 197/13 199/16 204/14 205/22 212/15 214/16
beyond [11] 18/23 24/2 52/11 80/5 81/21 101/6 141/11 145/1 157/15 184/12 219/16
bias [2] 34/21 141/4
biases [1] 111/15
big [2] 44/18 185/18
billion [1] 23/11
bills [1] 55/10
bin [2] 28/1 28/9
bin bags [1] 28/1
Birmingham [1] 38/25
birth [5] 125/24 163/24 163/25 165/13 171/24
birthing [6] 162/23 163/4 163/22 164/4 169/1 169/14
births [2] 171/25 171/25
bit [4] 7/8 59/1 163/20 194/11
black [11] 73/20 73/23 74/7 74/14 75/22 82/23 87/22 109/11 112/3 171/8 206/13
bladder [1] 32/6
blame [2] 70/2 104/6
blanket [4] 126/8 170/9 172/5 215/7
blazing [1] 99/8
blights [1] 130/18
blind [2] 83/10 220/9
blindness [2] 75/7 75/11
Bliss [2] 130/13 169/6
blithely [1] 140/3
blood [1] 41/6
blown [2] 141/10 213/3
BMA [16] 22/18 23/17 24/21 25/17 25/23 26/13 26/25 28/3 28/13 28/15 29/22 32/2 37/17 37/22 176/16 191/7
BMA's [4] 22/24 27/17 31/9 35/6
BME [1] 192/5
board [13] 6/17 16/20 17/4 18/10 19/11 41/23 41/24 50/23 50/23 104/3 187/21 205/8 220/21
boards [15] 13/19 13/20 15/3 16/15 16/22 17/12 17/18 17/25 20/5 79/25 83/8 84/2 84/21 85/11 187/25
bodies [17] 13/14 13/18 18/6 21/15 77/2 92/10 93/6 93/20 93/23 95/5 110/16 148/23 149/19 155/13 159/10 179/21 224/8
bodies' [1] 149/9
body [5] 32/24 36/13 154/3 164/3 214/3
bold [5] 37/22 38/3 88/20 88/24 221/15
boost [1] 84/14
booster [1] 185/5
bore [2] 61/4 118/22
borne [1] 96/10
bosses [1] 208/13
both [34] 5/5 12/11 12/21 16/12 22/1 32/12 35/13 72/23 75/6 82/25 91/3 92/2 93/9 94/5 94/13 94/13 105/9 125/13 129/10 147/7 166/23 168/9 168/15 173/18 173/22 177/4 182/5 185/3 194/12 198/13 200/1 201/23 204/7 214/22
bottle [1] 212/13
bound [1] 10/17
bowel [1] 32/6
box [4] 28/6 62/5 63/23 116/13
branches [1] 182/4
Branding [1] 110/9
breach [2] 104/21 126/22
break [10] 49/4 58/21 58/23 106/23 161/2 161/3 161/4 161/5 175/9 175/12
breathing [1] 30/12
bridge [2] 136/20 196/7
brief [3] 3/10 39/1 131/23
briefly [3] 28/17 91/18 205/2
brighter [2] 71/11 71/18
bring [5] 15/1 36/19 90/13 105/4 143/25
bringing [3] 68/21 84/13 92/20
brings [1] 31/12
Britain [1] 95/17
British [6] 22/19 22/22 74/13 98/18 102/25 224/10
broad [5] 47/16 178/7 195/22 199/18 205/3
broader [3] 48/17 115/1 188/20
broadly [3] 50/4 93/12 138/5
brought [5] 48/1 72/19 84/6 84/12 125/1
brushed [1] 155/7
brutally [1] 49/17
build [7] 4/21 22/6 47/10 58/6 58/13 119/24 214/16
buildings [3] 20/11 80/11 190/23
buildup [1] 4/20
built [5] 16/13 20/15 123/9 165/25 166/3
bullet [1] 143/16
bullying [1] 83/6
burden [5] 62/21 118/23 188/5 191/23 205/15
burdened [1] 222/3
Burial [1] 3/23
burning [1] 73/25
burnout [5] 43/1 55/12 55/15 55/18 72/16
Burton [4] 207/9 207/12 222/22 225/24
but [159] 3/11 4/20 4/24 5/11 5/21 6/5 6/8 6/15 8/5 8/18 9/6 9/12 10/5 11/5 12/8 12/15 12/24 14/8 14/11 14/24 16/6 18/14 19/23 22/12 30/9 30/19 31/15 31/21 35/20 35/23 43/19 44/12 50/5 54/6 55/9 59/14 59/21 62/25 63/11 64/17 66/6 66/9 66/14 69/16 70/7 71/19 72/24 73/6 75/3 76/2 76/6 76/17 78/9 78/12 79/19 80/4 81/7 86/12 86/15 87/11 87/13 94/5 94/9 95/2 98/8 98/13 98/22 102/20 103/12 103/16 103/21 104/18 106/25 108/10 109/10 116/5 116/12 117/10 117/16 118/25 119/3 119/11 119/14 119/23 120/3 122/7 123/5 125/11 125/24 126/20 128/5 131/24 132/13 134/3 134/14 134/18 135/2 137/1 137/6 137/14 138/16 139/23 140/17 141/4 143/17 144/20 145/19 146/2 146/13 149/11 149/11 149/18 150/17 152/4 153/7 153/8 156/1 156/6 158/5 160/4 162/24 162/25 167/7 167/20 171/5 171/20 173/9 179/7 179/8 179/17 180/10 183/2 186/19 194/15 195/15 195/23 195/25 196/25 197/3 198/1 198/13 200/18 201/4 206/16 208/22 209/8 210/22 211/22 212/17 214/15 214/22 215/5 215/7 216/18 217/18 218/20 219/16 220/21 222/5
buying [1] 53/7

C

Cabinet [1] 213/23
Cabinet Office [1] 213/23
Cadwaladr [1] 16/20
cagoules [1] 28/1
CAHMS [17] 194/9 196/11 197/3 197/5 197/14 198/16 199/20 199/23 200/17 200/25 201/11 203/1 203/19 204/14 204/22 205/8 205/12
CAHMS-specific [1] 205/12
calamity [1] 3/22
call [15] 18/23 39/17 51/22 55/1 57/6 71/22 75/2 75/4 76/13 113/13 119/18 130/7 174/11 179/25 190/16
call-out [1] 51/22
called [6] 7/25 154/25 195/2 198/4 202/8 214/6
calling [1] 145/9
calls [3] 40/13 58/4 160/2
calm [1] 216/25
came [10] 2/4 4/6 18/4 42/17 55/6 65/3 152/10 163/7 198/20 203/12
campaign [8] 56/22 60/9 121/7 121/9 176/15 182/15 215/24 225/8
campaigns [1] 188/13
Campbell [5] 59/6 59/7 59/9 72/2 224/19
can [66] 1/4 1/6 9/23 9/24 14/10 22/15 30/9 31/8 35/16 38/3 59/5 60/17 61/3 64/2 64/3 70/17 70/22 78/24 79/11 85/11 86/10 87/13 87/25 90/1 90/13 90/13 92/15 94/15 95/1 112/2 119/7 126/24 128/9 130/21 130/25 138/5 138/12 138/21 139/4 140/3 142/22 146/21 149/5 159/5 160/20 163/9 170/24 172/25 173/15 173/22 181/11 185/13 189/20 193/24 195/14 195/19 195/25 196/1 201/4 203/10 207/4 208/7 209/9 214/3 217/8 222/5
can't [8] 3/9 3/12 8/16 25/1 144/24 144/24 146/11 194/22
cancelled [4] 25/18 62/16 90/6 124/25
cancer [2] 139/14 139/15
cancers [1] 199/4
candid [1] 152/4
candidly [1] 153/15
cannot [14] 32/5 71/19 71/20 78/25 94/10 94/15 134/16 139/19 143/11 156/14 162/18 182/2 203/7 217/8
capabilities [1] 135/8
capability [4] 12/11 97/13 199/18 205/9
capable [1] 222/4
capacity [52] 3/8 4/12 18/14 20/15 21/5 21/9 23/20 23/25 24/2 24/3 25/7 34/7 34/9 35/5 35/7 35/9 35/13 37/24 57/20 73/13 77/20 78/3 78/15 78/16 78/20 78/24 79/2 80/13 80/14 80/15 80/21 81/9 91/25 92/1 92/20 97/13 125/7 129/6

C

capacity... [14] 141/21 172/6 197/8 199/18 200/7 200/8 201/1 201/6 201/9 202/21 204/22 205/1 205/7 211/6
capita [1] 24/16
capital [3] 22/8 22/10 97/15
capture [1] 118/10
cards [2] 141/1 141/9
care [128] 3/7 3/25 4/14 4/23 4/23 8/23 9/3 12/12 13/21 19/2 23/6 24/1 24/19 25/18 29/10 29/11 30/1 30/5 31/7 32/1 33/5 33/20 34/9 34/12 34/12 34/15 36/2 36/24 39/22 41/1 46/11 47/15 47/25 48/3 48/4 49/16 49/19 50/14 50/15 50/20 51/1 52/13 52/19 53/12 54/5 54/10 55/9 56/10 56/15 57/5 57/14 57/19 57/22 58/4 59/23 59/24 62/14 73/12 87/16 88/17 90/7 92/12 99/14 101/25 113/2 113/5 119/11 119/23 121/7 121/10 122/1 123/24 125/19 126/5 128/3 130/9 130/11 157/15 161/17 162/16 162/17 162/25 162/25 163/5 163/8 164/11 164/17 164/20 167/12 167/13 168/7 168/8 168/9 168/13 169/9 169/15 170/12 170/25 171/13 171/15 172/13 172/22 172/24 173/15 173/15 174/3 178/14 180/4 183/11 183/18 183/23 183/24 184/16 187/20 188/1 192/9 193/11 193/13 195/8 195/12 195/19 200/5 211/10 211/23 212/7 214/20 216/6 225/8
care-giving [1] 167/12
career [1] 185/20
careers [1] 188/18
careful [1] 137/15
carefully [3] 64/12 147/25 222/25
carer [6] 125/2 126/4 126/11 166/8 166/11 211/4
carers [11] 9/6 122/14 124/14 124/22 125/13 125/18 125/22 126/14 127/10 193/3 211/2
Carey [3] 1/6 121/3 175/16
Carey's [1] 132/1
caring [4] 18/16 27/8 29/7 50/11
carried [4] 21/11 21/19 40/21 182/3
carry [3] 107/6 157/18 157/24
carrying [2] 154/10 221/7
cars [1] 33/17
carved [1] 158/10
case [12] 12/4 45/20 46/5 54/7 90/9 90/10 92/5 94/1 100/15 140/6 202/25 207/5
cases [9] 26/21 61/21 166/5 168/2 174/17 185/6 198/7 201/19 215/10
cast [2] 64/7 210/19
casualties [3] 90/3 90/8 90/15
CATA [15] 32/12 146/20 150/24 152/8 152/9 152/10 152/17 152/20 153/4 153/7 153/14 156/1 158/2 160/21 176/16
CATA's [2] 146/22 160/17
catastrophe [1] 3/21
catastrophic [3] 25/25 203/10 206/2
catastrophically [1] 158/22
catch [3] 59/1 139/8 144/21
categorical [1] 8/22
categories [4] 100/18 101/24 104/4 219/13
categorised [2] 46/2 69/14
catering [1] 84/14
Catherine [3] 66/11 132/25 148/5
Catherine Todd [1] 66/11
catheterise [1] 32/7
caught [1] 131/21
cause [6] 90/3 93/17 93/17 148/20 162/2 193/15
caused [9] 4/5 18/15 126/25 127/1 151/22 152/13 200/8 219/20 219/23
causes [5] 88/5 159/21 193/15 202/18 220/14
causing [4] 2/14 156/22 177/6 186/22
caution [1] 181/10
cautioning [1] 181/16
cell [13] 6/17 6/24 29/16 141/4 151/5 151/9 154/2 154/16 154/24 155/13 155/19 157/17 165/20
cells [1] 6/19
central [8] 7/18 49/19 65/21 99/19 112/20 154/3 170/20 218/21
centralised [3] 19/17 84/3 117/5
centrality [1] 129/13
centrally [2] 21/7 80/1
centre [2] 48/12 207/17
centred [3] 112/16 123/20 123/25
centredness [1] 125/14
centres [1] 53/8
century [1] 3/2
CEO [5] 17/1 115/15 201/17 205/5 208/11
cerebral [1] 211/16
certainly [2] 74/4 169/6
cetera [1] 218/16
CEV [4] 132/11 133/6 136/23 208/21
CFS [3] 211/21 212/1 212/19
chain [2] 57/24 58/7
chains [1] 57/17
chair [9] 1/19 38/20 38/21 43/9 52/10 53/19 181/9 189/17 193/17
Chair's [1] 8/18
challenge [11] 2/18 14/11 26/11 45/9 69/17 115/23 124/7 134/8 149/4 151/20 202/9
challenged [5] 38/2 62/18 88/20 142/7 148/2
challenges [10] 12/25 18/13 20/2 46/20 50/25 54/16 110/19 118/14 152/6 198/19
challenging [2] 17/14 41/8
chance [1] 109/5
change [26] 7/20 20/17 26/2 29/17 35/21 43/11 60/18 60/18 61/17 63/4 63/14 69/22 70/9 71/25 76/25 77/7 94/8 104/18 108/25 109/7 112/16 113/18 140/23 157/14 181/18 193/18
changed [3] 71/8 71/8 103/13
changes [7] 7/16 60/7 126/9 138/6 146/6 172/5 212/4
changing [3] 33/17 69/24 185/13
chaotic [1] 81/14
chapter [1] 120/3
chapter but [1] 120/3
characterised [2] 102/17 150/15
characteristic [1] 37/15
characteristics [3] 75/18 75/19 88/11
charge [3] 120/16 147/3 148/15
charged [1] 2/20
charities [6] 33/25 174/12 176/16 207/11 207/13 225/23
charities' [1] 174/20
charity [1] 208/13
Charles [4] 38/4 38/6 49/2 224/14
Charlotte [1] 128/2
Charlotte McArdle [1] 128/2
chasm [2] 199/21 200/22
check [1] 213/9
checking [1] 59/4
checks [2] 86/14 164/15
cheese [4] 143/22 143/23 143/25 146/12
chief [13] 17/3 17/10 18/9 19/24 21/10 64/25 67/11 127/18 133/14 134/20 168/24 169/5 186/21
chief executive [5] 17/3 18/9 19/24 21/10 64/25
child [13] 133/9 165/13 194/18 194/25 196/19 200/20 201/25 202/3 202/7 202/16 202/20 203/10 205/18
child's [1] 202/17
childbirth [2] 61/25 172/25
childcare [1] 56/7
childhood [3] 185/8 185/9 203/21
childhoods [1] 185/14
children [43] 45/23 133/20 176/21 177/9 178/17 183/10 185/7 185/10 185/13 185/16 186/2 186/4 186/5 186/10 186/13 186/15 186/19 186/23 187/2 187/4 187/5 187/8 187/15 187/17 187/25 188/5 188/6 188/8 188/12 194/8 195/4 195/8 196/21 197/18 197/20 201/18 201/19 203/6 203/12 204/2 204/14 204/19 206/18
children's [2] 185/15 203/4
chime [3] 15/4 20/4 74/19
choice [3] 10/6 35/16 69/1
choices [2] 8/16 12/19
choose [2] 100/24 114/2
Choosing [1] 67/12
chose [1] 213/25
chosen [2] 15/9 124/1
Chris [14] 7/5 8/7 12/4 26/4 35/14 69/14 102/15 105/25 134/16 134/24 137/23 142/3 181/13 216/15
Chris Whitty [1] 216/15
Chrisp [1] 212/15
Christopher [3] 134/12 219/21 220/12
chronic [1] 97/10
chronically [1] 97/12
circulate [2] 139/2 192/20
circulating [1] 31/3
circumstances [10] 9/22 14/25 16/7 17/14 25/14 92/16 128/10 132/13 162/19 166/12
citizens [1] 222/20
claim [1] 67/10
claimed [3] 149/19 149/25 212/16
clamouring [1] 153/22
clarification [1] 16/14
clarity [3] 5/17 7/1 217/8
class [3] 96/4 112/22 222/20
classified [1] 28/25
classify [1] 37/11

C

cleaner [1] 100/3
cleaners [6] 99/14 101/25 103/8 114/13 114/16 188/22
cleaning [3] 84/5 84/13 190/22
clear [57] 5/15 6/23 7/7 16/3 17/16 18/18 19/4 19/10 19/13 19/24 29/16 29/24 44/11 44/13 46/9 60/23 72/25 73/7 78/21 80/24 85/5 87/21 92/6 92/19 93/13 103/12 105/5 126/21 127/18 128/4 128/8 129/22 132/10 132/16 146/23 146/24 148/18 149/2 151/1 152/25 154/11 167/2 175/2 175/3 175/4 181/25 196/10 198/14 200/11 201/21 205/25 206/6 206/21 212/1 214/25 216/19 220/20
clearer [4] 6/13 127/14 163/4 174/6
clearly [11] 2/18 60/10 61/3 79/11 80/8 94/2 102/7 104/20 135/3 184/6 192/25
client [1] 207/24
client's [1] 96/24
clients [3] 73/21 143/21 186/4
cliff [1] 136/19
clinic [1] 144/17
clinical [38] 10/2 20/21 21/3 50/10 50/20 50/22 88/2 92/10 93/6 93/22 93/25 94/3 98/2 98/12 98/12 100/10 100/17 114/15 138/17 145/20 146/4 152/25 176/5 180/10 181/5 183/14 188/1 188/13 188/20 188/20 198/14 211/12 211/17 214/19 215/23 216/7 217/23 219/8
clinically [26] 61/24 81/22 123/2 131/9 131/12 132/5 132/11 133/1 136/3 136/7 137/3 137/4 137/5 138/21 139/7 139/13 139/19 144/6 144/9 144/19 145/4 145/13 145/23 146/8 176/14 225/11
clinicians [6] 80/25 152/14 174/2 174/17 183/21 188/11
clinicians' [1] 81/15
clinics [4] 183/15 183/19 184/3 184/10
close [8] 15/11 16/2 16/17 24/2 45/11 47/19 149/12 150/12
closed [3] 46/25 51/9 59/21
closely [2] 121/10 123/18
closes [1] 118/21
closing [54] 1/3 1/11 1/15 13/14 13/16 22/19 22/22 28/14 35/22 38/5 38/8 38/14 42/18 49/6 59/8 72/5 89/3 89/11 95/11 97/2 107/8 121/7 131/9 146/16 161/8 175/18 176/18 178/4 187/13 188/2 194/3 194/5 194/14 207/7 207/11 207/20 224/3 224/5 224/7 224/9 224/12 224/15 224/17 224/20 224/22 225/1 225/4 225/7 225/10 225/12 225/15 225/18 225/20 225/22
closure [2] 57/13 184/1
closures [1] 197/6
clothes [1] 33/17
CMO [2] 70/22 184/18
CMO's [1] 137/23
CMOs [4] 24/8 155/17 179/5 216/3
CNOs [2] 24/8 155/17
co [7] 4/8 5/19 6/1 17/13 20/20 214/13 214/14
co-design [1] 214/13
co-operatively [1] 17/13
co-ordinated [1] 4/8
co-ordination [3] 5/19 6/1 20/20
Co-production [1] 214/14
CO2 [1] 144/13
cognitive [2] 126/2 215/6
cohesive [1] 58/4
cohort [3] 185/4 185/16 192/1
coincidence [1] 197/13
coincidences [1] 108/1
collaboration [1] 7/15
collaborative [3] 14/9 16/21 18/4
collaboratively [1] 17/25
collated [1] 80/2
collateral [1] 90/5
colleagues [7] 19/1 24/23 69/12 74/13 98/18 106/14 118/18
collect [2] 84/21 109/18
collected [1] 191/17
collection [6] 109/22 118/5 118/6 118/9 179/18 179/20
collective [1] 221/17
collectively [3] 13/20 22/2 67/14
College [3] 167/2 196/18 199/9
Colleges [4] 89/4 89/12 89/13 224/23
colossal [1] 134/13
colour [5] 75/7 113/14 120/10 123/16 220/9
combat [3] 83/22 147/12 190/2
combination [2] 29/11 61/9
combined [4] 26/24 60/4 62/21 118/17
come [14] 8/17 76/17 80/25 106/23 118/20 119/17 135/6 141/9 143/12 145/25 153/14 174/23 195/1 207/10
comes [4] 53/22 63/1 204/21 221/14
comfort [4] 29/20 30/8 60/15 126/23
comfortable [2] 131/6 144/24
comforting [1] 69/1
coming [3] 1/11 56/18 122/21
commend [3] 12/20 89/6 130/20
commending [1] 182/24
commends [1] 221/7
commented [1] 53/19
comments [4] 2/6 13/7 176/18 220/8
commission [2] 84/10 164/7
commissioned [4] 12/1 81/6 216/3 216/16
commit [3] 71/23 112/15 120/8
commitment [7] 11/14 21/14 71/17 114/1 119/13 128/20 218/2
committed [1] 17/23
Committee [2] 40/20 107/16
common [5] 60/11 62/2 165/1 166/20 197/7
commonly [1] 57/18
commonsense [1] 143/2
comms [1] 134/22
communicate [3] 134/17 144/25 196/4
communicated [1] 212/5
communicating [1] 51/11
communication [8] 17/17 62/25 63/1 63/3 110/2 110/9 125/10 126/3
communications [13] 93/13 132/24 134/16 134/19 135/5 174/6 181/21 208/2 208/6 208/9 208/24 209/11 218/25
communicator [1] 60/2
communities [14] 39/11 41/16 41/18 55/9 105/21 108/13 110/3 110/20 112/20 118/22 171/9 206/12 206/19 214/17
community [72] 9/9 17/7 38/11 39/5 39/9 39/13 39/15 39/17 39/21 39/23 40/1 40/2 40/9 41/7 41/12 41/14 42/1 42/5 43/1 43/3 44/2 44/18 44/21 44/25 45/3 45/14 45/16 45/21 46/1 46/2 46/10 46/13 46/17 46/21 47/4 47/24 48/3 48/8 48/10 48/17 48/21 48/22 49/18 49/22 50/4 53/13 53/24 54/2 55/12 56/8 56/13 56/24 57/1 57/4 57/6 57/11 110/22 120/11 123/21 125/1 133/8 139/22 145/1 173/19 194/22 195/12 195/20 197/9 203/8 205/14 206/10 222/9
comorbidities [1] 218/15
comparable [1] 71/1
compared [7] 24/16 26/22 55/25 82/24 167/1 199/14 218/18
comparison [1] 188/6
compassion [2] 60/11 163/20
compassionate [3] 18/16 68/23 123/23
compelling [4] 54/13 99/5 151/6 214/12
compensate [1] 124/19
compensation [2] 27/6 37/9
competence [2] 81/21 81/23
competent [4] 117/20 119/14 119/14 119/22
competing [1] 216/9
complain [1] 104/11
complaint [1] 220/10
complaints [2] 129/20 220/22
completed [2] 85/9 162/7
completely [3] 6/18 149/13 165/14
completing [1] 65/9
complex [7] 3/9 5/14 41/2 41/8 60/22 138/9 217/17
complexities [1] 18/15
complexity [2] 3/7 57/16
compliance [2] 208/16 209/16
complications [1] 117/11
complied [1] 26/13
comply [2] 135/8 140/14
compounded [7] 110/8 110/16 113/6 118/15 147/5 155/11 203/22
comprehensive [1] 60/23
comprise [1] 188/23
comprised [1] 95/15
comprises [1] 13/18
compromised [1] 18/24
conceded [1] 210/23
conceivable [1] 209/10
concept [1] 8/13
concepts [4] 109/10 111/2 112/10 216/20
concern [10] 30/24 49/21 52/1 57/10 65/13 67/9 123/9 136/10 154/12 201/16
concerned [5] 45/2 121/18 125/6 145/18

C

concerned... [1] 215/10
concerning [5] 2/25 117/24 155/5 167/4 183/22
concerns [36] 9/6 16/8 19/7 19/11 19/15 26/12 29/11 31/9 34/15 35/2 37/16 48/20 51/21 57/13 65/5 65/21 67/1 67/13 74/21 79/19 85/20 88/1 121/13 128/1 130/14 147/1 150/17 150/24 152/17 153/9 158/9 169/19 170/9 195/5 202/17 208/18
concession [2] 151/7 200/17
conclude [6] 3/11 64/15 120/6 157/2 193/12 206/21
concluded [1] 212/5
concludes [1] 49/1
conclusion [6] 14/2 94/21 119/17 142/8 147/15 166/18
conclusions [4] 10/15 39/3 118/20 221/6
conclusive [1] 186/20
concrete [3] 104/18 132/2 201/11
condemn [1] 190/13
condition [6] 36/23 73/14 87/5 87/8 88/8 202/23
conditions [13] 41/3 83/17 84/2 85/16 85/24 98/17 102/13 112/6 135/11 170/23 202/22 211/15 219/11
conducted [5] 86/14 116/23 130/23 130/24 186/20
confidence [9] 30/22 30/23 30/25 136/25 145/3 159/6 159/15 163/18 208/3
confident [3] 21/21 21/21 82/9
configuration [1] 35/15
confined [1] 99/24
confines [1] 78/11
confirmation [1] 141/4
confirmed [9] 26/5 45/14 103/13 179/5 184/18 189/23 208/15 211/20 212/18
confirming [1] 177/14
conflated [2] 214/23 217/20
conflict [1] 124/15
confront [3] 108/7 109/5 112/14
confrontation [1] 108/7
confronted [1] 208/20
confronting [1] 107/18
confuse [1] 182/11
confused [2] 214/23 217/20
confusion [1] 215/13
Congress [3] 72/5 72/8 224/21
connection [1] 39/8
connectivity [1] 58/8
conscientious [2] 13/24 18/16
conscientiously [2] 20/1 217/5
conscious [1] 215/3
consecutive [1] 75/5
consensus [3] 155/1 155/8 155/9
consent [2] 87/19 126/7
consequence [7] 4/15 118/24 134/3 143/14 170/21 203/9 206/1
consequences [19] 26/1 31/25 32/14 90/8 92/13 94/20 96/8 133/22 152/16 154/21 158/15 159/15 161/22 172/3 178/1 184/6 209/23 212/7 218/9
consequential [2] 178/5 190/19
consider [19] 8/10 10/25 11/2 60/4 67/4 67/5 78/14 83/24 85/23 86/21 146/5 151/13 158/25 169/21 177/1 181/23 188/19 214/13 222/23
considerable [5] 9/8 16/4 18/13 21/10 121/17
consideration [7] 77/3 103/22 115/7 128/11 140/22 205/21 217/21
considerations [4] 30/8 150/21 151/3 213/13
considered [16] 17/8 19/15 57/21 91/2 94/22 102/19 104/4 108/12 151/10 152/23 165/23 171/10 172/2 172/21 199/12 199/13
considering [2] 8/15 92/12
considers [2] 155/23 207/21
consisted [1] 51/4
consistencies [1] 194/15
consistency [3] 93/15 105/2 194/12
consistent [8] 37/1 68/23 86/25 87/19 93/13 155/3 167/17 205/5
consistently [6] 11/19 55/13 100/14 104/16 115/12 170/8
Consortium [4] 176/16 207/12 207/13 225/23
constant [1] 17/17
constantly [1] 54/18
constituent [1] 154/13
constitution [1] 128/20
constrained [2] 45/16 54/2
constraints [2] 16/5 34/8
constructive [3] 60/8 89/1 175/8
constructively [1] 213/1
consult [2] 129/5 209/21
consultant [1] 24/21
consultation [9] 9/11 122/18 130/2 172/16 211/8 213/4 214/2 214/5 218/25
consultations [5] 40/22 122/5 122/6 170/25 210/9
consultative [1] 16/21
consulted [1] 174/18
consulting [1] 209/19
contact [15] 56/18 129/22 144/10 149/12 155/24 156/7 156/8 173/3 174/1 197/17 201/14 204/13 204/16 209/3 210/6
contacted [3] 66/13 81/16 137/8
contacts [1] 196/25
contain [1] 160/17
containing [1] 51/4
contemporaneous [1] 151/9
contemporaneous minutes [1] 151/9
contemporary [1] 198/14
contended [1] 156/11
content [2] 72/23 218/5
contention [3] 148/10 156/6 219/24
context [8] 2/25 7/1 11/20 111/1 181/8 191/4 214/4 217/11
context-specific [1] 214/4
contingency [1] 204/21
continually [1] 152/20
continuation [1] 30/13
continue [19] 21/16 31/18 47/19 52/12 55/16 57/10 58/15 62/10 63/14 91/1 101/3 105/7 146/9 147/13 173/24 176/7 176/21 195/18 221/23
continued [9] 1/3 38/12 42/20 55/18 93/5 98/15 144/22 167/14 224/4
continues [4] 16/17 31/5 139/2 192/20
continuing [3] 33/24 94/6 156/4
continuity [1] 162/16
contract [2] 44/15 177/8
contracted [4] 55/24 66/12 99/22 189/6
contractors [1] 2/17
contracts [1] 105/16
contractual [2] 98/9 102/14
contradicted [1] 137/22
contrary [4] 148/11 152/24 159/4 186/12
contrast [4] 27/11 62/19 119/4 169/18
contribute [1] 38/13
contributed [3] 56/1 98/1 203/23
contribution [2] 48/22 159/13
contributors [1] 121/14
control [13] 6/7 25/4 52/5 65/22 73/16 82/7 84/7 92/15 133/17 143/11 148/14 165/22 173/3
controlled [2] 156/13 218/14
controls [3] 68/14 143/19 154/5
controversy [1] 216/12
controverted [1] 148/2
convenient [1] 110/11
Convention [2] 107/16 222/10
conversation [1] 10/22
convey [1] 60/22
conveyed [1] 200/1
conveying [1] 164/9
convinced [1] 66/13
convincingly [1] 146/21
cooperation [2] 48/18 152/5
cope [1] 23/6
cord [1] 32/4
core [9] 63/24 108/16 112/18 121/13 122/22 137/25 146/22 194/6 207/14
coronavirus [1] 210/5
coronaviruses [1] 28/20
corporate [1] 76/10
correct [3] 161/20 162/14 210/3
corridors [1] 80/10
corrupted [2] 147/1 150/23
cost [10] 2/5 2/10 8/17 48/12 69/23 69/25 88/9 109/3 142/15 142/16
costs [4] 2/15 43/15 84/1 98/4
cough [4] 157/11 157/12 157/12 157/14
coughing [3] 30/12 41/5 157/11
could [50] 5/8 12/1 15/1 20/25 25/4 29/4 33/8 33/9 34/11 40/10 43/22 49/4 52/12 53/18 53/18 62/5 62/6 62/9 62/14 70/5 95/5 96/7 96/24 114/5 116/12 135/17 151/24 152/4 153/1 153/4 157/18 158/17 160/10 161/2 161/4 163/3 168/25 172/11 174/25 175/3 175/4 186/10 187/5 196/3 199/6 199/23 200/16 212/17 213/1 221/5
couldn't [4] 134/14

C

couldn't... [3] 199/24 220/23 220/24
Council [1] 37/11
counsel [10] 1/12 14/4 15/11 15/14 51/13 63/21 71/3 121/5 175/15 207/23
count [1] 195/25
counted [2] 102/23 196/1
counter [1] 78/22
counter-productive [1] 78/22
counterfactual [1] 11/3
counterparts [1] 84/24
counties [1] 19/3
country [7] 40/1 56/25 120/5 141/24 148/12 188/25 203/16
counts [1] 196/1
couple [2] 166/13 166/14
couriers [2] 99/18 99/19
course [25] 1/8 13/25 17/8 22/9 69/22 69/24 85/4 107/6 122/10 123/22 124/8 135/25 137/13 143/16 151/23 151/23 153/4 167/5 173/11 178/25 195/23 201/6 201/7 209/7 217/2
courts [1] 200/3
CoV [7] 29/2 29/4 147/21 177/15 177/21 189/20 190/3
cover [1] 73/15
covered [3] 6/20 11/12 143/24
covering [3] 3/6 56/9 159/19
Covid [232]
Covid's [1] 178/20
Covid-19 [63] 12/3 18/15 21/12 25/14 26/6 29/8 31/3 35/20 36/3 37/21 41/13 45/25 50/12 52/16 56/22 57/4 59/8 73/17 83/1 87/21 90/17 97/3 112/7 118/2 131/21 142/13 146/16 146/19 147/10 147/11 147/16 151/17 155/23 161/16 162/1 164/7 172/6 174/19 175/25 176/4 176/13 177/6 179/13 179/16 182/4 183/13 184/22 186/1 186/11 186/13 187/8 189/2 189/4 189/6 190/18 192/19 192/20 192/25 197/22 211/9 219/25 224/18 225/13
Covid-19's [2] 147/22 157/25
Covid-19-related [1] 212/22
Covid-positive [1] 56/19
Covid-related [1] 31/14
Covid-safe [3] 187/5 192/21 193/6
CPR [1] 145/7
CQC [4] 201/24 202/7 211/20 215/11
CQC's [1] 215/16
cracks [4] 134/12 136/11 137/6 179/23
craft [1] 222/3
cramped [1] 68/17
crankish [1] 152/19
create [2] 77/10 119/2
created [9] 18/12 80/20 140/7 166/24 185/16 187/12 191/25 192/1 210/9
creating [3] 6/19 183/17 184/15
Creation [1] 215/20
credible [2] 80/19 198/6
credit [2] 18/17 153/22
crick [1] 63/23
crime [1] 206/20
crises [1] 159/17
crisis [12] 23/12 33/23 33/24 40/3 46/19 47/7 52/13 79/21 93/1 108/2 109/14 185/18
CRITCON [1] 216/3
criteria [3] 33/21 208/22 217/19
critical [16] 2/6 3/7 23/15 24/19 33/3 34/12 47/13 50/14 50/17 57/19 58/8 59/24 111/6 211/10 211/23 216/6
critically [3] 50/12 67/6 98/22
criticise [1] 167/5
criticised [1] 220/9
cross [2] 58/5 78/3
cross-government [1] 58/5
crucial [8] 39/21 41/19 56/15 72/24 76/14 172/19 173/11 173/24
crucially [3] 77/25 94/16 95/3
cruel [1] 114/2
crutches [1] 32/4
CTI [2] 121/15 207/16
CTI's [1] 104/9
cultural [5] 48/7 110/4 140/19 159/11 221/22
culturally [3] 117/20 119/14 119/22
culture [3] 14/12 37/13 104/6
cumulative [1] 111/22
curbs [1] 4/24
cure [1] 182/22
curing [1] 222/4
current [12] 38/20 47/20 77/1 91/23 159/6 177/5 179/19 182/20 193/16 205/8 206/15 222/20
currently [2] 34/1 192/24
curtailed [1] 172/22
cut [5] 98/3 98/4 106/24 137/13 137/17
cut-off [1] 137/17
Cutting [1] 172/2
CV [1] 145/25
CVF [5] 141/11 143/1 144/2 145/9 145/18
cylinders [1] 51/23

D

daily [2] 10/18 113/6
Daly [1] 68/24
damage [3] 32/4 90/5 204/7
damaging [5] 87/7 125/9 130/17 180/19 212/7
damagingly [1] 126/22
Dame [7] 104/14 136/16 137/24 138/14 171/4 184/24 186/24
Dame Jenny [5] 104/14 136/16 138/14 184/24 186/24
Dame Jenny Harries [1] 137/24
Dame Ruth May [1] 171/4
damning [1] 35/10
danger [5] 65/10 90/11 147/14 187/2 204/20
dangerous [5] 26/16 86/11 155/9 177/5 199/3
Daniel [1] 198/1
Daniella [2] 131/13 161/12
dare [1] 59/12
daresay [1] 60/20
darker [2] 115/7 115/13
Darzi [4] 57/13 97/7 98/20 103/23
data [47] 10/19 17/19 26/7 26/25 31/14 31/21 33/20 34/4 58/7 64/22 65/2 65/9 66/1 66/5 73/16 83/12 87/21 101/22 102/19 102/19 103/1 103/2 103/8 103/11 109/18 109/19 109/22 109/25 118/5 118/6 118/9 134/13 138/9 147/21 171/23 179/16 179/18 179/20 191/16 196/3 201/24 214/11 220/16 220/19 220/21 220/22 221/3
databases [1] 134/10
datasets [1] 103/5
date [4] 20/18 92/14 145/12 145/14
daughter [4] 59/16 196/5 196/7 198/23
Dawson [3] 64/21 65/9 165/18
Dawson's [1] 67/20
day [16] 23/6 23/6 31/20 31/20 32/7 35/13 35/13 40/22 51/4 54/19 61/13 61/13 66/17 196/6 198/7 207/10
days [4] 34/5 45/12 66/16 180/18
DCC [13] 207/21 209/8 211/2 213/6 213/22 217/2 218/12 219/17 219/23 220/7 220/14 221/7 221/10
Dda [1] 18/9
de [2] 154/2 222/20
de facto [2] 154/2 222/20
deadly [2] 29/5 30/11
deaf [1] 60/7
deal [3] 42/13 66/18 162/9
dealing [3] 3/3 5/13 18/22
death [9] 33/3 33/14 60/16 62/1 66/21 107/14 125/24 156/22 162/3
deaths [11] 4/5 25/11 26/21 26/23 31/14 73/23 101/17 101/19 102/21 115/19 215/8
debate [8] 3/7 10/12 25/16 69/10 69/13 157/5 216/17 217/7
debates [1] 8/4
debilitating [3] 32/14 186/11 192/10
decade [1] 97/11
decade's [1] 102/22
decades [1] 203/1
deceased [1] 71/14
December [4] 155/4 163/2 168/2 183/12
December 2020 [1] 183/12
decided [1] 21/6
decision [30] 3/4 4/1 7/1 8/4 10/3 10/4 25/23 29/2 59/24 78/8 109/24 110/16 111/19 112/20 114/9 121/22 138/17 145/17 146/25 150/12 151/14 154/25 156/9 159/24 160/12 190/6 210/20 213/14 213/15 215/21
decision-makers [8] 4/1 8/4 29/2 109/24 114/9 150/12 190/6 213/15
decision-making [13] 3/4 7/1 10/3 10/4 110/16 111/19 112/20 138/17 159/24 160/12 210/20 213/14 215/21
decision-takers [1] 154/25
decisions [21] 10/5 10/15 10/16 11/5 108/11 108/11 108/11 122/17 122/19 122/19 124/7 128/15 129/6 129/9 151/21 153/17 159/25 160/5 167/8 182/2 212/10
decisive [1] 118/4
declaration [1] 217/12
declared [1] 216/7
declaring [1] 4/10
declined [1] 97/25
decrease [1] 197/14
dedicated [3] 184/10 184/11 188/10
dedication [1] 54/14
deemed [4] 45/17 54/2 217/15 217/17
deep [1] 109/15
deep-rooted [1] 109/15
deeply [5] 108/4 114/3 118/25 145/18 180/16
default [1] 214/14
defensively [1] 66/9

D

deference [1] 141/4
deferred [1] 108/11
deficiencies [1] 109/15
define [1] 111/2
defining [1] 163/4
definitely [1] 169/13
definition [1] 145/25
definitions [1] 112/8
deflect [1] 153/24
Deflection [1] 159/19
Defoe's [1] 198/1
degree [1] 194/23
delay [5] 67/24 114/13 168/17 180/12 207/3
delayed [9] 62/15 90/6 109/23 115/16 168/21 170/25 183/23 201/12 201/12
delays [3] 134/11 167/20 168/11
deliberative [1] 217/4
deliver [4] 34/8 41/25 83/11 119/12
delivered [5] 6/16 41/13 56/23 94/9 163/10
deliveries [3] 40/15 54/20 132/19
delivering [2] 41/18 99/13
delivery [4] 28/5 92/8 93/3 170/4
demand [17] 24/20 40/7 41/10 42/5 54/23 58/13 85/20 97/21 178/8 199/24 199/25 200/8 200/21 201/2 202/21 205/8 209/11
demanding [1] 51/24
demeaning [1] 218/5
dementia [4] 67/19 126/2 127/15 127/15
democracy [2] 63/15 63/17
demonstrate [1] 143/25
demonstrated [6] 7/25 39/25 152/7 155/19 184/20 189/1
demonstrates [1] 116/8
demoralised [1] 56/2
demoralising [1] 44/5
denial [8] 8/22 61/17 125/13 147/5 149/6 149/10 149/23 160/13
denied [4] 66/14 125/8 126/16 211/23
dentist [1] 156/3
dentistry [1] 48/5
deny [1] 147/4
denying [1] 5/3
department [17] 64/10 64/12 64/15 64/19 64/24 65/4 65/15 65/20 66/8 66/24 67/7 67/15 68/1 68/11 68/19 69/7 103/6
depend [1] 12/16
dependent [1] 98/15
deployed [5] 10/6 74/24 142/21 142/22 216/2
deployment [7] 73/14 87/6 87/8 92/19 93/2 93/7 111/18
depression [1] 161/23
deprioritised [1] 168/7
deprivation [2] 41/18 112/5
deprived [4] 102/8 203/15 203/18 206/19
depth [2] 72/19 213/4
deputy [2] 18/9 19/23
derived [1] 7/4
descending [1] 64/17
describe [1] 130/14
described [23] 8/7 9/24 12/7 24/25 25/5 32/1 32/19 32/23 39/19 41/24 43/8 43/8 51/10 51/19 55/2 97/9 97/12 137/14 145/8 169/7 189/25 198/2 215/12
describes [3] 51/15 150/5 180/18
describing [1] 43/17
deserved [1] 110/25
deserving [1] 217/15
design [4] 34/21 115/21 134/4 214/13
designated [1] 191/20
designed [6] 20/10 76/16 83/22 115/7 116/21 143/8
desire [1] 7/4
despair [1] 198/11
desperate [1] 114/20
desperately [1] 108/14
despite [21] 26/9 53/12 56/14 61/12 103/11 105/16 114/8 115/11 116/14 118/1 135/23 136/15 142/15 155/18 169/19 174/19 184/24 187/14 192/9 213/22 219/5
destined [1] 26/1
destitution [1] 100/25
detail [8] 28/14 35/23 69/16 76/5 91/18 113/21 206/6 221/9
detailed [2] 27/4 178/3
details [1] 209/3
deteriorating [1] 164/1
determinants [3] 97/17 98/21 113/10
determination [3] 54/15 61/15 159/1
determined [4] 62/20 76/3 147/4 154/7
determining [1] 154/3
detrimental [1] 174/19
detriments [1] 146/3
devastates [1] 185/14
devastating [4] 101/12 107/25 113/19 120/3
develop [8] 20/12 23/17 58/10 77/14 118/7 119/15 128/3 191/9
developed [9] 20/24 32/12 58/1 76/15 110/17 145/19 189/6 191/21 204/21
developing [1] 187/6
development [7] 20/16 21/1 21/5 150/22 151/1 173/25 185/15
developments [1] 17/6
devices [6] 115/8 115/12 115/16 115/22 116/6 190/22
devise [1] 181/22
devised [1] 204/12
devoid [1] 76/7
devolved [4] 84/25 87/16 209/15 210/20
devotion [1] 59/16
DHSC [5] 7/11 11/17 103/6 208/23 209/21
diabetes [1] 185/9
diagnosis [2] 181/6 192/9
dialogue [1] 127/23
dictated [2] 190/5 190/9
did [51] 2/9 11/21 14/18 14/19 14/24 16/9 19/6 19/12 25/19 43/12 43/18 44/4 60/17 62/13 66/23 86/17 89/18 93/16 96/9 100/13 100/14 102/20 103/7 108/21 114/6 114/22 114/25 133/16 135/6 142/6 150/11 150/25 155/13 155/17 163/1 165/16 166/5 166/7 167/23 168/23 172/7 174/25 175/1 179/7 182/8 187/23 198/16 208/23 217/13 218/20 220/1
didn't [16] 52/17 59/1 133/7 133/8 133/12 135/7 135/9 135/13 136/7 136/7 137/9 140/9 140/9 143/24 166/25 168/1
die [7] 25/15 27/13 33/9 60/13 66/20 90/4 105/7
died [4] 27/1 27/8 34/20 131/19
dies [1] 87/2
difference [7] 55/23 93/25 125/17 142/12 166/8 175/4 213/10
different [21] 8/13 10/22 12/10 40/3 44/6 67/14 71/13 93/15 98/8 99/21 143/23 153/4 166/22 171/24 177/20 181/14 181/15 204/5 214/22 216/1 216/18
differential [1] 192/15
differently [3] 11/22 35/16 169/24
difficult [11] 14/23 16/7 41/9 52/22 128/10 158/17 174/25 185/21 201/14 217/18 218/1
difficulties [10] 1/7 34/13 46/22 83/16 93/17 126/3 129/25 142/1 164/9 220/1
difficulty [1] 107/5
digital [3] 24/5 171/2 206/9
digitally [1] 122/8
dignity [1] 60/15
dilated [1] 164/13
dilemma [1] 114/2
dilemmas [3] 3/3 7/22 7/25
diligence [1] 89/9
diluted [1] 4/23
diminish [1] 19/12
Dinah [1] 158/20
dire [1] 139/12
direct [9] 19/22 86/19 94/22 100/3 130/5 144/10 151/20 196/9 222/16
direction [8] 5/15 6/6 37/4 44/14 79/19 97/19 98/21 98/23
directives [1] 170/20
directly [10] 4/6 55/25 68/21 82/21 82/24 84/23 99/13 106/11 122/18 144/16
director [1] 18/8
disabilities [10] 12/3 127/16 210/17 210/25 211/3 212/3 212/8 213/3 218/3 222/10
disabilities weeks [1] 210/17
disability [17] 59/25 61/24 122/1 146/1 156/23 176/16 207/11 207/13 211/16 211/18 213/18 213/20 215/25 219/12 220/3 221/5 225/23
disabled [33] 17/18 60/4 63/13 122/9 123/15 164/8 164/9 185/16 192/1 209/19 209/21 209/23 210/10 211/5 211/22 214/1 214/6 214/17 214/24 215/1 215/9 218/9 218/17 219/6 219/13 220/11 220/23 221/17 221/20 221/22 222/8 222/13 222/18
disabling [1] 187/6
disablism [1] 215/3
disadvantage [5] 75/17 109/13 111/12 113/4 219/7
disadvantaged [3] 203/13 203/25 218/3
disagreed [1] 142/20
disarmingly [1] 200/16
disaster [1] 4/9
disbelief [5] 180/14 180/17 180/23 181/8 186/3
disbelieved [1] 193/14
discharge [1] 127/21
discharged [1] 124/24
discharges [2] 197/4 201/12
discipline [1] 184/4
disciplined [1] 74/22
disciplines [1] 154/18
disclosed [1] 96/12
disclosure [1] 148/23

D

discomfort [1] 156/21
discourage [1] 26/17
discouraging [1] 170/21
discourtesy [1] 70/16
discover [1] 196/6
discretion [1] 126/19
discriminated [2] 117/16 120/9
discrimination [4] 74/3 74/16 108/6 129/2
discriminatory [2] 206/13 218/5
discuss [2] 51/9 51/12
discussed [2] 154/7 154/16
discussion [2] 10/4 58/1
discussions [2] 33/10 67/21
disease [10] 4/3 29/5 30/11 37/12 90/2 90/4 182/24 185/8 188/4 191/21
diseases [3] 26/16 143/14 158/5
disempowered [2] 62/3 133/10
disempowering [2] 132/25 135/18
disheartening [1] 73/22
disinterest [1] 184/20
dismantle [1] 112/17
dismissed [2] 152/19 186/16
dismissive [1] 78/2
disorder [7] 33/22 195/1 196/13 198/25 199/25 205/24 207/3
disorders [3] 199/3 207/1 207/6
disparities [12] 102/2 109/23 112/3 113/19 117/21 117/25 119/21 218/17 219/1 219/20 220/7 220/17
disparity [1] 56/2
dispensed [1] 40/13
display [1] 59/17
disproportionate [15] 73/11 73/19 75/9 75/12 75/13 76/16 82/6 82/15 95/24 105/8 113/7 118/2 118/14 118/23 192/5
disproportionately [13] 34/24 41/17 74/24 82/23 103/15 111/12 112/12 117/8 117/15 118/17 119/5 119/6 137/5
disputes [1] 142/10
disregard [2] 116/8 116/10
disregarded [1] 3/13
disrupted [1] 197/23
disruptive [1] 152/19
disrupts [1] 185/14
dissent [2] 151/20 155/3
dissimilar [1] 78/6
dissonance [1] 215/6
distance [1] 25/6
distancing [4] 52/23 53/1 53/3 144/16
distant [1] 197/11
distinct [2] 103/22 180/9
distinction [1] 111/6
distinctions [1] 217/25
distinctly [1] 63/20
distracted [1] 157/8
distraction [1] 143/1
distractions [1] 198/10
distress [5] 34/7 97/22 126/16 126/25 127/7
distressing [2] 133/21 180/24
distributing [1] 40/5
distribution [5] 11/9 11/18 27/17 27/21 93/11
diverse [4] 13/1 36/13 114/23 132/12
diversity [6] 41/24 77/9 77/11 77/17 114/25 123/13
divide [2] 69/8 165/11
division [1] 11/16
divorced [1] 80/17
DIY [2] 28/2 53/8
DNACPR [11] 65/6 65/14 67/2 67/11 121/19 121/19 121/22 212/10 215/10 215/14 215/21
DNACPRs [4] 145/11 215/1 215/12 215/19
DNR [1] 19/9
do [59] 3/9 3/10 3/18 5/6 5/7 5/25 6/3 7/7 7/19 8/17 8/25 14/23 22/4 31/4 33/8 33/9 33/10 55/8 64/5 69/23 70/4 75/10 81/20 81/22 82/11 90/13 95/1 95/2 104/11 108/19 119/7 119/11 120/2 131/6 131/18 133/12 140/20 143/13 145/6 145/25 146/9 157/14 159/19 163/1 164/4 167/5 175/1 179/19 179/21 181/16 187/18 193/18 204/17 209/11 210/7 215/13 217/10 219/19 220/21
doctor [4] 30/17 32/1 33/5 90/23
doctor's [1] 201/3
doctors [10] 10/5 10/7 24/15 34/16 97/14 113/12 113/14 113/14 148/6 160/4
document [1] 215/21
documents [2] 80/24 96/12
does [12] 10/11 14/15 27/18 83/12 115/20 121/22 128/23 140/20 150/1 173/12 213/6 220/2
doesn't [6] 64/21 65/2 140/6 190/1 192/25 193/4
dogmatic [1] 157/1
dogmatically [1] 159/2
Doherty [1] 68/24
doing [8] 5/4 21/23 99/15 105/17 142/16 158/13 164/24 167/7
domestic [1] 40/5
Domingo [4] 49/4 49/7 58/19 224/16
don't [14] 5/24 7/6 32/8 32/21 69/25 128/12 141/8 142/14 181/16 181/17 185/23 216/14 218/11 220/19
done [16] 7/14 11/7 64/2 70/5 74/1 89/20 169/23 170/1 193/21 212/17 219/7 219/18 219/18 220/6 220/13 220/23
doom [1] 94/13
door [4] 39/19 133/3 162/11 199/1
doors [3] 40/18 53/21 59/21
Dorland [2] 131/1 131/5
double [1] 202/9
doubled [2] 40/16 161/24
doubling [1] 54/17
doubt [3] 25/9 30/5 141/11
doubts [1] 29/22
down [10] 63/1 97/10 104/8 126/22 130/21 134/22 141/9 141/10 167/1 203/12
Down's [1] 219/9
Down's syndrome [1] 219/9
downgraded [1] 97/13
downplay [1] 25/22
downsides [3] 8/11 8/16 166/22
DPOs [1] 214/9
Dr [31] 17/15 17/21 26/5 32/11 60/1 69/14 87/24 132/25 141/17 144/14 147/23 148/22 157/19 158/3 158/3 158/11 165/18 165/18 166/10 172/4 194/19 195/18 196/18 197/16 200/23 201/23 202/8 203/20 204/4 206/3 206/6
Dr Andrew [1] 17/15
Dr Barry Jones [1] 147/23
Dr Catherine Finnis [1] 132/25
Dr Frank Atherton [1] 204/4
Dr Gillian [1] 158/3
Dr Goodall [1] 17/21
Dr Habib Naqvi [1] 87/24
Dr Higgins [1] 158/11
Dr Jones [2] 69/14 148/22
Dr Lockhart [3] 196/18 197/16 203/20
Dr Nathalie MacDermott [2] 32/11 158/3
Dr Northover [3] 201/23 202/8 206/6
Dr Northover's [3] 195/18 200/23 206/3
Dr Sarah Powell [1] 60/1
Dr Shin [3] 141/17 165/18 166/10
Dr Warne [2] 26/5 165/18
Dr Warne's [1] 144/14
drafting [1] 213/1
draw [3] 47/10 123/12 208/14
drawing [1] 20/22
drawn [1] 217/4
dreadful [1] 198/6
drew [1] 90/22
drive [1] 135/21
driven [2] 81/4 114/20
drivers [2] 99/22 101/25
drop [1] 171/24
droplet [6] 29/14 69/8 151/15 153/2 155/24 156/10
droplet-transmitted [1] 151/15
droplets [1] 28/21
drops [1] 74/8
Drs [2] 197/21 203/14
drugs [1] 137/12
due [8] 18/13 34/5 42/15 46/19 85/16 110/3 111/15 162/1
dug [1] 3/24
duplication [1] 58/9
during [75] 2/10 18/10 19/24 22/23 24/5 24/22 27/1 27/11 28/16 35/7 38/21 39/16 39/18 39/24 40/14 42/5 43/16 44/9 48/21 49/11 51/1 54/5 59/20 61/21 62/11 65/16 82/5 82/17 83/16 85/13 86/13 90/14 91/6 92/22 94/14 95/24 96/1 97/3 99/1 99/9 100/2 105/13 109/9 109/14 111/7 111/17 111/25 118/6 118/14 118/23 129/7 139/14 147/7 149/8 158/22 161/24 162/1 162/5 163/16 163/25 164/11 167/22 172/9 173/1 173/8 174/13 199/5 200/2 200/20 201/11 201/22 203/16 204/12 210/14 212/21
duties [2] 113/3 202/5
duty [13] 5/3 18/23 69/5 75/15 75/21 78/9 78/18 128/18 129/4 129/5 130/7 138/1 202/6
dwell [1] 141/8
dying [7] 9/2 69/3 126/23 126/25 127/7 145/23 198/8
dynamic [2] 73/12 80/13

E

each [10] 40/24 40/25 51/4 51/5 91/18 145/23 174/13 178/25 182/14 196/20
ear [1] 64/7

E

earlier [7] 15/22 33/25 88/18 127/14 163/4 168/25 169/15
early [25] 15/24 42/17 42/19 42/21 52/14 64/23 73/23 93/5 98/5 145/14 147/19 162/17 163/8 166/3 167/24 173/13 179/7 180/18 186/12 202/22 203/5 203/21 205/11 206/10 206/16
early weeks [1] 52/14
earning [1] 98/7
easier [2] 144/25 194/11
easily [2] 36/19 217/19
easy [4] 2/5 110/11 174/23 207/18
Eat [1] 135/22
eating [4] 198/25 199/3 199/25 207/5
echoed [1] 16/24
economic [5] 106/6 113/4 191/12 191/18 197/24
economy [3] 56/25 101/23 135/22
ecosystem [1] 5/25
ectopic [2] 163/10 163/16
Ecuador [1] 3/24
edge [1] 6/5
edifice [1] 154/9
educate [1] 139/1
education [7] 94/4 94/7 94/10 111/23 139/5 181/5 185/15
educational [1] 188/13
effect [13] 87/7 92/23 124/23 126/10 136/23 191/2 196/17 201/11 202/7 202/14 206/22 210/18 216/10
effecting [1] 154/23
effective [20] 5/19 6/6 16/23 41/25 48/18 52/7 80/11 82/7 92/23 93/11 93/12 105/1 117/2 118/8 123/23 138/23 144/23 147/17 176/5 222/11
effectively [4] 142/23 210/23 211/7 219/15
effectiveness [4] 29/23 77/18 114/8 137/21
effects [14] 9/4 111/22 114/7 116/19 117/7 118/4 118/15 135/14 140/8 156/19 176/2 183/12 198/2 198/21
efficacy [3] 30/4 88/11 182/12
efficient [3] 93/3 93/7 207/18
efficiently [1] 138/7
effort [1] 76/3
efforts [2] 59/21 168/19
eg [1] 42/19
egregious [1] 109/20
EIAs [2] 213/3 214/5
Eighth [1] 37/5
either [7] 75/12 101/9 150/23 157/2 187/9 198/20 210/7
electronic [1] 66/2
element [2] 49/19 125/12
elements [2] 7/24 12/10
elephant [2] 109/9 139/17
elevate [1] 222/18
eliding [1] 216/20
eliminate [1] 95/1
Eliminating [1] 90/11
else [2] 52/18 214/7
Eluned [1] 14/17
email [1] 68/12
emails [1] 212/15
emanated [1] 16/16
embed [1] 112/18
embedded [5] 111/15 119/20 183/18 213/14 222/17
embrace [1] 162/3
emerged [1] 16/12
emergencies [4] 3/3 5/14 36/5 128/16
emergency [13] 4/10 5/15 7/16 9/14 22/25 23/7 24/11 35/7 35/13 58/17 89/24 142/1 217/12
emerging [1] 113/22
EMG [1] 154/7
eminently [1] 19/21
emotional [1] 170/14
emotionally [1] 25/20
emotive [1] 216/11
emphasis [2] 79/1 168/3
emphasise [3] 70/1 96/2 129/12
emphasised [2] 96/24 195/11
emphasises [1] 206/16
employed [17] 55/25 63/17 82/21 82/24 83/3 83/9 83/13 83/18 84/20 84/23 85/6 85/13 100/10 104/17 105/6 106/11 188/22
employees [1] 98/10
employer's [1] 85/17
employers [3] 26/13 76/24 100/16
employment [15] 82/17 88/8 96/3 96/8 97/19 98/16 98/19 99/4 100/22 104/1 105/16 106/5 106/9 111/24 137/11
employs [1] 83/6
empower [1] 14/20
empowered [2] 14/22 82/8
empowering [1] 135/18
enable [5] 9/17 47/12 132/15 170/2 181/6
enabled [1] 41/24
encapsulated [2] 15/7 104/9
encompasses [1] 111/20
encountered [1] 142/2
encourage [2] 10/18 10/25
encouraged [1] 38/2
encouragement [2] 87/15 87/18
end [17] 21/18 22/14 33/10 43/21 47/11 63/7 67/19 88/15 105/24 106/9 138/18 139/4 189/18 207/6 207/10 217/23 221/23
ended [3] 131/16 136/15 179/17
ending [3] 136/4 136/17 196/8
endorse [3] 179/25 191/7 192/6
endorsed [3] 116/3 183/15 205/4
endorses [2] 15/3 220/7
endure [2] 117/10 125/9
endured [1] 110/24
enduring [3] 65/5 65/13 181/8
enforceable [1] 222/16
enforced [2] 165/4 165/5
enforcement [1] 129/23
enforcing [1] 165/10
engage [5] 138/20 174/5 213/1 213/17 214/9
engaged [2] 18/19 146/24
engagement [7] 7/18 9/11 10/8 93/5 93/6 94/17 213/7
engagements [1] 213/19
engages [1] 217/5
engineering [1] 154/18
England [63] 1/15 1/17 3/9 4/8 5/5 5/18 5/23 6/1 6/18 7/11 7/13 8/1 10/9 11/1 11/17 13/23 24/17 25/12 26/22 26/23 28/4 32/1 34/4 40/25 44/8 44/16 44/17 44/20 46/25 53/19 56/10 56/12 57/12 69/12 71/1 76/9 76/23 76/24 77/5 77/8 77/11 79/13 79/16 80/20 83/12 84/13 84/24 128/4 135/20 155/4 163/1 163/3 167/21 168/1 168/12 185/11 187/13 197/17 201/17 209/15 218/21 220/15 224/6
England's [5] 5/16 6/7 74/6 79/17 102/1
England's June 2020 [1] 102/1
English [1] 164/5
enhanced [4] 30/3 116/25 136/21 136/22
Enhancing [1] 12/23
enjoy [1] 106/13
enormous [2] 23/1 54/13
enough [25] 4/21 44/25 49/18 76/17 79/8 92/16 103/12 120/13 120/13 120/14 120/14 134/15 135/5 135/7 135/9 135/13 135/16 138/13 140/21 148/18 152/3 164/16 168/20 187/24 189/19
ensure [40] 2/18 10/10 12/6 19/2 20/21 26/13 27/5 35/12 36/5 36/10 36/14 37/1 37/6 37/13 39/24 71/25 85/5 85/9 85/11 86/22 93/19 93/22 106/14 109/6 112/21 113/18 123/25 127/22 128/6 128/25 162/16 167/16 184/9 188/4 188/8 191/12 193/23 203/3 205/9 222/13
ensuring [18] 52/5 71/17 79/8 83/17 90/15 94/3 105/1 119/10 120/2 146/8 173/17 173/22 174/2 174/6 177/24 185/3 218/2 218/6
entail [1] 92/23
entered [2] 46/18 99/20
entering [2] 99/18 166/24
enthusiasm [2] 44/20 56/13
entire [3] 46/4 154/9 219/13
entirely [7] 19/14 65/14 70/3 86/4 199/15 216/18 219/8
entirety [1] 169/2
entitled [2] 98/18 126/18
Entitlement [1] 132/17
entity [1] 104/20
entrenched [4] 108/5 118/25 151/22 152/12
entrenchment [1] 141/3
environment [5] 45/25 98/14 104/19 140/16 202/10
environments [2] 35/1 100/20
epidemic [1] 141/22
epidemiological [1] 148/1
epitomised [1] 60/9
EPRR [2] 5/16 7/18
equal [3] 57/2 105/2 122/2
equalities [1] 213/23
equality [24] 74/7 74/15 74/18 75/16 77/2 77/8 77/11 77/17 77/18 83/14 84/9 84/14 85/3 85/4 126/19 129/4 129/4 145/21 146/1 146/6 146/7 213/13 213/18 218/23
Equality Act [1] 126/19
equally [15] 12/9 13/2 30/8 34/18 34/18 44/3 91/21 104/16 108/18 109/17 117/24 119/25 124/14 191/24 220/11
equipment [11] 20/13 28/2 28/10 28/22 77/25 115/4 115/5 116/2 119/16 142/24 158/7

E

equipped [3] 8/2 107/22 109/16
equitable [3] 117/19 183/11 184/9
equity [6] 112/16 112/18 114/1 117/14 119/9 119/20
Equity-centred [1] 112/16
equity-focused [1] 117/14
equivalence [1] 209/15
equivalent [5] 77/3 79/14 148/21 185/9 215/17
erased [1] 74/22
erosion [1] 94/18
erroneous [1] 160/2
errors [2] 61/25 69/24
escalated [1] 34/11
escalation [1] 214/20
especially [5] 2/5 83/3 142/17 157/20 167/21
espoused [1] 75/7
essence [1] 63/2
essential [18] 30/22 48/13 49/12 53/12 57/5 58/16 72/17 91/3 92/1 102/11 111/2 129/11 132/15 132/19 171/13 172/8 172/22 211/5
essentially [5] 134/17 140/13 153/3 155/9 165/18
establish [3] 214/3 215/18 220/13
established [2] 5/16 213/17
establishing [1] 158/12
establishment [3] 46/3 129/20 130/1
estate [6] 22/7 77/25 80/9 141/20 141/23 142/11
estates [5] 9/22 25/3 25/9 36/21 36/24
esteem [1] 199/16
estimated [1] 79/22
estimates [2] 31/22 34/19
et [1] 218/16
ethical [1] 124/6
ethnic [45] 34/20 41/23 73/20 73/24 74/8 74/21 75/22 82/23 84/11 84/15 87/25 88/1 101/17 103/20 107/8 107/21 108/15 109/11 109/13 110/3 110/7 110/9 110/15 110/20 111/13 112/2 112/4 112/11 112/19 112/23 113/11 114/11 115/9 115/16 116/4 116/15 117/8 117/14 118/2 118/6 118/13 118/21 171/9 204/6 225/5
ethnic-based [1] 118/6
ethnicity [5] 96/4 109/19 109/22 118/11 119/12
ethnicity-related [1] 118/11
evaluated [1] 77/10
evaluating [1] 154/3
evaluation [1] 115/22
Evans [3] 180/15 197/21 203/14
Evans' [1] 177/10
evasion [1] 160/14
even [56] 4/25 22/14 23/5 28/24 45/12 52/15 53/15 62/13 62/18 62/19 63/6 65/22 70/4 75/13 80/14 80/23 81/3 88/8 96/9 96/15 102/22 103/7 103/21 104/12 108/12 116/20 124/4 126/5 126/12 128/10 128/16 140/15 143/1 149/18 149/22 151/13 151/22 154/24 155/20 165/8 167/1 183/19 184/1 186/19 189/25 200/18 209/1 210/18 212/23 212/24 213/3 213/8 216/13 218/14 218/23 219/19
even months [1] 210/18
even weeks [1] 45/12
event [8] 29/20 58/16 104/21 205/9 209/22 214/21 216/3 216/8
eventually [1] 195/17
ever [9] 33/4 34/3 51/25 69/5 89/1 100/16 137/20 190/9 196/23
every [14] 18/23 24/7 54/19 108/18 110/21 122/25 129/22 131/2 132/10 153/23 185/17 198/7 204/17 215/6
everybody [2] 177/10 204/17
everyday [2] 30/11 129/17
everyone [8] 1/8 75/8 122/7 131/6 141/15 144/20 177/22 216/22
everyone's [1] 63/15
everything [4] 5/4 33/8 128/22 195/25
everywhere [1] 102/16
evidence [205] 2/4 6/11 8/8 11/14 11/15 14/2 15/5 15/7 15/11 16/3 16/14 17/8 17/9 17/11 17/16 17/20 18/7 18/11 18/12 18/12 19/4 19/10 19/21 20/5 21/13 21/18 22/14 22/23 23/16 27/23 28/16 29/15 29/24 30/1 32/10 36/1 36/7 38/16 40/2 40/19 41/4 41/21 42/9 44/9 45/13 47/11 48/7 49/11 52/9 53/4 53/16 53/25 54/13 55/1 56/11 59/11 59/13 59/14 59/17 60/1 60/8 60/11 60/19 60/23 60/25 61/9 61/11 61/14 61/19 62/9 62/11 63/5 63/6 63/7 63/11 64/13 64/15 65/23 66/10 67/3 67/17 67/20 69/7 69/9 69/11 69/15 69/18 69/22 70/8 70/10 70/23 73/21 74/20 75/7 76/11 77/22 83/11 83/15 87/6 87/17 89/6 89/7 91/6 91/13 91/24 94/2 95/21 95/25 96/11 96/15 99/5 100/4 101/1 104/3 109/20 111/3 118/3 122/24 129/8 132/11 132/25 133/22 134/8 137/20 140/8 141/2 143/2 147/20 147/23 147/25 148/2 148/23 149/4 150/4 150/6 150/9 150/12 151/7 152/23 152/25 153/12 154/22 154/23 155/17 155/20 156/7 156/12 156/14 157/17 157/19 158/15 159/3 159/7 160/15 161/19 162/13 164/12 164/18 166/2 167/3 169/18 170/13 170/15 170/19 171/7 172/7 172/12 174/3 176/3 177/13 178/7 180/9 180/24 181/10 182/5 185/2 185/24 186/24 189/1 189/18 189/20 190/4 190/25 192/7 194/13 195/18 199/20 200/19 201/21 201/24 204/15 205/25 206/3 206/21 208/8 212/24 213/9 213/19 214/12 216/18 217/20 218/14 219/22 219/22 219/24
evidence-based [5] 60/23 69/18 94/2 174/3 176/3
evidenced [2] 55/19 171/19
evident [1] 111/18
evidential [1] 196/14
evidently [2] 45/1 70/2
exacerbate [2] 31/11 112/23
exacerbated [3] 117/21 192/3 201/8
exacerbating [1] 88/6
exact [2] 5/1 31/20
exactly [3] 7/7 15/4 35/20
examine [2] 78/19 195/8
examined [1] 111/3
examiners [1] 26/21
examines [1] 58/3
examining [1] 112/11
example [39] 3/13 6/14 9/15 9/22 11/17 11/18 11/22 12/2 16/19 19/8 28/3 41/25 43/4 44/5 45/3 85/12 86/8 115/6 121/25 125/14 127/13 132/16 133/20 137/22 148/7 163/10 164/1 165/6 170/10 172/12 184/22 185/17 189/5 198/21 202/15 209/24 210/8 210/11 211/8
examples [3] 84/11 156/3 194/20
exceeded [1] 33/21
excellent [1] 60/2
exception [2] 210/24 214/14
exceptions [4] 165/25 166/3 166/5 210/9
exclude [1] 217/10
excluded [7] 44/1 98/17 122/8 125/4 154/19 156/10 173/11
excluding [2] 122/14 125/22
exclusion [8] 44/7 56/3 56/8 111/19 125/12 126/3 126/8 206/9
exclusionary [2] 114/7 208/12
excuse [3] 75/13 209/10 220/22
execution [2] 134/4 134/6
executive [9] 17/3 18/9 19/24 21/10 22/3 26/10 36/9 64/25 86/4
exercise [3] 112/10 116/13 121/15
exhausted [2] 8/24 216/6
exhausting [1] 180/22
exhaustion [1] 2/14
exigencies [1] 209/7
exist [5] 75/3 166/5 183/19 192/25 193/4
existed [1] 115/10
existence [1] 160/7
existing [17] 20/8 20/11 31/11 48/2 74/2 79/7 79/10 80/17 80/21 117/18 128/14 129/24 171/2 171/18 192/4 192/17 221/4
exists [3] 74/5 98/24 104/24
expand [1] 94/24
expanded [1] 79/19
expansion [1] 144/14
expect [1] 207/4
expectant [1] 123/16
expected [3] 72/3 120/20 210/1
expedient [1] 214/6
expenses [1] 43/16
expensive [1] 41/9
experience [23] 14/10 19/12 19/22 20/19 20/22 20/23 20/24 72/18 81/15 81/18 91/2 100/4 127/22 133/18 162/6 163/16 163/22 176/19 183/10 186/14 193/13 213/20 214/10
experienced [11] 4/23 30/2 33/19 34/3 34/18 40/17 42/14 61/5 99/2 127/6 152/14
experiences [7] 35/19 37/14 60/7 62/21 74/12 90/23 172/25
experiencing [2] 173/16 174/14
experimental [1] 134/5
expert [11] 40/10

E

expert... [10] 50/10 60/19 60/20 124/3 141/17 142/20 158/4 158/20 189/17 207/24
expertise [6] 65/21 90/21 148/14 154/17 154/18 198/14
experts [16] 9/10 24/8 29/25 33/20 50/15 143/3 143/7 155/25 165/22 166/7 182/25 183/16 184/2 211/13 216/4 216/15
explain [7] 72/18 103/17 150/2 160/7 182/13 186/25 216/4
explained [10] 41/21 83/16 94/2 147/24 153/2 154/21 163/23 172/20 208/20 211/13
explaining [3] 9/25 31/1 148/1
explains [1] 49/22
explanation [3] 80/19 168/4 168/16
explanations [1] 141/3
explicit [3] 36/6 108/10 210/9
explicitly [1] 6/12
explored [1] 11/21
exponential [1] 135/24
expose [1] 108/22
exposed [15] 3/17 27/19 33/3 57/16 61/13 99/12 102/11 104/5 105/15 109/14 115/5 116/19 125/6 197/22 201/7
exposes [1] 105/20
Exposing [1] 105/20
exposure [7] 26/22 34/17 98/14 102/5 166/10 203/21 205/23
exposures [2] 117/10 118/16
express [3] 164/22 176/12 202/4
expressed [4] 15/5 29/23 170/8 221/10
expressly [2] 127/16 151/10
extant [1] 146/23
extend [4] 13/25 76/10 77/13 130/25
extended [1] 71/5
extending [1] 169/1
extends [2] 77/24 207/15
extensions [1] 56/4
extent [6] 20/1 31/2 47/6 124/18 149/15 165/25
extraordinary [3] 2/9 17/22 155/22
extreme [1] 33/15
extremely [8] 42/13 103/18 132/12 133/1 136/3 136/8 137/4 222/22
eye [2] 61/3 64/7
eyes [2] 148/9 150/12

F

fabric [2] 25/9 39/10
face [29] 28/7 36/13 51/12 51/12 52/19 52/19 54/16 61/17 83/5 83/6 100/25 109/2 114/18 114/24 114/24 141/25 159/3 162/1 162/1 167/1 170/24 170/24 171/21 171/21 174/1 174/1 192/8 204/24 204/24
faced [12] 8/1 13/1 18/13 31/1 75/17 97/21 110/20 113/6 114/2 117/9 118/13 190/8
faces [1] 85/15
facial [1] 114/23
facile [2] 75/14 220/10
facilitate [3] 27/6 67/22 138/23
facilitated [1] 122/6
facing [4] 46/18 50/25 57/11 141/22
fact [23] 3/4 3/21 10/14 16/6 25/17 30/20 62/8 68/6 78/20 87/18 107/19 134/9 136/6 141/10 147/15 154/9 156/9 157/7 157/16 172/14 178/5 188/2 201/22
fact-finding [1] 3/4
facto [2] 154/2 222/20
factor [4] 31/2 81/6 102/16 182/6
factors [6] 82/25 88/10 88/14 112/6 119/2 197/23
facts [2] 155/11 215/18
factual [1] 2/20
faculties [1] 89/13
Faculty [1] 196/19
fail [1] 88/5
failed [8] 44/13 108/24 110/3 115/23 116/25 117/17 161/16 191/5
failing [3] 26/11 101/8 117/1
failings [7] 7/3 109/1 109/5 118/24 147/4 147/5 147/8
failure [29] 23/21 26/3 30/7 46/9 49/25 57/1 60/3 60/5 68/22 108/15 108/16 109/18 113/25 113/25 115/1 116/7 141/6 149/24 150/15 150/17 151/13 153/3 153/8 154/1 178/10 181/20 198/18 208/12 209/20
failures [11] 97/5 109/18 113/24 119/18 124/20 152/16 153/5 155/22 161/21 161/22 209/10
fair [1] 166/15
fairly [1] 105/11
faith [2] 133/16 163/17
fall [3] 85/21 90/3 136/10
fallen [1] 179/22
falling [2] 134/12 136/18
falls [1] 87/10
false [4] 30/19 78/22 136/24 157/3
familial [3] 124/22 125/18 127/10
familiar [3] 64/18 122/14 145/9
families [25] 53/6 59/9 63/10 66/25 121/22 123/2 127/4 127/20 127/23 129/5 129/21 131/10 131/13 166/23 173/10 174/15 174/21 175/5 176/12 176/14 186/15 198/7 203/24 224/18 225/11
families' [1] 172/18
family [20] 18/25 33/10 33/15 43/21 48/9 55/5 57/8 110/22 113/1 123/10 124/2 124/14 127/9 128/13 133/22 133/24 164/23 197/12 201/13 203/11
far [10] 23/10 28/22 33/3 38/3 45/1 60/21 87/3 101/20 137/19 159/15
far-reaching [1] 159/15
fast [2] 4/7 9/13
faster [1] 138/12
fatalistic [1] 140/5
fatalities [1] 86/9
fathers [1] 173/10
fatigue [1] 42/7
favour [1] 87/10
fear [6] 74/21 82/11 96/8 129/8 192/12 202/17
feared [1] 33/13
fearful [2] 126/10 167/3
fears [3] 29/12 88/2 171/1
feature [9] 17/15 60/25 81/8 81/25 82/3 95/25 96/15 198/16 218/20
features [1] 114/23
February [1] 40/13
fed [1] 158/18
Federation [2] 107/8 225/5
feedback [1] 129/21
feel [10] 37/15 43/12 43/18 66/23 74/15 82/9 85/19 131/6 189/9 216/22
feeling [4] 33/7 56/1 74/21 164/14
feelings [1] 173/3
feet [1] 57/1
fell [5] 128/16 134/19 137/6 179/8 197/5
fellow [1] 52/10
felt [11] 32/20 43/3 90/17 127/7 133/12 134/22 140/12 189/12 191/24 192/11 222/3
female [1] 34/22
FEMHO [8] 3/16 106/24 107/11 118/21 119/5 119/19 176/15 192/5
fenced [2] 171/20 184/11
Ferguson [2] 68/20 68/24
Ferguson's [1] 63/7
fester [1] 203/5
few [6] 24/18 24/20 32/19 40/9 59/14 154/24
few years [1] 32/19
fewer [2] 46/6 97/14
FFP2 [1] 142/25
FFP2s [1] 143/10
FFP3 [21] 28/11 28/18 29/2 29/7 29/9 29/12 29/23 30/4 30/7 36/2 51/14 114/7 142/25 150/18 151/11 155/6 156/12 156/19 156/21 189/23 190/2
FFP3 masks [1] 190/2
FFP3s [2] 143/8 143/13
Fidelma [1] 68/3
Fidelma Mallon [1] 68/3
field [2] 21/6 80/17
fifth [6] 36/17 122/17 178/18 188/15 201/9 205/21
fight [2] 180/25 181/2
fighting [2] 12/7 69/2
figure [1] 71/1
figures [7] 31/21 70/24 74/5 74/19 80/2 187/14 195/2
Filipino [1] 103/2
Filipinos [1] 102/24
fill [1] 124/19
filled [1] 179/14
films [1] 122/25
filters [1] 142/19
filtration [1] 193/8
final [9] 15/12 48/20 69/2 124/17 145/21 148/25 173/5 175/14 204/11
finally [20] 2/8 3/5 12/5 21/5 34/17 37/17 41/14 50/3 57/9 87/5 94/11 120/13 129/5 130/21 139/1 145/3 145/17 174/11 192/19 215/23
financial [4] 42/8 43/14 46/18 55/6
financially [1] 82/12
find [7] 81/17 134/11 137/9 145/1 147/15 151/16 217/25
finding [4] 3/4 10/14 149/5 185/22
findings [6] 13/8 48/24 102/3 164/2 164/6 178/4
finger [2] 64/18 120/1
finger-pointing [1] 120/1
finish [1] 218/13
Finnis [1] 132/25
Fiona [1] 114/14
Fiona McQueen [1] 114/14
fire [2] 27/13 139/23
firm [2] 21/14 35/6
first [54] 1/10 1/23 2/25 3/20 4/2 8/24 10/18 14/17 23/19 26/20 28/5 34/20 35/25 39/17 49/25 53/15 59/1 59/15 61/1 70/24 73/19 74/19 76/22 84/19 102/18 113/12 113/13 121/4 121/19 122/22 128/2

F

first... [23] 129/20 132/9 145/6 146/8 154/22 162/20 178/10 179/1 180/12 183/2 187/22 194/15 196/15 197/7 203/1 205/7 208/1 209/24 214/3 215/9 215/16 217/4 219/2
first months [1] 4/2
first-rate [1] 1/23
firsthand [1] 74/20
fit [9] 51/14 51/17 74/23 114/6 132/17 142/8 143/10 151/17 185/19
fits [3] 5/25 110/18 116/1
fitting [1] 34/22
five [7] 2/24 3/19 23/4 27/2 35/10 128/17 174/6
five years [2] 23/4 35/10
fix [1] 138/10
fixed [1] 188/22
fixed-term [1] 188/22
flagged [1] 101/22
flagging [1] 164/1
flaw [2] 109/19 115/10
flawed [5] 116/5 116/6 152/11 157/6 159/2
fleeting [1] 207/2
flexibility [2] 79/3 208/25
flexible [3] 12/16 92/16 93/1
flexibly [1] 36/20
floor [1] 33/1
flow [2] 19/16 40/5
flu [1] 180/20
flu-like [1] 180/20
fluid [3] 28/23 28/24 31/6
fluid-resistant [1] 28/24
focus [16] 6/24 73/8 79/7 89/14 125/11 128/9 131/24 135/7 135/9 135/13 137/25 141/12 147/2 168/19 168/19 206/19
focused [8] 2/1 5/21 103/20 117/14 136/12 183/5 207/20 219/8
focuses [1] 86/5
focusing [1] 132/1
focussed [1] 121/15
focussing [1] 123/21
follow [1] 82/8
followed [4] 82/11 121/10 218/8 218/25
following [7] 21/25 35/24 46/5 63/21 144/2 151/16 196/20
follows [5] 22/23 76/22 121/19 122/5 216/5
fomite [1] 153/2
Fong [5] 32/18 32/19 61/4 62/10 195/23
Food [1] 132/18
foolish [1] 198/10
force [4] 27/13 61/16 61/17 63/14
forced [5] 27/24 34/24 98/4 181/1 192/11
forces [1] 27/12
foreseeable [6] 108/2 178/11 179/2 179/3 197/20 198/16
forget [2] 11/11 70/22
forgive [1] 106/22
forgotten [2] 119/6 199/12
form [4] 32/8 108/6 137/20 209/25
formal [1] 213/3
formally [1] 180/12
format [2] 208/7 209/4
formed [1] 175/23
former [7] 49/15 54/1 65/23 139/10 156/2 187/22 210/4
formerly [1] 145/14
forms [3] 107/12 172/24 213/6
forthcoming [2] 187/10 221/12
Forum [1] 213/18
forward [10] 2/4 10/13 13/8 119/19 128/1 131/25 159/8 160/18 160/22 205/11
forward-looking [2] 131/25 160/18
found [9] 24/1 26/21 26/25 33/25 87/24 167/4 172/14 199/1 210/11
foundational [3] 194/15 195/5 195/22
four [32] 5/22 23/19 24/8 24/9 24/10 31/5 34/1 36/1 39/9 49/23 51/3 51/4 65/1 73/5 76/9 91/15 93/14 93/16 127/19 154/10 154/13 170/16 174/2 179/4 179/5 179/11 179/22 184/9 208/1 217/3 218/6 219/19
four years [1] 65/1
fourth [10] 10/14 23/24 36/14 46/16 122/14 178/16 185/7 199/18 205/17 218/10
fragility [1] 57/17
frail [1] 211/22
frailty [3] 211/12 211/12 211/17
framework [3] 8/6 8/15 112/10
frameworks [1] 117/25
frank [5] 17/10 134/21 137/24 200/16 204/4
Frank Atherton [1] 134/21
frankly [2] 144/18 167/19
free [1] 217/6
Freeman [1] 170/3
frequent [1] 126/9
frequently [2] 11/5 115/8
Friday [1] 200/4
friend [2] 124/2 130/9
friends [3] 125/13 125/22 128/13
fright [1] 198/8
frighted [1] 198/10
frightened [1] 140/11
frightening [3] 4/2 132/24 133/4
front [7] 14/19 39/19 90/24 133/2 148/7 158/2 188/18
frontline [28] 14/21 18/1 39/6 44/3 44/8 45/24 48/14 53/5 54/8 56/10 57/20 61/11 68/15 74/24 95/11 95/14 95/23 99/10 105/10 105/23 106/16 113/3 114/13 118/16 160/3 176/15 192/7 225/2
frontlined [1] 119/6
fronts [1] 107/22
FRSM [2] 100/7 142/24
FRSMs [3] 156/12 157/22 189/24
fruit [2] 142/20 193/10
frustrated [2] 9/25 56/2
frustration [1] 212/14
frying [1] 139/22
Fu [1] 165/17
fulfil [3] 47/12 78/18 206/17
fulfilled [1] 222/15
full [11] 32/15 47/24 79/14 83/23 85/12 92/9 145/10 207/18 213/3 214/5 215/16
full-time [2] 32/15 79/14
fully [7] 5/6 25/4 48/8 133/16 187/22 193/23 209/14
functioned [1] 132/17
functioning [2] 17/18 81/17
functions [1] 86/25
fund [1] 45/5
fundamental [12] 26/2 35/21 37/23 56/24 75/21 78/24 82/19 88/22 105/18 108/20 109/19 119/9
fundamentally [4] 4/24 12/9 76/18 155/8
funded [2] 21/7 183/5
funding [7] 22/8 22/11 36/25 46/17 97/11 183/24 184/11
funds [1] 98/18
furlough [1] 99/10
further [21] 3/15 11/21 22/3 29/21 30/4 77/14 110/16 112/23 144/14 147/19 149/3 153/11 160/10 180/5 184/13 190/4 192/16 203/25 206/8 210/10 220/13
futility [1] 157/8
future [57] 6/15 16/11 20/7 20/9 21/1 22/7 35/7 36/4 37/19 47/2 47/6 47/8 47/13 48/1 57/21 58/16 62/23 64/5 71/11 71/18 79/9 83/22 84/18 89/23 89/24 90/1 90/14 91/5 92/3 92/17 93/23 94/5 94/18 95/2 95/6 97/4 103/19 106/15 112/16 117/12 120/8 127/17 128/6 137/25 141/22 159/18 159/20 160/20 176/23 180/5 184/6 184/13 205/9 206/24 207/22 219/18 221/19

G

game [2] 64/17 64/18
gap [5] 136/20 175/23 179/14 195/3 199/20
gaps [7] 65/25 66/5 68/13 110/2 117/2 117/13 124/19
garden [1] 133/23
gather [1] 179/16
gathered [4] 6/4 74/20 103/1 103/3
gave [15] 6/11 14/22 18/11 19/10 60/11 96/18 100/3 126/20 132/25 166/2 182/5 190/4 194/20 213/19 216/17
gear [1] 116/2
gender [2] 34/21 112/23
general [14] 9/12 15/9 16/12 17/11 26/8 33/7 35/5 48/4 56/23 76/14 144/12 149/13 201/15 218/18
generally [4] 2/1 6/22 52/21 208/17
generate [1] 157/10
generated [1] 157/14
generating [4] 29/10 30/6 69/13 143/15
generational [1] 112/25
generations [1] 206/23
genie [1] 212/12
genuine [5] 3/20 57/7 93/25 164/10 217/7
genuinely [3] 9/23 43/7 48/9
geographical [1] 93/3
gestures [1] 113/18
get [17] 9/24 43/4 43/5 43/10 56/25 62/6 62/6 63/9 135/12 138/14 152/6 170/22 195/20 207/4 207/9 213/8 221/23
Gething [3] 14/3 166/13 169/25
getting [3] 137/11 153/1 197/10
gift [1] 90/12
gig [1] 101/23
gig-economy [1] 101/23
Gillian [2] 158/3 158/5
give [10] 2/4 14/21 55/8 65/7 65/20 78/22 95/21 111/1 134/14 222/12
given [27] 9/7 9/14 10/7 16/15 17/10 31/15 37/20 39/5 48/13 56/24 63/11 77/3 88/16 89/7 96/19 128/11 133/5 136/11

G

given... [9] 136/24 137/1 143/13 143/21 153/13 168/16 189/9 196/4 205/22
gives [1] 153/8
giving [7] 4/11 44/21 49/16 56/13 95/19 113/2 167/12
Glangwili [5] 15/9 18/10 18/13 18/18 19/5
glaring [1] 117/13
global [3] 3/1 3/20 108/1
globally [1] 4/5
gloves [1] 100/6
GMC [1] 34/16
go [15] 27/24 38/3 48/5 52/18 100/24 123/11 139/13 140/9 140/10 149/3 166/17 185/20 200/23 221/16 222/6
goal [1] 2/10
goes [4] 32/8 71/22 137/19 166/14
goggles [1] 28/1
going [20] 21/23 21/23 32/22 43/10 43/11 77/24 80/25 89/25 91/10 102/10 102/12 102/14 128/1 145/22 159/8 159/9 159/22 170/22 171/1 180/20
gold [1] 102/19
gone [4] 18/22 63/19 153/19 196/7
good [27] 1/4 10/13 16/17 18/5 38/7 58/25 59/3 63/2 72/7 85/6 121/2 121/3 122/18 130/22 130/24 131/12 133/16 134/15 138/13 140/14 146/18 152/2 164/16 168/4 172/17 175/14 193/18
Goodall [1] 17/21
Goodall's [1] 17/16
Gordon [2] 131/15 161/14
Gorton [1] 83/15
got [7] 29/18 30/15 65/19 65/22 71/21 147/3 193/3
Gould [1] 158/20
government [45] 5/21 16/16 16/22 17/5 17/12 17/24 22/11 39/7 43/19 44/6 44/13 48/7 48/10 48/15 54/6 58/5 80/3 93/21 95/4 96/22 102/17 106/15 138/1 138/5 138/8 151/17 151/24 154/3 159/1 164/6 170/20 174/7 175/24 182/8 186/9 187/23 188/3 209/8 212/22 213/17 213/25 214/17 218/19 218/22 222/13
government's [6] 53/14 94/17 135/21 140/14 206/15 208/14
governments [3] 24/10 58/10 206/7
gowns [1] 100/6
GP [6] 28/3 40/24 123/21 140/10 144/21 210/6
GPs [4] 24/20 210/8 212/7 220/25
graph [1] 196/3
grapple [2] 138/8 187/7
grasp [1] 218/1
grasped [1] 216/25
grateful [15] 13/11 22/17 38/12 49/2 58/20 88/25 95/9 96/20 106/20 107/10 120/21 131/3 194/6 207/14 207/23
grave [1] 214/24
graves [1] 3/24
great [7] 18/17 39/23 66/18 90/12 95/17 109/3 198/3
greater [14] 12/14 28/22 69/16 80/5 83/20 84/19 116/4 117/11 144/15 174/11 189/24 195/16 196/24 204/8
greatly [1] 122/11
Grey [7] 1/11 1/14 1/15 13/10 150/15 220/15 224/6
grief [3] 60/12 130/18 198/8
grieving [1] 110/22
ground [4] 79/24 85/14 152/23 213/10
groundwork [1] 138/10
group [34] 13/14 13/17 13/18 15/3 15/6 15/25 16/4 16/13 17/20 18/5 20/3 22/12 32/11 38/24 82/22 95/12 95/15 95/18 96/2 102/24 103/18 105/24 121/24 123/2 132/12 133/5 137/5 137/16 153/16 153/16 204/6 217/9 224/8 225/2
group's [2] 99/1 99/9
groups [37] 15/23 58/2 61/15 61/20 63/9 84/15 87/22 87/25 110/7 110/10 111/13 115/2 116/18 122/25 130/3 153/25 174/10 175/18 175/20 175/22 176/1 176/7 176/10 176/18 178/3 179/14 179/24 181/3 181/9 189/17 190/16 191/15 193/5 193/12 193/22 213/18 225/19
Groups' [1] 193/20
groupthink [1] 141/3
growing [1] 58/3
growth [1] 135/24
guarantee [2] 31/10 146/12
guaranteed [1] 98/14
guard [1] 137/2
guards [2] 99/16 101/25
guidance [62] 6/13 7/13 9/15 10/11 16/15 19/17 20/23 26/12 26/15 30/18 30/22 31/5 35/25 36/6 52/5 56/6 60/14 61/25 85/8 93/24 126/9 126/12 127/17 129/13 135/9 140/15 150/22 151/2 152/18 152/24 153/13 155/14 155/17 157/22 158/9 158/18 166/1 167/12 167/22 167/24 168/1 168/9 168/14 168/25 169/13 170/4 174/3 174/5 190/1 190/6 190/19 196/11 198/18 199/5 199/13 205/12 206/3 211/25 212/6 213/2 214/20 217/23
guide [1] 10/4
guided [1] 128/15
guidelines [4] 142/8 183/12 190/21 211/9
guiding [1] 144/16
guilt [2] 60/12 130/18
guilty [1] 216/20
Gupta [4] 95/10 95/12 106/20 225/3
GUPTA KC [2] 95/12 225/3

H

Habib [1] 87/24
had [109] 1/8 4/15 7/2 10/23 14/5 18/13 18/18 19/14 19/25 20/2 21/19 21/20 24/15 25/18 28/5 33/4 34/10 40/23 41/5 42/6 42/22 44/11 45/14 54/11 56/14 64/6 64/12 64/13 64/14 64/16 65/8 65/15 65/19 66/4 66/8 66/19 66/24 67/15 67/16 68/1 68/11 68/19 78/6 80/22 81/17 81/24 87/22 89/10 96/6 97/9 98/4 98/6 99/9 99/19 100/8 100/9 100/24 101/2 101/2 101/6 102/6 115/10 122/12 125/8 125/23 126/1 130/14 136/17 137/13 148/15 149/1 149/18 151/18 151/21 152/13 152/17 153/14 153/20 154/21 156/7 161/22 164/9 167/13 167/18 169/12 170/21 171/2 172/3 181/21 186/20 186/25 187/19 189/10 191/1 196/7 196/16 196/23 197/2 198/20 199/4 201/11 206/22 209/8 210/23 212/6 212/7 212/16 212/21 213/13
hadn't [2] 107/4 133/5
half [1] 98/5
hallmark [2] 160/4 160/14
halted [1] 162/18
hampered [1] 118/7
Hancock [24] 44/9 44/14 45/13 62/17 75/6 78/1 78/5 103/13 105/9 127/17 137/24 139/11 140/2 150/25 150/25 151/8 169/19 189/25 190/4 200/10 210/4 216/17 217/24 220/5
Hancock's [3] 140/19 169/22 219/22
hand [3] 13/6 126/14 219/23
handful [1] 154/24
handle [1] 51/23
handled [1] 136/18
hands [1] 171/17
hands-on [1] 171/17
hanging [2] 142/19 193/10
Hannett [5] 175/15 175/17 175/19 194/1 225/19
happen [8] 35/21 90/11 92/22 100/13 127/2 128/9 139/5 155/3
happened [7] 5/12 89/18 109/6 125/16 160/11 198/7 215/2
happening [2] 8/23 67/12
happens [1] 137/18
happy [2] 144/1 212/19
harassment [1] 83/6
hard [12] 1/21 4/7 5/6 12/4 102/10 109/2 110/10 143/6 204/3 212/13 217/24 219/17
harder [1] 102/12
hardest [3] 43/9 102/15 203/12
hardly [1] 209/4
hardship [1] 42/8
hardworking [1] 174/17
harm [18] 8/19 8/21 23/22 26/3 89/24 90/14 95/1 95/5 108/12 127/1 156/22 176/21 177/6 177/23 187/8 193/16 194/21 202/20
harm's [1] 14/14
harmed [1] 122/15
harmful [1] 186/16
harms [5] 5/8 81/9 120/14 175/2 176/23
harness [1] 20/25
Harries [6] 104/14 136/16 137/24 138/14 184/24 186/25
Harrison [2] 131/15 161/13
harrowing [1] 67/17
harsh [2] 134/1 219/5
has [133] 1/8 2/1 2/15 3/22 4/5 5/22 5/24 6/24 6/25 11/15 19/2 21/11 21/21 22/5 22/24 23/15 24/6 27/23 28/11 29/22 30/25 32/3 38/16 38/22 39/19 40/19 46/11 49/11 50/8 50/21 50/24 52/9 53/4 53/15 54/12 56/1 56/11 61/20 63/5 63/19 63/20 64/25 71/8 71/8 71/21 72/11 72/17 72/19 73/21 75/3 76/1 76/3 76/5 76/9 77/23 79/13 79/19 80/19 81/2 87/7 91/19 92/4 92/9 95/25 96/19 97/6 97/7 97/20 97/25 104/3 104/13 106/9 109/4 124/17 127/3 134/17 139/17

H

has... [56] 141/2 141/9 141/10 141/13 142/7 142/20 142/25 147/16 149/8 149/9 152/22 158/21 159/14 160/11 160/14 161/19 162/7 162/13 163/17 163/17 164/17 168/16 170/15 170/19 177/13 177/16 178/8 178/19 179/17 179/22 180/9 180/13 180/15 180/24 181/13 181/19 182/3 183/2 183/3 184/6 185/15 185/24 187/3 189/1 189/22 190/24 191/1 191/25 192/1 192/3 195/2 203/23 204/22 206/12 220/3 222/9
hasty [1] 129/9
have [241]
having [15] 10/21 33/9 46/9 65/11 65/19 66/11 74/22 92/17 128/2 155/18 163/16 166/22 168/10 169/7 180/25
he [61] 8/7 14/5 14/6 15/15 15/21 18/3 18/11 18/20 18/24 19/12 19/25 20/3 20/17 32/23 41/23 42/11 43/7 43/8 44/10 44/11 44/23 45/14 45/15 50/24 51/15 51/15 51/19 59/17 62/12 65/22 67/10 68/6 69/9 69/11 75/2 78/5 82/16 97/8 97/12 99/6 103/13 103/17 103/24 106/7 134/14 134/21 139/12 141/18 151/1 166/10 169/16 182/12 198/5 204/5 208/20 210/6 212/16 216/19 220/1 220/2 220/8
he's [1] 64/22
head [3] 4/9 37/24 195/14
headed [1] 200/19
headline [1] 141/18
headroom [2] 4/19 4/21
heads [1] 24/8
health [195] 9/17 12/12 13/14 13/17 13/19 14/3 15/3 16/20 16/22 17/4 17/12 17/17 17/18 17/25 18/5 18/9 18/25 19/11 20/4 21/15 22/25 23/5 23/11 23/12 24/1 24/9 24/12 26/9 26/14 31/25 32/17 33/22 33/23 34/2 34/18 35/8 36/8 37/3 37/22 39/18 40/10 40/10 41/15 41/18 41/20 42/2 42/7 47/18 47/18 48/17 48/18 49/16 50/2 50/23 54/1 54/12 55/4 55/17 56/10 56/21 57/14 58/2 58/14 58/15 58/17 62/17 64/10 64/19 64/24 65/20 70/12 73/12 75/3 75/6 76/12 77/16 79/24 83/7 84/2 84/21 85/11 86/4 87/16 90/24 91/22 92/13 93/13 94/6 94/6 95/11 95/15 95/23 97/15 97/18 97/24 98/21 99/11 101/21 102/1 103/19 104/7 104/12 104/21 105/4 105/20 105/24 105/25 107/13 109/16 110/2 110/6 111/23 112/17 113/9 113/10 115/14 115/17 117/10 118/8 118/13 118/14 122/2 128/21 130/10 134/2 139/10 147/8 149/20 154/14 155/4 155/13 155/15 155/15 159/10 164/2 170/15 171/17 171/22 172/18 175/24 176/2 176/15 177/7 179/21 180/11 181/12 181/20 182/2 182/4 182/15 186/12 187/21 187/25 188/13 188/17 188/24 188/24 189/22 189/22 191/25 192/18 193/16 194/8 195/8 196/16 197/17 197/19 197/24 198/4 198/19 199/4 199/11 199/17 200/5 200/20 201/20 202/2 202/6 202/22 203/4 203/4 203/12 203/18 203/22 204/10 204/24 206/7 206/12 206/20 206/23 212/5 218/15 218/21 224/8 225/2
Health's [1] 65/23
healthcare [211] 2/22 14/6 23/1 23/20 23/21 25/20 26/5 26/21 27/1 27/8 27/18 27/24 31/15 31/23 35/12 35/18 36/5 36/14 39/20 43/13 44/3 45/25 46/3 47/1 47/7 49/21 51/16 52/6 54/4 55/25 56/4 61/6 61/10 61/11 66/13 66/21 70/18 72/10 72/12 73/5 73/17 73/20 74/4 75/22 77/21 77/23 78/3 80/9 82/21 86/10 86/15 86/18 86/24 87/2 87/12 88/23 93/18 96/13 97/1 97/21 98/23 99/3 99/22 101/16 101/24 103/7 103/8 103/21 104/1 105/3 105/7 105/14 106/8 106/10 106/12 106/16 106/17 107/9 107/20 107/21 108/4 108/15 108/16 109/11 110/23 111/14 112/2 112/5 112/11 112/19 113/15 114/1 114/11 114/25 115/3 115/23 116/3 116/22 117/8 117/15 118/3 118/13 118/22 119/2 119/10 119/10 119/13 119/24 120/5 120/8 122/6 122/15 122/16 123/20 123/25 124/8 124/20 124/23 125/7 127/6 127/8 127/11 128/7 129/14 131/20 132/3 132/5 134/9 135/12 139/6 139/12 139/20 139/23 140/7 140/16 144/10 146/3 147/6 149/12 149/14 149/15 151/25 152/5 152/15 154/4 156/20 157/4 157/18 157/21 158/16 159/5 159/8 159/12 159/16 159/17 159/21 160/19 161/16 161/21 163/25 167/11 170/8 170/19 170/22 170/23 173/6 173/7 173/20 176/5 177/12 177/18 177/22 178/2 178/10 178/16 178/19 179/1 179/4 180/6 180/22 180/23 181/3 182/21 185/24 186/17 188/16 188/17 188/19 190/7 190/12 190/15 190/20 190/25 191/2 191/9 191/11 191/17 191/18 192/4 192/6 192/11 192/17 192/18 192/21 193/7 193/9 193/15 195/6 211/6 218/24 225/5
Healthier [1] 79/23
Healthworkers [1] 192/7
hear [10] 1/4 57/10 59/4 72/17 106/23 144/1 153/7 201/4 220/14 220/19
heard [76] 4/18 5/24 6/25 8/4 10/4 11/4 12/13 13/2 22/23 25/12 27/23 28/16 38/16 40/2 46/13 49/11 49/15 50/8 52/9 53/4 53/16 54/13 56/11 59/12 59/15 60/21 61/1 61/8 61/20 62/6 62/9 63/12 63/14 64/13 66/10 67/16 81/18 83/11 89/5 91/6 91/13 91/25 92/1 94/4 99/5 101/1 113/13 123/17 124/1 124/5 125/21 127/3 130/15 133/22 134/8 140/8 141/2 148/5 152/21 152/22 153/12 159/7 160/11 164/17 170/15 170/19 177/13 178/8 180/24 185/24 188/7 190/24 191/6 192/4 196/21 222/24
hearing [10] 59/4 63/6 63/21 110/1 148/25 164/22 177/8 207/16 220/4 223/5
hearings [11] 1/20 2/1 3/23 6/20 11/12 24/6 28/17 44/10 50/8 136/12 139/18
heart [4] 77/22 94/17 124/10 128/22
hearts [1] 158/21
heat [1] 217/18
Heathrow [1] 22/15
height [1] 212/25
heighten [1] 123/9
heightened [6] 56/18 101/7 113/2 117/9 118/16 139/3
held [3] 84/23 114/3 127/7
help [11] 45/10 49/14 52/17 70/18 129/23 135/22 137/11 139/5 206/24 214/11 222/5
helped [1] 209/25
helpful [9] 1/19 8/6 13/8 13/11 82/16 88/25 106/4 175/8 222/22
helping [4] 56/25 127/22 128/3 211/3
helpless [1] 33/8
hence [2] 195/17 196/1
Henderson [4] 89/2 89/4 95/8 224/24
HEPA [2] 142/19 193/8
her [36] 21/9 21/13 21/18 21/20 59/18 59/18 59/22 59/22 59/25 60/1 60/7 66/14 66/15 66/19 81/23 83/15 100/8 100/15 100/16 100/17 116/14 137/20 151/6 151/7 162/5 165/7 169/12 180/21 186/24 196/5 196/7 196/8 198/22 199/1 199/2 205/6
here [16] 1/10 3/15 7/3 12/1 47/14 47/16 65/18 71/19 107/1 145/6 175/2 193/18 204/20 207/16 218/12 218/13
heroic [1] 39/24
heroism [1] 61/11
herself [1] 199/2
hesitancy [3] 42/1 87/25 110/7
hesitant [1] 76/7
Hestia [1] 1/22
hierarchy [1] 143/20
Higgins [3] 158/3 158/6 158/11
high [32] 2/4 2/9 2/24 9/9 21/4 26/18 42/10 42/13 42/25 55/13 55/15 74/25 86/6 86/9 97/15 101/13 103/15 112/4 114/12 116/18 118/18 123/20 140/7 140/14 143/14 144/3 148/15 156/11 159/25 173/14 189/4 203/7
high-income [1] 97/15
high-level [1] 2/24
high-quality [1] 156/11
high-risk [5] 74/25 86/6 114/12 116/18 159/25
higher [17] 26/6 27/2 30/21 31/17 35/1 41/17 87/24 97/13 100/20 101/13 102/6 103/10 105/8 137/8 137/9 142/16 211/16
higher-risk [2] 35/1 100/20
highest [7] 4/10 101/20 101/24 102/4 102/5 114/9 208/12
highlight [3] 35/24 49/24 115/1
highlighted [9] 32/18

H

highlighted... [8] 35/14 43/14 113/14 115/15 121/12 123/6 192/8 208/11
highlighting [2] 118/1 221/14
highlights [1] 23/16
highly [4] 6/4 11/8 17/23 89/25
him [5] 32/20 59/18 67/14 208/13 216/19
himself [2] 115/18 216/21
hindered [1] 109/22
hinders [1] 205/18
hindsight [3] 160/3 170/1 171/4
his [42] 14/2 15/11 15/12 17/20 17/22 17/22 18/11 18/12 18/17 19/20 19/22 22/14 41/4 41/21 44/13 45/13 47/11 47/13 48/6 59/16 59/16 59/17 59/18 59/21 60/22 60/25 65/2 66/20 67/3 67/10 69/12 69/15 70/23 71/3 103/16 106/3 141/18 147/23 147/25 157/19 219/24 220/6
historic [1] 177/4
historical [3] 88/3 108/3 109/1
history [3] 148/1 198/14 206/12
hit [6] 71/12 98/5 102/10 102/12 102/14 204/2
hitherto [1] 206/17
hits [1] 36/18
hold [3] 71/14 83/12 94/9
holders [1] 222/19
holes [2] 143/23 143/24
home [13] 18/25 40/15 68/7 69/1 71/22 96/23 96/25 100/25 132/16 170/21 171/5 171/25 197/11
Home' [1] 133/11
home-made [1] 71/22
homes [3] 3/25 92/12 172/18
honest [2] 49/17 153/8
honesty [3] 94/15 94/16 152/7
honour [1] 27/13
hoods [2] 114/5 114/8
hope [11] 1/4 1/8 13/7 22/12 62/23 64/3 91/8 142/14 193/12 220/16 221/10
hoped [1] 153/14
hopefully [1] 221/19
hopeless [1] 135/3
Hopkins [4] 141/16 143/17 181/19 182/5
horrific [2] 33/6 34/13
horror [2] 61/5 62/12
hospital [53] 13/21 15/8 15/9 18/13 18/18 18/18 19/5 22/7 22/12 25/14 32/23 50/6 50/9 50/25 59/20 62/13 65/24 67/23 68/3 68/4 86/9 98/6 99/14 99/15 99/21 99/25 100/3 100/15 106/11 124/24 133/2 139/9 139/17 140/1 140/5 140/9 144/5 144/21 162/10 165/3 166/12 166/25 167/1 171/1 172/12 173/23 174/2 193/1 195/4 195/13 195/15 198/22 212/9
hospital's [1] 198/24
hospital-acquired [3] 139/17 140/1 140/5
hospitality [1] 207/17
hospitals [23] 3/25 11/23 15/18 20/8 20/9 20/20 21/6 51/20 61/7 68/17 80/17 80/22 99/16 99/18 99/20 99/23 104/24 105/17 126/13 131/21 173/19 193/3 197/11
hostile [1] 98/14
hours [5] 41/10 42/22 51/22 54/21 165/15
house [13] 12/21 12/22 84/6 84/8 84/12 84/14 98/9 100/7 105/4 131/1 131/5 140/25 141/9
household [2] 133/19 165/3
households [1] 112/25
housing [4] 97/18 102/9 111/23 113/5
how [52] 2/16 4/19 5/7 6/12 8/25 9/11 14/5 14/8 14/11 14/14 19/10 32/18 38/3 40/2 41/24 42/13 43/4 43/5 43/6 51/19 62/9 68/8 75/25 80/19 80/25 81/17 94/8 96/24 96/25 97/9 111/7 112/11 114/4 115/15 124/10 125/6 128/11 128/15 129/16 133/6 137/16 140/24 142/22 147/24 149/2 152/25 153/19 195/19 215/14 215/14 217/10 217/18
however [24] 25/24 27/17 37/20 48/6 49/15 52/18 72/17 73/8 74/3 86/8 90/12 91/10 108/7 110/11 116/25 132/22 175/2 182/12 184/20 209/1 212/4 213/21 220/25 221/21
HSC [3] 86/6 86/17 86/22
HSE [2] 86/12 86/13
HSE's [1] 26/15
HSIB's [3] 12/21 12/24 12/25
HTM [2] 142/8 190/21
HTM guidelines [1] 190/21
hub [3] 99/19 213/23 218/23
hubs [4] 56/7 206/10 206/16 206/17
huge [6] 40/6 43/17 54/23 89/5 125/11 167/6
hugely [4] 132/13 133/10 171/25 216/11
Hughes [3] 201/23 205/6 206/6
Hughes' [1] 202/16
human [9] 3/22 60/15 84/9 107/17 109/3 110/21 124/6 128/24 146/7
humility [1] 160/9
humour [1] 130/24
Humza [2] 187/22 213/5
hundreds [3] 62/14 71/9 145/22
hurriedly [1] 204/20
hurry [1] 164/15
hurt [1] 66/18
husband [2] 68/3 163/19
huts [1] 22/15
Hyam [4] 13/13 13/15 22/17 224/8
Hywel [1] 18/9
Hywel Dda [1] 18/9

I

I act [1] 161/10
I agree [1] 3/18
I also [1] 32/6
I am [5] 21/21 21/21 44/18 72/8 161/11
I ask [2] 171/14 200/23
I beg [1] 31/7
I began [1] 161/15
I begin [1] 39/15
I believe [1] 94/14
I can [2] 1/6 59/5
I can't [1] 146/11
I come [1] 119/17
I commend [1] 89/6
I conclude [1] 120/6
I consider [1] 8/10
I dare [1] 59/12
I daresay [1] 60/20
I didn't [3] 59/1 133/8 143/24
I don't [4] 7/6 32/8 141/8 185/23
I draw [1] 47/10
I expected [2] 72/3 120/20
I feel [1] 189/9
I felt [1] 189/12
I had [2] 66/4 81/17
I have [4] 133/8 133/9 162/20 222/24
I heard [1] 81/18
I hope [3] 1/4 1/8 62/23
I just [2] 59/3 130/21
I know [1] 69/16
I make [3] 1/16 13/16 194/15
I mean [1] 70/15
I move [1] 205/2
I must [1] 131/16
I needed [1] 24/22
I now [1] 32/4
I propose [1] 178/6
I provide [1] 20/6
I quote [2] 21/20 208/24
I really [2] 163/18 163/20
I recognise [1] 204/10
I represent [2] 107/11 131/12
I say [2] 38/10 70/16
I shall [4] 58/21 120/22 175/9 222/23
I sit [1] 130/21
I suspect [1] 106/25
I think [18] 1/10 8/9 14/8 14/12 14/15 14/18 14/19 14/21 15/17 59/6 106/22 121/4 150/8 160/25 162/8 163/15 169/10 223/1
I thought [1] 161/6
I tried [1] 135/2
I turn [4] 42/3 188/15 191/23 221/6
I understand [1] 1/6
I want [2] 89/13 158/14
I was [7] 24/23 59/3 81/17 133/8 163/19 163/21 185/19
I were [1] 185/19
I will [3] 91/18 146/13 194/9
I would [2] 169/10 200/13
I'd [1] 15/22
I'd say [1] 15/22
I'll [1] 140/24
I'll now [1] 140/24
I'm [18] 22/17 49/2 65/6 65/7 65/10 88/25 91/10 106/25 107/2 107/4 120/21 131/3 131/13 156/24 185/22 201/18 207/23 222/2
I've [1] 65/8
I've had [1] 65/8
iceberg [1] 195/9
ICU [3] 33/21 50/16 217/11
idea [4] 75/8 75/11 80/24 220/23
ideals [1] 5/12
identifiable [1] 174/20
identification [1] 176/8
identified [15] 19/13 19/20 20/5 36/25 66/1 82/25 91/15 92/24 116/12 138/7 164/8 172/4 203/14 204/16 220/24
identifies [2] 20/4 138/11
identify [9] 19/6 39/2 78/16 86/19 109/23 129/24 178/4 194/14 208/4
identifying [4] 2/22 79/25 90/13 134/6
identity [2] 185/18 185/23
idiotism [1] 198/10
ie [3] 8/22 104/24 195/3
if [80] 4/25 7/3 9/24 10/5 10/22 11/25 14/5 15/1 22/3 24/2 27/18 29/12 30/4 31/8 35/8 40/23 47/19 52/22 60/17 62/25 63/9 66/8 66/24 67/15 68/1 68/11 68/18 69/25 70/4 71/12 75/2 85/12 88/8 95/2 95/3 100/14

I

if... [44] 104/10 105/5 106/22 107/5 119/24 124/14 130/14 132/18 139/18 141/23 141/25 142/17 143/23 145/19 148/20 149/14 149/18 159/22 161/2 166/13 166/17 169/12 171/5 175/1 184/2 192/25 193/4 195/13 195/15 199/4 204/6 206/17 212/9 213/3 213/8 216/6 216/13 217/6 217/11 220/3 220/3 220/5 222/2 222/5
ignorance [1] 61/16
ignore [2] 94/10 109/3
ignored [6] 62/3 94/8 106/14 110/19 113/9 152/20
ignores [2] 156/9 156/13
ill [6] 50/12 90/3 107/22 109/16 157/10 166/18
ill-equipped [2] 107/22 109/16
illness [11] 33/4 180/21 186/23 187/6 188/7 194/20 194/21 194/21 197/1 197/23 203/10
illnesses [2] 34/6 110/24
illustrates [1] 158/9
images [1] 4/1
imagine [1] 126/24
imbue [1] 60/10
immediate [2] 123/10 181/4
immediately [1] 212/20
immigration [7] 96/9 100/22 102/13 103/23 103/25 105/16 192/13
imminently [1] 221/11
immune [1] 139/15
impact [72] 11/5 11/6 15/23 23/2 39/4 39/11 42/3 42/6 42/10 43/14 46/14 50/2 50/19 50/25 54/11 55/3 55/17 57/14 58/3 62/1 67/17 72/10 72/21 73/22 75/12 75/13 77/18 82/6 94/19 95/24 101/12 102/7 103/11 118/2 118/12 119/3 122/25 123/8 125/22 130/5 132/10 144/3 154/22 163/13 163/15 163/22 164/7 169/7 174/20 178/18 178/20 182/7 182/18 184/23 185/2 185/13 186/1 188/15 190/25 191/16 192/15 192/19 196/1 196/16 197/19 198/4 198/16 202/15 203/12 208/12 209/7 212/17
impacted [6] 31/19 56/7 110/22 117/8 126/17 162/8
impacts [20] 23/23 25/22 31/12 32/16 34/17 37/20 73/11 73/16 73/19 75/9 76/16 82/15 103/25 134/2 164/23 174/19 184/25 202/19 203/21 204/13
impaired [1] 208/21
impairment [1] 220/4
impairments [1] 126/3
impedes [1] 185/15
imperative [2] 108/17 216/13
imperfect [2] 11/8 12/18
implement [4] 37/10 44/13 64/4 64/5
implementation [6] 19/17 92/24 116/21 144/14 193/7 215/16
implemented [8] 25/4 63/9 66/3 85/14 95/4 144/19 209/14 221/11
implications [2] 101/6 182/3
implies [1] 110/13
imply [1] 121/22
implying [1] 212/8
importance [16] 3/14 5/4 5/6 20/20 52/3 72/25 95/23 105/10 105/11 122/22 135/11 141/15 153/13 158/19 172/7 195/11
important [32] 5/11 12/10 16/1 18/3 44/10 47/5 67/6 70/1 72/22 79/18 81/25 87/13 125/17 131/25 132/14 132/21 134/18 139/25 141/19 141/22 143/18 146/7 164/4 173/9 182/3 182/6 199/19 203/8 209/20 214/7 214/22 222/19
importantly [7] 31/3 71/12 93/14 135/15 209/16 211/13 218/11
imposed [1] 121/20
impossibility [1] 156/13
impossible [6] 52/22 104/8 140/13 157/20 157/23 201/14
impression [5] 17/3 78/23 167/2 209/25 210/3
impressive [1] 221/8
improper [2] 67/1 67/11
improve [12] 14/6 16/10 21/16 37/3 37/5 58/6 58/7 141/20 213/24 214/11 214/15 220/20
improved [6] 35/18 36/22 84/7 126/12 141/25 190/21
improvements [6] 22/12 35/6 36/25 175/3 181/5 213/2
improving [4] 22/9 119/8 132/6 142/11
Imrie [2] 153/6 155/25
Imrie's [1] 151/5
inability [1] 25/6
inaccessible [2] 208/9 209/4
inaccurate [2] 115/8 158/18
inaction [1] 102/18
inadequacies [6] 103/11 115/4 115/5 118/6 141/23 189/2
inadequacy [3] 177/15 178/14 182/20
inadequate [12] 24/4 35/7 100/14 100/23 109/22 116/11 126/22 135/3 177/21 178/16 189/10 190/11
inadequately [2] 33/12 154/20
inadvertently [1] 218/4
inappropriate [5] 65/6 65/14 81/11 89/21 202/10
inbuilt [2] 44/19 56/11
incarnations [1] 152/10
incidence [3] 101/13 184/19 191/16
Incident [1] 6/17
include [14] 3/6 20/6 58/12 75/16 76/21 102/20 103/7 129/15 174/8 182/17 183/7 184/14 200/2 206/9
included [8] 16/14 41/5 44/12 51/2 66/10 85/2 88/2 194/6
includes [4] 24/3 92/11 92/17 92/25
including [45] 1/22 2/14 2/16 10/19 12/11 22/8 24/7 26/4 27/25 29/25 32/10 33/16 36/11 36/15 39/10 52/4 52/6 52/9 53/7 59/23 63/16 80/9 82/1 87/23 93/2 111/23 114/15 122/19 130/3 130/13 131/20 141/17 147/20 152/25 155/2 156/2 158/15 162/17 173/15 173/25 174/16 195/12 202/24 212/10 218/24
inclusion [4] 77/9 77/12 77/17 112/19
inclusive [3] 117/18 118/10 128/4
inclusivity [2] 109/17 114/1
income [4] 97/15 97/18 98/19 101/23
incomes [1] 174/20
incomplete [3] 135/6 160/1 204/23
inconsistencies [2] 10/1 171/21
inconsistency [1] 68/5
inconsistent [3] 68/9 116/21 143/13
incorporate [1] 180/5
incorrect [2] 141/1 177/5
increase [8] 4/12 40/12 41/1 53/18 65/16 78/15 197/13 202/20
increased [20] 25/10 26/7 26/9 34/12 40/7 42/5 46/6 46/22 55/4 98/11 112/6 122/11 140/17 172/9 196/25 197/4 200/21 201/12 201/22 210/22
increases [2] 54/19 54/20
increasing [4] 79/2 87/12 187/16 203/25
increasingly [1] 149/8
incredible [1] 14/24
incredibly [2] 33/7 132/21
incurred [1] 43/16
indeed [22] 13/11 26/25 28/24 58/19 64/12 72/2 92/7 120/19 133/7 146/6 149/3 150/25 153/20 175/7 207/8 207/16 216/20 217/20 217/24 218/21 222/23 222/24
indefatigable [1] 61/14
independent [6] 38/11 38/18 38/25 57/12 95/17 143/3
independently [3] 36/23 67/13 77/10
independently-audited [1] 36/23
INDEX [1] 223/7
Indian [1] 102/25
indicated [1] 48/6
indicates [1] 200/19
indication [1] 42/9
indicators [1] 211/14
indictment [1] 35/10
indirect [4] 77/13 83/20 85/1 85/10
indirectly [8] 4/6 83/3 83/9 83/13 83/18 84/20 85/6 85/12
indiscriminate [4] 178/22 181/14 182/1 182/16
indispensable [1] 125/19
individual [16] 9/3 10/2 90/23 111/13 118/24 123/17 128/12 129/1 132/13 133/18 138/3 153/16 198/21 208/21 215/10 222/19
individualised [2] 121/20 128/25
individually [3] 21/22 22/1 101/9
individuals [8] 2/2 61/15 61/20 110/25 124/18 135/8 153/25 154/10
indoor [1] 142/4
Industrial [1] 37/10
ineffective [3] 82/10 110/8 139/21
inequalities [25] 3/14 3/17 23/13 31/11 41/20 42/2 47/18 57/15 74/2 103/20 108/3 111/7 111/21 171/2 178/20 191/25 192/4 192/18 203/18 204/1 204/5 206/8 212/17 222/5 222/7
inequality [3] 74/14 107/12 204/9
inequitable [1] 111/15
inequities [9] 107/20 107/21 111/22 112/15

I

inequities... [5] 113/17 117/18 117/23 118/16 120/14
inequity [1] 116/7
inertia [1] 61/17
inescapable [1] 24/6
inevitable [8] 4/15 23/3 90/10 101/12 113/8 119/4 140/2 174/22
inevitably [4] 2/13 88/24 99/12 177/16
inexpensive [1] 144/3
inexplicable [1] 198/18
inexplicably [1] 26/17
inextricably [1] 189/5
infected [4] 9/1 25/15 51/6 87/3
infection [32] 20/10 25/3 25/12 26/6 30/2 32/3 52/5 52/20 73/16 82/7 84/7 92/15 99/12 101/13 102/4 103/1 118/17 133/24 139/17 140/1 140/21 142/13 148/13 154/5 165/21 167/18 177/22 179/10 179/16 192/3 196/12 198/9
infections [8] 25/10 26/18 27/5 33/15 34/17 102/16 140/6 193/1
infectious [2] 143/14 158/5
inferno [1] 99/8
infinitely [1] 156/16
influence [1] 217/6
influenced [3] 88/10 151/2 167/8
influential [1] 203/2
inform [2] 72/23 196/10
informal [1] 40/21
information [18] 6/4 28/12 31/16 84/23 87/14 133/6 134/18 135/2 135/16 144/4 152/25 160/1 176/2 181/22 182/17 186/9 208/16 209/14
informed [9] 6/23 17/5 80/3 87/19 137/8 159/3 182/2 188/11 190/7
informing [2] 182/10 187/1
infrastructure [10] 16/5 18/14 19/18 20/8 22/7 24/5 36/24 48/2 48/16 80/18
inherent [1] 209/18
inhuman [1] 107/13
inhumane [1] 67/24
initial [11] 16/13 44/6 45/4 53/16 56/8 78/15 126/10 167/13 171/16 179/14 182/24
initially [3] 46/1 46/2 133/16
initiatives [1] 16/7
injections [1] 81/20
Injuries [2] 26/16 37/11
injury [4] 27/20 72/16 127/6 191/11
injustice [2] 105/18 107/12
innovation [1] 152/5
inpatient [20] 194/7 194/19 194/24 195/3 195/6 195/17 195/21 197/3 197/8 197/14 198/19 198/25 199/20 199/24 200/25 202/2 202/24 205/14 205/16 205/18
inpatients [3] 194/17 201/11 205/24
input [3] 69/19 130/6 155/25
inputs [2] 154/6 154/8
Inquiries [1] 12/23
inquiry [161] 1/18 1/21 1/22 2/1 2/15 2/20 5/22 6/25 8/2 8/14 10/21 11/11 11/25 12/20 13/4 13/24 13/25 14/3 14/5 15/6 15/9 15/11 16/25 18/7 21/8 23/14 25/25 27/23 28/11 29/19 29/25 35/11 37/22 38/13 38/16 38/22 39/3 40/2 40/19 43/17 44/9 45/13 47/12 47/23 48/14 49/11 50/7 50/16 50/21 50/24 52/9 52/17 53/4 53/15 54/12 55/7 56/11 60/21 63/22 70/1 74/20 76/5 78/4 78/7 78/9 78/11 78/19 89/8 89/14 89/16 89/17 90/12 91/8 91/14 95/2 95/19 96/11 96/19 99/7 108/19 109/4 111/1 119/19 120/12 125/21 127/3 129/12 129/18 130/22 131/17 131/17 131/24 137/21 139/11 141/2 143/1 144/2 145/10 146/5 147/7 147/9 149/9 152/21 152/22 153/15 154/24 155/20 159/13 160/11 162/5 162/13 163/14 163/24 164/17 170/15 170/19 174/24 176/19 176/25 177/3 177/8 177/13 178/6 178/8 178/25 179/6 179/24 180/2 180/24 181/4 181/13 181/23 182/14 182/25 183/4 184/8 185/1 185/24 186/7 186/24 187/7 188/4 188/19 189/1 189/8 189/23 190/13 190/17 190/24 191/15 192/14 193/5 193/17 193/20 193/22 200/6 209/6 211/13 216/4 216/16 221/8
Inquiry's [17] 9/10 11/13 15/14 23/25 24/8 33/19 37/17 50/15 73/7 78/13 78/18 107/18 141/17 146/6 183/16 194/10 196/1
insecure [3] 97/19 98/19 99/4
insensitivity [1] 110/4
insight [1] 86/18
insisted [1] 169/20
insistence [1] 157/2
insourcing [1] 84/17
inspection [3] 86/5 86/19 86/24
inspections [2] 86/12 86/14
instability [1] 197/25
instance [1] 110/8
instances [1] 172/4
instead [9] 29/9 67/7 108/2 113/14 141/8 151/15 153/23 183/17 199/8
instincts [1] 78/12
institution [1] 129/22
institutional [8] 108/5 109/8 111/3 111/9 111/17 112/9 119/1 154/13
institutions [6] 22/14 107/23 111/11 112/14 124/9 159/1
instructed [4] 44/11 72/8 131/14 161/13
Instructions [1] 144/5
insufficiency [1] 201/7
insufficient [4] 24/3 155/12 181/22 201/6
insufficiently [1] 165/12
integral [2] 43/12 46/10
integrate [1] 48/16
integrity [1] 152/8
intemperate [1] 2/6
intended [4] 38/14 39/1 66/4 211/18
intensity [1] 194/23
intensive [8] 29/9 29/11 30/1 30/5 33/20 50/15 157/15 202/24
intention [1] 196/7
intentionally [2] 25/22 111/11
interchangeable [1] 111/5
interconnected [1] 111/20
interest [3] 21/17 124/16 129/6
Interestingly [1] 84/4
interests [1] 5/10
interim [2] 177/1 211/20
interlaced [1] 61/10
intermittently [1] 32/7
internal [1] 18/20
internally [1] 143/12
international [3] 11/20 158/4 222/9
internationally [1] 21/2
interpretation [1] 198/24
interpreted [2] 200/17 211/21
interrupt [1] 106/25
intersectionality [1] 112/22
intertwined [1] 119/2
intervention [3] 86/7 170/13 211/24
interventions [7] 73/1 73/2 109/24 126/6 208/13 213/24 214/11
into [50] 7/19 20/16 20/19 23/17 42/21 44/19 45/7 48/17 56/11 56/12 56/18 59/19 62/13 62/22 63/16 64/17 77/24 78/3 85/21 86/18 91/13 100/20 100/24 102/9 104/18 136/23 139/23 144/17 144/22 146/12 150/24 151/6 163/2 165/25 166/6 166/11 166/17 180/6 181/7 182/25 183/6 183/7 183/8 195/13 198/10 198/11 198/11 199/6 210/3 217/22
intrinsically [1] 219/25
introduce [1] 196/2
introduced [6] 77/5 87/17 123/5 169/13 179/11 193/6
introduction [2] 190/22 210/13
invest [1] 36/14
investigated [1] 3/14
investigation [1] 57/12
investigations [2] 159/13 164/3
investing [1] 119/15
investment [6] 20/17 24/25 46/19 48/15 80/6 205/7
invisible [1] 193/14
invite [8] 80/15 149/3 151/15 178/24 179/24 180/2 181/9 189/17
invited [5] 65/19 137/10 181/23 183/4 184/8
invites [3] 39/2 47/23 209/9
involve [1] 159/24
involved [8] 7/6 94/12 127/21 127/22 155/19 160/12 168/8 171/15
involvement [3] 92/9 92/10 128/18
involves [2] 79/24 139/15
involving [1] 168/7
iPads [1] 127/7
IPC [50] 6/24 7/2 7/13 9/10 19/17 26/11 29/16 30/22 31/5 35/25 36/6 61/25 85/7 85/8 85/21 92/14 101/8 104/15 122/19 141/4 141/14 143/7 150/22 151/1 151/5 151/9 152/24 153/13 153/17 153/20 154/2 154/16 155/13 155/19 157/17 158/9 158/19 159/6 159/7 165/20 165/22 166/7 177/24 189/3 190/1 190/5 190/19 193/10 197/5 198/24
Iran [1] 3/24
Ireland [21] 59/8 63/9 64/11 64/18 66/5 66/22 66/23 66/25 70/11 70/18 71/1 71/8

I

Ireland... [9] 71/15 71/23 84/5 128/3 133/14 155/16 167/23 187/17 224/18
Irish [1] 71/16
irrelevant [1] 149/13
irrespective [1] 200/12
is [436]
isn't [1] 59/6
isolate [4] 25/7 46/4 202/11 202/13
isolated [2] 173/18 198/25
isolating [1] 82/12
isolation [8] 42/15 51/6 85/22 141/21 193/13 195/9 197/24 205/17
issue [26] 3/12 12/5 28/13 37/24 43/25 44/10 46/16 61/23 67/6 76/12 78/21 82/4 87/11 88/16 105/20 109/21 134/13 136/10 138/24 142/25 147/25 159/11 167/23 170/3 206/4 216/19
issue being [1] 216/19
issue carefully [1] 147/25
issue has [1] 142/25
issue in [2] 28/13 134/13
issue is [1] 87/11
issue may [1] 136/10
issue national [1] 167/23
issue of [3] 12/5 37/24 82/4
issue prior [1] 109/21
issue risk [1] 78/21
issue to [1] 88/16
issue was [1] 61/23
issued [2] 9/15 199/5
issues [40] 2/2 4/25 5/10 8/18 9/18 19/13 19/20 39/2 39/9 42/8 46/17 46/20 49/24 50/5 60/22 68/21 70/18 77/7 78/23 96/3 99/5 101/9 108/24 110/16 119/4 121/12 121/16 121/18 127/24 138/9 145/6 145/7 151/10 154/4 159/11 159/21 170/17 180/10 204/19 209/20
it [280]
it's [51] 2/5 3/12 5/11 8/10 12/10 12/15 14/23 63/12 64/23 71/6 88/25 94/8 109/5 111/22 116/6 119/8 119/10 119/13 119/18 120/1 120/1 130/23 130/24 140/11 140/13 140/13 140/17 143/6 143/12 144/5 145/1 146/23 146/24 162/7 166/16 166/17 174/23 174/23 181/8 185/18 185/22 194/17 200/18 201/16 203/8 205/25 214/6 217/18 218/12 220/5 220/20
it.wasn't [1] 136/12
Italian [1] 3/25
items [1] 27/25
its [54] 1/19 8/21 13/24 14/1 18/14 25/25 26/10 28/14 28/15 37/23 39/4 56/25 67/7 68/21 68/22 75/13 77/2 77/24 77/25 78/11 80/22 83/24 84/10 84/16 84/24 86/5 86/19 90/7 90/8 91/9 103/8 108/16 113/15 115/15 116/7 129/13 131/25 141/15 143/2 147/9 147/12 148/13 151/17 152/10 154/7 158/19 180/11 185/12 207/15 209/16 211/20 212/5 218/12 218/23
itself [8] 6/19 79/16 100/1 135/16 140/16 154/1 157/7 157/9
ITU [1] 216/10
IWGB [4] 95/17 96/18 99/6 101/11

J

Jackie [3] 211/4 212/12 212/18
Jackie O'Sullivan [2] 211/4 212/12
Jacobs [5] 72/4 72/6 88/25 220/8 224/21
January [1] 67/21
Javid [3] 115/18 136/16 182/10
JCVI [1] 185/2
Jean [1] 169/5
Jean White [1] 169/5
Jeane [1] 170/3
Jeane Freeman [1] 170/3
Jenny [9] 104/14 136/16 137/24 138/14 163/23 170/23 172/20 184/24 186/24
Jenny Ward [3] 163/23 170/23 172/20
jeopardising [1] 125/25
Joanne [1] 16/19
job [2] 98/8 133/9
jobs [2] 105/17 177/19
John [5] 38/4 38/6 49/2 59/15 224/14
John Sullivan [1] 59/15
John's [6] 60/9 121/7 121/9 154/22 176/14 225/8
John-Charles [1] 38/4
Johnson [1] 96/22
joined [2] 134/10 170/16
joined-up [1] 170/16
Jonathan [2] 38/17 43/14
Jonathan Rees [2] 38/17 43/14
Jones [7] 60/9 69/14 114/4 147/23 148/22 157/19 207/23
Josh [1] 50/22
Josh Miller [1] 50/22
Journal [2] 34/19 198/2
journey [3] 1/9 3/15 162/24
Jr [1] 107/15
JS [1] 110/12
judge [1] 5/11
judgment [2] 156/20 160/2
judgments [1] 89/21
Judith [1] 163/6
Judith Paget [1] 163/6
Julia [1] 60/9
Julia Jones [1] 60/9
July [3] 167/24 172/14 200/5
June [7] 67/22 79/22 102/1 168/13 169/20 200/5 218/20
junior [2] 129/10 207/23
just [38] 14/24 25/1 26/23 29/9 32/18 33/8 51/5 59/3 59/3 60/18 65/7 65/9 89/19 108/19 110/24 112/9 113/24 116/5 119/18 119/23 120/1 125/12 127/3 127/25 130/6 130/21 133/11 133/11 144/19 150/8 155/1 162/8 168/20 187/20 187/21 187/23 206/5 211/11
justice [3] 3/9 59/9 224/19
justifiable [1] 149/7
justification [1] 165/2
justifications [1] 29/20
justified [1] 181/19
justify [3] 30/7 147/4 149/4

K

Kanlungan [3] 95/18 96/18 101/10
Katrina [1] 68/24
Katrina Daly [1] 68/24
Kaye [10] 38/20 41/4 41/21 43/2 43/8 43/17 48/6 52/10 52/16 55/7
Kaye's [1] 47/11
KC [18] 1/15 13/15 59/9 95/12 107/9 121/8 146/17 175/19 207/12 224/6 224/8 224/19 225/3 225/6 225/9 225/14 225/19 225/24
keen [1] 107/2
keep [10] 17/5 42/23 49/25 54/15 55/5 63/10 123/3 133/2 139/19 217/14
keeping [2] 53/20 151/8
kept [2] 61/12 139/22
key [23] 12/10 23/16 39/5 39/9 45/22 47/13 49/24 52/1 56/6 56/21 58/15 84/6 89/15 95/25 105/22 111/2 113/22 121/13 122/21 125/24 150/11 154/19 155/1
Khaw [1] 165/17
Kids [2] 175/21 186/6
Kids' [1] 186/14
Kim [2] 131/15 161/13
Kim Harrison [1] 131/15
kind [2] 10/22 162/9
King [1] 107/15
King's [4] 1/12 71/3 121/5 175/15
King's Counsel [3] 1/12 121/5 175/15
Kingdom [1] 192/13
Kloer [7] 15/8 15/10 18/8 18/17 19/10 19/20 22/13
Kloer's [1] 19/4
knew [7] 64/20 67/14 101/3 101/4 148/4 148/6 192/2
knock [1] 140/7
knock-on [1] 140/7
knocked [1] 163/18
know [22] 9/6 11/12 15/1 32/21 52/18 64/2 69/16 71/14 89/25 106/3 107/11 133/12 145/9 154/2 159/23 166/25 215/2 215/3 218/11 218/11 219/1 219/19
knowledge [5] 10/17 50/10 94/23 150/1 167/15
known [12] 4/3 28/19 31/21 64/20 73/24 109/21 115/10 119/4 135/23 147/21 148/12 197/22
knows [4] 87/2 95/14 220/3 220/3

L

label [1] 132/12
labour [5] 98/2 98/12 165/11 166/5 169/2
lack [41] 6/25 9/4 10/8 17/19 23/19 24/3 25/7 25/8 30/19 34/9 39/12 44/20 45/4 46/16 48/24 51/15 56/13 65/21 76/2 77/7 102/13 103/22 104/5 110/15 115/21 116/17 117/4 117/24 125/6 136/14 136/19 156/11 170/16 173/4 180/11 183/23 190/13 200/6 201/9 202/20 206/11
lacked [2] 109/16 165/1
lacking [1] 76/1
lacks [2] 79/20 200/8
ladder [1] 204/4
Lade [1] 199/9
laden [1] 216/11
Lady [142] 1/16 13/7 13/16 18/5 22/5 22/13 22/21 37/25 38/7 38/9 39/1 39/8 39/23 41/12 41/14 42/3 43/24 43/25 45/20 46/16 46/23 47/8 48/13 48/20 49/1 49/8 49/9 58/18 58/25 59/3 59/10 61/8 61/18 62/19 64/8 64/23 65/6 65/7 65/25 66/4 70/13 70/15 71/14 71/20 71/22 72/7 73/19 78/13 80/13 87/5 88/18 88/21 89/5

L

Lady... [89] 94/21 95/7 95/13 96/21 106/10 106/16 106/19 106/25 107/7 107/10 107/11 108/2 109/8 110/21 112/8 112/22 113/20 114/19 116/5 118/12 118/20 119/17 120/4 120/18 121/2 121/9 122/4 123/12 123/18 125/5 127/24 130/7 130/14 130/20 130/21 131/3 131/12 133/22 136/10 139/25 142/14 143/25 145/8 146/18 146/22 147/10 147/19 149/18 151/4 151/12 151/23 152/9 158/8 158/14 158/24 159/20 160/23 168/5 171/11 175/14 175/20 188/15 193/25 194/4 194/5 207/7 207/13 208/1 209/6 209/18 210/15 212/18 213/12 214/18 214/25 215/15 216/1 217/2 218/10 219/4 219/16 220/12 220/19 221/6 221/25 222/2 222/17 222/21 223/2
Ladyship [11] 89/8 91/19 95/14 95/18 95/21 97/6 99/5 101/1 103/16 106/1 169/22
lag [1] 210/18
laid [3] 25/25 107/19 159/12
land [1] 76/13
landscape [1] 20/17
language [3] 122/10 143/17 198/13
large [8] 20/1 25/6 50/23 70/19 80/17 129/23 168/3 181/17
largely [3] 60/22 113/9 114/23
larger [1] 80/10
largest [2] 74/10 102/24
last [16] 12/7 32/18 49/15 53/20 114/16 149/2 175/10 187/14 190/24 194/24 200/4 207/4 207/9 211/8 216/10 221/6
lasting [2] 71/25 117/10
Lastly [2] 15/21 35/3
late [8] 33/20 100/11 100/14 162/22 163/7 198/20 218/20 218/22
late June 2020 [1] 218/20
later [8] 132/19 151/6 167/12 170/6 171/20 196/6 210/18 219/19
lateral [2] 19/16 40/5
latest [3] 31/21 55/20 189/19
latter [7] 8/15 8/23 27/10 125/18 140/4 183/21 201/16
laugh [1] 201/5
launch [1] 182/15
Laura [2] 151/5 155/25
Laura Imrie [1] 155/25
Laura Imrie's [1] 151/5
Lauren [1] 68/25
Lauren Mallon [1] 68/25
law [4] 104/22 129/13 146/2 149/17
lawyers [1] 207/19
lay [2] 6/6 138/10
layer [1] 102/18
layers [2] 85/15 204/9
leached [1] 217/22
lead [7] 63/17 63/17 91/7 109/7 120/17 160/8 181/17
leaders [2] 24/9 167/11
leadership [12] 37/4 71/23 76/25 108/17 119/22 147/6 152/7 159/6 159/11 159/14 159/24 220/6
leading [6] 57/17 105/2 110/18 148/13 162/2 221/19
leads [4] 7/2 43/24 77/17 221/10
learn [10] 16/9 21/12 66/9 78/20 134/22 153/8 156/25 160/9 176/19 215/18
learned [14] 2/23 14/16 19/19 20/24 64/1 64/4 66/5 70/10 78/17 105/22 109/7 120/7 129/7 221/15
learning [27] 5/7 6/11 9/15 15/15 15/19 15/23 20/22 20/25 21/2 21/25 22/3 22/5 61/16 76/25 89/22 91/4 91/16 93/19 93/20 127/15 210/25 211/16 212/2 212/8 215/8 220/3 221/4
learnings [1] 221/11
learnt [6] 8/15 12/6 21/22 58/12 207/21 220/17
least [16] 11/14 20/14 64/6 74/15 81/5 84/18 101/18 124/7 136/13 148/20 153/7 169/20 174/23 185/12 222/7 222/18
least June 2020 [1] 169/20
leave [2] 120/6 120/7
leaving [4] 31/19 63/22 117/2 219/14
led [13] 2/13 40/24 57/12 64/14 98/11 110/5 115/16 133/21 141/5 167/9 172/1 181/15 209/21
LeDeR [1] 215/8
left [26] 30/21 32/3 34/23 60/13 60/13 68/23 97/23 104/5 107/21 108/4 108/13 110/22 116/16 116/18 120/10 120/11 130/17 162/9 162/11 165/14 173/18 186/3 187/3 187/4 203/5 218/5
legacy [5] 60/12 71/17 107/18 130/17 141/23
legal [5] 85/18 129/11 129/15 208/20 219/6
legality [1] 126/6
legislation [1] 149/20
legislative [1] 130/8
legitimately [1] 140/12
lengths [2] 27/24 39/24
less [16] 11/5 35/1 37/6 37/14 47/1 50/7 82/17 83/6 85/19 106/5 115/12 124/17 177/20 195/20 195/21 199/12
lesson [6] 14/20 73/6 81/9 169/17 219/3 221/22
lessons [29] 2/22 4/25 5/7 6/15 8/15 11/22 12/6 14/16 15/15 16/9 19/19 21/12 21/25 22/4 58/11 64/1 64/4 70/10 78/16 78/20 89/22 91/4 91/12 105/22 109/6 120/7 207/21 220/17 221/15
let [12] 23/6 111/9 117/6 118/12 118/20 120/6 120/7 120/12 120/17 134/22 166/11 186/10
letter [2] 67/22 209/3
letters [4] 132/17 208/10 208/22 212/7
level [19] 2/24 4/10 4/10 5/17 7/21 34/11 41/24 75/20 86/7 91/21 129/10 137/8 137/9 183/20 190/5 190/9 208/13 210/21 220/10
levels [9] 30/2 34/10 46/23 57/2 86/9 87/24 114/9 190/4 190/10
levers [1] 4/12
liable [1] 200/9
lies [3] 104/20 109/1 132/12
life [24] 18/25 33/10 44/7 56/9 58/8 59/19 67/18 67/19 73/4 88/23 108/18 110/22 113/12 119/25 149/11 178/1 185/13 192/2 196/8 203/1 203/21 207/6 212/6 215/25
life-changing [1] 185/13
life-critical [1] 58/8
lifesaving [1] 66/15
lifted [1] 135/25
lifting [1] 32/25
light [4] 2/15 28/16 43/15 44/10
like [34] 1/18 1/20 2/24 13/23 13/23 22/9 22/15 29/18 32/20 63/9 68/20 68/23 68/24 89/6 96/3 100/11 101/10 101/10 103/7 124/2 130/10 134/11 136/2 136/18 139/20 153/4 154/18 171/22 174/12 174/24 180/20 213/18 216/14 221/4
likelihood [1] 195/16
likely [17] 9/8 12/15 22/25 31/10 31/17 34/25 74/16 82/25 83/1 83/4 83/5 85/19 85/21 87/3 89/25 135/24 139/8
likewise [2] 124/1 163/6
limit [5] 40/8 70/17 75/23 80/22 221/17
limitations [2] 92/8 189/3
limited [10] 11/9 51/13 68/18 70/21 112/5 113/4 133/25 168/18 213/6 213/7
limiting [1] 81/6
limits [1] 5/2
line [4] 14/19 90/24 148/7 188/18
liners [1] 28/9
lines [2] 6/23 54/17
linguistic [1] 110/4
linked [3] 88/1 172/11 189/5
Lisa [4] 143/17 155/2 155/22 165/17
Lisa Ritchie [3] 143/17 155/2 165/17
Lisa Ritchie's [1] 155/22
list [8] 20/6 66/4 66/6 157/2 157/5 157/7 157/8 219/10
listen [8] 14/10 14/14 62/9 62/20 63/3 67/12 130/7 153/3
listened [16] 61/21 62/2 62/19 64/12 66/8 66/11 66/24 67/15 68/1 68/11 68/19 69/20 96/10 101/11 152/22 188/7
listening [6] 3/11 43/9 63/5 64/14 121/14 156/24
lists [1] 23/8
little [11] 63/5 71/7 76/11 118/3 125/10 125/16 163/20 187/24 206/5 219/7 220/6
live [5] 59/15 64/7 112/4 166/13 192/2
lived [6] 19/12 109/10 112/24 165/2 213/20 214/9
livelihoods [1] 188/18
lives [23] 11/4 22/12 33/13 69/25 87/11 96/23 97/1 100/24 108/13 110/23 116/4 120/14 122/2 122/23 123/7 130/16 130/18 145/4 159/23 162/8 162/12 191/1 198/21
living [10] 33/17 102/8 112/6 126/2 134/1 166/9 210/24 218/3 219/9 220/1
loaned [1] 28/8
local [23] 5/20 9/20 9/21 9/22 9/23 13/18 17/12 17/25 19/10 20/15 41/8 53/7 53/8 80/4 126/19 157/20 166/23 167/16 167/17 168/3 174/7 210/20 220/25
located [2] 41/17

L

located... [1] 220/24
location [1] 65/24
locations [1] 98/8
lockdown [3] 9/16 196/20 208/9
locked [2] 171/13 199/1
Lockhart [3] 196/18 197/16 203/20
logistical [1] 113/25
London [1] 198/3
long [156] 27/7 31/19 32/11 32/12 37/5 37/7 37/11 40/17 41/10 42/22 46/19 58/11 59/15 60/5 60/6 61/23 65/5 65/13 66/6 71/11 75/8 79/12 79/17 101/14 117/6 117/7 117/7 125/9 127/1 135/14 136/15 140/25 161/22 161/23 163/15 168/4 175/18 175/20 175/21 175/21 175/21 175/22 176/1 176/2 176/5 176/7 176/9 176/10 176/18 176/22 177/8 177/10 177/17 177/21 177/23 178/3 178/11 178/13 178/14 178/17 178/19 178/20 178/23 179/2 179/3 179/7 179/13 179/14 179/17 179/18 179/24 180/1 180/4 180/9 180/11 180/13 180/14 180/16 181/3 181/6 181/7 181/9 181/12 181/15 181/21 182/1 182/7 182/11 182/16 182/19 182/21 182/22 182/25 183/1 183/6 183/8 183/10 183/12 183/16 183/19 183/25 184/2 184/5 184/10 184/11 184/16 184/19 184/21 184/23 185/3 185/4 185/6 185/8 185/14 186/4 186/6 186/11 186/14 186/19 187/2 187/6 187/8 187/11 187/16 188/9 188/10 188/12 188/15 188/24 189/4 189/7 189/17 190/16 191/1 191/2 191/9 191/15 191/17 191/20 191/23 191/25 192/3 192/10 192/15 192/16 193/5 193/12 193/16 193/20 193/22 200/6 206/12 212/3 213/13 215/14 225/19
Long Covid [105] 27/7 31/19 32/12 37/5 37/7 37/11 60/5 61/23 71/11 101/14 117/6 117/7 175/18 175/20 176/1 176/7 176/9 176/10 176/18 176/22 177/8 177/10 177/17 177/21 178/3 178/13 178/14 178/17 178/19 178/23 179/3 179/14 179/17 179/18 179/24 180/1 180/9 180/11 180/13 180/14 180/16 181/3 181/6 181/7 181/9 181/12 181/15 181/21 182/1 182/7 182/16 182/19 182/22 182/25 183/1 183/6 183/8 183/10 183/16 183/19 183/25 184/2 184/5 184/10 184/11 184/19 184/21 184/23 185/3 185/4 185/6 185/8 185/14 186/4 186/6 186/11 186/14 186/19 187/2 187/11 187/16 188/9 188/10 188/12 188/15 189/4 189/7 189/17 190/16 191/2 191/9 191/15 191/17 191/20 191/23 191/25 192/3 192/10 192/16 193/5 193/12 193/16 193/20 193/22 225/19
Long Covid Physio [1] 32/11
Long Covid's [1] 178/20
long hours [2] 41/10 42/22
long-standing [2] 65/5 65/13
long-term [21] 46/19 58/11 79/12 117/7 127/1 135/14 136/15 161/22 161/23 163/15 176/2 178/11 179/2 179/7 179/13 180/4 183/12 187/6 187/8 188/24 212/3
longer [10] 58/12 80/4 136/25 144/22 159/5 191/12 193/2 197/8 202/23 207/5
longer-term [1] 58/12
look [12] 10/18 13/8 20/7 29/18 91/18 152/3 184/4 193/22 195/18 212/19 217/9 217/13
looking [7] 5/8 44/25 49/18 54/15 58/10 131/25 160/18
looks [1] 160/22
loosely [1] 8/9
lopsided [1] 63/20
Lord [4] 57/13 97/7 98/20 103/23
Lord Darzi [3] 57/13 98/20 103/23
Lord Darzi has [1] 97/7
Lords' [2] 12/21 12/22
lose [1] 163/17
losing [2] 158/16 192/12
loss [11] 30/23 72/16 73/3 88/22 113/12 133/17 133/17 159/20 173/3 173/16 176/11
lost [8] 69/25 71/18 94/8 108/13 110/23 120/15 158/22 197/7
lot [7] 12/25 14/8 14/23 133/9 134/8 140/8 142/5
lotteries [1] 9/24
lottery [2] 166/21 167/15
love [1] 123/4
loved [12] 25/13 60/15 69/2 69/4 122/15 122/23 123/3 123/4 125/23 126/24 130/2 163/13
low [12] 23/10 82/25 86/13 97/18 98/19 101/23 102/8 102/9 105/6 135/23 142/19 193/10
low-hanging [2] 142/19 193/10
low-income [2] 98/19 101/23
Low-paid [1] 102/8
low-quality [1] 102/9
lower [6] 30/2 45/17 49/20 54/3 84/10 87/23
lowest [4] 34/3 99/3 100/18 102/6
lunacy [1] 198/11
lunch [1] 107/2
Luther [1] 107/15

M

M3 [1] 11/25
MacDermott [3] 32/11 158/3 158/4
made [29] 7/17 28/7 28/9 35/16 44/10 61/2 71/22 73/7 80/2 90/20 102/13 108/11 108/24 109/19 114/10 124/7 128/16 129/10 159/25 163/17 164/20 175/3 175/4 185/5 194/5 212/11 213/9 220/8 221/18
madness [1] 198/12
magic [2] 15/2 25/1
magnificently [1] 2/16
magnified [1] 99/4
main [5] 16/14 23/19 63/25 170/18 201/25
mainly [3] 168/6 168/8 171/15
maintain [6] 52/23 53/1 53/2 62/10 94/5 155/21
maintained [3] 39/24 47/19 173/15
maintaining [3] 21/3 40/6 46/23
maintenance [1] 23/10
major [2] 101/8 159/17
majority [5] 13/18 13/22 38/11 53/4 131/19
make [48] 1/16 2/24 11/7 13/4 13/16 14/8 35/4 35/11 47/14 47/16 60/6 60/18 64/6 78/9 82/16 95/22 96/13 106/5 127/18 127/25 128/9 129/3 129/5 131/6 132/3 132/4 132/7 138/5 144/8 144/24 144/25 146/12 149/5 151/17 152/2 153/11 156/20 176/19 178/6 178/25 182/2 190/18 193/18 194/15 210/24 212/1 217/16 220/16
makers [8] 4/1 8/4 29/2 109/24 114/9 150/12 190/6 213/15
makes [3] 103/25 142/11 180/3
makeshift [2] 27/25 114/20
making [29] 1/25 3/4 7/1 10/3 10/4 52/22 72/25 96/16 98/16 110/16 111/19 112/20 119/13 125/14 132/6 135/11 138/17 139/6 142/15 158/24 159/24 160/12 177/1 178/8 210/20 213/14 214/13 215/21 222/12
male [1] 114/24
malfunction [1] 65/8
malintent [1] 7/3
Mallon [2] 68/3 68/25
man [1] 114/24
manage [5] 14/11 58/13 92/3 123/5 172/6
managed [2] 44/15 208/17
management [9] 19/6 44/20 56/12 84/3 91/4 93/1 94/18 116/20 182/22
managers [2] 100/15 104/23
manages [1] 68/14
managing [1] 42/14
mandate [1] 88/4
mandated [1] 157/22
mandates [1] 193/9
manifested [3] 100/1 108/10 109/12
manifestly [1] 203/2
manifests [1] 111/14
manner [1] 66/19
manufacturing [2] 58/7 86/8
many [79] 2/11 3/6 3/9 6/14 10/24 10/24 13/1 15/18 20/3 25/12 31/18 32/9 40/3 40/17 41/9 42/8 45/5 45/21 52/14 57/18 60/2 60/6 60/17 61/5 61/6 61/6 61/7 61/11 61/21 62/4 63/22 68/25 75/25 76/7 76/14 81/18 90/17 97/17 100/4 102/20 108/24 112/3 112/23 114/11 114/18 116/15 121/13 121/13 121/14 121/16 123/2 124/5 125/7 127/5 127/9 130/18 131/20 133/6 133/18 134/10 134/21 136/7 136/18 137/9 141/16 145/25 148/7 148/16 157/10 166/4 166/5 166/19 167/11 174/16 174/17 192/11 193/19 203/24 206/25
many months [1] 134/10
marathon [1] 183/2
March [13] 9/16 31/22 40/13 56/5 107/17 156/9 185/9 196/6 197/4 197/15 211/9 216/3 217/23
March 1966 [1] 107/17
margins [1] 69/20
mark [1] 61/18
marked [3] 74/14

M

marked... [2] 136/19 184/20
markedly [1] 197/2
Marshall [2] 99/6 105/19
Marshall: [1] 104/10
Martin [1] 107/15
Martina [1] 68/20
Martina Ferguson [1] 68/20
mask [7] 28/23 31/6 139/4 144/11 156/21 170/10 193/8
mask wearing [1] 170/10
masks [24] 28/1 28/6 28/24 51/18 53/9 100/6 114/7 136/2 143/4 143/5 143/5 143/18 144/4 144/7 144/24 150/18 151/11 155/6 156/12 156/13 156/15 189/24 190/2 193/2
mass [3] 3/24 89/9 96/13
massive [3] 55/3 185/21 208/11
material [3] 89/9 188/14 208/19
materialised [1] 10/23
materials [1] 114/19
maternal [1] 162/2
maternity [9] 167/13 168/20 168/24 170/10 171/8 171/12 171/16 171/20 173/14
Matt [14] 44/9 62/17 78/1 78/5 127/17 137/24 139/11 140/19 150/25 169/19 200/10 208/11 210/4 219/22
Matt Hancock [11] 44/9 62/17 78/1 78/5 127/17 137/24 139/11 150/25 169/19 200/10 210/4
Matt Hancock's [2] 140/19 219/22
Matt Stringer [1] 208/11
matter [8] 14/15 30/24 75/10 112/8 131/2 162/19 201/16 213/21
matters [14] 3/10 6/6 12/19 14/13 19/9 20/4 122/25 124/4 132/11 162/10 173/1 178/1 185/17 207/1
maximise [2] 44/16 172/5
maximum [1] 36/5
may [41] 12/9 14/4 27/2 38/10 47/10 53/19 69/10 75/16 80/14 81/8 83/23 94/1 94/8 94/9 101/22 107/1 115/18 116/14 123/4 123/10 136/10 151/4 153/20 154/15 157/2 158/8 167/8 168/14 168/24 169/21 171/4 172/14 179/9 197/4 199/22 211/14 211/17 216/19 216/22 216/24 217/22
May 2022 [1] 168/14
maybe [2] 78/5 108/8
McArdle [1] 128/2
McBride [2] 25/8 133/15
McBride's [1] 69/11
McFarland [1] 186/6
McKay [1] 148/8
McQueen [1] 114/14
me [17] 31/12 32/3 43/24 65/7 68/25 81/16 106/22 107/4 111/9 117/6 118/12 118/20 131/18 143/21 153/23 163/17 163/19
mean [2] 70/15 173/12
meaning [3] 136/2 211/21 218/8
meaningful [7] 62/22 70/9 87/1 109/7 109/7 148/3 221/15
means [9] 75/12 86/6 91/25 119/9 119/15 123/21 149/5 182/1 202/21
meant [19] 19/5 25/3 34/8 34/9 34/21 46/4 53/9 99/11 116/2 117/17 126/4 126/11 180/13 180/21 185/19 186/14 197/6 212/16 213/14
meantime [2] 116/16 142/19
Meanwhile [1] 34/4
measured [1] 4/20
measures [34] 4/21 13/6 25/4 33/16 60/10 83/22 85/3 104/16 116/18 116/25 117/1 122/19 123/1 132/7 132/21 144/3 147/12 147/17 150/2 158/19 160/16 177/24 187/5 189/3 190/11 192/21 193/6 193/8 193/10 197/5 198/24 204/12 206/9 210/22
mechanical [1] 142/11
mechanics [1] 148/1
mechanism [2] 138/19 219/14
mechanisms [2] 79/4 85/10
media [1] 2/7
medical [26] 17/10 18/8 20/13 22/19 22/22 26/20 62/14 89/3 89/12 89/12 91/2 99/18 107/16 115/5 115/22 116/2 119/15 123/14 133/14 134/20 180/14 186/21 210/13 219/11 224/10 224/23
medically [1] 164/14
medication [2] 40/15 132/19
medications [1] 57/18
medicine [7] 50/15 50/19 55/4 57/17 57/23 58/3 58/6
medicines [13] 40/6 41/7 41/9 41/11 43/5 50/11 50/14 50/18 51/10 51/12 54/21 57/24 58/8
meet [11] 19/3 20/1 24/20 75/18 79/9 92/16 199/24 199/25 201/2 202/21 205/8
meetings [1] 154/16
melancholy [1] 198/11
member [5] 32/19 50/24 55/1 90/22 124/2
members [27] 15/6 16/3 33/11 33/15 40/11 42/8 43/10 43/12 43/18 43/21 43/25 46/12 52/14 90/23 95/19 96/18 96/24 99/1 99/9 113/1 122/24 123/1 125/19 133/23 158/3 193/20 196/21
membership [1] 41/22
memorably [1] 195/24
memories [1] 59/16
Mencap [5] 130/13 211/24 212/5 212/14 212/25
Meng [1] 165/17
mental [48] 9/17 23/11 33/22 33/23 34/2 42/7 55/3 55/17 92/12 118/12 118/14 118/19 129/6 134/2 181/20 194/7 194/20 195/1 195/7 196/12 196/16 197/1 197/17 197/19 197/23 198/4 198/19 199/4 199/11 199/16 200/20 201/19 202/2 202/6 202/21 203/3 203/4 203/9 203/12 203/22 204/8 204/10 204/24 205/24 206/19 206/22 207/1 207/3
mentally [1] 202/16
mention [4] 43/24 56/5 59/14 128/17
mentioned [2] 29/24 116/14
mere [3] 107/25 198/8 198/8
merely [2] 28/21 118/24
merits [1] 206/5
mess [1] 167/19
message [6] 107/4 171/5 181/22 182/11 198/13 200/1
messages [3] 133/1 133/4 181/17
messaging [15] 93/14 93/15 93/16 110/2 178/12 180/8 180/11 181/12 181/14 181/25 182/8 182/15 182/16 186/18 209/24
met [5] 33/21 112/21 180/23 186/3 208/21
methodology [2] 154/11 215/20
methods [3] 87/14 155/24 172/16
metre [2] 53/1 157/21
metres [3] 32/5 157/22 183/2
metrics [1] 118/11
Michael [2] 25/8 69/11
Michael McBride [1] 25/8
mid [1] 167/24
middle [2] 18/2 65/1
midnight [1] 42/20
midst [1] 3/22
midwife [1] 172/1
midwife-led [1] 172/1
midwives [3] 24/18 74/9 172/23
Midwives' [1] 167/3
might [22] 29/11 29/12 66/24 67/15 67/20 67/23 68/1 68/8 68/11 68/16 68/19 130/16 135/13 170/1 199/21 208/3 208/5 213/9 217/19 219/3 219/18 222/6
migrant [29] 34/23 63/13 85/15 85/25 95/11 95/14 95/23 96/6 96/17 98/12 99/11 100/5 100/19 101/19 101/21 102/22 103/3 103/9 103/12 103/14 104/11 105/7 105/23 106/12 106/13 176/15 192/7 192/11 225/2
migrants [3] 101/18 102/6 192/8
mild [1] 180/20
military [3] 65/18 79/5 81/3
milk [1] 164/22
Miller [3] 50/22 51/10 51/14
million [8] 4/5 23/9 41/13 73/4 79/17 124/21 125/2 176/20
mind [11] 20/11 124/21 146/14 194/3 194/6 194/6 194/9 200/2 201/24 206/15 225/21
mind's [3] 61/3 205/5 207/7
minds [2] 48/11 158/21
minimal [1] 186/13
minimise [1] 89/23
minimised [2] 90/15 187/9
minimising [2] 50/19 186/22
minister [6] 14/3 14/17 65/23 187/22 189/22 189/22
ministerial [1] 75/20
ministers [1] 62/17
minor [1] 41/2
minorities [1] 109/13
minority [43] 34/20 41/23 73/20 73/24 74/8 74/20 75/22 82/23 84/11 84/15 87/25 88/1 101/17 107/8 107/21 108/16 109/11 110/3 110/7 110/9 110/15 110/20 112/2 112/4 112/11 112/19 112/24 113/11 114/11 115/9 115/16 116/4 116/9 116/15 117/8 117/15 118/2 118/13 118/21 171/9 174/9 204/6 225/5
minute [1] 221/6
minutes [1] 151/9
mirrors [1] 164/2

M

miscarriage [1] 163/11
misconception [1] 180/19
misconceptions [1] 215/24
mishandled [1] 218/7
misinformed [1] 187/3
misled [1] 157/24
misplaced [1] 65/14
missed [1] 196/2
misses [1] 87/11
missing [4] 24/23 165/13 172/13 195/15
mistake [5] 25/23 160/7 160/9 195/9 210/24
mistakes [2] 120/2 221/18
mistrust [2] 60/12 110/5
misunderstanding [1] 75/21
misunderstood [4] 64/16 81/6 110/19 165/24
misuse [1] 214/25
misused [1] 218/7
mitigate [5] 104/25 116/23 118/4 184/19 206/9
mitigated [1] 5/9
mitigations [1] 136/1
mobile [1] 51/11
model [3] 80/16 143/22 219/12
modelling [5] 10/19 10/22 20/18 36/16 79/13
modern [2] 20/9 80/10
modernising [1] 142/10
modes [2] 141/1 149/25
modest [1] 209/20
modification [1] 126/8
modified [1] 210/16
module [43] 2/21 22/24 23/25 38/8 38/13 39/4 46/11 48/24 49/11 59/12 61/19 70/17 70/20 73/6 73/25 76/9 76/13 77/22 87/7 88/16 88/23 89/6 95/20 96/1 97/7 113/22 121/11 121/18 122/21 129/8 136/13 139/18 147/14 148/6 150/4 160/22 171/19 175/20 187/9 187/10 194/12 195/5 207/15
Module 1 [3] 23/25 97/7 147/14
Module 2 [2] 148/6 150/4
Module 3 [11] 38/8 39/4 48/24 95/20 96/1 113/22 136/13 139/18 175/20 194/12 207/15
Module 6 [1] 88/16
Module 8 [1] 187/10
module's [1] 2/19
Modules [1] 136/11
moment [4] 65/7 120/12 120/16 217/18
moments [3] 69/2 125/24 173/11
money [2] 14/23 44/17
mongering [1] 94/13
monitored [3] 173/24 184/25 192/15
monitoring [3] 167/16 168/12 199/2
monitors [1] 144/13
month [3] 34/20 55/21 67/21
months [8] 4/2 42/16 45/7 54/17 134/10 138/13 167/24 210/18
moral [6] 8/21 34/7 72/16 108/17 113/25 127/6
morale [2] 23/12 34/3
more [88] 3/8 3/18 4/19 4/20 5/9 7/14 7/24 8/6 9/1 17/4 23/4 23/15 24/12 29/17 32/5 32/9 33/3 34/25 35/23 36/8 36/19 40/14 40/16 41/2 44/21 50/4 55/19 56/13 59/19 61/8 68/21 70/7 73/2 80/9 82/16 82/18 82/24 83/4 83/5 85/21 87/3 89/17 89/19 93/12 98/8 105/15 106/4 108/19 109/19 109/25 127/21 127/22 128/5 137/15 138/5 138/7 138/23 139/8 142/5 142/5 142/21 142/22 144/12 144/24 149/22 151/6 151/22 167/12 168/25 170/1 177/3 181/11 183/5 185/5 189/13 196/23 197/10 199/21 202/23 206/5 208/24 213/7 214/8 214/16 217/15 218/11 219/25 220/19
Moreover [1] 37/9
Morgan [2] 14/17 169/12
morning [13] 1/4 1/7 1/11 38/7 43/20 58/25 59/3 72/7 88/19 150/15 191/7 192/5 220/14
Morris [1] 172/4
mortality [14] 101/14 101/21 101/24 102/5 102/7 103/1 103/3 103/8 103/9 103/15 118/18 218/10 218/17 219/2
mortgage [1] 43/23
most [32] 24/22 38/12 41/19 44/5 50/12 60/14 61/19 74/14 74/16 92/23 97/10 97/15 99/3 102/8 105/1 107/13 107/13 110/17 113/15 117/3 132/3 135/15 138/12 153/5 154/23 157/21 172/20 203/13 203/15 203/17 208/5 218/23
mostly [1] 145/23
mother [2] 162/4 173/2
mothers [1] 123/16
motivated [1] 160/5
move [8] 9/13 51/23 86/10 140/24 187/23 202/13 205/2 205/13
moved [5] 97/19 98/21 98/22 149/9 172/23
moving [11] 3/19 5/17 9/14 25/13 26/3 99/20 122/24 209/18 210/8 213/11 214/19
Mr [83] 13/13 13/15 22/17 22/18 22/20 38/1 38/4 38/6 44/14 45/13 49/2 51/10 51/14 64/21 65/9 65/22 67/3 67/9 67/20 69/9 70/13 71/3 72/4 72/6 75/6 88/25 89/2 89/4 95/8 103/13 105/9 106/22 107/1 107/5 120/19 121/5 121/6 121/8 131/4 131/8 131/10 131/16 140/2 146/11 146/15 146/17 150/25 151/8 156/5 160/24 160/25 161/9 169/22 175/7 189/25 190/4 194/2 194/3 207/8 207/9 207/12 207/24 209/2 213/8 213/12 213/18 214/11 216/17 217/24 220/5 220/8 222/22 224/8 224/11 224/14 224/21 224/24 225/9 225/11 225/14 225/17 225/21 225/24
Mr Burton [4] 207/9 207/12 222/22 225/24
Mr Dawson [2] 64/21 65/9
Mr Dawson's [1] 67/20
Mr Hancock [13] 44/14 45/13 75/6 103/13 105/9 140/2 150/25 151/8 189/25 190/4 216/17 217/24 220/5
Mr Hancock's [1] 169/22
MR HENDERSON [3] 89/4 95/8 224/24
Mr Hyam [1] 22/17
MR HYAM KC [2] 13/15 224/8
Mr Jacobs [5] 72/4 72/6 88/25 220/8 224/21
MR JOHN-CHARLES [3] 38/6 49/2 224/14
Mr Miller [2] 51/10 51/14
Mr Pezzani [4] 194/2 194/3 207/8 225/21
Mr Philippa [1] 207/24
Mr Rawat [1] 156/5
Mr Scott [1] 65/22
Mr Simblet [2] 146/15 160/24
Mr Stanton [4] 22/18 22/20 38/1 224/11
Mr Stringer [3] 209/2 213/8 213/12
Mr Swann [3] 67/3 67/9 70/13
Mr Swann's [1] 69/9
Mr Thomas [4] 106/22 107/1 107/5 120/19
Mr Wagner [5] 146/11 160/25 161/9 175/7 225/17
Mr Wilcock [1] 71/3
Mr Wolfe [4] 121/5 121/6 131/4 131/16
MR WOLFE KC [2] 121/8 225/9
Mr Yousaf [1] 213/18
Mr Yousaf's [1] 214/11
Mrs [1] 212/15
Mrs O'Sullivan [1] 212/15
Ms [51] 1/6 1/11 1/14 1/15 3/16 4/19 6/11 10/20 13/3 13/10 21/9 21/18 49/4 49/7 58/19 59/2 59/6 59/7 59/9 63/7 66/19 68/24 68/24 72/2 72/9 95/10 95/12 106/20 121/3 132/1 150/15 153/6 162/4 165/6 175/15 175/16 175/17 175/19 194/1 196/4 198/22 200/24 205/25 207/23 219/21 220/15 224/6 224/16 224/19 225/3 225/19
Ms Campbell [3] 59/6 59/7 72/2
MS CAMPBELL KC [2] 59/9 224/19
Ms Carey [3] 1/6 121/3 175/16
Ms Carey's [1] 132/1
Ms Doherty [1] 68/24
Ms Domingo [4] 49/4 49/7 58/19 224/16
Ms Ferguson [1] 68/24
Ms Ferguson's [1] 63/7
Ms Grey [4] 1/11 13/10 150/15 220/15
MS GREY KC [2] 1/15 224/6
Ms Hannett [3] 175/15 175/17 194/1
MS HANNETT KC [2] 175/19 225/19
Ms Imrie [1] 153/6
Ms Jones [1] 207/23
Ms Mullen [1] 165/6
Ms Nield [2] 59/2 200/24
Ms Paget [2] 21/9 21/18
Ms Pashley [1] 198/22
Ms Pashley's [1] 205/25
Ms Pritchard [6] 3/16 4/19 6/11 10/20 13/3 219/21
Ms Sen Gupta [2] 95/10 106/20
Ms Todd [2] 66/19 162/4
much [55] 1/13 3/15 4/13 6/25 9/11 11/4 11/7 12/13 12/16 13/3 13/10 15/22 21/13 22/5 22/16 38/1 41/2 49/3 49/22 58/19 61/8 72/2 72/10 76/23 79/7 82/18 89/1 94/4 95/8

M

much... [26] 106/21 111/2 120/19 121/6 125/6 131/4 142/16 146/10 146/11 146/14 160/23 160/24 163/21 169/16 175/7 177/13 183/1 194/1 204/8 204/8 207/8 219/22 220/19 220/22 222/23 223/2
Mullen [2] 164/18 165/6
multi [2] 102/9 112/25
multi-generational [1] 112/25
multi-occupancy [1] 102/9
multidisciplinary [3] 37/6 183/13 184/10
multiple [4] 180/25 190/25 195/10 197/6
mum [1] 185/18
must [62] 22/10 36/14 37/19 47/18 57/2 57/20 58/12 69/19 69/20 69/21 70/8 79/2 79/6 83/21 84/19 85/1 85/5 88/13 89/17 89/18 89/20 89/21 92/6 92/14 92/18 93/22 94/17 104/16 104/18 106/11 106/12 108/6 108/19 108/20 112/14 112/17 112/20 118/11 122/3 123/9 123/9 123/25 124/10 124/13 126/25 127/1 128/6 128/11 131/16 147/8 174/8 187/7 188/7 190/13 206/7 206/19 209/6 210/6 217/3 218/2 220/13 220/17
my [170] 1/16 13/7 13/16 17/3 18/5 22/5 22/13 22/21 32/3 32/4 37/25 38/7 38/9 39/1 39/8 39/23 41/12 41/14 42/3 43/24 43/25 44/24 45/20 46/16 46/23 47/8 48/13 48/20 49/1 49/8 49/9 58/18 58/25 59/3 59/10 61/8 61/18 62/19 64/8 64/23 65/6 65/7 65/25 66/4 66/6 70/13 70/15 71/14 71/20 71/22 72/7 73/19 78/13 80/13 81/16 87/5 88/18 88/21 89/5 89/11 94/21 95/7 95/13 96/21 106/6 106/7 106/10 106/16 106/19 106/25 107/7 107/10 107/11 108/2 109/8 110/21 112/8 112/22 113/20 114/19 116/5 118/12 118/20 118/20 119/17 120/4 120/18 121/2 121/9 122/4 123/12 123/18 125/5 127/24 130/7 130/14 130/20 130/21 131/3 131/12 132/9 133/22 136/10 139/6 139/25 142/14 143/21 143/25 145/8 146/10 146/18 146/22 147/10 147/19 149/18 151/4 151/12 151/23 152/9 158/8 158/14 158/24 159/20 160/23 161/6 161/15 162/20 163/15 163/18 163/19 168/5 170/18 171/11 173/5 175/6 175/14 175/20 185/18 186/3 188/15 193/25 194/4 194/5 207/7 207/13 208/1 209/6 209/18 210/15 212/5 212/6 212/18 213/12 214/18 214/25 215/15 216/1 217/2 218/10 219/4 219/16 220/12 220/19 221/6 221/6 221/25 222/2 222/17 222/21 223/2
my Lady [121] 13/7 13/16 18/5 22/5 22/13 37/25 38/7 38/9 39/1 39/8 39/23 41/12 41/14 42/3 43/24 43/25 45/20 46/16 46/23 47/8 48/13 48/20 49/8 49/9 58/18 58/25 59/3 59/10 61/8 61/18 62/19 64/8 64/23 65/6 65/25 66/4 70/13 70/15 71/14 71/20 71/22 73/19 78/13 80/13 87/5 88/18 88/21 89/5 94/21 95/7 96/21 106/10 106/16 106/19 108/2 109/8 110/21 112/8 112/22 113/20 114/19 116/5 118/12 118/20 119/17 120/4 120/18 121/2 121/9 123/12 123/18 125/5 130/7 130/14 133/22 136/10 139/25 142/14 143/25 145/8 146/18 147/10 147/19 149/18 151/4 151/12 151/23 152/9 158/8 158/14 158/24 159/20 160/23 168/5 171/11 175/14 175/20 193/25 207/7 207/13 208/1 209/6 209/18 210/15 212/18 213/12 214/18 214/25 215/15 216/1 217/2 218/10 219/4 219/16 220/12 220/19 221/25 222/2 222/17 222/21 223/2
Myhill [1] 16/25
myself [1] 42/16

N

namely [1] 178/9
Naqvi [1] 87/24
narrative [4] 2/21 98/13 120/5 149/9
narrower [1] 78/23
Natalie [2] 177/7 180/18
Natalie Rogers [1] 177/7
Nathalie [3] 32/11 158/3 158/4
nation [3] 97/24 182/15 206/24
nation's [2] 49/14 206/23
national [27] 5/18 5/19 6/17 7/2 7/20 9/20 10/12 20/20 38/5 38/9 52/13 58/10 79/12 91/20 92/6 101/20 102/24 116/16 167/23 170/4 175/24 206/7 211/25 214/20 215/6 217/12 224/13
nationally [3] 21/7 93/24 216/7
nations [16] 5/23 31/5 36/1 84/25 93/14 93/16 127/19 170/16 179/4 179/5 179/11 179/22 183/17 184/9 209/15 210/16
nations' [2] 73/5 87/16
naturally [1] 157/13
nature [10] 48/13 52/21 99/11 149/1 152/1 177/14 177/25 190/2 197/1 211/13
navigate [1] 211/6
nearing [1] 67/19
nearly [3] 24/16 124/21 210/12
necessarily [1] 70/21
necessary [17] 4/25 32/13 48/7 69/23 78/10 81/8 82/12 90/5 128/8 152/12 162/15 165/23 167/10 173/21 176/8 181/3 206/16
necessitate [1] 88/24
necessities [1] 119/24
neck [1] 63/23
need [66] 3/18 6/10 9/13 10/10 12/6 12/14 20/7 22/4 25/2 29/21 30/10 35/17 36/17 36/21 41/19 60/10 65/25 76/6 76/18 76/22 77/6 79/9 80/4 80/8 80/9 91/22 92/22 106/14 106/17 112/14 113/22 114/20 117/3 129/22 132/3 132/4 134/22 138/10 138/19 138/20 138/22 138/23 139/3 139/4 142/9 142/21 147/13 149/16 151/13 152/2 152/4 158/25 160/15 162/15 184/21 190/1 190/19 191/10 195/4 195/14 195/20 196/10 197/13 199/13 206/17 220/19
needed [31] 5/23 6/13 24/22 43/5 43/5 44/4 45/18 46/4 48/16 54/3 59/18 75/2 80/6 108/14 109/17 118/9 128/5 134/7 137/1 149/16 152/9 161/6 163/18 163/20 170/22 174/1 183/23 194/24 195/19 202/25 211/22
needing [1] 216/8
needs [35] 5/15 9/23 12/18 18/21 19/3 20/12 22/8 27/18 36/16 41/16 60/4 74/1 75/19 76/24 84/19 85/9 89/16 105/11 112/21 116/9 116/12 122/1 122/10 123/14 124/15 126/21 127/18 128/12 138/8 138/16 140/23 164/10 171/10 173/7 207/21
negative [5] 94/19 94/19 134/1 156/19 173/2
negatives [1] 15/17
neglect [6] 108/3 109/2 110/5 113/9 114/18 120/15
neglected [1] 213/13
negotiated [1] 83/18
Negotiating [1] 40/20
neighbouring [1] 68/6
neither [3] 100/15 179/21 183/11
neonatal [10] 162/17 164/17 164/20 165/7 166/17 168/9 168/13 169/9 170/10 173/14
neonates [2] 166/4 170/14
nervous [1] 140/11
NERVTAG [1] 154/7
nettle [1] 216/24
network [4] 39/25 46/19 47/17 48/16
networks [1] 173/20
never [17] 4/20 23/15 27/16 59/19 65/15 67/25 69/4 69/24 108/11 113/19 116/10 121/20 127/1 143/12 149/7 214/23 218/7
new [13] 36/7 57/25 66/2 130/8 170/12 174/15 174/21 185/6 185/8 191/21 191/25 192/17 198/1
newborn [3] 161/17 166/4 168/15
newly [3] 124/22 185/16 192/1
news [2] 163/9 164/23
next [24] 2/3 12/8 13/13 24/11 34/11 36/18 42/3 47/21 59/6 66/17 73/3 82/4 83/2 93/22 105/13 106/2 137/18 139/6 141/12 141/25 146/15 153/9 169/17 209/12
NHS [137] 1/15 1/17 3/1 3/9 4/8 4/8 5/5 5/14 5/16 5/18 5/20 5/23 6/1 6/7 6/12 6/18 7/11 8/1 9/22 10/9 11/1 11/1 11/17 13/1 13/3 13/19 13/23 14/18 17/21 21/10 21/24 22/2 25/9 25/16 25/24 27/10 33/24 33/25 34/1 34/4 35/15 36/21 37/13 39/20 40/8 41/4 42/12 44/13 44/16 44/17 44/20 45/4 45/6 46/10 48/9 48/10 55/24 56/1 56/12 56/17 57/8 57/12 58/5 58/9 58/11 62/10 74/6 74/10 74/13 76/9 76/23 76/24 77/1 77/8 77/11 77/12 77/16 79/13 79/16 79/17 79/22 82/4 83/7 83/12 84/12 84/24 87/8 96/23 96/25 97/8 97/11

N

NHS... [46] 97/20 97/23 98/3 100/10 102/25 103/5 104/17 106/11 106/15 109/15 115/14 121/24 122/12 124/12 128/4 128/19 128/22 134/14 138/8 140/20 141/20 141/23 142/10 159/1 159/10 163/1 163/3 163/17 168/1 170/3 174/7 174/16 174/17 188/21 199/22 200/12 201/17 208/19 209/22 209/24 210/2 214/21 216/24 220/15 221/13 224/6
NHS 111 [1] 122/12
NHS England [27] 1/17 3/9 4/8 5/5 7/11 8/1 11/1 11/17 13/23 34/4 44/16 44/17 44/20 56/12 76/23 76/24 77/8 77/11 79/13 79/16 83/12 84/24 128/4 163/1 163/3 168/1 220/15
NHS England's [4] 5/16 6/7 74/6 79/17
NHS trusts [1] 98/3
NHS Wales [3] 21/10 77/12 79/22
NHS's [3] 2/8 2/10 128/20
nice [6] 211/5 211/9 211/25 212/6 212/15 217/23
Nicholls [1] 154/22
Nick [12] 38/20 41/4 41/21 43/2 43/8 43/10 43/17 47/11 48/6 52/10 52/16 55/7
Nick Kaye [10] 38/20 41/4 41/21 43/2 43/8 43/17 48/6 52/10 52/16 55/7
Nick Kaye's [1] 47/11
Nicola [2] 32/10 189/5
Nicola Ritchie [2] 32/10 189/5
Nield [2] 59/2 200/24
night [1] 43/20
Nightingale [2] 65/24 80/16
Nightingale-style [1] 80/16
Nightingales [2] 10/21 81/5
nine [2] 35/24 161/19
nine weeks [1] 161/19
Ninth [1] 37/13
Nissen [1] 22/15
no [77] 1/10 3/11 4/3 7/3 8/11 8/16 10/10 12/24 22/6 25/9 28/5 31/15 42/12 51/24 66/18 67/8 67/8 68/13 70/15 75/5 80/19 80/24 81/14 81/16 81/17 83/4 96/6 96/9 99/10 100/8 100/12 100/21 101/11 103/1 103/2 103/17 103/25 116/16 120/10 120/11 121/24 124/15 133/25 136/1 136/1 136/2 136/25 137/11 137/11 137/12 142/7 142/10 142/20 153/16 154/11 159/5 161/4 161/4 162/19 165/2 167/16 168/3 168/11 168/11 168/16 179/18 182/22 186/8 186/18 191/11 193/2 201/4 202/1 204/25 206/3 209/9 214/8
Noakes [1] 148/5
Noakes' [1] 150/4
nobody [2] 153/23 203/11
non [14] 63/24 72/25 98/2 98/12 100/17 106/13 114/15 129/2 135/11 158/12 183/9 188/20 210/5 217/1
non-clinical [5] 98/2 98/12 100/17 114/15 188/20
non-coronavirus [1] 210/5
non-Covid-19 [1] 135/11
non-discrimination [1] 129/2
non-migrant [1] 106/13
non-pandemic [1] 217/1
non-pharmaceutical [1] 72/25
non-pharmacological [1] 183/9
non-State [1] 63/24
none [4] 98/9 179/3 179/11 198/1
nor [7] 5/4 45/25 69/4 69/4 100/15 183/11 217/15
normal [3] 24/2 42/17 42/18
normality [1] 135/21
normally [1] 25/19
Northern [22] 59/8 63/9 64/11 64/18 66/5 66/22 66/23 66/25 70/11 70/18 71/1 71/8 71/15 71/16 71/23 84/5 128/3 133/14 155/16 167/23 187/17 224/18
Northern Ireland [21] 59/8 63/9 64/11 64/18 66/5 66/22 66/23 66/25 70/11 70/18 71/1 71/8 71/15 71/23 84/5 128/3 133/14 155/16 167/23 187/17 224/18
Northover [6] 194/19 197/21 201/23 202/8 203/14 206/6
Northover's [3] 195/18 200/23 206/3
nosocomial [6] 11/23 25/10 25/11 140/1 140/21 142/12
not [310]
notable [2] 17/15 169/18
notably [2] 121/15 188/2
note [7] 17/20 20/3 108/19 123/1 126/19 127/9 132/17
noted [8] 7/10 12/4 57/13 84/11 84/13 88/19 115/18 170/23
notes [1] 145/13
nothing [11] 30/10 33/9 63/2 65/17 67/8 103/13 136/22 142/16 174/22 179/8 214/17
notice [2] 121/22 217/24
noticed [1] 123/19
notices [3] 67/2 121/20 215/13
notify [1] 202/6
notion [1] 78/2
notwithstanding [3] 45/24 69/9 198/15
novel [3] 70/3 119/3 184/16
November [5] 1/1 40/22 53/17 58/1 223/6
now [47] 1/10 3/11 3/12 7/10 10/12 11/25 15/2 21/23 21/23 32/4 32/13 35/9 35/23 39/15 58/21 62/20 105/12 106/9 106/23 107/6 117/10 120/22 138/11 140/24 141/9 141/15 142/21 144/19 149/1 153/11 154/2 158/23 161/3 162/10 175/9 176/21 181/20 183/3 184/1 187/13 193/2 193/24 198/4 206/21 216/1 216/25 219/19
NPA [16] 38/9 38/10 38/17 38/20 39/2 39/19 40/11 41/22 41/23 42/8 43/9 43/25 46/12 47/23 48/21 52/9
NPA's [2] 39/14 46/11
NPIs [1] 12/19
nuance [1] 88/14
number [20] 15/14 27/1 27/2 31/17 35/4 40/12 54/19 54/20 59/13 79/25 86/21 88/1 88/19 100/1 134/8 153/24 187/15 203/15 214/9 214/13
numbers [6] 23/10 24/3 34/12 92/2 110/24 181/17
numerous [2] 108/23 118/1
nurse [4] 68/12 69/4 123/22 123/23
nurses [6] 74/9 97/14 99/13 114/13 148/6 160/3
nursing [7] 24/17 67/11 74/10 127/18 163/21 168/24 169/5
nutrition [1] 199/2

O

o'clock [3] 43/19 43/20 223/1
O'Sullivan [4] 211/4 212/12 212/15 212/18
obdurate [1] 158/25
obfuscate [1] 148/17
obfuscation [1] 160/13
objectively [1] 214/6
obligated [1] 84/21
obligation [2] 128/21 222/3
obligations [5] 128/15 129/2 129/2 129/24 219/6
obliged [1] 164/14
observation [2] 82/14 148/25
observations [3] 15/4 35/5 153/11
observatory [4] 77/16 103/19 103/24 115/14
observed [3] 22/13 63/7 87/15
obstetricians [1] 24/18
obtain [2] 40/10 214/10
obtained [1] 126/7
obvious [7] 140/18 147/6 149/8 150/3 156/15 189/25 208/5
obviously [6] 74/2 157/10 157/15 159/24 162/7 222/23
occasion [1] 212/23
occasions [2] 76/7 88/19
occupancy [4] 80/10 97/14 102/9 197/5
occupational [6] 37/2 37/12 101/22 191/10 191/13 191/20
occupations [2] 101/23 102/4
occur [2] 10/12 84/19
occurred [1] 201/22
occurrence [2] 26/16 42/20
occurs [2] 24/11 157/21
OCMO [1] 186/25
OECD [1] 24/16
off [10] 51/9 74/8 106/24 136/18 137/13 137/17 144/7 195/14 210/12 217/16
offer [1] 112/13
offered [6] 5/17 6/22 67/16 68/8 165/4 183/20
offering [1] 208/24
offers [2] 120/3 221/15
Office [2] 186/21 213/23
Officer [7] 17/10 67/11 133/14 134/20 168/24 169/5 186/21
officers [1] 127/19
Offices [1] 79/12
official [3] 103/1 103/2 152/17
officials [2] 67/10 140/25
often [26] 34/22 45/11 50/7 51/20 52/12 64/8 100/11 100/13 107/14 110/2 113/2 114/13 114/16 116/12 125/3 125/9 126/12 126/17 126/23 163/11 165/4 168/21 172/22 209/22 215/12 218/8
Oh [1] 161/5
okay [1] 1/5
old [1] 141/24
older [2] 122/8

O

older... [1] 123/15
omission [1] 108/10
omitted [1] 188/2
on [335]
on DNACPR [1] 121/19
on government [1] 209/8
once [10] 29/15 71/22 85/1 135/25 165/8 168/18 177/3 202/11 208/20 210/20
one [72] 3/11 3/13 5/24 6/14 12/9 14/5 22/10 25/24 32/23 35/16 40/9 43/8 49/23 53/20 55/1 60/15 60/18 60/20 62/2 62/24 64/6 65/7 69/4 75/2 78/4 81/7 81/7 81/11 81/16 84/13 86/11 87/11 96/10 98/8 100/8 105/22 106/6 110/18 114/5 116/1 125/12 137/15 142/7 142/10 142/20 142/20 145/6 145/10 145/21 148/7 150/17 151/12 153/5 154/13 154/23 156/6 163/13 163/13 164/21 166/14 173/13 183/15 185/17 187/20 187/21 195/7 200/16 206/5 208/3 212/22 216/9 222/5
one-size-fits-all [2] 110/18 116/1
one-stop [1] 183/15
ones [10] 25/13 69/2 122/16 122/23 123/3 123/5 125/23 130/2 152/3 162/11
ongoing [12] 31/25 76/3 122/10 122/13 127/24 137/2 177/6 177/15 178/22 181/25 192/19 212/6
online [1] 210/7
only [46] 3/13 8/10 11/12 25/15 43/18 53/13 63/1 63/8 64/11 64/22 66/3 66/16 71/4 73/3 76/2 79/11 86/15 108/9 117/9 119/5 119/14 126/24 134/25 138/5 139/5 151/12 152/10 156/9 170/24 173/8 182/22 186/13 186/18 190/9 195/7 196/6 208/22 209/22 210/16 211/23 213/8 214/15 217/9 218/21 219/11 221/2
ONS [8] 26/6 26/25 31/14 31/21 101/21 102/19 179/15 187/14
onset [2] 71/7 197/3
onto [1] 69/3
onward [1] 41/3
onwards [1] 155/4
open [5] 14/9 15/16 18/19 25/6 53/21
opening [7] 42/17 68/18 71/3 90/19 96/21 132/1 161/15
operate [1] 216/8
operated [3] 3/1 111/7 112/1
operates [2] 111/13 124/11
operating [3] 148/6 213/15 216/22
operation [3] 68/4 68/7 116/7
operational [1] 170/4
operationalised [1] 81/1
operationally [1] 5/21
operations [2] 124/25 209/8
operatively [1] 17/13
opinion [1] 94/1
opportunities [1] 221/12
opportunity [10] 18/23 30/25 38/12 67/4 74/15 75/16 76/14 95/20 120/4 207/14
opposed [2] 46/3 137/3
optical [1] 48/5
optional [1] 172/2
options [3] 8/24 113/6 171/25
or [203] 4/4 4/6 4/23 4/23 5/10 7/8 7/18 7/20 8/16 8/22 9/5 11/1 11/3 11/4 11/9 11/23 12/9 13/6 19/16 20/10 20/14 21/6 22/3 22/25 25/22 27/21 29/8 33/21 37/14 43/12 44/1 45/12 45/17 50/9 53/8 53/10 61/17 61/20 61/23 61/23 61/24 61/24 61/25 61/25 61/25 62/1 62/15 62/16 63/13 63/13 63/17 64/4 64/5 64/7 64/16 64/16 64/20 67/10 67/18 67/19 68/24 69/2 69/9 69/24 70/16 71/10 74/22 75/9 75/13 75/17 75/18 77/7 79/5 79/6 80/25 81/3 81/15 82/12 83/4 83/6 83/14 86/19 89/20 89/24 90/6 90/6 93/4 93/25 100/14 100/22 100/24 101/9 102/13 104/1 104/10 104/17 104/23 105/16 108/1 110/19 110/23 111/11 111/13 112/24 113/5 114/13 115/23 116/24 118/4 118/24 119/3 119/8 119/12 121/21 122/1 123/23 124/2 124/6 125/8 126/3 127/7 128/13 129/11 129/23 130/9 136/7 137/8 140/3 140/11 140/11 141/22 144/11 144/21 145/7 146/20 147/4 148/2 148/7 148/22 149/14 150/24 152/19 153/2 153/16 153/17 153/25 154/7 154/19 154/22 156/22 157/3 157/13 158/17 161/3 162/18 163/10 164/10 165/4 165/20 166/16 167/18 171/2 172/22 173/16 174/18 174/23 177/20 183/14 187/9 192/2 194/18 194/21 197/12 198/20 198/24 199/13 201/14 201/15 202/2 205/18 210/7 210/17 211/16 212/2 212/2 213/5 214/5 214/7 214/23 215/3 215/22 216/13 217/19 217/20 218/4 218/5 218/7 219/12 219/18 220/2 220/3 220/4 221/18
oral [26] 3/10 8/8 11/12 11/15 14/2 15/7 16/3 16/14 17/9 17/20 18/11 19/21 38/13 49/1 49/9 73/10 90/20 97/2 131/23 136/12 147/23 155/16 161/15 190/24 206/3 207/20
orally [2] 3/6 15/5
order [9] 42/22 44/16 45/7 48/24 53/18 86/18 97/1 123/7 164/15
ordered [1] 3/23
orders [3] 19/9 145/7 212/10
ordinarily [1] 86/6
ordinated [1] 4/8
ordination [3] 5/19 6/1 20/20
organisation [2] 17/6 153/16
organisations [26] 5/20 9/21 21/22 21/24 22/2 26/12 27/12 63/18 90/22 93/21 95/16 96/13 101/10 107/9 111/14 116/22 130/4 130/12 153/25 154/6 161/9 161/11 170/8 174/13 225/6 225/16
organised [1] 6/18
original [3] 90/19 210/19 212/6
originated [1] 201/10
orthodoxy [1] 149/2
other [59] 12/2 16/24 18/20 20/4 27/12 40/7 41/3 44/3 47/25 49/20 49/25 53/1 55/6 56/4 56/17 62/17 74/11 77/15 81/20 85/3 91/12 91/23 92/4 95/4 95/22 97/15 99/19 126/2 126/14 131/1 132/7 139/9 142/13 146/13 147/21 150/8 153/24 153/24 154/6 158/15 159/10 159/13 165/9 165/14 170/7 171/25 172/24 182/3 194/11 195/12 199/14 208/13 210/22 212/21 213/6 216/1 217/25 219/23 221/18
others [28] 5/22 8/1 11/21 11/24 27/9 28/2 45/11 60/17 62/12 68/25 69/15 89/6 105/15 114/18 116/25 123/2 132/8 136/17 137/25 176/17 198/9 198/11 200/1 212/25 216/14 217/14 217/16 221/1
otherwise [8] 8/12 21/6 82/12 123/11 147/18 214/24 215/4 218/4
ought [5] 48/5 77/4 125/18 208/6 221/2
our [60] 1/20 2/3 2/14 6/9 6/15 6/22 6/22 7/24 15/16 16/2 17/6 18/22 19/1 19/3 28/5 28/7 35/22 42/17 42/18 49/1 58/15 59/16 61/3 71/14 73/15 73/21 76/21 77/14 79/20 85/24 88/18 90/19 90/22 91/24 94/24 95/3 96/21 96/24 97/2 107/20 113/20 119/1 120/16 123/4 123/6 123/7 123/8 123/9 124/8 130/16 136/10 139/12 141/23 160/19 162/8 162/12 177/6 186/14 196/21 214/2
ourselves [1] 162/9
out [56] 2/18 7/12 10/20 18/4 21/11 21/13 21/20 27/16 27/25 29/12 30/20 35/22 40/21 51/22 59/13 61/13 66/2 71/23 74/17 78/4 81/17 85/23 92/7 94/2 96/7 96/10 105/19 113/22 121/12 129/9 134/18 135/22 135/22 137/9 137/20 138/12 139/22 154/10 157/18 157/24 160/2 162/11 171/3 174/9 185/22 186/5 186/21 192/12 201/13 207/19 208/23 212/12 217/11 218/5 221/8 222/14
outbreaks [1] 20/11
outcome [3] 71/13 119/13 211/15
outcomes [12] 102/2 107/25 110/6 111/12 111/15 112/7 113/7 115/17 117/2 119/4 214/15 221/19
outdated [1] 68/17
outlier [1] 137/21
outliers [1] 69/15
outlined [1] 87/24
outpatient [3] 70/24 195/11 199/24
output [1] 209/22
outrageous [1] 215/7
outreach [1] 202/2
outright [1] 149/6
outset [14] 17/1 29/3 38/10 67/2 68/15 68/22 86/23 150/6 165/24 174/9 176/10 179/13 180/7 211/1
outside [4] 11/25 33/17 40/18 81/23
outsourced [26] 2/17 6/13 34/23 83/4 83/12 84/12 84/22 96/3 96/6 96/16 98/1 98/6 98/7 100/5 100/11 100/16 100/17 100/19 100/23 101/23 103/12 104/10 104/13 104/17 105/4 105/10
outsourcing [2] 83/25 98/3
outstripped [1] 41/10

O

over [29] 3/2 6/19 25/11 29/14 31/14 33/10 34/1 34/4 34/19 50/9 59/11 64/7 71/5 73/4 76/10 79/16 86/14 97/20 129/13 130/12 134/17 150/21 156/12 173/3 185/10 190/24 210/19 211/11 216/9
overall [9] 18/12 91/20 130/14 145/20 162/13 169/22 171/12 211/18 221/19
overarching [4] 16/2 91/13 221/21 222/11
overcome [2] 80/6 221/1
overcomes [1] 192/17
overcrowded [1] 112/24
overestimated [1] 211/14
overexposure [1] 101/6
overload [1] 181/16
overlooked [4] 44/1 96/17 125/3 146/9
overlooking [1] 219/13
overly [2] 127/5 165/1
overnight [1] 212/23
overrepresented [1] 114/12
override [1] 156/15
overriding [1] 2/10
overrun [2] 3/24 3/25
overseas [1] 98/13
oversight [6] 6/1 82/2 83/20 117/5 118/25 155/18
oversights [1] 115/1
oversimplification [1] 8/25
overstretch [1] 8/20
overstretched [1] 126/11
overstretching [1] 2/13
overtime [1] 54/18
overwhelm [2] 3/8 8/21
overwhelmed [9] 25/17 25/21 32/24 51/7 62/11 200/9 200/13 200/17 210/2
overwhelming [2] 43/7 135/21
overwhelmingly [2] 105/5 200/19
overwork [1] 129/9
overworked [1] 72/15
owed [1] 75/21
own [21] 18/24 21/25 28/7 45/6 53/7 90/7 90/8 101/6 140/15 141/17 143/2 146/7 148/9 150/12 152/24 157/18 158/6 159/23 166/20 188/24 199/1
owners [1] 104/23
ownership [1] 6/10
oximeters [1] 115/6
oxygen [5] 51/20 51/21 51/23 68/18 80/10

P

pace [1] 187/24
package [2] 143/19 143/19
packed [1] 102/9
packet [1] 143/25
Paddington [1] 71/21
paediatric [6] 183/7 187/11 187/12 187/18 188/10 201/15
PAGE [1] 224/2
pages [3] 76/10 76/11 96/12
Paget [3] 21/9 21/18 163/6
paid [5] 5/9 84/11 99/3 102/8 105/6
pain [1] 32/8
painting [1] 4/2
pair [1] 169/11
Pakistani [1] 87/22
palpable [2] 198/21 212/14
palsy [1] 211/16
pan [1] 139/22
panacea [1] 204/15
pandemic [226]
pandemic's [2] 117/6 198/19
pandemics [10] 20/10 21/2 37/19 90/10 91/4 92/3 94/18 95/6 159/20 191/22
panel [3] 156/2 214/1 214/7
Panesar [2] 38/23 42/9
paper [1] 67/22
parallel [1] 20/8
paramedics [1] 160/3
paramount [1] 10/3
pardon [1] 31/7
Parent [3] 161/8 161/10 225/16
parents [13] 165/2 168/10 168/16 169/8 170/12 170/15 173/22 174/15 180/25 186/2 186/4 187/3 188/11
parity [1] 199/16
Parliament [1] 202/4
part [30] 11/13 21/14 39/21 43/12 46/10 47/15 48/3 48/4 48/9 53/12 57/7 64/15 72/21 74/4 74/10 84/16 85/16 85/19 96/25 99/2 106/1 124/14 133/8 143/18 145/20 151/12 172/8 172/17 195/7 198/17
participant [2] 194/7 207/15
participants [3] 63/24 121/14 121/17
participate [1] 95/20
participated [2] 121/11 160/21
participation [2] 46/11 121/21
particles [1] 143/9
particular [18] 1/20 15/12 16/5 39/4 88/11 92/16 122/9 123/22 171/7 177/13 178/18 181/18 198/7 204/13 204/18 208/18 208/19 219/7
particularly [24] 42/25 67/18 98/2 109/14 110/10 113/3 117/7 117/13 125/23 126/17 131/17 135/20 141/20 154/12 166/18 170/5 185/25 202/25 204/3 206/13 206/18 207/2 207/5 214/5
partner [9] 48/11 59/23 66/19 163/24 164/13 164/21 165/7 166/14 173/4
partners [16] 9/5 128/2 162/23 162/25 162/25 163/4 163/5 163/11 164/10 165/13 169/2 169/3 169/14 169/14 173/10 173/18
partnership [2] 73/18 85/10
partnerships [1] 79/5
parts [6] 40/7 40/9 41/3 47/25 49/20 56/17
partum [1] 123/16
Pashley [1] 198/22
Pashley's [2] 196/4 205/25
passed [1] 162/4
passing [2] 33/15 81/2
passion [1] 198/8
passport [1] 132/14
passporting [1] 136/20
past [3] 24/5 97/20 120/2
patchwork [2] 21/19 117/4
pathogen [1] 142/18
pathogens [1] 142/13
pathway [4] 70/25 71/10 187/20 188/2
patient [27] 19/3 24/20 33/1 34/15 40/21 41/1 51/1 52/13 54/18 57/14 58/2 58/4 69/4 120/10 123/21 123/25 126/21 127/22 128/22 130/3 166/9 175/22 179/8 179/15 180/6 202/8 216/9
patient's [5] 124/1 124/10 124/15 125/19 127/9
patients [96] 2/11 4/14 4/22 4/22 5/5 9/5 10/24 11/4 19/1 19/8 21/17 23/23 25/7 25/18 28/7 29/8 31/7 31/13 32/24 33/6 34/11 35/18 36/3 36/6 39/18 40/10 40/15 45/10 46/23 50/12 51/3 51/6 51/8 51/9 51/11 51/13 52/19 53/3 53/6 54/5 54/16 54/21 56/19 61/6 67/19 81/10 95/6 99/13 99/23 101/5 105/21 115/9 115/17 118/18 119/11 121/8 121/9 121/21 122/15 124/23 125/23 126/17 126/23 127/4 127/7 127/11 127/15 128/7 128/18 129/21 130/2 130/10 144/6 144/9 144/16 144/20 149/14 149/15 157/21 160/19 166/23 172/6 178/2 180/25 181/1 185/4 188/11 189/10 197/6 197/8 197/11 202/20 206/14 217/11 217/13 225/8
Patients' [1] 183/22
Patrick [1] 134/25
Paul [1] 212/15
Paul Chrisp [1] 212/15
paused [2] 135/19 183/3
pausing [1] 136/17
pay [13] 27/7 43/6 43/22 43/22 55/10 74/9 82/25 83/5 85/12 100/23 102/6 132/18 137/12
PBPOs [7] 161/11 164/12 166/2 167/6 168/22 170/7 174/11
PBPOs' [2] 163/23 167/15
PCR [1] 11/10
peace [1] 14/24
peacetime [1] 7/15
Peacock [1] 72/9
peddled [1] 30/20
penalised [1] 82/11
Penultimately [1] 86/2
people [144] 7/6 8/9 9/1 9/25 23/1 45/18 45/21 54/3 55/8 60/13 68/20 68/23 70/4 75/19 82/17 88/2 90/3 90/3 90/6 92/4 106/3 106/5 115/13 122/9 122/9 122/18 123/13 123/15 123/15 123/16 124/9 124/12 124/21 125/8 126/25 128/12 131/5 131/19 131/21 132/4 132/5 132/13 132/15 133/2 133/5 133/7 133/18 134/12 135/12 135/17 136/8 138/12 138/20 138/21 139/2 139/19 139/21 140/9 145/14 145/22 145/25 146/9 152/12 152/23 153/1 154/25 155/1 157/10 158/17 159/22 161/17 164/8 166/19 170/22 173/6 173/9 173/17 174/4 174/8 174/14 174/21 175/5 177/7 178/17 179/9 184/4 185/7 185/10 185/19 186/2 186/5 186/10 186/19 186/23 187/3 187/15 188/5 188/6 188/9 188/12 192/1 193/18 194/8 195/8 196/22 197/16 197/18 197/20 197/22 203/17 204/14 204/20 206/18 209/19 209/21 209/23 210/1 210/5 210/10 210/17 210/24 211/15 211/22 212/2 212/8 213/2 213/20 214/24 215/1 215/9 218/3 218/9 218/17 219/6 219/14 220/1 220/11 220/24

P

people... [6] 221/17 221/20 221/22 222/8 222/13 222/18
people's [4] 122/23 125/13 170/19 204/9
per [3] 24/15 40/22 51/4
perfect [2] 6/8 61/2
performed [1] 16/6
perhaps [7] 6/20 64/22 125/2 135/15 161/2 194/11 194/20
perils [1] 199/6
perinatal [1] 161/23
period [3] 19/25 40/14 50/9
periods [4] 97/3 99/15 99/16 99/24
peripheral [1] 124/11
permitted [3] 65/15 127/16 163/11
pernicious [1] 108/6
perpetuate [1] 111/21
perpetuated [1] 108/9
perpetuating [1] 112/15
persist [2] 70/14 108/21
persisted [1] 185/12
persistent [5] 60/3 96/5 208/8 209/10 211/24
person [11] 123/20 124/3 125/14 126/1 156/16 156/16 173/20 194/19 202/10 205/18 208/4
person's [2] 211/6 214/7
person-centred [1] 123/20
person-centredness [1] 125/14
personal [10] 2/1 2/5 2/9 54/23 114/3 123/14 128/8 138/3 142/24 202/15
personalised [1] 138/17
personnel [1] 155/2
persons [4] 75/17 214/1 219/10 222/10
perspective [4] 50/7 131/25 165/22 196/2
persuaded [1] 179/15
pertinent [1] 104/9
pervasive [4] 70/19 107/20 180/17 180/19
petrol [1] 99/7
Pezzani [4] 194/2 194/3 207/8 225/21
PHA [1] 64/25
pharmaceutical [7] 40/20 42/24 49/6 49/10 49/12 72/25 224/16
pharmacies [20] 38/11 38/19 38/25 39/5 39/13 39/23 40/1 40/3 40/14 40/23 41/15 44/2 46/25 47/19 52/7 53/17 53/20 57/4 57/11 137/12
pharmacist [6] 38/17 38/18 38/23 38/24 50/22 51/2
pharmacists [40] 40/17 41/7 42/6 43/3 43/15 44/18 44/21 44/25 45/6 45/14 45/16 46/7 47/12 49/12 49/18 50/1 50/6 50/10 50/16 50/25 52/1 52/3 52/8 52/10 53/9 54/2 54/12 54/15 54/24 55/16 55/20 55/24 56/3 56/6 56/9 56/17 56/20 57/1 57/7 58/14
pharmacists' [1] 56/15
pharmacological [2] 183/9 183/9
pharmacy [68] 38/5 38/9 39/10 39/11 39/16 39/17 39/21 40/9 40/21 41/12 42/3 42/5 43/1 44/7 44/11 44/15 44/19 45/4 45/5 45/9 45/22 46/1 46/2 46/4 46/5 46/7 46/10 46/13 46/17 46/21 47/4 47/17 47/24 48/4 48/8 48/11 48/17 48/21 48/23 49/13 49/13 49/23 50/1 50/4 50/17 51/19 51/22 52/3 52/11 52/15 52/19 52/21 52/23 53/5 53/13 53/24 54/14 55/12 55/20 56/1 56/14 56/20 56/24 57/7 57/9 57/13 57/22 224/13
phase [1] 92/25
PHE [1] 156/7
PHE's [1] 181/19
phenomenon [1] 215/4
Philip [2] 15/8 18/8
Philippa [1] 207/24
Philippines [1] 101/20
phone [5] 33/10 40/13 51/11 54/17 210/7
physical [13] 9/4 24/4 31/25 32/16 77/24 81/7 99/15 99/17 107/14 170/13 199/17 204/8 211/3
physically [2] 25/20 51/23
physician [1] 19/23
physics [2] 60/23 154/19
Physio [2] 32/11 175/21
physiotherapist [1] 81/11
physiotherapy [1] 81/14
picked [2] 141/17 170/24
picture [5] 4/3 67/6 103/9 172/17 213/16
piece [2] 120/20 217/22
pieces [1] 154/23
pin [1] 104/8
pipelines [1] 80/11
pitch [1] 7/4
pivot [1] 86/23
pivotal [1] 117/22
place [23] 12/11 22/5 39/10 62/4 71/15 85/5 91/23 92/19 122/1 130/15 132/7 138/19 145/11 147/13 164/19 164/25 173/5 177/12 184/1 187/13 192/22 216/16 217/3
placed [5] 56/17 104/24 116/4 197/11 201/19
placement [3] 201/13 201/14 201/17
places [3] 53/20 131/22 141/24
Plague [2] 198/2 198/3
plagued [1] 117/23
plain [1] 74/5
plan [9] 7/14 77/4 77/9 77/12 77/13 79/18 79/20 79/24 221/13
planning [24] 20/9 20/12 82/3 85/2 85/5 91/3 92/9 92/11 112/16 115/3 117/12 117/14 117/19 127/21 128/6 128/8 180/3 180/4 184/14 196/10 198/17 199/5 199/19 205/11
plans [9] 21/24 36/11 58/11 68/16 83/14 85/5 92/11 92/19 174/9
platitudes [1] 30/20
play [3] 41/19 58/15 176/8
played [4] 47/5 56/21 141/11 176/7
plays [1] 72/24
pleading [1] 198/22
please [8] 49/5 65/7 107/6 131/1 146/15 195/1 220/21 223/1
pleased [2] 160/21 220/14
plenty [1] 141/2
pliable [1] 98/16
plight [2] 112/23 125/11
plus [1] 28/7
pm [5] 120/24 121/1 175/11 175/13 223/4
poignant [1] 9/3
point [15] 10/14 70/7 78/6 87/12 101/11 109/5 120/12 122/20 129/22 145/21 147/2 186/5 194/17 195/5 195/22
Point 1 [1] 194/17
point 2 [1] 195/5
pointed [3] 10/20 15/12 105/19
pointing [2] 64/18 120/1
pointless [1] 157/6
points [12] 2/24 7/17 9/12 10/17 15/15 25/17 28/17 33/23 127/25 128/1 158/15 194/16
polarised [1] 142/25
Polaschek [2] 131/14 161/12
police [1] 27/13
policies [16] 41/25 77/1 98/13 109/12 110/17 111/10 117/21 122/2 123/5 126/9 126/19 137/7 139/20 144/8 144/18 215/7
policy [21] 8/16 65/15 67/8 75/7 75/9 84/17 87/9 87/10 87/17 88/10 92/6 128/4 152/16 210/8 214/4 214/15 214/21 216/13 219/10 221/10 221/12
policy's [1] 75/11
political [8] 24/9 25/24 78/3 78/8 78/12 93/15 150/17 217/6
politicians [2] 69/21 81/4
politics [1] 151/16
poor [11] 68/18 77/23 83/4 84/1 97/18 125/9 180/10 204/7 211/8 211/15 220/22
poorer [4] 74/12 74/23 110/6 112/6
poorly [2] 34/22 129/9
popularity [1] 155/9
population [7] 12/11 13/22 18/22 23/12 26/8 191/24 218/18
populations [5] 41/8 41/16 115/25 116/9 119/16
port [1] 39/17
portal [4] 45/7 45/15 45/19 53/14
portering [1] 99/18
porters [4] 99/14 114/12 114/15 188/22
posed [3] 136/25 186/13 187/2
position [19] 23/6 27/17 28/16 54/8 62/16 64/24 67/7 69/12 97/7 105/12 147/25 148/17 148/18 149/5 150/11 152/20 154/13 195/20 222/20
positions [6] 69/3 147/6 151/22 152/13 159/14 181/24
positive [4] 46/5 56/19 108/25 219/5
positives [1] 15/17
possibility [6] 33/14 148/20 149/10 150/3 179/6 217/13
possible [18] 2/12 4/14 5/4 11/10 12/13 14/10 37/9 48/2 90/12 126/15 131/7 144/8 151/23 174/23 205/13 205/15 213/7 217/6
post [5] 48/12 64/23 64/25 70/7 123/16
post-pandemic [1] 48/12
post-partum [1] 123/16
postcode [3] 9/24 166/21 167/15
posthumous [1] 71/17
postponement [1] 4/23
postponements [1] 125/9
potency [1] 79/20
potential [5] 11/6

P

potential... [4] 47/24 100/25 109/4 159/14
potentially [8] 10/24 66/14 125/24 143/1 177/9 206/2 213/5 218/4
poured [1] 99/7
poverty [4] 98/7 102/16 171/2 203/24
Powell [1] 60/1
power [3] 60/6 63/16 64/5
powered [1] 114/4
powerful [9] 32/17 60/11 61/9 61/19 72/3 88/7 101/1 120/20 164/17
powerfully [2] 60/3 215/11
Powis [7] 104/15 127/13 163/3 169/16 183/22 208/15 216/15
Powis's [1] 10/11
PPE [63] 11/9 11/18 19/8 20/14 20/16 27/15 27/16 27/18 27/20 27/25 28/5 28/25 30/9 30/18 34/21 34/23 34/25 36/11 36/12 43/4 45/4 45/6 45/6 45/7 45/9 45/12 45/15 45/18 52/8 53/5 53/7 53/14 53/18 53/23 54/4 68/13 68/15 74/23 85/7 85/20 92/18 93/11 100/5 100/9 100/10 111/18 113/24 114/14 114/17 114/20 114/22 165/3 167/4 167/19 170/7 170/9 177/15 189/3 189/9 189/13 189/16 190/5 190/9
practicable [1] 213/5
practical [9] 85/23 89/23 93/9 128/9 135/7 135/17 144/3 164/18 209/21
practically [1] 75/23
practice [8] 40/24 48/5 56/23 76/19 83/19 129/17 144/8 144/23
practices [7] 109/12 111/10 111/16 111/18 116/3 122/3 127/5
practitioners [1] 91/2
pragmatic [2] 147/1 160/18
pre [10] 20/23 70/23 74/2 97/5 97/6 117/18 171/2 171/18 192/17 213/12
pre-Covid [1] 70/23
pre-existing [5] 74/2 117/18 171/2 171/18 192/17
pre-pandemic [3] 97/5 97/6 213/12
pre-prepared [1] 20/23
precarious [9] 73/13 82/4 82/5 82/17 100/21 102/13 104/1 106/5 106/8
precariously [1] 105/6
precariousness [2] 85/16 106/6
precautionary [12] 7/23 8/5 29/6 36/4 141/6 146/24 146/25 149/21 149/22 149/24 150/16 190/7
precautions [1] 8/17
preceded [1] 97/11
precious [1] 219/7
precisely [1] 98/19
predicated [1] 219/11
predict [1] 62/24
predictable [3] 102/7 113/8 200/7
predictably [1] 209/25
predominance [1] 149/12
predominantly [2] 73/8 149/11
predominated [1] 150/21
prefer [1] 143/19
preferring [2] 109/24 156/1
pregnancy [16] 61/24 161/8 161/10 162/16 162/17 162/24 163/8 163/10 163/16 166/4 170/24 173/7 173/14 173/16 173/16 225/16
pregnancy-related [2] 162/16 173/7
pregnant [16] 66/16 66/22 71/10 161/17 166/19 170/18 170/22 171/6 173/6 173/9 173/17 174/4 174/8 174/14 174/21 175/5
prematurely [1] 124/24
preparation [3] 57/21 106/1 207/25
preparations [2] 36/10 37/19
prepare [1] 161/6
prepared [6] 20/23 90/16 150/20 151/18 151/25 179/4
preparedness [11] 30/19 91/16 91/19 91/20 91/21 92/25 97/7 117/12 117/13 119/21 198/17
prescriptions [2] 40/12 54/19
presence [1] 63/20
present [3] 28/15 80/6 211/4
presentations [1] 196/24
presented [4] 17/14 46/20 52/15 196/22
presenteeism [1] 85/22
presenting [2] 151/19 197/2
presently [3] 79/8 79/13 83/9
presents [1] 83/16
president [2] 99/6 199/9
pressed [3] 76/5 182/12 219/17
pressure [9] 46/7 55/4 55/10 63/10 83/5 125/6 160/1 167/6 200/14
pressured [1] 100/20
pressures [3] 55/17 56/16 57/11
presumptuous [1] 62/24
pretty [1] 90/2
prevailing [1] 69/17
prevalence [6] 9/9 179/12 179/18 179/20 180/1 185/8
prevent [4] 156/15 176/22 184/21 185/6
prevented [1] 158/1
preventible [2] 5/3 108/12
preventing [1] 165/2
prevention [9] 52/5 73/16 82/7 84/7 92/15 148/14 154/5 165/21 206/20
prevents [1] 32/14
previous [4] 90/10 152/10 156/7 177/19
previously [1] 142/6
primarily [2] 89/22 155/23
primary [15] 13/21 36/23 39/22 46/11 47/15 47/25 48/3 48/4 49/19 53/12 54/9 57/5 66/13 105/23 183/18
prime [1] 106/24
principal [2] 39/2 46/16
principle [14] 7/23 8/5 8/11 10/2 87/19 88/7 146/24 147/1 149/21 149/22 149/24 199/16 214/14 219/16
principle' [1] 8/10
principles [3] 124/6 129/16 160/6
printer [1] 28/8
printout [1] 65/11
prior [5] 28/19 68/7 109/21 147/21 213/19
prioritisation [1] 216/7
prioritise [2] 115/2 216/9
prioritised [1] 118/11
priority [12] 45/18 49/20 54/3 54/6 72/23 100/18 132/19 163/12 183/8 185/4 193/16 199/13
Pritchard [7] 3/16 4/19 6/11 10/20 13/3 127/20 219/21
private [4] 2/17 79/6 124/18 165/8
privately [1] 188/21
pro [1] 185/20
proactive [5] 19/5 36/8 86/19 86/24 174/9
probable [1] 148/20
probably [3] 90/4 143/12 175/1
problem [20] 27/21 74/4 76/1 76/22 79/11 82/18 86/16 110/13 122/10 122/13 125/11 140/20 171/10 195/16 200/11 204/22 208/8 210/4 221/1 221/25
problematic [1] 149/22
problems [15] 27/16 32/6 75/3 78/24 86/20 88/22 132/22 136/9 152/13 155/11 156/3 158/12 167/14 203/4 212/20
procedural [1] 202/5
procedure [1] 157/13
procedures [4] 29/10 30/6 111/10 143/15
proceedings [1] 25/25
process [10] 67/21 81/13 99/21 101/8 130/23 138/17 150/23 164/15 215/21 217/4
processes [6] 82/1 111/16 112/20 119/8 129/21 214/15
procure [1] 158/6
procured [1] 114/22
procurement [1] 115/21
procurements [1] 119/8
produce [3] 93/24 111/12 158/12
produced [3] 74/5 155/13 157/13
producers [1] 176/3
producing [2] 2/20 159/3
product [1] 83/25
production [3] 57/24 157/1 214/14
productive [3] 1/19 13/24 78/22
profession [1] 180/14
professional [7] 17/23 54/24 81/23 92/10 93/6 93/21 93/23
professionals [6] 21/4 58/2 81/19 93/18 94/7 141/14
professions [1] 159/16
Professor [52] 10/11 15/8 15/10 18/8 18/17 19/4 19/10 19/20 22/13 25/1 26/4 32/18 32/19 35/14 60/19 61/4 62/10 69/13 75/1 82/14 102/15 104/15 105/25 107/9 110/12 133/15 137/14 137/19 141/14 142/7 143/3 148/4 148/5 148/8 148/22 150/4 157/12 158/20 163/3 165/17 177/10 180/15 181/13 181/19 189/18 192/23 195/23 208/15 210/23 216/15 220/12 225/6
Professor Banfield [2] 157/12 192/23
Professor Beggs [7] 60/19 69/13 141/14 143/3 148/4 148/22 189/18
Professor Beggs' [1] 142/7
Professor Catherine Noakes [1] 148/5
Professor Dinah Gould [1] 158/20
Professor Evans [1] 180/15
Professor Evans' [1] 177/10

P

Professor Fong [5] 32/18 32/19 61/4 62/10 195/23
Professor Fu-Meng [1] 165/17
Professor Hopkins [1] 181/19
Professor JS Bamrah [1] 110/12
Professor Kloer [5] 15/10 18/17 19/10 19/20 22/13
Professor Kloer's [1] 19/4
Professor McBride [1] 133/15
Professor McKay [1] 148/8
Professor Noakes' [1] 150/4
Professor Philip Kloer [2] 15/8 18/8
Professor Powis [2] 208/15 216/15
Professor Powis's [1] 10/11
Professor Sir [1] 105/25
Professor Sir Chris [2] 35/14 181/13
Professor Sir Chris Whitty [1] 26/4
Professor Sir Stephen [1] 163/3
Professor Snooks [2] 137/14 137/19
Professor Stephen [1] 104/15
Professor Summers [1] 25/1
Professor Whitty [3] 75/1 210/23 220/12
Professor Whitty's [1] 82/14
Professors [1] 182/5
profit [1] 158/12
profound [3] 153/13 206/22 215/5
profoundly [2] 203/2 207/1
programme [5] 93/4 132/23 134/5 136/21 136/22
programmes [1] 36/19
progress [2] 77/8 205/19
progressed [1] 165/12
prohibitions [1] 126/10
project [2] 79/25 81/4
projects [1] 79/16
prolonged [3] 99/14 99/16 99/23
promote [4] 76/25 128/18 182/8 206/10
promoted [2] 152/18 173/7
promoting [1] 167/22
prompt [3] 76/19 138/23 181/7
promptly [3] 85/7 195/14 207/3
promulgated [1] 210/16
prop [1] 140/25
proper [10] 19/14 36/15 37/8 37/8 86/5 111/1 122/17 126/7 130/1 149/4
properly [7] 31/1 46/9 76/5 143/9 161/16 167/17 173/13
prophylactics [1] 136/2
Proponents [1] 87/9
proportionate [1] 162/15
propose [2] 141/8 178/6
proposed [4] 35/23 119/20 130/4 222/6
proposing [1] 35/3
protect [30] 5/5 23/21 26/3 26/10 30/10 53/6 58/8 85/25 94/3 96/23 98/24 106/16 107/24 108/15 109/17 113/15 114/20 116/18 117/17 135/17 137/16 138/2 139/3 143/8 147/12 149/14 177/24 193/11 210/2 219/6
protected [10] 33/12 37/15 75/18 124/13 138/6 146/2 159/23 160/20 173/24 222/15
protecting [2] 52/3 173/13
protection [20] 28/22 30/3 31/10 36/5 57/2 100/9 102/14 110/25 117/2 128/25 136/21 136/22 145/5 149/16 177/21 189/24 190/5 190/9 190/14 191/6
protections [7] 35/18 98/9 106/13 136/21 137/1 137/11 152/3
protective [10] 28/10 28/21 60/10 116/2 116/25 129/24 132/7 142/24 147/17 158/7
protects [1] 106/17
protocols [1] 116/20
protracted [1] 176/4
prove [1] 35/7
proved [2] 126/21 212/25
provide [21] 4/13 5/19 20/6 21/16 39/13 47/4 57/1 86/24 89/22 112/10 127/8 157/3 161/21 172/24 174/18 178/3 181/20 191/5 191/11 195/19 214/3
provided [18] 6/2 17/19 28/3 28/11 29/25 46/12 50/10 55/24 56/4 100/6 115/8 164/12 189/3 189/24 190/8 190/14 191/18 203/8
provider [1] 57/5
providers [3] 93/20 176/1 199/22
provides [4] 28/22 42/9 68/14 187/24
providing [10] 9/2 40/4 46/22 52/18 53/8 56/15 68/12 116/24 123/23 132/14
provision [14] 50/20 52/7 56/7 83/5 87/14 171/24 172/5 178/14 180/3 183/24 195/7 197/9 201/1 204/24
provoked [1] 10/7
proximity [1] 45/11
proxy [1] 215/13
psychiatric [3] 197/12 201/15 201/18
Psychiatrists [2] 196/19 199/10
Psychiatry [1] 196/20
psychological [5] 37/2 93/10 126/10 145/15 196/17
psychotic [1] 194/21
PTSD [1] 172/25
public [67] 2/7 10/8 12/23 12/23 17/17 21/17 52/15 53/21 58/16 64/19 70/12 73/12 75/15 77/21 78/4 92/13 93/13 93/17 95/6 98/17 102/1 102/10 105/4 105/19 109/15 110/2 112/17 113/9 118/8 124/20 129/3 136/24 139/1 139/5 147/8 148/11 150/19 151/24 152/6 154/14 155/4 155/13 155/15 155/15 159/10 176/1 177/6 178/12 179/21 180/8 180/11 181/12 181/25 182/2 182/4 182/10 182/15 186/12 186/18 188/13 190/22 193/16 208/6 209/16 215/23 217/7 218/20
Public Health Wales [2] 17/17 155/15
publication [2] 77/18 187/20
publish [1] 168/1
published [9] 38/22 55/22 57/25 152/18 186/9 187/1 211/9 217/23 220/18
publishing [1] 155/14
pull [2] 4/11 91/12
pulse [1] 115/6
purchased [1] 28/2
purifying [1] 114/4
purpose [4] 92/7 142/9 191/5 205/19
purposeful [1] 19/17
purposes [1] 28/15
pursue [2] 146/25 150/16
pursued [2] 84/17 114/9
pursuit [1] 87/7
push [1] 116/14
pushed [1] 45/14
put [19] 14/13 22/25 41/4 45/10 110/12 126/5 128/22 138/19 143/23 145/11 164/25 186/21 187/5 193/24 210/12 211/4 212/12 212/13 216/19
puts [1] 177/22
putting [7] 32/24 32/25 33/1 52/12 52/20 132/7 209/2

Q

QCovid [1] 138/11
qualified [2] 81/20 156/2
qualitative [2] 214/10 221/2
quality [11] 85/6 97/18 102/9 123/20 124/4 124/5 126/4 127/8 148/16 156/11 215/25
quantitative [1] 214/10
quantity [1] 27/22
quarter [2] 34/5 79/17
queries [1] 54/18
question [15] 3/16 14/16 15/10 22/6 73/9 100/16 104/9 108/20 115/23 139/25 200/24 201/5 217/10 217/15 217/17
questionable [1] 126/6
questions [7] 63/21 63/24 73/25 78/1 78/19 95/21 153/15
queues [1] 40/18
quick [1] 187/24
quickly [7] 4/9 6/3 15/1 36/17 51/7 148/8 219/15
quite [3] 53/16 76/5 78/1
quote [5] 7/5 9/9 21/20 78/14 208/24
quoted [1] 71/3

R

race [9] 74/6 74/17 77/2 77/16 83/14 85/2 103/19 112/22 115/14
racial [3] 103/20 111/13 111/21
racialised [2] 204/2 206/11
racism [16] 61/23 73/11 76/12 76/20 108/5 108/9 109/8 111/3 111/4 111/9 111/17 111/20 111/25 112/9 119/1 120/15
racist [2] 77/4 77/12
raise [5] 37/15 50/6 74/21 85/20 179/8
raised [7] 19/7 19/15 26/12 34/16 65/21 101/9 208/18
raising [2] 67/1 97/21
ran [3] 27/16 210/3 217/11
randomised [1] 143/11
range [3] 36/12 36/13 205/4
rank [1] 217/10
ranking [1] 216/8
rapid [5] 20/22 21/1 154/11 211/9 217/22
rapidly [2] 20/25 36/11
rarely [1] 114/10
rate [9] 1/23 24/19 47/20 79/15 79/23 101/21 117/11 189/4 219/1
rates [18] 11/23 87/15 97/14 101/13 101/15 102/5 102/7 103/2 103/3 103/15 105/8 118/18 135/23 140/7 142/12 161/23

R

rates... [2] 167/18 218/10
rather [17] 2/2 30/19 51/11 91/11 93/12 107/2 109/25 118/25 133/18 137/16 155/10 155/21 163/5 196/25 201/5 203/5 219/11
rational [1] 181/24
rationale [2] 135/10 157/6
rationing [4] 10/11 157/3 214/21 216/2
ratios [1] 34/10
Rawat [1] 156/5
RCN [1] 176/17
RCOG [1] 172/4
re [4] 6/18 129/12 155/14 193/6
re-emphasise [1] 129/12
re-introduced [1] 193/6
re-organised [1] 6/18
re-review [1] 155/14
reach [7] 39/4 78/4 83/23 85/10 110/3 110/10 174/9
reached [2] 107/4 166/19
reaching [2] 10/15 159/15
reacting [1] 4/17
reactions [1] 196/18
read [14] 28/5 30/18 32/3 33/6 55/3 81/13 143/8 185/18 186/8 189/9 189/12 198/6 199/11 204/6
readied [1] 33/13
readily [2] 27/19 201/21
readings [1] 115/9
real [18] 14/10 42/12 51/21 76/2 149/11 154/11 154/21 161/20 161/22 166/22 166/24 167/7 178/1 187/2 190/8 213/10 215/4 216/24
realisation [1] 123/8
realistic [3] 9/12 22/10 36/16
realistically [2] 4/20 71/4
realities [3] 109/10 134/1 135/7
reality [10] 4/16 24/6 71/2 71/6 78/25 81/3 108/20 141/5 160/11 219/5
really [27] 14/13 14/15 14/25 14/25 15/22 18/5 44/17 63/15 66/8 66/24 67/15 68/1 68/11 68/19 79/21 133/5 133/11 133/12 133/12 141/19 155/1 163/18 163/18 163/20 220/1 220/2 220/5
realm [1] 78/4
realtime [3] 9/14 152/15 213/10
reason [4] 141/5 141/21 193/17 201/25
reasonable [4] 126/18 129/3 166/11 208/5
reasons [6] 12/3 86/5 140/18 141/8 160/5 194/18
reassurance [1] 157/4
rebuffed [2] 158/7 158/13
recall [2] 103/16 122/23
recast [1] 48/10
receive [4] 37/8 44/4 114/16 211/19
received [9] 18/7 25/19 40/19 48/25 50/21 87/6 100/10 100/11 154/6
receives [2] 85/6 85/8
receiving [3] 9/3 128/7 192/9
recent [2] 57/11 74/6
recent years [1] 74/6
recently [3] 97/8 99/20 156/2
reckon [1] 88/5
recognise [16] 3/13 5/8 18/3 27/7 30/15 46/10 48/8 60/5 70/3 166/7 172/7 177/24 178/11 185/25 190/17 204/10
recognised [13] 18/21 44/1 45/22 46/15 47/24 59/22 69/19 133/15 134/20 156/10 169/14 179/6 188/5
recognising [3] 43/11 69/23 180/13
recognition [14] 39/6 39/12 48/20 48/25 104/14 125/10 125/16 136/16 163/7 168/22 171/12 174/12 181/2 205/17
recommend [20] 12/1 30/7 31/6 47/23 48/14 84/16 129/18 130/8 144/2 145/10 180/2 181/4 182/14 183/4 184/8 185/1 191/16 192/14 192/16 193/5
recommendation [14] 14/5 37/10 78/8 80/2 88/13 105/23 141/18 142/15 183/15 209/13 213/22 220/16 222/6 222/12
recommendations [76] 3/5 7/20 12/5 12/22 12/24 13/2 13/5 13/9 19/19 20/3 20/7 23/24 35/3 35/4 35/12 35/23 37/18 37/23 39/14 47/9 47/10 62/22 63/8 64/6 72/24 73/9 76/15 76/18 77/15 78/2 78/10 78/21 80/8 82/1 86/21 88/21 89/23 90/21 91/8 91/11 91/24 94/22 94/24 95/3 106/7 108/23 113/21 119/23 130/15 132/2 147/9 158/24 160/15 160/18 160/22 176/20 176/22 176/25 177/2 178/5 178/9 178/24 188/8 190/18 193/23 194/13 205/2 205/3 205/5 207/22 213/11 215/15 215/17 218/24 221/16 222/4
recommended [7] 29/1 29/7 29/13 30/5 143/14 183/13 190/6
recommending [2] 36/2 146/5
record [3] 1/20 2/16 89/17
recorded [4] 103/10 196/20 198/3 201/25
recording [4] 31/16 72/21 76/19 215/20
records [5] 31/14 66/15 134/11 201/3 202/16
recover [1] 179/9
recovery [2] 13/4 48/12
recruited [2] 79/9 98/13
recruitment [1] 93/7
recurring [1] 96/5
redeployed [2] 81/16 81/19
redeployment [8] 8/20 81/8 81/11 81/13 82/1 93/8 116/24 171/16
redesignate [1] 151/14
redress [3] 24/24 47/3 48/24
redressing [1] 173/5
reduce [6] 58/9 95/5 106/2 133/6 205/15 206/7
reduced [5] 57/14 64/3 140/3 197/8 197/10
reduces [1] 47/18
reducing [10] 41/20 42/1 75/17 79/7 84/1 106/6 139/15 166/15 182/7 182/18
reduction [3] 105/3 172/15 173/2
Rees [2] 38/17 43/14
reference [10] 11/20 37/18 78/13 78/14 78/19 81/2 96/14 96/22 97/2 103/25
references [1] 199/19
referral [2] 41/3 195/13
referrals [1] 181/7
referred [2] 15/13 151/10
referring [1] 98/20
refers [1] 111/9
reflect [9] 36/1 67/5 88/13 114/25 122/3 153/8 165/16 190/1 211/17
reflected [8] 11/16 48/23 64/13 67/20 105/12 111/22 167/17 169/22
reflecting [2] 118/15 135/20
reflection [6] 6/12 69/6 70/8 70/10 139/12 169/10
reflections [2] 22/1 214/4
reflects [1] 88/21
reform [4] 68/16 109/7 112/13 142/9
reforms [2] 58/13 221/3
Refraining [1] 73/2
reframe [1] 57/6
refreshingly [1] 153/7
refusal [1] 30/14
refuse [3] 29/12 81/24 159/22
refused [4] 29/17 126/12 126/23 164/22
refusing [1] 165/6
refuted [1] 64/17
regard [9] 27/10 46/9 47/9 125/21 129/11 179/19 201/16 213/16 214/12
regarding [7] 2/25 25/16 35/17 56/6 209/10 214/20 214/21
regardless [3] 27/20 96/4 189/13
regards [1] 10/20
regime [2] 86/19 166/23
region [1] 31/23
regional [2] 6/18 7/20
register [2] 74/22 221/5
regret [2] 30/24 213/21
regrettably [2] 153/16 183/25
regular [4] 42/20 93/5 124/25 135/5
regularly [1] 100/18
regulation [1] 83/7
Regulations [1] 26/16
regulator [1] 87/1
regulatory [3] 73/13 86/2 104/21
rehabilitation [1] 183/14
reigns [1] 215/13
reinforce [2] 147/14 158/14
reinforced [4] 22/24 24/7 158/8 158/20
reiterate [1] 136/9
rejected [3] 88/9 148/11 180/15
relapsing [1] 182/23
relate [1] 37/19
related [10] 31/14 34/6 118/11 123/18 134/4 162/16 167/13 173/7 180/10 212/22
Relatedly [1] 220/7
relates [3] 10/14 27/21 92/21
relating [3] 19/9 43/4 77/15
relation [19] 7/12 7/18 27/15 41/25 62/25 65/24 69/7 100/5 103/17 151/11 155/12 156/19 194/10 194/17 202/7 204/19 209/19 215/9 215/18
relations [2] 62/24 214/2
relationship [1] 16/18
relationships [1] 214/16
relative [2] 130/9 216/25

R
relatively [2] 86/10 135/23
relatives [4] 69/3 71/15 125/13 125/22
relaxed [1] 210/21
relegated [2] 69/19 173/8
relegation [1] 49/19
relentless [1] 207/17
relevance [2] 88/16 200/6
relevant [4] 74/3 92/10 95/4 217/5
reliable [3] 31/16 81/18 115/12
reliance [5] 29/14 98/11 116/1 122/12 136/4
reliant [2] 103/24 220/23
relied [2] 115/24 156/18
relies [1] 82/7
religious [1] 114/3
reluctance [3] 169/23 171/8 172/11
reluctant [1] 185/25
relying [1] 53/8
remain [6] 10/3 23/10 125/3 139/2 188/1 190/11
remained [2] 86/13 136/3
remaining [1] 46/7
remains [7] 67/4 138/25 145/18 177/12 191/2 200/12 215/4
remarkable [4] 14/18 14/19 60/25 142/12
remarkably [1] 16/6
remarks [4] 3/10 194/5 194/14 207/7
remedial [1] 30/16
remedy [3] 76/22 86/20 193/24
remember [4] 10/16 195/1 199/3 203/9
remiss [1] 131/18
remote [9] 3/23 140/17 171/3 172/16 204/13 204/16 204/16 210/8 210/13
removed [1] 10/6
removing [4] 75/17 76/4 76/20 144/23
rendered [2] 139/20 193/14
reopen [1] 135/22
repeat [4] 35/9 35/19 91/11 120/2
repeated [7] 26/1 57/3 67/25 70/12 90/18 102/2 113/19
repeatedly [7] 42/17 45/12 64/1 66/12 200/2 200/3 205/4
repeating [3] 99/21 101/15 132/4
replace [1] 191/22
replicated [1] 219/2
report [26] 2/19 12/23 12/24 15/16 23/18 24/1 34/2 39/4 55/21 57/25 68/13 73/7 76/13 77/8 84/10 91/9 102/1 137/23 146/13 164/3 169/6 171/11 211/20 212/5 215/12 221/14
reported [11] 19/9 26/23 27/3 33/20 40/11 74/18 91/19 114/13 164/7 172/16 197/21
reporting [10] 16/8 26/15 26/17 26/19 27/4 55/14 86/17 168/11 172/15 191/21
reports [8] 74/7 103/21 103/24 108/23 118/1 143/7 184/22 218/21
represent [5] 10/12 107/11 131/12 195/13 206/23
representation [2] 74/7 110/15
representative [3] 124/2 130/3 163/23
representatives [1] 130/3
represented [3] 103/4 154/20 176/13
represents [3] 38/10 89/12 195/6
repurpose [1] 114/19
reputations [1] 151/21
request [2] 31/8 144/9
require [11] 36/4 36/18 37/4 37/18 78/14 114/6 138/10 147/17 150/9 191/9 195/17
required [18] 36/25 40/8 51/16 64/16 75/23 77/8 78/19 79/21 80/1 80/4 85/22 86/22 86/22 137/15 142/22 149/16 157/15 181/11
requirements [2] 42/15 129/12
requires [5] 3/15 113/17 128/24 158/23 221/25
requiring [3] 40/16 41/3 45/5
research [18] 12/1 88/3 93/20 115/11 119/15 142/22 144/22 176/3 182/25 183/1 183/5 183/7 183/8 184/7 210/11 215/8 220/13 221/3
researched [1] 69/18
reserve [1] 79/6
residence [1] 122/1
resigned [1] 201/5
resilience [15] 12/14 20/13 22/6 39/12 46/17 47/17 50/3 54/24 57/9 57/19 58/7 58/13 78/16 79/2 97/9
resilient [3] 12/13 24/12 47/1
resistance [1] 10/7
resistant [3] 28/23 28/24 31/6
resolved [1] 79/11
resolving [1] 78/23
resort [1] 194/24
resorting [1] 53/7
resounding [1] 153/21
resource [3] 72/13 117/14 216/10
resourced [3] 36/15 37/21 97/23
resources [16] 2/12 2/13 4/14 10/25 11/7 16/5 22/10 93/2 113/5 117/20 138/10 168/19 174/5 195/12 216/6 221/4
resourcing [2] 35/15 173/13
respect [13] 19/8 23/25 24/14 28/10 79/1 83/1 103/3 110/25 184/13 208/19 209/7 215/21 216/18
respected [1] 222/14
respectfully [1] 106/10
respectively [1] 67/4
respirator [2] 51/14 51/16
respirators [3] 29/23 143/5 190/20
respiratory [8] 19/23 28/10 28/21 51/3 114/5 143/9 156/8 158/6
respond [6] 20/15 47/1 47/20 68/22 159/17 178/11
responded [3] 18/21 20/2 68/2
respondees [1] 210/12
respondents [2] 52/25 55/14
responding [4] 13/1 46/21 55/1 158/1
responds [1] 28/17
response [42] 2/21 2/23 3/16 4/8 4/11 5/18 6/16 6/17 6/24 7/16 7/24 12/11 12/15 12/17 14/6 17/13 17/21 19/15 21/20 29/5 47/5 48/23 50/18 61/10 73/13 78/1 86/2 93/2 102/17 110/11 117/24 151/17 152/11 153/6 154/8 161/16 175/24 176/5 176/9 178/16 180/6 182/4
responses [6] 5/24 55/19 117/19 118/8 153/9 180/5
responsibilities [3] 7/12 11/16 26/14
responsibility [18] 7/9 14/21 14/22 26/10 51/2 63/16 76/23 84/3 89/19 104/8 104/12 104/19 138/3 153/17 153/24 155/18 179/20 196/5
responsible [5] 13/21 51/20 77/2 83/10 103/6
responsive [1] 19/11
responsiveness [2] 91/16 92/21
rest [4] 65/17 98/25 162/8 162/12
restart [1] 135/24
restates [1] 28/15
restore [2] 30/25 160/16
restored [1] 159/9
restoring [1] 145/3
restricted [3] 29/9 51/10 172/1
restrictions [14] 67/18 135/25 162/1 162/15 162/21 164/19 164/25 165/16 165/19 165/23 166/25 168/12 169/21 210/15
restrictive [3] 127/5 154/17 210/19
result [9] 86/17 97/20 108/25 113/8 118/25 127/4 172/25 196/9 200/21
resulted [7] 46/6 88/22 108/12 115/19 134/11 165/12 177/16
resulting [2] 42/7 197/10
results [4] 55/11 84/1 107/14 108/3
resumption [1] 179/25
retail [1] 46/2
retaining [2] 79/9 92/19
rethinking [1] 119/9
retreat [1] 151/7
retreated [1] 67/7
retrospective [1] 89/21
retrospectively [2] 67/5 70/5
return [8] 32/14 37/8 58/21 66/7 120/22 135/21 175/9 192/11
returning [5] 99/19 133/21 177/18 191/14 191/19
reusable [1] 20/16
reusing [1] 45/11
revealed [5] 64/14 73/22 117/13 134/1 180/9
reveals [1] 115/20
review [11] 22/1 36/23 77/1 97/8 141/19 145/10 145/13 155/14 155/17 185/2 190/19
reviewing [1] 21/24
reviews [3] 18/20 21/19 154/11
revised [2] 209/22 211/25
rewrite [1] 120/4
rhythm [1] 6/23
RIDDOR [7] 26/15 26/23 27/3 86/17 86/25 191/4 191/22
ridiculous [1] 157/16
rife [1] 139/24
right [20] 6/5 6/16 22/18 55/8 60/15 62/4 63/25 79/18 90/16 120/22 130/9 132/16 146/22 152/3 155/10 160/5 160/6 168/23 193/24 219/4
rightly [3] 45/17 95/25 105/9
rights [16] 84/9 107/17 121/7 121/10 124/6 124/10 128/8 128/24 129/1 146/7 222/10 222/11 222/13 222/17 222/19 225/8
Rights in [1] 107/17
rigorous [1] 165/21
rigorous analysis [1] 165/21
ring [2] 171/20

R

ring... [1] 184/11
ring-fenced [2] 171/20 184/11
rings [1] 2/18
rise [3] 98/1 153/8 203/15
rising [2] 55/16 205/8
risk [105] 8/6 8/12 8/13 8/19 8/23 8/25 9/1 9/8 21/4 25/10 26/6 26/7 26/9 27/19 29/5 30/21 34/23 35/1 45/10 51/24 52/4 52/12 52/20 55/15 55/18 56/18 73/3 73/17 74/23 74/25 78/21 82/2 82/25 85/7 85/20 86/6 87/9 90/11 95/1 100/13 100/20 100/24 101/7 102/16 104/15 104/24 104/25 105/3 112/25 114/12 116/4 116/11 116/11 116/15 116/17 116/18 116/20 116/23 118/16 126/5 133/6 133/24 136/3 137/9 137/10 138/3 138/12 139/3 140/14 146/23 150/14 157/18 157/20 157/23 158/1 159/25 166/16 167/8 168/3 177/11 177/13 177/22 178/22 181/14 182/1 182/2 182/16 184/1 186/5 186/13 186/18 186/22 187/5 190/8 190/10 190/12 194/23 194/25 197/22 202/20 203/7 204/7 211/14 214/23 219/15
risk-benefit [1] 87/9
risked [3] 53/10 63/22 219/13
risks [17] 3/4 7/22 30/14 31/1 36/7 61/12 88/5 102/2 113/6 166/10 180/3 180/12 196/11 196/12 205/22 205/23 209/18
risky [1] 51/24
Ritchie [6] 32/10 141/16 143/17 155/2 165/17 189/5
Ritchie's [1] 155/22
RNIB [2] 208/11 209/2
RNIB's [1] 209/3
RNID [1] 210/11
road [1] 167/2
roadmap [1] 112/13
robust [5] 109/19 117/24 142/8 165/16 201/24
Rogers [2] 177/7 180/18
role [29] 39/6 39/9 39/15 41/14 41/19 47/5 47/13 48/14 48/21 56/15 56/21 56/24 58/15 72/24 76/25 77/16 80/15 81/15 81/16 85/17 87/4 112/15 132/14 141/10 163/24 164/4 172/19 174/12 176/8
roles [7] 7/1 7/12 74/25 113/3 114/12 114/15 177/20
roll [1] 66/2
roll-out [1] 66/2
rolled [1] 138/12
rollout [1] 19/16
room [18] 25/7 59/4 62/7 63/6 63/21 64/9 109/9 120/6 139/18 164/14 164/20 164/22 165/8 176/14 177/8 199/5 207/18 217/16
rooms [5] 51/6 51/7 80/10 144/16 144/17
rooted [1] 109/15
Rosa [2] 131/14 161/12
Rosa Polaschek [1] 161/12
rose [3] 2/17 18/14 94/13
rough [1] 221/23
roughly [1] 70/23
roundtables [1] 176/6
route [4] 147/11 149/6 189/21 195/13
routes [5] 150/7 150/9 156/8 157/25 189/16
routine [5] 8/22 29/1 31/6 36/2 144/12
routinely [3] 96/17 186/16 190/13
Royal [11] 42/24 49/6 49/10 89/3 89/12 89/13 167/2 196/18 199/9 224/16 224/23
RPE [13] 28/22 29/1 29/13 31/4 31/8 32/13 144/23 153/17 154/4 157/14 158/12 160/13 170/7
RPS [11] 50/5 50/24 52/2 52/2 52/10 52/24 53/19 55/1 57/5 57/25 58/11
RPS's [3] 54/8 55/11 55/20
rubicon [1] 78/3
Ruby [1] 72/9
rule [1] 137/19
rules [9] 165/5 165/10 167/9 167/9 168/23 210/16 210/19 210/21 218/8
run [3] 25/23 29/11 48/2
running [2] 24/2 192/24
Ruth [3] 116/14 168/24 171/4
Ruth May [2] 116/14 168/24

S

sacrifice [3] 4/15 96/16 210/1
sacrificed [2] 188/17 188/24
sad [1] 63/12
sadly [6] 4/16 32/9 152/8 161/20 218/7 219/1
safe [21] 40/4 40/6 50/1 52/23 55/5 66/23 82/8 86/11 104/19 113/5 123/3 132/3 132/6 132/8 139/6 139/13 139/19 140/16 187/5 192/21 193/6
safeguarding [1] 172/19
safeguards [1] 155/12
safely [1] 211/7
safety [22] 26/9 26/14 27/6 30/19 30/20 30/23 35/5 35/17 36/9 52/1 54/4 85/3 86/4 104/22 114/3 115/2 126/4 131/22 149/20 164/3 202/18 210/22
SAGE [1] 154/6
said [54] 3/16 8/7 14/7 14/17 15/15 15/21 17/2 18/3 18/24 42/11 43/7 44/14 45/15 52/25 59/3 75/2 81/16 102/15 106/7 133/3 134/13 134/16 134/24 138/14 141/15 141/18 142/20 151/24 155/16 157/19 163/14 165/18 166/10 166/13 168/24 169/2 169/5 169/10 169/12 169/16 169/16 169/25 179/19 181/10 189/11 193/17 195/24 200/10 201/18 204/5 209/2 210/4 213/5 213/12
Sajid [6] 75/6 78/6 105/9 115/18 136/16 182/10
Sajid Javid [1] 115/18
same [31] 35/8 47/6 54/9 75/8 84/22 86/7 97/17 105/8 105/12 105/17 105/17 106/13 121/15 130/17 130/25 142/1 153/21 165/3 165/19 166/10 166/18 169/16 175/1 176/23 196/6 200/1 211/2 212/21 216/10 220/15 221/18
Sammie [1] 186/6
Sammie McFarland [1] 186/6
sanction [1] 104/21
Sanjeev [2] 38/23 42/9
Sanjeev Panesar [2] 38/23 42/9
Sara [1] 83/15
Sara Gorton [1] 83/15
Sarah [5] 60/1 201/23 202/16 205/6 206/6
Sarah Hughes [2] 205/6 206/6
Sarah Hughes' [1] 202/16
SARS [7] 29/2 29/4 147/21 177/15 177/21 189/20 190/3
SARS-CoV-1 [2] 29/2 147/21
SARS-CoV-2 [4] 29/4 177/15 177/21 189/20
SARS-CoV-2's [1] 190/3
satisfactory [1] 209/4
saturation [2] 214/22 216/24
save [4] 96/23 97/1 132/5 209/24
saved [2] 11/3 130/16
saving [1] 87/11
saw [2] 94/14 148/8
say [44] 1/25 2/8 5/24 6/8 15/22 38/10 44/23 70/16 75/4 76/11 84/18 87/9 100/21 120/13 123/4 126/20 137/19 140/4 146/25 147/2 147/8 147/14 148/24 149/3 149/22 150/14 150/17 150/24 150/25 153/18 153/25 156/3 159/5 166/3 167/7 168/5 174/24 200/13 203/16 204/18 208/5 211/2 217/3 221/21
saying [5] 5/3 41/5 48/6 123/19 161/15
says [6] 74/14 81/22 82/16 152/8 153/23 203/20
scalable [1] 184/15
scale [7] 3/2 4/17 33/18 36/17 79/21 134/7 211/12
scaling [1] 36/11
scan [4] 66/15 66/16 166/14 166/16
scans [2] 163/8 163/9
scarce [1] 198/6
scars [1] 25/21
scary [1] 189/14
scenarios [4] 10/19 10/23 199/14 217/19
scene [2] 1/23 163/9
scepticism [2] 80/16 180/16
scheme [4] 44/8 44/12 56/9 128/3
school [3] 45/23 56/7 197/6
schooling [1] 197/23
schools [3] 53/8 133/21 187/4
science [3] 150/13 151/16 165/17
scientific [11] 69/8 135/9 145/1 148/13 148/16 148/18 149/18 150/1 150/16 150/21 156/1
scientifically [1] 69/19
scientifically-recognised [1] 69/19
scientists [1] 49/13
scope [2] 70/20 221/18
score [1] 211/17
scores [3] 43/1 43/2 55/12
Scotland [11] 26/24 30/17 31/8 50/23 84/5 167/23 170/3 185/11 187/19 187/25 215/17
Scott [1] 65/22
Scottish [2] 187/23 188/3
screening [1] 62/15
scrutiny [2] 83/7 181/24
second [23] 8/25 10/25 21/14 23/21 32/3 36/4 77/6 85/1 92/21 99/2 107/16

S

second... [12] 123/12 128/6 170/18 178/12 180/8 197/19 205/11 210/8 213/11 213/24 219/3 222/20
secondary [4] 32/1 33/5 36/24 79/7
secondly [5] 3/2 50/2 122/4 130/1 156/11
Secretaries [1] 75/6
secretary [6] 49/16 54/1 139/10 200/4 210/4 220/10
section [6] 31/12 82/20 128/19 128/21 132/9 202/5
section 131 [1] 202/5
section 13H [1] 128/19
section 2 [1] 128/21
sections [1] 23/19
sector [16] 2/22 46/14 50/4 50/23 55/12 79/6 86/15 86/18 86/24 129/4 154/20 195/3 195/6 199/4 205/16 206/12
sectors [3] 86/6 111/23 154/19
security [2] 99/15 101/25
see [11] 1/4 38/3 61/3 65/18 67/8 108/9 112/2 133/7 152/13 201/4 217/18
seeing [5] 110/1 148/9 152/15 189/10 189/13
seek [4] 19/12 21/15 52/17 89/20
seeking [11] 21/12 39/18 82/14 89/14 140/15 155/10 157/3 180/22 180/23 193/11 210/12
seeks [2] 49/24 153/23
seem [1] 123/4
seemed [4] 3/22 67/10 140/2 147/3
seemingly [3] 29/17 53/22 165/10
seems [8] 59/25 62/8 64/23 65/17 65/22 67/12 140/4 141/15
seen [11] 3/2 12/22 56/3 61/14 75/25 88/23 123/14 161/25 169/8 196/23 215/12
seldom [1] 207/2
self [8] 42/15 46/4 70/2 85/22 130/22 194/21 202/11 202/13
Self-evidently [1] 70/2
self-harm [1] 194/21
self-isolate [3] 46/4 202/11 202/13
self-isolation [2] 42/15 85/22
Sen [4] 95/10 95/12 106/20 225/3
send [1] 150/19
sends [1] 110/12
senior [7] 20/21 44/20 56/12 129/10 134/9 168/22 200/3
sense [9] 44/24 60/11 61/2 66/18 76/2 165/1 166/20 188/20 213/8
sensible [2] 19/22 82/18
sensibly [1] 156/14
sensitively [1] 136/18
sent [2] 208/23 212/7
sentiment [2] 16/24 53/24
sentiments [1] 15/4
separated [1] 43/20
separately [1] 158/5
September [5] 67/22 71/4 136/4 189/19 210/11
sequelae [5] 178/11 179/2 179/7 180/4 184/16
series [3] 29/19 90/20 159/25
serious [24] 20/10 27/20 30/24 32/16 41/2 76/1 105/2 140/22 140/22 146/3 147/8 153/5 153/9 156/22 158/23 159/25 168/10 171/10 172/3 186/22 194/21 209/23 213/21 222/12
seriously [7] 30/4 31/18 142/5 142/7 168/5 181/1 202/4
serve [3] 41/16 55/9 124/9
served [3] 11/4 17/7 107/23
serves [1] 72/22
service [17] 12/12 14/12 27/13 27/14 34/19 40/10 47/18 48/19 56/21 58/14 58/15 74/4 75/3 76/12 172/5 172/8 202/2
services [61] 3/8 14/4 16/11 21/16 24/1 24/9 37/5 37/22 39/24 40/7 40/20 41/18 46/22 47/4 48/1 48/5 50/13 55/24 57/9 57/22 72/12 73/5 73/12 83/10 84/5 84/8 84/12 90/24 91/22 94/6 98/7 164/3 168/6 168/20 171/8 172/2 173/14 175/24 181/7 183/14 183/14 183/18 183/18 183/20 183/25 184/15 187/11 187/12 187/19 188/10 194/8 196/22 196/25 197/14 197/15 197/17 198/20 199/21 199/23 200/13 209/17
session [2] 175/10 175/14
sessions [1] 91/7
set [15] 1/19 1/25 8/21 9/13 21/13 35/22 78/11 85/23 94/2 113/21 213/25 218/23 222/4 222/11 222/14
sets [1] 196/3
setting [11] 7/12 9/20 26/18 46/3 68/5 86/10 92/7 128/7 139/9 150/23 177/12
settings [24] 35/19 36/12 52/6 57/23 116/22 122/15 127/11 130/11 139/20 139/23 152/15 170/10 171/24 172/12 177/22 190/12 190/20 192/21 193/7 193/9 199/12 199/14 201/20 212/8
settled [1] 222/9
seven [3] 178/7 178/22 196/15
seventh [2] 37/1 204/11
several [5] 177/19 183/25 187/12 204/15 209/20
severe [5] 23/9 34/15 110/24 112/7 194/20
severely [2] 51/12 118/7
severity [8] 23/2 37/20 101/14 179/12 182/7 182/18 184/19 197/1
shadow [1] 210/19
shall [5] 58/21 120/22 120/22 175/9 222/23
Shane [2] 131/15 161/13
shape [2] 114/24 123/7
shapes [1] 36/13
share [2] 21/2 84/24
shared [2] 76/25 93/19
sharing [2] 20/22 134/13
sharply [2] 74/8 197/4
she [31] 14/17 17/1 59/19 60/3 60/11 60/17 66/12 66/14 66/15 66/23 81/16 81/22 81/22 100/7 100/8 100/9 101/2 101/2 133/3 153/6 155/22 158/5 158/13 169/2 169/6 169/12 169/13 189/8 189/11 212/18 212/21
shed [1] 44/10
sheer [3] 33/18 61/4 123/12
sheeted [1] 147/13
Sheffield [1] 114/24
shield [1] 134/7
shielded [4] 134/22 137/7 145/14 219/10
shielding [16] 54/20 132/9 132/14 132/17 132/23 134/4 135/14 135/19 136/4 136/15 136/17 137/20 139/21 208/10 208/22 219/8
shields [1] 28/8
shift [5] 48/7 76/19 100/8 138/3 152/12
shifting [1] 104/6
Shin [3] 141/17 165/18 166/10
shock [1] 39/20
shocking [3] 27/23 101/14 107/13
shone [1] 2/15
short [12] 20/6 54/22 58/23 66/6 83/25 120/25 134/19 135/14 150/22 161/11 175/12 180/20
short-termism [1] 83/25
shortage [3] 24/17 27/20 50/19
shortages [11] 23/9 31/2 42/15 51/21 55/5 57/18 58/4 79/1 80/7 114/14 171/18
shortcomings [2] 116/8 122/12
shortfall [4] 24/15 24/24 79/14 79/16
shortly [1] 76/17
should [101] 3/11 6/12 7/14 7/16 8/24 9/14 10/2 10/12 11/20 15/24 17/8 20/10 20/14 21/6 29/6 39/3 44/12 48/1 48/10 54/6 54/9 63/12 64/20 65/17 69/5 73/6 77/1 77/3 77/7 77/9 77/13 81/25 82/2 84/21 88/15 89/14 89/22 91/14 113/12 116/10 121/20 124/9 127/10 127/13 127/20 128/15 129/15 129/16 130/6 130/6 138/1 138/2 142/4 147/2 147/14 147/24 148/11 148/12 151/2 152/18 152/21 155/3 156/19 163/12 168/5 169/11 169/23 171/5 171/13 172/2 172/21 177/1 180/5 182/14 182/17 183/7 184/11 184/14 186/3 187/9 188/5 188/8 188/11 189/12 190/6 190/9 195/18 196/10 199/6 206/9 209/14 210/7 211/11 212/1 212/11 214/23 215/14 217/2 219/17 221/3 222/15
show [3] 55/11 149/2 172/24
showed [6] 34/4 42/25 52/24 57/4 126/14 215/8
showing [3] 52/16 115/12 187/14
shown [4] 104/3 161/20 162/13 207/17
shows [7] 115/22 152/21 171/23 208/8 212/24 213/9 218/14
shut [1] 171/3
shy [1] 142/14
sick [6] 33/7 83/5 85/12 100/23 132/18 137/12
sickness [3] 34/5 53/11 173/16
sickness days [1] 34/5
side [3] 25/7 51/6 51/7
side rooms [1] 51/6
side-room [1] 25/7
sidelined [1] 62/3
sidelining [1] 45/3
sight [1] 74/5
signal [2] 110/13 150/18
significance [1] 190/17
significant [25] 24/25 28/12 40/12 42/6 44/5 46/14 46/20 48/22

S

significant... [17] 49/21 54/11 57/10 62/23 82/20 87/6 118/19 132/22 136/25 141/10 171/23 194/25 200/11 200/14 203/14 218/17 219/23
significantly [9] 36/21 56/8 95/5 97/25 102/6 103/10 105/8 166/16 203/17
signpost [2] 135/2 178/24
silence [2] 102/18 102/18
silenced [2] 61/16 62/3
silent [1] 184/23
silver [1] 143/16
Simblet [4] 146/15 146/17 160/24 225/14
similar [8] 14/16 15/18 32/9 74/17 84/9 122/12 213/19 215/22
similarly [6] 17/15 124/4 157/16 158/11 181/19 210/15
simple [3] 47/11 73/6 201/4
simplest [1] 105/1
simply [18] 3/9 28/15 30/13 65/4 65/12 69/11 88/4 91/11 119/7 135/15 140/20 158/18 164/16 165/14 196/24 199/12 206/20 206/24
simultaneously [1] 42/14
since [11] 32/21 46/24 55/13 61/22 64/23 65/1 67/2 71/5 157/20 169/20 179/17
sincerely [1] 95/18
single [7] 46/5 51/5 80/10 100/7 100/16 104/20 215/20
single-bedded [1] 51/5
singular [1] 183/11
Sir [27] 7/5 8/7 12/4 17/10 26/4 35/14 69/11 69/14 75/6 78/6 102/15 105/9 105/25 134/12 134/16 134/24 134/25 136/16 137/23 137/24 142/3 163/3 169/16 181/13 182/10 183/21 219/21
Sir Chris Whitty [9] 7/5 8/7 12/4 69/14 102/15 134/16 134/24 137/23 142/3
Sir Christopher [2] 134/12 219/21
Sir Frank Atherton [2] 17/10 137/24
Sir Michael McBride's [1] 69/11
Sir Patrick [1] 134/25
Sir Sajid [1] 105/9
Sir Sajid Javid [2] 136/16 182/10
Sir Stephen [1] 169/16
sit [5] 63/25 68/25 130/21 164/20 164/22
sites [2] 3/23 98/6
sitreps [1] 10/18
sits [1] 23/11
situated [1] 13/19
situation [8] 6/4 11/8 21/4 47/3 173/3 193/3 204/18 209/8
situations [4] 15/20 35/14 81/21 133/10
six [4] 26/7 51/5 51/5 205/3
sixth [6] 36/21 174/11 178/20 191/23 202/19 206/5
size [4] 5/24 69/8 110/18 116/1
ski [1] 28/1
skills [1] 120/9
skin [4] 115/7 120/10 170/12 170/12
skins [1] 115/13
Slater [2] 131/15 161/13
sleeping [2] 33/16 133/23
slices [1] 143/22
slogan [1] 96/22
slot [1] 207/9
slow [1] 187/11
small [5] 11/13 38/24 52/22 129/23 156/2
Smith [3] 131/15 161/13 199/9
sneezing [1] 30/12
Snooks [2] 137/14 137/19
so [82] 3/10 7/14 12/3 14/10 14/14 15/23 16/10 22/4 32/24 34/15 40/3 47/16 52/12 59/19 60/3 60/9 60/17 60/21 63/22 65/6 65/10 69/23 71/22 73/22 77/10 81/20 83/1 90/14 90/16 90/17 94/21 100/23 105/12 107/2 108/14 108/22 115/20 118/20 119/7 120/6 125/7 131/18 138/6 138/11 138/21 142/11 143/13 144/25 147/2 147/3 147/3 147/10 148/10 149/21 150/11 151/4 151/20 154/9 156/14 158/13 158/14 159/5 160/19 164/24 168/4 171/14 173/14 179/1 189/14 193/18 200/11 200/12 200/12 200/21 201/13 202/4 202/23 202/23 203/1 203/8 210/7 215/11
sobering [1] 71/6
social [22] 2/6 12/12 14/3 24/1 49/16 52/23 53/1 53/2 73/18 85/10 87/16 88/16 97/17 98/20 112/4 125/17 144/15 195/12 197/24 200/5 206/18 219/12
societal [1] 111/20
society [16] 49/6 49/10 74/2 97/21 98/22 130/16 133/8 134/18 146/3 178/21 192/24 203/3 211/25 215/4 222/5 224/16
Society's [1] 42/24
socioeconomic [4] 112/3 113/10 204/1 218/15
solace [2] 46/12 187/24
Solicitors [1] 72/9
solid [1] 69/17
solidarity [1] 176/12
solution [6] 71/21 83/25 114/5 145/2 209/5 222/1
solutions [2] 9/21 119/20
solve [1] 158/11
solved [2] 66/2 167/13
solves [1] 82/18
some [62] 5/8 10/5 11/15 15/1 27/15 32/8 41/13 42/9 42/16 45/7 46/12 58/10 61/1 62/8 68/8 69/24 78/23 87/25 91/13 94/9 98/3 105/14 116/22 122/7 122/8 122/20 130/7 139/2 139/14 141/24 149/11 152/19 153/11 153/11 155/1 158/14 160/1 161/6 165/13 168/6 168/22 170/23 170/25 171/21 177/19 183/17 187/8 194/11 198/7 198/8 198/10 199/3 208/3 208/23 210/10 210/12 211/21 216/12 219/19 221/16 222/2 222/6
some months [1] 45/7
somebody [2] 166/8 220/3
someone [5] 41/5 126/24 134/17 160/4 217/16
something [6] 130/11 140/3 141/13 162/7 214/7 215/22
sometimes [5] 2/4 2/6 99/17 139/15 160/1
somewhat [3] 140/2 213/16 222/3
soon [1] 135/19
sooner [1] 116/8
sorry [8] 59/1 65/6 65/10 106/24 106/25 107/3 107/4 207/10
sort [1] 152/19
SOS [1] 175/21
sought [9] 6/9 10/5 16/9 20/1 26/17 91/12 105/23 130/6 186/15
sound [1] 82/9
source [7] 16/15 27/25 41/9 45/5 53/5 193/1 197/7
sources [2] 180/25 204/15
sourcing [5] 11/18 41/11 50/18 53/23 54/21
space [3] 40/4 99/24 217/14
spaces [2] 25/5 52/21
Spanish [1] 3/25
spanned [1] 41/1
sparse [1] 187/12
speak [4] 96/7 96/9 125/8 164/5
speaker [1] 59/6
speaking [1] 123/15
speaks [1] 159/11
special [2] 71/15 130/25
specialised [1] 184/15
specialist [8] 50/16 123/22 172/23 183/17 183/21 183/23 187/18 188/10
specific [20] 3/8 5/10 7/24 9/12 10/17 13/4 19/7 35/4 56/5 75/19 103/17 116/12 167/12 168/25 194/17 205/12 205/21 208/18 209/13 214/4
specifically [3] 8/14 129/18 130/11
spectrum [1] 137/16
speculate [1] 208/3
speed [3] 116/14 212/16 221/8
spending [3] 99/14 99/16 99/23
spent [2] 41/10 54/21
spinal [1] 32/4
spoke [2] 114/4 216/14
sponsorship [1] 85/25
sporadic [1] 208/17
spot [3] 83/10 86/14 86/14
spotlight [1] 15/8
spotted [1] 212/20
spread [5] 27/5 51/8 147/12 156/8 177/5
spreading [1] 53/10
spreads [1] 142/18
spring [3] 55/22 103/14 187/14
stable [3] 211/15 211/17 212/2
staff [129] 1/22 2/9 2/14 2/16 4/18 5/5 6/14 8/19 8/20 14/11 14/13 14/19 15/13 15/16 15/19 16/8 17/22 18/1 18/19 18/20 18/21 19/7 23/9 23/11 23/23 24/4 25/1 26/3 26/10 27/7 28/7 29/7 29/12 30/20 30/21 30/22 31/1 31/4 31/8 31/11 31/13 31/18 31/25 32/20 32/23 33/3 33/13 33/19 33/21 34/1 34/5 34/7 34/19 34/22 35/18 36/6 36/19 37/3 39/11 41/10 42/4 44/11 46/1 46/6 53/1 53/9 53/23 54/8 54/14 61/6 61/12 72/14 74/8 74/11 74/11 74/15 74/21 79/8 79/10 79/14 79/17 79/25 81/3 81/3 81/7 81/8 81/10 81/14 83/3 83/12 84/15 85/4 92/13 92/19 93/7 93/9 95/6 98/12 100/7 100/10 100/17 103/4 116/15 122/16 124/12 126/11 127/6 131/1 131/17 144/5 158/1 160/20 163/21 163/25 166/24 167/3 167/5 169/4 171/16 171/18

S

staff... [9] 171/20 173/2 174/17 188/19 188/20 188/22 188/23 207/16 215/23
staffed [1] 80/21
staffing [12] 20/13 24/14 34/10 40/16 42/15 46/23 72/13 73/13 77/25 78/25 79/1 80/13
stage [2] 88/12 113/21
stages [3] 162/24 173/25 202/22
staggered [1] 144/15
stake [1] 7/2
stakeholder [1] 10/12
stakeholders [5] 7/19 58/3 153/3 213/4 217/6
stand [1] 59/13
standard [9] 9/20 74/7 74/18 85/3 102/19 114/24 150/23 208/17 209/14
standardisation [1] 116/17
standardised [1] 118/8
standards [2] 124/5 173/15
standing [9] 65/5 65/13 79/2 80/14 125/5 200/6 213/15 214/3 214/8
standout [1] 96/15
Stanton [4] 22/18 22/20 38/1 224/11
stark [8] 27/11 70/11 70/11 74/5 115/6 118/21 148/21 170/20
starkly [2] 98/23 108/22
start [17] 1/18 4/13 22/14 23/4 24/12 35/8 45/20 46/24 67/18 70/25 121/12 128/5 145/11 148/18 171/14 184/3 213/15
started [4] 32/21 73/25 175/15 218/12
starting [2] 36/22 42/19
starts [3] 91/23 184/5 214/8
state [19] 49/16 63/18 63/24 66/21 73/12 75/25 77/20 77/23 91/20 94/12 148/16 148/23 149/9 153/14 200/4 210/4 215/6 217/12 220/10
state's [1] 149/5
stated [5] 27/15 92/4 182/10 183/1 189/18
statement [62] 1/15 13/14 18/11 19/21 21/14 22/19 22/22 23/16 28/14 35/22 38/5 38/8 38/14 38/15 38/23 39/8 49/1 49/6 49/9 49/24 50/21 59/8 68/2 70/12 70/13 72/5 89/3 89/11 91/10 95/11 107/8 121/7 131/9 146/7 146/16 161/8 175/18 186/22 187/1 194/3 199/8 202/16 205/6 207/11 219/16 224/5 224/7 224/9 224/12 224/15 224/17 224/20 224/22 225/1 225/4 225/7 225/10 225/12 225/15 225/18 225/20 225/22
statements [11] 16/13 16/25 21/9 52/2 72/20 76/10 90/20 158/2 186/12 195/23 196/2
stating [1] 186/9
statistic [2] 70/22 110/21
statistical [2] 20/18 196/3
statistics [3] 71/2 74/17 195/22
status [10] 85/18 96/9 100/22 103/23 103/25 105/16 192/13 218/15 218/16 222/18
statutory [5] 128/14 128/21 132/18 137/12 202/5
stay [6] 45/10 96/22 96/25 100/25 170/20 171/5
stayed [1] 42/18
staying [1] 42/19
steer [1] 78/21
stem [1] 37/21
stemming [2] 88/2 196/16
step [1] 79/18
Stephen [5] 104/15 127/13 163/3 169/16 183/22
Stephen Powis [1] 127/13
stepped [2] 40/3 124/19
steps [17] 4/25 13/6 57/23 75/15 75/18 84/19 85/23 103/17 130/4 135/13 135/17 141/12 146/8 204/5 209/1 209/21 220/25
STI [1] 207/16
stick [1] 221/23
still [30] 5/11 12/1 25/21 31/3 31/4 62/8 62/20 71/19 80/19 92/5 102/12 126/12 145/22 146/2 149/19 151/13 155/23 168/2 171/21 180/13 180/17 186/2 187/18 188/1 190/1 190/12 193/1 210/6 217/14 218/16
stillbirth [1] 172/9
stillbirths [1] 172/10
stimulated [1] 157/13
stipulated [1] 210/6
stock [6] 20/14 20/15 27/21 36/16 92/18 190/5
stockpile [1] 36/12
stockpiles [1] 114/22
stockpiling [1] 117/20
stocks [1] 68/14
stone [1] 158/10
stop [2] 32/22 183/15
stopped [3] 162/18 171/23 172/22
stores [1] 28/2
stories [1] 25/13
story [6] 110/21 119/18 122/25 132/10 185/17 196/9
straight [2] 33/1 210/3
strain [3] 23/1 54/13 113/3
strained [1] 53/16
strategies [6] 83/14 92/18 92/24 110/9 112/17 113/9
strategy [8] 58/5 79/24 80/4 87/20 92/7 92/14 92/15 184/14
stream [1] 64/7
streamlined [1] 36/18
street [1] 208/4
strength [2] 63/11 123/6
strengthen [1] 57/23
stress [4] 34/6 42/7 124/12 203/24
stress-related [1] 34/6
stressed [2] 52/2 207/19
stressed-out [1] 207/19
stresses [1] 55/6
stressful [1] 6/5
stretched [4] 34/10 54/23 72/13 80/22
stretching [1] 4/14
strict [2] 165/1 170/5
stricter [1] 167/9
strictly [1] 165/6
strike [1] 168/23
striking [2] 75/5 140/13
stringent [1] 73/2
Stringer [4] 208/11 209/2 213/8 213/12
strived [1] 174/13
striving [1] 70/4
strong [3] 37/4 106/7 142/15
stronger [2] 36/8 214/16
strongly [3] 57/6 84/16 189/20
struck [7] 5/1 8/3 9/19 12/3 72/14 162/14 205/22
structural [14] 3/17 73/11 108/5 109/8 111/4 111/19 111/25 112/9 112/18 113/10 119/1 138/5 154/1 222/7
structured [1] 104/7
structures [9] 3/3 5/13 5/16 6/16 6/22 7/16 7/18 18/2 111/21
struggled [2] 34/22 53/5
struggling [1] 34/1
stubborn [1] 30/14
stubbornly [1] 29/16
stuck [1] 133/13
studied [1] 192/16
studies [7] 29/21 87/23 133/25 172/9 172/10 172/24 186/20
study [3] 11/14 172/14 192/2
stuff [1] 195/25
style [1] 80/16
Subcontracted [1] 103/4
subject [4] 104/20 157/7 194/7 194/10
subjected [1] 165/20
subjects [1] 194/11
submission [6] 16/2 76/15 77/15 90/19 94/25 161/19
submissions [36] 1/3 1/11 1/16 13/17 39/1 72/8 73/8 73/10 73/15 76/21 79/20 85/24 88/18 95/22 96/21 97/2 113/20 131/23 132/1 146/10 146/13 146/19 156/5 160/17 161/7 161/15 175/6 175/15 178/4 188/3 191/8 192/6 207/20 218/12 222/24 224/3
submit [3] 106/10 137/25 164/14
submits [1] 58/11
submitted [2] 89/7 146/22
subsequent [2] 187/1 190/14
substance [1] 76/8
substantially [1] 91/7
substantiated [1] 53/25
substantive [2] 79/3 81/15
substitute [2] 68/13 204/25
success [3] 56/21 125/25 153/21
successful [1] 204/13
successfully [3] 18/14 20/2 126/13
successors [1] 106/7
such [66] 3/7 3/8 7/3 7/14 8/19 10/6 11/17 12/19 16/8 16/25 19/11 19/13 20/15 26/13 27/12 28/11 29/20 30/11 32/17 42/22 47/5 66/21 79/5 83/22 87/17 88/10 88/10 97/18 99/17 104/7 111/14 113/5 113/18 114/12 114/18 115/1 115/6 116/24 117/1 117/19 130/5 130/9 138/16 145/18 149/19 154/6 154/19 155/25 156/14 158/25 161/22 165/10 166/3 167/19 173/1 173/2 182/16 188/8 197/23 201/22 211/15 216/4 216/13 216/17 221/8 221/12
sudden [1] 203/10
suddenly [3] 33/9 133/10 199/1
suffer [5] 146/2 176/21 187/8 188/7 193/19
suffered [6] 34/7 72/15 127/4 137/5 173/10 176/11
sufferers [1] 71/11
suffering [13] 4/16 32/13 37/7 62/13 90/17 103/15 108/13 123/10 126/24 185/11 186/15 192/10 193/13
sufficient [8] 20/14

S

sufficient... [7] 21/20 31/10 48/15 92/1 92/17 147/16 201/1
sufficiently [3] 90/16 141/6 164/13
suggest [11] 5/25 11/19 59/12 79/13 81/4 88/15 129/14 140/2 189/20 213/2 220/15
suggested [8] 39/14 75/1 127/17 160/17 172/11 177/4 186/12 213/8
suggesting [1] 181/21
suggestion [1] 168/6
suggestions [3] 15/12 144/15 160/19
suggests [4] 26/7 171/7 194/9 217/21
suicidal [2] 196/5 198/23
suicides [1] 161/25
suitable [5] 36/13 52/6 115/24 158/6 190/8
Sullivan [1] 59/15
summary [1] 21/8
summer [2] 66/12 186/20
Summers [1] 25/1
superintendent [2] 38/18 38/24
superiority [1] 29/24
supervision [1] 183/20
supplement [1] 79/4
supplies [3] 20/13 51/20 53/16
supply [22] 20/15 31/2 40/6 41/7 41/10 45/9 45/16 50/14 54/2 54/22 57/17 57/24 58/6 68/18 94/5 94/6 151/6 151/10 151/12 158/13 177/15 190/10
support [61] 1/23 5/20 9/2 9/5 9/17 15/24 19/1 29/15 37/2 37/5 37/8 40/4 42/12 44/4 47/25 48/18 51/21 54/9 57/2 57/22 58/7 84/15 87/14 93/9 93/10 108/14 125/1 127/11 128/8 128/12 128/13 132/21 136/15 136/20 138/19 138/20 145/15 145/17 152/5 162/18 163/13 164/4 167/13 171/22 172/21 173/4 173/20 174/19 175/22 176/12 176/20 190/14 191/10 191/13 191/18 194/23 197/7 206/10 206/16 206/20 219/24
supported [4] 43/12 124/13 130/12 137/22
supporter [2] 44/18 130/9
supporters [1] 162/23
supporting [5] 11/9 49/14 50/13 52/13 92/12
supports [4] 15/19 57/6 132/15 170/13
supposed [1] 131/22
supremacy [1] 129/13
sure [8] 14/9 47/14 47/16 90/2 134/21 135/11 161/3 222/2
surely [3] 89/17 89/21 145/1
surge [9] 4/21 21/5 35/6 54/23 80/15 81/9 200/7 202/21 205/9
surgery [3] 28/6 144/21 163/19
surgical [4] 28/23 28/24 31/6 143/5
surmount [1] 78/24
surprise [2] 198/9 203/11
surprising [3] 30/9 215/2 220/6
surrounding [1] 217/21
surveillance [4] 179/12 180/1 180/4 184/22
survey [11] 15/13 24/21 33/24 42/25 52/24 55/11 55/14 55/21 179/16 179/17 199/22
surveyed [1] 199/23
surveys [3] 18/20 85/4 179/15
surviving [1] 176/13
survivors [1] 127/1
Susan [3] 59/17 59/24 143/17
Susan's [1] 59/22
susceptibility [1] 112/7
suspect [1] 106/25
suspected [1] 29/8
sustainable [1] 37/1
sustained [2] 76/3 155/3
Swann [3] 67/3 67/9 70/13
Swann's [1] 69/9
Swansea [3] 17/1 17/4 38/19
Swansea Bay [2] 17/1 17/4
swathes [1] 25/18
swiftly [2] 9/13 116/22
swimming [1] 28/1
Swiss [4] 143/22 143/22 143/25 146/12
sympathy [1] 222/2
symptom [1] 157/11
symptomatic [1] 101/2
symptoms [11] 52/16 176/4 179/13 181/2 182/23 185/12 186/11 186/16 192/10 197/10 210/6
syndrome [1] 219/9
system [57] 5/14 6/17 13/3 14/9 20/16 31/16 43/13 44/12 44/24 45/2 47/1 48/17 49/17 49/21 56/12 66/3 66/22 68/14 70/19 75/10 86/25 92/2 97/1 97/12 100/1 100/22 103/21 104/7 104/12 105/14 105/25 106/8 106/17 107/20 108/4 113/15 115/23 116/6 119/2 119/24 123/25 124/9 124/10 124/13 124/20 125/7 126/15 139/12 139/16 159/17 160/19 185/25 191/21 193/15 195/7 200/8 211/6
system's [2] 14/6 108/15
systematic [2] 10/10 167/16
systemic [26] 55/23 70/19 74/3 75/23 76/12 76/19 86/20 96/2 108/3 109/1 110/5 111/7 112/13 113/8 113/17 114/18 116/8 117/23 118/15 120/13 196/17 202/14 221/22 221/25 221/25 222/4
systems [30] 22/9 23/1 23/5 23/20 24/12 35/8 35/12 36/15 39/21 77/21 77/23 82/9 82/10 96/14 97/16 109/13 109/16 111/20 116/3 117/17 119/10 130/1 134/6 167/16 178/10 179/4 179/11 193/8 195/6 222/16
systems' [1] 179/1

T

tackle [2] 79/21 140/21
tackling [1] 103/20
tactically [1] 116/3
tailor [1] 9/21
take [30] 3/13 6/9 13/5 23/17 24/24 30/16 37/6 49/4 62/13 75/15 76/24 83/23 90/16 100/9 108/22 109/25 135/17 138/13 142/4 144/7 151/22 153/22 156/1 161/2 161/4 161/5 168/5 175/9 209/20 210/17
take months [1] 138/13
taken [21] 10/15 10/16 16/21 22/5 29/6 30/25 47/3 57/23 59/19 76/6 133/16 134/17 150/2 150/24 151/21 153/5 190/6 199/6 202/3 209/1 220/25
takers [1] 154/25
taking [4] 20/18 75/18 160/5 217/15
talked [1] 8/9
talking [2] 8/12 30/12
Tamsin [1] 164/18
Tamsin Mullen [1] 164/18
targeted [2] 109/24 116/18
task [4] 2/25 4/9 23/14 194/10
tasked [1] 217/9
tasks [1] 99/17
taxi [1] 99/21
taxpayer [1] 44/16
TB [1] 147/21
team [13] 1/21 42/16 51/22 65/19 70/16 89/8 95/19 121/15 124/15 125/20 130/22 131/17 221/7
teams [31] 6/18 14/1 39/12 42/4 42/7 43/3 43/6 43/22 43/25 44/2 45/5 45/10 46/4 46/8 48/9 49/14 50/1 51/19 52/3 52/8 52/11 52/19 52/23 53/5 53/13 53/24 54/25 56/20 57/7 58/14 127/22
technical [3] 65/8 137/23 150/21
technically [1] 119/14
technicians [3] 49/13 50/17 55/20
teenager [1] 185/17
tell [2] 115/20 144/6
telling [4] 32/20 67/14 133/1 148/24
temporary [3] 33/17 80/17 152/2
ten [7] 24/5 66/2 113/12 113/13 149/2 190/24 221/13
ten weeks [3] 24/5 149/2 190/24
ten-year [1] 221/13
tendency [1] 150/8
tenor [1] 17/11
tens [1] 80/25
tent [1] 133/23
term [28] 46/19 58/11 58/12 79/12 79/18 80/4 117/7 127/1 135/14 136/15 144/22 161/22 161/23 163/15 176/2 178/11 179/2 179/7 179/13 180/4 183/12 184/16 187/6 187/8 188/22 188/24 199/21 212/3
termism [1] 83/25
terms [21] 6/15 11/19 19/19 21/11 37/18 60/24 72/13 78/13 78/13 78/18 82/6 83/17 91/24 93/9 93/22 111/5 148/13 168/9 183/20 184/6 200/25
terrible [2] 72/15 125/21
terrified [1] 33/14
terrorist [1] 32/20
test [2] 144/11 155/9
tested [5] 51/14 51/17 65/23 115/7 143/10
testified [1] 114/15
testimony [3] 9/4 32/17 115/15
testing [14] 19/16 45/25 67/23 92/6 92/8 100/18 114/6 144/12 167/19 168/18 168/19 168/19 193/9 210/22
tests [3] 11/10 40/5 74/23
text [1] 133/1
than [48] 2/2 11/23 17/4 27/2 28/23 32/5 33/4 35/10 40/14 40/16 44/21 47/2 49/20 51/11 55/19 56/14 59/19 70/7 71/1 74/13 83/7 89/17 89/19 97/15 98/8 103/10 105/15 108/19

T

than... [20] 109/25 133/19 137/17 139/9 142/5 143/4 143/5 149/23 151/6 155/10 155/21 156/16 163/5 167/9 177/3 189/24 194/11 196/23 203/5 219/11
thank [58] 1/6 1/13 1/22 1/25 2/3 2/8 13/10 13/12 13/16 13/23 22/16 22/17 22/21 37/25 38/1 38/7 49/2 49/8 58/18 58/19 59/5 59/10 72/1 72/2 72/3 88/24 89/1 95/7 95/8 95/13 106/19 106/20 107/7 120/18 120/19 121/6 130/22 131/4 131/4 131/5 131/11 146/10 146/11 146/14 160/23 160/24 175/6 175/7 175/8 175/16 193/25 194/1 194/4 207/8 222/21 222/22 223/2 223/3
thank-you [1] 2/3
thanking [2] 1/18 131/16
thanks [4] 13/25 95/18 130/25 207/15
that [832]
that's [10] 123/18 138/24 160/3 162/10 172/10 195/10 195/19 196/2 200/16 202/14
their [197] 1/23 7/7 7/12 11/6 16/11 18/24 20/5 21/25 26/14 29/17 29/24 32/14 33/1 33/13 33/16 34/2 35/2 37/3 38/14 39/5 39/10 39/11 40/7 40/18 41/14 42/4 42/7 43/3 43/6 43/22 43/22 43/25 44/2 45/5 45/23 47/13 48/8 48/11 48/13 50/2 50/13 51/9 51/12 52/8 52/15 52/21 53/2 53/6 53/6 53/7 53/9 53/21 54/5 54/24 55/10 55/17 56/24 57/7 58/14 62/4 62/6 62/15 62/15 63/23 65/16 65/20 66/20 66/20 69/1 69/2 69/2 69/3 69/4 69/21 70/4 71/16 74/13 75/7 81/21 85/17 85/17 85/18 87/4 90/23 95/19 96/8 96/9 96/18 98/14 98/15 98/15 98/16 98/18 99/11 100/21 101/5 101/6 102/11 102/12 103/21 105/15 105/20 105/21 106/13 110/23 111/6 112/7 112/15 112/18 112/21 112/23 114/8 115/17 116/21 119/12 120/9 120/10 121/25 122/15 122/23 123/3 123/21 124/1 125/10 125/23 126/4 126/5 127/1 127/4 127/8 129/16 129/21 130/2 130/5 131/2 131/6 133/6 133/24 137/8 140/10 144/7 146/4 148/9 150/12 152/24 155/16 155/20 157/18 158/6 159/9 159/23 164/9 165/7 165/13 166/20 166/23 167/7 169/1 172/20 173/10 173/25 174/13 175/5 176/12 176/19 177/18 179/20 181/2 184/21 184/22 186/2 187/5 188/17 188/17 188/18 188/24 191/1 192/6 192/12 193/12 197/11 201/24 203/3 203/11 204/19 205/19 205/19 205/24 206/19 207/24 207/25 210/6 211/17 211/18 215/12 219/22 222/19
them [58] 6/21 9/25 10/5 14/14 14/15 14/21 14/22 14/22 17/19 23/2 30/3 31/19 32/5 32/25 32/25 34/16 34/23 59/21 78/15 83/19 88/6 91/9 91/12 95/20 95/25 96/14 96/19 98/16 98/17 101/7 101/11 101/12 106/18 107/24 117/17 128/17 129/16 132/6 134/22 135/18 135/18 143/23 143/24 144/10 145/9 151/22 158/2 162/11 163/18 167/5 172/3 173/23 178/25 191/13 191/19 203/7 206/25 219/14
theme [12] 96/5 122/22 123/12 123/19 124/17 196/15 197/19 198/15 199/18 201/9 202/19 204/11
themes [10] 3/19 16/12 89/15 91/13 91/15 113/22 122/21 146/22 178/7 196/14
themselves [17] 14/14 33/13 45/10 52/12 52/20 53/6 114/19 114/21 133/7 135/17 138/20 139/4 156/21 160/7 166/19 174/12 210/1
then [38] 3/3 9/19 22/4 27/20 39/15 53/15 64/14 89/15 93/12 94/3 94/15 95/4 115/4 126/22 128/9 129/18 133/10 136/22 139/20 139/23 145/17 149/20 150/9 160/8 160/8 164/2 184/3 184/5 195/15 196/22 199/6 202/11 202/12 202/13 204/7 206/19 218/23 219/2
theoretical [1] 216/13
therapeutic [1] 205/19
there [172] 1/7 4/3 4/25 5/2 6/5 7/2 7/3 8/11 9/3 9/7 10/10 11/7 12/25 14/20 16/16 19/14 20/14 22/3 22/6 23/9 24/16 25/9 29/24 31/15 32/7 32/9 33/2 33/7 33/9 34/12 34/13 35/17 40/6 42/12 44/19 48/15 55/3 61/16 63/5 63/20 65/17 66/5 66/18 67/3 67/8 69/6 70/8 70/17 75/20 76/3 76/18 77/6 80/14 80/18 80/24 81/2 81/10 84/19 85/23 86/16 88/7 89/25 90/4 91/22 92/1 92/6 92/9 92/14 93/25 96/14 99/10 104/5 105/5 107/24 108/23 109/18 115/4 116/16 118/3 124/15 125/16 127/13 128/14 132/22 135/15 136/1 136/14 136/19 137/11 137/13 138/2 140/4 140/19 142/17 143/22 145/6 145/22 147/15 147/19 149/18 150/8 150/17 152/9 154/16 155/11 157/17 158/25 161/20 161/25 165/1 166/7 166/22 167/7 167/14 167/15 167/20 168/2 168/10 168/11 168/18 169/18 171/7 171/12 171/20 171/23 172/12 175/2 175/2 177/7 179/17 180/13 180/19 181/11 182/22 183/4 185/10 186/8 186/18 189/19 191/10 194/12 195/24 196/14 197/12 199/19 201/1 201/6 202/1 203/6 204/4 204/9 204/18 204/20 204/25 205/3 206/3 206/8 208/8 209/6 209/9 213/16 214/25 215/5 216/16 216/23 217/3 217/20 218/2 218/16 219/3 219/4 221/4
there's [10] 3/14 6/10 7/10 14/20 166/14 168/3 195/16 200/7 201/21 206/21
thereby [2] 27/19 203/25
therefore [17] 35/11 44/19 83/21 146/1 168/11 177/1 179/22 179/24 181/4 184/8 185/1 190/16 191/15 192/14 212/24 213/3 214/2
these [98] 1/16 2/15 3/23 4/1 4/24 6/20 7/19 9/7 13/7 13/16 15/19 25/22 30/13 32/16 34/15 39/1 43/2 46/20 50/5 50/8 51/2 56/3 68/21 72/7 73/8 73/10 75/3 77/7 77/14 83/11 91/6 92/23 94/21 94/24 96/10 99/4 101/3 101/8 101/9 101/22 103/11 104/4 105/11 105/20 107/25 109/5 109/9 110/8 110/16 111/5 112/6 112/10 113/7 113/17 113/21 114/8 115/8 115/15 116/7 116/17 117/9 117/21 117/25 118/4 119/2 119/23 119/23 129/11 129/15 130/15 131/23 132/21 133/4 134/1 138/9 144/18 146/18 149/2 151/2 157/23 163/9 170/17 172/1 172/11 176/18 176/25 181/23 184/24 194/5 194/14 199/6 199/14 200/13 202/19 204/12 206/17 207/20 217/19
they [193] 5/23 7/3 7/7 11/12 13/10 14/24 14/25 15/4 18/24 21/16 25/21 30/5 31/9 32/24 33/4 33/12 33/14 34/3 34/8 34/9 34/25 37/6 41/5 41/16 41/17 41/19 43/4 43/5 43/5 43/6 43/18 43/19 43/22 44/4 44/4 44/21 45/1 45/18 45/23 45/24 48/25 52/12 52/17 52/25 53/18 55/9 55/14 56/14 61/12 62/2 62/2 62/4 62/5 62/6 63/23 64/8 65/21 66/10 67/14 69/20 71/19 76/21 78/10 78/22 78/25 79/25 81/21 83/5 87/3 90/21 95/3 96/6 96/7 96/9 96/16 96/25 98/4 99/12 99/25 100/14 100/14 100/21 100/24 101/3 101/4 101/4 101/15 102/11 102/14 104/4 105/12 106/12 106/14 107/23 108/2 108/14 109/6 109/12 110/1 110/24 112/12 113/6 113/8 119/6 122/7 122/7 123/7 123/8 125/1 125/2 126/20 126/21 126/24 127/7 128/16 129/16 129/22 134/4 135/6 135/6 135/9 135/10 135/12 137/1 137/7 137/7 137/10 138/22 139/3 140/10 140/11 140/12 142/20 142/22 143/16 144/25 145/19 145/19 146/2 148/8 148/12 152/13 152/21 153/18 154/25 155/20 157/24 158/7 159/22 160/8 165/24 166/9 166/25 166/25 167/6 167/17 168/8 169/11 172/17 173/23 174/15 174/18 175/22 179/6 179/19 180/1 181/21 182/6 183/19 183/23 186/16 187/3 189/23 190/8 192/2 195/12 195/14 200/2 200/14 202/11 202/12 203/16 208/5 208/23 209/1 210/1 210/7 212/9 212/25 216/14 220/4 221/2 222/7
they'd [3] 29/18 30/15 33/8
they're [4] 195/14 195/15 205/4 207/2
they've [3] 98/22 156/24 187/19
thing [8] 18/5 55/8 62/2 165/19 175/2 195/10 214/7 216/1

T

things [19] 2/9 3/6 5/7 6/3 17/24 43/9 64/5 70/5 81/22 91/22 94/9 122/3 125/5 127/24 129/19 130/20 147/3 153/19 217/3
think [33] 1/10 7/6 8/2 8/9 8/16 13/13 14/8 14/12 14/15 14/18 14/19 14/21 15/17 59/6 59/11 106/22 121/4 133/16 147/18 150/8 151/4 153/20 154/15 158/8 160/25 162/8 163/15 169/10 207/9 219/3 220/1 220/2 223/1
thinking [5] 12/6 119/19 155/21 159/2 170/16
thinks [1] 78/5
third [15] 23/23 31/12 36/10 43/25 77/11 85/9 122/11 123/18 128/14 130/8 178/14 182/20 197/16 198/15 205/13
thirdly [2] 93/19 156/18
thirds [1] 199/23
this [283]
Thomas [6] 106/22 107/1 107/5 107/9 120/19 225/6
Thompsons [1] 72/9
thorough [1] 116/23
those [122] 2/3 2/13 6/10 9/17 10/22 12/3 13/25 15/3 16/6 19/13 22/1 25/13 27/13 28/17 30/1 37/7 43/1 57/19 62/1 63/16 64/3 67/13 67/19 69/13 69/16 71/18 71/18 71/23 75/19 76/11 76/17 78/18 82/10 83/10 86/15 87/23 88/9 88/14 88/18 89/7 91/8 91/11 91/18 94/22 101/7 101/19 102/2 102/5 107/15 110/17 117/2 119/11 122/3 122/20 123/10 125/5 126/2 126/13 126/17 127/24 128/1 130/20 133/9 133/20 133/25 134/3 134/6 134/21 138/2 139/21 140/14 145/7 145/15 146/10 147/3 147/4 147/5 147/6 148/15 150/20 150/24 151/21 151/21 152/6 152/14 152/16 153/21 154/8 155/11 155/19 155/21 156/3 156/17 158/11 159/14 160/8 160/12 161/21 165/11 166/5 166/12 168/2 171/1 173/16 174/14 175/6 188/20 188/21 191/7 193/11 193/11 194/13 194/14 197/1 197/15 203/1 207/7 211/3 211/11 212/2 214/9 219/9
though [2] 169/21 172/17
thought [10] 17/21 20/17 129/9 137/15 151/1 155/2 161/6 166/11 170/3 222/12
thoughts [2] 95/9 218/22
thousands [9] 10/24 62/14 71/9 80/23 81/1 96/12 100/4 109/11 116/19
threat [4] 82/5 137/1 137/2 216/24
three [25] 19/3 34/1 34/2 41/6 47/11 47/13 47/16 49/25 80/1 80/5 84/18 95/15 97/2 127/25 127/25 129/19 132/9 145/15 162/20 173/22 194/15 214/2 214/13 214/19 218/2
three weeks [1] 41/6
three years' [1] 80/1
three-year [1] 80/5
threshold [1] 26/18
through [31] 6/16 16/7 18/20 21/6 22/2 26/23 27/3 28/20 29/6 29/10 45/4 52/4 56/23 72/18 76/15 87/13 101/10 115/14 119/22 133/17 134/12 136/11 142/18 152/6 158/16 173/25 179/22 188/12 192/21 208/10 222/16
throughout [14] 2/11 19/25 42/21 48/25 49/23 56/15 59/17 59/18 60/21 90/24 96/7 139/18 169/2 186/8
thrown [1] 139/23
thrust [1] 136/23
Thursday [1] 223/6
thus [3] 121/16 147/2 197/13
tick [1] 116/13
tier [4] 99/2 99/25 105/14 105/24
tight [1] 44/17
time [37] 9/12 9/16 10/17 10/17 24/24 32/15 33/2 42/18 52/13 61/1 66/6 70/20 70/24 71/2 72/14 74/19 79/14 80/1 80/21 81/5 97/3 97/17 115/18 137/18 150/1 153/4 161/6 169/13 169/17 174/4 185/21 189/14 189/14 208/23 209/12 221/23 221/23
time-bound [1] 10/17
timeline [1] 11/25
timely [3] 118/3 181/6 214/4
times [20] 3/21 6/5 8/20 9/9 14/24 15/14 18/24 24/2 26/7 27/2 45/16 54/1 70/25 127/12 129/8 132/24 173/23 201/12 209/6 217/1
timescale [1] 134/14
Timing [1] 135/19
tinting [1] 94/13
tip [1] 195/9
tirelessly [2] 10/9 19/25
TJ [1] 66/19
today [14] 25/21 31/3 92/4 125/11 130/19 138/25 140/15 155/23 178/2 178/6 188/1 200/12 207/10 222/24
Todd [3] 66/11 66/19 162/4
together [8] 17/13 33/25 91/12 130/19 143/24 165/3 165/7 166/13
token [1] 113/18
told [20] 32/2 43/17 50/16 50/24 52/16 55/7 59/17 60/3 64/21 81/11 99/6 106/1 118/19 133/11 162/5 181/13 184/2 185/17 186/7 189/8
tolerated [1] 116/6
tomorrow [4] 71/12 105/6 222/24 223/1
tones [1] 115/8
too [34] 1/9 15/10 23/10 24/18 24/19 60/6 60/6 61/5 61/6 61/6 61/7 62/23 66/6 66/6 70/19 76/23 78/12 109/3 109/16 124/5 126/12 130/18 132/8 135/19 135/19 137/19 140/25 143/6 162/22 163/7 165/5 170/5 214/24 217/17
took [14] 4/9 62/4 67/10 81/14 103/17 114/19 118/18 134/10 151/5 153/17 167/11 168/4 168/13 208/12
tool [7] 138/16 216/2 216/4 216/13 216/17 217/22 218/7
tools [6] 10/4 10/6 115/24 118/10 145/17 145/19
top [5] 37/4 41/12 42/23 63/1 126/22
top-down [1] 126/22
topic [13] 3/5 73/21 88/13 139/6 157/1 170/18 173/5 209/18 213/12 214/19 216/2 216/11 218/10
topics [3] 11/17 162/20 208/1
total [4] 125/2 196/4 217/8 218/2
towards [4] 16/22 70/9 205/14 213/11
track [1] 179/12
Tracy [2] 16/25 154/22
Tracy Nicholls [1] 154/22
traded [1] 69/25
Trades [3] 72/5 72/8 224/21
tradition [1] 44/17
traditional [1] 114/7
tragedies [1] 108/1
tragic [2] 113/12 218/9
tragically [1] 25/15
train [1] 31/20
trained [3] 79/8 80/24 82/8
training [14] 81/2 82/2 85/7 85/21 94/4 94/7 94/10 100/11 100/12 129/14 181/5 184/6 214/19 215/23
transcript [2] 64/8 201/3
transfer [1] 62/21
transfers [1] 34/13
transformative [1] 112/16
transforming [1] 50/12
transitional [2] 136/14 136/19
translate [2] 7/19 104/18
transmissible [1] 28/20
transmission [38] 9/8 28/13 29/14 29/16 30/15 36/2 69/8 82/6 86/1 88/12 139/22 141/2 141/11 146/17 146/20 147/16 147/20 148/19 149/6 149/23 150/1 150/4 150/7 150/9 150/10 153/2 153/18 154/4 155/6 157/25 160/13 177/14 177/25 189/2 189/16 190/3 190/18 225/13
transmit [1] 29/4
transmitted [6] 30/11 140/24 147/11 151/15 155/24 189/21
transmitting [1] 113/1
transparency [4] 91/17 94/11 94/16 118/5
transparent [5] 16/8 18/19 27/4 36/22 94/12
transport [2] 99/22 102/10
trauma [4] 2/14 72/16 161/23 221/17
traumas [1] 33/18
traumatic [1] 32/18
travel [1] 1/7
travelling [1] 156/16
treat [7] 2/11 10/24 60/5 119/11 121/23 159/22 215/13
treated [11] 44/3 68/7 75/8 125/19 145/4 158/10 158/17 185/4 194/22 207/2 212/9
treatment [39] 25/19 29/1 44/6 49/22 55/23 56/2 62/15 66/20 70/25 71/10 84/10 93/4 105/2 115/16 119/12 121/25 123/23 125/8 125/25 126/5 126/6 135/12 139/14 139/15 195/2 195/11 195/17 197/9 199/20 199/21 200/22 202/24 202/24 203/7 204/25 205/14 206/13 207/3 211/19
treatments [7] 4/4 90/5 124/25 136/6 138/24 183/9 199/25
triage [1] 10/5
trials [3] 88/2 143/11 156/13
tribute [1] 27/8
tried [7] 135/2 140/25 148/17 151/17 158/6 158/11 167/18
tripled [1] 40/14

T

trite [1] 123/4
troubling [2] 72/11 115/20
true [7] 31/16 63/11 67/5 103/9 154/25 191/1 210/21
truly [2] 60/2 101/14
trump [1] 60/14
trust [14] 12/23 13/19 13/20 68/6 84/13 94/18 145/3 158/16 158/19 158/21 159/9 159/21 160/16 206/11
trusting [1] 214/16
trusts [12] 68/9 76/24 77/7 77/17 83/7 84/2 84/20 85/11 98/3 106/12 111/14 174/7
truth [5] 70/15 107/19 118/21 150/7 187/7
truths [1] 109/2
try [5] 63/3 124/19 152/12 194/14 221/1
trying [8] 4/13 7/7 52/17 55/5 62/5 71/9 71/20 135/4
tsunami [1] 4/6
TUC [7] 79/19 81/12 83/15 83/24 84/16 176/15 191/7
tumbling [1] 141/9
turn [15] 8/2 42/3 77/20 80/13 86/2 90/22 111/9 117/6 118/12 160/2 185/7 188/15 191/23 212/21 221/6
turned [3] 63/23 121/12 198/23
turning [10] 5/13 7/22 47/8 61/12 109/4 120/12 179/1 180/8 182/20 217/13
TV [1] 134/25
twin [1] 165/7
two [24] 15/12 15/15 19/8 26/20 34/2 35/4 38/16 38/18 75/5 99/25 105/14 105/24 111/2 145/6 145/13 161/25 173/17 180/9 199/23 203/1 214/9 216/20 217/8 217/19
two years [1] 26/20
two-thirds [1] 199/23
two-tier [2] 99/25 105/24
type [1] 138/11
types [1] 51/17
typical [1] 195/13
typically [1] 203/6

U

UK [36] 6/24 11/23 23/8 24/15 27/16 31/15 38/12 39/13 39/22 47/20 58/5 58/7 62/18 85/18 89/13 97/9 102/21 104/12 121/8 121/10 125/1 130/13 147/22 151/5 151/9 154/2 154/16 155/13 158/9 162/3 162/22 167/20 183/2 186/8 201/1 225/8
UK's [13] 23/5 23/10 23/20 24/12 39/20 72/12 73/12 77/20 77/23 87/20 98/6 182/24 189/25
UK-wide [1] 6/24
UKHSA [9] 7/2 7/10 7/11 149/20 155/5 156/5 179/19 184/18 184/20
UKHSA's [1] 181/20
ultimate [1] 96/16
ultimately [7] 107/22 110/6 115/17 157/5 157/23 174/22 221/21
UN [1] 222/10
unable [19] 10/23 31/19 33/11 34/8 45/6 52/25 53/2 53/10 74/21 90/6 100/21 132/18 177/19 182/13 186/17 186/25 191/19 192/2 206/24
unacceptable [2] 67/25 167/20
unacceptably [1] 154/17
unacknowledged [1] 124/23
unaddressed [1] 115/11
unanimity [1] 123/19
unanimous [2] 179/25 215/7
unattainable [1] 5/12
unavailable [1] 125/1
unavoidable [2] 4/16 108/1
unaware [1] 187/4
uncertainties [1] 12/18
uncertainty [4] 12/2 43/2 149/19 149/25
unclear [3] 152/24 161/2 199/11
uncomfortable [3] 30/9 107/19 108/7
unconnected [1] 25/14
uncontrolled [1] 192/20
UNCRPD [1] 222/14
undeniably [1] 63/12
under [20] 14/25 37/21 44/1 46/19 75/15 86/17 86/17 97/23 104/6 126/18 129/6 145/25 146/2 159/25 167/6 187/17 200/14 213/11 216/1 220/6
under-investment [1] 46/19
under-recognised [1] 44/1
under-reporting [1] 86/17
under-resourced [2] 37/21 97/23
underemphasised [1] 135/10
underfunded [1] 97/23
Underfunding [1] 98/1
underinvestment [1] 97/10
underlined [1] 87/7
underlying [3] 88/5 97/24 108/24
undermine [2] 184/3 199/15
undermined [3] 127/8 136/6 184/5
underpin [1] 111/2
underpinned [1] 128/20
underpins [1] 87/20
underprepared [1] 37/21
underprotection [1] 101/5
underscore [1] 209/9
underscored [1] 117/4
underscoring [1] 112/13
understaffed [1] 97/24
Understaffing [1] 98/11
understand [16] 1/6 11/21 19/7 27/5 63/4 64/21 65/2 82/13 109/6 111/7 130/12 138/21 153/19 160/4 194/18 208/7
understandable [4] 10/7 195/24 202/17 206/11
understanding [9] 41/15 61/25 72/21 94/23 111/6 112/8 126/21 180/10 181/11
understood [6] 72/12 82/22 124/14 170/6 216/12 216/19
undertake [1] 31/20
undertaken [5] 15/18 51/25 52/24 97/8 190/13
undertaking [1] 99/17
underway [1] 220/20
undoubtedly [4] 56/16 63/11 78/8 196/15
unedifying [1] 64/17
unemployment [1] 203/23
unequal [1] 73/22
unequivocally [1] 180/15
unethical [1] 88/3
uneven [1] 213/16
unexpected [2] 119/3 148/10
unexplained [1] 151/14
unfair [1] 49/22
unfit [1] 191/5
unfortunate [1] 170/21
unfortunately [3] 75/5 160/10 160/14
unheard [1] 120/11
unhelpful [3] 110/10 157/16 159/8
uniformly [1] 117/1
unintentionally [1] 111/11
Union [4] 72/5 72/8 95/17 224/21
unions [1] 101/10
unique [5] 41/15 110/19 116/9 176/8 198/19
uniquely [1] 86/11
uniqueness [1] 123/13
unit [1] 169/8
United [2] 95/16 192/13
United Kingdom [1] 192/13
units [2] 172/1 172/14
University [3] 16/20 17/4 18/9
unknown [4] 90/2 176/23 184/13 189/14
Unless [1] 47/3
unmet [2] 59/23 206/17
unmitigated [1] 177/5
unmonitored [1] 191/3
unnecessarily [1] 26/18
unnecessary [2] 134/3 164/15
unnoticed [2] 63/19 123/11
unpaid [2] 124/22 125/2
unprecedented [7] 3/1 12/8 12/9 33/19 54/16 70/3 120/4
unprepared [1] 113/15
unpreventable [1] 3/21
unprotected [2] 104/5 116/16
unrealistic [1] 133/19
unreality [1] 164/18
unreasonable [1] 9/7
unrelenting [1] 218/6
unremedied [1] 108/4
unremitting [1] 182/23
unrestricted [2] 168/10 168/15
unsafe [2] 34/10 140/12
unsatisfactory [1] 199/15
unscientific [1] 180/16
unseen [1] 120/11
unsuitable [1] 25/5
unsupported [4] 107/22 125/3 126/20 126/20
unsurprising [1] 72/11
unthinkable [1] 35/20
until [17] 14/4 42/19 43/20 45/7 53/17 62/4 101/16 109/2 137/10 163/1 166/6 167/24 168/2 168/13 168/13 187/19 223/5
until August 2020 [1] 45/7
until December 2020 [1] 168/2
until June 2021 [1] 168/13
until May 2021 [1] 14/4
untreated [1] 203/9
unwavering [1] 71/16
unwell [4] 62/20 181/1 196/23 202/16
unwilling [1] 90/6

U

unwillingness [1] 109/2
unworkable [1] 133/20
unworthy [1] 121/24
up [34] 20/18 25/1 36/11 36/17 40/3 40/22 41/5 49/4 51/3 59/23 61/12 62/4 63/10 75/2 75/4 76/13 79/24 92/14 96/13 101/16 113/13 116/15 124/19 134/7 134/10 138/14 140/25 159/19 160/25 164/15 170/16 170/24 213/25 218/23
upcoming [1] 221/12
update [2] 35/25 182/8
updated [4] 21/25 36/7 85/8 168/14
updating [2] 119/8 167/21
upgrade [1] 222/19
upgraded [1] 20/12
upgrading [1] 22/8
upon [16] 10/14 12/16 47/10 72/10 73/17 73/19 78/7 78/11 79/2 79/7 114/19 123/9 130/7 190/16 220/18 222/9
uptake [2] 87/12 87/23
urge [3] 8/14 13/4 222/11
urged [2] 60/17 188/19
urgency [2] 183/24 221/10
urgent [9] 23/15 35/17 35/21 36/25 47/3 142/9 142/21 176/25 191/10
urgently [5] 35/25 80/6 118/9 132/3 182/14
urges [5] 37/22 119/19 141/12 143/1 144/2
urging [1] 78/6
us [27] 1/4 4/7 4/11 28/8 47/14 47/22 49/4 59/17 60/3 61/1 70/18 91/7 98/25 106/16 110/14 115/20 120/6 120/7 120/17 133/9 161/4 161/5 184/2 214/17 214/18 220/20 221/19
usage [1] 50/11
use [25] 28/8 28/18 29/7 36/11 47/14 47/22 52/4 54/18 65/6 65/14 65/16 67/11 79/5 93/11 115/15 131/25 144/13 144/23 145/18 155/6 191/22 191/22 204/19 211/20 213/6
used [6] 57/18 57/19 211/14 212/1 217/9 221/5
useful [3] 8/11 181/22 195/23
user [1] 143/8
using [4] 11/9 172/16 211/12 212/10
utilised [1] 47/25
UVW [3] 95/16 96/18 101/10

V

vacancies [3] 24/17 79/8 79/22
vacancy [3] 24/19 79/15 79/23
vaccination [13] 56/22 73/14 87/5 87/8 87/12 87/15 87/20 93/4 100/19 137/10 182/6 182/12 182/18
vaccinations [4] 41/13 56/23 185/5 185/5
vaccine [10] 19/16 42/1 87/23 88/4 88/12 110/7 136/5 182/8 184/22 218/16
vaccines [9] 4/4 21/1 88/8 132/20 136/1 136/6 184/18 184/23 185/2
vain [1] 193/15
Vallance [1] 134/25
valuable [2] 48/11 91/3
value [11] 9/20 11/13 14/15 39/25 44/16 88/9 108/18 122/2 161/17 195/24 204/16
valued [1] 120/9
values [1] 119/25
Variability [1] 126/15
variable [2] 37/6 37/14
variation [1] 93/3
variations [1] 9/23
varied [1] 132/13
variety [1] 123/13
various [2] 14/1 18/2
vary [2] 9/22 183/19
varying [2] 5/24 135/8
vast [2] 25/17 131/19
Vaughan [3] 14/3 166/13 169/25
vehemently [1] 216/14
vehicle [1] 99/24
vein [2] 84/9 151/4
ventilation [14] 22/9 25/8 68/17 80/11 132/6 141/13 141/20 142/4 142/11 143/18 149/13 190/11 190/21 193/8
ventilations [1] 136/2
ventilator [1] 217/16
ventilators [1] 51/22
versus [1] 142/24
very [86] 1/13 2/24 10/21 12/4 13/3 13/10 13/11 13/11 14/23 15/16 15/24 17/13 22/16 22/17 28/11 29/3 30/24 33/11 38/1 44/17 49/2 49/3 49/21 58/19 58/19 58/21 63/6 66/17 72/2 76/11 77/22 79/7 84/18 86/13 88/25 89/1 95/8 95/8 98/24 104/9 106/20 106/20 120/19 120/20 120/21 121/6 125/25 131/4 133/4 134/18 141/24 146/10 146/11 146/14 148/18 151/1 153/9 160/23 160/24 163/11 163/21 174/25 175/7 175/7 180/20 180/21 183/1 190/8 194/1 194/20 200/14 207/8 207/10 207/23 212/13 213/21 214/22 216/1 216/24 218/16 218/22 219/23 220/14 222/22 222/25 223/2
via [2] 29/4 189/21
viable [1] 114/5
vice [1] 38/20
victims [3] 40/4 74/16 176/13
video [2] 154/23 201/4
view [9] 6/22 10/11 16/19 17/22 31/9 155/8 167/11 185/3 220/5
viewed [1] 204/21
views [2] 8/18 91/2
vigilance [1] 218/6
vigorously [1] 142/5
violence [1] 40/5
virtual [2] 122/4 122/6
virus [23] 28/23 51/7 53/10 70/3 86/1 87/2 88/11 113/1 116/19 117/10 117/16 135/16 136/25 138/7 139/2 144/21 152/1 156/22 170/5 176/3 184/17 220/2 220/2
viruses [2] 137/6 156/8
visa [2] 85/24 98/17
visas [2] 85/17 98/15
visibility [2] 83/20 84/20
visible [2] 50/7 85/1
vision [1] 80/5
visit [2] 33/11 165/7
visiting [19] 9/15 67/17 127/5 162/20 164/19 164/25 165/5 165/16 165/19 165/23 167/8 167/22 168/12 168/14 168/23 168/25 169/20 171/22 210/15
visitors [10] 9/9 67/23 122/14 125/17 127/14 162/24 162/25 163/5 171/17 172/18
visits [4] 4/24 9/6 164/21 170/2
visual [1] 220/4
visually [1] 208/21
vital [10] 24/11 27/5 35/11 47/4 73/6 94/5 124/12 154/17 194/18 206/4
vivid [2] 59/16 61/4
voice [8] 20/21 35/2 46/13 59/18 96/7 96/19 96/19 124/1
voices [5] 62/6 95/16 110/17 123/17 159/3
volume [1] 196/24
voluntarily [1] 123/1
volunteers [3] 40/17 79/5 81/1
voted [1] 63/16
vulnerabilities [2] 112/1 113/11
vulnerability [4] 106/2 146/4 219/9 219/12
vulnerable [45] 15/23 15/25 40/15 54/21 61/24 82/20 98/16 101/4 101/5 106/3 110/23 113/1 113/16 115/2 123/2 131/9 131/13 131/20 132/4 132/5 132/12 132/15 133/2 133/7 136/3 136/8 137/3 137/4 137/5 138/2 138/6 138/21 139/7 139/19 144/6 144/9 144/20 145/4 145/23 146/8 172/20 176/14 177/9 209/25 225/11

W

W1 [2] 100/11 101/1
W1's [1] 100/15
Waddoup [2] 131/13 161/12
wages [1] 98/7
Wagner [8] 131/8 131/10 146/11 160/25 161/9 175/7 225/11 225/17
wait [4] 109/25 143/11 179/8 187/19
waited [1] 197/8
waiting [8] 23/8 70/24 71/2 144/16 163/19 164/12 164/20 201/12
wake [4] 75/2 75/4 76/13 113/13
Wales [35] 13/19 13/22 14/4 14/6 15/9 16/3 16/16 17/11 17/17 17/22 20/21 21/10 21/11 21/15 22/8 22/11 26/24 31/8 33/5 55/2 74/18 77/4 77/12 77/12 79/22 79/24 84/4 134/21 155/15 164/8 167/21 167/22 168/14 187/17 215/17
walk [2] 32/4 32/5
walking [1] 193/4
want [11] 55/8 62/5 71/20 89/13 140/9 140/9 152/1 153/6 158/14 181/16 185/23
wanted [1] 64/2
wanting [3] 29/18 155/25 159/22
wants [1] 144/20
war [1] 12/7
ward [11] 51/4 81/18 163/23 166/17 170/23 172/20 198/25 202/1 202/3 202/9 205/18
wards [14] 51/3 51/8 51/15 61/6 68/17 69/3 99/15 126/13 165/4 170/11 197/12 201/15 201/15 201/18
warn [1] 55/16
Warne [2] 26/5 165/18
Warne's [1] 144/14
warned [2] 177/7 192/23
warnings [1] 101/9
wary [1] 220/21
was [357]
was somewhat [1] 213/16

W

wasn't [9] 11/11 33/2 53/17 67/12 113/24 135/16 140/10 164/16 168/20
waste [1] 120/17
watch [2] 69/1 200/23
water [1] 171/25
water births [1] 171/25
wave [5] 53/15 213/25 215/9 219/2 219/3
way [28] 10/13 14/14 18/16 18/19 25/24 27/11 63/8 68/23 69/2 80/18 82/19 87/1 104/7 105/1 123/6 123/7 130/22 130/24 135/3 148/3 159/23 189/5 192/21 193/19 200/16 208/10 221/16 222/6
ways [7] 21/3 40/4 50/13 100/1 128/9 153/1 197/6
wayside [1] 128/16
we [259]
we'd [6] 1/20 2/16 2/24 6/4 175/1 222/2
we'll [2] 3/10 106/22
we're [8] 1/10 3/6 5/3 47/14 47/16 162/9 162/11 162/11
we've [10] 10/3 11/4 12/7 15/16 91/6 91/12 91/25 94/4 123/19 124/5
weak [3] 103/18 150/6 150/7
weakened [1] 97/12
weakness [1] 7/17
wealth [1] 109/20
wear [2] 144/10 193/2
wearing [5] 27/25 143/4 143/4 170/10 189/12
Wednesday [1] 1/1
week [5] 40/25 49/15 145/24 212/21 212/22
weeks [14] 24/5 41/6 43/21 45/12 52/14 54/17 66/16 66/17 71/5 149/2 161/19 185/12 190/24 210/17
weight [2] 9/14 72/19
welcome [6] 8/18 104/18 121/16 127/25 128/5 168/22
welcomed [1] 126/14
welcomes [1] 206/15
welfare [2] 100/17 101/6
well [55] 5/16 8/7 14/20 15/13 15/17 15/19 16/6 16/10 16/23 17/12 18/25 21/3 24/4 42/25 45/10 50/3 54/12 55/18 55/21 57/18 58/21 66/14 69/18 72/11 73/24 80/14 81/17 94/1 115/10 115/19 118/19 123/8 124/17 126/4 130/5 131/18 136/7 137/22 145/8 145/9 151/4 157/15 166/6 170/14 170/14 171/19 172/1 174/24 176/22 183/8 188/21 202/6 204/8 218/8 220/11
well-being [15] 15/13 15/17 15/19 18/25 21/3 42/25 50/3 54/12 55/18 55/21 118/19 123/8 130/5 170/14 204/8
well-known [1] 73/24
well-meaning [1] 218/8
well-researched [1] 69/18
Welsh [14] 13/14 13/17 13/18 13/19 15/3 16/16 16/22 17/5 17/12 17/24 18/5 164/6 213/17 224/8
Welsh Government [1] 17/5
went [12] 33/15 39/23 44/23 52/11 59/23 61/9 115/11 131/24 135/12 193/23 204/18 212/9
were [290]
were: [1] 73/25
were: why [1] 73/25
weren't [5] 9/7 64/8 134/7 137/7 150/20
Westminster [1] 213/25
whammy [1] 202/9
what [80] 5/2 5/11 7/14 7/15 8/23 9/19 11/2 11/11 11/21 14/24 15/19 15/23 16/9 16/9 21/22 23/4 24/22 35/20 61/5 61/9 62/12 63/4 64/1 64/2 64/20 64/20 64/21 65/2 74/1 75/23 76/1 78/12 82/15 89/14 89/15 89/18 89/18 89/19 90/13 90/13 94/15 98/20 106/4 109/25 115/20 119/7 119/9 131/24 133/12 134/5 137/3 137/18 138/22 139/11 139/12 147/20 148/8 152/20 154/25 155/1 155/12 156/18 160/3 160/11 166/25 173/12 181/16 182/23 193/23 193/24 195/2 198/3 198/6 212/24 217/10 218/10 218/11 219/17 219/20 220/22
whatever [3] 78/4 119/12 141/5
whatsoever [1] 70/16
when [84] 2/5 4/16 8/7 8/15 9/13 10/15 17/24 24/11 24/14 30/20 32/21 34/7 36/7 36/17 37/9 43/10 52/15 53/22 59/11 59/19 60/13 62/11 62/18 62/20 65/19 65/22 66/11 69/22 70/16 72/14 80/21 81/20 82/10 82/12 85/22 87/2 89/18 96/9 96/15 98/5 100/5 100/10 102/11 102/12 124/23 124/24 124/25 126/7 126/12 130/4 134/14 134/17 135/1 135/6 140/15 142/17 142/17 143/9 153/4 154/12 154/15 157/24 158/5 158/11 163/19 164/1 173/20 180/22 182/12 186/14 195/1 199/5 200/7 200/9 201/17 208/18 209/1 210/4 216/9 217/8 217/11 218/14 218/18 220/8
When's [1] 43/11
whenever [2] 123/17 221/14
where [42] 6/10 8/11 32/8 40/10 52/18 61/16 65/3 78/10 80/24 81/10 81/21 87/17 93/25 104/19 104/23 105/14 112/25 116/20 120/8 120/10 120/11 120/13 126/16 131/16 136/24 139/24 143/22 166/8 172/4 174/1 183/19 195/20 201/19 202/10 203/6 203/7 205/13 205/15 207/2 209/6 214/5 215/10
whereas [1] 111/19
wherever [1] 48/2
whether [25] 5/23 7/17 8/4 11/8 19/16 21/5 21/19 25/16 27/21 43/22 61/23 77/3 78/7 80/16 104/17 115/24 140/1 157/12 159/21 166/15 166/16 166/16 181/23 199/11 214/6
which [99] 1/7 3/1 3/15 4/3 4/6 7/1 12/12 13/5 15/13 16/12 18/12 19/20 21/19 26/1 27/12 27/24 31/2 31/23 32/14 35/10 36/18 38/10 39/2 45/22 46/3 47/4 50/6 51/12 51/23 51/24 56/6 56/16 56/17 57/25 66/4 66/19 70/17 72/22 73/6 74/18 75/16 76/6 76/10 76/18 77/9 79/24 81/23 82/17 84/2 85/25 86/6 87/3 87/19 88/22 88/23 89/12 91/7 91/14 91/22 92/15 92/22 94/14 96/20 119/3 121/18 124/18 125/25 126/13 128/24 131/22 141/24 142/18 143/11 143/21 147/8 151/9 152/8 153/25 159/12 162/18 164/8 164/25 165/25 171/18 172/9 172/16 172/21 178/8 193/3 194/8 196/2 196/14 201/10 201/24 203/23 204/9 205/15 205/19 211/10
while [16] 19/11 22/24 27/8 28/2 31/8 34/23 42/14 45/23 50/1 52/23 64/3 152/3 164/21 187/22 212/4 217/14
whilst [5] 81/15 180/17 182/24 187/19 219/9
white [4] 74/11 74/13 114/24 169/5
Whitehead [1] 16/19
Whitty [18] 7/5 8/7 12/4 26/4 35/15 69/14 75/1 102/15 105/25 134/16 134/24 137/23 142/3 181/13 182/5 210/23 216/15 220/12
Whitty's [1] 82/14
who [113] 2/3 2/9 4/22 18/8 19/13 23/1 25/18 27/1 27/8 27/13 27/18 28/17 32/1 32/23 34/19 38/20 45/21 55/24 59/18 60/1 60/9 60/21 61/1 61/4 61/12 61/20 62/14 63/16 63/17 63/25 64/3 64/4 64/20 64/25 67/13 68/25 68/25 69/16 70/22 71/18 74/15 81/5 82/8 82/9 82/11 83/6 89/7 89/18 90/22 90/23 99/19 101/5 102/21 104/11 110/23 110/25 114/11 119/11 124/2 124/13 124/21 127/4 128/12 130/10 131/5 131/19 131/21 133/5 133/20 134/1 134/6 134/22 138/2 141/17 144/20 151/21 152/15 152/23 155/25 161/25 162/4 164/4 165/2 165/11 166/8 169/19 170/22 171/1 171/2 172/18 172/19 173/10 175/23 176/21 177/8 181/10 185/22 186/4 187/25 188/7 189/13 189/18 191/9 191/11 192/1 196/22 198/25 199/1 199/23 203/24 207/17 208/21 211/22
whole [8] 54/9 89/8 96/4 98/22 101/8 184/3 195/10 203/3
wholly [1] 98/15
whom [5] 16/16 32/12 59/15 125/8 148/5
whose [5] 17/11 25/13 68/3 123/10 185/8
why [26] 12/3 30/5 63/5 73/25 103/17 108/21 108/21 108/21 109/6 112/8 112/11 141/21 144/24 144/24 146/4 147/3 147/24 150/2 150/11 152/9 156/19 158/25 168/4 182/13 186/25 195/10
wide [1] 6/24
widely [5] 142/21 183/19 185/6 212/4 217/4
widened [1] 200/22
wider [13] 21/17 28/18 49/13 52/11 58/2 86/1 93/15 137/4 144/13 155/6 159/11 164/23 219/12
widespread [2] 30/23 81/10

W

wife [1] 59/18
Wilcock [1] 71/3
will [83] 4/20 5/15 12/17 12/22 21/8 22/1 22/4 24/24 28/13 35/7 35/12 35/21 35/22 36/18 37/3 38/3 47/6 47/20 55/22 58/15 58/16 59/13 59/15 62/24 63/1 64/6 66/7 69/15 71/4 73/15 76/17 76/21 77/14 79/25 88/10 90/2 90/3 90/3 90/4 90/5 90/6 90/7 90/11 91/8 91/18 94/19 94/23 103/16 113/20 128/5 130/5 131/18 138/9 139/3 141/25 142/16 143/12 146/12 146/13 149/13 152/2 156/6 156/24 157/10 158/24 159/19 160/2 160/15 160/17 177/7 177/8 178/3 194/9 194/14 194/19 195/16 205/15 207/4 207/6 214/15 216/23 220/16 221/16
willing [1] 69/21
willingness [1] 66/9
win [1] 158/23
window [1] 80/5
windows [1] 68/18
winning [1] 158/21
wisdom [1] 124/8
wish [1] 176/10
wished [2] 34/9 174/15
wishes [2] 50/5 96/2
within [39] 5/22 5/25 6/6 7/17 16/4 17/6 23/2 23/20 28/14 33/23 34/21 44/12 46/5 51/8 51/19 74/3 75/3 76/12 79/3 80/21 91/21 98/23 103/21 104/1 104/12 106/8 109/15 111/13 114/1 119/1 124/13 125/12 126/15 140/20 154/24 157/21 157/22 183/18 203/18
without [26] 26/1 32/5 32/13 34/24 35/21 40/11 48/6 53/21 108/13 110/17 115/7 121/20 122/17 123/10 129/10 130/23 167/14 187/4 188/1 188/6 193/13 198/9 199/2 210/9 214/18 219/14
withstand [1] 181/24
witness [23] 18/11 19/21 24/7 38/22 52/2 60/20 61/4 62/5 63/23 66/1 66/1 66/20 68/2 72/20 100/3 147/25 148/23 153/23 163/13 194/13 199/8 205/6 215/6
witnessed [1] 62/12
witnesses [42] 1/24 2/3 6/9 7/25 8/1 25/5 26/4 27/15 29/25 32/17 38/16 39/19 59/13 60/20 62/1 62/22 63/22 75/25 80/23 95/22 102/20 121/13 121/16 123/14 123/19 127/10 134/9 148/17 153/14 153/22 155/15 157/17 159/7 168/6 168/23 177/3 181/10 193/19 195/10 205/4 216/12 217/25
witnesses' [2] 179/25 194/13
witnessing [1] 118/17
Wolfe [6] 121/5 121/6 121/8 131/4 131/16 225/9
woman [4] 66/22 162/23 163/25 164/1
women [27] 71/10 113/2 161/17 161/25 164/4 164/9 164/12 165/11 165/14 166/19 166/24 168/7 168/8 169/1 169/3 170/18 170/25 171/15 172/13 173/5 173/9 173/17 174/4 174/8 174/14 174/20 175/4
won [1] 183/2
wonder [1] 133/25
wonderful [1] 15/2
word [1] 69/6
words [11] 17/22 24/21 25/8 30/17 33/4 72/19 106/3 107/15 132/1 139/10 177/10
work [69] 1/21 3/15 6/20 11/7 11/13 12/21 12/25 13/24 14/18 14/20 15/18 16/10 21/11 23/2 29/12 31/19 32/15 34/24 37/3 37/8 42/22 49/12 50/1 50/6 51/24 52/1 52/24 53/10 54/5 55/11 55/17 70/8 73/13 77/2 82/4 82/5 82/9 85/9 85/16 99/9 99/11 99/15 100/24 102/11 102/12 106/12 132/16 132/18 136/7 136/7 146/3 154/10 154/12 154/15 171/21 177/19 184/21 191/12 191/14 191/19 191/19 192/2 192/12 204/17 212/16 212/22 215/17 216/4 217/22
worked [13] 5/5 10/9 16/9 16/23 17/12 17/24 17/24 19/1 19/25 45/21 45/23 90/24 96/25
worker [11] 26/21 27/18 87/2 100/1 101/17 103/8 104/4 104/10 104/11 154/5 159/16
workers [138] 2/17 14/21 23/22 25/20 26/5 27/1 27/8 27/24 31/15 31/24 34/24 44/3 44/7 44/8 45/22 51/17 54/4 55/25 56/1 56/4 56/6 56/10 57/20 63/14 72/11 72/17 73/5 73/17 73/20 73/24 75/22 82/8 83/4 83/11 83/13 84/11 84/22 84/23 85/13 85/25 88/4 95/12 95/15 95/23 96/6 96/17 98/2 98/7 99/11 99/22 99/25 100/5 100/11 100/19 100/23 101/3 101/8 101/17 101/19 101/21 101/25 102/8 102/21 102/22 102/25 102/25 103/2 103/7 103/7 103/12 103/14 105/3 105/4 105/7 105/10 105/11 105/15 105/20 105/24 105/25 106/11 106/12 106/16 107/21 108/16 109/12 109/17 110/23 112/2 112/4 112/12 112/19 112/24 113/11 113/16 114/2 114/11 117/9 117/9 117/15 118/3 118/13 118/22 119/5 120/8 124/23 129/15 131/1 131/21 144/10 149/14 149/15 151/25 152/6 156/20 157/4 157/18 158/16 159/5 159/8 159/21 176/15 177/18 178/2 178/19 188/16 188/17 190/7 190/15 190/25 191/2 191/9 191/11 191/17 191/18 192/6 192/11 225/2
Workers' [1] 95/17
workforce [49] 31/23 36/16 42/24 46/18 55/11 55/21 57/20 72/15 74/6 74/11 74/17 77/13 79/3 79/4 79/6 79/13 79/18 82/21 82/24 83/9 83/14 83/18 83/21 83/24 84/14 84/20 84/22 85/1 85/2 85/2 85/3 85/6 85/11 85/15 85/19 86/1 87/1 87/13 88/17 92/2 92/18 98/24 98/24 99/3 103/23 104/2 104/17 115/1 188/23
workforces [1] 87/16
working [40] 5/20 16/4 16/17 18/4 19/22 25/5 30/1 32/12 33/5 37/14 43/1 43/19 45/11 45/24 50/13 50/22 51/15 54/18 56/20 71/24 72/18 74/12 84/1 96/4 98/8 99/13 100/20 101/3 101/4 104/19 138/14 149/12 152/14 154/10 177/20 188/21 189/15 193/11 216/23 217/9
workload [1] 54/17
workloads [4] 42/10 42/14 42/23 55/4
workplace [8] 26/22 27/6 53/2 86/11 104/23 177/16 189/6 191/5
workplace-acquired [1] 177/16
works [1] 119/16
workstreams [1] 6/19
world [5] 3/22 95/16 136/24 148/12 154/21
Wormald [3] 134/13 219/21 220/12
worn [1] 97/9
worried [1] 29/17
worries [1] 55/6
worry [2] 65/25 159/20
worrying [2] 43/21 202/25
worse [12] 11/23 23/6 29/15 35/9 70/25 116/19 124/7 125/15 157/3 168/1 197/10 207/4
worsen [1] 195/17
worsened [5] 23/13 197/2 200/20 201/10 203/18
worsening [1] 115/17
worsens [1] 202/23
worst [1] 207/5
worth [2] 101/15 102/22
worthy [1] 145/4
would [83] 1/18 4/19 8/18 10/6 10/15 10/21 10/23 11/3 12/16 13/4 13/23 15/2 15/25 17/20 20/7 20/16 20/19 25/19 40/23 43/4 43/6 45/22 64/7 65/7 66/10 68/5 68/6 71/12 73/3 73/4 78/22 80/20 81/1 82/15 84/16 85/25 91/7 93/17 98/3 101/2 103/9 105/7 106/4 128/5 130/10 130/17 133/18 134/15 138/13 141/19 146/1 150/19 150/24 152/1 152/4 152/7 153/6 153/14 153/22 155/20 167/1 169/3 169/10 169/13 181/15 182/11 186/1 193/10 198/4 200/13 202/10 202/11 202/12 202/13 211/2 211/23 212/9 212/19 212/20 213/7 213/23 216/7 222/17
wouldn't [1] 130/24
writing [4] 3/10 15/5 66/7 156/6
written [23] 7/10 11/14 15/7 16/13 16/24 17/9 20/5 28/14 35/22 38/14 38/22 72/19 73/15 76/21 77/14 79/20 85/24 90/19 94/24 113/20 147/23 160/17 178/4
wrong [18] 29/18 30/15 61/9 64/16 65/19 65/22 97/19 98/21 98/23 110/12 131/24 147/3 147/18 147/18 153/19 155/21 193/24 200/19
wrong-headed [1] 200/19
wrongly [2] 45/17 152/20
wrote [1] 198/5

Y

year [9] 33/25 66/2 71/7 74/19 80/5 163/2 198/2 219/19 221/13
years [13] 23/4 26/20 32/19 35/10 65/1 74/6 81/18 86/12 97/20

Y

years... [4] 115/11 200/3 200/4 204/22
years' [1] 80/1
yes [4] 65/10 149/10 175/17 223/2
yesterday [7] 7/10 58/1 63/8 63/15 64/11 188/3 193/17
Yesterday's [1] 156/5
yet [21] 53/22 62/16 65/2 66/3 70/9 72/11 108/19 114/7 115/8 125/2 151/12 176/23 179/3 182/7 184/13 189/25 191/1 192/25 206/2 208/7 215/8
you [179] 1/4 1/6 1/13 1/22 1/25 2/3 2/8 9/1 10/16 10/18 10/25 12/22 13/10 13/11 13/12 13/16 14/8 14/10 14/11 14/14 15/1 22/13 22/16 22/17 22/17 22/21 23/17 23/17 25/1 25/1 33/8 33/9 37/25 38/1 38/7 49/2 49/4 49/8 58/18 58/19 59/4 59/5 59/10 59/11 59/11 59/15 60/17 60/17 60/21 61/8 61/14 61/19 62/18 62/19 62/20 62/21 63/4 63/7 63/14 64/6 65/4 65/7 65/9 65/12 65/16 65/25 67/16 69/15 69/25 70/16 71/4 71/14 71/20 72/1 72/2 72/3 73/10 78/14 88/24 89/1 89/5 91/25 95/7 95/8 95/9 95/13 104/10 104/11 106/19 106/20 106/23 106/24 107/2 107/7 107/11 108/9 110/13 120/18 120/19 120/21 121/4 121/6 130/8 130/20 131/4 131/4 131/5 131/11 133/22 134/8 134/16 139/18 139/25 142/14 143/23 145/8 145/9 146/10 146/11 146/14 147/14 148/5 149/3 149/5 151/4 151/13 151/15 153/20 154/15 157/2 158/2 158/8 158/24 160/23 160/24 160/25 161/2 161/4 161/6 168/5 169/21 172/20 175/6 175/7 175/8 175/16 180/22 180/23 181/16 184/2 185/22 193/25 194/1 194/4 195/25 200/23 201/4 204/7 207/4 207/8 207/9 207/10 207/14 208/4 209/9 212/18 216/22 217/2 217/21 219/3 220/16 220/19 221/7 222/3 222/11 222/21 222/22 223/2 223/3
you adopt [1] 217/2
you know [3] 71/14 107/11 145/9
You'd [1] 33/8
you'll [3] 106/22 144/1 145/8
you're [8] 8/12 14/13 107/5 139/8 166/15 171/5 185/22 204/6
you've [12] 4/18 8/4 12/13 13/2 88/19 88/20 89/9 140/8 153/12 159/7 191/6 192/4
young [29] 172/19 178/17 185/7 185/10 185/21 186/1 186/5 186/10 186/19 186/23 187/2 187/15 188/5 188/6 188/9 188/12 194/8 194/18 195/8 196/22 197/18 197/20 197/22 202/9 204/14 204/19 205/18 206/18 207/6
younger [1] 212/2
your [49] 13/8 14/9 23/14 23/17 31/7 37/18 55/5 60/19 60/21 62/5 62/24 63/8 63/20 63/25 70/16 78/13 88/20 89/8 89/8 91/19 95/9 95/14 95/18 95/21 97/6 99/5 101/1 103/16 106/1 106/24 120/16 130/22 130/23 146/12 146/13 147/2 147/7 147/14 158/9 158/20 158/24 160/15 160/22 164/21 164/21 169/22 171/10 204/7 221/7
your Ladyship [10] 89/8 91/19 95/18 95/21 97/6 99/5 101/1 103/16 106/1 169/22
Yousaf [3] 187/22 213/5 213/18
Yousaf's [1] 214/11

Z

Ziggy [1] 162/4